QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Rosemarie Campbell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2022/922
DELIVERED ON:	9 June 2026
DELIVERED AT:	BRISBANE
HEARING DATE(s):	Pre-inquest conference 9 April 2025 Inquest 18 August 2025 – 19 August 2025 Written submissions post-inquest 10 November 2025 – 3 March 2026
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, health care related death, weight loss surgery, bowel obstruction, herniation, perforation, acute bacterial peritonitis, inappropriate discharge post operatively, poor and absent clinical record keeping, false clinical records and correspondence

REPRESENTATION:

Counsel Assisting:	G Diehm KC and S Ford
Dr Reza Adib	C Templeton instructed by Moray and Agnew
The Wesley Hospital	A Hughes instructed by Barry Nilsson Lawyers
Family	O Perkiss instructed by OMB Solicitors
RN Teresa Fomiatti	S Robb KC instructed by QNMU Law
Dr Daniel Burger	C Steele instructed by HBA Legal
RN Anna Langton	R Nattrass instructed by Hall Payne Lawyers

Contents

Introduction

1. Rosemarie Campbell, aged 62 years, died on 27 February 2022, due to complications following gastric bypass surgery undertaken at the Wesley Hospital on 24 February 2022.

2. Ms Campbell's death was a reportable death for the purposes of s8(3)(d) of the *Coroners Act 2003* ('the Act').

3. I determined, pursuant to s28(1) of the Act, that it was in the public interest to hold an inquest into Ms Campbell's death.

The investigation

4. During the coronial investigation, medical records were obtained from the Brisbane Obesity Clinic, being the practice run by Dr Reza Adib, the bariatric surgeon who performed the surgery and under whom Ms Campbell was admitted. Medical records were obtained from the Wesley Hospital, the Upper Coomera Medical Centre and Med Centres Pacific Pines, being the two general practices Ms Campbell had attended during the relevant time.

5. Statements from those relevantly involved in Ms Campbell's care, before, during and after her surgery on 24 February 2022, were also obtained. There were also statements provided by the Wesley Hospital and Uniting Care administrators in relation to reviews undertaken and improvements that have been made to clinical practices and procedures since Ms Campbell's death.

6. Members of Ms Campbell's family were also asked to provide statements addressing Ms Campbell's symptoms before and after surgery and her capacity to fund the surgery from her own savings.

7. Independent expert evidence was obtained from Professor Wendy Brown, upper gastrointestinal and bariatric surgeon. Professor Brown, who, amongst other things, is the Director of the Oesophago-Gastric Bariatric Unit at The

Alfred Hospital, provided three reports to the Court.[1] The latter two were supplementary reports in response to further information received by the Court.

8. Amongst other documents received during after the hearing of the inquest were Dr Adib's Medicare invoicing and PBS records of medication dispensed in response to prescriptions.

Autopsy results

9. On 1 March 2022, forensic pathology registrar, Dr Isaac Han, conducted an external and internal examination of Ms Campbell's body to establish her cause of death. Dr Han produced an autopsy certificate[2] and report.[3]

10. Dr Han concluded at that time:[4]

    i. Based on the circumstances surrounding Ms Campbell's death as outlined in the Police Form 1, consideration of the medical records, and postmortem examination with associated testing, the cause of death is sepsis secondary to acute bacterial peritonitis (bacterial infection within the abdominal cavity) and pneumonia, on a background of recent gastric bypass surgery.

    ii. PMCT showed a small bowel hernia with resultant small bowel obstruction, which would have produced small bowel dilation due to pressure build-up of bowel contents and gas.

    iii. Internal postmortem examination, including histology and microbiological analysis, showed fulminant bronchopneumonia, fulminant bacterial peritonitis with microscopic tears of the proximal small bowel, and focal ischaemic bowel, the rephrase (*sic*) strangulated hernia site. The strangulated hernia site is the most likely cause of bacterial spread, either directly through the strangulated necrotic (dead) bowel wall, or indirectly through distended/dilated up-stream small bowel as a result of small bowel obstruction (bacterial translocation).

    iv. The presence of peritonitis and pneumonia as two separate sources of infection, and microbiological confirmation of multiple bacterial species in multiple sampled sites is consistent with a

[1] Exs D1 – D3.
[2] Ex A2.
[3] Ex A3.
[4] Ex A3, p 13.

disseminated bacterial infection resulting in sepsis. Differentiation of the primary source of the sepsis (between peritonitis or pneumonia) cannot be determined, with both sources likely to have been contributory.

v. The surgical sites (both intra-abdominal and skin) were confirmed to be intact, with no ischaemia or definite dehiscence. The sutured liver subcapsular haematoma showed focal intraparenchymal haemorrhage. The acute pancreatitis seen is likely secondary to the acute bacterial peritonitis.

vi. The relative contribution of a post-surgical abdomen to bacterial translocation in an obstructed small bowel cannot be determined, but the surgical procedure was likely not a direct contributor to the cause of death.

vii. Toxicology showed therapeutic levels of analgesia and anti-nausea medications commonly used in a post-surgical patient, and therapeutic level of an anti-hypertensive medication.

11. As at that time, Dr Han had determined Ms Campbell's cause of death as:

    1(a) Sepsis *due to, or as a consequence of*
    1(b) Acute bacterial peritonitis and pneumonia
    Other significant conditions:
    2 Recent gastric bypass surgery.

12. On 27 June 2025, however, Dr Han produced an amended autopsy certificate[5] and report,[6] in which, he amended Ms Campbell's cause of death:[7]

> "Upon a review for the upcoming inquest, with the benefit of several additional years of experience, and in keeping with general consensus, the author's opinion is that Sepsis has not been definitely detected in this case. Sepsis in general is a difficult diagnosis to come to in the postmortem setting, and the autopsy findings here are insufficient to come to that conclusion. **The acute bacterial peritonitis and pneumonia are sufficient to have cause** [sic] **death independently.** The amended cause of death is as follows:

[5] Ex A6.
[6] Ex A5.
[7] Ex A5, p 14.

CAUSE OF DEATH

1(a).Acute bacterial peritonitis and pneumonia

Other significant conditions

2.Recent gastric bypass surgery"

13. Dr Han also clarified the following parts of his conclusions (as contained in his first report):

"**Additional comment**

I further refer to statements made under "Conclusion":

either directly through the strangulated necrotic (dead) bowel wall, or indirectly through distended/dilated up-stream small bowel as a result of small bowel obstruction (bacterial translocation).

And

The relative contribution of a post-surgical abdomen to bacterial translocation in an obstructed small bowel cannot be determined,

For clarity, the term bacterial translocation refers to gut (enteric) bacteria moving from inside the lumen of the intestines into the bloodstream or other sterile spaces, such as the peritoneal cavity. In this case, the route of bacteria entering the peritoneal cavity was identified as the microscopic tears and necrotic bowel seen on histology, and as such **the potential contribution of 'bacterial translocation' is retracted.**"

14. Essentially, the effect of Dr Han's revised opinion was that he could not definitively state that sepsis was a causal factor of Ms Campbell's death. The cause of death in his opinion was a combination of bacterial peritonitis with pneumonia from aspiration, due to an obstruction of the bowel.

The inquest

15. A pre-inquest conference was convened on 9 April 2025.

16. The inquest itself was held in Brisbane between 18 and 19 August 2025.

17. Following an opportunity for the interested parties to make submissions I determined the issues examined during the inquest, in addition to the findings required by s45(2) of the Act, were to be:

Issue 1:

(a): Whether the Roux-en Y gastric bypass surgery performed on the deceased was properly indicated, including as to whether there had been adequate investigation of her symptoms and whether, compared to alternative courses, the risks of the surgery compared to the possible benefits justified its performance.

(b): Whether the deceased was appropriately advised about the matters in (a) above prior to deciding to proceed with the surgery.

(c): When and why the deceased developed pneumonia and the consequences of having done so.

(d): The circumstances surrounding and the appropriateness of the deceased's discharge from hospital.

Issue 2: Cause of death – specifically, whether the cause of death included peritonitis and if so, when did it develop and why.

Issue 3: Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

18. The following witnesses gave oral evidence at the inquest:

i. Dr Isaac Han;
ii. Dr Reza Adib;

iii. Dr Daniel Berger;
iv. Ms Teresa Formiatti;
v. Ms Anna Langton; and
vi. Professor Wendy Brown.

19. At the inquest, legal representatives appeared on behalf of the family, Dr Adib, Ms Formiatti, Ms Langton and the Wesley Hospital.

Consideration of issues 1(a) and 1(b)

20. As Counsel Assisting submitted, it is convenient to deal with these issues together.

Ms Campbell's progress following her sleeve gastrectomy on 6 March 2020

21. On 6 January 2020, Ms Campbell consulted with Dr Reza Adib, General Laparoscopic Gastrointestinal Obesity Surgeon, about undergoing a sleeve gastrectomy. Her weight at that time was 130 kilograms, giving her a Body Mass Index ('BMI') of 44.5,[8] so morbidly obese. Ms Campbell was recorded as having reported no history of heartburn, indigestion or reflux.[9]

22. Following the consultation with Dr Adib, and for the purposes of the sleeve gastrectomy, on 14 February 2020, Ms Campbell consulted with a dietician.[10] Ms Campbell's 'goal weight' was recorded as being 85 kilograms.[11]

23. On 6 March 2020, Ms Campbell underwent the sleeve gastrectomy at the Wesley Hospital. The surgery was performed by Dr Adib.

24. Following the surgery, Ms Campbell consulted with a dietician from Dr Adib's practice on 16 March 2020 and 3 April 2020. As of 3 April 2020, Ms Campbell's weight was 109 kilograms.[12]

[8] Ex B1.1, pp 4 - 5; Ex C1, p 1.
[9] Ex B1.1, p 4.
[10] Ms Sharon Rochester.
[11] Ex B1.1, p 4.
[12] Ex B1.1, p 4.

