IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 4398

FINDING INTO DEATH WITH INQUEST

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

Amended on 20 September 2016, pursuant to section 76 of the Coroners Act 2008

Inquest into the Death of: BERNAS HASIBUAN

Delivered On:	15 September 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Vic 3006
Hearing Dates:	2nd – 6th February 2015
Findings of:	PETER WHITE, CORONER
Representation:	Ms Naomi Hodgson of Counsel for Alfred Health
Police Coronial Support Unit:	Senior Constable Tracey Ramsey

I, PETER WHITE, Coroner having investigated the death of BERNAS HASIBUAN

AND having held an inquest in relation to this death on 2, 3, 4, 5 and 6 February 2015
at the Coroners Court, Southbank
find the identity of the deceased was BERNAS HASIBUAN
born on 26 October 1960
and the death occurred on 16 November 2010
at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004
From:

1 (a) GASTROINTESTINAL HAEMORRHAGE

1 (b) HAEMORRHAGE FROM CYSTIC ARTERY POST LAPAROSCOPIC CHOLECYSTECTOMY

The Investigation

The purpose of a coronial investigation is to ascertain if possible the identity of the deceased person, the cause of death and the circumstances in which the death occurred. In the context of my investigation into the death of Mr Hasibuan. It is the medical cause of death, which is important including the mode or mechanism of death, together with the context or background and the surrounding circumstances of death, which are sufficiently proximate and causally relevant to the death. The broader purpose of a coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of an investigation and the making of recommendations by coroners, a matter generally referred to as the prevention role. Coroners are also empowered to comment on any other matter connected with the death, including public health, or safety or the administration of justice. These are effectively the means by which the prevention role may be advanced.

This finding is based on the totality of the material the product of the coronial investigation into the death. That is, the brief of evidence and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material will remain on the coronial file. In writing this finding I do not purport to summarise all of the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Issues at inquest

At the directions hearing the following matters were identified as appropriate matters for inquiry.

a) Whether there was a failure of escalation of a junior doctor's assessments of hypotension, following a laparoscopic cholecystectomy. (A gall bladder removal using keyhole surgery).

b) Whether there was a failure of escalation of Mr Hasibuan's falling haemoglobin, to more senior medical staff.

c) Whether there were failure(s) to activate a MET call, when MET criteria were met.

d) Whether there was a failure to recognise and act appropriately to dark bleeding from Mr Hasibuan's bowel on 15 November 2009.

e) Whether there was a failure to manage or transfer Mr Hasibuan to HDU or ICU, when he clinically deteriorated

f) Whether the decision not to perform a diagnostic gastroscopy when Mr Hasibuan had a significant drop in his Hb and episodes of hypotension, was appropriate.

Background

1. Bernas Hasibuan was a 50 year old man at the time of his death. He is survived by his wife and two daughters. Mr Hasibuan was a much loved family man and church pastor who had dedicated his life to helping others in both Indonesia where he was born and more recently in Melbourne. He was also a gifted musician.

2. Mr Hasibuan had non-insulin dependent diabetes. On 22 July 2010, he had a colonoscopy performed by Dr John Coleman. The procedure revealed multiple diverticulae in the left colon and a diagnosis of Diverticulosis was made.[1]

3. On Sunday 7 November 2010, he developed pain in his abdomen. The pain continued the next day and on Tuesday 8 November 2010 and he decided to go and see his family GP, Dr Barry Teperman. Dr Teperman sent him to get an x-ray at a nearby radiology centre. He was then told to go to an Emergency Department (ED) as the x-ray showed he was suffering from gall stones. He presented to the Alfred Hospital ED.

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[1] See Dr Coleman's report, which is contained within the medical records at page 168 of the inquest brief. A colonoscopy is a surgical procedure that enables an examiner (usually a gastroenterologist) to evaluate the inside of the colon (large intestine or large bowel). The colonoscope is a four foot long, flexible tube about the thickness of a finger with a camera and a source of light at its tip.

4. He was triaged at 5.45 pm as a category 3 patient. He was diagnosed with Cholecystitis and an ultrasound showed gall stones with wall thickening consistent with the diagnosis.[2] Blood tests showed that his Haemoglobin count was 145 and his white cell count was 13.7. His blood pressure was 120/80 and he had a pulse rate of 90. He was provided pain relief over night and was admitted to the ward at approximately 12.30 pm, on 10 November 2010.[3]

Wednesday 10 November 2011.

5. Mr Hasibuan underwent a laparoscopic cholecystectomy at 4 pm on Wednesday 10 November 2010.[4] The surgery was performed by Mr Atkin assisted by Dr Boukris. He was returned to the ward at 7.30 pm.

6. According to the operation notes the procedure was performed and considered normal. I note here the somewhat expanded account provided at inquest as set out in the evidence of Mr Atkin below and his different characterization of his finding of adhesions of the duodenum to the gall-bladder and in respect of his dealing with that issue.

7. Mr Hasibuan was returned to the ward and was given antibiotics intravenously. At 9 pm, the nursing notes indicated that the drain in his abdominal area had drained 100 mls of haemoserras ooze. [5] The clinical notes record that at 12.15 am the systolic BP was less than 100.

Thursday 11 November, 2010.

8. From the relevant nursing notes we learn that 400 mls of an unspecified fluid was drained since midnight. At 9.15 am his blood pressure was significantly lower at 86/58 with a pulse of 80 and at 9.27 am it was 85/55. According to the existing (written) protocol, a systolic pressure of less than 90 should have caused the activation of the MET call protocol, which did not occur in either instance.[6]

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[2] Cholecystitis is inflammation of the gall bladder.

[3] Exhibit 12 page 241

[4] A laparoscopic cholecystectomy is a procedure to remove the gall bladder.

[5] An operative cholangiogram is an operation in which the surgeon places a small tube or catheter into the cystic duct which drains bile from the gall bladder into the common bile duct. Haemoserus fluid is a clear watery fluid from a surgical wound, which was light pink in colour. See later the evidence of Mr Atkin on this issue.

[6] See discussion below on the failure to make a MET call, in respect of three systolic blood pressure readings of below 90, which was contrary to the then existing written protocol. See also discussion below as to then existing practise of exercising a discretion in respect of the making of such a call, although such written protocol criteria had been met. Dr Barker who attended on Mr Hasibuan, testified that at that time she was not familiar with the written protocol or the then hospital practise around the protocol. She did not activate a MET call on either of these occasions.

9. At 9.40 am on 11 November 2010, Mr Hasibuan felt unwell after having a shower. He was reviewed by Hospital Medical Officer (HMO) intern, Dr Kristeen Barker, whom I note had commenced work at the Alfred three days earlier.

10. Fresh blood (frank blood) was now found in the bile drain, not present this morning. His blood pressure rose to 94/60 after he was given intravenous saline. Dr Barker's notes of that attendance indicate that she considered shock or sepsis as possible causes for Mr Hasibuan's state. Dr Barker was to chase up the blood tests, and to cross reference them, in case a transfusion was subsequently ordered. At 10.05 am his pain score was 8/10.

11. A CT Cholangiogram was performed at 2 pm, due to what was considered excessive draining of bile.[7] The report stated that no evidence of any leak had been found.

12. Nursing notes from 2.15 pm state that the drainage tube was blocked by multiple clots of frank blood draining approximately 50mls. Prior to the blockage approximately 200 mls had been drained. *Bag has been changed.*

13. At 6 pm, he was reviewed again by Dr Barker. She noted that he was now *feeling very well,* he had eaten and his blood pressure remained stable. (At some point during the day he may also have been reviewed by Dr Boukris, but there are no notes contained in the medical records of this attendance). BP remained greater than 90 systolic.

14. After approximately two hours, the fluid in the drain changed to dark bile in colour with an increase in volume, (900 mls drained since 2400). The notes indicate that the HMO cover was made aware of this.[8]

Friday 12 November, 2010.

15. Dr Barker again reviewed Mr Hasibuan on the morning round together with the surgical registrars. She noted that Mr Hasibuan was clinically stable and feeling better with dark bilish fluid from drain output. The plan as made by the registrar was to continue Mr Hasibuan on a low fat light diet with IV fluids to cease if oral intake was adequate. A further plan made was for him to be discharged home early in the next week.

16. Later that day (the time is unknown), Dr Barker was informed of his blood results that showed his haemoglobin level had dropped from 130 to 78. Dr Barker said in her statement that she was concerned by this and immediately called Dr Boukris. Dr Barker did not

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[7] A CT cholangiogram is the imaging of the bile duct by CT scan.

[8] Exhibit 12, page 48, notes at 21.50.

document this conversation but stated that she was advised by Dr Boukris that in light of Mr Hasibuan's clinical status, the haemoglobin result was more in keeping with haemodilution from fluid resuscitation rather than on going bleeding.[9] Mr Hasibuan was to be monitored over the weekend for bleeding in order to determine if he needed a transfusion. The plan also included liaising with the gastroenterology team to arrange an endoscopic retrograde cholangiopancreatogram (ERCP), which was booked in for Monday 15 November.[10] *Felt hot and clammy following ambulating to toilet.* Dr Barker did not have further involvement with Mr Hasibuan.

17. The nursing notes from the evening of 12 November 2010 record that Mr Hasibuan remained tachycardic. He had minimal pain on resting but 8/10 pain on movement. The drain contained 200 ml of bile coloured fluid at 18.00 hrs. *UGIS team were aware with again no further order made.* HB at 78, *to monitor over weekend.* Endone and paracetamol given. Draining *Saturday 13 November, 2010.*

Saturday 13 November.

18. Nursing notes record that he required endone and temazypam over-night. On 13 November 2010, his vital signs were stable but he was noted to have periods of shortness of breath at 3.00 hrs and at 18.45, and was tachycardic. *Hemodynamically stable and afebrile. Drained 200 mls of faecally looking fluid until midnight.*

19. At 9 am seen by UGIS registrar. Reported pain 8/10 at 17.45 hrs and given paracetamol. Draining minimal output.

Sunday 14 November, 2010.

20. On 14 November 2010, he was first reviewed by nursing staff at 4.20 am. He was feeling anxious about going home and concerned he would not be ready. This anxiety continued into the afternoon. Felt very tired.

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[9] Ibid page 23. Dr Boukris did not support Dr Barker's evidence in respect of his contribution to this conversation. See evidence of Dr Boukris at paragraph 140 below and the further discussion at footnote 46. See also the criticism of haemodilution as a diagnosis, made as set out below by Mr Johnson, the Alfred's Director of Surgical Services. (Mr Johnson's further opinion was that a transfusion should have been ordered at this time).

[10] ERCP is a technique that combines the use of endoscopy and fluoroscopy to diagnose and treat certain problems of the biliary or pancreatic ductal systems. Through the endoscope, the physician can see the inside of the stomach and duodenum, and inject a contrast medium into the ducts in the biliary tree and pancreas so they can be seen on radiographs. ERCP is used primarily to diagnose and treat conditions of the bile ducts and main pancreatic duct, including gallstones inflammatory strictures (scars), leaks (from trauma and surgery), and cancer. ERCP can be performed for diagnostic and therapeutic reasons, although the development of safer and relatively non-invasive investigations such as (MRCP) and endoscopic ultrasound has meant that ERCP is now rarely performed without therapeutic intent.

21. The surgical covering doctor, Dr Victor Gutierrez, reviewed Mr Hasibuan for ongoing *severe abdominal pain* (9-10/10), a tender abdomen, low blood pressure and tachycardia, with minimal oral intake. He was transfused one unit of packed red blood cells (PRBC) and given endone. *Hemodynamically stable with very dry mucosa and bibasal crackles.*

Monday 15 November, 2010.

22. On 15 November 2010 at 2.15 hours his systolic blood pressure was 88, which again was below the level at which a MET call might have been made.

23. At 3 am, Dr Gutierrez's notes indicate that Mr Hasibuan's haemoglobin level was 75. At 5 am he was asked to see Mr Hasibuan as he was bleeding from his rectum, (dark red in colour). *PR bleeding a moderate amount.* He was noted to have *a drop in haemoglobin over the last two days*. The note stated that... *mildly hypovolemic. Observations better now.*[11] At page 56 and later at 57 Dr Guitierrez recorded

    1. *Abdo pain: Post op Differential Diagnosis Bleeding? Leaking?*
    2. *Decreasing Hb secondary to PR bleeding. Post Op was 130, today is 83. Drop due to?*
    3. *Decreasing BP and Tachy: secondary drop in hypovolemia.*

    At page 57 at some time after 5 am he further sets out his treatment plan for Mr Hasibuan,

    Mildly hypovolemic. Obs better now.

    Needs gastro referral in the morning (or ?)

    To be decided by home team.

    All bloods including coags. The underlining is mine

24. He was also noted to have had a recent colonoscopy. The plan was to administer one more unit of PRBC.

25. The later notes at 6.40 hrs from the UGIS WR (Dr Lanyon) state that 5 days post lap cholecystectomy, Mr Hasibuan had passed a dark bloody motion overnight with associated hypotension and severe abdominal pain. As above blood pressure had been measured at 88/-, this at 2.15 hours.

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[11] Medical notes exhibit 12, page 57. At page 58 nursing notes indicate that at 5 am he had *a mod-large PR Bleed on toilet dark red in colour...RMO notified and reviewed patient.*

(I note here that a MET call was not made in response to this presentation. I further note that in reaching its own decision on the matter the incoming team had informed itself of some of the more troubling aspects of the presentation considered earlier that morning by Dr Aguirrez).

26. A CT angiogram was conducted at 10.09 am. It located no active bleeding or the site of any bleeding, which would indicate that there was no bleeding taking pace at that time. The report from the ultrasound of his abdomen performed at 3.24 pm did not identify any free fluid.[12] It did identify a small collection but it was considered to be too small to be drained. The ERCP did not take place.

27. The nursing notes at 3.30 pm refer to low blood pressure and two episodes of PR bleeding his morning, *which apparently shows diverticulitis as per RMO.*

28. That evening the nursing notes state that Mr Hasibuan remained tachycardic but his haemoglobin count increased from 76 to 80. A third unit of PRBC was given. His haemoglobin was checked again at 3 am and was recorded as 103.

29. Nursing notes from 2 pm stated that his haemoglobin was 91. He had not had any further bleeding.

Tuesday 16 November, 2010.

30. At 2 am on the morning of 16 November was reported as having a haemoglobin level of 91.

31. At 4 am he was reviewed by nursing staff and found to be *complaining of abdomen pain* (last evening) *and given endone with minimal effect.*[13]

32. He was reviewed at 7.10 am by Drs Buawdari, Freeman and Lanyon. Dr Freeman led the review team. Mr Hasibuan's blood pressure was 115/69 and his heart rate was 105. His temperature was 38.3. Dr Lanyon who entered the clinical notes on behalf of the group noted that the fever was likely caused by a *chest source.* Mr Hasibuan was taken for a chest x-ray.

    Sitting out of bed. Complained of right UQ abdo pain. Impression: *Fever likely chest source...illegible* ... He was given PRN medication for pain at 2 pm *with no rectal bleeding that morning.*

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[12] IB 298

[13] Exhibit 12 page 62.

33. Mr Hasibuan was found slumped in his chair at approximately 6.15 pm. He was unconscious and not breathing. An emergency code blue call was made and staff returned Mr Hasibuan to his bed and commenced cardio pulmonary resuscitation. After 28 minutes, CPR was ceased as staff were unable to get a spontaneous return of circulation or heart rhythm.

Further evidence concerning these matters is set out below.

Dr Michael Burke [14]

34. Dr Michael Burke of the Victorian Institute of Forensic Medicine performed a post mortem medical examination on 18 November 2010. Dr Burke compiled a report of his findings at autopsy.[15] He found that,

The post-mortem examination showed no evidence of pulmonary thromboembolism. There was no evidence of significant heart disease that would lead to death.

The post-mortem examination showed a minor haemo peritoneum (200 ml of blood). However, the stomach contained a large blood clot, filling the stomach lumen. There was an additional cast of blood within the proximal small bowel.

Dissection of the surgical area showed a defect within the duodenum (photographed) and a dissection of the coeliac axis showed a defect in the cystic artery (not an aberrant artery),[16] *adjacent to the gallbladder fossa haematoma. The vascular findings were confirmed on post-mortem CT and angiography.*[17]

35. Dr Burke concluded that the cause of death was 1(a) gastrointestinal haemorrhage and 1(b) haemorrhage from cystic artery post laparoscopic cholecystectomy.

