IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 5618

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: WILLIAM JOHN COLHOUN

Delivered On:	15 August 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Date:	6 – 7 August 2012
Findings of:	Iain West, Deputy State Coroner
Representation:	Mr S. Cash appeared on behalf of Dr Nixon and Dr Mossop Mr J. Goetz appeared on behalf of Dr Kelly
Police Coronial Support Unit:	Leading Senior Constable Kelly Ramsey was present to assist the Coroner.

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of WILLIAM COLHOUN

without holding an inquest:

find that the identity of the deceased was WILLIAM JOHN COLHOUN

born on 6 January 1937

and the death occurred 4 December 2008

at St Vincent's Private Hospital, 59 Victoria Parade, Fitzroy 3065

from:

1 (a) MULTI ORGAN FAILURE

1 (b) POST OPERATIVE BLEEDING

1 (c) ENDOLUMINAL THORACIC AND ABDOMINAL ANEURYSM REPAIR

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

1. Mr William Colhoun was a 71 year old man who resided in Tasmania and who was admitted to St Vincent's Private Hospital in Melbourne, on 30 November 2008, for endovascular surgery involving endografting and stenting of his thoracic-abdominal aneurysm. His past medical history included hypertension, pulmonary embolism in 2006, chronic obstructive pulmonary disease, and an extensive thoraco-abdominal aneurysm that extended down a large part of the aorta from the chest to the abdomen. This aneurysm together with the aortic abdominal aneurysm was diagnosed in January 2006. In April 2008, a CT angiogram showed the thoracic-abdominal aneurysm had increased to 68mm and the aortic abdominal aneurysm had increased 60mm.

2. Prior to Mr Colhoun's admission to St Vincent's Private Hospital, there had been extensive discussion about the most suitable approach to attempt to repair the aneurysm. Eventually it was decided to take an endothelium approach, that is, to attempt to stent/graft the aneurysm by internal approach through the iliac arteries rather than by open surgery. This was thought to pose less risk than an open procedure where the chest and abdomen would have been opened. It was an extremely complex procedure that required the production of a custom made graft for Mr Colhoun. This resulted in delays in the procedure being undertaken, as the process of producing the final graft is complex and can take up to 3 months in the best circumstances. Further delays occurred in this case due to rebuilding work that had to be undertaken at the angiographic laboratory at St Vincent's Hospital.

3. As previously indicated, Mr Colhoun was electively admitted to St Vincent's Private Hospital on 30 November 2008, under Thoracic Surgeon Mr Ian Nixon, who had admitting rights at the hospital. The procedure was performed by Dr Peter Mossop, Director of Interventional Radiology at the hospital, with Mr Nixon's assistance. Following the supplying of the graft by its manufacturer, Cook Australia, and discussion between Mr Colhoun and Mr Nixon regarding the complexity of the procedure, the necessary consent was obtained and it was performed on 1 December 2008. The procedure was lengthy as it needed to be undertaken in multiple steps, with it ultimately taking around 10 hours to complete. Grafts were placed in the thoracic aorta, lower thoracic aorta and abdominal aorta with stents implanted in renal and mesenteric arteries, via an endoluminal. The combination of the abnormal anatomy and the techniques involved, made the procedure extremely complex. In addition, concerns following surgery of this nature, included risks of stroke, paralysis, kidney impairment and bowel problems.

4. Post operatively Mr Colhoun was admitted to the Intensive Care Unit (ICU), where for the first four hours he was relatively stable. However, he became persistently hypotensive and intravenous fluids and Ino-tropic medications were commenced to maintain his blood pressure. By 7am on 2 December 2008, 13 litres of intravenous fluids and blood products had been administered, with Mr Colhoun developing a metabolic acidotic state, acute renal failure and coagulopathy. Mr Colhoun was commenced on renal dialysis for his deteriorating kidney function and at 10pm, re-angiography was performed which unexpectedly found a renal artery tear, with active haemorrhage. This complication of renal artery dissection due to a stent had never been seen before by Dr Mossop. The tear was stented, but the profound blood loss led to further deterioration and on 3 December 2008, after discussion with family, a "not cardiopulmonary resuscitation" order was initiated. On 4 December 2008 further discussion with the family determined the withdrawal of active management. Mr Colhoun subsequently died of 7.40am.

