CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Whyalla in the State of South Australia, on the 27th and 28th days of March, 3rd day of April, and 21st day of July, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Michelle Lee Drechsler.

I, the said Coroner, do find that Michelle Lee Drechsler, aged 27 years, late of 6 Patton Street, Whyalla died at the Whyalla Hospital on the 28th day of April, 1998 as a result of aspiration of gastric contents associated with persistent vomiting following gastric stapling for morbid obesity.

1. **Background**

1.1 Michelle Lee Drechsler was a married woman with three children. She lived with her family in Whyalla. She had a family history of obesity (her father weighed 146kgs). She began putting on weight during her first pregnancy, and this reached extreme proportions after her third pregnancy in 1994.

1.2 Mrs. Drechsler was referred by her general practitioner, Dr. Jerome Connolly, to Dr. Luis Isabel, a general surgeon in practice in Whyalla, for consideration of a gastric bypass procedure, or gastroplasty (known to the layman as "stomach stapling") in June 1997. At that time she weighed 126kgs. Dr. Isabel referred Mrs. Drechsler to a psychiatrist, Dr. Jah, for assessment, and he detected no abnormalities. Accordingly, an operation was arranged for 27 October 1997 at the Whyalla Hospital.

2. **The operation**

2.1 On 27 October 1997 Dr. Isabel performed a vertical-banded gastroplasty. By the time of the operation, Mrs. Drechsler's weight had increased to 133kgs.

2.2 The operation was explained by Dr. Philip Game, a surgeon specialising in gastric surgery, who provided a report concerning the treatment given to Mrs. Drechsler. He said:-

> "It basically involves ... placing a row of staples down the stomach in a vertical fashion ... in order to make the operation work you have to pass ... something around the stoma (opening) as a restriction ... because the critical part of the operation is that ... the rate at which food will leave the pouch depends on the diameter ... of that stoma. So for example if I was doing the operation, I would have my anaesthetist pass a bougie (a long, solid, flexible rubber instrument, cylindrical in shape, of specified diameter), down through the mouth ... and then I would place the mesh around the outside of the stomach so that ... the lumen inside was of the diameter to allow that bougie through so you actually can graduate the size of your lumen ... These pouches are made as small as we can make them, because we found that with time they all stretch and ... we find that a smaller pouch with a reasonable outlet seems to have less stretch and work better with less risk of these staples dehiscing (coming apart) in the long term". (T.172-3).

2.3 Mr. Game explained the purpose of the procedure as follows:-

> "It decreases the amount of food (to be taken) and restricts the rate at which (the stomach) empties, so that people feel full for longer, so that they eat less, so that they are instructed to eat small serves of very well-chewed food and ... you actually have to eat more slowly and you have to wait for it to pass through that stoma into the main body of the stomach until you can start eating again. And if in fact you eat more than the pouch will allow or too quickly before it is emptied, then essentially (you will) vomit". (T.175).

2.4 Mr. Game explained that bougies come in "French" sizes, the size being computed by multiplying the diameter in millimetres by *pi,* or 22/7. He said that he uses a 38 bougie, which is about 12mms in diameter, or at minimum a 36, which is about 11.5mms in diameter (T.176).

2.5 Mr. Isabel made no note after the operation of the size of the bougie he used (T.130). He said that he normally uses a 27 bougie, which is about 8.6mms in diameter (T.96), although he conceded:-

> "I know how I conduct this operation with a 27 French standard bougie, which is smaller than most people would use. If a smaller bougie was used it may have been because a 27 wasn't available and perhaps a 24 was used, that is a possibility; I didn't particularly check the bougie, you call out 'Insert the 27 French bougie'". (T167-8)

A 24 French bougie is about 7.6mms in diameter.

2.6 Mr. Game told me that it is the surgeon's responsibility to ensure that the size of the bougie is correct, and this should be noted on the operation record (T.200). He also said that, in his opinion, even a 27 French bougie is too small, and he said that:-

> "The preferred technique used by the majority of surgeons who perform this operation in Australia is to carry out the stapling using a 36 or 38 French bougie to make the stoma". (Exhibit C.14, p3).

2.7 Mr. Game had consulted a colleague in Melbourne who had performed more than 3,000 of these operations, and he had been told that he had never heard of a bougie smaller than 32 French being used for this operation before (T.201). These are significant disparities since, as Mr. Game pointed out, the size of the stoma is a function of the square of the diameter (T.186), so that a 11mm stoma is larger than a 8mm one by a factor of 121/64, almost double.

