STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jodie Ann Pearson
Hearing dates:	4 – 6 February 2019
Date of findings:	1 March 2019
Place of findings:	Coroners Court, Newcastle
Findings of:	Magistrate Robert Stone, Deputy State Coroner
Catchwords:	CORONIAL LAW – unexpected death from a health related procedure, gastroscopy aspiration and respiratory arrest, communication issue between medical staff of vital information prior to procedure
File number:	2016/00057662
Representation:	Ms K Sant assisting the Coroner Ms K Doust for Nurse Lane and Nurse Lemonius Ms K Burke for Dr Michael Hicks Mr M Lynch for Hunter New England Local Health District Ms L McFee for Dr Eric Luu Mr S Kettle for Nurse Treacy Jobson Ms C Melis for Dr Gani
Non publication order:	

Findings:	**A. The date of death was on 19 February 2016;** **B. The time of death was 4.15pm;** **C. The place of death was John Hunter Hospital Newcastle;** **D. The cause of death was hypoxic encephalopathy and aspiration pneumonia and antecedent causes were aspiration of gastric contents following gastroscopy procedure.** **E. Manner of death: Jodie Ann Pearson died accidentally after a gastroscopy procedure was commenced that should not have taken place arising from a communication failure to inform the surgeon that new information was available.**
Recommendations:	That the policy now in place at Belmont District Hospital in its Clinical Handover from Day Surgery Nurse to Anaesthetic Nurse in Belmont Hospital Perioperative Unit policy be accepted and incorporated to apply to all Hospitals within the District and that consideration is given to ensure that the policy document identifies the particular staff member who will have responsibility for each assigned task.

Inquest into the death of Jodie Ann Pearson

Contents

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1. *The Coroners Act 2009* (NSW) *in s 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Jodie Ann Pearson*

Introduction

2. Jodie Pearson died on 19 February 2016, aged 47 years. Her death as defined by s 6 of the Act was not the reasonably expected outcome of a health related procedure and as such it was a "reportable death" to the Coroner. Ms Pearson had initially attended Belmont Hospital on 15 February 2016 as an outpatient for an elective procedure known as a "gastroscopy". As will be outlined in this decision, during the procedure she aspirated a part of a food mass in her stomach into her lung and had a respiratory arrest. Ms Pearson was subsequently transferred to John Hunter Hospital intensive care unit on the same day and passed away four days later.

The Inquest

3. Section 81 of the *Coroners Act* 2009 ("the Act") requires a coroner to make findings as to:

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

4. In addition, under s 82 of the Act, the Coroner may make recommendations in relation to matters connected with the death, including matters that may improve public health and safety in the future.

Background

5. I have effectively adopted Counsel Assisting's Opening remarks and her agreed background paper to provide the following material.

6. Ms Pearson was born on 5 July 1968 and was 47 years of age at the time of her death. She is survived by her partner, Paul Patterson, her daughter Ashleigh Pearson, her son Zachary Patterson, her father, Trevor Smith and other members of her family and friends.

7. Ms Pearson had a long history of gastrointestinal problems. She had very longstanding coeliac disease. She presented frequently to her general medical practice, Woodrising Medical Centre, with abdominal symptoms such as abdominal pain and weight loss.

8. In 2009, Ms Pearson was admitted twice to John Hunter Hospital with abdominal pain and severe loss of weight. She was diagnosed with gastric

outlet obstruction and malnutrition and also developed liver abscesses necessitating a two-month admission in hospital.

9. Further problems resulted in being admitted again on 12 February 2010 under Dr Gani with vomiting, weight loss and abdominal pain. Surgical procedures during that admission included a gastroscopy on 19 February 2010 that demonstrated a stricture of the pyloric channel in the stomach and also in the duodenum – a stricture being a tightening or narrowing of a passage, in this case the channel at the end of the stomach and part of the small bowel. An infusaport was inserted for TPN (total parental nutrition) on 3 March.

10. A distal gastrectomy was performed on 31 March 2010 for gastric outlet obstruction. The procedure was performed by Dr Lim with Dr Gani assisting. Dr Gani remained the specialist in charge.

11. After that admission, Ms Pearson continued to see her general practitioner and Dr Gani for problems related to her gastrointestinal tract. She was again admitted to John Hunter Hospital on 29 August 2015 with severe upper abdominal pain, which was diagnosed as a perforated ulcer.

12. At a further operation on 30 August 2015, a perforation was found at the site of the previous gastrojejunostomy.

13. Ms Pearson was subsequently followed up by Dr Murray, a doctor working with Dr Gani, who saw her in November 2015. The plan was to perform serum gastrin levels and arrange for her to have a follow up gastroscopy at Belmont Hospital. The purpose of the gastroscopy was to check whether complete healing of the ulcer had occurred and to exclude a type of infection called Helicobacter Pylori that can be associated with stomach ulcers. The necessary paperwork was completed to request that the hospital bring her in as a day only patient for the gastroscopy and it was booked for February 2016.

The Gastroscopy in February 2016

14. Ms Pearson had a gastroscopy performed on 15 February 2016 at Belmont Hospital. She had been instructed to fast before the procedure and confirmed she had done so when she attended the hospital. However, when the gastrostomy tube was passed into her stomach, a large amount of solid matter was encountered. The surgeon performing the procedure, Dr Jonathan Gani, said that he was not able to remove the solid matter in her stomach by suctioning.

15. After a discussion between the surgeon and the anaesthetist, Dr Michael Hicks, the procedure was halted and the gastroscope withdrawn. In the course of the gastroscopy tube and camera being withdrawn, Ms Pearson inhaled the contents of her stomach into her lungs and she suffered a respiratory arrest. She was resuscitated and transferred to John Hunter Hospital ICU but died there at around 4 a.m. on 19 February 2016.

Post Mortem

16. An autopsy was performed by Dr Allan Cala, a specialist in forensic pathology. Dr Cala found the direct cause of death was hypoxic encephalopathy and aspiration pneumonia and antecedent causes were aspiration of gastric contents following gastroscopy procedure.

Events immediately prior to this admission

17. On 4 February 2016, Ms Pearson presented to Dr Robert Sim at Woodrising Medical Centre with a distended abdomen. Dr Sim had been her main GP at that practice for a number of years. Dr Sim sent her to have a CT of the abdomen, which was done on 9 February 2016. The CT revealed "massive distension" of her stomach with a large amount of food residue present in the stomach.

18. Dr Sim saw her again on 11 February 2016, when he referred her to the emergency department at John Hunter Hospital, providing her with a referral letter. Dr Sim's letter addressed to the Admitting Officer at John Hunter Hospital states,

> "Thank you for seeing Mrs Jodie Pearson for further opinion and management of recurrence of her abdominal distension and pain with occasional vomiting. A recent C-T of her abdomen showed "massive distension of the stomach". The radiologist has spoken to me about her concern and the urgency of this to be addressed".

19. Ms Pearson was already scheduled to have a gastroscopy on 15 February 2016. Ms Pearson did not attend the emergency department but apparently brought these documents with her when she attended for her booked admission to Belmont Hospital on 15 February 2016.

Admission of 15 February 2016

Pre-admission

20. In preparation for the booked admission, Ms Brady RN telephoned Ms Pearson on 12 February 2016 to give her instructions and complete the relevant checklist. Ms Pearson was asked whether she had been unwell recently; the box for 'no' was ticked.

Admission

21. After attending the admissions desk at the Day Surgery Unit at Belmont Hospital, Ms Pearson was seen by the admissions nurse, Alison Hakes RN. Ms Pearson gave her an unsealed envelope, which she recognised as containing the results of a scan. Nurse Hakes wrote on the front of it "Attention Dr Gani", highlighted his name and placed the envelope at the front of her chart in Ms Pearson's folder (referred to in the evidence as the blue folder).

