CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Sean Thomas Montgomery
Hearing dates:	13 to 17 February 2023; 25 to 29 September 2023; 9 and 10 November 2023
Date of findings:	29 January 2024
Place of findings:	Coroners Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – elective surgery, post operative care, Private Hospital, no take back policy, transfer to Public Hospital, delay in return to surgery
File number:	2019/289855
Representation:	

Ms M Gerace SC, Counsel Assisting, instructed by Ms R Campbell (Crown Solicitor's Office)

Ms K Sant for Nepean Blue Mountains Local Health District, instructed by Hicksons Lawyers

Ms K Burke for Nepean Private Hospital, instructed by Minter Ellison

Ms E Elbourne for Doctor Peter Flynn, instructed by Meridian Lawyers

Mr C Jackson for Doctor Orde and Doctor Ahmed, instructed by Avant Mutual

Mr S Beckett SC for Doctor Bruce Graham and Doctor Anis Abdul-Rahman, instructed by Avant Mutual

Mr P De Mattia (John R De Mattia & Co) for the family of Mr Montgomery

Findings:

I make the following findings in relation to the death of Mr Montgomery, pursuant to s81 of the *Coroners Act 2009* (NSW):

Identity:

The person who died was Sean Thomas Montgomery.

Date of death:

Mr Montgomery died on 13 September 2019.

Place:

Mr Montgomery died in Nepean Public Hospital, Penrith NSW.

Cause:

The cause of Mr Montgomery's death was severe metabolic acidosis due to multi organ failure including liver ischaemia

Manner:

The manner of Mr Montgomery's death was complications of thoracoscopic repair of a chronic right diaphragmatic hernia

Recommendations

A transcript of the evidence is to be given to the Executive Officer of the Medical Council of New South Wales.

Introduction

1 In September 2019 Mr Sean Thomas Montgomery was aged 70. He was married to Anna, also aged 70. They had been married for 49 years. Their son, Sean Christopher was also married and he and his wife, Paulette have two sons.

2 Mr Montgomery was in quite good health apart for some breathing difficulty on exertion, such as walking. Scans were undertaken during the course of 2019, and Mr Montgomery's General Practitioner ('GP') referred him to Doctor Peter Flynn, a cardiothoracic surgeon, who had performed surgery on Mr Montgomery in 2007.

3 On 9 September 2019 Mr Montgomery underwent surgery for what was described as "redo of right hemidiaphragm".

4 Overnight, following that surgery, Mr Montgomery recovered poorly, and it became clear that further exploratory surgery was required to investigate the cause of Mr Montgomery's deteriorating condition.

5 Regrettably there were delays in returning Mr Montgomery to surgery.

6 Tragically after two further surgeries, on the 10th and 11th of September, Mr Montgomery suffered a cardiac arrest and passed away in Nepean Public Hospital on 13 September 2019.

Inquest

7 An inquest was commenced in February 2023, there was further evidence in September and the evidence was completed in November.

8 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this, there may nevertheless be factual findings revealing inappropriate, or worse, conduct.

9 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of death.

10 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

11 The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

(1) Mr Montgomery's family

(2) Doctor Peter Flynn

(3) Blue Mountains Local Health District, specifically Nepean Public Hospital

(4) Healthscope for Nepean Private Hospital

(5) Doctor Sam Orde

(6) Doctor Sulman Ahmed

(7) Doctor Bruce Graham

(8) Doctor Anis Abdul-Rahman

Witnesses

12 The following witnesses gave oral evidence in the inquest:

(1) Doctor Peter Flynn

(2) Doctor David Campbell

(3) Doctor Bruce Graham

(4) Registered Nurse Helen Gardiner

(5) Doctor Catherine Robins

(6) Doctor Anis Abdul- Rahman

(7) Doctor Sulman Ahmed

(8) Doctor Sam Orde

(9) Registered Nurse Jill McEvoy Williams

(10) Professor Ian Seppelt

(11) Registered Nurse Patricia Herley

(12) Doctor Yaroslav Mayorchak

(13) Registered Nurse Laura White

(14) Associate Professor Paul Myers

(15) Doctor Robert Costa

(16) Doctor John Roberts

(17) Doctor Lindsay McBride

(18) Registered Nurse Kendall Prendergast

13 Prior to holding the inquest a detailed coronial investigation was undertaken by the Officer in Charge ('OIC') Detective Senior Constable Kim Mifsud. The OIC compiled a

brief of evidence which included a post-mortem report by Doctor Jennifer Pokorny, forensic pathologist, as to the cause of death.

14 The OIC interviewed various witnesses, and their witness statements are contained in the brief of evidence.

15 The OIC also obtained all relevant policy documents so that it could be ascertained whether they were complied with.

16 All the documents and witness statements obtained during the coronial investigation formed part of the brief of evidence tendered into evidence during the inquest. All of that material, all other exhibits and all of the oral evidence at the inquest, has been considered in making the findings detailed below.

Issues considered in the Inquest

17 A list of issues was prepared and circulated to the sufficiently interested parties prior to the commencement of the inquest. That list identified the focus of the inquest would be on the manner of Mr Montgomery's death, with the following issues anticipated to be the primary issues for consideration:

(1) In relation to the operation performed by Doctor Flynn on 9 September 2019:

(a) Were there any indications for Doctor Flynn to convert to an open procedure to visualise and minimise the risks of injury to organs that had herniated into the chest cavity?

(b) Did the operation report appropriately document the nature and complexity of the procedure?

(2) In relation to the care and treatment provided by the High Dependency Unit ('HDU') in Nepean Private Hospital:

(a) Was Mr Montgomery's post-operative management appropriate and timely?

(b) Should Doctor Flynn have been notified on 9 September 2019 or overnight about Mr Montgomery's progress and deterioration?

(c) Was there a delay in recognising the need for urgent laparotomy?

(3) In relation to the Nepean Private Hospital's inability to perform the urgent laparotomy on the morning of 10 September 2019:

(a) What steps were taken to locate an anaesthetist?

(b) What system was in place to accommodate the emergency return to theatre of a patient?

(c) Was there any attempt to interrupt an elective list at the Private Hospital to have the emergency laparotomy performed?

(d) Did the Nepean Private Hospital rely on the resources of the co-located Nepean Public Hospital to treat private patients who required an emergency return to theatre?

(e) Whether there was a delay in transfer after the decision was made and if so, what were the reasons for that delay.

(4) In relation to the Nepean Public Hospital, whether the Coronial Checklist and Post-Mortem Consultation forms identified the criteria for reportable deaths under the *Coroner's Act NSW 2009*.

(5) Whether any recommendations are necessary or desirable arising from any matter connected with Mr Montgomery's death.

18 The list of issues does not limit what may be considered in an inquest. During the inquest further issues were dealt with in evidence as they arose.

19 In order to assist with consideration of some of the above issues, opinions were sought by the assisting team from the following independent experts:

(1) Associate Professor Paul Myers, general and vascular surgeon

(2) Doctor Robert Costa, cardiothoracic surgeon; and

(3) Doctor John Roberts, emergency physician.

20 Each of the experts provided reports, which were included in the brief of evidence tendered at inquest. They also gave evidence during the inquest.

21 In addition, Doctor Lindsay McBride, specialist anaesthetist was retained to give an expert opinion on behalf of Doctor Graham. Doctor McBride provided both a report and oral evidence.

22 The experts commenced their evidence without any challenge being made to their written reports or their expertise.

23 On behalf of Doctor Flynn, Associate Professor Myers and Doctor Costa were asked questions as to the number of plications they had dealt with in surgery.

24 The evidence established that Associate Professor Myers had not undertaken a plication and had not ever had to deal with a plication that had come undone. He had however repaired "*quite a few*" diaphragmatic hernias.

25 Doctor Costa had dealt with plications in surgery but was not aware of having to undertake a repair of a plication. He had reduced organs from the chest cavity but could not specify that those herniations were associated with pre-existing plication.

