CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kenneth Toll
Hearing dates:	23-27 September 2024 and 10 June 2026
Date of findings:	22 September 2026
Place of findings:	NSW Coroners Court - Albury
Findings of:	Judge Sally McLaughlin, Coroner
Catchwords:	Cause of death; pulmonary thromboembolism following bilateral knee replacement surgery; recognition of post-surgery symptoms; requirement for referral for specialist assessment.
File number:	2019/00226390
Representation:	Counsel Assisting the Inquest: Patrick Rooney of Counsel with James Herrington, Crown Solicitor's Office, instructed by Ms Penelope Smith and Ms Sarah Najjar, Crown Solicitor's Office The Toll Family: Ms J Hillier, instructed by Commins Hendriks Ramsay Health Care and Albury Wodonga Private Hospital: Ms R Mathur SC instructed by HWLE Lawyers Dr Elie Khoury: Mr S Barnes instructed by Unsworth Legal Dr Graham Libreri: Ms K Kumar instructed by Avant Law Dr Naylin Bissessor and Dr Jan du Plooy: Ms L McFee instructed by Makinson d'Apice
Findings:	Kenneth Toll died on 20 July 2019 at Albury Wodonga Private Hospital, Albury NSW 2640

The cause of Mr Toll's death was a pulmonary thromboembolism secondary to a deep vein thrombosis of the right calf following bilateral knee replacement surgery.

Mr Toll died in circumstances where following surgery he suffered from episodes of supraventricular tachycardia that required timely review and investigation by a cardiologist which did not occur.

Recommendations:

1 To the Executive Officer, Ramsay Health Care:

That Ramsay Health Care take all necessary steps including the need for further policy, to ensure that the medical records of patients at Albury Wodonga Private Hospital (AWPH) clearly identify when a patient has been referred to another clinician, by whom, for what purpose they were referred and for it to be clearly recorded in the medical records what the outcome of that consultation was.

2 To the Executive Officer of the Medical Council of New South Wales:

There are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about Dr Khoury, who is a person registered in a health profession, namely that Dr Khoury engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practice in a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of the evidence at inquest is to be provided to the Executive Officer of the Medical Council of New South Wales.

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REASONS FOR DECISION

Introduction

3 On 16 July 2019 Mr Kenneth Toll was admitted to Albury Wodonga Private Hospital for bilateral knee replacement surgery, which took place on 17 July 2019.

4 On 20 July 2019 Mr Toll was assisted to the bathroom by AIN Goodwin and a physiotherapist, and he sat on the commode chair to use the toilet and then was set up to shower himself while staff made his bed. He buzzed and when the nurse re-entered the bathroom he was found having slid from the commode, hitting his head on the toilet. After his collapse in the bathroom, CPR and other resuscitation efforts were immediately commenced by nursing staff.

5 Despite these efforts he could not be revived, and he was tragically pronounced deceased at 10.52am.

The role of the Coroner

6 Under the *Coroners Act 2009* (the Act) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely; the identity of the person who died, when and where they died, and what was the cause and manner of that person's death. In addition to these requirements the Coroner may make recommendations considered necessary or desirable in relation to any matter connected with the death which an inquest is concerned, including recommendations relating to public health and safety and that a matter be investigated or reviewed by a specified person or body.

7 Mr Toll's death was considered reportable because both the cause and manner of his death were not immediately clear.

8 The inquest received evidence in the form of statements and other documentation, which was tendered in court and admitted into evidence and

became Exhibit A. In addition, evidence was received from Dr Naylin Bissessor, Dr Graham Libreri, Dr Elie Khoury, Nurse Katherine Schubert, Nurse Teresa Hamer, Nurse Natasha Quinn, Nurse Karen Scalzo, Dr Jan Albert du Plooy, Nurse Katrina Sutton, Dr Heather Chaffey, Dr Ross Macpherson, Associate Professor Anthony Grabs, Associate Professor Mark Adams, Dr Myles Coolican and Dr Bernadette Eather. Mr Craig Ross, a friend of Mr Toll's family also provided a statement on behalf of the family.

9 All the evidence has been thoroughly considered and reviewed. I have been greatly assisted by, Mr Patrick Rooney, Counsel Assisting, Mr James Herrington and the Crown Solicitor's Office.

10 It is often recognised and appropriate to do so at the outset that the operation of the Act, and the coronial process, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. As a result of this process the usual private act of grief, which does not diminish significantly over time often compels loved ones to relive distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

11 It is recognised that for deaths that result in an inquest being held, the coronial process is often lengthy as it has regrettably been in Mr Toll's case. The impact that such a process has on family members who have unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

Mr Toll

12 Mr Toll was married to Wendy Toll for forty years. They had two children together, Lisa and Mark. Mr Toll was in the Australian Army for 20 years and posted to Bandiana in 1991.

13 Mr Toll left the Army in 1995 and began working for the Scots school in Albury and then at Don Sparks before working at Wodonga Council. Mr Toll was a

lawn mower operator at the Council. He had been in the Transport unit in the Army.

14 His family shared that Mr Toll would often joke and say that he was the kindest, sweetest, loving, generous, modest and most sincere person that God ever put breath into, and they believed he was right. That he would do anything to help others, especially if there was a beer involved, and always looked for the best in people. He was a loving and supporting husband, father, grandfather, brother, son and friend. His life and legacy will be one of serving his country and community.

15 Mr Toll developed knee issues whilst in the Army from working, driving trucks and other training exercises. He had complained about knee pain for a long time, and this had become even more of a problem later in life.

16 Mr Toll saw Dr Elie Khoury, an Orthopaedic Surgeon, in the past and had him perform arthroscopes to clean up the knee joints when he was in his 40s. Mr Toll was advised then that he would most likely be going to need knee replacements as he got older.

17 Mr Toll's sister, Judith Hawkins, also tells us about difficulties that Mr Toll was suffering with his knees. Mr Toll was active in his daily life and would make fire buckets and metal art as a side hobby. He was, however, always in pain whilst doing these activities.

18 Mr Toll's daughter, Lisa, mentioned that it had been his intention to have his knee surgery done as her mother and father had been planning a trip overseas and wanted it done before they went away.

19 Mr Toll was a much-loved member of the family, and his tragic and unexpected death was a shock to all.

Factual Background

20 Mr Toll's General Practitioner was Dr Douglas Colwell at the Wodonga West Medical Clinic.

21 Mr Toll's recorded medical history reveals that he had an extensive list of health issues, including type II diabetes, hypertension and obesity. He had undergone coronary artery angioplasty in February 2012.

22 At one point in time, Mr Toll was under the care of Cardiologist, Dr Naylin Bissessor, for left anterior descending artery disease.

23 There were several letters in the medical records from Dr Bissessor documenting his reviews of Mr Toll.

24 He was last seen by Dr Bissessor on 11 February 2019 (just under 6 months before Mr Toll's death), when he was noted to have a right bundle branch block pattern in sinus rhythm and was to be reviewed again in a year.

25 There is earlier evidence from correspondence dated 26 November 2018 articulating that Mr Toll has coronary artery disease with right bundle branch block, but that it was stable.

26 The records show that such information was forwarded to Mr Toll's General Practitioner, Dr Douglas Colwell, at Wodonga West Medical Centre.

27 The records also show that Mr Toll suffered from knee pain due to osteoarthritis for which he was referred to Dr Khoury. Dr Khoury first saw Mr Toll in 2006 when he arthroscoped his left knee.

28 The records contain a letter from Dr Khoury to Dr Colwell, dated 17 June 2019. In this letter, Dr Khoury reports that Mr Toll had "come to the point now where he is not walking very much, and it causes him a lot of pain and he is functionally incapacitated". This same day, Dr Khoury recalls discussing with Mr Toll the

possibility of having bilateral surgery as he was severely affected by arthritis in both of his knees.

29 He further noted that “Kenneth requires two knee replacements performed simultaneously. That will deal with his problems and have him mobilised and functionally normalised as soon as possible. We have discussed the benefits and risks, and I have also noted that he needs to have his blood sugars under control at the time of operation.”

30 Relevantly, Dr Khoury “*cc’s*” a copy of his letter to Dr Heinrich Schwalb who operated on Mr Toll’s perianal fistula three times and refers to Dr Schwalb’s procedures. There does not appear to be a reference by Dr Khoury to any of Mr Toll’s heart history, and no reference to Dr Bissessor.

31 I note that there are records of Dr Khoury which contain (amongst other things) correspondences between Dr Khoury and Mr Toll’s GP, a history of Mr Toll’s knee complaints, evidence of Dr Khoury’s conduct in respect of the subject surgery, and correspondences to Mr Toll’s wife and GP after his death.

32 Of significance, is the referral from Dr Colwell to Dr Khoury. The referral notes (amongst other things), a history of coronary artery angioplasty, hypertension, and a detailed history of Mr Toll’s medication which includes certain “heart medications”.

33 Strictly speaking, the expression “right bundle branch block pattern in sinus rhythm” is not identified, although aspects of Mr Toll’s detailed medical history are set out. For example, Betaloc [*metoprolol tartrate*] (amongst other medications) is identified in the correspondence. It is understood that Mr Toll was taking metoprolol for blood pressure prior to his surgery, rather than for any tachycardia.

34 Of further potential significance is the lack of identification in Dr Khoury’s records of any issues relating to, or exploring, or considering, the condition of Mr Toll’s heart. These may well be some of the “benefits and risks” discussed

between Dr Khoury and Mr Toll, but there appears to be no other reference to Mr Toll's heart condition throughout the currently available records.

35 There is evidence in the records of Dr Khoury that bloods were requested and collected on 19 July 2019. They demonstrate (amongst other things), mild anaemia.

Albury Wodonga Private Hospital
Pre-operative assessment

36 On 17 June 2019 (around a month prior to the surgery), Dr Khoury appears to have completed a Ramsay Health Care admission referral form regarding Mr Toll.

37 This noted that Mr Toll was to undergo a bilateral knee replacement with an expected hospital stay of four to seven nights. The estimated time of the operation was listed as 180 minutes and it was also noted that Mr Toll was a type II diabetic and taking oral anticoagulants or antiplatelet medication.

