
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : MICHAEL ANDREW GLIDDON JENKIN
HEARD : 17-18 FEBRUARY 2021
DELIVERED : 26 MARCH 2021
FILE NO/S : CORC 30 of 2017
DECEASED : CHURCHILL, CYRIL

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the coroner.

Ms R Paljetak (State Solicitor's Office) appeared on behalf of the WA Country Health Service (WACHS).

Ms M Naylor (Tottle Partners) appeared on behalf of Dr K Ng.

Mr S Denman appeared on behalf of Dr SM Ranasinghe.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of Cyril CHURCHILL with an inquest held at Broome Coroners Court, Hammersley Street, Broome, on 17 - 18 February 2021, find that the identity of the deceased person was Cyril CHURCHILL and that death occurred on 13 November 2017 at Royal Darwin Hospital from surgical complications following laparoscopic cholecystectomy for cholecystitis in the following circumstances:

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INTRODUCTION

1. Cyril Churchill (Mr Churchill) died at Royal Darwin Hospital on 13 November 2017 from surgical complications following the removal of his inflamed gallbladder. He was 68-years of age.
2. On 26 October 2017, Mr Churchill was transferred from Fitzroy Crossing Hospital to Broome Hospital following a three-day history of abdominal pain. Mr Churchill's gallbladder was removed on 27 October 2017 and following the procedure, his blood pressure became dangerously low despite repeated doses of medication, intravenous fluids and blood transfusions.
3. Clinicians disagreed as to the cause of Mr Churchill's symptoms with the anaesthetist suggesting internal bleeding and the surgeon favouring a septic event. Mr Churchill was eventually returned to theatre, where three litres of blood were removed from his abdomen. Mr Churchill was transferred to Royal Darwin Hospital on 28 October 2017, and initially, his condition appeared to improve. However, after about a week, his condition deteriorated. He was transferred to a hospice where he died surrounded by his family.
4. I held an inquest into Mr Churchill's death in Broome over the period 17 - 18 February 2021. The following witnesses gave evidence:
 - i. Dr Saranga Ranasinghe (General surgeon);
 - ii. Dr Kevin Ng (District medical officer - anaesthetist);
 - iii. Dr David Forster (District medical officer - anaesthetist);
 - iv. Dr Suzanne Phillips (Senior medical officer)
 - v. Dr Sascha Saharov (District medical officer - anaesthetist);
 - vi. Dr Stephanie Schlueter (Clinical lead, WACHS);
 - vii. Dr Alan Thomas (General and upper gastrointestinal surgeon); and
 - viii. Ms Rebecca Smith (Regional Director, WACHS - Kimberley).
5. The documentary evidence at the inquest comprised two volumes and included reports from the Police and independent experts, witness statements and medical notes. The inquest focused on the circumstances surrounding Mr Churchill's death, including his post-operative management.

MR CHURCHILL^{1,2}

6. Mr Churchill was born on 17 December 1948 at GoGo Station near Fitzroy Crossing, and he remained in the area for the rest of his life. He had one child with his first partner and three children with his second partner. Although he had separated from his second partner, they continued to live in the same community.
7. Mr Churchill was described as a religious person who was well respected by community members. Although he had previously consumed excessive amounts of alcohol, he gave up drinking in 2014 for health reasons. At the time of his death, Mr Churchill lived with family members in the Bayulu Community. He was generally able to care for himself and he walked around the Community on a daily basis.
8. Mr Churchill's medical conditions included: congestive heart failure, poorly controlled type-2 diabetes, chronic kidney disease, high cholesterol and high blood pressure. Although Mr Churchill's medical records do not refer to him being formally diagnosed with dementia, his daughter says he did have dementia and he was taking medication for this condition.

THE EVENTS OF 27- 29 OCTOBER 2017³

Admission to Broome Hospital^{4,5}

9. Mr Churchill presented to Fitzroy Hospital for the third time on 26 October 2017. He complained of right upper quadrant pain and underwent a diagnostic test for Murphy's sign⁶ which was positive. This suggested acute inflammation of the gallbladder (cholecystitis) and a portable ultrasound found Mr Churchill had gallstones and a dilated gallbladder.

¹ Exhibit 1, Vol. 1, Tab 6, Report - Sgt. T Langhorn (14.04.18)

² Exhibit 1, Vol. 1, Tab 7, Statement - Ms V Chiguna, paras 18-25 & 27-28

³ Exhibit 1, Vol. 1, Tab 6, Report - Sgt. T Langhorn (14.04.18), p3

⁴ Exhibit 1, Vol. 2, Tab 1, Fitzroy Hospital - Referral to Broome Hospital (26.10.17)

⁵ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Discharge summary (16.11.17)

⁶ The patient is asked to inhale while the area under the right ribs is palpated. Pain indicates a positive sign.

10. Mr Churchill was afebrile, meaning he did not have a fever, however a blood test known as C-reactive protein (CRP) was elevated and his white cell count was marginally high, meaning that his body was reacting to his inflamed gallbladder.⁷
11. Mr Churchill travelled to Broome from Fitzroy Crossing on the overnight bus and was admitted to Broome Hospital (BH) at about 7.45 am on 27 October 2017. When reviewed, he was found to have a palpable mass in his abdomen, which was thought to be his gallbladder fundus.⁸
12. A formal ultrasound was requested to confirm a working diagnosis of acute cholecystitis, although Mr Churchill's medical record (the File) does not make clear whether the planned ultrasound was performed.⁹
13. Mr Churchill was given intravenous antibiotics and additional blood tests were ordered. Other tests showed that Mr Churchill's CRP level had fallen, but that his lipase level was slightly abnormal. His vital signs remained stable during the morning and there was no evidence of "*preceding or imminent sepsis*".¹⁰

Removal Mr Churchill's gallbladder

14. Mr Churchill was reviewed at about 9.00 am on 27 October 2017, by Dr Saranga Ranasinghe (a general surgeon) and another colleague. At that time, Dr Ranasinghe had 18 or 19 years of experience, but when he reviewed Mr Churchill, Dr Ranasinghe had only been employed at BH for five days on a locum basis.¹¹
15. In view of Mr Churchill's reduced immunity due to his pre-existing co-morbidities, Dr Ranasinghe considered it would be best to surgically remove Mr Churchill's gallbladder to ensure that he did not develop any septic related complications.^{12,13}

⁷ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p1

⁸ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Integrated progress notes (7.45 am, 27.10.17)

⁹ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Integrated progress notes (7.45 am, 27.10.17)

¹⁰ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18) (29.12.18), p1

¹¹ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 7 & ts 17.02.21 (Ranasinghe), pp7 & 39

¹² Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 6-7

¹³ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 7

16. The risks of surgery were explained to Mr Churchill and he signed consent forms for the procedure and a general anaesthetic. The possible complications listed on the procedure form were: “*bleeding, infection and conversion to open*”.^{14,15,16}
17. A retrospective entry in the File states that Mr Churchill’s observations had been stable and that he was showered and changed into a surgical gown in readiness for surgery.¹⁷ He arrived at the operating theatre at 12.55 pm for a laparoscopic cholecystectomy (the Procedure),¹⁸ a “*keyhole*” surgical procedure for removal of the gallbladder.¹⁹
18. Dr Ranasinghe said that by the time he arrived at BH, he had performed numerous laparoscopic cholecystectomies. He said that although the Procedure is relatively common, it was more complicated in Mr Churchill’s case because of the acute inflammation in his gallbladder.²⁰
19. Dr Ranasinghe said he always performed the Procedure in the order in which he had been trained. To begin with, an incision is made in the patient’s abdomen and the “*operative field*” is exposed. Calot’s triangle²¹ is identified and the cystic duct, followed by the cystic artery are then identified and clipped. The gallbladder is then removed and any bleeding in the operative field is treated by diathermy, where a heated instrument is used to cauterise and seal blood vessels and tissues.²²
20. The Court commissioned Dr Alan Thomas, an upper gastrointestinal surgeon, to provide an independent assessment of Mr Churchill’s care. In Dr Thomas’ view, the more appropriate way to perform the Procedure is to clip and cut the cystic artery before the cystic duct, especially where the gallbladder is inflamed.²³

¹⁴ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Patient consent to anaesthesia (27.10.17)

¹⁵ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Patient consent to treatment (27.10.17)

¹⁶ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe 15.01.18), para 8

¹⁷ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Integrated progress notes (3.00 pm, 27.10.17)

¹⁸ A procedure whereby the gallbladder is removed by instruments inserted through a small incision in the abdomen

¹⁹ Exhibit 1, Vol. 1, Tab 22, Attachment A, Report - Theatre journey by operation (27.10.17)

²⁰ ts 17.02.21 (Ranasinghe), pp7-8

²¹ An important anatomical landmark bounded by the common hepatic duct, the cystic duct and the edge of the liver

²² ts 17.02.21 (Ranasinghe), pp14-15

²³ ts 18.02.21 (Thomas), pp213-215

21. Dr Thomas explained why in the following terms:

[T]he artery is less sturdy than the duct, and hence more likely to tear or avulse. Also transecting the duct alters the anatomy in the triangle making visualisation and definition of structures more difficult. The tearing or avulsing of the cystic duct would lead to bile leakage but this can be more calmly controlled with sutures, clips or even remedied with a drain and subsequent ERCP +/- a stent. Avulsing an artery or the surrounding veins leads to immediate or delayed bleeding which is harder to control or recognise.²⁴

22. From a layperson's perspective, there is an elegant logic to Dr Thomas' reasoning. However, in fairness, I note that an extract from a standard text on surgical procedures provided to the Court by Dr Ranasinghe through his counsel, describes the Procedure using Dr Ranasinghe's method.²⁵

23. At the inquest, Dr Ranasinghe said that of the four surgical colleagues he questioned about the order in which to conduct the Procedure, three said they used his method. However, Dr Thomas was unmoved by the "*straw poll*" conducted by Dr Ranasinghe and maintained that the method that he (i.e.: Dr Thomas) described was more logical and was to be preferred.²⁶

24. In this case, Dr Ranasinghe clipped Mr Churchill's cystic duct which was then closed using an endoscopic loop. Dr Ranasinghe then clipped the cystic artery and removed Mr Churchill's gallbladder. Three small areas of bleeding in the gallbladder bed were identified and cauterised using diathermy. At the end of the procedure, Dr Ranasinghe was satisfied that there were no areas of active bleeding.^{27,28}

25. After the operative field had been washed and the stump of the cystic duct had been checked for any leakage of bile, Dr Ranasinghe inserted a drain into Mr Churchill's abdomen.²⁹

²⁴ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p8

²⁵ Exhibit 1, Vol. 1, Tab 12B, Attachment to Statement - Dr SM Ranasinghe

²⁶ ts 17.02.21 (Ranasinghe), pp15 & 38 and ts 18.02.21 (Thomas), p213

²⁷ ts 17.02.21 (Ranasinghe), p34

²⁸ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Operation report (2.30 pm, 27.10.17)

²⁹ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Operation report (2.30 pm, 27.10.17)

26. Dr Ranasinghe said that this was not his normal practice, but he did so in this case because of the “*state of the operative field and the technical challenge*” and in anticipation of “*a small amount of post-operative bleeding*”.^{30,31,32}
27. During the Procedure, Dr Kevin Ng, a district medical officer and anaesthetist, mentioned that the gallbladder bed appeared to be “*oozy*”, meaning there appeared to be some bleeding. Dr Ng was also concerned that during the “*wash out*” at the end of the procedure, the fluid coming from Mr Churchill was not “*very clear*”. Dr Ranasinghe assured Dr Ng that the amount of ooze observed was not a cause for concern.^{33,34}
28. In statements made before the inquest, Dr Ranasinghe said he couldn’t recall whether Dr Ng had made an enquiry about Mr Churchill’s gallbladder bed, but he remembered thinking at the time, that the state of operative field was consistent with his experience of “*inflamed and/or septic gallbladders*”.^{35,36}
29. At the inquest, Dr Ranasinghe said did he recall Dr Ng enquiring about “*ooze*” from the gallbladder bed, by which he understood Dr Ng to be asking about bleeding.³⁷ However, Dr Ranasinghe said that he was not concerned about the state of Mr Churchill’s gallbladder bed and that it was quite common to see some bleeding, especially where the gallbladder was inflamed.³⁸

Post-operative management

30. After the Procedure was completed at about 2.16 pm, Mr Churchill was “*woken up*” by Dr Ng and taken to the recovery area at about 2.20 pm. Dr Ng gave a verbal handover to the nurse in the recovery area and before leaving Mr Churchill, Dr Ng satisfied himself that Mr Churchill’s observations were stable.³⁹

³⁰ ts 17.02.21 (Ranasinghe), pp 9-11 & 34

³¹ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe, (15.01.18) paras 11-12 and

³² Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 14

³³ Exhibit 1, Vol. 1, Tab 8, Report - Dr K Ng (08.02.18), p2 and ts 17.02.21 (Ng), pp46-47, 56 & 59

³⁴ Exhibit 1, Vol. 1, Tab 10A, Attachment SP1, MMEX notes (Dr K Ng, 29.10.17), p1

³⁵ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe, paras 11-12

³⁶ See also: Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 13

³⁷ ts 17.02.21 (Ranasinghe), p23

³⁸ ts 17.02.21 (Ranasinghe), p9

³⁹ Exhibit 1, Vol. 1, Tab 8, Report - Dr K Ng (08.02.18), p2 and ts 17.02.21 (Ng), pp47-48

31. However, at about 2.30 pm, Dr Ng was called back to the recovery area by nursing staff who were concerned that Mr Churchill's blood pressure had dropped and that he had become "*hypotensive*". Dr Ng noted that Mr Churchill seemed drowsy but did not consider he was confused. When asked how he was, Mr Churchill replied "*alright*". Dr Ng gave Mr Churchill repeated doses of medications (vasopressors and inotropes) designed to treat low blood pressure, as well as intravenous fluids and a medication to reverse the effect of the anaesthetic (flumazenil). Although there was a temporary improvement in Mr Churchill's blood pressure each time medication was administered, within a few minutes of each dose Mr Churchill's blood pressure dropped again.^{40,41}
32. Dr Ng considered that Mr Churchill's abdomen was distended and given Mr Churchill's poor response to blood pressure medications, became concerned that the most likely cause for Mr Churchill's hypotension was intra-abdominal bleeding.⁴²
33. Dr Ng did not think sepsis was likely and had never seen a patient become "septic" in the immediate aftermath of a surgical procedure. In Dr Ng's experience, when a locus of infection was removed, patients typically improved. As a result of his concerns about intra-abdominal bleeding, Dr Ng asked Dr Ranasinghe to urgently review Mr Churchill.^{43,44}
34. Dr Ranasinghe assessed Mr Churchill and considered his abdomen was soft and appropriately tender for a post-operative patient. He also noted that the drain he had inserted did not contain an excessive amount of blood. In contrast to Dr Ng, Dr Ranasinghe felt that the cause of Mr Churchill's symptoms was more likely to be a septic event during surgery (i.e.: a septic shower), where bacteria may have been released into Mr Churchill's bloodstream during the Procedure. However, it is widely accepted that the effects of a septic shower are transitory and generally resolve relatively quickly.^{45,46,47}

⁴⁰ Exhibit 1, Vol. 1, Tab 8, Report - Dr K Ng (08.02.18), p2 and ts 17.02.21 (Ng), pp47-48

