**Coroners Act, 1996**
**[Section 26(1)]**

***Western*** ***Australia***

# RECORD OF INVESTIGATION INTO DEATH

*Ref No: 29/17*

*I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of* ***June Valerie LOBBAN****, with an Inquest held at Perth Coroners Court, Court 58 & 51, Central Law Courts, 501 Hay Street, Perth, on 25-27 July & 1 August 2017 respectively, find the identity of the deceased was* ***June Valerie LOBBAN*** *and that death occurred on 9 May 2014 at Fremantle Hospital as the result of Intra-abdominal Sepsis and Shock with Multi-organ Failure following Intestinal Perforation complicating a recent Lumbar Spine Laminectomy, in the following circumstances;*

Counsel Appearing:

Ms F Allen assisted the Deputy State Coroner

Ms S Fox (25-27 July 2017) and Ms S Teoh (1 August 2017) (State Solicitors Office) appeared on behalf of Fremantle Hospital
Mr T Power (instructed by HWL Ebsworth Lawyers) appeared on behalf of St John of God Health Care Inc. and Nurses Sambanthamoorthy and Deasy
Ms B Burke (Australian Nursing Federation) appeared on behalf of Nurses Lockyer and Hadden
Mr E Panetta (Panetta McGrath Lawyers) appeared on behalf of Mr S Narula
Mr D Brand (MDA National) appeared on behalf of Dr S Lee

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## INTRODUCTION

On 1 May 2014 June Valerie Lobban (the deceased) had an elective L4/5 decompressive laminectomy with rhizolysis vertebroplasty (L4) and SMS strut (spinal procedure) at St John of God Murdoch Hospital (SJOG Murdoch). The spinal procedure went well and the deceased was restricted to lying supine until 3 May 2014 with pain relief, IV antibiotics and her regular medications.

In the early hours of 3 May 2014 the deceased first complained to nursing staff of feeling uncomfortable and

they noted her abdomen was distended. It was believed she was suffering from constipation, a known complication of spinal surgery, and she was treated according to the nursing postoperative constipation protocols. These were only partially effective and by the evening of 4 May 2014 the deceased complained of extreme discomfort with abdominal pain and nausea and her abdomen was distended and hard to the touch.

A resident medical officer (RMO) was requested to review her for the prescription of a fleet enema. This was ineffective and the RMO called the deceased's consultant neurosurgeon to discuss the situation. He was advised to contact a gastroenterologist. When that was unsuccessful the RMO contacted the on-call general physician who advised an abdominal X-ray. The RMO wrote a request for the X-ray and ordered the deceased be prepared for X-ray. He noted the deceased was to be reviewed by her treating team in the morning.

In the early hours of 5 May 2014 the deceased was in severe pain and needed pethidine. The X-ray was undertaken at 11.30 am and reported as showing "*free extra peritoneal air*" suggestive of a perforation of the stomach or bowel but no "*features of intestinal obstruction*". There is no indication these X-rays or reports were reviewed by anyone on the deceased's treating team, nor was she reviewed by her treating team that day.

At 6.00 pm on 5 May 2014 a rehabilitation and geriatric consultant, Dr Scott Lee, reviewed the deceased with the intention she would be transferred for rehabilitation following her spinal procedure. Dr Lee diagnosed the deceased with an intestinal perforation needing urgent surgical review, but was unable to refer her to anyone at SJOG Murdoch for over 24 hours. He arranged her urgent transfer to Fremantle Hospital (FH) for surgery that night.

The deceased underwent an emergency laparotomy at FH that night and a right hemicolectomy was performed. She had a perforated caecum with patchy necrosis of the caecum and faecal contamination of the peritoneum. Following that procedure the deceased did not improve and a second laparotomy was performed on 6 May 2014 and an end-ileostomy performed. Her abdomen was not closed and a VAC dressing was applied.

The deceased was returned to ICU with inotropic support. She developed multi organ failure and peripheral ischaemia. By the time she was taken to theatre for her VAC dressing to be replaced on 9 May 2014 she had distal bowel ischaemia. The deceased died later that night.

The deceased was 69 years of age.

The family of the deceased expressed concern about the deceased's medical treatment and her medical management

was reviewed in the Office of the State Coroner (OSC). The OSC sought the opinion of a consultant colorectal surgeon with respect to the deceased's medical management. Following receipt of that review the State Coroner considered it desirable (section 22 (2) *Coroners Act 1996* (WA)), an inquest be conducted into the circumstances of the deceased's death (section 25 *Coroners Act 1996* (WA)).

## BACKGROUND

### ***The Deceased***

The deceased was born on 25 June 1944 in Burma. She lost her father, then her mother at a young age and was brought up by step parents. She moved to Australia in 1980 and left school early to help raise her siblings.

The father of the deceased's only child, a son, died before her son was born, and the deceased later met and married Mr Lobban who treated her son as his own. The deceased worked in retail, and assisted in Home Economics at a high school, to help the family finances until her husband died and she retired.

The deceased had five grandchildren, with one dying shortly after birth. She was close to her son and his children, whom she saw often. She was a very good cook.[1]

[1] Communication from the deceased's son 20 July 2017

## ***Medical History***

The deceased's medical history included systemic lupus erythematosus, hiatus hernia, anaemia, shingles and anxiety, but her most significant issue was chronic back pain. She also had a hearing impairment and was a heavy smoker.

The deceased had been referred to Mr Soni Narula, Consultant Neurosurgeon, for management of her back pain and had also seen two pain specialists.

Mr Narula first saw the deceased in September 1999 when she had a C6/7 anterior surgical fusion from which she recovered well. He then managed the deceased's ongoing back pain conservatively. In September 2008 the deceased was referred back to Mr Narula and provided with injections into the lumbar spine and, about a year later, injections into the mid and upper cervical spine.

In 2013 she was noted to have acute fractures in her thoracic vertebrae and a recent DEXA scan revealed she was osteopenic.[2]

Following a vertebroplasty in 2013 for osteoporotic fractures, the deceased saw Mr Narula in January 2014 for pain in her lumbar spine and was diagnosed with a new osteoporotic fracture at L4 which radiated pain to her right

[2] Letter from GP Kelso Medical Group, Kardinya 29 May 2014

leg. An MRI showed stenosis at L3/4 with oedema in the L4 vertebral body. Localised isotope scan revealed degenerative changes in the deceased's thoracic and lumbar spine. Mr Narula recommended lumbar decompression of L3/4 with vertebroplasty at L4 and dynamic fusion with an SMS strut at L4/5 procedure.[3]

## SJOG MURDOCH

***1 May 2014 - Thursday***

Mr Narula conducted the L4/5 decompressive laminectomy with rhizolysis vertebroplasty (L4) and SMS strut on 1 May 2014 following the deceased's admission to SJOG Murdoch. During the vertebroplasty she was noted to have a cerebrospinal fluid leak, for which there was no obvious source and, as a precaution, the plan was the deceased was to be restricted to lying supine postoperatively until 3 May 2014. The procedure was otherwise uneventful and the deceased was provided with pain relief by way of fentanyl PCA and regular IV antibiotics.

