CITATION: *Inquest into the death Souzana Afianos* [2004] NTMC 003

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coronial
FILE NO(s):	D0036/2002
DELIVERED ON:	16 January 2004
DELIVERED AT:	DARWIN
HEARING DATE(s):	10, 11, 12, 13 & 14 November 2002, 29, 30 & 31 July 2003, 6 August 2003.
FINDINGS OF:	Mr V LUPPINO SM

CATCHWORDS:

Coronial – Inquest – Death by secondary haemorrhage – Unexpected death in hospital – Failure to detect haemorrhaging.

REPRESENTATION:

Counsel:

Counsel Assisting:	Mr J Tippet QC
Family:	Mr S Glascott
Dr P Treacy	Mr J Lawrence
Department of Health & Community Services	Ms S Seivers
Dr A Patton	Mr R Bruxner

Solicitors:

Dr P Treacy:	Paul Maher
Department of Health & Community Services:	Cridlands
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Judgment category classification:	B
Judgment ID number:	[2004] NTMC 003
Number of paragraphs:	105
Number of pages:	49

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0036/2002

In the matter of an Inquest into the death of

SOUZANA AFIANOS
ON 21 FEBRUARY 2002
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 16 January 2004)

Mr V LUPPINO SM:

1. Souzana Afianos ("the Deceased") died in the Accident & Emergency Department of the Royal Darwin Hospital at 7.20am on 21 February 2002. The cause of death was a secondary haemorrhage following a surgical procedure performed by Dr P Treacy in the Darwin Private Hospital namely, a stomach gastric banding operation.

2. The death in this case was unexpected for the reasons appearing in the body of these findings. As such it fell within the definition of "reportable death" in section 12 of the Coroners Act. An Inquest on the facts of this case is not mandatory and this Inquest has been held in exercise in exercise of the discretion given by section 15(2) of the Act.

3. The Inquest commenced at Darwin on Monday 11 November 2002 and concluded on Wednesday 6 August 2003. Counsel Assisting was Mr Tippett QC. Mr Glascott sought leave to appear on behalf of the family of the Deceased. Mr Lawrence, instructed by Paul Maher, sought leave to appear on behalf of Dr Peter John Treacy. Mr Richard Bruxner, instructed by

Messrs Hunt and Hunt, sought leave to appear on behalf of Dr Anne Patton. Ms Sievers instructed by Messrs Cridlands, sought leave to appear on behalf of the Department of Health & Community Services. Leave was granted in all cases pursuant to the provisions of section 40(2) of the Act.

4. By way of a background summary, the Deceased was qualified as an enrolled nurse and had been lecturing at the Tennant Creek Campus of the Northern Territory University. Before undergoing the procedure the Deceased obtained advice and sourced information on gastric banding. Having decided to undergo the procedure she consulted a General Surgeon, Dr John Treacy. After preliminary investigations confirmed the Deceased as a suitable candidate for the procedure, she underwent the surgery on 13 February 2002 at Darwin Private Hospital.

5. The surgical procedure was the implanting, by means of keyhole surgery, of a device known as a Swedish Adjustable Gastric Band. The procedure involved fitting the band around the uppermost part of the stomach. The size of the band when fitted was such that it contracted the stomach thereby dividing into two sections. The band is adjustable by means of injecting or removing fluid via a port placed under the skin. Gastric banding works by inducing a feeling of fullness after consumption of a much smaller quantity of food than would otherwise be the case. The result is that the person will eat much less and this in turn induces sustainable weight loss.

6. Dr Treacy was particularly well experienced in the performance of the surgery having then performed the surgery approximately 44 times in Darwin. He had attended a training course organised by the manufacturers of the band and had a representative of the manufacturers in the operating theatre when he first performed the procedure.

7. The surgery performed by Dr Treacy on the Deceased was uneventful. Dr Treacy's notes of the operative procedures undertaken by him have been

examined by Dr Gilhome, an expert independently engaged by the Coroner who said that the surgery was conducted with a high level of skill.

8. As is the normal course, Dr Treacy saw the Deceased regularly during the postoperative period. Arrangements were then made for the Deceased to contact Dr Treacy's room to arrange a post operative appointment on Wednesday 20 February 2002.

9. During her convalescence the Deceased was staying in Darwin at the home of her long time friend, Maria Florance at Yarrawonga. Mrs Florance collected the Deceased at the time of her discharge. She said that the Deceased was in pain at the time, a pain she described as the normal pain expected following a surgical procedure. Mrs Florance operated a restaurant and went to work after taking the Deceased home. She returned from work at approximately 11.30pm and found the Deceased to be in a lot of discomfort. As a result they agreed that the Deceased should attend at the Royal Darwin Hospital. There is a discrepancy between the hospital records and Mrs Florances' recollection as to the time of that attendance. At Accident & Emergency Department the Deceased was seen by Dr McNair. He diagnosed residual abdominal pain after surgery and gas in the belly. He prescribed medication and discharged the Deceased at approximately 6.15am that morning. No attempt was made to contact Dr Treacy during that attendance. Whether that should have occurred and whether the Deceased ought to have been discharged at that time in the circumstances was also an issue explored by the Inquest.

10. On Tuesday 19 February 2002 the Deceased continued to be in discomfort. She went with Mrs Florance to her restaurant and at dinner time the Deceased purchased some chicken and corn soup from a nearby Chinese restaurant. That soup had been pureed into a water like consistency. She consumed a small quantity only. Whether the Deceased complied with the dietary instructions she was given by Dr Treacy is also to be explored.

11. On Wednesday 20 February 2002 the Deceased was still feeling unwell. She was to arrange to see Dr Treacy that day. After calling Dr Treacy on his mobile phone, she proceeded to consult Dr Anne Patton at the Northern Territory University Medical Centre. Dr Patton noted signs of infection in the surgical wounds and attempted to contact Dr Treacy at his rooms and on his mobile phone. The purpose of the call was to have Dr Treacy's input into the type of antibiotic to prescribe. When the Deceased spoke to Dr Treacy that day he arranged to see her at 2pm that day. After seeing Dr Patton however, at approximately 1pm on that day, the Deceased cancelled the appointment with Dr Treacy and returned home and rested until retiring at around 10pm.

12. On Thursday 21 February 2002, before 5am, the Deceased woke the Florances with her screams. They found her in pain and bleeding. Ambulance officers attended and conveyed her to Accident & Emergency Department at Royal Darwin Hospital at 5.11am. Dr Treacy was called and promptly attended. By the time of his arrival, emergency procedures were well underway and continued for another hour. Those procedures were terminated at 7.20am and the Deceased was then pronounced dead.

13. The matters requiring determination and the issues explored at this Inquest were as follows:

    1. What was the cause of the death of the Deceased.

    2. Whether the surgery performed by Dr Treacy at Darwin Private Hospital on 13 February 2002 contributed to the unexpected death of the Deceased.

    3. Whether there is any defect in the design, construction or application of the band and if so, whether any such defect contributed to the death of the Deceased.

4. Whether the band that had been installed by Dr Treacy during that surgery was inflated immediately before its removal by the pathologist and if so, how it came to be inflated.

5. Whether the necrosis which started the chain of events leading to the death of the Deceased should have been detected by Accident & Emergency Department staff during the attendance of the Deceased on 18 February 2002 and whether the treatment then given was appropriate. (This involves consideration of a number of subsidiary issues such as the effectiveness of the abdominal examination then conducted and the discharge of the patient before the effects of the analgesia then administered had worn off).

6. Whether Accident & Emergency Department staff ought to have contacted Dr Treacy and/or notified him of the attendance of the Deceased on 18 February 2002 and whether that failure contributed to the death of the Deceased.

7. Whether it was appropriate for Dr McNair to have discharged the Deceased at 6.15am on 18 February 2002 and if not, whether the timing of the discharge contributed to the death of the Deceased.

8. Whether Dr Patton should have detected the necrosis that started the chain of events leading to the death of the Deceased during the attendance of the Deceased on 20 February 2002.

9. Whether the Deceased breached the dietary instructions given her by Dr Treacy and if so, whether that non-compliance contributed to her death.

10. Whether Dr Treacy should have made alternative arrangements to see the Deceased after she cancelled the appointment scheduled for 2pm on Wednesday 20 February 2002 and if so, whether that failure contributed to the death of the Deceased.

11. Whether the emergency treatment given at the Accident & Emergency Department of the Royal Darwin Hospital on 21 February 2002 was appropriate.

14. Dr Alistair McNair was the doctor who attended the Deceased at Accident & Emergency on 18 February 2002. His extensive notes were available to the Inquest. Favourable comments were later made by Dr Gilhome of the excellent quality of these notes which enabled a thorough consideration to be given of all the relevant history and the various steps taken. Dr NcNair is to be commended for the quality of his notes. He also provided a written statement (Exhibit 1 Folio 13) and he gave evidence by video conference link.

