STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Margaret MARIANI
Hearing dates:	5 – 7; and 10 – 12 February 2025
Date of findings:	14 August 2025
Place of findings:	State Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner of NSW
Catchwords:	CORONIAL LAW – complications of cholecystectomy surgery – grossly inadequate care and treatment provided at Forster Private Hospital – inadequate monitoring and poor record keeping of observations – delay in notifying surgeon of deterioration – deficiencies in practices and procedures
File number:	2019/00219251

Representation:	**Counsel Assisting the Coroner**: Mr Patrick Rooney of counsel, instructed by Ms Marnie Watts, Senior Solicitor together with Ms Sophie Hawkins-Adams, Solicitor and Ms Clara Potocki, Principal Solicitor of the NSW Crown Solicitor's Office. **Family**: Self-represented **Forster Private Hospital:** Mr Richard Lee of counsel, instructed by Ivan Li of Minter Ellison **Dr Mark Francis:** Ms Zoe Alderton of counsel, instructed by Claudia Chaffey of HWL Ebsworth **Dr Moheb Ghaly:** Mr Mark Lynch of counsel, instructed by Lyn Kearney of Avant Mutual **RN Lynette Martyn:** Ms Benish Haider, solicitor of New South Wales Nurses and Midwives' Association
Non-publication orders:	The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009*. Details of these orders can be found on the Registry file.

Findings:	**The identity of the deceased** The person who died was Margaret June Mariani. **Date of Death** Mrs Mariani died on 14 July 2019. **Place of Death** Mrs Mariani died at Manning Base Hospital, Taree NSW. **Cause of death** The cause of Mrs Mariani's death was due to complications of cholecystectomy surgery. **Manner of Death** The manner of Mrs Mariani's death was as a result of a steady deterioration in her physical presentation in circumstances where there would have been signs of peritonitis present earlier than 3.15pm on 13 July 2019 and where those signs were not recognised or escalated to the surgeon who performed the cholecystectomy surgery which impacted the provision of timely clinical care and treatment.
Recommendations:	1. That Forster Private Hospital give consideration to providing further training to all staff (including VMOs, CMOs/Locums and nursing staff) to ensure that the current policies and procedures are being adhered to with respect to documentation of patient's care. 2. That Forster Private Hospital give consideration to amending its policies and procedures to ensure that there is greater clarity in respect of the expectations of a VMO being contacted by a CMO/Locum or nursing staff and in what circumstances.

Contents

Section 81(1) of the Coroners Act 2009 (NSW) 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 Margaret June Mariani.

Introduction

1 This inquest concerns the death of Mrs Margaret June Mariani, who was known to her family and many friends as Betty.

2 Mrs Mariani was born on 2 June 1931. She died on 14 July 2019 at Manning Base Hospital, Taree, in the state of New South Wales at the age of 88 years.

3 Mrs Mariani died from medical complications arising from elective surgery performed on 12 July 2019 at Forster Private Hospital.

4 The identity, date and place of Mrs Mariani's death are not in dispute. This inquest has focused on the cause and manner of Mrs Mariani's death and the relevant contributing circumstances, including the care and treatment she received at Forster Private Hospital and Manning Base Hospital.

5 Mrs Mariani was the much-loved mother to her four children, and doting grandmother to her nine grandchildren and five great-grandchildren. She was described as being a vibrant person and the 'life of the party' to her family and many friends.

6 Members of her family have been constant advocates for her and have been unwavering in their determination to ascertain the reasons for her unnecessary death. Her four children have actively participated and contributed fulsomely during these proceedings, and I acknowledge the profound loss and anguish felt and experienced by her family and friends.

7 I would like to express my sincere condolences for their loss of this quite remarkable woman. I hope that her memory has been honoured by the careful examination of the circumstances surrounding her death and the lessons that have been learned from the circumstances of her passing.

The role of the Coroner and the scope of the inquest

8 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and how the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence adduced during the inquest, which may improve public health and safety.

9 Mrs Mariani's death was reported to the Coroner on 14 July 2019, as her death did not appear to be "the reasonable expected outcome of a health-related procedure carried out in relation to the person," or, in other words, was an unexpected consequence of her medical procedure. Her case was investigated and Magistrate Shields determined on 10 November 2019, that the case should not proceed to an inquest. Mrs Mariani's family sought a review of that determination. On 11 June 2021, the State Coroner directed that an inquest should be held, pursuant to section 29 of the *Coroners Act 2009* (NSW) (the Act).

10 During these proceedings, a brief of evidence containing statements, interviews, photographs and other documentation, was tendered in court and admitted into evidence. In addition, oral evidence was received from numerous witnesses. Written and oral expert evidence was received from Associate Professor Nicholas Williams, Professor Johan Duflou and Dr Steven Markowskei.

11 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by counsel assisting, Mr Patrick Rooney, Ms Zoe Alderton, counsel on behalf of Dr Francis, Mr Mark Lynch, counsel on behalf of Dr Ghaly, Ms Benish Haider, solicitor advocate on behalf of Ms Martyn, a Registered Nurse employed at Forster Private Hospital, as well as written submissions prepared by Mrs Mariani's four children who appeared in these proceedings on a self-represented basis. At times, I have embraced the various descriptions in these findings. The legal representatives for Forster Private Hospital did not provide written submissions at the conclusion of the evidence.

A Brief Overview of Mrs Mariani's Life

12 Mrs Mariani was born at St Margaret's Hospital in Darlinghurst. She was adopted into the loving family of Edward and Iris Murray.

13 Mrs Mariani was described as being the type of person who gravitated towards people and people gravitated towards her. She remained a lively and active octogenarian and was a well-respected member of the local Forster community.

14 Mrs Mariani was the vice-president of Forster Probus and patron of Forster Tuncurry Sports club. She was well known for her local charity work and community involvement.

15 She was described as an avid reader, who loved going to the movies, as well as being a "mad keen" follower of West Tigers rugby league team.

16 Mrs Mariani had suffered from asbestosis, which had caused scarring and pleural plaques in her lungs which resulted in restricting her respiratory function.

17 Mrs Mariani had a medical history which was significant for a transient ischaemic attack, gastro-oesophageal reflux disease, diverticular disease, tendonitis, a fractured right neck of her femur and had undergone a hysterectomy and lumbar laminectomy. She was also diagnosed with hypertension in May 2019.

Background

18 On 22 May 2019, Mrs Mariani was admitted to Manning Base Hospital for conservative treatment of pancreatitis secondary to gallstones, which was complicated by respiratory failure and pulmonary oedema. Mrs Mariani was under the care of Dr Ghaly. Her pancreatitis settled and she was discharged home on 29 May 2019.

19 After her discharge from hospital, Dr Ghaly indicated that they had several discussions regarding her treatment options for her gallstone-induced pancreatitis.

20 The standard treatment for her condition was the removal of the gallbladder. Mrs Mariani's asbestosis-related respiratory problems and her age potentially complicated her surgical outcomes.

21 On 9 July 2019, Mrs Mariani attended a consultation with Dr Ghaly, in the company of her daughter, Ms Karyn Hemming. Ms Hemming made contemporaneous notes during the consultation and stated in her statement in these proceedings that there was "no discussion of the potential risks." Ms Hemming was left with the impression that the surgery was a common and relatively simple procedure.

22 Mrs Mariani also attended the pre-admission clinic that same day. A Major Patient Alert Form was completed, which recorded her clinical alerts as including "Morphine – Vomiting, Sulphur – Skin reaction (rash), Endone – nausea and vomiting."

23 On 12 July 2019, Mrs Mariani, together with her daughter, Ms Hemming, attended Forster Private Hospital for a laparoscopic cholecystectomy, to be performed by Dr Ghaly. The anaesthetist was Dr Eva Wilson.

24 Mrs Mariani was admitted to the Day Surgery Unit at 12.30pm. She was transferred to the Operating Theatre at 2.04pm. Surgery commenced at 2.46pm and concluded at 3.35pm.

25 The surgery appeared to have proceeded without any complications, although a witness recalls someone commenting that "we haven't put the drain in."

26 Mrs Mariani was transferred to the Post-Anaesthesia Care Unit (PACU) at 3.36pm. She was described as being alert and breathing spontaneously. A Fentanyl Patient Controlled Analgesia (PCA) was commenced to manage her post-operative pain.

27 Whilst in the PACU, Mrs Mariani was instructed on the use of the PCA to manage her pain.

28 At 4.45pm, Mrs Mariani was transferred to the ward, where her daughter, Ms Hemming was waiting. Ms Hemming has confirmed that her mother activated the PCA "quite a number of times", which resulted in Mrs Mariani experiencing nausea. Ms Hemming indicated that a nurse said to them the "the button was pressed too many times", which had caused her to feel sick.

29 At approximately 8pm, Dr Eva Wilson attended on Mrs Mariani in the ward. Mrs Mariani was asleep. Dr Wilson had no concerns about the amount of Fentanyl that had been accessed by Mrs Mariani through the PCA at this time.

30 At 10.28pm, a progress note recorded that Mrs Mariani had vomited twice and had accessed her PCA button 11 times.

31 At 12.30am on 13 July 2019, Endorsed Enrolled Nurse (EEN) David Bowden observed that Mrs Mariani appeared to be experiencing pain and nausea. EEN Bowden and Registered Nurse (RN) Thomas checked the that the PCA pump was functional.

32 At 1.30am, EEN Bowden telephoned the on-call locum, Career Medical Officer (CMO) Dr Mark Francis, and advised him of Mrs Mariani's condition. Dr Francis prescribed 4mg Dexamethasone for her nausea, and 50-100mg of Tramadol for her pain. Mrs Mariani appeared to settle after she was administered the additional medications.

33 A progress note recorded at 5.20am, stated that "nausea and pain control have been a real problem" during the night shift.

34 At 10am, Ms Hemming returned to the hospital and observed her mother to be "in a good deal of pain" and required assistance to walk to her bed. Ms Hemming noted that her mother was "wincing in pain" and "dragging her

knees up in anguish" and asked the nurse on duty, RN Lynnette Martyn to call a doctor to examine her mother. No doctor attended.

35 Sometime around 12 – 1pm, Ms Hemming again requested RN Martyn call a doctor to examine her mother. Dr Francis attended and examined Mrs Mariani. No progress notes were recorded in the hospital records which document this examination.

36 At 3pm, Mrs Mariani's vital signs were recorded as being "Between the Flags" and she was reported to be progressively improving.

37 At 3.15pm, Mrs Mariani's condition was recorded as deteriorating, with her oxygen saturation level being at 84% and her blood pressure at 95/56 and a pulse rate of 108 bpm.

38 At 3.30pm, a rapid response was called due to the significant and acute deterioration of her condition. An electrocardiogram and chest x-ray were performed. Dr Francis' differential diagnosis included possible sepsis with a respiratory source, a possible pulmonary embolism and possible sepsis from an abdominal source.

39 Dr Francis deemed that Mrs Mariani required a level of medical support not available at Forster Private Hospital and arranged for an ambulance transfer to Manning Base Hospital. Mrs Mariani arrived at Manning Base Hospital at 4.31pm, with a Glasgow Coma Scale (GCS) reading of 8 or 9 from a possible 15.

40 A further CT scan was performed which indicated that Mrs Mariani had vomited some 500 mL of bilious vomit, which she had aspirated into her lungs.

41 At 8.20pm, a clinical decision was made to palliate Mrs Mariani.

42 At 2.55am on 14 July 2019, Mrs Mariani passed away in the Intensive Care Unit (ICU).

List of issues considered during the inquest

43 The following list of issues was prepared before the proceedings commenced, circulated to the interested parties, and was considered and provided focus during the inquest.

1) Determination of the statutory findings required under section 81 of the *Coroners Act 2009* (NSW), namely: the identity of the deceased, and the date, place, manner and cause of death.

2) Whether the cholecystectomy surgery was performed with appropriate care and skill, how the bowel perforations were caused and whether they were or ought to have been detected by the Surgical team.

3) The appropriateness and adequacy of post-operative care and treatment of Mrs Mariani at Forster Private Hospital, including:

    a) Whether there was adequate monitoring and record keeping of observations:

    b) Why no medical review was performed after Mrs Mariani's surgery and whether there was a delay in notifying the surgeon of Mrs Mariani's deterioration;

    c) Whether the response to Mrs Mariani's symptoms and deterioration was appropriate in terms of timeliness of response, diagnosis, medication and diagnostic measures;

    d) Whether there were any other deficiencies in the practices and procedures of Forster Private Hospital that may have contributed to Mrs Mariani's death.

4) Whether it is necessary or desirable for recommendations to be made in relation to any matter connected with the death pursuant to s. 82 of the *Coroners Act 2009*.

Surgery and placement of the drain on 12 July 2019

44 Dr Ghaly confirmed that he had twenty procedures scheduled for surgery at Forster Private Hospital on 12 July 2019. He indicated that most of the scheduled procedures were for skin lesions or endoscopies and that Mrs Mariani's procedure was the only "major operation". Dr Ghaly stated that her operation was classified as a "major operation" as the procedure involved "exposing the peritoneal cavity and taking an organ out (and as such) is considered major."

