IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5828

FINDING INTO DEATH WITH INQUEST

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

INQUEST INTO THE DEATH OF MAXWELL NORMAN CAMPBELL

Delivered On:	18 October 2018
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Date:	14 – 18 May 2018
Findings of:	CORONER JACQUI HAWKINS
Counsel Assisting the Coroner:	Leading Senior Constable Kelly Ramsey, Police Coronial Services Unit, instructed by Ms Natalie Savva, Coroners Court of Victoria
Representation:	Ms Jennifer Cowan of counsel representing the Campbell family, instructed by Ms Emily Hart, Maurice Blackburn Mr Paul Halley of counsel representing the Warringal Private Hospital, instructed by Ms Andrea De Souza, Minter Ellison Ms Anna Robertson of counsel representing Mr Ahmed

Aly and Professor Ronald Bellomo, instructed by Ms Caroline Tuohey, Avant Law

Mr Ben Jellis of counsel representing Dr Larissa Douglas, instructed by Ms Abby Neylon, Kennedys

Mr Robert Harper of counsel representing Mr Kiat Lim, instructed by Ms Ingrid Nunnik, Marsh & Maher Richmond Bennison Lawyers

Catchwords

GASTRIC BYPASS SURGERY, PULMONARY THROMBOEMBOLUS, POST-OPERATIVE RISKS, MEDICAL EMERGENCY TEAM (MET) CALLS, DIFFERENTIAL DIAGNOSIS, RESPONSIBILITY OF CARE, AVOIDANCE OF HINDSIGHT BIAS

CORONER HAWKINS:

SUMMARY OF INQUEST

1. On Sunday 16 November 2014, Maxwell Campbell was recovering from recent revisional gastric bypass surgery at the Warringal Private Hospital when he suffered a cardiac arrest and died a number of hours later from a pulmonary thromboembolism. This Inquest examined the possible causes for Mr Campbell's sudden cardiac arrest and considered whether the medical care and management by the clinicians involved in his care at the Warringal Private Hospital were appropriate.

BACKGROUND

2. Mr Campbell was 68 years old when he died. He lived in Cottles Bridge with his loving wife of 45 years, Lynette Campbell. They had three children, Robert, Sarah and Stuart.

3. Mr Campbell had a medical history of increased body mass index, anxiety, transurethral resection of prostate (2013), kidney cancer, ischaemic heart disease, hypertension, hypercholesterolaemia and gastro-oesophageal reflux disease.

4. In February 2013, Mr Campbell consulted a surgeon with symptoms of reflux that were not controlled despite maximal medical therapy. Multiple consultations and two gastroscopies occurred over the subsequent year and a half, with only transient improvement in Mr Campbell's symptoms. He continued to gain weight and a hiatus hernia was later identified.

5. Surgical options were discussed with Mr Campbell during these consultations and he advised his preference was to explore gastric bypass surgery. He was referred to a multidisciplinary team for assessment, including a Cardiologist and Bariatric Surgeon who considered him fit for surgery.

6. On 10 November 2014, Mr Campbell was admitted to the Warringal Private Hospital for the removal of the Laparoscopic Adjustable Gastric Banding (LABG), repair of the hiatus hernia and a gastric bypass procedure by Mr Ahmad Aly, Specialist Upper Gastrointestinal and Bariatric Surgeon. Extensive abdominal adhesions from the previous gastric band surgery were found and while the surgery itself was technically difficult, it was successfully completed.

7. Post-operatively, Mr Campbell received routine antibiotics, deep vein thrombosis prophylaxis with twice daily subcutaneous injections of 5,000 units of Heparin, compression stockings and pneumatic calf compressors. A morphine Patient Controlled Analgesia device was also commenced. Mr Campbell was observed in the High Dependency Unit for 24 hours prior to being moved to the surgical ward.

8. On the evening of 12 November 2014, Mr Campbell briefly developed a fever of 38.0 degrees Celsius and a C-Reactive Protein (CRP) blood test was found to be significantly elevated.

9. The next day, Mr Campbell complained of increased abdominal pain in the epigastric region. His vital signs remained unremarkable. A CT scan of the chest and abdomen revealed mild collapse of the lung bases with small pleural effusions and a possible small bowel perforation within a newly identified epigastric hernia. Mr Campbell was returned to surgery where a laparoscopy was undertaken to explore the area. At operation, Mr Aly found the bowel was entirely normal with no evidence of perforation, congestion, obstruction or incarceration. The hernia defect was repaired and the components of the Gastric Bypass Surgery were noted to all be intact. Mr Campbell was commenced on multiple intravenous antibiotics.

10. On 14 November 2014, Mr Campbell was showing signs of improvement. His intravenous antibiotics were continued, his vital signs were within normal limits and he was tolerating a regular diet.

11. The following day, Mr Campbell reported feeling unwell with sweating, shivering and nausea. A review was undertaken and it was thought that one of his antibiotics may have been contributing. The nausea was noted to have resolved later in the day however there were no further notes made with reference to his other morning symptoms having continued or abated.

12. At 5.30am on 16 November, 2014 a Medical Emergency Team (MET) call was made by nursing staff who found Mr Campbell perspiring and feeling generally unwell. Mr Campbell was reviewed by an Intensive Care Unit (ICU) Registrar who noted that other than requiring supplementary oxygen and having an elevated respiratory rate, he was well. Mr Campbell's condition was documented as being unclear and differential diagnoses of a cardiac event, sepsis or pulmonary thromboembolism were noted. Further blood tests were taken and a follow up review was planned for later that morning.

13. A morning review on 16 November 2014 noted that although being anxious, Mr Campbell looked well, with stable vital signs. A drop in his haemoglobin level was noted from the previous morning but this remained within safe limits. Tests were repeated and Mr Campbell reported that he was feeling unwell again and had suffered from dizziness following his shower. His vital signs remained unremarkable although his heart rate had climbed. His CRP result continued to decline while the repeat haemoglobin test revealed a further reduction but was stabilising.

14. On waking from a sleep at midday, Mr Campbell became agitated. His vital signs remained within normal limits although he continued to receive a low dose of supplemental oxygen via nasal prongs. A telephone order for Alprazolam was made and administered at 12.20pm.

