QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of William Edward Searle**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/975
DELIVERED ON:	26 June 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	14 June 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, Whipple procedure, restrained patient, supervision by correctional officers, mobilisation of prisoner in hospital, removal of nasogastric tubes, gastroparesis, deteriorating patient, aspiration.

REPRESENTATION:

Counsel Assisting:	Mr Brendan Manttan
Queensland Corrective Services:	Mr Colin Reid, i/b Legal Strategy and Services, QCS

Metro South Health:	Mr Steven Shepherd
West Moreton Health:	Ms Prudence Fairlie
Nurse Juvelle Maria:	Mr Gavin Rebetzke, i/b QNMU Law

Contents

Introduction

1. William Searle was aged 74 years. He died on 2 March 2019 while hospitalised at the Princess Alexandra Hospital (PAH). Mr Searle had a number of significant medical conditions. In September 2018, Mr Searle was diagnosed with a dysplastic ampullary mass[1] while he was a prisoner at the Wolston Correction Centre (WCC).

2. On 27 February 2019, Mr Searle underwent an elective Whipple procedure (pancreaticoduodenectomy). The surgery was uneventful and post-operatively Mr Searle was transferred to the Intensive Care Unit. He was extubated after a few hours in recovery and was discharged from the ICU to the PAH's Hepatopancreatic-biliary Unit (HPB Unit) the next afternoon.

3. On 1 March 2019, Mr Searle was reviewed urgently after his oxygen levels declined and his abdomen became distended. He was on free fluids orally and had not vomited. It was concluded there was an interruption to the normal muscle contractions of the intestines (ileus).

4. On 2 March 2019, at around 10.00am, Mr Searle vomited a large amount of faeculent fluid. He became unresponsive and needed bag-valve-mask ventilation. Mr Searle went into a pulseless electrical activity (PEA) cardiac arrest, followed by asystole. Medical staff provided CPR and adrenaline. He was intubated and a nasogastric tube (NGT) was used to decompress his abdomen. Despite medical efforts, he was declared deceased at 10.32am.

The investigation

5. The investigation into Mr Searle's death was led by Detective Acting Senior Sergeant David Caruana of the Corrective Services Investigation Unit (CSIU).

6. After being notified of the death DSS Caruana attended the PAH. Mr Searle's room had been secured by Custodial Corrections Officers. The officers informed police that Mr Searle was being restrained by leg irons only, permitting unrestricted movement while he was in bed. When he required medical treatment or physiotherapy this was accommodated by the officers.

7. Photographs of the scene and the body were taken a Scenes of Crime officer. Mr Searle was subsequently identified by way of fingerprint records.

8. A direction for a targeted coronial investigation was issued. This included seeking medical records, and obtaining statements from relevant medical staff about the diagnosis and treatment of Mr Searle's ampullary cancer and post-surgical observations and management. Statements were also obtained from QCS staff about post-surgical supervision, including the restraint of Mr Searle.

9. A Coronial Report was prepared and provided to the Coroners Court in June 2020.[2] This Report attached statements from the CCOs supervising Mr Searle that were dated 31 May 2020.

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[1] A rare cancer that develops in the ampulla of vater - a small opening that connects the bile and pancreatic ducts to the duodenum.
[2] Ex A5

10. DSS Caruana concluded there were no suspicious circumstances surrounding Mr Searle's death. While he did not conduct an expert medical review, he concluded that Mr Searle had undergone a 'high risk' procedure and died as a result of the aspiration of stomach contents.

11. In February 2020, the Clinical Forensic Medicine Unit (CFMU) was asked to examine Mr Searle's medical records and the relevant witness statements. Dr Hall from the CFMU provided a report for the Coroners Court in April 2021.[3]

The inquest

12. At the time of his death, Mr Searle was a prisoner detained under the *Corrective Services Act 2006*. As the death was a 'death in custody' an inquest was required by the *Coroners Act 2003*.

13. The inquest was held at Brisbane on 14 June 2023. All statements, medical records, photographs and materials gathered during the investigation were admitted into evidence. Four witnesses were called to give oral evidence.

14. The issues considered in the inquest were:

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

    - Whether the custodial correctional officers tasked to supervise Mr Searle complied with the relevant Queensland Corrective Services policies and procedures in place at the time of the death; and

    - Whether the actions of the nurse attending to Mr Searle at the time of his death were appropriate in the circumstances.

15. It was agreed at the pre-inquest conference in this matter that, in addition to the findings required by s 45 of the Act, the two additional issues would be explored. These issues arose because of factual discrepancies between statements made by RN Nguyen, and CCO Fetherston and CCO McMath. Following assertions in RN Nguyen's statement that the CCOs were absent from Mr Searle's room when he aspirated, both CCOs were referred to QCS Ethical Standards Group (ESG) for investigation. The level of supervision of Mr Searle had some significance as Dr Hall's opinion was that earlier intervention after Mr Searle aspirated might have been outcome changing.

16. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

[3] Ex A9

The evidence

Personal history

17. Mr Searle was born on 8 February 1945 in Melbourne, Victoria. He was survived by his brother and sister.

18. Mr Searle had a criminal history with entries for sexual offences committed against children. On 16 May 1980 (at age 35), Mr Searle was sentenced to imprisonment for 3 years on four charges of indecent dealing with a girl under 14 years, unlawful carnal knowledge of a girl under 12 years and indecent dealing with a boy under 14 years.

19. On 17 October 2010, Mr Searle was sentenced to five years imprisonment for one charge of indecent treatment of children under 12 with circumstances of aggravation. This offending had occurred in 1998. The term of imprisonment was suspended for five years after serving 12 months.

20. On 15 December 2010, Mr Searle was sentenced to nine years imprisonment for historical sexual offences including rape, indecent dealing with children and indecent assault. This offending had occurred between 1982 and 1984. The court ordered that eligibility for parole be fixed at 15 December 2013.

Medical history

21. Mr Searle had a medical history of Type 2 diabetes, depression, iron deficiency anaemia, hypertension, gastric reflux, high cholesterol and was an ex-smoker. He was on a number of medications to assist with his medical conditions.

22. On 10 June 2015, Mr Searle underwent upper endoscopy and colonoscopy at PAH as he was experiencing recurrent upper gastrointestinal symptoms and iron deficiency.[4] Mr Searle was found to have a large ampullary polyp (at the level of the entry point of common bile duct and pancreatic duct into the duodenum) that measured around 40mm. There were numerous colonic polyps that were removed through colonoscopic snaring.

23. On 26 August 2015, Mr Searle was re-admitted to PAH for a follow-up endoscopy. The result showed he had a 40x28mm lobulated mass at the ampulla extending to the deep mucosa with about 8mm intraductal extension. The mass was biopsied and a recommendation was made for Mr Searle to undergo an endoscopic resection by ERCP (endoscopic retrograde cholangio-pancreatography) which occurred on 6 January 2016. Histology identified tubulovillous adenomas – benign tumour with low grade dysplasia.[5]

24. Following the removal, Mr Searle was noted to be of reasonable health in prison. A plan was made for him to undergo regular surveillance endoscopy and yearly colonoscopies. His diabetes was noted to be under control and was only mildly out of range.

