IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 547

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	Lillian Olive Blanche McClurkin
Delivered On:	29 May 2014
Delivered At:	Melbourne
Hearing Dates:	17-20 October 2011
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr M Wilson QC appeared on behalf of Stanlake Hospital trading as Western General Hospital Mr S Cash appeared on behalf of Associate Professor Nottle.
Police Coronial Support Unit	Leading Senior Constable G McFarlane was present to assist the Coroner.

I, JACQUI HAWKINS, Coroner having reviewed the investigation into the death of LILLIAN OLIVE BLANCHE MCCLURKIN

AND the inquest[1] held by Coroner Hendtlass on 17-20 October 2011 in relation to this death

At MELBOURNE

find that the identity of the deceased was LILLIAN OLIVE BLANCHE MCCLURKIN

born on 14 March 1945

and the death occurred on 10 February 2007

at Western General Hospital, Gordon Street, Footscray, Victoria 2011

from:

1(a) PERITONITIS

1(b) ANASTOMOTIC LEAK AT GASTRECTOMY SITE

2 PATHOLOGICAL OBESITY

in the following circumstances:

SUMMARY OF CIRCUMSTANCES

1. Mrs Lillian McClurkin was 61 years old when she died at the Western Hospital following complications of a laparoscopic sleeve gastrectomy. She was the much loved wife of Brian McClurkin. They both resided at 32 Evans Crescent in Laverton.

2. Mrs McClurkin's medical history included depression, osteoarthritis, asthma, obesity[2] with gastric banding surgery in 2001 and 2004, lower back and neck pain, hysterectomy, ischaemic heart disease and cholecystectomy. Her long-term general practitioner was Dr Kieran Keane from Laverton Medical Centre.

3. Mrs McClurkin had experienced significant difficulty maintaining a healthy weight and this caused her much distress. Two previous weight loss surgeries, although successful in the short term, did not achieve sufficient sustained results. The impact of the second surgery was that she would often regurgitate her food which was affecting her quality of life. She remained however determined to lose weight and accordingly discussed further options with Associate Professor Peter Nottle in 2006.

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1 This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

2 Throughout this finding I have used the word obesity in a clinical sense however I note the comments of Mr McClurkin at inquest that he did not believe this term reflected how he perceived his wife.

4. On 30 August 2006 AP Nottle reviewed Mrs McClurkin and advised Dr Keane that her weight was 'stuck' and she had not come to terms with her dietary requirements. They discussed a sleeve gastrectomy which is a gastric reduction performed laparoscopically and a further appointment was made.

5. On 21 September 2006, AP Nottle reviewed Mrs McClurkin and scheduled surgery for December 2006 to remove the lap band and perform a laparoscopic sleeve gastrectomy. Mrs McClurkin presented with shortness of breath on exertion which AP Nottle thought might be associated with a degree of ischaemic heart disease. He ordered tests and on 5 October 2006 Mrs McClurkin had an electrocardiogram (ECG) which indicated sinus rhythm and non-specific changes. On 9 October 2006 AP Nottle cancelled surgery and referred her to a cardiologist, Dr Deepna Haikerwal, for cardiac assessment.

6. Dr Haikerwal conducted a number of cardiac and respiratory tests throughout October and did not identify evidence of any ischaemic heart disease.[3] On 8 November 2006 Dr Haikerwal gave AP Nottle clearance for Mrs McClurkin's surgery and the operation was re-scheduled for February 2007.

7. On 6 February 2007 Mrs McClurkin was admitted to the Western Private Hospital for the elective sleeve gastrectomy. At 1755 hours she was anaesthetised and the surgery commenced. AP Nottle was assisted by Dr Michael Lo, Registrar and Dr Wendy Penderick, Anaesthetist. The operation took over three hours to complete and was uneventful, although difficult because of the multiple adhesions to her abdominal wall from previous surgeries. Mrs McClurkin returned to the ward at 2320 hours.

8. Three days post-surgery, on 9 February 2007, Mrs McClurkin was being assessed by Dr John Mathew when she suffered a cardiac arrest. Dr Mathew immediately commenced resuscitation and was quickly joined by other nursing staff and eventually a Mobile Intensive Care Ambulance (MICA) team arrived.

