IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 004637

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Kenneth Ernest O'Brien
Date of birth:	28 November 1942
Date of death:	13 September 2017
Cause of death:	1(a) Intra-abdominal haemorrhage complicating elective umbilical hernia repair 2 Dilated cardiomyopathy and liver fibrosis
Place of death:	St John of God Health Care, St John of God Hospital Bendigo, 133-145 Lily Street, Bendigo Victoria 3550

INTRODUCTION

1. Kenneth Ernest O'Brien was 74 years old at the time of his death and lived independently in Castlemaine. He was widowed and is survived by his three sons.

2. Mr O'Brien's medical history included atrial fibrillation[1], sick sinus syndrome[2], severe tricuspid regurgitation[3] and ventricular tachycardia[4]. He had a pacemaker implantation and was prescribed an anticoagulant, apixaban[5] amongst other medications.

3. Mr O'Brien died at the St John of God Bendigo Hospital ("SJOG Hospital") on 13 September 2017, following an elective surgery for repair of a ventral[6] abdominal hernia two days earlier.

THE CORONIAL INVESTIGATION

4. Mr O'Brien's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* ("the Act"). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Mr O'Brien's death also meets the reportability criteria because it occurred following a medical procedure where the death is or may be causally related to the medical procedure which a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.[7]

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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[1] Irregular heartbeat where clots can form in the enlarged chamber of the heart.
[2] A condition where the hearts internal pacemaker is dysfunctional causing fast and slow rhythms.
[3] Leaking heart valve- affecting venous side of the heart.
[4] Rapid cardiac rate which can cause collapse.
[5] A direct acting anticoagulant used to prevent serious blood clot from forming due to atrial fibrillation.
[6] At the front of the abdomen or umbilicus.
[7] Section 4(2)(b)(ii) of the *Coroners Act 2008* (Vic) ("the Act").

8. Preliminary case management and triage of Mr O'Brien's matter by the Health and Medical Investigation Team[8] (**HMIT**) within the Coroners Prevention Unit[9] (**CPU**), identified a range of concerns about his pre-operative and post-operative management.

9. Having regard to this preliminary advice, I determined Mr O'Brien's death required further coronial investigation, including statements from Mr O'Brien's treating clinicians to respond to the clinical management issues raised. In doing so, specific questions were directed to the clinicians to explore their clinical rationale and decisions in providing Mr O'Brien the treatment and care he received.

10. Advice was also sought from the CPU concerning Mr O'Brien's operative and post-operative care and management at Hospital. The CPU provided advice which has informed and guided my investigation.

11. This finding draws on the totality of the coronial investigation into the death of Kenneth Ernest O'Brien. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[10]

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

Background circumstances

12. The available evidence indicates that Mr O'Brien had discovered a hernia several years prior to 2017.

13. In August 2017, Mr O'Brien attended upon his general practitioner (**GP**), Dr Dhananjay Mungi and reported feeling increased pain and tenderness in his umbilical region.[11] He further stated that he wished to undergo a repair.

[8] The HMIT is a specialist service that sit within the CPU, comprising of highly skilled and experience health care clinicians, independent of the health practitioners or institutions involved in the clinical management and care provided to the deceased. The HMIT provides advice to Coroners and assists them with their investigations.

[9] The CPU assist the coroner with research in matters related to public health and safety in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals under consideration and are therefore able to give independent advice to the coroners.

[10] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[11] CF, Medical Records from Botanical Garden Health.

14. On 22 August 2017, Mr O'Brien was referred to general surgeon, Mr Manny Cao for a surgery consultation. Mr Cao noted Mr O'Brien's ventral hernia appeared moderately large, slightly superior to his umbilicus, indicative of ongoing enlargement. He then informed Mr O'Brien that an operative repair was warranted as the hernia was large, the overlying skin was thin and was main cause of Mr O'Brien's discomfort.

15. Having also considered Mr O'Brien's advanced age and medical history, Mr Cao referred him to general physician and nephrologist, Dr Mani Thomas for a pre-operative assessment. Mr Cao also recommended Mr O'Brien undergo his surgery in a larger hospital in Bendigo.

16. On 29 August 2017, Mr O'Brien was referred to Dr Thomas for an opinion in relation to his overall risk to undergo an elective surgery. Although Dr Thomas noted that Mr O'Brien had significant risk factors, Dr Thomas considered that the surgery was a relatively low risk procedure and Mr O'Brien was overall fit for a surgery.

17. Mr O'Brien's surgery was then scheduled on 11 September 2017 at SJOG Hospital, with instructions of Dr Thomas to cease his apixaban two days prior to the surgery.

Immediate surrounding circumstances

18. On 11 September 2017, at 2.50pm, Mr O'Brien commenced his surgery as planned. The procedure was performed by Mr Cao, under general anaesthesia, administered by anaesthetist, Dr Jackson Harding.

19. During the surgery, a previously undiagnosed ascites[12] with ascitic fluid was found. Mr Cao informed Dr Harding of the possibility of a major haemodynamic fluid shift and proceeded to perform suction of approximately 1.5 litres of fluid prior to repairing the hernia. The hernia repair was subsequently carried out and haemostasis was checked at the end of the operation. No intraoperative complication was noted. Mr O'Brien was then taken to the to the recovery ward at 4.00pm.

20. Prior to his admission to the post-surgical ward, Mr Cao observed Mr O'Brien to be comfortable and his abdomen was mildly distended, consistent with Mr Cao's pre-operative observations. Mr Cao also noticed some mild ooze to his wound dressings but overall was satisfied of his post-operative course in recovery. Mr Cao and Dr Harding had also agreed to recommence his apixaban in the same evening.

[12] Fluid within the peritoneal cavity.

21. At approximately 6.45pm, Mr O'Brien's blood pressure (**BP**) was noted to be 110/70mmHg and Dr Harding was immediately contacted by nursing staff to discuss his BP. Although his BP had not breached the MET call criteria, it was suggested by nursing staff that his MET call[13] criteria were to be modified.

22. Dr Harding then ordered a slight reduction to Mr O'Brien's MET call trigger criteria for hypotension, to 90mmHg instead of 100mgHg. Mr O'Brien was admitted to the post-surgical ward shortly after at 6.55pm and his apixaban was administered at 8.15pm.

23. At 8.30pm, Mr O'Brien's BP was 75/60mmHg, indicating significant hypotension. A MET call was made and he was transferred to the ICU for vasopressor support. An ICU resident attending the MET call noted Mr O'Brien's *"BP was 70/50mmHg, his oxygen saturation was 91% on 6 litres inspired oxygen per minute and there was increasing abdominal distention".*

24. At 9.00pm, Mr Cao was notified of Mr O'Brien's condition and attended him immediately. His abdomen was observed in the same distended state as he was pre-operatively, without exhibiting any significant abdominal pain or tenderness.

25. Mr Cao also referred Mr O'Brien to a consultant general and renal physician, Dr Mani Thomas for a review. On examination, Dr Thomas noted that Mr O'Brien was *"well perfused"*, his abdomen was *"non tender [and] mildly distended but soft"*. He also noted Mr O'Brien was hypotensive.

26. At 10.30pm, Mr O'Brien was reviewed by on-call intensivist, Dr Sanjay Porwal. It was discovered that his BP continued to fall, and he was not responding to additional fluid replacement Dr Porwal also noted an International Normalised Ratio (**INR**)[14] reading of 1.6 and the abdominal X-ray scanning was consistent with "ileus[15]". A central venous line[16] and arterial line[17] were inserted to support his BP with vasopressor therapy.

[13] The Medical Emergency Team (MET) call is a hospital-based system, designed for a nurse to alert and call other staff for help when a patient's vital signs have fallen outside a set criterion.
[14] The International Normalised Ratio (**INR**) is the blood test that describes how quickly the blood clots compared to "normal". The target INR is often determined by the cardiologist and may be as high as 3.5 in mechanical valves. As the INR increases, the risk of bleeding will increase.
[15] Paralysis of bowel evident by dilatation on X-ray.
[16] Monitoring device for active fluid and resuscitation used in high dependency settings.
[17] Monitoring device for arterial blood pressure used in high dependency settings.

27. Mr O'Brien's condition continued to deteriorate, and he was transferred to the ICU and was immediately administered noradrenaline[18].

28. On 12 September 2017, at 12.00am the noradrenaline dosage was increased from 6 to 8mcg/minute and was further increased to 10mcg/minute at 1.00am, 14mcg/minute at 2.00am and 17mcg/minute at 3.00am.

29. In addition to noradrenaline, 2.4mg/hour of vasopressin[19] was also administered at 4.00am and 5.00am.

30. At 5.00am, Mr O'Brien was noted to have deteriorated significantly and required maximal inotropic support to maintain his BP. Dr Porwal was immediately called to attend Mr O'Brien.

31. Dr Porwal noted his condition as follow: *"unexpected significant deterioration overnight. Now shocked[20]. Falling hb[21] to 118 at 9pm to 88 at 6am"*. Dr Porwal then escalated his observations to Mr Cao and Dr Thomas, as he was of the view that there was an internal haemorrhage.

32. At 7.40am, Mr Cao reviewed Mr O'Brien and noted he was in refractory hypotension and his abdomen was more distended. At that time, Mr Cao, Dr Thomas and Dr Porwal suspected that there might be several possible underlying causes including internal bleeding, bowel injury, ischemic bowel or abdominal compartment syndrome and a diagnosis was unable to be confirmed unless an exploratory laparotomy was performed. However, it was understood that Mr O'Brien would not survive another surgery.

33. In light of Mr O'Brien's condition, Mr Cao consulted a senior surgeon at SJOG Hospital, Mr Tony Grey for a second opinion. Upon being advised of Mr O'Brien's condition, Mr Grey also indicated that he would not survive a laparotomy, however, could benefit from a laparotomy to determine further treatments.

34. Mr O'Brien's poor prognosis and medical futility of a return to the theatre were discussed at length with Mr O'Brien's family. They agreed to cease further inotropic support and redirect his care to comfort care.

[18] Infused medication to support blood pressure.
[19] Infused medication to support blood pressure.
[20] Critical condition where end tissues are not being adequately perfused with oxygen and nutrients and outlook is grave.
[21] Haemoglobin or blood count.

35. Mr O'Brien was provided with comfort measure at approximately 8.00pm and he passed away on 13 September 2017 at 5.02pm.

Identity of the deceased

36. On 13 September 2017, Kenneth Ernest O'Brien, born 28 November 1942, was visually identified by his son, James O'Brien.

37. Identity is not in dispute and requires no further investigation.

Medical cause of death

38. On 18 September 2017, Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of Kenneth Ernest O'Brien. Dr Bouwer also reviewed a post-mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83), E-Medical Disposition Form, letter to Dr Dhananjay Mungi and Mr Manny Cao, medical records from St John of God Health Care and Botanical Gardens Health. Dr Bouwer provided a written report of his findings dated 9 February 2018.

39. The autopsy revealed evidence of massive intra-abdominal haemorrhage from the umbilical surgery site where the surgical mesh was partly detached from the abdominal wall. There was a large sentinel[22] clot extending from the hernia into the abdominal cavity.

40. Dr Bouwer commented that the results of the post-mortem angiogram and venogram performed were inconclusive as there was inadequate perfusion of the anterior abdominal wall with contrast. The exact point of bleeding was not identified and there was no overt evidence of large calibre intraabdominal vessel or internal organ injury.

41. Dr Bouwer also noted evidence of natural disease, detected in the form of marked dilated cardiomyopathy[23] and marked liver fibrosis with a pattern suggestive of congestive hepatopathy[24].

[22] Marker or main.
[23] Heart weight 970 grams.
[24] Cardiac fibrosis.

42. Dr Bouwer ascribed the medical cause of death to 1 (a) intra-abdominal haemorrhage complicating elective umbilical hernia repair with contributing factors of dilated cardiomyopathy and liver fibrosis.

CPU REVIEW

43. In light of the circumstances surrounding Mr O'Brien's death, I requested the CPU to review the medical care and treatment provided to Mr O'Brien and provide a report. As part of its review, the CPU reviewed the court files which included statements from Mr Cao, Dr Thomas and Dr Porwal and referred to the medical records from SJOG Hospital.

44. The CPU noted Mr O'Brien as 74 years old man who had a significant history of cardiovascular disease. Medical records indicate that in November 2016, Mr O'Brien suffered from shortness of breath and was noted to have developed moderate mitral regurgitation on echocardiogram. The available evidence indicates that Mr O'Brien had not previously mentioned this symptom to Mr Cao, Dr Harding or Dr Thomas.

45. Following its review, the CPU identified late recognition of post-operative haemorrhage and an unrecognised coagulopathy were factors that contributed to Mr O'Brien's death.

Late recognition of post-operative haemorrhage

46. The CPU posited that Mr O'Brien developed a fatal complication of post-operative haemorrhage that progressed to unrecoverable multi-organ failure in the first twenty-four hours following his surgery.

47. According to Mr Cao, he was first notified of Mr O'Brien's deterioration at approximately 9.00pm on 11 September 2017. His observation of Mr O'Brien at that time suggested that there was no sense of urgency in exploring the cause of Mr O'Brien's deterioration.

48. Although Mr Cao stated he did consider post-operative bleeding during his subsequent review at 11.30pm, he felt that the haemoglobin result of 118 was "acceptable" given the intravenous fluid administered. Furthermore, he explained that an alternative diagnosis of fluid shift related to the ascitic fluid removal was a reasonable explanation for hypotension.

49. When asked about his interpretation of Mr O'Brien's falling haemoglobin level[25], Dr Porwal commented that a haemoglobin drop between 10 to 20 points is considered "relatively

[25] From 118 to 88 points.

common" with fluid resuscitation in Mr O'Brien's case. Such an observation is also commonly seen in the ICU.[26]

50. When asked specifically to address the possibility for earlier recognition of post-operative bleeding and his clinical decision of not returning Mr O'Brien to theatre overnight, Mr Cao stated that Mr O'Brien was stabilized on low dose inotropes and his falling haemoglobin could be explained in light of fluid shifts. Mr Cao also stated that his deterioration at 5.00am was "rapid" and it was not until after 6.00am that an intra-abdominal haemorrhage was suspected[27]. Thus, with such severity that there was no window for return to theatre to be realistically contemplated.

51. In the same question put to Dr Porwal, he stated it is his position to respond to Mr O'Brien post-operative treatment. However, Dr Porwal explained that he did raise concern about Mr O'Brien's condition when it became critical in the early hours of 12 September 2017 as he suspected that Mr O'Brien was suffering from post-operative complications. He subsequently raised his concern to Mr Cao and suggested a laparotomy.

Unrecognised coagulopathy and post-operative bleeding

52. By way of explanation, coagulopathy which is colloquially known as bleeding or clotting disorder. It is a condition in which the blood's ability to coagulate is impaired and can cause a tendency toward prolonged or excessive bleeding.

53. With reference to Mr O'Brien's forensic pathology report, the CPU noted that Mr O'Brien's liver disease was consistent with evidence of chronic hepatic congestion found. The CPU also stated that his liver disease was also expected given he was known to have severe tricuspid valve incompetence.

54. The CPU considered that Mr O'Brien was unable to overcome coagulopathy because his liver disease had the potential of causing blood clotting abnormalities which was further exacerbated by administration of his anticoagulant on the same night after his surgery.

[26] CF, Statement of Dr Sanjay Porwal, dated 20 June 2018.
[27] When the haemoglobin result was 81 and the INR of 2.0.

Appropriateness of Mr Cao's surgical decision making

55. The CPU also examined what information was available to Mr Cao at his pre-operative surgical consult, and what informed his surgical decision making.

56. According to Mr Cao, Mr O'Brien had been examined on three occasions pre-operatively by himself and Dr Thomas and that there was no clinical evidence to suggest "the possibility of ascites". Neither did Mr O'Brien's GP discover any clinical evidence of ascites throughout the course of consulting Mr O'Brien.

57. With the benefit of hindsight, Mr Cao stated he would not have offered Mr O'Brien the surgery if he had been aware of his chronic liver disease.

58. The CPU stated that Mr O'Brien was known to have severe tricuspid incompetence and this condition could have assisted Mr Cao to form the presumed basis of his liver disease. Despite that, the CPU stated that there were little in the way of little clinical markers that might led Mr O'Brien treating physicians to confirm a diagnosis of his liver disease.

59. Relevantly, Mr O'Brien underwent several examinations which did not detect ascites, and he also showed no peripheral stigmata of chronic liver disease. His liver function tests in the pre-operative period were also unremarkable.

60. The CPU formed the opinion that the opportunity for an earlier diagnosis did not therefore represent itself and as such did not of itself represent a significant missed opportunity to reassess the planned surgical approach for Mr O'Brien.

Should Mr O'Brien's bleeding have been recognised?

61. The CPU explained that there are many potential causes for low BP, including a fluid shift in response to the drainage of ascites and it can be difficult to differentiate the causes clinically. As discussed, Mr Cao did consider post-operative bleeding earlier after Mr O'Brien's surgery but felt that the relatively high haemoglobin level suggested an alternative diagnosis.

62. However, the CPU found that Mr Cao's excessively relied on the high haemoglobin level to reach a conclusion that Mr O'Brien was not bleeding because at the early stages of acute bleeding it is not expected that haemoglobin concentration will immediately fall. The haemoglobin falls over time as fluid shifts into the intravascular compartment diluting the haemoglobin concentration.

63. The CPU noted that Mr Cao did not give sufficient consideration on the possibility that the low BP was due to post-operative bleeding. Additionally, the gradually rising vasopressor requirements ought to have raised concerns with the ICU team about Mr O'Brien's circulatory state and the possibility of post-operative bleeding.

64. The CPU stated while the exact level of vasopressors in which a response should have been triggered is difficult to judge in the setting of a gradual change (as opposed to when there is a sudden change), it is commonly considered that low levels of noradrenaline (less than 5 or 10 mcg/min) are probably not of major concern. Furthermore, the doubling of vasopressor (noradrenaline) in a short period of time or need for a second agent (vasopressin) should trigger further consideration of the patient's condition.

65. In that regard, the CPU considered that the ICU team should have raised the possibility of post-operative bleeding as the cause for Mr O'Brien's hypotension in the early hours of 12 September 2017 between 1:00 and 4:00 am.

Should Mr O'Brien's bleeding and coagulopathy have been managed more aggressively?

66. With the benefit of hindsight, the CPU considered the absence of clinical suspicion of bleeding was a missed opportunity to withhold Mr O'Brien anticoagulant, and for earlier administration of fresh frozen plasma.

67. The CPU also considered Mr O'Brien was in a continuous state of deterioration post-operatively contrary to Mr Cao's stated opinion that Mr O'Brien's deterioration was sudden at 5.00am on12 September 2017.It would have therefore been possible for Mr Cao to identify bleeding if a laparotomy had been performed around the time Mr O'Brien's haemoglobin level began to fall.

68. The CPU further outlined that the need for hourly increase in inotropic support also failed to alert senior medical staff to Mr O'Brien's progressing instability, Unfortunately, it was too late when his treating clinicians recognised the need for a laparotomy.

SUBSEQUENT INVESTGATION

69. After the initial investigation, I determined to distribute the CPU report to Mr Cao, Dr Thomas and Dr Porwal with a view to provide opportunities for them to respond to the clinical management issues raised in the CPU report; and to SJOG Hospital with a view to ascertain whether any subsequent action has been taken since Mr O'Brien's death.

70. In conjunction with the opportunities to respond to the CPU report, Interested Parties were also invited to make submissions and provide any concessions and whether any of them had a view on whether there was a need for Mr O'Brien's matter to be heard in a public hearing.

71. None of the interested parties sought a public hearing, including a Mention Hearing and I determined this matter could be finalised by way of an In-Chamber Finding, save for potential adverse comments against SJOG Hospital and Mr Cao.

Was Mr O'Brien's death preventable?

SJOG Hospital's submissions

72. With respect to Mr Cao's post-operative management and the prospect of an early recognition of hypotension, SJOG Hospital submitted that ICU staff had *"from the outset considered post-operative bleeding"* and made record of "IAH" to indicate a possibility of an intra-abdominal haemorrhage.

73. SJOG Hospital further submitted they should not address any concerns that directly relate to Mr Cao's *"medical decision making"* and given his role as the treating surgeon.

Mr Cao's submissions

74. With respect to the late recognition of post-operative haemorrhage and with reference to using Mr O'Brien's haemoglobin level as an assessment, Mr Cao stated that *"I recognise that there was room for additional testing here, and that perhaps undue weight was placed on this single test result, rather than the totality of Mr O'Brien's clinical picture"*.

75. Mr Cao also conceded the possibility of post-operative bleeding was not *"at the forefront of [their] minds"* and he *"may not have placed sufficient weight"* on it as a differential diagnosis. As such he accepts, with the benefit of hindsight, further assessment may have assisted in identifying the post-operative bleeding.

76. With respect to the notification by the ICU team, Mr Cao submitted there was *"lack of communication from ICU staff regarding Mr O'Brien's steadily deteriorating condition"*. He further submitted that had he been alerted to the increasing vasopressor needs[28], early diagnosis of post-operative bleeding may have been made. Subsequently, he and other treating

[28] In the early hours of 12 September 2017, between 1.00 and 4.00am.

clinicians would have had the opportunity to institute measures to address the bleeding and try to stabilize Mr O'Brien before his condition became critical.

77. Additionally, Mr Cao also acknowledged that Mr O'Brien's coagulopathy risk arising from his atrial fibrillation could have been monitored for 24 to 48 hours after his surgery before recommencing him on his anticoagulant.

COMMENTS

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

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[29]

2. With respect to adverse comments or findings, the effect of the authorities is that they should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.

3. It is axiomatic that the assessment of any departure from norms or standards must be judged strictly without the benefit of hindsight. The trajectory that leads to a death may well be obvious after the event. Patterns or causal connections that can be traced from the privileged position of knowing the fatal outcome, may not have been obvious or even appreciable before that outcome.

4. While I am satisfied that the ICU team, including Dr Porwal, had raised the possibility of post-operative bleeding as at 6.00am, 12 September 2017, I concurrently note that the lack of communication by the ICU team as to Mr O'Brien's increasing vasopressor requirements between 12.00 to 5.00am did compromise Mr O'Brien's post-operative care to a certain extent.

5. I accept SJOG Hospital's submission that there was an opportunity missed in escalating Mr O'Brien's care during the early hours of 12 September 2017. I also accept Mr Cao's submission that the ICU team did not seek to escalate that concern to him or any other

[29] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the 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…'.

clinicians at that time. However, Mr Cao's oversight during that period of time cannot be overlooked, particularly as he initially suspected a possibility of post-operative bleeding.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Kenneth Ernest O'Brien, born 28 November 1942;

   b) the death occurred on 13 September 2017 at St John of God Health Care, St John of God Hospital Bendigo, 133-145 Lily Street, Bendigo Victoria 3550; and

   c) I accept and adopt the medical cause of death ascribed by Dr Heinrich Bouwer and I find that Kenneth Ernest O'Brien, a man with a medical history dilated cardiomyopathy and liver fibrosis died from intra-abdominal haemorrhage complicating elective umbilical hernia repair.

I convey my sincere condolences to Mr O'Brien's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this Finding be published on the Coroners Court of Victoria website in accordance with the rules.

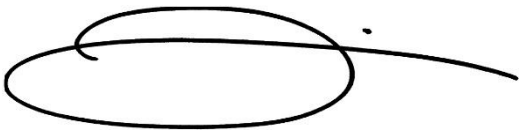
I direct that a copy of this finding be provided to the following:

James O'Brien

Madeleine Clohessy, In-House Senior Lawyer, St John of God Health Care

Peter Harris, Avant Law on behalf of Mr "Manny" Man Minh Cao

Signature:



AUDREY JAMIESON

CORONER

Date: 18 October 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.