36. Dr Burke testified that from the autopsy, the CT angiogram and his own examination, that the stomach was filled with blood and contained approximately 1 litre of blood clot (*formed like a sausage*).[18] He also found blood in the proximal small bowel.

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[14] Dr Burke is a Senior Pathologist at the Victorian Institute for Forensic Medicine and conducted an autopsy on Mr Hasibuan.

[15] See exhibit 1.

[16] See also reference to hepatic artery in Mr Campbell's report which reference may have come from an earlier version of Dr Burke's autopsy report. See discussion at transcript page 46.

[17] The cystic artery allows for blood flow into the gall bladder.

[18] See exhibit 1(a) (1) a copy photograph taken from a CT angiogram undertaken as part of the autopsy examination, as discussed at transcript page 18. The CT examination involved the use of a contrast infusion into the arterial system via the femoral artery.

Commonly when people bleed from up on high from their oesophagus, or from their stomach, or from the duodenum, the blood is acted upon by acids in your stomach. And so when the blood gets to your bottom, to your anus by the time it gets there the blood has changed character. So that it no longer looks like blood it no longer looks like a cast of blood, it looks like melena, which is like liquorice... And that would suggest...my understanding is that if you bleed very quickly-so if you have torrential blood loss, the blood can actually move all the way through the bowel and not change into melena... it would suggest to me that the bleeding has stopped. So you have blood within the stomach and small bowel, then no blood, no melena from that point all the way down. So this is an acute event clearly.

Are you able to say how long the blood had been there? I don't know is the honest immediate answer. However the fact that this gentleman was sitting in a chair and appearing well, and then within half an hour he-he'd passed away and his got a large amount of blood in his stomach and duodenum-I think that has occurred very quickly. I would have thought you are talking about hours, I wouldn't have thought it was less than that... It is going to take some time, but it would've been quite rapid bleeding when it occurred, I would have thought.[19]

37. The peritoneal cavity contained approximately 200 mls of blood which, would not be enough to cause someone's death. The edges of the defect were submitted for histological examination. There was,

Acute or chronic and acute inflammation, and no underlying pathological process such as vasculitis or amyloid-something that would either have caused bleeding or predisposed to it. Appeared normal otherwise.[20]

38. In further oral testimony Dr Burke was questioned about the CT cholangiogram performed on the 11 November 2010, which was undertaken to search for a biliary leak. It revealed no biliary leak, and no free fluid in the peritoneal cavity suggestive of bleeding into the peritoneal cavity, at that time. He was also questioned about the CT angiogram performed on Monday 15 of November, which revealed no active bleeding or the site of any bleeding. Additionally he was questioned about an ultrasound guided drainage attempted also on 15 November, where it was said that the collection of blood then in the gall bladder was too small to drain.

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[19] Transcript 22-23.

[20] Transcript 24. See also site of arterial defect identified by the witness in exhibits 1(a) (2) and 1(b), which show where blood was found in the stomach and the proximal small bowel.

39. In further examination Dr Burke was questioned about the falls in haemoglobin readings and also the drainage of frank blood reported on Friday November 12, but was unable to assist in respect of these matters. He was further questioned about a right hemi diaphragm, which appeared raised, and offered no opinion. He then remarked,

If I did not have this angiogram, I doubt very much...I don't think we (at autopsy) would have found the defects. Probably we would have found the one in the duodenum, I think but I doubt very much we would have seen the one in the artery, because after death there is no blood flow. So obviously when someone is alive and in surgery, there's blood flowing and you can sort of even then you get an idea of where the blood's coming from, and then you can narrow it down. Whereas after death we've just got a large area of blood and then we have to tease through and find the vessel...

Coroner. *Are you able to express an opinion as to whether or not in life a CT scan or an MRI scan would have detailed the existence of this flow of blood? ...I think I can here. (It is) that the post-mortem CT showed the changes. Showed the blood going from the artery into this retroperitoneal region and then into this bowel. It's clear that's because the defect was there.*[21]

40. Dr Burke further commented that there must have been some damage to the artery during surgery, which bled after the completion of surgery. *It was bleeding into fat and as the blood accumulated it would become harder for the artery to pump the blood in, and it might have been sealed off from the outside. That's just speculating.*

But to your question, the CT angiogram would have had to be performed when he was bleeding. Because say four hours before (he) was sitting in the chair, when he passed away-if they had have done the procedure then, they might not have seen anything. In fact there was... an angiogram.

Coroner. *If they had done the CT, they wouldn't have seen anything? Yes... unless that area is bleeding at that time, it is not going to show you anything.*

And the same with the MRI? Exactly yeah...the circumstances have to be such that they can show what is going on.[22]

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[21] Transcript 38-9.

[22] Ibid.

41. And later reference the ability of a CT angiogram to disclose a defect, *There has to be a defect there. There might have been a little plug of thrombus ...plugging the defect up until the time (he) had his catastrophic bleed, so that's the reason we were able to see it post mortem, because the defect was open.*[23]

42. Dr Burke was further questioned about the findings recorded on 15 November at 6.40 am, *BP 90 on 60 Heart Rate 105, afebrile Stats 97%,*

43. *Passed dark bloody motion overnight hypotension... PR Bleeding moderate amount... Patient noticed to have drop of haemoglobin over last days,* written by Dr Victor Guterrez, the surgical cover. *He goes on to write, the issues there are abdominal pain, under control with Tramadol. Drop in haemoglobin secondary to PR bleeding, recent colonoscopy. Mildly Hypovolemic. Observations better now.*[24]

44. In response Dr Burke offered that the bleeding could be a result of a previous episode. *Because all I can say is that at the time of autopsy he didn't have any blood in his large bowel...* He could have been bleeding from the time of his operation *but I think he stopped at some point and started again.*

45. The fact that he had probably a meter or a meter and a half of bowel without any blood or melena, would suggest that at some point in time the bleeding had stopped. Otherwise it would be all the way through. *That seems to me to be common sense.* It is not possible to say when that was... but he... *had a torrential bleed at the end.*[25]

46. Under further examination from Ms Hodgson of Counsel for the Alfred Hospital, Dr Burke was referred to the two defects, the cystic artery and the duodenum, and stated that he had never seen two such defects before. Dr Burke further testified that while it was not unusual for a defect to an artery to cause bleeding into the retro peritoneum or peritoneum that it was *clearly rare* for it to flow into the duodenum and from there into the stomach and proximal small bowel.[26]

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[23] Transcript 40-41.

[24] Transcript 43.

[25] Transcript 43-44

[26] Transcript 47-48

47. Dr Burke was further asked about whether the two defects earlier stated to be *a centimetre or two apart,*[27] might have been caused by the same injury, or at the same time.

48. *If you go to the histology, the duodenal defect. I say marked chronic and acute inflammation, so indicating whatever has happened has been going on for some time OK? ... That's the duodenal? That's defect two. So defect one the cystic artery... So this is a repair mechanism, so this has been going on for a couple of days... the fibrous tissue it's trying to heal itself. And it's been trying to heal itself. And it's been going on for a couple of days. ...You would think what ever has occurred has occurred at the same time...that's not definite...but pretty likely...but I don't know what procedures he had. If he just had the surgery it would seem pretty reasonable to say it all occurred in the surgery at that moment.*[28]

49. Dr Burke was further asked whether cholectystitis (inflammation of the gall bladder), may have caused the defect(s). Cholectystitis was said to be very common but he didn't think it likely that it caused a vascular rupture.

50. Dr Burke was then asked about the haemoglobin results of 140 grams per litre before surgery, and 130 the following day, which he agreed indicated very little inter-operative bleeding... His further opinion was that these figures do not indicate that the full thickness of the artery was cut during surgery.

    But there could have been something happen to the outer aspects of the vessel, and just causing trauma. Such as the expert has talked about traction, so the pulling of the vessel and stretching it, and maybe causing a split. And then with a chronic inflammatory process, it's then ruptured. But that's all speculation... trying to get my head around it now...to cause a secondary rupture of the vessel, we often say it's a low grade inflammation, low grade infection... but I didn't see any pus. [29]

51. Dr Burke was asked about the nursing notes for 15 November.[30] *Passed dark bloody motion overnight with associated hypotension. A PR bleed motion,* which he distinguished from melena which comes from up high in the gastro intestinal tract in the stomach, proximal

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[27] Transcript 47.

[28] Transcript 50.

[29] Transcript 52-53.

[30] Exhibit 12 page 57.

duodenum, because it's been effected by acids. *Unless as I said before, if you have a torrential blood loss, it can come out the other end as blood.*[31]

52. In regard to the absence of melena found in the bowel at autopsy, Dr Burke further testified that this meant that the bleeding had stopped at some time. This bleeding was associated with his death because of the volume of blood. His stomach was distended, it was a litre of blood. And then he had blood in his small bowel. It's a lot of blood, that's why he died. So that wasn't there the day before.

53. Ms Hodgson. *Do you say that was immediately post-mortem? Yes. Not prior to that? No I don't think so. It was all in continuity... it wasn't bleeding from the day before. This was a torrential blood loss... Hours, I would have thought so yes* [32]

54. Dr Burke additionally testified that there could have been some blood in the stomach a day before. That might or might not have resulted in a finding of melena at autopsy.

55. He was then asked by Ms Hodgson about the expert opinion of Dr Campbell that between 10 and 16 of November, *a considerable amount of blood was lost from the circulation, mostly into the bowel. It is of interest to note that at no stage was there was any hematemesis.*[33] And stated that he thought that was a correct statement.

56. *What do you say about his view that there was a considerable amount of bleeding for that six day period ....? So the question you're asking me is did he lose before the incident the last incident that led to (his) death? Can I say whether he lost a large amount of blood beforehand?*

57. *Yes? ... I don't know.*

58. Dr Burke was then asked further questions arising from the clinical notes and whether there was evidence of on-going blood loss between November 10 and 16, which he declined to answer.[34]

59. Dr Burke was then questioned about the drop in haemoglobin, from 130 post operatively on the morning of November 11, to 78 on the morning of November 12. *A decent drop I would have thought.*

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[31] Transcript 54.

[32] Transcript 56.

[33] Statement of Dr Campbell, Exhibit 8 page 3.

[34] Transcript 60-61.

60. And a CT angiogram on 15 November revealing no blood in the peritoneal cavity, which he found not surprising. He believed that the blood must have been getting into the bowel and that it was then passed out. And that there would be melena in the blood. *All I can say is that I can't explain the drop in haemoglobin. And maybe another can but I can't... I didn't see any collections of blood at autopsy, which would explain that.*[35]

61. To help better understand the finding to follow, I record here that I find that Mr Hasibuan died on November 16 of a gastro intestinal haemorrhage, which involved a bleed from the cystic artery. I adopt Dr Burke's findings as set out above in relation to the cause of death and also accept his explanation in respect of the bodily mechanism, which led to death as supported by the evidence concerning the post mortem contrast CT angiogram. In so finding I leave open the question of how the connection between the cystic artery and duodenum, which allowed for blood to flow in this manner, came into being.

Dr Kristeen Barker

62. At the time of Mr Hasibuan's arrival (pre-surgery) on Wednesday November 10, Dr Kristeen Barker had been working at the Alfred Hospital as an HMO in the upper gastrointestinal surgical team, for just 3 days, this as part of a relieving roster. She saw Mr Hasibuan on 10, 11 and 12 November. Dr Barker provided a statement outlining her assessments and treatment of Mr Hasibuan.[36]

63. On Wednesday November 10, she saw him with two upper gastro intestinal surgery registrars one of whom was Dr Boukris. She did not examine him herself. Their impression was acute cholecystitis and he was scheduled for a laparoscopic cholecystectomy later that day. (Mr Atkins and Dr Boukris undertook this surgery at 4 pm).

64. Dr Barker stated that on 11 November 2010, she was asked to see Mr Hasibuan as the HMO. He appeared *to be clammy*. She recorded at 9.40,

    BP (86/58), and ... now frank blood in drain, not present this morning.[37] The blood pressure was low and she underlined it because she was worried about it. He was drowsy when not interacting and his blood sugar was 13.1, *Which was a little bit high, but is not low, which is*

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[35] Transcript 63.

[36] See statement of Dr Barker at Exhibit 2.

[37] I note here that in her written statement exhibit 2, Dr Barker was in error when she quoted from her clinical note at exhibit 12 page 45, without reference to *frank* blood in drain.

what we would be worried about in this situation. [38] He was also complaining of abdominal pain and nausea.

65. Dr Barker was *concerned* about the fresh blood in drain and formed the impression that he may have been hypovolemic. She asked the nurses to replace 500 ml of fluid and to organise an ECG. She observed the ECG and noted no evidence of ischemia. She noted a positive response to the fluid infusion with BP improving to 94/60. She contacted her senior, Dr Bourkis, who advised her to chase the results of blood tests conducted that morning, and to perform a cross match in case he needed blood at a later stage and to continue fluid replacement, and that he would come and see Mr Hasibuan soon.[39] Her impression was that he may be suffering from, *shock, could be sepsis.*[40]

66. By 6 pm on November 11 Dr Barker noticed he was feeling *very well.* His systolic blood pressure was *95 to 98* and she believed he would have been infused with around *a couple of litres of fluid by then.* In fact over 4 litres.[41]

67. Reference her findings on November 11, Dr Barker was further asked if she was aware of the hospitals MET guidelines. She was not aware of the MET guidelines at that time. She was also not aware if she had received training in this matter at the time of her commencement at the Alfred, which as above I note was on Monday November 8, two days earlier. She agreed that his blood pressure was such that the MET call criteria was satisfied. She was at the time only aware that there could be a MET call and that she was, *happy to manage it herself and, see how it went.* [42]

68. Dr Barker was then asked if she had read the nursing notes for the afternoon and evening of 12 November, which refer to ongoing tachycardia and the finding of blood ranging in colour from *dark brown almost faecal coloured,* to *dark blue bile coloured with++in volume. 900 ml drained since 2400 hrs HMO cover aware.* She was the HMO cover at this time and testified

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[38] Transcript page 75 and her clinical notes at exhibit 12 page 45.

[39] Cross matching would also involve *putting blood* aside in the fridge for immediate use. Transcript page 80. The clinical notes do not reflect that Dr Boukris in fact saw Mr Hasibuan at any time on November 11.

[40] Transcript 76 further discussed at transcript page 81. And exhibit 12, page 46.

[41] Transcript 83 and exhibit 12, page 4.

[42] Transcript 77-79.

that she did not remember looking at the nursing unit notes.[43] She did not remember reading the note, *DT remains in situ Continue to drain dark bile-ish fluid.*

69. Again on 12 November 2010 Dr Barker attended on Mr Hasibuan during the morning round, together with two surgical registrars and noted that he was clinically stable. She recorded a plan, which was to commence him on a low fat diet and to cease fluids when his oral intake was adequate. The plan was to release him early next week. [44]

70. Later that morning she learnt of Mr Hasibuan's drop in haemoglobin from 130 to 78. She states that she contacted Dr Boukris, and that Dr Boukris advised that the drop in haemoglobin was most likely associated with hemodilution, rather than ongoing bleeding and, *in the light of improved clinical condition not for transfusion at present.*[45]

71. According to Dr Baker, Dr Boukris further advised her that his management plan was to review Mr Hasibuan's need for a transfusion depending on whether there was bleeding over the weekend and also to liaise with the gastroenterology team with a view to organising an ERCP. This was discussed with the upper gastroenterology registrar and the ECRP *to look for leak*, was to be performed on Monday. There was no note of this conversation.[46]

72. Dr Barker did not further raise the low haemoglobin and low blood pressure levels, with Mr Atkin or indeed with anyone else.

Dr Victor Gutierrez

73. Dr Guiterrez graduated from the medical school at Saint Mary's Catholic University in Peru in 2007 and completed his Australian medical Council Examination in early 2010. In November 2010, he was a resident medical officer at the Austin Hospital.

74. Mr Hasibuan had been given 10 mg of morphine with minimal effect.[47]

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[43] Transcript page 88 and exhibit 12 page 50.

[44] Exhibit 12, page 49.

[45] Exhibit 12, page 49.

[46] In testimony Dr Barker sought to amend this part of her statement paragraph 13, reference her failure to document her conversation with Dr Boukris, stating that from the medical record, *I have written, 'further to discussion with registrar'*, and that this should be taken to mean that (she) did discuss it with Dr Boukris. I note here that the medical record referred to, found at exhibit 12 page 49 states "*(P) Bleed over weekend and review decision to transfuse. Liaise with Gastro re ERCP to definitely look for leak +/- sphincterotomy (further to d/w Reg)*", and does not specifically refer to whether a discussion with, *Gastro re ERCP to "definitely look for leak"*, actually occurred. See transcript page 87.