45 Dr Ghaly gave oral evidence that he had discussed Mrs Mariani's options for the management of her pancreatitis after her hospital admission in May 2019, with one of her options being the removal of her gall bladder.

46 In his statement dated 18 December 2019, Dr Ghaly indicated:

> "In regard to the discussion I had with Mrs Mariani prior to the surgery, that was on many occasions, a few of them in the hospital prior to her discharge while she was recovering from the gallstone-induced pancreatitis attack, and on two other occasions in my office when she came post-discharge

from the hospital. The discussions were not only of concern about her age, but also in regard to her respiratory function due to the asbestos-related disease. We both had shared the concern about taking the surgery decision, having in mind these two issues, namely her age and respiratory function."

47 Dr Ghaly stated that he did "not exactly" have a recollection of the consultation with Mrs Mariani and her daughter before the surgery but believed that he would have discussed the associated risks of surgery with Mrs Mariani when she was in hospital with pancreatitis in May 2019. He indicated that it was his usual practice to discuss the risks of surgery with his patients.

48 Associate Professor Nicholas Williams, an Endocrine, Obesity and Upper Gastrointestinal Surgeon, described the laparoscopic cholecystectomy procedure as follows:

> "So keyhole surgery is undertaken by putting a camera through a little small hollow tube which we call a port, and so typically for a gallbladder you'll put a port in just underneath the umbilicus, the belly button, and then there might be three other small incisions made to insert the instruments in order to facilitate the surgery. Whenever you are doing any sort of operation that involves, you know, inserting instruments through small holes into the abdominal cavity, you know, a material risk of [inadvertent] injury of the bowel or the liver or another structure always exists. If that were to occur, you know, during the operation or in the course of the operation often it may be recognised at the time of surgery and then fixed."

49 Dr Ghaly perceived that the surgery had progressed "as smooth as I thought it could" and had not been notified of any concerns prior to his departure from the hospital sometime after 8pm.

50 Various medical staff present during the operation did not recall any concerns or difficulties with Mrs Mariani's surgery. Two of the nursing staff did recall an issue with the insertion of a drain.

51 EEN Heaslip recalled that the only unusual event during the surgery was when Dr Ghaly was prompted to insert a drain into the port by one of the other medical staff.

52 RN Waters recalled in her statement dated 21 November 2023, that:

> "at the end of the procedure, at the port where the draining tube had been fed and placed under the liver of the patient, I saw the drainage tube had been dislodged, by accident, with the cannula, by the surgical 1st assist Dr McCarney. I recall she said words to the effect "it's come out" to

Dr Ghaly. I said to Dr Ghaly "would you like to reinflate and position it correctly"? I recall Dr Ghaly said words to the effect "no, it should be fine because she was not actively bleeding" and "it should be alright." I recall Dr Ghaly told Dr McCarney to "just feed it back in", which she did.

53 RN Waters gave oral evidence, and commented that:

> "we had removed the camera, and had removed some of the cannulas for the procedure at that time, you could not determine exactly where it was going to be. Like the drainage tube, where it would end up in the abdomen."

54 Dr Ghaly gave oral evidence, stating:

> "I think the drain must have come out accidentally before we sutured it with a suture to secure it. Then we reinserted it. When we reinsert in the drain, there is no sharp object, it's a soft rubber tube. It went through the port and that could not have damaged anything."

55 He further commented:

> "The drain is to collect any unexpected fluid, mainly bile. A little bit of bloods, yes, can be drained but that doesn't cause a lot of problems if it's left behind. It's the bile that if left behind [or] if comes unexpectedly will cause what we call biliary peritonitis. It's very painful and it has to be addressed quickly. So, some surgeons selectively leave a drain in. I leave a drain in every case."

56 Associate Professor Williams was requested to provide his expert opinion in relation to the drain. In his third statement, dated 19 December 2024, he commented:

> "The purpose of the drainage tube is to drain off and collect in a bag any fluid such as bile or blood that may collect in the abdominal cavity following the surgical procedure. It is placed under the liver as this is the most dependent portion of the upper abdomen and thus the place at which fluids will tend to accumulate. If excessive blood was draining out of the tube, this would indicate that there was an ongoing bleeding source within the abdominal cavity. If there was bile-stained (bilious) fluid in the drain, this would indicate a more sinister problem of a bile leakage e.g. from a bile duct in the vicinity of where the gallbladder was attached."

57 Associate Professor Williams further stated:

> "In the case of Mrs Mariani, the drain did not drain off much fluid at all, neither bile nor blood, and ultimately it was removed the following day. I do not think this is likely to be relevant in this case. Even a properly placed

drainage tube may not necessarily drain off bile or small bowel content. In this particular case, if the drain had been placed correctly, it would be under the liver, whereas the small bowel injury was at the site of one of the port sites on the anterior abdominal wall where there was suture material and the small bowel perforation found at the autopsy, most likely the camera port. This is away from the internal surgical site itself where the gallbladder was removed from, and therefore small bowel leakage may not have appeared in the drain anyway."

58 In his oral evidence, Associate Professor Williams commented that although feeding the drain back in after it had dislodged was "not ideal", he noted that:

> "I don't really think that is a relevant part of this. Had she had a functioning drain in, and it was well-positioned, it would not necessarily, in fact, probably would not have alerted the clinicians that there was a problem with this patient any earlier because I don't expect that the site of the small bowel injury would've been anywhere near the intended drain position anyway."

59 Associate Professor Williams was of the view that the decision to proceed with an elective cholecystectomy was an appropriate decision, despite Mrs Mariani's age and comorbidities. He was of the opinion that:

> "Whenever you are doing any sort of operation that involves, you know, inserting instruments through small holes into the abdominal cavity, you know, a material risk of [inadvertent] injury of the bowel or the liver or another structure always exists. If that were to occur, you know, during the operation or in the course of the operation often it may be recognised at the time of surgery and then fixed. What can rarely happen though is you have what would be called a missed bowel injury where perhaps you or the assistant has inadvertently poked a hole in something, or using the diathermy, the heat energy device that we use to do the surgery may have burnt something. Or indeed, as what I think has happened in this case, when those incisions were being closed at the end of the operation a piece of the small bowel has been picked up with one of the sutures and not recognised. How commonly does this occur, it is an infrequent occurrence, fortunately."

60 Dr Ghaly expressed in his oral evidence that he had:

> "tried so hard to get the postmortem report for my own benefit to know what happened, what went wrong…" After perusing the postmortem report, he accepted that the "damage happened on closure…I don't believe the damage happened on entry, it happened on the way out. On entry, we

normally visualise it, recognise it, repair it, and no problem, but this happened afterwards."

61 The totality of the evidence suggests that the dislodging of the drainage tube did not contribute to Mrs Mariani's death as it was located in a different position from the area where the damage occurred. The area of damage involved a loop of small bowel which was inadvertently picked up with one of the sutures, creating an injury to the small bowel, with subsequent leakage of small bowel contents into the abdominal cavity.

62 The expert evidence suggests that although Mrs Mariani's bowel was perforated, the perforation does not imply a lack of care or skill on the part of Dr Ghaly or the surgical team. I am of the view that the surgery was carried out with appropriate care and skill.

Cause of death

63 At 8.20pm on 13 July 2019, Dr Jonathon Murtagh, a senior resident medical officer in the intensive care unit at manning Base Hospital attended on Mrs Mariani. At 3.30am on 14 July 2019, Dr Murtagh recorded the cause of Mrs Mariani's death as:

> "aspiration pneumonia secondary to query possible intra-gastrointestinal surgical complication from laparoscopic cholecystectomy."

64 Dr Murtagh then referred Mrs Mariani's death to the Coroner.

65 On 24 July 2019, Dr Issabella Brouwer, Chief Forensic Pathologist/Clinical Director, performed an autopsy on Mrs Mariani.

66 In her postmortem report dated 11 May 2020, Dr Brouwer noted the external examination:

> "showed signs of recent hospitalisation and abdominal surgery. At least 4 sutured recent surgical incisions were noted on the anterior abdominal wall. The longest of the three incisions to the left of the umbilicus had a septic appearance. Pus was present in the soft tissue deep to the sutured wound. An adhesion was present between the small bowel and the anterior abdominal wall adjacent to this surgical incision. Surgical suture material was observed in the vicinity of the fibrous adhesion. A large perforation was noted in the small bowel at the site of the adhesion. A severe peritonitis was present with pus and blood stained fluid in the abdominal cavity.

67 In addition, Dr Brouwer commented that:

> "The lungs were heavy and oedematous and showed severe bronchopneumonia on microscopic examination which is in keeping with an aspiration pneumonia. The pancreas showed features of chronic pancreatitis and peritonitis. The liver showed evidence of recent cholecystectomy, chronic inflammation and bile stasis."

68 Dr Brouwer stated that:

> "Streptococcus anginosus (S. milleri) was isolated from the postmortem blood culture. The organisms are recognised as normal human flora which is usually found in the oral cavity. The Anginosus group streptococci may cause severe systemic infection and the presence thereof in the blood culture suggested that the organism may have caused the systemic sepsis. The raised procalcitonin and CRO levels are indicative of systemic infection with high risk of sepsis."

69 Dr Brouwer opined that the cause of Mrs Mariani's death was due to "complications of cholecystectomy surgery."

70 Professor Johan Duflou, a Consulting Forensic Pathologist, confirmed in his statement dated 19 October 2020, that he agreed with Dr Brouwer's opinion regarding the cause of Mrs Mariani's death. He noted that:

> "it appears that the patient's small bowel was inadvertently injured during the laparoscopic surgery, with either perforation of the bowel at the time of surgery, or perforation of the bowel developing some time later as a result of the bowel loop becoming attached to the surgical incision by suture material. Given the nature of the inflammatory process identified on microscopy, it appears likely that there was early perforation of the bowel in this case."

71 Associate Professor Williams noted that:

> "Sadly, what has happened is at the time of suturing closed the incision for the camera port, a loop of small bowel has inadvertently been picked up with one of the sutures, thereby creating an injury to the small bowel with subsequent leakage of small bowel contents into the abdominal cavity. This is a rare but described complication of any keyhole surgery. It is an infrequent complication and does not necessarily imply any lack of care or skill on the part of Dr Ghaly."

72 On the balance of probabilities, the cause of Mrs Mariani's death was due to "the complications of cholecystectomy."

Use of Fentanyl delivered via Patient Controlled Analgesia (PCA) to manage post-operative pain and other pain relief administered on 12-13 July 2019

73 Dr Eva Wilson indicated that Mrs Mariani was documented to have an allergy to Morphine and Endone (or Oxycontin). Dr Wilson chose to administer a total of 200mcg of Fentanyl (together with other medications) during the surgery.

74 Post-operatively, Dr Wilson arranged for a further 1000mcg of Fentanyl in a 100-mil solution to be available via the PCA, meaning that a total of 20 doses of Fentanyl could be accessed by Mrs Mariani through the PCA over the next 30 hours. In addition to the Fentanyl, the post operative plan included the charting of Tapentadol and two anti-emetics.

75 Dr Wilson recalled that she had been informed by the ward nursing staff that Mrs Mariani had initially complained of some pain, but the pain had settled with the self-administered PCA Fentanyl. When Dr Wilson saw Mrs Mariani on the ward, she was asleep.

76 Dr Wilson confirmed that Mrs Mariani accessed the PCA 20 times following her surgery, which "was a very comparable dose to the dose that I gave her in 45 minutes of her surgery."

77 Dr Wilson explained that the:

> "PCA has a safety mechanism within it. So if the patient tries to press the button continuously, the patient get[s] an overdose of a strong opioid, so in this case the lockout time was set as five minutes which is a standard lockout time. So what we set on PCA is the lockout – how often the PCA would deliver the dose and the dose itself which was 10 micrograms, which is a low dose for someone who is older. Now, what it means that within an hour period, if the patient receives every single dose, the patient will be able to receive 12 doses, if patient maximally uses PCA. Pressing a hundred times throughout the hour, they would only receive 12 doses."

78 Dr Wilson was shown the "PCA Adult Observations" chart. The chart contained seven numbers under the heading "Total Demands/Attempts". At 6pm, the total primary PCA dose contains a handwritten entry, indicating the number 6. At 7pm, the number 2 is recorded and at 9pm the number 3 is recorded. The clinical "progress notes" indicate that RN Martyn was the author or these notations. The progress notes record that Mrs Mariani was nauseous or vomiting at 6pm. At 12.30am, the number 2 is recorded in different handwriting, together with the number 2 at 2am and the number 4 at 4.30am

and the number 1 at 6am. The notes record that Mrs Mariani was nauseous or vomiting at 12.30am, 2am, 4.30am and 6am. The column headed "Good demands/Successful" was blank.

79 Dr Wilson confirmed that these numbers indicated the number of times that either a successful or unsuccessful attempt was made to access the PCA, but the record does not state whether it was a successful or unsuccessful dose that was delivered.

80 Dr Wilson stated that she could "only infer from that total primary PCA dose, the total dose the patient received, that these are successful attempts."

81 The PCA chart also contained observations relating to the patient's pain scores. Mrs Mariani's scores are recorded as being within the severe range at 6pm, being a score of 7/8, 'asleep' at 7pm, and again within the severe range at 9pm, with a score of 9/10.

