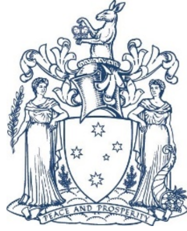

COR 2018 004091

IN THE CORONERS COURT OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

INQUEST INTO THE DEATH OF CHERIE VIRGINIA PEARL GUEST

Findings of:	Coroner Katherine Lorenz
Delivered on:	22 June 2023
Delivered at:	Coroners Court of Victoria
Hearing dates:	6 February 2023 - 10 February 2023
Counsel Assisting:	Rishi Nathwani
Coroners Solicitor:	Dylan Rae-White
Counsel for Mrs Guest's Family:	Robert Harper Instructed by Maurice Blackburn Lawyers
Counsel for Dr Joseph San Laureano:	Dugald McWilliams Instructed by HWLE Ebsworth Lawyers

Counsel for Dr Fabian Purcell:	Paul Halley Instructed by Wotton + Kearney
Counsel for Timothy Puyk & Victoria Parade Surgery Centre:	Morgan McLay Instructed by Barry Nilsson Lawyers

INTRODUCTION

1. On 18 August 2018, Cherie Virginia Pearl Guest was 61 years old when she died after complications arising from a cataract procedure performed on 13 August 2018 at Victoria Parade Surgery Centre (**VPSC**)[1] in Melbourne.

THE CORONIAL INVESTIGATION

2. Mrs Guest's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act)**. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. 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.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. This finding is based on the Coronial Brief, the oral evidence of all witnesses who testified at inquest, any documents tendered at inquest and the final submissions of counsel who appeared. It is unnecessary to summarise all of this material. It will remain on the Court file and I will refer only to so much of it as is relevant or necessary for narrative clarity.

6. In the coronial jurisdiction, facts must be established on the balance of probabilities.

EVENTS LEADING UP TO THE SURGERY

7. Mrs Guest had severe restrictive lung disease requiring 24-hour supplemental oxygen support, significant nocturnal hypoventilation syndrome and had previous hospital admissions for respiratory failure – the most recent to the Royal Melbourne Hospital (**RMH**) on 2 May 2018

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[1] Owned by Cura Group, VPSC is a Monday to Friday day procedure private hospital.

for treatment of community-acquired pneumonia complicated by fluid overload due to right heart failure. Mrs Guest was treated with intravenous (**IV**) antibiotics.

8. Mrs Guest had numerous medical morbidities including congestive cardiac failure, type 2 diabetes mellitus (**T2DM**), hypertension, scoliosis, anxiety, and obesity. Mrs Guest was able to mobilise independently at home but required a wheelchair when she went out.

9. Mrs Guest was under the care of general practitioners, a private respiratory physician, Professor Louis Irving and cardiologist, Dr Emmanuel Manolas.

10. In July 2018, Mrs Guest's general practitioner Dr Mary Zaky referred her to an ophthalmologist, Dr Joseph San Laureano for a diabetic eye check.

11. Her daughter Angela Guest (**Angela**) reported that at the time of the 2018 referral Mrs Guest "*lived life with some limitations but she lived life well*".[2] She could watch television if her chair was 2 – 3 metres away, she could read books on her kindle and was able to enjoy trips to the theatre and tennis.[3]

12. On 11 July 2018, Mrs Guest met with Dr San Laureano in his private rooms at Melbourne Eye Centre for her ophthalmology review. During the 20 minute consultation, Dr San Laureano advised Mrs Guest that she had advanced bilateral cataract and elevated intraocular pressure. Dr San Laureano recommended surgery initially in her left eye to remove a cataract and treat raised intraocular pressure with a Cypass shunt. Following this, the right eye would have surgery at a later date.

13. During the consultation Mrs Guest told Dr San Laureano that she could not lie flat. She explained that she slept on four pillows and struggled to breathe and started to cough when she was lying flat.[4] Mrs Guest asked him whether procedure could take place with her head raised. Mrs Guest's reliance on oxygen was apparent during the consultation because her oxygen cylinder was present in her wheelchair and the prongs were attached to her nose.

14. Because of her issue with lying flat, Dr San Laureano recommended a two-part operation using the femtosecond laser machine for the first part of the surgery (rather than conventional

[2] T509
[3] T21-22
[4] T22

cataract surgery) to minimise the duration she would be required to lie down (from 30 minutes to approximately 20 minutes).[5]

15. After the consultation, Angela and her mother were still concerned so Angela contacted the VPSC to suggest a "practice run" to test whether Mrs Guest would tolerate lying down for the procedure.

16. On 8 August 2018, Mrs Guest attended VPSC for the trial. The trial was conducted by Ms Natasha Pieries, an orthoptist employed by the Melbourne Eye Centre and a Registered Nurse employed by VPSC, Mr John Gardiner attended also.

17. During the trial Mrs Guest was able to lie flat for five minutes on two occasions and her oxygen levels were monitored using her home pulse oximeter. Mrs Guest asked the staff to tell her the reading for her heart rate and oxygen levels during the trial, which were 95% on 2 litres of oxygen and a heart rate between 100 and 110.[6]

18. Mr Gardiner's nursing notes state that, "*[Mrs Guest] needs extra encouragement with transfers and motivation. She experiences dizziness quickly and once she takes a few deep breaths, she relaxes and is able to [be] more herself".*[7] Angela recalled that Mrs Guest experienced dizziness at each section of the trial.

19. Partway through the trial Mr Tim Puyk who at the time was the Chief Executive Officer (**CEO**) and Director of Nursing (**DON**) at VPSC entered the room and reassured Angela and Mrs Guest about the procedure and told them that Angela could attend theatre on the day.[8]

20. Following the trial, Angela and Mrs Guest still had concerns about the surgery and on 10 August 2018, Angela telephoned Dr Fabian Purcell, an anaesthetist who was to be present during the procedure scheduled for the following week. During the telephone call, they discussed Mrs Guest's suitability for surgery and Angela gave Dr Purcell some information about her mother's oxygen dependency and her concerns that she "*changed colour upon being laid flat when she attended the VPSC two days previously*."[9]

21. Following this, Dr Purcell became concerned about the planned surgery and had conversations with Dr San Laureano and Mr Puyk about it. The substance of these conversations were the

[5] CB12
[6] CB30
[7] CB 462
[8] T29
[9] CB3

subject of factual dispute and evidence in relation to them was tested at inquest and is discussed later in this finding.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

22. On 13 August 2018, Mrs Guest presented for her procedure at VPSC.

23. The procedure was in two parts. The first part involved use of the femtosecond laser "*to open the anterior lens capsule and emulsify the lens.*"[10]

24. The second part of the procedure was for the cataract surgery in the operating theatre involving the removal of the emulsified lens, implanting a new lens and inserting the Cypass shunt. Dr San Laureano said that *"the process lasts around 15 minutes."*[11]

25. The first part of the procedure was performed by Dr San Laureano with assistance from the orthoptist, Ms Natasha Pieries.

26. Mrs Guest was assisted to lay flat for the femtosecond laser machine part of the procedure. Very shortly after lying down, Mrs Guest said she couldn't breathe, and her chest was hurting.

27. Angela gave evidence that the situation was different to the 'trial run'. As soon as the procedure ended, she saw that her mother's lips were blue. Angela realised that Mrs Guest's oxygen was not being monitored – and asked her sister to give her the oximeter. Once Angela measured it, she saw that her mother's oxygen levels were around 60%.

28. Immediately after the procedure, Mrs Guest was visibly unwell with a cyanotic appearance and had difficulty breathing. When her oxygen levels were measured by staff, it was 59 per cent and her supplemental oxygen was increased. Her heart rate was high, reported to be around 100-120 beats per minute.[12] Mrs Guest made a gradual recovery over 20 minutes.

29. As soon as the femtosecond laser part of the procedure was completed Dr San Laureano left the room to attend to other patients. Mrs Guest was then brought to the anaesthetic bay in preparation for the second part of her procedure in the operating theatre.

30. Dr Purcell was in attendance for the second part of the procedure.

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[10] CB12
[11] Ibid
[12] Ms Pieries, CB 36 and RN Gardiner, CB 31

31. Mrs Guest complained about breathing difficulties while lying down at the start of the second part of the surgery and her oxygen levels rapidly declined again to 59 per cent. Mrs Guest indicated that couldn't breathe and pleaded to sit up. It became clear that she was unable to tolerate the procedure. At this stage, Mrs Guest had not received any sedation or anaesthetic.

