FINDINGS and COMMENT of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Ernest Charles Willetts

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Magistrate Simon Cooper, Coroner, having investigated the death of Ernest Charles Willetts, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing dates

6 - 9 December 2021 at Hobart in Tasmania with final written submissions received on 29 April 2022

Representation

B Hilliard – Counsel Assisting the Coroner

M K Wilkins – Dr Lokesh Anand

N Readett – Dr David Murray

O Robinson – The State of Tasmania (Tasmanian Health Service) and Dr Mark Veldhuis

G Tremayne – Ms Judy Marston, Mr Willetts' Senior Next of Kin

In addition, although not formally represented during the course of the inquest, written submissions were received from Ball and Partners on behalf of Dr Justine Daruwalla

Introduction

1. On 30 September 2014, Ernest Charles (Ernie) Willetts died in the Launceston General Hospital (LGH). He had been admitted a month before suffering severe abdominal pain. Appendicitis was diagnosed and appendectomy performed. Mr Willetts appeared at first to be making a reasonable recovery. He was assessed as being suitable for discharge early on 2 September 2014. But before he could be discharged home his condition took a downward turn. Later that day, he underwent a gastroscopy which identified the presence of a lot of blood in his stomach. At some point he aspirated some of the contents of his stomach. Two urgent bronchoscopies followed, but his respiratory function did not recover.

2. Mr Willetts spent most of the last month of his life in the LGH Intensive Care Unit (ICU). On 29 September 2014, he requested all active treatment cease. He was transferred to a ward and made comfortable. He died the next day.

3. Mr Willetts was 80 years old when he died. He was born on 24 October 1933. At the time of his death Mr Willetts was in a long term relationship with Ms Judith Marston. Ms Marston described her life partner as a "*fit and well man... [who] looked after [their] house and large garden*" at Gravelly Beach, in the West Tamar.[1] He was interested in Ford cars and a member of a group of Ford fanciers which met regularly. Mr Willetts attended rallies and car shows on a regular basis. He was close to his sister and nieces and nephews.

4. The fact of Mr Willetts' death was not reported by the LGH in accordance with the requirements of the *Coroners Act* 1995. In fact, his death was not reported for over two (2) years, and only then by the Health Complaints Commission.

5. There is a suggestion in Mr Willetts' medical records[2] that contact was made with the Coronial Division and advice received that Mr Willetts' death was not one reportable in terms of the *Coroners Act* 1995. The note in the medical record is to the effect that an ICU registrar 'had a discussion [with] the coroner on call regarding this case as [patient] has had surgery in the last 4 weeks, however the appendectomy was not the cause of his death."[3] If that advice was given it was wrong. I observe that it was unlikely in 2014, and impossible in 2022, that a registrar would be provided with advice directly from a coroner. Even if the advice had come from a coroner in 2014, I note that whilst it undoubtedly was the case that the appendectomy was not the cause of Mr Willetts death, the gastroscopy may well have been and thus the death was on any reasonable view of it one reportable in terms of the *Coroners Act* 1995.

6. The result of Mr Willetts' death not being reported in accordance with the requirements of the *Coroners Act* 1995 was that no autopsy was performed - and the coronial investigation did not commence until more than two years after Mr Willetts' death had elapsed. I should say that I do accept, on the basis of evidence given by Dr Anthony Bell on the first day of the inquest, that the inability of a forensic pathologist to carry out an autopsy at the direction of a coroner did not, on this occasion, compromise the integrity of the investigation under the *Coroners Act* 1995.[4] Nonetheless that was in reality the result of luck and not design.

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[1] Exhibit C3, Affidavit of Judith Ann Marston, sworn 26 May 2017.
[2] Exhibit C4, page 212.
[3] *Supra*.
[4] Transcript, page 34, line 20.

7. In the event, the investigation into Mr Willetts' death was initially concluded by Coroner Chandler on 30 October 2017 by the delivery of an 'In Chambers Finding', that is a finding without holding a formal, public inquest. Unfortunately, Coroner Chandler did not have regard to any material from Dr Murray, the surgeon who conducted the operation which was a precursor to Mr Willetts' death. Coroner Chandler also made a number of findings adverse to Dr Murray. He did not have regard to that material because, even though he asked for it, the LGH failed to provide the material. It was not Coroner Chandler's fault. It was not Dr Murray's fault either. The delays associated with this investigation, the resulting additional expense and stress for all parties are entirely the fault of the LGH.

8. When Dr Murray became aware of the finding, and the fact that his views about the medical treatment received by Mr Willetts had not been considered by Coroner Chandler (because as I said Coroner Chandler had not been apprised of those views by the LGH), an application was made on behalf of the Tasmanian Health Service, by the Solicitor General, that the investigation be reopened.

9. On 21 April 2018 the Chief Magistrate directed that the investigation into Mr Willetts' death be reopened and the findings be re-examined by Coroner Chandler. Coroner Chandler retired in March 2019. Apart from holding a Case Management Conference in October 2018, Coroner Chandler was unable to re-examination of Mr Willetts' death before his retirement from office.

