CITATION: *Inquest into the death of Irene Magriplis* [2017] NTLC 008

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FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**High risk elective surgery, inadequate medical treatment, inadequate resources at Darwin Private Hospital, inadequate escalation procedure, no internal review, referral to Medical Board**

REPRESENTATION:

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

No. D0080/2015

In the matter of an Inquest into the death of

IRENE MAGRIPLIS
ON 30 MAY 2015
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Irene Magriplis died of sepsis caused by bile leaking into her abdomen after elective surgery at the Darwin Private Hospital. The surgery was to remove a growth adjacent to her bile duct. At the time, Mr Treacy, the surgeon was of the opinion that this elective surgery was necessary. He now concedes it was not.

2. There were many points at which the bile leak should have been addressed. It was not. She should not have died. In my view her death was preventable.

3. The autopsy revealed that this 75 year old woman was healthy in every respect excepting for the results of the operation. That knowledge has only increased the trauma to her loving family.

4. Throughout her admission to hospital her family constantly raised with hospital staff her pain and the "burning inside her abdomen". It is not the first time as Coroner I have been told of people ably describing their symptoms to the medical fraternity only to be ignored. In this case her abdomen was awash with bile. The doctors at the hospital did not take the time to properly investigate her symptoms until it was too late.

5. She was in such pain after the operation that she was kept in recovery for five hours. Thereafter she constantly spoke of the extreme pain she felt, the burning in her abdomen. One can only imagine the frustration of Mrs Magriplis and her family.

6. At 7.30am on the morning after the operation her body went into septic shock. Her blood pressure dropped to 72/38. In the Royal Darwin Hospital that would result in a "Code Blue" emergency response. Not in the Darwin Private Hospital. The 'rapid response' policy there is to call the surgeon (who was performing other operations at the time).

7. Her surgeon stated that had he known the full facts as to the drainage from her abdomen overnight he would have taken her back to the theatre immediately. But he said he did not know the facts. He did not take the time to investigate. He had a long theatre list that day commencing at 8.00am.

8. It was another five and a half hours before Mrs Magriplis was transferred to the Intensive Care Unit at the Royal Darwin Hospital and only then after her blood pressure dropped to 70/30 and her respiration rate and oxygen saturation reached critical levels.

9. After completion of his theatre list Mr Treacy reviewed Mrs Magriplis at 6.50pm and then again at 8.00pm that evening.

10. He felt at that stage she had a quarter chance of death but decided against reoperation. It was not until she deteriorated further that he reoperated at 2.00am the next morning and repaired a broken stitch which had resulted in a three millimetre hole from which bile was leaking. By that time it was too late. Her organs shut down and she died.

Background

11. Irene Magriplis was born 6 June 1939 in Kalymnos, Greece. She came to Australia in 1959. She was married soon after to Pantelis Magriplis and they had four daughters; Marina, Evone, Maria and Panormitisa (Tina). She was

the matriarch of the family and a grandmother. She was looking forward to attending the weddings of three of her grandchildren in August 2015.

12. On 9 February 2015 she attended on her General Practitioner, Dr Glynatsis. She had abdominal pain, nausea and mild jaundice. Blood tests and a CT scan were arranged. Due to an abnormally dilated common bile duct an endoscopic retrograde cholangio-pancreatography (ERCP) was recommended.

13. Her General Practitioner referred her to Mr Treacy, a General Surgeon in Darwin. Mr Treacy saw her on 20 February 2015.

14. Mrs Magriplis did not have a good command of English and took her daughter, Marina to the appointment to translate.

15. The procedure was performed on 25 February 2015. Mr Treacy found a "fleshy tumour" in the common bile duct. A stent was inserted into the common bile duct during the procedure and a biopsy performed.

16. The biopsied sample showed only chronic inflammation. There was no evidence of malignancy. Mr Treacy reported to her General Practitioner that he had booked Mrs Magriplis for another ERCP and removal of the stent on 15 April 2015.

17. On 5 March 2015, Mrs Magriplis along with her husband and daughter saw Dr Glynatsis. He said in evidence:

> "I said to her 'I prefer if there was any further treatment regarding surgery, that we proceed to a hepatobiliary unit down south'. And I made that again known to her when I saw her on 5 March. I did recommend that further surgery should be conducted elsewhere … I agreed that she really needed to go interstate to a proper unit to have it further treated, because of the problems that can occur."[1]

[1] Transcript p.65

18. The second ERCP procedure was carried out on 15 April 2015. Mr Treacy removed the stent and undertook further biopsies. Mr Treacy wrote to the General Practitioner stating:

> "If the repeat biopsies do not show a neoplasia I recommend interstate transfer for endoscopic ultrasound as I am suspicious of an adenoma or possible small carcinoma".

19. The report on the biopsy specimens indicated a suspected ampullary adenoma with low grade dysplasia, but no malignancy.

High Risk Surgery

20. I heard evidence during the inquest from a Hepatobiliary, Pancreatic and General Surgeon, Dr Anubhav Mittal. He works at the Royal North Shore Hospital, Sydney and regularly undertakes both complex and simple hepato-biliary and pancreatic procedures. His unit performs the highest number of pancreatic resections in New South Wales.[2] He is also Conjoint Senior Lecturer in Surgery at the University of Sydney. I found him to be a very knowledgeable and impressive witness.

21. He gave evidence that a surgical resection of an ampullary lesion is high risk surgery. He said:

> "Any operation that involves either the ampulla or the pancreatic duct or the pancreas is high risk because you can suffer catastrophic consequences of either things going wrong on the table or as in this case, things not going well in the post-operative period. So therefore it is high risk surgery. You can get pancreatitis. You can get leak from the joins. The pancreatic enzymes digest fat, protein and sugar and we are made of fat, protein, sugar, so they could end up digesting adjacent blood vessels etcetera. So for all of those reasons, any surgery of the ampulla or the pancreas is high risk."[3]

22. He said such cases should be discussed with a multi-disciplinary team where all imaging and investigations are presented. He said:

[2] Transcript p.53
[3] Transcript p.54

> "It's not just my opinion, but it's also in the AGITG (Australasian Gastro-Intestinal Trials Group) guidelines, published in the MJA (Medical Journal of Australia), for example, that a multidisciplinary meeting made up of experienced HPB surgeons, radiologists, oncologists, ideally even gastroenterologists are required, not to deliver care, but to help in decision making when it comes to these complex cases".[4]

23. Importantly, he said that such an operation should only be carried out in an adequately resourced hospital. Such a hospital would have a minimum of an intensive care unit (ICU) and 24 hour access to gastroenterology and interventional radiology.

24. I was told that Darwin Private Hospital, where the surgery was to be carried out, does not have an ICU. It does not have the resources for a multidisciplinary team and it does not have 24 hour access to gastroenterology.

25. On 27 April 2015 Mr Treacy saw Mrs Magriplis once more. Her husband and daughter were with her. Mr Treacy explained to Mrs Magriplis that she had a pre-malignant tumour and recommended resection. He said that without treatment she could get recurrent jaundice and the lesion could turn cancerous.

26. He told her it needed to be removed within 3 months. Her daughter told Mr Treacy that her mother was to attend three weddings of her grandchildren in August and asked if it could wait until then. Mr Treacy said it could not but that he would make an earlier date so that she would be fully recovered by August.[5]

27. Her husband said that he would like to get a second opinion from down south. He told Mr Treacy that their General Practitioner had suggested that it was best to go down south for the operation, preferably to Melbourne.

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[4] Transcript p.54
[5] Transcript p.80

28. Mr Treacy said words to the effect of:

> "Why do you need to drag your wife down south, when I can do the operation here. I have not done many operations similar, but I have in the same area. I am very confident the operation would be successful".[6]

29. The daughter of Mrs Magriplis translated those words. Mrs Magriplis then said to Mr Treacy in broken English, "I trust you with my life".

30. Mr Treacy then brought out the 'consent form'. He said to me that he told Mrs Magriplis the risks of the surgery. The family say that is not so. They say he asked Mrs Magriplis to sign the blank consent form saying that he would complete it later.

31. The procedure was noted on the form as "Trans Duodenal Resection of Ampullary Adenoma". The risks were noted as "Bile/Pancreas leak. Infection, DVT".

