JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	15-17 MARCH 2023
DELIVERED	**:**	31 AUGUST 2023
FILE NO/S	**:**	CORC 988 of 2019
DECEASED	**:**	DOBSON, JUSTIN MARK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the Coroner.
Ms J Buller with Mr M Olds (SSO) appeared for North Metropolitan Health Service.
Ms J Lee appeared for Nurse Johnston.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Justin Mark DOBSON*** *with an inquest held at Perth Coroners Court, Perth, Court 85, 501 Hay Street, Perth, on 15 March 2023 to 17 March 2023, find that the identity of the deceased person was* ***Justin Mark DOBSON*** *and that death occurred on 19 July 2019 at Sir Charles Gairdner Hospital, Hospital Avenue, Nedlands, from sepsis following haemorrhoidectomy in the following circumstances:*

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INTRODUCTION

1. Mr Dobson was a 46 year old man who underwent a routine haemorrhoid operation at Osborne Park Hospital in July 2019. He was in generally good health and never expected he would not return home to his wife and children. Sadly, Mr Dobson succumbed to profound sepsis two days after his operation. He had remained in hospital for his recovery and had been subject to ongoing monitoring, but the signs of his deterioration and developing sepsis were not recognised until it was too late to save him.

2. Mr Dobson's partner, Karen Blackshaw, wrote to the Court in February 2021 indicating her support for a discretionary inquest being held into Mr Dobson's death. Ms Blackshaw described her disbelief, along with her family, that someone can die from such a straightforward procedure in this day and age. She expressed her hope that an inquest might ensure lessons are learned that may prevent a similar death in the future.[1]

3. On 4 June 2021, the State Coroner directed that an inquest be held to explore the risks of sepsis and the need to follow an escalation pathway and/or clinical deterioration procedure, as well as whether Mr Dobson's death was preventable.

4. After seeking expert independent medical review of the care provided to Mr Dobson, I held an inquest into his death on 15 and 16 March 2023. As well as a large amount of documentary evidence being tendered in the form of medical records and witness statements, I heard oral evidence from Ms Blackshaw, the nurses and doctors and SJA paramedic involved in Mr Dobson's care. In addition, evidence was given by medical experts who reviewed Mr Dobson's care and provided their opinions about the standard of care, as well as expected general practice and policy in such cases. It was emphasised that sepsis is a known, but extremely rare, complication of anal surgery, and Mr Dobson was asymptomatic as he did not have a fever, which may explain why the health staff involved did not identify it sooner.

5. Following the inquest, I received some additional detailed information from the General and Colorectal Surgeon, Mr Rhys Filgate, who performed Mr Dobson's initial surgery and was involved in the later efforts to save his life. Mr Filgate had not been informed of Mr Dobson's unexpected deterioration following the haemorrhoidectomy. Mr Filgate advised that he would have expected to be kept informed when Mr Dobson was not sent home, but he was not contacted until very late in the events. If he had been consulted, it seems likely that Mr Filgate would have identified at an earlier stage that Mr Dobson was becoming very unwell, given his greater experience and training. Mr Filgate expressed the opinion it was possible, but unlikely, that earlier recognition might have altered the final outcome.[2] In any event, earlier recognition would have given Mr Dobson the best chance of survival. This opinion was shared by the other experts who gave evidence at the inquest.

[1] Exhibit 1, Tab 18.1.
[2] Exhibit 3.

6. Evidence was provided that the practitioners involved, and the North Metropolitan Health Service (NMHS), which is responsible for the administration of Osborne Park Hospital in conjunction with Sir Charles Gairdner Hospital (SCGH), have reflected on these events and made a number of changes, which are detailed later in this finding.

BACKGROUND

7. Mr Dobson lived with Ms Blackshaw and their two young children in Dianella. They had been in a relationship for many years and had been friends for even longer. They had spent time living together in Perth and Melbourne, before returning to Perth in 2012 for Ms Blackshaw's work. Mr Dobson had worked in various jobs and ran his own small business in Melbourne. Mr Dobson continued to do some casual work after their return to Perth, including working at Optus stadium and teaching some local children how to play the drums, as he was musically talented and played in a band. However, his main role was as the primary caregiver for their children and he enjoyed being a 'stay at home dad'. In his spare time, Mr Dobson also enjoyed collecting and restoring BMX bikes.[3]

8. Mr Dobson saw a general practitioner in Dianella. He had been diagnosed with a number of medical conditions, including asthma and depression, and he took regular medications for both conditions. Mr Dobson had been a chronic cannabis user in the past, having started smoking cannabis in his youth. In the six months leading up to his death, Mr Dobson had made some significant changes in his life to improve his health. Firstly, he had given up smoking cannabis. In addition, he had increased his activity level and had lost 15 kilograms in weight primarily by walking and playing with his children. Ms Blackshaw recalled he was the fittest he had been in years.[4]

9. Unfortunately, Mr Dobson had a chronic health issue in the form of haemorrhoids, which became progressively worse. It interfered with his ability to ride his pushbikes that he loved and eventually he decided to seek treatment. In 2019, Mr Dobson was referred by his GP for a surgical outpatient appointment regarding his painful haemorrhoids. He was allocated an appointment at Osborne Park Hospital.[5]

10. On 20 February 2019, Mr Dobson was reviewed in the General Surgical Clinic at Osborne Park Hospital by Surgical Registrar Dr Jason Laurens. Mr Dobson reported having haemorrhoids for more than six months, which were painful most days and had started to impact on his ability to work. At examination, he was found to have circumferential perianal skin tags, a single thrombosed external haemorrhoid and internal haemorrhoids. He was encouraged to make significant lifestyle changes, including changes to his diet and toileting methods, avoid straining and use Proctosedyl ointment. A review appointment was set for three months.[6]

[3] T 285; Exhibit 1, Tab 18.1.
[4] T 284 - 285; Exhibit 1, Tab 18.1.
[5] T 284; Exhibit 1, Tab 19.
[6] Exhibit 1, Tab 6 and Tab 6.1

11. Mr Dobson returned for a review at the General Surgery Clinic on 11 April 2019. He was seen by a Resident Medical Officer (RMO) who consulted with Mr Filgate. Mr Dobson had made significant changes to his lifestyle but continued to suffer ongoing pain and rectal bleeding. On examination, he had three large external haemorrhoids and a palpable internal haemorrhoid. Mr Filgate recommended a colonoscopy to investigate the rectal bleeding, and also surgery to treat the haemorrhoids, given the conservative management had not worked. Mr Dobson was waitlisted for a routine haemorrhoidectomy and referred for a colonoscopy. He signed a consent form for surgery that day.[7]

12. On 27 May 2019, Mr Dobson underwent a colonoscopy at Osborne Park Hospital and had three benign polyps removed.[8]

13. On 22 June 2019, Mr Dobson saw his GP with a report of left leg pain and redness. He was referred to the Emergency Department of SCGH with a suspected deep vein thrombosis (DVT). Mr Dobson gave a history of chest pain of several days' duration, shortness of breath and a one day history of left calf redness and swelling. His heart rate was noted to be increased, he had a raised temperature and his left calf was tense, hot and swollen. An ultrasound showed no evidence of a DVT. There was subcutaneous oedema suggestive of cellulitis, a bacterial infection of the skin. He was administered intravenous hydration and antibiotics and discharged that afternoon. Mr Dobson was reviewed by his GP five days later and he reported he was still taking antibiotics for the cellulitis. He was seen again by his GP on 4 July 2019 and reported feeling better.

OSBORNE PARK HOSPITAL ADMISSION AND SURGERY

14. Mr Dobson was seen at a pre-anaesthetic clinic at Osborne Park Hospital on 28 June 2019.

15. On 17 July 2019, Mr Dobson was admitted as a day patient to Osborne Park Hospital for an elective haemorrhoidectomy and possible band ligation surgery. There was evidence before me that a haemorrhoidectomy is, generally speaking, a routine surgery and not expected to have major complications, although there are always some risks. Most patients who undergo the surgery will be discharged either the day of surgery, or more commonly the following day.[9]

16. Mr Filgate performed the operation, with the assistance of Dr Laurens. Mr Filgate advised it was his routine practice to provide prophylactic intravenous antibiotics on induction of anaesthesia and the Operation Report indicates Mr Dobson was given intravenous metronidazole prior to commencement of surgery. A three-segment haemorrhoidectomy was performed, which was uncomplicated. Mr Dobson returned to the ward at 2.45 pm for recovery. Standard post-operative written instructions

[7] Exhibit 1, Tab 6.2 and Exhibit 3.
[8] Exhibit 1, Tab 15.
[9] Exhibit 1, Tab 6.1.

advised he should continue the antibiotic metronidazole for five days and he could go "home when comfortable,"[10] which was expected to be the following day.[11]

17. Mr Dobson was written up for various analgesia, noting the recovery from this surgery can often be painful and uncomfortable.[12] According to the medication chart, Mr Dobson was given metronidazole at 10.00 pm on 17 July 2019 and at 8.00 am and 4.00 pm on 18 July 2019. He was also given tramadol and oxycodone with good effect on the evening of 17 July 2019 and he initially appeared to be recovering well.

18. The medical records indicate that shortly after midnight on 18 July 2019, Mr Dobson informed nursing staff he had a fall in the bathroom. He had been sitting on the toilet and unsuccessfully trying to pass wind. When he stood up, he suffered a panic attack and fell on his bottom. He felt sweaty, dizzy and shaky at the time and was on the floor for about five minutes before getting up and making his way back to bed. Mr Dobson was reviewed by the RMO at 12.40 am and no sign of injury was noted. He had some right upper abdominal tenderness, reflux type symptoms and nausea. Mr Dobson's blood pressure, oxygen saturations, temperature and pulse rate were all in an acceptable range. He was prescribed the antacid Mylanta, antinausea medication and a sleeping tablet. He continued to receive analgesia for the pain and to seek nursing staff assistance if he needed to go to the toilet again.[13] Mr Filgate was not advised of the fall at the time it occurred. He only became aware much later in the course of events.[14]

THE NEXT MORNING

19. Dr Hayley Wallis had graduated with a Bachelor of Medicine in 2017 and after completing her internship at SCGH, she commenced her first year as an RMO. She was in her second year out and nearing the end of a 10 week general surgical rotation at Osborne Park Hospital at the time Mr Dobson was admitted for his surgery. Dr Wallis was rostered on the RMO day shift on 18 July 2019 and had commenced her shift on the surgical ward at around 7.00 am. Her first task was to conduct the ward rounds with the registrar, Dr Laurens.[15]

20. Shortly before the ward round, at the time of the nursing handover at about 7.30 am, Mr Dobson vomited and was given an antiemetic with good effect. He said he was feeling tired as he hadn't slept well overnight but was still alert.[16]

21. At 7.55 am, Mr Dobson was reviewed by Dr Laurens and Dr Wallis as part of the ward round. Dr Wallis recalled a medical student and possibly another RMO were

[10] Exhibit 1, Tab 6.4.
[11] Exhibit 1, Tab 6.
[12] Exhibit 1, Tab 6.
[13] Exhibit 1, Tab 6.5.
[14] Exhibit 3.
[15] Exhibit 1, Tab 7.
[16] Exhibit 2, Tab 1, Integrated Progress Notes, 18/7/19 0935.

also present. Dr Laurens had been part of the surgical team for Mr Dobson, but Dr Wallis had not previously been involved in his care.[17]

22. Dr Laurens advised he was unaware of Mr Dobson's panic attack and fall the night before, although he did recall that there was a focus on Mr Dobson's anxiety in the context of discussion of analgesia. Dr Wallis, on the other hand, recalled they were aware of the fall and it had been attributed to a panic attack and there were no ongoing concerns. Dr Wallis also recalled that Mr Dobson looked well but was obviously in pain and was downplaying his symptoms and discomfort.[18] Mr Dobson was nauseated, which was felt to be due to the analgesia and pain. His medication was changed to a trial of buprenorphine, as tramadol can cause nausea and it was also thought Mr Dobson might have developed a tolerance to tramadol as he had been taking it in the leadup to his surgery. Dr Laurens felt the nausea and pain he was experiencing were normal in the circumstances and Mr Dobson was medically cleared by Dr Laurens for discharge that day if the nausea and pain were under control.[19]

23. Dr Laurens explained that a haemorrhoidectomy is an extremely painful procedure, so he was not expecting Mr Dobson to have no pain, just that he was tolerating his level of pain with appropriate analgesia. Also, Dr Laurens explained that during the procedure, the introduction of the anaesthetic can affect the nerves that control the bladder, so it was important that Mr Dobson was voiding properly before he left to be clear that his bladder was functioning properly again and he was not retaining urine, which can cause pain and complications. This issue of urinary retention became an issue later in the day.[20]

24. Dr Laurens indicated in his evidence that the hospital was short staffed, as he was the only registrar at Osborne Park Hospital that day. Usually, there were two registrars on shift, but the other registrar was on leave and SCGH (which is the coordinating hospital for Osborne Park) was unable to provide cover that day. Accordingly, Dr Laurens was responsible for not only the General Surgery and Urology in-patients, but also the General Surgery outpatient clinic that afternoon. Dr Laurens commented that it was only a slight increase in his workload on the day, but he still had extra duties to complete. After completing the in-patient morning ward rounds with Dr Wallis, he then went about other duties and did not return to the ward or hear anything in relation to Mr Dobson again until later, while he was still in the afternoon clinic.[21]

25. As Mr Dobson had been cleared for discharge, Dr Wallis completed his paperwork and organised for the medications he would need to take home. She then went about other duties.[22]

[17] Exhibit 1, Tab 7.
[18] T 9 - 10.
[19] T 10, 52; Exhibit 1, Tab 6.
[20] T 53.
[21] T 54 - 55; Exhibit 1, Tab 6.
[22] Exhibit 1, Tab 7.

26. Registered Nurse Renate Denston had been allocated Mr Dobson as one of her patients that morning. Nurse Denston was made aware when she took over Mr Dobson's care that he had had a fall overnight and had a history of panic attacks. During the bedside handover with the night nurse, Mr Dobson vomited, so Nurse Denston assisted to give him an anti-emetic to help with his vomiting and nausea. She was also monitoring his pain and when he complained of rectal pain, she gave him analgesia. She gave him buprenorphine, as he had already been given tapentadol and it was too soon to give him another dose.[23]

27. A nursing entry recorded by Nurse Denston at 9.35 am indicated that Mr Dobson had passed blood in the toilet. His observations were noted to be normal (including BP 140/80 and HR 90) and his pain level was 6/10.[24]

28. Ms Blackshaw gave evidence that she had arrived at the hospital at about 9.30 am as she understood her partner had been discharged, so she was expecting to collect him and take him home to recuperate. When she arrived at Mr Dobson's room, he was struggling to urinate and told her he had passed only a small amount of urine when he had a bowel movement. He also mentioned he had fallen over the night before and thrown up that morning. Ms Blackshaw said she was sufficiently concerned by this information to prompt her to go to the nurses' station and question why he was being discharged if he had fallen over that night, recently thrown up and couldn't urinate. She recalled she was told the fall was most likely a panic attack from his first bowel movement, because it is painful, and the vomiting was from pain medications. However, they agreed that he could not go home if he was not voiding properly. Ms Blackshaw said she was also asked if she wanted to speak to the doctor that had discharged him, but at that stage she still felt okay and didn't want to bother anyone as she knew the staff were busy.[25]

29. Nevertheless, Ms Blackshaw said she remained concerned as Mr Dobson was obviously uncomfortable and she noticed he had a fan on him and no blanket on his bed, even though it was winter.[26]

30. Nurse Denston had discussed Mr Dobson with the day shift nurse coordinator, Registered Nurse Amy Rhoder, and Dr Wallis sometime between 10.00 and 10.30 am and mentioned he was still experiencing pain despite receiving buprenorphine. Nurse Denston recalled Dr Wallis came to Mr Dobson's bedside then and Nurse Denston and Nurse Rhoder gave Mr Dobson some more tapentadol, buprenorphine and some paracetamol, with the hope this would reduce his pain. Nurse Rhoder recalled Mr Dobson was clearly in pain and uncomfortable due to the haemorrhoidectomy, but was otherwise well, his colour was good and he was moving around the room. Nurse Rhoder explained that the aim was to reduce Mr Dobson's pain, as he wouldn't be discharged home if his pain was rated at 7 or 8 out of 10. The plan was to monitor him and see if the analgesia was effective and

[23] T 82 – 83; Exhibit 1, Tab 8.
[24] T 82 - 84; Exhibit 1, Tab 2, Tab 1, Integrated Progress Notes, 18/7/19 0930.
[25] T 286 – 287.
[26] T 287.

whether his pain level had dropped at a later time. Nurse Denston also removed Mr Dobson's cannula around this time, before she went on a break.[27]

31. When Nurse Denston returned from her break at about 11.00 am, Mr Dobson's pain had increased, rather than decreased, and he was tachycardic, with a heart rate of 110 beats per minute. His blood pressure had also dropped and was recorded as 110/60. Ms Blackshaw recalled seeing a heart rate reading of 116 and asked why it was so high, given he was resting in bed, but she was reassured that it was due to pain and potentially from his anxiety.[28]

32. In response to these observations, Nurse Denston spoke to Nurse Rhoder and she recalled she also informed Dr Wallis, although Nurse Rhoder said she, in fact, then spoke to Dr Wallis and asked her to review Mr Dobson, noting she had kept Dr Wallis informed that Mr Dobson had not been discharged as planned due to his observations and pain score. Nurse Rhoder recalled seeing Dr Wallis go into Mr Dobson's room. Nurse Denston then recalled Dr Wallis said that Mr Dobson had anxiety and that he was better off being discharged and going home. Dr Wallis prescribed the anxiety medication escitalopram, which had been ceased prior to Mr Dobson's operation, and also recharted him for tramadol (he had been taken off it earlier in case it was the cause of his vomiting). Nurse Rhoder recalled Dr Wallis was very present and in and out of Mr Dobson's room regularly thereafter, as the doctor's office was next to his room [29]

33. Ms Blackshaw was aware that Mr Dobson was still having ongoing issues with urinating throughout the morning. She recalled they had started doing bladder scans to see how full his bladder was and the nursing staff had encouraged him to have a warm shower to see if that would help. Ms Blackshaw assisted him in the shower, but he couldn't pass any urine at all, even though he tried.[30]

34. At 12.30 pm, Nurse Denston performed another set of observations on Mr Dobson. She did this as she was concerned about Mr Dobson by that stage.[31] Mr Dobson's respiratory rate was up, although his oxygen saturation was fine. His heart rate was slightly elevated and his blood pressure had now dropped further from the observations taken at 11.00 am to 100/60. Nurse Rhoder noted the observations were now in the 'orange zone' requiring senior nurse review. Nurse Denston had been keeping Nurse Rhoder informed verbally and she went at this stage to review Mr Dobson herself. Nurse Rhoder recalled Mr Dobson was walking into the toilet at that time and he was uncomfortable as he couldn't void. Nurse Rhoder was told Mr Dobson had a bladder scan which registered around 500 ml residual, so based on the policy she was familiar with, a catheter would be appropriate. Nurse Rhoder set up a catheter tray outside the room in case it was required. Nurse Denston had also decided on her own initiative to perform an ECG as she anticipated this would be

