QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Christopher Doughty**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2021/5363
DELIVERED ON:	7 July 2026
DELIVERED AT:	BRISBANE
HEARING DATE(s):	Vacated.
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: coronial investigation, health care related death.
REPRESENTATION:	DJ Schneidewin, Counsel Assisting
	J Hewson for Wide Bay Hospital and Health Service
	Avant Law for Dr Mazen Ashour

Contents

Introduction

[1] Christopher Doughty (**Mr Doughty**) was born on 18 August 1954 and died on 5 October 2021 in the Intensive Care Unit (**ICU**) of The Prince Charles Hospital (**TPCH**). He was aged 67 years at the date of death.

[2] In brief, Mr Doughty died from multi-organ failure secondary to an acute myocardial infarct, which was in turn secondary to an in-stent restenosis following cessation of dual antiplatelet therapy (**DAPT**) (Aspirin and Clopidogrel) at the Maryborough Base Hospital (**MBH**). The DAPT was ceased due to a gastrointestinal bleed (**GIB**) suffered by Mr Doughty, with the plan to restart the therapy in two-weeks' time.

[3] On 25 November 2021, Dr Paula Matebele, ICU Consultant, of TPCH notified the Coroner that Mr Doughty's death was considered to be a health-related death for the purpose of the *Coroners Act* 2003 (**the Act**). Dr Matebele provided the Coroner with the required Form 1A, Form 9 and Mr Doughty's clinical records.

[4] The Cause of Death Certificate dated 5 October 2021 (**CODC**) provides:[1]

> "*1(a) Multi Organ Failure"*
>
> *"1(b) Cardiogenic shock*
>
> *1(c) Acute Myocardial infarction*
>
> *1(d) Ischaemic heart disease & in-stent restenosis*"

Coronial jurisdiction

[5] Mr Doughty's death was a health care related death as defined by the Act. His death was thereby a reportable death under s.8(3)(d) of the Act.

[6] Pursuant to s.28(1) the Act of the, I considered that it was in the public interest to hold an inquest into Mr Doughty's death.

[7] An inquest is intended to provide the public with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death.

[8] The role of the Coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances surrounding the death, i.e. how the person died. Those circumstances are limited to events which are sufficiently connected to the death. The purpose of a coronial investigation is to

[1] Exhibit A1 BOE

establish the facts, not to cast blame or determine criminal or civil liability. Those are matters for other courts.

[9] The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[2] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the Coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer…In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*[3]

[10] In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[4] As outlined in 'The Australasian Coroners Manual':

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation. … Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there. … Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[5]

[11] David Schneidewin of Counsel was appointed Counsel Assisting for the purpose of the Inquest. He provided various recommendations, which resulted in further evidence being obtained from both factual and expert witnesses.

[12] A Pre-Inquest Conference (**PIC**) was held on 19 August 2025, and a second PIC was held on 26 November 2025.

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[2] *Briginshaw v Briginshaw* (138) 60 CLR 336
[3] *Briginshaw v Briginshaw* (138) 60 CLR 336, 362 – 363 (Dixon J)
[4] Findings of the inquest into the death of Pasquale Roasario Giorgio, [140] – [142]
[5] Hugh Dillon and Marie Hadley, The Australasian Coroner's Manual (The Federation Press, 2015) 10

[13] Following receipt of the further evidence, and in considering the submissions made by the parties at the PICs, I have determined that it is not necessary or in the public's interest to hear oral evidence in order to make the findings I am required to make under the Act.

[14] Accordingly, the hearing dates for the Inquest are vacated.

Revised List of Issues for Inquest

[15] At the PIC on 25 November 2025, the List of Issues was revised as follows:

1. *The findings required by s,45(2) Coroners Act 2003; namely the identity of the deceased (Mr Doughty), when, where and how he died, and what caused his death;*

~~2. *Whether Dr Mazen Ashour's treatment and management of Mr Doughty in the period 17 March 2021 to the date of his death on 5 October 2021was adequate and appropriate, including:*~~

   ~~a) *Whether or not Dr Ashour's follow-up of Mr Doughty following his receipt of Angela Wotherspoon's, Nurse Navigator, letter dated 19 August 2021 reporting a history of Mr Doughty experiencing melaena stools commencing one week following his previous discharge form the Hervey Bay Hospital (**HBH**) was adequate and appropriate?*~~

   ~~b) *Whether or not the investigations Dr Ashour arranged in response to the said reported history were adequate and appropriate?*~~

   ~~c) *Following on from those investigations, whether or not Dr Ashour's follow-up, treatment and management of Mr Doughty was adequate and appropriate?*~~

   ~~d) *Whether or not Dr Ashour's follow-up, treatment and management of Mr Doughty regarding the cessation of his antiplatelet therapy as referred to in the Discharge Summary from the HBH dated 22 September 2021 was adequate and appropriate?*~~

3. *Whether Mr Doughty's treatment and management at the Maryborough Hospital (**MBH**) and the HBH during the admission of 17 September 2021 to 22 September 2021 was adequate and appropriate, including:*

   a) *Whether or not the decision to cease Mr Doughty's dual antiplatelet therapy (**DAPT**), namely by ceasing Clopidogrel 75mg daily, but to continue the Aspirin 100mg daily was appropriate?*

   b) *Whether or not the initial investigations conducted on 17 September to investigate Mr Doughty's suspected gastrointestinal bleed (**GIB**) were adequate and appropriate?*

c) *Whether or not it was likely Mr Doughty was suffering a lower GIB that had not been identified on the endoscopy performed on 17 September 2021, as was considered to be the case at the medical review on the morning of 18 September 2021?*

d) *The likelihood or otherwise that the suspected lower GIB was active and ongoing with hematochezia at the medical review on the morning of 18 September 2021;*

e) *The appropriateness and need for the further investigations recommended to investigate the suspected lower GIB, namely colonoscopy and CT angiogram, recommended on the morning of 18 September 2021;*

f) *Whether or not the decision/ recommendation of the medical team at HBH to cease all antiplatelet therapy (i.e. including the Aspirin) on 18 September 2021 was appropriate?*

g) *Whether or not the rationale for ceasing the DAPT and, in particular, the decision to cease the Aspirin after 18 September 2021 as set out in Exhibit B5 of the Brief or Evidence at paragraphs [30] to [34] was appropriate?*

h) *Whether or not it was appropriate to discharge Mr Doughty on 22 September 2021 without restarting the DAPT?*

i) *Whether or not it was appropriate to discharge Mr Doughty on 22 September 2021 without at least restarting the Aspirin?*

j) *Whether or not it was appropriate to discharge Mr Doughty on 22 September 2021 without further consultation with The Prince Charles Hospital (**TPCH**) Cardiology Team to set a plan for restarting the DAPT and/or Aspirin?*

k) *Whether or not it was appropriate to discharge Mr Doughty on 22 September 2021 leaving it to his General Practitioner to review Mr Doughty for the purpose of restarting the DAPT in one to two weeks, and to consider liaising with his primary cardiologist in that regard?*

l) *Whether or not it was appropriate to suggest to Mr Doughty's General Practitioner that the time frame for restarting the DAPT was one to two weeks?*

m) *Whether or not it was recommended to Mr Doughty to recommence Aspirin prior to his discharge on 22 September 2021 and he refused? If so, whether or not the plan for restarting Mr Doughty's DAPT as recommended in the Discharge Summary was adequate and appropriate?*

4. *Whether any failure to provide treatment and management to Mr Doughty at HBH caused or hastened her death?*

5. *Whether the response to Mr Doughty's death on the part of HBH has been adequate and appropriate?*

[16] In view of the revised List of Issues, Dr Mazen Ashour, Mr Doughty's General Practitioner, and his legal representative were excused from appearing at the Inquest.

Factual Findings

[17] At the date of his death, Mr Doherty had an extensive medical history including, *inter alia*:

a) End stage chronic obstructive pulmonary disease and interstitial lung disease requiring home oxygen therapy and palliative care (emphysema and idiopathic pulmonary fibrosis (**IPF));**

b) A bicuspid aortic valve with moderate-severe aortic stenosis (although he was not a candidate for aortic valve replacement);

c) Thyrotoxicosis causing paroxysmal atrial fibrillation;

d) Hypertension;

e) Gout;

f) Panic Disorder and Depression;

g) Hyperlipidaemia;

h) Erectile dysfunction;

i) Diverticulosis;

j) Diverticulitis.

[18] Mr Doughty was also a smoker and had an adverse alcohol use history.

[19] He lived alone, suffered from social isolation, and had limited support.

[20] On 4 June 2021, Mr Doughty presented to the Emergency Department (**ED**) of the Hervey Bay Hospital (**HBH**) with acute pulmonary oedema as a result of his aortic stenosis.

[21] The echocardiogram reported by A/Prof. Angus Thompson on 4 June 2021 was performed with the indications of "*increased shortness of breath and decreased exercise tolerance*" and revealed, *inter alia*:[6]

> "*The aortic valve was bicuspid with fusion on the left and right coronary cusps. It was heavily calcified and restricted. There was severe aortic stenosis*.."

[22] Mr Doughty was admitted to the ICU of HBH between 4 June 2021 to 8 June 2021 to be stabilised before transfer to TPCH under the care of the Coronary Team for a coronary angiogram and percutaneous stenting (**stenting**).

[23] On 21 June 2021, at TPCH, Mr Doughty underwent an angiogram and had two stents inserted into the left anterior descending and left circumvex arteries.

[24] Mr Doughty was prescribed DAPT, namely Aspirin 100mg daily and Clopidogrel 75mg daily.

[25] During the course of his admission to TPCH, Mr Doughty was diagnosed with idiopathic pulmonary fibrosis.

[26] On 30 June 2021, Dr John Mackintosh (**Dr McIntosh**), Thoracic and Respiratory Physician, wrote to Dr Ashour as follows:

> "*I had the pleasure of consulting Christopher during his inpatient stay under our cardiology team. Christopher's chest CT demonstrated a usual interstitial pneumonia pattern of lung fibrosis consistent with a diagnosis of idiopathic pulmonary fibrosis. Christopher has done well to survive intubation in this context, however he has residual type 1 respiratory failure. This results from a combination of his IPF as well as co-morbid emphysema. I have advised Chris that the prognosis of IPF is between 3 to 5 years. Christopher's prognosis is likely to be at the shorter end of this spectrum as his disease is already relatively advanced. There is no treatment to reverse Christopher's lung fibrosis. Anti-fibrotic therapy would offer the ability to slow down his disease progression. Unfortunately Christopher's spirometry is obstructive which unfortunately precludes him from PBS subsidized anti-fibrotic therapy. I have advised Christopher that the only cure for this disease is lung transplantation. Whilst his age of 67 is advanced it does not preclude lung transplantation as an option. Unfortunately in Christopher's case there are a*

[6] Exhibit C3.1, p.55 BOE

number of other barriers to transplantation namely his social isolation and lack of a clearly defined support person. Additionally Christopher presents frail and would be unlikely to tolerate the rigours of surgery. Christopher would need to demonstrate six months abstinence from cigarette smoking. I have not arranged to see Christopher again but would be happy to be contacted should any of this require clarification. Additionally were Christopher to improve his functional and physical status, be abstinent from cigarette smoking and identify a support person, I would be happy to see him to discuss lung transplantation further."

