IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 5502

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**MR WILSON**[1]
Date of birth:	**15 March 1976**
Date of death:	**4 June 2019**
Cause of death:	**1a) Liver Failure with cirrhosis in the setting of recent paracentesis** **1b) Hepatitis C**
Place of death:	**Maryborough & District Hospital** **77 Clarendon St, Maryborough, Victoria 3465**

[1] To show my respect to ancient, traditional Aboriginal law in respect of naming or depicting deceased persons, I have endeavoured to refer to Mr Wilson's first name only where required by the *Coroners Act 2008* (Vic).

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Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Wilson was an Aboriginal man. He was 43 years of age and lived in Maryborough with his mother Shirley Wilson at the time of his death. Mr Wilson had a complex medical history that included: successfully treated Hepatitis C, Liver Cirrhosis, recurrent ascites[2] requiring drainage every six to eight weeks and umbilical hernia.[3] Mr Wilson required a mobility scooter and could only walk approximately 20 metres unaided.

2. On 16 May 2019, Mr Wilson had a minor fall at home.

3. On 17 May 2019, Mr Wilson attended Ballarat Hospital as he had noticed that abdominal contents were protruding from his umbilical hernia. Ballarat Hospital staff identified that the protruding abdominal contents were omentum[4] and that the skin over the protrusion appeared to have ulcerated.[5] Computed tomography (CT) scanning identified that Mr Wilson had a strangulated hernia with a narrow 6.7mm neck and containing omental fat.[6] Mr Wilson was transferred to the Austin Hospital where he underwent a successful hernia-repair. Mr Wilson was admitted to Austin Hospital Intensive Care Unit (ICU) for five days post-operatively due to the complexity of his underlying medical issues.

4. On 24 May 2019, Mr Wilson was discharged home from the Austin Hospital.

5. On 1 June 2019, Mr Wilson attended the Maryborough & District Hospital (MDHS) Urgent Care Centre in relation to his ongoing illness. His observations were normal at this attendance.

6. On 3 June 2019, Mr Wilson was admitted to MDHS due to recurrent ascites and shortness of breath. Additionally, abdominal distention was causing Mr Wilson pain at the site of the hernia-repair. MDHS staff commenced draining the ascites with the aim of

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[2] Ascites is the accumulation of abdominal fluid, especially in response to liver disease.

[3] Umbilical hernia is a condition where the intestine protrudes through the abdominal muscles at the belly button.

[4] Omentum is a non-bowel intra-abdominal tissue containing peritoneum, fat and other tissues. It has a protective function in the abdomen.

[5] Ulcerated skin is skin that is becoming an ulcer; an open sore that may be internal or external on the body.

[6] Visceral fat that sits on the omentum.

draining eight litres of fluid. Mr Wilson was administered subcutaneous morphine and sedation for pain-relief; he was in pain throughout the evening following his presentation.

7. On 4 June 2019 at 1.30am, Mr Wilson was found deceased in his hospital bed and a death certificate was completed; his death was not initially reported to the Coroner. The death certificate was completed by Dr Daniel de Villiers and ascribed the following medical cause of death:

    1 a) Liver Failure with cirrhosis (5 years)

    b) Hepatitis C (10 years)

8. On the relevant section of the death certificate, Dr de Villiers noted that Mr Wilson had an invasive procedure, the umbilical hernia-repair, within four weeks of his death. Dr de Villiers wrote that Mr Wilson had '*dehiscence*[7]*of a hernia due to ++ascites. Emergency repair 2w ago. Had no bearing on his death.*'[8] The death certificate erroneously cited that Mr Wilson was not an Aboriginal person.[9]

NOTIFICATION OF DEATH

9. On 8 October 2019, Coronial Admissions and Enquiries received an anonymous notification of Mr Wilson's death from Maryborough District Health Service. The anonymous reporters (AR) indicated a number of areas of concern and allegations in relation to the provision of medical care and treatment to Mr Wilson. I accepted the notification of Mr Wilson's death with the intention of determining whether it was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) [the Act]. Specifically, further investigation was required to determine whether Mr Wilson's death was:

    - unexpected, or
    - following a medical procedure where his death was or could be causally related to that medical procedure and a registered medical practitioner would not,

[7] Dehiscence is when a surgical incision reopens either internally or externally.