A *sphincterotomy* is an incision at the bile duct opening to aid drainage of bile duct stones.

[47] See discussion of clinical note, *complaining of severe abdominal pain 10 out of ten. Colic intermittent,* at transcript 185.

75. According to his statement Dr Gutierrez also saw Mr Hasibuan on the night of the 15th at around midnight, to manage his abdominal pain, which was described as a level 9-10/10. [48]

76. Mr Hasibuan was 4 days post laparoscopic cholecystectomy for acute cholecystitis. His past medical history was recorded as,

- Recent colonoscopy for PR bleeding: Diverticular disease
- Hypotension Type 2 diabetes

Post-Operative Progress

- Day 1 post-operatively CT cholangiogram was performed to investigate the possibility of a biliary leak. No evidence of contrast leaking to suggest bowel leak.
- Haemoglobin drop over 4 days, from 130 on day one to 83 on day four. *Drop due to? (i.e. unknown).*
- all blood results including haemoglobin and blood – pressure, from the date of surgery were available to him. *There was a fluctuation of blood pressure all the way through the 4 days. The heart rate was steady in the tachycardiac area. Secondary to hypovolemia, (dehydration).*[49] This result was seen as indicating that the was an, *abnormality going on with this patient... he was the same for four days fluctuating with the blood pressure, with the ongoing tachycardia.*

77. *I even recommended the CT IV cholangiogram... trying to find why the patient was not having the normal postoperative course.*[50]

78. At the time of his examination blood pressure was 100/60, heart rate 103 and oxygen saturation was 99%. There was a bilateral decrease in air entry due to on-going abdominal pain from the date of the surgery and bi-basal crackles.[51] He also had a distended abdomen, which was hyper-resonant and tender on palpitation with a decrease in bowel sounds. He was

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[48] I note here that Mr Hasibuan's wife in her statement, exhibit 11, states that on Sunday the 14th her husband told her that he couldn't sleep the previous night because of abdominal pain and that on the following day the 15th he told her that he was experiencing unimaginable pain the *previous night or two nights ago*, to the point where he was screaming and buzzed for the nurse to come...a doctor was present... See also discussion of clinical note for the 14th *complaining of severe abdominal pain ten out of ten ... on and off sort of pain, -*

at transcript 185.

[49] Transcript 175.

[50] Transcript 176.

[51] Transcript 177.

having difficulty breathing because of his pain. *It was post-operative pain because it was in the area where the surgery took place.*[52]

79. Dr Gutierrez identified the following issues:

- Abdominal pain: likely post-operative pain with the differential diagnosis being bleeding, or leak. And later bleeding or leak *is a complication from the operation. It's not caused by the operation, so it's a complication.*[53]
- Decrease in Haemoglobin over the previous four days.
- Haemodynamic signs of hypovolaemia: Likely from the minimal input.

His plan was for,

- Urgent bloods, Analgesia with tramadol, hyoscine.
- Antiemetic's.

80. At 3 am on the 15th he received the blood report which showed haemoglobin down to 75. He ordered a transfusion of one unit of packed red blood cells.

81. At 5 am he came back to re-assess due to further PR bleeding and found the haemodynamics stable, and his pain under control. His nurse had reported and documented an episode of PR bleed of dark red stool. The *dark red colour* suggested to him that the bleeding came from lower GI.[54] He considered,

> *that the recent colonoscopy with a positive finding for diverticular disease and PR bleeding ... could have explained the haemoglobin drop over the previous days...*
>
> *was secondary to some degree of PR bleed. And I mentioned the recent colonoscopy as clinically I thought ...the bleeding (was related to)... the diverticulitis.*[55] The underlining is mine.

82. His plan was to continue with IV fluids and to transfuse one more unit of blood. A new set of bloods including coagulation was organised for the morning. He handed over to the Upper

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[52] Transcript 193.

[53] Transcript 180.

[54] Transcript 202. *If it is black it is from the upper GI. If it is dark red maybe from around the colon ... descending colon. Rectal it will be bright red so I imagine most likely coming from the colon...*He was told by a nurse it was dark red in colour. Transcript 218. It says in the bowel.

[55] Transcript 204.

Gastrointestinal Surgery team (UGIS-H), *the home team, for them to decide what to do.* [56] Dr Gutierrez did not see Mr Hasibuan again.

83. In answer to further questioning Dr Gutierrez did not feel that the patient met the criteria to make a MET call. [57]

84. In further response to a criticism posed from the statement of expert witness Mr Campbell, [58] (which was that the major drop in haemoglobin and episodes of hypotension arose from an unrecognised major gastrointestinal bleeding after surgery and that had a gastroscopy been done on the 12th 13th or 14th of November, it would have shown a large amount of blood in the stomach. The site of the bleeding may not have been identified.

> *"It is disappointing that a CT angiogram did not show bleeding but this is a problem with all gastrointestinal bleeding, that it is intermittent.*
>
> *If the stomach had been found to be full of blood at a gastroscopy I think it is very likely that surgical intervention would have taken place and the outcome for this patient may have been different,"*(as opined by Mr Campbell),

85. Dr Gutierrez offered that he is and was not a surgeon or *specialist in this area,* which is why he sent it over *to the home team, to decide the most appropriate investigation.* He did not discuss the matter with the home team. [59]

86. He further testified about the drop in haemoglobin, which he thought may be attributable to Diverticulitis, and that his reported pain levels caused him to be worried. He was not aware of the next blood cell reading after he administered one unit of red blood cells on November 15, because he had no further involvement after he finished his shift.

87. In response to further questioning by Counsel for Alfred Health he stated that he was told by a nurse it was dark red in colour, (15 November at 5am). It says in the bowel chart, *all fresh melena.*[60] He also agreed that the pain level at 11.30 pm on 14 November, was marked as 12 out of 10.[61]

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[56] See exhibit 4 at page 2-3.

[57] Transcript 211.

[58] Dr Campbell is .

[59] Transcript 215-16.

[60] Transcript 218

[61] Inquest Brief, page 104

88. Dr Gutierrez was then taken to his note at page 57 of the brief where he recorded at around 5 am on the 15th that Mr Hasibuan was mildly hypovolemic... *obs better now.* Dr Gutierrez felt his, *obs better now,* comment may have been related to the pain score. He further agreed with Counsel for Alfred Health that there were a number of issues which might cause a PR bleed, following an operation.[62]

89. Dr Gutierrez gave further evidence as to what different coloured blood from a PR bleed might indicate. He was also questioned as to the relevance of increased bowel sounds.

90. Dr Gutierrez was then questioned about the Colonoscopy report[63] and the CT angiogram plan. He didn't discuss this particular plan when he handed over on the morning of the 15th although he felt that it was the appropriate course.[64] Dr Gutierrez had also ordered a second unit of blood at around 5 am. This was administered by the incoming *home team* at around 8.30 am.[65]

Dr Nicholas Lanyon

91. Dr Nicholas Lanyon was an Upper Gastrointestinal Surgery, Hepatobillary (UGIS-H) Intern, on 15 November 2010, *working under the supervision of senior colleagues,* (primarily Dr Freeman). He first came into contact with Mr Hasibuan on this day at 6.40 am. He had been on sick leave for the previous seven days. Dr Lanyon did not recall whether or not he received a specific handover from the weekend or night staff on 15 November. Dr Lanyon provided a statement based on his medical notes as he could not recall Mr Hasibuan's clinical state at each of the assessments.[66] Dr Lanyon's observations were recorded as follows. *Heart Rate 105, Blood Pressure 99/60, Oxygen Saturation 97%. He was afebrile. His abdomen was soft and not tender with a drain tube from the upper right quadrant, with minimal drainage noted at this assessment.*

92. He prescribed a further one unit of red blood cells late in the afternoon. At the time his haemoglobin was 80, which while acceptable was still low for a post-surgical patient. [67]

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[62] Transcript 223

[63] See medical notes at page 166-8

[64] Transcript 229

[65] Transcript 231

[66] Exhibit XX, IB p 23-4

[67] Transcript 435. (A haemoglobin of less than 70 is an independent indication for transfusion. Transcript 437).

93. Dr Lanyon gave further evidence that he would not have been happy to discharge a patient with Mr Hasibuan's history who presented following recent surgery with such symptoms. [68]

94. Given the PR blood loss noted the night before, the patient was made nil by mouth and an urgent CT Abdominal Angiogram was requested, which was performed later that morning.

95. According to Dr Lanyon he was made aware of the findings through Dr Freeman's 11.30 record, [69] and the plan was for intravenous antibiotics to be commenced and an ultra sound booked for attempted drainage and an endoscopic retrograde cholangiopancreatography, (ERCP) on 18 November. The ERCP request was discussed with a more senior member of staff, a Dr Casey, and re-booked for the following day.[70]

96. Dr Lanyon saw Mr Hasibuan again on 16 November at 7.10 am together with Dr Bhandari (UGIS-H) and Dr Freeman, who was the in charge. He made the following note. *Heart Rate 105, Blood Pressure 115.69 Oxygen Saturation 97%. He was febrile, 38.3C and noted to be on ongoing antibiotics.*

97. Dr Lanyon saw Mr Hasibuan later that day, (time not recorded but he believes this took place before 2 pm)

I have recorded my review that the patient was sitting out of bed, was complaining of Right Upper Quadrant abdominal pain on deep inspiration and had deep inspiration and had decreased breath sounds at the base of the right lung. My impression was that this new fever was likely due to a chest source exacerbated by poor deep inspiration sic, secondary to post-operative pain.[71]

98. His recollection of Mr Hasibuan on 16 November 2010, was that his observations were improving and he recalled the shock of all team members when informed of Mr Hasibuan's death.

99. He was not aware of a plan to discharge Mr Hasibuan on the 16th. He would have been expected to be aware of such a plan, because he would have had to prepare the discharge summary and discharge prescription.

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[68] Transcript 440.

[69] Exhibit 12, page 61. Dr Freeman was a (UGIS-H) Registrar and the Senior MO on the round. This was her only record arising from her attending on Dr Freeman.

[70] Exhibit 7, page 2.

[71] Exhibit 7, page 7.

Dr Larissa Freeman

100. Dr Freeman was a relieving surgical trainee registrar on 15 and 16 November 2010 at the Alfred Hospital working under the supervision of Mr Aitkin. She appears to have taken over in this role from Dr Thierry Boukris and recalled liaising with Mr Atkin about Mr Hasibuan but did not recall the details of that conversation. Dr Freeman was unable to recall her involvement with Mr Hasibuan and her statement detailed her medical notes.[72]

101. From those notes she stated that she reviewed Mr Hasibuan's angiogram at 11.30 am on (Monday) 15 November. The report indicated no active bleeding but known diverticular disease in the descending and sigmoid colon. There was a collection similar in size to that shown in the CT scan four days earlier. Her usual practise was to contact the responsible consultant after each ward round.[73]

102. *I discussed the CT angiogram (result) with Mr Atkin. The plan was for antibiotics, ultrasound guided drainage of the collection, ERCP on Thursday, and a light post diet drainage.*[74]

103. Dr Freeman was further questioned by Counsel for Alfred Health, Ms Hodgson, about her inter-action with Mr Atkin. She agreed that if Mr Atkin in fact saw Mr Hasibuan on 15 November as he indicated at page 3 of his statement that such a visit must have occurred independently of the ward rounds noted by Dr Lanyon at page 57 of the brief.[75] Dr Freeman did not make the notes recorded of her reviews on 15 and 16 November. Dr Lanyon was believed to have done so and she Dr Lanyon and Dr Bhandari attended those reviews. Dr Lanyon was the junior member of the team and the plan would be generated from herself, a more senior member of the team.[76]

104. Dr Freeman further agreed that if Mr Atkin further stated that he had been informed on 15 November that Mr Hasibuan had bled from the rectum that it is likely that that information came from her.[77] She also agreed that if Mr Atkin had said he had been told that the patient

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[72] Ibid, page 10-11 and transcript 253, where she testified that her seniority was such that her role included communicating with the consultant surgeon, when that was required.

[73] Transcript 253.

[74] Ibid, page 11. I note that the documentary evidence does not suggest that she spoke to Mr Atkin on other than this one occasion and that she had no recollection of other conversations with him, but could not discount the possibility that such had occurred.

[75] Exhibit 12 page 57, and transcript page 254.

[76] Transcript 258.

[77] Transcript 255.

was improving and keen to go home, that while she did not recall being party to such a conversation, she was not in a position to dispute that it took place.[78]

105. She next saw the patient on her round on 16 of November. His BP was 115/69, his oxygen saturation was 97%, his temperature was 38.3 and he was afebrile. A CT angiogram was requested to try and establish *the site of any bleeding, or sign of biliary leek.*

106. Dr Freeman further testified also in answer to question from Ms Hodgson, that she would be able to access a patient's blood results or CT Angiogram from any computer in the hospital and that if this occurred from a computer access remote from the patient, that it was unlikely that the patient's clinical file would be at hand. The only notes she recorded of her observations were made at 11.30 am on 15 November [79] At that time she recorded inter alia, *CTA. Nil active bleed.* At this point she had access to the results of the Angiogram, which had been conducted at 10.09. She may have read the results earlier and later returned to the ward where she made this note.

107. Additionally her testimony was that she would usually write up a receiving handover, so that she was not simply relying on her own memory.[80] She had a recollection of Dr Aguirre Gutierrez (who had testified that he handed over the patient at 5 am on the morning of 15 November), but no recollection of or a note made concerning receiving his handover.

108. Dr Freeman was then referred to the bowel chart.[81] And to the entries for 5 am and 8 am on November 15, which record separate bowel motion(s) being dark red in colour. These were to be distinguished from melena, which would be described as melena black.[82] This was a dark altered blood that was not melena. It's watery, *so not bright red fresh coming from the anus itself but somewhere slightly higher up.*[83]

109. Dr Freeman was a party to the decision to undertake a CT Angiogram. *It's very reasonable to think that that would be done in consultation with myself, or on my instruction.*[84]

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[78] See exhibit 12 page 61 nursing notes in respect of pain management.

[79] Exhibit 12 page 61, which included reference to her discussion with Mr Aitkin.

[80] Transcript 262.

[81] Exhibit 12 page 80.

[82] Transcript 264.

[83] Ibid.

[84] Transcript 267.

110. She acknowledged that in the record prepared concerning her review on 15 November, (together with Dr Bhandari and Dr Lanyon)[85] the drop in haemoglobin 130 to 83, is not recorded.[86]

111. Ms Hodgson.., *that's something you're not able to recall having any knowledge of is that the case? I don't recall that.*

112. Dr Freeman was then taken to exhibit 4(b) the HB flow sheet record, which shows 130 Hb on 11 November down to 78 on 12 November and then up to 86 and 83 on 13, 14 November and then down to 75 and 76 on 15 November.

113. *So as I understand it you weren't aware - sorry you haven't recorded anything about the level of haemoglobin in your note, that's correct? Mmm.*

114. *So as you don't have an independent recollection you can't tell the court whether you were aware of his levels over this period? That's true.*

115. She later stated however that, *It's very possible (I knew what was going on with the haemoglobin levels), I just don't remember.*[87]

116. Dr Freeman was further asked about the transfusion of three units of red blood cells over the course of November 15 and felt that was reasonable.

117. *In response to becoming hypotensive and bleeding, it is very reasonable to replace blood with blood.* ...Mr Hasibuan's bodily response was also seen as appropriate. *Normally the numbers will raise by approx. 10% per unit, so to go from approximately 75 to 103 with three units would be an appropriate response. It would also probably signify to me that there's no ongoing significant bleeding that's causing further loss.* [88]

118. *Later that morning after the ward round further blood is taken ...his Hb is at 91? Mmm.*

119. Ms Hodgson then questioned Dr Freeman about the infusion of IV saline and the Hb drop from 103 to 91.

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[85] Exhibit 12, page 57.

[86] I note that the note in question simply states - drop HB due to PR bleeding (recent colonoscopy),
- Mildly Hypotensive: Obs better now.

[87] Transcript 267

[88] Transcript 268.

