IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4262

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: ANNA AGNIESZKA BOWDITCH

Findings of:	**AUDREY JAMIESON, CORONER**
Delivered on:	**3 December 2018**
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	7 February 2018, 9 February 2 and 27 March 2018
Police Coronial Support Unit:	Acting Sergeant Sonia Reed
Appearances:	Mr Daniel Wallis of Counsel on behalf of Stephen Bowditch (Instructed by Maurice Blackburn Lawyers); Ms Rachel Ellyard of Counsel on behalf of Mr Audi Widjaja (Instructed by Avant Law); Mr John Constable of Counsel on behalf of Dr Yau (Instructed by Ball & Partners); Mr Michael Regos, Solicitor DLA Piper Lawyers on behalf of St. Vincent's Private Hospital (St Vincent's Health).

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I, AUDREY JAMIESON, Coroner having investigated the death of: ANNA AGNIESZKA BOWDITCH

AND having held an inquest in relation to this death on 7 February 2018, 9 February 2018 and 27 March 2018

at Southbank

find that the identity of the deceased was ANNA AGNIESZKA BOWDITCH

born on 5 October 1979

and the death occurred on 21 August 2014 **(organ donation occurred on 22 August 2014)**

at St. Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065

from:

1 (a) COMPLICATIONS OF FALL WITH FRACTURED ANKLE AND SUBSEQUENT DVT WITH EMBOLISATION

in the following summary of circumstances:

Anna Agnieszka Bowditch was admitted to St Vincent's Private Hospital on 16 August 2014 to undergo an elective surgical repair of an undisplaced fracture of her left fibula sustained in a fall 17 days earlier. Post operatively she developed a catastrophic stroke and despite surgical intervention for clot retrieval and intensive treatment, she did not recover and was declared 'brain dead' on 21 August 2014. The investigation of her death relates to her medical management proximate to surgery.

BACKGROUND CIRCUMSTANCES

1. Anna Agnieszka Bowditch[1] was 34 years old at the time of her death. She was born in Poland and immigrated to Australia with her family in 1990. Anna lived in Point Cook with her husband Stephen Bowditch and their daughter, Natalia aged 4 years. She worked as a brand manager in marketing.

2. Anna's medical history included post-natal depression for which she was prescribed the benzodiazepine Clonazepam, 0.5mg daily, and the anti-depressant medication Sertraline, 150mg daily. She was also prescribed the oral contraceptive pill Brenda-35 ED 1 daily. Since her diagnosis with post-natal depression, Anna had publicly represented the Post and Ante-natal Depression Association (PANDA).

[1] With the consent of Mr Stephen Bowditch, Anna Agnieszka Bowditch was referred to as "Anna" during the course of the Inquest. Save where I have determined formality requires the use of her full name, I have endeavoured to refer to her only as "Anna" throughout the Finding.

3. Other relevant medical history included complaints of tachycardia/palpitations in or around 2009 for which Anna was referred to a cardiologist for investigations. No cause of the palpitations[2] was identified. No treatment was instigated. Anna also had a history of migraines. She had no history or family history of clotting disorders.

SURROUNDING CIRCUMSTANCES

4. In July 2014, Anna and her family travelled to Hawaii for a holiday and special celebration. On 30 July 2014, while in Kona, Anna slipped on a tiled decking area surrounding a swimming pool, falling heavily onto her left ankle/leg. She attended Kona Community Hospital where her leg was x-rayed and she was diagnosed with a fractured left fibula, just above the ankle. She was subsequently placed in a plaster back-slab, strapped into place with a brace. She was advised that she did not require surgery but should take anti-inflammatory medication and was prescribed hydrocodone[3] for pain. Prophylactic anti-clotting medication was discussed with Anna but the doctor attending to her at the hospital felt that due to her age and otherwise relatively good health, the potential risk of haemorrhagic stroke outweighed the benefit. She was advised to attend on her own medical practitioner when she returned to Australia. Anna and her family continued with their holiday and she utilised crutches and a wheelchair for mobilisation assistance.

5. On 8 August 2014, Anna and her family flew to Oahu and on 9 August 2014 they returned to Australia on a Jetstar flight, arriving back in Melbourne on the afternoon of 10 August 2014.

6. On 11 August 2014, Anna attended general medical practitioner Dr Ahmed Nagla (**Dr Nagla**) at Guardian Medical, Sanctuary Lakes to seek further treatment for her fracture. On examination, Dr Nagla found mild tenderness around the ankle (lateral malleolus) but no swelling to her left knee. Vascular/neurological examination was normal with good capillary refill and no swelling. Dr Nagla sent Anna for a further x-ray of the limb which identified that the fracture remained an undisplaced fracture of the left distal fibula. As there did not appear to have been any improvement since the original x-rays were taken in

[2] In his *viva voce* evidence Mr Bowditch explained that the investigations were in relation to an accelerated or high heart rate not in relation to an irregular heart rate – Transcript of Proceedings (**TP**) @ p 45.

[3] Hydrocodone is a semi-synthetic opioid synthesized from codeine, one of the opioid alkaloids found in the opium poppy.

Hawaii, Dr Nagla provided Anna with a referral to Orthopaedic Surgeon Mr Audi Widjaja (**Mr Widjaja**), to explore her treatment options.[4]

7. On 12 August 2014, Anna attended the rooms of Mr Widjaja in Erin Street, Richmond. Her mother Mrs Elzbieta Wartalksa-Kula (**Mrs Kula**) accompanied Anna to the appointment. Following an assessment made by Mr Widjaja, he discussed with Anna her treatment options including leaving her leg in plaster for six weeks or to undergo surgical fixation of the fracture to allow for early mobilisation and rehabilitation. Anna opted for surgery which was scheduled for 16 August 2014 at St Vincent's Private Hospital.

8. On 13 August 2014, Mr Widjaja wrote to Dr Nagla to advise him of Anna's attendance on him on 12 August 2014 and his examination findings and to inform him that Anna had decided to proceed to surgery.

9. On 15 August 2014, Anna attended a pre-arranged appointment with general medical practitioner Dr Jo Ann Silva (**Dr Silva**) at Guardian Medical in the Sanctuary Lakes Shopping Centre for ongoing management of her post-natal depression. Anna reported to Dr Silva that she was a little anxious about the surgery scheduled for the following day and that she had experienced an episode of palpitations whilst on crutches but no other symptoms. Her heart rate was elevated at 110 beats per minute (**bpm**) but Anna told Dr Silva that this was normal for her and that she had been investigated for palpitations by a cardiologist in the past. She told Dr Silva that her heart rate increased quickly with minimal exercise and anxiety. Dr Silva suggested further investigations which Anna refused telling Dr Silva that the previous investigation had all been normal. Dr Silva advised Anna to inform the anaesthetist on 16 August 2014 about this. The remainder of the consultation centred on Anna's mental state and related issues.[5]

10. On 16 August 2014 at 7.00am, Anna was admitted to St Vincent's Private Hospital, 59 Victoria Parade, Fitzroy. She was seen by Anaesthetist Dr Peik Fei Yau (**Dr Yau**) for a pre-anaesthetic assessment. Medications listed at the time of admission were sertraline 150mg daily, clonazepam 0.5mg daily, Brenda-35 ED 1 daily, Naproxen daily and Vitamin D.

11. Anna was transferred to the operating theatre later that morning. She was anaesthetised at 12.20pm. The surgery to correct her fracture commenced at 12.48pm. She experienced an

[4] Statement of Dr Ahmed Nagla dated 16 February 2015 – Coronial Brief @ p 44.

[5] Statement of Dr Jo-Ann Silva dated 10 March 2015 – Coronial Brief @ p 43.

episode of hypotension post administration of the anaesthetic agent. The procedure was completed at 1.18pm without further incident and she was transferred to the post-anaesthetic care unit area at 1.40pm.

12. In the post-anaesthetic care unit, Anna developed slurred speech and hemiplegia of the left upper limb. The nurse looking after Anna asked Neurosurgeon Mr Christopher Thien (**Mr Thien**) who was passing through the unit to assess Anna as she was concerned about these symptoms when Anna had been responding and moving normally only moments before. Mr Thien made a quick assessment of Anna and determined that she required an urgent computed tomography (**CT**) scan and he took steps to organise the same. Mr Thien accompanied Anna to the CT scan room which suggested a diagnosis of an embolic occlusion of the middle cerebral artery resulting in cerebral ischaemia (stroke). Mr Thien informed Mr Widjaja and Dr Yau of these developments and asked the neurology team and the stroke intervention team to continue the care of Anna.[6]

13. At 3.16pm, Anna was transferred to St Vincent's Public Hospital for clot retrieval from the right middle cerebral artery and placement of an inferior vena cava filter. The procedure was complicated by damage to the common femoral vein and right external iliac artery – both vessels were repaired. The procedure was lengthy with arterial access time to flow restoration being 3 hours and 15 minutes and pre-procedure ischaemic time estimated at 2.5 hours. A transoesophageal echocardiogram demonstrated that Anna had a patent foramen ovale and right pulmonary artery clot.

14. On 17 August 2014 at 1.00am, Anna was transferred from the operating theatre to the Intensive Care Unit (**ICU**). At that time she was sedated, intubated and haemodynamically stable however once sedation was ceased it was apparent that her condition was dire. A CT scan later that morning demonstrated evolving cerebral infarction in the area of the right middle and anterior cerebral arteries with associated oedema and midline shift. Despite intensive and supportive care Anna failed to respond and there were signs of neurological deterioration.

15. On the evening of 20 August 2014, Dr Antony Tobin, Deputy Director of the ICU (**Dr Tobin**) met with Mr Bowditch and Anna's parents and discussed Anna's poor prognosis. Dr Tobin informed Anna's family that he was of the opinion that Anna was going to die as a result of her stroke.

[6] Statement of Mr Christopher Thien dated 25 March 2015 – Coronial Brief @ p 68.