2.8 I mention the size of the bougie used because Dr. Isabel's handwritten operation notes appear to indicate that the stoma after the operation was 5mm in diameter. Indeed, when the note was transcribed at the hospital, the size of the outlet was typed as 6mm. This was signed at the time by Dr. Isabel (see part of Exhibit C.9). When giving evidence, Dr. Isabel read the handwritten note as 8mm, and described the typewritten note as a "typographical error" (T.94). In view of subsequent events, I am not satisfied that this is correct. I refer in particular to the barium swallow on 30 October 1997 when the naso-gastric tube "just" passed through the stoma, the endoscopy performed on 17 April 1998, when the outlet was too narrow to admit the endoscope, to Mrs. Drechsler's excessive weight loss following the operation, and her continual vomiting, and to Dr. Gilbert's findings at autopsy that the outlet was only 4 - 5mms in diameter.

2.9 Dr. Isabel's note records that he experienced difficulty gaining access to the operation site, due to the size of the left lobe of the liver. It reads:-

> "Upper midline incision. Enormous left lobe of the liver noted. Almost impossible to gain access to the hiatus. The liver was otherwise very fatty, gall bladder normal. The left lobe was mobiled to gain access to the hiatus. Window was formed in the gastrosplenic ligament to gain access to the posterior wall of the stomach. A window was also created in the lesser curvature. A TA90 stapler was inserted and fired, creating about a 40ml pouch.

> The outlet about (6mm) reinforced with marlex. Nasogastric tube inserted. Wound closed with one proline and staples for the skin". (Exhibit C.13a).

Notwithstanding the access difficulty, the operation proceeded without incident. A report on a barium swallow carried out on 30 October 1997 reads as follows:-

> "The nasogastric tube just passes through the small gastric lumen along the lesser curve and currently just allows a small amount of barium to pass distally into the body and antrum of the stomach. The lumen of the outlet therefore is just larger than the current nasogastric tube". (see Exhibit C.9).

Mr. Game commented:-

> "The barium study carried out prior to Michelle Drechsler's discharge would confirm that this was indeed the size created (5 or 6mm) as a standard nasogastric tube is 16 French (5mm). It is my opinion that a stoma of that size would inevitably lead to excess weight loss, excessive vomiting and an inability to tolerate solids". (Exhibit C.14).

3. **Post-operative progress**

3.1 Mrs. Drechsler was seen by Mr. Isabel again on 13 November 1997. She had lost 13kgs in 17 days, down from 133kgs to 120kgs. Mr. Isabel said:-

> "All appeared to be satisfactory". (T.97).

3.2 Dr. Connolly saw Mrs. Drechsler on 20 November 1997. She had lost a further 6kgs in seven days. She saw him again on 4 December 1997. Her weight was then 108kgs. She had lost a further 6kgs in 14 days. She complained of a dry mouth, numbness to her hands and arms, inability to eat, a bad headache and no bowel function. She said that she had been vomiting. Dr. Connolly prescribed a laxative (T.80).

3.3 On 11 December 1997 Mrs. Drechsler was seen by Mr. Isabel. Her weight was 109kgs. She had lost a total of 24kgs in 46 days. She complained of being unable to keep solids down. Mr. Isabel told her that she should not have been eating solids. He said that she was happy with the extent of her rapid weight loss (T.98). Mr. Isabel saw her again on 3 February 1998, when her weight had dropped to 98kgs, a total of 13kgs in eight weeks, and a total of 37kgs in twelve weeks. He noted that she "feels well, exercising ..." (T.99).

3.4 Even though Mrs. Drechsler was clinically well, and happy with the rapidity of her weight loss, Mr. Game told me that her weight loss of 37kgs in twelve weeks was too rapid, although he conceded that the more recent figures of 13kgs in eight weeks was

"getting better" (T.188, T.208). He said that the ideal rate of weight loss is 1.2kg per week, levelling out at about one kilogram per week. He said that she should have been able to eat well-chewed solid food four to six weeks after the operation (T.180-181).

3.5 On 17 March 1998 Mrs. Drechsler was seen by Dr. Connolly, complaining of migraine headache. Dr. Connolly admitted her to Whyalla Hospital. The admission note reads:-

> "Events leading to admission: taking daughter to school - felt dizzy - headache - headache eased off - eyes blurry - went to doctor's surgery - came straight to hospital.
>
> General health: vomiting". (Exhibit C.9).