⁴¹ Exhibit 1, Vol. 1, Tab 10A, Attachment SP1, MMEX notes (Dr K Ng, 29.10.17)

⁴² Dr Ng agreed that this could have been due to gas in the abdomen after the Procedure: ts 17.02.21 (Ng), p60

⁴³ Exhibit 1, Vol. 1, Tab 8, Report - Dr K Ng (08.02.18), p2 and ts 17.02.21 (Ng), pp48-49

⁴⁴ Exhibit 1, Vol. 1, Tab 10A, Attachment SP1, MMEX notes (Dr K Ng, 29.10.17)

⁴⁵ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 14-16

35. In passing I note that neither Dr David Forster (a district medical officer and anaesthetist) nor Dr Tahlia Shepherd (a surgical registrar), both of whom examined Mr Churchill when they attended a subsequent medical emergency call (MET call), thought that his abdomen was distended.⁴⁸
36. Dr Ranasinghe says he recalls mentioning that “a scan” was required. He was not referring to a bedside ultrasound known as a Focussed Assessment with Sonography for Trauma (FAST scan), a diagnostic tool with which he had no experience. Rather, he meant a formal CT scan which, on his understanding, was 99% accurate in detecting free fluid. Mr Churchill was given additional antibiotics and Dr Ranasinghe then left the recovery area.^{49,50}
37. For the sake of completeness, I note that in a statement he gave prior to the inquest, Dr Ranasinghe said: “[Mr Churchill’s] *blood pressure stabilised during the resuscitation but he continued to remain tachycardic.*”⁵¹ However, at the inquest, Dr Ranasinghe clarified that at the time he made this statement, he did not have access to Mr Churchill’s medical notes and was relying on his recollection of events. At the inquest, having had the opportunity to review the File, Dr Ranasinghe properly conceded that at no stage after 2.30 pm on 27 October 2017, was Mr Churchill haemodynamically stable, meaning that his blood pressure continued to fluctuate.⁵²
38. Mr Churchill remained hypotensive despite being given intravenous fluids and repeated doses of vasopressors and inotropes. Dr Ng did consider sepsis was the most likely cause of Mr Churchill’s symptoms given the lack of clinical signs. Mr Churchill’s temperature was normal, he was not experiencing chills or rigors and he had normal feeling and pulses in his peripheries. For those reasons, Dr Ng concluded that Mr Churchill was not septic and instead, that blood loss was the most likely cause of his unstable condition.^{53,54}

⁴⁶ ts 17.02.21 (Ranasinghe), pp11 & 26 and ts 17.02.21 (Ng), p50

⁴⁷ ts 18.02.21 (Thomas), pp215-218

⁴⁸ Exhibit 1, Vol. 1, Tab 11, Statement - Dr D Forster (05.04.18), paras 19-20 and ts 17.02.21 (Forster), p142

⁴⁹ ts 17.02.21 (Ranasinghe), pp12-13 & 18

⁵⁰ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 14-16

⁵¹ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), para 18

⁵² ts 17.02.21 (Ranasinghe), pp245-246 & 249

⁵³ Exhibit 1, Vol. 1, Tab 8, Report - Dr K Ng (08.02.18), p2

MET call

39. Despite Dr Ng's best efforts, Mr Churchill remained haemodynamically unstable. Dr Ng made a MET call at 2.50 pm, on the basis that he was unable to stabilise Mr Churchill's blood pressure. The aim of a MET call is to summons a range of clinical staff, including nurses and doctors, in order to maximise the possibility that an unstable patient's condition can be improved.⁵⁵
40. When the MET call was initiated in this case, a number of clinical staff including medical officers and nursing staff attended the recovery area. One of the attendees was Dr Forster. He said that when he arrived the nursing staff looked "*very concerned*" and "*everyone was looking at me to do something*". Dr Forster requested a verbal handover but did not immediately assume a leadership role. He eventually did but felt "*quite awkward*" doing so given that Dr Ng was already in attendance.⁵⁶
41. After being told that Mr Churchill had undergone the Procedure and had persistently low blood pressure, Dr Forster asked if blood products had been ordered. He was told they had not been ordered and he asked Dr Ng to arrange this. Dr Forster's reasoning was that Mr Churchill had just come out of the operating theatre and had very low blood pressure. Giving a patient blood products in that situation would allow the clinical team to "*temporise things until you can stop the bleeding*".⁵⁷
42. Dr Forster says he asked Dr Ranasinghe to attend the MET call and that he did so. Following a discussion amongst attending clinicians as to the possible cause of Mr Churchill's unstable condition, Dr Forster was confronted with two distinct possibilities. On the one hand, Dr Ng said words to the effect of "*I'm really worried this patient is bleeding*". On the other hand, Dr Ranasinghe "*was very confident that the patient was suffering sepsis*".⁵⁸

⁵⁴ Exhibit 1, Vol. 1, Tab 10A, Attachment SP1, MMEX notes (Dr K Ng, 29.10.17)

⁵⁵ Exhibit 1, Vol. 1, Tab 8, Report - Dr K Ng (08.02.18), p2

⁵⁶ Exhibit 1, Vol. 1, Tab 11, Statement - Dr Forster (05.04.18), paras 2-6 and ts 17.02.21 (Forster), p138

⁵⁷ Exhibit 1, Vol. 1, Tab 11, Statement - Dr Forster (05.04.18), paras 8-10 and ts 17.02.21 (Forster), p139

⁵⁸ Exhibit 1, Vol. 1, Tab 11, Statement - Dr Forster (05.04.18), paras 11-13 and ts 17.02.21 (Forster), pp139-140

43. I have already explained the rationale for Dr Ng's diagnosis. As for the septic event diagnosis, at the inquest Dr Ranasinghe confirmed that although at no stage did he observe any clinical signs of sepsis, he relied on his 18 or 19 years of experience to determine that this was the most likely cause of Mr Churchill's condition.⁵⁹

44. In a statement dated 17 March 2020, Dr Ranasinghe said:

In consultation with Dr Forster, and in keeping with the clinical findings at the time, we entertained both the possibility of [a] septic shower and possible intra-abdominal bleeding to explain Mr Churchill's condition. At the onset, it is not easy to differentiate between the two conditions, and hence we commenced treatment for both whilst trying to identify whether there was intra-abdominal bleeding.⁶⁰

45. Dr Ng had repeatedly given Mr Churchill blood pressure medication without any sustained improvement, and was at a loss as to what to do especially as Dr Ranasinghe believed a septic event was more likely. Dr Ng said he initiated the MET call because:

[T]he patient needed to go back to theatre, in my mind and it was [like] a stalemate, and the only thing that I could think of doing at that point in time was calling a MET call.⁶¹

46. Dr Sascha Saharov (a district medical officer and anaesthetist) also attended the MET call. He says that during the MET call, he was aware that Dr Ranasinghe thought that Mr Churchill's deterioration was due to a septic event, whereas Dr Ng thought it was due to bleeding and lack of blood volume (haemorrhagic shock). Dr Saharov could hear ongoing discussion between Dr Ng and Dr Forster and recalled that Dr Forster kept an open mind, whereas Dr Ranasinghe and Dr Ng appeared to be entrenched in their respective positions.^{62,63,64}

⁵⁹ ts 17.02.21 (Ranasinghe), p40

⁶⁰ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 19

⁶¹ ts 17.02.21 (Ng), p50

⁶² Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 12

⁶³ ts 18.02.21 (Saharov), pp162 & 179-180

⁶⁴ ts 17.02.21 (Forster), p140

47. Dr Forster made the point that he could not unilaterally decide to return Mr Churchill to theatre. This was especially so in the face of the treating surgeon (Dr Ranasinghe), expressing the opinion that the cause of the patient's symptoms was not blood loss. As Dr Forster put it:

[A]s far as forcing someone's hand back to theatre, I am not gutsy enough to do that and so if I've got a person who...has a low blood pressure who the surgeon is saying I don't think it's blood loss, it's pretty gutsy for me to say you need to go back to theatre now and open it, and Kevin [Dr Ng] did not either. He was there too. We can only advocate for what we're thinking and keep on investigating, but I can't say to a surgeon you must take this patient back to theatre, because I respect the surgeon.⁶⁵

48. The evidence establishes that both intra-abdominal bleeding and a septic event were being actively considered as causes for Mr Churchill's symptoms. However, it appears that majority of the treating team were influenced by Dr Ranasinghe's view that a septic event was the more likely explanation. As it turned out, Dr Ng's assessment was entirely correct.⁶⁶
49. Despite the fact that Mr Churchill was being treated for both intra-abdominal bleeding and a possible septic event, his blood pressure remained dangerously unstable. In this context, the clinical team continued to grapple with the grave risk of returning Mr Churchill to the operating theatre, in circumstances where intra-abdominal bleeding had not yet been established as most the most probable diagnosis.⁶⁷
50. As the treating team attempted to balance these competing risks, they collected "*data points*" in a desperate effort to identify exactly what was causing Mr Churchill's persistently unstable blood pressure.

⁶⁵ ts 17.02.21 (Forster), p141

⁶⁶ ts 17.02.21 (Ranasinghe), p16; ts 17.02.21 (Ng) p51; and ts 17.02.21 (Forster), pp140-141

⁶⁷ ts 17.02.21 (Ranasinghe), pp32-33 & 44 and ts 17.02.21 (Forster), pp141-142

Data point - Drain

51. One of the data points relied on by the treating team was the amount of fluid being collected by the drain that Dr Ranasinghe had inserted into Mr Churchill's abdomen. With the benefit of hindsight, the absence of blood in Mr Churchill's drain may have been misleading. The evidence before me is that a drain in these circumstances should be placed on a "*low suction*" setting. This maximises the likelihood of fluid being drawn into the drain's collection bag without the risk of damage to surrounding tissue which can happen if the drain is placed on a "*high suction*" setting. Conversely, if a drain in these circumstances is placed on the "*gravity feed*" setting, it is unlikely to be effective at all.^{68,69}
52. In Mr Churchill's case, the only evidence as to what setting the drain was placed on is found in the operation report for the Procedure (the Report). I was told that operation reports are usually written by surgical registrars who are tasked with accurately recording the senior surgeon's instructions. In this case, the Report states that a drain was placed: "*via RUQ [i.e.: the right upper quadrant] port site into sub-hepatic space*". Under the heading "*Postoperative treatment*", the Report states "*Accurate drain chart please - keep on gravity*".^{70,71}
53. Thus, the Report unequivocally states that the drain was placed on a gravity setting and was to be left on that setting post-operatively. Despite this contemporaneous record to the contrary, Dr Ranasinghe said that his normal practice was to order any drains he inserted be placed on a low suction setting and he believes this is what he would have done in Mr Churchill's case.⁷²
54. Dr Ranasinghe could not recall whether he checked the Report for accuracy after it had been completed, although he said this was his usual practice. In any event, he could not account for the clear instruction in the Report that the drain was to be kept on a gravity setting.⁷³

⁶⁸ ts 17.02.21 (Ng), p47 and ts 18.02.21 (Thomas), pp209-210

⁶⁹ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), pp5-6

⁷⁰ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Operation Report, (2.30 pm, 27.10.17)

⁷¹ ts 17.02.21 (Ranasinghe), p37 and ts 18.02.21 (Thomas), p210

⁷² Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 14

⁷³ ts 17.02.21 (Ranasinghe), p37

55. Another purpose of an operation report is to provide nursing staff in the recovery area with instructions for the post-operative care of surgical patients. It stands to reason that nursing staff will comply with any instructions recorded on such a document.
56. In this case, Dr Ranasinghe could not recall what setting the drain was on when he reviewed Mr Churchill after the Procedure, although in his statement dated 17 March 2020, Dr Ranasinghe said:

Although I do not now recall positively checking whether the drain was on suction, I find it hard to believe that it wouldn't have been noticed, and rectified, either by myself or the numerous other doctors in attendance, if it had actually been on a gravity feed setting (given that we were all actively investigating the possibility of an intra-abdominal bleed).^{74,75}

57. Dr Forster was also unable to recall the drain's setting and said that the status of the drain was not his area. He said he "*would have seen the drain and assumed it was okay*".⁷⁶
58. Dr Ranasinghe referred to various techniques to ensure a drain had not become blocked with a blood clot or similar, including "*wiggling*" or "*twisting*" the tube. However, he was unable to recall whether these techniques had been used in Mr Churchill's case.⁷⁷ In any event, the scene around Mr Churchill's bed at the relevant time was described as "*chaotic*"⁷⁸ and in those circumstances, I cannot exclude the possibility that the drain's incorrect setting was simply overlooked.
59. On the basis of the evidence before me, it seems quite possible that Mr Churchill's drain was placed on a gravity feed setting following the Procedure, essentially rendering it ineffective. This is significant because for the majority of the treating team, the lack of fluid in Mr Churchill's drain tended to weigh against a diagnosis of internal bleeding.

⁷⁴ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 23

⁷⁵ ts 17.02.21 (Ranasinghe), pp17 and pp35-36

⁷⁶ ts 18.02.21 (Forster), p142

⁷⁷ ts 17.02.21 (Ranasinghe), p35

⁷⁸ ts 17.02.21 (Ng), p53

60. If the drain was on a gravity setting and therefore ineffective, the fact that it was collecting a limited amount of fluid would have provided the treating team with a false sense of reassurance.