15. Dr McNair qualified in England and had been working at Royal Darwin Hospital for some seven months at the relevant time. He said that he took a comprehensive history from the Deceased, made detailed notes as aforesaid and conducted an examination. He conducted an abdominal examination on two occasions during the course of the admission. He conceded that his examination was not ideal although he considered that it was sufficient for his purposes. The difficulty was that the Deceased claimed to not be able to lie down due to pain. As a result, the examination was conducted with the Deceased sitting and partly reclining. There is medical opinion to the effect that this would not have resulted in a satisfactory abdominal examination although there was variance on this issue. Dr McNair was confident that he could exclude internal bleeding as a result of his examinations and particularly because he was able to exclude rebound, guarding and tenderness. This does not appear to be disputed by the medical experts. There was no major disagreement about this despite much of the medical opinion commenting that the optimal position for a proper abdominal examination was the fully supine position. Moreover there seems to be agreement that even if the examination was inadequate, nothing else of any significance would have then been discovered if an examination in a fully

supine position had been performed. Clearly therefore it cannot be said that any failure to conduct an examination in the fully supine position was a contributing factor to the unexpected death. In any event, later evidence was to suggest that the Deceased's inability to lie down and therefore the level of her pain, was intermittent.

16. Part of the history taken by Dr McNair was of left flank pain radiating to the left shoulder. The Deceased told him that on the day of her discharge from Darwin Private Hospital her pain had increased during that day. She told him that whilst in Darwin Private Hospital her pain had been controlled with Panadeine Forte but she had been discharged on simple Panadeine.

17. Dr McNair explained why he ruled out any internal bleeding at the time. He said that if there were internal bleeding he would have expected the Deceased to be more unwell than was actually the case. He said that he would not have expected her to walk as easily as the Deceased did. He said he would have expected signs of low blood pressure, tachycardic pulse, signs of shock and adverse abdominal signs. Dr McNair said that the Deceased had no symptoms to make him think that she had any internal bleeding. This evidence was convincing and only challenged to the extent of securing a concession that the factors he referred to would only rule out severe bleeding and not minor internal bleeding.

18. Dr McNair made no attempt to contact Dr Treacy during that attendance but he discussed the matter with Dr Shand, the on call Emergency Registrar. The treatment he gave on that occasion was to top up analgesia by prescribing codeine phosphate. He said that this bought the level of analgesia up to a level equivalent to that which the Deceased had whilst an inpatient at Darwin Private Hospital. Dr McNair said that as a result of the history he obtained and his examinations and his discussions with Dr Shand, he was satisfied that the Deceased's problem was normal residual pain after surgery coupled with gas in the belly. He also prescribed a laxative to assist

with the gas. He said that the Deceased was asking to go home and he agreed to discharge her for a number of reasons. Her pain had decreased and her blood pressure was at reasonable level. He was satisfied with his diagnosis and lastly he was aware that the Deceased was to see Dr Treacy that Wednesday. He prepared a very detailed discharge summary for the Deceased's GP and he provided a copy to the Deceased. The Deceased left the hospital about 6.15am that morning i.e., Monday 18 February 2002.

19. One of the issues that arises at this Inquest is the appropriateness of the discharge at that time. This was because, as Dr McNair conceded, pain was one of the symptoms complained of and the effects of the analgesia given during the admission had not worn off by the time the Deceased was discharged. Accordingly the success of the treatment, and consequently the existence of other possible causes of pain, had not been determined at that point. This issue can be quickly dealt with. Both Dr Gilhome and Dr Baggoley, an expert in emergency medicine, agreed that the analgesia would not impact on an adequate abdominal examination. Similarly, Dr Baggoley at least, dismisses the impact of analgesia on temperature and he supports the conclusion later to be made by Dr Palmer on that account. The discharge of the Deceased at that time must also be looked upon in light of her then persistent requests to go home. Dr Baggoley agreed this was a relevant consideration.

20. Another issue which arises is whether Dr McNair should have called Dr Treacy to seek his views. It appears from his evidence that Dr McNair's training in England put a different emphasis on the need to contact treating surgeons in these circumstances. He said in evidence that he did not think it necessary to contact Dr Treacy given that he was satisfied with his examination and with his diagnosis. The evidence reveals that although the Deceased may have then had some minor bleeding which was of no consequence, the secondary haemorrhage which resulted in her death had then not apparently commenced. It appears from the overall evidence, and

despite the submissions of Mr Glascott to the contrary, that contacting Dr Treacy at that time would not have prevented the death in this case. Although Dr Treacy said he would have taken a number of steps such as a barium x-ray and the insertion a nasogastric tube, consensus amongst the medical personnel is that no test which would have been undertaken on 18 February 2002 would have pointed to the catastrophic bleed which was to occur on 21 February 2002. In light of that, nothing that was done or omitted to be done on 18 February 2002 contributed to the death. I accept that evidence overall. Although Mr Glascott submitted that had Dr Treacy been called he would have determined that the band was too tight and would therefore have loosened or removed it, there was no specific evidence to that effect, nor is that submission consistent with the evidence.

21. After her discharge from Accident & Emergency, apart from continuing to be in apparent discomfort and to make some complaints about pain, nothing eventful further occurred until Tuesday 19 February 2002. Mrs Florance said that the Deceased then appeared to still be in a lot of pain and discomfort and was breathing in a laboured and heavy way. She said that the Deceased had gone to her restaurant with her during that day. She said that at dinner time the Deceased went to the nearby Chinese restaurant and came back with chicken and corn soup. She said the Deceased told her that it had been pureed. Mrs Florance described the soup as being like dirty water and with the consistency of water. She observed the Deceased taking five or six spoonfuls and then commenting that she felt full. She said that the Deceased could not get comfortable and was constantly moving around. Arrangements were made for Mr Paul Florance to take the Deceased back to the house.

22. On the next morning (Wednesday, 20 February 2002) Mrs Florance said that the Deceased was still unwell and still in apparent discomfort and pain. She recalled that the Deceased left in the morning by taxi. Mrs Florance did not

again see the Deceased until Mrs Florance came home from work that evening which she said was at approximately 9.00 – 10.00pm.

23. Dr Patton was consulted by the Deceased on Wednesday 20 February 2002 at the Northern Territory University Medical Centre. Dr Patton provided a written statement (Exhibit 1 Folio 14) and was also called to give evidence. She saw the Deceased at around 10.45am on that day. It appears from the telephone records of the Florance's home that the Deceased may have arranged the appointment at 9.14am that day. It appears that she attended after she had the much considered five minute and forty second telephone conversation with Dr Treacy. That is discussed in more detail later in these reasons but for now it should be noted that during that call, Dr Treacy made arrangements with the Deceased to see her at 2pm that day. Dr Patton said in her evidence that the Deceased had told her that she had attempted to see Dr Treacy but was unable to. This, along with a number of the other things that the Deceased said about her medical appointments that day, does not tally with the available evidence. Dr Patton does not appear to have been told of the telephone conversation that the Deceased had only just concluded with Dr Treacy. This also is very puzzling.

24. Dr Patton said that the Deceased complained of pain and gave her a brief history of the surgery she had undertaken. She said however that the Deceased did not place any great emphasis on the pain nor did she describe any change in the pain. Dr Patton said that the Deceased told her that she was due to see Dr Treacy to have her dressings changed and accordingly asked Dr Patton to do that instead. Dr Patton told the Deceased that she should be reviewed by Dr Treacy. She said that she told the Deceased that she had no experience in post operative conditions generally and particularly had only limited knowledge of the gastric banding procedure.

25. Dr Patton described the results of her examination. As with Dr McNair two days earlier, the Deceased claimed that she could not lie down for a proper

examination. Dr Patton appreciated that this made the abdominal examination less than satisfactory. She said the examination was specifically for the purpose of determining whether there was any internal bleeding and consequently she was alert to the need to check for this. She noted that one of the dressings was clean but the other one was "mucky". On removal she saw that wound was infected. She said that it was necessary to prescribe antibiotics for the infection and not being experienced in the relevant surgical procedure and appropriate antibiotic, she attempted to contact Dr Treacy for his advice. She said that she first rang Dr Treacy's rooms at Darwin Private Hospital to learn that Dr Treacy was not in. It was suggested that she try his mobile number which she did. She says she could not get through. She was not very precise as to whether she left a message or not. She thought she may have and that the message would have contained a reference to the Deceased. She was a little more positive in her evidence in chief although there, unlike her answers in cross-examination, she thought that she had left the message with Dr Treacy's receptionist. Her evidence concerning this is uncertain and I think not sufficiently reliable enough to support a finding based on that. Dr Patton said that she stressed to the Deceased the need for her to see Dr Treacy that day. She said that the Deceased confirmed that she would do so.

26. I have no reason to reject the evidence of Dr Patton. I agree with the submission of Mr Bruxner that the principal reason that the Deceased gave for consulting Dr Patton was to change the dressings and that she did not put any great emphasis on the pain. This omission must be looked at in light of the Deceased's training as a nurse. It is inconceivable that she would have preferred to see Dr Patton in lieu of Dr Treacy if she was concerned about her pain. Her conduct in staying out until 4pm that day after having herself cancelled her appointment with Dr Treacy does not suggest significant incapacity. As I point out elsewhere in these reasons, there is evidence which suggests that the severity of the Deceased's pain was intermittent.

This may well be one instance where the pain level did not concern the Deceased.

