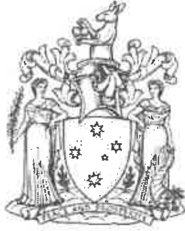

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1860

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**RONALD JOHN WOOD**
Date of birth:	29 DECEMBER 1949
Date of death:	22 APRIL 2018
Cause of death:	I(a) PULMONARY THROMBOEMBOLUS I(b) DEEP VEIN THROMBOSIS
Place of death:	15, CORAL PLACE, PENINSULA PARKLANDS RETIREMENT VILLAGE, 249 HIGH STREET, HASTING, VICTORIA 3915

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HIS HONOUR:

BACKGROUND

1. Ronald John Wood was 68 years old when he died on 22 April 2018 from a pulmonary embolus subsequent to deep vein thrombosis. Immediately prior to his death Mr Wood, a retired carpenter, lived with his wife, Lauretta Wood, at 15 Coral Place, Peninsula Parklands Retirement Village, 249 High Street, Hastings.

2. Mr Wood had a complex medical history which included severe ischaemic cardiomyopathy,[1] multifactorial dyspnoea[2], severe left ventricular dysfunction, morbid obesity, Type 2 diabetes (on insulin), chronic obstructive pulmonary disease, hypertension and hypercholesterolaemia. He also had a history of pulmonary emboli in 1990 and 2012 for which, in 2012, he was commenced on lifelong anticoagulant medication (warfarin).

3. On 28 May 2017, Mr Wood was taken by ambulance to the emergency department of Peninsula Health, Frankston **(the hospital)** with a history of increasing shortness of breath of three days' duration. Blood tests revealed that he was profoundly anaemic, and Mr Wood was admitted to hospital.

4. A statement was obtained from Mr Wood's treating gastroenterologist, Dr Sujievvan Chandran who stated that Mr Wood had:

   "symptomatic anaemia which was microcytic and hypochromic. Mr Wood's Haemoglobin was 74g/dL (which is profoundly low), his Ferritin was 10ng/mL (which is also profoundly low) and his B_{12} was low (these markers indicating profound anaemia)".

5. Prior to this finding, no source of bleeding was identified as a cause for the anaemia. During a consultation with treating colorectal surgeon, Mr Stewart Skinner on 27 November 2017, Mr Wood confirmed that he had not noticed any bowel symptoms prior to the finding of anaemia.

6. Mr Wood's anaemia was treated with a blood transfusion of 4 units of packed red blood cells followed by an iron infusion. He was referred to the hospital's colorectal outpatients' department and his name was placed on the hospital's waiting list to undergo a colonoscopy

[1] A disease of the heart muscle caused by narrowing of the coronary arteries.
[2] Shortness of breath caused by several conditions such as cardiomyopathy or chronic obstructive pulmonary disease

and gastroscopy to investigate potential causes for the anaemia. Mr Wood was discharged from hospital on 31 May 2017.

7. On 8 November 2017, Mr Wood was again admitted to the hospital and underwent a gastroscopy and colonoscopy performed by Dr Chandran. The colonoscopy revealed a large, ulcerated, non-circumferential, malignant-looking tumour in the rectum 4cm from the anus with oozing bleeding, which on histopathology was determined to be a moderately differentiated adenocarcinoma of the rectum. Dr Chandran arranged for Mr Wood to be seen in the hospital's colorectal surgical clinic.

8. In his statement, Dr Chandran explained that he was concerned about the increased risk of haemorrhage associated with anticoagulation medication such as warfarin which, he opined, put Mr Wood at significant risk of suffering a life-threatening bleed from the oozing/bleeding tumour. He stated:

> *"I considered the need to withhold Warfarin in the short term and weighed the risks of a recurring pulmonary embolism against the risk of an acute haemorrhage. I determined that in the circumstances, the risk of an acute haemorrhage favoured the withholding of Warfarin pending urgent medical review by the Colorectal unit. I would have advised Mr Wood that he should withhold his anticoagulant medication until he had been seen by the surgeons, due to the risk of bleeding and the significant consequences that that this would have given his co-morbidities"*

9. On 27 November 2017, Mr Wood was seen at the hospital's colorectal surgical clinic by Mr Stewart Skinner who referred him for an MRI[3] of the rectum and a PET[4] scan to determine whether he needed immediate surgery or a pre-operative course of chemotherapy and radiotherapy to reduce the size of the tumour prior to surgery.