9. She was taken to the Western Hospital Emergency Department to access more specialised care. A computed tomography (CT scan) identified gas under the diaphragm. Mrs McClurkin was returned to theatre for a laparotomy where it was established that she had

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3 Exhibit 10 - Statement of Associate Professor Nottle, pp2-3.

free fluid in the peritoneal cavity. Mrs McClurkin suffered an hypoxic brain injury at the time of her cardiac arrest and a decision to remove life support was made the following day.

10. Mrs McClurkin died on 10 February 2007.

JURISDICTION

11. At the time of Mrs McClurkin's death the *Coroners Act 1985* (Vic) (the Act) applied.

12. From 1 November 2009, the *Coroners Act* 2008 (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

13. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

14. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

15. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[5]

ASSIGNMENT OF INQUEST FINDINGS

16. Coroner Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Ian Gray, assigned the completion of this Finding into Death with Inquest (finding) to me pursuant to section 96 of the Coroners Act.

17. In writing this finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements and exhibits. I have also read the transcript of the inquest.

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4 Section 89(4) of the Coroners Act.

5 Sections 72(1) and (2) of the Coroners Act.

CORONIAL INVESTIGATION AND INQUEST

18. Coroner Hendtlass held an inquest into the death of Mrs McClurkin on 17 October 2011 for four days.

Viva Voce evidence at the Inquest

19. The following witnesses were called to give *viva voce* evidence at the Inquest:

- Mr Brian McClurkin, Mrs McClurkin's husband
- Dr Geoffrey Dreher, Medical Practitioner, Consultant to Latrobe Health Services
- Ms Vicki Canning, Chief Executive Officer, Western Private Hospital
- Associate Professor Simon Woods, Executive Director of Medical Services, Cabrini Health
- Mr Alan Thomas, Surgical Consulting Group
- Dr John Mathew, Consultant Physician in General Medicine, Endocrinology and Diabetes
- Associate Professor Peter Nottle, Director, Laparoscopic Surgery, Western Health

Submissions

20. At the conclusion of the Inquest interested parties were invited to provide written submissions. Counsel representing all of the interested parties, including Latrobe Health Services who were not a party to the inquest, provided written submissions, which I have considered for the purpose of this finding.

Issues investigated

21. Section 67 of the Coroners Act requires me to find:

a) the identity of the deceased

b) the cause of death, and

c) the circumstances in which the death occurred.

IDENTITY OF THE DECEASED

22. I find the identity of Lillian Olive Blanche McClurkin was without dispute and required no additional investigation.[6]

CAUSE OF DEATH

23. Dr Shelley Robertson, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) conducted a post mortem examination on 14 February 2007. Dr Robertson ascribed the cause of Mrs McClurkin's death to:

    1(a) PERITONITIS

    1(b) ANASTOMOTIC LEAK AT GASTRECTOMY SITE

    2 PATHOLOGICAL OBESITY[7]

24. AP Nottle believed the peritoneal leak commenced on the evening of 8 February 2007. He commented that the leak was probably initially contained within the abdominal walls until it burst into the peritoneal cavity. This in turn created an arrhythmia which resulted in her cardiac arrest. He confirmed that sudden sepsis into the peritoneal cavity is well known to cause arrhythmias of that nature.[8]

25. Associate Professor Simon Woods[9] agreed with AP Nottle and commented that when a stomach perforates, it can either perforate freely or, if it occurs a day or two after the operation, the surrounding tissue may attempt to wall it off and contain the leak. That contained leak may then burst causing peritonitis.[10]

26. I agree that given Mrs McClurkin's sudden decline on 9 February 2007 this is the most likely cause and evolution of the peritonitis and subsequent cardiac arrest. The cardiac arrest resulted in a long period of anoxia and it was felt that she had suffered a non-survivable brain injury.

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6 Statement of Identification completed by Brian McClurkin, husband of Mrs McClurkin dated 12 February 2007.