120. *It's difficult to interpret, (absent other indicators)... It wouldn't be very alarming to see that,*[89]

And later, *everything has to be taken on clinical grounds and interpreted you know with a view to putting it in a clinical context.*[90]

121. In relation to the planned endoscopic retrograde cholangiopancreatography (ERCP), Dr Freeman described it as a *fancy gastroscope.* She also offered that if there was bleeding which came from the cystic artery, before he had the PR bleeding that it would not have assisted in locating the source of that bleeding because,

If you put a telescope inside a tube you're not going to see what's happening outside of those walls from inside that tube, so I don't think you would have seen dark bleeding from that vessel.[91]

122. She was then referred to Mr Campbell's assessment at page 36 of the brief,

(It is very likely), *if it had been done on 12, 13 or 14 of November it would have shown a considerable amount of blood in the stomach.*

123. Dr Freeman did not accept this proposition stating that it would be difficult to say he had blood in his stomach as opposed to blood beyond his stomach as Mr Hasibuan hadn't vomited blood.[92]

124. And later,

Court, (There must have been bleeding) *inside and outside* (the stomach) *if there was bleeding into the duodenum?*

Sure. But we don't know what size that would have been. It has to be big enough to be visible to the naked eye on a scope, as opposed to something small...

If there was active bleeding at the time ... that you did the gastroscope, would that make the bleeding easier to reveal?...I think you would see blood coming from somewhere... you might

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[89] Transcript 269.

[90] Transcript 270.

[91] Transcript 271. ECRP'S were performed on Mondays and Thursdays only. Transcript 274.

[92] Transcript 271 and Dr Campbell's opinion at exhibit 8, at brief page 36.

or might not have seen a defect there,...but the use of gas necessary to inflate the stomach like a balloon so you can see inside the balloon, may have created more bleeding.[93]

125. Dr Freeman also testified that the plan was for a CT angiogram and x-ray, which took place on the Monday 15 November. The objective of the CT was to investigate the source of the bleeding, *which sent me down the path of a CT angiogram, rather than the source of the bile leak. The ECRP was to investigate the source of the bile leak.*

126. The ERCP was not able to be done on the Monday morning, (together with the CT Angiogram), and the next available time for this procedure which then booked, was for 18 November the following Thursday.[94] Dr Freeman further stated that the CT Angiogram was appropriately preferred because,

If we were to have any chance of operating and finding a site of the bleeding, without some sort of independent test telling us where the bleeding's coming from, we don't know which part of the gastro intestinal tract to target with the operation. [95]

127. In regard to the suggestion that MET call(s) should have been made under the MET call protocol, (i.e. where systolic pressure falls below 90), it was established by reference to the evidence of Ms Cronin that systolic blood pressure was recorded at being less than 90 on three occasions being at 9.15 am and at 9.27 am on 11 November, and again at 2.15 pm on 15 November. [96]

128. Coroner, *If a MET call had been made would the patient normally have been taken to the ICU?*

Not necessarily but a MET call triggers a clinical review by a team, and that team involves an intensivist, it is usually an intensive care registrar, the medical registrar attends and the home team attends as well...but by no means does it mean a definite admission to a higher acuity area.[97]

You referred to the Hb rate of 103, and being knocked back to 91, after the taking of three units of blood? Mmm.

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[93] Transcript 272-74.

[94] Transcript 275.

[95] ?

[96] Transcript 278. See reference to Dr Cronin's evidence below.

[97] Transcript 278.

*You said that displayed that there was no ongoing significant bleeding causing loss. So it would appear from both of the answers (*set out above*) that you were, at different times, looking to establish the cause of the bleeding? Mmm.*

Is that correct? I believe so.

...did it seem to you that the emphasis had to be on continuing through the period to understand what the cause of the bleeding was and where it was taking place?

Again I can't speak to what I was thinking at that time.

No one could have anticipated the source ...but it was a possibility that it was connected to the earlier surgery...What was more important was that there seemed to be evidence that it was ongoing and because (you) didn't know where it was starting from (you) couldn't know how to deal with it?

I think if we'd found evidence of active bleeding on the scan then we would have known how to deal with it. As to what might have been done to discover the source of the bleeding, the Angiogram was used,

but unfortunately it didn't tell us where the blood was occurring from.[98]

Should the patient have been operated on to seek to establish, why these readings were occurring and why there was ongoing pain?

... It's a difficult question. I think it is reasonable to say that it may well have been coming from the operative site, but we know that it could have come from other sites ... and to operate on someone without first trying to localise an area where the bleedings coming from.....the great length of bowel, that's many meters between the mouth and anus...not knowing where to look is quite difficult, it's a constant problem when people come in bleeding through the gastrointestinal tract without knowing where it is coming from.[99]

Finally ...it is of concern to me that your (original notes) appear to have disappeared?

...I was informed of his death the morning after...My first statement that went to the Coroners I don't know if I filled that or not or whether that was someone else...

When did you determine in connection with finding out about Mr Hasibuan's death that it was no longer necessary to keep your notes?

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[98] Transcript 280.

[99] Ibid.

...I can't remember...Its common practise to make such notes.[100]

Dr Thierry Boukris

129. Dr Boukris was working as an upper gastrointestinal surgical registrar and assisted Mr Atkin with the laparoscopic cholecystectomy procedure. Dr Boukris provided a statement but as he had not made any notes in the medical record, his statement was limited.[101]

130. Dr Boukris was able to establish that he was working at the hospital between 10 and 16 of November 2010, and that between 10 and 14 November he was working in the Alfred Main Ward Block where Mr Hasibuan had been located.

131. On 10 November 2010 he signed a consent form in respect of Mr Hasibuan's laparoscopic cholecystectomy and that he assisted Dr Atkin who conducted that procedure.

132. He made the following notes

GA (general anaesthetic) Lithotomy.

Laparoscopy as per Hassan technique.

5 ports in total. Dissection of triangle calot.

IOC (intra operative cholecystectomy) on 10 November 2010.

Hemostasis (the prevention of bleeding). Pangen (local haemostatic pad). And surgical (blood clotting agent) in liver bed.

Removal of gall bladder, Drain in bed. Suture of Ports.

Dressings.

Post Op.

drain

oral intake, sips of water.[102]

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[100] Transcript 282.

[101] See statement at exhibit 9. In 2010 Dr Boukris was an upper gastro intestinal registrar at the Alfred Hospital. He had trained in Paris where he was later an intern and then a registrar. He came to Australia in 2005 and worked at the Western Hospital for three years and then transferred to the Alfred, where he stayed for two years. He was legally qualified to practise medicine in Australia. He is now working as a surgeon in Israel, from where he testified by video link, (with access to Mr Hasibuan's clinical records and his statement). See also footnotes 102 and 103 below.

[102] Exhibit 9 page 2.

133. His recollection was that he attended ward rounds with his interns, (*the team).* He didn't carry out this work alone. He remembered Dr Barker, *a Scottish Dr.* He didn't make independent notes of his work with his various patients.

134. He recalled Dr Barker contacting him in relation to her finding concerning frank blood in the drain, which hadn't been there earlier in the morning. He recalled saying that an ERCP might be needed.[103]

135. Following a short adjournment a series of agreed questions were then put to the witness.

136. In response to a leading question Dr Boukris then stated that he did recall Dr Barker telling him on 12 November that there had been a drop in Haemoglobin from 130 to 78.

137. *I do recall it's because I read it, yes.*

138. *With that information what did you do?*

139. *I would have asked for a blood cross match ...to be sure all the things get ready if he needed any blood transfusion... and to be sure to also give him enough fluid.*

140. *Do you recall telling Dr Barker that the haemoglobin result was more in keeping with the haemodilution from fluid resuscitation rather than ongoing bleeding? I don't recall that specifically...*

141. *...in relation to the drop in haemoglobin do you recall telling Mr Christopher Atkin about the drop? I was concerned about the drop of haemoglobin...so therefore I would have thought that I would have given evidence about it to Mr Atkin... and we were used at the Alfred and wherever I worked to give a call to the senior that we were, but yeah, that's all I can say.*

142. *That was your usual practise...to call Mr Atkin in relation to a drop in haemoglobin, such as that? I would have spoken to the seniors about the progress of the patient and the issue that they would have had. Or if it was not me I would have asked someone else to do it, but I would have thought we would have done it, yes.*

143. *Mr Atkin ...says he wasn't told about it? I can't say anything that...we were a team of people dealing with that issue and most probably one of us see this issue we would have tried, or I don't know if we would succeed to give him that information ... (indistinct).*

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[103] At this point of Dr Boukris's evidence I indicated a concern with the taking of oral evidence from the witness and as to whether another approach might be adopted. It was then resolved that the Coroners assistant S/Const Ramsey and Ms Hodgson would jointly compile a written interrogatory for my consideration. Transcript 585-6.

144. *Mr Campbell says ...that he would have gone ahead with the gastroscopy after the bleed, which was indicated by a drop in haemoglobin sometime between the 12th and 14th. What do you say in relation to that procedure being done?*

145. *(The)... gastroscopy was already ordered, which was for later on...we got advice from the gastro registrar on the 12th and they did agree for us to do the endoscopy, which was later cancelled.*[104]

Mr Christopher Atkin [105]

146. Mr Atkin performed the laparoscopic cholecystectomy on 10 November 2010, with the assistance of surgical registrar Dr Boukris. He had not seen Mr Hasibuan prior to this time. He was not aware of his pulse, blood pressure or haemoglobin count prior to the operation but believed any abnormality would have been bought to his attention. [106]

147. In his witness statement dated 5 September 2012, he stated that,

At operation there were adhesions of the gall bladder to adjacent tissues including the duodenum. There was some bleeding, considerable washout fluid was used and there was bile spillage from a friable gall bladder... A considerable amount of washout fluid was used during the procedure. A drain tube was placed in the gall bladder fossa and there was post-operative drainage of green brown fluid drained in the immediate post-operative period consistent with bile spillage, peri operative bleeding and washout. [107]

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[104] Following the completion of the witness's evidence I indicated that I was disposed to direct myself that I should disregard his evidence, *because of the communication difficulty that we have had.*

I also asked the parties to later address me as to, *whether the language difficulty we have seen in evidence to day may have been a difficulty which existed when Dr Boukris was working with (Mr Hasibuan) and again when providing information to his colleagues.* See transcript at page 590-91.

[105] Mr Atkin is a general surgeon, employed at the Alfred Hospital. He has been performing cholecystectomies for approximately 35 years at a rate of between one and two hundred per year. He has been performing them laproscopically since the early 1990's. See transcript 382.

I note here that his statement was made to his solicitor on or about September 5, 2012, that is some 21 months after the occurrence of the events that were examined in this inquest. I further note that Mr Atkin made no entry in the clinical record indicating the fact of or the results of his two suggested one on one reviews of Mr Hasibuan (on the mornings of 12 and 15 November) from which he might have been assisted in the compilation of his account. It was not his habit to make such notes unless there was something significant found. Transcript 310.

It is also the case that apart from the one entry of Dr Larissa Freeman at exhibit 12 page 81 reference at 11.30 am on November 15, that there was no recorded evidence of any ongoing involvement in the management of Mr Hasibuan by Mr Aitkin, after the initial laparoscopic cholecystectomy procedure on November 10.

[106] Transcript 294.

[107] Exhibit 6 page 1.

148. He later described the adhesion of the duodenum *stuck to the gall bladder* as unusual.[108] And having to actively separate the gall bladder and duodenum...*that would have been done with scissors or with a diathermy hook.*[109] *...or by separating the tissues by stretching.*

149. *How do you say that went? As far as I could tell there was no problem.* [110]

150. Following the procedure *there was considerable bleeding from the gallbladder bed.*[111] Mr Atkin was unable to recall how much blood was lost in this manner. He used hemostatic agents to apply to that raw area to help stop the bleeding, this by stimulating the body's clotting process.

151. Mr Atkin was further asked if he recalled bleeding from the duodenum after he separated the duodenum off the gallbladder. He used considerable washout during the operation. He could not specifically recall looking at the duodenum again after dissecting the gall bladder. The washout was applied *through a tube which is both a sucker and a cannula, which allows us to squirt water in (and) wash away the blood and suck it away so we can see where there is any bleeding.*[112]

152. Mr Atkin was further questioned about the possibility of further bleeding from this area following the completion of the operation,

    ...the gall bladder is adherent to the liver and then dissecting the gallbladder off the liver. There's often bleeding associated with that...usually venous blood but the case we are hearing-but its more ooze rather than spurting blood.[113]

153. Mr Atkin was then questioned about the results of the autopsy examination.

154. *So in terms of blood loss into the duodenum is it possible – and what was found at autopsy was that there was a defect shown in the cystic artery adjacent to the gallbladder fossa hematoma. Is it possible blood could leak through the opening into the duodenum?*

155. *That's what appears to have happened immediately prior to Mr Hasibuan's death.*[114]

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[108] Transcript 295. Adhesion can be caused either because of inflammation to the gall bladder or to the duodenum, with the adhesion taking place at the inflamed part(s). Transcript 299-300.

[109] Transcript 297 and 298, where the nature of the operation was described by Mr Atkin by reference to the diagram at Exhibit 1(b), as marked by the witness at exhibit 6(b).

[110] Transcript 301.

[111] Transcript 298 and 301.

[112] Transcript page 303.

[113] Transcript 304-5.

156. In terms of the difficulty of the operation Mr Atkin stated that it was complicated in that additional techniques had to be used to stop the ooze from the gallbladder bed. Adhesions to the duodenum were not normal, but otherwise it was a relatively straight forward operation for an acutely inflamed gall bladder.

157. In terms of a recovery time for a patient with acute cholecystitis who undergoes a procedure such as gall bladder removal, a patient would be in hospital for a day or two following that procedure.[115] If there was evidence that bile is leaking and not draining out of the bile tube you might find generalised peritonitis...with the abdomen tender...the patient becoming febrile ...and may have a rise in the lumen level. This was not the case with Mr Hasibuan.

158. *And at any stage did he develop a temperature? He did... I believe he did on the Monday or Tuesday.*

159. *Were you informed of his temperature? I wasn't aware I don't think...just looking at my statement I can't see any mention of a temperature.* [116]

160. Mr Atkin further stated that he did not see Mr Hasibuan on Thursday 11 November 2010 but recalled that he was contacted by Dr Boukris during the late morning, due to his episode of feeling faint and lowered blood pressure. He was also informed that since midnight there had been a *considerable leakage of green-brown fluid. I understood at that stage that his haemoglobin was 130 grams per litre.* His later evidence was however that he couldn't recall if he was told at the time that his haemoglobin was 130.[117]

161. Mr Atkin also recalled that he requested a CT Intravenous Cholangiogram due to what he thought was a bile leak. Dr Boukris appears to have made no record of this instruction.

162. Mr Atkin could not recall if he was informed of the actual blood pressure reading at that time.[118] At 9.40 am the blood pressure was 86 over 58. [119] He further did not recall being told about Dr Barkers finding at the time that, *the bile drain now has frank blood in the drain not*

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[114] Transcript 306.

[115] Transcript 307.

[116] Transcript 309.

[117] Transcript 312.

[118] Transcript 310.

[119] See page 311. On two occasions on the morning of November 11 and within a twenty minute period the systolic blood pressure was measured at below 90, thus triggering the MET call protocol, with a MET call not made.

present this morning.[120] He would have expected to have been given this information. His further testimony was that he would also have expected a MET call to be made.[121]

163. He was informed later in the afternoon of the result that there was no evidence of contrast leaking and thus no suggestion of bile leak and that he received IV fluid and subsequently improved, and was drinking soup and free fluids.

164. *In the light of the apparent improvement I considered that it was not necessary to initiate any further orders at that stage.*[122]

165. Mr Aitkin further stated that on 12 November 2010, he reviewed Mr Hasibuan after his morning theatre list. There was 200 mls of green brown fluid drained from the drainage tube *and Mr Hasibuan was stable and feeling much better.* However due to the continuing leakage from the drainage site Mr Aitkin ordered an ERCP to be booked for the Monday, *in case the drainage hadn't settled.*[123] I note that no record was made of this review.

166. Mr Atkin also stated that, *I am aware that blood was taken in the morning of the 12th and that the result of the analysis indicates that Mr Hasibuan's haemoglobin level had dropped from 130 that previous day to 78. I can only assume that the result was not available at the time that I saw Mr Hasibuan, as I was not made aware of that result then, or at any later time during the period of my involvement.*[124] *As indicated when I reviewed Mr Hasibuan he appeared well and accordingly I did not consider a blood transfusion, and I was not involved in any discussion later in the day, as to whether Mr Hasibuan needed a blood transfusion.*[125]

167. From the evidence of Dr Barker we know that she in fact learnt of the fall in haemoglobin on the morning of the 12th following her morning round and that she then initiated a discussion with Dr Boukris concerning that matter. I also note that Dr Boukris testified that he believes

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[120] See footnote above.

