STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Into the death of Patrick Thomas
Hearing dates:	11 and 12 February 2019
Date of findings:	22 March 2019
Place of findings:	State Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E. Truscott
Catchwords:	Coronial Law- Cause and manner of death-
File number:	2013/00364820
Representation:	Counsel Assisting: Dr P Dwyer /Crown Solicitor's Office Sutherland Hospital: Mr I Fraser / Hicksons Lawyers Kareena Private Hospital: Ms L McPhee / MDA National Dr Kariappa: Mr P Rooney/Meridian Lawyers Dr Lehane: Mr S Barnes/ Avant Law
Findings:	**Patrick John Thomas died on 18 October 2013 at Sutherland Hospital. The cause of his death was intestinal failure/sepsis, arising from venous ischemia as a result of superior mesenteric vein division which occurred accidentally during a surgical procedure to remove colon cancer at Kareena Private Hospital on 9 October 2013**
Recommendations:	**To Chief Executive – South Eastern Sydney Local Health District** 1. That where a patient transferred for care from a private health facility dies in The Sutherland Hospital, there be a written protocol which provides for: a) the notification of the death to the Director of Clinical Services/General Manager of the private health facility from which the patient was transferred; b) the Director of Clinical Services at The Sutherland Hospital to notify the LHD Director of Clinical Governance of any such deaths for consideration of what action is

	required to be taken under the NSW Health "Incident Management Policy". **To the Chief Executive Officer, Kareena Private Hospital** 1. That where a patient transferred for care from a public health facility dies in the Kareena Private Hospital, there be a written protocol which provides for: a) The notification of the death to the General Manager/Chief Executive of the public health facility from which the patient was transferred; b) Communication between the Director of Clinical Services of Kareena Private Hospital and Director of Clinical Services of the public health facility as to whether follow up review is required, who is responsible and what resources should be shared. 2. Where a transfer for escalated care follows surgery, the surgeon must complete and sign a transfer document, outlining the nature of the operation, the complication (if any) and reasons for transfer. 3. That the Hospital implement training and education regarding the requirement of an RCA be conducted. 4. That the Hospital implement training and education regarding the requirement to notify a Coroner of a death.

IN THE STATE CORONER'S COURT
LIDCOMBE
NSW

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This inquest concerns the death of Patrick Thomas who was aged 52 when he died on 18 October 2013 at The Sutherland Hospital. Mr Thomas had two surgical procedures nine days prior at Kareena Private Hospital. Due to his requiring extensive intensive care he was transferred to Sutherland Hospital where he had a further three surgical procedures at Sutherland.

2. His death was not reported to the Coroner in the usual manner that is by the hospital completing a "Form A Report to Coroner". Rather, a surgical registrar issued a death certificate. Within a few days during a process involving Sutherland Hospital's governance, it was identified that the certificate should not have been issued and accordingly, a report was made to the coroner identifying the error. By that time Mr Thomas had been cremated after his funeral.

3. Patrick was the loved husband of Shirley and the eldest of 6 boys. His brother Mark attended the inquest and spoke on behalf of Patrick's family. He spoke of the support Patrick gave their mother Margaret when they lost their dad in 2009 and how Patrick was the mainstay for the family. Patrick is very much missed and the five years since his death have been a testament to the family's perseverance in discovering the circumstances leading to his untimely and unexpected death.

4. Patrick and Shirley met in 1986 and married sometime after. Their only child Bridget sadly passed away shortly before her second birthday in 1997. Patrick was a tradesman boilermaker and at the time of his death worked as a project manager for a high purity water company in Ryde. He and Shirley had intended that upon their retirement they would live in Port Macquarie no doubt enjoying fishing and boating.

Background

5. Patrick's health deteriorated in the first half of 2013 when he began having stomach aches and pains. Shirley encouraged him to seek medical advice, which he eventually did in September. Patrick and Shirley attended the after-hours GP service offered by Kareena Private Hospital and spoke with Dr McConnell, as over the weekend Patrick could not keep any food or drink down. Dr McConnell asked him to return on the Monday. He did so and Dr McConnell referred him for a CT scan and to attend Dr Sanjay Kariappa, a colorectal surgeon.