10. Mr Skinner noted in his statement that:

> *"At this stage it was not appropriate to recommence Warfarin because he was either going to have surgery or chemotherapy. Warfarin becomes unstable during chemotherapy and so normally in this situation patients are converted to prophylactic Clexane injections."*

[3] Magnetic resonance imaging scan gives detailed images inside the body.
[4] Positron emission tomography scan.

11. Mr Skinner continued as follows:

> *"The plan was to review Mr Wood in the Surgical Outpatients Clinic in 2 weeks' time to discuss the results of the investigations. Unfortunately, Mr Wood did not keep this appointment so there was not an opportunity to discuss his anticoagulation in the Surgical Clinic and to communicate with his General Practitioner at that time".*

12. On 22 December 2017, Mr Wood's case was discussed at the hospital's Multi-Disciplinary Colorectal Cancer Meeting which determined a plan for treatment that included eventual surgical excision of the tumour after pre-operative radiotherapy and chemotherapy with the aim of shrinking the tumour. Mr Wood received chemoradiation during January and February 2018.

13. On 29 March 2018, Mr Wood was admitted to hospital and underwent an ultra-low anterior resection[5] and ileostomy. Intraoperatively and post operatively, Mr Wood received the standard venous thrombosis embolism (**VTE**) strategies; pneumatic calf compressors were applied for the duration of the surgery, clexane was administered during surgery then daily until discharge and he wore TED[6] stockings. Mr Wood's recovery was uncomplicated and he was discharged on 6 April 2018. Warfarin was not recommenced.

14. On 19 April 2018, Mr Wood was readmitted to hospital under the general medical unit for management of hyperkalaemia[7]. He was discharged on 21 April 2018. In a letter to Mr Wood's general practitioner Dr Giannakakis, dated 21 April 2018, the medical registrar asked Dr Giannakakis to check Mr Wood's potassium level on 23 April 2018. No plan for future anticoagulation was documented during that admission.

[5] Resection of the left side of the colon and rectum. The colon is joined to the anus and a temporary ileostomy created to protect the anastomosis while it heals.
[6] Elasticised anti-emboli stockings.
[7] Elevated potassium level.

THE CORONIAL INVESTIGATION

Coroners Act 2008

15. Mr Woods's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because his death having occurred in Victoria, was unexpected, appears to have resulted from an accident or injury and not from natural causes.[8]

16. The Act requires a coroner to investigate reportable deaths such as Mr Wood's and, if possible, to find:

    (a) The identity of the deceased;

    (b) The cause of death; and

    (c) The circumstances in which death occurred.[9]

17. For coronial purposes, "*circumstances in which death occurred*",[10] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

18. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[11] It is not the Coroner's role to determine criminal or civil liability,[12] nor to determine disciplinary matters.

19. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

20. Coroners are also empowered to:

    (a) Report to the Attorney-General on a death;[13]

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[9] *Coroners Act 2008* (Vic) preamble and s 67.
[10] *Coroners Act 2008* (Vic) s 67(1)(c).
[11] *Keown v Khan* [1999] 1 VR 69.
[12] *Coroners Act 2008* (Vic) s 69 (1).
[13] *Coroners Act 2008* (Vic) s 72(1).

(b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[14] and

(c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15]

Standard of Proof

21. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[16] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[17] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[18]

22. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[19] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[20] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[21]

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[14] *Coroners Act 2008* (Vic) s 67(3).
[15] *Coroners Act 2008* (Vic) s 72(2).
[16] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[17] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[18] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[19] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[20] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[21] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

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

Identity of the Deceased - Section 67(1)(a) of the Act

23. On 22 April 2018, Mrs Lauretta Wood identified the deceased as her husband, Ronald John Wood, born on 29 December 1949.

24. Mr Wood's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

25. On 26 April 2018, Dr Malcolm Dodd, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a post-mortem examination upon Mr Wood's body. Dr Dodd provided a written report, dated 22 June 2018, in which he opined that the cause of Mr Wood's death was '*I(a) Pulmonary Thromboembolus; I(b) Deep Vein Thrombosis*'. I accept Dr Dodd's opinion.