7 Exhibit 13 - Inquest Brief of evidence, Autopsy Report, p5-6

8 Transcript of evidence, p269

9 Who was an expert engaged by Western Private Hospital to provide an opinion.

10 Transcript of evidence, p180

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

27. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Issues investigated as part of the Inquest

28. For the purpose of this finding I have considered the following issues:

- Decision to perform laparoscopic sleeve gastrectomy
- Consent to perform procedure and explanation of associated risks
- Time of commencement for the procedure
- Performance of procedure
- Onset of peritonitis
- Post-operative care including indications Mrs McClurkin was becoming unwell
- Resuscitation of Mrs McClurkin
- Inadequacy of documentation
- Changes to procedures and documents at Western Private Hospital

Decision to perform sleeve gastrectomy

29. Mrs McClurkin's first consultation with AP Nottle was in 2000.[11] He was thereafter involved in the management of her obesity. He had performed two lap band surgeries on Mrs McClurkin, in 2001 and 2004. However by 2006 it was evident that Mrs McClurkin was still experiencing difficulty managing her weight.

30. The primary reason for attempting the sleeve gastrectomy according to AP Nottle was that previous procedures had not been successful and had not produced adequate weight loss. Mrs McClurkin was also unable to tolerate the specific restrictions produced by the presence of the gastric band and experienced constant regurgitation, indigestion and heartburn after eating or lying down at night.[12]

31. AP Nottle further noted that a lack of understanding about eating behaviour is one of the major reasons for band failure.[13] It appears Mrs McClurkin had difficulty learning how to

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11 Exhibit 10 - Statement of Associate Professor Nottle, p1.

12 Exhibit 10 - Statement of Associate Professor Nottle, p3

13 Transcript of evidence, p246

modify her eating to account properly for the band which undermined the success of the procedures. This was documented by visits to AP Nottle's dietician.[14] The failure of the previous procedures significantly impacted Mrs McClurkin's quality of life.

32. As a result on 18 August 2006 AP Nottle discussed various options about other types of surgery that might assist her, including laparoscopic sleeve gastrectomy with a reversal of the lap band. AP Nottle stressed that she should discuss the procedure with Mr McClurkin and believed he made the increased risk of this surgery clear to her.[15]

Cardiac considerations and investigation

33. By 18 September 2006 Mrs McClurkin had decided to proceed with the sleeve gastrectomy and band reversal. AP Nottle thought Mrs McClurkin was experiencing shortness of breath on exertion which he thought might be associated with ischaemic heart disease. In a pre-operative assessment undertaken, her ECG showed ischaemic changes. Accordingly, on 9 October 2006 AP Nottle cancelled the planned sleeve gastrectomy surgery to allow for cardiac assessment with Dr Haikerwal.

34. On 23 October 2006 Mrs McClurkin underwent a Transthoracic Echo Report which indicated a normal left ventricular size and systolic function, no significant valvular abnormalities and mid-left ventricular hypertrophy. On 25 October 2006, she had a respiratory function assessment at Western Hospital which indicated normal spirometry with no significant bronchodilator response.

35. On 8 November 2006 Dr Haikerwal wrote to AP Nottle and confirmed that he had reviewed Mrs McClurkin and her results. He indicated he did not have any concerns about her having the sleeve gastrectomy procedure.[16]

Appropriateness of this type of surgery for Mrs McClurkin

36. The evidence demonstrated that all revisional surgeries are risky procedures.[17] Sleeve gastrectomy was a relatively new procedure in Australia at the time of Mrs McClurkin's

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14 Transcript of evidence, p250

15 Exhibit 10 - Statement of Associate Professor Nottle, p2.

16 Medical Records – Letter from Dr Haikerwal to AP Nottle

17 Transcript of evidence, p253

death. Since then there has been an increase in the number of bariatric procedures being performed in both the public and private systems.[18]

37. AP Nottle has significant experience and expertise with abdominal operations and this type of procedure.[19] As at 2008 he had performed 16 laparoscopic gastrectomies, 9 sleeve and 7 other.[20]

38. Although revisional surgeries generally are considered a risk, the operation of choice in the revisional setting is sleeve gastrectomy.[21] In fact most of the medical practitioners involved in this inquest agreed that sleeve surgery was appropriate. Dr Thomas said a gastric sleeve operation was absolutely a reasonable choice of operation after two lap bands.[22] Further he commented "I think it's the next appropriate step provided [she had] been counselled and I think in this circumstance [she had]".[23]