[4] C15 – CFMU Report at p. 3, para. 3.
[5] C15 – CFMU Report at p. 5, para. 2.

25. On 1 June 2016, Mr Searle was admitted to PAH for elective ERCP following the recent removal of the tumour. It was noted that residual tumour was present at the site of the previous procedure and this was treated with argon plasma coagulation, a form of cautery. A temporary pigtail stent was placed in the pancreatic duct and removed upon his discharge two days later.

26. An endoscopy in November 2016 showed small residual adenoma at the ampulla which was removed through cauterisation.[6]

27. In the first six months of 2017, Mr Searle was noted to be medically stable with his surveillance endoscopy in March 2017 revealing no abnormality. On 18 August 2017, he was admitted to PAH after having fevers and short runs of ventricular tachycardia secondary to sepsis from a blocked common bile duct (ascending cholangitis).[7]

28. Mr Searle was administered antibiotics after blood tests indicated infection. Once issues with heart arrhythmia resolved Mr Searle underwent an ERCP. A benign stricture was seen in the common bile duct, but no gall stone was noted. A stent was placed in the common bile duct. He was returned to WCC five days later.

29. Two days after discharge (25 August 2017), Mr Searle was re-admitted to PAH for non-specific abdominal pain. His white cell count and liver enzymes were high. A CT of the abdomen confirmed the stent was still in place. Mr Searle was prescribed antibiotics and discharged three days later. Records indicated that he may have passed a transient gallstone.[8]

30. On 12 September 2017, Mr Searle was re-admitted to PAH after reporting abdominal pain and having a fever. Ultrasound showed a thickened gallbladder with numerous gallstones. Mr Searle's gallbladder was removed as a result and the stent in the common bile duct was replaced.

31. In 2018, Mr Searle was seen by medical staff in WCC for diabetes management and skin lesions. In April 2018, he was treated with antibiotics for suspected urinary tract infections/inflamed testicle. His blood sugar levels were noted to be slightly out of range.[9] On 19 July 2018, he was admitted to PAH for a routine surveillance colonoscopy. The result showed six polyps in the colon and rectum with evidence of sigmoid diverticular disease. Mr Searle was discharged the next day for a further surveillance colonoscopy in 12 months.

32. On 23 September 2018, Mr Searle was taken to PAH with a fever, cough and presyncope (faintness). A chest x-ray revealed pneumonia and an abdominal ultrasound showed dilated common bile duct, intrahepatic bile ducts and possible obstruction in the pancreatic duct. On 27 September 2018, an ERCP was conducted which confirmed recurrent ampullary adenoma with ascending cholangitis. A 20-25mm length stricture in the distal bile duct with extraductal extension of recurrent tumour was also noted. These conditions were treated with ERCP dilation of the ampulla and stenting of the bile duct.

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[6] C15 – CFMU Report at p. 3. para. 2.
[7] C15 – CFMU Report at p.4, para. 1
[8] C15 - CFMU Report at p. 6, para. 1.
[9] C15 - CFMU Report at p. 4, para. 2.

33. In November 2018, Mr Searle underwent further endoscopy, and an MRI scan of his pancreas were conducted in December 2018 to determine further management.

Circumstances of death

34. In January 2019, the PAH informed WCC that Mr Searle required a Whipple procedure to manage his recurrent ampullary tumour. Mr Searle was prioritised as Category 1 with the procedure likely to occur in one month.

35. On 21 January 2019, Mr Searle consented to the Whipple procedure. The consent form indicated general risks including infection, bleeding, need for re-surgery, death, heart attack and stroke. The form also indicated specific risks including pancreatic peritonitis, ileus, vomiting and the recurrence of cholangitis if the procedure did not proceed.

36. On 31 January 2019, a 'code blue' was called at WCC after Mr Searle reported a fever, sweating abnormally and pain in his abdomen. Mr Searle was subsequently given antibiotics and the stent was changed. He was discharged back to WCC on 3 February 2019 with oral antibiotics to await the Whipple procedure.

Events leading up to the death

37. On 27 February 2019, Mr Searle underwent the Whipple procedure. The surgery showed ampullary tumour extending into the common bile duct with a stent in place. The tumour had not spread. It was noted that the procedure proved to be difficult due to 'body habitus' but there was minimal blood loss.[10] Histology of the ampulla and distal common bile duct indicated low-level pre-cancerous change and foci of high-grade dysplasia. No malignancy was found in the resected lymph nodes.

38. Mr Searle was transferred to the ICU after the surgery. It was noted he had poorly controlled diabetes and non-critical heart conduction abnormality. He was fitted with a NGT on free drainage, two abdominal drains and he initially passed adequate urine via a catheter. However, the amount of urine dropped overnight and required ongoing monitoring.[11]

39. On 28 February 2019 at around 9.21am, Mr Searle was noted to have a fever and his breathing was shallow.[12] He was alert and complained of being in pain. A septic screen request was sent and surgeons directed that the NGT be removed. Mr Searle was discharged from ICU and transferred to the HPB Unit.

40. Mr Searle was seen by a physiotherapist and was mobilised with the aid of a rollator (walking frame). He shuffled slowly with assistance.[13] He was given incentive spirometry to help breathing and lower his risk of getting pneumonia. Mr Searle was provided with a patient-controlled analgesia (PCA) device so he could administer opioids when in pain.

[10] C12 – PAH – DH INPT11.pdf at p.66.
[11] C15 CFMU Report at p. 8, para. 1.
[12] C12 – PAH – DH INPT11.pdf at p.33.
[13] C12 – PAH – DH INPT11.pdf at p.32.

41. Mr Searle was reviewed by the endocrine team who noted *'poor control and incongruence of report blood glucose level'*[14]. Mr Searle was noted to be 'nil by mouth' with insulin infusion and a plan was made to review his blood glucose level and adjust as required.[15] At 8.56pm, Mr Searle was noted to be stable and was using the PCA appropriately.

42. On 1 March 2019 at around 6.34am, Mr Searle's abdomen was noted to be distended and there was minimal drainage from the surgical drains. His urine output was still low. Mr Searle was prescribed metoclopramide as necessary. A review conducted by the physiotherapist indicated Mr Searle was 'well' despite being breathless and coughing thick green sputum. With the use of a rollator, Mr Searle was mobilised (while on nasal prong oxygen) by the physiotherapist. The physiotherapist asked staff to continue to mobilise Mr Searle over the weekend. The PCA was stopped, and Mr Searle was to be administered Endone as required for pain relief. Mr Searle tolerated a free fluid diet.

43. At 3.41pm, Mr Searle's chest x-ray showed '*...small bilateral effusions with compressive atelectasis of the adjacent pulmonary parenchyma…There is dilatation of the stomach and visualised bowel in the upper abdomen, with multiple air-fluid lever, possibly reflecting ileus in the immediate post-operative setting but bowel obstruction not excluded'*.

