QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Christopher Glen Essery**
FILE NO(s):	COR-4488/2020
JURISDICTION:	CAIRNS & BRISBANE
DELIVERED ON:	20 June 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	20 May 2024, 21 May 2024, 22 May 2024, 27 May 2024, 29 May 2024, 30 May 2024 and 12 July 2024.
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, health care related death, inflammatory bowel disease, optimisation for surgery, surgery.
REPRESENTATION:	DJ Schneidewin, Counsel Assisting
	HB Price, for Cairns and Hinterland Hospital and Health Service
	NW Needham, for Metro South Hospital and Health Service
	SL Lane, instructed by Caxton Legal Centre for the Next of Kin

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Introduction

[1] Christopher Glen Essery (Mr Essery) was born on14 February 1945.

[2] Mr Essery died at the Princess Alexandra Hospital (**PAH**) on 20 February 2019, at aged 74.

[3] The former Deputy State Coroner determined that the death was not reportable as defined by the *Coroners Act 2003* (**the Act**).

[4] By letter dated 9 March 2020,[1] Mrs Susan Essery (**Mrs Essery**) wrote to the then Deputy State Coroner and asked, in effect, for a reconsideration of his previous decision as she considered the death of her husband was due to a failure by clinicians providing his health care to treat and/or diagnose his condition.

[5] The State Coroner required Mr Essery's clinical records be produced from Mr Essery's treatment providers and then determined to reopen the investigation into the death of Mr Essery as a potential health care related death, as defined in the Act.

Coronial jurisdiction

[6] At the time of his passing, Mr Essery was a patient at the PAH.

[7] I consider that Mr Essery's death was a health care related death as defined by the Act. Mr Essery's death was thereby a reportable death under s.8(3)(d) of the Act.

[8] Pursuant to s.28(1) of the Act, I was satisfied that it was in the public interest to hold and inquest into Mr Essery's death.

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

[10] The role of the coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances surrounding the death, i.e. how the person died. Those circumstances are limited to events which are sufficiently connected to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Those are matters for other courts.

[11] The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[2] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence

[1] Ex A1 BOE
[2] *Briginshaw v Briginshaw* (138) 60 CLR 336

must be for the coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

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

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

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

Coronial investigation

[13] The coronial investigation revealed the following factual circumstances.

[14] Mr Essery had a past medical history including:

(a) Viral encephalitis in 2003;

(b) Bilateral inguinal hernias repaired in 2009 by Dr John Knott using mesh secured by tacks (**the mesh**);

(c) Epstein-Barr virus (**EBV)**, involving an ulcer of the rectum in 2017;

(d) Most relevantly, Mr Essery had complex Crohn's disease, being a chronic inflammatory bowel disease (**IBD**) characterised by

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

abdominal pain, change in bowel habit, weight loss, anaemia and fatigue that was diagnosed in July 2013 following biopsy of a perianal abscess. The perianal abscess was drained the following month. This condition resulted in further abscesses forming, along with fissures and anorectal fistulas that led to multiple episodes of drainage and the insertion of Seton sutures. Medical management involved immunosuppression with high-dose steroids and monoclonal antibodies.

[15] Mr Essery was admitted to the Cairns Base Hospital (**CBH**) on 1 February 2018 with fevers, diarrhoea and an elevated CRP[6] one day following a colonoscopy that revealed only mild patchy pan-colitis and a small healing rectal ulcer.

[16] A CT scan did not identify any collections and Mr Essery was managed with intravenous antibiotics and a tapering dose of oral steroids before being discharged on 3 February 2018 on oral antibiotics.

[17] On 8 February 2018, Mr Essery was admitted to the Cairns Private Hospital (**CPH**).

[18] Then, on 12 February 2018, a defunctioning loop ileostomy was performed By Dr Pieter Prinsloo (**Dr Prinsloo**) with formation of a stoma on the right side of the abdomen. The purpose of this was to 'rest' the bowel to aid healing prior to possibly performing a colectomy.

[19] Mr Essery was readmitted to CPH on 22 March 2018 for another flare up of his Crohn's disease and was treated with hydrocortisone and mercaptopurine.

[20] On 5 April 2018, Mr Essery was admitted to the CPH again with fever, abdominal pain, increased ileostomy output and rectal discharge, electrolyte disturbances and raised inflammatory markers, attributed to a flair of his Crohn's disease. Management included intravenous antibiotics and steroids as well as enteral feeding.

[21] Sigmoidoscopy on 20 April 2018 showed normal appearing colonic mucosa apart from scarring, primarily around the rectum, although the scope could not be advanced beyond 25cm due to a presumed stricture.

[22] A repeat abdominal CT scan was ordered on 14 May 2018 in response to deterioration with recurrent fevers and raised inflammatory markers whenever antibiotics were ceased. The scan revealed large intra-abdominal collections on both sides. Retrospective review of the CT scan by an expert suggests that a tack, or tacks were involved in the collections (see below).

[6] C-reactive protein; a non-specific marker of inflammation.

[23] These collections underwent CT-guided drainage the following day with '*thick green pus-like fluid*' aspirated; the culture of which grew several different species of bacteria.

[24] Repeat CT scan on 23 May 2018 showed no evidence of recurrence of the collections. However, it was thought that the CT scan showed poorly controlled Chron's disease. Mr Essery was also malnourished in the settling of immune suppression.

[25] On 25 May 2018 Mr Essery was transferred to the CBH for initiation of total parenteral nutrition (**TPN**) due to ongoing malnourishment and deconditioning, despite enteric feeds.

[26] Mr Essery made it home on 21 June 2018 only to be readmitted on 7 July 2018 and was found to have a subcutaneous abscess in the left flank within the abdominal wall.

[27] A CT scan on 8 July 2018 demonstrated a gas filled collection in the abdominal wall in the left flank. There was also a gas filled collection in the right side of the abdomen which extended to the pelvis and which was contiguous to two of the tacks related to the mesh. There was a second deep collection on the left side of the abdomen. Retrospective review of the CT scan by experts suggests that a tack (or tacks) and/or the mesh was involved in the collection, although there appears to be a difference of opinion as to the extent to which this is so.

[28] The left sided abdominal wall abscess was drained on 8 July 2018 by Dr Chiam who described two deep connections of the abscess but avoided exploring the extent of the connections because of concern about damaging the bowel.

[29] Mr Essery was commenced on IV meropenem and a plan was made to reduce his prednisone from 20 mg daily.

[30] On 10 July 2018, the right sided abdominal collection was drained under CT guidance.

[31] On 14 July 2018, abdominal wall cellulitis was noted and the abdomen was explored by Dr Hartslief in theatre. A connection with the small bowel was documented by injection of contrast into the site of the drainage. This bout of cellulitis was considered to be due to leakage of bowel contents into the abdomen and into the abdominal wall, caused by the Crohn's disease.

[32] Repeat imaging on 17 July 2018 demonstrated almost complete resolution of the right-sided collection but persistence of the ones to the left lower quadrant and flank despite the presence of the drains. On the right side the drain was seen to be adjacent to the site of hernia tacks.

[33] Whilst it was not possible to confirm on that study, it was felt highly probable that these collections communicated with bowel indicating the presence of enterocutaneous fistulas.

[34] TPN was recommenced from 19 July 2018.

[35] Repeat CT imaging with contrast on 24 July 2018 revealed a recurrent collection to the right side where the drain had been removed/ fallen out with extension to the abdominal wall. The presence of contrast was suggestive of a fistula prompting reinsertion of a drain the following day (25 July 2018).

[36] Over the next two weeks, there was continuing drainage of the enterocutaneous fistulae from right and left.

[37] Mr Essery was discussed at the Royal Brisbane & Women's Hospital (**RBWH**) colorectal Multi-disciplinary Team (**MDT**), and it was decided that surgery should be delayed until the enterocutaneous fistulas dried up.

[38] A flexible sigmoidoscopy was performed on 8 August 2018, which confirmed the distal sigmoid structure, with little inflammation in the rectum.

[39] An MRI was performed on 13 August 2018 because of concern for excessive radiation associated with the CT scanning. This demonstrated a right sided abdominal wall collection. Retrospective review of this scan suggests the mesh was involved in the collection on the right side.

[40] The collection was drained by Dr Chiam on 14 August 2018.

[41] On 17 August 2018, this drain site began to drain abdominal contents as well.

[42] After 6 weeks of broad-spectrum antibacterial coverage, antibiotics were ceased on 23 August 2018.

[43] An email sent on 27 August 2018 by Dr Jakob Begun (**Dr Begun**), Gastroenterologist at Mater Hospital in Brisbane, stated that proctocolectomy would be required in the future. In the meantime, surgical management of the current collections would likely be required. It was acknowledged that such a procedure would be at high risk of complications, so Dr Begun opined that the PAH was the most appropriate facility to deal with the complex management required. Although Mr Essery remained systemically well, increased discharge from the drain sites was noted and arrangements were made to transfer him to the PAH on 31 August 2018.

[44] On admission to the PAH, a detailed summary of Mr Essery's health 'journey' up until that time was documented. The history of bilateral hernia surgery was not recorded and whilst it was not listed under the previous medical history section in the Discharge Summary from CBH, the

paperwork provided did include an abdominal x-ray report from 14 July 2018 that noted evidence of previous hernia repair.

[45] Antibiotics and anti-fungal agents were recommenced on 1 September 2018 following the onset of fevers.

[46] An x-ray report of the lumbosacral spine on 3 September 2018 noted previous abdominal wall hernia repair but there is no documentation of this finding in the progress notes of the PAH.

[47] The opinion of the Colorectal surgical team on 11 September 2018 was to aim for control of the abdominal sepsis and to optimise nutrition prior to any surgical intervention. It was considered that in order to guide any surgery, the relationship between the small and large bowel to the enterocutaneous fistulas would need to be determined. The situation was discussed with Dr Peter Gourlas (**Dr Goulas**), Consultant Colorectal Surgeon, prior to him going on extended leave.

[48] Spontaneous eruption of a new surface collection resulted in cessation of oral intake and reliance upon TPN for nutrition.

[49] A subsequent CT scan on 18 September 2018 showed persistence of the known fistulas and collections with a possible new and deeper collection.

[50] Mr Essery's case was discussed at the Colorectal Multi-Disciplinary Team (**MDT**) meeting on 24 September 2018 with a consensus view that surgery would be considered only once the collections had resolved. Neither the previous bilateral hernia repairs nor the possibility of a foreign body in the form of mesh was documented in the notes from this meeting.

[51] Repeat sigmoidoscopy and ileoscopy on 24 September 2018 revealed only limited signs of active Crohn's disease at that time, which meant additional immunosuppression therapy was not required and the ongoing slow wean of steroids in order to improve wound healing was continued. The case was discussed by Gastroenterologists at the Inflammatory Bowel Disease (IBD) Complex Patient Meeting the following day with the plan to continue control of infection with antimicrobials, as well as to optimise nutrition with TPN.

[52] By the start of October 2018, the situation and apparent lack of progress was taking a toll on Mr Essery's mood and input from the psychiatric liaison team was requested, which eventually led to the recommencement of an antidepressant.

[53] A Radiology Multi Disciplinary Team meeting on 12 October 2018 noted complex anatomy making it difficult to define which parts of the bowel were involved in the fistulas prompting the performance of a fistulogram and CT scan on 16 October 2018. This scan confirmed communicating enterocutaneous fistulas to both sides of the abdomen with contrast seen in the jejunum and sigmoid colon.

[54] The fistulogram noted the presence of surgical tacks in the context of previous hernia repair, whilst the CT report noted the previous mesh repair of a left inguinal hernia. Neither report, however, included these points in their summary/conclusion and consequently, it seems, they were not 'cut and pasted' into the progress notes.

[55] Similarly, the report of an abdominal x-ray on 22 October 2018 that noted evidence of a 'lower abdominal/pelvic hernia repair' was not documented in the progress notes.

[56] An entry in the progress notes by the Colorectal team in October stated that definitive surgical plans had to await Dr Gourlas' return from leave.

[57] Consequently, another surgeon, Dr Bradley Morris (**Dr Morris**) was asked to consult on 2 November 2018 with his opinion being that surgery '*is likely to be at best futile, and at worst, result in further or more high output stomas. Chris will have no capacity to heal any serosal injury or bowel weakness, as evidenced by his systemic and laboratory malnutrition. I understand that without source control, Chris will likely continue to deteriorate, however at this stage I feel that an attempt at surgery in a hostile field will likely hasten his demise. I have explained to Chris and his wife that I am not sure there is a surgical solution, and his current situation may be preferrable to worsened fistulous disease with further surgery*'.

[58] An abdominal CT scan, performed on 21 November 2018, reported '*prior anterior abdominal wall mesh repair noted with both the left and right lower quadrant collections at the margins of the mesh*'.

[59] On 11 December 2018, Dr Gourlas was consulted, and he requested another CT scan with a view to performing further radiological drainage of collections, if possible. Although he thought surgery would be extremely high risk, Dr Gourlas felt surgery could be considered in February 2019 if Mr Essery improved.

