IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4320

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Brett MAYBUS

Delivered On:	31 JANUARY 2020
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Date:	25 & 28 OCTOBER 2019
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MR DARREN MICHAEL MCGEE
Representation:	MR CON MYLONAS ON BEHALF OF MR BRETT MAYBUS' FAMILY
	MS NAOMI HODGSON ON BEHALF OF ROYAL MELBOURNE HOSPITAL AND PETER MACCALLUM CANCER CENTRE

I, PHILLIP BYRNE, Coroner, having investigated the death of Brett MAYBUS
AND having held an inquest in relation to this death on 25 and 28 October 2019
at The Coroners Court of Victoria
find that the identity of the deceased was Brett MAYBUS
born on 29 July 1957
and the death occurred 29 August 2017
at Royal Melbourne Hospital, 300 Grattan Street Parkville, Victoria, 3050

The Finding does not purport to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

from:

1(a) HAEMORRHAGE COMPLICATING A LEFT ROBOTIC UPPER MEDIASTINAL LYMPH NODE CLEARANCE IN A MAN WITH METASTATIC SQUAMOUS CELL CARCINOMA

in the following circumstances:

BACKGROUND

1. Brett Maybus (hereafter referred to as Brett), 60 years of age at the time of his death, resided with his sister Ms Lisa Maybus in Mount Waverley. Brett normally resided in Darwin but was in Melbourne for medical treatment.

2. In September 2016 Brett, a public patient, underwent video assisted thoracoscopic surgery (VATS) pneumonectomy and systemic lymph node dissection due to Stage 111 squamous cell carcinoma. Brett received post-operative chemotherapy.

3. In early 2017, Brett received radiotherapy by the head and neck radiation oncology team at Peter MacCallum Cancer Centre (Peter Mac) for supraglottic squamous cell carcinoma. A follow up Positron Emission Tomography (PET) scan demonstrated no recurrence of cancer in the right lung and the post pneumonectomy space was clean. A further PET scan was arranged for June 2017.

4. On 22 June 2017 Brett saw Consultant Medical Oncologist Dr Kortnye Smith after the planned PET scan was indicative of a return of cancer. Amongst the issues discussed at that consultation was the prospect of a relatively new clinical project being run at Peter Mac titled the Comprehensive Cancer Panel test. Brett accepted that option. Without going into specifics of this test, the results demonstrated Brett did not have any unexpected genetic mutations with the cancer, meaning that there were no additional treatment options available. Dr Smith referred Brett to the radiation oncology department at Peter Mac where he was seen by Dr Mark Shaw, a specialist radiation oncologist. Dr Shaw arranged for the PET scan to be uploaded into the planning software with a view to determining whether further radiation was a viable option.

5. On 29 June 2017 Dr Shaw reviewed Brett in the outpatient clinic at Peter Mac. The PET scan showed a suspected nodal reoccurrence of cancer. Dr Shaw arranged for Brett to undergo radiotherapy planning, as in light of the earlier radiotherapy it was critical to seek to establish whether it was safe to undertake radiation in previously irradiated zones.

6. A biopsy of the node was to be performed on 26 July 2017 to confirm malignancy. Dr Shaw spoke with Brett by phone on 6 July 2017 and advised that if the biopsy proved the node to be malignant, and if surgery was not an option, a lower dose of radiation could be considered. As there is contention about what was conveyed by Dr Shaw on this issue, I do not propose to resolve that issue at this point, it will be addressed later in my finding.

7. On that day, Dr Shaw emailed Associate Professor Gavin Wright, Cardiothoracic Surgeon, advising that the radiotherapy plan demonstrated that radical radiation was not an option and queried whether there was a surgical option available (see exhibit H2).

8. On 10 July 2017 Brett emailed Dr Shaw asking that the next appointment be face to face. Brett also asked Dr Shaw whether he had received a response from Mr Wright as to the prospect of surgery. Dr Shaw, by return email, advised Brett that he would see him at the clinic and try to arrange a consultation with Mr Wright for the same day.

9. Dr Shaw saw Brett again on 20 July 2017 where a proposed review by Mr Wright on 7 August was discussed. Dr Shaw maintains that at this consultation he again advised Brett that radical radiation was not possible due to the overlap with prior radiotherapy fields; more on this issue later. Dr Shaw stated he did not see Brett after the consultation of 20 July 2017.

10. On 7 August 2017 Dr Shaw received a letter from Thoracic Surgery Fellow Dr Felicity Meikle in which she advised Dr Shaw that Mr Wright had reviewed the images, noted they showed an isolated mediastinal node in the 2L region between the left subclavical and the left carotid which Mr Wright believed he could reset robotically, a procedure which she stated Brett agreed to. Dr Meikle advised Dr Shaw that Mr Wright would attempt the procedure "*given the lack of other possible treatment options at this stage*".[1]

11. On 7 August 2017 following a meeting with Dr Meikle, Mr Wright, Brett and Ms Lisa Maybus in attendance, Brett signed a formal consent to the proposed robotic surgery; the document is co-signed by Dr Meikle. The formal consent document was exhibited (see exhibit C). At the time of signing, it is accepted that Mr Wright had left the meeting. The issue of whether the consent provided by Brett was an INFORMED CONSENT has been the principal focus of the inquest and will be addressed in detail later in this finding.

12. The elective robotic mediastinal lymph node dissection surgery was undertaken by Mr Wright at the Royal Melbourne Hospital commencing at 1pm on 29 August 2017, concluding at 8:45pm. Post-surgery, after Mr Wright had left the theatre, Brett was extubated. Shortly thereafter there was a dramatic sudden drop in Brett's blood pressure indicative of a major bleed. Dr Meikle, at this time being the principal surgeon, undertook an emergency

thoracotomy. She said she could not see a bleeding point, but observed what she described as a "torrential haemorrhage coming out of the mediastinum",[2] adding that the only time she had seen a bleed of that magnitude she considered it was likely an arterial bleed. Digital control of bleeding was obtained but Brett suffered a cardiac arrest. Full resuscitation measures were undertaken, but unfortunately Brett could not be resuscitated and at 9:45pm was formally declared deceased.

REPORT TO THE CORONER

13. Brett's death was appropriately reported to the coroner. The case was presented to me on the morning of 31 August 2017. Having considered the circumstances, having conferred with a forensic pathologist and noting the family consented to autopsy, I directed a partial autopsy and ancillary tests. I was advised that in the second family contact with the Coroners Admissions and Enquiries Office (CA&E), Ms Lisa Maybus, one of the nominated Senior Next of Kin, advised that the family had concerns about aspects of the surgery and in particular the issue of informed consent.