16. On 21 August 2014 at approximately 12.30pm, Anna Agnieszka Bowditch was declared brain dead. Dr Tobin had another family meeting to explain Anna's death. The family consented to Anna becoming an organ donor and this occurred on the morning of 22 August 2014.[7]

JURISDICTION

17. After brain death was determined, St Vincent's Hospital reported the death of Anna Agnieszka Bowditch to the Coroner. An E-Medical Deposition Form was completed by Dr Hayley Barns, ICU Doctor, on 21 August 2014. The possible cause of death was ascribed as *Right MCA stroke secondary to DVT and PFO.*

18. Anna's death was reportable pursuant to section 4 of the *Coroners Act 2008* (**the Act**), because it occurred in Victoria and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, section 4(2)(b)(ii) of the definition of reportable death was applicable because Anna's death occurred following a medical procedure where her death may have been causally related to that medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.

PURPOSE OF THE CORONIAL INVESTIGATION

19. The Coroners Court of Victoria is an inquisitorial jurisdiction.[8] The purpose of a Coronial Investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For Coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[10]

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[7] Statement of Dr Antony Tobin dated 23 March 2015 – Coronial Brief @ p 63.

[8] Section 89(4) *Coroners Act 2008*.

[9] Section 67(1) of the *Coroners Act 2008*.

[10] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

20. The broader purpose of Coronial Investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[11] Coroners are also empowered to report to the Attorney-General on a death to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice, and to make recommendations to any Ministerr public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[12] These are effectively the vehicles by which the prevention role may be advanced.[13]

21. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

22. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was because of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. The elements which mandate holding an Inquest are not present in the circumstances of Anna Bowditch's death.

23. Pursuant to section 52(1) of the Act, Coroners have absolute discretion as to whether to hold an Inquest. However, a Coroner must exercise the discretion in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

24. This finding draws on the totality of the material; the product of the Coronial Investigation into the death of Anna. That is, the court records maintained during the Coronial Investigation, the Coronial Brief and further material sought and obtained by the Court,

[11] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[12] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[13] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

the evidence adduced during the Inquest as well closing submissions from Counsel Assisting and Counsel representing the Interested Parties.

25. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

STANDARD OF PROOF

26. All Coronial Findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[14] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

27. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

28. A Statement of Identification was completed by Stephen Charles Bowditch at St Vincent's Hospital on 21 August 2014. A *Determination by Coroner of Identity of Deceased*, Form 8 Rule 32[15] was subsequently completed by myself on 25 August 2014.

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[14] (1938) 60 CLR 336.

[15] Section 24 *Coroners Act 2008.*

29. The identity of Anna Agnieszka Bowditch was not in dispute and required no additional investigation.

Medical Cause of Death

Post mortem examination

30. Dr Jacqueline Lee (**Dr Lee**), Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed a full post mortem examination on the body of Anna Agnieszka Bowditch. At autopsy, Dr Lee confirmed right middle artery stroke and its sequelae, patent fossa ovalis and deep venous thrombosis of the left leg. In the Autopsy Report,[16] Dr Lee described how a clot had developed in Anna's injured left leg, embolised and travelled through the pre-existing patent foramen ovale from the venous side of the heart to the arterial circulation. This emboli obstructed the major arterial supply to Anna's brain. There were also multiple emboli that had travelled through the venous circulation to the lungs. Dr Lee commented that there were clots in both major pulmonary arteries and their branches.

31. In the *Comments* section of the Autopsy Report,[17] Dr Lee identified that Anna had known acquired risk factors for deep vein thrombosis (**DVT**) being lower extremity trauma, use of oral contraceptives and immobilisation (casting of the leg and extended travel/prolonged sitting). Dr Lee also commented on Anna's weight with reference to the Anaesthetist's pre-operative notes depicting Anna's weight as 78kg and her height as 162cms equating to a body mass index (**BMI**)[18] of 29.7kg/m^2 placing Anna in the overweight but not the obese category.

Neuropathology

32. Dr Linda Iles (**Dr Iles**) Forensic Pathologist and specialist in Forensic Neuropathology at VIFM performed an examination of the brain. Dr Iles reported[19] the following neuropathological findings.

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[16] Autopsy Report of Dr Jacqueline Lee dated 25 January 2015 – Coronial Brief @ pp 1 - 16. Autopsy Reports are now referred to as Medical Examiner's Reports.

[17] Autopsy Report of Dr Jacqueline Lee dated 25 January 2015 – Coronial Brief @ p 15.

[18] Body Mass Index (BMI) is an index of weight-for-height that is commonly used to classify underweight, overweight and obese adults. BMI is defined as the weight in kilograms divided by the square of the height in metres (kg/m^2). According to the World health Organisation, the normal range of BMI in adults is 18.5 to 24.99kg/m^2.

[19] Neuropathology Report of Dr Linda Iles Forensic Pathologist dated 29 September 2014 – Coronial Brief @ pp 17 - 20.

a) Extensive right middle cerebral artery territory infarction:

i) History of endo vascular thrombus retrieval, right middle cerebral artery;

ii) Secondary cerebral swelling;

iii) Secondary right cingulate gyrus infarction;

iv) Ischaemic changes, right hippocampus; and

v) Brainstem oedema associated with downward displacement of the diencephalon.

b) Agonal venous sinus and early thrombosis.

33. Dr Iles commented that a small amount of residual thrombus was identified within the superficial cortical arteries and that refractile basophilic foreign material seen in small vessels was presumed to be related to the thrombus extraction procedure.[20]

Toxicology

34. Toxicological analysis of post mortem blood detected the antidepressant medication sertraline, the antiemetic metoclopramide and the analgesic, paracetamol.[21] Dr Lee reported that these medications did not cause or contribute to Anna's death.[22]

Forensic pathology opinion

35. Dr Lee ascribed the cause of Anna Agnieszka Bowditch's death to complications of a fall with fracture of left ankle and subsequent deep venous thrombosis with embolisation.

Conduct of my investigation

36. The investigation and the preparation of the Inquest Brief was undertaken by Senior Constable Craig Daniels on my behalf.

REQUEST FOR INQUEST

37. On 17 November 2014, the Court received correspondence from Zolis Lawyers and Consultants advising that they were acting on behalf of Mr Bowditch[23] and enclosing a

[20] Neuropathology Report of Dr Linda Iles Forensic Pathologist dated 29 September 2014 – Coronial Brief @ pp 17 - 20.

[21] VIFM Toxicology Report dated 11 September 2014 – Coronial Brief @ pp 21 – 25.

[22] Medical Examiner's Report of Dr Jacqueline Lee dated 25 January 2015 – Coronial Brief @ pp 1 - 16.

Form 26 Request for Inquest dated 13 November 2014. Within the application, reference was made to a letter Mr Bowditch had previously written to the Court dated 24 August 2014,[24] in which he stated *inter alia* that Anna's death could have been prevented during admission screening; pre-surgery testing; and post-surgical care; and that medical negligence by surgical staff at St Vincent's Private Hospital directly led to her death. In particular, Mr Bowditch suggested that the initial surgery should not have progressed given Anna exhibited several risk factors for DVT. In addition, Mr Bowditch suggested that his wife exhibited signs and symptoms of DVT and pulmonary emboli, including: pain in her fractured leg above the level of the break, sudden and unexplained shortness of breath, combined with increased heart rate.

38. A Form 28, *Decision by Coroner Whether or Not to Hold an Inquest into Death* was completed on 21 November 2014 indicating that I was not in a position to make a decision about whether an Inquest was required as Anna's death was still under investigation.

39. Additional investigation included *inter alia* an examination of Anna's preoperative risk assessment for thromboembolism. Initial discussions with the Health and Medical Investigation Team (**HMIT**)[25] indicated that it is well understood that DVT and pulmonary embolism (**PE**), are two manifestations of venous thromboembolism (**VTE**). The risk of post-operative VTE depends on a number of factors related to the surgical procedure itself, as well as a number of patient-related adverse risk factors, including: increasing age; prior VTE in the patient or family members; presence of malignancy or obesity; presence of an inherited or acquired thrombophilia; and one or more significant comorbidities, for example: heart disease, infection, inflammatory conditions, recent stroke and pre-operative sepsis. Specific to Anna, she did not have a personal or family history of clotting disorders and her patent foramen ovale was unknown pre-operatively but her known acquired risk factors for DVT included:

    a) lower extremity trauma;

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[23] Mr Bowditch had previously informed the Court by email on 4 September 2014 and again on 28 September 2014 that Mr George A Zolis was representing him *in any future action taken against the parties found to be negligent or criminally complicit in his (sic) wife's death.*

[24] Exhibit 1 – Letter from Stephen Bowditch to the Court dated 24 August 2014.

[25] The Health and Medical Investigation Team (HMIT) is located within the Coroners Prevention Unit (CPU). The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

b) use of oral contraceptives;

c) immobilisation (casting of the leg); and

d) extended travel/prolonged fatigue.

40. With the assistance of HMIT a review of the medical records revealed an absence of documentation of a formal pre-operative VTE assessment by Mr Widjaja. There was no documentation of Mr Widjaja's removal of the plaster back slab to examine Anna's calf or thigh, or to indicate that VTE risks were explained to her because there was consideration of screening for VTE.

41. An expert opinion was subsequently sought to address the management of Anna from Associate Professor Andrew Bucknill (**A/P Bucknill**) Director of Orthopaedic Surgery at Royal Melbourne Hospital. A/P Bucknill's report dated 23 December 2015[26] was received by the Court on 11 March 2016.

42. On 7 September 2015, St Vincent's Private Hospital provided the Court with its Venous Thromboembolism Prevention Policy which indicated that all adult admissions must be assessed for VTE risk within 24 hours of admission and subsequent treatment is provided as per the patient's risk factors. The categorisation of thromboembolic risk is determined by factors outlined in Risk Stratification ANZ Guidelines including *inter alia* immobility, thrombophilia, active inflammation, strong family history of VTE or obesity.