Mrs. Drechsler received injections of valium and maxalon. Her blood pressure was relatively normal at 100/75. Blood tests carried out at that time were within normal limits, so Mrs. Drechsler was allowed to be discharged home, telling the staff "she cannot sleep in hospital". Mr. Isabel said that these blood tests indicated that Mrs. Drechsler was receiving appropriate nutrition at that stage (T.128). Mr. Game said that this was not necessarily so. He said that there could have been changes to the levels of intra-cellular Potassium which would not show up in blood tests until these changes became "dramatic" (T.194). When asked whether he would suggest that follow-up tests should be taken, he said:-

> "As I say, the weight loss is too fast. I would not have been happy with that, I would have been wanting to know and looking at doing something to correct the problem". (T195).

3.6 Unfortunately, Dr. Connolly did not refer Mrs. Drechsler back to Mr. Isabel at that time. He was misled by the normal blood test, perhaps into assuming that the vomiting was associated with her migraine.

3.7 Mrs. Drechsler saw Dr. Connolly again on 1 April 1998. Her weight was down to 79kgs. She was unable to tolerate milk. He gave her a vitamin injection. She came back on 8 April 1998, by which time she had made an appointment to see Mr. Isabel.

3.8 Mrs. Drechsler saw Mr. Isabel on 16 April 1998. She weighed 75kgs, having lost 58kgs in just under six months. This is more than double what Mr. Game regarded as appropriate (20kgs - T.180). She told him she was "now not able to eat anything,

sometimes even milk gives rise to vomit" (T.100). He said that this obviously indicated an "outlet obstruction", so he arranged for an endoscopy the following day (T.101).

3.9 At endoscopy on 17 April 1998, Mr. Isabel found the outlet "stenosed" (narrowed) to between 5mm and 8mm (T.101). I think that conclusion assumes that the outlet was larger than that to start with which, for the reasons I have already outlined, I am not satisfied was the case.

3.10 In any event, Mr. Isabel dilated the outlet to 9mm, using a balloon attachment to the endoscope. This is still not as much as Mr. Game said was widely accepted as appropriate (11 - 12mm - T.176). Mr. Isabel acknowledged that this was a temporary method to tide her over until she could return to undergo surgical revision (T.102). He said that such review was not urgent, that it could be done in "the next couple of weeks" (T.104), and Mr. Game agreed (T.193).

4. **Events of 27 and 28 April 1998**

4.1 During the afternoon of 27 April 1998 Mrs. Drechsler suffered a "blackout" while teaching someone to drive a car. Her husband took her to the Whyalla Hospital, where it was noted:-

> "Presents at casualty door in private car semi-conscious, requiring lifting on to barouche. No medical history. Recent surgical history of stomach stapling Oct 97. Now very drowsy/lethargic - orientated, slightly slurred speech. Not able to remember incident. Was in car at the time (teaching a learner driver) when 'collapsed' - 1805". (Exhibit C.9).

4.2 At 6.33p.m. Mrs. Drechsler's blood pressure was alarmingly low at 72/47. Dr. Connolly saw her at 7.30p.m. and admitted her to hospital. At around that time, it was noted that she "vomited 75ml. undigested food" (Exhibit C.9). Dr. Connolly described her as "quite lucid, quite sensible" at that time (T.38). He admitted her for observation. He said that he did not call Mr. Isabel because she was "stable" (T.73).

4.3 The medical record indicates that Mrs. Drechsler's blood pressure remained low. As I said, on admission it was 72/47, at 7.45p.m. it was 85/50, and at 4.45a.m. it was 70/50, which were all readings which Mr. Game described as "significantly low" (T.197).

4.4 Dr. Connolly saw Mrs. Drechsler again at about 7.30a.m. on 28 April 1998. He wrote what he described as "jottings" in the medical record:-

> "observe + bloods
> query endo result last week".

I pause to observe here that Dr. Connolly's handwriting is not good.

4.5 Dr. Connolly said that he also told the nurse on duty that "she needs blood tests and to see Mr. Isabel" (T.43). He did not write this in the medical record, as he should have done.

4.6 Dr. Connolly said that he expected the blood test results to be telephoned to him if they were abnormal (T.43). In this, he displayed a surprising ignorance of hospital procedure in relation to pathology tests. I heard evidence from Dr. Krystyna Rowland, the head of the Diagnostic Services Laboratory at the Institute of Medical & Veterinary Science, who told me that the test requested was routine, and was not marked as urgent. It was processed in the normal way, the results were printed at 11.45a.m., and delivered to Dr. Connolly's surgery on the 2.00p.m. round, and to the ward on the 4.30p.m. round.