82 Dr Wilson confirmed that she was not contacted by nursing or hospital staff at any time after the surgery in relation to Mrs Mariani's pain or medications.

83 At 10.45pm, a nursing 'hand-over' occurred. RN Thomas and EEN Bowden commenced their shift, with EEN Bowden providing care to Mrs Mariani. During his ward rounds at around 11pm, EEN Bowden spoke with Mrs Mariani, who complained that she was "nauseated and had pain." EEN Bowden stated that he asked her if she had been accessing her PCA, and she confirmed that she had been "pushing (her) button". He stated that he was conscious of the fact that "pushing the button was making her nauseous."

84 EEN Bowden also recorded Mrs Mariani's pain scale as an 8 out of 10 at 12.30am in the clinical notes.

85 EEN Bowden then conferred with RN Thomas. They both agreed that they should speak with the on-call doctor, Career Medical Officer (CMO) Francis.

86 At 1am, EEN Bowden telephoned Dr Francis, in the presence of RN Thomas. EEN Bowden stated that he explained to Dr Francis that "Mrs Mariani was nauseous but had been administered Ondansetron and Maxalon during the evening of 12 July 2019 at 1752 hours and 2130 hours respectively. I also recall telling Dr Francis that Mrs Mariani was on PCA but was still experiencing pain."

87 Later during further questioning, EEN Bowden agreed that it was "possible" that he had not told Dr Francis that Mrs Mariani "had a PCA".

88 EEN Bowden stated that Dr Francis prescribed 4mg of Dexamethasone intravenously (IV) stat and 50-100mg Tramadol orally 6 hourly." These were administered by RN Thomas at 1.35am.

89 Dr Francis conceded that EEN Bowden "probably did mention the PCA to me and the allergies, but I have no distinct recollection of that, yeah". Dr Francis commented that:

> "my experience with PCAs has been, because the medication you put in them is relatively short-acting, it's very quick to turn on and very quick to turn off, that very often patients on a PCA are also prescribed a longer-acting tablet form of an opioid-based medication that's designed to smooth out pain and minimise the breakthrough that requires them to access a PCA. But Tapentadol is a reasonable choice for one of those longer-acting oral tablets. That is a cousin of the Fentanyl. So I guess the significance, is, when we were discussing what additional pain relief options she might need, if I'd known the Tapentadol was there, I would have had no reason to chart the Tramadol which was my choice for something that was a bit longer-acting to smooth her pain out."

90 Dr Francis agreed that he could have suggested to the nursing staff that Mrs Mariani be asked to press the PCA more frequently. However, he explained that he thought with an elderly patient that had been through:

> "a very rough day and requires a little bit of sleep, given how quickly the Fentanyl and the PCA turns on and then turns off, I thought it would probably be kinder rather than telling her to press a button every five minutes to give her something that was maybe a bit longer-acting so she wouldn't keep waking up in pain every half an hour [and] having to hit the button again, but I take your point that the alternative approach of just hitting the PCA button more is also very reasonable."

91 At 2am, EEN Bowden assessed Mrs Mariani's pain score as being 5 out of 10. At 4.30am, he assessed her pain score as 4 out of 10 and at 6am, he assessed her pain score as 5 out of 10. These scores were recorded in the context that Mrs Mariani was still accessing her PCA two times during the hour commencing at 2am, four times around 4.30am and once around 6am, in addition to the other pain medications prescribed by Dr Francis and administered by EEN Bowden from around 1am.

92 At 5.20am, the clinical notes authored by EEN Bowden state "Nausea and pain control have been a real problem this shift."

The appropriateness and adequacy of care and treatment at Forster Private Hospital on 13 July 2019

Ms Hemming's evidence

93 Ms Karyn Hemming provided a statement dated 15 October 2020, together with annexures to that statement, which included contemporaneous handwritten notes from her mother's consultation with Dr Ghaly on 9 July 2019 and an email to Forster Local Court, dated 16 July 2019. In addition, Ms Hemming gave oral evidence on 5 February 2025.

94 Ms Hemming confirmed that she had attended the pre-operative consultation with her mother and Dr Ghaly on 9 July 2019. Ms Hemming stated that "Mum was very fond of Dr Ghaly and they had a good rapport".

95 Ms Hemming understood from this consultation that the gall bladder procedure would be reasonably straightforward, and her mother would be in hospital for "a day or two" and would need support at home for approximately one week.

96 Ms Hemming confirmed that she had visited her mother after her surgery and stayed for about one hour. During that time, Ms Hemming noted that "Mum was feeling quite sick."

97 Ms Hemming returned to the hospital at around 10am on 13 July 2019. She perceived that her mother was suffering the same or greater pain and discomfort than the previous evening.

98 At around 10.30 – 10.45am, Ms Hemming recalled RN Martyn chiding her mother for sitting in a chair next to her bed, prior to her mother being assisted into bed. Ms Hemming recalled saying to RN Martyn that her mother was "very weak" and "this isn't like Mum."

99 Ms Hemming described her mother's pain symptoms at this time as follows:

> "Well, Mum was in pain. She didn't vomit much. She was drinking some water, and I asked the nurse for a doctor to come and see Mum, because I could tell things weren't right. Mum was in pain. And time went past and the nurse came in again, and I said again, "When is the doctor coming?" and the nurse said she'd spoken to the doctor, and "Do I need the doctor to come?" And I said, "Yes, please."

100 Ms Hemming stated that "My mother continued to wince in pain and dragged her knees up in anguish."

101 Ms Hemming confirmed that after her second request for a medical review of her mother, Dr Francis attended sometime between noon and 1pm. Ms Hemming described her interaction with Dr Francis as follows:

> "Dr Francis came to see Mum, and I said I was worried. She didn't seem right. She was in a lot of pain. Is this normal? She's very weak. He indicated that people can experience a lot of pain after this type of surgery, and he was looking at Mum's tummy and asking if I thought it was distended, but I wasn't sure so I said, "I'm not sure. I never seen Mum's naked tummy", and he was asking me had she eaten or drunk, and I said she's had a bottle of water, and she'd drunk tea, and then she was on another bottle with water, and she had a quarter of a - think it was egg sandwich, and she'd taken a couple of little bites of that."

102 Ms Hemming recalled Dr Francis indicating to her that he was "going to administer more medication to try and help with the pain." Ms Hemming left when visiting hours ended at 1pm and returned to the hospital at 3.20pm and was advised that her mother's condition had deteriorated and she was going to be transferred to Manning Base Hospital by ambulance. Ms Hemming followed the ambulance in her own car.

103 Ms Hemming was introduced to the medical staff at Manning Base Hospital. At this time, Ms Hemming noted the distension to her mother's stomach. Mrs Mariani was taken for a scan and during this process, she aspirated into her lungs.

104 Ms Hemming stated that Dr Ghaly arrived and indicated that something had "gone wrong" with the surgery and wanted to take her back to theatre. Ms Hemming recalled that the anaesthetist was of the view that Ms Mariani was not fit enough to survive further surgery due to his inability to intubate Mrs Mariani. Ms Hemming recalled her mother being transferred to the ICU. Her condition continued to deteriorate and was palliated.

RN Martyn's evidence

105 Registered Nurse Lynette Martyn has been a registered nurse for 42 years and has worked at the Forster Private Hospital for 33 years. RN Martyn continues to work at the hospital.

106 RN Martyn provided two statements in these proceedings, dated 9 December 2023 and 2 October 2024. RN Martyn also gave oral evidence.

107 RN Martyn confirmed from her perusal of medical records that she was rostered on duty on 12 July 2019 from 2.30pm until 11pm. She was further rostered on duty on 13 July 2019 from 7am until 3.30pm.

108 RN Martyn indicated during her oral evidence that she had little or no recall of the events of 12 and 13 July 2019.

109 RN Martyn was aware that Mrs Mariani had been prescribed Fentanyl for pain relief and that this was to be delivered via a PCA, together with oxygen via nasal prongs. RN Martyn noted in the progress notes that Mrs Mariani had accessed the PCA whilst in 'recovery', being the PACU.

110 RN Martyn stated in her oral evidence that observations on a surgical patient should be conducted "hourly for four hours, then fourth hourly. Except when they're on a PCA, or something like that, they're done more frequently. And that – then it can be three times a day, or four times a day."

111 RN Martyn noted that "narcotics that are in a PCA can cause nausea and vomiting."

112 RN Martyn did not recall saying to Mrs Mariani, in the presence of her daughter Ms Hemming, that Mrs Mariani was pressing the button too many times and that the medication was the reason why she was nauseous and vomiting, although she noted that these symptoms can be a common side-effect of the medication.

113 In her statement dated 9 December 2023, RN Martyn referred to the PCA observation chart and stated:

> "I can see that observations were taken at 18.00 hours, 19.00 hours and 21.00 hours which would have been taken during my shift. I cannot now confirm whether these were taken and recorded by me or if I had delegated the task while caring for other patients. I can see that there were no observations taken at 20.00 hours. I cannot now recall why these were not taken."

114 RN Martyn confirmed in her oral evidence that she had completed the PCA Adult Observations Chart at 6pm, 7 pm and 9pm on 12 July 2019, despite the requirement that observations should be conducted hourly for a post-operative patient. In addition, RN Martyn was asked why there was no pain score between 9pm and 12.30am. She stated:

> "Yes, there should have been. But at – you're handing over at about – you're trying to do your handover to night shift, like just after 10pm, 10.30. I can't remember exactly what time. And some – whether I just got – I don't know. I don't know why, I can't remember why."

115 RN Martyn confirmed that she had documented the number of times Mrs Mariani had accessed her PCA medication at 6pm, 7pm and 9pm, being 11 times in total. She indicated that she had notated the number of doses in

the incorrect line in the chart and had neglected to sign her initials accordingly. RN Martyn explained that she had never received any training to assist with the completion of this chart. She agreed that there was no way of determining how many unsuccessful attempts were made by Mrs Mariani during these periods of time.

116 In the PCA Adult Observation Chart, a pain score is required to be recorded. At 6pm, RN Martyn recorded a pain score of 7-8, at 7pm the notation reads "asleep" and at 9pm, Mrs Mariani's pain score is recorded as 9-10.

117 Despite the significant pain score reading recorded at 6pm and 9pm, the clinical records do not indicate that Mrs Mariani was provided with any additional pain relief until 10.28pm. The Standard Adult General Observation Chart (SAGO chart) refers to a pain reading between 7-10 as severe and falling within the "yellow zone", which requires a clinical review.

118 RN Martyn was asked whether she had any concern about the clinical records now. She commented that:

> "It's hard when people have pain because you don't know what their pain tolerance is, number 1. Number 2, after that operation a lot of patients have a fair bit of pain post-op, so it's not abnormal to have pain after that type of operation.

119 At 10.28pm, RN Martyn made a Progress Note that stated:

> "Has vomited x2. Has accessed PCA 11 times. Obs within flags. Drowsy at times, IV Panadol given. IV ondansetron and IV Maxalon given. Incontinent of urine x1. SCD's on pt changed. Pull up put on."

120 At around 7.15am on 13 July 2019, EEN Bowden completed a nursing "hand over" to RN Martyn.

121 In relation to her shift on 13 July 2019, RN Martyn could not initially recall being told at the morning 'hand-over' that the nursing staff on the night shift had called the locum Career Medical Officer (CMO) Mark Francis during their shift. Later, she stated that:

> "Maybe in the handover that, yeah, "I had to call the doctor." I can't remember that, I was never told that. Maybe I was but I can't remember, and that's the honest truth."

122 RN Martyn was questioned as to why it would be significant that the 'on call' doctor had been contacted overnight to provide a remedy for breakthrough pain. RN Martyn commented that "the Fentanyl wasn't working maybe, I don't know."

123 RN Martyn denied that it would be her role to notify the nurse in charge of the morning shift, RN Neill, as this would have been the responsibility of the "nightshift in charge nurse."

124 RN Martyn gave oral evidence that when she commenced her shift on the morning of 13 July 2019, the only documentation that she would have looked at was:

> "Just the observation chart and the medication chart. When you go to see the patient, you don't have time to read the notes at the beginning of the shift……A lot of times, you don't get a chance to read on until near – when you're documenting your notes."

125 The hospital records indicate that a pain score of 5 was charted at 6am on 13 July 2019, prior to the commencement of RN Martyn's shift. The next documented observations are recorded in the SAGO chart at 11.20am on 13 July 2019. At this time, no pain score was recorded. RN Martyn agreed that she should have charted a pain score at this time or earlier but could not provide a specific explanation for this significant oversight.

126 RN Martyn gave oral evidence that she recalled Mrs Mariani being in some pain during the morning of 13 July 2019, however, she could not recall the level of that pain. RN Martyn did not agree with the proposition that she should have had some concern for a patient in pain who had surgery the day before.

127 RN Martyn was asked what would constitute a concern regarding pain in a post-operative patient. She responded:

> "There's a lot of things to take into consideration, and it's a very hard thing to do because every patient has a different pain tolerance, and having a pain score is not always accurate, can I say, because I've had patients that have said they've got ten out of ten pain. They're laughing at a joke on their phone and eating McDonald's. So when you think ten out of ten's the worst extreme pain that you can be in, those patients are saying that in that there, you can guess that they're not being accurate. And then you've got people that are very stoic, and they'll say that they've only got one out of ten pain, but they're grimacing and curled up in a ball. So a lot of times, you're looking at how they look as well, not just going on a number. But after a – after that type of operation, I think – I don't think I've had any patients after that operation have had no pain."