39. AP Woods agreed that laparoscopic sleeve gastrectomy was certainly a valid option.[24] Further, he said there were no easy options with a patient who has a body mass index (BMI) of 49, which is at the upper limit of morbid obesity and bordering on what is known as super obesity. This level of BMI increases the risk of mortality and in that sense, "bariatric surgery is less risky than remaining obese".[25]

40. Given Mrs McClurkin's obesity and her previous failed lap band surgeries, I accept the evidence of experienced bariatric surgeons such as AP Woods and AP Nottle that a sleeve gastrectomy was the most appropriate surgery for her in the circumstances. This offered her the best opportunity to improve her quality of life and alleviate the difficulties associated with her co-morbidities that occurred as a result of her weight.

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18 Transcript of evidence, p240

19 AP Nottle was involved in a working group that developed a handbook for the Department of Health Victoria "Surgery for Morbid Obesity - Framework for Bariatric Surgery in Victoria's Hospitals" 2009 due to his experience with bariatric surgery. Exhibit 11

20 Exhibit 10, Statement of Associate Professor Nottle, p.5

21 Transcript of evidence, p253

22 Transcript of evidence, p194

23 Transcript of evidence, p199

24 Transcript of evidence, p144

25 Transcript of evidence, p144

Consent to perform procedure and explanation of associated risks

41. Mr McClurkin noted that he did not believe that Mrs McClurkin needed the surgery and that the family had tried to talk her out of it. In evidence Mr McClurkin made assertions that he did not believe Mrs McClurkin had been advised of all the risks associated with revision surgery. However, he admitted his wife was adamant that she wanted to undergo the procedure.

42. The evidence of AP Nottle is that he explicitly told Mrs McClurkin there was an increased risk of leakage following a sleeve gastrectomy over gastric banding because the staple line could give way.

43. In evidence Mr McClurkin indicated that he did not attend all visits with Mrs McClurkin when she consulted AP Nottle and could not be sure what conversations had taken place. Accordingly, it is difficult to accept some of his evidence that certain things, such as risk factors, were not discussed with Mrs McClurkin at these appointments.[26]

44. Therefore, I find that Mrs McClurkin was aware of the risks, was adamant that she wanted the surgery to assist with her weight loss and signed a consent form on the day she was admitted to hospital for this operation[27] with the knowledge that the surgery carried risks.

Time of commencement for the procedure

45. The procedure was scheduled for 1500 hours on 6 February, however the surgery was late to start and Mrs McClurkin was only anaesthetised at 1755 hours.[28] The procedure took three and a half hours in total. AP Nottle indicated that this is not unusual as it often takes that long because of the nature of the surgery. Further, he said "it has to be meticulous, you have to take your time and you have to get it right".[29]

46. Mr McClurkin expressed the view that AP Nottle rushed the procedure because he was running late.

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26 Exhibit 3 - Statement of Dr George Dreher and Transcript of evidence, p27

27 Medical Records, Consent Form signed and dated 6 February 2007

28 Transcript of evidence, p35-36

29 Transcript of evidence, p255

47. AP Nottle considered there was absolutely no issue with commencing the procedure at 1800 hours. He specifically confirmed that because staff are rostered to start later they are all fresh[30] and ready to perform their functions.

48. Similarly, in Dr Thomas' opinion, although the surgery was performed late in the day there was no indication there was any hurry. However he did say that although there is no problem with starting an operation at 1800 hours because this was an extremely delicate and difficult operation, he did not consider it should have been scheduled that late.[31] Further, Dr Thomas said that if an individual had been working throughout the day, he considered that they would not be at their best for an operation that required such consistent concentration.[32]

49. AP Nottle noted the reason for commencing surgeries late in the day is often a matter of list availability, as it is quite difficult to get a surgery listed.[33] As such afternoon/evening starts to elective surgery are not out of the ordinary.[34]

50. Ms Canning was of a similar view. She believed that scheduling operating sessions at Western Private Hospital was consistent with operating sessions scheduled throughout all private hospitals in Victoria.[35] Further if they did not schedule operations in the evenings, it would cause surgery waiting lists to blow out.