44. At 8.44pm, medical records noted Mr Searle was nauseous, refused free fluid dinner and vomited 30ml of fluid. He was given metoclopramide. He had a distended abdomen and had not passed flatus since the surgery. A second chest x-ray was ordered.

45. At 11.23pm, a rapid response team (RRT) attended to Mr Searle after he experienced decreased oxygen saturations (on nasal prong oxygen). The use of a non-breather mask improved Mr Searle's oxygen saturations. It was noted that Mr Searle still had a distended abdomen despite it being soft and it was not tender. Mr Searle said he was not able to breathe properly due to tightness around his abdomen. His abdomen was more swollen since surgery. It was thought that the distension was most likely a post-operative ileus. He was ordered to be sat right up with high flow nasal oxygen due to the desaturation of oxygen being attributed to his positioning in bed and splinting of the abdomen.

46. The second chest x-ray indicated *"Persistent bilateral pleural effusions with compressive atelectasis of the adjacent pulmonary parenchyma. The upper and mid zones of both lungs remain clear. RIJ CVL is in situ. No pneumothorax identified. Persistent dilatation of the stomach and visualised upper abdominal bowel loops. No free air beneath the diaphragm'*.[16]

47. On 2 March 2019 at around 4.17am, Mr Searle was noted by the ward doctor to have poor urine output, raised lactate and decreasing renal function. He had shortness of breath and was sweaty, tachycardic with raised blood sugars and raised white cell count. A CT pulmonary angiogram (CTPA) was ordered to rule out blood clots in the lung. The result showed no pulmonary embolism. However,

[14] C15 CFMU Report at p.8, para.1.
[15] C12 – PAH – DH INPT11.pdf at p.31.
[16] C15 CFMU Report at p.9, para. 2.

it showed Mr Seale's 'bilateral lungs' had collapsed. It was also evident from the result that Mr Searle had a large ileus.

48. At around 8.03am, medical notes indicated Mr Searle vomited, had reduced appetite, worsening renal function, low urine output, distended abdomen and had not opened his bowel.[17] At 9.10am, a nurse from the ICU outreach service saw Mr Searle but did make any treatment changes and echoed the earlier notes.

49. Registered Nurse Nguyen said that at one point Mr Searle wanted to have a shower. However, she advised him that she needed to change his insulin infusion syringe and intravenous fluid bag before he could shower.

50. At 10.05am, the nurse buzzer went off in Mr Searle's room. RN Nguyen went to the room. In her statement, RN Nguyen noted one custodial correctional officer (CCO) who was on his phone was in the room at the time and the second CCO was outside of the room talking on his phone. Mr Searle vomited (50ml) and RN Nguyen cleaned up the vomit and went out of room and reported what had happened to the nurse in charge, Clinical Nurse Maria (CN Maria), and disposed of the vomit bag in the pan room.[18]

51. RN Nguyen said that she returned to Mr Searle's room at around 10.10am. She noted the two CCOs (CCO Fetherston and CCO McMath) were not in the room. However, this was subsequently disputed by the CCOs who advised they were both present.

52. RN Nguyen found Mr Searle soiled in faecal looking vomit.[19] RN Nguyen notified CN Maria as the colour of the vomit was different from the earlier vomit and there was a lot of it. RN Nguyen returned to the room and was followed by CN Maria. Mr Searle was unresponsive and required bag-valve-mask ventilation. Mr Searle went into pulseless electrical activity cardiac arrest. RRT were called and CN Maria started chest compressions.

53. The RRT took over Mr Searle's treatment. He was administered cycles of adrenaline and CPR continued. Mr Searle was intubated and a NGT was inserted to decompress his abdomen. Despite intervention from an ICU consultant, Mr Searle was not able to be resuscitated. Mr Searle was pronounced dead at 10.32am.

CCO statements

54. CCO Shaun McMath's statement is dated 31 May 2020. On the date of the incident he was working with CCO Fetherston on a 6:00am to 6.00pm shift. Mr Searle was mechanically restrained with a leg iron attached to the hospital bed. Mr Searle was restrained but was able to receive medical treatment if required. At around 9.50am, CCO McMath heard Mr Searle ask a nurse for a shower but the nurse was not ready. The nurse asked Mr Searle to lie back down.

55. At around 10.00am, CCO McMath noticed blood coming from Mr Searle's mouth. He alerted a nurse and pressed the 'yellow staff assistance' button on the wall.

[17] C12 – PAH – DH INPT11.pdf at p.16.
[18] B6 - Statement – NGUYEN, Cindy at para. 9.
[19] B6 – Statement – NGUYEN, Cindy at para. 10.

According to CCO McMath nursing staff attended the room and began CPR at around 10.07am. At 10.35am, CCO McMath along with CCO Fetherston were advised by a doctor that Mr Searle had died.

56. CS Hearn attended Mr Searle's room and the room was secured as a crime scene. At around 12.00pm, DSS Caruana attended and spoke to both CCOs.

57. CCO Fetherston's statement is also dated 31 May 2020.[20] He confirmed, as per CCO McMath's statement, that Mr Searle was restrained with a leg iron.

58. During the morning, CCO Fetherston saw Mr Searle spit up small amounts of 'black liquid' and said 'both nurses that morning were aware of this'. At around 9.50am, CCO Fetherston also stated that Mr Searle wanted to shower but was told to lie back down as the nurse was not ready.

59. At around 10.00am, CCO Fetherston observed Mr Searle 'cough up' a large amount of black liquid' followed by 'an even larger amount' flowing out of his nose. CCO McMath alerted medical staff by pressing the 'call for nurse' button and medical staff arrived. At around 10.05am, the 'extra assistance' button was pressed by a medical staff member and other staff arrived in the room. CPR was commenced on Mr Searle at around 10.07am. At around 10.33am, Mr Searle was declared deceased.

60. At around 10.35am, CCO Fetherston and CCO McMath secured the room and notified CS Clark at WCC and CS Hearn at PAHSU. At around 12.00pm, DSS Caruana from CSIU attended and spoke to both CCOs.

Statements of medical staff from PAH and WCC

61. Statements were received from the following medical staff at PAH and WCC:

    a. Dr Shinn Yeung, Senior Hepatobiliary Consultant
    b. Dr Sarah Byrne, Hepatobiliary Surgical Fellow
    c. Dr Noel Hayman, VMO at WCC
    d. RN Ruth Phillips (attended to Mr Searle 1 March 2019)
    e. RN Matthew Farrell (attended to Mr Searle from 1 March 2019 until 7.30am on 2 March 2019)
    f. RN Cindy Nguyen (attended to Mr Searle before and at the time he aspirated).

62. The information provided by the medical staff is detailed above as part of Mr Searle's medical history and the circumstances surrounding his death.

CFMU Report

63. As noted above, the CFMU was asked to provide a report in relation to the health care provided to Mr Searle to see if there was an opportunity to prevent his deterioration. Dr Hall was provided the statements of medical staff to assist in his report. He was not provided the statements of the CCOs.

[20] In the statement the date of the incident was stated 2 February 2019. This should have been 2 March 2019.