[60] Following review of the CT scan performed on 13 December 2018 the radiologist felt the collections were not amenable to drainage. Once again hernia repair tacks were noted and reported to be within the collections.

[61] This CT scan was discussed at the Infectious Diseases Ward Round on 14 December 2018 where it was noted Mr Essery had an increasing white cell count, intraabdominal collections, and that there was a high risk of poor outcome should he develop resistance to meropenem. The CT findings as regards the hernia repair tacks were copied into the progress notes by Infectious Diseases team, but no additional comment about this was made by the admitting or surgical teams.

[62] After almost four months in the PAH, Mr Essery was transferred back to the CBH on Christmas Eve with the hope of regaining some strength prior to surgery. Recurrent intrabdominal sepsis prompted the recommencement of intravenous antibiotics and antifungal agents soon after admission to CBH.

[63] Mr Essery appeared to be progressing well until 14 January 2019 when recurrent fevers and radiological evidence of an extension of the left-sided collection prompted transfer back to the PAH on 17 January 2019.

[64] The admission note records the findings of '*bilateral iliac fossa collections which appears to be associated with surgical clips*' on the CT scan obtained at CBH on 27 December 2018.

[65] Surgery took place on 24 January 2019 revealing dense adhesions and five enterocutaneous fistulas involving multiple loops of small bowel and abscess cavities in both inguinal regions associated with the intrabdominal mesh from previous hernia repairs.

[66] As it was considered ill-advised to resect the affected bowel because any anastomoses would likely breakdown, affected areas of bowel were instead sutured.

[67] During the procedure, the mesh, along with a necrotic gallbladder, were removed.

[68] Bile-stained fluid from the right lower fistula prompted a decision to return to theatre on 1 February 2019.

[69] At that surgery, the breakdown of a previously repaired section of bowel was identified at roughly 50cm proximal to the existing stoma, with a decision made to resect that area and perform an end ileostomy forming a new stoma on the left side of the abdomen. The remaining areas of repaired bowel appeared intact on visual inspection at that time.

[70] Unfortunately, the surgical wounds began breaking down and there was evidence of further leaks.

[71] Bleeding from abdominal sites on 17 February 2019 necessitated a repeat abdominal CT scan that revealed worsening changes of peritonitis, along with free air in the abdomen that was suspicious for bowel perforation.

[72] Following discussions between doctors and the family, it was decided that no further surgical intervention would be attempted, and a decision was made to transition to comfort cares.

[73] Mr Essery passed away at 11:23am on 20 February 2019.

Death Certificate

[74] The amended death certificate issued 30 August 2019 specified the cause of Mr Essery's death as:

> "*1.Sepsis secondary to fistulating Crohn's disease;*
> *2.Abdominal sepsis associated with inferior mass*."

Inquest

[75] A Pre-Inquest Conference was held on 15 March 2024.

Issues for Inquest

[76] The List of Issues for the Inquest were:

> "1. 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;
>
> 2. Whether the care afforded to Christopher Essery at the Cairns Base Hospital was appropriate;
>
> 3. Whether the care afforded to Christopher Essery at the Princess Alexandra Hospital was appropriate.
>
> 4. Whether any aspect of the care afforded him caused or hastened his death;
>
> 5. Whether any failure to provide him with care caused or hastened his death."

Witnesses called

[77] In addition to the evidence contained in the Brief of Evidence (**BOE**), the following witnesses provided oral evidence at the Inquest:

(a) Dr John Reginald Knott;[7]

(b) Dr Pieter Willem Prinsloo;[8]

(c) Dr Merwe Hartslief;[9]

(d) Dr Roxanne Lokien Wu;[10]

(e) Dr Grant Withey (expert witness);[11]

(f) Dr Heng-Chen Chiam;[12]

(g) Dr Neal Martin;[13]

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[7] Ex G1.2 BOE; T1-11 – T1-27
[8] Ex G3.1 BOE, T1-27 – T1-56
[9] Ex C3.5 BOE; T1-58 – T1-70
[10] Ex C2.4 BOE; T2-4 – T2-42
[11] Ex D.4 BOE, T3-3 – T3-13
[12] Ex C3.4 BOE; T3-15 – T3-33
[13] Ex B3.2, B3.10, B3.16 BOE; T4-3 – T4-23

(h) Dr Candice Holland;[14]

(i) Dr Che-Yung Chao;[15]

(j) Dr Michael Whitby (expert witness);[16]

(k) Dr Peter William Gourlas;[17]

(l) Dr Joseph Cherng Huei Kong;[18]

(m) Dr Pramit Phal (expert witness);[19]

(n) Dr Michael Mar Fan (expert witness);[20]

(o) Dr Stephen Ian Allison (expert witness);[21]

(p) Dr Bradley Peter Morris.[22]

Hearing

[78] The Inquest commenced in Cairns on 20 May 2024 and continued in Cairns on 21 May 2024 and 22 May 2024. The Inquest was then adjourned to Brisbane for further hearing commencing on 24 May 2024 and continuing on 27 May 2024, 29 May 2024, 30 May 2024 and 12 July 2024.

[79] At the conclusion of the Inquest, I proposed:[23]

> "*DEPUTY STATE CORONER: I don't know, Ms Lane, whether you're going to be in a position to be able to answer this or you might need to speak to Mrs Essery afterwards but what I'm thinking, subject to anybody having a different view, is that we don't need to receive submissions as to whether or not the care afforded to Mr Essery at Cairns Hospital was appropriate. Does anybody have a view?*
> *MR SCHNEIDEWIN: I would support that position, your Honour.*
> *DEPUTY STATE CORONER: Mrs Essery, what I mean by this is I mean that I – the weight of evidence that is currently before me suggests that I could make only one finding and I'll be corrected if anybody has a different view but that finding, to my mind, having heard the evidence, having read all of the evidence, is that the*

[14] Ex B3.6 BOE; T4-24 – T4-37
[15] Ex B3.4 BOE; T4-39 – T4-55
[16] Ex D2 BOE; T4-57 – T4-71
[17] Ex B3.3 BOE; T5-4 – T5-46
[18] Ex B3.8 BOE; T5-48 – T5-79
[19] Ex D6 BOE, T6-5 – T6-18
[20] Ex D3 BOE; T6-19 – T6-58
[21] Ex D5 BOE; T7-3 - T7-25
[22] Ex B3.12; T8-3 – T8-36
[23] T8-36, LL 22 - 40

Cairns Hospital provided Mr Essery with appropriate care. So if that is the view of all of those at the bar table and if you do not have a view that's different to that, I will not require the parties to go to the extra steps of providing me with submissions in respect of the care provided him – provided to him at Cairns Hospital. I'll ask Mr Needham if he has a view before we might take some time for you to speak with Mrs Essery. I just think there – if that is the proceeding – the way we are going to proceed, we can save some cost and save some time by moving in that direction…"

[80] All parties represented at the Inquest agreed with the proposed approached.

[81] Consequently, there was no requirement for the parties to make any submissions in respect of Issue 2.

Evidence and findings on issues

Whether the care afforded to Mr Essery at the Cairns Base Hospital was appropriate?

[82] I find, in respect of Issue 2, that the care afforded to Mr Essery at the CBH was appropriate.

Whether the care afforded to Mr Essery at the PAH was appropriate?

[83] As to the status of Mr Essery's condition when he was transferred from Cairns to PAH, the expectations for his management at PAH, on 27 August 2018, Dr Begun, Gastroenterologist at the Mater Hospital in Brisbane, expressed the opinion that proctocolectomy would be required in the future. In the meantime, he thought surgical management of the collections Mr Essery then had would likely be required. It was acknowledged that such a procedure would be at high risk of complications, so Dr Begun opined that the PAH was the most appropriate facility to deal with the complex management required.

[84] At or about 11.33am on 28 August 2018, Dr Peter Kini entered the following note into the records of CBH:[24]

"*Case was discussed with Dr Neal Martin, Gastro/IBD specialist, at PAH.*
Dr Martin is happy to accept patient for further management at PAH ASAP.
I have informed Dr. Chiam, CBH Colorectal surgeon and Amanda Keating, CBH dietician of the plan.

[24] Ex C1.1, page 339 BOE

I have also informed the patient and his wife of the plan for transfer which they are very happy about.
We need to sort out all the paperwork and communication in regard to bed booking and transport arrangements."

[85] At Inquest, Dr Chaim explained his understanding of the purpose of the transfer as follows:[25]

"*And if you can just read that note and I'll ask you what you can recall about the situation at that time. Just read it to yourself?---Yes, I believe who – the gastro team made a decision to transfer him to a more major centre <u>for a second opinion</u> and <u>for consideration of more difficult surgery</u>.*
Okay. And you were consulted in relation to the surgical aspect of that decision?---Yes, I would have probably have spoken to somebody about it, yep.
And what was your view at that time in terms of Mr Essery's surgical risk?---It would still have been high.
Okay. Certainly not a risk that would be – would allow the procedure to be performed at Cairns Hospital?---We can do it, but it will probably be not be a good result.
Okay. More preferable to transfer to a tertiary centre?---<u>At least for another opinion, yep</u>."
(underlining added)

[86] Later, during examination by Counsel for PAH, Dr Chiam stated:[26]

"*Okay. So the plan to dry out through that – through the TPN wasn't as successful as we might have hoped?---Unfortunately, no.*
Yep. Is it after that that the PA becomes involved, so far as you're aware?---I think that we were sharing care with the gastroenterologists. The gastroenterologists were the main team looking after the patient, but we consulted regularly. So I believe the gastro team wasn't happy with the progression, so they made a decision to discuss with and transfer the patient. I'm not sure why it eventually went to the PA Hospital, but that's how it eventuated.
Sure?---There are surgeons at the PA who can manage this patient as well."

[87] Dr Hartslief's evidence about the decision to transfer Mr Essery to PAH was:[27]

[25] T3-27, LL25- 40
[26] T3-31, LL 9-19
[27] T1-67, LL 17-33

"*All right. And then – and again, indicate whether you can or can't recall specifically – as you know from the chronology of events, towards the end of August there was a decision made to transfer Mr Essery – – –?---Yes.*
– – – for further management?---Yes.
And it seems, at least from the Cairns Hospital perspective, it was for the purpose of some initial interim surgical management, with the view to definitive surgical management at some later date. Can you recall being involved in any discussions in relation to that decision?---I cannot specifically recall. I can only recall from what I've discussed with Dr Chiam in the last couple of weeks and from retrospectively going through the notes. Our – I think our collective feeling was that he probably needed major surgery but that we were very concerned that the surgery was very high risk and very likely to cause more damage, if not death, and that we felt that if such surgery was to be undertaken, it should be done in a tertiary centre, and that is why we didn't do major surgery on him in Cairns and why we referred him to – to Brisbane."

[88] Dr Wu was not directly involved in the care of Mr Essery whilst he was at CBH, but she undertook a thorough review of the record. In respect of the decision to transfer Mr Essery to PAH, she gave the following evidence:[28]

"*Can I ask you what – having regard to the record, what was Cairns Base Hospital's understanding of what would occur after that transfer?---<u>So our understanding would be that the underlying Crohn's disease, which was thought to be the culprit at the time, would be dealt with in a surgical manner, that is, removal of the affected bowel</u>. The ma – the part of the bowel to be removed wasn't specific, at this time, because – I have to say that before – before his deterioration and admission to Cairns Hospital, the private surgeons and physicians all believed it was just the colon and rectum, but Dr Hartslief's imaging showed that the small bowel was involved in one of the fistulae, which really made it difficult for people to understand. So – so they stopped talking about proctocolectomy and started instead referring to excision of the enterocutaneous fistulas, with no particular part of the bowel specified.*
And so they were potentially – that was a series of surgeries, potentially?---It pr – it was – <u>it would either be a very large single surgery or possibly there could have been a more definitive defunctioning operation with a par – with removal of one small bowel fistula and then coming back to do the other bit later</u>.."
(underlining added)

[28] T2-20, LL 5-20

[89] On the Discharge Summary dated 31 August 2018, Mr Essery's then issues were noted as follows:[29]

> "*1) Enterocutaneous fistulas on a background of Crohn's disease*
> *- pigtail drain re-inserted 25/7 via medical imaging into recurrent right abdominal wall collection*
> *- 42 days of Piptaz ceased on 23/8/18*
> *- definitive surgical management depending on progression with TPN and fitness for surgery / anaesthesia*
> *- Increasing pus discharge from both left and right ex-drain sites into coloplast bags 30/08/2018*
> *- remains systemically well*
> *2) Addisonian insufficiency*
> *- Risk of adrenal crisis with withdrawal of long-term exogenous corticosteroids*
> *- Prednisolone, currently 5mg (D3)*
> *3) General deconditioning and malnutrition*
> *- On cyclical TPN for enterocutaneous fistula*
> *- rate 150ml/hr*
> *- D42 (initiated on 19/7/18)*
> *- BSL remaining stable*
> *- Commenced polymeric diet.*
> *- Asymptomatic postural hypotension*
> *ARP : For IV fluids, antibiotics and TPN*
> *Weight 57.10kg (29/08)….*
> *…..*
> *Prior to this admission on the 07/07/2018*
> *- Prolonged admission under gastro and haem for severe fistulating crohn's and rectal lymphoma (7 weeks at*
> *Cairns Private under surgeon Mr Prinslou, followed by 4weeks in Cairns Base Hospital), onset of pelvic /*
> *intraabdominal abscesses ~ 6 weeks into admission*
> *- recently started on Vedolizimab, has had 2x infusions on persistent high dose prednisolone (20mg) in the*
> *meantime."*

[90] By the time of transfer to PAH, Mr Essery had been subject to optimisation therapy (TPN) for a period of 42 days without progress.