Direction Hearings

43. A Mention/Directions Hearings was held on 15 September 2016. Ms Rebecca Cohen, Solicitor appeared as Counsel Assisting. The aim of the Hearing was to explore the progression of my investigation and to afford the Interested Parties an opportunity to make submissions on whether there was sufficient material on which to conclude my investigation, without the need to proceed to an Inquest.

44. The Bowditch family through their legal representatives maintained their request for an Inquest and submitted that A/P Bucknill should provide a supplementary report after being furnished with additional information from Anna's mother, Mrs Kula, who was present at Anna's appointment with Mr Widjaja's on 12 August 2014, along with a proposed additional statement from Mr Bowditch. Mrs Kula was said to have a clear

[26] Exhibit 18.

recollection of what was discussed with Mr Widjaja during Anna's consultation with him and Mr Bowditch wished to outline the specific signs and symptoms of DVT that Anna had been experiencing.

45. In light of the discussions at the Hearing, a statement was requested from Mrs Kula, an additional statement from Mr Bowditch and an additional statement was also sought from Mr Widjaja to indicate whether he had in fact examined Anna for VTE. These statements were subsequently supplied to the Court as was an expert opinion from Mr Thomas Kossman,[27] commissioned by the family's legal representatives. On 31 March 2017, the Court received the supplementary expert opinion of A/P Bucknill[28] which addressed the content of each statement completed by Mrs Kula, Mr Bowditch and Mr Widjaja.

46. On 15 June 2017, a second Mention Hearing was held. Ms Cohen appeared as Counsel Assisting. Ms Cohen highlighted a number of inconsistencies between the statements of Mrs Kula, Mr Bowditch and Mr Widjaja, including varying accounts of what transpired at several consultations and the extent of Anna's symptoms. A/P Bucknill described the statements as 'incompatible'. Ms Cohen reiterated Forensic Pathologist Dr Lee had reported that Anna had a pre-existing patent foramen ovale, which was not known until after the catastrophic event. She reiterated the evidence that the presence of the patent foramen ovale increased Anna's risks of morbidity and mortality in respect of venous thromboembolism. Ms Cohen submitted that the investigation thus far indicated a level of agreement between the expert opinions of Mr Kossman and A/Prof Bucknill, however, the aforementioned inconsistencies between witness statements impeded the experts' ability to be conclusive. Based on Mr Bowditch's account, Mr Kossman raised concerns about Dr Yau's role in the events leading to Anna's death. Discussion was had on whether an independent expert opinion from an Anaesthetist was required. All Interested Parties agreed that factual disputes remained despite furthering my Investigation. Consequently, I determined that the Investigation would proceed to an Inquest.

47. During the second Mention Hearing, Interested Parties discussed the potential scope of my Inquest and agreed that it would not involve St Vincent's Private Hospital *per se*, would not involve the complications experienced during the interventionist clot retrieval surgery or whether Anna should have been prescribed prophylactic thrombolysis but

[27] Exhibit 19 - Expert Opinion Report from Mr Thomas Kossman, Orthopaedic Surgeon dated 2 December 2016 (provided to the Court on 24 March 2017).

[28] Exhibit 18 – Expert Opinion supplementary report from A/P Andrew Bucknill dated 1 March 2017.

would focus on, and be confined to, the involvement of both Mr Widjaja and Dr Yau in Anna's medical care.

48. On 12 December 2017, a Directions Hearing was held and Acting Sergeant (**A/S**) Sonia Reed from the Police Coronial Support Unit (**PCSU**) appeared as Counsel Assisting. The Directions Hearing provided an opportunity to discuss additional material distributed to the Interested Parties since 15 June 2017, including a supplementary statement from Dr Yau and expert opinion reports from Anaesthetists Dr Forbes McGain and Professor Paul Myles. Additionally, parties were provided with Anna's Pre-Admission Health Questionnaire completed and signed on 14 August 2014,[29] as well as her Observation Chart[30] for 16 August 2014. These documents highlighted details which equated to facts in dispute about Anna's symptomatology proximate to her surgery.

49. Legal Counsel for Mr Widjaja requested that the Bowditch family be asked to provide photographs of Anna with the plaster back slab *in-situ* and requested that Mr Widjaja be permitted to provide demonstrative evidence at the Inquest of how he performed the examination on Anna's fractured limb.

50. A/S Reed maintained her position as Counsel Assisting during the Inquest.

INQUEST

Viva voce evidence at the Inquest

51. *Viva voce* evidence was obtained from the following witnesses:
    - Stephen Bowditch;
    - Elzbieta Wartalksa-Kula;
    - Mr Audi Widjaja, Orthopaedic Surgeon;
    - Dr Peik Fei Yau, Anaesthetist; and
    - Concurrent Evidence Panel: Associate Professor Bucknill
      Mr Thomas Kossman
      Professor Paul Myles
      Dr Forbes McGain.

[29] Pre-Admission Health Questionnaire completed and signed by Anna on 14 August 2014 – Coronial Brief @ p 321.

[30] Observation Chart for 16 August 2014 (as part of the complete medical records) – Coronial Brief @ p 342.

ISSUES INVESTIGATED AT THE INQUEST

52. The issues deliberated at Inquest were:

    a) Whether Mr Widjaja performed a physical examination of Anna's fractured limb during consultation on 12 August 2014 and, if so, whether it was purpose sufficient and/or consistent with good medical practice; and

    b) Whether it was appropriate to proceed with Anna's surgery on 16 August 2014 given the information garnered by Mr Widjaja and Dr Yau through preoperative assessments and Anna's risk factors and symptomatology.

Consultation with Mr Widjaja on 12 August 2014

53. Mr Bowditch was not able to accompany Anna to her appointment with Mr Widjaja on 12 August 2014. Instead, Mrs Kula drove and accompanied her daughter and granddaughter to this appointment.[31] She recalled the inconvenience of getting Anna into Mr Widjaja's rooms: obtaining a parking spot, removing Anna's wheelchair from the rear of her car, assembling it, helping Anna to get to the wheelchair because she did not have her crutches, and pushing the wheelchair into the rooms with Anna's daughter propped on her lap.[32] She recalled that the Receptionist gave Anna a questionnaire to complete while they waited to see Mr Widjaja.[33]

54. Mrs Kula stated the appointment with Mr Widjaja was very brief, *about 15, 20 minutes at the most.*[34] Under cross examination, she maintained that she had a clear recollection of what occurred during the appointment; she had *paid really full attention* as it was her responsibility to help Anna recall the visit because Mr Bowditch had been unable to attend.[35]

55. Similarly, in her *viva voce* evidence, Mrs Kula maintained that Mr Widjaja did not physically examine or touch Anna's leg during the appointment.[36] She conceded that Mr Widjaja had explained the expected time frames for non-surgical fracture recovery

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[31] Exhibit 7 – Statutory Declaration of Elzbieta Wartalksa-Kula dated 5 October 2016, Transcript of Proceedings (**TP**) @ p 21, 53, 54.

[32] TP @ p 58, 59.

[33] TP @ p 59, 60.

[34] TP @ p 50, 61.

[35] TP @ p 61, 64, 72.

[36] TP @ p 63, 64, 65, 66.

compared with having surgery and, based on Mr Widjaja's advice, Anna *thought that surgery was the best option in her situation.*[37] During cross examination, Mrs Kula maintained that Mr Widjaja had not spoken of surgical risks.[38] She stated that she would have talked to her daughter about the risks of the operation had there been any specific discussion about surgery being dangerous.[39]

56. At the outset of his *viva voce* evidence, Mr Widjaja demonstrated how he had performed an examination of Anna's leg without removing the back slab or the bandage that was holding it in place. He conducted the demonstration with the assistance of his secretary who wore a plaster back slab with bandages on her leg, as Anna has done. In deference to his second statement[40] and a diagram of the compartments of the calf,[41] Ms Ellyard of Counsel stepped Mr Widjaja through how he described his examination in his statement while he demonstrated what the examination actually entailed.[42]

57. Mr Widjaja acknowledged that he did not make notes of the conversation he claimed that he had had with Anna[43] about treatment options and the risks and complications associated with surgery. However, he stated that it is his routine and standard practice to discuss the general risks, specific risks and anaesthetic risks of surgery.[44] Mr Widjaja stated that he does not provide any written material to his patients about risks and potential complications of surgery but said he has a standard approach to checking if the patient has understood what he has discussed with them.[45] Mr Widjaja stated that Anna did not have shortness of breath, calf pain or tenderness when he saw her on 12 August 2014.[46]

58. Mr Bowditch stated that he spoke to Anna after her appointment with Mr Widjaja and she informed him that she had decided to proceed with surgical repair of her fracture, rather than the non-surgical option which involved utilising the cast for a much longer period of approximately six to eight weeks. Mr Bowditch stated that Anna *wanted to make a quick*

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[37] TP @ p 68.

[38] TP @ p 69.

[39] TP @ p 69.

[40] Exhibit 9 – Statement of Mr Audi Widjaja dated 14 October 2016.

[41] Exhibit 10.

[42] TP @ pp 80 – 84.

[43] Exhibit 8 – Statement of Mr Audi Widjaja dated 15 February 2015.

[44] TP @ p 86.

[45] TP @ p 86.

[46] TP @ p 87.

recovery for the family.[47] In the course of the discussion about what had occurred at the appointment with Mr Widjaja, Mr Bowditch also asked Anna if she had *explained everything to the surgeon*[48] by which Mr Bowditch explained that he meant not only the known risk factors but also what he regarded as potential recent signs and symptoms.[49] Mr Bowditch related that Anna had responded by rolling her eyes and saying *yes, of course I did.*[50]

Completion of the Pre-Admission Questionnaire.

59. The Pre-Admission Questionnaire (**the Questionnaire**) seeks to capture the patient's medical history including details of medication prescribed and/or being taken by the soon to be admitted patient. Anna spoke to her mother and husband as part of the process of completing the Questionnaire.[51] Mr Bowditch recalled that Anna had specifically asked him about how best to depict the cardiac investigations that she had undergone a number of years earlier[52] and has consequentially circled "heart murmur" on the Questionnaire. Anna did not circle "Palpitations" and she ticked "no" in the box alongside the question about shortness of breath. In relation to the question about current medications, Anna indicated that she had last taken Hydrocodone on 11 August 2014.

