IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010/2404

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: GERARD ALEXANDER TIBBALLS

Hearing Dates:	7 March 2013 and 26 April 2013
Appearances:	Mr Trevor Wraight of Counsel on behalf of Ms Tonee Skipper and Associate Professor James Tibballs
	Mr Sean Cash of Counsel on behalf of Dr Anthony Taranto
	Mr Scott Smith of Counsel on behalf of Dr Noah Diner
Police Coronial Support Unit:	Senior Constable Remo Antolini - Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	8 December 2014
Delivered at:	Coroners Court of Victoria
	65 Kavanagh Street
	Southbank VIC 3006

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of **GERARD ALEXANDER TIBBALLS**

AND having held an inquest in relation to this death on 7 March 2013 and 26 April 2013

at the Coroner's Court of Victoria sitting at MELBOURNE

find that the identity of the deceased was **GERARD ALEXANDER TIBBALLS**

born on 5 October 1943

and the death occurred on 25 June 2010

at 15 Wordsworth Street, Moonee Ponds, 3039

from:

1(a) PERITONITIS

1(b) BOWEL PERFORATION SECONDARY TO SMALL BOWEL OBSTRUCTION CAUSED BY INTRA-ABDOMINAL ADHESIONS

in the following summary of circumstances:

1. On 7 March 2013 and 26 April 2013, an inquest under section 52(1) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Mr Gerard Alexander Tibballs.[2] Whilst the circumstances of Gerry's death do not warrant a mandatory inquest, I determined that a discretionary inquest was warranted to assist me with making my statutory findings, in particular the circumstances in which his death occurred.

[2] Mr Tibball's family requested that he be referred to as "Gerry" during the course of the inquest. For consistency, I have, in most part, avoided formality and also referred to him only as Gerry throughout the Finding.

2. Gerry was born on 5 October 1943. He was 66 years old at the time of his death. He lived with his partner, Ms Tonee Skipper, in Moonee Ponds, and was employed as a draftsman. Gerry generally enjoyed good health and was fit and active. He was not the type of person to burden others with his ailments, however, if he ever felt ill, it was generally related to stomach problems. There was no indication of major ongoing medical issues. Many years prior, Gerry underwent an operation to have his appendix removed.

BACKGROUND AND CIRCUMSTANCES

3. On 15 June 2010, Gerry told Ms Skipper that he was feeling unwell, and had been suffering vomiting and diarrhoea. He advised her that he had been to see a doctor and had been diagnosed with an infection. He was prescribed antibiotics, and was unable to work for the remainder of the week due to his illness, however, he was not bed ridden.[3]

4. On 19 or 20 June 2010, Gerry advised Ms Skipper that he had finished his course of antibiotics. Ms Skipper noticed that Gerry looked better, and described him as being up to "60% of his normal health".[4]

5. On 23 June 2010, Gerry attended at the Flemington Medical Centre, 9 Princes Street, Flemington, and consulted with Dr Noah Diner. Gerry advised Dr Diner that he had been suffering vomiting and diarrhoea in the previous ten days, but these symptoms had ceased the day before. Gerry denied being in pain, and he did not have a raised temperature. Upon examination, Dr Diner observed abdominal distension and generalised abdominal swelling, but no evidence of any masses, or an enlarged liver or spleen.[5] Dr Diner suspected a bowel obstruction, and referred him to the Future Medical Imaging Group (FMIG) in Moonee Ponds for an X-ray. Dr Diner completed a request form for an X-ray of Gerry's abdomen. The Clinical Notes on the request form stated, *"Abdominal pain + vomiting ? bowel obstruction ? other"*.[6] Dr Diner did not mark "urgent" on the request form. Dr Diner prescribed Gerry with Maxolon[7] for his nausea, and asked him to return the next day for the X-ray results.[8]

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[3] Exhibit 1 – Statement of Ms Tonee Skipper, dated 16 December 2010.

[4] Ibid.

[5] Exhibit 5 – Statement of Dr Noah Diner, dated 28 October 2010.

[6] Exhibit 8 – *Future Medical Imaging Group Request Form,* dated 23 June 2010 – Balance of Inquest Brief, p33.

[7] Maxolon (metoclopramide) is a drug used to treat nausea and vomiting associated with various conditions.