[27] T 130; Exhibit 1, Tab 8 and Tab 10.
[28] T 287.
[29] T 131 - 133; Exhibit 1, Tab 8 and Tab 10.
[30] T 287.
[31] Exhibit 1, Tab 8 [40].

required given his elevated heart rate. Dr Wallis then reviewed the ECG, as well as being informed of Mr Dobson's blood pressure reading and bladder residual.[32]

35. Nurse Denston's next entry in the medical records is untimed, but was added to the earlier entry and was apparently made by her at around 1.00 pm, after the ECG had been taken and just before handover to the afternoon shift staff.[33] The entry records the events of the hours between 9.30 am and 1.00 pm, including Mr Dobson's complaint of 8/10 pain despite analgesia, his heart rate of 116 - 117 beats per minute on a manual reading and his drop in blood pressure from about 112/62 to 100/60. His temperature had remained normal, but Mr Dobson was having difficulty passing urine and the bladder scan had revealed a urine residual volume of 570mls. Nurse Denston said she had performed the bladder scan just before 1.00 pm, as Ms Blackshaw had told her that Mr Dobson had been unable to urinate when he went to the toilet. Nurse Denston said this was the first time she had become aware Mr Dobson was having difficulty voiding, although Ms Blackshaw believed it had been apparent for most of the morning.[34]

36. Ms Blackshaw recalled that around this time the focus was on encouraging Mr Dobson to void. She had asked what it meant when his blood pressure reading was so low at around 12.30 pm, and she recalled she was told it was probably from the pain medications.[35]

37. Nurse Denston had been keeping Dr Wallis informed about Mr Dobson and she had sought a medical review when Mr Dobson's systolic blood pressure dropped to 100, as per the escalation pathway on the Observation Chart.[36] Nurse Denston recalled that when she spoke to Dr Wallis about the low blood pressure reading, she asked her if she wanted the IV cannula put back in and if she wanted her to give Mr Dobson fluids as fluid resuscitation is a common step when blood pressure is dropping. Dr Wallis did not take up Nurse Denston's suggestion for fluid resuscitation, as she indicated she thought the lower blood pressure readings were medication related.[37]

38. Nurse Dobson said she also discussed with Dr Wallis whether "Mr Dobson might be septic"[38] at this time.[39] Dr Wallis did not recall having a conversation with Nurse Denston about whether Mr Dobson might be septic. It was her belief sepsis was never mentioned at any time during the day.[40]

39. Nurse Denston, on the other hand, said she recalled that she had a casual conversation with Dr Wallis at this time about what might be happening, and in the context of that discussion Nurse Denston suggested "do you think he is septic, is he bleeding,"[41] as two possibilities for the low blood pressure. Nurse Denston said in

[32] T 94, 133; Exhibit 1, Tab 8 and Tab 10.
[33] T 84.
[34] T 84 – 86, 96 - 97; Exhibit 1, Tab 8 and Tab 2, Tab 1, Integrated Progress Notes, 18/7/19, 0930 cont. addit.
[35] T 288.
[36] T 84 – 85; Exhibit 1, Tab 8 and Tab 2, Tab 1, Integrated Progress Notes, 18/7/19, 0930 cont. addit.
[37] T 94 – 95; Exhibit 1, Tab 8.
[38] Exhibit 1, Tab 8 [47].
[39] T 94; Exhibit 1, Tab 8.
[40] T 45.
[41] T 95.

evidence she mentioned it because when she had previously worked at Joondalup Hospital as an enrolled nurse, they had implemented a sepsis pathway on the Observation Chart, and on the top of the pathway it listed identifiers. The identifiers included respiratory rate, heart rate, pain and low blood pressure, and if there were two or more identifiers present, the pathway would trigger a consideration of sepsis. Although the Osborne Park Hospital chart did not have the same prompt, given her previous training and use of the chart at Joondalup Hospital, Nurse Denston said Mr Dobson's observations triggered her to ask the question.[42]

40. Dr Wallis gave evidence she did not think of sepsis at the time but instead thought it was possible Mr Dobson's drop in blood pressure was due to the change in medications. It was also obvious they were not on top of his pain, which would have caused him anxiety, which was the likely reason for his increase in heart rate.[43] Dr Wallis was aware Mr Dobson took a regular antidepressant and he had mentioned he was an anxious person, so she took that history into account.[44] Dr Wallis reviewed the ECG at Mr Dobson's bedside at 12.48 pm, just after the ECG had been taken. The ECG showed sinus tachycardia, which means his heart rate was still elevated. There was nothing else abnormal about the ECG. Dr Wallis recalled that she chatted to Mr Dobson at his bedside while reviewing the ECG and recalled he was highly anxious, so she again put the tachycardia down to anxiety and pain.[45]

41. Nurse Rhoder recalled having a conversation with Dr Wallis just before 10.00 am about inserting a catheter to relieve Mr Dobson, but Dr Wallis did not want a catheter to be inserted. She understood Dr Wallis wanted to give Mr Dobson a little more time to void urine himself, so he could be discharged.[46]

42. The nursing staff for the afternoon shift arrived at 1.00 pm and Nurse Rhoder and Nurse Denston formed a huddle with the rest of the nurses from the morning shift and the nurses for the oncoming shift to do a handover at the ward's journey board. Nurse Rhoder recalled giving a handover of Mr Dobson's case to the oncoming Nurse Coordinator, Nurse Kay Johnston, and the other nurses, informing them that Mr Dobson was haemodynamically unstable, with low blood pressure and tachycardia. He also had issues with voiding and he had been seen by medical staff.[47] Nurse Johnston recalled that Nurse Forbes told them Dr Wallis had explained that Mr Dobson's hypotension was due to his pain medication buprenorphine and the tachycardia was due to his anxious nature. At the time of the handover, Nurse Johnston understood Mr Dobson was retaining urine of about 300 ml, although Nurse Forbes's evidence was that it was higher.[48]

43. Dr Wallis ordered bloodwork, which was taken at 1.35 pm. At this stage, Dr Wallis recalled Mr Dobson still looked well although he had an elevated heart rate and had trouble voiding. However, given his elevated heart rate, low blood pressure and

[42] T 95 – 96.
[43] T 11 – 12.
[44] T 12.
[45] T 12 – 13; Exhibit 1, Tab 7.
[46] T 133; Exhibit 1, Tab 10.
[47] T 134; Exhibit 1, Tab 10 and Tab 21.
[48] Exhibit 1, Tab 21 [18] – [21].

trouble voiding, he was not fit to be discharged, so she ordered the blood tests to obtain further information.[49]

44. Nurse Denston gave evidence she also gave a bedside handover of Mr Dobson's care to Registered Nurse Dana Forbes at around 1.00 pm, after the group huddle. She recalled Nurse Forbes expressed surprise at that time that Mr Dobson was still in the hospital and hadn't been discharged. Nurse Denston then went about preparing for the end of her shift at 3.30 pm and did not see Mr Dobson for about an hour and a half.[50]

45. Nurse Forbes gave evidence she remembered Mr Dobson's blood pressure was not stable at handover and his pulse was quite high. However, Nurse Forbes believes she understood at the time that, despite the fact his observations were not stable, Mr Dobson's observations only needed to be taken every four hours, which is the usual period for patients without issues. Nurse Forbes gave evidence her main concern for Mr Dobson at that time was his bladder residual, as his bladder scan of 570 ml was noted in the handover Patient Safety Checklist. She recalled the Osborne Park Hospital policy had recently changed in terms of the criteria for a catheter to be inserted, and Mr Dobson did not meet the new criteria, but she thought she would keep an eye on his bladder for that reason.[51]

46. Nurse Forbes recalled there were a lot of post-operative patients that day, and not long after taking over Mr Dobson's care, she went off to collect a patient from recovery.[52] The coordinator, Nurse Johnston, also remembered it "was a particularly busy shift and the acuity of the patients on the ward was quite high."[53]

47. Nurse Johnston recalled that at about 2.45 pm, Nurse Rhoder, the morning shift nurse coordinator, mentioned that Mr Dobson was retaining urine of 500 mls in his bladder and they then looked up the hospital's new urinary retention policy on the computer. The policy specified that if the patient is voiding (although it's unclear if Mr Dobson was actually voiding at all) then they can retain up to 800 ml before an in-dwelling catheter is inserted.[54]

48. At about 3.00 pm, Nurse Forbes went on her tea break, and Nurse Denston went in to give Mr Dobson a dose of escitalopram that had been ordered earlier. She became aware at that time that no observations had been recorded for Mr Dobson since Nurse Denston had done the last observations at 12.30 pm. As she understood the observations were supposed to be done hourly, they were overdue. Nurse Denston immediately initiated another set of observations at 3.00 pm.[55]

49. Mr Dobson's blood pressure reading at 3.00 pm had dropped to 90/50, although I note Ms Blackshaw recalled actually seeing the machine reading as 85/49.

[49] Exhibit 1, Tab 7.
[50] T 96 – 97; Exhibit 1, Tab 8.
[51] Exhibit 1, Tab 17 [20] – [21].
[52] T 113; Exhibit 1, Tab 17 [20].
[53] Exhibit 1, Tab 21 [12].
[54] T 261; Exhibit 1, Tab 21.
[55] T 96 – 97; Exhibit 1, Tab 8.

Ms Blackshaw also recalled the nurse said the machine might be broken so she would do it manually.[56] Nurse Denston went and informed Dr Wallis of the low reading and told her she was going to get a manual cuff machine from the nurse's station. Nurse Denston explained she did this as she wanted to be sure the blood pressure reading was accurate.[57] Nurse Denston stated that she told Dr Wallis at this time that if Mr Dobson's blood pressure was still low (when she manually checked it), she would make a MET call. Nurse Denston recalled that Dr Wallis told her not to make a MET call, as she was there, and Dr Wallis then went to Mr Dobson's bedside.[58]

50. Nurse Denston stated that she continued on to get the cuff from the nurse's station and "blurted out"[59] to her coordinator, Nurse Rhoder, Dr Wallis' response, as she was very frustrated.[60] Nurse Denston explained at the inquest that she was frustrated because she was very worried about Mr Dobson given his elevated heart rate, increasing respiratory rate and low blood pressure and felt a MET call was probably appropriate.[61] Nurse Rhoder recalled Nurse Denston told her that Mr Dobson's observations met the criteria for a MET call but Dr Wallis did not want her to make the MET call. At that time, Nurse Rhoder understood a doctor could override a request for a MET call.[62]

51. After collecting the blood pressure cuff, Nurse Denston returned to Mr Dobson's room, accompanied by Nurse Rhoder. She believes they returned to Mr Dobson's room at about 3.15 to 3.20 pm.[63] Nurse Forbes had returned from her break around this time, and she recalled being told by either Nurse Denston or Nurse Rhoder that Nurse Denston wanted to make a MET call and the doctor did not want a MET review to be called. Nurse Forbes was also told by Nurse Rhoder that she had set up a trolley with a catheter outside Mr Dobson's room. Nurse Forbes said she wanted to insert a catheter, but didn't because of the new protocol, which indicated it should be inserted only when the residual was 800 mls or more, instead of 500 mls.[64]

52. Dr Wallis gave evidence that from about 3.00 pm, she was in Mr Dobson's room with Nurse Denston, and then Nurse Denston got a senior nurse to join them, who it seems clear was Nurse Rhoder. Nurse Rhoder recalled when she entered the room, she saw a reading on the automatic blood pressure machine that was in the 80's, which was in the MET call criteria. They began checking Mr Dobson's blood pressure, taking it multiple times manually to check if they got a different reading when compared to the automatic one. Ms Blackshaw recalled the nurses kept taking readings with Mr Dobson in different positions, including lying on his back and with his legs raised and then sitting back up. They also got him to drink some water.[65] It seems clear the readings were concerning and it appeared to Ms Blackshaw that they

[56] T 288.
[57] Exhibit 1, Tab 8 [59].
[58] T 98; Exhibit 1, Tab 8 [60] – [61].
[59] Exhibit 1, Tab 8 [62].
[60] T 98; Exhibit 1, Tab 8 [62].
[61] T 101.
[62] Exhibit 1, Tab 10.
[63] Exhibit 1, Tab 8.
[64] T 114 - 115; Exhibit 1, Tab 17.
[65] T 288.

just kept trying until they "got a figure they were happy with because it was looking odd."[66]

53. Nurse Rhoder said she took Mr Dobson's blood pressure manually from his right arm and his left arm, while Dr Wallis and Nurse Denston were present. Nurse Rhoder recalled Mr Dobson's blood pressure was taken multiple times and fell in the high 80's, between 80 and 90 but closer to the 90 mark. Nurse Rhoder indicated that in hindsight she should have documented these observations in Mr Dobson's patient notes, as they did a lot more reading than were documented. I note she recalled they were "all around the 90 mark,"[67] although in the message Dr Wallis next sent to Dr Laurens, she mentions a systolic blood pressure reading of 85 and then a manual reading of 79.[68] I also note that there is a late entry in the Integrated Progress Notes that records that Ms Blackshaw witnessed a manual reading of 85/49 on his right arm around this time, which is consistent with the message sent by Dr Wallis, although it was not recorded on the Observation Chart.[69]

54. In the end, despite these low readings, Nurse Rhoder recalled the cumulative effect of Mr Dobson's multiple blood pressure readings was that he was felt to be on the borderline for a MET call. It was noted he did not appear unwell and Dr Wallis was present, so it was decided he did not meet the criteria for a MET call at that stage. Instead, Dr Wallis contacted Dr Laurens to discuss Mr Dobson.[70]

55. I also note Ms Blackshaw's evidence was that she did recall someone around this time querying whether they should call Mr Filgate, but she heard Dr Wallis say 'no' and that she would speak to Dr Laurens.[71]

56. Mr Dobson's blood test results had come back by this time and showed a normal full blood count. Dr Wallis explained she had been considering blood loss or complications from surgery might be the cause of Mr Dobson's pain, but the blood result suggested this was not the case.[72] It did show Mr Dobson's creatinine was elevated, which Dr Wallis thought was explicable for a number of reasons, including anaesthesia, post-operative dehydration and his high post-void residuals due to his urinary retention.[73] The results also showed a raised urea level.[74] These is evidence these results, taken with the low blood pressure, might have suggested infection at that stage. However, Dr Wallis gave evidence she was not thinking infection at that stage, as she had been taught that infection following surgery would usually take a couple of days to develop, not one.[75] Mr Dobson's white blood cell count was also not elevated, which would usually occur if there was some sort of infection process present.[76] There is later evidence about the white cell count having some

[66] T 288.
[67] T 135.
[68] T 18 – 19, 107, 135; Exhibit 1, Tab 6.6 and Tab 8 and Tab 10.
[69] Exhibit 2, Tab 1, Integrated Progress Notes, 26/2/2020.
[70] T 18 – 19, 107, 135; Exhibit 1, Tab 8 and Tab 10.
[71] T 288.
[72] T 15.
[73] T 16; Exhibit 1, Tab 7.
[74] Exhibit 1, Tab 7.
[75] T 15.
[76] T 15, 20 - 21.

abnormality, but this does not appear to have been recognised by Dr Wallis at the time.

57. Dr Wallis recalled Mr Dobson was still complaining of pain and she felt he was anxious about the level of pain. He also wanted to go home, which probably added to his anxiety.[77]

58. Dr Wallis contacted Dr Laurens by WhatsApp message to request he review Mr Dobson and also to ask him for any ideas, as she couldn't understand why his blood pressure was dropping.[78] The messages provided by Dr Laurens show he received the first WhatsApp message from Dr Wallis at 3.10 pm. Dr Laurens was in clinic at the time seeing patients. Dr Laurens said he was surprised to hear that Mr Dobson had not yet been discharged. In the message, Dr Wallis indicated that Mr Dobson was "doing all odd things" and in particularly he hadn't voided for 6 hours despite drinking well and a bladder scan showed 580 ml. His HR was elevated and he was very anxious. His blood pressure was also decreasing, for an unknown reason. Dr Wallis noted Mr Dobson was afebrile and his blood results were normal. She asked Dr Laurens if he could provide any suggestions in relation to the low blood pressure.[79]

59. Dr Laurens did not speak to Dr Wallis at this stage, so the only information he received was via the WhatsApp message. He queried whether the blood pressure was a manual reading and whether Mr Dobson was symptomatic to his low blood pressure, as buprenorphine can drop blood pressure a touch. He also suggested Mr Dobson be encouraged to void or the nurses would need to insert a catheter. After a brief further exchange of information, including Mr Dobson having a manual blood pressure reading of 79, Dr Laurens indicated he would come and see Mr Dobson after he had finished in the clinic.[80]

60. Dr Laurens explained at the inquest that he suggested Dr Wallis encourage Mr Dobson to try to void on his own as there is a risk of trauma to the urethra or bladder, and also risk of infection, with a catheter. In addition, putting in a catheter would have delayed Mr Dobson's discharge, even if he had been otherwise well, as he would have to stay overnight for a trial of void the following day. It is not unusual for a patient to have issues voiding following a haemorrhoidectomy as it can take a little time for the bladder to relax to allow urination, so it was not alarming and Dr Laurens felt it would likely resolve without the need for catheterisation.[81]

61. Dr Laurens gave evidence that after hearing the manual reading of 79, he thought "that's a really low blood pressure."[82] Dr Laurens also said that a low blood pressure alone is not concerning, although he acknowledged that the observation charts used by the nursing staff will trigger a MET call based on only a low blood pressure, if it

[77] T 13 - 14.
[78] T 18 – 19.
[79] T 20; Exhibit 1, Tab 6 and 6.6.
[80] Exhibit 1, Tab 6 and 6.6.
[81] T 59 – 60, 77 - 78.
[82] T 55.

is below a certain level.[83] Dr Laurens explained that in his experience, he will often see a surgical patient with an extremely low blood pressure, but the person is otherwise systemically well, and it is only when there are a number of changes that it usually becomes concerning. Therefore, it is important to increase observations but little else will usually be done in relation to a low blood pressure on its own.[84]

62. Dr Laurens acknowledged in his statement that he did not tell Dr Wallis to initiate a Medical Emergency Team (MET) call, although the observations Dr Wallis communicated in the WhatsApp message met the criteria for a MET call (due to the low blood pressure reading), and in those circumstances a MET call should have been made. Dr Laurens stated that in his experience, MET calls are usually initiated by the nursing staff who record the abnormal observations. The only person who has the authority to override a MET call is a consultant.[85] Dr Laurens said he thought at the time if the nursing staff and Dr Wallis had been worried, they would have called a MET call, without the need for him to suggest it. However, he has since changed his practice and will suggest it if the person meets the criteria.[86]

63. Dr Laurens simply advised Dr Wallis that he would come and see Mr Dobson when he was free and, in the meantime, she should encourage Mr Dobson to drink fluids and attempt to void. Dr Laurens still had one or two patients in the clinic at this time, who had been waiting for hours to be seen at that stage, so he prioritised finishing the clinic, understanding Dr Wallis would continue to monitor and treat Mr Dobson in the meantime.[87] Dr Wallis understood that Dr Laurens would be coming sometime between 4.00 and 5.00 pm, based on when the clinic would normally finish.[88]

64. Dr Wallis accepted in her evidence that the systolic blood pressure reading of 85, which dropped to 79 on a manual reading (as recorded between 3.00 pm to 3.20 pm and reflected in the messages she sent Dr Laurens), was a low reading and if it had been documented on the observation chart, it would have fallen within the purple zone and that would have prompted a MET call. At the time, however, Dr Wallis considered she had spoken to Dr Laurens and he had indicated he would come soon, so it wasn't necessary to make a MET call. Dr Wallis did not record Nurse Denston suggesting she make a MET call, given the low reading, but in hindsight Dr Wallis agreed a MET call should have been made.[89] I will return to the issue of the MET call later.