4.7 Dr. Rowland explained that if the blood test is requested in the afternoon, the results, whether abnormal or otherwise, are telephoned through to the requesting doctor in case the written result is not received until the next day (T.214). This is what happened in March of that year when Dr. Connolly requested a blood test for Mrs. Drechsler.

4.8 As it transpired, the blood test requested on 28 April showed that Mrs. Drechsler's Potassium level was 2.5. Dr. Rowland commented:-

> "This is a significant low Potassium that needs treatment, but it is not at the level at which we phone a result because obviously each laboratory has its set of critical results and this is just before the level that we phone. We phone at 2.4 and that level is 2.5, so that would not have been phoned". (T.215).

4.9 Dr. Connolly should have been aware of these procedures. If he has admitting rights to the Whyalla Hospital, he is under a duty to ensure that he is familiar with the services available at the hospital in the interests of his patients.

4.10 Dr. Connolly also assumed that, since Mrs. Drechsler had been admitted to a surgical ward, she would be seen as a matter of course by Mr. Isabel on his morning ward round on 28 April 1998. Mr. Isabel told me that this was not necessarily the case (T.111). He pointed out that there had even been psychiatric patients in that ward.

4.11 Dr. Connolly seems to have assumed too much. It is surprising that a medical practitioner in a regional centre, with admitting rights to a small general hospital, did not understand these basic issues.

4.12 Dr. Connolly did not make an entry in the casenotes referring Mrs. Drechsler to Mr. Isabel. He did not even direct that a copy of the blood test be sent to Mr. Isabel (T.83), yet he assumed that Mr. Isabel would take over the carriage of Mrs. Drechsler's case without a communication of any kind. In my view, this is an inappropriate, and indeed unprofessional, approach towards referring a patient with a serious condition to a consultant.

4.13 For his part, Mr Isabel went to the ward at about 8.30am on 28 April 1998. He said:-

> "I walked into the surgical ward, we do a normal round in the morning and sitting virtually in front of me I saw Mrs. Drechsler sitting in bed with her legs crossed smiling at me. So I approached her and asked her what she was doing in hospital and she explained to me how she had a fainting episode the day before and her G.P. had admitted her to hospital for investigation". (T.104-5).

He said that he asked Mrs. Drechsler a few questions about her symptoms out of "general curiosity" (T.105). He said:-

> "From what she told me, it looked satisfactory at that stage. She had eaten, she had maintained satisfactory intake once we did the dilatation, she was comfortable, she was not vomiting on that morning. I could not say that there seemed to be a surgical problem at that stage, but I don't normally investigate fainting episodes". (T.112).

4.14 I have had much difficulty reconciling Mr. Isabel's evidence about this visit. At one stage, Mr. Isabel told Mr. Bowler, counsel for Mr. Drechsler, that it was a "social conversation" (T.144). However, in evidence in chief, he said that when Mrs. Drechsler asked him if she could go home, he said:-

> "From my point of view, if your G.P. is not going to do any other tests for you, then <u>from a surgical point of view our plan of action</u> is as planned but you need to check with Dr. Connolly to make sure that he's happy with your condition, if he's not planning any other investigations". (T.106).

4.15 Mr. Isabel did not examine Mrs. Drechsler that morning, did not see the blood test results, and did not read the casenotes. His evidence is to be contrasted with an entry made by a sixth year medical student, accompanying Mr. Isabel on his rounds, in the Medical Record (Exhibit C.9) as follows:-

> "Surg. Note - S/B Dr. Isabel
> S (subjective) vomiting still
> Eating still difficult
> Wt (weight) loss has levelled out ~ .5kgs every 2/7
> O (objective) :
> A (assessment) : narrowed G - O (gastro - oesophageal) orifice post surgery
> P (plan) Ensure T.D.S
> Discharge today
> Follow up in clinic".

"Ensure" is a dietary supplement. The note is then signed by the medical student. The time that the note was made has not been endorsed on the record, although the next note is at 10.30a.m. so that it may be safely concluded that it was made before that time.

4.16 Mr. Isabel refused to contradict that entry in the medical record, saying merely that it was the medical student's interpretation of what occurred. I found his evidence on this point illogical and circuitous (see T.153-158).

