IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006364

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Ronald William Beaumont
Date of birth:	9 September 1949
Date of death:	16 November 2023
Cause of death:	ACUTE MYOCARDIAL INFARCTION COMPLICATED BY MULTIPLE ORGAN FAILURE
Place of death:	Frankston Hospital 2 Hastings Road, Frankston Victoria 3199
Keywords:	Dual antiplatelet therapy; withholding medication; Sentinel Event review

INTRODUCTION

1. On 16 November 2023, Ronald William Beaumont was 74 years old when he died at Frankston Hospital. At the time of his death, Mr Beaumont lived with his wife, Carol Beaumont, at their home in Tootgarook, Victoria.

2. Mr Beaumont's medical history included ankylosing spondylitis, ischaemic heart disease, stroke, previous coronary artery stent (2021), intentional weight loss, severe peripheral vascular disease and profound spinal stenosis treated with laminectomy.

3. Mr Beaumont was described as a keen guitarist, and the limited use of his right shoulder significantly affected his quality of life. He pursued a total shoulder replacement with the hope that he might be able to play guitar again.

THE CORONIAL INVESTIGATION

4. Mr Beaumont'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. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Ronald William Beaumont. 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.[1]

[1] 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

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

Circumstances in which the death occurred

8. On 12 October 2023, Mr Beaumont was admitted to Frankston Hospital for an elective right shoulder replacement and was discharged home the following day. While in hospital, he experienced diarrhoea and received Gastro-Stop to assist.

9. On 14 October 2023, Mr Beaumont complained of stomach pains and diarrhoea. His wife provided him Gastro-Stop to assist with the symptoms.

10. On the morning of 15 October 2023, Mr Beaumont's stomach pains were so severe that he called an ambulance. Paramedics assessed him and transported him back to Frankston Hospital where he was found to be experiencing an ST-elevated myocardial infarction (**STEMI**). He was transferred to the cardiac catheterisation laboratory where he underwent a successful angiogram and percutaneous coronary intervention (**PCI**) with one stent inserted.

11. Mr Beaumont was transferred to a ward for a cardiology admission. Upon echocardiogram, he was found to have an ejection fraction of 30% with left anterior descending (**LAD**) territory hypokinesis.[2] Clinicians commenced him on dual antiplatelet therapy (**DAPT**).

12. During his admission, Mr Beaumont reported ongoing abdominal pain and intermittent diarrhoea/constipation. He underwent a CT of his abdomen which revealed duodenitis, with no features of diverticulitis. The duodenitis was initially treated with an intravenous proton pump inhibitor (**PPI**), which was later downgraded to an oral PPI. The general surgical team recommended lifelong PPI on discharge for gastro-oesophageal reflux.

13. According to Ms Beaumont, she and her husband observed a putrid smell from Mr Beaumont's shoulder bandage. She stated that she had asked the Orthopaedic Team to review it for several days. According to Peninsula Health, Ms Beaumont did not express these concerns until 19 October 2023 when they noted her concerns that the wound was not healing.

14. Regardless of which version of events is correct, a member of the Orthopaedic Team reviewed Mr Beaumont on 19 October 2023 in the presence of his wife. According to Peninsula Health, there was extensive bruising present, which was deemed to be as expected in the context of

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Hypokinesis is 'diminished contraction' of the heart muscle.

DAPT. The dressing was reportedly intact with no features of infection, and Mr Beaumont's range of motion was as expected. The Orthopaedic staff member recommended that nursing staff change the dressing. When nursing staff changed the dressing, they observed a malodorous smell and the "*presence of old ooze*". They cleaned the wound and replaced it with a new dressing.

15. Mr Beaumont was discharged home on 20 October 2023. His discharge medications included ticagrelor 90mg twice daily for 12 months and lifelong aspirin 100mg daily. His discharge plan included follow up with his general practitioner (**GP**) after one week, cardiac outpatient review after four to six weeks, and cardiac rehabilitation in the community.

16. On 27 October 2023, Mr Beaumont attended an orthopaedic outpatient review, where a surgeon examined the wound and observed a breakdown of tissue. The wound was cleaned with chlorhexidine and redressed. Mr and Ms Beaumont were unhappy with the outcome of this appointment, so they decided to book an appointment with their GP for a second opinion.