[8] Exhibit 5 – Statement of Dr Noah Diner, dated 28 October 2010.

6. At approximately 12.38pm on 23 June 2010, Gerry attended at the FMIG, and an X-ray was performed by a radiographer. At 1.12pm, Gerry left the clinic before receiving the results of the X-ray. Between 1.12pm and 1.23pm, the X-ray results were reviewed by Radiologist, Dr Anthony Taranto. Dr Taranto discovered findings consistent with a small bowel obstruction. Dr Taranto knew that these findings were serious and marked the report as "urgent" so that the results could be typed and forwarded to Dr Diner without delay. Sometime between 1.32pm and 1.52pm, Dr Taranto telephoned Dr Diner and communicated the results of the X-ray. Dr Diner requested that Dr Taranto call Gerry and advise him of the results. At 1.52pm, the X-ray report was distributed electronically to Dr Diner's clinic. The X-ray report conclusion stated, *"Marked small bowel distension with air fluid levels consistent with small bowel obstruction or intestinal ileus. Surgical referral is recommended".*[9] At 1.56pm, Dr Taranto telephoned Gerry with the intention of communicating the results to him personally, however, Gerry did not pick up the phone. Dr Taranto left a message on Gerry's voicemail.[10]

7. Later that day, Gerry advised Ms Skipper that he had been to see a doctor and had an X-ray performed. He told her that he was returning to the doctor the next day for the results. During this conversation, Ms Skipper recalls that Gerry mentioned that he may have a "blockage".[11] Ms Skipper confirmed that she observed a sealed envelope containing X-rays at their house.[12]

8. On 24 June 2010, Ms Skipper returned home and found Gerry lying on the bed fully clothed. He told her that he had missed his doctor's appointment because he fell asleep. Ms Skipper noticed that Gerry was looking very pale, and told him that she was going to call an ambulance. Gerry told her emphatically that he did not want an ambulance called. He asked her to get him some Voltaren and Hydrolyte, which she did. Later in the evening, Ms Skipper became aware that Gerry was suffering stomach cramps.[13]

9. On the morning of 25 June 2010, Ms Skipper offered to take Gerry to the doctor but he refused. Later that afternoon, Ms Skipper noticed that Gerry was looking much worse, and

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[9] Exhibit 8 – *Future Medical Imaging Group Report*, dated 23 June 2010 – Balance of Inquest Brief, p37.

[10] Exhibit 3 – Statement of Dr Anthony Taranto, dated 18 January 2011.

[11] Exhibit 1 – Statement of Ms Tonee Skipper, dated 16 December 2010.

[12] Transcript of evidence, p6.

[13] Exhibit 1 – Statement of Ms Tonee Skipper, dated 16 December 2010.

insisted on calling an ambulance. Gerry told her to hold off calling an ambulance until after peak hour had ended. Ms Skipper fixed up the doona Gerry was lying under, and he asked her to ensure that the doona clips were not near his stomach.[14]

10. At approximately 5.15pm, Ms Skipper heard a noise from the bedroom. She entered and found Gerry on the floor leaning against the bed. He had been vomiting into a bucket, and Ms Skipper observed that the vomit was black. Ms Skipper immediately called emergency services. When she re-entered the bedroom, Gerry was unresponsive and was not breathing. Ambulance paramedics arrived, however, Gerry could not be revived.[15]

INVESTIGATION

Identity

11. The identity of Gerard Alexander Tibballs was without dispute and required no additional investigation.

The medical investigation

12. On 1 July 2010, Dr Mikkaela McCormack, Pathology Registrar at the Victorian Institute of Forensic Medicine (VIFM), performed an autopsy on the body of Gerry under the supervision of Dr Melissa Baker, Forensic Pathologist. Findings included evidence of acute peritonitis[16] with evidence of faeculent fluid[17] within the peritoneal cavity, and fibrino-purulent exudate[18] covering both the small and large bowels, mesentery,[19] liver and pancreatic surfaces; a small bowel obstruction; intra-abdominal adhesions with extensive involvement of the small bowel, and also involving the large bowel, right abdominal wall, right hemi-diaphragm[20] and the liver. Cultures of post-mortem peritoneal swabs showed the presence of multiple bacteria consistent with peritonitis. Biochemistry results showed

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[14] Ibid.