***2 May 2014 - Friday***

The deceased was reviewed by Mr Narula at 3.00 pm on 2 May 2014 and she appeared to be progressing well. Her drains were removed and she was advised she could start eating and would be allowed to mobilise on Saturday, 3 May 2014.

[3] Ex 1, tab 17

***3 May 2014 - Saturday***

In the early hours of 3 May 2014 the progress notes indicate the deceased's abdomen was distended and uncomfortable and she felt as though she had wind. She was managing diet and fluids and her pain relief was changed to oral medication. She was provided with peppermint tea.[4]

Mr Narula reviewed her again at 9.00 am and he advised all the drains could be removed. He asked that Dr Lee, Consultant Physician from Geriatric and Palliative Medicine review her as soon as possible with regards to her future rehabilitation.

A nursing entry at 12.35 pm recorded the deceased as complaining of pain and of not opening her bowels. She was provided with the laxative Movicol as directed in the nursing postoperative constipation protocol (bowel protocol).

The progress note for 6.00 pm indicated the deceased was still complaining she had not opened her bowels and she was given another dose of Movicol. Her observations continued to be stable.

***4 May 2014 - Sunday***

At 9.20 am the deceased was given a Glycerol suppository and Bisacodyl suppository as per the "*bowel protocol*". This resulted in only a small bowel motion noted at 12.40 pm

[4] Ex 1, tab 8

and her oxygen saturations were noted to have dropped to 84%. The deceased was provided oxygen via nasal prongs.

By 7.00 pm the deceased was complaining of extreme discomfort with abdominal pain and nausea and her abdomen was distended and hard to the touch.[5]

The nurses working on the deceased's ward for the afternoon shift were Enrolled Nurse (EN) Susan Lockyer, Registered Nurse (RN) Editha Hadden and Clinical Nurse (CN) Coordinator, Kerri Riseborough. Their shift was from 2.00 pm to 9.30 pm. The deceased was part of the "*work load*" allocated to EN Lockyer and RN Hadden. It was RN Hadden who administered the deceased's oxygen and noted the deceased had advised she was in extreme pain. Following the administration of nasal oxygen the deceased's oxygen saturations increased to 94%.

Following the deceased's complaint of extreme pain she was reviewed by EN Lockyer who consulted with CN Riseborough and it was decided the deceased was still suffering from constipation and required the use of a fleet enema, which needed to be approved by a doctor. EN Lockyer considered the deceased's discomfort may be more than that associated with the normal constipation associated with spinal surgery,[6] although CN Riseborough's

[5] Ex 1, tab 8
[6] t 26.07.17, p136

recall[7] was that the deceased's symptoms were typical of constipation following neurosurgery.

EN Lockyer called for the resident medical officer to review the deceased to approve the fleet enema.

There was no neurosurgical RMO on call for the ward that evening and a locum RMO from St John of God Subiaco, Dr Niall Fennessy, had been rostered for that shift. He was not familiar with the Murdoch Hospital and this was his first shift in that capacity at that location. His shift ran from 12.30 pm to 8.30 pm on Sunday 4 May 2014.

The function of the RMO was to be available around the entire hospital to attend to requests from nurses for the review of patients of concern. He was contactable by both a telephone and pager.

In evidence Dr Fennessy advised that he could not recall whether he visited the St Michaels Ward where the deceased was located, in response to a call from a nurse or as part of his rounds. EN Lockyer was clear she recalled requesting the RMO to attend. Dr Fennessy understood the deceased was the patient of a neurosurgeon, Mr Soni Narula, and he reviewed the medical notes before considering the fleet enema. He noted she had lower spinal surgery on 1 May 2014 and since that time had received a number of

[7] Ex 1, tab 22

aperients for constipation and received some pain relief. Dr Fennessy was familiar with the fact that type of surgery could cause constipation and could see from the notes the deceased had been treated appropriately for constipation. He was concerned the fleet enema was a fairly robust treatment and wanted to be sure it was appropriate for her signs and symptoms.

Dr Fennessy reviewed the deceased at about 7.20 pm and formed a preliminary view she was constipated and made a plan for her treatment. He observed the deceased to be uncomfortable with a level of pain of 5-7 out of 10 which he considered it to be at the high end of the pain score for constipation and that her abdomen was tense and distended. He noted she had been eating and drinking and had not vomited. The previous laxatives had not effectively assisted with her constipation and she was feeling bloated. On listening to her abdomen he could hear normal bowel sounds and noted her single, isolated recording of a low oxygen saturation on room air.[8]

As a result of his review of the deceased, her notes and her history he charted the fleet enema for the deceased and asked the nurses to inform him if the enema was unsuccessful or they were otherwise concerned about the deceased. Dr Fennessy explained that fleet enemas are usually fairly effective quickly, and that if it was not effective

[8] t 26.07.17, p106

he would start to be concerned there may be a reason, other than constipation, for her signs and symptoms.

The deceased was provided with the fleet enema at 7.40 pm.

***Conversation with Mr Narula***

Following Dr Fennessy's charting of a fleet enema for the deceased, it came to the time for him to finish his shift at 8.30 pm. He received a phone call from the night duty manager for a hand over. Dr Fennessy expected that handover to be to another doctor, however, when he realised it was not to be to another doctor, he decided he better go back down and review the deceased to see how she was following the fleet enema.[9]

On his return to the deceased Dr Fennessy re-examined her and found the same scenario as when he had examined her earlier, including the fact she had still not opened her bowels. The fleet enema had not worked. This concerned Dr Fennessy and he knew the next thing he needed to do was to call the consultant under whom the deceased was admitted to hospital. Consequently he called Mr Narula with his concerns. Dr Fennessy's evidence was that Mr Narula listened to everything he had to say, did not interrupt him, nor ask any questions, and at the conclusion of the telephone call Mr Narula advised Dr Fennessy he needed to speak with a gastroenterologist.