128 RN Martyn confirmed that whilst the PCA was connected to a patient the pain scores would be charted on the PCA Adult Observation chart. Once the PCA was removed, the pain scores would be charted on the SAGO chart.

129 In her statement dated 9 December 2023, RN Martyn stated:

> "In my progress note, I have documented that the PCA was taken down. I would have spoken to Dr Ghaly or the CMO and then taken the PCA down after checking with a doctor. This is because it is a doctor's decision. I do not now recall when the PCA was taken down. The oxygen therapy and nasal prongs are also removed when the PCA is stopped. Annexed and marked "G" is a copy of the PCA medication order form documenting the PCA was discarded at about 14.40 hours. This may not be the time that the PCA was actually taken down, rather the time when I had another nurse able to witness the medication being discarded."

130 RN Martyn was unable to indicate the time the PCA was removed from Mrs Mariani. She offered some suggestions, such as:

> "It would've – I'm – it – we don't take down PCAs without a doctor's – saying to take it down, but it would've been at the beginning of the shift. Like, I started at seven, so probably around 8-ish or something like that."

131 Later in her oral evidence, this exchange occurred:

> Q. "And you have no memory of whether you were involved in the PCA being taken down with Mrs Mariani, is that right?
>
> A. I would have taken it down, yes.
>
> Q. So it would have been you, yes okay?
>
> A. I can't remember, but I – it probably was me.
>
> Q. Does that mean your best expectation is that it would have been you taking down the PCA at the start of the shift?
>
> A. Yes.
>
> Q. Do you need to get a doctor to direct you to do that first?
>
> A. Yes. Unless it's been written in the post-op orders "take down at, you know, AM next morning" or whatever. I don't know, but yeah, we don't do it off – without permission or guidance.
>
> Q. Do you have any memory of Dr Mark Francis at all?
>
> A. No
>
> Q. Dr Francis was the CMO who was contacted in the early part of the morning to prescribe the dexamethasone. His evidence was that he didn't have any involvement with the direction given to the PCA to be taken down,

if I can ask you to assume that's what he said. Who would the doctor have been in this case for Mrs Mariani to direct you to take the

A. Dr Ghaly.

Q. And if that hadn't occurred by telephone you'd expect that to be written somewhere for you to know to do that?

A. Yes, but generally I think it's done by telephone because he didn't come in that morning."

132 Dr Wilson confirmed that she had prescribed 1000 micrograms of Fentanyl in a 100-mil solution. Mrs Mariani had accessed 21 mils of the solution before the PCA machine was removed, leaving 79 mils of Fentanyl available. RN Martyn gave oral evidence that 79 mls of Fentanyl was discarded at 2.40pm.

133 RN Martyn was asked to explain the discrepancy between the approximate time the PCA was removed from Mrs Mariani and the time the fentanyl was discarded. She stated:

"Only one person has a key to the PCA machine. Two people have to witness that being discarded. So you are – all the nurses are so busy during the day, you take the PCA off the patient, and you go and put it – the whole machine, which is all locked up, into the treatment room, until you have time to find the nurse that's got the keys, and then discard it."

134 RN Martyn indicated that the treatment room is located close to the nurse's station and is locked.

135 RN Martyn could not recall seeing or speaking with Mrs Mariani's daughter, Ms Hemming on the morning of 13 July 2019. She also could not remember being asked by Ms Hemming on two separate occasions to ask for a doctor's review of her mother, due to her obvious pain. RN Martyn could not confirm that it took at least one hour after Ms Hemming's second request for Dr Francis to attend on her mother.

136 Similarly, RN Martyn had no recollection of speaking with Dr Francis during or after his review of Mrs Mariani, sometime between noon and 1pm.

137 RN Martyn recalled checking Mrs Mariani's drainage bag at around midday, and "would've called him (Dr Ghaly) to tell him how much was in the drainage bag." She continued by stating:

"I don't know what I've actually told him, but looking back at the notes to prompt my memory, I would've told him about the drainage bag, that she was in pain, that bit of a – maybe I told him about the moist chest and

would've told him about being nauseated and vomiting. I – yeah, I try and tell the doctors what's – of course, I try and tell the doctors what's going on."

138 The notes that RN Martyn was referring to were her progress notes from her shift on 13 July 2019. The notes bear the time 1500 hours, or 3pm, and are reproduced as authored:

> "Had used 21 mls of fentanyl at start of shift. IVT (intravenous therapy) completed this morning & no further orders. Given anti emetics. Tolerated some fluids at meal times & in between. Incontinent ++++ of urine. PCA taken down. IVC (intravenous cannula) capped. Showered by staff. Pull up on. Obs within flags. Seems a bit vague at times. Progressively improved as day progressed. Drinking well now. Does sound moist in chest & encouraged to cough only a few mls in drainage bag at 12 MD. Phone call from Dr Ghaly & may be removed. Total of 50mls when removed (including in tubing). IVC tissued at 1400 and removed."

139 RN Martyn confirmed that Mrs Mariani seemed a bit vague, however, she could not recall specifically when this was, although she suggested that:

> "I've written "progressively improved", so maybe she was a little bit vague at the first – in the morning. Some of the patients can get a little bit confused and drowsy and stuff on the fentanyl. I know that it hasn't explained everything, but yeah. And sometimes post anaesthetic can affect them as well. The anaesthetic medications can make some patients confused and stuff like that as well."

140 In the SAGO chart, RN Martyn had charted that Mrs Mariani was "Alert" at 11.20am on 13 July 2019.

141 According to EEN Robinson, the shift handover between herself and RN Martyn occurred at 2.50pm, at Mrs Mariani's bedside.

142 In her statement dated 5 December 2023, EEN Robinson stated:

> "As part of the handover RN Martin said that Mrs Mariani was not able to follow simple commands to take a deep breath and/or cough. This stood out to me as I could see at the bedside that Mrs Mariani could not cough. I was concerned about Mrs Mariani and after the hand over I continued to speak to RN [Martyn] who was leaving at the end of her shift. I went to the Nurses Station and I scanned the progress notes. I recall Mrs Mariani had a lot of pain overnight. RN Cathy Neale was there. I discussed my concerns about Mrs Mariani with RN Neale. I remember I told her words to the effect

> "there is something not right can you look at the patient." RN Neal agreed to attend."

143 EEN Robinson returned to Mrs Mariani and "could immediately see Mrs Mariani's vital signs were not between the flags" and initiated a rapid response. She recalled that Dr Francis and RN Neale attended in response.

144 RN Martyn could not recall telling EEN Robinson that Mrs Mariani was experiencing difficulties taking a deep breath during the handover. RN Martyn commented that:

> "Sometimes they can't take a deep breath because of the pain from the surgical wounds. They're declined to take a deep breath, because they think it's going to hurt."

145 RN Martyn could not recall when she noticed that Mrs Mariani's chest sounded moist. She thought that she had "told the doctor, I did tell the doctor about that. But I can't be positive or specific." Similarly, she couldn't recall when Mrs Mariani was incontinent.

146 RN Martyn insisted that Mrs Mariani deteriorated very quickly after she had completed the handover to EEN Robinson. RN Martyn could not recall when she had last seen Mrs Mariani prior to the end of her shift. She stated that "if I gave medications at 2pm, I wouldn't have been able to give medications to her if she was extremely unwell, you know what I mean?"

147 Ultimately, RN Martyn accepted that Mrs Mariani had been in pain during her shift, however, attempted to suggest that post-operative pain was not unusual. She agreed that she had not recorded in her progress notes any mention of Mrs Mariani being in pain during her shift. She also conceded that it would be difficult for Dr Francis to know what the situation was when he saw Mrs Mariani in the absence of any pain scores.

148 She accepted that family members are often more reliable indicators of a patient's unusual presentation.

149 RN Martyn suggested that she had contacted "the CMO" after the set of observations were done at 3.15pm, after the conclusion of her shift.

An assessment of RN Martyn's evidence

150 Given RN Martyn's years of experience as a nurse, certain assumptions as to competency may ordinarily be assumed. This was not the case on the established facts of RN Martyn's care for Mrs Mariani.

151 RN Martyn failed repeatedly to record or accurately chart the very basic clinical notes. She failed to make contemporaneous notations of critical information, decisions, consultations and removal or administration of opioid or S8 drugs.

152 Her explanation surrounding the removal of the PCA was highly unprofessional. She agreed that the PCA should not be removed from a patient without a specific direction from a doctor, whether that was an oral direction or a notation. Despite that acknowledgment, she was unable to identify which doctor had provided her with that direction. The clinical notes do not disclose such a direction, and both Dr Ghaly and Dr Francis deny that they gave such a direction.

153 RN Martyn made no contemporaneous notation as to the direction and timing of the removal of the PCA. She suggested that the PCA must have been removed some time prior to, or around 11.20am on 13 July 2019, as she had documented that Mrs Mariani was now on 'room air', rather than receiving oxygen via nasal prongs.

154 Extraordinarily, RN Martyn provided an explanation that after the PCA had been removed, it was wheeled to the examination room and the remaining preparation of 79 mls of Fentanyl was locked inside the examination room until some unidentified nurse "with the keys" was available at 2.40pm to dispense with the remainder of the Fentanyl.

155 Of even greater concern was RN Martyn's evidence that she had never formally charted Mrs Mariani's pain score at any time during her shift on 13 July 2019. She repeatedly apologised during her oral evidence for her failure to record or chart any detail of Mrs Mariani's care. Her 'progress note' at 3pm on 13 July 2019, was neither contemporaneous nor meaningful.

156 Dr Markowskei gave expert oral evidence as follows:

> "I did mention that I felt that the nurses should have noted that the doctor was asked to see the patient as part of their handover, as part of their written record. I do feel that is the case and I would have preferred that for completeness in regard to the nursing notes."

157 RN Martyn's evidence was inconsistent, often evasive and lacking in substance. She attempted to sheet blame onto others, including other nursing staff and doctors. She acknowledged that her record keeping and monitoring were deficient, however continued to apportion blame to other, often unidentified individuals. This appeared to be an attempt by her to project her shortcomings onto others to apportion blame away from herself.

158 Whenever RN Martyn's evidence is at odds with other testimony, the alternate testimony should be preferred.

RN Neal's evidence

159 RN Cathy Neal provided two statements dated 8 November 2019 and 1 February 2023. Ms Neal also gave oral evidence on 6 February 2025.

160 RN Neal confirmed that she had commenced her shift at 7am on 13 July 2019, as the Nurse Unit Manager (NUM). As the NUM, RN Neal did not have a patient 'load', however, was available to any nursing and medical staff for clinical issues.

161 RN Neal recalled attending the handover between the night shift and the day shift on the morning of 13 July 2019. She recalled being advised that Mrs Mariani had experienced nausea overnight, however, could not recall being told that she had experienced excessive pain.

162 RN Neal confirmed that she was aware that Mrs Mariani had a PCA, however, could not recall being made aware when the PCA was removed. RN Neal stated that a PCA would be removed only after a doctor had authorised its removal.

163 RN Neal stated that if a patient was connected to a PCA, the relevant pain scores should be recorded on the PCA pain score chart. RN Neal was asked:

> Q. "Then if there's nothing in the PCA chart about pain after 06.00 hours and nothing reflected in the SAGO chart about pain prior to you writing 333 (at 4pm, 4.15pm and 4.30pm), does that tell us it's not recording anywhere in the record?"
>
> A. "That would be my conclusion."

164 RN Neal confirmed that if the PCA was disconnected at around 2pm, that she would expect that recordings of pain scores would have continued up until the PCA was disconnected.

165 RN Neal also stated that when a PCA is taken down, "It should be discarded immediately, and co-signed by a registered – either two registered nurses, or an endorsed enrolled nurse."

166 RN Neal was questioned about her interpretation of the PCA chart. RN Neal stated that she would interpret the notes to indicate that the PCA was "in situ" until 14.40 hours, when it was recorded in the notes as having been discarded.

167 RN Neal confirmed that she would have expected the clinical observations to have continued and been recorded on the PCA chart until the PCA was removed.

168 RN Neal stated that at no time had she been made aware during the morning handover that Mrs Mariani had been unwell. RN Neal also indicated that at no time had she been advised that Dr Francis had been asked to review Mrs Mariani some time between noon and 1pm on 13 July 2019, and that she would ordinarily expect to be advised by staff if such a request had been made.

169 RN Neal stated that at no time had she been advised that Mrs Mariani had difficulties coughing or that her breathing sounded 'moist'.

170 RN Neal confirmed that if nursing staff had any concerns at all, including where a patient's vital signs were not being 'between the flags' it would be "quite reasonable to ring a doctor." She indicated that her practice would be to contact the CMO first, rather than the surgeon.

171 RN Neal couldn't recall seeing Mrs Mariani after the morning handover, or at any time up until 3.15pm. At 3.15pm, RN Neal recalled conducting another round of the ward with the afternoon nurse-in-charge. She "immediately noticed Mrs Mariani was pale, diaphoretic (sweating) and her respirations were increased." RN Neal called a rapid response, with Dr Francis attending shortly afterwards. At 5pm, RN Neal advised the Chief Executive Officer that Mrs Mariani had been urgently transferred to Manning Base Hospital by ambulance.