38 Mr Toll signed a consent form for the operation, also dated 17 June 2019. It would appear on the face of the consent form that Dr Khoury had formed a view that day that he would carry out a bilateral procedure for Mr Toll. He appears to have secured Mr Toll's consent for the bilateral procedure and booked an admission at the AWPH for Mr Toll for that procedure.

39 Mr Toll signed the "Patient Health History" section of the admission form, and it is dated 18 June 2019. On the form, Mr Toll's previous medical procedures are recorded (presumably by Mr Toll) as follows:

> "*Appendixes, 1962;*
> *Knee arthroscope (both), 2000;*
> *Hernia, 2015;*
> *Colonoscopy, 2016;*
> *Fistula, 2018.*"

40 On the same page in the form, the “Yes” box is ticked in response to the question, “Have any other doctors been consulted in relation to this admission, e.g. cardiologist physician?”. Those doctors are not identified, on the form.

41 The Patient Health History also records numerous medications being taken by Mr Toll as his regular medications.

42 Additionally, Mr Toll’s cardiovascular problems are listed as “elevated cholesterol, triglycerides” and “blood pressure problems”, with no further detail as to his medications for these, other than “tablets”.

43 Perhaps significantly, Metoprolol is a beta-blocker which can also be used to treat tachycardia. As noted above, Betaloc was identified in the referral letter from Dr Colwell to Dr Khoury.

44 Furthermore, in addition to Metoprolol (and Esomeprazole, presumably for GERD), Mr Toll identified that he was taking:

(1) Vytorin (for lowering cholesterol and triglycerides);

(2) Lipidil (for lowering cholesterol and triglycerides);

(3) Zanidip (a calcium channel blocker);

(4) Telmisartan (for lowering high blood pressure/hypertension).

45 A Pre-Surgical Anaesthetic Assessment appears to have been conducted on Mr Toll on 20 June 2019, with the Anaesthetist noted as “GL” (presumably Dr Graham Libreri). This is recorded on the form titled “Anaesthetic Record”. It lists Mr Toll’s weight as 105 kilograms and notes the following pre-operative instructions and medication, “Spinal plus GA, one art line plus HDU. Stop Aspirin 1/52”.

46 The pre-anaesthetic assessment section of the form itself contains extremely limited information. This has since been supplemented with further evidence. Otherwise, the form identifies “Naylin Bissessor – Angiogram – 4Y”.

47 An “Inpatient Pre-Admission Clinical Pathway” document, completed on 15 July 2019 by a nurse in preparation for his admission, records that Mr Toll’s Aspirin was “last taken 6/7” ago. In the comments section, there appears to be a reference to “ECG”.

Admission

48 Upon his admission to the AWPH at around 1700 on 16 July 2019, an “Admission Checks and Screening Tools – Adult Inpatient Admissions” form (ACST), was completed by RN Schubert. This included a section titled “Venous Thromboembolism (VTE) Risk Screen”, which assessed Mr Toll as “high risk” of VTE in light of the following risk factors; “Major surgery”, “Orthopaedic surgery” and “Age > 40 years (unless otherwise well, ambulant and no other risk factors)”.

49 The ACST recommended certain surgical and medical prophylaxis for patients identified as being at high risk of VTE:

> “*<u>Surgical</u>*
> *If no contraindication (e.g. bleeding), use low molecular weight heparin – Enoxaparin 40 milligrams daily (some patients may require a dose reduction)*
> *And*
> *Graduated compression stocking or intermittent pneumatic compression device*
> *<u>Medical</u>*
> *If no contraindication (e.g. bleeding), use low molecular weight heparin – Enoxaparin 40 milligrams daily (some patients may require a dose reduction)*

Unfractioned Heparin is preferred following myocardial infarct where full anticoagulation is not used

Or

If low molecular weight Heparin or unfractioned Heparin is contraindicated, use graduated compression stocking (contraindicated in stroke patient) or intermittent pneumatic compression device."

50 Mr Toll's diabetes was also identified as a "special risk" for VTE.

51 Mr Toll's "Admission Referral Form", which he had signed on 18 June 2019, appears to have been further reviewed upon his admission by RN Schubert on 16 July 2019.

52 Handwritten notes in the Patient Health History section record that Mr Toll had received advice from specialist rooms regarding ceasing Aspirin from 10 July 2019.

53 The progress notes upon his admission and prior to his surgery the next day suggest that an ECG was performed and reviewed by Dr Khoury, and that Mr Toll had settled on the ward and that his vital signs were normal.

Surgery

54 A "Surgical/Procedural Safety Checklist" was completed at 0830. "Yes" is ticked to the question whether thromboprophylaxis had been ordered, although whether this was chemical and/or mechanical is not specified.

55 An "Intra Operative Report" notes Mr Toll arrived in theatre at 0830, that anaesthesia commenced at 8.50 a.m., that the operation commenced at 0900. and that Mr Toll entered recovery at 1140.

56 The report does not make any reference to Mr Toll being provided TED stockings or sequential compression devices (SCDs). Both are mechanical forms of thromboprophylaxis.

57 The report also records that Mr Toll was administered 4,000 mg of tranexamic acid during the surgery.

58 A typed Operation Note detailing the surgery performed was completed by Dr Khoury, noting Mr Toll had undergone bilateral total knee replacement. There is also a typed Operation Record detailing the surgery in Dr Khoury's records.

59 The Operation Notes records no abnormalities concerning the conduct of the procedure. Brief contemporaneous handwritten entries were also made by Dr Khoury on an Operation Report. The handwritten notes are brief, with eleven letters making up the entirety of the notes under the heading "Detail of Operation" and are difficult to decipher.

60 The Anaesthetic Record for the operation prepared by Dr Libreri similarly illegible and requires deciphering.

61 Mr Toll appears to have been taken to the recovery ward at 1140. He was discharged to the High Dependency Unit (HDU) at 1307.

Post-surgical care and review

Day One, 17 July 2019

62 At 1340, Mr Toll was reviewed by nursing staff. He made no complaints of pain and had a blood sugar level SL of 6.1 mmol.

63 A coagulation pathology report was generated at 1620 which revealed "APTT: 23, INR: <0.9: fibrinogen: 1.4 and TCT 15".

64 The result of the fibrinogen (1.4) is slightly lower than 'normal'. The result of APTT (Activated Partial Thromboplastin) is even further below the reference range and it is understood that this is an abnormal reading.

65 A full blood examination was also conducted which was reported as normal.

66 At 1500, Mr Toll was administered 6 grams of Cephazolin (an antibiotic), followed by 40 milligrams of Clexane (an anticoagulant) at 2000 and regular Panadol.

67 At 2150, Mr Toll was reviewed by RN Hamer, who recorded that his observations were stable, but that he had vomited twice. Reference is also made to there being no concerns at the time of RN Hamer's review.

68 RN Hamer subsequently noted, at 2200, that oral analgesia had been withheld due to Mr Toll's vomiting. An antiemetic was administered.

Day Two, 18 July 2019

69 At 0730, Mr Toll was attended to by nursing staff and his observations were recorded as "stable". Mr Toll was also reviewed by Dr Khoury, in the course of the morning.

70 RN Scalzo then made a progress note at 0930 to the effect that Mr Toll's heart rate was irregular. In that note, reference is also made that "Dr Khoury will refer Pt to Dr du Plooy for R/V". Dr Jan du Plooy is a Cardiologist who practiced in Albury at the relevant time.

71 The note also identifies that Mr Toll appears to have suffered an episode of supra ventricular tachycardia, for which he was given a beta-blocker (Metoprolol) to lower his heart rate.

72 An important issue explored in this Inquest was the extent to which Mr Toll was investigated in respect of this tachycardia generally, by whom (and with what specialty), when this occurred and what the outcome of any assessment was.

73 It also appears from the evidence that Dr Libreri, Mr Toll's Anaesthetist, was also contacted in relation to his post-operative medication.

74 Mr Toll was reviewed by physiotherapy at 1000, where it is recorded "SVT this a.m. HR (Heart Rate) 170 to 184, now 93". The Physiotherapist further noted

that Mr Toll was “not for getting up as per nurse (secondary) to (supra ventricular tachycardia)”.

75 At 1050 hours, Mr Toll complained to RN Scalzo of rib pain, and oral Panadol/Nurofen/Palexia was administered.

76 At or about this point in time, Mr Toll’s circulation to both legs was noted to be normal, his heart rate was noted to be “90 -95”, with a blood pressure of 148/80 and Telmisartan was given as charted.

77 At 1550, Mr Toll was administered 2.5 milligrams of Metoprolol (the beta-blocker) intravenously “for HR > than 90”.

78 At 2145, nursing staff reported that Mr Toll had, again, had an episode of tachycardia and that his heart rate had risen to 125 bpm. 2.5 milligrams of Metoprolol (the beta-blocker) was again given intravenously and it was noted that this was administered with “good effect”.

Day Three, 19 July 2019

79 At 0215 hours, Dr Chaffey was contacted by nursing staff regarding a further occurrence of Mr Toll’s elevated heart rate. A corresponding progress note indicated that Dr Chaffey was phoned regarding Mr Toll’s SVT rate of 160-170 bpm @ 0154am lasting 2 minutes. Reference in the note is also made to his heart rate later becoming 90 beats per minute. Importantly, reference is also made that the “pt needs cardiology review”.

80 Mr Toll was, again, reviewed by nursing staff and a progress note was recorded at 0530 which indicated that there had been no further episodes of SVT and that Mr Toll’s SR rate was 80-90 bpm.

81 A 50 mg dose of Palexim was administered at 0600 and at 2200. Mr Toll was attended to by physiotherapy shortly after his first dose and his heart rate was recorded as 93.

82 Mr Toll appears to have stood up during the physiotherapy session for the first time since his operation.

83 A subsequent nursing note at 1130 indicates that Dr Khoury had been made aware of Mr Toll's two "more" episodes of SVT and that Dr Du Plooy, Cardiologist, had "reviewed ECG", and directed no further action.