10. The matter was assigned to me following Coroner Chandler's retirement.

11. Fundamental to the re-opened investigation was a factual dispute as to causation between Dr Bell, Medical Advisor to the Coronial Division and Dr Murray the surgeon in question. The Solicitor General submitted, I thought with some force, that the differences between Dr Bell and Dr Murray could only be resolved by hearing evidence at an inquest. An application was made pursuant to section 27 (1) of the *Coroners Act* 1995 on behalf of the Tasmanian Health Service (which of course operates the LGH and employed Dr Murray) that an inquest be held. I ultimately determined in the exercise of my discretion that an inquest should be held. An inquest is a public hearing.[5]

12. In some respects I have reached different conclusions to Coroner Chandler about important aspects of Mr Willetts' treatment. This is only because I had access to significantly more evidence than Coroner Chandler.

[5] Section 3 of the *Coroners Act* 1995.

What a coroner does

13. Before considering the circumstances of Mr Willetts' death it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death that 'occurs after a medical procedure, and the death may be causally related to that procedure and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death'.[6] The term 'medical procedure' has a wide statutory definition. The *Coroners Act* 1995 provides that it means:

> *'A procedure performed on a person by, or under the general supervision of, a medical practitioner and includes –*
>
> (a) *Imaging;*
>
> *(b) An examination whether internal or external; and*
>
> *(c) A surgical procedure*'.[7]

14. Obviously, Mr Willetts' death meets this definition. In light of the fact that, as I mentioned earlier, Mr Willetts' death was not reported until two (2) years after his death, I think it is appropriate to highlight the fact that the obligation to report a reportable death is, in terms of the *Coroners Act* 1995, a personal one, and the failure to comply with that personal obligation is an offence.[8]

15. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. When conducting an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.[9] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

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[6] *Supra.*
[7] *Supra.*
[8] See section 19 of the *Coroners Act* 1995.
[9] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

16. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

17. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[10] 'How' has been determined to mean 'by what means and in what circumstances',[11] a phrase which involves the application of the ordinary concepts of legal causation.[12] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

18. It is also important to recognise that a degree of caution must necessarily attend this aspect of the coroners function. Self-evidently, the analysis involves a consideration of all the circumstances involving the death including decisions that were made at the time that may or may not have impacted upon the ultimate outcome. Coroners enjoy the distinct advantage of knowing exactly what occurred when making that assessment – something medical practitioners involved in the care of a patient who ultimately dies do not when administering that care. Put another way, the clarity that hindsight brings to a review of the circumstances of death must be tempered with a recognition that that clarity was not available to those involved in Mr Willetts' care and treatment.

19. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[13]

20. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[14] A coroner must ensure that any person (and the term 'person' means legal person, which includes any legal entity) who might be the subject of an adverse finding or

[10] Section 28(1)(b) of the *Coroners Act* 1995.
[11] See *Atkinson v Morrow* [2005] QCA 353.
[12] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[13] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[14] See *Annetts v McCann* (1990) 170 CLR 596.

comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

21. In accordance with this requirement all parties who were identified as having a potential interest in the outcome of the inquest ride death identified, apprised of the fact of the inquest and provided complete disclosure of all documentation relevant to the investigation. All interested parties were also afforded the opportunity to appear at the inquest and be represented by lawyers.

Issues at the inquest

22. In advance of the inquest a number of issues, in addition to those mandated by the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. Those matters included:

    a) Whether the cessation of Mr Willetts' Proton Pump Inhibitor medication (PPI) upon his admission to the LGH had a cascading effect or any affect which, culminated in his death;
    b) Whether Mr Willetts suffered from a gastrointestinal haemorrhage or a paralytic ileus (or both) and whether it was appropriate to treat that condition or combination of conditions by way of a gastroscopy on 2 September 2014;
    c) Whether there was a failure of procedure in relation to the placement of the cuff of the intratracheal tube during the gastroscopy procedure and whether that failure had any bearing upon the aspiration of gastric materials and Mr Willetts' deterioration in ultimate death; and
    d) Whether there was a failure of communication between staff at the LGH and Mr Willetts' Senior of Kin subsequent to his death in relation to the commencement of the coronial enquiry into his death.

23. The last matter – the question of communication – does not in my view fall within my jurisdiction to consider. It does not form part of the circumstances of death. Logically, given the focus of any coronial investigation is the death of the person in question, what happened following the death is unlikely to be relevant to that investigation. I do not consider that it is either necessary or appropriate in the discharge of my obligations under the *Coroners Act* 1995 to consider the matter in any detail. I express no view about the adequacy or otherwise of communication between staff at the LGH and Ms Marston.

24. However, the other three issues – the circumstances of the cessation of PPI medication, the appropriateness of a gastroscopy and the placement of the intratracheal tube – were all the subject of a significant amount of complex expert

evidence and written submissions at the inquest. I will turn to consider those three issues shortly.

Evidence at the inquest

25. After several case management conferences designed to ensure issues were identified and all evidentiary material made available to all interested parties for hearing, an inquest was held in Hobart in December 2021. A significant amount of documentary material was tendered and a number of witnesses called to give evidence. The details of the documentary material appear as annexure A to this finding. The witnesses called to give evidence and answer questions were:

    a) Dr Anthony Bell – Medical Advisor to the Coronial Division;

    b) Associate Professor Jonathon Cohen, Consultant General Surgeon – Vascular and Colorectal;

    c) Dr Andrew Jakobovitis, Consultant Gastroenterologist;

    d) Dr Mark Veldhuis, Consultant Gastroenterologist;

    e) Professor David Morris, Surgeon;

    f) Dr David Murray, Surgeon;

    g) Ms Judith Marston, Mr Willetts' partner;

    h) Dr Lokesh Anand; Anaesthetist; and

    i) Dr Jurstine Daruwalla, General Surgeon.