6. On 20 September Patrick had a staging CT Abdomen and Pelvis scan. The report concluded that there was *"a 30 cm segment of terminal ileal wall thickening, oedema and surrounding vascularity and circumferential thickening at the hepatic flexure without evidence of bowel obstruction or perforation. Although the patient's history may point to infective cause, the presence of two bowel segment abnormalities suggests inflammatory bowel disease (pattern not typical for lymphoma)".*

7. Dr Kariappa reviewed his CT scan and saw an apple core constriction on a portion of the large bowel located near the liver. Blood test results suggested an elevated carcinoembryonic antigen (a tumour marker sometimes associated with colon cancer) but its potential significance was uncertain particularly because Patrick smoked cigarettes, which can also cause an elevation. Dr Kariappa explained that a CT scan was not a reliable investigation for hollow organs, such as the bowel and recommended that to determine the cause of the

abnormality Patrick should undergo a gastroscopy and colonoscopy as soon as possible.

8. On 26 September 2013, Patrick underwent both procedures performed by Dr Kariappa. The colonoscopy revealed more than 30 polyps in the colon, together with a proximal transverse colon adenocarcinoma. Biopsies were taken and sent to pathology marked urgent and an appointment was made for Patrick to discuss the results four days later.

9. On 27 September, the Pathologist advised Dr Kariappa that the biopsy of the obstructing lesion was consistent with adenocarcinoma. On 30 September, Dr Kariappa received further results from the Pathologist showing that the microsatellite status (the "MSI") was stable, indicating against the possibility that the cancer had spread.

10. Both Patrick and Shirley attended Dr Kariappa that day where they discussed the finding. As Patrick had symptoms of obstruction (pain and vomiting) and an impassable cancer, Dr Kariappa recommended that he undergo surgery.

11. Dr Kariappa advised Patrick that because the CT scan of his abdomen had not demonstrated any metastases, a cure was still possible. Dr Kariappa recommended surgical resection by way of a laparoscopic right hemicolectomy. In order to explain the operation, he drew several diagrams showing the location of the tumour, and the critical structures near the tumour. Since there was no evidence of hereditary cancer, and the fact that the MSI was stable, Patrick, in consultation with Dr Kariappa, decided that rather than have a total colectomy the best surgical option was an extended right hemicolectomy.

12. On 2 October 2013, Patrick underwent a staged CT scan of his chest. It was reported as showing no significant abnormality within the chest; however the scan extended a short distance into the liver, which showed areas of decreased attenuation in the right lobe of Patrick's liver.

13. On 8 October 2013 Patrick's case was discussed at a multidisciplinary team meeting held at St George public hospital, Kogarah. Attendees at that meeting included a radiologist, an oncologist and colorectal surgeons. The team reviewed the CT scan films of Patrick's chest. It was agreed that the liver lesions looked like metastases, and that an ultrasound should be performed post-operatively to demarcate the liver lesions further, but not to delay the surgery. However, it was determined that the obstruction should be removed as soon as possible so that cancer treatment involving non-surgical options would be available to Patrick. (The earlier abdominal pelvic CT scan films, which would have shown all of the liver, were not available to the meeting and the report provided to Dr Kariappa only referred to the study of the bowel. Those scans showed that the bowel cancer had metastasised to Patrick's liver).

First Operation at Kareena Hospital on 9 October 2013

14. On the morning of 9 October, Dr Kariappa commenced Patrick's operation laparoscopically. That involved a process called pneumoperitoneum, where the abdominal cavity is inflated with gas to allow the use of laparoscopic procedures. Dr Kariappa mobilised the ileocolic blood vessels but he says as he was dividing the right colon mesentery, he encountered unusually excessive bleeding. Given that the area is not one usually associated with significant bleed vessels, Dr Kariappa initially thought that he was in the wrong plane and that he was dealing with pancreatico-duodenal vessels that normally lie medial to the normal operative plane. He satisfied himself that he was in the correct plane and proceeded to lengthen the midline extraction port and controlled the bleeding by ligature.

