FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 300/07

Inquest into the Death of LAUREN KATHERINE JAMES

Delivered On:	6th August, 2010
Delivered At:	Coroners Court of Victoria sitting at the County Court of Victoria, Melbourne
Hearing Dates:	4th, 5th, 6th, 9th and 10th November, 2009 16th, 17th, 18th, 19th and 20th March, 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation: Coroners	Leading Senior Constable Tania CRISTIANO from the State Assistants Unit appeared to assist the Coroner.
	Mr Gary HEVEY of Counsel appeared on behalf of the family of Ms James, instructed by Ms Kiera Menzies of Clark Toop & Taylor.
	Mr Robert HARPER of Counsel appeared on behalf of Mr Simon Dal Zotto, instructed by Ms Kate Booth/Ms Laura Vines of Maurice Blackburn.
	Mr David GRACE Q.C. appeared on behalf of Dr Gerard Sormann, instructed by Ms Philippa Duxbury of John W. Ball & Sons.
	Ms Sean CASH of Counsel appeared on behalf of Mr Tam DIEU, instructed by Ms Kate Hughes of Avant Law.
	Mr John CONSTABLE of Counsel appeared on behalf of Dr Mervyn Cass, instructed by Ms Lara Larking of Avant Law.

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 300/07

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: JAMES
First name: LAUREN
Address: 72 Princess Street, Kew, Victoria 3101,

AND having held an inquest in relation to this death on 4th, 5th, 6th, 9th and 10th November, 2009 and 16th, 17th, 18th, 19th and 20th March, 2010

at the County Court of Victoria

find that the identity of the deceased was LAUREN KATHERINE JAMES born on the 5th March, 1980,

and that death occurred on the 22nd January, 2007,

at 72 Princess Street, Kew, Victoria 3101

from 1(a) COMPLICATIONS OF LIPOSUCTION SURGERY

in the following circumstances:

INTRODUCTION[1]

1. Lauren Katherine James was a twenty-six year old woman who resided with her partner Mr Simon Dal Zotto. Her maternal grandmother Ms Margaret Braley resided at a unit at the rear of the same property. Ms James had no significant medical history and no known medical problems. She was fit and healthy. In late 2006, having researched

[1] This is a brief summary of the circumstances leading to Ms James' death. Some aspects will be dealt with in more detail below.

liposuction, Ms James decided she wanted to have liposuction surgery to her lower buttocks, thighs and knees. She contacted The Centre of Cosmetic and Plastic Surgery, 73 Kooyong Road, Caulfield, (COCAPS) an accredited clinic where day procedures/surgery including suction-assisted liposuction was performed. The Director of COCAPS is Mr Gerard Sormann, a Plastic and Reconstructive Surgeon of high standing and with many years experience.

2. I was told during the inquest that about 50% of liposuction surgery performed in Australia is performed in comparable day procedure clinics and that this setting is not unsuitable for liposuction surgery. Nor was there any suggestion that Ms James was not an appropriate candidate for liposuction surgery should she so choose.

3. At her first consultation at COCAPS in late November 2006, Ms James met with Nurse Morris who provided her with general information about the procedure and the recovery period and took a general health history from her. At her second consultation on 5th December 2006, Ms James was seen by Dr Mervyn Cass, a General Practitioner who effectively managed the clinic, assessed patients medically and formally referred patients to the appropriate surgeon. She also had her first consultation with Mr Tam Dieu, a Plastic and Reconstructive Surgeon, who had been performing liposuction surgery in private practice since February 2004. He attended at COCAPS about once each fortnight to perform liposuction, but was otherwise unassociated with the clinic.

4. Ms James attended a pre-operative session on 8th January 2007 where she underwent a full medical examination, including routine pre-operative blood tests, and an ECG, which was reported as normal. She weighed 65kgs and at 165cms in height had a healthy body mass index of ~ 24. The cost of the surgery was $8,000.00 inclusive of all post-operative care. She was provided with further information about the procedure and with medications according to the COCAPS protocol - Arnica, Atenolol, Temazepam, Panadol, vitamin and iron supplements. As her heart rate was less than 50bpm she was instructed not to take the Atenol,ol which was meant to slow heart rate/circulation so as to reduce bleeding.

LIPOSUCTION SURGERY - 19th JANUARY 2007

5. Ms James was administered a general anaesthetic by Anaesthetist Dr Andu Borsaru. Mr Dieu made eight small incisions and performed the surgery by infiltrating the sites sequentially with 1900ml of tumescent fluid (normal saline with 1ml Adrenaline and 20ml Naropin) and then using 6mm and 4mm cannulae to suction out 1800ml of fat.

There were no anaesthetic or other surgical complications, and after a period in the Recovery Room (from 12:10pm) and then in "Step-Down" (from 12:45pm), Ms James was discharged home in the care of her partner Mr Dal Zotto shortly after 3:00pm.

THE EARLY POST-OPERATIVE PERIOD

6. Nurse Bray made routine post-operative telephone contact with Ms James on the afternoon of Saturday 20th Janaury 2007 and there were no concerns apart from mild-moderate discomfort which was adequately controlled by the analgesics provided to her at COCAPS for post-operative use - "Capedex" (Digesic, 2 tablets 4 times/day) and "Nurofen" (Ibuprofen, 2 tablets 3time/day).