84 It was noted that there could be possible follow-up at a later date for "? ablation (a surgical procedure to block abnormal signals in the heart), Happy for T/F to ward today".

85 Mr Toll was transferred to a ward at 1145.

86 A retrospective note reported that his dressings were intact with some "ooze to the right drain site, ice pack in situ. Analgesia given as charted with good effect. Vital signs stable as charted. RIB nil concerns voiced ATOR".

87 At 1400, 1600 and 2000, Mr Toll's observations were stable as charted. Mr Toll received a 50mg dose of Clexane at 2000, and a 50 grams dose of Palexim at 2200.

Day Four, 20 July 2019

88 Mr Toll is recorded as having slept well, but to have woken at 0430 complaining of being cold. The nursing note indicates that his left knee was swollen and that a "large amount of ooze" was flowing. Mr Toll was given his usual medications and an analgesic.

89 A physiotherapy note (incorrectly dated 19 July 2019 at 0948) appears after that entry. The note suggests that Mr Toll's observations were "stable as charted".

Mr Toll's Arrest

90 There are entries in the progress notes of a retrospective nature concerning Mr Toll's sudden arrest.

91 An entry by AIN Goodwin suggests that Mr Toll was walked to the bathroom by the Physiotherapist and AIN Goodwin, where he sat on the commode chair to use the toilet and then was set up to shower himself while staff made his bed.

92 He is recorded to have buzzed when the shower was completed, whereupon he was found by AIN Goodwin to have slid from the commode, hitting his head on the toilet.

93 After Mr Toll collapsed in the bathroom, CPR and other resuscitation efforts were immediately commenced by nursing staff.

94 During the resuscitation attempts, Mr Toll was administered 4mgs of IV adrenaline over the course of approximately 30 minutes.

95 Dr Chaffey also reported the sequence of events in a retrospective clinical progress note that included details of all steps carried out to attempt to revive Mr Toll. A reference is also made that says: "… Old ECG's not SVT".

96 A detailed account of the resuscitation efforts is also recorded in a clinical progress note of RN Clayard.

97 Mr Toll was pronounced deceased at 1052.

98 Dr Khoury made a note on 20 July, "called at 10.34…Pt. arrested – witnessed, CPR started immediately. Pt died. No rhythm established despite Adrenalin, CPR, Interbation, Cardiac shock. Pt. relatives notified, Coroners Case." This is the only progress note recorded by Dr Khoury post-surgery.

99 Members of Mr Toll's family arrived at the AWPH shortly thereafter.

The post-mortem examination

100 A Post-Mortem examination was conducted on 29 July 2019 by Dr Melissa Thompson (Pathology Registrar).

101 An Autopsy Report was prepared by Dr Thompson and Dr Rebecca Irvine (Senior Staff Specialist Forensic Pathologist) on 7 May 2020.

102 The autopsy findings included the discovery of a large, coiled saddle thromboembolus which was identified within the pulmonary arteries. The embolus extended into the parenchymal vessels in both lungs, most prominently on the right side. No macroscopic evidence of organisation of the thrombus was identified. Opening of the vessels of the right calf revealed a thrombus in situ.

103 The conclusion of the clinicians who prepared the Autopsy Report identified that Mr Toll's direct cause of death was from a pulmonary thromboembolism. A deep vein thrombosis of the right calf is listed as an antecedent cause.

104 Dr Lorraine du Toit-Prinsloo, Forensic Pathologist (Senior Staff Specialist) provided a report dated 14 September 2024 in which she specifically addressed the questions of whether fat emboli or fat embolism syndrome was a contributing factor to Mr Toll's death. Dr du Toit-Prinsloo agreed with the findings of Dr Thompson and was of the opinion that fat embolism or fat embolism syndrome did not contribute to the cause of death.

Issues considered during the inquest

105 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) Determination of the statutory findings required under s 81 of the *Coroners Act 2009*, including manner and cause of death.

(2) Was Mr Toll's pre-operative care reasonable and appropriate, including having regard to;

(a) The assessment undertaken by Dr Khoury and Dr Libreri of Mr Toll's suitability for surgery

(b) Pre-admission communication between Mr Toll's treating doctors, including whether assessment by Dr Bissessor was requested;

(c) Pre-operative care provided to Mr Toll at AWPH;

(d) Assessment of Mr Toll's risk of venous thromboembolism (VTE).

(3) Was the performance of Mr Toll's surgery by Dr Khoury and Dr Libreri reasonable and appropriate?

(4) Was Mr Toll's post-operative care reasonable and appropriate, including having regard to;

(a) Post-operative measures implemented to counter any risk of VTE;

(b) The diagnosis of and response to Mr Toll's episodes of heart arrhythmia;

(c) Whether a referral of Mr Toll for review by Dr du Plooy was made and whether this review occurred.

(5) Whether any recommendations should be made pursuant to s 82 of the *Coroners Act 2009*.

106 To assist with consideration of some of the above issues, opinions were sought from the following independent experts as part of the coronial investigation;

(a) Dr Myles Coolican, Orthopaedic Surgeon. Bachelor of Medicine, Bachelor Surgery from the University of New South Wales. Fellow of the Australian Orthopaedic Association and a fellow of the Royal Australasian College of Surgeons. Knee Surgeon and President of the Australian Knee Society and the immediate past chair of the ISAKOS knee Arthroplasty Committee.

(b) Dr Ross Macpherson, Anaesthetist. Consultant Emeritus at the Department of Anaesthesia and pain management, Royal North Shore Hospital in Sydney. Clinical Professor of Anaesthetics at the University of Sydney. 30-year career in clinical anaesthesia, pain management. Previously head of preadmission clinic at Royal North Shore Hospital. Diploma of Perioperative medicine awarded by the Australia and New Zealand College of Anaesthetists. With a speciality including clinical anaesthesia, including orthopaedics, emergency anaesthesia, pain management and pain assessment.

(c) Associate Professor Anthony Grabs, Vascular Surgeon. Director of surgery at St Vincent's Public Hospital for 13 years, with particular speciality in DVT and PE.

(d) Associate Professor Mark Adams, Cardiologist. Medical degree with first class honour and a PhD in cardiology, having trained at Royal Prince Alfred Hospital and at Harvard University. Currently head of Cardiology Department at Royal Prince Alfred Hospital.

107 Each of the experts provided one or more reports, which were included in the brief of evidence tendered at Inquest. Each expert also gave evidence during the Inquest.

Issue One Manner and Cause of death

108 The unequivocal, unanimous and compelling evidence establishes that the cause of death was a massive pulmonary thromboembolism.

109 The autopsy report of Dr Melissa Thompson and Dr Rebecca Irvine provided conclusive findings as to this being the cause of death, and their findings were confirmed by Dr du Toit-Prinsloo. Dr du Toit-Prinsloo opined that fat embolism syndrome did not contribute to Mr Toll's death.

110 Notwithstanding the certainly of these expert's findings the evidence at Inquest explored fat embolism syndrome with the experts engaged.

111 Associate Professor Adams was unable to comment on fat embolism syndrome but opined that Mr Toll's death was the result of a catastrophic pulmonary embolism leading to cardiac arrest on 20 July 2019, preceded by the development of multiple smaller pulmonary emboli during Mr Toll's earlier episodes of SVT, with the emboli arising from the development of the deep veinous thrombosis.

112 Associate Professor Grabs considered that Mr Toll's death was not related to fat embolism syndrome. He explained that fat embolism syndrome was not a common issue, but that orthopaedic surgeons recognised it as a "rare complication, that's known basically from the time of surgery and that it is most often noticed by anaesthetists during surgery when there is an occurrence of unexplained tachycardia and hypoxemia, especially if the marrow has been instrumented, or noticed by recovery nursing staff immediately in the postoperative period." In cross examination he agreed that symptoms of fat embolism may occur between a period of 24-48 hours after surgery and that they "frequently occur at the time of surgery". He was definitive in his opinion that "Mr Toll's intra operative course and immediate post-operative course did not demonstrate features of fat embolism syndrome. He was considered stable following the left knee replacement and the right side was undertaken. His observations and clinical course following surgery were fairly standard".

113 He opined that Mr Toll's cause of death was the development of a catastrophic pulmonary embolism, rather than the development of multiple small emboli, given that no small emboli were found during the autopsy. Putting aside the

autopsy findings he agreed it was possible the multiple episodes of SVT may have reflected the formation of small emboli.

114 Dr Coolican's evidence was that fat embolism syndrome did not have anything to do with Mr Toll's death. His evidence was that the major damage caused by fat embolism syndrome will be "obvious fairly quickly and certainly within minutes of the torniquet being released during surgery".

115 It is submitted on behalf of the family that Dr Coolican's opinion on fat embolism syndrome was based upon the fact that he had not seen it occur in the context of joint replacement, however that is factually incorrect. Dr Coolican was specifically asked to provide an opinion based on the intramedullary cannulation of two long bones. He outlined, "Fat embolism has been described with intramedullary cannulation of long bones for the treatment of fractures and there would have been a small chance of Mr Toll suffering fat embolism if four long bones were cannulated." He clearly considered that it was a small risk for Mr Toll. Then described that while he had not personally seen a case of it in bilateral knee replacement, he accepted it has been described.

116 He further explained that if bilateral knee replacements are carried out with intramedullary rodding of the bones, the more bones that are subject to intramedullary rodding the greater the chance of the fat embolism, but this was extremely rare and not the cause of Mr Toll's demise. Dr Coolican explained that given the fat droplets that have the potential to cause fat embolism syndrome would disperse through the lung fields immediately after release of the tourniquet, these features would be evident soon after surgery. That this would have been clear to Dr Khoury within hours of surgery and there were no clinical features to suggest fat embolism syndrome.

117 Professor MacPherson declined to give evidence about fat embolism syndrome, other than to say that its occurrence under anaesthesia during surgery is rare and that when it does occur hypotension and hypoxemia might be expected and that Mr Toll's anaesthetic record demonstrated none of these symptoms.

118 In light of the unequivocal evidence as to the cause of death and the exclusion of fat embolism syndrome as contributing to Mr Toll's death, the evidence that another of Dr Khoury's patients had a cause of death believed to be fat embolism syndrome is irrelevant in this Inquest.