14. An autopsy was performed at the Victorian Institute of Forensic Medicine by Dr Essa Saeedi, a Fellow Forensic Pathologist supervised by Forensic Pathologist Dr Heinrich Bouwer.

15. I subsequently received an Autopsy Report dated 12 February 2018 in which the cause of Brett's death was stated to be:

> **I(a) HAEMORRHAGE COMPLICATING A LEFT ROBOTIC UPPER MEDIASTINAL LYMPH NODE CLEARANCE IN A MAN WITH METASTATIC SQUAMOUS CELL CARCINOMA**

Dr Saeedi advised no obvious bleeding site was identified at autopsy. However, autopsy demonstrated severe triple coronary artery disease with 85-95% stenosis and moderate myocardial fibrosis, right lung fibrosis with changes of pulmonary hypertension.

16. I include the following excerpt from the Autopsy Report in relation to aspects of the cardiovascular system. Dr Saeedi advised:

Aorta & major branches:	There is moderate atherosclerosis of the aorta. All ostia are widely patent. There is no dissection or aneurysm.
Common Carotid arteries:	The common carotid arteries are unremarkable.
Vena cava & portal vein:	The portal vein, vena cava and major tributaries are

[1] Statement of Dr Felicity Meikle, 18 October 2019, paragraph 18
[2] Transcript page 53.

unremarkable. No thrombus is present.

Mediastinum:	Haemorrhage around the left aspect of the mediastinum is seen surrounding the major veins with associated surgical staples. Multiple mediastinal lymph nodes are identified with no obvious tumour deposits macroscopically. No obvious site of bleeding can be identified.

Dr Saeedi opined:

> *"In this case the acute blood loss that occurred is further compounded by the extent of ischaemic heart disease which may have contributed in death."*[3]

Although Dr Saeedi made that comment in his report, he made no reference to it in the more formal part of the Partial Autopsy Report under CAUSE OF DEATH I(a). All I can say is the cardiac condition may have been a contributing factor.

ROLE OF THE CORONER

17. Section 67 of the Coroners Act 2008 provides three core findings I am required, if possible, to make:

    - The identity of the deceased person
    - The medical cause of that person's death
    - The circumstances surrounding the death

18. In my considered view, the fundamental role of the coroner is often misunderstood within the broader community. Often families in particular are left with an unfulfilled expectation when the performance of the entity they see as responsible for the death of their loved one is not stridently criticised by the coroner.

19. From my perspective, the judgement of Callaway JA in *Keown v Khan* (1999) (VR 69) was a landmark judgement. Adopting a statement in the Brodrick Committee (UK) Report His Honour said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame".*

and added:

[3] Transcript page 4.

"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceedings which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."

In *R v South London Coroner: exparte Thompson* [1982] 126 SJ 625 Lord Lane commented:

"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning blame".

20. Again in *Keown v Khan* Justice Callaway made a comment which assists in determining whether an act or omission can reasonably be considered a causal or contributing factor in a death, as distinct from a "background circumstance", that is a non-causal factor. In considering this dichotomy His Honour said one should consider whether an act complained of departed from a norm or standard, or an omission was in breach of a recognised duty.

21. Several New Zealand cases assist in explaining the apparent conundrum between concluding an entity has caused or contributed to a death, but not laying, or apportioning blame. See *Louw v McLean* (1998 High Court of New Zealand unreported 12 January 1988) and *Coroners Court v Susan Newton and Fairfax New Zealand* [2006] NZAR 312. The notion is that in finding causation or contributing to a death the implicit attribution of responsibility is unavoidable.

22. In *Harmsworth v The State Coroner* (1989) VR 989 Nathan J broached the subject of the extent of coroner's powers, observing that power is not "free ranging", but must be restricted to issues sufficiently connected with the death being investigated. His Honour stated that if not so restricted, an inquest could become wide, prolix and indeterminate.

23. The principle was restated in *R v Doogan; ex parte Lucas Smith and Ors* (2006) 158 ACTR 1. In *Doomadqee & Anor v Deputy State Coroner Clements* (2005) QSC 357, Mr Justice Muir commented that coroners are not "roving Royal Commissioners"; and added:

"It is significant also that rules of evidence do not bind a coroners court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial enquiry".

24. The principles enunciated in Rogers v Whitaker [1992] 175 CLR 479 will be dealt with in detail later in this finding.

FURTHER INVESTIGATION

25. The issue of the standard of proof that I must bring to bear requires consideration. Fundamentally, the time honoured "Briginshaw test" (Briginshaw v Briginshaw (1938) 60 CLR 336) is appropriate. The Supreme Court of Victoria has discussed the "Briginshaw test" in several coronial matters, canvasing the standard of proof to be applied in considering whether an act or omission by someone acting in a professional capacity, such as a doctor or nurse, is a causal or contributing factor in a death (see Anderson v Blashki (1993) 2VR89 and Health and Community Services v Gurvich (1995) 2 VR 69). In essence those authorities dictate that findings of causation/contribution should not be made on "inexact proofs, indefinite testimony or indirect inferences", but only on cogent and persuasive proofs – in the final analysis a comfortable degree of satisfaction must be reached to conclude an act or omission was a causal or contributing factor in a death.

26. The Autopsy Report was not received until 12 February 2018.

27. As stated, concerns regarding surgical management were raised with CA&E at the second family contact. The concerns were formalised by Ms Lisa Maybus, initially in the form of 31 questions posed in letters of 29 January 2018 and 13 February 2018. Following my normal practice, I forwarded copies of Ms Maybus' letters of concerns to Mr Wright with a request that he address the questions posed.

28. Mr Wright responded to the 31 questions posed in a statement dated 14 April 2018.

29. Ms Lisa and Mr Kurt Maybus lodged a further letter dated 2 May 2018 constituted by a further 74 questions they wanted Mr Wright to address. A copy of that letter was provided to Mr Wright with a further request that he respond to the additional matters raised.

30. In a timely manner, Mr Wright provided a second statement dated 23 May 2018 in which he addressed each of the 74 additional questions posed.

31. From the outset, when I provided copies of the letters of concerns in general terms, I invited Mr Wright to address issues that could be seen as relevant to my investigation, not some issues I saw at the periphery.

32. Copies of Mr Wright's statements were provided to the family with an indication I would determine the future course of the matter after they had an opportunity to digest the material and respond if so desired.

33. On 20 June 2018 I was provided with further material submitted by Ms Maybus and a request that I give her further time to respond to Mr Wright's second statement. I extended the time for a response to the end of July 2018. In that correspondence Ms Maybus sought to "raise

some queries with the Forensic Pathologist who conducted Brett's partial autopsy". In light of that request I had my registrar arrange what VIFM refer to as a family meeting where issues concerning the autopsy can be discussed with the relevant pathologist. I add that these meetings are not under the auspices of the Court, but generally the Court is supportive of such meetings. I understand that a family meeting did occur on 28 June 2018 with the attendees Ms Maybus and Mr Kurt Maybus, Forensic Pathologist Dr Heinrich Bouwer, Family Liaison Officer Ms Rebecca Coombes and Pathology Liaison Nurse Ms Natalie Morgan.

