CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Heather Winchester
Hearing dates:	8-12 May 2023
Date of findings:	28 February, 2025
Place of findings:	Coroners Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – elective surgery, informed consent, Jehovah's witness, documents indicating wishes, documents prepared in USA, unsuitability of documents for NSW
File number:	2019/304802
Representation:	Counsel assisting: Ms E Elbourne instructed by Mr P Armstrong of the NSW Crown Solicitor's Office The Winchester family: Ms B Epstein of Counsel instructed by Ms T Woods of Catherine Henry Lawyers Christian Congregation of the Jehovah's Witnesses Australasia Limited: Mr A Casselden SC and Mr E Engwirda of Counsel instructed by Ms S Leeke The Hunter New England Health District: Ms K Kumar of Counsel instructed by Mr S Sherwen of Makison D'Apice Lawyers Dr A Naseem and Dr A Woods: Ms R Rodger of Counsel instructed by Mr J Kamaras of Avant Law Dr D Chilton: Ms R Mathur of Counsel instructed by Ms D Jackson of MDA National

Findings:

I make the following findings in relation to the death of Mrs Winchester, pursuant to s81 of the *Coroners Act 2009* (NSW):

Identity:

The person who died was Heather Winchester.

Date of death:

Mrs Winchester died on 27 September 2019.

Place:

John Hunter Hospital, Newcastle.

Cause:

The cause of Mrs Winchester's death was multiple organ failure due to severe anaemia both being secondary to blood loss post elective [redacted] hysterectomy surgery with contributing factors being ischaemic heart disease, chronic kidney injury and diabetes

Manner: Mrs Winchester died after an elective hysterectomy. When Mrs Winchester entered surgery, the anaesthetic and surgical teams had differing understandings of whether she would accept a transfusion of packed red blood cells. Following surgery, a CT scan revealed a large pelvic hematoma with ongoing arterial haemorrhage. In the following hours and days, the differing understandings of the surgical and anaesthetic teams led to stress, confusion, and anxiety for Mrs Winchester's family and multiple clinicians. Mrs Winchester underwent a second surgery to treat the pelvic haematoma on 26 September and a third surgery being a laparotomy to pack the abdomen and close on 27 September. Mrs Winchester required a transfusion in order to save her life as she had lost approximately 1,000 ml of blood. On the basis of Mrs Winchester's expressed wishes as verbally conveyed to Dr Searle, consideration of the documents in Mrs Winchester's file, and the taking of legal advice following the initial surgery, Mrs Winchester was not given a transfusion

Recommendations .**To the Hunter New England Local Health District**

1. That the Hunter New England Local Health District put in place a requirement, (as distinct from an expectation), that a member of the surgical team must review the pre-anaesthetic clinic notes prior to surgery. Whether this is part of an updated clinical procedure safety policy or contained in some other document is a matter for the Local Health District.

2. The timeout procedure contained in the Clinical Procedure Safety Levels 1, 2, and 3 policy document be reviewed so that any anomalies, for example, a blood screen conducted for a patient that has refused a transfusion, are identified before surgery.

3. A procedure be implemented that is followed by all relevant medical staff whenever a patient identifies as a Jehovah's Witness, which includes;

    a) advising the patient of the availability of the Jehovah's Witness Hospital Liaison Committee and informing the patient that they can contact the committee if they so wish;
    b) an appropriate form for partial refusal of blood products;
    c) a checklist of blood products that the hospital has available for patients;
    d) a list of all documentation which should be sought from the patient.

4. That the Chief Executive at Hunter New England Local Health District takes steps to resume regular meetings between the church's hospital liaison committee and the directors of medical services at each hospital within the district, with the aim to develop strategies to enhance clinicians' understanding of what treatment would be considered reasonable and compatible with Jehovah's

Witness patients generally and what resources are available to staff in such circumstances.

5. Training and education provided to visiting medical officers and locums be reviewed to ensure they understand how to access all relevant electronic records and their responsibility to do so.

To the Christian Congregation of Jehovah's Witnesses Australasia

1. That all New South Wales congregants be advised that Worksheets 1 and 2 are no longer to be relied upon, and that they should not be used at all for any purpose. This advice should be relayed through all available resources, including literature, both electronic and print, information to elders, and at places of worship.

2. That the church advise congregants in New South Wales the precise status of the development or otherwise of products from human or animal haemoglobin which could be used to treat patients in New South Wales when those patients are suffering with acute anaemia or massive blood loss. This advice should be relayed through all available resources including literature, both electronic and print, information to elders and at places of worship.

Introduction

1 Ms Heather Winchester died on 27 September 2019 at John Hunter Hospital, Newcastle (JHH) on 25 September 2019. Mrs Winchester had undergone surgery for [redacted]. There was a subsequent surgery to treat a pelvic haematoma that had occurred as a result of the first surgery. Those two surgeries took place at Maitland Hospital.

2 Mrs Winchester was then transported to John Hunter Hospital, where she was cared for in the intensive care unit and underwent a laparotomy on 27 September at 8.40am.

3 Having been born on 11 January 1944, Mrs Winchester was 75 when she died.

Inquest

4 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this, there may nevertheless be factual findings revealing inappropriate, or worse, conduct.

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of death.

6 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding the inquest a coronial investigation was undertaken by the Officer in Charge (OIC) Leading Senior Constable Bamber.

8 The OIC interviewed various witnesses, and their witness statements are contained in the brief of evidence.

9 The OIC also obtained all relevant policy documents so that it could be ascertained whether they were complied with.

10 All the documents and witness statements obtained during the coronial investigation formed part of the brief of evidence tendered into evidence during the inquest. All of that material, all other exhibits and all of the oral evidence at the inquest, has been considered in making the findings detailed below.

Witnesses

11 The inquest into Mrs Winchester's death was held on 8 to 12 May 2023 at the Coroners Court at Lidcombe. Due to factors beyond anyone's control, there was a substantial delay in the parties' submissions being completed and that in turn led to a delay in these findings being completed. I wish to convey to the family of Mrs Winchester my deep regret that circumstances have led to these findings being delivered so long after the oral evidence was completed

12 The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

(1) Mr Winchester's family

(2) The Christian Congregation of Jehovah's Witnesses (Australasia) Limited

(3) The Hunter New England Local Health District

(4) Dr Azra Naseem

(5) Dr Andrew Woods

(6) Dr Daniel Chilton

Witnesses

13 The following witnesses gave oral evidence in the inquest:

(1) Doctor Azra Naseem

(2) Ms Elizabeth McIntyre

(3) Dr Daniel Chilton

(4) Ms Jasmine Moore

(5) Dr Andrew Woods

(6) Dr Kenneth Jaaback

(7) Mr Andrew Child

(8) Dr Adrienne Searle

(9) Dr Peter Choi

(10) Mr Mathew Kemertzis

(11) Professor Michael O'Connor

(12) Dr Robert Ford

Issues considered in the Inquest

14 A list of issues was prepared and circulated to the sufficiently interested parties prior to the commencement of the inquest. That list identified the focus of the inquest would be on the manner of Mrs Winchester's death, with the following issues anticipated to be the primary issues for consideration:

(1) Determination of the statutory findings required under s. 81 of the Coroners Act 2009, namely: the identity of the deceased, and the date, place, manner and cause of death.

In relation to the manner of death:

(2) The adequacy and appropriateness of the care provided to Mrs Winchester, including:

a) whether Mrs Winchester should have been offered this surgery in the first place;

b) whether the risks of the surgery and any available alternatives were properly explained to Mrs Winchester;

c) the nature and extent of her consent, including her refusal of [some] blood products and including whether she and/or her treating doctors were able to clarify any uncertainties about which blood products she could and could not accept;

d) whether appropriate contingencies were put in place to manage Mrs Winchester should she suffer a bleed during or after her operation, noting her refusal of [some] blood products;

e) whether the initial surgery conducted by Dr Naseem was conducted competently; and

f) whether the second operation conducted by Dr Naseem was conducted competently, including whether it was scheduled with appropriate urgency.

(3) The adequacy of the systems in place at Maitland Hospital to identify and resolve any uncertainties in relation to the consent provided by Mrs Winchester, including:

a) whether Dr Naseem was aware of the apparent anomalies in which blood products Mrs Winchester had consented to receive before she commenced the initial surgery; and

b) whether the relevant policies were adequate in dealing with what appears to be conflicting forms of consent and, if so, were they followed.

Pursuant to s. 82 of the Coroners Act 2009

(4) Whether it is necessary or desirable to make any recommendations in relation to any matter connected to Mrs Winchester's death

15 The list of issues does not limit what may be considered in an inquest. During the inquest further issues were dealt with in evidence as they arose.

16 In order to assist with consideration of some of the above issues, opinions were sought by the assisting team from the following independent experts:

(1) Professor Michael O'Connor, obstetrician and gynaecologist

(2) Dr Gordon Flynn, intensivist

17 Each of these experts provided reports, which were included in the brief of evidence tendered at inquest. Professor O'Connor gave oral evidence during the inquest. Dr Flynn was not required to give oral evidence or to be cross-examined.

18 In addition, Dr Robert Ford, obstetrician and gynaecologist, was retained on behalf of Dr Naseem to provide a report which was also included in the brief of evidence tendered. Dr Ford gave concurrent evidence at the hearing with Professor O'Connor.

Background

19 Mrs Winchester was a much-loved wife, mother and grandmother. She was born on 11 January 1944. When she left school her father encouraged her to enter nursing, however before even commencing her studies, she met John Winchester, fell in love and married in 1962. John and Heather had three children, Christine, Elizabeth and Peter. Elizabeth, whose married surname is MacIntyre, attended each day of the inquest and gave evidence. Other family members also attended when they could. It is clear Mrs Winchester is dearly missed.

20 Mrs Winchester is said to have loved babies and spoiled her grandchildren with breakfast in bed, birthday and Christmas presents she couldn't afford, and lots of love, kisses and cuddles.

21 Growing up, Mrs Winchester was not overly religious and only turned to religion after a very traumatic personal loss. Initially, she had joined the local Salvation Army, but then befriended Jehovah's Witness doorknockers and became a member of the Christian Congregation of Jehovah's Witnesses (Australasia) ("the Church"). Although her family did not share her faith, they acknowledged and accepted her adherence to it.

Attendances upon Dr Naseem

22 Substantial aspects of the factual matters I will now set out are drawn from Counsel Assisting's helpful factual summary in her written submissions.

23 As set out in clinical records Mrs Winchester had a history of Type 2 diabetes, ischaemic heart disease and hypertension. She had undergone a triple bypass in 2006.

24 On 31 May 2019, Mrs Winchester, with her daughter Elizabeth, attended an appointment with obstetrician and gynaecologist Dr Azra Naseem in her rooms for issues relating to a [redacted]. During that consultation Dr Naseem had a discussion with Mrs Winchester in relation to management of her [redacted]. Mrs Winchester was offered [redacted] however was reluctant to accept it at that

stage. Doctor Naseem provided Mrs Winchester with a pamphlet headed “surgical treatment of [redacted]”. At that stage Mrs Winchester had not yet decided whether she would have surgery.

25 On 5 July 2019 Mrs Winchester again attended an appointment with Doctor Naseem, accompanied by her daughter Elizabeth. At this consultation Mrs Winchester completed a “request for admission” form and a “consent for medical procedure/treatment” form with the proposed procedure being [redacted]”. Mrs Winchester circled that she did not consent to a blood transfusion if needed and wrote alongside the circled words “Jehovah”.

26 After Mrs Winchester completed the consent form Dr Naseem advised her to bring her advanced care directive (ACD) with her “when she came in for surgery”.

27 There was some suggestion at inquest that Dr Naseem should have requested Mrs Winchester to bring her ACD with her to show to Dr Naseem in her surgery at an appointment prior to Mrs Winchester’s admission to hospital. Whilst this approach may be seen as best practice it would not have made any difference to Dr Naseem’s understanding as the content of the ACD was consistent with the content of the consent form.