26. Following the hearing of evidence a timetable was made for the delivery of written submissions. Submissions were received from all interested parties and from Dr Daruwalla. I have, of course, had specific regard to the content of those submissions.

Background

27. Mr Willetts medical history included a heart attack in 1978, an abdominal aortic aneurysm repair in 2003, and femoro-popliteal bypass grafts in both legs in 2010. Relevant also is the fact that Mr Willetts had a history of Barrett's oesophagitis and gastro-oesophageal reflux disease for which he took regular medication. The condition, simply put, involves a thickening of the lining of the tube which connects the mouth to the stomach as a result of acid reflux. The standard treatment necessary to

control the condition is medication in the PPI class of drugs. Mr Willetts was prescribed such a PPI – Pariet.

28. Generally speaking the diagnosis of conditions such as Barrett's oesophagitis normally involve endoscopic procedures. Mr Willetts' medical history included multiple endoscopic investigations in the five or so years leading up to August 2014.

29. During the morning of Saturday 30 August 2014, Mr Willetts awoke with abdominal pain. His condition did not improve so he went to a see an 'out of hours' doctor service where he was seen by general practitioner, Dr Stephen Tredinnick.

30. After taking a history and examining Mr Willetts, Dr Tredinnick told him to go to hospital. That is what Mr Willetts did. Dr Tredinnick also telephoned the LGH's Emergency Department and told someone there (it is unclear who) that Mr Willetts was on his way. He wrote out a referral letter for Mr Willetts and attached to it a list of Mr Willetts' then current medication. The list included the PPI, Pariet. He gave that letter and list to Mr Willetts.

31. Mr Willetts went straight to the LGH taking the referral letter and attached medication list with him. The referral letter and list of medications were certainly given to someone upon his arrival, either an administrative employee or possibly a nurse, because both are in his medical records.[15] His medical records at the LGH indicate he was examined in the hospital's emergency department and a provisional diagnosis of appendicitis arrived at. That diagnosis was completely correct as further investigations were to demonstrate. He was duly admitted to the hospital's surgical unit for surgical review under the overall care of Mr Kirkby, Surgeon.

32. A CT scan performed the next day, Sunday 31 August 2014 confirmed the diagnosis of appendicitis. Once the diagnosis was confirmed, Mr Willetts underwent an open appendectomy at about 1.20pm performed by surgeon Dr Murray. The procedure was apparently successful and relatively uneventful. Mr Willetts' appendix was found to have been inflamed, a finding which confirmed that the diagnosis upon admission was correct, as well as Dr Tredinnick's advice to Mr Willetts to attend the LGH as a matter of urgency.

33. Following the appendectomy, Mr Willetts was troubled by reflux and nausea. Given his medical history, that he was suffering reflux was hardly surprising. Mr Willetts' medical records indicate that post surgery, he was reviewed on 1 September 2014.

[15] Exhibit C4, pages 40 – 41.

Notes in his medical record indicate that he felt improved. In addition the notes indicate that his observations were within appropriate parameters, he was afebrile and his wound was clear.

34. Generally speaking, Mr Willetts appears to have made a reasonable improvement from the appendectomy until two days after the operation.

Course of treatment following appendectomy

35. Mr Willetts' medical records indicate that on Tuesday, 2 September 2014, Dr Murray saw Mr Willetts at about 7.45am. Mr Willetts was seen in the context of a standard ward round with other members of the surgical team. Dr Murray noted that Mr Willetts was again improved that morning and was for consideration for discharge that day.

36. At about 10.50am Mr Willetts vomited a dark material described by the intern who viewed the vomit to resemble "black coffee ground" vomitus.[16] It would seem that following the vomit Mr Willetts may have been examined by an intern, Dr Lim, who must have actually viewed the vomit and recorded it as resembling coffee grounds. There is no reason to doubt the accuracy of her record in the medical records. She probably also examined Mr Willetts. Dr Lim certainly noted that he was no longer for discharge – an entirely appropriate decision.

37. The preponderance of evidence indicates that coffee ground vomitus is strongly indicative of a gastric bleed.[17] The evidence viewed as a whole satisfies me to the requisite degree that the vomit observed by Dr Lim was altered blood. In reaching that conclusion I do not overlook the evidence of Dr Murray and Professor Cohen at the inquest to the effect that the vomit was stagnant gut contents. I do not consider that the evidence about that issue could be anything other than an educated, although honest, guess. Neither, obviously, saw the vomit.

38. The evidence about the clinical significance of the coffee ground vomitus came from Dr Bell, Dr Jakobitis and Dr Veldhuis. All three doctors were very clear in their evidence that coffee ground vomit meant internal bleeding. Dr Veldhuis' explanation of the phenomenon was that:

[16] Exhibit C4, page 80 of 610.
[17] See for example transcript Dr Bell page 12, line 19, Dr Jakobovits page 78, line 12, Dr Veldhuis page 86, line 6. Professor Cohen expressed a different view (transcript page 59, line 2), but, respectfully, I do not consider he was right. His view is simply against the weight of all the other evidence.

