CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 21st, 22nd and 24th days of November 2011, the 12th day of December 2011, the 17th, 20th, 21st, 22nd, 23rd and 24th days of February 2012, the 9th day of March 2012, the 7th, 9th, 10th and 11th days of May 2012 and the 1st day of November 2012, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Lauren Michelle Edgar.

The said Court finds that Lauren Michelle Edgar aged 28 years, late of 43 Edwards Street, Brighton, South Australia died at Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 10th day of March 2008 as a result of multi-organ failure due to Clostridium perfringens myonecrosis complicating liposuction. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Lauren Michelle Edgar, aged 28 years, died at the Royal Adelaide Hospital (RAH) on Monday 10 March 2008. She was certified deceased at 10:28am that day. Ms Edgar had been transferred to the RAH from the Flinders Medical Centre (FMC) during the previous day. She had been admitted to FMC during the Saturday morning of that long weekend, having been taken there by her parents after a number of days of worsening pain and discomfort.

1.2. Ms Edgar had undergone a liposuction procedure on Wednesday morning, 5 March 2008. This procedure had taken place in the rooms of Dr George Kerry, a cosmetic surgeon practising in Melbourne Street, North Adelaide. Ms Edgar had been discharged to her home at Brighton immediately following the procedure. She had

caught a taxi home. Following her discharge, she was not examined again by Dr Kerry.

1.3. Ms Edgar had been a physically healthy young woman prior to the liposuction procedure, although the Court understands that she had been on a disability pension in respect of an illness that had a psychological component. Ms Edgar died as a result of having contracted a Clostridium perfringens (clostridium) infection that led to gas gangrene affecting her legs and pelvis. There can be no question but that Ms Edgar contracted the infection consequent upon the liposuction procedure. The procedure had involved the abdomen and both thighs, front and rear, and had required the making of five separate small incisions in the skin of her legs and abdomen through which the procedure was conducted. The only explanation for the introduction of the clostridium bacterium into Ms Edgar's bodily tissues would be by way of one or more of the incisions. A live issue in the Inquest was whether the bacterium had been introduced during the procedure itself or subsequently through closed, sutured and dressed incisions.

1.4. It is pertinent to observe here that gas gangrene consequent upon the invasion of bodily tissues by the clostridium bacterium is a rare occurrence in countries such as Australia, and certainly rare in the context of wounds caused during surgical procedures. However, gas gangrene consequent upon the clostridium bacterium being introduced into the tissues is a known possible lethal complication of liposuction and is reported in medical literature[1]. The specific clostridium bacterium under discussion exists in the bowel and/or vagina in a certain percentage of the population. It can exist on the skin in the vicinity of the perineum. For this reason, rigorous sterilisation of the skin in this region is an imperative in surgical procedures that involve penetration of the skin such as liposuction.

1.5. In this Inquest I examined a number of issues that included the following:

a) Whether Ms Edgar provided proper and informed consent to the liposuction procedure;

b) The circumstances in which Ms Edgar contracted her fatal infection, and in particular whether the infection was contracted during the course of the liposuction procedure itself or subsequently;

c) Whether if the infection had been contracted during the course of the procedure a source of the infection could be identified;

d) Whether proper and adequate post-operative advice and care had been provided to Ms Edgar, and in particular whether the effects of her infection could have been ameliorated by more appropriate and timely post-operative care;

e) Whether more timely provision of medical and surgical care may have prevented Ms Edgar's death and;

f) Whether in any event Ms Edgar's death could have been prevented.

2. Cause of death

2.1. A post-mortem examination was conducted in respect of Ms Edgar by Dr Karen Heath who is a forensic pathologist at Forensic Science South Australia. Dr Heath provided a report in respect of her post-mortem examination[2]. In her report Dr Heath expresses the cause of death as 'multi-organ failure due to Clostridium perfringens myonecrosis complicating liposuction with a contributing factor of paracetamol and codeine toxicity'.

2.2. Dr Heath explains that Ms Edgar's death was due to multi-organ failure that was in turn due to Clostridium perfringens myonecrosis involving gas gangrene of the left leg, thigh and pelvis and rectus abdominis muscle following liposuction.

2.3. Dr Heath's report does not express any opinion on the subject of whether or not the infection was contracted during the liposuction procedure or subsequently, except to say that the infection and consequent myonecrosis were conditions that had liposuction as their origin. On the other hand, a great deal of evidence in respect of that subject was given by clinicians involved in Ms Edgar's care prior to her death and also by independent experts who have examined this matter. I will deal with that issue in due course.

2.4. The only other matter arising from Dr Heath's report that needs to be mentioned here is her opinion that a contributing factor in respect of the death in this case was paracetamol induced hepatotoxicity as well as codeine toxicity. This opinion was

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[1] Exhibit C27e, Major and Lethal Complications of Liposuction: A Review of 72 Cases in Germany between 1998 and 2002\ (various authors – Plastic and Reconstructive Surgery • June 2008 Volume 121, Number 6)

[2] Exhibit C2a

premised upon elevated paracetamol levels detected at the FMC upon Ms Edgar's admission. This was thought to have contributed to abnormal liver function and coagulopathy. It is evident, however, that a more attractive and logical explanation for the abnormal liver function and coagulopathy would be Ms Edgar's infective pathology. In addition, there is doubt about the accuracy of a report concerning the level of paracetamol in her blood at a particular point in time during the course of her care. In the event I did not understand any represented party in these proceedings to advocate a position that either paracetamol or codeine toxicity, or both in combination, played any significant role in Ms Edgar's clinical presentation and death. It is for that reason that I do not include by way of contributing factors paracetamol and/or codeine toxicity in the recitation of the cause of death in these findings.

2.5. However, the question of paracetamol and codeine ingestion is of significance for other reasons. Ms Edgar had consumed a large number of Panadeine Forte tablets in the period between the Friday afternoon following her liposuction procedure and her presentation to the FMC on the Saturday morning. Panadeine Forte is a paracetamol and codeine based analgesic that can only be supplied upon a doctor's prescription. As will be seen, Dr Kerry, the medical practitioner who had performed the liposuction procedure in respect of Ms Edgar on the Wednesday of that week, had prescribed Panadeine Forte for Ms Edgar during a telephone conversation that he had with Ms Edgar on the Friday afternoon. In that conversation, Ms Edgar had indicated that she was suffering pain. Dr Kerry then made an arrangement with a pharmacist for the filling of a prescription of Panadeine Forte. Later in the afternoon the Panadeine Forte was collected from the pharmacy by Ms Edgar's father. It is apparent that Ms Edgar consumed Panadeine Forte tablets significantly in excess of the number prescribed or recommended and one can only conclude that she did so because she had experienced a significant level of pain during the relevant period. The high levels of paracetamol and codeine detected in her blood upon admission to the FMC is thus explained.

2.6. I find the cause of Ms Edgar's death to have been multi-organ failure due to Clostridium perfringens myonecrosis complicating liposuction.

3. Clostridium perfringens

3.1. Clostridium perfringens (Clostridium) is a bacterium found in soil and is often present in the bowel and the vagina as normal flora. It produces spores that are extremely small and which, when they land in a suitable environment, begin to multiply. In order to infect an area of human tissue it needs an hospitable environment that is anaerobic or oxygen free. Once embedded in this kind of environment it rapidly multiplies and produces a number of toxins, the most destructive of which is the alpha toxin. The toxin produces a number of effects including the reduction of muscle blood flow that in turn can shut down blood supply to the tissues in the vicinity of the organism causing those tissues to die and become anaerobic. The toxins produced by the organism can emanate from a small site of infection and rapidly spread through the tissues causing gas gangrene which results in gas within the tissues. The other significant effect of the alpha toxin is to produce within the body as a whole, sepsis that can rapidly lead to multi-organ failure.

3.2. The clostridium organism thrives on an anaerobic, that is to say an oxygen depleted, environment. Such an environment can be set up in the first instance during a liposuction procedure that involves the introduction of a tumescent solution that assists in the process in ways that I will describe presently. The action of the organism also leads to further oxygen depletion in the affected tissues.

3.3. The evidence suggested that gas gangrene in a very rare condition, but as seen earlier its association with liposuction has been recorded.

3.4. The liposuction technique in question in this particular case is known as the tumescent technique. Tumescent fluid that includes as its components adrenaline and lignocaine, is injected into the fatty layers directly below the skin's surface through small incisions in the skin. The technique is designed to prepare the fatty layer for ease of subsequent extraction. As well, it has a tendency to anaesthetise the areas concerned so as to obviate the necessity for a general anaesthetic. Rather, the patient is sedated to a degree that reduces discomfort and renders the patient incapable of retaining memory of the procedure. The fluid also lessens bleeding. One effect of the infiltration of tumescent fluid pursuant to this particular technique is its tendency to create an anaerobic environment within the bodily tissues, for the most part caused by its inhibiting effect on blood supply to the tissues. The anaerobic environment thus created is hospitable to the Clostridium bacterium.

3.5. Although the incidence of gas gangrene from Clostridium in this country is rare, the infection once contracted can have devastating and rapid consequences. Thus, in liposuction procedures the proper and effective sterilisation of instruments, of the patient's skin and of the environment in which the procedure is to take place is essential. I should add here that the clostridium organism is not the only source of bacterial tissue necrosis that needs to be guarded against by the proper administration of appropriate sterilisation techniques, but it is the organism that is relevant as far as the issues in this Inquest are concerned.

3.6. If a clostridium infection is contracted, early detection, diagnosis and treatment by a number of different treatment modalities is of paramount importance.

4. <u>The relevance of Ms Edgar's background to the issues of consent to and the appropriateness of the procedure</u>

4.1. Ms Edgar was 28 years of age. She lived at home with her parents and her brother at their residence in Brighton. Ms Edgar was not employed at that time. I have already alluded to the fact that she was in receipt of a disability pension in respect of a psychological illness for which she had been treated. At the time with which this Inquest is concerned Ms Edgar was taking Risperidone which is an antipsychotic drug as well as having other properties. This medication had been prescribed to her in respect of the psychological illness. The fact that Ms Edgar was taking this medication was known to Dr Kerry. It is therefore said that there may have been a need for greater care to be taken as to whether or not Ms Edgar's consent to this elective procedure was one that had been given in an appropriate frame of mind or whether her motivation in undergoing the procedure or her expectations should have been more closely evaluated. The further suggestion is that it may have been advisable, if not necessary, for the medical practitioner carrying out the procedure to have spoken to her general practitioner before the procedure was carried out.

4.2. It is true that when Ms Edgar's parents discovered that it was their daughter's intractable intention to go ahead with the procedure, they were most unenthusiastic about it, believing that their daughter's concerns about her self image could be addressed by exercise and lifestyle choices. There was also the matter of the cost of the procedure, approaching something of the order of $7,000 which in the event, to Mr Edgar's deep dismay, was revealed to have been financed by a credit provider, and

which was a sum that they may have thought was not commensurate with what might have been expected in terms of the enhancement of Ms Edgar's appearance or her self-esteem. Further to all of that there was a suggestion during the course of the evidence that Ms Edgar may have been seduced into selecting the particular medical practitioner to perform the liposuction procedure on the basis of what is alleged to have been inaccurate advertising, insofar as a prominent advertisement in the Yellow Pages indicated that the particular practice in question had received a *'high commendation'* from an accrediting Commonwealth agency, a claim that the cynic might view as being calculated to induce rather than reassure, when any commendation that had been expressed by that agency in respect of that practice was quite arguably something other than what had been described in the advertisement. The advertisement also depicted slogans that some might say would be more at home in an advertisement for a spa or a gymnasium, such as *'Look Good Feel Great'* and *'Do it for yourself'*, a slogan that Ms Edgar parroted to her parents when questioned about her motivation.

4.3. I have considered all of these matters carefully. There is no suggestion that Dr Kerry was not qualified or lacked the requisite experience or expertise to carry out a liposuction procedure of the kind that Ms Edgar was to undergo. Ms Edgar was a suitable candidate for the carrying out of the procedure in question. It cannot be said that her quest for enhancement of her self image, or for an improvement in her appearance in the eyes of others, was wholly irrational. There is no suggestion for instance that by the time she actually underwent the procedure she harboured any unreasonable expectation in respect of the procedure as far as improvement of her appearance or self-esteem is concerned. There is no evidence that Dr Kerry misrepresented or exaggerated any of the benefits that might have been derived by Ms Edgar in undergoing the procedure, that he secretly held a belief that she would derive no benefit from it at all or that he kept any information from her that might have changed her mind about the benefits of the procedure in her particular case. Furthermore, this was an elective procedure that despite what ultimately happened does not carry any unusual intrinsic degree of risk if carried out by competent and experienced hands. As well, on two separate occasions prior to the day on which the procedure was ultimately carried out, Ms Edgar was seen within the practice. The first of these occasions occurred some weeks prior to the carrying out of the procedure and there is no suggestion that Ms Edgar was actually, or in her own mind, locked into undergoing the procedure by anything said by the practitioner or his staff.

4.4. Dr Kerry told the Court that he had raised the issue with Ms Edgar as to whether he should speak to her general practitioner and that she had not given the requisite consent for such an approach to occur. Dr Kerry had enquired of Ms Edgar as to whether in the light of her having taken Risperidone she had experienced any problems with schizophrenia to which she had responded by saying that she had used the drug in connection with chronic fatigue. It must be said that any acceptance by a medical practitioner of an explanation such as that would have to be viewed as naïve if not perverse; Dr Kerry said he concluded that the drug '*can be used in depression which can be associated with chronic fatigue and that's the way I took it from the patient*'[3]. He stated in cross-examination by Mr Swan, counsel for Mr and Mrs Edgar, that he had sought further information from the patient herself about her use of Risperidone and had considered whether it might be appropriate for him to approach her general practitioner about that to which she had refused. In this regard, it is worthwhile observing here that patients seeking cosmetic surgery, as opposed to specialist surgery generally, do not go through the usual 'gatekeeping' referral by a general practitioner and therefore do not necessarily receive any other professional opinion about whether their expectations are reasonably held or will be met. Dr Kerry acknowledged in his evidence before the Court that seeking clarification regarding Ms Edgar's use of Risperidone would have been an appropriate enquiry to make because it would have been relevant information to have considered before making a decision about whether the surgery should be proceeded with in her case. The fact that the patient herself had refused to facilitate access to that information was a matter that Dr Kerry rightly acknowledged would possibly militate strongly against proceeding with the surgery[4]. In the event, however, there is no evidence to suggest that appropriate enquiries would have revealed information about Ms Edgar that inevitably would have rendered it unreasonable for Dr Kerry to have proceeded with the surgery. Dr Kerry did concede in cross-examination by counsel assisting that it would have been appropriate for him to have suggested that Ms Edgar obtain a second opinion before proceeding with liposuction and that it would also have been appropriate given the nature of the medication that she was taking for a psychological referral to have been undertaken before proceeding with the surgery[5]. The Court agrees with those concessions.

[3] Transcript, page 691
[4] Transcript, page 693
[5] Transcript, pages 735-736

5. Dr Kerry and his surgical methodology

5.1. Dr Kerry obtained his basic medical qualifications in 1975 from the University of Adelaide. He began private practice as a general practitioner in 1977. Dr Kerry does not have general surgical or plastic surgical qualifications. The field of cosmetic surgery is not a specialty recognised by the Australian Medical Council. There is in existence an Australian College of Cosmetic Surgeons which is currently seeking recognition of cosmetic surgery as a surgical specialty. Dr Kerry is a member of that College.

5.2. Dr Kerry commenced undertaking cosmetic procedures in 1988 under the mentorship of a senior practitioner in Melbourne. He also underwent mentorship under the guidance of certain practitioners in the United States. Between 1988 and 1992 Dr Kerry experienced mentorship in Melbourne. He did this by way of sitting in on consultations, viewing various cosmetic procedures and participating in post-operative care and counselling of patients. He commenced undertaking certain procedures himself in 1988. In 1990 he began attending conferences, workshops and clinics in hospital settings in the United States. He continued with this activity until approximately 2001. In the intervening period he was tutored in a number of cosmetic procedures including liposuction. He was mentored by United States practitioners by way of consultation, preparation for surgery, performance of surgery and post-operative care. He was trained in the maintenance of sterile fields both as a medical student and by a general surgeon during his final year of medicine at University. Dr Kerry also told the Court that he was involved in general surgical procedures at private hospitals in Adelaide. He also worked with plastic surgeons.

5.3. It appears that Dr Kerry's expertise in liposuction has been derived in the most part from his experiences in the United States where he worked under practitioners who regularly performed the procedure. As part of that he observed aseptic techniques and practices associated with the liposuction procedure. He first started undertaking liposuction practice in his own right in 1990. Over the years he has attended various conferences and conventions relating to liposuction and is a Member of the American Academy of Cosmetic Surgery.

5.4. Dr Kerry's first cosmetic surgical practice commenced in premises in Gouger Street in the city. He moved to the Melbourne Street, North Adelaide premises in 2001.