7. On the morning of Sunday 21st January 2007 Ms James was able to leave the house briefly when she went with Mr Dal Zotto to the local pharmacy for a short time. She felt unwell however in the afternoon and Mr Dal Zotto contacted Dr Cass who advised further analgesia and to call COCAPS in the morning if she was not better.

THIRD POST-OPERATIVE DAY - 22ND JANUARY 2007

8. This period is dealt with in some detail below. Suffice to say that Ms James was reviewed by Dr Cass and Mr Sormann at COCAPS at about 11:00am and discharged at about 11.30am, after administration of pethidine and provision of "Endone" tablets. Mr Dieu was contacted and appraised of this review and the plan was to further review Ms James in the afternoon. Mr Dal Zotto became increasingly concerned for Ms James during the course of the afternoon and evening and made several attempts to contact COCAPS. Mr Dieu called him at 6:30pm to reassure him that Ms James' clinical presentation was normal and that he would review her the next morning if things did not improve. Ms James continued to deteriorate. She fell in the bathroom at around 8:00pm and was assisted back to her bed by Ms Braley. She fell/collapsed a second time which prompted a call to emergency services shortly after 9:00pm. Ambulance officers arrived, and requested MICA back-up. Despite the resuscitative efforts of both crews for over 45 minutes, Ms James died where she lay, in the hallway of her home.

INVESTIGATION

9. This finding is based on the totality of the material, the product of the coronial investigation of Ms James' death. That is the original inquest brief compiled by the State Coroners Assistants Unit, documents provided by The Centre of Cosmetic and Plastic

Surgery, the statements of those witnesses who testified and any documents tendered through them during the inquest, the expert statements/reports of those witnesses not required to testify at the inquest and the submissions of Counsel. All this material will remain on the coronial file together with the inquest transcript.[2] In this finding, I do not propose to summarise all the material/evidence, but rather will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

10. The primary purpose of the coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death, the circumstances in which the death occurred[4] and any other prescribed particulars.[5] The cause of death refers to the *medical* cause of death, encompassing where appropriate, the *mode* or *mechanism* of death, while the *circumstances* refers to the context in which death occurred, or the background and surrounding circumstances. These circumstances must be sufficiently proximate and causally relevant to the death, and not merely circumstances which might form part of a narrative culminating in the death.

11. A secondary purpose of the coronial investigation arises from the coroner's power to report to the Attorney-General on a death they have investigated; to make recommendations to any Minister, public statutory authority or entity on any matter connected with the death, including public health and safety or the administration of justice; or to comment on any matter connected with the death, including public health or safety or the administration of justice. Whilst left to be implied in its predecessor Act, the *Coroners Act 2008* explicitly articulates a *prevention* purpose or focus for coronial findings and recommendations, that is a purpose or focus on reducing the number of preventable deaths.[6]

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2 Since 1st November 2009 when the *Coroners Act 2008* (the Act) came into operation, access to the coronial file or documents within it may be sought pursuant to section 115.

3 The Act requires certain deaths to be reported to the coroner for investigation. Section 4 defines reportable deaths and, apart from a jurisdictional nexus with Victoria, relevantly includes a death *"that occurs following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death"* - see section 4(2)(b).

4 See section 67 of the Act for the findings which a coroner must make if possible and section 67(2) which provides that a coroner need not make findings with respect to circumstances where an inquest was not held **and** the coroner finds that the deceased was not a person placed in custody or care immediately before they died **and** that there is no public interest to be served in making such findings.

5 Section 3 defines "prescribed" as meaning prescribed by the regulations unless otherwise provided. As yet no particulars have been prescribed under the Act.

6 See the Preamble to the Act and the Purposes - *"to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making*

12. It should also be noted that a coroner is specifically prohibited from including in a finding or comment any statement that a person is or may be guilty of an offence.[7] This gives rise to something of a paradox, as there is also an obligation to report the matter to the Director of Public Prosecutions, if at the conclusion of a coronial investigation, the coroner believes that an indictable offence may have been committed in connection with the death.[8]

13. Of the matters I am required to ascertain, if possible, the identity of the deceased and some aspects of the circumstances were uncontroversial. I find, as a matter of formality, that Ms Lauren James born on 5th March 1980, late of 72 Princess Street, Kew, died at her home at or about 10:15pm on 22nd January, 2007.[9] The focus of the coronial investigation of Ms James' death, including the inquest, was twofold - ascertaining the medical cause of her death and assessing the adequacy of post-operative care provided to her by or at COCAPS.

THE MEDICAL CAUSE OF DEATH

14. It is relatively unusual for there to be contention around the medical cause of a reportable death where there has been a full postmortem examination or autopsy, as there was in this case. **Dr Shelley Robertson**, a Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) with almost twenty years experience in forensic pathology at that time, performed an autopsy on the morning of 25th January, 2007 and provided a detailed report of her findings.[10]

15. Dr Robertson formulated the cause of death as *"1(a) Complications of liposuction surgery"* and advised that - *"It is likely that death resulted from a combination of factors following on from the cosmetic surgery (liposuction) procedure performed 3 days prior to death. These factors include sepsis, decreased respiratory function secondary to microthrombi, fat emboli, probable inhalation of gastric contents and infection, and central nervous system depression due to a combination of drugs (pethidine and*

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of recommendations, by coroners;" - section 1(c).