Whipple procedure

64. Dr Hall referred to literature regarding the Whipple procedure. The procedure is complex, involving resection of the head of the pancreas along with the pancreatic duct, portion of the common bile duct (and gallbladder if present) duodenum with proximal 15cm of upper small bowel, distal stomach and reconstructing a connection of stomach remnant with the upper small bowel, as well as reconstruction of bile duct and pancreatic stump/duct entry to the small intestine while balancing potential complications such as fistula formation.[21] The procedure is used to surgically manage resectable pancreatic cancers and non-malignant neoplasms of duodenum, bile duct, or pancreatic duct like ampullary adenoma.

65. Dr Hall noted that a Whipple procedure is high risk with an average operation time of 5.5 hours, an average of 350ml blood loss and perioperative mortality of 4%. Generally, the procedure can be achieved using laparoscopic methods which leads to longer operative time but less bleeding and admission time in hospital. Most patients do not require admission to ICU and the use of a NGT is generally not required with patients walking early after the procedure. Post procedure management includes managing drain output, nutrition, wound care as required and return of bowel function.

66. There needs to be monitoring of the amount and appearance of secretion. For example, checking for bile, blood, cloudiness (indicative of pancreatic fluid) and monitoring fluid for presence of amylase (pancreatic enzyme). An increase in amylase is associated with the development of pancreatic fistula. Surgical drains are removed after a couple of days in the absence of leak if the patient is tolerating diet. In majority of cases, patients can resume oral fluids by day 1-2 post surgery and move onto solid diets in the following 2-3 days.

67. Rarely, if there are peri-operative complications, parenteral nutrition (feeding nutritional products through IV) may be needed. Delayed gastric draining may be signalled by vomiting and is more frequent in people with diabetes, a history of previous abdominal surgery or a history of cholangitis. The incidence is around 17%. CT scan of the abdomen is recommended as vomiting may also be a sign of pancreatic fistula.

Gastroparesis/Diabetic Gastroparesis

68. Dr Hall referred to literature defining gastroparesis as *"a syndrome of objectively delayed gastric emptying of solids, in the absence of a mechanical obstruction, with cardinal symptoms of nausea, vomiting, early satiety, belching, bloating, and/or upper abdominal pain"*.[22] A common cause of gastroparesis is a Whipple procedure. Another cause is taking medications such as narcotics, tricyclic anti-depressants, and calcium channel blockers.

69. Dr Hall said that signs of gastroparesis include abdominal distension and/or tenderness with no rigidity or guarding with or without succussion splash (sloshing sound when the abdomen is rocked side to side). Mechanical obstruction ought to be excluded if gastroparesis is suspected.

[21] C15 – CFMU Report at p.13, para. 1.
[22] C15 – CFMU Report at p.14, para. 2.

70. Patients with Type 1 Diabetes are also more likely to develop gastrointestinal symptoms. Hyperglycaemia higher than 11.1 mmol/L can contribute to delayed gastric emptying, with chronic hyperglycaemia associated with increased risk of neuropathy. Risk factors include diabetic neuropathy, nephropathy, obesity, poor glycaemic control and duration of diabetes over 10 years. Dr Hall referred to literature that stated gastro-oesophageal reflux disease (GORD) is also common in diabetics where neuropathy can lead to lower oesophageal sphincter pressure, impaired clearance of the oesophagus and delayed gastric emptying. Impaired neural control of gastric function can lead to the development of diabetic gastroparesis.

Nasogastric Tubes

71. NGTs are used to manage acute bowel obstruction and prolonged ileus. NGTs decompress the stomach to prevent recurrent vomiting and make the patient comfortable. They are also used to administer medications and the provision of enteral feedings/fluids. Generally, NGTs are not used after abdominal surgery for gastric decompression as prophylactic use does not considerably lessen the incidence of post-operative ileus or pulmonary complications. Vomiting and distension of the abdomen are more common in the absence of NGTs. In the presence of prolonged post-operative ileus or early small bowel obstruction the use of NGTs is recommended.

Opinion as to management of Mr Searle's adenoma in WCC and PAH

72. Dr Hall said that the management of Mr Searle's ampullary adenoma from 2015 and beyond by WCC medical staff and PAH staff was appropriate. The referrals and follow up were timely. The surgical notes revealed that the Whipple procedure was conducted with due skill and care despite difficulties associated with Mr Searle's obesity.

73. Dr Hall stated that the Whipple procedure was the correct procedure to manage Mr Searle's adenoma, given his issues with recurrent cholangitis, recurrent tumour, bile duct requiring restructuring with stent and infection occurring in the past.

74. Dr Hall concluded that Mr Searle was afforded the same care and medical attention that would be available to a person not in custody.[23]

75. Dr Hall disagreed with Dr Hayman's assessment of Mr Searle having 'good diabetic control' at WCC. He viewed it as stable, albeit poor control, due to it being moderately out of range. In the context of an incarcerated person, it would be regarded as 'reasonable' and 'safe' in that the ranges of diurnal glycaemic swings were not in danger of producing hypoglycaemia nor concerning hyperglycaemic episodes. Dr Hall agreed with Dr Hayman's assessment that Mr Searle had an interest in his diabetic/diet management and complied with medication and medical/dietetic advice. Mr Searle's poor glycaemic control had also been noted by the endocrinology team at PAH.

Opinion as to post-operative care in PAH

[23] C15 – CFMU Report at p.16, para. 2.

76. According to Dr Hall, Mr Searle's diabetes, central obesity and prior surgery placed him at high risk in terms of complications. He was also at higher risk of gastroparesis than the average patient after surgery due to the history of poorly controlled diabetes. He was also taking two medications (amitriptyline and lercanidipine) that can contribute to gastroparesis as well as needing opioid medication after surgery.

77. Dr Hall noted that relevant literature quoted the occurrence of gastroparesis as 17% for all patients undergoing Whipple procedure. Accordingly, it could be argued that there was a 'very real chance' that this complication could occur as opposed to it being remote possibility. Dr Hall stated this was not flagged during the admission and that it could be a likely outcome that should have been monitored closely.

78. Dr Hall assumed correctly that Mr Searle was discharged from ICU to a dedicated hepatobiliary ward, where such outcomes would be monitored more aggressively. He said that in those circumstances the communication of the risk was poor.

79. Mr Searle's NGT was removed on day two and he was started on free fluids soon after. Dr Hall thought that this was a reasonable decision given most patients who undergo a Whipple procedure do not require a NGT. However, the literature suggests that one of the caveats for removing a NGT is that the patient is mobilised as this would assist in gastric motility.

80. Dr Hall understood that Mr Searle was cuffed and manacled to the bed.[24] The physiotherapist had asked for staff to mobilise Mr Searle over the weekend. The limitation of his bed restraint was recognised. According to Dr Hall, his level of mobilisation was another important consideration that should have been entertained when medical staff were examining his abdominal distension, nausea and discomfort.

81. Dr Hall stated that on the evening and early hours prior to Mr Searle's death, staff attended to Mr Searle on two occasions for increased work of breathing desaturations. The two x-rays taken showed evidence of (at least) an ileus, and gut obstruction could not be excluded. Ileus does not necessarily elicit clinical evidence of tenderness or guarding and the stomach may be soft to palpation.