26 It was submitted on behalf of Doctor Flynn that neither expert could give an informed, educated opinion about the surgery performed by Doctor Flynn.

27 I reject this submission for the following reasons:

(a) No objection was taken to the expertise of these two experts.

(b) No expert evidence was called on behalf of Doctor Flynn to challenge the views of the experts, which had been set out in their reports.

(c) The lack of experience of Associate Professor Myers and Doctor Costa in plication surgery is not a matter which affected their qualifications to

give expert evidence in relation to the surgery performed by Doctor Flynn which was a repair of a diaphragmatic hernia.

(d) Each of the experts had direct surgical expertise in the repair of diaphragmatic hernias.

(e) The experts, where necessary, identified any issues outside their expertise

28 Both experts were well qualified to give the opinions they set out in writing and expressed in oral evidence.

29 I found all the expert witnesses to be impressive witnesses. Their answers were considered, and they each gave evidence within their expertise.

Background to Mr Montgomery's surgery

30 Mr Montgomery had his diaphragm surgically plicated by Doctor Flynn, a specialist cardiothoracic surgeon, in 2007. This is a surgery where the diaphragm is pleated by sutures. The plication involved folding over parts of the diaphragm and stitching them down so that they do not elevate on inhalation.

31 The 2007 surgery was required because Mr Montgomery suffered what is known as phrenic nerve palsy. Phrenic nerve palsy is irreversible and results in the diaphragm tissue atrophying (wasting away), and over time it also makes the diaphragm muscle itself thinner, with a central tendon becoming more friable (more easily tears, and or bleeds). Because of the friability of the weaker tissues, holes or defects can form in the diaphragm.

32 Subsequent to the 2007 surgery Mr Montgomery did not suffer any difficulties other than shortness of breath from time to time, on exertion which he reported to at least two GPs from about 2012 onwards.

33 In July 2019, Mr Montgomery saw his GP in relation to his shortness of breath. He was referred for x-rays. The initial x-rays were reported as showing a pleural effusion. Upon further investigation a significantly raised right hemidiaphragm (half diaphragm) was identified (the diaphragm is the muscle that separates the chest cavity from the

abdomen and serves as the main muscle for respiration). The X-rays also appeared to show loops of bowel in the chest cavity. Mr Montgomery was referred to Nepean Radiology for a CT scan to be undertaken.

34 The CT scan report from Nepean Radiology read, in part, as follows:

> There is a large defect through the right hemidiaphragm with transverse diameter 13.7 cm and AP diameter of 12.5 cm. Abdominal organs had herniated through the defect to fill at least two thirds of the right hemithorax. Herniated organs include most of the right lobe of the liver, and most of the right half of the colon. There is (sic) some loops of small bowel as well. The duodenum extends into the chest and the head of the pancreas is pulled towards the diaphragmatic defect.

(The "right thorax" is the right chest. "Hernia" refers to the abnormal protrusion of tissue through an opening).

35 Upon reviewing the CT results, Mr Montgomery's GP referred him to Doctor Flynn. Mr Montgomery saw Doctor Flynn on 6 August 2019.

36 Doctor Flynn had access to the letter from Mr Montgomery's GP, the CT scans and the radiologist's report.

37 Doctor Flynn was unsure whether he considered the radiologist's written report. His evidence was that radiologists were often wrong, in that, in surgery he would on occasion find the patient's presentation was different to the radiologist's interpretation.

38 Doctor Flynn discussed the scans with Mr and Mrs Montgomery. The evidence is that Mr and Mrs Montgomery had the scans in their possession and that Doctor Flynn viewed the scans using two monitors, one of which was facing Mr and Mrs Montgomery.

39 In evidence, when he returned to the witness box in September 2023, Doctor Flynn explained that he had only viewed the images on one of the available planes (the axial plane). He demonstrated in court how the imagery on the axial plane led him to reach the view that whilst some of the stomach organs were in the chest cavity, they were still nevertheless most likely under the diaphragm rather than having herniated through the diaphragm and moved into the chest cavity. In giving this explanation Doctor Flynn conceded that at some points on the images, the diaphragm could not be seen to be

continuous and as such it was "*up for discussion*" as to whether there had been a herniation. Whist I accept "*up for discussion*" is likely a turn of phrase, the fact is Doctor Flynn did not do anything to clarify whether there had been a herniation of the diaphragm.

40 Most alarmingly, Doctor Flynn did not look at any plane other than the axial plane when reviewing the CT imaging. When taken to the coronal plane imaging in evidence, in September 2023, Doctor Flynn accepted that the combined effect of the imaging depicted the organs had likely herniated through the diaphragm into the chest cavity. Only a few of the coronal plane images needed to be shown to Doctor Flynn for that to be established.

41 The expert evidence was that a reasonably competent surgeon would, upon viewing the images, reach the conclusion that the organs had herniated through the diaphragm. I accept that evidence.

42 In evidence, the experts agreed that they would expect a surgeon such as Doctor Flynn to consider and review all the CT imaging and the report of the radiologist. It was noted that after reviewing both the imaging and the report, the surgeon could then go over any areas of uncertainty with the radiologist if required. It was pointed out that it is important for a surgeon to properly consider the imaging prior to surgery "*to get an understanding of the landscape, because it may influence how you conduct the surgery*".

43 The radiology imaging, properly considered, clearly and unequivocally demonstrated herniation of organs including the liver, right half of the colon with some loops of small bowel into the thoracic cavity and this should have been recognised by Doctor Flynn. Both Doctor Costa and Associate Professor Myers gave evidence that they would have been preparing for surgery on the basis that it would be necessary to relocate or reduce the organs out of the thoracic cavity and close the defect and that they would expect a reasonably competent cardiothoracic surgeon to have reached the same conclusions.

44 Doctor Flynn explained that he had in the past relied on viewing only the axial plane of scanned images and that that approach had previously been successful. In the absence of any corroboration, I am unable to accept this evidence. I found Doctor Flynn to be an unimpressive witness. I formed the view that his approach to aspects of his work revealed a lack of attention to detail and an apparent desire to prioritise

speed over precision and thoroughness. Examples of this arose not only in evidence concerning Doctor Flynn's treatment of Mr Montgomery but also in relation to how he conducted himself as a witness during the inquest, as I will now touch upon.

45 Prior to the commencement of the hearing, Doctor Flynn was served with a subpoena, to which there was an incomplete response. When this issue was raised during Doctor Flynn's evidence, he gave evidence that he had organised for his secretary to respond to the subpoena and said that he had not checked or reviewed the proposed response to the subpoena. This was not a satisfactory approach to take in relation to a court order to produce documentation.

46 In relation to referring letters from Mr Montgomery's GP, Doctor Flynn gave evidence that he had letters from Mr Montgomery's referring GP at home on his desk. He had those documents at home, so his evidence went, because he was coming to court the next day. When Doctor Flynn returned to court the following day, he was asked by Mr De Mattia whether he had brought the letters to court with him. Doctor Flynn gave evidence that he had checked the material on his desk but could only find the electronic material which he had already produced. A short service subpoena was issued that afternoon requiring that Doctor Flynn produce all medical notes, documents, reports, investigations, scans, imaging, records, correspondence and information held relating to Sean Thomas Montgomery by 16 February at 12pm. On 16 February correspondence was provided by Doctor Flynn's solicitor confirming that no further documents had been located by Doctor Flynn and that the documents previously produced to the Court were those "stored electronically".

47 Doctor Flynn's positive assertion that the letters of referral were on his desk was wrong, in circumstances where he told the Court that he had those very letters at home on his desk the day before he gave that evidence. This evidence indicated Doctor Flynn's preparedness to say whatever he thought may best serve his interests at the time a particular question was asked, as distinct from considering the content of each question and making sure he gave an accurate answer. I will refer to other examples demonstrating the unreliability of Doctor Flynn's evidence where appropriate throughout these findings.

48 As for the Doctor's lack of thoroughness, the insufficient examination of the scans and his approach to answering the court order for production are two examples. I will refer to other examples throughout these findings.