[8] Coronial File, Mr Wilson's Death Certificate, dated 4 June 2019, Part Four –Supporting Information, 17: *"was there an operation or invasive procedure performed on the deceased within four weeks of the death?"*

[9] Ibid, Part Two – Deceased's Details, 13: *"was the deceased of Aboriginal or Torres Strait Islander origin?" "No"* is selected.

immediately before the procedure was undertaken, have reasonably expected his death.

10. Forensic medical investigations were not able to be conducted as Mr Wilson's death had not been reported contemporaneously. I directed that Court staff contact the Maryborough District Health Service to request a statement outlining the hospital's involvement with Mr Wilson.

INVESTIGATIONS

Coroners Prevention Unit investigation

11. On 20 January 2020, the Court received a statement from Director of Medical Services at Maryborough District Health Service Dr Sophie Ping. I also received Mr Wilson's medical records from the Austin Hospital and Maryborough District Health Service. Upon receipt of this information, I requested assistance from the Coroners Prevention Unit (CPU)[10] to, *inter alia*, consider the assertions and questions raised by the AR.

12. The AR made the following assertions in relation to Mr Wilson's medical management and death:

    a. Mr Wilson's death certificate did not record the recent surgery at the Austin Hospital or the drainage procedure at MDHS.

    b. Mr Wilson's resuscitation plan was for no resuscitation, but the AR believe that Mr Wilson would not have been fit to consent to this. The AR stated that his family were not consulted.

    c. The AR asserted that Mr Wilson had a fast heart rate and low blood pressure when he attended MDHS on 3 June 2019. The AR allege that Mr Wilson was prescribed morphine, despite concerns raised by nursing staff, and that some nursing staff withheld the morphine due to concerns about the appropriateness of prescribing given his presentation.

[10] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

d. Mr Wilson was walked from ED to the ward.

e. The Austin Hospital had elected to operate on Mr Wilson only two weeks earlier.

f. Eight litres of fluid were drained from Mr Wilson's abdomen without providing volume expansion with albumin.

g. Limited observations were taken for Mr Wilson.

h. Mr Wilson's regular medications were charted despite being for palliation.

13. The AR also raised the following questions to which the CPU provided preliminary responses or indicated that further information was required:

a. Why was Mr Wilson kept at Maryborough instead of being transferred?

Palliating Mr Wilson at MDHS was an appropriate course if he was genuinely for palliative care only.

b. Why was the invasive procedure not mentioned on the death certificate?

Unknown

c. Why was a large volume drainage performed without albumin[11] replacement?

It would be normal practice to do this as it helps to restore the circulating blood volume. Albumin is an expensive blood product, and if the goal of removing the fluid was simply to make Mr Wilson comfortable in the setting of palliation, then albumin would not be given.

d. Was the patient or his parents informed of their resuscitation status?

Unknown

e. Is the diagnosis of end stage liver failure accurate and if so, why did the Austin Hospital perform an elective umbilical hernia repair?

[11] Albumin is the major protein found in human plasma. It is a blood product derived from blood donations. The aim of giving albumin is to raise the protein level in the patient's blood in order to try and reduce the loss of fluid into the abdomen and other tissues. As it is relatively expensive and limited in supply, one would not generally administer it for palliative reasons.

Yes, Mr Wilson had severe end stage liver disease, to the point of being considered (but refused) for liver transplant. The hernia repair undertaken at the Austin Hospital was not elective. It was done as an emergency because his abdominal contents were coming out of the hernia.

f. How is the clinical case review process not addressing these issues with all involved? Are the medical staff and hospital management actively hiding such details?