82. On the evening of 1 March 2019, Mr Searle complained of having difficulty breathing due to tightness in his abdomen, nausea and being uncomfortable. Dr Hall thought these concerns coupled with the findings on the x-rays should have raised concerns of the possibility of ileus developing and that Mr Searle was at risk of aspiration due to the level of bed restraint. Rather than managing the probable cause of the above issues, Mr Searle was sat up in bed and his oxygen flow was increased.

83. During the medical review at 4.17am on 2 March 2019, (six hours prior to death) nothing was done apart from arranging a CTPA later in the morning despite Mr Searle being short of breath, diaphoretic, having worsening renal function, raised lactate and raised white cell count on blood tests. The CTPA which was

[24] This was not established on the evidence.

conducted 90 minutes prior to Mr Searle aspirating showed distension of the abdomen and oesophagus with fluid, signalling potential aspiration.

84. Dr Hall's opinion was that there were three missed opportunities for medical staff to review Mr Searle's clinical condition and recognise his potential for aspiration pneumonia – specifically recognising Mr Searle was at increased risk due to his poorly controlled diabetes and the medication he was taking as a result of major upper abdominal surgery.[25]

85. Dr Hall's opinion was that the first missed opportunity arose on the evening of 1 March 2019. Mr Searle had complained of his abdomen expanding and that he was having difficulty with his breathing. He had also refused his dinner. There was also the presence of the x-ray result showing ileus. These issues raised opportunities for discussion with his treating surgeons regarding the possible need for NGT decompression.

86. The second missed opportunity was the review at 4.17am. Despite complaints from Mr Searle, his blood test result being out of range with raised lactate, nothing was done apart from a request for CTPA. These issues ought to have raised concerns and was an opportunity to discuss Mr Searle's clinical picture with his surgeons to explore the need for NGT.

87. The third opportunity arose following the CTPA at 8.40am. Dr Hall said that while the report was not immediately available, the scan would have been seen by the radiographer with nursing/medical staff attending to provide the intravenous contrast. The images would have appeared on a screen in real time as the scan was being conducted, providing an opportunity during this time to alert the treating team to potential aspiration.

88. Dr Hall also addressed the alleged absence of the correctional officers in the room as Mr Searle aspirated. Dr Hall recognised that the officers are not medical personnel. However, they are the guardian of the restraint devices. Dr Hall stated that if an officer had been present in the room when Mr Searle vomited, the officer would have been in a better position to provide assistance by sitting Mr Searle up and protecting his airway. As it was, Mr Searle was restrained to the bed. The clinical picture at 4.17am, suggested Mr Searle was unable to roll or sit without assistance from others.[26]

89. Dr Hall concluded that there was ample opportunity for medical staff to review Mr Searle's clinical situation, from considering whether there was a need for re-insertion of NGT when he was displaying signs of distress as a result of a distended abdomen and difficulty breathing, at least discussing this with the treating surgeons. Mr Searle's medical history should have been considered post-surgery as it was apparent that he was above the average risk of gastroparesis and ileus.

90. Dr Hall stated the re-insertion of a NGT is a simple procedure and can be done bedside. He thought that timely intervention and re-insertion of a NGT on the evening of 1 March or morning of 2 March would have been outcome changing. He also suggested that the absence of appropriate supervision by the corrective

[25] C15 CFMU Report at p.17 at para. 2
[26] It was ultimately clear that Mr Searle was sitting without his hands cuffed.

officers deprived Mr Searle of potential outcome changing assistance when Mr Searle aspirated.

Response from the PAH

91. The EDMS at the PAH, Dr Bell, was invited to comment on the concerns raised by Dr Hall's report. Dr Bell provided that report to Dr O'Rourke, Hepatopancreatic-Biliary (HPB), General and Liver Transplant Surgeon and A/Director HPB Unit at the PAH.

92. Mr Searle's death was referred to the HPB Unit Morbidity and Mortality (M&M) meeting and the monthly Division of Surgery M&M meeting. Those in attendance agreed with Dr Hall's opinion and concerns.

93. In June 2021, Dr Bell advised that Enhanced Recovery After Surgery (ERAS) is an internationally studied and recognised protocol on how to manage patients who have undergone a Whipple procedure. The aim of ERAS is to expedite recovery and reduce complications. However, Dr Bell acknowledged ERAS may not have been appropriate for Mr Searle who was at higher risk for complications including gastroparesis because of his diabetes, obesity and immobility.[27]

94. Dr Bell said that that all consultants are now required to specify if patients undergoing Whipple procedure are a candidate for ERAS post-surgery. Dr O'Rourke said it could be argued that there was no contraindication to place Mr Searle on the ERAS protocol postoperatively.

95. Dr Bell said that the M&M meeting recognised opportunities to improve consultation between junior medical officers and senior members of the Treating Team (TT). It was identified that a 'relatively junior' HPB team was involved in managing the post-operative ward rounds involving Mr Searle. While the protocol was followed, it was not recognised that Mr Searle's condition was deviating from accepted ERAS recovery parameters.

96. Junior medical officers during their orientation to the HPB Unit are now provided education to ensure consultation between junior and senior TT members, especially when a patient's condition is deteriorating. There is now also direct liaison with the Consultant prior to a NGT being removed.

97. In further correspondence in June 2022, Dr O'Rourke noted Dr Hall's assumption that Mr Searle was not mobilised was not correct. He was seen by a physiotherapist the day after his surgery and was able to walk 20 metres. He was assessed as an 8 out of 10 for mobility. He was seen again on Friday 1 March 2019 and mobilised 40 metres. The physiotherapist asked nursing staff to mobilise him over the weekend and encourage him to sit.[28]

98. Dr O'Rourke noted that the first post-operative chest x-ray on the afternoon of 1 March 2019 was ordered by the HPB junior medical team on their afternoon ward round. This x-ray showed a very large gastric bubble indicative of gastroparesis. While this should have been obvious to a senior medical officer with experience

[27] B 8
[28] B 10

in post-operative Whipple patients, in the absence of the formal x-ray report, interpretation of x-ray images is dependent on individual clinician experience.[29]

99. Dr O'Rourke considered that the fact the first x-ray was not reviewed by the clinician who ordered it on Friday 1 March 2019 more accurately represented the first missed opportunity for Mr Searle.

100. He also agreed that the evening of 1 March 2019 was a missed opportunity as the intern had formed the view that the abdominal distension was secondary to a post-operative ileus, and desaturation was likely secondary to positioning/splinting. Dr O'Rourke said that while the process was likely micro-aspiration, this is not a diagnosis easily made by an intern.

101. Dr O'Rourke did not agree that the review at 4.17am was a missed opportunity, because:

- the x-ray report was not available.
- raised lactate does not indicate ischemia. This is a non-specific marker of illness which does not point to a cause. There are many reasons associated with a raised lactate in the early post-operative period.
- the decision to order a CTPA in the context of what were extremely low saturations was not unreasonable.