5.5. Dr Kerry explained a number of accreditation measures that his practice has undergone including at the hands of AMADA[6] and more latterly the ACHS[7]. As at the time of the events with which this Inquest is concerned, his practice had accreditation from ACHS which was then currently in force.

5.6. Dr Kerry told the Court that as of March 2008 he had performed approximately between 2,500 and 3,000 liposuction procedures and that since that time as at the date of the Inquest had performed between another 500 and 1,000 procedures. Over the past 22 years liposuction has been a regular feature of his medical practice. He assured the Court that he has experienced no incident of the kind involving Ms Edgar before or since.

5.7. Dr Kerry explained the nature of the liposuction procedure that does not need to be described in any detail except where relevant for the purposes of these proceedings and I will identify those features in due course. Dr Kerry explained his methodology and his sterility practices, that involved him being the only person scrubbed as part of any liposuction procedure but with the assistance of a person he referred to as a ‘scout’ who would be, whilst not scrubbed, clothed in protective clothing.

5.8. Dr Kerry also explained the method by which an operating table is draped, how instruments are opened and how a sterile field is maintained in general.

5.9. Dr Kerry explained in some detail the methodology involved in tumescent liposuction and the aseptic measures undertaken during such a procedure including skin preparation. Ms Edgar’s procedure involved the removal of fatty tissue from the thighs and abdomen. This necessitated the creation of five incisions of 1mm to 2mm which would be large enough to admit the instruments required to perform the procedure. Only one abdominal incision was required and that was created just below the umbilicus. Two other incisions were created at the front of the upper thigh area and, according to a photographic depiction[8], the incisions were created at the same level as, and a few centimetres away from, the vaginal introitus. The two remaining incisions were created in the approximate area of the folds of the skin at the bottom of the buttock area, at the approximate same level and a few centimetres away from the anus as depicted in a second pictorial diagram[9].

[6] Australian Medical Association and Dental Association
[7] Australian Council on Health Care Standards
[8] Exhibit C23, tab (b), page 3
[9] Exhibit C23, tab 5, page 6

5.10. Dr Kerry explained that he performed the liposuction procedure in respect of Ms Edgar by firstly removing fat from the abdomen which meant that she would have been lying in the supine position to begin with. Once having performed the procedure in respect of the abdomen and inner thighs, Ms Edgar would have needed to have been turned to the prone or face down position to enable the procedure to be conducted in respect of the outer thighs. As far as the carrying out of the procedure in the supine position is concerned, Dr Kerry explained how he applied aqueous betadine to the skin in order to sterilise it. This involved applying it to the skin from just below the breasts to just above the patient's knees. In the prone position, again according to Dr Kerry, aqueous betadine was applied to the back, buttocks and thighs, again to the level of the knees.

5.11. There was a material divergence in the evidence concerning the method by which the vaginal, peri anal and anal areas of the patient's body were applied with betadine. This divergence arose in the following circumstances. Dr Derrick Selby is an anaesthetist who on a number of occasions performed anaesthetic services for Dr Kerry, including services in respect of liposuction procedures. Dr Selby commenced private practice in 1987 and began performing anaesthetic services for Dr Kerry in the early 1990s. Dr Selby provided a statement to the Inquest[10] and gave oral evidence. Dr Selby told the Court that he had performed anaesthetic services for Dr Kerry on perhaps a dozen separate occasions. Dr Selby was the anaesthetist during the procedure involving Ms Edgar. Dr Selby provided a detailed description in relation to a number of aspects of Dr Kerry's procedures in liposuction surgery, including in respect of the duties and activities of Dr Kerry's staff, the method of turning the patient from one position to another and in respect of skin preparation. Dr Selby told the Court that Dr Kerry utilised a betadine solution that he stated was applied with a sponge and wiped over a large area '*way beyond the surgical site*'[11]. As far as the anterior abdominal wall is concerned, Dr Selby suggested that it would be applied high up on the abdomen to the rib cage and well down the front of the patient's legs, almost to the knees. Crevices in between would all be covered by betadine. Dr Selby confirmed that skin preparation in respect of the second site that was to be operated on was not undertaken until the turning of the patient had occurred. Dr Selby also confirmed that the incisions on one side are sutured and closed before the patient is

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[10] Exhibit C22
[11] Transcript, page 180

turned prior to the procedure being conducted in respect of the other side. Dr Selby suggested that contamination of the wounds at the turning of the patient was therefore unlikely[12]. In cross-examination by counsel for Dr Kerry, Mr Livesey QC, Dr Selby agreed with a leading proposition put to him by Mr Livesey QC that in the case of the treatment of a woman, the betadine was also applied between the buttocks, in the groin area and around the vagina area[13]. However, in re-examination by counsel assisting the Coroner, Mr Lindsay, the following exchange of questions and answers took place:

> 'Q. Yes. And when and how would it be applied to the anus and vagina area.
>
> A. It would not be deliberately applied; it may trickle down there under gravity.
>
> Q. So those areas were not swabbed with skin preparation.
>
> A. No.
>
> Q. After the patient is turned and the second part of the procedure began, I think you described that the betadine is applied again, this time with the patient in the supine position.
>
> A. Yes.
>
> Q. Again, if any betadine is getting to the anus and vagina region it's because of trickling down.
>
> A. Yes.' [14]

It will be noted that the subject as to the manner in which betadine was applied to the anal and vaginal area was introduced by counsel assisting by way of a non-leading question that did not in any way suggest the method of application that Dr Selby would reveal in response to that question. This method of application as described by Dr Selby was not the subject of any further challenge by counsel on behalf of Dr Kerry notwithstanding that Mr Livesey QC was given leave to ask further questions on an unrelated topic following counsel assisting's re-examination.

5.12. Dr Selby's original witness statement[15] does not reveal in any material detail any description of Dr Kerry's treatment of the peri anal area, in particular the anus or vagina.

5.13. Dr Selby added that in respect of the procedure involving Ms Edgar, he could '*recall nothing out of the ordinary with this case*'[16].

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[12] Transcript, page 198
[13] Transcript, page 207

5.14. Dr Kerry on the other hand told the Court that in the case of a female patient lying on her back:

> 'I have an instrument called a Babcock which is like a clamp, and that clamps a rolled square gauze that's been rolled up. I've done this myself while gloved and I will wipe around the labile area and just inside. Once that has been done I then discard that gauze, the Babcock is wiped with another sterile gauze and that's discarded. Then I'll put another clean gauze which is clamped by the Babcock in readiness to be used for later.' [17]

Similarly, when the female patient is turned onto her front:

> 'I use a swab that is soaked with Betadine and I give a slow single stroke, when I get to the anal area I give it a little prod so that it goes, the Betadine goes just within the anal canal.' [18]

In respect of both areas, Dr Kerry asserted that he also swabs with betadine between the legs, front and back[19].

5.15. Ms Christina Petridis was at all material times an employee of Dr Kerry who worked as a receptionist and also performed theatre duties as a 'scout'. Ms Petridis provided two statements[20] and as well gave oral evidence in the Inquest. Ms Petridis confirmed that Dr Kerry would, as it were, paint the patient with betadine from the breast area down to the knees in the case of a woman lying on her back. This would include all of the areas of the skin which were to be treated. Counsel for Dr Kerry, Mr Livesey QC, asked Ms Petridis:

> 'Q. Including in the groin area.
>
> A. Yes.
>
> Q. Around the vagina.
>
> A. Yes.' [21]

According to Ms Petridis, when the female patient was on her stomach, betadine solution would be applied from about the position of the bra strap to behind the knee area. She was asked:

> 'Q. What about between the buttocks; was solution placed there as well.
>
> A. It was placed everywhere.

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[14] Transcript, page 242. It will be observed that Dr Selby describes the procedure in reverse order to Dr Kerry.
[15] Exhibit C22
[16] Transcript, page 229
[17] Transcript, page 511
[18] Transcript, page 520
[19] Transcript, page 511 and 520
[20] Exhibit C6a and C6b
[21] Transcript, page 328

Q. Placed everywhere.

A. Yes.' [22]

5.16. In cross-examination by Mr Lindsay, counsel assisting, Ms Petridis told the Court that Dr Kerry would use a clip with gauze attached to it and he would paint over the whole body and into the groin area, through the pubic hair and the whole area. She said that anything that was visible or was exposed was covered with betadine[23]. She said that if the procedure involved the inner thigh, then Dr Kerry would move the leg and cover the whole area. When the patient was on her front Dr Kerry would wipe over '*the buttock area and down*'[24]. Ms Petridis said that she did not know how or whether Dr Kerry applied between the legs[25]. When counsel assisting asked Ms Petridis whether she agreed or disagreed with Dr Selby's evidence that betadine was left simply to trickle down to those intimate areas, Ms Petridis said:

> 'I don't - I couldn't say specifically it was only because it trickled down. I assumed he intentionally went there.' [26]

She then went on to say that she actually saw Dr Kerry do that[27]. Ms Petridis did not know whether Dr Kerry ever explained to female patients his practice in respect of touching intimate parts of their anatomy[28].

5.17. Dr Kerry asserted in his evidence that during the workup he routinely explained to female patients what he would do by way of sterilisation of intimate areas. Dr Kerry believed, rightly, that specific consent should be obtained from a female patient to touch those areas involving as it does a penetration of those areas. Although at the relevant time there was in existence a document that the patient was required to sign entitled '**INFORMED CONSENT TO PERFORM LIPOSUCTION SURGERY**'[29], the document does not set out anything about the need for any intimate touching as part of any sterilisation procedure. It does make specific reference to the making of incisions, in respect of consent to being photographed before during and after the treatment and sets out other matters in respect of which an acknowledgement is sought from the patient that certain explanations have been provided.

[22] Transcript, page 339
[23] Transcript, page 409
[24] Transcript, page 409
[25] Transcript, page 409
[26] Transcript, page 409
[27] Transcript, page 410

5.18. There was no documentation by way of practice directions or manuals that concerned the method by which sterilising liquid would be applied to the body of a patient, and in particular in relation to its application to intimate areas of the female anatomy, and especially whether it would involve penetration of the vagina or anus.

5.19. The evidence evinced general agreement that sterilisation by way of allowing the liquid to accumulate by way of gravity to potential sources of infection such as the vagina or anus, as distinct from direct application to those areas, would be less than ideal if not unacceptable.

5.20. The question as to whether Dr Kerry sterilised the vaginal, peri anal and anal areas by direct and penetrative application of betadine, or whether the liquid was simply left to trickle under the influence of gravity to those locations on the body is not easy to resolve. Mr Livesey QC on behalf of Dr Kerry suggested that it would be wrong for the Court to prefer the evidence of the anaesthetist, Dr Selby, having regard to the fact that he was present at no more than 12 liposuction procedures conducted by Dr Kerry and that his attention was necessarily on matters other than skin preparation. It is suggested that Dr Selby would have had no reason to be concerned in the nice detail involved in that process. On the other hand, I do not regard 12 separate occasions as giving rise to any proper lack of opportunity on Dr Selby's part to recognise and recall Dr Kerry's procedures in this regard, even if on some occasions when skin preparation was taking place his attention may have been focussed elsewhere. This would be all the more so if Dr Kerry's invariable practice was as Dr Selby has described. Furthermore, Dr Selby's evidence in this regard emerged quite spontaneously and without recourse to any form of leading by counsel, acknowledging of course that this in itself does not mean that Dr Selby's evidence is completely accurate or for that reason alone must be accepted. Dr Selby's evidence would also be in keeping with an understandable reluctance on the part of a doctor in the position of Dr Kerry to apply direct force, be it penetrative or otherwise, to those areas of a female body without that person's prior consent and whilst that person was sedated and therefore not in a position to resist or otherwise question what was being done to her. If Dr Selby is correct about the method of skin preparation for the intimate parts of the female anatomy, and if as he says there was nothing unusual about Ms Edgar's procedure that came to his mind, then one might arguably infer that

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[28] Transcript, page 410

there was nothing out of the ordinary as far as he was concerned about skin preparation and that therefore the method that he says Dr Kerry utilised was probably utilised in Ms Edgar's case.

5.21. My view is that the evidence of Ms Petridis lacked sufficient precision to take the issue substantially further.

5.22. Dr Kerry of course is in the best position to describe the methodology that he adopts in respect of skin preparation in respect of the more intimate areas of a female body. Dr Kerry was adamant that he applied betadine directly to the intimate areas and rejected Dr Selby's observations in that regard. Dr Kerry stated also that he obtains specific consent from female patients, including Ms Edgar, to apply the sterile solution to those parts of the body, and yet no notation was ever made of any such consent being obtained even when the very detailed consent form could have easily provided for the recording of the same. The practice manager, Dr Kerry's wife Ms Cathryn Kerry, who is routinely present during pre-operative work up with the patient, did not provide supportive evidence in this regard, although I am not certain that there may have been instances in Ms Edgar's case where she was not present. And as indicated earlier, there is no documented record of obtaining the patient's consent in any other written material.

5.23. I do not need to decide or make any observation about the lawfulness or otherwise of applying such force to a female person without her consent in the context of liposuction surgery because Dr Kerry himself acknowledged that it would be inappropriate to proceed without the person's specific consent and in any event it would seem obvious that as a matter of prudence it would be essential to obtain the woman's consent having regard to the possibility that she might change her mind about the procedure if she knows that such intimate contact was to take place. It is not as if, for example, that this was a gynaecological procedure which by necessary implication would involve a touching of and penetration of the vaginal orifice. In short, I have unresolved reservations about the accuracy of Dr Kerry's evidence concerning the manner in which he applies betadine to the intimate parts of a woman's body. I am somewhat concerned in this regard that although this would clearly be a matter upon which Dr Kerry could hardly be mistaken, no person represented in the Inquest put it to Dr Kerry directly that he was being deliberately

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[29] Exhibit C23, tab 4.3

untruthful about that issue. Nevertheless, I am not in a position where I can accept what Dr Kerry has said about this issue having regard to the doubts engendered in my mind by Dr Selby's evidence, compounded and certainly not put at ease by the absence of written consent to the applications of force that Dr Kerry maintains he performs. Thus I am unable to make any finding about the manner in which Dr Kerry applied betadine skin sterilisation to the intimate parts of a woman's body, either routinely or in the case of Ms Edgar specifically.

5.24. The matter of skin preparation, particularly as it was conducted in respect of the vaginal and anal areas, known sources of a Clostridium organism, is not an unimportant one. There were no less than five incisions made to Ms Edgar's body in the vicinity of the vagina and anus. Dr Kerry told me that in the course of administering the tumescent infiltrate, he used the one metal Klein needle for the entire procedure involving repetitive introduction into all five incisions. Dr Kerry agreed with counsel's calculations that given the need to repeatedly load the needle with the tumescent solution, there would have been approximately 44 occasions on which Dr Kerry disconnected the syringe from the end of the Klein needle, drew up the infiltrate from a sterile jug on the table and then injected the infiltrate into one of Ms Edgar's five incisions. The cannula used to extract the fatty tissue is not withdrawn repeatedly in the manner that the Klein needle is withdrawn, but clearly in a case such as Ms Edgar's it is inserted the once in each of five different incisions. The scope for an instrument, particularly the Klein needle, to come into contact with skin or a part of the anatomy that has been imperfectly sterilised is manifest, notwithstanding Dr Kerry's suggestion to the contrary. It appears to have been universally accepted during the course of the evidence that if the intimate parts of Ms Edgar's body were sterilised in a fashion described by Dr Selby, this would be a questionable method of sterilisation that would add to the risk of contamination.

5.25. The evidence regarding Dr Kerry's method of skin preparation of intimate areas that can be potential sources of bacteria was on the whole unconvincing one way or the other. While inadequate sterilisation of the vaginal, anal and perianal areas would be capable of providing an explanation as to how clostridium bacteria could be introduced into the tissues during the course of a liposuction procedure, and specifically in Ms Edgar's case, such a finding would be based on suspicion only. Thus I do not make any specific finding about such a possibility in Ms Edgar's case.

6. The Department of Health investigation

6.1. Dr Anne Koehler is a senior medical consultant and is the Director of the Communicable Disease Control Branch of the South Australia Department of Health. Dr Koehler holds the degrees of Bachelor of Science and Bachelor of Medicine and Bachelor of Surgery, all from the University of Queensland. She is a Fellow of the Royal College of Pathologists of Australasia (Microbiology). She is also a Master of Public Health. Dr Koehler's speciality is microbiology and she has practised extensively in that discipline of medicine. Her curriculum vitae[30] suggests that she has published widely in respect of microbiology.

6.2. The Communicable Disease Control Branch of the Department of Health acts pursuant to the powers set out in the Public and Environmental Health Act 1987. The Department's functions include the prevention of the spread of notifiable diseases in South Australia.