34. Apparently at the meeting someone suggested that the family lodge submissions addressing their issues.

35. In any event, a fulsome submission dated 10 August 2018 was lodged; all 126 pages. It would appear the family have undertaken significant research, utilising, I suspect, the internet. Importantly, the principal initial concern raised is also comprehensively addressed in the extraordinarily comprehensive submission.

36. I might add that as I look through my file, I note some dozen plus memoranda I penned to my coroner's solicitor (at least one of which I directed a copy be provided to the family), instructing various actions be taken to progress the matter which, on any view, has taken a tortuous course. In matters such as this as concerns are lodged, responses sought, the responses referred back to the "complainant" for comment, the comments referred back to the entity complained of for a further response, and so on.

37. In any event, by November 2018 I had concluded that the only way to progress the matter was to proceed to a Mention/Directions hearing.

38. The first Mention hearing was listed for 13 December 2018, basically to give me the opportunity to engage with Ms Maybus and Mr Kurt Maybus in an open forum where I could articulate my position in relation to the future course of the matter. I felt that the matter was not being sufficiently progressed by being inundated with written material. I proposed to discuss the scope/parameters of my investigation and seek to determine the future course of the matter. The family were advised that the Mention/Directions hearing was a preliminary hearing, no evidence would be led. I proposed to confirm that the principal, if not sole focus of a formal inquest would be on the contentious issues surrounding informed consent. In broad terms, whether the possible risks associated with the proposed robotic surgery were adequately conveyed to Brett to enable him to give an informed consent; including whether the previous radiation treatment made the prospect of robotic surgery problematic and whether alternative treatments were available. I wanted to make it clear that this was not a

"party/party" procedure, that the scope of an inquest hearing was a matter for me, not the interested parties.

39. On 13 December 2018 I conducted a comprehensive Mention/Directions hearing at which Ms Maybus and Mr Kurt Maybus attended unrepresented, with Royal Melbourne Hospital and Peter Mac represented by Mr Michael Regos of DLA Piper solicitors. As well as discussing the matters referred to in the previous paragraph, I raised the prospect of a "family meeting". Previous experience has demonstrated family meetings, outside the formal court setting, are often productive. I made it clear that while such a meeting is not under the auspices of the Court, I am generally supportive of the process.

40. I was subsequently advised that the interested parties were amenable to the family meeting and one had been scheduled. In an email to Mr Darren McGee dated 12 March 2019 Ms Maybus and Mr Kurt Maybus advised that a meeting with "some of the clinicians and executive team" from the Royal Melbourne Hospital was scheduled for 1 April 2019.

41. I subsequently received another email from Ms Maybus and Mr Kurt Maybus dated 7 April 2019 advising that the proposed family meeting was "cancelled", on the basis that the hospital did not agree to the meeting being recorded. In the email it is stated the family apparently thought the meeting was going to be "more of an informal and casual discussion" with Associate Professor Wright and were surprised that members of the executive management would be attending. That comment surprised me somewhat as in her earlier email Ms Maybus indicated that clinician and "executive team" members were to be at the planned meeting. In any event, I was somewhat disappointed that the proposed meeting did not proceed. The email of 7 April 2019 went on to again re-iterate the issues surrounding whether sufficient information was conveyed to Brett to enable him to give informed consent. I had presumed it was understood by all that a "family meeting" was <u>not</u> an alternative to a formal inquest.

42. I was puzzled by the content of the final paragraph of the email of 7 April 2019 which read:

> *"Alternatively, if you believe the time and resources of the Coroners Court could be better utilised in other issues, we would also respect your decision that would allow you to finalise your report in relation to the death of our brother, Brett Maybus."*

43. At my request, on 24 April 2019, I had Mr McGee enquire of Ms Maybus and Mr Kurt Maybus as to what they were seeking to convey by that final paragraph, because although it came as somewhat of a surprise, from a coronial perspective it appeared the family were prepared to accept that I proceed to finalisation "on the papers" <u>without</u> formal inquest.

44. In a response dated 3 May 2019, Ms Maybus and Mr Kurt Maybus indicated that what I thought was being conveyed was not! The email went on to indicate what issues the family anticipated would be addressed at inquest; the very issues I had, at the Mention hearing, indicated would be my focus.

45. The email also included a list of people Ms Maybus and Mr Kurt Maybus expected to give evidence at the proposed inquest. The list included Mr Wright and Dr Kortnye Smith and also three of the participants who were to attend the family meeting which did not proceed.

46. In an email of 23 May 2019, at my request, Mr McGee enquired as to on what basis some of the clinicians, who the family anticipated would give evidence at inquest, were involved in the consent process, because on the face I could not see the nexus.

47. In an email response the following day, Ms Maybus and Mr Kurt Maybus agreed that Mr Wright and Dr Smith were "actively and personally" involved in the consent process and suggested the other entities were "linked" to the informed consent process. As I could not see the "link" I asked Mr McGee to enquire of Ms Maybus and Mr Kurt Maybus as to how these entities were "linked".

48. I might add that Mr McGee invited K&L Gates, solicitors, who by then represented RMH and Peter Mac, to indicate who they considered could give evidence on the focus issue of informed consent.

49. In an email of 13 June 2019, Ms Maybus and Mr Kurt Maybus provided a list of people they maintained were sufficiently "linked" or involved to warrant my calling them as witnesses. I formed a tentative view that other than Mr Wright, Dr Meikle, Dr Mark Shaw and Dr Kortnye Smith the others did not have sufficient connection to warrant them being called to give evidence at the formal inquest hearing.

50. I sought a statement from Anaesthetist Dr Timothy Haydon who Ms Maybus and Mr Kurt Maybus asked to be called. After receiving his statement, I advised the parties I did not propose to call Dr Haydon because he had only been involved in the formal consent to the administration of the anaesthetic for the procedure, not the surgical procedure itself.

51. As an impasse had been reached, I directed the matter be listed for a second Mention/Directions hearing at which I proposed to finalise the list of witnesses I determined could give relevant evidence in relation to the issue I had consistently indicated I proposed to pursue.

52. In preparation for the formal inquest hearing I asked that each of the proposed witnesses lodge formal statements that would be tendered as exhibits in evidence in chief. Although

there were some delays in the provision of the statements requested, the required statements were provided and exchanged before the formal inquest listed for two days, Friday 25 October and Monday 28 October 2019.