32. Following a disagreement[13] between Drs Purcell and San Laureano about Mrs Guest the procedure was ceased. A second anaesthetist, Dr James Griffiths, and a second anaesthetic nurse had arrived to assist. A diagnosis of acute pulmonary oedema was made, and steps were undertaken to manage this.

33. Mrs Guest continued to deteriorate and she required intubation to gain control of her ventilation. Mrs Guest was successfully intubated at 1105 hours and a third anaesthetist, Dr Alan Strunin had arrived to insert an arterial line. Mrs Guest required inotropic medications to maintain normal blood pressure.

34. Mrs Guest was gradually stabilized. Dr San Laureano decided to continue with her cataract removal and insertion of a lens in her left eye. Dr San Laureano's evidence was that the surgery had to be continued as the first part of the procedure opened the capsule and broke the lens. If the second part was not performed, this could result "*in decompensation of the eye due to the consequent inflammatory response with the risk of losing the eye*."[14]

35. When Mrs Guest was laid flat for the cataract removal, she once again desaturated and needed to be positioned with her head elevated to provide haemodynamic and respiratory stability.

36. Dr San Laureano admitted that Xylocaine was administered to Mrs Guest despite her documented adverse reaction to it. Dr San Laureano said in his statement:

"*0.5ml of lignocaine was administered intracamerally… after she has been stabilised. As it was intracameral, it posed no risk to her…. intracamerally administered medication does not enter the vascular space so even medication that patients may react to can be safely administered via this route... and so did not contribute to her problem.*"[15]

37. The cataract removal and insertion of lens were completed without further deterioration while waiting for Mobile Intensive Care Ambulance (**MICA**) staff to arrive at 1200 hours.

[13] Dr Purcell CB7, Angela Guest, CB511
[14] CB16
[15] CB17

38. Mrs Guest was transferred to St Vincent's Hospital at 1315 hours.

St Vincent's Hospital

39. On arrival to St Vincent's Hospital, Mrs Guest remained intubated and required high levels of respiratory support. Despite this, it was difficult to maintain adequate ventilation and oxygenation given Mrs Guest's underlying severe restrictive respiratory disease and other medical co-morbidities.

40. Mrs Guest was reviewed by a respiratory physician and intensivist, Professor John Santamaria on 14 August 2018. Professor Santamaria agreed that Mrs Guest had severe restrictive lung disease due to obesity and kyphoscoliosis contributing to the difficulty in achieving adequate ventilation. He was unable to identify any rapidly reversible components to improve her ventilation. His advice to commence antibiotics to treat possible infection and commencing an anti-coagulant to treat potential blood clots was actioned in ICU.

41. Professor Louis Irving, Mrs Guest's private respiratory physician, was also consulted by the ICU on 14 August 2018 and he confirmed the severity of Mrs Guest's "*restrictive lung disease with brittle ventilatory control and hypoventilation*."

42. Mrs Guest was also reviewed by Dr Galligan from the cardiology team. Mrs Guest underwent an electrocardiogram, echocardiogram and blood tests which excluded a cardiac cause for her deterioration.

43. Despite maximum supportive measures, Mrs Guest did not show any improvement nor response to treatment. Multiple meetings were held between the ICU treating team and Mrs Guest's family members to discuss her progress and direction for care. Family members expressed consistently they would like active treatment to be continued. However, given Mrs Guest's progress and lack of response to treatment, a medical decision to redirect her care to palliative care was made on 17 August 2018.

44. Mrs Guest died at 0257 hours on 18 August 2018.

Identity of the deceased

45. On 18 August 2018, Cherie Virginia Pearl Guest, born 15 November 1956, was visually identified by her daughter, Ms Angela Guest.

46. Identity is not in dispute and requires no further investigation.

Medical cause of death

47. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 22 August 2018 and provided a written report of her findings dated 13 December 2018.

48. The post-mortem examination revealed diffuse alveolar damage. This is the pathological correlate of acute respiratory distress syndrome. In this case, Mrs Guest had a prolonged hospital stay cumulating in diffuse alveolar damage. There was significant natural lung disease and hypertensive heart disease. Dr Parsons noted the presence of emphysema.

49. Dr Parsons noted the presence of Laudanosine, Lignocaine and Tryptase in the blood.

50. According to Dr Parsons, Mrs Guest had a prolonged hospital stay cumulating in diffuse alveolar damage. Mrs Guest had significant natural lung disease and was said to have had an adverse reaction to sedation and upon lying flat. Dr Parsons recommended the case be reviewed by a fellow of the Australian and New Zealand College of Anaesthetists for an opinion as to whether the anaesthetic contributed to her death.

51. Dr Parsons provided an opinion that the medical cause of death was 1 (a) *Diffuse Alveolar damage in a woman with end stage chronic obstructive pulmonary disease following cataract surgery.*

52. On 5 January 2019, Mr Reginald Guest and Angela wrote to the Coroners Court setting out some concerns about the Medical Examiner's Report, following which the Court requested that VIFM review Mrs Guest's medical records, the Medical Examiner's Report and histopathological slides taken from Mrs Guest's lungs. VIFM provided the slides to Professor Catriona McLean of the Alfred Hospital for a secondary review. On 23 April 2019, Dr Linda Iles, a Forensic Pathologist from VIFM provided a Supplementary Medical Examination Report (**Supplementary Report**).

53. The Supplementary Report confirmed features suggestive of diffuse alveolar damage. However, Dr Iles commented that because of the extent of underlying lung pathology, it was difficult to comment on any preceding chronic lung disease. Based on this review, it was Dr Iles' opinion that it was more appropriate to ascribe the cause of death as 1. "*Diffuse alveolar damage in a woman with restrictive lung disease following cataract surgery*."

54. The Supplementary Report did not comment on the other issues, including whether an adverse reaction to Lignocaine contributed to her death.

55. I accept Dr Iles' opinion.

FAMILY CONCERNS

56. Mrs Guest's family wrote to the Coroners Court outlining their concerns regarding Mrs Guest's medical care in emails dated 21 August 2018, 16 September 2018 and 5 January 2019.

57. Broadly, the concerns of the family fell into the following categories:

    a. Mrs Guest's suitability for surgery in light of her inability to lie flat.

    b. Whether the surgery should have been performed at VPSC at all.

    c. That Mrs Guest did not have oxygen saturation monitoring during her procedure.

    d. Issues regarding consent to the procedure, including consent to the use of Xylocaine and the continuation with the second part of the surgery after Mrs Guest became unwell during the first part of the procedure.

    e. Concerns with the care at St Vincent's Hospital, related to end of life care.

FURTHER INVESTIGATIONS

58. Considering the circumstances of Mrs Guest's death and the concerns raised by her family, the Court's Health and Medical Investigation Team of the Coroners Prevention Unit (**CPU**) reviewed Mrs Guest's case.[16]

59. The CPU gave advice that there were a number of factors related to Mrs Guest's care which appeared to be suboptimal. They were:

    a. Lack of formal pre-operative assessment prior to surgery at VPSC despite knowledge about Mrs Guest's suitability for surgery.

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[16] 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.

b. Lack of escalation procedure at VPSC. Even though Dr Purcell and Mr Puyk both expressed concerns regarding Mrs Guest's suitability for procedure they did not formally decline Mrs Guest's admission to VPSC for her procedure. Dr Purcell and Mr Puyk indicated that Dr San Laureano wanted to proceed with the procedure despite the high operative risk and the concerns raised.

c. Lack of reassessment of surgical suitability after clinical deterioration during the first stage of the procedure.

d. Administration of a medication on patient's allergy list without informed consent, being Xylocaine. Although it did not appear that Mrs Guest had an allergic reaction, the administration of a medication listed as a patient's allergy without their consent an unsafe practice.

60. Following my commencement as a Coroner on 8 February 2021 the case was transferred to me. I reviewed the material in the file, including the medical records, statements, correspondence, and advice from CPU. Subsequently, I wrote to Drs San Laureano and Purcell and to the VPSC setting out the concerns I held about the medical care provided to Mrs Guest.

61. Following receipt of further evidence including various expert reports submitted by the interested parties at a directions hearing on 20 August 2021 a scope of inquest was agreed between the interested parties and the matter proceeded to inquest.