27. At approximately 1.00pm that day the Deceased telephoned Dr Treacy's rooms. The call was reliably confirmed by Nicole Cox, Dr Treacy's receptionist, when she gave her evidence. Ms Cox said that she had occasion to recall the telephone conversation she had with the Deceased on that day as Dr Treacy had told her of the death the following day. That had caused her then to remember the details and she has recalled those details ever since. I consider that to be very plausible, notwithstanding that no note was made of the conversation at anytime thereafter. Ms Cox said that Deceased told her she had gone to the University, had overdone it, was feeling too tired and therefore cancelled the appointment. She recalled immediately thereafter telephoning Dr Treacy to advise him of the cancellation. I thought it odd that the Deceased chose to cancel the appointment with Dr Treacy yet attended the appointment with Dr Patton. After all, it appears the appointment arranged with Dr Treacy was arranged before she attended her appointment with Dr Patton. She could quite easily have cancelled Dr Patton's appointment and that obviously would have been the preferable course in all the circumstances.

28. The Deceased then apparently returned to the home of Mrs Florance arriving there at approximately 4.00pm. This does not fit comfortably with the cancellation, at 1.00pm, of her 2.00pm appointment with Dr Treacy citing that she was too tired to attend. She went to bed at approximately 10.00pm that evening. Mrs Florance said that she saw her when she got home from work. She said she was then still in apparent discomfort.

29. The dramatic events in relation to this matter occurred on the morning of Thursday, 21 February 2002. Mrs Florance said she was woken at about 5.00am that morning by screams for help from the Deceased. Mrs Florance said that she went into her lounge room and saw the Deceased standing by

the lounge holding a pillow to her stomach. She said there was blood everywhere. Mrs Florance said that the Deceased was standing and calling out for help. Mrs Florance said that she pressed a towel onto her stomach and an ambulance was called. According to St John Ambulance records, officers attended at 4.32am, which precedes the time that Mrs Florance said they were called. Mrs Florance's recollection of the time cannot be correct.

30. The Deceased was conveyed to the Accident & Emergency Department of the Royal Darwin Hospital arriving at 5.11am where she was in intubated and treated. Dr Treacy was called at 6.00am and he arrived at the Hospital very promptly thereafter, namely at approximately 6.20am. Resuscitation procedures by emergency staff were well underway when Dr Treacy arrived and continued for approximately another hour until the Deceased was pronounced dead at 7.20am. Dr Baggoley was very impressed with the response of Dr Treacy and of Accident & Emergency staff. I have no reason to fault the response of either.

31. The primary source of evidence of the cause of death came from Dr Ranson, the forensic pathologist who performed the autopsy. He gave evidence to the Inquest by video link on two occasions, the first on 12 November 2002 and the second on 6 August 2003. In addition to that evidence Dr Ranson produced an Autopsy report and two supplementary reports. The Autopsy report was dated 25 June 2002 and became Exhibit 1 Folio 10. The first supplementary report became Exhibit 30. The second supplementary report became Exhibit 36.

32. In summary form the salient features of Dr Ranson's autopsy report and evidence are as follows.

    1. There was no damage to any of the arteries or veins which would account for the haemorrhage subsequently found.

2. There was a large amount of blood in the abdomen. His estimate was two litres.

3. There was significant haemorrhagic tissue in the region of the site where the gastric band was placed. There were signs of older bleeding consistent with the recent surgery and there were tissues which showed signs of infection.

4. In consequence of the absence of any obvious damage to blood vessels and given the presence of the necrotic tissue at the infection site, he concluded that the source of the bleeding was the infection site.

5. There was nothing else to relate the band to the necrotic tissue and infection process other than its placement in the direct area of the infection and the necrotic tissue. There was nothing to connect the placement of the gastric band with damage to any structure which may have caused the bleeding.

6. The formal cause of death in his opinion was a secondary haemorrhage, i.e., a haemorrhage occurring at a later time to, and not related to a physical process. Applied to the current case, it is a haemorrhage not connected with the physical surgery but occurring later as a result of an infection or secondary process. The actual mechanism of death was that as a result of the hypovolaemic shock due to the haemorrhage, the insufficient quantity of blood in the veins resulted in damage to organs, in particular to major organs leading to a shut down of those organs and ultimately death.

7. In his view, the bleeding must have been present for a matter of hours to build up in the abdomen to the extent that it could leak out as it did. Although this was the most likely scenario, he could not

totally rule out the less likely scenario that an extended slow bleed might have the same effect.

33. Dr Ranson was extensively questioned in relation to the band itself and in particular whether there was air in the band before he removed it in the course of the autopsy. This is one of the major issues in this Inquest. He confirmed that when he removed it, it was not completely flat but neither was it fully inflated. He qualified this statement by saying that he had no expertise in the appearance of the band at any of the stages of inflation and therefore could not comment on whether it was normal or abnormal. He did express the view however that the inflation of the device can cause necrosis and inflammation because as it is inflated it will push on other organs. He confirmed that any pressure causes the risk of necrosis and therefore the risk of a secondary bleed.

34. Dr Ranson said that he removed the band from the body by first tying off the tube connecting the reservoir to the band. He then cut the connecting tube and removed the band separately from the tube and the reservoir. Photographs numbered 19, 20 and 21 in Exhibit 1 show the band in situ. In the course of his evidence Dr Treacy agreed that the band appeared partially inflated in those photos and he estimated that the band contained two to three millilitres of air.

35. Dr Ranson was recalled to give evidence when the issue of air in the band assumed a greater prominence once further investigations were undertaken. This is what prompted the preparation of his two supplementary reports (Exhibits 30 and 36). His further evidence was directed in particular the issue of whether or not he could have introduced air into the band during the course of the autopsy. His supplementary reports and evidence on this issue was inconclusive. It did not exclude the possibility that air entered the band during post mortem procedures. The gist of his evidence was that he could not recall at what stage in the autopsy procedure the band was removed and

consequently when the tube was cut. He had a vague recollection of the tube being cut but could not say when that occurred in the autopsy procedure by reference to the sequence of photographs. He confirmed that his focus at the time was more the source of the bleeding rather than the contents of the band.

36. Questioning which suggested that the photographs showed a sequence did not assist him in recalling whether he may not have cut the band until a certain point in the sequence of photographs. Although he conceded that it was possible that he, for example, cut the tube before photograph number 21 was taken, (and he said that it would not have been unreasonable to have then cut the tube), he could not specifically recall and could not rule out it having had been cut at some time before or after. He said that the tube may well have even been cut early in the procedure or might have been cut just before removal. I think that the net effect of this evidence is that it cannot be ruled out that Dr Ranson did not introduce air into the band in the removal process notwithstanding that he tied off the tube for that purpose. Even in relation to the tying off, he could not specifically recall the action of tying it off or cutting and he could not indicate the nature of the tie off or whether it was sufficient to ensure that no air could be drawn into the band. As far as I could tell there was no reason for him to take any precautions in that regard at that time. He in fact commented that the tube was quite a thickish tube which would have resisted an air tight tie off. That in itself may account for the air in the band.

37. It is regrettable that Dr Ranson was not more familiar with gastric banding as I suspect that had he been aware of the significance of air in the band he would have taken steps during the autopsy to ensure that the issue could be properly resolved. Senior Constable Lade's evidence on this issue was that the tube was cut after the photograph 19. She further stated that it was only cut to assist in its removal and that it would not have been cut if it could have been removed intact. She said it had to be cut as it was intertwined in

organs. Although she is more positive than Dr Ranson on this issue, viewing the evidence as a whole, I cannot rule out that any air in the band was introduced inadvertently during the post mortem.

38. Dr Treacy's evidence on this issue is also important. He pointed out that photograph 16, which self evidently was taken before the photographs 19-21, shows the band apparently deflated. The rather obvious conclusion he drew is that the tube was cut between the time when photographs 16 and 19 were taken. That conclusion seems inescapable to me. I was also impressed by the reasons that Dr Treacy gave to explain why it was not possible that there was air in the band at the time of the surgery. Firstly he said the band would not fit through the keyhole incisions with any air in the band. Secondly he said that he would have clearly seen if the band had air in it given that he has a magnified view through the cameras inserted into the abdomen. Thirdly he said that it would not fit properly around the stomach and could not be properly fitted if it had air in the band. These reasons seem quite plausible and logical in my view. If I accept that the presence of any air in the band would have been obvious to Dr Treacy at the time of the surgery and that its presence also meant that installation into the abdomen and proper placement would have been hampered, then there is no reason why Dr Treacy would have proceeded with the fitment in that event. The extensive evidence heard by the Inquest really presents only two alternatives to explain the air in the band namely, inadvertence by the pathologist or fault on the part of the surgeon. On the evidence before me I do not hesitate to rule out the latter and as I cannot rule out the former, the resulting conclusion is obvious.

39. That then leaves the question of what commenced the chain of events leading to the secondary haemorrhage. I think that Dr Gilhome's evidence is central to that issue given the findings I have made to date. As all other options explored in the evidence having been dismissed it leaves only the normal risk of surgery which Dr Gilhome referred to. Dr Gilhome has

extensive experience in procedures of laparoscopic banding. His credentials are impressive. He has performed in excess of 150 laparoscopic banding procedures to treat obesity. He has a particular interest in laparoscopic minimal access surgery, upper gastrointestinal tract surgery and trauma. He is familiar with the band used by Dr Treacy for the subject procedure although he prefers to use a different band which has a slightly different physical appearance. He confirmed however that the procedure for the surgery is the same in both cases as is the outcome. I say at the outset that I was very impressed by Dr Gilhome. He is clearly well qualified and very knowledgable and he presented his evidence and opinions with a high level of objectivity.

