IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2006 / 4376

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: NOELLA RAE CLOHESY

Delivered On:	29 August, 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	11, 12 and 13 November 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr A Mukherjee on behalf of the relatives of the deceased Dr S Keeling on behalf of Warringal Private Hospital Mr B Ihle on behalf of Mr N Goldwasser Mr C Winneke on behalf of Dr M Waterfield
Police Coronial Support Unit	Senior Constable K Ramsey

I, JUDGE IAN L GRAY State Coroner, having investigated the death of NOELLA RAE CLOHESY

AND having held an inquest in relation to this death on 11, 12 and 13 November 2013
at Melbourne
find that the identity of the deceased was NOELLA RAE CLOHESY
born on 27 January 1944
and the death occurred 17 November 2006
at Warringal Private Hospital, 216 Burgundy St, Heidelberg
from:

1 (a) MULTI ORGAN FAILURE

1 (b) LACERATED AORTA COMPLICATING

1 (c) ABDOMINAL SURGERY FOR LAPAROSCOPIC BAND SURGERY AND HERNIA REPAIR

CONTRIBUTING FACTORS

2 ISCHAEMIC HEART DISEASE, HYPERTENSION, PAST HISTORY OF SMOKING, OBESITY

in the following circumstances:

Background – Brief Summary

2. Mrs Noella Clohesy was 62 years old at the time of her death. Mrs Clohesy had a medical history including hypertension, ischaemic heart disease which had required previous angioplasty and stenting, peptic ulcer, epilepsy and depression.

3. Mrs Clohesy was considered appropriate for a gastric lap band procedure. The procedure was to be conducted at the Warringal Private Hospital. A consent form was signed on 7 November 2006. On 15 November 2006 Mrs Clohesy attended at hospital for the procedure to be performed by laparoscope. Mrs Clohesy weighed 102 kilograms and was 167 centimetres tall, her BMI equating to 36.6.

4. Prior to surgery commencing Mrs Clohesy had a blood pressure of 105 over 65. Anaesthesia was commenced at 13.45 hours. Shortly after, Mrs Clohesy became brachycardic and hypotensive. This was not deemed to be unusual by the anaesthetist and ephedrine was administered. Mrs Clohesy's blood pressure remained low but her pulse increased. Surgery

commenced at 14.05 hours.

5. According to the surgeon, early in the surgery, Mrs Clohesy lost relaxation for a short time causing a "*vigorous heaving motion*"[1] as she contracted her muscles. The anaesthetist then re-established relaxation and surgery continued. Blood was seen on the trocar blade. The surgeon conducted a search of the peritoneal cavity but no bleeding or damage could be located. Surgery for the lap band was then continued.

6. Early in the operation, Mrs Clohesy became hypotensive and it was difficult for blood pressure measurements to be recorded. The difficulty in recording blood pressure continued until after the lap band surgery.

7. A hernia repair was then conducted. At this time, the fact that the patient had been hypotensive was communicated to the surgeon.

8. At the completion of the hernia repair, a femoral line was opened which revealed the systolic blood pressure was 50-60. Aramine, ephedrine and fluids were given and raised the pressure to 80-90 before it fell again. The surgeon conducted a final check for bleeding and closed the repair site. By this time, other doctors were assisting and advising on Mrs Clohesy's condition.

9. Other doctors remained in theatre to stabilise Mrs Clohesy. As her condition did not improve and tests for a cardiac condition did not indicate any problems along with her reading remaining low a provisional diagnosis of intra abdominal bleeding was made. Treatment was then commenced to stabilise Mrs Clohesy awaiting surgery to locate the site of any bleeding.

10. At 18.50 hours a second laparoscopy was conducted which located a 1cm tear in the aorta. A vascular surgeon then attended and repaired the tear. Treatment was then undertaken to stabilise Mrs Clohesy.

11. Mrs Clohesy continued to deteriorate and died on 17 November 2006 from multi organ failure.

Cause of Death

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[1] Statement of Mr Nicki Goldwasser, p1.

12. The autopsy was performed by Dr Shelley Robertson on 23 November 2006.

13. Dr Robertson gave the cause of death as:-

    1 (a) multi organ failure

    1 (b) lacerated aorta complicating

    1 (c) abdominal surgery for laparoscopic band surgery and hernia repair

    Contributing Factors

    2 Ischaemic heart disease, hypertension, past history of smoking, obesity.

14. The cause of death in this case is clear and uncontested: there is no dispute that Dr Robertson's report is an accurate description of the medical cause of death. It is accepted that the laceration of the aorta during the laparoscopic lap band surgery procedure performed by Mr Goldwasser led to the blood loss which brought on the multi-organ failure – the primary cause of Mrs Clohesy's death.

15. At the outset of the inquest through his counsel, and again at the conclusion of his own evidence at the inquest, Mr Goldwasser "*acknowledged his professional shortcomings*"[2]. I state at this point that I accept that Mr Goldwasser's acknowledgments were entirely appropriate, that he was deeply affected by the death of Mrs Clohesy and that his subsequent introspection and his expression of regret were sincere. His counsel, Mr Ihle put the following:

> *"It is to Mr Goldwasser's great and overwhelming regret that the injury to Ms Clohesy occurred during the insertion of the Visiport and the subsequent diagnosis of the injury and subsequent blood loss was delayed. This led to Ms Clohesy's ultimate and tragic death. Further, Mr Goldwasser accepts that his leaving the hospital may have contributed to a delay in the further surgical management of her condition. Mr Goldwasser's heartfelt sorrow and sense of loss go out to the family who have suffered the consequences and will continue to do so in the future. This tragedy has also had a lasting effect on him."*[3]

16. Also at the outset of the inquest, Mr Winneke, on behalf of his client Dr Waterfield, the anaesthetist, made an explicit concession. He did so in these terms:-

> *"it would be his concession, Your Honour, in his evidence that he did not communicate his concerns as to the issue relating to the blood pressure to them during the course of the operation. He didn't do so as he considered that the procedure was going smoothly. He felt albeit that there were issues with regard to the blood pressure that it was preferable that the operation be completed.*
>
> *Now, Your Honour, with the benefit of hindsight and in retrospect he recognises that Mr*

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[2] Submission of Mr Nicki Goldwasser, pg 1.

[3] Transcript pg 10 & 11.

Goldwasser should have been informed of his difficulties in measuring Mrs Clohesy's blood pressure. Equally, Your Honour, he would acknowledge that the possibility arising from the measurement of haemoglobin level may - it may have alerted him to the possibility of low blood pressure due to blood loss.

Unfortunately, Your Honour, he will say that he was simply not aware of the potential for retroperitoneal blood loss to occur without it being visible in the operative field. Essentially that's what he will say, Your Honour."[4]

17. I accept the sincerity of Dr Waterfield's concession and acknowledgment.

Focus/Scope

18. The focus of the investigation at inquest was on the circumstances surrounding Mrs Clohesy's death in the context of the laparoscopic lap band surgery. The central circumstance under investigation was the fact that bleeding resulting from the aortic injury was not detected and therefore not stopped for a long period. The bleeding took place over more than four hours. It led to the multi-organ failure. It is not contested that the cause of the bleeding was the aortic injury sustained when the abdominal aorta was cut inadvertently by the trocar blade.

19. A central issue was that of communication between the surgeon and the anaesthetist during the course of the lap banding operation

20. The questions were:-

- Did the anaesthetist properly (or at all) communicate the patient's decreasing blood pressure levels and his concerns about them to the surgeon?
- Did the surgeon and anaesthetist address/detect or suspect the true cause of the decreasing blood pressure and should they/could they have done so?
- What was done when, and by whom, to deal with the emergency created by Mrs Clohesy's blood loss?
- What were the reasons for and circumstances surrounding Mr Goldwasser's departure from the hospital and his delayed return after he was caught in traffic?
- Were the actions of either Mr Goldwasser and/or Dr Waterfield professionally below the appropriate standard and should they therefore attract criticism in these findings, bearing in mind the need to apply the *Briginshaw* test/standard?

The Witnesses

[4] Transcript pg 9 & 10.

Evidence was given by:-

The surgeon, Mr Goldwasser

The assistant surgeon, Mr Steedman

The anaesthetist, Dr Waterfield

Consultant, Dr Sylvester

Experts, Mr Thomas and Professor O'Brien

Timeline of the operation/medical procedure.

21. The procedure was conducted on 15 November 2006. The timeline for that procedure was:-

13.45 – Commencement of anaesthesia.

14.05 – Commencement of operation with "Visiport insertion under direct vision" (from surgical notes).

15.15 – Dr Waterfield detects problems with blood pressure.

17.00 – Dr Waterfield asks for assistance.

17.30 – Mr Goldwasser "closed" the operation.

18.50 – Operation to repair the punctured aorta.

22. After completing the lap band procedure, Mr Goldwasser performed a procedure on a hernia.

23. There is no serious suggestion that the care provided by Warringal Hospital and the steps taken prior to the operation being conducted were ineffective or inappropriate. I accept that standard procedures took place before the conduct of the operation on 15 November 2006. This followed admission, registration and a telephone consultation with the patient on 14 November 2006. I accept the submission on behalf of Warringal Hospital that the "*nursing care provided for Mrs Clohesy between admission to Warringal on 15 November 2006 and her death on 17 November 2006 was appropriate*"[5]. I accept also that "*the evidence...supports the contention that the hospital infrastructure and intensive care services provided to Mrs Clohesy were appropriate*".[6]

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[5] Submission on behalf of Warringal Hospital, pg 4.

[6] Ibid, pg 5.