22. Ms Hakes believes she handed over to Ms Kim Ritter RN, discharge nurse. Ms Ritter had minimal involvement with Ms Pearson, if any, as her main job was looking after those who had had their procedure. She does not recall having any involvement with Ms Pearson.

23. Beverley Taberner RN was working in the perioperative area near the operating theatres as a handover nurse. Nurse Taberner remembers receiving a handover from another nurse, who she believes was the admissions nurse.

24. Ms Treacy Jobson, endorsed enrolled nurse, was working as an anaesthetic nurse and received a handover from Nurse Taberner in anaesthetic bay 1. An adult pre-procedure checklist was completed at around this time, which Ms Taberner says is usually completed during the handover to the anaesthetic nurse. The checklist notes that Ms Pearson had fasted, recording she had last eaten at 7 p.m. the night before and last had some water at about 9 a.m. that morning. The form was completed at 1320 (1.20 p.m. in the afternoon).

25. Nurse Jobson gave evidence at the Inquest. She said she opened the blue folder, removed an envelope she noted was marked for Dr Gani and gave the envelope to Dr Eric Luu, a salaried medical officer working with the surgical team.

26. The focus of the inquest was primarily concerned with how the procedure came to go ahead as it did notwithstanding the letter, CT report and scan. Dr Luu asserts in his evidence that he gave what he received to Dr Gani. This is denied by Dr Gani. Dr Ross MacPherson, an anaesthetist, has provided an independent expert report confirming that the findings in the CT report indicated the patient would be at increased risk of regurgitation and aspiration, even if properly fasted.

Issues and Witnesses

27. The issues that were explored in the hearing relate to manner and cause of death, and primarily relate to events subsequent to the handing by Ms Pearson of Dr Sim's referral letter of 11 February 2016 and the CT report and scan (if there was one) to the admissions nurse at Belmont Hospital. The deceased person's identity, date and place of death were not in issue.

28. Prior to the commencement of the inquest, with agreement of the legal representatives for all persons of interest the following issues were identified:

    - Was Dr Jonathan Gani made aware of the referral letter and/or CT scan by hospital staff, including by Dr Eric Luu?
    - Was Dr Michael Hicks made aware of the referral letter and/or CT scan by hospital staff, including by Dr Eric Luu?
    - Would the procedure have gone ahead if Dr Jonathan Gani and/or Dr Michael Hicks were aware of the referral letter and/or CT scan?
    - Did Belmont Hospital have adequate policies and procedures in place to ensure that relevant medical information, such as referral letters and

investigations, is brought to the attention of surgeons, anaesthetists and other medical practitioners?

29. As will be outlined in evidence subsequent policy changes have been made at the Hospital. It is also necessary for consideration be given as to whether any recommendations are necessary or desirable pursuant to section 82 of the Act.

30. Witnesses that were called at the Inquest were:

    1) Ms Christine Osborne, general manager of Belmont Hospital.
    2) Ms Beverley Taberner, registered nurse, working in the perioperative area as a handover nurse.
    3) Ms Treacy Jobson, enrolled nurse, working as an anaesthetic nurse.
    4) Ms Alison Lemonius, registered nurse, working in the operating theatre.
    5) Ms Carolyn Lay, registered nurse, working as a scout nurse in the operating theatre.
    6) Dr Eric Luu, career medical officer.
    7) Dr Michael Hicks, anaesthetist.
    8) Dr Jonathan Gani, surgeon.
    9) Dr John Olsen, medical superintendent of Belmont Hospital.
    10) Dr Ross Macpherson, expert anaesthetist.
    11) Ashleigh Pearson, Ms Pearson's daughter.
    12) Paul Patterson, Ms Pearson's long term partner.

31. Dr Ross MacPherson, an independent expert anaesthetist, provided a report stating that Dr Hicks should have been informed of the contents of the letter and CT report and that had either he or Dr Gani been aware of that material, the procedure should have been cancelled or other steps taken to ensure patient safety. Dr Macpherson considered the resuscitation efforts reasonable in the circumstances. He explained that, in his view, the other theoretical option of anaesthetising Ms Pearson and intubating her was not feasible in a practical sense. Accordingly, the focus of the inquest was on how the procedure came to go ahead as it did, rather than on the response to the emergency that occurred.

32. While not in the order the following witnesses were called, their evidence was uncontroversial:

33. **Beverley Joy Taberner** gave evidence on the first day of the inquest. As at February 2016 she was working at Belmont hospital in the day only unit and was qualified as a registered nurse. On 15 February she was working at what is known as a handover nurse in the perioperative area. Her duty was to handover the patient from admissions then on to an anaesthetic nurse. Nurse Taberner has no actual memory of her interaction with Ms Pearson. Her evidence is based on what is her usual practice rather than her actual memory of this particular patient. She has no recollection of seeing an envelope in relation to Ms Pearson or any film or scan however her usual practice would be that if there was an envelope and and/or scan she would ensure that it was ready to show to the anaesthetic nurse – the handover occurring in the anaesthetic bay. Again her usual practice is to have a conversation with the

anaesthetic nurse with the patient present. The conversation would include the patient's ID, making sure they have the appropriate forms in connection with ID, the right date of birth and the right medical number and any clinical information that is important – for example if their blood pressure was not normal, allergies, anything metal in their body, piercings, pacemakers and if they have brought anything with them to show the doctor.

34. She was shown Ms Pearson's "adult pre-procedure checklist" form and she acknowledged that she completed part of that form which comprises a total of two pages. Her evidence was that the admission nurse completed the entirety of the first page of the document and that she assisted with the second page of the document. She acknowledged that her signature was on the second page under the heading "procedural suite verification". This part of the form was signed and dated and indicates completion at 14:00 hours. Nurse Taberner says that she completed the form or filled it out and nurse Jobson signed it. She was taken to a line in the second page of the form that says "correct imaging data available if applicable". The box next to this line is ticked and Nurse Taberner indicated that it meant that she and the anaesthetic nurse had a handover of some sort of scan or other imaging data. She said if a person didn't have a scan with them then it would be have been completed with "NA" or left blank. She says the procedure in the usual course of events for the handing over to the anaesthetic nurse takes about 5 to 10 minutes.

35. Nurse Taberner said that she still works in this same area of the hospital and that the Hospital has brought in a new procedure in relation to any additional material brought in with the patient. The new material is now placed within a red envelope which goes with other admission documents and the envelope must be given to the anaesthetic nurse, and the nurse must take it to the surgeon in charge of the procedure and it must be signed off that he/she received it.

36. **Treacy Ann Jobson** gave evidence that she was an endorsed enrolled nurse with an extra qualification in anaesthetics. She was working at the Belmont hospital on 15 February 2016 as an anaesthetic nurse. Her duties on the day were to effectively check the patient into the anaesthetic area, and complete the documentation to assist with the administrating of an anaesthetic. She acknowledged that her signature appeared on the second page of a document headed "adult pre-procedure checklist". She gave answers that indicated that she received a handover from Nurse Taberner which included an envelope addressed to "Dr Gani". She was taken to the second page of the adult pre-procedure checklist and she agreed that a tick next to the line with the statement "correct imaging data available if applicable" meant that there was some imaging available either on the hospital computer system or could also include imaging that had been done by a private imaging service and that the patient had brought the imaging scans with them to the procedure. She said it was not her usual practice particularly in a theatre undertaking colonoscopies and gastroscopies to look at x-rays or any other type of film. She did not remember whether the entry on the first page of the checklist with the handwritten statement "CT scan results attached" was brought to her attention or not. When she was re-examined she said that she had a memory of seeing the words "CT scan results attached" – in any event she did not look for them

and assumed that they were in the folder that had come with the patient from admissions.

