

FINDINGS AND RECOMMENDATIONS

COURT DETAILS

Court State Coroner's Court of NSW
Case number 1223/09

PROCEEDINGS

Inquest into the death of **Heidi Maree CLARKE**
Hearing dates 28.03.2011 - 01.04.2011
Date of findings 01.04.2011
Place of findings Wagga Wagga Local Court
Findings of Deputy State Coroner, Magistrate Hugh Dillon

FINDINGS

I find that Heidi Maree Clarke-Lewis died on 30 April 2009 at Wagga Wagga Base Hospital, NSW as a result of a massive intra-abdominal haemorrhage caused by injuries to her right common iliac artery and vein during laparoscopic salpingectomy for an ectopic pregnancy

RECOMMENDATIONS

1. To Minister for Health:

I recommend that NSW Health undertake a feasibility study of the costs and benefits of introducing electronic recording of surgical procedures conducted in NSW Health Hospitals.

2. To Director Medical Services Murrumbidgee Local Health Network:

- (i) I recommend that the service consider adopting or incorporating in its protocol "communication with family / relatives in Ors" a checklist of the type proposed by Ms Tracy Collins in this inquest (copy attached)
- (ii) I also recommend to the Director that the Local Health Network review its current on-call procedures for clinicians within its jurisdiction.

REPRESENTATION

Assisting the coroner Ms P Dwyer (Dr), Ms M Heris (Sol)
Representing the family Mr Ian Roberts (SC) Mr T Abbott (Sol)
Mr J Harris (Sol)

Other parties

Mr R Weinstein (Bar) Ms M Smith (Sol) for Dr S Nassief
Mr G Gregg (Bar) Ms D Jackson (Sol) for Dr J Killen
Mr W Hunt (Bar) Ms K Doust (Sol) for NSW Nurses
Association

Mr S Maybury (Bar) Ms K Chambers (Sol) for Drs Hicks
and Harrison

Ms J Sandford (Bar) Ms V Hoeben (Sol) for Murrumbidgee
Local Health Network (formerly GSAHS)

SIGNATURE

Signature

Name

Magistrate Hugh Dillon

Capacity

Deputy State Coroner

Date

5 April 2011