62. These findings are made by reference to the scope of inquest, and largely reflect the concerns of the family in relation to the medical care provided by Dr San Laureano, Dr Purcell and VPSC. The issue raised by the family in relation to the end-of-life care provided at St Vincent's Hospital was not pressed by the family and was not the subject of further investigation.

INQUEST

63. There were no issues in relation to Mrs Guest's identity, nor the medical cause of death. As is often the case the primary focus of the coronial investigation and inquest into Mrs Guest's death was the circumstances in which she died, specifically whether she was a suitable candidate for cataract surgery considering her significant co-morbidities, the decision for the surgery to take place at VPSC rather than a public hospital with critical care facilities and the adequacy of her medical management before and during the cataract surgery.

64. At inquest evidence was given by Angela, Dr San Laureano, Dr Purcell, Mr Puyk, nursing staff and a panel of four medical experts (**the panel)** comprising ophthalmic surgeons Dr Colin Clement and Associate Professor Max Conway and anaesthetists Dr Phoebe-Anne Mainland and Dr Brendan Irvine. These medical experts gave their evidence concurrently, a procedure commonly referred to as a 'hot tub'.

65. In advance of giving evidence each panel member was provided with the Coronial Brief.

66. On the day the panel gave evidence, the panel was presented with a list of questions and allowed to consider their answers in private. The Court reconvened in the afternoon to hear their evidence.

ISSUES AT INQUEST

Mrs Guest's fitness for cataract surgery and the decision to proceed with the surgery at VPSC on 13 August 2018

67. Mrs Guest's fitness for surgery and the decision to proceed with the surgery at all, and specifically, at the VPSC was examined at inquest and was the source of some disputed evidence.

68. There were factual disputes between Dr Purcell and Dr San Laureano about their discussions about Mrs Guest's suitability for the procedure. The primary dispute was whether Dr Purcell maintained his position with Dr San Laureano that he wanted the procedure cancelled or whether Dr Purcell ultimately agreed with Dr San Laureano's position that surgery should proceed or otherwise deferred to Dr San Laureano. Some of the evidence related to Dr Purcell's eventual attendance at the second part of the procedure in a reduced capacity as "back up" only, and what "back up" meant in the context of elective surgery of this kind.

69. The expert panel unanimously agreed that Mrs Guest was not fit to undergo surgery as of 13 August 2018 **at any institution** because she had significant underlying comorbidities and her health status had not been adequately investigated and then optimised prior to the surgery. The panel elaborated that in a case such as this, usually the surgeon would defer the initial medical assessment to the anaesthetist and then, based on the findings and recommendations of the anaesthetist, a multidisciplinary assessment would take place prior to surgery.[17]

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[17] T614

70. The expert panel agreed that it was not appropriate for Mrs Guest's surgery to be undertaken at VPSC and the surgery should have only taken place after she had a proper multi-disciplinary assessment and deemed to be fit to undertake the procedure at a hospital with critical care facilities including an intensive care unit or high dependency unit, oxygen and anaesthetic monitoring.[18]

71. Further, the experts advised that the pre-anaesthetic assessment undertaken by Dr Purcell on the morning of 13 August 2018 was adequate for the purpose of determining that surgery **should not go ahead** that day but inadequate for determining whether it was safe for Mrs Guest to undergo surgery **at some other time** in the future.[19]

72. Dr Clement said further that even if Mrs Guest had been assessed fully and later found to be fit for surgery, it would still have remained inappropriate for her to have the surgery at a day surgery centre such as VPSC. Because the femtosecond laser surgery is only available in private day surgery centres and not public hospitals with critical care facilities – it was never appropriate for her to have undergone the procedure using the femtosecond laser machine.[20]

73. Dr Clement elaborated that the so-called benefits that the femtosecond laser cataract surgery would allow her to have breaks between the stages were "*overstated*", because breaks can also be accommodated during manual surgery.

74. Crucially, the main benefit of having manual surgery over the femtosecond laser procedure is that in manual surgery there is full monitoring from the beginning of treatment and an ability to have the surgery performed in an inclined position, which cannot be done with stage one of the femtosecond laser procedure. Additionally, with traditional cataract surgery, the procedure can be aborted at the very early stages without threat or damage to the eye and there is a reduced need to mobilise and transfer the patient.

75. I accept the evidence of the expert panel that the appropriate course was to defer Mrs Guest's surgery and for her to be optimised for surgery at a later date following a multidisciplinary assessment. If surgery were to proceed following such an assessment it should have been by means of conventional manual surgery in a public hospital with critical care facilities after it was considered safe to proceed.

[18] T631
[19] T624
[20] T632

76. In an email to Dr Purcell on 23 July 2018, Mrs Guest and Angela raised concerns about Mrs Guest's fitness for surgery and whether the surgery should proceed.

77. Dr Purcell received the email when he returned from leave and called Angela to discuss her concerns on 10 August 2018. During the telephone call, Angela gave Dr Purcell information about her mother's oxygen dependency and inability to lie flat and her concern that Mrs Guest had "*changed colour upon being laid flat when she attended the VPSC two days previously*" for the trial run.[21]

78. After speaking with Angela, Dr Purcell formed a view that the planned surgery was going to be "*very, very problematic*"[22] and these concerns were "*amplified*" by the information provided about various tests including oxygen saturation, lung function tests and an echocardiogram.[23]

79. Specifically, Dr Purcell formed the opinion that Mrs Guest could have restrictive lung disease borderline or outright respiratory failure[24] and consequently Mrs Guest was a high risk anaesthetic patient, as she was "*an ASA 4 patient (a patient with incapacitating systemic disease which is a constant threat to life) with no clear-cut diagnosis".*[25]

80. At inquest, Dr Purcell described his concerns about Mrs Guest having the procedure as "*profound*" and having "*red flags*". He said he recognised that Mrs Guest had a real risk of respiratory failure and that as an ASA-4 rated patient Mrs Guest had no reserves, could deteriorate badly, and would require critical care services if she did deteriorate.

81. Importantly, the VPSC Patient Admission Selection Criteria in force at the time made clear that patients deemed to be an ASA-4 risk were not suitable for surgery. The criteria set out within the document is expressed as mandatory.

82. Dr Purcell concurred that a patient "*of this nature*" was outside the parameters of surgery that could be performed at VPSC as the VPSC did not provide surgery for ASA-4 rated patients, noting that the VPSC anaesthetic chart has tick boxes for ASA1-3 only.

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[21] CB3
[22] T198
[23] T199
[24] T200
[25] CB3. The ASA scale refers to the American Society of Anaesthesiologists Physical Status Classification System which is used to assess and communicate a patient's pre-anaesthesia medical comorbidities. The scale is a 5 step classification system with ASA1 referring to a healthy patient with no acute or chronic disease and a normal BMI for age.

83. Dr Purcell said that on 10 August 2018 he raised the concern with Dr San Laureano and Mr Puyk that Mrs Guest was not a suitable candidate for the procedure at VPSC given her high anaesthetic risk and "*risk of deterioration with requirement for transfer by critical care service*." [26]

84. Dr Purcell suggested to Dr San Laureano that her procedure should be performed at Royal Victorian Eye and Ear Hospital (**RVEEH**). Dr San Laureano did not agree and wanted to proceed with the surgery at VPSC, as the RVEEH did not have critical care services either and would not provide a higher level of care to reduce the risk. In response, Dr Purcell said "*I reiterated that I would not be willing to provide sedation or general anaesthetic' but would be present as a 'backup*."[27]

85. Dr Purcell claimed that after the in person pre-anaesthetic assessment on the morning of the surgery he told Dr San Laureano that "*I've seen the patient*" and that "*I did ask Dr San Laureano one last time that he reconsider*" with Dr San Laureano's response being "'*No she'll be fine' or words to that effect*"[28] and further "*Well, I would say that I tried to cancel and, ah, my, ah - my opinion, um, my - sort of, you know - sort of my considered - you know, was rejected… by Dr San Laureano.*"[29]

86. Dr San Laureano admitted that Dr Purcell had told him of his concerns about Mrs Guest's suitability for surgery at VPSC and his opinion that Mrs Guest should not have surgery at VPSC.[30] Dr San Laureano said he considered whether the surgery should be performed at RVEEH but did not think it was an option as RVEEH did not have the facilities for the two-part procedure and the risks of surgery was the same as VPSC; that is, critically-ill patients would have to be transferred out to St Vincent's Hospital and cannot be managed within RVEEH.