[15] Exhibit 1 – Statement of Ms Tonee Skipper, dated 16 December 2010.

[16] Peritonitis is an inflammation of the peritoneum, the thin tissue that lines the inner wall of the abdomen and covers most of the abdominal organs.

[17] Faeculent (feculent) means the nature of, or containing, waste matter.

[18] Fibrino-purulent is characterised by the presence of both fibrin and pus. Fibrin is a fibrous, non-globular protein involved in the clotting of blood. Exudate is fluid, cells or other substances that have been slowly exuded, or discharged, from cells or blood vessels through small pores or breaks in cell membranes.

[19] The mesentery is a fold of visceral peritoneum that anchors the abdominal viscera to the posterior wall of the abdomen.

[20] The right hemi-diaphragm is the right half of the diaphragm, the muscle that separates the chest cavity from the abdomen that serves as the main muscle of respiration.

findings consistent with a degree of renal impairment. Dr McCormack ascribed the cause of Gerry's death to acute peritonitis, which had most certainly occurred in the setting of a small bowel perforation, which has complicated a small bowel obstruction caused by intra-abdominal adhesions. Dr McCormack stated that the most common cause of intra-abdominal adhesions is prior abdominal surgery. She believes it is likely that Gerry's appendectomy led to the formation of the intra-abdominal adhesions. These adhesions led to a small bowel obstruction and a micro-perforation of the bowel, and the subsequent development of peritonitis.[21]

INQUEST

Jurisdiction

13. The role of the coronial system in Victoria involves the independent investigation of deaths to determine the cause of death, to contribute to the reduction of the number of preventable deaths and for the promotion of public health and safety and the administration of justice.

14. Section 67 of the *Coroners Act 2008* sets out the statutory role of the Coroner in that a Coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

15. A Coroner may comment on any matter connected with the death and may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[22]

Evidence at Inquest

16. *Viva voce* evidence was obtained from the following witnesses at the Inquest:

- Ms Tonee Skipper
- Dr Melissa Baker, Forensic Pathologist at the VIFM
- Dr Anthony Taranto, Radiologist at the FIMG
- Associate Professor Morton Rawlin, Medical Practitioner; and
- Dr Noah Diner, General Practitioner.

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[21] Exhibit 2 – Autopsy Report of Dr Mikkaela McCormack, dated 26 August 2010.

[22] Section 72(1) and (2) of the *Coroners Act 2008* (Vic).

17. Ms Skipper gave evidence that she had known Gerry for 31 years. She described him as being "stoic", and on the occasions he did feel ill, he would still get up and get on with his daily activities.[23] She could not confirm when Gerry had his appendix removed, except to say that it occurred before she knew him.[24] She stated that Gerry often suffered stomach upsets and queasiness, however, he would never elaborate further than to say he was not feeling well.[25] She stated that from 15 June 2010 until 23 June 2010, Gerry was out of bed and dressed every day, and it was not until 24 June 2010, that Gerry appeared very unwell.[26] Ms Skipper believed that Gerry was taking Voltaren for pain during this period, but she could not give evidence about how much he was taking, or how frequently he was taking it.[27]

18. Dr Baker gave evidence that the adhesions identified at autopsy can cause the bowel to twist on itself and cause an obstruction. However, the exact site of a bowel obstruction is not typically identified at autopsy due to the processes involved in conducting an autopsy. The process can result in the entire bowel being twisted, and in this circumstance, it was not possible to identify the site of the obstruction. She confirmed that the adhesions were located on the right side of the small bowel, and were likely linked to the previous appendectomy. She stated that adhesions are a common cause of small bowel obstruction.[28]

19. Dr Baker could not state when the perforation occurred, however, given the extent of fibro-purulent exudate (pus) over the surface of the bowel and organs, she was of the opinion that it would have been present for at least several hours. Dr Baker opined that it is possible that if it was a small and slow leak, it may have built up over several days.[29]

20. Dr Taranto gave evidence that bowel perforations cannot always be identified in X-rays. He stated that it is entirely possible that the perforation was present during the X-ray taken at

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[23] Transcript a of evidence, p7.

[24] Transcript of evidence, p5.

[25] Transcript of evidence, p4.

[26] Transcript of evidence, p7.

[27] Transcript of evidence, p10.

[28] Transcript of evidence, p13-14.