[121] Transcript 312-13.

[122] Ibid page 2.

[123] Ibid.

[124] I note that in later evidence Mr Aitkin stated that he did become aware of a fall in Haemoglobin on the morning of November 15. See Exhibit 6 page 3. See also his evidence concerning the haemoglobin report on November 12, at transcript 312-13 where he states that he could not remember if he was told of the haemoglobin drop to 130, but that this would not have caused concern because, (he) *lost some blood during the operation.*

[125] Exhibit 6 page 2.

that he then discussed this matter with Mr Atkin.[126] As above Dr Barkers clinical notes reveal that frank blood was found in the bile drain on the morning of November 11.

(I further observe that on the assumption that Mr Atkin's undocumented review occurred, that evidence from other parties does not suggest that he was accompanied by a team member, or other).

168. It is also the case that senior team member Dr Freeman's own failure to record the fall in the haemoglobin level did not cause her to agree with counsel (during her evidence) that at the time under examination she was unaware of that matter, or that it was not a part of her discussion as to how treatment should be continued. I further observe that her evidence that she was looking for the cause of blood loss as set out in my summary of her evidence above, is consistent with the fact (as would be expected) that she was indeed aware of the haemoglobin fall and was interested to establish why it had occurred. Also relevant is that this occurred in a setting in which Mr Hasibuan's recovery was seen to be taking an unusually long time, with his condition fluctuating and during which he had become hypotensive.

169. Mr Atkin further stated that he couldn't recall the conversation but believes he was contacted by the registrar on the Saturday morning, (November 13). According to Mr Atkin he was informed that the patient felt alright, was afebrile and that his observations were stable. The drainage tube had drained 200mls over the previous 24 hours and was to continue. The ERCP was still planned for Monday. *In those circumstances I did not believe there was a basis for me to alter the orders, and I did not.*[127]

170. Mr Atkin further stated that he was not involved in the management of Mr Hasibuan on November 14 but saw him again on the morning of 15 November, (again not documented), and was informed of the bleeding from the rectum and that he had been transfused, due to the drop in haemoglobin.[128] *Mr Hasibuan's haemoglobin level was 75 grams per litre and his blood pressure was 99/60, heart rate of 105. The haemoglobin level increased to 103 later in the day following further transfusion.* [129]

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[126] See footnote 104 above, in which terms I again direct myself. See also Mr Johnson's evidence that he believes that this result would have been returned on the 11th.

[127] Ibid. Again there was no record made of this discussion.

[128] See exhibit 6 page 3. There was no record made of Mr Atkins attendance at this time.

[129] Exhibit 6 page 3.

171. *I was informed that... (he) had recently undergone a colonoscopy as a result of per rectal bleeds and this had diagnosed diverticulitis. This was considered a possible source of the bleeds,* (which interpretation of the presentation I note was later criticised in the evidence of Mr Campbell).

172. *I was informed that he had been seen during the UGIS ward round and a CT angiogram had been ordered to determine if there was any ongoing bleeding and its source.*

173. Mr Atkin also stated that he was informed of the results of the CT angiogram and that the results did not provide grounds for concern. He requested an ultrasound to see if the collection described on the CT could be drained. He was later informed that the ultra sound detected the tracts of the previous drainage, *and the fluid remaining around segment 5 is too small for drainage.*

174. Mr Atkin further testified that he did not see Mr Hasibuan again was not informed of the chest symptoms on 16 November 2010, nor was he involved in the order of the chest x-ray. Mr Atkin also stated that at no stage was he informed of the fresh blood in the drain in tube, on the 11th.

175. He further stated that,

If I had been aware of the drop in haemoglobin from 130 to 78 and there had been demonstrable external blood loss and an ongoing failure to respond to fluids, which was not the case, then I may well have considered doing an earlier CT angiogram. [130]

176. Furthermore,

The investigations showed no active bleeding at the time from either the diverticular disease or the gall bladder fossa. It is not unusual for bleeding not to be detected on imaging as it frequently stops by the time the imaging is performed.

It was not thought at any time that Mr Hasibuan had bleeding from the gall bladder fossa communicating with a perforation of the duodenum. The combination of these two events is exceedingly uncommon.

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[130] See however footnote 124 above.

Mr Ian Campbell [131]

177. As part of my investigation I requested an expert opinion from Mr Ian Campbell regarding Mr Hasibuan's treatment. Mr Campbell was provided with the Medical Examiner's Report, the statements from treating clinicians, clinical guidelines from Alfred Health and the medical records.

178. Mr Campbell noted that *this is an extremely rare combination of events to occur and I have never seen or heard of it in my thirty five years of surgical experience.* He summarised that there must have been injury or trauma to the *cystic artery* during the laparoscopic cholecystectomy.

179. Mr Campbell's opinion was that when it became apparent that the haemoglobin had fallen to 78, the treating surgeon should have been contacted.

180. The gastro-intestinal bleeding was unrecognised and he should have been on an intestinal bleeding protocol.

181. The response to the drop in haemoglobin from 138 to 78 on 12 November was inadequate. When the PR bleeding occurred, gastro intestinal blood loss should have been suspected.

182. The *surgical and gastroenterology treating teams* became side tracked with their investigation of the biliary leak.

183. Mr Campbell further testified that *with the type of bleeding which occurred, one would normally expect the patient to have vomited blood, and this didn't occur in this patient...If a gastroscopy had been performed and shown a large uncontrolled basically bleeding duodenum, which at the time would have been interpreted as a bleeding duodenal ulcer...The options would be to try and control it with X-ray treatment ...or surgery under general anaesthetic, perform another operation to open the patients abdomen, investigating to see exactly what's going on and endeavouring to fix this. Depending on the circumstances this could be done laparoscopically. Initially that's keyhole surgery, or it could be done as an open operation depending on the facilities available and depends on the patient's condition at that time, which would have to be discussed with the patient's surgeon and anaesthetist.*

184. *...when do you say it was appropriate? If I'd seen the patient with a stomach full of blood ...you would attempt to wash out (the blood) –that's the gastroscopy. It would all be*

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[131] Dr Campbell is a visiting Consultant surgeon and the supervisor of surgical training at the Wimmera Base Hospital. He testified from the Horsham magistracy.

clotted...and exceedingly difficult to wash out in these circumstances. ... If you could actually see a bleeding site at the gastroscopy you can inject it to obtain an adequate view...

185. In this case we now know that you wouldn't have been able to see the bleeding site because it was several centimetres away in the cystic artery.

186. *So you have to accept that the patient has an uncontrolled bleeding. Treatment of uncontrolled bleeding, if you can't inject it there or put clips on it, would be surgical investigation and surgical treatment of the bleeding site...In this case you wouldn't find a bleeding ulcer,*

You'd find the bleeding from somewhere round the cystic artery band then you'd have to fix that.

187. Mr Campbell further testified that a gastroscopy should have been undertaken by the time. *... two things happened. There's the ongoing bleeding, although there was bleeding documented from the bowel ...it's not commented on whether it's dark blood or bright blood. And later its' definitely commented from the hospital note that it is dark blood. This was attributed as Diverticular disease. Diverticular disease will cause bright bleeding but rarely causes dark bleeding. Dark bleeding on the other hand has usually been altered to some extent by the bowel and it's nearly always from the upper gastrointestinal tract, meaning the stomach, duodenum or the early part of the small bowel.*

188. *Something has caused the patient to drop their haemoglobin from 138 to 78. That means they have bled something like one to two litres of blood, probably nearer to two litres of blood over a couple of days.*[132]

189. Mr Campbell further pointed out that only a small amount of this quantity of blood had come out in the drain and not enough to explain that level of drop in the haemoglobin level.

190. We have got *the significant fall in haemoglobin plus dark blood from the bowel, to me implies a need to go at least to the high dependency unit and to be thought of as gastro intestinal bleeding protocol until you prove otherwise.* The underlining is mine.

191. *Investigation of gastro intestinal bleeding usually involves an upper gastrointestinal scope or gastroscopy. ... This patient didn't have the endoscopies, (he) had a CT angiogram. The*

[132] Transcript 482-83.

problem with that is that it is good if it shows there is bleeding but ...bleeding can be intermittent, so it can bleed quite quickly and then it gets clots on it, then it stops.

192. *Then blood pressure may go up –settles down and then the blood pressure may go up then the clots fall off and it starts bleeding again. If the CT angiogram at the time of surgery ...had active bleeding at that time, things would have been different. But the CT angiogram...if it's not bleeding at the time the CT angiogram won't show it.* [133]

193. He further testified that in such circumstances you need to repeat the haemoglobin test and on confirming the result that you need to transfuse the patient.

194. *When the patient is in a satisfactory condition and their pulse or blood pressure is satisfactory I would do a gastroscopy, probably a colonoscopy as well... A CT angiogram is complementary to (these) procedures, it's not a replacement for these procedures.* [134]

195. *At what time would you have done a laparotomy...?*

196. *Probably on the morning of the 15th ...You would like to think that they would have had a gastroscopy at 8 or 9 o'clock that morning... it would have been done in theatre and then with the stomach full of blood associated with that, we would have proceeded following that (gastroscopy).*

197. *It has been suggested that it is possible that with a gastroscopy that blood may not have been visible?*

198. *... If it had been pushed into the duodenum there must have been bloods present. If there is blood coming out of the ... rectum, there must be blood in the duodenum, even with intermittent bleeding. I think it is extremely unlikely that there wouldn't have been blood in the duodenum at that stage. I think there would have been blood in the stomach and blood in the duodenum. Bleeding from the cystic artery would never have been seen... There was a lot of blood in the stomach at the time of autopsy (but that's another day later).*

199. *But the (fact) that blood got into the stomach at the time of autopsy (death) means that blood can get into the stomach two days beforehand.* [135]

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[133] Transcript 483-84.

[134] Transcript 485.

[135] Transcript 486.

200. In further evidence Mr Campbell testified that it was not possible that haemodilution had been a factor in reducing Mr Hasibuan's haemoglobin level from 138 to 78. He was further questioned about the drop in blood pressure on 11 November.[136] He considered that this was a sustained drop in pressure which, *means that something is wrong with the patient...it means either that the heart is not pumping properly or there is not enough material for the heart to pump properly,* (or because of) *severe infection.*[137]

201. Mr Campbell was then questioned in respect of the haemoglobin levels. He stated that in respect of the level of 103 at 3 am on November 16, after the delivery of three units of blood, and then at a level of 91 at 9.08 am that,

And it then started falling again (after the transfusion) which would suggest that there has been ongoing bleeding...Continued bleeding and by the episode of bleeding, whether it's continuing to trickle or whether there has been a clot that stopped and restarted. [138]

202. Mr Campbell further testified that because of the effects of both the anaesthetic and the surgery that blood pressure would normally resume at a normal level (in a man of 50 years following a laparoscopic cholecystectomy) within an hour of the conclusion of the anaesthetic, i.e. one to two hours after the conclusion of the procedure. He further stated that blood pressures of 86 on 58 and 88 on 55, both recorded on the 11th, the day following surgery, were not indicative of a normal recovery. Mr Campbell went on to comment on the possibility of the bile leaking in the period following such a procedure and how if you are draining 50 to 100mls in the first 24 to 48 hours, *it doesn't necessarily mean anything major's gone wrong.* [139]

203. In this case there was a bit of blood (external) and a bit of bile leakage and they both stopped. It was decided to investigate the bile leak with an ultra sound and then an ERCP. The ERCP did not proceed basically because the patient's bile leak stopped.

204. *It is interesting to speculate that if the ECRP had been done that day, that would have involved putting a telescope straight into where the bleeding site was and at least they would have found the bleeding...but the indication disappeared with the cessation of the bile leak*

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[136] The systolic pressure was recorded at 86, 85, 90, 92, 97 and 95. Transcript 488.

[137] Transcript 489. There was no evidence of a high fever at this time.

[138] Transcript 492.

[139] Transcript 496.

(and) there was (then) no indication to proceed with it...there was no indication to do an ERCP really at any time in this patient.[140]

205. Mr Campbell was further questioned about the 100mls of bile which included fresh blood, found in the bile drain at 9.40 am on the morning following the procedure. He would maintained a close observation of the output but would not have intervened at this point.

206. In regard to the heavy pain experienced on the 14th Mr Campbell further commented that this on day four means that,

The normal recovery is not happening ...It is not a normal post-operative course on day 4 to have severe pain.[141]

207. He then testified as to possible causes of pain also testified that internal bleeding can also cause pain.

208. *Objectively in this patient it could have been from bleeding. The same sort of pain could have happened and certainly with the benefit of hindsight could have been from the hole in the duodenum with some leakage of bowel contents and gas into the peritoneal cavity. And that can be a cause of pain as well. Now whether it is caused by the gas or by bowel fluid or acid coming into the peritoneal cavity you don't know.*[142]

209. In regard to the note written by Dr Gutierrez dated November 14,

210. It suggests that something has gone wrong in the upper part of the abdomen. In this context it can be bleeding it could be perforation ...and his assessment note. *Abdominal pain post op query bleeding query leakage,* was appropriate.[143]

211. Mr Campbell additionally testified that a MET call should have been made following the drop in the blood pressure below 90.

212. *If that had occurred, one would like to think that between the senior surgical person present and the senior anaesthetic person present they would have cottoned on that something wasn't right ... Probably if he had called it something, a better outcome might have been achieved.*[144]

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[140] Transcript 498.

[141] Transcript 501.

[142] Transcript 503.

[143] Transcript 504.

[144] Transcript 507.

213. Mr Campbell's further opinion was that if there was a suspicion of gastrointestinal bleeding with evidence of blood coming out of the rectum or from the mouth, and blood pressure less than 100 and haemoglobin less than 100, the appropriate course was to admit the patient to the intensive care unit.[145]

214. *So hypothetically if a MET call had been made I would like to think that the patient would be transferred to a high dependency unit and seen in consultation with the gastroenterology people and the possible bleeding sites would be investigated.*

215. *what mislead people here was that the colonoscopy had been done and the diverticular disease which is common, was labelled as the course of the bleeding. DVT causes bright blood bleeding from the bowel. It rarely causes dark bleeding. Dark bleeding implies that the blood has been altered which usually means it is partly digested, which means it's usually comes from the stomach or duodenum. Investigation of dark bleeding requires reasonably early gastroscopy-not in the middle of the night usually but the next morning.*[146] The underlining is again mine.

216. Under further questioning Mr Campbell was asked about Mr Aitkin's view that at no stage was a gastroscopy indicated. In response Mr Campbell referred to the November 15, 6.40 am documentation made by the team led by Dr Freeman, *indicating the passing of dark bloody motion overnight (I think) with accompanied by hypotension.* [147] Dr Campbell further referred to surgical cover Dr Gutrierrez (Victor) and his note earlier in the morning of November 15, also at exhibit 12 page 255 and his note concerning a drop in Haemoglobin and PR bleeding and its relationship to *recent colonoscopy.* He considered that these observations indicated the need for a gastroscopy and indicated how such a presentation would have been treated at the Horsham Hospital. [148]

217. Mr Campbell's further evidence in response to questions from Ms Hodgson, Counsel for Alfred Health was that at Horsham hospital nearly all cholecystectomies are undertaken laproscopically and that he would perform approximately one per week, with about 25% of

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[145] Transcript 509.

[146] Transcript 510.

[147] See notes made by Dr Lanyon at exhibit 12 page 255. While Dr Campbell referred to, *accompanied by hypotension,* the words recorded by Dr Lanyon were, *passed a dark blood motion overnight with associated hypotension,* which I note were the words (appropriately) used by Counsel for Alfred Health when examining Dr Freeman, at transcript page 263.

[148] Transcript 509.

these a response to an acute cholecystitis or an inflamed gall bladder. In cases where a bile leak occurred about 5 to 10 %, and that this would settle within a few days, most without any intervention.

218. Such a patient would only be discharged, after the bile leak has been *sorted out*. Mr Campbell was further asked about an earlier reference to hepatic artery now amended to cystic artery. He stated that there was no doubt that there was an arterial injury, which caused the blood loss.[149]

219. Mr Campbell also again testified that the failure to elevate the case to the Consultant following the fall in haemoglobin, noted by Dr Barker, was inappropriate. He was then asked about the colour of the stool found on the ward round on November 15, and the colour of blood found by the surgical cover overnight. His testimony was that *dark blood* and *melena* are used interchangeably and that he didn't believe the bleeding came as a result of diverticular disease because of his low blood pressure at that time.