EEN Robinson's evidence

172 Endorsed Enrolled Nurse Rebecca Robinson prepared one statement dated 5 December 2023 for these proceedings. EEN Robinson commenced her shift at 2.30pm on 13 July 2019 and was allocated the care of Mrs Mariani.

173 EEN Robinson received a handover from RN Martyn at Mrs Mariani's bedside at about 2.50pm. EEN Robinson recalled in her statement the following:

> "As part of the handover RN Martyn said that Mrs Mariani was not able to follow simple commands to take a deep breath and/or cough. This stood out to me as I could also see at the bedside that Mrs Mariani could not cough. I was concerned about Mrs Mariani and after the handover I continued to speak to RN Martyn who was leaving at the end of her shift. I went to the Nurse's Station and I scanned the progress notes. I recall Mrs Mariani had a lot of pain overnight. RN Cathy Neal was there. I discussed my concerns about Mrs Mariani with RN Neal. I remember I told

her works to the effect "there is something not right can you look at the patient." RN Neal agreed to attend."

174 EEN Robinson returned to Mrs Mariani and took her vital sign observations. She stated:

> "I could immediately see Mrs Mariani's vital signs were not between the flags. I yelled for RN Neal whop was down the hall. I initiated a rapid response by pressing the button on the wall. RN Neal and CMO Mark Francis attended."

Dr Mark Francis' evidence

175 Dr Mark Francis provided three statements in these proceedings, dated 19 November 2019, 24 February 2020 and 30 October 2024. He also gave oral evidence on 7 February 2025.

176 Dr Francis was a relatively junior practitioner and had been offered a locum position at Forster Private Hospital. He had recently performed the same role on one prior occasion at the hospital.

177 He understood that he would be the only CMO at the hospital the weekend commencing 12 July 2019, and that he would be 'on call' for any case that "was considered urgent enough that it couldn't wait until Monday when the CMO shifts recommenced, and that urgency could take all sorts of forms."

178 He indicated in his oral evidence that he understood from the hospital that he didn't need to physically attend the hospital unless an acute issue arose or there was a specific request made for his advice or review.

179 Dr Francis confirmed that he elected to attend the hospital on Saturday 13 July 2019, from 8am until 6pm.

180 Dr Francis stated that he received a telephone call from a male nurse at around 1am on 13 July 2019, regarding Mrs Mariani. He agreed that the nurse was EEN Bowden.

181 He recalled being told that the patient had recently undergone an elective laparoscopic cholecystectomy and was experiencing some nausea and vomiting. He stated that he could not recall being told that Mrs Mariani was receiving pain relief via a PCA, although he conceded that he would have asked what kind of pain relief options were available to her, including intravenous or tablet-based therapy.

182 Dr Francis stated that he formed the opinion that Mrs Mariani was likely experiencing post-operative nausea and vomiting, after having interrogated EEN Bowden.

183 Dr Francis formed the view that he would provide a phone order for further medications, and that it was not necessary to contact the surgeon, given that there were no obvious markers which were indicating that Mrs Mariani was outside her expected post-operative parameters.

184 Dr Francis indicated that he was prepared to attend the hospital at any time if he perceived that his attendance was necessary and appropriate. He stated that he had intended to attend the hospital later that morning to assess patients generally and to chart Mrs Mariani's medications.

185 He gave evidence that he attended the hospital at around 10am on 13 July 2019. He reviewed the medication chart and countersigned the verbal orders that he had made during the earlier telephone conversation.

186 Dr Francis reviewed the progress notes which recorded Mrs Mariani's issues with nausea and pain during the shift, and the effect on Mrs Mariani of the prescribed medication from earlier that morning. He confirmed that he reviewed Mrs Mariani's pain chart and the SAGO chart.

187 When questioned about the lack of pain scores on the PCA chart after 6am on 13 July 2019, he conceded that he should have gone and physically reviewed Mrs Mariani and spoken to her about her pain score.

188 Dr Francis confirmed that it is his usual practice to speak with nursing staff after reviewing a chart, however, he had no specific recollection of the events on 13 July 2019.

189 Dr Francis stated that if a nurse is free and available, or where a serious concern is raised with him by nursing staff, he would ordinarily request the assistance of a nurse to attend a patient review with him.

190 Dr Francis was shown the medication charts, which showed that some medication was charted at 2.40pm. He accepted that he must have had a conversation with a nurse, after his consultation with Mrs Mariani between 12 – 1pm, about a change of medication.

191 Dr Francis recalled being approached by one of the nursing staff, requesting that he attend on Mrs Mariani. He recalled that he was told that Mrs Mariani's daughter had requested the review, as opposed to the request emanating from one of the nursing staff.

192 He could not recall the conversation he had with the nurse but indicated that he ordinarily would have sought more information from an on-duty nurse, to obtain her opinion of the patient's presentation.

193 Dr Francis gave oral evidence that he then attended on Mrs Mariani and conducted a clinical assessment at around 1pm. Dr Francis had not made reference to his attendance on Mrs Mariani at this time in his first and second statements and only provided details of his attendance on her after receiving a further request for clarification from the Crown Solicitor's Office.

194 He became aware that Ms Hemming had provided evidence that she had told him that her mother was "in too much pain and seemed very weak and that this didn't seem right", however, he could not recall her saying that to him.

195 Dr Francis stated the following in his third statement dated 30 October 2024:

> "I conducted a clinical examination. I recall that I looked at her abdomen. In line with my usual practice, I believe I would have palpated and auscultated the abdomen, however I do not have a specific recollection of whether I did or did not do this on this occasion. However, I did note that her abdomen was mildly distended at the time of my review. I asked Mrs Mariani and her daughter about how distended it was in relation to her baseline. I recall being told by Mrs Mariani's daughter that she was unsure as she does not usually look at her mother's tummy. I did not consider the finding of a mildly distended abdomen to be of particular concern, as this was consistent with Mrs Mariani having had gas inserted into the abdomen as part of the surgery. I would have been concerned if Mrs Mariani's abdomen was tender and hard (which it was not) as this can be a sign of peritonism (inflammation of the lining of the abdomen). I recall that there were no concerning features in respect of Mrs Mariani's appearance. She did not look pale or like she was in significant discomfort. She was able to speak to me. Her vital signs all remained within expected parameters."

196 He also recalled being asked by Ms Hemming "if these symptoms (pain and nausea) were normal for the period within 24 hours of a laparoscopic operation. Given my understanding of Mrs Mariani's clinical condition (as outlined above), I indicated to her that it *can* be normal."

197 He noted that Ms Hemming stated that she told him that her mother was:

> "in too much pain and seemed very weak and that his didn't seem "right". I do not have a specific recollection of her saying this to me. In any case where a family member reports pain, it is my usual practice to look at the

clinical situation, how much pain relief has been administered and the patient's vital signs."

198 Dr Francis ultimately considered:

> "Mrs Mariani's pain and nausea to be as expected for a patient who had not had adequate medication for the expected post-operative nausea and pain following her surgery."

199 Dr Francis was questioned about whether he should have contacted the surgeon, Dr Ghaly, given there were no recorded pain scores evident in either the PCA or SAGO charts from 6am on 13 July 2019. He agreed that it would have been reasonable to contact Dr Ghaly after the 1pm assessment, however:

> "on the basis of the information I had, what I found in the assessment, I didn't see any reason why that would be necessary at that stage".

200 Professor Williams stated that:

> "I would have thought though at a minimum if we have a patient who is falling outside what would be the normal post-operative expected course the first thing that I would think would be reasonable to do would be to ring the surgeon and to let them know what was going on. The surgeon, we haven't spoken about the surgeon, but the surgeon has not seen the patient since they left the operating theatre, they didn't review them the night before, they haven't reviewed them the morning of. That I think as a minimum as what, you know, what I would do."

201 Dr Francis conceded that he had failed to record the details of this assessment with Mrs Mariani in the clinical notes. In his third statement he noted that prior to being able to record his notes, an "acute situation" arose with another patient. He remained with this patient until he was contacted at 3pm by a nurse requesting his urgent review of Mrs Mariani, as her vital signs had suddenly deteriorated. He confirmed that he finalised his notes after returning from Taree Hospital later that evening.

202 Dr Francis stated in his second statement dated 24 February 2020, that on review at 3.15pm:

> "Mrs Mariani's abdomen was soft but tender around the laparoscopy sites. There was no guarding or rigidity. On percussion of the peri-laparoscopy sites, there was tenderness. There was some central abdominal distension, but Mrs Mariani stated this was normal for her."

203 It was his view that Mrs Mariani was "more acutely unwell" at this time. He noted that he did "not consider her abdomen was any more distended (or rigid) at the earlier review at 13.00 hours, compared to the review after 15.15 hours."

204 He disputed RN Neal's stated opinion, that at this time, she:

> "noticed Ms Mariani's abdomen was distended. I palpated it and it felt tight and rigid. Mrs Mariani did not appear to be in significant pain although her abdomen was tender to the touch. However, there was no redness visible."

205 Dr Francis denied that he had been approached by any of the nursing staff seeking permission to disconnect the PCA at any time during 12-13 July 2019.

206 Professor Williams opined that Dr Francis' lack of clinical experience in managing post-operative surgical patients led him to fail to recognise the symptoms and signs of an acutely unwell patient.

207 Dr Francis should have reviewed Mrs Mariani on the morning of 13 July 2019, particularly when he had attended the hospital to chart the medications that he had directed in the early hours of 13 July 2019.

208 Given his limited surgical experience, it would have been reasonable and appropriate for Dr Francis to have contacted Dr Ghaly to discuss Mrs Mariani's condition, particularly after his assessment of her at around noon to 1pm.

209 It is noted however, that Dr Francis did not have access to accurate and contemporaneous nursing records at the time of his assessment at around 1pm, due to RN Martyn's failure to accurately document Mrs Mariani's observations.

Dr Moheb Ghaly's evidence

210 Dr Ghaly provided one statement dated 18 December 2019 and gave oral evidence at the inquest on 5 February 2025.

211 Dr Ghaly indicated that it was his normal practice to visit patients after surgery. He conceded that he could not confirm that he had seen Mrs Mariani on the evening of 12 July 2019, and although it was possible that he had not seen her, "it's very unlikely."

212 He stated that he attended at the Manning Base Hospital the following morning to review his patients. He was intending to visit his patients at Forster Private Hospital later that day. He confirmed that after he had finished his rounds at Manning Base Hospital, he attempted to call Forster Private Hospital to speak with the nursing staff. He indicated that his call connected to a call option system, and when he selected one of the available options, the call was not

answered. He stated that he attempted this on three occasions without success.

213 At 1pm, he received a phone call from one of the nursing staff at Forster Private Hospital, confirming that Mrs Mariani was "all right". He stated that he asked the nurse specifically about the drain and whether there was any bile in the drain and was told "No". He then directed that the drain could be removed, although Mrs Mariani was not to be discharged for "another day at least".

214 Dr Ghaly stated that it had been his intention to attend Forster Private Hospital later that day.

215 Dr Ghaly indicated that he received a phone call at around 3.30pm or 4pm from a nurse at Forster Private Hospital telling him that Mrs Mariani had deteriorated and was being transported to Manning Base Hospital. He stated, "That was the first I knew about any untoward complication."

216 Dr Ghaly gave oral evidence regarding his expectations that he would be contacted about a patient under his care.

217 He stated that he would have expected to have been contacted at 12.30am on 13 July 2019, if Dr Francis had made a "phone order for four milligrams of dexamethasone intravenously stat and for 50-to-100-gram milligrams of Tramadol."

218 Dr Ghaly gave evidence that "to get a phone call in the middle of the night, something is serious, and I know she's a sensible lady without exaggeration of her symptoms from knowing her. So for her to complain is important in the middle of the night."

219 Dr Ghaly gave oral evidence that he had not been advised that any doctors had reviewed Mrs Mariani at any time after her surgery, prior to being informed by telephone that her condition had deteriorated dramatically.

220 He further contended that he should have been contacted by Dr Francis after the 1pm examination. He stated that he had seen many patients following gallbladder surgery who "bounce back the next day." He suggested that in Mrs Mariani's case:

> "for somebody to consume or use the PCA for so much and in pain and can't move, throwing her legs up and in pain, somebody should alert me, ask me, is that to be expected? At least, I would have responded to that at any time."

221 He further stated:

> "contact me, tell me, is that to be expected? Is that normal? I don't know how many have seen post-op gallbladders. I have seen many…for somebody to consume or use the PCA for so much and in pain and can't move, throwing her legs up and in pain, somebody should alert me, ask me, is that to be expected? At least, I would have responded to that at any time."

222 Dr Ghaly continued, stating:

> "I think she's got a high threshold, and she put up with a lot, and I know that she pulling the legs up is a sign of something drastic is happening. I regret not seeing her at that time. I would have operated and the outcome would have been different."

223 Dr Ghaly suggested that in his opinion:

> "The severity of the pain and the tenderness on touching her tummy would be more important than the distension." He confirmed that if he had been informed of that presentation in a patient, particularly Mrs Mariani, he would have attended "straightaway", even in the middle of the night.

