CITATION: *Inquest into the death of Ali Achmadun Djawas* [2019] NTLC 004

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0055/2017
DELIVERED ON:	16 April 2019
DELIVERED AT:	Darwin
HEARING DATE(s):	12 & 13 March 2019
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Elective surgery, lack of information as to risks of surgery, unnecessary surgery, poor communication by Hospital, lack of appropriate discharge procedure and information, anastomotic leak leading to death**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Top End Health Service:	Stephanie Williams
Counsel for family:	Peter Bellach

Judgment category classification:	B
Judgement ID number:	[2019] NTLC 004
Number of paragraphs:	101
Number of pages:	27

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0055/2017

In the matter of an Inquest into the death of

ALI ACHMADUN DJAWAS

ON 1 APRIL 2017
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. The deceased, Ali Djawas, was born in Kupang, Indonesia on 28 May 1946. He arrived in Darwin in 1972. The following year he married his first wife and together they had three children. They separated and in 1983 he married his second wife. They also had three children. They separated in 1990 and he married his third wife, Annisa. They had two children and remained together until his death on 1 April 2017.

2. Neither Mr Djawas nor his wife, Annisa spoke English as a first language. He could understand and speak basic English. His wife understood more than she could speak, although again only at a basic level. His children, raised in Darwin, speak English fluently.

3. Prior to going into hospital for elective surgery on 13 March 2017 his family considered Mr Djawas to be in good health, to have a healthy diet and to be active. However, he did have a number of chronic diseases: hypertension, Type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary Disease (COPD).

4. On 2 July 2016 Mr Djawas was informed by his General Practitioner that one of two stool samples tested in the National Bowel Screening initiative

had returned a positive result for blood. He was referred to the Royal Darwin Hospital for review.

5. On 30 September 2016 he had a colonoscopy that identified what was thought to be a caecal mass near the juncture between the small and large intestines. Biopsies did not indicate that it was cancerous.

6. On 3 November 2016 Mr Djawas underwent a CT scan. However, the scan did not show a mass.

7. He had another colonoscopy on 30 January 2017. The comment relating to that procedure was: "previously seen and tattooed lesion seen again. This is on the IC valve (ileo-caecal valve). Appearance consistent with a sessile serrated adenoma. Multiple biopsies. Even if pathology is benign, endoscopic removal will be very difficult given location (on IC Valve). Two other small polyps removed from the left side (2-3mm)".

8. On 14 February 2017 Mr Djawas was seen by the Surgical Senior Registrar at the Surgical Consultant Clinic at Royal Darwin Hospital (RDH). Mr Djawas was with his wife Annisa. They were told that there was a polyp in a position that was difficult to get at and that even though the biopsy samples had been benign the polyp might be malignant. They were provided with three options:

    A. The first option was conservative management. That was, to check on the polyp from time to time to determine if it became more of a problem. However, there remained a suspicion in the minds of the doctors that the polyp was cancerous. It was suggested to Mr and Mrs Djawas that option would not provide peace of mind.

    B. The second option was to have Endoscopic Mucosal Resection (EMR). Mr and Mrs Djawas were told that could not be performed in Darwin and they would have to go south. They were also told that

given the position of the polyp it was doubted that EMR would be successful.

C. The third option was to have a laparoscopic right hemicolectomy. It was said that would remove the polyp and provide definitive treatment.

9. Mr Djawas asked what was best for him. The Surgical Senior Registrar said she would ask her consultant. She left the consulting room and spoke to Mr Toonson. She returned and told Mr and Mrs Djawas that the best option was the laparoscopic right hemicolectomy.

10. A "Consent for Procedure" document was prepared and was signed by Mr Djawas. An image of the two pages of that "Consent" are below. It is notable that:

A. Although the form makes provision for indicating whether or not an interpreter is required, no consideration was given to that issue either for Mr Djawas or his wife. Other parts of the medical notes indicate that at least the understanding of his wife was an issue. For instance, the ICU Nursing Care Plan had the emergency contact as his wife but written next to it were the words: "Doesn't speak English".

B. Although the form makes provision for the patient to signify their level of understanding by ticking the boxes on the reverse side, none were ticked;

C. There is no mention of the risk of death under the heading "Disclosure of Material Risks".

Northern Territory Government | DEPARTMENT OF **HEALTH**

CONSENT FOR PROCEDURES / TREATMENT

Principal name
Other name(s)
D.O.B.
HRN
Sex

DJAWAS
ALI
M 70Y28/05/1946 0105093
OP H SG2
DR: GS2 TOONSON E60765699

Address must be documented if patient details are hand written

NOTE: Consent for Emergency treatment under the Emergency Medical Operations Act (EMO) must be obtained using the Emergency Consent form.

Interpreter's requirements — refer Consent Guidelines Part 4

Specific language requirements (if any) _____

Interpreter services required: ☐Yes ☐No

Part A - Consent Obtained

To the Director of Medical Services, RDH. Hospital

I, ALI DJAWAS. (The Named Patient)
(Patient's Full Name)

or, _____ (Responsible Person)
(Name of Legal Guardian / Responsible Person)

of (insert address) _____

hereby consent to the above Named Patient, being: myself / child / Ward / Other – specify _____
(circle one)

undergoing the treatment/procedure of Laparoscopic RIGHT hemicolectomy +/- open **(The Named Treatments)**
(please ensure all treatment and procedures are listed)

Part B - Information provided including material risks

Declaration of doctor / proceduralist (to be completed by the clinician gaining consent)

☑	I confirm that I have explained to the patient/legal guardian/responsible person the nature and effect of this treatment/procedure
☑	I have also explained the alternative treatments / procedures which are available.
☑	I have provided the patient with information specific to the procedure and encouraged their discussion and clarification of any matters.
☑	I have discussed with the patient the risks associated with this procedure including the risk of not having the procedure.