EVIDENCE – THE INQUEST HEARING

53. The formal inquest hearing proceeded on Friday 25 October 2019 and Monday 28 October 2019. Ms Maybus and Mr Kurt Maybus were represented by Mr C Mylonas of counsel, Royal Melbourne Hospital and Peter Mac by Ms N Hodgson of counsel. I took evidence from Dr Felicity Meikle by way of video link from New Zealand, Ms Lisa Maybus, Dr Kortnye Smith, Dr Mark Shaw and Associate Professor Gavin Wright. Each witness adopted their formal statement as true and correct. Each statement was then exhibited as that witnesses' evidence in chief. I propose to deal with the evidence of each of the witnesses.

Evidence of Ms Maybus

54. Before turning to the evidence of the clinicians involved, I turn to Ms Lisa Maybus' evidence in chief contained in her formal five-page statement accepted into evidence as Exhibit F. Ms Maybus stated she accompanied her brother to all his consultant medical appointments except that with anaesthetist Dr Timothy Haydon.

55. At the consultation with medical oncologist Dr Kortnye Smith, Ms Maybus claims that the possibility of surgical lymph node excision was discussed with Dr Smith who suggested that option was "too dangerous". I include an excerpt from Ms Maybus' statement:

> *"Dr Smith's response was so firm and adamant that Brett and I did not ask any further questions about the possibility of excising the lymph node and there was no further discussion whatsoever with Dr Smith regarding this. That was why we understood Dr Smith made the referral for radiation therapy to Mr Trevor Leong, Radiation Oncology, at Peter MacCallum Cancer Centre as we understood the excision of the lymph node was not an option."*[4]

As will be seen, Dr Smith does not accept the claim that she said surgery would be "too dangerous". That is a contention I may address later in my finding, when I come to formulating my conclusions.

56. In her statement, Ms Maybus refers to the consultation with Dr Mark Shaw, radiation oncologist at Peter Mac, following Dr Smith's internal referral. Ms Maybus concedes Dr Shaw discussed the issue of "overlap" and the possible impact of further radiotherapy impacting previously irradiated zones. Ms Maybus stated:

[4] Statement of Lisa Maybus, 22 October 2019, paragraph 9

"We understood that a lower dose of radiotherapy could be given immediately, which would slow the growth of the cancer or the higher dose could be given in 3 months time which we understood to be curative. I do not know if Dr Smith was informed the radiotherapy was in doubt. The results of the immunotherapy testing were not available at this time. At this stage no other treatment alternatives were being considered as Dr Shaw had made the referral to Mr Wright."[5]

This is yet another issue where there is contention which I will also address when I come to reaching conclusions. Interestingly Ms Maybus states the question of surgical excision of the lymph node was discussed with Dr Shaw who advised he had discussed that alternative with Mr Wright who would provide advice as to that prospect.

57. Ms Maybus also maintained that in discussion with Dr Shaw at the face to face consultation on 20 July 2017, when discussing the "overlap" issue if further radiotherapy was to occur, Dr Shaw referred to the possibility of damage to "internal structures" but did not refer to risk of damage to blood vessels and arteries specifically.

58. Ms Maybus says that when the prospect of surgical excision was raised and Brett enquired as to the safety of the procedure, Dr Shaw indicated that was a question more appropriate for Mr Wright.

59. In her statement, Ms Maybus refers to the meeting of 7 August 2017 that Brett had with Mr Wright and Dr Meikle at which, after examining the planning images generated by Dr Shaw, Mr Wright advised that it was his view that the lymph node could be successfully excised robotically.

60. Ms Maybus states that on a number of occasions Brett sought reassurance as to the safety of the procedure. She conceded that Mr Wright said the procedure proposed was difficult/"tricky" due to the location of the node, but suggested the robotic procedure was the best chance of accessing the area and successfully excising the lymph node.

61. Ms Maybus states that Brett understood that if the lymph node could not be accessed robotically, Mr Wright could revert to open surgery to successfully complete the operation to excise; in her statement she referred to that prospect as a "back up plan".

62. As will be seen Mr Wright does not agree with that version of the discussion; another area of contention I have to seek to resolve.

63. Yet another area of contention surrounds what was, or perhaps more significantly, what was not discussed with Dr Felicity Meikle at the consultation of 7 August 2017. Ms Maybus

[5] Statement of Lisa Maybus, 22 October 2019, paragraph 13

maintains that issues surrounding the potential risks associated with the robotic procedure were not canvassed. As I will discuss shortly Dr Meikle does not accept that was the case.

64. In broad terms Ms Maybus contends that the possible risks associated with the procedure were not adequately conveyed to Brett to enable him to provide a consent that was adequately informed.

Evidence of Dr Smith

65. Dr Kortnye Smith, medical oncologist at Peter Mac, consulted Brett in the presence of Ms Maybus on 22 June 2017 after he had a PET scan which was indicative of a return of cancer. Dr Smith opined that in her discussions with him she formed the view Brett was "very switched on and engaged in his treatment". Brett and Dr Smith discussed an extra test called the Comprehensive Cancer Panel Test, which, after consideration, Brett agreed to participate. Subsequently, Dr Smith advised Brett that unfortunately the test demonstrated no additional treatment options were available so that the "standard of care" options that had previously been discussed were all that could be provided. In her formal statement, Dr Smith said she advised Brett "localised treatment" was the best option adding that by "localised treatment" she referred to either surgery or radiation treatment as a curative rather than palliative treatment.

66. In earlier material, and in her formal statement, Ms Lisa Maybus claimed that in response to a question as to the prospect of surgery to excise the suspected cancerous lymph node, Dr Smith suggested that surgery was not a realistic option stating "no, it's too dangerous". In her statement and in evidence Dr Smith denied she made that comment stating that she was not qualified to offer such an opinion and would rely on her specialist colleagues to proffer an opinion on the issue. I am not satisfied Dr Smith made that statement. Ms Maybus claimed that after the consultation having regard to what she claims Dr Smith said, she and Brett considered that surgery to excise the lymph node was not an option.

67. In the event, Dr Smith, following a Peter Mac "standard approach", referred Brett to a member of the Radiation Oncology Department, Dr Trevor Leong, by way of an Internal Referral Form (tendered and exhibited as Exhibit "E").

Evidence of Dr Shaw

68. As it turned out, on 29 June 2017, Brett saw Dr Mark Shaw, a radiation oncologist at the outpatient clinic at Peter Mac. Dr Shaw advised that radiotherapy was the preferred option, but radiotherapy planning needed to be undertaken to determine whether, in light of the earlier radiotherapy in March, further radiotherapy was an option.