Issue Two Pre-Operative Care

Was Mr Toll's Pre-operative care reasonable and appropriate?

Issue 2(a)

119 The first issue explored in relation to Mr Toll's pre-operative care was in relation to the assessments undertaken by Dr Khoury and Dr Libreri as to his suitability for surgery and whether he was a suitable candidate for bilateral knee replacement surgery.

120 Experts considered a range of factors including Mr Toll's cardiac history and general health prior to consideration of the appropriateness of Mr Toll undergoing the surgery.

121 Dr Coolican, Associate Professor Grabs, Professor Adams and Professor MacPherson all opined that Mr Toll was an appropriate candidate for bilateral total knee replacement.

122 Dr Coolican asserted that: "Mr Toll was overweight with a BMI of 34, Type II diabetes and some minor cardiac issues but with no significant coronary artery disease as shown at his post-mortem examination. It is unlikely that any of these factors had any influence on his demise." In oral evidence Dr Coolican stated that Mr Toll was 'an appropriate candidate' (for surgery) with what he considered to be minor cardiac issues and risk factors including his weight and type 2 diabetes.

123 With respect to risk factors, Associate Professor Grabs considered the following to be of significance:

“Mr Toll's only modifiable risk factor was his weight and the choice between single arthroplasty and double arthroplasty. The increased length of time on the operating table is a recognised risk however it is not a major contraindication given Mr Toll had no past history of deep venous thrombosis or pulmonary embolism. Although I cannot comment specifically on the necessity of the bilateral knee arthroplasty in Mr Toll’s case, bilateral arthroplasty has an acceptable risk profile to be considered an appropriate choice in some patients.”

124 With respect to co-morbidities, in his supplementary report, Professor MacPherson said:

“*Mr Toll had no significant co-morbidities. No respiratory history and what amounted to a clean bill of cardiac health from his cardiologist. All pre-operative tests were normal. Therefore, I did and still would consider him a very suitable candidate for the proposed surgery.”*

125 With respect to Mr Toll’s cardiac history, Associate Professor Adams said:

“Mr Toll had either insignificant coronary artery disease, myocardial bridging, or coronary artery disease treated percutaneously in the past and now very stable. This would place Mr Toll as having intermediate clinical predictors of adverse events based solely on his diabetes but with good functional capacity. In addition, the type of surgery that Mr Toll was undergoing would be considered intermediate risk rather than high−risk according to current guidelines. The combination of surgical risk and patient risk in this case suggests a low risk of adverse cardiac events and that no further work up is required prior to surgery, based on the guidelines current in 2019 (ACC/AHA guidelines update for perioperative cardiovascular evaluation for noncardiac surgery −executive summary, Circulation 2002, attachment 3)”.

Issue 2(b)

Pre-Admission Communications between treating doctors and whether assessment by Dr Bissessor was requested?

126 The evidence establishes that Mr Toll was not seen by a cardiologist prior to the bilateral knee surgery. Relevantly, Professor MacPherson did not consider that a pre-operative cardiac consult was required because, "…. Considering the results of Ken Toll's previous assessment in November of the preceding year, there would be no indication for any further assessment" and that "Critically, Dr Libreri had access to the review undertaken by the cardiologist only six months prior. This review was comprehensive and demonstrated good LV (left ventricular) function and, importantly, an echocardiogram performed after stress testing showed no ventricular wall abnormalities. In summary, Mr Toll had very good function which would not have an impact on surgery or anaesthesia."

127 In respect of the knowledge obtained by the Anaesthetist, Dr Libreri alone, Professor MacPherson said that:

"*Whether Dr Libreri was satisfied with the information provided by the cardiologist is entirely up to him. If Mr Toll came to me in a large public hospital preadmission clinic, I would be more than satisfied with the current set of results, namely a recent cardiology review which determined no significant cardiac disease, and, most important a recent exercise stress test and a stress ECHO test which is the gold standard of cardiac assessment…Our general guidelines are that these sorts of tests need be repeated only if either the results were abnormal, or the patient health had changed significantly. None of these were applicable to Mr Toll".*

128 Associate Professor Adams agreed with the views of Professor MacPherson.

129 Dr Coolican considered that Mr Toll should have been seen by a cardiologist pre-operatively and that Dr Khoury's failure to consult with Dr Bissessor prior to surgery was inadequate care. He said:

"The appropriate perioperative assessment of a patient undergoing bilateral knee replacement varies and depends upon the patient's general health and medications…. It is usual in the setting where the patient is under the care of a physician to involve that physician in the decision as to whether the patient is fit and whether any special precautions are required. This would likely include advice on temporary cessation of medication such as antiplatelet and anticoagulation medication."

130 In his supplementary opinion, Dr Coolican said:

"*It is clear from the referral dated 27th May 2019 that Mr Toll had undergone a prior coronary angioplasty and this information was available to Dr Khoury. It is my opinion that Dr Khoury should have arranged a cardiac review for Mr Toll prior to the surgery. It is likely that if a cardiologist was regularly reviewing Mr Toll after the surgery, the diagnosis of a pulmonary embolism associated with tachycardia and low oxygen saturations would have been made rather than a misdiagnosis of supraventricular tachycardia followed by Mr Toll's demise*"

131 Ultimately, Dr Coolican maintained that whilst a referral by either Dr Khoury or Dr Libreri ought to have been made for Mr Toll to see Dr Bissessor pre-operatively, it was still reasonable for Dr Khoury to proceed with Mr Toll's operation.

Finding

132 Mr Toll was an appropriate candidate for the bilateral total knee replacement surgery.

133 Dr Bissessor's documentation, which was five months old at the time of assessment provided a clear picture of potential cardiac risks and was sufficient for Dr Libreri to conclude that no cardiac factors precluded Mr Toll from undergoing non-cardiac surgery.

134 Accordingly, I am satisfied that Mr Toll's pre-operative care was reasonable and appropriate, despite the absence of a renewed pre-surgery consultation with Dr Bissessor.

ISSUE 2(c)

Pre-operative Care at the AWPH

135 The expert evidence considered the pre-operative care provided by Dr Khoury and whether that care was reasonable and appropriate.

Discussions with Mr Toll

136 In evidence at Inquest, Dr Khoury had no express recollection of what he discussed with Mr Toll. He gave extensive evidence of his 'usual practice'. He did not specifically recall any response from Mr Toll only that he was very keen to proceed with the surgery, even though all the risks of surgery had been discussed.

137 Dr Coolican was critical of the lack of detail provided in Dr Khoury's correspondence on 17 June 2019 to his treating doctor stating that it "…makes no mention of Mr Toll's general health or medications and how these issues factored into the decision to offer bilateral knee replacements." His evidence was that it is "standard practice to enquire about and outline in the correspondence health issues that are relevant to the patient's ability to tolerate the procedure and accordingly it is unlikely that Dr Khoury discussed Mr Toll's general health issues with him. If this is the case, I regard Dr Khoury's assessment of Mr Toll as incomplete."

Consent

138 With respect to consent, Dr Coolican noted the following:

"*Whilst Dr Khoury's statement indicates that he reluctantly agreed to perform bilateral knee replacements, there is a consent form signed by the patient and*

there is no mention of any reluctance to perform BTKR in the contemporaneous correspondence." (emphasis added)

139 In supplementary evidence, Dr Coolican said:

"*Mr Toll and Dr Khoury signed a consent form on 17/6/2019 for BTKR. Dr Khoury's correspondence says, "Kenneth requires two knee replacements performed simultaneously." I do not agree that Dr Khoury expressed any reluctance to perform BTKY. "if Dr Khoury had reluctance to perform the surgery, he would not have consented the patient for BTKR".* (emphasis added)

140 Dr Coolican was critical of the lack of written record of the consent process taken by Dr Khoury stating, "It is not possible for me to comment on the consent process that occurred when Mr Toll saw Dr Khoury on 17 June 2019. There is no written record in the correspondence that Dr Khoury discussed the risks and benefits of the surgery as well as the usual outcome, but this may have been done verbally and not documented".

141 As articulated above, Dr Khoury gave evidence as to his "usual practice" rather than any specific memory of discussions with Mr Toll.

142 Associate Professor Grabs said the following:

"Based on the brief provided, two independent practitioners with experience in this area, have discussed the options with Mr Toll of a single knee replacement or a bilateral knee replacement. This is in full knowledge of his previous medical conditions with no single factor, precluding a bilateral operation. In my opinion, an adequate consent has been obtained and supported by Mr Toll."

143 Professor MacPherson had strong regard to the statement evidence of Dr Libreri. He said:

"*According to the statement made by Dr Libreri, it appears that he met with the patient personally prior to the day of surgery and had a comprehensive discussion about the proposed anaesthetic and surgery. Mr Toll understood*

these risks and was happy to proceed. Surgical risks would have been appropriately discussed with the surgeon."

144 During his evidence before the Inquest Dr Khoury was asked about the surgical process and it was suggested that the process commenced about a month before the surgery, he explained that:

"*well, the process of the surgery, but the process of patient preparation takes a long time. So in other words, we don't come to a day when somebody sees me and then that decision is made immediately. That decision is made with a lot of consideration, and it takes me a lot of time to think about it and to think about the patient in context. So when Mr Toll presented in 2018, we had another rethink after more that 12 years of treatment. And a result of that rethink was well it's probably all getting close but not quite" and "that on 17 June he presented with the problem of, as previously described functional disability, significant pain, difficult mobilisation. And therefore, we discussed the possibility of bilateral knee replacement, as Mr Toll was very keen to have both knees replaced.*"

145 The objective evidence contained within the consent forms, signed by Dr Khoury does not support a finding that he had any reluctance to perform the surgery and his evidence that the decision was arrived at "after a lot of consideration and a lot of time" is inconsistent with him having any reluctance.

Finding

146 Dr Khoury agreed to perform Mr Toll's bilateral knee replacement surgery. As the surgeon he was responsible for deciding what surgery should be performed.