The following written information sheets/pamphlets have been provided: _____

This procedure requires:
☑ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation
An anaesthetist will explain the risk of general or regional anaesthesia to you.

Disclosure of material risks

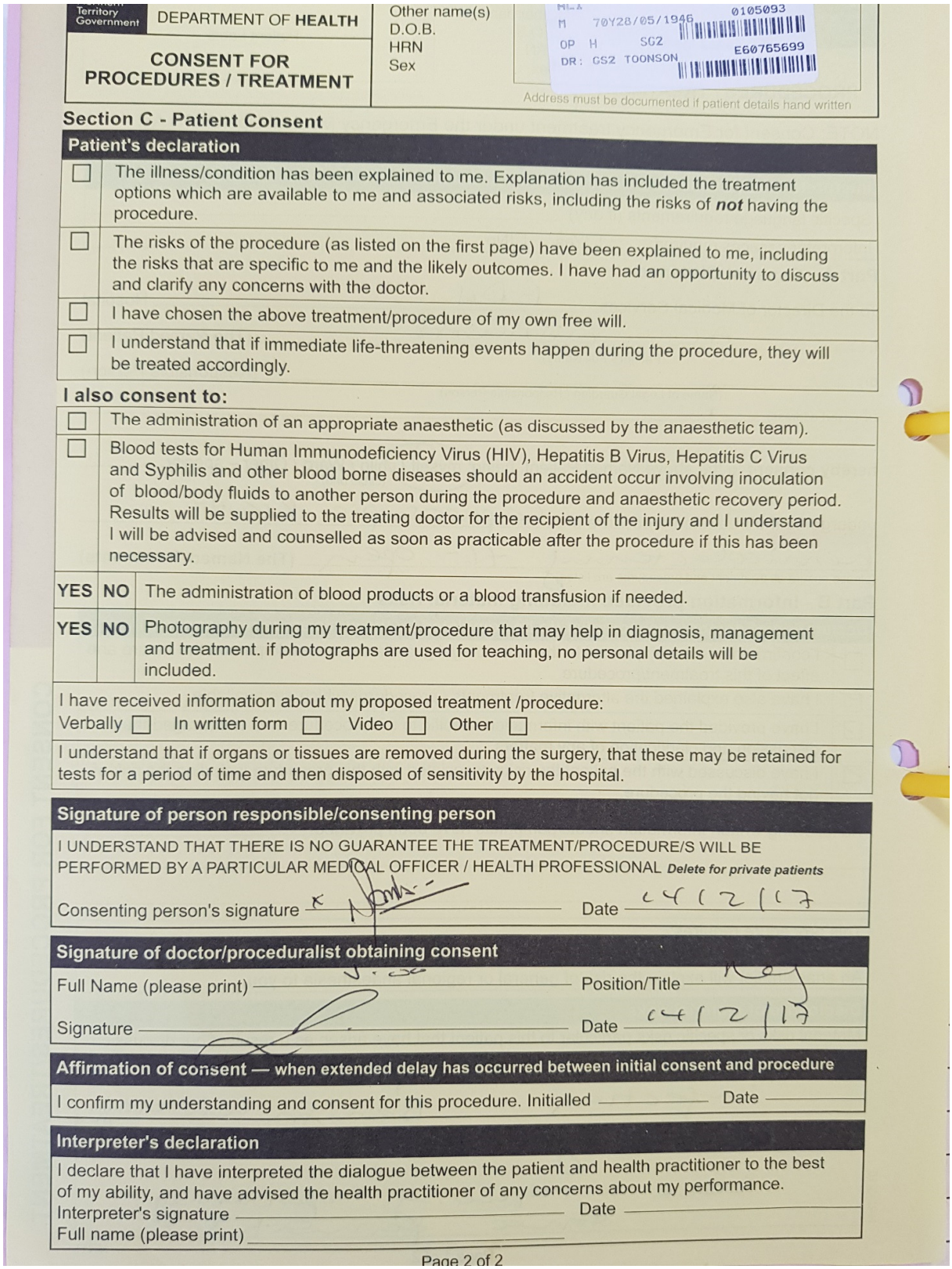
Material risks or specific risks particular to this patient that have arisen as a result of our discussion are:

pain
infection
bleeding
leak — requiring laparotomy, stoma formation
open.
Benign histology

CONSENT FOR PROCEDURES/TREATMENT

HR2-3/15

MR11



Territory Government | DEPARTMENT OF HEALTH

CONSENT FOR PROCEDURES / TREATMENT

Other name(s)
D.O.B.
HRN
Sex

M 70Y28/05/1946 0105093
OP H SG2
DR: GS2 TOONSON E60765699

Address must be documented if patient details hand written

Section C - Patient Consent

Patient's declaration

☐	The illness/condition has been explained to me. Explanation has included the treatment options which are available to me and associated risks, including the risks of ***not*** having the procedure.
☐	The risks of the procedure (as listed on the first page) have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor.
☐	I have chosen the above treatment/procedure of my own free will.
☐	I understand that if immediate life-threatening events happen during the procedure, they will be treated accordingly.

I also consent to:

☐	The administration of an appropriate anaesthetic (as discussed by the anaesthetic team).
☐	Blood tests for Human Immunodeficiency Virus (HIV), Hepatitis B Virus, Hepatitis C Virus and Syphilis and other blood borne diseases should an accident occur involving inoculation of blood/body fluids to another person during the procedure and anaesthetic recovery period. Results will be supplied to the treating doctor for the recipient of the injury and I understand I will be advised and counselled as soon as practicable after the procedure if this has been necessary.

YES	NO	
YES	NO	The administration of blood products or a blood transfusion if needed.
YES	NO	Photography during my treatment/procedure that may help in diagnosis, management and treatment. if photographs are used for teaching, no personal details will be included.

I have received information about my proposed treatment /procedure:
Verbally ☐ In written form ☐ Video ☐ Other ☐ _____

I understand that if organs or tissues are removed during the surgery, that these may be retained for tests for a period of time and then disposed of sensitivity by the hospital.

Signature of person responsible/consenting person

I UNDERSTAND THAT THERE IS NO GUARANTEE THE TREATMENT/PROCEDURE/S WILL BE PERFORMED BY A PARTICULAR MEDICAL OFFICER / HEALTH PROFESSIONAL ***Delete for private patients***

Consenting person's signature _____ Date 4/2/17

Signature of doctor/proceduralist obtaining consent

Full Name (please print) _____ Position/Title _____

Signature _____ Date 4/2/17

Affirmation of consent — when extended delay has occurred between initial consent and procedure

I confirm my understanding and consent for this procedure. Initialled _____ Date _____

Interpreter's declaration

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.
Interpreter's signature _____ Date _____
Full name (please print) _____

Page 2 of 2

11. A request for "urgent" admission was also made by the Surgical Senior Registrar to the Royal Darwin Hospital for a "Laparoscopic right

hemicolectomy ? malignant polyp". It was said the anticipated length of stay was "3 – 4 days".

Informed decision making

12. Mr and Mrs Djawas were not told that the specific procedure being recommended was a significant procedure that carried a risk of death more significant than the other options presented. They were left to try and balance the risks between procedures carrying a lesser risk and major surgery without sufficient information. There were a number of complications listed on the consent form, but none of them fatal.

13. The Surgical Senior Registrar stated in evidence:

> "I would have said that there is always a small risk whenever someone goes onto the table … But nowadays, that risk is quite small".[1]

14. In relation to advising about the possibility of death, the consultant said:

> "That had not been previously something I would routinely discuss … because it usually leads to, 'Well what is the risk? What is the number? What is the percentage? And that is unknown"[2]

15. Mr Toonson agreed that the risk of death should be discussed with patients and indicated that is now his practice.[3]

16. There was a variety of information as to the percentage of the risk of death. Mr Toonson said that only that day he had become aware that the risk might be as high as 5 percent. That was apparently from an application marketed to doctors. I was informed that surgeons at the Royal Darwin Hospital now generally consult such applications.

[1] Transcript p 75
[2] Transcript p 22
[3] Transcript p 22

17. However, Mr Keck, a colorectal surgeon, was less convinced about the accuracy of such applications or that the surgery carried that level of risk. He stated in speaking of the five percent risk:

> "I have not seen the evidence behind this calculation of death risk, although I understand that there are algorithms available to predict death based on outcomes of surgery in patients with various underlying comorbidities. My own opinion is that these algorithms are not always reliable.
>
> My advice to any patient undergoing right hemicolectomy would be that the risk of death after surgery would be less than 5% and probably closer to 1% or 2% based on data from the Bi-National Colorectal Cancer Audit Data which is compiled and published by the Colorectal Surgical Society of Australia and New Zealand."[4]

18. Mr Djawas saw the anaesthetist on 7 March 2017 at the pre-admission clinic. It was noted that he had "good exercise tolerance". His weight was recorded as 74.2 kilograms and his blood pressure 170/96.

19. The operation was undertaken by Mr Toonson and a Surgical Fellow, assisted by the Surgical Senior Registrar on 13 March 2017 between 10.20am and 2.00pm. Mr Djawas was in recovery until shortly after 4.00pm. By all accounts the operation went well. The ileo-caecal valve was found to have no malignancy. There was no polyp or tumour identified.

Recovery

20. There is no evidence to suggest that the surgeons spoke to the family after the operation, to assist in their expectations or the plan for his recovery. That appears to have contributed to how the family perceived what happened thereafter.

21. Mr Djawas arrived on the ward at about 4.30pm. His oxygen saturation levels dropped from 96% to 92% and he was provided oxygen initially with

[4] Report dated 29 March 2019 p 2

nasal prongs at 4 litres per minute and then a face mask at 6 litres per minute. His family visited him that evening until visiting hours finished.

22. The next morning (14 March) on the General Surgery ward round with Mr Toonson it was noted that his oxygen saturations were 94% on 4 litres with nasal prongs and his temperature was 37.8 degrees. Blood testing was sought and mobilisation encouraged.

23. Throughout that day his discomfort, abdominal distension and pain increased, and his oxygen saturations decreased. He was in respiratory distress. The impression was that he had an ileus (paralysed bowel). Mr Toonson explained an ileus:

> "An ileus is a functional problem where the muscles themselves aren't squeezing everything along. Everything like stuns and I just describe it to the patients as the muscles go on strike after surgery, from infection or from drugs, pain relief or anaesthetic drugs."[5]

24. On 15 March (day 2 post operation) he had a sore stomach, hadn't passed wind, vomited twice and remained on 6 litres of oxygen per minute with a mask. It was noted that he looked unwell.

25. On 16 March (day 3 post operation) his heart rate rose to 110 and at one point to 180. His blood pressure rose and the distension of his abdomen increased. His oxygen saturations were falling. At 8.30am it was thought he may have an anastomotic leak. A CT scan indicated gas throughout the bowel and collapse of the lung bases.

ICU

26. He was transferred to the intensive care unit (ICU). He was very drowsy. Throughout the day he was given two doses of methylnaltrexone to try and counteract the effect of the opioids he was being provided and Tazocin for hospital acquired pneumonia.

---

[5] Transcript p 28

27. The use of methylnaltrexone was questioned by one of the experts as potentially leading to a breakdown of the anastomosis. Mr Toonson said he had never heard of its use in any other hospital. A colorectal surgeon provided an opinion indicating there was no evidence that the drug was unsafe but there was also no evidence it was helpful.

28. The Director of ICU gave the following explanation for its use:

> "Methylnatrexone is a drug that is related to Naltrexone which is … used to reverse the effect of opiates in people who have become comatose from opiates and so on. Methylnatrexone is a different form of that drug so it does reverse the effect of opioids in some areas, and particularly the gut, but the way the molecule is it doesn't reverse the beneficial effects of opioids which are those to relieve pain.
>
> And Mr Djawas was on some opiates for his pain relief both before he came to ICU and during ICU and opiates are strongly associated with ileus after operation and constipation and failure of the gut to move. So the rationale was mechanistic in that the drug has been looked at in post-operative ileus. It doesn't appear to have a positive signal for benefit but there is no signal for harm, but on the balance that ileus is a multifactorial problem, it's got problems related to stress, to sepsis, to handling of the gut and to opioids and so on, that by administering that drug we deal with one small part of that equation … not in the over-belief that it was really going to be … a main player in the overall thing but trying to just give a little bit of support to all the different angles of ileus."[6]

29. On 17 March (day 4 post operation) his heart rate rose (140 – 190) and blood pressure increased (166/92). Mr Djawas felt his chest was being squeezed and was short of breath. His C-reactive protein (CRP) was 300, indicating infection. However, that afternoon he passed wind on three or four occasions and felt more comfortable. It was considered that the ileus was resolving.

30. At 7.30pm Mr Djawas woke confused and delirious. He pulled out his nasal gastric tube, his intravenous cannula and monitoring pads. He was provided

[6] Transcript p 65

an anti-psychotic and his family called. When his son arrived at 8.20pm Mr Djawas was no longer delirious. It was considered his delirium had been a side effect of the Tazocin. Thereafter he slept well.

Return to the Ward

31. By the morning of 18 March (day 5 post operation) his heart rate and blood pressure were back to normal. His oxygen saturations improved. He had two bowel movements. He got out of bed and was in good spirits. Blood taken at 5.50am indicated that his White Blood count (WBC) was in the normal range (6.0). He was transferred from ICU back to the ward early that afternoon.

32. On the ward, the plan was to get Mr Djawas to sit out of bed and mobilise as much as possible. That was necessary to assist his lungs. However, the need to mobilise had not been explained to the family. Mr Toonson said that explaining the need to mobilise to the family was ultimately, as the admitting surgeon, his responsibility. However, he went on to say that he had a team and that the communication would generally be expected to happen through the team. That team also included nurses. However he said:

> " … but I can understand that sometimes what nurses say or request is not given as much respect as what's said by a lead surgeon."[7]

33. The nurses were attempting to mobilise Mr Djawas. That led to a difference of opinion with his family on the evening of 18 March 2017. The family said he was still too unwell and weak. To exacerbate matters he had a bowel motion while on the way to the toilet on a commode chair. The family were very concerned at the embarrassment and perceived lack of dignity that followed. The family became angry.

34. On 19 March (day 6 post operation) Mr Djawas was noted to be feeling much better. His bowels had opened again and he was wanting to go home.

[7] Transcript p 29

35. On 20 March (day 7 post operation) it was noted that he was eating and drinking well and that his bowels were functioning appropriately. The plan was to aim for discharge in the next one or two days. At midday the physiotherapist noted that Mr Djawas was slowly improving, was still "below premorbid" and not safe for discharge.

36. On 21 March (day 8 post operation) the surgical team noted his blood pressure to be 180/80 and recommended that his Tazocin be continued for a further 2 days. Blood taken at 7.20am that morning indicated that his WBC was above normal levels at 13.6 (normal = 4 – 11). Mr Toonson said later that the raised WBC was a "missed red flag". He said it should have prompted a delay in discharge had he known. However, he said the surgical team did not communicate the blood results to him.

37. With the benefit of hindsight it is possible that if Mr Djawas had been kept in Hospital another day or two that may have assisted. However, the mere fact of the slightly elevated WBC was not considered by Mr Keck (colorectal surgeon) to be grounds for delaying discharge. He said:

> "Mr Toonson … mentions that his white cell count was elevated at the time of discharge at a level of 13. While I can understand that this is a cause for concern in retrospect I do not believe that an isolated elevation of the white cell count is enough to mandate deferral of discharge in a patient following right hemicolectomy. His CRP was noted to have fallen to a level of around 70 and in general this is suggestive of a very low risk of major sepsis or anastomotic leak following colorectal surgery."[8]

Discharge

38. On 22 March (day 9 post operation) at 7.55am it was noted that Mr Djawas would be discharged that day. Blood taken at 8.45am indicated his WBC to be 13.1. That result was also said to have not been communicated to Mr Toonson by his team.

[8] Report dated 11 January 2019, p 5

39. Mr Djawas was reviewed by the physiotherapist at 12.15pm. He said he was feeling well and was keen to go home. He was cleared for discharge by the occupational therapist at 2.30pm and at 8.30pm was noted to be waiting for his discharge medication. The medication was delivered to the ward and he was noted to leave in the company of his wife and son.

40. The point of discharge was in my opinion the point of the most crucial failure in communication. Mr Djawas had just had a major operation. One of the major risks of that operation was an anastomotic leak. Most leaks should they occur are said to happen in the first seven days. However leaks are known to happen after that time.

41. The family were given little information on his operation and no information on the ongoing risks and what the signs of a leak might look like. They were not told of the seriousness of a possible leak or of the potential for sepsis. They were not told of the urgency to bring him back to the hospital at a very early stage.

42. Despite the discharge taking over 12 hours, a discharge summary was not provided to the family. They were unhappy about the lack of paperwork and information and the lack of any organised follow-up. They contacted the clinic and the clinic then contacted the Community Care Nurses on 24 March 2017.

43. A Community Care Nurse visited Mr Djawas the same day, Friday 24 March 2017. The nurse told the family the wound was weeping a little and to keep an eye on it.

44. The discharge summary was not prepared until two days after discharge. On 24 March 2017 it was faxed to the referring general practitioner rather than being sent to the family. Relevantly it stated:

Discharge Care Plan:

1. You will be seen in the surgical outpatients clinic in the next 4 – 6 weeks for a review

2. There have been some adjustments to your medications

   – please continue to take the new medications as prescribed

   – take pain relief as needed.

If you have increasing abdominal pain, ongoing fevers or are otherwise unwell or concerned then please do not hesitate to see your GP or come into the ED.

45. On Saturday, 25 March 2017 Mr Djawas developed significant abdominal pain. In the opinion of Mr Keck and Mr Toonson, it is likely that was when the anastomotic leak commenced. The pain became progressively worse over the weekend.

46. The Community Care nurse visited again on Tuesday, 28 March 2017. She noted that the wound was gaping open and leaking purulent exudate (pus). She called the ambulance to take him back to hospital.

Re-admission

47. Mr Djawas arrived at RDH by ambulance at 11.36am. It was noted that he was complaining of a pus discharge from the wound site and pain to his legs. He was noted to be warm to the touch. His temperature was 38.1 and his respiratory rate 22. He was referred for surgical review. The surgeon diagnosed him as being septic and peritonitic. He was booked for a laparotomy at 10.00pm.

48. At operation it was found that the anastomosis had leaked and resulted in faeculent peritonitis. The leak was corrected and his abdomen washed out with warm saline solution. During the operation he became more unstable. It was clear to the surgeon that Mr Djawas was very unwell. The surgeon was of the view that his decline was driven by shock and a resultant ischaemic liver injury.

49. He was transferred from the operating theatre to ICU at 2.45am 29 March 2017. However he required increasing support. That afternoon an ICU consultant spoke to the family indicating that Mr Djawas was very sick and may die.

50. On the evening of the following day (30 March) it was explained to the family that Mr Djawas was at a high risk of dying in the next 12 – 24 hours. By the morning of Friday 31 March 2017 it was clear that Mr Djawas was in multi-organ failure due to septic shock from the anastomotic leak. That was explained to his family as well as the very high chance that he would die.

51. The surgeons had another relook laparotomy at 10.30am. It was thought that perhaps he had developed ischaemic bowel that was preventing recovery. However there was no further contamination or ischaemia.

52. That afternoon it was explained to the family that Mr Djawas was on maximum level support and there was a high chance he would die. At 10.25pm it was noted that his lactate levels were rising. The family were contacted and advised that they may wish to visit as it was unlikely that Mr Djawas would survive the night.

53. At 7.00am 1 April 2017 his heart rate was noted to be dropping (20 – 25 beats per minute) and his blood pressure was very low (40/20). His family were gathered around him. It was clear that he did not have long to live. With the agreement of the family, organ support was withdrawn. Mr Djawas died at 7.30am.

54. The cause of death was concluded to be multi-organ failure due to septic shock that was consequent upon faecal peritonitis due to anastomotic leak.

Issues

55. The circumstances of the death of Mr Djawas raise a number of issues:

    a. Whether the surgery should have been conducted;

b. Whether sufficient understanding of the options was given to Mr Djawas such that he could make a reasoned decision and thereby provide informed consent;

c. The level of communication with the family;

d. The almost non-existent level of information provided during the discharge process.

Indication for surgery

56. During the course of the coronial investigation my office obtained two expert reports that made comment on whether the surgery was appropriate. The first was from Professor Jonathan Fawcett. He is a Professor of Hepatopancreaticobiliary Surgery and Consultant Surgeon, University of Queensland and Director, Queensland Liver Transplant Service and Director of Surgery, Princess Alexandra Hospital. Professor Fawcett was of the view that proceeding to surgery was reasonable. He wrote:

> "The patient first presented with a positive faecal occult blood test and two colonoscopies identified a suspicious looking area at the ileocaecal valve although biopsies failed to confirm the presence of a suspected serrated adenoma. I think that this is not an uncommon clinical scenario and it still seemed reasonable to proceed with surgery as further endoscopic intervention was unlikely to have generated either further information or indeed have been able to treat the lesion had the presence of it been confirmed. Given that there was a positive occult blood test, then this perhaps adds weight to the indication for surgery."

57. The second expert report was from Mr James Keck a colorectal surgeon. He is the Acting Head of Colorectal Surgery at St Vincent's in Melbourne and the Clinical Director of Colorectal Surgery for Eastern Health in Victoria. He is also the immediate past President of the Colorectal Surgeons Society of Australia and New Zealand. In his opinion the issue was that there was insufficient reason for Mr Djawas to undergo the surgery. He thought that the pictures taken at colonoscopy did not indicate a tumour or polyp, the biopsies were normal as was the CT scan. He wrote:

"Mr Djawas had a +ve faecal occult blood test prior to colonoscopy and this was one of two tests, the other being –ve. It is well recognised that positive occult blood tests are falsely positive in at least 50% of cases and therefore the presence of a +ve faecal occult blood test did not, of itself automatically mean there was significant pathology in the colon. Mr Djawas underwent colonoscopy on 30th of September 2016 where a lesion was described as sitting on the ileo-caecal valve. This was described at one point as a mass lesion, although my impression of the photographs that are present in the record you have sent me indicates that there was prominence of the valve and no definite mass. Biopsies of this mass, in any case, showed normal colonic mucosa. After the first colonoscopy Mr Djawas had a trip overseas but was seen by outpatients in Royal Darwin Hospital where a C.T. scan was performed and this did not show any mass lesion or abnormality in the caecum. He underwent a further colonoscopy on 30th January 2017 and, once again, there was some prominence of the ileo-caecal but my impression of the photographs that have been provided do not indicate that this was a typical tumour. A description was given that the lesion was likened to a serrated adenoma but I think this cannot be determined by visual inspection and, once again, biopsies of the ileo-caecal valve showed signs of inflammation without any sign of polyp or adenoma. The signs of inflammation were labelled as tiflitus which is a very nonspecific diagnostic label for nonspecific inflammation or the region of the appendix and the caecum."[9]

"My assumption is that the surgeons managing Mr Djawas assumed that there must have been some sort of polyp or cancer present based on the macroscopic appearance of the caecum and ileo-caecal valve despite the fact that two sets of biopsies had not shown any evidence of any benign or malignant tissues. I think the results of these biopsies should certainly have given pause for thought along with the negative CT scan. I would have expected that if a benign or malignant neoplasm had been present between September 2016 and March 2017 then there would have been some sign of this on CT scan and some evidence of progression of the lesion at colonoscopy. In conclusion, therefore, I think that there were very weak grounds at best for recommending surgery in the case of Mr Djawas and I think he probably should have been treated expectantly with colonic surveillance of the right colon. I cannot see any real justification for subjecting him to a right hemicolectomy in this circumstance. In the statement of Dr Toonson he says that the patient was offered an opinion in Adelaide with a view to endoscopic mucosal resection of the presumed serrated adenoma that was thought to be present. Certainly, if he had been sent to the Royal Adelaide Hospital then I

[9] Report dated 11 January 2019 p 3

think colonoscopy performed there would have, once again, shown that there was no lesion present and would have confirmed the fact that there was no indication for surgery … I think that the decision to go ahead with surgery placed him at unnecessary risk."

58. When Mr Toonson was asked about the opinion of Mr Keck, he said:

> "I would like for him to have addressed the issue of bleeding in summarising." [10]

59. On that basis and prior to submissions I indicated that I would have my Office put that aspect to Mr Keck.

60. On 3 April 2019 my Office received a further report from Mr Keck dated 29 March 2019. He wrote in part:

> "In the highlighted area from Mr Toonson's evidence it is clear that he was concerned about the fact that the lesion observed in the caecum in Mr Djawas bled on the two occasions that it was observed at colonoscopy. The fact that this lesion bled is evidence that there was abnormality of the ileo-caecal valve region of the colon in Mr Ali Djawas. This was confirmed on the final pathology report of the right hemicolectomy specimen which showed non-specific inflammation and a suggestion of possible mucosal ischaemia. Mucosal ischaemia refers to a lack of blood flow through the lining of the bowel.
>
> Mr Toonson refers to the fact that he was concerned about the potential for ongoing bleeding and therefore in the long run the risk of anaemia developing. He acknowledged that no anaemia had developed to date, although iron studies have not been undertaken. The patient's haemoglobin level was normal prior to surgery, however I accept that this was a factor in the decision making in relation to recommending right hemicolectomy for Mr Djawas. I think the real significance of this bleeding, however, was that it continued to raise suspicion in the mind of Mr Toonson that there may be some sort of underlying tumour which had been missed.
>
> …
>
> I believe that if pathology had been adequately reviewed in a multidisciplinary meeting then it is highly likely that surgery would

[10] Transcript p 48

> not have been recommended for Mr Djawas, particularly as his final pathology showed no evidence of any benign or malignant tumour.
>
> …
>
> In summary, I still believe that the evidence for recommendation of surgery in the case of Mr Djawas was not strong and that a reasonable option would have been to avoid surgery and continue with colonoscopic surveillance in the absence of any evidence of either a benign polyp or a malignant tumour."

61. The view of Mr Keck in that report was accepted by Top End Health Service and Mr Toonson who indicated that faced with a similar scenario he would "take a conservative approach and seek the input from a colorectal multidisciplinary team meeting prior to recommending right hemicolectomy".[11]

Understanding the Options

62. There were a number of aspects that impacted the level of understanding Mr and Mrs Djawas may have had about the options.