7 Section 69(1).

8 Section 49(1) - the obligation to report to the DPP falls on the Principal Registrar once the coroner forms the requisite belief. See also section 67(2).

9 I note that the time of death is an approximation based on the evidence of the ambulance and MICA paramedic officers who attended from 9:16pm and 9:30pm respectively - see transcript pages 144-161 for details of their resuscitative efforts and limited response in Ms James.

10 Exhibit V was the 7 page autopsy report which included Dr Robertson's formal qualifications and experience.

propoxyphene). It is also possible that her underlying focal coronary artery disease may have also contributed to this."

16. At inquest, Dr Robertson expanded on her findings and opinion and was cross-examined at length by Counsel representing the various parties. While she agreed that there was evidence of septicaemia or an infection within the blood, she maintained that there was no evidence at autopsy of *necrotising fasciitis*, a known but rare complication of liposuction surgery. Dr Robertson testified that she was familiar with necrotising fasciitis and had seen several cases involving the condition, but did not believe Ms James' was one of them. She explained that what she saw at autopsy was extensive bruising or diffuse haemorrhage into tissues associated with operative sites (in contrast with haematoma or a more localised collection of blood within tissue) but no evidence of necrosis in the fascia. She agreed by reference to photographs of the inner and outer left thigh that blisters or bullae had developed and had burst, but maintained that there were not the concomitant necrotic changes in underlying tissue which would indicate the presence of necrotising fasciitis.[11]

17. Mr Hevey cross-examined Dr Robertson about the two pathogens identified in postmortem blood cultures, namely *proteus mirabilis* and *enterococcus faecalis*.[12] Apart from the limitations of postmortem microbiology which she characterised as *"notoriously unreliable",*[13] Dr Robertson agreed that these pathogens could be associated with necrotising fasciitis, but added that they are very common postmortem contaminants and, in a postmortem as opposed to a clinical sample, are not diagnostic of necrotising fasciitis without further evidence.[14]

18. When aspects of **Associate Professor Eisen's** report[15] were put to her, Dr Robertson agreed (a) that the presence of these pathogens together in postmortem blood cultures was unlikely to indicate the presence of necrotising fasciitis and more likely to represent postmortem contamination, and (b) that if the cultures had shown a pure growth of *streptococcus pyogenes* this would have increased the likelihood of necrotising fasciitis antemortem, as this was a pathogen which Dr Robertson more readily associated with the

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11 Transcript pages 476, 478, 482, 498, 505.

12 Transcript page 477 et seq and VIFM report of Microbiology Culture Results dated 07/02/07, part of Exhibit RR, the balance of the brief.

13 Dr Robertson's evidence was that it was even more difficult to successfully culture postmortem tissue than blood - transcript page 486.

14 Transcript pages 483-486.

15 Associate Professor Damon Eisen, a Consultant Infectious Diseases Physician, provided a medico-legal reports to solicitors representing Dr Sormann - Exhibits II & JJ.

condition.[16] Subsequently, Assoc Prof Eisen gave evidence at inquest consistent with his report in relation to these two issues. He also added that in the absence of overt findings of necrotising fasciitis at autopsy, the likelihood was that if necrotising fasciitis was present at all it was in its early stages and not causative of death.[17] As to the cause of Ms James' death, he agreed that there were a number of autopsy findings which suggested that death resulted from cardiorespiratory compromise in association with an infection or sepsis.[18]

19. A number of other medical practitioners provided reports in relation to Ms James' death and most also testified at inquest. Some provided medico-legal opinion to individual parties, others were nominated by their college or professional bodies to provide an independent expert assessment to the coroner. The main focus of some reports was the cause of death, while others were mainly concerned with an assessment of clinical management and provided incidental opinions or comments about the cause of death. The following is a summary, in order of testimony, of those opinions or comments which have informed my conclusion about the cause of Ms James' death.

20. **Dr John Flynn** is a Cosmetic Practitioner from Queensland who was nominated by the Australasian College of Cosmetic Surgeons to provide an independent expert assessment for the coroner.[19] In his report he agreed with the general thrust of Dr Raftos' report. He added that although it is clearly possible that septicaemia was the main clinical cause of death, he considered that an alternative cause may be airway obstruction in a patient with compromised reflexes due to medication and after her last fall, a possibility he maintained at inquest.[20]

21. **Dr John Robert Raftos** is an Emergency Physician who provided a medico-legal opinion on behalf of the family of Ms James.[21] In his report, based on the autopsy findings of Dr Robertson, Dr Raftos concluded that the most *probable* cause of Ms James' death was septicaemia associated with post-operative infection, and identified a number of factors which were not of a magnitude to cause death but *may* contribute to death in a person who is critically ill from another cause - 60% narrowing of the left anterior