37. Her usual practice in respect of large envelopes containing films or scans is to put them under the patient's head (under their pillow) or on the patient's body so that they wouldn't fall off. She remembers that the envelope was about the size of a half A4 page and that the envelope had the words "attention Dr Gani". She took this envelope from the patient's folder, the envelope was "hole punched" in the front of the folder, and she remembers Ms Pearson telling her a few times that it was important that the letter reach Dr Gani. Ms Pearson did not tell her the content of the letter or anything about the CT scan or report but she did say that she had had a scan recently. Her recollection is that she said it more than once and she remembers also Ms Pearson discussing that she was allergic to Lyrica.

38. Nurse Jobson remembers Dr Hicks the anaesthetist coming out to the anaesthetic bay and introducing himself to Ms Pearson and she believes that she must have interrupted the conversation that he was having with the patient to ask Ms Pearson if she was cold and she said "yes" and so she said to Ms Pearson that she would go and get her a blanket. She left Dr Hicks to continue with his assessment as she recalls placing the envelope in her gown pocket. As she was walking out of the door of the anaesthetic bay near the operating theatre door flaps Dr Luu was standing there. Her evidence is that she gave the envelope to Dr Luu. Her best recollection was that she said to Dr Luu words to the effect "Eric, it's very important to the patient that Dr Gani gets this letter". She then continued on to get the blanket for the patient. She does not remember any other conversation with Dr Luu.

39. Her evidence was that she was away for about five minutes and on her return Ms Pearson was being pushed in through the operating doors into the theatre. She put the blanket on Ms Pearson and asked Ms Pearson to turn over on her left hand side and she assisted in connecting the monitoring and other tasks preliminary to the commencement of the procedure. She noticed that Dr Gani was in the room on the computer. She remembers Dr Hicks coming in with the patient into the theatre. Her recollection is that during the "Time out procedure" she contributed to that procedure as a potassium allergy was mentioned and she volunteered that the patient was also allergic to Lyrica.

40. Importantly she does not recollect there being a film or scan separate to the envelope that she took from the folder and handed to Dr Luu. She has no recollection of any one referring to a CT scan in the operating theatre or the letter from the GP. She was in the theatre throughout the procedure until it was terminated. She did not mention the envelope to Dr Hicks as it was addressed to Dr Gani nor did she convey to Dr Hicks that there was an envelope in existence.

41. She remembers speaking to Dr Luu the following day or the day after and asking him if he had given the letter to Dr Gani but she now does not remember his response. She also remembers attending a debriefing session at the John Hunter Hospital and remembers that nurse Alison Lemonius attended along

with Dr Gani, Dr Hicks, Dr Bradshaw an anaesthetist, Dr Gary Russell another anaesthetist and operations assistant Rob Griffiths. She said Dr Luu did not attend.

42. She also confirmed the new procedure concerning the handing over of documents provided by the patient on the day of their procedure which I have outlined in the evidence given by Nurse Tabenener.

43. **Alison Lee Lemonius** was, until she retired two years ago, a registered nurse in charge of one of the operating theatres at the Belmont Hospital. At the time of Ms Pearson's procedure Carolyn Lay was the second registered nurse that assisted in the theatre and they both could take alternate roles depending on who was in charge. They are described as circulating nurses and whoever is the second nurse is also referred to as a scout nurse. She remembers going out to see Ms Pearson in the anaesthetic bay and introducing herself and her usual practice is to wish the patient well and to provide a positive atmosphere. She was not told about any letter or CT scan report or any CT scan film. She remembers that Dr Luu was the surgical registrar; the anaesthetist was Dr Michael Hicks. She has worked with Dr Gani on many occasions and it was his usual practice to go out to the anaesthetic bay and greet the patient – "he always does that". Her recollection was Dr Gani walking towards or out towards the anaesthetic bay before the procedure. She has no recollection of Dr Luu speaking to Dr Gani in the operating theatre and there was certainly no conversation about any letter or scan from anyone until after the event had happened. Her recollection was Dr Luu came in part way through the procedure.

44. She described that there were two workstations within the operating theatre. One contains a desk or table that contains Dr Gani's private files relevant to a patient (paper documents) and another workstation that also has a computer on it that the nurses would use. She was asked to describe Dr Gani's usual practice concerning a patient before commencing a procedure and she indicated that Dr Gani would review the paper files/medical folder (that he keeps) and then would look on the computer to look at any relevant materials on the computer. She has no specific recollection that Dr Gani carried out this usual procedure for Ms Pearson. She also thought it Dr Gani's practice to look at his medical folder when they saw the patient in the anaesthetic room because he did not like the patient having their anaesthetic before he had spoken to them. If for some reason he did not have time to see the patient in the anaesthetic bay then he would normally look at the folder in the operating theatre – she said it didn't always happen and might depend on timing and what was happening within the theatre.

45. **Carolyn Ann Lay** continues to work as a registered nurse at Belmont District Hospital and was doing so in February 2016. She was rostered to work as a scout nurse in Dr Gani's theatre on 15 February 2016 and was with Ms Lemonius who was appointed the team leader for that day. Her tasks concerned those that had to be performed within the operating theatre. She was not aware of any letter, scan results or any CT scan prior to the procedure commencing and she has no recollection of Dr Luu referring to an envelope or

observing him giving it to Dr Gani. She has worked with Dr Gani on many occasions and although she is usually in the theatre she is aware that the doctor usually has a discussion in the anaesthetic bay but sometimes it could be in the operating theatre itself. She says he would usually say a few words to them at the very least either in the anaesthetic bay or the operating theatre. She recalls that the doctor would usually have his own private files and in addition there would be a folder that is generated when the patient presents for their day admission and that that would come with the patient into the operating theatre. She said sometimes the doctors looked at the hospital folder "if they want to look at them, if there something they need to look at, they will look at it".

46. Although she works part-time she is aware of a change in the procedure that has come about since this tragedy.

47. **Dr Michael Hicks** is a specialist anaesthetist who qualified in July 2017. Prior to that he was a provisional fellow and an advanced trainee working at Belmont Hospital on 15 February 2016. His four years as a registrar fellow was completed or concluded in or around July 2016.

48. He commenced his day at Belmont Hospital in another theatre in the morning and moved to Dr Gani's list in the afternoon which he recalls was at about 1 PM. He described the list as a "routine scope list" which included gastroscopies and colonoscopies. Relying on notes that he wrote after the procedure he remembers taking a history from the patient in the anaesthetic bay. He said that from his point of view he is predominantly interested in the cardiovascular respiratory system, any history of reflux, any previous problems with anaesthesia, any allergies to any medications, any other medical systems that may be involved in the patient taking medications (the history of taking medications) and any history of smoking and alcohol consumption and dental issues.

49. On the electronic record he assessed her as an ASA risk of 2 which is an anaesthetic risk. In hindsight he thinks that that was incorrect and perhaps should have been a 3. In his opinion an ASA 2 is a person with a mild systemic disease and Ms Pearson was not mild and given the nature and extent of her gastrointestinal disease, her asthma and her medication for reflux he believes she should have been rated ASA 3. He could see from the list of medications that she had a problem with reflux and so he explored that in some discussion with her.

50. He was aware that she had a complex gastrointestinal history which he could read from the electronic record. He had also read a referral letter from Dr David Murray and in that letter there was a brief description of some of the previous medical events which have been referred to earlier in this decision. He was also aware of discharge summaries contained within the John Hunter Hospital computer system. He was aware that the current gastroscopy was a follow-up after she had had a perforation of an ulcer the year before in 2015. He accepted that she was not a straightforward patient medically and that she had had multiple admissions for gastric problems. He told the inquest that he remembered having a discussion with Dr Gani about Ms Pearson prior to the

list commencing having reviewed on the computer that morning the listings for the day.