32. Mr Treacy did not tell Mrs Magriplis that the surgery was high risk. He did not tell her that the hospital was not properly resourced for such an operation. He did not tell her that he did not have access to a multi-disciplinary team. He did not tell her that she might die from the procedure.

33. It is therefore unsurprising that she was happy to consent to the surgery without the benefit of the second opinion urged upon her by her General Practitioner and family.

34. On that same day, Mr Treacy wrote to the General Practitioner stating:

> "I have explained to Mrs Magriplis that she has a pre-malignant tumour and I am recommending resection. Without treatment she will get recurrent jaundice and the lesion can turn into cancer. Hence I have scheduled her for laparotomy and transduodenal resection of ampullary adenoma on the 27th May at the Darwin Private Hospital. The operation will take about three hours to do and she will be one

[6] Transcript p.81, 126 Mr Treacy gave evidence that he has done 4 or 5 such operations since 1997 (Transcript p.122)

week in hospital with up to four weeks full recovery. I indicated that I am aiming for cure. She is aware of the potential risks of bile or pancreas leak at surgery."

35. If he had a multidisciplinary team Mr Treacy might have undertaken more testing before coming to the conclusion that such high risk surgery was required. After excision of the tumour, the histopathology showed that there was no dysplasia or invasive malignancy.

36. If surgery had been required Mr Treacy might also have been advised to undertake a less invasive procedure such as an endoscopic resection. Dr Mittal told me that this was the appropriate operation in the circumstances and accompanied by less morbidity.

37. On 27 May 2015 surgery commenced at 10.16am. The procedure was completed at 1.11pm. Mrs Magriplis was then moved to the Recovery Unit (Recovery).

38. In Recovery the staff struggled to get Mrs Magriplis' pain under control. She was given Fentanyl and Paracetamol intravenously. Eventually it was decided that the Patient Controlled Analgesia machine was not working.

39. During the time she was in surgery and Recovery her family waited outside. They couldn't get any information on how Mrs Magriplis was going. Eventually they were told that she would have to stay in Recovery until her pain was under control.

40. At 3.45pm another machine was obtained to provide the Patient Controlled Analgesia. By 6.00pm it was decided that Mrs Magriplis could leave Recovery.

41. When she was eventually wheeled out, Mrs Magriplis told her daughter that she had extreme abdominal pain. She said she was burning inside, not feeling well and not breathing well. She looked pale. She was taken directly to the High Dependency Unit (HDU).

42. The HDU was an area on the ward with three beds that were monitored by one nurse. The nurse was a Registered Nurse but had no special training in intensive care procedures and no training for working in the HDU.

43. The family stayed in the HDU area while their mother was settled. She continued to complain of feeling nauseous, having extreme abdominal pain, being thirsty and burning inside. She was given Maxolon for the nausea and vomited.

44. The family noted the abdominal drain. There was light coloured, blood like fluid at the top of the drain and a thick discharge beneath. They spoke to the nurse about it. The nurse then spoke to a supervisor. However they were not given an explanation as to whether that was significant or not.

45. The family were told they couldn't stay overnight. Throughout the night Mrs Magriplis was kept on oxygen therapy of two to three litres per minute. Her respiratory rate was fairly constant until midnight. After that it became more erratic, dropping to 15 breaths a minute at 2.00am and then rising to 27 breaths per minute at 4.00am.

46. The observations were recorded on an "Adult General Observation Chart" (Chart). The Chart was of the "track and trigger" variety. It had a white area indicating normal observations bounded first by a yellow zone and then a red zone after that.

47. The instructions to the Chart stated that the yellow zone indicated the need for a clinical review. The following was in capitals, "IF A PATIENT HAS ONE (1) OR MORE CLINICAL REVIEW CRITERIA PRESENT, YOU MUST CONSULT PROMPTLY WITH THE NURSE IN CHARGE AND ASSESS WHETHER A CLINICAL REVIEW IS NEEDED …"

48. One of the actions then required was the recording of repeat observations within 30 minutes.

49. At 4.00am the recording of 27 breaths a minute was in the yellow zone. There is no indication in the notes or on the chart that any action was taken including the taking of repeat observations within 30 minutes.

50. Indeed the very poor state of the recording in the medical notes generally (from nurses and doctors) is a significant issue in this case, as will become apparent.

51. The nurse on the shift from 9.00pm until 7.00am left one entry in the notes. It was at 4.15am. It stated:

> "NSG: Settled. Awake at times overnight. IVT continues. Art line insitu, IDC draining concentrated urine > 30mls\hr. IV Panadol attended. Tolerating ice. PAC attended. NIL concerns voiced ATOR, NGT on free drain. Dressing dry & intact. 1 x redon insitu. Care per pathway."

52. The 'consciousness' scores dipped into the yellow zone from 11.00pm to 7.00am with the exception only of 4.00pm when the recording was in the normal zone. No concern was noted.

53. If the "pain scores" on the Chart are to be believed Mrs Magriplis had no pain until midday on 28 May 2015. However they are clearly not correct. They do not accord with the evidence from the family. They do not accord with the recollection of the anaesthetist, or at times the pain scores on the Patient Controlled Injector sheet.

54. The last observations taken by the night shift nurse were at 6.00am. At that time all but the 'consciousness' scores were in the normal zone.

55. The morning shift nurse arrived at 7.00am. After receiving the handover she told me that she would have called the doctor because the drain was full and "de-vacced". She said he told her to change it. There is no note about the colour of the fluid.

56. The family arrived back at the HDU at about 7.00am also. Mrs Magriplis told her family she was still experiencing extreme abdominal pain and was

burning inside. The anaesthetist, Dr Harbison came by on his morning rounds. He said everything was fine.

57. At 7.30am the nurse took the first set of observations for that shift. She found that the blood pressure of Mrs Magriplis had fallen from 120/60 at 6.00am to 72/38 at 7.30am. That was deep into the red zone on the chart. Oxygen saturations were in the yellow zone at 93% despite being on 3 litres of oxygen per minute, her heart rate had risen sharply from 80 beats per minute to 100 beats per minute (albeit still in the normal zone). The nurse did not record other observations on the chart.

58. I heard evidence from Dr Charles Pain, the Executive Director of Medical Services at the Royal Darwin Hospital, that those observations at the Royal Darwin Hospital require a Code Blue to be called. A Code Blue is the highest emergency escalation for a patient.

59. The instructions to the Chart state that the red zone is the "Rapid Response" zone. The Instructions for that zone advise (in capitals):

> "IF A PATIENT HAS ONE (1) RAPID RESPONSE CRITERION PRESENT, CALL FOR A RAPID RESPONSE …"

60. The further instructions state at point 4, "Repeat observations every 5 minutes until the team arrives".

61. What that means seems clear on a reading of it. However it became a point of some confusion at the inquest. The General Manager of the Darwin Private Hospital, Dr Joanne Seiler, gave two different versions. She filed a statutory declaration on 3 March 2017 explaining what it meant:

> "The system at DPH requires that where a patient exhibits one (1) or more of the base clinical review criteria, protocol for the initiation of a 'clinical review' must be initiated. This requires contact and reporting to the patients VMO. More serious indicators are identified as 'rapid response' criteria. If this is indicated a 'Rapid Response

> Call' or "Code Blue" is called which mobilises the RDH Rapid response team."[7]

62. However in evidence Dr Seiler told me that if the observations went into the yellow zone the protocol was to call the RMO (resident medical officer) and when it fell into the red zone the protocol was to call the VMO (visiting medical officer). However, there is nothing in the policy documents that makes that clear. On a document titled "Rapid Response Criteria" various criteria are set out. At the foot of the page the following is written:

> "Immediately contact:
>
> RMO OR
>
> Admitting surgeon, Physician or Obstetrician (VMO)
>
> In the event of a cardiac or respiratory arrest call a Code Blue immediately as per the Darwin Private Hospital protocol "

63. If that is indeed the escalation protocol it leaves patients at the Darwin Private Hospital as having an inferior escalation response to those in the Royal Darwin Hospital.

64. The system is also unlikely to be consistent with the *National Standards on Safety and Quality in Health Care*. Standard 9 requires escalation and rapid response systems "capable of delivering specialised, timely emergency assistance to patients whose condition is deteriorating".