60. Anna signed the Questionnaire on 14 August 2014 at 11.13am.[53]

Anna's symptoms 14 – 16 August 2014

61. Prior to the evening of 14 August 2014, Anna had only complained about feeling tired, particularly when mobilising. Mr Bowditch said that Anna first complained about feeling a bit short of breath on the evening of 14 August 2014.[54] On 15 August 2014, Mr Bowditch witnessed Anna being short of breath. He explained that Anna was in her wheelchair at the time and had wheeled herself to their daughter's room to assist him with

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[47] TP @ p 23, 47.

[48] Coronial Brief @ p 34, Exhibit 2 – Statement of Stephen Bowditch dated 19 March 2015, TP @ p 29.

[49] TP @ p 29.

[50] TP @ p 29.

[51] TP @ p 24.

[52] TP @ p 26.

[53] Coronial Brief @ p 322, Medical Records.

[54] TP @ p 11. Mr Bowditch later clarified that Anna had not complained of shortness of breath on the evening of 14 August 2014 but that he had witnessed her breathing more heavily. He said that on 15 August 2014 *was when it was really, really clear.* - TP @ p 42.

dressing their daughter. *She was breathing really quickly…to the point where I actually thought she was having an asthma attack.*[55] He also described Anna's symptoms as a *gaspy sort of breath.*[56] Mr Bowditch went in search of an inhaler and when he returned to Anna her breathing had settled down but she exclaimed that her heart was *really racing.*[57]

62. These episodes occurred again *at various times*[58] during the day, particularly when Anna was mobilising: for example, moving from her wheelchair to her crutches. Mr Bowditch also described these episodes as Anna *gasping.*[59] Mr Bowditch impressed upon Anna to tell Dr Silva of these episodes given that Anna was scheduled to see her that day in relation to the ongoing management of post-natal depression. Anna later told Mr Bowditch that she had informed Dr Silva of her symptoms but nothing abnormal was detected apart from her normally elevated heart rate.[60]Anna told Mr Bowditch that Dr Silva had queried whether she was anxious about her surgery. Mr Bowditch acknowledged that *Anna was a bit anxious about the surgery the next day*[61] but he felt that did not explain his wife's shortness of breath and racing heart rate.

63. Mrs Kula had coincidentally bumped into her daughter at the doctor's surgery on 15 August 2014. Anna was in her wheelchair in the waiting room ahead of her appointment with Dr Silva.[62] Mrs Kula stated that she caught up with Anna again in the waiting room after their respective appointments and Anna had told her mother that she had been *really short of breath that morning* and that she had got scared because it felt very serious.[63] Mrs Kula enquired if Anna had told the doctor that she had just seen and Anna confirmed that she had but that the doctor thought perhaps Anna was just very anxious about surgery the next day and that Anna should inform the hospital staff.[64]

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[55] TP @ p 9 – 10.

[56] TP @ p 19.

[57] TP @ p 10.

[58] TP @ p 11.

[59] TP @ p 12.

[60] Mr Bowditch stated that Anna's resting heart rate was typically in the range of 90 – 110 beats per minute – TP @ p 44.

[61] TP @ p 13.

[62] TP @ p 70.

[63] TP @ p 51, 72.

[64] TP @ p 51 - 52, 72 -73.

64. Mr Bowditch also said that Anna had at various times complained of pain and aching in her leg since fracturing it but that the closer it got to her surgery the more she seemed to be in pain. He stated that the pain in combination with Anna's shortness of breath and racing heart made him *concerned that there was perhaps something going on that needed investigation.*[65]

65. On the day of her surgery, 16 August 2014, Mr Bowditch observed that Anna was getting *out of breath* with short movements and *exerting herself when she was moving from one position to another* and at the same time Anna would say that her heart felt like it was racing.[66] Mr Bowditch described Anna's breathing as *laboured* at these times; *she was breathing much quicker than you would normally expect her to...*[67] He said her breathing would settle to normal after completing relatively simple manoeuvres.

66. Mr Bowditch accompanied Anna to St Vincent's Private Hospital. They checked in at the Reception desk in the foyer of the building, handing over the Questionnaire to the Receptionist. The Questionnaire was subsequently returned to Anna and she was instructed to take it with her and give it to the ward staff. At this stage, Anna had not made any alteration to the Questionnaire to reflect the episodes of shortness of breath and palpitations she had experienced since completing it on 14 August 2014 because, as Mr Bowditch explained, they were going to advise the admitting staff in person.[68]

Pre-Anaesthetic consultation with Dr Yau on 16 August 2014

67. Mr Bowditch was present when Dr Yau attended on Anna in the ward to complete a pre-anaesthetic assessment. Mr Bowditch recalled the conversation with Dr Yau, including that he had *chimed into the conversation* about Anna's recent episodes of shortness of breath and complaints about palpitations,[69] because he had witnessed it on exertion and *felt that it was on exertion that was the most important part.*[70] Mr Bowditch said that there were three things that he specifically remembered about Dr Yau's pre-anaesthetic assessment of Anna, including that: Anna had spoken about pain she was experiencing

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[65] TP @ p 16.

[66] TP @ p 11.

[67] TP @ p 12.

[68] TP @ p 30, 46.

[69] Mr Bowditch explained that by "palpitations" he was describing that Anna was experiencing an *increased and somewhat erratic heart rate*- it would *suddenly beat faster and then calm down* – TP @ p 43.

[70] TP @ p 31.

such as an intense and sharp pain near the break and a pain in her calf below the knee,[71] he had told Dr Yau about Anna's shortness of breath on exertion; Dr Yau had said she had made a note about these things and that she would discuss it, although Mr Bowditch could not recall whether the discussion was to be with a colleague or her team.[72]

68. Dr Yau said that the pre anaesthetic consultation is to assess the patient's suitability for anaesthetic and what risk an anaesthetic would pose to them.[73] She listed the routine questions she would ask during these consultations, including: the patient's history of anaesthesia, family history of anaesthetic problems, any history of allergies and current medications. If a patient did not volunteer their medical history, Dr Yau stated that she would ask questions about specific systems, such as: breathing issues, asthma, epilepsy and heart problems.[74] In response to the question about any heart problems, Anna advised Dr Yau about her history of palpitations.

69. Dr Yau said she would usually listen to a patient's heart and lungs but could not recall if she did so in Anna's case as she had not made any notes. However, Dr Yau did recall discussing Anna's heart rate of 100bpm; Anna advised that her normal resting heart rate was between 90 and 100bpm which had been previously investigated.[75]

70. Dr Yau explained the type of conversation she usually had about pain with her patients during pre-anaesthetic consultations. She stated that she asks them about the severity of pain they are experiencing and how much analgesic medication they are taking, so that she can plan the patient's anaesthetic regime.[76]

71. Dr Yau's evidence was that there was no discussion about shortness of breath during Anna's pre-anaesthetic consultation.[77] She did not recall saying that she would discuss any potential issues or symptoms with anybody.[78] Dr Yau said that if she had been advised of Anna's symptoms of shortness of breath or unexplained pain she would have recommended to Mr Widjaja that the surgery not proceed. She explained that those kinds

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[71] TP @ p 33, Exhibit 3 – Statutory Declaration of Stephen Bowditch dated 5 October 2016 @ paragraph 23.

[72] TP @ pp 31-32.

[73] TP @ p 136, 146.

[74] TP @ p 136-137, 151.

[75] TP @ p 138.

[76] TP @ p 138.

[77] TP @ p 141, 143, 151.

[78] TP @ p 143.

of symptoms would be out of proportion with what she would expect of someone with a fracture, which therefore would have caused her concern.

72. Dr Yau stated that she did not tell Mr Widjaja about Anna's history of palpitations because she was not concerned about them.[79] She said that it was not routine to communicate with the surgeon all of the patient's medical history unless there was something of concern that would change the medical management of the patient. Dr Yau said she would not necessarily discuss a patient's stable disease which posed no concerns with the surgeon, as she would expect them to know the patient's medical history.[80]

73. Dr Yau's practice was to make shorthand notes on a scrap piece of paper during the pre-anaesthetic assessment and that she would transcribe these notes onto the anaesthetic chart during the operation, once the patient was anaesthetised and stable.[81] The handwritten notes record information about each patient whom Dr Yau administered an anaesthetic during the day's operation list. She stated that she shreds these notes at the end of each list.[82]

Recorded observations and communications with nursing staff

74. According to Mr Bowditch nursing staff at St Vincent's Private Hospital were also informed by himself and Anna about recent episodes of shortness of breath on exertion.[83] Nursing staff also specifically asked Anna about pain to which she responded: *Well, it is not as bad as child birth*.[84] Mr Bowditch stated that, at this stage, Anna was becoming frustrated at being asked the same questions repeatedly.

75. At 8.30am and 11.30am on 16 August 2014, nursing observations record that Anna's pain was zero out of a possible 10 on both occasions.[85]

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[79] TP @ p 139 - 140.

[80] TP @ p 149.

[81] TP @ p 141, 153, 154.

[82] TP @ p 144.

[83] Exhibit 2 – Statement of Stephen Bowditch dated 19 March 2015, TP @ p 39.

[84] Exhibit 3 – Statutory Declaration of Stephen Bowditch dated 5 October 2016 @ paragraph 26, TP @ p 40.

[85] Coronial Brief @ p 342.

Information that should be communicated to the surgeon

76. Mr Widjaja consulted with Anna before her surgery. Mr Bowditch was not in attendance at the time. In his second statement, Mr Widjaja said that he was not aware that Anna had experienced palpitations on 15 August 2014. Mr Widjaja stated that, as part of his routine, he would have checked Anna's consent form and the Questionnaire. Anna did not mention to Mr Widjaja that she had experienced palpitations the day before and although he conceded that palpitations are mentioned in the Questionnaire, Mr Widjaja could not remember asking Anna a specific question about it. He did however, recall asking Anna if anything had changed since he last saw her in his consulting rooms on 12 August 2014 and since she had filled out the paperwork. Anna had responded that *nothing had changed*. She similarly did not volunteer to Mr Widjaja that she had been experiencing shortness of breath on exertion.