51. He agreed that when he reviewed Ms Pearson in the anaesthetic bay he did not ask her whether she had had any recent imaging, recent pathology results or whether she'd been to see her general practitioner recently. He could not recall specifically asking her whether she had been well recently or whether there had been any recurrence of her abdominal pain. He acknowledged that he had not read the "adult pre-procedure checklist" prior to his discussion with Ms Pearson. Importantly he did not see any envelope containing either a CT film or any other document. If he had seen an envelope addressed to Dr Gani he said that he would not have opened it. If he had been given an envelope by a patient with words to the effect "I've got documents I want Dr Gani to see, it's important" he would have ensured that Dr Gani received the envelope.

52. He was taken to the referral letter prepared by Dr Sim. He agreed from reading the letter he would have gone looking for the CT or the CT report and would not have gone ahead with the anaesthetic without an opportunity to review at least the CT report. From reading the CT report he was aware there was a large amount of food and fluid residue in the stomach. Ms Pearson had indicated she had fasted and not eaten since 7 PM the night before. That would have normally been standard and adequate fasting before a gastro-scope with a patient with a normal stomach. He agreed that the stomach should be empty for two reasons; so there is no risk of regurgitation and the second reason is that the surgeon can actually see something in the stomach not obscured by contents in the stomach.

53. His usual procedure was particularised by this answer:
"in this particular case I think – these are high turnover lists we're trying to get through all of the patients so everyone can have their procedure. What I would often do is see the patient in the anaesthetic bay, take a history, perform an examination and I would be documenting my review during the procedure, that would be I think fairly common practice."

54. He was aware after Ms Pearson was transferred to John Hunter Hospital that there had been discussion of a CT film or results of a scan but does not recall seeing the film nor does he remember anybody looking at films in a lightbox.

55. He attended a meeting with family members immediately after the retrieval of Ms Pearson to the John Hunter Hospital and a further meeting with family members on about 7 March 2016. At the 7 March meeting he recalled that a family member asked about scans and whether they had been given to a doctor. He was quite vague about his recollection of the meeting. He thought it possible that he did mention an issue about there being different areas of information, that a clinician does not have access to all scans /reports generated by a private imaging provider or pathologist or some other private medical facility as those results and/or information are not automatically uploaded on the hospital computer system.

56. He accepted that in this particular matter it would have been useful to have read the adult pre-procedure checklist however said normally “it’s just not done but I agree that it would be a useful thing to do as another check but I haven’t seen it done”. His evidence was that a lot of patients go through a pre-operative clinic and there is an assessment conducted by one of his colleagues so that in that situation you are unlikely to look at the document because all of the information that you could get would be on the anaesthetic review from the preoperative assessment. He did not recall in this particular matter the time out procedure however acknowledged that anybody within the theatre could call out and provide an answer to the specific questions asked in the time out.

57. He indicated that he had not been spoken to in relation to an investigation undertaken by the hospital under the terms of a “London protocol investigation”. He had not been interviewed nor had he seen the results of the investigation. He therefore had no input into the investigation undertaken.

58. The following two witnesses were medical practitioners and their evidence relates to the main issue at the inquest and that is whether or not the GP referral letter, and CT scan results and/or CT scan film were provided to the senior surgeon Dr Gani by Dr Luu.

Dr Eric Luu

59. In February 2016 Dr Luu was employed as a senior resident medical officer. He had qualified as a medical practitioner, followed by a year as an intern and then another year as a resident. In February 2016, the start of his third year post qualification, he was working at Belmont Hospital full-time and his role included looking after surgical inpatients on the ward, assessing patients in the emergency department, participating in the on-call roster after hours and assisting in the operating theatre. As at February 2016 his experience undertaking procedures such as colonoscopies and gastroscopies was very limited – he had been in the role for a maximum of about two weeks. The doctor acknowledged that he would have not been able to complete a procedure such as described on his own at that time in view of his inexperience.

60. After the tragedy occurred he was spoken to by Dr Olsen, medical superintendent, on two occasions, the records of which formed part of the brief of evidence in the Inquest. The first was over the telephone in a conversation in or about July 2016 and the second was conducted in person with Dr Olsen in about September 2016. In his conversation with Dr Olsen he did not remember the specifics of any conversation concerning the GP referral letter or scan results that he says he gave to Dr Gani. He remembers giving the letter to Dr Gani in the operating theatre.

61. The doctor was also asked whether he could recall a conversation that he had with a Dr Regalo. He recalled speaking to this doctor fairly shortly after the procedure, within a few days to a week. He remembered the conversation at the time was essentially a fact finding conversation. He does not remember being asked about the letter from the GP or about any scans. He says however

he gave an account of what he thought had happened to the doctor but he did not keep any notes of the conversation he had with Dr Regalo nor was he provided with any notes from this doctor.

62. He was not asked to provide or prepare any notes in relation to the tragedy and although he was told that there was a debrief session about a week after Ms Pearson died he did not attend the debrief, which was at John Hunter Hospital, as he was rostered to work at Belmont Hospital on that day.

63. He had an understanding that a debrief was not only a fact-finding exercise but also for people to express their concerns or feelings about what happened in this upsetting event. He did not know of any London Protocol Investigation or of any results from that investigation.

64. In his evidence at the inquest he remembered receiving the envelope from Nurse Jobson and it was about the time that he had spoken to Ms Pearson. Contrary to what he had told Dr Olsen he said that he did speak to Ms Pearson prior to the procedure which he said was his usual practice, even at that time. He said "I would have taken her through the consent form, which the procedure was for a gastroscopy so I would have explained to her what the procedure involved and what the possible complications were. I would have confirmed that she was fasted and I would have asked her whether she had any concerns and I would have asked her whether she had been unwell recently".

65. He said that Ms Pearson did not mention a letter from the GP during the conversation nor did he observe a CT scan. Ms Pearson did not mention that she had been unwell recently. Again contrary to what he initially told Dr Olsen he says that he read the GP referral letter, that he was aware it was from her general practitioner and that he was under the impression that it was a referral for the procedure that she was to have that day. He recalls that the envelope contained more than one page. He has a recollection that Nurse Jobson said to him when she handed over the envelope to him something to the effect of "this is a letter for Dr Gani".

66. He has no recollection of the nurse stressing any importance to the letter being given to Dr Gani or more importantly that Ms Pearson wanted the letter to go to Dr Gani. Regardless he says he would have treated it as an important document. He remembers the envelope being the size of about half of an A4 size page. He does not remember whether there were words on the front of the envelope stating "attention Dr Gani". He has no recollection as to whether or not he put the pages back into the envelope. He says he has a specific recollection of returning to the operating theatre and giving it to Dr Gani. He cannot remember what he said to Dr Gani. It was suggested that he might have said something along the lines of "here's a referral letter from Jodie's GP"– but he could not even remember if words were said like that. He cannot remember the CT scan or whether that was mentioned to Dr Gani either. He does not recall there being a CT scan present in the operating theatre after the procedure. He was aware that there was something with the referral letter – a report. He was asked by me whether he read the report and his answer was "I

think I may have glanced at it". He said he kept the referral letter and the other pages together – that he would not have separated the documents.

67. It has to be remembered that Dr Luu was inexperienced at the time. His responsibilities in any surgery environment would have been very limited. In his third year at Belmont Hospital as at February 2016 he had done a couple of "scope lists a week" which contained about eight scopes per list (most being colonoscopies). It was the beginning of his contact with the operating theatre environment. He said that he would have had some exposure to operating theatres and theatre protocol during his internship and resident years but that would have been limited and on a piecemeal basis.

68. He was asked this question "and it's against that background of relative inexperience that you read the letter and understood it to just be a referral letter?" His answer was "yes".

69. In hindsight he knows it was not just a referral letter and had important information contained within it. Even in 2016 he understood there was a risk of aspiration if the patient had a full stomach.

