



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003430

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Peter Ronald Dunmore
Date of birth:	29 May 1960
Date of death:	19 June 2024
Cause of death:	Peritonitis and ischaemic small bowel <u>Contributing factors</u> Hypertensive and ischaemic heart disease
Place of death:	15 Halsbury Place Skye Victoria 3977
Keywords:	Peritonitis; ischaemic small bowel, aberrant pathology alerts; efficacy of incident review

INTRODUCTION

1. On 19 June 2024, Peter Ronald Dunmore was 64 years old when he died at his home in Skye, Victoria.
2. Mr Dunmore's medical history included hypertension and smoking. He was prescribed amlodipine and perindopril to treat his hypertension.

THE CORONIAL INVESTIGATION

3. Mr Dunmore'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.
4. 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.
5. 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.
6. This finding draws on the totality of the coronial investigation into the death of Peter Ronald Dunmore. 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 evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

Circumstances in which the death occurred

7. On 21 May 2024, Mr Dunmore presented to Monash Medical Centre with a several-week history of abdominal pain, diarrhoea and weight loss. In the emergency department, Mr Dunmore's blood tests revealed electrolyte derangement.
8. After initial investigations in the emergency department, Mr Dunmore was reviewed by the general surgery, vascular surgery and gastroenterology teams and underwent blood tests, CT scans of his abdomen and pelvis (CTAP), and later, a CT angiogram (CTA) of his abdomen and pelvis. Significant findings from these investigations included:
 - a) A 22 to 32 mm segment of occlusion of the superior mesenteric artery (SMA),² which was found on both the CTAP and the CTA.
 - b) Elevated white cell count (WCC).³
 - c) Elevated C-reactive protein (CRP).
9. The various teams who reviewed Mr Dunmore concluded that there was no acute surgical problem that required immediate intervention and opined that the occlusion of the SMA was 'chronic', as there were collateral blood vessels to the small bowel from other arteries in the abdomen, the coeliac artery and inferior mesenteric artery (IMA). Elsewhere, there was extensive atherosclerosis of the abdominal aorta and its branches.
10. The Acute Surgical Unit (ASU) also reviewed Mr Dunmore. They noted the CT scan findings and examined Mr Dunmore's abdomen, documenting "*soft, mildly distended but not tender*".
11. Mr Dunmore was also referred to the vascular surgery team for admission. Emergency Department staff requested a bed for Mr Dunmore at 2.18am on 22 May 2024 and the Vascular Team reviewed Mr Dunmore in the emergency department at approximately 9.00am. The vascular intern documented that Mr Dunmore's abdomen was "*soft, non-tender, not peritonitic*".

² The superior mesenteric artery (SMA) supplies blood to much of the midgut in the human body. Specifically, it provides arterial supply to the distal duodenum, the jejunum and ileum (i.e., the small bowel), the caecum and appendix, the ascending colon and the proximal two-thirds of the transverse colon (i.e., approx. half the large bowel).

³ The WCC can be elevated in infection, inflammation and many other conditions including pain and physiological stress.

12. Clinicians spoke to Mr Dunmore about the SMA occlusion and recorded various lifestyle recommendations as, “*optimise lifestyle factors +++, stop smoking, cholesterol optimisation, lifelong aspirin*”.
13. Mr Dunmore’s blood test results were included in the same entry. They appeared to have been copied and pasted from the pathology results (or were automatically inserted by the medical record software). Of note, Mr Dunmore’s CRP level was documented as “*237 mg/L Critical 21/05/24 17:48:00*”. This is discussed in further detail below.
14. The Vascular Team formed the impression that this was a “*chronic SMA occlusion with compensating IMA and coeliac*”. They declined an admission under the Vascular Unit and referred him to the Gastroenterology Team for admission. It is not clear from the records whether Mr Dunmore was seen by a Vascular Consultant, or whether his case was discussed with a Vascular Consultant.
15. The Gastroenterology Team were concerned about the possibility of malignancy and arranged an urgent colonoscopy and gastroscopy for 28 May 2024. The Gastroenterology Team did not admit Mr Dunmore, noting “*no need for Gastro admission (will sit on ward not receiving active treatment while awaiting endoscopy)*”. Mr Dunmore was discharged from the Emergency Department on 22 May 2024.
16. The discharge documentation recorded a plan to commence “*aspirin, statin and NRT [nicotine replacement therapy]*”. According to Mr Dunmore’s family, he did not commence any of these medications.
17. Mr Dunmore returned to the Monash Medical Centre on 28 May 2024 where he underwent a gastroscopy and colonoscopy. The findings of these procedures were as follows:
 - a) The gastroscopy demonstrated no significant abnormalities of the stomach and duodenum. There was no evidence of ischaemia in these areas.
 - b) The colonoscopy demonstrated normal terminal ileum.⁴ There was also a comment regarding an area of mildly eroded (linear pattern) mucosa that was found in the caecum and slight pale mucosa in the right colon. The exam was otherwise normal