Data point - FAST scans

61. Another data point used by the treating team were a series of FAST scans. As the name suggests, the FAST scan is a point of care ultrasound commonly used in trauma situations. Studies have shown that in trauma situations the accuracy of FAST scans ranges between 75% - 100%. However, the usefulness of FAST scans in non-trauma situations is not well-established.^{79,80,81}
62. In Mr Churchill's case, a series of FAST scans failed to show significant free fluid in his abdomen and this weighed against internal bleeding as the cause of his symptoms. Although FAST scans are routinely used by clinicians at BH, there are no written procedures to guide such use.
63. On the 17 February 2020, the WACHS Emergency Medicine Leadership Group (EMLG) had a meeting and noted with concern, the policy vacuum within WACHS in relation to the use of FAST scans. The EMLG recommended that a policy be developed to set out matters such as the competency standards for operators and the clinical indications for the use of FAST scans.⁸²
64. At the inquest, I was surprised to learn that despite the fact that exactly one year and one day had elapsed since the EMLG meeting, there was still no policy guidance for clinicians employed by WACHS with respect to the use of FAST scans.⁸³ This is clearly unacceptable and in my view should be urgently addressed. I note that both Dr Stephanie Schlueter (an emergency medicine consultant) and Ms Rebecca Smith (Regional Director, WACHS - Kimberley), agreed that a policy on FAST scans should be implemented in WACHS.⁸⁴

⁷⁹ See: <https://radiopaedia.org/articles/focussed-assessment-with-sonography-for-trauma-fast-scan>

⁸⁰ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p5

⁸¹ ts 18.02.21 (Schlueter), pp189 & 196 and ts 18.02.21 (Thomas), p209

⁸² Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), pp6-7

⁸³ ts 18.02.21 (Schlueter), p190

⁸⁴ ts 18.02.21 (Schlueter), pp190-191

65. The evidence as to the appropriateness of using FAST scans in non-trauma situations is somewhat conflicting. Dr Thomas expressed the view that in Mr Churchill's case, the use of FAST scans was an error because:

This was not a trauma situation. Gas had been administered into the peritoneal cavity during the operation. This affects ultrasound penetrance and interpretation. Fluid (probably N/Saline) had also been used as a "wash" during the operation. There was oedema in the tissues and a drain had been placed. Also, direct pressure over a recently operated area and over new skin incisions would have been required. All of these would have complicated the performance and interpretation of the ultrasound scan. The accuracy of ultrasound scanning is known to be highly user dependent. In this scenario, ultrasound would have been difficult, compromised and is unproven at best. It only served to complicate matters and to give false reassurance that ultimately delayed treatment.⁸⁵

66. However, Dr Schlueter expressed a different perspective. She provided the Court with a report primarily dealing with the appropriateness of using FAST scans in Mr Churchill's case, and felt that the evidence of Dr Thomas on this point had been slightly overstated.⁸⁶
67. Dr Schlueter explained that FAST scans have a number of advantages including the fact that they can be performed at the patient's bedside so that any resuscitation efforts can continue uninterrupted. The FAST scan is easily repeatable, does not expose the patient to radiation and can provide an immediate diagnosis in life-threatening conditions. Further, the machines which perform FAST scans are portable and readily available.⁸⁷
68. However, Dr Schlueter acknowledged that FAST scans have known limitations. These include: the competency of the operator, patient obesity and gas in the abdomen (as can occur after a surgical procedure). Other limitations include the type of injury the patient has sustained, the stability of the patient and the amount of free fluid being detected.^{88,89}

⁸⁵ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p5

⁸⁶ ts 18.02.21 (Schlueter), p198

⁸⁷ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p3 & ts 18.02.21 (Schlueter), p189

⁸⁸ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p3 & ts 18.02.21 (Schlueter), p189

69. In Dr Schlueter’s view, the use of the FAST scan as an adjunct to Mr Churchill’s clinical assessment was appropriate. However, as she pointed out, the limitations of FAST scans mean that as a diagnostic tool, it should not be “*the only test to guide subsequent clinical decision making and management*”.⁹⁰
70. In this case, it appears that clinicians were aware that a negative FAST scan did not necessarily exclude internal bleeding.^{91,92} However, Dr Ranasinghe said he was unfamiliar with the FAST scan as a diagnostic tool and he relied on the skill of the operators, including Dr Forster to interpret the results.⁹³
71. The limitations of the FAST scan were demonstrated in a stark manner in this case. Despite the fact that Mr Churchill was subsequently found to have three litres of free fluid in his abdomen, none of the FAST scans (with the possible exception of one) showed anything of concern.
72. Although the evidence at the inquest was that repeat FAST scans did not detect any blood in Mr Churchill’s abdomen, there is some evidence to the contrary. First, in his prospective entry in the clinical notes on 27 October 2019, Dr Ng states “*urgent FAST scan by sonographer...nil significant free fluid*” [my emphasis].⁹⁴ In his retrospective clinical summary, Dr Ng said he thought that one of the FAST scans did in fact show some free fluid.⁹⁵
73. Dr Ng’s observation that one of the FAST scans showed some free fluid is supported by Dr Forster. In an undated transfer summary he prepared for Royal Darwin Hospital (RDH), Dr Forster stated:

Bedside U/S [i.e.: ultrasound] by ultrasonographer revealed only slight free fluid.⁹⁶

⁸⁹ See also: <https://radiopaedia.org/articles/focussed-assessment-with-sonography-for-trauma-fast-scan>

⁹⁰ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p8 and ts 18.02.21 (Schlueter), p190

⁹¹ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 17

⁹² ts 17.02.21 (Ranasinghe), pp17-18 and ts 17.02.21 (Ng), p52 and see also: ts 18.02.21 (Thomas), p209

⁹³ ts 17.02.21 (Ranasinghe), p13

⁹⁴ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Integrated Progress Notes (Dr Ng, 27.10.17)

⁹⁵ Exhibit 1, Vol. 1, Tab 10A, Attachment SP1, MMEX notes (Dr K Ng, 29.10.17)

⁹⁶ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Inter-hospital transfer summary (Dr D Forster, undated)

74. Dr Forster’s reference to a bedside ultrasound must be understood to be a reference to a FAST scan because the transfer summary notes that a later “*formal U/S revealed a large clot near the gallbladder bed*”.⁹⁷

Data point - blood tests

75. Another of the diagnostic procedures performed by the MET team was a venous blood gas test. Mr Churchill’s blood gas results suggested he was “*acidotic*” which is suggestive of bleeding.⁹⁸ The results of another blood test which measures haemoglobin (a protein in red blood cells) also suggested bleeding, although it is not entirely clear when the results of these tests became available to the MET team.^{99,100}

Suboptimal communication during MET call

76. Dr Saharov also attended the MET call, although he was on the scene after others because he had come from a more distant part of the hospital. When he arrived in the recovery area, Dr Saharov saw Dr Ng attempting to insert an arterial line used to monitor Mr Churchill’s blood pressure, administer medications and take blood samples.^{101,102}
77. Dr Ng was unable to insert the arterial line and Dr Forster stepped in to do so. Dr Saharov recalled that Dr Ng seemed a bit put out at this and that Dr Ng seemed frustrated about his interaction with Dr Ranasinghe.¹⁰³
78. As he had arrived later, Dr Saharov was on the periphery of the MET team and was helping the allocated scribe record relevant information. Dr Saharov overheard the MET team discussing whether Mr Churchill’s condition was due to bleeding (a diagnosis favoured by Dr Ng) or a septic event (a diagnosis favoured by Dr Ranasinghe). Dr Saharov recalled that Dr Forster was “*quite focussed on rectifying the problem*” and appeared to be keeping an open mind, in that he wasn’t settled on either explanation for Mr Churchill’s dangerously low blood pressure.¹⁰⁴

⁹⁷ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Inter-hospital transfer summary (Dr D Forster, undated)

⁹⁸ Exhibit 1, Vol. 1, Tab 13A, SAC1 Clinical incident investigation report (undated)

⁹⁹ ts 17.02.21 (Forster), pp144-145

¹⁰⁰ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p14

¹⁰¹ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), paras 5-10

¹⁰² ts 18.02.21 (Saharov), pp158-159

¹⁰³ ts 17.02.21 (Forster), p166

¹⁰⁴ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 12 and ts 18.02.21 (Saharov), pp158-159

79. In a statement dated 28 February 2020, Dr Saharov observed that “*the communication between the surgeon [Dr Ranasinghe] and Dr Ng was, in my view, not optimal*”.¹⁰⁵ At the inquest Dr Saharov expanded on this comment and said that Dr Ng looked exasperated and unhappy and was shaking his head as the discussion with Dr Ranasinghe progressed.¹⁰⁶
80. As to the nature of the interchange between Dr Ranasinghe and Dr Ng, Dr Saharov made these observations:

They weren't actually listening – they weren't hearing each other's messages. The whole idea of communication is to convey a message, and have it heard, and, if necessary, acted upon. And the surgeon wasn't hearing what Dr Ng was trying to convey. I think Dr Ng was hearing what the surgeon was trying to say, but disagreed with it, and so really...it wasn't a constructive conversation. They weren't getting anywhere. They were at opposite ends. And they weren't engaging in the why...They just were saying what they thought and...the discussion didn't come to any, sort of, agreement or compromise.¹⁰⁷

81. From Dr Saharov's perspective, it was clear that Dr Ng was exasperated in the face of Dr Ranasinghe's resolute and apparently entrenched position that sepsis was the cause of Mr Churchill's unstable blood pressure. Dr Saharov said that although he was not involved in the decision-making process during the MET call, he agreed with Dr Ng's assessment that, on the face of it, blood loss and not sepsis was the cause of Mr Churchill's unstable condition.¹⁰⁸
82. Like Dr Ng, Dr Saharov is an anaesthetist and from his perspective, infection (sepsis) was the least likely of the possible causes for a significant drop in blood pressure. Further, Dr Saharov did not think a septic shower event would have caused Mr Churchill's ongoing instability.¹⁰⁹

¹⁰⁵ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 13

¹⁰⁶ ts 18.02.21 (Saharov), p161

¹⁰⁷ ts 18.02.21 (Saharov), p161

¹⁰⁸ ts 18.02.21 (Saharov), pp162 & 179-180

¹⁰⁹ ts 18.02.21 (Saharov), pp162 & 173

83. Dr Saharov noted that repeat FAST scans were negative for free fluid and it was decided that Mr Churchill required “*formal imaging such as a CT scan*”. At around that time or possibly a little earlier, Dr Ng came up to Dr Saharov and said words to the effect of “*You know, I really think this guy is bleeding. He needs to go back to theatre*”.^{110,111} Dr Saharov said he agreed with Dr Ng, but felt that he (Dr Ng) needed to be speaking to Dr Ranasinghe directly. Dr Saharov’s response was along the lines of: “*I think you’re right, Kevin...[but] you don’t need to convince me you need to convince the surgeon*”.¹¹²
84. Dr Saharov also described the interaction between Dr Ranasinghe and Dr Ng as “*stilted*” and said that it did not improve as the MET call progressed. The view that Mr Churchill needed to return to the operating room immediately was held by Dr Ng, Dr Saharov and several senior nurses that attended the MET call.¹¹³
85. With the benefit of hindsight, Dr Saharov said he regretted that he had not spoken up in support of Dr Ng during the MET call, although he doubted that Dr Ranasinghe would have been swayed even if he had done so.¹¹⁴
86. However, Dr Saharov agreed that had he expressed his view that Mr Churchill needed to return to theatre immediately, then in concert with input from senior nursing staff, this may have been enough to shift the consensus of the MET team thinking away from sepsis as the more likely diagnosis and towards internal bleeding.^{115,116}
87. In fairness to Dr Saharov, I should point out that regardless of his views about returning Mr Churchill to theatre immediately, he also shared the concern of the majority of the MET team about the risks associated with doing so. There was a real risk that Mr Churchill might die as a result of being given a second anaesthetic.

¹¹⁰ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), paras 19-20

¹¹¹ ts 18.02.21 (Saharov), p166

¹¹² ts 18.02.21 (Saharov), p167

¹¹³ ts 18.02.21 (Saharov), pp165-166 & 167

¹¹⁴ ts 18.02.21 (Saharov), pp165-166 & 167

¹¹⁵ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 21

¹¹⁶ ts 18.02.21 (Saharov), pp163, 165-166 & 167

88. As Dr Saharov put the position in his statement:

I cannot say with certainty that I would have made the decision to return the patient to theatre at this point in time (i.e.: at the time of his conversation with Dr Ng). The patient was very unstable and his blood pressure could have dropped again to dangerous levels upon the application of a second general anaesthetic. There was a risk that the patient could have been killed by the second general anaesthetic in circumstances where it was not certain that a return to theatre was required.¹¹⁷

89. In my view, the importance of effective communication during a MET call is self-evident. As Dr Schlueter noted, a range of “[N]on-technical aspects” can affect the quality of a resuscitation effort. As she put it:

[R]esuscitation team dynamics, communication, non-escalation and cognitive biases also critically influence resuscitation outcomes. Although it is difficult for me to comment on these in detail, it appears that there were conflicting opinions as to the cause and best treatment options within the team as described in Dr Ng in his notes on the 29th October 2017 and Dr Saharov’s statement on the 28th February 2020. Escalation to the SMO (i.e.: Senior Medical Officer) as a more senior and independent team leader could have assisted to manage resuscitation conflicts at that time.¹¹⁸

90. I will say more about the importance of clear leadership and effective communication during a MET call later in this finding. However, I now wish to deal with the decision to return Mr Churchill to the operating theatre to investigate the cause of his internal bleeding.

Return to theatre

91. The MET team had significant concerns about sending Mr Churchill for a formal CT scan because his blood pressure was so low. Indeed, there was a real risk that he might die on the way to the radiology department or during the scan itself.¹¹⁹

¹¹⁷ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 22

¹¹⁸ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p15

¹¹⁹ ts 17.02.21 (Forster), pp141-142

92. Nevertheless, Dr Ng said he thought that Mr Churchill's blood pressure could have been managed whilst he underwent the CT scan,¹²⁰ and eventually, at about 4.30 pm, Dr Ranasinghe and Dr Forster went with Mr Churchill to radiology to observe the results of the scan first-hand and to provide resuscitation (if required).^{121,122}
93. At the suggestion of the radiologist, instead of a CT scan Mr Churchill underwent a better quality ultrasound which was faster and involved less risk. The ultrasound showed signs consistent with intra-abdominal bleeding and it was at that point that the decision to return Mr Churchill to theatre was made.¹²³
94. Dr Ranasinghe said he had reflected at length on Mr Churchill's case and in particular whether an earlier CT scan should have been ordered. He said that had an earlier CT scan shown evidence of free fluid, he would not have hesitated to return Mr Churchill to theatre.¹²⁴
95. In a statement dated 17 March 2020, Dr Ranasinghe said:

Whilst I accept that, with the benefit of hindsight, I might have been unduly influenced by the lack of blood in the drain and the repeat negative FAST scan results, and his condition was at least initially consistent with a septic shower, I regret not arranging a formal CT or ultrasound earlier, particularly in the context that I can now see that his pulse pressure was narrowing. Nevertheless, I was very concerned at the risks that would be associated with a potentially unnecessary return to theatre, and I was doing my best to treat/manage both possibilities pending clarification as to the cause of his post-surgical condition. With the benefit of hindsight, I also have to say that I am surprised at how much time did pass between the procedures (i.e.: the cholecystectomy and subsequent "*wash-out*"), because it certainly did not feel that that was the case at the time.¹²⁵

¹²⁰ ts 17.02.21 (Ng), p52

¹²¹ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 19-20

¹²² ts 17.02.21 (Ranasinghe), p14 and ts 17.02.21 (Forster), pp142 & 144

¹²³ Exhibit 1, Vol. 1, Tab 11, Statement - Dr D Forster (05.04.18), paras 28-32 and ts 17.02.21 (Forster), p144

¹²⁴ ts 17.02.21 (Ranasinghe), p41

¹²⁵ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), paras 32-33

96. In retrospect, Dr Ranasinghe also agreed it would have been possible to have taken Mr Churchill for a formal CT scan at an earlier stage, even given his unstable condition. Dr Ranasinghe said he regretted the fact that this had not occurred and that if an earlier CT scan had shown free fluid in the abdomen, Mr Churchill would have been returned to theatre immediately.¹²⁶
97. Mr Churchill was taken back to the operating theatre at about 5.25 pm. During the procedure to investigate the source of his internal bleeding (the Second Procedure), Dr Ranasinghe was assisted by Dr Forster (as lead anaesthetist) and Dr Saharov (who managed the administration of medications and blood products).^{127,128,129,130,131}
98. Although Mr Churchill's blood pressure was dangerously low at the start of the Second Procedure, after careful investigation, Dr Ranasinghe was able to locate the source of the bleeding, a defect in an aberrant branch of Mr Churchill's cystic artery, which he then repaired.^{132,133,134,135}
99. Approximately three litres of blood was drained from Mr Churchill's abdomen during the Second Procedure, which was completed at about 7.00 pm. By the time he was returned to the recovery area, Mr Churchill was in a "*critical but stable condition*".^{136,137}
100. As a result of this complication in his treatment, it was decided to transfer Mr Churchill to the RDH for further management.^{138,139}