70. He says that his usual practice in 2016 would be to have read the medical file that accompanied the patient into the anaesthetic bay. He would "generally" look at the "Request for Admission" which would outline why the patient was there and whether they had any medical issues, he would often read referral letters that the patient brought with them as well. He would have a look at the adult pre-procedure checklist but not always look at the nurses' notes. He said he would also rely upon any verbal handover from the anaesthetic nurse or the nurse that brought the patient into the operating theatre. He has no recollection now of looking at the adult pre-procedure checklist in respect of Ms Pearson on 16 February 2016. He remembers having a conversation with Dr Gani surrounding her previous medical issues and he believes that this took place in front of his computer after having seen her notes – his memory is unclear but he thinks that might be the case.

71. He does not remember Dr Gani being with him in the anaesthetic bay when he spoke to Ms Pearson. He said that from his experience it was not unusual for patient to bring in a referral letter even if the referral had taken place much earlier. His assumption when he first saw the envelope was that it was a referral letter and even after reading it and it being addressed to the admitting officer of John Hunter Hospital (not Dr Gani) he concluded at the time that it being addressed to the admitting officer John Hunter Hospital "is of limited significance because patients will be seen in hospitals within the network and have their procedures at other hospitals".

72. As for the clinical details in the letter, he said "I would agree that they are concerning, with hindsight, and I do regret not – well, I do regret – it is to my regret that that was not clear to me at the time". His impression even after reading the letter was that Ms Pearson was still having the procedure for the reasons outlined in the referral letter. He does not remember whether he put the contents of the envelope back into the envelope. He has no real recollection

of whether he saw Ms Pearson first then received the envelope or in the reverse order. He does not remember specifically giving a clinical handover regarding Ms Pearson to Dr Gani which would have been his usual practice even at that time – that is to present a summary of the patient's condition. His recollection was that he handed the letter to Dr Gani at the doctor's workstation. When it was put to him by Dr Gani's counsel that Dr Gani denied that he received a letter or report or any kind of clinical handover Dr Luu disputed that.

73. He was referred to Dr Olsen's report in which it was stated that he saw Dr Gani reading the contents of the envelope. He was asked if that was an accurate recollection of what he said to Dr Olsen at the time. He gave a fairly long answer to the effect that it was quite late at night, he was on shift in the acute general surgery unit that he did not have a lot of time to collect his thoughts and "there are things now, looking back on it, that I don't necessarily think reflect the truth" (I gathered from this that he was referring to the contents of Dr Olsen's report).

74. He says he was present in the operating theatre during Jodie Pearson's timeout procedure and that he has some recollection of the procedure taking place. He does not remember the specific question "does this patient have any imaging or pathology results" being asked and in his experience it wasn't often asked in an elective scope procedure list. He agreed that he had the ability to speak up in the timeout process and he would have felt comfortable doing that.

75. In his evidence he did not have a clear recollection of looking at CT scan images with Dr Gani after the procedure although that is referred to in the statement that he gave to Dr John Olsen. He acknowledged that he had remained in the operating theatre from the time that Ms Pearson was wheeled in prior to the procedure to the time that she was transferred out. He acknowledged that it was possible that his recollection of Dr Gani looking at the GP referral letter and the CT scan report may have been at a point after the procedure and not prior. He had no recollection of Dr Gani saying words to the effect "it would have been useful if we had these scans previously" after the procedure.

76. He said it would have been his usual practice in giving another doctor a document such as a letter to identify what it was that you are giving him.

Dr Jonathan Stephen Gani

77. Dr Gani gave evidence that he is a general surgeon with a large practice in gastrointestinal surgery. He acknowledged that he had been looking after Ms Pearson since approximately 2009.

78. Dr Gani gave evidence about Ms Pearson's previous gastrointestinal issues and his involvement in her treatment from 2009 up until 2015. These issues were generally described as complex medical issues and no medically qualified witness contested that description. I do not intend to set out in this decision the treatment that she had received and that was described by Dr Gani in his evidence. The last time Ms Pearson was assessed was by one of his

associates Dr Murray in November 2015. Following his examination he discussed Ms Pearson's management plan with Dr Gani and Dr Murray discussed specifically the need for a gastroscopy as a follow-up to establish whether her previous ulcer had healed and to establish whether she did or did not have helicobacter pylori which is an agent for peptic ulceration.

79. Dr Gani did not see Ms Pearson prior to her admission for the gastroscopy in February 2016 nor did he have any communication from any other doctors about her in the meantime prior to the day of the procedure.

80. The doctor discussed his usual procedure in meeting patients and indicated that they fell within a number of categories. He would see some patients in the anaesthetic bay if he had not seen them previously. Ms Pearson did not fall into that category and he greeted her in the operating theatre. He asked her how she was going and his recollection of her response was either "fine" or "good" – one of the two.

81. From records kept of the operation Ms Pearson came into the operating room at 2:11pm and the procedure started at 2:13pm – a period of some two minutes. Dr Gani did not ask anything else. He said it was his usual practice to review his notes and other information prior to the procedure commencing which would include his private room medical records, written notes that he might have made of consultations and copies of either his own correspondence, incoming correspondence and copies of any relevant results that relates to the care of the patient through his dealings with the patient. He said that it would have included Dr Murray's letter that he wrote to the GP in November 2015 which he may have accessed either from his private medical records or from the hospital's computer system known with the acronym CAP (clinical access portal). He agreed that was the most recent document that he had read and that he had no other information about how Ms Pearson had been progressing with her health from November 2015 to 15 February 2016.

82. He says as a result of this tragedy he has changed the question that he asks patients when he first sees them rather than saying something to the effect "how are you going?" he now says "how have you been since we last saw each other?" He does not remember any discussion prior to Ms Pearson coming in with Dr Luu nor does he remember discussing Ms Pearson with Dr Hicks at any time prior to the procedure. It is not his usual practice to read the hospital clinical notes folder or "blue folder" as it is described. He says he gains his information from the clinical access portal, from his own records and talking to the patients. He says also there is an opportunity at any stage for nursing staff to provide him with potentially any important information that they become aware of. He did not consider there were any gaps in the process of gathering information to bring him up to date as he felt or anticipated that a patient would volunteer new information or that one of the processes that he had described would have brought new information to his attention. He said he had done many hundreds of procedures every year and the procedure that he had in place had not caused any problem previously.

83. Counsel assisting asked the doctor the following question:

"Q. Do you think at that stage in a process that just before the procedure starts or two minutes before it starts that just asking someone, "how are you going?" and them responding "good", gives you any useful information?

"A. Well, part of it is – I mean, it applies to patients who I've known well. So if they are patients that I haven't known, I would meet them in the anaesthetic bay and take a detailed history but under the circumstances this was a follow-up patient for whom I had no expectation their health had significantly changed since they been seen in my clinic a couple of months beforehand and that was meant as a greeting and an opportunity for them to tell me anything new if there was anything new to say and, you know, 99% of the time there never is."

84. He confirmed that it was an afternoon list starting at about 1 PM and that there had been two previous scope procedures preceding Ms Pearson which had both been colonoscopies. His records indicate that he performed them and given that Dr Luu was a very new registrar his recollection is that he performed the vast majority of each procedure. His usual practice would not have been to leave the operating theatre while the procedure was in progress given the inexperience of Dr Luu.

85. His recollection was that the letter from the GP and the CT report and the actual images were all available together and they were found on the write up table that he uses and where he keeps his private medical records. He could not remember whether they were still in an envelope nor could he remember whether the envelope was marked with "attention Dr Gani". The CT films were also in the same place. His evidence was that no one mentioned to him that they were putting films there. He confirmed what he had said in his statement that because there was a significant change in Jody's condition as set out in the GP referral letter and CT report and the potentially increased risk with her having a gastroscopy he would have had concerns about proceeding with the gastroscopy. He said he would have wanted to have a more detailed conversation with the patient before making any decisions about ongoing treatment.