> "*When bleeding is in contact with an acidic contents, changes, it becomes quite dark, and that's what the description of hematemesis as being coffee ground vomitus, it looks like coffee grounds once you finish*".[18]

39. I am quite satisfied that Mr Willetts' 280 mL vomit as recorded in his medical record as having occurred at 10.50am on 2 September 2014 was not the vomit of stagnant gut contents but rather clear evidence of gastrointestinal bleeding. In reaching that conclusion I obviously reject Dr Murray's evidence about the point. I consider he was no better placed than any of the other doctors who gave evidence and who also did not see the vomit. His contention that it was "*an incorrect assumption*"[19] that Mr Willetts had an upper gastrointestinal bleed is, I think, incorrect.

40. However it is far from clear to me, on the evidence, whether Dr Lim did or would necessarily have been in a position to recognise the significance of what she saw. Dr Lim did not give evidence at the inquest. There was no evidence as to her experience or training but it is reasonable, I think, to conclude as an intern she was very junior indeed.[20] There was evidence at the inquest that for inexperienced medical practitioners there was difficulty attending identification of the difference between vomit indicative of a gastric bleed (which resembles coffee grounds) and vomit of stagnant gut contents (black and watery), the latter not indicative of a gastric bleed.

41. What does seem clear on the evidence is that, in accordance with the then applicable protocol, Dr Lim contacted a more senior doctor, then Surgical Registrar Dr Daruwalla and informed her as to the situation in relation to Mr Willetts. This was, in my view, the correct thing for Dr Lim to have done, both from the perspective of the applicable protocol and common sense.

42. Nonetheless, although senior to Dr Lim, as at 2 September 2014, Dr Daruwalla was one of the most junior members of the LGH surgical team. She gave evidence at the inquest and said, and which I accept, she had neither the authority nor the medical experience to authorise any changes to the management of a surgical patient.[21] She said, and I also accept, that she provided general advice to Dr Lim but only after she had consulted with someone more senior in the surgical team, a Dr Khan, then a surgical registrar. Her 'phone records show she spoke to Dr Khan on 5 occasions between 10.38am and 1.52pm on 2 September 2014. I am quite satisfied that at least some, if not all, of those calls concerned Mr Willetts.

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[18] Transcript, page 95, lines 28 – 32.
[19] Exhibit C17 – letter Dr Murray to Dr Peter Renshaw, undated, page 3 of 3.
[20] Dr Murray said at the inquest an intern is a first year doctor – transcript, page 162, line 14.
[21] Statement of Dr Jurstine Daruwalla, Exhibit C14, paragraph 4.

43. Dr Daruwalla also said that, although she did not actually recall doing so, she probably also spoke to Dr Murray or Mr Kirkby about Mr Willetts during the same period. All of this was completely appropriate. Dr Daruwalla said in her evidence that she could not recall physically examining Mr Willetts and that if she had, in accordance with her normal practice, she would have expected it to have been documented. I should say that I considered Dr Daruwalla's evidence[22] to have been forthright and as accurate as the circumstances allowed. I did not understand any counsel to challenge it. She was, to my mind, a witness of the truth and there is no room for any criticism of her evidence nor of the manner in which she performed her duties, so far as they related to Mr Willetts, on 2 September 2014.

44. Returning to the course of events, it does seem clear that no one more senior than an intern examined Mr Willetts, and his vomit, the immediate aftermath of his vomiting event. Certainly it is evident that Mr Willetts was not examined by anyone senior within the surgical team before he was referred to the gastroenterological team.

45. Testing indicated also that at about the same time Mr Willetts had a moderate decrease in haemoglobin levels, and an increase in urea, both of which are signs indicative of internal bleeding.[23] In fact, virtually all the evidence supports a conclusion that Mr Willetts was suffering from internal bleeding by mid to late morning on 2 September 2014.[24]

46. The medical records indicate that Mr Willetts was seen by a registrar within the gastroenterology team at about 2.00pm. A decision was made that he should undergo an upper gastrointestinal endoscopy. The endoscopy was performed under the supervision of Dr Veldhuis.[25] Dr Veldhuis did not examine Mr Willetts and appears to have agreed with the registrar (advanced trainee) that a gastroscopy was both indicated and necessary.[26] His approach appears to have been appropriate in the circumstances. It was obviously a procedure not without risk, but one that I accept was necessary in the circumstances.

47. The gastroscopy was performed at about 5.00pm. It demonstrated Mr Willetts was suffering moderately severe reflux oesophagitis. His stomach was found full of altered blood that extended into the duodenum. The bleeding point was not able to then be identified. To my mind, the fact that his stomach was found full of altered blood

[22] See exhibit C14 generally.
[23] Exhibit C13, paragraphs 6 and 7, comments Dr Veldhuis.
[24] See Dr Bell, exhibit C7, page 4. Dr Jakobovitis , C12, page 2. Professor Morris, C15, page 2.
[25] Exhibit C13, paragraph 12.
[26] *Supra*, paragraph 8.

suggests strongly that his vomit at 10.50am the same day was of altered blood and indicative of a gastric bleed. The alternative is that between vomiting stagnant gut contents and undergoing the gastroscopy he developed a gastric bleed. Whilst I suppose this is logically possible, it seems inherently unlikely, particularly coupled with the description in his medical record of coffee ground vomitus.