15. Dr Kariappa mobilised the hepatic flexure noting that the bulky obstructing cancer had equally bulky lymphatics enveloping the middle colic vessels. Dr Kariappa explained that the cancer had distorted the anatomy, with collateral vessels becoming enlarged and distorted where the main vessels had become affected by tumour. As a result of the distorted anatomy and pathology, Dr Kariappa converted the operation to an "open procedure" so that he was able to

better visualise, mobilise, dissect and take vascular control of the middle colic vessels.

16. Dr Kariappa believed that he had located and isolated the middle colic vein ("MCV") encased in tumour, and he proceeded to ligate or tie off the vein below the mass of enlarged lymph nodes also encased in the tumour. This procedure involved a resecting or cutting 3 cm of the vein. However, it was not the MCV but rather the superior mesenteric vein ("SMV") that he had divided, which had the profound effect of reducing the venous blood returning to the heart.

17. Patrick became progressively haemodynamically unstable. Dr Kariappa was not aware of his error as there was no obvious blood loss. The anaesthetist was concerned that Patrick's instability may have been due to a primary deterioration in Patrick's cardiac state. Dr Kariappa stopped operating to allow for Patrick's condition to be stabilised with the provision of fluid and drugs to increase blood pressure. Patrick stabilised sufficiently for Dr Kariappa to complete the surgical procedure by ileostomy (which involves bringing the end of the small bowel to the skin.)

18. Concerned about Patrick's haemodynamic instability, Dr Kariappa consulted with other specialist doctors - an Intensivist and a Cardiologist. Despite their review and extensive ICU treatment, Patrick's condition did not stabilise. An echocardiogram indicated that there was no evidence of any cardiac abnormality and Dr Kariappa suspected that an injury to the SMV was the cause of Patrick's instability, which was confirmed on an emergency laparotomy.

19. Dr Kariappa spoke with Shirley. In her statement to the police Shirley said that Dr Kariappa told her "Everything went well with getting the cancer off the bowel, but when I took the cancer off there was another cancer on the artery to the bowel. Unfortunately, I nicked the main artery and he had massive blood loss and two cardiac arrests". In his evidence, Dr Kariappa said it was unlikely that he would have used those words as he would not describe the need to replace two litres of blood as a massive blood loss and that the echocardiogram did not show that Patrick had experienced any cardiac arrests.

20. It may be that Shirley was told of Patrick's blood loss in those terms only by the anaesthetist who also spoke to her as she outlines in her statement. In any event it was extremely shocking news to Shirley and Patrick's family. Shirley was aware of the surgical accident and, when asked by Dr Kariappa about what she wanted him to do about Patrick, she replied "fix him".

21. Dr Kariappa tried to do just that. He unsuccessfully sought the assistance of a vascular surgeon to assist him in a planned second surgery – one surgeon suggested that Patrick proceed to palliative care. Having no time to wait, Dr Kariappa secured the assistance of an experienced general surgeon and they proceeded to a second surgery.

22. At 6.20pm, Patrick was taken back to surgery. In the first surgery Dr Kariappa had inadvertently resected the SMV with the tumour. The two ends of the SMV were 3cm apart. A graft was required to rejoin it. Due to the consequent inadequate blood supply the distal 60cm of Patrick's small bowel had undergone irreversible venous ischemia and accordingly that required excision or removal.

23. The surgeons used a section of the inferior mesenteric vein ("IMV") as a graft, and blood flow was re-established. The 60 cm of ischaemic bowel was removed. A temporary abdominal closure device (VAC dressing) was applied, as it was anticipated that a repeat laparotomy would be required within the next five days.

24. Patrick was returned to ICU and stabilised over the next few hours. Shortly before midnight he was transferred to The Sutherland Hospital as, at that time, Kareena Private Hospital did not have adequate facilities for patients requiring intubated ventilation for a period in excess of 24 hours. The plan at that time was 48 hours of intubation, with a re-look laparotomy in the next 24-48 hours.

25. Dr Kariappa holds an appointment at The Sutherland Hospital so Patrick was admitted and remained under his care.

26. On 10 October 2013, Dr Kariappa reviewed Patrick. The ICU team were providing extensive drug therapy and fluid support and Patrick was stable.

27. On 11 October 2013, Dr Kariappa arranged for Patrick to be reviewed by a gastroenterologist. Later that day, he returned Patrick to theatre and changed the VAC dressing.