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16 Transcript pages 486-7.
17 Transcript page 932-6 & 938.
18 Transcript page 938.
19 Exhibit O was Dr Flynn's report dated ~18/08/08 including his formal qualifications, affiliations and extensive experience in cosmetic surgery including liposuction - see also transcript page 327-8 re qualifications and pages 325-6 re cause of death.
20 Exhibit O page 9 (brief page 101) & transcript page 319, 323, 330, 334
21 Dr Raftos' 21 page report dated 26/03/08 was accompanied by a detailed CV including his formal qualifications, affiliations and experience as an Accident & Emergency Physician - Exhibit P.

descending (LAD) coronary artery; bronchopneumonic changes/aspiration; microthrombi and fat embolism (both accepted complications of liposuction surgery; and aneamia due to blood loss arising from the extent of post-operative bruising.[22] Dr Raftos did not depart from his opinion as to cause of death when he testified at inquest, [23] although he did agree with Dr Flynn's hypothesis that respiratory failure may have caused or significantly contributed to death.[24]

22. **Mr Ian R. Carlisle** was nominated by the Royal Australasian College of Surgeons as an appropriate expert to provide an independent assessment for the Coroner from the perspective of a Plastic and Reconstructive Surgeon.[25] In his report, Mr Carlisle noted the various autopsy findings but stated that in his belief the most significant were those of infection. By reference to photographs of the left thigh in particular, he noted swelling, and identified evidence of fasciitis and necrosis *"typical of the infective process of necrotising fasciitis"*.[26] At inquest, Mr Carlisle described the nature of necrotising fasciitis and its potential for rapid deterioration, the difficulties in diagnosing it, particularly in its early stages, the autopsy findings which pointed to it as a possibility and those which were neutral. As I understood his evidence he maintained necrotising fasciitis as his preferred hypothesis for the cause of Ms James' death.[27]

23. A medico-legal opinion was sought from **Professor John Francis Cade**, on behalf of Mr Tam Dieu. Prof Cade is an Intensive Care Physician and Anaesthetist.[28] In both his report and his evidence at inquest, Prof Cade stated that the cause of Ms James' death was almost certainly multifactorial, involving respiratory failure caused by a combination of microemboli, aspiration (possibly precipitated by respiratory depression from the narcotic analgesics pethidine, oxycodone and dextropropoxyphene) and infection. While he agreed that necrotising fasciitis would have been a reasonable causative diagnosis to be explored clinically, he discounted it as a factor causative of death on the basis of Dr Robertson's autopsy findings.[29]

24. **Associate Professor Donald Marshall**, a Plastic & Reconstructive Surgeon, provided a medico-legal opinion on behalf of the James family. In his report he adopted

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22 Exhibit P page 6-7.
23 Transcript page 292 et seq where this is inferred rather than explicit & pages 310-11, 315.
24 Transcript page 314.
25 Mr Carlisle's report dated 07/04/09 with ancillary documents was Exhibit Q and his evidence commences at transcript page 341.
26 Exhibit Q (page 151 of the brief).
27 Transcript pages 381, 383-4, 392, 403-4, 409, 413.
28 Prof Cade's report was Exhbit KK and the transcript of his evidence commences at page 945 with his formal qualifications & affiliations.
29 Exhibit KK page 1 & transcript pages 946-7, 966, 969, 976-8.

Dr Raftos' conclusions regarding the cause of death being probably multifactorial, but his evidence at inquest was primarily about aspects of clinical management/post-operative care.[30]

25. A medico-legal opinion was also provided by **Dr Merrole Faye Cole-Sinclair**, a Specialist in Laboratory & Clinical Haematology, to solicitors representing Mr Tam Dieu.[31] In her report, Dr Cole-Sinclair expressed the opinion that Dr Robertson's formulation of the cause of death was not unreasonable from the macroscopic and microscopic findings contained in her autopsy report, however she added that she could find no evidence on which to absolutely exclude or definitely attribute death to infection. Dr Cole-Sinclair was not required to testify at inquest.

26. **Dr Anthony Landgren**, a Specialist Anatomical & Forensic Pathologist, provided a medico-legal opinion to solicitors representing Dr Sormann.[32] Having reviewed the autopsy report and other material provided to him, Dr Landgren agreed with the conclusions reached by Dr Robertson. In particular, he stated that Dr Robertson had identified clear evidence of sepsis, histological features of bronchopneumonia and a "left shift" in circulatory inflammatory cells consistent with a systemic reaction to infection.[33] He echoed Dr Robertson's reservations about postmortem microbiological cultures, and described the isolated pathogens as "not commonly associated with pneumonia but may be seen in septicaemia."[34]

CONCLUSIONS AS TO CAUSE OF DEATH

27. The weight of the evidence supports a finding that the cause of Ms James' death is as formulated by Dr Robertson. That is, death resulted from the complications of liposuction surgery, namely sepsis, decreased respiratory function secondary to microthrombi, fat emboli, probable inhalation of gastric contents and infection, and central nervous system depression due to a combination of drugs (pethidine and propoxyphene).