69. On 6 July 2017 Dr Shaw phoned Brett to advise that the planning scan demonstrated an unacceptable "overlap" on the previously irradiated zones indicating curative radiation was not an option. Because there is contention as to what Dr Shaw said I include here an excerpt from paragraph 14 of his statement.

> *"I informed Mr Maybus that if the biopsy proved the node was malignant, and if surgery was not an option, then it was possible that we could administer a lower dose of radiation, which would have been palliative and would not have been sufficient to eradicate the disease. I told him that the other alternative would be to wait a further three months and perform another PET scan, to see if the cancer had progressed and then reconsider options at that time."* (exhibit K, pages 16 and 18)

I accept Dr Shaw's evidence on the issue.

Evidence of Mr Wright

70. In 2018, Mr Wright provided two statements addressing numerous concerns raised by Ms Lisa and Mr Kurt Maybus. Subsequently, he provided the formal statement for the inquest hearing dated 17 October 2019. That last statement was accepted by Mr Wright as true and correct and tendered as exhibit "K".

71. In his statement at paragraphs 5-6 Mr Wright, in response to issues initially raised by Ms Maybus, reiterated some of the risk factors he claims to have discussed with Brett. In his formal inquest statement Mr Wright says that he proposes to "address more generally" the matters discussed at the consultation of 7 August 2017. In paragraph 7-15, Mr Wright refers to the matters discussed. Paragraphs 16 and 18 are significant. I therefore include them in this finding; Mr Wright wrote:

> *"During the discussion, I believe it was Ms Maybus who asked if there were any other options available for Mr Maybus. Although I cannot recall the discussion verbatim, I believe I said that due to the overlap in the radiotherapy fields, further radiotherapy was not a curative option due to the risks it posed. I said that radiotherapy could only be offered at palliative doses to try to slow down the cancer. This was based on my previous communications with Dr Shaw. I also said that he did not have any immunotherapy trials open to him. There were no other treatment options and Mr Maybus was happy to proceed with the resection in those circumstances."* (exhibit K, pages 16 and 18)

and:

"I did not talk Mr Maybus into undergoing this procedure. Mr Maybus wanted a curative treatment for his cancer and was informed about the alternative palliative treatment options. He chose to undergo the procedure after being informed about the details of the procedure and the risks involved."

72. Once again contention surrounds the care issue of the adequacy of what was conveyed to Brett, an issue I will address later in the finding when I form a conclusion.

THE CAUSE OF THE MASSIVE FATAL HAEMORRHAGE

73. Because of its significance I return to the cause of death, but with the focus now on the source of the fatal bleed.

74. At comment 4 of his autopsy report Dr Saeedi wrote:

"Post mortem examination revealed: 60ml of blood stained fluid in the left pleural cavity with mediastinal haemorrhage and surgical gauze; no obvious bleeding site is identified at autopsy (operative notes describing venous bleeding for the mammary vein near the innominate which was staunched with gauze)."

I conclude the latter part of Dr Saeedi's comment related to the small intraoperative bleed identified and remedied during the procedure.

Evidence of Dr Meikle

75. As Dr Meikle undertook the post-operative thoracotomy surgery, I have examined her statement and viva voce evidence to see if she identified the bleeding site. In her statement exhibit "A' Dr Meikle does not elaborate on the issue.

76. Mr Mylonas examined Dr Meikle on the issue in viva voce evidence. It was put to Dr Meikle that she did not see a bleeding point; she agreed but added she saw what she described as the "torrential haemorrhage"[6] coming out of the mediastinum, the magnitude of which she said she had only previously seen as an arterial bleed. Dr Meikle said she could only hazard a guess, but she suggested a blood vessel the size of a large artery was involved. She went on to say that at the time she considered the bleeding had come from the aortic arch.

77. As to the cause of the massive fatal bleed Mr Wright in his statement of 14 April 2018 (Exhibit L) advised that his working diagnosis at the time was that the original high dose radiation had weakened the major arteries in the vicinity of the aortic arch resulting in a post procedure rupture. Mr Wright stated that that conclusion was reached without being privy to the report by the forensic pathologist who performed the autopsy. As the basis of his initial

[6] Transcript page 53.

view Mr Wright said he had previously experienced a somewhat similar event, albeit a couple of days after surgery, where an artery started to "disintegrate"[7] in a patient who had previously had radiation therapy resulting in a significant bleed. As I understand it that patient survived.

78. Having examined the autopsy report and noting that at autopsy severe atherosclerotic stenosis of the proximal left anterior descending coronary artery and the distal right coronary artery with moderate to severe stenosis of the circumflex was identified, Mr Wright suggested an alternative cause for the massive bleed observed by Dr Meikle.

79. He said:

> *"...the sequence effect was more likely that a bleed from a smaller vessel, has occurred which has caused a period of low blood pressure and very tight coronary arteries, this means there is almost no blood flow to the heart muscle. The heart muscle then fails, which creates a vicious circle, there's no blood pumping through the same coronary artery and the heart goes into what is called cardiogenic shock, which means it fails to pump at all. And this explains why the patient could not be resuscitated but sparked the fact that Dr Meikle was able to compress the area and we had an anaesthetist actively resuscitating the patient. The patient was completely unresuscitatable and this is a very good explanation---"*[8]

80. In light of that explanation I asked Mr Wright how he would explain the "torrential haemorrhage" observed by Dr Meikle. In effect he said even trained medical personnel can overestimate the amount of blood lost. Mr Wright went on to say:

> *"Now, having the benefit of the autopsy report which showed no ruptures to any of the great vessels, what conclusion do you draw?--- Well, I can only surmise that a minor vessel – there are veins, such as the internal mammary vein which runs behind the sternum.*
>
> *Yes?--- Ah, there are veins that run across – across the top of the aorta. One of them called the superior intercostal vein.*
>
> *Yes?--- Ah, now, as a surgeon, I have quite significant anatomical knowledge of this area which even may exceed that of a pathologist, not to denigrate the pathologist at all. Ah, so it may be that those named vessels may not have been obvious to the*

[7] Transcript page 158.
[8] Transcript pages 158-9.

pathologist, ah, and the other thing is a bleed could have occurred and then a post-mortem clot or – or something occluded an obvious hole."[9]

81. Dr Meikle stated she "obtained digital control"[10] of the bleed. That suggests to me that there must have been a hole/rupture/tear, call it what you will, in a major blood vessel that she stemmed by digitally occluding the fault. In spite of that the extent of blood loss was such that unfortunately Brett could not be resuscitated.

82. As seen, there are competing hypotheses in relation to the cause of the massive haemorrhage. Having given the matter earnest consideration, I am not persuaded by Mr Wright's revised hypothesis. I conclude Mr Wright's initial hypothesis was correct. I am satisfied there is a clear direct nexus between the previous radiotherapy and the fatal haemorrhage.