15. At approximately 12.25pm, Mr Campbell suffered a cardiac arrest. A Code Blue was initiated and airway resuscitation measures were implemented followed by a brief period of cardio pulmonary resuscitation (CPR). Despite normal blood pressure being obtained, airway management was difficult which required Mr Campbell to be intubated. A further Electro Mechanical Dissociation (EMD) occurred at 12.43pm with the recommencement of CPR. Multiple doses of adrenaline were administered, however a blood sample for testing was unable to be obtained despite multiple attempts. With spontaneous circulation finally being achieved at 1pm, Mr Campbell was transferred to the ICU. He was noted to have fixed and dilated pupils at this time.

16. Once in the ICU, Mr Campbell suffered a further EMD cardiac arrest and CPR was recommenced. Further doses of adrenaline and alteplase were administered at 1.21pm due to the suspicion that a pulmonary embolism was responsible for Mr Campbell's persistent haemodynamic instability. Further alteplase was administered 10 minutes later with increased bleeding from Mr Campbell's abdominal drain tubes noted which required five units of red blood cells being transfused in response to his newly identified anaemia. Spontaneous circulation was returned at 2.00pm.

17. Mr Campbell remained extremely unwell but stabilised for approximately two hours however this was achieved with maximal doses of adrenaline and noradrenaline intravenous infusions. Blood tests revealed a stabilised haemoglobin level but he had developed impaired liver and kidney function in addition to severe acidosis with a pH level of 6.8. There was increased

blood output via his drain tubes as well as bleeding from his mouth and newly inserted central venous catheter. Mr Campbell's family were updated regarding his extremely poor prognosis.

18. Later in the afternoon, Mr Campbell developed myoclonic jerking movements, indicative of a hypoxic brain injury. At 5.20pm, Mr Campbell suffered a further EMD cardiac arrest with full resuscitation measures commenced again. At 5.30pm the decision to discontinue CPR and intravenous medication was made after consultation with an ICU Consultant. In the presence of his family, Mr Campbell quietly passed away at 5.31pm.

THE PURPOSE OF A CORONIAL INVESTIGATION

19. Mr Campbell's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act 2008* (Vic) (Coroners Act), as his death occurred in Victoria and was unexpected.

20. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial[1]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

21. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[2] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation.

22. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

23. The circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

24. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

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[1] Section 89(4) *Coroners Act 2008*
[2] *Keown v Khan* (1999) 1 VR 69

25. Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

26. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[3] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

CORONIAL INQUEST

27. Lawyers representing Mrs Campbell from Maurice Blackburn requested an Inquest in November 2016.

28. On 28 February 2017, I conducted a mention hearing to discuss whether further investigations were required and the need for expert witnesses.

29. Once all the further investigative material, which included expert reports, had been received on 9 February 2018, I held a directions hearing and indicated my intention to hold an Inquest and set the scope and the witnesses for an inquest. An Inquest was held on 14-18 May 2018.

Witnesses

30. The following witnesses were called to give *viva voce* evidence at Inquest:

- Dr Maalinda Sumuntha Bandara Herath, Intensive Care Registrar, Sunshine Hospital
- Mrs Lynette Campbell
- Mr Ahmed Aly, Specialist Upper Gastrointestinal and Bariatric Surgeon
- Ms Karen Barry, Registered Nurse, Warringal Private Hospital

[3] (1938) 60 CLR 336

- Ms Gladys Miranzi, Registered Nurse, Warringal Private Hospital
- Dr Larissa Douglas, Intensive Care Specialist, Warringal Private Hospital
- Professor Ronald Bellomo, Consultant Intensive Care Specialist, Austin Hospital and Royal Melbourne Hospital
- Ms Ellen Warburton, Enrolled Endorsed Nurse, Warringal Private Hospital
- Ms Kristin Pugh, Assistant Nurse Unit Manager, Warringal Private Hospital
- Mr Kiat Lim, Upper Gastrointestinal and Bariatric Surgeon.

31. The following expert witnesses participated in giving concurrent evidence.

- Professor David Morris, General Surgeon, University of NSW and The St George Hospital
- Conjoint Associate Professor Michael Talbot, Consultant Upper Gastrointestinal/Bariatric Surgeon, University of NSW and The St George Hospital
- Professor Jack Cade, Intensive Care Specialist, The Royal Melbourne Hospital
- Associate Professor Craig French, Director of Intensive Care, Western Health
- Mr Justin Bessell, General & Upper Gastrointestinal Surgeon, Calvary Wakefield Hospital and Flinders & Adelaide Universities.

IDENTITY OF THE DECEASED

32. On 16 November 2014, Mr Campbell was visually identified by his wife, Mrs Lynette Campbell. His identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

33. On 20 November 2014, Dr Greg Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Campbell and reviewed the Form 83 Victoria Police Report of Death, the e-medical deposition form, the Warringal Private Hospital medical records and the post mortem computed tomography (CT) scan.

34. Post mortem examination revealed the presence of pulmonary thromboemboli in the left pulmonary artery and middle lobe of the right lung. Deep vein thrombosis (DVT) was present in the left lower leg. The anastomosis from the gastric bypass procedure was intact.

35. According to Dr Young, pulmonary thromboemboli are dislodged blood clots that pass into the lung's blood circulation, resulting in blockage of the blood vessels in the lungs. Most cases are due to blood clots arising in the deep veins of the legs, in other words DVT. Mr Campbell had obesity and recent surgery which both can contribute to a pro-thrombotic state.

These are significant risk factors for the development of DVT (along with smoking, other causes of immobility, some medications, malignancy and inherited clotting disturbance).

36. Dr Young noted that microbiology cultured *Enterobacter aerogenes* and *Enterobacter cloacae* from blood and the right lung. The presence of these organisms in the blood, in the setting of gastrointestinal surgery, may represent bacteraemia rather than simple contamination. Serum CRP was elevated at 54.6 mg/L consistent with inflammation.

37. Dr Young noted that "*thrombolysis for the treatment of pulmonary thromboembolism would have increased the risk of bleeding*".

38. The post mortem also revealed the presence of an incidental clear cell renal cell carcinoma in the left kidney ("kidney cancer"). Dr Young commented that whilst the presence of malignancy increases the risk of DVT, this is not likely to have caused or contributed to death.