6.3. Dr Koehler first became involved in this matter on Sunday 9 March 2008, at a time before Ms Edgar had died. Although a Clostridium perfringens infection was not to be regarded as a notifiable disease unless encountered in a context of suspected food contamination, there was nevertheless a need to investigate Dr Kerry's practices lest other patients of his had been affected. Dr Koehler met Dr Kerry at his Melbourne Street rooms that day, the purpose being to determine whether a potential source for the infection could be identified through Dr Kerry's practices and procedures. Dr Koehler wanted to examine Dr Kerry's operating environment and, in particular, his processes regarding instrument sterilisation. As well, Dr Koehler examined the operating environment generally and made certain observations and noted a number of general concerns that included that while the operating room looked 'superficially clean'[31], it was in her view too small and would have been quite crowded. She was also concerned about the air reticulation system which consisted simply of an air-conditioning unit in the wall of an old house which she regarded as unsafe, although not unique to cosmetic surgery practices around the country[32], and certainly not in keeping with the type of air reticulation that is required in hospital operating theatres. Dr Koehler also pointed out that there is no accredited training program in cosmetic surgery, although the public might think otherwise. She suggested that if a medical

[30] Exhibit C5b
[31] Transcript, page 293

practitioner calls themselves a surgeon it carries an implication that they have undergone accredited surgical training consisting of a number of years of intensive hospital training in which topics such as skin infection and operating theatre design are part of the learning process. Other concerns expressed by her related to the ability to properly sterilise Klein needles that are used to infiltrate the fatty tissues that are the subject of the liposuction procedure. In this regard Dr Koehler referred to the fact that the ends of Klein needles are closed and might harbour contaminated material that is difficult to remove and sterilise. Another concern that she expressed which also related to the use of needles was the possibility that the same needle is used at multiple sites that enhances the risk of infection from incomplete sterilisation of the skin. I digress here also to record that the surgeon Dr Phillip Griffin who was involved in Ms Edgar's care at the FMC and who has himself carried out liposuction procedures, expressed similar misgivings about certain aspects of such procedures as carried out in small surgeries and the inherent risks of contamination. It is fair to say, however, that none of the matters that Dr Koehler identified as possible concerns can be positively shown to have had any bearing on the outcome in this case, or could be identified as a possible source of the Clostridium infection sustained by Ms Edgar. In this regard she stated as follows:

> 'And I - it would be surprising if I had been able to identify the particular source, but I had identified a number of concerns, I mean, as I said, the operating room wasn't up to the standard of an operating theatre, it didn't have the appropriate air-flow, didn't have the appropriate air filtration, he was using povidone iodine skin disinfectant which is now not the first line recommended skin disinfection. The Klein needle, I thought, was a risk, I thought there was a risk with him using the same instrument to penetrate a number of body sites. Then there were the instrument sterilisation matters which Nurse Bail had identified as well. So I felt that we'd identified a number of things that could have gone wrong, but I couldn't pin point if any particular one of those had been the cause in this case and you very rarely can.' [33]

The person referred to in that passage is Judith Bail, a registered nurse, who subsequent to Dr Koehler's examination of the premises would conduct her own examination.

6.4. Dr Koehler attended at Dr Kerry's rooms on both Sunday 9 March and Monday 10 March 2008, the latter date being subsequent to Ms Edgar's death. The particular instruments that had been used in Ms Edgar's procedures have never been specifically

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[32] Transcript, page 294
[33] Transcript, page 283

isolated or identified. In accordance with Dr Kerry's usual practice, long instruments such as Klein needles and cannulas used in tumescent liposuction are sent almost immediately to the Ashford Hospital for sterilisation. However, Dr Koehler took possession of a number of Klein needles and cannulas from Dr Kerry's rooms all barring one that had been subjected to sterilisation processes at some point. These instruments were examined at the Institute of Medical and Veterinary Science to determine whether or not they were sterile and in particular whether Clostridium was present on any of them. The result of the examination was that all of the instruments bar two were completely sterile. The two that were not sterile bore bacteria that were not Clostridium and can be, according to Dr Koehler, explained by the fact that one of them was the instrument that had not been sterilised since use and the second was an older instrument that, although it had been sterilised, its sterilisation use by date had passed and it did not appear to have been intended for use in any event. Thus it is that there is no evidence that any of Dr Kerry's instrument sterilisation processes, either conducted in his rooms or on his behalf by the Ashford Hospital, were in any way defective. The random sampling conducted by Dr Koehler in fact suggests otherwise. The concern that Dr Koehler expressed about Klein needles possibly having trapped material in the blind end therefore does not in reality arise as far as issues in this case are concerned. One thing of note, however, was that Dr Koehler testified that she was assured by Dr Kerry that he would from that point on utilise disposable Klein needles rather than reusing sterilised needles. Dr Kerry told the Court that he has used disposable Klein needles ever since these events.

6.5. I have already referred to the involvement of RN Judith Bail. Ms Bail has a particular interest in matters involving sterilisation in surgical settings. At the time with which this Inquest was concerned she had been seconded to Dr Koehler's unit. On Tuesday 11 March 2008 she was tasked by Dr Koehler to attend at Dr Kerry's rooms to examine his practices and procedures. Ms Bail prepared a report[34] that purported to identify as an issue of concern a failure to remove gross soil from surgical instruments that might subsequently cause imperfect sterilisation. In the event Ms Bail was said to have characterised this concern as minor. If the concern was a real one, it could hardly be characterised as minor. However, Ms Bail suggested that the impression she obtained about the failure to remove gross soil had been obtained through conversations with persons at Dr Kerry's practice. Other evidence suggests that this

was not a failing within that practice. In any event, I have already referred to Dr Koehler's seizure of instrumentation that proved at random selection and examination to be sterile. As I understood the position, the surgical instruments given to Ashford Hospital for their sterilisation processes are routinely cleaned for gross soil removal prior to sterilisation. To my mind the issue that Ms Bail purported to identify is of no moment in terms of the issues in this Inquest.

6.6. The investigation by the Department of Health of Dr Kerry's rooms and processes did not examine in any depth, other than at a superficial level, matters such as the cleanliness of surfaces in the operating room. In particular, no swabs were taken of surfaces for the presence of bacteria. In addition no detailed investigation was made in relation to the important subject of skin preparation processes except to identify that the kind of skin preparation liquid being utilised was iodine based. However, in this context Dr Koehler indicated that skin sterilisation was rarely, if ever, perfect. Dr Koehler said one could never be '*confident of eliminating 100% of organisms from the skin*'[35]. She added that if an organism survived on the skin despite sterilisation it could easily be collected by a surgical instrument coming into contact with it on the skin's surface and then being introduced into the tissues through an incision in the skin[36]. Dr Koehler said that that could then lead to gas gangrene and a case of Clostridium and that the incubation period of gas gangrene after injury is commonly 1 to 3 days[37]. Other evidence led in the case overwhelmingly suggests that contact between imperfectly sterilised skin and the instrument used in a liposuction procedure could be a fecund source of bacteria.

6.7. By letter dated 14 March 2008 Dr Koehler wrote to Dr Kerry advising that the Department of Health had not detected any problems with inadequate sterilisation of their surgical instruments and indicated that they were satisfied that the sterilisation and infection control procedures in the surgery were appropriate and adequate. As well, Dr Koehler advised that there was no cause for concern found in relation to sterilisation facilities at the Ashford Hospital.

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[34] Exhibit C4b
[35] Transcript, page 272
[36] Transcript, page 272
[37] Transcript, page 272

7. Ms Edgar's condition following her procedure - as described by her parents

7.1. Ms Edgar's parents are Mr Adrian Edgar and Mrs Leila Edgar of Brighton. Both Mr and Mrs Edgar provided witness statements to the police[38]. Both also gave oral evidence during the course of the Inquest.

7.2. According to the statement and oral evidence of Mr Edgar, on Wednesday morning 5 March 2008 he spoke to his daughter Ms Edgar who told him that she would be home from the procedure sometime in the late morning. Mr Edgar gave her enough money for a taxi home. The next time he saw her was that evening when he arrived home from work. At that stage his daughter was lying on a couch. She said that she was 'okay' but sore. That night Mr Edgar noticed that Ms Edgar was wearing the compression stockings that had been provided by Dr Kerry's practice and which were supposed to remain on for some time. He saw her walking to the toilet with them on and she was 'walking very gingerly'[39]. She was moving side to side and so it appeared to Mr Edgar that she had pain in both of her legs. In his oral evidence Mr Edgar said that he thought he recalled seeing Ms Edgar wearing the stockings at some point during the following day, the Thursday, possibly in the morning although in his evidence he did not appear to be confident about the time at which he had seen her wearing them that day. He does not recall again seeing the stockings on his daughter after the Thursday[40].

7.3. Mr Edgar went to work on the Thursday morning, 6 March 2008. Before he left home he went into Ms Edgar's bedroom to see how she was. He detected that she was in pain. At that time Mr Edgar established that his daughter was in possession of and had taken Capadex, which is a painkiller. She was also in possession of some Temazepam, which is a sleeping tablet. The Capadex and Temazepam had earlier been prescribed by Dr Kerry during the pre-operative period leading up to the procedure on Wednesday 5 March 2008. It is evident from markings on the packaging that the prescriptions were filled during Thursday 6 March 2008. There is no evidence to explain by what means Ms Edgar was able to have the prescriptions filled on that day. It remains a possibility that Ms Edgar drove herself to the Jetty Road, Glenelg pharmacy which is the supplier as described on the boxes. In the event, Ms Edgar would not consume all of the Capadex tablets as evidenced by the

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[38] Exhibit C10 and Exhibit C14 respectively
[39] Exhibit C10a, page 6

fact that some remain in the packaging tendered to the Court. As already alluded to, in the next 24 hours she would obtain stronger pain relief in the form of Panadeine Forte.

7.4. On arriving home from work that Thursday evening, Mr Edgar went straight into Ms Edgar's bedroom to see how she was, expecting her to be a little better. However, he described her as having been 'still very, very uncomfortable'[41], although she did not verbally confide in him what she was experiencing. Mr Edgar told me in evidence that in fact Ms Edgar did not really need to verbally volunteer the level of pain that she was experiencing on the Thursday evening. He said:

> '… she didn't have to. I mean, I could see that she was very uncomfortable.' [42]

He did not detect anything unusual about the quantity of painkilling medication she had taken at that point.

7.5. Mr Edgar played golf on Friday 7 March 2008. When he arrived home sometime during the afternoon he went straight in to see his daughter. She had a sheet covering her so he could not see the condition of her legs or whether or not she still had the stockings on. According to Mr Edgar's statement it was obvious that Ms Edgar had been waiting for him to come home as she immediately told him that she had spoken to Dr Kerry and that Kerry had arranged for a script to be filled at a pharmacy. Earlier that afternoon, it is known that Ms Edgar had two telephone conversations with Dr Kerry as a result of which Dr Kerry had arranged for a prescription of Panadeine Forte to be made available for her and which would need to be collected from a named pharmacy at Glenelg. In due course I will return to the circumstances in which these telephone conversations occurred. On being told of this arrangement by his daughter, Mr Edgar went to the pharmacy to fill the prescription and obtained the Panadeine Forte. This was probably around 5pm. When he returned home he immediately gave the Panadeine Forte to his daughter. In his oral evidence Mr Edgar explained that he had left to go to the pharmacy as quickly as he could because he could see that Ms Edgar was 'more uncomfortable'[43]. In cross-examination in respect

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[40] Transcript, page 24
[41] Exhibit C10a, page 7
[42] Transcript, page 19
[43] Transcript, page 16

of the events of the Friday afternoon, the following exchange took place between counsel and Mr Edgar:

> 'Q. Now, you refer to seeing your daughter on the evening that she wanted the Panadeine Forte.
>
> A. Yes.
>
> Q. At that time, your recollection was that she was clearly, to your observation, uncomfortable.
>
> A. Yes.
>
> Q. She didn't say that there had been an escalation in pain, did she.
>
> A. She didn't need to; I could see it.' [44]

7.6. Mr Edgar worked on Saturday 8 March 2008. Before he left for work he went into Ms Edgar's bedroom to see how she was. He observed that Ms Edgar already appeared to have taken considerably more Panadeine Forte tablets than had been recommended. The recommended dosage on the box states that the consumer should take 1 or 2 tablets every 4 to 6 hours when required 'FOR SEVERE PAIN' and states further '… do not take more than 8 in 24 hours'[45]. When Mr Edgar said something to his daughter to that effect that she had taken a quantity in excess of that recommended, she replied that she had done so because she had needed it. To Mr Edgar she appeared to be very groggy and not rational. At that point his principal concern about his daughter was that she had taken more painkilling medication than had been recommended. In the event, it is apparent from the number of tablets remaining in the box that Ms Edgar took 16 tablets between the late Friday afternoon and mid Saturday morning. Mr Edgar left for work at about 8:15am. Mrs Edgar also checked on her daughter that morning. At approximately 9:15am Mr Edgar was telephoned by his wife who reported on Ms Edgar's condition. As a result of this conversation, Mr Edgar rushed home. That morning Ms Edgar was taken by her parents by car to the Emergency Department of the FMC. On the way to the car Ms Edgar was able to stay on her feet, albeit barely. She looked a little yellow and the appearance of yellowness increased as time wore on. According to Mr Edgar, at some point during the Saturday at the FMC, Ms Edgar told her parents that she had asked somebody whether she could get an infection from the liposuction procedure and that his daughter had said that the reply had been 'she said I wouldn't'. There is no

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[44] Transcript, page 22

[45] Exhibit C12

evidence that can in any way identify any female person who had or may have assured Ms Edgar that she would not experience an infection.

7.7. According to Mrs Edgar's statement and oral evidence she had not been at home during the Wednesday on which her daughter had undergone the procedure. When Mrs Edgar arrived home between 5pm and 5:30pm, her daughter was lying on the couch and did not look well. Mrs Edgar describes her as groggy, that her face was white and that she had pain in her legs, particularly the left leg. She also had a very low appetite. At that point Ms Edgar was apparently taking Panadol at the recommended dose. Later that evening Ms Edgar arose from the couch, walked to her bedroom and went to bed. That night Mrs Edgar observed that her daughter had been wearing black tights. In her oral evidence Mrs Edgar said that Ms Edgar had not said much on the Wednesday evening but it was clear that she had been feeling tired.

7.8. Mrs Edgar went to work on the morning of Thursday 6 March 2008. Ms Edgar was still asleep at that time. When Mrs Edgar arrived home that night, her daughter was very quiet and resting on her bed. At one point she got out of bed and ate some food. Mrs Edgar describes her daughter as 'shuffling around in a lot of pain'[46]. Mrs Edgar asserts that it was at that point that she noticed that Ms Edgar's stockings were no longer being worn. Mrs Edgar observed that her daughter's legs were swollen. Mrs Edgar asked her daughter why she had taken the stockings off, to which Ms Edgar replied that it was so painful and that Dr Kerry had told her to take them off. Mrs Edgar makes this assertion in her witness statement which was taken on 19 December 2008. She reiterated that assertion in her oral evidence[47].

7.9. It has been established from telephone records that on the Thursday afternoon a telephone communication did occur between the telephone at Dr Kerry's practice and Ms Edgar's mobile phone. It is also known that Ms Edgar spoke on the telephone to Dr Kerry on two occasions on the Friday afternoon. However, as far as the Thursday is concerned, Dr Kerry insists on his oath that he did not speak to Ms Edgar on that day, although he states that he had unsuccessfully attempted to telephone her at approximately 8:30 that morning. He then gave instructions for his staff to telephone Ms Edgar to see how she was, but he does not agree that he spoke to Ms Edgar himself on the Thursday and denies that he at any time told her to take the stockings

[46] Exhibit C14
[47] Transcript, page 28

off or gave her permission to do so. As well, he denies that the subject of Ms Edgar taking her stockings off was ever raised with him.

7.10. The evidence of Mrs Edgar that Ms Edgar had said that Dr Kerry had told her to take the stockings off, that this conversation with her daughter had taken place on the Thursday and that Ms Edgar was not wearing the stockings on the Thursday evening was all unchallenged in cross-examination by Mr Livesey QC, counsel for Dr Kerry. I add here that this does not of necessity mean that the Court must accept that evidence, especially if it appeared to be intrinsically unlikely or was contrary to other evidence in the case. There is, naturally, also a question as to how much weight can be accorded to Ms Edgar's hearsay assertions about what Dr Kerry allegedly said to her. I will return to these issues in due course.

7.11. Mrs Edgar does not appear to have been aware of Ms Edgar's consumption of Capadex or Temazepam during the Thursday. However, according to Mrs Edgar's witness statement, on Friday morning 7 March 2008 her husband told her that he had given some painkillers to Ms Edgar who had then gone back to sleep. Mrs Edgar herself left for work and when she arrived home her husband was preparing to go the pharmacy, he having said that Ms Edgar had spoken to Dr Kerry and that Kerry had organised a script for stronger painkillers to be filled at a pharmacy at Glenelg. This was clearly a reference to the Panadeine Forte.

