IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4552

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**ROBERT HUMPHREYS**
Findings of:	**CORONER PETER WHITE**
Delivered on:	19 November 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	5, 6, 7, 8 and 9 March 2018
Counsel assisting the Coroner:	Sergeant Weir, Victoria Police

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Coroners Case number 4552 of 2015

Inquest into the death of MR ROBERT MICHAEL HUMPHREYS

CORONER PETER WHITE

Held, in Melbourne on the 5, 6, 7, 8 and 9 March 2018.

Key words.

Post-surgery management of a paralytic ileus condition in a 71 year old man recovering from an open, Juxta renal, Abdominal Aortic Aneurism repair.

Representation

Mr Mukherjee of Counsel for the family of MR ROBERT MICHAEL HUMPHREYS

Mr Halley of Counsel for Cabrini Health

Mr Bourke of Counsel for Dr Cox

Mr Robertson of Counsel for Nurse Xue

Sergeant Weir, Coroners Assistant.

COURT

I find that Mr Robert Michael Humphreys aged 71 years, died at Cabrini Hospital on 7 September, 2015,

From, 1(a) ASPIRATION

(b) PARALYTIC ILEUS

(c) RENAL INJURY

(d) CONVALESCENT PHASE OF ABDOMINAL AORTIC ANEURYSM REPAIR

In the following circumstances:

BACKGROUND

1. Mr Robert Humphreys (Mr Humphreys) was a 71-year-old man diagnosed with 7.2 centimetre asymptomatic abdominal aortic aneurysm (AAA) in 2015. The diagnosis was the result of an incidental discovery during an ultrasound for urinary symptoms.
2. After confirming the size and location of Mr Humphreys AAA using a Computerised Tomography (CT) angiogram, vascular surgeon, Dr Geoffrey Cox (Dr Cox), decided the most appropriate method of repair was by way of open surgery. In light of the increased risk of cardiovascular disease to patients diagnosed with AAA, Dr Cox referred Mr Humphreys to a cardiologist, Dr Victor Wayne, who ultimately assessed Mr Humphreys as fit for surgery.
3. On 26 August 2015, the surgery was performed at Cabrini Hospital with Mr Humphreys being admitted postoperatively to the Cabrini Intensive Care Unit (ICU) for two days before being discharged to the ward.

4. Mr Humphreys' postoperative recovery phase was complicated by an acute kidney injury reflected in reduced urine output and significant derangement in electrolytes. This was treated by an infusion of diuretic frusemide.
5. On 27 August 2015, clear oral fluids commenced with the return of bowel sounds and the nasogastric tube was removed. On 31 August 2015, medical records suggest that Mr Humphreys complained of an uncomfortable distended abdomen.
6. By 2 September 2015, Mr Humphreys was believed to have an ileus,[1] exhibiting symptoms such as abdominal distention, discomfort and vomiting green fluid. The intake of oral fluids ceased at this time, although the nasogastric tube was not re-inserted. Sips of fluids were recommended the following morning when bowel sounds were heard.
7. Nine days following surgery, on Friday 4 September 2015, Mr Humphreys was referred to a dietitian for review. The dietitian assessed him as mildly malnourished due to inadequate oral intake related to the dietary restrictions due to the ileus. At this stage, he commenced 'Resource' dietary supplements to provide high energy and high protein fluids.
8. From 3 September 2015 into the few days which followed, Mr Humphreys intermittently vomited with his abdomen appearing to remain distended. Pain relief was administered to treat his ongoing pain and discomfort.
9. **There was a plan for his discharge to rehabilitation on 5 September 2015 before returning home. During the day of 6 September 2015, he was reluctant to eat and drink and was on occasion faecal incontinent. He was also experiencing nausea and vomiting.** Biochemistry blood tests showed a raised serum creatinine, urea and low bicarbonate.
10. A blood pressure reading of 113/60 mmHg in the morning prompted nurses to withhold the administration of perindopril and anti-hypertensive medication. He was treated with intravenous fluids and IV anti-emetics.[2]
11. Under Dr Cox's plan, Mr Humphreys was due to be reviewed the following morning. At 1.00am he requested a shower and was assisted by a nurse in doing so. Later, at 2.00am, he became agitated and requested the administration of oxygen.
12. At 3.20am Mr Humphreys was found collapsed and unresponsive on the floor, two minutes after a nurse had left him to answer a call bell. Cardiopulmonary resuscitation (CPR) was commenced, which was ultimately unsuccessful and he died 30 minutes later when CPR ceased.

FORENSIC INVESTIGATION

13. Senior Forensic Pathologist, Dr Malcolm Dodd, conducted a full autopsy examination and post-mortem CT scan at the Victorian Institute of Forensic Medicine (VIFM) and determined that the immediate cause of death was one of aspiration of gastric content in a man who has developed paralytic ileus in the

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[1] The medical term for a lack of movement somewhere in the intestines that leads to a buildup and potential blockage of food materials, which can also lead to an intestinal obstruction.
[2] Anti-emetics are anti-nausea and vomiting medications.

context of being in the convalescent phase of an abdominal aortic aneurysm (AAA) repair.

14. The leading cause of death was one of aspiration leading to hypoxic cardiac arrest. Dr Dodd noted that ***Is.***[3] *[a] considerable amount of gastric material was identified within both major and minor airways* and that the *examination of the abdominal viscera disclosed extensive distention of both small and large bowel with conspicuous fluid levels.*

BROAD ISSUES

15. The primary issue identified for examination was the adequacy of postoperative medical management provided to Mr Humphreys in the period following his transfer from the ICU to the ward until his death some nine days later.

EVIDENCE

Dr Malcolm Dodd[4]

Coroner White:

16. Dr Dodd is a Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM). On 9 September 2015, he performed an autopsy on the deceased. Dr Dodd read his statement regarding the results of the autopsy. Those matters are summarised at paragraphs 13-14 above.[5]
17. Dr Dodd explained the terms *torsion* refers to the twisting of the bowel causing an obstruction; and *intussusception* denotes when one part of the bowel *more of less telescopes into another part of the bowel so it sort of becomes drawn inwards on itself causing obstructions...*[6] Dr Dodd went on to say that intussusception was *quite a rare phenomenon so the bowel moves in an action called peristalsis so it constricts and pushes material along in a forward direction.*[7] Sometimes such things as nodules, polyps or thickenings in the bowel get pushed through, causing the bowel to behave like a telescope, where part of the bowel slides inside the other. While the bowel can be withdrawn again it constitutes a form of obstruction.[8]

18. **The conclusion drawn by the identification of aspirated gastric material into both the major and minor airways is that fluid has made its way into the tissue of the lung itself. This means the very small bronchial tubes and the alveolar air spaces have been filled with aspirated gastric material as was identified under the microscope. This is relevant to the primary cause of**

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[3] Medical Examiner's Report (MER), 11.
[4] See the statement of Dr Dodd, including accompanying CT images, in Exhibits 1 and 1A-H.
[5] The statement of Dr Dodd is also represented in full by the Medical Examiner's Report (MER) in the Coronial Brief.
[6] Inquest into the Death of Mr Humphreys Michael Humphreys, Coroners Court of Victoria, (Coroner White) 5-9 March 2018, (*Transcript*) 2.
[7] Transcript, 2.
[8] Ibid.

death in this case as it demonstrates the aspirated material was not only in the large airways but flooded his lungs as well.[9]

Coroner's Assistant Sergeant Weir:

19. The external examination showed the deceased's abdomen was distended and *fluctuant*; meaning that when palpated the fluid inside the abdominal cavity can be felt. This can be seen within the CT imagery,[10] which is taken on a primarily horizontal plane showing the gas and fluid levels. ***In other images dilated loops of the small and large bowels are visible as well as the gas and conspicuous fluid levels. The autopsy verified the finding of paralytic ileus.***[11]

Mr Bourke:

20. The definition of an ileus is a non-mechanical obstruction of the bowel ***so that the bowel literally shuts down… Peristaltic waves cease to occur, the bowel dilates, becomes fluid filled until it potentially reverses itself, and it can affect virtually the entire gastro-intestinal tract, predominantly [the] stomach more than the large bowel.***[12]

21. The reversibility of an ileus fundamentally depends upon the cause of the ileus, which could be many. The causes can include but are not limited to: general anaesthesia, handling of the abdominal organs during an intra-abdominal procedure, electrolyte disturbances, a decline in renal function, or ischemia.[13]

22. Dr Dodd, in forming the views expressed in his statement, had, in addition to the autopsy, the benefit of the pre-mortem CT scans, toxicology reports, biochemistry results, the Form 83, the medical deposition as well as a physical examination of Mr Humphreys. Dr Dodd had not previously had access to the clinical notes from the hospital.

23. Mr Bourke put to Dr Dodd that the post-mortem CT imaging was not necessarily inconsistent with a resolving ileus; in particular with the frequent diarrhoea demonstrating that material was travelling through the bowel. Dr Dodd answered:

    I'm not sure if I can comment. The passage of diarrhoea just might be the fact that the bowel is so distended, at some point it just releases its content. That is perceived to be a bout of diarrhoea, it may not be due to peristaltic bowel action…[W]hat I'm saying is if the bowel is sufficiently distended it may just release its content, if the sphincter weakens somewhat, the very runny fluid material, rather than being solid faecal material could easily evacuate from the patient, and that would be put down in the notes as diarrhoea, it might not be active peristalsis returning at that point, it might just be the bowel emptying itself under gaseous pressure, and the fact that its predominantly fluid there and

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[9] Transcript, 3.
[10] Tendered and marked as Exhibits 1A-H.
[11] Transcript, 5-6.
[12] Transcript, 7.
[13] Transcript, 7-8.

there's very little control, it may not have active bowel movement behind that action.[14]

24. Mr Bourke further questioned Dr Dodd on whether he was able to make a comment concerning whether fluid was passing from the small bowel into the large bowel, and if it was, whether that might be considered an active bowel to that extent. Dr Dodd answered that he could not comment on whether the fluids represented any bowel movement:

    What happens with an ileus in particular is that the bowel becomes literally paralysed and it distends and you may not necessarily have muscular action pushing fluid through, it may just simply fill under gravity... So you have distended bowel and it will just trickle down like a water fountain in some ways, find its next level.[15]

25. **Dr Dodd acknowledged that the post-mortem examination itself could not differentiate between an ileus and a resolving ileus.**[16]

Mr Mukherjee:

26. **Dr Dodd stated that he remained confident that the state of the paralytic ileus was underlying what caused Mr Humphreys' aspiration, and ultimately his death.**[17] On the basis of their being no mechanical obstruction present, Dr Dodd identified this as a paralytic ileus. Dr Dodd agreed that the pre-mortem CT scan disclosed, ***gross gaseous distension of the small and large bowel,***[18] which is illustrated particularly in Exhibit 1(f), the sagittal plane image. This observation was, in the initial stages of the finding, not necessarily connected to the conclusion of paralytic ileus, but noted as a marked distinction. That distinction may have had '*causes yet undisclosed*' but after completing the examination and determining that there was no obstruction, **it fell into the category of paralytic ileus.** This can also be said of the marked distension of the all the small bowel loops and distension of the large bowel; without the presence of a mechanical obstruction, a paralytic ileus would be the deductive diagnosis.[19]

27. Dr Dodd also agreed that the distension was not subtle but clearly marked. **The CT scans further indicate that large amounts of gas and fluid filling the some parts of the bowel, with other areas showing conspicuous fluids**. The bowel is demonstrably static. Signs of movement would appear as areas of the bowel which would be collapsed on itself, *because the peristaltic waves are moving things along, so they'd be inconspicuous little doughnuts, doughnut-shaped images, some would have a little bit of gas, some of them a bit of fluid. All of these are just dilated, just yawning, lax, open and dilated.*[20]

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[14] Transcript, 10-11.
[15] Transcript, 12.
[16] Transcript, 12-13.
[17] Transcript, 13.
[18] Transcript, 15.
[19] Transcript, 16-17.
[20] Transcript, 19.

Mitchell Thomas Humphreys

Coroner White:

28. Mitchell Humphreys (Mitchell), the son of the deceased, gave evidence that his father lived in Cann River, a small country town approximately 450 kilometres from Melbourne in East Gippsland. Mitchell and his sister were born and raised in Cann River where his father owned the timber mill and employed around 60 people of the 500-person population. Mr Humphreys started working in the mill with Mitchell's great uncle as an 18-year-old and gradually took over the business and opened mills in the surrounding towns in Wangara, Orbost, Club Terrace as well as Cann River.

Q: *And so he's someone who has devoted a lifetime's work to this particular industry?*

Ans: *Not just the industry, to the town. My father was heavily involved in some major bushfires. He co-ordinated a lot of the major bushfires [fighting efforts]. He co-ordinated a lot of the major bushfires [fighting efforts] that occurred down in East Gippsland. He was very community orientated. He built the kindergarten. He was sort of, I suppose, a quasi-mayor of the town. Very involved in the school as well.* [21]

Q: And what was his domestic situation at this time? Who lived in the household?'

Ans: *My father has a house in Cann River at which he was co-ordinated with timber mills during the week. He would then drive up and live with my mother at Tura Beach which is just out of Merimbula in New South Wales. They'd spend the weekends together playing golf and socialising and then Mum would ship Dad back to Cann River to proceed to work and that was their life.*[22]

29. Mitchell attended the hospital each day after his surgery to check on his father's health.[23]

30. Mitchell and his partner, Ms Tanya Strik, visited the deceased at approximately 5.40pm on 6 September 2015 and noticed a marked deterioration. In his statement he notes:

'He was disorientated, struggling to focus and slurring his words. Tanya tried to help him eat. He had a small amount of soup and sorbet. Tanya and I both discussed how unwell my father seemed.'[24]

31. Mitchell took photographs of his father's legs, the skin on which appeared quite mottled.[25] He took the photographs prior to his conversation with Dr Cox. Mitchell texted the images to his sister who was a qualified nurse with over 20

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[21] Transcript, 69.
[22] Transcript, 70.
[23] Exhibit 2: Statement of Mitchell Humphreys & Transcript, 29.
[24] Ibid.
[25] Exhibit 2(a).

years' experience. She urged him to bring it to the attention of the in charge nurse, Jean Bowes (Nurse Bowes) who then contacted Dr Cox.[26]

32. Mitchell confirmed that prior to Nurse Bowes' conversation with Dr Cox, she examined Mr Humphreys, touching his legs to establish circulation and listening to his breathing to hear the catching. At that stage, however, Mitchell described Mr Humphreys as *'quite out of it'* and was more concerned about his exhaustion and shortness of breath. Mitchell wasn't sure if Mr Humphreys had noticed the mottling of the skin on his legs.[27]

Mr Mukherjee:

33. Mitchell had last seen his father the day before sometime during the mid-morning. Saturday morning during his visit the deceased has seemed coherent, they were able to converse about the events of the weekend and they discussed Mitchell's children. The deceased told Mitchell he was not able to eat much lunch and they discussed his frustration about not being able to hold anything down:

    He wasn't able to keep anything down, or even eat anything. He was having issues with his breathing and issues with his throat... But we were able to converse in a manner of where he was able to indicate to me how he was feeling, and he was getting extremely frustrated and tired, but he was still very lucid, he was still very conversive with me on Saturday.[28]

34. Mr Mukherjee asked: *...You mentioned he was having difficulty with his diet. Does that mean he was having trouble eating food and had been for a few days by the time of that Saturday morning?*

    Ans: *I wasn't just troubled with him eating food, I wasn't even willing to bring my children in on that day because of the smell in the room, given how many times he was passing, um, how many times either trying to get to the toilet or attempting to get to the toilet...[trying to defecate]. So the smell was quite overpowering to the point where he was feeling, starting to feel very frustrated and distressed about it...But he was able to communicate that with me.*

    Q... *So Saturday morning you said earlier that he was having trouble eating food and that had been lasting for a few days, is that correct?*

    Ans: *That's correct...[H]e was getting more and more frustrated because initially after the operation... he was able to eat, only a small amount, but he was able to eat. But as he became more and more uncomfortable and he did discuss the fact that his stomach was giving him a lot of trouble in relation to how bloated it was becoming, but also his inability to try and hold things down.*

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[26] Transcript, 29.
[27] Transcript, 43.
[28] Transcript, 31.

Q: *Your father reported to you that his stomach was bloated. Did he say how long it had been bloated for?*

Ans: *No, he expressed that he's been bloated for some time and you could even tell, it was rock hard.*

Q: *On the Saturday morning did you feel, did you touch your father's stomach?*

Ans: *Yes...It was like feeling a rock.*

Q: *And had it been like that before?*

Ans: *No*

Q: *Before his operation?*

Ans: *No. He was always a big man, Your Honour, and he had had a stomach stapling many years ago, but the softness of the stomach versus what I felt was ... with my minimal experience, was quite different.*[29]

35. When Mitchell visited his father the following day the 6th of September, he noticed that he had significantly deteriorated.

Q: *What had got worse in terms of what you've described?*

Ans: *Dad was almost incoherent in the way he communicated with us, he was extremely weak.*

Q: *In what way was he incoherent, could he make full sentences, could he communicate?*

Ans: *No, he was struggling to identify Tanya when we first arrived. It took him a while to get his focus even on me, to the point of recognising me. He was exhausted and his breathing, and his breathing catching got quite a lot worse...[I]t was very concerning, which we raised, and he was very uncomfortable about even being able to move up off the bed to get into a sitting position let alone get up and able to get to the toilet at that point.*

Q: *What can you tell us [about] how well he could eat?*

Ans: *Um, he really struggled to keep any food down. Tanya had...a little plastic bowl with some sorbet and some ice cream in it... [T]here was no solid food.*[30]

36. Mitchell was agitating with the charge nurse, which was followed by contacting Dr Cox at this stage, while Tanya continued to try to feed small amounts to his father, although he did not actually see the food being swallowed. Mitchell spent most of the visit on this night out of the room.[31]

37. Mr Humphreys was having trouble keeping things down in the sense that, the fluids and/or food kept dribbling out of his mouth. Mr Humphreys struggled to

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[29] Transcript, 31-4.
[30] Transcript, 34-5.
[31] Transcript, 35.

swallow anything because of the pain he was experiencing and the gasping noises he was making, which was raised with the charge nurse.[32]

38. Mitchell did not look at his father's stomach again because he was more concerned with what he could see of his father's legs. The main focus that evening was his father's fatigue and disorientation. His face had become extremely puffy and Mitchell was concerned by the appearance of his legs. The appearance of his legs was different from Saturday.[33]

39. The in charge nurse, Sister Jean Ray Bowes (Nurse Bowes) was called in to look at Mr Humphreys. Mitchell also asked her to call Dr Cox:

Q: *What did you say?*

Ans: *I said that I was extremely concerned about my father's condition. I said that he shouldn't be left unattended at all, um, he needed more care. I don't think I used the word intensive care. I'm not medically savvy. It was along the lines of he definitely needs somebody with him at all times.*[34]

Q: *Did Nurse Bowes call Dr Cox, as far as you can tell?*

Ans: *Yes, Nurse Bowes called Dr Cox in front of the charge nurse's station... [T]he phone call was around our concerns in relation to my father, um, I believe, but again it was – I couldn't hear Dr Cox... [M]y understanding was that Dr Cox was there instructing some additional tests to be conducted the following day.*

Q: *What information did Nurse Bowes convey to Dr Cox in your presence?*

Ans: *She conveyed, to my knowledge, and again I'm not medically savvy and I think that sort of a dialogue can go along without remembering exactly the detail but it was along the lines of my concern in relation to my father's throat, in catching it, and in relation to his legs...I believe she may well have even spoken about chart records and bloods...*

Q: *Was there any conversation by Nurse Bowes to Dr Cox about your father's inability to eat or his lack of ability to eat?*

Ans: *No, not from my memory.*[35]

40. By approximately 8.30pm or 9.00pm, Mr Humphreys asked both Mitchell and Tanya to leave so he could get some rest and because he could see how upset and agitated Mitchell was becoming.[36]

41. Nurse Bowes relayed to Mitchell that Dr Cox did not think it was necessary to come in that night, and that he would be coming in the following morning and

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32 Transcript, 35.
33 Transcript, 35.
34 Transcript, 36.
35 Transcript, 37.
36 Transcript, 38.

ordering further tests. At that time Mitchell became more agitated with Nurse Bowes and concerned about the level of care his father could expect that night.[37]

42. Mitchell saw his father each day after his operation and witnessed Mr Humphreys' health deteriorate rapidly over the three days prior to his death. Two days after his operation (just following his release from ICU), Mr Humphreys was able to sit up and take himself to the toilet. He was communicating well and looking forward to getting well. Mr Humphreys relayed to Mitchell that he had been advised at that point that everything was going well and if his progress continued he would be discharged in a couple of days.[38]

Mr Halley:

43. The last phone call Mitchell had with his sister that night he estimates was between 8.30pm and 9.00pm out the front of the hospital when he was leaving. He was quite distressed. He asked his sister to try to make contact and agitate for additional escalation of his father's care.[39] In later discussions about the matter between Mitchell and his sister, she did not specifically tell him that the charge nurse had offered to escalate the matter to a medical registrar, but his sister told him that *she was being guided by the nurse.*[40]

44. Mitchell acknowledged that he believed the charge nurse had told him that Dr Cox was in Morwell at the time, but it could have been another hospital staff member.[41]

45. Mitchell confirmed in his evidence that it was his view at the time that his father seemed incoherent and distressed, despite Nurse Bowes' statement suggesting Mr Humphreys did not appear incoherent or distressed. Mitchell also confirmed his evidence that he found Nurse Bowes dismissive of his request to send the photographs of his father's legs to Dr Cox.[42]

46. Mitchell agreed that Nurse Bowes had relayed that it was unnecessary to send the images of Mr Humphreys' legs as she had adequately made Dr Cox aware of the leg problems.[43]

Mr Bourke:

47. On Saturday 5 September 2015, Mitchell recalls visiting his father during the mid-morning but did not recall seeing Dr Cox during that visit. Mr Bourke put to Mitchell Dr Cox's recollection that Mr Humphreys was doing sufficiently well that day to contemplate a discharge as early as Monday 7 September 2015. Mitchell recounted in response that during that morning that, *my father had had a*

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[37] Transcript, 40-1.