Unknown

Preliminary CPU advice

14. The CPU advised me that it was not possible to definitively determine whether Mr Wilson's death was related to his proximate surgical procedure or if it was only attributable to his chronic condition. The CPU noted that the elapsed 18 days between the procedure and Mr Wilson's death did make it appear less likely that he had suffered a surgical complication.

15. The CPU informed me that the medical care provided to Mr Wilson by his treating GP Dr de Villiers at MDHS was reasonable in circumstances where Mr Wilson's goals of care were comfort and palliation. However, the medical notes relating to Mr Wilson's last presentation were scant and did not clearly identify the goals of care.

16. In light of the preliminary advice provided by CPU, I sought a statement from Mr Wilson's treating GP Dr de Villiers to clarify the outstanding issues.

Further Investigation

Statements of Dr de Villiers

Chronology of Treatment

17. Dr de Villiers provided two statements to the Court. He made his first statement on 18 May 2020. On 1 July 2020, Dr de Villiers informed the Court that the first statement was completed without the benefit of access to the Maryborough District Health Service medical records. He provided a second statement with '*additional responses and clarification to the questions from the Coroners Court'*.[12]

[12] Coronial File, *Second Statement of Dr Daniel de Villiers*, dated 30 June 2020, p 1 of 3.

18. Dr de Villiers informed me that he first saw Mr Wilson on 23 December 2016. Mr Wilson was admitted to MDHS for liver failure with Hepatitis C and previously untreated liver cirrhosis. Dr de Villiers was the treating doctor on that admission. On 3 February 2017, Mr Wilson consulted Dr de Villiers as his primary treating GP for the first time and he was referred for specialist care in Ballarat.

19. In 2018, the surgical clinic at Ballarat Health Services (BHS) reviewed Mr Wilson to determine his suitability for a hernia repair. At that time, Mr Wilson did not suffer any abdominal wall rupture with intestinal content protruding from the hernia. BHS medical practitioners determined not to go ahead with the repair, in light of Mr Wilson's end-stage liver disease. On that occasion, BHS estimated that Mr Wilson's hospital mortality rate ranged between 50%-80% if he were to have the procedure.[13]

20. Over the course of their doctor-patient relationship, Dr de Villiers witnessed Mr Wilson's health deteriorate incrementally. By 2019, Mr Wilson required palliation; there was no active treatment that could reverse his condition, other than a liver-transplant. Unfortunately, Mr Wilson had been unable to abstain from drinking alcohol for the requisite six-month period and therefore was not a viable transplant candidate.

21. Dr de Villiers continued treatment for reversible causes of illness. Mr Wilson's treatment was mainly symptomatic, by means of the periodic drainage of fluid from his abdominal cavity. He also appeared to be developing intermittent confusion due to hepatic encephalopathy.[14] Mr Wilson was referred to Ballarat Base Hospital for specialist gastroenterologist care on a number of occasions. The specialist assisted in Mr Wilson's goals of care by providing medication-regime-advice for Mr Wilson, which was followed at MDHS.

22. In 2019, Austin Health provided advice in relation to Mr Wilson's suitability for a liver transplant and also performed a hernia-repair in 2019. Dr de Villiers explained that the repair was performed in the context of significant hernia growth, resulting in a rupture of the abdominal wall with intestinal content protruding from the hernia.

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[13] Dr de Villiers appended a letter from Ballarat Base Hospital stating Mr Wilson's apprehended hospital-mortality-rate.

[14] Encephalopathy is the alteration of normal mental and brain function, in this case due to chronic liver disease. Many substances that are normally cleared from the blood by the liver accumulate and affect mental function.

23. On 3 June 2019, Dr de Villiers stated that treatment plan was to manage Mr Wilson's ascites associated with end-stage liver cirrhosis and to provide nutritional support. The immediate plan was to perform paracentesis drainage of the ascitic fluid. During Mr Wilson's final admission to MDHS, medical investigations showed evidence of liver failure, low serum sodium and a raised white blood cell count. Dr de Villiers explained that consideration was given to administering albumin to Mr Wilson. However, it is not readily available in the rural setting and it was considered that Mr Wilson would derive little benefit as it would be quickly lost from his circulation.