28 Mrs Winchester attended Dr Naseem again on 3 August, 10 August and 7 September 2019.

29 On 12 August 2019, Dr Naseem wrote to the Hunter New England LHD requesting that Mrs Winchester be allocated an early surgery date. As a result, Mrs Winchester was booked for surgery on 25 September 2019 at Maitland Hospital. It had previously been indicated to Mrs Winchester that she may have to wait up to a full year for the surgery to occur. However, the [redacted] had failed and Mrs Winchester's daughter had contacted the surgery on a number of occasions indicating [redacted] and that her mother was in a deal of discomfort.

Attendance upon Dr Chilton

30 On 11 September 2019, Mrs Winchester attended a consultation with anaesthetic registrar Dr Daniel Chilton at Maitland Hospital. At the time, Dr Chilton was a first-year

anaesthetic registrar and who had been working at Maitland Hospital for just over a month. According to Dr Chilton, Mrs Winchester told him that she was a Jehovah's Witness and she presented him with a two-page document entitled "Worksheet 1" and "Worksheet 2". These worksheets were dated 5 July 2018.

31 Dr Chilton gave evidence that he went through the worksheets with Mrs Winchester point by point and noted that she had indicated an acceptance of haemoglobin. Dr Chilton says he discussed this point in particular with Mrs Winchester, because it was his understanding that giving haemoglobin was synonymous with giving packed red blood cells (PRBC) and he was aware that some members of the Jehovah's Witness faith refused to receive PRBC.

32 Dr Chilton asked Mrs Winchester twice whether she was happy to receive packed red blood cells, and she replied with words to the effect: "I have gone through this document with a Church Senior, whatever I have ticked I am happy with."

33 Dr Chilton told Mrs Winchester to resume taking aspirin.

34 It is to be noted that at this stage Doctor Naseem had Mrs Winchester's consent to surgery, understanding Mrs Winchester would not consent to a blood transfusion and that Mrs Winchester had ceased taking aspirin. In contrast to this position, Doctor Chilton understood that Mrs Winchester would consent to receiving packed red blood cells and he had placed her back on aspirin.

Admission to hospital and steps pre surgery.

35 Mrs Winchester was admitted to Maitland hospital on 23 September, two days prior to her surgery.

36 Mrs Winchester completed a patient health questionnaire in which she indicated that she was not taking blood thinners.

37 Endorsed Enrolled Nurse (EEN) Moore completed the adult pre-procedure checklist on 25 September 2019 at about 12:15pm. In that document Nurse Moore had ticked "consent for blood transfusion indicated on consent form" and had written alongside the tick "PAC & platelets".

38 Dr Chilton set out in his progress note written on 27 September 2019 that he saw Mrs Winchester on the ward at around 12.30pm on 25 September. Dr Chilton's progress note indicates that he noted Mrs Winchester had not had a blood "Group and Screen" performed and when he went to take a blood sample Mrs Winchester asked what the test was for. Dr Chilton explained that the test was needed in order to give her blood products if they were required. He set out in the note that he had reminded Mrs Winchester of the conversation they had on 11 September 2019, and told her that he had understood that she was happy to receive packed red blood cells but did not want to receive plasmapheresis and that Mrs Winchester agreed that this was correct.

39 Mrs Winchester's [redacted] surgery took place on 25 September 2019 commencing at 3:39pm.

40 Following surgery, at 6:34pm on 25 September 2019, a 'rapid response' (Medical Emergency Team) was called, with concerns that Mrs Winchester was experiencing bradycardia (a slower than normal heart rate) and a possible vasovagal response (vasovagal syncope causes a person's heart rate and blood pressure to drop suddenly). A CT scan of her abdomen revealed a large pelvic haematoma with active ongoing arterial haemorrhage, as well as moderate left hydronephrosis (swelling of the kidney, which occurs when urine cannot drain from a kidney and builds up in it as a result).

41 Dr Adrienne Searle was the Senior Resident Medical Officer in Obstetrics and Gynaecology on nightshift at Maitland Hospital on 25 September. At handover at 8pm, Dr Searle was made aware the Mrs Winchester was suffering a suspected vault haematoma (collection of blood in the area where the uterus had been) and a contrast CT had been ordered. Dr Searle gave evidence that she attended upon Mrs Winchester at 9pm. From review of the medical records Dr Searle was aware that Mrs Winchester was a Jehovah's Witness and that her advance care health directive included "*I direct that no transfusions of whole blood, red cells, platelets or plasma be given to me under any circumstances*". Doctor Searle was aware that Mrs Winchester was now actively bleeding. She specifically asked Mrs Winchester both before and after her CT scan whether she did not wish to receive PRBC even if it meant she would die. Mrs Winchester on both occasions confirmed "No, I don't want them", and indicated that her husband and daughter Elizabeth were aware of her wishes even though they did not like them. She was lucid, and Dr Searle was satisfied she could competently express her wishes.

42 At about 10:40pm, Dr Kavina Sidhu, the Intensive Care Senior Resident Medical Officer (SRMO) at Maitland Hospital, rang Dr Jeram Hyde (one of the on-call Intensive Care Specialists at JHH), regarding the possible transfer of Heather Winchester to JHH. Dr Hyde was advised Mrs Winchester had undergone an elective [redacted] hysterectomy and [redacted] earlier that day, and that she had a background of Type 2 diabetes, ischaemic heart disease necessitating three vessel coronary artery bypass graft (CABG), hypertension, dyslipidaemia and was a Jehovah's Witness who did not accept blood products including red blood cells or clotting factors but would accept albumin.

43 Dr Sidhu advised that Mrs Winchester remained in the post-anaesthetic recovery unit at Maitland Hospital and had labile blood pressure both intraoperatively and in recovery post-operatively. Dr Hyde was also told that Mrs Winchester had been in recovery since approximately 5pm and had blood pressure ranging from extremely low (55/31 mmHg) to very high (227/75 mmHg). She had required bolus doses of medications (metaraminol and ephedrine) for her low blood pressure both on initial arrival at recovery post-operatively, and a few hours later.

44 In consultation with other specialists, including Dr Kenneth Jaaback (gynaecologist, gynaecological cancer specialist and Director of Gynaecologic Oncology and Colposcopy at JHH), it was decided that although a return to the operating theatre at Maitland Hospital carried significant risks, the risks of delaying surgical control of active bleeding outweighed this, and transfer to JHH without haemorrhage control was not yet safe.

Second surgery

45 At 12:40am on 26 September 2019, Mrs Winchester returned to the operating theatre at Maitland Hospital for further surgery. Dr Naseem says she specifically asked Mrs Winchester if Floseal could be used, as it is derived from a blood product, and she agreed “yes”, but said not blood. Mrs Winchester on the second operation Consent Form ticked “I do not consent to a blood transfusion” and wrote that her non-consent was because she was a Jehovah’s Witness. Dr Searle and Dr Ahmed were present, and Dr Searle completed the Resuscitation Plan, in which Mrs Winchester again said no to blood transfusion, as well as no to CPR.

46 The contemporaneous Operation Report of Dr Naseem records that Mrs Winchester was examined [redacted] for any "bleeders" (blood vessel cut during surgery which requires clamping, cautery, or ligature to seal it), with none found. On laparotomy, a vault haematoma of about 500mls was found and evacuated. A small bleeder over the vault was sutured. All the pedicles (structure connecting an organ to the body) from the primary surgery were checked, and no bleeding was found. Floseal was sprayed to the vault, a drain was placed in situ, and the abdomen was closed in layers. Floseal was also sprayed to the vault [redacted] The anterior repair line and [redacted] vault sutures were opened to check for any bleeders and were re-sutured. A [redacted] pack was placed. Cystoscopy (examination of the lining of the bladder) was also performed. The total estimated blood loss was about 1,000ml. In recovery, Mrs Winchester received albumex, which contains blood proteins but not whole blood cells.

47 At about 3am on 26 September 2019, Mrs Winchester's care was handed over to the John Hunter Transfer Service.

The John Hunter Hospital treatment

48 Mrs Winchester was transferred by ambulance to JHH in Newcastle, where her condition continued to deteriorate. At 4:36am on 26 September 2019, she was admitted to the ICU. The transfer letter prepared by Dr Searle mentioned Mrs Winchester would not accept some products and would not accept PRBC.

49 There is no issue in the inquest as to the care delivered to Mrs Winchester at JHH and as such the following factual analysis focuses upon broad issues of care at JHH as they related to consideration being given as to whether blood could be transfused.

50 Just after 11:00am on 26 September, a family meeting was conducted during which Mrs Winchester's progress since admission to ICU was discussed, along with the plan for further investigations and the risks and challenges of respecting her request for no blood products in line with her religious beliefs.

51 A further family meeting took place at 4:11pm the same day, during which Dr Woods explained to the family that there was no evidence of ongoing intra-abdominal bleeding and that a CT scan would be conducted to check for occult bleeding (bleeding which is not visible) and also to obtain more information regarding the suspected ureteric injury.

52 At around 4pm, Mrs Winchester was reviewed in ICU by Obstetrics and Gynaecology Consultant Dr Kenneth Jaaback. She was recorded as being sedated and intubated, and although unwell was initially stable despite her falling haemoglobin levels. Dr Jaaback recalls that there was no clear evidence of ongoing bleeding, despite her need for increasing inotropic support (inotropes are drugs that tell the heart muscles to beat or contract with more power or less power). There was to be no surgical intervention overnight unless Mrs Winchester became hemodynamically unstable.

53 At about 9.30pm, Registrar Dr Madzivanyika discussed the case with Dr Jaaback and said that Mrs Winchester's noradrenaline requirements were increasing, however clinically her abdomen was unchanged from the previous examination. Dr Madzivanyika also discussed the results of a CT scan of Mrs Winchester's abdomen and pelvis which had now been performed, which identified a pelvic haematoma which had marginally decreased in size from the previous CT scan conducted at Maitland Hospital. Given the stable surgical findings, Dr Jaaback decided that it would be unwise to take Mrs Winchester back to theatre at that time.

27 September 2019

54 In the early hours of Friday 27 September 2019, Dr Madzivanyika again called Dr Jaaback to advise that Mrs Winchester's condition was deteriorating. When Dr Jaaback reviewed her later that morning, he noted Mrs Winchester's haemoglobin was dropping and she continued to need increasing administration of noradrenaline. Despite this, she remained hypotensive with increasing signs of renal failure and acidosis (too much acid in body fluids).

55 According to Dr Jaaback, Mrs Winchester was critically unwell and required a blood transfusion. However, he was aware that she was a Jehovah's Witness and had refused blood products. Dr Jaaback had seen the ACD dated 14 August 2019, and the list of blood products that Mrs Winchester would and would not accept dated 5 July 2018, he was not aware of the discussion between Mrs Winchester and Dr Chilton on 11 September 2019 about accepting some blood products. That conversation did not form any part of Dr Jaaback's consideration of her wishes, as he was not aware of it.

56 Dr Jaaback telephoned Mrs Winchester's daughter Elizabeth and discussed his concerns about her mother's situation. He says he recalls speaking to a very rational but tearful lady, who told him that her mother was the only one in the family who was

a Jehovah's Witness and that she was desperate for her mother to be given blood. According to Dr Jaaback, Elizabeth told him that if her mother was awake and understood the situation she was in, her mother would clearly agree to receiving blood.

57 At around 6am, Dr Jaaback contacted the on-call senior surgeon, Dr Jon Gani, who agreed that Mrs Winchester should be given blood. However, Dr Gani also recommended that decision be checked with hospital management before doing so.