[27] On 7 July 2021, Mr Doughty was transferred back to HBH where he was admitted under the care of Dr Win Han Tang (**Dr Tang**)[7], Physician, between 7 July 2021 to 12 July 2021.

[28] During this admission, Mr Doughty had an episode of acute pulmonary oedema and was briefly in ICU at HBH. He was found to be thyrotoxic, which was considered to be the cause of Mr. Doughty's paroxysmal atrial fibrillation. He was commenced on the anti-thyroid medication, carbimazole.

[29] On 12 July 2021, after he had settled, Mr Doughty was transferred to MBH for rehabilitation. During this admission, an application for home oxygen was made and provided prior to his discharge.

[30] On 13 July 2021 Dr Ashour's practice received a letter from TPCH referring to Mr Doughty's recent inpatient admission under the cardiology team. The letter noted a diagnosis of idiopathic pulmonary fibrosis with a prognosis of three to five years. This letter was imported into the practice's electronic medical record on 8 August 2021, along with pathology results for tests ordered from Hervey Bay Hospital and copied to the practice.

[31] Dr Ashour's practice attempted to recall Mr Doughty for a follow up review consultation eight times between 18 July 2021 and 25 July 2021.

[32] On 22 July 2021, Mr Doughty was discharged home from MBH. According to the Discharge Medication Record of 20 July 2021[8] he was continued on DAPT: Aspirin 100mg daily and Clopidogrel 75mg daily. The ongoing use of Clopidogrel was noted to be temporary and was for review in June 2022.

[33] On 26 July 2021, Mr Doughty attended a telephone consultation with Dr Ashour and explained that he had been in hospital for the previous seven weeks with emphysema, however he was now at home on oxygen. He requested a prescription for Valium 5mg, which Dr Ashour provided.

[7] Exhibits B1.1 and B1.2 BOE
[8] Exhibit C3.1, p.62 BOE

[34] Mr Doughty was recalled to Dr Ashour's practice again for review on 30 July 2021, 1 August 2021 and 3 August 2021.

[35] On 10 August 2021, Dr Ashour conducted a home visit to check in on Mr Doughty and to review his medication. Dr Ashour did not alter or prescribe any medications on that occasion. He advised Mr Doughty of the importance of him attending the emergency department if his condition deteriorated.

[36] Throughout August 2021, Mr Doughty was regularly visited by a Nurse Navigator (**NN**), Angela Wotherspoon (**RN Wotherspoon**) of the Hervey Bay & Maryborough Hospitals Nurse Navigator Service (**NNS**).

[37] On 18 August 2021, RN Wotherspoon made the following note following a home visit to Mr Doughty:[9]

> *"HV to client this am. Sitting in lounge without home 02 in situ. States that he has not been requiring it for more than a few hours per day and only at times of exertion. Nil visible shortness of breath RR 18 HR 104 and irregular. Nil pain. Sleeping well with aid of Phenergan for sinusitis; appetite good; weight TBC as has nil scales; mood returning to normal with recent change in antidepressant. Diazepam PRN however is only taking 1-2 weekly at present. Not taking his oral ordine; has continued on Kapanol as per discharge from MBH. Has four days of his webster roll remaining. GP attended a home visit last week however pt did not request prescriptions at this time. PC to Priceline pharmacy at Station Square; pt requires repeat prescriptions for all medications. Nil kapanol in his last four days of remaining webster roll as prescription did not accommodate this. Offered to contact GP; pt declined as he will contact them post NNAV visit. Pt has experienced daily dark black tarry stools over the past 1-2 weeks. States this is related to his aspirin and Clopidegrol. Strongly recommended that he contact GP for an a review appt so that this can be discussed and investigated as required. C/O dizziness on rising. Discussed potential for low Hb if melaena stools. Revisited falls prevention, marching feet on the spot, using walking aid (declined) and reducing alcohol intake. Revisited 02 safety and cigarette smoking. Pt maintains that he has ceased smoking cigarettes and is also very aware of risks with oxygen. Currently drinking between 6-10 cans of beer per day; disinterested in cutting back or ceasing the same. Supported in completing energy rebate form from MASS. NNAV Resource folder provided to patient with information on Pulmonary Fibrosis, care of home oxygen and tubing, pulmonary rehabilitation leaflet, discharge summary and medication summary, NNAV information and local support services. To complete taxi subsidy application; awaiting passport photograph from pt. Revisited MAC and ACAT process.*

[9] Exhibit C2.3, p,5 BOE

Currently receiving domestic support fortnightly with recent application to MAC for increased care needs. Pt feels that he has returned to his baseline however given disease status and likely progression encouraged to consider options via MAC at time of assessment. Pt easily confused and overwhelmed with paperwork and information. Difficulty in recalling previous topics of conversation with NNAV and discrepancies in previous information provided. Pt has had a falling out with his best friend Doug who was to be his EPOA. Discussed alternative such as Public Trustee. Estranged from all family and limited friends. To provide information on public trustee however pt would like some time to see if he and his friend reconnect. Pt for follow up when passport photographs completed."

[38] Also on 18 August 2021, Dr Ashour conducted a telehealth consultation with Mr Doughty and noted that he was still at home on oxygen. He reminded him of the advice given at his previous consultation, which was to attend the emergency department if his condition deteriorated. Mr Doughty had been advised to have his flu vaccine and so arrangements were made for him to be reviewed in person to facilitate that. Mr Doughty did not mention any other issues during that consultation and, relevantly, did not mention experiencing black, tarry stools.

[39] On 19 August 2021, RN Wotherspoon made the following note:[10]

"PC from client this am. Contacted GP practice yesterday re GP review for prescriptions and malena (sic) however pt has not heard from them. Advised to contact practice again this am to advise of need for medications. GP may be content to send through prescriptions to pharmacy without medical review. Revisited Malena stools and need for follow up regarding the same. Pt will follow up with GP practice."

[40] On 19 August 2021, the RN Wotherspoon wrote to Dr Ashour reporting, *inter alia*:

"Christopher also mentioned to me yesterday that he is experiencing melaena stools. They commenced approximately 1-week post discharge form MBH. They occur daily and are consistently black, tarry and soft in nature. He has linked this to his aspirin and Clopidegrol medication. I have strongly

[10] Exhibit C2.3, p.4 BOE

> *recommended he attend an appointment with you to discuss this further.*"[11]

[41] Dr Ashour received the letter from RN Wotherspoon on 19 August 2021. In accordance with RN Wotherspoon's request, he provided prescriptions for the medications set out in the discharge summary from the MBH so that Mr Doughy could receive his next Webster pack.

[42] Mr Doughty consulted Dr Ashour at the practice on 24 August 2021. He presented with shortness of breath and reported that he remained on home oxygen. Dr Ashour noted that he had reviewed his medication recently. Mr Doughty reported that he had been suffering from per rectal (**PR**) bleeding for the last two weeks, as well as lower back pain. Dr Ashour referred him for a range of investigations and pathology testing including faeces occult blood test; a full blood count; urea, electrolytes and creatinine blood test; comprehensive metabolic panel; liver function tests; iron study; vitamin B12; and urine microscopy, culture and sensitivity test. He also referred him for a plain x-ray of his lumbo-sacral spine.

[43] On 24 August 2021, Mr Doughty underwent the blood tests ordered by Dr Ashour, which revealed that his haemoglobin level was low at 87 g/L (reference range 125-175).[12] Mr Doughty was clearly anaemic. The Sullivan Nicolaides pathologist commented:

> "*Causes of macrocytic anaemia are: B12/ folate deficiency, haemolytic anaemia, cytotoxic drugs, myelodysplasia and other bone marrow disorders, multifactorial e.g. Macrocytosis or liver disease*."

[44] Vitamin B12 deficiency was considered unlikely on the pathology results.

[45] The other potential causes for the anaemia were not excluded on pathology testing.

[46] Contact was made with Mr Doughty by Dr Ashour's practice on 25 August 2021 to arrange a follow-up appointment to discuss his test results and consider an appropriate management plan. He advised that he would contact the practice to make an appointment when he could make transportation arrangements. The practice contacted him again by telephone and text message on six occasions between 26 August 2021 and 3 September 2021, requesting that he return for review to discuss the results of his recent investigations.

[47] Mr Doughty did not respond to these requests.

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[11] Exhibit C2.3, p,2 BOE
[12] Exhibit C3.1 p.34 BOE

[48] On 17 September 2021, Mr Doughty presented to the MBH ED complaining of shortness of breath on exertion and a pre syncopal episode. It is unclear whether this was a self-initiated presentation or whether he was referred (the former seems most likely). The treating doctor was Dr Janine Pollock (**Dr Pollock**).

[49] Mr Doherty's haemoglobin level was found to be low at 50 g/L (reference range 125-175), and he again reported the history of PR bleeding followed by melaena (being about 1 month after he initially reported this to the RN and about 3 weeks after he reported it to Dr Ashour).

[50] Medical staff thought this to be suggestive of a significant gastro-intestinal bleed (**GIB**). The primary diagnosis was "*intra-abdominal haemorrhage,*" and he was treated with blood transfusions and an intravenous proton pump inhibitor to reduce the acidity in his stomach.

[51] It was considered that the suspected GIB was likely secondary to the DAPT.

[52] At 13:38 hours on 17 September 2021, Dr Pollock made the following entry:[13]

> "*Contacted Dr Mishras reg TPCH*
>
> *Advised that at 3 month stage should reain (sic) on at least one antiplatelet, lower bleeding risk with aspirin if stop plavix*
>
> *Happy that ECG and troponin changes are likely due to low HB*
>
> *Dr Mishra is currently on leave but she will contact me back if any plan or further changes to plan, I will recontact her if no call back at 4pm*."

[53] Dr Mishra's Registrar at TPCH has not been identified, but ultimately nothing turns on that.

[54] At 13.43 hours on 17 September 2021, CN Michelle Town made the following entry:[14]

> "Advised HBH TL that patient is being transported to HBH ED. handover given."

[55] The details of the handover are not recorded in the MBH ED records.