224 He continued, stating:

> "The vomiting could have been explained by the narcotics she had, so that's not a reliable symptom, but it's the pain and not a good response for the analgesics she's getting."

225 Dr Ghaly gave evidence that he had an expectation that he would be contacted by Dr Francis, given the breakthrough pain and nausea that Mrs Mariani was experiencing at 12.30am on 13 July 2019, whilst accepting that it is not required on every occasion where there might be an issue in a patient's presentation.

226 He agreed the decision to make a call to a surgeon by a medical officer was a discretionary one, Dr Ghaly stated, "but the doctor hopefully would realise this is a bit abnormal or unusual, should I be talking to the surgeon or give me a phone call? It would take a few minutes."

227 Dr Ghaly again emphasised that he expected to be notified of excessive pain, given that it is one of the indicators of a bowel perforation. He stated that he expected he would be notified both at around 12.30am, as well as in the middle of the following day, when Mrs Mariani was examined by Dr Francis.

228 Dr Ghaly stated that if he had been advised of Mrs Mariani's presentation at 1pm on 13 July 2019, he would have "made a decision to take her back to theatre, as soon as possible."

229 Dr Ghaly accepted the opinion of Associate Professor Williams that he should have reviewed Mrs Mariani on the day of the surgery and again the following morning, being 13 July 2019.

230 Associate Professor Williams commented:

> "Yeah. Look, I mean, I think in this case, it is regrettable that the surgeon did not come and review the patient either on the night of surgery or the morning after. I'm not aware of why this is the case, whether he had pressing business elsewhere or was away or perhaps it is not his usual routine to review patients in hospital the day after surgery. I – if it were my practice, and working in a regional centre – I mean, there are lots of reasons why we can't go in and see patients the next day. You know, I might be away or – one would usually organise for somebody to go and review the patient in my stead. At a minimum, I would expect the nursing staff to give me a call the morning after to let me know how the patient's going, or you know, sometimes in my hospital, the nurses will even ring me and say, you know, "Dr Williams, are you having a bit of a sleep in? Like, are you coming in to review, you know, these patients, you know, today or not?" Certainly by the time we've now – its now lunch time, and the family are concerned, and the surgeon still hasn't been in to see the patient. It is, you know, my humble view that it would've been entirely appropriate for the CMO who doesn't know the hospital, doesn't know the surgeon, doesn't know their routines, to ring them up and fill them in on what's going on."

231 Professor Williams was asked:

> Q. Is that particularly the case if the CMO was made aware or otherwise discovered that the surgeon had not seen the patient in the morning?
>
> A. Yes. That would be even more reason to ring the surgeon."

232 Dr Ghaly was of the view, having reviewed the expert opinions and the postmortem report, that:

> "I think the accident happened on closure with the needle going in a loop or small bowel. I could not have seen and the needle gone into it, and the bowel is damaged. It started leaking fluids. The volume is increasing with time, symptoms and signs are getting worse, and that explained her pain and suffering."

233 Dr Ghaly denied that he had either charted the removal of Mrs Mariani's PCA or given any oral direction that the PCA should be removed on 13 July 2019.

234 Dr Ghaly should have reviewed Mrs Mariani on the morning of 13 July 2019. Dr Ghaly accepts this criticism. It is noted, however, that Dr Ghaly was not

contacted by Dr Francis at any time on 13 July 2019 and appraised of her symptoms relating to pain or the need for additional medications.

235 It is further noted that Dr Ghaly attempted to contact the hospital on at least three occasions without success and indicated that he would have attended the hospital promptly if any concern had been raised regarding Mrs Mariani's presentation. It is clear that he spoke with RN Martyn on one occasion on 13 July 2019, regarding the drainage tube, however, was not advised of any other issues with her presentation.

Expert evidence

236 During the expert conclave, Associate Professor Williams and Dr Markowskei were asked for their opinions as to what symptoms Mrs Mariani was likely to have developed after surgery that would have been problematic, and when these symptoms would have become noticeable.

237 Dr Markowskei indicated that if a bowel is perforated during laparoscopic surgery, and not recognised intraoperatively, the patient will have no clinical signs. He noted that the clinical signs would develop over a period of time, and specifically they would manifest in a sudden medical event.

238 Professor Williams was of the opinion that there would have been sufficient signs the following morning after the surgery, and by the middle of that same day, and any time up until 3pm, which would have indicated that Mrs Mariani was experiencing a medical condition that required investigation.

239 Professor Williams gave oral evidence, stating:

> "People do suddenly deteriorate in hospital, I agree with that. But that's heart attacks, strokes, and things that the other expert mentioned before. We already know that this patient's family were saying hours earlier "there's something wrong with Mum."

240 Both experts were asked to provide their opinion as to whether a patient is more likely to deteriorate over a long period of time, or suddenly, after sustaining a bowel perforation.

241 Professor Williams stated:

> "Fortunately, these events are rare overall, so it's not something that fortunately us surgeons have a lot of experience with detecting small bowel injuries. But it is most likely that the patient would have been definitely outside the expected course on the first post-operative day, and I expect that the deterioration in these cases would be more likely to be gradual than precipitous. Sepsis can be precipitous, yes, and we've heard that yes,

old people have less physiological reserve, and it may have been quite sudden that she decompensated and lost blood pressure. But in terms of the global assessment of the patient, their abdominal examination I expect that there would have been a gradual rather than a sudden deterioration."

242 Dr Markowskei responded:

"Yes. Well the reason you deteriorate after a bowel perforation is obviously leakage into the peritoneal cavity of feculent matter that's got bacteria in it that your peritoneal cavity has no method of dealing with. So every day you manage to have feculent material and you don't have a problem but once you have a hole in your bowel you certainly do. And the mechanism of that problem, it's not the feculent material that causes the problem, it's not the leakage itself that causes the problem, it's the fact that you develop an infection.

That is the mechanism by which you become profoundly unwell. So you can tick along quite nicely for some time with bowel leaking into the peritoneal cavity. Perhaps, to be fair, you may be slightly out of the normal post-operative parameters. But not enough for even the most astute clinician to notice it. Until things start to happen, like your blood pressure falls, your pulse rate goes up, you develop fever, your white cell count unexpectedly goes up, and a range of other features. Now that timeframe can be quite variable, depending on where it's leaking into, how walled off it is, how much material leaks. What kind of material it is? Is it small bowel contents, large bowel contents? And as I illustrated earlier with perforated bowel in gynaecology patients after laparoscopy, the diagnosis is not made for three days as a median time. It takes time to develop these symptoms.

The issue is that you have a condition where the patient leaves the operating theatre with nobody aware that they have a perforated bowel. Nobody. And I'm sure Dr Williams would say, no one is aware. And then, slowly but surely, and over a timeframe that varies from patient to patient, you become aware. And that timeframe can be quite reasonably long. It's not in the four hour later, it's not necessarily several hours later. It's not necessarily at 7.30 in the morning. It could even be later in the afternoon. So to sort of suggest that the patient needs to have some sort of clinical findings, well, if they always had clinical finings that we could simply assess, and write them down on a chart, we wouldn't have anyone who has a perforated bowel that has a mortality problem.

Now, the mortality in this condition is extremely high. Some studies put it at 44%. Now that's across everyone, all around the world, in large studies.

The mortality rate of a perforated bowel remains high, and that is because it's not initially recognised, because it's subtle. And because it causes catastrophic sepsis. And particularly in elderly patients, that is not at all withstood."

243 Dr Markowskei had indicated that post-surgical issues could manifest within 12 – 48 hours. He was asked if that could have been as early as 3.30am on 13 July 2019. He stated:

"Could be. Yes, it could be. If there's a large leak, and the patient develops acute sepsis very quickly. Or it can be a more subtle, smaller leak, where the sepsis is delayed. It could be, as I mentioned earlier, walled off, so you don't really get a lot of bowel contents going into the bowel. So there's going to be a lot of variability. And sepsis itself is very variable. And elderly patients don't display septic symptoms. And nor do they display acute abdomens very clearly either. So with elderly patients, the normal findings of tenderness, guarding, rebound. These finding can be extremely subtle and not found. So if you present to an emergency department in your 90s, and you have an acute abdomen, the clinical findings can be quite minimal. And usually requires investigation to find the cause. So I believe that she likely didn't have significant findings. And if she did have significant findings, why are all her observations totally normal?"

244 In contrast, Professor Williams opined that Mrs Mariani was most certainly outside the expected course of post-operative events. He stated:

"After a laparoscopic cholecystectomy, I think that what we are seeing in this case here falls outside of what I would expect the normal course to be. Notwithstanding, and I do accept that there is of course a spectrum of post-operative recoveries. People have different pain thresholds, for example. People have different comorbidities. And I fully concur with the other expert that we're talking about an elderly comorbid patient here. So I would not be expecting her to be bouncing out of bed and going home first day. But there's enough in this case, that she has not followed what I would expect to be a normal post-operative course for day 1 post-laparoscopic cholecystectomy. Even in somebody in their late eighties."

245 Dr Markowskei was asked whether it was possible that RN Martyn reported that Mrs Mariani was well at 2.50pm and then suffered an acute deterioration by 3.15pm, that her deterioration could have occurred solely during that "25-minute window". Dr Markowskei stated:

"That's a difficult question to answer. She had gone from the nurses handing over at the bedside, and being happy to hand on to each other, and

continue on doing the handover, to being acutely unwell over a timeframe. So that's a change. What timeframe that happened, I'm not exactly sure. I have suggested the possibility she aspirated as well in the hospital. And that would be pretty well instant. You vomit into your lungs, your lungs are occluded by vomit, and you can't breathe. She's had previous episodes of acute pulmonary oedema, or episode. That could also occur very, very quickly in older patients. Usually not as quickly as say an aspiration. It normally occurs over, you know, half an hour or so. Again, it's difficult to say. But she has moved from a point where she was in bed, reviewed by the nursing staff physically looking at her, to having a medical emergency call in a very short space of time."

246 Dr Markowskei agreed that some of the symptoms of post-operative peritonitis can be masked by the ordinary post-operative symptoms.

247 Professor Williams was asked to comment on the same proposition. He stated:

> "Whilst I accept that, you know, very acute deteriorations can occur in these patients, given what we know from the autopsy about what was going on, it is far more likely than not that this patient had been steadily deteriorating throughout the day, and that there would have been signs of peritonitis present earlier than at that 3.15 review."

248 Dr Duflou commented in his report that:

> "If it is accepted that the patient was seriously ill at 15.15 hours, it would follow that the patient had been ill in the time leading up to this, and that she would also have been very unwell some 15 minutes earlier. Given the clinical observations subsequent to this, acknowledging that from the material provided I am unable to ascertain the exact times of those later medical observations, and taken together with the autopsy findings, it appears very likely that the patient's apparent sudden deterioration as a result of her bowel perforation pre-dated the nursing staff observations of 15.00 hours. Indeed, it is very likely a competent examination of the patient at any time prior to this on 13 July 2019 would have identified a significant abdominal problem, and if it had been identified early enough appropriate surgical treatment of the patient could have been initiated."

249 Professor Williams and Dr Markowskei were asked to provide their opinions as to the timeframe associated with the detection of a bowel perforation.

250 Dr Markowskei stated that:

> "It would vary between patients. It would vary depending on their age, their other comorbidities, but it would be some time. As I say in this very large study, it was one to 13 days, and in my report, I said you would probably notice something somewhere between 12 to 48 hours, but that's extremely variable, and the signs are extremely subtle. It's not as if the patient sort of presents with an obvious bowel perforation four hours later. Mm."

251 Professor Williams offered a different opinion, stating:

> "You can't really generalise about how patients with these injuries are going to present because it is really completely variable depending on the nature of the injury and the individual patient. I mean, you can look at sort of thousands of them and then, you know, derive an average, but by way of example, if you have a frank hole in a piece of small bowel, then that patient would be showing symptoms of abdominal misadventure immediately. If, on the other hand, you had a thermal injury, a thermal injury may not turn into a frank hole for a week or more after surgery. So it really depends on the nature of the small bowel injury in that particular patient."

Signs of peritonitis post-surgery on 12 July 2019

252 Professor Williams was asked on behalf of Dr Ghaly, whether he could reasonably "opine as to when before 3.15pm (on 13 July 2019) there would have been signs that could have been observed?"

253 Professor Williams responded:

> "No, there's no way of knowing for sure exactly. We can just put the pieces together and work backwards if you like; the fact that this patient was so unwell from their abdominal sepsis that they'd passed away, you know, later that night or, you know, in the early hours of the following morning. We know that there was a deterioration at 3 o'clock, we know that there was some content leaking into the abdominal cavity before that time, so on would expect that at some stage during the day on the 13th there would have been a deterioration of the patient's abdominal signs. But there's no way of sort of putting a particular time on the clock and saying this is the time at which I expect the patient would have, you know, would have become peritonitic."

254 Professor Williams was asked whether he would have expected there to have been observable signs of peritonism in the immediate post-operative period in the recovery ward. He opined that:

> "No. I think it would be unlikely that there would be some signs of peritonism in the immediate post-operative period in recovery, in the recovery ward."