Language Barrier

63. The first was the potential barrier that having English as a second language posed. The family of Mr Djawas say that he understood that he was having a polyp out. They say he did not (and nor did they) understand that he was having a large part of his colon removed. They say that he thought it was a minor surgical procedure.

64. Enquiry should have been made by the doctors as to Mr and Mrs Djawas' level of understanding. Commendably, Mr Toonson has reflected on that issue. He said:

> "I always make an effort to ensure that they know, the patients and whoever is in the room with them, what's being said. But I think on reflection of this case, obviously I'm wrong sometimes, and I think a way of testing is perhaps asking them to explain back to me what

[11] Submissions on behalf of Top End Health Service provided 11 April 2019

> procedure they are having. But until then, me simply asking 'do you understand?' … or 'do you have any questions or concerns?' That is obviously insufficient." [12]

65. There was also a ready mechanism on the "consent form" to prompt a discussion about understanding. The very first area on the form relates to "Interpreter's requirements". The question posed is whether interpreter services are required. That was ignored.

66. It is not ideal that the process by which patients consent to potentially risky operations is recorded on a single form. That particular form is minimal and makes use of tick-a-box to even further minimise the effort required to record the consent. However even the minimal requirements of that form were not completed as intended.

67. Top End Health Service makes no effort to ensure that the forms are completed correctly. They are not checked or audited. That is not an insignificant issue. The Health Service employs the doctors, it provides indemnity to the doctors and it provides the forms it expects to be completed. Presumably, Top End Health Services understands the potential consequences of failing to obtain appropriate consent.

Warning of Material Risks

68. The second barrier was the lack of information. There was insufficient information for Mr and Mrs Djawas to properly evaluate the options available.

69. The level of information and warnings that must be provided by doctors to patients has long been understood. It is 27 years since the High Court of Australia decided the case of *Rogers v Whittaker* [1992] HCA 58. In that case the Court determined that a 1 in 14,000 risk of developing sympathetic ophthalmia and losing the sight in the patient's one remaining good eye was

[12] Transcript p 26

a risk of which the patient should have been made aware by the doctor. The High Court stated:

> "The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."[13]

70. The only exception to that was stated to be therapeutic privilege. That is, where the provision of information poses a serious psychological threat to the patient. It is difficult to imagine such a situation arising in an elective context.

71. In this case the Surgical Senior Registrar said that she would have given a general warning:

> "I would have said that there is always a small risk whenever someone goes onto the table … But nowadays, that risk is quite small."[14]

72. However that was not a warning that drew a distinction between the differing risks of ongoing colonoscopies, endoscopy and a major operation.

73. Mr Djawas had a right to know that the risk was significant. So did his wife. As I said during the course of the Inquest:

> "If you're going to have a sit down with the patient and the spouse it makes a mockery of it if the spouse can't understand. You want to make sure both of them can understand. I might agree to a 1:20 chance of an operation, but I suspect my wife would belt me and say no." [15]

---

[13] *Rogers v Whitaker* [1992] HCA 58 at paragraph 16
[14] Transcript p 75
[15] Transcript p 116

74. The guidelines issued by the *National Health and Medical Research Council* (NHMRC) state:

> "Doctors should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare."

75. All patients would attach significance to the risk of dying. It is therefore a material risk.

76. Without information about the varying risks of the options, there was really nothing between the options other than the "peace of mind" the surgeons indicated that the operation would bring. Perhaps because of that Mr Djawas turned to the medical professionals for a recommendation.

Communication with the family

77. There must be a distinction drawn between the first and second admissions. During the second admission, although the family perceived that there was insufficient communication there was a great deal of communication detailed in the medical notes. It is likely that by that stage the family were still trying to understand what had gone so drastically wrong. That may have affected their ability to absorb the communication that it was likely their father would die.

78. During the first admission the communication was clearly lacking. There is no evidence of any meaningful communication by the surgical team with the family. The family were particularly unhappy about the lack of communication after surgery, after transfer from ICU and on discharge.

Discharge

79. The failure to communicate properly with the family on the day of discharge is likely the most proximate omission having a direct connection with the death of Mr Djawas.

80. It is likely that neither Mr Djawas nor his family were inclined to return to the hospital unless it was necessary. That had a lot to do with their perceptions of his treatment to that point. However, if the family had been properly informed on his discharge it is much more likely that he would have returned to the hospital at a time when he had a better chance of survival.

81. The failure to provide to the family even a discharge summary added to the absence of meaningful information.

Institutional Response

82. After the death of Mr Djawas and despite the evident issues, Top End Health Services did not undertake a review. There was very little reflection at all. The institutional response for the Inquest was provided by Dr Charles Pain. He holds the positions of Executive Director of Medical Services and the Executive Director of Clinical Governance for the Top End Health Services.

83. It was said that the death of Mr Djawas was discussed at the Surgical Morbidity and Mortality meeting (M&M) on 5 April 2017. No documentation was provided in support of that assertion. However, during the Inquest Dr Pain provided a document that indicated the death of Mr Djawas was discussed on the Surgical Grand Rounds on 11 April 2017. The note stated:

"Issues discussed were:

- A second opinion was discussed with another surgical colleague about the best treatment for the patient;
- The patient was presented with lots of different treatment options of which going down south was one;
- The patients previous admission and whether there were any signs of potential complications i.e. the atelectasis from the ileus and the

patient's stay in ICU for 48 hours and whether he was discharged too early (however his WCC was normal, he was opening his bowels and tolerating diet).

The Surgical division has collated the surgical Consultants into areas of specialty which this case supports."

84. Dr Pain indicated that the Inquest provided an opportunity to undertake a more extensive review. He undertook that review himself and provided a statement of 127 paragraphs and 25 annexures.

85. He concluded that:

- The decision to operate was reasonable;[16]
- Communication with the family regarding his surgery, plans for mobilisation and discharge was insufficient;[17]
- There was a breakdown in the relationship that may have influenced Mr Djawas in not wishing to return to hospital despite becoming unwell at home;[18]
- The breakdown was at least in part due to shortcomings in communication by nursing staff;[19]
- The clinical notes had gaps;[20]
- Patients and their family need sufficient instruction and resources to enable care at home following discharge. That was not documented in any of the notes.[21]

[16] Paragraph 82
[17] Paragraph 87
[18] Paragraph 88
[19] Paragraphs 94 and 117
[20] Paragraph 95
[21] Paragraph 96

86. It was obvious that the review by Dr Pain recognised many of the shortfalls in communication. There was however an initial unwillingness to concede that insufficient information was provided to Mr Djawas and his wife to enable a reasoned decision as to whether to undergo the operation. In addition there was a seeming attachment to the idea that Mr Djawas had been told he could go south for a second opinion when that was clearly not the case on any version.

Comment

87. Mr Djawas died after having unnecessary elective surgery. The primary reason for having the surgery was because his surgeon held a sincere belief that it was the best option for him. It is likely that if the surgeon had taken the case and the pathology results to a multi-disciplinary team the surgery would not have been recommended.

88. Mr Djawas was given insufficient information about the respective risks of the various options to be able to distinguish the benefits and detriments of each of the options for himself. He therefore relied on the recommendation of the surgeon.

89. Obviously if he had not had the surgery he would not have died following an anastomotic leak. However, having the surgery did not inevitably lead to his death. The surgery appeared to have been undertaken in a competent manner. His problems immediately after surgery were dealt with in a skilled and proficient manner in ICU. He was recovering well until a few days after discharge when he developed the anastomotic leak.

90. However, he did not return immediately to hospital. Had he done so he may well have survived the leak. He did not return to the hospital primarily because there was very little or no information provided to the family on discharge from the Hospital. There was no appreciation as to the very real possibility of the development of a leak and sepsis.

91. They were not told the extent of the operation, they were not told that half his colon had been removed. They were not told that the join might leak. They were not told what to look for and they were not told the seriousness of the situation if he developed symptoms suggestive of a leak.

92. The family were not given a discharge summary. Even if it had been prepared and given to them on that day, it did not contain the information necessary to recognise the possibility of a serious deterioration. It indicated that he would be reviewed in 4 to 6 weeks and in the meantime he could be taken to a GP or the Emergency Department if his condition deteriorated.

93. The family did not understand that the pain he experienced was unexpected. By the time the Community Care Nurse saw Mr Djawas four days after the leak commenced it was likely too late.

94. I find it worrying that the death of Mr Djawas did not prompt a review by Top End Health Service. Reviewing such cases is necessary for continual reflection and improvement. If the death of a person such as Mr Djawas after elective surgery, does not prompt a review, one wonders what would. In the case of such deaths it is not necessary that I conduct an Inquest. I do so as a matter of discretion.

95. However if the institution is unwilling or unable to conduct adequate reviews and families do not have their concerns treated seriously, then it is more than likely that these matters will continue to be dealt with through Inquests.

96. This is not the first time communication issues have been identified as issues at the Royal Darwin Hospital. On 21 September 2018 I delivered findings in relation to two deaths, those of Mr Fensom and Mr Wilson. Communication was a central issue in both of those Inquests. However, in this case those issues played a rather more central role. The lack of proper communication on discharge may well have led directly to this death.

Formal Findings

97. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased is Ali Achmadun Djawas, born on 28 May 1946 in Kupang, Indonesia.

(ii) The time of death was 7.53am on 1 April 2017. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was multi-organ failure due to septic shock consequent on faecal peritonitis due to anastomotic leak following an elective laparoscopic right hemicolectomy 13 March 2017.

(iv) The particulars required to register the death:

1. The deceased was Ali Achmadun Djawas.
2. The deceased was Indonesian.
3. The deceased was retired.
4. The death was reported to the Coroner by the Royal Darwin Hospital.
5. The cause of death was confirmed by Dr Sarah Jones.
6. The deceased's mother was Masturah Djawas and his father was Achmadun Djawas.

Recommendations

98. I recommend that Top End Health Service ensure that an appropriate assessment is undertaken of the needs of patients and their support persons for interpreter services prior to the provision of options for treatment and warnings as to risks of procedures.

99. I recommend that Top End Health Service do all such things to ensure that patients are properly informed of the risks of procedures and that documentation relating to those communications and consent is properly completed and regularly audited to ensure compliance.

100. I recommend that the Top End Health Service ensure that appropriate communication is had with patients and supporting family members when discharged. That communication should at a minimum include a written discharge summary.

101. I recommend that the Top End Health Service ensure objective reviews of all deaths arising in the context of elective surgery, are undertaken. That such reviews consider and record reasonably appropriate recommendations for ongoing improvement.

Dated this 16 day of April 2019.

_____

GREG CAVANAGH
TERRITORY CORONER