⁴ Terminal ileum is the last part of the small bowel prior to it entering the large bowel at the caecum. This is the upper limit of the view obtained during a colonoscopy.

throughout the examined colon with no evidence of bleeding or a mass in the entire colon.

18. A biopsy demonstrated histological findings of mild focal active colitis⁵ in the left and right colon and rectum, but this was not considered to represent ischaemic colitis.
19. The anaesthetic documentation from this procedure documented that Mr Dunmore's medications only included an antihypertensive medication, with no reference to aspirin, NRT or a statin.
20. Mr Dunmore returned to the Monash Medical Centre on 7 June 2024 where he underwent a CT scan of his chest, as part of the work-up for suspected cancer. This was performed as an outpatient procedure. The results demonstrated emphysema, some small pulmonary nodules and extensive coronary artery calcification. Mr Dunmore's brother-in-law, Paul Fisher, also attended the CT scan appointment. Mr Fisher spoke to the Vascular Team reception, in an attempt to arrange an earlier appointment with the Vascular Clinic (which was booked for 1 July 2024). The notes documented by the Vascular Clinic staff member stated, "*Please ring Peter's Brother-in-law Paul...Pt. very unwell and will not go to Emergency*".
21. It appears from this documentation that an appointment at the Vascular Clinic was booked for 17 June 2024, although other documentation suggested an appointment was booked for 24 June 2024.
22. Mr Dunmore attended his general practitioner, Dr Sai Andey, on 18 June 2024. According to the patient records, the presentation was for "*sub-acute abdominal pain*". Dr Andey found Mr Dunmore had epigastric tenderness and prescribed him Nexium. I note for completeness that Mr Fisher stated that Mr Dunmore told him that Dr Andey had said it was "*too dangerous to give him any kind of medication*". This is discussed in further detail below.
23. Mr Dunmore's brother, Mark Dunmore last saw his brother alive on the evening of 18 June 2024. Mark Dunmore stated that he offered to make his brother food, however Mr Dunmore declined and complained that he was still in pain and was experiencing diarrhoea.
24. On the afternoon of 19 June 2024, Mark Dunmore found his brother unresponsive on the hallway floor. Mark Dunmore called emergency services, and paramedics attended a short time later and confirmed that Mr Dunmore was deceased.

⁵ Inflammation of part of the colon or the large bowel.

Identity of the deceased

25. On 19 June 2024, Peter Ronald Dunmore, born 29 May 1960, was visually identified by his brother, Mark Dunmore.
26. Identity is not in dispute and requires no further investigation.

Medical cause of death

27. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an autopsy on 26 June 2024 and provided a written report of his findings dated 27 July 2024.
28. The post-mortem examination revealed acute peritonitis and ischaemic small bowel. The latter was due to the occlusion of the superior mesenteric artery (an antemortem finding). A perforation site was not identified. There was background hypertensive and ischaemic heart disease.
29. There were no injuries found at autopsy that could have caused or contributed to the death.
30. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.
31. Dr Beer provided an opinion that the medical cause of death was *1(a) Peritonitis and ischaemic small bowel* with contributing factors of *hypertensive and ischaemic heart disease*.
32. Dr Beer opined that the death was due to natural causes.
33. I accept Dr Beer's opinion.

FAMILY CONCERNS

34. Mr Dunmore's brother-in-law wrote to the Court on behalf of his family to express their concerns about the treatment his brother received at Monash Medical Centre on 21 May 2024, as well as the outpatient appointments in June 2024. He also queried the appropriateness of the general practitioner's advice the day before Mr Dunmore's death. The concerns included:
 - a) That Mr Dunmore was discharged without any medication.
 - b) That Monash Medical Centre brought the Vascular Clinic appointment forward, but this would have been too late for Mr Dunmore.