[38] Transcript, 43.
[39] Transcript, 49.
[40] Transcript, 51.
[41] Transcript, 52.
[42] Transcript, 52.
[43] Transcript, 53.

huge incident, I believe, on the Saturday morning, where he had an extremely messy diarrhoea or movement that had basically gone all over the room and all over the floor.[44]

48. Mitchell stated that, *based on that and how uncomfortable he was and the fact that I didn't bring my children in for the rest of that weekend, it wasn't my view that he was in any condition to be leaving.*[45] Mitchell did not witness the incident but received a text message from his father explaining it, and informed that the room was still being cleaned up when he (Mitchell) arrived.[46]

49. Mitchell did not recall having a conversation on Saturday 5 September 2015 with Dr Cox where the doctor opined that Mr Humphreys appeared to have improved sufficiently to discharge him on Monday 7 September 2015 into Mitchell's care. Mitchell acknowledged there was a less formal conversation about discharge with his father and/or perhaps nursing staff about being discharged to Mitchell's home to make it easier to get to any further rehabilitation appointments or care.[47]

50. Mr Bourke put to Mitchell that Dr Cox would give evidence that he was not in Morwell on Sunday 6 September 2015.

51. Mitchell was not aware of whether Dr Cox had attended his father earlier on the afternoon of 6 September 2015, only that his father had been prescribed Lomotil by Dr Cox according to the nurse. Nor was he aware that Dr Cox had seen his father the previous day. Mr Bourke put to Mitchell that had he been aware that Dr Cox had seen Mr Humphreys both on the Saturday and earlier on the Sunday that he would have gained more comfort from the information conveyed from Nurse Bowes' phone conversation with Dr Cox that he would see Mr Humphreys the following morning:

    Ans: *I may well have had a comfort around seeing him the next morning but that wasn't when I wanted him to be seen. I wanted him to be seen that evening and under much insistence by me I requested that somebody see him because I could see how visibly distressed he was and how much his condition had diminished in the time that I'd seen him previously.*[48]

Tanya Strik

Coroner's Assistant Ms Weir:

52. Tanya Strik (Tanya) is the partner of Mr Humphreys' son, Mitchell. She is a Victoria Police member of 20 years' experience.[49]

53. Tanya adopted her prepared statement in her evidence to the court save for a chronological change, which should reflect her evidence as being that *'Mitch took*

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[44] Transcript, 60.
[45] Transcript, 60.
[46] Transcript, 61.
[47] Transcript, 62-3.
[48] Transcript, 67-8.
[49] Transcript 74-5, 78.

a photo of Poppy's legs' after Nurse Bowes' examination of Mr Humphreys and after Nurse Bowes' conversation with Dr Cox on 6 September 2015.[50]

54. Tanya confirmed that she was present when Mitchell took the photographs, contained in Exhibits 2(b) and (c), of Mr Humphreys on 6 September 2015.[51]

<u>Mr Mukherjee:</u>

55. Tanya visited Mr Humphreys on both 3 September and 6 September 2015 and noticed a change in his condition from her first visit to her second visit. She did not notice Mr Humphreys having been fitted or using a nasogastric tube on either occasion.[52]

56. On 3 September 2015, on her visit with Mr Humphreys, Tanya gave evidence that he seemed okay,[53] but that she noticed a different colour to his skin. Although Mr Humphreys was in bed and not mobile at that stage, he conversed normally and even made jokes. He asked Tanya to look at his iPad because he was having trouble with his emails. Mr Humphreys was coherent in speech.[54]

57. Tanya confirmed that Mitchell was concerned and had told her something of the difficulties Mr Humphreys had been experiencing after the operation such as needing to go to the toilet quite a lot and *'explosions'*:[55]

    Q: *Just to be clear...explosions, and that's defecation you're talking about?*

    Ans: *Yes... [A]nd Mitch was just worried about it because it was becoming so distressing for Poppy.*[56]

58. Tanya also reiterated that on her first visit she noticed Mr Humphreys' skin, *has like a light yellow tinge to it, which was a little bit different to what I know Poppy to look like.* [57]

59. Further on her first visit, Tanya was not aware of any problems Mr Humphreys was having to do with vomiting. She did not recall whether she saw Mr Humphreys eating any food during that visit.[58]

60. On 6 September 2015, Tanya visited Mr Humphreys a second time, arriving with Mitchell. Her evidence was that Mitchell told her the day before that Mr Humphreys, *[h]ad showered eight times because he couldn't stop pooing and had vomited. Mitch told me this had happened over 20 times in a day:'*[59]

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[50] Transcript, 75; In her statement, Exhibit 3, the photo taking should be placed after the paragraph which ends *'...hadn't slept much'* and before the paragraph which begins *'Mitch asked if he could send the photo...'*.
[51] Transcript, 76.
[52] Transcript, 77-8.
[53] Transcript, 78.
[54] Transcript, 78.
[55] Transcript, 78-9.
[56] Transcript, 79.
[57] Transcript, 79.
[58] Transcript, 79.
[59] Transcript, 80.

Was this something that you had an opportunity to witness when you saw Mr Humphreys on that Sunday?

Ans: *...Well, to walk into the room, it just – it was just – it just smelt terrible... It smelt like something was rotting, it was awful... And we tried to ignore that because we didn't want to embarrass him.*

Q: *Did you see a deterioration in Mr Humphreys condition from the Thursday to the Sunday?*

Ans: *I saw a major deterioration from the way he was on Thursday to Sunday.*

Q: *'Could you describe the features of that deterioration to His Honour?'*

Ans: *'... [T]he first thing was that I went up and kissed him on the forehead because it was Father's Day, and I know him very well, I had a really good relationship with him... And he just stared at me like he didn't know who I was and I stroked his face and said, 'It's me Poppy, it's Tanny' and he didn't recognise me, and I got concerned and I said to Mitch, '[h]e doesn't know who I am'. And so the first thing was that, he was quite disorientated, he was sort of looking at the lights and looking up and he just wasn't himself.*

Q: *Did he recognise you after you spoke to him?*

Ans: *Yes, after a little while, probably... after about five minutes because Mitch went over as well, and he sort of got his bearings again.*[60]

61. Tanya had been part of the family structure for about 10 years. She and her two children were treated as part of the family and regularly spent holidays together at a house in Tura Beach. She estimated she would see Mr Humphreys more than a few times a year: each major holiday and whenever he was in Melbourne:[61]

Q: *Is there anything else about the disorientation that you can tell us?*

Ans: *It wasn't just me, it was his surroundings, he was just like – he was looking around, he didn't seem to recognise Mitch first up either... And he was laying down, he hadn't been asleep, he was awake when we walked in... his eyes were open, I hadn't woken him up or anything... [B]ut as I said, that got a little better as the time went on that we were in the hospital.'*

Q: *You talk about the skin being a deeper yellow...What can you tell us about that from the change you saw from Thursday?*

Ans: *... I only noticed his face on Thursday because I didn't really – he was in bed most of the time that I was there on the Thursday night, but on the Saturday his face was, not just his face, it was his arms as well, he just looked – his skin was changing colour... didn't expect it.*

Q: You then go onto say that he asked for a drink of water, you poured it for him and he took a few sips but couldn't really have much. What do you mean by [that]?

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[60] Transcript, 80-1.
[61] Transcript, 81.

Ans: *So I only gave him a very, very small amount, and the way I probably qualify is, I'm a mum, and I know that if you're looking a bit dehydrated, even just a little drop, a few drops is going to help you feel a little better straight away... I had to put it up to his mouth, it was probably all in all about a tablespoon of water he actually tolerated while I was trying to get it into his mouth, in little tiny sips... And I just want to get...a bit of moisture in his mouth again.*

Q: *Your partner recalled that at one point you were trying to feed him soup and sorbet, do you recall that?*

Ans: *Yes, I do... [B]y then he was sitting up in bed, when the tray table came we put him up in bed, so he was sitting upright, and I was pretty much trying to force him to eat, because the meal had come, and he wasn't really drinking much, and I just got little teaspoon sized portions and was just trying to put little bits in his mouth but... he didn't really want to eat. It was me that was trying to make him eat.*

Q: *Did he say he didn't want to eat or was it that he was having difficulty eating?*

Ans: *Well, it was both. He was having difficulty, so every time, especially with the water, when he had a sip of water, which I thought was a bit strange, he was like going like (demonstrating) like trying to catch his breath when he swallowed...[B]ut, I knew it was important to have water, so it was good that the sorbet was there, because that was similar to water, so he was doing the same sort of thing, trying to catch his breath, and he shook his head, because I said, 'Do you want something else?' And I was trying to give him something, and he shook his head and didn't want to take anymore.*[62]

62. Mr Mukherjee then directed Tanya to her statement at page 49 of the Inquest Brief which read:

    During the time we were in the hospital every 30-40 seconds, Poppy would catch his breath and looked as though he was frightened each time it happened.[63]

63. Tanya confirmed her recollection that Mr Humphreys would catch his breath as often as her statement suggests and that it was difficult for Mr Humphreys to consume even small quantities of soup and sorbet.[64]

64. Tanya confirmed in her evidence that she was alarmed by the appearance of the mottled-coloured skin on Mr Humphreys' legs, although she did not have an opportunity to see his legs on the first Thursday visit. She and Mitchell shared each other's concerns about Mr Humphreys' legs, breathing difficulties, disorientation and demeanour, his inability to eat and drink properly, as well as the number of trips he had made to toilet in the previous 24 hours.[65]

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[62] Transcript, 81-3.
[63] Inquest Brief into the circumstances of the death of Mr Humphreys Michael Humphreys *(Inquest Brief)* 49.
[64] Transcript, 84.
[65] Transcript, 85.

65. Tanya also agreed that something of the difference of appearance that she had observed was demonstrated in the images taken of Mr Humphreys found at Exhibits 2(a) to 2(c).[66]

66. Tanya additionally testified about the image Mitchell took of the mottling on the skin of Mr Humphreys' legs and that Mitchell told her... *he'd shown the nurse and then... he also showed her again while we were in the room when she came back a second time.'* [67]

67. Tanya gave further evidence that she was not present when Nurse Bowes called Dr Cox. She stayed in the room with Mr Humphreys during the whole visit, save for her leaving the room while he was taken to the toilet.[68]

68. Mr Humphreys, assisted by a nurse, went to the toilet once during Tanya's visit. Mr Humphreys' hospital room was a single occupancy room with a bathroom. Tanya returned to the room approximately ten minutes later when the nurse was helping Mr Humphreys back into his bed. Shortly after Mr Humphreys suggested they go and rest. She did not see Mr Humphreys attempt to eat anything further after she'd earlier attempted to feed him the sorbet and soup.[69]

69. When asked by Mr Mukherjee whether there was anything in particular she wished to bring to the Coroner's attention about Mr Humphreys' condition prior to his death she stated:

   ... [P]robably the main thing... is just the fluid intake. There just wasn't any – and I think in the back of my mind, after what... I was aware of with the amount of times poppy was needing to go to the toilet that he just wasn't getting enough fluids, which was why I was trying to get something into him.[70]

70. Mr Mukherjee went on to ask:

   Q: Were you witness to part of the conversation that took place between himself and the senior nurse present, Ms Bowes?

   Ans: Yes, I was in the room...with the nurse, but I wasn't at the nurse station. I stayed in the room.

   Q: Most of the conversation had taken place outside?

   Ans: ... [Y]es, it had but there was still a conversation that happened in the room... not long before we left.

   Q: Do you recall what was said in that conversation?

   Ans: Well... Mitch was trying to bring to the attention of the nursing staff what was happening because he wasn't sure that they were aware of what was happening so... we were both trying to point out... to the nurse about the

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[66] Transcript, 85-6.
[67] Transcript, 87.
[68] Transcript, 87.
[69] Transcript, 87-8.
[70] Transcript, 88-9.

breathing. For me it was poppy's legs that were really alarming so we asked her to have a look at them... and she did. It was very brief... [I]n terms of the breathing difficulties, the response from the nurse was...

Q: The same nurse?

Ans: Well, I actually don't know if it was the same nurse, in all honesty. I think there was actually two nurses from memory. That night my focus was completely on poppy and Mitch and... I'd be lying if I said it was one nurse. I actually don't know. Actually, in my mind I believe it was two nurses that came in.

Q: Do you recall becoming aware that [D]r Cox was not going to be called in that evening, or would not be attending that evening?

Ans: Yes.

Q: Where were you when that occurred?

Ans: I was in the room.

Q: Who was in the room with you?

Ans: Mitch and poppy.

Q: I see. So Mitch informed you of that?

Ans: Yes.[71]

Q: Did you have a sense of [why] he wasn't coming, he can't be here or did you have a sense of he isn't coming because his previous assessment doesn't indicate that that's needed?

Ans: ... I was of the understanding that...he didn't foresee that it was serious enough and that he was coming in the morning to check him.[72]

Q: Was there mention at any time that he had previously seen Mitch's father that day?

Ans: No.[73]

Mr Halley:

71. Tanya confirmed that a nurse or Nurse Bowes came in to see Mr Humphreys and examined his legs. The nurse told her that it was mottling that was visible on Mr Humphreys' legs. Tanya also gave evidence that the colour of the mottling was more purple than the photographs indicated. Tanya conceded that the nurse examining Mr Humphreys' legs in person would better be able to describe the appearance to a doctor rather than via a photograph but said:

... [T]he nurse is medically qualified so she's going to be able to describe it very well. However, in her description it might not – visually, it's probably a better

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[71] Transcript 89-90.
[72] Transcript, 90.
[73] Transcript, 91.

idea just to back up what she's saying so that she can – so the doctor can have a much better understanding of what the condition was:[74]

Q: But your evidence is that the photograph shows red mottling and it was in fact purple mottling?

Ans: It was...like bruising where it's not just one colour...It was mainly deep purples though...

Q: That photograph doesn't show that does it?

Ans: I think it does to a certain extent but from my memory it was deeper than that.

Q: ... She [Nurse Bowes] will say that she examined the legs in terms of the temperature of the legs and the peripheral pulses to show – see if there was peripheral pulses... [Y]ou're not medically qualified so would you be able to say whether she examined the pulses or not?

Ans: I can describe what she did. I don't know what it all meant but I can describe what she did... When she came into the room and Mitch and I were pointing it out, she put a hand over the top, just put it around – you know, she was asking poppy what he could feel and she said, 'Does it hurt', I think, he said no... [A]nd that was the extent of the examination.

Q: Well, she'll say that's not correct, that she actually felt the dorsum... or top of the foot and behind the ankle to see if there were any pulses present?

Ans: I don't recall that happening...

Q: You won't positively say that didn't happen, would you?

Ans: No, I can't positively say that but I can't recall it happening.[75]

72. Mr Halley went on to cross-examine Tanya about Mr Humphreys' breathing difficulties and the reporting of that issue to Nurse Bowes:

Q: The nurse says it's more of a – there was a catching or a difficulty swallowing rather than a difficulty breathing. Is that what you're really talking about?'

Ans: [T]hat is probably how I'd describe it as well because it's like a difficulty when he was swallowing and he was trying to catch his breath. It sort of came during... just 30 or 40 seconds but it was just sort of like that (indicating).'[76]

Q: And she says she actually gave him a sip of water and he was able to swallow that sip of water. Do you remember that occurring?'

Ans: Yes, I do.

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[74] Transcript, 92.
[75] Transcript, 92-3.
[76] Transcript, 93-4.

Q: You've said in your statement she asked Mr Humphreys whether he was in pain when he was swallowing, and he was able to answer the questions that she asked him?

Ans: Yes, that's correct, but in saying that, the sip of water, the nurses asked him… we wanted to show her what was happening so we got him to sip water because it was happening that way for us when we were trying to give him some and the reason he took the water was because… that's how it happens and he did catch his breath when she gave him the water.'

Q: Then there was an interaction, you say, between the nurse and Mr Humphreys senior in which he pointed to – and indicated that he was having some pain in his chest and that the nurse commented that that might be to do with the tube that he had down after the operation. Do you recall that happening?'

Ans: Yes, I do.

Q: Then the nurse did make enquiries about how much Mr Humphreys had been eating, didn't she?

Ans: Yes, that's right.

Q: And you told her exactly what he'd been able to eat and I presume that would have been the sorbet and you were trying to – soup that you had been feeding him?

Ans: Yes, very small amounts.

Q: And small sips of water?

Ans: Yes.

Q: And all those things happened when the nurse came to see Mr Humphreys?

Ans: That's right.[77]

73. Tanya confirmed that she was not present for the conversation the nurse had with Dr Cox and agreed that after the conversation with Dr Cox, the nurse returned to the room. She could not recall if Nurse Bowes was the nurse who came to the room each of the three times a nurse entered in her presence, but acknowledged it was the *'best possibility'* that it was Nurse Bowes each time. Tanya did not reject Mr Halley's proposition that Nurse Bowes did re-enter the room and that her evidence would be that she did so a further time at the end of her shift at 10pm. Counsel recognised this last visit would have occurred after Tanya and Mitchell had left the hospital.[78]

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[77] Transcript, 94-5.
[78] Transcript, 95.

Dr Peter Tomlinson

Coroner's Assistant Sergeant Weir:

74. Dr Peter John Tomlinson is a semi-retired general and vascular surgeon. Dr Tomlinson was asked by Mr Humphreys' family to provide an opinion as to the quality of the care provided particularly in the postoperative phase.[79]

75. Dr Tomlinson read his statement to the court, and in it expressed the general view that Mr Humphreys' postoperative care fundamentally suffered from a failure to recognise the symptoms and signs of a paralytic ileus:

    Mr Humphreys was correctly diagnosed, correctly treated with surgery but let down by inadequate postoperative care and neglect.[80]

76. Dr Tomlinson further noted in his statement:

    The symptoms and signs of a paralytic ileus are evident... Yet, there appears to have been no recognition of these symptoms and signs. A simple abdominal X-ray would on the balance of probabilities, revealed gastric and small bowel dilatation and the diagnosis would have been made. Even if there was no abdominal X-ray performed this was a clinical diagnosis and treatment should have consisted of bowel rest and intravenous nutrition. Bowel rest should have included a nasogastric tube connected to suction. Given the timeframe after surgery there should have been consideration to commencing intravenous hyper-alimentation.[81]

77. Dr Tomlinson was asked to elaborate on what is meant by the concept of *bowel rest:*

    Well, firstly, the nasogastric tube connected to suction and bowel rest. Having no content, either food or liquid, going down through the gut itself and actually suction to reduce any secretions passing through the [system], whether into the small intestine and being propelled along the elementary canal. When I mentioned intravenous nutrition...that's in the immediate post-operative period, fluid and electrolytes based on his requirements on a 24-hour basis.[82]

    Q: Through the gastric tube?

    Ans: No intravenously... I think the gastric tube should have been used for suction and partly resting... With the passage of time if his gut wasn't working, well the intravenous and nutrition should be of a more substantial nature, one would call with (word indistinct PW), some food hyper alimentation, that's the introduction intravenously into the blood stream of more substantial nutrients.[83] *.. I think after 7 to 10 days of no nutrition that would not have been unreasonable to think about, and I think in his statement Dr Westcott in his statement mentioned that timeframe as well.*

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[79] Exhibit 7: Statement of Dr Tomlinson (*Inquest Brief);* Transcript, 257.

[80] *Inquest Brief,* 40 (Exhibit 7, 4).

[81] *Intravenous hyper-alimentation* refers to the administration of nutrients by intravenous feeding.

[82] Transcript, 258.

[83] Transcript 258.

78. In relation to diagnosis, Dr Tomlinson further stated that having regard to the absence of a full record, I have the feeling that there was a 'rush' in the management of Mr Humphreys postoperatively. I feel that there should have been greater monitoring of and observation his postoperative gut and renal function... *The vomiting of loose stools, reduced oral intake and other symptoms... shows a distinct lack of care and appreciation of the presence of post-operative paralytic ileus.*

    Q: Assuming Dr Cox attended at midday on 6 September 2015 do you consider he should have attended on him again that afternoon or evening, based on his condition?

    Ans: Yes. The nursing staff were concerned about Mr Humphreys condition and requested review. Dr Cox should have responded and attended.

    Q: If yes, what should have been done during this review?

    Ans: Mr Humphreys was deteriorating with persistent symptoms and signs of a non-functioning gut due to a prolonged and persistent paralytic ileus. The measures described (above) should have been carried out.

    Q: If Mr Cox could not attend hospital that afternoon evening, do you consider that urgent review by another physician or admission to the ICU would have been appropriate.

    Ans: Yes.

    Q: Do *you consider that sufficient consideration was given to the risks of aspiration and paralytic ileus?*

    Ans: No... A competent vascular surgeon should have given consideration to a paralytic ileus and all the complications that may have arisen.

    Q: Do you consider that a nasogastric tube should have been used to treat Mr Humphreys' nasogastric symptoms?

    Ans: Yes most definitely. A nasogastric tube was essential to Mr Humphreys' treatment of his paralytic ileus.

    Q: In your opinion on the balance of probabilities do you consider that Mr Humphreys' death was preventable?

    Ans: Yes without any shadow of doubt.[84]

    Q: Reference the use of the nasogastric tube connected to suction. At what time would you have undertaken that approach?

    Ans: Immediately.

    Q: So even without taking an x-ray to see if there was a problem?

    Ans: Absolutely, immediate post-operative management... part of the management would have included bowel rest... nasogastric tube on suction with complete

[84] Exhibit 7 page ....

bowel rest for a period of time to be ascertained along with his clinical picture post-operative.

Q: And would that have been a normal approach?

Ans: Yes.

Q: In 2015?

Ans: Yes.

79. Dr Tomlinson was then questioned in regard to the earlier evidence given by Dr Dodd. Dr Tomlinson agreed with Dr Dodd's findings in regard to the cause of death. He was referred to the scans taken after death, specifically Exhibit 4.1(a). Dr Tomlinson stated that he wasn't a radiologist but that he could see from the scan that there was both air and fluid in the stomach: the black portion being air and the grey portion being fluid, the fluid including gastric contents and fluid. And that this would be the distal part of the stomach going down to the first part of the duodenum. That was consistent with paralytic ileus *with the stomach full of mostly fluid content, some air and it is functionally not emptying properly.* In reference to the second slide, 1(b), Dr Tomlinson said he could see dilated loops of both large and small bowel, with all the bowel having pockets of air and fluid, with the black portions air and the grey fluid. [85]

Mr Mukherjee

80. Dr Tomlinson stated that a paralytic ileus would occur frequently following this sort of vascular surgery.

    Mr Humphreys had a juxtarenal abdominal aortic aneurysm. Most are infrarenal, below the renal arteries. Mr Humphreys had an aneurysm which was a distinct subset in that it was juxtarenal. Accordingly, to repair the aneurysm it was necessary to put an aortic clamp above the renal arteries, which would occur in only about 4% of infrarenal aneurysms.[86]

    'For all sorts of reasons this increased the difficulty of the surgery. And two, a direct extrapolation is, it would be the possibility or likelihood of having complications, one of which was a paralytic ileus.' [87]

81. Dr Tomlinson also spoke about how the procedure might be carried out and the degree of manipulation involved in each process. All that dissection all that manipulation of the gut, the guts almost natural response is to complain and it will for want of a better phrase, be on strike.
82. Dr Tomlinson was then questioned about the medical record and taken to the note that '*...on completion of the anastomosis, the graft was clamped and the suture line checked for homeostasis and found to be satisfactory. Flow was then restored to the renal and visceral vessels. The ischemia times was 50 minutes.'*

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[85] Transcript page 262-64 and exhibits 1(a)-(h).
[86] See diagram at Attachment A to this finding.
[87] Transcript 269.

Q: Does this have any bearing on the likelihood post operatively of a paralytic ileus, or not?