28. Although the possibility of necrotising fasciitis in its early stages cannot be entirely excluded, the weight of evidence before me does not support a finding that this was a

30 Exhibit MM page 2 and transcript commencing at page 1003.
31 The five page report dated 03/09/09 was part of Exhibit RR, the balance of the brief.
32 The three page report dated 29/10/09 was part of Exhibit RR, the balance of the brief.
33 Consistent with the report of Dr Cole-Sinclair, he stated that trauma associated with liposuction may also have contributed to the systemic reaction observed - the "left shift". See footnote 29.
34 See footnote 30.

probable cause of death or probable contributory factor. Even accepting Dr Robertson's evidence about the unreliability of postmortem (blood and) tissue cultures, it would have been preferable to have taken tissue cultures and then considered what weight, if any, should be attached to the results. At the very least the results would add to the factual matrix and could potentially exclude necrotising fasciitis, confirm infection and/or identify any pathogens in tissue.

29. While the finding of natural disease in the form of focal coronary artery disease was unexpected, I am satisfied that Ms James was asymptomatic, and that although unable to exclude the possibility that the disease contributed to death, I am not satisfied that this was probable as opposed to merely possible.

THE ADEQUACY OF POST-OPERATIVE MANAGEMENT

30. As already foreshadowed, it was the adequacy of post-operative management on the third post-operative day, Monday 22nd January 2007, that was the main focus of the coronial investigation and inquest into Ms James' death. Many aspects of pre-operative procedures were questioned during the inquest,[35] as were aspects of the procedure itself,[36] the surgeon's qualifications to perform liposuction,[37] and the choice of discharge medications/analgesia.[38] These issues were ultimately, either clarified during the course of the inquest, dispelled by the weight of other expert evidence, or insufficiently relevant or proximate to the cause of death.

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35 The protocol for provision of "atenolol" pre-operatively - although it was clarified that Ms James' was not required to take it as her heart rate was 47bpm (less than 50bpm) - transcript pages 291,

The adequacy of documentation provided pre-operatively as regards the risks associated with general anaesthetic and with liposuction was discussed but appeared ultimately to conform with prevailing standards - transcript pages 189, 277, 391, 1015-20.

36 The size of the cannulae used, the relatively short time taken to complete the procedure and the increased risk of trauma was questioned by Dr Flynn (Exhibit O & transcript page), addressed by Dr Dieu (transcript page 179) and also by Dr Carlisle (Exhibit Q & transcript page 349-51).

The need for routine antibiotic prophylaxis was raised but the weight of opinion was that it is not recommended for the procedure - ie suction assisted liposuction - transcript page186,

37 At transcript page 105 and following there is discussion about the fact that both Plastic & Reconstructive Surgeons and Cosmetic Practitioners/Surgeons perform liposuction in Australia, and about their relative strengths. The weight of the evidence before me did not support a finding of any inadequacy or problem with the procedure as performed by Mr Tam Dieu, who was a Plastic & Reconstructive Surgeon. However, I note that independent experts affiliated with each side agreed that irrespective of a medical practitioner's provenance or primary qualifications, there was a need for specific training and experience in performing liposuction surgery. (Dr Carlisle - Exhibit Q & transcript ; Dr Flynn - Exhibit O & transcript page 331 et seq.)

38 Transcript page 131 - Capodex, Nurofen (for the first two post-operative days), Diazepam (5mg - first night only), Metoclopromide PRN & clinical notes in Exhibit RR. Transcript page for the Anaesthetist, Dr Borsaru's evidence.

31. The context within which the post-operative management of Ms James falls to be assessed, is that of a preventable death of a previously fit and healthy twenty-six year old woman following elective cosmetic surgery by way of suction assisted liposuction. It is relatively unusual in my experience, to have evidence from such a range of expert medical witnesses, not only that the deceased *may* have survived with optimum clinical management but that she *would probably* have survived.[39] And this, from expert medical witnesses who were all well aware of the somewhat problematic cause of death as discussed above. Prof Cade put Ms James' chance of survival at its highest, testifying that had she been admitted to hospital in the afternoon of 22nd January 2007, she would *undoubtedly* have survived.[40] Dr Raftos puts the time for effective intervention as late as shortly before 9:00pm prior to her collapse and the calling of an ambulance.[41]

32. To some extent it follows, but in any event there is consensus among the expert witnesses who testified on this issue, that Ms James' presentation at COCAPS for review on the morning of 22nd January 2007, should have prompted more than the simple administration of further or stronger analgesia.[42] A patient who had been previously well, was experiencing increasing pain on the third post-operative day, after a normal enough clinical course on the preceding two days, required investigation of the cause of her increased pain, even without the indications of assymetrical swelling and greater pain in the left thigh region than the right. Without distinguishing the roles of the respective medical practitioners at this juncture, and what they knew or should have known about her clinical presentation, COCAPS as an entity failed in its obligation to provide adequate post-operative management of Ms James.

33. The more difficult question is whether any of the medical practitioners who were either involved in the provision of post-operative care to Ms James on 22nd January 2007, or should have been, so departed from the standards of their profession as to warrant an adverse coronial finding or comment. The determination of this question is not assisted by significantly divergent accounts between witnesses, inconsistent accounts from the same witness/es, a degree of reconstruction or *ex post facto* rationalisation on the part of some witnesses, the confounding effect of the particular arrangments for post-operative care at COCAPS, and the understandable effects of shock and trauma on all witnesses,

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39 Exhibits O, P, Q, KK, MM & transcript 292, 332, 365, 372. This is my interpretation of the effect of their evidence in its totality, including the treatability and/or preventability of those factors implicated in the cause of Ms James' death.

40 Transcript page 971.

41 Exhibit P and transcript pages 291-292.

42 Limiting my references here to their evidence at inquest - see transcript pages 246-7 for Dr Flynn's evidence in this regard; pages 282, 288 & 308 for Dr Raftos'; pages 345-6, 348 for Dr Carlisle's; page 1009 for Prof Marshall's.

particularly those close to Ms James, her partner Mr Simon Dal Zotto and her grandmother Ms Margaret Braley.

34. The standard of proof applicable to coronial findings generally is the civil standard of proof on the balance of probabilities with the *Briginshaw* gloss or explication.[43] The effect of the authorities is that adverse findings or comments should not be made against a professional person in their professional capacity unless the evidence affords a comfortable level of satisfaction that a failure to comply with the standards of their respective profession has been established as contributing to death.[44] It is that standard which I have applied to the evidence to reach my conclusions about what happened on 22nd January 2007, as regards the post-operative care provided to Ms James.

35. In the traditional model, a treating surgeon maintains responsibility for the post-operative care of his/her patient. While it is understood and acceptable that other medical practitioners may assist by reviewing a deteriorating patient when the treating surgeon is unavailable, they do not thereby assume responsibility for the patient beyond the extent of their review as locum and only as required by exigencies.[45] The arrangements at COCAPS departed from this norm in that post-operative care was shared between the treating surgeon and Dr Mervyn Cass who was the point of first contact for patients in the post-operative period providing a *triage* function akin to the role of a hospital resident. Dr Cass would deal with more routine post-operative matters and would exercise his discretion about the need to contact the treating surgeon for their clinical input or intervention with respect to more complex matters, or matters beyond his own expertise.[46]

36. In accordance with this arrangement, when he first became concerned about Ms James' condition on the afternoon of Sunday 21st January 2007, Mr Dal Zotto contacted the COCAPS paging service and Dr Cass returned his call a short time later. There are differences in the versions of each party to this conversation which I am unable to resolve. I find it equally likely that Mr Dal Zotto is mistaken about the sequence of symptoms in Ms James' deterioration and that Dr Cass was advised of bleeding and diarrhoea and failed to recollect or attach significance to these symptoms at that time. What is common ground is that Mr Dal Zotto told Dr Cass that Ms James was in pain and that Dr Cass

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43 *Briginshaw v Briginshaw (1938) 60 C. L. R. 336 especially at 362.*

44 *Anderson v Blashki [1932] 2 V.R. 89 at 95 per Gobbo, J; Secretary to the Department of Health and Community Services and Ors v Gurvich (1995) 2 V.R. 69 per Southwell, J; Chief Commissioner of Police v Hallenstein [1996] 2 V.R. 1.*

45 Exhibit Q, MM and the whole tenor of Mr Sormann's evidence on this issue.

46 Transcript pages 110, 134, 609 et seq, 824 et seq.

advised an increase in analgesia and to ring COCAPS in the morning to come in for review if the pain did not settle.[47]

37. The phone call was in due course placed and Mr Dal Zotto took Ms James to COCAPS for review the following morning arriving at about 10:30-10-45am. According to Mr Dal Zotto, Ms James required assistance to walk into the clinic and onto the examination trolley. After Dr Cass and Mr Sormann examined her, Ms James was reassured that the bleeding and pain were normal. She was given an injection for further pain relief and Endone tablets to take if the pain continued. They left at about 11.30am with the understanding that if her bleeding and pain worsened, Dr Cass would consider her for admission to hospital. Ms James was to be reviewed at about 4:00pm.[48]

38. **Nurse Bray** was one of the Registered Nurses employed at COCAPS who attended to Ms James on this occasion. She described Ms James as ambulating unaided but requiring assistance to the examination room and to get onto the trolley for examination. It was apparent that Ms James was in pain ,which she attributed to her left thigh. Once she had removed the bike shorts she was wearing in lieu of the prescribed pressure garment, it was apparent that she had bruising and swelling on both sides, but that the left thigh was slightly more bruised and swollen than the right, and firmer to palpation.[49] Nurse Bray was present when Ms James was examined by Dr Cass and by Mr Sormann. She left the examination room to obtain the 100mg Pethidine prescribe by Mr Sormann to relieve Ms James' pain and Zofran 4mg for nausea. She agreed that no investigations were discussed or ordered by the doctors, that the plan of management appeared to be "wait and see" the effects of the Pethidine and that consideration might be given at a later time to the need for hospitalisation if her pain persisted.[50]

39. **Nurse Morris'** evidence was broadly consistent as far as observations of Ms James. She described her as sitting "slumped in a chair", drowsy but easily rouseable and visibly distressed. She was wearing bike pants in lieu of her post-procedure garment which she explained she had been unable to put back on after her shower that morning. Nurse Morris noted severe bruising to both legs and buttocks, which she described as normal following liposuction and swelling of both legs from hip to ankle, with the left

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47 Exhibits A, Z, AA and RR the balance of the brief which contains the clinical notes. Transcript pages 31 and 616, 628.