- c) That Dr Andey did not send Mr Dunmore directly to hospital on 18 June 2024.

FURTHER INVESTIGATIONS AND CPU REVIEW

35. As part of the investigation, I directed that further information be obtained from Monash Health and Mr Dunmore's general practitioner. I also referred the case to the Coroner's Prevention Unit (CPU)⁶ for an independent review of the medical treatment Mr Dunmore received in the period immediately prior to his death.

Discharge from MMC on 22 May 2024

36. The CPU noted the discharge documentation recorded a plan to commence aspirin, statin and NRT. On the morning of 22 May 2024, Monash Medical Centre staff ordered these medications, when they originally planned to admit Mr Dunmore. There was no evidence on the patient records that Mr Dunmore was provided with a supply of these medications upon discharge, or that he was given a prescription to fill after discharge.
37. In his correspondence to the Court, Mr Fisher stated that Mr Dunmore was discharged from Monash Medical Centre on 22 May 2024 with no medications.
38. Dr Andey stated that he received this discharge summary, although had no specific memory of reviewing it. The discharge summary contained a brief reference to Mr Dunmore being commenced on new medications "*commence aspirin + statin + NRT*", however it was not prominent and was not recorded in the relevant 'discharge medication' section of the summary.
39. The anaesthetic medication records from Mr Dunmore's gastroscopy and colonoscopy on 28 May 2024 indicated that his current medications were "*anti-BP*". There was no reference to aspirin, cholesterol lowering medication or nicotine replacement therapy. The CPU opined that considering all the available evidence, Mr Dunmore was not taking these medications following his discharge on 22 May 2024. I accept this conclusion.
40. The CPU noted the discharge advice document that is normally provided to patients following an Emergency Department attendance usually includes their diagnosis, treatment, medication

⁶ 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.

changes, planned follow-up, tests to be followed up by the general practitioner, and specific symptoms that should prompt the patient to return to the Emergency Department. This does not appear to have been completed or provided to Mr Dunmore on this occasion.

41. The CPU concluded that Mr Dunmore was discharged on 22 May 2024 without his new medication (or a prescription or advice to obtain this new medication). Dr Andey made no reference to these medications.

Monash Health Serious Incident Review

42. Monash Health performed a Serious Incident Review following Mr Dunmore's death. The Serious Incident Review panel concluded:

We believe that after the initial presentation to the ED, and the imaging performed at that time, that the assessment of the SMA occlusion being chronic was correct and that the collateral arterial blood supply from the coeliac and inferior mesenteric arteries was adequate for gut perfusion and viability as demonstrated on the CTA (22/5/2024).

Of more concern is the grossly elevated CRP and the apparent lack of consideration about the cause of this or its significance. We were unable to establish if this was recognised by the assessing doctors, as it seems they were unaware of this result at the time of the ED presentation.

43. The CPU noted that the CRP result was recorded by treating teams on several occasions while Mr Dunmore was in the Emergency Department. The CRP result was also included in the clinical notes for the urgent endoscopy request which was written by the Gastroenterology Team on 22 May 2024. There was also a note that indicates that the Gastroenterology Consultant was involved in Mr Dunmore's care at that point.
44. Following the Serious Incident Review, Monash Health formulated the following recommendations:

- a) *Presentation of this case at a multidisciplinary meeting (such as a grand round) of ED team, general surgery, vascular surgery and gastroenterology as obligatory attendees.*
- b) *Consultation with pathology services regarding grossly elevated CRP results, results of same and recommended follow-up by clinical teams.*

Supplementary statement of Dr Alan Saunder, Monash Health

45. Following receipt of the Monash Health Serious Incident Review, the Court obtained a further statement from Program Director of Surgery and Interventional Procedures Program at Monash Health, Dr Alan Saunder.