39. Dr Young provided an opinion that the medical cause of death was 1a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF RECENT SURGERY. I accept this as the cause of death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Scope of the inquest

40. The purpose of the inquest was to investigate the following issues:

- Mr Campbell's surgical risks;
- The MET call at 5.30am;
- ICU Handover;
- Responsibility of care;
- Mr Lim's assessment and review at 8am;
- Mrs Campbell's observations and concerns post MET call;
- Whether a MET call was warranted at 10am;
- Whether a CTPA could have been performed at any stage prior to the cardiac arrest;

- Avoidance of hindsight bias;
- Whether Mr Campbell's death was preventable; and
- Any prevention opportunities?

Mr Campbell's surgical risks

41. Mr Campbell's revisional gastric band surgery was high risk, particularly in the context of his comorbidities which included ischaemic heart disease, obesity and kidney cancer. According to Mr Aly, revisional gastric band surgery is always more difficult and potentially more hazardous than primary surgery.[4] Mr Lim agreed and explained the risks as bleeding, infection and leaks.[5]

42. Any surgery carries risk of DVT and pulmonary embolus. This includes laparoscopic and abdominal surgery. A Clinical Practice Guideline on the prevention of DVT and PE[6] in surgery classifies different types of surgery and patient factors into risk categories. Mr Aly said that abdominal surgery of this nature and in this patient population is of a moderate to high risk category and therefore the recommendations are for a combination of strategies to be employed. Those strategies are chemoprophylaxis or medication that is designed to reduce the risk of clotting. Mechanical prevention with anti-embolic stockings have also been shown to be effective in reducing the risk, as well as mechanical prophylaxis using sequential compression devices particularly during surgery and sometimes after surgery[7]. Mr Aly said the guidelines in major abdominal surgery generally recommend two or three of those strategies, with the option of using all three, which is his routine practice and the practice of most surgeons in this area.[8]

43. The expert evidence was consistent with Mr Aly and Mr Lim. Professor Talbot stated "*the best strategies to mitigate these risks are pre-operative optimisation of a patient seeking surgery entering the hospital stay, a combination of mechanical and chemical prophylaxis or early ambulation.*"[9]

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[4] Transcript of evidence, p80
[5] Transcript of evidence, p91
[6] National Health and Medical Research Council; *Clinical Practice Guideline: For the Prevention of Venous Thromboembolism in Patients Admitted to Australian Hospitals,* 2009
[7] Transcript of evidence, p82-83
[8] Transcript of evidence, p83
[9] Transcript of evidence, p492

44. Mr Aly stated that the risk of bleeding in this type of case is around three per cent and the risk of DVT and pulmonary embolism is less than half a per cent.[10] Deaths associated with this type of surgery are extremely rare, but are nonetheless significant.[11] The expert evidence was also consistent with this. Professor Talbot quoted the Michigan Collaborative Bariatric Data[12] which provides a risk stratification and scoring system for patients having bariatric surgery. Once this is applied to Mr Campbell, his risk was less than one percent at the end of the original revisional surgery.[13] He said that having a second procedure modifies the risk but the experts were unable to quantify it.[14] Professor Talbot agreed that kidney cancer increases risk[15] but the experts were unable to quantify it.[16]

The MET call at 5.30am

45. At 5.30am on 16 November 2014, Registered Nurse (RN) Karen Barry made a Medical Emergency Team (MET) call due to concerns about Mr Campbell, namely that he had experienced two separate episodes of cold sweats and felt unwell.[17]

46. Dr Larissa Douglas, ICU Registrar at the time and Gladys Miranzi, ICU RN attended the MET call. According to RN Miranzi, upon review Mr Campbell appeared to be in good spirits. He was not in respiratory distress, he was not sweating, was talking and demonstrated a good sense of humour.[18] He did not complain of any pain.[19]

47. Dr Douglas conducted a physical examination, took a set of observations, arranged further investigations, including an ECG, blood tests, venous blood gases, lactate, blood cultures and a full blood count.[20] The only significant finding was tachypnoea, with a respiratory rate of 26, which was mildly elevated.[21] Dr Douglas' opinion was that "*he hadn't been quite right for quite a period of time*"[22] as he had returned to theatre, had experienced a previous sweating

[10] Transcript of evidence, p91-92
[11] Transcript of evidence, p82
[12] Exhibit 32 – Michigan Bariatric Surgery Collaborative Study
[13] Transcript of evidence, p491
[14] Transcript of evidence, p492
[15] Transcript of evidence, p492
[16] Transcript of evidence, p518
[17] Exhibit 6 – Statement of Karen Barry dated 12 April 2018, para 5-6, Transcript of evidence, p123
[18] Transcript of evidence, p160
[19] Transcript of evidence, p161
[20] Transcript of evidence, p175
[21] Transcript of evidence, p174, 200
[22] Transcript of evidence, p175

episode and had remained on oxygen throughout his admission.[23] Tachypnoea is an early sign of sepsis, and can occur in myocardial infarcts or heart failure, in pulmonary embolus and when there is significant bleeding.[24]

49. The MET call was thorough and took approximately 40 minutes. Dr Douglas documented her examination, differential diagnoses and management plan, which was for review by Mr Lim.[25]

Differential diagnoses

50. As part of her examination, Dr Douglas considered three potential differential diagnoses in order of concern. She documented her thoughts as "*unclear cause of patient condition: ?sepsis, ? cardiac event, ?? PE*".[26] At the end of the MET call Dr Douglas had not reached a position where she could exclude any of those possible diagnoses with certainty.[27]

51. There were no signs to suggest one diagnosis more strongly than the other. When Mr Campbell's case was discussed at the ICU handover with Dr Maalinda Herath, his belief was that Mr Campbell remained undifferentiated and a diagnostic dilemma.[28]

52. Mr Aly commented that the fact that Dr Douglas listed pulmonary embolus as her third differential diagnosis suggested it was at the lower end of her index of suspicion.[29] Mr Lim was of the same belief and thought pulmonary embolus was her least likely diagnosis.[30]

53. Dr Douglas claimed that there is no test specific for pulmonary embolus. The only diagnostic test of pulmonary embolus suitable for Mr Campbell would have been a CT pulmonary angiogram (CTPA). It is not standard practice to order that test if pulmonary embolus is considered unlikely. Her evidence was that she was first aiming to rule out the other two diagnoses.[31]

54. At the completion of the MET call, Dr Douglas did not consider there was a reason to admit Mr Campbell to ICU because he did not require any intensive care intervention at that stage.[32]