40. He could not fault Dr Treacy's preoperative assessment, his management and his operation technique. In particular he noted there was good haemostasis at completion of the procedure indicating that there was no bleeding at that time. He said that the Deceased's management postoperatively and until discharge was entirely satisfactory. He approved the prescription of analgesia for abdominal pain and discomfort and the arrangements for review on 20 February 2002. He said that pain and discomfort for a short period following the procedure is an expected consequence. The pain typically lasts for three to four days and the discomfort can last for up to a week. The pain can include shoulder pain from diaphragm irritation.

41. He considered that the history given by the Deceased on her admission to Accident & Emergency on 18 February 2002 of left shoulder tip pain as indicating a diaphragmatic irritation. This could in turn imply some slight bleeding. However, as the Deceased's examination, her abdominal signs, her blood pressure and pulse were normal, he did not consider that any bleeding was excessive. He considered that it was less than satisfactory that the abdominal examination was not conducted with the patient in the supine position. He said that he would be concerned if a patient refused to lie down

because of pain. He qualified this however by indicating that it would not be unusual for obese people to experience discomfort when lying down. He said this would indicate abdominal pain which may have indicated the need for a CT scan. However, he doubted that a CT scan would have been informative at that time as it would not have shown the infection nor the slight bleed which he thought was occurring at the time. He said that imaging would not have detected the infective process on 18 February 2002. He said that there was no one test which then would have shown the onset and progress of the infection. Particularly, he said that although a high white cell count would normally indicate an infection, in this case at that time that result would have properly been attributed to the recent surgery.

42. He maintained his view throughout that the existence of the abdominal pain indicated the need for review by the surgeon. He was critical of the fact that Dr Treacy was not contacted at that time because he had the expertise to determine, better than anyone else, what the abdominal pain complained of by the patient resulted from. Ultimately however, given that the patient's condition appeared stable and to settle with oral analgesia, he doubted that any further treatment would have been instigated. He confirmed that in his view there was no evidence of the secondary haemorrhage on 18 February 2002, although what occurred was the prequel to that condition. Having regard to the symptoms of the Deceased between the 18th and the 20th February, in his opinion a laparotomy was not indicated at the time as there was no obvious evidence of interperitonial catastrophe. He said that would not have warranted the risk of further surgery. I think all this is very telling.

43. He said that given the apparent normality of the signs and observations at that time, he could not really fault Dr McNair's treatment on that occasion. He agreed that Dr McNair's actions all appear reasonable and that Dr McNair had good reason to feel comfortable with what he had done and the discharge of the patient. The effects of the codeine phosphate given by Dr McNair would not have masked the rebound or guarding and would only

have masked the normal pain reaction. That medication would have been unlikely to affect tenderness.

44. He considered that the treatment given by Dr Patton to have been appropriate according to the circumstances. He thought that the discharge noted by Dr Patton on 20 February 2002 was an infection of the local wound and not related to the ultimate infective process leading to the secondary haemorrhage.

45. He agreed that an intake of vitamised soup would be acceptable and not in breach of dietary instructions. In any event he opined that even had solids been ingested at the time, that would not have been causative of the death. I thought this to be very interesting in light of all the discussion of pressure causing necrosis.

46. He did not consider it unusual that the site of the secondary haemorrhage was unidentified in the autopsy report. He confirmed that a secondary haemorrhage can occur between 7 and 10 days postoperatively but he thought that the actual secondary haemorrhage in this case would have started in a matter of hours, possibly as little as two hours, before the patient woke screaming on 21 February 2002. This is consistent to a certain extent with the opinion of Dr Ranson on this issue. He said that the relatively instantaneous nature of secondary haemorrhage is not something that can be prepared for and this was particularly so in this case as on 18th or 20th February, there were no clear signs of a secondary haemorrhage. Hence he could not suggest that the hypervoleamic shock syndrome could have been avoided.

47. His evidence regarding the cause of the process leading up to the secondary haemorrhage is best summarised by his answer to a question from counsel assisting, at page 185.5 of the transcript. I set that out in full hereunder:-

> Doctor, the application of the band – and I'm continuing on with the subject matter that you referred to under the hearing 'Autopsy

> Report' – the fact that the application of the band is bound to cause necrosis; is it not?
>
> Not so much the band itself but the – the operative process. Fat is a pool of (inaudible) tissue. It doesn't like being operated on, fat tissue. And nearly always with trauma from just the surgery itself, you know, bruising of the fat tissue when you're manipulating and operating can cause saccharomyces which is (inaudible) fat cells that have had very poor blood supply and that really is the focus for infection particularly with a foreign body. But (inaudible) operate on a patient and re-operate that there is some saccharomyces. There's basically a small amount of saccharomyces is often a common scenario, that is to say operating a patient. It's not necessarily related to the band per se. Although if the band was too tight one could assume that would happen, but I don't see any evidence of that in the autopsy report, histology, or in the patient's clinical presentation. She seemed to have no problem in swallowing and if it was too tight, she would have had problems in swallowing. So I believe that that necrosis is a consequence of surgery per se rather than the band.

48. Dr Gilhome is independent and I thought a most impressive witness with particular expertise with the subject surgery. The explanation given as set out in the preceding paragraph is the only possible cause which has not discounted. Moreover his explanation is plausible and persuasive. By a process of elimination of all other possible causes I find, in accordance with Dr Gilhome's view, that the process leading up to the secondary haemorrhage resulted from the operative process without fault on the part of any person.

49. Dr Christopher Baggoley, a specialist emergency physician since 1996 and currently the head of the Emergency Department at Ashford Hospital in South Australia, was called to give evidence essentially as an independent expert in emergency medicine. His evidence was particularly relevant to the issue of the adequacy of the protocol for contacting treating surgeons in the case of operative patients attending at Accident & Emergency. He also provided two reports, the first dated 12 June 2002 and the second dated 8 October 2002. Those reports were tendered as a bundle and marked Exhibit 3.

50. He said that the optimal position to conduct an abdominal examination is the supine position as he would be looking for signs of softness and rebound. He said the results would not be as reliable if the patient was not lying down. The patient's obesity would also present a problem in conducting an adequate abdominal examination. He would have been concerned had he obtained a history that the patient could not lie down because of pain.

51. He was of the view that it would be necessary to wait for the effects of the analgesia to wear off before discharging the patient. He said this was because the signs given by the Deceased of settled pulse, reduced pain level and blood pressure could all have been due to the effects of the analgesia and not necessarily the treatment of the underlying problem.

52. He was aware of the protocol of Royal Darwin Hospital in relation to contacting consulting surgeons in the case of post operative patients. This was set out in the statement of Dr Palmer. The relevant part is that *"…It is expected of all staff working in the Emergency Department that if a patient who has had an operative procedure attends in the Emergency Department with a post-operative complication, and the presentation is out of the ordinary, that the operating doctor (Consultant Surgeon) should be contacted…"* Dr Baggoley said that what was "out of the ordinary" was always going to be a matter of interpretation. However he said that in the particular case he would have been influenced by the fact that the patient thought the pain was sufficient to warrant her attending at 3.30am in the morning and that the patient would not lie down because of the pain. In his view, these were factors which suggested that the presentation was "out of the ordinary". On the other hand, he said the fact that the patient had said that pain was the same as when she had been an inpatient and that she had been given reduced analgesia on discharge from Darwin Private Hospital would counter that. Overall he said that made the protocol difficult to apply. He did point out however that the patient was discharged at approximately

6.15am and this would have been at quite a suitable time to contact the consultant surgeon having regard to regular routines.

53. He was concerned that there might be ambiguity and differences of interpretation with the existing protocol which obviously therefore would require rectification. Subject to that, he considered that the protocol in place was a good one.

54. He acknowledged that doctors trained overseas might have a different culture to that in Australia in relation to contact of consulting surgeons. Indeed, given Dr McNair's evidence, it is clear that it is his different training more than the protocol which resulted in Dr Treacy not being contacted that day. Dr McNair said that had he known then that Dr Treacy would have wanted to be contacted or informed, he would have done so, presumably whether or not the matter was or was not "out of the ordinary". This assumes importance in the context of the recommendations I make hereunder.

55. Dr Baggoley confirmed that it would have been difficult for Accident & Emergency staff to detect slight bleeds. He defined a slight bleed as less than 500mls. He based this on 500mls being the typical amount donated by a blood donor and which does not cause an erratic pulse. He said that a 15% loss of blood is required before the pulse is affected and before there are other signs which would also indicate bleeding. A 15% loss translates to a loss of 750mls on average. In his view it would not have been possible to discern the events occurring at the date of death from the events on the presentation on the 18 February 2002. He pointed out that on 21 February 2002 the Deceased had a major abdominal bleed of the order of two litres. He noted that it was not old blood according to the autopsy report and this suggested therefore that the severe bleed was recent to the time of death. There was however no evidence of any significant bleeding on 18 February 2002. This is consistent with Dr Gilhome's opinion.

56. He agreed that the absence of a diagnosis for the cause of pain meant that the Hospital should have contacted Dr Treacy and at least kept the Deceased in Hospital until the analgesia wore off. It is puzzling that he also thought there was no diagnosis of the cause of pain as clearly there was. That diagnosis was in the notes and it was confirmed also in the discharge summary given to the Deceased at the time. That view must therefore be seen in that light. He emphasised that the simplest way forward on 18 February 2002 would have been to ask Dr Treacy to see his patient. This would have been preferable because of the surgeon's knowledge of the patient and the surgery. Dr Gilhome expressed the same sentiment.