Ans: The cross clamp across the aorta was above the renal arteries. I think it is one place, I can't see it but it was being described as being at the level of the diaphragm, which would mean that the blood flow to not just the renal arteries but also to the arteries which ply the stomach and the small bowel as well as the large bowel, would have had no flow into those vessels, to perfuse those organs for 50 minutes... There without a blood supply for that time... that has to be realised that is what we would call warm ischemia... blood flow to those tissues ceased for 50 minutes under a normal temperature. There are some facilities who may repair these and have cold ischemia so that when they are clamped, they might identify those vessels say going to the kidney's and might infuse them with a cooling solution to cool them down, so that it's not warm ischemia, not body temperature, but its below body temperature, which helps preserve those tissues to minimise and reduce the risk of damage to those tissues when they have no blood to them... If it is warm ischemia the damage will be quicker and more extensive that if it is over the same length of time and the tissue was cooled. The cooling protects the tissue. The cells and slows the metabolic rate, cools them down and they become less prone to damage.

Q: What actually is the damage? What happens to these cells?

Ans: Start to get cell necrosis, the process of cellular death starts. But given time there is a period of time when recovery will be complete or recovery will be partial.

Q: Was a cold ischemia a normal part of an operation of this kind in 2015?

Ans: Repairing a juxtarenal aneurism can be repaired without having a cold solution protection. That's with the proviso that it is not anticipated that the clamping time or warm ischemia is going to be extensive. If it is going to be extensive then more prudent... to do it not under warm ischemia but to cool the tissues down... This applied in 2015... and 50 minutes of ischemia would have been regarded as an acceptable time, to have the aorta clamped in order to repair this... without having a cooling system in place... I think that's acceptable... it is well recognised that up to 30% of people in this situation will have some degree of tissue damage, especially with the kidney's with this degree of ischemic time with warm ischemia... It is regarded as an accepted risk... although you have to recognise that there will be a consequence and a possibility of complications.

Q: The 30% of cases?

Ans: Yes. There is a lot of talk in the notes about this being a repair of an aortic aneurism and no extraction of the fact that this has been a juxtarenal aneurism... and having a clamp above the renal vessels or above or at the diaphragm, it just increases the risk and I think a lot of the comments would be more appropriate to

aneurisms that are purely infrarenal, where you don't have to clamp above the renal arteries. 88

83. In response to further questions, Dr Tomlinson said that he thought his comments applied to the reports prepared by both Dr Westcott and Dr Cox. Dr Tomlinson also confirmed that a juxtarenal aneurism was one that required a clamp above the renal artery. *It implies what's called a neck of the aneurism is of insufficient length and disease free if you like, to put a clamp on the aorta, below the renal artery, and have a distance below the clamp bon which to sew the graft that you are putting in place. There is just not enough room.*[89]

    Dr Tomlinson was then questioned about the renal impairment problem. He said that, *if you had known of a renal impairment problem before* (the surgery), *I think you would probably consider whether you would use some sort of cooling mechanism for the organs you were clamping.* [90]

84. In regard to the management of the bariatric surgery, Dr Tomlinson referred to that surgery in 1998 causing some dissection of the tissue around the stomach and that this will cause some denerving of a certain portion of the stomach, *which may interfere with motility.*

    Q: You go on to say that more often than not the stomach is the last part of the indistinct to recover prom post-operative paralytic ileus, and this would have been exacerbated in Mr Humphreys because of the previous gastric surgery...

    Ans: I think all of those factors add up to an increase in the likelihood of paralytic ileus occurring...

85. Dr Tomlinson further considered that the prospect of the onset of a paralytic ileus occurring in such circumstances *is likely.*[91] He also considered that that the degree of manipulation of the abdominal content and general handling of that would have been sufficient cause for a degree of paralytic ileus.[92] Dr Tomlinson also testified about how the procedure might be carried out and the degree of manipulation involved in each process. *All that dissection all that manipulation of the gut, the guts almost natural response is to complain and it will for want of a better phrase, be on strike. It won't work properly... it will lose its function of motility at times, especially when there is on top of that, ischaemic damage or interruption of blood flow, there will be a degree of cellular dysfunction as well.* [93]

86. Dr Tomlinson was then referred to Dr Cox's statement at page 16 where he refers to Mr Humphreys transferring to Ward 4 Central (Cabrini) on 28 August where he developed *post-operative ileus reduced bowel function. This is a normal and expected post-operative event.*[94] Dr Tomlinson agreed with this assertion.

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[88] Transcript 272-73

[89] Transcript 274.

[90] Transcript 264.

[91] Transcript 276.

[92] Transcript 276.

[93] Transcript 277.

[94] Transcript 277 and page 171 of the brief.

87. *Q: Dr Cox goes on to refer to the reintroduction of oral fluids and the removal of the nasogastric tube on 27 August 2015, which was followed by abdominal distension and vomiting suggesting a persisting ileus. Oral fluids were removed until bowel function again returned. IV fluids were maintained throughout. He was then able to tolerate oral fluids and then diet. A dietician review was performed... See also page 171 of the brief. Abdo soft at 8.30 4/9. Seen by Dr Cox. What is your clinical opinion of his clinical situation on 4 September?*

    Ans: It does suggest that there in... that there is some resolution of the paralytic ileus.

    Q: Because you wouldn't allow him to have free fluids if that blockage remained in place?

    Ans: Correct.

88. Q Following on at page 172 there is an entry at the top of 4 September, 15 which says faint bowel sounds noted. Abdomen remains distended. At 15.20 what happens then is that there is a patient (Humphreys) vomiting and refusing anti emetics. Is that in anyway relevant to a recurrence of paralytic ileus or not?

    Ans: If the patient is continuing to vomit, *it suggests to me that there is a continuation of the paralytic ileus that the gut is not working correctly... not sure if the nasogastric tube is in at the moment. I presume it is not because he is vomiting. If he had a functioning nasogastric tube... that would be on suction and the patient wouldn't have any suction there to vomit...*

    The other thing I would comment is you say (in the record) *that bowel sounds are present, slightly reduced or whatever. I mean there are bowel sounds and there's bowel sounds right. I can see that all of these entries reference bowel sounds are all documented by the nursing staff... I mean bowel sounds may be present but are they normal. I think it is wise for the surgeon looking after the patient to listen to the bowel sounds themselves... Just because you hear bowel sounds doesn't mean the gut is working.* [95]

89. *Q: You mention a nasogastric tube... Dr Cox says at page 16, that the nasogastric tube is removed on 27 August. Going back to Friday morning 4 September at brief 172, despite the passage possibly of some flatulence and some softening of the abdomen there is the patient vomiting 300mls at 3.20 and 500mls at 6.40 that evening. What if anything does that indicate to a vascular surgeon about the state of the ileus?*

    Ans: To me it indicates that the ileus persists... I have mentioned that it's the last part of the gut usually to recover from this process... The stomach can have quite a prolonged, paralytic ileus at times. In fact anyone can have a prolonged paralytic ileus and it's not unknown for people to have problems with gut motility, you know three or four weeks down the track from the original surgical procedure... and the stomach can persist for some time with a paralytic ileus and

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[95] Transcript 277-81.

that's one of the reasons why I would expect a nasogastric tube to be left in situ until you are sure that everything is going in the normal direction... and the stomach was emptying.[96]

90. Q... *And if you find yourself having removed it prematurely is it difficult to reinsert?*

    Ans: No patient likes to have them put down. It can be quite challenging... If it is necessary you can still do it.

    Q: What would make it necessary?

    Ans: Well if there were indications that they still had a paralytic ileus and vomiting would be (the) prime reason to reinsert.

    Q: Let's break this down further. What is it about the fact of the vomiting on the part of the patient that indicates to a vascular surgeon about anything to do with the paralytic ileus?

    Ans: It would indicate that the stomach was is not operating properly, it didn't have its normal motility to have a forward propulsion of contents into the small gut that after time with the build-up and distension it went the other way.

91. *Q: The next entry please at 172, 5 September 2015 is a Saturday? A nursing entry, it states that Abdomen very distended and firm plus plus. Do you regard that as a change in description of the abdomen being softer as previously seen?*

    Ans: Yes... it suggests that the paralytic ileus is continuing and possibly becoming more extensive.[97]

92. *Q: Can you look at Dr Cox's statement at page 18 please where he says in the penultimate paragraph, 'I note that the preliminary autopsy findings have suggested that the cause of death be aspiration secondary to a prolonged ileus. These findings are not supported by the clinical course. While he developed an initial ileus which was prolonged, his diarrhoea demonstrates the presence of transit through the bowel"...*
    In your opinion is a vascular surgeon entitled to be reassured about the functioning of the gastrointestinal tract and the gut on the basis of a large amount of loose watery brown bowel action in the context of vomiting and a very extended abdomen... and no further vomiting overnight. Ice and H2 only over night?

    The 7 o'clock entry is a vascular surgeon entitled to think there is no paralytic ileus present or developing at this time or are they entitled to be re assured that this patient's gut and GE tract is improving?

    Ans: I wouldn't get reassurance that the gut was improving. I would not have got reassurance that the paralytic ileus had passed... Given the function of the large bowel is mainly on fluid... the passage of a large amounts of watery brown diarrhoea, under the circumstances of this case would lead me to believe that the

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[96] Transcript 283-4.
[97] Transcript 285.

gut was still not working and that the large bowel was not working. If the gut was working properly not just in mobility but in function one would expect there not to be profuse diarrhoea... you would not expect watery diarrhoea in someone who had a normally functioning colon. And I think the colon is not working because... its paralytic... it is not performing its duty it is not absorbing fluid... it is expulsion under pressure rather than anything of a motile function for the propulsion of faeces.

Dr Tomlinson continued... *knowing that the paralytic ileus and gut function is not going to be good after this surgical procedure you would be acutely aware of all signs, any signs that would give you an indication the gut was not working, and I think the profuse diarrhoea is a sign that it is not working properly.*[98]

93. *Q:* How reassured would you be by no further vomiting?

Ans: Reassured? I would be happy that the patient wasn't vomiting. But the fact that he wasn't vomiting would not reassure me that his ileus had passed... He is a large man... He is distended. It might be that he hasn't vomited but he might well have a quite dilated stomach and not vomited.

Dr Tomlinson was next questioned in regard to the Saturday 5 September entry: Seen by Dr Cox, IV (canula) and PCA (patient-controlled analgesia) down, can commence soft diet, question mark, home on Sunday to son's house. The canula was to provide a line ... it keeps the patient hydrated especially if they are not taking oral fluids in or it can just be ongoing medication.

As to the commencing of a soft diet Dr Tomlinson stated, *I am not sure what to comment on it, but given the circumstances that I feel he still has problems with an ongoing ileus, I think the introduction of a soft diet is premature...* [99]

94. *Q: What should you be continuing to do at this point if not introducing a soft diet?*

Ans: I would be concerned that the patient still had problems with the paralytic ileus and his gut wasn't functioning. At this stage which is five to eight days post operatively... discussion nine days post I would be concerned that his gut wasn't working, and as I've said before I would have had a nasogastric tube on suction and I would have been doing tests on a daily basis to see what's happening with the gut, and that might be simply serial abdominal x-rays to see whether the gut is extended by fluid or gas. To give me an indication of what's happening to the paralytic ileus and giving a progression over time of a trend, and I suppose if a trend is such that his gut's getting better, with all that information, or whether there is a large gastric aspirate from a neo gastric tube, whether that is an indication that there's a passage of fluid from the stomach to the rest of the gut with a lack of aspirate if there was fluid to be introduced orally, it's a combination of all of these things which would lead me to make a judgement on whether diet should be progressed or not.

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[98] Transcript 286-8.
[99] Transcript 290.

And if they were not being progressed I would be thinking of introducing some parenteral nutrition, which would also help the paralytic ileus...[100]*It is intravenous fluid not oral fluid. What it does, it increases nutrition intravenously and has an effect of decreasing the gut secretions as well so it helps with these distended loops and fluid collections... It's a functional blockage not a mechanical blockage.*

95. *Q: So it stops working and creates the effect of blockage?*

    Ans: Yes it is a functional blockage.

100. Under further questioning, Dr Tomlinson set out how *a course of x-rays would show dilated loops of bowel, large or small bowel, will show you how large the stomach is and it may or may not show you air fluid levels similar to a CT Scan. A CT scan is not necessary every day... You can adequately follow with plain abdominal x-rays, which you can compare from day to day... It would be an added factor in your diagnosis. From the clinical it would be affirming (of) a clinical picture that the gut (was) not working and allow you to get some valuation on whether there was a progression one way or the other with regard to the ileus .*[101]

Mr Bourke.

96. In further cross examination, Mr Bourke took Dr Tomlinson to his evidence concerning the desirability of a pre-surgery consultation and examination by the anaesthetist, not one occurring just prior to surgery... *A formal consultation is a consultation which allows you one more time, better assessment and the ability if in doubt to order further investigations to help you in assessing that patient...* [102] *I would suggest that he has looked at the teeth, yes. I can't see any written information there about an examination of the uvula. When someone has a history of sleep apnoea, ah or function of the uvula.*
97. Dr Tomlinson was then taken to his report at brief page 38 where he spoke of Mr Humphreys' history of sleep apnoea and that he would have had a soft palate with a large uvula, which would have increased the risk of trauma associated with the passage of a nasogastric tube at operation and make it more difficult.

    Dr Tomlinson was not aware of any other aspect of the history which might hinder the passage of a nasogastric tube. *It's a firm tube. It's not hard, it's not soft. But the passage of a nasogastric tube difficulty and impediments to it, are usually associated with the oropharynx rather than the stomach itself...*

98. *Q: As well as increasing the risk of trauma associated with intubation posed by someone with a prominent soft palate and swollen uvula it is likely to make a nasogastric tube more uncomfortable for a patient with that condition?*

[100] Transcript 291.
[101] Transcript 293.
[102] Transcript 330.

Ans: I think any nasogastric tube is uncomfortable in anyone. Someone with a prominent uvula it would be an added irritation, yes. [103]

Q: … You are not criticising the choice of surgery or the way it was performed?

Ans: No.

Q *And not criticising that there was a 50 minute period of warm ischemia?*

Ans: No.

Q: And not suggesting some period of cool ischemia.

Ans: Not at all.

Q: But from a period of such restriction of flow of blood it would be expected that here would be some type of acute kidney injury?

Ans: Up to 30% of people would get some form of renal impairment after… some studies suggest higher… Irreparable damage would occur if you had a clamp on for more than two hours of warm ischemia.

Dr Tomlinson agreed that the record at brief page 153 established that a catheter (an IDC), had been inserted at surgery and reviewed two days later on 28th of September. [104]

He also agreed that on 4 September at 4.20 hrs the clinical record indicates *IDC with good output. And further that the note at 8.30 reads, seen by Dr Cox. May have free fluids orally today remove IDC.*

Q: At page 39 of your report you say Mr Humphreys progressed well… and you discuss the nature of the bowel sounds and you talk about their quality, whether they were tinkling?

Ans. *Mmm.*

99. *Q. And you gave evidence that you wouldn't necessarily rely on a nurse's description in relation to those sounds?*

Ans. *Correct…*[105]

Q. *And you go on to say, 'All these signs suggest and point directly to a continuing state of gut paralysis and an intestine not recovered from the surgery and the performance of co-ordinated motility and functions of absorption'. What does that mean exactly?*

Ans: He continued to have a paralytic ileus… (with symptoms) *… being ongoing after the first four days, yes.* [106]

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[103] Transcript 333-4.
[104] Transcript 338-39.
[105] Transcript 341.
[106] Ibid.

100. Q. *See record at page 172, 5 September, which says, 'is very distended' and at 7.00 'Abdomen very distended and firm plus, plus'. That is the last reference in the notes, to both 'very distended and firm'?*

Ans. *Yes they are.*

(Counsel. Not suggesting that further references indicate a softness or palpability in the stomach).

Q. 5 September at 21.30 second last line, '*Nil complaints of pain, only discomfort on abdo'. So prior to events of 6 and 7 September, that's the last reference to pain?*

Ans. *Can I also suggest from your last reference PCA (Patient ... ...) used.*

Coroner. *There is also ongoing reference to 'distended stomach' during those observations on the 5th and 6th*

Mr Bourke. *Yes, Your Honour. I was relying on the, 'very distended'.*[107]

101. In regards to the newly produced fluid chart, Dr Tomlinson was asked to confirm that there were two last episodes of vomiting on 5 September, which are also recorded in the nursing notes page 173 as 'vomiting x 2 dark brown colour fluids', which appear to have occurred at 4.30 pm (20mls) and 7.30 pm (30mls). He agreed with this summation of the record and that the last record indicated a relatively small episode. This was not faecal matter, it's a description of what it is not necessarily faeces... It is small bowel fluid content that looks like faeces, but it is not faeces, its small bowel fluid or gastric fluid.[108] It is just describing what it looks like. Not where it came from. In regard to the nausea reported at 9.30 pm on 6 September, (the most recent complaint of nausea) Dr Tomlinson said that he believed, *this was related to gastric dilation causing the nausea rather than medication, but that, he couldn't be 100% certain.*

He couldn't add anything to the record, *decreased oral fluid intake,* and the words *faint bowel sounds*, last mentioned on 4 September at 3.20 pm record page 172. And later as the record reflects, *Patient passed large amount loose watery brown bowel action at 6.15,* and it says, *no further vomiting?* [109]

102. Q: *If a patient is recovering from paralytic ileus what would be the nature of the first bowel movement that you'd expect from them.*

Ans: They are often loose. I wouldn't describe them as watery, but I'd describe them as loose, there is a subtle difference I think.

Q: Diarrhoea?

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[107] Transcript 344.
[108] Transcript 336.
[109] Transcript 348.

Ans: Diarrhoea being a loose motion, yes... I wouldn't expect it to continue as it did you see you are alluding to references on page 173 and the next day 'Incontinent of faeces, diarrhoea by 6'. That is not a normal recovering bowel.

103. *Q: You go on to say at page 39 of your report, 'there continued to be signs of functional bowel obstruction. Despite this Mr Humphreys was given soup for dinner, Lomotil and Gastro-stop. So it appears that at that time you were referring to his meal on Sunday 6 September?*

Ans: Probably.

104. *Q: At that time what were the symptoms and signs of functional bowel obstruction?*

Ans: Well he had continuing distension, some degree of discomfort or pain, he had diarrhoea, he had vomited, his gut was not working properly.

Q: The actual dinner process appears to correspond with what Mr Humphreys junior and Ms Strik were saying in relation to them being present at around the early evening of 6 September at 21.30?

So I am trying to identify what precisely you are saying are the functional bowel restrictions at that time Dr Tomlinson?

ANS: I am confused as to the question.

105. *Q: Your report says there continues to be symptoms and signs of bowel obstruction. Despite that he is given soup for dinner Lomotil and Gastrostop... So I am trying to identify what precisely your saying are the functional bowel restrictions at that time.*

Ans: I thought I had answered that. His continuing problems with distension, the episodes of vomiting, diarrhoea, all lead to my conclusion that he had a functional object, i.e. a paralytic ileus, and his gut is not working. To go into the minutiae, in my view is not necessarily irrelevant but clouds the issue that the overall picture is this patient had a non-functioning gut and in my opinion was not treated properly with a nasogastric tube on suction, bowel rest, intravenous fluids and perhaps some alimentation towards the end, after nine days. And it was not recognised and dealt with that this fellow had continuing paralytic ileus and non-functioning gut, which has ended up in resulting in a massive vomit, an inhalation and death.

106. *Q: In the last paragraph at page 40 of your report you say, 'The symptoms and signs of paralytic ileus are evident as seen above, yet there appears to have been no recognition of these symptoms and signs. A simple abdominal x-ray would on the balance of probabilities reveal gastric and small bowel dilation and the diagnosis would have been made. Even if there was no abdominal x-ray performed this was a clinical diagnosis and treatment should have consisted of bowel rest and intravenous nutrition...*

Ans: That's correct.[110]

Q: Go to page 169, the second last entry. 8.00 *See by Mr Cox. Watched catheter output as still... The next line is, 'Has ileus... No nasogastric tube at this time'.*

Ans: Yes it does but it may also reflect that the seriousness wasn't recognised, especially in view of the 'no nasogastric tube at this time'.

Q: Written by a Nurse..., and you are well aware of the secondary issues and complications associated with the insertion of the nasogastric tube?

Ans: When does one do anything, you have to weigh the risks of doing some harm or doing some good against each other. In my view there is more harm in not putting down a nasogastric tube than in putting one down.

Q: You have just said it's a bit of a weighing exercise in relation to the issue of nasogastric tubes, and you are aware that they have the effect of draining the stomach but rendering the gastro oesophageal function of the patient incompetent at the same time?

Ans: I don't believe that's an issue.

107.. *Q: I suggest it is and that being the case, that a patient may be more likely to aspirate with a nasogastric tube inserted rather than not?*

Ans: No not if you put the nasogastric tube suction on, the tube, empties the stomach.

Q: Consider questions about his discomfort and how with a reported swollen uvula, might find it particularly uncomfortable...

Ans: I don't think they are reasons to not put down a nasogastric tube.

108. *Q:* Dr Cox will give evidence that he continued to have gastric staples in situ from his previous gastric procedure?

Ans: Fine

109. *Q: And for that reason, insertion of a nasogastric tube would be more difficult for him to perform, and involved risk to the patient?*[111]

Ans: As I said I don't think that is an indication not to put the nasogastric down. It probably may mean that if there was a perception of difficulty it shouldn't have been left to the nursing staff to do it, a medical practitioner perhaps should have done it. I don't think it's a reason for not putting it down.[112]

Following further discussion as to the potential to use an anaesthetic to put down a nasogastric tube, Dr Tomlinson stated that he would not have recommended the use of an anaesthetic in this case... *Not with someone who I suspected had an ileus and a dilated stomach... Preferably it would be done with the patient sitting up and awake, slowly, with the patient's cooperation to help project the nasogastric*

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[110] Transcript 351.
[111] Transcript
[112] Transcript 355-56.

tube down through the oropharynx and into the oesophagus by asking him-encouraging him to co-operate with the passage of the tube with swallowing.[113]

110. *Q: You just mention x-rays and you referred in your evidence to serial x-rays and I suggest that that is just not a feature of current medical practise in dealing with this paralytic ileus condition?*

    Ans: Well you'd be wrong.

    Q: Can I suggest to you that you just referred to bowel action and loose bowel action and I suggest that the course of treatment here has been the introduction of oral fluids on the basis of the return of bowel function which commenced with first of all that loose watery bowel action and then continued with ongoing diarrhoea?

    Ans: What's the question?

111. *Q: Suggest reflected recovery?*

    *Ans: As I said before I didn't feel that the bowel actions were reflecting recovery at all, in fact I suggested that the bowel actions reflected that the colon wasn't acting correctly, that bowel actions were profuse. They were dire diarrhoea. The normal function of the absorbing fluid was not happening and it was all going south as a bowel action so I don't think what you say is *accurate.*[114]

112. *Q: And you are saying with an unresolved ileus of this duration that that was necessary...*

    Ans. Yes. ...