86. After he discovered the letter and report and the film – he said he put the film in the lightbox which is over the write up desk and he reviewed the film. His recollection is that Dr Luu was there when he viewed them and his recollection is he said "that would have been useful if we had known about this beforehand". Nothing was said by Dr Luu and Dr Gani said words to the effect "you can see the stomach's distended, and she has a food bolus". Again Dr Luu did not say anything. Dr Luu did not at any time volunteer that he had been aware of the existence of the film.

87. In his experience it was unusual for a patient to bring in a referral letter at the time of the procedure and he certainly did not have an expectation that a patient would bring a referral on the day of the procedure. If he had been told that Ms Pearson had a referral letter he says he would have looked at it

because he was not expecting one and potentially there might be new information.

88. He said there were three people directly involved in the "timeout" which is done in the operating theatre. He and Nurse Carolyn Lay were doing the calling and the person recording the timeout on the computer was Nurse Lemonius. Nurse Lay would be sitting with the patient's medical records in front of her and he would be standing to the patient's left and looking at the patient's wrist band and they would be confirming that what's on the wristband and what is in the medical records are the same. His recollection of what exactly he did say on this day is poor. He recounted that it is a procedure where you call what you believe to be the situation and other members of the team have the ability to contradict you or to concur and if there is no disagreement than what you have called is recorded and it forms part of the perioperative report. He accepted that when it is happening people do not stop what they are doing.

89. He was questioned about the procedure of just saying "how you going" and suggested the question on its own did not likely produce any new clinical information. He disagreed. He said this this was a patient he really knew well, had a long-standing therapeutic relationship with and had seen on numerous occasions and he thought that if there were any issues she would convey them to him and would have no hesitation in doing so. He accepted that while it has an inference of a greeting rather than an attempt at a medical history in his view it gave the patient the opportunity to say anything to him that they felt was appropriate.

90. It was suggested to the doctor that it would have been of good practice particularly with a patient with a complex gastrointestinal history to have gone out into the anaesthetic bay and taken a short history even if he knew the patient from previous consultations. The doctor's answer was as follows:

> "Well, I'm happy for you to suggest it to me. The situation that existed was there was a lot of information for me to have in my mind before commencing the procedure and I think the time between the last patient leaving and Jody coming into the theatre was about eight minutes and I believe I would have used all of that time on information gathering, both from my medical records and from the computer system and because she's had a number of complicated operations with an unusual anatomical arrangement, before I commence the procedure it was really important that I had in my mind precisely what her postsurgical anatomy was because otherwise I wouldn't have been able to perform the endoscopy properly or interpret its findings. So that was the focus of what I was doing. I did read David Murray's – my fellow's letter from the clinic visit in November and I believe that appraised me of her state of health then and I didn't – I wasn't expecting to be told that there had been any changes between that time and I believe that my – the way I interacted with patients was both a greeting and an opportunity for them to tell me anything."

The doctor did not consider that she would have any hesitation in telling him any of her recent problems without more than a simple prompt.

91. The doctor's recollection of the second meeting with the family of Ms Pearson after Ms Pearson had died relates to an issue as to what Dr Gani said after he was asked by Ms Ashleigh Pearson (the daughter of the deceased) words to the effect "what happened to the scans"? It was put to him that his response was words to the effect "they were in the operating room, but we do not look at them because 90% of the time they are not relevant". He said he did not say that. His recollection was that he said "the patients are always told to bring their scans. They always bring their scans and 90% of the time they are not relevant". He could not recall if he gave the family an explanation as to why the scans were not viewed. He said his explanation to the family as to the GP letter and CT report was that he was not aware that they were in the operating theatre.

92. He did not recall Dr Luu being present in the theatre before the procedure nor any conversation with Dr Luu where he might have mentioned a referral letter. He would have considered a referral letter new information that warranted looking at because in his view Ms Pearson was not referred as the gastroscopy was initiated through his clinic back in November. Effectively it would have been outside the pathway by which she had come to have her gastroscopy.

93. He was asked his recollection about the CT scan films or images and his recollection was that they came in an A3 big envelope, or alternatively perhaps on a CD small enough to fit within the existing envelope that the referral letter and CT report were in – his better recollection or firmer recollection is that they were in an A3 envelope. He did not ask anyone within the operating theatre how the films got to be in the operating theatre – he had assumed that they had been on the patient's bed or under the patient's bed and that probably the wardsman had picked them off and put them on the side table. At the time he made no enquiries. He said that even at the debrief the question was not asked as to who brought the x-rays in or how they came to be there.

94. The doctor was cross-examined by Dr Luu's Counsel and he denied that he had received any material or an envelope with material in it from Dr Luu. He accepted that he had not spoken or taken any opportunity subsequent to the events to speak to Dr Luu in the several weeks after Ms Pearson had died. Dr Gani indicated that because Dr Luu had not come to the debriefing session he had assumed that Dr Luu was feeling a bit vulnerable about the whole thing and he did not want to be heavy-handed about things. He had assumed that the doctor had put the envelope on the side table and had done so as if that was an effective handover to him. He rejected the assumption that he had elected not to review the material when handed to him by Dr Luu because he had incorrectly assumed that the material would be irrelevant.

95. He was reminded in his cross examination by his own counsel as to whether there were other matters that he would have called in the timeout procedure and until prompted about imaging data by his own Counsel then remembered that would have been one of the first things he would have called out. He says that the term he uses is "relevant radiology reviewed". He said this would have

been called out after patient identification and consent confirmation – one of the earlier questions.

Resolution of the issue

96. I consider on balance I favour and find Dr Gani's version that the envelope and contents were not found until after the procedure. I accept Dr Gani's version that the documents were located on the work table and had not been handed to him nor was he made aware of them. I do not accept Dr Luu's recollection that he handed the documents to Dr Gani. In my opinion Dr Luu was very vague and could not recall any specific conversation he had with Dr Gani. He gave some evidence about what he "would have" done rather than being specific. His recollection of events was poor - not helped by the passing of years until asked to provide a statement to the Coroner. He could not provide detail as to whether he handed the envelope with contents in it or out of the envelope, he was not sure where he gave them to Dr Gani, he said he "would have" said something to Dr Gani but has no recollection of what. He conceded that some things said to Dr Olsen were incorrect. He has a recollection of Dr Gani reading the material yet in evidence concedes it may have been after the event. I make this decision without being influenced by what is termed the London Protocol investigation. Neither this doctor, or Dr Hicks or nurses were the subject of any interview. I do not accept it carries any weight at all.

97. On balance I consider the sequence of events to have been that Dr Luu had a brief conversation with Ms Pearson in the anaesthetic bay, that he was then handed the envelope by Nurse Jobson with the instruction to hand it to Dr Gani. That he read the GP letter and glanced at the CT report and incorrectly assumed it was no more than a referral for the procedure she was about to have. That it was found on the work table after the procedure was halted leads to the conclusion that it was placed there by Dr Luu, however this was unfortunately not put to Dr Luu in his evidence.

98. Nurse Jobson asked Dr Luu a day or two after the event if he had given the envelope to Dr Gani and she couldn't remember his response. In her statement she indicated when asked about the envelope he said he did give it to Dr Gani.

Other issues – Conclusion

99. Dr Gani's previous use of saying "How are you" is not in my opinion reasonable and appropriate to provoke a patient – even one he knows well from previous consultations, into providing useful information about any recent problems. It is the first words said to the patient by the consultant and can very well be accepted as a greeting. Plainly Ms Pearson did so. He has indicated in his evidence that he has now changed his greeting to the patient- "how have you been since we last saw each other?" Even so with this change to his introduction I consider it is still possible that a patient not divulge information. I consider it warrants further consideration.