[29] Transcript of evidence, p15.

the FIMG, but it could not be detected due to the limitations in X-ray technology and the very small amount of gas that comes out of the small bowel when there is an obstruction. Dr Taranto stated that if he had seen free gas on the X-ray, he would have considered the situation extremely urgent.[30]

(a) Management by Dr Anthony Taranto

21. Dr Taranto gave evidence of the usual procedure undertaken when a patient comes in for an X-ray, and what is expected of the relationship between the referring doctor and the Radiologist. Dr Taranto stated that when a patient comes in with a referral marked "urgent", the patient is asked to stay at the clinic after their X-ray has been performed, so that the results can be reviewed by the Radiologist and a report typed up while the patient is still present. The patient is then given the report and their X-ray films, and instructed to return to their doctor. [31] If unexpected or serious results are found, Dr Taranto stated that the process of "raising the alarm" was up to him. He stated that his practice was to ring the referring doctor to advise them of the findings, and to prioritise the typing of the report and send the results to the doctor without delay.[32] It is not generally expected that the Radiologist would ring the patient with results.[33] Dr Taranto stated that in instances where he does contact a patient with urgent results, he tells the patient to return to their referring doctor rather than go directly to hospital. He does this because he prefers that patients have the results explained to them by their doctor, who is ultimately better placed to manage a patient than he is.[34] He stated that he is reluctant to give medical advice to a patient that is outside of his field of diagnostics.[35] Dr Taranto stated that the only circumstances in which he would instruct a patient to go directly to hospital, was if he was aware that there was no prospect of the patient being able to consult with their treating doctor, such as, if it was outside of a medical centre's business hours or the doctor was not available.[36]

22. When Gerry arrived at the FIMG his referral was not marked "urgent", and therefore, he was not asked to stay at the clinic to await the results. By the time Dr Taranto reviewed the

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[30] Transcript of evidence, p32-33.

[31] Transcript of evidence, p18.

[32] Transcript of evidence, p30.

[33] Transcript of evidence, p41.

[34] Ibid.

[35] Transcript of evidence, p42.

[36] Ibid.

X-rays, Gerry had already left the clinic.[37] Dr Taranto described the results of the X-ray as "unexpected" because he believed that it was a routine X-ray as it had not been marked "urgent". When he reviewed the X-ray films, he realised it was serious and prioritised the case as urgent.[38] He started the process of having the report typed and sent to Dr Diner's clinic electronically.[39] He stated that he rang Dr Diner after he had verified the results of the X-ray at 1.32pm, but before they were sent to Dr Diner electronically at 1.52pm.[40] Dr Taranto confirmed that he spoke to Dr Diner directly on the telephone, and told him that the X-ray results confirmed a bowel obstruction. He stated that Dr Diner specifically requested him to call Gerry himself. Dr Taranto's recollection of the telephone call was that Dr Diner asked, *"Could you send the patient to hospital or send the patient back to me?"*.[41] Dr Taranto stated that he told Dr Diner that he would send Gerry back to him.[42] Dr Taranto denies the assertion that Dr Diner requested him to send Gerry to the hospital only. Dr Taranto stated that he did not tell Dr Diner that he would advise Gerry to go to the hospital.[43]

23. Dr Taranto accepted that he did not call Dr Diner back to advise that he had not spoken to Gerry personally, however, Dr Taranto is of the opinion that Dr Diner was not entitled to assume that he had advised Gerry to go to the hospital.[44] Dr Taranto stated that he did not believe that he had accepted the full duty of care of Gerry when he had the conversation with Dr Diner. When he left the message for Gerry, he was acting in accordance with his standard practice, which was to tell the patient to return to their treating doctor.[45]

24. Dr Taranto gave evidence that he rang Gerry, and recalls being put through to Gerry's voicemail. Dr Taranto stated that the message he left advised Gerry that there were serious findings on the X-ray that needed attention. He instructed Gerry to return to the FIMG to

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[37] Transcript of evidence, p18.

[38] Transcript of evidence, p30.

[39] Ibid.

[40] Transcript of evidence, p35.

[41] Ibid.

[42] Ibid.

[43] Transcript of evidence, p37.

[44] Transcript of evidence, p44.