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[23] Transcript of evidence, p181
[24] Transcript of evidence, p200
[25] Transcript of evidence, p188
[26] Coronial brief, p113 – medical records
[27] Transcript of evidence, p199
[28] Transcript of evidence, p32
[29] Transcript of evidence, p105
[30] Transcript of evidence, p461
[31] Transcript of evidence, p177
[32] Transcript of evidence, p201

Dr Douglas spoke to Mr Lim on the phone at approximately 6.15am and explained her examination that she was concerned about Mr Campbell and was unable to explain why he was diaphoretic, that she was considering several diagnoses and had ordered tests.[33]

55. Given that the incidence of pulmonary embolism in people having bariatric surgery is about one per cent, Professor Bellomo considered the possibility of Mr Campbell having developed a pulmonary embolus was low. [34] Further, in the hierarchy of possibility, it was not on the highest level and other diagnostic possibilities had to be logically and sequentially looked for and excluded or confirmed before moving to the less likely possibility.[35] Professor Bellomo thought Dr Douglas' view was reasonable as there was not enough information to support pulmonary embolus as the most likely diagnosis.[36] He said he could find no fault with Dr Douglas' approach.[37]

56. The expert panel agreed that there were no signs specific to pulmonary embolus being present at the time of the MET call and felt that that Dr Douglas' response and investigations were appropriate[38]. Further, there was no indication at the time for Mr Campbell to require intensive care therapy.[39]

57. Counsel for Dr Douglas submitted that no witness including Professor Bellomo, Mr Lim and all of the experts made any criticism of her and that her care and management plan was reasonable and appropriate. I agree entirely.

ICU handover

58. ICU handover usually occurs at approximately 8am. Dr Douglas remembers three people were present at handover, including herself, Dr Herath and Professor Bellomo.[40] Whilst Professor Bellomo had no specific recollection of being present for the handover, Dr Douglas was confident he was there and that he was aware there was a patient on the ward who had

[33] Transcript of evidence, p201
[34] Transcript of evidence, p241
[35] Transcript of evidence, p242
[36] Transcript of evidence, p242
[37] Transcript of evidence, p243
[38] Transcript of evidence, p493
[39] Transcript of evidence, p496
[40] Transcript of evidence, p186

been the subject of a MET call.[41] However, she was unsure whether Professor Bellomo listened to the whole handover.[42]

59. Dr Herath recollects that the handover indicated Mr Campbell was stable, needed supplemental oxygen, had some concerning features because Dr Douglas had been unable to identify a cause for Mr Campbell's malaise or sweating and that Mr Lim was going to follow up.[43] Dr Herath did not assess or review Mr Campbell and does not think he would have had a chance to review the blood tests. Dr Herath said that pulmonary embolus was in the back of his mind. He said clinicians are always concerned about the potential for a pulmonary embolism. Dr Herath said Professor Bellomo knew Mr Campbell was undifferentiated and needed follow up.[44] Dr Herath had no concerns with Dr Douglas' handover and thought it was appropriate.[45]

60. Professor Bellomo stated he became aware of the MET call at around 8am but could not remember how he became aware of it.[46] His understanding was that the care had been handed back to the primary surgeon.[47] Despite this, Professor Bellomo went to see Mr Campbell at approximately 8am in order to ascertain his condition, the stabilisation of his vital signs, that there were no other complaints or symptoms and that the plan for the surgeon to take over would occur expeditiously.[48] Upon review, Professor Bellomo was satisfied that the situation did not fulfil the core criteria for a MET call and he observed Mr Lim in attendance.[49]

61. The ICU handover was not criticised by any of the experts.

Responsibility of care

62. The evidence was overwhelming that once Dr Douglas had completed her attendance on Mr Campbell, the responsibility of his care was primarily with Mr Lim. Whilst responsibility always rests with the consultant surgeon,[50] the ICU responsibility is to intervene in an

[41] Transcript of evidence, p187
[42] Transcript of evidence, p187
[43] Transcript of evidence, p12
[44] Transcript of evidence, p13
[45] Transcript of evidence, p29
[46] Transcript of evidence, p224-225
[47] Transcript of evidence, p225
[48] Transcript of evidence, p226
[49] Transcript of evidence, p230
[50] Transcript of evidence, p180

emergency and then give information to the surgeon who was Mr Lim in this case.[51] Mr Lim did not dispute this and admitted that he had primary responsibility for Mr Campbell.[52]

63. This is consistent with the National Consensus Statement on Clinical Deterioration[53] and the Warringal Private Hospital's statement on MET calls.[54]

64. The expert panellists were in agreement and confirmed that the patient is under the supervision of the admitting doctor unless they are transferred to the ICU[55] and they considered it was clear in the protocols.[56]

65. Mr Aly's evidence slightly differed in that he acknowledged the surgeon has responsibility but it is not necessarily their responsibility alone,[57] as a post-MET setting is always one of cooperative care.[58]

Mr Lim's assessment and review at 8am

66. Mr Lim conducted a review at sometime between 7 and 9am, but thinks it was probably around 8am.[59] His evidence was that Mr Campbell would have been the first person he saw that morning due to the MET call.[60] Mr Lim examined Mr Campbell and he appeared well. He noted "*he was alert, he was appropriate, he was interactive, [and] he was not confused*".[61] According to Mr Lim, Mrs Campbell was not present when he examined Mr Campbell.[62] Mr Lim did not recall ever being told he was grey in colour, or had abnormal breathing.[63]

67. Mr Lim reviewed the blood tests results that had been taken at 6.15am[64] and noted an increase in white cell count. Consequently, he was unable to rule out sepsis or infection as a possible differential diagnosis. Troponin test results were still outstanding and a cardiac cause could not be excluded. Mr Lim noted in the medical records that he was "*anxious but looks well*

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[51] Transcript of evidence, p179
[52] Transcript of evidence, p393-394, 403
[53] Exhibit 11 – *National Consensus Statement: Essential Elements for recognising and responding to acute physiological deterioration, Second Edition*
[54] Transcript of evidence, p180
[55] Transcript of evidence, p496
[56] Transcript of evidence, p497
[57] Transcript of evidence, p107
[58] Transcript of evidence, p89
[59] Transcript of evidence, p442, 448
[60] Transcript of evidence, p395
[61] Transcript of evidence, p396
[62] Transcript of evidence, p396
[63] Transcript of evidence, p433-434
[64] Transcript of evidence, p448

otherwise".[65] He said he advised Mr Campbell of the abnormal blood results and the plan was to continue monitoring on the ward.[66]