220. *Put altogether that means significant bleeding. I doesn't say where it's coming from... It's unlikely to be diverticular disease with a large amount of dark blood or any amount of dark blood associated with hypotension, that's a blood pressure less than a hundred, and tachycardia...*[150]

221. Mr Campbell then referred to the Wimmera Hospital Gastro Intestinal pathway and re-stated his opinion that *...it's important that if the bleeding is recognised that it is investigated. If it's not investigated you can't...go forward and treat it and stop it.* And he further testified that bleeding from the gallbladder bed (as described by Mr Aitkin) was common, *after any sort of cholecystectomy, open or laproscopically...* [151]

222. *And that (he) should have been managed on a protocol or pathway or clinical workload for gastro intestinal bleeding.* [152]

223. Mr Campbell further testified that the CT angiogram (November 15) was not particularly helpful because there was no bleeding taking place over the five minutes that the CT

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[149] Transcript 514.

[150] Transcript 523.

[151] Transcript 526-29 and exhibit 8(a).

[152] Transcript 529-30.

angiogram, was taking place. He considered however that there was still evidence of active bleeding on that day.

224. *It is pretty blatant from the graphic observations chart for 15/11 that the pulse stayed at 105, 110 and the blood pressure was 90 from the whole day, I think... The blood pressure on 14/10 was 100... (it) was never more than 100 from midnight on... There's ongoing bleeding.*[153]

225. Mr Campbell then referred to the gap in observations between 11.25 and 16.36,

226. *And in fact if you look at-the blood pressure stayed the same and the pulse has gone up, there is a five hour gap in observations which is significant...*

227. *And then how would I assess on going bleeding?*

228. *It depends what comes out of the rectum... out of the mouth, it depends on the central venus line that I would have inserted in the patient if they'd been in a high dependency area. It depends on their colour, it depends on their skin, tachycardia, whether they've just got pale, sweaty St Johns Ambulance type first aid things. And you can't say because the documentation is not there...*

229. *...he was off receiving an ultrasound abdomen at 3.24 pm?*

230. *You have not documented that. Wherever he is in hospital there should have been documentation of at least hourly observations and there isn't.*[154]

231. Ms Hodgson then examined Mr Campbell about the evidence given by the examining pathologist Dr Burke, concerning the course of the bleed. Dr Burke had commented on the bleed in the hours before death and Mr Campbell agreed that the bleed at that time happened quickly. Mr Campbell further commented that he didn't think there was a lot of blood in the stomach the day before because it there had been there would have been hematemesis or the vomiting of blood. That's what the textbooks say but it doesn't always happen that way. Mr Campbell then agreed that,

232. He bled to death from a "..." that's what he bled to death from.[155]

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[153] Transcript 533.

[154] Transcript 536.

[155] Transcript 543-4. I believe the words missing from the transcript were *internal bleed,* which is consistent with the rest of his evidence.

233. Mr Campbell was then further cross-examined about his statement as to the likelihood that a gastroscopy *on the 12, 13 or 14 of November would have shown a considerable amount of blood in the stomach.*

234. He responded that he should say, *stomach or duodenum.* And that there had been *significant bleeding into the bowel by 6am on November 15. Probably you could add the 15th ... most of the blood on the 15th was acute bleed. I didn't say all of the blood was acute bleed because you can't tell. There can be a small amount. If there's a massive amount of blood in the stomach you will vomit it up.*

235. Mr Campbell commented further on the autopsy report and referred to the hole in the cystic artery and stated that the microscope slides taken by Dr Burke, showed there had been chronic inflammation, *meaning the changes to the present both in the hole in the artery and the hole in the duodenum had been present for enough (time) to get chronic inflammation which is at least a couple of days.*

236. *So they didn't just both go bang, you know, five seconds...* [156]

237. Mr Campbell then referred (again) to Mr Hasibuan's hypotension and the drop in haemoglobin that had gone on for some time. And further to the ultra sound and CT scan showing changes underneath the liver, weren't enough to account for something like *what I estimate was one to two litres of blood* (loss).

238. *So that blood had to go somewhere else and it went through the hole in the duodenum, which was already there. And then some of the blood that went into the bowel came out of the bowel.*

239. *Q It went through the hole in the duodenum and then? Then came out the rectum And the transit time on it was fast enough that it didn't have time to get digested, therefore it wasn't melena – meaning altered blood or black blood or blood clots or dark blood.* [157]

240. *Q You are talking about the (haemoglobin) drop from 130 to 78 (between the 11th and 12th of November)? Yes*

241. *Q And the night of the PR bleeding was on... the night of the 14th of the 15th? ...Yes*

242. *Q Is it your evidence that two days...two and a half days is not long enough for that blood to become malena... It's possible. I have already given evidence that it was a lot of blood*

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[156] Transcript 548.

[157] Transcript 548-49.

possibly between one and two litres and there's a lot of blood and it may not have been digested *...Remember the man has already had a complicated surgery. The bowel doesn't necessarily function normally. Because this was a day or two after a complicated surgery ...with two documented complications ...on the autopsy findings.*[158]

243. And, *I stand by that if a gastroscopy on the 12th, 13th or 14th would have been abnormal... I think it would have showed blood. There is a hole in the duodenum, which it may or may not have shown...*

244. *... Four millimetre hole. Depends whether there was blood there, if there was clot there, but it probably would have shown it.* [159]

245. Mr Campbell was then further cross examined about his statement to the effect that,

The surgical and gastroenterology teams became side tracked with the investigation of a biliary leak.

246. His view was that the management of the biliary leak was carried out by the taking of the CT cholangiogram on November 11, and then by observation.

247. *The problem back on the 11th was really that the patient was bleeding somewhere and it got- because there was bile in the drain, it was assumed it was from bile leak, and the attempts were to sort out the bile leak.*

248. A bile leak has no relation to and can never be an explanation for the haemoglobin drop.

249. His further opinion was that the CT angiogram and ultrasound conducted on Monday the 15th was *an inadequate response.*[160]

250. And that the appropriate response was instead *either* a laparotomy or a laparoscopy initially, *would be equally acceptable.* [161]

251. In the case of a laparotomy,

You have a look for cause. You look where the most –well you look outside the bowel and then you look inside the bowel. So you start...at the stomach, you follow the stomach round, see if there's blood in the stomach... You can see if there is blood in the stomach.

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[158] Transcript 551-52.

[159] Transcript 552.

[160] See transcript and text at 556-57.

[161] Transcript 558.

... You look inside the bowel (You can see blood through the bowel wall... you follow that round, and you wouldn't have had to go very far because you would have found the cause, which was a hole in the duodenum. And then you would have to manage that on its merits.

And you say on laparotomy you would have been able to see the perforation at that time?

Well in this case you would have. There'd be a clot outside the bowel. You'd wash the clot away and you'd find the whole in the duodenum. Then you'd wash the rest of the clot away and you'd find it – the hole in the cystic artery.

...And I've mentioned it that it may be easy to fix or it may...not be easy to fix. But at least you know what you they (the injuries) are, and you get the appropriate person or if necessary, appropriate help to manage it... the arterial thing would have been easily fixable, and the duodenal injury probably would be relatively easy to fix but maybe more complicated.[162] The underlining is mine.

252. Mr Campbell was then further cross-examined on the haemoglobin drop *which he described as a very big drop for any sort of cholecystectomy...A normal gall bladder...a straightforward gall bladder hardly bleeds, and you wouldn't expect the haemoglobin to fall at all...*

253. *It's documented as basically a gall bladder...with no evidence that the surgeon was out of his depth. The surgeon is well experienced in this field and it's a bigger haemoglobin drop than you'd expect.*

254. His additional opinion was that the blood that caused the haemoglobin drop went into the bowel, which has a very big capacity.

255. *You can put two litres of blood or a litre and a half of blood into the bowel and it just sits there...*

256. The *bowel doesn't function normally after anaesthetic, or after surgery. If there is blood in the bowel it will come out at some time.* [163]

257. *The night that he died there was –the blood on Sunday night was a further bleed from the circulation straight through the hole in the duodenum. The hole in the duodenum must have been present from the time of surgery.*

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[162] Transcript 559.

[163] Transcript 562-64.

258. *It's a very unusual combination of factors, which makes it very difficult for people to sort it out. But that's my interpretation of what happened.*

259. Dr Campbell was aware of the practise that clinicians from the same team might themselves respond to a MET call situation without the MET call actually being made. His further evidence was that in those circumstances if he were the registrar he would have increased intravenous fluids and gone away and reviewed the patient in a couple of hours.

260. If a MET call had been made in accord with the then existing protocol however a larger group would have been obliged to attend. That included the Intensive Care Registrar, the Intensive Care Liaison Nurse, a Medical Registrar, Parent Team Registrar Resident and an Anaesthetic Registrar. *So you can speculate what would have really happened if a MET call had been made there in 2010.* Now however you would get a better response because people are used to it and they're not new and it's a proven benefit to the patients, which means to everybody.[164]

261. *And it's a support to junior staff so they don't actually have to think because in the past people would see this and they would say oh wait an hour and now they are not meant to wait an hour they are meant to confidently ring up help and someone more senior than the cover intern is available to see (the patient) and make appropriate treatment plans ...rather than the intern or the junior nurse stuck with looking after the patient.*

262. The problem was that it was a complex case and for there to be arterial bleeding is not unusual, but for arterial bleeding into the duodenum is extremely rare. Notwithstanding that difficulty the presentation which existed through this three day period was such that the matter should have been elevated for review to look for all the possibilities, which included intraperitoneal bleeding and bleeding into the bowel.[165]

Mr William Johnson

263. Mr William Johnson, the Program Director of Surgical Services at the Alfred Hospital provided a statement in relation to the care provided to Mr Hasibuan.[166] He was not directly involved in Mr Hasibuan's treatment. He stated that Mr Hasibuan was not, *a straight forward case.* After the operation he was progressing satisfactorily and was stable. The possibility that the drop in haemoglobin on 12 November 2010 was cause by significant blood loss was

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[164] Transcript 573.

[165] Transcript 575.

[166] See statement of Mr William Johnson undated at Exhibit 10.

not considered as, apart from the blood and clots in the drain tube, there was no evidence of overt bleeding. The CT scan showed no abnormality to suggest a problem around the site of surgery. The rectal bleed was considered a new problem and given Mr Hasibuan's recent diagnosis of diverticular haemorrhage, this was considered to be the likely cause of the bleed. Mr Johnson stated that the CT angiogram did not show any bleeding.

Staffing and specifically weekend staffing at the Alfred

264. In evidence to the inquest Mr Johnson testified that the UGIS teams at the Alfred have a head of unit and a series of consultant surgeons who work within the unit which is usually comprised of a Fellow x 2, one doing Alfred GI surgery and one doing Hepatopancreatico-Bilary surgery and there are sort of two separate sub teams. Mr Hasibuan was under the Hepatopancreatico-Bilary unit so the team was a fellow a registrar and a resident.

265. *There are more Consultants one looking after each particular patient. There are fewer junior staff in this particular grouping, so there not specific teams all designated to look after one patient...The Consultant will be responsible for the patients that he has operated on or seen...The registrar or Fellow would take the lead, the registrar is second in line and they are responsible for all of the patients in that section of the unit. There maybe five ...to eight patients in the unit at that time. There could be more...*

266. *But the junior staff are responsible for the day to day running of the ward. They report to the registrar who reports to the Fellow who reports to the consultant if necessary. At any level any one of them of course can report to the consultant.*[167]

267. Mr Johnson further explained that the staffing arrangements were different at the weekend. On Saturday mornings the units do their rounds with the full team, but from 12 o'clock there is a reduction in staff levels with one resident taking on responsibility for the three general surgical units. *This sort of structure was considered a high risk on our risk register.*[168]

268. Mr Johnson further pointed out that the case of Mr Hasibuan was one of the *lights* which demonstrated the need for changes to occur, *and led us to a change in policy.* He apologised again to Mrs Hasibuan for what had happened to her husband.[169]

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[167] Transcript 598.

[168] Transcript 599.

[169] Transcript 599-600.

Met Call guidelines.

269. Mr Johnson then discussed the Escalation of Care Guideline in place at the Alfred and described how it set up clinical review criteria as distinct from medical review criteria, which were already in place.

270. *...what I mean is that the deterioration of a patient which occurs (leading to) the signal to notify the residents ...was (previously) left to the discretion of the nursing staff on the basis of the parameters that they had reserved to them. So it was (theirs was) a clinical decision that was made and could be varied.*[170]

271. Under the former protocol,

...there was then no mandatory level to escalate to a clinical review. ... (the protocol) involved notification to the house staff that there was a problem. It was relied that the nursing staff would determine a problem and (make) an appropriate signal up the chain.[171]

The (units) medical team if they were on the ward at the time would then consider the matter and if the clinical team felt that a MET call was not necessary, they could handle it and override that particular decision.

There were three occasions (in Mr Hasibuan's case) where measures reached MET call criteria. When the blood pressure was less than 90... and that should have been escalated to a MET call, if that was known. But on those occasions the residents were called and were happy they had control of the situation and therefore no such call was made.

Now those two things have changed dramatically. [172]

The MET call is made, the medical emergency team comes, which is made up of the intensive care team, and they come and assess the patient. Nursing and Consultant or Fellow or Senior Registrar. They will come and assess the patient and contribute ... and manage the patient in that situation.[173]

272. And further,

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[170] Transcript 601.

[171] Ibid.

[172] Transcript 602. The changes spoken of are set out at exhibit 10(a) The Escalation of Care Guidelines and 10(b) The Graphic Observation Chart.

[173] Transcript 607.

As part of the process we surveyed junior staff to find out how they felt about escalating to (their) Consultants. And the questionnaire we put out 80% or 85% of residents and registrars actually said they were afraid to escalate to a Consultant because they may be abused, which is unusual and because the Consultant may think less of them because they couldn't handle the problem.[174]

273. Mr Johnson, went on to explain how the system now works with focus on weekend work and the manner in which senior clinical staff are monitored in respect of MET call management.

274. He described the process, which has resulted in more MET calls,[175] *an unbelievable success, and I have to say we're fairly pleased about that.*[176]

275. The witness further described his expectation. (He stated), *I expect the staff to take ownership of the patient's problem and to work through the problem as best they can, to a point where they decide, 'I can handle it or I escalate it'. And that's our teaching we encourage people to escalate.* The underlining is mine.

Orientation training.

276. On the question of training provided to newly arrived Doctors, Mr Johnson testified as to how all newly arrived interns, residents and fellows are provided with orientation after having been divided into two categories-those who have worked in the hospital before and those who have not.

277. They then undertake the orientation programme which for first year residents will take several days. All Alfred protocols are addressed *and run through.* The protocols include the MET protocol, and the escalation of care and resuscitation guidelines, *all of the things that are set up to run the hospital properly...We go through the graphic observation chart, we introduce them to escalation, introduce them to clinical leads, etcetera,*[177]

278. Mr Johnson further addressed the process involved adjusting to new protocols and in settling in to work at the Alfred, especially for those coming from a different hospital environment.

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[174] Transcript 610, and 616 where the witness describes that since the mandatory MET call criteria has been in place, they do not have incidents of this kind occurring.

[175] Transcript 614-17, and Counsels submission to the Court which establishes that .....

[176] Transcript 612.

[177] Transcript 619.

We have a very large number of people who apply to come (to work) to our hospital...We have an intense interview process which is undertaken by consultant staff and members of the workforce unit. And quite frankly we go into the background of the individuals and we choose people who come to the Alfred that we believe are going to contribute to the Alfred...

279. *In 2010 with Mr Hasibuan's case it is true there were MET criteria there but it is equally true that a person from Scotland could decide that they could handle the case and not activate a MET call because they had that option.*

280. *It wouldn't matter now where they came from ... Now if there's - if the person reaches MET call criteria, it doesn't matter what they think. The MET call will be activated.*

281. *...as a newbie if you like you can certainly be involved in reviewing the case, working up the case, making decisions about what you think should happen.*

282. But you will then be followed up by the MET team who will come and review the case and decide what is going to happen.

The clinical review outcome committee.

283. Mr Johnson provided additional testimony as to the work of the clinical review outcome committee and informed that he was responsible for reviewing deaths in the surgical area and discussing these within this committee.

284. In respect of the clinical management of Mr Hasibuan, Mr Johnson further observed that this process was not something that was carried out in an adversarial way or with a view to criticism of someone, but rather because of the incredible opportunities for learning, *and sometimes policy change as occurred in this case here.* Such an approach is intended to help improve the outcome for future patients.