26. Dr Dodds commented that:

> *"Further pathological entities include cardiac enlargement with moderate biventricular dilatation, an admixture of mature scar tissue and relatively recently formed scar tissue within the heart for scar tissue within the heart on a background of triple vessel ischaemic heart disease and benign nephrosclerosis.*
>
> *Examination of the pons (a part of the brain stem), disclosed a conspicuous area of rarefication of neuropils within the central region. This finding is known as central pontine myelinolysis and may occur during periods of electrolyte imbalance."*
>
> *There was evidence of mild renal impairment."*

27. Toxicological analysis of post-mortem samples was negative for common drugs and poisons.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

28. At approximately 9.30pm on 21 April 2018, Mr Wood went to bed, telling his wife that he felt "*fine*".

29. At approximately 6.30am on 22 April 2018, Mrs Wood heard her husband cough and went to check on him. She noted that that he was asleep and that there was nothing to cause her to be

concerned. Mrs Wood returned to check on her husband at approximately 8.00am and, finding him unresponsive, called emergency services.

30. Paramedics who attended were unable to resuscitate Mr Wood who was declared deceased at the scene.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

31. In his statement, Mr Skinner noted that Mr Wood's death was reviewed within the hospital's Department of Surgery and also referred to Safer Care Victoria.

32. The hospital's internal review concluded that each of the specialists involved in Mr Wood's care focussed on their specific area of expertise but none of them considered an ongoing plan for Mr Wood's anticoagulation.

33. As a result of the internal review, the hospital's department of surgery implemented the following recommendations:

34. First, patients undergoing major abdominal surgery and major surgery for cancer are routinely discharged on prophylactic clexane injections for a period of one month post-operatively. Mr Skinner noted that there is good clinical evidence that this significantly reduces the risk of DVT and pulmonary embolus after major surgery.

35. Secondly, general medical perioperative physicians are now routinely involved in the perioperative management of patients undergoing major surgery so that there is one medical specialist involved who can take an overview of the overall medical care of the patient, rather than multiple specialists focussing on their specific area of practice.

36. For the sake of completeness, I referred this matter to the Coroners Prevention Unit (**CPU**)[22]for an assessment of the adequacy of the changes implemented by the hospital in response to Mr Wood's death.

37. At first instance, the CPU advised me that it was reasonable to temporarily cease Mr Wood's anticoagulation, however, given Mr Wood's significant risks for thromboembolism (past

[22] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

history of pulmonary embolism, cancer, major surgery and a high BMI [23]), it was concerning that that there was no anticoagulation plan postoperatively.

38. Although discharge summary letters were sent to Dr Giannakakis, the letters are silent as to an anticoagulation plan. The CPU noted that this case highlights the importance of a clearly articulated plan for ongoing anticoagulation for a patient with cumulative risks for venous thrombosis embolism and a change in medication.

39. The CPU advised me that the changes already implemented by the hospital would be strengthened by clinical practices that enhance effective communication between health professionals and patients for ongoing management and monitoring of anticoagulation therapy. Such a practice would be consistent with the Australian Commission on Safety and Quality in Health Care consensus VTE Prevention Clinical Care Standard[24] published since Mr Wood's death. Taking the advice of the CPU into account, I have made the recommendation set out below

40. I am satisfied, having considered all of the available evidence, that no further investigation into Mr Wood's death is required.

FINDINGS AND CONCLUSION

41. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Ronald John Wood, born on 29 December 2018;

    (b) Mr Wood's death occurred;

        i. on 22 April 2018 at 15, Coral Place, Peninsula Parklands Retirement Village, 249, High Street, Hastings;

        ii. from a pulmonary embolus secondary to a deep vein thrombosis; and

        iii. in the circumstances described in paragraphs 28-30 above.

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[23] Body Mass Index

[24] Australian Commission on Safety and Quality in Health Care "Venous Thromboembolism Prevention Clinical Care Standards, October 2018. A VTE standard to guide individual hospital VTE procedures.

RECOMMENDATION

I recommend that Peninsula Health expand all relevant clinical practice guidelines to require that, when patients at risk of VTE are discharged from hospital, both the patient and their general practitioner receive written guidance on anticoagulation. This should be done in accordance with Quality Statements 3, 4 and 7 of the Australian Commission on Safety and Quality in Health Care Clinical Care Standard on Venous Thromboembolism Prevention (October 2018)

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this finding be published on the internet.

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

    (a) Mrs Lauretta Wood, senior next of kin.

    (b) Ms Fiona Karmouche, Lander and Rogers Lawyers;

    (c) Ms Amy Regan, MDA National Insurance;

    (d) Ms Amber Salter, Peninsula Health, Frankston

    (e) First Constable Daniel Chrisp, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 29 May 2020