    Q: and less worse in terms of impact, than not do anything about it?

    Ans: Absolutely.

113. *Q: Mr Humphreys had nine days with nil orally and your recommendation appears to be ongoing bowel rest, is that correct?*

    Ans: Yes... Bowel rest would cease...*when his ileus returned-recovered and his bowel function resumed.*

    Q: How do you assess recovery from ileus?

    Ans: Clinically... assuming the patent has a nasogastric tube on suction, how much aspirate is coming back from the stomach and, ah what the formation of the stools are, whether there is distension or not, whether there is pain or not which, if they've got a marked ileus, might not be terribly painful because if the ileus-if the gut is not working properly and the muscle is not contracting, you may not get a lot of pain from the gut itself. You might get discomfort and pain from the gut itself... you might get a slowly recovering ileus, because parts are getting back to normal... and another part is not.

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[113] Transcript 357.

[114] Transcript 360. The word transcribed is *'inaccurate', which I am satisfied was incorrect. PW.

Now all of this would be aided by your getting some progress… abdominal x-rays… to see what the distribution of gas and fluid levels are in the abdomen and whether there is a progression of gas down through the bowel by comparing day by day.

In answer to your question as to how would I treat it, how would I assess it, I'd assess it clinically with either parameters to verify the clinical impression.

Q: So you are effectively saying you would impose bowel rest by means of inserting a nasogastric at that point in a patient who's been nine days nil orally?

Ans: Mmm

Q: Are you saying you would wait until almost full recovery, based on your description of the recovery process of the ileus?

Ans: In a case where there is severe paralytic ileus like this, recovery would be slow, so your introduction of various changes would also be slow… The nasogastric tube has been down for a while and you have had suction and you have a reasonable amount of suction coming back, you might

see a decline in the fluid that aspirated from the nasogastric tube which might indicate that the fluid is going both ways… If there is not much then you might assume that the stomach was going the normal way and if that happens… continues to happen well you would continue to increase fluids and one the person was taking oral fluid and there was minimum nasogastric aspirate you would then perhaps be in a position to remove the tube and increase clear fluids… All that would I indicate along with x-rays along with perhaps the distension receding and verified with x-rays demonstrating the passage of gas and fluids through the abdominal-contents, through the bowel… you may then start introducing a normal diet.[115]

114. In further questioning on behalf of Dr Cox, Dr Tomlinson was referred to a clinical entry for 5 September at 21.30 '*… passed urine in toilet, diarrhoea times six this shift, watery. Mr Cox has been notified. No further orders. Incontinent of faeces*', and then the next entry 6 September 2015 at 5.35, '*Unable to sleep exhausted from multiple trips and episodes of bowel actions. Bowels opened five times overnight. Large explosive watery brown colour*'. And then the entry at 2 pm, '*Bowel open 5 times, incontinent of faeces. Commenced on Lomotil and given as chart*'.

Q: I suggest based on that history that the prescription of Lomotil was quite appropriate… in the light of his frequent diarrhoea?

Ans: No.

Q: Why not?

[115] Transcript 359-60.

Ans: He hadn't got any properly motile bowel. To give Lomotil would aggravate, could aggravate the situation and stop the recovery of the ileus.

115. *Q: 'Unable to sleep exhausted from multiple trips'... So appropriate to prescribe remedial medication to try to ease the diarrhoea?*

    Ans: No. No. The appropriate course of action is to deal with the cause which is ileus... to assist maybe a rectal tube could be inserted...but it doesn't get down to the fact that you have to deal with the underlying problem, which is not being dealt with.[116]

116. Dr Tomlinson was then questioned about Mr Humphreys' swollen uvula.

    Q: You say at page 41, 'The swollen uvula, cough and swallowing difficulties are further symptoms that the treating doctor should have been able to recognise, the symptoms being word unclear PW, to degree of fluid retention'...

    Ans: One can't be accurate but given his history of... sleep apnoea... I would suggest that he perhaps had some preponderance of his soft palate which caused him some airway... obstruction when he was sleeping and during is post-operative period when he was having lots of fluids intravenously when he was sick, perhaps with the irritation of the nasogastric tube as well... and he has developed some swelling and oedema of the uvula and I think someone gave him some steroids for it, which can help reduce the swelling.

    Q: The reference to steroids is a page 162... dated 27 August and it appears to be while he was in the 1CU, it says 'Review swollen uvula. Then on examination swallow uvula actually resting down on to base of tongue, and then the reference, Start Dex (Dexamethasone) if fails to improve'. There is no reference between those times to Mr Humphreys complaining of a problem with his swollen uvula?

    Ans: I accept that. But the problem with his Uvula... could also have been an exacerbating problem to his ileus indirectly... a sore throat an irritated throat... it is not a reason not to put a nasogastric tube down... You could say perhaps it is a reason to put it down because he has a sore throat and he's exacerbating his illness by swallowing all of this air because he has got this uvula all swollen and irritating so it can be a factor to suggest you put a nasogastric tube down... You can go both ways if you like but overall I think it is an insignificant factor in his post-operative course.[117]

    Q: The forensic pathologist Dr Dodd found no abnormality of the uvula, post mortem.

    Ans: Good.

117. *Q: In regard to the fluid chart what happens to fluid during the course of a paralytic ileus.*

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[116] Transcript 363-4.
[117] Transcript 365-6.

Ans: As you see on the CT scan will end up distending the bowel and in some circumstances as I believe in this person's case, the fluid collection delivered to the colon, was not contained by his rectum and anus and he was having uncontrolled diarrhoea and I think it is a result of you know, fluid being within the bowels and not being absorbed.

Q: In a recovery... would you expect to see increasing urine output as the fluid from the bowel is effectively absorbed in circulation in the body?

Ans: It depends on his state of hydration, from other extraneous input to the fluids, like intravenous lines and so forth, how much fluid is going in in total, but yes with recovery of the bowel you will get increased absorption and the body will deal with getting rid of excess fluids with urine.

Q: I suggest if you have had a chance to now review the (newly introduced fluid records), *that entries for the 5, 6 and 7 September show reasonable fluid intake and urinary output for Mr Humphreys?*

Following discussion as to the meaning of these records, Dr Tomlinson was taken to the entries for 4 and 5 September where it was suggested that they indicated adequate fluid intake. Dr Tomlinson did not agree. '*It reflects an adjustment of the fluids, it doesn't mean that they are absorbing it... It is not necessarily absorbing it in any significant factor. I think to rely on that as evidence of a resolving paralytic ileus and resolving gut function is ridiculous.*'

Dr Tomlinson further rejected Counsel for Mr Cox's suggestion that his same analysis should apply to 6 September. [118]

118. Dr Tomlinson was then asked about his opinion that Dr Cox should have attended on Mr Humphreys on 6 September, based upon his reported condition.

Q: What is that based on?

Ans: The nursing staff requested Mr Cox. I think the entries say they rang him and asked for advice, they wanted advice. I thought they actually requested his attendance?

Coroner.

I believe they asked whether... when he indicated he wasn't attending, whether he wanted the matter reviewed by another Doctor... a medical registrar.

Ans: Well I believe he should have been reviewed.[119]

119. *Q: You haven't seen anything in the notes that indicate any issue with Mr Humphreys' vital signs have you Dr Tomlinson? Blood pressure, pulse respiratory function?*

Ans: Shortness of breath difficulty getting breath, But not on a chart... no.

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[118] Transcript 371.
[119] Transcript 372-73.

Q: You are familiar with Met call criteria?

Ans: Yes.

Q: It was appropriate for Dr Cox not to attend, that there was no significant change to his condition?

Ans: As I said before, I thought that this fellow had an unresolved problem, the staff were concerned, and there should have been some medical attendance... I think he had abdominal distension, he had an unresolved ileus and I think he was at risk.

Mr Halley

120. *Q: Very quickly your evidence is that the mottling of the legs and any problems that there may or may not have been reviewed are irrelevant to the outcome of this case?*

Ans: Yes.

121. *Q: Nurses are unreliable taking bowel sounds because they are not trained to do so?*

Ans: Yes.

122. . *Q: It is a Doctor's role to make a diagnosis?*

Ans: Yes.

123. *Q: Interpreting blood results...?*

Ans: I am sure a lot (of nurses) can but it is not their role.

Q: You gave evidence before you would like to know the GFR (kidney function). *If you look at the blood result it is here so if you go to maybe page 103-4.*

Ans: It would have been the first question I would have asked, but with this particular patient having known what the GFR was doing in relation to the creatinine, I think it is a pertinent question.

Q: You are aware that an EGFR is entirely based upon the creatinine level and is adjusted for a patient's age and sex?

Ans: Yes.

Q: So a Dr being given the creatinine level should be able to work out, if they want the GFR?

Ans: Should be able to work out, especially being guided by what it was over the last few days... Another trend if you like.

Coroners assistant.

124. Q. In regard to Mr Cox's prescription of Lomotil on 6 September you indicated that was not appropriate, can you tell the court what Lomotil is prescribed for?

Ans: To decrease the bowel activity and contractions and to decrease the effect of propulsion of contents.

Q: You said it wasn't appropriate, it could aggravate and stop the recovery?

Ans. You could aggravate a recovering gut you have a situation where the gut is not contracting properly, it is not doing its desired job of propulsion of contractions. *To give Lomotil is to supress that action, an action which you wish to see.*

125. *Q: At page 169, the nurse has written, 'has ileus'*

Ans: Yes.

Q: At that time 2 September?

Ans: Yes.

Q: Next page 3 September at 2100 it says abdo is softer and comfortable?

Ans: Yes... and again on 4 September, 'Abdo soft'.

Q: So that would be an indication of some sort of recovery of the ileus?

Ans: Not necessarily... he may have had his half a dozen bowel actions that he has evacuated some of the contents but it doesn't necessarily mean when you take it in context with everything else it doesn't to me support a recovering ileus.

Q: So then we go down the page 4 September 12.35 this is a dietician entry which is *'Distended Abdo'* and *'patient self-limiting free fluids'. So we have changed from a 'soft abdomen to a distended abdomen' in a day and then the following day I think at 1300, p172, the first entry, 'Abdomen remains distended'.*

Ans: Yes.

Q: Then we have 5 September (172) 'abdo very distended and firm, plus plus'?

Ans. Yes.

Q: 'Abdomen remains distended'

Ans: Yes.

Q: Then we go to 21.30... The seventh line says there is only discomfort in regard to the abdomen?

Ans: Yes.

Q: Then another line on 6 September, 'Abdomen distended'

Ans: Then it's between that entry there at 6 September at 5.35 hours and the next entry which is 6 September 1400 hrs

Ans: Yes.

Q: That Mr Cox had attended and examined Mr Humphreys?

Ans: Mmm.

Q: And again it says abdomen distended... so the presumption is that from the entry from 5.35 to the entry at 1400, that it was his abdomen distended and again it was still the same at 1400. So between the time that Dr Cox has assessed him back on 2 September, what do you say about his condition? Is it deteriorated or improved in regard to the ileus?

Ans: It certainly has not improved. It has remained stagnant, but I think looking at that it would suggest to me that it has been deteriorating.

126.. *Q: Page 104. The patients stool chart? ... in relation to the bowel actions and descriptions of the bowel actions. All of them appear to watery and brown or dark brown in colour?*

Ans: Correct.

Q: Does that indicate a recovering abdomen or ileus?

Ans: No.

Mr Mukherjee.

127. *Q: On the issue of Lomotil, you said it could aggravate... Does it have any influence on vomiting whatsoever?*

Ans: No influence on vomiting...

Q: You gave an answer to Mr Bourke about the feculent nature of the vomit at page 174, 'massive feculent vomit' In terms of the nature and quality of that vomit, is that likely to be the same or not the same as the dark brown coloured fluid that is referenced to the vomiting on page 173, at... and 21.30 hours?

Ans: It is obviously not the same fluid but it is the same process. Gastric contents.[120]

128. Court reference Nurse Bowes told Dr Cox that the other blood tests were normal, and it appears from the pathology report that they were not normal.
129. The Coroner questioned Dr Tomlinson in relation to Mr Humphreys' general deterioration along the following lines:
Q: '...We've heard evidence that it appeared to family members that by that afternoon or late afternoon of 6 September, there had been a considerable deterioration in Mr Humphreys' condition as compared with the previous day. Having regard to what you have looked at for us in respect of the test results and also having regard to the observations paid by nurses and others concerning the intake and the excretion of fluids, what do you say about that observation? Would you have expected in this patient a serious level of deterioration by the evening of 6 September?'
A: '...[Y]es.'[121]

Jeanette Ray Bowes

Coroner's Assistant:

130. Jeanette Ray Bowes (Nurse Bowes) is a nurse of some 50 years' experience who was the charge nurse, or the nurse unit manager of the ward, where Mr

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[120] Transcript 382.
[121] Transcript, 311.

Humphreys was being treated on the afternoon and evening prior to his death. Her shift that day began at 2.00pm and ended at 10.00pm on 6 September 2015.[122]

131. Nurse Bowes recalled Mr Humphreys' son approaching her with concerns about his father's condition at approximately 6.20pm or 6.30pm that evening. The main concerns expressed were the mottling of Mr Humphreys' skin on his legs and his difficulty swallowing. Nurse Bowes called Dr Cox in response to the family's concerns. She could not recall whether there was a conversation with Dr Cox about a MET call at that time. Nurse Bowes was open to possibly having reported to Dr Cox that Mr Humphreys' vital signs were stable.[123]

132. During the phone conversation that evening with Dr Cox, Nurse Bowes queried whether he wanted a medical registrar to review Mr Humphreys. Dr Cox responded that he did not think it was necessary. Nurse Bowes felt comfortable with this course of action at the time being cognisant of Dr Cox's plan to attend to Mr Humphreys the following morning.[124]

133. Later, after her phone call with Dr Cox, Nurse Bowes received a phone call from Mr Humphreys' daughter, herself a trained nurse. Nurse Bowes recalled the discussion mainly revolving around the family concerns about Mr Humphreys' breath catching *every 30 seconds*, and to a lesser extent the mottled appearance of the skin on his legs.[125]

134. In her initial evidence Nurse Bowes agreed that in her conversation with Mr Humphreys' daughter, she offered to escalate the concerns regarding Mr Humphreys' condition to a medical registrar; and that following that offer, Mr Humphreys' daughter answered that, *'she would leave it to [Nurse Bowes] clinical judgement.'*[126]

135. Nurse Bowes gave evidence that she estimates she visited Mr Humphreys approximately three to four times during this shift and was attentive to the concerns raised with her. Prior to calling Dr Cox, she examined Mr Humphreys' legs looking for indications of circulation problems and was satisfied that as his lower legs showed no mottling, his circulation was fine. During her examination of Mr Humphreys, Nurse Bowes also tested his swallowing by giving him sips of water to swallow. Although he did swallow smalls amounts, Mr Humphreys did have difficulty swallowing and did catch his breath.[127]

Mr Bourke:

136. Mr Bourke raised with Nurse Bowes the discussion with Dr Cox, and in particular the possibility of a MET call being made in Mr Humphreys' case:

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[122] Exhibit 5; *Inquest* Brief, 19; Transcript, 140.
[123] Transcript, 141-2.
[124] Transcript, 142.
[125] Ibid.
[126] Transcript, 144.
[127] Transcript, 145-6.

Q. Mr Cox is saying that you told him that Mr Humphreys did not meet the criteria for a MET call.

Did you say that or did you simply give him the vital signs?

Ans. Ms Bowes: I can't honestly say that I said that, but I did give him the vital signs. I can't recall mentioning the MET call.

Q. So if you had – I'm just suggesting that if you [had] determined that those criteria were met, you would have made the MET call yourself?'

Ans. Yes or if I was concerned about the patient that we needed extra support, I would do a MET call.

Q. And Ms Bowes, any nurse can initiate a MET call by means of first of all, escalating it to other nurses on the ward?'

Ans. Yes.[128]

137. Nurse Bowes clarified that all the ward nurses, including Nurse Xue, have the authority to initiate a MET call if they are concerned about a patient or notice sudden changes. More often, however, a nurse is more likely to report the concerns to a nurse in charge and flag their intention to do a MET call or seek guidance on the need to do a MET call.[129]

138. In her phone conversation with Dr Cox, Nurse Bowes recalled that he enquired as to the results of the blood tests he's ordered earlier that day, and she reported that results of the tests were normal. Dr Cox then specifically asked about Mr Humphreys creatinine levels and she reported that they were elevated at 402.[130]

Mr Mukherjee:

139. Nurse Bowes acknowledged that her diary reflected that she would have been caring for M Humphreys the previous day on 5 September 2015, although she does not specifically recall it.[131]

140. The medical registrars would normally start duty overnight from about 8.00pm to attend patients who experience problems overnight. Nurse Bowes gave evidence that she would be more inclined to call on a registrar if the patient needed a drug order or something similar, but to contact a consultant, in this case Dr Cox, if they were concerned about the patient.[132]

141. Nurse Bowes gave evidence that if she had become aware of further deterioration in Mr Humphreys, for example, a large vomit, or his circulation had deteriorated or he had become disorientated or confused, she would have again contacted Dr Cox or done a MET call.[133]

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[128] Transcript, 153.
[129] Transcript, 154.
[130] Transcript, 155.
[131] Transcript, 156-7.
[132] Transcript, 159-60.
[133] Transcript, 160-1.

142. Nurse Bowes did not pass on the risk of Mr Humphreys vomiting when she handed over the Nurse Xue because he had not vomited that day and it had not been an issue.[134]

143. In her discussions on 6 September 2015 with Mitchell Humphreys, Nurse Bowes was not aware that Mitchell was trying to convey to her the extent of his father's deterioration from the day before, merely that he was concerned about his difficulty swallowing and mottled skin on his legs.[135]

144. Her main concern with Mr Humphreys' condition at the time was *'the constant diarrhoea, because it was making him very tired…because it was persistent and it was tiring him out.'*[136]

145. She had also noticed Mr Humphreys' catching his breath and made a note on that he had been *'slightly short of breath on exertion.'*[137] A further note by another nurse indicated Mr Humphreys complained of nausea and Nurse Bowes gave evidence she had noticed (in addition to a record in the medical notes) that his abdomen was distended.[138]

146. Nurse Bowes could not recall whether she was aware or whether it was mentioned during her phone call with Dr Cox that he had seen Mr Humphreys that day.[139]

147. Mr Mukherjee asked Nurse Bowes to address her phone call with Mr Humphreys' daughter at about 7.00pm or later 6 September 2015:

Q: 'And what was the nature of the discussion, please?'

Ans: 'Um she said that she was concerned about her father… [a]nd the mottling of the upper legs, upper thighs…Um, and I said I'd contacted, and I can't remember exactly what I said but I tried to reassure her that I checked the circulation.'

Q: Ms Humphreys' evidence …in her statement at p.52 in reference to that conversation says, 'She then asked me if I wanted her to escalate to the medical registrar. I answered by telling her as the in charge of shift [nurse] and after her assessment that I would be guided by her clinical judgement. I was 600 kilometres away from Cabrini at the time and that if she felt it was warranted, I trusted her clinical judgement to escalate if she thought it necessary.' Now is that broadly the gist of what the conversation was between you and Ms Humphreys? … Does this accord with your recollection of the conversation as well?'

Ans: Yes.

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[134] Transcript, 162-3.
[135] Transcript, 165.
[136] Transcript, 166.
[137] Transcript, 167.
[138] Transcript, 170.
[139] Transcript, 171-2.

Q: Well why were you offering the option of escalating to a medical registrar to someone who wasn't there at the time with the patient?

Ans: I'm presuming because I knew she was a nurse and she'd worked at that hospital.

Q: Right. But as a nurse you also appreciated that it's difficult for someone to make a decision when they're not seeing the patient?

Ans: Yes...I do realise that.

Q: Why did you not take a position to call the medical registrar?

Ans: Because I didn't think it was warranted at that stage.

Q: Right. And yet if she's said yes, escalate it, you would have escalated it, would you?

Ans: Well if you're going to get the medical registrar to review a patient, you usually go through the surgeon.

...

Q: So you would need to go through Dr Cox to engage the services of the medical registrar?

Ans: Yes, usually, or unless you were concerned about a sudden deterioration in the patient.

Q: You would need Dr Cox's permission to engage the medical registrar, is that right?

Ans: Well usually that's... [in the absence of an emergency] that's the case.

...

Q: ...You were therefore offering the option to escalate to the medical registrar for Ms Humphreys, are you not? If she had said yes, you would have sought to engage the services of the medical registrar, once again, according to Dr Cox that's what you're doing, aren't you? Otherwise you're making an option that you're not going to fulfil. You're saying to her, do you want me to escalate your father to the medical registrar?'

Ans: I can't actually recall saying that.

Q: Right. Well that was why I asked you whether you agreed whether this was accurate or not?

Ans: Well I'm sorry I can't actually recall saying that.[140]

148. In her evidence, Nurse Bowes also acknowledged at one stage that although the family wanted her to call Dr Cox, she herself also thought it was necessary after assessing Mr Humphreys.[141]

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[140] Transcript, 175-7.
[141] Transcript, 179.

149. While Nurse Bowes was aware that the family had concerns around Mr Humphreys' swallowing and mottled skin, she was not aware that they believed he was not receiving sufficiently high care. She did not recall Mitchell Humphreys suggesting that his father needed more intensive care and closer monitoring.[142]

150. Nurse Bowes said, in her view, she was primarily asked to look at his swallowing problem. She was aware from his time in intensive care that he had a swollen uvula and was also aware that Mr Humphreys has been reviewed by an ear, nose and throat specialist. She acknowledged she probably did not examine Mr Humphreys' uvula and was not confident she could identify whether it was still swollen or not. To that end the she wrote a note which read, *Swollen uvula may still be a problem.*[143]

151. In delivering the blood results to Dr Cox over the phone that evening, Nurse Bowes recalled Dr Cox specifically asking for the creatinine results which were elevated, a fact she relayed to the doctor.[144] Otherwise the notes reflect Nurse Bowes commenting, '*Bloods appear OK.*'[145]

152. Mr Mukherjee also challenged her evidence about the way the blood results were conveyed to Dr Cox over the phone, that in fact the GFR reading of 12 on the results indicated Mr Humphreys was experiencing kidney failure. Nurse Bowes' evidence reflected that she could not recall either noticing or relaying the GFR result to Dr Cox. Mr Halley made the point that the GFR results throughout Mr Humphreys stay at the ward ranged from 9 on 29 August, 1 September it was 11 and on 2 September it was 14, all results under 15 which would indicate kidney failure.[146] Further that it was the role of the doctor attending to the patient in this instance to interpret those results.

153. Nurse Bowes gave evidence that Mr Humphreys was never seen by a nephrologist while on her ward.[147]

Coroner's Assistant Ms Weir:

154. Ms Weir drew her attention to further abnormal results indicated by Mr Humphreys' blood test. Nurse Bowes gave evidence that she was looking at the results which are more regularly reported to doctors such as the sodium, potassium and chloride. Nurse Bowes stated that she would rarely report on bicarbonate or GFR results.[148]

Tony Xue[149]

Coroner's Assistant Ms Weir:

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[142] Transcript, 180-1.
[143] Transcript, 182.
[144] Transcript, 186.
[145] Transcript, 187.
[146] Transcript, 187-94.
[147] Transcript, 202.
[148] Transcript, 204-5.
[149] Exhibit 4: Statement of Tony Xue.