Bleeding as a potential differential diagnosis

68. During the phone call to Mr Lim, Dr Douglas remembered reading out the blood gas results. Mr Lim was worried about the haemoglobin drop and mentioned bleeding as a possible differential diagnosis to Dr Douglas.[67] Mr Lim saw the blood result and suspected bleeding.[68] He did not note it in the medical records[69] and cannot remember whether he told nursing staff.[70] Nurse Warburton recalled that Mr Lim referred to bleeding.[71] At Inquest, Mr Lim acknowledged it would have been useful to note the concern in the medical records.[72]

69. The haemoglobin drop from 13.3 to 10.9, according to Professor Bellomo suggested bleeding as a potential differential diagnosis.[73] Dr Douglas was less concerned about bleeding. She agreed it was possible but with no complaint of pain, no tachycardia, a very soft abdomen and with nothing coming out of the drain tubes, it seemed less likely to her.[74]

70. Mr Aly commented that it was reasonable for Mr Lim to consider bleeding as a differential diagnosis because given the risks associated with the type of surgery it was a more likely explanation considering the symptoms described and the observations recorded.[75] Mr Aly stated that although there was a suspicion and indication of potential bleeding, it was not dramatic, nor was it torrential bleeding that demanded immediate attention. He accepted it was a diagnostic dilemma, and it was reasonable to be high in the diagnostic hierarchy, which could be confirmed with a repeat haemoglobin a couple of hours later.[76] This is what occurred when Mr Lim was later advised of the haemoglobin result of 10.2. Mr Lim felt that number indicated some numerical stability, but also confirmed his suspicion of bleeding. Mr Lim was

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[65] Coronial brief, medical records, p114
[66] Transcript of evidence, p396
[67] Transcript of evidence, p191
[68] Transcript of evidence, p397
[69] Transcript of evidence, p405
[70] Transcript of evidence, p399
[71] Transcript of evidence, p324
[72] Transcript of evidence, p406
[73] Transcript of evidence, p311
[74] Transcript of evidence, p177
[75] Transcript of evidence, p111
[76] Transcript of evidence, p112

also reassured that it was not drastically abnormal and the results were what he thought they would be.[77]

71. The experts also agreed that bleeding was a potential differential diagnosis.[78] That Mr Lim would consider the diagnosis of bleeding with a haemoglobin drop of three points overnight, was entirely plausible according to Mr Bessell.[79]

72. The expert panellists also considered that Mr Lim's examination, investigations, management and documentation was appropriate between 7 and 9am.[80] Whilst it was acknowledged the bleeding was not mentioned in the notes, Professor Talbot said that Mr Lim's actions demonstrated his concerns about bleeding.[81]

Mrs Campbell's observations and concerns post MET call

73. At approximately 7.30am, Mrs Campbell received a phone call from Mr Campbell and asked her to come to the hospital because he was feeling unwell. Mrs Campbell arrived at the hospital between 8 and 8.15am. She thought he looked dreadful because he was a very ashen colour and his shoulders were lifting with every breath he took.[82] Mrs Campbell had grave concerns for her husband and had never seen him like that before.[83] She stated she was so shocked at how ill he looked, she went straight to the nurses' station to see who she could speak to and she saw Dr Lim was sitting at the desk in the nurses' station.[84]

74. There appears to be conflicting evidence between Mrs Campbell's recollection of this event and Mr Lim's. Mrs Campbell's evidence was that she spoke to Mr Lim while he was at the nurses' station after 8am about Mr Campbell's colour and laboured breathing and he did not advise her there had been a MET call. She also remembers that Mr Lim asked if Mr Campbell suffered from panic attacks.[85]

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[77] Transcript of evidence, p400
[78] Transcript of evidence, p494
[79] Transcript of evidence, p531
[80] Transcript of evidence, p497
[81] Transcript of evidence, p498
[82] Transcript of evidence, p41
[83] Transcript of evidence, p76
[84] Transcript of evidence, p56
[85] Transcript of evidence, p60

75. Mr Lim on the other hand, remembers seeing Mrs Campbell in her husband's room but denies her raising any concerns with him[86] or that he queried panic attacks[87] even though he prescribed medication for panic attacks.[88] Mr Lim's evidence was that he definitely did not remember hearing concerns about Mr Campbell being ashen in colour or having laboured breathing.[89] He thought that this was something he would have remembered.[90] He believes that if Mrs Campbell had raised these concerns he would have re-examined her husband.[91]

76. The experts were unable to make an assessment because they had no evidence of whether Mrs Campbell told Mr Lim about the ashen colour and laboured breathing.[92] Further, Mrs Campbell's concerns about Mr Campbell's deterioration were not documented, therefore Mr Lim could not be expected to note about deterioration when it was not documented.[93]

77. Counsel for the Campbell family submitted that Mrs Campbell's memory is more likely to be reliable than that of Mr Lim and her evidence ought be accepted because she wrote a letter to the Court 12 days after his death and gave consistent oral evidence. They submitted by contrast Mr Lim did not make any contemporaneous notes of the conversation and did not provide a statement until almost a year after Mr Campbell's death.[94] It was further submitted that a finding should be made that there was a missed opportunity, in that Mr Lim should have re-attended Mr Campbell following the discussion with Mrs Campbell.

78. Counsel for Mr Lim submitted that Mr Lim disputes he was told about the alleged concerns, however even with complete acceptance of Mrs Campbell's version of events, the family's submission remains fundamentally flawed because the evidence does not establish to the requisite standard of proof that the death was avoidable at or after 8.15am.