65. In this case the nurse called Mr Treacy (the VMO). He attended for a review. It is not known exactly when he reviewed Mrs Magriplis because there is no time against his entry in the medical notes. However he had a lengthy theatre list that day and he indicated in evidence that due to that his attendance would have been before 8.00am.

66. On review, Mr Treacy noted that Mrs Magriplis was thirsty, in pain and had moderate naso-gastric bile output and a small volume of 70ml bile stained

[7] Paragraph 34

fluid in the abdominal drain. He directed fluids for rehydration, chest physiotherapy and asked that blood be sent off for testing (the results not expected for some hours). Mr Treacy then went to theatre leaving Mrs Magriplis in the care of the nurse.

HDU

67. I heard from the three shift nurses that staffed HDU for the time Mrs Magriplis was there. The nurses were no longer working at the Darwin Private Hospital. Two of the nurses left to work at the Royal Darwin Hospital and the other at the time of the inquest, Registered Nurse Kelly Lawton, was working at Westmead Children's Hospital. She provided the following evidence:

> "Most of the patients that we had in the HDU unit wouldn't necessarily go into other HD units in other hospitals. They would still necessarily be nursed on a ward, just with a lesser patient load. So our HD unit didn't always function as an actual HD unit. It was just closer monitoring overnight and during the shift.
>
> Q. So what you're saying is that it probably shouldn't be classed as an HDU in the normal sense?
>
> A. Yes.
>
> Q. Just a place for higher observations?
>
> A. Yes.
>
> Q. That was your understanding, was it, when Mrs Magripilis was there?
>
> A. Yes.[8]
>
> Q. During your time at Darwin Private Hospital did anything change in relation to the staffing or operation of HDU that you observed?
>
> A. There was lots of staffing changes. Nobody really wanted to work in there. It originally had a manager then that got taken away

[8] Transcript p.36

and got absorbed back into the ward and run through the ward's manager.

Q. Why didn't people want to work there?

A. We just - most of us didn't feel safe in a three bed room by yourself. People forget you're there and sometimes when you do need help, it sometimes gets hard to get help."[9]

68. The *College of Intensive Care Medicine of Australia and New Zealand Guidelines* recommend that a nurse in charge of the HDU have post registration qualification in intensive care. None of the three nurses on the three shifts while Mrs Magriplis was in the HDU had such qualification.

69. Dr Seiler signed a second statutory declaration on 7 March 2017 (the second day of the inquest) after hearing the evidence of the nurses. In that declaration she said that nurses allocated to HDU required advanced clinical skills and that Darwin Private Hospital had competency based packages available to teach and assess the skills of the nurses. However no packages, completed by the nurses, were attached. The one nurse that was able to be asked about that package (because she was recalled) told me that she had seen it around but didn't believe she had ever completed it or signed it.

70. The staffing of HDU also seemed at odds with paragraph 11 of the Darwin Private Hospital *High Dependency Unit Procedure Manual* which states:

> "The unit will be staffed by two HDU trained Registered Nurses and the DPH RMO at all times. The nursing staff will work on a ratio of 1:2 and this will be influenced by patient acuity".

71. The evidence was that there was only one nurse for three patients and the RMO was only available if called.

72. Within Table 2 on page 10 of the *High Dependency Unit Procedure Manual* are the "Core Nursing Skills Required in the HDU". One of the required skills is "Management of fluid balance". It requires:

[9] Transcript pp.38 & 39

"Accurate input and output recording. Ability to recognise and respond to fluid imbalance."

73. The nurses on those three shifts appeared unable to properly and accurately write up the Fluid Balance Sheet. For the entries in the Fluid Balance Sheet on 27 May 2015 there were no progressive totals for either the intake or output. If the object of the sheet is to determine the fluid 'balance' then that creates a significant issue.

74. Various entries were clearly in the wrong columns and on two occasions figures were written and then crossed out, but no further entries made. On 28 May 2015 there were no outputs noted for the drain excepting for the entry at 7.00am where it stated "400 – change drain".

75. The nurse told me that she wrote the progressive totals for that day including those after midnight (those before she came onto her shift). Those totals take into account the 400 millilitres on the change of the drain, but no other amounts from the drain. Not even the 70 millilitres that Mr Treacy saw just before 8.00am. No hourly amounts were recorded on the Sheet after midnight other than the 400ml.

76. I also heard from Dr Charles Pain that the HDU was unlikely to comply with the *College of Intensive Care Medicine of Australia and New Zealand Guideline.* To comply, a High Dependency Unit must be geographically part of the intensive care complex of the hospital and be operationally linked to the ICU.[10]

Failure to Recognise Fluid Draining from Abdomen

77. Mr Treacy told me that had he been aware there had been 400 millilitres in the drain overnight he would have taken Mrs Magriplis back to the theatre for reoperation immediately. If he had done so, the reoperation would have occurred 18 hours earlier. The failure to recognise that the drain had been changed is therefore of crucial importance.

[10] Pain para 56

78. At that point in the evidence I asked Dr Treacy the following question:

> "So am I to take it, if it was on the chart and you didn't look at the chart - you've made a crucial error - or if it wasn't on the chart the nurse has made a crucial error? Is that right?

79. Mr Treacy answered, "Yes".[11]

80. He said he did not see the notation of 400 millilitres in the Fluid Balance Sheet on his review that morning. That may have been the case. The nurse told me that it would have been written along with the other observations at the end of the hour. That was 8.00am. It is therefore possible that she wrote it shortly after Mr Treacy had reviewed Mrs Magriplis and left for the operating theatre.

81. That raises a significant issue: If a nurse writing on the Fluid Balance Sheet is the only system ensuring that the deteriorating condition of Mrs Magriplis was recognised and treated appropriately, the system is unsafe.

82. Of course part of the system is the hourly updates to the Fluid Balance Sheet. If they had been done there would have been hourly amounts in the drain, more easily seen and detected.

83. The nurses told me there was another system. They said that the drain couldn't be changed without a direction from the treating doctor. The nurse that came on shift at 7.00am told me that she would have phoned Mr Treacy. With the intervening period neither she nor Mr Treacy could recall that specific phone call. If the call was made, one might have expected Mr Treacy to recall it thirty or so minutes later when he saw Mrs Magriplis.

84. However, also on the Fluid Balance Sheet from the night before was 280 millilitres in the "drain" column made up of a number of entries recorded prior to midnight.[12] One might think a doctor looking at the Sheet and seeing

[11] Transcript p.137

[12] Mr Treacy disputes that all of these figures should have been in that column (email to Paul Maher dated 5 February 2017). However should they have been sighted they

no notations for the last 8 hours might look over the page, the more so given the rapid deterioration of Mrs Magriplis.

85. The other system in place was the track and trigger system requiring an escalated response. However, as mentioned, that was ineffective.

Communication

86. If the VMO, the anaesthetist and the nurse were the "rapid response team" as the General Manager would have me believe, they apparently didn't communicate as a team on the rapid deterioration of Mrs Magriplis. That might have been because they were not together in the one space at the one time. Or it might be that Mr Treacy was on his way to doing other things. Or, that they simply didn't see themselves as a "rapid response team".

87. Nevertheless, one would anticipate there should have been discussion with the nurse. That would have assisted the investigation into the shock that Mrs Magriplis was clearly suffering. Mr Treacy did not appear to turn his mind to the possibility of septic shock despite bile being in the drain and despite bile leakage being one of the noted risks of the surgery. He sought no tests be done to determine whether Mrs Magriplis was suffering from sepsis.

88. He thought it more likely hypovolemic shock (although he also checked for cardiogenic shock). Her pain was 8 out of 10. He told the family the pain was due to the surgery and that she should keep pressing the button for her pain. The daughter of Mrs Magriplis told me that by that time she was too weak to press the button.

89. Mrs Magriplis continued to complain of the extreme pain she was in and the burning she was experiencing inside her lower abdomen. Her daughter told me:

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would have alerted Mr Treacy to the fact that the 70mls was not the total drainage since operation.

> "She never stopped telling me she was in pain. Never. The whole time from the start to – they put her to sleep. Her words were always, 'I'm in pain Marina. I'm burning. I'm tired,' and I kept telling her, 'It will be okay, Mum'."

90. One might ask what further or better description was required that her abdomen was awash with bile. She was in shock. She was in agony and telling the doctor she was burning inside.