24. Dr de Villiers said that he did not discuss Mr Wilson's presentation on 3 June 2019 with other medical attendants, as he did not consider it necessary. Mr Wilson was being treated for his ascites at MDHS, and medication was being provided pursuant to specialist gastroenterologist advice. Dr de Villiers stated that other medical attendants could have assisted with Mr Wilson's treatment at that stage.

25. In his statement, Dr de Villiers did not indicate whether he expected Mr Wilson's imminent death at that time. However, the admission diagnosis was end-stage liver cirrhosis and ongoing alcohol use; examination by the admitting doctor and Dr de Villiers did not lead to any other major differential diagnoses. Furthermore, Mr Wilson's admission was not discussed with any other medical service or specialist.

GP Communication with Family

26. Dr de Villiers stated that he discussed that Mr Wilson was for palliation with his patient and his mother Shirley on several occasions. He wrote:

> *I explained that his liver failure was end-stage and he was for palliation with symptomatic relief for his ascites by way of paracentesis. Indeed, as outlined in my original statement, Mr Wilson and his mother requested that I write letters confirming his poor prognosis in relation to his criminal charges, and I understood that they were aware of his terminal condition and shortened life expectancy based on my many discussions with them.*
>
> *It was not my usual practice to contact Mr Wilson's mother and father on every admission (if they were not otherwise present at the hospital), given his age, the fact that I understood that they were aware of his admission, and the fact that his condition*

was deteriorating over time without any prospect of reversal. I note that the admission summary states that Mr Wilson had contacted his parents. I further believe that Mr Wilson was an adult with the right to privacy. [15]

GP Consideration of Reportable Death

27. Dr de Villiers stated that Mr Wilson's death was the expected outcome of end stage liver disease. Mr Wilson's death was not caused by the paracentesis performed on 3 June 2019 or by the earlier hernia repair at the Austin Hospital. Dr de Villiers stated that there was no subjective nor objective indication of any complication related to the paracentesis or hernia repair; Mr Wilson drained clear ascitic fluid. In those circumstances, Dr de Villiers did not consider Mr Wilson's death to be reportable to the Coroner.[16]

28. Dr de Villiers stated that he did not include the paracentesis on Mr Wilson's death certificate as he did not consider it to be an *'operation'* nor *'invasive procedure'*, pursuant to Part Four of the death certificate. He explained that his understanding of the terms in the following manner: '*Mr Wilson had a grossly distended abdomen due to at least seven to eight litres of ascites fluid. This conferred a very large, safe space for paracentesis. There was no risk to underlying organs and the paracentesis was thus very safe and technically uncomplicated.*'[17]

MDHS Statement

29. MDHS Director of Medical Health Services Dr Sophie Ping provided a statement to the Court that addressed Mr Wilson's admission to the health service on 3 June 2019. Dr Ping's statement generally reflected the information contained in Dr de Villiers statements. However, she also said that a resuscitation care plan was completed for Mr Wilson during his final admission to MDHS. The care plan noted that Mr Wilson was for "*Goals of Care D: Comfort During Dying – Terminal Care*". Dr Ping informed me that this was based on a prognosis of hours to days of life expectancy. She commented that the paracentesis was still performed despite palliation, in order to maximise Mr Wilson's comfort during those hours to days.

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[15] Above n 12.

[16] 'The Coroner' as a general term, referring the Duty Coroner at the time of Mr Wilson's death.

[17] Above n 12 p 3 of 3.

Family Concerns: ABC Interview

30. Mr Wilson's mother Shirley Wilson made a number of relevant comments in an interview with the Australian Broadcasting Corporation (ABC) on 17 May 2020.[18]

31. Mrs Wilson stated that Mr Wilson's family *'had the impression that he was going to be drained, come home, heal and be okay'*. She informed the ABC that Mr Wilson had contacted his parents from MDHS prior to his paracentesis on 3 June 2019. During that telephone conversation, Mr Wilson had asked that his mother and father come to collect him from hospital once the procedure was complete and he had seen the doctor.