51. I agree with Dr Thomas' conclusion that there was no evidence of anything having been omitted or having gone wrong as a consequence of the operation starting at that time.[36]

Performance of procedure

52. A number of factors were discussed at inquest as to the performance of this procedure. Revisional surgery can be quite difficult due to previous surgeries causing scar tissue and a thickening of the abdominal wall. It can also be complicated and technical due to the fact that it is done laparoscopically.

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30 Transcript of evidence, p254
31 Transcript of evidence, p188
32 Transcript of evidence, p188
33 Transcript of evidence, p254
34 Transcript of evidence, p255
35 Transcript of evidence, p85
36 Transcript of evidence, p199

53. The operation report indicated that Mrs McClurkin had extensive adhesions to the anterior abdominal wall due to her two previous lap band surgeries. This thickens the wall of the stomach and they first had to be removed. There were a lot more than had been evident after the first operation[37] and their removal took a long time. AP Nottle commented that these adhesions were an unexpected complication.

54. Surgeons rely on automated staplers which deliver six rows of staples. The staples used during revisional surgery are of a certain size and in some areas of the stomach can be loose or tight depending on the scar tissue.[38] In this case AP Nottle oversewed the opening to limit the risk of leakage.

Use of a drain

55. There was a suggestion that a drain should possibly have been used to avoid the difficulties presented by the leak that ultimately occurred.[39] AP Nottle indicated that he did not put a drain in place in this instance and believed that this was consistent with standard practice.[40] He noted "the problem with the drains is that they don't necessarily diagnose a leak and they can lead to a false sense of security".[41]

56. Dr Thomas said "I think at the time this operation was done, which was relatively early in the evolution of the laparoscopic procedure, the majority of surgeons would have placed a drain".[42] He agreed however that even now there was no real consensus as to whether a drain should be used.[43]

57. Ultimately it is a matter for each individual surgeon. Interestingly the surgeons that gave evidence who had used drains during this type of surgery both admitted that it did not detect the leak, therefore ultimately did not assist the treatment of their patients. Specifically, Dr Thomas said that out of 320 sleeve gastrectomies he had performed he had experienced one leak and it was not identified up by the drain.[44]

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37 Transcript of evidence, p255
38 Transcript of evidence, p169
39 Transcript of evidence, p145
40 Transcript of evidence, p257
41 Transcript of evidence, p258
42 Transcript of evidence, p189
43 Transcript of evidence, p190
44 Transcript of evidence, p191

Onset of peritonitis

58. There was discussion at the inquest about when the onset of peritonitis occurred. Most of the medical practitioners agreed that there was probably a slow contained leak into the peritoneal cavity on 8 February, before it burst in the afternoon of 9 February 2007.

59. AP Nottle believed the leak probably occurred on 8 February when her pulse was noted to increase.[45] He considered that the reason Mrs McClurkin did not deteriorate rapidly was because it was a small hole which was enough to control the leak initially.[46]

60. AP Nottle commented that he had never seen a patient rise out of bed who was suffering from generalised peritonitis and walk anywhere with or without assistance. He commented "if they're about to have a cardiac arrest, in other words die from ... peritonitis, it's just not something that anyone can do".[47]

61. Peritonitis usually occurs quickly. AP Woods considered that it was extraordinary for Mrs McClurkin's blood pressure to have gone from normal and her being able to walk around to her sudden arrest. This suggests there may have been some underlying vulnerability.[48]

Post-operative care including indications Mrs McClurkin was becoming unwell

62. To determine when the decline in Mrs McClurkin's health manifested and became apparent the post-operative care given to her was closely considered as part of the inquest.

63. Medical practitioners rely heavily on basic observations including pulse, temperature, the general look of the patient, inquiring how they feel and physical examination when assessing a patient post operatively.[49] AP Woods noted that in comparison to a leaner patient the detection of abdominal distension in an obese patient can be quite difficult. He added if you have a morbidly obese patient, it may not be apparent at all.[50]

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45 Transcript of evidence, p268
46 Transcript of evidence, p268
47 Transcript of evidence , p268
48 Transcript of evidence, p180
49 Transcript of evidence, p144
50 Transcript of evidence, p144

64. In addition according to Dr Thomas, the classic signs of peritonitis are often not present in obese individuals because they have a much greater tolerance and it is also difficult to elicit the signs because of the larger stomach.[51]

Clinical Assessment - 7 February 2007

65. On the first day post operation, Mrs McClurkin was drowsy but easily woken and had little pain. At 0800 hours AP Nottle reviewed Mrs McClurkin, ordered the removal of the nasogastric tube because she was uncomfortable and ordered a repeat test on haemoglobin levels. The blood tests indicated they were of a normal range.

66. At 1410 hours Mrs McClurkin was nauseated, vomiting small amounts, not tolerating fluids and complaining of pain that was unrelieved by Tramadol. The anaesthetist was informed and she ordered the Patient Control Analgesia (PCA) be commenced. At this stage Mrs McClurkin's condition was considered consistent with her post-operative stage and her nausea and pain was controlled with anti-emetics and the PCA.[52]

67. At 1800 hours Mrs McClurkin became tachycardic but was afebrile and the tachycardia later settled.

Clinical Assessment - 8 February 2007

68. On the second day of post surgery at 0515 hours, Mrs McClurkin was alert and oriented and the PCA was providing good pain relief. At 0700 hours she told AP Nottle that the pain had settled but she had abdominal cramps and lower abdominal pain. Blood tests were ordered, returned and showed a very mild elevation in her white cell count.[53] Unfortunately, this was not documented in the patient history and was only later discovered as part of the hospital's root cause analysis.

69. The PCA continued and Mrs McClurkin complained of pain and her nausea persisted. Her urinary output was poor and concentrated. Mrs McClurkin was reluctant to move or ambulate. During the day frequent demands on PCA were recorded on the pain control chart and documented in nursing notes.[54] The physiotherapist also noted a complaint of an

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51 Transcript of evidence, p198
52 Exhibit 5.9 - Root Cause Analysis.
53 Transcript of evidence, p264
54 Exhibit 5.9 - Root Cause Analysis.

increase in pain. However, the root cause analysis noted that nursing staff did not report Mrs McClurkin's condition to medical staff.[55]

70. According to AP Nottle there were encouraging signs. For example, he saw that as of 0730 hours there had been no need for pain relief since midnight the night before. Moreover there was no fever, no tachycardia and she had a normal abdominal examination. Based on these observations, AP Nottle concluded that this was a picture of a patient improving not deteriorating.[56]

Clinical Assessment - 9 February 2007

71. At 0450 hours Mrs McClurkin was provided with ventolin to assist with her asthma. She also had trouble moving and was nauseous and had vomited. Unfortunately this information was not passed on to AP Nottle.[57]

72. At 1100 hours tachycardia was observed and a concern was raised by nursing staff. AP Nottle asked Dr Lo to review Mrs McClurkin because she was having problems with her breathing.[58] Dr Lo ordered a chest xray and repeat blood tests which were printed at 1313 hours. The blood results showed that the levels of creatinine and urea had risen significantly in 24 hours indicating severe kidney disease. AP Nottle was not notified by Melbourne Pathology or nursing staff of these blood results. According to Melbourne Pathology's protocol these results were not sufficiently abnormal for urgent telephone reporting.[59]

73. In addition, Mrs McClurkin's urine output remained low[60] and there was a positive fluid balance recorded on the Fluid Balance Chart. Dr Lo reported back to AP Nottle and said that there was either a chest problem or fluid overload.[61] Mrs McClurkin was reviewed by Dr Mathew at 1730 hours and almost immediately upon his arrival went into cardiac arrest.

74. AP Nottle was not informed of any deterioration in the patient's condition after the discussion with Dr Lo.

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55 Exhibit 5.9 - Root Cause Analysis.
56 Transcript of evidence, p264
57 Transcript of evidence, p265
58 Transcript of evidence, p266
59 Exhibit 5.9 Root Cause Analysis.
60 Exhibit 5.9 Root Cause Analysis.
61 Transcript of evidence, p267

75. Overall the clinical picture was initially consistent with someone recovering from a sleeve gastrectomy. When things did start to decline in Mrs McClurkin's health I consider although communication between nursing staff and treating medical practitioners was not always optimal, things were acted on as quickly as possible.

Resuscitation of Mrs McClurkin

76. At 1730 hours on 9 February, Dr Mathew reviewed Mrs McClurkin and found that she was sitting on the bed, cyanosed with rattly breathing. Dr Mathew asked Mrs McClurkin to take some deep breaths which sounded clear on the stethoscope however she suddenly stopped breathing and became unresponsive. She had no heart sounds and her mouth was full of material which may have been gastric in origin. Resuscitation was immediately commenced and Dr Mathew was quickly assisted by medical and nursing staff from the coronary care unit, closely followed by a MICA unit. At 1915 hours Mrs McClurkin was transferred by ambulance to Western Hospital Emergency Department.

77. There was contradictory evidence about where Mrs McClurkin collapsed and was resuscitated. Mr McClurkin was initially in the room when Mrs McClurkin collapsed and believed that she was lying on a meal trolley when the medical staff were attempting CPR.[62] In evidence Dr Mathew was certain she was on the bed when he commenced resuscitation.[63] I consider the weight of the evidence suggests that Mrs McClurkin was resuscitated on her bed.

78. As to the time and adequacy of resuscitation Dr Mathew believed everything happened with commendable speed.[64] Ms Canning added the procedure was to immediately call MICA who were there within three minutes. Nursing staff would administer oxygen and CPR until they arrived or there was medical attendance on site. She confirmed the coronary care staff were instructed and trained in giving first line resuscitation until MICA arrived.[65]

Inadequacy of documentation

79. Concern was raised that medical record keeping practices may have led to problems with Mrs McClurkin's care and management. Dr Dreher noted the "medical record of Western

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62 Transcript of evidence, p16
63 Transcript of evidence, p231
64 Transcript of evidence, p232
65 Transcript of evidence, p118

Private Hospital is difficult to follow at times as few providers identify themselves by signing their name to any entry".[66]

80. AP Nottle and other medical staff indicated that they were able to understand and follow the medical records, despite their inadequacies.

81. Counsel for the hospital submitted that although there was a basis for criticism of the format and compilation of the various medical records at the time of Mrs McClurkin's admission, it did not contribute to her death.[67]

82. The documentation in the Western Private Health medical records was less than optimal. The medical records often lacked information, accuracy and clarity. However, Western Private Hospital proactively acknowledged these issues through their root cause analysis and Ms Canning candidly accepted that they were neither acceptable in their format nor compilation at the time.

Changes to procedures and documents at Western Private Hospital

83. Many lessons were learned as a result of Mrs McClurkin's death. Suggested improvements to documents and processes were recommended following the root cause analysis, to prevent such an incident occurring again.

84. Specifically, Western Private Hospital made the following recommendations in relation to processes:

- Introduction of Met Call (Medical Emergency Team) to establish criteria for reporting patients' condition to the consultant or registrar.
- Registrar to write in history when patient has been reviewed.
- Melbourne Pathology to contact consultant and nurse in charge of abnormal blood results in a timely manner.
- All laparoscopic revision bariatric cases to be managed in the High Dependency Unit.
- Staff are to document in history when they have contacted consultants regarding change of condition.

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66 Exhibit 3 - Statement of Dr Dreher, p4

67 Legal Submissions on behalf of Western Private Hospital dated 17 February 2012, p1

- All abnormal investigation results are to be notified to treating consultant by the nurse looking after the patient.
- Grade 5 nurse on duty to be notified of any change in patients' condition.
- Nursing staff to document in patients' history when a patient is reviewed by a consultant.
- Nursing staff to document in history if contact is made by telephone regarding a patients' condition between medical and nursing staff.[68]

85. In response to issues identified with respect to documentation Ms Canning noted that there were multiple forms requiring improvement and Western Private Health have attempted to rectify this.[69]

86. Specifically, Western Private Hospital introduced the following new documents as a result of this incident:

- *Observation Form*[70] - sheets are now colour coded making it easier to record observations and determine when things are outside safety parameters. [71] Ms Canning commented that there is now the ability for the consultant to write down specific reportable observations that they need to be notified about. There is also the 24-hour fluid balance summary which is included so there is access to the overall picture in a more easily recognised fashion. The last page contains instructions for the nursing staff on how to complete the charts.[72]
- *Patient Controlled Analgesia*[73] – pain score is now 1 out of 10 and on the bottom of the page.[74]
- *Fluid Balance Worksheet*[75] – Ms Canning commented that the fluid balance worksheet has removed the negative progressive total for the intake column. At the bottom of the sheet it does have a total intake and total outcome column to be completed.[76]