102. Dr O'Rourke agreed that timely intervention with placement of an NGT would have been outcome changing. Ideally, this would have occurred on the afternoon of 1 March 2019 after the first chest x-ray. However, the clinical focus remained on Mr Searle's decreased saturations and need for oxygen after the second chest x-ray and rapid response on the ward.

103. Dr O'Rourke agreed that communication of the risk of gastroparesis was poor. However, it was very unusual that Mr Searle did not have a large vomit, and the absence of a large vomit was probably what detracted both nursing and junior medical staff from consideration of gastroparesis. He agreed with Dr Hall that there were opportunities for discussion with the treating surgeons but acknowledged that some junior staff may be reluctant to call senior medical officers in the middle of the night.

104. Dr O'Rourke said that following Mr Searle's death, Metro South Health has become more highly selective as to whether the patient is a suitable candidate for ERAS. Gastroparesis requiring re-insertion of an NGT would be a reason for a patient to come off ERAS and this has occurred in many cases since Mr Searle's death

Statement of Assistant Commissioner, Southern Region Command, Custodial Operations, QCS

105. On 22 July 2021, AC Roeder provided a statement. At the time, AC Roeder was not aware of RN Nguyen's statement about the corrective service officers until she was provided Dr Hall's report. AC Roeder stated she nor the QCS had received a copy of RN Nguyen's statement.

[29] This x-ray was not formally reported until four days after Mr Searle's death.

106. According to AC Roeder, Mr Searle's death was reported to the WCC supervisor at the PAH Secure Unit (PAHSU) at approximately 10.35am on 2 March 2019. This report inferred both CCOs were in the room as it discussed that both officers saw Mr Searle vomiting black fluid from his mouth and then from his nose. The report stated 'staff' called out to the nurse and pushed the 'extra staff assist button' to call a code.[30]

107. The allegation that the CCOs guarding Mr Searle were either on their mobile phones and/or outside of the room was subsequently referred to the QCS Ethical Standards Group (ESG) for assessment and investigation.

108. In addition to the referral to ESG, AC Roeder asked the Operational Policy and Practice Group to revise the current External Escorts Custodial Operations Practice Directive (COPD) which applies to escorting of prisoners outside of prisons and within PAHSU.

109. The changes to the COPD specifically include that escorting officers *"must remain vigilant at all times and ensure observations of the prisoner are such that changing circumstances can be responded to at the earliest opportunity to maintain the security and well-being of the prisoner".*[31]

QCS ESG Investigation

110. On 22 November 2021, the Coroners Court received material from QCS in relation to the investigation of the alleged conduct of the two CCOs. The material was included a report from ESG Principal Investigator, Darren Brown, dated 30 September 2021.

111. Mr Brown interviewed both CCOs as part of his investigation and provided material corroborating the version of events provided by them. Mr Brown also looked into whether there was CCTV in the room but there was none.

112. Four allegations were brought to the attention of CCO Fetherston and CCO McMath. Allegations 1 and 2 related to both CCOs being absent from their post or duty without authority during an external escort of a prisoner. Allegations 3 and 4 related to both CCOs failing to ensure the health and welfare of Mr Searle by failing to adequately supervise him.

CCO Fetherston

113. The investigation revealed that CCO Fetherston completed an officer's report on the afternoon Mr Searle died. The report was forwarded via email to CSO Clark at WCC at 2.30pm on 2 March 2019.[32] The officer's report contained the same information provided by CCO Fetherston in his police statement. He was standing by the doorway of the room and noticed Mr Searle cough up a large amount of black liquid followed by 'an even larger amount'. CCO McMath pressed the 'call for nurse' button to alert staff. At 10.05am, after the 'extra assistance' button was pressed, more medical staff arrived and CPR commenced at around 10.07am.

[30] B9.1 – Annexure – ROEDER, Ursula.pdf at p.1.
[31] B9 – Statement – ROEDER, Ursula.
[32] CCO Emails received on 17.03.22.

114. On 31 August 2021, CCO Fetherston was interviewed by Mr Brown. During the interview, CCO Fetherston recalled that he observed Mr Searle spit up black bile, blood and the nurse wiped it away.[33] Around 30 seconds later, Mr Searle vomited 'a whole bunch of bile' and he realised the seriousness of the situation. He saw CCO McMath press the duress button near the bed and the 'crash team' came into the room.[34] Mr Searle was declared deceased shortly after and he notified his supervisors at PAHSU and WCC.

115. CCO Fetherston could not recall how Mr Searle was restrained when asked during this interview.[35] CCO Fetherston confirmed that Mr Searle was to be observed constantly as part of the COPD as he was a prisoner with external escorts.

116. CCO Fetherston described the room as 'fairly big' with a single bed and toilet/shower to the side. For the majority of the time, he stood between the bed and the door. There was one exit from the room and the nurse's station was 'just outside the door'.[36]

117. CCO Fetherston stated that personal mobile phones are to be used during emergencies only. He could not recall the name of the nursing staff the day of the incident.

118. RN Nguyen's version of events was put to CCO Fetherston. He commented that he was definitely in the room as he remembered exactly what happened at the time. He asserted that he and CCO McMath were in the room. He said his officer's report and his 'offsider's' statement corroborated his statement. He had forwarded his officer's report to CS Clark upon completing it at WCC on the same date.

119. When asked, CCO Fetherston confirmed he did not leave his post on the day of the incident, he had no reason to leave his post and he provided adequate supervision to Mr Searle.[37] He was always in the room and QCS staff did not leave the room until after the case was handed over to CSIU.

CCO McMath

120. CCO McMath, like CCO Fetherston completed an Officer's Report and emailed the same to CS Clark at 2.40pm on 2 March 2019. The Officer's Report was consistent with the police statement CCO McMath provided. At 10.00am he saw fluid coming out of Mr Searle's mouth and he alerted the nurse. The fluid started flowing out of Mr Searle's nose and he pressed the 'yellow staff assistance' button' on the wall.[38] Staff attended the room and started CPR. After Mr Searle was declared deceased, he and CCO Fetherston contacted CS Clark at WCC and CS Hearn at PAHSU. After the room was secured and CSIU arrived, he returned to WCC.

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[33] ESG Material – Attachment 23 – Transcript – ROI – Shawn Fetherston at p. 10, Line 138.
[34] Ibid. 27
[35] ESG Material – Attachment 23 – Transcript – ROI – Shawn Fetherston at p. 12.
[36] ESG Material – Attachment 23 – Transcript – ROI – Shawn Fetherston at p. 17.
[37] ESG Material – Attachment 23 – Transcript – ROI – Shawn Fetherston at p. 31-32
[38] ESG Material – Attachment 21 – Officer's Report of CCO Shaun McMath.

121. On 1 September 2021, CCO McMath was interviewed by Mr Brown. CCO McMath's recollection of events was similar to those in his police statement and officer's report. However, he provided additional information. He stated that after witnessing black fluid come out of Mr Searle's mouth, he pressed the nurse button. He told the nurse 'something is not right with him', as he said this *"it was as if someone opened a tap and fluid started coming flying out of his mouth and nose"*.[39]

122. When asked if he left the room at any point that morning, CCO McMath stated he could not recall. He may have left the room to get coffee but CCO Fetherston would have been in the room. They would never leave the room at the same time. When they needed the bathroom, they used the bathroom adjoining the patient's room. He could not recall if CCO Fetherston left the room. If one of them had to leave one would stay in the room.