Reliance by Dr Khoury on Dr Libreri

147 Dr Khoury's evidence of 26 September 2022 made clear that he relied on Dr Libreri to ascertain the patient's suitability to undergo surgery and that he relied on Dr Libreri telling him that Mr Toll could tolerate a bilateral knee replacement.

148 The expert's opined in varying ways on this issue, with general agreement that a surgeon has to rely on another expert about a patient's fitness for surgery. Professor MacPherson set out that the usual practice would be for the surgeon to propose what the surgery would be and the anaesthetist would then assess the patient based on the proposed surgery.

149 Associate Professor Adams' evidence was that

"*Mr Toll was seen by Dr Khoury on 17June 2019 and was scheduled for a double total knee replacement. In his letter he mentions the need to have tight blood sugar level control perioperatively and the ischiorectal fistula but does not comment on Mr Toll's cardiac history. I don't think this is unusual as it would be common for many non-cardio surgeons to leave this operative risk assessment to the anaesthetist doing the case."*

Finding

150 The expert evidence establishes that Mr Toll's pre-operative care provided at AWPH was reasonable and appropriate.

Issue 2 (d)
Assessment of Venous Thromboembolism (VTE)

151 As noted in the background facts, upon Mr Toll's admission to the AWPH at around 1700 on 16 July 2019, an ACST ("Admission Checks and Screening Tools – Adult Inpatient Admissions") form was completed by RN Schubert.

152 This document included a section titled "Venous Thromboembolism (VTE) Risk Screen", which assessed Mr Toll as "high risk" of VTE considering the following risk factors; "Major surgery", "Orthopaedic surgery" and "Age > 40 years (unless otherwise well, ambulant and no other risk factors)".

153 The evidence at Inquest explored the significance of VTE risks given the fact that Mr Toll was undergoing bilateral knee replacement surgery rather than a single knee replacement.

154 The experts unanimously agree that all joint replacements have a risk of deep venous thrombosis and pulmonary embolism and that bilateral knee replacement was a higher risk compared to a unilateral knee replacement. Associate Professor Grabs explained that:

"…All surgical procedures result in tissue damage, with subsequently local and systemic inflammatory factors being activated. The duration of surgery as well as the systemic inflammatory response due to the surgical trauma is increased in bilateral procedures. Any surgery lasting greater than 2 hours is considered a major risk factor in the development of the VTE."

155 Dr Coolican's evidence considered that the decision to perform bilateral knee replacement did mean that Mr Toll was more likely to suffer a pulmonary embolus than if one knee had been replaced and that this should have meant a higher vigilance for the features of a pulmonary embolism. He did not suggest that the decision to perform the bilateral surgery given this higher risk was inappropriate but that higher vigilance for its occurrence was required.

156 Dr Khoury agreed during that Mr Toll was high risk for VTE and one of the consequences of surgery he was trying to mitigate was VTE. He accepted that the risk was increased because two operations were being performed and tourniquets were being used.

Findings

157 Mr Toll was a high risk for VTE.

158 Dr Khoury and nursing staff were aware of the high risk finding recorded on the VTE Risk Screen.

159 Mr Toll's pre-operative care was reasonable and appropriate given that AWPH staff had regard to his high risk of VTE.

THE SURGERY

Issue Three

Was the performance of Mr Toll's surgery by Dr Khoury and Dr Libreri reasonable and appropriate?

160 A number of issues were considered by the expert evidence in relation to the performance of Mr Toll's surgery including the use of a tourniquet, of re-infusion drains, and tranexamic acid as well as the surgical technique.

Use of tourniquet

161 Dr Coolican and Associate Professor Grabs both agreed that the use was acceptable with Dr Coolican explaining that:

"*When a tourniquet is not utilized, overall blood loss is less. It is more ideal to perform the surgery without a tourniquet and to use navigation avoiding the use of an intramedullary jig which diminishes blood loss and diminishes debris entering the venous circulation at release of the tourniquet".* And further that, "*Whilst morbidity and mortality is less in the absence of use of a tourniquet and the absence of intramedullary alignment jugs, it was in my opinion still reasonable for Dr Khoury to perform bilateral simultaneous knee replacements with the use of tourniquets."*

Use of re-infusion drains

162 Dr Coolican indicated that he had "no criticism of the use of re-infusion drains in a setting where a tourniquet is used" and Associate Professor Grabs provided the following opinion "There is no evidence available to suggest blood reinfusion from the drains would increase the risk of deep venous thrombosis or pulmonary embolism."

Use of tranexamic acid

163 Associate Professor Grabs indicated the following:

> *"It appears tranexamic acid was administered at the time of surgery. The dose of four thousand milligrams (4 grams) probably was as a periarticular injection with 2 g being delivered to each knee arthroplasty. This was not adequately described in the brief provided. The use of tranexamic acid during knee arthroplasty is an acceptable practice in the surgery provided there are no contraindications. In Mr Toll's case there were no obvious contraindications."*

164 Dr Coolican did not consider that the use of topical tranexamic acid had any influence on Mr Toll's demise.

Surgical technique

165 Dr Coolican's evidence is most relevant to the consideration of the technique used by Dr Khoury. He clearly stated that he had no criticism of the surgical technique and no issue with the use of the intramedullary alignment jigs and rods.

166 Dr Coolican was resolute in his evidence that fat embolism or fat embolism syndrome did not have anything to do with Mr Toll's death and that the surgical technique was not relevant to the cause of Mr Toll's death.

167 In answering questions about the risk of fat embolism for bilateral knee surgery and the cannulation of four long bones specifically, Dr Coolican described the use of rods as "the old-fashioned way". When he gave this evidence, he was describing how reference points are required when the bones are cut. He did not opine that he had any criticism of this "old-fashioned way".

168 There was no criticism of the performance of Dr Libreri at surgery.

Finding

169 The performance of Mr Toll's surgery by Dr Khoury and Dr Libreri was reasonable and appropriate.

POST-OPERATIVE CARE

Issue Four

Was Mr Toll's post-operative care reasonable and appropriate?

Issue 4(a)

Post-operative measures implemented to counter any risk of VTE?

170 The VTE Prevention and Prophylaxis policy which was in force at AWPH in July 2019 required patients identified as a risk of developing a VTE should receive appropriate mechanical and/or pharmacological prophylaxis. In addition to the hospital policy Dr Khoury had a "Bilateral Total Knee Replacement Mr Khoury – Clinical Pathway".

171 Dr Khoury's evidence was that there was a prophylaxis plan for Mr Toll because he was high risk of VTE. He explained that the Clinical Pathway document outlines what has been pre-ordered for a patient and there is a clear pathway to be followed for each of his patients, which is followed by nursing staff without any need for further order from him.

172 Dr Coolican indicated that patients undergoing recovery from knee replacement will usually have a sequential compression device applied to the non-operated limb during surgery and for bilateral knee replacements, sequential compression devices are applied in the recovery room. Compression dressings around the lower calf usually mean that TED stockings are not applied until the dressings are removed typically on the first post operative morning. Injectable DVT prophylaxis should commence either on the evening of the day of surgery or the following morning.

173 He considered Dr Khoury's surgical pathway to be reasonable and observed that it was important that the surgeon reviews the patient during the

postoperative period and confirms that the intended pathway is being followed by the ward staff and making satisfactory progress and that transfer of all responsibility for the delivery of postoperative care without checking is an inappropriate abrogation of responsibility.

174 He observed that given Mr Toll stood on 18 and 19 July but otherwise remained in bed or seated for meals, given this low rate of mobility, the use of TED stockings and sequential compression devices were important to minimise the chance of deep venous thrombosis and pulmonary embolus.

175 Associate Professor Grabs agreed that the recommendations for prevention of DVT and pulmonary embolism included the use of both pneumatic calf compression and TED stockings, however in the case of a total knee replacement he opined TED stockings can cause issues and was not critical of the absence of TED stockings in Mr Toll's care.

Ted Stockings or sequential compression devices

176 Dr Libreri's evidence was that it would have been impossible to put TED stocking on Mr Toll because of the bandages on his legs.

177 Dr Khoury, Dr Libreri and the nursing staff did not have a specific memory of observing Mr Toll wearing AV impulse boots on 17,18, 19 or 20 July.

178 The physiotherapist and nursing notes do not mention Mr Toll having TED stockings or sequential compression devises at any stage during his admission. Further the DVT prophylaxis had not been filled out, with no documentation as to whether there were mechanical prophylaxis measures for Mr Toll.

179 The only contemporaneous evidence in relation to these measures are contained in the Clinical Pathway document. Nurses Hamer and Scalzo in their evidence confirmed that the signatures alongside entries in this document meant the measures had been taken or were in place.

180 The difficulty is that it is not clear exactly what those signatures are recording, noting either an absence of signatures or their placement in the column. They are as follows;

(1) 17 July, there is no signature next to AV impulse boot for both feet of knee replacement.

(2) 18 July AM entry there is a signature next to both stand with physio and AV impulse boot to both feet.

(3) 18 July PM and N there is one signature in each column.

(4) 19 July in AM there are no signatures.

(5) 19 July PM there are three signatures in line with Mobilise with Physio, Shower FWB and SOOB meals, there is no signature directly against AV impulse boot to both feet,

(6) 19 July N column there are two signatures in line with mobilise with physio and between shower, FWB and SOOB meals.

(7) 20 July in the AM entry there are three signatures against the action for ambulant as per physio instructions, SOOB meals and **may remove AV impulse boot.** (emphasis added)

181 There is no contemporaneous documentation by Dr Khoury that indicates he checked that his clinical pathway was being followed. In evidence Dr Khoury stated that it was not his practice to look for the AV impulse boots during his rounds. That the patients' legs are under a blanket and he does not see them. At times he might ask a nurse "are there compression?"

182 Given the signatures in the clinical pathway document and the evidence of nurses Hamer and Scalzo, Mr Toll may have been wearing AV impulse boots at the times they were directly signed as in place in the pathway. Particularly noting there is a discrete entry that they were removed on the morning of

20 July. However, the brevity of the documentation in relation to their application, particularly in relation to when they were applied is unsatisfactory.