[45] Transcript of evidence, p47-48.

collect the X-rays and then go straight to his doctor.[46] Ms Skipper's evidence that she saw Gerry with the X-rays at their home, suggests to Dr Taranto that Gerry did indeed return to the FIMG and collected his X-rays, as there was no way possible that Gerry could have left the clinic with them immediately after he had his X-ray performed.[47] This also suggests to Dr Taranto that Gerry received the voicemail message, as it would be very unusual for a patient to return and pick up X-rays on their own accord.[48] Patients are not expected to collect their own X-rays unless they are specifically instructed,[49] with the general practice being that X-rays that are not marked "urgent" are collected from the clinic and delivered by courier to the referring doctor within 24 hours.[50]

25. The Court requested Dr Christopher O'Donnell, Diagnostic Radiologist at the VIFM, to provide an opinion on the radiological imaging of Gerry, and specifically to comment on the abdominal radiographic findings. Dr O'Donnell opined that the appearances on the X-ray are consistent with either a small bowel or large bowel obstruction with no features of a bowel perforation present. He reported that the radiographic findings were significant and potentially life threatening. Dr O'Donnell is of the opinion that results such as these should be conveyed to the referring clinician as soon as practical, and he is satisfied that Dr Taranto actions fulfilled his clinical obligation to convey the results to Dr Diner.[51]

(b) Management by Dr Noah Diner

26. Dr Diner gave evidence that during the consultation, Gerry denied any history of significant illnesses or prior medical conditions.[52] During the examination of Gerry's abdomen, Dr Diner did not observe the scar from Gerry's appendix operation.[53] Dr Diner stated that he suspected that Gerry was suffering from a bowel obstruction, but he was not absolutely certain, which is why he ordered the X-ray.[54] Dr Diner stated that he recalls telling Gerry that the X-ray was necessary to exclude a bowel obstruction, however, he may have used the

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[46] Transcript of evidence, p26.

[47] Transcript of evidence, p27 and p33.

[48] Transcript of evidence, p33-34.

[49] Transcript of evidence, p46.

[50] Transcript of evidence, p33.

[51] Exhibit 8 – Balance of Inquest Brief – Statement of Dr Christopher James O'Donnell, dated 7 June 2011, p29.

[52] Transcript of evidence, 84.

[53] Transcript of evidence, p90.

[54] Transcript of evidence, p84.

term "blockage". He also recalls telling Gerry that it was a very serious matter, and to return to see him with the X-ray results, or go directly to hospital if the symptoms got worse. Dr Diner stated that at the time of the examination Gerry looked relatively well, so he felt it was appropriate to have Gerry return to him the following day.[55] Dr Diner confirmed that he did not mark the X-ray request "urgent", because at the time he was not aware what effect marking "urgent" on the request had. It was his understanding that X-rays were performed immediately, so there was no need to mark a request "urgent".[56]

27. Dr Diner stated that he does not remember his conversation with Dr Taranto word for word, however, he recalls being "fairly vocal" in telling Dr Taranto that Gerry needed to go to the hospital.[57] Dr Diner stated that during the telephone call, Dr Taranto advised that he was not sure if Gerry was still at the clinic, however, he agreed to contact Gerry by telephone. Dr Diner stated that Dr Taranto did not say what he would tell Gerry.[58] Although he does not specifically recall it, Dr Diner conceded that it is likely that Dr Taranto did in fact say that Gerry would be advised to return to him.[59] Dr Diner stated that either referring Gerry back or sending him to the hospital would be appropriate instructions in the circumstances.[60] Dr Diner stated that he did not call Dr Taranto back to ensure that Gerry had been spoken to, however, he would have expected that Dr Taranto would have called him back if he had been unable to contact Gerry.[61] He stated that he assumed that Dr Taranto had spoken to Gerry because he did not hear back from Dr Taranto advising otherwise. He further assumed that, because Gerry did not come back to see him, Gerry had gone to the hospital or sought assistance from another doctor.[62] He based this assumption on the belief that Gerry had spoken to Dr Taranto, and would follow medical advice to attend hospital.[63]

28. Dr Diner gave evidence that he is of the view that if a patient is still at the Radiologist's clinic, it is of benefit to the patient to have their results communicated by the Radiologist,

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[55] Transcript of evidence, p91.

[56] Transcript of evidence, p85.

[57] Transcript of evidence, p88.