77. Mr Widjaja said he did not look at the Pre-Anaesthetic record as he said that it is a document primarily used by the Anaesthetist, not the surgeon.[86] He later gave evidence that the document was not available to him at the time he consulted with Anna on the morning of her surgery.[87]

78. Mr Widjaja said that had he been made aware of the palpitations he would not have proceeded to surgery.[88] He said that he would have postponed the surgery to enable reassessment of the suitability of surgery for Anna. Mr Widjaja maintained that he would have cancelled the surgery if Dr Yau had provided him with this information despite acknowledging that: he had worked with Dr Yau since 2012, he accepted her assessment about a patient's fitness for anaesthesia and he had previously cancelled surgery on her expressed opinion that a patient was not fit to proceed. Mr Widjaja said he would not have proceeded to surgery even if Dr Yau had specifically told him that it was her professional opinion that Anna was fit for the surgery despite her experiencing heart palpitations the previous day.[89]

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[86] Coronial Brief @ p 342.

[87] TP @ p 121-122.

[88] *Ibid,* TP @ p 89.

[89] TP @ p 90.

79. Dr Yau concurred that she had been working with Mr Widjaja for several years and that they had a fairly good working relationship *in that there were no difficulties with communication or communicating to each other any problems or issues that we've had.*[90]

The Surgery

80. Anna was transferred to the operating theatre with the bandaged back slab *in situ*. Mr Widjaja stated that it was usual for the back slab to be removed once the patient was anaesthetised and he recalled that this occurred in Anna's case.[91] Mr Widjaja saw Anna's limb unencumbered by the bandage and back slab for the first time just prior to the surgery.[92] He stated that there was nothing abnormal about her ankle at that time, such as swelling or a blister.[93]

Concurrent Evidence

81. On 9 February 2018, a panel of four expert medical witnesses was convened for the purpose of giving their evidence concurrently. The panel comprised of Associate Professor Andrew Thomas Bucknill Orthopaedic Surgeon,[94] Mr Thomas Kyle Kossman Orthopaedic Surgeon,[95] Professor Paul Stuart Myles Anaesthetist,[96] as well as Dr Forbes McGain Anaesthetist and Intensive Care Physician[97] (**The Panel**).

82. Upon convening, the Panel informed me that they had reached consensus on all of the questions put to them.[98] The questions put to the Panel and their unanimous responses were as follows:[99]

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[90] TP @ 153.

[91] TP @ p126, 127.

[92] *Ibid*

[93] TP @ p 127.

[94] Exhibit 18 – expert opinion Reports of Associate Professor Andrew Bucknill dated 23 December 2015 and 1 March 2017.

[95] Exhibit 19 – expert opinion report of Mr Thomas Kossman dated 2 December 2016.

[96] Exhibit 20 – expert opinion report of Professor Paul Myles dated 29 June 2017.

[97] Exhibit 21 – expert opinion report of Dr Forbes McGain dated 11 August 2017 and 28 November 2017.

[98] TP @ p 181.

[99] The numbering of the questions is different in the Finding than reflected in the Transcript of Proceedings but the order of the questions to the Panel has not been changed.

(i) **What are the risk factors of DVT?**

Obesity, immobilisation, long haul flights, the oral contraceptive pill, malignancy, increased age and family history or past medical history.[100]

(ii) **Did Anna present with any of these risk factors in isolation or in combination?**

She did; Anna had an elevated BMI of nearly 30, had been immobilised for at least 12 days prior to her surgery, had recently taken a long haul flight and was taking the oral contraceptive pill.[101]

(iii) **Was enough consideration given to Anna's presenting risk factors?**

The Panel agreed there had not been enough consideration; surgery probably should not have proceeded in the presence of these significant risk factors.[102]

(iv) **Did Anna present with signs and symptoms indicative that she may have had a DVT?**

None of the medical records reflect that Anna had signs and symptoms suggestive of DVT.[103]

(v) **Are heart palpitations a symptom of DVT?**

No, but they are a symptom of pulmonary embolus.[104]

(vi) **Is pain a symptom of DVT or a fracture in general?**

Pain is a symptom of both DVT and of fractures in general but the site of the pain may differ between the diagnoses. In the circumstances of Anna's fracture, one may experience pain at the effected ankle joint. If a DVT forms, pain commonly occurs in the muscle belly of the calf.[105] Pain may also occur in the thigh if an above-knee DVT has formed.[106]

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[100] TP @ p 176.

[101] TP @ p 177.

[102] TP @ p 177.

[103] TP @ p 178.

[104] TP @ p 178.

[105] Associate Professor Bucknill described this as the widest part of the calf, just below the knee – TP @ p 180.

[106] TP @ p 179.

(vii) **What are the risk factors for a pulmonary embolism?**

They are similar to the risk factors for DVT and include: long haul flights, prior DVTs, cancer, familial causes, age, oral contraceptive pill, and some other drugs. An extensive DVT is more likely to end up as a pulmonary embolis.[107]

(viii) **Did Anna present with any of these risk factors in isolation or in combination?**

She did. Similarly to the response about her risk factors for DVT, Anna: had a fracture, was immobilised, was taking the oral contraceptive pill, had a recent long haul flight and was overweight.[108]

(ix) **Was enough consideration given to Anna's presenting risk factors?**

No. Given the presence of multiple risk factors, the situation required further reflection on whether or not Anna ought to have surgery. A/P Bucknill expanded on the Panel's consensus view. He stated that, in Anna's case, the indications for surgery were weak and the presence of her additional risk factors *would push the risk benefit balance in favour of not operating.*[109]

(x) **Did Anna present with signs and symptoms indicative that she may have had a pulmonary embolism?**

No. According to the signs and symptoms documented by the medical staff, Anna did not have a pulmonary embolus.[110]

(xi) **Are palpitations in isolation a symptom of pulmonary embolus?**

Yes, they can be but palpitations are non-specific and very common for any person coming into hospital for any type of surgery. In Anna's case, there were other reasons why she may have had either tachycardia or palpitations without it being an obvious cause of pulmonary embolus. It should be considered but it would be a low probability explanation.[111]

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[107] TP @ p 180.

[108] TP @ p 181.

[109] TP @ p 182.

[110] TP @ p 183.

[111] TP @ p 184.

(xii) **Is shortness of breath a symptom of pulmonary embolism?**

Yes, it can be and it is an extremely important symptom for anybody having surgery or anaesthesia and must be investigated further.[112]

(xiii) **Can shortness of breath due to pulmonary embolus occur with or without physical exertion?**

Yes, it can occur without physical exertion.[113]

(xiv) **Would you expect shortness of breath due to pulmonary embolus to be physically obvious?**

Sometimes. The physical symptoms of pulmonary embolus are variable on a large scale; a patient may have extreme shortness of breath or they may appear to have none.[114]

(xv) **Once shortness of breath due to pulmonary embolus is present would you expect it to be constant or can it be sporadic?**

As stated, the physical symptoms are variable. Shortness of breath due to pulmonary embolus can be sporadic or constant. The variability in the size of a pulmonary embolus can play a role in symptom presentation.[115]

(xvi) **Anna had a back-slab in place and was using crutches and a wheelchair to move around – do you consider her to be immobile?**

Anna had reduced mobility. Specifically, her leg was immobilised and even more specifically the venous muscle pumps in her calf were immobilised. This causes stasis of the blood which is a contributing factor to developing DVT.[116]

(xvii) **Was Mr Widjaja's consultation with Anna on 12 August 2014 appropriate?**

It was not adequate, his examination of the leg was insufficient and the plaster slab should have been removed so that the skin could be seen throughout the

[112] TP @ p 184-185.

[113] TP @ p 185.

[114] TP @ p 185.

[115] TP @ p 185-186.

[116] TP @ p 186.

leg.[117] On behalf of the Panel, Mr Kossman explained that it is good clinical practice to remove the bandage and plaster to examine the limb. In addition to checking for DVT, removing the plaster and bandages allows the medical practitioner to see any problems caused to the skin, whether the plaster is intact and effective, and the general state of the effected limb.[118]

A/P Bucknill emphasised that some of the signs and symptoms of DVT such as redness of the skin, engorgement of the veins, swelling and tenderness would be more obvious without the presence of the bandages and back slab:

So although as Mr Widjaja has demonstrated, it is possible to perform a limited examination through the bandages, that examination is going to be less sensitive than one that involves full removal of the back slab and the bandages, so that you can see the skin and feel the calf unimpeded.[119]

(xviii) **Was the explanation of risk and complication sufficient?**

There was no documentation of what risks were explained so the Panel felt the explanation was not adequate.[120]

(xix) **What would constitute the ideal examination of a limb, having regard to the particular circumstances?**

That the slab and bandage be removed entirely. The plaster and bandage should probably have been replaced with a CAM boot[121] or walker.[122]

(xx) **What if anything is the significance of Anna's unhealed fracture?**

The Panel said that they would not expect to see any evidence of healing of the fracture on x-ray only twelve days after the injury. An assessment on healing through any reduction in tenderness would require knowledge of how tender the limb was previously and, as such, the Panel felt that it would be impossible,

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[117] TP @ p 186.

[118] TP @ p 187.

[119] TP @ p 187 – 188.

[120] TP @ p 188.

[121] A controlled ankle motion **walking boot**, or **CAM boot**, also sometimes called a below knee **walking boot**, is an orthopaedic device prescribed for the treatment and stabilization of severe sprains, fractures, and tendon or ligament tears in the ankle or foot.