48. The evidence is that the procedure may have been complicated by macro aspiration of gastric contents and blood.[27] I say 'may have been' because the basis for that suggestion is a note made by a medical practitioner – Dr Varma – who did not give evidence at the inquest. It is however recorded in the medical records[28] and I must say it is an unusual thing to record if it did not happen.

49. Dr Velduis, the supervising consultant, did give evidence and said in effect he had no memory of events, had no recollection of an aspiration, but that if an aspiration had occurred it would usually be recorded. His evidence was that the procedure was not completed "*as far as* [he could] *read from the notes*".[29]

50. Dr Morris, when asked about recording of incidents during surgery, expressed a wish (perhaps hope) that had an observable aspiration event occurred during the gastroscopy it would be recorded in the anaesthetic record. He said he expected that an experienced anaesthetist would record such an event. The obvious point about that is for the aspiration to be recorded it must have been observed and appropriately recorded.

51. All this again illustrates the difficulty associated with conducting an investigation many years after a death has occurred.

52. On the evidence I do not consider I can be satisfied to the requisite legal standard that Mr Willetts did in fact aspirate during the gastroscopy procedure on 2 September 2014, nonetheless he may have. I simply cannot reach a concluded view. I am however satisfied that he aspirated at some stage on 2 September 2016, that aspiration of gastric contents was significant[30] and was the cause of Mr Willetts' respiratory failure and death some days later.[31]

53. In any event, following surgery Mr Willetts was moved from the recovery area to the hospital's ICU. After initial improvement and discharge to a medical ward,

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[27] Exhibit C4, page 72.
[28] *Supra.*
[29] Transcript page 91, line 25.
[30] Exhibit C15, paragraph 25
[31] Exhibit C4, page 212, Exhibit C7,

unfortunately Mr Willetts steadily deteriorated. His lung function became particularly poor and he had difficulty breathing. By 12 September 2014 Mr Willetts was so unwell that he was readmitted to the ICU.

54. He continued to deteriorate from that point forward. He developed a respiratory, circulatory and renal failure. Liver function tests demonstrated significant abnormality. His medical records indicate that throughout this time Mr Willetts continued to receive appropriate, standard ICU therapy and organ support.

55. Despite appropriate medical treatment after his re-admission to the ICU, Mr Willetts' condition continued to deteriorate. On 29 September 2014, he requested all active treatments be ceased. Accordingly, respectful of those wishes, his tracheostomy and other invasive lines were removed, he was provided pain relief and end-of-life comfort care. He died the following day.

56. I do not consider that any of the treatment administered to Mr Willetts at the LGH after 4 September 2014 was anything other than of an appropriate standard. I did not understand any of the parties at the inquest to submit to the contrary.

57. The focus then of a consideration of the evidence of the treatment received by Mr Willetts commences upon his arrival at the emergency department of the LGH in the evening of 30 August 2014. It concludes, with the gastroscopy performed on 2 September 2014 and the re-introduction of Pariet in the immediate aftermath of that procedure. I turned to consider the issues arising during that identified period.

The effect of ceasing Mr Willetts' Proton Pump Inhibitor (PPI) medication

58. As I have already mentioned it seems beyond doubt that Mr Willetts, when he presented to the LGH ED, had with him a referral letter and list of medications prepared by his GP.[32] I did not understand the State of Tasmania to submit to the contrary. As I have already noted, the referral letter included with it a list of his current medications. One of those medications was by daily doses of a PPI (Pariet).

59. The admitting emergency room doctor Dr Rajasingh said in his evidence[33] that, not surprisingly, given the effluxion of time, he had no direct memory of the circumstances surrounding Mr Willetts' admission. He said he could not recall seeing the GP letter.[34] He conceded however it was possible he overlooked the regular Pariet medication on the list. In any event, what is clear is that Pariet was not transcribed into the

[32] See paragraph 27 above.
[33] Exhibit C19,
[34] *Supra.*

medication chart by Dr Rajasingh or indeed anyone else. As Mr Robinson on behalf of the State of Tasmania submits, correctly in my view, it is not open to determine that there was any failure on Dr Rajasingh's part to take a full history. I also accept that he dealt with Mr Willetts to the best of his ability. Nonetheless, he, or someone, failed to transcribe Pariet into the medication chart. In addition, the fact that it had not been transcribed into Mr Willetts' medication chart contained within his LGH medical records does not appear to have been recognised by anyone.

60. I also think the point made by Dr Rajasingh in his affidavit is a good one that his role was limited to determining whether or not Mr Willetts should be admitted to the LGH and, once admitted, responsibility for any patient vests in the medical staff employed in the unit to which a patient is admitted.[35]

61. The first time any mention of Pariet appears in Mr Willetts' medical records is in his medication chart for his pre-anaesthetic consultation on 31 August 2014 (before the appendectomy).[36] It follows in my view that, at the most, Pariet was omitted from the medical records and relevant medication charts for no more than 14 or 15 hours. In light of evidence which I will discuss shortly it is my concluded view that notwithstanding the initial omission the issue of Pariet generally played no role in the ultimate outcome for Mr Willetts.