INFORMED CONSENT TO SURGERY

83. I now return to what I see as the critical issue; was the "consent" evidenced in the formal consent form (Exhibit C) an "informed consent".

84. In Rogers v Whitaker [1992] 175 CLR 479 the High Court considered the issue of informed consent in respect of medical treatment. I include an excerpt from the authoritative decision:

> *"The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it."[1992] 175 CLR 479 at 490*

It seems clear that when advising a patient of potential risks the medical practitioner is required to have regard to the likelihood of particular adverse outcomes, including death.

85. I also remind myself that when considering whether or not Brett was adequately advised about the nature and need for the surgery, and the risks associated with it, to give an informed consent, is an exercise I have to undertake without the benefit of hindsight. It is self-evident that if Brett considered there was a real prospect he would not survive the surgical procedure he would not have consented to it proceeding. Ms Hodgson raised with Mr Wright the level of risk associated with the robotic surgery. Mr Wright described the procedure as a "generally safe operation", "conceptually and anatomically and surgically quite a straightforward procedure" with "very acceptably low risk." Ms Hodgson asked Mr Wright if he could provide a statistical number to the risk. Mr Wright responded:

[9] Transcript page 163.
[10] Transcript page 53.

Your Honour as I said, without being able to give a number, which I think is impossible, because I have no data to base such a number, ah, but my estimate would be that this is well short of the risk of pneumonectomy. But of course, not zero with that risk. Ah, so if I was to give a range, I would say between – between a wide range of between one and five per cent, ah, risk from the surgery. Um and possible even the lower end than that.[11]

86. It may appear obvious, but I remind myself that it was Brett who had to consider whether he would consent to surgery, not Ms Lisa Maybus; although I acknowledge she was intimately involved in the process. Ultimately, the choice was one for Brett.

87. In considering his options and making a choice, I note Brett was obviously an intelligent man, variously described as "switched on and engaged", "quite proactive and able and willing to advocate for himself", able to and did "ask insightful questions", "quite analytical", "very engaged with his therapy." I conclude Brett was well able to make a reasoned choice. The point remains, were the potential risks associated with the proposed robotic surgical procedure, and any available alternative treatments, adequately conveyed to Brett to enable him to give informed consent.

88. In material lodged by Ms Lisa and Mr Kurt Maybus it was suggested the formal consent document was inadequate/deficient in that it did not make reference to the specific risks associated with Brett's proposed surgery. It was suggested I should consider making a recommendation that the formal consent document be revised to be more proscriptive in detailing all the possible adverse outcomes of the surgery. I do not propose to make such a recommendation, primarily because matters of potential risk are for detailed discussion between patient and surgeon prior to the formal signing; the document is basically generic; as Mr Wright said the "final step" in the process.

89. Although the document could be seen as what one might call a "one size fits all" document, there are references in the formal consent document which are significant.

    - The first dot point in PART C states "bleeding could occur and may require a blood transfusion and/or return to the operating room." That, in my view, does not relate to a minor bleed.
    - In the final dot point, it is stated death resulting from the planned procedure is a possibility.

90. Several other important points are included in PART D the Patient Consent, namely:

[11] Transcript page 170.

- In the first dot point an acknowledgement that the patient understood the risks specific to him/her.
- In the eighth dot point that the patient signing the consent form acknowledges that he/she was able to ask questions and raise concerns. The questions and concerns were discussed and answered to the satisfaction of the patient.

It is in that context that the fact Brett was engaged, proactive, insightful and analytical is pertinent. The consent form should not be viewed in a vacuum.

91. While it may appear trite, I have concluded Brett wanted to live; I do not believe he was the type of man who would merely sit back and let nature take its course, he was looking for a cure.

92. The discussions with the four clinicians involved were predicated upon seeking a positive outcome; he hoped to return to work. I do not believe mere "observation", with no treatment, was ever considered an option by Brett.

93. In relation to Brett's understanding of the options, it is primarily what information was conveyed by Mr Wright and Dr Meikle that will determine whether the consent to the procedure was informed or not. However, I believe I am entitled to also have regard to the information provided by Dr Smith and Dr Shaw as to what treatment they could, or more importantly could not provide. Leaving aside for the moment the critical question, I am satisfied that the information provided to Brett by Dr Shaw was that what he could offer was not curative, but at best may delay the progress of the diagnosed cancer.

94. Mr Mylonas put to Mr Wright that it was he, not Brett, who made the decision to proceed to the robotic surgery. Mr Wright did not accept that proposition, but accepted it was his responsibility to inform Brett of the risks associated with the procedure to give him sufficient information to make an informed decision as to whether the likely benefit outweighed the risk. Mr Wright maintained that the procedure was not high risk. That evidence was not countered by competing expert evidence. I am satisfied that despite the tragic outcome, and without the not inconsiderable benefit of hindsight, the procedure was not one that carried a significant risk of an adverse event, let alone death. It is noteworthy I suggest that Brett consented to the earlier surgery where his left lung was removed, a procedure that uncontradicted evidence establishes was a procedure that carried a significantly higher risk than the proposed robotic procedure.

95. I am satisfied that by the time Brett and Ms Maybus engaged with Dr Meikle on 7 August 2017, after Brett was advised that the biopsy performed some two weeks earlier demonstrated

metastatic squamous cell carcinoma of the lymph node, the discussion centred around the prospect of surgery. Interestingly, Dr Meikle stated Brett told her that Dr Shaw had previously advised him that curative radiotherapy was not an option and he was seeking advice as to the surgical options.

96. In answer to a question put by Mr Mylonas, Dr Meikle confirmed that she informed Brett that the greatest risk of the proposed surgery was blood vessels could be damaged.

97. Dr Meikle agreed that Brett, and Ms Maybus, asked that if the operation was successful it would be curative of the cancer. Dr Meikle also accepted that Brett and Ms Maybus, on a number of occasions, queried whether the proposed surgery was "safe". Dr Meikle stated that both she and subsequently Mr Wright advised that the lymph node was between the left common carotid and left subclavian behind the clavicle, a position difficult to access. Dr Meikle said it was she, not Mr Wright that advised Brett that the procedure may not be able to be satisfactorily completed and they may have to revert to open procedure to deal with a significant bleed if one occurred, but not to resect the lymph node.

98. As to a bleed, Mr Mylonas put to Dr Meikle that the bleed referred to in the consent form referred to "nuisance or minor" bleed. Dr Meikle rejected that claim stating:

> *"No, the bleeding that is referred to on the consent form is also life threatening bleeding requiring a blood transfusion or conversion to open operation in order to control."*[12]

99. I accept Dr Meikle's evidence in that regard primarily due to the fact that the need to transfer, or revert to open surgery would not occur if the bleed was only a "nuisance or minor" bleed. On this point Dr Meikle conceded that she did not refer to "haemorrhage" as such as it is not a term she uses with lay patients.