87. Dr San Laureano contended that both Dr Purcell and Mr Puyk had agreed for the surgery to proceed at VPSC. Dr San Laureano also stated that in previous cases, Dr Purcell had declined to be a patient's anaesthetist if he felt uncomfortable and Mr Puyk had rejected requests for admission, but they had not done so in Mrs Guest's case. Following his conversations with Dr Purcell and Mr Puyk, Dr San Laureano felt comfortable for the surgery to proceed at VPSC.

[26] CB4
[27] CB4
[28] T225
[29] T227
[30] T164

88. Dr San Laureano claimed that "*I thought that I gave a convincing argument to Dr Purcell … – and Mr Puyk - about why I felt she should be done at [VPSC]*" and that "*it was a mutual decision between all three of us to proceed based on the information available at the time*"[31] When asked why he did not defer to Dr Purcell, Dr San Laureano said that "*I did defer to Dr Purcell because he agreed with me in the end."*[32]

89. On 10 August 2018, Mr Puyk had a conversation with Dr Purcell about Mrs Guest's suitability for surgery at VPSC after being advised by hospital staff that Dr Purcell had raised concerns about Mrs Guest's fitness for surgery and then a further conversation with both Dr San Laureano and Dr Purcell about Dr Purcell's concerns.[33]

90. At inquest, Mr Puyk admitted that he knew that Mrs Guest had been assessed as an ASA-4 patient by Dr Purcell,[34] and that Mrs Guest was ineligible for surgery at VPSC because of her ASA-4 rating.[35]

91. Additionally, three of the registered nurses who had contact with Mrs Guest on the day of her surgery gave evidence about Mrs Guest's fitness for surgery. Registered Nurse Jennifer Johnson, who was a clinical nurse specialist for anaesthetics at VPSC gave evidence that she spoke with Dr Purcell in the morning prior to surgery and he told her that Mrs Guest was on home oxygen and that he would assess her prior to deciding whether the surgery would proceed. Nurse Johnson understood that as Mrs Guest was on home oxygen, and she would be an ASA-4 patient.

92. Nurse Johnson observed that prior to surgery, Mrs Guest was short of breath and anxious. Nurse Johnson told the court that she was "*alarmed*" by Mrs Guest's appearance prior to surgery.[36]

93. As a result of Mrs Guest's presentation prior to surgery, Nurse Johnson, after consulting with Dr Purcell and Dr San Laureano that Mrs Guest "*didn't look like she was ready*" changed the order of the surgery list so that Mrs Guest was listed third instead of second.[37]

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[31] T114
[32] T168
[33] CB19
[34] T389-390
[35] T390.
[36] T462.
[37] T462

94. Registered Nurse John Gardiner who was present both at the 'trial run' on 8 August 2018 and at the surgery on 13 August 2018 gave evidence that he was "*astounded*" when he discovered that Mrs Guest's surgery was to proceed after she had been determined to be an ASA-4 risk.[38] During the trial run, Nurse Gardiner had observed Mrs Guest's anxiety at lying flat, her obvious health issues including the use of a wheelchair, with an oxygen tank attached, which was running all the time.

95. Registered Nurse Jon Hooper, who at the time was the coordinator of anaesthetics and recovery at the VPSC also concurred that he did not consider Mrs Guest to be fit for surgery at VPSC due to her ASA-4 status.

96. Dr San Laureano was the only witness who considered that Mrs Guest was fit for surgery and he gave candid evidence about this at inquest. Specifically, Dr San Laureano said he was not concerned about the risks of surgery to Mrs Guest, despite her comorbidities, her inability to lie flat and her reliance on oxygen which was evident to Dr San Laureano during the consultation. This was consistent with Angela's evidence that Dr San Laureano told Mrs Guest "*there were no risks*".[39]

97. Dr San Laureano told the Court that it was not his practice to consider the comorbidities listed on GP referral letter as "*they don't say very much*."[40] Dr San Laureano admitted that he did not believe it was his responsibility to assess his patients determine if they are fit for surgery.

98. Dr San Laureano clarified that, "*I have many patients who present in that manner, with a similar long list of problems and they rarely pose a problem for us, and Mrs Guest did not throw up any specific red flags to say to me this patient is different to any of the others I've seen previously….So, yes of course they're absolutely important but are they directly impacting on me, on what I'm proposing to do – the answer is no.*" [41]

99. In cross examination, Dr San Laureano said that "*at no stage did I think she was going to have a respiratory arrest. That thought never entered my mind*."[42]

100. Dr San Laureano did not accept that he had been told by Dr Purcell that Mrs Guest had been classified as an ASA-4 patient. Dr San Laureano's evidence was that he spoke to both Dr

[38] T505
[39] T24
[40] T104 - 107
[41] T106
[42] T165

Purcell and Mr Puyk about several concerns and was aware of Dr Purcell's assessment that Mrs Guest was a high anaesthetic risk and that she had "*major issues, including respiratory, but the specific details are things that I left to him*."[43]

101. I am unable to resolve the factual dispute about whether the specific risk of **respiratory arrest** was told to Dr San Laureano by Dr Purcell or others but in any event, Dr San Laureano should have undertaken his own assessment of Mrs Guest prior to surgery to ensure she was fit to proceed.

102. Dr San Laureano did not recognise or consider the possibility that Mrs Guest would suffer serious complications from undergoing surgery, including the risk of respiratory arrest because he failed to undertake his own medical assessment of her prior to the surgery taking place. It was incumbent on him to do so as a qualified ophthalmic surgeon in any case but especially in these circumstances where he was on notice of Mrs Guest's precarious health by way of the GP referral letter listing Mrs Guest's co-morbidities, the concerns raised by Angela and then Dr Purcell, and her obvious and visible reliance on oxygen during his consultation on 11 July 2018.

103. His evidence was that he relied on the opinion of others and that "*it is routine practice in ophthalmology for the assessment of patients' systemic problems to be deferred to other practitioners*."

104. Further, Dr San Laureano explained that he considered that as ophthalmologists are "*different to other medical specialists in that eye surgery does not impact on other body systems and is to some extent separate from other parts of the body. It is rare that surgery on the eye will impact, or will be impacted by, the workings of other parts of the body."* Dr San Laureano stated further that *"[f]or that reason, and unlike non-ophthalmic surgeons, I rely heavily on my anaesthetist when considering a patient's risk factor further surgery as it is very uncommon for me to have a patient whose comorbidities impact on the decision to proceed with eye surgery*."[44]

105. The relevant guideline for an ophthalmic surgeon to undertake an assessment of a patient's fitness for surgery is set out in the Royal Australian and New Zealand College of

[43] T164.
[44] CB 546-547

Ophthalmologists Preferred Practice Patterns dated June 2021 (**RANZCO PPP**) which states, that:

"The ophthalmologist planning cataract surgery should have an understanding of their patient's general medical condition and how it might impact on the surgery and the anaesthesia. Consultation with the patient's treating practitioner and the anaesthetist might be important. Diabetic control and diabetic peri-operative plans are important."

106. Further, the RANZCO PPP requires the surgeon to assess the patient's suitability for surgery including the patient's ability to lie supine for the surgery and the patient's current diabetic control.

107. While I accept that Dr San Laureano may defer to other specialists with more knowledge about specific non-eye related health conditions, it was not reasonable to delegate all responsibility for non-eye related care to others without fulfilling his own professional obligations to undertake his own assessments in accordance with the standards set out in the RANZCO PPP. Further, once Dr San Laureano was told of Dr Purcell's concerns about the surgery, he should have taken some steps to satisfy himself as the treating surgeon that the surgery was safe for Mrs Guest.

108. Even when he was made aware of that a trial had been undertaken by his employee, Ms Pieries, he made no inquiries of what it entailed to determine if it replicated surgical conditions or was in any way adequate.

109. I agree with the submission of Counsel Assisting that it is troubling that Dr San Laureano placed reliance upon the trial run in forming his view that Mrs Guest was fit for surgery when he had no information about the trial conditions and its suitability as an assessment tool, other than an assertion from his employee that it had been successful.

110. The expert conclave concluded, and I accept that the trial run was an inadequate tool for assisting to determine Mrs Guest's fitness for surgery. It was not undertaken under medical supervision, in surgical conditions, it was short in duration and there was no draping.

111. In failing to meet his professional responsibilities set out in the RANZCO PPP and make a proper assessment of Mrs Guest's fitness for surgery including conferring with Dr Purcell and others, Dr San Laureano failed to recognise that Mrs Guest was unfit for surgery on 18 August 2018. Had he undertaken the inquiries expected of him as a surgeon, he would have

recognised the risks to Mrs Guest. In failing to do so, his conduct fell well below what was expected of him as an ophthalmic surgeon.

112. Mr Puyk admitted at the inquest that he had concerns about Mrs Guest's surgery proceeding and that he "*escalated*" these concerns to the anaesthetist.[45] Notwithstanding his own concerns, and his knowledge that Mrs Guest was an ASA-4 patient Mr Puyk conceded in cross examination that he failed to apply the VPSC patient selection criteria policy in place at the time and cancel the surgery, which would have had the effect of overriding the decision of the surgeon, Dr San Laureano.

113. As the CEO of VPSC, Mr Puyk was responsible for ensuring that a patient such as Mrs Guest, who did not fall within the hospital's accepted parameters for day surgery, was not admitted into VPSC's care.

114. I do not accept the submission made on behalf of Mr Puyk that the court would need an expert opinion of a 'peer' of Mr Puyk's to make such a finding. As CEO and DON, Mr Puyk had an obligation to ensure that the hospital's policies were complied with – this necessarily includes not allowing patients to be admitted who did not meet the admission criteria. The relevant policy did not give him any discretion about this. Additionally, there was no evidence before the court that Mr Puyk attempted to apply the hospital's policy and was overridden by either Dr San Laureano or Dr Purcell. Mr Puyk's failure to cancel the surgery (or even make any attempts to do so) was a breach the relevant hospital policy and contributed to Mrs Guest's death.

115. I accept the evidence of Dr San Laureano that he believed that he had reached agreement with Dr Purcell about whether the surgery should proceed. Dr San Laureano generally gave candid and forthright evidence and had a better recall of the events being examined at inquest than Dr Purcell who admitted to the court several times that he had difficulty in recalling the specifics of events and conversations in relation to Mrs Guest.

116. In closing submissions, counsel for Dr San Laureano invited me to find that the ultimate decision to undertake the surgery was 'collaborative' between Dr San Laureano, Dr Purcell and Mr Puyk as the CEO and DON of VPSC. I do not accept the decision was "collaborative" as it implies there was a meeting of the minds in relation to the decision to go ahead. However, I do find that Dr Purcell's concerns and misgivings about the surgery were not clearly

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[45] T360

articulated and may have led others to have a higher confidence in the safety of the proposed procedure than they otherwise would have if he had acted decisively.

117. In closing submissions, Counsel Assisting invited me to find that Dr San Laureano went on with the surgery contrary to the views of others and was **wilfully blind** as to the risk to Mrs Guest in doing so. I accept that Dr San Laureano proceeded with the surgery contrary to the view of others and knew of Mrs Guest's inability to lie flat and reliance on home oxygen but I do not accept that he was 'wilfully blind' in doing do.

118. As set out in reply submissions filed on behalf of Dr San Laureano, such a submission suggests recklessness on the part of Dr San Laureano. There was no evidence before the court that Dr San Laureano was reckless. I accept that at the relevant time, Dr San Laureano held a genuine belief that the surgery was safe to proceed.

119. However, there was no basis for such a belief because he had not assessed Mrs Guest as he was required to do and he continued to hold this belief even after he had been told by Dr Purcell about his concerns and later, on the day of surgery that Dr Purcell would only be available as back up. His belief that the surgery was safe was contrary to the information available to Dr San Laureano that it was not safe.

120. At the very least, prior to the surgery taking place, Dr San Laureano had a duty to make proper inquiries of Dr Purcell about his concerns and to consult with Mrs Guest's treating doctors when the concerns had been raised, and to conduct his own proper assessment. These duties are expected of any competent surgeon acting prudently in receipt of patient information and conform to the expectations set out in the RANZCO PPP.

121. Dr San Laureano admitted that he delegated all non-eye related health assessments to others, but when told by Dr Purcell that the surgery was not safe, he did not accept the advice by Dr Purcell and cancel the surgery.

122. By failing to recognise the medical risks to Mrs Guest clearly available at that time and failing to act upon the advice of Dr Purcell by either cancelling the surgery or seeking further specialist advice, Dr San Laureano's care fell well below the standard expected of him as a surgeon.

123. Under cross examination from counsel for Mrs Guest's family about Mrs Guest's respiratory risks as assessed by Dr Purcell, Dr San Laureano accepted that had he known that information

prior to surgery "*I would have said to him, 'Do you really think this is okay to proceed?'* [46] and that if Dr Purcell had said no *"Well, if he said no I would have stopped. I would not have done it*."[47]

124. In written submissions filed on behalf of Mrs Guest's family, it was submitted that Dr Purcell's evidence did "*not rest comfortably against the evidence of Nurse Gardiner*." Nurse Gardiner had given evidence that the ASA-4 score in the pre-operative anaesthetic sheet[48] initially had not been filled in by Dr Purcell in the usual course. Nurse Gardiner says that he raised the omission with Mr Puyk and that he and Mr Puyk went to ask Dr Purcell to fill it in. Dr Purcell then completed the score in the document.[49] Nurse Gardiner explained that because Dr Purcell wrote the score of ASA-4 on the form and signed it, that it was perceived as Dr Purcell saying it was "*alright to proceed with the procedure.*"[50]

125. Nurse Gardiner also gave evidence that, in his opinion if Dr Purcell had wanted the procedure cancelled it would have been (after a discussion with Mr Puyk).[51]

126. Based on her experience as a nurse at VPSC, Nurse Jennifer Johnson concurred that if Dr Purcell had concluded that the surgery should have been cancelled following his pre-anaesthetic assessment, it would have been.[52]

127. The evidence demonstrated that Dr Purcell could have and should have cancelled the surgery as he knew it was not safe to proceed. By failing to do this in a clear fashion, and by remaining involved in an elective procedure in an ill-defined way as "back up" his conduct fell below that which should be expected of an experienced anaesthetist who should be relied upon to manage a patient's safety during surgery.

What was Mrs Guest told about the risk to her of proceeding with the surgery

128. The evidence before the court established that Mrs Guest was cautious and wary about undergoing the cataract surgery and wanted to be provided with all relevant medical advice in order for her to make medical decisions for herself.

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[46] T165
[47] T163-166
[48] CB468
[49] T515
[50] T524- 525 L24-2
[51] T525
[52] T484

129. The email from Angela to Dr Purcell dated 23 July 2018 demonstrates that Mrs Guest was cautious about the surgery and her caution was noted by various hospital witnesses, including Nurse Gardiner[53] and Mr Puyk, who saw Mrs Guest just after the trial.[54] In addition, other significant evidence demonstrating Mrs Guest's general caution and desire for proper information about the risks of the procedure included the presence and use of Mrs Guest's own pulse oximeter at medical appointments, the instigation of the trial run and telephone calls to VPSC for assurance after speaking with Dr Purcell.

130. According to Angela's evidence, at the consultation on 11 July 2018, Dr San Laureano did not discuss any of the risks of surgery, in fact, Dr San Laureano asserted there were no risks.

131. On 10 August 2018, following the call between Mrs Guest and Dr Purcell, Mrs Guest contacted VPSC to follow up the concerns which had been raised. The VPSC nursing notes recorded by Registered Nurse McCarthy state:

"…the Anaesthetist for her proposed surgery had called her and raised concerns relating to her health and her suitability to be a patient at VPSC. She requested that she be able to speak to the Pre-Op Unit Manager that she had personally met and been assessed by, she wanted him to reassure her that VPSC was able to accommodate her."

132. Registered Nurse John Gardiner was Pre-Operative Unit Manager referred to in the nursing notes. Mr Gardiner said in his statement that Registered Nurse McCarthy called him to relay the concerns of Mrs Guest but he did not call Mrs Guest back as he subsequently became aware that Dr San Laureano had made contact with Mrs Guest and her daughter Angela, "*and it was decided surgery would proceed."*[55]

133. Mr Puyk conceded in cross examination that he did not raise his concerns about the surgery to Mrs Guest or her family.[56]

134. Angela's viva voce evidence was that Dr Purcell informed her about his concerns regarding Mrs Guest's suitability for surgery **at VPSC** and told Angela that the surgery would have been better at a hospital, describing VPSC as "*an office with medical equipment*"[57] but he did not tell her that the surgery should be cancelled.

53 T506
54 T388
55 CB31
56 T431
57 T33

135. Angela said further that after her conversation with Dr Purcell on 10 August 2018, she had contacted Dr San Laureano and was "*advised… that we should not worry and that Dr Purcell was likely exaggerating as he had just returned from leave and didn't want a difficult patient*."[58]

136. In his statement, Dr San Laureano did not recall this telephone conversation.

137. Angela told the court that on the morning of the surgery, Dr Purcell informed Angela and her mother that he would not be giving Mrs Guest general anaesthetic but she would receive an eye anaesthetic and that he "*would be there*".

138. According to Angela, on the morning of the surgery, Angela and Mrs Guest were not told by anyone that there had been discussions about cancelling the surgery because of the health concerns or that Mrs Guest had been categorised as an ASA-4 patient.[59]

139. I prefer the evidence of Angela to that of Dr Purcell regarding what was discussed about the surgery and, specifically whether Dr Purcell told Angela the surgery should be cancelled. There is no record in Mrs Guest's medical notes that Angela or Mrs Guest had been told about cancellation discussions or a record of telling Mrs Guest that she was an ASA-4 patient. If they had been told this information and decided to proceed (against medical advice) it is certain that the hospital and Dr Purcell would have recorded it.

140. Additionally, Dr Purcell took no contemporaneous notes of the telephone call which he was more likely to do if he had told Angela that the surgery should not proceed at all. Further, Angela told the Court – and I accept, that she only became aware of the ASA-4 rating when she read the coronial brief for the first time just prior to the inquest.

141. In his viva voce evidence, Dr Purcell conceded several times that he had great difficulty remembering the details of his conversations and the events leading up to Mrs Guest's death. Angela, on the other hand, had a good recall of the events leading up to her mother's death, and set out in writing her concerns about her mother's care in significant detail very soon after her mother's death. I am persuaded by the strong and consistent evidence before the Court about the cautious approach taken by Mrs Guest and her family towards the surgery, that Mrs

[58] T34, CB 510

[59] T41.

Guest would not have proceeded had she had been told that Dr Purcell had serious concerns about the procedure going ahead

142. I accept that Dr Purcell had expressed concerns to Angela about the surgery proceeding at VPSC but I do not accept his evidence that he told either Angela or Mrs Guest that he had effectively withdrawn his services and that he was only available as back up.

143. As a result of his failure to convey that he had effectively withdrawn his services other than as "back up" Angela and Mrs Guest were left with an impression that Dr Purcell did not considere that his anaesthetic services needed for the first stage, that the surgery was safe to proceed and that he would "*be there*" for the second part of the surgery.

144. Specifically, I find that Dr Purcell did not raise with Angela the detail of the profound risks he had identified about Mrs Guest, including that:

    a. She was an ASA-4 rated patient.

    b. He had grave concerns about her undergoing surgery at that time at any location.

    c. Her lack of reserves were severe and could lead to deterioration requiring critical care facilities.

    d. She needed optimisation of her condition prior to any surgery.

    e. The surgery scheduled for 13 August 2018 should be cancelled.

    f. If the surgery proceeded, he would only attend as "back up".

145. Given Dr Purcell's strongly held views about the surgery not going ahead, he had an obligation to tell Mrs Guest these matters. His actions in attending the surgery conveyed to Mrs Guest and Angela that the surgery was safe to proceed.

146. Dr Purcell gave evidence that he felt he faced an ethical dilemma about waking away from Mrs Guest after he had identified the risks to Mrs Guest and that he was between a "*rock and a hard place*" because if he had walked away, he may be perceived to have "*abandoned*" her.

147. In written submissions to the Court, counsel for Dr Purcell submitted that he should not be criticised for making himself available should an emergency arise in circumstances where he identified a foreseeable risk.

148. I am not persuaded by this submission. Knowing that Mrs Guest was not fit for surgery on 13 August 2018 and that she may suffer respiratory failure if the surgery went ahead, Dr Purcell could have stopped the surgery by withdrawing his services, but he did not so.

149. As I stated earlier, the role of Dr Purcell in the surgery as "back up" was ill-defined and problematic. His decision to mark the pre-operative anaesthetic sheet with "ASA-4" caused Nurse Gardiner to think that Dr Purcell considered the surgery was safe to proceed. Nurse Johnson gave evidence that she was aware that Dr Purcell would not be providing sedation but was not told he would only be available as "back up".[60] Similarly, there was no record in the notes about "back up".

150. I accept the submission of Counsel Assisting that Dr Purcell's presence as "back up" provided a layer of legitimacy and comfort for Dr San Laureano and others and that had he not attended as back up the procedure may have been cancelled.

151. The actions of Dr Purcell in failing to decisively withdraw his services and rather, deeming his presence at the surgery as "back up" caused confusion in relation to his role in the surgery and gave the impression that he was not sufficiently concerned about Mrs Guest's fitness for surgery to seek to have the surgery cancelled. As a consequence, Dr Purcell did not provide the level of care that Mrs Guest was entitled to expect from a specialist anaesthetist.

152. Further, and crucially, had Dr Purcell been present during the first part of the procedure, there may have been proper monitoring of Mrs Guest which would have informed Dr San Laureano that proceeding with the second part of the procedure was problematic.

Proceeding with second part of the surgery

153. Dr San Laureano did not admit to seeing the signs Mrs Guest's of deterioration noticed by others during the first part of the procedure, including the cyanosis, blue lips and shortness of breath - even though he was performing the procedure close to her face and swivelled her out from under the machine when the procedure was complete. Other attendees in the room gave evidence that Dr San Laureano did or must have seen the symptoms of the adverse event.[61]

154. Dr San Laureano also submitted to the court that even if he had been aware of Mrs Guest's decompensation during the first stage it was the responsibility of others, including anaesthetic nurses and perioperative staff to deal with it as he was focussed on the eye.[62] I do not accept

[60] T466.
[61] For example, Nurse Gardiner T525
[62] T120, 137

this submission because he was the only doctor in the room and as such assumed responsibility for Mrs Guest's care in circumstances where the anaesthetist was not present and was available only as "back up".[63]

155. After the first part of the procedure, Angela and Mrs Guest had conversations with Mr Puyk and Ms Pieries and asked them to stop the next part of the procedure going ahead. Angela and Mrs Guest were concerned that given the decompensation during the laser part of the procedure, which was of short duration, they were afraid that having to lie flat for the second part for upwards of 20 minutes "*was going to be a disaster*".[64]

156. Angela told the Court that she and Mrs Guest had asked whether the second part of the surgery could be postponed but was firmly told by staff they had no other choice but to proceed since she had already completed the first part.

157. This is contradicted by the evidence of Ms Pieries, who stated that she had told Mrs Guest at the trial that the second part of the procedure had to be performed after the first part.[65] I do not accept Ms Pieries evidence in this regard. There is no record in Mrs Guest's medical notes indicating that Ms Pieries warned Mrs Guest that the second part of the procedure had to proceed after the laser section, and it is inconsistent with the information Dr San Laureano conveyed to Mrs Guest, that the surgery was a 'two part' procedure and that she could sit up if she needed to between the two stages. Had she been told that the surgery must proceed after the first stage even if she **decompensated**, Mrs Guest was most likely not to have agreed to undergo the procedure.

158. While waiting for the second part of the procedure Mrs Guest was heard by others, including VPSC staff to repeat loudly that she didn't want to lie down again.

159. Nurse Gardiner had concerns about the second part of the procedure proceeding. He recalled telling the anaesthetic staff about what had occurred during the first part of the procedure prior to the second part of the surgery commencing.