62. Dr Bell was particularly critical of the manner in which Mr Willetts' PPI medication was managed at the LGH. He described in his evidence the failure to record Pariet PPI as "*careless medical practice*".[37] It certainly is open to conclude the failure to transcribe Pariet into Mr Willetts' medical record was unfortunate, but I do not consider that it was in anyway causally related to his death.

63. There is no evidence at all that casts any light on why the PPI was not reintroduced straight away following Mr Willetts' appendectomy. Indeed when Mr Willetts first complained of heartburn and reflux post-surgery he was treated with Mylanta before a PPI was recommenced on 2 September 2014. It may well be the case that someone in the surgical team turned their mind to the issue of Pariet and made a conscious clinical decision not to reintroduce it for a time. This would be consistent with at least one school of thought in relation to the use of the medication.[38] That there is no evidence about the issue is another result of the fact that Mr Willetts' death was not reported

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[35] *Supra.*
[36] Exhibit C4 – page 225.
[37] Transcript – page 8, line 14.
[38] For example associate Professor Cohen said that "Pariet in the context of acute appendicitis and an operation is neither relevant nor necessary". See exhibit C11, page 4.

for a considerable period of time. It meant that who may or may not have made such a decision (or indeed whether such decision was in fact made at all) could not actually be identified.

64. I think viewing the evidence as a whole the highest that the matter can be put is that it is possible that the failure to continue and/or reintroduce early the PPI might have led to an increase in the acid secretion in Mr Willetts' gut which in turn may have contributed to gastric bleeding. There was evidence, which I accept, that ceasing a PPI does not have an immediate effect or to put it another way, PPIs continue to have an acid suppressive effect for up to three (3) days after they are ceased.[39]

65. It follows that whilst I am satisfied that it is likely the fact that Mr Willetts was medicated with a PPI was not recognised upon his admission to the LGH, the evidence does not allow a conclusion that the failure to administer it after admission and before mid-morning on 2 September 2014 played any role, directly or indirectly in relation to Mr Willetts' death.

Gastrointestinal bleed or paralytic ileus?

66. As with the question of the utility or otherwise of Pariet, there was conflicting evidence in relation to whether Mr Willetts had suffered a gastrointestinal bleed or a paralytic ileus (or possibly both). And just as with the question of the utility or otherwise of Pariet, the investigation of this aspect of the circumstances of Mr Willetts' death was significantly hampered by the fact that when the evidence at the inquest was heard, nearly 8 years had passed since Mr Willetts' death. Also, as with the Pariet issue, my findings necessarily involve an element of deductive reasoning. Having said that I have reached the following conclusions.

67. The vomiting event at 10.30am on 2 September 2014 should have alerted medical staff to the likelihood that Mr Willetts was suffering a gastrointestinal bleed and the probability, or at the very least possibility, that he had a paralytic ileus. Although Mr Willetts may have had a paralytic ileus by late morning that day, I do not consider that there any reason for one to have been diagnosed earlier, in particular when Dr Murray completed his ward round earlier that morning. At the time of that ward round there is no evidence at all that Mr Willetts had any symptoms which should have alerted anyone to the possibility that he had an ileus. It would not seem that anyone involved in Mr Willetts' treatment averted to the possibility of a paralytic ileus until the morning after the gastroscopy.

[39] Exhibit C15- Report Professor Morris, page 4.

68. However, I do consider that examination by a more experienced medical practitioner after the vomit may have led to a firmer diagnosis. In fact that did not happen. The evidence was that a paralytic ileus could have been clearly confirmed (or its existence disproved) by CT scan. In fact, no CT scan was ordered. I consider that Mr Willetts should have been examined by a more senior member of the Surgical Team before he was referred to the Gastroenterological Team. There was no evidence at the inquest as to why that had not, or could not have, happened.

69. Had the existence of a paralytic ileus been affirmatively identified (assuming that there was in fact an ileus), then the evidence was that the appropriate management would have been the insertion of a nasogastric tube on the ward and the administration of PPI medication. The procedure is relatively speaking routine, performed by nursing staff. If there had been an ileus, earlier administration of a nasogastric tube would likely have reduced the stomach contents which in turn would have reduced the risk of further vomiting and consequent aspiration.

70. I note Professor Morris' evidence that performing a gastroscopy on a patient with a paralytic ileus before the insertion of a nasogastric tube to clear stomach contents is hazardous.[40] Equally, I recognise, and prefer, the alternative view articulated by Dr Veldhuis that from a gastroenterological point of view, performing a gastroscopy upon a patient with an ileus is acceptable as long as the anaesthetic is administered by way of rapid sequence induction and intubation.[41] I prefer Dr Veldhuis' evidence for no other reason than that he is a specialist in the area.

71. Nonetheless it does seem to me, viewing the evidence as a whole, that no particular consideration was given to the possibility that Mr Willetts had a paralytic ileus. In fact, the first mention of an ileus is found in Mr Willetts' medical record the following day in a note made by Dr Murray at 7.20am.[42] That having been said, given that the evidence does not enable me to reach a concluded view as to whether in fact Mr Willetts did have a paralytic ileus, which caused or contributed to his death, any analysis of the result of the approach is at best highly theoretical. It seems to me sufficient to highlight the fact that the circumstances of Mr Willetts' presentation mid-morning on 2 September 2014 ought to have alerted his treating team to the possibility of a paralytic ileus.

72. In addition, I am cognisant of Dr Veldhuis' evidence at the inquest when he said:

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[40] Transcript page 124.
[41] Transcript page 91, lines 5-10.
[42] Exhibit C4, page 66 of 610.

> *"I think you said before that you can, to a degree, treat an ileus by way of the gastroscopy, is that right?*
>
> *Well, the rate of such a gastroscopy would be equivalent to the rate of aspiration from a nasogastric tube and the first thing that we ever do in a gastroscopy, ileus or not, is we clear the stomach of any contents and in the event that there is significant contents that are unable to be cleared, or that we are concerned that there is aspirating occurred or occurring that will place the patient at significant risk, then we would potentially abandon the procedure."*[43]

73. But ultimately, given that the question of whether or not Mr Willetts was in fact suffering from a paralytic ileus, the discussion is as I have already highlighted, theoretical at best.

Whether there was a failure of procedure in relation to the placement of the cuff of the intratracheal tube during the gastroscopy procedure

74. This issue was a quite proper area of investigation, particularly in light of the fact that I am satisfied on the evidence that the operative cause of Mr Willetts' death was the aspiration of gastric contents (which logically may have occurred in the context of either the placement or use of an endotracheal tube). I have already discussed in some detail earlier in this finding the situation in relation to the vomit at 10.50am recorded by Dr Lim in Mr Willetts's medical records. Mr Wilkins on behalf of Dr Renard makes the good point that although measured as having a volume of 280 mL, it is a reasonable conclusion to reach that at least some of the vomit was at that time aspirated.

75. In addition, the medical records indicates that there were two vomiting events before Mr Willetts underwent the gastroscopy in the early evening of 2 September 2014.[44] The relevant note, made by Dr Varma and another doctor unable to be identified now, was made at 2.00pm or thereabouts. There is no earlier record of a vomit (apart from the 10.50am incident) and the previous entry in the medical records is made at 1.00pm. It is reasonable to conclude, in my view, that the second vomiting incident occurred between 1.00pm and 2.00pm. As with the vomiting incident at 10.50am, it is also reasonable to conclude I think, that some of the vomit was likely to have been aspirated.

[43] Transcript page 91, lines 13-21.
[44] Exhibit C4, page 76.

76. Thus, my conclusion is that by the time Mr Willetts underwent the gastroscopy, it is more probable than not that he had aspirated gastric comments twice. Accordingly, the procedure itself must be viewed against that background.

77. There is no evidence that there was an aspiration during the procedure itself. For an aspiration of gastric contents to occur whilst a gastroscopy was occurring, it is necessary for the endotracheal tube to be in the incorrect position. There was no evidence at the inquest which supports a finding that the endotracheal tube was misplaced at any time during the gastroscopy. Dr Anand gave comprehensive and careful evidence about the issue which I considered particularly persuasive. Part of that evidence involved a helpful demonstration by him of the correct placement of an endotracheal tube using an actual tube (which was later tendered as an exhibit in evidence[45]). Dr Anand's evidence was fully supported by contemporaneous notes. There is no evidence that contradicts it. I did not understand any counsel for any interested party to seriously challenge his evidence.

78. In short, there is no reason not to accept it and, to the contrary, every reason to be satisfied that his evidence was accurate.

79. Doing the best that I can, it seems that the most likely conclusion to be drawn from all the evidence is that the tube was correctly positioned initially. If Mr Willetts aspirated during the gastroscopy, it seems that was most likely to have occurred prior to the second bronchoscope, when possibly the cuff of the endotracheal tube moved, perhaps as Mr Willetts body moved, or was moved to facilitate the procedure.

80. I acknowledge that an alternative view is open, based upon the note made by Dr Varma in Mr Willetts' medical record, to the effect that the procedure was complicated by macro aspiration of gastric contents and blood.[46] There are several things to say about this note. First is the fact that despite what appears to be a widespread assumption, it does not show that any aspiration occurred during the procedure itself. Rather, it indicates that there was a macro aspiration of gastric contents and blood, something uncontroversial and which I am satisfied, as I have already indicated, occurred prior to the procedure. Second, Dr Varma did not give evidence at the inquest and therefore what was meant by the note is unable to be determined with a degree of precision. Third was the evidence from Dr Veldhuis, which I accept, that he had no recollection of an aspiration occurring but that if it had occurred it would have been recorded. Dr Morris made similar observations about an

[45] Exhibit C 20.
[46] Exhibit C4, page 72 of 610.

expectation about the recording of an event as significant as an aspiration during the gastroscopy. Finally, even if there was a vomit during the gastroscopy, assuming the endotracheal tube was in the correct place, that would not have led to an aspiration.