32. Mrs Wilson said that her son had previously told her that he would like his family to be by his side when he died. Mrs Wilson was not sure why his family had not been contacted by the hospital to inform her that her son's health was deteriorating so that they could attend to him. Mrs Wilson was concerned that something wrong had occurred during the course of her son's care and treatment on 3 June 2019. Further, she implicitly indicated her concern that her son had not been treated well due to his alcoholism.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. The medical care and treatment provided by MDHS and Dr de Villiers was reasonable and appropriate in the circumstances. A review of the medical records, Dr De Villiers Statements, and the MDHS statement indicates that Mr Wilson had a chronic illness for which there was no recourse but palliation, in the context where he suffered alcoholism and was not a viable candidate for liver-transplant. The treatment for reversible causes of illness also appears reasonable and appropriate. Further, the evidence available to me shows that Mr Wilson and his family were aware of the seriousness of his condition and the palliative care and treatment being provided.

2. On the evidence presented to me, Mr Wilson's death was reportable to the Coroner pursuant to section 4(2)(b) of the Act: Mr Wilson's death *could be* causally related to

[18] Charlotte King & Andy Burns, *Coroner investigates death of Edward Wilson at Maryborough Hospital after whistle-blower raises concerns,* ABC News, Last Updated 18 May 2020, <ABC LINK>.

that medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected his death.

3. I make the determination that Mr Wilson's death was reportable for the following reasons:

   I. I accept the advice of the CPU that, without the benefit of forensic medical examination, it is not possible to determine whether or not there was a causal relationship between Mr Wilson's death and the surgical hernia-repair or paracentesis;

   II. Dr de Villiers' reasons for not reporting Mr Wilson's death to the Court relied solely on his determination that there was a lack of a causal relationship between the death and the surgical hernia-repair or paracentesis;

      i. Dr de Villiers did not rationalise nor indicate that, immediately before the paracentesis was undertaken, he reasonably expected Mr Wilson's death to be an outcome of that procedure.

      ii. The test contained in the Act is objective. However, the CPU have advised that Dr de Villiers' care and treatment of Mr Wilson was reasonable and appropriate in the circumstances, therefore I have no cause to seek further input to determine an objective medical opinion in relation to Dr de Villiers' expectation.

4. Where the reportability of a death is in question, it is preferable that a medical practitioner contact the Court for advice. Especially in the circumstance of an immediately proximate medical procedure or surgery. However, it is rare that a person's death requires almost complete investigation before it may be determined whether or not it is reportable pursuant to section 4 of the Act. Therefore, I do not make any further comment in relation to Dr de Villiers' decision not to report Mr Wilson's death to the Coroner.

5. Whether or not Dr de Villiers ought to have included the paracentesis on the death certificate is not a question that I must resolve in order to dispense with my statutory duties to make Findings with respect to Mr Wilson's death. However, it was raised as a point of concern by the AR, it is relevant to Dr de Villiers decision not to report Mr Wilson's death and there is sufficient information to make some comments on the issue.

6. The paracentesis was an "invasive procedure" pursuant to the query posed in the Medical Certificate of Cause of Death (MCCD) completed in relation to Mr Wilson.[19] I consider that the question posed in the MCCD refers to a general, dictionary-definition interpretation of the term "invasive medical procedure": '*involving the introduction of instruments or other objects into the body or body cavities.*'[20] In this instance, the interpretation of that term does not rest with the relative safety of the procedure nor the technical ease with which it may be performed, as postulated by Dr de Villiers. However, I note that there is no worldwide accepted definition for "invasive procedure" in the medical field.[21] Furthermore, I note that the High Court of Australia has discussed levels of "invasiveness" in medical procedures.[22] However, the question of whether an individual has had an "invasive medical procedure" and the question of how "invasive" a medical procedure may be, are evidently different.