7.12. According to Mrs Edgar's statement and her oral evidence[48], when she saw her daughter on the Friday Ms Edgar's pain was stronger than that of the previous day. Mrs Edgar said that Ms Edgar complained of more pain that night and that her assessment was that her daughter's pain 'was much stronger that (sic) she had on the previous day'[49]. Mrs Edgar would become aware that over the course of the night Ms Edgar took considerably more medication for pain relief than had been recommended.

7.13. Neither Mr Edgar nor Mrs Edgar, either in their statements or in their oral evidence, claim to have examined Ms Edgar's legs on the Friday, but both assert that she was apparently in greater pain than the previous day.

7.14. Mrs Edgar states that after her husband had left for work on the Saturday morning, she checked on her daughter. This occurred at about 9am. Mrs Edgar observed that

[48] Transcript, page 29
[49] Exhibit C14, page 7

Ms Edgar's legs appeared to be enlarged, red and patchy. She said that at that point there were oozing blisters all over her daughter's legs and that she was yellow. After communicating with her husband he returned home and they then proceeded to take Ms Edgar to the FMC.

7.15. Mrs Edgar stated that her daughter's last words to her at the FMC were as follows:

> 'Mummy, I don't know what I'm doing here. I don't know why I am in so much pain. Dr Kerry said I wouldn't be in pain. She said when I asked her if I could get an infection she said no.' [50]

According to Mrs Edgar, her daughter repeated this statement. As seen, this evidence is in essence corroborated by Mr Edgar's evidence.

7.16. Dr Kerry would also give some evidence about the level and nature of Ms Edgar's pain as it was described by her to him during the Friday afternoon telephone conversations. I state here that as far as the reality of Ms Edgar's state of discomfort is concerned, as distinct from the manner in which she may have described it in a phone conversation, I prefer to rely on the evidence of Mr and Mrs Edgar who made their observations of their daughter's condition first hand. I accept their evidence about that. The conclusion I reach from the evidence of Mr and Mrs Edgar is that on the Thursday Ms Edgar was in more pain and discomfort than she had been on the Wednesday evening. Further, the conclusion is also inescapable that on the Friday afternoon she was in significantly more pain than she had been on the Thursday. It is worthwhile observing that Ms Edgar had not fully consumed the Capadex pain relieving medication before she was supplied with Panadeine Forte. In my view this is in keeping with Ms Edgar requiring stronger pain relief than what Capadex could provide. Furthermore, the fact that she took considerably more Panadeine Forte tablets than what was recommended indicates that she was experiencing a significant level of pain, and a level of pain that was not being relieved by medication taken at a recommended dosage. In so concluding, I have taken into account what some might argue was evidence of erratic consumption of Risperidone on Ms Edgar's part, but the observations of her parents of her actual condition lead me to conclude that not only was Ms Edgar taking Panadeine Forte because of a significant level of pain, she was taking it because of an increased level of pain over a period of 48 hours and, in particular, an increase in the level of pain from the Thursday to the Friday afternoon.

[50] Exhibit C14a, page 8 and Transcript, page 29

7.17. I will deal with the question of when it was that Ms Edgar took the stockings off and in what circumstances, but it is clear enough that her reasons for taking them off were due to intolerable pain and a belief that their removal might assist in the relief of that pain.

8. Ms Edgar's post-operative care

8.1. Ms Edgar was discharged on the same day as her procedure. She caught a taxi from Melbourne Street, North Adelaide to her home at Brighton. In the normal course of events Ms Edgar would not be seen again within Dr Kerry's clinic except in respect of the removal of sutures. This would be expected to take place at the end of one week. Dr Kerry also explained that ultrasound administered by a physiotherapist is also part of the post-operative treatment[51]. The compression garment (interchangeably referred to in the evidence as a stocking or corset), which is designed to aid in the shaping of the tissues subsequent to the actual procedure itself, would be expected to be worn for six weeks[52]. Certainly, there was no routine in place for Dr Kerry to examine a patient, including Ms Edgar, for post-operative complications. Rather, an arrangement was in place for Dr Kerry, or an employee within his practice, to phone the patient the day following surgery to enquire as to the state of the patient's wellbeing at that point in time. This provided the patient with an opportunity to express any concern that the patient might have in relation to his or her post-operative recovery. I was told that in the normal course Dr Kerry would personally make this phone call during the morning following the procedure, but that if he was unsuccessful in contacting the patient he might delegate the task to a member of his staff. That member of staff would then be expected to report to Dr Kerry once telephone contact with the patient had been made. Dr Kerry told the Court that his staff were not permitted to tender any advice to the patient in any such call or at all, but that any problem identified by the patient should be reported faithfully to him and that this would include a complaint of pain. If such a complaint was relayed to him, he would '*insist that I speak to the patient*'[53].

8.2. It will be remembered that according to the evidence of Mrs Edgar, her daughter was no longer wearing the stocking as of the Thursday evening following the procedure. As well, it will be recalled that Ms Edgar told her mother on the Thursday that Dr

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[51] Transcript, page 495

[52] Transcript, page 495

Kerry had told her to take the stockings off. Ms Edgar had told her mother this in answer to her mother's enquiry as to why Ms Edgar had taken the stockings off. Dr Kerry denies that he told Ms Edgar to take the stockings off and in fact states that at no time on the Thursday did he speak to Ms Edgar on the telephone. The first conversation that he had with Ms Edgar was, he says, on the Friday afternoon after Ms Edgar contacted the surgery.

8.3. The fact of, the identity of the person who made, and what was said during a follow-up call to Ms Edgar on the Thursday is a material issue in the case as it might have elucidated her condition that day and it might have explained how it had come to pass that Ms Edgar had taken her stocking off and why. In the event, in circumstances I will now describe, the evidence about this issue became lamentably obfuscated.

8.4. Dr Kerry told the Court that in accordance with his usual practice he rang Ms Edgar on her mobile phone immediately after his arrival at the clinic sometime between 8:20am and 8:30am on the Thursday morning. He said he would have phoned at about 8:30am. His recollection is that he rang her mobile phone and that there was no answer. He stated that he then instructed Ms Christina Petridis to telephone Ms Edgar during that morning. There is no note made by Dr Kerry that would evidence his unsuccessful attempt to call Ms Edgar. His reason for not having such a note is that he forgot to make one[54].

8.5. It is known that at 1:36pm on the Thursday, a call was made from the practice to Ms Edgar and that the connection lasted 2 minutes and 42 seconds. Dr Kerry insists that he did not participate in that telephone conversation. It is implicit, if not explicit, in his evidence that Ms Petridis, whom he had instructed to follow-up on the call, must have made it. He would ultimately reveal to the Court that she said that she made the call herself. In Dr Kerry's evidence in-chief as adduced by his own counsel he did not tell the Court what the result, if any, had been of his instruction to Ms Petridis and whether or not, and with what information, she had reported to him if indeed she had made any such call to Ms Edgar. It was in his cross-examination by Mr Swan, counsel for Mr and Mrs Edgar, that Dr Kerry for the first time asserted that he believed that Ms Petridis had reported back to him that day and told him that '*Lauren*

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[53] Transcript, page 529
[54] Transcript, page 529

was okay, she was fine'[55]. In his cross-examination by Mr Swan, Dr Kerry revealed that Ms Petridis had successfully contacted Ms Edgar '*and spoke to her*'[56]. He said that this had occurred during the morning but he was unable to provide a precise time at which Ms Petridis imparted that information. He did say that '*Christina came into the room and told me that Lauren was fine*'[57]. This evidence leaves an impression with the Court that Dr Kerry's position on this is that Ms Petridis had stated that she herself had spoken to Ms Edgar as distinct from relaying information that may have been imparted to her by some third person who had spoken to Ms Edgar. This impression is reinforced by the following passage of evidence given in cross-examination by Mr Swan:

> 'Q. Christina Petridis was working for you at the time of these events, was a very careful employee, wasn't she.
>
> A. Yes.
>
> Q. And you say that she reported to you that she'd had a conversation the day after the surgery, that she'd had a conversation with Lauren.
>
> A. Yes.
>
> Q. And that Lauren had said she was okay.
>
> A. Yes.
>
> Q. I suggest to you that Christina Petridis did not say anything like that to you, and did not tell you that she'd had a telephone conversation with Lauren Edgar, that's correct isn't it.
>
> A. No.' [58]

8.6. In cross-examination by counsel assisting Mr Lindsay, Dr Kerry reiterated that it was his belief that Ms Petridis had informed him of the outcome of the inquiry made of Ms Edgar that day but stated that if it had not been Ms Petridis, then it either would have been his daughter Madeline who from time to time worked in the practice[59], or possibly Dr Kerry's wife, who also worked in the practice as its manager[60].

8.7. In any event Dr Kerry stated in cross-examination by Mr Lindsay that he did not on the Thursday, or at all, tell Ms Edgar to take the stockings off. Dr Kerry in this context acknowledged that if a patient was asking to take stockings off it would be an

[55] Transcript, page 757
[56] Transcript, page 706
[57] Transcript, page 706
[58] Transcript, pages 715-716
[59] Transcript, page 758
[60] Transcript, page 393

unusual matter that required investigation, and that if the patient was asking to take the stockings off because of pain, there would be an even greater need for that to be investigated[61]. He told the Court that he never had any conversation with Ms Edgar about whether or not she should take the stockings off and no member of his staff reported any such conversation to him, acknowledging that he would have expected his staff to report such a conversation if it had taken place[62].

8.8. There is no note within Ms Edgar's clinical record at Dr Kerry's practice of any telephone enquiry, attempted or otherwise, being made of her on 6 March 2008 at any time by any person. There was a procedure in place for the documenting of such enquiries, but I was not satisfied that the procedure was universally and constantly adhered to. Despite agreeing earlier that Ms Pertridis was a very careful employee, Dr Kerry suggested that Ms Petridis was '*hopeless with her notes*'[63]; indeed Dr Kerry went so far as to say that she very rarely recorded things and that was one of his main issues of contention with her[64].

8.9. As things had transpired, Ms Petridis, who no longer worked in Dr Kerry's practice but had the same legal representation in the Inquest as Dr Kerry, gave her oral evidence prior to Dr Kerry's evidence. In circumstances that I will come to, Ms Petridis would be recalled after Dr Kerry had given his evidence. Shortly before the commencement of this Inquest, Ms Petridis provided a written statement supported by her affidavit[65], both dated 18 November 2011. In that witness statement, which in the first instance was provided to her instructing solicitors, she states:

> 'I have no recollection of making a follow-up call to Lauren Edgar nor, if I did make that call, what was discussed.' [66]

In her oral evidence on the first occasion, she was asked in cross-examination by Mr Swan, counsel for Mr and Mrs Edgar:

> 'Q. In relation to Ms Edgar, you certainly don't recall being asked to do it.
>
> A. No.' [67]

Ms Petridis made it clear that in any conversation that she would have had with a patient she would have reinforced the notion that the patient was not allowed to take

[61] Transcript, page 754
[62] Transcript, page 755
[63] Transcript, page 780
[64] Transcript, page 780
[65] Exhibits C6 and C6a
[66] Exhibit C6a, page 15
[67] Transcript, page 387

the garment off[68]. As well, she would report everything that was said by the patient to Dr Kerry regardless of whether pain was reported or not as '*he liked to know*'[69].

8.10. Ms Pertridis' evidence that she had no recollection that she had been asked to, or had, made the call was given by her at a time before Dr Kerry himself would assert in his evidence that he had asked Ms Petridis to make the call after he had unsuccessfully attempted to do so himself. In this context, Ms Petridis suggested that as best as she could recollect, she had not worked on the Thursday, an assertion that ultimately would prove to be incorrect. I found it odd, even allowing for the passage of time, that Ms Petridis could not be more positive as to whether or not she made the follow-up call herself. I say this because Ms Edgar's death on the following Monday was such an unusual, dramatic, emotional and well-known event as far as this practice was concerned that one would have expected Ms Petridis to recall whether or not Ms Edgar at a time after the procedure had complained of any discomfort or had imparted any other concerning information, or indeed had said that everything was perfectly fine. Be that as it may, on the first occasion that Ms Petridis gave evidence she agreed with the proposition that her lack of recollection probably meant that she herself did not speak to Ms Edgar the day after the procedure[70]. It is noted that at no time during Ms Petridis' evidence on this first occasion did Dr Kerry's counsel, who was also Ms Petridis' counsel, put to her what Dr Kerry would say in his evidence, namely that he had instructed Ms Petridis to make the call and that Ms Petridis later that morning reported to him that she had spoken to Ms Edgar and that Ms Edgar was fine.

8.11. After Dr Kerry gave evidence, Ms Petridis was recalled in the light of the assertions that Dr Kerry made about her involvement in the follow-up call on the Thursday. As alluded to earlier, telephone records revealed that at 1:36pm on the Thursday a call had been made from the Melbourne Street practice of Dr Kerry to Ms Edgar's mobile telephone number and that the conversation had lasted for 2 minutes and 42 seconds. There is no record of any earlier attempted or actual telephone communication. Another material revelation that emerged as the Inquest progressed was that Ms Petridis did in fact work on the Thursday after all. A further statement taken from Ms Petridis and furnished by her and Dr Kerry's solicitors[71] states that despite these

[68] Transcript, page 388
[69] Transcript, page 389
[70] Transcript, page 393
[71] Exhibit C6b

revelations, she still had no recollection of speaking to Ms Edgar on the Thursday. However, the statement asserts that she has a recollection of being asked by Mrs Kerry on the weekend of Ms Edgar's death about whether a telephone call had been made to the patient on the day after her procedure and that she recalled saying to Mrs Kerry that such a call had been made. None of this evidence emerged during the first occasion on which Ms Petridis gave oral testimony before the Court. In her oral evidence on the second occasion Ms Petridis reiterated that Mrs Kerry had asked her on the weekend whether a phone call had been made on the Thursday and had replied affirmatively but whether she had made it or someone else had made it she did not know[72]. Ms Petridis appeared to agree with counsel assisting that if it was correct that Mrs Kerry had asked her these questions on the weekend, particularly having regard to her knowledge of the fact that Ms Edgar was gravely ill, she would have remembered if she had made the call herself[73]. But she appeared to maintain her position that all she could was that she recalled telling Mrs Kerry that a phone call had been made but does not remember if she made the call or if she instructed someone else to make the call. Ms Petridis suggested that the other person who possibly could have made the call was Dr Kerry's daughter, Madeline. She said that the other scout, Helena, did not make calls[74]. Specifically, when Dr Kerry's account that she had told Dr Kerry on the Thursday that Ms Edgar was fine was finally put to Ms Petridis, she said that she had no recollection of having done so. At one point in her oral evidence on the second occasion, Ms Petridis agreed with a proposition that the circumstances suggested that she did not personally make the call[75] and then suggested that the person most likely to have made the call was Dr Kerry's daughter, Madeline. Ms Pertridis' evidence in my view was most unsatisfying.

8.12. As alluded to earlier there are no records of the call having been made or who made it. There was a form that was meant to have been filled out but the evidence demonstrated within this practice that there was a lack of rigour in ensuring that these follow-up calls were properly documented and so nothing can be inferred from an absence of a record in this particular case. For Ms Petridis' part, she rejected the suggestion made by Dr Kerry that she was very poor with her paperwork[76].

[72] Transcript, page 1163
[73] Transcript, page 1163
[74] Transcript, page 1164
[75] Transcript, page 1173
[76] Transcript, page 1156

8.13. Mrs Cathryn Kerry who is Dr Kerry's wife and the practice manager was called to give evidence. Mrs Kerry confirmed that Dr Kerry would make a routine telephone call to the patient the day following a procedure. She stated that the call was mostly made by Dr Kerry himself, but would be made in his stead by Ms Petridis if time precluded Dr Kerry from doing so. The other person who may have been asked from time to time was their daughter, Madeline[77]. Mrs Kerry also indicated that she herself made such calls occasionally[78]. Mrs Kerry corroborated other evidence that the system of documenting these follow-up calls was ad hoc and lacked rigour.

8.14. Mrs Kerry told the Court that she had made enquiries of her staff as to the identity of the person who had made the follow-up call on Thursday 6 March 2008. She spoke to Ms Petridis and to her daughter, Madeline, and as well to an assistant who runs her stock control, a person by the name of Helena. She also enquired of a person by the name of Amy who worked in the practice and who had said that she could not remember whether she had made a call. Contrary to Ms Petridis' evidence, Mrs Kerry said that she did not make any enquiries at the time of the events with which this Inquest is concerned; the enquiries were made at a later point in time[79]. I took it from her evidence as a whole that no-one in her practice at any stage indicated to Mrs Kerry, the manager, that they had made the follow-up call. Mrs Kerry said that her husband had told her that Ms Petridis had made the call[80]. Much of Mrs Kerry's evidence about her own enquiries was somewhat confusing insofar as having indicated initially that she had certainly made enquiries whether anyone had made the follow-up call amongst her staff, including Ms Petridis,[81], she later said that she had no recollection of ever speaking to Ms Petridis about whether or not she had made the call[82].