65. Nurse Rhoder said she stayed with Mr Dobson until Nurse Forbes returned at about 3.20 pm. She told Nurse Forbes that Mr Dobson had low blood pressure and was being monitored, and Dr Laurens was coming to review him. She also pointed out the trolley with the catheter was there if Mr Dobson required it. Nurse Rhoder recalled she also went and relayed the same information to Nurse Johnston, who had taken over as Nurse Coordinator, and told her that Dr Wallis was present and did not

[83] T 57.
[84] T 57.
[85] Exhibit 1, Tab 6.
[86] T 57.
[87] Exhibit 1, Tab 6 and Tab 7.
[88] Exhibit 1, Tab 6 and Tab 7.
[89] T 23 – 24.

think a MET call was necessary. Nurse Rhoder said she was "absolutely certain"[90] she had this conversation with Nurse Johnston before she finished her shift.[91] Nurse Rhoder also said that she assumed at the time that Mr Filgate would be made aware by Dr Laurens that he was reviewing Mr Dobson, although she did not raise that with anyone.[92]

SECOND REVIEW BY DR LAURENS

66. Dr Laurens recalled he finished the clinic and then went to see Mr Dobson at about 4.00 pm. Nurse Denston had left by this time, after handing Mr Dobson over to the next nursing shift, but Dr Wallis was still present. At the time Dr Laurens arrived, Mr Dobson was sitting up in bed, talking, Ms Blackshaw was present and Mr Dobson's most pressing need appeared to be the need to void his bladder. Dr Laurens recalled Mr Dobson's blood pressure had returned to within normal limits (although still slightly low) so he no longer met the criteria for a MET call at that stage.[93] He had also not complained of any dizziness, which is usually associated with low blood pressure.[94] Dr Laurens remembered Mr Dobson seemed keen to go home and both he and Ms Blackshaw had asked about when he would be discharged.

67. Ms Blackshaw gave evidence she remembered Dr Laurens telling Mr Dobson that if he didn't pass urine he would have to have a catheter again, which wouldn't be nice, and if he urinated he could go home.[95]

68. Dr Laurens recommended that Mr Dobson go downstairs for a walk and to perhaps get a coffee, and then see if he was able to void. He could then be checked to see whether his observations stayed within normal limits. Ms Blackshaw said that after Dr Laurens left, they did try, but Mr Dobson was only able to walk to the room next door before turning back and returning to bed.[96]

69. As buprenorphine is known to lower blood pressure, Dr Laurens suspected that may have been the cause of the low reading. Given he had now ceased the buprenorphine, if his blood pressure then increased on its own, Dr Laurens felt this would show it was more likely that buprenorphine was the cause of the low blood pressure. Dr Laurens also noted that Mr Dobson never looked clinically unwell, which he said he found reassuring.[97] Dr Laurens' instructions, as recorded in the Integrated Progress Notes by Dr Wallis, were that he was happy for Mr Dobson to be discharged and leave that night if he was able to void and his bladder scan was less than 300ml and his systolic blood pressure was above 110. Hourly observations and hourly bladder scans were requested.[98]

[90] T 141.
[91] Exhibit 1, Tab 10 [49].
[92] T 136.
[93] T 61; Exhibit 1, Tab 6.
[94] T 19; Exhibit 1, Tab 7.6.
[95] T 288 – 289.
[96] T 61, 289; Exhibit 1, Tab 6; Exhibit 2, Tab 1, Integrated Progress Notes 18/7/19 1630.
[97] T 61; Exhibit 1, Tab 6; Exhibit 2, Tab 1, Integrated Progress Notes 18/7/19 1630.
[98] T 26; Exhibit 1, Tab 6.6; Exhibit 2, Tab 1, Integrated Progress Notes 18/7/19 1630.

70. Dr Laurens stated that he instructed Dr Wallis and the nurse that if Mr Dobson was not discharged home that afternoon, then they should contact him so he could inform Mr Filgate. Dr Laurens noted it was usual practice to inform the consultant in those circumstances, although it was not written in a policy.[99] Dr Wallis recalled Dr Laurens giving that instruction to the nursing staff, noting that she was also about to end her shift that day so she assumes it was not directed at her. Dr Laurens agreed the request was not specifically directed at Dr Wallis, but at the nursing staff as well.[100]

71. Nurse Johnston, the afternoon nurse coordinator, recalled having a separate conversation with both Dr Wallis and Dr Laurens, rather than speaking to them together. She spoke to Dr Wallis in the doctor's office next door to Mr Dobson's room at about 4.30 pm and they discussed the plan with regards to his care. Nurse Johnston said she asked a series of questions about Mr Dobson's blood pressure and tachycardia and was told the buprenorphine and the anxiety were the two related causes. Nurse Johnston did not recall being told Mr Dobson's systolic blood pressure needed to be above 110 before he could be discharged, although Dr Wallis did record this as part of the plan in the notes. Nurse Johnston said she believes she would have queried this with Dr Wallis if it had been mentioned, as she would have wanted to know how that increased blood pressure could be achieved without a canula and intravenous fluids. Nurse Johnston also said she did not recall being asked to call Dr Laurens if Mr Dobson did not go home, noting once the doctors had gone home, it was extremely unlikely any nurse would send him home in those circumstances.[101]

72. Nurse Johnston recalled being paged at approximately 5.10 pm and she went and met Dr Laurens in the nursing station. She recalled he told her the same information that Nurse Forbes had handed over earlier, namely that his low blood pressure was due to buprenorphine and the tachycardia was due to anxiety. Nurse Johnston understood the discharge instructions were that they should follow the hospital's urinary retention policy and if Mr Dobson was voiding with urinary residuals under 300 mls then he could be discharged from the ward. Nurse Johnston did not mention being told to contact Dr Laurens if Mr Dobson was not discharged.[102]

73. Dr Laurens completed his shift at around 5.00 pm that day. There was no registrar for him to hand over to when he left, so his only conversation with a doctor was with Dr Wallis before he left. Dr Laurens was not contacted about Mr Dobson again that evening. He first learned of the later events when he returned to work at Osborne Park Hospital again the next morning, when he was informed that a MET call had been made and Mr Dobson had been transferred to SCGH. Dr Laurens immediately called Mr Filgate to let him know, but Mr Filgate was already aware as he had been contacted the night before and conducted an emergency laparotomy on Mr Dobson. Mr Filgate told Dr Laurens that he had not been aware until late the previous evening that Mr Dobson had not been discharged home, and commented that Dr Laurens

[99] Exhibit 1, Tab 6.
[100] T 47, 74 75.
[101] T 260 – 263, 280.
[102] T 261 – 263; Exhibit 1, Tab 21.

should have advised him. Dr Laurens accepted, in hindsight, that he should have discussed Mr Dobson with Mr Filgate prior to finishing his shift the previous day, when Mr Dobson had not gone home as initially planned.[103]

74. In his statement, Dr Laurens indicated he did not know at the time of reviewing Mr Dobson after clinic on 18 July 2019 that Mr Dobson's creatinine and urea were up. He did not believe this information was relayed to him, although it was recorded by Dr Wallis in the medical note entry made at the time of Dr Laurens' second review.[104]

75. However, Dr Wallis said in her statement the second review with Dr Laurens proceeded as recorded in the progress notes, which included the urea and creatinine results, and which were recorded contemporaneously during the review in the presence of Dr Laurens and indicated they were higher than the normal limit and trending up.[105] In her evidence at the inquest, Dr Wallis also said that she remembered showing Dr Laurens the blood results, although they did not go specifically through them.[106]

76. Having heard Dr Wallis' evidence, Dr Laurens accepted it was possible Dr Wallis may have shown him the blood results, although he did not recall looking at them himself, or in particular noting the raised urea and creatinine levels.[107]

77. Dr Wallis gave evidence it was clear those results were abnormal and showed an issue with his renal function, but Dr Wallis felt there were many options why they would be abnormal, including his urine retention and the effects of the anaesthetic.[108] Dr Wallis gave evidence the low white blood cell count, lack of a fever and the fact he looked comfortable all pointed away from infection at that time in her mind. Her main concern was his increase in pain at the time, but she had very little experience with haemorrhoid patients.[109]

78. Dr Laurens stated in hindsight the raised urea and creatinine was significant, because coupled with the tachycardia and low blood pressure, it signalled that Mr Dobson might be showing signs of sepsis. Clinically, sepsis occurs when at least two organs are dysfunctional, and while the tachycardia and low blood pressure related to the heart, the creatinine and urea results showed his renal function (kidneys) may also have been impaired.[110] However, at the time, Dr Laurens said he thought Mr Dobson was in urinary retention, which can cause derangement in the renal function. Therefore, even if he had focussed on the rising creatinine at the time, he probably still would have thought it was because of the urinary retention, which causes backflow of the urine up into the kidneys, which alters their ability to filter properly. The difference in knowing about the creatinine is that Dr Laurens believes he would have thought Mr Dobson was unlikely to be discharged due to his urinary retention

[103] Exhibit 1, Tab 6.
[104] Exhibit 2, Tab 1, Integrated Progress Notes 18/7/19 1630.
[105] T 45 - 47; Exhibit 1, Tab 6 [32].
[106] T 33.
[107] T 62.
[108] T 32 – 33, 46.
[109] T 33.
[110] Exhibit 1, Tab 6.

issue, so he would have called Mr Filgate and informed him before he left at the end of his shift. This could, then, have been an opportunity perhaps to discuss Mr Dobson's case more generally, or alternatively have at least put Mr Filgate on alert that there was an issue with his patient at an earlier stage.[111]

79. Dr Laurens was unaware at this time that Mr Dobson had attended SCGH ED on 22 June 2019, only a few weeks before, in relation to a cellulitis infection in his leg. At that presentation, Mr Dobson's C-Reactive Protein (CRP) was recorded as 280, which is very high. CRP is a protein created by the liver and is an inflammatory marker. High CRP numbers are normally recorded on patients with underlying health conditions, such as diabetes or a significant inflammatory condition. A number as high as 280 would usually only be seen in someone who has perforated their bowel or has extensive inflammation of an organ. Dr Laurens stated that he would have been assisted to know Mr Dobson's previously recorded high CRP, as given Mr Dobson did not suffer from any underlying health conditions, his high CRP may have suggested that he would not have a good recovery from surgery. However, he wasn't sure if it ultimately would have changed his care on the day and whether the high CRP and his later infection was just a coincidence. It seems the information was available in the pre-admission blood work patient results, as attached to Dr Laurens' statement, and Ms Blackshaw gave evidence they raised it in their pre-admission appointment on 28 June 2019, but it does not appear to have been brought to Dr Laurens' attention.[112]

80. Dr Laurens gave evidence, in the context of what he was seeing at the time, he did not think of sepsis, although now in hindsight there are these features that put together, could have suggested it. Dr Laurens noted that sepsis is extremely rare following a haemorrhoidectomy and if it does occur, would normally take about 72 hours to set in and start affecting a patient. Mr Dobson's rapid development of sepsis following a haemorrhoidectomy was a rare event, and the fact that he developed cold sepsis, was even more rare. Mr Dobson was not exhibiting any signs of classic sepsis, such as a fever and increased respiratory rate. Mr Dobson still looked well and his blood pressure had returned to a normal, although low, level without any intervention other than simple oral hydration and a change of medication. While Mr Dobson had a high heart rate, it could be attributed to pain, urinary retention and anxiety. Therefore, Dr Laurens felt at the time there were other reasons for Mr Dobson's presentation. Dr Laurens noted that doctors are trained that when you hear hoofbeats you look for "horses not zebras"[113] at the starting point, and there was nothing about Mr Dobson's clinical presentation at the time that suggested a rare case of sepsis following haemorrhoidectomy as the obvious diagnosis.[114]

81. At the time he left the hospital on 18 July 2019, Dr Laurens believed Mr Dobson would most likely be discharged home that night and he did not consider there was any need to contact his consultant, Mr Filgate, at that time. Dr Laurens said he did leave instructions that he should be contacted if Mr Dobson was not discharged that night, so he could then advise Mr Filgate. He recalled he directed this request

[111] T 62, 69.
[112] T 65 – 67, 285; Exhibit 1, Tab 6 and Tab 6.7.
[113] T 63.
[114] T 62 – 64.

generally to Dr Wallis and the nursing staff, although Nurse Johnston said she did not recall being asked to do this.[115] Dr Laurens accepted that in hindsight he should have contacted Mr Filgate before leaving at the end of his shift, even though he thought Mr Dobson was likely to be discharged home soon.[116]

82. Dr Wallis also finished her shift at around 5.00 pm. She stated she did not complete a handover of Mr Dobson to the after-hours RMO, Dr Elizabeth De Jong, despite the fact he had not been discharged as expected by that time, because "there was nothing of concern as Dr Laurens was happy and discharge was expected"[117] that afternoon/evening. Dr Wallis was asked, in hindsight, whether she believes she should have done a handover to the oncoming RMO. Dr Wallis said that she found it a tough question to answer, as she remembered that after Dr Laurens had attended she felt reassured and felt perhaps she had overreacted to the situation. Dr Wallis had updated Mr Dobson's discharge medications, he didn't need any active treatment and she remembered seeing him walking with his partner to the coffee shop, so she felt the concern was over.[118] Ms Blackshaw later advised that they never made it to the coffee shop, as Mr Dobson was only able to walk a short distance before he had to return to his room.[119]

83. Dr De Jong gave evidence that, in hindsight, it "would have been a massive benefit to have known what the blood pressure readings were throughout the day, what change had been made by the …. surgical team, what the impression was from the surgical team" via a handover at the start of her shift. Specifically, she believes she would have been assisted by the impression of the most senior doctor, Dr Laurens, who had reviewed Mr Dobson, going forward into the evening. Dr De Jong believes if she had known about the issues with Mr Dobson at the start of her after-hours shift, she would probably have touched based with the nursing staff sooner rather than later, to check what was happening with him. As it was, Dr De Jong described coming in to see Mr Dobson for the MET call without context as "horrible,"[120] and it is clear she found the experience traumatic as a junior doctor leading her first MET call, particularly knowing the eventual tragic outcome.

MR DOBSON'S DETERIORATION

84. Nurse Denston recalled she had handed over Mr Dobson's care to the nurses present at the nursing station. She believed Nurse Kay Johnston, who was replacing Nurse Rhoder as the coordinator for the afternoon shift, was present at that time, although Nurse Johnston stated she did not recall a discussion with Nurse Denston that day. Nurse Denston recalled she told the afternoon shift nurses that Mr Dobson had rectal pain and was on hourly observations for his heart rate and low blood pressure. He was still able to walk and did not look sick or pale, but in her opinion he did not look like a normal patient who was ready for discharge. Nurse Denston remembered

[115] T 62 – 64, 74, 279 - 280.
[116] T 64.
[117] Exhibit 1, Tab 7 [33].
[118] T 27, 44.
[119] Exhibit 2, Tab 1, Letter from Samantha Smith dated 10.1.2020.
[120] T 200.

Mr Dobson didn't appear to be eating or comfortable because he was in so much pain. At the time she finished her shift, Nurse Denston said she did not feel reassured that Mr Dobson was getting better.[121]

85. It is clear from the medical records that, despite Nurse Denston's handover, hourly observations were not performed on Mr Dobson for the first few hours. Nurse Forbes had explained in her evidence she believed Mr Dobson only required the usual four hourly observations. She had been involved in the review by Dr Laurens, after Nurse Denston left, and she felt reassured that Mr Dobson's concerning observations were in hand after that review. Also, Nurse Forbes said she was in and out of Mr Dobson's room between 3.00 pm and 6.00 pm and she recalled Ms Blackshaw was there with him and Mr Dobson was mobile and appeared well. Nurse Forbes gave evidence she was more concerned about Mr Dobson's ongoing bladder residual. Nurse Forbes had spoken to Dr Laurens about her concern that Mr Dobson wasn't voiding, but had been told to continue to attempt to get him to try to void on his own, noting the new policy did not mandate a catheter at that level. Nurse Forbes had been told by Nurse Johnston that Dr Lauren's instruction was that if Mr Dobson's urinary residual was below 300 ml, he could go home.[122]

86. Nurse Johnston, who had spoken to Dr Laurens and Dr Wallis about Mr Dobson before they both finished their shifts, agreed that the conversations with the doctors had provided some reassurance for the afternoon nursing shift, commenting, "Reassurance is the key word."[123]

87. Nurse Forbes completed her first set of observations for Mr Dobson at 6.00 pm. She did them manually and recorded the results in the Observation Chart. Nurse Forbes said she was not happy with these observation and Mr Dobson also told her that he was in pain, rating it as 6/10. Mr Dobson's blood pressure was still concerningly low at 90/60 and she recalled checking it a couple of times, before letting her shift coordinator, Nurse Johnston, know that Mr Dobson's observations for hypotension and tachycardia met the 'Medical Review' criteria. Nurse Johnston recalled Nurse Forbes also told her at that time that Mr Dobson was voiding small amounts and the bladders scans showed his urinary residuals were approximately 500 mls.[124]

88. Ms Blackshaw recalled at this time that Mr Dobson's heart rate was so high that the student nurse suggested the machine was probably faulty because the observations didn't match Mr Dobson's appearance as he looked well. Ms Blackshaw acknowledged in her evidence that Mr Dobson was quite personable and very chatty, so he was joking with the nursing staff and probably not making it clear how uncomfortable he was. She also noted that he had a Mediterranean background, so he had a nice natural tan that may have disguised the fact he wasn't feeling well. They also didn't want to be there, so both Ms Blackshaw and Mr Dobson kept asking when he could go home. Nevertheless, it is clear from Ms Blackshaw's evidence that

[121] T 102, 105 - 107; Exhibit 1, Tab 8 and Tab 21.
[122] T 115, 122 - 124; Exhibit 1, Tab 17 and Tab 21.
[123] T 263, 289.
[124] T 115 - 117; Exhibit 1, Tab 17 and Tab 21.

there remained concerning signs throughout the afternoon, which the hospital staff appeared to explain away with various different reasons.[125]

89. Nurse Johnston told Nurse Forbes to check Mr Dobson's blood pressure and pulse manually and to check it again in half an hour. Nurse Forbes indicated in her statement she understood Nurse Johnston was going to escalate the blood pressure issue by paging the RMO on shift, as the escalation policy indicated a medical review was required.[126] Nurse Johnston stated that she paged the on-call doctor after speaking to Nurse Forbes, but there was no reply.[127]

90. Nurse Johnston then came into Mr Dobson's room and spoke to Nurse Forbes about Mr Dobson's pain medication, as he was on tapentadol, which required two nurses to dispense. Nurse Forbes then administered paracetamol, celecoxib and some tapentadol to Mr Dobson for his pain.[128] Nurse Johnston recalled at this time Mr Dobson "appeared quite well, as he was lucid and talking."[129] He said he still had pain in the same area of his bottom that he had mentioned to Nurse Johnston when she had checked in with him at about 4.00 pm.