49 As a consequence of not thoroughly reviewing Mr Montgomery's CT imaging, Doctor Flynn failed to recognise that organs had in fact herniated through the diaphragm. His primary assessment was that the organs had *not* herniated through the diaphragm. His differential assessment was that the organs *may* have herniated through the diaphragm. In his letter to Mr Montgomery's GP, Doctor Flynn wrote:

> Thanks for referring Sean Montgomery, who as you know I saw him (sic) back in 2007 where I plicated his diaphragm because of phrenic nerve paralysis. It looks like the plication has now become undone or he has developed a hernia in his diaphragm. Certainly it appears as if there is a significant amount of bowel up in his chest and that is causing his shortness of breath.
>
> I have recommended that it be repaired at this time as he is now 70 although the oldest patient I have plicated on was 90. I have booked him in for operation.
>
> I will keep you informed of his progress.

50 The first point of note is that this correspondence, as Doctor Flynn explained in evidence, was the full extent of his record of his consultation with Mr Montgomery. This is a further example of the Doctor's lack of thoroughness. Secondly, the correspondence makes clear that the Doctor's assessment was that he would be undertaking a plication.

51 Arrangements were made during the consultation for Mr Montgomery to have surgery at Nepean Private Hospital with a planned admission date of 9 September 2019. Mr Montgomery signed a form headed, "Healthscope, consent for medical and/or surgical treatment". Under the header "The agreed operation/procedure/treatment is" Doctor Flynn had written "Redo repair of right hemidiaphragm". Under the heading "patient consent" the general risks of surgery were set out. Mr Montgomery signed the form within that section.

52 There was no space on the form for the specific risks of the surgery to be set out and Doctor Flynn did not prepare any separate document setting out the specific risks. When he was asked about this, Doctor Flynn indicated he did not see any requirement to keep any written record of the warnings he had given Mr Montgomery of the surgery to be undertaken and more specifically Doctor Flynn said he did not see the need to advise Mr Montgomery that if the organs had herniated through the diaphragm the surgery would involve pushing the organs back in to the stomach cavity through the

hole in the diaphragm with the attendant risk of the organs being damaged. Doctor Flynn was asked whether he accepted that the consent process required him to give the patient warnings about the specific risks for the surgery to be undertaken rather than just general operated risks. Despite accepting this, Doctor Flynn was nevertheless of the view that he did not need to give the patient information about the risk of damage to the organs because of his view that the risk was exceptionally small.

53 In contrast to Doctor Flynn's approach, the experts were of the view that it was necessary to warn a patient of all the specific risks of the surgery to be undertaken. They indicated that a surgeon has a responsibility to ensure the patient understands as far as possible the type of surgery to be performed and the specific risks of that surgery. In this case, one of the specific risks was the risk of injury to organs in the surgery and the consequential risk of complications should that occur. That should have been conveyed by Doctor Flynn to Mr Montgomery. The risks included the risk of death. The operation carried significant risk of morbidity and mortality for Mr Montgomery.

54 In addition, the experts were of the view that all risks should be documented.

55 On the second page of the document under the heading "admission details" Doctor Flynn wrote in the area provided for "diagnosis", the words "ruptured diaphragm". Given that this was not Doctor Flynn's primary assessment of the cause of the surgery he was to undertake, I consider the wording to be another example of the Doctor's lack of thoroughness and lack of attention to detail. Doctor Flynn sought to pass off the obvious conflict between the expressions "ruptured diaphragm" and "redo repair of right hemidiaphragm" by claiming *"it was the same operation"*. It is clear from the evidence of the experts when explaining the risks involved in repairing a diaphragmatic hernia that there were significant differences between the two operations.

56 I find that at the end of the consultation Mr Montgomery signed a consent form in which the risks of surgery were set out in general terms only, and that Mr Montgomery was not ever given any full explanation of the planned surgery and the possibility of organs having to be moved ("reduced", "mobilised") if it was found during surgery that the organs had herniated into the chest cavity. Consequently, Mr Montgomery was not given any warning of the risk of injury to the organs, should they need to be moved and he was not given any warning of the consequential risk of complications should that risk materialise.

Did Doctor Flynn lie in his evidence about the "hole" in the diaphragm

57 In relation to the consultation, a separate issue arose wherein the family submitted that I should find that Doctor Flynn had told Mr and Mrs Montgomery that there was a hole in the diaphragm. The submission was developed to argue that I should find that Doctor Flynn had lied in his evidence when he indicated that he did not know there was a hole in or rupture of the diaphragm.

58 It was further submitted that Mrs Montgomery's statement, wherein she asserted that this had been said, was not challenged in any way and as such I should accept the statement as set out.

59 Firstly, it should be noted that it is common in inquests to not cross examine family members. In particular, this is the case in relation to what might be described as ancillary matters.

60 Secondly, it was not ever suggested to Doctor Flynn that he had told Mr and Mrs Montgomery as a positive fact that there was a hole in the diaphragm, and that he had lied about this throughout his evidence.

61 Thirdly, in his letter to the GP, Doctor Flynn, contemporaneously to the consultation, indicated his view that he was to repair the plication rather than reduce organs that had herniated through the diaphragm. There was absolutely no reason for Doctor Flynn to lie about the surgery he proposed to undertake.

62 An analysis of Doctor Flynn's state of mind is complicated to some degree by Doctor Flynn's reference to "ruptured diaphragm" as the "diagnosis". However, as I have indicated above, I view this as another example of the Doctor's imprecise approach rather than evidence that he knew there was a hole in the diaphragm.

63 Based on Mrs Montgomery's statement, I have no doubt that Doctor Flynn referred to a hole in the diaphragm during the consultation. However, I am satisfied that this was likely in the context of explaining that there may have been a herniation.

64 On the evidence before me I am unable to conclude that Doctor Flynn deliberately lied in his assertion during evidence that he did not know there was a hole in the diaphragm prior to Mr Montgomery's surgery.

Doctor Flynn's approach to the surgery

65 During his evidence Doctor Flynn was at pains to point out that the risks faced by Mr Montgomery were small.

66 He initially refuted any suggestion that if the organs had herniated some time prior to the surgery and had adhered to each other and or the diaphragm that the need to divide adhesions to reduce the organs increased the risk of trauma to them.

67 Shortly thereafter in his evidence he accepted that the need to divide organs did present a risk in the following terms:

> *"So the answer is yes, there is a risk. The risk is exceptionally small and, compared to all the other risks that go on at the time, insignificant".*

68 Doctor Flynn was of the view that the main risks facing Mr Montgomery were the risks of him being elderly, requiring an anaesthetic and the fact that the operation was in the area of the chest.

69 The experts were of the view that repairing a diaphragmatic hernia, requiring reduction of organs, poses a clear risk of trauma to the organs. Doctor Flynn's view that the risk was minimal and insignificant, is not a view held by the experts.

70 As to approach, Doctor Costa would have included consultation with an upper GI surgeon and would have involved one in the procedure. Associate Professor Myers agreed. Both Associate Professor Myers and Doctor Costa agreed that it would have been appropriate for a cardiothoracic surgeon and an upper GI surgeon to do the procedure together.

71 There was no easy answer to whether an abdominal or thoracic approach was to be preferred in isolation, but consideration needed to be given to a combined approach to achieve adequate reduction of organs and addressing adhesions.

72 As to initial approach, Doctor Costa said an initial thoracoscopic approach was acceptable but if there were any particular difficulties in any area with the thoracoscopic approach, then conversion to an open procedure should be foremost in the surgeon's mind. Associate Professor Myers would have preferred an open approach. Dr Ahmed

said that when it is necessary to reduce the liver, this cannot be done easily with keyhole surgery because the liver is a very heavy organ and cannot be managed with simple keyhole instruments and you would usually need your hands to manoeuvre the liver out of the hernial defect and mobilise it down. As shall be set out later in these findings Dr Ahmed gave evidence of the injuries caused by Dr Flynn's use of keyhole instruments in his attempts to reduce the liver.

73 On the evidence I am unable to conclude that the surgery should have been started as an open procedure. In my view the extent of the adhesion of the organs and the appearance of the liver were significant indicators that Doctor Flynn should have converted to an open procedure.

Doctor Flynn's Surgery (the "first surgery")

74 Doctor Flynn's evidence was that as soon as he looked through the thoracoscope he realised that a number of Mr Montgomery's intestinal organs had herniated into the chest cavity.

75 Doctor Flynn continued the procedure thoracoscopically and in his evidence he at various stages strongly expressed the position that this was basically the same surgery as a plication. His evidence was that it was not more difficult, just longer than a plication.

76 Doctor Flynn's claim that there was a very low risk of damage to organs is difficult to reconcile with the damage occasioned during his surgery. In this regard it is convenient to now consider the observations made by Doctor Ahmed during the second surgery, in which, the extent of the damage occasioned to Mr Montgomery's organs during the first surgery was revealed.

Second surgery

77 Doctor Sulman Ahmed is and was in 2019 an upper GI surgeon at Nepean Public and Private Hospitals. On the morning after Mr Montgomery's first surgery Doctor Flynn asked Doctor Ahmed to review Mr Montgomery. The lead up to that review shall be more fully developed later in these findings. Following that review, Doctor Ahmed and Doctor Flynn agreed that Mr Montgomery should undergo a laparotomy. Doctor Ahmed undertook a laparotomy on Mr Montgomery at about 2pm on the 10th of September.

78 Doctor Ahmed's observations included the following:

(1) The (second) operation was major and complex.

(2) On entering the abdomen, there was enteric fluid from the bowel. There was a hole right at the end of the small bowel. Mucosa was on view and the inner lining of the bowel was showing as there had been a full thickness perforation.

(3) There were mesenteric tears and defects indicating the bowel had been handled roughly and that a significant amount of force had been used to push the bowel from the chest into the abdomen. The tears and defects occurred as instruments were used to push the bowel back into the abdomen.

(4) The right colon was dusky (dark in colour) and ischaemic (lacking in blood supply). The bowel had moved back into the chest, twisted, and part of the right liver had twisted as well and blood flow to those organs had been compromised.

(5) The right liver was quite abnormal and was dusky due to ischaemia. The liver was bruised and swollen. There was a blunt force injury to the dome of the liver, a hole in the liver so severe it had injured a bile duct and bile was leaking. This was caused by the instruments used to push the liver back down.

(6) Mobilising the liver was quite difficult and it was chronically stuck in position.

(7) It was necessary to wash out the abdominal cavity.

(8) Part of the right colon and part of the small intestine were removed.

(9) The gallbladder was removed because it looked ischaemic.

(10) Proceeding to anastomosis (rejoinder of the bowel) was deemed unsafe given Mr Montgomery's condition. A decision was made, in consultation with Doctor Ellis-Clark to defer anastomosis until Mr Montgomery was more stable.

(11) The mesh repair undertaken by Doctor Flynn was observed (from the remnants) to have been attached or sutured to the edge of the hole.

(12) Repair of the hernia was difficult as it was a large hole and it could not be opposed and the tissue quality was poor, from previous scarring and the recent surgery.

79 I found Doctor Ahmed to be a most impressive witness. His answers to questions were considered, thorough and thoughtful. He impressed as a dedicated, careful and caring surgeon. In any area of conflict between his evidence and that of Doctor Flynn I prefer the evidence of Doctor Ahmed. There is no criticism of any of Doctor Ahmed's actions.

80 Doctor Flynn had said in evidence that only the liver was hard to push back into the abdominal cavity whereas Doctor Pardey, who assisted Doctor Flynn in the surgery, set out in her statement that whilst the small bowel was able to be reduced very readily the large bowel, liver and gall bladder were more difficult to reduce.

81 Associate Professor Myers and Doctor Costa noted that the instruments used to divide adhesions and mobilise organs in thoracoscopic surgery were small and more likely to damage organs then the methods used in open surgery.

82 Both expressed concern about the method of mesh repair used by Doctor Flynn and said there was a need to secure the mesh to the strongest part of the remaining diaphragm, including with overlap. Associate Professor Myers said tacking the mesh to the edge of the hernia was "*asking for trouble*". Associate Professor Myers said he would have attached the mesh to the chest wall. Doctor Costa agreed that was possible in this case even thoracoscopically.

83 Based on the observations of Doctor Ahmed, the comments of the experts and the evidence of Doctor Pardey I accept that the bowel and liver were injured when Doctor Flynn forcefully reduced these organs from the chest cavity. I am also satisfied that Doctor Flynn failed to appropriately and securely attach the mesh necessary to repair the hernia in the diaphragm.

Doctor Flynn's operation Report

84 I now return to a chronological consideration of the care of Mr Montgomery.

85 Following Mr Montgomery's surgery Doctor Flynn prepared an operation report.

86 Doctor Flynn's operation report, relevantly read as follows:

> Procedure: The abdominal contents were found in the chest including the liver and gall bladder. The abdominal contents were reduced into the abdomen. The edges of the hole were approximated with 0 tycronusing the endostitch. Mesh was placed over the hole and tacked to the diaphragm. A Pain Buster and a 24FG chest Drain were inserted.
>
> Closure: 3/0 vicryl to the skin

87 There is no reference in Doctor Flynn's operation report to the difficulties in reducing the organs.

88 Both Doctor Costa and Associate Professor Myers agreed it was appropriate to document all findings and any difficulties in the operation report. They pointed out that the operation report serves as a guide for those caring for the patient post operatively. Doctor Costa said the operation report did not paint a complete picture of the problems encountered. Both experts said they would have documented observations about the condition of the liver.

89 Doctor Orde, the on-call intensivist, reviewed the operation report on 9 September, to understand the operation and what was done and any difficulties and to assess if there were any problems that may occur down the track. As Doctor Orde accepted, if such information is in an operation report it may cause those caring for the patient to have a higher index of suspicion.

90 He observed that the report did not indicate that there had been any difficulties. In his experience it was not uncommon to see difficulties encountered recorded in an operation report.

91 From Doctor Orde’s point of view, it would have been helpful if the report had included that there were difficulties mobilising the liver, that the right side of the liver was dusky. Those observations would have been of interest for him and would have been important to know.

92 Doctor Orde also noted that it was not common for a surgeon to go and speak to the HDU intensivist at the Private Hospital. In his view it did not happen enough. He said in his experience, it happened more readily in the public hospital.

93 Somewhat alarmingly, Doctor Flynn was of the firm view that he did not think there was any need for him to tell any medical staff that he was worried about the liver having some pathology other than chronic atrophy.

94 I find that Doctor Flynn's operation report:

(1) Did not accurately record the operation performed by him and had the potential to mislead readers as it tended to portray an uneventful procedure.

(2) Did not include all of his relevant findings at surgery including the appearance of the liver, and the friability of the tissue repaired.

(3) Did not record his observations of organs reduced, including in particular his observations of the liver, atrophy of the right side, and the appearance of being dusky.

(4) Did not record the significant effort required to mobilise and reduce the organs from the herniated space.

Care of Mr Montgomery overnight

95 Following surgery, Mr Montgomery was first taken to the recovery ward at 3:15pm and then to the HDU at 4:25pm.

96 Mr Montgomery was seen by Doctor Catherine Robins, a Career Medical Officer ('CMO') at about 4:35pm shortly after his arrival in the HDU.

97 On examination Mr Montgomery was hypotensive (low blood pressure) with a mean arterial pressure ('MAP') of 60-62. MAP is the average arterial pressure throughout one cardiac cycle. The evidence was that a MAP of (at least) 65 was considered necessary to maintain adequate blood flow to the organs.

98 Doctor Robins caused a 500ml bolus of fluid to be administered. This resulted in an improvement in Mr Montgomery's MAP to 70.

99 Around the time Doctor Robins assessed Mr Montgomery Doctor Orde also arrived in the HDU. Doctor Orde was the on-call intensivist at the Private Hospital on the 9th and 10th of September 2019. He was working a 24-hour shift.

100 Following assessment in the presence of Doctor Robins, and consideration of the operation report as well as Doctor Robin's observations, Doctor Orde put a plan in place which included monitoring for signs of urine output, aiming to maintain a MAP of 65 or above, continuing intravenous fluids and continuing morphine.

101 Doctor Robins understood Doctor Orde wanted "close monitoring". Doctor Robins was unsure what that meant in practice beyond following the high dependency unit protocol of hourly observations.

102 At 7:10pm, Doctor Robins reviewed Mr Montgomery again after being contacted by nursing staff about an increase in his heart rate. Doctor Robins attended and examined Mr Montgomery and noted his blood pressure was 90/50 with a MAP of 60. She recorded Mr Montgomery's non-invasive blood pressure as 104/56 and calculated the MAP to be 73.

103 Concerned about Mr Montgomery's clinical condition, Doctor Robins contacted Doctor Orde to discuss his progress. Doctor Orde concluded that the arterial line was not reading properly and directed that Mr Montgomery's blood pressure should be taken non-invasively. Nursing staff were to continue close observations in accordance with high dependency policy and were to alert the on-call CMO or Doctor Orde in case of any change, concern or deterioration.

104 Doctor Robins handed over care to Doctor Abdul-Rahman at approximately 8.00pm. Doctor Abdul-Rahman was a CMO rostered overnight for the whole of the Hospital. She was a junior Doctor.

105 Doctor Abdul-Rahman first reviewed Mr Montgomery at 10pm after being notified by two nurses of their concern. Doctor Abdul-Rahman noted there had been no urine output and wanted to insert a catheter, however Mr Montgomery did not want a catheter at that point. Doctor Abdul-Rahman determined to give Mr Montgomery a couple of hours to see if he passed urine spontaneously.

106 Doctor Abdul-Rahman had to attend to other patients and did not return to see Mr Montgomery until around 2am after again being called by nursing staff expressing concern for Mr Montgomery. Doctor Abdul-Rahman gave evidence that she would not normally have a trial of void go for that long, however her other commitments in the Hospital, as the sole CMO responsible for 109 patients, delayed her return to Mr Montgomery.

107 Upon review Doctor Abdul-Rahman established that Mr Montgomery was tachycardic from 11pm until 2am and had not passed urine for in excess of 10 hours post operation.

108 In addition, Mr Montgomery's blood pressure was borderline throughout this period and his MAP dropped below target just after 11pm, again between midnight and just before 1am, and was noted to be below target again at 2am.

109 At 2:30am, Doctor Abdul-Rahman inserted a catheter to facilitate urine output. Mr Montgomery's heart rate settled temporarily after relieving Mr Montgomery of some retained urine.

110 About 30 minutes after inserting the catheter, Doctor Abdul-Rahman identified that Mr Montgomery's observations had deteriorated rapidly. Mr Montgomery had started to become hypotensive again and on examination the Doctor identified that Mr Montgomery's abdomen was slightly distended (swollen from internal pressure).

111 Doctor Abdul-Rahman:

(1) Commenced metaraminol infusion to assist in maintaining blood pressure and was able to achieve a MAP over 64.

(2) Took venous blood gas at about 3am. The venous blood gas result was not available in the records. Dr Abdul-Rahman documented in a retrospective note written at 6.30am, the venous blood gas test identified Mr Montgomery was acidotic with Ph of 7.1, lactate 8, and potassium of > 5.6. Dr Abdul Rahman described these findings as demonstrating metabolic acidosis with hyperkalaemia and hyperlactatemia.

(3) An arterial blood gas ('ABG') was taken at 3:44am confirming Mr Montgomery was acidotic with a lactate reading of 8.05 and with similar results to those found on the venous blood gas taken at 3am.

112 Any lactate reading above 4.00 is considered as warranting further investigation. Between 3am and approximately 4am Doctor Abdul Rahman contacted Doctor Orde on two occasions to discuss her findings and concerns and the commencement of metaraminol.

113 As on-call intensivist, on a 24-hour shift, Doctor Orde was some 25 minutes away from the hospital. Doctor Orde indicated he would return to review Mr Montgomery and advised Doctor Rahman to continue metaraminol.

114 Mr Montgomery's metaraminol needs continued to increase in order to maintain blood pressure and his heart rate increased to between 120 to 130 bpm. Doctor Abdul-Rahman advised Doctor Orde of those results.

115 Doctor Orde arrived at the hospital sometime after 4:15am and likely close to 4:30am (the evidence does not allow for precise findings as to time as the clinicians recall as to time varied).

116 Upon assessing Mr Montgomery, Doctor Orde was unsure about what was causing his clinical condition. Doctor Orde recognised how unwell Mr Montgomery was, having regard to his vital signs overnight of persistent hypotension, severe metabolic acidosis and low blood volume. However, at this stage Doctor Orde found that Mr Montgomery did not look as unwell as "the numbers" (vital observations) suggested he was. Nevertheless, Doctor Orde put in place a plan for treatment which included continuing medication to try and stabilise blood pressure and further investigations by way of blood tests, and CT of the chest, abdomen and pelvis. Doctor Orde considered the results of these tests would inform the ongoing management of Mr Montgomery.

117 Doctor Orde then left the hospital to go home and get changed before coming back in.

118 At some stage between 6:00 and 6:30am (again it is not possible to be precise as to time due to the differing recollections of the clinicians) the radiologist provided a verbal

report on the CT scan identifying that part of the liver had herniated back into the chest cavity, and that the right paddock lobe of the liver was poorly perfused.

119 Doctor Abdul-Rahman contacted Doctor Orde to update him on the verbal report. As Doctor Orde put it: "*the report indicated the operation had not gone well and the liver was in trouble*".

120 Doctor Orde then called Doctor Flynn to advise him of the contents of the verbal report. Doctor Flynn commenced readying himself to go to the hospital.

121 Further arterial blood gases which were taken at 6:23am showed a reduction in lactate from 8 to 4.8 which was an improvement, but Mr Montgomery was still acidotic.

122 A liver function test (LFT) was ordered, and the results were verbally available some time prior to the finish of Doctor Abdul-Rahman's shift (8:15am). The results of the LFT indicated there was something deeply wrong with the liver. Doctor Abdul-Rahman updated Doctor Orde about the abnormal results.

Findings in relation to the overnight care

123 The expert evidence of Doctor John Roberts, Emergency Physician was that the overnight care for Mr Montgomery was of a high standard. Nevertheless, Doctor Roberts and the other experts acknowledged that Mr Montgomery's chances of survival would have increased with earlier recognition of the cause of Mr Montgomery's troubling observations. In this regard, there were a number of missed opportunities following Mr Montgomery's surgery, which I shall now identify.

124 The first missed opportunity lay in Doctor Flynn's failure to complete a thorough and accurate operation report. I am satisfied that if the operation report was accurate, it would have increased the chances of earlier assessment of the damage done to Mr Montgomery's organs in surgery.

125 The second missed opportunity lay in Doctor Orde's failure to specify more regular observations than hourly. Doctor Orde agreed it was his obligation to specify if he wanted more frequent observations and in evidence, indicated that, if a patient is hypotensive or unwell the observations should be done more often and with the benefit

of hindsight, he should have directed that the observations be more frequent than hourly.

126 The third missed opportunity lay in the fact that neither Doctor Abdul-Rahman nor Doctor Orde recognised the severity of Mr Montgomery's condition when reviewing his observations between 12am and 1am. Doctor Orde considered, with the benefit of hindsight, that this time period was when Mr Montgomery would have benefitted the most from further investigations, including a CT scan, to see what was happening. During this period Mr Montgomery had failed to void for a further 2 to 3 hours after Dr Abdul-Rahman had wanted to insert a catheter, had consistently low blood pressure and his heartbeat had been fast.

127 A number of factors contributed to this missed opportunity. Firstly, the observations were not frequent enough. Secondly, Doctor Abdul-Rahman, as a junior CMO had responsibility for 109 beds, and thirdly Doctor Orde as overnight on-call intensivist was not always on site, and at times, trying to get some rest away from the hospital.

128 In retrospect, Doctor Orde said that if he had been contacted around 1:00am he would have gone into the hospital and likely would have done the exact same things as were done and ordered by him at 4.30am. As it was, Doctor Abdul-Rahman didn't get back to see Mr Montgomery until after she was contacted at around 2:00am and thereafter she did not contact Doctor Orde until the two occasions between 3am and approximately 4am. No criticism is levelled at Doctor Abdul-Rahman for the delay given she, as a junior doctor, was the sole CMO attending to some 109 beds.

129 The missed opportunities had the potential to have an impact on Mr Montgomery. If the CT scan, which identified the re-herniation of the liver, had been done earlier, it may have resulted in Mr Montgomery being returned to surgery during the night. The evidence was that an overnight anaesthetist was on call as well as staff for the surgery, and a theatre would have been available. Had the decision been made early enough to make it possible to take Mr Montgomery back to theatre before 7am, the surgery likely could have been done at the Private Hospital, and increased Mr Montgomery's prospects of survival.

130 The scope of the inquest did not include a detailed analysis of the allocation of nursing and medical officer resources within the Private Hospital. Nevertheless, I would

encourage Nepean Private Hospital to continue reviewing its policies to ensure it always provides adequate nursing and medical officer staffing.

Decision to return Mr Montgomery to surgery

131 Having been contacted after 6am and updated as to various test results Doctor Flynn rang Doctor Ahmed at sometime between 7:15am and 7:30am with a request to review Mr Montgomery providing Dr Ahmed with some brief information about the surgery he had performed

132 Doctor Ahmed attended upon Mr Montgomery almost immediately upon arriving at the hospital and observed that Mr Montgomery was quite unwell, suffering mild right upper quadrant pain, a tender, distended stomach, abnormal overnight blood gases, having required medication to support blood pressure, raised lactate and acidosis, acute renal impairment and raised potassium. Doctor Ahmed queried whether there was bowel sepsis, liver injury and the need for a laparotomy.

133 Doctor Ahmed then reviewed Mr Montgomery with Doctor Flynn. Doctor Flynn provided further information about the operation, including what he did and what he was concerned about, reviewed the scans (checking for fluid from possible perforation and concern about the liver noting the right liver had herniated into the right pleural space and appeared abnormal) and blood results and came to the view the patient was not only unwell but needed an operation.

134 Doctor Ahmed recalls Doctor Flynn's main concern to be "bowel perforation sepsis". The Doctors agreed surgery was required as soon as possible.

135 In the meantime, Doctor Orde had returned to the hospital and was attending to Mr Montgomery's care needs which included inserting a central line to provide venous access for the administration of Noradrenaline (to increase blood pressure) and Augmentin (for sepsis).

Delay in getting into surgery

136 By not long after 8am on the 10th of September it was clear to everyone involved in Mr Montgomery's care that he was extremely unwell, and it was necessary that he be

taken back to surgery as soon as possible. The evidence also established that any delay in returning Mr Montgomery to surgery reduced his prospects of survival.

137 Shortly after reviewing Mr Montgomery, Doctor Ahmed went with Doctor Flynn to the floor manager in order to advise the floor manager that Mr Montgomery needed an urgent laparotomy. Doctor Ahmed took a phone call and Doctor Flynn had the conversations with the floor manager. Doctor Ahmed's understanding was that the floor manager was trying to make arrangements for Mr Montgomery to be returned to surgery.

138 In September 2019 [and now] Nepean Private Hospital did not have an on-call anaesthetist available during the day on Monday to Friday. The evidence is that there was an on-call anaesthetist during the night-time but not the daytime. This meant that a call out had to be made to anaesthetists by way of a SMS text message by what was known as the "HosPortal" system.

139 At 9:00am a message was sent by the HosPortal system to a list of 87 anaesthetists which read "*Anaesthetist required at Nepean Private Hospital approx midday today to assist Drs Flynn and Ahmed with a laparotomy. Call theatre manager Trisha on (number indicated)".* There was no response to this text.

140 At 10:41 a second text was sent to 87 anaesthetists which read "*Anaesthetist required at Nepean Private Hospital today to assist Drs Flynn and Ahmed with a laparotomy. Please call theatre manager ASAP on (number indicated)*". Again, there was no response.

141 Associate Professor Myers and Doctor Costa were both very critical of both the lack of detail and urgency in the message distributed and the inability to arrange for an anaesthetist to attend. Doctor McBride, who was retained on behalf of Doctor Graham, provided an example of a message distributed in relevantly similar circumstances at Royal North Shore Private which relayed the urgency of the required surgery.

142 Associate Professor Myers and Doctor Costa gave evidence of the need for advanced arrangements to ensure anaesthetists were available so that surgery is not delayed because of the unavailability of an anaesthetist.

143 Returning to the efforts to get Mr Montgomery into surgery, Doctor Graham who had been the anaesthetist in the first surgery received a call after 10:45am asking him to go to the Private Hospital. Doctor Graham attended the Private Hospital and spoke with Doctor Orde as well as speaking with Doctors Flynn and Ahmed by phone. Doctor Graham understood that Mr Montgomery was significantly unwell and had to go back to theatre and that he was going to be transferred to the public hospital. Doctor Graham then returned to the public hospital and provided Doctor Campbell, the duty anaesthetist at the public hospital, with information relevant to the first surgery. Doctor Graham was the anaesthetist in a busy surgery list in the public hospital on the 10th of September and could not make himself available for Mr Montgomery's return to surgery however his involvement in discussions with Doctors Orde, Flynn and Ahmed ultimately helped facilitate Mr Montgomery's surgery taking place in the Public Hospital.

144 Within the evidence there was a thread asserting that Doctor Orde had at various stages appeared unconcerned as to Mr Montgomery's state and that this disposition somehow contributed to the delay in Mr Montgomery being returned to surgery.

145 I am satisfied that this is not the case. Doctor Orde impressed as a caring and compassionate practitioner. He was visibly disturbed by the suggestion that he appeared to some fellow clinicians to be unconcerned. Indeed, he apologised if this was the way in which others interpreted his demeanour, and suggested his fatigue may have contributed to the way in which he expressed himself.

146 Contrary to any suggestion that Doctor Orde contributed to any delay I find that it was not his responsibility to ensure Mr Montgomery's speedy return to surgery, rather, his responsibility was to continue to treat Mr Montgomery pending his return to surgery. Only a surgeon could have booked and facilitated the earlier return to surgery.

147 When Doctor Graham spoke with Doctor Orde, Doctor Orde was attending to Mr Montgomery and despite Doctor Graham's assertions as to Doctor Orde's perceived lack of concern as to the urgency of Mr Montgomery's return to theatre it was clear from Doctor Graham's subsequent actions in returning to the Public Hospital to speak with the duty anaesthetist before returning to his own list, that Dr Graham understood Mr Montgomery was going to be transferred for surgery and he took immediate steps to facilitate that course.

148 Doctor Mayorchak was Doctor Flynn's registrar and was on duty in the public hospital from 8:00am on the 10th of September. Doctor Flynn contacted Doctor Mayorchak at 12:15 pm and asked him to book the surgery for Mr Montgomery in the public hospital. Doctor Mayorchak expeditiously and efficiently attended to this task and the relevant form was completed by 12.27pm.

149 In September 2019 the Private Hospital had three categories of emergency surgery. The first of these E0 was for immediately life-threatening situations, E2 was for life-threatening situations and the categorization E4 indicated that surgery was required in less than four hours. Mr Montgomery's return to surgery was given an E4 classification. When Doctor Mayorchak completed the paperwork, he marked the surgery as E4. This classification was indicative that the surgery should take place within four hours and it was the same classification Doctor Orde had conveyed to Doctor Graham in their conversation. In this instance Mr Montgomery was heading to surgery by 1:42pm.

150 The delays in returning Mr Montgomery to surgery were unacceptable. This was accepted in oral evidence by Doctor Flynn and Doctor Orde as well as all the experts.

151 The evidence at inquest did not provide any explanation as to why there was such a substantial delay. There was some general evidence along the lines of "*conversations were occurring*" and "*people were trying to arrange the surgery*", however there was next to no detail as to precisely what was done.

152 Doctor Flynn suggested in evidence that it was Doctor Ahmed's responsibility to arrange the surgery as he was going to be the lead surgeon. Doctor Ahmed rejected this suggestion. He gave evidence that there was never any formal handover of Mr Montgomery's care to him. No paperwork was done, as would occur, if a formal handover was taking place. The expert evidence was that it remained Doctor Flynn's responsibility in the circumstances of this case where Doctor Flynn had admitted the patient and operated on the patient who had become unwell following that surgery. It was Doctor Flynn's responsibility to cause the second surgery to happen as soon as possible.

153 Doctor Flynn's evidence in this regard was an attempt to deflect blame away from himself. The fact is, it was Doctor Flynn's registrar, who booked the surgery, at Doctor Flynn's request. Doctor Flynn ultimately asked Doctor Mayorchak to book the surgery because it was his responsibility to do so.

154 There was no satisfactory evidence from Doctor Flynn explaining why he did not organise to have the surgery booked until 12:15pm. The theatre manager, Registered Nurse Herley had no recollection at all of events on the day in question. Somewhat surprisingly her evidence was that she didn't keep any record of requests for "take back" (take back to theatre for further surgery) patients.

155 There was no satisfactory evidence as to why there was such a long gap between the first and second HosPortal messages.

156 There is ample evidence of the public hospital's capacity to assist in situations such as this. The public hospital was 5-7 minutes' walk from the Private Hospital. It had a duty anaesthetist during the daytime as well as in the vicinity of 14 anaesthetists plus many junior anaesthetists.

157 Given the capacity of the public hospital to assist I find the delay between the SMS texts inexplicable. As soon as the first SMS was not responded to it was Doctor Flynn's responsibility to take immediate steps to get Mr Montgomery into surgery.

158 What the evidence did establish was that there were a number of factors as to why the delays in returning Mr Montgomery to surgery were so extensive.

159 Firstly, the Private Hospital did not have any take back/break theatre policy in place at the time for any surgery other than obstetrics. Whilst the evidence was vague as to precisely what steps were taken to try and organise a theatre in the Private Hospital the lack of an appropriate policy did not assist in organising for the surgery to take place.

160 Secondly, there was no on call anaesthetist.

161 Thirdly, the HosPortal messages failed to convey the urgency of the situation and were completely ineffective.

162 Fourthly, Doctor Flynn as the responsible surgeon, failed to take control of the process of returning Mr Montgomery to surgery.

163 As has been set out above time was of the essence in relation to Mr Montgomery's prospects of recovery and the inexplicable delay was inexcusable.

164 The Private Hospital has attended to some of the factors which contributed to the delay. The steps identified in the evidence are:

(1) It has put in place a break theatre policy for take back surgery identified as the Healthscope Emergency Surgery policy.

(2) The floor manager is now personally responsible for the SMS text messaging.

(3) Whilst there is still no on-call anaesthetist during the daytime the Private Hospital has indicated it has "taken on board' the expert evidence as to the need for the content of messages to make clear the nature and urgency of the surgery for which an anaesthetist is required.

The third surgery

165 I have detailed above the findings of Doctor Ahmed during the second surgery. Towards the end of that surgery Doctor Ahmed was unsure as to whether he should re-join the small bowel. Doctor Jodie Ellis-Clark, a colorectal surgeon was spoken to by Doctor Flynn and Doctor Ahmed to seek her opinion. The joint decision was to delay the rejoinder until Mr Montgomery was more stable.

166 On the 11th of September a third surgery was conducted by Doctor Ellis-Clark. Doctor Ellis-Clarke undertook a re-look laparotomy in which she resected a further 10cm of ileum (end of bowel). Doctor Ellis-Clark did not re-join the small bowel but rather put in place a stoma (small hole plus collection bag) due to her concern as to Mr Montgomery's stability. Doctor Ellis-Clark observed the right side of the liver to be "very purple and unhealthy"

167 Professor Ian Seppelt was involved in the treatment of Mr Montgomery in the Public Hospital in his capacity as Senior Staff Specialist in Intensive Care Medicine.

168 Professor Seppelt first saw Mr Montgomery on the morning of the 11th of September, when he observed Mr Montgomery to be in multi organ failure, on a mechanical ventilator, acidotic and with an acute kidney injury.

169 Following surgery at the hand of Doctor Ellis-Clark on the afternoon of the 10th of September, Professor Seppelt's treatment plan included continuous renal replacement therapy (a form of dialysis).

170 On the morning of the 12th there was no improvement in Mr Montgomery's condition and on the morning of the 13th there were signs of further clinical deterioration.

171 At 2:40pm on the 13th of September Mr Montgomery had a witnessed cardiac arrest in the presence of his family and medical nursing staff and was unable to be resuscitated.

172 There is no criticism of the care delivered in the Public Hospital.

173 Following Mr Montgomery's death Professor Seppelt prepared a medical certificate setting out Mr Montgomery's cause of death ('MCCD').

174 A MCCD is appropriate when a matter is not to be referred to the Coroners Court. However, as Mr Montgomery's death was an unexpected outcome of a medical procedure it was required to be referred. The error was rectified quickly, and Mr Montgomery's death was referred to the Coroners Court. It came to light in the process that forms the hospital was using, in addressing the issue of referral, were out of date. This error was also attended to.

Critical systems review

175 Following Mr Montgomery's death the Private Hospital undertook a critical systems review ('CSR').

176 The review was undertaken by Registered Nurse Prendergast who had no training in undertaking such a review.

177 Registered Nurse Laura White was the patient flow manager in 2019 when Mr Montgomery was admitted to the Private Hospital. In 2022 she commenced the role of quality manager which included responsibility for overseeing investigations into incidents within the hospital. This position enabled her to give evidence regarding the appropriate processes for critical system reviews.

178 From 2018 the Private Hospital had in place a Critical Systems Review Policy. Consideration of that Policy and Registered Nurse White's evidence about the appropriate implementation of the policy make clear the substantial flaws in the CSR following Mr Montgomery's death.

179 The CSR should have been undertaken by a team with appropriate skills and experience to comment upon the medical and nursing care delivered to Mr Montgomery, identify any deficiencies and make appropriate recommendations. The reviewing team should not have included anyone involved in the care of Mr Montgomery. The clinicians involved in Mr Montgomery's care should have been consulted.

180 There was no evidence of any consultation with any clinician involved in Mr Montgomery's care other than a possible brief corridor discussion with Doctor Orde, of which no note or record was made.

181 Registered Nurse Prendergast had been involved in Mr Montgomery's care and as such should not have been given the responsibility of conducting the review. Additionally, her lack of training in relation to conducting reviews meant it was wholly inappropriate to ask her to conduct it.

182 The CSR was totally inadequate. There was no acceptable explanation as to why a nurse with no knowledge of the relevant policy was asked to conduct the review.

183 I am satisfied by the evidence of Registered Nurse White that she has an adequate, understanding of the CSR Policy and that she now plays an effective role in oversighting the review of investigations at the Private Hospital. This should help maximise the prospect that future CSRs are conducted appropriately.

The cause of Mr Montgomery's death

184 As set out above Mr Montgomery suffered a cardiac arrest on the 13th of September 2019. However, the cardiac arrest occurred in the context of the consequences of the first surgery. There were varying descriptions in the evidence of the medical conditions leading to death.

185 In Professor Seppelt's MCCD, which as explained above, was ultimately not relied upon, the cause of death was noted as "*severe metabolic acidosis*" and "*acute liver ischaemia*". The antecedent causes were listed as "*injury to descending colon and hemicolectomy*", "*thoracoscopic plication of diaphragm*" and "*chronic herniation of right diaphragm*".

186 In oral evidence Doctor Roberts expressed the view that liver ischaemia was the cause of the severe illness that led to death. In his written report he expressed himself more fully, as follows:

> Mr Montgomery died because of a failed repair to a diaphragmatic hernia, which caused ischaemic injury to gut, gall bladder and liver, followed by bowel perforation and multi organ failure. The liver ischaemia leading to liver failure was the most significant and irreversible organ failure.

187 In his written report Associate Professor Myers opined: "*the ultimate cause of death was infarction (tissue death) of the right side of the liver due to portal vein thrombosis (narrowing or blockage by blood clot) and perforation of the terminal ileus*."

188 In her autopsy report Doctor Jennifer Pokorny, forensic pathologist, described the disease or condition directly leading to death as "*complications of thoracoscopic repair of chronic right diaphragmatic hernia*". Doctor Pokorny listed amongst her "*significant findings", "atrophic right liver with extensive infarction and venous thrombosis".*

189 Importantly, Doctor Pokorny also noted that the multiple surgical procedures had limited her ability to assess features of the initial hernia repair. In this regard I note the findings of Doctor Ahmed in the second surgery, detailed above, are of great assistance in understanding what occurred in the initial hernia repair.

190 It was submitted on behalf of Doctor Flynn that the causative damage to the liver had occurred prior to the hernia repair and it was that pre-existing damage to the liver which caused Mr Montgomery's death.

191 I reject this submission for the following reasons.

192 Firstly, I note that in Doctor Flynn's statement of 15 December 2022, he referred to a small and suffused liver, which would recover once it was replaced into its correct position.

193 Secondly, whilst I accept that there were signs of liver damage when it was observed in the first surgery, the expert evidence makes it clear that the liver can regenerate.

194 Thirdly, whilst Associate Professor Myers accepted that the right liver had become atrophic and largely non-functional over years and that at autopsy there was a portal vein thrombosis, he went on to explain that "*a portal vein thrombosis in an otherwise healthy person might make someone a bit unwell but it won't kill you*". The conclusion to be drawn from this is that even if there was some form of blockage of the portal vein, as suggested by Doctor Flynn in his statement of 15 December 2022, and in his oral evidence, that blockage would not have killed Mr Montgomery.

195 Fourthly, it is evident that the operation performed by Doctor Flynn and the failure of the mesh repair which led the liver to re-herniate caused additional injury to the liver.

196 I find that the cause of Mr Montgomery's death was severe metabolic acidosis due to multi organ failure including liver ischaemia.

197 These conditions occurred as a result of complications of the thoracoscopic repair of Mr Montgomery's chronic right diaphragm hernia and they led to Mr Montgomery suffering a cardiac arrest.

Whether any recommendations required pursuant to s82 of the Coroners Act

198 As set out above the Private Hospital has made a number of changes in its processes and policies since the tragic passing of Mr Montgomery. Those changes make it unnecessary to make any recommendations in relation to the Private Hospital.

199 Counsel assisting has submitted that a complaint should be made in relation to Doctor Flynn by giving a transcript of these proceedings to the Executive Officer of the Medical Council of New South Wales.

200 Sections 151A (2) and (3) of the *Health Practitioner Regulation National Law (NSW)* provide:

151A Referral of matter by Court

(1) If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession.

(3) If a notice or a transcript of evidence is given to the Executive Officer under this section –

a) a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates; and

b) the Executive Officer must give written notice of the notice or transcript of evidence to the National Board for the health profession in which the person is or was registered.

201 Section 139B of the National Law relevantly provides:

139B Meaning of "unsatisfactory professional conduct" of registered health practitioner generally [NSW]

(1) ***Unsatisfactory professional conduct*** of a registered health practitioner includes each of the following –

a) **Conduct significantly below reasonable standard**
Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

202 It was submitted by Counsel Assisting that a complaint could be made because of a number of aspects of Doctor Flynn's professional conduct as referred to during submissions.

203 The relevant aspects of Doctor Flynn's conduct include:

(1) His failure to adequately view Mr Montgomery's CT scans prior to surgery.

(2) His failure to adequately warn Mr Montgomery of the risks of the surgery to be undertaken.

(3) His inappropriate approach to the court order to provide documents by delegating the role to his secretary.

(4) The contradictory evidence he gave in relation to records he purported to have at his home the day before he first gave evidence.

(5) His lack of care during surgery resulting in extensive damage to Mr Montgomery's organs.

(6) His failure to prepare an adequate operation report.

(7) His failure to take all necessary steps to achieve Mr Montgomery's timely return to surgery.

(8) His steadfast desire to maintain positions which the evidence overwhelmingly showed to be wrong. When Doctor Flynn returned to the witness box in September, he sought to demonstrate how it was that viewing of the axial plane of the CT scans showed the organs had not herniated the diaphragm when it was patently obvious, on a full and proper consideration of the scans, that they had done so. Similarly, he was insistent throughout his evidence that the repair hernia operation was not more difficult than the repair plication.

204 It was submitted on Doctor Flynn's behalf that it was not appropriate to lodge a complaint.

205 In relation to the operation, it was submitted that what Doctor Flynn genuinely thought to be a straightforward operation turned out not to be so, and as such he should not be the subject of a complaint because of an error of judgement.

206 Firstly, it is to be noted that this submission is at odds with Doctor Flynn's oral testimony. Throughout his evidence Doctor Flynn maintained that the operation undertaken was not a more difficult operation than a plication repair. Doctor Flynn repeatedly claimed the only difference between the two operations of any significance was that the herniation made the operation longer. This was, in my view an indicia of Doctor Flynn's continuing poor judgement

207 Secondly, the primary reason for Doctor Flynn not knowing what the surgery was, lay in his failure to adequately consider the CT scans.

208 In relation to Mr Montgomery's return to theatre it was submitted that the failings were systemic and involved individuals other than Doctor Flynn. Whilst there were deficiencies in the system, as I have set out above the primary responsibility lay with Doctor Flynn and he failed to meet it.

209 In relation to the operation report it was submitted that any suggested deficiency in the report was not significant enough to ground the making of a complaint. I disagree, the inadequacy of the operation report was a significant failing in that it failed to inform those caring for Mr Montgomery overnight of what were significant matters relating to the appearance of the liver and the difficulty in reducing the organs.

210 I am well satisfied that, as the legislation requires, the evidence given during the inquest may indicate a complaint could be made about Doctor Flynn. In particular, I am satisfied that a complaint could be made as to Doctor Flynn's unsatisfactory professional conduct. A transcript of the evidence is to be given to the Executive Officer of the Medical Council of New South Wales.

Findings under s81 of the Coroner's Act:

211 For all the above detailed reasons I make the following findings:

Identity:

The person who died was Sean Thomas Montgomery.

Date of death:

Mr Montgomery died on 13 September 2019.

Place:

Mr Montgomery died in Nepean Public Hospital, Penrith NSW.

Cause:

The cause of Mr Montgomery's death was severe metabolic acidosis due to multi organ failure including liver ischaemia.

Manner:

The manner of Mr Montgomery's death was complications of thoracoscopic repair of a chronic right diaphragmatic hernia**.**

Closing

212 I acknowledge and express my gratitude to Counsel Assisting Ms Gerace SC and her instructing Solicitor Ms Campbell of the Crown Solicitor's Office. I also thank the Officer in Charge Detective Senior Constable Kim Mifsud for the work undertaken in the police investigation and in compiling the initial brief of evidence.

213 On behalf of the Coroners Court of New South I offer my sincere and respectful condolences to Mr Montgomery's wife Anna, her son Sean Christopher, her daughter-in-law Paulette and her grandsons as well as extended family and friends of Mr Montgomery.

214 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales

31 January 2024