Clexane

183 Another aspect of the prophylaxis plan for Mr Toll was the use of Clexane. Associate Professor Grabs indicated that the recognised dose of Clexane for prophylactic use as recommended by the NH and MRC guidelines would be 40mg daily and that given that one of the major complications of knee arthroplasty is blood loss at the time and in the post-operative period, it would have been reasonable to prescribe a dose of 40mg in the immediate post-operative course.

184 This was the dose prescribed for Mr Toll in Dr Khoury's clinical pathway, and it is accepted that the medical chart records it as being administered on 17,18 and 19 July.

Mobilisation

185 Mr Toll was unable to mobilise until his spinal block wore off, which in accordance with the evidence of Dr Khoury and Nurse Hamer was not on 17 July. The clinical pathway documentation by Nurse Scalzo was that Mr Toll had stood with physio on the morning of 18 July and the nursing note recorded that he was not for getting up as per nurse SVT but it was recorded "Rx 1. Bed ex's – IQ 3 hold, ankle pumps and heel slides (tick) to do hourly. P/R/V PM".

186 It is difficult to reconcile these two notes, one indicating that he stood with the physiotherapist and the physiotherapist indicating he was "not for getting up".

187 In accordance with the expert evidence, it is clear that his lack of mobilisation further increased his risk of a pulmonary emboli.

Finding

188 In accordance with the expert's review Dr Khoury's clinical pathway was reasonable and in accordance with guidelines. However, the lack of clear

contemporaneous documentation of the implementation of the pathway and the lack of any notes by Dr Khoury confirming his pathway was being followed is unsatisfactory. There is no contemporaneous evidence that would allow a finding that Dr Khoury ensured that the pathway was being complied with as was required.

Issue 4(b)

The diagnosis of and response to Mr Toll's episodes of heart arrhythmia

189 On 18 July 2019 Mr Toll had an episode of tachycardia with a heart rate of 176 between 0818 and 0820, which was considered to be possibly supraventricular tachycardia. With a further episode of tachycardia recorded by nursing staff at 2145 with a heart rate of 125 bpm. He also required increasing supplemental oxygen on 18 July 2019 and complained to nurses of nausea and was clammy.

190 On 19 July 2019 at 0215 Dr Chaffey was contacted by nursing staff regarding a further occurrence of Mr Toll's elevated heart rate at a 160-170bpm at 0154 lasting 2 minutes.

191 In relation to the actions of Dr Libreri, Professor MacPherson opined that his actions were appropriate. That SVT is a common event post-operatively and the management by Dr Libreri in terms of the intravenous prescription of the Metoprolol and the recommendation to the surgeon for a cardiology referral was all that was required in his role as the anaesthetist.

192 Dr Coolican considered that:

"Whilst it is evident from Dr Khoury's statement that he considers the ongoing medical care of Mr Toll was the responsibility of Dr Libreri, it should be pointed out that Dr Libreri is an anaesthetist and it is unusual for an anaesthetist to provide ongoing postoperative medical care. This is usually the responsibility of either the surgeon who sees the patient most days after the surgery or another medical specialist – usually a physician – that has been consulted by the surgeon prior to surgery."

193 There is a contest between the experts as to what Mr Toll's episodes of heart arrhythmia were demonstrating but significant to these episodes and Mr Toll's ultimate cause of death was the evidence of Dr Coolican and Associate Professor Adams about the required response, notwithstanding the ultimate definitive cause.

194 Dr Coolican opined that the tachycardia along with the oxygen saturation were consistent with small pulmonary emboli having occurred, and explained that:

"*a patient that had undergone BTKR and has a combination of a tachycardia and low oxygen saturations has suffered a pulmonary embolism until proved otherwise by a CT scan of the pulmonary arteries known as a CTPA."* And further "*That orthopaedic surgeons that perform bilateral knee replacements have a sensitivity to the complications of pulmonary embolism and so if one of my patients has a combination of a tachycardia and a lower level of oxygen, to me that is a pulmonary embolism until proved otherwise by a CT scan of the pulmonary arteries known as CTPA. So to my mind there was evidence that Mr Toll was having small pulmonary emboli and that he needed to have anticoagulation and he needed a CTPA*."

195 Dr Coolican stated that he would expect an orthopaedic surgeon to:

"*have a sensitivity to the diagnosis of pulmonary embolism and so a tachycardia of any form combined with a low oxygen level is something that triggers our thought that is this a PE, and in that setting you would organise, firstly you'd start treatment for pulmonary embolism with anticoagulants and secondly you'd organise the test the next time you could get a slot in the radiology department*."

196 In his opinion there were features of concern with Mr Toll's cardiorespiratory function that Dr Khoury did not recognise as potentially due to a pulmonary embolism, and his post-operative care was not adequate.

197 While Associate Professor Adams' evidence was that he would not expect an orthopaedic surgeon to see an episode of SVT and identify that it might be

caused by a pulmonary embolism, it was his view that a referral to a cardiologist was important after Mr Toll developed supraventricular tachycardia and particularly after he had a second further episode because in the absence of Mr Toll having a history of SVT, it could be a pulmonary embolus or the onset of atrial fibrillation and in either case the treatment required the administering of anticoagulants to manage the risk of stroke.

198 Dr Khoury disagree in his evidence with the view of Dr Coolican and Associate Professor Adams that small pulmonary emboli were forming between 18 and 20 July 2019 and his evidence was "there was nothing at the time suggesting multiple pulmonary emboli, if that did happen you can actually see the oxygen saturation plummeting".

199 Dr Coolican was critical of Dr Khoury position that the necessity for Mr Toll to undergo a CT scanning of the pulmonary arteries was not a matter for him to decide as it was not his area of expertise. Dr Coolican's considered that:

"… *pulmonary emboli are an acknowledged complication of knee arthroplasty particularly bilateral knee arthroplasty and a sensitivity to its diagnosis should be part of his medical expertise. Dr Khoury does not need to be a trained positional cardiologist to diagnose a pulmonary embolism or to have a sensitivity to its presence*".

200 Associate Professor Adams opined that:

"*Pulmonary embolism is frequently accompanied by atrial tachycardia and AF, this is thought to occur because the elevation in pulmonary artery pressure causes stretching of the right atrium (Vyas et al, Acute pulmonary embolism, Stat Pearls, NCBI bookshelf 2024, attachment 6). Although less commonly associated with pulmonary embolism SVT has been seen as the sole symptom for pulmonary embolism in some cases (Zwecker et al, Supraventricular tachycardia as a presenting sign of pulmonary embolism in paraplegia, case report and review, Paraplegia 1995, attachment 7), and it is recognised that the development of SVT in pulmonary embolism carries a worse prognosis (Kumiet*

al, Impact of supraventricular tachycardia on outcomes inpatients admitted with acute pulmonary embolism, JACC 2022, attachment 8).”

201 He considered that if the SVT had been investigated at an earlier stage there may have been an opportunity for effective treatment, but that it needed to be remembered that patients with SVT complicating pulmonary embolism have a worse prognosis.

202 It is accepted that Associate Professor Grabs did not agree that the SVT was associated with small emboli. He relied on the post-mortem findings and that the pathologist was able to identify that there was no coronary artery significant stenoses. That he believed that multiple small pulmonary emboli would have been identified by the pathologist at the time of autopsy, he opined that “ based on that report this is where I’ve associated that I do not believe that the episodes of the tachycardia were associated with small emboli”. In the absence of the autopsy report he would have said there was a possibility that the episodes of tachycardia may reflect small emboli.

Finding

203 Dr Coolican’s evidence in relation to the required response to the post-operative symptoms was compelling. Particularly when considered in the context of the well-known and documented high risk of pulmonary embolism for Mr Toll, and his expertise as an Orthopaedic Surgeon.

204 Dr Khoury failed to recognise that Mr Toll was possibly suffering from a pulmonary embolism and to take appropriate steps to mitigate that possibility.

205 The consensus of the majority of experts was that Mr Toll required a review by a cardiologist. Whilst Dr Coolican agreed a cardiologist or general physician review ought to occur, he was adamant that Dr Khoury did not require a cardiologist to manage a pulmonary embolism.

206 Dr Khoury and Dr Libreri both agreed in evidence that they formed the opinion that Mr Toll required a cardiologist’s review.

207 Associate Professor Adams' evidence was that a telephone referral was preferable because it would permit a dialogue to occur between the physician and the cardiologist as to necessary next steps based on that discussion and clinical indicators.

208 If there had been a consultation by a cardiologist, Associate Professor Adams' evidence was that what ideally would happen is that there would be a review of the patient's history, a physical examination as well as review of ECGs to determine the type of arrythmia, why it is occurring and what the management plan is. That when faced with a situation where a cardiologist is considering PE, the Wells score is used to consider the risk. That Mr Toll's situation would have resulted in an intermediate score, and one which a cardiologist would consider moving to further testing, including a D-dimer and an echocardiogram. That while both tests had their limitations, they would have guided the level of risk and had the echocardiogram not been normal or not available it would be appropriate to go straight a CTPA or a CT pulmonary angiogram.

209 Associate Professor Adams' evidence was also that in circumstances where an echo or CTPA were not going to be immediately conducted the empiric treatment would be commencing Intravenous heparin, either that or therapeutic Clexane. That this treatment does not need to await the arrival of a cardiologist. That rather than just worrying about the cardiologist coming and seeing the patient a lot can be achieved just from a phone call and that phone conversation where a cardiologist would be thinking, "well, what's causing this SVT? Maybe we need to rule out a pulmonary embolism and that might involve them asking a few more question, perhaps saying "Can we send off a D-dimer? And if there was any question about it and there was going to be delay, the cardiologist might say "that's going to take too long. We don't have time. You need to start this patient on a heparin infusion in the meantime until we get those things sorted out" which would be the treatment if it was a pulmonary embolism.

210 Associate Professor Adams' was also of the view that it is not uncommon in his practice to get a call in relation to a similar situation "at night we might not necessarily say drag the registrar in to do an echocardiogram but look it sounds

concerning. Let's start some heparin now and in the morning, we'll get an echocardiogram or a CTPA."