Medical management

285. Mr Johnson was then taken to the medical management of this case and stated his view that this was an *extraordinarily complex case. It falls into two parts one is a misleading haemoglobin of 130 when a bleed was occurring. And why that should be. And the second one is the second event, which took place on the Sunday night following into the Monday morning. And the ...significant lessons that can be learnt from that.*[178]

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[178] Transcript 624. Further reference was then made to the changes that occurred as a result of Mr Hasibuan's case, which included the introduction of the *Let Me Know* brochure, in which hospital visitors to a family member are invited to report any perceived changes in a loved one, this initially to nursing staff. Mr Johnson further offered that this

286. Mr Johnson then referred to Mrs Hasibuan's concerns for her husband and specifically his extreme anxiety. If these things were bought up they may be resolved and may have assisted in the result. *I think would've given us more opportunity to perhaps find out what exactly was going on.*

287. In regard to the clinical management Mr Johnson further testified that in his view it was likely that at 7 am on the day after the operation (i.e. on the 11th) Mr Hasibuan appeared well and at 9.30 am he was bleeding with hypotension and frank or fresh blood in the bile drain, as noted by Dr Barker. The haemoglobin was taken at 7 am was 130, which was so early in the evolution of the bleeding process that he appeared well. [179]

288. *I am sure that the haemoglobin came back later that day ...And when it came back at 130 I'm sure the surgical team felt there had not been a significant amount of bleeding and that this was not a problem...Now I guess my feeling was that that he had in fact at that time bled...*

289. *Now of course if a litre of blood off somebody and make them hypotensive – low blood pressure and I measure their haemoglobin (at that time) their haemoglobin won't have changed at that time because there has been no time for equilibration to occur within the system.*

290. *Now 24 hours later when the haemoglobin was measured again at 7 am the following morning or thereabouts* (i.e. on the 12th) *it came back late in the afternoon at 78.*[180]

291. Mr Johnson further explained the process leading to a drop in haemoglobin and observed how at this stage Mr Hasibuan would still have appeared relatively well.

292. He had tachycardia (however) although he was resting in bed. And the staff viewed this as hemodilution.

It was like hemodilution was some sort of diagnosis. Now hemodilution is not a diagnosis, and in actual fact if a patient has bled ... and you do nothing at all, then the body will (respond by) *shifting fluid from the extravascular compartment into the vascular compartment to expand it. And that fluid will not of course have red blood cells in it.*

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introduction had proven an excellent addition to the policies designed to provide safe management *and extremely valuable to patient care.*

[179] Mr Johnson offered his view that this appearance was misleading.

[180] Transcript 631.

And if you look over a period of eight hours when equilibration will occur the blood ...the haemoglobin will fall to a level equivalent to that which has been lost.

Now of course you can change that by infusing fluids. You may infuse saline which means that you accelerate this equilibration. Now he did have saline infused and the following morning (the 12th) his haemoglobin was 78...It's a good measure of what's going on, and he had lost a significant amount of blood at that point. Now like I say two unit's three units and there are formulae you can use to look at that.[181]

... The second thing was that the CT cholangiogram that was done, when you go back and uncompact the system, which was showing the bile leak, and you go back and look at the individual scans, there was no evidence that there was any blood in the peritoneal cavity... nothing of significance. So that blood had gone somewhere...

Yes? But not enough to explain two litres. And I guess the other thing was there was no other free fluid in the peritoneal cavity, and the gas that was present was ...compatible with post-operative. So there was no evidence of a leak from anywhere such as the duodenum.

...Mr Hasibuan was feeling better, but he was a 50 year old man lying in bed so I would expect him to be feeling better. But still I would have been concerned at the drop in the haemoglobin.[182]

...his haemoglobin levels remained constant from there...And his blood pressure stayed down with the tachycardia. So I believe that there was an event which occurred,

(not at that stage at least in respect of the duodenum)*...so I can't explain where the blood went to but I am sure there was a significant loss of blood.*

Now if we then go forward to the second incident on the Sunday night, the registrar (Dr Aguirre -Gutierrez) ...I thought did a very good job... there were MET call criteria, which were met and of course decided not to proceed with that. Today of course a MET call would've been called.

Handballing to another team.

293. Mr Johnson then expressed reservation in respect of the decision by Dr Aguirre to leave the decision on treatment to the incoming UGIS team on the Monday morning. *This is not a*

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[181] Transcript 632.

[182] Transcript 634-35.

patient that you are going to handball down the track, this is a patient that you have right now and it's your patient...Now, if a MET call was activated that's the process that would take place. Now the opportunity therefore was missed of a patient who had had some days before a laparoscopic cholecystectomy by a very competent surgeon ...there was a bleed which occurred, related to the operation. [183]

294. Mr Johnson went on to explain his view as to the presentation on Sunday night-Monday morning, November 14 and 15.

295. The patient developed particular acute tenderness in the right upper quadrant of the abdomen, which extended medially. Bloods were measured and it was decided to give a further unit of blood *and gave another couple of units later on, because Mr Hasibuan passed some blood through the rectum.*

296. *Now the trouble with handing the patient over is that by the next morning Mr Hasibuan was feeling better. So the urgency tends to go out of the situation, which is why the MET call the night before would have changed things I believe.*

297. So instead of going back to the primary problem which was the gall bladder, we introduced a second problem which is the fact that some months before he had a bleed from his bowel which had been diagnosed as a diverticular bleed. A colonoscopy at that time showed multiple small diverticuli in the sigmoid colon. There was no evidence that they had been bleeding but they could have been.

298. This was set upon as the probable cause and either way a CT Angiogram was undertaken. This was a correct decision and there was no evidence on the CT Angiogram of bleeding or of a bleeding point. That's relatively significant but bleeding will only show on the CT Angiogram if there is bleeding *at a rate of one to two mls or two to three mls a minute. So if the bleeding has stopped or is less than half a mls a minute it won't show up.*

299. *Going back to CT Angiogram again, despite the fact that something had happened to Mr Hasibuan and he'd passed blood...there was no blood around...just a small clot in the gallbladder bed...but no blood or free fluid in the peritoneal cavity.*

300. So again we have a dilemma where a patient has had a bleed and we can't explain where it's gone. Now he eventually had three units of blood and his haemoglobin came up and his blood pressure came up. But then the following day his blood pressure-his haemoglobin started to

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[183] Transcript 636.

sag again at 3 pm on the Tuesday. And no action was taken about that... And his haematocrit state from the preoperative levels had remained low throughout.[184]

301. That's the figure that is used to estimate blood loss...it certainly indicated a significant blood loss...These figures were all present in the electronic record and would guide decision making.[185]

302. Mr Johnson then went on to explain the change in haematocrit levels and described the fall of .38 down to .23 on the day following the operation as a very significant loss. *And that's where you get the figures of a litre* (in blood loss) *or something like that.* Thereafter these levels remain relatively stable... and that was despite getting three units of blood on the Monday after the initial event.

303. *The difficulty with this approach was that if there had been a MET call on the Monday morning then there would have been quite a change in the management of Mr Hasibuan, because it would have been accepted that what was happening then was something which was a complication of the operation. Because under normal circumstances...having a laparoscopic cholecystectomy by a competent surgeon that he had even with everything going right would have probably be discharged on day two or day three, you would expect that. We are now down at day five and there is a problem. Now by the following morning this had all been resolved. Mr Hasibuan was feeling better, tummy was soft. And so the handball that occurred to the oncoming team-seemed whatever was happening on the* (Sunday) *night, had resolved.*

304. *And the bleeding came on then we got to diverticular disease, which means we were way away from the problem that was going on. Now the three units of blood were given-was some improvement in the haemoglobin, but the haematocrit did not change, greatly. And the haemoglobin ...began to sag again. (The haematocrit levels were established and reported at the same time as the haemoglobin levels). See further discussion of the significance of these levels and their relationship with the patient's haemodynamic status in the evidence of Mr Johnson from transcript page 655-56.* The underlining is again mine.

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[184] The measure of the oxygen carrying capacity of red blood cells.

[185] Transcript 638-39.

305. Mr Johnson then went on to suggest that had the problem been escalated on the Monday morning, and there had been recognition that the problem was occurring in the upper gastrointestinal tract, that would have redirected the focus.

306. He further suspected that Mr Hasibuan *may have had a leak from the duodenum at that point. It may have been due to trauma at the time of the operation,* (he was unable to say).[186]

307. Mr Johnson further stated that at the time Mr Hasibuan was observed by his wife with blood on his pants as he tried to get to the toilet, that he had melina. *The melina itself was not particularly relevant. What is relevant is that if you have upper-intestinal bleeding it generally takes 24 to 48 hours to appear in the stool. It very much depends on the volume of the stool...And of course if it's bleeding quickly then the blood is going to be brighter. It doesn't have time to have the changes that might occur in other circumstances.*

308. *... Because what happened then was-having been given three units of blood there was a sag in the haemoglobin and it went up a bit, and his blood pressure went up-and everything looked to be going very well.*

309. And then the sag in his blood pressure which was accepted as a result of diverticular bleeding. But in fact was occurring was an extraordinarily rare situation, which *... was a complication of the communication from the bed of the gallbladder, which precipitated a sentinel bleed, which is when he had severe pain the night before-I think that is probably what happened.*[187]

310. *Then he had the bleeding, it got* (characterized) *as diverticular disease when in actual fact it was coming from the upper gastrointestinal tract. His haematocrit remained relatively low, and then I believe at some time later on the evening of the final day Mr Hasibuan had a catastrophic bleed...and unfortunately he died of blood loss...*

311. Court: *When do you think the injury to the duodenum occurred?*

312. *I think it occurred at the time of the operation. But there was no perforation of the duodenum...there was injury to it, which could be due to adhesions...or to the inflammatory process that occurred at the time of the operation...And the duodenum wall ... gave way on the Sunday night...or the early hours of Monday morning.*

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[186] Transcript 643-44.

[187] Transcript 644-45.

313. *Which is why the activation of a MET call could have changed things quite dramatically. Because he would have been seen by the MET team as he was seen by the covering resident, which would have indicated that the problem was not down below but in the upper abdomen.*

314. (A colonoscopy) *would have been a complete waste of time. It would have shown blood in the colon because we know he has got that. But it wouldn't have shown the problem. The thing that would have happened...the focus would have been shifted to the upper gastrointestinal tract.*

315. *And I believe had that been done with the evidence of the bleeding that had been going on ...that a gastroscopy would have been activated to look and see what was going on. And the gastroscopy would have shown blood. It would not have made the diagnosis...It would have activated an attempt to identify the bleeding site in the upper gastrointestinal tract.*

316. *If the gastroscopy had not disclosed the source of the bleeding ...would a further laparotomy have been conducted?*

317. *There would have been more blood transfused, because the protocol for management of the upper gastrointestinal haemorrhage indicates in the first instance you stabilise the patient....But at some point we say six units of blood in an upper gastrointestinal bleed. If we haven't got control of the bleeding with six units of blood gone in, seven maybe-then you would do a laparotomy.* The finding of blood in the upper gastrointestinal tract would have activated your search for the source, *which inevitably in this ... case would have led to a laparotomy.*[188] The underlining is mine.

318. In respect of the suggestion attributed to Dr Boukaris that the haemoglobin drop from 130 to 78 may have occurred as a result of hemodilution, rather than significant blood loss, Mr Johnson stated that hemodilution is a natural process caused by blood loss and not a diagnosis and that it can't be used to explain blood loss. [189]

319. His further criticism of the management of Mr Hasibuan was to the failure to make a MET call at this time. Although his blood pressure had come back up, both his haematocrit and haemoglobin were low. It appeared that you had a stable situation, *you would do nothing about that.* But at that time the underlying problem was that he wasn't hemodynamically

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[188] Transcript 646-47. See also the additional discussion of his reasons for this opinion at transcript 648.

[189] Transcript 650-51.

stable *and a MET call would have changed that...because they would have been much more directional in re-establishing the patient.* [190]

320. His further opinion was that Mr Hasibuan later had a *sentinal event...a catastrophic haemorrhage.* This occurred in conjunction with a breaking of tissue into the duodenum or the cystic vessel and associated pain with the contents of the duodenum ultimately escaping into a blood vessel, which led to bleeding from the cystic duct into the duodenum.[191]

321. This was far from clear to those engaged at the time, *but had the MET call been activated on the Sunday night when the blood pressure dropped down into the 80's again suggesting hypotension, then I believe a different scenario would have been followed.*[192] *If there had been a MET call at that time which was indicated or was over ruled and if alternatively a registrar HMO3 at that time thought, "well this is a bit strange I'll ring Mr Atkin."...Neither of those things happened...If the MET call had happened the MET call would have seen the patient ...and that would have focused the problem on the upper gastrointestinal tract...The problem was that it didn't happen, and the handover the next morning,... Mr Hasibuan was feeling better in inverted commas...he was probably feeling better just because the bleeding wasn't continuing and the pain had settled down and he was bleeding into the duodenum...giving the blood cells may have put his blood pressure up and that may make him feel a bit better...and he was receiving pain relief in someone who shouldn't have pain.* On the Monday morning and he *was not in a good way,* which was recognised.

322. *We emphasize to our registrars and residents, everybody, that when you see a patient, you're not seeing a patient as a cover for Mr Atkin, Mr Johnson or anybody else you're seeing the patient as your patient, and you have to make a clinical decision about this patient. And saying we'll wait till the morning is no decision.* [193] The underlining is again mine.

323. On the general monitoring of Mr Hasibuan, Mr Johnson testified the diagnosis of diverticular bleeding in respect of November 15 when his blood pressure fluctuated and that he seemed in the afternoon to be *exceedingly well, ... (this) was reassuring in the sense that such a bleed does not cause a great deal of anxiety as 90% of them stop bleeding within 12 hours. You*

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[190] Transcript 656.

[191] Transcript 659-60. See my finding in respect of blood flow at paragraph 39 above.

[192] Transcript 660.

[193] Transcript 671. See also transcript 672 in regard to error in respect of the exercise of the discretion not to make a MET call in this instance.

don't need to take haemoglobin every four hours if someone is losing blood progressively over a period of time it's much more valuable to follow their pulse rate and their blood pressure to tell you what is going on, as a guide to what's happening in the circulation. Haemoglobin does not affect MET calls.[194]

324. Mr Hasibuan was known to be extremely anxious about going. He was reassured he would not be sent home until he was ready to go.[195] The only time melina appeared in the bowel was on the Monday. There were two separate bleeds. The blood that had been lost in the first bleed is not explained. But I guess there may have been a misunderstanding of what came out of the drain tube and around the drain tube. And there is a story about clots in the bed and clots blocking the drain tube and around the drain tube ...so I am not clear about how much blood was lost externally at that time okay, ... but it went somewhere.[196]

325. Three periods of bleeding one, between the 11th when we see a drop in blood pressure to 86 and 85 and 12th when we see the a drop in Haemoglobin from 130 to 78...*the signal that that was happening was when he had his collapse.* The second period was at around and after midnight on Sunday night the 14th when he had extreme abdominal pain and a drop in blood pressure, and a third incident of catastrophic bleeding which led to his death on the Tuesday evening. If there had been hematemesis the vomiting of blood or melena the pathway would have been hematemesis, melena pathway and therefore a gastroscopy would have been ordered and carried out. *The patient would be transfused in a compatible fashion. And of course if you couldn't find the bleeding point and the transfusion was continuing the patient would go to laparotomy.*

326. The bleeding following the operation would initially have been thought to come from the gall bladder bed. *I would then have got the next day's haemoglobin, which came back at 78. I would have been surprised at that... And it seemed to settle down and the patient to stabilise albeit at a lower blood pressure. And the bleeding did not seem to continue and the bleeding changed to bile and so we were focused on the biliary system and the CT cholangiogram. So I would not be thinking of an upper gastrointestinal cause of bleeding.* In answer to a further question from Ms Hodgson, in respect of the Sunday night bleeding of dark blood and whether they should they have followed a melena protocol (or stuck to their other

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[194] Transcript 689.

[195] Transcript 676.