25. On 4 June 2020, Ms Campbell had post-surgical appointments with Dr Adib and the dietician.[13] Thereafter, she consulted with dieticians on 19 August,[14] 3 September and 3 December 2020.[15] The final appointment occurred on 4 March 2021,[16] following which the regular appointments ceased.

26. At Ms Campbell's final appointment on 4 March 2021,[17] she weighed 87 kilograms with a BMI of 29.8. Ms Campbell's goal weight was still 85 kilograms. For the first time, Ms Campbell was recorded as reporting that she "finds water hard to swallow".[18]

27. There are no records from any of the appointments with the dieticians or Dr Adib in 2020 or 2021 that explicitly state that Ms Campbell reported suffering from any reflux-like symptoms. Dr Brown did describe difficulty swallowing as "an associated feature" of Gastro-oesophageal Reflux Disease (GORD) however.[19]

28. On 11 July 2020, however, Ms Campbell had attended upon Dr Suhana Raju at the Med Centre Pacific Pines. Dr Raju's notes from that consultation recorded "3 months post gastric sleeve Dr Adib" and "GOR on Nexium".[20] I proceed on the basis that GOR is an abbreviation for Gastro Oesophageal Reflux.

29. Nexium is a proton pump inhibitor that reduces stomach acid and treats gastro oesophageal reflux.[21]

30. Pre-operatively, it was part of Ms Campbell's discharge plan following the sleeve gastrectomy on 6 March 2020, for her to be discharged with medication for symptoms including reflux.[22] Dr Adib stated that "All

[13] Ex B1.1, p 3.
[14] This appears to have included a consultation with a nurse in relation to blood tests.
[15] Ex B1.1, p 3.
[16] Ex B1.1, pp 2-3.
[17] Which was with a different dietician (Ms Annette Pinto).
[18] Ex B1.1, p 3.
[19] Ex D1 paragraph 8.
[20] Ex B2.1, pp 3-4.
[21] Paragraph 23 of the final statement of Dr Adib.
[22] Ex B1.1, p 4.

patients that undergo sleeve gastrectomy receive a script for 28 days of Nexium 40 milligrams once a day orally."[23]

31. The Wesley Hospital discharge records suggest that Ms Campbell was discharged with "Nexium – reflux – once daily" (there was an order signed for by the anaesthetist, Dr Federov, for 30 days supply on discharge).[24]

32. In the consultation on 11 July 2020 with Dr Raju, Ms Campbell's complaint was of symptoms of reflux[25] on Nexium. This suggests, firstly, that Ms Campbell was still taking Nexium and secondly, that despite doing so, she was experiencing reflux symptoms.

33. I do accept, however, that there is a degree of ambiguity to the statement. It is possible, for example, that Ms Campbell was experiencing symptoms at that point in time and had been having them earlier whilst taking Nexium, before the supply ran out, with a gap in between. It is also possible that Ms Campbell had not used all of the Nexium initially and had resumed taking it but was still experiencing symptoms of reflux. Another possibility is that the hospital had given her more than 28 days' worth of Nexium on discharge,[26] though that seems unlikely, given Dr Federov's order. In any case, I conclude Ms Campbell was then experiencing symptoms of reflux at the time of seeing Dr Raju. It is noted though that the Nexium Ms Campbell got on discharge following the subject second operation in 2022 was the subject of a script from the anaesthetist, Dr Federov, with no repeats. That it was filled is evidenced by the PBS records.[27] The absence of evidence of a filled script on the March 2020 discharge leaves it unknown how much Nexium she had access to in the first few months following that discharge. However, it is less likely it was a long supply without a further script or a PBS record of dispensing. Given

[23] T1 – 15, LL 43 – 45.
[24] Ex B3.16, p 5.
[25] It cannot be assumed that the general practitioner's reference to GOR actually were symptoms of reflux as opposed to what Ms Campbell described herself as being reflux, given Professor Brown's evidence about true and false reflux.
[26] Exhibit B3.16 pages 2-3 provides only for Nexium 1 tablet per day and was to be collected from the hospital pharmacy, without specifying the total quantity that was being given.
[27] See exhibit F7.

Dr Federov's order, consistent enough with Dr Adib's intention, I am satisfied the supply on discharge was limited to 28 or 30 days.

34. Notably though, according to Dr Raju's records, Nexium was not prescribed on 11 July 2020, though other medications which were not reflux medications were. The Nexium dispensed from the Wesley Hospital does not appear on the PBS records either however the PBS record in F7 only covers the period starting 1 September 2020, 6 months or so post discharge.

35. Nexium was prescribed by Dr Troy Cartwright, another general practitioner, at Med Centres Pacific Pines, on 13 August 2021. On that occasion, Dr Cartwright prescribed Ms Campbell 40 milligrams of Nexium. These records are sparse for detail though, with it simply being recorded as "confirmed dose and need for ongoing treatment as per surgeon".[28]

36. The evidence of both Dr Adib and Professor Wendy Brown is to the effect that a significant number of patients will develop symptoms of reflux following a sleeve gastrectomy, and for a significant portion of those patients, the symptoms will persist.[29] Accordingly, it can be taken that Ms Campbell was experiencing symptoms at that point in time. Her daughter, Chantelle McLendon, said that her mother was having regular issues with reflux and that they had numerous conversations trying to figure out if it was her diet, despite the fact that she was following the diet plan given to her post the 2020 surgery.[30]

37. In relation to the Nexium script issued by Dr Cartwright, the PBS records show that there were two dispensations of Nexium pursuant to that script - one on 11 September 2021 and the other on 4 December 2021.[31]

38. It is notable that Ms Campbell sought a script for Nexium on 13 August 2021 (implying that she was experiencing reflux symptoms at that time)

[28] Ex B2.1, p 6; Ex F7, p 1.
[29] T1-16, LL 47 – 49; T1-17, LL 1-4; T2-7, LL 10-24.
[30] Exhibit E paragraphs 19-26.
[31] Ex F7.

but did not first fill that script until 11 September - around four weeks later.[32]

39. The PBS records show only one other dispensing of Nexium, namely, on 26 February 2022 - the day Ms Campbell was discharged from the Wesley Hospital following a Roux-en-Y gastric bypass procedure.[33]

40. There remain some other mysteries with respect to the prescribing and dispensing of Nexium in response to Ms Campbell's complaints of reflux.

41. The second dispensing pursuant to Dr Cartwright's script occurred about one month before Ms Campbell contacted Dr Adib on 5 January 2022 (that is, when the second packet she obtained pursuant to the script from Dr Cartwright would be expected to be running out). There is some confusion in the PBS records concerning Dr Cartwright's script as to how many repeats there were, but it seems reasonably safe to assume that there was only one.

42. Looking at Dr Adib's billing history from his own internal software concerning Ms Campbell's attendances, it is evident that he charged her for a consultation on 5 January 2022. It is known that on that day he provided her with a script for a six-month supply of Nexium.[34] Dr Bryce Joynson (from Med Centre Pacific Pines) also prescribed Nexium for Ms Campbell on 5 January 2022 with one repeat.[35] Dr Adib provided a further script on 14 February 2022, being his last consultation before Ms Campbell's Roux-en-Y gastric bypass.[36]

43. None of those three scripts issued in January and February 2022 were ever filled by Ms Campbell, on the available evidence. This suggests that she did not take Nexium from 5 January 2022 through until the Roux-en-Y gastric bypass in 2022.

[32] Ex F7.
[33] Ex F7.
[34] Ex C1.5; Ex B1.1, p 2.
[35] Ex B2.1, p 7.
[36] Ex B1.1, p 2.

44. Counsel Assisting submit that an inference that might be drawn from all of the above circumstances is that Ms Campbell's reflux symptoms were not severe, though they no doubt existed and may have been troubling for her. A competing inference is that they were severe but that she found the medication ineffective, so she did not persist in taking it.

45. In evaluating these inferences, it should be accepted that Ms Campbell contacted Dr Adib with some complaint on 5 January 2022. It seems unlikely that it was a complaint about her weight, though. To that end, when Ms Campbell spoke to the dietician on 14 February 2022, after booking in the Roux-en-Y gastric bypass, her goal weight was recorded to be 83 kilograms. She was, at the time, 88 kilograms.[37] It is implausible that she sought, contemplated or agreed to have further surgery of this kind for the purposes of losing five kilograms of weight.

46. Given that there was no current referral to Dr Adib at the time of the conversation on 5 January 2022 and that Dr Adib commended that Ms Campbell get one, it can be accepted that she initiated the contact with Dr Adib herself because of some complaint. The only complaint that seems to have any real credit is that of reflux symptoms and it should be assumed that the symptoms were significant enough for her to seek out a consultation with her surgeon about them.

47. It should be observed that in his letter to the general practitioner on 15 February 2022, Dr Adib described Ms Campbell as suffering "from a lot of gastroesophageal reflux disease".[38]

48. Dr Adib's submissions point to scripts for Nexium issued by him to Ms Campbell on each of 6 May 2021 (6 repeats) and 5 January 2022 (5 repeats) as being evidence of her suffering from severe and intractable GORD. That none of those scripts were ever filled (as for the script from Dr Joynson) is submitted to be best explained by the patient having an existing supply or the PBS records being inaccurate. There is no evidence

[37] Ex B1.1, p 2.
[38] Ex B1.1, p 14.

of where an existing supply covering this period would have come from. It is improbable the PBS records would be so wrong. The PBS scheme subsidises purchases of medication by patients. Pharmacists no doubt depend upon the proper processing of dispensed scripts to be paid.

49. The matter is not helped by Dr Adib having made no meaningful record at the time of his prescription as to the reasons and context for doing so. This absence of record is compounded by the matters dealt with later in these reasons as to his record keeping and credit.