100. I do not accept, on balance, that Dr Gani called out anything about "new imaging data" or "other relevant data" in the time out procedure. He made reference to some items not being called out if not relevant. He needed to be prodded or reminded about this particular point. It was not said without assistance from his Counsel. Another reason is that there were possibly two people who could have called out something - certainly Dr Luu who was at least aware of a CT scan report. The other is Nurse Jobson who was aware of an envelope but not of its contents. She did assist in the adult pre procedure checklist by acknowledging "correct imaging data available". She agreed she did not read any of the documents and if there were scans available she was not qualified to interpret them. However her involvement in the second page of the checklist infers awareness of some imaging data. It is possible she was not present in the theatre for the whole of the time out process as she had gone to get a blanket for the patient and that may have compromised her ability to have input. I am also satisfied that some form of scan film was there and available. There was reference to "scans" by Ashleigh Pearson at one or two meeting with doctors and others after the event. No one contradicted her that they, "scans" were not present and Dr Gani said at the very least they were.

Ashleigh Victoria Pearson

101. Ms Pearson confirmed that there were three meetings with doctors. One at Belmont Hospital on the day of the gastroscopy and the second occurred at John Hunter Hospital in the intensive care unit and the third which took place at Belmont Hospital after her mother had passed away. She recollects that at either of the meetings at Belmont Hospital she had asked about the scans. Her best recollection is that she said:

> "Mum had had scans done. I asked Dr Gani that she said that she brought them and I asked what had you know what happened to them, did she mention them? Dr Gani had said no that she didn't mention them to him or to Dr Hicks either and that Dr Gani had said – this is the part I can't 100% could recall which meeting that it was at, whether it was at the meeting at Belmont Hospital on the day of the gastroscopy or… That they were in the room, they were on the desk, they were in the room but it's not part of their procedure, their normal procedure, to look at those tests because 90% of the time they not relevant."

She thinks that this conversation occurred at the second meeting although she does recall scans being discussed at all of them. She said she still has an actual memory of Dr Gani saying those words because she was taken slightly back… "But at the same time I thought well it makes sense in a way because I can picture that being the case. Like people turning up to have a gastroscopy bringing scans of their knees and things like that so it did make sense to myself."

102. Counsel for Dr Gani put this question to Ms Pearson:

> "Q. Just picking up on the question that was just asked by counsel assisting, to the best of your recollection did Dr Gani say

something along the lines of “the patients are always told to bring in their scans and 90% of the time they are not relevant” is that correct?

A. Yes”

Paul Lee Patterson

103. Mr Patterson was Ms Pearson’s long-term partner. He remembered attending a meeting at Belmont Hospital in March 2016 along with Jody’s daughter, Ashleigh, her father Trevor, and her uncle Mark. He remembered Ashleigh asking something to the effect “what happened to the scans, like Jody took in on the day”. He remembers words to the effect “Dr Gani said he was dealing with Jody for the last 10 years, that he had referred to his own notes on Jody and like the scans were 99% irrelevant. So yeah he didn’t look at them”. He said this just stuck in his head. Again counsel for Dr Gani put a different version of Dr Gani’s response and Mr Patterson preferred his own version and recollection.

104. I am not satisfied on balance that Ashleigh Pearson’s version of her recollection of what Dr Gani said concerning the scans and other documents is accurate as in her statement. Ashleigh attributes Dr Gani saying words to the effect “we did not look at the scans because 90% of the time they are not relevant”. Dr Gani said that he would have said something like “the patients are always told to bring their scans and 90% of the time they are not relevant”. His explanation is that you cannot determine relevance until you have looked at them. My impression from observing Ms Pearson and Mr Patterson was that they were not exactly sure what was said concerning that particular phrasing.

John Robert Olsen

105. Dr Olsen had up until recently been the Director of the emergency department at the Belmont Hospital and the medical superintendent of the hospital and from the beginning of this year is now the director of medical services.

106. He did not take part in any of the early investigative procedures, being on leave when the debriefing session occurred and he did not take part in the London protocol report.

107. He gave evidence that in general terms, in clinical practice within a hospital environment there is a general understanding that the specialist in charge of the patient is the person to whom all relevant information needs to be referred. In respect of a registered practitioner in their training and experience, he said “I personally would expect that the individual person would know that if there was information that was relevant then it needs to be given to the doctor in charge”. Further that it is their responsibility to ensure that the specialist in charge knows that the information is available and has an awareness of it. It was accepted that one of the key principles in a safe clinical

handover is “to ensure documentation of all important findings or changes of condition” are part of the handover process. From his investigations he was not aware of what occurred to the CT scan films or images.

Ross Duncan MacPherson

108. Dr MacPherson is a practising specialist anaesthetist who prepared an expert report for the purposes of the Inquest. There was no issue with his opinion as expressed in his report. In summary – paraphrasing - that if the letter from Ms Pearson’s GP and the CT scan report had been given to Dr Hicks or Dr Gani prior to the procedure then it would have been cancelled or certain steps taken to ensure patient safety. He said if there was a decision made to continue with the surgery then the type of anaesthetic involved would include factors such as protection of the airway and minimising the risk of aspiration and regurgitation involving endotracheal intubation would have been undertaken. He also gave an opinion that the resuscitation efforts undertaken by Dr Hicks and the theatre team were appropriate in the circumstances.

109. He accepted that Dr Hick’s evidence that he either fills in his forms, the details of the history taken and medications identified, either in the anaesthetic bay or during the course of the operation after the patients have been sedated was a normal current practice and he had no criticism of it. He accepted that the conduct of intending to fill out the forms was interrupted as a consequence of the event that took place after the scope was removed.

Christine Osborne

110. Ms Osborne is the general manager of Belmont Hospital coming into that position in July 2016 with a background as a registered nurse and midwife.

111. Subsequent to the investigation into Ms Pearson’s death there arose some systems issues that were identified and recommendations were made to change certain policies at Belmont Hospital. One of the changes is incorporated into a policy document called “preparation of inpatients for surgery and interventional procedures.” It is an existing policy that has been reviewed, the last review being in March 2017. It sets out the procedure or steps to be followed when preparing a patient for surgery or other interventional procedure. The components that are within the policy document are considered mandatory.

112. In July 2018 two memoranda were issued pertaining to the day surgery staff and in particular when additional documents were presented to the day only unit by patients. For any additional documents be it letters, pathology results, imaging reports and so on they are to be placed in a red envelope so that they could be displayed prominently in the folder and they are easier to see when the folder is handed over to the anaesthetic nursing staff. The next mandatory stage is that the unit anaesthetic nurse has the responsibility of informing the consulting surgeon or anaesthetist that there are new documents that the

patient has brought in. A new policy document, tendered at the inquest and entitled “Clinical Handover from Day Surgery Nurse to Anaesthetic Nurse in Belmont Hospital Perioperative Unit”, puts the responsibility onto the anaesthetic nurse to ensure that the consulting surgeon or anaesthetist is aware of the documents no matter the contents of the documents.

113. Ms Osborne indicated that an investigation took place that is known as a “London protocol” and from that protocol some issues were identified which included poor communication between the day stay nurse and anaesthetic nurse and thereafter the lack of communication between the nursing staff to the medical staff. It was further recommended that one anaesthetist be rostered on for a full day in the operating theatre.

114. In relation to the new policy document that relates to the identification of new documents it was pointed out that the policy did not stipulate who had the responsibility of asking about new material or new documents. Ms Osborne agreed it would be useful to make it clear whose responsibility that is. Further the new policy document did not make it clear who was to refer the documents to the consulting surgeon and anaesthetist and while in practice it is done by the anaesthetic nursing staff it would be helpful to spell out who has the responsibility.