[91] The Discharge Summary noted: *"-> for expedited transfer to PA for ongoing perioperative medical management and operative input under Dr Martin's care*."

[92] Dr Holland, an advanced trainee Infectious Diseases Registrar at PAH, stated that the "*reason for transfer at that time was to <u>seek the input of tertiary specialist care</u>, predominantly the <u>inflammatory bowel disease</u>*

[29] Ex C2.2.2 BOE

gastroenterologists and surgical expertise that were specific to inflammatory bowel disease ."[30] (emphasis added)

[93] Given Mr Essery's prolonged period on TPN at CBH and lack of progress, as well as the evident reason for his transfer to PAH, I consider that early post-admission Consultant Gastroenterology and Consultant Colorectal Surgical review would have been appropriate.

[94] In my view, this is something Mr Essery could reasonably have expected to occur as part of formulating an appropriate management and treatment plan.

[95] Otherwise, in considering the appropriateness of the care afforded to Mr Essery at the PAH, there are number of sub-issues:

a) Whether there was an appropriate post-admission Consultant Gastroenterology and Consultant Colorectal Surgical review to formulate an appropriate treatment and management plan for Mr Essery at PAH?

b) Whether the ongoing care of Mr Essery at PAH was appropriate?

c) Whether any regard, or appropriate regard was given to the presence of the mesh and the implication of such for the treatment and management of Mr Essery at PAH?

Early post admission review

[96] As stated, Mr Essery was admitted to the PAH on 31 August 2018. He was admitted under the Gastroenterology Team. Mr Essery had been accepted for admission to PAH by Dr Martin.

[97] At the Inquest, Dr Martin explained the usual procedure for reviewing patients admitted under the Gastroenterology Team:[31]

> "*Okay. So Mr Essery came to be admitted at the Princess Alexandra Hospital from about the 31st of August, from my recollection. Now, just in terms of – he came to be admitted under the gastro team; is that correct?---Correct.*
> *As the primary team – – –?---Correct.*
> *– – – to be providing the treatment and care of Mr Essery. Now, in terms of I guess procedure – or usual approach to a – taking in a new patient under the care of the gastro team, what generally occurs in terms of admission, history-taking, who takes the history, what sort of things are inquired about the entry – if you*

[30] T4-25, LL 4-6
[31] T4-7, LL 5-50

could provide a – just a generally summary?---So I guess if – if – if a patient is unwell and needs to come to PA, what would usually happen is the Registrar or consultant of the team would contact the – the Registrar at the hospital. Then the Registrar would talk to the relevant gastroenterologist. So whether that would be whoever's on take that day or if there's a specific concern. So if it's – if it's a inflammatory bowel disease, then it would come to whoever's on the ward for inflammatory bowel disease – and that would be either myself, Jeff or Daniel Berger.
Yep?---That's – and then they would come to the hospital. If they're quite unwell, sometimes they'll go through the emergency department and get reviewed by the emergency department for whatever reasons. If they're not too unwell, they go directly to the bed in the ward. And then usually the resident will come and admit the patient – that means take a full history, write up all their medications they need to be on, and then the patient will usually be reviewed by the Registrar as well. Maybe add to the history. Make sure everything's all done. And then depending on how sick they are, they consultant might come along on their ward round – usually there'll be a few ward rounds a week, but if somebody's quite unwell, they might – might need to be reviewed immediately.
Okay. And when did you first review Mr Essery – do you have a recollection of that?---I think – I think Jeff was on in September – Jeff Chao – you don't mind if I use first names, do you?
Not at all?---Jeff – Jeff was on in September.
Yes – sorry. So that we understand what you're saying there, you do it – you take in patients – – –?---We rotate monthly.
You rotate – – –?---Yeah.
– – – monthly to take patients under your care. Yeah?---Pretty much. Yeah. I mean, I – I – I don't know if I was on the ward at the time when I got contacted, but I was happy to accept him because, you know, I think he needed to come down to Brisbane. But yes, Jeff – I think Jeff was on – I – I don't think I saw Mr Essery when he first arrived – I don't know if I just popped my head in to say hi or not – I don't think – – –
Right?--- – – – I'm not sure. But the first time formally would have been at the end of September when I was taking over the ward."

[98] Dr Martin indicated that he understood Mr Essery was initially reviewed by Dr Che-Yung (Jeff) Chao (**Dr Chao**) on 6 September 2018[32] (see below).

[99] In the meantime, Mr Essery was reviewed by Dr Holland, then an Advanced Trainee in Infectious Diseases (**ID**) medicine. According to her statement:[33]

"5. On 3 September 2018 at approximately 10.29am I performed an initial consult following referral. As part of this initial assessment, I noted his previous medical history including reason for transfer to PAH,

[32] Dr Chao in fact first reviewed Mr Essery on 4 September 2018
[33] Exhibit B3.6 BOE

*previous medical imaging and pathology testing as well as previous and current medication. I particularly noted the acute issue of his infections and noted the type of organisms that had been identified from samples sent for testing and previous antimicrobial treatments. I reviewed his current antimicrobial medications. I reviewed his current blood results particularly noting the C Reactive Protein (**CRP**) and White Cell count (**WCC**). My impression was bilateral Enterocutaneous fistula (a connection between his small bowel and the skin on both sides of the abdomen), which were free draining. My initial recommendation was to continue tazocin and caspofungin and await the results of the planned imaging of MRI and small bowel series."*

[100] Dr Holland undertook subsequent reviews on 4 and 5 September 2018, the first of those reviews being part of the consultant ward round with Dr Naomi Runnegar, ID Staff Specialist. In general terms, the ID plan for Mr Essery at that time was to continue tazocin and casofungin and to await the colorectal surgical review of the images thus far available, and to then assess whether any further ID intervention was required.[34]

[101] Mr Essery was first reviewed by a member of the Gastroenterology Team, Dr Chao, on 4 September 2018. According to Dr Chao's statement:[35]

a) He recounted the progress of Mr Essery's Crohn's disease and the treatments he had undergone to date;

b) He noted Mr Essery's reduced appetite and oral intake;

c) He addressed patient concerns relating to the use of protein supplementation and informed Mr Essery that the supplements would help maintain gut health and potentially improve inflammation;

d) He reiterated the complex nature of Mr Essery's condition to him, his wife and daughter who were present;

e) He informed the Esserys that they had to manage his abdominal collection/ infection first, but that surgery would likely be required as part of his future management once his condition improved and he was fit enough to undergo the surgery.

[102] At the Inquest, Dr Chao explained the interplay between the Gastroenterology Team and the Colorectal Surgeons (albeit in the context of a point in time much later in Mr Essery's management) as follows:[36]

> *"…we still – we continued to request review by the colotomy surgeons to assess his conditioning. And then potential role for surgeon. Because I – it's not just up to us to decide whether patients should go for surgery or not. We need to consider – we*

[34] Exhibit B3.6 BOE, Paragraphs [11], [12]
[35] Exhibit B3.4 BOE, Paragraph [16]
[36] T4-47, LL 37-50 – T4-48, LL 1 -17

need to involve the specialist surgeons, because they will have the ability to assess whether, you know, there's the surgical technicalities and the success rate or benefit and complication rate etcetera. So ee – at that time, we still continued to engage the colorectal team. And that's why Dr Morris came to review the patient further to provide an additional opinion as to, you know – at that time, it's clearly showing that Mr Essery has not made any significant improvement in the medical condition. And also his clinical condition – the deconditioning and malnutrition has not improved also. That's why even though that things have not improved, we con – we ask them to return to review the patient again to see whether surgery is potential – can be offered, and the timing of surgery. So that's why we've never excluded surgery, in terms of the management. And then that provides more opportunity for them to review what's been happening including images, and then to determine whether that more assistance can be offered. Because we're already providing them the maximum amount of medical therapy as we can, as a gastroenterologist. So we continue to ask the question, can we do surgery, if he – if he can do surgery, when can we do surgery. Yes.

Yeah. And I accept that that's a surgical decision, not a gastroenterologist decision, but as the gastroenterologist who's undertaking the medical management of the patient who is not progressing, you would at least be, as you've described, inviting or requesting the surgeons to review the situation because it's the case, isn't it, that Mr Essery by this point was getting to the stage where only surgery was likely to resolve his issue, would you agree with that proposition?---Exactly. And that's why I made it very clear in my first meeting with Mr and Ms Essery and their daughter, that surgery's likely to be needed, but Mr Essery need to improve clinically in order to be able to go – undergo abdominal surgery to – to achieve a certain success rate. Yes."

[103] Quite evidently, each of the ID and Gastroenterology teams forecasted that definitive management of Mr Essery's condition would likely involve surgical intervention and looked to the Colorectal Surgical team's views in that regard to inform their interim management of Mr Essery. As had been the case with each of the ID and Gastroenterology teams, early Colorectal Surgical Consultant review should have been expected.

[104] It would seem that upon transfer to the PAH, Mr Essery was assigned to the care of Dr Gourlas, Consultant Colorectal Surgeon, being one of six colorectal surgeons in the Colorectal Surgical team. At the Inquest, Dr Gourlas explained that:[37]

"*Okay. Doctor, you came to first become aware of Mr Essery in late August and early September of 2018. Is that correct?---Yes.*

[37] T5-5, LL1- 15

And at that time, what did you understand was the situation that Mr Essery was in and the purpose for his transfer to the Princess Alexandra Hospital?---The handover was that he had had severe fistulating Crohn's disease that had been – treated for a number of months at Cairns Base Hospital. They had tried to transfer him to the Royal Brisbane and Mater Hospitals but they were turned down, thinking they couldn't achieve anything further. He was accepted by Dr Gillespie and Dr Martin at the PA Hospital. I was advised the afternoon before I went on long service leave that he had arrived and I requested that he – it sounded to me as though he wasn't fit for surgery at that point in time and I requested him to be placed at our multidisciplinary team meeting on the Monday. That's a meeting that I'd set up when I came back from Cambridge, which was attended by all the surgeons, radiologists, pathologists, etcetera to – for a decision as to what – so we present complex cases at these meetings to try and get the opinion of everyone as to what the further management going forward should be."

[105] Later in his evidence, Dr Gourlas explained:[38]

"*And I just then want to draw your thinking back to how you became involved at that time. And that was on the eve of your going on long service leave, I understand; is that correct?---I – I – so we have a – a roster system where the person is on-call on a Monday, does on-call for the hospital for the rest of the week, so it was my lucky week to be on call that week - - -*
Right?--- - - - but I was leaving after that Thursday operating leave – session to go on long service leave.
All right. So he happened to come under your – Mr Essery came under your care because of the way the rosters worked, essentially?---Yes."

[106] Although Mr Essery came under Dr Gourlas' care in the way described above, Dr Gourlas did not physically review Mr Essery before going on leave (he first reviewed Mr Essery on 11 December 2018 after he returned from long service leave).[39] Rather, he referred Mr Essery's case for discussions to the Colorectal MDT meeting, to be conducted the following Monday (MDT meetings were conducted every Monday).

[107] However, Mr Essery's case was not discussed at the MDT meeting the following Monday. It was not until approximately 3 weeks later on 24 September 2018, when Mr Essery's case was presented to the MDT by the then Colorectal Surgical Fellow, Dr Joseph Kong (**Dr Kong**) (see below).

[38] T5-15, LL37 – 46
[39] T5-17, LL1-2

[108] Further, although the Colorectal Surgical Fellow, Dr Kong, reviewed Mr Essery regularly, Mr Essery was not physically reviewed by a Colorectal Surgical Consultant until 2 November 2018 when Dr Bradley Morris (**Dr Morris**) agreed to review him (see below).

[109] To put this into context, there is no record or other evidence to indicate that in the period 31 August 2018 to 2 November 2018 (a period of about 8.5 weeks) Mr Essery was physically reviewed by a Consultant Colorectal Surgeon, notwithstanding that he was referred to PAH for that purpose and it was generally understood by others involved in his care (ID and Gastroenterology) that colorectal surgical opinion would likely guide the treatment and management of Mr Essery at PAH.