28. On 12-13 October 2013, there appeared to be some improvement in Patrick's overall clinical condition.

29. On 14 October 2013, Patrick was returned to theatre for a re-look laparotomy, with the assistance of a vascular surgeon, Dr Gabrielle McMullen. A clot had formed in the original graft, it was cleared and Dr McMullen performed a replacement graft. Patrick was returned to the ICU.

30. From 15-17 October 2013, Patrick's condition remained relatively stable.

31. On 18 October 2013, a planned re-look laparotomy was performed. Despite there having been no dramatic changes in Patrick's haemodynamics, his entire small bowel from the distal duodenum to the level of the ileostomy was identified as non-viable. The SMV vein graft had occluded (closed up), and there was no palpable pulse in the superior mesenteric artery. It was at this point that Dr Kariappa appreciated that, despite his best efforts, Patrick could not survive. He reapplied the VAC dressing, Patrick was returned to ICU and Dr Kariappa spoke with Shirley and Patrick's family.

32. On 18 October 2013, Patrick's life support was switched off and he died shortly surrounded by his loved ones. Patrick had not regained consciousness at any time after the first operation nine days earlier.

33. On 28 October 2013, Patrick's death was reported to the Coroner by the Clinical Director of Sutherland Hospital - the issue of why it was not reported sooner is discussed later. In investigating the manner and cause of death, the Coroner ordered a report from Professor Anthony Greenberg, who gave evidence in these proceedings. Professor Greenberg is a General and Gastro-Intestinal

Surgeon with significant clinical and forensic experience, who has given evidence in this court many times. In his initial report (T27), it was initially suggested that Patrick's primary injury, an inadvertent division of the superior mesenteric vein, may have been as a result of surgical error in the initial surgery, in the form of excessive traction to the right colon or hepatic flexure during mobilisation, or a technical error leading to a division of the SMV.

34. That report was served on Dr Kariappa, who denies that the division of the SMV occurred that way. He says that he used the appropriate surgical technique of mobilising around the middle colic and not applying upward traction. Dr Kariappa's explanation is that the involvement of the vessels by tumour significantly distorted the anatomy and unfortunately resulted in the inadvertent removal of a segment of involved vein in the course of the re-section of the tumour.

35. Professor Greenberg provided two supplementary reports in 2017 (T28) and gave short evidence. Professor Greenberg accepts Dr Kariappa's explanation and accepts that Dr Kariappa did all that he could to preserve Patrick's life. I am of the same view.

Death Certificate

36. In October 2013, Dr Christopher Lehane was working as Dr Kariappa's surgical registrar. Dr Lehane had finished his duties at The Sutherland Hospital shortly prior to Patrick's second operation. He attended Kareena Private Hospital and assisted Dr Kariappa in the second surgery. After Patrick's death, staff from the Intensive Care Unit contacted Dr Lehane and asked him complete the necessary documents to record Patrick's death.

37. Dr Lehane was unsure whether Patrick's death should be reported to the Coroner and he contacted Dr Kariappa to discuss the issue with him. Dr Kariappa erroneously advised him that he need not report Patrick's death to the Coroner but could fill out a death certificate. He narrated to Dr Lehane what he should write on the death certificate.

38. Dr Lehane wrote that Patrick's death was caused by "Intestinal failure/sepsis", due to "SMV division/venous ischaemia", with other significant contributing conditions listed as "metastatic colon cancer/lung mets/tumour adjacent to the SMV". Another doctor completed a cremation certificate and forwarded a copy of that to the Kareena Private Hospital.

39. On 21 October 2013, Kareena Private Hospital updated Patrick's hospital record (which had been closed on 16 October) that he had died.

Failure to report death to the Coroner

40. On 25 October 2013, Mr Thomas was cremated and on 28 October 2013, Dr Martin Mackertish, then the Director of Clinical Services at The Sutherland Hospital wrote to the State Coroner advising that Patrick's death had incorrectly not been reported.

41. Section 6 of the *Coroners Act* 2009 defines the circumstances in which a death should be reported to the coroner. Under s. 6(e) a reportable death includes one where "the person's death was not the reasonably expected outcome of a health-related procedure carried out".