Significance of CRP test in a patient with abdominal pain

46. Dr Saunder explained that the CRP test is conducted to determine the potential degree of inflammation in a patient. When asked about the significance of a CRP of 237, which was described as “*critical*” in the records, Dr Saunder opined that this was the “*writer’s opinion*” and that “*grossly elevated*” was a preferable description. Nevertheless, Dr Saunder explained that a CRP of this level required a “*clinical explanation*”.
47. The CPU noted that the presentation of the test results, being neatly formatted with precise times and units of measurement, was unlikely to have been typed by the doctor who made the note, but rather ‘copy and pasted’ from the pathology notes into the electronic medical record (or the results were automatically populated in the electronic medical record). For this reason, the CPU opined that the “*critical*” label was a ‘flag’ that was attached by the pathology service, rather than an opinion of the doctor who made the entry in the medical record. I accept this conclusion.
48. The CPU agreed with Dr Saunder that a CRP of this level required a clinical explanation as it is indeed grossly elevated. Also, a CRP at this level suggested a high likelihood of serious underlying pathology, warranting further clinical assessment and appropriate investigations to determine the source of the inflammation.
49. The CPU noted that pathology results often have the pathologist’s comments appended to them, especially when they are significant. In the present case, there were no comments from the pathologist appended to the results.

Relevance of elevated CRP to ‘chronic SMA occlusion’; other causes of elevated CRP considered

50. Dr Saunder noted that a chronic SMA occlusion would not be expected to cause a CRP elevation to this extent.

51. He noted that the Gastroenterology Team were concerned about an inflammatory or malignant gastrointestinal condition and therefore arranged for an urgent gastroscopy and colonoscopy. In the setting of a patient with a soft and non-tender abdomen and otherwise normal blood tests, the CPU considered this to be a reasonable response. Dr Saunder indicated that this course of action was taken because the Gastroenterology Team were concerned for an inflammatory or malignant condition. The CPU opined that this may suggest that the Gastroenterology Team were aware of the CRP result and therefore were investigating it. This is supported by their recording of the CRP result in their endoscopy referral.

Efficacy of 'result alerts' from the pathology service

52. Dr Saunder was asked to comment on the efficacy of the 'result alerts' generated by the pathology service, when medical staff already appeared to be aware of the CRP results. Dr Saunder responded that consultation with the pathology service gave rise to the following recommendation:

it had been noted that abnormal results are sometimes missed amongst other results, and not always noted by busy clinical staff scanning multiple results. An alert system to aberrant results such as a CRP of 237, should highlight such a variation to busy staff and provoke their critical thinking and acumen and wonder why and what is the explanation of such a result in the context of their patient's presentation.

53. The CPU noted that an effective alert system needs to be more than a phone call from pathology staff to a junior clinician covering the unit at the time. This is further discussed below.

Assessment of care – Dr Andey

54. Mr Dunmore first consulted with Dr Andey in April 2024 for abdominal pain, diarrhoea, bloating and loss of appetite. Dr Andey organised blood tests and an abdominal ultrasound, then referred Mr Dunmore to a private gastroenterologist in the fortnight prior to Mr Dunmore's first presentation to Monash Medical Centre. The tests organised by Dr Andey produced unremarkable results and Mr Dunmore did not see the private gastroenterologist, as he attended Monash Medical Centre instead.
55. After the 22 May 2024 attendance at Monash Medical Centre, Dr Andey appears to have been managing Mr Dunmore with limited information from Monash Health. The CPU observed that it was difficult to gain an accurate impression of Mr Dunmore's condition over this time,

as there was limited detail recorded in Dr Andey's medical records. However, it does not appear that Mr Dunmore, his brother or brother-in-law expressed any specific concerns to Dr Andey.

56. Dr Andey stated that he could not specifically recall reading the discharge summary from 22 May 2024. In any event, the discharge summary lacked important details and information that may have been of assistance. This important information (if recorded on the discharge summary) may have raised Dr Andey's index of suspicion when reviewing Mr Dunmore on 18 June 2024.
57. It does not appear that Dr Andey received the results of Mr Dunmore's gastroscopy and colonoscopy on 28 May 2024 from Monash Medical Centre.
58. During Mr Dunmore's final presentation to Dr Andey on 18 June 2024, Dr Andey did not record any observations of vital signs. There was no description of Mr Dunmore being acutely unwell, however the notes are very brief. The abdominal examination was recorded as "*epigastric tenderness*" and an impression of "*?gastritis*".
59. In the absence of any detail about Mr Dunmore's presentation on 18 June 2024, it is difficult to understand how unwell he was at the time. Mr Dunmore reportedly told his brother after the appointment that Dr Andey said it was "*too dangerous*" to give him medication. Mr Fisher queried why Dr Andey did not send Mr Dunmore to hospital if prescribing medication would have been dangerous. Unfortunately, there are no notes by Dr Andey concerning this issue.
60. As a matter of procedural fairness, the Court wrote to Dr Andey to provide an opportunity to respond to an extract of my draft proposed findings. Despite numerous opportunities, Dr Andey did not respond to any communication from the Court and did not file a response.