¹²⁶ ts 17.02.21 (Ranasinghe), pp15, 19-20, 32 and 41

¹²⁷ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 20-25

¹²⁸ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), paras 25-29

¹²⁹ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), paras 26-27

¹³⁰ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Operation report (7.00 pm, 27.10.17)

¹³¹ Exhibit 1, Vol. 1, Tab 22, Attachment A to Dr T Shepherd's statement (13.03.20)

¹³² Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 20-25

¹³³ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), paras 25-29

¹³⁴ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), paras 26-27

¹³⁵ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Operation report (7.00 pm, 27.10.17)

¹³⁶ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 26-27

¹³⁷ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 31

¹³⁸ Exhibit 1, Vol. 1, Tab 12, Statement - Dr SM Ranasinghe (15.01.18), paras 26-27

¹³⁹ Exhibit 1, Vol. 1, Tab 12A, Statement - Dr SM Ranasinghe (17.03.20), para 31

Management at Royal Darwin Hospital

101. Mr Churchill arrived at RDH via the Royal Flying Doctor Service on the morning of 28 October 2017. He was found to have no signs of ongoing bleeding and was diagnosed with multiple organ dysfunction syndrome (MODS) following “*profound hypotension secondary to massive haemorrhage with subsequent massive transfusion in Broome*”.¹⁴⁰

102. Mr Churchill was admitted to the intensive care unit at RDH where he was managed for the following issues over the next week:¹⁴¹

- a. Sepsis with MODS: a CT scan of Mr Churchill’s abdomen was suspicious for ischaemic bowel in several areas with associated partial bowel obstruction and ongoing blood in the peritoneal cavity (haemoperitoneum). No further surgical options were available and following discussions with Mr Churchill’s family, treatment with antibiotic medication was ceased on 11 November 2017; and
- b. Renal failure: this was initially treated with continuous veno-venous haemofiltration (CVVHF), a temporary treatment for patients in acute renal failure who are unable to tolerate dialysis and are unstable. CVVHF was ceased on 10 November 2017;

103. Mr Churchill’s medical condition did not improve and following discussions between his family and his treating team it was decided to treat him palliatively. Mr Churchill’s family arrived in Darwin on 12 November 2017 and it was agreed that he be transferred to the RDH hospice.¹⁴²

104. Mr Churchill was made comfortable at the hospice and received medication for pain, abnormally rapid breathing (tachypnoea) and agitation. At first there were times when he was responsive to staff but his condition deteriorated and he died at the RDH hospice, surrounded by his family, at 1.05 pm on 13 November 2017.^{143,144}

¹⁴⁰ Exhibit 1, Vol. 2, Tab 2, RDH medical notes - Combined Admission and Handover Notes (28.10.17)

¹⁴¹ Exhibit 1, Vol. 2, Tab 2, RDH medical notes - ICU Summary (12.11.17)

¹⁴² Exhibit 1, Vol. 2, Tab 2, RDH medical notes - Medical Discharge Summary - General (12.11.17)

¹⁴³ Exhibit 1, Vol. 2, Tab 2, RDH medical notes - Medical Discharge Summary - General (13.11.17)

¹⁴⁴ Exhibit 1, Vol. 2, Tab 2, RDH medical notes - Confirmation of Death form (13.11.17)

CAUSE AND MANNER OF DEATH

*Post mortem examination and results*¹⁴⁵

- 105.** A forensic pathologist (Dr Marianne Tiemensma), conducted an internal post mortem examination of Mr Churchill's body on 21 November 2017 at the mortuary at RDH.
- 106.** Dr Tiemensma found evidence of recent surgical intervention, including healing incisions. Mr Churchill's brain was noted to be small and somewhat atrophic (indicating a loss of brain cells) and his coronary arteries showed evidence of hardening and calcification (coronary artery atherosclerosis). An increased amount of pericardial fat was also noted on Mr Churchill's heart.
- 107.** Approximately 800 ml of fluid was found in Mr Churchill's peritoneal cavity and there were fine fibrinous peritoneal adhesions (bands of tissue that join abdominal organs to each other or to the abdominal wall). The appearance of Mr Churchill's intestines was in keeping with ischaemic bowel (where blood vessels supplying the bowel with blood become narrowed or blocked).
- 108.** Mr Churchill's kidneys were small and there was evidence of chronic kidney disease. The surfaces of the kidneys showed multiple areas of scarring and there were numerous small cysts (sac-like pockets of fluid, air or other substances). Mr Churchill's pancreas showed extensive fatty infiltration and his gallbladder bed was haemorrhagic and friable.
- 109.** Although abdominal sepsis was not identified on a macroscopic level, histological examination confirmed suppurative inflammation associated with micro-abscesses. Fungal organisms were detected in the mesentery (the tissue which attaches the intestines to the posterior abdominal wall).
- 110.** Other post mortem findings included: a very pale myocardium with possible acute myocardial ischaemia (loss of blood flow to the heart) and pale liver, spleen and kidneys.

¹⁴⁵ Exhibit 1, Vol. 1, Tab 5 - Post Mortem Examination Report for the Coroner

*Cause and manner of death*¹⁴⁶

- 111.** At the conclusion of the post mortem examination, Dr Tiemensma expressed the opinion that the cause of Mr Churchill's death was surgical complications following laparoscopic cholecystectomy for cholecystitis.
- 112.** Dr Tiemensma noted that Mr Churchill's multiple organ failure was most likely the result of the reported massive blood loss following his laparoscopic surgery. I accept and adopt Dr Tiemensma's opinion as to the cause of death. Further, given that Mr Churchill's internal bleeding was caused by the inadvertent cutting of an aberrant branch of his cystic artery during a surgical procedure,¹⁴⁷ I find that death occurred by misadventure.

ANALYSIS OF POST-OPERATIVE MANAGEMENT

*SEA review*¹⁴⁸

- 113.** On 12 December 2017, a significant event review meeting (SEA) was held at BH. The meeting was attended by clinicians involved in Mr Churchill's care, including Dr Ranasinghe (via video-link), Dr Ng and Dr Forster. Following the SEA, an unsigned report dated 14 December 2017, was prepared (the SEA report).
- 114.** The SEA report sets out the timeline of events and list things the team thought were done well, as well as those that could have been improved. The SEA report noted the differing perspectives being expressed by Dr Ng and Dr Ranasinghe as to the cause of Mr Churchill's low blood pressure and the results of the Second Procedure, where three litres of blood was removed from his abdominal cavity.
- 115.** The SEA report concluded that Mr Churchill's intra-abdominal bleeding had been caused by an aberrant branch of the cystic artery being cut during the Procedure. As the SEA report noted, this is a known complication of the Procedure and about 20% of people have aberrant cystic arteries.¹⁴⁹

¹⁴⁶ Exhibit 1, Vol. 1, Tab 5 - Post Mortem Examination Report for the Coroner, p10

¹⁴⁷ ts 17.02.21 (Ranasinghe), pp9 & 14

¹⁴⁸ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17)

¹⁴⁹ See also: ts 17.04.21 (Ranasinghe), p15

116. The SEA report noted that the lack of blood in Mr Churchill’s drain “*may have then been a potential red herring*” and in combination with a soft non-distended abdomen and a series of negative FAST scans:

[C]ontributed to an initial assessment that sepsis rather than haemorrhage was the cause for the hypotension.¹⁵⁰

117. The SEA report also noted that while intra-abdominal bleeding remained a “*working diagnosis*” immediately after the Procedure, the consensus of the MET team was that resuscitation and stabilisation of Mr Churchill’s condition was the priority for management “*while working towards a definitive cause for the hypotension*”.¹⁵¹

118. The MET team were understandably concerned about the very real risk that Mr Churchill would die on the operating table if he was returned to theatre whilst he was so unstable.

119. The SEA report noted that repeated FAST scans did not detect free fluid in Mr Churchill’s abdomen and that:

There is some speculation that FAST scans in this circumstance may have a level of inaccuracy that was not appreciated by the treating teams. Nevertheless, [the] 4 scans by qualified personnel provided the team with a level of assurance that blood loss was less likely, although not discounted.¹⁵²

120. The SEA report expressed the view that Mr Churchill’s acute kidney damage and the acute ischaemia (i.e.: restriction of blood flow) to his coronary and mesenteric vessels (i.e.: the vessels servicing Mr Churchill’s abdominal organs) was likely the result of the extended period of low blood pressure he had endured in a context where he had poor physiological reserve to begin with.¹⁵³

¹⁵⁰ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), p5

¹⁵¹ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), pp5-6

¹⁵² Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), point 6 on p6

¹⁵³ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), point 7 on p6

121. The SEA report considered that the following things had been “*done well*”:

- a. The recovery nurse called Dr Ng at an early stage;
- b. Dr Ng made a MET call as soon as it became clear that standard resuscitation methods were not working;
- c. The MET call was responded to promptly by senior staff;
- d. The surgeon and the anaesthetist remained involved in Mr Churchill’s care and the surgeon accompanied Mr Churchill to the radiology department to view the scan results first-hand;
- e. During the resuscitation episode, verbal communication was **excellent** [emphasis added] and at all times the whole team was involved in the decision making process; and
- f. The differential diagnoses remained broad and treatment was given for both sepsis and blood loss.¹⁵⁴

122. Whilst there is evidence to support the assertions set out in (a) to (d) and (f) of paragraph 121 above, the evidence of Dr Ng and Dr Saharov directly contradicts the assertion in (d). As mentioned, the communication during the MET call was far from satisfactory and the interaction between the key players, Dr Ng and Dr Ranasinghe, was described as “*not optimal*”.¹⁵⁵

123. The SEA report sets out four areas where things “*could have been done better*”. The first relates to the standard of documentation in the File, which I will address later in this finding. For now, it is worth emphasising that in this case, not only were key documents missing from the File, observations from a completely different patient were included.

124. The SEA report refers to a degree of conflict during the MET call “*with the initial DMO anaesthetist...[i.e.: Dr Ng]...quietly saying on the side that he felt that the patient should be going straight back to theatre*”.¹⁵⁶

¹⁵⁴ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), p6

¹⁵⁵ Exhibit 1, Vol. 1, Tab 21, Statement - Dr S Saharov (28.02.20), para 13

¹⁵⁶ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), p7

- 125.** With respect, this is a mischaracterisation of Dr Ng’s clinical involvement with Mr Churchill. Dr Ng’s uncontradicted evidence at the inquest was that on four separate occasions, he had expressed the view that the cause of Mr Churchill’s low blood pressure was internal bleeding and that he needed to be returned to theatre. Those four occasions were: when Dr Ng was first called to review Mr Churchill in recovery; at the start of the MET call; prior to an appendectomy procedure being performed on another patient; and before Mr Churchill was taken to radiology for a CT scan.^{157,158}
- 126.** In light of that evidence, I have difficulty understanding how Dr Ng can be said to have been “*quietly saying on the side*”. Dr Saharov gave evidence about the “*stand-off*” between Dr Ranasinghe and Dr Ng and the suboptimal communication between them,¹⁵⁹ and in my view, the SEA report’s assertion about Dr Ng in this regard is not only wrong, it is misleading.
- 127.** The SEA report addresses the fact that during the MET call, leadership was less than satisfactory and occurred organically rather than by formal allocation. Initially, it seems that Dr Ng was viewed as MET call leader, but that after he was unable to insert an arterial line and Dr Forster stepped in and did so, he (Dr Forster) assumed the leadership role.¹⁶⁰
- 128.** The leadership situation may also have been exacerbated by the communication breakdown between Dr Ranasinghe and Dr Ng. In that context, Dr Forster may have felt obliged to step forward as a concerned “*independent*” clinician. In any case, it is unfortunate that more effort was not made to encourage Dr Ranasinghe and Dr Ng to explain the reasons why they had arrived at their different conclusions for the cause Mr Churchill’s instability.
- 129.** The final area for improvement identified by the SEA report was the suboptimal liaison that occurred with Mr Churchill’s family when he was admitted to BH and when he was subsequently transferred to RDH.

¹⁵⁷ ts 17.02.21 (Ng), p76

¹⁵⁸ ts 17.02.21 (Ranasinghe), p22

¹⁵⁹ ts 18.02.21 (Saharov), pp162 & 179-180

¹⁶⁰ ts 17.02.21 (Ng), p56 and ts 17.02.21 (Forster), pp138 & 145

130. Whilst I agree that this is an area where improvement is warranted, I acknowledge that BH had difficulties with contacting Mr Churchill’s family. They lived in a remote location and no mobile or landline number was on file for the nominated next-of-kin. It appears that staff at RDH also had difficulty contacting Mr Churchill’s family. I am also aware that Court staff had similar issues in relation to this inquest and that a mobile number which had been provided for one of Mr Churchill’s relatives did not answer when repeatedly called.

131. The SEA report made four recommendations for “*change or action*”. The first was to look at sourcing “*crew resource training programs*” and “*graded assertiveness training*” to empower those members of the team to be “*more proactive with speaking up where they have concerns*”. If this recommendation is directed at Dr Ng, it is misguided. He did speak up - four times.

132. As I have already noted, it is Dr Saharov who says he wished that he and senior nurses had spoken up during the MET call. Dr Saharov agreed with Dr Ng’s assessment that Mr Churchill needed to return to theatre immediately, but did not feel in a position to express his views. At the inquest, he put the position this way:

I actually felt disempowered when I attended...[*the MET call*]...partly because I had only just arrived back in Broome, and Dr Forster is far more senior than me, not in years, but in experience...so I was kind of a new kid on the block. As well as that, I hadn’t worked with...[*Dr Ranasinghe*]...very much and didn’t have a working relationship with him, so...I didn’t feel like I could step up and take control of the situation.¹⁶¹

133. In my view, the issues during the MET call included not just the lack of assertiveness by some staff, but also a lack of effective communication. The SEA report’s recommendation in this respect should have been expanded to focus on improving leadership during MET calls and on encouraging clinical staff with different opinions to explain the “*why*” for their clinical views, rather than merely their conclusions.