42. Nobody expected that Patrick would die as a result of the first surgery performed on 9 October 2013 at Kareena Private Hospital. It was clear to Dr Kariappa that the accidental severance of the SMV was the event that ultimately caused Patrick's death, despite the graft repairs and the ICU intervention. Though Patrick was an ICU patient in The Sutherland Hospital, it was due to what had occurred at the Kareena Private Hospital and it was quite appropriate that Dr Lehane and/or Dr Kariappa be asked to determine whether the matter should be referred to the Coroner. Indeed, had Dr Kariappa not had an appointment at The Sutherland Hospital and Patrick was under the care of another doctor employed there, one would expect that the originating surgeon would be asked to be involved in the decision about whether the death was reportable.

43. Under s. 38(1) of the *Coroners Act* "a medical practitioner must not give a certificate as to the cause of death of a person[…]if the medical practitioner is of the opinion that:

(a) the person's death is a reportable death"

44. The failure to refer Patrick's death has been scrutinised closely to understand how it came about and as to whether Dr Kariappa was attempting to avoid revealing the surgical mishap in the first operation.

45. Dr Lehane gave a statement and evidence about how he came to complete the death certificate. I accept that he was acting under the instruction of a senior doctor and I accept his evidence that he has re-read his obligations under the *Coroners Act* and he appreciates now that the death should have been reported to the Coroner. I accept that Dr Lehane has now familiarised himself with the obligations upon a medical practitioner to report a death to the Coroner and is aware that he can seek advice from a number of services including the hospital as well as the Coroners Court.

46. Dr Kariappa gave evidence that he was unfamiliar with the Coroners legislation and believed that because he knew what the cause of death was that the matter did not need to be reported to the Coroner. He says that he is now aware of the requirements and that if he has any uncertainty he is aware that he can seek advice from either the Coroner's office or the hospital directorship. Likewise I accept that evidence and I do so for a number of reasons.

47. Firstly, the cause of the ischaemic failure is identified in the certificate, namely SMV division. An SMV division cannot occur naturally. Secondly, it would appear that the surgical accident is a rare event for Dr Kariappa to experience and he found it utterly stressful and distressing and knew clearly what had occurred. He had told Shirley Thomas after the first operation that he had nicked the artery. He has now explained it clearly when asked without any attempt to resile from this. Thirdly, he seems to have laboured under the misapprehension about what happens in the Coroner's jurisdiction and what

post mortem procedures are involved in the jurisdiction. Essentially, Dr Kariappa thought that he only had to report a death if the cause was not known in which case an autopsy would be ordered by the Coroner. Dr Kariappa said that as he already knew the cause, there was no need to report the matter to the Coroner.

48. The Coroner makes a range of orders upon the receipt of a report of a death; those orders include directions as to what investigation is to be carried out to ascertain a cause of death as well as to ascertain the manner or circumstances of someone's death. In terms of an autopsy under s. 88 of the Act, the least invasive procedure is required to be carried out, which means in Patrick's case, having undergone numerous surgeries, it would be reasonable to expect that an order would be made requiring a forensic pathologist to review the medical records and, only if necessary, review the anatomical surgery.

49. Such a review would have required the surgical records from both Kareena Private Hospital and The Sutherland Hospital to be sent to the Coroner. The Coroner's office can obtain those records to provide to a forensic pathologist.

50. As I understand it, the Kareena Private Hospital records did not accompany Patrick to The Sutherland Hospital and the file was closed two days before he died. However, given that Dr Kariappa had been Patrick's treating doctor at both hospitals, he would have been in a position to complete a Form A in which he would have set out what had occurred.

51. It is worth noting that a review of Dr Kariappa's surgical notes, which were mainly diagrammatic, does not, without explanation, identify what went wrong in the first surgery. Indeed there is no mention of a division of the SMV. There should have been a written description of what had occurred in both the first surgery and the second surgery where the first graft was constructed. The need for record keeping is obvious and without it, concerns about the reasons for lack of transparency arise.

52. The requirement for unexpected deaths to be reported to the Coroner, even where the cause is known, is not to cast blame on anyone, but to identify any

issues concerning public health and safety and the investigation or review of matters by persons or bodies. That is one of the objects of the Act (s. 3 (e)).