8.15. Madeline Kerry who gave oral evidence testified that she had not been asked either by Ms Petridis or by Dr Kerry to speak to Ms Edgar after her liposuction procedure and that she did not speak to her after that procedure[83]. She could not remember whether over the relevant weekend she had been asked by her mother to recall whether or not she had spoken to Ms Edgar on the telephone[84]. Madeline Kerry confirmed that from time to time she had been asked by Dr Kerry to make follow-up calls to patients to see

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[77] Transcript, page 1070-1071
[78] Transcript, page 1072
[79] Transcript, page 1077
[80] Transcript, page 1080
[81] Transcript, page 1076
[82] Transcript, page 1082
[83] Transcript, page 1241
[84] Transcript, page 1242

how they were. She also confirmed that Ms Petridis also made such calls. In fact the default position as it were was that Dr Kerry would ask Ms Petridis to make the call in the first instance. One piece of evidence of note given by Madeline Kerry was that Ms Petridis never asked her to make follow-up calls. Her father was the only person who ever asked her to do that. She rejected the suggestion that it was possible that she made the follow-up call in Ms Edgar's case[85].

8.16. The sole thing that is certain is that a 2 minute and 42 second phone connection to Ms Edgar's mobile telephone originated at Dr Kerry's practice at approximately 1:36pm on the Thursday. There is no direct evidence as to who made that call to Ms Edgar. I have no doubt that a telephone conversation occurred between someone at Dr Kerry's practice and Ms Edgar on the afternoon of that day. The call was initiated from the practice and I find that this was the routine follow-up call. As to the identity of the person who made that call, there is only hearsay evidence insofar as Dr Kerry asserts that Ms Petridis told him that she had made the call and that Ms Edgar indicated that she was fine, an assertion that Ms Pertridis fails to support. What does not gel with the known facts is that Dr Kerry states that this call reportedly had taken place in the morning, whereas it is known that a call was made from the practice to Ms Edgar's mobile phone at 1:36pm.

8.17. I repeat that it would seem odd that if Ms Petridis had made the call herself in accordance with the instruction that Dr Kerry said he gave her, that she would not remember having done so, particularly if she is correct that she had been asked very soon after the events in question whether she had made such a call. In addition, having regard to the fact that Ms Edgar had only recently been in the practice undergoing a procedure and that she had soon after become seriously ill, a call that had been made during the day immediately following the procedure in order to ascertain what the condition of the patient was would very likely be remembered. The fact that no person in the practice appears to have assumed ownership to having made the call brings into question whether or not Dr Kerry himself, after all, made that call. The notion that he did so would be in keeping with Mrs Edgar's evidence that on the Thursday evening her daughter had informed her that Dr Kerry had told her to take the stockings off because of pain. This in turn might underpin a suggestion that Dr Kerry knew as early as the Thursday afternoon that Ms Edgar was

[85] Transcript, page 1251

in considerable discomfort to the point where he gave her permission to take off the stockings, a matter that he would not normally countenance without appropriate investigation. However, there is an obvious limit to the weight that can be given to Mrs Edgar's hearsay evidence regarding what her daughter told her in respect of Dr Kerry's alleged involvement in the removal of the stocking. Dr Kerry denies any such involvement in the removal of the stocking, or any knowledge of Ms Edgar's condition on the Thursday, but his denials have to be gauged against the fact that undoubtedly a call was made from his office and that there is no evidence that any other person who was in a position and likely to have made the call asserts that they made that call, including Ms Petridis the very person whom he says told him she had made the call.

8.18. This issue could easily have been resolved had proper records been made at the time of the follow-up call.

8.19. I have not been able to reach any conclusion about the identity of the person who made the follow-up call to Ms Edgar on Thursday 6 March 2008. To my mind the possibility that Dr Kerry himself had a telephone conversation with Ms Edgar on that day has not been entirely excluded. There is a manifest conflict between the evidence of Dr Kerry and Ms Petridis, the resolution of which has not been assisted by the fact that both witnesses had the same legal representation. The complexity of the issue is heightened by the fact that Dr Phillip Griffin, one of the medical practitioners involved in Ms Edgar's treatment at the FMC, gave evidence that Dr Kerry told him that he had in fact conducted a phone conversation with Ms Edgar in which she had indicated that she wanted to take off the stockings. But Dr Griffin testified that Dr Kerry had told him that this conversation with Ms Edgar had occurred on the Friday, not the Thursday. Dr Kerry does not admit any conversation with Dr Griffin along those lines. In any case, Dr Griffin's evidence has not advanced the resolution of the issue as to whether or not Dr Kerry spoke to Ms Edgar on the Thursday and had told her to take the stocking off on that day. However, as will be seen, Dr Griffin's evidence as to his conversation with Dr Kerry was important for other reasons.

8.20. There is no doubt that Dr Kerry and Ms Edgar spoke on two separate occasions on the afternoon of Friday 7 March 2008. Naturally, the only firsthand account of what was said in these conversations comes from Dr Kerry himself. There are notations made

in respect of these telephone conversations by Dr Kerry within Ms Edgar's clinical record. The entry is set out as follows:

> '7.3.08 (she rang 3-00pm) I returned her call (3-10pm)
> $^{C}/_{O}$ generalised pain – she said she had
> 'a virus in her legs pre-op (??) & this is ↑ her pain' (??
> I told her I will organise Pan Forte.
>
> Immediately rang chemist 95 Jetty Road, Glenelg
> I then rang her back to confirm that all this was
> OK. Her father, Adrian, was to pick up tabs
> within the hour
>
> I will ring her again in next 1-2 days
>
> I told her to meet me @ surgery within 1hr
> She said it is OK 'I just need more stronger pain relief'
> How about → hospital – 'No, it's OK'.' [86]

Dr Kerry testified that he compiled the greater part of that note on Friday 7 March 2008 except for the last 3 lines which he wrote on 9 March 2008 at a time when it was known by him (through Dr Koehler) that Ms Edgar was seriously ill in hospital. Reference to Dr Kerry having told Ms Edgar to meet him at the surgery or to go to hospital thus did not form any part of his original note in respect of the Friday afternoon conversation. In his evidence Dr Kerry told the Court that at about 3pm on the Friday afternoon he was at home when he received a call from one of his staff to advise him that Ms Edgar had telephoned wanting more tablets. He then phoned Ms Edgar and asked her how she was feeling. She had responded by requesting 'something a little stronger'[87]. She had said that she was aching all over and when asked whether she had any pain in a particular place or whether it was sharp, she had replied in the negative. She had denied fever, feeling cold or being shivery or experiencing nausea. When Dr Kerry offered to see Ms Edgar in his surgery, she declined and repeated that she wanted something stronger for the pain. He offered to come to her home and she declined that as well. As a result of this conversation Dr Kerry states that he organised some Panadeine Forte through the chemist at Glenelg. He then told the Court that he rang the chemist and arranged a prescription for Ms Edgar of 20 Panadeine Forte tablets with directions for her to take 1 or 2 three times per day. He then rang Ms Edgar back and told her of these arrangements. He thinks that he repeated that he was happy to see her at the clinic or at her home and reassured

[86] Exhibit C23, tab 5, page 20
[87] Transcript, page 531

her that it was no trouble. Her response had been that she would be fine. Dr Kerry told her that she could always go to the hospital. He indicated that he would ring her again in one or two days[88]. Dr Kerry agreed that he wrote the belatedly made note about his offer to see Ms Edgar after he had spoken to Dr Koehler '*realising the disastrous situation*'[89].

8.21. In his evidence in chief Dr Kerry stated that his notation about Ms Edgar saying that she had had a virus in her legs pre-op was a reference to something that she had said in the first conversation on the phone on the Friday afternoon. Dr Kerry indicated in his evidence that he did not know what that meant[90], but took it from her that she was referring to a condition that she had prior to her operation and that it was this phenomenon that was increasing the current level of pain in her legs[91].

8.22. In cross-examination by Mr Homburg, counsel for Dr Griffin, Dr Kerry suggested that Ms Edgar's complaint of pain in the telephone conversation was not unexpected. He said that although it was not common for patients to seek additional and stronger pain relief post-operatively, it had happened in the past[92].

8.23. In cross-examination by Mr Swan, counsel for Mr and Mrs Edgar, Dr Kerry denied that Ms Edgar had said that her pain was increasing, although he stated that in his experience patients can increase in pain over the first two to three or even four days because of increasing swelling[93]. He also suggested that he did not take Ms Edgar as indicating to him that there was something taking place beyond what she had expected[94]. He agreed with Mr Swan that although he had made certain offers and suggestions to her about what she might do, he had not given her any advice as to what she should actually do[95].

8.24. In cross-examination by Mr Lindsay, counsel assisting, Dr Kerry acknowledged that in his practice documents it is recorded that he would tell patients to expect a minimal amount of pain that would usually be controlled by mild analgesia such as Capadex combined with Temazepam[96]. Dr Kerry told the Court that he would describe the pain

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[88] Transcript, page 533
[89] Transcript, page 533
[90] Transcript, page 606
[91] Transcript, page 616
[92] Transcript, page 590
[93] Transcript, pages 707-708
[94] Transcript, page 708
[95] Transcript, page 709
[96] Transcript, page 747

that a patient might expect as a general aching in their arms, legs and joints as if they had been to the gym the day before. Ms Petridis also gave evidence that she had given patients more or less the same information. Dr Kerry therefore agreed that complaints of pain above a mild level could be significant and could involve an indication of an unusual response including a developing infection. He agreed that complaints of pain above the predicted mild level needed to be assessed properly[97]. But he also said that Ms Edgar did not sound as if she was in any distress[98] and sounded '*as if she was okay*'[99]. Dr Kerry also stated that he did not feel that Ms Edgar needed to go to hospital but gave her the various options and left the matter to her judgment[100]. He denied that there was any conversation with Ms Edgar about whether she should take her stockings off[101]. In cross-examination by Mr Lindsay, Dr Kerry agreed that in the Friday conversations with Ms Edgar he should have enquired of her as to how much painkilling medication she had already taken before prescribing something stronger[102]. Dr Kerry agreed with cross-examining counsel that Panadeine Forte was for severe pain depending on the person's pain tolerance. In the circumstances he suggested that the request for stronger pain relief was clinically appropriate[103] and that he believed the cause of her pain was due to increased swelling associated with liposuction. Dr Kerry made what appears to be a questionable assertion that one would possibly prescribe Panadeine Forte to a patient who was describing the type of pain that one might experience after a gymnasium workout[104]. Dr Kerry did say in answer to questions put by myself that in the normal course of events by the Friday afternoon, Ms Edgar should have been on her feet, mobile and walking around and have been able to drive a motor vehicle. Dr Kerry said that she had not said anything in either telephone conversation about her mobility or otherwise and it seems a fair assumption that Dr Kerry did not ask her any questions about that either. He did acknowledge that he asked Ms Edgar who would be picking the Panadeine Forte up for her but in my view did not satisfactorily explain why he made any assumption that she would not be able to pick them up herself[105], except to say that his understanding was that she did not have any transport[106]. In re-examination

[97] Transcript, page 747
[98] Transcript, page 765
[99] Transcript, page 770
[100] Transcript, page 771
[101] Transcript, page 755
[102] Transcript, page 761
[103] Transcript, page 775
[104] Transcript, page 776
[105] Transcript, page 784
[106] Transcript, page 785

Dr Kerry stated that in the past he had prescribed Panadeine Forte to other patients who had sought additional pain relief on the second post-operative day.

8.25. It does not appear to have occurred to Dr Kerry that a reason for a request for stronger pain relief might imply a level of pain that would otherwise be intolerable on the part of the person so requesting. The effect of Dr Kerry's evidence is that he detected nothing in Ms Edgar's description of her own condition that suggested there had been an increase in the level of pain that she had been experiencing, nor that she was suffering from a severe or significant level of pain. He had left it to Ms Edgar's own judgment as to whether or not she should be seen by him either at his clinic or at her home, or whether she should go to hospital. As earlier indicated, the reality appears to have been that by the Friday afternoon Ms Edgar was in significant pain and discomfort as observed by her parents and that she had taken the stockings off as a result. She had in reality received insufficient relief from the analgesia that she had already been taking. Of course Dr Kerry was at a disadvantage in that he did not see Ms Edgar on the Friday afternoon but it would not have been a giant leap for him to infer, at least as a reasonable possibility at that point, that Ms Edgar was experiencing a level of pain and discomfort that was not in keeping with the usual post-operative presentation two days after the event. The question is whether it was reasonable for Dr Kerry to conclude that there was no aspect of Ms Edgar's condition that required investigation for the possibility of post-operative infection and whether it was reasonable for Dr Kerry to refrain from insisting that he see his patient personally to make a proper clinical assessment of her condition.

8.26. To place Dr Kerry's evidence about his conversations with Ms Edgar on the Friday afternoon in full context, it is pertinent here to mention in detail the evidence that Dr Phillip Griffin gave concerning what Dr Kerry told him of these conversations. Dr Griffin who was one of the clinicians involved in Ms Edgar's care at the FMC gave a long statement to police in November 2011[107]. Included within his statement is a description of a conversation that he had on the telephone with Dr Kerry at a time subsequent to Ms Edgar's hospitalisation. Dr Griffin had made a note of this conversation with Dr Kerry soon after its occurrence. Dr Griffin also gave oral evidence in the Inquest in which he confirmed his account of this conversation. Dr Griffin states that at about 1pm on Sunday 9 March 2008 he received a telephone call

[107] Exhibit C27c

from Dr Kerry about Ms Edgar. During this conversation Dr Kerry told Dr Griffin that he had spoken with Ms Edgar on the Friday; she had called reporting pain in her leg. Dr Griffin's note of his conversation with Dr Kerry is as follows:

> 'Friday: Called Dr Kerry: 1500 hours very painful: wanted to remove the corset and have stronger pain relief: he told Ms Edgar he spoke with her, thought she was doing alright, but needed some more analgesia: no sense of impending catastrophic illness.' [108]

8.27. According to Dr Griffin, Dr Kerry had indicated that the pain particularly involved Ms Edgar's left leg. Dr Kerry told him that she had required stronger pain relief. He also told Dr Griffin that he had spoken with Ms Edgar and had thought that she was rational and orientated with no signs of significant illness. He had derived no sense of her developing a major complication. Dr Griffin said that Dr Kerry told him that he had issued a script for Panadeine Forte. It will be observed that the note prepared by Dr Kerry himself in respect of his Friday afternoon telephone conversations with Ms Edgar describes her as having complained of 'generalised pain' and contains no reference to a desire on her part to take the compression garment off. Dr Kerry said in his evidence that he could not recall telling Dr Griffin that Ms Edgar had told him that she wanted to remove the corset and could not recall that Ms Edgar had actually in fact told Dr Kerry that on the Friday[109]. In saying that he could not recall saying any of this to Dr Griffin, or whether Ms Edgar had told him that she wanted to take the corset off, I took these assertions as outright denials that he had told Dr Griffin this, or that Ms Edgar had told Dr Kerry that she wanted to take the corset off. He told the Court that he had not said anything to Dr Griffin in any telephone conversation with him that Ms Edgar had given an indication of severe or significant pain.

8.28. I accept the evidence of Dr Griffin that Dr Kerry told him that Ms Edgar had told Dr Kerry on the Friday afternoon that she was very painful, or words to similar effect, and that she wanted to take her corset off. There is no discernible reason for Dr Griffin either to be untruthful or mistaken about this. In addition, he made a note of this conversation on the same afternoon that the conversation had occurred. It follows that I find that there was also discussion at some point between Dr Kerry and Ms Edgar about the removal of stockings. Regardless of whether or not Dr Kerry actually gave his permission for Ms Edgar to remove the stockings, the fact that she was wanting to remove them is very much in keeping with Mrs Edgar's objective evidence

[108] Exhibit C27d
[109] Transcript, page 606

that her daughter had removed the stockings and had done so because of the pain that she was experiencing. In the discussion that had taken place between Ms Edgar and Dr Kerry about removal of the stockings, I find that it was in the context of a complaint made by Ms Edgar to him of a level of discomfort and pain that he ought to have appreciated was inconsistent with the level of pain that would normally be experienced at that post-operative stage.

8.29. The reasonableness or otherwise of Dr Kerry's reaction to the telephone conversations with Ms Edgar on the Friday afternoon was considered by a number of experts who gave evidence in the Inquest about that and other matters. Dr John Flynn is a cosmetic surgeon who provided a number of reports to the State Coroner in relation to this matter[110]. Dr Flynn also gave oral evidence in the Inquest. Dr Flynn is an independent expert witness whose basic medical qualifications were obtained from the University of Queensland in 1976. He holds a Diploma from the Royal Australian College of Obstetricians and Gynaecologists. He is a Fellow of the Australasian College of Cosmetic Surgery. He is a Fellow of the Royal Australian College of General Practitioners.