Assessment of care – Monash Health

61. The CPU opined that the medical care and investigation by Monash Health from 21 to 22 May 2024 was reasonable and Mr Dunmore was discharged with appropriate arrangements for further investigations. The examination findings do not suggest that Mr Dunmore had peritonitis at that time. The CPU explained that Mr Dunmore would not have survived with untreated peritonitis for almost a month (if he did indeed have peritonitis at this time).
62. The CPU considered that the abnormal CRP result was probably appreciated, at least by the Gastroenterology Team, who arranged urgent investigations because they were concerned for

an inflammatory or malignant condition. They also recorded the CRP result in their clinical notes on the endoscopy booking form. The CPU also concluded that when Mr Dunmore underwent his colonoscopy and gastroscopy on 28 May 2024, it was unlikely that he was suffering from acute peritonitis.

63. Following the gastroscopy/colonoscopy, Mr Dunmore attended on 7 June 2024 for a CT scan of his chest. His brother-in-law accompanied him and asked for an earlier appointment because he was very unwell but was also unwilling to attend the Emergency Department. There is no information in the medical records concerning this request or which takes the complaint of being “*very unwell*” any further.
64. Despite the apparent severity of his condition, Mr Dunmore did not seek further medical care until 18 June 2024.
65. Although Monash Health advised Dr Andey of the appointments for endoscopies on 22 May 2024, there was no record of the results in Dr Andey’s notes. Also, there is no reference in the Monash Health records of copies of the reports being sent to Dr Andey and it does not appear that Monash Medical Centre provided Dr Andey with a copy of the results.
66. The CPU noted the limited information about the new medications intended for Mr Dunmore and that he did not commence this regime.
67. The CPU explained that the failure to commence cholesterol lowering or NRT medication would not have had any effect in the short time frame involved in this case. However, the CPU noted that aspirin can have its desired effect on blood clotting within hours. If it were commenced as recommended on or about 22 May 2024, it is possible that the risk of a thrombotic complication may have been mitigated over the following three weeks. The CPU opined that this could not be known with certainty and acknowledged that the post-mortem examination did not specifically examine for the site of arterial occlusion that was responsible for the ischaemic small bowel.

Assessment of Monash Health discharge summary

68. The CPU noted that the discharge summary provided by Monash Health to Dr Andey did not meet the minimum requirements for a discharge summary. Specifically, it did not include:
 - a) A clear primary diagnosis or clinical concern. The principal diagnosis recorded by Monash Health was “*pain in abdomen*”, but this is a symptom and not a diagnosis. An

impression of “*chronic SMA occlusion with compensating IMA and coeliac*” was recorded in the ‘cut and pasted’ notes that make up the summary.

- b) A list of new medications commenced at Monash Medical Centre (which should also include dosages and administration instructions.
 - c) Details of planned follow-up.
 - d) Significant pathology test results.
 - e) Significant radiology test results.
 - f) Specific advice or requests for the treating general practitioner.
 - g) A follow-up plan.
69. The CPU noted there was no narrative or advice for the general practitioner regarding the potential underlying problem. The body of the discharge summary appeared to be a ‘copy and paste’ of the clinical notes from the various teams who reviewed Mr Dunmore. The CPU observed that the discharge summary did not give a clear picture of the ‘problem’. Moreover, it did not conform to the ‘Best practice in writing discharge summaries’ published by Monash Health’s Centre for Clinical Effectiveness in 2018.
70. The CPU further explained that the requirements for a discharge summary generated from an electronic medical record system are outlined by the Australian Commission on Safety and Quality in Health Care’s document ‘National Guidelines for On-Screen Presentation of Discharge Summaries’.⁷ Mr Dunmore’s discharge summary did not meet these minimum requirements.
71. Furthermore, patients should receive a printed copy of their discharge summary upon leaving the hospital. This practice enhances patient understanding of their care plan and supports adherence to post-discharge instructions. This did not occur, and the relevant part of the medical record was not completed.