[110] Dr Gourlas gave the following evidence about this circumstance at the Inquest:[40]

> "*And it strucks – strikes me that that is somewhat surprising, given the state of – the condition that he was in. Do you have any comments about that?---I think Dr Martin mentioned to me that he had spoken to Dr Morris a few times to ask him to turn up to see the patient, but - - -*
> *He told you that after you returned; is that right?---He told me that a few times.*
> *Given – is it otherwise the case that the registrars are simply reporting to the consultant that's on call and that could be any consultant from week to week to week?---Mostly, yes.*
> *Okay. And can I suggest to you that for a patient as critical as Mr Essery, that really is problematic from a – you know, a continuum of care?---Yes, I agree. I must say, I was surprise[d] that he was still there when I came back from long service leave.*
> *Well, what was your expectation? Having formed that provisional plan when you went on long service leave, did you have a – something in mind in terms of what would likely happen while you were away?---Well, I – ideally, you would have got him to a point where he was fit enough to have undergone surgery and someone would have performed the surgery."*

[111] Counsel for Mrs Essery also took up the issue of early Colorectal Surgical Consultant review with Dr Gourlas, in respect of which he provided the following evidence:[41]

> *"But the first time he was physically seen by a consultant was when Dr Morris saw him in November; is that – that's correct, isn't it?---According to the notes.*
> *I think counsel assisting asked you that. So notwithstanding there are six surgeons who are potentially on roster during that three*

[40] T5-19, LL24 - 44
[41] T5-40, L45 – T5-52, L4

months, he was only seen for the first time in November. Doctor, is it possible that while you were on long service leave your patient fell through the cracks and wasn't attended to as he should have been?---Well, every day the patient is seen by a registrar, fellow, and nursing staff. So there's documents of that every day, so I don't think he fell through the cracks. Whether or not the fellow thought that he would – had a significant issue that he should be calling another consultant for advice, I'm not sure. If he felt that things weren't improving or he wasn't improving, he would normally – I get phone calls every week from the fellow saying, "This is an update. What do you think?" So, you know, I – I don't think he fell through the cracks. He's been seen every day, sometimes twice a day.

But not obviously by consultant colorectal surgeons, and not until November - - -?---No.

- - - was he actually assessed by one?---Well, clearly, they mustn't have thought that there was a concern that they need to cause – call a consultant. I can't really - - -

Okay. Well, can I ask you to [indistinct] given your assessment of Chris when you returned on the 11th - - -?---Yeah.

- - - would you have expected that he perhaps would have been assessed by consultant colorectal surgeons sooner than he was in November?---<u>Possibly</u>.

Would you have thought that might be more appropriate in his case, which I [indistinct] was a particularly complex one?---Yes.

And what you're saying, though, is that it was really up to the fellow, so this is Dr Kong - - -?---Mmm.

- - - to determine whether that assessment was required at an earlier stage?---Yes.

If you had not been on long service for that three-month period, is it likely you would have assessed him sooner yourself?---Well, I'm in there one day a week, and typically I try to catch up with patients on that day.

So is that a "yes", sorry?---Well, yes, if I was worried about a patient.

I see. And would that have been dependent upon what Dr Kong was telling you about the patient?---Well, if a Fellow calls me and says they have got a problem with a patient, I'll go in and see them that day.

Okay. And, otherwise, your usual procedure would be to try and see a patient when you're in there once a week?---Yes.

So is it true what – is it fair to say, then, that perhaps if you had not been on leave at that time, that you might have seen your patient at an earlier time than Dr Morris did, in person and assessed him physically?---<u>Probably.</u>"

(emphasis added)

[112] At the time of Mr Essery's admission to the PAH, Dr Kong was in his first year as a Colorectal Surgical Fellow. He first examined Mr Essery on 4

September 2018. As to his role and that of the Colorectal Surgical Consultants' role in reviewing Mr Essery, he gave the following evidence:[42]

> "*And one of the things that has been raised in the course of this inquest is whether, from a systems – from a systems point of view, it would have been more appropriate to assign another consultant to Mr Essery, given Dr Gourlas would be absent for such a considerable period of time. Now, do you have any comments about that – about the appropriateness or otherwise of that?---Yeah. So it's quite normal, when Peter – Dr Gourlas went away that the next – the following week, whoever the consultant is covering colorectal, I will report to that consultant, which is, I believe, Dr Brad Morris, according to the clinical notes.*
> *And is that the consultant you then - - -?---And - - -*
> *Is that the consultant you then report to consistently throughout the period that Dr Gourlas is away or do you report every week to a different consultant, depending who is on call?---No. So it – it's quite normal to just report to one consultant for continuity of care, particularly someone complex like Dr – Mr Essery.*
> *And it's your recollection that that consultant was Dr Bradley Morris; is that what you're saying, having review the notes?---Yes, that's right.*
> *And is it – I'm sorry to be – if I'm repeating myself, but is that then – the effect of that, then, is that Dr Morris effectively stands in the shoes of Dr Gourlas for the period that Dr Gourlas is away; is that how you see it?---Yes, he would be the responsible consultant - - -*
> *Okay?--- - - - until Dr Gourlas is back. All right. Now, we know that Dr Gourlas had already departed for his long service leave by the time of the MDT meeting on the 28th of September. Were you in attendance at – did you present the patient at that meeting or did Dr Morris present the patient at that meeting?---I presented the patient, I believe, on – and I have documented on my clinical notes.*
> *Okay. And that meeting, I gather, involved all of the consultants who were available at that time in the team?---Yes, that's right.*
> *Okay. And - - -?---Yeah.*
> *And it seems that Dr Morris was available at that meeting – or was at that meeting; is that correct?---Yes.*
> *Okay. And - - -?---Correct.*
> *- - - I appreciate – and you can again refer to the notes or what you have learnt from the notes – what was the plan in relation to managing Mr Essery at that meeting?---According to the notes, it says to:*

[42] T5-58, L22 – T5-59, L34

Continue the current management of a period of optimisation and to treating any intra-abdominal collections to control the infection.

All right. And your ongoing role, then, Dr Kong, is to review the patient on a regular basis and then report back to the consultant as necessary; is that a reasonable description of your function after that?---Yeah, so I believe I saw him every two to three days, depending on the clinical needs and I would report back to Dr Morris if a scan is done or if there was any intervention required, because ultimately, the consultant is responsible for the patient and it is my role to make sure that the consultant is aware of each surgical intervention - - -

Yes?--- - - - because if there was any complications related to the recommendation – it's mainly for patient safety, all right? You don't want to cause any harm to individual patients…."

[113] Later in his evidence, Dr Kong stated the following:[43]

"*I was genuinely concerned at the time [at the his initial review of Mr Essery on 4 September 2018] when I first met him and was very guarded with my recommendation to him with – and therefore I, at the time, I've spoken to Peter Gourlas – Dr Gourlas about him. I'm not even sure whether I've made him come to see the patient. I can't remember. I would normally if the patient are extremely high risk so that the consultant can make an independent assessment.*

Yes, it doesn't appear as though Dr Gourlas did see him at that time. Dr Gourlas didn't see Mr Essery until 11 December and - - - ?---Yep.

- - - so perhaps he didn't – so it appears that he didn't come as you thought he might have. Can I also tell you that it doesn't otherwise appear from the record that any consultant reviewed Mr Essery - - -

DEPUTY STATE CORONER: Colorectal surgeon.

MR SCHNEIDEWIN: Any consultant colorectal surgeon reviewed Mr Essery in person until Dr Morris did in the beginning of November 2018. It seems that that's a long period of time without colorectal consultant review. Would you agree with that?---Yes. I would.

Do you have any recollection of seeking consultant review prior to the 2nd of November 2018?---I don't have any recollection, but – well, I don't have any clear recollection, but I would have – I would have spoken – I would have updated Dr Brad Morris about every – everything that has happened with Mr Essery."

[114] Dr Morris gave the following evidence about this issue on the last day of the Inquest:[44]

[43] T5-67, LL8 - 32
[44] T8-18, L40 – T8-21, L6

"- - - to the Princess Alexandra Hospital and as we understand it, upon being admitted to the hospital, he was admitted under the – primarily under the gastroenterology team and that a colorectal surgeon was also assigned to his management and who that was, it seems, depended on who happened to be on call at that particular point in time. Would you agree that that was how the process worked in terms of the assignment of the colorectal surgeon?---Yeah, I – I think most, as a routine, as a general, would be the case.

Okay, and that happened to be Dr Peter Gourlas or Gourlas - - - ?---I – I believe so.

- - - at that time? And as we understand the evidence and as we know, this was very close to the time that Dr Gourlas went on long service leave or was to go on long service leave and we also know that he wasn't – he didn't review the patient before he went on long service leave. The – there's some contradictory evidence about what then happens in those circumstances. Some have given evidence to the effect that in the circumstances where the surgeon who's been assigned for the patient is absent, on leave or whatever reason can't review, a person in the position of Dr Kong would inform or report to whichever colorectal surgeon happened to be on call from one week to the next and the effect of that evidence seemed to be that that might be a number of colorectal surgeons throughout the period that the primary surgeon is on leave. Other evidence suggests that a person in Dr Kong's position would report to the surgeon who happened to be next on call after the primary surgeon went on leave and that that surgeon effectively took over the care or all the management of the team and that was Dr Kong's view. Now, what was your understanding in those circumstances? Who was directing the ship from a surgical perspective for the 12 weeks that Dr Gourlas was away on leave?---I think that the structure of the PA colorectal unit is that the – the director is quite explicit in providing a colorectal surgeon 24 hours a day, seven days a week for the entire year.

And this is Dr Luton? Is that who you're - - -?---Dr Lutton.

Lutton, yes?---Yeah, and – and what this means, that over and above you're rostered on call in emergencies, you are around for the week with the view that any subspecialties that don't have the expertise to deal with a colorectal problem or any specific inpatient problems that need colorectal as opposed to general surgery could be dealt with and – and that's – that's a big difference from any other unit I've worked in. It means you're on unpaid on call but with an expectation that you're committed to 24 hour seven coverage at the PA colorectal unit once every four – six weeks. Depending on the number of consultants, once every six weeks, perhaps. There are – there are several pathways for referral and it really didn't matter to the unit how that happened. They may have come via registrars, fellows, director, consultants

from other hospitals or other units. Generally speaking, the person on for the week would – it was – it coincided that if you were on a Monday night on call for emergency, you cover all general surgery and then the remainder of the week, you were the colorectal person and – and that meant that most knew things that came in a Monday night, you were around to, you know, tidy up over the course of the week and so generally speaking, the person on the week would be the first port of call for – for the fellow. In saying that, the – the unit is very collegiate in the sense that any – I won't say all but it would be very frequent and every week, a treating surgeon will say can we look at this? At the end of our [indistinct] would be a unofficial, hey, I've got this patient, can this radiologist – particular radiologist look at the scans? What do you guys think? This is what we're thinking. And so it was ne – no one of significant complexity at the PA was ever managed by a single surgeon. There was never that – that's Dr Lutton's patient, I'm not getting involved. It was all very much, yeah, this is what I would do, no, I wouldn't do that, and much of that is all directed via CTs and – and multidis – multidisciplinary team meetings and – and lots of patients can be managed. You know, we talk about rectal cancer and defined management without ever meeting the patient and you know, perhaps there are pros and cons to that. For – in the period of leave, I would – I would suggest that if there's someone that that surgeon knows is going to cause a problem or is like, hey, this guy might need a col – his colon out in the next week, that would be handed over. If – on – on a ward of complex patients, if – and this is still sort of the model of practice. If something happens and that surgeon's not involved, the – the fellow would go to the surgeon on call because they're around. If that person's not on call, they'd go to the next one and there isn't a single surgeon in that unit who wouldn't help out Dr Kong or any fellow or registrar or intern. I – I think that the discussions around Mr Essery, and I can't recall, but knowing how that unit functions, the discussions around Mr Essery surgically, particularly with Dr Kong, far exceed what's written in the notes. He [Dr Kong] did a ward run every day on every patient barring, I think perhaps a weekend. I think we gave him one weekend off a fortnight. So he was there 12, 14 hours a day. He knew everything and everything about everyone on the ward and every day, he would come into theatre and operate with the consultant and while you're operating, we would talk about what's on the ward, what's happening and you would grill him, teach him, educate him, discuss, oh, this guy's got this patient and so it would be – it would seem near impossible to me that that wasn't happening far more regularly than is perhaps notated, so I – I think I've distracted from your ques – question, sorry.

Yes, I think the concern about this - - -?---Yeah.

- - - is that – that is, you know, there's always a consultant available, consultant, colorectal surgeon available on a 24/7 basis on a weekly roster - - -?---Yeah.