17. Mr and Ms Beaumont visited their GP, Dr Rob Jeffs, on 30 October 2023. Dr Jeffs stated that upon examination of the wound, he observed purulent discharge with a 1cm sinus. He took a swab, dressed the site and commenced broad-spectrum antibiotics. Dr Jeffs also organised a blood test to guide future management decisions. Dr Jeffs recommended Mr and Ms Beaumont re-present to hospital. Dr Jeffs withheld the recently commenced dapagliflozin to prevent further dehydration and slightly increased Mr Beaumont's dosage of prednisolone.

18. Mr Beaumont visited Dr Jeffs again on 1 November 2023. Mr Beaumont demonstrated slight improvement in the localised cellulitis. His blood tests indicated a mildly elevated C-reactive protein (**CRP**), with a slightly low calcium and mild renal impairment.

19. Mr Beaumont returned to Frankston Hospital on 3 November 2023 for review of his shoulder. The orthopaedic clinician noted it was tender and open, so they washed, cleaned and packed it. The clinician also escalated their concerns to the original surgeon who performed the procedure. The original surgeon agreed to perform a surgical washout on 6 November 2023.

20. Prior to the second surgery, the Orthopaedic Team contacted the Cardiology Unit and Mr Beaumont's interventional cardiologist about antiplatelet management for the second surgery. The advice was not to cease any antiplatelet medication (aspirin and ticagrelor) for one year.

21. Mr Beaumont attended Frankston Hospital on 5 November 2023. That evening, a Medical Emergency Team (**MET**) call occurred due to asymptomatic systolic hypotension. Mr Beaumont also reported a two-week history of dark stools. Clinicians performed an ECG and blood tests, and the results were consistent with anaemia. Mr Beaumont received a transfusion of packed red blood cells, and a CT mesenteric angiogram was ordered to investigate possible active bleeding. Mr Beaumont was due to receive his normal medications.

22. The CT showed no active arterial bleeding and no concerning intraabdominal abnormalities. The blood transfusion continued overnight, and Mr Beaumont remained alert and oriented.

23. On 6 November 2023, Mr Beaumont's medications were marked as withheld "*fasting for OT* [operating theatre]" by the morning nurse. These medications included Mr Beaumont's aspirin and ticagrelor. The nurse had first contacted an Orthopaedic Hospital Medical Officer who advised to withhold the medications.

24. The Orthopaedic Intern discussed Mr Beaumont's case and the plan for surgery with the Anaesthetic Registrar. They discussed his vascular and cardiac history, including the recent stent. The Anaesthetist recommended a review by the Perioperative Medicine Team to ensure Mr Beaumont was optimised for the surgery. The Perioperative Registrar advised that they would not be able to provide any meaningful benefit, given the surgery was due to take place in only a few hours. The Perioperative Registrar agreed to review Mr Beaumont after surgery. The Orthopaedic Intern also discussed this case with the Cardiology Registrar, who advised not to stop the DAPT pre-operatively, due to a high risk of complication.

25. That afternoon Mr Beaumont underwent a right shoulder washout under anaesthetic. There were no issues encountered during the procedure, and no opening or visible defect to the joint. He was returned to the ward at 4.00pm.

26. That evening, at about 6.15pm, a MET call occurred due to an increased respiratory effort. Staff performed blood tests (including troponin) and a chest x-ray. They also administered his regular medications including ticagrelor. The blood test results revealed a rise in troponin and Mr Beaumont was commenced intravenous saline. He was monitored overnight, where his troponin levels continued to rise.

27. Mr Beaumont experienced another MET call at 9.24am on 7 November 2023 for increased respiratory effort and rate, and elevated heart rate and. He was reviewed by the Cardiology team shortly before 10.00am for a possible non-ST elevated myocardial infarction (**NSTEMI**). Mr

Beaumont was transferred to the Cardiology Ward for further management. Clinicians planned to consider an angiogram, once Mr Beaumont recovered from the surgery and anaesthesia.