24. In relation to the hernia repair, I find that Warringal Hospital was not informed by Mr Goldwasser prior to surgery that Mrs Clohesy was to undergo a hernia repair. This is not contested. I agree with Mr Thomas that "*a more stringent checking of consent forms is required and a 'time out' should be employed*".[7] Clearly, the consent form signed by Mrs Clohesy on 15 November 2006 stated that the surgery was for lap banding and did not include consent for hernia repair. I accept that Warringal was not aware that Mr Goldwasser intended to undertake a hernia repair on 15 November 2006 and I accept the matters set out in Warringal Hospital's submission in support of that proposition. I accept also evidence of Dr Waterfield on the point that he "*had no idea the patient was going to have an incisional hernia (repair)*"[8] and that the first he became aware of it was that "*when Mr Goldwasser began to ask for the...instruments*"[9]. I note and accept that "*there is no mention on the booking form for the operation or the consent form of an open repair of incisional hernia.*"[10]

25. Mrs Clohesy's past history included hypertension, ischaemic heart disease, bronchitis, epilepsy and depression. There had been three previous abdominal operations. The evidence does not suggest, and no witnesses expressed the view, that any of Mrs Clohesy's previous conditions indicated that the lap banding surgery should not take place. In short, on the medical evidence there was no reason why the procedure should not occur, as planned on 15 November 2006.

The laparoscopic procedure.

26. Mr Goldwasser's statement (Exhibit 20) sets out the detail of the procedures he performed. The operation was described as "*insertion of Lap Band, repair of incarnated hernia*". His assistant was Mr Paul Steedman and the anaesthetist was Dr Michael Waterfield. Present was Nurse Melanie Griffin, Inamed representative (the manufacturer/supplier of the Lap Band). Other persons present were nursing and operating room technicians and staff provided by Warringal Hospital.

27. In his statement, and in his evidence, Mr Goldwasser stated that he routinely asks the anaesthetist if it is ok to proceed at the outset. Entry is gained in to the abdominal cavity with

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[7] Further statement by Suzanne Hall, Director of Clinical Services, Warringal Hospital, pg 1.

[8] Transcript pg 281.

[9] Transcript pg 282.

[10] Report by Mr Alan Thomas, pg 3.

the use of a Visiport. His statement describes the mechanism of the Visiport and his observation of its progress. He said in his statement:-

> *"at the moment of triggering through the peritoneum the patient suddenly performed a vigorous heaving motion and contracted her abdominal muscles. The comment was made to the anaesthetist that the patient had "lost relaxation" and he said he was attending to it."*[11]

28. He stated that at the time the endoscopic view was momentarily obscured and he saw a small smear of blood. He then stated:-

> *"When muscle paralysis was re-established and the anaesthetist had indicated it was OK to proceed, vision was quickly re-established and gas was insufflated into the peritoneal cavity to achieve a pneumo-peritoneum. The entire peritoneal cavity was inspected carefully and no active bleeding, residual blood or tissue haematoma could be found."*[12]

29. He believed the patient was stable and continued the operation He described the balance of the lap banding procedure:-

> *"All this occurred in an uneventful manner, the operative field was bloodless and there was no communication from the anaesthetist that anything was amiss."*[13] *"Prior to this a careful inspection to the peritoneal cavity was again performed, systematically looking above and below the live lobes, the area of the LapBand, spleen, paracolic gutters, pelvis and intestines. There were no collections of blood and no sign of any bleeding. Thus the liver retractor and all the remaining ports were removed and the access port was inserted."*[14]

30. He then described the repair to the *"incarcerated incisional hernia"* and stated that:- *"as part of the procedure the peritoneal cavity was entered and no active bleeding was encountered."*[15] I accept this as an accurate summary of the surgery performed by him.

31. Mr Goldwasser then referred to becoming aware that another anaesthetist was present and said there was "some activity" present on the anaesthetic side of the raised sterile drapes:-

> *"Upon inquiring I was informed that there was a problem maintaining the patient's blood pressure. (The anaesthetist said that in fact he had had difficulty in determining the blood pressure even before the operation started). The abdominal wound was closed but there had been no visible bleeding/blood loss."*[16]

32. The non-disclosure (or failure) of the anaesthetist to inform the surgeon that there had been difficulty determining blood pressure from the outset is a major issue in this case.

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[11] Statement of Mr Nicki Goldwasser, pg 1.

[12] Ibid, pg 1.

[13] Ibid, pg 2.

[14] Ibid, pg 2.

[15] Ibid, pg 2.

[16] Ibid, pg 2.

33. After completing the procedures Mr Goldwasser says that he drove "around the block"[17]. I will comment on this later in these findings.

34. In his report, under the heading "Difficulties encountered during the initial surgery" Mr Goldwasser says:-

> *"From time to time the muscle relaxant wears off and the patient spasms and makes spontaneous movements during surgery. In this instance, when muscle relaxation was again re-established, a normal and a good intra-peritoneal view was obtained, and on a systematic survey no evidence of bleeding or injury was found. The anaesthetist did not express any concern about the stability of the patient and gave the go ahead for the operation to proceed."*[18]

35. On the evidence, it is clear that both Mr Goldwasser and Mr Steedman considered that the lap band procedure was essentially routine. Each confirmed that after the initial blood was seen on the tip of the trocar blade, checks were done for bleeding but none could be found, and each considered that the procedure was then carried onto completion in a relatively routine fashion.

36. At inquest Mr Goldwasser was asked:-

> *"During that time were you confident of the anatomy that you were exploring and engaging with the Visiport? – Yes...We know today and you have conceded that the use of the Visiport caused the injury to the aorta. At which point do you say today and at what time do you think you caused that injury? – I would say the injury happened at the time of the introduction of the Visiport into the patient. Which is, in other words, the start of the procedure? – Yes...Does that mean, Mr Goldwasser, you're saying that the patient first of all moved. Secondly, that that movement caused this procedure to go outside where you wanted it to, and thirdly that it therefore injured the aorta? – Yes. Why was this something that you didn't recognise at the time? – There was no evidence that I could detect that that occurred. Did you therefore have a suspicion that it had occurred? – Not really at the time. I was cognisant that an episode had occurred but it's not the first time that there had been a scenario with a patient who has jerked or moved during an operation."*[19]

37. Mr Goldwasser's evidence was that the "heaving" movement occurred during the process of inserting the Visiport. As to what followed, his evidence was:-

> *"I'm asking you now what you knew after the patient moved. Why do you not recognise or why did you not recognise that after this patient had moved in the manner that you suggest that there could be injury, inadvertent injury?"* His evidence was: *"The anaesthetist informed me that the patient was stable. When I proceeded to have the view of the*

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[17] Ibid, pg 3.

[18] Ibid, pgs 3 & 4.

[19] Transcript – pgs 405 & 406.

intraperitoneal cavity with the endoscope, I did a survey. That means looking, and this is something I do regardless of whether there's any movement of the patient or not. I did a survey of the intraperitoneal cavity which did not show any evidence whatsoever of blood loss or bleeding. So you suspected there had been an injury, did you?---No... What I said was that I didn't suspect an injury.

Why not?---There was no cause to specifically suspect an injury.

Why?---At that time there was no evidence of an injury having occurred.

What evidence, if any, did you look for?---Well, after the relaxation had been re-established, I then inserted the scope into the peritoneal cavity, performed the survey and there was no evidence of any injury.

At the time you were doing that, Mr Goldwasser, did you or did you not suspect a possibility of an injury?---Yes.

You did?---I think - I think that I was reassured by the fact that the survey failed to demonstrate any bleeding or blood loss.

Mr Goldwasser, at the time you were entering - starting this procedure with the Visiport, did you therefore suspect an injury? I want to be absolutely clear about this. Did you suspect an injury?---I didn't suspect an injury to the aorta.... Did you have in mind the devastating consequences that might flow if you had injured the aorta at the time that you began this procedure?---I didn't really consider that what had happened would have caused a severe injury.

However, you'd recognise this as a vigorous heaving motion?---Yes.

At the time?---Yes.

You heard from Professor O'Brien that in his opinion, and his experience this is an extremely rare occurrence if it did indeed occur. You heard that evidence, didn't you?---I heard that evidence.

This would have been a rare thing to happen to the degree that it did in your description; a vigorous heaving motion?---Not in my experience.

You see it a lot, do you?---I've seen it quite often, yes.

But it didn't cause you enough concern to think that this unusual incident, albeit not so in your experience, could have caused damage beyond the normal range of anatomy in your opinion?---I didn't think so, no.

And hence there was no need to check?---Well, I did check.

But you didn't check that there'd been a damage to the aorta, did you?---It's not such a straight forward proposition to say that laparoscopically you can check the aorta, not directly."[20]

38. Mr Goldwasser then gave evidence to the effect that it was not until there was a diagnosis of bleeding and hypovolemic shock that he retrospectively considered that there might have been an injury to the aorta occurring at the point in time when the patient moved.[21]

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[20] Ibid, pgs 407 – 410.

[21] Ibid, pgs 411-412.

39. In relation to whether there was, or was not, a "heaving" motion, anaesthetist Dr Waterfield says that he did not see a "vigorous heaving". (I note that he had the same vision on the screens as the surgeon). He was then asked:- *"So what did you see, if anything?---I didn't see anything. I heard um, Mr Goldwasser say, "Michael, the patient's heaving". OK - and so I gave the muscle relaxant."*[22] On this issue assistant surgeon Mr Steedman was asked "*Do you have a recollection of seeing a vigorous heaving motion?---No*"[23], Dr Waterfield said "*I didn't interpret it as a vigorous heaving motion.*"[24] I note that the surgeon, assistant surgeon and anaesthetist were all watching the same patient on the same screens. Professor O'Brien doubted that there was a "heaving" in the way described by Mr Goldwasser. In any event I am prepared to accept that there was some movement although I consider that the word "heaving" is probably an exaggerated description of it. I will deal in greater detail with this issue later in these findings.