123. CCO McMath disputed the content of RN Nguyen's statement. He said that CCO Fetherston was on his work phone. Meanwhile, he was studying criminology and had a book on his lap and he was looking through his book. He alerted the nurse to come in.[40] When the nurse came, he pressed the button again to get more staff as he observed Mr Searle was not breathing. CCO McMath stated the vomit was more than 50ml as he will never forget what he saw and that the nurse never reported to anyone. He said the nurse was crying as she tried to wipe Mr Searle's mouth.

124. CCO McMath said that the nurse was 'panicky' and was 'dabbing' at Mr Searle's mouth. He yelled to her that Mr Searle was not breathing. After the nurse started crying and was still trying to wipe Mr Searle's mouth, he reached over her and hit the 'emergency yellow button'.[41] He stated that he was standing slightly back from the bed. CCO Fetherston was in the room by then and not in the doorway. Medical staff came running in and provided treatment. Mr Searle was pronounced deceased around 10.30am.

125. CCO McMath disagreed with Dr Hall's statement that Mr Searle was deprived of potential outcome changing assistance.

126. CCO McMath completed the Escort Occurrence Log after his shift. The log indicated that at 10.00am he *'alerted nurse to prisoner vomiting'*. At 10.05am he *'pressed yellow button for staff assistance'* and at 10.07am *'hospital staff began CPR'*.

Interviews with other QCS staff

127. As part of the investigation CCO Woodfield was interviewed on 2 August 2021. CCO Woodfield was not present at the time of the incident as he had finished the night shift and was replaced by CCO McMath and CCO Fetherston. CCO Woodfield stated that Mr Searle was 'gravely ill' and had been advised by medical staff that Mr Searle was expected to pass away in the next few days. CCO Woodfield confirmed a 'code blue' was called during the night.

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[39] ESG Material – Attachment 27 – Transcript ROI – Shaun McMath at p. 8.
[40] ESG Material – Attachment 27 – Transcript ROI – Shaun McMath at p. 22 – Line 376.

[41] Ibid. 33.

128. CS Hearn was also interviewed. CS Hearn is the liaison officer between Queensland Health and QCS prisoner's care at PAH. He commented that external escort outside PAHSU is the responsibility of the 'home' correctional centre. Apart from providing some documentation to the external escorts, CS Hearn could not recall much about the incident.

Incident Report of CS Clark

129. As noted above, both CCOs provided their officer's reports to CS Clark at WCC on the afternoon of 2 March 2019. CS Clark drafted an incident report which stated that officers on duty observed that at around 10.00am black fluid came out of Mr Searle's mouth and then from his nose. Staff called out to a nurse and pressed the extra staff assist button to call a code. CS Clark did not attach the officers' reports with his incident report.

130. The allegations against CCO McMath and CCO Fetherston were not capable of being substantiated.[42]

Addendum report from Dr Hall

131. On 7 January 2022, an addendum report was received from Dr Hall after he was asked to comment on the CCOs version of events and on the statement provided by Dr Bell.

132. Dr Hall commented that as indicated in his original report, he understood that the roles of the two CCOs was to supervise Mr Searle in relation to security and not as clinicians in the absence of medical staff. His understanding was and remains, that if there was a need for medical intervention or an emergency, that CCOs would alert medical staff and attend to basic first aid until medical staff arrived.

Comments on response from EDMS PAH

133. Dr Hall was pleased that Mr Searle's death was referred to the HPB M&M and the Division of Surgery Meeting where it was recognised that Mr Searle did not meet the protocol standards of conventional post-operative management (ERAS) due to the need for him to be restrained, and his comorbidities that placed him at higher perioperative risk.

134. Dr Hall stated that the initiatives developed as a result of Mr Searle's death are reasonable. The initiatives have encouraged dialogue and revision of how to manage individual cases in respect of the ERAS protocol leading to determining cases that would be safe to follow the protocols or cases that require alternative planning. The initiatives have led to improvements and review of patient safety being communicated to consultants and educating junior staff with the type of information that needs to be communicated to detect early or anticipated complications. Dr Hall noted that the PAH response acknowledged the unique situation of patients in custody and captured this in the recommendations.

135. Dr Hall concluded that patients in custody carry risks specific to maintaining a balance between security of the patients and other people at the hospital (staff, visitors etc) and the need to allow the prisoner privacy and be provided appropriate health care.

[42] ESG Material – Investigation Report (1) at p. 3.

Statement from RN Juvelle Maria

136. On 6 May 2022, the Coroners Court received a statement from CN Maria, who was the clinical nurse in charge at the time of Mr Searle's death.

137. Understandably, given the time that has passed, CN Maria had little independent recollection of Mr Searle's death. She recalled Mr Searle having Whipple surgery. She recalled in the hours leading to his death that she was told Mr Searle was not well. She recalled attending to Mr Searle straight away and she observed a correctional officer in the room but could not recall whether there one or two officers. She noted Mr Searle was in an 'upright position but slouched forward'. She started CPR straight away and called for the MET team.

138. CN Maria described the events that followed with other staff attending and providing treatment to Mr Searle without success.

Autopsy results

139. On 6 March 2019, Dr Beng Ong conducted an external and partial internal (neck, chest and abdomen) post-mortem examination. A toxicology test and CT scan was also conducted.

140. The post-mortem examination revealed evidence of recent medical and surgical intervention. The small bowel was distended with liquid present in accordance with ileus (interruption with movement of intestine). The surgical site demonstrated intact anastomosis and appeared normal. However, microscopic result showed localised secondary infection. There was no evidence of residual tumour.

141. According to Dr Ong, there was regurgitated material in the mouth and oesophagus. There was vomit in the trachea, bronchi, intrapulmonary airways, and in the alveolar spaces. The heart showed mild ischaemic change and was borderline enlarged. There was significant blockage due to atherosclerosis in the left anterior descending artery, a major vessel that supplies blood to the heart. There was mild blockage in the circumflex artery. The post-mortem examination revealed renal tubular necrosis given Mr Searle's history of reduced renal function and showed fatty changes in the liver.

142. The lungs showed evidence of emphysema and this was considered contributory to death in keeping with the cause of death being aspiration.

143. The heart related and liver conditions were found to not have contributed to death.

144. According to Dr Ong, the post-mortem examination revealed severe aspiration that involved vomit entering not only into the airways but also in the alveolar spaces of the lungs. The underlying cause was in accordance with ileus, which is a recognised complication of any abdominal injury but more prominent in injury involving the intestines. The existence of an infection could lengthen the period of the ileus.

145. Dr Ong concluded the cause of death to be:[43]
1(a) Aspiration of gastric contents*, due to, or as a consequence of*
1(b) Paralytic ileus, *due to, or as a consequence of*
1(c) Whipple surgery for tubulovillous of the pancreatic duct.