58 As a result of this advice, Dr Jaaback contacted the Manager of the hospital, Debbie Bradley, who attended the ICU. According to Dr Jaaback, Ms Bradley initially agreed that Mrs Winchester should be given blood, but felt it was important to first seek legal advice. The JHH internal legal representative Karen Berry was consulted, and she advised that blood should not be given.

59 Ms Berry confirmed that advice with a senior NSW Health lawyer in Sydney. Dr Jaaback was told that he or the Winchester family could approach the court to have Mrs Winchester's directions overruled, however given her rate of decline it was felt there was little benefit in doing so. Mrs Winchester's condition continued to deteriorate, with increasing need for inotropic support. Although the pelvic ultrasound performed at Dr Jaaback's request at 4.30am that morning demonstrated that the haematoma had not increased, Dr Jaaback felt that this may have indicated an accumulation of the previous pelvic bleed, as he would expect the haematoma to otherwise resolve, and not remain stable.

60 Dr Jaaback considered the results of the ultrasound, along with Mrs Winchester's increasing tachycardia, deteriorating hypotension despite inotropic support, and her increasing lactate, and felt that her only chance of improvement was to perform a repeat laparotomy to "pack the abdomen and close, keeping her ventilated throughout". He discussed this plan with Dr Gani, who agreed that this was her only chance of survival, albeit small.

61 Mrs Winchester was returned to the Operating Theatre at 8:40am on 27 September 2019. Dr Jaaback was assisted by Dr Woods. During the laparotomy they noted "significant bladder wall oedema with minimal free blood in the pelvis, but no other correctable pathology was visible." The pelvis was packed with large sponges, after applying further Floseal fibrin sealant to the pelvic floor. They closed the skin,

anticipating the possible need to take Mrs Winchester back to theatre in 24 to 48 hours to remove the packs and close the abdomen if her condition was to improve.

62 Mrs Winchester was returned to the ICU where she continued to deteriorate, with further need for increased inotropic support, further lactic acidosis and renal failure. Her wishes were further discussed and confirmed with her family, who strongly disagreed with her express choice. Mrs Winchester died at 4:40pm on Friday, 27 September 2019.

Issue 2 The adequacy and appropriateness of the care provided to Mrs Winchester

2 a) whether Mrs Winchester should have been offered this surgery in the first place;

63 Following Mrs Winchester's early appointments with Dr Naseem she experienced ongoing difficulties from her prolapse and its treatment.

64 On 6 July 2019 Ms MacIntyre rang the surgery to advise that her mother's [redacted]

65 On the 17 and 24 July 2019 Mrs Winchester's daughter again contacted the surgery and indicated that her mother was [redacted] Mrs Winchester also experienced [redacted] On 19 July Ms McIntyre called to say her mother was "in lots of pain and it's getting worse".

66 On 3 August 2019 Dr Naseem wrote to the GP as follows:

> "she has been having [redacted], I have been trying to organise an early surgery for her. I have finally been able to organise one for a list in September. She will however need admission before surgery for optimising her health"

67 On the 5 August 2019, Mrs Winchester's daughter again called Dr Naseem's surgery indicating the [redacted] and emailed asking what the plan was for her mother.

68 On 10 August 2019, a new [redacted] and Doctor Naseem discussed with Mrs Winchester the option of [redacted] which is a surgical treatment option for [redacted] in which [redacted]. It [redacted] does not require any abdominal incisions. The surgery and recovery are relatively quick. Mrs Winchester made clear that she did not want [redacted].

69 On the expert evidence, [redacted] was the safest option raised with Mrs Winchester and the surgery ultimately undertaken the next safest option.

70 On the 7th of September Mrs Winchester reported during consultation that she kept [redacted] and again confirmed that she did not want [redacted]

71 It was clear on the evidence that Mrs Winchester's difficulties continued right up until the time of surgery. The difficulties included [redacted], pain and discomfort to the extent that Mrs Winchester could not stand for more than an hour each day, and [redacted].

72 On the evidence the only basis on which Dr Naseem could have refused to perform the surgery was if she had thought the treatment was "unreasonable, offering negligible prospect of benefit to the patient or was of no therapeutic value". There was no suggestion in the evidence that there was no prospect of benefit to the patient nor that there was no therapeutic value.

73 Assessing the reasonableness of the surgery calls for an assessment of the risks of the surgery as against the potential benefits. The expert evidence was that whilst bleeding was common after this surgery, the risk for all patients of needing a blood transfusion was one in one hundred (1/100). As shall be addressed below, Mrs Winchester's co-morbidities increased the risk for her and whilst this should have been fully explained to her it did not preclude the surgery being offered.

74 The force of the evidence was that there was no acceptable alternative remaining for Mrs Winchester but for hysterectomy given her decreasing quality of life, increasing health risks of [redacted] and her refusal of [redacted]

75 I accept that Doctor Naseem discussed [redacted] with Mrs Winchester on more than one occasion. As Doctor Naseem put it;

> "So, when I discussed the things with her and I offered the [redacted], she kept on saying no. She came across to me as an intelligent woman, a bit conservative, but very intelligent person and it's my duty to respect her, what, what her views are".

76 I am of the view that it was appropriate for Dr Naseem to offer to undertake the surgery, however as developed below the risks should have been far more completely explained to Mrs Winchester.

2 b) whether the risks of the surgery and any available alternatives were properly explained to Mrs Winchester; and

2 c) the nature and extent of her consent, including her refusal of [some] blood products and including whether she and/or her treating doctors were able to clarify any uncertainties about which blood products she could and could not accept;

77 It is appropriate to deal with these two sub-issues together. The starting point is to consider what risks were explained to Mrs Winchester by Dr Naseem.

78 There is some tension between the evidence of Dr Naseem and Mrs Winchester's daughter on this issue.

79 Dr Naseem said that she discussed the risks of bleeding, infection, injury to bowel, bladder, ureters, vessels and nerves, VTE (venous thromboembolism) and [redacted] with Mrs Winchester. These risks were all referred to in the pamphlet "surgical treatment of [redacted]" which had been given to Mrs Winchester. The pamphlet was created by the Australian and New Zealand Obstetrics and Gynaecology College. Importantly, in the pamphlet it is noted "*this pamphlet is intended to provide you with general information. It is not a substitute for advice from your doctor and does not contain all the known facts about the treatment of* [redacted]

80 Mrs Winchester's daughter gave evidence that the risks discussed in her presence were only in general terms. I accept that evidence.

81 Doctor Naseem's evidence included a reference to “the risks we mainly discuss” which does not suggest any specific content. Doctor’s correspondence to Mrs Winchester’s GP on 5 July 2019 stated “we discussed the risks of surgery” without providing any detail.

82 The ‘request/consent for medical procedure treatment’ standard form which Mrs Winchester signed, included the wording “*Dr Naseem and I have discussed the present condition and the various ways in which it might be treated, including the above procedure or treatment”* and continued *“the doctor has told me that the procedure/treatment carries some risk and that complications may occur; an anaesthetic, medicines or blood transfusion may be needed and these may have some risks; additional procedures or treatments may be needed if the doctor finds something unexpected; the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care”*

83 There was no evidence from Dr Naseem that she specifically addressed the increased risk Mrs Winchester faced because of her medical obesity, diabetes, previous heart surgery or ischaemic heart disease. I accept the expert evidence that these matters should have been discussed. Whilst there were consultations when Mrs Winchester’s daughter was not present there is nothing in Dr Naseem’s evidence or in the consent signed by Mrs Winchester to suggest that Doctor gave Mrs Winchester sufficiently detailed advice about the risks she faced.

84 In submissions on behalf of Dr Naseem it was pressed that it was unlikely that Dr Naseem would have raised the previously undiscussed [redacted] without giving Mrs Winchester any reason as to why she was now recommending a different surgery to that already planned. It was also pointed out that Doctor Naseem’s further evidence was that she drew to Mrs Winchester’s attention the fact that one in 100 women require a return to theatre or a transfusion which meant that refusal of transfusion increased the risk of surgery. Doctor did not volunteer this evidence but rather embraced it in response to leading questions. I am disinclined to attach any weight to that evidence. The asserted unlikelihood of Dr Naseem not providing [redacted] reasons in relation to discussions around [redacted] does not lead me to conclude that there were detailed discussion of the risks faced by Mrs Winchester.

85 I am satisfied that Dr Naseem’s explanation of the risks was in general terms, and did not include any discussion, let alone detailed discussion, about Mrs Winchester’s co-

morbidities. To that extent the advice to Mrs Winchester as to the risks of surgery was inadequate.

86 The next aspect of Mrs Winchester's consent relates to the fact that whilst Dr Naseem had consented Mrs Winchester to surgery in which she would not accept a blood transfusion, Dr Chilton, as Anaesthetic Registrar, was of the understanding that Mrs Winchester would accept a transfusion of packed red blood cells. The fact that the surgeon and the anaesthetic registrar had different understandings as to the circumstances in which the surgery would occur was a completely unacceptable situation and a further failing in relation to Mrs Winchester's consent. The surgery should not have taken place in circumstances where these different understandings existed.

87 The next issue in relation to Mrs Winchester's consent is in relation to aspirin. Doctor Naseem had told Mrs Winchester to cease taking aspirin. Dr Chilton told her to recommence taking aspirin. Dr Chilton did not advise Dr Naseem that he had told Mrs Winchester to resume taking aspirin. At surgery Dr Naseem did not know if Mrs Winchester was taking aspirin. Dr Naseem's evidence was that if she had known Mrs Winchester was taking aspirin, she would have postponed the operation for at least five days.

88 It is not clear whether Mrs Winchester was in fact taking aspirin given that on her admission documentation it was recorded that she was not on any blood thinners.

89 The uncertainty surrounding whether Mrs Winchester was taking aspirin was also completely unsatisfactory. It was a further issue compromising Mrs Winchester's consent.

2 d) whether appropriate contingencies were put in place to manage Mrs Winchester should she suffer a bleed during or after her operation, noting her refusal of [some] blood products;

90 Dr Naseem arranged for Mrs Winchester to enter hospital two days in advance of her surgery so as to [redacted] and by Mrs Winchester remaining lying down. All of these steps were appropriate.

91 The evidence was that the anaesthetic team had responsibility for blood transfusion and blood products during surgery, hence their conduct of the anaesthetic record and pre-anaesthetic assessment. Any concerns as to the conduct of the surgery were to be escalated to the surgeon. Consequently, no criticism can be made of Dr Naseem for not consulting with a haematologist. Regrettably, as was mentioned above and will be discussed below, the anaesthetist was of the view Mrs Winchester would accept a transfusion and as such did not make any enquiries as to alternatives to blood or steps to take if there was objection to blood transfusion.

92 Beyond the preparatory matters referred to above the only step Dr Naseem had in mind in relation to the risk of blood loss sufficient to require transfusion was to do her best to ensure there was no bleeding. This was appropriate given that the weight of the evidence was that it was the anaesthetic team who had responsibility for blood transfusion and blood products.

2 e) whether the initial surgery conducted by Dr Naseem was conducted competently; and

2 f) whether the second operation conducted by Dr Naseem was conducted competently, including whether it was scheduled with appropriate urgency.

93 Sub issues (e) and (f) can be dealt with in short order. The unchallenged expert evidence was that both the initial surgery and the second operation were conducted competently and that the delay in relation to the second surgery was acceptable in the circumstances.

(3) The adequacy of the systems in place at Maitland Hospital to identify and resolve any uncertainties in relation to the consent provided by Mrs Winchester, including:

a) whether Dr Naseem was aware of the apparent anomalies in which blood products Mrs Winchester had consented to receive before she commenced the initial surgery;

94 It is clear that when Dr Naseem commenced Mrs Winchester's first surgery she was not aware which blood products Mrs Winchester had consented to receive.

95 The order of events requires detailed consideration.

96 Mrs Winchester signed a consent form dated 5 July 2019 on which she had indicated that she would not accept a transfusion. This form was placed in her medical file.