4.17 In my opinion, whatever Mr. Isabel's intention, he gave everybody else in the ward that morning the impression that he had indeed "seen" Mrs. Drechsler in the clinical sense. Any reservations he had in his own mind about that were unstated to anyone else. For example, the next entry in the medical record made by the Registered Nurse at 10.30a.m. reads:-

> "Seen by Dr. Isabel as above. To review in rooms and commence on Ensure/Sustagen/advice given. Dr. Connolly notified happy for discharge". (see Exhibit C.9).

As far as the nurse was concerned, clearly Dr. Connolly's instruction that Mrs. Drechsler should be seen by Mr. Isabel had been fulfilled, and there was no reason for any further action to be taken by her.

4.18 Discharge

At about 10.30am, Dr Connolly was telephoned by the nurse and told that Mr Isabel had seen Mrs Drechsler and that she was for "discharge and follow up in the rooms". He said that he was surprised and said "Are you sure?". The nurse retrieved the casenotes, and read out the note made by the medical student I have quoted above (T44).

4.19 Dr. Connolly said that he simply acquiesced, thinking that Mr. Isabel had discharged Mrs. Drechsler home (T.44). The nurse noted Dr. Connolly's agreement, as I have also already mentioned.

4.20 Mrs. Drechsler was given a prescription for Mersyndol Forte (Exhibit C.10) signed by the surgical registrar, which, Dr. Connolly said, fortifies his view that Mr. Isabel had indeed taken over conduct of the case (T.71).

4.21 In my opinion, Mrs. Drechsler's discharge in this manner was highly unsatisfactory, indeed almost farcical. Through a breakdown in communication, both Dr. Connolly and Mr. Isabel thought that the other was directing the case. As it transpired, neither of them was. This resulted in Mrs. Drechsler being discharged from Whyalla Hospital before the results of the blood test became available. If this had not occurred, she should have remained in Whyalla Hospital, and her low blood/Potassium levels could have been addressed (see Mr. Game's comments at T.206). Dr. Connolly did not

become aware of the test results until about 6.00p.m. that evening, when he was going through his paperwork (T.48).

4.22 This episode does neither doctor any credit. Mr. Isabel blamed Dr. Connolly's "telepathic referrals" (T.167), and I agree. However, he contributed to the situation by "seeing" Mrs. Drechsler that morning, and giving everyone the impression that he was treating her. I agree with him that more attention to detail, and "more strict definition of roles" may have led to a different result.

5. The final collapse

5.1 Mr. Drechsler said that his wife arrived home from hospital at about 11.30a.m. on 28 April 1998 (T.11).

5.2 At about 6.30p.m. Mr. and Mrs. Drechsler visited a friend's house for dinner. Mrs. Drechsler had a very small amount of food - Mr. Drechsler said that she had half to three-quarters of a dessertspoon of baked potato and vegetables (T.22). She went and laid down after that, as she said she was feeling "dizzy" (Exhibit C.7, p1). A little time later, she called out to her husband, and when he went into the bedroom he saw that she was unresponsive, and her eyes and mouth were wide open. On the way to the Whyalla Hospital in the car, Mr. Drechsler said that his wife stopped breathing during the journey, and he could not feel a pulse (Exhibit C.7, p2).

5.3 Dr. Peter Windsor, a specialist physician, was called in and arrived at the hospital at about 8.05p.m. He reported to police:-

> "I was told the patient had been brought into the hospital in an arrested state by private car. I noticed CPR in progress and I could see she had a considerable amount of vomit around her airway. I know this patient as Michelle Lee Drechsler. On further examination I noticed she had fixed dilated pupils and no heart beat, flat line tracing on ECG. I intubated her, an IV was put in by Dr. Monkhouse. She was hand-ventilated and given multiple doses of adrenalin plus IV fluids. At about 8.23p.m. resuscitation was discontinued as the patient had no response. She had fixed dilated pupils, no heart beat. I certified life extinct at 8.23p.m." (Exhibit C.1a).

6. Cause of death

6.1 A post mortem examination was carried out on the body of the deceased on 1 May 1998 at the Forensic Science Centre at Adelaide by Dr. J.D. Gilbert, forensic pathologist.

Dr. Gilbert's report is Exhibit C.2a. He diagnosed the cause of death as:-

> "Aspiration of gastric contents complicating metabolic abnormalities associated with persistent vomiting and poor oral intake following gastric stapling for morbid obesity". (Exhibit C.2a, p1).

