CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr William John Edmunds
Hearing dates:	5 - 9 December 2022 8 - 9 March 2023
Date of findings:	9 March 2023
Place of findings:	Albury
Findings of:	**Magistrate Erin Kennedy** **Deputy State Coroner**
Catchwords:	CORONIAL LAW – Cause and manner of death, surgical error, Hartmann's procedure, ileus, stoma, iatrogenic mechanical bowel obstruction, peritonitis, open disclosure, open disclosure at the time of error being discovered, involvement of original surgeon in any additional treatment
File number:	2019/0037940

Representation:	Mr Matthew Robinson, Counsel Assisting, instructed by Ms Clara Potocki (Crown Solicitor's Office) Ms Kate Williams of KW Medical Law Specialists for Suzanne and Wade Edmunds (family) Ms Maria Gerace for Albury Wodonga Health, instructed by K&L Gates Ms Eva Elbourne for Dr Liu-Ming Schmidt, instructed by HWL Ebsworth Mr Peter Aitken for Professor David Tuxen, instructed by Moray & Agnew Mr Tim Saunders for Dr Ajay John, instructed by Meridian Lawyers

Findings:	I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW): **The identity of the deceased** The deceased person was Mr William John Edmunds. **Date of death** Mr Edmunds died on 2 December 2019. **Place of death** Mr Edmunds died at Albury Campus of Albury Wodonga Health, 201 Borella Road East Albury NSW 2640. **Cause of death** Mr Edmunds died as a result of complications of peritonitis. **Manner of death** Mr Edmunds died as result of the complications of peritonitis which was contributed to by the surgical error made by Dr Liu-Ming Schmidt on 7 November 2019 which gave rise to the requirement of the further surgical procedure performed on 15 November 2019. Other contributing causes to his physical decline and death included the prolonged delay in diagnosis of a mechanical bowel obstruction together with underlying natural causes.
Recommendations:	I make the following recommendations pursuant to Section 82 of the *Coroners Act 2009* (NSW) **To the Health Care Complaints Commissioner (HCCC)**: That the brief of evidence, transcript of evidence given at the inquest, and a copy of the findings in the Inquest into the death of William Edmunds be forwarded to the HCCC to consider and investigate the care and treatment that Dr Liu-Ming Schmidt provided to Mr Edmunds between 7 November 2019 – 2 December 2019 at the Albury Campus of Albury Wodonga Health to determine whether any disciplinary action is required. **To the Executive of Albury Wodonga Health**: That consideration be given to the implementation of a surgical audit tool to facilitate the capture and recording of data in real time in respect of surgical outcome.

	To the Executive of Albury Wodonga Health and the Australian Commission on Safety and Quality in Health Care: That consideration be given to the implementation of a policy, or promulgation of a directive, that mandates the presence of a witness at the initial disclosure of a medical complication where the disclosure is made by the health practitioner who made the error. The witness would be equal to, or more senior than, the practitioner who made the error. That consideration be given to the implementation of a policy, or promulgation of a directive, which requires, where practicable, that a patient who has experienced an avoidable medical error be informed that they may decide whether the health practitioner who made the error has further involvement in their care.

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INTRODUCTION

1. Mr William John Edmunds was 79 years of age at the time of his admission to Albury Wodonga Health on 7 November 2019 having recently been treated by regional hospitals including Corowa Hospital, Berrigan Multipurpose Service, and Goulburn Valley Health for a number of health issues, where he was treated and released. On 6 November 2019 after having a sudden fall after returning home on 5 November 2019 from Corowa Hospital, an ambulance was called, and Mr Edmunds was conveyed to Corowa Hospital.

2. Mr Edmunds was assessed by Dr Htike Aung who obtained a history from Mr Edmunds of his fall that day. Dr Aung records that it was his intention to admit Mr Edmunds to Corowa Hospital and arrangements were being made to move him the following day for further testing, but during the night he became gravely ill and an urgent transfer was arranged in the early hours of the morning.

3. Mr Edmunds was taken to Albury Wodonga Health by ambulance to the emergency department on 7 November 2019. He was ultimately diagnosed with Pneumoperitoneum consistent with a perforated hollow viscus – a perforated bowel - which required urgent lifesaving surgery.

4. A procedure called a "Hartmann's" procedure was undertaken, which is a type of colectomy that removes part of the colon and sometimes rectum. This procedure involved the removal of affected bowel, cleaning out of the affected cavities and creation of a stoma to allow a colostomy bag to be connected while Mr Edmunds recovered. This requires the remaining rectum to be sealed, creating what is known as Hartmann's pouch. The surgery was not successful because Dr Liu-Ming Schmidt who was the senior consultant surgeon conducting the surgery made a catastrophic error. She brought out the wrong end of the bowel to form a stoma, causing a mechanical bowel obstruction.

5. This is not a usual or anticipated risk of this procedure. Mr Edmunds initially seemed to improve but then began to deteriorate. Given the unusual nature of the error it was not detected until a period of 8 days after the surgery had elapsed. Mr Edmunds by that time was very unwell. It took a further surgery to correct the error, and a further two surgeries were needed as a result of additional complications. After the four surgeries he remained in the intensive care unit until he passed away on 2 December 2019.

6. The inquest into his death focused on the nature of the surgical error that was widely thought to be avoidable, together with medical care and treatment provided by Dr Schmidt following the surgery in the period of time leading up to the identification of the error. An issue arose as to the adequacy of the open disclosure by Dr Schmidt given to Mr Edmunds and his family about the true nature of the error. Much of the evidence related to the limited contact Dr Schmidt maintained with her patient after

surgery, and her failure to order a CT scan when suggested by the intensivist, which was the only manner of detecting the error.

7. The family raised the issue of the suitability of her involvement in ongoing treatment in Mr Edmunds care after the identification of the error, and the performance by her and another doctor of a second necessary rectification operation. They raised the issue of whether an individual has the right to choice of the doctor following such an error.

8. The inquest also traversed an issue arising in country hospitals particularly where there are limited tools for monitoring surgical outcomes and among other things a tool would make more transparent medical errors and allow a way to measure that skills are being maintained and individual medical standards being kept to a reasonable level.

9. Although Mr Edmunds was 79 and had a number of comorbidities, he had been leading a full and interesting life. He was the much-loved father of three adult children, and he had just started in a new relationship. He had many reasons to continue living a fun loving and interactive life. Although his prospects of surviving the first surgery was always going to be challenging even if the surgery had been conducted correctly, there is no doubt that the error made lessened his odds considerably.

10. Pursuant to s 27 of the *Coroners Act 2009* (NSW) ("the *Coroners Act"*), an inquest is required to be held where it appears to the Coroner that the manner and cause of death has not been sufficiently disclosed. Section 81 (1) of the *Coroners Act* requires the recording of formal findings, if findings can be made, with respect to the identity, the date and place of death, and the manner and cause of death.

11. The evidence establishes cause of death. Mr Edmunds died as a result of complications of peritonitis. Manner of death remained to be determined and the purpose of this inquest is to determine the manner of death and explore whether there are lessons to be learned from Mr Edmunds' death.

12. The purpose of an Inquest is not to attribute blame to any person or persons for Mr Edmunds' death, although it may identify acts or omissions by certain individuals that caused or contributed to Mr Edmunds' death. The work of Dr Schmidt and other medical staff at Albury Wodonga Health were necessarily explored.

13. A thorough coronial investigation has been conducted into the circumstances surrounding Mr Edmunds' death. This investigation has considered a vast amount of materials received from many different sources, including the following: Albury Wodonga Health; Corowa Hospital; The NSW Ambulance Service; Statements from treating clinicians at Corowa Hospital; Statements from treating clinicians at Albury Wodonga Health; An Executive Response from the Director of Medical Services at Albury Wodonga Health (Dr Glenn Davies); Court appointed experts and experts

appointed on behalf of Dr Schmidt and Professor Tuxen; and very importantly, statements provided by Mr Edmunds' family.

14. The primary issues which were examined in some detail during the course of this inquest were as follows:

    1. Statutory findings required under s. 81 of the *Coroners Act*, including manner of death.

    2. In relation to the surgical procedure performed on 7 November 2019 by Dr Schmidt:

        i. Whether Dr Schmidt was sufficiently qualified and relevantly experienced to warrant her having performed the procedure, and to justify her having been on call as a general surgeon;

        ii. The role of Dr Schmidt's surgical error in causing or contributing to Mr Edmunds' death;

        iii. The adequacy of intra-operative assistance available to Dr Schmidt, and the appropriateness of Dr Schmidt completing the surgical procedure without an assistant; and

        iv. The availability of an experienced surgical colleague to assist Dr Schmidt and, if available, whether it was incumbent upon Dr Schmidt to seek assistance.

    3. The adequacy of post-operative monitoring and management in the period 7 November 2019 to 15 November 2019, by the ICU team and surgical team, including:

        i. whether errors made during Mr Edmunds' initial surgery should have been identified at an earlier stage;

        ii. the requirement, if any, for radiological imaging to be performed during that period;

        iii. the adequacy of 'ileus' as a diagnosis for the duration of that period; and

        iv. whether a provisional or differential diagnosis of mechanical bowel obstruction should have been considered having regard to Mr Edmunds' signs and symptoms, including his high nasogastric tube output.

4. The appropriateness of the surgical procedure performed on 15 November 2019.

5. The adequacy of the post-operative planning following the 15 November 2019 surgery, including in respect of post-operative radiological imaging to allow or prompt diagnosis of bowel obstruction.

6. Whether any recommendations are necessary or desirable in relation to any matter connected with Mr Edmunds' death.

REFLECTION ON THE LIFE OF MR EDMUNDS

15. Mr Edmunds was born on 22 February 1940. He was 79 at the time of his admission to Albury Wodonga Health. He resided in Oaklands, New South Wales with his son Dean. He was a widow. The family provided a family statement which painted a picture of Mr Edmunds being fun loving, supportive and caring. He was exploring a new relationship; he was active enjoying being with family and friends. He liked to socialise, enjoyed a drink with friends and a smoke, and a horse race or two. He was interested in his family and they in him. The family described Mr Edmunds as a strong man who once carried a piano on his back and that they are a close family with a strong sense of right and wrong.

16. His wife of many years died in 2016. At the time of his death, he had a son, Wade, and a daughter Suzanne.

17. He also had a son, Dean. The family lost Dean suddenly the very day the surgical error was identified requiring Mr Edmunds to have rectification surgery the day he lost his son. This part of the narrative was reflected on many times during the inquest by various witnesses. The distress of hearing that a major surgical error had been made would be significant enough. This family however was reeling from the sudden loss of Dean that morning. Mr Edmunds was in the middle of what must have been a state of profound shock and grief, when trying to absorb the news of the surgical error.

18. Information obtained from Dr Yaramati, general practitioner, disclosed that Mr Edmunds had a number of medical comorbidities in November 2019 including high blood pressure, elevated cholesterol, advanced heart failure together with atrial fibrillation on a background of bypass surgery in 2009, emphysema, chronic obstructive pulmonary disease, COPD, gastro-oesophageal reflux disease, GORD, arthritis, and an enlarged prostate.

19. He was on Symbicort and Ventolin for asthma and emphysema; Aspirin and Rivaroxaban for blood thinning; Furosemide for heart failure; Lipitor for elevated cholesterol; Metoprolol for irregular heartbeat; Perindopril and Prazosin for high blood pressure; Citalopram for depression and Esomeprazole for GORD.

CHRONOLOGY OF RELEVANT FACTS

THE EVENTS LEADING UP TO THE SURGERY

20. Counsel and solicitor assisting prepared a thorough chronology of events which is set out below. There were a few factual disputes about some of the events, which I will deal with following the essentially agreed chronology of events. The facts are detailed, and I consider it necessary to repeat them so a full picture can be painted of the factual matrix leading to Mr Edmunds death beginning on 23 October 2019.

21. On that day, at 1:55 pm, Mr Edmunds' neighbour contacted triple zero and requested an ambulance attend Mr Edmunds' home. Mr Edmunds was experiencing difficulty breathing. Mr Edmunds was conveyed to Berrigan Multipurpose Service which provides a 24-hour Accident and Emergency Department. Berrigan Multipurpose Service is a small facility with 14 beds and four hospital beds.

22. Upon Mr Edmunds' arrival, physicians at Berrigan Multipurpose Service requested further investigation including ECG monitoring which was unavailable at Berrigan. Ordinarily, Mr Edmunds would have been transported to Albury Wodonga Health, but it was reporting a "code black" at the time and was unable to receive patients. Instead, Mr Edmunds was transferred to Goulburn Valley Health, arriving in the afternoon.

23. Whilst at Goulburn Valley Health, Mr Edmunds was diagnosed with viral pneumonia. He was positive for RSV, and was diagnosed as suffering from infective exacerbation of his chronic obstructive pulmonary disease. His breathing was noted to be laboured, and there were signs of heart failure.

24. Mr Edmunds was appropriately treated during the course of his admission to Goulburn Valley Health including with antibiotics, and he was discharged on 30 October 2019 to Corowa Hospital as part of what is referred to as a "step down" process to gradually ease Mr Edmunds back into the community.

25. On 30 October 2019, following admission to Corowa Hospital as part of the step-down process, Mr Edmunds was reviewed by Dr Htike Aung on 30 October 2019.

26. Dr Aung records in his statement, and it accords with the clinical records, that on reviewing Mr Edmunds, his temperature was normal, his blood pressure was 138/70, his heart rate was 100 and his oxygen saturations were 93% on 2 litres of oxygen via nasal prongs. His breath sounds were quiet with no wheeze, his heart sounds were soft, and his abdomen soft and non-tender.

27. Dr Nigel Murray first saw Mr Edmunds on his morning round on 31 October 2019. He recalled in his statement that Mr Edmunds had a good night the night prior in terms of sleep and general health. There was a discussion about ceasing smoking, and his

social situation. A plan was recorded to start chest physiotherapy, wean Mr Edmunds from supplemental oxygen, and finish the current course of antibiotics which had been commenced at Goulburn Valley Health.

28. Dr Murray reviewed Mr Edmunds the following day. Mr Edmunds reported improvement in that he had mobilised and walked to the bathroom, and back to his bed. Consistently the recorded plan, Mr Edmunds was being gradually weaned from supplemental oxygen, and had spent an hour at a time on room air only.

29. Dr Murray did not work at Corowa Hospital over the weekend of 2 and 3 November 2019, but saw Mr Edmunds on Monday, 4 November.

30. On 4 November 2019, Dr Murray recorded continued improvement over the weekend, noted that Mr Edmunds' breathing had return to its baseline, and that he did not require supplemental oxygen.

31. On 5 November 2019, it was determined that Mr Edmunds was ready for discharge home. He was maintaining oxygen saturations of 92% on room air which was satisfactory having regard to his premorbid state. Dr Murray records that during the time he was involved in Mr Edmunds' care, he "did not display any signs or symptoms suggesting diverticulitis or other issues relating to his abdomen". Dr Murray treated Mr Edmunds appropriately.

32. Mr Edmunds was discharged home on 5 November 2019 with a plan for a review by Dr Murray in a fortnight, and referral for review by the Aged Care Assessment Service, together with home cleaning services having been established. Discussions were also had concerning Mr Edmunds' participation in a pulmonary rehabilitation class, although it appears that there was no capacity in the short term for Mr Edmunds to access such services in his local area.

33. There are no concerns in respect of the adequacy or reasonableness of care Mr Edmunds received at Berrigan Multipurpose Service, Goulburn Valley Health, nor Corowa Hospital.

34. On 6 November 2019, Mr Edmunds was using the bathroom at his home when he collapsed. He was located about 20 minutes after collapsing by his neighbour. An ambulance was called, and he was conveyed to Corowa Hospital.

35. Dr Aung again became involved in Mr Edmunds' care.

36. Mr Edmunds was triaged as category 3 at 7.29 pm and assessed by Dr Aung, on his estimate, at about 8.00 pm. He typed the note of his assessment retrospectively later that evening.

37. Dr Aung obtained a history from Mr Edmunds of his fall that day. He reported that prior to his presentation, Mr Edmunds had collapsed in his bathroom at home after urinating. Mr Edmunds described feeling faint after standing up from the toilet and falling onto both elbows. Dr Aung observed skin tears to both elbows. Mr Edmunds did not experience a head strike or unconsciousness.

38. Dr Aung obtained a history from Mr Edmunds of generalised abdominal pain starting around midday that day which he reported had settled after the administration of morphine by paramedics. He was not constipated during his recent stay in Corowa Hospital and said his bowels had opened the previous day. He denied a history of abdominal surgery or bowel problems and described his breathing as 'not bad'.

39. Mr Edmunds' vital signs were within the normal range and Dr Aung reports that there we no signs of peritonism. Dr Aung did note some tenderness over the left abdominal area, and identified an umbilical hernia which was not strangulated.

40. Dr Aung records that it was his intention to admit Mr Edmunds to Corowa Hospital, he was intending to organise blood tests, and abdominal imaging in the form of X-ray and/or CT the following morning.

41. At around 11.00 am on 6 November 2019, Mr Edmunds began to complain of lower central abdominal pain. A bladder scan was performed which showed 430ml of urine.

42. At around 1.00 am on 7 November 2019, Mr Edmunds complained of worsening abdominal pain and was given morphine for pain and ondansetron for nausea. He thereafter became haemodynamically unstable with a drop in his blood pressure. His abdomen began to show signs of peritonism including generalised guarding, rigidity, and extreme tenderness.

43. His transfer to Albury Wodonga Health was arranged. He was transferred out by ambulance at 1.53 am.

MR EDMUNDS' TREATMENT AT ALBURY WODONGA HEALTH

44. On 7 November 2019 at 2:29 am, Mr Edmunds arrived at Albury Wodonga Health by ambulance. He was triaged at triage category 1 reflecting the life-threatening nature of his illness and the requirement for immediate review. He was noted to be hypotensive, with a blood pressure of 96/72. He was groaning in pain, and in the foetal position. He was sent immediately to the resuscitation area of the Emergency Department.

45. Three minutes after triage, at 2:32 am, Dr Vineet Das, the on-call surgical registrar, was contacted, and asked to attend the hospital. Dr Das has provided a statement. He also attended and provided evidence. Dr Das was at home in Wodonga when the call

was received from Albury Wodonga Health, and It took him about 15 minutes to arrive at the hospital.

46. At 2.40 am Mr Edmunds' son, Dean, was contacted and informed by nursing staff of Mr Edmunds' poor condition.

47. An emergency CT scan was performed of the Abdomen and Pelvis, and reported upon by Dr Ryan Walklin at 2.50 am He noted:

> "Pneumoperitoneum consistent with a perforated hollow viscus. There is extensive intraperitoneal faecal material and fluid within the pelvis, and an abnormally thickened sigmoid which may be the site of perforation. Concern is raised for an underlying malignancy and urgent surgical referral is recommended."

48. After the report of the CT scan, Dean was contacted again and informed that Mr Edmunds had a bowel perforation. He was advised that a surgeon was on their way to see Mr Edmunds.

49. At 2.56 am, Mr Edmunds was "advised of his current situation" and provided consent to be intubated. Dr Vineet Das, the surgical registrar, estimates that he arrived at the hospital between 2.50 am and 3.00 am. The notes record that Dr Das reviewed Mr Edmunds at 3.00 am consistent with his recollection of his arrival time.

50. Dr Das' retrospective note of that review was recorded at 3.15 am. With the benefit of abdominal CT having been performed, Dr Das noted that Mr Edmunds presented with peritonitis and viscous perforation (being a full-thickness disruption of the intestinal wall).

51. Dr Das contacted Dr Schmidt, the on-call consultant general surgeon, and discussed his findings with Dr Schmidt, including his plan for surgery. Dr Schmidt agreed that surgery was required, and agreed that Mr Edmunds could be admitted under Dr Schmidt's care.

52. Dr Das recorded a plan including admission under Dr Schmidt, and exploratory laparotomy with repair of viscous perforation and possible bowel resection. Consent for surgery was obtained over the telephone from Mr Edmunds' son, Dean.

53. Dr Schmidt arrived at the hospital at approximately 3.15 am. Dr Schmidt noted in that it was evident to her that if she did not perform immediate emergency surgery, Mr Edmunds would die within hours.

54. At 3.45 am, Dr Das reviewed another patient in the emergency department who had a CT scan which was suggestive of a perforated viscus. Dr Das said that he informed Dr Schmidt of the other patient's state before Mr Edmunds' operation commenced.

55. At 4 am Dr Das recorded, following a discussion with Dean, that Mr Edmunds was not for Cardiopulmonary resuscitation.

56. The Surgical/Procedural Safety Checklist indicates that Mr Edmunds arrived in the operating theatre at 4.00 am. Time Out, which is the time the entire operating theatre team reviews the patient's identity, the procedure, and the surgical site before surgical incision, occurred at 4.15 am hours. The operation report, completed by Dr Schmidt, is silent as to the operation commencement time, so as such this is the best indication as to the time surgery commenced. Sign out occurred at 5.35 am, indicating that the surgical procedure had concluded.

57. The handwritten operation report of Dr Schmidt records that Dr Schmidt was assisted by Dr Das.

58. Dr Schmidt's operation report notes that the bowel was accessed via a midline laparotomy and a quadrant wash was performed on account of faecal contamination of the abdominal cavity. Sigmoid perforation was noted, and it records that a Hartmann's procedure was performed.

59. As previously explained, a Hartmann's procedure is a type of colectomy that removes part of the colon and sometimes rectum (proctosigmoidectomy). The remaining rectum is sealed, creating what is known as Hartmann's pouch. The remaining colon is redirected to a colostomy, forming a stoma.

60. In her first statement of 14 April 2022, Dr Schmidt records that the "distorted anatomy and extensive contamination made the operation difficult". Dr Schmidt goes on to state, "I confirmed with the assistant, Dr Das, what we believed were the distal and proximal ends. Both ends were stapled off with the plan to exteriorise the proximal end forming an end colostomy". Later, she says:

> "during the operation, another patient had presented in extremis to the Emergency Department with an acute abdomen. This patient required urgent surgical attention. After the distal and proximal ends had been identified and stapled and the rectal stump marked, I asked Dr Das to attend to the other patient as there was no one else available."

61. There were two factual disputes arising from this evidence. Firstly, Dr Schmidt says that during the operation, another patient presented in extremis. That other patient is the patient whom Dr Das says he consulted pre-operatively. Dr Schmidt recalls there was an urgent need for Dr Das to absent himself from the surgery, that does not accord with the evidence of Dr Das who believed there was no urgency to leave the surgery and consult with a patient that he had already seen.

62. Secondly, there is a factual issue as to whether Dr Das was involved in identifying the distal and proximal ends of the colon. Dr Das does not give that account in his

statement nor in his oral evidence. While it is a relevant factual issue, it is potentially academic. Dr Schmidt, as the general surgeon, was responsible for ensuring that the correct end of the colon was exteriorised. However, her evidence suggests Dr Das had a part to play in the error, whereas he says he did not, or at least didn't recall being part of the identification process.

63. 'Colostomy LIF' appears in the operation report, indicating a colostomy was placed in the left iliac fossa. A sump drain was placed in the right iliac fossa. Dr Schmidt recorded a post-operative plan of admission to the ICU, nil by mouth, and for Mr Edmunds to continue with IV antibiotics.

64. The identity of the anaesthetist is not recorded on the operation report, but is known to be Dr Thanh Tran. Dr Tran was the on-call anaesthetist during the night of 6 November 2019, and attended the hospital promptly upon being called to attend.

65. Dr Tran recalls in his statement that when he reviewed Mr Edmunds in the emergency department, he had already been intubated. He said that he moved Mr Edmunds immediately to theatre as he was unstable. Upon Mr Edmunds arriving in theatre, Dr Tran began to place lines and administer medication to stabilise Mr Edmunds' condition and allow appropriate anaesthesia for surgery. Post-operatively, Dr Tran remained with Mr Edmunds in ICU until he was satisfied that Mr Edmunds was stable.

66. Dr Schmidt made a surgical error, bringing the upper end of the rectal stump of the colon out as a stoma onto the abdominal wall with the distal end of the colon being oversewn and left inside the abdomen, leading to an iatrogenic bowel obstruction.

67. On 7 November 2019, Mr Edmunds was admitted to ICU as Dr Schmidt had planned and was reviewed by Dr Tran, as I have already discussed.

68. An ICU Registrar, Dr Azizan, reviewed Mr Edmunds in ICU. On examination, Dr Aziz Azizan noted Mr Edmunds was intubated. He had oxygen saturations of 99% with a respiratory rate of 18. His BP was a much improved. He was noted to be sedated with propofol and fentanyl and to have good urine output via an indwelling catheter. His laparotomy wound was noted to be clean, and a drain was in place.

69. At 6.45 am, a nurse noted Mr Edmunds' stoma was, "pink/red, warm" with "nil output". The nurse also noted the absence of bowel sounds.

70. In a subsequent untimed entry, Dr David Clancy, intensivist and Director of Emergency and Intensive Care Services at Albury Wodonga Health, and Dr Kok Hin Lim, a resident, recorded an entry in the clinical records. They noted 'dark output' in respect of the stoma. They commenced total parenteral nutrition because Mr Edmunds was noted to be cachectic. Mr Edmunds was ventilated and sedated, and Dr Clancy observes in his statement that he did not want to extubate immediately given Mr Edmunds' complex comorbidities including end stage lung disease.

71. At 10.50 am, Mr Edmunds was reviewed by the surgical team, led by Dr Ahmed Rahman. Dr Schmidt was not present. Dr Rahman's evidence was that Surgical Ward Rounds were usually registrar led. At the time of the review, Mr Edmunds remained ventilated and intubated.

72. At approximately 6 pm, Mr Edmunds complained to a nurse of abdominal pain. He was commenced on patient-controlled analgesia in the form of fentanyl. The nurse recorded that the stoma was 'dusky' and 'not active'.

73. It is uncontroversial that the stoma was not capable of passing faecal material, perhaps other than what was present in the rectal stump at the time of the surgery, in circumstances where the rectal stump had been exteriorised. It was necessarily incapable of passing faecal material until the revision surgery on 15 November 2019.

74. A nursing entry at 6.35 am on 8 November 2019 records the stoma to be dusky. The surgical drain was noted to have drained 70mLs of old blood.

75. Thereafter, Mr Edmunds was reviewed by Dr Eric Moyle, intensive care physician, and Dr Luke Fox, ICU Registrar. The detailed note of the review was made by Dr Fox at 8.50 am. Shock secondary to abdominal sepsis was noted to be resolving. Mr Edmunds' Glasgow Coma Score was 14. He was alert to person but not alter to time or place, and he was confused. A plan was recorded in respect of Mr Edmunds' future management.

76. A subsequent untimed surgical review, led by Dr Rahman, recorded "ooze" from the stoma, and a plan to continue with the ICU plan.

77. At 11.45 am, a junior medical officer assigned to the surgical team recorded, "Dr Schmidt updated re patient's progress". Dr Schmidt did not personally review Mr Edmunds.

78. There was a further review on 8 November 2019 by Drs Moyle and Fox at 4.05 pm noting Mr Edmunds to be "plucky and disorientated". He was given Clonidine, a medication, for sedation.

79. At 3.00 pm, a nurse noted increasing confusion, together with a dusky stoma, the presence of old blood, and the absence of faecal matter.

80. On 9 November 2019 there was a further ICU review by Drs Moyle and Fox. The entry in the clinical records is untimed, but noted by Dr Moyle to have occurred between 8.40 am and 11.30 am. Drs Moyle and Fox noted an improvement in Mr Edmunds' confusion but observed "minimal output in stoma". In that same entry, there was an indication that there was "nil output".

81. In a nursing entry at 11.30 am, a nurse recorded, “Bowels not open]/stoma = dusky = blood in stoma bag = sluggish bowel sounds”.

82. An untimed review by the surgical registrar followed. It was noted that the stoma was oedematous. A plan including review by the stoma nurse, and leaving the surgical drains in place, was recorded.

83. A nursing entry at 5.20 pm noted that the stoma was dusky with “nil faecal output”. Blood was observed in the stoma bag.

84. On 10 November 2019 at 11.15 am, Mr Edmunds was reviewed by Drs Moyle and Fox. They noted “450 out NG this mane” indicating that the nasogastric tube had output of 450 ml in the morning. The abdomen was noted to be distended and a bedside abdominal ultrasound was performed. Dilated loops in the small bowel were identified, and it was recorded that there had been nil activity in the stoma, including no output. An impression of ileus was recorded.

85. After 10 November 2019, Dr Moyle was not thereafter involved in Mr Edmunds’ care in his capacity as an intensive care physician. He was involved in his role as an Anaesthetist in the Acute Pain Service. Dr Moyle said:

> “On 10 November 2019, Dr Fox and I had the impression that Mr Edmunds was suffering from an ileus. I did not consider this was concerning at 3 days post-operatively”.

86. After the review by Drs Moyle and Fox, Mr Edmunds was reviewed by the surgical team, including Dr Das. The surgical team noted 450 ml output from the nasogastric tube that morning, with 80mLs the day prior. A vomit was also recorded. A plan was recorded to keep the nasogastric tube on free draining, together with four hourly aspiration.

87. At 9.29 pm on 10 November 2019, Dr Azizan reviewed Mr Edmunds. He recorded, “abdo distended, stoma nil output, NG on free drainage – faecal fluid”. In other words, faecal fluid was being drained through the nasogastric tube. This was clarified in the evidence, that the fluid was of the appearance of faecal fluid given the time it had remained in the stomach unable to move through the blocked bowel.

88. In a nursing entry at 6.15 am on 11 November 2019, RN Pettit recorded “stoma not active – 100ml of blood removed from stoma bag, nil [bowel sounds]”.

89. The surgical team, led by Dr Rahman, reviewed Mr Edmunds at 9.30 am. They noted, “abdo soft, non-tender”. In respect of the stoma, they recorded, “blood stained, 100mL. Looks dusky. Bowel sounds not heard”. In respect of “Plan/suggest” they recorded, “D/W Dr Schmidt re ? drain out”. The word ‘ileus’ appears, but it is unclear whether that was the surgical teams’ diagnosis.

90. Subsequently, Professor David Tuxen, intensivist reviewed Mr Edmunds, together with Dr Lim, an ICU resident. Professor Tuxen was the intensive care physician involved in Mr Edmunds' care on 11, 12, 13, 14, and 15 November 2019.

91. The entry on 11 November 2019, made by Dr Lim, noted a diagnosis of ileus. It was recorded that there was nasogastric draining, and an increase volume of drainage. It was recorded that there were no bowel sounds, and minimal blood around the stoma. A plan was recorded which included chest x-ray which was performed and reported to be normal.

92. Returning to the chronology of events, at 1.35 pm a junior medical officer with the general surgery team recorded, "Dr Schmidt updated re pt progress". An updated plan was recorded which provided "(1) drain out, (2) continue sips clear fluid for comfort."

93. In an untimed entry recorded early in the morning of 12 November 2019, Dr Foxcroft, an ICU Registrar, recorded the presence of occasional bowel sounds. The abdomen was noted to be distended but soft. Mild diffuse tenderness was also identified. An impression of "ongoing ileus" was recorded.

94. Later that morning in a nursing entry recorded at 3.30 am RN Milroy, noted Mr Edmunds to have blood pressure of 160/100. He was administered Metoprolol to manage his blood pressure. His oxygen saturation was 91% despite receiving supplemental oxygen via nasal prongs. His stoma was noted to be dark pink in colour and inactive. Blood clots were identified in his stoma bag. Sparse bowel sounds were noted in the left upper quadrant. The nasogastric tube was noted to have drained 130mLs of "dark green offensive fluid".

95. In an untimed review led by Dr Rahman, Mr Edmunds was noted to have blood pressure of 143/103. The plan is recorded as "continue nasogastric free draining".

96. At 9.00 am on 12 November 2019, Mr Edmunds was reviewed again by the ICU team, led by Professor Tuxen. They noted that Mr Edmunds was day five post operative. They recorded "ileus (no improvement)". They noted nasogastric output the day prior of 840mLs. It was noted that Mr Edmunds' oxygen saturations were at 94% despite supplemental oxygen via nasal prongs. Mr Edmunds was noted to have a respiratory rate of 18. In respect of the stoma and abdomen, it was noted "soft. Mild tenderness. Still no [bowel sounds]." A plan was recorded of "ward ready" and "chest x-ray".

97. Professor Tuxen notes that he was, "concerned by the lack of resumption of bowel activity and high NGT output and that there was something not right in the abdomen, possibly an anastomosis leak, an abscess, or some bowel obstruction". He records that he raised his concerns with Dr Rahman after the morning surgical rounds, and that Dr Rahman stated he would relay Professor Tuxen's concerns to Dr Schmidt.

98. In a nursing entry at 4.45 pm, Mr Edmunds' oxygen saturations were noted to have dropped to 90%. His blood pressure was 160/80 despite Metoprolol. The stoma was noted to be "dusky in colour – still not active". Faint bowel sounds were noted to be present.

99. In an ICU review at 5:00 pm, Professor Tuxen and Dr Lim reviewed Mr Edmunds again. It was noted that his bowels were "not opened". "No flatus" was recorded, and nasogastric output of about 30mLs over the preceding six hours was noted. The plan was to continue current management.

100. The first review on 13 November 2019 was by Dr Malcolm Foxcroft, ICU Registrar. In respect of the abdomen, Dr Foxcroft recorded, "soft. Diffusely tender. No bowel sounds". Dr Foxcroft appears to record an impression of ISQ, meaning in status quo, The plan was to continue current management.

101. In an untimed entry on 13 November 2019, but presumably during the morning surgical rounds, Mr Edmunds was reviewed by Dr Schmidt. This appears to be the first time Dr Schmidt personally reviewed Mr Edmunds after the operation, although Dr Schmidt asserted in her statement that, "I reviewed the patient with the surgical team daily and was kept up to date about the patient's progress". This was not the case.

102. The entry on 13 November 2019 records "ileus" and "bowel sounds present this morning". It appears that the nasogastric tube was noted to have drained 840 ml of liquid. The stoma was noted to be oedematous, and there was a query in respect of whether the was an obstruction. To that end, the entry records, "? Obstructed".

103. Despite that query of obstruction, the plan did not provide for imaging. The plan provided that Mr Edmunds was to mobilise, which he had been doing with the assistance of physiotherapy, and continue on a clear fluid diet as tolerated. It also provided that sugar be applied to the stoma site to "aid oedema" and a plan to spigot (i.e. close) the nasogastric tube the following day was recorded.

104. After the surgical review, Mr Edmunds was reviewed by the Acute Pain Service, including Dr Moyle, at 8.40 am. He was noted to have received Fentanyl overnight via his PCA machine. His pain was noted to be 8/10 on movement/coughing, and 5/10 while at rest. Additional fentanyl, beyond PCA fentanyl, was prescribed.

105. The next entry on 13 November 2019 is the ICU ward round led by Professor Tuxen. All that is recorded in respect of that round is the date, the names 'Tuxen' and 'Lim', and the time. Dr Lim, in his statement said:

> "I can see that there is an incomplete entry…... I think this should have been the 13 November 2019 morning ward round and it appears that it was not documented. This was an error. I cannot now recall this ward round but based

on my experience of ward rounds being done twice a day if the patient was in the ICU, I think it is likely there was a ward round on the morning of 13 November 2019, but no record of the round was made in the progress notes."

106. Professor Tuxen, in his supplementary statement, observes:

> "On 13 November 2019 (6 days post-surgery), I reviewed Mr Edmunds during the morning round. I noted that Dr Schmidt had reviewed Mr Edmunds in ICU, while I was reviewing another ICU patient at the time and Dr Schmidt left the ICU without speaking with me.
>
> Mr Edmunds did not appear significantly unwell. He was afebrile, his heart rate (93) and blood pressure (155/100) were stable. His oxygenation (SaO2 99%) was improved on low level oxygen support. He again had bowel sounds. His abdomen was described as "soft, diffusely tender" and later, "mildly uncomfortable".
>
> As Mr Edmunds was failing to progress and continued to have no stomal output and increased gastric aspiration output, I raised with Dr Rahman, surgical registrar, my concern that Mr Edmunds may have a bowel obstruction or other intraabdominal complication and that this needed more consideration by the surgical team, and that a CT may have been required. In response, Dr Rahman advised me that he would pass on my thoughts to Dr Schmidt, but that the surgical team were not concerned and the plan was to continue the current surgical plan of a "wait and watch" approach."

107. Professor Tuxen's telephone records appear to demonstrate that he made a telephone call to Dr Schmidt on the morning of 13 November 2019. He initially incorrectly identified that call as having been made on 12 November 2019. Dr Schmidt in her supplementary statement states, "I do not recall being contacted by Professor David Tuxen regarding Mr Edmunds".

108. A nursing entry by RN Pettit notes sugar was applied to the stoma. The stoma was noted to appear inflamed and dusky. It remained inactive.

109. An ICU review at 5.00 pm by Drs Tuxen and Lim noted the diagnosis of ileus. Mr Edmunds' abdomen was said to be "mildly uncomfortable". He was noted to have an increased aspiration output of 600mLs. His abdomen was noted to be distended with sluggish bowel sounds. A plan for abdominal supine x-ray was recorded. Despite the plan for abdominal x-ray, imaging was not performed on 13 or 14 November 2019.

110. At 11.00 pm, Mr Edmunds was reviewed by Dr Foxcroft, ICU registrar. Dr Foxcroft noted the diagnosis of ileus. It was recorded that Mr Edmunds was not tolerating feeds

even at a low rate, and his bowels had not opened. Dr Foxcroft recorded an impression of "ongoing ileus".

111. On 14 November 2019, Mr Edmunds was reviewed by the Acute Pain Service of 6.55 am. He was noted to have received 1320 micrograms of Fentanyl in the previous 24 hours. That was a substantial increase in Fentanyl bearing in mind that the day prior it was 840mLs, and the day prior to that was 280 micrograms.

112. A registered nurse recorded a nursing entry at 6.35 am on 14 November 2019. It was noted that Mr Edmunds had total nasogastric output the day prior of 1150 mls. The stoma was noted to be inactive.

113. A surgical team review, led by Dr Rahman, appears next in the progress notes. The diagnosis of ileus is recorded. Although it is difficult to decipher, there appears to be an indication that a finger can be passed through the stoma. The plan was recorded as "(1) plan as per ICU with thanks. (2) NG free drain. (3) Sips of clear fluid".

114. At 8.40 am, a retrospective note by the ICU team, led by Professor Tuxen, appears in the records. Slow progress and prolonged ileus was recorded. So too was failed enteral feeding. The abdomen was noted to be distended but improved since the day prior. The stoma was noted to be oedematous. A plan of prokinetics was adopted, together with an instruction to continue current management. The plan recorded the day prior for abdominal x-ray was not followed.

115. A nursing entry at 6 pm on 14 November 2019 noted that Mr Edmunds was experiencing increasing pain. His abdomen was noted to be tight, distended and tender. He was said to have no bowel sounds. The stoma was noted to be protruding, and it was recorded that the surgical team was aware of same.

116. At 9.35 pm Dr Foxcroft reviewed Mr Edmunds. He noted the, "prolonged post-op ileus". He recorded an impression of ongoing ileus and provided a plan to continue prokinetics and "(2) ? step down to surg ward".

117. The surgical team reviewed Mr Edmunds in the morning and noted his abdomen to be soft and mildly distended. The stoma was noted to be, "dusky since OT. Nil necrosis. No output". The nasogastric tube was noted to have 400mLs of output. A plan of nasogastric tube free draining, clear fluids, and "per ICU with thanks" was recorded.

118. At 8.28 pm Mr Edmunds was reviewed by the Acute Pain Service comprising Drs Moyle, Aung, and Clancy.

119. The Acute Pain Service entry is a detailed one and appears to identify Mr Edmunds' significant and prolonged pain relief requirements. The prolonged nature of the post-op ileus is also recorded, as is a rating of 6/10 on the visual analog scale for pain.

Methylnaltrexone was recommended to improve bowel motility. Ketamine was recommended if pain continued to increase.

120. Dr Maddison Bullock, surgical junior medical officer, made an entry in the progress notes at 9.00 am Dr Bullock noted that Dr Schmidt had been updated on Mr Edmunds' progress. A suggestion, although not a plan, of lactulose 15mL was recorded.

121. At 9.45 am Dr Bullock recorded a further entry. Dr Bullock noted, "Dr Schmidt has discussed pt with Mr John. Mr John suggests (1) NBM (2) CT abdo with IV + PO contrast". "Mr John" is Dr Ajay John, general surgeon.

122. Dr John was not, however, first contacted about Mr Edmunds by Dr Schmidt. Professor Tuxen states in his statement of 8 April 2022:

> "Either on the evening of 14 November 2019 or early morning of 15 November 2019, I contacted Mr Ajay John, General Surgeon, who was on-call at that time, provided him with a summary of Mr Edmunds' admission and progression and asked him to review Mr Edmunds. It is unusual to contact a Surgeon (who is not the patient's main surgeon) and to do so was an indication of my level of concern."

123. Dr John's recollection is that he received a call from Professor Tuxen in the morning of 15 November 2019. He states:

> "My recollection is that early in the morning on Friday 15 November 2019 I received a call from Professor David Tuxen, Intensive Care Physician about John Edmunds who was at the time under the care of Dr Schmidt, VMO Consultant Surgeon. Prof Tuxen was concerned about the patient's lack of progress after a Hartmann's procedure and wanted a second opinion. Mr Edmunds had failed to progress but more importantly had worsening abdominal distension, an increasing NG output and nil stoma output - not even gas. I was advised that over the past week, the failure to progress had been attributed to an ileus. I advised Prof Tuxen that I would commence my surgical list but would come to see Mr Edmunds between patients."

124. Dr John recalls that he thereafter received a telephone call from Dr Schmidt, and Dr Schmidt requested a second opinion in respect of Mr Edmunds.

125. In an ICU review by Professor Tuxen and Dr Fox at 10.10 am Mr Edmunds' stoma was noted to be "pink, non-functioning". His abdomen was noted to be distended. His pain was noted to be "disproportionate to post-op timeframe". Consistently with Dr John's recommendation, the ICU team noted the plan for CT Abdomen.

126. A stoma nurse reviewed Mr Edmunds at 12.20 pm. The abdomen was noted to be "very tight and distended". The stoma was noted to be "under some tension". It

appears necrotic disease was suspected. Stomal output was noted to be minimal and limited to "old blood only".

127. Mr Edmunds was in a great deal of pain and was very gravely unwell when he was informed of Dean's sudden death. Mr Edmunds was thereafter provided with support by the social work team but was understandably devastated.

128. CT Abdomen and Pelvis with IV contrast was reported on by Dr Patterson, registrar, at 1.56 pm. Her report concluded that there was no evidence of high-grade bowel obstruction. She considered that the findings were in keeping with an "incomplete obstruction / ileus."

129. Dr Paterson's report was incorrect. There is no criticism of that fact. So irregular was the CT Abdomen and Pelvis that one expects it would have been difficult for a radiologist, let alone a radiology registrar, to make sense of the imaging.

130. Dr John did not agree with the report, and went and spoke with the radiologist. In his statement he states that he went to the radiology department to review the films with the radiologist and Professor Tuxen. Looking at the films and tracing the left colon, he considered that it appeared to end in the pelvis with staples. The stomal loop could not be traced well on the CT as it was collapsed and surrounded by dilated loops, but did not seem to be connected to the left colon.

131. Dr John returned to see the patient again. He noted that the stoma had not been working and that it was, he records, day 7 post-surgery. It was in fact day 8. Dr John hypothesised that the wrong end of the stoma may have been brought out. To test the hypothesis, he put a quantity of blue dye down the stoma and subsequently conducted a rectal examination which confirmed blue dye in Mr Edmunds' rectum.

132. He thereafter arranged for a contrast x-ray to be undertaken, which demonstrated that the dye which was put in the stoma went down to the rectum instead of up toward the stomach. He records in his statement that it was a complication he had seen previously.

133. A nursing entry at 3.40 pm appears to reflect the considerable deterioration in Mr Edmunds' condition. It was noted he became tachycardic with a heart rate of 120bpm. He was hypertensive at 170/105. His oxygen saturations fell to 85% and he reported feeling unable to breathe. He had a respiratory rate of 25 breaths per minute. He required high flow supplemental oxygen via nasal prongs and considerable reassurance. He reported feeling exhausted. His abdomen was noted to be distended and tight, particularly around the stoma. The stoma was noted to be oedematous, non-productive, and dusky. He had no bowel sounds.

134. An open disclosure process thereafter ostensibly took place with Mr Edmunds and subsequently with Wade by telephone. There was an issue in respect of the adequacy

of Dr Schmidt's open disclosure, and whether Dr Schmidt explained the surgical error in a manner which was comprehensible to Mr Edmunds and Wade, and sufficiently transparent in respect of the error. That will be discussed below.

135. Consent was obtained from Mr Edmunds for the performance of a transverse loop colostomy. Dr Ajay John noted in the records that it was, "planned as a rescue procedure".

136. Dr John records in his statement:

> "I considered performing a transverse loop colostomy as a defunctioning measure (and deferring reconstruction) reasonable as I felt that it would be the most efficient way to fix the issue, carried the least surgical and recovery risk to Mr Edmunds and would provide Mr Edmunds with the opportunity of a better and quicker healing and recovery."

137. The operation report for 15 November 2019 records Drs Schmidt and John as the surgeons. Neither is noted to be the assistant. The surgery performed was a diverting loop colostomy through a right transverse incision. By reference to the Surgical/Procedural Safety Checklist, the procedure took no more than 30 minutes.

138. Associate Professor Paul Myers, who provided an expert report, regards the surgery performed as quite reasonable. In forming that opinion, he notes that Mr Edmunds was seriously ill and had finally had the diagnosis made of iatrogenic bowel obstruction. Associate Professor Myers notes that the major surgical imperative was to relieve the obstruction, and that is what the surgical procedure sought to do by the quickest and least interventional means that was surgically possible.

139. Expert evidence demonstrates that by 15 November 2019, Mr Edmunds' condition had deteriorated to such a degree that his death had become more likely than not.

140. In that respect, Associate Professor Myers observes that the primary procedure in Mr Edmunds' case had a 30% risk of mortality. He goes on to observe:

> "thus I think by 15 November 2019 i.e. eight days following his resection, with an iatrogenic bowel obstruction, Mr Edmunds was heading towards death. Whilst I would not necessarily say that it was inevitable, I suspect it was more likely than not".

141. Between 16 and 21 November 2019, although the stoma commenced to function, Mr Edmunds did not progress.

142. CT Abdomen was performed on 21 November 2019 at 4.38 pm, requested by Dr John. The findings on the CT scan demonstrated a gross distal small bowel obstruction

proximal to the stoma. Bowel leading up to the stoma was noted to be markedly collapsed.

143. Thereafter, Dr John returned Mr Edmunds to the operating theatre for the performance of a "re-look laparotomy (damage control) and subtotal colectomy". Dr John was assisted by Dr Muralidhanan, and Dr Luke Baitch was the anaesthetist.

144. The surgery took slightly longer than two hours The procedure was halted on account of an acute deterioration in Mr Edmunds' condition. The deterioration commenced at the conclusion of the colectomy and the decision was made to staple off the enterostomies and return to theatre when Mr Edmunds had stabilised for definitive repair. A vacuum assisted closure dressing was applied.

145. Mr Edmunds was returned to ICU post-operatively intubated and with the VAC dressing on low intensity pressure.

146. Dr John reviewed Mr Edmunds on 22 November 2019. He noted a plan to return Mr Edmunds to theatre the following day for definitive repair and stoma formation if Mr Edmunds was well enough. He was not well enough the following day.

147. It was not until 24 November 2019 that Mr Edmunds was considered fit for return to theatre for definitive repair. Surgery was performed by Dr Michael Kelly, general surgeon, assisted by Dr Ng. The anaesthetist was Dr Baitch. The operation report describes the planned surgery as a "re look laparotomy + small bowel resection + anastomosis + end ileostomy."

148. As planned, the small bowel was resected and anastomosed. The terminal ileum was exteriorised to the previous transverse colostomy stoma site. Saline was used to wash out the ileum prior to the partial closure of the previous transverse colostomy wound. The surgery took approximately two hours. The clinical records indicate the surgery was considered to be a success. Mr Edmunds returned to ICU ventilated and sedated.

149. ICU review on 26 November 2019 appeared to suggest improvement. Mr Edmunds' analgesia and sedation requirements were observed to be "minimal". He required limited ventilation support. The stoma was functioning well.

150. On 27 November 2019 at 9.30 am Mr Edmunds was extubated and sedation was weaned. He sadly woke, however, to discover he had missed Dean's funeral.

151. On 28 November 2019, a nurse observed an "extremely offensive" wound. Purulent and serous discharge was observed around the wound. Wound swabs were taken. Mr Edmunds has a serious infection.

152. Mr Edmunds' condition thereafter deteriorated. A family meeting was held on 29 November 2019, and it was determined that care would shift to palliative. On 2 December 2019 at 5.50 am Mr Edmunds died.

153. According to the autopsy report prepared by Dr Bernard I-Ons, internal examination revealed multiple collections of pus on the right and left side of the abdomen and covering the surface of the liver, spleen and peritoneum which was diffusely necrotic. The bowel was distended and necrotic and the lumen filled with offensive yellow material. Swabs were positive for a bacterium called Enterococcus faecium.

154. Mr Edmunds' chest showed an enlarged heart with changes of chronic ischemia and a small area of recent ischaemic infarction which was three to five days old. There were bilateral pleural adhesions and effusions, the right kidney had a small incidental right renal cell carcinoma, and a thyroid nodule was present.

155. Dr I'Ons found that Mr Edmunds' cause of death was complications of peritonitis and that the surgical management on presentation to Albury Wodonga Health was suboptimal.

156. It does not appear to be disputed there was a significant surgical error on 7 November 2019 by Dr Schmidt.

157. Dr Schmidt, during the performance of Mr Edmunds' first surgery on 7 November 2019, inadvertently brought out as a stoma the upper end of the rectal stump, leading to an iatrogenic – or surgeon caused – mechanical bowel obstruction. That is by connecting the wrong end of the bowel to the opening, she effectively cut off Mr Edmunds' bowel.

158. Associate Professor Myers is highly critical of the surgical error. In his primary report of 4 September 2020, he observes:

> "I cannot envisage any situation that would see the distal end of the descending colon closed off and the upper rectum anastomosed to the anterior abdominal wall as a definitive procedure.
>
> Whilst clearly this had to be inadvertent i.e. it is not possible in isolation that it could have been deliberate, I find it difficult to imagine how a mishap of this magnitude could occur."

159. Associate Professor Alan Meagher, who also provided an expert report, does not dispute that a surgical error occurred, although he considered that such an error can conceivably be made, and in his opinion hypothesised why in this case the error occurred, attributing it to an extremely distorted anatomy, leading Dr Schmidt into error.

160. It similarly was not in dispute that the surgical error contributed to the extent of peritonitis, and thus to Mr Edmunds' death. Whether Mr Edmunds would have died if not for that surgical error due to his comorbidities is a relevant issue.

161. The adequacy of Mr Edmunds' management after 15 November 2019, either by the surgical team or the ICU team was not an issue in this inquest. That is in circumstances where the expert evidence appears to support the view that Mr Edmunds was, by 15 November 2019, unlikely to survive.

162. Further, in relation to the necessity of the surgery, although there was a suggestion that Dr Stuchbery, the surgical director, thought Dr Schmidt ought to have delayed the surgery until later in the morning, that was not his evidence. In his evidence, Dr Stuchbery volunteered that he was surprised by the performance of the surgery by Dr Schmidt, as he observed that a pattern of behaviour by Dr Schmidt had emerged where she handed over some emergency surgeries to the next surgeon on the on-call roster. In respect of Mr Edmunds' surgery, Dr Stuchbery considered, "the operation was completely necessary and needed to be done immediately". He went on to observe that Dr Schmidt, "had done the right thing and a good thing getting up and doing an operation at that hour of the morning." I accept that in order to save his life, Mr Edmunds required that surgery.

163. The expert surgeons similarly supported the performance of the surgery by Dr Schmidt.

164. The inquest did not examine in any significant detail the adequacy of Mr Edmunds' management after 15 November 2019, either by the surgical team or the ICU team.

EVALUATION OF THE EVIDENCE

CONSIDERATION OF THE EVIDENCE RELATING TO CONDUCT IN THE FIRST SURGERY BY DR SCHMIDT

165. Dr Schmidt's evidence was tested. I make the general observation that it was internally inconsistent in oral evidence, it was internally inconsistent between the various statements that she made, it often did not sit with the documentary evidence, and it also was often in contrast to other witnesses' recollection and documentation. It was unreliable, which I explore below in particular detail, but as a result unless corroborated carried little weight as a result.

166. Dr Schmidt's evidence was that during Mr Edmunds' operation, another patient presented to emergency. She says a call came through to theatre. The call was taken by the theatre nurse, and the theatre nurse conveyed a request from the emergency department that a surgeon review a sick patient in emergency.

167. Dr Das' recollection was that he reviewed the relevant patient in emergency prior to the commencement of Mr Edmunds' surgery. He conducted a brief review of the patient in emergency before attending to theatre for the purpose of Mr Edmunds' surgery. He recalled their presentation was "essentially the same" as Mr Edmunds. He recalls they were unstable and had a perforated viscus. He had a recollection of very briefly discussing that patient with Dr Schmidt pre-operatively. He recalls that the limit of his discussion in respect of that other patient was to inform Dr Schmidt that there was another general surgical patient in emergency.

168. I accepted Dr Das' positive memory of consulting the patient in ED prior to Mr Edmunds' surgery. In Dr Das' view he did not need to leave the surgery to attend to that patient.

169. Both experts, Associate Professor Myers, and Associate Professor Meagher, considered that it was reasonable for the surgery to be completed by Dr Schmidt with the assistance of the scrub nurse without Dr Das in the circumstances as she explained them, that is that an emergency consult arose while they were both in surgery. While the presence of a doctor assisting might have increased the prospects of Dr Schmidt's surgical error being identified, that is perhaps only with the benefit of hindsight. It remains another unusual feature of this case, however, that Dr Das was in his view unnecessarily excluded from the surgery. I was satisfied on Dr Das' account that he was unsure why it was necessary for him to reconsult with the patient at that point.

170. Dr Schmidt's evidence was that he did not leave until after she identified and confirmed with Dr Das what she believed to be the distal and proximal ends. Dr Das does not recall that, but he fairly accepted that did not mean that it did not happen. It is unclear when Dr Das left the surgery based on the evidence, and as stated previously, the reasonableness of his conduct is not in question. He was a surgical registrar, and he was the assistant surgeon. It was not his responsibility to identify the distal and proximal ends. Dr Schmidt accepts that it was her responsibility. Dr Schmidt kept poor surgical records of the surgery, so much of what occurred in the surgery was not contemporaneously noted.

171. The evidence of Associate Professor Myers was to the effect that if a genuine attempt had been made to identify and mark the rectal stump after the distal end was resected, it would have been correctly identified. When he was asked whether a general surgeon ought to have been capable of identifying one end from the other notwithstanding distorted anatomy, he was clear in his evidence that they ought to be able. When he was asked whether he can reconcile the failure to exteriorise the correct end with the suggestion that the rectal stump was marked, he indicated he could not. Submissions were made on behalf of Dr Schmidt that she may well have marked the stump, but the wrong end being marked was then exteriorised.

172. Dr Schmidt asserts that Mr Edmunds' distorted anatomy and extensive faecal contamination made the operation difficult. She was unable to offer an explanation as to how an error of such magnitude could occur. She said, "I'm still reflecting, over

the last three and a half years, why it has happened.", she said, "it is very regretful that the error was made and I don't know how it would have happened". Dr Schmidt did agree that a reasonably skilled general surgeon ought to be able to exteriorise the correct end of the colon, although nevertheless insisted that she took reasonable precautions to avoid the error she made.

EXPERT EVIDENCE AND EVIDENCE FROM OTHERS ON THE ERROR

173. Associate Professor Myer's opinion was that distorted anatomy is inevitable in a patient with diverticular disease. He does not believe distorted anatomy is an explanation for failing to identify the correct end of the colon. He observed in his supplementary report that recurrent diverticular disease leads to thickening and shortening of the affected bowel, however, went on to observe, that the anatomy is not so distorted that one cannot resect the affected part of the bowel.

174. Associate Professor Myers was not familiar with the operation report by Dr John that depicted a diagram that Associate Professor Meagher relied upon as evidence that the bowel of Mr Edmunds was very unusual in presentation. Associate Professor Meagher also noted that Dr John from the CT review was able to see an extremely elongated bowel. His opinion was therefore with an urgently ill patient, with an extremely distorted bowel, unusually elongated and looping around with the presence of extensive faecal material requiring a 5 litre wash out, that it was understandable in some circumstances that this error was made. Associate Professor Meagher did not see the CT scan himself. He drew from the comments made by Dr John and the picture drawn by Dr John and the fact that the error was even possible to make to hypothesise how this occurred.

175. On this issue, Associate Professor Meagher's written opinion was to the effect that the anatomy was so distorted that a "really experienced colorectal surgeon … probably would have realised the anatomy was abnormal or would have recognised that it just wasn't quite the normal pattern", and accordingly would have avoided the error. He appeared to posit that in Dr Schmidt's circumstances, not having a subspeciality in colorectal surgery, the error which occurred was readily conceivable. This evidence was somewhat confusing. The bowel was said to be so very distorted that it was obviously differing from the usual, yet on the other hand, he said that in effect only a really experienced colorectal surgeon would have realised. I accept on the evidence of Dr John and of Associate Professor Meagher that there were some very unusual features that presented in Mr Edmunds case. However, I do not accept on the evidence before me that a general surgeon should not have been alive to the obvious distortion of the bowel, and therefore put on notice that extra attention and care needed to be taken in the procedure.

176. Associate Professor Meagher on the last day of evidence expressed an opinion that his hypothesis based on Dr John's evidence of the CT scan and surgical drawing of Mr Edmunds bowel that this highly unusual anatomy could explain a mistake of this magnitude being made. It would not, he opined be made by an experienced colorectal

surgeon, but he could accept that a general surgeon who did not have enough experience of this type of operation may have not realised. Associate Professor Meagher did not look at the CT scan himself and based his view on the evidence of Dr John.

177. This issue was not made clear as being a major hypothesis during the inquest. It was not explored with Dr John in any real detail. He managed to conduct further surgery and did not make complaint about Mr Edmunds anatomy preventing him from doing so. It was not explored with Dr Stuchbery or the other general surgeon who gave evidence. There were complications in the AVL of the evidence of Associate Professor Myers, and he could not see the diagram when it was attempted to be shown to him over the screen.

178. Dr Schmidt said that she was experienced, and through her statements gave evidence that she had performed 424 elective and emergency major abdominal surgeries, which included 88 laparotomies for trauma/sepsis/bleeding/obstruction, 18 right hemicolectomies, 5 anterior resections, 1 abdominal perineal resection, 1 total colectomy and 1 Hartmann's procedure.

179. Further, Professor Glenn Guest, a general surgeon with interests in colorectal and minimally invasive surgery has provided an opinion in respect of this issue. Professor Guest conducted an external review for Albury Wodonga Health. In his report he observed:

> "A single error by a surgeon does not in itself indicate a lack of competence and this particular error has been reported by experienced surgeons elsewhere, however it is relatively uncommon and generally thought to be preventable with sufficient experience of the primary surgeon."

180. Dr Stuchbery, the director of surgery and a general surgeon himself, gave evidence when asked if it was a complication that he had seen previously. He replied, "It's not a complication. It's a mistake." Dr Stuchbery gave the following evidence

> "Q. In your experience as the Director of Surgery at Albury Wodonga Health, is it a mistake which can be avoided by the application of due care and skill?
>
> A. Yes.
>
> Q. It's not a mistake that is sometimes inevitable or inherent in the performance of Hartmann's procedure in a person with distorted anatomy?
>
> A. No, when you perform a Hartmann's procedure, the anatomy is always distorted by the pathology. However, if the operation is conducted correctly, it is a mistake that should not and would not happen."

181. Dr Ajay John equally found it difficult to understand how an error of this type can occur.

182. Dr Schmidt had performed a Hartmann's procedure only once in the five years prior to Mr Edmunds' surgery, but when Dr Stuchbery was asked about whether it was of concern to him that Dr Schmidt was called upon to perform the Hartmann's procedure in those circumstances, his response, in part, was as follows:

> "… a Hartmann's procedure is a routine general surgical operation which all surgical trainees are taught to do and ought to be able to carry out competently once they are consultant surgeons. It's true that doing an operation more frequently … increases one's skills and efficiency, but, to be honest with you, doing a Hartmann's procedure is a bit like riding a bike. It's … a routine operation, once learnt, ought to be able to be carried out competently by a general surgeon."

183. Associate Professor Myers observed in his report first report of 4 September 2020 that he found it difficult to comprehend how the error occurred:

> "I cannot envisage any situation that would see the distal end of the descending colon closed off and the upper rectum anastomosed to the anterior abdominal wall as a definitive procedure.
>
> Whilst clearly this had to be inadvertent i.e. it is not possible in isolation that it could have been deliberate, I find it difficult to imagine how a mishap of this magnitude could occur."

184. After hearing the evidence on this issue I prefer the evidence of Associate Professor Myers, Professor Guest, Dr Stuchbery and Dr John that this was an avoidable error, even in the case of a significantly distorted bowel, over that of Associate Professor Meagher. It is not a sufficient answer to attribute this error to Dr Schmidt's lack of colorectal surgery experience. While that contributed, the very reliable and direct evidence of Dr Stuchbery was that as a general surgeon the Hartmann's procedure is like riding a bicycle, and that once learnt, a consultant general surgeon ought to be able to perform it competently. Additionally, it is no excuse, to blame distorted anatomy. Distorted anatomy is on the expert evidence inevitable in a Hartmann's procedure, and it ought to have been anticipated. Further, Dr Schmidt should have been alerted by the unusual anatomy in this case, but taken the proper care and attention to ensure she was carefully undertaking the surgery while faced with that challenge. Dr Schmidt's own admission is that she cannot explain how she made this error.

185. Associate Professor Meagher understandably considered the matter as an expert colorectal surgeon, and gave an opinion of what he considered a general surgeon's limitations might be in this area if not regularly undertaking this surgery. This view was not shared by all other general surgeons giving evidence in the proceedings, even

Dr Schmidt seemed to recognise this. The experts did not necessarily agree the procedure was like "riding a bike" and although this evidence by Dr Stuchbery may be thought to downplay the complicated nature of this surgery, I did not consider his evidence in total to be doing so.

186. The effect of his evidence was that at Albury Wodonga Health he would expect the hospital conducted around two of these surgeries each week. He stressed the need to take the operation thoroughly and carefully. It was his view that given the type of surgery and presence of bowel and associated fluids and bodily material resulting in very messy conditions more surgical assistance may be required. He stressed the importance of having a good view, adequate abdominal retraction, and exposure, which is achieved by a combination of mechanical implements but more importantly surgical assistance. He suggested the need, in some cases, for several assistants, however it is for the surgeon to make that decision. In no way did he downplay the difficulty of the conditions of the surgery.

187. The nature of his evidence was that to practice as a general surgeon one would expect this type of surgery to be necessary to be done at any time, in an emergency setting and that the skills to do so were essential.

POST OPERATIVE TREATMENT BY DR SCHMIDT

188. Dr Schmidt's management of Mr Edmunds post-operatively did reflect a concerning degree of disinterest and detachment in her patient. Her practice was not consistent with any other senior doctor or expert who gave evidence in the inquest.

189. Professor Tuxen was getting worried by 12 November 2019. He was raising his concerns with the surgical team but being told through Dr Rahman that the surgeon was not worried. They were of the view it was an ileus and would resolve, and that 'watch and wait' was appropriate.

190. In an untimed entry on 13 November 2019, Mr Edmunds was finally reviewed personally by Dr Schmidt, and this was the first and only time she saw him post surgery and prior to the identification of the error. She did not hand over to any other colleague to ensure he was seen by a colleague if she was unable to attend to him herself. There was a lacuna in the evidence as to any reasonable explanation for her lack of attention to Mr Edmunds post operatively. The fact that Dr Schmidt did not review Mr Edmunds until 13 November, which was day six post-operatively, reflects the level of involvement that Dr Schmidt had with her patient. On her own account Mr Edmunds was a high risk patient, who was gravely ill and why she didn't review him herself remains unexplained.

191. It is necessary to consider the evidence given to the inquest by Dr Schmidt on this matter. In her statement of 14 April 2022 she stated, "I reviewed the patient with the

surgical team daily and was kept up to date about the patient's progress". She did not review the patient daily.

192. During the process of self reporting about the error on 11 December 2019, Dr Schmidt stated, "I saw the patient every second day". She did not see the patient every second day.

193. Dr Schmidt accepts that she misled Dr Davies, but denied that was her intention. During examination-in-chief, Dr Schmidt accepted that in December 2019 she had a "pretty clear recollection" of Mr Edmunds. She accepted that it is not often her patients die. She accepted that it is not often her patients die following a surgical complication caused by her. This was a significant event in her professional life, and she asserted that she has "a clear recollection from the 7th to the 15th". Dr Schmidt did not give careful and correct evidence in those statements in relation to the frequency that she visited Mr Edmunds. The expert engaged on her behalf was also given incorrect information upon which to base his report in that regard.

194. As submitted, and I accept, Mr Edmunds was a critically unwell man admitted to hospital under Dr Schmidt's care, and Dr Schmidt believed, according to her statement of 2 December 2022, that Mr Edmunds had a 50% risk of mortality heading into the first procedure and that post-operatively, his prognosis was "extremely guarded". In those circumstances, it was not appropriate for Dr Schmidt to leave it to the surgical registrars to review Mr Edmunds.

195. The expert evidence from the surgeons is to the effect that Mr Edmunds required daily review by the consultant.

196. Similarly, Dr John gave the following evidence, "if there is a critically unwell patient, I'll try and make time at some stage every day to go and see that patient."

197. The failure to review Mr Edmunds' daily, or even every second day was a lost opportunity for Dr Schmidt to intervene. Certainly, she would have been acutely aware of Professor Tuxen's belief that there may be abdominal complications, and his view that a CT scan was indicated. It would also have allowed better communication with intensive care who were part of the multidisciplinary team caring for Mr Edmunds.

198. Dr Schmidt accepted that the lack of stomal output, increasing nasogastric tube output, increasing requirement for fentanyl, and the presence of abdominal distension, was enough that she ought to have at least considered ordering a CT scan prior to 15 November 2019. She accepted that each of those matters are signs and symptoms of prolonged post-operative ileus, but also mechanical bowel obstruction, and that in those circumstances, prolonged post-operative ileus being a diagnosis of exclusion, she needed to exclude bowel obstruction. She was unaware of the increasing need for pain relief and nasogastric output because she neglected to visit him herself, or even make the enquiry of her surgical team about these important

facts. Associate Professor Meagher was not troubled by these results, however he agreed she ought to, at the least, have been aware of these factors.

199. Dr Schmidt had found the surgery difficult on her own account, she says that she was inexperienced in this surgery, and had not performed it for 5 years. These are further reasons why she ought to have accepted the suggestion to have an early CT scan to exclude any other factor to explain Mr Edmunds' failure to improve.

200. After Dr Schmidt's review of Mr Edmunds on 13 November 2019, she did not see him again until the surgical error was diagnosed. She did not speak to Professor Tuxen, return his telephone calls, nor order any radiological imaging. That she did not take the time to speak directly with Professor Tuxen while she was in ICU is an issue that also remains unexplained. On her account she didn't even know that Professor Tuxen was the treating ICU physician as at 13 November 2019.

201. It was the evidence of Dr Schmidt that she did speak to Dr Moyle about Mr Edmunds. This account was first raised in oral evidence by Dr Schmidt and could not be explored with Dr Moyle who had already given evidence. I do not have the benefit of Dr Moyle's recollection. Dr Schmidt said that she believed Dr Moyle to be the intensive care physician managing Mr Edmunds on 13 November 2019. Dr Moyle was conducting an Acute Pain Service round on 13 November 2019 and was not otherwise working in ICU.

202. When Dr Schmidt was asked why she did not speak to Professor Tuxen about Mr Edmunds' progress on 13 November 2019, she answered as follows:

> "A. I spoke to Dr Eric Moyle, in my recollection as … I was, … leaving the ICU, I did an early round, he was, …, coming to do his pain round. I didn't realise at the time that he was not the ICU consultant,…, on. I only realised that this morning when I heard … Professor Tuxen said he was the consultant on. So I thought on the 13th that Dr Eric Moyle was the ICU consultant.
>
> Q. What did Dr Moyle tell you when you spoke to him on 13 November 2019?
>
> A. We talked about progress and…h—
>
> Q. Doctor, wouldn't Dr Moyle have said to you, "I don't know what his progress is like. I've only seen him for the purposes of an acute pain service round"?
>
> A. Ah, no, I had reassurance on the day from Dr Moyle that the patient was doing okay. That was my recollection."

203. Her account therefore was that until the 5th day of inquest she remained unaware that Professor Tuxen was Mr Edmunds' ICU treating doctor on 13 November 2019. To accept this evidence would mean that every conversation a Registrar had with her had

never mentioned Professor Tuxen, that she reviewed his chart once and did not recognise who was his ICU doctor. Professor Tuxen, I accept, left a message for her that she did not return. Professor Tuxen did speak to her when a decision was made by him to seek a second opinion from Dr John. The evidence that she gave on this point was concerningly unreliable, and another example of where Dr Schmidt was not being careful in the evidence that she was giving.

204. Dr Moyle was a very impressive and reliable witness, and he was not given the chance to comment on this evidence. If Dr Schmidt assumed this fact, it is further evidence of the lack of care and attention she was providing to Mr Edmunds.

205. Dr Schmidt's own evidence that, "when I do have patients in the Critical Care Unit I'm very reliant on the ICU consultants, who are very experienced", sat uncomfortably with her account that this was only her second patient in ICU, and the fact that she had made no direct contact with Professor Tuxen until the 15th.

206. Dr Schmidt did give evidence that she was consulting with surgeons in her private rooms about Mr Edmunds. Dr Schmidt gave evidence that she consulted a number of surgeons within her private rooms about Mr Edmunds, one of whom was a very well regarded general surgeon with a subspeciality in upper gastrointestinal surgery. She said, "he has extensive experience in abdominal surgery" and "we defer to him".

207. Dr Schmidt was questioned about this:

> "Q. It's of almost no utility at all, is it, to speak to a surgeon in general terms about a patient if you can't provide to that surgeon details about how the patient is actually progressing.
>
> A. I was providing him with details that he asked.
>
> Q. Did you provide him with nasogastric tube output?
>
> A. I don't recall specifically.
>
> Q. It's very difficult to get any kind of sensible advice from another surgeon, would you agree, unless you can present to them the information they need in order to make a diagnosis?
>
> A. Yes."

208. It is hard to see how any other surgeon that Dr Schmidt may have consulted could have assisted her in a situation where Dr Schmidt herself was not across all of the details of Mr Edmunds' condition, including his nasogastric tube output, nor his increasing requirement for pain relief.

WHEN SHOULD THE CT SCAN HAVE BEEN ORDERED?

209. When a review was conducted by Professor Tuxen Mr Edmunds's abdomen was said to be "mildly uncomfortable". He was noted to have an increased aspiration output of 600mLs. His abdomen was noted to be distended with sluggish bowel sounds. A plan for abdominal supine x-ray was recorded. In oral evidence, Professor Tuxen gave the following answer as to why he recorded a plan for abdominal x-ray:

> "If, usually in discussion with the Surgical Team we would seek agreement to get a CT scan. I had raised a CT scan but there was no support for that. I thought, gee, we might as well, we can get a chest X-ray. That doesn't involve contrast. It doesn't involve transport. That's an easy simple thing we can do. But as I thought about that, that was my thought on the ward round. As I considered that afterwards, that would be not very helpful at all. It wouldn't help to discriminate accurately between a bowel obstruction and a paralytic ileus so I, I didn't pursue that the next day."

210. Professor Tuxen's basis for the decision to dispense with the planned abdominal x-ray was not, in the opinion of the Professor Ian Seppelt and Associate Professor George Skowronski, unreasonable.

211. Both expert intensivists agreed that a CT scan ought to have been performed on 13 November 2019. Again, however, they were not critical of Professor Tuxen for the absence of that scan.

212. Dr Ajay John said that he would have ordered a CT scan by day four or five being 11 or 12 November 2019. He explained that the features which would prompt such a scan include increasing nasogastric tube, present from the 10th, and an increasing abdominal distension.

213. Associate Professor Myers considers that by 13 November 2019, Dr Schmidt ought to have ordered imaging to exclude bowel obstruction.

214. Dr Schmidt's agreed with that proposition in her oral evidence as follows:

> "Q. Do you say it [CT] should have been ordered on 13 November?
>
> A. In hindsight, I would. But at the time, I didn't.
>
> Q. Even putting aside hindsight, having regard to the absence of stomal output, the increasing nasogastric tube output, the increasing requirement for fentanyl, the presence of abdominal distension, that was enough, was it not, to cause you to order a CT scan?

> A. Yeah, when you put it like this, they are all signs and symptoms of a prolonged postoperative ileus as well as a mechanical bowel obstruction, so I should have considered earlier than the 15th to order a CT scan in hindsight."

215. Professor Glenn Guest. in respect of the delay in investigation, said the following:

> "A period of conservative management is appropriate whilst being vigilant of any signs suggesting further problems e.g. sepsis or mechanical bowel obstruction. The eight day period before instigating further investigation is surprisingly longer than I expected and in my experience, requests for further investigations would be initiated either by the ICU team or the surgical team based on the duration of the post-operative ileus and the clinical reviews and blood tests."

216. Later in his report, Professor Guest observes:

> "Day 6 post operatively (13/11/2019) there is documentation of abdominal distension, increased pain and increased nasogastric output. A suggestion of an obstruction was made after clinical reviews by both the surgical and ICU team. This may have been an opportunity to further investigate and in my opinion a CT scan would usually be considered at this time."

217. Associate Professor Alan Meagher, the expert engaged by Dr Schmidt, does not consider that imaging to exclude bowel obstruction was required as at 13 November 2019. Associate Professor Meagher's written opinion was that in the absence of "a strong reason to suspect significant intra-abdominal pathology such as an anastomotic leak or a bleed" a CT would not be ordered until day 7 or 8. He observed, "Dr Schmidt's post-operative monitoring and management of the patient from 7 to 15 November 2019 was reasonable and in keeping with peer professional standards". He made that observation on the false belief and instructions that she had in fact been visiting the patient at least every second day. He agreed in evidence that she should have been attending to the patient personally.

218. Associate Professor Meagher also gave his view as a very experienced colorectal surgeon, as opposed to a general surgeon's point of view, and appeared out of step with the other evidence, all of which suggests that Mr Edmunds did need the scan by 13 November 2019. This does not detract from the competency of a general surgeon's skills, however, it is accepted that given the fact that a general surgeon is multi skilled to perform all types of surgery, often in an emergency situation, it is understandable that they might and perhaps should move sooner to investigate than perhaps a colorectal surgeon would.

219. The majority of the evidence supports a finding that the CT should have been ordered on 13 November 2019. Each general surgeon and intensivist gave that evidence, it was only Associate Professor Meagher who differed.

EVENTS ON 14 AND 15 NOVEMBER 2019

220. Professor Tuxen's evidence is that he said in response to the statement that the stoma was not obstructed, "that doesn't exclude obstruction beyond your finger further up the bowel and doesn't really resolve the issue of no output and high nasogastric aspirate".

221. Professor Tuxen gave evidence that at this point, after speaking with Dr Rahman, he formed the view that a second surgical opinion was warranted. He had already raised his concerns with the surgical team, through Dr Rahman. He had made a telephone call to Dr Schmidt, as verified by his telephone records. Additionally, registered nurse Rochelle Tuxen, Professor Tuxen's wife, gave evidence that she recalled Professor Tuxen's, "frustration at unanswered phone calls and the lack of progression of the patient."

222. Professor Tuxen gave evidence that on 14 November 2019 he contacted Dr John in the evening of 14 November 2019. His evidence was as follows:

> "It is my recollection that I contacted Dr John on the evening of 14 November 2019. I was concerned there was a problem in the abdomen causing the failure of resumption of bowel function. I discussed the possibilities I was concerned about, and that a CT might be needed. As Mr Edmunds was not urgently unwell and showing some features of improvement, Dr John said he would review Mr Edmunds in the morning if he hadn't improved."

223. There was a factual dispute between this and Dr John's evidence that he did not receive a telephone call from Professor Tuxen until the morning of 15 November 2019.

224. This conflict in evidence is not of concern. It is expected that when witnesses are giving independent recollection of events that on some occasions and in some details, evidence will differ. Dr John first gave a written account to Dr Glenn Davies in December 2019 less than a fortnight after Mr Edmunds' death. In that account, Dr John's evidence was that he was first contacted by Professor Tuxen on 15 November 2019. There is good reason to believe that contemporaneous account. Additionally, given Dr John's involvement in Mr Edmunds' care commenced upon receiving that telephone call, I accept this was a significant call, to be asked to wade into the arena of another doctor, and Dr John recalls where on his drive he was, turning off the freeway onto the East Albury off ramp when the call came. This does not detract from the reliability of Professor Tuxen. I accept that his level of concern was significantly heightened on 14 November 2019 and that he had formed the view that he needed to act by getting a second opinion.

225. As Dr John was parking his car in the hospital carpark, he received a telephone call from Dr Schmidt. Dr Schmidt also requested a second opinion in respect of Mr Edmunds.

226. What prompted Dr Schmidt to seek Dr Ajay John's assistance is an issue. In her first statement Dr Schmidt asserted that she sought Dr John's assistance because Mr Edmunds' progress was "stagnant". In her third statement, she said, "I asked Dr Ajay John for a formal consult and help with ongoing management as the patient was not progressing as expected."

227. This evidence does not sit with the timeline of events, nor the medical records, and documentary evidence of what was taking place.

228. Indeed, on 14 November 2019, Dr Schmidt was not sufficiently concerned about Mr Edmunds' condition to attend to see him, let alone order a CT scan of his abdomen. The suggestion, which Dr Schmidt advances, that on 15 November 2019 she became so concerned by the absence of stomal output for greater than a week that she took the significant step of seeking a second opinion from a general surgeon has an air of unreality to it.

229. What is known, by reference to Professor Tuxen's telephone records, is that he made a telephone call to Dr Schmidt on 15 November 2019 at 8:58 am. He called the same number he had called two days prior. The call proceeded for 117 seconds. Professor Tuxen's recollection of this telephone call is that he informed Dr Schmidt that he had approached Dr John and sought a second opinion.

230. Dr Schmidt said the following:

> "Q. Why was it that on the seventh day postoperatively, you were not concerned, but when it is the eighth day postoperatively and there is no progress, you are suddenly very concerned?
>
> A. … I was concerned given it was day 8 and my understanding at the time was that postoperative ileus ranged between two to seven days and that was going beyond the week mark. I was going to give Mr Edmunds a chance for a week to see if he … would progress and his stoma would start to, ah, produce significant amount of, um, um, output, but day 8 I thought, ah, he was stagnant, and I'm not, um, I'm not sure why he's not progressing, so given that I, I have colleagues and I've discussed the case and they haven't really given me a lot of guidance, I wanted a formal consult. I wanted formal input with, um, Mr Edmunds' care.
>
> Q. You knew though, didn't you, that CT was the best diagnostic modality?
>
> A. Yes, I did. Yeah.
>
> Q. Why on 15 November 2019 did you not just order a CT scan?

A. Well, like you heard yesterday, it's a combined decision between the surgeons and the, ah, ICU consultants. It's quite a big undertaking for ICU patients to go down to CT and I, I didn't want to create, I suppose a lot of, I just wanted a second, ah, surgeon who's more experienced to, ah, to agree that a CT scan is needed and then we can proceed.

Q. Is it not more likely that you called Dr Ajay John on 15 November 2019 because Professor Tuxen had told you that he had involved Dr Ajay John?

A. I, I, that's a possibility because I don't recall speaking to Professor Tuxen, but in his statement he said he had, ah, asked for a CT scan, and I agree with him, and I was happy for him to organise it. I never at any stage obstructed that decision."

231. The surgical team review on 15 November 2019, led by Dr Rahman, is untimed, but necessarily occurred before the 8.28 am Acute Pain Service review which is timed and appears in the clinical records immediately after the surgical team review. The surgical team recorded a plan of nasogastric tube free draining, clear fluids, and "per ICU with thanks". It is not apparent from that entry that the surgical team had determined it was time to take a different approach in respect of Mr Edmunds' management.

232. Dr Bullock, a junior medical officer within the surgical team, made an entry in the progress notes at 9.00 am. Dr Bullock noted that Dr Schmidt had been updated on Mr Edmunds's progress. A suggestion, although not a plan, of lactulose 15mL was recorded. Dr Bullock's statement makes plain that she did not personally speak with Dr Schmidt, but had documented what she had been told to document by Dr Rahman after Dr Rahman spoke with Dr Schmidt. It appears that Dr Schmidt suggested lactulose, but certainly did not suggest Dr John needed to be consulted, nor that a CT was required.

233. The position had changed by 9.45 am. Dr Bullock recorded then that Dr Schmidt had discussed Mr Edmunds with Dr John, and noted what Dr John had recommended. This is after she first was called by Professor Tuxen, and after she had spoken to Dr John. It was Dr John that changed the course of Mr Edmunds treatment.

234. I do not accept that Dr Schmidt was independently and suddenly alert to Mr Edmunds' failure to progress, enough that she coincidently sought a second opinion. The evidence supports that it was Professor Tuxen that sought the second opinion, and it appears from Dr Schmidt's earlier statements that she was trying to suggest that she had realised that there was an issue with Mr Edmunds and sought help. I do not accept her reliability on this point given the weight of the evidence.

235. I cannot accept Dr Schmidt's evidence that she contacted Dr John because she had determined that a second opinion was required. It follows that Dr Schmidt contacted Dr John because she was aware that he had been involved by Professor Tuxen.

WAS THERE APPROPRIATE OPEN DISCLOSURE BY DR SCHMIDT?

236. Dr John contacted Dr Schmidt and informed her of the surgical error. Dr John informed Dr Schmidt that it would be necessary to conduct an open disclosure process with the family. Dr John recalls going through the imaging with Dr Schmidt. Dr Schmidt does not recall that and says that she was at her private rooms when she received the telephone call.

237. On Dr John's evidence, he offered to participate in the open disclosure process with Dr Schmidt:

> "I offered to talk to the patient together with Dr Schmidt as I appreciated that it could have been a difficult conversation and wanted to provide Dr Schmidt with support. At this point, Mr Edmunds remained Dr Schmidt's patient."

238. Dr Schmidt asserts that she did not understand Dr John to have made that offer. She said in evidence:

> "Look, I, I would have fully embraced it if that was my understanding, that, um, he offered, but I did not, um, understand at the time that he had offered to be present. I, um, all I had received, information, was that I had made an error during the first operation so I was in shock and I was pretty devastated that that was the reason for the prolonged non-progression, so that was the first I had heard, and I had never, I had never heard of this complication before so I was, um, quite, um, I suppose very upset with myself and, um, so that, ah, was overwhelming news that day that, um, ah, this, ah, significant error has occurred during the first operation."

239. I accept that Dr John extended the offer to be present during the open disclosure meeting. It may be that Dr Schmidt does not recall the offer.

240. In her statement Dr Schmidt gave the following account of disclosing the error:

> "On 15 November at 1540 hours, Mr Edmunds had an acute deterioration. After reviewing the CT scan and following discussion with Dr John, I saw Mr Edmunds in the ICU at 1700 hours. I admitted and explained the error to Mr Edmunds, and to his son, Wade, via telephone. I drew a diagram for Mr Edmunds at his bedside. I communicated with the ICU team. I explained the need to return to the operating theatre to relieve the obstruction and obtained informed consent from Mr Edmunds."

241. There is an issue about whether Dr Schmidt advised Mr Edmunds that she had made an error. There is additionally an issue about whether Dr Schmidt advised his son, Wade Edmunds, of the error.

242. In the clinical records, Dr Schmidt made an entry in the clinical records comprising two sketches of the abdomen. The text accompanying the sketches records, “Day 8 post Hartmann’s. Not progressing. CT noted. Needs revision of the stoma. Loop colostomy. Informed consent obtained from patient.”

243. Dr Schmidt accepted that “needs revision of stoma” was inaccurate as she was not performing a revision of the stoma. The language “needs revision of stoma” tends to suggest that a routine revision was required, as distinct from a serious procedure to correct a major surgical error.

244. Nowhere in the text accompanying the sketches was there an indication that Dr Schmidt had disclosed a serious surgical error. Dr Schmidt accepted that her documentation of the open disclosure was inadequate.

245. Additionally, the sketches were inaccurate in their representation of the error and the proposed surgery in evidence Dr Schmidt said the following:

> “Q. … Is there anything about that image that indicates to Mr Edmunds that you made a significant surgical error?
>
> A. It was a diagram of the error.
>
> Q. Doctor, respectfully, how is that a diagram of the error?
>
> A. It demonstrates the stapling of the proximal end and the opening of the distal end.
>
> Q. In your experience, would a patient know what the proximal end is?
>
> A. I didn’t use those technical words, I used very plain language when I spoke to Mr Edmunds.
>
> Q. How would drawing a diagram that indicates the stapling of the proximal end tell Mr Edmunds anything about the significant surgical error that you made?
>
> A. Ah, I agree. I’m very sorry that the picture is inadequate.”

246. On 15 November 2019, Registered Nurse Tuxen was working in ICU as a team leader. As team leader her role was to oversee the nursing care of the patients in ICU. She gave evidence that she accompanies the doctors on the ICU doctors on ward rounds, together with any other surgeons or physicians on their rounds.

247. She gave evidence and had a clear memory of the events of 15 November 2019. When asked why she had a clear memory, she explained:

> "because I was upset about what had happened that day. I hadn't been involved in anything like that before. He had received distressing news that his son had suddenly died. He then, within hours, received news that his surgery had gone incorrectly, and he was very flat and upset, and it was upsetting."

248. Registered Nurse Tuxen gave evidence that prior to Dr Schmidt arriving in ICU, she was aware of the CT results. When Dr Schmidt entered the ICU, "I was interested, one, to hear what she was going to say to the patient and, two, because I knew the patient was distressed, ..., and there were no family present, I wanted to support him as well when she,… approached the bedside."

249. Registered Nurse Tuxen did not hear the entirety of the conversation Dr Schmidt had with Mr Edmunds. Nevertheless, from what she did hear, Registered Nurse Tuxen said Dr Schmidt, "told him he needed further bowel revision surgery". Registered Nurse Tuxen does not recall Dr Schmidt telling Mr Edmunds that she had made a surgical error. She does not recall Dr Schmidt saying that the wrong end of the colon had been brought out as a stoma.

250. Registered Nurse Tuxen recalled that Mr Edmunds was flat and quiet and depressed, but said to Dr Schmidt, "you do whatever you have to do, doctor".

251. Registered Nurse Tuxen gave evidence that following the discussion between Mr Edmunds and Dr Schmidt, Ms Tuxen told Dr Schmidt that Mr Edmunds did not understand what he had been told. She said that as a result, Dr Schmidt collected a blank progress note and returned to Mr Edmunds' bedside. Registered Nurse Tuxen gave evidence that during that further discussion, Dr Schmidt at no point was heard to tell Mr Edmunds that she had made a serious surgical error, nor a surgical error, nor that she had exteriorised the wrong end of the rectal stump. Registered Nurse Tuxen recalled that Registered Nurse Gillian Milroy was present during the discussion.

252. Registered Nurse Tuxen gave evidence that from the sketches, she herself did not understand what the error was. That was a matter with which Dr John agreed, and the inadequacy of the documentation of the open disclosure caused Dr John to perform his own open disclosure with Mr Edmunds and Wade Edmunds.

253. Registered Nurse Milroy also gave evidence about this issue of the discussion between Dr Schmidt and Mr Edmunds. Mr Edmunds was one of the patients Registered Nurse Milroy was caring for on 15 November 2019. Registered Nurse Milroy indicated that as Mr Edmunds was in ICU, Mr Edmunds would have been either the only patient assigned to Registered Nurse Milroy's care that day, or one of two patients.

254. Registered Nurse Milroy gave evidence that it is her practice to be present, if she can be, when a doctor is consulting with one of her patients in ICU. Registered Nurse Milroy gave evidence that she saw Dr Schmidt walk to Mr Edmunds' bedside and so she went over to her patient.

255. Registered Nurse Milroy gave evidence that when she arrived at the bedside, she heard Dr Schmidt inform Mr Edmunds that the original surgery hadn't gone as planned and there had been a blockage and that he required another surgery to fix the blockage.

256. While she was present at the bedside, she did not hear Dr Schmidt inform Mr Edmunds that a surgical error had occurred. She did not hear Dr Schmidt inform Mr Edmunds that she had exteriorised the wrong end of the colon. When Registered Nurse Milroy was asked about the adequacy of the explanation that was provided, she said that she believed Dr Schmidt had not told him about the error that had occurred but instead just told him that there was another operation required because of a blockage. Registered Nurse Milroy recalled that Registered Nurse Tuxen was present during the discussion.

257. So concerned was Registered Nurse Milroy by the nature of Dr Schmidt's explanation that she prepared a handwritten note which documented her concerns. She gave evidence that it was a note she prepared when she went home on the evening of 15 November 2019. She said that she writes notes if she feels that something had occurred which she may need to recall subsequently. She explained her diligent practice as a result of knowing how long proceedings can take to come about and that it is her method to assist her recollection if needed.

258. That note was lengthy, but contemporaneously it provides:

> "Surgeon whom performed original surgery came to see patient to explain and was already talking to patient when I presented to bedside. Nurse in charge and ICU resident were in attendance. I did hear the surgeon state that the original op had not worked and there was a blockage that needed to be rectified, and therefore Mr – required another operation that night. Mr – thanked the surgeon and signed the consent and then left. Open disclosure did not occur at this point in my opinion."

259. Dr Fox was also present when Dr Schmidt spoke to Mr Edmunds, but he had a very limited memory of the discussion between Dr Schmidt and Mr Edmunds. Nevertheless, he did believe Dr Schmidt had disclosed an error. He said that he didn't recall whether Dr Schmidt went through the specifics of the error, but he believed she mentioned an error was made in the surgery. He recalled the discussion as brief. He did not recall whether he formed the impression that Mr Edmunds understood what he had been told. Dr Fox did not have a strong memory of the event or the details. He wasn't involved by Dr Schmidt in the discussion, and it seemed he just happened to be there, as opposed to the two nurses who made it their business to support the

patient. He was doing his best to assist the inquest, however the evidence of the two nurses together with the documentation is the reliable evidence of what transpired.

260. Registered Nurses Tuxen and Milroy were not, on their own evidence, present for the entirety of the conversation, however they both seemed very committed to the treatment of Mr Edmunds that day. They knew he was very unwell, they knew he had just that day been devastated with the news that his son had suddenly died, and the same day was to be told of a major surgical error which would require him, in his already unwell state, to undertake further surgery. I accept that they saw Dr Schmidt arrive in ICU and it is clear they missed only a small part of the conversation. By Dr Schmidt's own evidence, the initial part of the conversation she had with Mr Edmunds, involved her talking about Dean Edmunds death, and she conveyed her sympathies to Mr Edmunds' in respect of Dean's death. There was plainly limited additional time for her to disclose that she made an error and I accept the information provided to Mr Edmunds was unsatisfactory.

261. Mr Edmunds was a critically unwell patient who was distressed by his physical condition, and news of his son's death. He was entitled to a detailed explanation of the error which occurred and time to process and consider what he had been told. The witnessed disclosure of the error made by Dr Schmidt was deficient, and not delivered in a manner or detail which Mr Edmunds was capable of understanding. Simple language such as "I made a mistake in the surgery" or "I caused your bowel to be blocked or shut off so it can't work again until we fix that blockage that I caused" would have been a very easy way to explain in a sentence or two what had occurred. Dr Schmidt's notes did not disclose her error, nor did her words. This was unfair to Mr Edmunds.

262. Registered Nurse Tuxen was persuasive in her evidence. She had the added interest that her husband had been involved in the care of Mr Edmunds and had taken steps to get a second opinion. She was aware of her husband's frustration when trying to reach Dr Schmidt. She was well aware of the significance of what had taken place, and presented as very reliable in her recollection.

263. Registered Nurse Milroy equally was a reliable and careful witness. The contemporaneous note was further evidence that she was sufficiently concerned about the adequacy of what occurred. She took the unusual step of separately documenting the conversation having foreseen the possibility of legal proceedings in the future arising from the outcome Mr Edmunds had.

264. Another relevant piece of evidence was that Registered Nurse Tuxen was sufficiently concerned that she told Dr Schmidt that Mr Edmunds couldn't understand what she was saying, and followed up by informing Dr John about her belief as to the inadequacy of the consent.

TELEPHONE CALL WITH WADE EDMUNDS ON OPEN DISCLOSURE

265. Dr Schmidt documented that she telephoned Wade Edmunds following her discussion with Mr Edmunds. Her evidence of that telephone call was difficult to follow. On the one hand she said she spoke to him. Then she later said that she could not recall whether she spoke with Wade Edmunds, or whether she left him a voicemail. When asked what she would have said in a voicemail, she agreed that she wouldn't have told him about the surgical error in a voicemail. Wade Edmunds did not speak to her, that I accept. The note made might relate to a message that Dr Schmidt left. The failure of Dr Schmidt to properly explain her error to family members of Mr Edmunds sits with her failure to properly explain the error to Mr Edmunds himself, and her own documentation in the medical records which leave no trace of the error she made.

266. The performance of a transverse loop colostomy was planned. Dr Ajay John noted in the records that it was "planned as a rescue procedure". He performed the open disclosure appropriately with Mr Edmunds and his family.

THE MEDICAL CONDUCT OF DR AJAY JOHN AND PROFESSOR DAVID TUXEN AND GENERAL CARE BY DOCTORS AT ALBURY WODONGA HEALTH

267. Dr John was a very impressive witness. He was asked to step in and provide a second opinion, which he immediately did. He reviewed Mr Edmunds' case, inspected the scans, which he said he had a keen general interest in. He did not agree with the CT report, and he was correct. He identified the error that had been made in surgery. He determined an appropriate method of surgery to rectify the error, keeping in mind that Mr Edmunds was by this stage much weakened by illness. He went further in his care for Mr Edmunds, and offered to be present for the rectification surgery. He also offered to participate in the open disclosure to Mr Edmunds prior to the remedial surgery, however, Dr Schmidt did not take up his offer. He himself undertook open disclosure to Mr Edmunds and his son to ensure that he understood what had occurred, and what was intended to be done about it.

268. Dr John was of great assistance to the inquest, and provided critical evidence in the case. He was also provided essential assistance to Mr Edmunds and his family and did all he could to resolve the matter to the benefit of Mr Edmunds. It was very clear from the way he presented, and the way others referred and deferred to him that he is a greatly admired doctor and a very personable and caring physician. His approach was refreshing, and a problem that he said that he has in separating himself from his patient was one that most people would think was a very good trait in a doctor. He spoke in high regard of Mr Edmunds, who he painted as a gentleman, who faced a tragic day of loss of both his son and his erroneous surgery with dignity and grace and unwavering politeness.

269. Dr John did all he could in the unusual circumstances of this case and cannot be criticised for the care and assistance he provided to Mr Edmunds.

270. Professor Tuxen gave very important evidence also. He also spoke with high regard and fondness for Mr Edmunds. He took over his care on 11 November 2019, and he quickly became concerned with Mr Edmunds lack of progress. He was focusing on ileus which seemed a reasonable diagnosis, he gave the account that after bowel surgery it is not unusual for the bowel to take a lengthy period to recover and operate functionally. Mr Edmunds had a number of comorbidities, and his age was a significant factor. He explained that the usual process when there were concerns about a patient in his care that he would speak about the case with the surgeon and determine the best course of action to take. He found this case very unusual. He was making recommendations through the surgical team to Dr Schmidt, the messages that he was relaying to her through the team came back with an indication that she was not concerned and that no scans were required. In his many years of practice he found this most unusual. He said in most cases it would be a surgeon requesting scans and the intensivist holding back because of the intensive care aspect and risk to the patient of transport for the scan, rarely the other way around. He did not indicate from an intensive care position that Mr Edmunds could not be safely moved for a CT scan to be conducted.

271. When he was questioned about why he simply didn't override the Dr Schmidt, it was apparent that in his view that would be an extraordinary and drastic thing to do. He said undertaking any test must serve a purpose. He is an experienced intensivist, and his role was to get a person well enough to move off the ward. The surgeon's role in his view was to drive the next course of action, ensure surgical success, or determine if any other surgical intervention was required. The purpose of any further scan would be to identify if any further surgical intervention was required, and that of course was in the purview of the surgical team who were telling him that they held no concerns.

272. Although Professor Tuxen acknowledged in hindsight that he could have managed certain aspects of Mr Edmunds' care differently, he did not accept that his management was unreasonable or inconsistent with that expected of a reasonable intensive care physician. Professor Seppelt, and Associate Professor Skowronski, both of whom were impressive expert witnesses, were not critical of Professor Tuxen's management of Mr Edmunds. It was clear from his evidence that he was a caring, careful, and very experienced physician. He wanted the best outcome for Mr Edmunds, and acted in a way which he had rarely, if ever, done before by calling for a second opinion, in effect side stepping the surgeon who was responsible for the care of Mr Edmunds.

273. I accept Professor Tuxen's account that in this case it was for the surgical team to authorise the further scan. I accept that he did all he could to attempt to ensure a scan was undertaken, he then ultimately made contact with Dr John which was outside normal convention.

274. This case highlights the need for surgeons, hospital staff, and junior doctors to have an effective method of raising concern. What might be considered slightly outdated politeness within medical hierarchy should be set aside in favour of the life of the

patient. The need for surgeons to act if concerned about another surgeon's ability to perform was also the view of Associate Professor Meagher. Associate Professor Myers thought this would be a rare thing to do. This should also be seen in the prism of country hospitals, and the fact that these surgeons were visiting medical officers, not hospital staff.

275. Professor Tuxen was careful and caring in his treatment of Mr Edmunds. Similar to Dr John, Professor Tuxen did all he could in the unusual circumstances of this case and cannot be criticised for his care and treatment of Mr Edmunds. No one expected that an error of this magnitude had been made.

276. Dr Clancy was also an excellent witness, and his treatment of Mr Edmunds was exemplary. He showed compassion and kindness once he stepped in to take over the care of Mr Edmunds. He participated in full open disclosure with the family. It is also relevant to note that he participated fully in the inquest process, and ensured that he attended almost every day of the inquest to hear the critical evidence. This reflects the importance given to Mr Edmund's case by the hospital.

277. In Mr Edmunds final days, by reason of the shift to palliative care, the level of care he required did not call for continued management in the ICU. Mr Edmunds could have been managed on a ward. Nevertheless, Dr Clancy, as the most senior ICU physician in the ICU, decided that Mr Edmunds should remain in the ICU, so he had the benefit of continual nursing care, and supervision by an ICU physician. That decision, allowed Mr Edmunds' final days to be made more comfortable, ensured better pain control, and is indeed a credit to Dr Clancy and the ICU team.

CONCLUDING REMARKS – FINDINGS

278. The evidence leads to the following findings. Mr Edmunds died at Albury Wodonga Health on 2 December 2019 as a result of complications of peritonitis which was contributed to by the surgical error made by Dr Liu-Ming Schmidt on 7 November 2019 which gave rise to the requirement of the further surgical procedure performed on 15 November 2019. Other contributing causes to his physical decline and death included the prolonged delay in diagnosis of a mechanical bowel obstruction together with underlying natural causes.

279. As set out above, the ongoing care provided by Dr Schmidt troubled many of the witnesses in the inquest. The remainder of the staff treating Mr Edmunds all presented as caring, concerned, and diligent operators. Dr Schmidt did not appear to work as part of the multidisciplinary team, failed to follow up with personal visits to her patient, failed to keep track of the specific chart results as to his progress and as the most senior member of Mr Edmunds surgical team did not engage directly with the senior intensivist to even discuss Mr Edmunds case. These were missed opportunities and at the end of the inquest there was an absence of evidence to explain this departure from expected patient management post-surgery.

280. Dr Schmidt made a surgical error which gave Mr Edmunds a much reduced chance of recovery. The error is not an expected or anticipated error. I cannot determine why that error was made, and for that reason these findings should be referred to the Health Care Complaints Commission (HCCC) who are responsible in its protective capacity to ensure the ongoing safety of patients in NSW.

RECOMMENDATIONS

RECOMMENDATION ONE

281. There was no evidence to suggest Dr Schmidt was not appropriately trained to perform the surgery. The question of whether there was a lack of attention and care afforded to Mr Edmunds' by Dr Schmidt throughout his treatment was an issue that arose from the evidence in the inquest.

282. In light of the above and for the reasons set out at [278] – [280], I am satisfied that further investigation into Dr Schmidt's conduct as a consultant general surgeon is warranted and make the following recommendation:

> That the brief of evidence, transcript of evidence given at the inquest, and a copy of the findings in the Inquest into the death of William Edmunds be forwarded to the Health Care Complaints Commissioner to consider and investigate the care and treatment that Dr Liu-Ming Schmidt provided to Mr Edmunds between 7 November 2019 – 2 December 2019 at the Albury Campus of Albury Wodonga Health to determine whether any disciplinary action is required.

RECOMMENDATION TWO

283. Dr Stuchbery gave evidence about the capacity of Albury Wodonga Health to track or monitor surgical complications. He explained that there is no formal process, and that complications are discussed at morbidity and mortality meetings. In order to be discussed, the complications need to be recalled by the surgeon, self-reported, and voluntarily placed on the agenda for discussion at the MMA. He explained as follows:

> "The formal process at that time, and still stands today, is that deaths and complications in the General Surgical Unit are discussed at the monthly morbidity and mortality meeting, which was referred to earlier is in fact no way to accurately track deaths and complications in Albury Wodonga Health then or now, although the process is being instituted."

284. Dr Stuchbery gave evidence about improvement to this process through the creation of a surgical audit tool. He said as follows:

> "The audit tool would comprise hardware and software. The hardware would be computer terminals and keyboards at strategic locations. I would anticipate that most of the data entry would be done by junior medical staff, in turns residents and registrars but also by the surgeon if appropriate, and the data entry would be contemporaneous, which is the major deficiency of the present system that we use."

285. His evidence about the benefit of a surgical audit tool was as follows:

> "The surgical audit tool would allow more accurate data collection contemporaneously and would allow … better selection of the cases to be discussed at the meeting. … The audit tool would also allow us to conduct some further analysis and research into our performance and allow us to determine if the operations that we're doing and the care that we're giving falls within the accepted standards. That really is not possible at present or is possible to a lower degree of accuracy than we would like."

286. Accordingly, I make the following recommendation to the Executive of Albury Wodonga Health:

> That consideration be given to the implementation of a surgical audit tool to facilitate the capture and recording of data in real time in respect of surgical outcome.

RECOMMENDATION THREE

287. The Executive of Albury Wodonga Health and the Australian Commission on Safety and Quality in Health Care could consider implementing a policy, or producing a directive, in respect of disclosure of complications to patients. That initial disclosure of that error, if it is to be conducted by the medical practitioner who made the error, should occur in the presence of a colleague of equal seniority.

288. Accordingly, I make a recommendation to the Executive of Albury Wodonga Health and the Australian Commission on Safety and Quality in Health Care in the following terms:

> To give consideration to the implementation of a policy, or promulgation of a directive, that mandates the presence of a witness at the initial disclosure of a medical complication where the disclosure is made by the health practitioner who made the error. The witness would be equal to, or more senior than, the practitioner who made the error.

RECOMMENDATION FOUR

289. Finally, when an error such as that which occurred in the instance case occurs, a patient is entitled to be informed, that they may request the doctor who made the error no longer be involved in their care. That will not always be feasible, but where it is, the opportunity should be extended to a patient.

290. While the doctors who gave evidence in this matter believed it was appropriate that Dr Schmidt remain involved in Mr Edmunds' care, and believed that Dr Schmidt had an obligation to the patient, from a community perspective it is difficult to escape the view that if Mr Edmunds or his family truly understood the nature of the error which had been made, and were given the opportunity, they may not have elected to proceed to future treatment under the care of a that surgeon.

291. The choice and consent should remain with the patient to accept that surgeon as the continuing surgeon or to change surgeons. The evidence from the doctors was generally a surgeon would be present at the rectification surgery if not conducting it. In most cases it would be reasonable to have the surgeon repair the error, but surely this must always be the decision of the patient after open disclosure. In this matter Mr Edmunds was too unwell to advocate for himself, and his family would have done so If given the opportunity and choice, which they were not.

292. Accordingly, I make a recommendation in the following terms to the Executive of Albury Wodonga Health and the Australian Commission on Safety and Quality in Health Care:

> To give consideration to the implementation of a policy, or promulgation of a directive, which requires, where practicable, that a patient who has experienced an avoidable known medical error be informed that they may request that the health practitioner who made the error have no further involvement in their care.

ACKNOWLEDGEMENTS

293. Thank you firstly to the family of Mr Edmunds, for participating in the inquest and providing helpful questions and insights to look towards positive reforms.

294. Thank you to the parties and the representatives. The inquest was conducted in a manner which ensured documentation and evidence was heard in a timely and appropriate manner.

295. A particular thank you to Counsel assisting, Mr Robinson, and solicitor assisting, Ms Potocki. The inquest was presented in a fair and thorough manner. There were extensive materials to cover and complex medical issues to traverse, and the team

impressively knew the material and issues comprehensively and presented the case for Mr Edmunds in an appropriate and streamlined manner.

FINDINGS AND RECOMMENDATIONS

296. I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW):

The identity of the deceased

The deceased person was Mr William John Edmunds.

Date of Death

Mr Edmunds died on 2 December 2019.

Place of death

Mr Edmunds died at the Albury Campus of Albury Wodonga Health, 201 Borella Road East Albury NSW 2640.

Cause of death

Mr Edmunds died as a result of complications of peritonitis.

Manner of death

Mr Edmunds died as result of complications of peritonitis which was contributed to by the surgical error made by Dr Liu-Ming Schmidt on 7 November 2019 which gave rise to the requirement of the further surgical procedure performed on 15 November 2019. Other contributing causes to his physical decline and death included the prolonged delay in diagnosis of a mechanical bowel obstruction together with underlying natural causes.

297. I make the following recommendations pursuant to Section 82 of the *Coroners Act 2009* (NSW):

To the Health Care Complaints Commissioner (HCCC):

1. That the brief of evidence, transcript of evidence given at the inquest, and a copy of the findings in the Inquest into the death of William Edmunds be forwarded to the HCCC to consider and investigate the care and treatment that Dr Liu-Ming Schmidt provided to Mr Edmunds between 7 November 2019 – 2 December 2019 at the Albury Campus of Albury Wodonga Health and whether any disciplinary action is required.

To the Executive of Albury Wodonga Health:

2. That consideration be given to the implementation of a surgical audit tool to facilitate the capture and recording of data in real time in respect of surgical outcome.

To the Executive of Albury Wodonga Health and the Australian Commission on Safety and Quality in Health Care:

3. That consideration be given to the implementation of a policy, or promulgation of a directive, that mandates the presence of a witness at the initial disclosure of a medical complication where the disclosure is made by the health practitioner who made the error. The witness would be equal to, or more senior than, the practitioner who made the error.

4. That consideration be given to the implementation of a policy, or promulgation of a directive, which requires, where practicable, that a patient who has experienced an avoidable medical error be informed that they may request that the health practitioner who made the error have no further involvement in their care.

298. I extend my sincere condolences to Mr Edmunds children, Suzanne and Wade, and the family and friends of Mr William Edmunds

299. I now close this inquest.

Magistrate E Kennedy

Deputy State Coroner

9 March 2023