155. Tony Xue (Mr Xue) was the ward nurse caring for Mr Humphreys during the morning of his death on 7 September 2015.[150]

Mr Mukherjee:

156. Mr Xue gave evidence that although Mr Humphreys complained of not being able to catch his breath, his respiratory rate was fine and he was unable to see signs that Mr Humphreys could not breathe. Mr Xue checked his vital signs and Mr Humphreys' oxygen saturation was good, his respiratory rate was good as well as his heart rate and blood pressure.[151]

157. On 6 September, Mr Xue estimates he was looking after between four and five patients on the ward that evening.[152]

158. Mr Xue gave evidence he did not have chance to look at the handover notes in relation to Mr Humphreys until approximately 12 or 1.00am on the morning of 7 September as he was helping Mr Humphreys to the bathroom for a period of time.[153]

159. Mr Xue gave evidence that as a matter of course he would read the progress notes, however, he does not specifically recall reading about Mr Humphreys' difficulty swallowing.[154] He had been made aware that Mr Humphreys had undergone an AAA operation and was approximately 12 or 16 days post-operation, and had multiple loose bowel actions and Mr Xue was told by afternoon staff, *I need to keep an eye on him.*[155]

160. Mr Xue was told Mr Humphreys was a high falls risk and to pay particular attention to any dehydration following his diarrhoea.[156]

161. Mr Xue did regular checks on Mr Humphreys, at least every half hour, to check his condition, ensure he was toileted and safe in terms of his falls risk.[157]

162. Mr Humphreys requested oxygen at approximately 1.40am and Mr Xue recalls helping Mr Humphreys go to the toilet each time apart from once at about 1.00am, at which time he didn't call because it was too urgent.[158]

163. Mr Xue was the person who found Mr Humphreys on the floor of the toilet and pressed the emergency button. At the time he was answering a call from another patient in the neighbouring room.[159]

164. When Mr Xue re-entered Mr Humphreys' room and found him on the floor of the bathroom, he was conscious and fluid was coming out of his mouth but not a large

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[150] Transcript, 96.
[151] Transcript, 101-2.
[152] Transcript 103.
[153] Transcript, 104.
[154] Transcript, 105.
[155] Transcript, 106.
[156] Transcript, 107.
[157] Transcript 109.
[158] Transcript, 114-5.
[159] Transcript, 117.

amount at that stage. Mr Humphreys had a fall and Mr Xue was focused on turning him to his side to ensure his airway was clear, but he was physically unable to manoeuvre the patient in this way.[160]

Mr Halley:

165. Mr Xue called a doctor to obtain advice in relation to providing Mr Humphreys oxygen and also to raise his concern about Mr Humphreys' diarrhoea. Mr Xue was unable to recall whether he or a nursing colleague on the shift, spoke directly with the doctor about Mr Humphreys on that occasion.[161]

166. Loperamide was administered to Mr Humphreys at approximately 2.00am to help control his bowel actions.[162] All the observations of Mr Humphreys are normal from about 22.30 hours that day other than the change to the oxygen flow rate. In light of this, Mr Xue agreed with the assertion that it was more likely the oxygen was given for comfort purposes rather than breathing difficulties.[163]

Mr Bourke:

167. Mr Xue did not initiate a MET call for Mr Humphreys leading up to the fatal vomit because his vital signs were stable, and he did not reach any of the criteria. Mr Humphreys seemed alert and had the mobility to walk to the toilet with the assistance of a nurse so under those circumstances, his condition specifically did not meet the criteria that *"Nurse concerned that patient likely to deteriorate without prompt treatment."*[164]

Dr Victor Samuel Wayne[165]

Coroner's Assistant Ms Weir:

168. Dr Victor Samuel Wayne (Dr Wayne) is a cardiologist working as a senior consultant at the Alfred Hospital and also in private practice at Cabrini Hospital. Mr Humphreys was referred to Dr Wayne by Dr Cox in order to perform a coronary angiogram in light of Mr Humphreys' AAA, his multiple coronary risk factors and an abnormal Thallium exercise test result which had been performed pre-operatively. In analysing the results of Mr Humphreys' coronary angiography, Dr Wayne found only minimal coronary artery disease and concluded that he would be safe to undergo the AAA surgery.[166]

169. Dr Wayne attended upon Mr Humphreys postoperatively to *keep an eye on his cardiovascular status,* but he saw that these matters appeared to remain stable and the postoperative concerns related more to renal impairment and a subsequent ileus.[167]

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[160] Transcript, 119-20.
[161] Transcript, 122-4.
[162] Transcript, 125-6.
[163] Transcript, 129.
[164] Transcript, 135.
[165] Exhibits 6, 6A, 6B, 6C; *Inquest Brief,* 20.1ff.
[166] *Inquest Brief,* 20.1.
[167] Ibid.

Dr Geoffrey Cox

Coroner's Assistant Weir:

170. Dr Geoffrey Cox (Dr Cox)[168] is a medical practitioner, specifically a vascular surgeon who performed Mr Humphreys' AAA surgery and oversaw his post-operative care.

Mr Bourke:

171. Dr Cox gave evidence he practices at the Alfred Hospital in Prahran and at Cabrini Hospital in Malvern. He also consults in Morwell in the Latrobe Valley three Fridays per month.[169]

172. Dr Cox heads the Vascular Craft group, which involves oversight responsibilities for other vascular surgeons who consult and practice at Cabrini. The responsibility includes preparing the on-call roster for the hospital and chairing a regular craft group (usually held three times a year) to raise any practice issues and to analyse any adverse events which occur.[170]

173. Dr Cox is also involved in training vascular surgeons both in Australia and in internationally as well as teaching medical students.[171] He has been performing AAA operations since completing his vascular surgical training in 1990 and Dr Cox estimates that he performs between 20-30 cases per year.[172]

174. As part of the usual postoperative course, Dr Cox advises all patients that they will experience a postoperative ileus:

... I tell them that for a period of time after the surgery the bowel will not work and they will not be able to eat or drink anything and they will get all their fluids via a drip... And once the patient starts passing flatus again...[i]t's a sign that the air is transmitting through the bowel, and that we can reintroduce fluids... I also tell them that because they've not eaten anything, that those initial bowel movements are going to be loose, or they're going to have a degree of diarrhoea. And I tell them it will usually take a number of weeks before the bowels actually return back to normal. And that's not to say that I expect them to have diarrhoea for three to four weeks, but it does take time for normal bowel function to return.

...

Q: And what is your practice with managing patients with ileus post-surgery?

Ans: ...[T]he management of ileus is bowel rest, so the patient is nil orally, although we'd usually give the patient a little bit of ice to suck, because otherwise the mouth gets very dry and they find it very uncomfortable, but the point is not to give them fluid, because it will only make them uncomfortable... There's no

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168 Exhibits 8: Statement of Dr Cox (supplemented by accompanying Exhibits 8a, 8b, 8c, 8e, 8f, 8g, 8h and 8i).
169 Transcript 401.
170 Transcript 401-2.
171 Transcript 402.
172 Transcript, 405.

evidence that passing a nasogastric tube will facilitate the recovery of an ileus. Insertion of a nasogastric tube is to control vomiting if there is a particularly persistent problem. The disadvantages of a nasogastric tube is that they are uncomfortable, they do cause irritation of the nasopharynx, and because it passes from the oesophagus through into the stomach you actually render the sphincter or the valve at the top of the stomach incompetent...because you're holding it open with a tube, and there's actually some evidence that you can slightly increase the risk of reflux, so that's the passage of material back from the stomach into the oesophagus by having a nasogastric tube in place.[173]

175. The surgical aspect of Mr Humphreys' treatment was considered a success and he was moved to the intensive care unit where his condition was stable. Mr Humphreys overall medical management was conducted by the intensive care physicians *because they're available all the time, there's a fellow there at all times, they do ward rounds twice a day, and as the surgeon, I would come in and do a ward round at least once a day, and if...they had any concerns they would contact me and I would review them additionally, and in general they would take the role of conducting the medical management of the patient at that point...but in terms of any surgical decisions, they would defer that to me.*[174]

176. In terms of attending Mr Humphreys, Dr Cox gave evidence he saw him each day he was an inpatient, save for the day that he died in the early hours.

Q: And why isn't that documented in the progress notes?

Ans: Your Honour, this has been a very enlightening and embarrassing situation to me. And so my practice, because I've tended to care for the patients myself, I felt that it was less important to write notes because I was essentially writing them to myself. If I had multiple physicians involved, then you need to write something so they know what your thoughts are, and I thought, well I'm just doing this on my own, I don't need to write it down. Well, having reviewed the issues here, if I had written them down, this would have made things a lot more sensible. It is clearly much better medical practice, and this is one of the issues we identified at Cabrini when we reviewed the things, and I have undertaken to mend my ways. I won't say that I'm a saint just yet, but I am certainly aiming to make notes each time I see the surgeons, certainly for these complex multi-day stays.[175]

177. Dr Cox explained that it is usual for an ileus to be accompanied by a degree of distension following surgery due to the accumulation of fluid and some vomiting may be a feature of an ileus but not necessarily so and may occur post-surgery for a multitude of reasons.[176]

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173 Transcript, 406-7.
174 Transcript, 427-8.
175 Transcript, 428-9.
176 Transcript, 553-4.

The difficulty…is not in diagnosing the ileus but to identify when the ileus is resolving because clearly, it does not go from zero activity to 100 per cent activity instantaneously. So, it's a gradual recovery.[177]

178. Mr Bourke referred Dr Cox to his statement to the sentence that begins, *"once bowel sounds were present and he was passing flatus, oral fluids were introduced and his naso-gastric tube was removed on 27 August 2015."*[178]

Q: [W]hat type of bowel sounds are you referring to in that sense?

Ans: Okay, so, obviously it is important to listen to the abdominal cavity with a stethoscope and I would concur with both the testimony of Mr Tomlinson and Mr Westcott that we do not rely on the report of bowel sounds by the nursing staff. This is something that we do ourselves to assess that. Reference is being made to the presence of tinkling bowel sounds which are high pitched which is suggestive of a less complete resolution of the ileus. Obviously if the bowel sounds it means the bowel is contracted because that's what makes the sounds but it can suggest it is less completely recovered.[179]

179. Dr Cox sought to clarify a point in his statement which suggested that the nasogastric tube was removed on 27 August 2015 (the day after ICU) but also inaccurately suggests that fluids were re-introduced on that day. The fluid balance charts tendered and marked as Exhibit 7(a), reflect the first re-introduction of any form of fluids was at 18.00 hours on 30 August 2015. Prior to this Mr Humphreys was restricted to ice chips to prevent mouth dryness.[180]

180. Although nursing staff had previously assessed Mr Humphreys' bowel sounds, Dr Cox testified that he made his own assessment of Mr Humphreys in this regard, independent of nursing notes. According to Dr Cox then he assessed the bowel sounds using a stethoscope over the abdomen and listened in all four quadrants to assess activity in each. [181] I note that Dr Cox did not seek to explain how he was able to remember these events and results, or explain how he might have had specific recall of the results of his examination, of the different patients he managed concurrently.

181. Dr Cox gave evidence that it was his decision on 27 August 2015 to remove Mr Humphreys' nasogastric tube:

That was my decision which moved on the basis that the level of aspirates were low and it was also contributed to the fact with the discomfort on the back of the nasopharynx and the need for a nasogastric tube is not relevant to the recovery of the ileus as has been stated by Mr Westcott. The use of the nasogastric tube reduces the discomfort from vomiting. It does not enhance the recovery from the ileus. So, someone has frequent vomiting then placing a nasogastric tube will

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[177] Transcript, 554.
[178] Exhibit 8, 3; *Inquest Brief*, 16.
[179] Transcript, 554.
[180] Exhibit 7A; Transcript, 555.
[181] Transcript, 555.

reduce the discomfort from the vomiting. So, it's for symptomatic relief, not for therapeutic benefit.[182]

...

Q: ...[W]hat do you mean by the level of aspirates?

Ans: So, there is very little fluid coming up from the tube and that reflects that the likelihood of vomiting in that... period of time is low.[183]

182. Mr Bourke directed Dr Cox to his statement which read, *He then developed abdominal distension with vomiting, suggesting a persisting ileus*:[184]

Q: What is the significance of, first of all, the abdominal distension?

Ans: So, as has been discussed by...both Mr Tomlinson and Mr Westcott, the diagnosis of an ileus is a combination of features, of which dist[ension] is one of them.

So the fact that he was not tolerating the oral fluids with vomiting and the fact that there was some increase in distension despite the presence of bowel sounds suggested to me that while the ileus was recovering in fact it had not recovered enough to a degree that it was appropriate to continue with oral fluids and so we went back to rescuing the bowel again... [W]e felt that the bowel, although it was functioning, it was not functioning to a satisfactory degree and that it was appropriate to rest the bowel for a further period of time.

The Coroner: And this was when?

Ans: So, the fluid balance charts show that fluid was introduced initially at 1600 hours on 30 August... And it was ceased again at 1400 hours on 31 August... So, all the entries up to that point [where fluids commenced] were ice chips only.[185]

183. Following the recommencement of fluids at 18.00 hours on 30 August 2015, the fluid balance charts reflect apple juice, sorbet, chicken soup and soda water being given. The next day at 14.00 hours the chart indicates 200mls of cranberry juice was given but *sips only*; and fluid chart of 1 September 2015 reflects no oral fluids at all being given.[186]

184. Dr Cox gave evidence that he sought to rest the bowel in Mr Humphreys' case by ceasing oral intake. He reiterated that use of the nasogastric tube would not facilitate a resting of the bowel, *only a relief in symptoms for someone suffering from frequent and distressing vomiting.*[187]

185. *Recovery from ileus is assessed by way of a clinical diagnosis and is multi-factorial.* Presenting features which may indicate recovery from ileus are; the

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[182] Transcript, 555-6.
[183] Transcript, 556.
[184] Exhibit 8, *Inquest Brief*, 16.
[185] Transcript, 561.
[186] Transcript, 561.
[187] Transcript, 562.

return of bowel sounds, the passage of flatus, a bowel movement, the absence of vomiting and the level of distension.[188]

[T]he most important feature...in my opinion, [is] the passage of bowel movement and flatus because that's the only thing that [is] coming all the way through. Vomiting, while a feature of...ileus, can also be a feature of other things as well, and so when we look at vomit, what we're looking at is the volume and, to a degree, the nature of the vomit...If I can also point out...the assessment of distension can be very difficult in someone who weighs 126 kilograms. It is also the most subjective of all measures that we have and so to make comparisons between observations on different days by different people, it certainly contains scope for error...[189]

186. Dr Cox, during his evidence, expressed his view that abdominal X-rays or serial X-rays would not have added to or assisted with the diagnosis in this case. It was possible for x-ray to show some level of fluid and air fluid levels but would not indicate whether the bowel was in recovery or not. There would be satisfactory progression if there was some passage through the bowel.

The reason for doing X-rays or, indeed, the CT scans, is if the clinical course deviates from the expected pathway and then you're really looking for some sort of other pathology that's been superimposed on top of the paralytic ileus that would require more active treatment.[190]

187. Dr Cox agreed the progress notes reflect that on 3 September 2015 he attended upon Mr Humphreys and instructed staff that Mr Humphreys *'[m]ay have sips of fluid orally today.'*[191] The rationale for his decision was that:

... [W]e'd rested the bowel for another couple of days and based on the clinical scenario...I felt that it was reasonable to again try and introduce oral fluids. So I felt that the ileus at that time was... well resolving to a degree where it was appropriate to try recommencing oral fluids...[B]y sips of fluid, that means we're...giving small volumes to assess the outcome.[192]

188. Dr Cox gave evidence that on that day he did not consider that there was any reason for the re-insertion of a nasogastric tube. He acknowledged there was reference to one episode of vomiting the day before (2 September 2015) of *150mls of greenish fluid. But there's no record of any...vomiting...other than that episode.*[193]

189. Dr Cox read aloud an entry from the progress notes from 08.30 hours on 4 September 2015 which stated:

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[188] Transcript, 562.
[189] Transcript, 563.
[190] Transcript, 563-4.
[191] *Inquest Brief*, 170; Transcript, 566.
[192] Transcript, 566-7.
[193] Transcript, 567.

Seen by Mr Cox, may have free fluids orally today, remove indwelling catheter.[194]

190. Dr Cox acknowledged it was his decision to give free oral fluids that day and remove the catheter. It was based on his assessment that Mr Humphreys was passing flatus although the bowels had not been opened. Mr Humphreys had tolerated small amounts of fluid the day before with no episodes of vomiting (other than 2 days earlier on 2 September 2015) and his abdomen was softer. He decided to remove the catheter based on the monitored substantial improvement in renal function; Mr Humphreys was mobile and his urine output was satisfactory and he considered such an *invasive measure,* was unnecessary. They could monitor Mr Humphreys' urine output through a bottle. Dr Cox further did not give consideration to the re-insertion of a nasogastric tube at that time because there was no vomiting.[195]

191. The progress notes from the morning of 4 September 2015 indicated the following:

Ob stable, afebrile, ambulating independently, showered with supervision. Tolerating free fluids, IDC [out]...Void at 140 and 120mls...IV [therapy] continues, 100ml per hour plus PCA minimal use. Heart rate slightly irregular. Abdominal wound exposed, healing well, BNO [bowels not open], HNPF [has not passed flatus], faint bowel sounds noted, abdomen remains distended, comfortably sitting out of bed. Nil concerns voiced ATOR [at time of review].[196]

192. Dr Cox gave evidence that this summary indicated to him that Mr Humphreys was tolerating fluids and that there had been no vomiting. His urine output was satisfactory and bowel sounds were present although has not passed any bowel action. He interpreted the *'Nil concerns voiced',* as the nurse having no concerns but conceded it could be interpreted that Mr Humphreys himself had expressed no concern.[197]

193. The next entry on 4 September at 15.20 hours read:

Patient vomit 300mls, refuse anti emetics. Faint bowel sound noted. Notified nurse unit manager. Encourage patient to take fluids slowly and close monitor.[198]

194. Dr Cox acknowledged that this log reflected that Mr Humphreys had vomited 300mls on 4 September 2015. He was not notified of this event.

195. The next entry at 18.40 hours indicated:

Patient vomit 500mls. Notified NUM [nurse unit manager]. PRN anti emetics given [with] some effects. Patient...A+O [alert and orientated], obs stabile, afebrile, denies pain. PCA morphine ongoing, PUIT [passed urine in toilet].

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194 Transcript, 567.
195 Transcript 568-9.
196 Transcript 569-570; *Inquest Brief*, 172.
197 Transcript, 570-1.
198 *Inquest Brief*, 172; Transcript, 571.

Voiding good amounts of urine, post-voiding residual was 35mls. Abdo distended, bowel sounds noted, wound abdo exposed. Nil signs of any infection, bowels not open, tolerating free fluids, nil other issues.[199]

196. This progress note indicates that there were two episodes of vomiting on 4 September 2015 and that the patient did not appear to be distressed by it. The note contradicts itself in the sense that the patient is vomiting yet notes he is tolerating free fluids. Although not all vomiting under these circumstances is due to ileus and could have been a reaction to the morphine, or other causes. Dr Cox gave evidence that, similar to the vomit earlier that day, he was not informed of this event.[200]

197. The next note was at 07.00 hours on 5 September 2015:

Satisfactory. Slept intermittently. IV therapy continues. PCA [patient controlled analgesia] used regularly. Voided, bladder scan 73mls. Abdomen now very distended and firm ++. Bowel sounds heard. Patient passed large amount, loose watery brown bowel action at 0615. No further vomiting overnight. Ice and water only overnight.[201]

198. Dr Cox gave the following evidence in relation to his interpretation of that note:

Well first of all, despite the vomits, previously there'd been no further vomiting....[I]t does report that ...in the nurse's opinion, well this nurse's opinion that the abdomen was distended and firm...[W]hich may have been a concern, but on the other hand, bowel sounds were still present and on a positive note, the patient has in fact opened their bowels which clearly demonstrates that there is some bowel function.

Q: What's your comment on the nature of the reported bowel action being 'large amount, loose watery brown'?'

Ans: Ok, so a large amount is good... I tell all patients that they're going to have diarrhoea when their bowels first start open...[S]o a watery bowel action is certainly consistent with that... [202]

199. Another note on 5 September 2015 at 11.40 hours states:

Seen by Mr Cox. IV and PCA down. Can comment soft diet. Query home on Monday to son's house.[203]

200. Dr Cox stated that in light of the fluid chart reflecting Mr Humphreys having tolerated a total of 1,926mls of oral fluids, he made a decision that Mr Humphreys was able to maintain hydration without the need for an IV. Likewise, with

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[199] Transcript, 571-2.
[200] Transcript, 572.
[201] *Inquest Brief*, 172; Transcript, 574.
[202] Transcript, 574-5.
[203] *Inquest Brief*, 172; Transcript, 575.

evidence of some bowel function, Dr Cox made the decision that Mr Humphreys could start on oral analgesia.[204]

Q: What was your view as to the state of Mr Humphreys' condition at that time?'

Ans:I note the concern about the distension – I again, reflect back to my fact that of all the features of resolving [distension] is the least objective of the objective things. We have bowel sounds, we have bowels open. We had tolerating fluids and we have a good diaresis suggesting that the fluid is being absorbed from the bowel.

Q: Once again, did you give any consideration to re-insertion of the nasogastric tube at that time?