97 That file was available to Dr Chilton when he attended upon Mrs Winchester on September 11, 2019. For reasons which are not adequately explained in the evidence Dr Chilton either did not look at the form or, if he did look at it, he did not consider it carefully enough.

98 If Dr Chilton had appropriately considered the consent form on 11 September 2019, then I accept he would have raised the issue with Dr Naseem and likely their different understandings would have been clarified.

99 Dr Naseem's evidence was that if there were any issues that needed to be "corrected" they would be brought to the attention of the surgeon by the anaesthetic team. Doctor Naseem's further evidence was that she did not look at all of Mrs Winchesters paper file prior to surgery.

100 As set out above EEN Moore completed the adult pre-procedure checklist on 25 September 2019 at about 12:15pm. In that document EEN Moore had ticked "consent for blood transfusion indicated on consent form" and had written alongside the tick "PAC & platelets". EEN Moore gave evidence of her usual practice. She had no independent recall of her attendance upon Mrs Winchester. It is difficult to understand how she came to note that PAC and platelets had been indicated on the consent form when clearly, they hadn't.

101 As submitted by the Church I can't rule out the possibility that EEN Moore may have been present at the same time as Dr Chilton attended upon Mrs Winchester for screening for receipt of blood products and that she overheard their conversation.

102 As set out above Dr Chilton's evidence was that on 25 September, he confirmed with Mrs Winchester that she would accept packed red blood cells.

103 Doctor Naseem saw Mrs Winchester's 14 Aug 2019 ACD in the anaesthetic bay on the day of surgery. The ACD did not change Doctor Naseem's understanding of Mrs Winchester's consent.

104 Immediately prior to the first surgery, and in accordance with policy, there was a "timeout". As Dr Choi pointed out, the express function of the timeout is "to cover across any risks that may have been missed".

105 Dr Naseem indicated that the timeout was a routine procedure during which the consent form is "spoken out loud by the team and that's the patient's name, date of birth, their medical record number, whatever is written, handwritten on that page is spoken out loud."

106 Dr Naseem recalled that the consultant anaesthetist was on the phone to the cardiologist for some time during the timeout. Dr Naseem had no recollection of whether Dr Chilton was present during the time out and Dr Chilton himself had no recollection of the timeout.

107 I accept that had Dr Chilton been present during the reading of the consent form highlighting 'not for blood transfusion' the inconsistent instructions given by Mrs Winchester would have been raised by Dr Chilton with the surgical team. My assessment of Dr Chilton is that he was an honest witness.

108 Dr Chilton gave evidence that if he had heard during the surgery that Mrs Winchester was not consenting to a blood transfusion it would have been incumbent on him to interrupt, stop and let everyone in the theatre know they had different understandings of Mrs Winchester's consent. I accept this evidence.

109 Had the conflicting understanding been identified at any stage then appropriate steps could have been taken, including possibly cancelling the operation at very short or late notice so that there could be a further discussion with Mrs Winchester clarifying what had been said to Dr Chilton and possibly EEN Moore as compared to her signed consent and her ACD.

b) whether the relevant policies were adequate in dealing with what appears to be conflicting forms of consent and, if so, were they followed.

110 The conflicting understandings of Mrs Winchester's consent relate not only to the issues in relation to blood products and blood transfusion but also the issue in relation to aspirin.

111 The factual matters relating to blood products and blood transfusion have been considered immediately above. In relation to aspirin, it is clear that Dr Naseem told Mrs Winchester to stop taking aspirin whilst Dr Chilton told her to resume taking aspirin.

112 The weight of the evidence at inquest was that it was reasonable for Dr Chilton not to raise with Dr Naseem the fact that he had asked Mrs Winchester to resume taking aspirin. In this regard it is to be noted that Dr Chilton did discuss the prospect of Mrs Winchester's surgery with her cardiologist including discussing the issue of Mrs Winchester resuming taking aspirin. Dr Chilton gave evidence that the preoperative instructions document containing a list of medications, including aspirin was copied and placed on the electronic file.

113 The record-keeping systems in place at Maitland Hospital in 2019 were far from satisfactory. There was a hard copy file, which was kept at the hospital, plus two different software systems which were accessible, either at a desktop at the hospital or, remotely, with appropriate software. It was only in one system, the "Medchart" system, that there was a record of a patient's prescribed medications. As Dr Choi observed, information in relation to medication to some extent is always ultimately dependent on the patient as even though medication may be prescribed, and the script filled out, there remains the final step of the patient taking the medication. Having the information in three places was less than ideal. The evidence was that the paper file was very bulky. As indicted above Dr Naseem gave evidence that she did not look at all of Mrs Winchester's file prior to surgery and it was not suggested to her that she should have checked on what medicines Mrs Winchester was taking.

114 Dr Choi gave initial evidence that the two opportunities to resolve the differing understandings in relation to aspirin were when the patient was attended upon by the surgical team after being admitted prior to surgery and the second opportunity would have been during the timeout. In developing that evidence, Doctor indicated that neither Dr Chilton, nor Dr Naseem would have had any reason to raise the issue of aspirin as each thought it was settled, albeit that once again their understandings were different. Any issue as to the taking of aspirin was in a different category to blood transfusion in that the timeout procedure did not specifically require that the medications be read out aloud.

115 I am unable to comment as to why the surgical team did not pick up the discrepancy in relation to aspirin as the team members were not cross examined on this issue given

that the expert opinion was that aspirin was not likely of any relevance to Mrs Winchester's ultimate outcome. It is to be noted however that Dr Naseem would have postponed the surgery for at least five days if she had discovered Mrs Winchester was taking aspirin.

116 In 2019 at Maitland Hospital the medical records were not as user friendly as they should have been.

117 Dr Choi indicated in his evidence that a single digital patient record was being developed and it was planned that it would be in place in the Hunter New England Local Health District in 2024. In that system the medication will be in the same location as the electronic medical record.

118 Dr Choi accepted the need to reinforce the requirements for medicine reconciliation pending the implementation of the single digital patient record. Doctor indicated medicine reconciliation was a process well understood by clinicians. With respect to the issue of the aspirin (and other medications), Dr Choi indicated a belief that the new software system will essentially remove as much of the uncertainty as any software system can. It will essentially allow a single record of a patient's medications to be provided in a fixed standard format and accessible to everybody across the state. Doctor went on to say, "*and so, we would not have the lack of clarity as to whether somebody had stopped the medication or not because there would be a single record and a single source of truth.*"

119 Dr Choi's optimism as to when the Single Digital Patient Record would commence at Maitland Hospital did not obscure the reality that steps needed to be taken in the interim at Maitland Hospital to deal with the inadequacies identified in this inquest in relation to medicine reconciliation.

120 Dr Choi's evidence was that if there hadn't already been some reminder to clinicians at Maitland to make sure the electronic records, including the Medchart record, is checked prior to surgery, that he would commit to doing so.

121 The system in place for final checking of any issues or problems leading up to surgery (the timeout) was, at the relevant time, set out in one of the Hunter New England Local Health District policies headed "Clinical Procedure Safety (Level 1, 2 and 3)".

122 The flowchart within the policy specified steps to take at both “sign in”, prior to sedation, and during “timeout” immediately before commencing surgery. At sign in the anaesthetist confirms with other team members a number of things including the “risk of bleeding/confirm valid group and screen”.

123 If that step was taken, it should have been realised that on the one hand Dr Chilton had conducted a group and screen and on the other Mrs Winchester had indicated she would not receive a blood transfusion.

124 The policy also required that during timeout, the senior proceduralist leads a number of steps including “planned procedure matches consent”. This is the point at which Dr Naseem indicated in evidence that she read out aloud the consent signed by Mrs Winchester. At a later point during the timeout the proceduralist was to provide a procedural brief including anticipated events and critical steps and concerns were to be verbalised. Once again if the step had been taken and the anaesthetic team received the relevant information from Dr Naseem, the different understandings in relation to blood transfusion would have been recognised.

125 The system in place for “sign in” and “timeout” was on its face adequate in order for the different understandings in relation to blood transfusion to be recognised. The failure to do so in my view occurred because those charged with the responsibility of participating in both sign in and time out did not give the processes sufficient attention. The evidence would suggest that some of the participants were distracted from giving their full attention to the process. This is as inexplicable as it is unacceptable.

THE ROLE OF THE CHURCH IN THE INQUEST

126 Before discussing the worksheets which Mrs Winchester presented to Dr Chilton, it is helpful to have some understanding of the approach of the church in relation to blood transfusion and blood products. I will discuss this in the context of the church's role in the inquest, given the submissions of counsel assisting.

127 Counsel assisting submitted that a finding is available that the church made deliberate efforts to frustrate the fact-finding process associated with the inquest. Secondly, counsel assisting submitted that there is sufficient evidence to make a finding that the church failed to cooperate fully with this inquest.

128 The church provided substantial and compelling responses to these submissions, and in circumstances where I don't propose to make either finding, I will not set out the respective arguments in more detail than is necessary to make the following points.

129 Counsel assisting complained that the church, in correspondence under the hand of Mr Pecipajkovski, sought to downplay the advice given to followers of the faith about blood transfusions and that the information provided respectively by Mr Pecipajkovski and Mr Kemertzis was inconsistent. I do not accept that this was the case. Rather, the submission incorrectly interprets Mr Pecipajkovski's following wording:

> *"elders do not advise followers or congregants on what medical treatments they can and cannot accept*"

and misunderstands the church's approach. In his correspondence, Mr Pecipajkovski drew attention to lesson 39, which is headed, God's View of Blood. In part, it reads:

> "*some procedures clearly violate God's law. These include the transfusion of whole blood or any of its main components: red cells,* white cells, platelets, and plasma."

130 On face value, it is difficult to reconcile that extract with Mr Pecipajkovski's assertion that the church and its elders do not advise followers or congregants on what medical treatments they can and cannot accept. However, this was not an attempt to mislead the inquest. As explained at inquest by Mr Kemertzis, who gave evidence in his role as the associate director of the Public Information Department at the Australasian Branch Office of Jehovah's Witnesses, in order for an individual to become a baptised Jehovah's Witness, they first must accept that transfusions of whole blood and its main components are to be refused as a violation of God's law.

131 Approaching the issue that way means that the church and its elders do not later advise congregants as to whether they can accept a blood transfusion, but rather the congregant accepts it as a basic tenet of being a Jehovah's Witness.

132 Whilst to some, this might be considered as the church giving medical advice, the church sees it as religious advice. The distinction might be thought by some to be one of semantics, given the advice clearly touches upon medical issues. As agreed to by Mr Kemertzis in evidence, the church is conveying to individuals its interpretation of

the Bible. However, I accept unreservedly that Mr Pecipajkovski was faithfully setting out the church's position in his correspondence.

133 An issue associated with the church's contention that it does not tell congregants through elders what medical treatment they can and cannot accept is the issue of the church maintaining through Mr Kemertzis that it does not give medical information to congregants. In response to a question from counsel assisting as to whether the church provides any information to followers on the risks of not having a blood transfusion, Mr Kemertzis responded :

> "*We don't provide medical information for followers*."

134 On further questioning by another legal representative, Mr Kemertzis confirmed his evidence had been that:

> "*We, the church don't provide medical information to congregants*."

And was then asked specifically:

> "*Is that correct that your evidence that we, namely, the Jehovah's Witness Church, does not provide medical information to congregation members?"*

Mr Kemertzis answered:

> "*We're not a medical organisation, we're a religious organisation*."

He was then asked if the answer to the question was yes or no, and Mr Kemertzis then answered:

> "*I'm not quite sure how to answer that. I'm just thinking whether worksheet 1 and 2 qualifies as medical information. Yeah, I'm not sure I'd qualify that as medical information, so no."*

135 When questioned further, Mr Kemertzis then described worksheets 1 and 2 as:

> "*Almost like a dictionary of medical terms*."