57. Dr Baggoley also impressed me. I think the main thrust of his evidence is that he put great emphasis on the fact that Dr Treacy should have been called by Accident & Emergency staff on 18 February 2002. For reasons apparent in the body of these findings, I do not think however that there is any causative connection between that failure and the death of the patient on 21 February 2002.

58. Dr Peter John Treacy gave evidence on three occasions during the course of the Inquest. His evidence commenced on 14 November 2002 and concluded on 31 July 2003. In the intervening period a report was obtained from the Therapeutic Goods Administration addressed to whether the reservoir port had been punctured. This inquiry was made because of the suggestion of Dr Treacy that marks on the reservoir membrane might have indicated that the air found to be in the band at the time of the autopsy could have been introduced by this means. The Therapeutic Goods Administration report, which became Exhibit 22, ruled that out. Another document was also obtained in the intervening period and was also received. That document was the manufacturer's procedure manual. It contained a recommended procedure for evacuating the band of all air before placement. The report from the Therapeutic Goods Administration also established that the specified procedure had not been followed by Dr Treacy and that also then

became an issue which had to be explored given that it presented another means by which air may have found its way into the band.

59. In the course of his evidence Dr Treacy explained the checks conducted on the band before it is introduced into the body. He said he checks it during the course of the operation and before it is introduced into the abdomen by inflating it with a saline solution and entirely immersing it in fluid. This is to ensure there are no leaks. He then deflates the band and sucks all air out of the band using a needle and a syringe.

60. Dr Treacy confirmed that bleeding is a surgical risk in general terms but was not any greater a risk in this operation. He said that the Deceased's surgery was normal and uneventful. Particularly, no abnormal bleeding was noted during the procedure and he noted good haemostasis at the conclusion of the procedure i.e., all operative bleeding had stopped.

61. He confirmed that the surgery on the Deceased and her post operative care was uneventful. He saw her daily until her discharge on 17 February 2002. He gave evidence of the arrangements he made with the Deceased on discharge. As she was discharged on a Sunday, he could not give her a set appointment time so it was left on the basis that he would call her, or vice versa, to arrange an appointment for the Wednesday.

62. He said that he had been unaware of the Deceased's attendance at Accident & Emergency in the early morning of Monday 18 February 2002 and of her discomfort at that time. He said that his first contact with the Deceased after the discharge was on 20 February 2002 by telephone. He said that he could not recall the precise contents or sequence of the phone call however he recalled:

1. That she had been to the Accident & Emergency Department at Royal Darwin Hospital.

2. That he had expressed surprise that she did not contact him when she experienced the pain and discomfort and also that the Royal Darwin Hospital had not notified him of her attendance.

3. That she said that she was given pain relief when she had attended at Accident & Emergency.

4. That she had been to a Chinese restaurant and had some soup with some food stuff in it, corn as far as he could recall.

5. That he told her that the consumption of the Chinese food was possibly the cause of her discomfort.

6. That arrangements were made for him to see her in his rooms at 2.00pm that day.

63. The extent of the recorded part of his voicemail message became relevant to piecing together whether messages may or mat not have been left on Dr Treacy's voicemail. It is clear from the evidence that persons leaving a message are timed and charged from the commencement of the recorded message. It was established that the Dr Treacy's mobile phone carrier charges for calls in 30-second increments. Dr Treacy described the recorded greeting he had on his voicemail as at February 2002. It comprised announcing his name, the invitation to leave a message, directions as to what to do in urgent cases and directions as to who to ring if only an appointment was sought. Although Dr Treacy suggested that the duration of the recorded part of his message could be of the order of 30 seconds I think more realistically it is less than half that time.

64. He confirmed that there was only one telephone discussion with the Deceased. He made an interesting comment that given the circumstances, (no doubt referring to her untimely death in highly unusual circumstances the following day), he would have recalled any other discussion that he had had with the Deceased. I certainly accept that that is likely to be the case. It

is in fact the same reason proffered by his receptionist as to why she was able to recall details of her discussions with the Deceased. Dr Treacy in fact made a similar comment relating to his recall on a number of other occasions during the course of his evidence. I would have certainly expected him to recall any significant event which occurred in relation to the management of the Deceased's condition consequent upon her subsequent tragic death.

65. Dr Treacy was extensively cross-examined on this point. Bearing in mind the duration of the call, bearing in mind that the Deceased had attended at Accident & Emergency in the early hours of the preceding morning, bearing in mind also that the Deceased was a person with some medical training and would therefore be better placed than the ordinary person to know what information was important for her doctor to know and to be able to succinctly provide that information, I expect that a call of that duration in such circumstances would have resulted in a considerable amount of information being passed. Despite Mr Lawrence's powerfully put submissions on this issue, I find it difficult to accept Dr Treacy's claimed lack of recall of any greater detail than that outlined in paragraph 62. I think much more must have been said both by the Deceased and by Dr Treacy. Dr Treacy offered as an explanation the fact that he may have been in a public place when he took the call and therefore would have been reticent to discuss much of a patient's private details for confidentiality reasons. That simply does not add up in the context of a telephone call of the duration specified and the circumstances specified. If, as I suspect, more was discussed, then I can only assume that it must have been material. However, that does not enable me to conclude that he was then aware of issues which might have led to the death being avoided. Indeed, all the evidence is to the contrary.

66. In relation to his actions following notification of the cancellation of the appointment by the Deceased, Dr Treacy said that he was notified of the

cancellation by his receptionist Nicole Cox at approximately 1.00pm that day. This was reliably confirmed by Ms Cox when she gave evidence. Dr Treacy said that he then made notes of what he had learnt that day. The note he made was in evidence. It was *"2.00pm App't made by me - patient rang and cancelled - did not want to come. I will arrange review ASAP and told me has been eating Chinese food!! > Told stay on liquids only - this may be causing her discomfort"*. He indicated that it was his intention then to call the Deceased to arrange to see her as soon as possible. He then indicated that he had a busy schedule the rest of the day and in fact was in surgery until approximately 10.00pm.

67. He said that the next thing relevant that occurred is that at approximately 6.00am the following morning, he was woken by his Registrar at home to be told that the Deceased was seriously unwell. He promptly went to the hospital and saw the Deceased. She was being resuscitated by Emergency staff and he was overseeing their actions and providing assistance. He was present when she was pronounced dead at 7.20am.

68. In relation to the issue of air in the band, Dr Treacy confirmed that there should not have been air in the band at the autopsy. As a preliminary he agreed that if the band was partly inflated it would cause a constriction which would lead to necrosis and would result in a greater risk of hemorrhaging. All this was very important in the context of the issues in the Inquest as Dr Treacy confirmed that one reason why the band is not adjusted for the first three months is to enable the healing process to occur and therefore to reduce the risk of necrosis and infection. He was asked to speculate if there was air in the band to the extent as indicated by photograph 24 and if it had been present over the four days between the time of the placement and the death, whether that would cause necrosis. He said that the band exerts low pressure only and he doubted that it, of itself, could lead to necrosis. He further refuted the suggestion that the placement of the band or compression caused by it while the tissues surrounding it are

swollen creates more than a nominal risk of infection. He went as far as to say that the recommendation not to inflate the band for three months is more to prevent slippage of the band than for the purpose of reducing the risk of infection.

69. He then elaborated on the procedure he adopts for removing all air from the band after it is tested for leaks. It was noted that the procedure he adopts is not in accordance with the manufacturer's instructions as set out in the procedure manual which had been put in evidence. The procedure manual suggests that the air be extracted through the actual reservoir port by use of a Huber needle. He confirmed that instead he uses a syringe to remove the air directly from the tube connecting the port to the band and before the tube is connected to the port. There was much questioning about this apparent deviation from the manufacturer's specification. Dr Treacy gave a number of instances where he and other experienced surgeons in the use of the band vary the procedure as indicated in the manual. He said that was the way he was trained to perform the procedure with this particular band. He further said that a representative of the manufacturer was present when he performed his first procedure. The evacuation of air was done in the same manner and the manufacturer's representative made no adverse comment.

70. Dr Treacy gave approximately eleven instances of known variations to the procedures set out in the manufacturer's procedure manual both in relation to variations he undertakes and others known to be taken by other surgeons. In addition he highlighted aspects of the manual where he follows the procedure recommended by the manufacturer but is aware that other surgeons do not. He even said that the manufacturer itself, on its web-site, provides an alternative to part of the procedure which does not appear in the manual. Finally he confirmed that he had performed four similar operations since the surgery on the Deceased and that in each case he evacuated air from the band using the same method as he did in the case of the current surgery.

71. Despite the extensive questioning on the point I think nothing turns on that. I do not consider that any air in the band was attributable to the alternative procedure used by Dr Treacy. I say this despite Mr Glascott's submissions to the effect that the inadequacy of the alternative procedure was the cause of air in the band. That is not supported by the evidence. Moreover, given the apparently extensive use of this alternative, if it were inadequate then many more cases of similar problems would have surfaced. This issue was thoroughly explored in cross-examination and I am prepared to accept Dr Treacy's evidence on this issue. It is consistent with the views of Dr Gilhome.