- - - of who's on call, who's not on leave. Sounds like it provides good cover - - -?---Yes.
- - - for when the treating surgeon is absent or what have you?---Yeah.
But the concern that – well, what might seem to be – well, what seems to be an obvious concern is continuity of care for a patient. Now, I guess you described a collegiate environment which may ameliorate that concern to some extent?---Yeah.
I'll come back to that but I just want to canvass this with you: that system might work okay and reasonably well in circumstances where treating surgeons are absent on leave for shorter periods of time but when a treating surgeon with a complex patient is on – is to go on leave for a very extended period of time, what I'm suggesting to you is it would have been better for that particular patient or those – or indeed, all the patients of that particular surgeon to be handed over to another treating surgeon given the extended period of time. Have you got some comments about that?---I – I – I would concede – I would concede that that's – that's reasonable.
Okay. And that doesn't appear to have occurred on this particular occasion, that there was a handover of Mr Essery to any of the other surgeons on the team by Dr Gourlas for that 12 weeks that he was away?---I'm not aware that – that there was - - -
Well, he wasn't handed over to you in a formal way, I gather?---Correct."
(emphasis added)

[115] Further, as to whether Mr Essery was effectively under his care in the absence of Dr Gourlas, and as to his usual practice in reviewing patients under his care, Dr Morris stated:[45]

"*Okay. Now, I want to canvass these points with you in that context. Dr Gourlas gave some evidence, and I can take you to the transcript if we need to, to this effect: that if he had been – if he had not been on leave, it's likely that he would have reviewed Mr Essery at a very early stage in his admission, personally reviewed Mr Essery, and probably would have re-reviewed him relatively regularly, perhaps on a weekly or fortnightly basis, throughout that 12-week period that he was absent. That would have been his practice. Does that accord – would that accord with your practice for those patients that were under your care or for which you'd been assigned as the treating surgeon?---I – I believe so, yeah. Yeah, I think there would be some fluid – fluidity around how often someone requires to be seen. They maybe need to be seen in an hour this week, today. In an IVD* [sic – IBD] *setting where it's a, hey, heads up, this guy's going to come to your way six to 12 months, I think that that's a little bit – little bit different.*

[45] T8-21, L8 – T8-22, L10

DEPUTY STATE CORONER: Mr – sorry. Sorry, Doctor. Continue?---It would be my practice to review patients on the ward as the treating consultant regularly and then if there was a departure from their expected care is actually probably the trigger for me. There may be patients I operate on that do really well and go home in a couple of days that I didn't see but as soon as something departed or as soon as a concern was raised by the fellow, that would be a trigger over and above. If someone needs an operation that day, as a fellow-led unit, that fellow is – depending on their expertise and experience, the fellow would come to you and tell you the story and say this IVD [sic – IBD] *patient has an – an acute problem, that we need to take that colon out tonight. You might not – you – that might be enough. You might look at the scans, the numbers and that. That's enough of a decision. <u>But it would be my practice typically to review someone, yeah, in a reasonable timeframe depending on the perceived acuity of their problem</u>.*

MR SCHNEIDEWIN: Her Honour might have a question but if I may, I'll just continue. As I was indicating to you previously, there is contradictory evidence about how it was or who it was that would take over Mr Essery, if I can put it that way, in the absence of Dr Gourlas for the 12 weeks he was on long service leave and the effect of Dr Kong's evidence ultimately seemed to be that because you happened to be next on call when Mr Gourlas went away, that he had assumed that you were the consultant to go to – be the go-to consultant, if I can put it that way, during that period of time. Now, do you have any comments about that? Do you agree – would you agree with that proposition or?---Would the implication be that Mr Essery was under my – 11 weeks prior to me seeing him?

Yes, I think that that is the inference to be drawn from that?---Yeah, I don't – I don't think that I accept that that - - -

Okay?--- - - - is reasonable.

And I am just getting back to the point that I raised with you before. From your perspective, there was no formal handover to you from your recollection?---Not that I recall and if by formal, you mean documented, then I've not seen - - - Okay?--- - - - that that's the case."

[116] Finally, as to the concerns around Mr Essery not having been reviewed by a Colorectal Surgical Consultant until his review of 2 November 2018, Dr Morris stated:[46]

"*Now, one of the other concerns is the period of time from admission to the time that you, in fact, did review Mr Essery and it seems from the record and it's now been confirmed by Dr Luton, Lutton, that your consultation or your review of Mr Essery on the 2nd of November 2018 was the first time there was consultant colorectal review of Mr Essery. Now, I'll come back to how that*

[46] T8-22, LL12 - 33

came about shortly but just from a general point of view, from your point of view, and it's been put to Dr Gourlas as well, it seems that that period of time, from the date of the admission to the 2nd of November, is a considerable period of time for a patient like Mr Essery not to have been reviewed by a consultant colorectal surgeon, having regard to his situation. Now, do you have any comment about that?---I think that that in a patient with a surgical problem, that the concern is valid and it would not be my practice to leave a patient for three months had they a surgical problem for a surgically remedial problem, so I – I – I think that that's a reasonable statement. What is a reasonable timeframe to see somebody that you know doesn't have a surgical problem or has a problem that you can't fix? I'm not sure I'm going to put a timeframe on that and I suspect that, you know, we would have known about Mr Essery's condition and – and without even – without taking primary responsibility, we would have said, no, you know, he can't have an operation or he can or – when I saw Mr Essery, he wasn't a surgical candidate at that time, so I'm not sure what the consultant review at that time added except perhaps some clarity. Had I seen him at one months or two months earlier, it would seem that had I seen him all the way back to March or April or May, I think my entry may have been exactly the same in retrospect."
(emphasis added)

[117] Clearly, when Dr Morris consulted with Mr Essery on 2 November 2018, it was his opinion that Mr Essery was not a suitable candidate for surgery at that time.

[118] However, the effect of the above evidence from Dr Morris seems to be that unless Mr Essery was in fact a suitable candidate for surgery, i.e. unless he had a "*surgically remedial problem*", he was not a patient who warranted early post-admission review by one of the Colorectal Surgical Consultants, whether that be for the purpose of contributing to the formulation of an appropriate treatment and management plan or otherwise, and notwithstanding that, quite evidently, each of the ID and Gastroenterology teams forecasted that definitive management of Mr Essery's condition would likely involve surgical intervention. As Dr Holland put it, her understanding of the purpose of Mr Essery's transfer from Cairns to PAH was to "*seek the input of tertiary specialist care, predominantly the inflammatory bowel disease gastroenterologists and surgical expertise that were specific to inflammatory bowel disease."* Again, this is something Mr and Mrs Essery could reasonably have expected to occur as part of formulating an appropriate management and treatment plan.

[119] With all due respect to Dr Morris, in the context of the purpose for Mr Essery's referral and admission to the PAH, I have great difficulty in accepting as appropriate an approach that would not see Mr Essery undergo Colorectal Surgical Consultant review until 8 – 9 weeks post

admission on the basis that he did not have a "*surgically remedial problem*" (if that were, in fact, the explanation for the delay).

[120] Having regard to the suite of evidence referred to above and otherwise surrounding this issue I make the following findings:

a) The early post-admission reviews of Mr Essery by the ID and Gastroenterology teams at PAH were appropriate.

b) Although Mr Essery was admitted under the care of Dr Gourlas per the protocol that new patients be admitted under the Colorectal Surgeon who was on call that week, Dr Gourlas went on extended leave without first reviewing Mr Essery. Instead, he referred Mr Essery's case to the Colorectal MDT, with the expectation that the MDT would consider the case the following Monday. This did not occur. The MDT did not review Mr Essery's case until approximately three weeks later, on 24 September 2018.

c) There was otherwise no formal or informal handover of Mr Essery's care to another Consultant in the Colorectal Surgical team.

d) Indeed, there appears to be some confusion or uncertainty over what the system was and which of the Consultants had the carriage of Mr Essery's care during Dr Gourlas' long service leave.

e) Dr Kong, the Colorectal Surgical Fellow who did conduct regular reviews of Mr Essery during Dr Gourlas' absence, thought that he was to report, on an ongoing basis, to the Consultant on call the week following Dr Gourlas going on leave, namely Dr Morris. He thought it was important for continuity of care in the case of a complex patient like Mr Essery to report to one Consultant on an ongoing basis.

f) However, Dr Morris did not accept that Mr Essery was effectively under his care throughout the period Dr Gourlas was on leave.

g) Dr Gourlas thought the system was that the registrars and fellows were to report to whichever of the Consultants was rostered on, or on-call per the rotating weekly roster, an understanding that is, perhaps, consistent with Dr Morris' stance.

h) The rotating weekly roster for the on-call Consultant clearly provided benefit to patients when treating Consultants were on leave or absent for short periods by ensuring 24/7 Consultant coverage.

i) However, Dr Gourlas' agreed that in cases of Consultants going on extended leave, the rotating weekly roster could cause issues with the continuity of care of patients, particularly for complex patients like Mr Essery. Similarly, Dr Morris acknowledged as "reasonable" the proposition that when a treating surgeon with a complex patient is to go on leave for a very extended period of time (as in the case of Dr Gourlas), it would have been better for that particular patient (or, indeed, all the

patients of that particular surgeon) to be handed over to another treating surgeon for the duration of the extended period of leave.

j) Consequently, although Dr Kong was concerned about the continuity of Mr Essery's care, and sought to ameliorate that by, in his recollection, reporting to a single Consultant, Dr Morris, it seems that, in reality, no single Colorectal Surgical Consultant took up the responsibility for or "ownership" of Mr Essery's care during the period of Dr Gourlas' extended leave.

k) As stated, Mr Essery's case was presented to the Colorectal MDT about three weeks after Dr Gourlas had intended. The case was presented by Dr Kong, not a Colorectal Surgical Consultant. There was no Consultant review or examination of Mr Essery at the time of the MDT. Whilst it is patently obvious that Dr Kong was, at that time, already an accomplished consultant surgeon, with impeccable credentials and highly regarded by the Colorectal Surgical Team (Dr Morris quipped in evidence that Dr Kong was so qualified "*he literally could take our jobs*"[47]), it remains the case that in the hierarchy of decision making in the treatment and management of Mr Essery, Dr Kong, as a fist year Colorectal Surgical Fellow, was to defer to the decision of a Consultant. Dr Kong certainly understood that to be the position, stating that "*ultimately, the consultant is responsible for the patient and it is my role to make sure that the consultant is aware of each surgical intervention.*"

l) The MDT's recommendation on 24 September 2018 for the management of Mr Essery's condition was recorded as: "*continue the current management of a period of optimisation and to treating any intra-abdominal collections to control the infection".* The recommendation was otherwise non-specific in terms of recommended timeframe for the said period of optimisation (noting that Mr Essery had already submitted to an extended period of optimisation in Cairns without improvement: see below); nor did it provide for a timeframe for Colorectal Surgical Consultant review. Although it may be that Dr Martin and others requested Consultant review from time to time, there is no record of any such review until Dr Morris' review of 2 November 2018.

m) Many of the above factors, including that:

   i) Mr Essery, a very complex patient, was allocated to a Consultant immediately before he went on extended leave;

   ii) there was a rotating weekly system in place for Consultant cover apparently resulting in the situation whereby no single Consultant took responsibility or "ownership" for Mr Essery's care during the period of Dr Gourlas' extended leave; and

   iii) the recommendation of the Colorectal MDT for Mr Essery's management was "open ended";

[47] T8-17, L18

likely contributed to the failure to perform an early post-admission Consultant review of Mr Essery, and the long delay of about 8.5 weeks before Mr Essery was ultimately reviewed by Dr Morris.

n) Given the complexity of Mr Essery's case, the condition he was in at admission to PAH, and the purpose for which he had been transferred from Cairns to PAH, I find that the failure to perform an early post-admission Colorectal Surgical Consultant review as part of the formulation of a treatment and management plan for Mr Essery was not appropriate.

[121] I note that by its Submissions of 5 February 2025, the Metro South Hospital and Health Service (**MSHHS**) submits to the following effect:

a) On the discrete issue of earlier Consultant Colorectal Surgical review with Mr Essery and his family, it is accepted that the timeframe in this case was too long;

b) Once it became apparent that Dr Gourlas would not have time to review the patient personally prior to taking pre-arranged leave, steps beyond those taken in this case may have been reasonably expected;

c) It accepts that a Consultant Colorectal Surgical review, including a consideration of the whole of the record, was required at an earlier stage;

d) Whilst it can be accepted that the time between Mr Essery's admission, and the time of formal review by Dr Morris appears to be too long, it is also true that inflammatory bowel disease, in this case Crohn's, is complex, difficult to predict, and its severity can vary broadly from patient to patient;

e) In this case, it is clear that Mr Essery was being actively monitored by numerous clinicians on a daily basis, or close thereto. Whilst this does not directly impact upon the necessity for Consultant Colorectal Surgical review and care-planning, "*it would be a distortion of the evidence to suggest that Mr Essery 'fell through the cracks'*".

[122] The MSHHS' concessions as to the long delay in Mr Essery undergoing Consultant Colorectal Surgical review are appropriate.