[9] t 26.07.17, p106

Dr Fennessy believed he had put his examination and findings with respect to the deceased very clearly and Mr Narula, in evidence, agreed Dr Fennessy seemed to be quite clear. Mr Narula was confident that Dr Fennessy was confident the problem was constipation.[10]

Dr Fennessy does not agree he was confident it was constipation. He was concerned and confused as to what was going on because the deceased had not responded as he had expected her to, she was still in pain and her abdomen was tense. It was because he was concerned he had called Dr Narula. The fact Dr Fennessy indicated he was concerned was supported by two of the nurses who overheard parts of the conversation. EN Lockyer indicated she could hear Mr Narula advise the RMO that he did not believe the problem was surgery related and the RMO would need to contact a gastroenterologist.[11] Similarly RN Sambanthamoorthy had arrived for her night shift early. Her night shift commenced at 9.00 pm but she was on the ward by approximately 8.40 pm and was standing at the nurses' station receiving handover from the afternoon coordinator, RN Riseborough.

RN Riseborough informed RN Sambanthamoorthy the deceased was complaining of abdominal pain and was being reviewed by the RMO. In her statement RN Sambanthamoorthy said she could hear what the RMO was

[10] t 25.07.17, p66
[11] t 26.07.2017, p136

saying over the phone to a person she assumed to be Mr Narula, but could not hear the other end of the conversation. She listened because she wanted to be "*in the loop*" about the deceased as she would be caring for her overnight. She overheard the RMO telling the person on the other end of the telephone that he was concerned about the deceased.[12] She understood from what the RMO was saying that Mr Narula had told him he was to call a gastroenterologist to review the deceased. RN Sambanthamoorthy remained at the desk doing other things and heard the RMO continue to make telephone calls with respect to seeking help for the deceased.

EN Lockyer also advised that while she was doing other things she was aware of the fact the RMO was on the phone for a considerable amount of time to different people.

Dr Fennessy advised the court that having been advised as to a course of action he attempted to put that in place by calling a gastroenterologist. Dr Fennessy explained each hospital is different and he was not familiar with SJOG Murdoch. He had been told to call a gastroenterologist but had not been provided with any suggestions. He needed to ask somebody for a name and number. Dr Fennessy telephoned the emergency department and someone there gave him a name and number for a gastroenterologist and Dr Fennessy phoned that number.

[12] Ex 1, tab 21, t 26.07.17, p142

Dr Fennessy again explained who he was and "*before I could say anything, I was told that person was not on call and they were not to give me advice. And they hung up*".[13]

Similarly RN Sambanthamoorthy overheard that second call and advised the court "*the other consultant told the RMO that it was – Dr Narula needed to ring him. It was protocol for one consultant to ring another*".[14] After that RN Sambanthamoorthy heard the RMO made another call. She believed it was to Mr Narula to convey that information. She heard that conversation which as far as she was concerned was Mr Narula advising the RMO he needed to arrange an abdominal X-ray.

Dr Fennessy explained he had not called Mr Narula back. He had felt that calling the consultant at home on a Sunday night at the end of his shift was indication enough of his concern and he now felt the problem was his and he needed to do the best he could for the deceased.

Dr Fennessy rang the emergency department again and asked what the protocol was in terms of getting medical advice. He was told there was a general physician on call and that was the medical advisor to call at night. Dr Fennessy called the number he was given, which was a mobile, and again introduced himself and explained what the problem was and his concerns. At the conclusion of his

[13] t 26.07.17, p108
[14] t 26.07.17, p142

explanation to the general consultant physician he was told he needed to contact the deceased's surgeon. When Dr Fennessy advised the consultant physician he had called the deceased's surgeon and the surgeon thought it was constipation and was asking Dr Fennessy to follow that up, which is what he was doing, then the on call consultant advised Dr Fennessy to arrange an abdominal X-ray.[15]

The conversation RN Sambanthamoorthy heard was Dr Fennessy speaking to the on-call consultant physician about what he should do. There followed an order for an abdominal X-ray.

Dr Fennessy agreed he did not write urgent on the abdominal X-ray because he was told by one of the nurses that it could not be done overnight. It was his preference it be done as soon as possible but he accepted that if that was not possible overnight, that was the protocol in SJOG Murdoch.[16]

RN Riseborough, the nurse coordinator to whom he handed the request for an abdominal X-ray said in her statement she had asked the RMO whether he wanted it to be done now or if it could wait until the morning. She stated that Dr Fennessy said "*in the morning was fine*".[17]

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[15] t 26.07.17, p109
[16] t 26.07.17, p110
[17] Ex 1, tab 22

Dr Fennessy also agreed he had queried whether the deceased had an obstruction on the request for the abdominal X-ray, but had not used the word 'obstruction' when speaking with Mr Narula. The reason was because he was seeking advice and input, rather than alerting the radiologists to possible problems. Dr Fennessy pointed out he was not going to be in the hospital when the result was to be received, and he also left a plan the deceased should be followed up by her team in the morning. He expected the deceased would be medically reviewed the following morning and the abdominal X-ray would be available to assist with her further management.[18]

Having made a plan the deceased should have an abdominal X-ray, continue to be monitored and be reviewed by a medical team in the morning, he believed he had done as much as he could for the deceased and left the hospital. It was also his belief that if there was something untoward on the X-ray the deceased's medical team would be advised of that problem. It was his experience, as a radiological registrar, that air under the diaphragm was a concern and would be communicated in a timely manner to an appropriate person able to manage the situation.[19]

## ***Situation Overnight***

It is not clear what exactly happened to the request for an abdominal X-ray, but on the evidence I suspect it was not

[18] t 26.07.17, p111
[19] t 26.07.17, p112

actioned until business hours the following morning by the ward clerk, 'urgent' may have expedited the process.

RN Sambanthamoorthy was the deceased's nurse overnight and she was aware of the deceased being in pain and that her pain was worse than it had been the last time RN Sambanthamoorthy was on shift the previous night. The nurse understood the order for the abdominal X-ray was from Mr Narula, having only heard the RMO's end of the conversation. RN Sambanthamoorthy considered the deceased's clinical signs remained stable overnight and that her pain level, although increased from previously, was not of such concern as to warrant her needing to contact the deceased's consultant, as the only available medical input overnight.[20] It is not clear this would have expedited the abdominal X-ray.