[58] Transcript of evidence, p86.

[59] Transcript of evidence, p87.

[60] Transcript of evidence, p86-7.

[61] Transcript of evidence, p100.

[62] Transcript of evidence, p94 and 95.

[63] Transcript of evidence, p98.

rather than return to see him, so the patient can be informed of the results immediately. However, he conceded that as the primary physician, he has the major role in the care of the patient.[64]

29. Dr Diner gave evidence that he is aware that once a bowel obstruction is diagnosed, it is a medical emergency, and requires admission into hospital.[65] Dr Diner agreed that if Gerry had been admitted to hospital on 23 June or 24 June, Gerry's death could have been prevented.[66] Dr Diner conceded that, in hindsight, he should have made further enquiries.[67]

30. Dr Diner acknowledged that there was a "glaring error" in not having Gerry's telephone number or next of kin details.[68] He stated that obtaining patient details was the responsibility of the reception staff, and since this incident, he now ensures that this has been done when consulting with the patient.[69] Dr Diner stated that he was aware of the methods a practitioner could use to contact a patient in an emergency, and in this case, he would have contacted the FIMG to obtain Gerry's number or searched the White Pages.[70]

(c) Expert opinion concerning the clinical management of Gerry by Dr Diner

31. The Court requested Associate Professor (A/Prof) Morton Rawlin to provide an expert opinion concerning the clinical management of Gerry by Dr Diner. In his statement,[71] A/Prof Rawlin was of the opinion that Dr Diner's initial treatment of Gerry – further investigation (X-ray), prescribing an antiemetic,[72] and treatment with advice and clear fluids – was appropriate. He stated that normal practice would be to warn the person to either return to the doctor's clinic or present to hospital if symptoms worsened. A/Prof Rawlin was of the opinion that in circumstances of serious illnesses that require definitive treatment, it would have been prudent to ensure that the patient was notified in a timely manner. He

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[64] Transcript of evidence, p94.

[65] Transcript of evidence, p91.

[66] Transcript of evidence, p96.

[67] Transcript of evidence, p95.

[68] Transcript of evidence, p88.

[69] Transcript of evidence, p95.

[70] Transcript of evidence, p88-89.

[71] Exhibit 4 – Statement of Associate Professor Morton Rawlin, dated 29 November 2011.

[72] An antiemetic is a drug used to treat nausea and vomiting.

stated that leaving a voicemail message is insufficient and ill advised. A/Prof Rawlin stated that further attempts to contact Gerry to discuss his clinical status should have occurred.[73]

32. In his *viva* voce evidence A/Prof Rawlin stated that a number of options are open to medical practitioners to enable them to contact patients in an emergency. These include repeated calls to the patient, contacting known next of kin, express or registered mail, or in extreme circumstances, they could ask the police to locate a patient. A/Prof Rawlin stated that if he was presented with a similar case to Gerry's, he would continue to try to contact Gerry, and would be concerned if no contact was made within 24 hours.[74]

33. A/Prof Rawlin believes that a difficulty arose because Dr Taranto agreed to call Gerry. That conversation, in effect, "muddied the waters" because it became unclear as to who was taking over the care of the patient.[75] A/Prof Rawlin is of the opinion that generally it is the General Practitioner who retains the duty of care, and it would have been prudent for Dr Diner to make a follow up telephone call to Gerry to ensure that he was aware of the situation.[76] A/Prof Rawlin stated that in situations where he knows a Radiologist has spoken to a patient, he would expect a follow up telephone call from the Radiologist confirming that they have spoken to the patient. A/Prof Rawlin is of the opinion that it was not prudent for Dr Diner to assume Gerry went to the hospital, and he should have called Gerry to ensure the information got through to him.[77]

34. A/Prof Rawlin stated that it is not unreasonable for a Radiologist to send a patient back to their treating doctor rather than the hospital. It is an advantage to a patient, because there is an opportunity for their doctor to "triage" them. For example, the doctor can refer a patient to a private hospital, where they can receive treatment sooner and be admitted directly under the care of a surgeon, rather than wait for hours in an Emergency Department.[78] Also, it is of benefit for a doctor to speak personally to the patient so that they can ensure a patient understands the seriousness of their condition, especially in situations where a patient is known to avoid medical treatment and minimise symptoms. A/Prof Rawlin believes that a

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[73] Exhibit 4 – Statement of Associate Professor Morton Rawlin, dated 29 November 2011.