Ans: Well, there'd been no vomiting overnight. I thought that the fact that the bowels were opening was an encouraging sign, and so there was no – in my opinion, there was no indication for a nasogastric tube at that time.[205]

201. The progress notes on 5 September 2015 at 21.30 hours stated:

Patient alert & orientated. Orals stable. Afebrile. Complained of nausea and vomiting x 2. Dark, brown coloured fluid. Dr Cox been notified. Meclizine and Zofran given as ordered. Patient didn't eat any dinner, only had some fluids, small amount. Ice given, [increase] oral intake, PUIT [passed urine in toilet], diarrhoea x 6 this shift, water. Mr Cox notified. Nil further orders. Incontinent faeces, pad and pans in situ, abdominal suture line exposed. Nil complaints of pain, only discomfort on abdo medication given as chart. Ambulating independent. [206]

202. The note indicates that there were two vomits on that shift, both of which are referred to in the fluid balance chart dated 5 September 2015 at 16.30 and 19.30 hours. The volumes recorded are small, being 20 and 30 mls respectively. When viewed against the entirety of the fluid Mr Humphreys consumed that day, some 1470 mls by mouth, Dr Cox reasoned that the remaining fluid which was not vomited, transited through the stomach into the bowel. This would be supportive of the fact that there is at least partial function of the bowel consistent with a resolving ileus.[207]

203. Due to the low volume of vomit, Dr Cox attributed the vomiting to another cause and so directed antiemetic medication be given.[208]

204. Dr Cox reviewed Mr Humphreys approximately at midday on 6 September 2015, when Mr Humphreys complained of frequent diarrhoea in since the morning of the day before, and he was soiling himself and not able to reach the bathroom in time. In his statement, Dr Cox states there was no cause evident for the diarrhoea

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[204] Transcript, 575.
[205] Transcript, 576.
[206] *Inquest Brief*, 173; Transcript 576.
[207] Transcript, 577.
[208] Transcript, 577-8.

and he had no abdominal pain nor blood in the bowel movement. Dr Cox prescribed Lomotil and ordered blood tests of electrolytes to assess Mr Humphreys' hydration.[209]

205. In *viva voce* evidence, Dr Cox said of that consultation:

So when I saw him at the time, he was absolutely exhausted...[H]e'd been up all night and during the day with frequent diarrhoea and he was extremely distressed by that, and...embarrassed because he was not able to get to the toilet in time and so he was soiling himself and that's unfortunately not uncommon if people have precipitous diarrhoea and they're of a large size and their mobility is restricted. So there is the diarrhoea. There was no vomiting, there was nothing to suggest...that this was anything other than really a hyperactive bowel at this time and because of the effect it was having on him, because I needed to slow it down so he could actually get some sleep...I recommended the use or prescribed Lomotil to try to decrease the frequency of the bowel movements, so that he could...get some rest.[210]

206. Mr Bourke then took Dr Cox to the passage in his statement where he was contacted on the evening of 6 September 2015 regarding Mr Humphreys' condition. Dr Cox was advised Mr Humphreys was now complaining of persistent coughing and was agitated. A rash on his legs was also reported. His vital signs were normal and he did not fit the criteria for a MET call. Dr Cox enquired about the results of the blood tests ordered earlier that day and was advised they were normal. When he asked for the results, he noted that Mr Humphreys' creatinine level was again elevated, and that renal function had deteriorated. Dr Cox attributed this to dehydration secondary to Mr Humphreys' vomiting and diarrhoea.[211]

207. On 6 September 2015, Dr Cox's evidence is that he had spent the day operating at Cabrini Hospital and the night having a meal with his family for Father's Day. He denied having been to Morwell that day. Between Dr Cox's review of Mr Humphreys at midday and in the evening when he was contacted by nursing staff, he recounted the change in Mr Humphreys' condition:

[W]ell he certainly did not have a rash on his legs earlier in the day, so that was a new finding. Although the description as given to me over the phone was...very non-specific...and not suggestive of any pathological process.[212]

208. Dr Cox then enquired about vital signs, in particular Mr Humphreys' respiratory rate and oxygen saturation, and stated that he was reassured that was within the normal range. Any deviation from the normal range would have been a clear indication that Mr Humphreys had deteriorated and that medical review was required. However, with those elements being stable, coupled with the fact that

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[209] *Inquest Brief*, 17.
[210] Transcript, 578-9.
[211] *Inquest Brief*, 17.
[212] Transcript, 579.

Dr Cox had reviewed him earlier in the day and that the concerns raised did not seem to relate to critical issues, he felt that he could see Mr Humphreys the following morning when he started work.[213]

209. Dr Cox was asked by the Coroner:

Q: Do these criteria adequately deal with someone who has this patient's history?

ANS: [I]n what aspects of his history do you mean, Your Honour?

Q: Well I'm talking about a prolonged paralytic ileus. I'm sorry, a prolonged ileus?'

Ans: ...A paralytic ileus is not something that one would expect to cause acute deterioration in the patient's condition. So it's not part of the assessment...on the obs charts.[214]

210. Dr Cox recalled that Nurse Bowes contacted him approximately 6.30pm or 7.00pm on the 6 September 2015. His evidence agreed with Nurse Bowes in this regard.[215]

211. Mr Bourke asked Dr Cox about his view at that time about the state of Mr Humphreys' ileus condition:

[T]he concerns raised by the family were of catching of the breath and a rash on the legs. There was [no] reported vomiting at all. He obviously continued to have diarrhoea again suggesting...a hyperactive bowel rather than a non-active bowel and so there was nothing in what was communicated to me [which] suggested the ileus was any worse or had deteriorated. And the fact, the fact that he had ongoing diarrhoea and was tolerating oral fluids and was not vomiting, again, would suggest that there was bowel function present. And again if we look at the – for objective data, if you look at the fluid balance chart for 6 September, and again it's not added up so you'll have to trust my, my maths. So it's 400, 510, 710, 810, 1010, 210, 410, 610, 1810, so 1810mls of fluid in over the course of the day with no vomiting. So we have heard evidence that he was having trouble swallowing but the objective evidence from the nurses, in fact, showed that he was able to take quite a large amount of oral fluids in.[216]

212. In terms of renal function, Dr Cox felt it was unnecessary to check the pathology each day (as opposed to every two to three days) as they had seen a *clear trend of revering renal function.*[217]

213. Mr Bourke asked Dr Cox:

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[213] Transcript, 581-2.
[214] Transcript, 582.
[215] Transcript, 582-3.
[216] Transcript, 583.
[217] Transcript, 584.

Q: In your view, as at the evening of 6 September [2015]...was there evidence of Mr Humphreys suffering from any other acute abdominal condition?

Ans: ... No.[218]

214. Dr Cox acknowledged, however, that the electrolytes showed a further renal deterioration between 4 September and 6 September, and the creatinine level had risen from 256 to 402. He attributed that to the fluid loss stemming from Mr Humphreys' diarrhoea and *Dr Cox intended to repeat the testing the following day and restart IV therapy, reinsert a urine catheter and involve a nephrologist at that time.*[219]

215. Dr Cox also gave evidence that, taking in account that Mr Humphreys had taken approximately 1800mls of fluid by mouth with no vomiting, continued to have bowel sounds and bowel action, the risk of aspiration was low. This is despite the distension of the abdomen.[220]

216. Mr Bourke asked:

Q: Dr Cox, what is your view as to whether or not Mr Humphreys' death on 7 September 2015 was preventable by you?

Ans: I do not believe it was preventable. There was nothing in his situation when I saw him at midday on 6 September [to] suggest that he was about to aspirate and there was nothing in the description of his condition on the evening of 6 September to suggest that he was going to aspirate. And at that time, there was no indication for insertion of a nasogastric tube and as was testified by Mr Westcott, nasogastric tubes do not prevent aspiration. They paradoxically can increase the risk of regurgitation of gastric contents but as he correctly stated, it may have prevented it because anything may have happened, but in general, it is not – it does not stop it from happening.[221]

<u>Mr Halley:</u>

217. In the context of discussing the phone call between Nurse Bowes and Dr Cox on the evening of 6 September 2015, Dr Cox noted that Nurse Bowes had advised that all Mr Humphreys' blood results were normal. After he made a specific enquiry in relation to Mr Humphreys creatinine level, Dr Cox, contrary to Nurse Bowes' opinion, considered the level to be abnormal.

Q: ...So [as] a careful doctor, if a nurse told you that the tests are normal, then you enquire about the test and it's abnormal, you'll ask them about all the tests, won't you?

Ans. ...I was informed by her that the rest of the tests were normal.[222]

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[218] Transcript, 584.
[219] Transcript, 584.
[220] Transcript, 586.
[221] Transcript, 587.
[222] Transcript, 596-7.

218. Dr Cox agreed with Mr Halley's assertion about the conversation that occurred on the evening of 6 September 2015 with Nurse Bowes; Dr Cox gleaned all the appropriate information, filed that which he deemed relevant, and made the decision that there was no need to attend Mr Humphreys that evening.[223]

219. Dr Cox also reiterated his evidence that he embarrassed and contrite about his record keeping in this matter and is now endeavouring to document his patient visits.[224]

220. At the time of Nurse Bowes' phone call, there was no indication that a nasogastric tube was needed. Further, having regard to Mr Humphreys' vital signs noted and fluid charts beyond that time, the observations remained within the normal range right up until the time Mr Humphreys was found to have a had a cardiac arrest.[225]

Mr Mukherjee:

221. During Mr Mukherjee's examination of Dr Cox, the Coroner raised an enquiry about the extent to which the doctor examined Mr Humphreys with a stethoscope himself to listen for bowel sounds.

Q: You have told me that on each occasion you reviewed Mr Humphreys, you took out your stethoscope and listened yourself... for the information you were seeking to obtain?

Ans: No, I didn't say that, I said that when I was making an assessment of whether bowel sounds were present and suitable, it was appropriate to give fluids, then I would examine the patient myself.

Q: Right...I thought I understood you to say that you used your stethoscope to determine your own evidence in regard to bowel sounds on each occasion you undertook a review. Did I misunderstand that evidence?

Ans: No, I did not...I think you've misunderstood, Your Honour, so I certainly assessed his bowel sounds, but it is not necessary to assess that on every occasion.'

Q: ...What do we know then about...your evidence in regard to bowel sounds? I had understood you previously to say that on each occasion you saw him, you used a stethoscope to measure that and you gave some evidence and it's been broadly given by other medical witnesses in this case, that the understanding of bowel sounds is a very subjective matter and I see you nodding in agreement. I just want to know, on what occasions you did actually listen for the bowel sounds to assess them yourself.

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223 Transcript, 599.
224 Transcript,
225 Transcript, 599.

Ans: Well, I think a good answer is in the reverse, if someone is having their bowels open and has bowel activity, then it is not necessary to listen to the bowel sounds, because the bowel is clearly functioning.

Q: Can you recall for me the occasions upon which you listened for bowel sounds?

Ans: So, I would listen for bowel sounds... I would probably not have listened on the first day, because I expect that that's going on. I would then usually listen on subsequent days, up to the point when I introduce fluids for the first time.'

Q: All [right], look, we['ll] come to what you would usually do, but are you able to offer, with any degree of confidence... the occasions, which day during the course of this period, this nine day period, ten day period, you actually listened for bowel sounds yourself?

Ans: We're talking about two and a half years ago...So I...cannot say that on 6 September at 4.15 in the afternoon, I listened for bowel sounds....So I can only tell you what is my normal practice.'

Q: Alright. So, there was one occasion when you are confident that you listened for bowel sounds?

Ans: There... [was] more than one occasion.

Q: More than one occasion. And there are no notes to the effect that you listened for bowel sounds on that occasion, because there's no note anywhere in reference to your observations that you recorded bowel sounds?

Ans: Correct. [226]

222. Mr Mukherjee put the following to Dr Cox's regarding his decision not to re-insert the nasogastric tube following his awareness of Mr Humphreys' vomiting on 4 September:

Q: If you had been alive to the extent that I suggest to you that you should have to the possibility of a prolonged paralytic ileus which I suggest to you, you were not, you would have put a nasogastric tube into this patient on Friday 4 September 201[5], that evening after two vomits?'

Ans: I think we've established earlier that I was not contacted about the vomits on that previous evening, so I learnt about them the next morning. There had been no vomiting overnight and the bowels had been opened, and I think...if you recollect, reflect when Mr Westcott was asked about that, he indeed proposed that he may have perhaps put a nasogastric tube in at that time and then qualified it and said but there's very little come out since, so I probably would have taken it out again.

Q: Are you, therefore suggesting that once you knew about the vomits the next day that you were inclined to put a nasogastric tube into this patient?

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[226] Transcript, 602-3.

Ans: No. No, and if I remind you of the evidence of Mr Westcott, that the insertion of the nasogastric tube is not for the treatment of paralytic ileus. The insertion of the nasogastric tube is for symptomatic relief of vomiting. And so while he had had a large volume vomit on 4 September, there had been no further vomiting over the course of the night.'

Q: Dr Cox, I suggest to you that because of diarrhoea as you've mentioned in your letter to the Coroner, that it didn't matter how many times this patient vomited because you had transit through the bowel, did you not, and therefore you did not think you were treating a paralytic ileus?

Q: ...I was suggesting to you that the reason why you were further reassured that you didn't need to take that action (of re-inserting the nasogastric tube) was because you had the patient passing a large amount of loose watery brown bowel action as noted here?

Ans: No.

Q: So that's not correct?

Ans: No.

Q: So even the vomits in themselves did not warrant, in your opinion, the application of a nasogastric tube?

Ans: The patient had not vomited again overnight and so there was no reason to put a nasogastric tube in at that time.

Q: And your opinion, your actions were not changed by the fact there was longstanding abdominal distension. Could you answer that with a 'yes' or 'no' first please?

Ans: No.

Q: That didn't change your opinion?

Ans: No.

Q: The fact that he had vomited very recently before didn't change your opinion?

Ans: No. Because when I assessed him in the morning, the vomiting had ceased.

Q: Yes. But there's a risk, isn't there, that if it's a paralytic ileus that he would have vomited again; isn't that right ?... Please answer that question. There's a risk of vomiting again?

Ans: Okay. The answer to that question is yes, there is.

Q: ... So, therefore, that was not sufficient. That was not sufficient for you to warrant a nasogastric tube. There had been abdominal distension before. Why did you not do a radiological confirmation of whether there was anything going on in this distended abdomen at any point?'

Ans: Because it's not indicated.

Q: Not indicated by what?

Ans: By the clinical course.

Q: Which is what?

Ans: That there were features to suggest that the ileus was resolved.

Q: And which features exactly do you rely upon to reach that conclusion?

Ans: Presence of bowel sounds... The passage of flatus... the passage of bowel movements... And the nature and rate of any vomiting. Distension is also important. As I continue to state, in the absence of girth measurements and comparisons by different nursing staff, it is very difficult to make a reliable comparison.

Q: But here you are, Dr Cox, not making any notes. It's very important, isn't it, that we look carefully at these notes to see what's going on...?

Ans: It's obviously very important, yes. It's very important to look at other notes, yes.

...

Q: You cannot be sure that when describing your treatment to His Honour of Mr Humphreys that you looked at these notes in any detail at the time prior to his death?

Ans: It is well, again it's two and a half years, but it is certainly my practice to look at the nursing progress notes or, more importantly, to discuss it with the nurse who is looking after the patient at the time. [227]

Coroner White:

223. The Coroner sought to clarify Dr Cox's final evidence in this way:

Q: Dr Cox, just one further question. You've freely admitted that error occurred in respect of your failure to make notes of your own observations during the course of your visits with Mr Humphreys. The notes that have been made on your behalf do not include reference to such matters as distension of the stomach, do not include reference to such matters as bowel sounds. You have also told me, and I think it is common ground between all of the medical witnesses who have attended that there is a difficulty in relying upon the evidence of different nursing staff in regard to bowel sounds. And good reason has been given for that and it is not disparaging of nurses, it is simply a matter of being able to compare sounds with the same set of definitions in place. Is there any other evidence upon which I can rely in respect of your observations concerning... [Y]ou've told me that you believe you made one observation with the stethoscope and I misunderstood you to say that in respect of all these visits you'd been taking these bowel sounds. But you've told me today that this is not the case. My question is this: is there any basis upon which I can make findings that reflect the accuracy of the position in regard to bowel sounds and yes, essentially in regard to bowel sounds. Is there any evidence that I can refer to, in your estimate, [which] amounts to reliable

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[227] Transcript, 649-54.

recorded evidence of the documentation of the existence or otherwise of bowel sounds?

Ans: So first I would like to clarify with my evidence was that I examined, listened for bowel sounds on several occasions but not necessarily on every occasion. But I acknowledge that there is no, to my knowledge, any other evidence within the notes to confirm that. Again, as I've said, I apologise, I'm very contrite. What I would like to point out, it is not my expectation that the nurses make notes on my behalf... And I would certainly not criticise them for omitting things, because it is not part of their clinical duties.

224. *Q: And similarly in regard to distension, is there any evidence upon which following your approach to these matters, and I acknowledge your evidence that suggests this is the least reliable of criteria in assessing prolonged paralytic ileus but is there any other evidence that I can rely upon in determining the accuracy of the position in regard to distention?*

Ans: No, Your Honour...All I can say is that going ahead, you know, I would write abdo soft, bowel sounds present and document all of those things.[228]

Dr Mark Westcott [229]

225. Dr Mark Westcott (Dr Westcott) is a practicing vascular and endovascular surgeon employed as the Director of Vascular Surgery at St Vincent's Hospital Melbourne. Dr Westcott has also been engaged in private practice at St Vincent's Private Hospital Melbourne for the past 11 years. His further qualifications are outlined in both of his statements contained in Exhibit 9.

Coroner's Assistant Ms Weir:

226. Dr Westcott agreed with Dr Dodd in relation to the cause of death in Mr Humphreys' case.[230]

227. In Dr Westcott's subsequent statement dated 24 January 2017, he was asked by this court to document if and how Mr Humphreys deviated from the usual recovery from an AAA operation. In one observation he stated:

The first recorded bowel action ("large amount loose watery brown") was at 0615 on 5 September. The 'Stool Observation Chart' documents a further 28 watery bowel actions over the following 48 hours. [231]

A further two vomiting episodes on the afternoon of 5 September of dark fluid are noted.

A massive feculent vomit was noted at the time of the cardiorespiratory arrest about 0330 hrs on 7 September.

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[228] Transcript, 706-8.
[229] Exhibit 9: Two statements of Dr Mark Westcott; Inquest Brief, 24-36.
[230] Transcript, 432.
[231] Inquest Brief, 32.

When asked about Dr Cox's statement that there were signs that Mr Humphreys had recovered from the paralytic ileus in the days preceding death, Dr Westcott commented that the recorded multiple bowel actions in the 48 hours preceding... death are suggestive *of at least a partial resolution of his paralytic ileus and that the ongoing vomiting suggested that resolution was not complete.*

In regard to any ongoing investigations which might have been undertaken to assess the reasons for the continued gastro-intestinal symptoms, Dr Westcott commented the need for investigations would be influenced on a day to day basis, with frequent monitoring and management of electrolytes in the context of acute renal impairment. Further *imaging of abdominal x-ray or CT scanning may have been warranted if Mr Humphrey developed increasing abdominal distension particularly in the context of absolute constipation.*[232]

228. Ms Weir then questioned Dr Westcott along the following lines:

Q: Now, looking at that description and the frequency of the, you've termed it 'diarrhoea', do you class that as a normal functioning bowel movement?

Ans: No. In short, the bowel doesn't normally function that well but in the recovery period as ileus is resolving, particularly when there's been a retention of a very large volume of fluid with the gastrointestinal tract copious diarrhoea is commonly seen in the recovery period after ileus.

The Coroner: Copious diarrhoea?

Ans: Most of the motions there are described as quite small so it's really difficult to comment on the total volume of diarrhoea here... It suggests the patient has lost control of his bowels as well simply by the sheer number of attendances at stool...[S]o I'm a little hesitant to decidedly say whether it's in the normal range of recovery after ileus. I had alluded earlier to ischaemic colitis as being something that's potentially concerning in a post-operative patient. The absence of any blood in the motions here went against that and so I guess it's less concerning tha[n] if it had also been accompanied by some blood in the motions which could also be another reason for copious diarrhoea in the post-operative period.

The Coroner: So the number of visits, you can't talk about the quantity of the excretion, but the number of the visits doesn't surprise you?

Ans: It's more than one would usually see but I don't see it as being a stand-out feature here. To me this is more suggestive that the patient is incontinent and having lost control of the bowels as well rather than necessarily reflecting terrible intra-abdominal mischief...

Q. Could it be reflective of an ongoing paralytic ileus?

Ans: If anything [it] was more reflective of a resolving ileus...[233]

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[232] See exhibit 9.
[233] Transcript, 436-7.

229. In relation to the distension of Mr Humphreys abdomen, Dr Westcott was questioned in relation to the observation notes recorded on 4 September:

Q: [S]o it's…4 September, the first entry there…abdomen remains distended and that appears to be from one of the nurses?

Ans: Yes.

Q: Then on 4 September at 15:20 we have a notation that the patient vomited 300mls?

Ans: Yes.

Q: And there's a note there to closely monitor. Then we go to the entry after that, again patient vomited 500mls and the third line of that entry it says 'abdomen distended'?

Ans: Yes.

Q: So we've had a change from the day before to the 5th, from the 4th to the 5th, that his abdomen has gone from soft to distended. So if you're saying that the ileus is resolving, wouldn't it be that the abdomen would continue to remain soft instead of getting worse and progressing to a distended…?

Ans: I guess one of the real difficulties in the diagnosis of a persistent ileus is that it's not a binary function. You're not all of a sudden going to have the bowel completely paralytic and then all functioning well… That different sections of the gastrointestinal tract may be behaving quite differently at a given point in time…So there can be changes in the timing of a return to function of the upper tract, the stomach, the proximate small bowel, the more distal small bowel and the large bowel as well, so it is one of the clinical difficulties in assessing [a] post-operative patient [as] to what degree of confidence you can have that the patient will be able to tolerate oral fluids and feeds based on the combination of symptomatic descriptions of distension, palpitation of the abdomen and then more objective findings such as whether there are any bowel actions or the presence of bowel sounds as well as vomiting, so it's not unexpected to see some changes in the degree of abdomen distension in the week after abdominal surgery.'

Q: But changes, and correct me if I am wrong, but changes that indicate deterioration, are you saying that going from soft to distended isn't a change?

Ans: It is a change…it can be a change and, for instance, it is not uncommon on the introduction of a change in diet and increase in the amount of fluids or transition to solids to again have worsening of the ileus after that and some increased distension after the reintroduction or increased intake of oral fluids and food.[234]

230. Dr Westcott was taken to the progress notes specifically on 5 September, which lists a watery brown bowel action and two vomits of 300mls and 500mls

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[234] Transcript 439-40.

respectively. Dr Westcott described the amount of vomit as *'moderately large.'*[235] Dr Westcott also interpreted the note which described Mr Humphreys' abdomen as *'firm ++'* to indicate some degree of persisting ileus.[236]

231. Dr Westcott noted in his evidence that although there was a large amount of watery brown bowel action recorded, bowel sounds were also heard which was suggestive of some return of function alongside an ileus.[237]

Q: And pass[ing a] large amount of watery brown bowel action. Does that indicate that the ileus is getting worse or not?

Ans: At the time of this entry it would be 12 hours since the last vomit and bowels are open and bowel sounds are heard and so I'd see that as an encouraging sign that the ileus is resolving.[238]

...

Q: Now we've had Dr Dodd, the pathologist, give evidence, and we've had Dr Tomlinson as you've read give evidence yesterday. Dr Dodd when he was asked a question in relation to diarrhoea and his explanation for the bowels emptying, he was saying [it was] emptying itself under gaseous pressure. Would you agree with that or not agree with that?