40. Mr Goldwasser has insisted from the outset that the movement of the patient coincided with a loss of vision on his part. There is no reason not to accept his evidence on this point. The next thing that he did was to survey the area and satisfy himself that there was no evidence of any bleeding. He was asked if he suspected bleeding and he said that he did not. He then said:- "*No, but that doesn't mean you don't reassure oneself that bleeding hadn't occurred.*"[25] He then said:- "*I did not feel that there was sufficient injury that occurred especially to cause bleeding.*"[26] He maintained his insistence that he did not believe that what had occurred would have caused a significant injury. He satisfied himself of this in his words:- "*By introducing the endoscope after relaxation had been achieved and doing a survey, and not seeing any bleeding.*"[27] His evidence then was:-

> *"That sounds like a check for bleeding to me. Is that what you did?---It's an automatic thing that one checks for at all times during the operation.*
>
> *So it would have happened with or without the vigorous heaving motion?---Correct.*

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[22] Ibid, pg 295.

[23] Ibid, pg 87.

[24] Ibid, pg 295.

[25] Ibid, pg 415.

[26] Ibid, pg 415.

[27] Ibid, pg 417.

Therefore the vigorous heaving motion made no difference to your procedure at this time, did it?---No.

Thank you. So the procedure went on as normal according to your routine practice, didn't it?---Yes"[28]

41. The issue in the context of the surgical procedure is whether Mr Goldwasser was fully aware of the position of his instrument and how far it was from the aorta. The criticism of Mr Goldwasser is that he was not aware, at the time when the injury was sustained, exactly where his instrument was, but should have been aware of it.

42. In this context the following evidence of Mr Goldwasser is relevant:–

"I'm saying his opinion there is that all of this must have occurred without the surgeon realising where he was or what he was passing through?---At the time that it occurred I was at the point of the parietal peritoneum. Thereafter, vision was lost.
Vision was lost?---Yes.
Yes?---And I had no concept that I was proceeding further in.
I see. And you recognised that at the time did you?---I had no concept that I was proceeding further in.
You lost vision. That's also undesirable is it not?---Yes.
What does a loss of vision at this critical time do to your understanding of where you are in the anatomy?---You lose vision, you lose vision.
You can't see what you're doing? That's correct isn't it?---At that point in time I didn't believe I was doing anything.
What do you mean by that?---Well, when the heaving - when the heaving occurred I stopped whatever it was that I was doing."[29]

43. He went on to say, in explaining what he meant by "*proceeding further in*":-

"Well, I thought that I had stopped. Everything happens in a split moment, split second. When the heaving occurred I stopped. I'd already committed myself to the firing at the point of the parietal peritoneum, which is just under the muscle layer and as that - and while that was - while I was doing that firing the heaving occurred and I stopped, but I couldn't - I wasn't quick enough to stop the firing. But I didn't appreciate that it had gone in a lot further."[30]

44. Professor Paul O'Brien was called as an expert[31]. Professor O'Brien in his statement said:-

"The optical port allows a visualisation of the tissues encountered as the port - as the port is passed through the subcutaneous tissues, the muscle layers and the parietal peritoneum. Their optimal use requires that the surgeon recognise these various tissue layers as the tip of the device passes inwards and stops advancing the instrument after passing the parietal peritoneum." He goes on to say:- *"This could not have occurred in this case. For the injury to have occurred the cutting blade of the device which projects about one millimetre*

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[28] Ibid, pg 417

[29] Ibid, pg 418-419.

[30] Ibid, pg 420.

[31] His qualifications are "MD - MBBS (Honours) from Monash, then an MD and then an FRACS, a Fellow of the Royal Australasian College of Surgeons" – Transcript p98.

from the top with each firing would have had to pass the parietal peritoneum without the surgeon noticing, pass across the upper aspect of the greater omentum, pass through the transverse mesocolon, pass between the loops of the small intestine, pass through the peritoneum of the posterior abdominal wall, pass through the retroperitoneum fat layer, reach the anterior layer of the abdominal aorta and then cut a whole on the aorta to reach its lumen. All of this must have occurred without the surgeon realising where he was or what he was passing through. In an obese female there is typically a distance of 9-10 cm from the parietal peritoneum and the anterior wall of the aorta. Given that the Visiport should have stopped advancing just beyond the parietal peritoneum, the transit for the remaining distance is difficult to explain."[32]

45. He was asked about his report (Exhibit 8) by reference to his comment under the heading "*The injury was a technical error*". He was asked:-

"The comments about loss of muscle relaxation and the patient moving suddenly are a distraction and probably irrelevant. There has to have been a failure to follow correct technique for this event to occur." How confident are you in that conclusion?---I'm strongly confident.....But before you've got any insufflation you have to think about why it would change anything by having the muscles tighten. If anything, it enables the device to go through the muscle more easily. But once it's gone through the muscle it's got a long way to go in a lady such as Mrs Clohesy before it gets to the abdominal aorta. So by tightening it doesn't change that basic rule. And the implication was that it was a jerk. The - the Visiport has a little cutting blade at the bottom that projects out about 1 millimetre every time we fire it. So it suddenly shoots out and back again. You can't even see it it's so quick. But it cuts about 1 millimetre. The distance from the abdominal wall resting to the aorta, I estimated was maybe nine or ten centimetres. Even if I'm compressing it by pushing - you're pushing quite hard with this device, you're not just lightly holding it, you have to push - you might halve that distance but you've got still four or five centimetres. That takes 50 firings. That's not the way it reads. So, if anything, muscle relaxation makes it less likely to cause a perforation of the abdominal aorta..... And so for the surgeon, if there's a sudden movement, that can throw them offline and they've lost track of just where they were. One of the key things with an optical port, whether it be the Visiport or others that are available, is to keep track of where you are of the anatomy.... Professor, when you conclude at Point No.1 that the injury was a technical error what you really mean is that this was operator error, don't you?---Sure."[33]
Now, as I understand what Mr Goldwasser will say in his evidence, that that heaving of the abdominal muscle was accompanied by a movement forward towards the Visiport, albeit slight, but a movement by the patient forward as their abdominal muscles contracted. Is that something that you've taken into account at all in authoring your report?---As I said, you usually have the tensing of the muscles and I think it usually occurs when you - when you lose complete relaxation quickly. It's usually an effect rather than the cause. But I can't - I can't see a momentary lapse of relaxation with someone not pushing forward causing the peritoneum to be incised, the retroperitoneum being incised and everything in between and the fat and the abdominal aorta itself. There has to be a compensatory pushing forward, which is possible, or the - the point at which it was fired

[32] Exhibit 8: Report of Emeritus Professor Paul O'Brien.

[33] Transcript pp 101, 102, 103, 104.

was actually in the retroperitoneum already."[34]

He then detailed the trajectory of the Visiport/trocar through the anatomy.

46. On the subject of the patient's obesity he said:-

> *"The obesity of the patient, if anything, makes the process safer as there is greater distance between the abdominal wall surface and the abdominal aorta. The Visiport normally would pass from the skin to the parietal peritoneum as shown, a distance of maybe 4 – 8 cm depending on the thickness of the subcutaneous fat. The Visiport is pushed with considerable force and so there is compression of the fat layer and also there is some approximation of the parietal and posterior peritoneum but this latter effect is less in an obese person than a thin person.*
> *Loss of muscular relaxation does not account for event that happened. Before any insufflation has occurred, loss of muscle relaxation tightens the anterior abdominal wall making to more difficult to reach the aorta. It is only after insufflation, when the peritoneal cavity is filled with gas to create space that a loss of muscle relaxation will compress of that gas, further gas flow, which is pressure-regulated, will cease and the space is lost. That is not relevant in this case.*"[35]

47. The criticism of Mr Goldwasser is that he was not quick enough to stop the firing, didn't appreciate that "*it had gone in a lot further*"[36], he should not have let this occur, and that it only occurred because he had effectively "lost his way" within the anatomy and did not know with sufficient precision where the blade was when he fired it at that critical moment. In fact the blade had come into contact with the abdominal aorta.

48. It is clear that the injury to the aorta, leading to the blood loss and ultimately to the death, was caused, accidently, by Mr Goldwasser. In that sense, he clearly contributed to the death by causing the original injury. However, I accept that Mr Goldwasser was clearly not aware that he had caused an injury, that he searched for blood and found none, and that he then proceeded with the operation having been assured by the anaesthetist that all was in order.

Mr Goldwasser's departure from the surgery and the hospital.

49. In his statement (exhibit 21) Mr Goldwasser said:-

> *"There was no conscious decision on my part to leave the hospital. When I was eventually informed that there was difficulty obtaining a blood pressure on the patient, I was also told that this was a problem even before the commencement of the surgery. The patient had a past history of cardiac ischaemia, including an acute myocardial infarct. Throughout the operation no bleeding was observed, even though it had been sought. Her abdomen was lax, non distended and even somewhat scaphoid whilst she was being actively resuscitated. I considered cardiac ischaemia was the most likely aetiology. I was*

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[34] Ibid, pg 55-56.

[35] Report from Emeritus Professor Paul O'Brien, pg 3,

[36] Ibid, pg 3.

most distressed by the sequence of events and felt frustrated that I was not able to contribute. Over the years when I have been on call for surgical emergencies I have spent a lot of time driving from my home to the hospital. I would mentally go through the potential differential diagnoses and the steps I would take to manage each one. Thus for me the car became an environment where I would think through and analyse events. It was under these circumstances that I found myself driving in my car. I acknowledge that this was an unwise and inappropriate action to take.
My intention was not to leave the hospital for another destination, but to perform a circuit and return, always staying close to the hospital.
I find it difficult to determine how long I was away from the hospital after receiving the first call – probably in the region of 15 minutes – I was on my way back but stuck in heavy traffic.
It seemed to me the period between the first and second telephone calls was about 5 – 6 minutes, the latter as I was pulling up outside the hospital.
Again I find it difficult to determine the length of time but I would put it at about 20 – 25 minutes."[37]

50. In evidence he said:-

"You've accepted there was a delay in the diagnosis of the hypovolemic shock and bleeding. You in your view may or may not have had a contribution to that delay. I'm asking you to clarify what your view on your contribution, if any, to that delay is?.. Well, my initial understanding of what was occurring or what was thought may have occurred is that she had a cardiac issue which was responsible for the hypovolemia. I think that on my part it was a great mistake that I left the hospital. Yes?... And that would have contributed to the delayed management."[38]

51. Mr Goldwasser was asked questions about when he wrote his postoperative notes (Exhibit 9). In dealing with that point, he spoke further of his departure from the hospital. His evidence was:-

"What did you do after you finished writing this note, Mr Goldwasser?---I put it with the rest of the patient's notes.
And then what did you do?---At that point in time the – my ongoing impression was that it was a cardiac issue.
Yes?---And it was unresolved, and what was happening to the patient was a major event and I went down to speak to the family, and in particular Mr Clohesy, and explain to him that at the end of the operation there has been a problem maintaining the patient's blood pressure, that it appeared to be a cardiac problem and it hadn't been finally sorted out.
That's reflected in the question mark that you've put in your notes, isn't it "? Cardiac problem"?---Yes.
So you weren't sure that this was a cardiac problem, were you?---It was a working diagnosis.
It was your working diagnosis, was it?---Not only my working diagnosis.
But your working diagnosis also?---Yes.
At that time. Then you left the hospital, didn't you?---No.
What did you do?---Well, I had – I had been told, before I left the theatre, that the patient

[37] Exhibit 21 – Statement of Mr Nicki Goldwasser paras 6, 7 10, 11 & 12.

[38] Transcript pgs 397 & 398.

was going to be transferred to the intensive care unit. When I spoke to Mr Clohesy it was opposite the intensive care unit, a room which was opposite the unit, and then I waited for the patient to be transferred. The patient didn't appear, so I returned to the operating theatre and I reviewed the patient, particularly examined the patient's abdomen. I – I asked if there had been any further progress in working out what the problem was.
Yes?---And at that time I was told there was no further news.
Was this after you'd written your notes and completed your post-operative orders?---Yes.
And then what did you do?---Then, unfortunately, I was distressed at the time. I was – it's – no doctor is happy when there is a major problem with their patient. I was distressed at the time. I was considering what the options were as to what the diagnosis was. And for no good reason I found myself going to my car and driving around the block.
What do you mean for no good reason?---Well, it was a silly and mistaken thing to do.
Why was it, in those circumstances, silly and mistaken?---Because the patient was ill, was desperately ill, and I know full well especially it has been further reinforced that I should stay in the vicinity while the diagnosis was being processed. But at the time I really felt that it was a cardiac problem and that she was being attended to by people who specialise in that area... Why did you get into your car, Mr Goldwasser?---Over the years I have been called to emergencies and most of my thought process as to working out what was going on was driving from my home to the site of the emergency and processing what I was going to do in – how I was going to react to what particular circumstances there might be. Rather like planning a chess move. And that's what I did in this case.[39]

52. Under cross examination by Dr Keeling, for Warringal Hospital, Mr Goldwasser's evidence was:-

" Where you said, "I find it difficult to determine how long I was away from the hospital after receiving the first call, probably in the region of 15 minutes. I was on my way back but stuck in heavy traffic. It seemed to me that the period between the first and second telephone calls was about five to six minutes, the latter as I was pulling up outside the hospital. Again I find it difficult to determine the length of time but I would put it at about 20 to 25 minutes." And my question is, if this operation started at 19.50 hours – and that's if – that meant that you arrived – you would have left - - -?---At 19.50 or 16.50?
19.50?---Not 18.50.
No, I'm asking if it's found that this operation commenced at 19.50 hours and you allow maybe 15 minutes from the time that you arrive back at the hospital to the commencement of the operation, then 20 to 25 minutes means that you didn't leave the hospital until after seven o'clock, do you agree with that?---I've – I've got no idea and that 12 – Question 12 was in response to a question by the Board and I don't recall exactly what the question is. I really find it very difficult to talk about times, I have to say.
Yes, and also are you saying that you're not sure how long you were gone from the hospital?---I can't say how long I was gone exactly because I didn't time it. I didn't think it was – I – I don't know how long it was.... I suggest to you that you were – on the basis of your own evidence, that you were gone for 15 minutes or so before you get the second call and it only takes you five or six minutes to get back, that there's something that doesn't add up there in terms of - - -?---I was already on my way back when I received both calls.
Right. By the time you receive your first call you're already on the way back?---Yes. Yes.
And if it was five or six minutes, you say in this statement between calls, is that correct?---I don't remember exactly how long it was, that's a guesstimate.

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[39] Transcript pages 430 – 432.

Yes, the period between the first and second telephone calls was five to six minutes, and the latter as you're pulling up outside the hospital, so you're saying that you were only five minutes or so away from the hospital when you got the first call, is that correct?---I was in almost stationary traffic and I was inching back towards the hospital. I don't remember exactly where I was at the point I received the calls. My intention had never been to be far away from the hospital at all. And I don't – if there were no traffic problems I would not have been absent for any extended period of time."[40]

53. Mr Thomas, in his opinion, stated:-

"What view do you take of Dr Goldwasser driving around the block in these circumstances?---I - I - I can't fathom that at all."[41] ..... *"I think that's completely unacceptable."*[42] ..... *"I just want to make it clear on behalf of my client, he's not suggesting that he didn't do anything wrong by leaving the building?---Sure"*[43] .... *"But it's not good clinical practice to leave before you got your absolute diagnosis or the patient has gone to the intensive care unit."*[44]

54. I agree with Mr Thomas' assessment that Mr Goldwasser's departure from the hospital, *"completely unacceptable"*[45] and note Mr Goldwasser's fulsome concession on the point.

The Blood Pressure issue

55. This issue was examined in the context of the communication between the anaesthetist and the surgeon, the monitoring of the patient's blood pressure by the anaesthetist, the changes in the patient's blood pressure during the procedure and the subsequent level of significant bleeding.

56. The anaesthetist was Dr Michael Waterfield, a highly experienced anaesthetist. His statement and evidence referred to his pre-operative assessment and examination. He detailed the medications Mrs Clohesy was on before her surgery, and when they had been ceased. He noted that metoprolol and perindopril had been taken on the morning of admission together with drugs for gastric irritation and antidepressants. He considered her to have peripheral obesity – very fat arms and legs - and that it was hard to feel her radial pulses. At his first examination, prior to the operation, he assessed her blood pressure as "relatively low" at 105/65. His statement referred to the induction of anaesthesia and the maintenance of anaesthesia. He maintained the normal monitoring processes in respect of pulse waves, arterial blood saturation, ECG, end tidal CO2, non-invasive blood pressure monitoring. The

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[40] Ibid, pgs 467 – 469.

[41] Ibid, pg 38.

[42] Ibid, pg 39.

[43] Ibid, pg 64.

[44] Ibid, pg 64

[45] Ibid, pg 39.

anaesthetic procedure commenced at 13.45 hours on 15 November 2006. The operation itself commenced at 14.05 hours. In his notes Dr Waterfield states that:-

> *"within a very short time, before the abdominal surgery was underway the patient became bradycardic, 45/min and hypotensive, 80 mm systolic. In view of her pre-operative anti-hypertensive medication (Metoprolol) this was not surprising."*[46]

He gave ephedrine and the pulse rate increased but as he says in his report *"the blood pressure remained low and difficult to obtain with the N.I.B.P. cuff."*[47] He stated that *"the arterial saturation was always normal or near normal (98% - 93% range)."*[48] He referred to the intravenous administration of *"several doses of 0.5 mg aramine but only transitory rises in the blood pressure were obtained."* [49]. The anaesthetic record (Exhibit 3) tracks the blood pressure readings between 13.45 hours and 17.45 hours – a 4 hour period covering the laparoscopic surgery and hernia procedure performed by Mr Goldwasser.

57. The systolic blood pressure fluctuated but remained under 100mm but for one reading at 15.30 hours.

58. Early in his statement Dr Waterfield says *"There seemed no satisfactory explanation for the relatively low blood pressure. Certainly there was no revealed blood loss."*[50] He said in both his statement and in evidence that he began to doubt the accuracy of the non-invasive blood pressure readings as he was obtaining numerous error signals. He described the operation as:-

> *"proceeding very well.....but the unsatisfactory B.P. readings remained a concern. After nearly three hours I had given three litres of lactated Ringer's I.V. and numerous doses of Aramine. I had re-checked the operation sucker tubes, the drainage bottles and the operation site, and there was absolutely no evidence of any intra-peritoneal blood loss."*[51]

59. At this stage (after nearly 3 hours) he asked for help from another anaesthetist. He was joined in the surgery by Assistant Director of Intensive Care, Dr Bagshaw and then Dr JB Love, anaesthetist. Both made statements for this investigation. He stated that the initial thoughts of Drs Bagshaw and Love corresponded with his – that there must be some impairment of the patient's cardiac function, and that a cardiologist's advice ought to be obtained and that a better method of measuring blood pressure instituted. In his statement, he then described the actions taken to establish a femoral artery line, which confirmed that the hypotension was real

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[46] Report of Dr Michael Waterfield, 22/1/2008, pg 2

[47] Ibid, pg 2.

[48] Ibid, pg 2.

[49] Ibid, pg 3.

[50] Ibid, pg 3.

[51] Ibid, pg 3.

and *"only responding poorly to increasing doses of intra-vascular isotopes."*[52] As he said *"The central venous pressure was also low, so it became apparent that despite there being no revealed blood loss, blood loss must in fact be the problem."*[53]

60. In his report under the heading "Comment", Dr Waterfield said:-

> *"I was aware that blood pressure recordings were low and unsatisfactory but I did not recognise that it was due to a concealed blood loss. To have a major blood vessel punctured at operation and not see any bleeding must be extremely rare."*[54]

61. He said in his statement, and again in court, that in his 45 years of anaesthetic experience, he has never previously heard or read of it. He described Mr Goldwasser as:-

> *"careful and meticulous.....and if he were aware of any bleeding it would be his priority to attend to it. At the end of the operation he inspected the peritoneal cavity and wrote in the notes that there was no intra-peritoneal blood."*[55]

62. Towards the end of his statement, Dr Waterfield said:-

> *"the really devastating blood loss took place after the operation had been completed when the gas pressure had been released from the abdomen. At this stage the patient was under the care of myself, another anaesthetist and two senior intensivists."*[56]

63. Dr JB Love, consultant anaesthetist, provided a statement. He attended the operating theatre at 16.30 hours on 15 November 2006. He was asked to provide emergency assistance. In his statement, he states:-

> *"The operation had been underway for a number of hours when I was called to the theatre. I could not feel a pulse in her upper limbs although she had a palpable carotid pulse. Dr Waterfield informed me that the measurement of her blood pressure with an automated cuff had been difficult during the operation and associated with a number of error signals from the machine. The radial and brachial arteries were difficult to palpate and had not been cannulated for direct measurement of blood pressure although this would have resolved the uncertainty as to what the blood pressure was."*[57]

64. He described the actions that he and Dr Waterfield then took. He noted that while this was happening Mr Goldwasser complete the laparoscopic band operation and commenced the hernia operation. He then noted:- *"No discussion occurred between the surgeon and the*

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[52] Ibid, pg 4

[53] Ibid, pg 4.

[54] Ibid, pg 5

[55] Ibid, pg 5

[56] Ibid, pg 5

[57] Statement of Dr J B Love pg 1 & 2.

anaesthetist about the patient's condition at this time and the appropriateness of proceeding with the second procedure."[58] Later in his report he says:-

> *"Postoperatively during a discussion between Dr Waterfield and myself, Dr Waterfield stated that intra-operatively he had not informed the surgeon Mr Goldwasser that he was experiencing difficulty measuring the blood pressure."*[59]

65. Dr Waterfield, in evidence, did not dispute that he did not inform Mr Goldwasser of his concerns about blood pressure. Clearly this is recognised by his concession made at the outset of the inquest.

66. Dr Kevin Chan, Intensive Care Fellow at Warringal Hospital, co-wrote with Dr W Silvester, a clinical summary of events leading to death. In it he states:-

> *"There was significant periods of time during the operation when the blood pressure was unrecordable by sphygmomanometer. The blood pressure was not measured by intra-arterial cannulation. .....There was recognition by the anaesthetist that there was a problem with the patient's circulation."*[60]

67. Associate Professor William Silvester provided a statement and also gave evidence at the inquest. He was the Intensivist on call for the ICU of Warringal Hospital on the day in question. On 15 November 2006 he was called to assist with assessment and resuscitation of Mrs Clohesy. He went to the theatre, was briefed by Dr Bagshaw and told that there:-

> *"was no arterial access for blood pressure monitoring, that the anaesthetist (Dr Waterfield) had reported difficulty in obtaining blood pressure readings throughout the case and that Mrs Clohesy had received multiple boluses of Metaraminol throughout the operation."*[61]

68. He was told by Dr Bagshaw that he could not obtain a blood pressure reading and that he (Dr Bagshaw) had inserted a left femoral arterial line confirming Mrs Clohesy's systolic blood pressure was very low. Dr Bagshaw had then inserted an internal jugular catheter confirming a low central venous pressure despite the administration of IV fluid, consistent with blood loss. A/Prof Silvester stated that Dr Bagshaw's observations led him to a presumptive diagnosis of *"acute haemorrhage and haemorrhagic shock."*[62]

69. A/Prof Silvester inserted a large bore left internal jugular access catheter, and coordinated the fluid resuscitation of Mrs Clohesy. He gave evidence of the fluids he obtained, and administered to Mrs Clohesy. He dealt in detail with the subsequent treatment of Mrs Clohesy

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[58] Ibid, pg 2.

[59] Ibid, pg 4

[60] Clinical Summary & Events Leading to Death, Dr Kevin Chan and Dr W Silvester, pg 1.

[61] Statement of A/Prof William Silvester, Exhibit 10, para 10.

[62] Ibid, para. 12.

after the operation. He referred to the acute renal failure on 16 and 17 November 2006, a rise in her amylase level, a rise in her INR, ensuring dependence on a glucose infusion to maintain her blood sugar level – "*consistent with ischaemic hepatitis caused by the blood loss and hypovolaemic shock that occurred during the original operation.*"[63]

70. In his evidence, Dr Waterfield agreed that he should have spoken to the surgeon about his concerns about falling blood pressure, and not waited 1¾ - 2 hours into the operation[64]. This means that he should have done so at not later than approximately 15.50 hours. It is clear that the injury to the aorta was sustained very early in the operation, indeed effectively at the commencement of the operation. It is clear that from that point in time Dr Waterfield had "concerns" about Mrs Clohesy's blood pressure. On the whole of the evidence it is also clear, and he concedes, that he did not communicate his concerns either adequately or at all to the surgeon.

71. Clearly, sustained and continued bleeding led to the hypovolaemic shock and the ischaemic injuries that caused the death. Blood loss is the primary cause of death. Experts called at the inquest were critical of Dr Waterfield's failure to communicate his concerns to Mr Goldwasser. In my opinion, their criticisms are justified.

72. Mr Thomas, is a consultant general surgeon at Fremantle Hospital, Western Australia. In his report he said that he had reviewed all documents, noted the pre-operative management of the patient (and did not criticise it), noted Mrs Clohesy's previous significant medical conditions, including ischaemic heart disease. He noted that, as far as he could delineate from the notes, "*there was no suggestion of continued or severe angina.*"[65] He noted there was a history of hypertension, bronchitis, epilepsy and depression. He said, "*None of these conditions seemed acute or severe and all were quiescent or well controlled.*"[66]

73. He noted the medications taken by Mrs Clohesy. He stated:- "*Having reviewed the documents supplied I do not believe there are any concerns as regards the pre operative process.*"[67] He did not believe that "*any further pre-operative referrals to other specialists was necessary.*"[68]

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[63] Ibid, para 22.

[64] Transcript pgs 290 – 291.

[65] Report of Mr Alan Thomas, pg 2.

[66] Ibid, pg 2.

[67] Ibid, pg 3

[68] Ibid, pg 3.

He did observe that a "*pre operative set of blood tests, an ECG and possibly a chest X ray would have been indicated.*"[69]

74. In dealing with the events in the theatre on 15 November 2006 on the issue of blood pressure he said noting the induction (commencement) anaesthesia at 13.45 – 13 55 hours. He referred to the induction agents, the muscle relaxation, intubation and said " *all this was standard and initially uneventful.*"[70] He then referred to the significant bradycardic down to 42 min at its lowest within 20 – 30 minutes. He noted "*bradycadias and hypotension are not uncommon during the induction processes especially in patients taking beta blockers such as metoprolol*"[71] (which Mrs Clohesy was taking). He then noted that:-

> "*there was a normalisation of pulse rate within 5 – 10 min. There was little improvement in the systolic pressure for 2 hours (up to 16.15 hrs when systolic pressure is documented above 90 mmHg for the first time since induction). The improvement of blood pressure was also transient and the only reading over 100 mgHg was at 16.15 hrs. After this the readings were variously recorded between 80 and 90 mmHg systolic.*"[72]

75. He then referred to the various injections of intravenous fluids and noted that Dr Waterfield had noted on the anaesthetic sheet that there was difficulty in obtaining accurate BP readings during the operation. He noted the anaesthetic record and the operation notes and the presence of fresh blood on the tip of the Visiport. This had been attributed to Mr Goldwasser and Dr Steedman as pre-peritoneal blood rather than intra or retroperitoneal bleeding. He then said:-

> "*Dr Waterfield has stated in his testimony that there seemed no satisfactory reason for the relatively low blood pressure and he doubted the automatic blood pressure monitor cuff. This query persisted for the duration of the operation.*"

76. He went on to say :-

> "*There was no expression of concern about hypotension communicated to the surgeon at any point during the Lap Band operation or the subsequent incisional hernia repair. Instead Dr Waterfield was of the opinion that upon not seeing any obvious blood loss and from his previous knowledge of the meticulousness of the surgeon that the cause of the apparent hypotension was either cardiac in origin, a rare response to Mianserin and anaesthesia or ineffective non invasive monitoring.*
> *Whilst it is much easier to think logically about these events in the cold light of day and with knowledge of the outcome I have the following comments to make about the operative course.*

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[69] Ibid, pg 3.