Signs of peritonitis on the morning of 13 July 2019

255 It was suggested to Professor Williams, on behalf of Dr Ghaly, that there would be "no reason to expect that signs of peritonitis would have been observable" by Dr Ghaly if he had conducted his usual post-operative review between 7am-10am on 13 July 2019.

256 Professor Williams stated:

> "No, I don't agree with that. I think that had he examined the patient on the13th it's more likely than not that he would have elucidated signs on his examination that were – the patient would have been, I think, more tender than he would have been expecting had he examined the patient before...."

257 Professor Williams was then asked, "how he could draw that conclusion", and responded:

> "Surgeons are obviously very, very used to examining their own patient. It is our day job to examine people's abdomens and to have an appreciation of what is an expected and an unexpected amount of pain after [an] operation. Given what unfolded in the afternoon and evening in that particular patient I think it is quite – I would expect more likely than not hat an examination at that time period would have revealed a patient who was more tender than the normal, than would have been expected."

Expert conclusions

258 Professor Williams opined that it is far more likely than not that Mrs Mariani had been steadily deteriorating throughout the day, and that there would have been signs of peritonitis present earlier than 3.15pm on 13 July 2019.

259 Dr Markowskei maintained that there had been a more sudden deterioration in Mrs Mariani's presentation.

260 Dr Duflou also provided the opinion that Mrs Mariani was deteriorating over a longer period of time, and it was unlikely that she experienced a sudden deterioration between 3pm – 3.15pm on 13 July 2019.

261 The evidence Professor Williams is to be preferred, given his greater surgical experience as an Endocrine, Obesity and Upper Gastrointestinal Surgeon. It is also noted that Dr Markowskei based some of his opinions on the basis of research papers, as well as perceiving that the clinical notes and observations were 'normal'. Clearly, the notes made, or indeed not made by RN Martyn were inaccurate and lacking any contemporaneity.

Forster Private Hospital Executive Evidence

262 Ms Deanne Portelli was the Regional Chief Executive Mid-North Coast NSW for the Healthcare Group. At the time of Mrs Mariani's admission in 2019, Ms Portelli was the Chief Executive Officer of Forster Private Hospital.

263 Forster Private Hospital forms part of the Healthe Care network and was owned by China's Luye Medical Group after their 2015 acquisition of Healthe Care.

264 Ms Portelli confirmed that the hospital had undertaken a "London protocol" regarding aspects of Mrs Mariani's admission, as well as other unrelated cases.

265 Ms Portelli confirmed that Recommendation 9 related to Mrs Mariani's admission. In particular, it related to her family being advised by staff that their mother was in theatre, when she was still waiting for her procedure in the day surgery unit. A webPAS system has since been implemented which allows for the tracking of patients.

266 Recommendation 10 related to the problems experienced by Dr Ghaly regarding his attempts to contact nursing staff by telephone on three separate occasions on 13 July 2019. The hospital has now implemented a system where the nurse in charge of a shift has a dedicated mobile phone to receive calls from VMOs.

267 Another recommendation that didn't specifically arise from Mrs Mariani's admission, but had some relevance was the implementation of a team 'huddle' for all staff in the middle of a shift. Ms Portelli stated:

> "Because the understanding of the team (the London protocol team) was that there was no issue with the communication at – you know, in the case with Mariani. In regards to the observations being between the flags, et cetera. So this was recommended most likely, from my experience, in the public sector with the Centre for Excellence Commission. And also the 20 years I spent at the Sydney Adventist Hospital, where I was part of an innovation team, and safety huddles were really important to introduce to a clinical environment."

268 Ms Portelli confirmed that 'R.E.A.C.H' posters had been placed in various locations in the hospital to assist patients and their families. It is a system to assist "patients, their families and carers to raise their worries with staff about changes in a patient's condition." The posters display a mobile phone number which can be contacted if a patient or their family have concerns that the patient is not receiving timely or appropriate care.

269 Ms Portelli described it as being an initiative from the Centre of Excellence Commission in the public sector. In 2020 or 2021, the initiative was rolled out across all Healthe Care Private Hospitals.

270 Ms Portelli described the hospital as consisting of two wards, being the medical surgery ward and the rehabilitation ward. The two wards are located on separate floors, with the rehabilitation ward directly above the surgery ward. Ms Portelli estimated that in 2019, the surgical ward would average 18-22 patients on any day. Ms Portelli confirmed that during Mrs Mariani's admission "there were four nurses on, RN and EN, and an in charge. And there were 22 patients on the ward."

271 Ms Portelli confirmed that CMOs and locum doctors receive the same orientation that Dr Francis received in 2019. She described the orientation component as consisting of sending:

> "out the job description, as to what they would be required to do for the hospital. But the – all the things that I mentioned before. And also, we have an orientation like information pack, that's kept in – that's sent to them by email before they come for reading. And also in the front of the CMO roster book on the ward."

272 Ms Portelli also confirmed that a locum/CMO is given:

> "a walk-through of the ward. And I somewhat recall Dr Francis saying that he was shown around the ward, not the whole hospital. So that would be normal practice."

273 Ms Portelli was asked to comment on the contact process between a CMO/locum and a surgeon at the hospital. Ms Portelli indicated that:

> "So what we have in place is that there is a fairly standardised process, across any hospital that a locum would work, in regards to the communication between a patient, nurse, CMO, specialist. So I know that in smaller towns, there's a lot more connectivity between the nurses and the local VMO. They call them by their first name sometimes, which you wouldn't see if you were going to show the respect to a specialist who you don't particularly know. But the communication setup is such that, you

know, the nurses have up on a whiteboard who the CMO is for the day, and their contact details. And they have the roster. So the nurses and the CMOs work very closely together."

274 Ms Portelli was questioned as to whether there was any hospital policy which informed a surgeon when they were expected to visit a patient after surgery. Ms Portelli stated:

> "We have what we call bylaws for all Healthe Care hospitals, and their engagement with visiting medical officers, and those bylaws give us, or give the doctors, a – the boundaries in which they work within, in engagement with a Healthe Care hospital" and these bylaws were in place in July 2019.

275 Ms Portelli denied that there were any cultural issues at play in July 2019, relating to CMOS/locums or nurses contacting surgeons out of hours, particularly late at night.

276 Ms Portelli confirmed that in July 2019, all medical records held at Forster Private Hospital were paper records. She stated that the hospital records remain paper based rather than being electronically generated. Ms Portelli commented that:

> "What we're talking about is electronic medical record, and the electronic medical record is a very expensive IT platform, and it is not without fault. So, it's not a perfect diamond, so it's really, to weigh up, I get a number of VMOs who come to our hospital and say, "Thank goodness you're paper based." In working in the public sector where there is electronic medical record, there's also records that aren't electronic that can add to risk because you aren't looking at the full patient file when you're looking at the electronic record, you also need to refer to hardcopies for various different things. At least with a hardcopy, and I'm saying this in defence of some of the pros and cons of electronic medical record as to hardcopy, you see everything to do with the patient file in one file in front of you."

277 Ms Portelli was asked about the shortcomings of the paper record if a CMO or VMO are not on site and have no connectivity to assess a patient's progress or deterioration. Ms Portelli stated:

> "It is one of the limitations and hence why the importance of that communication to be ISBAR, I suppose, framework to ensure that we get the appropriate messages through."

278 In that regard, Ms Portelli was unable to confirm the training that staff may have received regarding the ISBAR, stating:

"I actually couldn't answer that. I do know that there is education that was provided in 2019 in regards to documentation and what was core competencies required of the RN Ens, et cetera, specifically ISBAR. Yeah, I would need to refer to back to the notes."

279 Ms Portelli stated that in July 2019:

"The ISBAR process is up on the wall near the phones, to encourage the staff members who are educated in that space in how to communicate, to ensure comprehensiveness and clarity. We do have, of course, VMOs who work with us over a longer period of time who don't have access to those records, so they do have a line of questioning to ensure that they do receive the information that they're after."

280 Ms Portelli was asked about the process in place in July 2019, whereby discussions between doctors and nurses would be recorded. She stated that:

"The only way we would be able to know what that conversation entailed and even the nurse themselves later I guess, would be the fact that they documented in the notes. That they'd had that conversation... Conversations that happen between a specialist and a nurse would routinely be documented in the progress notes."

281 Ms Portelli was asked:

Q. "Did you consider from hearing the evidence that there was any issue arising from staff at the hospital, insofar as documenting events is concerned?"

A. "I've heard the potential issues. It's really for me to, I guess, go back to the clinical advice from the director of clinical service to say, was there any deviation [from] our process and policy? And if so, address that. But from what I understand, is that our policies and process for documentation is fairly clear on what's expected."

282 Ms Portelli had been present in Court when RN Martyn gave evidence. Ms Portelli and was asked to comment generally on nurses documenting their care giving, and she stated:

"My understanding is that there is a process and a system in place for documentation. And that there was a particular staff member who didn't necessarily comply with that, and said that she's admitted to do."

283 Ms Portelli gave oral evidence that Forster Private Hospital carries out an audit of the paper-based records every six months to ensure that nurses are filling out the appropriate paperwork.

284 Ms Portelli was asked:

> Q. "Given we've focused a bit on the paper records versus the electronic records, is part of the difficulty with auditing, whether staff are reviewing the progress notes, the fact that they're in paper? For example, as I understand the way that the electronic record might work, you have a better understanding of knowing when people have looked at records or not. Do you have any information to shed about difficulties in auditing whether or not people have looked at records? Like how would you literally do that other than asking them if they had?
>
> A. "That's a good question, and you would need to ask the health professional that they had. I would suggest maybe even electronically."

285 Ms Portelli was asked about the CMO books and handover notes, and why they were destroyed after Mrs Mariani's case have been referred to the Coroner. Ms Portelli described the practice at Forster Private Hospital where the handover notes are printed:

> "and they are a guide that the nurses have through the shift to be able to give themselves reminders of various different times for various medications or obs, et cetera. So they use that as their notes, and it is to protect patient confidentiality that they're put into the confidential bin before they go home."

286 Ms Portelli described the CMO book as:

> "it's called a book, it's a folder. And in there is basically a task list. And the nurses will write on there tasks that need to be done for a particular patient, such as a medication chart needs to be, you know, renewed for example. And then the CMO will just cross it off. So it's not a document that you would actually keep, that would be meaningful."

287 Ms Portelli confirmed that the CMO book is not usually destroyed at the end of a shift. "Maybe in a day or so after. As it's replaced with new tasks." Ms Portelli was asked that if Mrs Mariani's death had been reported to the Coroner, wouldn't that "require the hospital to keep the CMO record?" Ms Portelli stated "There was no indication of such, no."

288 Ms Portelli confirmed that if a patient has been connected to a PCA for pain management, a surgeon would ordinarily provide standing orders in the post-operative instructions or other notes or directions about when the PCA was to be disconnected. She also stated that a nurse is required to consult with either the surgeon or the notes prior to disconnecting the PCA.

289 Ms Portelli was asked to comment about the length of time that Mrs Mariani's PCA was stored in a room after its removal. She stated that:

> "Best practice would be within the shortest amount of time to the disconnection. Best practice. Putting the fentanyl pump into a locked area is a practice that is done when they're looking for the keys. For an extended time period, I'd prefer that not to be the case."

290 Ms Portelli agreed that education and training was very important to ensure that hospital policies were implemented, records were contemporaneous, and appropriate care was delivered to patients.

291 Ms Portelli's evidence was particularly confusing regarding the education and training of staff, both in 2019 and currently.

292 Ms Portelli confirmed that "There is training and education, on all of the documentation requirements, equipment use, et cetera."

293 Ms Portelli stated that:

> "we have quite an intensive education plan and program for nurses. So we actually pay for nurses to attend some kind of education for half an hour every day. So it's quite a significant investment from a small hospital, to ensure that the nurses are kept, you know, up to date with any sort of education. The education plan does include documentation in servicing, on a regular basis."

294 Ms Portelli explained:

> "when I say, "we had an educator for the hospital", we actually had a clinical educator that was involved in the clinical care of patients, so her role wasn't to take patient load, but to provide bedside education for the staff, to provide assessment of competencies along with other senior staff, to provide and coordinate an education plan and deliver in-service, and her availability was quite generous, four days a week."

295 Ms Portelli went on to explain that this education role had "just recently been reduced, because it was seen as being quite excessive for the size of the site." She confirmed that the role had been reduced from four days per week to two days per week.

296 A number of propositions were put to Ms Portelli, largely reflecting the concerns of Mrs Mariani's family:

> Q. "They said there's an issue of public health or safety to address. Do you disagree with that, or agree with that?"

A. "I'm not aware of any public safety issue, no."

Q. "They say that pain, vomiting, and abdominal swelling were observed but overlooked, or given insufficient attention as a possible symptom of peritonitis. Are you able to respond to that?"

A. "Not that I'm aware of."

Q. "They say there was a lack of awareness concerning the high clinical suspicion that should be given during the first 24 hours of a post-operative gastrointestinal surgery. Are you able to respond to that?"

A. "Within the systems and the processes we have in place, not that I'm aware of."

Q. "The family say there was a lack of frequent and detailed communication between those providing post-operative care and the treating surgeon. Do you have a comment or response to make about that?"