At the time of the deceased's operation the anaesthetist had prepared a medication chart for medications which could be given to the deceased in certain circumstances.[21] Initially, following the operation the deceased was given various analgesics, but those had been gradually withdrawn as her condition from the operation appeared to improve. However, early in the morning of 5 May 2014, the deceased was complaining of extreme pain and RN Sambanthamoorthy administered the first dose of pethidine

[20] t 26.07.17, p144
[21] Ex 1, tab 8 PRN Medication Chart

it had been necessary to give the deceased since her operation.[22]

The deceased was administered 100mg of pethidine at 2.25 am by RN Sambanthamoorthy, as she was authorised to do. RN Sambanthamoorthy advised the inquest that if she had given the pethidine as charted, and it had not covered the deceased's pain, she would have called the doctor. There was provision, however, for the deceased to receive 100mg of pethidine every three hours and, at 5.40 am, the deceased was administered another 100mg of pethidine due to her pain levels. This was not done by RN Sambanthamoorthy and it has not been possible to determine who administered the second dose. However, under the protocols, there was no need to advise a medical officer of that once authorised. RN Sambanthamoorthy indicated the deceased's pain level had been poor at 2 o'clock, but had risen to a 6 or a 7 by 2.25 am which is why she administered the first dose of pethidine.[23]

CN Deasy took over from RN Sambanthamoorthy overnight at the commencement of her shift at 7.00 am on 5 May 2014. CN Deasy said in evidence had she noticed the two lots of pethidine three hours apart, she would have been concerned the deceased was exhibiting more pain and requiring more narcotic analgesia compared to other spinal

[22] t 26.07.17, p146
[23] t 26.07.17, p148

patients she had cared for.[24] I appreciate there was no medical cover overnight and the protocols did not require nurses to ring consultants overnight when providing charted analgesia, however, I am concerned that is a significant level of pain for day four following an operation when pethidine administered at 100mg had not been necessary beforehand.

The deceased did not undergo medical review on the ward that morning although there is a physiotherapy entry recording the deceased could not participate in rehabilitation due to her level of pain.[25]

**Summary of Oral Pain Medication**

| Date | Time given | Medication |
|---|---|---|
| 3 May 2014 | 02:15 | Panadeine Forte |
| | 08:50 | Panadeine Forte |
| | 14:45 | Panadeine Forte |
| | 20:35 | Endone 10mg |
| | | |
| 4 May 2014 | 06:15 | Endone 10mg |
| | 11:45 | Panadeine Forte |
| | 16:30 | Endone 10mg |
| | | |
| 5 May 2014 | 02:25 | Pethidine 100mg |
| | 05:40 | Pethidine 100mg |
| | | |

**Summary of Laxatives**

| Date | Time given | Medication |
|---|---|---|
| 3 May 2014 | Movicol | 09:00 |
| | Movicol | 18:00 |
| 4 May 2014 | Movicol | 08:00 |
| | Bisacodyl Supp | 09:20 |
| | Glycerol Supp | 09:20 |
| | Coloxyl & Senna | 16:30 |
| | Movicol | 16:30 |
| | Fleet Enema | 19:40 |

Treatment provided to the deceased since her complaint of pain starting 3 May 2014

[24] t 26.07.17, p155-156
[25] Ex 1, tab 8

## ***Abdominal X-ray***

The deceased had her abdominal X-ray at 11.30 am on 5 May 2014. She had both a supine and an erect abdominal X-ray and chest X-ray. The chest X-ray showed *"a large volume of free extra peritoneal air"*. Free air is gas or air trapped within the peritoneal cavity, but outside the bowel and suggests a possible stomach or bowel perforation. The deceased's abdominal X-ray showed an empty rectum, a *"moderately loaded large bowel particularly the ascending colon and caecum"* and "*slight distension of the proximal large bowel but there is no feature of interstitial obstruction*". This was in response to the RMO's query as to an obstruction. Free air within the peritoneal cavity is an indicator about which any clinician would be concerned.[26]

There is no evidence the contents of that report were brought to the attention urgently of anyone involved in the care of the deceased. It was apparently faxed to Mr Narula's rooms at 3.00 pm that afternoon, but he was in surgery and did not know whether anyone had attempted to bring it to his attention. The report had actually been produced on 5 May 2014 at 1.10 pm.[27]

Mr Narula agreed in evidence he would have recognised a problem with air in the peritoneal cavity despite his specialty being neurosurgery. Also, if he had known there

[26] t 25.07.17, p73
[27] t 25.07.17, p71 & Ex 3 X-ray report and attachments

was a need for an urgent X-ray he would have ensured it was done or if he had known the results of the X-ray he would have ensured that prompt action was taken in view of the obvious problem.[28]

Certainly there was no review of the deceased following the reporting of the X-ray result recorded in the deceased's notes. Nor had there been a morning medical review as planned by Dr Fennessy.

## ***Review by Dr Lee***

Dr Lee attended on the deceased at 6.00 pm on 5 May 2014 in response to Mr Narula's earlier request the deceased be reviewed by a rehabilitation consultant in preparation for transfer for rehabilitation.

Dr Lee attended expecting to assess the deceased's suitability to be transferred to his care at an inpatient rehabilitation care unit at Attadale Hospital. He was of the belief he would be managing the deceased to optimise her functional recovery after her spinal surgery, once all the medical and surgical issues were finalised.

Instead Dr Lee attended on the deceased and discovered it wasn't *"a routine rehabilitation referral".*[29] He observed the deceased to be in a lot of pain and reviewed her X-ray. It

[28] t 25.07.17, p72
[29] t 25.07.17, p95

was Dr Lee's view, as a rehabilitation specialist, the deceased was exhibiting all the clinical signs of peritonism and he realised something urgent needed to be done for the deceased. Dr Lee advised the court he had not read the X-ray report, but had observed the images for himself and there were obvious anomalies in the scan with significant air in both hemidiaphragms.

As Dr Lee commented:

> *"The clinical signs pointed towards peritonism, which, you know – which, you know, is a worrying – a worrisome thing for an acute abdomen, and so an acute abdomen, by definition, is acute abdominal pain caused by a potential intra-abdominal pathology which would potentially require urgent surgical intervention*".[30]

Dr Lee attempted to obtain blood results for the deceased which he assumed would have been taken, however, there were none.[31] As a result all Dr Lee had was the fact there was evidence of peritonitis, however, no clinical markers by which he could estimate how seriously the deceased was affected. Dr Lee diagnosed the deceased with an acute abdomen secondary to either a perforated stomach or bowel and identified the fact she required urgent general surgical review.