72. Dr Treacy was asked why he has seemed to emphasise, on two occasions in his notes, that the Deceased had consumed Chinese food. The emphasis was in the form of double exclamation marks. This note had been made both in Dr Treacy's private note and when he made a notation in the Hospital case notes approximately half an hour after the death. Dr Treacy had given evidence up to that point that he thought that cause of death might have been something to do with a blood clot, hence at least in relation to the entry on the date of death, the preoccupation with the Chinese food and the emphasis in the form of exclamation marks appears to be quite peculiar. Although I thought he was unconvincing in his explanation particularly with respect to the Hospital case notes, I do not think that anything turns on that.

73. Dr Treacy resisted the suggestion that the examinations performed at the Accident & Emergency Department by Dr McNair were inadequate as the patient was not lying down. He said that he was unconcerned about the fact that there was no diagnosis of the cause of pain made on 18 February 2002 as he said it is not always possible to diagnose the cause of abdominal pain. Again, this comment is rather odd in light of the fact that there was a diagnosis for the cause of the abdominal pain. Many of the medical experts seem to ignore this, something that I find not only puzzling but also difficult to reconcile. He conceded that had he examined the Deceased on 18

February 2002 that he may not have been able to diagnose the cause of abdominal pain but he did agree that the fact that the patient complained of pain when lying down and felt the need to attend at Hospital because of the pain at 3.30am in the morning were factors which raised the level of concern.

74. Dr Treacy said that had he been consulted then, he would have ordered a full blood count test and a urea electrolyte test. He said however that the possibility of a bleed was not something that would have occurred to him from the history taken by Dr McNair as the Deceased did not show low blood pressure and a raised pulse. He said that he also would have suspected that perhaps the stomach was not emptying and therefore he would have passed a tube into the stomach to check on this. Dr Treacy indicated that the tests he suggested were more immediately necessary than a CT scan. He said that a CT scan is not the best way of investigating the stomach area. There is nothing in Dr Treacy's evidence to support the submission of Mr Glascott that had Dr Treacy been called on 18 February 2002, he would have taken steps which would have lead to the discovery of air in the band. In any event my finding is that there was no air in the band until during the course of the autopsy. Nonetheless, there is no evidence that the steps Dr Treacy would have taken, would have lead him to investigating the possibility of air in the band at that time.

75. He indicated that he had not been aware of Dr Patton's attempt to contact him on 20 February and only learnt of that attempt when reading through Coronial documents. He says that he does not recall getting a call from her on his mobile and that he would have attended to that had she done so. He confirmed that the two phone entries indicated on Exhibit 25, (Dr Patton's phone bill), relevantly showed the telephone number of his rooms and his mobile. Dr Treacy conceded that the entry in his telephone account (page 13 of Exhibit 26) at 11.23pm on 20 February 2002 was in fact a retrieval of his messages at that time. He concedes that if Dr Patton had left a message at

the time she claimed then he would have retrieved it then. He however maintained that he had no recollection of any message from Dr Patton and that he had no recollection of what messages he retrieved on that occasion. Again, if that message related to the Deceased, then for the same reasons that I expected better recall of the discussions between Dr Treacy and the Deceased on the eve of her untimely death, I would expect him to also recall any message left by Dr Patton if Dr Patton had identified the Deceased as the topic of her call. In that event I would not credit any answer which claimed a lack of recall whether in total or in part.

76. Dr Treacy conceded that if Dr Patton had left a message which he had only retrieved at 11.23pm he would not have called her back then and most likely would have called her back next morning. This is of course very plausible and sensible. The events of the next morning obviated the need to return the call, again assuming that the Deceased had been identified as the topic of the call. This would excuse his failure to return the call. Dr Treacy therefore has nothing to gain by feigning a lack of recall. Combining this with the somewhat uncertain nature of Dr Patton's evidence regarding whether she left a message and if so its content, leads me to conclude that if Dr Patton did leave a message, then she did not identify the Deceased as the topic of her call. If she did leave any message then there is no dispute that Dr Treacy did not call her back and I so find.

77. Dr Treacy said that even in retrospect, had he seen the Deceased at that 2pm appointment he does not believe that there was then anything at the time which indicated that she was at a risk of dying. Dr Treacy expressed the view that there was no indication of infection when the patient was discharged from the Darwin Private Hospital on 17 February 2002 and subsequent analysis of the pathology report contained nothing to retrospectively change his view about that. Although he conceded that he would have been more concerned about the cancelled appointment had he then known the full details of the history taken at Accident & Emergency on

18 February 2002, he iterated that as of that date, there was nothing which indicated the possibility of a massive secondary haemorrhage. This is consistent with the rest of the evidence. This very much counters Mr Glascott's submissions where he concluded that had Dr Treacy seen the Deceased on the occasion of her attendance at Accident & Emergency, i.e., two days earlier, that he would have taken steps which would have prevented the death.

78. The contents of Dr McNair's discharge letter were put to Dr Treacy. He said that he would not have thought it was necessary for him to attend Accident & Emergency at that stage. This was on the basis that the only complaint was pain, it was a pain that had been the same as during her admission and it was pain that had increased but had been relieved by panadine forte. Again, this counters Mr Glascott's submission. He confirmed that during his working time in Darwin he is not always contacted if his patients attend at Accident & Emergency. He said this applied both before and after the death in this case. He said that whether he is called or not depends on the circumstances. He said that at the least he would like to be told if one of his patients did attend at Accident & Emergency, especially if they were a private patient. He said that he has discussed this with Dr Palmer both before and after the death in question. This is very relevant in terms of the recommendations that I make hereunder.

79. Miss Stephanie Dubois was the triage nurse on duty at Accident & Emergency on 18 February 2002. She gave evidence in relation to procedures followed regarding the attendance on patients at Accident & Emergency. She said that she recalled the Deceased specifically as she had reason to have her memory jogged by her untimely death within a short time of her attendance at Accident & Emergency on that night.

80. She confirmed that the date and time on the Royal Darwin Hospital Emergency Department Medical Record (Exhibit 1 Folio 8) is automatically

generated by the computer and cannot be altered. It notes an arrival time of 3.34am on 18 February 2002. She said that it would only be in the event of the computers not being operational that a manual date would be inserted and in any event that would then be affected by a backdated entry through the computer. She confirmed however that the computers were fully operational on that night. She said that her role was to take a history and assign a triage category.

81. She confirmed that the Deceased was not made to wait at all on the night in question. She confirmed that there were no other people in the waiting room. Importantly, she recalled that it was not a particularly busy evening. She said that it is not possible for a patient attending Accident & Emergency to attend at the wrong desk, nor is it possible for a patient to enter Accident & Emergency and not be seen by the triage nurse or the receptionist.

82. The evidence of Mrs Florance regarding the waiting time was put to her and, not surprisingly, she could not explain that discrepancy. She accepted that a computer error in the recording of the time might account for that but she considered this to be very unlikely. It also very much cuts across her evidence that there was no fault with the computer as far as she knew on that night.

83. Mr Paul Florance and Mrs Maria Florance also gave evidence inter alia directed to the time that the Deceased and Mrs Florance attended at Accident & Emergency on the morning of Monday 18 February 2002. On this issue Mrs Florance said that they would have arrived no later than about midnight and she would not concede any later than 12.30am. Maria Florance was quite persuasive in her explanation as to why she was so certain of the time, tying it in as she did from an arrival home from work earlier than normal because of a sense of not feeling well on her own part. Mr Florance confirmed that his wife came home earlier but not because of

illness on her own part but because of her concern for the condition of the Deceased.

84. When reminded that according to telephone records, a call was made from his home phone number to Royal Darwin Hospital at approximately 2.50am on 18 February 2002, Mr Florance then recalled that was a call that he made. He said that he actually spoke to his wife at the time. He said that he had rung her on her mobile but there was no answer and he therefore then rang the hospital number. He said that the nurse called his wife to speak to him and that she told him that the Deceased was still in the cubicle waiting to be seen. He said that he specifically recalls the phone call as he had woken up and was alarmed that his wife and the Deceased had not returned from the Hospital and was concerned that something might have happened to them. He therefore had good reason to recall an unusual and one-off phone call. It is interesting to note however that Mrs Florance could not specifically recall her husband telephoning her and I would have thought that if the discussions which her husband described took place then she would have good reason to recall that.

85. This evidence of Mr and Mrs Florance totally contradicts to the records of the Hospital, which indicates arrival at 3.34am followed by consultation with Dr McNair at 4.00am. It is interesting to note that the actual time on the time which Dr McNair saw the Deceased on either version is consistent the difference being that Maria Florance claims a wait of up to three and a half hours in the lead up to that consultation.

86. In relation to Mrs Florance's evidence, although I have no doubt that she has done her best to recite events as they actually occurred, there are certain aspects of her evidence which I think indicates that it is unreliable. I do not say this in anyway as a criticism of Mrs Florance. She was involved in a very emotional situation. She obviously cared very much for the Deceased who was her friend of many years. The events of finding her at her home in

an obvious state of pain, distress and bleeding heavily would have been very distressing. The ultimate death of the Deceased shortly thereafter would only have added to the distressing nature of the incident. I think it is quite indicative of the level Mrs Florance's distress that she indicated in her evidence that she was then selling her house because of the memories of that very distressing event. No doubt the distressing nature of the events that she observed effects her recall of those events and it is for that reason that I think her evidence is generally not reliable. Overall I think that Mrs Florance's evidence is coloured by her sense of great loss over the death of her very close friend. Her highly emotive claim that no one at the Accident & Emergency Department wanted to know them or do anything for them highlights this. I do not accept her evidence where it conflicts with other more reliable evidence.