Whether a MET call was warranted at 10am

79. Ellen Warburton was an Endorsed Enrolled Nurse (EEN) which means there are clinical aspects of nursing that she is not qualified to do and needed supervision by a registered

[86] Transcript of evidence, p411
[87] Transcript of evidence, p414
[88] Transcript of evidence, p454
[89] Transcript of evidence, p412
[90] Transcript of evidence, p412
[91] Transcript of evidence, p411
[92] Transcript of evidence, p498
[93] Transcript of evidence, p499
[94] Submissions on behalf of Campbell family, p4

nurse.[95] At the nurse's handover on 16 November 2014, Nurse Warburton can only remember being told that Mr Campbell appeared a little anxious and seemed a bit panicked.[96]

80. At approximately 10am, after Nurse Warburton showered Mr Campbell he reported he felt dizzy and a little faint.[97] When she put him back to bed he stated that he felt awful and like he was going to die.[98] She noted in the records that he appeared "*pale and clammy*". She checked his observations and gave him extra oxygen. Nurse Warburton said that this was routine after someone has a vasovagal episode (fainting episode) and gets up for the first time and ambulates.[99] Nurse Warburton was not aware of Mr Campbell having any chest pain[100] and did not consider a MET call was warranted.[101] She noted her observations in the medical records and spoke to the Nurse in Charge, Kristin Pugh who advised her to continue to monitor him. RN Pugh's evidence was that it is quite normal for patients to feel unwell, light headed, dizzy, and sometimes actually faint or have a vasovagal event post a shower, after surgery.[102]

81. Nurse Warburton informed Mr Lim about Mr Campbell's vasovagal fit at about 12pm. She could not recall what he actually advised her but her understanding was that Mr Lim gave no further orders.[103]

82. The experts, in particular Associate Professor Talbot agreed that a vasovagal event was a reasonable explanation for Mr Campbell's presentation after the shower.[104]

83. In evidence, Professor Bellomo stated that it would have been reasonable to make a MET call at 10am which would have led to a full assessment.[105] The expert panellists also considered that had the ICU registrar been informed of the vasovagal event it may have increased the chances of a CTPA being ordered.[106] Professor Cade's evidence was that it would have been preferable to refer Mr Campbell back to the medical team; either Mr Lim or ICU after the

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[95] Transcript of evidence, p319
[96] Transcript of evidence, p323
[97] Transcript of evidence, p334
[98] Transcript of evidence, p327
[99] Transcript of evidence, p334, 348
[100] Transcript of evidence, p345, 347
[101] Transcript of evidence, p338
[102] Transcript of evidence, p375
[103] Transcript of evidence, p351
[104] Transcript of evidence, p499
[105] Transcript of evidence, p277-278
[106] Transcript of evidence, p500

vasovagal.[107] Professor Morris agreed. He stated he would have preferred if Nurse Warburton had communicated with Mr Lim or ICU but conceded a nurse does not have the same 'clinical gestalt' as him and agreed it did not meet the MET call criteria.[108] Professor Morris later explained his opinion was in the context of a person who had a MET call a few hours earlier, *"which means that one's concern about that patient ... was considerable."*[109]

84. Associate Professor French commented that these sorts of incidents are frequently encountered by nursing staff and are often not escalated to medical staff for review. He said it is very difficult to say with any certainty what someone should or should not have done at the time.[110] Mr Bessell explained that it was quite reasonable for Nurse Warburton to act on her judgment at that time and he did not think it was unreasonable that she did not call a MET call at that time.[111] Associate Professor Talbot agreed with Mr Bessell and Associate Professor French.[112]

85. Counsel for the Campbell family submitted that I should accept the evidence of Professor Morris and Professor Cade.[113] They also submitted that the nursing staff did not fully appreciate the significance of the episode that occurred at 10am, given the context of the earlier MET call. It was submitted that a failure to call for a medical review was a lost opportunity to re-assess Mr Campbell and undertake additional investigations, reconsider the differential diagnoses, potentially perform a CTPA and successfully treat the PE.[114]

86. Counsel for Mr Aly and Professor Bellomo submitted that such a finding should not be made, even if with hindsight Mr Campbell's symptoms may have warranted such a call. Instead the evidence of Associate Professor French should be preferred to the effect that with hindsight and knowing the final diagnosis, the cause of Mr Campbell's death may seem clear. He added it is difficult to say with certainty what someone should or should not have done at that time, particularly the nurses.[115]

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[107] Transcript of evidence, p502
[108] Transcript of evidence, p513
[109] Transcript of evidence, p513
[110] Transcript of evidence, p503
[111] Transcript of evidence, p503
[112] Transcript of evidence, p503
[113] Submissions on behalf of Campbell family, p5
[114] Submissions on behalf of Campbell family, p1
[115] Transcript of evidence, p502

87. Submissions on behalf of Mr Aly and Professor Bellomo suggested that the nurses were aware of the MET call criteria set out in the Deteriorating Patient Escalation Response Protocol[116] and could have made a MET call if they had a concern about Mr Campbell.[117] However the evidence was that Mr Campbell's condition did not met the criteria for a further MET call to be made.[118]

88. Counsel for the Warringal Private Hospital submitted the actions of Nurse Warburton and RN Pugh were reasonable, as a vasovagal episode was a reasonable explanation for Mr Campbell's presentation after his shower.

Whether a CTPA could have been performed at any stage prior to cardiac arrest?

89. The only diagnostic test for pulmonary embolus suitable for Mr Campbell would have been a CTPA however it is not standard practice to order that test if a pulmonary embolism is considered unlikely. The evidence was that a CTPA could have been arranged at any time, but according to Dr Douglas there are difficulties associated with ordering one on a weekend because there is no radiographer on site, which meant that a radiographer would have to be called in and set up the machine, which takes some time.[119] She explained that she wanted to rule out the other diagnoses first and therefore she did not consider a CTPA was warranted at the time of the early morning MET call.[120]

90. Associate Professor Talbot agreed.[121] He explained the experts felt that there were no indications for a CTPA to be performed with the initial MET call, but as alternate diagnoses fell by the wayside, especially given the episode of syncope demonstrated at 10am, the need to consider a CTPA became relatively stronger."[122] However, he said there was a difference of opinion about whether it was mandated for the medical team to order at CTPA because it was not clear at the time whether the syncope episode had been passed on to medical staff."[123]

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[116] Exhibit 7 – Deteriorating Patient Escalation Response 31 Protocol, coronial brief, p451
[117] Submissions on behalf of Mr Aly and Professor Bellomo, p5
[118] Submissions on behalf of Mr Aly and Professor Bellomo, p5
[119] Transcript of evidence, p177
[120] Transcript of evidence, p177
[121] Transcript of evidence, p494, 539
[122] Transcript of evidence, p495
[123] Transcript of evidence, p495

Professor Morris said if medical staff had been notified about the 10am episode a CTPA should have been done.[124]

91. Associate Professor Talbot's evidence was that if a CTPA had been performed prior to his arrest at 12.30pm, it is likely a pulmonary embolus would have been picked up. [125]