Kareena Private Hospital follow-up review of operation

53. The lack of opportunity for scrutiny and review of Patrick's case was not only evident in the failure to report his death to the Coroner but also a failure in the hospital process itself. In NSW, and indeed throughout Australia, processes exist for hospitals to review unexpected adverse outcomes of medical treatment including, of course, surgical procedures.

54. One such investigation process is called a "Root Cause Analysis" which is an internal review process carried out in public hospitals and other community services. The review is aimed at identifying the root cause/s, contributing factors and/or system failures so that recommendations for changes and improvements can be made and implemented to prevent adverse patient outcomes. Once a report is completed, upon request a copy is sent to the Coroner. Though it is a report that is not admissible in these proceedings (so as to encourage full and frank disclosure) the fact of a report having been done is admissible. The reason the Coroner is interested in receiving such a report is to ensure that a coronial investigation does not duplicate reviews and recommendations which have already been made. Many an inquest is dispensed with where the Coroner is satisfied that the RCA has dealt with matters sufficiently so that there are no issues remaining for inquest.

55. In this case, no RCA was conducted by either Kareena Private Hospital or The Sutherland Hospital. The legislative and policy regime in place in 2013 intended for an RCA to be carried out in circumstances similar to Patrick's death. The process of an RCA is and was at the relevant time, governed by the *Health Administration Act* 1982, which has been amended since September 2013. Section 20L of the Act provided (in brief) that an RCA should follow a "reportable incident".

56. The *Health Administration Regulation* 2010 (in place as at October 2013), at reg 13, defined "reportable incident" for the purposes of s. 20L of the Act as meaning "an incident of a type set out in the document entitled *NSW Department of Health Policy Directive PD2005_634 Reportable Incident Definition under section 20L of the Health Administration Act*, as published in the Gazette on 23 December 2005".

57. That Policy Direction (V 2, T 40) defined a "reportable incident" as including one that has "Serious clinical consequences", further defined to include "the death of a patient unrelated to the natural course of the illness. And differing from the immediate expected outcome of the patient management".

58. Dr Kariappa gave evidence that Patrick's case came before the Kareena Private Hospital Patient Care Review Committee in February 2014, because Patrick had been transferred out of Kareena to Sutherland for a higher level of care. Dr Kariappa presented the case to the Committee. The notes indicate that Patrick had stage 4 liver cancer but really Patrick's death was unrelated to the progression of his cancer. The Committee did not identify any actions or recommendations required. While it is good that such a presentation was conducted I think it is no substitute for a formal review process that Patrick's death required the Kareena Private Hospital to engage in.

59. In a follow-up statement from the Kareena Private Hospital, the current Director of Clinical Services said that though it was accepted that the case involved a surgical complication that was managed, and the patient then transferred to Sutherland Hospital for a higher level of care, it was not a matter from which an RCA should be conducted because the incident did not have "serious clinical consequences" or "major clinical consequences" as defined by the legislation whilst the patient was in the care of Kareena Private Hospital.

60. In a statement from The Sutherland Hospital, the Director of Clinical Services acknowledges that Patrick's death may have been a reportable incident, warranting an RCA, but if it was, it should have been conducted by Kareena Private Hospital and not The Sutherland Hospital.

61. Mr Steven Rajcany, the current Chief Executive Officer at Kareena Private Hospital gave evidence. He said that since 2015, the hospital has Level 2 ICU care which means that it is a very rare event for a patient to be transferred for escalated care. Indeed in 2018, there were no transfers. In 2013 there were 4 transfers, one of which was Patrick.

62. He said that there were no formal arrangements in place between the hospitals whereby there would be a notification of a patient's death. He said that though the cremation certificate was sent to Kareena from Sutherland that did not trigger any response (other than it being put on an already closed file).

63. In his evidence Mr Rajcany now agreed the hospital should have conducted a review by an RCA. It is without doubt that the surgical accident at Kareena Private Hospital did result in serious or major clinical consequences. However, it seems that Kareena Private Hospital had deemed Patrick's transfer out of its care as ending their involvement with any outcome of their treatment of Patrick. That cannot be an appropriate outcome.