¹⁶¹ ts 18.02.21 (Saharov), p185

134. I also acknowledge the need to encourage all staff to put forward their differing clinical perspectives in a forthright manner. Dr Saharov pointed to the work being done at BH in this respect:

I think, we need to foster that, and we do actually do that. So Dr Forster is the medical educator of the hospital, and he actually fosters that in our junior staff, that they can actually step up and take those leadership roles if they believe it's necessary, and no one else is. And we also need to empower the nurses to be able to do that, because I'm sure the nurses at this MET call would have had similar concerns and frustrations and weren't able to voice them.¹⁶²

135. At the inquest, Dr Schlueter agreed that whilst effective communication training courses are available and can be valuable, the issue has a more fundamental aspect. As she put it:

You know, it starts really from...when you join a new...hospital, to...be encouraged to speak up, to be encouraged to pick up the phone and ring the consultant or the most senior decision-maker [and] not be...afraid to [do so]. We have to build that culture. That...starts with us as senior...practitioners and [to]...be kind to each other as well. So...that that kind of culture is...established, a culture of trust and respect, and a culture where...greater assertiveness is embraced...and all members of the team are...heard at the same time. So...education is...one way, but also, you know, building a culture ...within the organisation.¹⁶³

136. With respect to MET team leadership, Dr Saharov said that it is now his practice to “*make it very, very clear who is the actual leader of the resuscitation...[i.e.: MET call].*”¹⁶⁴ He also said that when he attends a MET call now, he doesn't necessarily specify that only a medical officer can be the MET team leader. As he put it:

[A]s Dr Phillips said, when we're very stretched with resources, I don't necessarily stipulate that a doctor is the leader. In many resuscitations, a senior nurse is very, very appropriate.¹⁶⁵

¹⁶² ts 18.02.21 (Saharov), p185

¹⁶³ ts 18.02.21 (Schlueter), p199

¹⁶⁴ ts 18.02.21 (Saharov), p170

¹⁶⁵ ts 18.02.21 (Saharov), p184

- 137.** In this case, more effective leadership during the MET call may have addressed the impasse between Dr Ranasinghe and Dr Ng and may have helped to open up a more productive discussion about which of the possible diagnoses (sepsis or blood loss) was more likely to be correct.
- 138.** I wish to emphasise that by referring to the need for more effective leadership during the MET call, I am not being critical of Dr Forster. At the time he assumed leadership during the MET call he was in the process of inserting an arterial line. Thereafter he was very task-focussed and was doing his best to identify the cause of Mr Churchill's unstable condition.¹⁶⁶
- 139.** I note that the last recommendation in the SEA report is relevant at this point. It suggested that clinical staff be reminded to escalate any case that results in a serious adverse event to the Senior Medical Officer (SMO) or Regional Medical Director as soon as possible. In this case, Dr Suzanne Phillips, who at the time was the Senior Medical Officer at BH, was not directly told about Mr Churchill's situation and instead, discovered what had occurred during one of her routine walks around the hospital a day or two after relevant events.¹⁶⁷
- 140.** To that recommendation, I would add that staff should be reminded of the importance of considering involving the SMO in the management of patients like Mr Churchill. In her evidence at the inquest, Dr Phillips said that had she been alerted to the MET call, she might have assisted by acting as scribe and/or by seeking a second opinion from another senior surgeon.¹⁶⁸
- 141.** I actually think that had Dr Phillips been involved in the MET call, she may have been able to help by encouraging Dr Ranasinghe and Dr Ng to explain the reasons for their respective views. Dr Phillips may also have been able to foster an environment in which other staff (like Dr Saharov and some senior nurses), felt empowered to express their different clinical perspectives.

¹⁶⁶ ts 18.02.21 (Saharov), pp159-160 & 170

¹⁶⁷ ts 17.02.21 (Phillips), pp99-100

¹⁶⁸ ts 17.02.21 (Phillips), pp134-135

- 142.** Other recommendations in the SEA report including holding short drills in theatre relating to the allocation of duties, including the important role of “*scribe*” and dealt with the need for contemporaneous documentation for all assessments and decisions. There was also the useful suggestion that medico-legal, critical incident management and open disclosure issues be included in the orientation process for medical staff.
- 143.** At the inquest, Ms Smith confirmed that the SEA Report recommendations have been implemented at BH. Roleplays dealing with assertiveness, decision making, role allocation and the importance of an allocated scribe have been conducted. Surgical staff have been reminded about the need for contemporaneous documentation and all new doctors undertake an orientation process that covers medico-legal, clinical incident management and open disclosure processes. The need to escalate appropriate matters to the SMO has also been reinforced.¹⁶⁹

SAC1 review

- 144.** A confidential clinical investigation report referred to as a “*SAC1*” was also completed after Mr Churchill’s death. The purpose of a *SAC1* review is to establish what occurred and, where appropriate, make recommendations for immediate improvements. In this case, the *SAC1* made the following finding, with which I respectfully agree:

A confirmed diagnosis of intra-abdominal haemorrhage should have been recognised earlier. Although the FAST scan results were negative and the fluid volume of the drain was minimal the patient’s overall clinical condition suggested bleeding over sepsis. There was a significant reduction from the preoperative HB level of 145 to the postoperatively HB level of 101 and subsequently 84 – this plus the patient’s sudden deterioration in his clinical condition (the patient was also hypotensive and not febrile) is enough to diagnose haemorrhage and eliminate sepsis. The patient’s blood gas results suggested that the patient was acidotic – which indicates that there is bleeding. It is uncommon for septic shock to occur so rapidly after the offending infection was removed.¹⁷⁰

¹⁶⁹ Exhibit 1, Vol. 1, Tab 24, Report - Ms R Smith (30.12.20), pp6-7

¹⁷⁰ Exhibit 1, Vol. 1, Tab 13A, *SAC1* Clinical incident investigation report (undated)

145. The SAC1 noted that the treating team did not escalate any diagnostic or treatment concerns to the Senior Medical Officer. As I have already observed, had that occurred in Mr Churchill's case, it would have provided Dr Phillips with an opportunity to provide leadership and clinical direction. The SAC1 also identified the fact that the documentation in this case was largely completed retrospectively and made this case "*difficult to follow*".

*Case review by Dr Thomas*¹⁷¹

146. As I have already noted, Dr Thomas reviewed Mr Churchill's care and provided a comprehensive report to the Court. He noted that when Mr Churchill presented to BH, he showed no signs of preceding or imminent sepsis.¹⁷²

147. However, five minutes after arriving in the recovery area following the Procedure, Mr Churchill's blood pressure was very low, his pulse was very fast, and there was only a transient response to inotropic agents and intravenous fluids. At that time, Mr Churchill was in postoperative shock and Dr Thomas outlined the possible causes:

- a. cardiogenic shock: this is a life-threatening condition where the heart is unable to pump enough blood for the body's needs.¹⁷³ An ECG performed when Mr Churchill was admitted to BH identified some minor defects, but was essentially unremarkable and there was no evidence of acute ischaemia. Whilst a repeat ECG may have been useful, there was no chest pain or cardiac instability during the operation suggestive of a cardiogenic cause;¹⁷⁴
- b. neurogenic shock: is defined as an injury to the spinal cord causing symptoms including irregular blood circulation.¹⁷⁵ In this case, no spinal or epidural anaesthetic was given to Mr Churchill and there was no indication of any intracerebral event. Therefore a neurogenic cause for Mr Churchill's instability would have been "*exceedingly unlikely*";¹⁷⁶

¹⁷¹ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18)

¹⁷² ts 18.02.21 (Thomas), p207

¹⁷³ See: <https://www.mayoclinic.org/diseases-conditions/cardiogenic-shock/symptoms-causes/syc-20366739>

¹⁷⁴ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p3

¹⁷⁵ See: <https://www.ncbi.nlm.nih.gov/books/NBK459361/>

¹⁷⁶ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p3

- c. anaphylactic shock: occurs where there is a severe potentially life-threatening allergic reaction.¹⁷⁷ In Mr Churchill's case, there was no respiratory compromise, wheeze or rash to suggest an anaphylactic event;¹⁷⁸
- d. septic shock: is a serious infection that causes the body's immune system to attack itself and causes a significant drop in blood pressure.¹⁷⁹ With a septic event there is usually a fever and a bounding pulse. Dr Thomas noted that "*in this case, there was no indication of sepsis at all...Sepsis would be highly unlikely especially in the context of no pre-operative or intra-operative issues*";¹⁸⁰ and
- e. hypovolaemic shock: is a clinical state in which loss of blood or plasma causes insufficient tissue perfusion.¹⁸¹ In this case, there was evidence of bleeding during the Procedure and a drain was inserted as a precautionary measure. Dr Thomas noted that "*The most common post-operative issue of major concern, after a laproscopic cholecystectomy, is bleeding*". Mr Churchill signed a form acknowledging that blood of his blood type was held in case of internal bleeding. Dr Ng had commented on bleeding during the Procedure and as Dr Thomas observed:

There was evidence of a hypovolaemic state in the immediate post-operative timeframe...The cause of the patient's condition had to be assumed to be blood loss here and appropriate action would have been an immediate return to theatre coupled with simultaneous inotropic and fluid resuscitation.¹⁸²

148. In the summary section of his report, Dr Thomas said that he had no issue with the decision to remove Mr Churchill's gallbladder, but that: "*With the decision to operate acutely comes an obligation to be aware of increased risks during and after the operation*".¹⁸³

¹⁷⁷ See: <https://www.mayoclinic.org/diseases-conditions/anaphylaxis/symptoms-causes/syc-20351468>

¹⁷⁸ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p3

¹⁷⁹ See: <https://www.healthline.com/health/septic-shock>

¹⁸⁰ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), pp3-4

¹⁸¹ See: <https://www.bmj.com/content/348/bmj.g1139>

¹⁸² Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), pp4-5

¹⁸³ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), pp8-9

149. With respect to why a diagnosis of bleeding should be preferred in cases like Mr Churchill's, Dr Thomas made the following observation:

The default cause of such hypotension in a post-operative patient has to be bleeding. Such significant and acute post-operative bleeding is best controlled by direct and early re-operative intervention.¹⁸⁴

150. Dr Thomas explained why bleeding should have been the default diagnosis in the following terms:

So the commonest complication from a laparoscopic cholecystectomy requiring ...[the patient]...to be taken back to theatre would be bleeding, and that has to be your prima facia diagnosis unless you can prove otherwise. So it's a recognised complication, it's a recognised complication of pretty much every operation, it's a standard on consent forms, and if you work on the basis that it's bleeding then it's something you can do something about immediately. The rest of it you can exclude, if you want, on your way to the resuscitation, but the whole point of having a recovery unit is that they're observed closely in that recovery for acute events that can be dealt with, and the most common of those is bleeding.¹⁸⁵

151. Dr Thomas emphasised that in Mr Churchill's case, there were no clinical signs of sepsis at any stage:

I don't think there was any evidence of sepsis at any point. As I pointed out in the report there was no temperature, there was no particular tachycardia beforehand, the blood tests were already improving. The gallbladder appearance during the case suggests a bit of mild inflammation there. There was no issue getting the gallbladder out, so big, thickened gallbladders tend to be more difficult. You have to expand the laparoscopic hole to get them out. There was no sign of any pus around. There was no sign of any bile blockage. Liver function tests were not indicative of significant jaundice at all so there was no indication of sepsis beforehand. And in the recovery, apart from physiological parameters being deranged, there was nothing to indicate sepsis post-procedure either, in my mind.¹⁸⁶

¹⁸⁴ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p9

¹⁸⁵ ts 18.02.21 (Thomas), p207

¹⁸⁶ ts 18.02.21 (Thomas), pp207-208

152. For those reasons, Dr Thomas concluded that the working diagnosis of septic shock rather than internal bleeding was “*erroneous*” and seems to have been based on “*little more than moderately raised pre-operative inflammatory results and the initial examination findings on admission*”. Dr Thomas said this line of thought: “*seems to have clouded the logical and speedy diagnosis and any potential remedy in this case*”.¹⁸⁷

153. In terms of why the diagnosis of bleeding may not have been given the emphasis it should have had in Mr Churchill’s case, Dr Thomas acknowledged that sometimes, clinicians may be in a situation where they “*can’t see the wood from the trees*”. As he explained:

There is a separation sometimes between what you’re faced with and your perception of what’s going on, so – and sometimes that’s difficult to overcome when you don’t see overt bleeding in front of you, but it has to be on your mind.¹⁸⁸

154. In this case, Dr Thomas considered that the rapidity of Mr Churchill’s deterioration strongly suggested a major event such as bleeding, a cardiac event or a pulmonary embolism. As far as Dr Thomas was concerned, given that Mr Churchill had just come out of theatre, the cause of such deterioration was typically going to be bleeding.¹⁸⁹

155. Dr Thomas said that he had seen deterioration due to sepsis after surgery in patients who “*had a gradual stormy course during surgery*”, but never in case like Mr Churchill’s and “*never that quickly*”. Dr Thomas also said that he had never seen a case of sepsis:

[C]ome from somebody who - there’s no concern [for] in the operating theatre to full-blown septic shock in the recovery phase. That’s almost always going to bleeding.¹⁹⁰

¹⁸⁷ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p9

¹⁸⁸ ts 18.02.21 (Thomas), p208

¹⁸⁹ ts 18.02.21 (Thomas), pp208 & 22

¹⁹⁰ ts 18.02.21 (Thomas), pp208 & 22

156. With respect to the delay in returning Mr Churchill to theatre, Dr Thomas expressed the following opinion:

From recovery and the point of significant hypotension to return to theatre took approximately 2½ hours, with the re-entry into the abdominal cavity close to 3½ hours (based on theatre nursing documentation). The team performed another operation (i.e.: appendectomy) whilst this individual (i.e.: Mr Churchill) remained compromised and undiagnosed with a life-threatening issue. I consider this to be a serious error in judgment.¹⁹¹

157. Dr Thomas was asked to consider whether Mr Churchill's prognosis would have been different if internal bleeding had been accepted as the more likely cause of his unstable condition at an earlier point.¹⁹²

158. Dr Thomas responded by saying:

So the general[ly] accepted scenario where somebody is coming in in a shocked state is that you need to correct that as soon as possible and take remedial action as soon as is practical as well. All the data, whether it's from trauma or operative or cardiogenic nature, suggests that a delay in the attempted normalisation worsens prognosis. The greater the problem to begin with...[that is]...the lower the blood pressure, the poorer the tissue perfusion - the worse an individual does. Even as little as 10 minutes of significant hypotension can have an effect on mortality, but the longer that process goes on without being corrected the greater the risk. It's difficult to quantify that risk, but every minute counts...So in long-winded terms, the quicker the better. Would you have done better going in quicker? Yes, you would. How much better? Very difficult to quantify...but certainly a three and a-half hour delay in someone who was struggling to perfuse his tissues...has had quite devastating results.¹⁹³

¹⁹¹ Exhibit 1, Vol. 1, Tab 14, Report - Dr A Thomas (29.12.18), p9

¹⁹² ts 18.02.21 (Thomas), p208

¹⁹³ ts 18.02.21 (Thomas), p211

Summary of Dr Thomas' case review

159. In summary, Dr Thomas said the decision to remove Mr Churchill's gallbladder was correct although he would have clipped the cystic artery before the cystic duct to reduce the possibility of avulsion of the cystic artery and/or of encountering abnormal anatomy because of distortion of the operative field.¹⁹⁴

160. As for Mr Churchill's postoperative management, Dr Thomas' position is as follows:

In the recovery, however, there was a patient who was clearly struggling, hence the MET call, and at that point serious consideration...[should have been given to]...taking that patient back ...[to the operating theatre]...as soon as possible with full fluid resuscitation [which] should have been given and prioritised, in my mind.¹⁹⁵

161. As for the delay in addressing the internal bleeding, I take Dr Thomas' evidence to be that it would obviously have been preferable for Mr Churchill to have been returned to theatre at an earlier stage and that his outcome would probably have been better if this had occurred. However, taking into account of Mr Churchill's significant co-morbidities and a range of unknowable clinical factors, it is unsurprising that Dr Thomas was not able to quantify what effect any delay in returning Mr Churchill to theatre may have had on his ultimate health trajectory.¹⁹⁶

*Case review by Dr Schlueter*¹⁹⁷

162. As I have already noted, Dr Schlueter's report primarily focussed on the appropriateness of using FAST scans in Mr Churchill's case. However, relevantly for present purposes, Dr Schlueter also addressed the question of: "*Whether the treating team should have done anything different on response to the patient's hypotension?*".