92. Professor Cade said it depends how strong the suspicion of pulmonary embolus is.[126] He commented that the choice is a clinical decision made by the person on the ground at the time, based on the strength of the suspicion of a pulmonary embolus.[127]

93. Professor Bellomo stated that the only time that pulmonary embolus became a clinical suspicion was at the time of the cardiac arrest at 12.30pm.[128]

94. Counsel for the family submitted that Professors French, Cade and Morris were all strongly of the opinion that the 10am episode was an indication to perform a CTPA.[129] It was submitted that the conclave as a whole acknowledged that as alternative diagnoses fell by the wayside, and in view of the 10am episode the indications to consider CTPA became relatively stronger.[130] It was suggested that the majority view ought to be considered.[131]

95. Counsel for Mr Lim submitted that there was a lack of consensus that a CTPA even ought to have been ordered at any time.[132] Further, even if a CTPA had been ordered at 10am it is unlikely that it would have been performed before 12.30pm. Counsel for Warringal Private Hospital also agreed with this proposition.[133]

96. Counsel for Mr Aly and Professor Bellomo submitted that if the nurses did not make a MET call at 10am, it is then unfair to expect Mr Lim to have ordered a CTPA. The reason is he had not seen the second set of blood test results until they became available at 12.05pm, he had not diagnosed pulmonary embolism, nor did Mr Campbell's observations or vital signs support such a diagnosis. It was submitted that even if a CTPA had been ordered, such a test

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[124] Transcript of evidence, p534
[125] Transcript of evidence, p495-496
[126] Transcript of evidence, p539 Submissions on behalf of Campbell family, p5
[127] Transcript of evidence, p540
[128] Transcript of evidence, p289
[129] Submissions on behalf of Campbell family, p5
[130] Transcript of evidence, p495, Submissions on behalf of Campbell family, p5
[131] Submissions on behalf of Campbell family, p5
[132] Transcript of evidence, p537-538, Submissions on behalf of Mr Lim, p4
[133] Submissions on behalf of Warringal Private Hospital, p4

would have taken several hours to arrange, perform and interpret and it is not standard procedure to order such a test.[134]

Avoidance of hindsight bias

97. A coronial inquiry is wholly retrospective. It seeks to identify the circumstances of what occurred and why. In undertaking this investigation, I have had the benefit of seeing the clinical picture associated with Mr Campbell in the hours that led to his tragic death. It is easy to be critical of clinicians when, as a Coroner, I have the benefit of understanding the complete and very complex picture. I acknowledge that at the time of Mr Campbell's death, all the pieces of the puzzle were not known or understood by the clinicians responsible for his care.

98. In making my findings regarding the circumstances of Mr Campbell's death, I am mindful of the potential for hindsight bias. I have particularly considered what His Honour Justice Hayne referred to in *Vairy*[135] when he said that resolving a question of fact "*is not to be undertaken by looking back at what has in fact happened, but by looking forward from a time before the occurrence of the injury*".[136] Consequently, I have been cautious when making my findings of fact to make them on the basis of what the clinicians involved with Mr Campbell prior to his death, could reasonably have known and done in the hours prior to his death.

99. The circumstances of Mr Campbell's death were unique in that pulmonary embolus is an uncommon event and low risk in this type of surgery. The evidence was that he was a diagnostic dilemma. A number of witnesses and experts were cognisant of the potential for hindsight bias.

100. Professor Talbot said that there was a lack of clear evidence that allowed the clinicians to consider pulmonary embolus as a likely diagnosis. He commented that it is easy to criticise the clinicians for their management when they are asked to deal with a complex patient, especially when that patient at the time presents with minimal clues or clinical signs to direct the clinician down the appropriate diagnostic pathway.[137]

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[134] Submissions on behalf of Mr Aly and Prof Bellomo, p6
[135] *Vairy v Wyong Shire Council [2005]* HCA 62, 223 CLR 422
[136] Ibid, 223 CLR 422 at 443
[137] Exhibit 22 – Statement of Professor Talbot dated 25 October 2017, coronial brief, p384

101. Professor Bellomo considered Dr Douglas and Mr Lim went through a process which was logical and reasonable to consider possibilities that on the basis of information available to them at the time were more likely, and that process of investigation was reasonable.[138] He articulated it highlights the difficulty in understanding real-time judgments once you know the final answer. [139]

102. Upon reflection, Mr Lim commented "*I don't think I would have done anything differently simply because there was nothing for me to go on to act any differently. With the benefit of hindsight, of course, he died from a PE – of course, the diagnosis was missed. But faced with the same situation again, I would still do the same thing.*"[140]

Whether Mr Campbell's death was preventable?

103. There were mixed feelings by the experts about whether Mr Campbell's death could have been prevented, which ranged from possible to probable.[141] According to the experts it depended on the timing of its recognition. The evidence was clear that the earlier the clinical suspicion and investigation for pulmonary embolism, the better the chance of survival.

104. Associate Professor French said that if anti-coagulation had commenced at the time of the first MET call, it was likely his death would have been prevented. If it had commenced at about 10.30am then there was a probable chance.[142] Professor Cade agreed if a pulmonary embolus had been diagnosed at the first MET call it would have very likely prevented death.[143] However, if the suspicion had not occurred until about 11am or 12pm, then the window was so small that the undoubted benefit could not be quantified as strongly preventative.[144]

105. Counsel for the Campbell family submitted that if a number of things had occurred differently such as Mrs Campbell's ability to escalate her concerns and if Mr Lim had been requested to review Mr Campbell after the vasovagal episode, then there may have been a higher index of

[138] Transcript of evidence, p273
[139] Transcript of evidence, p273
[140] Transcript of evidence, p466
[141] Transcript of evidence, p505
[142] Transcript of evidence, p505
[143] Transcript of evidence, p506
[144] Transcript of evidence, p506

suspicion of a pulmonary embolus. It was submitted that a finding ought to be made that Mr Campbell's death was preventable or potentially preventable.[145]

106. Submissions made on behalf of Mr Lim, Mr Aly and Professor Bellomo and the Warringal Hospital submitted the evidence does not establish a finding that the death of Mr Campbell was potentially avoidable.[146]

107. Counsel for Mr Aly and Professor Bellomo submitted that even if Mr Lim had re-assessed Mr Campbell and suspected a pulmonary embolus at 10am and ordered a CTPA, the outcome would not have been any different.