28. On 8 November 2023, the Orthopaedic Intern reviewed Mr Beaumont. The Intern documented an open disclosure discussion with Mr and Ms Beaumont about the missed doses of DAPT and its potential contribution to his NSTEMI. Mr and Ms Beaumont confirmed that he last had his DAPT dose on the morning of 5 November 2023 and therefore missed two doses (nighttime dose on 5 November and morning dose on 6 November 2023).

29. From 8 to 13 November 2023, Mr Beaumont's condition steadily deteriorated. He experienced incipient cardiogenic shock, complicated by worsening renal and hepatic dysfunction as well as pulmonary oedema. By 13 November 2023, Mr Beaumont's shoulder wound was noted to be completely healed, notwithstanding his deteriorating condition.

30. On 15 November 2023, an Intensive Care Consultant reviewed Mr Beaumont and advised that dialysis would not alter his prognosis or improve the quality of his life. Following discussions with his family, Mr Beaumont was transitioned to palliative care. He was considered too unstable to be transferred to the palliative care ward and remained in a medical ward. Mr Beaumont passed away at 8.38pm on 16 November 2023.

Identity of the deceased

31. On 16 November 2023, Ronald William Beaumont, born 9 September 1949, was visually identified by his wife, Carol Beaumont.

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

Medical cause of death

33. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an autopsy on 21 November 2023 and provided a written report of his findings dated 27 December 2023.

34. The post-mortem examination showed no evidence of any traumatic injury which would have contributed or led to death.

35. The post-mortem CT scan showed right shoulder orthopaedic hardware, coronary calcification, pleural effusions and increased lung markings.

36. The post-mortem examination confirmed an acute myocardial infarction involving the anterior wall of the left ventricle. There was associated coronary artery disease with stent in situ within the left anterior descending coronary artery. The stent was patent.

37. The post-mortem examination also showed acute pancreatitis which was associated with calculi within the pancreatic duct. Dr Burke opined that this likely explained the deceased's abdominal pain and the CT finding of stranding within fat.

38. Dr Burke provided an opinion that the medical cause of death was *1(a) Acute myocardial infarction complicated by multiple organ failure*. He noted that the death was due to natural causes.

39. I accept Dr Burke's opinion.

FAMILY CONCERNS

40. Mr Beaumont's family submitted extensive concerns of care about Mr Beaumont's treatment from Peninsula Health[3] in the period shortly before his death. In summary, the concerns were:

    a) That the surgeon who signed the consent form for Mr Beaumont's shoulder surgery was not the surgeon who actually performed the procedure.

    b) That Mr Beaumont was not sent home with antibiotics following his shoulder surgery.

    c) That Mr Beaumont had a stent inserted while he was "*still in the corridor of Frankston Hospital. The surgery was not conducted in a private room under sterilised conditions*".

    d) Mr Beaumont's wife was not advised after he experienced the first heart attack.

    e) While Mr Beaumont was recovering from his first heart attack, he and his wife observed his shoulder wound had a foul odour. They repeatedly asked the orthopaedic team to review it; however, it took four days for this to occur. When the surgeon attended to review the wound, they only performed mobility tests and did not check the wound itself and asked a nurse to change the bandages. Ms Beaumont reported that her husband was not given any antibiotics.

[3] I note that since Mr Beaumont's death, Peninsula Health has been amalgamated into Bayside Health with other health services. For simplicity, I have referred to the services as Peninsula Health throughout this finding.

f) When Mr Beaumont attended Frankston Hospital on 27 October 2023 for a review of his shoulder, the clinician looked at the shoulder and asked him to return after one weeks but did not prescribe antibiotics. Mr Beaumont decided to get a second opinion from his GP.

g) When Mr Beaumont attended his GP on 30 October 2023, the GP took a swab from the wound which reportedly tested positive for *proteus mirabilis*.

h) When Mr Beaumont returned to hospital on 5 November 2023, he did not receive his nightly medication, nor his morning medication on 6 November 2023.

i) Following his second surgery, Mr Beaumont suffered a second heart attack, but his family were not informed immediately.

j) Mr Beaumont's family were asked on 13 November 2023 whether they wanted him to receive dialysis. While they decided 'yes' very quickly, the dialysis did not occur that day or the next morning.

k) On 14 November 2023, when Mr Beaumont's family agreed to transition him to palliative care, they observed that he was not receiving sufficient pain relief and as such he was in pain and uncomfortable.

l) When Mr Beaumont passed, Ms Beaumont was unable to find anyone to report the death to and was not given any information about the next steps.