[123] As to the MSHHS' final point, whilst I agree that it could not be said that Mr Essery "*fell through the cracks*" in the sense that he was overlooked was not afforded any appropriate care and management in a general sense during his admission to PAH (as discussed below), the fact remains that no single Colorectal Surgical Consultant took up the responsibility for, or "*ownership*" of Mr Essery's care during the period of Dr Gourlas' extended leave. From a systems perspective, in the context

of providing appropriate health care, that is a matter of concern. As discussed below, in the case of Mr Essery, earlier Consultant Colorectal Surgical review may not have altered the outcome of his disease, but a systems failure such as this could result in significant adverse effect on other patients if it were to occur on other occasions.

Mr Essery's ongoing care at PAH

[124] I find that, in general, the ongoing care afforded to Mr Essery at PAH was appropriate.

[125] However, one of the issues that concerned me during the Inquest was the extent to which regard was given (if at all) to the previous attempt at optimising Mr Essery at CBH when the plan for a further attempt at optimisation of Mr Essery at PAH was set. I took up the issue with Dr Kong as follows:[48]

> "*DEPUTY STATE CORONER: Doctor, I am absolutely frustrated by the concept of medical optimisation after he arrived at PA, in circumstances where what you have described as optimising this patient had occurred for three months at Cairns hospital. Why is it that that three months doesn't count as, "Well, we've tried optimising and it didn't work."?---I guess because it's in a different institution and I don't - - -*
> *But somebody could have looked at the Cairns records. They could have looked at, "What did we feed him? How often was he fed? What antibiotics he was given, what route were they given by." You know, are there still susceptible bugs. That analysis could have taken place, surely, and – to see whether or not there was anything that had not been tried, which I understand. But it just seems to me that the evidence, at least to this point in time, is that he arrived at Cairns and the rule was, "You must optimise," without recourse to a three-month admission for optimisation that had occurred at another tertiary hospital?---Yeah. So – so normally we would – I – I don't have any records to compare, sorry. I haven't actually read through what your Honour has done. But you're right, your Honour, we would normally look at what's been done and changed to try and further optimise a patient. I have – yeah. I'm a surgical consultant, so I have very little experience in nutritional optimisation, and I do rely on the other team – the gastroenterologist, the dietician – to tell me whether a period of optimisation is worthwhile.*
> *……..*
> *MR SCHNEIDEWIN: Just so we're clear, then, the surgery team might think it appropriate to attempt optimisation because you don't want to perform surgery unless you have to, or it's more appropriate to perform the surgery if the patient is optimised, or better to perform the surgery if he's optimised. So you might have that concern that the patient should be optimised, but what you're*

[48] T5-63, L32 – T5-64, L47

saying is, once that's raised as a requirement for surgery, is it then down to the medical team to make an assessment as to whether or not they can do anything further to optimise the patient; is that what you're saying, that they should tell you whether they can or they can't?---Yes. It's multidisciplinary effort with multidisciplinary discussion, but, normally, I would rely on the gastro and dietician to allow me to know whether there's any value in optimisation.
And I think the point that her Honour is making is that, when one looks at the record here from the two institutions – that is, the Cairns Public Hospital and then the Princess Alexandra Hospital. There does not seem to be any change in the protocol in respect of optimisation when the patient is admitted to the Princess Alexandra Hospital. Is that something that you think, from a surgical point of view, that should have been discussed with the surgeons when they're making their decisions around whether to perform surgery or not?---Yes, that – would have discussed with the surgeon. Should, sorry.
Should be discussed with the surgeon because is it – it's the case, isn't it, that if the – if the likelihood of optimisation is de minimis, the surgeons then have to make a different decision, don't they, in terms of their management of the patient?---I will be quite – as a consultant right now, I would be quite fearful to make that decision without a period of optimisation.
Okay?---Like, truly fearful.
Yes. So your preference would still be to have a further go at optimisation?---At least an attempt from our team.
Yes, I see. I see. So, notwithstanding what had happened previously, your preference as a consulting surgeon now would be for a further period of optimisation from the people that you work with and that your – that are in your team?---Yeah.
Okay?---That's right."

[126] Earlier in his evidence, Dr Kong had stated:[49]

> "*All right. Did you understand at the time of your initial review that Mr Essery had already gone through a relatively long period of medical management for the purposes of optimisation?---I did not – I do not recall and I did not appreciate it – do not recall it at all what Cairns have done*."

[127] It remains unclear to what extent, if at all, the period of attempted optimisation of Mr Essery at CBH was considered by the MDT when setting the plan for a further period of attempted optimisation at PAH. Certainly, the optimisation protocol adopted at PAH appears to have been the same, or substantially similar, to that which had been engaged at CBH.

[49] T5-55, LL24-28

[128] This issue that arises is whether there was, in fact, a plan for timely treating Colorectal Surgical Consultant review during the course of the further attempted period of optimisation in line with what would be generally expected when treating and managing a complex patient like Mr Essery.

[129] Counsel for Mrs Essery took up the issues of the duration of the period for a further attempt at optimisation and the timing of treating Colorectal Surgical Consultant review with Dr Kong:[50]

> "*I would like to talk about the evidence you gave to counsel assisting in respect of the best time – the best time period for optimisation. And you talked about it being six to 12 weeks. Is that – that's right?---Yes. There is no best time period. The general rule where we assessed every – every six weeks is the normal norm to give it a period of optimisation.*
>
> *Yes. and – and you did give some evidence about the fact that it's obviously dependent upon the individual patient and their case. But what I understand you to say is giving it six to 12 weeks would be the norm. And then is it the case that after that, that's when you would be wanting to have that difficult conversation with the family about whether to move to palliation or go ahead with surgical management, knowing the very high risks of that surgery?---Yes, that's right.*
>
> *All right. So beyond the six to 12 week period – and can I take it unless you see some marked improvement in the patient in that six to 12 week period, what is the value of further optimisation as opposed to having that difficult conversation at that end of that 12 week period?---At the end of the 12 week period, I would definitely have the conversation with the patient, normally.*
>
> *Okay. And that's wearing your consultant's hat now?---As a consultant, yeah.*
>
> *Yep. Okay. So we know, obviously, though, that Chris had the six to 12 weeks of optimisation at the PAH and that that took - - -?---Yep.*
>
> *That took us to the beginning of November. And is that the reason that Dr Morris had the review of Chris at that time, because they – you'd reached the end of that beginning – sorry. Let me try that again. Because that period, your usual period of optimisation, had effectively come to an end?---I don't have any recollection, but that would – the reassessment would normally take place at six weeks mark, and the questions – the clinical notes – has been*

[50] T5-72, L17 – T5-75, L44

asked by the gastroenterology, whether there's any role for surgical intervention.

Okay. Now, we know from the notes and you may also have seen from reading them that Dr Morris didn't feel that Chris was in a fit state to go to surgery at the time of that review in November of 2018. Do you recall reading that in the notes?---No, I don't. Sorry.

All right?---I actually didn't sign these notes.

Okay. And you've said you don't recall having been involved in that conversation; is that right?---I don't recall having that conversation.

Okay. Would Dr Morris have been the consultant that you were continually reporting to during the period that Dr [Gourlas] was away?---Yes.

And so would it - - -?---For the continuance of care.[51]

Yes. And so would it have normally been the case that if your consultant was going to review a patient – for instance, at this stage, where you've had six to 12 weeks of the optimisation, which was the initial plan, would it not normally have been the case that if your consultant was then reviewing that patient to see if the plan would change that you would've been involved or had some sort of recommendation for that consultant?---Yeah. So I would normally see the patient – explain to the consultant who is taking over what the initial plan by Dr Gourlas would be and then continue to review the patient ***every six weeks****.*

…

That's okay. You did say in answer to a question by counsel assisting, though, that it did seem to you a long time that there would be no review by a consultant from the 31st of August to the 2nd of November, which is how long it did take before Dr Morris did review him. Is that the case? Did it – does it seem to you to be unusually long or a little bit long or – can you help us there?---So as a consultant, you know, it's unusually long not to review a patient, particularly when I have presented the case. Because as consultants, we picked up flags from our trainees, and when there's a red flag, we normally want to review the patient in person and make an independent assessment, but that's speaking from a consultant's hat. I – I don't remember how – how many times

[51] As outlined above, in his evidence Dr Morris did not accept the proposition that Mr Essery was effectively under his care during the period of Dr Gourlas' absence.

I've spoken to Brad, what I've said to Brad – or Mr – Dr Morris – sorry – and what difficulties I have with Dr Morris.

Okay. Thank you for that. I might ask this, then. Do you think that if Dr Gourlas had not been on long service leave during that period that the review might have happened – the review by a consultant of the colorectal surgery team might have happened sooner than it did with Dr Morris, who was effectively on call and covering for Dr Gourlas?---I believe Dr Gourlas would probably review the patient earlier, although I don't think that would change the plan.

Okay. Dr Gourlas told us that it was his practice to review most, if not all, of his patients on a weekly basis when he was at the hospital each week. Can I ask for your recollection of that. Do you remember him doing that?---So Dr Gourlas is very meticulous and very approachable. So he does review his patients quite often. I just can't remember how often. If I present the case to him, particularly someone complex like Mr Essery, he would then review the patient the following week."

(emphasis added)

[130] Later under examination by Counsel for Mrs Essery, Dr Kong, wearing his current consultant's hat, expressed to following opinion about how he would have managed a patient like Mr Essery:[52]

"*You mentioned in answer to questions from counsel assisting that – and you said you were being very blunt. You thought Chris' dice had been cast the moment he arrived. What I'd like you to do is put your consultant hat on now, please, and tell me that if you - - -?---Yes.*

- - - were dealing with this case now, if Chris arrived in your care today and you looked at the condition he was in now, would you still be wanting a period of optimisation at your institution of six to 12 weeks?---So independent – let's say I'm independently – an independent consultant. I will first have a look at everything knowing what I know now without knowing the primary outcome, I'll speak to the gastroenterology team and ***give him at least a six weeks optimisation period*** *with a view of* ***re-assessing in person****. And if there is* ***no shift in the nutritional status****, I'll probably speak to the family and Mr Essery his self about whether the* ***options of whether palliation or surgical intervention****. And this – and I would even offer a second, if not a third, opinion from another surgeon to review the patient in person and have that same discussion and have a clear documentation that, you know,* ***the risk of surgery is extremely high, might be futile****.*

[52] T5-76, LL19 - 39

But notwithstanding the risk, you would say that that conversation if you were in charge or you were the consultant should be had with the family sooner rather than later; is that right?---Yes."
(emphasis added)

[131] Dr Kong's approach, as a Colorectal Surgical Consultant, seems to accord generally with the view of Dr Gourlas. At the Inquest, Dr Gourlas' evidence around this issue was:[53]

"*Okay. And can I suggest to you that for a patient as critical as Mr Essery, that really is problematic from a – you know, a continuum of care?---Yes, I agree. I must say, I was surprise that he was still there when I came back from long service leave.*

Well, what was your expectation? Having formed that provisional plan when you went on long service leave, did you have a – something in mind in terms of what would likely happen while you were away?---Well, I – ideally, you would have got him to a point where he was fit enough to have undergone surgery and someone would have performed the surgery.

And how long would that have been, do you think, knowing what you knew - - -?---It

- - - at the time – I know it's difficult?---I had a patient this year that was – after three months in Townsville Hospital, I tried to get her better for two weeks, found I couldn't and then I operated, because it wasn't succeeding and she did well.

I see. So whilst it might have been ideal to optimise Mr Essery and improve his prospects for surgery, there is a point in time where, if optimisation is not achieved or improvement is not achieved, regardless, surgery has to be undertaken?---Well, yeah, I made – there was – someone made a note that they should try for at least six weeks and – and after you've developed a – a new fistula, the rule is don't operate within six weeks because the vascular adhesions are so severe that it can cause a catastrophic event. So I can see why there was a delay in that point of view. My view when I returned was we'd had months of attempts to try and get him better, but hadn't been successful, and that maybe we should try and do something, because I couldn't see that this was going to end well by doing – on going on what we were doing.

…..

[53] T5-19, L35 – T5-22, L16

Yeah. But I think the point that I was trying to extract from you – I'm sorry the question was a bit clunky – what they were doing to optimise him is essentially what was being done at the Princess Alexandra Hospital to optimise him. They adopted essentially the same course?---Yeah, they – everyone does something similar. I mean, we're fortunate we've got some extra specialists with different expertise that were able to add some other things in as well.

…..

And you'll see there, at the bottom of paragraph , Dr Kong expresses the view that:

It's routine to wait for three months to optimise the patient.

Would you agree or disagree with that?---Oh, it's hard to put a time on it. It's definitely – you wouldn't go in within six weeks because of those severe vascular adhesions. Three months – it was – I think it was – it's hard to put a time on it. I mean, you – you – if they're improving and you get them to a point – it's largely a clinical decision based on what improvement you've had. If you can get them – their albumin up into the mid-twenties and get some weight back on them so that they have he got some physiological reserve to survive and get through the operation, then that's what you're aiming for. I don't think you can say, "We're going to give you two weeks or three months and – and that's it. After that" – it's really a – a clinical decision as to when you think they're fit enough to undergo an operation.