Other significant conditions

2. Emphysema

Conclusions on Coronial Issues

Findings required by s. 45

146. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all of the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – William Edward Searle

How he died – Mr Searle was a 74 year old man with recurrent ampullary adenoma. He was admitted to hospital for an elective pancreaticoduodenectomy (Whipple procedure). He was supervised on an acute surgical ward by custodial correctional officers. He was managed postoperatively under the Enhanced Recovery After Surgery Protocol. He deteriorated and died after aspirating on gastric contents as a result of gastroparesis.

Place of death – Princess Alexandra Hospital WOOLLOONGABBA QLD 4102 AUSTRALIA

Date of death– 2 March 2019

Cause of death – 1(a) Aspiration of gastric contents, *due to, or as a consequence of*
1(b) Paralytic ileus, *due to, or as a consequence of*
1(c) Whipple surgery for tubulovillous of the pancreatic duct.

Other significant conditions

2. Emphysema

Other issues

[43] Autopsy Report at p.10.

Whether the custodial correctional officers tasked to supervise Mr Searle complied with the relevant Queensland Corrective Services policies and procedures in place at the time of the death.

147. In her statement, RN Nguyen said that 10.05am, the nurse buzzer went off in Mr Searle's room. RN Nguyen went to the room. RN Nguyen noted one custodial correctional officer (CCO) who was on his phone was in the room at the time and the second CCO was outside of the room talking on his phone. Mr Searle had vomited and RN Nguyen cleaned up the vomit and went out of room and reported what had happened to CN Maria and disposed of the vomit bag in the pan room.

148. According to RN Nguyen's statement, she returned to Mr Searle's room at around 10.10am to find him soiled from the second larger vomit. She noted the two CCOs were not in the room at that time.

149. In her oral evidence, RN Nguyen maintained that the CCOs were not in the room when she returned from cleaning up the first vomit, but she accepted that her focus was on Mr Searle at the time, and not on the CCOs. However, she acknowledged it has been a long time since the incident, and that she could not precisely remember everything that happened that day. RN Nguyen told the inquest that she was busy attending to the four patients under her care during the shift, and documenting her interactions with the patients. There were over 20 interactions with Mr Searle and PAH medical staff recorded on the morning of 2 March 2019.[44]

150. CN Maria's evidence was that when she entered Mr Searle's room with RN Nguyen, she noticed one of the CCOs sitting in the chair near the window. She was not sure where the other CCO was. She said it was the usual practice for two CCOs to be nearby when a prisoner is on a non-secure ward, such as a HPB Unit. When RN Maria was asked about Mr Searle's restraints when she attended to him, she said that his hands were not restrained, as she was able to turn him over to check his airway. His right leg was shackled.

151. CCO Fetherston and CCO McMath said in their initial police statements, and in their interviews with Mr Brown, that they were present in Mr Searle's room.

152. In his oral evidence CCO McMath said that he was seated in the chair near the window, at the foot of Mr Searle's bed, when he saw a black stream coming from Mr Searle's mouth. CCO Fetherston's evidence that he was near the door of the room and was on the phone to a supervisor when this occurred.

153. Consistent with the findings of the ESG investigation, I am satisfied that at the time that Mr Searle had the aspiration event, CCO McMath and CCO Fetherston were both present in Mr Searle's room. There was no need for them to release Mr Searle's handcuffs as he was only shackled by the leg at that time. I am satisfied that Mr Searle was already sitting up when he aspirated, in accordance with the instructions given by the treating team.

154. I am also satisfied that CCO Fetherston and CCO McMath both complied with the relevant Queensland Corrective Services policies and procedures in their supervision of Mr Searle.

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[44] C12

Whether the actions of the nurse attending to Mr Searle at the time of his death were appropriate in the circumstances.

155. I accept the submission from Counsel Assisting that the most weight in considering the response of RN Nguyen should be given to the evidence of CN Maria. Her evidence was that that RN Nguyen was concerned about Mr Searle when after he first aspirated and that she acted appropriately. I am satisfied that RN Nguyen's actions as she attended to Mr Searle were appropriate.

156. CCO McMath asserted that RN Nguyen panicked and was crying while she attended to Mr Searle after he aspirated. This was in stark contrast to CN Maria's positive assessment of RN Nguyen's actions on the day. CCO McMath's evidence was not raised until September 2021 during the ESG investigation – almost 30 months after the death.

157. CCO McMath's evidence was that he had pressed the emergency call button. However, CCO Fetherston recalled that CCO McMath initially pressed the nurse call button, and the nurse attended. CCO McMath acknowledged in his evidence at the inquest that his entries in the Escort Occurrence Log on 2 March 2019 in relation to the timing of nurse attendance at Mr Searle's room were approximate and not comprehensive as they were completed later that day. For example, while the escort log indicated that he alerted RN Nguyen to Mr Searle vomiting at 10.00am, the hospital record shows he was administered a glucose solution at 10.02am and he had a small vomit at 10.05am.[45]

158. CCO Fetherston said in evidence that the nurse cleaned Mr Searle up in response to the nurse call button being pressed. She left the room, and as she was leaving Mr Searle had a second, larger vomit. This is largely consistent with RN Nguyen's evidence. CCO McMath was only able to remember the second, larger vomit. Neither nurse was able to recall during their evidence who had pressed the relevant call buttons.

159. The confusion about the response of the nursing staff in this matter appeared to arise from the CCOs misunderstanding of how calls for emergency assistance were made at the PAH. While CCO McMath pressed the emergency call button on the wall, this does not mean that the nurses were not properly attending to the patient.

160. I also accept that CN Maria called a Code Blue from the portable dect phone that she carried, which was appropriate in the circumstances.

161. The fact there are discrepancies between the accounts of the nurses and the CCOs over four years after Mr Searle's death is not of great significance. There was no evidence of any breach of policy or inappropriate conduct by either the nurses or the CCOs which had any impact on the outcome for Mr Searle.

162. Consistent with Dr Hall's opinion, I am satisfied that the medical care and treatment provided to Mr Searle at the Wolston Correctional Centre was appropriate and sufficient. I also agree with Dr Hall's opinion that the medical care and treatment at the PAH was also appropriate and sufficient, with the

[45] C12, p12.

exception of the several missed opportunities acknowledged by Dr O'Rourke to recognise Mr Searle's gastroparesis and risk of aspirating.

163. In relation to the missed opportunities, I am satisfied that Mr Searle's case has been given appropriate consideration by the PAH's HPB team. This has led to the development of better procedures in relation to the postoperative care of patients who have undergone a Whipple procedure which will address the issues in future similar cases.

164. I also note that there have also been changes made to the QCS COPD in that it expressly states the need for escorting officers to be vigilant at all times to be able to respond to changing circumstances while maintaining the security and well-being of the prisoner.

165. In those circumstances, I consider there are no comments or recommendations to be made in this matter under s 46 of the *Coroners Act 2003*, as sufficient remedial action has been taken by the PAH and QCS.

166. I close the inquest.

Terry Ryan
State Coroner
BRISBANE