50. The view I form is that Ms Campbell did suffer from GORD between the two surgeries. It troubled her enough to raise it with her doctors as described herein. She trialled Nexium as prescribed on discharge but found it did not work to satisfactorily relieve her symptoms. That she was troubled by such symptoms is supported by the evidence of her family members as to her complaints. She did not seek further scripts for it from Dr Raju. She was given two scripts by Dr Cartwright which she used in whole or in part, but inconsistently from 11 September 2021 (not filling it until a month after it was issued), and then not exhausting a month's supply until the next script was filled, on 4 December 2021, some 8 weeks later. Her GORD was not resolved by this use of Nexium and she sought further advice from Dr Adib on 5 January 2022. I think it likely she did not fill the script or any of the repeats issued by Dr Adib in May 2021 or January 2022 (or indeed in February 2022) or by Dr Joynson on 5 January 2022, because she considered it ineffective in resolving her symptoms.

Dr Adib – credibility and reliability

51. I accept Counsel Assisting's submissions that I should have concern about both the credibility and reliability of Dr Adib's evidence and his records. His evidence needs to be approached with caution.

52. My concerns about believing Dr Adib's evidence when uncorroborated are compounded by his records and correspondence. I note that one difficulty with his records arises from his use of pre-emptive text and of templates, with Dr Adib himself disowning the accuracy of some things recorded.

53. Dr Adib's credibility was seriously undermined by the "To whom it may concern" letter that he wrote on 14 February 2022, in aid of supporting Ms Campbell's early access to superannuation to fund the surgery he had offered her.[39] The letter was intended to be relied upon by those responsible for the supervision of superannuation savings i.e. the Australian Taxation Office (see ex B2.6).

54. Its contents were, in most material respects, untrue. There is very little within the one-page letter that was in fact true. Dr Adib's oral evidence[40] makes this undisputable. I would accept that Dr Adib knew the falsity of it when he signed it, as Counsel Assisting submitted I should.

55. Dr Adib's evidence before the Court, ultimately, was that the real reason for offering the Roux-en-Y gastric bypass was to treat GORD.[41] The letter, however, makes no mention of that.

56. Instead, the letter represents that the reason for the operation was to allow Ms Campbell to curb severe obesity. Dr Adib even asserted in that letter that her obesity was a "life threatening condition".

57. He conceded in evidence that it was, in fact, not a life-threatening condition. He also conceded that her obesity was not at the level of seriousness he had described in the letter. Even adjusting for an error in recording her BMI as 29 instead of 30.1, it was seriously misleading to describe that as "at the high risk end of the morbidly obese scale" when it was in fact barely class 1 obesity.

58. In the end, he made multiple concessions about the falsity of the contents of the letter, as he was bound to do.

59. Dr Adib sought to explain away the falsity of the letter by referring to it as a "standard letter"[42] and template:[43]

[39] Ex B2.4.
[40] See T1-30 to T1-35.
[41] T1-32, LL 9-12.
[42] T1-30, L 42 and T1-31, L 27.
[43] T1-31, LL 41-46.

> "Yes. This is a template generated by my front desk. I accept full responsibility. This is a template for release of super. Ms Campbell approaches me, says, "I would like to have this operation. I would like to pay with my super", you know, my expenses, and this is a template for – not done by me – yes, I agree, signed by me – for the release of super. These are the template for the release of super. I concur with you…"

60. On the other hand, he also sought to explain away the document by saying that it was constructed as it was to enable "the boxes to be ticked" for the requirements of the Australian Taxation Office ('ATO') that allow early access to superannuation for health reasons.[44]

61. The two explanations are not consistent. The second explanation is undoubtedly the true one. It is highly improbable that Dr Adib mistook the contents of the letter before applying his signature to it.

62. The letter was said to be based on a pro forma version designed to allow early access to superannuation. It is plain that he intended for Ms Campbell's application to be successful, and it follows that he wrote a letter that contained false statements for that purpose. His explanation for doing that, when surely he must have known that he ought not, was that it was his patient's choice.[45] That of course is no excuse at all. That his rooms had such a template letter, casts doubt on the use of it being patient initiated. In any event, it was an egregious breach of his responsibilities as a medical practitioner to have signed such a letter. It reflects very poorly on his credit generally and re-enforces the unreliability of his contemporaneous records.

63. Counsel Assisting also submitted that it was evident from the general practitioner records that Dr Adib encouraged Ms Campbell's general practitioner to support the application. The submission was that Dr Adib's most recent statement,[46] dated 8 August 2025, sought to imply that what appears in the general practitioner records carried with it the implication that the general practitioner agreed with him as to the diagnosis and the

[44] T1-30, LL 30-31.
[45] T1-31, LL19-21.
[46] Ex C1.1.

appropriateness of the treatment[47] (see paragraph 78 of ex C1.1). It was submitted that an examination of the general practitioner records does not allow that conclusion to be reached. Rather, the submission went, it reads as a deference.

64. Dr Adib submitted there was no evidence of such encouragement. Exhibit B2 contains the records of the general practitioner's practice. They include a letter from Dr Adib to Dr Joynson of 15 January 2022. It advised of the plan for the surgery to get rid of reflux and to "assist with an extra 15kg of weight loss". That letter reference was fallacious. The patient had no such desire and Dr Adib admitted at the inquest that the surgery was for reflux.

65. Dr Joynson was provided with a copy of the admittedly false letter from Dr Adib for the ATO. He was also provided with a copy of Dr Adib's completed form for the ATO to facilitate superannuation access. That form also falsely declared that the "life threatening" medical condition the treatment was for was "morbid obesity". Those claims, false in the mouth of Dr Adib, were replicated in the like form completed by Dr Joynson, which, in section F, referred to Dr Adib's impugned letter of 14 February to support the application.

66. I am satisfied he more than encouraged the support. He harvested the support. His evidence that sought to identify an endorsement of his conduct by the GP was disingenuous.

67. Dr Adib's most recent statement also contends that Ms Campbell's presentation in February of 2022 involved symptoms of a particular kind and variety. He had said elsewhere though that he could not remember what she had complained of.[48] What he was prepared to do, therefore, was to assume that she had the symptoms he claimed were the typical symptoms of somebody presenting with a complaint of GORD.

[47] Ex C1.1, [78].
[48] Ex C1.1, [43].

68. Professor Brown's evidence was against such a textbook presentation. Complaints of GORD symptoms vary from patient to patient, and one cannot simply claim that a patient presented with a particular character of symptoms,[49] because that is what is typical.

69. Professor Brown acknowledged that there were certain classical symptoms of volume reflux, rather than GORD exclusively.[50] The problems with lack of reliable records, the credibility of Dr Adib and this clinical proposition mean there is uncertainty as to the true symptom complex, in a detailed sense.

70. I accept Counsel Assisting's submissions that Dr Adib's claims that Ms Campbell complained of sleeping with multiple pillows, waking with a yellow fluid on her mouth and on her pillows, and having other symptoms of what is described as "volume reflux", namely regurgitation of stomach content on bending over, are not shown on the evidence to actually be the symptoms that were being complained of by Ms Campbell. Rather, they are the symptoms that Dr Adib would now speculate that she complained of, given that he was determined to get across that she complained of symptoms of GORD and he neither properly recorded her symptoms nor investigated them. She may or may not have had those or other symptoms.

71. It is no answer, as Dr Adib would otherwise submit, that the patient complained of "reflux" when there is no record of the particulars of the complaint as discussed by Dr Brown and given Dr Adib's evidence at ex C1.1 paragraph 43.

72. None of these things should be a problem if Dr Adib took a proper history and kept proper records of it. He may or may not have done the former.

[49] T2-61, LL 7-10.
[50] T2-77, LL 34-43. See also T2-60.

73. In his records for the consultation of 14 February 2022, the symptoms that Ms Campbell complained of are recorded as being "There is ++GORD history of heartburn or indigestion or volume reflux."[51]

74. Dr Adib claimed that this should have read "and"[52] – that is, ++GORD history of heartburn *and* indigestion *and* volume reflux. I do not accept that evidence

75. It simply cannot be said what Ms Campbell's symptoms were because no proper record was kept and the indiscriminate use of unedited "drop down" items in the notes undermines any confidence that they represent any one possible account of what was discussed. A sufficient lack of care in their generation is apparent so as to regard them as wholly unreliable.

76. Further, with respect to Dr Adib's reliability, Dr Adib claimed in his most recent written statement and in oral evidence that when the endoscopy was being performed by Dr Berger, he could see on the screen that there was mucosal ulceration and redness, consistent with serious gastroesophageal reflux disease.[53] His self-serving reference to him pointing that out to his assistant surgeon should be ignored. There is an abundance of reason to reject what Dr Adib claimed about that.

77. Firstly, Dr Adib never mentioned this until 8 August 2025, some three years after Ms Campbell's death. Secondly, had he observed such a thing at the time, a surgeon in his position and with his experience ought to have realised that it was a significant finding. The evidence of Professor Brown and Dr Burger show that.

78. Had Dr Adib truly observed such a thing, a close and careful examination would be undertaken out of concern for the possibility that there was a serious underlying condition, such as cancer. Biopsies may be taken during the course of that procedure, though a judgment might reasonably be made, depending upon what was being observed, that it was

[51] Ex B1.1, p 2.
[52] T1-28, LL 34-35.
[53] Ex C1.1, [89]; T1-43, LL 23-29.

appropriate to defer that and to go on and conclude the procedure, including because to take the biopsies with the procedure not yet completed may jeopardise the safe completion of the procedure. However, if the option was taken to defer, a plan should be made to come back to review, by gastroscopy, the area some weeks or months later, to see if it had resolved and, if not, to take biopsies. Further, a note would be made of what was observed and what was done about it or the plan to manage it.[54]

79. Dr Adib of course made no such note nor any plan for a gastroscopy review. He also did not ask Dr Burger to take biopsies.