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[13] Exhibit C2.3, p.238 BOE
[14] Exhibit C2.3 p.238 BOE

[56] At 13:56 hours on 17 September 2021, Dr Atul Dhital (**Dr Dhital**), the ED consultant at MBH recorded his involvement in Mr Doughty's care as including:

> "*Consultation*
>
> *Surg – HBH – accepted care of patient*
>
> *Medical – HBH – aware of patient and will review pre-admission.*
>
> *TPCH cardiology – agree ECG and clinical picture consistent (sic) with T2 MI – would prefer aspirin to be continued in view of recent stents – happy to be involved in further care*."

[57] Mr Doughty was then transferred to the HBH ED sometime after 13.43 hours on 17 September 2021. Subsequently, Mr Doughty was admitted to the HBH but remained in the ED. There was initially some confusion about which team he was to be admitted under. I note the following entries in the ED records:[15]

a) At 00:13 hours on 18 September 2021, Camilla Lyttle wrote:

> 67M transferred from MBH on 17th Sept
> ? UGIB
> Taken to theatre for a scope, nil obv source of bleeding
>
> Pt is a surgical admission who was for an ICU bed post-op
> ICU nil beds so being managed in resus but is under the care of the ICU/surgical team. No ICU nurses available to nurse the patient
>
> Pt awaiting ICU bed when available

b) At 08:55 hours on 18 September 2021, Gareth Davies wrote:

> spoke to EVa - ICU Reg - she says Chris is not under ICU
>
> they have documented that fit for surgical ward (but no one told us)
>
> I've informed surg PHO - Josh
>
> he says they're going to dicuss with medics
>
> Chris is NOT an ED patient - any further issues to be relayed to Josh

[15] Exhibit C1.2 pp.6-7 BOE

c) At 09:10 hours on 18 September 2021, Gareth Davies wrote:

> spoke to Raju - ICU are not admitting but are still expecting him to have PRBC infusions for Hb 118, are aware he has arterial line + having metaraminol boluses
>
> Raju has explained reasons for ongoing PRBC infusion - aiming for higher haematocrit to assist with BP with his known aortic stenosis
>
> we'll give 1 x unit PRBCs as per Raju but we need a inpatient team to be responsible for adjusting his QADDS
>
> Medical Consultant is here reviewing - doesn't want to adjust QADDS - wants to discuss with TPCH
>
> I have rung ICU again and asked Eva to com and adjust the QADDs to a level that they feel is appropriate given his comorbidities
>
> THIS PATIENT IS NOT ED's RESPONSIBILTY

d) At 09:36 hours on 18 September 2021, Gareth Davies wrote:

> spoke to Josh - surg PHO - he is aware that Chris has not be accepted by ICU or medicine
>
> he is currently trying to sort this out and agrees to be responsible for Chris at this stage

e) At 10:49 hours on 18 September 2021, Leanne Chappell wrote:

> taken over care at 0700. multiple discussions with ICU as is kindly documented by ED consultant. Have given 10ml calcium gluconate as requested prior to 1 unit PRBC with 50ml NS flush.
> IV potasssium running as requested. meteraminol infusion finished nil more written up. QADDS currently 3. pt on 2LNP (pt on home 02) sats 94%. RR 16, BP cuurent;y 106/50 map 71. HR 68, T 37.0.
> pt to remain NMB as waiting Surg to deside on another scope. Pt voiding in bottle has passed 690 ml urine. fluid balance updated.
> pt assisted to move around in bed is able to to turn self.
> morning meds as charted.
> Await further plan.

f) At 12:19 on 18 September 2021, Leanne Chappell wrote:

> seen by surg for ct today and start bowe prep at 4 pm. Can have lunch then clear fluids onwards.

[58] Notwithstanding, the plan to cease the DAPT (to cease Clopidogrel) but to continue Aspirin was understood by both the surgical team and the medical team at HBH, I note the following entries:

a) At the surgical consult on 17 September 2021, the PHO for Dr Joshua Teo (**Dr Teo**) wrote: "* *must stay on Aspirin*";[16]

[16] Exhibit C1.2 p. 98 BOE

b) At the medical review at or about 16:40 hours on 17 September 2021, Dr Lalith Disawage (**Dr Disawage**) (admitting PHO) wrote: "*Continue Aspirin as per Cardiology*";[17]

[59] Mr Doughty consented to undergo an endoscopy, which found no active sources of bleeding and only some mild irritation around the pylorus (the end of the stomach immediately before the point where the stomach joins the duodenum).

[60] At 23:45 hours on 17 September 2021, Dr William McSweeney (**Dr McSweeney**), the surgical registrar, documented his concerns about having to manage an inotrope-dependent patient by himself in the ED when Mr Doughty should have been in the ICU (but for "*severe capacity issues in ICU"*.) and that he had requested medical consultant review "*three times".*

[61] There was a further surgical review with Dr Teo and Dr McSweeney at or about 08.05 hours on 18 September 2021. It seems that the Surgical team did not think they could provide any further input and were seeking that the Critical Care Unit/ Medical team take over Mr Doughty's care.

[62] There is an ICU outreach note entered into the record at or about 08:05 hours on 18 September 2021 which records the ICU outreach plan to be, *inter alia*, as follows:[18]

> "- *Does not require acute coronary intervention.*
>
> - *Med team to liaise with cardiology re: definitive [unclear] plans and with Surg team before restarting antiplatelets*"

[63] A medical consultant review was undertaken by Dr Gunanathan Pratheepan (**Dr Pratheepan**) with Dr Jack Jefferies (**Dr Jefferies**) at or about 09:15 - 09:30 hours on 18 September 2021.[19] Dr Pratheepan thought Mr Doughty might have suffered a lower GIB which would not have been seen on the endoscopy performed the day prior. He recommended that consideration be given to performing a CT angiogram and a colonoscopy. Dr Pratheepan's plan/recommendation otherwise included:[20]

a) To seek an opinion from TPCH cardiology unit to develop and implement a cardiac plan for Mr Doughty. He says this was necessary because "*untreated aortic stenosis would continue the risk of ongoing bleeding from possible angiodysplasia. The DAPT should be stopped because of*

[17] Exhibit C1.2 p. 103 BOE
[18] Exhibit C1.2, p.115 BOE
[19] Exhibit C1.2, pp.108 & 109
[20] Exhibit B5, paragraph [26] BOE

ongoing bleeding and Mr Doughty was already having his 5th unit of blood transfusion";

b) To stop Mr Doughty's DAPT (which included ceasing the plan to continue Aspirin alone);

c) Ensure that Mr Doughty's haemoglobin levels remained above 100 g/L;

d) Transfer Mr Doughty to the care of the Medical team if the colonoscopy and CT angiogram did not reveal an active source of bleeding.

[64] Dr Pratheepan says that given his "*consultative role*" he was not involved in the implementation of the above plan. They were merely his recommendations to the Surgical team under whose care Mr Doughty was at the time.[21]

[65] As regards his recommendation to cease the DAPT (including Aspirin alone), Dr Pratheepan explains his rationale as follows:

> 33 Continuing a single antiplatelet agent like asprin would minimise the risk of ongoing bleeding but would not stop it completely when a patient is profoundly bleeding, as Mr Doughty was. Considering the risks of each scenario, on balance, I concluded that until the cause of the GI bleeding had been definitively diagnosed, it was in Mr Doughty's best interest at that time to cease DAPT.
>
> 34 In Mr Doughty's case, as the source of lower GI bleeding was not identified but causing significant transfusion requirements and hemodynamic instability, I decided that the benefits of ceasing the DAPT short term would out weigh the the benefits of continuing DAPT or a single antiplatelet agent - asprin. My recommended management plan was not that Mr Doughty cease DAPT indefinitely. Rather, the above mentioned risks could be reassessed with the benefit of a definitive diagnosis and a treatment plan, once established.

[66] In making the recommendation to cease Aspirin, Dr Pratheepan does not state that he sought cardiology input.

[67] According to the medication chart the last dose of Aspirin was given at or about 08:00 hours on 18 September 2021. It was then ruled out as "*ceased*" on the chart. It is not clear who marked the Aspirin as being ceased on the chart.

[21] Exhibit B5, paragraph [27] BOE

[68] There then appears to have been a discussion and plan to perform the CT angiogram on 18 September 2021 and to prep Mr Doughty for the colonoscopy to be performed on 19 September 2021.

[69] The CT angiogram was performed at or about 12:29 hours on 18 September 2021 and did not reveal any evidence of bleeding, but there were indications of possible fluid overload.

[70] The colonoscopy was cancelled because Mr Doughty refused to undertake the necessary preparation.

[71] From on or about 19 September 2021, Mr Doughty came under the care of Dr Wing Han Tang (**Dr Tang**), Staff Physician, at HBH. Insofar as the DAPT is concerned, Dr Tang states:[22]

> "*43. The Surgical team had discussed with me Mr Doughty's refusal to have the colonoscopy and his desire to discharge home against medical advice. We were concerned that there was still a source of ongoing bleeding, which we were unable to confirm due to his refusal to have the colonoscopy performed. I advised the best plan was to keep him admitted for further observation with respect to his gastro intestinal bleeding and to observe how he responded to the diuretic and blood pressure medication.*
>
> *44. I recall having a lengthy discussion with Mr Doherty regarding his antiplatelet medication in the context of the drop in haemoglobin level observed overnight and the possibility that he may have ongoing gastro intestinal bleeding. I cannot recall the dates on which I had these conversations but I recall having more than one discussion with Mr Doughty, during his admission, about his antiplatelet medication and the risk of further GIB when recommencing the medication. I discussed that he may develop a slow GIB from recommencing the antiplatelet medication and there was also a risk of a further massive bleed. I explained the risks associated with not taking antiplatelet medication in light of his recent stents including a stent thrombosis heart attack. I discussed the risk of bleeding associated with recommencing just aspirin alone compared with recommencing DAPT including clopidogrel.*
>
> *45. I was aware that Mr Doughty had recently undergone stenting and required DAPT to reduce the risk of clots forming on the stents. I recall suggesting that we should*

[22] Exhibit B1.1 BOE

trial recommencing Aspirin whilst Mr Doughty was still an inpatient so we could closely observe and manage any rebound bleeding.

46. I recall that Mr Doughty refused to recommence the aspirin as he was worried that he would develop bleeding again. I wanted him to remain an inpatient so we could monitor his response to the frusemide and bisoprolol.

…

51. I recall having further discussions with Mr Doughty during this attendant [reference to review of 21 September 2021] regarding resuming DAPT. I explained to Mr Doughty that the Cardiology team at TPCH indicated that they wanted him to continue on aspirin. I explained that it was best for him to remain in hospital when recommencing aspirin so we could observe for any recurrence of GIB. Mr Doughty did not want to start taking aspirin out of fear that he would develop further GIB which would prolong his stay in hospital. Mr Doughty strongly indicated that he did not wish to remain in hospital and wanted to discharge home against medical advice. I explained to Mr Doughty that I was very concerned that he remained in heart failure and it was not safe for him to be discharged home, I was concerned that he was at high risk of developing a stent thrombosis as was only three months post stenting which is a high risk period.