Any prevention opportunities?

108. During the course of this investigation it became apparent that Mrs Campbell was unaware she could escalate her concerns about her husband's deteriorating condition.[147] There is no doubt that this caused her extreme frustration and pain.

109. After Mr Campbell's death, in approximately 2017, the "Ramsey Rule" was introduced by the Warringal Private Hospital. It empowers a patient or family member to talk to a nurse or doctor about any issue or concern they may have.[148] A brochure explaining this process is now provided to families and is placed in each room. As this was one of the key concerns raised at the Inquest which has now been addressed by the Warringal Private Hospital, I do not consider there are any further prevention opportunities.

FINDINGS

110. Having investigated the death of Mr Campbell and having held an Inquest in relation to his death on 14 -18 May 2018 at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Maxwell Norman Campbell born on 27 May 1946; and

[145] Submissions on behalf of Campbell family, p5
[146] Submissions on behalf of Mr Lim, p1, Mr Aly and Professor Bellomo, p6 and Warringal Private Hospital, p1
[147] Transcript of evidence, p43
[148] Transcript of evidence, p382

(b) that Mr Campbell died on 16 November 2014, at the Warringal Private Hospital from 1a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF RECENT SURGERY;

(c) in the circumstances described above.

111. Revisional gastric band surgery is high risk but the weight of the evidence was that the risk of pulmonary embolus was less than one percent in Mr Campbell's case. Deaths from pulmonary embolus associated with this type of surgery are extremely rare.

112. Dr Douglas was an impressive witness and her response to the MET call was exemplary. I find Dr Douglas conducted a very thorough examination and appropriate investigations, and succinctly documented this and her management plan. Even though Dr Douglas accurately considered pulmonary embolus as a potential differential diagnosis, I find there were many confounding factors associated with Mr Campbell's presentation and at the time of handover he remained a diagnostic dilemma. I find that the handover from Dr Douglas to Dr Herath, Professor Bellomo and Mr Lim was entirely appropriate and above reproach.

113. I find that Mr Lim appropriately acknowledged that he had primary responsibility of Mr Campbell on 16 November 2014. The weight of the expert evidence supports a finding that Mr Lim's examination, investigation and management was appropriate at his review of Mr Campbell at 8am. I acknowledge that Mr Lim admitted that he should have documented his thoughts that bleeding was another potential differential diagnosis and that these notes would have assisted nursing staff and other clinicians. The balance of the expert evidence was that bleeding was a potential differential diagnosis. This case serves as an example to remind clinicians about the importance of accurate documentation in medical records. Clinical notes are extremely important and should adequately outline the thoughts and plans of the clinician conducting the review and examination so there is no doubt in the next clinicians mind as to what was to occur in the future.

114. I am unable to resolve the factual dispute between Mrs Campbell and Mr Lim about whether there was a discussion about his colour and breathing at 8am, as both witnesses appeared to be truthful. However, if Mrs Campbell did tell Mr Lim about her concerns about her husband, Mr Lim acknowledged that this was something that would have required re-examination. Mr Lim's evidence is that he did not review Mr Campbell or see him after approximately 8.15am.

Despite this factual dispute, I find there is no evidence that if further investigations had occurred at this time, it would have ultimately changed the outcome.

115. Based on the evidence of Nurse Warburton and RN Pugh, I agree that a vasovagal episode at 10am was a reasonable assumption based on their experience and knowledge of many similar events that occur with patients post shower. I accept that Mr Campbell's condition at 10am did not meet the MET call criteria and therefore agree with the majority of the experts that Nurse Warburton's response was reasonable and based on her knowledge and experience.

116. I find that there was no evidence to support that a CTPA was required at the time of the initial MET call. Further, considering no medical review occurred at 10am or at any time before 12pm, there was no realistic opportunity for a CTPA to have been ordered or performed. Even if Mr Lim or the ICU had been informed about the vasovagal episode at 10am, the evidence is that it would still have taken some time to call the radiographer in, set up the machine and have Mr Campbell scanned. Therefore, given the evidence I do not consider there was an earlier opportunity to have performed a CTPA.

117. I find that Mr Campbell's medical care and management on 16 November 2014 at the Warringal Private Hospital was reasonable and appropriate.

118. The events of Mr Campbell's death can only be seen in clear focus with the benefit of hindsight. It would be unfair to suggest that any of the nursing staff or clinicians could have accurately predicted the outcome when there was a lack of clear evidence that allowed clinicians to consider pulmonary embolus as the most likely diagnosis, when it is such a unique event in these circumstances. Therefore, having thoroughly examined all of the evidence I do not consider that Mr Campbell's death was preventable.

119. I wish to express my gratitude to the medical experts who participated in providing concurrent evidence. Their professionalism and expertise enabled me to better understand the medical evidence in this case.

120. The tenacity of Mrs Campbell in searching for the answers to better understand her husband's death is to be admired. I acknowledge that the coronial jurisdiction can be a distressing and difficult process and that Mr Campbell's death has had an immeasurable impact on his family. I wish to express my sincere condolences to the Campbell family and I acknowledge the grief that you have endured as a result of your loss.

121. Pursuant to section 73(1) of the Coroners Act 2008, I order that the finding be published on the internet.

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

- The Campbell family
- Dr Larissa Douglas, Intensive Care Specialist, Warringal Private Hospital
- Mr Kiat Lim, Upper Gastrointestinal and Bariatric Surgeon.
- Mr Ahmed Aly, Specialist Upper Gastrointestinal and Bariatric Surgeon
- Professor Ronald Bellomo, Consultant Intensive Care Specialist, Austin Hospital and Royal Melbourne Hospital
- Warringal Private Hospital
- Professor David Morris, General Surgeon, University of NSW and The St George Hospital
- Conjoint Associate Professor Michael Talbot, Consultant Upper GT/Bariatric Surgeon, University of NSW and The St George Hospital
- Professor Jack Cade, Intensive Care Specialist, The Royal Melbourne Hospital
- Associate Professor Craig French, Director of Intensive Care at Western Health
- Mr Justin Bessell, General & Upper Gastrointestinal Surgeon, Calvary Wakefield Hospital and Flinders & Adelaide Universities

Signature:

JACQUI HAWKINS
CORONER
Date: 18 October 2018

Coroners Court of Victoria