81. While it is possible that Mr Willetts had an aspiration before and then during the gastroscopy, for the reasons I have discussed above, I do not consider that is likely. I am quite satisfied on the evidence that Mr Willetts did aspirate gastric contents, and that aspiration was the cause of his death, the evidence leads me to the conclusion that it is more probable than not he aspirated before the gastroscopy. However, I do acknowledge that the evidence, at this distance in time, is not definitive.

Formal Findings

82. On the basis of the evidence at the inquest I make the following formal findings pursuant to section 28 (one) of the *Coroners Act* 1995.

a) The identity of the deceased is Ernest Charles Willetts;

b) Mr Willetts died in the circumstances set out earlier in this finding;

c) The cause of Mr Willetts' death was aspiration pneumonia; and

d) Mr Willetts died on 30 September 2014 at the Launceston General Hospital, Launceston in Tasmania.

Comments, recommendations and concluding remarks

83. The circumstances of Mr Willetts' death does not require me to make any recommendations pursuant to section 28 (1) of the *Coroners Act* 1995. I do however think it is appropriate to make some comments in relation to medical records generally. The fact that the handwriting of medical practitioners is (not in all cases) poor, is fertile material for humour in the community at large. Unfortunately, there is a real basis in truth for this general perception. The medical records of any patient are crucial piece of information for those involved in the treatment of that patient at later times. They are also crucial when a coroner is attempting to unravel what occurred. This is particularly so in a case like Mr Willetts where then unravelling takes place some years after the death and no one involved in his treatment has any independent recollection anymore of why decisions were taken and, in many cases by whom.

84. That is absolutely the case in relation to Mr Willetts. In many instances, his medical records contained entries that were completely illegible, indecipherable or unintelligible, even to the extent that the author of the entry was unable to be

determined. At its most basic, apart from potentially jeopardising the safe treatment of a patient, it makes the investigation of death, and therefore the necessary attempts to identify what (if anything) went wrong, and to make recommendations to avoid similar deaths in the future, very difficult indeed. I am certain I am not the only coroner who has experienced similar difficulties.

85. I observe that many, probably most general practices in Tasmania seem to have adopted a computerised record keeping system. This substantially enhances both patient care and investigation in that it completely eliminates issues associated with legibility. Which doctor within a practice saw a particular patient when, for how long, what advice was given, diagnosis arrived at and treatment provided is all quite clearly recorded and beyond doubt. The ability for confusion and misunderstandings are basically eliminated.

86. I **comment** that an improvement generally in relation to record-keeping, in particular the legibility of entries would make investigation of what went wrong (if anything) after a death in a medical setting considerably easier. It may be that the time has come for serious consideration to be given to utilising computers to avoid the difficulties associated with endeavouring to read handwriting of varying legibility.

87. I express my thanks to all counsel involved in relation to what has proved to be a complicated and difficult inquest.

88. In conclusion I wish to express my sincere and respectful condolences to Ms Marston on her loss.

Dated 7 October 2022 at Hobart in the State of Tasmania

Magistrate Simon Cooper
Coroner

Annexure A

C1	RECORD OF INVESTIGATION INTO THE DEATH OF ERNEST WILLETTS – 30/10/2017 (Plus ANNEXURE)	CORONER ROD CHANDLER
C2	REPORT OF DEATH	TASMANIA POLICE
C3	AFFIDAVIT	JUDITH MARSTON (SNOK)
C4	MEDICAL RECORDS	LAUNCESTON GENERAL HOSPITAL
C5	IMAGING AND IMAGING MEDICAL REPORTS	TASMANIAN HEALTH SERVICE
C6	MEDICAL REVIEW	RN LIBBY NEWMAN
C7	MEDICAL REPORT FOR THE CORONER – dated 10/5/2017	DR ANTHONY J BELL
C8	MEDICAL REPORT FOR THE CORONER – dated 10/5/2017	DR ANTHONY J BELL
C9	MEDICAL REPORT FOR THE CORONER – dated 22/09/2020	DR ANTHONY J BELL
C10	MEDICAL REPORT FOR THE CORONER – dated 22/06/2021	DR ANTHONY J BELL
C11	REPORT – dated 05/05/2020	ASSOCIATE PROFESSOR JONATHAN COHEN
C12	REPORT – dated 14/5/2020	DR ANDREW JAKOBOVITS
C13	COMMENTS	DR MARK VELDHUIS
C14	STATEMENT	DR JURSTINE DARUWALLA
C14 (1)	APPENDIX 1	DR JURSTINE DARUWALLA
C14 (2)	APPENDIX 2	DR JURSTINE DARUWALLA
C14 (3)	APPENDIX 3	DR JURSTINE DARUWALLA
C14 (4)	APPENDIX 4	DR JURSTINE DARUWALLA
C14 (5)	APPENDIX 5	DR JURSTINE DARUWALLA
C14 (6)	APPENDIX 6	DR JURSTINE DARUWALLA
C14 (7)	APPENDIX 7	DR JURSTINE DARUWALLA
C15	PROOF OF EVIDENCE	PROFESSOR DAVID MORRIS
C16	SUPPLEMENTARY LETTER	PROFESSOR DAVID MORRIS

C17	LETTER TO DR RENSHAW	DR DAVID MURRAY
C18	STATEMENT	DR LOKESH ANAND
C19	STATEMENT	DR EDWIN CLEMENT RAJASINGH
C20	EET TUBE	