115. Ms Osborne indicated that the new policy and procedures that have been implemented at Belmont Hospital are also being looked at for implementation over the whole of the Hunter New England Health District and that it is being discussed with clinical governance at this time.

116. At the conclusion of the evidence at the inquest Ms Ashleigh Pearson came up to the front of the court and addressed us all. With considerable poise she expressed on behalf of her family and herself the family’s gratitude and thanked the officer in charge of the investigation Senior Constable John Williams, Ms Sant Counsel Assisting and Mr Mullane, from the Crown Solicitors for all of their hard work time and effort. She indicated that their mother meant a great deal to them and that the process that had come about with the investigation and ultimate Inquest, to have gone into it with such depth she considered was of great help to understand what actually took place and made it clearer as to what occurred. She indicated that from the Inquest she hoped that there were changes in procedures so that other families would not have to go through the same grieving process and loss as they had to. She concluded by saying “thank you very, very much to everybody involved and thank you”

Fact Finding

117. From the evidence I make the following findings:

I. Jodi Pearson presented to Belmont District Hospital on 15 February 2016 and brought with her the recent CT report, a letter from her general practitioner and CT scan image.

II. Ms Pearson drew these documents to the attention of the admission nurse who made a note of them – specifically made a note that there were CT results attached on the patient's adult pre procedure checklist.

III. The documents that Ms Pearson brought in with her became attached to her patient folder and accompanied her.

IV. Ms Pearson mentioned the documents during a conversation with Nurse Jobson, the anaesthetic nurse and she took the envelope that contained the CT report and the GP letter from the patient folder. She noted that the envelope had on it "attention Dr Gani".

V. Nurse Jobson handed the envelope to Dr Luu. She said to Dr Luu that Ms Pearson had requested the envelope go to Dr Gani as it was important. Nurse Jobson left Dr Luu with the understanding that the doctor would provide the envelope to Dr Gani in the operating theatre prior to the procedure commencing.

VI. Dr Luu read the GP letter but in view of inexperience and not asking any questions of Ms Pearson did not understand the importance of the content of the letter. Dr Luu thought the letter was a referral letter for the procedure that Ms Pearson was having on that day being a gastroscopy.

VII. On balance I cannot be satisfied that Dr Luu effectively communicated in any way that he had a letter for Dr Gani to read nor am I satisfied on balance that he gave the envelope directly to Dr Gani.

VIII. Dr Gani did not read the letter or the CT scan report or the CT scans until after the procedure was halted and the patient sent to the ICU at John Hunter Hospital.

IX. After Ms Pearson was transferred to the intensive care unit at John Hunter Hospital, Dr Gani found the letter, CT report and CT scan on his work table next to his computer. That it was found on the work table after the procedure was halted may lead to the conclusion that it was placed there by Dr Luu but I cannot make a firm finding as it was not put to Dr Luu in his evidence.

X. On balance I accept that the CT scan films were also in existence and placed on the work table. Whether they were a larger A3 size or a smaller CD type size I am unsure from the state of the evidence. Because no one else saw them I am inclined to the proposition that the film was on a disc and likely in the envelope.

XI. It is certain that if Dr Gani and/or Dr Hicks were made aware that Ms Pearson stomach contained a food bolus then the procedure would not have taken place on the day.

XII. There is no criticism of the nursing staff who were involved either with Ms Pearson's pre-admission procedure, her admission and the

conveying of Ms Pearson to the anaesthetic bay. There can be no criticism of Nurse Jobson as she had handed the envelope to Dr Luu. There is no criticism of the actions of Nurse Lay and Nurse Lemonius who performed their tasks as they were expected to in the operating theatre.

XIII. There is no criticism of Dr Hicks the anaesthetist. He conducted a pre-procedure consultation as is his usual practice. He was not made aware of any new medical event or condition so that in his mind at the time of the procedure it was to be a normal gastroscopy. There is no criticism of Dr Hicks in his efforts to revive Ms Pearson nor is there any criticism of any doctor or medical staff within the operating theatre in relation to their efforts in attempting to revive Ms Pearson.

XIV. There were policies in place at the time of the procedure however there was a communication breakdown that occurred in this matter. It occurs at a time between the obtaining of the information by Dr Luu, importantly his interpretation of that information and his efforts in passing on that information to Dr Gani. I am not satisfied on balance that Dr Gani did call out in the timeout procedure "any current or relevant medical imaging data available". It is possible that Nurse Jobson may have been absent for part of the timeout procedure (she was obtaining a blanket for Ms Pearson) and only came in to the operating theatre when part of the callout procedure was taking place. However what she did hear enabled her to call out about the drug allergy Ms Pearson suffered for Lyrica. Furthermore Dr Luu did not make any effort to call out if in fact he was aware of the CT scans or had understood the content of the CT report results. Dr Luu said at best he only glanced at these. If Nurse Jobson had been in the operating theatre if it had been called out then likely as she did with the drug allergy issue she may well have raised it although she was not aware of the contents of the envelope nor does she remember any scans or other imaging data.

Recommendation

118. There will be a recommendation made at the conclusion of this inquest that consideration be given by the Hunter New England Local Health District that the policy now in place at Belmont District Hospital in its Clinical Handover from Day Surgery Nurse to Anaesthetic Nurse in Belmont Hospital Perioperative Unit policy be incorporated to apply to other Hospitals within the District and that consideration be given to ensure that the policy document identifies the particular staff member who will have responsibility for each assigned task.

Conclusion

119. I described these sad events as a tragedy - and they were. All the people involved in Ms Pearson's procedure who gave evidence are hardworking and caring medical people. On the conclusion of their evidence those significantly involved gave a very heartfelt and genuine apology to the family about the

events of the day and its fatal consequences. Unfortunately, assumptions were made about the state of her health, Ms Pearson herself who told a number of nursing staff about the envelope and report did not then tell the consultant. There can be no blame about this. She had already told a number of nurses about it and likely felt confident that the information would be passed on to the consultant. I hope lessons have been learned- particularly not to take anything for granted, to make appropriate inquiry of the patient about any recent attendances at doctors or hospitals.

120. I sincerely hope that the process of this inquest has provided to the family of Ms Pearson some feeling of closure. That her death, while tragic, has brought some changes to the way in which people will be assessed and treated in the future. From her death other people have learned from their errors and that is a very important matter and one that the Pearson family can take with them. Further there is a significant and lasting outcome arising from her death and that is the change in procedure.

121. I extend again my sincere condolences to Ms Ashleigh Pearson and her family on the death of her much loved mother.

122. I take this opportunity of thanking the officer in charge of the investigation Senior Constable John Williams. I acknowledge the great help and assistance of Counsel Assisting, Ms Kathy Sant and her instructing solicitor Mr P Mullane from the Crown Solicitor's Office. The help of other Counsel and solicitors who represented persons of interest is also gratefully acknowledged and appreciated.

123. I am also grateful for the manner and way they approached the Inquest and the assistance provided to the Inquest.

Formal Findings:

I find:

A. The date of death was on 19 February 2016;
B. The time of death was 4.15pm;
C. The place of death was John Hunter Hospital Newcastle;
D. The cause of death was hypoxic encephalopathy and aspiration pneumonia and antecedent causes were aspiration of gastric contents following gastroscopy procedure.
E. Manner of death: Jodie Ann Pearson died accidentally after a gastroscopy procedure was commenced that should not have taken place arising from a communication failure to inform the surgeon that new information was available.

Recommendation:

To Hunter New England Health District:
That the policy now in place at Belmont District Hospital in its Clinical Handover from Day Surgery Nurse to Anaesthetic Nurse in Belmont Hospital Perioperative Unit policy be accepted and incorporated to apply to all Hospitals within the District and that consideration is given to ensure that the policy document identifies the particular staff member who will have responsibility for each assigned task.

R Stone
Deputy State Coroner
Newcastle