80. It is also telling that Dr Burger could not recall having observed mucosal ulceration and redness, consistent with serious gastroesophageal reflux disease.[55] Whilst he said that this was a procedure that he was undertaking for a particular purpose – one which was neither diagnostic nor investigative, clearly, the effect of his evidence was that he would expect to have noted the finding and to have conceived of a plan (including for surveillance in the weeks to few months after the original endoscopy).[56]

81. It is also to be recalled that Dr Han inspected the inside of the oesophagus in the autopsy and observed no macroscopic evidence of reflux disease, including no mucosal ulceration (he did not examine the surface microscopically).[57]

82. Dr Adib's evidence about what he observed in this respect should be treated as being of recent invention. It was a self-serving claim to *ex post facto* attempt to justify the management that he had undertaken.

83. It is submitted by Dr Adib that it was not put to him by Counsel Assisting that this claim was a recent invention. This is a rather mechanical view of how recent invention is raised in cross-examination. The matters above in my findings, reflecting Counsel Assisting's submissions, were the subject

[54] T2-65, LL 33 to T2-66, LL 14.
[55] T1-72, L 42.
[56] T1-73.
[57] T1-6, L 35.

of evidence explored with Dr Adib and Dr Burger. They plainly raised for implication that the claimed observation and discussion were untrue, for these identified reasons. It is of course not to say that the patient had not experienced reflux chronically but that Dr Adib had recently invented this particular account to protect himself against a risk of a finding adverse to him.

84. I also accept Counsel Assisting's submission that a further troubling feature of Dr Adib's evidence was his initial response to a Coroner in his letter of 7 September 2022.[58] In that letter he engaged in blatant hyperbole when he spoke of Ms Campbell being prepared by a team of "dieticians, psychologists, nurse practitioners" as well as himself.[59]

85. There was no psychologist involved at all. There was one dietician, not multiple. There was one dietetic appointment (on 14 February, by telephone). The "nurse practitioners" was in fact one nurse who appears to have been involved in the admission of Ms Campbell on the day of her surgery. There is no record at all of any particular involvement of any moment outside of the ordinary in the records in that respect. It was very much to his discredit that Dr Adib so misrepresented the nature of what had been done.

86. I reject Dr Adib's submission that his evidence does not discredit him. He engaged in deliberate and substantial exaggeration about the quality and intensity of the pre-operative care Ms Campbell was provided by him, when the only reason he could have done so was to mislead the investigating Coroner. Together with his letter intended for the ATO, it reflects a disturbing tendency to exaggerating matters pertaining to his surgical service, tending to further raise concern about what advice he gave Ms Campbell.

87. I find that Ms Campbell made a telephone call to Dr Adib on 5 January 2022, with a complaint of reflux-like symptoms. He had a discussion with

[58] Ex C1.
[59] Ex C1, [4].

her in which the conclusion was reached that a Roux-en-Y bypass was an option for her but that she would need a new referral. His evidence was that she declined, in that conversation, an investigative endoscopy. The implication of this was that further surgery was her remedy.[60] In the absence of a contemporaneous note I cannot be satisfied Dr Adib did offer an endoscopy on 5 January. It is not documented then or in the note of the 14 February consultation. I do not accept Dr Adib's submission that his provision of a script for 6 months worth of Nexium on 5 January was inconsistent with a shared view that surgery was then intended as the remedy to be pursued. For the reasons I have found, Ms Campbell was not likely to have viewed Nexium as any answer to her complaints. There is no suggestion it was Dr Adib's view that it was and no reason to think she would have led him to think she would trial that in preference to surgery. Whether he should have counselled her on that path is another matter. Ms Campbell telephoned her general practitioner that day, securing a referral and then seeing Dr Adib again on 14 February 2022. If there was a plan to trial more medication as the remedy, she would not have sought the further referral that same day. Dr Adib rather hurriedly booked her in for surgery to be performed just 10 days after the in person consultation. The only documented consultation of any material kind with an allied health practitioner was the telephone call with the nurse later on 14 February, during which Ms Campbell was given information about the diet that she needed to follow. Some blood tests were subsequently taken for various biological markers. It would be difficult to imagine a more minimalistic approach in advance of such significant surgery.

88. Dr Adib submits the surgery was not rushed. He points to a seven week delay between the phone call of 5 January and the surgery. He says there was, as evidenced by his notes and his statement, a long and detailed discussion on 14 January.

89. I consider the surgery was rushed. The surgery was in serious contemplation on the basis of a phone call, representing the first contact

[60] See Ex C1.1 paragraphs 40-49.

between them for six months. A formal consultation following a referral was required and the surgery was performed 10 days later. It was not urgent, in a clinical sense. The funding of it as planned between doctor and patient had not been achieved. The pre-surgical check list the patient was given for an operation to be performed on 24 February was said, in a document created on 14 February, to require a deposit within two weeks (after the operation) and the final payment by 10 February (four days before the booking).

90. These arrangements were chaotic. In the clinical context, the arrangements were inconsistent with a cautious, conservative approach to evaluating the place of surgery.

91. I accept Counsel Assisting's submission that Dr Adib's record-keeping around the relevant events was appalling. He conceded both in his last written statement and in his oral evidence that his records were affected in many instances, by being pro-formas or templates or documents filled by drop-down text or some other such difficulty. As a result of that, incorrect content was included in records. There were claims or concessions, depending upon how one looks at what was being said, that there were other things which were said or done that were not included in the records.

92. It can be readily accepted that a doctor's records are never a transcription of exactly what was said or done. It is another thing however to see that no note has been made describing, at least in a summary way, something quite significant that was said or done or not said or not done.

93. There were consultations for which there were no notes at all. There was one consultation for which there was a note but it says nothing of the consultation content. In that instance, being the consultation on 5 January 2022, the consultation would appear to have been substantial but yet nothing is recorded. A script for medication was provided.[61] Dr Adib's statement though says that Ms Campbell told him all her complaints and

[61] Ex B1.1, p 2.

that he gave her advice about having a gastroscopy, which she declined. Also, that he otherwise gave her advice about major surgery that she could then undergo.[62] That none of that was documented at all is such a departure from what was to be properly expected of Dr Adib as to be incredible.

94. Turning to Dr Adib's surgical record-keeping, his operation record, of which he created two versions, warrants particular attention.

95. As was submitted, the starting point is that this was a pre-filled document that described every step that was supposed to be taken, it would seem, in a sleeve gastrectomy conversion to a Roux-en-Y gastric bypass. Clearly, all of this was typed and printed well in advance of the procedure occurring.

96. The patient label was then applied. One version made its way to Dr Adib's records[63] and the other made its way onto the hospital file.[64] The differences between those two documents are not necessarily of themselves important – the mere existence of two different versions is what is concerning.

97. Leaving aside an immaterial difference at the top of the page, one version of the document recorded the time taken for the hiatus hernia repair said to have been performed, whereas the other document did not.[65] Dr Adib's submission that it was material to the Medicare claim he would make, how long the surgery went for, so it would appear on his copy, does not explain its absence on the other. Furthermore, the second document, on the hospital file, recorded a brief description of what was involved in the hiatus hernia repair, being "dissection and repair", whereas the version in Dr Adib's own file did not.

[62] Ex C1.1, pp 4-5.
[63] Ex B1.1, p 96.
[64] Ex B3.1, p 34.
[65] The version contained in Dr Adib's records (Ex B1.1, p 96) being the version that included the time taken. See also: T1-48, LL 22-25.

98. Reading the pre-filled operation record chronologically, it would imply that the hiatus hernia repair occurred before the gastric bypass part of the procedure. It would seem from Dr Adib's oral evidence though that may or may not have been true.[66]

99. Most concerningly, significant events that did happen in the operation were not recorded and something that did not happen in the operation was included - by virtue of the pre-filled form.

100. These things concern the involvement of Dr Burger. It was unanticipated that there would be a difficulty passing the bougie through the oesophagus. Dr Burger was called in to assist endoscopically. It turned out that the bougie could still not be passed and so the relevant part of the procedure requiring access inside the stomach was undertaken through the use of the endoscope, controlled by Dr Burger.[67] None of this appears in the operation record.

101. Instead, the operation record shows that the bougie was used to perform the tasks that were expected to be performed with it during the procedure, which it was not.

102. Dr Burger's own record being included in the hospital records does not excuse such misleading surgical records.

103. Apart from this being a terrible dereliction of his responsibilities with respect to record-keeping, possibly giving rise to problems if Ms Campbell had had a complication that required further surgery ultimately, there can be no confidence in the accuracy of the operation record in this inquest.

104. Another odd feature of the operation record was that both versions had a handwritten note on them recording the three applicable Medicare items for the surgery. So too did the intraoperative nursing record.[68] In each case one of the items was 31572. This was the item number for the Roux-en-Y gastric bypass part of the surgery, which was done. Exhibit F9 shows

[66] T1-39, LL 12-17.
[67] Dr Berger exhibit C6.
[68] Ex B3.1, p 20.

that the item number is only applicable for a patient with clinically severe obesity.

105. Dr Adib confirmed he was familiar with the relevant Medicare items.[69] He then confirmed Ms Campbell did not have "clinically severe obesity".[70] It follows that the item number was not applicable. It also follows though, that there had been a plan to charge it. Indeed, Dr Adib still claimed that the operation done corresponded to the item number.[71]

106. On day two of the inquest,[72] Dr Adib's counsel tendered an extract from Dr Adib's billing software[73] which showed that item number 31572 was not billed to Medicare for this operation.