136 He then accepted that he could see the questioner's point that the church was therefore providing medical information.

137 Upon further questioning on this issue, Mr Kemertzis accepted in lesson 39, entitled, *God's View of Blood*, the church not only provides medical information in relation to fractions from platelets, the composition of blood, some blood fractions being used in medicines that help to fight disease or help to stop bleeding, but the church also provides medical opinion when asserting within the lesson that:

> "*It is possible to adhere to God's law about blood and receive quality non-blood medical care."*

138 Mr Kemertzis gave this evidence in his role as associate director of the Public Information Department at the Australian Branch Office of the Jehovah's Witnesses. The department officially represents the Jehovah's Witnesses to government officials, academics, the media, and other entities. At the time of giving evidence, he had been a Jehovah's Witness for some 19 years.

139 Against that background, it is somewhat concerning that Mr Kemertzis had to correct himself in his claim that the church did not provide medical information to followers.

140 In submissions, the church acknowledged Mr Kemertzis' evidence that the church did not provide medical information to followers, then asserted that Mr Kemertzis had already given evidence of the supply of medical information by his indication in his written statement that the worksheets included basic information regarding commonly used products that may contain derivatives of primary blood components, being blood fractions, and medical procedures that may involve the use of their own blood.

141 The church suggested that Mr Kemertzis was perhaps drawing a distinction between basic information and information in the nature of advice. I reject this submission.

142 The full extract of the relevant paragraph of Mr Kemertzis' written statement is as follows. It relates to the 2006 article to which the worksheets were attached:

> "*The article cited a number of Bible texts referencing God's law on blood and explained that adherence to this law precludes accepting a transfusion of blood or any of its four main components, red cells, white cells, plasma or platelets.*

It included basic information regarding commonly used products that may contain derivatives of primary blood components, blood fractions and medical procedures that may involve the use of their own blood."

143 Contrary to the church's submission, in his written statement Mr Kemertzis was referencing the article, he was not expressing his own view or any view as to whether the church provides medical information. The church's acknowledgement in its submission that the above is medical information makes all the more curious Mr Kemertzis's initial oral assertion that the church did not provide medical information to its followers.

144 I found Mr Kemertzis to be a variable witness. At times he easily and readily answered questions, whilst at other times he was uneasy in his answers and on yet other occasions I found his lack of knowledge puzzling and difficult to accept given his position. One example of his answers being uneasy was when he was first asked the question as to whether the church gives any advice on the risk of not having a blood transfusion Mr Kemertzis' answer was in fact a question asking if the reference was to medical risks.

145 Given the inquest's focus on medical matters and given that Mr Kemertzis had been present during the entire inquest, his response was difficult to understand. When Mr Kemertzis was asked, "*Any other sort of risk*?", and he answered, "*No, I just wanted to clarify that that's what was meant*". It was crystal clear what the questioner was asking. I found Mr Kemertzis' response mystifying.

146 Another example of Mr Kemertzis' evidence being problematic arose in relation to the worksheets Mrs Winchester showed to Dr Chilton. In his written statement Mr Kemertzis indicated that the worksheets were not intended to be provided as a document to doctors or other healthcare personnel, rather they were for a congregant's personal use to assist them in completing their advanced healthcare directive.

147 He went on to set out that this was clearly stated in *Our Kingdom Ministry* articles and quoted from the 2009 edition of *Our Kingdom Ministry*, which suggested a congregant use the worksheet:

"*To make their personal decisions about what options they would accept or refuse. Finally, a congregant was encouraged to be sure they had accurately transferred their choices to their DPA card*."

148 In oral evidence Mr Kemertzis confirmed that the worksheets were for the personal use of the congregants. In later evidence, whilst confirming that congregants should discuss medical decisions with their clinicians, Mr Kemertzis indicated that what he meant in referring to the above extracts and in his oral evidence was that the worksheets should not be given to the clinician to keep. The relevant evidentiary extract is as follows:

"Q. *So, how was the follower to discuss with the medical practitioner the relevant procedures without reference to the worksheets?*

A. What I meant by that was that it wasn't intended to be handed over to the doctor as a document that he would retain on his medical file. It could be used as a discussion point upon visiting the doctor."

149 Neither the statement content nor the early oral evidence came across as indicating that approach. Both those bodies of evidence came across as clearly emphasising that the worksheets were for personal use.

150 In my view, when the above extracted question was asked, Mr Kemertzis saw the need to alter his approach and consequently accepted that the doctor could be shown the documentation (emphasis added). He tailored his evidence to suggest he had meant that all along. I found the tailored evidence unconvincing.

151 In my view, any medical practitioner who had a discussion based upon the worksheets or indeed any other document would be best advised to retain a copy of the documents and place them on the medical file.

152 Counsel assisting further submitted that when written to on 10 June 2022, the church was specifically asked to provide a statement from an authorised person and yet in Mr Pecipajkovski's response, no statement was provided and no explanation was given as to why there was no statement. No further request for the statement was made. That may be explained by the fact that the first request was ignored. It should be noted, however, that as the church correctly pointed out in submissions, no legal

obligation to supply a statement existed when Mr Pecipajkovski provided his response. Mr Kemertzis gave evidence under subpoena, and it was both sensible and helpful that he provided a statement without any further request having been made.

Worksheets 1 and 2 ("the Worksheets")

153 Worksheets 1 and 2 are the documents which were shown to Dr Chilton by Mrs Winchester on 11 September 2019 in the pre-operative anaesthetic clinic. They were the subject of substantial consideration in the inquest. The worksheets were published in *Our Kingdom Ministry*, a publication for Jehovah's Witnesses, as a part of a 2006 article, "How do I view blood fractions and medical procedures involving my own blood?"

154 Within the article, it was pointed out that the worksheets are not legal documents and that congregants may use their answers to help them complete their DPA (durable power of attorney). As set out above at the commencement of Mrs Winchester's surgery, the anaesthetic registrar, Dr Chilton, was of the view that Mrs Winchester would accept a blood transfusion if necessary, and the surgeon was of the view that she would not. This was a completely unsatisfactory situation. All possible steps should be taken to minimise the risk of the same situation arising in the future. I should make clear that the consultant anaesthetist did not give evidence in the inquest, and the notes made by Dr Chilton would have been available to him.

155 In written submissions, the church argued that the worksheets were not misleading in that any putative confusion or putative ambiguity was the fault of Dr Chilton, and that Dr Chilton ought not to have satisfied himself by interpreting the worksheets as he did. I reject this submission. The worksheets had been provided by Mrs Winchester to Dr Chilton, he considered them and discussed them with Mrs Winchester and came to the view that Mrs Winchester consented to a transfusion of packed red blood cells. The manner in which the church says the worksheets should be interpreted is not determinative of the way in which they will be read and interpreted by others.

156 The circumstances explored in this inquest make it clear that an anaesthetic registrar who had passed years of medical study and who impressed as a caring professional came to an honestly held belief upon considering the worksheets and discussing them with Mrs Winchester, that Mrs Winchester would accept a transfusion of packed red blood cells. Once the worksheets were published and/or distributed, congregants were

open to use them in whatever way they wished, including presenting them to clinicians who would interpret them as best they could and discuss them with their patient.

157 The church submitted that Dr Chilton was the only practitioner who concluded that Mrs Winchester would accept packed red blood cells. In a strict sense, that is the case, but as the church also recognised in submissions, Dr Searle found the haemoglobin question confusing. She similarly found the reference to "interferons" confusing. In addition, clinicians at John Hunter Hospital, on considering Mrs Winchester's file, at one stage determined a transfusion should be given and the John Hunter Hospital liaison officer expressed the view the worksheets were confusing.

158 The provision of medical information by the church in the worksheets opened up the possibility of varying interpretations and approaches. Once the worksheets are in the hands of congregants, they may fall to be interpreted by clinicians with varying degrees of understanding of religion, let alone the Jehovah's Witness faith. In addition to the submission that the worksheets were not misleading, the church also submitted that they were not inappropriate. I attach the worksheet to these findings to aid understanding of my following comments about them.

159 As a standalone document, it is notable that the worksheets do not contain any reference to the Jehovah's Witness faith. This is explained by the fact that the worksheets were part of a lesson readily available to congregants online. However, the worksheets were able to be separated from the lesson and consequently be considered without any reference to the lesson. The worksheets contain no explanation of how they are to be read. There is no indication if headers are to interact vertically or laterally or both. They contain no statement specific to Jehovah's Witnesses such as, "Jehovah's Witnesses do not accept blood transfusions".

160 The left-hand column of Worksheet 1 is headed “Unacceptable to Christians”. A reader with some understanding of Christianity and its various strands may find this header either wrong, confusing, or misleading, given that some strands of Christianity do not refuse blood transfusion as a fundamental part of their faith. A reader with little or no understanding of Christian beliefs may not understand the intent of the header at all.

161 Despite what I have set out above in relation to Mr Kemertzis' evidence about being baptised as a Jehovah's Witness and accepting the fundamental tenet, the evidence on this topic varied during the inquest. In this regard, Mr Child gave evidence that, "It's

up to that person as a Christian", and that even though the left-hand column says, "Unacceptable to Christians", “it is still up to the person to make their minds up”.

162 Columns 2 and 3 of Worksheet 1, which have the header “Your Personal Decision” may lead a reader to think that a Christian can make their own decision in relation to the matters identified in columns 2 and 3, including haemoglobin. Column 2 has the subheading “Fractions” and column 3 the subheading “Choices You Need To Make”.

163 Under the further sub-header “Haemoglobin” the following appears:

> *"Products being developed from human or animal haemoglobin could be used to treat patients with acute anaemia or massive blood loss."*

164 Immediately alongside that entry, under the header “Choices You Need To Make” are the words:

> *"I accept haemoglobin or I refuse haemoglobin."*

165 Whereas the medical information under the heading "Fractions" talks about products ‘being developed’, and haemoglobin “could be used”, the words "I accept" are, by contrast, in the present tense. The worksheet, and in particular column 2, and in particular the section relating to haemoglobin, calls for a determination as to what the reader accepts at the time of filling in the worksheet.

166 In both 2018, when Mrs Winchester completed the form, and 2019, when Mrs Winchester was operated upon, there were no haemoglobin “products” available in Maitland, the Hunter New England Local Health District, or indeed New South Wales. Haemoglobin could only be received by packed red blood cells. In my view, it was completely inappropriate that the worksheets in this form were available to Mrs Winchester to complete in 2018, when there were no haemoglobin products available to her and no clear explanation of that situation either in the worksheets or in the applicable teaching.

167 It is worth referring to Lesson 39 and the medical opinion contained therein that “*it is possible to adhere to God's law about blood and receive quality non-blood medical care*”. Whilst Mr Kemertzis accepted that this was a medical opinion, in my view, it is also apt to be characterised as medical advice. As at 2018, when Mrs Winchester

completed the worksheets, there was no non-blood medical care available in Maitland Hospital, John Hunter Hospital or indeed in New South Wales as an alternative to a blood transfusion.

168 In submissions, the church pressed that, contrary to Dr Chilton's evidence, haemoglobin can be administered other than by packed red blood cells. The submission misses the point. At issue is what was available to Mrs Winchester when she completed the form and when she underwent surgery. The church's submission went on to indicate Dr Chilton acknowledged haemoglobin can be administered by other than packed red blood cells when he conceded that Mrs Winchester may have been consenting for artificial haemoglobin and non-human donor haemoglobin.

169 That asserted concession needs to be put in full context. The progress note upon which the submission relies was made on 27 September 2019, two days after Mrs Winchester's first surgery. In the note, Dr Chilton indicates that he was discussing Mrs Winchester's situation with Dr Wright, the Director of Anaesthetics at Maitland Hospital. Dr Chilton also confirmed that he was only made aware of a 2019 document regarding Mrs Winchester's wishes, her advanced care directive, on 27 September, he having not been aware of the document until that day.