Ans: I'm not really sure how he can draw that conclusion how he can draw that conclusion. It's certainly feasible that that could be the case, but in the presence of bowel sounds I'd be more inclined to think there's some return of peristalsis in the bowel... or the forward movement, the contractility... the normal contractility of the bowel... Your Honour, to clarify, that this is not a binary event. It doesn't all switch on at once. That there may be some sections of the bowel that start to contract ahead of others and so it's not that all of a sudden ileus is over. I guess further to that... I was given a copy of Dr Dodd's comments on Monday so I have had a chance to read those. And I guess I just want to emphasise that ileus is really a clinical diagnoses. There's not a pathological finding where one can be certain that there's still ileus as against a diagnosis of distended colitis or other findings which are clearly demonstrable at autopsy. There are features that can be found at autopsy that are suggestive and consistent with ileus, but I would contend that it's a clinical diagnosis.

The Coroner: Just let me ask you this at this point. A reference to bowel sounds being heard, what may that have been?

Ans: That's suggesting that there's movement of fluid and gas within the bowel and so any contraction of the bowel will be pushing fluid forward and there will be bubbling of gas in amongst the liquid stool or liquid gas for intestinal contents... I believe there has probably been some discussion this week about the different sorts of bowel sounds that may have been heard as well which are rarely

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235 Transcript, 444.
236 Ibid.
237 Transcript, 444.
238 Ibid.

pathognomic, rarely can they be associated with complete confidence of a specific condition such as bowel obstruction or such as more return of function, so there's a range of sounds that would be heard, but the presence of some bowel sounds tell us that the bowel is contracting at least in part.'

Q: '... there was some discussion and if you've read the transcript it's very helpful, Dr Dodds mentions tingling [sic] a[s] that sound. Dr Tomlinson also mentioned the sounds of tingle, so I think he'd indicated that he wouldn't be confident with the bowel sounds written by a nurse because he would want to listen to them himself?'

Ans: 'Tinkling bowel sounds, classically described as occurring in a bowel obstruction, because there is a greater gaseous [distension] of the bowel due to the complete blockage of the bowel, but it still reflects activity of the bowel contracting against that obstruction.'

...

Q: 'So you still say that despite what I've outlined there about vomiting, the bowel sounds that he hadn't – that he stopped vomiting overnight on the 5th, that it was, it would seem to you to be consistent that his ileus was resolving?'

Ans: 'Despite the moderately large vomits that occurred on the 4th ... the fact that that didn't continue overnight and there's now evidence of a bowel motion 12 hours later is suggestive that there's some resolution.'[239]

232. Referring to the progress notes made on 5 September 2015, Ms Weir put the following to Dr Westcott:

Q: '...So that nursing note was at 21:30, there's notes of vomits at 16:30 and 19:30 of 20mls and 30mls respectively, so small volumes. They're small amounts, compared to the previous day?'

Ans: 'Yes.'

Q: 'But halfway through the entry of 5/9/15 it has that he was incontinent of faeces; is that right?'

Ans: 'Yes.'

Q: 'Would that indicate to you that his distended abdomen which is noted in those entries from the nursing staff may have caused that to occur?'

Ans: 'I can't draw that conclusion. If – it's figure, I'm more inclined to interpret that he's been – and he had very minor vomits, there's a comment there though he didn't eat any dinner, he actually only had some fluids, small amounts, but he's tolerating some fluids. I'm inclined still to be thinking this is a picture of incomplete resolution of ileus, but there are signs of resolution occurring.'

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[239] Transcript, 445-7.

Q: 'Dr Tomlinson gave evidence yesterday to say that these symptoms indicated that the ileus wasn't resolving and that there's an indication that it was a non-functioning gut. Would you agree with that?'

Ans: 'I've just told you I believe that this is more suggestive of some resolving ileus. I don't argue that this is not a normally functioning gut. It's absolutely not normal at this point, but there's some suggestion of return to function.'

Q: 'So you disagree with Dr Tomlinson in that he says it's a non-functioning gut because he's incontinent and unable to control his bowel movements?'

Ans: 'I can't draw that conclusion.'

The Coroner: '... Just to be clear, are you giving that evidence having regard to the symptoms as they presented at that time... plus what we now know as a result of the pathology done post-mortem?'

Ans: 'It would be difficult to be completely confident at that time that there wasn't a greater mischief going on... to absolutely exclude other pathology, and I've alluded a couple of times to ischaemic colitis or bowel ischemia, which if left untreated is obviously of great concern.'[240]

233. Dr Westcott discussed his approach towards the vomiting and nasogastric tube:

Witness: 'So if the patient continues to vomit large amounts, then there's a relatively stronger indication for drainage. If the vomiting is resolving, then one is inclined to take a fairly conservative approach, not put the patient through the trauma and the possible complications of a nasogastric tube, but rather wait, look to reintroduce fluids as tolerated, and to me this is a sign that there is some return of bowel function.'

Q: 'I just want to talk about the vomiting that you're talking about then. So the symptoms of vomiting are ceasing. If I can take you to – and I appreciate its jumping ahead – but if I can take you to the – page 174, 7 September, at 3:45 hours... When the Code Blue is called. On that first entry there, the fifth line from 7 September, the word "massive" is underlined and it's "massive feculent vomit"... "All over patient and floor"... Whilst the records indicate that he hadn't vomited since the 5th, that vomit there indicates that, and correct me if I'm wrong, that there's a large amount of food or fluid in his stomach that he's vomited... Would that be consistent with or the reason for it being the [distended] abdomen and causing pressure to force it back up?'

Ans: 'In part that can be a factor, but also for it to be truly feculent vomiting it's suggesting that it's – that the content has spent some time within the small bowel, is partially digested and then has returned, so I'm more inclined to think that there's reverse peristalsis, that is that the bowel has actually contracted, pushed the fluid back into the stomach and then vomited.'[241]

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[240] Transcript, 448-50.
[241] Transcript 450-1.

234. Ms Weir also questioned Dr Westcott in relation to the prospect of reinserting the nasogastric tube:

Q: 'So there was suggestion by Dr Tomlinson that if he, Mr Humphreys had have been given a nasogastric tube with suction to remove some of the contents from his stomach, that may have alleviated the amount of vomit and maybe the aspiration at the time of death. Would you agree with that?'

Ans: 'A nasogastric tube…or free drainage will usually reduce stomach contents, pulled content within stomach, but it could also be overwhelmed, and this is the sort of situation we see when a patient has a true bowel obstruction; it may be overwhelmed by reverse peristalsis in the sudden refluxing of small bowel content into the stomach as well. So what – I can't draw any conclusions here is the timelines that any fluid has refluxed from the small bowel and into the stomach here, so I can't comment definitively how effective a nasogastric tube would have been at draining that feculent vomit.'

…

Q: 'Mr Humphreys' family attended at the hospital on the evening of 6 September and they had spoken to the nursing staff concerned with how his presentation was, how he'd deteriorated. Are you able to say that – so are you saying that if a nasogastric tube was given at, say, 6 September at 14:00 hours or even at 18:30 when Dr Cox, or around that time, was contacted, would that have been able to – are you able to say whether if a nasogastric tube at that time would have eliminated the massive vomit, feculent vomit later on?'

Ans: 'Can I take a step back…And the first thing is whether there was an indication symptomatically; I've already suggested that a nasogastric tube is useful for symptomatic relief and if there'd been ongoing vomiting through the course of the day, given events the day prior, then there would have been a reasonable case for putting a nasogastric tube in. In the absence of any vomiting as far as I can tell from the fluid balance chart on the nursing notes during the day of the 6th, I don't believe there was a clinical indication to be putting a nasogastric tube to drain stomach contents. It would be ineffective in draining small bowel contents which was likely to be the major cause of the distension at that point.'[242]

235. In response to Dr Westcott's view in evidence about the decision not to reinsert a nasogastric tube in Mr Humphreys' case, the Coroner asked about other possible testing:

The Coroner: 'What might otherwise have been done to test what was going on?'

Ans: 'A plain abdominal scan in the erect – sorry, an abdominal x-ray, a plain abdominal x-ray in the standing position or the erect position will demonstrate fluid and air levels and may help confirm the clinical diagnosis and look at which parts of the bowel are particularly distended and if there was seen to be a very

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[242] Transcript, 453-4.

large volume distended stomach at that point, then a case is strong for putting in a nasogastric tube. If it...simply showed gross distension within the small bowel and/or large bowel, then there's no indication for a nasogastric tube. The other test to do would be a CAT scan as well which again can give some further information, particularly if there a high degree of concern about a mechanical obstruction. But it's an effective test for that.'

The Coroner: 'A CT scan would show what was going on in the stomach as well?'

Ans: 'Correct.'[243]

236. Dr Westcott agreed that reinsertion of the nasogastric tube would have drained some of the content from the gastrointestinal tract, notwithstanding his expressed reservations about the use of nasogastric tubes in this way, and specifically in Mr Humphreys' case in the context of his swollen uvula.[244]

237. Dr Westcott gave evidence that it was unusual for increased intra-abdominal pressure to result in *'terrible diarrhoea'*[245] and more regularly it would be indicative of *'increased motility within the gut or movement of the large bowl...to have those recurrent motions suggests to me that the bowel has become hypermotile, having been grossly distended and having had a large amount of fluid within it. [If] [i]t was purely a pressure effect you'd perhaps get one very large release without perhaps the ongoing release.'*[246]

<u>Mr Bourke:</u>

238. Dr Westcott interpreted the vital signs recorded in the progress notes about Mr Humphreys as normal.[247]

239. Mr Bourke asked Dr Westcott to comment on Dr Cox's view reflected in his statement that at the time of Nurse Bowes' call to him, and based on the information regarding Mr Humphreys' condition provided at that time, he felt it was unnecessary for either himself or a medical registrar to conduct an urgent review. Dr Westcott said in evidence that he felt this was, *'a reasonable action based on the information to hand.'*[248]

240. In relation to the renal failure Mr Humphreys showed, Mr Bourke asked:

Q: 'Are you able to comment on whether or not kidney failure should have been added as a cause of death in Mr Humphreys' death, Mr Westcott?'

Ans: '...Yes. It would be reasonable to see as a contributing factor insofar as the renal impairment may have been a contributing factor to the prolonged ileus and it may have added to the difficulty with fluid balance in the post-operative period.

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243 Transcript, 454-5.
244 Transcript, 474-5.
245 Transcript, 481.
246 Ibid.
247 Transcript, 483-4.
248 Transcript, 486.

I guess just elaborating somewhat, another contributing factor to the prolonged ileus would have been the necessity for a 50 minute period of warm ischaemia or the supreceliac clamp that was needed, so a relative period, small bowel ischaemia which the operation necessitated also being a contributing factor to the ileus.'[249]

Mr Mukherjee:

241. Mr Mukhejee took Dr Westcott to his statement[250] where he observed that *'[t]he most notable but not unexpected deviation from an uncomplicated post-operative recovery was the development of acute renal failure...'*[251] Dr Westcott agreed with Mr Mukherjee's characterisation of this being *'one of the worst things about [Mr Humphreys'] post-operative recovery was therefore the development of acute renal failure...'*[252]

242. In relation to the post-mortem findings and cause of death, Dr Westcott gave evidence to the effect that he supported Dr Dodd's view that there was a paralytic ileus but added that *'...one is not able to comment on a post-mortem whether this is a complete ileus, that the ileus is a clinical diagnosis and we've – I've referred to a number of the findings clinically that suggest it's in part a resolving ileus.'*[253]

243. Dr Westcott disagreed with the statement put to him by Mr Mukherjee that Mr Humphreys was suffering from significant renal impairment during this stay in hospital. He pointed out that Mr Humphreys' EGFR levels began to recover, showing his level being at 21 on 4 September, indicating a return of renal function.[254] Notwithstanding this evidence, Dr Westcott confirmed his view that a referral to a nephrologist was the advisable course when Mr Humphreys' EGFR levels were seen to fall *'substantially from the preoperative value'*[255] which is what occurred on 6 September according to the blood results.

244. Mr Mukherjee put to Dr Westcott that a nephrologist may have taken a more proactive approach to the management of Mr Humphreys' kidney failure. Dr Westcott responded that:

I haven't identified any aspects of the fluid management here that I find contentious, so it would be pure speculation for me to expect what [a] nephrologist may do differently.

Q: So you can't say one way or another – you can't say whether a nephrologist would adopt a wait and see approach either, can you?

Ans: I don't know I can't comment for a nephrologist....

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249 Transcript, 486-7.
250 *Inquest Brief*, 32.
251 Ibid; Transcript, 491.
252 Transcript, 491.
253 Transcript, 490-1.
254 Transcript, 497.
255 Transcript, 499.

Q: '...I appreciate this is a hypothetical matter, but if a nephrologist has been involved and had been able to apply a more pro-active approach, these figures would therefore have improved even further, would they have not?'

Ans: 'No...I'm not sure if Your Honour needs any clarification about acute tubular necrosis, the period of ischemia or lack of blood supply to the kidneys during the operation was necessarily quite prolonged due to the surgical, the technical challenge of the surgery and a section of the kidney called the tubules is most prone to damage during a period of no blood supply. The usual course of recovery after acute tubular necrosis is that within a period of seven to ten days after the insult to the kidney we see a recovery of renal function without any specific treatment over avoiding major dehydration or drugs and medications which are particularly toxic to kidneys. The time course of the recovery of renal function after the initial decrease in renal function was along the expected lines. The only unexpected creatinine refers to the 6th September when there was a deterioration in renal function and I think I've explained that, to me, the most likely cause of that would seem intravascular dehydration or depletion, but again at that stage I would expect that to correct over time with rehydration as well.'

The Coroner: 'Would the declining [status] of the kidney function have contributed directly to the paralytic ileus?'

Ans: 'That's correct, that's my belief.'

...

Q: 'But it does, as you said earlier contribute, in answer to His Honour's question, does contribute to the likelihood of the onset of the paralytic ileus?'

Ans: 'Correct.'[256]

245. Dr Westcott gave evidence that the clinical diagnosis of a paralytic ileus is arrived at according to *'a constellation of signs and symptoms.'* [257] He agreed that distension of the abdomen is another factor which is relevant to such a diagnosis, as well as the presence of vomiting and, to a lesser extent, nausea.[258] Dr Westcott also agreed that, in retrospect, in Mr Humphreys' case, it was likely that 'complaints of nausea, notwithstanding the presence of vomit' would be consistent with the presence of paralytic ileus.[259] The third and fourth factors Dr Westcott agreed were relevant, was the inability to tolerate an oral diet, and the fourth factor would be the use of radiological examinations to detect the presence of an ileus.[260]

246. Arising from this Mr Mukherjee asked about radiological investigations in these cases:

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[256] Transcript, 501-2.
[257] Transcript, 503.
[258] Ibid.
[259] Transcript, 504.
[260] Transcript, 505.

Q: 'Could you kindly explain to us in elementary terms, if you would, how it is that radiology can help you diagnose a paralytic ileus?'

Ans: 'Radiological studies be it by x-ray or CT scan are useful to show which parts of the bowel are distended and which are fluid filled, where there are air and fluid levels and it's particularly useful to distinguish a functional obstruction, such as a paralytic ileus from a mechanical obstruction where there may be a twist in the bowel or intussusception or other causes. And moreover, CT scanning can also look for other causes, such as schematic bowel or lack of blood supply to the bowel, which could be contributing to a similar symptom cluster.'[261]

247. The following evidence contained with Dr Cox's statement was put to Dr Westcott:

"In hindsight, given the presence of his diarrhoea as well as the severity, I was concerned about some sort of late bowel complication. Possibilities include ischaemic colitis or an incomplete bowel obstruction."[262]

248. Mr Mukherjee then asked the following:

Q: '[W]hat would you do to check if [those conditions were] what you were concerned about?'

Ans: 'A CT scan would be the most helpful diagnostic study... to look for ischaemic colitis or incomplete bowel obstruction in the first instance...[a]nd specifically the use of some oral contrast may be beneficial to improve the sensitivity of the test.'

Q: '...And you kind looked through the notes at lunchtime. Did you see any evidence of action taken to investigate either a ischaemic colitis or an incomplete bowel obstruction?'

Ans: 'No, I didn't.'

...

Q: 'You've got diarrhoea taking place on the evening of 5 September 15. And had you taken one then, that would obviously tell you that you would have, knowing what we know about this particular patient with the post-mortem, that there would be no ischaemic colitis or there would be no bowel obstruction, would that be correct?'

Ans: 'That's correct.'

Q: 'And that would lead you almost certainly to a diagnosis of paralytic ileus or should, should it not?'

Ans: 'Yes, it would...And I would expect particularly in seeing the post-mortem CT scan there as well, that we wouldn't have seen a grossly distended large bowel at that point [prior to morning of 6 September]...So I suspect at that point, when

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[261] Transcript, 506.

[262] *Inquest Brief*, 17; Exhibit 8.

there's been a number of large bowel motions before that, the we would no longer have seen a grossly distended large bowel.'[263]

249. Dr Westcott agreed that the evidence suggested abdominal distension persisted throughout Mr Humphreys' postoperative period.[264] He agreed that vomiting was amongst the most distressing symptoms, *well associated with a severe ileus.*[265] Dr Westcott expressed his view that, had he taken over Mr Humphreys' care following his vomiting on 5 September, he would have thought a persistent ileus was present.[266]

250. It was a balancing exercise to assess in view of the discomfort and risks associated with the reinsertion of the nasogastric tube, whether it was necessary to provide symptomatic relief and remove the contents of the stomach in light of the persistent ileus.[267] On 4 September, following Mr Humphreys' vomiting, particularly the second higher volume vomit, is the point at which there is the strongest indication for the reinsertion of nasogastric tube.[268]

251. Mr Mukherjee questioned Dr Westcott about the possible prevention effect of the reinsertion of the nasogastric tube prior to the fatal vomit:

Q: It follows as a matter of logic, and I suggest to you that it must, that the contents of the stomach capable of being vomited out would have been far far decreased with the presence of the nasogastric tube; that's correct isn't it?

Ans: Yes, if there was a nasogastric tube inside you at that point.

Q: This is assuming that there has been proper treatment by a nasogastric tube, monitored closely by a vascular surgeon who is alive to the consideration that this patient needed some dramatic relief, it's on that assumption. Do you agree therefore that the contents of the stomach at the time of 3.45 on the night of 7/9/15 would have been greatly reduced had this patient been treated with a nasogastric tube?

Ans: I would agree they would have been reduced. As I've spoken of earlier today, what's unclear is the time course over which small bowel content has refluxed into the stomach, as evidenced by the fact that this was a feculent vomit...and whether it would have overwhelmed a nasogastric tube in any event.[269]

<u>Mr Bourke:</u>

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[263] Transcript, 507-9.
[264] Transcript, 516-7.
[265] Transcript, 521.
[266] Transcript, 523-4.
[267] Transcript, 526.
[268] Transcript, 527.
[269] Transcript, 538-9.

252. Dr Westcott agreed that there was no indication on the progress notes that Dr Cox was advised of either vomit and there was no other indication based on the notes that the reinsertion of the nasogastric tube was beneficial.[270]

Associate Professor Peter John Lowthian

Coroner's Assistant Ms Weir:

253. Associate Professor Lowthian (Mr Lowthian), is an Executive Director of Medical Services and Clinical Governance at Cabrini Health. Mr Lowthian provided two statements to the Court in relation to this matter. Each contained relevant measures related to review and possible improvements to clinical practice as well as escalation procedures following Mr Humphreys' death.

254. In his first statement,[271] dated 11 February 2016, Mr Lowthian confirmed that a review of Mr Humphreys' death had taken place as part of a regular mortality screening process undertaken by Cabrini Health's Clinical Governance Unit. In addition, he discussed Mr Humphreys' management with Dr Cox. Although Mr Lowthian did not consider the following to be preventative of the ultimate outcome in this case, these processes identified three system improvement opportunities: first, unsatisfactory documentation in the medical record by the treating vascular surgeons postoperatively which Dr Cox has undertaken to improve; second, the possible need for physician input into patients with aortic aneurysm repairs; and third, improvements in the systems for families to escalate concerns.[272]

255. Mr Lowthian's statement further indicated that Cabrini Health intended to continue a planned implementation of the "CARE" (Call and Respond Early) Program to assist patients and their families and carers with a clearly defined means of escalating concerns regarding the patient's condition. The program was piloted in 2015 at Cabrini Children's Centre and has been subsequently rolled out *'to three further clinical areas at Cabrini... Further evaluation is planned prior to the program being rolled out to all clinical areas. Our goal is to have full implementation of the program by the end of 2016.'*[273]

256. In Mr Lowthian's subsequent statement, dated 8 March 2018, outlined *inter alia* that at the time of Mr Humphreys' death in 2015, Root Cause Analyses (RCA) were not used by private hospitals in Victoria. This was because they were not required to be part of the Victorian Sentinel Events Program. In 2015, Cabrini Health began voluntarily reporting sentinel events to the Department of Health and Human Services (DHHS) *'using the COAG approved Sentinel Events List.'*[274]

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270 Transcript, 541.
271 Exhibit 10; *Inquest Brief*, 21.
272 Exhibit 10; *Inquest Brief*, 21-3.
273 Exhibit 10; *Inquest Brief*, 23.
274 Exhibit 10A; *Inquest Brief*, 23.1; Transcript, 712.

Cabrini Health has now aligned itself with sentinel reporting and review processes and adopted the categories of events relevant in Victoria.[275]

257. The circumstances of Mr Humphreys' death would now be considered by Cabrini Health as an event which would be reviewed using RCA methodology.[276]

258. The review process, as it was at Cabrini Health in 2015, identified there was a lack of documentation in the peri-operative phase made by Dr Cox and a lack of peri-operative physicians or teams in the ward to manage complex surgical patients. Mr Lowthian stated that the peri-operative specialist physicians at Cabrini are either nephrologists or general physicians, each with extensive backgrounds in peri-operative care. He subsequently discussed with Dr Cox the possibility that the Vascular Surgery Speciality Group consider involving peri-operative physicians in the management of their complex cases, such as patients recovering from open abdominal aortic aneurysm surgery.[277]

259. Since making his first statement, Mr Lowthian confirmed that Dr Cox has indicated to the Vascular Surgery Specialty Group that he considers best practice in relation to major vascular surgery patients to include the involvement of peri-operative physicians. A further nephrologist has been accredited to Cabrini to support the management of complex patients. File audits have also been performed on Dr Cox's cases over the period June to October 2017. While the results show some improvement in Dr Cox's documentation, Mr Lowthian stated further improvement is requirement to meet Cabrini Health documentation requirements. Dr Cox has been provided with these audit results and advised that further audits will be conducted.

260. Mr Lowthian also reported that while the "Call and Respond Early" system[278] has been introduced across the hospital, follow up audits have revealed a low level of understanding and take-up of this system by family members. A re-launch of this system was scheduled for March/April of 2018.

<u>Mr Mukherjee:</u>

261. Mr Lowthian gave evidence that although the "Call and Respond Early" program was not yet in place at the time of Mr Humphreys' death, a MET call could have been placed by any of the nursing staff *'if they believe it is necessary irrespective of the [vital] signs.'*[279]

262. Mr Mukherjee questioned Mr Lowthian with regard to the MET call system:

Q: 'As I understood the MET call system which I believe was introduced...[to] overcome the difficulty that may arise for medical staff who might feel embarrassed or even intimidated by the idea of having to run their concerns past the consultant before they responded to what they believe was a need to get a

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[275] Ibid.
[276] Ibid.
[277] Exhibit 10A; *Inquest Brief,* 23.2.
[278] To empower family members in escalating their concerns regarding patients' health.
[279] Transcript, 717-18.

doctor [or] emergency physician to the patient. It was to overcome the need to go through all of these hoops before that could occur. I'm just as concerned as I was when I first read this... that the same inhibition exists when one is required to run this matter by a consultant in respect of these purple instance criteria's, the most serious of presentations before that MET call is made. Do you have any view of that?'