[74] Transcript of evidence, p54.

[75] Ibid.

[76] Transcript of evidence, p55 and 56.

[77] Transcript of evidence, p57.

[78] Transcript of evidence, p61-62.

voicemail message would not have been sufficient to emphasise the gravity of a situation to such a patient.[79]

35. A/Prof Rawlins was shown the Patient Record relating to Gerry from Dr Diner's practice.[80] It was noted that Gerry's telephone number was omitted from his contact details, and no next of kin was named. A/Prof Rawlins stated that it is an oversight of the practice, and clinics need to ensure that they have full and up to date details of their patients. He stated that it is an easy thing for a doctor to miss, but he believes that it is something that should be checked.[81]

36. A/Prof Rawlin stated that an obstruction in the small bowel is a variable entity. Sometimes symptoms can arise quickly, other times it can take a period of time for symptoms to arise and become visible on an X-ray. He stated that in his experience, small bowel obstructions tend to be a slow course, which then reach a point where they become clinically obvious.[82] He stated that as long as there is no perforation, the chances of survival are very good, however, once a perforation occurs, it becomes an emergency situation, and there is a significant chance of death occurring.[83] He stated that small bowel obstructions usually require an admission to hospital for three to four days.[84] A/Prof Rawlin is of the opinion that Gerry's presentation at his consultation with Dr Diner indicated that it was unlikely that the perforation was present on 23 June or 24 June, however, he believes that if Gerry had been admitted to hospital prior to his collapse on 25 June, his death may have been preventable.[85]

Submissions

37. At the conclusion of the Inquest, Counsel appearing on behalf of Interested Parties and the Coroner's Assistant provided final submissions, which I have considered for the purposes of these Findings.

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[79] Transcript of evidence, p76.

[80] Exhibit 7 – *Complete Record.*

[81] Transcript of evidence, p73.

[82] Transcript of evidence, p59.

[83] Transcript of evidence, p77-78.

[84] Transcript of evidence, p65-66.

[85] Transcript of evidence, p69.

Application of the relevant law

38. It is not the role of a Coroner to lay or apportion blame however, from time to time it is necessary to conclude on the evidence that certain conduct/behaviours/intervention could have prevented a death. In such cases these conclusions may form part of the Findings on the cause of death and the circumstances in which the death occurred. Calloway JA stated in *Keown v Kahn*:[86]

> *In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was a breach of a recognised duty.*

39. The standard of proof for coronial findings of fact is the civil standard, on the balance of probabilities as expounded in *Briginshaw.*[87] Coroners should not therefore make adverse comment about or findings against individuals unless the evidence provides a comfortable satisfaction that their departure from the prevailing standards of their profession, has caused or contributed to the death under investigation.

FINDINGS

1. I find the identity of the deceased is Gerald Alexander Tibballs.
2. I accept and adopt the medical cause of death as identified by Dr Mikkaela McCormack and find that Mr Gerald Alexander Tibballs died from peritonitis, in the setting of a bowel perforation secondary to small bowel obstruction caused by intra-abdominal adhesions.
3. I accept the evidence of Ms Skipper that she observed X-rays at their residence. I therefore accept that Gerry received Dr Taranto's voicemail message. The difficulty I am left with is knowing whether Gerry was fully aware of the severity of his condition. There is no evidence to suggest that he was aware that his condition was life threatening. I find that, despite his stoicism, if Gerry was aware that his life was in imminent danger, he would have accepted Ms Skipper's offers to call an ambulance.

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[86] (1999) VR 69 at 76.

[87] *Briginshaw v Briginshaw (1938) 60 CLR 336 @ 362-363.* " The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

4. I accept the evidence of Dr Taranto that a patient is better served returning to their General Practitioner for confirmation of their diagnosis. I find that Dr Taranto fulfilled his clinical obligation as a Radiologist to communicate the urgent results to Dr Diner. It would have been preferable for Dr Taranto to have advised Dr Diner that he did not speak directly to Gerry, but that omission does not absolve Dr Diner of his responsibilities. Despite Dr Taranto not speaking directly to Gerry, the evidence suggests that Gerry did receive the voicemail message as he appears to have returned to the clinic and obtained his X-rays.