¹⁹⁴ ts 18.02.21 (Thomas), p210

¹⁹⁵ ts 18.02.21 (Thomas), p210

¹⁹⁶ ts 18.02.21 (Thomas), p210

¹⁹⁷ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21)

- 163.** Dr Schlueter noted that throughout the resuscitation process, the treating team remained concerned about bleeding as a cause for Mr Churchill's unstable condition. This much is clear from the fact that two units of blood were administered in the first hour after the Procedure and by the fact that additional blood products were ordered by Dr Ng at Dr Forster's suggestion during the MET call.¹⁹⁸
- 164.** As part of the resuscitation process, the team repeated formal blood tests and blood gases. These assessments demonstrated a "*significant drop in haemoglobin (red cell count)*" and a clinical picture caused either by acute blood loss; rupture or disruption of red blood cells (haemolytic anaemia); or the genetic disorder, sickle cell disease. Given that Mr Churchill had no history of haemolytic anaemia or sickle cell disease, it was Dr Schlueter's view that "*acute blood loss was the most likely cause given the clinical setting*". As Dr Schlueter acknowledged, a blood test result with the words "*consistent with acute blood loss*" was only available later and "*real-time reporting by a Haematologist could have influenced the team's decision making*".^{199,200}
- 165.** Despite the fact that Mr Churchill was being given large doses of medication to control his blood pressure (vasosuppressors and inotropes) his blood pressure remained dangerously low. Dr Schlueter said that in her experience, overwhelming sepsis is "*usually somewhat responsive to aggressive vasosuppressors and/or inotrope support*".²⁰¹
- 166.** Dr Schlueter's view was that Mr Churchill's clinical signs favoured blood loss, because:

In the context of a "*technically difficult*" operation...with concerns raised by the DMO anaesthetist for bleeding at the end of the operation...the sudden, rapid and sustained clinical deterioration of cardiovascular collapse with haemodynamic instability in the absence of sufficient pre and/or intraoperative instability indication sepsis favours haemorrhagic shock rather than septic shock.²⁰²

¹⁹⁸ ts 17.02.21 (Ng), pp64 & 65

¹⁹⁹ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), pp13-14

²⁰⁰ ts 17.02.21 (Ranasinghe), p17

²⁰¹ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p14

²⁰² Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p14 and ts 18.02.21 (Schlueter), p192

- 167.** Dr Schlueter acknowledged the legitimacy of the treating team’s initial concerns about taking Mr Churchill back to theatre when the cause for his instability was unclear. She also referred to the best practice of resuscitating a patient before intubating them, as would be required if Mr Churchill was to undergo a further surgical procedure.
- 168.** Dr Schlueter said that Mr Churchill’s co-morbidities added to the complexity of the treating team’s decision making process. Nevertheless, Dr Schlueter concurred with Dr Thomas’ view about the need to return Mr Churchill to theatre, saying:

I concur with him [Dr Thomas] on the fact that this predisposition of poor physiological reserve and Mr Churchill’s compromised, life-threatening condition at that time, required a return to theatre to assist to optimise his physiology ASAP.²⁰³

- 169.** Notwithstanding this observation, Dr Schlueter considered that the delay in returning Mr Churchill to theatre was “*reasonable*” in as much as it was caused by a delay in reaching a definitive diagnosis for the cause of his instability, as well as efforts to stabilise his condition before returning him to theatre so as to reduce the risks that he might die after being given a second general anaesthetic.²⁰⁴
- 170.** However, Dr Schlueter also acknowledged the obvious point that at some stage in the balancing exercise, the concern that Mr Churchill might not survive a further anaesthetic would become academic if he bled to death in the recovery area.²⁰⁵

Comments on Dr Schlueter’s case review

- 171.** With respect, Dr Schlueter’s opinion that the delay in returning Mr Churchill to theatre was “*reasonable*”, rather begs the question. Both she and Dr Thomas say that on the basis of Mr Churchill’s clinical picture and given the data points which were known at the time, blood loss was the more likely cause of his unstable condition.

²⁰³ Exhibit 1, Vol. 1, Tab 25, Report - Dr S Schlueter (29.01.21), p15

²⁰⁴ ts 18.02.21 (Schlueter), p193

²⁰⁵ ts 18.02.21 (Schlueter), p199

- 172.** In that context, the treating team’s delay in arriving at what Dr Thomas referred to as the “*default diagnosis*” for a patient like Mr Churchill, (namely blood loss), seems more difficult to justify. I accept that it is easy to be wise in hindsight. In the agony of the moment and in the context of a bedside scene described as “*chaotic*”,²⁰⁶ I can see how a strongly held view (i.e.: that the more likely diagnosis was a septic event) might prevail even in the presence of evidence to the contrary.
- 173.** Further, in this case, it seems that the treating team’s concerns about returning a very unwell Mr Churchill to theatre made them understandably cautious. It also seems that the team drew some comfort from the fact that Mr Churchill’s drain was essentially clear and that repeated FAST scans failed to show free fluid in his abdomen.
- 174.** I have already discussed issues relating to the drain and the FAST scans but I want to again emphasise the obvious limitations of the FAST scan as a diagnostic tool in this case. Despite the fact that three litres of blood was eventually removed from Mr Churchill’s abdomen, none (or possibly only one) of the FAST scans had showed any free fluid.
- 175.** Given that Mr Churchill’s internal bleeding was caused by the inadvertent cutting of an aberrant branch of his cystic artery during the Procedure,²⁰⁷ it must be the case that the blood in his abdomen accumulated gradually. Nevertheless, even the FAST scan performed shortly before Mr Churchill was taken to the radiology department (at a time when he must have had a considerable amount of blood in his abdomen) failed to detect any free fluid.
- 176.** Given that Mr Churchill’s deterioration was so rapid and the fact that he was not responding to increasingly more aggressive blood pressure support, it is unfortunate that the treating team did not arrive at a diagnosis of blood loss as being the more likely cause of Mr Churchill’s instability at an earlier stage than they did.

²⁰⁶ ts 17.02.21 (Ng), p53

²⁰⁷ ts 17.02.21 (Ranasinghe), pp9 & 14

ISSUES RELATING TO THE MMEX NOTE

Overview

- 177.** Dr Ng was one of the few clinicians involved in Mr Churchill’s care who made a prospective entry in the File. He did so on 27 October 2017. He also drafted a retrospective entry for the File that he began on 27 October 2017 and completed on 29 October 2017. That entry was made using a computer system known as MMEX,²⁰⁸ and for that reason, I will refer to Dr Ng’s retrospective entry as the “*MMEX note*”.
- 178.** WACHS says that the MMEX note was not placed on the File because, in accordance with its record management policy, the MMEX note was a medico-legal report and therefore had no place in a medical record. However, after the MMEX note was removed, no substantive efforts were made to capture its contents for the benefit of the File.

The MMEX system

- 179.** The MMEX system is an electronic clinical information system that was developed to allow clinical notes to be typed into a patient’s record and then shared between clinicians and health services based in the Kimberley. It is internet-based and users must have a login and password to access the system. Clinicians at BH were able to access MMEX records kept by the Broome Regional Aboriginal Medical Service (BRAMS), but only with the consent of the relevant patient.²⁰⁹
- 180.** Clinical information entered into the MMEX system can be printed out in what I will refer to as a “*letter*” format or “*integrated notes*” format. Versions of the MMEX note in both formats appear in the Brief. In letter format, the information typed into the MMEX system is printed out on plain paper without patient identification information or the relevant hospital or health service’s name. In contrast, when printed in the integrated notes format, the information appears on a form with the hospital or health service name, a form number and patient identification information.^{210,211,212}

²⁰⁸ ts 17.02.21 (Ng), pp53-54

²⁰⁹ Exhibit 1, Vol. 1, Tab 10A, Statement - Dr S Phillips (13.03.20), paras 9 & 12-13

²¹⁰ Exhibit 1, Vol. 1, Tab 10A, Statement - Dr S Phillips (13.03.20), para 8

²¹¹ Letter format: Exhibit 1, Vol. 1, Tab 24, Attachment 6 to Report - Ms R Smith (30.12.20)

²¹² Integrated notes format: Exhibit 1, Vol. 1, Tab 9, Attachment to Letter - Dr K Ng (03.04.18)

- 181.** The evidence establishes that the MMEX system was widely used at BH until February 2017, at which time a written notice was issued to staff advising that the system would no longer be “*supported*”. However, at no stage were staff at BH directed (in writing or otherwise) not to use the MMEX system and staff logins for the MMEX system were not cancelled. There is evidence that the MMEX system was being used after February 2017, although this is disputed by Dr Phillips.^{213,214}
- 182.** Dr Ng said that he and others used the MMEX system in order to ensure that entries intended for a patient’s record were legible.²¹⁵ Be that as it may, the point here is that at the relevant time, Dr Ng had a valid BH login and password for the MMEX system and was therefore authorised to access it.²¹⁶ Any assertion to the contrary is false.

Was the MMEX note removed from the File?

- 183.** In this case, Dr Ng typed up an account of his clinical involvement in Mr Churchill’s care using the MMEX system which he accessed using his BH login and password. On 29 October 2017, he placed the MMEX note at the front of the File in a loose-leaf fashion, with the expectation that it would become a permanent record on the File.²¹⁷
- 184.** Dr Phillips, who was working a night shift at BH, says that shortly after midnight on 29 October 2017, she was shown the MMEX note by a ward clerk who asked where it should be placed in the File. Over the previous day or so, Dr Phillips had discussed Mr Churchill’s case briefly with Dr Forster, Dr Shepherd and several of the nursing staff, but had not spoken with Dr Ng. During her brief discussions with other clinicians, Dr Phillips was told that Mr Churchill about the Procedure and that Mr Churchill had suffered post-operative internal bleeding. She was also told that when Mr Churchill had been transferred to RDH, he was in “*quite good condition with [a] good coagulation profile*” and it was hoped he would “*do very well*”.²¹⁸

²¹³ ts 17.02.21 (Ng), pp70, 80 & 89-90

²¹⁴ Exhibit 1, Vol. 1, Tab 10A, Statement - Dr S Phillips (13.03.20), paras 10-11 and ts 17.02.21 (Phillips), p112

²¹⁵ ts 17.02.21 (Ng), p80

²¹⁶ Exhibit 1, Vol. 1, Tab 24, Report - Ms R Smith (30.12.20), p6 and ts 18.02.21 (Smith), p226

²¹⁷ ts 17.02.21 (Ng), pp53-54

²¹⁸ ts 17.02.21 (Phillips), pp99-100

185. Dr Phillips says she read the MMEX note and determined that it was not an integrated progress note, but rather that it “*read like a medico-legal report*”. At the inquest, Dr Phillips said she showed the MMEX note to the after-hours nurse manager and they had agreed it was a medico-legal report.²¹⁹ However, in an email to Sergeant Trent Langthorn (Officer Langthorn), the police officer investigating Mr Churchill’s death, she sent on 25 April 2018, Dr Phillips put the point differently. In that email, Dr Phillips said she showed the after-hours nurse manager the MMEX note and that:

She concurred the notes were not written in a way to indicate that they were an objective summary and she was concerned, as I was, that they were not factual.²²⁰

186. In any event, Dr Phillips took the MMEX note and placed it in an in-tray in her office where it subsequently remained.²²¹

187. Although the MMEX note was not affixed to the File in a “*permanent*” manner, Dr Ng had placed it with other documents on the File with the clear expectation that it would become part of the File. It is therefore incorrect to say that the MMEX note was not “*placed on the File*” although it may be possible to say that the MMEX note was not “*placed in the File*”.

188. At the inquest, Dr Phillips initially said that she had not removed the MMEX note from the File because “*they were loose-leaf in the front of the chart*”. Instead she said she had directed that the MMEX note not be placed on the File.²²² It may be possible to say that Dr Phillips did not “*take the MMEX note off the File*” in the sense that she did not remove clinical notes which had been permanently affixed thereto. However, by placing the MMEX note in an in-tray in her office, Dr Phillips clearly “*removed the MMEX note from the File*” because after she did so, the MMEX note was no longer part of, or included with, other documents on the File.

²¹⁹ ts 17.02.21 (Phillips), p101

²²⁰ Exhibit 1, Vol. 1, Tab 10, Email Dr S Phillips to Sgt. T Langthorn (25.04.18), p1

²²¹ ts 17.02.21 (Phillips), p111

²²² ts 17.02.21 (Phillips), p110

- 189.** Any other characterisation of Dr Phillips’ actions in this regard is unsupported, either by the evidence or by the plain meaning of English words. At the inquest, Dr Phillips conceded that by placing the MMEX note in an in-tray, she had removed it from the File.²²³
- 190.** Although Dr Phillips said she had never previously removed a clinician’s treatment notes from a patient’s record, her evidence at the inquest was that she had not done so in this case. Her reasoning was that because the MMEX note was a medico-legal report and not a clinician’s treatment record, it had no business being on the File in the first place.²²⁴
- 191.** Dr Phillips also said that by removing the MMEX note from the File she was acting in accordance with WACHS record management policies and she appears to have drawn some comfort from the fact that several of her colleagues agreed with her characterisation of the MMEX note and thereby supported its removal from the File.²²⁵
- 192.** However, even if Dr Phillips is correct and the MMEX note was a medico-legal report (a position with which I respectfully disagree), this is the least important aspect of this whole issue. Of far greater concern to me is the fact that after the MMEX note had been removed no substantive steps were taken to capture, for the benefit of the File, the detailed clinical information the MMEX note contained.
- 193.** Dr Phillips says that she contacted Dr Ng on 31 October 2017, to tell him that the MMEX note had not been placed on the File because she had deemed it to be a medico-legal report. She further says that she offered Dr Ng the opportunity to make a retrospective entry in the File detailing his involvement in Mr Churchill’s care.^{226,227} For his part, Dr Ng says Dr Phillips told him that the MMEX note had been removed from the File and that it “*no longer existed*”. He does not recall being told that the MMEX note had been removed because it was deemed to be a medico-legal report and denies that Dr Phillips asked or told him to make a retrospective entry if he wanted to.

²²³ ts 17.02.21 (Phillips), p110

²²⁴ ts 17.02.21 (Phillips), pp116 & 125

²²⁵ ts 17.02.21 (Phillips), pp125-126

²²⁶ Exhibit 1, Vol. 1, Tab 10, Email Dr S Phillips to Sgt. T Langthorn (25.04.18), pp1-2

²²⁷ ts 17.02.21 (Phillips), p132

194. On this point, Dr Ng's said:

No she didn't and when I think about things I don't really see why she would have asked me [to do so] because I probably would have written very close to the same account of events.²²⁸

195. My difficulty in determining what actually transpired is that there is no entry in the File, contemporaneous or otherwise, that records Dr Phillips' decision to remove the MMEX note from the File and her reasons for doing so. Further, there is no record in the File of any offer Dr Phillips made to Dr Ng about adding a retrospective entry to the File and/or any response he made to any such an offer.²²⁹

196. Notably, Dr Phillips said that if the MMEX note had been handwritten into Mr Churchill's integrated progress notes, she would "*absolutely not*" have removed it from the File. Ms Smith gave similar evidence.²³⁰

197. In this case, the MMEX note was printed in letter format (i.e.: on plain paper) and other than Mr Churchill's name, it bore no patient identification information. Further, the MMEX note lacked a medical record form number and the name of the relevant hospital. The absence of this information and the fact that the MMEX note was not signed were cited by Ms Smith as the primary reasons why she supported the removal of MMEX note from the File.²³¹

198. The importance of the evidence of Dr Phillips and Ms Smith on this point cannot be understated. It is clear that had the MMEX note been handwritten into the File, it would not have been removed.^{232,233}

²²⁸ ts 17.02.21 (Ng), pp85 & 86

²²⁹ Exhibit 1, Vol. 2, Tab 1, BH medical notes

²³⁰ ts 17.02.21 (Phillips), p113 and ts 18.02.21 (Smith), pp230-231, 234 & 235

²³¹ ts 17.02.21 (Ng), p54 and ts 18.02.21 (Smith), p227

²³² Exhibit 1, Vol. 1, Tab 10, Email Dr S Phillips to Sgt. T Langthorn (25.04.18)

²³³ ts 17.02.21 (Phillips), p113 and ts 18.02.21 (Smith), pp227, 230-231 & 234

Was the MMEX note a medico-legal report?