91. Dr De Jong was the RMO rostered to do the after-hours cover for all but the Obstetrics and Gynaecology ward that evening. Dr De Jong had started as an RMO for NMHS that year and had only been seconded to Osborne Park Hospital on 10 June 2019. She was generally working in the Young Adult Rehabilitation specialty but did additional night shifts/after-hours shifts covering the hospital's general wards. On 18 July 2019, Dr De Jong was working the after-hours shift for only the seventh time. She had already worked a day shift in the Young Adult Rehabilitation Ward before starting the after-hours shift at 4.30 pm, so she was rostered to fulfil a 15 hour shift that day. Dr De Jong recalled she had been given a handover from the Young Adult Rehabilitation Registrar and Medical RMO for two new patients she needed to admit, but had not received a handover from the surgical team, being Dr Laurens and Dr Wallis that day. Therefore, Dr De Jong was unaware of Mr Dobson and the fact he had not been discharged as planned.[130]

92. Dr De Jong recalled it was a very busy shift that evening, with her duties including admitting the two new patients and attending to assess an elderly patient after a fall and also responding to a concerned relative. Dr De Jong said she did not receive a page in relation to Mr Dobson at 6.00 pm. She therefore remained unaware that there were any issues with Mr Dobson at that time.[131]

93. Nurse Johnston recalled that the nursing student who had been shadowing Nurse Forbes for her shift, came in to see her at around 6.30 pm and advised her that Mr Dobson's blood pressure remained the same manually. There is no record of this

[125] T 289, 291..
[126] T 115 - 117; Exhibit 1, Tab 17 and Tab 21.
[127] Exhibit 1, Tab 21 [56].
[128] T 115 - 117; Exhibit 1, Tab 17 and Tab 21.
[129] Exhibit 1, Tab 21 [58].
[130] T 198 – 200; Exhibit 1, Tab 9.
[131] Exhibit 1, Tab 9.

in the observation chart. Nurse Johnston stated she then tried again to contact the after-hours doctor and waited for a period of time, but they did not phone back. [132]

94. Nurse Forbes recalled she was quite busy, as she had several post-operative patients she was caring for who had recently come from theatre, which required collecting them from recovery, getting them settled into their rooms and doing observations every half an hour. The ward was also down a nurse for about an hour from 5.10 pm to 6.20 pm as a nurse from Ward 6 had to go to another area to relieve other nurses for tea breaks.[133] Nurse Forbes said she was told by Nurse Johnston at around 6.45 pm that, despite the doctor being paged, they had not phoned back by that time. As noted above, Dr De Jong stated she did not receive any such page.[134]

95. Nurse Johnston stated that she tried to contact the after-hours doctor again by paging them twice at around 6.45 pm. There was no return phone call, which she said was not unusual as they were often busy. Nurse Johnston then rang the Osborne Park Hospital switchboard and asked to be connected to the after-hours doctor. Nurse Johnston stated she was then put through to a male doctor, whose name she does not recall. She explained who she was and where she was phoning from and asked the doctor if he was aware of Mr Dobson. The male doctor said he was not aware of him. Nurse Johnston recalled she then explained Mr Dobson's situation and that he required a medical review. The doctor responded that he was busy with a patient and had a few patients to see, but he would come as soon as possible.[135]

96. Nurse Johnston did not make a record of this interaction with a doctor in the medical notes at the time, but said the conversation occurred at around 6.45 pm. It is clear that if she spoke to a male doctor at around 6.45 pm, the doctor was not Dr De Jong. There was a male RMO on the after-hours shift in the Obstetrics & Gynaecology Ward, Dr Jesse Durdin, but he was not the on-call doctor for Ward 6 and Nurse Johnston said she did not speak to Dr Durdin. Nurse Johnston suggested she might have spoken to another doctor still in the hospital, someone other than the two after-hours RMO's. She was sure it was a male doctor and that the doctor said he was busy and would come to the ward to review Mr Dobson when he could.[136]

97. Nurse Forbes did not do another set of observations for Mr Dobson until 7.00 pm.[137] Mr Dobson's observations, written in the chart as taken at 7.10 pm, are a little difficult to interpret. His blood pressure reading was drawn onto the Observation Chart as recording about 105/60 on a manual reading, however a notation was also written in as 90 for the systolic reading. Nurse Forbes did not recognise the handwriting, but thought it might have been entered by a student nurse who was shadowing her. Nurse Forbes did not think the 90 systolic reading was correct, as her recollection was that it was 105. However, she did note that Mr Dobson's pulse was also quite high, at about 115 bpm. Nurse Forbes gave evidence she wasn't sure if the increased heart rate was due to pain, but noted it fell in the medical review section.

[132] Exhibit 1, Tab 21.
[133] Exhibit 1, Tab 21 [12].
[134] T 124 – 125; Exhibit 1, Tab 17 and Tab 21.
[135] T 264 – 266; Exhibit 1, Tab 21.
[136] T 265.
[137] T 117.

She said she was aware Nurse Johnston had already instigated a medical review at 6.00 pm, so she said she did not take any further action in that regard.[138]

98. Nurse Forbes also recalled Mr Dobson rang the call bell at some stage and asked her to look in the toilet, as there was some blood in the toilet. She checked it and noted it was only a couple of spots, so she reassured Mr Dobson that it was not concerning.[139]

99. Nurse Forbes had been keeping Nurse Johnston informed of Mr Dobson's situation and she understood Nurse Johnston was also keeping an eye on him, given Nurse Forbes was busy with other patients, one of whom required a lot of assistance.[140] Nurse Johnston stated that after speaking with the male doctor, she entered Mr Dobson's room at about 7.00 pm and asked him how he felt. He said the pain was similar to what he had stated earlier. He denied any rectal bleeding and said he wasn't feeling nauseous but hadn't eaten his dinner. Nurse Johnson stated she advised Nurse Forbes to commence a fluid chart for Mr Dobson for fluid intake/output accuracy and to discourage mobilisation because of his low blood pressure and fall the night before.[141]

100. Nurse Johnston took her dinner break from around 7.20 to 7.45 pm. She spoke to the After-Hours Nurse Manager, Janice Zhu, on her return and gave her a handover of the ward status, which included Mr Dobson's status. Nurse Johnston recalled she explained they were waiting for a medical review for Mr Dobson and she asked why the second on-call doctor was not called in if the after-hours doctor was busy, but did not receive an answer.[142]

101. Ms Blackshaw gave evidence that she finally confirmed with the nursing staff at about 8.00 pm that Mr Dobson was not coming home. Ms Blackshaw had to go and sort out their children, who had been left with her mother on the basis that she would only be gone for the morning, yet she had now been gone the whole day. Accordingly, Ms Blackshaw left the hospital to relieve her mother and then she needed to take her mother home to collect more clothes, as she had to stay over to help again the next morning when it was expected Mr Dobson would actually be ready for discharge. Ms Blackshaw was not, therefore, able to be there for the following hours as Mr Dobson's situation continued to worsen. Ms Blackshaw was actually still trying to sort out her children and mother and make arrangements for the next day when she later received the call to advise that he was being transferred to SCGH.[143]

102. The only nursing entry made by Nurse Johnston referring to a conversation with the on-call doctor was made at 8.30 pm. Nurse Johnston stated that entry referred to her conversation with the on-call doctor at approximately 6.45 pm. Nurse Johnston does not refer to another conversation with the on-call doctor that night. However, Dr De

[138] T 118 - 119; Exhibit 1, Tab 8.
[139] T 123; Exhibit 1, Tab 17.
[140] Exhibit 1, Tab 17.
[141] Exhibit 1, Tab 21; Exhibit 2, Tab 1, Fluid Balance Work Sheet.
[142] T 267; Exhibit 1, Tab 21.
[143] T 289.

Jong does recall receiving a call from a nurse sometime between 8.00 pm and 8.30 pm about Mr Dobson and requesting a medical review.

103. Dr De Jong, the on-call RMO, is a female doctor and she stated that the first page she received in relation to Mr Dobson was between 8.00 pm and 8.30 pm, asking for a medical review of Mr Dobson. After receiving the page, Dr De Jong called the number back using the Ward 3 telephone and spoke to a nurse. Dr De Jong could not recall the identity of the particular nurse. Dr De Jong recalled she was told Mr Dobson had a low blood pressure and a fast heart rate and required medical review. She recalled being told words to the effect, "his numbers don't look great"[144] but he appeared clinically well.[145]

104. On further discussion, it became apparent to Dr De Jong that Mr Dobson had had a low blood pressure and fast heart rate for most of the day. The nurse advised Dr De Jong that Mr Dobson had been reviewed by the surgical team earlier that afternoon for his low blood pressure and elevated heart rate and the plan was for discharge home once he was voiding well and his blood pressure had stabilised. Dr De Jong recalled that the nurse advised her Mr Dobson continued to look well and was asymptomatic, despite his observations. His bladder scan was 600 ml with no urge to urinate, but she believed he had been eating and drinking well all day.[146]

105. Dr De Jong stated that she recognised that Mr Dobson needed medical review given his heart rate and blood pressure was abnormal and that he had potentially gone into urinary retention. However, she also already had a heavy workload with other patients still awaiting her medical review. Dr De Jong felt reassured that, at the time, Mr Dobson appeared otherwise stable with no acute clinical deterioration from the medical review by the surgical team earlier that afternoon, other than what she understood was a new suspected urinary retention issue. In the circumstances, Dr De Jong stated she instructed the nurse to continue to encourage oral hydration and to encourage him to void, then to repeat his bladder scan in one hour if there was no urine output, with the thought he might need re-catheterisation. Dr De Jong noted that urinary retention is not uncommon for patients who undergo surgery, and the cause can be multifactorial. Dr De Jong stated that she was not aware of his earlier bladder scan and reduced urine output over the previous hours. This extra knowledge might have assisted her, as it can indicate a serious issue, one option being sepsis.[147]

106. The nursing note made by Nurse Johnston at 8.30 pm in Mr Dobson's Integrated Progress Notes recorded that she had spoken with the on-call doctor regarding Mr Dobson's blood pressure and urine retention of 600 mls and the doctor would review the patient "ASAP."[148] Nurse Johnston maintained that she made this note at 8.30 pm, but the discussion with the male on-call doctor actually occurred at 6.45 pm. If that was the case, it is unclear why she did not do anything further when Dr De Jong had still not attended by the time she was making the note. In accordance with the hospital escalation policy, a medical review should have occurred within

[144] Exhibit 1, Tab 9 [37].
[145] Exhibit 1, Tab 9.
[146] Exhibit 1, Tab 9.
[147] Exhibit 1, Tab 9.
[148] Exhibit 2, Tab 1, Integrated Progress Notes, 18/7/19, 2030.

30 minutes and in the absence of that occurring, a MET call should be considered. A MET call was not, however, made at any time before 9.30 pm.[149]

107. Nurse Johnston's evidence was that she did not recall a conversation with a female doctor between 8.00 pm and 8.30 pm.[150] She did not think she spoke to another doctor after speaking to the male doctor at around 6.45 pm. It is unclear, then, who spoke to Dr De Jong, if it was not Nurse Johnston. Nurse Forbes' evidence was that she left all contact with the on-call doctor to Nurse Johnston, who was feeding back information to her. Nurse Rhoder and Nurse Denston had gone home by this time. The replacement nurse for Nurse Johnston did not arrive until about 9.00 pm, so it would not have been her who made the call. Nurse Johnston said she could not explain that phone call to Dr De Jong.[151]

108. Dr De Jong made detailed notes a few days after becoming aware of Mr Dobson's death. In her notes, Dr De Jong set out the events of 18 July 2019 from 4.30 pm when she commenced her shift. Dr De Jong recorded she had been talking to the daughter of an elderly patient from 6.15 pm. The patient had a fall and Dr De Jong had performed a neurology exam and then contacted another doctor to form a plan. She wrote up her notes for this patient around 7.00 pm and then began admitting another patient, who had been waiting three hours. While admitting this patient, which took until about 8.00 pm, Dr De Jong said she received the page about Mr Dobson.[152]

109. Dr De Jong stated that she responded and told the nurse she would add a review of Mr Dobson to her list of tasks and attend to him as soon as possible after reviewing her other patients who were already waiting. She also instructed the nurse to let her know if there were any concerns in the meantime. Dr De Jong detailed in her notes the tasks she then performed for other patients before she received the MET call at 9.30 pm. It's clear from her notes that Dr De Jong was very occupied at this time managing other patients.[153]

110. I am unable, on the evidence before me, to make a finding as to the identity of the male doctor Nurse Johnston says she spoke to at 6.45 pm, nor the nurse who spoke to Dr De Jong at around 8.00 pm. It does seem strange that it was not the two of them that spoke to each other, as much of the rest of the information would match that scenario, but both witnesses were firm in their evidence, so I am left with some uncertainty about the events surrounding the pages and calls regarding medical review until the MET call was made at 9.30 pm. Whilst this is undesirable, given the lapse of time, I do not think trying to call other witnesses who were on shift that day will assist.

111. As noted above, the Osborne Park Hospital escalation policy dictated that a MET call should have been made when the medical review did not occur within 30 minutes of the low blood pressure reading. This did not occur. On Nurse Johnston's evidence,

[149] Exhibit 1, Tab 21.
[150] Exhibit 1, Tab 21.
[151] T 268.
[152] Exhibit 1, Tab 9.1.
[153] Exhibit 1, Tab 9 [43] and Tab 9.1.

she had been trying to get a medical review from around 6.00 pm without success, so a MET call should have been considered from about 6.30 pm, but a MET call was not made until 9.30 pm. Nurse Johnston was asked at the inquest if she was aware of the policy that a MET call should be considered when a doctor has not attended for a medical review within 30 minutes. Nurse Johnston acknowledged the policy existed and said she did discuss a MET call with Nurse Forbes and, because Mr Dobson appeared well, and she had that reassurance, she didn't consider making a MET call at the time. Nurse Johnston also gave evidence that making a MET call in such circumstances wouldn't be practical given the busyness of the doctors.[154]

112. Nurse Johnston conceded in her evidence that potentially a MET call should have been called because Mr Dobson wasn't reviewed on time, but said "you have to consider the other factors around that,"[155] noting the doctor was busy, they knew Mr Dobson wasn't bleeding, he was drinking and as far as they were concerned, he was voiding small amounts. She said they had started a fluid chart to try to achieve more accurate management of his urine but felt that otherwise it was appropriate to wait for the doctor to become available.[156] It was also emphasised in the submissions filed on Nurse Johnston's behalf that the policy required her to consider a medical review after 30 minutes, which she did, but she was reassured that Mr Dobson seemed well and she exercised her clinical judgment that a MET call was not required. It was also emphasised that she also used her judgment when Mr Dobson's observations changed and met the MET call criteria, as she was finishing her shift, as noted below.[157]

113. Nurse Johnston stated that she handed over to the oncoming night shift staff, experienced Clinical Nurse Jenny Brownlie, at 9.00 pm and explained that she was concerned about Mr Dobson and they were still waiting for a medical review. Nurse Johnston gave evidence she said she was going to go and see Mr Dobson again after the handover and if she was concerned, then she would be calling the on-call doctor again before she left.[158]

114. At 9.30 pm, Nurse Forbes made a nursing entry and documented Mr Dobson's systolic blood pressure of 90 and pulse rate of 101 to 102. She noted the on-call RMO was aware of these observations. Mr Dobson's bladder scan had been between 550 – 600 mls throughout the shift. It was also documented that Mr Dobson had walked around the ward a couple of times with his partner but mainly had been in bed. He had passed a small amount of blood in his stools and was given his regular analgesia and tramadol for pain relief.[159] Nurse Forbes recalled she was making her entry in Mr Dobson's Integrated Progress Notes and doing the handover to the night shift nurse when the MET call was made. She recalled it was made in particular because of the low blood pressure reading.[160]

[154] T 279, 282.
[155] T 282.
[156] T 279, 282.
[157] Closing Submissions on behalf of Nurse Johnston filed 27 April 2023.
[158] Exhibit 1, Tab 21.
[159] Exhibit 2, Tab 1, Integrated Progress Notes 18/7/19, 2100.
[160] Exhibit 1, Tab 17.