107. These odd circumstances have not been explained. Ultimately, aside from showing that the 31572 procedure was not one that attracted public funding unless done for obesity above 40 BMI (or 35 in other circumstances), it doesn't directly bear on the cause of death. It is a further instance demonstrating the falsity of records for Dr Adib made at the time of the surgery.

108. Contrary to Dr Adib's submission, this was, as I have found, "odd". He submits it is usual practice to use billing codes as shorthand for the procedure performed. The bypass part of the surgery was already described on the record. The item numbers were listed under a heading at the bottom of the form under a heading "Billing items". Next to the item numbers were "MBP", "GAP" and "Cover" - Exhibit B3.1 page 2 from the Wesley Hospital records. Ms Campbell had private health cover with Medibank Private, which would explain the MBP. Item 31752 was not shorthand for a procedure performed on Ms Campbell as she did not have clinically severe obesity. I accept the submission of Counsel Assisting, consistent with my above finding, that this is another instance of a false record made by Dr Adib at the time of the surgery and that at that point in

[69] T1-4, L 15.
[70] T1-4, L 43.
[71] T1-48, L 1.
[72] See T2-81.
[73] Ex C1.5.

time, he intended to charge for that item number but later changed his mind, for reasons not explained.

Dr Adib's practices

109. Dr Adib's statement[74] indicates that his practice had been reviewed by an auditor from his medical indemnity insurer and that he had, as a result, undertaken further professional education and changed certain aspects of his practice.[75] It is commendable that he has done so.

110. Another feature of Dr Adib's practice that has been identified by Counsel Assisting as problematic and, hopefully, improved upon, was his practice of seeing a patient once and scheduling them in for surgery at that same appointment. That practice has, inferentially, been accepted by him as problematic, in circumstances where he gave evidence that he now no longer follows it.[76]

111. Dr Adib says that he now sees patients at least twice (even if one of those appointments is a telehealth appointment) so that he can provide all relevant information about the prospective surgery. He does not schedule patients in for surgery until after the second consultation.[77]

112. Here, Dr Adib did speak to Ms Campbell twice about the surgery. However, it can be very much doubted that the advice provided to her was of the quality to which he now aspires.

113. Concerns about the quality of the advice and information provided to Ms Campbell arises from the following circumstances, as identified by Counsel Assisting.

114. Firstly, the consultation on 5 January 2022 was evidently so informal, that no meaningful record of it was made at all.

[74] Ex C1.1.
[75] Ex C1.1, [136] – [137].
[76] T1-37, LL 7-16.
[77] T1-37, LL 7-16.

115. Secondly, Dr Adib booked Ms Campbell in for the surgery the very next consultation that he had with her, being on 14 February 2022. I have already made findings about that process. It is troubling that the discussion could have advanced as far as it did in such as informal setting.

116. In his last written statement, Dr Adib claimed to have given very detailed advice and information to Ms Campbell during the 14 February 2022 consultation.[78] This was said to have included a "long discussion about all of the risks and benefits".[79] Such claims, however, are inconsistent with what he recorded in his notes and in the letter to the general practitioner as to what was discussed in that respect. Both documents are very limited in detail.[80]

117. It was put to Dr Adib that in the letter written for the purpose of gaining early access to superannuation,[81] Ms Campbell was said to be expected to pay the cost of the surgery on the same day. Dr Adib sought to justify this by, once again, relying on the letter as being a template.[82]

118. Dr Adib's attempted explanation though was contradicted by other documents generated and given to Ms Campbell about the arrangements for payment, canvassed earlier in these findings, which spoke about a deposit that had to be paid some two weeks hence but that the full payment for the procedure had to be made on a date that was in fact four days before the consultation.[83]

119. Once again, Dr Adib sought to attribute this chaotic documentation as being a series of clerical errors.[84] It speaks though of something more than that.

120. On the evidence before the Court, there was absolutely no urgency for the surgery. Dr Adib accepted that that was the case.[85] I have already made

[78] Ex C1.1, [61] – [62].
[79] Ex C1.1, [62].
[80] Exhibit B1.1 page 2; B1.1 page 14.
[81] Ex B1.1, p 17.
[82] T1-32, LL 14-25.
[83] Ex B1.1, p 18.
[84] T1-32, LL 23-43.
[85] T1-32, L 45.

findings about the plans for surgery being rushed. Those circumstances are combined with the ones discussed further herein about the lack of other investigation as proposed by Professor Brown about alternative diagnoses and possible alternative treatment that might be required.

Conservative management

121. In his last written statement, Dr Adib claimed that Ms Campbell had attended upon him complaining that foods that she had been eating to try to control her GORD had caused her to gain weight.[86]

122. There is no convincing evidence that there had been anything material by way of weight gain. Ms Campbell would seem to have managed to reduce her weight to something like 87 kilograms following the sleeve gastrectomy (taking her just out of the class 1 obesity and into the overweight group, on BMI) but her weight had increased by one kilogram to 88 kilograms. It would seem true to say, as Dr Adib otherwise did, that Ms Campbell's weight had therefore stabilised. Her BMI was 30.1, barely in the range of class 1 obesity.[87]

123. Dr Adib made no record of having explored Ms Campbell's diet and its potential relationship to symptoms of GORD. When cross-examined about this, there was little he could say in circumstances where he had no memory of any detail.[88] According to Professor Brown, this would be the first and most important thing to be speaking to the patient about.[89] The inference from Dr Adib's evidence on the whole, as well as his records and the circumstances that emerge from them, was that there was very much a focus on surgery as the only solution.

124. A dietician might instead have been engaged. On Dr Adib's records, however, no dietician had ever spoken to Ms Campbell about such matters.

[86] Ex C1.1, [59].
[87] Class I obesity is 30 to 34, class II obesity is BMI 35 to 39 and class III obesity is 40 and above.
[88] T1-33, L 16-28.
[89] T2-63, LL 8-15.

125. Professor Brown gave evidence about her practice. She would first offer a gastroscopy to the patient with a view to investigating. She would do this, only after having obtained a lot more detail from the patient about what the complaints were and what appeared to be involved in triggering them.[90] I cannot be satisfied that Dr Adib did that in any meaningful way at all, as Counsel Assisting submitted.

126. Dr Adib claims to have offered Ms Campbell a gastroscopy and he spoke of the expense that would be involved in such investigative steps. According to Dr Adib, Ms Campbell declined a gastroscopy.[91] The claim that Ms Campbell declined a gastroscopy for cost-related reasons, and Dr Adib's explanation about the costs involved, are difficult to reconcile. In this sense, the expense of a gastroscopy would have been readily met by the out-of-pocket expenses that Ms Campbell was going to incur in proceeding to surgery. Indeed, the evidence from Ms Campbell's family is that she had the financial resources to afford that investigative step[92] and there seems no reason to think that she would not have pursued it if it was offered to her. Dr Adib submits that just because she could have afforded the procedure is not a reason to reject his evidence that he offered it. I have already canvassed my great reservations about Dr Adib's credit and observed he made no note about this advice or the decision of the patient on either 5 January or 14 February. There is no good reason to accept his uncorroborated evidence of such an offer.

127. In his evidence, Dr Adib persistently referred to the conversion procedure as the gold standard treatment for GORD.[93] One is drawn to the inference that his opinion of that gold standard caused him to not only focus upon it, but also rush to it, as the solution to Ms Campbell's problems when instead, other possibilities should have been explored.

128. It is not open for the Court to conclude that the Roux-en Y gastric bypass offered to Ms Campbell was inappropriate or unsuitable. As Professor

[90] T2-63, LL 26-49 to T2-64, LL 1-27.
[91] Ex C1.1, [155]; [163].
[92] Exs E3, E6, and E7.
[93] See: T1-27, L 30; T1-41, L 46, T1-46, LL 38 and 47, and T1-55, LL 18, 23 and 24.

Brown said, it is simply not possible to say ultimately whether it was or it was not.[94] Unfortunately, not enough is actually known about what Ms Campbell's presenting complaint nor about what might have been discovered had other investigations, even if only limited to a gastroscopy, been undertaken. Those things are not known because Dr Adib either did not explore them or, to the extent he did, he did not document them. His oral evidence that sought to fill the gaps cannot be relied upon.

129. Given my findings about the actual filling of scripts for PPI medication, another conservative path that stood to be explored was what medication had been taken and for what duration. Dr Adib's submissions here reflect an assumption Ms Campbell had used the medication prescribed far more than she appears to have done so. It cannot be said doing so by Dr Adib would have changed the course of events.

130. It is true Dr Brown's evidence was to the effect that there were no prescribed prerequisites by way of investigations before Dr Adib could offer this surgery to Ms Campbell and that practice amongst surgeons varies to the extent other investigating courses would be offered first. It is as much as can be said that Dr Adib appears to have been more inclined to go straight to surgery than a number of his peers would be.

Conclusions as to issues 1 (a) and (b)

131. As noted above, Mrs Campbell suffered from reflux symptoms that led to her re-engagement with Dr Adib in the weeks prior to her second surgery in February 2022. It may have been appropriate for Ms Campbell to be offered the Roux-en-Y gastric bypass as a conversion from the sleeve gastrectomy to deal with those symptoms. However, there was limited assessment and exploration of other options for investigation and treatment prior to that surgery being scheduled and performed.

132. The limitations implied an inadequacy in information provided to Ms Campbell about those further investigations and options. That said, Ms

[94] T2-76, LL 7- 25.

Campbell seemed to be discouraged by her own experience from the prospect medication would help her.

133. The path to surgery was unnecessarily rushed. At the very least, a gastroscopy ought to have been offered prior to committing to this serious surgery. Whilst I have not been prepared to find it was offered by Dr Adib, his claim that it was offered means I should reject any suggestion in his later submissions that it need not have been recommended by him as a first investigation. It cannot be said however that it would have, other than opportunistically, prevented her death.