FURTHER INVESTIGATIONS AND CPU REVIEW

41. Following receipt of the family's concerns, I directed further material be obtained including statements from Peninsula Health (operators of Frankston Hospital) and Dr Jeffs. Peninsula Health were asked to respond to the concerns raised by Mr Beaumont's family, amongst other matters. I also referred this case to the Coroner's Prevention Unit (**CPU**)[4] for an independent review of the medical treatment Mr Beaumont received.

Statement of Associate Professor Shyaman Menon

[4] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

42. Peninsula Health Executive Director of Medical Services and Clinical Governance, Associate Professor (**A/Prof**) Shyaman Menon provided a statement addressing the concerns raised by Mr Beaumont's family. They also supplied a copy of the Root Cause Analysis which they performed after Mr Beaumont's death.

Change of surgeon for first shoulder surgery

43. A/Prof Menon explained that the surgical consent form signed by Mr Beaumont on 26 May 2023 outlined that there was no guarantee that the surgery would be performed by a particular surgeon. Due to the lack of bed availability on the initially allocated date, a revised date for the surgery meant that a different surgeon performed the procedure.

44. The CPU opined that this is consistent with usual care in public hospitals.

Time to discharge and post-operative antibiotics

45. A/Prof Menon noted that discharge home within 24 hours of shoulder surgery is not unusual if the patient is well and has supports at home. Mr Beaumont was assessed by a physiotherapist and occupational therapist and was found to be suitable for discharge home.

46. A/Prof Menon explained that three doses of intravenous antibiotics were administered during the surgery and no oral antibiotics were considered necessary. He explained that this approach is in line with antimicrobial stewardship, helping to decrease antibiotic resistance in the community. The CPU concurred with this response, noting that this represented normal, routine care in public hospitals.

First heart attack – communication and location of procedure performed

47. A/Prof Menon noted that Mr Beaumont underwent a series of urgent procedures including a cardiac ultrasound, angiogram and stent insertion upon his arrival at Frankston Hospital. It was not documented whether any of the clinical staff offered to inform Mr Beaumont's next of kin about these procedures. Peninsula Health acknowledged that the level of communication with the family at this time did not meet the needs of the family. They also explained that they would explore ways to improve communication with families at times of critical procedures.

48. A/Prof Menon explained that Mr Beaumont underwent the relevant procedures in appropriate locations. The cardiac ultrasound was a bedside ultrasound, conducted in the emergency department. The angiogram and stent insertion occurred in the cardiac catheterisation

laboratory. I consider the claim that Mr Beaumont had a stent inserted while he was "*still in the corridor of Frankston Hospital*" is completely unlikely and I accept the evidence of A/Prof Menon concerning the locations where the various procedures were undertaken.

49. Peninsula Health also acknowledged that communication from the Orthopaedic Team during their review of Mr Beaumont following his first heart attack was inadequate and offered an apology to Ms Beaumont. During the orthopaedic review, Mr Beaumont's wound was noted to have some oozing present, however this was thought to be attributable to his blood thinning medication. A/Prof Menon opined that this may have contributed to the steri strips sticking to his wound (which is not uncommon), however this is not indicative of infection. The CPU also concluded there were no signs or symptoms indicative of infection.

Communication with GP

50. At the time of Mr Beaumont's review on 27 October 2023, the surgical opinion was that antibiotics were not required. The wound was cleaned and dressed during this appointment with a further follow-up scheduled for 3 November 2023. The surgeon's opinion and instructions for wound care were communicated in a letter to Dr Jeffs dated 27 October 2023. The letter emphasised the need to keep an eye on the wound, given that there was a fresh arthroplasty underneath.