91. The frustration of the family was immense. It was still present when telling the story in court. Marina described how the pleas of her mother were continuously ignored and brushed aside by the doctors and nurses.

Deterioration

92. The blood pressure of Mrs Magriplis stayed in the red zone until 9.30am. It then began to rise. By 10.00am her blood pressure had risen sufficiently to be in the "normal" area of the Chart.

93. However at 11.00am her oxygen saturations dropped into the red zone and by 12.00pm her blood pressure was once more in the red zone along with her respiration rate. At the time Mr Treacy was still in the operating theatre. He told me that he communicated through his anaesthetist in the theatre (who could take the calls).

94. The nurse called Dr Harbison. She said he gave her support. He prescribed Fentanyl for pain. But there was no rapid response. There was no Code Blue.

95. At 12.25pm Mr Treacy left the theatre and at 12.30pm conducted a review. The note relating to that review is not where one might think it would be amongst the other medical notes. It is on a separate sheet in the part of the file that related to the ERCP day procedures. That may indicate that the review was not at the bedside.[13] The note states:

> "Low BP 70/30, Low urine 30 ml/hr & dark colour – Thirsty

[13] The family of Mrs Magriplis did not see Mr Treacy in HDU at that time.

JVP ?2-3cm

ASSESS – Frail, [words difficult to decipher]

PLAN Albumin 500 ml/hr, CXR

If fails to respond, may need inotropes (in RDH)

Fast please"

96. There was no mention of the drain. At that time it is likely there was more bile stained fluid in the drain. When Mrs Magriplis was admitted to ICU the Royal Darwin Hospital notes state, "Drain – bile stained drainage 150mls (Mr Treacy aware)". Mr Treacy told me those words mean he was told.

97. Mr Treacy ordered more fluids and a chest X-ray. He seemed not overly concerned at that time, although thinking that her blood pressure might need to be supported by inotropes (not available in HDU). He continued with his theatre list until 5.56pm.

98. When asked whether at that time he would have looked at the Fluid Balance Sheet, he said:

> "I've asked myself this question and that 400 was in the chart and I only identified it was there months later so I must not have looked at the chart and seen it or else it was not written in the chart at that time because I was not aware until months later that the drain bottle had been changed and that there was 400mls. So I don't know whether it was that I didn't look at the chart or whether it wasn't written there. As I have indicated, I would look at those charts."[14]

Transfer to ICU

99. Dr Harbison however spoke to staff at the ICU sometime after 12.30pm. The time is not known because there is no note of the call. However after that call the ICU Registrar arrived to examine Mrs Magriplis. She was soon thereafter transferred to ICU. The timing of when that happened is not at all certain. The documents state that she was discharged from Darwin Private

[14] Transcript p.137

Hospital at 2.40pm. However there is an admission note in the Darwin file at 2.30pm. The notes of the initial investigations in ICU were written up at 3.45pm.

100. The best timing is probably from the nurse in the HDU who told me she started writing up her notes of the shift, before handing over the Darwin Private Hospital file, at 1.10pm. She did so while at ICU awaiting the admission of Mrs Magriplis.

101. On arrival at ICU Mrs Magriplis was still in pain with a pain score of 5-6 out of 10. She was commenced on a noradrenaline infusion to support her blood pressure, antibiotics for the sepsis and due to her rapidly falling oxygen levels, even on 100% oxygen, she was intubated and ventilated at about 6.00pm.

102. Dr Mittal wrote in his expert report:

> "At 1530 day 1 post-op when the patient was transferred to the Intensive Care Unit at Royal Darwin Hospital, she had normal liver and renal function but had worsening circulatory and respiratory failure. She had upper abdominal pain and difficulty breathing. These facts combined with the presence of bile in the abdominal drain should have prompted an immediate return to theatre for suspected biliary peritonitis and a leak from the duodenum or small bowel elsewhere as difficult adhesions had been divided in the first procedure."

The CT Scan prior to 8.00pm

103. After the review at 6.50pm Mrs Magriplis was sent for an urgent CT scan of her abdomen and pelvis. Dr Mittal told me that was unlikely to assist because what is looked for is free gas and free fluid that would ordinarily be indicative of a perforation or leak. But in the first post-operative day there will be both free gas and free fluid in the abdomen. That is the normal response of the body after surgery. He also said that it was potentially

damaging because it was exposing an unwell patient to contrast agent that was nephrotoxic and may damage the kidneys.[15]

104. Mr Treacy reviewed Mrs Magriplis at 6.50pm and then spoke to the family. He told them that she would be taken for a CT scan and depending on the results of that she may need to be taken back to the operating theatre for a "wash out of her abdomen".

105. The CT scan results were at best ambiguous. They did not rule out a bile leak but did not confirm one. By the time Mrs Magriplis returned from the scan her temperature was 38.1 degrees.

Continued failure to identify drain volume

106. When asked whether that review was an opportunity to see the notation of the 400ml in the Fluid Balance Sheet, Mr Treacy stated:

> "I do not believe - and I am quite certain of this - that the Darwin Private Hospital notes were with the patient at that time."[16]

107. He was asked what confirmed to him that was the case. He said:

> "You can appreciate that she had come to the intensive care unit and I was trying to catch up with all that I had been hearing by telephone in the operating theatre that afternoon leading up to and during and after her transfer, so I was getting second-hand information relayed. I would then want to make my own individual assessment of all of the information, and I can recall being frustrated that I could not do that."[17]

108. Due to those answers I had the nurse from the HDU recalled. She told me she took the original file over and wrote her notes in it while waiting the admission of Mrs Magriplis to ICU.

[15] Transcript p.57
[16] Transcript p.138
[17] Transcript p.139

109. I also heard evidence from Panormitisa, one of the daughters of Mrs Magriplis. She said she saw the nurse take the Darwin Private Hospital notes to ICU.

110. I have no doubt that the Darwin Private Hospital file was available to Mr Treacy in ICU.

Review at 8.00pm

111. At 8.00pm Mr Treacy reviewed Mrs Magriplis again. He was of the opinion that she was suffering pancreatitis and bilateral chest infection. He did not consider there was any benefit from reoperating. He sought a second opinion from another surgeon. However he did not request a review. He telephoned the surgeon and provided the facts as he saw them. One of those facts was that there was no bile in the drain.[18] The surgeon agreed with Mr Treacy that there was no indication to reoperate.

112. Dr Mittal wrote in his report:

> "The volume of bile in the abdominal drain can be unreliable as drains can get blocked or drainage can be positional. Therefore, the decision not to take the patient to theatre at 2000 should not have been based on the volume of bile that had come out of the abdominal drain.
>
> Temperature elevation or not is irrelevant at this juncture, and the worsening condition of the now critically ill patient should have, yet again prompted a return to theatre.
>
> In my opinion, the decision to return to theatre was delayed and the reasons given for this delay are not justifiable."

Reoperation

113. Mr Treacy reviewed Mrs Magriplis again at 1.20am (29 May 2015). At that time he gave consideration to "the possibility of abdominal inflammation from bile leak".[19]

[18] Statement of Dr Ruth Hardstaff
[19] Statutory Declaration of Mr Treacy dated 12 October 2015 paragraph 30

114. She was taken back into theatre at 2.00am. Mr Treacy found a 3 millimetre hole in the duodenum and bile throughout the abdomen. He said of the earlier operation:

> "I put in several stitches, one of those stitches and I don't know why, either came undone, or cut through, or for whatever reason at one point at one location within the bowel, the duodenum, there was a gap and bile was leaking from that gap at the site where a previous incision had been made in the bowel."[20]

115. He closed the hole and washed out the abdomen. He left the abdomen open in the expectation of repeating the wash out.

Death

116. However, it was too late. Mrs Magriplis continued to deteriorate and went into multi-organ failure. At 11.30am that morning a meeting was held with the family and the very poor prognosis was explained.

117. The family sought second opinions. They were provided and it was confirmed that there was nothing that could be done at that point to save the life of Mrs Magriplis. She died at 11.30am the following day, 30 May 2015.

118. An autopsy was performed by Dr John Rutherford. In his opinion she died of "septic complications following surgical resection of duodenal ampullory adenoma".

RESPONSES

119. The responses to the death of Mrs Magriplis by both Mr Treacy and the Darwin Private Hospital are deserving of comment.