…

58. [referring to the last review prior to discharge on 22 September 2021] I recall having a further discussion with Mr Doughty with respect to his DAPT. It was difficult to persuade Mr Doughty to start taking his antiplatelet medication again. The pharmacist and I explained to him that he needed to follow up with his general practitioner in one to two weeks' time with a view to restarting his antiplatelet medications again….I recall asking the resident medical officer to document my discussions with Mr Doughty with respect to his antiplatelet medications and his refusal to take them in his medical records. I note that no discussions were documented in the progress notes and I believe this to be an oversight."

[72] Concerningly, Dr Tang's discussions with Mr Doughty about his DAPT as outlined above are not documented in the record. Indeed, some of what

Dr Tang says about those statements appears to be inconsistent with the record. For example:

a) At 10:50 hours on 20 September 2021, Dr Tang documented:

   i) That Mr Doughty's haemoglobin remained in the normal reference range at 134 (although it had dropped slightly from 148 the day prior);

   ii) The plan was to commence discharge planning with referrals to physiotherapy, occupational therapy and the social worker;

b) At 09:30 hours on 21 September 2021, Dr Alexandra Melon (**Dr Melon**) documented on Dr Tang's behalf that the plan was for discharge the following day provided the blood results (presumably the haemoglobin) was stable.

[73] Additionally, I note that:

a) In respect of the consultation of 21 September 2021, Dr Melon states:[23]

> "*I cannot recall any specific discussions relating to the status of or recommencing Mr Doughty's DAPT. In my experience if this was discussed in my presence during the medical ward round I would have noted this in Mr Doughty's medical records*."

b) Yashani Algama, the HBH pharmacist to whom Dr Tang refers to, states:[24]

> "*Given that there was no plan documented for restarting Mr Doughty's antiplatelet medications at the point of discharge and considering the increased risk of complications without antiplatelet treatment, as per my usual practice, I am confident that I would have raised query with the Medical team. Having noted TPCH Cardiology team's initial recommendation to continue Aspirin alone upon Mr Doughty's admission to HBH, I would have suggested that the Medical team consider restating at least Aspirin alone on discharge until he was reviewed again or to obtain further advice from TPCH cardiology team about a plan for restarting his antiplatelet therapy.*
>
> *Based on the notes entered in the Discharge Medication Record and the Discharge Summary, the recommendation from the treating team was not to restart the antiplatelet therapy at that*

[23] Exhibit B12, paragraph [20] BOE
[24] Exhibit B15, paragraph [39] BOE

point in time and to have Mr Doughty's GP follow this up in one to two weeks to restart them."

[74] Yashani Algama also states:[25]

> "*With Mr Doughty, I would have discussed the medication changes that occurred while he was admitted and discussed the medications that had been ceased or temporarily stopped at his bedside. I would have explained to him that his DAPT had been temporarily stopped with the plan of having his GP review this with a view to restarting the medication/s within two weeks. I would have discussed the risks of not recommencing the DAPT at this point in time and the importance of seeing his GP as soon as possible to have this followed up. I would have also advised him to seek immediate medical attention if he develops any further symptoms/ concerns*."

[75] I note that Yashani Algama does not state that Mr Doughty was unaccepting of the advice provided or that he conveyed any of the concerns about restarting the DAPT (or, for that matter, Aspirin alone) as Dr Tang recalls.

[76] On 22 May 2025, Dr Christopher Zappala (**Dr Zappala**), Director of Medical Services Fraser Coast WBHHS, wrote to me stating, *inter alia*, the following:

> "*Mr Doughty presented in Sept 2021 with symptoms of gastrointestinal bleeding after having coronary stents inserted two months prior at The Prince Charles Hospital (**TPCH**). The DAPT that had commenced following the stenting was thought to be the most likely aggravating factor for the bleeding. The gastrointestinal bleeding was very significant, and Mr Doherty required multiple blood transfusions. In this precarious state he evolved to develop a type 2 myocardial infarction and significant hypotension, requiring inotropic agents and ICU care. Dr Doughty was extraordinarily unwell and his life was in peril from this event and the severity of this has influenced both the clinicians and the patient in their future decision-making regarding ongoing DAPT therapy.*
>
> *Liaison with TPCH cardiology occurred early in the admission. Cessation of the DAPT was universally agreed with TPCH at that time and upon reflection I remain comfortable with this decision as do our clinical teams. In our recent review we have involved our staff cardiologist, Dr Siavish Javadi, and he also concurs with the decision to cease DAPT at this time given the magnitude of*

[25] At paragraph [46]

the blood loss from the gut and the fact the source of bleeding was unknown and therefore uncontrolled.

….

Given the source of the bleed was (so far) not identified and hence untreated, the team were in the unenviable position of balancing the risk of re-clotting/AMI without DAPT therapy with the risk of exacerbating the already very serious bleeding if he were to recommence. Our clinicians recall several undocumented discussions with Mr Doughty regarding this issue. There was universal reticence to re-start DAPT or even just aspirin, including by Mr Doughty himself, given the magnitude of blood loss on this therapy and the mortal peril this had placed him in. Dr Tang, the general physician/geriatrician looking after him just prior to his discharge recalls several discussions of this nature with Mr Doughty. She also recalls providing verbal instruction to Mr Doughty that some form of anti-platelet therapy would need to be re-started within a week or so after discharge, at the outside."

[77] At the invitation of Counsel Assisting, Dr Tang has provided a supplementary statement dated 20 November 2025, by which she provides the following clarification:

"***Clarification of evidence in my original statement***

A comprehensive clinical overview was provided in my previous statement, therefore I will just reiterate the main points here: I took over Mr Doughty's care on 19 September 2021 until his discharge on 22 September. Mr Doughty had multiple complex comorbidities, including non-operable severe aortic stenosis, chronic obstructive pulmonary disease (COPD) and pulmonary fibrosis requiring home oxygen, ischaemic heart disease with a stent inserted in June 2021, Graves' disease with hyperthyroidism, depression, and chronic alcoholism.

During this period, my primary focus was monitoring any sign of active bleeding, optimising his heart failure management, and treatment of symptomatic anaemia. His clinical condition was closely monitored for any evidence of ongoing bleeding including physical examination and daily blood test. We also reviewed his other medical issues, including thyroid function and gastrointestinal symptoms.

Looking back on the admission, I still have some personal recollection of Mr Doughty. I clearly recall that he was very keen to return home and resistant to any treatment or interventions that might delay this.

While Queensland Health recommends that the team comprise one registrar and two residents, the medical unit at Hervey Bay

Hospital was understaffed. At the time of this incident, due to the clinical workload, I was only able to complete my ward rounds with one junior doctor, as the other was engaged in urgent clinical duties for other patients under our care.

I recall that there were daily discussions regarding the risks and benefits of resuming antiplatelet therapy. As set out in my previous statement, these occurred on 20, 21 and 22 September 2021. I regret that my junior did not specifically record these conversations. I am now more alert to what is being scribed in the record about my consultations, and I endeavour to ensure that all relevant information has been captured.

Given Mr Doughty's presentation with significant gastrointestinal bleeding, but also a recent coronary stent insertion (three months prior), his dual antiplatelet therapy had been temporarily ceased.

Once the bleeding appeared to have stopped, I had strongly advised continuation of aspirin as single antiplatelet therapy. As his clinical condition and haemoglobin level were stable, we offered to restart aspirin during his hospital stay to allow for close monitoring of his haemoglobin levels and vital signs. I believe this recommendation was clearly communicated to Mr Doughty by me, however in these discussions I also had to explain to him the risks associated with resuming aspirin therapy. I cannot specifically recall, but I believe I would have told him that if we did recommence it, he would have to stay in hospital longer for monitoring. This is because we could not be sure he would not bleed again, and because he would need medical care if he did. Given the extent of the bleed he had prior to and during the admission, a further bleed of that magnitude could have been catastrophic, particularly if he was at home alone.

Mr Doughty declined to take aspirin, expressing concern that it would prolong his hospital stay. This is in keeping with his long-standing and repeated desire not to be in hospital. Mr Doughty had requested discharge against medical advice on more than one occasion.

As a geriatrician, I was acutely aware of Mr Doughty's multiple comorbidities and social isolation, both of which posed challenges to treatment adherence and continuity of care.

During this admission every effort was made to optimise his medical condition, address his gastrointestinal bleeding, and support his overall recovery through multidisciplinary involvement. I actively ref erred him to allied health professionals, including a physiotherapist supported his mobilisation and chest exercises to reduce deconditioning and prevent complications, and a pharmacist reviewed to explain the adjustments of his medications for heart failure and thyroid function.

The continuation of antiplatelet therapy following recent coronary stenting is a well-established and widely recognised treatment guideline. As Mr Doughty did not exhibit angina or any clinical signs suggestive of stent thrombosis, I did not feel I needed to seek advice from the local cardiology team or from the cardiologists at The Prince Charles Hospital (TPCH). Furthermore, when Mr Doughty declined aspirin, despite our explanation that this recommendation originated from TPCH, his decision remained unchanged.

The challenge during this admission was in counselling Mr Doughty to resume aspirin therapy while carefully balancing the competing risks of recurrent gastrointestinal bleeding and stent thrombosis.

I believe the importance of resuming aspirin was clearly conveyed to Mr Doughty with more than one discussion. I would not have done this if he was not clinically stable enough and suitable for resuming aspirin before discharge. However, given his persistent reluctance, I could only advise him to consult his general practitioner (GP) following discharge, as I believed his GP had better rapport and could reinforce the need for resuming antiplatelet therapy with closer and more timely follow-up for his symptoms.

In terms of the timeline and plan, I understand that others who had responsibility for Mr Doughty's care prior to me had intended that, if not DAPT, at least aspirin would be recommenced. It was my intention also, while Mr Doughty was under my care, that the aspirin be re-started. This was in the knowledge that aspirin could well have cause a re-bleed, potentially with dire consequences for Mr Doughty. This is why we wanted to monitor him,

Clinical plans have to change and adapt, depending on circumstances. In this case, despite counselling, Mr Doughty refused to re-start the aspirin as an inpatient. I was then faced with having to alter the clinical plan."

[78] I will return to Dr Tang's supplementary statement below.