[30] t 25.07.17, p95
[31] t 25.07.17, p96

Dr Lee then proceeded to do everything he could to ensure the deceased was urgently and appropriately treated. He contacted Mr Narula in surgery and they discussed between them that the deceased required urgent surgical review but Dr Narula was in theatre himself and unable to attend. Dr Lee took it upon himself to obtain that review for the deceased, but unfortunately there was no on call general surgeon consultant available in SJOG Murdoch at that time. Dr Lee located two general surgeons, but both were unavailable and one of them suggested Dr Lee attempt to transfer the deceased to FH. FH was the closest tertiary hospital with a general surgical specialty. Dr Lee discussed that with Mr Narula and Dr Lee then organised the deceased's admission for Mr Narula by contacting the on call surgical registrar at FH.

Dr Lee discussed with the surgical registrar his concern the deceased had a perforation and it was agreed the deceased should be transferred and accepted into the care of the on call surgical consultant at FH.[32]

Dr Lee agreed it was not his responsibility and that normally it would be the responsibility of the deceased's team, however, he understood Mr Narula was in surgery and would not be able to assist. As a result Dr Lee did those things because he was concerned about the deceased and it was faster and more efficient if he did it himself.

[32] t 25.07.17, p97

The deceased was transferred from SJOG Murdoch to FH by the St John Ambulance Service (SJAS) at 6.52 pm on 5 May 2014. The patient care record from SJAS indicated the deceased was transferred due to a suspected perforated bowel/acute abdomen and that on route to FH she was in significant pain. She was given IV Fentanyl and her abdomen was distended and tender on palpation.[33]

The deceased left SJOG Murdoch at 7.20 pm and was handed over at FH by the SJAS at 7.47 pm.

## FREMANTLE HOSPITAL

The triage admission for the deceased indicated she arrived at FH ED at 7.44 pm and that her abdomen was noted to be very hard, tender and she had decreased bowel sounds. She was given a triage code of three. Her history included her basic observations and the fact she was four days post operatively with air under her diaphragm on abdominal X-ray.[34]

At 8.25 pm the deceased was noted to have had a laminectomy and was four days post-surgery, she was speaking in short sentences, stable observations with a pain score 7 out of 10. It was noted she said her pain was better than it had been before, although it became worse with

[33] Ex 1, tab 9
[34] Ex 1, tab 9

movement. She had decreased bowel sounds in all quadrants and a temperature of 37.1°C. The plan was she be seen by the surgical team for review.

By 9.40 pm the deceased had been seen by the surgical team and the plan was for surgery that evening. The deceased was admitted under the care of general consultant surgeon, Mr Sanjeeva Kariyawasam.

Surgery was undertaken that evening by surgical fellow, Dr Matthew Henderson. He was working with the upper gastrointestinal (GI) team, which was general surgery C team in May 2014. That team had four consultants, one fellow, one registrar and two to three interns.

Dr Henderson undertook the surgery for the deceased with colorectal surgical registrar in training, Dr Jacinta Cover. It is unclear from the surgical record as to who actually performed the operation but Dr Henderson advised in evidence it was likely they both contributed in that one surgeon would have been to one side of the deceased and the other surgeon to the other side. The fact the surgical record records Dr Cover first is not relevant to the reality.[35]

Neither Dr Henderson nor Dr Cover had any independent recollection of the first or second operation with respect to the deceased overnight on 5 May 2014. Dr Henderson

[35] t 01.08.17, p210

considered failure to recall a right hemicolectomy in a sick patient was unremarkable.[36]

Dr Henderson advised that on the notes the first operation performed on the deceased on 5 May 2014 was a very routine procedure despite the fact it was emergency surgery. He was on call that night and he could not recall whether he was in the hospital or needed to be called from home which was very close by. If he had been at home he would have been advised about the deceased's presence and the need for surgery. He would have discussed the fact she needed to be prepped for surgery that evening and for Dr Cover and the on call registrar, Dr Dilevska, to make the arrangements to get her to theatre.

Dr Henderson did not believe a delay of two hours once at FH for surgery was excessive. Dr Henderson and Dr Cover did not normally work in the same team, but due to the situation at night and those on call, the team working on the deceased that night was Dr Henderson, Dr Cover and Dr Dilevska.[37]

The deceased had been assessed by the surgical team as a possible perforated duodenal ulcer and was taken to theatre to undergo a laparotomy. In theatre it was found there was no perforated gastric/duodenal ulcer, but there was pelvic contamination and gross frank faecal contamination of the

[36] t 01.08.17, p215
[37] t 01.08.17, p210

peritoneum, with a perforated caecum with patchy necrosis of the caecum.

Dr Henderson and Dr Cover performed a right hemicolectomy by removing the perforation and the tissue around it and re-joining the intestine. Dr Henderson stated there was no evidence of an obstruction having caused the perforation and he believed it was due to ischaemia. Histopathology of the removed caecum after the operation indicated that:

> "*The area adjacent to the perforation shows ischaemic changes with mucosal ulceration and foci of surface fibrinous exudates, as well as congested blood vessels in the lamina propria. That's the portion surrounding the perforation.*"[38]

Dr Henderson did not have the benefit of the histopathology at the time of the hemicolectomy, however, had checked in the deceased's file on understanding he was to give evidence.[39]

From the operation note Dr Henderson could see the deceased had required extensive washout due to the amount of faecal contamination throughout the peritoneal cavity. In the opinion of both Dr Henderson and Dr Cover the surgery went well and they believed they had done as

[38] t 1.08.17, p211-212, Ex 2
[39] Ex 2

much as possible to alleviate the deceased's symptoms and risk, although there is a high rate of morbidity with peritoneal sepsis, depending on the amount of time the contamination has continued.

FH had no idea when the perforation was likely to have occurred and, in evidence, Dr Henderson agreed it would appear from the SJOG Murdoch record it was likely the perforation occurred around midnight between 4th and 5th May 2014. That would give a down time of 24 hours which was significant.[40]

Dr Henderson noted from the record the deceased had spent longer than usual in recovery following the right hemicolectomy in view of the fact the operation finished between 2-2.30 am on 6 May 2014, but the deceased was not transferred out of recovery until 7.30 am. Dr Henderson did note this was an unusually long time for someone to spend in recovery and then to go to the ward, rather than ICU. This was unusual.[41] He could not explain the delay because the recovery process was usually something overseen by the anaesthetist, who would only discuss it with the surgeon if there was a problem from a surgical perspective. It had not been discussed with Dr Henderson.[42] Dr Henderson believed it would be his normal practice to suggest a patient such as the deceased

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[40] t 01.08.17, p230-231
[41] Ex 1, tab 14
[42] t 01.08.17, p214

be transferred to ICU post operatively, however, it was a decision to be made between the anaesthetist and the ICU team.