Mr Treacy

120. On 12 October 2015 Mr Treacy made a statutory declaration about his involvement in the care and treatment of Mrs Magriplis. The declaration was

[20] Transcript p.122

primarily a recount of the events. In that declaration he wrote:[21]

> "I reviewed Mrs Magriplis at 8.00am on 28 May 2015 in the High Dependency Unit. I noted she was thirsty, in pain. No cough. I noted moderate naso-gastric bile output and a small volume of 70ml bile stained fluid in the abdominal drain overnight."

121. He wrote also about the assessment of Mrs Magriplis on admission to ICU:[22]

> "There was a total of 150ml of bile stained fluid present in the abdominal drain since operation."

122. Both of those statements are incorrect because to each there needs to be added the 400mls that was in the drain changed between 7.00am and 8.00am on the morning of 28 May 2015. Mr Treacy told me that it was months after the death of Mrs Magriplis that he first became aware of the 400ml of fluid.[23]

123. On 20 April 2016 Mr Treacy's lawyer responded to the expert report of Dr Mittal. The letter from the lawyer was presumably on instructions.[24] In that letter at paragraph 13, the following was stated:

> "There was only a very small amount of bile (70ml) in the drain that appeared within several hours of the patient returning to the ward after the operation, and was noted by Mr Treacy the following morning. There was minimal if any further bile stained fluid out of this abdominal drain thereafter."[25]

124. Mr Treacy made another declaration on 6 March 2017. He did not mention that his earlier declaration and the letter from his solicitor were in error. He did not mention that he had discovered that there was 400ml of fluid changed just prior to his arrival at HDU on the morning of 28 May 2015. He did not mention that it was of such significance that if he had seen it in the

[21] Paragraph 21
[22] Paragraph 25
[23] Transcript p.137
[24] Indeed it was later confirmed that paragraph 13 was written by Mr Treacy.
[25] Paragraph 13

chart he would have immediately taken Mrs Magriplis back to the operating theatre.

125. When the nurse gave evidence on the first occasion (she was later recalled) she said she changed the drain because it was full and fluid immediately ran into the fresh drain. Mr Treacy's Counsel, Mr Miles Crawley, did not cross-examine her about changing the drain or the 400ml entry in the Fluid Balance Sheet.[26]

126. On 8 March 2017 Mr Treacy was led through his evidence-in-chief by his Counsel. Mr Treacy did not mention during that evidence that his previous statements were misleading and incorrect or that he had discovered the notation on the Fluid Balance Sheet.

127. It was not until Counsel Assisting asked him specifically about the evidence of changing the drain that Mr Treacy told me that he hadn't seen the notation of the 400ml at the time and he believed if it was there he would have seen it.

128. In submissions Counsel Assisting criticised Mr Treacy for his failure to disclose such a crucial fact at an earlier point in time.

129. At the end of the submissions by Counsel for Mr Treacy I invited him to specifically address those criticisms. The following exchange took place:

> "CORONER: No, no, don't sit down. So as between the nurse and Dr Treacy in terms of credibility, what am I to make of Dr Treacy's responses in two affidavits and one long detailed letter no doubt on instructions to Mr Maher where at no stage until yesterday afternoon does he mention dramatically the liquid?
>
> MR CRAWLEY: Sir, Dr Treacy has explained what he did and why he did it. He's not sought to deflect the blame by saying someone didn't tell me something and had I known I would have done something different. That's essentially that situation.

[26] Transcript pp.48-51

THE CORONER: Treacy's saying he dramatically realised two months later. There's no doubt about it, he realised how important that was.

MR CRAWLEY: Yes.

THE CORONER: There's not even a hint on anything in all his responses until yesterday afternoon about it. What am I to make of that? Counsel Assisting says effectively that it goes to his credibility. Have you got a response or not?

MR CRAWLEY: Yes, I have. I say Sir that Dr Treacy was responding by saying what he did and why he did it. To the extent that you're investigating his conduct, that is his response.

THE CORONER: Thank you.

MR CRAWLEY: He said what he did and he's said why he did it. Now without seeking to make excuses saying well if someone had told me something different I would have done something different, he accepts the failings insofar as his conduct was concerned and he indicates how he's changed his conduct and in my submission, that's as far as it needs to go."

130. It went further. The following day Mr Maher, the solicitor for Mr Treacy, sent a letter to Counsel Assisting. The letter in part stated:

"I enclose with this letter a copy of a letter emailed to me by Mr Treacy on 5 February 2017, written shortly after he had had the opportunity to examine the coronial file and the first tranche of supplementary documents received from your office, which I had posted to him on a USB on 20 January 2017. This was the first time he had seen the fluid chart entry referring to 400mls in the drain. You can see that Dr Treacy was very surprised to see what was on that chart and that this was for him a most significant issue. Subsequently, these events occurred:

1. In the week prior to the inquest Dr Treacy met with me and counsel. Uppermost in Dr Treacy's mind was the fluid chart and the reference to 400mls of fluid. He told us, as he later confirmed in his evidence, that he would routinely check these charts if they were available, but he was certain he had not seen that entry. He was personally wanting these matters to be put to the coroner.

2. My advice to him was that it would be inappropriate to press before the coroner the view that one or more of the nursing staff had failed to make a timely entry in the fluid chart, or that they had failed to ensure the chart was available for Dr Treacy to check when he attended Mrs Magriplis, or that they failed to draw his attention to something as important as the changing of the drain.

3. I pointed out that a coronial inquest is not a civil claim, the coroner is not interested in allocating blame, and he is unimpressed when parties attempt to do so.

4. My advice was therefore that the significant fact for the coroner was that Dr Treacy believed there was only a small amount of bile in the drain, and that should be his evidence-in-chief. If in cross-examination, the fluid chart became significant, then it would be appropriate to openly and comprehensively deal with the matters Dr Treacy had raised, but that would be preferable to doing so in chief as it would (or should) then not be seen as attempting to allocate blame.

5. Had Mr Treacy had his way, he would have raised the fluid chart in his evidence-in-chief with alacrity. It now appears that my advice had achieved exactly the opposite result to that which was intended, but Dr Treacy should not be blamed for that. I can absolutely assure you that Dr Treacy did not fail to speak of the fluid chart in his evidence-in-chief through a desire to conceal it and to avoid allegations that he may have erred.

6. I also ask you to reflect upon Dr Treacy's answers in cross-examination. As soon as you mentioned the fluid chart he openly stated that it was a matter which had been causing him great concern. He did not hesitate to agree with His Honour's suggestion that this meant that either he or the nurses at DPH were at fault. He did not in any way downplay the significance of the entry and he did not attempt to enter into a debate about who was to blame, notwithstanding that his evidence was that he would have noticed it had it been available to him."

131. It is a most unusual course to provide such further evidence and submissions after the inquest, especially as Counsel for Mr Treacy was asked to deal with those very issues in the inquest. However given that my findings may have a significant impact on Mr Treacy I believed it appropriate to consider the letter and attached email.

132. It is sought that I accept that Mr Treacy in not disclosing his discovery about the 400ml was simply trying to shield nurses from being blamed or perhaps shield himself from looking as if he was blaming the nurses or both.

133. It is an interesting proposition. It seeks to join, as if inextricably linked, the failure to detect the fluid and the blame of the nurses. Yet just the day before his Counsel had not linked them. He had told me that Mr Treacy was not making excuses and accepted his errors.

134. What Mr Treacy said he discovered was that Mrs Magriplis had a significant amount of fluid draining from her abdomen 17 hours after the operation. At the point he is said to have discovered it, he had already made declarations that were factually incorrect.[27]

135. If the discovery of the fluid was not linked to blaming the nurses there was no reason not to rectify the incorrect declarations. If the discovery was linked then I am asked to accept that he chose to leave those incorrect declarations as part of the record before me rather than blaming the nurses.

136. I note the advice to Mr Treacy was to be open with his answers only "if" the fluid chart became significant. I find it difficult to accept that he did not correct those false accounts for fear only of laying blame on the nurses.

137. Even on the most favourable view of the facts (for Mr Treacy) there are significant issues. The most favourable view would be that the nurse failed to seek permission to change the drain and didn't write up the Fluid Balance Sheet until after Mr Treacy had seen Mrs Magriplis just prior to 8.00am on 28 May 2015.