[196] Transcript 681-682.

protocol)...*Look I can't say that, ...obviously in my situation I would have thought that I would be much more suspicious that the problem was coming from the upper gastrointestinal tract and would have followed that protocol really.*[197]

327. Mr Johnson was again asked about transfusing the patient and reiterated that he would have transfused the patient when he had a haemoglobin reading of 78 on November 12th, *because he was still potentially hypovolemic...and* (I would have) *given maybe two units of packed blood. Any reason...he wasn't transfused?* (I surmise that it appeared), *he was well.*[198]

Catherine Cronin

328. Ms Cronin is currently the Clinical Service Director of Surgical Service at Alfred Health, and qualified as a Registered Nurse. Ms Cronin provided a statement in response to written questions posed to her about medical emergency intervention team protocols.[199] She was not directly involved in Mr Hasibuan's care. She stated that the Medical Emergency Response Guideline was intended to provide guidance to staff and was not intended to impose a mandatory obligation on staff to make a MET call, as it is a matter for their clinical judgement.

329. *Mr Hasibuan's blood pressure was recorded as < 90 systolic at 9.15 (86/58) and 9.27 hrs (85/55) on 11 November the day after his surgery, and again at 0215 hours (88/-) on 15 November.*[200] On three separate occasions then, Mr Hasibuan's blood pressure fell to a level that according to the written protocol should have triggered at MET call. Relevantly extreme pain as described by Mrs Caroline Hasibuan, was also experienced by Mr Hasibuan.

330. I note however that Ms Cronin stated,

Taking into account Mr Hasibuan's overall clinical picture and that medical staff were present and aware of the blood pressure readings, no MET call was made in accordance with the usual practice at the time.

(Mr Atkin agreed with this evidence. Mr Johnson and Dr Campbell both acknowledged the practise of exercising a discretion not to elevate even where a MET call criteria was reached, but testified that the failure to elevate this case led to error in terms of the responses to Mr

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[197] Transcript 693.

[198] Transcript 696-97.

[199] Exhibit 12 page 14 and the then current MET Call guideline at exhibit 12 pages 123-129 and Escalation of Care guideline at exhibit 12 pages 131-141.

[200] Exhibit 12 page 15.

Hasibuan's presentation, when appropriately an upper intestinal bleed protocol should have been adopted).

Finding

331. After a consideration of all of the evidence as well as Counsels written submission I find that the post-surgery care provided by the supervising surgeon and the Upper gastroenterology team was sub-optimal in that the there was a failure to respond appropriately to Mr Hasibuan's initial instances of severe hypotension as well as the bleeding of frank blood into his bile drain and to his later rectal bleeding of dark blood, further severe hypotension and localised ongoing heavy pain.

332. This changing presentation occurred over the five days following the laparoscopic cholecystectomy surgery on 10 November, and over the relevant time might have reasonably been believed to be connected with a post-surgery gastro intestinal bleed and warranting of the adoption of a gastro intestinal bleed protocol.

333. Three specific periods of significant internal bleeding occurred over this time, the first between the 11th and 12th when we see severe hypotension, and from the blood report on the 12th an earlier drop in Haemoglobin from 130 to 78 (in the circumstances of Dr Barker having found and noted, frank blood in the bile drain on November 11). I note that at this time Dr Barker states that she was advised by Dr Boukris that this drop was likely due to haemodilution, evidence with which Dr Boukris did not agree. I also note Mr Johnson's opinion evidence, which I accept, that haemodilution is not a diagnosis and also that blood product should have been transfused at this time.

334. The second and more time critical incident occurred after midnight on Sunday/Monday night the 14th / 15th when Mr Hasibuan had extreme abdominal pain and again a significant drop in blood pressure.

335. The third incident was the right upper quadrant abdomen pain and a catastrophic bleeding on Tuesday afternoon, which bleeding led to his death that evening.

336. As above I find that error arose through this period because of a continued focus on biliary leaking, rather than the possibility of a surgery related perforation leading to an internal bleed, and the need to bring that bleed under control. In so finding I note the highly unusual event under which it is suggested that on the day of his passing, blood flowed from a cystic artery perforation into a nearby and adjacent perforation of the duodenum. I further note the post

procedure bleeding in the area of the stomach and duodenum, which unusually had to be surgically separated from what was a friable gall bladder and that the gall bladder itself was seen at surgery to be acutely inflamed. [201] I also note the generalised bleeding, evidence of which was observed in the region of the gall bladder at or near the end of the procedure, and the efforts made at that time by Mr Atkin and Dr Boukris, before they were able to stabilise the bleeding.[202]

337. Also relevant were the significantly reduced blood pressure readings recorded on the three occasions referred to above, and the fact that the earlier of these were ultimately met by blood transfusions that temporarily led to improved blood pressure.

338. As to the progress of the care provided I observe again that no clinical notes or other were made by Mr Atkin of his two unaccompanied bedside visits on 12 and 15 November and I find that in these circumstances his recollection of these matters as recorded in his statement made some twenty one months after the events under examination, constitutes an unreliable record of same.[203] Accordingly I attach little weight to his evidence concerning these matters.

339. Coming now to the presentation on the Sunday night and Monday morning (14/15 November), Dr Larissa Freeman a gastro intestinal department registrar, took over care responsibilities from Dr Guitierrez the on call surgical registrar, who had provided care and ordered analgesic medication over much of the weekend.[204] I accept Mr Johnson's opinion that Dr Guittierrez did an admirable job in his write up of the patient. I also accept that Dr Guittierrez was concerned by Mr Hasibuan's presentation and wanted the input of senior gastro intestinal departmental staff. However in these circumstances and for the reasons offered by Dr Campbell and Mr Johnson I am satisfied that he should have exercised his discretion in favour of making a MET call at the time, rather than choosing to leave the matter to the incoming team in the morning to consider what was by then a changed presentation.

340. I have not been able to establish whether there was a direct handover to Dr Freeman on the early morning of November 15 concerning Mr Hasibuan's condition. It is accordingly unclear

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[201] Transcript 298 and 301. Mr Atkin was unable to say whether there was bleeding from the duodenum in the immediate post-surgery period, although from the evidence of Dr Burke it appears more probable than not that injury to this tissue occurred at the same time and in conjunction with an injury to the adjacent cystic artery.

[202] See discussion above in conjunction with footnotes 108-11.

[203] See statement of Mr Atkin dated September 2012 at exhibit 6 and evidence at transcript 310, as discussed above, to the effect that he made no contemporaneous notes concerning these visits.

[204] It is unclear whether an oral handover to Dr Freeman actually took place before Dr Guiterrez left the ward at 5 am.

as to the extent to which Mr Hasibuan's earlier hypotension and pain issues were emphasized to the incoming team although it is clear from the notes of Dr Lanyon that Dr Freeman and her team were aware of some of the more troubling aspects of his presentation earlier that morning.

341. I further find that the need to activate did not disappear at handover and for the reasons suggested as set out above, I also find that the failure to escalate after MET criteria were satisfied earlier that morning, (by either Dr Guiterrez) or the later incoming Gastro Intestinal team who I am satisfied suspected internal bleeding but remained unaware of its source, was less than best practise.

342. I additionally note that during this period the incoming team continued to carry out its duties under Mr Atkin, who on his evidence remained uninformed about significant events which were relevant to his patient's condition. I also find that the failure to make a MET call either before or after that handover cost Mr Hasibuan and his family the opportunity of having his condition immediately reviewed by appropriate intensivists, as I am satisfied would now occur.

343. Mr Hasibuan's passed away following a catastrophic bleed earlier that afternoon. As discussed in her evidence set out above I find myself satisfied that during this period Dr Freeman was aware of the changing presentation, which included hypotension and later upper right quadrant chest pain and that she suspected internal bleeding and wanted to establish its origins.

344. I further accept the evidence of Mr Campbell and Mr Johnson and hold that the source of the internal bleeding should have been more actively sought by Mr Atkin and his team, with a gastro intestinal bleeding protocol adopted as soon as the abovementioned symptoms were first observed. I am further satisfied that certainly by the Monday morning if not before, that a gastroscopy should have been performed to seek to locate the source of Mr Hasibuan's suspected bleed.

345. I also accept that depending on the results of the gastroscopy, a laparotomy would have further facilitated the finding of the source of the bleed as well as the repair to the cystic artery and duodenum, as required. In so finding I reject Mr Atkins contrary view on this matter.

346. Given the complexities of the presentation and the absence of an explanation for same, I also find that the falls in blood pressure referred to above should have resulted in MET calls being made on each of the occasion's that Mr Hasibuan's systolic rate fell below 90.[205]

347. In this regard it is relevant that the first two instances of hypotension occurred within 24 hours of a surgical procedure during which the duodenum was surgically separated from friable tissue. It is also the case that it was known that the surgery had led initially to an uncertain level of blood loss from the bed of the gall bladder.

348. It is further relevant across the board that at different times over what was an unusually long hospital stay following such a procedure that there was a fluctuating presentation, which included deterioration, with on November 15th a rectal bleeding of dark blood indicative of a possibility of bleed from or near the upper gastrointestinal tract, together with lowered haemoglobin and haematocrit counts, as well as hypotension and extreme pain.

349. In addition I am satisfied that the preliminary diagnosis of diverticular bleeding accepted by Dr Gutierrez before his departure and in conjunction with the rectal bleed of dark blood, was speculative in nature, and should have been treated accordingly by the incoming team.

350. I further find that on both the receipt of the report concerning the first drop in blood pressure below MET call criteria level, coupled with the finding of (an uncertain amount) of fresh bleeding in the drain on the Thursday, and again on the occasion of the rectal bleeding of darkened blood and hypotension with acute abdominal pain on the Sunday night Monday morning, that MET call(s) in accord with the then existing written protocol (as modified by the so called discretionary power), should have occurred.[206]

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[205] Having regard to the proximity of the first and second blood pressure readings below 90 on the 11th I consider that there were two such instances where a MET call should have been made, i.e. on the 11th and again on the 15th. As above I note that Mr Atkins evidence was that although he was not sure if he was told of the actual BP level(s), that he believes he discussed the low blood pressure and draining issues with Dr Boukris on the morning of 11 November, and believes that a MET call should have been made. I also note his further evidence that a MET call may not have occurred in the circumstances of gastro intestinal clinicians being available on the ward at that time.

It is also relevant that Mr Atkin gave his evidence in a very firm and decisive manner, which suggested that he if he had given a direction on this matter that he would have expected his direction to be followed. The absence of full notes by Drs Boukris and Barker do not permit me to determine how it was the decision not to escalate at this time was reached. It is also relevant that the clinician immediately concerned was Dr Barker who had worked on the ward for just two days. Her testimony was that at that time she was not familiar with the Alfred's MET protocol.

[206] In so finding I accept Mr Campbell's evidence that a MET on 11 June may not have immediately changed the manner in which Mr Hasibuan was treated. I am satisfied however that it would have led to an examination of the need for the introduction of a gastrointestinal bleed investigation and that certainly by the events of the night of the 14th/15th, that such a call would have provided clinicians with a more productive pathway.

Comment

351. MET call criteria, which were first established in St Vincent's hospital Sydney in 1990, were intended to allow for resuscitation experts to review appropriate cases and to provide emergency treatment.

352. I am persuaded by the evidence of Mr Johnson that changes to the MET call system initiated since the death of Mr Hasibuan, as detailed above, have proved to be a success at the Alfred Hospital and are consistent with the provision of the best possible response to a medical emergency.[207] An additional aspect of the making of such a call is that in certain cases the call invites a review of the on-going treatment provided in a Hospital setting, which may or may not be meeting the needs of a particular patient, this by those with experience in emergency medicine.

353. I further find that if a MET call had been so made in this case that a senior clinician with experience in intensive care from outside the treating team would at some point have been called to address Mr Hasibuan's severe hypotension and his suspected hypovolemia. As set

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I have further reviewed the protocol in place at that time (exhibit 12 pages 123-128. Medical Emergency Response Alfred Date approved May 2008 Review Date May 2011), and find no reference to a residual discretion given to medical officers not to follow same. Rather it is stipulated in the Introduction at page 123 that,

A Met call should be initiated when a patient is deteriorating and meets specific criteria, (see dot point 2).

I also note that in her statement Ms Cronin refers to the development of the newer Escalation of Care Guideline which commenced in early 2011, (which followed Mr Hasibuan's death in November 2010), and that at the time of writing her statement in October 2011, that this protocol, the *Guideline for Escalation of Care,* was being trialled on Ward C. At the bottom of this document exhibit 12 page 134, in the *Flowchart*, it is highlighted that,

If a patient reaches MET call criteria at any time, activate a MET call response. This guideline was approved in February 2011, with a review date of May 2011.

It is relevant that while the latter was not the applicable guideline at the time of Mr Hasibuan's death, that three months later in February 2011, the exercise of a discretion in regard to the application of MET call criteria was as before, not part of the written guideline.

The evidence before me does not establish how the discretion not to make a MET call at the time under examination was established and whether this was simply an informal arrangement within the Alfred hospital at that time, or had instead become the subject of a secondary protocol, or other written memorandum.

I further observe that one of the great attractions of a MET guideline is that it takes away discretion from a junior clinician who may feel conflicted if required to decide whether to call in a specialist from outside of his/her department, and further that I can see no advantage in leaving a relatively junior and newly appointed medical officer, to deal with issues concerning the delivery of emergency care to a patient threatened by severe hypotension.

[207] See paragraph 272 concerning statistical data relevant to elevation issues discussed above. See also footnotes 206.

In this same regard I have been unable to establish why and in what circumstances the original written protocol (exhibit 12 pages 123-28), which also gave clear direction on the issue of MET calls and the making of such a call, was caused to give up ground on this issue.

out the evidence of Mr Campbell suggests that if this had occurred in a timely manner that a different outcome was likely.[208]

354. It is also the case that Mr Atkins management of Mr Hasibuan's care appears to have occurred with the former remaining somewhat remote from his team and with certain important features of the presentation not appreciated by him. These include the finding of frank blood in the biliary drain on the 11th, the dramatic fall in the haemoglobin count reported on the 12th, in respect of a test also taken on the 11th and the abdomen symptoms and fall in haemoglobin to 91g/L, observed on the 16th.

355. Finally I must observe that both the standard of clinical note taking and reference to earlier taken notes by the Doctors concerned with the care of Mr Hasibuan, was less than adequate. There were also other significant communication failures. These failures had consequences for Mr Hasibuan as can be seen in the evidence of Mr Atkin who testified that in the circumstances that presented in the ward on November 11, he believed that a MET call should have been made. We of course know that this did not occur.[209] The fact that this opinion was presumably available to on duty staff, and was apparently not sought, is one example of such unsatisfactory communication.

356. A further example is found in the evidence of Dr Barker who testified that she did not remember being informed of the nurse's findings concerning darkened bile found in drain, on the evening of November 11.[210]

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[208] Internal bleeding following abdominal surgery as occurred in this case, has the potential to be life threatening and should be distinguished from the investigatory process needed to understand the source, and or the cause of any such bleeding. I further find that a reasonable suspicion of internal bleeding might be found in cases such as Mr Hasibuan's, notwithstanding the absence of an immediate explanation for blood loss. Suspicion should have caused that possibility to have been adopted as a working diagnosis, i.e. before any possible source of the bleeding was identified.

[209] Transcript 312-13. Information concerning the finding of *frank* blood in drain and severe hypotension on November 11 was available at that time but appears not to have been communicated to Mr Atkin.

[210] Her apparent failure to acquaint herself with earlier nursing notes is relevant here. See paragraph 14 above, concerning the nursing note that the HMO cover *was* informed about the darkened bile found.

See also discussion at paragraph 67 above. (Dr Barker testified that at the relevant time she was not specifically aware of the Alfred MET protocol). It is also relevant that Dr Barker was left with what must have seemed like too much to comprehend, in respect of what remained a difficult and unresolved presentation.

It is not part of the evidence that Dr Boukris or another was specifically required to provide Dr Barker with supervision and I find that an absence of supervision of such a recently employed HMO, particularly around the decision to make or not to make a MET call, further complicated the management of Mr Hasibuan.

357. In conclusion I wish to thank Ms Hodgson of Counsel, my assistant Senior Constable Tracey Ramsey, and the witnesses who testified together with Mrs Hasibuan and her family, for their assistance in the conduct of this inquest.

I direct that a copy of this finding be provided to the following:

The family of Mr Bernas Hasibuan
The Chief Executive Officer Alfred Hospital
Mr William Johnson
Mr Christopher Atkin
Dr Larrisa Freeman
Dr Thierry Boukris
Dr Kristeen Barker
Dr Michael Bourke
Mr Ian Campbell
Senior Constable T Ramsey
The Manager Coroners Prevention Unit, Attention Ruth Bergman.

Signature:

PETER WHITE
CORONER
Date: September 15, 2016.