⁷ <https://www.safetyandquality.gov.au/sites/default/files/2019-06/National-guidelines-for-on-screenpresentation-of-discharge-summaries-Sep-2017.pdf>

Assessment of Monash Health Serious Incident Review

72. The CPU considered that Monash Health's Serious Incident Review was superficial in this instance and suggested that a Sentinel Event Report (Category 11, Subcategory 1) was warranted.⁸ A Sentinel Event Report would have involved external expert panel members (vascular surgeons), who would have assessed the reasonableness of the clinicians' decision making. The CPU also considered the individual recommendations made and provided advice as follows.

Recommendation 1 - case presentation

73. As noted above, one of the recommendations from the Serious Incident Review was to present this case at a multidisciplinary meeting. This is unlikely to be an effective prevention strategy, as errors are rarely due to individual factors and they typically arise from systemic weaknesses. Lasting change requires system-level interventions, not one-off awareness campaigns. One-off education interventions have negligible lasting impact on behaviour or outcomes in large organisations unless embedded within a broader quality and systems improvement initiative.
74. The CPU explained that a one-off presentation is unlikely to have a lasting impact because:
- a) Passive learning (such as presentations) results in poor long-term retention.
 - b) Clinicians are often under time pressure. Without reinforcement, the message is likely to fade quickly.
 - c) Turnover of unit staff means that the lesson from a one-off presentation is not retained in the unit when staff move on.
 - d) Without changes to workflows, protocols, alerts or decision-support tools, the underlying conditions that allowed the error to occur remain unchanged.

Recommendation 2 – Result alert notifications

75. As noted above, the second recommendation from Monash Health's Serious Incident Review related to consultation with its pathology service in relation to the elevated CRP results.

⁸ Subcategory 1 – Clinical process or procedure Description This subcategory covers adverse events involving clinical procedures and processes resulting in serious harm or death. It includes any delay, failure or complication of a process or procedure related to clinical review, a test, investigation, or treatment resulting in serious harm or death of a patient.

76. The Court specifically asked Monash Health about the effectiveness of this recommendation. As the result was referenced in several entries from different teams, the CPU opined that it was unclear whether the Monash Health Serious Incident Review panel actually spoke to the relevant clinicians about the CRP result.
77. The Court asked Monash Health how the recommendation would be effective, when it appeared from multiple entries in the medical record that clinicians knew about the result. Monash Health responded:

This recommendation was made in consultation with our pathology team as it has been noted that abnormal results are sometimes missed amongst other results, and not always noted by busy clinical staff scanning multiple results. An alert system to aberrant results such as a CRP of 237, should highlight such a variation to busy staff and provoke their clinical thinking and acumen to wonder why and what is the explanation of such a result in the context of the patient's presentation.

78. The CPU considered that such an alert system is unlikely to have made a difference if it had been in place at the time of Mr Dunmore's attendance. With a view towards the issues of human factors and patient safety, real-time alerts for grossly abnormal pathology results may be an effective intervention to prevent an 'oversight' as occurred here, but only if the alert is properly designed and integrated into the clinicians' workflow. I agree with this conclusion.
79. An effective alert system requires more than just a phone call to a junior doctor or the doctor covering a specific team afterhours and should be based upon human systems principles. Not all alerts are effective, and their design and implementation are important as alert fatigue is a major risk. Alerts work by interrupting cognitive errors, enhancing team awareness, reducing reliance on memory and promoting timely action, which are all key to reducing preventable harm in complex systems.
80. If too many non-actionable or low-urgency alerts are issued, clinicians may begin to ignore or override them reflexively. Alerts must be rare (only for truly critical results) and must be actionable (next steps must be specified).
81. Alerts require forcing functions that prevent further action until the critical issue is addressed and a well-designed alert should act as a 'hard stop'. For example, an alert may require senior review or documentation of clinical rationale before discharge. Alerts that redistribute critical

information, for example, to the nurse unit manager, registrar or consultant, can amplify shared situation awareness.