138. However, there is no doubt that at that time the notations in the 'drain' column of the Fluid Balance Sheet had been made up to midnight. The notations in the drain column added up to 280ml. The last entry at midnight

[27] Although the time when he said he made the discovery was variously 'months' or 21 months after the death of Mrs Magriplis.

is 70ml. Before that was 10ml at 9.00pm, 20ml at 8.00pm, 80ml at 7.00pm and 110ml at 6.00pm. There are other figures before that and they may or may not relate to the drain.

139. It is not possible that Mr Treacy saw those notations and continued to hold the view that the 70ml he saw in the drain was the total amount since the operation.

140. That leads to the likelihood that Mr Treacy did not view the Fluid Balance Sheet when he saw Mrs Magriplis on the morning after the operation. He must have assumed that what he saw in the drain was the total since the operation. On a favourable interpretation, perhaps he felt entitled to make that assumption because he hadn't received a call about changing the drain.

141. Having said that, the weight of the evidence is that the nurse did seek permission from Mr Treacy to change the drain. The nurses on the night and day shifts were adamant that a drain would not be changed at the Darwin Private Hospital without seeking the permission of the surgeon. The nurse on the day shift conceded that she couldn't recall making the call almost two years after the event but insisted she would have done so. I accept her as a frank and honest witness.

142. In circumstances where Mrs Magriplis was clearly in shock and Mr Treacy was directing more fluids be given one might think failing to look at the Fluid Balance Sheet less than ideal.

143. The failure to look at the Fluid Balance Sheet clearly continued even when writing the statutory declaration for the coronial investigator on 12 October 2015 and the letter from his lawyer on 20 April 2016.

144. He also cannot have looked at the nursing notes on those occasions because at 1.10pm on 28 May 2015 the nurse wrote in the notes these words:

> "Reardon drain changed as bottle was full & had de-vacced."

145. One of the interesting aspects in relation to the email from Mr Treacy to his lawyer is his conclusion after his discovery. He stated:

> "Had I noted 400 in the chart, or seen 400ml in the drain, I would have been more concerned and noted the fact."

146. That was written on 5 February 2017, a month before the inquest. On 8 March 2017 he told me unequivocally he would have taken Mrs Magriplis straight back to theatre. That is clearly a significantly more urgent response than being more concerned and making a note.

147. It may well be that it has taken Mr Treacy sometime to come to the conclusion that Mrs Magriplis should have been taken back to the theatre immediately. Perhaps it was not fully formed on 5 February 2017. It might also suggest that if he saw or knew about the 400ml on 28 May 2015 he may not have given it the attention it deserved.

148. However, it should also be said that by the end of the inquest Mr Treacy had accepted many of the errors made. The final submissions of his Counsel were appropriate and significant given the responses prior to that time. He stated in part:

> "There are a number of points that if something had been identified or done differently the outcome may have been affected …
>
> The very first thing is the initial diagnosis of the nature of this growth. It is tragic that we know that despite having been believed to have been a malignant or pre-malignant tumour, in fact from tests done after it was removed, in fact it was neither. And that is a very major thing. If that had been identified at the outset then the procedure undertaken would not have been undertaken … it was not a situation where because of the potential for cancer it needed to be a complete removal to make sure it was all got and would not recur. What we have is a situation, there were two ERCPs as you know. The first one found chronic inflammation, nothing more but noted the word of caution that the biopsy may not be entirely representative. So it was repeated.
>
> In fact in both of those endoscopies Dr Treacy noted the appearance of the tumour which to him seemed pre-malignant or malignant. You

may recall he made reference to the friability of the tumour which made him suspect cancer and that guided to a large extent the actions thereafter.

The biopsy that was taken of the second – on the second ERCP was reported as being a suspected ampullary adenoma and basically that confirmed that we are dealing with a pre-malignant or if not a malignant tumour. And that was what guided Dr Treacy.

Now we know that was wrong and Dr Treacy knows that was wrong. Dr Treacy told you how at the time there was no histopathologist in private practice in Darwin but the tendency – that the usual practice was for surgeons to send their path samples off to Perth to be assessed. That had he had a local person he could have spoken to and more importantly could have actually have viewed the slides themselves to determine what he was dealing with.

Now we have the advantage that that now has changed and there is such a pathologist in Darwin. So at that point if the same procedure happened again there would be that additional material to help make that original diagnosis accurate. That's the first step.

But the point simply is that there is now present in Darwin another specialist with whom he can consult and there indeed has been set up a multidisciplinary team from different specialities that can discuss the case with as well.

And the significance of that is that he will have the benefit of other people's experience and views rather than purely his own assessment as supported as he saw it by the pathology results. So that's a positive improvement in relation to the situation in Darwin as it is at the moment.

The next question is that of second opinion. Dr Treacy's evidence was that he said to the patient that they of course are entitled to seek a second opinion but he recognises the way in which he expressed himself was discouraging of that course and that was inappropriate and not his intention. So that although Mrs Magriplis was very keen to have it in Darwin, the way in which he expressed himself encouraged her in that belief rather than giving her a more balanced assessment of the question of a second opinion. So that is an area again where he recognises a shortcoming and he recognises an improvement is required in terms of dealings with his patients and explaining those aspects."[28]

[28] Transcript pp.210-212

149. It is gratifying those insights were gained through the course of the inquest and they were put so honestly and frankly.

150. What is so striking about the treatment provided to Mrs Magriplis, however, is that at almost every point, it was problematic as noted in the following paragraphs.

The failure to undertake sufficient testing to determine whether the high risk surgery was required

151. Doctor Mittal told me that in his practice they would have asked for an endoscopic ultrasound. He said that procedure provides information on the dimensions of the tumour and can also be used for a fine needle aspiration that would again confirm whether it was cancerous or not. He said:

> "The advantage of the fine needle aspiration is that we can get a deep ultrasound guided biopsy so you know exactly where you are targeting and that you indeed have good tissue samples. The other option, if you suspect the lesion involves the common bile duct, we would ask for a spy glass, which is a fibre optic examination. And that can actually look into the bile duct, visualise the lesion and then take a more substantial biopsy."

152. Mr Treacy turned his mind to seeking an endoscopic ultrasound through a gastroenterologist in Adelaide. However after the results of the second ERCP he did not believe that it was required. His decision in that respect would have been assisted greatly by the involvement of a multi-disciplinary team.

Failing to form or consult a multidisciplinary team about the diagnosis and manner in which to proceed with a high risk and complex case

153. In the *Medical Journal of Australia* on 4 May 2015 there was an editorial on the rise of pancreatic cancer. The following was stated:

> "An avenue to optimise outcomes for patients is to ensure that all receive high-quality care in the most appropriate setting … it is thus important that all patients without metastatic disease are reviewed by a multidisciplinary team in a major centre to determine the resectability of their pancreatic tumours. In addition, resections

> should be performed in hospitals that carry out a large number of these procedures annually, as this has been shown to improve survival."[29]

Failure to inform Mrs Magriplis of the risks

154. The information that doctors are required to give patients is governed by the law and detailed in guidelines issued by the *National Health and Medical Research Council* (NHMRC). Those guidelines include the following:

> "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."[30]

155. The information to be given includes:

> "other options for investigation, diagnosis and treatment, the degree of uncertainty of any diagnosis arrived at, and the degree of uncertainty about the therapeutic outcome."[31]

156. The failure to inform Mrs Magriplis of the options available for diagnosis, the high risk involved in the surgery and the other options available to Mrs Magriplis to mitigate those risks played a key role in the eventual outcome.

Dissuading Mrs Magriplis from seeking a second opinion

157. The Code of Conduct for medical practitioners states that good medical practice involves (among other things):

> "Supporting the patient's right to seek a second opinion."[32]

158. The NHMRC guidelines also state:

> "The doctor should … allow the patient sufficient time to make a decision. The patient should be encouraged to reflect on opinions, ask more questions, consult with the family, a friend or advisor. The

[29] MJA 202(8) 4 May 2015 p402
[30] p.11
[31] p.11
[32] 2.2.8

patient should be assisted in seeking other medical opinion where this is requested."[33]

159. The dissuasion of Mrs Magriplis is particularly difficult to understand. It was clearly to her advantage to obtain treatment where the high risks could be appropriately mitigated.

Undertaking the high risk surgery in a hospital without the resources to mitigate those high risks

160. Not only was the Darwin Private Hospital not a hospital that fitted the description of a hospital that did a large number of similar operations annually, it did not have a multi-disciplinary team, an ICU or gastroenterology.

Failing to properly investigate the fall of her blood pressure to critical levels on the morning of 28 May 2015

161. Mr Treacy was called to review Mrs Magriplis between 7.00am and 8.00am on 28 May 2015 because her blood pressure had dropped to a critical level and was in the red zone (the rapid response criteria) of the track and trigger Chart.

162. Mr Treacy noted that her blood pressure was less than 100, that she was in pain and that she had bile in the drain.

163. We know now that at that time Mrs Magriplis was in septic shock. Even at the time however, there was sufficient reason to investigate whether that was the case.

164. When asked whether obtaining blood gas would have been appropriate, Mr Treacy said:

> "I was concerned that she had low blood pressure and I was interested in her response. I did not request a blood gas because my - because I was relying upon the blood results to give me a result

[33] p.12

within, I would hope, two or three hours. I was not looking at wanting a result within five minutes."

Failing to identify the amount of fluid drained from her abdomen

165. The Fluid Balance Sheet was at the foot of the bed on a table. Mr Treacy is unlikely to have looked at it for the reasons already noted.

166. The nurse was in attendance when Mr Treacy was in the HDU. It must follow that it is also unlikely that he spoke to her about the fluid levels.

167. The seeming failure to look at the Fluid Balance Sheet or talk to the nurse about the fluid balance remains perplexing.

Failing to take Mrs Magriplis back to the operating theatre until it was too late

168. Mr Treacy said that had he recognised the 400ml and the change of the drain he would have taken Mrs Magriplis back to theatre immediately. However, even without that, there were significant signs that Mrs Magriplis should have been taken back to theatre.

169. Dr Mittal stated:

> "Look, its not unheard of that in the early post-operative phase there may be a leak of bile or pancreatic juice from an anastomosis, from a join. However, if that occurs, which clearly it did in this case, and was indicated by bile present in the drain, then the course of action depends on how the patient is doing. So if the patient is doing okay and doing well, you would follow a conservative approach, because you don't want to jump back and make things worse. However, if the patient is not well, and is clearly developing first systemic inflammatory response syndrome, followed by multi-organ dysfunction syndrome, you want to intervene early so you can, one, see and improve the situation, two, wash things out, and three, provide wide drainage."

170. Dr Mittal indicated that the time at which Mrs Magriplis should have been returned to theatre was after transfer to the ICU when it was noted she had worsening circulatory and respiratory failure:

> "These facts combined with the presence of bile in the abdominal drain should have prompted an immediate return to theatre."

Failing to call for a Rapid Response Team at 12.30pm when the blood pressure, respirations and oxygen saturations of Mrs Magriplis all fell into the red zone

171. It was plain that the improvement in blood pressure after the administration of fluids at 8.00am had only been temporary. When Mr Treacy reviewed Mrs Magriplis at 12.30pm she had deteriorated further.

172. However Mr Treacy continued to persist with providing more fluids. He did however indicate that if that was not successful she would need to be taken to the Royal Darwin Hospital and wrote "fast please" as an indication that she may need to go back to theatre.

173. However by that time she was in a critical condition, not only was her blood pressure failing once more but her respiratory function was failing. In the Royal Darwin Hospital a Code Blue would have been called (for the second time). A Code Blue was not called at any time. Dr Harbison did make a call to ICU and the Registrar was sent over to review Mrs Magriplis.

Attending to other patients during 28 May 2015 while Mrs Magriplis deteriorated

174. On the first occasion Mrs Magriplis' blood pressure fell into the red zone Mr Treacy attended. It is not known for how long. But he then went to operating theatre leaving Mrs Magriplis in the care of a nurse with no specific training for HDU or ICU.

175. The nurse was able to call Dr Harbison and she said he provided her with good support. However that is significantly different than a Rapid Response Team or the care that Mrs Magriplis would have received in ICU should a Code Blue have been called.

176. On the second occasion that Mrs Magriplis' blood pressure dropped she was clearly very unwell and deteriorating and yet again, Mr Treacy was content to leave her with the nurse.

177. This is not a case of a single error or even a series of errors. The whole care and treatment of Mrs Magriplis appears flawed from the beginning and at each significant step thereafter.

Darwin Private Hospital

178. The Darwin Private Hospital provided their formal response to the Coronial Brief of evidence at 4.50pm on Friday 3 March 2017. The inquest began the following Monday. That was in the context of the General Manager of Darwin Private Hospital being advised of the inquest on 25 August 2016. On 2 February 2017 lawyers for the Darwin Private Hospital requested a copy of the coronial brief.

179. The response provided on 3 March 2017 was a statutory declaration by the General Manager of the Darwin Private Hospital, Dr Joanne Seiler. She indicated that throughout her career she has held positions as an academic, Clinical Nurse Manager, Director of Operations and Director of Nursing. She said she has been involved in the management of Hospitals and Health Services for over twenty years and had a doctorate in Business Administration.[34]

180. Paragraph 4 of her declaration was in these terms:

> "DPH is one of the forty eight (48) hospitals operated by Healthscope Limited (Healthscope). Healthscope is committed to the provision of optimal private health care for residents of Darwin and the Northern Territory. Healthscope prides itself on patient centred care. We strongly support transparent public reporting of healthcare quality data, and inquiry into the treatment and management of individual patients."

181. Paragraph 28 stated:

[34] Paragraphs 1& 2, Statutory Declaration dated 3 March 2017

> "DPH is committed to providing the highest quality of care to patients. To achieve this reviews are conducted of all sentinel events, requirements for escalation of care to another facility and mortality by a Patient Care Review Committee."

Sentinel Event

182. Attached to the declaration were 27 annexures. One of them, a Healthscope Policy titled, "Incident Management-Patient". In that Policy "sentinel event" was defined:

> "Sentinel Event – An Event in which death or serious physical or psychological harm to a patient has occurred or may occur. An adverse outcome that has the potential for a medical malpractice claim and/or Coronial case."

183. In that same Policy it was stated:

> "Near Miss, Incident and Sentinel Event identification, notification, management, analysis and sharing of lessons learnt are an integral component of the Healthscope safety and quality and risk management program."

184. Another Policy titled "Sentinel Event Management". Under "Procedure" at point 6 of the Policy stated:

> "A Root Cause Analysis (RCA) if applicable, or Critical Systems Review, is to be conducted in compliance with Healthscope Policy 2.02."

185. A copy of Healthscope Policy 2.02 was not provided. However a diagram at page 9 of the Sentinel Event Management Policy noted that a "Riskman" entry went to the General Manager who directed the RCA or Critical Systems Review that was then fed into a shared learnings report and from there to the Risk Register.

186. On 16 January 2017 Counsel Assisting sent a letter to the General Manager of Darwin Private Hospital. It stated:

> "Could you please provide a copy of all documentation (including letters, emails and reports):

1. Prepared due to the death of Irene Magriplis; and

2. Submitted to Healthscope head office in relation to her death."

187. There was no response to that request. The General Manager was asked about that when giving evidence. She provided a 'Riskman' report and confirmed that was the only document fitting the request. There was no Root Cause Analysis. There was no Critical Systems Review.

188. I asked her why that was so when the policy clearly defined the deterioration and death of Mrs Magriplis as a sentinel event. She initially said it was because, "Mrs Magriplis did not die in the Darwin Private Hospital".[35] When I pointed out that the place of death was not part of the definition, I was told it was because Healthscope did not classify the death of Mrs Magriplis as a sentinel event. Dr Seiler provided the following evidence:

> "The risk man that we submitted is reviewed by Healthscope and it was not defined as a sentinel event".
>
> Q. I'm sorry, who does the defining?
>
> A. The National Risk Quality Manager.
>
> Q. And why does the National Risk Quality Manager do the defining?
>
> A. It's their job."[36]

189. It was disappointing that Healthscope was willing to allege that they conduct reviews into all sentinel events in the very case they did not.

190. As I have often said, the Coroner's Court is not a court of perfection. Most people at some time fall into error. But having recognised the error it is important that it not be repeated. To ensure that, there must be a review performed seeking to understand why the systems permitted the errors and where improvements can be made.