170 In relation to the worksheets, Dr Chilton indicated that he and Dr Wright acknowledged the reference to red cells in column 1, and to, "only" “I accept haemoglobin” in the right column, and they acknowledged the potential ambiguity that Mrs Winchester may have been consenting for artificial haemoglobin and non-human donor haemoglobin.

171 Drs Chilton and Wright noted the possibility that Mrs Winchester did not understand the potential difference, and that ambiguity may have existed in relation to Mrs Winchester's understanding of packed red blood cells. In making this note, Dr Chilton was not resiling from his understanding as it existed when he met with Mrs Winchester in September 2019, rather, with the benefit of hindsight and the 2019 document, he revisited the worksheet.

172 He was asked specifically whether, as part of his conversation with Dr Wright, he ever came to accept that there may be some ambiguity in relation to how Worksheet 1 and Worksheet 2 should be read. He answered that he thought “*with the benefit of hindsight and the progression of the case, the complexities that were not initially*

apparent became apparent". In my view, a full understanding of Dr Chilton's note, and his evidence in relation to it, emphasises the potential of the worksheet to confuse.

173 The church further submitted that the worksheets were irrelevant, given Mrs Winchester had capacity to make decisions. The worksheets were not irrelevant. The church made the worksheets available to Mrs Winchester and Mrs Winchester presented the worksheets to Dr Chilton as part of her discussion with him. Together with that discussion, the worksheets formed the basis of Dr Chilton's understanding of Mrs Winchester's consent.

174 In addition to the completely unacceptable position of the differing views of Dr Chilton and Dr Naseem as to Mrs Winchester's consent in relation to blood transfusion, it was equally unacceptable that Mrs Winchester was called upon to clarify her position while she was in the position she was in when Dr Searle spoke to her about her consent to the second surgery. Whilst there is no challenge to Dr Searle's assessment that Mrs Winchester fully understood what she was being asked when Dr Searle sought to clarify whether she would accept a blood transfusion, it is demonstrably less than ideal that Mrs Winchester was being asked to clarify her position while she was post-surgery and haemorrhaging internally.

175 Indeed, the church's own documentation correctly acknowledges that this situation should be avoided if possible. At paragraph 21 of his written statement, Mr Kemertzis extracted the following from an edition of *The Watchtower*:

> "*Surely the best time to weigh such matters (making a personal decision involving blood) is not in hospital, possibly when we are in pain and under pressure to make a quick decision. Now would be the time to do research, complete a legal medical document indicating your wishes and speak with your doctor."*

176 The evidence of Mr Kemertzis was that all the Jehovah's Witness documents were printed in America. In my view, the worksheets were and remain inappropriate for use in New South Wales. They had a significant capacity to confuse or mislead, and what occurred in relation to Mrs Winchester is an example of the problems that may arise from the church seeking to provide medical information to congregants in New South Wales within documents published in America.

177 In a further submission in relation to the worksheets, the church noted that Mrs Winchester's daughter, Christine Taylor, attended the clinic with her mother, that is, when Mrs Winchester met with Dr Chilton. The church in submissions described as extraordinary that if Christine had understood her mother had reversed her position on packed red blood cells, she would not have told her family very soon afterwards, and as even more extraordinary that she was silent during the family meetings at the John Hunter Hospital where overturning her mother's refusal was discussed at length.

178 The church then submitted that the only possible inference is that Ms Taylor did not leave the clinic on 11 September with the same understanding as was held by Dr Chilton and that the failure to obtain a statement from Ms Taylor or to call her to give evidence at the inquest despite her presence at the clinic is unexplained on the evidence. I reject these submissions.

179 The submissions fail to properly acknowledge the nature of the proceedings and draws inferences which in my view are not available, or at least are most certainly not the only available inference. It was open to the church at any time to approach the assisting team and ask them to take a statement from Ms Taylor and for the church to explain why they wanted a statement taken. This was not done.

180 The source of the information as to Ms Taylor's attendance at the clinic with her mother was from Ms Taylor's sister's statement, that is, the statement of Ms MacIntyre. There was no indication in that statement as to what Ms Taylor did during the attendance at the clinic. Ms MacIntyre gave evidence. There was no examination of her by the church at all, relevantly no examination of Ms Taylor by the church as to whether she had any further understanding of what Ms Taylor did or did not do when she accompanied her mother to the clinic.

181 It is not possible to conclude that Ms Taylor was present, let alone present at all times, during Dr Chilton's conversations with Mrs Winchester. All that is known is that she accompanied her mother to the clinic.

The cause and manner of Mrs Winchester's death.

182 Dr Woods certified the cause of death as cardiogenic shock with antecedent causes being ischemic heart disease and complications of the hysterectomy. In his report to the coroner dated 31 August 2022, expert Dr Gordon Flynn opined that the most likely

cause of Mrs Winchester's death was multiple organ failure due to severe anaemia, both being secondary to blood loss post elective surgery. Contributing factors were her history of ischemic heart disease, chronic kidney injury, and diabetes. He agreed with the cause of death stated in Dr Woods' death certificate.

183 I am of the view the cause of Mrs Winchester's death is best described as multiple organ failure due to severe anaemia, both being secondary to blood loss post elective hysterectomy surgery, with contributing factors being ischemic heart disease, chronic kidney injury, and diabetes.

184 The manner or death is that Mrs Winchester died after an elective hysterectomy. When Mrs Winchester entered surgery, the anaesthetic and surgical teams had differing understandings of whether she would accept a transfusion of packed red blood cells. Following surgery, a CT scan revealed a large pelvic hematoma with ongoing arterial haemorrhage. In the following hours and days, the differing understandings of the surgical and anaesthetic teams led to stress, confusion, and anxiety for Mrs Winchester's family and multiple clinicians. Mrs Winchester underwent a second surgery to treat the pelvic haematoma on 26 September and a third surgery being a laparotomy to pack the abdomen and close on 27 September. Mrs Winchester required a transfusion in order to save her life as she had lost approximately 1,000 ml of blood. On the basis of Mrs Winchester's expressed wishes as verbally conveyed to Dr Searle, consideration of the documents in Mrs Winchester's file, and the taking of legal advice following the initial surgery, Mrs Winchester was not given a transfusion

Recommendations

185 I turn now to the question of whether any recommendations are required pursuant to s 82 of the *Coroners Ac*t. Counsel assisting has submitted that I make a number of recommendations. Fourteen of those proposed recommendations were directed to the Hunter New England Local Health District ("LHD")as follows:

> a) the Anaesthetic Record and Pre-Operative Assessment form should be amended to specifically include a question, similar to the question on allergies and located above or below that, about transfusion and refusal. This should be made available to and read by the surgeon (not just the anaesthetist) before commencing surgery, in the same fashion as apparently already occurs in the private hospital sector;

b) the Pre-Admission Clinic form should also be amended to specifically include a question about transfusion and refusal, rather than just “Allergies/Alerts”;

c) the Adult Pre-Procedure Checklist, should have a line added asking about whether the patient has an ACD, so that the question is asked immediately prior to the surgical procedure;

d) consideration be given to a requirement that a member of the surgical team or the nurse filling out the Pre-procedure Checklist cross-check the answers provided with the Consent for Procedure Form;

e) consideration be given to placing the words ‘accepts blood transfusions’ on the surgical safety Check List Time Out & Sign Out electronic questionnaire to be completed by the surgical team;

f) a procedure be implemented that is followed by all relevant medical staff whenever a patient identifies as a Jehovah’s Witness (or any other faith which opposes transfusion), including:

- o a checklist of issues to be discussed with the patient prior to their surgery;
- o a list of documents to be requested from the patient, including any Enduring Guardianship forms and any Advance Care Directives;
- o a checklist of blood products that the hospital has available that the patient would consent to; and
- o a prompt to obtain consent from the patient to contact the Jehovah’s Witness Hospital Liaison committee or Helpline if the need arises;

g) there be a requirement to alert the surgeon and (if already allocated) the anaesthetist at the time of the pre-operative assessment and well prior to surgery if there is any type of treatment refusal, to enable the surgeon to consider and if necessary implement an appropriate plan well in advance

of surgery, including in this case the appropriate timing of the surgery, any cessation of anti-coagulant or anti-platelet therapy, and the appropriate location for the surgery to take place, preferably with the plan to be discussed at an MDT.

h) a form or alert be introduced which alerts ALL medical staff to a refusal of transfusion in the same manner as is currently done for allergies. This alert could be placed on the front of the paper file (if still used), and/or at the top of the EMR in the same manner as for allergies;

i) The Chief Executive at HNELHD take steps to resume regular meetings between the Church's Hospital Liaison Committee and the Directors of Medical services at each Hospital within the District, with the aim to develop strategies to enhance clinician's understanding of what treatment would be considered reasonable and compatible with Jehovah's Witness patients generally and what resources are available to staff in such circumstances.

j) the Time Out procedure contained in the Clinical Procedure Safety (Levels 1, 2 and 3)PD2017_032: PCP 2 be reviewed, so that any anomalies (for example, a blood screen conducted for a patient that has refused a transfusion) are identified before surgery;

k) training and education provided to Visiting Medical Officers (VMOs) and locums be reviewed to ensure they understand how to access all relevant electronic records and their responsibility to do so;

l) that a process to audit the compliance of VMOs with all relevant LHD policies and procedures is developed and implemented, if not already in place;

m) consider the implementation of a procedure and/or system that records all medication being taken by a patient at the time they are admitted, as well as any changes to that medication after admission, in the one location. This information must be readily available in real time to all medical staff responsible to the patient;

n) if any of the above rely on the implementation of the new state-wide hospital records and management system or the issue of state-wide guidelines and/or protocols, then consideration should be given to the urgent implementation of interim measures by the HNELHD to more quickly achieve the required outcome

186 Following receipt of submissions on behalf of the LHD four of those recommendations were not pressed. In my view, that approach was appropriate.

187 So that the parties might understand my findings in relation to recommendations, I will use the subparagraph numbers used in the submissions of counsel assisting. I note that recommendations D, H, L, and M were not pressed. It is convenient to deal with recommendations A, B, C, and E together. It will be noted that each of these recommendations proposes adding words to an existing form. The Hunter New England Local Health District opposes each of these recommendations, submitting that the current forms adequately cater for what is sought to be achieved by the recommendations and notes counsel assisting's submissions that confusion as to Mrs Winchester's consent arose because of misleading documentation and errors in communication.

188 The proposed recommendations need to be considered in the context of my findings that the misunderstandings occurred because of the following factors:

(1) Dr Chilton either did not consider or did not consider properly the consent form on file during his attendance upon Mrs Winchester on 9 September 2019 in clinic;

(2) EEN Moore failed to consider or properly consider the consent form when she was conducting the pre procedure checklist and consent documentation.

(3) all involved clinicians failed during either sign in or timeout to recognise the different understandings Dr Chilton and Naseem held in relation to whether or not Mrs Winchester would accept a blood transfusion.

189 That having been said, it should be borne in mind that the purpose of recommendations is to reduce the risk of a repeat of any failings which have been revealed at inquest. It is clear enough that, as submitted by the Hunter New England Local Health District, the anaesthetic record, pre-operative assessment form, and the pre-admission clinic

form have both ample space and an appropriate place for issues in relation to blood transfusion to be recorded. Whilst I can see some benefit in the information being recorded in an identified and discrete place on the forms as submitted by counsel assisting, that approach would not in my view address the failures that occurred in Mrs Winchester's circumstances.

190 The recommendations in relation to the adult pre-procedure checklist and the surgical safety checklist, timeout and sign out electronic questionnaire fall into a different category, in that there is no place or field for that information to be added.