87. In all the circumstances, the evidence in the Hospital records and the evidence of Ms Dubois as to the admission time is to be preferred. Ms Dubois logically and systematically explained the Hospital's procedures. Her evidence was entirely the more objective. The proposition put to Mr Florance to explain the telephone call to Hospital at 2.49am, i.e., that it was to forewarn the Hospital that the Deceased would shortly be attending at Accident & Emergency Department for treatment seems the most likely explanation. This is supported by the fact that the actual admission was approximately 35 minutes later and the Deceased had to travel in from Yarrawonga, a travelling distance consistent with a travel time which would coincide with an arrival at the Hospital at approximately 3.34am. In my view the Hospital has correctly recorded the arrival time. I should add that had I preferred the evidence of Mr and Mrs Florance, then although a comment would be called for, that delay would not in any way have contributed to the untimely death of the Deceased.

88. Mr Florance also gave evidence about a number of other matters. He gave evidence about what occurred in the morning of Wednesday 20 February

2002. He said that the Deceased had told both he and his wife that she had an appointment at 10.30am with Dr Treacy. This was not correct as the evidence shows that she had an appointment at that time with Dr Patton. I wonder whether perhaps the omission of details in the conversation between the Deceased and the others and certain assumptions on the part of Mr and Mrs Florance might have led to this misapprehension that the appointment was with Dr Treacy. I say this because it is clear that there was no appointment in place with Dr Treacy at the time. Moreover if the Deceased made a call from the home of the Florances at Yarrawonga at 10.16am to arrange an appointment then she could not even have attended a 10.30am for the appointment with Dr Patton. That leads me to conclude that the appointment with Dr Patton must have been arranged earlier that morning. I suspect that the call identified on the telephone records for the Florance's home as being to the Northern Territory University switchboard at 9.14am was the occasion when that appointment was made. That cannot be said with certainty as the Deceased worked for the University and could have been calling for reasons associated with her work. It appears the Deceased may have given some attention to work matters that day by reason of the explanation she gave to Ms Cox for cancelling the appointment with Dr Treacy. Moreover this ties in with the comment that Mr Florance made that he was going into town for an appointment at 9.30am and offered to take the Deceased to her appointment at that time. That offer obviously must have been made before 9.30am. He said that she declined because citing that it was too early for her. Clearly she must have known then when her appointment was for her to make such a statement. The appointment certainly could not have been made after the Deceased spoke to Dr Treacy as that call concluded at approximately 10.20am and it would have been very optimistic of the Deceased to thereafter arrange an appointment with Dr Patton 10 minutes later when clearly it would take her much longer than that in travel time alone. Interestingly Mr Florance said that when she arrived back at the house at approximately 4.00pm on Wednesday 20

February 2002, the Deceased claimed that she couldn't get to see Dr Treacy and had to see a doctor at the University. He says that the Deceased specifically said that her original appointment with Dr Treacy was at 10.30am and that it was put back to 2.00pm. None of this fits in with the other evidence of events on that day, evidence that I find consistent and credible.

89. Mr Florance's evidence was that the Deceased spent most of her time at home when she was with him lying down. Under questioning from me he indicated that this was lying down in the full supine position on her bed in her room. Mr Florance even went as far as to say that she sometimes slept on her side and even went as far as to say which direction she was facing. From all that I have to assume that he directly observed the Deceased and that his recall is good. He also said that on their return from Accident & Emergency Department on the morning of 18 February 2002, that both his wife and the Deceased went to bed and slept for a while. This was interestingly only some two hours after the Deceased had apparently reported to Dr McNair that she could not lie down because of the pain. Similarly when the Deceased got home after apparently attending the appointment with Dr Patton on Wednesday 20 February 2002, he said that Deceased went and laid down.

90. Importantly, this shows that the Deceased was able to lay down on two occasions which were only a short time after reporting to doctors (McNair and Patton) that lying down was too painful. There is no possible reason why the Deceased would have misled the doctors about her pain symptoms. If Mr Florance is correct in his recall, then this can only be reconciled on the basis that the level of pain and discomfort was intermittent. I think that further vindicates the treatment given at Accident & Emergency on 18 February as well as the discharge on that date. It suggests that if the Deceased had been kept in Accident & Emergency for another one to two hours, her complaints might have subsided.

91. Dr Didier Palmer is currently, and was in February 2002, the Director of Emergency Medicine at Royal Darwin Hospital. He too is a well-qualified expert in his field. He provided two statutory declarations which were respectively tendered as Exhibits 5 and 18. He gave evidence of the procedures usually followed when a patient attends at Accident & Emergency Department. He gave evidence of the layout of the Department and importantly he described that the triage nurse sits in a booth and geographically is the obvious and first contact point for any person entering Accident & Emergency.

92. He described the computer system in operation in Accident & Emergency. This confirmed the evidence given by Ms Dubois. Additionally he said that the computer generated time record could not be changed by staff.

93. He was questioned in regards to abdominal examinations in the Accident & Emergency context. Although he confirmed the ideal is to lie flat he said that for a number of reasons, including obesity, some patients cannot lie flat. He says that an examination in a reclined or semi-reclined position can be adequate. He explained this by saying that what the doctor looks for in an abdominal examination is lumps and any issues relevant to the peritoneal lining. These he said are able to be detected in a semi-reclining position. He said there is in fact no diagnostic significance in a patient not being able to lie down when taken as a whole if there is no peritonitis. This is very much at odds with the evidence of Dr Baggoley and Dr Gilhome, although it fits in to a certain extent with that of Dr Treacy on this point.

94. In relation to whether a patient still under the effects of analgesia should be discharged, he said that the usual position is that discharge should be after four hours but that in any event this is a matter of judgment and is to be viewed in the light of the all relevant circumstances. Particularly, in the case of the Deceased he said that also relevant was the fact that the Deceased had been in receipt of panadeine forte while in Darwin Private Hospital but had

been discharged on simple panadeine. He noted that the codeine phosphate was prescribed to take the level of analgesia up to the level that she had while in Darwin Private Hospital. It therefore appeared that the problem was inadequate analgesia and once medical staff were satisfied that that was the nature of the problem, a conclusion which he said was open to them based on the observations and history, it was quite acceptable to discharge her at the time that she was.

95. Regarding the protocol for contact by Accident & Emergency staff of treating surgeons in the case of post-operative patients, Dr Palmer confirmed that contact with a treating surgeon is not done as a matter of course. He confirmed that the Accident & Emergency staff see many minor post-operative complaints. Examples are a minor infection, problems with the fitting of plaster and the like. He said that in most cases the consultant would not be able to add anything at all and then consequently routinely calling treating surgeons would be nothing more than nuisance value. I note however that Dr Treacy wanted to be notified of the Deceased's attendance on 18 February 2002, whether it was a routine attendance or not.

96. He was questioned as to whether the presentation of the Deceased on the occasion in question was a presentation which was "out of the ordinary" within the meaning of the protocol. He stated the obvious when he said that it was a matter of judgment. I note that Dr Baggoley criticised this apparent ambiguity in the protocol. Although he agreed that someone going to the trouble to attend at 3.30am in the morning was a sign of something "out of the ordinary", the whole thing needed to be looked at overall and not just according to individual facets. He said that he disagreed with Dr Baggoley's assessment that the position could be interpreted as "out of the ordinary". However, I think that looking at it overall, if I had to interpret that protocol based on the situation which presented itself to Dr McNair that morning, I would consider it out of the ordinary and not a minor complication. I do not agree with the submission of Ms Sievers that there is no deficiency in the

current protocol. Although Dr Baggoley said that generally it is a good protocol, he noted the obvious in saying that the application of the protocol is a matter of interpretation. Dr Palmer called it a matter of judgment. Leaving the matter of description aside, that two expert medical practitioners disagree as to the application of the protocol on the facts of this case highlights that there is scope for improvement.

97. There is therefore a significant disagreement between Dr Baggoley and Dr Palmer in relation to the interpretation of the protocol. Mr Tippett submitted that Dr Palmer was not frank and was defensive. Ms Sievers criticised this as she alleged that the submission was based solely on Dr Palmer's steadfast maintenance of his professional view on matters of expert opinion and his refusal to agree with the propositions that were put to him. Without agreeing that Mr Tippett's submission was motivated in such a way, I am however not prepared to say that Dr Palmer was not frank in his evidence or was defensive. His views were based on his interpretation of the protocol. Moreover that interpretation is available on the facts of this case, albeit it is an interpretation that I do not agree with. My criticism of Dr Palmer however is not related to this difference of opinion. My criticism is that I perceived he was reluctant to concede (and address) what I consider to be an obvious problem with the protocol, evident by the fact that two well qualified professionals differ as to the interpretation of the protocol on the facts of this case. This is not a matter of a difference in professional opinion. I thought that he was inappropriately dismissive of available alternatives for notifying treating surgeons.