[79] On 21 November 2025, Dr Zappala also responded to Counsel Assisting's invitation to clarify certain aspects of his earlier correspondence:

"*I have been advised that Counsel Assisting has invited Wide Bay Hospital and Health Service (**WBHHS**) to provide further evidence in this matter. I would like to take this opportunity to clarify previous comments regarding re-starting dual anti-platelet therapy and the risks this posed to Mr Doughty, in the context of his admission from 17 - 22 September 2025.*

In my previous letter I wrote 'there was universal reticence to re-start DAPT or even just aspirin, including by Mr Doughty himself, given the magnitude of the blood lost on this therapy and the mortal peril this had placed him in.'

At the time of my previous letter, Dr Wing Han Tang had not yet provided her supplementary statement (dated 20 November 2025). The content of that statement clarifies her intentions in relation to recommencement of aspirin therapy.

I remain of the view that any anti-platelet therapy provided to Mr Doughty, even on discharge, was very possibly life-threatening. I now better understand from Dr Tang's supplementary statement that, even taking this into account, the decision had been made towards the end of the admission when Dr Doughty was more stable, to recommence aspirin alone at some point in the near future…..

I also said that 'Our collective opinion remains that re-starting any anti-platelet therapy would have caused significant risk of recurrence of life-threatening bleeding.'

This risk was well-recognised by the team. Aspirin alone could have caused another catastrophic bleed. That said, Dr Tang was clearly balancing the estimated future risk posed by the stent with the risk of a re-bleed. Her evidence is now clear that, once he had stabilised and was nearing discharge, Mr Doughty was urged to take aspirin in the community and be monitored by his GP. I believe this was a compromise position in light of the precarious, complex clinical context and his refusal while in hospital. Mr Doughty's refusal to remain an inpatient, despite counselling to do so, compounded the situation."

[80] As acknowledged by Dr Tang, in her supplementary statement, at the time of discharge on 22 September 2021, Mr Doughty was hemodynamically stable with a haemoglobin level in the normal reference range at 149 g/L.

[81] I find as follows:

a) It was Dr Tang's preference that, once Mr Doughty was hemodynamically stable, he be recommenced on Aspirin 100mg to manage the risk of thrombosis;

b) Given the risk for further catastrophic bleeding with Aspirin 100mg alone, it was Dr Tang's preference that Mr Doughty remain an inpatient when Aspirin 100mg was recommenced so that his risk for bleeding could be monitored;

c) Although not documented, Dr Tang had a number of conversations with Mr Doughty around recommencing Aspirin 100mg and she recommended that it be recommenced whilst he remained an inpatient

for the reason stated above. Mr Doughty declined this recommendation because he did not want to stay in hospital. Despite the lack of documentation in this regard (and the absence of any others recollecting that the conversations occurred in their presence), I have no reason to find that these conversations did not take place. That Mr Doughty declined such a recommendation is consistent with his history of non-compliance with medical advice generally, including his decision to refuse colonoscopy being the investigation that would have most likely determined the source of his GIB.

d) Dr Tang has explained the lack of documentation around the conversations she had with Mr Doughty about recommencing Aspirin 100mg on the basis that her junior staff (whether by reason of workload or otherwise) omitted to record the conversations on multiple occasions. Again, I have no reason not to accept this explanation but ultimately it was the responsibility of Dr Tang to ensure that the notes accurately recorded the recommendations that were made, particularly given the critical nature of the recommendations and the fact that Mr Doughty repeatedly declined the recommendations against advice. In respect of this critical aspect of Mr Doughty's treatment and management, the record keeping was not adequate and appropriate and the ultimate responsibility for that rests with Dr Tang.

[82] The HBH Discharge Medication Record of 22 September 2021 records that Aspirin 100mg and Clopidogrel 75mg was ceased on 19 September 2021, with the explanation *"? Upper GI bleed: GP to review in 2 weeks*."[26]

[83] However, I note the medication chart of HBH records that Aspirin 100mg was initially written up on 17 September 2021 and two doses were given, one on 17 September and the other on 18 September, after which it was ceased (according to the chart). Clopidogrel was not written up at all on 17 September 2021[27] and there is no record of it having been administered during the admission of 17 September 2021 dated 22 September 2021.[28] In so far as the Clopidogrel 75mg being ceased on 19 September 2021 is concerned, the HBH Discharge Medication Record appears to be inaccurate, but I find that nothing turns on this.

[84] The HBH Discharge Summary for the admission of 17 September 2021 dated 22 September 2021 is contained on Dr Ashour's records.[29] It records the reason for admission as "*Presented with PR bleeding 1/52 then followed by Malena (sic)*." It otherwise contains the following recommendation to the GP:

[26] Exhibit C1.2, p.158 & p.161 BOE
[27] This is confirmed by the evidence of Dr McSweeney: Exhibit B9, paragraph [36] BOE
[28] Exhibit C1.2, pp. 172 – 177 BOE
[29] Exhibit C3.1 starting at p.3 BOE

"*Dear Doctor*

Kindly review Christopher who presented with GIB required transfusions. His DAP stopped and UGI Endoscopy showed no active bleeding and refused Colonoscopy.

He was advised for fluid restriction.

His thyroid function needs to be rechecked as anti-thyroid medication stopped due to hypothyroidism.

His antiplatelet stopped due to his bleeding but need to review to restart medication in 1- 2 weeks. Consider leasing [liaising] with his primary cardiologist.

Please review other medication with him also."

[85] By her supplementary statement, Dr Tang states:

"*Regrettably, there was no documented plan in the clinical notes dated 22 September 2021 regarding the timeframe for GP follow-up, nor was there documentation of my discussions with Mr Doughty about aspirin therapy.*

Further, although I am certain that I had a discussion with Mr Doughty about the need and plan for aspirin therapy when discharged, I cannot specifically recall whether I instructed Mr Doughty to resume aspirin on discharge with subsequent GP review in one to two weeks for haemoglobin monitoring, or whether I advised him to seek review with his GP prior to resuming aspirin because of his expressed concern about re-bleeding.

Accordingly, I cannot confirm whether the discharge summary statement: 'Need review to restart medication in 1-2 weeks. Consider liaising with his primary cardiologist' was entered on my instruction or was interpreted and recorded by my junior doctor based on his understanding of the discussions between Mr Doughty and myself.

I cannot now recall in my discussion with Mr Doughty the timeframe in which I verbally told him to see the GP. If I was dealing with this case again today, I would say to the patient something to the effect of 'you need to start the aspirin once you go home, and see your GP as soon as possible to monitor your haemoglobin'.

The discharge summary was finalised on 22 September 2021 at 14:49, the same day as discharge, reflecting my junior doctor's effort to complete it promptly to support effective communication of the ongoing care plan. Unfortunately, due to clinical workload constraints, I was unable to review or clarify the discharge summary or follow up with the patient prior to discharge.

I was unaware that my discussions and recommendations on resuming aspirin had not been documented in the progress notes or that the discharge summary was not prescriptive about this until I was subsequently asked to review the case notes for the coroner's inquest. I did not receive a call from patient, his GP or community pharmacist for any enquiry for the treatment post discharge. This may be because he had not reached out to these services for treatment."

[86] Dr Ashour states:[30]

"*It is not clear from the practice's medical records when the discharge summary dated 22 September 2021 was received and I do not have an independent recollection of reviewing it. I acknowledge that it is in the practice's records contained in the brief of evidence.*

Facsimiles received by the practice are usually printed and stamped with the date of receipt and a box for the practitioner to tick once the document has been reviewed, indicating what action the practitioner would like taken in response e.g.: the document scanned into the record, the patient recalled, the patient recalled urgently etc. The instructions are then actioned by the practice staff and the document is scanned into the records.

I note that the discharge summary does not have a stamp indicating when it was received and there are no instructions on the document indicating that the document was reviewed by a practitioner.

To the best of my recollection and based on the absence of a 'date and action' stamp or some other notation indicating what action I wanted taken, I do not believe that I received the Harvey Bay Hospital Discharge Summary for Mr Doughty's admission in September 2021. I accept that it may be been received by the practice at some stage, however I do not believe that it was sent to me for review.

….. therefore I did not take any steps in response to the recommendations contained in it. Mr Doughty did not contact the practice either to make an appointment.

[30] Exhibit B16

Had I received it, I would have liaised with Mr Doughty's cardiologists and asked for Mr Doughty to be recalled to the practice for review, as I had done many times before."

[87] Despite Dr Ashour's conclusion that he did not view or action the HBH Discharge Summary recommendations, it seems that Mr Doughty might have had an appointment to see Dr Ashour following discharge regardless. In that regard there is a note of the NNS dated 28 September 2021 recording that "*He [Mr Doughty] has got appointment with GP on next Tuesday*", which would have been 5 October 2021 (the day Mr Doughty passed away). As to whether the NNS record is accurate is not clear as there is no evidence from Dr Ashour's practice that such appointment had in fact been scheduled.

[88] In respect of the process of Mr Doughty's discharge from HBH on 22 September 2021, I find as follows:

a) Given that Mr Doughty had declined to recommence Aspirin 100mg and remain in hospital so his risk for bleeding could be monitored, and given the risk for in-stent thrombosis was relatively low without recommencing Aspirin 100mg (see evidence of Dr Karasch below), it was appropriate to discharge him on 22 September 2021 without restarting Aspirin 100mg <u>provided that there was a clear plan in place for him to recommence Aspirin 100mg in the community shortly after being discharged</u>;

b) Although it would have been preferential to consult further with the TPCH Cardiology team about a plan for Mr Doughty recommencing Aspirin 100mg in the community <u>before his discharge</u> (in that TPCH Cardiology team would have then been on notice that the Aspirin had been ceased contrary to the earlier recommendation that it be continued, and that there was a need for its recommencement to be reconsidered in the community), at the time of discharge it is not likely TPCH Cardiology team would have made any recommendation other than that Aspirin 100mg be recommenced, leaving HBH medical staff in precisely same predicament they were in where Mr Doughty had declined to follow that advice;

c) Despite this predicament, in my view the discharge process was not adequate, nor appropriate, in that:

    i) Despite the critical nature of the issue and Dr Tang's stated preference that Mr Doughty be recommenced on Aspirin 100mg, the Discharge Summary and notes did not record a timeframe for Mr Doughty to contact his GP for that purpose;

ii) The Discharge Summary was not clear as to what was the intended timeframe for recommencement of APT, or even what APT was recommended;

iii) The Discharge Summary did not state that, in fact, the recommendation was that Aspirin 100mg be recommenced, that such recommendation had been made while Mr Doughty had been an inpatient, that it was the preference of medical staff at HBH that he remain an inpatient to monitor the effects of recommencing Aspirin 100mg, and that such recommendation had been declined by Mr Doughty against advice. In my view, all that would have been important information to be provide to the GP;

iv) It was not otherwise appropriate to leave it to Mr Doughty's GP to work out what was required. In my view, where Mr Doughty was discharging from HBH against medical advice, it would have been appropriate for HBH medical staff to facilitate consultation between the GP and TPCH Cardiology team to consider what was necessary in terms of recommencing APT in the community, or at least to notify each what HBH's recommendation was and that Mr Doughty was discharging without complying with that recommendation;

v) Regardless of what was advised to Mr Doughty about the need to contact his GP after discharge (such advice is not documented), it was not appropriate, in my view, to leave it up to Mr Doughty to make that contact in the context of his known non-compliance with medical advice.