8.30. Dr Flynn performs liposuction procedures. He has a licensed day hospital in Queensland attached to his practice.

8.31. Dr Flynn gave evidence on a number of different aspects involved in this matter. This included his view as to the appropriate course of action for Dr Kerry to have taken in the light of the telephone conversations between Dr Kerry and Ms Edgar on the Friday afternoon. It is fair to say that Dr Flynn took a more lenient view of Dr Kerry's response than that taken by other experts who gave evidence in the Inquest. Dr Flynn's views need to be gauged against the fact that in his practice he typically arranges a routine post-operative consultation either on the first day or second day post-operatively, or both. He adopts this practice because it gives him an opportunity to examine the patient so as to be sure that there are no complications developing or that if there are, one could act upon them quickly. It is also important in that it inculcates a sense of moral support in the patient. Dr Flynn also told the Court that he usually provided patients with his mobile phone number and asked them to phone him at any time should they be concerned.

[110] Exhibits C29, C29a, C29b and C29c

8.32. Dr Flynn told the Court that if a patient had told him two days post-operatively that she wished to take off the compression garment he would have advised the patient to come into the surgery to explore the reason for the pain, if for no other purpose than to eliminate the possibility that the garment was an inappropriate size. In any event he would want to explore the reason why the patient was in so much pain[111]. Dr Flynn said that pain was variable and there tended to be some increasing pain once the anaesthetic effect of the local anaesthetic wore off after approximately 12 to 18 hours. He suggested that if a patient was managing in those circumstances, that would be fine, but that if they were not, it was best to find out why not,[112] and the method of finding out would be to ask the individual to come to the clinic. As far as prescribing stronger pain relief as Dr Kerry had, Dr Flynn was of the view that this was not an inappropriate thing to have done, but it would have been preferable for this to have been undertaken in the context of a personal consultation. Dr Flynn suggested that increasing post-operative pain would raise a concern that something that needed particular attention was developing. He opined that simply providing greater pain relief without working out exactly why the patient required such relief was 'not the best way to go'[113]. In such circumstances there is a question as to whether the pain is reflective of the patient not tolerating normal pain or whether some other mechanism was taking place that required attention. If the patient was speaking simply of strong pain without necessarily describing it as increasing, the doctor's appropriate response would depend upon the contents of any conversation with the patient about that, whether the patient was managing and whether the situation was stable[114]. If a request by the patient for stronger pain relief, in particular Panadeine Forte, was accompanied by her seeking advice about taking the corset off, Dr Flynn was of the view that it would have been preferable for the doctor to have seen the patient personally.

8.33. Dr Flynn stated that it was common for patients to complain of pain in the two or three days following a liposuction procedure when the residual effect of anaesthetic has worn off. He suggested that the most uncomfortable period would probably be

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[111] Transcript, page 1114
[112] Transcript, page 1114
[113] Transcript, page 1116
[114] Transcript, page 1117

the third day. He acknowledged that breakthrough pain despite analgesia would give rise to a potential for concern but one would not automatically be concerned. He said:

> 'It's the conversation with the patient about that pain and how they're managing it which will give you a concern or not.' [115]

8.34. Dr Robert Young is the Director of the Intensive Care Unit at the RAH. Dr Young provided a statement to the Court and gave oral evidence[116]. Dr Young was involved in Ms Edgar's treatment at the RAH after her transfer from the FMC. Dr Young was principally called to give evidence about Ms Edgar's treatment at the RAH, particularly in relation to the extent of and timing of the provision of hyperbaric oxygen as a treatment modality. However, he also gave evidence concerning clinical assessment of pain, particularly as it might involve symptomatology of underlying infection following surgery and which might be caused by gas gangrene in a wound. Dr Young gave some evidence concerning the type of pain that might be experienced in this setting and suggested the classic presentation of gas gangrene was pain which was excessive for the wound. He suggested that pain out of keeping with a wound:

> '… is a very big flag for something going wrong and in general in medicine pain that is not consistent with the pathology in front of you should always raise one's concern.' [117]

When asked specifically about Ms Edgar's situation on the Friday afternoon as described by her parents, Dr Young provided an opinion that if the pain on the Friday had been worse than the pain on the Thursday, there was indication that something was wrong. He said that pain after a surgical procedure becomes progressively better over time[118]. It is to be acknowledged that Dr Young's evidence was given in the context of what was the reality in respect of Ms Edgar's progression of pain between the Thursday and the Friday and not on the basis of how she may have described it to Dr Kerry in a telephone conversation.

8.35. Dr Phillip Griffin, who I have already referred to, is a medical practitioner who has specialist qualifications in plastic and reconstructive surgery. He is a clinically active specialist plastic and reconstructive surgeon working in both public and private surgical areas. He has performed liposuction procedures. He has longstanding experience in the treatment of difficult wounds. Dr Griffin did not provide any

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[115] Transcript, page 1133
[116] Exhibit C26
[117] Transcript, page 900
[118] Transcript, page 906

material in respect of this matter until a time after the Inquest had started. He provided material in the context of concerns that he wished to raise in respect of the use and timing of hyperbaric treatment of Ms Edgar at the RAH. As head of the Plastic and Reconstructive Surgery Unit in the FMC, he had been involved with Ms Edgar's treatment. It will be remembered also that Dr Griffin gave evidence of his phone conversation with Dr Kerry on the Sunday afternoon.

8.36. Dr Griffin provided a number of reports to the Court and he gave oral evidence. His evidence covered a number of topics but naturally included reference to the telephone conversations with Dr Kerry and he also commented upon the significance of such a doctor/patient telephone conversation that had occurred between Dr Kerry and Ms Edgar. Dr Griffin agreed with a number of propositions that were put to him by Mr Livesey QC, counsel for Dr Kerry, including that pain from liposuction might extend well into the first 48 hours following surgery[119] and that pain in and of itself would not necessarily be a sign of anything in particular but that one would need to ask more questions about that pain[120]. When specifically asked by counsel about the significance of Ms Edgar's seeking more pain relief and Dr Kerry having offered to see the patient in his rooms and whether that had been an appropriate response, Dr Griffin said the following:

> 'Well - these questions start to lead into what is sort of a sixth sense of the active clinician. I think a person who is doing office and day surgery is exposed to patients calling them with questions. I can really only refer to my own practice in this area. It's unusual for a patient to call me in the first 48 hours and each time they do, I remind myself that they're not calling for no reason, there is a reason why the person would be calling. In asking the different questions, you end up with an index of clinical suspicion. Sometimes, even after the telephone call's finished, I've said to myself 'Well actually, that's not right' and so I've called back and explored the different options which you've nominated. On seeing a person, you have - actually seeing them rather than telephone call managing, you have much better abilities to get all of the information needed, the examination information you need to make a diagnosis of why they're having increasing pain. Sometimes your clinical sixth sense will fail you. You won't diagnose the emerging infection. But these complaints of pain, these requirements for repeat scripts, that's the most common cause for the phone call, in my experience.' [121]

[119] Transcript, page 982
[120] Transcript, page 982
[121] Transcript, pages 983-984

8.37. Dr Griffin also said that whilst one could not, as it were, force oneself on the patient:

> '… if you're finding professionally that you get more and more uneasy, then you have to reconcile that and that's not reconciled by a patient refusing to attend.' [122]

Dr Griffin acknowledged that in his field of medicine one might have a higher index of suspicion that something wrong was happening than that gained by a person in a cosmetic practice who might have had little experience in the treatment of difficult infective wounds. Dr Griffin did agree that if Ms Edgar's complaint had simply been one by way of a request for additional pain relief and that nothing was extracted from the patient that did not excite concern, then offering to see the patient in the doctor's rooms or at home would be an entirely appropriate way of responding[123]. Of course that acknowledgment has to be examined against the background that according to Dr Griffin, Dr Kerry was told more than simply that she wanted stronger pain relief by Ms Edgar. According to Dr Griffin, Dr Kerry said that he had been told by Ms Edgar that she was 'very painful'. Dr Griffin had not unnaturally also inferred from what Dr Kerry had told him that Ms Edgar was implying that she was experiencing increasing pain; if she was very painful and wanted to remove the corset, it would immediately raise a question as to why she had not wanted to remove it the day before. Dr Griffin opines that one would gain a sense of increasing pain from her conversation[124].

8.38. Dr Griffin who has performed liposuction procedures himself and is familiar with the tumescent technique, told the Court that the technique is surprisingly comfortable for the patient and that a person often does not have a large amount of pain 48 hours after surgery[125]. He contrasted the situation with that experienced after a liposuction procedure that did not involve the tumescent technique and which is conducted under general anaesthetic. He suggested that following such a procedure, the patient would experience a lot more bruising and pain but that the pain generally settled within 24, 48 or 72 hours. Dr Griffin agreed that the pain following tumescent liposuction might be described as that experienced after a gym workout or similar to the pain associated with a corked thigh, but in response to questions from counsel assisting, and he suggested that the level of pain that justified a prescription of Panadeine Forte two days after liposuction would raise in his mind a list of differential diagnoses even allowing for the fact that people have varying responses to pain. To him the pain

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[122] Transcript, page 984
[123] Transcript, page 985
[124] Transcript, page 998

might indicate bleeding into the wound or the development of a more serious complication such as what was taking place with Ms Edgar. Dr Griffin said that he would be questioning himself as to why he needed to provide such a prescription when he did not actually have a diagnosis underlying that prescription[126]. He suggested that in his experience, pain described by patients 48 hours after an operation and which prompts a requirement for more pain relief is '*very uncommon*'[127]. He would not prescribe Panadeine Forte simply because the patient asked for it. Because such a request would have been out of the ordinary, he would want to see the patient first.

8.39. As to whether Ms Edgar's description of pain had been one simply involving an indication of significant pain or on the other hand increasing pain, Dr Griffin suggested that a complaint of significant pain would need to be qualified with the patient by way of discussion and questioning as to whether the pain had increased or decreased or had not improved[128]. His experience was that pain is at its worst following liposuction when the local anaesthetic has worn off and decreases from one day to the next. He suggested that persisting pain is not normal. Whether the pain be characterised as significant or increasing, his view was that an immediate clinical review of the patient was required[129].

8.40. Finally on this topic Dr Griffin suggested that there were a number of difficulties involved in making assessments from telephone consultations such as those between Dr Kerry and Ms Edgar. Such difficulties included the language involved in the conversation and the psychological state of the participants. For example, a medical practitioner such as a surgeon could experience what amounted to a state of denial about the possibility of complications. Dr Griffin said that one needed to take '*an objective step back and actually look at the events and realise that something is going wrong*'[130]. He suggested that one needed to re-evaluate the position after such a telephone conversation to ensure that one has not ignored important signs raised during a conversation. He suggested that a medical practitioner in those circumstances was always at liberty to phone back and clarify[131].

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[125] Transcript, page 1010
[126] Transcript, page 1012
[127] Transcript, page 1012
[128] Transcript, page 1019
[129] Transcript, page 1020
[130] Transcript, page 1021
[131] Transcript, page 1022

8.41. Professor John Cade was Director of the Intensive Care Unit at the Royal Melbourne Hospital until 2008. From that time on he has been the Principal Specialist in Intensive Care at that hospital. Professor Cade is a Doctor of Medicine, Doctor of Philosophy and Fellow of the Royal Australasian College of Physicians, Fellow of the New Zealand College of Anaesthetists, Fellow of the College of Intensive Care Medicine and a Fellow of the American College of Chest Physicians. Professor Cade had no involvement in Ms Edgar's treatment. He provided a wholly independent analysis of Ms Edgar's management, including post-operative management. Professor Cade provided a number of reports[132]. Professor Cade reported that in his view Ms Edgar's post-operative care was not optimal. In the Inquest, Professor Cade gave oral evidence to the same effect[133] and specifically related this opinion to the clinical setting as it existed on Friday 7 March 2008. His interpretation of the events of the Friday afternoon was that Ms Edgar had complained of 'increasing pain'[134]. Like Dr Griffin, Professor Cade suggested increasing pain on the second post-operative day from a variety of procedures is relatively uncommon. His view was that pain should be '*going the other way*'[135] on that particular day. Whether or not the pain had been described by Ms Edgar as increasing, significant or strong, Professor Cade said:

> 'I think the pain descriptors are very personal matters. I think the fact that there has been a call about problematic pain, whether it is more severe, whether it is increasing, whether it is of a porous nature, the fact that there is problematic pain on that day warrants some consideration of its cause.' [136]

Professor Cade made the obvious point that there was significance in the fact that Ms Edgar herself had initiated the call on the Friday afternoon, its significance deriving from the fact that she had been experiencing breakthrough pain beyond the analgesia that she had already been taking and that on the second post-operative day there was a potential problem that needed to be considered[137]. He suggested that it would be almost impossible to consider her condition accurately and carefully without an actual inspection[138].

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[132] Exhibit C31a, C31b and C31c
[133] Exhibit C31a, page 2
[134] Transcript, page 1199
[135] Transcript, page 1200
[136] Transcript, page 1200
[137] Transcript, page 1200
[138] Transcript, page 1200

8.42. Professor Cade acknowledged the difficulty involved in Ms Edgar declining to come into the clinic or be seen at her home, but the need for a practitioner to put forward a more persuasive case to the patient of the need to be examined had to be considered. In other words, the doctor may well suggest to the patient that there is a concern about what the patient is saying and that there are tactics that could be tailored to the particular situation. Professor Cade suggested that it would have been perfectly reasonable to say in such circumstances something to the effect '*I am worried that you might be developing an infection*'[139]. In cross-examination Mr Livesey QC, counsel for Dr Kerry, Asked Professor Cade to consider the telephone conversation as being one in which Ms Edgar had simply described herself as aching all over and that she all she wanted was stronger pain relief, and to consider this together with Dr Kerry's offer to see her. To this Professor Cade suggested that there was nothing in such a description that would naturally suggest gas gangrene but it did point to a problem with the wound[140]. Professor Cade suggested in this context that one would need clarification of what 'aching all over' meant because she had experienced a very extensive set of wounds as part of the procedure[141].

8.43. Professor Cade, in my view, made the persuasive point that in a situation where no routine face-to-face follow-up consultation was arranged between doctor and patient, that there would need to be a lower threshold of concern where a patient initiated a complaint of pain. He said:

> 'I would have thought if there isn't a scheduled follow-up and the patient actually initiates a call two days later because of problems that they perceive then that has to be respected and that has to be dealt with by a face-to-face attendance.' [142]

8.44. Having accepted Dr Griffin's evidence that Dr Kerry told him that Ms Edgar had described herself as very painful with a desire to remove the corset, together with all of the other matters that Dr Kerry noted, there was in the opinion of the Court an obvious need for Ms Edgar to be personally seen by Dr Kerry and I so find. There ought to have been a heightened level of concern on his part and it simply was not appropriate for him to leave it to Ms Edgar as to whether or not she should be seen personally by him. It will be remembered that Dr Kerry himself acknowledged that a desire on the part of the patient to remove the compression garment because of pain

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[139] Transcript, page 1021
[140] Transcript, page 1229
[141] Transcript, page 1230
[142] Transcript, page 1202

would require appropriate investigation. It is difficult to see how such an investigation could be conducted without a personal examination of the patient. Even if I was wrong about the acceptance of Dr Griffin's evidence about his phone conversation with Dr Kerry, on Dr Kerry's own description of his conversation with Ms Edgar there was certainly enough concern raised in what she told him to have given rise to a need for her to be seen personally. In my view the preponderance of the evidence demonstrates that such a decision should not have been left to her. There was enough in what Ms Edgar did say to give rise to an almost irresistible inference in the mind of any reasonable medical practitioner that the pain relief that she had already been employing was not working and that her pain was sufficiently serious to have broken through the analgesic effect of her existing medication. On anyone's version of events, the pain that Ms Edgar was experiencing at that point in time, and was describing to Dr Kerry, was not consistent with pain that one would normally associate with a gym workout or a corked thigh. Dr Kerry could and should have inferred that Ms Edgar was experiencing a level of pain that was unusual and a level of pain that required medical evaluation by personal consultation.

8.45. Although the question of whether or not Dr Kerry did in fact offer to see Ms Edgar on the Friday is also not entirely free of difficulty, particularly having regard to the fact that he very belatedly documented that aspect of their discussion, I am prepared to find that this discussion did occur. However, to my mind in any event the evidence is overwhelmingly in favour of the view that Dr Kerry should have taken it upon himself to insist more persuasively that Ms Edgar be reviewed that day.

9. <u>The mechanism of introduction of Clostridium perfringens in Ms Edgar</u>

9.1. In Dr Griffin's supplementary report[143] he comments upon the aetiology of the gas gangrene infection in Ms Edgar. In his report he expresses the 'strong opinion'[144] that her infection began through the introduction of Clostridium perfringens organisms which were contaminating the skin of the groin at the time of the liposuction procedure. It will be remembered in this context that Dr Griffin himself has had experience in the performance of liposuction procedures and is familiar with the tumescent liposuction method. In his view inevitably there would be generous contact between instrument and skin throughout the arc of treatment, in Ms Edgar's

143 Exhibit C27b
144 Exhibit C27b, page 2

case around the buttocks, upper thighs and inner thighs. Dr Griffin refers to other risks of contamination that are posed by the need to reposition the patient on the operating table. He also refers to the possibility of patient flatulence under sedative anaesthesia. He suggests that even a small group of Clostridium perfringens organisms together with their toxins would be enough to start the early infection in tissues treated by a liposuction procedure. Dr Griffin also suggested in his report that the time course of Ms Edgar's illness was compatible with the development of gas gangrene at the time of surgery. As well, the distribution of the infected tissue at the time of her presentation suggested that the infection began in the left thigh. The gravamen of his report was that the procedure of liposuction carries a high risk of transferring skin organisms via the liposuction cannula deeply into the surgical wound which is itself a hypoxic environment due to the infiltration of the previously injected fluids. He suggests that superficial infection of a sealed wound would not carry the devastating consequences that Ms Edgar suffered. Dr Griffin repeated his opinions when he gave oral evidence and firmly stated that in his view the most likely time of entry of the bacteria was during the liposuction procedure performed by Dr Kerry[145]. Dr Griffin also repeated his view that the most likely source of infection would be by way of surgical instruments coming into contact with organisms on the skin which are then transferred into the depths of the wound[146].

9.2. Dr Young expressed a similar view but placed possibly greater emphasis upon the integrity of the wounds after suturing and bandaging as giving rise to an unlikelihood of subsequent contamination. When asked by me whether it was possible for the organism to penetrate the underlying tissue through a sutured wound, Dr Young said:

> 'My understanding is that it's not a penetrating organism so it won't burrow down into the wound. It would be introduced into the base of the wound while the wound is open and the wound would be closed over the top of it to produce the sort of infection that you describe. So my understanding of clostridia is that if you had a closed wound and you applied, you know, painted it with clostridium over the top of the wound, my understanding is that it wouldn't burrow down into the wound, that would be unlikely. If it could find a nidus of ischemic tissue in the wound, it may infect that, but a well sutured wound that is closed and then has clostridium placed on top of it would be less likely. All things are possible of course.' [147]

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[145] Transcript, page 960
[146] Transcript, page 963
[147] Transcript, pages 893-894

Dr Young said that he was not familiar with a scenario involving introduction of clostridia following surgery by means of contact with a wound that has not yet healed. He said:

> 'I don't believe I've seen a case where a clean wound has been contaminated subsequently with clostridia and become infected with clostridia.' [148]

Dr Young further explained that in Ms Edgar's case he had worked under the assumption that this was an infection that had been introduced at the time of the surgery and had spread. He had based that assumption on the extent of the disease insofar as it involved many different areas of an extensive size and had progressed so rapidly. Dr Young added the rider that he could not determine the exact source of the infection and how the infection entered[149].

9.3. Dr Evan Everest is an Intensive Care Consultant. He is a Fellow of the Royal College of Physicians and the College of Intensive Care Medicine. He has worked as an intensivist at the FMC for many years. On Saturday 8 March 2008 he was on duty as the Intensive Care Consultant on-call at the FMC. That afternoon he was involved in Ms Edgar's management. Dr Everest provided a statement of witness[150]. He examined Ms Edgar and was involved in other testing in respect of her condition that day. In his statement Dr Everest had this to say as to the origin of the infection:

> 'I can't speculate where the organism came from in Ms Edgar's case. It is a common organism in the bowel. I have treated a few cases where the clostridia just arose spontaneously. Importantly, it must be introduced deep into the tissues, and it won't survive on the surface. It is predominantly spores that go in, and then the spores grow once they are in an environment without oxygen.' [151]

9.4. In his report[152] Professor Cade stated that in his view there was insufficient information to conclude whether or not the infecting micro organism was implanted at the time of surgery or whether the surgical wounds became infected subsequently. He said that the known time course of Clostridium perfringens infection (ie. 8 to 72 hours) covers either possibility. He went on to say that it was not possible to identify with certainty the origin of the infecting micro organism but suggested that contaminated surgical instruments could have been to blame. He did say, however,

[148] Transcript, page 895
[149] Transcript, page 909
[150] Exhibit C20a
[151] Exhibit C20a, page 10
[152] Exhibit C31a

that he thought it more likely that the infection was acquired from the patient's own enteric flora on the first or second post-operative day.

9.5. Before dealing with Professor Cade's oral evidence at the Inquest, in which he proffered a modified view as to origin, I should point out that Dr Griffin in his statement[153] commented on Professor Cade's written opinions and indicates that he would differ with Professor Cade's views. Dr Griffin explains in his statement that the liposuction procedure carries a high risk of transferring skin organisms via the barrel of the liposuction cannula deeply into the surgical wound and the hypoxic environment therein. Dr Griffin also suggested that the time course of the illness is compatible with the development of gas gangrene at the time of the surgery. He explains that gas gangrene is developed in wounds up to 7 days after the injury but that in Ms Edgar's case severe illness was definitely well-established by the time of her admission to the FMC within 72 hours of the operation.

9.6. In Professor Cade's oral evidence he qualified the views that he had expressed in his report. He signified his agreement with Dr Young's views that the bacterium was not a penetrating organism and that in Ms Edgar's case it was most likely that the wounds had been closed over the top of the organism to produce the sort of infection that Ms Edgar developed. Nevertheless, Professor Cade said that it was not possible to be dogmatic about whether the micro organism had been introduced in surgery or in the post-operative period[154]. His view as expressed in his original report had modified or evolved to the extent that if it was correct that the wounds had been sutured, closed and covered with bandages, then that would very likely mean that the organism was introduced at the time of surgery. Nevertheless, Professor Cade remains of the view that it is possible that the infection was acquired from the patient's own flora post-operatively[155].

9.7. Professor Cade placed some store on whether or not the incisions had been bandaged and had remained so post-operatively. Dr Kerry gave evidence that he sutured each and every incision and applied a bandage to each. There were five incisions in total and all of them were treated in that fashion. He performed suturing on the first set of incisions before he turned the patient. It is true that there is no direct evidence as to what the state of the incisions or the bandages were at the time of Ms Edgar's

[153] Exhibit C27c
[154] Transcript, page 1194

presentation to the FMC. There is no evidence one way or the other about that. If the sutures were removed, it would beg the question as to how they were removed and why. Leaving aside the question of remaining bandages, it does not seem likely in the opinion of the Court that Ms Edgar herself would have removed the sutures for any reason other than the pain and discomfort associated with an infection already contracted. It is difficult to think of any other reason that would explain their removal by her. More likely perhaps is the possibility that she removed the bandages in order to inspect the wounds, but there is no persuasive evidence of this either. In any event, I accept Dr Young's evidence that the micro organism is not a burrowing one that would penetrate a sutured incision. As well, the evidence is that the depth and extent of the infection suggested something other than a superficial infection of a sealed wound. The same consideration applies to the devastating consequences once the infection was established[156].

9.8. To my mind, penetration of the wounds by this organism post operatively is, on the evidence that I heard, a highly unlikely source of the infection. I find on the balance of probabilities that the micro organism was introduced at the time of the liposuction procedure and not post-operatively. The precise method of introduction has not been established. However, out of all of the possible competing explanations, the most likely explanation is that it was introduced from Ms Edgar's own skin and transferred into the deep tissues by means of the instrument or instruments used in the liposuction procedure.

10. <u>The question of Ms Edgar's survivability</u>

10.1. It will be remembered that Ms Edgar did not present to the FMC until shortly after 10am on Saturday 8 March 2008, 3 days after her liposuction procedure and approximately 19 hours since she had spoken to Dr Kerry on the telephone on the Friday afternoon. A number of the medical practitioners who gave evidence in this Inquest have suggested that by the time of Ms Edgar's presentation on the Saturday morning her fate was virtually sealed. In this regard Dr Young points out that by that time Ms Edgar was already in established multi-system failure[157]. For his part, Dr Griffin suggested in his report that her mortality upon admission was something of the order of 97% which, plainly, is almost a matter of certainty.

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[155] Transcript, page 1220

10.2. Professor Cade also pointed out in his evidence that at the time of her presentation on the Saturday morning Ms Edgar was critically ill and by that stage it is clear that the wound infection was at a very advanced stage with very marked systemic toxicity. It was what he termed a '*very parlous situation and one that is extremely difficult to turn around*'[158]. Professor Cade agreed with Dr Griffin's calculation of the odds as they existed on the Saturday, also agreeing that the degree of mortality in those circumstances is very high[159].

10.3. The question that has arisen is whether Ms Edgar would have enjoyed any better prospects of survival if she had presented earlier, and in particular on the Friday afternoon or early evening after she had spoken to Dr Kerry on the telephone. For these purposes I indicate that I do not intend to discuss the issue as to whether or not her chances of survivability would have been greater still if she had been examined or assessed on the Thursday, which was the day after the procedure. The evidence is by no means clear as to what signs she may have been exhibiting on the Thursday and there is uncertainty in any event about the identity of the person who spoke to Ms Edgar on that day and what was said. On the other hand, her condition on the Friday afternoon and what was said between herself and Dr Kerry, and whether she should have been examined on Friday afternoon is a different question. I have already indicated that I find that Dr Kerry should have examined Ms Edgar at the first available opportunity on the Friday afternoon.

10.4. There are two separate questions that require consideration in respect of the issue of survivability. Firstly, there is a question as to the likelihood of an earlier diagnosis of gas gangrene being made if Ms Edgar had presented at a hospital and been appropriately assessed subsequent to her telephone conversations with Dr Kerry. Secondly, there is also a question whether in any event an earlier diagnosis and earlier commencement of treatment would have altered Ms Edgar's chances of survival for the better.

10.5. As to the first of those questions, the basic premise according to Dr Griffin is that diagnosis becomes easier as the illness becomes more serious[160].

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[156] Exhibit C27c, page 17
[157] Transcript, page 797
[158] Transcript, page 1206
[159] Transcript, page 1206
[160] Transcript, page 978

10.6. Mr Edgar did not purport to actually see the condition of his daughter's legs on the Friday. Mrs Edgar observed that Ms Edgar's legs were swollen on the Thursday evening. She did not purport to see the condition of her daughter's legs on the Friday at all. The blistering that Mrs Edgar ultimately did observe would not be observed until she examined her daughter's legs on the Saturday morning. Mrs Edgar speaks of having observed jaundice for the first time on the Saturday. However, there is little doubt that Ms Edgar's general condition, particularly in respect of pain, was worse on the Friday afternoon than it had been on the previous day. Whereas Dr Griffin's opinion was that if there had been a review of the patient in the first 24 hours following the procedure there probably would have been nothing to detect, he suspected that on the Friday night a CT scan would have revealed gas in the tissues[161]. Whether a general practitioner examining Ms Edgar would have made a diagnosis of gas gangrene without recourse to sophisticated diagnostic measures is naturally another question. However, Dr Griffin suggested that a doctor performing a clinical review at the 48 hour mark post surgery would at least be able to make a decision about whether or not the patient should be referred to a hospital[162]. He expected that a competent surgical practitioner would be able to make a diagnosis of the wound infection and complication and would take due steps to treat it[163].

10.7. Dr Young for his part, as seen earlier, suggested that pain which was excessive for the wound would be a '*very big flag*' for something going wrong[164]. But he did state that it would be very difficult to say what Ms Edgar's clinical presentation would have been on the Friday afternoon. Having said that, he suggested that he would have found it surprising that she would not have had some signs the day before her presentation at FMC. Dr Young suggested that if Ms Edgar was developing pain on the Friday, which I find to have been the case at a significant level, he strongly suspected that Ms Edgar was at that point developing infection and in that case a surgical review would have been warranted. As to how she may have presented to a general practitioner such as Dr Kerry, Dr Young said that one would hope that a skilled clinician would have identified that the wound was tender and progressing in the wrong direction. He reiterated that pain would have been the 'flag'. With all of those signs at the disposal of the general practitioner the appropriate plan would have

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[161] Transcript, page 1024
[162] Transcript, page 1020
[163] Transcript, page 1021
[164] Transcript, pages 900-906

been referral to hospital at that stage[165]. Dr Griffin and Dr Young clearly agree on that point.

10.8. Professor Cade, who is an intensive care specialist, told the Court that he would see cases of gas gangrene every two, three or four years. This is not in any way surprising given the rarity of the condition in this country. The infrequency with which an intensivist such as Professor Cade sees a case of gas gangrene in my view does not of itself detract from any opinion that he might have expressed concerning methods of diagnosis or survivability. Professor Cade suggested that on the Friday afternoon the wounds must have been abnormal given subsequent progress[166]. He suggested that if the wounds were looking other than pristine, that is to say swollen, reddened or inflamed, the patient should have been sent to hospital for more formal inspection and antibiotics. He suggested also that while the progress of the disease is rapid, it is not so rapid that there would have been nothing to see on the Friday with a sudden deterioration on the Saturday morning. He suggested that there would have been '*footprints*' identifiably on the Friday afternoon[167]. Professor Cade agreed that if a patient on the telephone had denied jaundice, swelling, redness or no temperature, while such observations expressed by a patient would not carry the same weight as it might from someone clinically experienced, a diagnosis of gas gangrene would not loom large in the mind of a general practitioner[168]. On the other hand, information that was confined to a complaint of generalised pain and a need for stronger pain relief, whilst naturally not suggesting gas gangrene, would point to a problem with the wound. As seen earlier Professor Cade was of the view that clarification would need to be sought in relation to such information. He went on to say that one might be thinking of an infective process in those circumstances such as Staphylococcus and that this belief might be engendered by the fact that the perineal region is involved giving rise to a concern about enteric organisms[169]. In this context he suggested that a wound infection would not be taken lightly whatever the cause. Even absent specific clues for gas gangrene, one would marshal some of the diagnostic resources and that would include hospitalisation, culture and observation[170]. In addition, if the complaint of pain was one of strong pain as opposed to generalised pain, strong pain is much more likely to have a local origin.

[165] Transcript, page 907
[166] Transcript, page 1205
[167] Transcript, page 1207
[168] Transcript, page 1229
[169] Transcript, page 1232
[170] Transcript, page 1232

10.9. In my view there was general agreement in the evidence that while on the Friday afternoon a diagnosis of gas gangrene would not have been made by a person in Dr Kerry's position on the basis of a clinical review of his patient such as Ms Edgar, there would have been sufficient evidence in Ms Edgar's presentation to dictate her immediate hospitalisation.

10.10. The conclusion that I reach on the evidence is that if Dr Kerry had examined Ms Edgar on the Friday afternoon it is more likely than not that concern about her condition would have been generated in his mind. I say this because in my assessment it is highly unlikely that any reassurance could have been derived from Ms Edgar's actual presentation. She was in significant pain and on the evidence it is very likely that her legs would have been showing some sign of infection or some sign that would have given rise to concern such as to lead to her hospitalisation on the Friday afternoon. In addition, in the nature of things there is good reason to suppose that if Ms Edgar had been seen at her home, that one or both of her parents could have informed Dr Kerry of their daughter's actual condition and progress over the previous 48 hours, none of which could in any sense be regarded as reassuring or not requiring further intensive investigation in a hospital setting. In the Court's opinion it is almost unthinkable that Ms Edgar would not have immediately been taken to hospital if she had been medically examined by Dr Kerry on the Friday afternoon.

10.11. The next question is whether or not if Ms Edgar had been brought to hospital on the Friday afternoon an earlier diagnosis of gas gangrene and commencement of treatment would have taken place. In this regard it will be remembered that on the Saturday when she did present a positive diagnosis of gas gangrene was not immediately made; nor was treatment for that particular pathology including surgical debridement commenced for some hours. Mr Livesey QC for Dr Kerry suggests that there was a 7 hour hiatus on the Saturday between presentation and commencement of surgical debridement which was the first meaningful modality of treatment. Although Dr Griffin in his evidence agreed that if Ms Edgar had presented on the Friday evening there is no reason to think that there would have been foreshortening of the timeframes that occurred on the Saturday because conditions at FMC might not be any different on a Friday evening, he added that he would personally be disappointed in a delay of 7 hours in case of this nature. He believed that with all processes working correctly one would normally be seeking to have the person in the operating room within 3 or 4 hours.