[122] TP @ p 188.

at single point examination, to make a judgement about whether the fracture was healing or not.[123]

(xxi) **What are the risks, if any, of proceeding to surgery on a fracture of this age? (12 days old at the time of Mr Widjaja's examination).**

The risk of DVT is higher after 12 days than if operating within hours of the original injury. If operating at 12 days post-injury rather than immediately after the injury, there is a higher risk of developing issues with the soft tissues: the skin or swelling under the skin.[124]

(xxii) **Considering the identified risk factors and symptoms, should further investigations have occurred?**

The Panel said that they would not have requested any further investigations at that time – they would obtain more information from the clinical history and examination before making a decision about further investigations.[125]

(xxiii) **What investigations are necessary to establish/exclude DVT or pulmonary embolus?**

A duplex ultrasound would be the standard investigation for a DVT and a CT angiogram would be the standard investigation to look for a pulmonary embolism.[126]

(xxiv) **Would it have been reasonable or necessary in the circumstances to have conducted any of these investigations?**

A more detailed examination of the limb and possibly more detailed questioning and history would be required prior to making a decision about further investigations. Professor Myles added that the information contained in the medical documentation provides no indication that an ultrasound or CT scan was needed. A more complete examination might influence the decision.

A/P Bucknill sought to emphasise that the question about whether further investigations were reasonable or necessary had to be considered in context of

[123] TP @ p 189.

[124] TP @ p 189 – 190.

[125] TP @ p 190.

[126] TP @ p 190 -191.

the known strong and multiple risk factors that Anna had. He said: *So although nothing has been documented in terms of physical signs and symptoms, we do have documentation of some very, serious risk factors.*[127]

Mr Kossman also sought to emphasise that, in his opinion, by not taking down the plaster and bandages it actually prevented the ability *to find the clinical signs of a possible already existing DVT.*[128] Particularly in the presence of other known risk factors such as a long haul flight. Mr Kossman went on to expand on what a clinician might do if they had any doubts that there may be a DVT present and concluded that *the key factor is the physical examination.*[129]

(xxv) **If there was a suspicion of DVT, would it be reasonable to proceed to surgery?**

The answer depends somewhat on what the proposed surgery is and the strength of the indications for that surgery. In Anna's case, *the indications for surgery were marginal at best* and the Panel felt that it would not be reasonable to proceed to surgery in the presence of a DVT.[130] Dr Kossman expanded on that point and said the Panel had unanimously determined that they would not have operated on Anna.

(xxvi) **If a PE was present prior to surgery where would you expect Anna to complain of associated pain?**

There may be chest pain but the symptoms of pulmonary embolis are varied. Similarly, there may be calf pain associated with DVT, or there may be no pain at all.

(xxvii) **If pain was present due to a DVT or PE, would medication have managed it?**

Medication could manage the pain but not mask or hide it completely.[131] Dr Myles stated that the medication Anna was taking is more effective in

[127] TP @ p 191.

[128] TP @ p 192.

[129] *Ibid.*

[130] *Ibid.*

[131] TP @ p 194.

targeting fracture pain. It would be unlikely to effectively alleviate calf pain due to DVT.[132]

(xxviii) **What would you expect the response to be if shortness of breath and pain were present in a patient?**

The patient would experience increased anxiety and distress. Additionally, chest pain or calf pain in association with shortness of breath are strong indicators of DVT and/or pulmonary embolism. This would qualify as a medical emergency necessitating admission to hospital, further investigations and, probably, anti-coagulation.[133] In the event that the pain was restricted to the calf only, the response may not require anticoagulation.

(xxix) **Hypothetically, if the investigations revealed a DVT or PE, what would be the management/treatment?**

The first line of management would be cancellation of the surgery and further investigations. Additionally, anticoagulation may be provided depending on the site of the DVT. If it is determined that a pulmonary embolus is present the management/treatment would be anticoagulation and perhaps other more invasive therapies.[134]

(xxx) **Hypothetically, if Anna had elected to pursue the conservative treatment and had an unknown DVT or PE, could this have resulted in a fatal outcome?**

Yes, it could have resulted in a fatal outcome even at home. However, it is probably more likely that a PE will occur at the time of surgery during mobilisation of the fracture.[135]

(xxxi) **Was Dr Yau's pre-operative assessment of Anna appropriate?**

Yes, the standard pre-operative assessment Questionnaire was appropriate.

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[132] TP @ p 195.

[133] TP @ pp 195-196.

[134] TP @ p 196.

[135] TP @ p 197.

(xxxii) **When should consultation between a surgeon and an anaesthetist occur?**

Communication between anaesthetist and surgeon could occur at any time prior to starting the anaesthesia or any intervention. Mr Kossman elaborated that anaesthesia would not commence until the surgeon had arrived in the operating room and so there would always be a quick interaction between the surgeon and anaesthetist where problems would be discussed.

Professor Myles stated that there would always be some sort of communication between the surgeon and the anaesthetist before commencing the induction of anaesthesia. He said that at any point prior to commencing the anaesthetic, if there is a concern or lack of clarity about what is being done or is there any particular risk it would be best practice that they are articulated.[136] If there is little communication or no more than a greeting, there is an assumption between the surgeon and anaesthetist that there are indeed no concerns.[137]

(xxxiii) **Would you expect a surgeon to review pre-operative anaesthetic records?**

No, it would not be routine for a surgeon to do this.

(xxxiv) **Anna completed a Pre-Admission Questionnaire. Would you expect the physician to go over this document with the patient?**

Yes, the anaesthetist ought to go over this document with the patient.

(xxxv) **Would you expect the document to be manually altered if the patient verbalised different answers to those on the Questionnaire?**

No, the document would not necessarily be altered. A separate notation should be put on the patient's record and this should be done contemporaneously, if possible.[138]

Professor Myles emphasised that it would also be equally reasonable for an anaesthetist to document that additional or changed information at any point up to and including during the anaesthetic.[139] Mr Kossman added that, from a surgical perspective, if an alteration or addition to either the records or the

[136] TP @ p 198.

[137] TP @ pp 198-199.

[138] TP @ pp 200-201, 203.

[139] TP @ p 201.

patient's document is deemed necessary, it is initialled or signed and dated by the author.[140]

(xxxvi) **Are there any standardised guidelines in respect to this occurrence?**

The Panel did not believe so and confirmed that is was professional practice to sign and date any corrections or alterations to the record.

(xxxvii) **Was the explanation given by Anna in relation to her heart palpitations and cardiologist assessment in 2009, sufficient not to warrant further investigation?**

Yes, it was sufficient not to warrant further investigations. Professor Myles said that the tests conducted in 2009 were very important. They provided documentation of a borderline tachycardia or off and on tachycardia. A stress echocardiography recorded that Anna had a resting heart rate of 105bpm, with an increase to 120bpm with exercise, peaking at 188bpm with the cardiologist reporting that Anna had a tachycardia or high rate response to exercise. That information indicated that a higher heart rate was a personal characteristic of Anna's and not a sign of illness. In consideration of this, her history of palpitations/tachycardia can easily be explained by something else, such as anxiety about the surgery. Therefore, the increased heart rate or palpitations did not change the risk assessment of pulmonary embolism in Anna.[141]

(xxxviii) **Would you expect it to be investigated further?**

No, as indicated above.

(xxxix) **Are palpitations a negative feature for surgery?**

No in the vast majority of cases as heart palpitations are very common.[142]

(xl) **Anna reported that she had a usual resting heart rate of 90-100. What is the normal resting heart rate?**

A normal heart rate in an adult is 60-100bpm; Anna's heart rate sat in the high range of normal.

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[140] TP @ pp 201-202.

[141] TP @ pp 204-205.

[142] TP @ pp 205-206.

(xli) **Was enough attention paid to Anna's heart rate?**

Yes, for those reasons already articulated; Anna had been investigated by a cardiologist and it was known that she had a relatively high rate.

(xlii) **Is a high resting heart rate a negative feature for surgery?**

Not so for Anna. Her heart rate was in the high-normal range and (on admission) Anna's heart rate was recorded as being in the upper limit of her normal.[143]

(xliii) **What is the normal range for blood pressure?**

For an adult the normal range is 100-140 systolic and 50-90 diastolic.

(xliv) **Would you have been concerned about the post induction blood pressure reading of 85 on 50?**

No, anaesthetic drugs routinely make blood pressure drop – 85/50 would be what would be expected. Professor Myles elaborated that a blood pressure post induction of anaesthetic to 85 on 50 is very typical of a healthy, normal person having a normal anaesthetic.

If a pulmonary embolus had been present in Anna before induction, Professor Myles would have expected an even greater drop in her blood pressure. He said that the fact Anna's blood pressure did drop lower upon induction of anaesthesia *would suggest that there was a further lack of evidence of pulmonary embolism* at that point in time.[144]

(xlv) **Was Anna's blood pressure sufficiently managed once the operation was completed and dressings applied? Should more attention have been paid?**

Yes, there was appropriate post-operative nursing and anaesthetic care, including written orders about how to manage a lower blood pressure by the anaesthetist to nursing staff.

[143] TP @ p 206.

[144] TP @ p 208.

(xlvi) **Anna had an undiagnosed patent foramen ovale (PFO). Hypothetically, had this been known, would you have assessed and managed her differently?**

No, a patent foramen ovale is a relatively common, typically trivial defect in the heart occurring in approximately 25% of adults. It only becomes relevant in certain circumstances such as when the pressures in the right side of the heart exceed those of the left side. For example, in the setting of a pulmonary embolism where there is blockage to the arteries to the lung, pressure in the right side of the heart will increase. The pressure would increase to a moderate extent in the setting of a very small pulmonary embolism and drastically in the presence of a very large embolism. When pressure increases in the right heart, the patent foramen ovale opens up, enabling a blood clot to move freely into the left side of the heart where it is pumped to the rest of the body. Because a quarter of all blood flow from the heart goes to the brain, the most common event following a paradoxical embolism is stroke.[145] Nevertheless, knowledge of the existence of a patent foramen ovale would not change a surgical plan unless you were concerned about DVT or pulmonary embolism.[146]

(xlvii) **Are palpitations a feature of PFO?**

No, unless an atrial septal defect (**ASD**) is present which is not relevant in Anna's case.

(xlviii) **Is a high resting heart rate a feature of PFO?**

No again, unless there is actually an ASD which is not relevant to Anna's case.