[89] On 6 October 2021, Dr Andrew Haggerly, Intensivist, TPCH wrote to Dr Ashour as follows:

> "I regret to inform you of the death if Christopher Doughty in The Prince Charles Hospital ICU on 05/10/2021. Christopher Doherty was admitted on 02/10/2021, transferred from Maryborough Hospital following and inferior STEMI. Chris was lysed in Maryborough and subsequently transferred to the Prince Charles Hospital for an emergent PCI. Chris unfortunately deteriorated and was in frank cardiogenic shock on arrival. He was transferred to the Intensive Care Unit, intubated, and an Intra-Aortic Balloon Pump was placed to facilitate angiography. He was found to have in-stent thrombosis of a recently placed stent within the Circumvex vessel. Angioplasty to this lesion was performed.
>
> Unfortunately Chris failed to thrive. Despite mechanical and pharmaceutical support of his cardiogenic shock we were unable to make progress. Chris unfortunately became unsupportable

following a rapid deterioration on the evening of the 5th October 2021. Following discussions with Chris' next of kin (Doug), a decision was made to stop all active treatment. He died shortly after in the presence of the Intensive Care staff who were at his bedside during his death."

Concerns

[90] Contrary to the advice of TPCH Cardiology team to continue Aspirin 100mg, it appears that the DAPT was ceased entirely, as follows:

a) Clopidogrel 75mg was not written up by Dr McSweeney when Mr Doughty was admitted to HBH on 17 September 2021 and there is no other record that it was administered during the course of the admission;

b) Aspirin 100mg was initially written up by Dr Doughty in accordance with the recommendation of TPCH Cardiology team, but it was ceased after two doses were given (on 17 September 2021 and 18 September 2021, according to the record).

[91] The DAPT was not recommenced prior to Mr Doughty's discharge from HBH on 22 April 2021. Nor was Aspirin 100mg alone recommenced despite the advice of TPCH Cardiology team that it should continue.

[92] It also does not appear that there was any further consultation between the medical staff at HBH and TPCH Cardiology team to set a plan about Mr Doughty's antiplatelet therapy prior to his discharge on 22 April 2021.

[93] On 29 November 2021, Dr Griffiths of the CFMU observed:[31]

> "There are at least 5 published trials relating to discontinuation of clopidogrel after 3 months in patients following stent procedures. These in the main, show no statistical increase in major adverse cardiac events in patients who have stable ischaemic heart disease with discontinuation after 3 months compared to 12 months....but who remain on life-long aspirin.
>
> There is conversely a significant increase in such events is clopidogrel is ceased within the first 3 months. This is a complex area of cardiology, with many patient variables and it would be in the province of an interventional cardiologist to provide a clear picture. If Mr Doughty had been maintained on at least aspirin, as

[31] Exhibit A2, BOE

was the clinical intention, his chances of survival would have been better and this could have been outcome changing for him.

Late stent thrombosis can still occur in patients who have had Drug Eluting Stents even while taking DAPT, and the risk can extend for more than one year after the procedure."

[94] Subsequently, Dr MacCormick of the CFMU observed:[32]

> "Considering there was no active bleeding identified at endoscopy, he was haemodynamically stable at discharge with a haemoglobin level of 149, and the cessation of aspirin was contrary to cardiology advice, I am surprised that aspirin was ceased by the medical team during the admission at Hervey Bay Hospital. This clinical decision was outcome changing, making this a healthcare related death."

Expert opinion

Dr Ian Dickinson, General Practitioner

[95] Dr Ian Dickinson (Dr Dickinson) has provided a report dated 5 September 2025[33] by which he opines (relevant to the revised List of Issues) to the following effect:

a) Most Medical Practitioners would understand that there would be some risk in stopping DAPT, shortly after coronary stents had been deployed. Mr Doughty had had coronary stents for about three months. Standard procedure for this is well known in General Practice.

b) DAPT is usually continued for 12 months with aspirin being taken for life. The risk is with a clot forming in the stent and blocking blood supply to the heart muscle causing a heart attack.

c) General Practitioners would be guided by the specialist medical practitioners caring for the patient with regard as to the cessation of DAPT and its reinstitution.

d) Dr Ashour would have understood these risks, however he would be guided by the doctors at the Harvey Bay Hospital and their advice documented in the Discharge Summary dated 22 September 2021.

e) He would not expect a general practitioner in the position of Dr Ashour to make contact with the patient's treating cardiologist to seek their input as regards to the cessation of the antiplatelet therapy.

[32] Exhibit A3 BOE
[33] Exhibit D1

f) Usually General Practitioners would wait for the patient to make contact within the timeframe suggested in the discharge summary. Then they would review and discuss the discharge summary together.

g) The timeframe in the discharge summary was lacking clarity. The recommendation is to review Mr Doughty's anti-platelet therapy in 1 to 2 weeks. "*This is vague indeed; was it just to be reviewed in that time? Was it to be restated in that time? Was it 7 days or 14 days or some where in-between? Was one or both agents to be restarted? The directions to Dr Ashour as a General Practitioner needed to be much more precise*."

h) General Practitioners are not privy to all the trials and tribulations that might have occurred in hospital. This would be especially so in Mr Doughty as he was a difficult patient with multiple co-morbidities and he had only come under the care of Dr Ashour recently.

i) Dr Ashour had a limited view, in the sense that he only had a summary to understand what in this case, was a very complex situation. It appears that the Harvey Bay Hospital asked the least qualified person (that of a local GP) with the least amount of knowledge of Mr Doughty's admission, to make what was the most crucial decision in his management.

j) One would think that the decision to restart DAPT would best be performed by the Specialist Teams that had been looking after Mr Doughty. Those teams should have liaised with the Prince Charles Hospital with regard to the reintroduction of the anti-platelet therapy. Throughout the medical records the doctors at both the Maryborough Hospital and the Harvey Bay Hospital sought advice from cardiologists at the Prince Charles Hospital, yet they did not seek that advice with regard to restarting Mr Doughty's anti-platelet therapy. Instead they abrogated their responsibility to the local General Practitioner with an inadequate recommendation which was unclear in its expression.

k) Most General Practitioners would review the discharge summary when the patient presented as directed in the summary. They would assume that the timeframe mentioned in the discharge summary would be communicated to the patient, and that the patient's condition would be stable and not need intervention in that time. In the discharge summary under the heading "*Recommendation to the Patient*" the only notation is "*nil entered*". With a patient who has proven himself to be quite challenging with respect to compliance let alone medical management, you would expect that there would be detailed advice to the patient which would further allow Dr Ashour to understand Mr Doughty's circumstances and management.

l) The doctors at Harvey Bay Hospital should have sought advice from the specialists at The Prince Charles Hospital as to when Mr Doughty's anti-platelet therapy should have been restarted. They had sought that advice on a number of occasions during his admission.

m) General Practitioners would not have the expertise to know when to restart this therapy in such a complex patient without clear specialist direction.

n) "*It would seem to me that restarting the anti-platelet therapy earlier, would have a less adverse outcome if Mr Doughty did re-bleed*."

o) "*From my perspective as a General Practitioner (who has not worked directly in the public hospital system for many years), I would have thought that once Mr Doughty was stable with a normal haemoglobin and no further signs of bleeding, that his anti-platelet therapy (with respect to his aspirin) would best be restarted while he was in hospital where he could be monitored closely for signs of bleeding*."

p) "*This was a man who was socially isolated with very little support, on home oxygen and with mobility issues, who was non compliant by nature. I realise that this would have delayed his discharge, but to my mind this would have been the safest option*."

Dr Jeff Karrasch, Consultant General Physician

[96] Dr Jeff Karrasch has provided a report dated 30 September 2025[34] by which he has opined to the following effect:

a) Dual antiplatelet therapy is widely recognised as a cause of increased bleeding, including gastrointestinal bleeding, and it is apparent from the history in the brief that Mr Doughty reported this problem commencing shortly after the DAPT was commenced.

b) An upper gastrointestinal endoscopy was performed as appropriate, and although it was thought most likely to reveal a source of bleeding, it in fact did not. Accordingly, a CT angiogram was performed to try and pinpoint the area of bleeding, but was negative suggesting there was no active bleeding at the time. It was therefore decided to proceed to a colonoscopy looking for a lower gastrointestinal source of bleeding, but this was declined by Mr Doughty.

c) Dual antiplatelet therapy is more likely to cause or perpetuate gastrointestinal bleeding and it was appropriate to cease DAPT but to continue aspirin initially, whilst the source of bleeding was investigated and hopefully treated, although this proved not to be possible. The risk of in-stent thrombosis and cardiovascular complications from ceasing the clopidogrel at this point (three months) was small, and the benefit for the bleeding likely to be substantially greater, so this was in my opinion appropriate.

d) Once the available investigations had been performed, with no cause of the bleeding delineated, the treating physician was in a very difficult position.