[35] Transcript pp178,179
[36] Transcript p.179

191. As has been noted above, in this case there was not just one error. There were many. Some were specific to the Darwin Private Hospital. For instance, there was very little control over what was done by VMO's in the hospital, poor note keeping, apparent failure of communication between the doctors and nurse, failure to have an adequately resourced HDU and failure to have an adequate escalation policy.

Sub-optimal Care

192. However, Healthscope seemed unwilling to recognise any lack of care or error. The General Manager of Darwin Private Hospital insisted in her evidence that the treatment provided to Mrs Magriplis at the Darwin Private Hospital had been "optimal":

> "Q. Do you believe that Ms Magriplis obtained optimal private health care from the Darwin Private Hospital?
>
> A. In relation to the care that we provided Ms Magriplis in the time that she was with us we provided optimal care. It is unfortunate the result but the care that we provided I believe was optimal."[37]

193. Similarly, when asked about the Darwin Private Hospital escalation policy of calling the doctor compared to the Royal Darwin Policy where a Code Blue would be called:

> "Q. As a system, is the Darwin Private Hospital system less robust than the Royal Darwin Hospital system?
>
> A. I don't know the Royal Darwin system that well, so I can't compare. I can say that within our hospital this is the policy that we have and we followed it on this particular day.
>
> Q. Do you think …that if a Code Blue had been called it would have been more optimal private health care than simply calling the VMO and the anaesthetist?
>
> A. I can't – I can't comment on that."[38]

[37] Transcript p.175
[38] Transcript p.187

194. Eventually there was some concession from Dr Seiler. When asked about the pain levels of Mrs Magriplis, the poor note keeping by the doctors and nurses, the apparent poor communication levels between the doctors and nurses and the poor state of the Fluid Balance Sheet she agreed that was sub-optimal and in the case of the latter probably lead to sub-optimal care.[39]

Royal Darwin Hospital

195. Dr Charles Pain the Executive Director Medical Services, Clinical Governance and Health Systems Improvement for the Top End Health Service provided a statutory declaration dated 27 February 2017. In contrast to the Darwin Private Hospital he acknowledged that a review should have been undertaken and provided information as to the lessons that might be learned.

196. I thank Dr Pain for his thoughtful and helpful evidence. He stated in his conclusions:

> "One of the key lessons from the sad case of Mrs Magriplis is that we must improve the capability of our joint systems for recognising and responding to deteriorating patients at RDH and DPH."

System Improvement

197. In his last statutory declaration signed on 6 March 2017, Mr Treacy provided the following as improvements that he said had occurred in his practice since the death of Mrs Magriplis:

> "a. He has enhanced existing and developed new lines of communication and collaboration with local and interstate colleagues;
>
> b. He has been involved in the recruitment of another Hepto-Billary Surgeon to Darwin;
>
> c. He shares rooms with the new surgeon and speaks with him daily;

[39] Transcript p.190-193

d. He has arranged for the visit to Darwin of a Gastroenterologist that specialises in Endoscopic Ultrasound to upskill and educate Mr Treacy and hospital staff;

e. A new pathologist now works in Darwin with whom Mr Treacy can discuss cases."

198. Mr Treacy also outlined system changes at the Royal Darwin Hospital. He said they were:

"a. The general surgery units had been rearranged so that there is a dedicated Hepato-Biliary and Gastro-Intestinal unit;

b. The unit conducts weekly ward rounds of the public and private hospitals. At the end of the ward round all complex cases are reviewed and all surgical events reviewed at the Royal Darwin Hospital Surgery Morbidity and Mortality meetings;

c. A complex case committee has been established in Royal Darwin Hospital at which complex cases can be reviewed and discussed.

d. Surgical Credentialing services have been enhanced at the Royal Darwin Hospital;

e. A co-ordinator of surgical audit services has been appointed at the Royal Darwin Hospital;

f. A resident Gastroenterologist has been recruited;

199. Mr Treacy told me there had been changes at the Darwin Private Hospital. The import of what he stated was that there were new colour coded track and trigger systems where nurses understood the threshold and called a "code blue". He also said that they now had a "second call" specialist list so that if one specialist is on leave, out of town or unavailable the other could be called.

200. In his conclusion, Mr Treacy stated:

"If I was presented with such a case now, I would have the benefit of, and would utilise, the availability of a local second opinion. I would be less reliant upon my own clinical findings, even if supported by pathology reports. I would discuss the case with the

pathologist and a colleague, and subject to those discussions would be more likely to proceed with endoscopic therapy.

Post surgery, with the benefit of the new systems, I would expect earlier identification of deterioration and its likely cause and call for specialist retrieval resources in response at an earlier time."

201. There is some doubt whether those changes have occurred or are simply under consideration. For instance, under the heading of "DPH Response to the Death of Mrs Irene Magriplis" in Dr Seiler's statutory declaration of 3 March 2017 there is an outline of the changes. They are:

> "a. Consideration of a 'nominated VMO'. It is said, "this would require DPH VMO's to nominate an alternate VMO to review their patients if they are unable to attend the DPH and physically review their patients". That would appear to align to the "second call" specialist that Mr Treacy mentioned. However in this case it is said only to be under consideration.
>
> b. An updated escalation protocol. The protocol makes it clear that there is still no escalation to the Royal Darwin Hospital Rapid Response Team before a Code Blue is called and a Code Blue is only called for respiratory and cardiac arrests. In that regard nothing has changed since May 2015."

202. It is therefore not possible from the evidence before me to determine what changes have been made and whether or not they are effective in strengthening the systems such that the circumstances of this case are unlikely to be repeated.

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

> (i) The identity of the deceased was Irene Magriplis born on 6 June 1939, in Kalymnos, Greece.
>
> (ii) The time of death was 11.30am on 30 May 2015. The place of death, Royal Darwin Hospital in the Northern Territory.
>
> (iii) The cause of death was septic complications following surgical resection of duodenal ampullary adenoma.

(iv) The particulars required to register the death:

1. The deceased was Irene Magriplis.

2. The deceased was of Greek descent.

3. The deceased was a pensioner at the time of her death.

4. The death was reported to the Coroner by Marina Diakogiannis, the daughter of the deceased.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother was Polimnia Skardasi and her father was Nickolaos Rigas.

204. Section 34(2) of the *Act* operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

Comment

205. There are times when using the more neutral terms of "error" or "a series of errors" are inadequate as a description. This is such a time. To do so has a propensity to disguise the scale of the inadequacies in the medical treatment of Mrs Magriplis.

206. Despite many of those inadequacies there should have been systems that prevented them having a fatal outcome. However, there were not:

a. There was no multidisciplinary team at Darwin Private Hospital to assist in making a proper diagnosis and determining the most appropriate treatment.

b. The surgery was high risk and Darwin Private Hospital allowed it without having adequate resources and systems to mitigate those risks.

c. The risks were heightened rather than mitigated because Darwin Private Hospital did not have:

   i. an adequate HDU; and

   ii. an adequate escalation policy for deteriorating patients.

207. To learn from such failures Darwin Private Hospital and Healthscope must be willing to identify and admit failures and follow their own policies to review them and improve. In this inquest they have not demonstrated an ability or willingness to do that.

208. Other protective requirements, such as the provision of all material information to a patient so as to enable informed consent are enshrined in the law, the Code of Conduct for medical practitioners and the Guidelines of *National Health and Medical Research Council.* They were not followed by Mr Treacy. Likewise the requirements to provide support for obtaining a second opinion.

209. I may make recommendations and reports pursuant to section 35(2):

> "(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

Referral

210. I **refer** these findings to the Medical Board of Australia.

Recommendations

211. I **recommend** that Darwin Private Hospital not permit high risk surgery to be undertaken where it does not have the resources to mitigate those risks.

212. I **recommend** that Darwin Private Hospital implement an escalation system to provide a proper rapid team response when the rapid response criteria are met.

213. I **recommend** that should the Darwin Private Hospital continue to operate a High Dependency Unit that it be properly and appropriately resourced and in conformity with Standard 9 of the *National Standards on Safety and Quality in Health Care* and the Guidelines of the *College of Intensive Care Medicine of Australia and New Zealand.*

214. I **recommend** that the Department of Health and the Top End Health Service consider these findings and recommendations in their dealings with and licensing of the Darwin Private Hospital.

Dated this 30th day of March 2017

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GREG CAVANAGH
TERRITORY CORONER