Following that initial operation, the deceased deteriorated and she was transferred to ICU due to ongoing pain and a deterioration in her observations by the team conducting the morning ward review. The deceased was reviewed by the surgical team on 6 May 2014 and taken back into theatre for a "*relook*" laparotomy.

This operation was again undertaken by Dr Henderson and Dr Cover. On opening the abdomen they found fibrin coating on the small bowel and colon, but no enteric contents and no evidence of a leak. The anastomosis looked viable and there was no reason for the deterioration, but Dr Henderson decided it would be safest to take down the anastomosis and perform an end ileostomy. The deceased still had some small bowel peristalsis and the bowel was viable.

Dr Henderson said the reason for the second operation was due to the deceased's worsening renal function, increasing abdominal pressure and worsening inotropic requirements. It was a concern about her systemic state rather than a concern with the anastomosis.[43]

[43] t 01.08.17, p227

On this occasion the team did not close the deceased's abdomen and a VAC dressing was applied. She was managed in ICU with inotropic support.

Dr Henderson said in evidence that with sepsis it is sometimes the case that a patient will deteriorate further before improving.[44]

The deceased continued to deteriorate and she was again taken to theatre on 9 May 2014. Dr Henderson said this was because of the discussions at the ward round as well the fact the VAC dressing required to be changed. He did have a recollection of this operation. On removing her VAC dressing Dr Henderson could see the deceased's sepsis was widespread and he felt there was nothing further that could be done. Before finalising that decision Dr Henderson requested the attendance of three senior consultants to discuss his intended course of action.[45]

Dr Henderson called Professor Fletcher, Professor Bartolo and another consultant to confirm his findings at the third operation. He stated the decision to perform a third operation and whether to proceed or to cease all further input is a substantial decision and it was one he would not make on his own.[46] Dr Henderson said he had a recollection of this particular operation and his need to call

[44] t 01.08.17, p218
[45] t 01.08.17, p219
[46] t 01.08.17, p219

an intraoperative review. All consultants present agreed that the deceased's situation was now irreversible and the operative position should not be pursued.

It was agreed the deceased had a distal bowel ischaemia and nothing more could be done.

She died shortly before midnight on 9 May 2014.

## POST MORTEM REPORT

The post mortem examination was undertaken by Dr Jodi White, Forensic Pathologist on 14 May 2014.[47]

Dr White found the deceased had an enlarged, softened dilated heart, with mild to moderate coronary artery disease, heavy fluid laden lungs with likely consolidative changes, large bilateral pleural effusions, a soft and congested liver with ascites, and an absent gallbladder.

There was evident peritonitis with purulent adhesions throughout the abdomen with soft mottled kidneys, peripheral oedema with peripheral stigmata of severe sepsis. Microbiology grew a range of bacteria and fungi. Histopathology confirmed extensive ischaemic changes in the small intestine and features consistent with multi-organ failure.

[47] Ex 1, tab 4

Toxicology was appropriate and Dr White gave a cause of death as intra-abdominal sepsis and shock with multi-organ failure following intestinal (obstruction and) perforation complicating a recent lumbar spine laminectomy.

There is no suggestion the spinal surgery caused a perforation due to surgical error and the perforation of the caecum appears to have been due to ischaemia. There was no evidence of intestinal obstruction and while the fact of earlier surgery may have affected the deceased's ability to compensate for sepsis following the perforation, it certainly was not the cause of the perforation.

The evidence supports ischaemia as the cause of the perforation rather than obstruction leading to ischaemia, then perforation. It was for that reason Dr Henderson had noted the extent of soft fluid faecal contamination in the peritoneal cavity.[48] In view of the lack of evidence of obstruction I have removed obstruction from the given cause of death for the deceased.

## PROFESSOR PLATELL'S EVIDENCE

Professor Cameron Platell, Consultant Colorectal Surgeon, was asked to review the treatment and management of the deceased in both SJOG Murdoch and FH. Professor Platell practices at SJOG Subiaco.

[48] t 01.08.2017, p211

***St John of God Murdoch***

In Professor Platell's opinion the delay in diagnosis of the deceased's perforated bowel was exacerbated by the systems in place at SJOG Murdoch. Generally, any perforation of the intestine of a patient is associated with a high morbidity and mortality rate and the longer the delay between diagnosis and surgery the worse the prognosis becomes. This was confirmed by Dr Henderson in his evidence when he referred to the need for surgery within hours, but not being as critical as for some operations, which need to be done within minutes.

The system in place at SJOG Murdoch, with no overnight cover for investigations, as advised to RMO Fennessy, or medical advisors for review, delayed the performance of an abdominal X-ray as a diagnostic tool for diagnosing the perforation. At the time RMO Fennessy reviewed the deceased it is likely the perforation had not yet occurred, a CT scan would have been a better diagnostic tool.

In Professor Platell's opinion review by a consultant surgeon would have prompted urgent CT scanning rather than X-ray. However, X-ray is what was available and what was asked for and did indicate the likelihood of a perforation by the time it was done. In Professor Platell's view the preferable time for the deceased to have had a CT scan would have been Sunday 4 May 2014 when her abdomen

was noted to be distended and she continued to be unable to clear her bowels despite her clinical appearance.[49]

Professor Platell was critical of the fact the deceased was managed solely from the perspective of constipation without any real consideration of an alternative diagnosis, despite ongoing laxatives and ultimately early morning pain relief.[50] He understood that when she was noticeably unwell on the Sunday there was little by way of medical cover available on the wards, but was clear RMO Fennessy should have been given more support when he raised concerns as to her signs and symptoms. Professor Platell was adament it was the admitting consultant who remained responsible for a patient, whether the deterioration related to the surgery or some other problem, and that if engaging the assistance of another consultant, it was appropriate it be done consultant to consultant.[51]

Professor Platell was of the opinion it was more likely the deceased had developed ischaemic bowel due to her underlying comorbidities, however, was clear the deceased remained Mr Narula's patient until he had successfully transferred her to an alternative consultant.[52]

Mr Narula agreed the deceased was his responsibility and that he had known her for a long time and he was obviously

[49] t 25.07.17, p52
[50] t 25.07.17, p8
[51] t 25.07.17, p11, p49, p51
[52] t 25.07.17, p9, p16, p25

concerned as to her welfare.[53] Essentially, Mr Narula said he did not understand from Dr Fennessy's phone call, Dr Fennessy was not confident of his diagnosis. The fact he had not heard from Dr Fennessy again reassured him that all was being appropriately attended to and there was no need for him to be further involved in the deceased's care.