5. A death certificate was issued certifying the death as

    1 (a) Multi Organ Failure

    1 (b) Post Operative Bleeding

    1 (c) Endoluminal Thoracic and Abdominal aneurysm repair.

The death came to the attention of the Coroner following an attempt to register the death certificate with the Registrar of Births Deaths and Marriages. As 'post operative bleeding'

appeared on the death certificate the Registrar referred the matter to the Coroner, since it was a reportable death under the Coroners Act. As the death had not directly been reported to the Coroner, no autopsy was performed in this case. Following the reporting of the death by the Registrar, the family wrote to the Coroner raising a number of concerns, with the primary concern being the delay of the hospital to surgically intervene and determine the cause of the ongoing post operative instability. A further very distressing issue for the family is what was described as "the appalling lack of communication" between the doctors involved in Mr Colhoun's care and family members, who were attempting to get answers regarding care and management.

6. I am not satisfied on the evidence before me that there was unacceptable delay to surgically intervene and determine the cause of Mr Colhoun's post operative instability. There is almost an irresistible urge in these types of cases to rely on wisdom and hindsight to assess professional performances, after the patient's eventual medical outcome is known. Mr Colhoun presented a confusing picture with periods of stability, followed by deterioration, followed by stability and then further deterioration, from approximately 4pm on 2 December 2008. Dr Kelly (Intensive Care Physician) gave evidence that during Mr Colhoun's time in ICU he was considering a range of causes for his condition. They were:

    a. the possibility that one of the superior mesentery artery stems had become blocked and was restricting blood flow;

    b. the possibility of ischaemic valve;

    c. possible bleeding from canulant puncture sites in the retro perineum;

    d. the concern about poor infusion to the left kidney; and

    e. given issues associated with Mr Colhoun's mild aortic disease, a possibility of him having suffered a cardiac event.

He conceded that at 3am on 2 December 2008, had he known Mr Colhoun had a bleeding dissection, different action would have been taken. Whilst Mr Nixon believed that bleeding was the obvious cause, I do not believe that it was so clear that justified intervention at this point. In hindsight the logical explanation is there must have been a bleed, that stabilised before bleeding again.

7. The evidence supports a finding that there was appropriate interaction between Mr Nixon, Dr Kelly and Dr Mossop, even though contact could not always be made with Mr Nixon given his work schedule.

8. At the direction of the Coroner a review of Mr Colhoun's death was undertaken by the Court's Clinical Liaison Service.[1] The review team stated, "*Whilst there was some time taken to understand the cause of Mr Colhoun's deterioration, during this period many treatments were instigated and reviews were undertaken. Mr Colhoun was reviewed by the intensivists, Mr Nixon, Dr Mossop, a general surgeon for ischaemic valve as a cause of deterioration and a neurosurgeon, regarding possible spinal cord problems resulting from impaired blood supply to spinal cord. Although Mr Nixon was critical of this and says that, in retrospect, blood loss was clearly the cause, it would seem that experienced intensivists and surgeons and other clinicians did not expect the renal artery bleed. This appears to have been a rare complication of an extremely complex procedure and the management appears to have been reasonable, despite the delay in diagnosis*". In these circumstances and in the absence of any contrary expert opinion, I am satisfied that the management and treatment of Mr Colhoun was within the parameters of reasonable health care practice.