I mean, ideally, the aim is to get them fit enough to undergo the operation?---To survive without complications.

Yes. But there is a point when that's not going – that doesn't occur in some patients, including, for example, the one you've just referred to - - -?---Yes.

- - - earlier in your evidence - - -?---Yes.

Where notwithstanding an absence of improvement, surgery is nonetheless an option for the patient to consider at that time, isn't it?---That's what I decided when I came back.

Yeah. And it does seem, can I suggest, that waiting three months for the prospect of improvement, on top of a long period of time where that has already been attempted at another facility - - -?---Yeah.

- - - seems to be a considerable period of time and, can I suggest, placing the patient at the risk of becoming worse?---I – I see your

point. I mean, he's already had a few months of attempt at getting better for surgery. Then you've got a few more months. I don't know – I wasn't at that MDT meeting. I don't know why they said three months. I – you know, but I see your point. You've got to, at some point, decide, "We're getting nowhere. What are we going to do?"

[132] As a potential explanation for the MDT's decision to prolong the further attempt at optimisation at PAH, the following was put to Dr Gourlas:

> "*Could I – we heard some evidence last week to this effect: that – and it's not direct evidence, so it's not high-quality evidence, but I'll put it to you anyway – that there might have been a view, Doctor, that you were the most equipped surgeon at the Princess Alexandra Hospital to deal with this patient and that the time considered for optimisation was to allow you to return to perform the surgery. Do you have any view about that?---I'm not that good. All - - -*
>
> *DEPUTY STATE CORONER: Your colleagues seem to suggest, though, Doctor?---It's a slight exaggeration, your Honour. But, look, all – all of us – all seven surgeons at PA have been highly trained. They – they all do the surgery in private. I'm not the only one. The only reason I tend to inherit a lot is because I set up the joint IBD clinic, with the others, after having seen how successful it is overseas, and so I do end up doing this, and some of the others specialise in other types of tumours. So we all do this in private work.*
>
> *MR SCHNEIDEWIN: Can I take that to mean that your evidence is, in your view, there was no reason to wait for your return for surgery to be performed on Mr Essery?---I don't think so."*

[133] As to the pros and cons of submitting Mr Essery to a further period of attempted optimisation, Dr Gourlas stated:[54]

> "*Okay. All right. Now, I don't want to go over old ground, but just to reposition ourselves, in that period of delay – which now, it seems, there was a long period of attempt at optimising Mr Essery before he came to the Princess Alexandra Hospital, and then another long attempt, it seems, at optimising him whilst – <u>for the entire duration of your long service leave, it seems, which is about three months, and in those periods he has been exposed to the faecal matter and the collections in his abdomen throughout that entire period. They are spreading, if I can use - - -?---Yes.</u>*

[54] T5-22, L37 – T5-23, L20

- - - a very loose term, throughout the abdomen. We can expect that, in that period of time, what in fact is occurring is he's becoming a more and more complex patient surgically because of the risk of increasing adhesions?---Yes.

Because of the spread of the infection?---Yes.

Because of the probably greater area of involvement of the bowel; is that right?---Yes.

So all of those things are making the situation worse - - -?---Yes.

- - - as opposed to better with the passage of time?---Yes. Would you agree with that?---Agree.

So that he was becoming – if he was already a high-risk candidate for surgery when he arrived at the Princess Alexandra Hospital, by the time you've returned from long service leave, he was an extremely high-risk patient – even at high risk. Do you agree with that?---Yeah, I agree. I mean, it's a catch 22, isn't it? You want him to survive the operation and heal but, at the same time, the longer you leave it, the worse it seems to get because pus takes the path of least resistance, so it keeps spreading to other areas. And – so by the time I operated, his entire small bowel from his duodena, which is the first part after the stomach, through to his stoma, was heavily scarred – cocooned in – around the five areas of the fistule."

(emphasis added)

[134] Having regard to his evidence on this issue, had he not gone on extended leave, I infer it is likely Dr Gourlas would have had a discussion with Mr Essery and his family about surgery (including the high risks involved in such surgery) at or around 6 weeks following Mr Essery's admission to PAH, even if Mr Essery had shown no improvement in response to the further attempt at optimisation. I find that having such a discussion of this nature between a Consultant Colorectal Surgeon and Mr Essery and his family at or about that time would have been the appropriate course to take, but that did not happen.

[135] By its Submissions of 5 February 2025, the MSHHS submits to the following effect:

a) Whilst the MSHHS accepts that consultant surgical review ought to have occurred earlier (particularly given that the purpose of the transfer was for at least consideration of surgery), there was no "*surgical emergency*."[55]

[55] Paragraph [22] MSHHS Submissions

b) It is not clinically appropriate to provide a set timeframe for surgery given Mr Essery remained cachectic throughout his hospital admission at the PAH. It was clinically appropriate for a consultant surgeon to make professional judgement on Mr Essery's fitness for surgery as it is their professional obligation to provide safe clinical care within their scope of clinical practice and their Hippocratic Oath to minimise suffering whenever a cure cannot be obtained. In this case, we submit that the weight of the evidence suggests Mr Essery was never a candidate for surgery and would not have survived an operation.[56]

c) It is reasonable criticism that there was no embedded process for formal review of a complex patient in the lengthy absence of the initial consultant surgeon. Whilst it may be that cases of IBD, especially Crohn's, have wide variance, it is conceded that in a case of this complexity, particularly with this lengthy history of hospitalisation, required earlier consultation and review, including reference to the prior treatment journey at CBH. Dr Allison also considered that a formal handover ought to have occurred.[57]

d) Whilst there was no formal handover from a consultant colorectal surgeon, the treatment plan to condition Mr Essery to be fit for surgery was clinically appropriate given Mr Essery's complex medical condition.[58]

[136] The concessions regarding the absence of an embedded process for formal review and formal handover of a complex patient like Mr Essery are appropriate concessions.

[137] It can be accepted that Mr Essery did not present at anytime with a "*surgical emergency*", but that is not the point of the concern. It can also be accepted that it is not clinically appropriate to set a timeframe for surgery without taking into account the clinical situation of the patient, but that is also not to the point.

[138] The point is Mr Essery should have been reviewed by a Consultant Colorectal Surgeon after a further period of optimisation, probably at around the 6-week mark, where a discussion could have been had with Mr Essery and his family about future treatment and management, including whether that would involve surgery (albeit high risk), further attempts at optimisation, or palliative care. This did not happen in the way that it should have until Dr Gourlas returned from leave. That was not appropriate.

[139] I find that early post-admission Colorectal Surgical Consultant review (as opposed to review by a Fellow and referral to the MDT) would have

[56] Paragraph [23] MSHHS Submissions
[57] Paragraphs [24] & [25] MSHHS Submissions
[58] Paragraph [26] MSHHS Submissions

allowed the opportunity to provide a more definitive and considered plan for Mr Essery along the lines Dr Kong suggested, namely:

a) To provide Mr Essery with a further period of attempted optimisation of at least six-weeks' duration;

b) To review Mr Essery, in person, by the same Consultant at or about six-weeks of attempted optimisation;

c) If there was no shift in the nutritional status, a discussion about the options of palliation *v* surgical intervention with clear documentation that the risk of surgery would be high and might be futile;

d) The offer of a second, if not a third, opinion from another surgeon to review Mr Essery in person and to have that same discussion about palliation *vs* surgical intervention.

[140] I find that if a single Consultant from the Colorectal Surgical team had taken responsibility for and "ownership" of Mr Essery's care in Dr Gourlas' absence (so as to ensure continuity of care for Mr Essery), there is no reason why that Consultant could not have conducted a review at or around the 6-week mark, had a discussion with Mr Essery and his family about surgery *v* palliative care and, if the decision was to proceed with surgery, perform the surgery. Certainly, Dr Gourlas did not consider it necessary wait for his return from leave for such a course to be adopted.

[141] The first Consultant Colorectal Surgical review of Mr Essery was undertaken by Dr Morris on 2 November 2018, at or about 8 ½ weeks post admission to PAH. However, according to Dr Morris, this review was not conducted by him on the basis that he was the Consultant responsible for Mr Essery in the absence of Dr Gourlas. Dr Morris was asked by Dr Martin to undertake the review.

[142] I find that Dr Morris' review of Mr Essery was thorough and well-documented.

[143] However, Dr Morris' review and discussion with Mr and Mrs Essery appears only to have been directed to disavowing them of an expectation that there was a surgical solution for his condition. It is clear he was not prepared to perform surgery and surgery was not offered. Otherwise, he did not take "*ownership*" of Mr Essery as one of his surgical patients, or as a patient that might be a candidate for surgery in the future. Apart from requesting an updated CT scan (which took a further three weeks to perform), it appears the only plan was to continue with the medical optimisation measures which were, by then, also proving to be futile and the reason why he was asked by Dr Martin to undertake the review in the first place. It is also not clear what Mr and Mrs Essery understood the plan to be following the review and the discussion Dr Morris had with them. There is no clear plan noted in the record. There was no follow up by Dr Morris.

[144] A further 5 to 6 weeks passed before Dr Gourlas returned from leave and first reviewed Mr Essery on 11 December 2018, at which time the plan for surgery was made. By then Mr Essery had withstood many months of optimisation therapy during which his condition had not improved and he progressively became a more and more complex patient to treat and manage.

[145] In this regard, I do not accept the proposition of MSHHS that "*Mr Essery was never a candidate for surgery*." That is evidently not the case because:

a) Dr Gourlas considered it reasonable to offer surgery after his return from leave even though Mr Essery had shown little or no improvement throughout the long period of optimisation therapy he had by then undergone;

b) It was Dr Gourlas' expectation that Mr Essery would have gone to surgery (or at least been considered for it) in his absence, noting that he was "a bit surprised" to see Mr Essery was still in the unit on his return from leave;

c) According to Dr Gourlas, any one of a number of the Consultants in the Colorectal Surgical team were equipped to perform the high risk surgery Mr Essery required, whether he had been optimised for it or not (although I accept Dr Morris was not prepared to offer the surgery when he reviewed Mr Essery on 2 November 2018).

[146] I find that by the time Mr Essery went to surgery he was an extremely high-risk candidate for surgery (as was accepted by Dr Goulas in evidence) and had, with the passage of time, become progressively higher risk for surgery while Dr Gourlas was away on leave. I find that whatever Mr Essery's prospects for successful surgery might have been when he was transferred to PAH, those prospects likely diminished further with the passage of time during the unnecessarily prolonged and futile attempt at further optimisation.

[147] Having considered all of the evidence and the parties' respective submissions, I find as follows:

a) The failure to perform an early post-admission Colorectal Surgical Consultant review as part of the formulation of a treatment and management plan for Mr Essery was not appropriate;

b) Submitting Mr Essery to a further period of optimisation therapy was appropriate provided the previous optimisation at CBH was reviewed to inform optimisation at PAH and the initial treatment and management plan made provision for Colorectal Surgical Consultant review at or about six weeks (or earlier if considered necessary). This did not happen, which was not appropriate;

c) At such review there would have been the opportunity to reconsider the plan for Mr Essery and whether that should have then included surgical management, palliation or some other measures (if available). Mr Essery was not availed that opportunity, which was not appropriate;

d) The failure to formally handover Mr Essery to another Colorectal Surgical Consultant given Dr Gourlas' planned long period of absence to ensure continuity of care was not appropriate;

e) The fact that no single Consultant in the Colorectal Surgical team took responsibility for and "ownership" of Mr Essery to ensure continuity of his care during Dr Gourlas' long period of absence was not appropriate;

f) The long delay of about 8.5 weeks before Mr Essery was first reviewed by a Colorectal Surgical Consultant (Dr Morris on 2 November 2018) was not appropriate;

g) At the 2 November 2018 review, there was the opportunity for Dr Morris to take responsibility for and "ownership" of Mr Essery from a surgical perspective, even if he was not then prepared to offer surgery, to participate with the other disciplines in reconsidering the plan for Mr Essery moving forward. That did not happen. Instead, the only plan was to continue with optimisation measures, which were clearly not working and had not worked for an extended period, including at CBH. This caused Mr Essery to endure ongoing ineffective therapy. This plan as the only plan at that point was not therapeutic for Mr Essery and was not appropriate;

h) Given Mr Essery's failure to improve over the many months of optimisation therapy, Dr Goulas' offer to perform high risk surgery after he returned from extended leave and his treatment and management of Mr Essery after that time was appropriate.