***Fremantle Hospital (FH)***

Professor Platell was also critical of the appropriateness of the surgery performed at FH. At the time of his original review Professor Platell had not had the benefit of seeing the histopathology of the caecum removed during the first operation at FH.[54] On viewing the histopathology prior to giving evidence, Professor Platell was still unable to comment on whether the deceased had suffered an obstruction which caused the perforation, or the perforation was solely the result of an ischaemic bowel. He did believe, however, the histopathology supported his view ischaemia extended beyond the area removed.[55]

It was Professor Platell's opinion a different type of operation should have been conducted at first instance which would have involved removing the ischaemic area, but not re-joining the cut edges at that point. Rather drawing them

[53] t 25.07.17, p68-69
[54] Ex 2
[55] t 25.07.17, p31

out of the abdominal cavity to drain and ensuring the remaining intestine was viable.[56]

Both Dr Henderson and Dr Kariyawasam disagreed the histopathology indicated a different surgery would have been preferable. They indicated that while the mucosa appeared ischaemic to the margins of the removed piece, it was the smooth muscle which needed to be joined and that was viable at both margins.[57] This was confirmed by the histopathology of the anastomosis at the second operation.[58]

Both Dr Henderson and Dr Kariyawasam indicated the histopathology of the removed caecum, with the perforation, confirmed it was ischaemia which caused the perforation, that is poor blood supply, but it could not be clarified as to what caused the ischaemia.[59] While ischaemia extended to the mucosal margins of the removed tissue that did not apply to the underlying smooth muscle.

Dr Henderson pointed out that while the mucosa of the small bowel can die, the bowel can remain viable. Provided the attachment was of the outside muscular layer it was possible for purple mucosa (dying) to be reinvigorated because it is not frankly ischaemic, in which case it would be black.[60]

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[56] t 25.07.17, p18-19, p33
[57] t 26.07.17, p167
[58] Ex 2
[59] t 26.07.17, p165, t 01.08.17, p211
[60] t 1.08.17, p222

Both Dr Henderson and Dr Kariyawasam said with hindsight they may have performed the second operation of 6 May 2014 initially, but that was only in hindsight. Dr Henderson was adamant the operation he initially performed was in accordance with best practice, and he was unable to find the operation described by Professor Platell as preferable for the first operation, in the literature.[61]

There was also some disagreement between Professor Platell and the FH surgeons about different aspects of the surgery performed, but I accept the FH surgeons were those actually viewing the situation with the deceased and acted in a manner they considered to be in the best interests of the deceased at the time. Her final deterioration was unusually rapid and unexpected to all concerned. I believe that was largely due to the original delay in diagnosis of the perforation.

## CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 69 year old female with serious back pain which had required ongoing intervention over the years. She was treated conservatively as far as possible, but when it became necessary for her functionality corrective surgery was performed.

[61] t 01.08.17, p212

The laminectomy performed on 1 May 2014 was to improve the deceased's quality of life and Mr Narula undertook that to assist with the deceased's back pain and provide her with relief and more movement. Mr Narula reviewed the deceased following surgery and was happy on 3 May 2014 with her progress. He put plans in place for her to undergo rehabilitation, following mobility with physiotherapy.

Unfortunately the deceased developed an ischaemic bowel, probably not related to the actual surgery itself, but possibly related to the effects of surgery requiring immobility, and anaesthesia and analgesia promoting constipation. She began to develop symptoms of intra-abdominal pressure. SJOG Murdoch had reduced medical coverage over the weekend which is when the deceased's difficulties surfaced.

It is my view the deceased was appropriately reviewed by the locum RMO from SJOG Subiaco, but he was not provided appropriate orientation for the different hospital campus. He was not informed of the protocols in place at SJOG Murdoch, and was not assisted by input from those who did. He did not understand the deceased may not undergo medical review on morning rounds, that it was possible for a consultant to order an urgent CT scan or X-ray out of normal business hours, and was not provided with guidance when it was obvious he had concerns about the deceased to the extent he rang her consultant for clarification. I accept he did not specify his concern, but he did provide an

overview which covered both the indicators and contradictors for constipation.

The failure by SJOG Murdoch to ensure appropriate review of the deceased on the morning of 5 May 2014 after her difficulties overnight exacerbated a significant delay in the deceased obtaining proper review and treatment which would have contributed to the extent of sepsis resulting in multi-organ failure.

Dr Fennessy certainly put in place measures he believed would see the deceased reviewed appropriately first thing on Monday morning, with the results of an abdominal X-ray. Unfortunately that did not occur and, despite the deceased's increasing pain levels, the deceased was not reviewed until Dr Lee attended her on the evening of 5 May 2014, for her assessment for rehabilitation.

By that time the deceased was extremely unwell, as evidenced by the X-ray taken at 11.30 am that morning and reported at 1.10 pm. The evidence strongly suggests that reporting was not drawn to the attention of any appropriate practitioner, otherwise I am sure the deceased would have been reviewed. It was an obvious concern and should have provoked contact with the ward, at least, despite Dr Fennessy's failure to use the word "*urgent*".[62]

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[62] t 25.07.17, p72

Dr Lee very appropriately liaised with all parties and arranged for the deceased's urgent transfer to FH due to the unavailability of appropriate medical intervention at SJOG Murdoch. It is likely by that time her perforation had been leaking faecal matter into her peritoneal cavity for a minimum of 12 hours and most likely longer. This was a serious scenario, but Dr Lee had the advantage of being a consultant in his own right and able to take appropriate consultative action.

The deceased was admitted to FH where she received an urgent laparotomy that evening, which due to the extent of the perforation and faecal contamination extended into the early hours of 6 May 2014.

Having heard the evidence of both Professor Platell and the clinicians from FH I appreciate there is a difference of view as to the appropriate surgery. I am not in a position to comment upon that dispute, especially with the benefit of hindsight and histopathology which was not available to the surgeons during the course of the operation. They had visual input as to the circumstances of the deceased.