Ans: '...There is...a difference in public and private settings, in that in the public setting you have house offices registrars, et cetera underneath consultants... In the private setting the key clinical team are the nurses and the consultants... [W]e do have some units where we have registrars, but they are not there 24 hours a day as in the public setting.'

...

Q: 'Dr Cox made a distinction between the setup at the Alfred Hospital with the series of registrars in teams, et cetera and the position at a private hospital and it's one that you have also made. With respect, I don't think that distinction...talks about possibly the difficulty of implementation, it doesn't talk about the need for implementation. It doesn't talk about whether or not the system that exists that requires these sort of matters to be taken through the responsible consultant removes that issue of "I don't want to talk to the consultant about this, my gosh I'll be seen as challenging the consultant," it removes the difficulty, the emotional difficulty that exists in making a report of that kind. Do you see that as an issue?'

Ans: '...I acknowledge what you're saying, that's precisely why the first one is in fact if the nurse is concerned they can call a MET call straightaway. They don't have to go through any of the hoops.'

Q: 'Well it seems to me that the way this is set up doesn't direct the nurses' attention in that way. Do you understand the observation that I'm making?'

Ans: 'I hear the observation you're making.'

Q: 'You don't agree with it?'

Ans: 'Well I know that's the intention of it and I will certainly take your observation back anyway, whatever your findings...[b]ecause we review this all the time...We have a working party who reviews this.'[280]

Coroner White:

263. The Coroner discussed the MET call system with Mr Lowthian as it presently exists and evidence was given that further open the MET call criteria, as has been trialled in other hospitals, has not been shown to improve outcomes. However, Mr Lowthian acknowledged the decision by staff as to whether to make a MET call under a given circumstance is a difficult one. In relation to the MET call criteria, the following exchange occurred with the witness:

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280 Transcript, 721-2.

Q: '...So you have indicated a willingness to review the way this passage [the MET call criteria] is written?'

Ans: 'Yes.'

Q: 'And I am likely to make a recommendation along those lines.'

Ans: 'Yes.'

Q: 'You're saying, however, that there is no precedent for further extending the criteria [under which] a MET call should be made?'

Ans: 'Look, I think it's very difficult. I'm not aware of precedents...the one thing would be for example, if there's active bleeding...But otherwise I think it's very difficult to know, because where do you call the MET call in, for example, this case and I'm not an expert...but where do you call that along a period of time, or do you call it or should you not. This was an unfortunate and dreadful event that occurred...And had a dire consequence...I suppose that's the dilemma always.'

Q: 'Well that's very helpful. I mean this just came from Mr Cox's observation and that's why I raised it for you. And it just appeared to me that there may have been other criteria that may have been particularly relevant to this particular discipline that may have satisfied the MET call or would have been appropriate in all the circumstances?'

Ans: 'We will certainly...be taking this back. As I say I know our deteriorating patient committee which is headed up by an intensivist...has this on their work plan right at the moment in terms of reviewing it.'[281]

FINDING

264. I have reviewed all the evidence together with Counsels submissions and as set out above I find that Mr Humphreys, aged 71, died at the Cabrini Hospital in Malvern, on 7 September 2015,
From 1(a) Aspiration
(b) Paralytic Ileus
(c) Renal Injury
(d) Convalescent Phase of Abdominal Aortic Aneurysm Repair.

265. Also as set out, Mr Humphreys was aged 71 and had been found to have a 7.2cm asymptomatic abdominal aortic aneurysm. He was a former smoker with treated hypertension and hypercholesterolemia. He was morbidly obese with a BMI of 39, despite previous lap band surgery in 1998.

266. He was referred to Vascular Surgeon Dr Geoffrey Cox (Dr Cox) and was assessed as not suitable for endovascular grafting on the basis of his CT angiography. Preoperative non-invasive cardiac stress testing revealed moderate ischemia in the LAD region so coronary angiography was performed. This

[281] Transcript, 724-5.

revealed what was described by Coronary specialist Dr Victor Wayne (Dr Wayne), as *virtually normal coronaries,* and did not preclude surgery.

267. The surgery was noted to be complex due to Mr Humphreys' obesity and scarring from his previous gastric surgery and obstructive sleep apnoea. In addition there were surgical complications encountered such as significant intra operative blood loss, the requirement for a supra aortic clamp and lengthy surgery time due to his comorbid conditions of obesity and abdominal adhesions.

268. The highly specialised surgery undertaken by Dr Cox, proceeded successfully on 26 August 2015 at the Cabrini Hospital, Malvern with Mr Humphreys transferred to the Intensive Care Unit (ICU) immediately following surgery.

269. In the immediate postoperative period Mr Humphreys developed an acute kidney injury and a swollen avula. A nasogastric tube that had been inserted following surgery on 26 August, to assist with suction of bodily fluids from the stomach was removed on 28 August at the direction of Dr Cox. Mr Humphreys remained in the ICU for two days and on 28 August he was transferred to the ward.

270. The questions addressed in this inquest focus on Mr Humphreys' postoperative care and specifically relate to the care provided in the ward from 31 August, to the date of his death on 7 September 2015.

271. In addition to the evidence of Dr Cox on the issue of his post-surgical management of Mr Humphreys, the Inquest also heard from a Court appointed expert, Dr Mark Westcott, and Dr Peter Tomlinson who was called by Mr Humphreys' surviving family. All three were noted to be highly experienced vascular surgeons with the latter two judged to be experts in their field and given leave to give opinion evidence.

272. It is relevant to note here that Dr Cox himself is also a highly experienced and qualified vascular surgeon who currently chairs the Vascular Craft group which involves oversight responsibilities for other vascular surgeons who consult and practise at Cabrini.[282] He also undertakes training of vascular surgeons both in Australia and internationally.[283]

273. As to the sequence of events that occurred following Mr Humphreys' return to the ward I direct myself of the danger of hindsight and the unconscious tendency to regard a known event as more probably or likely than it was.

274. Having so directed myself and reflected again on Counsels submissions I record that-

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[282] See paragraph 170 above.

[283] See paragraph 117 above.

a) The early postoperative course of recovery for Mr Humphreys was reasonable and within the range expected of a patient who had undergone an open aortic aneurism requiring placement of a supra –coeliac aortic clamp.[284]
b) The most notable deviation from an uncomplicated recovery was the development of what became acute renal failure, due to acute tubular necrosis as a result of the 50 minutes of abdominal clamping.
c) At this stage there was a reasonable expectation that renal function would recover towards normal without the need for dialysis, although this was an issue which Dr Cox properly conceded he might reasonably have referred for the consideration of a nephrologist.
d) Nursing notes on 29 August record the presence of bowel sounds and the passage of flatus. I note here that Dr Cox concedes that the presence of relevant bowel sounds were findings that should only be made by the treating specialist and that diagnosis based upon the recorded findings of nursing staff as to this matter, was an inappropriate basis for a medical diagnosis to be made.[285]. I further note that Dr Cox's explanation that as he was the only treater it was not necessary for him to record his own notes as he was only reporting to himself, belies the fact that confusion as to the medical history will inevitably emerge when a Consultant surgeon manages a number of similarly recovering cases concurrently, and also when another Doctor might be called in to provide advice during an emergency, or on some other occasion when the managing Consultant is unable to attend.
e) Abdominal distension and passage of flatus was noted on 31 August and 1 September, with abdominal discomfort noted on 1 September. On 2 September a 100ml vomit of bile coloured liquid was noted in the morning, and 150ml of greenish fluid in the evening. Passage of flatus was noted on 3 September. The abdomen was soft on 4 September. Further vomits of 300ml and 500ml were recorded. [286]
f) Over this time Mr Humphreys did not have the further use of a nasogastric tube.
g) I also note the criticism made by Dr Tomlinson of the use of a fluid chart in assessing the status of a paralytic ileus. [287] There was no contrary opinion offered and I accept Dr Tomlinson on this issue. I further record my own concerns reference the difficulty in maintaining accurate records in such a case as set out.[288]
h) A dietician review on 4 September noted prolonged restriction of fluid intake, including limited oral fluid intake.
i) Coming now to the 5th and 6th of September, the first recorded bowel action of a, *large amount loose watery brown* occurred at 6.15am on 5 September. It is

[284] See attachment A to this finding.
[285] See paragraph 176.
[286] See paragraph 194-197.
[287] See paragraph 117.

also the case that the Stool observation chart, documents a further 28 bowel actions over the following 24 hours.

j) A further two vomiting episodes on the afternoon of 5 September of dark brown fluid are also noted. I also observe that Dr Cox stated that he did attend on Mr Humphreys on 5 September but was not informed about either of these later events, and that he only became aware of these separate vomiting incidents on the 6th.

k) As I understand his evidence Dr Cox considered that the vomiting on the 5th was rendered unimportant symptomatically, as it had been overtaken by the improvement in Mr Humphreys condition, as evidence by his ongoing bowel motions over this period.

l) Also relevant are the findings of a distended stomach on 5 September and 6 September as complemented by the observation of Mitchell Humphreys on 5 September, that his father's stomach was '*rock hard.*' And the further finding of ascending creatinine on September 6, as described by Nurse Bowes.

m) It is common ground that over this time Mr Humphreys did not have the use of a nasogastric tube. I also note Dr Westcott's view that based upon the clinical notes a nasogastric tube was not called for on either September 5 or 6.

n) Also relevant is his view that a nasogastric tube is helpful to provide symptomatic relief and that it is likely to reduce stomach contents. [289] And that either a CT or x-ray or both are helpful in establishing the existence and condition of a paralytic ileus, and what may be going on in both the bowel and the stomach.[290]

o) I also note and in the absence of contradictory evidence I accept the evidence of Nurse Xue that when he took over the night shift responsibility from Nurse Bower for Mr Humphreys at 10 pm on June 6, as one of five patients for whom he was responsible,[291] that he was informed simply *to keep an eye out for this patient*, as he had experienced loose bowel actions during the PM shift.

p) A *massive feculent vomit* was noted at 03.30 hours on 7 September, which was followed by aspiration and Mr Humphreys' cardiorespiratory arrest.

THE STATUS OF THE PARALYTIC ILEUS FOLLOWING THE RESUMPTION OF VOMITING ON SEPTEMBER 5TH.

275. I note the evidence of Dr Cox on this matter as set out above. Broadly Dr Cox considered that there was every reason to believe from Mr Humphreys' bowel actions during the 5th and 6th was evidence that his paralytic ileus was resolving.

276. Dr Westcott's opinion was that the multiple bowel actions in the 48 hours before Mr Humphreys' death were, '*suggestive of at least partial resolution of his paralytic ileus, but that the ongoing vomiting suggested that the resolution of the*

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289 See paragraph 232.
290 See paragraph 233.
291 See paragraph 157.

ileus was not complete.' [292]. He also considered that Dr Cox's response to the ongoing bowel action was reasonable.

277. As against this I note the evidence of the examining pathologist Dr Dodd who explained that his autopsy examination revealed the existence of an ongoing functional blockage of the bowel, which he considered **may be indicative of the fact that the ileus was not resolving at or in the period before the time of death**. I also note his further opinion as to the manner in which the diarrhoea **may have been excreted**, not as a result of a resolving or partly resolved ileus but as a result of pressure build up within the bowel, this because of the huge accumulation of fluid and fluid and gas in the stomach at that time, and its need to escape. The emphasis is mine.

278. In regard to this evidence and most particularly the actions and alleged omissions made by Dr Cox, I direct myself again as to the dangers of hindsight bias.

279. I also note the opinion of Dr Tomlinson. In regard to the period following the commencement of vomiting on the 5th of September and the ongoing findings of an extended stomach and a finding of distended stomach "++." His opinion was that these bowel movements were not typical of a normally resolving ileus and it was not reasonable for Dr Cox to conclude that the ileus was resolving without first testing that hypotheses with either a CT or x-ray examination, the latter of which should have been ongoing.

280. I note Dr Cox's specific objection to the use of an x-ray examination to establish the status of a thought to be resolving paralytic ileus, as set out in his the cross examination of Dr Tomlinson. [293] On the evidence of both Dr Westcott and Dr Tomlinson I reject Dr Cox's assertion on this issue. [294]

281. I also note Dr Cox's view that it was unusual for a paralytic ileus to lead to the aspiration of bodily contents, and for such an occurrence to be a threat. [295]

282. After a review of all of the evidence and submissions, and after applying the Briginshaw standard, I accept Dr Tomlinson's opinion and find that it would have been appropriate for the introduction of ongoing x-rays, or if necessary a CT scan to monitor the condition of the stomach and bowel following the vomiting which occurred on September 5th and also the continuous excretions, which took place on both September 5 and 6.

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[292] See paragraph 225.
[293] See his cross examination of Dr Tomlinson at paragraph 110 (together with Dr Tomlinson's view of the matter) and Dr Cox's further opinion as expressed at paragraph 184.
[294] See Dr Westcott's contrary position at paragraph 225.
[295] See paragraph 207.

283. In so finding I have considered both Dr Westcott's and Dr Cox's contrary views, but find that a more conservative approach to the management of this patient should have been taken.

284. I also find that I am satisfied by the evidence that aspiration and cardiorespiratory arrest, following the vomiting of stomach contents in a situation where there has been a build-up of fluids following and during the progression of a paralytic ileus, remains a potential result of such an unresolved condition.

285. Where there were only uncertain indications of a possible resolution (or other), the use of either ongoing x-rays to investigate trends, or if necessary a CT to investigate the current status of the condition was warranted. I further find that this was especially so given Mr Humphreys' age, medical history and length of post-surgery hospitalisation.

286. On all of the evidence, I am additionally satisfied that had Dr Cox taken such a course on September 5, 6 or the early morning of the 7th that it would have led him to the conclusion that the paralytic ileus was not resolving, or had stopped resolving and that the postoperative management had to start again with total bowel rest supported by the re-insertion of a nasogastric tube with suction, this to seek to actively protect against the possibility of further vomiting leading to aspiration and arrest.

287. I accept that a nasogastric tube with suction does not supply a cure to a Paralytic ileus. I am however satisfied that its use in the manner suggested by Dr Tomlinson would have provided a positive impact upon the fluid and gas build-up, and that it would also have provided Mr Humphreys with some level of relief from his high level of discomfort. More significantly, I am also satisfied that it would have lessened the chances of further vomiting, and the further possibility that aspiration would occur. In so finding, I note Dr Cox's reservation about using a nasogastric tube on a patient with an apparently swollen uvela, and also Dr Tomlinson's contrary view of that issue as set out above. [296]

288. I also find that such a course should have occurred on a day to day basis and should have continued while the abdominal distension was unresolved as suggested by Dr Tomlinson.

289. Mr Humphreys' condition may also have required the intravenous delivery of hydration and nutrition, and after the findings reference renal failure, should also have involved a much earlier input from a consultant nephrologist.

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[296] See Dr Cox's reservation concerning the use of a nasogastric tube and Dr Tomlinson's response at paragraphs 106-09.

290. I also note the concessions made by Dr Cox concerning his failure to contribute to the clinical record and the particular significance of that failure in respect of the reliance of both himself and hospital staff on notes concerning the existence of bowel sounds. It is also relevant that he gave inconsistent evidence as to how he went about measuring such sounds when conducting rounds himself.[297]

291. In the circumstances, I find Dr Cox's evidence as to these particular observations can be given little weight.

292. I come now to the dispute as to the condition of Mr Humphreys during the late afternoon on the 6th when his son Mitchell Humphreys and his partner, Tanya Strick, arrived to see Mr Humphreys. There is also dispute as to the nature of a verbal exchange which then took place between Mitchell Humphreys and Nurse Bowes, who was the highly experienced Nursing Sister in charge of the ward on that afternoon and evening; this continued until her departure at the end of her shift at approximately 10.00pm that night.

293. Broadly both Mitchell Humphreys and Tanya Strick testified as to the fact of Mr Humphreys' deteriorating condition, which they found on 6 September as compared to the condition that Mitchell had observed the previous day, and the condition Tanya observed when she last visited Mr Humphreys on September 3rd.

294. They also described his deteriorating mental state and general condition and their exchange with Nurse Bowes on those issues, and on Mitchell's wish that his father receive immediate and full time care.

295. As against this Nurse Bowes testified that Mr Humphreys did not indicate the level of deterioration described by the couple, but that his mottled skin and his son's level of agitation warranted a call to his surgeon Dr Cox, whom she paged. On her evidence she then discussed the matter with Dr Cox and passed on details of her own observations including his vital signs and creatinine level, and later relayed Dr Cox's decision that he would not come in, but would review Mr Humphreys the following day, a Monday.

296. It is also common ground that in this conversation she additionally spoke to Dr Cox and offered to arrange for an on-duty Cabrini medical registrar to review Mr Humphreys, an offer which Dr Cox also rejected.

297. Also relevant is the evidence that later in the evening Nurse Bowes was contacted by a woman who identified herself as a registered nurse, the daughter of Mr Humphreys and then a resident in NSW. According to her initial version of this contact, Nurse Bowes also offered to arrange a review by a medical registrar

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[297] See paragraphs 180 and 221.

if she so wished, this for the reason that she was a nurse and had previously worked at the Cabrini.

298. Having reviewed again the evidence of Mr Mitchell Humphreys and his partner and that of Nurse Bowes, I find myself satisfied that Nurse Bowes was not a reliable historian as to the events under examination.

299. As against this I find the evidence of Mitchell Humphreys and Tanya Strick highly credible. I find then no reason to disbelieve either Mitchell Humphreys or his partner as to the deterioration in Mr Humphreys' condition as they found him in the late afternoon on 6 September. I also note Dr Tomlinson's evidence concerning his belief that such a deterioration, as observed by the couple, was consistent with what he would have expected to find at this time.[298]

300. I find then that there was as alleged a significant deterioration in the condition of Mr Humphreys between his son's visits on the 5th and 6th of September, and that his plea for a greater level of care to be provided, and for his surgeon to attend, should be understood to have been made in that context, (and it seems without knowledge of the additional fact regarding his father's deteriorating renal function).

301. I also find that despite Nurse Bowes later withdrawing from her position on this matter, that an offer was in fact made by her to Mr Humphreys' daughter that a medical registrar would be called to review Mr Humphreys if she so wished, but that this offer was not taken up.

302. I have been unable to establish to a satisfactory degree of certainty whether when she made the call to Dr Cox on the evening of September 6. Nurse Bowes, who had worked in the unit on the previous day and should therefore have been aware of the events of that morning, and the ongoing difficulties faced by Mr Humphreys, was herself conscious of what I am satisfied was a deterioration in his condition or was simply oblivious to the change that was so obvious to his son and his partner.

303. Nurse Bowes impressed as very much a loyal employee and may also have understood the meaning of the trend in the creatimine findings. Given her level of experience coupled with her further offer to Dr Cox to seek the assistance of an on call medical registrar, I find that it seems likely that she was troubled by Dr Cox's decision on that matter.

CONCLUSION

304. Having regard to all of the evidence, I find then that the management of Mr Humphreys' postoperative care on by Dr Cox on 5, 6 and 7 September was

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[298] See paragraph 129.

suboptimal. I further find that the undertaking of a radiological examination after Mr Humphreys return to vomiting on 5 September was called for at that time and thereafter and that the indication for same was further confirmed by Mr Humphreys continuing distended stomach, the unusual nature of his ongoing and concurrent bowel movements, and his deteriorating general condition as confirmed by his son the following evening.

305. I also find that Dr Cox erred by failing to attend on Mr Humphreys himself, or arranging for a medical review as requested by Nurse Bowes on the Sunday evening. Nurse Bowes was a very experienced nurse working in a highly sophisticated hospital system and I can see no reason why an experienced surgeon adopting a normally conservative approach to patient care would reject the suggestion that at the very least a medical registrar should be permitted to conduct a review[299].

306. I also find as above that Dr Cox erred because he failed to consider that the possibility that this was an ongoing paralytic ileus should be tested by radiological examination. In all the circumstances, I find that it was not reasonable for him to have excluded the risk of cardio respiratory aspiration, without undertaking such an examination.

307. I further find that it is more probable than not that such an examination would have revealed the true condition of Mr Humphreys' progressing ileus and the need to reinstitute bowel rest and to start care again. As unpopular as such a decision may have been, the re-insertion of a nasogastric tube with suction on either the 5th 6th or 7th as part of that care was called for and would have provided Mr Humphreys and his family with his best chance of survival.

COMMENT

308. Although she appears to have understood her role differently, I am satisfied that at the relevant time Nurse Bowes had a discretion to make a MET call if she believed that a patient review was called for and that she could do so with or without the approval of Dr Cox. I also understand that this can be a difficult responsibility to manage particularly in a case where a potential threat to well-being cannot be measured by a fall or failure in vital signs.

309. In this situation and as raised with the parties, I consider that further direction should be provided to Cabrini nursing staff in situations where as here, the threat to the patient is specific to signs which may reflect an unfavourable physiological condition or responses to such a condition but is not one that can be measured or understood by a change in vital signs.

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[299] Refer to paragraphs 117-123

RECOMMENDATION

310. I recommend that Executive Director of Medical Services and Clinical Governance at Cabrini Health confer with interested parties and provide further direction to nursing staff concerning when and in what circumstances a patient whose presentation following vascular surgery of the kind undertaken by Mr Humphreys, should be made the subject of a discretionary MET call by a member of nursing staff.

...

311. In conclusion, I extend my sincere condolences to Mr Humphreys' family and friends for their loss.

DISTRIBUTION

I direct that copies of this finding be provided to:

The family of Mr Robert Humphreys.

Dr Geoffrey Cox.

Dr Victor Wayne.

Sister Jeanette Bowes.

Nurse Tony Xue.

Dr Mark Westcott.

Dr Peter Tomlinson.

Dr Malcolm Dodd, Victorian Institute of Forensic Management.

Dr Peter Lowthian, Executive Director Medical Services and Clinical Governance Cabrini Health.

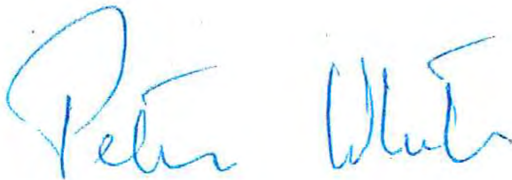
The Chief Executive Cabrini Health.

The Chief Executive Safer Care Victoria.

The Manager Coroners Prevention Unit, Attention Dr Sara Ward and Ruth Bergman.

Sergeant Tracey Weir, Police Coronial Support Unit

Dated this 19th day of November 2018.



PETER WHITE

CORONER.