48 Exhibit A.

49 Exhibit DD & EE and transcript from page 715. Nurse Bray also assisted with anaesthetics during the procedure on 19th January 2007 and made the routine follow-up phone call to Ms James on 20th January 2007 when she completed the pro forma checklist in the clinical notes (part of Exhibit RR) - see transcript page 722 and following.

50 Exhibit DD & EE and transcript pages 724, 734 and following.

thigh larger than the right.[51] Apart from administering the Pethidine and Zofran injection, Nurse Morris also provided Ms James with Endone tablets (oxycodone hydrochloride 5mg x 20 tablets), as prescribed by Mr Sormann, for ongoing analgesia to be taken one every six hours commencing at 5:00pm, that is after the Pethidine was expected to have worn off. Nurse Morris also testified that the possibility of a hospital admission was mentioned to Ms James several time,s but she insisted on being cared for at home, and that Mr Sormann told Ms James to keep her legs elevated during the drive home and at home and instructed her (ie Nurse Morris) to provide Ms James with pillows from the clinic for this purpose.[52]

40. Ms James was discharged by Nurse Morris at about 11:30am, without reference to any COCAPS protocol or directions from either Dr Cass or Mr Sormann as to any minimum period of observations after administration of the pethidine. Whilst I accept that Nurse Morris was a properly qualified nurse with extensive experience and that Mr Sormann relied on her clinical judgement in this regard, the weight of expert evidence before me supports a finding that the use of pethidine in an ambulatory patient in these circumstances was questionable, and more so without a significant period of observation in the order of three-four hours after administration.[53]

41. I have detailed the two nurses accounts as I found them to be credible and reliable witnesses, and also because I find it probable and reasonable that what was apparent to them about Ms James clinical presentation, should have been apparent to both doctors who examined her.[54] **Dr Cass'** first statement dated 24th January 2007[55] and his entries in the clinical notes are his earliest available documented observations of relevance to this investigation. It is this account which sits most comfortably with the evidence overall. According to this account Ms James complained of severe pain in the left thigh both medially and laterally, there was no evidence of deep vein thrombosis but her thigh was swollen and tense. Her calves were soft, non tender and no abnormalities were detected in the groin. Peripheral pulses were present and normal. In the absence of any clinical evidence of deep vein thrombosis or chest pain suggesting pulmonary embolus, the cause of pain was considered to be a haematoma in the left thigh. Ms James was provided with increased analgesia and Dr Dieu was informed.

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51 Exhibits R & S and transcript 436 and following.

52 Exhibits R & S and transcript page XXX

53 See comments made pursuant to section 67(3) of the Act below and the references to the relevant expert evidence at footnote 41.

54 Excluding of course those observations of Ms James before they entered the examination room.

55 Exhibit A. His second statement Exhibit ZZ dated 01/10/07 is in response to a number of questions about COCAPS procedures rather than addressing the clinical management of Ms James.

42. Similarly, **Mr Sormann's** statement dated 8th July 2009 sits most comfortably with his clinical notes and the evidence overall than the much more detailed account contained in the "instructions" provided to his legal representatives.[56] However, the omission from the first statement of any reference to the left thigh as being the focus of Ms James' pain and indeed to any localisation of swelling is in my view, colourable and self-serving. Mr Sormann's entry in the clinical notes clearly indicates that Ms James complained of severe pain in the *left* thigh medially and laterally.[57]

43. The crucial telephone call to Mr Tam Dieu at 11.30am is described in some detail by Mr Sormann in his first statement. The gist of the conversation according to Mr Sormann is that he told Mr Dieu that Ms James had extensive but not unusual bruising, a degree of pain which was not unusual, that he had administered 100mg Pethidine and that he should consider her for admission to hospital under his care for pain control if she did not settle.[58] A feature of Mr Sormann's evidence at inquest was his insistence that this conversation was an effective "handover" or rather return of the patient to the care of her treating surgeon after a locum intervention on his part and an expectation that Mr Dieu would review her as soon as possible.[59]

44. **Mr Dieu's** account of this conversation in his statement does not allude to the possibility of a hospital admission for Ms James. He was at his consulting rooms at Dandenong in the morning and at the Royal Children's Hospital conducting research in the afternoon. He was in no meaningful or relevant sense "unavailable" to attend to a post-operative patient such as Ms James. However, he testified that he gleaned no sense of urgency from Mr Sormann's telephone call to him at his consulting rooms, was reassured by his assessment that the pain and bruising was not unusual and planned to review Ms James about six hours later, when the pethidine had worn off. In the end, he did not call until 6:30pm when he was at home.[60]

45. In the intervening period all was not well for Ms James. After initial relief from the Pethidine injection, Ms James started to deteriorate in the afternoon, and from about 3:45pm Mr Dal Zotto made a series of telephone contacts with COCAPS in which he conveyed his concern and her symptoms - bleeding/oozing from incision sites, blood blisters, ongoing pain. Dr Cass called Mr Dieu at 4:07pm and advised him of these

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56 Exhibits FF and GG (from the bottom of page 3) respectively. Obviously there is no criticism implied of Mr Sormann's inclusion of his very extensive and impressive curriculum vitae.
57 Exhibit FF and clinical note dated 22/2/07 in Exhibit RR the balance of the brief.
58 Exhibit FF.
59 Transcript pages
60 Transcript page 134-5 and following, 166 and 203.

developments and of the need to check on Ms James. Three calls made by Mr Dal Zotto to the COCAPS paging service between 5:27pm and 6:06pm, were apparently despatched by the paging service, but never received by Dr Cass.[61]

46. When he did finally call at 6:30pm, Mr Dieu spoke to Mr Dal Zotto and reassured him that the blisters were likely to be related to the tapes and the swelling, reassured him that the swelling and bruising were not unexpected and that if Ms James was not feeling well by the following day he would like to review her at COCAPS. Mr Dieu's preparedness to "reassure" so comprehensively without eliciting any further history or details from Mr Dal Zotto, based presumably on information he had received seven hours earlier from Mr Sormann, over two hours earlier from Dr Cass and without having reviewed the patient himself, is one of the less edifying aspects of the circumstances surrounding Ms James' death. To the extent that Mr Dieu's evidence is at odds with Mr Dal Zotto's that he was told to give Ms James one Endone tablet at this time and did so, I find the latter more credible.

CONCLUSIONS

47. I find that Dr Cass, Mr Sormann and Mr Dieu were all under an obligation to ensure that arrangements at COCAPS for the provision of post-operative care were not only understood between them, but operated effectively from the patient's perspective. This required clear communication between them and co-operation. I further find that those arrangements modified, but did not fundamentally change, the treating surgeon's obligation to provide post-operative care, by interposing a triage contact with Dr Cass.

48. I find that at the review at 11:00am on 22nd January 2007, Dr Cass and Mr Sormann both failed to appreciate that Ms James was showing the signs of post-operative complications which required investigation and not just increased analgesia. As a consequence, Mr Sormann's discussion with Mr Dieu failed to communicate any urgency, as no urgency was perceived at the time. Their plan for Ms James can fairly be described as "wait and see" with a review envisaged at 4:00pm or thereabouts. I find it reasonable that Dr Cass deferred to Mr Sormann in the formulation of the plan for Ms James, but that he bore some ongoing responsibility for ensuring that the further review by Mr Dieu actually took place. I find that Mr Sormann's telephone discussion with Mr Dieu was sufficient to absolve him of any individual responsibility for Ms James' post-operative care thereafter, as opposed to any obligation he may bear as Director of COCAPS.[62]

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61 Exhibit OO and transcript page

62 See Dr Ceber's report in Exhibit RR, the balance of the brief.

49. I find that Mr Dieu failed in his obligation to provide adequate post-operative care to Ms James. He failed to review her in a timely way after the telephone discussion with Mr Sormann at 11:30am, during which he was appraised of sufficient facts to warrant investigation of the underlying cause of her increasing pain and her departure from the normal or expected clinical course. I do not accept that any failings on his behalf are expiated by reference to an appropriate deference to Mr Sormann as a senior surgeon. I find his telephone call to Mr Dal Zotto at 6:30pm, a wholly inadequate clinical response in all the circumstances, and his suggestion as late as 9:15pm that an emergency ambulance take Ms James to COCAPS so he could review her there, disturbing.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. I was advised at the inquest of changes made at COCAPS following Ms James' death which reflect a tacit acceptance of perceived problem practices. Patients are now given their treating surgeon's direct contact details to facilitate direct communication. A protocol is now in place which restricts the dispensing of "Endone" (oxycodone hydrochloride) to the hospital setting, and requires that all patients requiring injectable opiates remain at COCAPS for a minimum of three hours with full observations recorded over this time.[63] These are commendable initiatives which should improve patient safety at COCAPS.

2. This case highlights that one challenge for surgery performed in a day procedure clinic is the delivery of post-operative care. Whilst this broader issue is well beyond the reasonable scope of a coronial investigation of Ms James' death, it is apparent from this investigation that good lines of communication and clear communication between medical practitioners, staff and patients, as well as the clear demarcation of responsibilities, are imperatives for patient safety. To quote Professor Marshall's pithy testimony in this regard, without these imperatives - *"responsibility shared is responsibility reduced".*[64]

63 Exhibit AA which also details other changes to procedures/protocols.
64 Transcript page 1012.

DISTRIBUTION OF FINDING

The family of Ms James and all other parties represented at inquest
Royal Australasian College of Surgeons
Mr Ian R. Carlisle
Australasian College of Cosmetic Surgery
Mr John Hinton Flynn
Medical Practitioner's Board of Victoria
Nurses Registration Board
Department of Human Services - Health
Victorian Institute of Forensic Medicine

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 6th August, 2010