I take note of Professor Platell's views as to the optimal procedures initially, but also note that did not appear to reflect practice in general surgery at FH in May 2014, nor did histopathology indicate a problem with the healing of

the anastomosis.[63] Regardless, the deceased did not improve and the consultant under whom she had been admitted to FH asked she be returned to surgery which was performed by Dr Henderson. The deceased was deteriorating and Dr Henderson performed a second operation, which in hindsight he may have done initially, if he had the benefit of knowing the extent of her compromised system.

It is clear by that time the deceased's system was so insulted she did not have the ability to compensate. She continued to deteriorate. The difficulty with sepsis is that once it becomes established, if it cannot be reversed by the removal of infected material and IV antibiotics, it will progress to multi organ failure. Once multi organ failure is in progress there is no prospect of improvement.

Unfortunately that was the situation with the deceased and her system was unable to recover from the extent of her infected peritoneum, sepsis, and the resulting multi organ failure.

It is clear the deceased had a difficult life but after overcoming difficulties in her youth, I am heartened by the fact her middle years appear to have been healthy and productive. She leaves behind a devoted son and well-loved

[63] t 01.08.17, p211, 221, 227

grandchildren who will remember the positives about their grandmother and her exceptional cooking.

## MANNER AND CAUSE OF DEATH

I am satisfied, on all the evidence, the deceased died as the result of sepsis arising from ischaemia of her caecum and its resulting perforation. I am not in a position to determine the cause of the ischaemia, but it would seem to be a whole of situation outcome. The deceased's underlying conditions, her need for surgery and the necessary immobility following surgery may well all have contributed to a reduced blood flow to her bowel and initiated the later problems.

The delay in diagnosis of the perforation and the need for appropriate surgery did not improve the deceased's prospects for a successful outcome.

I am unable to say with certainty that appropriate intervention early on 5 May 2014 would have changed the outcome in view of all the contributing factors. It would, however, have improved the deceased's chance of survival.

I am satisfied the deceased died as the result of the perforation of her caecum, the contamination of her peritoneum with faecal material and the resulting sepsis.

I find death occurred by way of Natural Causes.

## RECOMMENDATIONS

Due to the concerns raised by Professor Platell and explored during the course of the inquest I provided counsel with my concerns arising out of the evidence as to the system in place at SJOG Murdoch in May 2014 for the early diagnosis of deteriorating patients.

In response I was provided with a statement and evidence from Clinical Risk Manager, Melissa Moran,[64] and the statement of the Director of Medical Services and Director of Hospice and Palliative Services, Dr Alison Parr.[65]

One of my major concerns had been the lack of medical cover at SJOG Murdoch over the weekends. While it is the case surgical patients will always remain under the care of the consultant surgeon responsible for their admission to the hospital, problems may arise which are not within the expertise of those surgeons. The protocols require appropriate consultant to consultant transfer and in the situation Dr Fennessy met on the evening of 4 May 2014, it was clear he was left in the position of doing the best he could with the resources of which he was, or was not, made aware.

I understand from the statement of Dr Parr that all surgical RMOs at SJOG Murdoch are now directly employed to work

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[64] Ex 4
[65] Ex 5

at SJOG Murdoch and an orientation problem would not arise. SJOG Murdoch now employs RMOs and they are provided with orientation, are familiar with the specific hospital environment and know how to access information and support during their shifts. Improved medical cover and communication has been progressing since the death of the deceased by the use of night duty RMOs, employed RMOs and additional RMOs attached to different specialties.[66] This would have assisted Dr Fennessy with providing an RMO to RMO handover.[67]

An employed RMO would have understood he or she could request an urgent X-ray overnight, through an appropriate consultant if that was necessary and in probability would be a consultant the RMO would know. That would have ensured the deceased received her abdominal X-ray or a CT scan on 4 May 2014 and the results would have been reviewed by a clinical practitioner capable of dealing with the outcome. That may have noted a problem for the deceased before perforation or shortly thereafter, which would have significantly improved her prognosis.

I am satisfied there is now a new protocol in place at SJOG Murdoch for the reporting of radiological information to persons with the ability to put in place appropriate responses. While the new protocol for the communication of serious radiological responses appears to be appropriate, I

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[66] t 25.07.17, p74 – Mr Narula's wish list
[67] t 26.07.17, p106

note the email discussion outlined in exhibit 3 implied that was also the case in May 2014, but there is no evidence it had occurred on this occasion. Consequently I am minded to make a recommendation, despite the fact I am satisfied protocols are now in place there be communication between the radiologists and relevant clinicians.

**RECOMMENDATION NO. 1**

**SJOG MURDOCH ENSURE THE SKG RADIOLOGISTS CONTACT THE APPROPRIATE CONSULTANT UNDER WHOM A PATIENT IS ADMITTED WHERE THERE IS A SERIOUS RADIOLOGICAL RESULT REQUIRING URGENT ATTENTION.**

I understand the difficulty with charted analgesics, and a patient's observations as charted on the various charts for clinical review. I am concerned, however, that among the medications for which the deceased was charted, the fact she needed pethidine on the 4th day post operatively when she had not required analgesia of that level before, was not escalated to, at least, clinical review. I note Dr Parr's view that is a controversial matter where the patient has been withdrawn from on demand analgesia, but will nevertheless make a recommendation related to the need for medical review when a patient has suddenly needed an unexpectedly high level of analgesia. This is related to the fact the deceased received no medical review on the morning of 5 May 2014, despite that being Dr Fennessy's documented plan.

**RECOMMENDATION NO.2**

**WHERE THE OVERNIGHT CARE OF A PATIENT HAS REQUIRED INTENSIVE INTERVENTION THE CLINICAL NURSE MANAGER SHOULD ENSURE THAT PATIENT RECEIVES APPROPRIATE MEDICAL REVIEW THE FOLLOWING MORNING IF OBSERVATIONS HAVE NOT WARRANTED A MEDICAL REVIEW EARLIER.**

I am comforted by the fact SJOG Murdoch appears to have undertaken extensive review and improvement since May 2014 which would see more timely intervention in a case such as the deceased.

I do not propose to make any recommendations with respect to the surgery undertaken at FH. I note the opinions of Professor Platell and the evidence of Dr Kariyawasam and Dr Henderson and trust the tragic scenario for the deceased in this case will encourage critical review of procedures to ensure clinicians take note of suggested practices where they believe it to be relevant and helpful to their own practice.

E F Vicker
**Deputy State Coroner**
7 December 2017