7. I have not sought that information in relation to the AR's assertion that the MDHS clinical case review of Mr Wilson's death did not include *'all involved'*. It is not relevant to the circumstances of Mr Wilson's death and therefore I may not seek it for the sole or dominant purpose of making a comment where I may otherwise dispense with my statutory duty to make Findings in relation to Mr Wilson's death.[23]

8. The AR indicated that they intended to contact the media in relation to Mr Wilson's death. Therefore, the Court was aware of media involvement and ultimately alerted to the fact that the ABC was conducting an interview with Mrs Wilson. In these circumstances it is appropriate to address the concerns she raised with the ABC as if she had raised them with the Court directly.

9. In circumstances where Mr Wilson's death was anonymously reported to the Coroner, Mrs Wilson's concern about errors in her son's medical care is utterly understandable. However, as previously stated, there is nothing to suggest that Mr Wilson received

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[19] Completed by Dr Daniel de Villiers pursuant to the *Births Deaths and Marriages Registration Act 1996* (Vic).

[20] Lexico | Dictionary.Com & Oxford University Press Collaboration, *Invasive*, accessed 24 November 2020, https://www.lexico.com/definition/invasive

[21] Cousins S, Blencowe NS, Blazeby JM. What is an invasive procedure? A definition to inform study design, evidence synthesis and research tracking. *BMJ Open*. 2019;9(7):e028576. Published 2019 Jul 30. Date accessed 25 November 2020 <LINK>.

[22] See Re JANE (1988) 85 ALR 409.

[23] Harmsworth v The State Coroner [1989] VR 989.

anything but reasonable and appropriate medical care and treatment. There is certainly no evidence to suggest that he was not afforded proper care due to his alcoholism.

10. Mr Wilson, his family, Dr de Villiers and treating medical practitioners at MDHS had disparate understandings of his prognosis. I have accepted that Mr Wilson and his mother were informed that he was being provided palliative care. However, Mr Wilson had been provided palliative care for a number of months. At first instance, palliation indicated a lack of active treatment rather than comfort measures upon imminent death. At the time of completing Mr Wilson's resuscitation care plan, treating practitioners expected his death within days or even hours. Explicitly conveying that information to Mr Wilson and thereby providing him with the opportunity to contact his family would have clearly been preferable for all involved.

11. I extend my sincere condolences to Mrs Wilson for the loss of her son, as well as to his other family members and friends.

FINDINGS

1. I find that Edward Charles Wilson, born 15 March 1976, died on 4 June 2019 at Maryborough & District Hospital, 77 Clarendon St, Maryborough, Victoria 3465.

2. I find that Mr Wilson suffered several complex comorbidities including liver failure with cirrhosis and abdominal hernia.

3. I find that Mr Wilson's goals of care were palliation with treatment for reversible causes of illness at the time of his death.

4. I find that Mr Wilson and his mother Shirley Wilson were aware of his goals of care at the time of his death.

5. I find that Mr Wilson received reasonable and appropriate medical care and treatment during his admission from 3 June 2019 to 4 June 2019.

6. I find that cause of Mr Wilson's death was liver failure with cirrhosis in the setting of recent paracentesis and Hepatitis C.

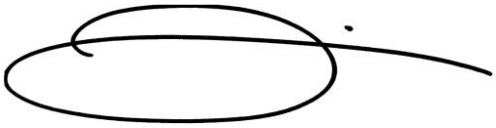
Pursuant to section 49(2) of the *Coroners Act 2008* (Vic) and regulation 16 of the *Coroners Regulations 2019* (Vic), I direct that the Principle Registrar provide a copy of my Findings to the Victorian Registrar of Births Deaths and Marriages in order to:

a. re-register the cause of Mr Wilson's death, and

b. appropriately identify that he was an Aboriginal man on his Death Certificate.

I direct that a copy of my Findings be provided to the following:
Shirley Wilson
Dr Daniel de Villiers
Director of Medical Health Services of Maryborough District Health Services Dr Sophie Ping
Victorian Registrar of Births Deaths and Marriages

Signature:



AUDREY JAMIESON
CORONER
Date**: 10 February 2021**