100. In relation to the issue surrounding the discussion between Mr Wright and Brett about the difficult location of the lymph node, Dr Meikle agrees that she could not recall Mr Wright mentioning the prospect of damage to blood vessels, or trachea specifically. Dr Meikle conceded that Mr Wright did not discuss the prospect of a substantial or particularly lethal haemorrhage.

101. It was suggested to Dr Meikle that after Mr Wright left the consultation she merely put the consent form in front of Brett to sign. Dr Meikle rejected that suggestion insisting that she went through the points on the consent form with Brett before he signed. I accept her evidence in that regard.

---

[12] Transcript page 35.

102. Mr Mylonas pressed the issue with Dr Meikle suggesting that during discussions the only two risks discussed with Brett were the difficulty of access and the prospect of reverting to an open procedure. Again, Dr Meikle rejected that claim and restated that the prospect of bleeding was indeed discussed.

103. In relation to a heightened risk of bleeding Dr Meikle said she was aware the area, including the aortic arch and large vessels, had been irradiated and accepted that posed a heightened risk which she maintained had been discussed.

104. Having discussed in some detail the evidence of the clinicians involved, both their statements and viva voce evidence, particularly the evidence of both Dr Meikle and Mr Wright, I turn to the conclusions I have reached and the bases upon which they are founded.

105. I have sought to apply the principles enunciated in Rogers v Whitaker (1992) 175 CLR 479. At paragraph 16 of the joint judgement of Mason CJ, Brennan, Dawson, Toohey and McHugh it is stated:

> *"We agree that the factors referred to in F v. R. by King C.J. ((39) (1983) 33 SASR, at pp 192-193) must all be considered by a medical practitioner in deciding whether to disclose or advise of some risk in a proposed procedure. The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege."*

I add that I do not believe the "therapeutic privilege" caveat is relevant here.

106. As well as the nature and purpose of the proposed treatment informed consent requires the patient to be advised of the material risks, being risks that are relevant to all patients undergoing the proposed procedure, together with the risks that are known by the medical practitioner to be relevant to the particular patient (the subjective limb of the principle), together with any additional information the patient seeks.

107. The High Court, concluding that the approach of King CJ in the Full Court of the Supreme Court in South Australia in F v R (1993) 33 SASR 189 was correct, stated that what is sufficient information as to the material risk required to be provided to the patient for a consent to be informed, is a question for the Court, not whether what was conveyed accords with the practice in the profession.

108. In her separate judgement, Gaudron J, while agreeing with the reasons of her fellow justices, made several additional comments which have assisted in considering the subjective test I am required to apply in relation to the adequacy of the information conveyed to Brett, particularly by Mr Wright and Dr Meikle. At paragraph 5 of her judgement Her Honour commented:

> *"Diagnosis and treatment are but particular duties which arise in the doctor-patient relationship. That relationship also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstanced of the patient. A patient may have special needs of concerns which, if known to the doctor, will indicate that special or additional information as required. In a case of that kind, the information to be provided will depend on the individual patient concerned."*

109. If a hypothetical prudent patient would likely attach significance to the risk, the objective test, and if Brett would likely have attached significance to the prospect of damage to a major blood vessel, a vessel or vessels possibly compromised by previous radiation therapy, the subjective test, then that particular risk would need to have been adequately conveyed to enable Brett to give an informed consent.

110. In my considered view the crux of the judgement in Rogers v Whitaker required Mr Wright and/or Dr Meikle to provide to Brett sufficient information concerning material risks associated with the procedure. I have to turn my mind to what can reasonably be seen as a material risk. As I understand the law, although an identified risk may be relatively rare, so long as it is real and foreseeable, not "far fetched or fanciful" (per Mason J in Wyong Shire Council v Shirt (1980) 146 CLR 40 @ 47), that particular risk would need to have been conveyed to the patient considering consenting to the proposed procedure.

111. The question then remains, was sufficient information as to that possible heightened risk conveyed.

112. I include in this finding what I see as the principal submissions made by both Ms Hodgson and Mr Mylonas in relation to what I consider to be the determinative issue concerning whether Brett's consent, as evidenced in the signed consent form, was fully informed in accordance with the principles enunciated in Rogers v Whitaker.

113. Ms Hodgson submitted:

> *"There is also no evidence before the Court that any blood vessel, great or small, was compromised by previous radiotherapy such that it caused the acute blood loss Mr*

Maybus sustained. The only evidence on this point was the earlier supposition by A/Prof Wright, prior to being aware of the autopsy results. A/Prof Wright withdrew this conclusion after having had the benefit of the autopsy findings. Further, A/Prof Wright opined that based on what he saw during the surgery, as well as the pathological findings at autopsy, there is no evidence that Mr Maybus had compromised vessels from prior radiotherapy. Accordingly, there is no evidence before the Court that the acute blood loss was in any way attributable to radiotherapy.

Accordingly, it cannot be said that irradiated vessels were a 'material risk' that Mr Maybus ought to have been informed about as they were not relevantly causative of his death. Further, and in any event, Mr Maybus was aware that the surgery was to be performed in the irradiated area and he was informed that surgeons may cause damage to the blood vessels in the immediate area where the lymph node was identified."[13]

Submitting that there is no evidence that any blood vessel was compromised by previous radiotherapy resulting in the fatal haemorrhage, Ms Hodgson contends that as not causative it was not necessary to inform Brett that the prospect of damage to irradiated blood vessels was a material risk.

114. In his initial submission Mr Mylonas contended that neither Mr Wright, nor Dr Meikle, specifically informed Brett that the previous radiotherapy may have impacted blood vessels including arteries. The issue was put to Mr Wright in examination; I include the relevant excerpt from the transcript (page 193). Mr Mylonas asked:

"All right. So you did not – just to be clear about all this, you did not say the tissues have been irradiated and this constitutes a significant risk to you?

Mr Wright responded:

"I did not make that particular statement but he – he knew, and I'd already discussed with him, about the fact that the radiation had come into the top of his chest, Mr Maybus – Brett, as you say – is not – he was an intelligent man; he could not conclude otherwise. I – I believe he knew there was radiation in the chest, I told him that that – that there are increased risks for that surgery. Of course I did not say this could cause radiation damage to your artery, I didn't go into that sort of detail (my emphasis), but I conveyed the risk that this procedure was small, and still is a small risk procedure, but the potential benefit of the potential cure outweighed that risk."

[13] Submission on behalf of Melbourne Health and Peter Mac, 11 November 2019, paragraphs 33-34

115. Mr Mylonas in his submission in reply submitted:

> *"Not at any stage in any submissions, witness testimony or discussions was the issue of the impact of the radiation treatment on the arteries mentioned. The assumption that Brett should have been aware of this due to the overlap of the radiation fields relating to the oesophagus is insupportable. This was an example of a specific risk that applied to Brett that should have been disclosed on the Consent Form as detailed in Section D that outlines "... the risks specific to me" have been explained by the Doctor.*
>
> *Wright knew that there was a concern about safety. He also knew of the previous irradiation and that this posed specific risks to Brett. In those circumstances the risk was material notwithstanding the low absolute probability just like in Rogers and Whittaker (sic)."*

CONCLUSIONS

116. Prior to formalising the conclusions I have reached, I wish to make a general comment about aspects of the evidence surrounding several contentious issues.

117. Ms Maybus has taken issue with significant parts of the evidence of literally all four of the medical practitioners involved. For instance, her claim that Dr Smith said surgery was "too dangerous", her contention that Dr Shaw advised that treatment he could provide was curative, not palliative, her belief that Mr Wright, and/or Mr Meikle, advised that if the robotic procedure had to be aborted excision of the lymph node could be successfully completed by "open" surgery.

118. I have had to consider where the weight of evidence lies. In relation to these, and several other instances where I have not accepted Ms Maybus' evidence.

119. In relation to these instances I wish to make it clear that I do not suggest Ms Maybus has been untruthful. I have concluded that in some instances she has misconstrued what was sought to be conveyed, or has unwittingly engaged in retrospective reconstruction/hindsight, a phenomenon often seen in this jurisdiction when a family member, acutely aware of a tragic outcome, seeks to rationalise events leading to the untimely death of a loved one.

120. I am satisfied that due to the earlier radiotherapy to the region in the chest where surgery was proposed, there was a heightened risk of damage to blood vessels in that area. Although risk was "heightened" I conclude the evidence demonstrates that the risk was still relatively low. However, the fact that it was a material risk would be sufficient to require it to be conveyed.

121. I am satisfied that in light of the proximity of the massive bleed to the completion of the surgical procedure, to suggest it was coincidental flies in the face of common sense and is highly unlikely. The prospect of damage to the blood vessels was conveyed in the nature of general, non-specific risk where, as submitted by Mr Mylonas, that prospect was a specific risk unique to the deceased.

122. It is obviously true that Brett was aware his chest had been previously irradiated, but the assumption made by Mr Wright, referred to in paragraph 113, was one in which in my view was not reasonably open to him.

123. While the information about heightened risk was significant, I do not accept this was a high risk procedure. The evidence establishes to my satisfaction that in spite of the outcome, the risk of such an event actually occurring remained low.

124. I am further satisfied that on the basis of the information conveyed Brett accepted that whilst there were attendant risks, the procedure was not high risk and a risk he was prepared to take.

125. I do not believe the "heightened" risk due to previous radiation was specifically adequately conveyed to Brett.

126. Consequently, after some vacillation, I conclude that in the absence of that specific heightened risk being adequately conveyed to Brett, his "consent" to the robotic procedure was not fully informed.

127. However in my view the matter does not end here. I have considered whether the outcome would likely have been different had that additional critical information been adequately conveyed to Brett.

128. Ms Maybus maintains that had Brett been properly informed about the heightened risk of damage to blood vessels in the immediate area due to previous radiotherapy he would not have gone ahead with the proposed surgery. I suggest that contention is clearly founded on hindsight.

129. I am convinced that when he weighed the risk against the expected benefit Brett would have consented to the robotic procedure; for all intents and purposes, other than death, it was his only option.

FORMAL FINDING

130. I find that Brett Maybus died on 29 August 2017 at The Royal Melbourne Hospital, from cardiac arrest following a massive haemorrhage due to the rupture of an undetermined blood vessel, which I am satisfied was compromised by previous radiation therapy. The haemorrhage occurred upon extubation following robotic surgery to excise a cancerous mediastinal lymph node.

131. I am unable to say what part, if any, severe ischaemic heart disease, demonstrated at autopsy, played in Brett Maybus' untimely death.

132. Pursuant to section 73 (1) of the *Coroners Act 2008* I direct that a copy of this finding be published on the Coroners Court of Victoria website.

COMMENT

133. Pursuant to section 67 (3) of the *Coroners Act 2008*, I make the following comments in relation to the death.

134. Initially the family suggested I should make recommendations as to the form of consent, to expand that document to include, in a particular case, virtually all risks. Ultimately, I think it fair to say counsel for both the family, RMH and Peter Mac did not pursue that suggested proposal. I do not propose to endeavour to recommend a template for a revised form. In evidence Mr Wright agreed with Mr Mylonas that the signing of the formal consent to surgery was merely the "final step" in the consent process and is done after discussion between patient and surgeon. He replied:

> *"Consent ... it's at the end of the process."*[14]

Mr Mylonas put to Mr Wright that it is the prior discussion that is important, Mr Wright replied:

> *"Yeah. Not so much the signing."*[15]

The critical aspect of seeking informed consent to a procedure is the discussion between doctor and patient that occurs prior to the signing of the formal consent form.

135. Mr Mylonas, observing that there were no progress notes of the discussions between doctor and patient regarding the attendant risks of the proposed procedure in the medical records, nor virtually anywhere else, save the formal consent form, put to Mr Wright that these discussions ought to have been recorded, perhaps by way of audio recording. Mr Wright accepted that could be done.

136. Although I do not propose to make a formal recommendation, I suggest this matter throws into sharp focus the benefit of at least having some contemporaneous notation of

[14] Transcript page 204.

discussions in relation to attendant risks, particularly those specific to the particular patient; the subjective element of the Rogers v Whitaker principle. If the pertinent discussion was for instance audio recorded, it could be retrieved if the issue subsequently became contentious.

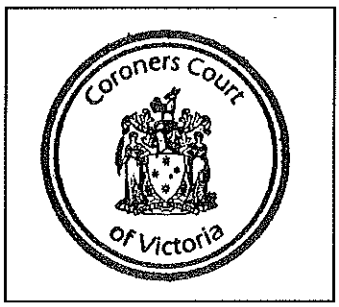
DISTRIBUTION OF FINDING

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

- Mr Con Mylonas, on behalf of the family of Mr Brett Maybus;
- Ms Caroline Rubira, K&L Gates, on behalf of Royal Melbourne Hospital and Peter MacCallum Cancer Centre;
- Ms Laura Sparks, Quality and Safety Unit, Peter MacCallum Cancer Centre;
- Dr Malcolm Mohr, Pathology Department, Melbourne Health, Royal Melbourne Hospital; and
- First Constable Hamilton Moore, Reporting Officer, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 31 January 2020



[15] Transcript page 204.