134. There appears to have been considerable carelessness and indeed deception in the way in which Dr Adib went about securing the arrangements for the surgery, including with respect to documentation designed to secure funding by access to superannuation to fund the surgery. That false claims as to the reason for the surgery being performed had to be and were advanced to the relevant authorities with a view to securing the funding bears upon the question as to the appropriateness of the advice for the surgery in the first place. If falsehoods had to be offered to secure the funding, then it does not seem that the critical need for the surgery, as expressed in the superannuation application, actually existed. It also leads to sufficient doubt that Ms Campbell was properly informed about legitimate justification for the surgery prior to it being proceeded with.

135. The conclusion on issues 1(a) and (b) must be that whilst ultimately it is possible that the surgery was an appropriate course for Ms Campbell's clinical condition, she was not properly informed about matters relevant to her decision to proceed with the surgery and further, any advice that she was provided was inappropriate and inadequate because there had not been adequate investigation, including by way of a recommendation for endoscopy, investigation of issues regarding diet and medication compliance.

Consideration of issues 1(c) and 1(d) and 2

136. Again, it is convenient to deal with these issues together.

Ms Campbell's discharge post the Roux-en-Y gastric bypass

137. Ms Campbell's operation was performed on the morning of 24 February 2022. The time of the surgery is recorded as:[95]

Patient in room	09:10
Anaesthetic start	09:16
Surgery start	09:23
Surgery stop	11:04
Anaesthetic stop	11:06
Arrival in PACU	11:20

138. At 11:45 it was recorded in the post-anaesthetic care nursing record that Ms Campbell's observations were stable. She denied pain or nausea.[96]

139. At 12:17 she complained of 7/10 pain. The anaesthetist was contacted and gave a phone order for Tramadol. [97]

140. At 12:30 it was said that her pain was manageable. She remained drowsy and was easily roused with verbal stimulation. She was able to lift her head. It was noted that she was suffering from subcutaneous emphysema on arrival in the PACU however it was improving by the time of her transfer to the ward. [98]

[95] Ex B3.1. p 20.
[96] Ex B3.1, p 38.
[97] Ex B3.1, p 38.
[98] Ex B3.1, p 38.

141. The first nursing note in the ward is at 14:40. It was said that Ms Campbell had arrived at about 12:45. She was alert and orientated. Medications were given as charted. There was no complaint of nausea or pain. She had not passed urine. There were nil other concerns. [99]

142. At 16:00 it was said that the nasogastric tube was very uncomfortable and Ms Campbell was having difficulty tolerating it. Dr Adib ordered the removal of the tube.[100] At 19:00 her observations were said to be stable, she was afebrile. She denied having pain and nausea and no other complaints were voiced. [101]

143. In the morning at 05:00 the nurse attending recorded that Ms Campbell's observations were unremarkable. She had not complained of pain or nausea. No other clinical concerns were noted. [102]

144. At 14:15 hours, a nursing note recorded that Ms Campbell's observations were stable. She was afebrile. She denied pain and nausea and no complaints were voiced. [103]

145. The next note on 25 February is untimed, though is described as being "pm". Ms Campbell's observations were said to be stable and there was no complaint of pain. She did complain of nausea and was given a PRN anti-emetic as charted, with effect. No further concerns were raised.[104]

146. On 26 February at 03:15 hours, a nursing note recorded that Ms Campbell's cares were as per her care plan. She was afebrile and her observations were said to be within acceptable limits. Ms Campbell had vomited 100 millilitres around 23:30 with a PRN intravenous dose of Ondansetron being given subsequently. She was said to have denied further anti emetics when she had a vomit of 60 millilitres around 01:00 hours. A PRN doze of Palexia immediate release 100 milligrams (PRN dose prescribed was 50 to 100 milligrams) given for abdominal pain

[99] Ex B3.1, p 39.
[100] Ex B3.1, p 40.
[101] Ex B3.1, p 40.
[102] Ex B3.1, p 40.
[103] Ex B3.1, p 41.
[104] Ex B3.1, p 41.

scored as “8/10” with effect. It was charted as given at 00:15 hours. Ms Campbell’s bowels were recorded as not opening.

147. The next and last progress note was on 26 February at 12:00 hours. Ms Campbell was recorded as being discharged into the care of her husband. She was said to be still vomiting a number of times, even though anti-emetics had been administered. Ms Campbell was said to be keen to discharge and herself stated “she will feel better and recover better at home”.[105] The implication of that of course was that she was not feeling better then.

148. Dr Adib was contacted shortly before midday regarding Ms Campbell’s nausea and vomiting and an additional Maxolon order was given – 10 milligrams oral “6/24 PRN”. The drug was ordered from the pharmacy. Ms Campbell’s observations were said to be “stable” and she was said to be “otherwise well not lightheaded”. She was accompanied to the front entry for collection by her husband. The nursing note was signed by Nurse Fomiatti.[106]

149. Reference is had to the Q-AADS chart.[107] The 24th of February chart can be excluded as less relevant.

150. Ms Campbell’s observations were at 03:55 all within normal range. Her blood pressure was recorded as being 137/96. It is to be noted that based on her usual systolic blood pressure, a target systolic blood pressure of 140 was determined and recorded as against the Q-AADS chart for the 24th and the 25th of February. No target was recorded on the chart for the 26th but plainly it was still to be 140.

151. At 08:00 however, her blood pressure had dropped to about 110. Nothing was noted by the nursing staff at that time, despite the fact that that Ms Campbell ought to have been scored 1 for that, which would have required escalation to the nurse supervisor.

[105] Ex B3.1, pp 41 - 42.
[106] Ex B3.1, p 42.
[107] Ex B3.1, pp 43-45.

152. At 08:05 Ms Campbell's blood pressure was recorded as being about 138 and so had improved materially a short time thereafter. A change of that order calls into question the reliability of either reading.

153. At 11:40 her blood pressure was said to have been at about 128. At 15:45 it was around about 118 and was at a similar level at 19:15. At 23:35 it was just over 140. 118 recordings ought to have seen escalation to the shift supervisor too, but no escalation to the team leader was documented.

154. Throughout that time, Ms Campbell's oxygen saturations remained within the band of 95 to 97.

155. On 26 February 2022, there were three sets of observations recorded in the chart. At 04:50, Ms Campbell's oxygen saturation were marked as being at about 96. Her blood pressure was recorded as being at about 130.

156. At 08:30 however her oxygen saturation had deteriorated to about 94. The band of 90 to 94 should have scored a 1 on the Q-AADS chart and of itself, warranted notification to the team leader.

157. At that same time, Ms Campbell's blood pressure had dropped to about 118. That again should have scored a 1 on the Q-AADS, which on its own also warranted notification to the team leader. The cumulative score of 2 still made it as for notification to team leader.

158. Nurse Fomiatti has submitted that the blood pressure score at 8:30 am was in fact correctly scored by her as "zero", on the proper interpretation and that the common reference in these proceedings to the score properly being one is wrong. That submission is made despite its express acknowledgement that Nurse Fomiatti has made multiple admissions that it should have attracted a score of one. The submission is misplaced. It has as its basis that the Q-ADDS form for 26 February did not have in the relevant box, a note of a target systolic BP different from the default of 120. On the form, a different target based on usual

BP can be nominated. That had been done for MS Campbell on the form in use for 24 and 25 February, with 140 BP recorded. It was this usual BP which made the 110's reading at 8:30 on 26 February as scoring one. The submission is that absent an entry of 140 on the 26 February form, the otherwise default of 120 became the reference. An examination of the box on the form shows that is wrong. The box requires either the usual or the default to be selected by a tick. It was blank. The result was Nurse Fomiatti would understand it was overlooked as to a nomination of either usual or default, not that the default was applicable. Common sense would say to look at the day before and continue that (or seek an order). Nurse Fomiatti's repeated admissions no doubt reflected her appreciation of that.

159. At 12:00, Ms Campbell's blood pressure had improved to about 125 but her oxygen saturation had deteriorated to about 93.

160. Both the nurse on duty at 04:50 and Nurse Formiatti, on duty for the latter two of those sets of observations, had the total Q-AADS score as 0. The latter two scores were plainly wrong.

161. The fluid balance chart for 25 February was not completed, save for the recording in the output section of a vomit at 23:30 of 100 mils.

162. On 26 February 2022, it included 400 millilitres of input and 350 millilitres of output in the form of vomits, with 60 millilitres recorded at 01:00, 100 at 08:00, 200 at 11:30, giving a total of 350.

163. The input of 400 millilitres included 50 millilitres said to have been taken at 12:00 – that is, at the time of discharge. The truth of the matter is then that Ms Campbell did not even have a positive balance of 50 millilitres at a practical level at the time she was discharged at 12:00, because it was yet to be known whether she would retain that 50 millilitres.

164. From about 7.00 am on the day of discharge, 26 February, the nurse with direct responsibility for the care of Ms Campbell was Nurse Fomiatti.

165. The evidence, as already noted, shows that Nurse Fomiatti recorded observations for Ms Campbell at 8:30 am and again at around the time of discharge at midday.

166. As discussed above, on the Q-ADDS chart, at 8.30 am, there were two observations[108] that ought to have scored a point of 1 each and each required escalation to the team leader under the Q-ADDS system.

167. There was an oxygen saturation that was certainly recorded as being either 94 or 93, depending upon how one would interpret the chart and a blood pressure reading of 118, as against a target blood pressure, as recorded for the days, previously, of 140.

168. There were concerns held by Nurse Fomiatti about the circumstance that Ms Campbell was vomiting or "spitting" fluid up, despite the administration of the standard anti-emetics.

169. Nurse Fomiatti was clear, especially in her oral evidence, however that she considered that Ms Campbell was otherwise well and she had recorded a progress note at midday to that effect.

170. Nurse Fomiatti notified her concern about the persisting vomiting to the team leader, Nurse Langton. Nurse Fomiatti was clear in her oral evidence that she did not make that notification because of a concern that it would be inappropriate for Ms Campbell to be discharged that day. Rather, she was concerned that it was of importance to achieve better management of her nausea and vomiting so as to allow Ms Campbell to retain fluid.[109]

171. In oral evidence, Nurse Fomiatti, when asked about the escalation of the issue at 8:30 concerning oxygen saturations, gave evidence that she may have escalated such matters.[110]

[108] Ex B3.1, p 43.
[109] See for instance T2-14 line 5.
[110] T2-5 L 20 and L 40.

172. It would seem unlikely that she did do so, however. It would seem to be inconsistent with her assessment that Ms Campbell was otherwise well and that she had in fact recorded a Q-ADDS score of 0. In the absence of an actual recollection, let alone the absence of a note of having done so, the better view is that Nurse Fomiatti did not consider that there was any concern about the oxygen saturation or the blood pressure and did not specifically notify those issues with Nurse Langton. She seemed when giving oral evidence to continue to regard those readings as not being of concern, in such a patient.

173. Nurse Fomiatti acknowledged that the Q-ADDS process with respect to notification to a team leader in these sorts of circumstances was a mandatory one.[111]

174. The reason Nurse Fomiatti did not specifically notify Nurse Langton of the blood pressure or oxygen saturation observations from 8:30am or indeed, the blood pressure observation at midday was because she made errors in the scoring. The fact she recorded scores of 0 shows she did not appreciate at the time that they were in fact abnormal results on the Q-ADDS chart.

175. It is known from the evidence of Nurse Langton, the team leader, that the conversation that subsequently took place with Dr Adib by telephone following Nurse Fomiatti's notification about the concerns regarding ongoing vomitting occurred sometime after 11:32am, that being the time when Nurse Langton sent a text message on the ward phone to Dr Adib, trying to make contact with him and requesting that he telephone.[112] It is also to be appreciated that the conversation between the two nurses took place before the midday observations, as did the conversation with Dr Adib. The improvement in the blood pressure then by those last observations, leaving the Q-ADDS score as 1, was plainly not in their minds or discussed. That it was still wrongly assessed as a score of 0, shows that the change in blood pressure did not figure in Nurse

[111] T2-5 L 35.
[112] See exhibit C3.

Fomiatti's thinking at all. She regarded Ms Campbell as well, apart from the vomiting, the whole of the time. The oxygen saturations were at 93% then.

176. The subsequent discharge took place at around about midday. The conversation with Dr Adib took place in the presence of Nurse Fomiatti, though the call was not on speakerphone. The evidence is unfortunately not particularly reliable as to what it was, exactly, that was discussed. No record was made by any of the practitioners of what Dr Adib was told and what his response was, other than for the charting of an oral order by him for Maxolon, a medication that speeds up stomach emptying and which it was anticipated could be given in addition to the other medication that had been given, and that might assist with respect to the Ms Campbell's symptoms.

177. From the evidence of both nurses, it is clear that a concern about Ms Campbell vomiting as having a persisting problem was raised with Dr Adib and that the standard medications intended to appropriately control such symptoms had been exhausted. Dr Adib's oral evidence at times suggested that he was told that Ms Campbell's symptoms had in fact settled on the standard medication. Such a suggestion can be rejected – the circumstances of the nurses making contact with him and the order that he gave for Maxolon as a second line treatment are consistent with only a conclusion that he was told that there was an ongoing problem of vomiting. He could not have thought otherwise.

178. Nurse Langton's recollection of the conversation was limited. She could recall telling Dr Adib that Ms Campbell had wanted to discharge because of the floods and that was despite her nausea and vomiting. She said that while she would typically check the fluid balance if there were serious concerns about vomiting, she could not recall if she did so on this occasion.[113] Similarly, she could not recall if Ms Campbell's vital signs were discussed, though she did not think that they would have

[113] Ex C3, [12].

been, given that the Q-ADDS score did not flag any concerns and that Ms Campbell "appeared clinically stable". She had no recollection of any discussion about a change in vital signs with Nurse Fomiatti.[114] Her evidence was also to the effect that measures of the kind in the oxygen saturation level or the blood pressure as recorded at 8:30am would not necessarily have been of concern to her.[115]

179. Nurse Langton gave oral evidence that the practice under the Q-ADDS system was that a score of 1-3 as against the observations would result in continued four hourly observations, if not more frequent, depending upon what the score was for.[116] She noted that this was based on practice and her experience in nursing, rather than any particular written instruction. Obviously, a patient being discharged would not receive such observations.

180. Nurse Langton said she was unaware of any formal policy at the hospital with respect to the involvement of the admitting doctor in the discharge process. She said that the instruction to accredited doctors at the hospital (as contained in the by-laws current at the time of Ms Campbell's admission in February of 2022[117]) that the treating doctor was to review the patient before discharge was, on one reading of it, different than was the practice, though her evidence allowed for the idea that that by-law might be read in a way to say that the doctor could review the patient even the evening before discharge, approving of a discharge the following day, subject to conditions such as the patient remaining well.[118] It is noted Dr Adib had recorded a standing order on the operation report on the 24th to the effect that Ex C3, [13].could be discharged on the 26th, if well.[119]

181. Dr Adib accepted in oral evidence that when telephoned about Ms Campbell, he asked no questions as to what her vital signs actually

[114] Ex C3, [13].
[115] Ex C3, [13].
[116] T2-31 to T2-32 L10.
[117] Ex F9, p 19, (s).
[118] T2-33 to T2-34.
[119] Ex B3.2, p 34.

were. He simply accepted the description given to him that she was otherwise stable. He asked no questions about how much she had vomited.[120]

182. He also accepted that had he attended at the hospital and reviewed Ms Campbell, it was likely that he would have appreciated that her condition was such that she should not be discharged.[121]

183. In her first report, Professor Brown noted that Ms Campbell's observations had been deteriorating prior to her discharge, consistent with what was put to Nurse Langton above. She had been vomiting over the morning leading up to discharge and was still vomiting at the time, despite the standard prophylactic medication being administered. The volumes being vomited were larger than she would expect, given the size of the small pouch of remnant stomach. For these reasons, in Professor Brown's opinion, Ms Campbell should have been kept in hospital and not discharged. She thought that if she had been more closely monitored in hospital, it is likely that the bowel obstruction would have been diagnosed, with an early return to theatre to reduce the hernia, which may have avoided all of the sequelae of necrosis of the bowel.

184. Professor Brown confirmed in her oral evidence that the circumstances of the patient going from needing no narcotic analgesia to needing it, to going from feeling a bit nauseated to actually vomiting as much as she was taking in, was a patient about whom there should have been sufficient concerns as to mean not to discharge.[122] She said that it was not right to regard a patient that was vomiting near as much as she was taking in post a procedure like this one as being within the normal range for a bariatric procedure of this kind. Nausea was common but vomiting that volume was uncommon.[123] It is noteworthy that each of Nurses Fomiatti and Langton as well as Dr Adib kept placing emphasis in their

[120] T1-51, L45.
[121] T1-52, L45.
[122] T2-69 L10.
[123] T2-69 L30.

evidence upon how common it was for patients to have vomits after this sort of surgery. None of them though gave evidence that challenged what Professor Brown said in that respect and there was no challenge to her evidence on that point.[124]

185. Professor Brown considered the vomiting volume compared to intake as the critical feature in that respect, saying that she would have held a concern against discharge even without the additional history about the onset of pain and the administration of Palexia.[125] I do also accept that the Palexia had likely worn off in its effect by the morning of 26 February and that Ms Campbell was not continuing to complain of pain before her discharge. While that episode of pain overnight is relevant to the cause of death, it has less significance for the actions of the nurses. A surgeon though, if told of it, in the broader context, may have attached some significance to it, as Professor Brown did.

186. Professor Brown said, with respect to discharge practices, there is a practice, used by some in the profession, called "criteria-led discharge" whereby nursing staff would be authorised to make decisions regarding discharge, as long as the patient fulfils certain criteria.[126] There were no particular criteria established for this discharge, though Professor Brown went on to speak of the care plan for laparoscopic bariatric patients that was included in the patient's records as providing something akin to "criteria-led discharge". The new clinical pathway document[127] promulgated in 2023, is a significant improvement on that and should have been of great utility in the circumstances that presented here, though the requirement for a Q-ADDS score of 0 will only be as good as the assessment of the score that has been made.

[124] T2-69 L30.
[125] T2-69 L20.
[126] T2-78 L35 to T2-80.
[127] Ex B3.5.

187. Professor Brown accepted that it was the very common practice for doctors to see their patients on day one post-operatively but not see them on the day of discharge.

188. She further said that there were risks with respect to a discharge process that did not include a doctor reviewing a patient on the day of discharge. She accepted that there were also risks when a doctor did, and particularly, if they did it too quickly and did not look at the observation charts too. Her own practice is to see patients every day and if she could not see them, to arrange for another doctor to do so.

189. She said that on the rare occasion she was to discharge a patient without herself or another doctor reviewing the patient for her, she would ask the nurse for the observations. She said that if it was a nurse that she knew and trusted and the nurse said that they were normal, she would usually take that at face value.

190. Her evidence was that the discharging doctor needed to know what the trend of the observations had been by the time of discharge and needed to know other important events, such as here that Ms Campbell had needed to be given Palexia for pain. She observed that Palexia was a drug for pain that her patients would rarely need, so that if a patient had needed it, she would be worried.[128]

191. Submissions made to me to the effect that it was reasonable for Dr Adib to rely on the nurses reporting to him in not overriding the otherwise planned discharge, relying on Dr Brown's evidence about her practice, are rejected as overlooking the important qualifications she made about the information she would require the nurse to give her.

192. It is noted that in exhibit B3.6, Schedule 2 at page 6, being an exhibit that contains the 2019 Wesley Hospital procedure as a *General Guide to Adult Vital Signs,* that there is a flowchart that carries with it the instruction that if a patient's oxygen saturations are less than 94% or a

[128] See T2-80.

patient's blood pressure is less than 10% of baseline or that their pulse is greater than 10% of baseline, the matter is to be notified to the team leader and observations are to be continued hourly for two hours.

193. That instruction, if it be that, is obscurely located and neither of the nurses appeared to be aware of it. It was not complied with. No criticism should be levelled at the nurses about that.

194. As to the timing of the events that directly led to the death of Ms Campbell, Professor Brown considered that onset of pain that was evidenced by the nursing note made in the early hours of the morning of 25 February was likely a relevant time in the chain of the causal events.

195. She said that up until then Ms Campbell's recovery appeared to be progressing normally but that something changed around midnight and that it was probably then that the hernia either occurred or became apparent. The hernia involved the bowel popping into the defect.

196. She said that it was unusual for there to be a complaint of pain at that time when there had not been pain before, as it would be expected that pain would be becoming less. She said that the timing then of the commencement of the vomiting was further confirmation that this was all connected to the by-then occurrence of the bowel obstruction.

197. She said that the decreased oxygen saturations that morning were likely reflective of increased pain resulting in Ms Campbell not breathing to the point of filling her lungs. She said that at that time the pulse rate started increasing and the blood pressure started to go down, all of which was suggesting again that something had been occurring in the early hours of the morning and that would be when the hernia occurred. The obstruction would have been getting progressively worse and the blood supply to the bowel would be becoming compromised.[129]

198. She said that the aspiration event would have occurred with the vomiting though she could not say when. It could have been when Ms Campbell

[129] T2-68 LL5-35.

was still in hospital but could equally have been after discharge, when she was at home.[130]

199. Dr Han's evidence was that the necrosis that led to the peritonitis, as seen on post-mortem, would have taken hours to days to develop. He said that a hernia does not always immediately lead to strangulation. In between, there could still be a period of obstruction.[131] That evidence then is consistent with Professor Brown's evidence that the hernia and obstruction had occurred by the early hours of the day of discharge.

200. In terms of the aspiration pneumonia, Dr Han said that there had been an aspiration of foreign material consistent with vomit and indeed he thought that that was the likely source. In terms of timing, he thought that a couple of days "could" elapse between the aspiration and the time of death.[132]

201. That evidence is not neatly reconcilable. However, having regard to the clinical course and the opinions of those two doctors, I accept Counsel Assisting's submissions that the bowel obstruction caused by the hernia had occurred by midnight on the 25th going into the 26th of February 2022. The peritonitis itself probably had not occurred until after the patient was discharged. The aspiration event more likely than not did happen before the discharge but pneumonia itself as a result had not developed until after the time of discharge, given the expectation it would take some time to develop from the initial aspiration. That timing is consistent too with the vital signs at discharge only being soft signs of the deterioration of Ms Campbell. I do not consider the symptoms of vomiting to have been such soft signs however.

202. The cause of death is otherwise dealt with earlier in these findings.

[130] See T2-68 L40.
[131] T1-8 LL5-15.
[132] T1-8 LL25-40.

Investigation findings

Conclusions

203. Whilst strong criticisms can be made of the advice about the appropriateness of the surgery that was ultimately provided to her and the adequacy of the information that she was given prior to making her decision to proceed with the surgery, it cannot be concluded that the surgery was necessarily inappropriate of itself, it cannot be said that those inadequacies were themselves the cause of Mrs Campbell's death. It is a concern enough in itself though that, even if the surgery was appropriate, it is likely that the work up of the patient through alternatives to surgery was inadequate and the advice given to her was likely not properly balanced.

204. Ms Campbell's deterioration on the morning of her discharge from hospital on 26 February 2022 was such that she ought not to have been discharged. It ought to have been appreciated that Ms Campbell was sufficiently unwell that she ought not to be discharged from hospital. The Q-ADDS scores ought to have resulted in a continuation of observations four hourly, not discharge, if calculated correctly. There ought to have been an appreciation that the patient should not be discharged given her fluid balance and until it was established that the additional medication did bring her vomiting under control.

205. Nurse Langton's evidence was quite telling.[133] Patients being discharged following surgery would be expected to be getting better by that time, not worse. Ms Campbell was getting worse and that was apparent. Enough was known that if thought about properly, Dr Adib would have seen and reviewed her, not allowed her discharge.

206. Dr Adib was not informed of Ms Campbell's deterioration, in particular with respect to her oxygen saturations but also with respect to her blood pressure.. He was not informed of her fluid balance results. He ought to

[133] See T2-38 to T2-39.

have been told of all of those things. He would properly have been told of the overnight path and giving of Palexia but also that there was no ongoing complaint of pain.

207. Nurse Fomiatti only told Nurse Langton of her concerns about nausea and vomiting, because she did not appreciate the Q-ADDS score of 1. Nurse Langton should have reviewed the relevant records that would have told her those things. She was the one to have the conversation with Dr Adib. She cannot have done so. Had Dr Adib been informed of those things, it would have been incumbent upon him to have come in to review Ms Campbell. Whether he would have is not the point. Even though it might be thought that it would have been appropriate for him to come in to review Ms Campbell in any event before her discharge, his not doing so on the information he was provided with was consistent with a well-established practice at the hospital and indeed perhaps in surgery more generally, noting though that some surgeons will more commonly review patients in person before agreeing to their discharge.

208. Having said all of that, Dr Adib should have asked more questions, especially about the volume of vomiting. Whilst being told Ms Campbell was otherwise well, as he likely was, might explain not asking about vital signs, he was told Ms Campbell was vomiting, was not told how much, but did not ask. Had he have been told the fluid balance figures, it is be inferred he should have been alerted to Ms Campbell's perilous state. Dr Adib followed a practice for discharge quite different from that described by Professor Brown as her own. Given the option taken by him not to review patients immediately before an order for discharge was given, it was incumbent on him to ask many more questions than he did, when a concern was actually raised with him and to have a much lower threshold for coming in to review the patient. On what he was told and not told, he should have both asked more questions and then come to review Ms Campbell in person.

209. Dr Adib submits that he need not have been so alert as to ask questions about the volume of her vomiting, because the evidence is that post-operative vomits are common in this surgery.

210. Both for the nurses and Dr Adib, this contention cannot be so simply accepted here. This patient's vomiting was not satisfactorily controlled on the normal medication. It was necessary that it be controlled. The actions of all three of them show they each knew that. Their respective answers were to acquiesce in her discharge with additional medication, to a home very distant from the hospital, with an impending flood, and no knowledge as to why her symptoms weren't controlled by the normal medication and no knowledge as to whether it would be controlled by the new medication.

211. Had Dr Adib been alerted to the issues of concern and attended upon Ms Campbell, it would seem that he would not, acting appropriately, have agreed to Ms Campbell's discharge and indeed, she would have been assessed and investigated for the cause of her complaints. Had that assessment and investigation occurred, it is likely that the issue with respect to the herniation and in turn perforation of her bowel would have been discovered and corrective surgery undertaken. It is likely that these things would have prevented the further deterioration and that Ms Campbell would have survived this surgical complication. The timing of the aspiration likely before discharge and its progress to infection would have been a risk however the cause of death was the combination of an untreated pneumonia compounded by peritonitis. Professor Brown's evidence at T2-58 canvassed these matters. Both complications are treatable and while death may still occur, it can be inferred from this evidence that it would more likely than not have been avoided had Ms Campbell not been discharged and instead had been reviewed by Dr Adib. Herniation of the bowel itself, if in hospital, would not normally be fatal. While aspiration in these circumstances increases mortality, a smaller proportion of these patients, if in hospital, die.

212. Instead, Ms Campbell was discharged home. Her condition continued to deteriorate and she died at home the next morning, after her agonal collapse. It can be supposed that being discharged in the condition she was played a part in not realising when at home that she needed to be in hospital.

213. As to issue 3, exhibits C5 and C7 give a narrative around reviews of policies and procedures by the Wesley Hospital following Ms Campbell's death. There have been improvements in those areas with discharge criteria, vital signs procedure, the clinical pathway and patient information about recovery from bariatric surgery. The discharge criteria were undergoing further review at the time of the hearing.

214. The changes appear appropriate. There is said to be training given to ensure nursing staff are familiar with policies and procedures.

215. The policies and procedures at the time of Ms Campbell's surgery in these respects can be criticised and especially the lack of formal discharge criteria. That said, enough information and knowledge existed as to mean the discharge was premature. Training and audit about compliance should be a focus for the hospital.

Findings required by s. 45

216. The evidence contained within the brief, in addition to the oral evidence heard at inquest, is sufficient to support the following findings under section 45(2) of the Act:

Identity of the deceased – Rosemarie Campbell

How she died – Ms Campbell died as a result of complications following a gastric bypass procedure undertaken at the Wesley Hospital on 24 February 2022.

Place of death – 4 Hatutu Street PACIFIC PINES QLD 4211 AUSTRALIA

Date of death– 27/02/2022

Cause of death – 1(a) Acute bacterial peritonitis and pneumonia
Other significant conditions:
2. Recent gastric bypass surgery

Comments and recommendations

217. In accordance with s46 of the Act, a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest which relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. Comments may take the form of recommendations to government or to particular agencies to make or consider systemic changes or amendments to existing policies or procedures.

218. As discussed above in respect of issue 3, improvements as to the Wesley Hospital's discharge criteria, vital signs procedure, clinical pathway, nurse training, and patient information about recovery from bariatric surgery, have been made since Ms Campbell's death. The discharge criteria were undergoing further review at the time of the hearing. These improvements are appropriate and in those circumstances, no formal recommendations are warranted.

I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE