



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Christine Joy Flynn

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that:

- a) The identity of the deceased is Christine Joy Flynn;
- b) Mrs Flynn died following the perforation of her pericardial sac during a laparoscopic hiatus hernia repair;
- c) The cause of Mrs Flynn's death was haemopericardium; and
- d) Mrs Flynn died, aged 68 years, on 5 December 2023 at Calvary St Vincent's Hospital, Launceston, Tasmania.

In making the above findings, I have had regard to the evidence gained into Mrs Flynn's death including:

- Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Declaration of Life Extinct – Dr Tom Hall, 5 December 2023;
- Report – Dr Donald Ritchey, Forensic Pathologist;
- Records – Ambulance Tasmania;
- Medical Records – Calvary Health Care Tasmania;
- Serious Clinical Incident Investigation – Calvary Launceston;
- Medical Records – Launceston General Hospital;
- Report – Dr Anthony Bell, Medical Adviser to the Coronial Division;
- Report – Clinical Associate Professor Rob Bohmer, Consultant General Surgeon; and
- Detailed information received from Mr George Flynn.

Circumstances of death

Mrs Flynn underwent elective laparoscopic repair of a hiatus hernia on 4 December 2023. Surgery was reportedly uncomplicated. Approximately two hours after she complained she did not feel well and developed hypotension for which medication was administered. Later she developed nausea and collapsed and died as a result of a cardiac arrest shortly after midnight, in the early hours of 5 December 2023.

Investigation

The fact of Mrs Flynn's death was reported in accordance with the requirements of the *Coroners Act 1995*. After formal identification, her body was taken to the mortuary at the Royal Hobart Hospital where experienced forensic pathologist Dr Donald Ritchey performed an autopsy.

Dr Ritchey identified the presence of copious partially clotted blood in the pericardial sac along with a 2 mm perforation of the inferior sac overlying the diaphragm adjacent to surgical rivets securing a diaphragm mesh patch (that is to say where the hernia repair had occurred).

I am satisfied that the mechanism of Mrs Flynn's death was a pericardial tamponade causing acute congestive heart failure and fatal arrest. The cause of her death was a haemopericardium as a result of the perforation of her pericardial sac which occurred during the laparoscopic procedure she underwent on 4 December 2023.

Given the circumstances of Mrs Flynn's death I sought the advice of Consultant General Surgeon Mr Rob Bohmer a specialist in gastrointestinal surgery.

Mr Bohmer provided a report in which he expressed the opinion, that the use of mesh in a hiatus hernia repair is controversial, and that the use of tacks especially anterior to the oesophagus carries a risk of pericardial injury with devastating results (as occurred in this case). His opinion was based in part upon multiple studies showing no clear advantage for mass repair balanced against the potentially catastrophic consequences in the event of failure.

I accept Mr Bohmer's opinion.

Comments and Recommendations

The circumstances of Mrs Flynn's death require me to **recommend**, pursuant to section 28 of the *Coroners Act 1995*, that practitioners should be alert to the risks of the use of tacks for

mesh fixation in hiatal hernia repairs and consider either using glue for mesh fixation or avoiding mesh fixation entirely.

I extend my sincere condolences to the family and loved ones of Mrs Flynn.

Dated: 7 November 2024 at Hobart, in the State of Tasmania.

Simon Cooper

Coroner