115. Nurse Johnston went in to see Mr Dobson at around 9.20 pm, so around the time Nurse Forbes was making her entry in the Integrated Progress Notes. Nurse Johnston found Mr Dobson standing at the side of the bed trying to use a bottle to pass urine. She asked him how he was feeling and Mr Dobson said he wasn't feeling too great. Nurse Johnston asked him to return to bed and she became alarmed when he seemed confused and didn't know which end of the bed to get back into, although he was still lucid. Nurse Johnston then took Mr Dobson's blood pressure both electronically and manually and found it fell in the MET call criteria. The Observation Chart records Mr Dobson's blood pressure reading at 9.30 pm was 90/55. Nurse Johnston stated she spoke to a registered nurse, Fred Moyo, who was standing outside the door. Nurse Johnston asked Nurse Moyo to stay in the room with Mr Dobson, while she went to the nursing station to make the MET call and get the resuscitation trolley.[161]

116. The records show a MET call was made at around 9.30 pm. Later documentation suggests it was made because Mr Dobson's blood pressure had dropped to 66/48 and he showed features of hypoxia.[162]

117. Dr De Jong stopped what she was doing on Ward 3 and immediately responded to the MET call on Ward 6. This was Dr De Jong's first MET call while doing the after-hours RMO shift at Osborne Park Hospital. On the way there, she met Dr Jesse Durdin, who was also responding to the call. Dr Durdin was working as the after-hours Obstetrics & Gynaecology RMO that night. There was no Registrar on shift, so the MET call was led by the two RMO's, with Dr De Jong technically the Team Leader for the MET call, although Dr Durdin was more experienced so he perhaps took a larger role than might otherwise be the case. Dr Durdin had apparently also reviewed Mr Dobson the night before after his fall, so he had met him before. Dr De Jong gave Dr Durdin a handover in the lift based on what she had been told in the earlier phone conversation with Nurse Johnston. I understand a Clinical Nurse Specialist, Ms King, also attended the MET call.[163]

118. Dr De Jong recalled that on their arrival, Mr Dobson was sitting up in bed, alert and notably anxious. She asked why the MET call had been made and then saw the blood pressure reading on the automatic blood pressure machine, which showed his blood pressure was 68/47 with a heart rate of 120 bpm. Dr De Jong said she didn't feel the need to repeat that blood pressure as that "was a necessary blood pressure to act on straight away, anyway."[164] These observations are similar to what was recorded on the MET Report at that time, which documents Mr Dobson's blood pressure at 9.30 pm as 68/49 and his heart rate was 123 bpm. His respiratory rate was 24 and his temperature was 36.7°, so he was afebrile.[165]

119. Dr De Jong took a brief verbal history from Mr Dobson who said he was feeling dizzy and light-headed (consistent with his low blood pressure) and he was very anxious and worried. His hands and feet were cool to touch, suggesting he was peripherally shut down, but his central perfusion was normal. Dr Durdin set about

[161] T 269 – 270; Exhibit 1, Tab 21.
[162] Exhibit 2, Tab 1, Transfer Letter to SCGH dated 18/7/19 prepared by Dr Durdin.
[163] T 269 – 270; Exhibit 1, Tab 21.
[164] T 204.
[165] Exhibit 1, Tab 9 and Tab 9.1; Exhibit 2, Tab 1, MET Report 18/7/19, 2130.

trying to get cannula access, which was difficult because Mr Dobson was quite peripherally shut down. When the cannula was inserted, Mr Dobson was given intravenous fluids and his blood pressure improved to 106/54 by 9.45 pm.[166]

120. Mr Dobson told Dr De Jong he had been passing fresh blood in the toilet bowel, which was the first time she had been informed of this symptom. Dr De Jong was concerned that Mr Dobson might be bleeding externally or internally, which would explain his low blood pressure and fast heart rate. With Mr Dobson's consent, his anal area was reviewed and noted to be painful but there was no fresh blood seen and an examination of his abdomen did not suggest he had a massive intra-abdominal collection of blood. The venous blood gas also indicated Mr Dobson's haemoglobin was stable, which really excluded bleeding as a differential diagnosis.[167]

121. The two doctors considered anaphylaxis, but there were no new medications charted that day and his deterioration appeared to be gradual, so there was no suggestion of anaphylaxis.[168]

122. Being aware of Mr Dobson's urinary retention and the fact he had still not voided, a decision was made to insert an indwelling catheter and 600 ml of concentrated urine was drained. Although he was given intravenous fluid, there was not an increased output after that. An ECG showed sinus tachycardia, which is an abnormal finding, but it was unclear what it signified.[169]

123. After Mr Dobson was given oxygen, the Code Blue was stood down at 10.05 pm, although it was noted his blood pressure remained in the trigger zone for a MET call (recorded as 95/53 on the MET Report). The Code Blue was reactivated at 10.15 pm while the emergency team were still in attendance, with Mr Dobson's blood pressure readings noted to be dropping down to around 80/50.[170]

124. Mr Dobson's venous blood gas showed that he was acidotic and blood tests showed a number of abnormal results suggestive of acute kidney injury. Dr De Jong recalled that both she and Dr Durdin were confused as to why the lactate was so high and the PH so low in the context of Mr Dobson's clinical appearance. Dr De Jong gave evidence what was most confusing at the time was that Mr Dobson was afebrile and she believes this was a red herring that caused her to think his deterioration was unlikely to be due to sepsis.[171]

125. Mr Dobson's blood tests showed a number of abnormal results suggestive of kidney injury.[172]

126. Dr De Jong noted that Mr Dobson's venous blood gas was extremely deranged, and it was apparent there was something going wrong. Both Dr De Jong and Dr Durdin

[166] T 204; Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report 18/7/19, 2145.
[167] T 205 - 206.
[168] T 206.
[169] T 206 – 207; Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report 18/7/19.
[170] Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report 18/7/19.
[171] Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report 18/7/19.
[172] Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report 18/7/19.

were "stumped"[173] by the result and were struggling to find a reason for it. In hindsight, Dr De Jong said she believes Mr Dobson was still compensating quite well as a young man for the sepsis, which made it harder to identify. They decided to contact Mr Filgate for advice.[174]

127. Dr De Jong called Mr Filgate at 10.17 and discussed with Mr Filgate the circumstances of the MET call and the examination finding and investigations, including the unexplained metabolic acidosis. Mr Filgate advised Dr De Jong to give further intravenous fluid and he indicated he would stay on the phone while they performed another venous blood gas. Unfortunately, the blood gas machine began a rinsing cycle at that time, which can take 20 to 30 minutes, so Dr De Jong indicated she would cause Mr Filgate back when the repeat results were available. The night shift doctor had arrived by this time and she came to assist with the MET call. Dr Durdin was also still there and he was trying to assist Dr De Jong to identify why Mr Dobson was still deteriorating.[175]

128. Mr Dobson's repeat venous blood gas result came back and showed a worsening metabolic acidosis. Mr Dobson had also deteriorated and had an increased oxygen requirement. Dr De Jong called Mr Filgate back at around 10.47 pm and advised him of the result as well as the fact Mr Dobson's systolic blood pressure was still dropping despite more fluid, and his oxygen requirement was increasing. Dr De Jong recalled Mr Filgate "mentioned the rare chance that this could sepsis post haemorrhoidectomy"[176] and advised that Mr Dobson should be given a dose of the intravenous antibiotic Tazocin immediately. He also advised they should arrange a chest x-ray and Mr Dobson needed to be transferred to SCGH for urgent surgical and medical review.[177]

129. An ambulance was called on a Priority 2 at 11.07 pm, which means the call is urgent but normal driving conditions. Dr De Jong rang the SCGH ED Duty Consultant and advised of the transfer, which was accepted. Mr Dobson's blood pressure had fallen to 85/58 at that time and dropped to 75/50 at 11.10 pm. It was noted at 11.15 pm that Mr Dobson's oxygen saturations had dropped to 91% when lying flat and his blood pressure fell when he was sitting up. A chest x-ray showed fluid overload at 11.20 pm. The first dose of Tazocin was recorded as being given at 11.25 pm.[178] Dr De Jong had also notified Ms Blackshaw by this time and had arranged that she would call her back when the ambulance arrived.[179]

130. The St John Ambulance team, Paramedics Angharad Jones and Karen Murray, had arrived at Osborne Park hospital at 11.17 pm and they made their way to Mr Dobson's room by about 11.25 pm. They noted there was a lot of activity in his room at that time and there was a delay in the ambulance officers being able to access Mr Dobson as the medical staff were still treating him. Mr Dobson was sitting

[173] T 208.
[174] T 207 – 208, 215.
[175] T 207 – 208; Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report 18/7/19.
[176] T 210; Exhibit 1, Tab 9 [81].
[177] Exhibit 1, Tab 9.
[178] Exhibit 1, Tab 9; Exhibit 2, Tab 1, MET Report, 1st and 2nd Form.
[179] T 210; Exhibit 1, Tab 9.1.

on the hospital bed receiving oxygen via nasal prongs on their arrival and someone was performing a chest x-ray. Mr Dobson appeared very anxious and agitated. The paramedics believed Mr Dobson's oxygen saturations were not being monitored, so when they were able to reach him, they placed him on the SJA monitor and noted his oxygen saturation was low. This resulted in a move from nasal prongs to an oxygen mask. As the antibiotic Tazocin was running, they also needed a doctor to sign a special authorisation form to allow the paramedics to keep the medication running while Mr Dobson was transferred.[180]

131. Once Mr Dobson was on the stretcher, a nurse called Ms Blackshaw so he could speak to her on the phone before he was transferred. Mr Dobson was anxious and distressed at this time and appeared to be struggling to breathe but, consistent with the kind of man he was, Mr Dobson was still able to joke with Ms Blackshaw and told her he loved her before they ended the call. At that time, the seriousness of the situation was still not apparent to everyone, so Ms Blackshaw had no idea that would be the last time she would ever be able to speak to him.[181]

132. Mr Dobson was assisted to keep the oxygen mask on and it was noted by Ms Jones that his oxygen saturations were not improving and his central capillary refill was greater than five seconds, which indicated poor perfusion. Based on these observations, the two paramedics recognised that Mr Dobson was unwell and made the clinical decision to convey Mr Dobson on Priority 1 (lights and sirens as time critical) to SCGH, whilst calling ahead to notify receiving medical team. They left Osborne Park Hospital at 11.53 pm, after waiting for about half an hour for Mr Dobson to be ready for transfer.[182]

EMERGENCY TRANSFER TO SCGH

133. The ambulance arrived at the Sir Charles Gairdner Hospital (SCGH) Emergency Department at 12.05 am on 19 July 2019 and Mr Dobson was handed over by the SJA paramedics in the resuscitation area at 12.07 am. He was in severe respiratory distress, with very low oxygen saturations (60-70%), an elevated heart rate of 150 and a tender, tense abdomen. Venous blood gases showed severe acidosis and he was diagnosed with septic shock. Mr Dobson was transferred to the Intensive Care Unit and placed under the care of experienced ICU Consultant Dr Tim Patterson. Mr Dobson was intubated, ventilated and a dialysis catheter was inserted before a CT scan was obtained. By this stage, it was becoming clear that Mr Dobson was in fulminant septic shock. Mr Filgate attended SCGH and Mr Dobson underwent examination under anaesthetic to try and identify the source of the infection. Unfortunately, the source of his septic presentation could not be identified, which reduced his chances of survival.[183]

134. Mr Dobson returned from theatre to the ICU and he remained haemodynamically unstable despite being on inotropes. At 6.15 am, Mr Dobson was in pulseless

[180] Exhibit 1, Tab 11 and Tab 12; Exhibit 2, Tab 3.
[181] T 290.
[182] T 190 – 194; Exhibit 1, Tab 12.
[183] T 194; Exhibit 1, Tab 14; Exhibit 2, Tab 2; Exhibit 3.

electrical activity arrest and CPR was commenced. The resuscitation efforts were unsuccessful and after 25 minutes they were ceased and Mr Dobson was declared deceased shortly before 7.00 am.[184]

135. There are no criticisms of the emergency care provided to Mr Dobson at SCGH. All efforts were made to try to save him. Ms Blackshaw, who was with Mr Dobson in the hospital at the end, recognised the efforts of the staff at SCGH and acknowledged it was a miracle they were able to keep him alive for as long as they did that morning.[185]

MR FILGATE

136. Mr Filgate had not been asked to provide a report, nor attend the inquest, as it had initially been thought that his primary involvement was only in the surgery, of which there was no criticism. It became apparent during the inquest that Mr Filgate had also been involved in the MET call and the emergency treatment at SCGH. After the inquest, at the request of the Court, Mr Filgate very helpfully provided detailed information about his involvement in Mr Dobson's MET call and his treatment after transfer to SCGH, as well as his contact with Mr Dobson's family after his unexpected death. Mr Filgate also answered a number of questions put to him about his expectations about the care Mr Dobson would receive on 18 July 2019 from the nursing and medical staff who were on shift at Osborne Park Hospital.[186]

137. Mr Filgate is a Specialist General Surgeon and Sub-Specialist Colorectal Surgeon and he works for NMHS out of SCGH, OPH and also King Edward Memorial Hospital, as well as privately at Hollywood Private Hospital. Mr Filgate performed a routine haemorrhoidectomy on Mr Dobson on 17 July 2019 at Osborne Park Hospital, which was part of his normal practice. Mr Filgate noted the procedure was uncomplicated intraoperatively and when Mr Filgate reviewed him in the post-operative round that afternoon, Mr Dobson was subjectively and objectively well.[187]

138. Mr Filgate stated that, as per his standard practice, he left instructions with his registrar (Dr Laurens) to review all patients from that day's operating list the following morning and to contact him if any were not discharged as planned. The following morning, Mr Filgate was not contacted by the surgical team so he assumed that all patients, including Mr Dobson, had been discharged without complication as planned.[188]

139. Mr Filgate was unaware that Mr Dobson was still admitted to Osborne Park Hospital and had been exhibiting ongoing signs of low blood pressure and tachycardia and urinary retention until he was contacted by Dr De Jong at 10.16 pm that evening. Dr De Jong advised that Mr Dobson had a MET call for hypotension. Mr Filgate's initial response was that he did not know Mr Dobson was still in hospital. Dr De

[184] Exhibit 1, Tab 14; Exhibit 2, Tab 2; Exhibit 3.
[185] T 290.
[186] Exhibit 3.
[187] Exhibit 3.2.
[188] Exhibit 3.2.

Jong advised that Mr Dobson had been feeling unwell, with nausea and mild abdominal pain, that he had gone into urinary retention requiring an indwelling urinary catheter and developed hypotension. There was mention he had passed blood when opening his bowels. Mr Filgate advised giving further intravenous fluids and obtaining a blood gas, ECG and chest x-ray, as at that stage it seemed bleeding was the most likely cause. He advised Dr De Jong to call him back when the results of the blood gas and fluid were known.[189]

140. Dr De Jong, on behalf of the Osborne Park Hospital team responding to the MET call, contacted Mr Filgate again at 10.51 pm and advised that Mr Dobson's hypotension had improved slightly but he remained tachycardic. She also advised that his blood gas demonstrated a stable haemoglobin but a significant metabolic acidosis, with raised lactate and significant base excess. Based on that information, Mr Filgate's opinion of the likely cause of the deterioration changed from bleeding to either a significant septic episode or global hypoperfusion such as a massive myocardial infarction (heart attack) or pulmonary embolus. Mr Filgate commented that overwhelming sepsis is an extremely rare but documented complication of haemorrhoid surgery. He advised immediate Tazocin and ongoing fluid resuscitation and transfer to SCGH for resuscitation and CT chest/abdomen/pelvis.[190]

141. After Mr Dobson was transferred to SCGH and admitted to ICU, Mr Filgate was contacted by the surgical registrar to advise him that the CT had been completed and Mr Dobson was still deteriorating. A picture of fulminant septic shock without a clear source was indicated and Mr Filgate advised the registrar to mobilise the on call surgical team to assist in theatre as surgical intervention was required to attempt to localise Mr Dobson's source of sepsis. Mr Filgate attended SCGH and Mr Dobson was taken to theatre. A laparotomy was negative and Mr Filgate specifically excluded necrotising soft tissue infection. It became clear during the procedure that Mr Dobson was critically unwell and, without a definite source of sepsis to control, his chances of survival were limited.[191]

142. Mr Filgate had spoken to Ms Blackshaw prior to performing the laparotomy to obtain her consent and following the surgery Mr Filgate again spoke to Mr Dobson's family to discuss the operative findings and prognosis. Mr Filgate then left the hospital. He was contacted by Dr Patterson at 6.48 am and informed that despite all further attempts, Mr Dobson had passed away. Dr Patterson and Mr Filgate agreed to offer Mr Dobson's family a meeting to answer any questions they may have, and a meeting then took place on Monday, 22 July 2019 with Ms Blackshaw and Ms Blackshaw's brother. Mr Filgate indicated that he was open with the family that he believed the staff at Osborne Park Hospital failed to recognise the deterioration until it was too late and he had not been kept adequately informed of the situation. Mr Filgate expressed his belief that earlier intervention with antibiotics may have changed the outcome for Mr Dobson, but he also observed the fulminant infection was running rampant and in his opinion it was possible nothing may have changed the final outcome. Mr Filgate also noted that given how rare severe sepsis is after a haemorrhoidectomy, there might still have been a delay in giving antibiotics, even if

[189] Exhibit 3.2.
[190] Exhibit 1, Tab 3.2.
[191] Exhibit 1, Tab 3.2.

Mr Dobson's deterioration had been recognised earlier. Mr Filgate assured Mr Dobson's family that a full investigation into Mr Dobson's death would occur and both doctors expressed their sympathy and condolences.[192]

143. Mr Filgate indicated that he would consider it essential for the treating consultant to be contacted as soon as any patient was not following an expected post operative course, or if any change to the agreed post operative plan occurred. He commented this would be considered standard practice across both the public and private sectors, and thus he would have expected to have been informed when it was determined Mr Dobson was not well enough to go home as planned. Mr Filgate said he would expect to be contacted by any member of nursing or medical staff at any time, day or night, whenever it was felt necessary, and all junior medical staff are given his mobile phone number for this purpose.[193]

144. Mr Filgate advised the Court that since the death of Mr Dobson, he now requires the registrar to contact him after their ward round to confirm that his plan has been carried out for each patient, even if there is not change to the plan.[194]

CAUSE AND MANNER OF DEATH

145. A post mortem examination was performed on 23 July 2019 by Forensic Pathologist Dr Clive Cooke. Dr Cooke noted changes of recent medical treatment, including a haemorrhoidectomy. There was some haemorrhage into the pelvic soft tissues, but no evident infection. Arteriosclerotic hardening of the arteries was present, with narrowing of arteries on the surface of the heart was visible. The heart muscle appeared to be slightly pale, but was otherwise normal. The lungs showed congestion and there was increased fluid in the body cavities. The organs appeared to be otherwise healthy.[195]

146. Microscopic examination showed blood clots in the small vessels in the lungs and pelvic soft tissues, with inflammation around the anus associated with bacterial organisms. Microbiology testing showed the presence of bacteria in the body tissues (*Streptococcus pyogenes* and *Staphylococcus aureus*). There was evidence at the inquest that both these bacteria are commonly found on the skin and in the upper respiratory tract, and are not bacteria that are usually associated with the anal area. Staphylococcus and Streptococcus bacteria are also the most common causes of cellulitis. If they enter the bloodstream, they can both rapidly cause serious, life threatening infection and sepsis.

147. Toxicology analysis showed the presence of numerous medications, consistent with the recent medical care.[196]

[192] Exhibit 3.3.
[193] Exhibit 3.
[194] Exhibit 3.
[195] Exhibit 1, Tab 4.1.
[196] Exhibit 1, Tab 4.1 and Tab 5.

148. At the conclusion of all investigations, Dr Cooke formed the opinion the cause of death was sepsis following haemorrhoidectomy. I accept and adopt the opinion of Dr Cooke as to the cause of death.

149. There is no evidence there were any surgical complications and no evidence of infection at the site. The source of Mr Dobson's infection, leading to sepsis, was never able to be identified. The two bacteria that were present are commonly found on the skin. It is possible there was a connection with Mr Dobson's previous bout of cellulitis, but no definite connection could be established and there was also evidence that overwhelming sepsis is a rare but documented complication of haemorrhoid surgery.

150. In the circumstances, there is nothing to suggest medical misadventure (an injury caused by medical treatment), and so I find the manner of death was by way of natural causes.