- 199.** Before and during the inquest, various reasons were advanced to justify the removal of the MMEX note from the File. One of the earliest and most prominent was that the MMEX note had no place on the File because it was a “*medico-legal report*”.
- 200.** Unfortunately, although the WACHS Health Records Management Policy (Records Management Policy) makes clear that medico-legal reports should not be placed on a patient’s medical record, the Records Management Policy is silent as to exactly what constitutes a medico-legal report.²³⁴
- 201.** Clinical supervisors are therefore placed in an invidious position. In the absence of clear policy guidance, they are left to make their own subjective assessments as to whether a clinical entry warrants exclusion on the basis that it is a medico-legal report. In this case, as I have noted, Dr Phillips’ first concern was the format of the MMEX note. It looked to her like a medico-legal report.²³⁵
- 202.** In an email to Dr Phillips sent at 11.27 am on 25 April 2018, Officer Langhorn asked for an explanation for why the MMEX note was no longer in the File.²³⁶ At the time, Dr Phillips did not have access to relevant records because she was on a secondment in Perth.^{237,238} Nevertheless, at 12.44 pm the same day, Dr Phillips sent an email to Officer Langhorn in which she described the MMEX note in the following terms:

The notes appeared to be an individual practitioner’s medico-legal report - as if prepared for a lawyer, rather than for a patient’s record. The retrospective report appeared to have been written as a justification of the individual practitioner’s role in the events to explain their action and inaction and to blame others for their actions or inaction.²³⁹

²³⁴ Exhibit 1, Vol. 1, Tab 16, WACHS Health Record Management Policy, p4

²³⁵ ts 17.02.21 (Phillips), p101

²³⁶ Exhibit 1, Vol. 1, Tab 10, Email - Sgt. T Langthorn to Dr S Phillips to (25.04.18)

²³⁷ ts 17.02.21 (Phillips), p110

²³⁸ Dr Phillips was on a secondment to King Edward Memorial Hospital, see: ts 18.02.21 (Smith), p224

²³⁹ Exhibit 1, Vol. 1, Tab 10, Email - Dr S Phillips to Sgt. T Langthorn (25.04.18), p1

- 203.** With respect, the assumptions underlying this statement are demonstrably false. As Dr Ng confirmed at the inquest, and as he could have explained at the time had he been asked, he did not intend the MMEX note to be construed as “*contemporaneous notes for his own medico-legal purposes*”, nor did he consider the MMEX note to be a medico-legal report.²⁴⁰
- 204.** Instead, Dr Ng considered the MMEX note as a genuine attempt on his part to summarise Mr Churchill’s clinical care at BH. As far as he was concerned the MMEX note was an accurate summary of the care provided to Mr Churchill and his intention (as well as his clear expectation) was that the MMEX note would be placed permanently on the File.²⁴¹ The most basic of enquiries with Dr Ng at the time would have revealed these plain facts.
- 205.** Having carefully considered the contents of the MMEX note, I have difficulty understanding how the document can properly be characterised as a medico-legal report. Further, I do not accept that on its face, the MMEX note has clearly been written by Dr Ng in order to protect his legal position and/or to blame his colleagues.
- 206.** However, regardless of the view I have taken, the question of whether or not the MMEX note was or was not a medico-legal report is a red herring. From my perspective, the far more important issue is what should have happened after Dr Phillips decided to remove the MMEX note from the File. Before dealing with that issue, I want to address the question of whether the MMEX note was inaccurate.

Was the MMEX note inaccurate?

- 207.** In her email to Officer Langthorn, Dr Phillips said the MMEX note was “*a medico-legal report that justified his...[i.e.: Dr Ng’s]...actions and or inaction and which could be seen to be defaming others*” and was: “*predominantly a highly subjective and potentially inaccurate summary of events from his...[Dr Ng’s]...perspective*”, when compared to the rest of the MET team’s interpretation of events.²⁴²

²⁴⁰ ts 17.02.21 (Ng), p80

²⁴¹ ts 17.02.21 (Ng), pp80-82

²⁴² Exhibit 1, Vol. 1, Tab 10, Email Dr S Phillips to Sgt. T Langthorn (25.04.18), pp1 & 2

- 208.** In my view, Dr Phillips’ comments were a mischaracterisation of the MMEX note and were particularly unfortunate given that they were made in an email to the police officer investigating Mr Churchill’s death.
- 209.** In a subsequent statement signed on 15 February 2021, Dr Phillips repeated her view that the format and content of the MMEX note suggested to her that it was a medico-legal report and may not be accurate or objective. In summary, she said that the MMEX note did not capture the concerns being expressed by other members of the MET team and was based on: “*Dr Ng’s selective recollections of what was said and what was done based on selective parts of the whole narrative*”. Dr Phillips also said that the MMEX note conveyed the false impression that Dr Ng was: “*the only one concerned about the patient’s potential for blood loss and expedient return to theatre*”.²⁴³
- 210.** Prior to the inquest, Dr Phillips was given the opportunity to identify those parts of the MMEX note which she considered may have been inaccurate and/or defamatory. In a supplementary statement to the Court, Dr Phillips referred to several aspects of the MMEX note which she said were inaccurate.²⁴⁴ Her reasoning was essentially that the passages she identified were not a verbatim account of what had occurred and/or had made assumptions about the decision making processes of other clinicians. However, Dr Phillips’ supplementary statement did not identify any aspect of the MMEX note which in her view was or might be defamatory.²⁴⁵
- 211.** At the inquest, Dr Phillips was given a further opportunity to identify those parts of the MMEX note that were, in her view, either inaccurate and/or defamatory. Dr Phillips identified what she considered were inaccuracies in several passages of the MMEX note. One of her concerns related to the fact that Dr Ng had used the word “*felt*” instead of “*said*”.²⁴⁶

²⁴³ Exhibit 1, Vol. 1, Tab 10B, Statement - Dr S Phillips (15.02.21), para 8

²⁴⁴ Exhibit 1, Vol. 1, Tab 10B, Statement - Dr S Phillips (15.02.21)

²⁴⁵ Exhibit 1, Vol. 1, Tab 10B, Statement - Dr S Phillips (15.02.21), paras 9-14

²⁴⁶ ts 17.02.21 (Phillips), pp102-110

212. The other identified concerns related Dr Ng's alleged failure to fully capture the views of other clinicians and/or what they had said and further, that Dr Ng had created the false impression that he was the only clinician who was concerned about blood loss and the need to return Mr Churchill to the operating theatre.²⁴⁷
213. Dr Phillips' concern that the MMEX note was written in a narrative style and did not fulsomely record the views of the other clinicians involved in Mr Churchill's care could just as easily be levelled at the retrospective entry made by Dr Forster on 31 October 2017.²⁴⁸ However, for myself, I would not see criticism of either the MMEX note or Dr Forster's retrospective entry on either of these bases as valid.
214. In my view, the concerns about that MMEX note which Dr Phillips identified in her supplementary statement and at the inquest could have been resolved by way of a discussion with Dr Ng at the time. However, that discussion did not take place for reasons which were not explained.
215. In addition to expressing concerns about the format and content of the MMEX note, Dr Phillips' email to Officer Langthorn also contained an assertion about the manner in which Dr Ng had accessed the MMEX system to create the MMEX note, namely:

In addition, having due regard to the MMEX governance process, I am unclear **how**...[Emphasis added]...Kevin Ng accessed the patient's BRAMS MMEX record in order to make an MMEX entry WACHS Kimberley medical practitioners only have the right to read and record notes in the MMEX record *with the patient's verbal consent*...[original italics]...As the patient was in Darwin ICU at the time and could not provide consent to do so, I seriously questioned the legality of the MMEX record in terms of complying with privacy laws and the implications of making such a non-objective entry in another health service's medical record, let alone making ANY entry in another health service's medical record where WACHS has no rights to record. To my mind this is a medico-legal minefield.²⁴⁹

²⁴⁷ ts 17.02.21 (Phillips), pp102-110

²⁴⁸ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Integrated Progress Notes (Dr Forster, 31.10.17)

²⁴⁹ Exhibit 1, Vol. 1, Tab 10, Email Dr S Phillips to Sgt. T Langthorn (25.04.18), p2

216. In a statement she made on 13 March 2020, Dr Phillips explained that when she had written her email to Officer Langthorn, she had assumed that Dr Ng had accessed Mr Churchill’s BRAMS medical record in order to prepare the MMEX note, because at the time, BH “*did not support MMEX for its own medical records*”. Specifically, Dr Phillips said:

However, I was “unclear”. I could not confirm this against the BRAMS MMEX database because I would have needed patient consent to access this record as well and this was not possible. I did not consider that Dr Ng had entered the notes into the Broome Hospital MMEX database as this archived clinical record was not being used by any Broome Hospital clinicians.²⁵⁰

217. Notwithstanding this subsequent explanation, the point is that the plain words of Dr Phillips’ email to Officer Langthorn are not qualified in this way. In her email Dr Phillips does not say that she thought Dr Ng may have accessed Mr Churchill’s BRAMS MMEX record, or that she was unsure whether this had occurred. Instead, Dr Phillips told Officer Langthorn she was unclear **how** Dr Ng had accessed Mr Churchill’s BRAMS MMEX record.²⁵¹

218. In other words, on a plain reading of her email, Dr Phillips was informing Officer Langthorn, the police officer investigating Mr Churchill’s death, that Dr Ng had improperly accessed the BRAMS MMEX system in order to prepare the MMEX note, she was just not sure how he had done so.

219. At the inquest, Dr Phillips properly conceded that her previous assertions about Dr Ng’s access to BRAMS MMEX system were false and entirely without foundation.²⁵² Although Dr Phillips gave evidence that at the time she wrote her email to Officer Langthorn she did not have the records in front of her because she was in Perth, as I have noted the terms of her email are unqualified and unequivocal.^{253,254}

²⁵⁰ Exhibit 1, Vol. 1, Tab 10A, Statement - Dr S Phillips (13.03.20), paras 14-15

²⁵¹ Exhibit 1, Vol. 1, Tab 10, Email Dr S Phillips to Sgt. T Langthorn (25.04.18), p2

²⁵² ts 17.02.21 (Phillips), p112

²⁵³ ts 17.02.21 (Phillips), p110

²⁵⁴ Dr Phillips was on a secondment to King Edward Memorial Hospital, see: ts 18.02.21 (Smith), p224

220. Dr Ng was clearly authorised to access the MMEX system for two reasons. First his login and password for the BH MMEX system were still operational and second, at no stage had BH issued a directive (in writing or otherwise) that staff were not to use the MMEX system. Ms Smith confirmed that in accessing the MMEX system, Dr Ng had used his BH login and password.^{255,256}

221. I am troubled by the fact that Dr Phillips provided information about one of her subordinates, namely Dr Ng, to a police investigator in circumstances where the most basic of enquiries with Dr Ng would have established that the information was false.

222. In passing, I note that on 2 November 2017, Dr Phillips called a meeting at BH to discuss concerns that had been raised by Dr Ng. Dr Forster, who gave an account of that meeting, said he was told about the MMEX note (which he had never seen) by Dr Phillips some days after Mr Churchill left BH. Dr Forster says at the request of Dr Phillips, he made a retrospective entry in the File although he thought “*notes made on the day by the team*” were “*sufficient enough*”. As for the meeting itself, Dr Forster said:

During the meeting Sue [Dr Phillips] said “*I have seen Kevin’s notes and they were retrospective and subjective [and] not factual information*”. Sue told us that Kevin’s notes were inappropriate and were not contained with the patient’s medical notes...I have never seen the notes made by Kevin and I did not see anyone with them in their possession during that meeting. During the meeting Kevin did not respond to Sue’s comments about the medical notes.²⁵⁷

223. Dr Phillips also referred to the MMEX note as “*defamatory and blaming of others*” in a letter she wrote to Dr Phil Montgomery dated 17 April 2018. That letter had been written in response to allegations that she had removed and destroyed a signed medical record from the File (i.e.: the MMEX note).²⁵⁸

²⁵⁵ ts 17.02.21 (Ng), pp89-90

²⁵⁶ Exhibit 1, Vol. 1, Tab 24, Report - Ms R Smith (30.12.20), p6 and ts 18.02.21 (Smith), p226

²⁵⁷ Exhibit 1, Vol. 1, Tab 11, Statement - Dr D Forster (05.04.18), paras 38-45 & 47-48

²⁵⁸ Exhibit 4, Letter - Dr S Phillips to Dr P Montgomery (17.04.18)

224. Dr David Gaskell, the then Regional Medical Director, considered Dr Phillips' response before writing to her in these terms:

In deciding that Kevin Ng's MMEX print-out was a medico-legal report which did not justify being part of the official hospital clinical record, your decision-making and course of action as the Senior Medical Officer were, I consider, justifiable and appropriate. Fully satisfied with your explanation, therefore, I consider that no further action is required in respect of these allegations.²⁵⁹

225. As for the assertion in Dr Phillips' email to Officer Langthorn that the MMEX note "*could be seen as defaming others*", I accept that clinicians are not usually legally trained and may not understand the meaning and import of legal terms. However, for that very reason, I recommend that in future, caution should be exercised by any person contemplating describing all or part of another clinician's treatment notes as either "*defamatory*" or "*possibly defamatory*" to any person, much less to a police officer.

What should have happened after the MMEX note was removed?

226. Clearly, any legitimate issues with the format or content of the MMEX note could and should have been raised directly with Dr Ng at the time the MMEX note was first discovered. Dr Ng could then have been reminded about WACHS document policies and afforded the opportunity to address those aspects of the MMEX note which he agreed were, on reflection, in need of correction. In that way the content of the MMEX note could have been included in the File in accordance with WACHS policy.

227. Instead, in what became a "*zero sum*" approach, the MMEX note was simply removed from the File in circumstances where no substantive effort was made to capture the valuable information that it contained. From my perspective, the critical question is whether any part of the MMEX note added to the sum of knowledge about Mr Churchill's clinical management. On any proper analysis, the answer to that question is emphatically "*Yes*".