51. A/Prof Menon noted that Dr Jeffs reviewed Mr Beaumont on 30 October 2023 and formed a different view. He ordered antibiotics and requested second daily review. Correspondence from the surgeon to Dr Jeffs following the 3 November 2023 review described the wound dehiscence as being due to increased bleeding through the middle of the wound. One week later, the orthopaedic surgeon elected to take Mr Beaumont back to theatre for a precautionary wash out.

52. In the surgeon's correspondence to Dr Jeffs dated 6 November 2023, he explained that the return to the operating theatre was a precautionary measure. He noted the wound looked quite clean, however there was clearly some dehiscence in the middle part of the wound. He explained that he was able to excise the necrotic edges and washed the wound thoroughly. He did not find any clear need to perform an arthrotomy despite a thorough look and noted that this did present *some* risk of a joint infection. On balance, he felt it was more appropriate to wash the wound as a superficial wound only. He requested ongoing antibiotics and requested a review after one week.

53. The CPU did not identify any issues or deficiencies with respect to the approach taken by the orthopaedic surgeon.

Second shoulder admission – missed medications

54. The Peninsula Health review panel found potential miscommunication regarding continuation of Mr Beaumont's DAPT. A/Prof Menon noted that open disclosure occurred at the time and the review process included pertinent recommendations to address this issue. This is discussed further below.

Deterioration following second shoulder surgery

55. A/Prof Menon noted that Mr Beaumont demonstrated signs of deterioration in the period after his second shoulder surgery. His cardiac enzymes indicated an NSTEMI, however he opined that this was not thought to have been caused as a result of the two missed doses of DAPT.

56. The CPU noted that there are two types of acute myocardial infarction. The first type occurs when there is an occlusion of a coronary artery or a stent. In these cases, patients are placed on lifelong antiplatelet therapy. The second type of acute myocardial infarction occurs when there is a mismatch between oxygen supply and demand, without an occlusion. Increased stress causing a mismatch between oxygen supply and demand can be psychological or physiological, including surgery.

57. The CPU noted that if Mr Beaumont had suffered an occlusion, then an argument could be made that the interruption of his medication may have contributed contributor as clots are prevented by aspirin. However, the CPU explained that the role of aspirin in the second type of acute myocardial infarction is far less certain.

Dialysis and CT brain results

58. A/Prof Menon noted that following the second shoulder procedure, Mr Beaumont's treating team sought an expert opinion from the renal team and the intensive care team in relation to his declining renal function. While staff discussed dialysis with Ms Beaumont as a treatment option, the renal team felt that long-term dialysis was not recommended and short-term dialysis would be poorly tolerated due to Mr Beaumont's comorbidities and heart function. The intensive care team agreed with this opinion and noted that an intensive care dialysis would not alter his prognosis or improve quality of life.

59. A/Prof Menon explained that the CT brain scan was performed to investigate Mr Beaumont's declining limb function. The results did not reveal any acute abnormalities, and within one hour of the test, a decision to transition to palliative care was reached.

60. The CPU noted that this version of events is consistent with the contemporaneous records in Mr Beaumont's medical records. The CPU also noted that this is also consistent with usual practice.

Palliative care

61. A/Prof Menon noted that as part of Peninsula Health's internal review, a palliative care expert was consulted and asked to review the palliative care provided to Mr Beaumont. A/Prof Menon noted that the palliative care ward is the most appropriately placed ward to receive end-of-life care, however Mr Beaumont was not well enough to be moved from his location on a medical ward to the palliative ward.

62. The review found that the pain relief was ordered according to usual protocols, however it also acknowledged that breakthrough pain may have been better managed with more frequent palliative care consultation. Peninsula Health has since notified and reminded all units concerning the availability of 24/7 palliative care advice.

63. A/Prof Menon noted that while the 'care of the dying' pathway was followed in this case, it was unclear if the information on next steps and bereavement was provided to Mr Beaumont's family. The review identified a further learning to improve communication with the families during palliation when it occurs outside the palliative care unit.

64. The CPU noted that while health services may try to care for a patient in the preferred environment, sometimes factors beyond their control prevents this from occurring. This was the case for Mr Beaumont who was too unstable to be moved to the palliative care ward.