ROOT CAUSE ANALYSIS

151. Following Mr Dobson's death, a Root Cause Analysis (RCA) was conducted by Osborne Park Hospital, as required under the relevant legislation. A copy of the RCA report, which was dated 28 February 2020, was provided to the Coroners Court.[197] The RCA panel included Dr Patterson, the ICU Consultant from SCGH who was involved in Mr Dobson's treatment immediately prior to his death, a General Surgeon from Osborne Park Hospital and other relevantly qualified panel members. The RCA identified numerous problems with Mr Dobson's medical management. I note that not all of the actions taken by staff were recorded, so some of the actions taken were not known to the panel at the time of their review.[198]

152. In summary, the panel found:[199]

- The escalation pathway was not followed at 11.00 am on 18 July 2019 when Mr Dobson's pulse rate warranted a senior nurse review.
- No further observations were recorded until 12.30 pm despite the protocol stating hourly observations were required from 11.00 am.
- The next recorded observation at 3.00 pm fell into the 'Medical Review' zone and prescribed monitoring every 15 minutes. Only one record of 15-20 minute observations was actioned, then there was nothing recorded until 6.00 pm.
- The documentation during the deterioration was poor and procedures were not followed. There was no '*Escalation to Clinical Review'* sticker in the notes, no recording of observations as per the Adult Observation and Response Chart (Observation Chart) and no compliance with the Osborne Park Hospital Clinical Deterioration Procedure.

[197] Exhibit 1, Tab 14.
[198] Exhibit 1, Tab 14.
[199] Exhibit 1, Tab 14.

- Blood tests in the afternoon showed raised Creatinine and Urea. This should have alerted medical staff that something was not right with Mr Dobson, but nothing appears to have been actioned.
- Osborne Park Hospital staff had difficulties finding a non-rebreather mask for use during the MET call and the venous blood gas machine was going through a flush cycle at the time it was needed, but neither was felt to be contributory to Mr Dobson's death.

153. Overall, it was acknowledged by the RCA panel that Mr Dobson's signs and symptoms of sepsis had not been accurately recognised and responded to, and more timely responses to Mr Dobson's deteriorating observations may have resulted in a different outcome. It was determined that the failure to identify a deteriorating patient and activate a MET call resulted in a delayed transfer to SCGH and contributed to the patient's death.[200]

154. In terms of root causes, the panel identified communication between staff was poor and escalation/urgency of information between nursing and medical staff did not occur. There was a failure to follow the required response when observations fell into a coloured area of the Observation Chart, such as recording the observations regularly.[201]

155. The RCA panel also noted there was minimal documentation in the in-patient notes and observation chart after 4.00 pm. This made it difficult to track Mr Dobson's deterioration over the afternoon/evening and to understand what steps were being taken at what time to escalate his care.

156. The ICU Consultant on the panel noted that SCGH were introducing an Inpatient Sepsis Pathway to better improve outcomes for patients. He pointed out that Mr Dobson received his antibiotics at 11.35 pm during his transfer to SCGH. In the management of sepsis, the earlier the review and commencement of antibiotics, the better the outcome, and every hour delay increases mortality by 8%.[202]

157. The following recommendations were made:[203]

- Improve education in using the Observation Chart;
- Determination of Senior Nurse Review or Medical Review frequency of observations must be followed as per chart;
- Consider the use of a sticker specifically for review by Senior Nurse/Medical Staff;
- Consider the implementation of RPH's inpatient sepsis management plan.

158. Interestingly, the RCA did not explore the issue of the availability of doctors and staffing levels at Osborne Park Hospital, and whether this contributed to some of the events. This was despite the fact that concerns were raised by both nursing and medical staff about the busyness of the shift, the lack of doctors (and particularly

[200] Exhibit 1, Tab 14.
[201] Exhibit 1, Tab 14.
[202] Exhibit 1, Tab 14.
[203] Exhibit 1, Tab 14.

experienced doctors) on the after-hours shift and the increased acuity of patients, which was said to have led to delays in Mr Dobson being regularly monitored and medically reviewed.

159. Comments were made by some of the witnesses that Osborne Park Hospital was "terribly understaffed"[204] on the evening shifts in terms of medical staff and quite junior doctors were often the most senior staff member on shift. At the relevant time, there were only two RMO's rostered on shift to provide after-hours cover at Osborne Park Hospital. One of the RMO's was rostered to cover the Obstetrics & Gynaecology ward, with an overseeing Registrar allocated specifically to that specialty after hours. The other RMO was required to cover all of the other Osborne Park Hospital wards, including the surgical patients, the stroke/geriatric patients and the Mental Health Unit. It was noted that they were all geographically spread out, with some in different buildings, which also meant they had to cover a lot of ground to review patients.[205]

160. I note below that, although this issue was not address in the RCA, it has been considered separately by Osborne Park Hospital and changes have been made to medical and nursing staffing on the after-hours and night shift.

WAS MR DOBSON'S DEATH PREVENTABLE?

Expert Opinion of Professor Cade

161. Professor John Cade is an Emeritus Consultant in Intensive Care at Royal Melbourne Hospital and a Professorial Fellow at the University of Melbourne. Professor Cade was originally requested to review Mr Dobson's case and provide an opinion on behalf of Ms Blackshaw. His report was provided to the Court as part of the investigation and Professor Cade gave evidence at the inquest to speak further to his conclusions.[206]

162. Professor Cade found no issues with the procedure performed on 17 July 2019 and noted the postoperative plan was routine and included the antibiotic metronidazole for five days. The issues with Mr Dobson's medical care arose the following day.

163. Professor Cade was asked what diagnosis he believed ought to have been considered by the doctors who reviewed Mr Dobson early in the day on 18 July 2019. Professor Cade observed that Mr Dobson was a previously well man with new onset hypotension and tachycardia. In those circumstances, he indicated there would be three significant problems that should immediately come to mind. The first one in a surgical patient would be bleeding. The second was whether the patient has suffered a cardiac event. The third would be whether the patient has an infection or, in other words, sepsis.[207]

[204] T 67.
[205] T 198; Exhibit 1, Tab 9.
[206] Exhibit 1, Tab 15.
[207] T 218.

164. There was some report of Mr Dobson bleeding into the toilet, Professor Cade noted after a haemorrhoidectomy some bleeding into the toilet would be inevitable, so it is a question of quantity. He observed it would need to be a very big bleed to cause hypotension and tachycardia in an otherwise well man, and it would be expected the bleeding would be external, so it would not be overlooked. That was clearly not the case for Mr Dobson, and the lack of evidence of significant bleeding, along with relatively unchanged haemoglobin, excluded the likelihood of a significant bleed.[208]

165. In terms of a cardiac event, an ECG performed at 12.48 am was normal, other than sinus tachycardia, and excluded any evidence of an acute cardiac event.[209]

166. Accordingly, Professor Cade expressed the opinion the third possibility, namely infection, should have been considered at a relatively early stage. Professor Cade suggested that sepsis should be high on the list of differential diagnosis for a patient who deteriorates in hospital, particularly in a post-operative setting and where the operation has been through a contaminated area (rectum and anus). Professor Cade commented that it is important for sepsis to be considered, "because its consequences are so severe if missed."[210] Professor Cade said that he would "think medical staff at any level, including medical students, the nursing staff at any level, and members of the public, would have, hopefully, a consciousness of the frequency and importance of sepsis."[211] He noted that they have been holding World Sepsis Day for at least 20 years and it is prominently featured in acute care units and emergency departments, with the aim of ensuring it is prominently in people's thoughts.[212]

167. Professor Cade acknowledged that the absence of a temperature in Mr Dobson's case may have caused some confusion, "as the presence of temperature is one of the hallmarks of a serious infection, but its absence doesn't rule it out, especially if there are other signs." In Mr Dobson's case, Professor Cade noted there were plenty of other clues, including the abnormal findings of low blood pressure and tachycardia in a post-operative setting, that still suggested the possibility of sepsis.[213] In addition, the absence of a high temperature should have been considered in the context of Mr Dobson being given paracetamol and celecoxib that can lower temperature, thereby masking the temperature rise that might otherwise be occurring due to infection.[214]

168. In Professor Cade's opinion, "the correct screening tests were conducted by the early afternoon, and the results pointed to early sepsis as the likely problem at that time though unfortunately these results appear to have been overlooked."[215]

169. Professor Cade also acknowledged that the white blood cell count may have been seen as reassuring, as it is also "one of the key clues in sepsis."[216] However, he noted

[208] T 219.
[209] T 220.
[210] T 220.
[211] T 220.
[212] T 220 – 221.
[213] T 221, 232.
[214] T 233.
[215] T Exhibit 1, Tab 15.1, p. 3.

that to look at a white cell count alone is incomplete and its components are just as important. Professor Cade explained that a white cell count can be normal, but abnormal in appearance. That was the case for Mr Dobson, as the haematologist reported a left shift in the neutrophils, which is a sign of infection. Professor Cade said this is pretty basic information and he would have expected it to be understood by a junior doctor as a clue that all is not well and there is the possibility of infection.[217] Professor Cade also noted the elevated urea and creatinine, which are markers of renal function, also indicated that all was not well, noting that early organ dysfunction and particularly kidney dysfunction are markers of sepsis.[218]

170. Professor Cade did not suggest in his evidence that there could not have been other explanations for these various noted features, but he said that taken together, the 1.35 pm lab results "showed some clues as to early sepsis,"[219] although they were not read that way by the reviewing doctors that afternoon. When told that the doctors had considered the raised urea and creatinine were related to Mr Dobson's urine retention, Professor Cade agreed that this was "good thinking."[220] Professor Cade commented that at this stage, while the clues were there to think of sepsis, and they were not particularly difficult to identify, "they were early, and you could say they were a little subtle."[221] Accordingly, he did not think it was wrong to be considering they were signs of other issues.

171. In terms of when a MET call should have been made, Professor Cade gave evidence he thought 11.00 am was too early for a MET call. However, in accordance with the hospital's own calling criteria, a senior nursing review should have been made at 11.00 am, a medical review should have occurred at 12.30 pm (given the persistence of the abnormal observations) and a MET call should have been made at 3.00 pm. The evidence suggests the senior nursing review was sought at 11.00 am, and the medical review by Dr Wallis did occur just after 12.30 pm. It was the need for a MET call at 3.00 pm that was not met, and there was evidence from Nurse Denston that this was because she was effectively overruled by Dr Wallis.[222]

172. Professor Cade's opinion was that the clinical clues of sepsis had escalated by 3.00 pm, and had reached the hospitals own MET call criteria at that time, so a MET call should have been made at that time. This should then have resulted in the surgeon, Mr Filgate, being notified and likely consultation with more senior staff at SCGH. Professor Cade believes it is then likely they would have recommended Mr Dobson be given antibiotics and be transferred to SCGH at that time, as this would be the "wise response"[223] in the circumstances and noting the MET call requires a team of people to consider the problem in some depth.

173. If a MET call had been made, followed by administration of antibiotics and transfer to SCGH mid-afternoon, in Professor Cade's opinion there was a significantly

[216] T 221.
[217] T 221 - 223; Exhibit 1, Tab 7.5.
[218] T 223.
[219] T 223.
[220] T 224.
[221] T 224.
[222] T 224; Exhibit 1, Tab 15.1, pp. 3 - 4.
[223] T 225.

improved chance that Mr Dobson would have survived. He noted that the mortality statistics are well described in this setting. Mortality in early sepsis is up to 10 per cent, so up until 3.00 pm Mr Dobson's chances of survival would have been at least 90 per cent. His chances of survival steadily diminished over the following hours, so that by 9.30 pm, when the MET call was finally made, Mr Dobson was seriously unwell. Professor Cade observed the window to successfully treat his developing sepsis "had been closing all day. From 9.30 it was closing … very fast."[224] By 9.30 pm, Mr Dobson had significant organ failure and was deteriorating, so Professor Cade estimated his chance of survival was probably only around 40 to 50 per cent. By 11.30 pm, not long after Mr Filgate had directed that Mr Dobson be given antibiotics urgently and transferred to SCGH, Mr Dobson's chances of survival had diminished to 10 per cent and the risk of mortality was now around 90 per cent. Therefore, between 3.00 pm and 11.30 pm, Mr Dobson's chances of survival went from 90 per cent to 10 per cent.[225]

174. Professor Cade commented that even without a MET call being made at 3.00 pm, it was an opportune time for the Osborne Park Hospital doctors to call their more senior colleagues at SCGH medical staff for guidance. As he noted, "you don't have to arrive at the intensive care unit in an ambulance to access these resources" and Professor Cade believes it was a missed opportunity there to seek advice from a readily available source.[226]

175. Similarly, Professor Cade considered the failure to call Mr Filgate at 3.00 pm, given it was his surgical patient, also a missed opportunity to seek guidance and advice from a more experienced doctor who should have been kept informed when his patient was unexpectedly deteriorating. Professor Cade commented that notifying Mr Filgate should have been obligatory, as the "surgeon should always be in the loop."[227] This is consistent with Mr Filgate's evidence that he had expected to be notified if any of his patients were not discharged as expected.

176. Professor Cade made the same comments about the action of the doctors who responded to the MET call at 9.30 pm, noting they took some time to contact Mr Filgate, who then properly directed the transfer to SCGH. Professor Cade suggested being more willing to make contact with senior colleagues, either through staff at SCGH or an Osborne Park Hospital consultant, was an obvious avenue to overcome the limited resources and lack of experience of the Osborne Park Hospital MET call team in the evening. Professor Cade noted that "you don't need resources to be faster off the mark"[228] in picking up the phone.

177. The delay when the ambulance crew arrived was also noted. Professor Cade suggested it was "a further reflection of the ongoing disorganization of the MET process which had been in progress since 9.30 pm," but he felt it was unlikely to have been material to Mr Dobson's eventual outcome.[229]

[224] T 226.
[225] T 226 – 227.
[226] T 227.
[227] T 227.
[228] T 230.
[229] Exhibit 1, Tab 15.1, p. 6.

178. Professor Cade commented that Mr Dobson's death "is a tragic case that just reminds us all of the lethality of sepsis and despite all the … international publicity and the campaigns, there are still cracks in the system."[230] Professor Cade observed that there have been educational programs and widespread focus on sepsis in hospitals for at least 20 years, but it seems that somehow, despite best efforts, there's an occasional crack in the system and the clues that a patient is developing sepsis are missed. Sadly, Mr Dobson's case is one such example.[231]

179. Professor Cade noted the problem in this case was not with the hospital's calling criteria, but that the criteria for calling a MET call were not attended to over a prolonged period. Professor Cade observed that by 3.00 pm, it should have been clear that the diagnosis was beyond the reasonable scope of the facilities at Osborne Park Hospital and required tertiary care, namely transfer to SCGH.[232]

Expert Opinion of Dr Tan

180. Dr Patrick Tan is a General and Colorectal Surgeon who currently works as a consultant at St John of God Subiaco and Royal Perth Hospital in Western Australia. Dr Tan was requested by the Court to review Mr Dobson's surgery and post-operative care and provide his expert opinion on the standard of the care and treatment, given his experience in performing this type of surgery.

181. Similarly to Professor Cade, Dr Tan made no criticism of the surgery, nor the emergency care provided to Mr Dobson at SCGH immediately prior to his death. The focus of his concerns was the post-operative care on 18 July 2019 at Osborne Park Hospital.[233]

182. Like Professor Cade, Dr Tan noted that the deterioration in Mr Dobson's condition started at about 11.00 am on 18 July 2019 and became worse over hours, eventually resulting in the MET call at 9.30 pm when Mr Dobson went into septic shock. Dr Tan also noted there were limited vitals observations taken over this period.[234]

183. Dr Tan expressed the opinion the medical reviews performed by both medical and nursing staff were appropriate, in the sense of the observations taken and investigations ordered, but unfortunately the interpretation of the signs and blood tests performed at 1.30 pm were incorrect. Dr Tan noted that the bloods taken at 1.35 pm on 18 July 2019 for investigation of Mr Dobson's unexplained tachycardia and hypotension showed a subtle decrease in the white cell count with increase in neutrophils as well as a deterioration in his renal function. In Dr Tan's opinion, these should have raised concern about possible sepsis. The subtle drop in white cell count

[230] T 232.
[231] T 232.
[232] Exhibit 1, Tab 15.1, pp. 4 - 5.
[233] Exhibit 1, Tab 16.1.
[234] Exhibit 1, Tab 16.1.

was an early sign of sepsis and that would fit with signs of tachycardia, tachypnea, hypotension and slight rise in baseline temperature.[235]

184. Dr Tan agreed with Professor Cade that a MET call should have been made at 3.00 pm but noted it was cancelled by Dr Wallis. Dr Laurens then came to review Mr Dobson and both he and Dr Wallis did not inform Mr Filgate of Mr Dobson's condition, which Dr Tan described as "an error of judgment and management."[236] Dr Tan commented that it is unusual not to inform the consultant of the patient's condition after the ward round in the morning, but also noted that it did not appear Mr Filgate had called in or been on to the ward. Dr Tan noted that both Dr Wallis and Dr Laurens did not recognise the subtle changes to Mr Dobson's condition and they also did not inform Mr Filgate of his condition or seek his advice at the relevant time of their review at 3.00 pm to 4.00 pm. As a result, no additional antibiotics were prescribed until Mr Filgate was finally contacted late in the evening by Dr De Jong.[237]

185. Consistent with the opinion of Professor Cade, Dr Tan considered a MET call should have been made at 3.00 pm when Mr Dobson met the MET call criteria for hypotension. Usually, this would have resulted in the consultant being informed, which would have alerted Mr Filgate to Mr Dobson's circumstances, and this would likely have resulted in Mr Dobson being closely monitored or transferred to SCGH.[238]

186. As to whether it might have prevented the outcome, Dr Tan's opinion varied to some extent from that of Professor Cade. Dr Tan explained that his opinion varied because he believes Professor Cade was talking about general sepsis in terms of the mortality rates, whereas Dr Tan's evidence was given in the context of "overwhelming sepsis from haemorrhoid surgery which is very, very rare."[239] Therefore, Dr Tan's answer to the question whether Mr Dobson's death was preventable was the more cautious answer of, "Perhaps"[240]

187. As noted above, Dr Tan gave this answer in the context that this type of infection after a haemorrhoidectomy is "extremely, extremely rare."[241] Dr Tan said he had surveyed his colleagues as to who gives antibiotics postoperatively and he found that the younger ones do and the older ones generally don't. When they do, they generally prescribe metronidazole pre-operatively and continue it post-operatively, as was done for Mr Dobson. That particular antibiotic is a general one to treat anaerobic bacteria which are high in the bowel. Unfortunately, Mr Dobson had other bacteria for which this antibiotic appears to have been ineffective.[242]

188. Dr Tan noted that overwhelming sepsis post haemorrhoidectomy is an extremely rare complication, but when it does occur it can be difficult to detect and carries a high

[235] T 240; Exhibit 1, Tab 16.1.
[236] Exhibit 1, Tab 16.1, p. 10.
[237] Exhibit 1, Tab 16.1, p. 10.
[238] Exhibit 1, Tab 16.1, p. 10.
[239] T 241.
[240] Exhibit 1, Tab 16.1, p. 10.
[241] T 236.
[242] T 236.

mortality rate.[243] Dr Tan provided a systemic review article that emphasises that "[a]lthough extremely uncommon, severe sepsis does occur post-treatment for haemorrhoids and all surgeons who treat such patients should be aware of the potential complications and alert to their presenting features."[244] That is because in the rare event it occurs in these circumstances, a significant number of the patients (10 out of 38) died. Notably, like Mr Dobson, most of the patients were well before surgery.[245] Therefore, Dr Tan expressed the opinion that Mr Dobson's death was possibly preventable if his deterioration had been recognised earlier and intravenous antibiotics commenced and then transfer arranged to SCCH. Like Professor Cade, Dr Tan considered Mr Dobson should have been transferred to SCGH at 3.00 pm when the MET call criteria was first reached.[246] However, Dr Tan also commented that Mr Dobson's deterioration was "very, very quick."[247]

189. As to what other options had been available to the doctors earlier in the day, Dr Tan gave evidence as a consultant, he would always expect to be informed of his patient's status after a ward round, and he would particularly have expected the consultant would have been informed around 3.00 pm to 4.00 pm when there were issues with Mr Dobson but still talk of discharging him. Whether or not he would have suggested transfer at that stage, Dr Tan believes if he was informed of a similar patient, he would probably be thinking of starting antibiotics even though he would not be expecting Mr Dobson to have overwhelming sepsis at that stage. Dr Tan also indicated at that stage he would not be expecting a patient to be discharged and would want to keep him in for observation. Therefore, he disagreed with Dr Laurens' instruction that Mr Dobson could still be discharged if his systolic blood pressure was 110 and he had voided. [248]

190. In summary, Dr Tan said he would not generally expect his interns, the RMO or the service registrar to know about overwhelming sepsis from haemorrhoid surgery since it is so rare. When it does occur, the mortality is very high, especially when it develops very, very quickly. However, Dr Tan considered Mr Filgate should have been notified at a much earlier stage of Mr Dobson's situation, including after the ward round, from 11.00 am when he began to deteriorate and again at around 3.00 pm when the blood tests had come back in and it seemed clear Mr Dobson was not going home. In addition, a MET call should also have been made at 3.00 pm. These all presented opportunities for sepsis to be considered and treated. While additional antibiotics and resuscitation may not have saved Mr Dobson, he had an increased chance of survival the earlier these steps were taken.[249]

[243] T 235.
[244] Exhibit 1, Tab 16.3, p. 748 – note that Mr Filgate also referred to the same article.
[245] Exhibit 1, Tab 16.3, p. 748.
[246] Exhibit 1, Tab 16.1, p. 11.
[247] T 237.
[248] T 238.
[249] T 241, 246 - 249.