²⁵⁹ Exhibit 5, Letter - Dr D Gaskell to Dr S Phillips (11.05.18)

228. In those circumstances, greater efforts should have been made to ensure that the content of the MMEX note was included in the File in what was deemed to be an appropriate way and it is most unfortunate that this did not occur. However, at the conclusion of the inquest, I was pleased to note that Dr Phillips acknowledged, through counsel, that with the benefit of hindsight, she would have acted differently and would have “*done more*”. Specifically, I was advised that:

Consistent with her ...[i.e.: Dr Phillips]...role at the time as the senior medical officer with ensuring responsibility for compliance with policy, she thinks it would have been appropriate to sit down with Dr Ng to ensure that the information was captured in the medical record, bearing in mind the scant documentation that we have in this health record and that she could have done that in a way to ensure that his note was consistent with the policy but also to ensure that the information has been captured.²⁶⁰

Correcting the content of MMEX note

229. As I have explained, the evidence at the inquest was that if the MMEX note had been handwritten or printed out from the MMEX system in an integrated notes format, it would have been placed on the File.²⁶¹ In those circumstances, the WACHS policy entitled: “*Documentation - Clinical Practice Standard*” (the Documentation policy) would then have been applied.²⁶² The Documentation policy provides that where an entry in a patient’s medical record is found to be inaccurate or deficient, the entry should be ruled through with a single line (so it is still legible) and annotated with the words “*written in error*”. Where appropriate, corrections or additional information can then be inserted or added.²⁶³

230. Had Dr Ng accepted (after consultation with Dr Phillips), that all or part of the MMEX note was incomplete or inaccurate, he could have made changes to the MMEX note in accordance with the Documentation policy. Obviously that could not occur in this case because the MMEX note never made its way onto the File.

²⁶⁰ ts 18.04.21 (Phillips), p281-282 and see also: ts 18.04.21 (Paljetak), pp283-284

²⁶¹ ts 17.02.21 (Phillips), p113 and ts 18.02.21 (Smith), pp230-231 & 234-235

²⁶² Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard

²⁶³ Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard, p3

- 231.** Where a clinician’s account of their involvement in a patient’s care is deemed to be inappropriate for whatever reason, significant steps should be taken to ensure that an appropriate entry is prepared. Further, given the gravity of removing a clinician’s notes from a patient record, it is my view that as a minimum, both the fact of the removal and the reasons for that removal should be clearly recorded in the relevant patient record.
- 232.** The absence of any notation in the File about the fact that the MMEX note had been removed (and the reasons why this was done) is puzzling. The upshot is that the File was deficient because Dr Ng’s comprehensive summary of Mr Churchill’s clinical treatment was not included. Further, as I have just pointed out, there was no indication in the File that any such summary had ever existed, much less that it had been removed.
- 233.** Had Dr Phillips made a notation in the File explaining her decision to remove the MMEX note, there would have been no basis for the disciplinary proceedings she was subsequently subjected to.²⁶⁴ Further, had greater efforts been made to ensure that Dr Ng’s valuable clinical insights were included in the File, the quality of Mr Churchill’s patient record would have been improved. For this reason and others that I will now address, the quality of entries on the File was suboptimal.

Quality of the Notes

- 234.** The Documentation policy relevantly provides that entries in a patient’s health care record “*must provide an accurate description of each patient’s episode of care or contact with health care providers*”.²⁶⁵ The patient’s full name, date of birth and unique medical record number must also appear on such entries and all entries must be contemporaneous, include the date and time, be made in black, water-fast ink and be:

[A]ccurate statements of clinical interactions between the patient and their significant others, and the health service relating to assessment; diagnosis; care planning; management / care / treatment / services provided and response / outcomes; professional advice sought and provided; observation/s taken and results.²⁶⁶

²⁶⁴ Exhibit 4, Letter Dr S Phillips to Dr P Montgomery (17.04.18)

²⁶⁵ Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard, p1

²⁶⁶ Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard, p2

- 235.** The Documentation policy also provides that entries should be signed and include the name and designation of the writer and be written in plain language.²⁶⁷ Although much was made of the fact that the MMEX note was written in a narrative style and purported to cover the full extent of Mr Churchill’s “*clinical journey*”, I was not able to find any aspect of the Documentation policy that prevented entries of this kind.
- 236.** In terms of the need to make entries in a patient’s medical record, as the Documentation policy points out: “*The absence of documentation infers care is not completed and may be interpreted by a court of law as evidencing neglect of the patient*”.²⁶⁸
- 237.** As to the timeliness of entries in a patient’s medical record, other than the general requirement that entries are to be contemporaneous, the Documentation policy requires medical officers: “*to make an entry in the health care record at the time of the events including when reviewing the patient, or as soon as possible afterwards*”.²⁶⁹
- 238.** In this case, as both the SEA and the SAC1 identified, the vast majority of entries in the File (other than observation charts and similar documents) were made retrospectively. I accept that in a busy regional hospital with limited staff, it may not always be possible to comply with every requirement of the Documentation policy, however, the lack of contemporaneous entries in this case is obviously unsatisfactory.²⁷⁰
- 239.** At the inquest, Ms Melanie Naylor (counsel for Dr Ng), identified another problem with the File. The problem related to a seven-page document entitled “*Numeric Trends: Vitals*” (Vitals Record), which I was told are records of a patient’s vital signs when they are in theatre. At the inquest it was confirmed that pages 2, 5, 6 and 7 of the Vitals Record related to a patient other than Mr Churchill.²⁷¹

²⁶⁷ Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard, p2

²⁶⁸ Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard, p3

²⁶⁹ Exhibit 1, Vol. 1, Tab 17, WACHS Documentation - Clinical Practice Standard, pp2, 3 & 4

²⁷⁰ Exhibit 1, Vol. 1, Tab 13, Significant Event Analysis Report (14.12.17), p7

²⁷¹ ts 18.02.21 (Paljetak), pp204-205

240. Counsel for WACHS, Ms Rachel Paljetak, advised she had taken instructions from the current SMO at BH, Dr David Woodward. He explained that at the relevant time, a printer used to print the Vitals Record did not allow “*individual*” printing. As a result of human error, records belonging to another patient were inadvertently placed on the File. Dr Woodward advised that the relevant printer is no longer in service and that different monitors are now used at BH. Further, blood pressure observations are now recorded contemporaneously in a patient’s anaesthetic record. Although what occurred in this case is obviously very concerning, it appears that as a result of new equipment and changes to procedures, the error cannot be repeated.²⁷²

241. For the sake of completeness, I must briefly refer to an issue which relates to the management of the File by BH following Mr Churchill’s death. More specifically, the issue relates to the whereabouts of the anaesthetic record relating the Procedure (which I have previously referred to in this finding as “*the Report*”).²⁷³ On 9 March 2020, Mr Brendyn Nelson, who at the time was counsel assisting the Court, sent an email to the State Solicitor’s Office (the SSO) seeking information on the whereabouts of the Report.

242. In a letter to the Court dated 13 March 2020, Ms Paljetak advised that the copy of the File provided to the Court on 24 November 2017 contained the Report. However, a further copy of the File sent by BH to the Perth office of WACHS on 3 July 2019 did not contain the Report. As Ms Paljetak then explained:

It is therefore likely that the [Report] was removed from Mr Churchill’s original patient file at some point between 24 November 2017 and 3 July 2019. My client is not able to shed light on when [the Record] was removed from Mr Churchill’s original patient file in this period, by whom or for what purpose. The importance of having a complete and accurate patient medical file cannot be overstated and is reflected in [the Documentation policy]. I am instructed that my client is very concerned by the removal of [the Record] from Mr Churchill’s original patient file.²⁷⁴

²⁷² ts 18.02.21 (Paljetak), pp204-205

²⁷³ Exhibit 1, Vol. 2, Tab 1, BH medical notes - Operation Report, (2.30 pm, 27.10.17)

²⁷⁴ Exhibit 1, Vol. 1, Tab 23, Letter SSO to Court (13.03.20), p2

243. As Ms Smith acknowledged at the inquest, it is clearly concerning that the management of the File at BH was such that an important document such as the Report was able to simply disappear from the original File.²⁷⁵ Fortuitously, the version of the File originally provided to the Court did contain the Report, otherwise the material before me would have been deficient in a material way.

COMMENT ON STAFFING LEVELS

244. During the inquest, Dr Saharov spoke about the increasing pressure on staff at BH in these terms:

The last point I want to make, we need adequate staffing. We're desperately short of everyone in the Kimberley, but...Broome Hospital is becoming busier...As the region gets more and more stressed with lack of staff, because of borders...and more workers coming to Broome Hospital, we're busier than ever. Our staffing has not increased proportionally. It has gone backwards and as a result, we have more and more (indistinct) overload. We don't have the capacity to respond to emergencies with a...cognitive capacity that we need both, let alone the physical capacity.²⁷⁶

245. Whilst the evidence before me is that additional staff would not have had an impact on Mr Churchill's outcome, staffing pressures are relevant to his death in another way, namely the use of locum staff. I have already referred to Dr Schlueter's evidence about the importance of building a hospital culture in which there is mutual trust and respect and where assertiveness is encouraged. During the inquest, I asked Dr Schlueter about the impact on that culture of using locums and we had the following exchange:

Just on that last point about building trust and respect, do you agree with this proposition; it takes time to build trust and respect between clinicians. Do you agree with that?---*Yes, it does.*

The longer you work with someone, the better able you are to communicate openly with them?---*Absolutely.*

²⁷⁵ ts 18.02.21 (Smith), p234

²⁷⁶ ts 18.02.21 (Saharov), p187

Is it more difficult in circumstances where you have a lot of locum ...staff that are coming into the hospital and going out? It is difficult in those circumstances to build that trust and respect?---*Yes, absolutely, and I think in a fluctuating workforce is...a...huge challenge to not only Western Australia, but...to...the rural parts of Australia in general.*

I'm not critical of Broome Hospital for using locum staff. Locum staff are better than no staff, but, in a perfect world, would you agree with me that if you could have a more stable population of medical staff, particularly senior medical staff, then trust, respect issues, communication issues are going to necessarily be enhanced?---*Yes. It's...only going to be easier. But on...the other hand, establishing...from...the beginning and acknowledging the fact with a fluctuating workforce, that it is a challenging and...difficult to build that trust over a very short period of time. That time needs to be utilised...to build trust right from the beginning...and set...the ground rules or ground culture, so to speak.*²⁷⁷

246. In general terms, I am not critical of the use of locum staff by BH, in the sense that locum staff are better than no staff at all. However, I am concerned about the implications of relying on locum staff as opposed to recruiting and retaining staff that reside in the local area on a permanent basis.

247. In this case, Dr Ranasinghe was a locum and had only been at the hospital for five days when he became involved in Mr Churchill's care. His status as a locum surgeon did create issues. First in terms of his familiarity with local procedures (e.g.: the formal CT scan issue)²⁷⁸ and second in terms of the rapport he had been able to develop with other staff. Dr Saharov gave evidence that he was unwilling to challenge Dr Ranasinghe's clinical opinion on the basis that they had not developed a working relationship.²⁷⁹

248. For those types of reasons, it is my view that it would be preferable for the use of locum staff at BH to be kept to a minimum and for current staffing levels to be reviewed.

²⁷⁷ ts 18.02.21 (Schlueter), p200

²⁷⁸ ts 17.02.21 (Ranasinghe), pp12-13 & 18 and

²⁷⁹ ts 18.02.21 (Saharov), p185

RECOMMENDATIONS

249. In light of the observations I have made in this matter, I make the following recommendations:

Recommendation No.1

For the guidance of clinicians, Western Australian Country Health Service (WACHS) should, as a matter of priority, develop a policy for the use of point of care ultrasound (PoCUS), including FAST scanners. The policy should set out minimum education, training and credentialing requirements for practitioners using PoCUS as well as guidance as to the appropriate clinical circumstances in which PoCUS should be used.

Recommendation No.2

WACHS should amend its Health Records Management Policy to provide guidance to staff as to exactly what constitutes a medico-legal report and why such documents may not appear on a patient's health record.

Recommendation No.3

WACHS should amend its Health Records Management Policy to provide that, as a general rule, entries made by clinicians in or for a patient's health record are not to be removed, left unfiled or deleted. Where the person in charge of a health service determines that a clinician's entry is to be removed from, or not placed in a patient's health record, that person should clearly document (in the relevant health record), exactly what has been removed or not placed on the patient's medical record and the reasons for that decision, having regard to any issues of legal professional privilege that may attach to the document. Further, any document containing a clinician's entry that has been removed or not placed on a patient's health record should be retained by the relevant health service.

Recommendation No.4

WACHS should take steps, including the provision of training, aimed at improving communications between clinicians involved in patient care. In particular, WACHS should ensure that in a situation where clinicians disagree as to the management of a patient, there is a process in place to resolve that disagreement in a timely and efficient manner.

Recommendation No.5

WACHS should amend its Clinical Escalation Including Code Blue – Medical Emergency Response Policy to provide that the role of Medical Emergency Response Team Leader is clearly identified at the start of the Medical Emergency Response call and thereafter when that leadership role changes.

Comments relating to recommendations

250. After reviewing the available evidence, I determined that it would be appropriate to make five recommendations. It is my practice to forward a draft of any recommendations I intend to make to interested persons appearing at an inquest and invite comment.

251. In accordance with that practice, on 10 March 2021, Mr Will Stops (counsel assisting) forwarded a draft of the above recommendations to counsel for WACHS, Dr Ng and Dr Ranasinghe.²⁸⁰ Dr Ranasinghe had no comment about the recommendations.²⁸¹ Dr Ng made submissions about recommendation 3,²⁸² and WACHS made submissions about recommendations 1 and 3.²⁸³ I carefully considered those submissions and made what I considered were appropriate amendments to my draft recommendations.

²⁸⁰ Email - Mr W Stops (10.03.21)

²⁸¹ Email - Mr S Denman to Counsel Assisting (16.03.21)

²⁸² Email - Ms M Naylor to Counsel Assisting (18.03.21)

²⁸³ Email - Letter SSO to Counsel Assisting (19.03.21)

CONCLUSION

- 252.** Mr Churchill was a 68-year old man who was admitted to BH on 27 October 2017. He underwent a procedure to remove his inflamed gallbladder and thereafter, he developed dangerously low blood pressure. Two causes for his unstable condition were considered, namely sepsis and blood loss. Unfortunately, it took some time for Mr Churchill's treating team to conclude that blood loss was more likely and therefore, that the risk of returning him to the operating theatre to address this issue was justified.
- 253.** On the basis of the available evidence, I concluded that Mr Churchill's treating team should have identified blood loss as the more probable explanation for his unstable condition at an earlier point than they did. Although it would clearly have been preferable for Mr Churchill to have been returned to the operating theatre at an earlier stage, on the basis of the evidence before me, it is not possible to quantify the effect that this delay may have had on his prognosis, especially given his co-morbidities.
- 254.** I found that the cause of Mr Churchill's death was surgical complications following laparoscopic cholecystectomy for cholecystitis. For the reasons I explained, I found that his death occurred by way of misadventure.
- 255.** In this finding I also addressed the quality of the documentation in Mr Churchill's medical record and what should have happened when a clinical record prepared by Dr Ng was removed from that record. I have also referred to issues of communication and leadership during medical emergency calls and as a result of my observations, I have made five recommendations, which I hope will be embraced.

MAG Jenkin
Coroner
26 March 2021