9. Sadly the family description of there being an appalling lack of communication between the medical staff and the family is supported by the evidence. Neither, Dr Kelly, Mr Nixon or Dr Mossop took the time after the death of Mr Colhoun to sit with the family and discuss the reason for his death. During the course of his post operative management, it was approximately 30 hours after surgery that Dr Mossop called the family to advise that they had discovered a bleed. This was the first contact to offer any explanation regarding the procedure itself and its success or otherwise and of Mr Colhoun's progress within ICU. Dr Mossop apologised for not speaking to the family earlier as he thought Mr Nixon had spoken to them. Mr Nixon apparently thought that Dr Mossop had spoken to the family; neither had.

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[1] The Clinical Liaison Service (now called Health and Medical Investigation Team, HMIT) is a unique initiative of the Coroners Court of Victoria and the Victorian Institute of Forensic Medicine (VIFM) to improve patient safety. The HMIT is part of the Coroners Prevention Unit (CPU) established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. HMIT is staffed by practising Physicians and Nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement similar deaths may be avoided in the future.

10. Mr Nixon was seen by the family for the first time on the afternoon of 3 December 2008, the day before Mr Colhoun died. He attended at Mr Colhoun's bedside in ICU, read the progress notes and did not acknowledge Mr Colhoun's wife, daughter or son. The first opportunity they had to speak with Mr Nixon was 16 days after the surgery had taken place and only after a complaint was made to the hospital.

11. Mr Colhoun's daughter, Melanie Colhoun, wrote to the St Vincent's Private Hospital on 5 February 2009 setting out the family's distress and concern regarding the way they were treated by the medical officers involved in her father's management. Ms Colhoun in the letter sets out the details of her father's history and the family's lack of knowledge of what was occurring during his intensive care admission. She states, *"I honestly believe that the lack of communication from both Peter Mossop and particularly Ian Nixon, caused much unnecessary distress for my father and also for us. I believe that it was highly unprofessional and that the total lack of communication care from both surgeons whilst dad was in hospital and after his death is unfathomable and inexcusable"*. This letter prompted a meeting being arranged between the hospital's Chief Executive Officer, its Medical Director, its Patient Liaison Manager and Dr Mossop and Mr Nixon. Both Mr Nixon and Dr Mossop were requested to provide a response to the letter and questions raised within it, with this subsequently being done. At the meeting Dr Mossop and Mr Nixon were apologetic for the unnecessary distress experienced and both felt it was a timely reminder that communication between not only themselves, but with their patients and a patient's family, was paramount in delivering overall care.

12. In his letter of 9 April 2009 to Ms Colhoun, Mr Nixon set out answers to the questions that she had asked and apologised for the lack of communication following both the procedure and her father's death. He assured her that this would not happen again. Having further questions about her father's management, Ms Colhoun wrote to Mr Nixon on 30 September 2009. On getting no response the letter was resent on 1 December 2009; it was again sent on 16 February 2010 and again sent on 28 May 2010. There has been no reply to this letter, neither from Mr Nixon, nor from his rooms.

13. COMMENT

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

Mr Colhoun's daughter describes the lack of communication in this case as, 'unfathomable and inexcusable'. Her restraint of language is commendable. In over 20 years experience in this jurisdiction, I am well aware of the professional care and compassion extended to patients and families, by the vast majority of doctors. Regrettably, however, there are some doctors who seem oblivious to the high professional standards their profession aspires to, and to the common courtesies people are entitled to expect. It is a sad indictment that there is a need to formulate a recommendation aimed at addressing this lack of professionalism.

14. RECOMMENDATION

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected to the death.

St Vincent's Private Hospital ensure, (either by developing and maintaining an education program, or some other means) that doctors with admitting rights, and hospital medical officers, keep family informed of the medical progress and outcomes of patients under their care.

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

The family of Mr William Colhoun

Secretary, Royal Australasian College of Surgeons

Mr Ian Nixon

Dr Peter Mossop

Dr William Kelly

Medical Director, St Vincent's Private Hospital

Investigating Member, Victoria Police

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: **15 August 2013**