A. "The frequency of communication with the admitting doctor?

Q. "Yes"

A. "I am not aware of any issue with that, other than the fact that there was the issue that we addressed in regards to a surgeon having quick access. Like as soon as they ring, it's handled with the mobile phone."

297 A number of other propositions were put to Ms Portelli. One of the most telling was her response to the question about the family's concern that there had been insufficient note taking and that this had impacted on the adequacy of Mrs Mariani's care. Her response was:

> "The insufficient notetaking has been noted. However, the impact on the care of the patient, I couldn't make a comment about. I'm not aware that there was."

298 During her oral evidence, Ms Portelli appeared to concede that the only change that had been implemented by the hospital in light of Mrs Mariani's death, related to the provision of a mobile phone to the nurse in charge for the purpose of receiving calls from surgeons/VMOS and CMOs.

299 Ms Portelli's evidence was vague, deflective, and full of bureaucratic 'speak.' Her demeanour in the witness box was concerning, with her smiling and laughing for no obvious reason, and failing to acknowledge the gravity of her situation and that of the Hospital.

300 Ms Portelli did not appear at any time during her oral evidence to comprehend that there were multiple and clear systemic issues present, both in July 2019 and currently.

Considerations and findings

301 Mrs Mariani had a number of comorbidities when she presented to Forster Private Hospital for an elective laparoscopic cholecystectomy on 12 July 2019.

302 Mrs Mariani was supported by and received appropriate advocacy from her family, particularly her daughter, Ms Hemming on both 12 and 13 July 2019.

303 Post surgery, Mrs Mariani was connected to a PCA machine to assist with her pain management.

304 At various times on both 12 and 13 July 2019, Mrs Mariani was observed to be experiencing significant pain, both by medical staff and her family. Unfortunately, her pain management charts were either not completed, partially completed or incorrectly completed.

305 A lack of appropriate communication hampered the care and treatment of Mrs Mariani. The lack of communication commenced with the inadequate orientation of Dr Francis as the locum CMO. It continued and included failures to obtain direct authorisation to disconnect the PCA, advise Dr Francis of family concerns about symptoms and pain management, and communication between doctors and nurses. Dr Ghaly did not attend a post-surgery review at any time on 13 July 2019, although he expressed frustration with his attempts to contact nursing staff by telephone on 13 July 2019.

306 If Dr Ghaly had attended the hospital for a review on the morning of 13 July 2019, it is more likely than not that he would have detected that Mrs Mariani's abdomen was more tender than normal or expected.

307 RN Martyn's monitoring of Mrs Mariani was grossly inadequate and likely negligent. Her record keeping, or lack thereof, was grossly deficient and impacted on the information which could or should have been made available to both Dr Francis and Dr Ghaly.

308 The systemic failures at Forster Private Hospital were egregious and legion. Despite undertaking a London Protocol, only one change relating to the provision of a mobile phone to the nurse in charge of the ward, has been implemented.

309 The systemic failures by the Hospital included:

- poor, incomplete, or inaccurate clinical records,

- the continued use of paper records and the inadequacy of biannual audits,

- the use of the PCA, the lack of documentation regarding the removal of the PCA and the supposed storage of the PCA containing unused Fentanyl for an unknown period of time in a room,

- confusing evidence regarding ongoing education and training of staff,

- failure to implement a more appropriate orientation for locum practitioners,

- lack of clarity of communication between VMOs and CMOs.

Treatment received at Manning Base Hospital

310 The expert opinions concluded that there were no care and treatment issues apparent during Mrs Mariani's treatment on 13 – 14 July 2019 at Manning Base Hospital. I accept their evidence and find that Mrs Mariani received appropriate care and treatment at Manning Base Hospital.

Proposed referral of RN Martyn

311 Consideration has been given to the appropriateness of referring RN Martyn to the Nursing and Midwifery Board of Australia and/or AHPRA, pursuant to section 82 of the *Coroners Act* 2009 (the Act), on the grounds that:

a. Her monitoring of Mrs Mariani was grossly inadequate;
b. the record keeping of RN Martyn was grossly deficient;
c. there was a lack of appropriate care and treatment received by Mrs Mariani from RN Martyn.

312 Section 82(2) of the Act states:

> "(2) Without limiting section (1), the following are matters that can be the subject of a recommendation -
>
> (a) public health and safety,
>
> (b) that a matter be investigated or reviewed by a specified person or body."

313 Consideration has also been given to section 151A of the *Health Practitioner Regulation National Law* (NSW) (the *National Law*).

314 Sections 151A(2) and (3) state:

> (2) If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession.
>
> (3) If a notice or a transcript of evidence is given to the Executive Officer under this section –
>
> > (a) a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates; and
> >
> > (b) the Executive Officer must give written notice of the notice or transcript of evidence to the National Board for the health profession in which the person is or was registered.

315 Section 151A of the *National Law* does not define or provide any guidance as to what may constitute "reasonable grounds". Section 3A states that:

> (1) The main guiding principle of the national registration and accreditation scheme is that the protection of the health and safety of the public must be the paramount consideration.

316 Section 3B states that:

> In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.

317 Section 151A of the *National Law* provides a mechanism where evidence received during coronial proceedings may serve to ground a complaint to the Medical Council. The section does not provide any basis for how such a complaint is to be assessed, investigated or considered, nor what action may be taken.

318 It is noted the provisions and language of section 151A(2) of the *National Law* imposes a low threshold regarding a referral. In other words, section 151A(2) does not impose a requirement that the evidence in these proceedings has established a complaint, but rather that the section may be enlivened if the coroner has reasonable grounds to believe that the evidence may indicate that a complaint could be made.

319 Clearly, section 151A(2) is not mandatory. It permits a coroner the discretion as to whether a complaint should be made by providing the transcript of the proceedings to the Medical Council of New South Wales.

320 Section 144 of the *National Law* provides a number of grounds for a complaint about a registered health practitioner, as follows:

a) A complaint the practitioner has, either in this jurisdiction or elsewhere, been convicted of or made the subject of a criminal finding for an offence.

b) A complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct.

c) A complaint the practitioner is not competent to practise the practitioner's profession.

d) A complaint the practitioner has an impairment.

e) A complaint the practitioner is otherwise not a suitable person to hold registration in the practitioner's profession.

321 Section 139B of the *National Law* provides an extensive definition of the types of conduct which may be categorised as unsatisfactory professional conduct. The most pertinent consideration in relation to these proceedings would appear to be section 139B(1)(a), which reads as follows:

> 139B (1) ***Unsatisfactory professional conduct*** of a registered health practitioner includes each of the following—
>
> (a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. … (emphasis in original)

322 In the abovementioned construction of the provisions of the *National Law*, it would appear that if there were reasonable grounds to believe that the evidence given during this inquest may indicate a complaint could be made, a transcript of that evidence may be provided to the Medical Council.

323 On behalf of RN Martyn, it was submitted that the "issues and failures that occurred as a RN Martyn should not be isolated and identified for referral."

324 It was further submitted that:

> "Although there were aspects of care provided by RN Martyn that she conceded could have been improved and would be the subject of adverse

comment or findings, it is submitted that the coroner ought exercise her discretion in not referring RN Martyn under section 82(2) as the evidence does not ground a finding that these deficiencies would render it necessary or desirable for her to be referred to the NMBA/AHPRA. Further there is no independent expert evidence from a nurse that the deficiencies accepted by RN Martyn amounted to a "gross failure" or were "grossly deficient" in the context of the scope of practice of an RN in the circumstance of this case."

325 The matters raised on behalf of RN Martyn relating to the proposed referral can be broadly categorised as subjective matters. Their relevance does not relate to the commencement phase provided by section 151A, but rather to considerations which the Health Care Complaints Commission or the Nursing and Midwifery Board of Australia may have pursuant to section 145B.

326 Section 145B of the *National Law* identifies the various courses of action available to the Council upon receipt of a complaint, including:

a) make any inquiries about the complaint the Council thinks appropriate;

b) refer the complaint to the HCCC for investigation;

c) refer the complaint to a Professional Standards Committee or the Civil and Administrative Tribunal;

d) direct a health practitioner to attend counselling; and

e) determine that no further action should be taken in respect of the complaint.

327 It is not for this jurisdiction to consider the appropriateness of any possible civil penalty which may be imposed if a nursing practitioner was referred pursuant to the legislation, however, it is noted that, if there has been no further professional transgression in circumstances where there has been such a significant elapse of time, the imperative for professional condemnation and correction may be lessened.

328 Taking into consideration the circumstances relating to RN Martyn's professional involvement in Mrs Mariani's care and treatment, I intend to refer her conduct to the HCCC and the Nursing and Midwifery Board of Australia, pursuant to section 151A of the *National Law*. A copy of the transcript of these proceedings will be annexed to the referral.

329 I am of the view that RN Martyn's actions or inactions were grossly deficient and amounted to conduct which was contrary to the health and safety of the patient who was within her care.

Proposed recommendations

330 At the conclusion of the evidence, two draft Recommendations were proposed by counsel assisting and circulated to the legal representatives involved in this inquest.

331 No party sought to be heard regarding the appropriateness of making these two Recommendations. In particular, no submissions were received from the legal representatives for Forster Private Hospital.

332 The two recommendations proposed by counsel assisting are as follows:

Recommendation 1: That Forster Private Hospital give consideration to providing further training to all staff (including VMOs, CMOs/Locums and nursing staff) to ensure that the current policies and procedures are being adhered to with respect to documentation of patient's care.

Recommendation 2: That Forster Private Hospital give consideration to amending its policies and procedures to ensure that there is greater clarity in respect of the expectations of a VMO being contacted by a CMO/Locum or nursing staff and in what circumstances.

Conclusions

333 Mrs Mariani was entitled to the highest level of care and treatment when she was admitted for surgery at the Forster Private Hospital on 12 July 2019.

334 The injury occasioned to Mrs Mariani during surgery was not as a result of negligence on behalf of Dr Ghaly or the surgical team.

335 The resulting care and treatment Mrs Mariani received was significantly deficient in numerous ways.

336 The evidence is capable of establishing that if Mrs Mariani's symptoms, including her pain and discomfort, had been investigated at the request of her daughter on the morning of 13 July 2019, it is more likely than not that she could have been re-admitted to theatre for a corrective procedure.

337 Mrs Mariani's death was preventable.

338 The lack of professional review of the systemic issues by Forster Private Hospital are significantly concerning in terms of the health and safety of potential or future patients.

339 Mrs Mariani's family gave a compelling and eloquent family statement. Their distress and advocacy have been boundless.

340 It is clear that Mrs Mariani was greatly loved by both family and friends and that her death has caused much heartache.

Findings pursuant to section 81(1) of the Coroners Act 2009 (NSW)

341 As a result of having considered all of the documentary evidence, and the oral evidence given at the inquest, I make the following findings pursuant to section 81 (1) of the Act.

The identity of the deceased

342 The person who died was Mrs Margaret June Mariani.

Date of Death

343 Mrs Mariani died on 14 July 2019.

Place of Death

344 Mrs Mariani died at Manning Base Hospital, Taree NSW.

Cause of death

345 The cause of Mrs Mariani's death was due to complications of cholecystectomy surgery.

Manner of Death

346 The manner of Mrs Mariani's death was as a result of a steady deterioration in her physical presentation in circumstances where there would have been signs of peritonitis present earlier than 3.15pm on 13 July 2019 and where those signs were not recognised or escalated to the surgeon who performed the cholecystectomy surgery which impacted the provision of timely clinical care and treatment.

Recommendations

347 Pursuant to section 82 of the Act, Coroners may make recommendations connected with a death. I am of the view that the evidence supports that the recommendations outlined below are appropriate and are necessary or desirable to be made in relation to Mrs Mariani's death.

348 Accordingly, I make the following recommendations pursuant to section 82 of the Act:

1. That Forster Private Hospital give consideration to providing further training to all staff (including VMOs, CMOs/Locums and nursing staff) to ensure that the current policies and procedures are being adhered to with respect to documentation of patient's care.

2. That Forster Private Hospital give consideration to amending its policies and procedures to ensure that there is greater clarity in respect of the expectations of a VMO being contacted by a CMO/Locum or nursing staff and in what circumstances.

349 I have formed the view that there are important public health and safety matters that arise on the available evidence in this matter and in light of that view, a copy of these findings and the transcript of the evidence of the inquest should be provided to the NSW Ministry of Health and the NSW Minister for Health and Minister for Regional Health for consideration.

Referral

350 Pursuant to section 151A(2) of the Health Practitioner Regulation National Law (NSW) a copy of the transcript of the evidence from the Inquest is to be sent to the Health Care Complaints Commission and the Nursing and Midwifery Board of Australia along with a request that the management of Mrs Mariani by RN Martyn in July 2019 be examined.

Conclusion

351 I would like to acknowledge my gratitude to Mr Patrick Rooney of counsel and Ms Marnie Watts, Senior Solicitor; Ms Sophie Hawkins-Adams, Solicitor; and Ms Clara Potocki, Principal Solicitor for their significant assistance, commitment, support and preparation of this case.

352 Finally, I would like to again record my most sincere condolences to Mrs Mariani's family.

353 I now close this inquest.

Joan Baptie

Magistrate Joan Baptie

Deputy State Coroner

14 August 2025