191 The issue is what step or steps best reduce the risk of the relevant failures being repeated. This case has made clear that simply recording something in one of the documents or forms does not deal with any lack of communication between the anaesthetic team and the surgical team. In my view, the Hunter New England Local Health District's response to recommendation G provides guidance as to an appropriate approach which can be applied to recommendations A, B, C, and E, as well as G.

192 Recommendation G reads as follows:

> *"There be a requirement to alert the surgeon and, if already allocated, the anaesthetist at the time of the pre-operative assessment and well prior to surgery if there is any type of treatment refusal to enable the surgeon to consider and, if necessary, implement an appropriate plan well in advance of surgery, including in this case the appropriate timing of the surgery, any cessation of anticoagulant or antiplatelet therapy, and the appropriate location for the surgery to take place. Preferably with the plan to be discussed at MDT (multidisciplinary team)"*

193 The Maitland Hospital now has a system in place where the pre-anaesthetic clinic notes are scanned into the patient's electronic records behind the request for admission. Previously, the paper record would need to be retrieved to access the pre-anaesthetic clinic notes. The request for admission document contains a copy of the consent form and information relating to the procedure and any issues in relation to the patient's health status.

194 The patient's electronic records are readily accessible by members of the surgical team in the anaesthetic bay and/or in the operating theatre, and the expectation of the

Hunter New England Local Health District is that a member of the surgical team would review both the request for admission and the pre-anaesthetic clinic notes before the surgery proceeds.

195 It is my view that the best approach in relation to recommendations A, B, C, E, and G, is that I make one recommendation:

> **that Hunter New England Local Health District put in place a requirement, (as distinct from an expectation), that a member of the surgical team must review the pre-anaesthetic clinic notes prior to surgery. Whether this is part of an updated clinical procedure safety policy or contained in some other document is a matter for the Local Health District.**

196 In making this single recommendation, I bear in mind the evidence that the Ministry of Health State Forms Committee is working on a form dealing with refusal of blood products.

197 The foregoing ties in neatly with recommendation J, which reads:

> "*The timeout procedure contained in the Clinical Procedure Safety Levels 1, 2, and 3 policy document be reviewed so that any anomalies, for example, a blood screen conducted for a patient that has refused a transfusion, are identified before surgery*."

198 The response of the Hunter New England Local Health District was as follows:

> *"Hunter New England is agreeable to instituting this recommendation."*

In indicating that agreement, the Local Health District noted that the Ministry for Health, in conjunction with the Clinical Excellence Commission, was currently reviewing the policy document, Clinical Procedure Safety PD 2017, from which the Local Health District document, Clinical Procedure Safety Levels 1, 2, and 3 was derived.

199 It was further noted by the Local Health District that it will fully implement any changes to its own policy so that it reflects any revisions to the corresponding Ministry of Health policy directive.

200 I will make the recommendation as drafted.

201 The next proposed recommendation was that a procedure be implemented that is followed by all relevant medical staff whenever a patient identifies as a Jehovah's Witness or any other faith which opposes transfusion, including a checklist of issues to be discussed with the patient prior to their surgery, a list of documents to be requested from the patient, including any enduring guardianship forms and any advanced care directives.

202 Thirdly, a checklist of blood products that the hospital has available that the patient would consent to, and fourthly, a prompt to obtain consent from the patient to contact the Jehovah's Witness Hospital Liaison Committee or helpline if the need arises.

203 The Local Health District submitted that:

(1) It is willing to further explore the appropriate procedures to take once a patient identifies as a Jehovah's Witness and made the following points. It has no difficulty with the clinician advising the patient of the availability of the Jehovah's Witness Hospital Liaison Committee.

(2) It is a matter for the patient to seek support from a liaison officer should they wish.

(3) The Ministry of Health State Forms Committee in conjunction with the Clinical Excellence Commission are currently considering a new state-wide form dealing with partial refusal of blood products.

(4) A checklist of blood products and an accompanying patient fact sheet on different blood products is being considered as part of the development of a new state form, the development of which is in its early stages and will require consultation amongst various clinicians to ensure that it is workable and practicable in addressing any confusion about blood products a patient will or will not accept.

204 Additionally, it is anticipated that the form will also likely collect information as to the existence of any advanced care directive. The form will be applicable to any patient who refuses some blood products, regardless of the reason for refusal.

205 Taking into account the matters raised by the Local Health District, I will make the following recommendations:

> **A procedure be implemented that is followed by all relevant medical staff whenever a patient identifies as a Jehovah's Witness, which includes;**
>
> - **advising the patient of the availability of the Jehovah's Witness Hospital Liaison Committee and informing the patient that they can contact the committee if they so wish;**
> - **an appropriate form for partial refusal of blood products;**
> - **a checklist of blood products that the hospital has available for patients;**
> - **a list of all documentation which should be sought from the patient.**

206 Recommendation I proposed by counsel assisting was:

> "*that the Chief Executive at Hunter New England Local Health District takes steps to resume regular meetings between the church's hospital liaison committee and the directors of medical services at each hospital within the district, with the aim to develop strategies to enhance clinicians' understanding of what treatment would be considered reasonable and compatible with Jehovah's Witness patients generally and what resources are available to staff in such circumstances."*

207 The Hunter New England Local Health District responded by referring to Dr Choi's evidence that he sees there would be a benefit with resuming regular meetings to enhance the clinician's understanding of what treatment would be considered reasonable and compatible with the Jehovah's Witness religious beliefs, but stressed that the involvement of the committee should only occur at the request of the patient.

208 The Local Health District further submitted that it is important to ensure that clinicians are not guided by the church in relation to what treatment can and cannot be provided to Jehovah's Witnesses patients, but that each patient directs what the treatment will

entail, including whether they will accept any blood products, and if so, which ones. I understand the approach of the Local Health District in this regard. In making the recommendation, I understand that Hunter New England Local Health District accepted it on the basis they have outlined. It is with those observations that I make the recommendation as drafted.

209 The Hunter New England Local Health District is agreeable to instituting recommendation K, which reads as follows:

> *"Training and education provided to visiting medical officers and locums be reviewed to ensure they understand how to access all relevant electronic records and their responsibility to do so."*

210 Recommendation N reads:

> *"If any of the above rely on the implementation of the new state-wide hospital records and management system or the issue of state-wide guidelines and or protocols, then consideration should be given to the urgent implementation of interim measures by the Hunter New England Local Health District to more quickly achieve the required outcome."*

211 The Hunter New England Local Health District agreed to implement the recommendation, "Where it can be practically achieved".

212 Rather than make a recommendation along the lines as it was drafted, I think it more appropriate that I acknowledge in relation to the recommendations that I have made, the response of the Hunter New England Local Health District may be impacted upon by any steps already taken by Hunter New England Local Health District, the Ministry of Health, or any other relevant body, including but not limited to steps in relation to the review of any policy, procedure, or forms and the implementation of the state-wide hospital records and management system, bearing in mind the time between the evidence and the delivery of these findings.

Recommendations to the Christian Congregation of Jehovah's Witnesses Australasia

213 Counsel assisting submitted the following recommendations should be made:

(a) *Worksheets 1 and 2 be removed from public access;*

(b) *A message be conveyed to all followers in Australia that worksheets 1 and 2 have been withdrawn and can no longer be accessed, and that any follower in possession of these worksheets should not use them and destroy any version in their possession;*

(c) *A review be conducted of all material targeted at elders and congregation members in Australia to ensure that all medical and legal terms are accurate, not confusing, and consistent with Australian medical practice and laws, it is also recommended that Australian medical and legal professionals be engaged to assist in this task;*

(d) *A message be conveyed to all followers in Australia that any material accessed from an overseas source may contain medical and legal terminology that does not apply in Australia and if necessary, they should seek an Australianised version of that material and/or discuss any unmodified material with their doctor and/or legal advisor.*

214 It is convenient to deal with proposed recommendations A and B together. The church submitted that the proposed course was premised on a conclusion that the document was misleading and in part the source of confusion, and restated its position that Dr Chilton was the source of any confusion. I have found the worksheets had a significant capacity to confuse or mislead.

215 The church further submitted that there is no evidence that the worksheets have been an issue in any other clinical situations. This is not to the point. This inquest was focused upon Mrs Winchester's death and the circumstances surrounding it. It was no part of the inquest to investigate other clinical situations.

216 The church next submitted that the worksheets had been effective in other cases (plural) and cited *Hunter and New England Area Health Service v A*, and footnoted that no criticism was made of the worksheets, which were accepted as a valid advanced care directive. The submission does not fully reflect what relevantly was said in *HNE v A*. In a single judgment, McDougall J identified two worksheets in evidence as Worksheet 1 and Worksheet 2, and described the worksheets, noting that on worksheet 1, Mr A had refused dialysis. At paragraph [45], his Honour said:

"By worksheet 1, Mr A indicated that he would refuse five specified forms of medical treatment, but that he would accept one. It is not necessary to go to the details"

217 The case was concerned with Mr A's right to refuse dialysis as indicated in the worksheet. The case did not involve any detailed consideration of worksheet 1.

218 The church next submitted that Dr Naseem explained the surgical risk on the correct understanding that Mrs Winchester would not accept a blood transfusion. This submission again misses the point that it was completely unacceptable for Mrs Winchester to enter surgery with the anaesthetic team and the surgical team having different understandings as to whether the patient would accept a blood transfusion.

219 Somewhat incongruously, the church then argues both that there is an obvious advantage to congregants in the worksheets when placed in the broader discussion about blood transfusions, blood fractions, and autologous blood management, whilst immediately thereafter pointing out that the evidence is that congregants are not now referred to the worksheets. On the basis of my findings, there is no benefit to New South Wales residents being directed to the worksheets. The worksheets are apt to mislead and confuse.

220 Given the evidence that congregants are not now referred to the worksheets and that the worksheets are not referred to in lesson 39, which is the current teaching applicable to “God's View of Blood”, I am at a loss to understand why the church wants the worksheets accessible at all. In my view, they serve no practical purpose and have the real potential to create confusion. It is to be hoped that after the church considers these findings, it may have a better understanding of how the worksheets may lead to confusion. Given that congregants are not now referred to the worksheets, the church should deliver a strong message to New South Wales residents that this is the case.

221 The church is a proud entity strongly committed to its beliefs. Significant responsibility attaches to those administering a church which has as a fundamental tenet the rejection of transfusion of whole blood and its main components.

222 In determining to make a recommendation, I am of the view that I have to consider my geographical jurisdictional limit. Bearing that in mind, together with the submission

that what is suggested may be seen as a universal takedown order, I will modify the proposed recommendations A and B to the one recommendation as follows:

> **That all New South Wales congregants be advised that worksheets 1 and 2 are no longer to be relied upon, and that they should not be used at all for any purpose. This advice should be relayed through all available resources, including literature, both electronic and print, information to elders, and at places of worship.**

223 It is trite to observe that the observations and findings underpinning the foregoing recommendation have applicability in geographical areas other than New South Wales, in particular in geographical areas in Australia other than New South Wales. Whilst I am of the view I have no jurisdiction to make recommendations in relation to any other state or territory, I would invite the church to give serious consideration to steps it might take in response to the matters identified in these findings.

224 Proposed recommendations C and D can also be dealt with together. The church submitted that proposed recommendations C and D deal with novel concerns in that they never featured in any way in the inquest and further submits that they are baseless and that their belated introduction is unfair and that there is no basis to suggest that they are connected to the manner and cause of death. Recommendations C and D draw attention to the church's use of medical and legal terms in its literature and, in particular, the fact that some of the medical and legal terminology is sourced from America. The submission that the underpinning matters did not feature in any way in the inquest is wrong.

225 The issue of the use of American legal terminology arose in the context of Mr Kemertzis' reference to, "Her durable power of attorney". Mr Kemertzis was asked if durable power of attorney is an American term for an enduring guardianship document. Mr Kemertzis answered, "Yes, all our documents are from our headquarters in America".

