IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 2427

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	Leigh Thomas Aiple
Date of birth:	18 September 1982
Date of death:	12 May 2014
Cause of death:	I(a) Pulmonary thromboembolism
Place of death:	36 Carween Avenue, Mitcham, Victoria

INTRODUCTION

1. Leigh Thomas Aiple was a 31-year-old man who lived in Mitcham at the time of his death.
2. In April 2014, Mr Aiple travelled to the Beverly Wilshire Medical Centre in Kuala Lumpur, Malaysia where he had multiple plastic surgery procedures performed on 17 April 2014 and 22 April 2014.
3. He returned to Australia on 11 May 2014 and his mother, Grace Muscat collected him from the airport.
4. On the morning of 12 May 2014 Ms Muscat found Mr Aiple collapsed in his room struggling to breath. She contacted emergency services however Mr Aiple could not be resuscitated and he died at the scene.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Aiple's death was reported to the Coroner as it appeared to be unexpected and so fell within the definition of a reportable death in the *Coroners Act 2008.*
6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
7. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including Ms Muscat, and the forensic pathologist who examined Mr Aiple. The brief also includes Mr Aiple's medical records from Beverley Wilshire Medical Centre, emails between Mr Aiple and Ms Muscat and photos of his wounds following surgery. The brief also includes an expert report and supplementary report prepared by Professor Mark Ashton and responses by Dr Mohamad Nasir Zahari, Mr Aiple's treating surgeon in Kuala Lumpur.
8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

IDENTIFICATION OF THE DECEASED

9. On 12 May 2014, Grace Muscat visually identified Mr Aiple's body as being that of her son Leigh Thomas Aiple, born 18 September 1982.
10. Identity is not in dispute and requires no further investigation.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Background

11. Mr Aiple had a medical history including sleep apnoea (for which he used a CPAP machine) and obesity. His weight was 124.6 kg and his body mass index was 40.2, which is considered Grade III Obesity.
12. Although Mr Aiple's mental health had suffered in the last years of his life, he had a close and loving relationship with his family.[2]
13. When he was 27 years old, Mr Aiple joined the Australian Defence Force (ADF) and successfully completed recruit training at Kapooka. Months later, Mr Aiple called his mother in distress and told her that he was being bullied in relation to his snoring.[3]
14. During this time Mr Aiple lost a great deal of weight and developed loose, excess skin over a number of areas of his body. Mr Aiple reported the bullying at the ADF also focused on his excess skin.[4]
15. The bullying had an effect on Mr Aiple's mental state. Ms Muscat recalls that Mr Aiple told her that he felt '*pressured*' to leave the ADF, which he eventually did. When he returned home, she recalls that he was '*so depressed, there was nothing we could say or do to pull him out of this deep hole*'.[5]
16. As Mr Aiple continued to have negative feelings about his body, he consulted with plastic surgeon Dr Richard Maxwell. Dr Maxwell operated to remove some excess skin from around Mr Aiple's chest.[6]
17. Mr Aiple wanted to have a further operation to remove the excess skin around his stomach, '*but couldn't afford it within Australia, this is when he decided to go overseas as it was 1/3 of the cost.*'[7]
18. Ms Muscat recalls that in April 2014 Mr Aiple received a payout from the ADF '*in regards to the taunts and disrespect whilst in the army.*'[8]

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[2] Statement of Grace Muscat dated 14 December 2014, Coronial Brief p 6
[3] Ibid
[4] Ibid.
[5] Ibid p 7.
[6] Ibid.
[7] Ibid p 8.

Overseas surgery

19. Mr Aiple chose to use this money to have further plastic surgery overseas.
20. Mr Aiple booked his trip through Gorgeous Getaways.
21. Ms Muscat stated, '*Gorgeous Getaways would organise all of Leigh's flights, accommodation and liaised with the Beverley Wilshire Clinic in Kuala Lumpur, Malaysia.*' [9]

Gorgeous Getaways

22. Gorgeous Getaways is an operator co-ordinating overseas travel with plastic surgery.[10] In 2014 they provided advice on their Website regarding '*where and who to go to for affordable, quality plastic surgery, optical and dentistry treatments*' as well as coordinating clients' accommodation and treatments.[11]
23. Among several overseas destinations for surgery, Gorgeous Getaways advertised options in Kuala Lumpur, Malaysia. They stated on their website that in this location '*Hospitals are private and certified to internationally recognised standards with the same or higher as you would expect at home*'.[12]

Beverly Wilshire Medical Centre

24. One facility advertised by Gorgeous Getaways was the Beverly Wilshire Medical Centre (BWMC) in Kuala Lumpur, Malaysia, described as '*a boutique medical centre, offering surgical and non-surgical procedures using state-of-the-art equipment and highly-skilled, experienced specialists*'.[13]
25. Gorgeous Getaways provided profiles of several surgeons at the BWMC including Dr Mohamad Nasir Zahari. According to the Gorgeous Getaways website in 2014:

> '*Dr Nasir is a board certified surgeon specialises in all aspects of plastic surgery and reconstructive surgery. He is renowned for his skills with minimum incisions for natural appearance of the breasts, short-scar facelift, and modified abdominoplasty (tummy-tuck).*

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[8] Ibid
[9] Statement of Grace Muscat dated 14 December 2014, Coronial Brief p 8
[10] Gorgeous Getaways is now owned by TaqTik Health, a corporation headquartered in the United States which does business as Gorgeous Getaways.
[11] 'What We Have to Offer', Internet Archive capture of www.gorgeousgetaways.com dated 21 September 2014.
[12] 'Quality and Standard of Care in Malaysia', Internet Archive captures of www.gorgeousgetaways.com dated 3 November 2013 and 21 September 2014 (quoted passage identical in both captures).
[13] 'Beverly Wilshire Medical Centre (BWMC)', Internet Archive capture of www.gorgeousgetaways.com dated 20 August 2014.

Dr Nasir is a member of the elite "Malaysian Association of Plastic, Aesthetic and CranioMaxilloFacial Surgeons (MAPACS)" from 1999 until present. He believes in extensive research, unparalleled academic training and teaching.'[14]

Travel to Kuala Lumpur and surgeries

26. On 11 April 2014 Mr Aiple travelled to Kuala Lumpur. He signed consent forms for procedures to be performed by Dr Nasir.[15]
27. On 17 April 2014, Mr Aiple underwent surgery comprising liposuction of the abdomen, a lateral chest lipectomy/lift, extended abdominoplasty and an inner thigh lift. There is discrepancy in the coronial brief regarding the length of time of the surgical procedures. According to Dr Nasir the surgery lasted just under eight hours, from 10.40am to 7.15pm.[16] However according to Professor Ashton the surgery lasted ten hours from 9.30am – 7.30pm[17]
28. Five days later, on 22 April 2014, Mr Aiple underwent further surgery, namely a neck lift, a submental lipectomy, right upper eyelid ptosis repair with bilateral upper blepharoplasty and upper lip augmentation. According to Dr Nasir the procedures lasted just over three hours, from 3.00pm to 6.10pm [18] and according to Professor Ashton the operation went from 14.20 – 19.10 making the surgery 4 hours and fifty minutes.[19]
29. Mr Aiple was admitted to BWMC on 17 April 2014 and on 23 April 2014 he was discharged from the BWMC to his hotel room.[20]

Post-operative treatment and complications

30. Mr Aiple was in Kuala Lumpur, Malaysia for three weeks. His recovery was complicated by wound dehiscence requiring re-suturing and wound discharge. Following his surgical procedures he was discharged from hospital to a hotel with wound dressing performed by visiting health care/nurse attendants employed by Gorgeous Getaways. He was re-admitted to BWMC from 6-10 May 2014 following 'fainting' episodes.
31. Mr Aiple was visited at his hotel room by Gorgeous Getaways carer Misty for dressing of wounds on the mornings of 24 April 2014 and 25 April 2014.[21]

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[14] Ibid.
[15] Email from Grace Muscat to the Coroners Court of Victoria dated 16 July 2014; Gorgeous Getaways consent forms, Coronial Brief p 113-117.
[16] Statement of Dr M Nasir Zahari (undated), Coronial Brief p 20.
[17] Supplementary Report by Professor Ashton dated 8 September 2017 Coronial Brief p 26.26A
[18] Statement of Dr M Nasir Zahari (undated), Coronial Brief p 20.
[19] Supplementary Report by Professor Ashton dated 8 September 2017 Coronial Brief p 26.26A
[20] Beverly Wilshire Medical Centre Patient Discharge Form dated 23 April 2014, Coronial Brief p 93.1.
[21] Notes of Gorgeous Getaways carer 'Misty', Coronial Brief p 83.

32. On 25 April 2014 Mr Aiple sent an email to his mother containing pictures of swelling in his legs and feet.[22]

33. On 26 April 2014 Mr Aiple sent further emails to Ms Muscat describing swelling in his legs and throughout his body.[23]

34. On 29 and 30 April 2014, Mr Aiple attended the BWMC. According to Dr Nasir's statement:

> '*After the discharge from ward, [Mr Aiple] came to the out-patient clinic for review at 9:30 a.m. on the 29 April 2014. [Mr Aiple] complained of fluid discharge from two areas with small dehiscence on the; left lateral abdomen 0.5cm and; back wound 0.5cm. The right thigh wound also showed some redness. All other wounds showed good healing. I had performed needle aspiration which had obtained 500 mls of blood-stained seroma.*
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> *On the 30 April 2014, [Mr Aiple] came to the clinic at 9:30 a.m. complaining of high volume discharge coming from the open wounds on the abdomen. I had performed incision and drainage by extending the open wound on the left lateral abdomen to about 5cm and packed the wound loosely with povidone-soaked ribbon gauze to make the opening patent for several days to allow a better control of the abdominal seroma discharge.*'[24]

35. On 1 May 2014 Mr Aiple sent a message to his Gorgeous Getaways carers that stitches on his back had burst open. Carers attempted to contact Dr Nasir but were unsuccessful. They then spoke to Dr Jalil of BWMC who advised them to send Mr Aiple to BWMC. Mr Aiple's carer Juliana arrived to his hotel room at 7.30pm and prepared Mr Aiple to leave. Juliana noted that the stitches had burst open and that the '*room was in a mess with blood stained robes, towels, bedsheets*'.[25]

36. As Juliana was preparing Mr Aiple to go to the BWMC, they received a call from Dr Nasir. Juliana recorded that '*After [my] informing him of the situation and [of] the wound, Dr Nasir advised me not to worry just put a dressing on the wound and bring client in, first thing the next morning. I asked him twice for confirmation of what was said*'.[26]

37. Juliana then changed Mr Aiple's dressings. She recorded that Mr Aiple was very *'angry'* about his open wounds and leakage. She left him for the night at 9.40pm and returned the following morning to bring him to the BWMC.[27]

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[22] Email from Leigh Aiple to Grace Muscat dated 25 April 2014, Coronial Brief p 159.
[23] Emails from Leigh Aiple to Grace Muscat dated 26 April 2014, Coronial Brief p 163-165.
[24] Statement of Dr M Nasir Zahari (undated), Coronial Brief p 21.
[25] Notes of Gorgeous Getaways carer 'Juliana', Coronial Brief p 79.
[26] Ibid.
[27] Notes of Gorgeous Getaways carer 'Juliana', Coronial Brief p 79-80.

38. On 2 May 2014, Dr Nasir states, '*[Mr Aiple] came to the clinic at 10:00 a.m. with 3 areas of wound dehiscence: 10 cm long dehiscence on the mid-back wound; 2 cm long dehiscence on the right back wound; 2 cm long dehiscence on the right lateral chest wound. I had performed closure of all wounds under local anaesthesia using 2:0 ethilon sutures in the clinic treatment room*'.[28]

39. On 3 May 2014, Dr Nasir states, '*[Mr Aiple] came to the clinic at 9:15 a.m. with wound dehiscence 3 cm long dehiscence on the left thigh. I had performed closure of the wound under local anaesthesia using 2:0 ethilon sutures in the clinic treatment room. The abdominal ribbon gauze packing was changed to a new one.*'[29]

40. On 5 May 2014, according to Dr Nasir, '*[Mr Aiple] came to the clinic at 9:15 a.m. with wound dehiscence 2 cm long dehiscence on the right thigh. I had performed closure of the wound under local anaesthesia using 2:0 ethilon sutures in the clinic treatment room. The abdominal dressing was also changed*'.[30]

41. At around 11.00am on 6 May 2014, Gorgeous Getaways carer Kumari attended Mr Aiple's room and changed his dressing. She records that Mr Aiple was pale and tired and had not eaten since the previous night. She states that he '*was feeling nauseous*' and '*was very pale and almost passed out*'. She then '*informed [Gorgeous Getaways carer] Juliana to inform Dr Nasir of the above incident during post consult which is due this afternoon*'.[31]

42. At 1.54pm on 6 May 2014 Kiran Kaur of Gorgeous Getaways emailed Dr Caren Por of the BWMC. Ms Kaur informed Dr Por that Mr Aiple had '*almost fainted while [Kumari] was doing his dressing. Kumari says this is due to hypoglycaemia .... He is also losing a lot of blood.*' Ms Kaur also informed Dr Por that '*he is still leaking fluid everywhere and in my nurses opinion it seems to be getting worse and infected*'.[32]

43. The nursing notes indicate considerable disquiet amongst nursing staff and carers looking after Mr Aiple.

44. Mr Aiple had six areas of wound dehiscence, including one on the mid back being 10 cm long.

45. Dr Nasir states that on 6 May 2014 '*the agency representative informed me that [Mr Aiple] had developed fainting, and the back wound that was sutured earlier had re-developed dehiscence. [Mr Aiple] was brought to the clinic and examination revealed that [Mr Aiple] was alert and orientated. [Mr Aiple] was not pale and afebrile with a pulse of 125 beats/min, Blood Pressure of 136/97 mmHg and SpO2 of 96% on room air. Blood glucose*

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[28] Statement of Dr M Nasir Zahari (undated), Coronial Brief p 21.
[29] Ibid.
[30] Ibid.
[31] Notes of Gorgeous Getaways carer 'Kumari', Coronial Brief p 84.
[32] Report attached to email from Kirin Kaur to Dr Caren Por dated 6 May 2014 at 1.54pm, Coronial Brief p 85.

level tested was 8.8 mml/L. In view of the fainting episodes and the wounds' condition, I had decided to admit [Mr Aiple] into the ward for an investigation, observation and management of the wounds on that same day. Since [Mr Aiple] was reported to have lost a lot of fluid, I was thinking in the line of hypovolaemia.'[33]

46. Dr Nasir states that Mr Aiple appeared to recover: '*[Mr Aiple's] condition improved significantly after infusion of intravenous fluids and after [Mr Aiple] took his meals and drinks in the ward*'.[34]

47. On 7 May 2014, Mr Aiple sent an email to Ms Muscat including the following:

'*[F]or the last 4 days I've been losing fluid at a dangerous level. And I haven't been able to replenish it fast enough. I fainted on two different days when the girls were doing my dressings. I've been short of breath and my heartbeat has been beating rapidly, like crazy. I'm sick of water, don't even want to look at it anymore. So now I'm taking electrolytes for every second or third drink. I can only really walk properly now for the past 2 days, finally! I was always too sore, full of liquid, feeling giddy and drowsy or just generally uncomfortable.*'[35]

48. On 9 May 2014, Mr Aiple sent an email to Ms Muscat as follows:

'*Get ready for the fact I MAY not come home tomorrow, if I have another bad day. I blacked out yesterday in the bathroom and woke up on the bathroom floor .... Still don't know whether I fell or not, but my head sustained no injury. No concussions. But when I got off the floor ..., I started hyperventilating and couldn't breathe. My chest was tight and heartbeat was dangerously rapid. I almost had a similar experience just before. I've had NO energy for 4 days now. Just letting you know, in case this behaviour continues when I get home. They don't seem able to solve my issues here, they just say "I've never seen your kind of case before" it's a little scary hearing that.*'[36]

49. On the morning of 10 May 2014 Mr Aiple's Gorgeous Getaways carer Juliana attended to him at the BWMC. She arranged for nurses to change his dressings and helped him prepare for his flight later that day. She records that Dr Nasir informed Mr Aiple that '*all is well*' and that he was '*fit to travel*'. Juliana made arrangements for nurses to change Mr Aiple's

[33] Statement of Dr M Nasir Zahari (undated), Coronial Brief p 21.
[34] Ibid.
[35] Email from Leigh Aiple to Grace Muscat dated 7 May 2014, Coronial Brief p 175.
[36] Email from Leigh Aiple to Grace Muscat dated 9 May 2014, Coronial Brief p 174.

dressings again before his departure, and recorded that '*he was cheerful and looking forward to going home*'.[37]

50. Dr Nasir states that Mr Aiple was given '*anti DVT stocking and advised to use during flight. [Mr Aiple] also had been advised to perform lower limb exercise while seated in the plane, and to periodically walk during flight*'.[38]

Events proximate to death

51. Mr Aiple took a flight to Australia and arrived at Tullamarine Airport on 11 May 2014 where he was met by his mother, Ms Muscat.[39] Ms Muscat brought Mr Aiple home to 36 Carween Avenue, Mitcham. She reports that his wounds were '*horrid*', appeared to be infected and that there was a '*gaping hole*' with '*slight fluid oozing out*'. Mr Aiple was in '*a lot of pain*' throughout the day.[40]
52. On the morning of 12 May 2014, Ms Muscat heard a crashing sound from Mr Aiple's room at around 6.15am. When she went to check on him, he appeared to have collapsed by the side of his bed and was no longer wearing his CPAP mask. He was '*sweaty and clammy*' and she recalls him struggling to breathe. Ms Muscat contacted emergency services.[41]
53. Emergency services arrived and attempted CPR, but Mr Aiple did not recover and he died at the scene.

CAUSE OF DEATH

54. On 16 May 2014, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Aiple's body and provided a written report, dated 23 May 2014. In that report, Dr Burke concluded that a reasonable cause of death was '*I(a) Pulmonary thromboembolism*'.
55. Dr Burke commented that:

> '*There was recent and old thromboembolism. The pulmonary thromboembolism was associated with deep venous thrombosis within peripheral calf veins.*

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[37] Notes of Gorgeous Getaways carer 'Juliana', Coronial Brief p 81-2.
[38] Statement of Dr M Nasir Zahari (undated), Coronial Brief p 22.
[39] Ms Muscat states in her statement that when she collected Leigh from Tullamarine he was not wearing compression stockings and she '*...does not believe he was ever given compression stockings, as when Leigh returned home, the stockings were not sighted, we searched the one and only room Leigh slept in and his travel bag was not unpacked...yet no compression stockings, there were 2 compression body suits...*' Statement of Grace Muscat dated 14 December 2014, Coronial Brief p 13.
[40] Statement of Grace Muscat dated 14 December 2014, Coronial Brief p 14.
[41] Ibid.

Risk factors for deep venous thrombosis include stasis of blood flow, damage to the endothelial lining of blood vessels, and changes in blood coagulation.

Recent surgery and long haul flights are relative risk factors for the development of deep venous thrombosis and subsequent pulmonary thromboembolism.

There is no evidence to suggest the death was due to anything other than natural causes.'

56. I accept Dr Burke's opinion as to cause of death.

CORONIAL INVESTIGATION AND REVIEW OF CARE

57. On 16 June 2014, accepting Dr Burke's opinion that Mr Aiple's death was due to natural causes, I made a determination pursuant to section 17 of the *Coroners Act 2008* that no further investigation was necessary.
58. On 16 July 2014 Ms Muscat contacted the Court by email requesting that Mr Aiple's death be investigated further due to her concerns regarding his medical care and the involvement of Gorgeous Getaways. Ms Muscat provided documents relating to Mr Aiple's recent surgery and death.[42]
59. I considered the new facts and circumstances communicated by Ms Muscat, and on 24 July 2014 I directed that the investigation be re-opened pursuant to section 77(3) of the *Coroners Act 2008*. I requested that a Coronial Brief be prepared.
60. After the Coronial Brief was received, I referred the case to the Health and Medical Investigation Team (HMIT) of the Coroners Prevention Unit (CPU)[43] for review. Following this review I sought an expert report regarding Mr Aiple's medical care and how the overseas surgery compared with equivalent Australian standards for such procedures.
61. This report was prepared by Professor Mark Ashton, Clinical Professor of Surgery at the University of Melbourne and former Head of Plastic Surgery at the Royal Melbourne Hospital (2001-2016). Professor Ashton was provided with a copy of the Coronial Brief which included Mr Aiple's medical records from the Beverly Wilshire Medical Centre.
62. I asked Professor Ashton to provide information on venous thromboembolism (VTE) and preventative measures which should be taken to prevent VTE (VTE prophylaxis). I also

[42] Email from Grace Muscat to the Coroners Court of Victoria dated 16 July 2014.

[43] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

asked him to review Mr Aiple's surgical procedures at the BWMC particularly the number of procedures and the time frame over which they were performed.

63. In addition, I asked that Professor Ashton comment on Mr Aiple's post-operative complications, in particular his wound dehiscence and his wound discharge (seroma), as well as his post-operative care and transfer from hospital to hotel.

64. Professor Ashton provided a report dated 2 February 2017, and a supplementary report dated 8 September 2017 after being provided with additional medical records.

65. The Court provided copies of Professor Ashton's reports to Dr Nasir and he provided responses to both reports.

Coroners Prevention Unit review

66. The CPU review noted that the forensic pathologist, Dr Burke had identified the presence of a recent and old thromboembolism. Both the left and the right pulmonary arteries were distended and occluded by coils of thromboembolism. The pulmonary thromboembolism was associated with deep venous thrombosis within peripheral calf veins.

67. Pulmonary embolism (PE) is a form of venous thrombosis embolism (VTE) and refers to an obstruction of the pulmonary artery. The clinical presentation of PE is variable and often nonspecific, making diagnosis challenging.

68. There are numerous risk factors for the development of VTE in surgical patients and the CPU review noted Mr Aiple's VTE risk factors which included marked obesity, surgery, prolonged travel with limited movement and venous stasis. CPU also noted there is a reportedly lower incidence of VTE in Asian populations. [44]

69. The CPU review noted Mr Aiple was administered with 20 mg daily doses of enoxaparin, provided with leg compression stockings and encouraged to ambulate. However he remained lying in bed for periods and following discharge from hospital immediately embarked on a long flight back to Australia.

Expert report by Professor Mark Ashton

- **Risk factors for venous thromboembolism (VTE)**

70. Professor Ashton noted that:

[44] Menaka P and Douketis J. 'Prevention of venous thromboembolic disease in surgical patients.' Accessed in the Uptodate Clinical database, October 2015.

'Risk stratification for VTE is challenging but essential and requires consideration of both patient- and procedure-specific risk factors. Several models for risk stratification exist, all have important limitations. There is no risk model that has been developed that accurately reflects so many surgeries being performed at the one time, let alone two major episodes of multiple surgeries within a week.'[45]

71. Professor Ashton identified Mr Aiple had several relevant risk factors, including the following:

'Major surgery (surgery > 45 minutes) is universally accepted as a key risk factor for VTE. Furthermore, there is evidence that, with each additional hour of surgical time the risk increased by a further 32%.'[46]

'Obesity is defined as a body mass index (BMI) above 30 kg/m^2. Obesity leads to a two- to threefold risk of VTE. The risk associated with severe obesity (BMI > 40 kg/m^2) is even higher.'[47]

'Travel by air, car, train or bus for 4 or more hours all increase the risk of VTE by about two-fold for several weeks after travel.'[48]

72. He then enumerated which risk factors applied to Mr Aiple in relation to his two operations. For the operation of 17 April 2014, his risk factors included at least '*Major surgery (8.35h), Significant obesity, Recent air travel* and *Being confined to bed (>72 H)*'.[49]

73. For the operation of 22 April 2014, Mr Aiple's risk factors included '*Major surgery (3.10h), Surgery within a month of previous major surgery, Being confined to bed (>72h) again* [*and*] *Swollen legs*'.[50]

- **VTE prophylaxis**

74. Professor Ashton referred in his report to the National Health and Medical Research Council (NHMRC) which has published a practice guideline for the prevention of VTE in hospitalised patients.

75. In general, the preferred method of prophylaxis is dependent upon the risk of post-operative VTE, which is determined by the type of surgery and patient related risk factors.

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[45] Expert opinion of Professor Mark Ashton dated 2 February 2017, Coronial Brief p 26.9.
[46] Ibid.
[47] Ibid p 26.10.
[48] Ibid.
[49] Ibid.
[50] Ibid.

76. According to the NHMRC guideline, Mr Aiple's risks for VTE included marked obesity, his inclination to remain in bed during post-operative recuperation, combined with airline travel and the associated limited movement and venous statis.

77. Multimodal VTE prophylaxis is ideally started during hospitalisation, either before or shortly after surgery and continued at least until the person is fully ambulatory. Options for primary VTE prophylaxis include pharmacologic and/or mechanical methods, which have variable efficacy and bleeding risk. In general, the preferred method of prophylaxis is dependent upon the risk of postoperative VTE which is, in turn, determined by the type of surgery and a scoring risk stratification called the Caprini score.

78. The NHMRC writing committee referred to two international guidelines on preventing VTE, including the 2012 clinical practice guidelines published by the American College of Chest Physicians on 'Prevention of VTE in Non-orthopedic Surgical Patients'[51].

79. In Professor Ashton's opinion, interpretation of this document indicates Mr Aiple should have been considered at high risk for VTE for both episodes of surgery.

80. The manufacturer's recommendations for the dosing of Clexane are 20mg/day for moderate risk patients and 40mg/day for high risk patients.[52]

81. In his supplementary report, Professor Ashton addressed VTE prophylaxis during and immediately following Mr Aiple's surgical procedures on 17 April 2014.

82. Professor Ashton commented that:

> '*...notes clearly document the operating time taken for the procedures, that an extensive lipectomy and large volume liposuction was performed on the 17th April 2014 lasting 10 hours, and a second extensive procedure lasting 4 hours 50 minutes was performed 5 days later. The new notes confirm that the medical staff were aware of Mr Aiple's BMI, and that Clexane was only given for the 17/4, the 18/4 and the 19/4. No Clexane was given after this time. There is no mention of the reasoning behind the cessation...*
>
> *These supplementary notes confirm that Mr Aiple was a high-risk patient. The documentation of his BMI of 40.02 and the admission notes of Dr Nasir confirm that the medical staff were aware that Mr [Aiple] was at high risk of wound dehiscence and wound breakdown. They also state that they are aware that Deep Vein Thrombosis is a risk of this procedure.*

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[51] Gould et al, 'Prevention of VTE in Nonorthopedic Surgical Patients: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines', (2012) *CHEST* 141(2)(Supp) e227S (ACCP Guidelines).

[52] Expert opinion of Professor Mark Ashton dated 2 February 2017, Coronial Brief p 26.11.

In summary, the administration of 20mg of subcutaneous clexane for only 3 days in a high-risk patient with a BMI of 40.2 undergoing 2 extensive operations is not standard VTE prophylaxis.'[53]

83. In his original report Professor Ashton analysed the medical notes from BWMC of 27 April onward which considered the significance of Mr Aiple's two 'fainting' episodes on 6 and 8 May 2014.

84. Professor Ashton commented that:

'The nursing notes particularly those of the 2nd episode on the 8th May are absolutely typical for PE [pulmonary embolism] and describe a sudden, rapid and severe deterioration. The nurses document that Mr Aiple was well overnight, and that at 0700 he was "stable and alert"[.] At 0800 he requested to go for a shower. The nurse suggested breakfast first, but Mr Aiple refused and was asked to take the shower by himself. Mr Aiple emerged from the bathroom at 0815 "looking weak and complaint unable to breath and sweating. applied oxygen with F/mask SL. and allowed to rest on bed. SPO 81%."

This hypoxia was significant in that it did not improve with oxygen and was prolonged. At 12.30, that is, 4hours 15 min later the SpO_2 was 90%. Dr Nasir himself documented a SpO_2 of 92% on room air at 1100. He also documented that Mr Aiple was well the day before. Repeated episodic, severe, sudden desaturation associated with severe breathlessness is pathognomonic of Pulmonary Embolism.

To be quite clear, this is literally the full hand for a diagnosis of Pulmonary Embolism. Mr Aiple has known risk factors, the onset and nature of Mr Aiple's symptoms are textbook for Pulmonary Embolism, the clinical signs are those of Pulmonary Embolism, and the failure to respond to oxygen is absolutely typical of a embolis disrupting pulmonary function.'[54]

85. Professor Ashton connected his analysis of BWMC notes to the Forensic Pathologist's medical examination report and drew the following conclusions:

'Further, the histopathology report for the post mortem examination identifies recent and organising thrombus in both the lungs and deep calf veins. (that is, a repair process had began to remove the blood clot – this process takes days to a week[.)] This is important, as it confirms that emboli of thrombus were being discharged from the calf into Mr Aiple's lungs for a considerable period prior to death, and that the DVT was not the result of Mr

[53] Ibid p 26.28.
[54] Ibid p 26.20 (references omitted).

Aiple's immobilisation whilst he flew home from Malaysia to Melbourne. It also confirms that the most likely explanation for the 2 "fainting episodes" was syncope associated with PE. That the left calf had no residual thrombus indicates that this was probably the site for the fatal clot that travelled to Mr Aiple's lungs. It is also noted that the photo on [page 159 of the Coronial Brief] and the email from Mr Aiple [dated 25 April 2014] describe significant calf swelling. Mr Aiple says he discussed the calf swelling with the medical staff, but there is no documentation of this conversation or subsequent examination of the lower extremity by Dr Nasir.'[55]

86. Professor Ashton made the following comments on the consideration of the possibility of VTE:

'It is also clear from the provided notes that Dr Nasir was not considering VTE as a possible diagnosis for the fainting and breathlessness and was initially thinking hypovolaemia on the 6th May or atelectasis on the 8th May. The ordering of the chest X ray was appropriate and is the standard of care. It is ordered to exclude atelectasis of a cause of the desaturation and tachycardia. If the [chest X ray] is reported as normal (as was the case with Mr Aiple) the next step is to exclude Pulmonary Embolism.

No examination of the calves was performed. No ECG was performed. No ultra-sound of the calves was performed. No VQ scan (or CTPA) was considered. The calf examination and a 's1q3t3" sign or a sinus tachycardia on the ECG would have strongly suggested VTE. The VQ scan would have been definitive.'[56]

- **Review of Mr Aiple's surgical procedures at BWMC**

87. I asked Professor Ashton to comment on the appropriateness of Mr Aiple's surgical procedures on 17 April 2014 and 22 April 2014 and compare how such procedures would have been scheduled and performed in Australia.

88. Regarding Mr Aiple's care prior to his operations, Professor Ashton commented that:

'The pre-operative consultation, and the scope and spacing of the individual operations are NOT of an international standard.

[55] Ibid p 26.15 (references omitted).
[56] Ibid p 26.20 (references omitted).

Mr Aiple is a high risk patient. His BMI is over 38kg/m^2, and therefore he is at increased risk of wound breakdown, seroma, surgical site infection, skin breakdown and necrosis, with complication rates of 40% regularly reported.

The initial full consultation was conducted on the 11 April 2014 and the first surgery conducted on the 17 April 2014.

I cannot see evidence of a second or third consultation in the notes provided by Dr Nasir. A second consultation is considered the minimum standard of care in Australia. In my personal practice a third or fourth consultation is routine.'[57]

89. On a review of BWMC records, Professor Ashton concluded: '*The documentation of [Mr Aiple's] BMI of 40.2 and the admission notes of Dr Nasir confirm that the medical staff were aware that [Mr Aiple] was at high risk of wound dehiscence and wound breakdown. They also state that they are aware that Deep Vein Thrombosis is a risk of [Mr Aiple's] procedure*'.[58]

- **Surgery on 17 April 2014**

90. The procedures performed on17 April 2014 were Liposuction of the abdomen, Lateral chest lipectomy/lift, Extended Abdominoplasty and Inner Thigh lift. [59]

91. Professor Ashton commented that '*Dr Nasir's operative record documents an extensive lipectomy in which 4.94kg of soft tissue were removed, and liposuction of 1.6litres. This would be classified as "large volume liposuction"*'.[60] Professor Ashton noted that '*large volume liposuction is well documented to be associated with significant complication rates, including death, and pulmonary embolism*'.[61]

92. Comparing these procedures to Australian practice, Professor Ashton stated:

'*The combination of these procedures in one operation is unusual in Australia and would not be considered standard of care.*

In Australia, it would be usual to perform the abdominal liposuction and abdominoplasty during one hospital admission and anaesthetic. The chest lipectomy and thigh lift would be

[57] Ibid p 26.12 (references omitted).
[58] Supplementary opinion of Professor Mark Ashton dated 8 September 2017, Coronial Brief p 26.28.
[59] Letter from Dr M Nasir Zahari to whom it may concern dated 10 May 2014, Coronial Brief p 40.
[60] Ibid p 26.27.
[61] Expert opinion of Professor Mark Ashton dated 2 February 2017, Coronial Brief p 26.13.

performed during a separate hospital admission and anaesthetic a minimum of 3 months later.'[62]

- **Surgery on 22 April 2014**

93. The procedures performed on 22 April 2014, were Neck lift, Submental lipectomy, Right upper eyelid ptosis repair with bilateral upper blepharoplasty and Upper lip augmentation using restylane vital light filler. [63]

94. Professor Ashton noted that the upper lip augmentation used 1mL of Restylane HA filler and was performed under general anaesthetic. He noted: '*This is a high-risk procedure. Inadvertent intra-arterial injection is not uncommon and can lead to significant tissue necrosis of the lip, the nose and blindness. Detected early, the intra-arterial injection is reversible. The most reliable warning sign of inadvertent intra-arterial injection is severe, excruciating pain and subsequent subtle tissue pallor. By giving the patient a general anaesthetic these vital early warning indicators are removed, placing the patient at significant risk.'*[64]

95. Regarding the scheduling of the procedures, Professor Ashton stated:

'*It is normal to experience significant swelling and fluid retention after surgery such as extensive liposuction, abdominoplasty and chest lipectomy. Any subsequent facial aesthetic surgery would normally be delayed until well after this has resolved and might typically be a period of 4 to 6 months.'*[65]

- **Review of discharge and treatment of wound dehiscence**

96. I requested that Professor Ashton review Mr Aiple's postoperative care and transfer from hospital to hotel on 23 April 2014. I specifically asked whether this was an appropriate time to discharge Mr Aiple for hospital and what the expected length of time would be in an Australian hospital. I also requested that Professor Ashton discuss wound dehiscence in particular as a complication in Mr Aiple's case.

97. Professor Ashton commented that '*This is a little difficult to answer as the combination of procedures significantly exceeds normal Australian protocol.'*[66]

98. He noted that on 23 April 2014 '*Mr Aiple was discharged out of hospital even though [his] back wound had developed a 0.5cm dehiscence*'.[67]

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[62] Ibid. .
[63] Letter from Dr M Nasir Zahari to whom it may concern dated 10 May 2014, Coronial Brief p 40.
[64] Expert opinion of Professor Mark Ashton dated 2 February 2017, Coronial Brief p 26.13.
[65] Ibid.
[66] Ibid p 26.15.

99. Professor Ashton compared this to Australian practices:

'*The usual treatment for an early wound dehiscence in Australia is to take the patient back to theatre and repair and re-suture the wound. At this time (the 23rd April) the wound was clean, not infected and had a very good chance of healing primarily. The second best scenario would be to immobilise Mr Aiple with strict bed rest and appropriate VTE prophylaxis. The expected time to heal this dehisced wound without resuturing would be in the order of 6-8 weeks.*

The very worst things that could have been done would be to discharge Mr Aiple out of hospital. It means the surgeons loses control of the amount of rest and physical activity Mr Aiple is undertaking. Regular dressings are not able to be performed and the wounds will almost certainly become infected.'[68]

100. Professor Ashton identified several factors that increased the risk of wound dehiscence for Mr Aiple:

'*1. Mr Aiple was significantly overweight, preoperatively, with a BMI of [over] 38. This is well documented to be associated with wound breakdown and dehiscence.*

2. Multiple procedures were performed simultaneously. This meant that surgical sites that had recently been sutured could not be protected from pressure. As an example, the back wound dehiscence almost certainly occurred whilst he was lying on his back on the operating table having his second operation.

3. Mr Aiple was aggressively mobilised and discharged out of hospital the morning after his surgery – this meant he had little or no appropriate bed rest or protective immobilisation.

[4.] Mr Aiple was malnourished (as evidenced by his low albumin) and anaemic.

[5.] The presence of large volume seromas and the absence of drains also increased the risk of wound dehiscence.'[69]

101. Professor Ashton referred to Mr Aiple's return to the clinic on 2 May 2014 with several areas of wound dehiscence, and commented:

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[67] Ibid.
[68] Ibid.
[69] Ibid p 26.17-26.18.

'The occurrence of these significant wound dehiscences would normally alert the surgeon to an underlying problem.

To regain control, the standard of care in Australia would be to readmit the patient to the hospital for bed rest, assess the serum albumin (it will almost certainly [be] low) and perform a dedicated repair of the wounds in the operating theatre, under ideal conditions. The expected admission time- even with ideal management would be one week in hospital.

However in this case, a compromised suturing of the wounds is performed. The procedure was performed in the clinic treatment room. This is distinct from a clinic operating *theatre in that the room is designed to change dressings and treat simple wounds. It is not designed for surgery. No general anaesthetic is available, and as a consequence, any surgery is compromised.'*[70]

102. Professor Ashton notes that again on 5 May 2014 '*rather than readmit Mr Aiple to hospital, the wounds are re-sutured in the clinic treatment room and Mr Aiple is sent back to the hotel*'. Professor Ashton considered that Mr Aiple was '*appropriately*' readmitted to hospital on 6 May 2014 following the 'fainting' episodes. [71]

- **Wound discharge**

103. I requested that Professor Ashton comment on the cause and management of Mr Aiple's wound discharge post-surgery. He made the following general comments:

'A seroma [ie wound discharge] is a common occurrence after abdominoplasty and liposuction. It is the result of damage to the lymphatic vessels in the soft tissue integument of the lower abdomen. This occurs when the soft tissue is elevated off the underlying deep fascia and musculature as part of the redraping procedure. Normally a drain is placed to collect any fluid that accumulates. A large seroma, that is not treated, places excess tension on the sutured wounds and makes wound dehiscence more likely.

A post-operative seroma should be expected after a large abdominoplasty and is the diagnosis of exclusion for post operative swelling. Once detected, the seroma should be drained, and additional supportive care implemented. These include, but are not limited to,

[70] Ibid p 26.16.
[71] Ibid p 26.17.

compression garments, bed rest and return to theatre for formal drainage and reinsertion of a drain.'[72]

104. Professor Ashton referred to Mr Aiple's presentations to the BWMC for review on 29 April 2014 and 30 April 2014, and noted:

'That Mr Aiple presented to the outpatient clinic on the 30th April complaining of high volume discharge coming from the open wounds is predictable and is preventable. There was a window of opportunity here to readmit Mr Aiple back into hospital, take him to theatre, re-suture the wounds and insert a drain to safely drain away the seroma fluid.'[73]

105. Professor Ashton commented on Mr Aiple's treatment for seroma as follows:

'Whilst a seroma was corrected assessed and drained, by the time it was diagnosed the abdominal wounds had already started to break down. Once this occurs, the seroma fluid will continue to drain out of the open wound. It will make management of the wound very difficult indeed as the patient will continually soil the dressing and underlying clothing/bed linen. The dressings not infrequently need to be changed hourly. This is very labour intensive, and consequently is very difficult to implement. As a result, the patient invariably ends up lying in soiled linen. In a hot tropical environment, and because of the high protein content of the lymph fluid, bacteria rapidly colonize the wounds, and the area becomes infected.

Mr Aiple would have been best managed by return to the operating theatre at the Beverley Wilshire for formal debridment and closure of his wounds. Ideally, the surgeon would wash out the abdominoplasty wound, and insert a new drain into the cavity to drain the seroma fluid in to a sealed closed collection bottle system.'[74]

- **Surgeon's qualifications and standard of medical facility**

106. Professor Ashton was asked to comment on Dr Nasir's qualifications and the standard of the BWMC facility. Dr Nasir trained as a doctor at the University of Melbourne, had training in general surgery in Scotland, obtained a Master of (General) Surgery at the National University of Malaysia and undertook training in plastic surgery at the same university. Professor Ashton stated Dr Nasir is fully trained to Malaysian standards and is accredited with their regulatory body.

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[72] Ibid p 26.18.
[73] Ibid p 26.16.
[74] Ibid p 26.19.

107. The BWMC is a medical day stay hospital with overnight facilities and specialises in cosmetic surgery, aesthetic medicine, hair transplant, stem cell therapy and dentistry.

108. Professor Ashton noted BWMC is licenced with the Malaysian Ministry of Health and accredited by the Malaysian Healthcare Travel Council to serve medical tourists. It has appropriate equipment to conduct surgery and has the latest in investigative and procedural equipment.

Dr Nasir's response to Professor Ashton's report

- **VTE risk factors and VTE prophylaxis**

109. Dr Nasir noted that the BWMC has adopted the 2013 Malaysian Clinical Practice Guidelines (MCPG) regarding VTE.[75]

110. According to Dr Nasir, Mr Aiple was risk-stratified according to the MCPG and '*the risk stratification of surgical patients and prophylactic recommendations would classify [Mr Aiple] as moderate risk (not high or highest risk) in view of obesity and surgery greater than 30 mins. [Mr Aiple] had arrived from Australia but the first surgery was undertaken 7 days after arrival to Malaysia, not immediately upon arrival. The [MCPG] closely mirror that of the 9th edition of the Antithrombotic Therapy and Prevention of Thrombosis Evidence-based Clinical practice Guidelines by the American College of Chest Physicians (ACCP)*'.[76]

111. Dr Nasir noted that '*patients undergoing plastic and reconstructive surgery have a lower risk and incidence of VTE as compared to other target populations (such as general, abdomino-pelvic, bariatric, vascular or orthopaedic surgeries) for the same risk score'* and that in addition the committee who prepared the ACCP guidelines '*consider that most plastic surgery patients to be at average risk for bleeding complications, recognizing that the consequences of wound hematoma in patients with free flaps can be dire*'.[77]

112. With regard to which mechanical and pharmacologic VTE prophylaxis, Dr Nasir stated that the MCPG '*recommended the use of LDUH or LMWH only. The dosage recommendations were not stated therefore doctors generally followed the recommendations of the manufacturer (enoxaparin [ie Clexane]) 20mg/day for moderate risk patients*'.[78]

113. Regarding dosage, Dr Nasir stated that:

'*I use a lower dose of Clexane to avoid possible risk of bleeding. This was due to my personal experience of several of my patients who had developed significant haematoma,*

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[75] Letter from Dr M Nasir Zahari to the Coroners Court of Victoria dated 8 April 2017, Coronial Brief p 26.1.
[76] Ibid.
[77] Ibid p 26.2.
[78] Ibid.

especially in breast and facelift surgeries. Additionally, I routinely use patient control analgesia (PCA) in major surgery cases to allow patient to ambulate early, and apply the anti-embolic stocking continuously for the duration of healing. As for the duration of the Clexane, there were authors who had mentioned that 3 doses would be sufficient after cosmetic surgery (Patronella, Ruiz-Razura, Newall, et al; Aesthetic Surg J 2008;28:648-655)'.[79]

114. I have read the article Dr Nasir refers to in support of using '3 doses'. Using the risk assessment model in the article, Mr Aiple scored 3 points (2 points for major surgery and 1 point for obesity) which gives him a risk assignment of 'high'. The article recommends '*low – molecular weight heparin such as enoxaparin, 40 mg/day beginning on postoperative day 1 and continuing for 2 more days.*'

115. This suggests Dr Nasir should have prescribed Mr Aiple 40mg/day rather than 20mg/day.

116. The recommendations conclude:

'*Lastly, it is imperative to maintain close observation of the patient for the first 4 weeks after surgery and to advise the patient to avoid long periods of immobilization, such as prolonged car rides or air travel.*' [80]

- **Appropriateness of numerous surgical procedures**

117. Dr Nasir noted that he conducted a preliminary consultation with Mr Aiple by email via Gorgeous Getaways and another more detailed consultation after Mr Aiple arrived at the BWMC. There was another detailed discussion of the procedures to be performed on the day before Mr Aiple's first operations.[81]

118. Regarding the volume of liposuction, Dr Nasir stated:

'There is no definite definition of a high volume liposuction although it is generally accepted as a liposuction of 5 litres or more. The volume of the liposuction 1.6 litres per se cannot be considered large volume liposuction. However, in this case, if the lipectomy weight is added on, then it becomes a large volume liposuction/lipectomy. Performing large volume liposuction/lipectomy is not an uncommon cosmetic surgery practice.'[82]

119. According to Dr Nasir,

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[79] Letter from Dr M Nasir Zahari to the Coroner Court of Victoria dated 24 October 2017, Coronial Brief p 26.7.
[80] Patronella, Ruiz-Razura, Newall, et al; *Thromboembolism in High-Risk Aesthetic surgery: Experience with 17 patienst in a review of 3871 consecutive cases* Aesthetic Surg J 2008;28:648-655 at 654.
[81] Letter from Dr M Nasir Zahari to the Coroners Court of Victoria dated 8 April 2017, Coronial Brief p 26.2-26.3.
[82] Letter from Dr M Nasir Zahari to the Coroners Court of Victoria dated 24 October 2017, Coronial Brief p 26.7.

'*Combination of procedures can be safely performed in a clinically healthy individual.*'[83]

- **Discharge and complications of wound dehiscence and discharge**

120. Regarding Mr Aiple's discharge from the BWMC on 23 April 2014, Dr Nasir stated that '*it was an appropriate time to discharge. Mr Aiple was stable clinically, ambulating well and deemed fit for discharge. The dehiscence was quite small (0.5 cm) and according to my clinical judgement, had the ability to close spontaneously*'.[84]
121. Regarding Professor Ashton's comments on his re-suturing of wounds in a clinic treatment room, Dr Nasir noted that '*this is a clean room that has sufficient sterile surgical instruments, a flexible clinical treatment bed and a good over-head lighting facility. All procedures performed are assisted by fully registered staff nurses.*'[85]
122. Dr Nasir stated that wound dehiscence '*is a common and expected complication especially in the case of Mr Aiple. I had taken all the necessary steps to minimize the risk and also performed the necessary treatment when it occurred.*'[86]
123. Regarding wound discharge, Dr Nasir stated '*My management of post-operative seroma is frequent and repeated drainage using needle aspiration technique and application of compression garment. In the case of recurrent large amount seroma, I would then perform drainage using drain tubes, including wound debridement and washing, performed in the operating theatre*'.[87]

- **Response to fainting episodes**

124. Dr Nasir provided the following comments on his response to Mr Aiple's fainting episodes on 6 May 2014:

'*Following complaints of fainting episodes, [Mr Aiple] was assessed medically and then admitted to the ward as a precaution and further observations and management. The steps taken include close monitoring of blood pressure, pulse, temperature and pulse oximetry. Since the working diagnosis was that of hypovolaemia with possible underlying sepsis, the patient was also started on intravenous fluids and antibiotics. In addition to close monitoring, the doctor also conducted daily ward rounds and the patient was only certified fit for discharge after clear signs of recovery including improvement in vital parameters, ambulating normally without assistance.*

[83] Letter from Dr M Nasir Zahari to the Coroners Court of Victoria dated 8 April 2017, Coronial Brief p 26.3.
[84] Ibid.
[85] Ibid.
[86] Ibid.
[87] Ibid.

While I did consider the diagnosis of DVT/PE, this differential diagnosis would normally be less common than hypovolaemia and/or sepsis following plastic surgery. ... [T]he incidence of VTE following plastic surgery is generally lower than that for other surgeries, in patients with the same risk factors. Other supporting factors that indicated the cause of the fainting episodes to be due to hypovoleaemia and/or sepsis are:

a) Patient had lost fluid with the wound serous discharge.

b) Patient had hypoalbuminaemia which more likely indicates sepsis than VTE.

c) On clinical assessment, patient had light-headedness and tachycardia which responded to fluid resuscitation alone.

d) Patient's blood pressure was generally stable and did not fall below 100mmHg systolic pressure.

e) Patient's pulse oximetry readings were 95-96% at room air on 1st admission and 2nd admission. There was a recorded reading of 92% at 0900hrs on 8/5/14 but subsequent rechecks showed above 96% at room air.

f) Patient did not complain of any calf pain and tenderness throughout admission, even though he was ambulating.

g) Patient responded to fluid resuscitation and oral antibiotics during admission and on the morning of 09/05/14 he was ambulating well with no complaints.

Since hypovolaemia and sepsis was more probable than VTE, and the patient responded well to strategies to treat hypovolaemia and sepsis, and he was ambulating well with no calf tenderness, therefore I did not feel it was justified to refer the patient for a V/Q scan or spiral CT scan. Had the patient not responded to fluid therapy and antibiotics and had he continued to complain of breathlessness or showed signs of haemodynamic compromise (including tachycardia with hypotensions) or had he complained of new symptoms such as calf tenderness or hemoptysis, then I would surely have considered VTE and actively seek to confirm or exclude it.'[88]

Conclusions

125. There are two aspects to Professor Ashton's reports.

126. The first relates to his differing *diagnosis* to Dr Nasir regarding Mr Aiple's VTE risk and the significance of his 'fainting' episodes. This led to a difference of opinion regarding treatment. I note that Professor Ashton has had the benefit of hindsight when preparing his reports.

[88] Ibid p 26.3-26.4.

127. The second aspect of his reports refer to the differing *standards* of care and treatment between Australia and Malaysia such as the number of surgical procedures conducted at the one time, the spacing of the two operations, as well as the treatment of wound dehiscence and discharge.

- **Differing diagnosis: VTE & 'fainting episodes'**

128. Professor Ashton assessed Mr Aiple as high risk for VTE, and noted that the administration of 20 mg of subcutaneous clexane for only 3 days '*is not standard VTE prophylaxis treatment.*'
129. Dr Nasir assessed Mr Aiple as a moderate risk only. As the Malaysian Clinical Practice Guidelines do not specify recommended dosage for low molecular weight heparin or low dose heparin he stated doctors generally follow the manufacturer's recommendations for moderate risk patients. He stated he used a lower dose to avoid possible risk of bleeding and that as to duration, '*there were authors who had mentioned that 3 doses would be sufficient after cosmetic surgery (Patronella, Ruiz-Razura, Newall, et al; Anaesthetic Surg J 2008; 28:648-655.)*'
130. As mentioned above, using this study, Mr Aiple would be assigned a high risk and the recommendations prescribe low molecular weight heparin such as enoxaparin, 40mg/day for 3 days.
131. Professor Ashton stated that Mr Aiple's fainting symptoms post-surgery were '*the full hand for a diagnosis for a pulmonary embolism. Mr Aiple has known risk factors, the onset and nature of Mr Aiple's symptoms are textbook for Pulmonary Embolism'* however Dr Nasir came to the conclusion the evidence supported Mr Aiple as having hypovolaemia and/or sepsis.
132. Professor Ashton connected his analysis to the finding by forensic pathologist Dr Burke that '*...confirms emboli of thrombus were being discharged from the calf into Mr Aiple's lungs for a considerable period prior to death, and the DVT was not the result of Mr Aiple's immobilisation whilst he flew home from Malaysia to Melbourne.*'
133. Dr Nasir noted in his view hypovoaemia and sepsis was more probable than VTE and Mr Aiple responded well to strategies (fluids and antibiotics). In the absence of other symptoms he did not actively seek to confirm or exclude VTE.

- **Differing standards**

134. With respect to the appropriateness of Mr Aiple's multiple surgical procedures on 17 April 2014 and 22 April 2014 Professor Ashton commented that:

In assessing Mr Aiple's VTE risk, '*...There is no risk model that has been developed that accurately reflects so many surgeries being performed at one time, let alone two major episodes of major surgeries within a week.*'[89]

'*The pre-operative consultation, and the scope and spacing of the individual operations are NOT of an international standard.*'[90]

'*The combination of these procedures in one operation is unusual in Australia and would not be considered standard of care.*'[91]

135. Professor Ashton noted the '*combination of procedures significantly exceeds normal Australian protocol.*' [92]
136. Dr Nasir stated that a '*Combination of procedures can be safely performed in a clinically healthy individual.*' [93]
137. With respect to wound dehiscence, Professor Ashton was of the view that Mr Aiple should have been either taken back to surgery for early wound dehiscence to be repaired and re-sutured or strict bed rest and appropriate VTE prophylaxis and the expected healing time would be 6-8 weeks. He noted: '*The very worst things that could have been done would be to discharge Mr Aiple out of hospital.*' [94]
138. Professor Ashton stated:

'*To regain control, the standard of care in Australia would be to readmit the patient to the hospital for bed rest, assess the serum albumin (it will almost certainly [be] low) and perform a dedicated repair of the wounds in the operating theatre, under ideal conditions. The expected admission time- even with ideal management would be one week in hospital.*'[95]

139. In respect of wound discharge, Professor Ashton stated:

'*That Mr Aiple presented to the outpatient clinic on the 30th April complaining of high volume discharge coming from the open wounds is predictable and is preventable. There was a window of opportunity here to readmit Mr Aiple back into hospital, take him to theatre, re-suture the wounds and insert a drain to safely drain away the seroma fluid.*'[96]

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[89] Expert report by Professor Ashton dated 2 February 2017, p 26.9 (references omitted).
[90] Expert report by Professor Ashton dated 2 February 2017, p 26.12 (references omitted).
[91] Expert report by Professor Ashton dated 2 February 2017, p 26.13 (references omitted).
[92] Expert report by Professor Mark Ashton dated 2 February 2017, Coronial Brief p 26.15
[93] Letter from Dr M Nasir Zahari to CCOV dated 8 April 2017, Coronial Brief p 26.3.
[94] Expert report by Professor Ashton dated 2 February 2017, p 26.15 (references omitted).
[95] Expert report by Professor Ashton dated 2 February 2017, p 26.16 (references omitted).
[96] Ibid p 26.16.

140. In Professor Ashton's view there were significant and multiple deviations from the accepted standard of care in the treatment of Mr Aiple's wounds. [97]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

141. I note Ms Muscat stated that cost was a consideration in Mr Aiple's decision to seek cosmetic surgical treatment overseas. Although it is not clear from the evidence, there is a suggestion Mr Aiple may have had medical advice that the surgical procedures he desired could not all be done at once in Australia.
142. I note the Australian Society of Plastic Surgeons has been gravely concerned about the risks associated with medical tourism, believing them to be significant and under estimated by the Australian population.
143. The standards of medical practice in Australia are amongst the highest in the world and those Australians who seek medical services such as plastic surgery overseas may not be aware there may be a difference in standards.
144. Whilst the medical qualifications of practitioners may be appropriate and the quality of medical centre facilities overseas appear reasonable, the Australian medical tourist will not necessarily be aware of the differences in standards of medical practice and management of patient care that this case illustrates.
145. I note The Department of Health (Commonwealth) in its Travellers' Health Alerts, Travel Health Information has a warning about medical tourism:

    '*If you plan to travel overseas to receive medical care, including a cosmetic procedure, keep in mind that the quality of care you receive may be different from that of medical care in Australia.*' [98]

146. I note this also is repeated on the Department of Foreign Affairs and Trade smart.traveller.gov.au website under Medical Tourism.

RECOMMENDATION PURSUANT TO SECTION 72(2) OF THE ACT

147. That the Chief Health Officer consider the merits of taking a similar approach to the Department of Health and Department of Foreign Affairs and Trade to publish a Health Advisory along the same lines as referred to above. This will serve to increase the breadth of material available to advise Victorian consumers of medical services overseas to be aware

[97] Expert report by Professor Ashton dated 2 February 2017, p 26.18 (references omitted).
[98] Department of Health website www.health.gov.au (accessed 30 November 2017).

that the quality of medical care provided in other countries may not be of the same standard as that provided in Australia.

FINDINGS

148. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Leigh Thomas Aiple, born 18 September 1982, died on 12 May 2014 at Mitcham, Victoria, from I(a) Pulmonary thromboembolism in the circumstances described above.
149. I acknowledge the grief endured by Mr Aiple's family in the wake of his death and the concerns expressed by his mother, Ms Muscat in her correspondence with the Court and in her statement.
150. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this finding be published on the internet.
151. I direct that a copy of this finding be provided to the following:

Ms Grace Muscat, senior next of kin, C/ Maurice Blackburn Lawyers

Mr Thomas Aiple, senior next of kin

Dr M Nasir Zahari, Beverly Wilshire Medical Centre

Professor Mark Ashton

Mrs Loraine Reinsfield, Gorgeous Getaways

Mr Anthony Benner, Oze Travel Representation

Australian Society of Plastic Surgeons

Australian Commission on Safety and Quality in Health Care

National Health and Medical Research Council

Royal Australasian College of Surgeons

The Department of Health, (Commonwealth)

Chief Health Officer, Department of Health and Human Services (Victoria)

Senior Constable Christopher Robinson, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

CORONER

Date: 4 December 2017