Additional concern not considered by A/Prof Menon

65. The CPU noted an additional concern raised by Mr Beaumont's family that was not canvassed by A/Prof Menon's statement, namely, Mr Beaumont's pre-surgical assessment.

66. The CPU noted that pre-surgical assessments screen for suspicious signs and symptoms such as chest pain or an ECG that suggests ischaemic heart disease. If these issues are detected, further investigations are conducted including stress tests or angiograms. These tests are not routinely performed in asymptomatic patients as the harm from the tests themselves can

outweigh the benefits. In this regard, the CPU explained that this is similar to attending a GP for a routine check-up. If an asymptomatic person presents to a GP, there is no guarantee that something unpredictable will not happen.

Peninsula Health Root Cause Analysis

67. Many of the issues and themes canvassed above were considered as part of Peninsula Health's Root Cause Analysis (**RCA**), so will not be repeated here. The RCA identified the two lessons learnt and made three recommendations.

68. The lessons learnt were:

    a) The unclear process for the completion of medical admission notes for the 'out of hours' direct inpatient admission when the patient was scheduled for orthopaedic surgery the following day, increased the likelihood of miscommunication and inadequate regarding the plan for DAPT management during the preoperative period.

    b) The inadequate utilisation (and completion) of the post-death section of the 'care of the dying pathway' on a non-palliative care ward likely contributed to the failure to meet the communication needs of the family. The pathway guides staff on post-death care and management, including providing families with information on next steps and offering bereavement support.

69. The recommendations included:

    a) In accordance with the current Clinical Pathway 'Direct Admission Process for Frankston Hospital Inpatient Units', the Orthopaedic home unit is to establish the unit's process for 'out of hours' direct inpatient orthopaedic admissions – to be seen by either the Orthopaedic Hospital Medical Officer or the covering specialty Hospital Medical Officer for formal 'History and Examination' at admission, as well as medication charting. There should be collaborative generation of an admission plan with the on-call Orthopaedic Registrar. The robust and patient specific care plan must then be clearly documented in the electronic medical record by the home team.

       Additionally, for effective communication, the Orthopaedic Registrar coordinating the referred direct inpatient admission is to:

       - Including the care plan on the orthopaedic handover worksheet

- Communicate the planned admission and plan for management to the Orthopaedic team covering overnight or on the weekend when the planned admission is to occur.

b) Provide education to nursing staff on 5FN ward (where Mr Beaumont died) regarding the post-death section of the 'care of the dying pathway' in relation to communicating with families/carers and providing information on next steps and available bereavement supports, including documentation in the medical record.

c) Review the clinical pathway for '*Direct Admission Process for Frankston Hospital Inpatient Unit*' to clarify the responsibilities of the admitting home unit on admission regarding patient assessment and care plan.

Summary of contributing factors

70. The CPU explained that every surgical procedure carries routine risks that a patient must consent to:

    a) Every time an incision is made, there is a risk of bleeding or infection.

    b) Every time blood thinning medication is withheld before a procedure to minimise the risk of bleeding, there is a risk that the condition for which the blood thinning medication is prescribed, can re-occur or worsen.

71. Because these risks are small, when there is an adverse outcome, the CPU explained that outcome bias can lead people to think there must have been a poor process, rather than a statistical chance. This is not necessarily the case. When an adverse event does occur against the odds, the doctor's role is to recognise and respond to it appropriately.

Appropriateness of approach in relation to anticoagulation therapy prior to both shoulder surgeries

72. With respect to the withholding of aspirin for the first surgery, the CPU explained that this is standard and recommended practice by both cardiologists and surgeons. Assessed across the population, the risk of bleeding from not withholding aspirin far outweighs the risk of a heart attack.

73. In relation to the medication error during the second admission, where the DAPT was inadvertently withheld against the cardiologist's recommendation, the CPU agreed with Peninsula Health. While this was an error, the second heart attack did not involve a clot and

therefore, it cannot be said that withholding this medication was causal. I agree with this conclusion.

<u>Antibiotic treatment post-surgery</u>

74. The CPU noted that the decision not to prescribe antibiotics after the first surgery was reasonable and was in keeping with current practice, for the reasons stated by A/Prof Menon (above).

75. The CPU further noted that cefazolin (or the oral equivalent, cefalexin) is first line treatment for joint infections. However, this agent can contribute to both hepatic and renal impairment. As such, the CPU opined that earlier antibiotic use would not have had a different outcome. I accept this opinion.

<u>Timeliness of orthopaedic review</u>

76. The CPU noted that there were no overt signs of infection (fevers, sweats, chills) that would have indicated an earlier orthopaedic review was required. The CPU emphasised the unintended consequences of both surgery (post-operative myocardial infarction) and antibiotics (hepatic and renal impairment). In those circumstances, it is not possible to say that an earlier review would have resulted in a different outcome.

<u>Likely contributing factors to renal failure</u>

77. The CPU explained that there were potentially several contributing factors in Mr Beaumont's renal failure. This included contrast-induced nephropathy, acute tubular necrosis, ankylosing spondylitis associated auto-immune damage and/or antibiotic associated acute interstitial nephritis. I accept this to be the case and that it is not possible to conclude which of these factors may have been responsible.

78. The CPU also noted in the medical records a renal team consultation on 14 November 2023. The renal team was similarly unable to determine which of the above factors were contributing to Mr Beaumont's renal failure.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ronald William Beaumont, born 9 September 1949;

b) the death occurred on 16 November 2023 at Frankston Hospital, 2 Hastings Road Frankston, Victoria 3199, from acute myocardial infarction complicated by multiple organ failure; and

c) the death occurred in the circumstances described above.

80. Having considered all the circumstances, I am not satisfied that there is a causal connection between the incorrect withholding of Mr Beaumont's DAPT prior to surgery and the subsequent myocardial infarction.

COMMENTS

Pursuant to section 67(3) of the Act I make the following comments.

81. A/Prof Menon explained that this case was reported to Safer Care Victoria as a Sentinel Event[5] on 5 September 2024 under Category 7 – Medication Error Resulting in Serious Harm or Death. Following Peninsula Health's RCA, on 16 October 2024 they requested that the case be withdrawn as a Sentinel Event, as their review panel had concluded that there was no direct causal link between the medication error and the patient harm or outcome. Safer Care Victoria accepted the withdrawal of the case as a Sentinel Event on 31 October 2024.

82. While Ms Beaumont lodged an email complaint with Peninsula Health shortly after Mr Beaumont's death, her email reportedly did not contain details of the complaint. Peninsula Health attempted to follow up with Ms Beaumont without success. On 3 January 2024, Peninsula Health received a copy of the Medical Examiner's Report which included reference to the concerns raised by Ms Beaumont.

83. Peninsula Health noted that in the absence of sufficient detail to trigger an internal clinical review, the Medical Examiner's Report was not disseminated to the Safer Care / Quality Unit until July 2024, following receipt of the Court's request for a statement. This was some ten months after Mr Beaumont's death. It was at this time that Peninsula Health communicated with Safer Care Victoria to determine whether the case was a 'Sentinel Event'. The CPU observed that this is not the only case in which this issue has arisen and drew my attention to the death of Tasman Tribe[6] as an example of a delayed recognition of a Sentinel Event.

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[5] A "Sentinel Event" is an adverse patient safety event which results in serious harm or death.

[6] Finding into death without inquest – Tasman Tribe.

84. The Coronial Admissions and Enquiries section (**CAE**) of the Victorian Institute of Forensic Medicine operates 24 hours a day and can provide advice to clinicians who are trying to determine whether particular circumstances amount to a Sentinel Event. Safer Care Victoria has a Sentinel Event hotline and email intended to provide similar assistance. It is clear that a conservative approach should be adopted if there is any doubt whether an occurrence amounts to a Sentinel Event and, if necessary, these sources of information should be used to assist in the decision to report, and the reporting process itself.

85. Peninsula Health appropriately acknowledged that a clearer and more consistent escalation pathway would support the conservative approach outlined above.

I convey my sincere condolences to Mr Beaumont'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:

Carol Beaumont, Senior Next of Kin

Peninsula Health (now Bayside Health)

Safer Care Victoria

Senior Constable Jarrod Shepherd, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 28 April 2026

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.