226 Mr Kemertzis was further asked if he thought it possibly confusing to some that they read of a “durable power of attorney” but their card is referred to as an “advanced care directive”. Whilst Mr Kemertzis expressed his personal opinion to be that it is clear that they are one and the same thing, it is my view that it is clearly preferable that when citizens of New South Wales are completing documents relating to the authorisation of

others to make decisions on their behalf, or seeking to express accurately their own decisions, that the language of any document they are reading is both clear and consistent with New South Wales practice and documentation.

227 The church's use of medical terminology and its applicability and accuracy for New South Wales residents was a significant issue in the inquest, in particular in relation to the worksheets. Mr Kemertzis was specifically asked in relation to Worksheet 1 whether there was a need to spell out under "red cells and haemoglobin" that to have a blood transfusion you cannot just have haemoglobin; you will need to accept red cells. Mr Kemertzis answered, "For those specifics, I guess", and then indicated:

> *"This is not a form that's currently in use, and further it's a global form. It was probably not quite right to refer to them as a form as their purpose was explained in the accompanying article. The sheets weren't intended to be a single reference, they're something to help the congregant. But of course, these are medical matters and they should discuss the specifics with their doctor as to how it applies to them at this point in time in this geographical area."*

228 In later evidence, Mr Kemertzis accepted that the implications for Mrs Winchester ticking "yes" to haemoglobin when going to Maitland Hospital and completing a worksheet provided from America were different to the implications of ticking that in other parts of Australia or America. In further questioning, it was specifically raised with Mr Kemertzis whether he would accept that it is best the church does not engage in publishing documentation that is contradictory to your faith. The question was asked in relation to Worksheet 1. Mr Kemertzis answered that he did not find the worksheet contradictory to his faith.

229 These questions and answers clearly raised the issue of the accuracy and applicability of the worksheets.

230 I reject the submission that matters underpinning the proposed recommendations were not connected with Mrs Winchester's death. The terminology “connected with”, in s 82 of the Coroners Act of New South Wales, is in my view deliberately different to terminology such as "causative of". One of the issues explored during the inquest was the nature and extent of Mrs Winchester's consent. The worksheets and the advanced

care directive and the literature around these documents was explored in detail during the inquest.

231 As the church points out in further submissions, the only legal term referred to by counsel assisting in support of the suggested recommendation refers to the durable power of attorney. Whilst, as I said earlier, it is clearly preferable that precise language be used in relation to legal rights, I am not persuaded any recommendation should be made regarding the use of legal language based on the evidence in this inquest. In relation to medical information, the church submits that to make the sort of recommendation counsel assisting argues for would have staggering implications for American medical journals. The proposed recommendation is not concerned with medical journals. It is concerned with the information conveyed by the church to its congregants and their need to clearly understand their medical options.

232 I again must recognise my geographical jurisdictional limit so that any recommendation would apply to New South Wales only. As set out above, the inquest consideration of medical information and language focused upon the worksheets and, in particular, the greatest focus was in relation to haemoglobin and red blood cells as referred to in the worksheets.

233 If the church accepts my first recommendation, there would be no need for any further recommendation arising from the evidence in this inquest. However, given that the church opposed the recommendation being made, I cannot proceed on the assumption that it will now be accepted. I will limit the second recommendation to matters touching upon products available to congregants in New South Wales in circumstances where the congregant refuses transfusion of whole blood or packed red blood cells.

234 The second recommendation is:

> **That the church advise congregants in New South Wales the precise status of the development or otherwise of products from human or animal haemoglobin which could be used to treat patients in New South Wales when those patients are suffering with acute anaemia or massive blood loss. This advice should be relayed through all available resources including literature, both electronic and print, information to elders and at places of worship.**

235 I again observe that if the church adopts recommendation 1, then there will be no need to adopt recommendation 2. I also again observe in relation to the recommendation that the church is invited to consider the principles and findings underlying it and give consideration to applying it in geographical regions outside New South Wales.

236 The church submitted that the following recommendation should be made:

> *"that a state-wide policy be made addressing the needs of patients that refuse blood transfusion and that the Australasian branch office of the Jehovah's Witness be consulted in that process."*

I note the information previously referred to that the Ministry of Health, through its agencies, is considering issues in relation to partial refusal of blood. This proposed recommendation deals with, as I read it, the absolute refusal of blood transfusion.

237 New South Wales Health (or the Ministry of Health) were not represented in the inquest, and as such, I will not make the suggested recommendation. Nevertheless, I acknowledge that New South Wales Health may see merit in the recommendation, and with that in mind, I direct that a copy of these findings be served upon the New South Wales Minister for Health so that consideration might be given to fully exploring all issues in relation to the approach of Jehovah's Witnesses in relation to blood and its main components.

Formal findings

238 The formal findings are:

Identity of the decease: The person who died was Ms Heather Winchester.

Date and place of death: Mrs Winchester died on 27 September 2019 at John Hunter Hospital in Newcastle, New South Wales.

Cause of death: The cause of Mrs Winchester's death was multiple organ failure due to severe anaemia, both being secondary to blood loss, post elective hysterectomy surgery, with contributing factors being ischemic heart disease, chronic kidney injury, and diabetes.

Manner of death: Mrs Winchester died after an elective hysterectomy. When Mrs Winchester entered surgery, the anaesthetic and surgical teams had differing understandings of whether she would accept a transfusion of packed red blood cells. Following surgery, a CT scan revealed a large pelvic hematoma with ongoing arterial haemorrhage. In the following hours and days, the differing understandings of the surgical and anaesthetic teams led to stress, confusion, and anxiety for Mrs Winchester's family and multiple clinicians. Mrs Winchester underwent a second surgery to treat the pelvic haematoma on 26 September and a third surgery being a laparotomy to pack the abdomen and close on 27 September. Mrs Winchester required a transfusion in order to save her life as she had lost approximately 1,000 ml of blood. On the basis of Mrs Winchester's expressed wishes as verbally conveyed to Dr Searle, consideration of the documents in Mrs Winchester's file, and the taking of legal advice following the initial surgery, Mrs Winchester was not given a transfusion.

239 I would like to thank the assisting team, which, given the period of time, has involved a number of members, and it's been an involved inquest. The team has taken a very dedicated approach and been of great assistance to me. I also thank the parties for their participation in the inquest and the assistance they've provided to me throughout the inquest.

240 Finally, on my own behalf, and all at the Coroners Court, I pass on sincere and respectful condolences to Mrs Winchester's family and friends.

241 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales

28 February 2025

Note: On the 26 February 2025 extracts of this judgment were read in open court. I indicated at that time that the full findings would be published as soon as possible. This final form of my judgment differs from the transcript of 26 February 2025 in that it contains more content, corrects infelicity of expression and corrects content.

Full Name Heather Margaret Winchester

Address [redacted]

WORK SHEET 1 Date 5.7.18

UNACCEPTABLE TO CHRISTIANS

WHOLE BLOOD

	YOUR PERSONAL DECISION	
	FRACTIONS	Choices You Need to Make
PLASMA	**ALBUMIN—UP TO 4% OF PLASMA** A protein extracted from plasma. Types of albumin are found also in plants, in foods such as milk and eggs, and in the milk of a nursing mother. Albumin from blood is sometimes used in volume expanders to treat shock and severe burns. These preparations may contain up to 25 percent albumin. Minute amounts are used in the formulation of many other medicines, including some formulations of erythropoietin (EPO).	✓ I accept albumin or — I refuse albumin
	IMMUNOGLOBULINS—UP TO 3% OF PLASMA Protein fractions that may be used in some medicines that fight viruses and diseases, such as diphtheria, tetanus, viral hepatitis, and rabies. They may also be used to guard against some medical conditions that threaten the life of a developing baby and to counteract the effects of snake or spider venom.	✓ I accept immunoglobulins or — I refuse immunoglobulins
	CLOTTING FACTORS—LESS THAN 1% OF PLASMA There are various proteins that help blood to clot in order to stop bleeding. Some are given to patients who tend to bleed easily. They are also used in medical glues to seal wounds and to stop bleeding after surgery. One combination of clotting factors is known as cryoprecipitate. **Note:** Some clotting factors are now made from nonblood sources.	✓ I accept blood-derived clotting factors or — I refuse blood-derived clotting factors
RED CELLS	**HAEMOGLOBIN—33% OF RED CELLS** A protein that transports oxygen throughout the body and carbon dioxide to the lungs. Products being developed from human or animal haemoglobin could be used to treat patients with acute anaemia or massive blood loss.	✓ I accept haemoglobin or — I refuse haemoglobin
	HAEMIN—LESS THAN 2% OF RED CELLS An enzyme inhibitor derived from haemoglobin that is used to treat a group of rare genetic blood disorders (known as porphyrias) that affect the digestive, nervous, and circulatory systems.	✓ I accept haemin or — I refuse haemin
WHITE CELLS	**INTERFERONS—A TINY FRACTION OF WHITE CELLS** Proteins that fight certain viral infections and cancers. Most interferons are not derived from blood. Some are made from fractions of human white blood cells.	✓ I accept blood-derived interferons or — I refuse blood-derived interferons
PLATELETS	At present, no fractions from platelets are being isolated for direct use in medical treatment.	

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WORK SHEET 2 Date 5. 7. 18

YOUR PERSONAL DECISION

PROCEDURES INVOLVING THE MEDICAL USE OF YOUR OWN BLOOD

***Note:** The methods of applying each of these medical procedures vary from physician to physician. You should have your physician explain exactly what is involved in any proposed procedure to ensure that it is in harmony with Bible principles and with your own conscientious decisions.

NAME OF TREATMENT	WHAT IT ACCOMPLISHES	Choices You Need to Make (You might want to speak to your physician before accepting or refusing any of these procedures.)
CELL SALVAGE	**Reduces blood loss.** Blood is recovered during surgery from a wound or body cavity. It is washed or filtered and then, perhaps in a continuous process, returned to the patient.	✓ I accept __ I might accept* __ I refuse
HAEMODILUTION	**Reduces blood loss.** During surgery, blood is diverted to bags and replaced with a nonblood volume expander. Thus the blood remaining in the patient during surgery is diluted, containing fewer red blood cells. During or at the end of surgery, the diverted blood is returned to the patient.	__ I accept ✓ I might accept* __ I refuse
HEART-LUNG MACHINE	**Maintains circulation.** Blood is diverted to an artificial heart-lung machine where it is oxygenated and directed back into the patient.	✓ I accept __ I might accept* __ I refuse
DIALYSIS	**Functions as an organ.** In haemodialysis, blood circulates through a machine that filters and cleans it before returning it to the patient.	✓ I accept __ I might accept* __ I refuse
EPIDURAL BLOOD PATCH	**Stops spinal fluid leakage.** A small amount of the patient's own blood is injected into the membrane surrounding the spinal cord. It is used to seal a puncture site that is leaking spinal fluid.	✓ I accept __ I might accept* __ I refuse
PLASMAPHERESIS	**Treats illness.** Blood is withdrawn and filtered to remove plasma. A plasma substitute is added, and the blood is returned to the patient. Some physicians may want to use plasma from another person to replace that from the patient's blood. If so, this option would be unacceptable to a Christian.	__ I accept __ I might accept* ✓ I refuse
LABELLING OR TAGGING	**Diagnoses or treats illness.** Some blood is withdrawn, mixed with medicine, and returned to the patient. The length of time one's blood is outside the body may vary.	✓ I accept __ I might accept* __ I refuse
PLATELET GEL; AUTOLOGOUS (MEANING "MADE FROM YOUR OWN BLOOD")	**Seals wounds, reduces bleeding.** Some blood is withdrawn and concentrated into a solution rich in platelets and white cells. This solution is applied on surgical sites or wounds. Note: In some formulations, a clotting factor taken from cow's blood is used.	✓ I accept __ I might accept* __ I refuse