98. I say this as I note that a copy of the discharge summary handed to the Deceased on her discharge for her GP could have easily been provided to Dr Treacy. Given that one of the factors that Dr McNair took into account when discharging the Deceased was that she was due to see Dr Treacy soon thereafter, the significance of doing so is obvious. Dr Palmer confirmed that Dr Treacy is a consultant staff member of the Royal Darwin Hospital. I

expect that there would therefore exist facilities or options whereby a copy of the discharge summary could have been provided to Dr Treacy without much inconvenience. Dr Palmer confirmed that Dr Treacy's private rooms, as with many of the consultants of the Hospital, are at Darwin Private Hospital, a short distance from the Royal Darwin Hospital. He conceded that Royal Darwin Hospital is probably placed better than any other Hospital in Australia in these circumstances by reason of the fact that there is only the one public hospital and the one private hospital in Darwin and they are in close proximity. Although Dr Palmer conceded that the Hospital might have provided a copy of the discharge summary to Dr Treacy, he attempted to explain away this failure with suggestions of likely problems with fax machines and delays through internal post. That is nonsense as far as I am concerned. Even Ms Sievers conceded that this could have been done and that Dr Treacy could have been conveniently notified that morning during handover. This highlights my criticism of Dr Palmer's position.

99. Having regard to all the evidence, I now make my findings. Firstly the formal findings required by section 34(1) of the Coroners Act are as follows:

1. The identity of the Deceased was Souzana Afianos born on 12 September 1960 at Tennant Creek in the Northern Territory of Australia.

2. The time and place of death was at the Royal Darwin Hospital, Accident & Emergency Department on 21 February 2002 at approximately 7.20am.

3. The cause of death was secondary haemorrhage following gastric banding surgery.

4. The particulars required to register the death are:

   (a) The Deceased was a female.

(b) The Deceased was of Australian origin.

(c) The death was reported to the Coroner and the death was confirmed by post mortem examination.

(d) The cause of death was secondary haemorrhage following gastric banding surgery.

(e) The pathologist, Dr David Leo Ranson viewed the body after death and carried out the post mortem examination.

(f) The Deceased was employed as a University Lecturer at the Tennant Creek Campus of the Northern Territory University as it was then known.

(g) The Deceased's usual address was 54 Ambrose Street, Tennant Creek.

100. The remaining findings are set out in the body of this document but I repeat each here in summary form for convenience. They are:-

1. The cause of death was secondary haemorrhage following gastric banding surgery. The actual process leading up to the haemorrhage commenced following the surgery but the actual haemorrhage commenced a matter of hours before the death.

2. The gastric banding surgery performed by Dr Treacy, including his assessment and postoperative management of the Deceased, was competently and appropriately undertaken. In particular the process utilised by Dr Treacy to evacuate air from the band before its fitment was appropriate notwithstanding the deviation from the manufacturer's procedure manual.

3. There is no defect in the design, construction or method of application of the gastric band that contributed to the death.

4. The air in the gastric band evident in the photographs taken during the course of the autopsy likely resulted during the autopsy process and was not due to any act or omission of Dr Treacy during the surgery.

5. On 18 February 2002, the Deceased attended at Accident & Emergency at the time noted on the Hospital records, namely at approximately 3.34am. She was thereafter seen by Dr McNair at approximately 4.00am.

6. Subject to the proviso that Dr Treacy ought to have been contacted on 18 February 2002, the assessment and treatment of the Deceased at Accident & Emergency on that occasion was appropriate.

7. The failure of Accident & Emergency to contact Dr Treacy before discharging the Deceased on 18 February 2002 did not contribute to the untimely death of the Deceased.

8. The Deceased complied at all times and in all respects with the dietary instructions given her by Dr Treacy.

9. The necrosis which started the chain of events resulting in the fatal haemorrhage was properly not detectable by Accident & Emergency Department staff on 18 February 2002, nor would it have been detected had Dr Treacy then seen the Deceased.

10. Likewise, that necrosis was properly not detectable by Dr Patton when the Deceased consulted her on 20 February 2002, nor would it have been detected had Dr Treacy seen the Deceased on that day at 2pm.

11. If Dr Patton left a message on Dr Treacy's voicemail at approximately 11.10am on 20 February 2002, she did not identify the Deceased as the topic of that call. Dr Treacy would have retrieved

any such message at 11.23pm on the same day. He did not return Dr Patton's call thereafter. If a message had been left then it was not unreasonable for Dr Treacy not to have returned Dr Patton's call at the time he retrieved the message.

12. Dr Treacy's actions after the Deceased cancelled her appointment with him for 2pm on 20 February 2002 was not inappropriate in the circumstances and did not contribute to the death of the Deceased.

13. The Royal Darwin Hospital Accident & Emergency Department protocol regarding the contact of treating surgeons of surgical patients is ambiguous and inadequate to that extent.

14. The Accident & Emergency Department treatment of the Deceased on 21 February 2002 was appropriate.

Recommendations.

101. Section 34(2) of the Act enables me to comment on any matter, specifically including public health or safety, connected with the death in this case. Some comment is warranted on the evidence.

102. The death in this case was not occasioned by any blameworthy conduct on the part of the treating surgeon or any of the other medical professionals with whom the Deceased came into contact from the time that she underwent the gastric banding surgery at the Darwin Private Hospital to the time of her tragic death. Furthermore, despite there being what I consider to be an obvious shortcoming in the Royal Darwin Hospital Accident & Emergency Department protocol relating to contact of consultants of surgical patients, this shortcoming likewise did not contribute to the death of the Deceased. Sadly, the death appears to have been unavoidable. However there will no doubt be cases where the deficiency in the protocol may assume a greater significance and may also be causative of an unnecessary death. Pre-emptive

and prompt attention to rectify the ambiguity I have identified to prevent that situation occurring is warranted.

103. In addition, in my view, consideration ought be given to having provision for a back up precaution inserted into the protocol. The provision I suggest is to require routine notification to, as opposed to routinely contact of, treating surgeons of an attendance of an operative patient at Accident & Emergency in all cases even where no other action is warranted or required. This should be able to be achieved quite simply. I am not suggesting anything such as that which Ms Sievers described as an unworkable dogma which would routinely see surgeons unnecessarily troubled in the middle of the night. I concur that that would be unreasonable. I also accept that the Accident & Emergency Department do not have the capacity or resources to routinely keep surgical patients in hospital until they can be seen by their treating surgeons. The notification I am suggesting would not have to occur immediately in the majority of cases and should not therefore have to be an administrative problem. Certainly it would not have to unnecessarily upset the routine of the Accident & Emergency Department. In the subject case for example it could have been achieved simply by providing Dr Treacy with a copy of the discharge summary. Ms Sievers was prepared to concede that the Hospital could have done that in this case. She also acknowledged that Dr Treacy could have been advised later that morning at handover. That therefore is two simple ways that notification of attendance could have been given in this case. There are no doubt many other simple and appropriate options, eg a copy of the notes could have been sent to Dr Treacy's private rooms. A simple pigeon hole system could be set up in an appropriate place. E-mail notification should be easily achievable. In this case the typed discharge summary could easily have been made an attachment to an e-mail to Dr Treacy. The rather unique position of the Royal Darwin Hospital and the Darwin Private Hospital, not only their proximity but also that many of the surgeons practising at Darwin Private Hospital are also consultants at the

Royal Darwin Hospital, should facilitate a simple, convenient and efficient system of notification.

104. I expect that treating surgeons would appreciate such routine notification as it will then optimise the postoperative care of their patients. It is of interest to note that the treating surgeon in this case clearly wanted to be notified of his patient's attendance at Accident & Emergency. He expressed annoyance when he learnt of this failure. He has discussed this matter with Dr Palmer. I would expect that any treating surgeon dedicated to the care of his or her patients would want such notification. The unique position of the Royal Darwin Hospital that I have referred to should easily facilitate a process of consultation between the Director of Emergency Medicine and treating surgeons who practise in Darwin. Such a process would enable treating surgeons to have input into the protocol. I hope that my suggestion for routine notification would be a topic of that consultation process. Consultants could have input into the types of situations where they would want to be notified and/or consulted and for that matter whether they prefer to receive the routine notification I have suggested. They could also have input into their preferred method of notification. I expect the result of that consultation process will be a workable protocol, purged of ambiguity or differences of interpretation, which would best meet the needs of patients and the requirements of treating surgeons without unnecessarily impacting on Accident & Emergency's valuable resources. I recommend that such a consultation process begin as soon as possible and that the protocol be amended to accommodate the findings of that process.

105. I also note that despite the Royal Darwin Hospital having an induction program to orientate doctors who train overseas, and apparently did so at the time that Dr McNair commenced his service at the Hospital, a possible factor in the failure of Dr McNair to contact Dr Treacy on 18 February 2002 could have been directly attributable to his overseas training. This queries the effectiveness of the induction program on this aspect at least. Any such

deficiency needs to be promptly addressed. This recommendation is not limited in terms of the subject protocol but is equally relevant in relation to all necessary aspects of medical practise in Darwin and in Australia to the extent that practise in this country might vary with practise overseas. All necessary instances of variation should be identified and specifically addressed in the induction program. Noting that the Royal Darwin Hospital draws its medical staff from many different countries, the potential for problems similar to the subject case is significant enough to warrant pre emptive attention.

Dated this 16th day of January 2004.

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V.M. LUPPINO
Coroner