64. The Sutherland Hospital did not have a process by which such an incident triggered a response pathway whereby a notification of death was sent to the transferring hospital to trigger a mortality review. I think that such a protocol for such a pathway is essential to ensure appropriate review and analysis.

65. Neither hospital has sufficient processes in place to ensure the adequate review of patients who are transferred between hospitals.

66. Dr Justine Harris gave evidence about the review processes available to The Sutherland Hospital where a surgical injury occurs and that a Death Review Committee reviews every hospital death. In Patrick's case there were no incidents to investigate which had arisen in The Sutherland Hospital. Indeed, she said that there was nothing in the material that indicated that there had been a surgical accident whereby the SMV was repaired.

67. Dr Harris though it would be possible to escalate a review of a patient involved in both private and public sectors by notifying the respective Clinical Governance authorities.

Conclusion

68. This investigation and inquest had identified a number of issues which arose in Patrick's care and the subsequent lack of appropriate review. I am of the view that Dr Kariappa disclosed to Shirley Thomas in basic terms that Patrick's first surgery did not go well because "he nicked the artery". I accept that that incident was highly stressful to Dr Kariappa and that he did all he could to repair the SMV but, unfortunately, these attempts were ultimately unsuccessful. Processes of fulsome medical notes, communication between hospitals and a preparedness to engage in full and open review are essential in our health care system. That did not occur in this case as there were not the appropriate policies and review pathways in place to ensure that such review was triggered and engaged in. That situation arose five years ago and there is now a need to make recommendations to put such processes in place.

69. It may be that ultimately the review would demonstrate, as this inquest has, that there were no systemic problems relating to Patrick's death itself but rather the systemic problems rested in the process about reviewing his death. That lack of process unnecessarily causes deep stress and distress to families who are already dealing with an unexpected loss of their loved one. As Dr Harris remarked, Patrick's death was unrelated to the progression of the cancer and in my view there has been insufficient regard to that fact.

70. Draft recommendations have been considered by the respective hospitals and I have received and considered submissions from each. I have determined that the recommendations should not be limited to the Kareena Private Hospital and The Sutherland Hospital relationship but in the case of the former to a public health facility and in the case of the latter to a private health facility.

71. The Kareena Private Hospital opposes the making of recommendations in relation to education and training about when a death should be notified to a Coroner and when an RCA is required to be conducted on the basis that there is currently sufficient training and education in place. Given the statements provided by the hospital in this investigation resisting any acknowledgement as to either requirement, a position that Mr Rajcany ultimately conceded in evidence, together with the fact that Kareena Private Hospital has not given any evidence about such processes, I am of the view that the recommendation is required.

Findings:

That Patrick John Thomas died on 18 October 2013, at Sutherland Hospital, as a result of intestinal failure/sepsis, following SMV division and venous ischemia that resulted from a surgical accident at Kareena Private Hospital during surgery to remove colon cancer on 9 October 2013.

Recommendations:

To Chief Executive – South Eastern Sydney Local Health District

1. That where a patient transferred for care from a private health facility dies in The Sutherland Hospital, there be a written protocol which provides for:
    a) the notification of the death to the Director of Clinical Services/General Manager of the private health facility from which the patient was transferred;
    b) the Director of Clinical Services at The Sutherland Hospital to notify the LHD Director of Clinical Governance of any such deaths for consideration of what action is required to be taken under the NSW Health "Incident Management Policy".

To the Chief Executive Officer, Kareena Private Hospital

1. That where a patient transferred for care from a public health facility dies in the Kareena Private Hospital, there be a written protocol which provides for:
    a) The notification of the death to the General Manager/Chief Executive of the public health facility from which the patient was transferred;
    b) Communication between the Director of Clinical Services of Kareena Private Hospital and Director of Clinical Services of the public health facility as to whether follow up review is required, who is responsible and what resources should be shared.

2. Where a transfer for escalated care follows surgery, the surgeon must complete and sign a transfer document, outlining the nature of the operation, the complication (if any) and reasons for transfer.
3. That the Hospital implement training and education regarding the requirement of an RCA be conducted.
4. That the Hospital implement training and education regarding the requirement to notify a Coroner of a death.

Magistrate Truscott

Deputy State Coroner
22 March 2019