6.2 During the post mortem examination, Dr. Gilbert noted:-

> "A vertical row of staples separated the gastric body from the fundus. The residual lumen comprised a 4 to 5 mm diameter orifice at the upper end of the row of staples. The proximal part of the stomach contained approximately 100ml of semiliquid, partly digested food material. Only about 10 to 20ml of similar material was noted in the distal stomach". (Exhibit C.2a, p2).

6.3 Dr. Gilbert commented:-

> "The autopsy confirmed the presence of aspiration of gastric contents. There was significant narrowing of the outlet of the gastric pouch. Although the outlet had been dilated to 9mm eleven days before death, it measured only about 4 to 5mm in diameter at autopsy. The liver showed severe fatty change. Fatty change may be seen in association with obesity but, in addition to conditions not relevant here such as diabetes and alcoholism, it may also be seen as a result of malnutrition and starvation.
>
> It appears most likely that the death was a consequence of prolonged narrowing of the outlet of the gastric pouch to the extent that the deceased's nutrition was suboptimal. In addition, over the last 3 months of life she had suffered repeated episodes of vomiting related to the obstruction. Due to both vomiting and impaired dietary intake she was at risk of electrolyte disturbance such as the hypokalaemia noted on the morning of her death. Her fatty liver may have impaired her ability to maintain normal blood glucose levels though there was no objective evidence of this earlier on the day of death or the day before. Her post mortem insulin and C-peptide levels were normal so there was no evidence that hyperinsulinaemia contributed to the death.
>
> I have attributed death to aspiration of gastric contents complicating metabolic abnormalities associated with persistent vomiting and poor oral intake following gastric stapling for morbid obesity". (Exhibit C.2a, p5).

6.4 Mr. Isabel joined issue with Dr. Gilbert's diagnosis, pointing out that at her death Mrs. Drechsler still weighed 76kgs, indicating that she was "hardly malnourished" (T.114). He also argued that her hypokalaemia (low Potassium) was "mild to moderate" at 2.5 (T.117), and was unlikely to have caused her to faint. Dr. Rowland agreed (T.221). Mr. Isabel argued that her very low blood pressure, demonstrated on 27 April, may have precipitated the fainting attack and fatal aspiration (T.118).

6.5 Mr. Game, on the other hand, commented in his report:-

> "It appears that the resuscitation attempts were unsuccessful following her aspiration, probably due to the severe hypokalaemia which caused a terminal arrhythmia". (Exhibit C.14, p5).

6.6 The low Potassium levels seemed to have been a result of the vomiting, not the cause of it. Whatever the cause of the fainting (vaso-vagal, hypotensive, or arrhythmic), it will not be possible to reach a firm conclusion on the basis of the evidence. I think that the most that can be concluded is that the manner in which the gastroplasty was performed by Mr. Isabel, producing a stoma, or opening which was far too small, was responsible for the excessive vomiting suffered by Mrs. Drechsler over an extended period. This vomiting may or may not have been associated with the fainting episode, but it was certainly associated with Mrs. Drechsler's aspiration. I therefore find that the cause of death was:-

> "Aspiration of stomach contents associated with persistent vomiting following gastric stapling for morbid obesity".

7. **Recommendations**

7.1 I have expressed concern at a number of aspects of the clinical practice conducted by both Dr. Connolly and Mr. Isabel in this case. Section 25(2) of the Coroners Act empowers me to make recommendations which may prevent or reduce the likelihood of the recurrence of a similar event in future.

7.2 I do not think that it is appropriate to make recommendations addressing specific aspects of clinical practice conducted by members of a learned profession. However, I think it is appropriate to make recommendations in this case which address general aspects of what occurred here.

7.3 Accordingly, I recommend that:-

- Dr. Connolly reviews his clinical practices with a view to becoming familiar with hospital protocols and procedures, particularly in relation to pathology tests, admission practices, discharge practices, and referral between practitioners;

- Mr. Isabel reviews his clinical practice with a view to complying with professionally accepted standards in relation to surgical procedures, referrals from general practitioners (particularly ensuring that all medical professionals involved in a case are aware of whether he has assumed responsibility for the treatment of a patient or not), and record-keeping (particularly in relation to surgical procedure notes).

Key Words: medical practitioners; surgery; hospitals

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 21st day of July, 2000.

……..……

Coroner

Inq.No.14/2000