[34] Exhibit D2

e) Mr Doughty had suffered a severe and life-threatening gastrointestinal bleed and was lucky to have survived that, given his other comorbidities. Further bleeding would have run a substantial chance of being fatal, and the risk of that was diminished by ceasing aspirin.

f) However, ceasing aspirin in addition to the clopidogrel increased the risk of cardiovascular complications, and in-stent thrombosis and was the basis of the Prince Charles Hospital Cardiology Team requesting that it continue.

g) The planned short one to two week cessation of aspirin was not unreasonable, given that it takes approximately 10 days for the antiplatelet effect of aspirin to disappear, and the risk of in-stent thrombosis during that period was probably no higher than the risk of recurrent gastrointestinal bleeding. This was not the case and instead, thrombosis did occur. However that the decision to cease the aspirin at that time for that brief period in the setting of life-threatening gastrointestinal bleeding was not unreasonable.

h) It is likely that there was a lower gastrointestinal source of bleeding. An upper GIT source had been reasonably excluded by the normal endoscopy, and the next most likely source was the colon, either through angiodysplasia, or in association with Mr Doughty's known diverticulitis. There was evidence consistent with ongoing bleeding as at 18 September 2021.

i) On 18 September 2021, Mr Doughty's haemoglobin had improved from 46 the day before to 118, after transfusion of at least five bags of packed red blood cells. Mr Doughty remained critically unwell and dependent on inotropes for cardiac support and hypotension. Dr Pratheepan, the staff physician who attended Mr Doughty on 18 September recorded "*Likely still having ongoing bleeding...unstable clinically...on fifth bag of blood*". Whilst the haemoglobin rose to a peak of 118 after transfusion, it had fallen to 100 again by the 21 of September, suggesting ongoing bleeding.

j) It is likely that the suspected lower GIB was active and ongoing at the medical review on morning of 18 September 2021.

k) The further investigations (CT angiogram an colonoscopy) were appropriate and needed. Had the CT angiogram revealed an active source of bleeding, it would have allowed targeted treatment, and in its absence an inspection of the lower bowel with colonoscopy was the appropriate next test. Regrettably, it was declined by Mr Doughty.

l) The unhelpful CT angiogram indicated that bleeding was not active at that moment in time. In the absence of any defined source of bleeding on the upper GIT endoscopy, it was still likely that a lower source of gastrointestinal bleeding existed.

m) Ceasing the aspirin as well as the clopidogrel obviously increased the risk of cardiovascular complications and in-stent thrombosis. Conversely, continuing it increased the chance of further gastrointestinal bleeding which Mr Doughty had already suffered with life-threatening levels of anaemia in association with his other comorbidities.

n) With the benefit of hindsight, ceasing the aspirin did have disastrous and eventually lethal consequences for Mr Doughty, but the likelihood of this in the one to two week period following cessation of aspirin was relatively low, and therefore the rationale for ceasing the DAPT after 18 September for a defined relatively short period of time to limit further bleeding was not unreasonable or inappropriate.

o) The medical team at HBH ought to have understood the increased cardiovascular risk for Mr Doughty in ceasing the DAPT. Ceasing clopidogrel at three months post stent is low risk and reasonable. Ceasing aspirin as well is a significant risk. This is the reason it was planned to restart the antiplatelet therapy in one to two weeks, which is roughly the period of time it takes for the antiplatelet activity of the DAPT and aspirin in particular to wear out of the system.

p) Further Cardiology input from Mr Doughty's treating team at TPCH would have contributed to the decision faced by the treating physician in attendance at that time. They would presumably have again requested that aspirin therapy be reinstituted if at all possible, and the treating physician would again have faced the dilemma of doing so being likely to increase or cause recurrent life-threatening gastrointestinal bleeding. Accordingly, it was reasonable and appropriate for them not to further discuss the situation with TPCH.

q) It was reasonable to plan to restart the antiplatelet therapy in the planned one to two weeks, and hence appropriate to discharge him without restarting the DAPT. Recurrent bleeding was still a significant risk at that stage.

r) It would have been reasonable for Dr Pratheepan to arrange recommencement of antiplatelet therapy himself from HBH. It is however the recommendation that wherever possible, responsibility for the follow-up therapy after hospitalisation should be returned to the patient's general practitioner. Accordingly writing to the general practitioner requesting he review, restart the DAPT in one to two weeks, and consider liaising with his primary cardiologist was, if not ideal, appropriate.

s) Mr Doughty was offered recommencement of aspirin and observation, presumably as an inpatient, and refused. Had he not refused, recommencement of aspirin under observation would have been appropriate, but having refused to do so, the recommendation that it be recommenced in one to two weeks as an outpatient was appropriate.

t) It is apparent from the history that Mr Doughty was frequently non-compliant with medical advice, including self-discharging against medical advice on multiple occasions. However, he could not find any evidence in the brief that he had been non-compliant with his DAPT.

u) Mr Doughty was an extremely ill man, with multiple life-threatening comorbidities, with the life expectancy estimated as at the bottom of a two to five year range. His risk was further compounded by his non-compliance with medical advice, and he had of course stated that he did not want intensive resuscitation and had an ARP in place to this affect.

v) His parlous end-stage respiratory disease in association with multi-bed vascular disease and aortic stenosis in particular, meant that gastrointestinal bleeding was a very great risk to him, and "*to be honest, I am surprised he survived the initial drop in haemoglobin to 46, albeit with evidence of further myocardial damage*."

w) It is highly likely that further bleeding would have had disastrous and possibly been fatal, as unfortunately was the in-stent thrombosis.

x) Continuing aspirin or DAPT was just as likely to have resulted in disaster and eventual death of Mr Doughty as ceasing it, and accordingly, without the benefit of hindsight, and with consideration of Mr Doughty's health at the time of the presentation, the care provided was reasonable and appropriate under the circumstances.

Associate Professor Anthony Camuglia, Interventional Cardiologist

[97] Associate Professor Anthony Camuglia (**A/Prof. Camuglia**) has provided a report dated 27 October 2025[35] by which he has opined to the following effect:

a) Mr Doughty (**CGD**) had the comorbidities of coronary artery disease, paroxysmal atrial fibrillation, peripheral vascular disease, moderate to severe valvular aortic stenosis, episodic congestive cardiac failure, hypertension, dyslipidaemia, depression and Grave's disease with hyperthyroidism. In addition, and perhaps most significantly, CGD had an extensive history of tobacco smoking with consequent advanced mixed chronic lung disease (predominately chronic obstructive lung disease) being treated with inhalers, home oxygen supply and as required oral opioid therapies. CGD had also been referred to a palliative care team while at PCH.

b) In early June 2021 CGD was admitted to HBH and subsequently transferred to TPCH with decompensated congestive cardiac failure

[35] Exhibit D3

precipitated by the onset of idiopathic autoimmune hyperthyroidism (Graves disease).

c) During this admission at both HBH and TPCH evaluation of underlying contributing substrates to the cardiac failure precipitated by the Graves disease were identified and evaluated and included two vessel coronary artery disease, valvular aortic stenosis and atrial fibrillation.

d) As part of the management strategy a multidisciplinary decision was made to proceed with stenting to the narrow coronary arteries around CGD's heart to reduce his symptoms of angina. As a result, CGD underwent a coronary stenting procedure at PCH on 21 June 2021 with drug eluting stents (small metal scaffolds) to the left anterior descending coronary artery and the dominant left circumflex artery without complication. Following this, the patient was stepped down to HBH, then MH before being discharged home on appropriate dual antiplatelet therapy (date of discharge from MH was 22 July 2021).

e) On 17 September 2021 CGD presented with severe anaemia arising from subacute on chronic life-threatening gastrointestinal bleeding to MH. The most likely underlying cause of bleeding was Heyde's syndrome secondary to aortic valve disease. This is a condition with occult angioectasia of the small or large bowel and will be exacerbated and unmasked by dual antiplatelet therapy (i.e. aspirin and clopidogrel). Other potential aetiological substrates including diverticular disease or neoplasia (e.g. bowel cancer) are other possible differential diagnoses.

f) The team at MH contacted the treating cardiology team at MH on 17 September 2021 who recommended continuation of lone agent aspirin single antiplatelet therapy (**SAPT**) and cessation of clopidogrel.

g) On 18 September 2021 CGD was transferred to HBH for ongoing management. He underwent upper endoscopy but not lower endoscopy (patient did not consent to lower endoscopy).

h) While at HBH, CGD was not prescribed clopidogrel and had aspirin ceased. He was discharged home following medical stabilisation on 22 September 2021 on no antiplatelet therapy with a plan in the discharge summary (but not apparent in the clinical notes) for antiplatelet therapy to be considered by the treating general practitioner in the coming weeks.

i) The purpose of dual antiplatelet therapy (DAPT) after a coronary stenting procedure is to prevent stent thrombosis/occlusion, heart attack and death.

j) It is usually recommended that DAPT with two agents (e.g. aspirin 100 mg daily and clopidogrel 75 mg once daily) be administered for anywhere between 3 to 12 months, but as a bare minimum 1 to 3 months (depending on bleeding risks and other factors).

k) Following the initial period of DAPT, the standard recommendation is then to follow this with SAPT indefinitely/life-long. Normally this would be SAPT with something like aspirin 100 mg once daily (although lone clopidogrel 75 mg once daily is an acceptable alternative and in patients with atrial fibrillation lone DOAC would also be acceptable).

l) CGD's bleeding was driven by DAPT in combination with probable previously sub-clinical Heyde's syndrome secondary to aortic valve disease or possible another underlying substrate for bleeding in the gastrointestinal tract. Given the clinical history and previous blood test results the gastrointestinal bleeding was likely predominantly precipitated by the DAPT.

m) The advice to cease DAPT and continue SAPT is the appropriate management strategy in this setting. The standard of care would be for SAPT to continue without interruption although a brief (i.e. few days) of cessation of SAPT could be considered. Even if SAPT was interrupted temporarily (i.e. for a few days) it would be unusual not to recommence this prior to hospital discharge. In addition, if there was ongoing uncertainty around SAPT strategy at discharge both an informed consent shared decision-making risk benefit type discussion with the patient and re-engagement with the treating team at PCH would have been indicated. Performance of colonoscopy (or not) would not change this position or recommendation.

n) In general, it would be below the required standard of care for discharge without SAPT in the absence of clear documentation and planning around this in the specific circumstances surrounding CGD's care. Deferral to the general practitioner to have sorted this out is not reasonable, appropriate or safe. It does not meet the required standard.

o) As a quality improvement measure the recommendation would be to reinforce unit education around shared decision making, interdisciplinary liaison and patient centred care and the documentation of same.

p) In relation to whether CGD's demise was healthcare related, it is quite possible and perhaps probable that the failure to reinstate SAPT was material to the timing of the demise of CGD by precipitating late stent thrombosis. This would render the death of the deceased as possibly healthcare related. Having said this, given CGD's comorbidities and competing health issues, it is also entirely possible that CGD may have

died at or around the same time (i.e. within days or weeks) even if SAPT had been recommenced. CGD had a guarded prognosis from his health issues and had already been referred to a palliative care team by PCH.

q) Put another way, it is entirely possible, and not unlikely, that CGD would have died at or around the same time even if he had been discharged on SAPT. It would be impossible to provide a specific quantum of the relevant probabilities.

Issue 3

Whether Mr Doughty's treatment and management at the Maryborough Hospital (MBH) and the HBH during the admission of 17 September 2021 to 22 September 2021 was adequate and appropriate

[98] In respect of Issue 3, I find as follows.

[99] Issue 3(a): The decision at or about the time of his admission on 17 September 2021 to cease Mr Doughty's DAPT, namely by ceasing Clopidogrel 75mg daily but to continue the Aspirin 100mg daily, was appropriate.

[100] Issue 3(b): the initial investigations conducted on 17 September 2021, namely the endoscopy performed on that date, to investigate Mr Doughty's suspected GIB were adequate and appropriate.