<u>The presence of the mesh</u>

[148] On this issue, Counsel Assisting made submissions to the following effect:

a) Given the extent of the radiology and associated reporting available from the CBH, it is difficult to understand how some of the medical practitioners treating and managing Mr Essery at PAH were not aware of the presence of the mesh (and tacks) and its apparent involvement in the collections until very late in his treatment or, in some instances, not at all. Clearly, not even the discharge summary from CBH on discharge to PAH was reviewed at PAH and that is so even after hearing the lengthy evidence about the issue at the Inquest;

b) Having been first advised about the presence of the mesh and its involvement in some of the collections after the surgery of 24 January 2019, Mrs Essery's concerns and frustrations around the issue are readily understandable;

c) The better of view of the evidence is that it is likely the mesh became secondarily infected from the original source of the infection, namely the bowel and the subsequent abscess and fistulas that developed. Given the period of time the mesh had remained *in situ* without issue, it is not likely to have been the primary source of the infection;

d) The evidence also suggests that if the presence of the mesh and its involvement in the collections had been known at an earlier time, then ideally it would have been appropriate to surgically remove the mesh (whether it was considered the source of the infection or not). However, surgical removal of the mesh would have required Mr Essery to be optimised for surgery (if that could be achieved) or else it would have been better to deal with the mesh at the time of the definitive surgery to control the source of infection (which, of course, would have been much higher risk surgery if optimisation efforts had not achieved gains);

e) The issue of concern is not so much whether earlier surgery should have been performed to deal with the [possibly] infected mesh, but rather whether definitive surgical treatment to control the source of the infection should have been performed earlier than was the case and regardless of whether or not there had been improvements in Mr Essery's condition through the optimisation measures taken. At that definitive surgery the mesh could have been removed if considered necessary and, if performed at a time earlier than it ultimately was, it may have been a case of the mesh not being so significantly involved in the collections;

f) There was a lost opportunity to perform earlier definitive surgery (or at least to consider doing so at an earlier time). That opportunity was likely lost because there was no appropriate early post-admission Colorectal Surgical Consultant review of Mr Essery as part of the formulation of the treatment and management plan for him, and because no single Colorectal Surgical Consultant took responsibility for and "ownership" of Mr Essery during the period of Dr Gourlas' extended leave;

g) In proceeding on the basis that this is the primary issue of concern, the issue in relation to the presence of the mesh is incidental.

[149] By her Submissions dated 15 January 2025, Counsel for Mrs Essery submits that although Mrs Essery generally agrees with Counsel Assisting's submissions, she does not entirely agree that "*the issue in relation to the presence of the mesh is merely incidental*", although it her dissent in that regard may come down to an issue of degree rather than a significant difference of opinion. Neverthelss, it is submitted that Mrs Essery strongly agrees that the evidence suggest that "*there was a lost opportunity to perform earlier definitive surgery (or at least to consider doing so at an earlier time), and that it is possible that earlier surgery would have give [Mr Essery] a better chance of survival*." In this regard, Counsel for Mrs Essery submits that earlier identification and consideration of the infected mesh would have been likely to prompt earlier definitive surgery or, at least, consideration of earlier definitive surgery. Counsel for Mrs Essery submits that there is a significant absence of firm evidence to

suggest that the mesh was recognised at all prior to the procedure on 24 January 2019. I concur.

[150] Counsel for Mrs Essery goes on to submit:

a) That the preponderance of the evidence is to the effect that the presence of the mesh was a relevant factor in any consideration of the appropriate treatment provided to Mr Essery at PAH;

b) Mr Essery was fighting abdominal sepsis which, ultimately, involved the mesh;

c) The possibility that the mesh was infected was not considered in Mr Essery's management and treatment at the PAH, noting the absence of reference to it in the medical records and Dr Gourlas' evidence at the Inquest that he was surprised that the mesh was involved with the bowel when he conducted the surgery;

d) Despite all other efforts, Mr Essery was unable to be optimised for surgery;

e) It is likely the infected hernia mesh contributed to Mr Essery's poor state of health (even if it was a secondary source of infection);

f) Earlier (and appropriate) recognition and consideration of the presence of the mesh and whether it was infected is likely to have contributed significantly to the possibility that definitive surgery would have been performed, considered or, at the very least, discussed with Mr and Mrs Essery at an earlier stage.

[151] The MSHHS submits to the following effect:

a) The mesh was certainly secondarily infected;

b) In such a complex patient such as Mr Essery, it is entirely understandable that the presence of mesh was not considered a clinical priority. Indeed, whilst the CBH had noted its presence, no clinical urgency was placed upon that fact. With the exception of Dr Mar Fan, both CBH and PAH witnesses and Dr Allison agree, nonetheless, that considering the fact of its presence may have featured more prominently; neither consider it would have changed Mr Essery's course;

c) simply removing the mesh as a surgical solution as espoused by Dr Mar Fan was not a position adopted by any other surgeon;

d) Dr Mar Fan accepted that the infection had very likely caused a hole in the bowel from as early as April 2018. He believed that surgery at the end of July 2018 to remove the mesh would have reduced the infection burden. He said '*Certainly, in my view, I feel that that, you know, if the surgery would have been done a bit earlier, especially up in Cairns, just the removal of the mesh, the outcome could certainly have been different*.'

e) Dr Mar Fan stated an operation to remove the mesh would likely be relatively straightforward. This was an erroneous understanding of the complexity of the removal of the mesh based on a belief, inter alia, that the position of the mesh would make for an easy operation;

f) Dr Prinsloo and Dr Chiam both gave evidence that Mr Essery was not fit for a major surgery in May 2018, and that the removal of the mesh was considered a major surgery;

g) Dr Hartslief, general surgeon CBH, concurred with this view. Whilst he was uncertain as to whether CBH had specifically documented the existence of the mesh, he accepted in hindsight that the imagery indicated the high likelihood of mesh involvement in the collection. He had not recalled it as an aspect at the time he performed the percutaneous drainage on 8 July 2018;

h) Whilst accepting he may have given this aspect greater consideration at the time, his view was that specific identification of the involvement of the mesh was insignificant in the overall picture, and irrelevant to this treatment plan;

i) The issues of infection and fistula were clearly the major consideration of the treating team in Cairns. Whilst the possibility of mesh involvement does not appear to have been specifically considered by at least the surgical team, no Cairns-based witness indicated that it was plausible the mesh was the primary source of infection. Even if it were, the leakage from the bowel remained the key concern;

j) It is relevant to note that both expert radiographers, Dr Withey and Dr Phal ultimately concluded that the imaging definitely showed the collections associated with the mesh was on 8 July 2018. Dr Phal considered that the collections were associated with Crohn's disease;

k) In any event, the removal of the mesh with or without repair of the bowel would require a laparotomy, an operation that Cairns was capable to perform, but reluctant to consider in the absence of a referral to a tertiary hospital. Mr Essery was just too unwell;

l) The PAH was of the same view. Neither gastroenterologist, Drs Martin nor Chong, recalled specifically the issue of mesh being discussed, but neither considered that, even in hindsight, the treatment plan would have changed.

m) Dr Gourlas did not consider that the mesh was driving the infection, nor that removal of it would have materially improved Mr Essery's very poor state of health. Dr Morris was of the view that, in the context of Mr Essery's state, the mesh was a question relevant to surgical intervention rather than medical support.

[152] Having considered all of the evidence and the submissions of the parties, I find as follows:

a) The mesh was secondarily infected;

b) It is likely the secondarily infected mesh was contributing to Mr Essery's poor condition;

c) Given the extent of the radiology and associated reporting available, it is difficult to understand how some the medical practitioners treating and managing Mr Essery were not aware of the presence of the mesh (and tacks) and its apparent involvement in the collections until very late in his treatment or, in some instances, not at all;

d) The presence of the mesh, let alone that there was radiological evidence of it being involved in the collections, was not appreciated by the treating medical practitioners at the PAH and it played no role in their decision-making about Mr Essery's treatment and management;

e) Surgery directed to removing the infected mesh, if it had been identified, would have been very difficult and there would have been significant risks in proceeding with surgery for sole purpose of removing the mesh. Mr Essery was not considered fit to undergo risky surgery for that purpose alone;

f) Whilst it is possible that identification of the presence of the infected mesh might have prompted the earlier performance of the definitive surgery, I am not satisfied to the requisite standard that identification of the presence of the infected mesh would have prompted the earlier performance of the definitive surgery;

g) However, subject to Consultant Colorectal Surgical recommendation and patient election, there was a lost opportunity to perform earlier definitive surgery (or at least to consider doing so at an earlier time). That opportunity was lost because there was no appropriate early post-admission Colorectal Surgical Consultant review of Mr Essery as part of the formulation of the treatment and management plan for him, no appropriate Colorectal Surgical Consultant review after a further period of attempting optimisation, and because no single Colorectal Surgical Consultant took responsibility for and "ownership" of Mr Essery to follow up during the period of Dr Gourlas' extended leave.

[153] In the latter regard I reject the submission of the MSHHS at paragraphs [61] and [62] of its Submissions dated 5 February 2025. Dr Goulas' evidence as to his colleagues' respective capabilities to perform the surgery was clear. I accept his evidence in that regard. It transcends mere speculation and is sufficient to ground the finding I have made. I accept that Dr Morris did not offer the surgery after his consultation with Mr Essery on 2 November 2019, but that was in the context where Dr Morris maintained he was not the Consultant responsible for Mr Essery. If it were, in fact, the case that no other surgeon on the ward would have been willing to operate in the period Dr Goulas was on leave, it was open to the MSHHS to place that evidence before me. The MSHHS did not to do so.

Whether any failure to provide him with care caused or hastened Mr Essery death?

[154] As to the balance if issues before me, the issues are better put as "*whether Mr Essery would have enjoyed a better outcome, including whether he would have survived, if he had been offered and undertaken definitive surgery earlier than was the case?*". I intend to deal with the issue briefly.

[155] If earlier definitive surgery had been performed at PAH in the period of Dr Gourlas' long service leave, such surgery would have been performed when Mr Essery was in a parlous condition, as described by Dr Morris in his entry of 2 November 2018. It would have been high risk surgery (as was the surgery Dr Gourlas performed in January 2019). It is not possible to say, on the evidence, to the requisite standard, that it is more likely than not Mr Essery would have enjoyed a better outcome if the surgery had been performed at that earlier time. Indeed, the weight of the evidence suggests the contrary, i.e. it is likely that the same or similar post surgery complications would have arisen leading ultimately to Mr Essery's demise.

Findings required by s 45 of the *Coroners Act 2003*

[156] I make the following findings required by s.45 of the Act:

Identity of the deceased – Christopher Glen Essery, born on14 February 1945

How the deceased died – The deceased died from sepsis secondary to fistulating Crohn's disease and post surgery complications following surgical treatment for such on 24 January 2019

Place of death – Princess Alexandra Hospital in Brisbane, Queensland Princess Alexandra Hospital in Brisbane, Queensland

Date of death– 11:23 hours on 20 February 2019

Cause of death – The deceased's death was caused by Sepsis secondary to fistulating Crohn's disease and post surgery complications following surgical treatment for such on 24 January 2019

Comments and recommendations

[157] The inappropriate failings which led to there not being a single Colorectal Surgical Consultant responsible for Mr Essery's care during the period of Dr Gourlas' extended leave were systemic in nature, borne out of a

rotating rostering system directed to ensuring 24/7 Colorectal Surgical Consultant cover.

[158] Whilst such a roster provides clear advantages for patients when Consultants take short periods of leave, it creates obvious continuity of care issues for complex patients like Mr Essery when Consultants go on extended leave.

[159] Moreover, the system appears to have given rise to some confusion as to which of the Consultants in the Colorectal Surgical team were considered responsible for Mr Essery's care during the period of Dr Gourlas' leave. Dr Kong thought that he was to report to Dr Morris on an ongoing basis to ensure continuity of care. Dr Morris did not accept the notion that he had the care of Mr Essery while Dr Gourlas was away. Dr Gourlas thought the system required that the Fellow (Dr Kong) report to whichever of the Consultants happened to be rostered as on-call in that week, although he acknowledged this did present some continuity of care issues for complex patients like Mr Essery.

[160] The PAH presented no evidence to the Inquest addressing this systemic problem. There is nothing to indicate that the system has since been changed.

[161] The PAH's general approach to the issues at Inquest (and in the statements of evidence it provided in response to Form 25 Requests for Information issued prior to Inquest) was to the effect that Mr Essery was never optimised for surgery and that the outcome he suffered was unavoidable and likely would have occurred regardless of whether surgery was offered and performed at an earlier time. Whilst that might be true in the case of Mr Essery, it rather misses the point of concern, namely that the system might give rise to some other similar situation for another patient in respect of which that patient's outcome could have been materially different if the continuity of care issues did not arise.

[162] In the circumstances, pursuant to s.46 of the Act, I make the following recommendation:

> That MSHHS review, and give consideration to, changing any existing protocols directed to providing Consultant coverage on a rotating roster basis in the Colorectal Ward or the IBD Clinic at the PAH which gives rise to a risk of not providing effective continuity of care for patients during periods of extended leave of the patient's admitting or treating Consultant.

I close the inquest.

Stephanie Gallagher

Deputy State Coroner

Brisbane