(xlix) **If Anna had elected to pursue the conservative treatment and had an unknown DVT or PE or both, would the existence of a PFO caused a fatal outcome?**

The panel said that, yes, sadly, a fatal outcome was extremely likely. Anna may have suffered DVT or pulmonary embolism in other circumstances, such as at home or getting off the plane. In those circumstances her PFO is equally relevant and a stroke was equally likely to have occurred. If Anna had suffered

[145] TP @ pp 208-209.

[146] TP @ p 209.

a stroke outside the hospital or medical setting, a fatal outcome was probably more likely.[147]

83. At the conclusion of the formal questions put to the Panel, I invited Counsel for the Interested Parties to ask any questions that had not already been broached. Mr Wallis sought clarification from the Panel about what should be done with information conveyed by a family member to medical and nursing staff, about the concerns of Mr Bowditch in respect of his observations and interpretation of Anna's alleged shortness of breath on exertion.[148]

84. Ms Ellyard for Mr Widjaja sought clarification from the Panel on a number of issues including:

    a) The timing of the formation of the DVT could not be known with any degree of certainty save that it must have been present at the time of surgery.[149]

    b) Whether Mr Widjaja failed to be sufficiently cognisant of the risk factors for Anna even though he depicted what his thought processes were in this regard during his consultation with her on 12 August 2016. Both Mr Kossman and A/P Bucknill maintained their collective opinion that such thought processes are not sufficient unless accompanied by a sufficient physical examination (that is, by removing the bandage and back slab).[150]

    c) A/P Bucknill and Mr Kossman were of the opinion that the relative benefits versus risks of surgery were firmly in favour of no surgery.[151] A/P Bucknill stated that there was no scientific evidence to suggest that there is any benefit to surgery in this type of fracture. He did, however, acknowledge that there was evidence to support that Anna had made the decision to proceed with surgery as it was the option that would have enabled her to mobilise more quickly.

    d) Ms Ellyard proposed that, at the time of Mr Widjaja's examination of Anna on 12 August 2014, there were no ascertainable signs and symptoms of DVT. However, neither A/P Bucknill nor Mr Kossman agreed with this proposition on the grounds

[147] TP @ p 211.

[148] TP @ pp 213-218.

[149] TP @ pp 218-219.

[150] TP @ pp 222-223.

[151] TP @ pp 230-231.

that the examination demonstrated by Mr Widjaja in Court was not sufficient to actually detect DVT. They indicated that a medical practitioner needs to look for DVT and palpate the back of the calf muscle; to only palpate from the side is insufficient.[152] Removing the back slab would enable the practitioner to conduct a more sensitive examination and perceive more subtle signs and symptoms that can only be seen by looking at the limb.[153] Although Mr Widjaja was able to perform an examination, it was not a complete examination or it was not sensitive enough.[154]

e) Both Orthopaedic Surgeons acknowledged that they were aware of the outcome, Anna's death, before writing their reports. However, neither A/P Bucknill nor Mr Kossman believed that their individual opinions or their answers to the questions posed to them as Panel members, were influenced by hindsight bias.[155]

85. Mr Regos on behalf of St. Vincent's Private Hospital sought clarification from the Panel:

a) That the panel was of the opinion that Anna already had a DVT in the days leading up to the surgery;

b) That undergoing the surgery increased Anna's risk of dying from complications of a pulmonary embolism; and

c) In the event that Anna had opted for conservative management of her fracture, it was more likely than not she would have died from the complications of pulmonary embolism.

86. In responding in the affirmative to all of Mr Regos' questions Professor Myles stated that *the risk of pulmonary embolism could have happened with or without surgery, but was probably aggravated by surgery. But the risk of stroke and death from the pulmonary embolism itself, once that had happened, that was more likely to happen at home than in the hospital.*[156]

87. Mr Constable on behalf of Dr Yau merely sought clarification that the nominated spokesperson on any particular question posed to the Panel was based whether the

[152] TP @ p 233.

[153] TP @ p 234.

[154] TP @ p 235.

[155] TP @ pp 235-237.

[156] TP @ p 239.

question fell wholly or predominately to a particular area of expertise – anaesthesia or orthopaedic surgery.[157] A/P Bucknill concurred.

88. In a final question to the Panel, I sought to understand whether removing the plaster back slab and bandages from Anna's leg would be difficult or time consuming. A/P Bucknill responded that a pair of scissors is all that is needed to cut through the crepe bandage holding the back slab in place and the thin layer of insulating wool around the limb to expose it for a full examination. The back slab can be reapplied with a fresh crepe bandage. The process he said, would take approximately five minutes.[158]

Application to adduce further evidence

89. I received an *Application to Adduce Further Evidence* from Mr Widjaja after evidence was finalised but prior to hearing closing submissions on 9 March 2018.

90. On 27 March 2018, I handed down my Ruling on the Application, determining not to grant same. Ms Ellyard indicated that she did not need to get instructions from her client regarding his appeal rights.

91. Closing submissions were subsequently heard.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Mr Bowditch implied that the medical records were bereft of his and Anna's communications about her recent acute onset of symptoms because they were deficient.[159] In response to a question[160] about the lack of reference to shortness of breath in Mr Widjaja's records, Mr Bowditch stated: *...it's very convenient the medical records are very scant.*[161] This statement implies that Dr Silva, Mr Widjaja, Dr Yau and the nursing staff at St Vincent's Private Hospital[162] all failed to document a potentially

[157] TP @ pp 239-240.

[158] TP @ p 240.

[159] Anna's symptoms which Mr Bowditch said had been communicated but were not recorded on patient medical records include: pain in her left leg, shortness of breath on exertion and palpitations.

[160] The question was posed by Mr Constable of Counsel appearing on behalf of Dr Yau.

[161] TP @ p 34.

[162] TP @ p 39 & Exhibit 2 – Statement of Stephen Bowditch dated 19 March 2015.

significant diagnostic symptom and/or that they have "conveniently" altered their respective records after Anna's death.

2. Mr Bowditch remained resolute in his account of conversations that were had. When giving evidence, he oft referred to his letter to the Court which was written on 24 August 2014, only three days after Anna's death. Mr Bowditch submitted that it represented a contemporaneous account which I should accept over deficient medical records. Mr Bowditch confidently stated the letter was 100 percent accurate in terms of what he witnessed and in what he had said to various people.[163]

3. I accept that Mr Bowditch believes his account to be true, however his line of reasoning is not otherwise supported. I am cognisant that documentation examined within the Coronial jurisdiction is often found to be lacking, deficient or indeed absent and there have been some shortcomings identified in Anna's case. However, there is no other evidence that supports Mr Bowditch's account of his conversations with medical practitioners and staff. Three medical practitioners did not document that Anna suffered shortness of breath upon exertion. This cannot be a coincidence and supports each of those practitioner's evidence that they were not told that Anna was experiencing shortness of breath on exertion.

4. The difference in the evidence of Stephen Bowditch and Dr Yau about the content of the conversation during Dr Yau's pre-anaesthetic assessment of Anna Agnieszka Bowditch is difficult to reconcile, save that I consider there is an element of hindsight bias to Stephen Bowditch's account of events. This is not a criticism of him and indeed it is anticipated, to varying degrees, when someone recounts immediate surrounding circumstances to a personal tragedy. In this regard, I accept the submissions of Counsel for Dr Yau that it is likely that Stephen Bowditch is mistaken about what occurred at the pre-anaesthetic assessment and it is conversations with medical practitioners, including Dr Yau, immediately following Anna's stroke when shortness of breath assumed greater relevance.[164]

5. Mr Widjaja's evidence about his recollection of the appointment with Anna is difficult to reconcile with the evidence of Mrs Kula. His memory of Anna's appointment in his rooms appears very clear but the source of his memory is not substantiated with his own

[163] TP @ p 39.

[164] Transcript of Submissions on 27 March 2018 @ p 42.

documentation. He acknowledges that his own contemporaneous notes about his consultation with Anna on 12 August 2014 are brief. He stated that his "scribble"[165] is a memory aid for him, not others, and I accept that they would facilitate that purpose to some degree. Mr Widjaja also said that had he been concerned about anything it would have made it into these notes.[166] Mr Widjaja's letter to Dr Nagla on 13 August 2014 supports the fact that his notes were contemporaneous.[167] I accept Dr Widjaja's "scribble" as a contemporaneous document of his examination of Anna. However, the same does not reflect that his examination was undertaken without fully visualising the limb or palpating it unimpeded by the bandage and back slab. Furthermore, there is nothing in the "scribble" to support that he did adhere to his "usual practice" of explaining the risks associated with surgery.

6. Mr Widjaja denied that he was reconstructing the events relevant to his involvement with Anna.[168] During cross examination, Mr Widjaja did not resile from his recollection of Anna using crutches on the day of her attendance on him on 12 August 2014. In this regard, his memory was not supported by contemporaneous notes; they were silent to Anna's mode of mobilisation. Mr Widjaja was adamant that Anna did not come into his rooms on 12 August 2014 in a wheelchair despite Mrs Kula's evidence to the contrary.[169] The evidence of Mrs Kula is preferred in this regard as I accept that the combination of difficulties associated with parking, removing the wheelchair from the car, and manoeuvring Anna's wheelchair with Natalia on Anna's lap add weight to Mrs Kula account of her memory of the day. Ultimately, however, little turns on how Anna mobilised into Mr Widjaja's rooms on 12 August 2014.

7. It is difficult to accept the significance that Mr Widjaja has attached to Anna's history and complaints of palpitations[170] in his *viva voce* evidence. I accept that he may have been denied direct communication from either Anna or Dr Yau about the contemporaneous event[171] but his steadfast position that he would have cancelled Anna's surgery if he had

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[165] Exhibit 12.

[166] TP @ p 99, 114-115, 127.

[167] Exhibit 14.

[168] TP @ p 95.

[169] TP @ p 102.

[170] Specifically those on 15 August 2014.