211 Dr Coolican agreed with Associate Professor Adams, that the referral should be from consultant to consultant, with the surgeon calling the cardiologist and further that the surgeon would not have to wait for the cardiologist or general physician before starting the anticoagulation regime. He opined that the morbidity of anticoagulation is minor, but the morbidity of not using it is significant.

Issue 4(c)

Whether a referral of Mr Toll for review by Dr du Plooy was made and whether this review occurred

212 There are no contemporaneous clinical notes by Dr Khoury or Dr Libreri in relation to Mr Toll's post-surgery symptoms, any discussion between them about this or any note of a referral to a cardiologist. There is no record in the Doctors Orders section of the clinical record. Further to this, even on the tragic passing of Mr Toll on 20 July 2019, no retrospective note was made by Dr Khoury. The note made by Dr Khoury on this date records scant details of Dr Khoury's notification of his cardiac arrest and death.

213 Dr Libreri did not make a referral and did not follow-up whether Mr Toll had been seen by a cardiologist. Both Professor MacPherson and Associate Professor Adams agreed that it was Dr Khoury's responsibility to make the decision for the referral to a cardiologist, with Associate Professor Adams adding that it would have been reasonable for Dr Khoury to delegate such a referral to Dr Libreri but this would have required clear communication about who was performing this task. There is no evidence that Dr Khoury delegated the task of referral to Dr Libreri. Dr Libreri said he understood that Dr Khoury had made a direct referral to Dr du Plooy. There was no evidence as to what caused him to form this belief.

214 There are only two contemporaneous notes regarding the referral, both made by nursing staff. RN Scalzo's note on 18 July 2019 included:

215 "*Pt (patient) reviewed by Dr Khoury this am (morning) ? SVT (arrow up) 176-0818-0821 – Valsalva manoeuvre x 2 – reverted – Sr/SF (arrow up) 90-110 ECG, tick – Dr Khoury will refer patient to Dr du Plooy for review (R/V).*" (emphasis added)

216 At 1130 on 19 July 2019 Nurse Quinn recorded *"*Pt S/B Dr Khoury, aware of x2 more episodes of SVT, Dr du Plooy has r/v ECG, NFO at this time. For possible follow-up later dated for ? ablation, happy for transfer to ward today*".* Nurse Quinn was unable to recall where the information came from which permitted her to make the note. That she had either had a conversation with Dr du Plooy or another nurse had relayed information to her.

217 The complete lack of any documentation by any of his treating physicians is highly unsatisfactory.

218 The difficulty of this limited note by Nurse Quinn is that the source of the information is unknown and it is unclear if it is first, second or remote hand information, it is also unclear whose opinion attaches to the entry, including who was "happy for transfer to ward today".

219 Dr Libreri said he was told by a nurse that Mr Toll had been seen by Dr du Plooy. His evidence was as follows:

> "*I would suggest that, that it went, that I, as I said I popped my head in early Friday morning, and "How's Mr Toll going", "He, he's going to the ward today" and the nurse must have also said that Dr du Plooy has seen him, which would have put my mind at ease.*".

220 It is clear from the phrasing of his evidence that he is constructing what must have occurred based on RN Quinn's note and not from any reliable independent recollection.

221 Dr Khoury could not recall making the referral to Dr du Plooy "I can't recall, but I think that I was going to on 18 July and it would have been in my, it would have been my practice to do so." And "I can't recall making a referral but that's

probably what I would have done." He said that his usual process for referring a patient to a cardiologist was varied and included either ringing the rooms or writing a note (in the history) or sending a text."

222 Dr Khoury agreed he had a view about what actions Dr du Plooy took but he could not say how or when or if he was referred by him. He later gave evidence he did refer him. He said that looking at the nursing records that he understood Dr du Plooy had reviewed the ECG and that there were no further orders, and he had a vague memory of being told that. He said that he had been informed of this, based on the note made by Nurse Quinn. He then said that "I would have been called, and I have a vague recollection of being called about it but yes, and I relaxed then because Dr du Plooy was involved." He agreed that he did not know what steps Dr du Plooy had carried out beyond what was recorded in the note. When asked if he believed it was necessary to follow up to speak to Dr du Plooy to check what he had or hadn't done he said "not at that point. And, I may well have been reassured over the phone, you know." (emphasis added)

223 It is submitted on behalf of Dr Khoury that at approximately 1100 on 19 July 2019 Dr Khoury received a telephone call from hospital staff during which was communicated to him the information contained in RN Quinn's 1130 note and that on that basis he "Formed the firm impression that Dr du Plooy was across Mr Toll's cardiac situation". However, the answers at the Inquest outlined above make clear that this position is based on what is contained in the note of RN Quinn. He was continuously speculating about what would and may have happened and having a vague recollection. Based on the tenner of his evidence at inquest and his reliance on the contents of RN Quinn's note, it is not accepted that he received a call from hospital staff in relation to Dr du Plooy having reviewed Mr Toll.

224 Further the submission that he was not challenged on having received this phone call is misleading given his own evidence was that he "would have been called and had a vague memory of the call" in of itself undermines the credibility and reliability of this evidence.

225 The evidence establishes that on 4 December 2019 Dr Khoury sent a message to Dr du Plooy “Jan, I am preparing a hccc report re Mr Toll. Did you see him when he had his SVT or did you just review his ECG. I have been asked to clarify.” This message establishes that less than five months after Mr Toll’s passing Dr Khoury did not know if Dr du Plooy had seen him or just reviewed the ECG (as recorded in the nursing note).

226 There is no evidence that establishes that Dr Khoury referred Mr Toll to Dr du Plooy.

227 Dr du Plooy was adamant that he did not review Mr Toll and he never received a request from Dr Khoury or Dr Libreri to review him. He had no records relating to Mr Toll in his Genie medical system and his mobile phone records included in the brief of evidence indicated he had not received a call from Dr Khoury or Dr Libreri during the relevant period. He denied that it was possible for a call to have been made to his consultation rooms and staff neglected to pass on the message.

228 Further to this he said that usually referrals were made to his mobile and his practice staff request a formal referral for billing and Medicare purposes. There was no patient file or invoice in his office software, there was no clinical note recorded by him consistent with his practice.

229 In relation to Nurse Quinn’s note and the accuracy of that record, it was his evidence that he could not recall being in HDU at 1130 usually on Fridays he consulted in his rooms after 0800 ward rounds until his 1700 ward rounds. He also gave evidence that consistent with his clinical practice he would not recommend potential treatment until he had seen a patient and that as an interventional cardiologist, ablations are not within his area of expertise. In cross examination he accepted that he had the expertise to refer a patient to an electrophysiologist and further that “we have to assume these notes are correct.”

230 In response to Dr Khoury’s message on 4 December 2019, he replied:

"*Hi Elli, I just saw the ECG. The staff told me he was known to Naylin…I was planning to chase up some info from Naylin and see him the Saturday morning. The staff often show me ECG's and use that as a teaching opportunity*."

231 It was only after seeing this message that Dr du Plooy recalled having any knowledge or involvement with Mr Toll. He recalled being asked "What do you think about this ECG?" that this was a question for the nurse and not the patient and that at the same time he was told "you may get a referral to see this patient". His evidence was that he would only have seen him on the Saturday morning if he had received a referral, which he did not.

232 The evidence further established that the catheterisation lab was 50 to 100 metre walk from the HDU and that at times he has cause to visit his patients in the HDU. Whilst he was unable to recall whether on 19 July 2019, he was called to see any one of his patients that he had performed a procedure on the day before and he agreed he may have been called and attended the HDU.

233 It is possible that Dr du Plooy was approached by staff in relation to reviewing Mr Toll. This is consistent with his text message of December 2019 "the staff told me he was known to Naylin" and that he had just seen an ECG shown to him by a nurse.

234 It is difficult to interpret the note "happy for transfer to the ward today" in circumstances where RN Quinn is referring to Mr Toll having being seen by Dr Khoury and also Dr du Plooy reviewing the ECG.

235 Notwithstanding the tragic death of Mr Toll, Dr Khoury did not find it necessary to speak with Dr du Plooy about his treatment until 4 December 2019. This is also highly suggestive that he had not made a referral or considered that Dr du Plooy had reviewed Mr Toll as at 20 July 2019 but that in December 2019 he was aware of RN Quinn's note and was seeking some five months later to clarify what involvement he had.

Finding

236 The evidence does not establish that Dr Khoury referred Mr Toll to Dr du Plooy for review. He did not have any discussion in line with what Associate Professor Adams would deem an appropriate referral in the circumstance.

237 While the evidence does establish that Dr du Plooy reviewed an ECG believed to be Mr Toll's, the circumstances of this review are limited to the note of RN Quinn and the text message of Dr du Plooy five months later, in circumstances where Dr du Plooy was heavily reliant on records and had limited independent recollection of any involvement in Mr Toll's care.

238 The evidence establishes that Dr du Plooy did not have a consultation with Mr Toll.

239 Dr Khoury failed to ensure an appropriate referral was made to a cardiologist, such that the post-operative symptoms could be properly considered by such a specialist.

240 Having failed himself to recognise the potential of pulmonary thromboembolism, he also failed to ensure an appropriate specialist was engaged to review Mr Toll's symptoms and to consider commencing empirical therapy with the anticoagulation regime.

241 Dr Libreri and Dr Khoury failed to document any consultations, requirement for referral, conversation or action taken regarding Mr Toll post-surgery and prior to his death. They also failed to make any retrospective notes following the passing of Mr Toll. Their evidence was heavily reliant on a single nursing note.

Response of Albury Wodonga Private Hospital to Mr Toll's death

242 The evidence of Dr Eather establishes the response taken by AWPH in relation to Mr Toll's death. The hospital made a number of changes to policy and procedures in direct response to Mr Toll's death.

243 They conducted their own investigations, including a Root Cause Analysis following which on 11 October 2019, restrictions were placed on Dr Khoury which meant he could not perform any bilateral knee arthroplasties until an independent Scope of Clinical Practice Review (Review) had been conducted. AWPH engaged Dr Omar Khorshid to conduct an independent in person review which occurred on 11 December 2019, and his report was provided on 29 December 2019. Following this report further conditions were imposed on Dr Khoury's practice.