[101] Issues 3(c) and 3(d): I accept Dr Karrasch's opinion to the effect that, notwithstanding the improvement in his haemoglobin levels after transfusion of at least five bags of packed red blood cells, Mr Doughty remained critically unwell and dependent on inotropes for cardiac support and hypotension. I accept that whilst his haemoglobin rose to a peak of 118 after transfusion, it had fallen to 100 again by the 21 September 2021, suggesting ongoing bleeding. I therefore accept that it is likely that the suspected lower GIB was active and ongoing at the medical review on morning of 18 September 2021, and I find accordingly.

[102] Issue 3(e): In the above circumstances, it was appropriate to recommend further investigations on the morning of 18 September 2021, namely colonoscopy and CT angiogram.

[103] Issues 3(f) and 3(g): In the above circumstances, the decision/recommendation of the medical team at HBH to cease all antiplatelet therapy (i.e. including the Aspirin) on 18 September 2021 was appropriate and the rationale for doing so as set out in Exhibit B5 of the Brief or Evidence at paragraphs [30] to [34] was appropriate.

[104] Issue 3(h): Given his risk for further or ongoing catastrophic GIB, and the limited additional benefit DAPT would have provided to Mr Doherty at that time as outlined by Dr Karrasch in his report, it was appropriate to

discharge Mr Doughty on 22 September 2021 without restarting the DAPT.

[105] Issues 3(i), 3(j), 3(k) and 3(l): My findings in respect of these issues are contained at paragraph [88] above.

[106] Issue 3(m): My findings in respect of this issue are contained at paragraphs [81] above.

Issue 4

Whether any failure to provide treatment and management to Mr Doughty at HBH caused or hastened his death

[107] A. Prof Camuglia opined to the effect "*it is quite possible and perhaps probable*" that the failure to reinstate SAPT (aspirin 100mg) was material to the timing of the demise of Mr Doughty by precipitating late stent thrombosis.

[108] However, he also opined that, given Mr Doherty's comorbidities and competing health issues, it is "*entirely possible*" that Mr Doughty may have died at or around the same time (i.e. within days or weeks) even if SAPT had been recommenced. Mr Doughty had a guarded prognosis from his health issues and had already been referred to a palliative care team by TPCH. Put another way, it is "*entirely possible*", and "*not unlikely*", that Mr Doughty would have died at or around the same time even if he had been discharged on SAPT. However, it would be impossible to provide a specific quantum of the relevant probabilities.

[109] Dr Karrasch's evidence is to a similar effect. He said ceasing the aspirin as well as the clopidogrel obviously increased the risk of cardiovascular complications and in-stent thrombosis. With the benefit of hindsight, ceasing the aspirin did have disastrous and eventually lethal consequences for Mr Doughty, but the likelihood of this in the one-to-two-week period following cessation of aspirin was relatively low.

[110] However, Dr Karrasch also opined to the effect that Mr Doughty was an extremely ill man, with multiple life-threatening comorbidities, and with the life expectancy estimated at the bottom of a two to five year range. His risk was further compounded by his non-compliance with medical advice. His parlous end-stage respiratory disease in association with multi-bed vascular disease and aortic stenosis in particular, meant that gastrointestinal bleeding was a very great risk to him. It is highly likely that further bleeding would have had disastrous and possibly been fatal [if Aspirin 100mg had been restarted], as unfortunately was the in-stent thrombosis. Continuing Aspirin or DAPT was just as likely to have resulted in disaster and eventual death of Mr Doughty as ceasing it.

[111] Having regard to the evidence of the experts, I find as follows:

a) Not restarting Mr Doughty on Aspirin 100mg at or about the time of his discharge from HBH (or shortly thereafter) likely materially contributed to his death in that it is likely this precipitated (or did not prevent) late stent thrombosis.

b) However, it is not likely that not restarting Mr Doughty on Aspirin 100mg at or about the time of his discharge from HBH (or shortly thereafter) hastened his death in any material way (if at all) given his co-morbidities and his risk for a catastrophic bleed leading to his death if he had been restarted on Aspirin 100mg.

Issue 5

Whether the response to Mr Doughty's death on the part of HBH has been adequate and appropriate?

[112] By his correspondence dated 22 May 2025,[36] Dr Zappala states:

> "*I can see that a cardiology review was internally recommended prior to Mr Doughty's discharge, however this did not take place. There was a comment in the discharge summary, which was prepared and sent within 24 hours of leaving hospital, asking the GP to consider liaising with TPCH cardiology team. This cardiology contact would have been preferable had it occurred by the inpatient clinical teams. Dr Tang and colleagues have reflected on this discharge process and that they should have perhaps contacted TPCH cardiology team themselves…..*
>
> *….*
>
> *I surmise that we could have conducted a 'tighter' discharge process that gave more assurance and direction to Mr Doherty and his GP as the ongoing caregiver. The discussions with Mr Doherty while an inpatient were reinforced with a request to the GP in the discharge summary to reinitiate DAPT within 1-2 weeks and to consider liaising with TPCH cardiology team. The requirement to restart DAPT was also noted on the pharmacy discharge as a comment at the end. I accept that both of these written messages were not necessarily easily locatable and/or acted upon.*
>
> *WBHHS is very aware of the critical importance of a secure, well informed and communicated discharge process that leaves the patient confident in their ongoing care requirements and commitments. We are currently undertaking a district wide discharge summary review process to examine interventions that will improve both the timeliness and accuracy/helpfulness of our discharge summaries. This includes creating templates to ensure the most helpful information is conveyed, including follow-up*

[36] Exhibit B19

appointments, medication adjustment, dressing changes and so on. The surgical wards are also developing discharge checklists to ensure all aspects of a safe discharge are attended to and when established, we intend to extend this to other clinical areas in a manner that best suits those clinical teams.

As a simultaneous component of this we have increased our education to junior doctors (the principle authors of discharge summaries). This aims to improve global medical communication, but including discharge summaries, and teach that these matters are as much about their own professionalism as they also relate to clinical need and accuracy.

I can assure you the medical leadership and executive of WBHHS are firmly focussed on improving our discharge process and by extension our quality of care, plus our collegiality with our private sector and community-based colleagues.

In Summary

I remain of the view that WBHHS clinicians did well over an extended period in managing Mr Doughty's complex and increasingly challenging care. The clinical teams and Dr Tang personally have reflected on this case and the care provided. They have accepted there was opportunity to improve documentation of medically relevant discussions with the patient and I do not regard this as a significantly recurring problem. They have also accepted that a firmer, more obvious plan to restart DAPT or aspirin might have been helpful, and I do believe this has already been incorporated in daily clinical practice for these clinicians. The more personal approach in contacting colleagues, in this case at TPCH, has been understood and accepted as a learning going forward. The WBHHS discharge process review I've alluded to will have tangible outcomes that will consolidate then learnings from Mr Doughty's case.

…

Since Mr Doughty's death we have developed a cardiology service led by on-site cardiology specialists on the Fraser Coast. They provide a responsive consultation service and advice and I'm of the view Mr Doughty's case would have been thoroughly discussed with one of our cardiologists and it is highly likely in-person consultation would have occurred to help guide our other clinical teams who were involved in Mr Doughty's care. This would obviate the historic difficulties of liaison with tertiary centre cardiology services.

Mr Doughty died over three years ago, and in the intervening time many patient safety improvements have been made (not in response to this death but generally throughout the health

service). I have considered the need to conduct a systemic investigation, however I do not see the utility in doing so now as I believe the learnings possible have been acknowledged and assimilated by clinicians with ongoing work underway to augment this.

WBHHS takes its responsibilities to safeguard patients from harm very seriously, and I can assure you that if I felt an investigation at this stage was necessary, I would have asked Clinical Governance to undertake one. As always, we engage in continuous review and learning to improve the outcomes for our patients and local area and take any helpful advice to improve our patient and community care."

[113] Additionally, I note that Dr Tang has explained and acknowledged:[37]

a) "*While Queensland Health recommends that the team comprise one registrar and two residents, the medical unit at Hervey Bay Hospital was understaffed. At the time of this incident, due to the clinical workload, I was only able to complete my ward rounds with one junior doctor, as the other was engaged in urgent clinical duties for other patients under our care….. I recall that there were daily discussions regarding the risks and benefits of resuming antiplatelet therapy. As set out in my previous statement, these occurred on 20, 21 and 22 September 2021. I regret that my junior did not specifically record these conversations. I am now more alert to what is being scribed in the record about my consultations, and I endeavour to ensure that all relevant information has been captured*."

b) "*Regrettably, there was no documented plan in the clinical notes dated 22 September 2021 regarding the timeframe for GP follow-up, nor was there documentation of my discussions with Mr Doughty about aspirin therapy*."

c) "*On reflection, and with the benefit of hindsight, I agree that the DS [Discharge Summary] could have been clearer and more prescriptive about the timeframe and exactly what it was the GP was being asked to do. As I stated above, I cannot say whether my junior interpreted my plan in his own words in the DS, or added in his own clinical judgment about the timing of the recommended GP review….. As a result of the reflection I had on this case, in cases involving complex clinical decisions, I ensure the discussion is documented in the clinical notes, either by myself or by providing clear instructions to junior staff and reviewing their entries for accuracy. I also ensure DSs clearly communicate the management plan to the patient and GP, in compliance with Wide Bay Hospital and Health Service guideline (WBBHHS-PRO-0277, section 3.5)….. I also encourage my juniors to insert important information into the draft DS even prior to the patient being discharged, to ensure it is handed over*

[37] Supplementary statement dated 20 November 2025

on discharge and not mistakenly left out….. In complex cases, I prepare the discharge summary myself."

[114] As outlined above, my concerns regarding Dr Doughty's treatment and management at HBH centre on the paucity of the documentation (particularly given Mr Doughty's non-compliance with the recommendations made about restarting Aspirin) and the discharge process.

[115] Having regard to the above, I am satisfied that the response to Mr Doughty's death in the context of these issues has been adequate both at the institutional and individual practitioner level.

Issue 1- Findings pursuant to s.45 *Coroners Act 2003*

[116] I make the following findings pursuant to s.45 *Coroners Act 2003*:

(a) The deceased person is Christopher Doughty, born on 18 August 1954;

(b) The deceased died from multi-organ failure secondary to an acute myocardial infarct, which was in turn secondary to an in-stent restenosis following cessation of dual antiplatelet therapy (DAPT) to manage a gastrointestinal bleed caused by the DAPT.

(c) The deceased died on 5 October 2021;

(d) The deceased died in the Intensive Care Unit of The Prince Charles Hospital, Queensland;

(e) As to what caused the deceased to die, the direct cause was in-stent restenosis following cessation of DAPT and not restarting Aspirin 100mg.

[117] I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE