IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 005934

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

*Amended pursuant to section 76 of the **Coroners Act 2008** on 19 October 2023*

Deceased:	GA
Delivered on:	6 October 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 10, 13,14 and 15 December 2021
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the Coroner:	Ms Catherine Fitzgerald of Counsel, instructed by Ms Natalie Savva, Senior Coroner's Solicitor
Representation:	Mr Colin Mandy S.C, instructed by Mr DT, appeared on behalf of the family. Mr Stephen Moloney of Counsel, instructed by Ms Louise Williams from Kennedys, appeared on behalf of Mr Nicholas Houseman. Ms Fiona Ellis of Counsel, instructed by Ms Catherine Tuohey of Avant Mutual, appeared on behalf of Dr Chantal McNally. Mr Abhi Mukherjee of Counsel, instructed by Mr John Aranga of Avant Mutual, appeared on behalf of Associate Professor Lefkovits. Ms Debra Foy of Counsel, instructed by Mr Mark O'Sullivan from Minter Ellison, appeared on behalf of Cabrini Hospital.

TABLE OF CONTENTS

INTRODUCTION

1. Mrs GA was an 86-year-old married woman who resided with her husband Mr LV in Caulfield North. Apart from her husband, Mrs GA was survived by three adult children, including her son Mr DT who has been the main family advocate in relation to the coronial investigation of Mrs GA's death.

2. Mrs GA was a reasonably active and independent woman for her age. Her past medical history included atypical chest pain (from at least 1985), hysterectomy with residual leg oedema (July 1996), surgical repair of a detached retina (1997), hypercholesterolaemia, pneumonia (June 2013), surgical repair of fractured neck of femur (June 2016), and colonoscopies (most recently in 2013).

3. Relevantly, Mrs GA had been reviewed by cardiologists at Wattletree Cardiology since at least 1985. Both Associate Professor Jeffrey Lefkovits (**A/Prof Lefkovits**) and his predecessor Dr Gordon Mushin noted a history of occasional episodes of chest pain over the years and both assessed these as atypical chest pain not likely to represent symptomatic coronary artery disease.[1]

4. A/Prof Lefkovits, who first consulted with Mrs GA in 1997, stated that she had not reported significant chest pain since about 1998. A 12 lead ECG undertaken at that time was reported as normal. Her only cardiovascular risk factor was hypercholesterolaemia which was managed with lipid medication for a time but not since 2014. Shortness of breath was intermittently reported but this was mild, and in his view, not likely to relate to coronary disease. The only objective cardiac test in her records was a stress test in 1997 which was satisfactory and not suggestive of significant coronary disease. Since that, there had been no clinical need for any further cardiac tests.[2]

5. When last reviewed by A/Prof Lefkovits in November 2016, Mrs GA did not have either definite or likely underlying coronary disease, or any other significant structural or other cardiac problem and was for review in 12 months' time. She was clinically stable from his perspective and asymptomatic from a cardiac standpoint. Mrs GA's lipids were acceptable, with a high proportion of HDL cholesterol (2.7 mmol/L) that is considered cardioprotective.[3]

[1] Letter dated 10 May 2018 from Associate Professor Jeffrey Lefkovits to Mr DT at inquest brief page 46.
[2] Ibid page 45.
[3] Ibid page 46.

OVERVIEW OF THE CIRCUMSTANCES[4]

6. On 30 August 2017, Mrs GA consulted dermatologist Associate Professor Christopher McCormack (**A/Prof Mc Cormack**) who identified a skin lesion on the dorsum (back) of her left hand he considered to be a probable squamous cell carcinoma (**SCC**) and recommended excision. He understood from a previous interaction with Mrs GA and her son that they preferred any invasive procedure to be referred to a plastic surgeon rather than be undertaken by A/Prof McCormack in his rooms. Mrs GA was accordingly referred to Mr Nicholas Houseman (**Mr Houseman**), a plastic and reconstructive surgeon, to whom she had been referred previously.

7. On 13 November 2017, Mrs GA was seen by Mr Houseman who also considered the lesion to be a probable SCC. He recommended excision of the lesion and a split skin graft under sedation with local anaesthesia. On 16 November 2017, Mrs GA signed a consent form for the surgery which was scheduled for 21 November 2017 at St Francis Xavier Cabrini Hospital, Malvern (**Cabrini Hospital**).

8. On this date, Mrs GA was seen by anaesthetist Dr Chantal McNally (**Dr McNally**) for the first time. Dr McNally discussed the procedure with Mrs GA and conducted a pre-operative anaesthetic assessment. During the assessment, Mrs GA indicated she was very concerned about the anaesthetic and had not yet signed the acknowledgement of consent for anaesthesia. After their discussion, Mrs GA signed the acknowledgement of consent for anaesthesia and the surgery proceeded as planned.

9. During the surgery, Dr McNally administered a combination of the intravenous anaesthetic propofol and an analgesic agent fentanyl to provide sedation for Mrs GA during injection of the local anaesthetic by the surgeons at the sites of the lesion and the skin graft on Mrs GA's thigh. The surgery was completed by Mr Houseman without any apparent complications.

10. As dressings were being applied at the end of the surgery, Dr McNally noticed a deterioration in Mrs GA's clinical state. She was bradycardic, hypotensive and had a dusky skin colour. Mrs GA was given 100 percent oxygen via mask, and ephedrine, atropine and fluids intravenously. The surgical suite emergency alarm was activated and three anaesthetists, including a cardiac anaesthetist, and a cardiologist responded. Cardiopulmonary resuscitation (**CPR**) commenced.

[4] This is a broad overview of the circumstances in which Mrs GA's death occurred, intended to assist understanding of the finding. The circumstances will be discussed below in more detail and by reference to the evidence at paragraphs 42 and following below. To the extent of any inconsistency, the latter is to be preferred.

When Dr McNally realised Mrs GA was in cardiac arrest, a formal Code Blue was called and an intensivist and intensive care nurse responded bringing* the resuscitation trolley with them.

11. After about six minutes of CPR including the administration of adrenaline, there was a return of spontaneous circulation. Mrs GA was intubated, and an arterial line inserted before her transfer to the intensive care unit (**ICU**). Unfortunately, investigations revealed Mrs GA had suffered a hypoxic brain insult and did not regain consciousness while in the ICU.[5]

12. On 23 November 2017, following discussions of her prognosis between the family and medical staff, the decision was taken to withdraw life-sustaining therapies and adopt a palliative approach. Mrs GA was kept comfortable until she passed away and was verified deceased a few hours later, on 24 November 2017.

INVESTIGATION AND SOURCES OF EVIDENCE

13. This finding is based on the totality of the material the product of the coronial investigation of and inquest into Mrs GA's death. That is, the inquest brief that includes the forensic pathologist's report, Mrs GA's medical records, witness statements, expert reports and several submissions made by her son Mr DT on behalf of the family;[6] the evidence of the witnesses required to testify at inquest and any documents tendered through them; the evidence of the expert panel; and the final submissions of counsel for the various parties.

14. All of this material, together with the inquest transcript, will remain on the coronial file.[7] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

[5] Inquest brief page 815 is the histopathology report which indicated that on examination of the lesion there was 'no in-situ or invasive malignancy' with a conclusion that it was a solar keratosis.
[6] The compilation of material will be referred to as the "inquest brief" in the rest of this finding.
[7] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

PURPOSES OF A CORONIAL INVESTIGATION

15. The purpose of a coronial investigation of a *reportable death*[8] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9]

16. Mrs GA's death falls within the definition of a reportable death in section 4 of the Act, satisfying both the jurisdictional nexus required by section 4(1) and section 4(2)(b) which relevantly defines as reportable a death that occurs during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure, and was unexpected.[10]

17. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[11]

18. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[12]

19. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public

[8] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria required by section 4(1) of the Act, a reportable death is generally one that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury – see the various paragraphs of section 4(2). In some cases, the death is reportable due to the cause or mechanism of death (for example sections 4(2)(a) and (b)) and in others, due to the status of the deceased immediately before death (for example section 4(2)(c), (d), (e) and (f).

[9] Section 67(1).

[10] Note that the word "unexpected" is a paraphrase. The verbatim descriptor in section 4(2) is "*a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death."*

[11] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[12] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

health or safety or the administration of justice.[13] These are effectively the vehicles by which the coroner's prevention role can be advanced.[14]

20. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[15] However, this general prohibition does not prevent a coroner from including a comment or a statement relating to a notification to the Director of Public Prosecutions (**DPP**) if they form the requisite state of mind, namely they believe that an indictable offence *may* have been committed in connection with the death.[16]

21. I note in this regard that the deceased's family* have asserted and maintained throughout the coronial investigation of her death, that an indictable offence may have been committed by Dr McNally in connection with the death of Mrs GA, and that I should therefore make a referral to the DPP under section 49 of the Act.[17]

IDENTITY

22. Mrs GA, born 15 March 1931, aged 86, was identified by her daughter Ms BU who signed a formal Statement of Identification to this effect on 24 November 2017 before Dr Philpot, an ICU consultant at Cabrini ICU.

23. Mrs GA's identity was not in issue and required no further investigation.

CAUSE OF DEATH

24. Mrs GA's body was brought to the Coronial Services Centre where specialist forensic pathologist Professor Stephen Cordner from the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination of the body in the mortuary, reviewed the Victoria Police Report of Death to the Coroner (**Form 83**), a Medical Deposition from Cabrini Hospital, and post-mortem CT scanning of the whole body undertaken at VIFM (**PMCT**).

[13] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[14] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[15] Section 69(1).
[16] Sections 69(2) and 49(1) of the Act.
[17] Transcript pages 13-14 where this request is reiterated by Mr Mandy in opening the family's case and Ms Ellis' submissions and discussion at pages 604 and following.

25. Having done so, Prof Cordner provided a written report concluding with advice that it would be reasonable to attribute Mrs GA's death to *1(a) Complications of probable ischaemic heart disease in an elderly woman while undergoing surgery to the left hand.* Despite the peri-operative setting of Mrs GA's cardiac arrest, at that time, Prof Cordner was of the view that her death was due to natural causes.[18]

26. Prof Cordner's advice and formulation of Mrs GA's cause of death was given in the context of a clearly articulated and strongly pressed objection to autopsy made on religious grounds by Mr MC, on behalf of his father Mr LV, who was formally the Senior Next of Kin for coronial purposes.[19] Having taken the family's objection into account and armed with Prof Cordner's advice and formulation of the cause of death, I directed that the investigation of Mrs GA's death proceed without autopsy.[20]

27. At the time, the family had not raised any concerns about the clinical management and care provided to Mrs GA during her last episode of care. Had those concerns been expressed at the time, I may have made a different decision about the threshold need for an autopsy. Had an autopsy been performed, it is *possible* that the cause of death or the circumstances in which the death occurred *may* have been further elucidated.[21]

28. As the coronial investigation of Mrs GA's death progressed, it was apparent that the family's concerns were primarily focused on anaesthetic management, in the belief that this caused or contributed to Mrs GA's death. I asked Prof Cordner for a Supplementary Report explaining the forensic pathologist's approach to formulation of the cause of death, in particular, in the absence

[18] Prof Cordner's four-page inspection report dated 8 December 2017 is at pages 1-4 of the inquest brief.

[19] Senior Next of Kin for coronial purposes is defined in section 3 of the Act which sets out a hierarchy in which the spouse or domestic partner of a deceased person, if they had one immediately before death, takes precedence over all other relatives.

[20] Section 8 of the Act outlines factors to be considered when exercising a function under the Act including – that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected (section 8(c)); that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information (section 8(e)); and, the desirability of promoting public health and safety and the administration of justice (section 8(f)).

[21] While Prof Cordner was *doubtful* that an autopsy would have added to the understanding of Mrs GA's death, he added that this was not certain and that one aspect that could have been elucidated by an autopsy was the extent of the *probable* significant narrowing of one or more of the coronary arteries. In this regard, note too, the following exchange between Ms Fitzgerald and Prof Myles during questioning of the expert panel – *"In this matter, there was no autopsy performed. I was just wondering if you can explain whether or not the performance of an autopsy might have had a role to play in relation to the coronary artery disease that we know as the subclinical? …I'm not sure that we would be hugely, ah, advantaged, even had there been an autopsy. We may have more specifics about the degree of – well, we would have more specifics about the degree of coronary artery disease, but we would still be having the – pretty much the same discussion that has been had, ah, I presume throughout all of these proceedings, about the, ah, circumstances in which the, ah, death occurred."* Transcript pages 501-502.

of an autopsy, and (effectively) invited him to revisit his formulation of Mrs GA's cause of death.[22]

29. Prof Cordner explained that other than a minority of cases involving significant trauma where the cause of death is apparent, the cause of death is dependent on the quality and quantity of information available about the death. In some cases, some of the information will be beyond the competence of the forensic pathologist to assess, such as the contribution of anaesthetics to Mrs GA's death. Prof Cordner noted that, at the time of his original report, there was less factual information than might otherwise have been available to him as there had been no autopsy. He was reliant on the Form 83, the medical deposition which is taken at face value unless there is some obvious reason not to do so, and the PMCT findings. In Mrs GA's case, the external examination did not result in any observations relevant to the cause of death.[23]

30. Prof Cordner explained his formulation of the cause of death as *complications of probable ischaemic heart disease in an elderly woman while undergoing surgery to the left hand* was not a definitive formulation and allows for the possibility of other opinions.

31. As to the first aspect of the formulation of the cause of death being ischaemic heart disease, Prof Cordner commented as follows:

    a. *"The existence of moderate calcification of the coronary arteries does not itself mean that there was significant coronary atherosclerosis – that is, greater than 75% narrowing of one or more of the coronary arteries. There is a broad association between the degree of calcification of the coronary arteries and their narrowing, but no more than that. The breadth of this relationship extends to those with little if any calcification having very severe coronary atherosclerosis and to those with considerable calcification having no significant narrowing."*[24]

    b. *"It would not be surprising if a woman of 86 years had significant narrowing of the coronary arteries, and the observation of moderate calcification of the coronary arteries on the CT examination provided a modest degree of support for that."*[25]

[22] The request to Prof Cordner was by email dated 18 August 2017, see page 4E of the inquest brief.
[23] Page 4B of the inquest. Note that Prof Cordner consulted with Dr Chris O'Donnell, VIFM's consultant radiologist about the PMCT finding of moderate coronary calcification.
[24] Pages 4B-4C of the inquest brief. Note that Prof Cordner was using the terms "ischaemic heart disease" and "significant narrowing of the coronary arteries" interchangeably.
[25] Page 4C of the inquest brief

c. *"The echocardiogram done after the collapse showed an 'akinetic inferior and anterolateral left ventricular wall' and suggests the existence of ischaemic heart disease, but does not specifically suggest that ischaemic heart disease precipitated the collapse. Low blood pressure associated with the collapse from another cause on a background of coronary atherosclerosis may itself have led to these consequences visible on the echocardiogram. But the echocardiogram does lend credence to the existence of ischaemic heart disease being present."*[26]

d. *"The raised troponin indicates myocardial (or heart muscle) damage, and supports the conclusions [above]."*[27]

32. Based on the above, Prof Cordner was of the view that Mrs GA probably had ischaemic heart disease. However, it does not follow that she must have suffered the symptoms and exhibited the signs of ischaemic heart disease in life. In his view, this probability does not really alter the approach to be taken to appraisal of the role played by anaesthesia which remained to be resolved on its own merits and fell beyond his field of expertise.[28]

33. The second aspect of Prof Cordner's formulation is the reference to the death occurring while undergoing surgery to the left hand signifying a temporal and potentially causal connection with the surgery including anaesthesia/sedation. While the surgery is not as obvious a stressor on the heart as, say, running a marathon, Prof Cordner maintained removal of the lesion is at the lower end of being a stressor on the heart, and obtaining the graft perhaps a bit more so. Combined with sedation, the surgery represents a potential risk period, and a somewhat greater one for someone with ischaemic heart disease. In his view, the surgery was therefore a circumstance worthy of inclusion in the formulation of the cause of death.[29]

34. At inquest, Prof Cordner was questioned about this second aspect of his formulation of the cause of death. He clarified that he was positing a continuum of potential physiological stressors with a 'sleeping person' at the low end of the continuum and a 'marathon runner' at the higher extreme. He maintained that Mrs GA's surgery, encompassing the anaesthetic/sedation, albeit

[26] Ibid.
[27] Ibid.
[28] Pages 4C and 4D of the inquest brief.
[29] Page 4C of the inquest brief.

relatively minor, was nevertheless a physiological stressor at the lower end of the continuum and therefore appropriate to include in the cause of death.[30]

35. The evidence of the expert panel relevant to anaesthetic management will be dealt with in some detail below. However, for present purposes, I note that the expert panel comprised of Prof Cordner and five experienced anaesthetists who were asked, among other things, *"What caused Mrs GA's cardiac arrest? Did she suffer a circulatory or cardiac arrest? What was the cause of that arrest?"*[31] They were unanimous in their response that Mrs GA suffered a bradycardic arrest secondary to relative hypoperfusion in a patient with subclinical coronary artery disease.[32]

36. Implicit in the expert panel's responses to this question and the questions about the cause of the arrest that followed was the view that the surgical setting was a factor in Mrs GA's death.[33]

37. In answer to a question from Mr Mandy on behalf of the A family about the causative sequence, Prof Myles as spokesperson explained the causative sequence in terms consistent with Prof Cordner's reasoning:

> *"…it is near universal that a patient receiving deep sedation or anaesthesia will have lower blood pressure. The drugs, ah, dilate the blood vessels and lower blood pressure…expected, more so in older people of course…we typically aim to protect …systolic blood pressure of about 100…or a mean blood pressure of 60 to 65, so that is what we would think of as an accepted standard. So in the anaesthetic record, the blood pressure was trailing along at that lower level of what we think would be reasonable range for an average patient…the fact that…there was this severe bradycardia escalating into heart block and full cardiac arrest, um, needs an explanation. And the most probable explanation we have is that there was subclinical, or unknown or undetected, coronary artery disease. What supports that view…is that the thin wall – inferior wall of the heart is the absolutely classic situation in a patient who's had subclinical, or no symptoms, of…some degree of coronary artery disease, particularly in the right coronary artery which supplies that inferior wall of the heart.*[34]

[30] Transcript pages 498-500.
[31] See transcript page 481 where Dr McMillan re-casted the question as *"Did she suffer a respiratory versus cardiac arrest?"* and Prof Myles as spokesperson for the panel accepted this.
[32] Transcript pages 481-487.
[33] Transcript pages 481-495.
[34] Transcript pages 487-488.

38. In combination, the weight of the expert evidence supports a finding that the Mrs GA's death was caused by *a bradycardic arrest secondary to relative hypoperfusion while undergoing surgery to the left hand in a patient with subclinical ischaemic heart disease*.

39. I have added the words "while undergoing surgery" to the formulation proposed by the expert panel for the sake of clarity and completeness. This does not necessarily connote any deficiency in surgical or anaesthetic management but is intended to simply convey that "but for" the fact that Mrs GA was undergoing surgery which involved sedation, she would not have died at the time and in the manner that she did.[35] The evidence pertaining to anaesthetic management and its adequacy, and its contribution to Mrs GA's death, if any, will be addressed below.[36]

40. While natural disease in the form of ischaemic heart disease is part of this formulation, this is not a death from natural causes as that term is understood in the coronial jurisdiction. Rather, it is a death that resulted from a combination of underlying natural disease in the form of ischaemic heart disease not previously known, in the setting of, and as a complication of surgery.

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

41. Apart from refinement of the medical cause of death already addressed above, the focus of the coronial investigation of Mrs GA's death was on the adequacy of the clinical management and care provided to her during her last episode of care encompassing –

    a. The decision to excise the skin lesion surgically and its appropriateness including the inter-related issues of the decision not to take a biopsy before excision, the choice of wound closure and the decision to use local anaesthetic and sedation.

    b. The adequacy of anaesthetic management by Dr McNally including the decision to use local anaesthetic and intravenous sedation; pre-anaesthetic assessment and the process of obtaining the patient's consent; the administration of anaesthetic and other drugs; patient monitoring during the procedure; management of bradycardia/hypotension, cardiac arrest and resuscitation; and the adequacy of record keeping.

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[35] Transcript pages 464-465, 496. Note the expert panel's evidence to this effect - *"What is the significance, if any, of the period between the second dose of drugs and Mrs GA's deterioration? What if there was a lesser period, does this provide any evidence regarding whether the deterioration was anaesthetic drug related? --- Prof Myles: …this becomes quite a complex issue…it may or may not be related, we cannot be really be certain ourselves…obviously there was no evidence of direct deterioration. But I think in our conversation, I think we were agreeing that the at least residual effect of either the first or the combination doses ah would at the very least tend to have an effect on both blood pressure, ah possible heart rate and that whether it was at five or even 20 or 30 minutes later there would be some relationship between the two…I think that was unanimous."*

[36] See paragraphs 88 and following below.

The decision to excise the skin lesion surgically

42. A/Prof McCormack's evidence in the inquest brief took the form of letters written to Mr DT in response to his requests for information regarding his mother's death and a statement provided in response to a request from the court.[37] As well as these letters, A/Prof McCormack attended the inquest where he expanded on his evidence and was cross-examined by counsel assisting me and counsel representing the parties.[38]

43. A/Prof McCormack graduated in medicine from Monash University in 1986 and completed his dermatology training in 1996. He has worked in both the public and the private sectors and is currently the Director of the Melanoma and Skin Cancer Tumour Unit at the Peter MacCallum Cancer Centre, Parkville. He described himself as a dermatological oncologist or a dermatologist who specialises in skin cancer with over 20 years' experience in his field.[39]

44. Mrs GA consulted A/Prof McCormack on 30 August 2017 on referral from her GP Dr Susan Cohen (**Dr Cohen**) for the purposes of a skin review. He had seen her for the same purpose on five previous occasions.[40] At inquest, A/Prof McCormack explained that a skin review involves review of any patient history, discussion of any concerns or new lesions and close examination of the whole of the patient's skin for any concerning skin changes or lesions.[41]

45. On 30 August 2017, A/McCormack identified a lesion on the dorsum or back of Mrs GA's left hand which he thought was a probable squamous cell carcinoma (SCC) with a differential diagnosis of a hypertrophic or thickened solar keratosis. According to A/Prof McCormack, solar keratosis is a skin lesion that can mimic and is at times clinically indistinguishable from an SCC, and is a premalignant lesion that occurs in sun-damaged skin. Moreover, people with solar keratoses are more likely to develop an SCC. His evidence was that there is not only one way to approach such a lesion, and that it would also have been reasonable to take a partial biopsy to confirm the diagnosis. However, with a suspicious lesion in a patient like Mrs GA who had

[37] Letters to Mr DT dated 3 April 2018 at page 5, 16 May 2018 at page 7, 6 June 2018 at page 8, and 6 August 2018 at page 9 of the inquest brief respectively, and letter to the court dated 21 Oct 2021 at pages 10.1-10.3 of the inquest brief. An A4 size photograph of the dorsum of Mrs GA's left hand showing the skin lesion in question is at page 10 of the inquest brief. See also transcript page 28 in this regard. The medical records provided by A/Prof McCormack to the court are at pages 1366-1411 of the inquest brief.
[38] A/Prof Mc Cormack's evidence is at transcript pages 25 to 72 inclusive.
[39] Transcript pages 31-32.
[40] 16 December 2013, 25 August 2014, 28 April 2015, 1 February 2017 and 17 September 2016 – see page 10.1 of the inquest brief.
[41] Transcript page 30.

previously had a skin cancer, he maintained that it was reasonable to proceed straight to surgery for an excisional biopsy.[42]

46. A/Prof McCormack was mindful of an earlier consultation when he wanted to take a biopsy of a lesion on Mrs GA's leg, and she (and whoever had accompanied her on that occasion) indicated a preference that a plastic surgeon undertake the biopsy. He understood that this preference was extant and unchanged. This influenced subsequent consultations including the consultation on 30 August 2017 which accordingly concluded with a referral to Mr Houseman.[43] A/Prof McCormack described a patient-centric approach in which the patient's wishes as well as the characteristics of the lesion are taken into account in determining how best to proceed.[44]

47. A/Prof McCormack testified that if he had been given permission to treat Mrs GA's lesion, he would have excised it under a local anaesthetic in his rooms which were set-up for such minor procedures. Prior to testifying, A/Prof McCormack had reviewed his own data and was able to advise that in the previous financial year he had undertaken 800 excisions in his rooms under local anaesthetic without any mind-altering anaesthetics. This involved marking up the lesion allowing an appropriate margin of clinically normal tissue; administration of local anaesthetic; allowing time for the anaesthetic to take effect; excision of the lesion and closure or suturing in an elliptical fashion with a smaller lesion or taking a skin graft in the case of a larger lesion.[45]

48. Mrs GA's lesion was potentially one that could have been removed in A/Prof McCormack's rooms where a skin graft could also be done up to a certain size.[46] That said, he maintained that the excision could also have been done in theatre and stated that many plastic surgeons will only excise such lesions in theatre. While such procedures are commonly done either in rooms or in

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[42] Transcript pages 33-35, 49.

[43] Inquest brief pages 4-5 where this preference is mentioned in a letter from A/Prof McCormack to Mr DT and page 10.2 where it is reiterated in a letter provided to the court in response to a formal request under the Act (Form 4).

[44] Transcript pages 36-39. See especially pages 38-39 – *"…you have to take, again, a patient-centric approach and assess what the patient wants and needs, in combined with the lesions characteristics. So, um, in an ideal world we never want to cut out something that's not a cancer, but that's not reality. It was very reasonable, um, to take a full excisional biopsy; however, in many cases …patients may say they only want a partial biopsy so they can decide … – if anything further is needed. So you can't just make a concrete ruling that you should do one thing or the other, but in this case it was – it was very reasonable to go down the path of, um, undertaking an excisional biopsy."* See also transcript page 44 where he gives evidence to the same effect.

[45] Transcript pages 42-43. Note that A/Prof McCormack did not speak in term of 'smaller or larger lesions', that is my paraphrase – *"…where possible myself or Dr Houseman if possible would do a primary closure, which means you cut it out like an eye shape and then close it side to side. It's called an ellipse (indistinct) closure. Sometimes if the lesion's thicker and a bit too much tension on the skin, they may elect to do a graft, um, where you take tissue from somewhere else to fill the defect."* As to the appropriate size of the margin see transcript pages 45-46.

[46] See transcript pages 547-548 for a discussion about the 'blind spot' in A/Prof McCormack's evidence in that he was not asked and it is therefore not clear what manner of wound closure he would have used if he had removed the lesion in his rooms.

theatre, the decision about how to proceed is determined by reference to the nature of the lesion and the patient's preference.[47]

49. A/Prof McCormack was cross-examined about performance of a biopsy to confirm the clinical diagnosis of SCC, as an alternative to excision of the whole lesion. While he agreed that a shave biopsy and a punch-hole biopsy were both reasonable options, he maintained that with a lesion of this size, the advantage of excision was 'that the lesion is fully treated and dealt with'.[48]

50. The mechanism by which A/Prof MCormack referred Mrs GA to Mr Houseman was to send him a copy of the report of the consultation he sent to Dr Cohen which contained all the relevant information.[49] He described this practice of simply 'copying in' the specialist as common in his field. The expectation was that Mr Houseman, although aware of A/Prof McCormack's assessment, was not bound in any way by that assessment but would make his own assessment of Mrs GA's lesion and develop a management plan.[50]

51. Mr Houseman is the plastic and reconstructive surgeon to whom A/Prof McCormack referred Mrs GA. Mr Houseman provided a statement in response to a formal request under the Act and also testified at inquest where he was represented by Mr Moloney of Counsel.[51] Mr Houseman's formal qualifications and extensive experience are set out in his statement.[52] Relevantly, he specialises in reconstructive plastic surgery, his practice centres around the treatment of skin cancers, their excision and reconstruction, and is based at Cabrini Hospital.

52. Each year, Mr Houseman said he performs approximately 750 procedures in his rooms using only local anaesthetic. In additional, he operates on approximately 1250 patients in theatre; 75%

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[47] Transcript pages 43-44. In cross-examination by Mr Mandy, A/Prof McCormack indicated that he undertook 50 skin grafts in the previous financial in his rooms associated with excisions of lesions see transcript pages 52-52. As to patient preference, see also transcript page 58. I note that in correspondence with Mr DT, A/Prof McCormack was at pains to say that if he had been given permission to treat the lesion he would have excised it in his rooms under local anaesthetic because he does not have access to an operating theatre but *"different physicians will have different way of approaching the removal of skin lesions … there is no definite one routine standard of care".*

[48] Transcript pages 46-49. At page 47 A/Prof McCormack described a punch-hope biopsy as a form of incisional biopsy for a lesion of this size and drew a distinction between this and an incisional biopsy done on a larger lesion.

[49] The report/referral is at page 1386 of the inquest brief and is discussed at transcript pages 40-41. It refers to a finding of a probable SCC, a differential diagnosis of a hypertrophic solar keratosis, no regional adenopathy, and a recommendation for excision for which he had made a referral to Mr Houseman.

[50] Transcript pages 41-42.

[51] Mr Houseman's statement dated 10 October 2021 is at pages 26.4-26.9 of the inquest brief. His medical records are at pages 1294 and following

[52] Inquest brief at page 26.4. As well as his practice treating skin cancers, Mr Houseman performs hand, microsurgery, abdominoplasties and breast surgery including post cancer reconstruction and reductions. He has practised in public hospitals for 13 years as a consultant surgeon, was head of the plastic surgery unit at the Northern Hospital for 10 years, and a consultant at both the Royal Melbourne Hospital and Western Hospital for 10 years. He has worked at Cabrini Hospital for 22 years, 12 as head of the plastic surgery craft group and for the last two years as chair of the medical staff.

of these operations are performed using sedation and local anaesthetic; the remaining 25% performed under general anaesthetic.[53] Over the preceding 23 years, Mr Houseman had performed at least twenty thousand surgical procedures using the combination of local anaesthetic and intravenous sedation without significant complications.[54]

53. Mrs GA was known to Mr Houseman as he had been treating her since 2013 in relation to various skin lesions.[55] He found her a delightful patient who he thought had a clear understanding of her medical condition and what their consultations were about. He could not recall her expressing any particular anxiety in relation to surgery or anaesthesia.

54. On one occasion, 31 March 2014, he performed an excision of a left forearm lesion in his rooms under local anaesthetic with direct closure of the wound. He described the latter as the simplest way of closing an excisional wound into a straight line with the wound being directly pulled together with sutures. This is to be contrasted with *a skin flap* which involves rearranging the adjacent skin and *a skin graft* which involves taking skin from elsewhere on the patient's body and applying it to the wound. He thought Mrs GA was fine with that particular procedure.[56]

55. By way of background, Mr Houseman explained that in metropolitan Melbourne general practitioners generally refer patients with suspected skin cancers to dermatologists and/or plastic surgeons, the former usually performing simple excisions and biopsies and the latter performing the more complicated excisions, whereas in regional areas general surgeons have more of a role in skin cancer surgeries.[57]

56. In his statement, Mr Houseman referred to the "McCormack referral" noting that Mrs GA was seen for a skin cancer review; was assessed as having a probable skin cancer on the dorsum of

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[53] Mr Houseman testified that the use of local anaesthetic and intravenous sedation is *"particularly commonplace in actual plastic surgery more than any other area of surgery and particularly common in skin cancer work…that's an outlier amongst the other areas of surgery"* – transcript page 80.

[54] Inquest brief page 26.5. Transcript pages 79-81.

[55] Inquest brief page 26.5. *"11. On 28 April 2013, Mrs GA consulted me in relation to a basal cell carcinoma (BCC) on the left forearm, and possible BCC on the right forearm. At the consultation, I applied liquid nitrogen to a number of keratoses on her hands. 12. On 12 February 2014, Mrs GA consulted me in relation to a large lesion on her left forearm which I arranged to excise under local anaesthetic in my rooms. At the consultation, I applied liquid nitrogen to a number of keratoses on her hand and forearm. 13. On 31 March 2014, I excised the left forearm lesion and directly closed the wound. 14. On 7 April 2014, I reviewed Mrs GA after the procedure to remove the lesion on her left forearm and confirmed that the histology reported the lesion was a BCC with clear margins. A check-up appointment was arranged for six months. 15. On 28 August 2014, Mrs GA presented due to concern about a lesion on her leg. I reassured her that the lesion was healing and would be reviewed in the future."* I note that the date of the last consultation may be incorrect – see medical records at page 1295 of the inquest brief which record a consultation date of 25 August 2014. Mr Houseman also treated Mr GA over a similar period.

[56] Transcript pages 81-82.

[57] Transcript pages 77-78. According to Mr Houseman, general surgeons do not usually play a role in the treatment of skin cancers in metropolitan Melbourne as they may do in regional Victoria.

her left hand with no regional lymphadenopathy; and that the referral recommended excision of the lesion.[58] At inquest, he agreed that, in form, the referral was a copy of A/Prof McCormack's report to Dr Cohen. He described this as a very common practice, especially between practitioners who know each other and work together, and do not require a more formal referral introducing the patient and so on.[59]

57. Mr Houseman agreed that A/Prof McCormack was a highly qualified expert whose opinion he regarded highly and would assume that any diagnosis he made was correct. In terms of a 'pecking order' among specialists, Mr Houseman considered dermatologists 'would probably be above plastic surgeons' in diagnosing skin cancer as this was their particular area of expertise. Nevertheless, he would absolutely make his own independent assessment of the lesion, but as SCC is an extremely difficult lesion to diagnose, he would take comfort from a concurring view from someone with such expertise.[60]

58. On 13 November 2017, Mrs GA attended upon Mr Houseman accompanied by her husband. Mr Houseman inspected the lesion using magnifying loupes and examined and palpated the lesion. Having done so he concurred with A/Prof McCormack's clinical assessment that it was likely an SCC that should be excised. The appearance and feel of a skin lesion on palpation are used to assess whether it is likely to be benign or malignant. Whereas solar keratoses are confined to the surface of the skin, on palpation, an SCC has more substance and induration at its base. On palpation, Mrs GA's lesion was consistent with the diagnosis of an SCC. Excision was therefore indicated to prevent local spread which might require a more significant procedure and reconstruction in the future, as well as minimise the risk of regional and distant metastases. [61]

59. The fact that Mrs GA was referred to Mr Houseman without a biopsy having been performed to confirm the diagnosis of SCC was 'totally normal'.[62] According to Mr Houseman, biopsies are often performed by referring dermatologists. However, where the diagnosis is likely to be cancer, or the site of the lesion is difficult anatomically, patients are often referred without a biopsy for definitive excision and wound closure, as in Mrs GA's case.[63]

60. The rationale for this practise is that excision of a lesion clinically considered probably malignant usually results in definitive treatment and a certain diagnosis, whereas a biopsy may

[58] Inquest brief page 26.5. Transcript pages 87-88.
[59] Transcript page 87.
[60] Transcript pages 89-90.
[61] Inquest brief page 26.6 and transcript page 89.
[62] Transcript page 91.
[63] Inquest brief page 26.6.

not provide a definitive diagnosis and may not exclude malignancy with certainty. Moreover, in frail think skin such as that on the dorsum of Mrs GA's hand, a biopsy can leave an open wound with increased risk of infection that fails to heal, with an increased risk of graft failure, and scarring and inflammation post biopsy that can confound delineation of margins during subsequent surgical excision.[64]

61. At inquest, Mr Houseman expanded on the two types of biopsies that that would have been appropriate and their limitations. A punch biopsy involves sampling perhaps a quarter or a third of the lesion which may not necessarily include the malignancy and the results may be falsely reassuring. A shave biopsy is problematic to perform on the dorsum of the hand as it involves sampling very close to the underlying tendon. As the aim is always to remove the skin cancer and one layer of normal tissue, the risk is that subsequent excision will interfere with the tendon and the functionality of the relevant finger.[65] It was with these complexities in mind that Mr Houseman decided that the best approach was to excise the lesion on Mrs GA's left hand 'in one go rather than doing a biopsy, waiting for the results and then going back in again.'[66]

62. The location of the lesion on the dorsum of the hand also had consequences for the type of wound closure or graft required following excision and, in turn, the need for an operating theatre and the equipment generally available in an operating theatre.[67]

63. The skin on the dorsum of Mrs GA's hand was extremely frail and thin and Mr Houseman did not consider it possible to close the wound directly as tension on the margins of the wound would tear through the skin. Similarly, a skin flap was not possible due to the quality of the skin adjacent to the lesion. While Mr Houseman testified that he has done many skin flaps in his rooms, and skin flaps can be applied to most parts of the body, the dorsum of the hand and the dorsum of the foot are two areas where it is hard to do a skin flap successfully.[68] According to Mr Houseman, while he could perform a skin graft in his rooms, he generally only did so in the case of a 'very, very small' graft as might be applied to the fingertips after trauma to fingertips where a full-thickness skin graft could be used.[69]

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[64] Ibid.
[65] Transcript page 92.
[66] Ibid. *"Are we to understand that you did turn your mind to the possibility of doing a biopsy in the first instance, or not? - - - It passed my mind for a millisecond and then when I looked at her hand I realised the best form of treatment for her was to have it excised. So it wasn't discussed with her, a biopsy."*
[67] Transcript pages 81 and following generally.
[68] Inquest brief page 26.6 and transcript pages 83-84.
[69] Transcript page 83-84, 95-97. See also inquest brief at page 26.6. A full thickness skin graft involves using local anaesthetic and using a hand-held scalpel to cut skin to fit the wound site before directly closing the resultant wound

64. The alternative and preferred method of wound closure for Mrs GA was a split-thickness skin graft that involves the cutting of one layer of skin only using an air driven dermatome which can regulate both the width and the thickness of the harvested skin and improves healing at the donor site and, with fenestration of the harvested skin before application, improves the prospects of successful grafting at the recipient site.[70]

65. During the consultation on 13 November 2017, Mr Houseman informed Mrs GA that the procedure to remove the lesion would need to be performed in theatre where the equipment for harvesting the skin was located. Further, as the procedure was uncomfortable and noisy, it was common practice to provide intravenous sedation. The anaesthetic used during the procedure would be a combination of local anaesthetic with intravenous sedation administered by a specialist anaesthetist, like the anaesthetics administered to Mrs GA previously. He did not recall either Mrs GA or her husband raising any concerns about the proposed procedure or anaesthetic.[71] At inquest, Mr Houseman testified that Mrs GA did not seem particularly phased by the diagnosis and recommended treatment which he attributed to the earlier consultation with A/Prof McCormack.[72]

66. While Mr Houseman agreed that he would have told Mrs GA that the procedure would be performed under local anaesthetic with light sedation, he recognised that sedation levels are on a continuum from very light to very heavy and maintained that the level of sedation on the day was a matter for the anaesthetist.[73]

67. Under cross-examination by Mr Mandy, Mr Houseman agreed that he did not advise Mrs GA that the procedure could be performed without sedation. He maintained that – *"...you really want to provide an environment which will give you the best quality outcome and keep [the patient] safe and comfortable um I think and giving sedation is – is the gold standard form of treatment for this type of surgery."*[74]

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at the donor site. This may result in a graft of more variable thickness with the risk of creating a full thickness wound at the donor site.

[70] Inquest page 26.6-26.7 and transcript pages 97-100 where Mr Houseman produced an air dermatome for inspection and explained how it enables harvesting of skin tailored both as to width and depth depending on the requirements of the patient's wound. He also explained that skin shrinks by about 20% once removed so a larger piece of skin needs to be taken from the donor site to allow for shrinkage. Exhibit B was a USB stick containing a video showing the dermatome in operation and demonstrating, inter alia, the noise that emanates from its use – transcript 168-169.

[71] Inquest brief page 26.7 and transcript pages 97, 127-128.

[72] Transcript page 97.

[73] Transcript page 126-128, 131-135.

[74] Transcript page 128.

68. Counsel Assisting me, Ms Fitzgerald, took Mr Houseman to the opinion of Mr Thomas Michael McKenzie Long (**Mr Long**) which had been provided to the A family and was included in the inquest brief.[75] Mr Houseman was invited to comment about the opinion that 'sedation was not necessary for the procedure' Mrs GA underwent. Mr Houseman's evidence was that while 'it is not actually necessary to give sedation it certainly provides the patient with the comfort and safety as well as enabling him to perform the best operation he can' and that while many operations can be done without sedation, that does not mean that is the best way to perform the operation.'[76]

69. Another aspect of Mr Long's report put to Mr Houseman was the opinion that he should have told Mrs GA that the operation could be performed without her having sedation. Mr Houseman accepted that while sedation was certainly not 100% necessary *"…it's absolutely common practice throughout Victoria that anyone having a skin graft is given sedation 99.9 per cent of the time by any plastic surgeon doing this type of procedure. So I think – I mean I'm just offering what is routine standard best quality care."*[77]

Expert evidence about the decision to excise the lesion surgically

70. Mr Long is a general surgeon who completed his undergraduate degree in 1960 and obtained his fellowship in 1966. His formal qualifications and experience include 30 years at the Royal Melbourne Hospital (**RMH**) as a general surgeon, 13 years in charge of surgical training at the RMH, and a close association with plastic surgeons during this time, as well as experience as a forensic pathologist. Mr Long also had a busy country practice in which he dealt with skin tumours two to three times per week over 30 years on referral from GPs. As at the date of the inquest, Mr Long had not operated for 15 years and was engaged in medico-legal work. [78]

71. Mr Long's opinion was based on material provided to him and the photograph of the lesion taken by A/Prof McCormack.[79] He agreed that physical examination of the lesion placed Mr Houseman in a better position to assess whether it was an SCC and agreed there were limitations inherent in his reliance on the photograph.[80] He advocated for a more conservative approach, in particular due to his perception of Mrs GA's frailty, by taking either a shave biopsy or an

[75] The opinion of Mr Long took the form of two letters to Mr DT dated 24 July 2019 and 7 August 2019 at pages 49-63 and pages 64-88 respectively of the inquest brief including attachments.
[76] Inquest brief page 51 and transcript page 103.
[77] Transcript pages 104-105.
[78] Transcript pages 513-514, 529. Mr Long's curriculum vitae is at pages 55-57 of the inquest brief.
[79] Inquest brief page 10.
[80] Transcript pages 516-517.

incisional biopsy with a narrow margin allowing for primary closure by suture under local anaesthesia without sedation. Depending on rapidity of growth in the lesion or symptoms, he might simply observe the lesion for a period.[81]

72. Whatever doubts Mr Long may have been thought to have cast over Mr Houseman's treatment plan, it was abundantly clear from his evidence at inquest that he was not saying that the plan was not reasonable. Rather, that he would have adopted a different course that he characterised as conservative and appropriate for an elderly patient.[82]

73. Mr Keith Louis Mutimer (**Mr Mutimer**) is a specialist plastic surgeon who provided an expert opinion on behalf of Mr Houseman that is included in the inquest brief. Mr Mutimer obtained his undergraduate degree in 1977 and his Fellowship in Plastic and Reconstructive Surgery in 1986.[83] Although initially scheduled to attend the inquest, due to time constraints and the significant consistency between his opinion and Mr Hunter-Smith's, Mr Mutimer was not ultimately called.

74. For all the commonality between their two opinions, aspects of Mr Mutimer's report warrant emphasis. As regards the excision site, he commented that a defect of 25-30mm on the dorsum of the hand of an elderly patient with frail skin almost certainly would have direct wound closure issues, including wound breakdown, infection, chronic wound problems and pain. Consequently, most plastic surgeons would recommend a skin graft for a defect of this size given its location, particularly in a patient with frail skin.[84]

75. Another important aspect of Mr Mutimer's report relates to the Cancer Council of Australia (**CCA**) Clinical Guidelines Keratinocyte Cancer which states, inter alia, that *"principal benefit of early detection of KC's is to diagnose and excise primary tumour when it is small in size and before extension into the deeper dermis and subcutis or metastases occurs".* Hence the CCA recommendation for excisional biopsy where possible and appropriate, as this facilitates study of

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[81] Inquest brief page 53 and transcript pages 516, 524-526, 533. Note that the expert panel were unanimously of the view while a lay person may describe Mrs GA as frail based on her age, she was not frail in the medical sense – transcript page 446.

[82] Transcript page 519 – *"…I can't say that his practice was not acceptable or it certainly is very acceptable for treatment of a lesion. And he did that in the most appropriate way and I understand his reasoning. And I can't disagree with that…"* Transcript page 520 – *"Ms Fitzgerald: Can I ask you this, Dr Long. Would I be correct in characterising your evidence in this fashion? You've come to a view about how you would have managed Mrs GA and this lesion, but having read the statements ---? ---Yes. --- of Mr Houseman, Mr Mutimer and Mr Hunter-Smith, you don't disagree that they have come to a different decision and that it was reasonable? Would that be a correct characterisation of what we understand your evidence to be? --- Yes. That's correct.* See also transcript page 531.

[83] Mr Mutimer's formal qualifications and experience are set out in his expert opinion dated 4 November 2021 at inquest brief 222.114 and his curriculum vitae is at pages 222.122-131.

[84] Inquest brief page 222.118.

the architecture, cytological appearance and extent of the tumour and the adequacy of excision. Alternatives in the form of incisional biopsies are indicated if the clinical diagnosis is in doubt or the lesion is in a cosmetically sensitive location such as the face. However, these are no more than sampling and cannot guarantee there is no carcinoma in the rest of the lesion.[85]

76. In conclusion, Mr Mutimer's opinion was that Mr Houseman's recommendation for excision and skin grafting was reasonable and appropriate and would be a decision adopted as proper by the majority of plastic surgeons involved in the management of skin cancer.[86]

77. As regards the choice of intravenous sedation with local anaesthetic, although ultimately a matter to be determined by the anaesthetist, Mr Mutimer advised that this is a well-accepted method of providing satisfactory anaesthesia for surgery involving skin malignancy.

78. Mr David Hunter-Smith is a plastic and reconstructive surgeon who also provided an expert report on behalf of Mr Houseman that is included in the inquest brief.[87] He has 25 years clinical experience in both the private and public healthcare setting; holds the position of Professor of Surgery at Monash University; relevantly, chairs the melanoma and complex skin cancer service at Peninsula Health (in association with the Alfred melanoma service); and is a presiding member for Medical Panels Victoria.[88]

79. In his report, Mr Hunter-Smith expressed the opinion that it was reasonable and appropriate for Mr Houseman to recommend and arrange excision of the lesion and repair of the defect with a split thickness skin graft, while recognising that it is a common and somewhat difficult decision to choose the best pathway for management of thickened, hypertrophic skin lesions such as the one on Mrs GA's hand. Further, Mr Hunter-Smith stated that diagnosis of skin cancer can be made by biopsy or by the opinion of a specialist dermatologist and set out the types of biopsies and their limitations.[89]

80. Mr Hunter-Smith also outlined available treatment options and their suitability for the lesion in this case, noting that excision with histological examination is the most common treatment pathway for skin lesions such as this when considered to have a high probability of malignancy,

[85] Inquest brief page 222.119.
[86] Inquest brief page 222.120.
[87] The report dated 21 October 2021 is at pages 222.78-222.82 of the inquest brief.
[88] Mr Hunter-Smith's curriculum vitae is at pages 222.84-222.113.
[89] Inquest brief page 222.79 and transcript pages 549-550.

and concluding that reconstruction by skin graft whether full thickness or split thickness appears to be a more reasonable option than a local skin flap.[90]

81. Mr Hunter-Smith's opinion about the benefits of excision and reconstruction with a skin graft, was in keeping with Mr Houseman's – *"[benefits include] complete histological assessment of the specimen and treatment in one sitting. The use of a dermatome in this case was better than a simple skin graft knife…The dermatome is a precise instrument used in plastic surgery to remove a thin layer of skin in a very controlled fashion to minimise scarring, bleeding and deformity. The skin can be taken off in a meticulous way allowing regular uniform thickness of skin to be taken which reduces morbidity in the healing phase for the patient."*[91]

82. As regards the choice of anaesthetic, Mr Hunter-Smith considered that a general anaesthetic in conjunction with local anaesthetic was unnecessary for the removal of this skin lesion. While he agreed that the use of local anaesthetic alone was one option, he noted that the effects of pain and anxiety can lead to complications and issues including pain, non-compliance and movement, and stress for both the patient and the surgical team, that can lead, in turn, to poor patient outcomes. Mr Hunter-Smith therefore agreed with the decision to perform the procedure under intravenous sedation with local anaesthetic, saying – *"My experience is that local anaesthetic with sedation is the most pleasant and effective way to remove skin cancers from the elderly and this is my preference when performing such operations. The unpleasant injection of local anaesthetic can be relieved using sedation, allowing complete infiltration of the local anaesthetic around the skin lesion site so that surgery can be performed in a controlled manner…The use of local anaesthetic with sedation was the reasonable and appropriate choice…"*[92]

83. At inquest, Mr Hunter-Smith was critical of the approach suggested by Mr Long, describing it as the 'wrong advice' to give to a patient such as Mrs GA.[93] Notwithstanding the devastating outcome for Mrs GA, Mr Hunter-Smith's evidence is that one has to assume that people will live for a very long time, particularly if they are fit and healthy and treat them with curative intent, and not palliatively as he inferred from Mr Long's report and evidence. Therefore, excision of

[90] Inquest brief 222.80. See also page 222.81 where Mr Hunter-Smith states – *"The surgeon is tasked with the responsibility of assessing the patient's comorbidities and weighing up the risks and benefits of the proposed treatment. Excision of a skin lesion and skin grafting as was performed is considered a straightforward and simple procedure by plastic and reconstructive surgeons. The choice of the surgical technique used for the treatment of the skin lesion in this case was reasonable and appropriate."* Transcript page 551-552.

[91] Inquest brief page 222.81.

[92] Inquest brief page 22.82 and transcript pages 555-560.

[93] Transcript pages 543-544. I note that Mr Hunter-Smith disagreed with Mr Long's assessment that the lesion had not grown in the 10 weeks between A/Prof McCormack's consultation and Mr Houseman's. Comparing the photograph of the lesion taken in A/Prof McCormack's rooms and the histopathology report, he thought there was evidence of significant growth in the lesion – transcript page 547.

an SCC or probable SCC which reduces the risk of recurrence, and reduces the risk of spread, is the preferred treatment choice.[94]

84. Mr Hunter-Smith was cross-examined about treatment options and the feasibility of different methods of wound closure or reconstruction at the excision site. He noted that different surgeons may approach the same lesion differently and that the patient's fitness for surgery would be an important factor in arriving at a treatment plan. He considered Mrs GA to be 'fit enough for surgery' and agreed with Mr Houseman's assessment that the frailty of the skin on the dorsum of her hand supported a skin graft as the best option for wound closure.[95]

85. In answer to questions about Mrs GA responding to or appearing to sense the dermatome, Mr Hunter-Smith said it often happens, despite the use of local anaesthetic at the donor site to numb the area. He testified that the dermatome is sharp, stimulating and can be painful if there are small areas that have not been sufficiently anaesthetised by the local anaesthetic, or if the local anaesthetic is wearing off in which case the anaesthetist *"will often give a bit more sedation just to sort of take the edge off that – off that part".*[96] He described the dermatome as a little bit noisy and said that it vibrates backwards and forwards and makes a buzzing sound at about 82 decibels.[97]

86. Mr Hunter-Smith was asked several questions about anaesthetics which he felt were beyond his expertise. However, he agreed that patient preference would be taken into account in determining the need for sedation. Beyond discussing the need for sedation with the anaesthetist, he expected the anaesthetist to determine the level of sedation and to titrate dosing to achieve the desired effect.[98]

87. Mr Hunter-Smith was an impressive witness at inquest who was cross-examined by all counsel other than Mr Mukherjee representing A/Prof Lefkovits. Mr Hunter-Smith reiterated that the choice of treatment plan involves balancing multiple factors including the nature and location of

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[94] Transcript pages 544-545, 574-575.
[95] Transcript pages 550-554, 562.
[96] Transcript pages 556-557.
[97] Transcript pages 563-564.
[98] Transcript pages 550, 555-559, 566-567. See also page 571 – *"Mr Mandy: Yes. If Dr Houseman did not inform Mrs GA that her procedure could be performed without sedation would you consider it appropriate for him to have asked for her to be sedated for the procedure? --- So what normally happens is that we will say to the patient, 'The normal procedure is that you will come to hospital, make it as comfortable as we possibly can for you. Use a local anaesthetic with sedation and the procedure will go ahead and you'll be comfortable.' Um. And then – then we'll get a response from the patient, which will either be, 'Oh, no, I don't want sedation, I'm worried about it', or 'I don't' want a local' or, 'Oh, God, no, I want a general anaesthetic.' But do we – do we specifically every time say, um, 'You can have local anaesthetic, local sedation or a general anaesthetic'? Probably not. We probably don't. Maybe we should. But we probably don't…"*

the lesion, and the characteristics and preferences of the patient. In the case of the lesion on the dorsum of Mrs GA's hand, he maintained that excision of the lesion using local anaesthetic and intravenous sedation and the application of a split skin graft was an appropriate treatment plan; it was the plan he would also have recommended; and a plan that would be commonly chosen by their peers.[99]

The adequacy of anaesthetic management

88. Dr McNally is the anaesthetist responsible for Mrs GA's anaesthetic management during the procedure. Dr McNally provided a statement detailing her formal qualifications and experience, addressing the questions asked of her about Mrs GA's anaesthetic management on 21 November 2017 as well as criticism of her anaesthetic management made by Dr David Daly (**Dr Daly**) in medico-legal reports commissioned by or on behalf of the A family.[100]

89. Dr McNally also provided a letter to her from the Australian Health Practitioner Regulation Authority (**AHPRA**) dated 25 June 2019 advising the outcome of the AHPRA Board's investigation of a notification by Mr DT about the anaesthetic management provided to Mrs GA on 21 November 2017. While the AHPRA investigation was not on all fours with a coronial investigation there is a significant overlap of issues and some overlap in the sources of evidence considered.[101] The Board's decision was to take no further action in the matter and, in its reasons included the following – *"The Board considers the likelihood and possible consequences of any risks associated with your performance and determined that there would be no impact on patient safety; as such it is appropriate to take no further action."*[102]

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[99] Transcript pages 555-559, 561, 565, 573-574.

[100] Dr McNally's statement dated 13 June 2019 is at inquest brief pages 20-26. See transcript pages 174-175 for the sources relied on by Mr McNally when she made her statement. Dr Daly's reports dated 30 September 2018 and 23 February 2019 addressed to Ms Kathryn Booth, Maurice Blackburn are at pages 27-35 and 36-44 respectively of the inquest brief. Dr Daly's formal qualifications and experience are set out in his first report. He obtained his graduate degree from the University of Melbourne in 1989 and his fellowship in 1998. As at 2018, Dr Daly had been a staff specialist anaesthetist at the Alfred Hospital for over 19 years involved in clinical work and teaching anaesthetic trainees and the provision of anaesthetics in both the public and private hospital setting. Dr Daly was one of the witnesses in the expert panel which took place on the third day of hearing, 14 December 2021 – see transcript pages 445-503.

[101] Note that the AHPRA Board's decision/reasons included the following *"Confirmation from the Coroners Court of Victoria, Medical Examiner indicating the findings of Ms GA's death were by natural causes with no human involvement."* This needs to be read with a gloss due to the state of evidence now available - see paragraphs 24 and following above.

[102] Inquest brief pages 26.1-26.3. Note section 7 of the Act which states that *"It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officer – (a) to avoid unnecessary duplication of inquiries and investigations; and (b) to expedite the investigation of deaths and fires."* On occasions, the nature of the investigation by another investigative authority may obviate the need for a coronial investigation or for an inquest. In this case the disparity of the written expert reports about anaesthetic management available to me prior to the inquest militated toward the need for an inquest to ascertain if there was consensus.

90. Ms Ellis led Dr McNally's evidence-in-chief. Dr McNally is the Director, Cabrini Department of Anaesthesia and Pain Management and a specialist anaesthetist currently in private practice. She described her practice as largely consisting of paediatric, obstetric and plastic surgery anaesthesia and stated that she regularly works with four plastic surgeons (twice weekly for over 12 years) with the majority of that work involving local anaesthesia and sedation for minor skin procedures in elderly patients, similar to Mrs GA. [103]

91. Dr McNally conducted a pre-anaesthetic assessment of Mrs GA on 21 November 2017, shortly prior to commencement of the procedure in the anaesthetic room outside the operating theatre. Dr McNally had recourse to the medical records where nursing staff had documented Mrs GA's vital signs, oxygen saturations, weight, height, fasting time and allergy and drug reactions, relevantly to 'penicillin Ibilex'.[104] Having reviewed the medical records including consideration of Mrs GA's medical history, co-morbidities and previous anaesthetic history, Dr McNally noted that no issues with previous anaesthetics ("nil probs") and gave Mrs GA an ASA score of 3 indicating systemic illness with some impact on day-to-day life.[105]

92. Counsel Assisting, Ms Fitzgerald "put" to Dr McNally the criticism made by Professor Yehuda Ginosar that Mrs GA was alone when she conducted the pre-anaesthetic review. Dr McNally explained that Mrs GA was the patient and appeared competent, but she would have organised for the family to participate if Mrs GA wanted them involved.[106]

93. The anaesthetic plan ultimately documented by Dr McNally was for sedation and local anaesthetic (summarised as "for sedation + LA"). In arriving at this plan Dr McNally considered the requirements of the particular procedure based on her experience, discussion with Mr Houseman about what he needed to perform the procedure, and her pre-anaesthetic review and discussion with Mrs GA.[107]

94. In Dr McNally's experience, multiple injections of local anaesthetic are required around the excision and the donor site to provide analgesia. The dermatome is basically a vibrating knife used to slice a layer of skin off and is very noisy. The taking of the skin graft is not performed under local anaesthesia alone as it is difficult to completely anaesthetise the site with local

[103] Inquest brief page 20 and transcript pages 175-177.
[104] Inquest brief page 964 and transcript page 177-178. At transcript pages 178-179 Dr McNally testified that Ibilix/cephalexin is a first-generation oral cephalosporin commonly used in such procedures.
[105] Transcript pages 179-180. Dr McNally denied being told by Mrs GA that she was short of breath that day.
[106] Transcript page 430 and inquest brief page 92. See also footnote
[107] Transcript pages 182-187 and inquest brief page 23.

anaesthesia and the noise of the equipment can be very distressing to an awake patient. It would be highly unusual not to use sedation for this procedure.[108]

95. Aside from the noise, Dr McNally testified that the use of the dermatome is systemically stimulating – a reference to the body's sympathetic response to pain and discomfort expressed systemically – the concern being not just about the risk that the patient will move but about systemic cardiovascular responses such as tachycardia and hypotension.[109]

96. Dr McNally was aware that Mrs GA was concerned about the anaesthetic and had not signed the acknowledgement of consent.[110] At inquest, she expanded on the detailed discussion she had with Mrs GA to assuage her concerns about the anaesthetic, including discussion about her experience with a colonoscopy in 2013. Dr McNally felt Mrs GA was reassured that the anaesthetic used would be similar to that used in 2013 and accordingly signed the acknowledgement of consent.[111]

97. Dr McNally testified that she was herself reassured by Mrs GA's toleration of the spinal anaesthetic she had received in June 2016 for repair of a fractured hip which she considered a major procedure[112] and the intravenous deep sedation she had received for a colonoscopy in October 2013.[113] Both these previous procedures informed her anaesthetic management of Mrs GA.[114]

98. Dr McNally inserted an intravenous cannula into Mrs GA's arm before she was taken into theatre. In terms of monitoring, once in theatre and on the operating table, Dr McNally applied a Hudson mask and provided supplemental oxygen. The type of Hudson mask used for delivery of supplemental oxygen also provides carbon dioxide (**CO2**) monitoring.[115] Oxygen saturations were monitored by application of a probe to a finger on Mrs GA's right hand which provides a

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[108] Inquest brief page 23.
[109] Transcript pages 194-195.
[110] Inquest brief pages 23 and 967 and transcript pages 187-188.
[111] Inquest brief page 918 and transcript pages 186-187, 302-303.
[112] Transcript pages 189-191 and inquest brief 427-429 for the relevant anaesthetic record.
[113] Transcript pages 192-198 and inquest brief 422 for the relevant anaesthetic record. Note that the anaesthetic drugs used for the 2013 colonoscopy were – midazolam 2.5mg, fentanyl 100mg and propofol 100mg. Note that Dr McNally's evidence was that she did not review earlier anaesthetic records for colonoscopies Mrs GA underwent in 2002, 2005 or 2008 – see transcript page 199.
[114] See transcript pages 430, 434-436 for Dr McNally's rationale in the choice and dose of anaesthetic drugs administered to Mrs GA.
[115] Transcript pages 206-210, 437. *"So it's really a very inaccurate measurement of end-tidal CO2, but what it does give you is a trace that allows you to see that there's continuous respiration…I look at the waveform and how often it's happening, whether it's flattening, whether it's there, to really assess respiration…So if you were having an obstructed airway or you were suppressing respiration, you would get a flattened curve and you would see the change happening…"*

figure as well as a trace. The oxygen saturations that were documented in the Anaesthetic Record were taken from this probe.[116] According to Dr McNally, in the case of sedation, as opposed to general anaesthetic, it was not usual to document the end-tidal CO2 readings from the Hudson mask.[117]

99. Dr McNally applied a three-lead electrocardiogram (**ECG**) which she described as beyond the requirements for monitoring in this situation. This enabled her to see any changes in the heart rate, as well as any arrhythmias and also gave an idea of the heart rhythm.[118] As with the end-tidal CO2 trace from the Hudson mask, the three-lead ECG is a 'quick indicator that something's gone wrong rather than a true diagnostic test.'[119]

100. In addition to the above, a non-invasive blood pressure cuff was applied to Mrs GA's arm to enable monitoring of her blood pressure during the procedure.[120] The blood pressure was taken at five-minutely intervals and commenced after Dr McNally gave the first dose of anaesthetic.[121]

101. All the various monitors were connected to and displayed on the anaesthetic machine which had default settings and would sound an alarm if any of the parameters being monitored (heart rate, blood pressure and capnography) strayed outside those settings.[122] Dr McNally testified that she constantly monitored Mrs GA during the procedure and that up until 10.50am, her blood pressure was equal to or above 100mmHg systolic and her heart rate was in the high 60s.[123]

102. According to Dr McNally, she gave a first dose of anaesthetic drugs being 50mhs propofol and 50mcgs fentanyl. She explained that propofol is an intravenous anaesthetic commonly used to provide procedural sedation in a dose dependant manner. It has a short duration of action as it is rapidly distributed into peripheral tissues. A single dose typically wears off within minutes and often requires repeat doses to maintain the sedative effect. Fentanyl is a short acting synthetic opioid analgesic with a rapid onset of action. There are recommended doses per kilogram of body weight for both propofol and fentanyl, however, in practice they are both cautiously titrated

[116] The clearest copy of the Anaesthetic Record is at page 430 of the inquest brief where SaO2 is documented as 98 on three occasions during the procedure.
[117] Transcript page 211.
[118] The relevant guideline is Exhibit C – Australian and New Zealand College of Anaesthetists (ANZACA) Guideline on Monitoring During Anaesthesia (PS18 2017), first promulgated 1988, current document April 2017.
[119] Transcript pages 212-213.
[120] Transcript page 214-215.
[121] Transcript page 218 and inquest brief page 430, noting that the first set of observations were taken and documented as at 10.20am.
[122] Transcript page 218-219.
[123] Transcript pages 217-18, 232 and 428 and inquest brief page 430 (and 963).

for clinical effect. When using multiple doses, the clinical effect of the initial dose should be considered in determining incremental doses.[124]

103. The first dose was given prior to infiltration of the local anaesthetic by the surgeons with the intention of sedating Mrs GA deeply enough to tolerate the infiltration of the local anaesthetic. Dr McNally continued to watch Mrs GA – *"So there's lots of information that I'm scanning and taking into account to assess the effect of sedation. And when I'm comfortable with the level of sedation then I would notify the surgical team that it could be appropriate now to proceed with local anaesthetic infiltration."*[125] While there is no documentation of the time the first dose of anaesthetic was given, Dr McNally's explained that it would have been given before the time when the first set of observations were documented which was at 10.20am.[126]

104. In terms of determining an intraoperative timeline,[127] Mrs GA's surgery did not commence until infiltration of the local anaesthetic was completed by the surgeons, the surgeons left theatre to scrub and the patient was draped. According to the operation report, Mrs GA's surgery did not start until 10.36am. It follows that the first dose of anaesthetic agents (given by Dr McNally) and the infiltration of the local anaesthetic (administered by Mr Houseman and/or his assistant surgeon at the two sites)[128] all occurred before that time.[129] This fact is consistent with and supportive of Dr McNally's estimate that she gave the first dose before 10.20am.

105. Dr McNally gave evidence that the effects of propofol, in particular, and fentanyl although to a lesser extent, do not last very long and start to wear off within minutes such that while you may still have some sedative effect you might not have the desired depth of sedation.[130] In cross-examination by Mr Mandy, Dr McNally's evidence was that based on her knowledge of the pharmacology of fentanyl, the peak effect following an intravenous dose occurs at around five to

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[124] Inquest brief page 23.
[125] Transcript pages 217-218.
[126] See footnote 115 above.
[127] "Intraoperative" is used broadly to include the administration of local anaesthetic and the sedation that preceded it.
[128] Mr Houseman's assistant was Dr Peter Langford who provided a statement for the inquest brief (see page 26.10-26.11) but was not required to attend the inquest. Relevantly, his stated *"I am unable to specifically recall it if was me or Mr Houseman who administered the local anaesthetist. The administration of local anaesthetic proceeded routinely and without incident. The operation also progressed in a completely routine fashion. The skin cancer was cut out with a margin around the cancer. The defect, approximately 2.5 cm in diameter, was treated with diathermy for haemostasis and resurfaced with a split skin graft taken from the right thigh using a dermatome. The meshed skin was secured with 5 chromic suture and dressed with Jelonet, gauze, crepe bandage and a "one step" fibreglass backslab held in place with more crepe bandage. After the operation had finished, before the patient was transferred from the operating table back on to the trolley, it was noted that Mrs GA was bradycardic. A rapid assessment was done followed by a code blue and the commencement of CPR."*
[129] Transcript pages 220-221.
[130] Transcript pages 221.

six minutes, and could be delayed in an elderly patient for a couple of minutes but not at the 15 minute mark as was suggested by Mr Mandy.[131]

106. The point at which Dr McNally thought she probably focused most closely on Mrs GA was during infiltration of the local anaesthetic which she considered painful and highly stimulating to the patient, in case she needed to administer an extra dose of anaesthetics, as indeed happened.[132] In her statement, Dr McNally stated that towards the end of the local anaesthetic injection, Mrs GA opened her eyes and this prompted her to give the second dose of anaesthetics.[133] At inquest, she gave evidence broadly consistent saying – *"... I remember Mrs GA opening her eyes towards the end of the local anaesthetic infiltration in the thigh which I consider the most painful part of it and so I gave her another dose of sedation to tolerate the further local anaesthetic administration but also knowing that once the surgery started, we've got the split skin graft machine being used as well so, um, that's why I gave her the second dose and those doses then."*[134]

107. As a result of this observation of Mrs GA, Dr McNally administered a second dose of anaesthetic drugs, choosing to give the same doses as before, namely 50mgs propofol and 50mcgs fentanyl. Her rationale was that she wanted to achieve a deep level of sedation to enable Mrs GA to tolerate the rest of the infiltration of local anaesthetic and the harvesting of the skin graft. Dr McNally also took into account that Mrs GA had tolerated approximately the same doses of propofol and fentanyl during the 2013 colonoscopy.[135]

108. Once again, the timing of the second dose of anaesthetics is not documented in the medical records. Dr McNally's evidence was that the second dose would have been given at least five minutes if not longer after the first dose had been administered allowing time for her to assess the sedative effects of the first dose and to notify the surgeons that they could start giving the

[131] Transcript page 308-310. Note Dr McNally's evidence that *"either way, all these drugs cause respiratory depression and that's why we monitor respiratory, um, function and monitor airway and saturations – all the things we do, because you need to be ready for a respiratory depression at any time, and be watching for it closely."* Also note her evidence that the peak respiratory depression and peak analgesic effect occur at the same time as *"it's the same opioid receptors that are involved in respiratory depression and analgesia."*

[132] Transcript page 222.

[133] Inquest brief page 23.

[134] Transcript page 223, 321, and 434-436 where Dr McNally reiterates that she was aiming for unconscious sedation. See also Mr Hunter-Smith's evidence in this regard at transcript pages 228 and 322.

[135] Transcript pages 224-225, 431. The additional use of midazolam 2.5mgs during the 2013 colonoscopy is significant according to both Dr McNally (transcript page 203) and the expert panel due to its synergistic effect with the other anaesthetic drugs.

local anaesthetic. Given Dr McNally's evidence about the timing of the first dose, the second dose was likely given after 10.25am and logically, before 10.36am. [136]

109. The timing of the anaesthetic doses, in particular the second dose, is significant as it speaks to the potential existence of a temporal relationship between the administration of the anaesthetic drugs and/or a causal relationship, if any, with Mrs GA's clinical decline. The expert panel's view of this relationship will be addressed below.

110. Accepting that this decline becomes evident shortly after 10.50am, Mrs GA's clinical state and observations in the interim period between the commencement of the operation at 10.36 am and 10.50am are important. Dr McNally's evidence is that in that 14-minute period she continued monitoring Mrs GA to ensure she is tolerating the anaesthetic, stable and comfortable and that all her observations are within acceptable limits. She did this 'by looking at Mrs GA and her responses, but also mainly by looking at her blood pressure, heart rate, the fact that she is continuing to breathe, the trace, and observing that her airway remained unobstructed.[137] Once Dr McNally was comfortable with all those things, she turned her attention to writing in the anaesthetic record. This did not involve her leaving Mrs GA's side.[138]

111. As to the nature of Mrs GA's decline, Dr McNally explicitly refuted the suggestion that the administration of propofol and/or fentanyl caused a gradual decline in Mrs GA's heart rate and blood pressure that she did not notice, reiterating that Mrs GA was continuously monitored using the various modalities discussed above. Moreover, her evidence was that no alarms sounded to any departures from acceptable parameters.[139]

112. Rather, what Dr McNally saw was a sudden drop in Mrs GA's heart rate that she described in the following terms – *"...the procedure had finished ... And at that time, um, literally as the last dressing [sic] were going on, I'm standing at the head of Mrs GA looking at the monitor and I watched the heart rate go from 60s to 50s to 40s to 30s in front of my eyes, which I've never seen before...you can get some bradycardial reductions in heart rate at different times either from surgical stimulation or from medications but I have never seen...an acute event where the heart rate goes from mid-60s through down to 30s ... at that time I stopped everyone in theatre by saying there's a problem."*[140] Dr McNally responded by pressing the blood pressure monitor to

[136] Transcript pages 224-226.
[137] Transcript pages 227-228.
[138] Transcript pages 228, 232 and 438-439.
[139] Transcript pages 233-234, 428-429.
[140] Transcript page 235.

get a current reading, noting that the monitor was producing five-minutely readings and the reading displayed could be up to five minutes old. Dr McNally waited for the monitor to cycle and arrive at a reading and when it did, she realised *"we're in trouble because we've got an unrecordable blood pressure".*[141]

113. Dr McNally's evidence about her initial response to Mrs GA's bradycardia and the resuscitative effort that followed was largely informed by her "retrospective note" made in the medical record later that night, at 8.25pm.[142] The note was written without access to the medical records which had accompanied Mrs GA to the ICU. At inquest, Dr McNally was criticised for the delay in committing her recollection of events following Mrs GA's deterioration to writing and for the lack of a clear sequence and timeline. Dr McNally accepted this criticism and conceded that her memory of events may have been more accurate if notes were written more contemporaneously with the events and with access to Mrs GA's medical records. Nevertheless, she maintained that the retrospective note was the most accurate record of her memory of events.[143]

114. The first thing Dr McNally recalled doing after noticing the bradycardia and alerting those in the operating theatre to a problem was to draw up and give 2mgs of ephedrine IV which increases both blood pressure and heart rate, titrating carefully so as not to "overshoot" as ephedrine has a long-lasting effect. After waiting to see its effect but not long after, perhaps 20 to 30 seconds, she gave another dose of 2mgs ephedrine IV and increased the rate of fluids to allow full flow through the IV cannula.[144]

115. When Dr McNally saw no response to the two doses of ephedrine, she gave 600mcgs of atropine as it works very quickly to increase heart rate and can quickly reverse bradycardia into a normal rhythm or even to tachycardia and so requires careful titration. After waiting perhaps 10-15 seconds, as atropine is known to work quickly, and noting that it did not have the desired effect, she gave another 600mcgs of atropine. Again, there was no change in Mrs GA's condition.[145]

116. According to Dr McNally 'a lot of things are happening at the same time'. Dr McNally commenced bag valve ventilation as soon as she had given the second dose of atropine; the anaesthetic nurse asked her if she needed help; when Dr McNally indicated she did, the nurse

[141] Transcript pages 236-237. This is consistent with Mr Houseman's observations of a drop in Mrs GA's heart rate, albeit his evidence was less detailed – see transcript pages 110, 122.
[142] Inquest brief pages 66-68.
[143] Transcript pages 243-245, 260, 274.
[144] Transcript pages 237-240.
[145] Transcript page 241-243.

pressed the "emergency buzzer" at 10.53am; other staff in the operating suite were alerted and responded.[146]

117. When cross-examined about the suggestion that CPR should have been commenced immediately after she first noticed Mrs GA's bradycardia and hypotension, Dr McNally said she expected Mrs GA's heart rate would have improved with ephedrine and atropine and that her choice of intervention was a standard response to bradycardia, which is not an uncommon phenomenon particularly with sedation techniques. While you need to give some time for these interventions to work, this was a serious bradycardia that was time critical so not much time could be given. Also, in all the cases of bradycardia which Dr McNally had encountered, this was the only time there was no response to these medications.[147]

118. The responders to the emergency buzzer were anaesthetists Dr Jones, Dr Umramubar, cardiac anaesthetist Dr Tan and cardiologist Dr Martin. There are no contemporaneous notes of the activity of these clinicians, and it is not entirely clear who commenced CPR. Dr McNally thought it might have been the assistance surgeon Dr Langford, however, in his statement (not written until 3 November 2021), he did not mention having done so.[148]

119. While it is not entirely clear when the incident was escalated and a Code Blue called, the documented generated by the attendance of the responding clinicians, usually comprising an intensivist care consultant or fellow and an intensive care nurse, indicates "CPR commenced" at 10.54am. Dr McNally's evidence was that would have asked someone to call the code when she started bag mask ventilation as it was then obvious that they were dealing with a cardiac arrest. In cross-examination by Ms Foy on behalf of Cabrini Health, Dr McNally agreed that the notation "CPR commenced" could well indicate that CPR was underway on the arrival of the Code Blue team.[149]

120. In her retrospective note Dr McNally had CPR commencing at 10.55 for some six minutes before there was a return of spontaneous circulation and a heart rate of approximately 140. The MET/Code chart notes CPR ceasing at 10.59am with a heart rate of 142. Thereafter the chart has

[146] Pages 242-243, 383-384 regarding the reach of the emergency buzzer.
[147] Transcript pages 464-470. In expanding on the majority view of the expert panel that the doses and drugs administered by Dr McNally in this instance were appropriate, Prof Myles said at transcript page 469 *"the standard first treatment of any bradyarrhythmia under anaesthesia, ad pretty well every anaesthetist in the country would use atropine or a similar drug to treat the bradycardia, particularly if it's causing or associated with hypotension or low blood pressure…"* Note also, Dr McMillan's comments at transcript pages 470-471.
[148] Inquest brief pages 26.10-26.11.
[149] Transcript page Inquest brief page 955 is the MET/Code chart scribed by J. Goodley, one of the nurses in the operating theatre. The EMT/Code chart is a pro forma document on the resuscitation trolley.

contemporary notes of Mrs GA's observations, intubation and the administration of drugs to keep her sedated and transferred to the ICU.[150]

121. After giving a fulsome account of her management in evidence-in-chief, Dr McNally was cross-examined at length by Mr Mandy on behalf of the family and, to a lesser extent by other counsel. Ultimately, I found her a credible witness who did her best to recall events and to explain the rationale for her management. She made appropriate concessions and demonstrated appropriate professional reflection about her practice.

Expert evidence about the appropriateness of anaesthetic management

122. A range of expert reports were obtained by the parties and by the court pertaining to the adequacy of anaesthetic management and the timeliness and adequacy of resuscitation. Even allowing for differences in the questions each expert was asked to address, there was a broad range of opinions in their reports about material facts and, on my reading, some opinions were irreconcilable, and it was difficult to glean a consensus view. This disparity of views militated towards the need for an inquest, which also accorded with the wishes of the A family, as well as suggesting a need for the expert witnesses to be heard concurrently.

123. An expert panel[151] was accordingly convened to assist me to determine the weight of expert opinion about the adequacy of anaesthetic management and the timeliness and adequacy of resuscitation.[152] In appropriate cases, the practice in this jurisdiction is to convene such a panel comprising witnesses who have already provided a report commissioned by one of the parties or by the court.

124. This is an evolving practice that may be modified by individual coroners depending on their preference or the nature of the issues to be determined. In this case, the expert witnesses were each sworn in or affirmed before I gave them instructions about the process and what was required of them, with particular focus on the standard of proof and the desirability of a consensus view being reached, if possible. They were told that failing unanimity, majority

[150] Inquest brief page 955 and transcript pages 248-249

[151] Sometimes referred to as a "conclave of experts" or a "hot-tub". To be distinguished from concurrent evidence proper where several witnesses may be in the witness box being asked same question/s and giving individual responses.

[152] I note that the expert panel's evidence pertaining to the formulation of the medical cause of death has already been outlined under Cause of Death at paragraphs 36-38 above.

views, dissenting views or even individual answers were acceptable, if they were unable to agree.[153]

125. The panel was provided with the questions which had been previously provided to the parties and settled with consideration of their input. The experts then left the inquest and were sequestered. They were given time and privacy to consider the questions amongst themselves and to collaborate in arriving at an answer/s before returning to the courtroom when the inquest proper reconvened. Assisting Counsel, Ms Fitzgerald, then asked the questions of the panel seriatim. The questions and the panels' answer/s were transcribed and formed part of the evidence at inquest.[154]

126. Apart from Prof Cordner, the panel comprised the following five anaesthetists:

a. Dr David Daly (**Dr Daly**), whose reports are dated 30 September 2018 and 23 February 2019.[155]

b. Dr Neville Gibbs (**Dr Gibbs**), whose reports are dated 1 and 26 June and 4 September 2020.[156]

c. Dr Adele McMillan (**Dr McMillan**), whose report is dated 5 August 2020.[157]

d. Professor Brendan Smith (**Prof Smith**), whose reports are dated 17 February, 9 March and 14 November 2021.[158]

e. Professor Paul Myles (**Prof Myles**), whose report is dated 18 September 2021.[159]

127. The expert panel did not include Professor Yehuda Ginosar (**Prof Ginosar**) whose expert report/s were submitted to the court on behalf of the family.[160] The inquest proceeded without hearing from Prof Ginosar who was outside the jurisdiction, and without demurrer from the A family. His evidence is therefore untested and is against the weight of the evidence of the expert panel; he has a personal association with Mrs GA's family which is an inherent conflict of

[153] Transcript pages 352-358.
[154] Transcript pages 445-503.
[155] Inquest brief at pages 27-35 and 36-44 respectively. Note the additional material/commentary provided by Mr DT referenced in the inquest brief index under Family Correspondence.
[156] Inquest brief at pages 118-128, 129-136 and 141-144 respectively. Note the additional material/commentary provided by Mr DT referenced in the inquest brief index under Family Correspondence.
[157] Inquest brief at pages 145-157. Dr McMillan was the court's independent expert witness.
[158] Inquest brief at pages 158-207, 208-222 and 222.65-222.77 respectively. Note the additional material/commentary provided by Mr DT referenced in the inquest brief index under Family Correspondence.
[159] Inquest brief at pages 222.1-222.64.
[160] Inquest brief pages 89-117 and 520-561.

interest; and his opinions regarding the standards of anaesthesia cannot be preferred to the expert panel which spoke to the standards of acceptable practice for anaesthetists in Australia, and more specifically Victoria. It is the latter standard by which Dr McNally's anaesthetic management must be assessed.[161]

128. In summary, the evidence of the expert panel pertaining to anaesthetic management and management of Mrs GA's bradycardia/hypotension, cardiac arrest and resuscitation was as follows:

a. Dr McNally's decision to use intravenous sedation with analgesia was appropriate for the proposed surgical procedure[162] and sedation would have been used in the vast majority of similar cases in Australia.[163]

b. Despite some identified inadequacies in the documentation of the pre-anaesthetic assessment,[164] the assessment itself was satisfactory.[165]

c. It was reasonable for Dr McNally to conduct the pre-anaesthetic assessment with Mrs GA in the absence of her family.[166]

d. Dr McNally accorded with standard practice in choosing her drug doses based on a combination of pre-operative assessment of the patient, consideration of previous responses to anaesthetics and the observed clinical response to the initial dose.[167]

e. It was reasonable for Dr McNally to be informed in the choice of drugs and doses by the record of Mrs GA's colonoscopy performed by Dr Brian Cox in 2013.[168]

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[161] In this and paragraphs that follow up to the section on The Standard of Proof and following, I have relied on and wish to acknowledge the submissions of Assisting Counsel, Ms Fitzgerald, dated 7 March 2022 which are I found both accurate and succinct.

[162] Transcript page 449 – Prof Myles as spokesperson described this as the unanimous view of the panel in terms of the approach or extent of sedation; highlighted the description of the continuum of sedation as most accessibly expressed in Dr Daly's report at inquest brief page 37; and stated it was "*certainly a very common approach right across Australia, every day of the week."*

[163] Transcript pages 453 – Prof Myles as spokesperson said that while anaesthetists across the country will vary slightly in how they give sedation, both in terms of the choice and dosage of drugs, which is partly determined by the patient and the procedure itself, *"it is a very common practice for a degree of sedation to be provided, um I would say in the vast majority of similar such cases across the country, and that drug selection …drug types ah are again very, very common."*

[164] Transcript pages 447-448. On my reading these were majority views in both cases. Prof Smith was the only expert to find fault with the assessment. Given Mrs GA's history of pneumonia and scoliosis which compromised ventilation, there was a reason to examine the chest and document any findings.

[165] Transcript pages 447 and 449.

[166] Transcript page 449. This was a unanimous view.

[167] Transcript page 452. This was a unanimous view.

[168] Transcript pages 452-453. This was a unanimous view.

f. The documentation of the anaesthetic delivered by Dr McNally and the nature and level of monitoring provided was to an acceptable standard and accorded with the relevant guidelines.[169]

g. The choice of the drugs propofol and fentanyl for the sedation was reasonable.[170]

h. The initial doses of 50 mgs propofol and 50 mcgs fentanyl administered by Dr McNally were reasonable, [171] albeit at the very upper limit of appropriate doses.[172]

i. Accepting Dr McNally's evidence that she planned to achieve unconscious sedation, it was reasonable to give a second dose in response to Mrs GA opening her eyes,[173] and it is common practice to give a second dose ahead of the use of the dermatome.[174]

j. The second doses of 50 mgs propofol and 50mcgs fentanyl administered by Dr McNally were not reasonable, and the highest reasonable doses in the circumstances would have been in the range of 10-40mgs propofol and 0-25mcgs of fentanyl.[175]

k. Mrs GA had been clinically stable up until the acute deterioration first noticed to be bradycardia/hypotension when the final dressing was being applied shortly after 10.50am.[176]

l. The initial response by Dr McNally to Mrs GA's deterioration was appropriate. Specifically, the initial drugs and fluid administered were appropriate. [177]

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[169] Transcript pages 450-451. This was a unanimous view. Prof Myles offered a comment about the need for end-tidal carbon dioxide monitoring in the event of a general anaesthetic and acknowledgement that Dr McNally "noted" the capnography trace in her retrospective note made later than evening. The guidelines are referenced ANZCA PS09 2014 (inquest brief page 69 and following) and ANZCA PS18 2017 (Exhibit C).

[170] Transcript page 453. Prof Myles as spokesperson said that the unanimous view was that the choice of propofol and fentanyl was reasonable, and this is a very common practice across Australia.

[171] Transcript page 454. Prof Myles as spokesperson gave the majority view that the doses were reasonable. He added a rider that the safety of an anaesthetic also depends on the setting and the experience of the anaesthetist – *"…in the setting that we have … the majority view is that it was reasonable."*

[172] Transcript page 460. Prof Gibbs explained that *"…while there was… the majority agreement that the dose was reasonable, everyone agreed that that was the very upper limit of a dose that we would use … in that situation.*

[173] Transcript page 461. This was a unanimous view.

[174] Transcript page 463. This was a unanimous view. Note that this also accords with Mr Hunter-Smith's evidence set out at paragraph 85 above.

[175] Transcript page 463. Prof Myles as spokesperson said that the expert panel's unanimous view was that these doses were not reasonable, and the experts considered reasonable doses to be in the range of 10-40mgs of propofol and 0-25mcgs of fentanyl.

[176] Transcript page 471. This was a unanimous view. Prof Gibbs added that the agreement/unanimity was based on the total record which included records written after the event … so the observations at that particular time …the saturations were okay, but we did not see evidence of respiratory rate or … any CO2 monitoring. In answer to a later question, at transcript page 491, Prof Myles stated he looked at the records for any changes following administration of the second dose of anaesthetic and *"…there was no indication of any change in blood pressure or heart rate…"*

m. The responses to the emergency buzzer and the code blue were timely and appropriate.[178]

n. There was no delay in the commencement of bag mask ventilation, cardiopulmonary resuscitation (**CPR**) or intubation.[179]

o. The personnel who responded to the emergency buzzer were appropriately experienced and all appropriate monitoring, investigation and procedures were conducted.[180]

p. While the experts did not condone the heavy crossing out of cephalexin from the anaesthetic record and considered it unreasonable, they were also of the opinion that it was irrelevant.[181]

129. It will be apparent from the summary of the expert panel evidence above that the only deficiency in Dr McNally's management supported by the weight of the evidence is that the second dose of anaesthetic drugs administered to Mrs GA was excessive.[182] Logically this raises the "more complex question" of causation considered by the expert panel, namely whether the deterioration in Mrs GA's state was a direct consequence of administration of the second dose of anaesthetics specifically, or the anaesthetic drugs more generally, or whether some lesser causal connection or contribution was in play.

130. The concern of the expert panel was that administration of the second dose of anaesthetic drugs would increase the risk of bradycardia and hypotension. However, they considered that the time between the administration of the second dose of anaesthetic drugs and Mrs GA's deterioration being of the order of 20 minutes indicated that this risk did not eventuate.[183] Nevertheless, as has been mentioned above, the unanimous view of the expert panel was that there would be some relationship, expressed by Prof Myles as spokesperson in the following terms:

> *"...firstly it may or may not be related [the second dose and the deterioration], we cannot really be certain ourselves...the anaesthetic record itself does not indicate any immediate direct effect so, in other words, it wasn't a direct effect of the second dose or the doses given...then obviously there was no evidence of direct deterioration. But I think in our*

[177] Transcript page 465. Prof Myles as spokesperson stated that the was a majority view was that this was appropriate with some clear disagreement about doses of the drugs used – ephedrine 2mgs and atropine 600mgs x two.
[178] Transcript page 472.
[179] Transcript page 471-472.
[180] Transcript pages 471-473.
[181] Transcript page 480.
[182] Transcript pages 464, 491, see also paragraph 39 above under "Cause of Death".
[183] Ibid.

conversation…we were agreeing that the at least residual effect of either the first or the combination doses ah would at the very least tend to have an effect on both blood pressure, ah possible heart rate, ah possibly or certainly respiratory rate and that whether it was at five ten or even 20 or 30 minutes later there would be some relationship between the two."[184]

131. The expert panel's clarification of the nature of Mrs GA's deterioration and the tragic outcome despite timely and appropriate resuscitation is also important to note. They described a blood pressure trailing along at the lower level of what would be considered reasonable for an average patient, then severe bradycardia escalating into heart block and full cardiac arrest. Whilst their majority view was that the right drugs were used, they were not effective. It was only once adrenaline was given that there was an improvement. However, by that stage the cardiac arrest had gone on long enough to lead to brain damage from which Mrs GA did not recover.[185]

132. On behalf of the expert panel, Prof Myles suggested that the most probable explanation for this sequence of events was that the existence of subclinical, unknown or undetected, coronary artery disease and that what happened was that Mrs GA had: *"a vulnerable conduction system that's dependent on a certain blood pressure…that was all unknown to anybody, and under anaesthesia…or sedation, that lowish blood pressure…had just been dropped to a point that in fact her perfusion to the conduction system of the heart was insufficient, leading to the bradycardia heart block, and once restored again, it's okay. So there was minor cardinal injury, probably, but no infarction."*[186]

133. According to Prof Myles, this aspect of Mrs GA's cardiac function was not demonstrated or indicated in the information available to Dr McNally at the relevant time and would not have been apparent to him or most competent anaesthetists. It follows that it is only in retrospect is it apparent that Mrs GA was more vulnerable than expected during sedation due to this underlying and unknown limitation of her cardiac function that was no known by Dr McNally at the time.[187]

[184] Transcript pages 464-465.
[185] Transcript pages 487-490.
[186] Transcript pages 492, 494-495.
[187] Transcript pages 464 and 490-492.

STANDARD OF PROOF

134. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, having regard to the 'Briginshaw sliding scale'.[188] When finding facts, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available evidence relevant to the questions in issue in the investigation.[189] When considering whether that level of satisfaction has been achieved, regard must be had to the seriousness of the allegation; the inherent likelihood or unlikelihood of an occurrence of fact, and; the gravity of the consequences flowing from a particular finding.[190]

135. This is particularly so with regard to adverse comments or findings about an individual in their professional capacity which should only be made when a coroner has reached a state of comfortable or reasonable satisfaction based on the evidence that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death.[191]

136. It is axiomatic that the materiality of any departure from applicable standards must be assessed without the benefit of hindsight, only on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may become apparent subsequently, or may even be obvious once the tragic outcome is known, are to be eschewed in favour of a fair assessment made from the perspective of the individual at the material time.

FINDINGS AND CONCLUSIONS

137. Having applied the applicable standard of proof to the available evidence, I find that:

a. The identity of the deceased is Mrs GA, born on 15 March 1931, aged 86.

b. Mrs GA died at St Francis Xavier Cabrini Hospital, Wattletree Road, Malvern, Victoria 3141, on 24 November 2017.

c. The medical cause of Mrs GA's death is bradycardic arrest secondary to relative hypoperfusion while undergoing surgery to the left hand in a patient with subclinical ischaemic heart disease.

[188] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336.*
[189] *Anderson v Blashki [1993]2 VR 89 at 96; Secretary to the Department of Health and Community Services v Gurvich [1995] 2 VR 69 at 73;*
[190] *Briginshaw v Briginshaw, op cit, at 362.*
[191] *Ibid.*

d. The clinical management and care provided to Mrs GA by A/Prof McCormack in respect of the lesion on the dorsum of her left hand was reasonable and appropriate.

e. More specifically, the clinical assessment of a probable SCC with no regional adenopathy and referral to Mr Houseman with a recommendation that the lesion be excised was in accordance with the wishes of Mrs GA and reasonable and appropriate in the circumstances.

f. The clinical management and care provided to Mrs GA by Mr Houseman in respect of the lesion on the dorsum of her left hand was reasonable and appropriate by reference to current standards of practice among plastic and reconstructive surgeons.

g. More specifically, the decision to excise the lesion on the dorsum of Mrs GA's left hand in theatre using local anaesthetic and intravenous sedation and harvesting and application of a split skin graft was best practice by reference to those standards.

h. Dr McNally's anaesthetic management, including her pre-anaesthetic assessment, monitoring and response to Mrs GA's deterioration was reasonable and appropriate, apart from the second dose of anaesthetic drugs.

i. Dr McNally appropriately conceded some deficiencies in her documentation and having reflected on these, gave evidence that she has improved her practice in this regard.

j. The weight of expert evidence supports a finding that the second dose of anaesthetic drugs, being 50mgs propofol and 50mcgs fentanyl administered by Dr McNally was excessive, and therefore not reasonable and appropriate.

k. That said, the weight of evidence does not support a finding that Dr McNally's administration of the second dose of anaesthetics was, as a matter of causation, the reason for Mrs GA's unexpected deterioration and the cascading effects that led to her death.

l. The weight of evidence supports a finding that the fact of Mrs GA's surgery and sedation, as opposed to any deficiencies in either, provided the setting in which her death occurred and was therefore causally relevant to her death.

m. Mrs GA's subclinical ischaemic heart disease was unknown prior to her surgery. Her death was therefore unexpected, unpredictable and not preventable in the way that that term is understood in this jurisdiction.

n. Having now reviewed the inquest brief, the transcript and the submissions of counsel, I am not of the belief that an indictable offence may have been committed by Dr McNally

in connection with Mrs GA's death. There is therefore no basis for a referral to the DPP under section 49(1) of the Act.[192]

o. Mrs GA's death was unexpected by everyone involved in the surgery on 21 November 2017, and no less by the deceased's family.* I wish to convey my sincere condolences to everyone involved and, in particular, to the family for the loss of their wife, mother and grandmother. It is apparent that they have been distressed and have many questions about the circumstances in which she died. I have endeavoured to answer those questions based on the available evidence in the hope of providing some comfort or closure to all concerned.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

This finding will therefore be published in its totality except that the name of the deceased will be deleted prior to publication; Mrs GA substituted for the deceased's name wherever it appears; and other family names redacted accordingly. This is at the family's request and without demurrer from any of the parties.

[192] Assisting Counsel, Ms Fitzgerald's submissions on this point are succinct and apposite.

DISTRIBUTION OF FINDING

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

Mr LV and Mr DT

A/Prof McCormack

Mr Houseman c/o Kennedys Lawyers

Dr McNally c/o Avant Lawyers

A/Prof Lefkovits c/o Avant Lawyers

Cabrini Hospital c/o Minter Ellison

Australian Health Practitioner Regulation Agency – for information only.

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 6 October 2023

*** Wherever it appears indicates an amendment made pursuant to section 76 of the Act on 10 October 2023 – insertion of footnote 5 consequent changes to numbering of footnotes that follow, paragraph 10, paragraph 21 and paragraph 137 (o).**

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.