[70] Ibid, pg 3

[71] Ibid, pg 3.

[72] Ibid, pgs 3 & 4.

In most circumstances when operating upon obese patients especially when the blood pressure is difficult to obtain due to limb obesity an arterial line (direct puncture of an artery, usually the radial in the wrist) is performed. I believe this should have occurred in this case. If puncture of the radial was not thought possible then a more central puncture such as the femoral artery should have occurred. If needed an ultra sound probe could have been brought into the theatre prior to commencement of the operation to facilitate this.

During the case if there was doubt as to the efficacy of the automatic blood pressure monitor a manual sphygmomanometer (blood pressure device) should have been sought."[73] *"there are not many circumstances that would cause a failure or only a minimal response. I can think only of these: Mycardial event, Blood loss (hypovolaemia) and anaphylactic reaction. All of these should probably result in an abortion of the operation or at least suspension of the procedure after communication of concerns with the surgeon."*[74]

77. And:-

"Ultimately here there has been a rare but known complication of the use of bladed trocars to gain access to the abdominal cavity. There has been a failure to associate hypotension with occult blood loss and a failure of the anaesthetist to communicate concerns during the surgical procedure. Once surgery had been completed there was some further delay in reoperating due to a failure to recognise the possibility of occult blood loss and due to the surgeon leaving the hospital. In my opinion there is no one event that has caused the death of Mrs Clohesy but an unfortunate set of circumstances, co-incidences and incorrect assumptions".[75]

78. His evidence at the inquest was:-

"Just in relation to that, Dr Goldwasser states and will give evidence that he was not aware of any hypotension during the course of the operation. Now, does that change your opinion of failing to associate this with blood loss?---No, he wasn't aware of it and you would - well, I would expect my anaesthetist to - to express some concern as to what was going on at the upper end. ...Is it fair to say that there's nothing substantive in terms of disagreement between you and Professor O'Brien when it comes to highlighting the deficiencies of care that was received by the patient in this case?---I think we're pretty much in agreement."[76]

79. Asked why in his opinion the surgery should have been delayed, he said:-

"Well, you have an uncontrolled situation with the heart rate going down I think to 42 and the blood pressure systolic being about 90. So if that situation requires remedy then allow that remedy to occur before the commencement of surgery itself. So it is simply because it's uncontrolled."[77]

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[73] Ibid, pg 5.

[74] Ibid, pg 6.

[75] Ibid, pgs 8 & 9.

[76] Transcript pgs 32, 33, 34, 36.

[77] Transcript, pg 37.

80. He was asked about Dr Waterfield's statement to the effect that it "*must be extraordinarily rare for aortic punctures to bleed without intra-abdominal bleeding or obvious signs*"[78], Mr Thomas was asked his opinion: "*How obvious should that point be to someone in Dr Waterfield's position?*"[79] He didn't think Dr Waterfield would come across that "*in any element of his training.*"[80] He himself (Mr Thomas) had dealt with three stabbings and described them as "*akin to a ruptured aortic aneurism.*"[81] He went onto say:-

> *"Probably most anaesthetists who've been in practice that length of time would have come across a ruptured aneurism and there is an analogy there and you do get that period of stability with very few signs before the catastrophic rupture occurs. In that case I would expect him to know about the aneurism scenario. Whether he made the connection between that and a similar effect occurring from a stabbing - well, clearly he didn't. Should he know that? I - as a surgeon I know that. As an anaesthetist, I don't know how many anaesthetists would. I think - I think everybody dealing in this field now should know, if they don't already. Is it fair to say that you're certainly clear that Mr Goldwasser should have known?---Yes.*"[82]

81. On the issue of communication between surgeon and anaesthetist, Mr Thomas had this to say:-

> *"Yes. Now, clearly you would say that, and as a general proposition (indistinct) said, I suppose, that it's important to communicate, that is, professionals engaging in a surgical procedure, anaesthetists and surgeons, have got to communicate with each other?---Absolutely.*
> *And if there are concerns, then it's important that they be communicated, you would say?---That's correct.*"[83]

82. Mr Thomas was asked by Mr Mukherjee (on behalf of Mr Clohesy):-

> "*And again in your capacity as an expert to this inquest can I get a sense from you that looking at this case in the round, in its totality, how far outside the scope of good clinical practice was the treatment administered to this patient?*"[84]

His answer was:-

> *"If you take all this together I think you have to conclude that it's a significant departure from a normal clinical pathway... I think the combined - the combined issues from both - both sides, if you've got everything together then I think that falls well below the standards acceptable.*"[85]

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[78] Ibid, pg 37.

[79] Ibid, pg 37.

[80] Ibid, pg 37.

[81] Ibid, pg 37.

[82] Ibid, pgs 37 & 38.

[83] Ibid, pg 70.

[84] Ibid, pg 39.

[85] Ibid, pg 40.

The opinion of Professor O'Brien

83. Professor O'Brien was convinced that Dr Waterfield hadn't recognised that there was serious bleeding or "*blood loss driving hypotension*"[86] and therefore didn't alert the surgeon.

84. Mr Thomas and Professor O'Brien agreed on the "deficiencies" of the approach taken by Dr Waterfield in managing the low blood pressure.

85. On the issue of the standard of the care provided, Professor O'Brien's opinion was:-

> *"And so I've made an opinion, that's all it is, that he hadn't recognised that there was serious bleeding. Either way if he had recognised there was serious bleeding, there's a duty on the anaesthetist to communicate that to a surgeon, is there not?---Absolutely. And I can't imagine any anaesthetist who recognised that would have the slightest hesitation to say to the surgeon something is wrong. And that's why I have the opinion that he hadn't been aware that there was bleeding. It's just - it's unthinkable that an anaesthetist thought there was blood loss driving hypotension and didn't say to the surgeon, "Something's wrong."..... in your professional opinion, as an expert to this court, was there a departure from acceptable standard of care, acceptable and reasonable treatment in the treatment of this patient, looking at both the anaesthetic treatment and the surgical treatment?---I don't know how you score these things, I don't have a scoring system. But there clearly was a departure from a reasonable level of care. We all make technical errors as surgeons, that's a part of our life. I've made technical errors. I'm sure anaesthetists at times are slow at making a diagnosis. And every anaesthetist will say, "I should have picked that up earlier." But in this situation I think it's gone beyond what is that reasonable level."*[87]

86. On the issue of communication between surgeon and anaesthetist, Professor O'Brien had this to say:-

> *"Well, if they don't communicate. But the silence is a communication. A silence to me - I can say nothing to my anaesthetist the whole operation because there are no issues. My anaesthetist is doing his or her job, I'm doing my job, we don't have any need to swap words. There's no checklist that we go through. .... But it just happened that Dr Waterfield didn't seem to feel he needed to communicate something to Dr Goldwasser."*[88]

87. In his view, the anaesthetist had made a diagnosis and is dealing with the issue without worrying the surgeon:–

> *"He's making a diagnosis, he can recognise hypotension and he's making a diagnosis that's related to a vasovagal effect or related to some pre-existing dehydration or whatever, you have to ask Dr Waterfield. But that's something in his responsibility and he will manage it. And bradycardia and hypotension at the start of an operation is not uncommon and our anaesthetists will just simply manage it and they won't even tell me unless it's quite profound. But they expect it to come back up pretty quickly. ..... And so it's a diagnosis. And he's made - at one stage he's got a diagnosis. He's working on that.*

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[86] Ibid, pg 105.

[87] Ibid, pgs 105, 106, 107 – 108.

[88] Ibid, pgs 108, 109.

What puzzles me is why he stayed with that diagnosis for as long as he did. ... You're looking at the chart and you're saying what's happening, why isn't something more active happening. ... You should be rethinking the possibilities and looking for other possible options."[89]

He described as "unthinkable" the proposition that the anaesthetist having recognised the extent of the blood pressure problem, would not communicate it to the surgeon.

88. Cross examined by Mr Winneke for Dr Waterfield, Professor O'Brien conceded that he is not an anaesthetist but made the following points:-

"I'm looking at a blood pressure chart and I'm saying something is wrong. .... I'm just looking at a patient's chart and I'm saying there's something badly wrong and there's not a response. Well, I'll come to that in due course?---That what I keep focusing on."[90]

89. Professor O'Brien agreed that in the circumstances he would not be surprised if there was *"bradycardia and a degree of hypotension."*[91] He then gave the following evidence:-

"Now, that again from your perspective of a surgeon you would say to the anaesthetist - well, you wouldn't say, I suppose - but you would leave it to the anaesthetist to form his own view about whether or not the degree of bradycardia and hypotension is, as far as they're concerned, satisfactory and if it's, as far as they're concerned, satisfactory, you as a surgeon would be content to proceed. Is that correct?---Yes, with a qualification that I'm aware of this happening because my anaesthetists commonly say to me at the start of a procedure can you just hold off for a minute, the blood pressure's a bit low, and I stop."[92] *..... " You say in your statement that, "I cannot see why the anaesthetist was so slow in reacting. Here was a person failing before his eyes yet he took hours to react appropriately." I take it it was on the basis of the anaesthetic report that you came to that conclusion, is that right?---The anaesthetic page, yeah. The anaesthetic page?---Yeah. Yeah, persisting hypotension. Are you aware that there are views or there have been views that surgery can be carried out with a degree of hypotension?---May well be. I guess we're in a situation where the lady's got a hole in her aorta and she's hypotensive and to go off into some other area doesn't help me a lot in my thinking."*[93] *... "You might ask whether it's normal to have persisting hypotension during surgery during anaesthesia and that's something you should - I would - my impression would be no, but as a surgeon. But you need to address that to an anaesthetist and say is this as an acceptable pattern for a patient in routine elective surgery."*[94] *... But again, what you're conceding is what reasonable blood pressure is, the reasonable parameters, to be fair, are not your area of expertise?---Well, we don't accept hypotension as being a normal state and therefore we say why is this so. We have to look for a cause. And if we haven't got a simple cause that we can correct, in an operating theatre where we're doing things inside the abdomen it's*

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[89] Ibid, pg 109.

[90] Ibid, pg 144.

[91] Ibid, pg 146.

[92] Ibid. pg 146.

[93] Ibid, pg 148.

[94] Ibid, 148-149.

very simple to ask the surgeon, "Do you think there's some bleeding? I can't get the blood pressure up." He's trying to get the blood pressure up. He knows he wants to get the blood pressure up. He's got a clear view the blood pressure is too low but he hasn't said to the surgeon, "We have a problem."[95] .... *"And in your statement you've said that - and I take it that the point that you make is that the blood pressure remained low throughout the course of the procedure and that was a concern. Is that right?---Absolutely. You do accept that the blood pressure did rise to above 100? ---I can't recall the detail now of that page. But there was a pattern on it that was a worrying pattern of hypotension."*[96] .... *"Well, if it's written there I would accept that Dr Waterfield wrote it down correctly. And if there was a rise to about 100 would that be of some significance?---If it remained stable at that. One of the other things I'm conscious of was that Dr Waterfield had difficulty in measuring the blood pressure. And of course that leaves him and then Mrs Clohesy very vulnerable. It's so important in this situation to have some accurate measure of blood pressure."*[97]

90. After some discussion about the anaesthetic record (Exhibit 14), and what the readings are, it was agreed that at about 16.15 hours the blood pressure appeared to be 100 and thereafter dropped down again to 90. Professor O'Brien then gave the following evidence:-

"Now, that might be a concern that it drops down again?---All the time I think fluids were being given. They're going somewhere. They're not holding the blood pressure in spite of those things. Laparoscopic surgery doesn't lose any fluid as a normal process. So you've got to say why are we chasing this, why are we looking, why are we - sorry, chasing the blood pressure. When we're giving fluids it should be up into a normal range."[98] ... *And that's the sense that you got. I take it that you read his report in which he said he considered the possibility of blood loss? Did you read that?---If he really considered it he would have said something to Dr Goldwasser. It's just, as I said, unthinkable that something would be in the mind of the anaesthetist of that importance and that relevance to the surgeon are not communicated, if it's really a key thought."*[99] ... *"Dr Love, Dr Bagshaw, Dr Goldwasser, Dr Steedman didn't consider bleeding, or at least didn't conclude that it was bleeding. And indeed Dr Goldwasser left the surgery?---And that was a mistake. But you're critical of Dr Waterfield for not picking it up? ---I'm critical of the care that was given in managing this person's prolonged hypotension. I'm not trying to lay blame anywhere. I'm trying to help the Coroner and understand what might have led to this lady's death."*[100] ... *"I felt the Coroner was moving towards a situation of saying, well, the problem here is failure of communication. And I was thinking, well, I don't see it that way. I see it as failure of recognition of a problem, not of communicating the problem, but I feel they hadn't recognised the problem. They didn't need to communicate because they had nothing in their mind to communicate."*[101] ... *"And what's*

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[95] Ibid, pg 149.

[96] Ibid, pg 151.

[97] Ibid, pg 151.

[98] Ibid, pg 152.

[99] Ibid, pg 153.

[100] Ibid, pg 154.

[101] Ibid, pg 154- 155.

that evidence?---Well, persisting hypotension in the face of fluid replacement."[102] ... *"Are you able to offer a view as to what the patient's anti-hypertensive medication might - what effect that might have had, if any?---No, not particularly. I did note she was on anti-hypertensive, but I'm not sure whether they were given that day or not. Well, if they were given on that day would it be relevant?---I - you'd have to ask the anaesthetist, sorry. Well, did you take that into consideration when you made this statement?---No. Why not?---Because I don't think it's relevant. I think here's someone who's got hypotension, prolonged, and you've got to find a cause. And they haven't got a cause. And yet things are allowed to continue. But what I'm asking you, sir, is that - I'm asking you what effect, in your view, the anti-hypertensive medication might have had?---Well, I doubt it would have much. But I don't know exactly what it would have. But if I was looking after the patient the first thing I would do would look for remediable causes. And I - and one of those is to stop losing blood."*[103]

I agree that the failing here was a failure to "recognise" the problem.

91. Mr Winneke asked if blood loss should have been considered as a possible cause of the hypotension. Professor O'Brien said that it should have and this was his evidence:-

"Equally, it would be reasonable in circumstances where there is no apparent blood in the operative field, no apparent blood in suction tubes to consider alternative possibilities for the hypotension. Is that reasonable to do?---You should consider all but have them in priority. But once you've got the problem of persisting hypotension one of the first things we'd do would be to stop operating. And that didn't happen. And what you say is that the anaesthetist should have mentioned to the surgeon that he was concerned about hypotension? ---Yep."[104]

In this evidence, Professor O'Brien makes sensible concessions but the essence of his opinion appears to be unchanged.

The Submissions

<u>The surgeon – Mr Goldwasser</u>

92. I agree with the submission that the "*material issue for consideration by this Court is when, and under what circumstances, was the trocar blade fired so as to cause the injury as it did?*"[105]. I agree that the last firing of the blade must have been the one that occasioned the injury.

93. In relation to the "heaving motion", I have already said that I regard Mr Goldwasser's language as exaggerated but I note that the submission draws attention to the evidence of Dr Waterfield as soon as the event happened:-

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[102] Ibid, pg 155.

[103] Ibid, pg 155-156.

[104] Ibid, pg 159.

[105] Submission on behalf of Mr Nicki Goldwasser, para 5.

"It is significant to note that Mr Goldwasser made a comment regarding the heaving motions to his anaesthetist, Dr Waterfield, as soon as it happened. Dr Waterfield gave sworn evidence on this:
"So what did you see, if anything? ---I didn't see anything. I heard um, Mr Goldwasser say, "Michael, the patient's heaving". OK – and so I gave the muscle relaxant."[106]

94. I accept that the patient moved and that Dr Waterfield's evidence provides some corroboration of the surgeon's description of the movement.

95. The essence of Mr Goldwasser's position on this is that the movement of the patient precisely coincided with the final firing of the trocar blade leading to the cutting of the abdominal aorta.

96. In the submission, the following theory is advanced :-

"It was the final firing at the anterior peritoneal wall (which would most likely have abutted the posterior peritoneum and therefore the aorta) which Mr Goldwasser says he was physically committed to doing when Mrs Clohesy "vigorously heaved". Such heaving would have compressed the limited space and structures between the end of the trocar and the aorta. It would have also drawn the peritoneum taut, and the aorta wall taut. Undoubtedly this is when the aorta was damaged. It was the disastrous conflation of those two occurrences (the firing which was already passed a point where it could be stopped and the unexpected heaving) at the exact same time which brought the blade into contact with a critical vessel to which it should never have been close."[107]

97. This theory is cogent enough as an explanation, but Mr Goldwasser's own evidence contains concessions that he was not certain exactly where he was at the point of the last firing of the trocar. This part of his submission needs to be seen in the light of that concession.

98. Ultimately, I conclude that he accidentally cut the aorta and that when he did, he appears not to have known precisely where the end of the trocar blade was. Whether Mrs Clohesy's movement was a vigorous "heaving" or otherwise, I accept that the movement coincided in time with the immediate proximity of the trocar blade to the abdominal aorta. The positioning of the trocar blade at that point, was clearly potentially dangerous and, noting that movement of patients are not unusual (indeed common, on Mr Goldwasser's evidence), he had clearly allowed the blade to get too close to the abdominal aorta. The proximity of the blade to the abdominal aorta suggests a degree of carelessness.

99. However, I do not make this finding on the higher standard of proof required by the application of the decision in *Briginshaw*.[108] I do not do so because it is not possible to determine with sufficient accuracy the contribution of the movement of the patient to the

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[106] Ibid, para 9.

[107] Ibid, para 20.

[108] *Briginshaw v Briginshaw (1938) 60 CLR 336*

position of the blade to justify a clearly adverse finding against the surgeon on the point. I am satisfied that the movement of the patient has probably contributed to the proximity of the blade to the abdominal aorta. However it is not possible to determine with precision the degree of that contribution. Mr Goldwasser should have known with greater certainty and precision where the trocar blade was, and exhibited a degree of carelessness in its positioning at this point, but the patient's movement must be factored in to the evaluation of the professional failing on the part of this extremely experienced surgeon on this occasion and, applying the *Briginshaw* test, I am not satisfied to the necessary degree.

100. In relation to Mr Goldwasser leaving the hospital, having regard to the whole of the evidence and given his concession, again applying the *Briginshaw* standard, I find that this conduct did indeed fall below the relevant professional standard.

The anaesthetist – Dr Waterfield

101. I accept the submission made on Dr Waterfield's behalf to the effect that:-

> "*the evidence does not enable the Coroner to conclude that the tragic outcome would have been averted if Dr Waterfield had informed Mr Goldwasser of his concerns earlier than he did.*"[109]

102. I accept that this would involve a degree of speculation – the outcome would not necessarily have been averted. However, given the evidence about Mrs Clohesy's other co-morbidities (none of them immediately life threatening), it probably would have been averted. It is reasonable on balance to conclude that if the bleeding had been stopped at 15.15 hours, or shortly after, Mrs Clohesy would probably not have died.

103. I agree that it cannot be concluded that any conduct of Dr Waterfield's was directly "*causal*"[110] in relation to Mrs Clohesy's death. However, his failure to communicate his concerns about hypotension over time (and clearly he agrees that he should have) ultimately falls below the relevant standard. It seems to me elementary that surgeons and anaesthetists would be expected to be, (and normally would be), communicating during the course of a procedure such as this, to ensure that both are aware of any concerns the other had as the operation progressed.

104. Applying the *Briginshaw* standard, Dr Waterfield's failure to communicate his concerns about falling blood pressure did, in my view, fall below an acceptable standard. He had concerns,

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[109] Submission on behalf of Dr Michael Waterfield, para 42.

[110] Ibid, para 41.

but didn't tell the surgeon he had them; he sought the assistance of other anaesthetists and told them that he had had concerns during the course of the operation, but he did not communicate these concerns to the surgeon. He should have done so at or soon after 1500 hours.

Warringal Private Hospital

105. The submission on behalf of Warringal Hospital states:-

> *"The evidence before the Court supports the following findings, pursuant to the provisions of s.67(3) of the Coroners Act 2008 (Vic), in which a coroner may comment on any connection between the conduct of Warringal and Mrs Clohesy's death.:*
> *(a) nursing staff provided appropriate care to Mrs Clohesy, including pre-operative care;*
> *(b) provided appropriate equipment and facilities for the medical care of Mrs Clohesy;*
> *(c) was not informed by Mr Goldwasser that Mrs Clohesy was to undergo a hernia repair;*
> *(d) had appropriate accreditation procedures for visiting medical practitioners; and*
> *(e) did not contribute to Mrs Clohesy's death."*[111]

106. I accept the evidence of Ms Suzanne Hall and the submission as set out above.

COMMENTS

107. I note the evidence given by Mr Thomas, under cross examination by Mr Ihle (for Mr Goldwasser):-

> *"It's this bit that I'm specifically concerned with, "In particular it should be emphasised that significant retroperitoneal bleeding can occur without any intra-abdominal sign." That's a major focus of the recommendations part of your report," ... "Is that in there because realistically without a knowledge of this case the level of knowledge that is out there amongst, well, from your perspective, amongst the surgical and anaesthetic communities about retroperitoneal bleeding without any intra-abdominal signs is potentially not really well understood by those who engage in this type of operation?---It - it's certainly possible." ... "Anybody who's seen it in the emergency department or during (indistinct) would know that you can have occult retroperitoneal blood loss. Anybody who's dealt with stabbings, et cetera, will be aware of that. Does everybody? I simply don't know."... "And it's something which would not in the ordinary course be obvious when one is searching for internal bleeding? ---No, you wouldn't - you wouldn't see it if you looked for internal bleeding, no, you wouldn't. And it certainly wouldn't be amongst the top list of things you'd expect to see if there was a perforation of the aorta?---Sorry, could you phrase that again? Well, the fact that - - -?---It's exactly what you would see from a perforation of the aorta. You'd see either - either massive intra-abdominal bleeding or you'd seen occult retroperitoneal bleeding. But after your review of this case and all the materials in this case you thought that was something that required particular emphasis on the significance of this issue? ---Yes, everybody who*

[111] Submission on behalf of Warringal Private Hospital, paragraph 45

partakes in this type of surgery using these types of instruments to gain entry into the abdomen should be aware that this is possible, yes."[112]

108. Professor O'Brien made a point of vital importance in his evidence when he stated:-

> *"...you can work in the area of elective surgery for so long you don't get the opportunity to have the feel for the emergency'* and *'we should think about people who are in a situation where they could have the occasional emergency probably should be doing refresher course simulator courses to at least remind them of what to look for and how to respond."*[113]

109. There was a clear consensus about the need to ensure a high level of awareness about the possibility of retroperitoneal bleeding after an accident involving the aorta, bleeding which may not be visible potentially for hours with a high risk of blood pressure reduction and hypovolaemia. Neither Dr Waterfield or Mr Goldwasser turned their mind to the possibility that Mrs Clohesy was bleeding into the retroperitoneum area and that this would not be visible even on a careful survey as was conducted by the surgeon. It was agreed by all that the message needs to be clear to anaesthetists and surgeons about this risk. This is the key lesson to be learned from this case.

110. On the more general issue of communication between anaesthetists and surgeons, the position taken by Warringal Private Hospital was that it is elementary that surgeons and anaesthetists communicate during surgery and that it should therefore require no specific protocols, rules, guidelines. This has to be correct.

111. I note that Suzanne Hall stated, in her statement dated 9 August 2013, that since 2008, the Victorian Audit of Surgical Mortality (VASM) has sought to review all deaths associated with surgical care in Victoria by undertaking an external investigation and audit. VASM is a group comprised of representatives of the Victorian Government's Department of Health, the Victorian Surgical Consultative Council and the Royal Australasian College of Surgeons. VASM distributes a quarterly de-identified 'lessons learned' document to all hospitals and doctors in Victoria. Warringal Hospital joined the VASM auditing process at the beginning of 2011. If the incident involving Mrs Clohesy occurred now, Warringal Hospital would notify VASM of the circumstances of her death. Suzanne Hall told the Court at hearing that notification of VASM of an incident is a means of disseminating information regarding circumstances that have led to a patient's death to medical practitioners. Mr Alan Thomas, in testimony, stated that notification of incidents to VASM was appropriate. Warringal Hospital

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[112] Transcript, pgs 50-51

[113] Transcript, pg 124

considers that notification of the incident with Mrs Clohesy to the Medical Practitioners Board Victoria is a means of disseminating the lessons to be learned from her death.

112. I note also Professor O'Brien's comment on the necessity of medical devices being used correctly:

> *"All medical devices must be used correctly. If the device has a significant potential for harm to the patient if misused, a specified training program should be written into the approval for the device to be added to the Australian Register of Therapeutic Goods. Anaesthetists and surgeons must be able to recognise any of the acute adverse events that could arise during the particular surgical procedures for which they administer the anaesthetics or perform the operation. Refresher courses dealing with this, perhaps using the simulator programs that are available, should be required."*[114]

FINDINGS AND CONCLUSIONS

113. Mrs Clohesy's death was caused by multi-organ failure resulting from blood loss.

114. Both the surgeon and the anaesthetist contributed to the death.

115. The surgeon's accidental cutting of the abdominal aorta, in my view, exhibited a degree of carelessness. However, bearing in mind that any adverse finding requires satisfaction at a higher standard of proof (*Briginshaw),* I do not find that this action ultimately justifies such a finding. However, I find that the surgeon's departure from the hospital was completely unacceptable in the circumstances. I make this finding bearing in mind the need to apply the higher standard of proof (*Briginshaw*).

116. I find that the anaesthetist's failure to respond in a timely way to the patient's blood pressure readings and his failure to communicate his concerns about those readings, fell well below an acceptable standard of professional conduct. I make this finding bearing in mind the need to apply a higher standard of proof *(Briginshaw).*

117. The fact and manner of the concessions made by both Mr Goldwasser and Dr Waterfield were appropriate and helpful in the context of the purposes of the coronial jurisdiction. I fully accept that both surgeon and anaesthetist were deeply affected by the death of Mrs Clohesy. I also accept that they displayed genuine introspection and that their expressions of regret were entirely sincere.

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[114] Report from Emeritus Professor Paul O'Brien, pg 5.

RECOMMENDATIONS

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

1. There should be a greater awareness raised of the risks of perforating the aorta whilst inserting the Visiport in a Lap Band procedure and for resultant bleeding not necessarily showing in the operative field. I recommend that the Royal Australasian College of Surgeons state or re-state, and build into its information and education programs, dissemination of the fact that significant retroperitoneal bleeding can occur without any intra-abdominal signs.

In relation to obesity training, I note Mr Thomas' comment that the Royal Australasian College of Surgeons presently has "no guidelines for recognition of obesity training". I adopt his proposed recommendations:

2. Currently the Royal Australasian College of Surgeons has no guidelines for recognition of obesity training. The Royal Australasian College of Surgeons be encouraged to produce the guidelines based on advanced laparoscopic experience and familiarity in operating around the gastro oesophageal junction. The colleges should also ensure familiarity with cross clamping major vessels is taught during training as major bleeding is the fear of most surgeons whatever their discipline.
3. Dissemination of lessons learned from this case should be made known to the wider surgical and anaesthetic communities including other subspecialties involved in advanced laparoscopic procedures. In particular, it should be emphasized that significant retroperitoneal bleeding can occur without any intra abdominal signs.

Noting Professor O'Brien's recommendation about refresher courses highlighting emergency situations in hospitals, I recommend:-

4. The respective professional colleges in Victoria for anaesthesia and surgery should incorporate mandatory training for those in the private sector dealing with elective procedures to undergo specific training in dealing with emergency situations. Such training should be on an annual basis.

I apologise for the lengthy delay in bringing this case to a conclusion and extend my condolences to the family of Mrs Noella Clohesy.

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

The family of Mrs Noella Clohesy

Mr Blair Clohesy

Warringal Private Hospital

Mr N Goldwasser

Dr M Waterfield

Senior Constable K Ramsey

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 29th August 2014