[171] TP @ p 121-122.

been availed of that information, regardless of Dr Yau's own assessment of its significance, is difficult to reconcile with his earlier evidence that he had previously always trusted Dr Yau's assessment.[172] Mr Constable of Counsel questioned Mr Widjaja on this persistent position asking him: *....if Dr Yau had come to you and said Anna had some palpitations yesterday that were short-lived, recovered, she was anxious about the surgery*...but Mr Widjaja maintained that he would have cancelled the scheduled surgery.[173]

8. I accept that it was in the general purview of the anaesthetist's professional assessment and discretion not to inform Mr Widjaja of the history of palpitations communicated to her by Anna. I agree with the submissions from the family that it is crucially important information and as the Panel indicated, should prompt more questioning of the patient, Anna. I consider that if the combined symptoms had been known to Dr Yau it would have been appropriate for her to inform Mr Widjaja.

9. I make no criticism of Dr Yau for making a retrospective note in the medical records on 16 August 2014. Contemporaneous notes are preferred and generally considered more accurate but a retrospective note is preferable to no notes; the note remains proximate to the catastrophic events and Dr Yau has appropriately identified it as a retrospective note. I accept that her omission to mention the reported palpitations in that retrospective note was unintended.

10. The qualifications of the concurrent evidence panel, particularly those of the orthopaedic surgeons, was not challenged by Mr Widjaja. I consider them eminently qualified to comment on what is appropriate practice of another orthopaedic surgeon. I accept that if Mr Widjaja did an examination as he demonstrated to the Court on two occasions, it was not an adequate examination. Similarly, it was not consistent with the practice of the independent orthopaedic surgeons on the Panel, who I take to be representative of their speciality. It is a technique that in all the circumstances and on the weight of the evidence, does not equate to good medical practice because it is not justifiable. It is not justifiable because it denies a fulsome examination of the limb. A less than fulsome examination potentially denies the surgeon a true appreciation of what that limb looks like – its colour, integrity or whether any pain can be initiated by palpation.

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[172] TP @ p 122.

[173] TP @ p 92, 93.

11. Coronial recommendations may be made to any Minister, public statutory authority or entity on any matter connected with a death or fire which the Coroner has investigated.[174] In the context of the aforementioned sentence, the word "entity" cannot reasonably be considered to refer to an individual person. For this reason, I have restricted the following to comments: Firstly, Mr Audi Widjaja ought to engage with the Royal Australasian College of Surgeons and/or an orthopaedic unit at a major public hospital with the aim of ensuring that his limb examination techniques are consistent with current acceptable practises; Secondly, he ought to provide written material to his patients about the signs and symptoms of fracture associated complications, including but not limited to Venous Thromboembolism. The evidence of the expert panel indicates that would represent best practice.

FINDINGS

1. I find that the identity of the deceased is ANNA AGNIESZKA BOWDITCH born on 5 October 1979 and whose brain death was declared at St. Vincent's Hospital, Fitzroy on 21 August 2014.

2. I find that Anna Agnieszka Bowditch had a number of known risk factors for the development of venous thromboembolism, being: the fracture to her left fibula and consequential immobility, a recent long-haul flight from Hawaii back to Australia, medication in the form of the contraceptive pill, and borderline obesity with a body mass index of 29.7kg/m^2.

3. I find that Anna Agnieszka Bowditch attended a consultation appointment with Mr Audi Widjaja, Orthopaedic Surgeon, at his rooms in Richmond on 12 August 2014 and I accept the evidence of Mrs Kula to the extent that she accompanied Anna Agnieszka Bowditch to this appointment. I do not need to make findings on whether Anna Agnieszka Bowditch was on crutches that day or in her wheelchair except to reiterate that Mrs Kula's evidence is more compelling in this regard.

4. I find that there is clear and cogent evidence that Mr Widjaja did examine Anna Agnieszka Bowditch's left leg on 12 August 2014. The evidence of Mrs Kula that Mr Widjaja did not perform any examination of Anna Agnieszka Bowditch's leg is not accepted as the weight of the evidence is to the contrary. There is a contemporaneous

[174] *Coroners Act 2008* (Vic) s72(2).

document created by Mr Widjaja of his examination of Anna Agnieszka Bowditch and in further support that he did in fact perform an examination there is a contemporaneous document in the form of a letter he wrote dated 13 August 2014 to Dr Nagla about Anna Agnieszka Bowditch's attendance and his examination of her.

5. I find that the examination of Anna Agnieszka Bowditch's left limb and fracture site by Mr Widjaja on 12 August 2014 was however, less than fulsome and could not be described as a practice that would fully inform a medical practitioner about the status of a fractured limb.

6. I find that the practice adopted by Mr Widjaja to examine Anna Agnieszka Bowditch's fractured limb without removing the bandage and back slab was not consistent with good medical practice at the time or now. The failure to remove the bandage and back slab to fully visualise and examine the limb also defies logic and common sense when the whole process would have consumed approximately an additional five minutes of the surgeon's time.

7. I find that a full visual examination and unimpeded palpation of the limb would have better informed Mr Widjaja about whether there were any concerning signs or indices of the development of venous thromboembolism. If a deep vein thrombosis was already present as has been suggested, then signs and symptoms may have been identified through an unimpeded examination of Anna Agnieszka Bowditch's limb and the course of her medical management significantly redirected to confirm diagnosis and implement preventative measures.

8. I am not able to make any findings that there were signs and/or symptoms of venous thromboembolism present on 12 August 2014. However, the lack of a fulsome examination also denied Mr Widjaja the opportunity to compare the state of the limb when he finally did view it unencumbered just prior to surgery. And although similarly I cannot make findings that such a comparison would have altered the outcome for Anna Agnieszka Bowditch, it is difficult not to characterise it as an opportunity lost to have possibly improved on the medical management of Anna Agnieszka Bowditch. Any other scenarios than what actually occurred are no more but no less than possibilities.

9. I find that the risk factors for the development of VTE were known to all of Anna Agnieszka Bowditch's medical practitioners including Mr Audi Widjaja,

Orthopaedic Surgeon, and Dr Peik Fei Yau, Anaesthetist. Her risk factors were not insignificant, but I agree and find that risk factors do not equate to signs and symptoms.

10. I find that, despite Anna Agnieszka Bowditch's contact with a number of health professionals on her return to Victoria from Hawaii, there is a dearth of documentary evidence that she was experiencing any signs and symptoms of venous thromboembolism, save for her disclosure of palpitations, both from a medical history perspective and the recent experience she had on 15 August 2014.

11. I find that there is documentary evidence that was completed by Anna Agnieszka Bowditch herself which indicates that she was not experiencing any other common or widely accepted symptomatology that could be equated to the presence of a deep vein thrombosis or pulmonary embolus. For example, she has specifically answered "no" to a question about shortness of breath.

12. AND I accept and adopt the evidence of the Panel that palpitations *per se* or in isolation to other signs and symptoms of venous thromboembolism would not reasonably lead a health professional to suspect the presence of the same. Similarly, there is a dearth of documentary evidence that she was experiencing any calf pain.

13. I find that the pre-operative anaesthetic assessment conducted by Dr Yau was reasonable and appropriate and I make no adverse comment or finding against Dr Peik Fei Yau's involvement in the care and anaesthetic management of Anna Agnieszka Bowditch on 16 August 2014.

14. I find that Anna Agnieszka Bowditch opted to undergo the medical/surgical procedure for fracture repair and fully consented to the same.

15. I find that Anna Agnieszka Bowditch died following a medical/surgical procedure at St Vincent's Private Hospital to repair an undisplaced fracture of the left fibula sustained in a fall whilst on holiday in Hawaii.

16. I find that the death of Anna Agnieszka Bowditch is causally related to the medical/surgical procedure but where a medical practitioner, including her orthopaedic surgeon Mr Audi Widjaja and Anaesthetist Dr Peik Fei Yau, would not immediately before the medical/surgical procedure was undertaken, have reasonably expected her death.

17. I find on the balance of probabilities that Anna Agnieszka Bowditch suffered a pulmonary embolism during this medical/surgical procedure.

18. However, in all the circumstances, I am unable to find that the death of Anna Agnieszka Bowditch was preventable. The possibility remains that had she not opted for undergoing the surgical procedure but instead opted for conservative management, that she could have suffered the same catastrophic effects from venous thromboembolism. The presence of a patent foramen ovale significantly increased her risk of a fatal outcome from the dislodgement of a deep vein thrombosis, enabling it to traverse from the venous side of the heart to the arterial circulation and obstruct the major arterial supply to the brain, which did occur. The presence of a patent foramen ovale was not known to Anna Agnieszka Bowditch's clinicians. This catastrophic outcome of the development of a deep vein thrombosis could not have reasonably been known or foreseen. This catastrophe could have occurred at any time.

19. I make no adverse comment or finding against St Vincent's Private Hospital or their staff involved in the care and management of Anna Agnieszka Bowditch.

20. I accept and adopt the medical cause of death as ascribed by Dr Lee and I find that Anna Agnieszka Bowditch tragically died from complications of a fall with fracture of the left ankle and subsequent deep venous thrombosis with embolisation.

RECOMMENDATIONS

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendation(s) connected with the death:

1. With the aim of promoting public health and safety and preventing like deaths through the early detection of Venous Thromboembolism, I recommend that the Royal Australasian College of Surgeons use the circumstances of Anna Agnieszka Bowditch's death to create a learning tool for orthopaedic surgeons on how to conduct fulsome and rigorous physical examination of a fractured limb.

To enable compliance with section 73(1) of the *Coroners Act 2008* (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this Finding be provided to the following:
Mr Stephen Bowditch by his legal representative at Maurice Blackburn Lawyers
Mr Audi Widjaja by his legal representative at Avant Law
Dr Peik Yau by her legal representative at Ball and Partner
St Vincent Private Hospital by its legal representative at DLA Piper Lawyers
Royal Australasian College of Surgeons
Australian Health Practitioner Regulation Agency

Signature:

AUDREY JAMIESON
CORONER
Date: **3 December 2018**