Expert Opinion of Mr Filgate

191. Like Dr Tan, Mr Filgate noted that overwhelming sepsis is an extremely rare but described complication of anal surgery, including haemorrhoidectomy, with the incidence estimated to be well less than 0.1% (<1/1000). Having reviewed the medical records, Mr Filgate believes it was clear from about 11.00 am on 18 July 2019 that Mr Dobson was becoming very unwell, with significant variation from the expected post operative course. Mr Filgate expressed the opinion to Mr Dobson's family that he believed earlier intervention with antibiotics may have changed the outcome for Mr Dobson. However, he also observed the fulminant infection was running rampant and in his opinion it was possible nothing may have changed the final outcome. Mr Filgate also noted that given how rare severe sepsis is after a haemorrhoidectomy, there might still have been a delay in giving antibiotics, even if Mr Dobson's deterioration had been recognised earlier.[250]

Expert Opinion of Dr Ercleve

192. Dr Tor Ercleve is the Medical Co-Director of Acute Services at SCGH. He is also a consultant in Emergency Medicine. Dr Ercleve was not involved in Mr Dobson's care, nor the RCA, but he reviewed Mr Dobson's medical records and the RCA Report, as well as the expert reports of Professor Cade and Dr Tan prior to giving evidence at the inquest. Dr Ercleve summarised that from the medical records, it appears Mr Dobson transitioned from being well post-operatively to having an infection to developing sepsis and then dying tragically from septic shock.[251] As to when exactly Mr Dobson transitioned from one stage to the next, was of some conjecture and varied between the experts.

193. Dr Ercleve acknowledged that as early as 11.00 am, Mr Dobson was recording some observations, such as a drop in his blood pressure and rise in his heart rate, that could have been an early manifestation of sepsis. However, he also noted there were other explanations to initially accounts for his tachycardia, hypotension and urinary retention, such as the buprenorphine, pain and recent surgery. His altered parameters warranted a senior nurse review, which occurred.[252]

194. From around 12.30 pm, when Mr Dobson was reviewed by Dr Wallis, it was clear Mr Dobson was not responding to pain management and had shown signs of early haemodynamic deterioration. His blood pressure had fallen within the Observation Chart senior nurse review criteria again and there was clear evidence that Mr Dobson was experiencing urinary retention.[253] Dr Ercleve noted that given Mr Dobson met the senior nurse review criteria, he required observations to be taken every hour, consistent with Nurse Denston's understanding. However, no further observations were taken until Nurse Denston returned to Mr Dobson's care at 3.00 pm, so the escalation pathway was not being followed by the afternoon nursing staff.[254]

[250] Exhibit 3.3.
[251] T 148.
[252] Exhibit 1, Tab 20.
[253] Exhibit 1, Tab 20.
[254] Exhibit 1, Tab 20.

195. By 3.00 pm, Mr Dobson's blood pressure (based on recorded readings of 90/50 in his right arm and 100/70 in his left arm) qualified for medical review according to the Observation Chart. Some of the blood pressure readings taken after 3.00 pm were not available to Dr Ercleve, as they were not noted down in the records he reviewed, but he noted one taken at 3.15 pm showed 100/70, which may have reduced the nurses' sense of urgency.[255]

196. When the blood results began coming in after 1.35 pm, they showed blood abnormality, but Dr Ercleve noted it was not of a type that a junior medical officer might consider 'characteristic' of sepsis. Dr Ercleve noted that junior doctors are mor likely to associate an abnormal rise in white cells and neutrophils with infection, rather than mild acute renal failure and reduced urine output, although they are also hallmarks of sepsis (early organ failure because of poor tissue perfusion). However, the blood results did show a left shift in the neutrophils, which may have been a red flag, but it was unclear to Dr Ercleve whether the doctors involved noted it.[256] Dr Ercleve commented that he would have expected a Registrar conducting a Medical Review to independently review the bloodwork results, which does not appear to have happened in this case.[257] I note Dr Laurens indicated in his evidence that he has now changed his practice and will always review the blood results himself, but he did not do so at the time.

197. By the time of the 4.00 pm review by Dr Laurens, Dr Ercleve commented that on a background of persistently low blood pressure, fast heart rate, deteriorating renal function and ongoing pain issues, other causes should have been considered, including sepsis.[258] Dr Ercleve expressed the opinion that from about 3.00 pm, and certainly after 4.00 pm, "an escalation in care was clearly warranted to exclude other causes for his deterioration given his lack of improvement to other differentials. An increase in the frequency of monitoring and response to treatment with regular medical review was required."[259] Dr Ercleve also commented that based upon Mr Dobson's bloodwork results and observations, it would have been appropriate for a handover to the after-hours RMO to occur.[260]

198. Unfortunately, none of this occurred, and instead the nursing staff appeared to be reassured that Mr Dobson no longer required regular monitoring and the RMO who had come on shift was unaware of any issues in relation to Mr Dobson. Dr Ercleve commented that clinical handover has been strongly reinforced since Mr Dobson's case.[261]

199. Dr Ercleve commented that it would have been appropriate to commence antibiotics as soon as sepsis had been suspected or recognised, but based on the medical records, it was not clear to the RMO's or Registrar until the second point of contact with

[255] Exhibit 1, Tab 20.
[256] T 151.
[257] Exhibit 1, Tab 20.
[258] Exhibit 1, Tab 20.
[259] Exhibit 1, Tab 20, p. 4.
[260] Exhibit 1, Tab 20.
[261] T 155.

Mr Filgate at 11.00 pm, when he advised that Tazocin (a powerful antibiotic) be commenced. Dr Ercleve noted that it requires a doctor to 'think sepsis' before it can start to be treated. Since Mr Dobson's death, a major focus in the changes implemented have been around helping doctors to 'Think of Sepsis' through the implementation of guidelines and escalation policies.[262]

200. Dr Ercleve commented in his report that the complexities of defining sepsis and the absence of characteristic features like fever, localised swelling and a raised white cell count added to the difficulties of the junior doctors in identifying early manifestations of this significant disease in Mr Dobson and led to the delay in transferring him to SCGH for definitive care.[263]

201. Dr Ercleve explained in his evidence at the inquest that the best way to judge deterioration in a patient is to look at the trajectory of a patient. In this case, it was expected that Mr Dobson was going to recover, and when he deviated off the trajectory, one needed to ask questions as to 'why?'[264] It's clear that the medical officers were coming up with reasons, such as the buprenorphine to explain the low blood pressure, and pain for the increased heart rate, so it seemed that there were some thoughts into what was going on, but unfortunately they reached the wrong conclusions.[265] Mr Dobson's case was also complicated by the fact that he did not have some of the common features associated with sepsis, such as a fever.[266]

202. Dr Ercleve noted Professor Cade's comments that had a MET call been made and Mr Dobson transferred to SCGH at 11.00 am, or any time up to 3.00 pm, his chances of survival would have been over 90%. Dr Ercleve acknowledged that there is no doubt that fluid resuscitation and intravenous antibiotics to cover for post operative infection should have been commenced at Osborne Park Hospital much sooner, although in his opinion the more realistic time for that to have been considered by the relevant staff was at 3.00 pm. Dr Ercleve noted that survival rates in sepsis are not linear; however, a delay of eight hours to the administration of Mr Dobson's first antibiotic (between from 3.00 pm to 11.00 pm) "would have substantially affected the likelihood of Mr Dobson's survival."[267]

Finding as to whether Mr Dobson's death was preventable

203. While it might appear to an ordinary person that a haemorrhoidectomy would be prone to incidents of infection following the procedure, given the area being treated, the general evidence was that infection after this procedure is rare. However, as Professor Cade indicated, if something does go wrong, "it's pretty obvious what's at the top of the list,"[268] infection being a key one of them. In addition, given infection

[262] Exhibit 1, Tab 20.
[263] Exhibit 1, Tab 20.
[264] T 148.
[265] T 149.
[266] T 150.
[267] Exhibit 1, Tab 20, p. 4.
[268] T 228.

is "one of the most worrying of surgical complications,"[269] it needs to be considered and addressed at an early stage.

204. There was a suggestion in the evidence that Mr Dobson's recent history of cellulitis might have been relevant. Mr Dobson's CRP recorded at the time indicated a serious bacterial infection. It was made clear this was relevant, but more from the perspective that it might have indicated Mr Dobson had an underlying vulnerability to infection, rather than the same organism being responsible for this final infection. However, Dr Tan did note that the organisms grown from the post mortem examination were both bacteria from the skin, one of which (staph aureus) is usually the cause of cellulitis. Accordingly, he said it did make him wonder whether the cellulitis was actually treated or if there were still residual issues at the time he went to Osborne Park Hospital for surgery. Either way, like Dr Laurens and Professor Cade, Dr Tan suggested it was important information in terms of monitoring Mr Dobson in the post-operative period.[270]

205. Despite attempts at SCGH, the source or "culprit pathology"[271] of the infection was never able to be identified in this case, but there was evidence this is not unusual as very often the organism has directly invaded the blood. Without being able to implement source control, the other two arms of sepsis treatment, antibiotics and resuscitation, then become the only lines of treatment. These were done properly at SCGH and the experts noted there was nothing in the emergency care provided at SCGH that would warrant any criticism. Sadly, by the time Mr Dobson had arrived at SCGH, he was in advanced septic shock and the mortality at that stage is "extraordinarily high."[272] The opportunity to identify the sepsis and successfully treat occurred well before Mr Dobson was transferred to SCGH, and regrettably that opportunity was missed.

206. Considering the opinions of all of the medical experts together, I am satisfied that there were opportunities to identify, and take action in relation to, Mr Dobson's deterioration from 11.00 am, and by 3.00 pm it was obvious that Mr Dobson was significantly unwell. At that time, Mr Filgate should have been notified and Mr Dobson should have been transferred to SCGH. These actions would almost certainly have resulted in Mr Dobson being administered additional antibiotics and fluid resuscitation for possible post operative infection many hours before 11.00 pm. The window for Mr Dobson's survival was closing over those hours, so those missing hours were critical. Although it cannot be said with absolute certainty that Mr Dobson would have survived if his deterioration had been properly identified and the appropriate steps taken around 3.00 pm, it can be said that those steps would have substantially improved his likelihood of survival. As it was, by the time those steps were taken, any chance of recovery had gone.

[269] T 228.
[270] T 228 – 229, 231, 237 - 238.
[271] T 225.
[272] T 226.

CHANGES SINCE MR DOBSON'S DEATH

207. As noted above, the RCA panel made a number of recommendations arising out of the investigation into Mr Dobson's death. NMHS provided information during the inquest in relation to the progress that has been made in implementing those recommendations.

Recommendation 1

208. The first recommendation was to improve education in relation to acute clinical deterioration and correct use of the Observation and Response Chart. The NMHS advised a number of educational initiatives were implement at Osborne Park Hospital in 2020 in response, and are now embedded in practice. These include:[273]

- using a de-identified version of Mr Dobson's clinical scenario as a teaching tool as part of the annual Core Competency Day for nurses;
- nursing 'in-service' sessions covering topics such as MET call criteria, severe sepsis and septic shock and use of 'Escalation to Clinical Review' stickers;
- providing an electronic copy of each 'in-service' presentation in a folder on the computers at the Nurses' Station for the education of new staff and refresher training for existing staff;
- providing RMO's during orientation with resources on sepsis and providing 'in-service' sessions for registrars and RMO's;
- The Mortality & Morbidity meetings occur quarterly and review patients with suspected sepsis transferred from Osborne Park Hospital to SCGH amongst their cases;
- A "take 5 approach (stop, look, assess, control and monitor) with a primary focus on awareness of the clinical practice guidelines for sepsis, sepsis pathway and flowchart and specific tasks for clinicians" was planned to be presented to both nurses and medical staff following the inquest.

209. Of note, a biennial staff survey was implemented at the hospital in response to the RCA finding that some staff lacked the knowledge and confidence to activate a MET call in response to clinical deterioration. Comparison data for the 2019 and 2021 surveys indicate significant improvement in staff (both medical and nursing) confidence in calling a MET when worried about a patient, and there were less reported occurrences of being advised by a colleague not to call a MET.[274]

210. Dr Ercleve advised that at the time of the inquest, SCGH was about to hold a "Sepsis Awareness Day' to encourage staff to 'Think of Sepsis' and it is planned to hold a similar event twice a year, coinciding with the intake of new doctors, to increase the profile of sepsis and prompt health staff to think of it as a possibility when a patient is deteriorating. Dr Ercleve noted that by making sepsis one of the clinical care

[273] Exhibit 1, Tab 19, p. 2.
[274] Exhibit 1, Tab 19, p. 3.

standards, it emphasises that it is important and that a lot of work has been done, although more needs to be done.[275]

Recommendation 2

211. The second recommendation related to ensuring the Observation Chart was followed in terms of taking observations and escalation of review to a senior nurse review or medical review. The NMHS advised that the Osborne Park Hospital policy for 'Clinical Deterioration' was reviewed and replaced in November 2019. The procedure details mandatory requirements for escalation responses and actions as indicated on the Observation Chart and also mandates additional communication between certain staff in the case of clinical deterioration, including escalation to the responsible Consultant by the reviewing Medical Officer if a patient meets the criteria for escalation to medical review two or more times in a 24 hour period.[276]

212. In addition, in order to prompt clinicians to consider the possibility of sepsis, the Observation Chart was reviewed and updated in March 2021 with an added action item 'Check sepsis criteria,' with instructions on when to initiate the sepsis pathway (the sepsis pathway being implemented under recommendation 4).[277]

Recommendation 3

213. The third recommendation addressed consideration of the use of a sticker specifically for review by senior nurse or medical staff. Although Osborne Park Hospital already used a sticker to document patients reviews following escalation, the RCA panel suggested splitting that into two stickers, one for nurse review and one for medical review, might provide greater clarity relating to the management of care. NMHS advised that the recommendation was not adopted as the existing sticker was compliant with the recommended clinical handover format, but education was provided on the correct use of the stickers, as available audit data suggested that the compliance rate with correct use of the stickers was only around 50%.[278]

[275] T 170 – 171.
[276] Exhibit 1, Tab 19, p. 3 and Tab 19.4A and 4B.
[277] Exhibit 1, Tab 19, p. 4 and Tab 19.5.
[278] Exhibit 1, Tab 19, pp. 4 – 5.

Recommendation 4

214. The fourth recommendation of the panel was for Osborne Park Hospital to consider the implementation of an inpatient sepsis management plan. NMHS advised that following Mr Dobson's death, an adult sepsis pathway was developed by medical staff at Osborne Park Hospital in collaboration with colleagues from SCGH, based on similar models used in NSW and other tertiary hospitals in WA. It was accompanied by a clinical guideline, which provided details on how to use the pathway and specified the criteria where an immediate medical review is required. The pathway was approved for piloting at the hospital in May 2020, but audit data from 2020 and 2021 suggested inconsistent use of the pathway by clinicians, so the trial was not found to be successful.[279]

215. Following the release of a new Sepsis Clinical Care Standard by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in 2022, a new sepsis pathway was designed suitable for use across both Osborne Park Hospital and SCGH. The draft pathway was endorsed for trial in March 2023 and it is planned to obtain feedback so any necessary changes can be implemented in the final version.

Staffing Changes

216. In addition to the changes made in response to the RCA panel recommendations, NMHS acknowledged that the investigation into Mr Dobson's death revealed that medical staffing after hours at Osborne Park Hospital was no longer adequate to safely manage the increasing acuity of patients at the hospital. Following Mr Dobson's death, medical staffing levels were reviewed and increased to include a registrar and an RMO on duty until 10.45 pm, and then one additional RMO after 10.45 pm. The After-Hours RMO cover on Saturdays was also replaced by a more senior medical officer until 10.45 pm, as it is recognised that the patient load on Saturdays is often heavy and complex.[280]

217. In addition, on call support from senior clinicians (consultants) is now available for RMO's on duty after hours. Specifically, the RMO must telephone the on-call consultant every evening at 8.30 pm to discuss any clinical issue in the hospital, communicate any patients of concern and seek advice as appropriate. This is in addition to any ordinary communication with the allocated consultant for a patient.[281] Dr Ercleve noted that the consultant expecting the call eliminates any possible reluctance on the part of the clinical staff to disturb a consultant, and he commented it is, therefore, a good change.[282]

218. Changes have also been made in relation to the staffing profiles for MET calls, so that on weekdays between 4.30 pm and 11.00 pm and on weekends between 8.00 am and 11.00 pm, the team consists of one Registrar, one RMO and one Nurse Manager

[279] Exhibit 1, Tab 19, p. 5.
[280] Exhibit 1, tab 19, p. 7.
[281] Exhibit 1, tab 19, p. 7.
[282] T 155, 158, 163.