10.12. Asked by counsel assisting, Ms Kereru, what diagnostic measures may have been implemented in hospital on the Friday in the absence of overt blistering or exudate from wounds that might have been sampled, Professor Cade said:

> 'I think what would happen would be that the wound would have been swabbed for what it was worth even if there is no exudate because it doesn't have to be macroscopic and if the patient had a temperature, blood cultures would be taken, but it would then be a very difficult diagnosis and it could well be missed at a very early stage and it may require some further hours to become apparent. At least presumably it would have then been apparent under observation at 2 a.m., something like that perhaps, not as late as lunchtime the next day. But it's not just a lay-down misere if she had come in Friday afternoon, it would all be peachy and she would have been cured and well. It's a very difficult scenario. I think it's very likely that she would have been able to be successfully managed but the diagnosis may well have been not up in the bright lights at that stage.' [171]

10.13. The conclusion I reach is that the likelihood is that if Ms Edgar had been sent to hospital on the Friday afternoon, her Clostridial infection would have been diagnosed earlier than it ultimately was on the Saturday and that appropriate treatment would have been undertaken also at an earlier point in time.

10.14. As to the key issue concerning survivability, all of the expert medical practitioners were of the view that there is some difficulty in dogmatically suggesting that Ms Edgar would have survived if she had presented to hospital on the Friday at a time after her conversations with Dr Kerry. There are several factors involved in such an assessment, including the rapidity of diagnosis and the actual extent of her condition on the Friday. Dr Griffin at one point in his evidence agreed with cross-examining counsel, Mr Livesey QC, that the prospects of survival on the Friday evening may have been equally grim as they were on the Saturday[172]. In his own words Dr Griffin suggested that given all appropriate treatment survivability was '*a very difficult issue*'[173]. That said, Dr Griffin did refer to cases published in the literature in which a person suffering from gas gangrene had survived with appropriate care[174].

10.15. When questioned by Mr Livesey QC whether there was any certainty about any different outcome if treatment by way of debridement had commenced at about 10pm on the Friday, Dr Young said that he thought the earlier one could address the infection the better. He could not be certain that the treatment would be successful if

[171] Transcript, pages 1214-1215
[172] Transcript, page 987
[173] Transcript, page 1025
[174] Transcript, page 1025

treatment had commenced earlier, but said that the chances of success would be greater. Dr Young added that if the disease had been as extensive on the Friday as it had been on the Saturday, that a prognosis would have been very grim the same expression utilised by Dr Griffin. If not as extensive, Dr Young suggested that there was still a high degree of speculation involved in assessing her chances[175].

10.16. Professor Cade expressed a greater level of confidence in Ms Edgar's chances if treatment had occurred earlier. He had this to say:

> 'On the previous day I think her survival would have been very likely. It would be very unlikely that she would not have survived if she had been seen in hospital the previous afternoon. This is a very rapidly progressive condition. It's not so rapid that there would be nothing there on Friday and suddenly happen on Saturday morning, but it is rapid hours in a day or two, so I think there would have been footprints there fairly obviously identifiably so on the Friday afternoon.' [176]

That answer appears to be premised on the existence of a set of diagnostic cues that would have enabled an early diagnosis on the Friday. There is some additional uncertainty about that issue as already seen.

10.17. There is no means by which any safe conclusion can be drawn that Ms Edgar would have survived if she had presented at hospital following Dr Kerry's conversations with her on the Friday afternoon. All that can be said at best is that her chances of successful treatment may have been greater. Of course, one cannot in anyway know whether if Ms Edgar had survived upon earlier presentation, she still would not have suffered some significant disfigurement and serious deficit of her quality of life.

11. Other issues considered

11.1. There were a number of other issues considered in this Inquest as having possibly formed part of the circumstances surrounding Ms Edgar's contraction of a Clostridium infection. These issues included whether aqueous betadine as a skin sterilisation preparation was appropriate in all of the circumstances, or whether an alcohol based preparation ought to have been utilised. Another issue that was canvassed, albeit only to a superficial level, was whether or not in procedures of this kind prophylactic antibiotics should be administered to cover the patient against contraction of a bacterial infection during the procedure itself and/or following the procedure in the immediate post-operative period.

[175] Transcript, page 908
[176] Transcript, page 1207

11.2. As to the first of these issues there is no evidence that the use of aqueous betadine as a skin preparation in Ms Edgar's case was a measure that was in any sense out of the ordinary or not in accordance with standard surgical practice, at least as far as the cosmetic surgical industry is concerned. For instance, Dr Flynn gave evidence that aqueous betadine was the skin preparation that he utilised. The suggestion that aqueous betadine was not an appropriate disinfectant was made by the surgeon, Dr Griffin, who it will be remembered has practised liposuction from time to time. Dr Griffin suggests that a more appropriate surgical preparation consists of Chlorhexidine, an alcohol based product. Some of the evidence suggested that this was a substance that could irritate the sensitive membranes in the vaginal and perianal area and that for this reason it was not the ideal preparation. It is difficult if not impossible to say whether the outcome for Ms Edgar would have been any different had an alcohol based preparation been used in her case. Equally as difficult is this Court having any role to play in making any possible suggestion for change in respect of the sterilising liquids used in cosmetic surgical procedures. All that can be said is that a question mark or concern has been raised in respect of whether or not aqueous betadine is an appropriate solution to be used in these surgical environments and that in the opinion of the Court the matter would certainly be a proper subject for further consideration.

11.3. As to the need for prophylactic antibiotics in either the surgical or post-surgical setting, the evidence suggested that as far as prevention of Clostridium perfringens infection is concerned, the administration of prophylactic antibiotics that would cover such an infection either operatively or post-operatively is simply not feasible or is not warranted because of the rarity of an infection of this kind being contracted. That said, I point out that Dr Flynn gave evidence that he utilises antibiotics in the post-operative phase. There may be a case for the administration of prophylactic antibiotics operatively or post-operatively which might cover other possible bacterial infections short of Clostridium perfringens. In this regard it is worthwhile observing that where prophylactic antibiotics are used during surgery or in the post-operative phase, and where a patient shows signs and symptoms of a developing infection notwithstanding, a clinician's suspicion of the existence of an infection by an organism not covered by the antibiotics utilised, such as clostridium, might well be heightened.

12. The role of hyperbaric oxygen therapy

12.1. On the Sunday of the weekend in question Ms Edgar was transferred to the RAH where she underwent, among other treatment measures, hyperbaric oxygen therapy. Such therapy is said to aid in the treatment of gas gangrene by providing an oxygenated environment thereby mitigating the deleterious effects of the anaerobic scenario in which the Clostridium perfringens micro organism is said to thrive. Dr Griffin raised the timing of the hyperbaric oxygen therapy provided to Ms Edgar as an issue of concern. A number of other practitioners who had been involved in Ms Edgar's treatment at the FMC echoed that concern. On the other side of the ledger, clinicians at the RAH, including Dr Young, resisted the proposition that hyperbaric oxygen therapy was either belatedly delivered or would have had a positive effect in any event. As part of that stated position it was said that the debridement of necrotic tissue that had taken place, particularly at the FMC, was inevitably going to be ineffective because of the extent of the disease in Ms Edgar's case. The debate involved a close examination of the intrinsic value of hyperbaric oxygen as a treatment modality for gas gangrene. This gave rise to a scenario in which this Court might be asked to pass a general scientific judgment in respect of a matter in which it is obvious that reasonably held expert medical and scientific opinions would legitimately differ. I was not persuaded that this is a proper function of the Court. It did not appear to the Court to be in the public interest even to attempt to do so other than to receive the evidence about that issue and to endorse a recommendation that has been crafted and which might elucidate the subject in a more scientific setting than could be provided in this jurisdiction.

13. Conclusions

13.1. The Court reaches the following findings and conclusions.

13.2. Ms Edgar died on 10 March 2008 of multi-organ failure due to Clostridium perfringens myonecrosis complicating liposuction.

13.3. Ms Edgar underwent a liposuction procedure on Wednesday 5 March 2008. The proceduralist was Dr George Kerry. There is no evidence to suggest that Ms Edgar's consent was not a fully informed one. However, it is clear that before agreeing to perform the surgery, Dr Kerry should have given more careful consideration to the question of Ms Edgar's frame of mind and either made enquiries of her general

practitioner concerning her psychological condition or hesitated before agreeing to perform the procedure. However, there is no evidence from which a conclusion can be drawn that information from Ms Edgar's usual medical practitioners would have altered the outcome.

13.4. I find that on the balance of probabilities the Clostridium perfringens micro organism was introduced during the liposuction procedure itself and at a time prior to the suturing and closing of her five incisions. I find that the micro organism was introduced by an instrument used in the procedure, most probably the Klein needle utilised to introduce the tumescent solution preparatory to the procedure itself. The most likely explanation out of all competing explanations is that the micro organism was picked up by an instrument from the skin surface of Ms Edgar. There is insufficient evidence from which a conclusion can be drawn that there had been inadequate sterilisation of Ms Edgar's vaginal, anal or perianal areas.

13.5. There was not in existence any formal post-operative review contemplated or conducted in connection with the post-operative phase of Ms Edgar's procedure. However, I find that a person unknown, but undoubtedly situated at Dr Kerry's practice, spoke to Ms Edgar on the telephone at approximately 1:36pm on Thursday 6 March 2008, which was the day following the procedure. It has not been possible to establish whether or not that person was Dr Kerry himself.

13.6. I find that Ms Edgar had removed the compression garment at some point before Friday evening 7 March 2008. I also find that Ms Edgar told her mother that Dr Kerry had told her to remove the garment. There is no direct evidence that Dr Kerry told Ms Edgar to remove the garment or gave her permission to remove it. It is possible that Ms Edgar removed the garment at her own initiative. I am not certain that Mrs Edgar is accurate that the garment had been removed by the Thursday evening. It is possible that it was on the Friday evening Mrs Edgar made her observation that the garment had been removed. In my view, the matter does not require resolution as I am satisfied that Ms Edgar, at some point no later than the Friday afternoon, raised with Dr Kerry that she wanted to remove the garment because of a significant level of pain.

13.7. Dr Kerry and Ms Edgar spoke on the telephone twice during the afternoon of Friday 7 March 2008. The telephone conversations were initiated by Ms Edgar. I accept the

evidence of Dr Griffin that on Sunday 9 March 2008 Dr Kerry told Dr Griffin that Ms Edgar had told him on the Friday afternoon that she was very painful and wanted to remove the corset. I also find that on the Friday afternoon Ms Edgar had in fact told Dr Kerry on the telephone that she was very painful, if not in those exact words, in words to that effect. I also find that Ms Edgar gave Dr Kerry to understand that she wanted to remove the corset for that reason. I am mindful that having regard to the nature of the findings set out in this paragraph, such findings should not be made lightly or on evidence that is doubtful or inexact[177]. There is no evidence that Dr Kerry told her to remove the corset or gave his permission for her to remove the corset on the occasion of this conversation. It is possible that Ms Edgar, having already removed the corset by the time of the Friday afternoon telephone conversations with Dr Kerry, was seeking Dr Kerry's reaction to that fact. The other possibility is that she removed the corset after her conversation with Dr Kerry. In any case her stated desire to remove the corset was, together with her assertion of pain, indicative of a level of pain and discomfort that was unusual for a patient to experience at that point post a liposuction procedure. I also find that Ms Edgar's seeking stronger pain relief was a further indication of her unusual level of pain and discomfort. What Ms Edgar told Dr Kerry in these telephone conversations was reflective of her actual condition as described by her parents on the Friday afternoon. Regardless of what, if anything, Ms Edgar may have said about the condition of her legs, I find that the information that she did give Dr Kerry about pain, her desire to remove the corset for that reason and her stated need for stronger analgesic medication should have generated significant concern in Dr Kerry's mind about her welfare.

13.8. The notations that Dr Kerry made in the clinical notes to the effect that he offered to see Ms Edgar that afternoon were belatedly made at a time after Ms Edgar's hospitalisation and serious illness was known to Dr Kerry. Whilst I continue to have a nagging doubt as to whether this aspect of their telephone conversations had occurred in reality, I find on the balance of probabilities that the matters so recorded were discussed. I find that even if Dr Kerry had made any such suggestions to Ms Edgar, the level of concern about Ms Edgar should have been sufficient to have warranted insistence on his part that she be examined by him that afternoon.

[177] Briginshaw v Briginshaw (1938) 60 CLR 336

13.9. I find that if Dr Kerry had examined Ms Edgar on the Friday afternoon her condition at that point in time was such that Dr Kerry should have immediately referred Ms Edgar to hospital.

13.10. I find that if Ms Edgar had been hospitalised on Friday afternoon, 7 March 2008, an earlier diagnosis of Clostridium perfringens with gas gangrene would have been made and that treatment would have been commenced earlier than it was on the following day when Ms Edgar ultimately presented to the FMC.

13.11. It is not possible to determine with sufficient certainty whether, if appropriate treatment had commenced on Friday 7 March 2008 Ms Edgar, would have survived.

14. Recommendations

14.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

14.2. In 2008 the Australian Health Ministers' Conference requested an examination of the adequacy of consumer safeguards in relation to cosmetic, medical and surgical procedures. The Australian Health Ministers' Advisory Council referred the matter to its Clinical, Technical and Ethical Principal Committee which established the Inter-Jurisdictional Cosmetic Surgery Working Group to undertake the review. The Working Group was tasked with identifying, and reviewing the adequacy of, consumer safeguards in relation to cosmetic, medical and surgical procedures and in particular, safeguards relating to advertising, marketing and recruitment; information available to consumers and informed consent; regulatory coverage; and professional/clinical standards of practice. The Working Group was requested to make appropriate recommendations.

14.3. The final report of the Working Group dated November 2010 was tendered to the Inquest[178]. Much of what this Court may have been minded to recommend is included in this final report. Many of their recommendations do not directly arise from the events with which this particular Inquest is concerned, except that the report does obliquely refer to this matter and another coronial matter in another Australian jurisdiction.

14.4. The report refers to a number of matters of concern in respect of cosmetic surgery including, but not limited to, the need to avoid conveying to the public impressions that a cosmetic surgeon is specially qualified or specialises in such a surgical discipline when in fact any registered medical practitioner may set themselves up in practice and call themselves a cosmetic surgeon. In this regard the Working Group pointed out that where the cosmetic surgery industry sells procedures directly to the public, a general practitioner referral is not required, meaning that the general practitioner is not able to offer an independent view on the procedure unless specifically sought by the patient. The general practitioner is also potentially uninvolved in post-procedural care.

14.5. The quality and nature of post-procedural care is another matter of concern that the Working Group identified. The Working Group concluded, correctly in the view of the Court, that the operating medical practitioner is responsible for all aspects of pre-operative, operative and post-operative care and that this includes the provision of relevant information to the patient including the appropriate response when the patient experiences unusual pain or symptoms, and the ensuring of the existence of protocols to cover all aspects of post-operative care including the full range of possible complications.

14.6. The need in some cases for a psychological evaluation of the patient is also listed as a matter for consideration, together with a cooling-off period between initial consultation and performance of the procedure.

14.7. The Working Group also identified as an issue of concern the use of false, misleading and deceptive advertising and in particular the use of testimonials in such advertising.

14.8. The Court endorses the recommendations that the Working Group has made in respect of the topics referred to in the preceding paragraphs in this Finding and I would direct this endorsement to the attention of the Australian Health Ministers' Advisory Council, the Australian Commission on Safety and Quality in Health Care, the South Australian Minister for Health and the Australian Medical Council. In particular the Court endorses the recommendation of the Working Group that there should be a national framework covering cosmetic, medical and surgical procedures which includes a baseline of requirements relating to the training, expertise and qualifications of cosmetic surgeons and in respect of the regulation of places where

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[178] Exhibit C30

such surgery occurs, compulsory licensing and standards for private health facilities and the promulgation of specific guidelines for the work up of patients contemplating cosmetic medical and surgical procedures.

14.9. The Court makes the following further recommendation that I also draw to the attention of the entities referred to in the preceding paragraph.

1) That the cosmetic surgery industry be advised that an acceptable level of post-operative care must include a personal post-operative consultation with the patient within the first 24 to 48 hours of a liposuction procedure.

14.10. I have already referred to the issue that involved the administration of hyperbaric oxygen as a treatment modality in relation to gas gangrene. I foreshadowed earlier in these findings that I would endorse an agreed recommendation in respect of this issue. Mr Michael Riches, counsel for the Adelaide Health Service, has indicated to the Court that SA Health under the direction of the Quality and Safety Branch will convene a Committee of appropriately skilled and qualified practitioners to develop and disseminate treatment guidelines in accordance with the recommendation if the Court was minded to make that recommendation. The Court is so minded. I make the following recommendation:

2) SA Health refer to an expert Committee within SA Health the issue of the appropriate clinical management of patients presenting to public health units and who are diagnosed with gas gangrene for the purpose of formulating and disseminating treatment guidelines for such presentations, and having regard to the efficacy and timing of antibiotic treatment, surgical fasciotomy necrotic tissue debridement, intensive medical support and hyperbaric oxygen therapy and where such treatment be provided.

Key Words: Liposuction; Clostridium perfringens

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

Seal the 1sth day of November, 2012.

Deputy State Coroner

Inquest Number 37/2011 (0325/2008)