244 Dr Khoury appealed against the conditions placed on his practice, with the appeal occurring on 24 April 2020 before a member of the Ramsey Health board, the risk committee and independent experts. On 9 July 2020 following this appeal the panel recommended to the Australian Risk Management Committee of Ramsay Health Care Australia that conditions be lifted from Dr Khoury's practice on the basis that there were now sufficient risk mitigation strategies in place at the Hospital, including a restriction on bilateral knee replacements that applied to all orthopaedic surgeons until additional polices had been implemented. As a result, subject to Dr Khoury's compliance with a number of requirements of the Review the conditions on his practice were lifted.

245 As a result of Mr Toll's death, the Hospital updated its Admission Exclusion Policy which excludes certain high-risk patients from some surgeries. They also developed a Bilateral Knee Replacement – Clinical Criteria for consideration policy and established an approval pathway for bilateral knee replacements, which came into effect in December 2020. The approval pathway includes specialist medical review and clearance, anaesthetic clearance, senior nursing review by a Nurse Unit Manager and Director of Clinical Services and executive approval. If a patient is considered appropriate for a bilateral knee replacement, they will be admitted to the High Dependency Unit in the post-operative period. If the risk assessment concluded that a patient would need intensive care management post-operatively, the Hospital would exclude them from the surgery.

246 Relevantly AWPH took a number of steps to audit its policies and procedures in relation to Venous Thromboembolism. In December 2020 and January 2021, a VTE prophylaxis audit was conducted of post-operative records to ensure the identification of high-risk patients, the documentation of that identification and the communication of an appropriate action plan including a VTE risk audit.

247 In addition, in direct response to Mr Toll's death, a best practice clinical pathway was established in relation to VTE prophylaxis which was standardised according to a patient's level of risk, that is required to be followed by all practitioners, including visiting Medical Officers rather than the use of preference cards, such as the Bilateral Total Knee Replacement Mr Khoury – Clinical Pathway. This clinical pathway directs that all patients receive a standardised level of VTE prophylaxis according to their assessed risk level, and that all patients receive the necessary preventative care, rather than receiving different types of care depending on the practice of their treating physician.

Is it necessary or desirable to make recommendations?

248 In light of the evidence at this Inquest exposing repeated failures by physicians to record important information, including specifically a referral by Dr Khoury to a cardiologist it was submitted by Counsel Assisting, supported by both Mr Toll's family and Dr Khoury that a recommendation ought to be made to Ramsay Health Care:

"*That Ramsay Health Care take all necessary steps including the need for further policy, to ensure that the medical records of patients at AWPH clearly identify when a patient has been referred to another clinician, by whom, for what purpose they were referred and for it to be clearly recorded in the medical records what the outcome of that consultation was*."

249 Ramsay Health submit that it is not necessary for the Court to make such a recommendation because, firstly the Hospital has already taken steps to address issues around record keeping and, second, the requirements with respect to record keeping are already made explicit in the regulatory and policy

frameworks within which medical practitioners must currently operate and finally that a policy requiring written documentation of referrals is impracticable for a number of reasons.

250 While the evidence establishes that Ramsay Health has implemented procedures to improve clinical documentation, including weekly reviews of delays in recording clinical incidents or any failures to recognise a deteriorating patient, there is no evidence of a procedure sought to further ensure detailed documentation of referral to another clinician by a treating physician.

251 Whilst Dr Khoury has suggested the implementation of a particular document used in other hospitals it is accepted that Ramsay Health and AWPH would have to consider a policy which can be easily integrated into its hospital keeping system.

252 There is nothing in the suggested recommendation that would require nursing staff to be responsible for the documentation, the referral or the follow up, or as submitted by Ramsay Health. Further the suggested recommendation does not anticipate that a physical form would need to have been completed before a referral can take place.

253 Given the complete lack of documentation of Mr Toll's post-operative care by his treating physicians, it is desirable that this recommendation be made to further ensure that medical practitioners comply with their obligations which would further prioritise patient safety.

Referral of Dr Khoury

254 Pursuant to section 82 of *the Act*, a Coroner may recommend that the Medical Council or Nursing Council or the Health Care Complaints Commission (HCCC) investigate or review the conduct of a registered health practitioner if the Coroner considers it necessary or desirable to do so.

255 The Toll family submit that the Coroner would find it desirable if not necessary to refer Dr Khoury to the HCCC and refer in their submissions to the findings of

Magistrate Lee (as he then was), of 31 October 2023 in the Inquest into the death of Adam Fitzpatrick.

256 In that decision His Honour was considering a recommendation specifically to the Medical Council (not the HCCC) and his Honour set out the legislative framework of the *Health Practitioner Regulation National Law* (NSW).

257 Whilst the Toll family have specifically sought a referral to the HCCC, they have referred specifically to the mechanism for a referral to the Medical Council of New South Wales. Further both Counsel Assisting and Dr Khoury have addressed a referral to the Medical Council in their submission (not the HCCC). The appropriate consideration therefore is whether a referral should be made to the Medical Council.

258 Relevantly section 151A (2) and (3) provide:

151A referral of matters by Courts

(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.

259 Relevantly, the Medical Council and Nursing Council of New South Wales are both Councils established under section 41B of the National Law. While section 151A does not explicitly define, or otherwise provide guidance as to, what may constitute “reasonable grounds”, the guiding principles set out at section 3A of the National Law provides 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.

Section 3B of the National Law provides:

Objective and guiding principle

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

260 Section 144 of the *National Law* sets out a number of grounds for complaint about a registered health practitioner and provides:

The following complaints may be made about a registered health practitioner –

(a) **Criminal conviction or criminal finding**

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) **Unsatisfactory professional conduct or professional misconduct**

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

(c) **Lack of competence**

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

(d) **Impairment**

A complaint the practitioner has an impairment.

(e) **Suitable person**

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

261 It is understood that the submission on behalf of the Toll family suggest that a complaint could be made about the profession conduct and/or competence of Dr Khoury.

262 Section 139 of the *National Law* provides:

139 Competence to practice health profession (NSW)

A person is competent to practise a health profession only if the person –

(a) has sufficient physical capacity, mental capacity, knowledge and skill to practise the profession; and

(b) has sufficient communication skills for the practice of the profession, including an adequate command of the English language.

263 Section 139B of the National Law relevantly provides:

139B Meaning of "unsatisfactory professional conduct" of registered health practitioner generally (NSW)

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

(a) **Conduct significantly below reasonable standard**

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

264 It is submitted by the Toll family and acknowledge on behalf of Dr Khoury that the threshold for referral is "relatively low".

265 As Judge Lee observed in Fitzpatrick at 28.20

> "that the use of the words '*believe*', '*may indicate*' and '*could*' in section 151A(2) of the HPR individually and collectively impose a relatively low threshold by which that provision might be engaged. Therefore, section 151A(2) does not impose any requirement that the evidence in actual or contemplated coronial proceedings establishes a complaint. Instead, section 151A(2) may be engaged if a coroner has reasonable grounds to believe that the evidence may indicate that a complaint could be made…
>
> …a complaint is not fettered by any consideration as to whether a registered health practitioner has, for example, demonstrated appropriate reflection or undertaken any additional education, training or personal and professional development following an adverse event which is the subject of a complaint. These matters are, in essence, matters which may bear upon how the Medical Council or Nursing Council may assess and deal with a complaint, utilising the powers available to the relevant Councils.

266 Dr Khoury opposes such a referral being made and submits that the matters advanced by the Toll family in support of the referral, including the referral to Dr du Plooy and the ongoing lack of engagement by Dr Khoury in his treatment of Mr Toll are not established having regard to the differing views of the expert witnesses.

267 Whilst Counsel Assisting did not recommend such a referral in his initial closing submissions, it was submitted in reply that given the threshold for referral is

relatively low it is open for the exercise of discretion to refer to be utilised as requested by the family.

268 Given the findings made in relation to Issue Four, there are reasonable grounds to believe that a complaint could be made about Dr Khoury such that a transcript of evidence ought to be provide to the relevant Council pursuant to section 151A of the *Health Practitioner Regulation National Law* (NSW).

Recommendations

269 To the Executive Officer, Ramsay Health Care:

That Ramsay Health Care take all necessary steps including the need for further policy, to ensure that the medical records of patients at AWPH clearly identify when a patient has been referred to another clinician, by whom, for what purpose they were referred and for it to be clearly recorded in the medical records what the outcome of that consultation was.

270 To the Executive Officer of the Medical Council of New South Wales:

There are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about Dr Khoury, who is a person registered in a health profession, namely that Dr Khoury engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practice in a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of the evidence at inquest is to be provided to the Executive Officer of the Medical Council of New South Wales.

Findings

271 I would like to acknowledge and express my gratitude to Mr Patrick Rooney, Counsel Assisting, and Mr James Herrington, Ms Penelope Smith and Ms Sarah Najjar from the Crown Solicitor's Office. The assisting team has worked diligently and methodically to assist the conduct of the coronial investigation. They have gathered, scrutinised and considered the evidence

and ensured that all relevant issues were properly examined. I am extremely grateful for their tireless efforts and for their empathy and professionalism that they have shown during all stages of the coronial process.

272 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Wendy, Lisa and Mark, to all of Ken's family and friends and to the many people who knew and loved him.

273 Consistent with the documentary and oral evidence at the inquest, I make the following findings:

Identity

The person who died was Kenneth Toll.

Date of death

Mr Toll died on 20 July 2019.

Place of death

Albury Wodonga Private Hospital, Albury NSW 2640.

Cause of death

The cause of Mr Toll's death was cause of death was a pulmonary thromboembolism secondary to a deep vein thrombosis of the right calf following bilateral knee replacement surgery.

Manner

Mr Toll died in circumstances where following bilateral knee replacement surgery he suffered from episodes of supraventricular tachycardia that required timely review and investigation by a cardiologist which did not occur.

274 I close this inquest.

Judge S McLaughlin
Coroner
NSW Coroners Court Albury
Date 22 September 2026

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