160. The evidence showed that Angela asked staff to speak with Mrs Guest's respiratory specialist prior to the second stage commencing. The staff did not agree to this request but told Angela

[63] The expert panel concurred that Dr San Laureano had assumed responsibility for managing and monitoring Mrs Guest during the first stage once he knew that the anaesthetist would not be present. T619-620.
[64] T46
[65] CB35

that she could try to call him herself. Angela tried to contact him, but he was on leave.[66] When Mrs Guest was taken into theatre, Angela and her mother told Drs San Laureano and Purcell that if something goes wrong Mrs Guest needs to be sat up. According to Angela, Dr San Laureano agreed, saying "*yes, not a problem*."[67]

161. Dr Purcell accepted that he had responsibility for Mrs Guest's well-being during the second part of the procedure but also said he was not really aware of the decompensation during the first stage, including the reports of cyanosis, difficulty breathing and chest pain. Dr Purcell said that if he had known about the decompensation, he would have assessed her criticality. But he did examine her and found nothing untoward. In this regard, Dr Purcell's evidence is difficult to reconcile against the evidence of Angela who gave compelling evidence about her mother's distress during this time.[68]

162. In deciding to take responsibility for Mrs Guest during the second part of the procedure, Dr Purcell had an obligation to make proper enquiries about what had taken place during the first part of the procedure. Had he done so – by listening to the concerns expressed by Mrs Guest, Angela, or asking the staff present during the first phase of the procedure - he would have been fully aware of the extent of the earlier decompensation and could have given advice to Dr San Laureano and Mrs Guest about options forward, including to withdraw.[69]

Informed consent

163. Because Mrs Guest was not told of the risks to her, including the risk of respiratory failure if the procedure went ahead, it follows that she did not give informed consent. It is a well-established principle that treatment providers have a duty to warn about the material risks of the treatment, procedure or other intervention as part of obtaining a person's consent. The failure to adequately warn a person of these risks is a breach of the treatment provider's duty of care to the patient.[70]

164. In the case of Dr San Laureano, because he failed to inform himself of the risks to Mrs Guest of the surgery by undertaking the assessment of her general health and making enquiries of her other treating practitioners, it was inevitable that he also failed to inform Mrs Guest of those risks.

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[66] T47
[67] T49
[68] T48
[69] Expert panel, T461 - 463
[70] *Rogers v Whitaker* (1992) 175 CLR 479

165. Mrs Guest did not consent to receiving Xylocaine during the procedure. She believed she was allergic to it and Dr San Laureano knew this. Even if Mrs Guest was incorrect in her belief that she was allergic to the medication, the administration of it by Dr San Laureano was against her expressed wishes, was a breach of his duty to her and deprived Mrs Guest of her right to make an autonomous decision about this for herself.

166. The expert panel concurred that given the serious decompensation that occurred during the first stage, it was incumbent on her treating team to explain to Mrs Guest that she had the option not to proceed with the second stage of the procedure, and what the possible risks of proceeding or not proceeding were, including that if she proceeded she may risk another serious respiratory event which could lead to complications, including death - versus the risk of losing her eye-sight if she did not proceed. Such a discussion did not take place and as a result, Mrs Guest did not give her informed consent to the second part of the procedure.

167. The failure to advise Mrs Guest of the possible consequences of a further decompensation and the options available to her- including to refuse the surgery, resulted in Mrs Guest proceeding to the second stage of the surgery.

Managing and monitoring of Mrs Guest during the procedure

168. I accept the submission by Counsel Assisting that the monitoring and management of Mrs Guest's condition during the femtosecond laser part of the procedure was inadequate. Dr San Laureano, Ms Pieries, Dr Purcell and VPSC staff, including Mr Puyk were aware that Mrs Guest was reliant on home oxygen – her oxygen equipment was present during her consultation with Dr San Laureano on 23 July and during the trial run on 8 August. Notwithstanding this, the VPSC did not have an oximeter available, and Mrs Guest had to provide her own and Angela and her sister used it in the first part of the procedure.

169. Under cross examination, Mr Puyk accepted it was wrong not to have an oximeter available and in use during Mrs Guest's surgery.

170. Further, despite the significant decompensation which occurred during the procedure, including the shortness of breath and change of colour, both Dr San Laureano and Dr Purcell claimed not to have been told. In the case of Dr San Laureano, I do not accept that he did not know about the decompensation. He was positioned close to Mrs Guest and the evidence was consistent that her deterioration was visible and audible.

171. In the case of Dr Purcell, the failure to communicate what occurred during the first part of the procedure when he wasn't in the room possibly occurred due to Dr Purcell's confused "back up" role, but it in any event, such a breakdown of communication was not of the standard expected during a medical procedure. It goes without saying that in theatres, the roles and responsibilities of each participant must be clear and unambiguous otherwise patient safety is compromised.

The Root Cause Analysis by VPSC

172. Following Mrs Guest's death, VPSC reported Mrs Guest's death to Safer Care Victoria as part of Safer Care Victoria's Sentinel Event Program.[71] As part of its report, Mr Puyk prepared a "cause and effect" diagram[72] and submitted it to Safer Care Victoria. The Guest family were not involved in the review process and therefore had no opportunity to comment on the review or provide their feedback to the report prior to receiving it as part of the coronial brief.

173. The diagram and the report were the subject of cross examination at inquest and contain a number of concerning statements which were not factually based or omitted key information, including:

    a. In response to why the family had not contributed to the Sentinel Event investigation "*the daughter was well aware about our concerns and the risks of going ahead with surgery*." As set out in this finding, such a conclusion is not supported by evidence. Angela was not properly advised about VPSC's concerns and the risks of going ahead with surgery.

    b. The document did not record that Mrs Guest did not meet the VPSC selection criteria policy and was ineligible for admission to VPSC.

    c. The document makes no reference to the concerns raised by Dr Purcell about Mrs Guest's lack of fitness for surgery.

    d. The document nominates that the "*patient and daughter pushing for surgery*" and "*surgeon pressured to perform surgery*" as cause and effect. These statements were patently wrong. Dr San Laureano gave evidence that he was not pressured by the

[71] A Sentinel Event occurs when something goes wrong with a patient's care, which causes the patient serious harm or death that could have been prevented.
[72] T71

family to perform the surgery. There was no evidence from any other witness that Mrs Guest or Angela pressured any person to have the surgery performed.

174. As a result of the Root Cause Analysis and sentinel event information provided by VPSC, Safer Care Victoria was not appraised of the significant patient safety issues which arose in Mrs Guest's surgery or the proper facts and circumstances leading up to her death, leading Safer Care Victoria to conclude erroneously, among other things that "*Cherie consented to the laser procedure being performed, despite being advised of the procedural risks*."[73]

175. Under cross examination, Mr Puyk was unable to explain the basis for the statement in his submission to Safer Care Victoria that the family were pushing for surgery.

176. When asked about the material submitted to Safer Care Victoria at the inquest, Angela said that she considered it to be "*abhorrent*".

177. In his submissions, Counsel Assisting invited me to find that the document was misleading, abhorrent and "*an attempt to mitigate criticism for Cherie's death*."

178. While I am unable to find that Mr Puyk **deliberately intended** for the document to mislead Safer Care Victoria about the root cause of the adverse event, I find that the document contains statements which have no factual basis and omits key information which may have had **the effect of misleading** Safer Care Victoria.

179. That Angela would find such a document to be abhorrent is understandable in view of the circumstances of the surgery and her mother's death as they came to light during the inquest. It is not only plainly wrong but also obscures the significant failings in the care provided to Mrs Guest and indicates a lack of insight about those failings. Such an approach to a root cause analysis undermines the purpose for undertaking sentinel event reviews which is to undertake a transparent review of an adverse event to reduce the chance of it happening to someone else.

Responses to concerns

180. In submissions to the Court, VPSC outlined a number of changes made to strengthen patient safety. In particular, the following policies were provided to the Court prior to and following the inquest. They were:

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[73] CB534-536

a. VPSC amended operation/procedure consent V2;

b. Cura Day consent to medical treatment policy;

c. Management of a Serious Incident Policy along with Appendices A and B;

d. Cura Day Hospitals Group shared decision making policy version 2; and

e. Cura Day Hospitals Group medical committee terms of reference.

181. In its written submissions, VPSC invited me to consider a recommendation that the Australian New Zealand College of Anaesthetists develop a guideline for an anaesthetist escalation of concerns in circumstances where they form the view that a patient is not fit for anaesthesia but where they are still going to attend a surgery on "stand by" or "back up".

182. I do not consider that such a recommendation is appropriate or necessary, in circumstances where I have found that it was not appropriate for anaesthetists make themselves available for "back up" in elective procedures for patients who are not fit for the procedure. In elective procedures, where an anaesthetist considers a patient is not fit, it is incumbent on the anaesthetist to clearly articulate the risks to both the surgeon and the patient and ultimately, to withdraw services if necessary.

183. In a written statement provided prior to the inquest, Dr San Laureano told the court he had reflected on his treatment and management of Mrs Guest and as a result had implemented changes to his practice and that going forward, it would be his practice to refer any patients with significant co-morbidities back to their GP for referral to their relevant treating specialist for clearance for surgery prior to Dr Lan Laureano booking them for surgery. Dr San Laureano stated further that *"[I]f a patient such as Cherie presented to me again, I would refer her back to the GP and ask that the GP facilitate Cherie to be assessed, in this case, by her respiratory physician, and that her respiratory physician provides me with a letter confirming he or she consider the proposed surgery was safe to proceed*."

184. While this change of practice may somewhat improve Dr San Laureano's practice, it does not address some of the shortfalls in his approach to patient care which were identified at inquest. These are that:

a. Dr San Laureano is required to undertake his own assessment of his patient – this is not a duty he can entirely delegate to others.

b. When concerns are raised by others about a patient safety issue – whether it is staff, the patient or another doctor, Dr San Laureano should seek further advice and reflect on whether the surgery is appropriate.

c. Dr San Laureano is required to understand the specific risks of each patient regarding the proposed surgery and tell the patient those risks in order for the patient to give informed consent to the surgery. This necessarily means that Dr San Laureano must tell the patient risks which have been identified by other health care practitioners of which he has been told.

FINDINGS AND CONCLUSION

185. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the standard set out in *Briginshaw v Briginshaw*.[74] The effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused, or contributed to the death. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight. There must be a fair assessment of the evidence based on what was known or should reasonably have been known or done at the time.

186. With those principles in mind, I make the following findings:

a. the identity of the deceased was Cherie Virginia Pearl Guest, born 15 November 1956.

b. the death occurred on 18 August 2018 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from DIFFUSE ALVEOLAR DAMAGE IN A WOMAN WITH RESTRICTIVE LUNG DISEASE FOLLOWING CATARACT SURGERY.

c. Dr Purcell assessed Mrs Guest and formed an opinion that she was a high-risk anaesthetic patient and assessed her as an ASA-4 patient – that is, a patient with incapacitating systemic disease which is a constant threat to life, with no clear cut diagnosis and was not fit for surgery.

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[74] (1938) 60 CLR 336

d. Mrs Guest was not medically fit for surgery at any facility on 13 August 2018 because of her significant underlying comorbidities and health status.

e. Prior to having surgery, Mrs Guest should have been assessed by a multi-disciplinary team with input from her treating specialists and been optimised prior to surgery.

f. As an ASA-4 rated patient, it was not appropriate for Mrs Guest to have had surgery at VPSC at any time. Following a proper assessment, if surgery was to proceed at all, it should have taken place at a hospital with critical care facilities, such as an intensive care unit or high dependency unit with oxygen and anaesthetic monitoring.

g. The pre-anaesthetic assessment on 13 August 2018 was only adequate to determine that Mrs Guest was not ready for surgery on that day but inadequate for determining whether it was safe for Mrs Guest to have surgery at a later date.

h. The femtosecond laser procedure was an inappropriate choice for the first part of the procedure. The procedure should have done using manual techniques because it can be performed on an incline and it can be stopped during the early stages.

i. Mr Puyk knew that Mrs Guest was an ASA-4 rated patient. As the CEO and DON, he was responsible for ensuring that she was not admitted to the hospital for surgery as she did not fall within the hospital's accepted parameters for day surgery.

j. Dr San Laureano knew that Mrs Guest was oxygen dependent, could not lie flat and had significant medical conditions including a significant respiratory condition, which were set out in the GP referral letter.

k. Dr San Laureano failed to undertake his own assessment of Mrs Guest' suitability prior to surgery, and otherwise failed to act on information available to him that she was not fit for surgery, as he was obliged to do in accordance with the standards set out in the RANZCO PPP in place at the time.

l. Had he undertaken the inquiries and assessments required of him, Dr San Laureano would have recognised the risks to Mrs Guest in having the surgery. In not doing so, his conduct fell well below what was expected of him as an ophthalmic surgeon. Dr San Laureano knew that Dr Purcell held the opinion that Mrs Guest was not suitable for surgery at VPSC given her high anaesthetic risk and risk of deterioration with a requirement for transfer to a critical care service.

m. Nursing staff at VPSC who had contact with Mrs Guest on the day of surgery were concerned about the procedure going ahead because of Mrs Guest's lack of fitness for surgery.

n. Prior to the surgery, both Dr San Laureano and Dr Purcell were professionally obliged to tell Mrs Guest of the specific risks to Mrs Guest identified by Dr Purcell, including that she had been assessed as an ASA-4 patient and was not fit for surgery on 13 August 2018. Their failure to explain the risks to Mrs Guest was a breach of their respective professional duties to her.

o. Dr Purcell's role as "back up" was ill defined, caused confusion, and gave the impression to Mrs Guest and her family and nursing staff that he considered it was safe to proceed with the surgery.

p. Given his grave concerns about the surgery, Dr Purcell was obliged to seek to have the surgery cancelled and if that did not occur, he was obliged to withdraw his services. His failure to do so was a breach of his professional duties to her.

q. Mr Puyk, as the CEO and DON was obliged by the relevant VPSC selection and admission policy to cancel Mrs Guest's surgery because she did not meet the mandatory criteria set out in the policy. His failure to do so was a breach of his professional duty to her.

r. Dr San Laureano was obliged to cancel the surgery in the circumstances where he had not fulfilled his obligation to assess Mrs Guest's fitness for the procedure, Mrs Guest and Dr Purcell had raised concerns and he had not made proper inquiries about the adequacy of the trial run.

s. The trial run was inadequate for determining Mrs Guest's suitability for surgery. Specifically, it did not replicate surgical conditions, was of a shorter duration than the surgery itself and was not medically supervised.

t. Dr San Laureano did not know the trial run had taken place until afterwards. When he was told about it, he was obliged to make inquiries as to the adequacy of the trial as a tool to assess Mrs Guest's fitness for surgery. His failure to make these inquiries was a breach of his duty to assess her fitness for surgery.

u. The monitoring during the first part of the procedure was inadequate. Armed with the knowledge that Mrs Guest was dependent on oxygen, VPSC should have had appropriate monitoring equipment available.

v. Dr San Laureano was responsible for Mrs Guest's medical care during the first part of the procedure because Dr Purcell was not in the room during this procedure. Dr San Laureano could have and should have known about her decompensation during the first stage as had an obligation monitor Mrs Guest, and then to communicate the decompensation to Dr Purcell prior to the second stage.

w. Dr San Laureano was further obliged to consider the risks to Mrs Guest of the potential for further decompensation if the second part of the procedure went ahead. The specific risk should have been communicated to Mrs Guest so she could make an informed choice about proceeding with the second stage even if she was at risk of losing sight in her eye.

x. Mrs Guest was not told that the second part of the surgery **must** proceed after the section, even if she decompensated. Had Mrs Guest been properly of this, she was most likely not to have consented to the procedure at all.

y. Mrs Guest did not consent to Dr San Laureano administering Xylocaine during the procedure. She believed she had an allergy to it and Dr San Laureano knew this. The administration of the medication against her consent was a breach of his duty to her.

187. Having considered all the circumstances, I am satisfied that Mrs Guest's death was preventable and the failure to cancel the surgery caused Mrs Guest's death.

I convey my sincere condolences to Mrs Guest's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Reginald Guest, Senior Next of Kin

Maurice Blackburn on behalf of the family of Mrs Guest

Barry Nilsson Lawyers on behalf of Victoria Parade Surgery Centre

Donna Filipich on behalf of St Vincent's Health

Wotton + Kearney on behalf of Dr Purcell

HWL Ebsworth on behalf of Dr San Laureano

Safer Care Victoria

Australian Health Practitioner Regulation Agency

Royal Australian and New Zealand College of Ophthalmologists

Australian and New Zealand College of Anaesthetists

Senior Constable Christopher Williams, Coroner's Investigator

Signature:

Date: 22 June 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.