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68 Exhibit 5.9 Root Cause Analysis.
69 Transcript of evidence, p109
70 Exhibit 5.1 – Observation form
71 Transcript of evidence, p95
72 Transcript of evidence, pp95-96.
73 Exhibit 5.2 – Patient Controlled Analgesia form
74 Transcript of evidence, p87
75 Exhibit 5.3 – Fluid Balance Worksheet

- *Overnight Pre-Admission Assessment*[77] – as conducted over the phone with all patients coming in for elective overnight surgery.[78]
- *Intravenous Order*[79] – is a completely new form which has a more legible format.[80]
- *Western Private Hospital Medical Calling Criteria*[81]
- *Referral Algorithm for Clinical Deterioration*[82] – the algorithm can now assist identify a patient's clinical deterioration and explicit instructions on what to do for the nursing staff.[83]
- *General Policy on Documentation*[84]

87. I acknowledge the concerted effort made by Western Private Hospital to systematically review, identify and proactively rectify issues arising from the circumstances of Mrs McClurkin's death. The role of a coroner is greatly assisted by an open and collaborative approach to the reduction of preventable deaths and the promotion of public health and safety. To this end I commend Western Private Health for their approach to the coronial jurisdiction.

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76 Transcript of evidence, p93
77 Exhibit 5.4 – Overnight Pre Admission Assessment form
78 Transcript of evidence, p96
79 Exhibit 5.5 – Intravenous Order
80 Transcript of evidence, p97
81 Exhibit 5.6 – Western Private Hospital – Medical Calling Criteria
82 Exhibit 5.7 – Referral Algorithm for Clinical Deterioration
83 Transcript of evidence, p99
84 Exhibit 5.8 – General Policy on Documentation

FINDINGS

88. On the basis of all of the evidence available to me and on the balance of probabilities, I make the following findings.

89. I accept the cause of death provided by Dr Shelley Robertson and find that Lillian Olive Blanche McClurkin died on 10 February 2007 from:

1(a) PERITONITIS

1(b) ANASTOMOTIC LEAK AT GASTRECTOMY SITE

2 PATHOLOGICAL OBESITY

90. Given Mrs McClurkin's obesity, identification of her post-operative decline was difficult. The most probable account of events is that she had a peritoneal leak which was contained for three days post operation which then burst explaining her rapid deterioration and the fatal outcome.

91. I find that Mrs McClurkin was adamant that she wanted the surgery to assist with her weight loss and had signed a consent form on the day she was admitted to hospital for this operation[85] with the knowledge that the surgery carried serious risks.

92. I find that given Mrs McClurkin's medical history, including two previous lap band surgeries which had failed to assist her with her weight loss, AP Nottle's decision to conduct a laparoscopic sleeve gastrectomy was clinically appropriate. I was impressed with AP Nottle's forthright evidence and I find that his care and management was reasonable and appropriate in the circumstances.

93. I find that the resuscitation provided by Dr Mathew and other nursing and medical staff at the Western Private Hospital was reasonable and appropriate in the circumstances.

94. The documentation contained in the medical records was less than optimal however I find this did not contribute to her death. I acknowledge Western Private Hospital's concessions about the inadequate documentation and commend the improvements that have been made as a consequence of Mrs McClurkin's death. In light of this remedial action, I do not propose to make any recommendations pursuant to section 72(2) of the Coroners Act.

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85 Medical Records, Consent Form signed and dated 6 February 2007

95. Finally, I acknowledge the grief that Mrs McClurkin's family have experienced as a result of losing their loved one. I would also like to thank Mr Brian McClurkin for his patience and understanding over the course of the coronial investigation.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- Mr Brian McClurkin
- Western Private Hospital
- Associate Professor Nottle
- Latrobe Health Services

Signature:

Jacqui Hawkins

Coroner Jacqui Hawkins
Date: 29 May 2014