Opportunities for preventative intervention

82. The CPU suggested I recommend that Monash Health review the format of its electronic discharge summary with a view to a standardised content and format that assists the reader to understand the clinical problem and provide ongoing care to the patient. The CPU considered the Monash Health Centre for Clinical Effectiveness 2018 publication on this topic and the Australian Commission on Safety and Quality in Health Care standards as appropriate templates.
83. Simply ‘cutting and pasting’ multiple disjointed clinical notes into a discharge summary is unlikely to provide the necessary narrative, context and information required to communicate essential information to clinicians and the patient.
84. I am satisfied the suggested recommendations are warranted. Namely, to improve the discharge summaries provided to patients with specific instructions, and to ensure the format is compliant with the relevant standards. Also, that Monash Health implement a formal pathology alert system to alert clinicians to aberrant pathology results.

Procedural fairness response

85. As a matter of procedural fairness, the Court wrote to Monash Health with an extract of my proposed findings and provided an opportunity to respond. Monash Health only sought to respond to one aspect of the draft findings, namely, the CPU’s characterisation of the Serious Incident Review as ‘superficial in this instance’.
86. Monash Health explained that pursuant to its Quality and Safety processes, the Surgery Program undertook a formal Serious Incident Review in relation to this case. The Serious Incident Review was conducted by a senior multidisciplinary panel comprising the Program Director of Surgery (who chaired the review), the Director of Gastroenterology, the Service Director of General Surgery, the Director of Vascular Surgery and the Senior Quality Improvement Partner for the Surgery Program.
87. Monash Health submitted that the Serious Incident Review brought together senior clinical leadership from the relevant specialties with dedicated Quality and Safety expertise and oversight. It further submitted that the panel undertook a detailed review of the circumstances

surrounding the patient's care, relevant systems and processes and considered contributing factors and opportunities for improvement.

88. Pursuant to Monash Health's Quality and Safety processes, where a Serious Incident Review identifies significant care management issues or concerns that warrant further investigation, the matter can be escalated to a Serious Adverse Patient Safety Event (**SAPSE**) review. In this case, the panel did not identify care management issues that required escalation to that level of review.
89. In relation to the CPU's criticism of Recommendation 1 (case presentation), Monash Health noted that mesenteric ischaemia is regularly assessed and discussed by Monash Health's Vascular Surgical Unit and is not limited to Mr Dunmore's case. The diagnosis of mesenteric ischaemia remains challenging and requires a high degree of clinical suspicion. There is no simple diagnostic test that reliably identifies all patients requiring intervention and assessment frequently relies upon careful clinical judgment and the expertise of experienced clinicians.
90. The Serious Incident Review panel recognised these diagnostic challenges and considered that an educational response was appropriate. Therefore, Recommendation 1 focused on education and discussion to reinforce awareness and emphasise the need for early escalation to senior clinicians. The panel considered that this recommendation was proportionate and directed towards improving future clinical practice.
91. I accept the description of the Serious Incident Review and the further details of the process provided by Monash Health. I do not adopt the characterisation used by the CPU that it was 'superficial in this instance', and I am satisfied that the Serious Incident Review process was appropriate in the circumstances.

FINDINGS AND CONCLUSION

92. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Peter Ronald Dunmore, born 29 May 1960;
 - b) the death occurred on 19 June 2024 at 15 Halsbury Place Skye Victoria 3977, from 1(a) peritonitis and ischaemic small bowel with contributing factors of hypertensive and ischaemic heart disease; and
 - c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

- (i) That Monash Health update its discharge summary templates to necessarily include patient discharge advice which is to encompass any changes to medication, any follow-up arrangements, and specific instructions about any changes to the patient's condition that should prompt medical review.
- (ii) That Monash Health amend its applicable policies and procedures to ensure that patients being discharged on new or altered prescription medication must be provided with a supply of the medication or a prescription for the medication and appropriate advice from the prescribing doctor.
- (iii) That Monash Health implement a system to alert clinicians to pathology results that are likely to require further investigation. Such a system should operate in addition to the pathology report itself and be designed upon human factors principles to maximise the prominence of the alert so that it may be properly integrated into clinicians' workflows.

I convey my sincere condolences to Mr Dunmore'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:

Shirley Dunmore, Senior Next of Kin

Monash Health

Senior Constable Christopher Boal, Coronial Investigator

Signature:



Coroner Paul Lawrie

Date: 24 September 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.