(Clinical). Between 11.00 pm and 8.30 am, the teams consists of two RMO's and one Nurse Manager (Clinical).[283] It was also mentioned that additional changes were proposed to be implemented in the months after the inquest resulting in a SCGH After-hour Team (CAT) being located at Osborne Park Hospital, which will potentially involve additional staff and, importantly, will operate under the governance of the SCGH Intensive Care Unit, who will provide leadership and direction in planning care for patients of concern.[284]

219. Noting the workforce challenges that all health services have experienced with maintaining staffing during the pandemic (not only within this State, but also nationally and internationally), NMHS advised that the combined SCGH and Osborne Park Hospital group are now 100% recruited for medical staff as of February 2023.[285]

220. Another issue that arose during the investigation into Mr Dobson's death was the lack of handover between the medical officers when they transitioned in the afternoon from the day to the after-hours shift, which meant that Dr De Jong was unaware of Mr Dobson and his issues until late that evening. NMHS advised the Osborne Park Hospital Clinical Handover and Communication policy has been replaced by a combined policy with SCGH, which outlines that the After-Hours Medical Officer will meet with the After-Hours Clinical Nurse Managers (CNM) at approximately 4.00 pm Monday to Friday and on Saturdays/Sundays and Public Holidays both at 8.30 am and again at 8.30 pm to discuss the status of inpatients. This discussion will include any patients of concern, new admissions, transfers and discharges.[286] By formalising this process and setting times for it to occur, it will hopefully ensure that another on-call doctor will not be placed in the same position as Dr De Jong.

221. Other organisational changes at Osborne Park Hospital were also referred to by NMHS and Dr Ercleve. Dr Ercleve noted that the changes arising from Mr Dobson's death are not just what is written down in the policies and protocols, "but it has also changed culture."[287] He explained that there has been an effort to change the culture in NMHS to encourage all staff to ask questions and escalate matters, so that the experience and instinct of nursing staff is valued and the nursing staff and medical officers works as a team. Dr Ercleve, who works at SCGH, indicated that he personally encourages the senior nursing staff to feel comfortable calling him if they have concerns and he believes more consultants are willing to be called in those circumstances.[288] The 8.30 pm mandatory call to the on-call consultant by the RMO is also a good tool in this regard.[289]

[283] Exhibit 1, Tab 19, p. 7.
[284] Exhibit 1, Tab 19, p. 8.
[285] Exhibit 1, Tab 19, p. 8.
[286] Exhibit 1, Tab 19, p. 7.
[287] T 154.
[288] T 163.
[289] T 155.

Staff Reflections

222. Nurse Forbes had indicated in her statement that after Mr Dobson's death a sepsis pathway had been introduced and she had used it a couple of times and had found it a very useful mechanism. Nurse Forbes indicated that Mr Dobson's case had emphasised to her how important the observations are in assessing a patient's condition, as even when a patient looks well, the observations may tell a different story and need to be considered carefully. Nurse Forbes gave evidence that in a similar situation today, she believes sepsis would have been more likely to be at the forefront of her mind in a case like Mr Dobson's.[290]

223. Nurse Forbes also noted the introduction of an escalation medical review sticker, "has been really good,"[291] although it seems the sticker was actually available before and just not used. She had noticed there are also a lot more doctors around, which she found helpful, and noted the doctors are communicating better with each other about patients of concern.[292]

224. Nurse Forbes commented that one of the difficulties in this case was trying to get a doctor to come and do a medical review of Mr Dobson. She understood the on-call RMO had been paged by Nurse Johnston at around 6.00 pm, but they were busy with other duties and could not attend. Nurse Forbes said she wished she had been a little bit more forceful about insisting the medical review occurred sooner, but it was difficult given there were not many options for medical review at that time of night on a weekend. Nurse Forbes indicated that it would have been unusual for her to try to contact the consultant, Mr Filgate, in those circumstance, although it might have been appropriate for the nurse coordinator to do so. She agreed that this would have been made much easier if Mr Filgate had been notified earlier during the day that there was an issue with Mr Dobson, so he would have been apprised of the situation and possibly expecting a call.[293]

225. Nurse Rhoder also gave evidence the introduction of the Sepsis Pathway has been well supported at Osborne Park hospital and now that it is in the Observation Chart, she believes it is in front of mind for nursing staff.[294]

226. Nurse Johnston indicated that she has been pleased to see an increase in doctors, particularly a registrar on the afternoon shift, and nurse managers now on the ward to deal with MET calls and other matters.[295]

227. Nurse Denston was asked at the inquest whether she felt there was anything more that she could have done, and she said she felt she had done more than what she needed to do and escalated Mr Dobson's care often, trying many different things to try to resolve Mr Dobson's issues. She had relayed any concerns she had to

[290] T 121; Exhibit 1, Tab 17.
[291] T 121.
[292] T 121 – 123.
[293] T 120 – 121; Exhibit 1, Tab 17.
[294] T 137 - 138; Exhibit 1, Tab 10.
[295] T 273 – 276.

Dr Wallis and her Nurse Coordinator and had done her best to ensure that Mr Dobson received a high standard of care.[296]

228. I agree that it appears Nurse Denston was appropriately concerned for Mr Dobson and tried to raise her concerns with more senior staff and ensure that all efforts were made to resolve his symptoms. It is clear she appreciated he needed regular monitoring and stepped in when it was overlooked. I consider Nurse Denston's evidence to be a good example of the need for doctors to trust the instincts of a conscientious nurse, who has ongoing care of a patient. Nurse Denston's indication she was thinking of making a MET call when Mr Dobson's blood pressure reading fell was the right decision in hindsight. It may or may not have prevented the ultimate outcome, but it at least would have led to the involvement of Mr Filgate in the situation at a much earlier stage, allowing access to his experience and ensuring he was aware that there was a rising concern for his patient.

229. As noted above, Dr Laurens had first spoken to Mr Filgate the day after Mr Dobson was transferred to SCGH. Mr Filgate commented during that conversation that Dr Laurens should have contacted him when Mr Dobson was not discharged home the previous day. Dr Laurens accepted, in hindsight, that he should have discussed Mr Dobson with Mr Filgate before completing his shift that day. He did state that he had asked Dr Wallis and the nurse to call him if Mr Dobson was not discharged home later that day, and if that happened he planned to speak to Mr Filgate, but because he was not contacted, he did not speak to Mr Filgate at all about Mr Dobson until he returned to work the next day and heard about Mr Dobson's transfer.[297]

230. Dr Laurens gave evidence he changed his practice after this incident and now he has a very low threshold for considering sepsis and will consider and explore that possibility if anything is abnormal. He has also learned over time to now take the observation chart himself when reviewing a patient and views it himself, although that change did not arise solely as a result of this case. He will suggest a MET call be made if a patient meets the criteria and I am sure he informs his consultant more regularly if there are issues with a patient. Dr Laurens very frankly admitted that Mr Dobson's death has "haunted him"[298] for the last three and a half years and it is obvious he has thought about it a lot over that time with regret and considered what he might have done differently.[299]

231. Dr Wallis did not recollect telling Nurse Denston not to make a MET call, but she did give evidence that she felt like she was escalating the concern by asking Dr Laurens to come and review Mr Dobson, so she didn't think a MET call would have changed anything. If she had not been able to contact Dr Laurens, Dr Wallis believes it might have been different, but having contacted him, she felt reassured.[300] Dr Wallis agreed she probably would have called Mr Filgate if she couldn't get hold

[296] T 103.
[297] T 72; Exhibit 1, Tab 6.
[298] T 75.
[299] T 72, 75, 79.
[300] T 25 - 26.

of Dr Laurens, but when she knew he was coming up from the clinic, she felt that was a sufficient escalation of the care.[301]

232. If a MET call had been made at an earlier stage, it would have most likely prompted the attending RMOs to call the surgical registrar, Dr Laurens, anyway and he would have been asked to review Mr Dobson. Therefore, the process would have been much the same as what occurred when Dr Wallis contacted Dr Laurens via the WhatsApp group. However, what would have changed is that Dr Laurens would have called Mr Filgate to advise him that a MET call had been made in relation to Mr Dobson for low blood pressure before Dr Laurens went to see him. This is because the policy requires that the consultant is notified when a MET call is made. He would then, at least, have been more aware of Mr Dobson experiencing some issues at an earlier stage.[302]

233. Dr De Jong spoke of the difficult shift she faced as the only RMO on the after-hours shift responsible for all but the Obstetrics & Gynaecology Ward, which meant she was pulled in many different directions to review complex patients and also having to attend any emergencies. She had also found the lack of a handover disadvantaged her in relation to Mr Dobson's case when she became aware he was unwell.[303] It was clear from her evidence that Dr De Jong had found this a traumatising experience as a junior doctor and she expressed her regret and condolences to Mr Dobson's family for his loss. She noted it was a tragic outcome and it has affected her going forward as a junior doctor. Dr De Jong was pleased to hear of the changes that had been made to staffing at Osborne Park Hospital on the after-hours and night shift, and also supported more efforts to provide a handover of patients between the medical staff.[304]

Ms Blackshaw

234. Mr Dobson's partner, Ms Blackshaw, spoke eloquently at the inquest about her reasons for requesting an inquest. She made no criticism of Mr Filgate or any of the staff at SCGH, as she acknowledged they provided a high standard of care once they became involved. However, Ms Blackshaw said she felt that the medical and nursing staff at Osborne Park Hospital ignored the signs around them. In particular, and quite rightly, Ms Blackshaw questioned why Mr Filgate had not been informed of his patient's deterioration after he was not discharged, as expected.[305]

235. Ms Blackshaw expressed her satisfaction that some changes have been made at Osborne Park Hospital since Mr Dobson's sudden death and it pleases her to think that some people may have been saved in that time. Her main concern was to ensure that there is some kind of trigger point, where if a patient isn't discharged, then the

[301] T 26.
[302] T 70, 73; Exhibit 1, Tab 19.4A.
[303] Exhibit 1, Tab 9.
[304] T 216.
[305] T 292 – 293.

consultant is told that their patient is not well enough to go home, regardless of whether they meet a MET call criteria.[306]

236. The information provided by NMHS indicates under the new policy, the responsible consultant must be notified by the reviewing medical officer if any patient meets criteria for escalation to medical review two or more times within a 24 hours period.[307] In addition, there is the mandatory discussion of all patients with the on-call consultant every evening. I believe these two changes, together with better staff guidance and training on the escalation policy generally, should hopefully answer Ms Blackshaw's concerns for a 'trigger' to bring the consultant into the communication loop.

237. Ms Blackshaw also noted that the policies and processes were in place to escalate Mr Dobson's care, but they were not acted upon by the staff on the day.[308] I agree with Ms Blackshaw's comment at the inquest that doctors and nurses need to be trained to pay attention to the actual observations and not simply take reassurance that a patient appears well. [309] It was clear from the evidence that when observations were taken that were concerning, but they did not match how Mr Dobson appeared clinically, attempts were made by the doctors and nurses to try to find the flaw in the reading (such as a faulty machine) or to take multiple readings until they got a better one, rather than thinking about the possibility that Mr Dobson was compensating and the low reading was correct. They also took reassurance from features such as Mr Dobson's normal temperature, without considering that he was receiving analgesia that might mask an increased body temperature, and he was also dressed lightly with a fan on in the middle of winter that suggested otherwise.

238. The information provided by NMHS in relation to increased staff training, particularly using features of Mr Dobson's actual case as a training tool, will hopefully address these concerns and ensure that lessons are learnt for future cases.

COMMENTS ON PUBLIC HEALTH

239. The reality is that at the time of Mr Dobson's death and today, the public health system in Western Australia is stretched, with a huge demand placed on healthcare services. Dr Ercleve commented that from a NMHS perspective, there is more activity in the hospitals and a finite number of resources, which means that they have to try to safely distribute patients and meet demand. Accordingly, if there are empty beds in Osborne Park Hospital and ramping outside a tertiary hospital, higher acuity patients may need to be moved to Osborne Park Hospital to free up beds at SCGH. The risk needs to be distributed safely, but given there is only SCGH and Osborne Park Hospital in the group, there are limited options.[310]

[306] T 293 – 294.
[307] Exhibit 1, Tab 19, p. 4.
[308] T 295 – 296.
[309] T 294.
[310] T 157.

240. Dr Ercleve emphasised that there are screening options to ensure that high risk patients are not sent to Osborne Park Hospital, but it might mean that patients of a higher acuity than might be ideal could be moved at times. To counter the increasing acuity of patients and increasing demand, increased resources in the form of more doctors and more senior doctors have been provided.[311] That is not only in the addition of medical staff to certain shifts, but access to senior medical staff in the form of on-call consultants and engagement with the SCGH medical teams.

241. A matter that was also raised was the possibility of electronic digitisation of medical records in the public health system, so that clinical staff have access to all of a patient's records from the public health system. It was relevant in this case in relation to Mr Dobson's earlier presentation for cellulitis. It was noted that there is a planned implementation taking place, starting with Fiona Stanley Hospital and then gradually expanding to other hospitals, but it is a hugely complex and expensive venture. Dr Ercleve noted that automating some of the systems will decrease frontline staff's workload, which will have a significant flow on effect and improve care. Dr Ercleve also observed that full automation carries its own risks, and may lead to unnecessary escalation of cases, which can be time consuming and absorb resources. However, he considers this is the way the health system is heading.[312]

242. I am aware that the current State Government has committed to completing the first stage of an Electronic Medical Record at WA hospitals at Perth Children's Hospital and SCGH, and it will hopefully eventually be fully rolled out to all the public hospitals in this State. It is hoped that a Digital Medical Record will reduce preventable patient deaths and improve staff communication and productivity and patient flow. The cost of this project is significant and must also deal with necessary upgrades of older infrastructure at some hospitals, so it is a long-term project rather than a quick solution. However, it is important to acknowledge that the government has started the implementation as part of a long-term commitment. Given this matter is already in hand, albeit it will take some time to fully implement, I do not intend to make any recommendation in that regard.

243. It was necessary for the NMHS as an organisation, and the individual staff involved personally, to reflect upon how this likely preventable death occurred in a man who was in the care of one of WA's public hospitals, surrounded by trained and qualified health staff. They have done so both through the RCA and other processes. I note the other changes made by NMHS have addressed specific concerns raised in the investigation into Mr Dobson's death, so I do not make any further recommendations as to changes that ought to be made.

OTHER COMMENTS

244. I noted at the inquest that I was likely to make an adverse comment in relation to the two medical officers involved in Mr Dobson's care at around 3.00 pm, namely Dr Wallis and Dr Laurens. I am always reluctant to single out individual practitioners

[311] T 158 – 159.
[312] T 160 - 162.

in such cases, as I know the pressures they face in the workplace on a daily basis. I have no doubt both Dr Wallis and Dr Laurens are diligent and careful doctors who were trying to make good decisions in relation to Mr Dobson's care on the day. However, based upon the evidence before me, there were two missed opportunities in this case to take a step that might have prevented Mr Dobson's death.

245. My comments are not made in relation to the fact the two doctors missed the diagnosis of sepsis, as I acknowledge there is evidence that it was a difficult diagnosis to make given Mr Dobson was not exhibiting some of the usual symptoms of sepsis, he appeared clinically well and there were other plausible explanations for many of his symptoms. I accept both Dr Wallis and Dr Laurens were appropriately concerned and carefully considered Mr Dobson's symptoms, but unfortunately reached the wrong conclusion and attributed those symptoms to more common post-operative complications rather than the rare case of sepsis that was actually present.[313]

246. My adverse comments are more directed solely to two things. The first, in relation to Dr Wallis, is the failure to make a MET call when Mr Dobson met the criteria at 3.00 pm. I accept that a nurse could also have made a MET call, but there was evidence before me that I accepted that at least one nurse considered making the call and was dissuaded by Dr Wallis as she was already there and dealing with the patient. The responsibility, therefore, rested upon Dr Wallis then to make the call. Dr Wallis accepted in hindsight a MET call should have been made at 3.00 pm based on Mr Dobson's observations. This would, by all accounts, have prompted Mr Filgate to be notified.[314]

247. The second, in relation to Dr Laurens, is the failure to notify Mr Filgate when he became aware Mr Dobson had not been discharged home as expected. and Dr Laurens has indicated he cannot explain why he did not contact Mr Filgate and concedes it was an error on his part.[315]

248. Both missed steps would have had the effect of escalating Mr Dobson's care to Mr Filgate, at least in terms of him being notified and consulted, and potentially led to an earlier diagnosis of sepsis or at least transfer to SCGH and eventual diagnosis of the same.

249. I made it clear to counsel appearing on behalf of NMHS and Dr Wallis and Dr Laurens that I have no intention of referring either doctor to any other body. I am satisfied they were both working to the best of their ability to try to care for Mr Dobson appropriately but, regrettably, they both made an error in judgment. I have no doubt they both regret now that they did not escalate the matter and Dr Laurens, in particular, has clearly reflected upon this matter often over the last few years and has made changes to his practice as a result of it, as well as the general experience he has gained since that time.

[313] Outline of Submissions on behalf of the North Metropolitan Health Service filed 28 April 2019.
[314] Outline of Submissions on behalf of the North Metropolitan Health Service filed 28 April 2019.
[315] Outline of Submissions on behalf of the North Metropolitan Health Service filed 28 April 2019.

CONCLUSION

250. This is a tragic case of a generally healthy 46 year old man who died unexpectedly from sepsis following a routine haemorrhoidectomy. There were continuing signs of his deterioration from around 11.00 am on 18 July 2019 and the generally agreed expert opinion was that from 3.00 pm it was clear that Mr Dobson was seriously unwell, potentially developing sepsis, and he required an escalation in his care. Unfortunately, this didn't occur until much later that evening, when the window of opportunity to save Mr Dobson had all but vanished.

251. The delay in recognising, appropriately assessing and managing Mr Dobson's deterioration resulted in a lost opportunity to commence antibiotics earlier and quite possibly save Mr Dobson's life. That is because the earlier sepsis is identified and treated with antibiotics and fluid support, the better the outcome.

252. It is true that Mr Dobson's case was not an ordinary presentation for sepsis, which made it more difficult to identify. Unfortunately, that is not unusual for cases of sepsis that come before this Court. That is why education around sepsis and sepsis pathways are so important in hospitals, with the emphasis for all health staff to 'think sepsis' at an early stage given the potentially fatal consequences of missing the diagnosis.

253. Mr Dobson was clearly a very loved and important member of his family. His loss has had a profound impact on his partner and children and extended family, particularly because it happened so suddenly and unexpectedly. He had no idea his last conversation on the phone with his partner as he was going to the ambulance would be their last and he had no chance to say goodbye to his young children. A procedure that should have been routine ended up taking his life. It is with a hope that lessons would be learned from his death that Ms Blackshaw has supported an inquest being held in this case, so that other families will not have to suffer in the same way Mr Dobson's family have suffered. It has unfortunately taken a number of years to get to this place, but I hope that Mr Dobson's family have gained some reassurance from this inquest that his death will not be forgotten and that all involved have thought long and hard about how similar deaths can be prevented in the future.

S H Linton
Deputy State Coroner
31 August 2023