5. In the circumstances, I make no adverse finding against Dr Taranto.

6. I find that there was a serious departure from prevailing standards of responsibility for continuum of care of Gerry by Dr Diner. Dr Diner was fully aware of the seriousness of the situation, and knew that Gerry needed to be hospitalised. It was a serious departure of responsibility for continuum of care for Dr Diner to attempt to pass this responsibility onto Dr Taranto. I find that the primary care of Gerry remained with Dr Diner, and he was unable to relinquish himself from that position. It was incumbent upon Dr Diner to take reasonable steps to ensure that Gerry was aware of the gravity of his condition, and adhere to medical advice. Dr Diner could not have forced Gerry to attend hospital if he was determined not to go, however, he was obliged to ensure that Gerry was able to make an informed decision about his treatment. A reasonably prudent medical practitioner in these circumstances would have, at the very least, made the call, if for no other reason than to inform themselves that their patient was cognisant of their critical condition and the need to obtain urgent medical attention.

7. It is difficult to reconcile Dr Diner's evidence of his knowledge of Gerry's condition, with his failure to make urgent attempts to obtain Gerry's contact details from the FIMG.

8. At the consultation on 23 June 2010, Dr Diner suspected that Gerry had a bowel obstruction, which he knew was a life threatening condition requiring urgent treatment, yet he took no steps to ensure he had Gerry's contact details should the suspected diagnosis be confirmed. Dr Diner's failure to obtain or ensure he had, basic contact details of a patient he suspected of having a life threatening condition fell short of what is reasonably to be expected of a reasonably prudent general medical practitioner in the same circumstances.

9. I find that Dr Diner departed from a norm or prevailing standard of his profession by making an assumption that Gerry had gone to the hospital. This assumption was not based on any evidence that was reasonably open to him. He omitted to take reasonable steps to ensure his

patient, whom he knew had a life threatening condition, was himself aware of the urgency and/or at a facility where he could receive appropriate treatment.

10. In all of the circumstances, I find Dr Diner's omissions causal.

11. I note that Dr Diner accepted that he was the primary physician vested with the definitive care of Gerry[88] and that in hindsight, he should have made further enquiries to ensure that the relevant information had been conveyed to his patient given the seriousness of his condition.[89] What is more important however, with regards to my statutory prevention role, is that following Dr Diner's evidence and submissions, I was not convinced that he appreciated the gravity of his acts or omissions, referring to them rather as "reasonable assumption[s]".[90]

12. In considering the totality of the evidence, I find that it has been proved to a *reasonable satisfaction*[91] the death of Gerry could have been prevented. His death was foreseeable, and the acts and/or omissions of Dr Diner contributed to the fatal consequences. Although Gerry was known to downplay his medical issues, and perhaps unduly suffer, I find no evidence to suggest that Gerry would not have followed medical advice if he knew that his life was in immediate danger. Gerry was denied the opportunity to make his own decision regarding his treatment.

13. Dr Diner's lack of attention to the management of Gerry is not reflective of the standard the Victorian public expect of their trained medical professionals. Accordingly, I direct that a copy of these findings be provided to Dr Diner's professional and regulatory bodies.

14. I make no recommendations in this matter as the circumstances relate to one particular practitioner and I consider it would be trite to recommend that a doctor ensures they have the contacts details of a patients they suspect have a life threatening condition or indeed that a medical practitioner follow up with these patients when a life threatening condition is confirmed.

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[88] Transcript of evidence, p 94, lines 10-12.

[89] Transcript of evidence, p 94-95.

[90] Transcript of evidence, p 127.

[91] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the findings be published on the internet in the absence of any objection to the same.

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

- Ms Tonee Skipper
- McNab and Starke, on behalf of Ms Skipper and Associate Professor James Tibballs
- Ms Mia Campbell, Avant Law, on behalf of Dr Anthony Taranto
- Ms Bronwyn Francis-Martin, Thomsons Lawyers, on behalf of Dr Noah Diner
- The Australian Health Practitioners Regulation Agency
- Royal Australasian College of Physicians
- Royal Australian College of General Practitioners; and
- Acting Sergeant Frank Cardi.

Signature:

AUDREY JAMIESON
CORONER
Date: **8 December 2014**