Coroners Act, 1996

[Section 26(1)]

Western  Australia

RECORDOFINVESTIGATIONOFDEATH

Ref No: 13/13

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of Katina LEVISSIANOS with an inquest held at Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth, on 5 - 6 March 2013 find the identity of the deceased was Katina LEVISSIANOS and that death occurred on 4 November 2009 at 8 Ivers Court, Langford, as a result of Aspiration of Gastric Contents in Association with Gastric Necrosis, in a lady with a Gastric Band Device in the following circumstances:

Counsel Appearing :

Ms Kate Ellson assisted the Deputy State Coroner
Mr Dominic Bourke (instructed by Clayton Utz) appeared on behalf of Mr A Kierath
Mr P Tottle (Tottle & Tottle Partners) appeared on behalf of Dr WAS Diamond and Dr CT Yeap

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INTRODUCTION

Katina Levissianos (the deceased) underwent a laparoscopic adjustable gastric band insertion on 5 February 2008 to assist her with weight control. It was very successful. The deceased lost a significant amount of weight.

On 2 November 2009 the deceased had been feeling unwell, for two days. She believed she was developing an infection, and consulted the family General Medical Practitioner (GP), Dr Yeap, who performed a home visit at the request of the deceased's husband.

The deceased was still unwell on 3 November and asked the GP to re-attend. She complained of ear ache and vomiting but was adamant her lap band was not to blame[1]. Her GP suggested she go to hospital as he could not diagnose a problem. The deceased declined, but agreed she would attend hospital if she did not improve with antibiotics. Dr Yeap gave her a prescription for Augmentin Duo Forte[2].

The following day the deceased's mother came to care for her while her husband was at work, but did not arrive until 11:30am. The deceased's mother found the deceased in bed and unresponsive.

Paramedics called to the home could not resuscitate the deceased.

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[1] Transcript 06.03.2013, pg 143
[2] Transcript 06.03.2013, pg 140

She was 55 years of age.

REFERRAL FORSURGERY

Mr Kierath is an experienced general surgeon specialising in the area of weight management surgery. He was one of the first general surgeons to practise in this area. He is very experienced with all types of weight management surgery, however, in 2007 the favoured surgery was laparoscopic gastric banding (lap banding) due to the fact it was the least intrusive of the bariatric surgeries.

Mr Kierath first saw the deceased on 29 January 2008. She was at least 60% above her recommended body weight and was reasonably aware of the effects of gastric lap banding having had both a cousin and friends undertake surgery with Mr Kierath.

The deceased discussed lap banding surgery with Mr Kierath and it is clear from Mr Kierath's notes he and the deceased discussed her prior attempts at weight control, her medical problems, including her depression arising from her inability to control her weight, her borderline diabetes, her peri-menopausal symptoms and HRT, and her attitude to gastric banding surgery.

Mr Kierath's notes also include comprehensive drawings indicating the precise nature of lap banding, the expected weight loss, the complications which can arise from any general surgery under anaesthetic and those specifically related to lap banding[6].

The deceased was provided with written information with respect to the operation. This included an extensive pamphlet containing information about the operation Mr Kierath provides to all his patients. Mr Kierath advised the court the booklet in question is based on that of Paul O'Brien from the centre for Obesity Research and Education in Melbourne, but with his contact details[7].

The booklet contained information to the effect vomiting will occur in most people at some time, and generally when a patient has eaten too much or too quickly[8].

Mr Kierath then wrote to Dr Diamond informing him of the fact he had reviewed the deceased on that day, 29 January 2008, and she was considering the "pitfalls, benefits and potential outcomes", prior to informing Mr Kierath of her decision.

It does not seem to have been a difficult decision for the deceased because she advised Mr Kierath very quickly she wished to have the operation. Mr Kierath performed a

[6] Exhibit 1, Tab 15; Transcript 06.03.2013, pg 122
[7] Transcript 06.03.2013, pg 132
[8] Exhibit 1, Tab 11 *"The lap band"*

laparoscopic adjustable gastric band insertion on the deceased on 5 February 2008. The specific surgery preferred by Mr Kierath at that time, and in fact until very recently the generally preferred bariatric surgery, was the laparoscopic adjustable gastric band insertion. This involved inserting an inflatable band around the upper part of the stomach to create a very small stomach lying above the band.

The rest of the stomach remains below the band but the smaller upper pouch controls the volume of food consumed at any one time. Once surgery has been performed food goes into the small stomach and will then empty slowly through the lumen left by the band. The lumen can be reduced further by inserting fluid into the band once the surgeon is satisfied it is appropriately in place and the initial surgery has healed. There are other forms of bariatric surgery but at that time these were considered to be much more intrusive and therefore of more major concern to a patient's health with respect to the operation itself.

Numerous bariatric surgeries have been carried out in recent years and due to the long-term need for after care with the laparoscopic adjustable gastric band insertion, another form of surgery, gastric sleeve surgery, is becoming popular. While the initial surgery for gastric sleeve surgery is a major operation and involves physically removing approximately two thirds of the stomach, the aftercare is usually considered to be less concerning. However, the gastric sleeve is irreversible while the gastric band can be adjusted and is reversible.

The fact of the life long need for an understanding of the gastric banding operation needs to be well appreciated by both patients and their GPs to whom after care may devolve following successful surgery.

After the deceased's operation Mr Kierath followed her progress fortnightly, initially, and on 15 February 2008 wrote to Dr Diamond to inform him the operation had been performed without complications and the deceased had already lost a considerable amount of weight. He was satisfied with the healing of the laparoscopic insertion and intended to commence inflation of the band in approximately another two weeks.

Dr Diamond did not see the deceased again until the 30 July 2008 when he checked the position of her port subdermally and followed up with investigative blood work to assess her biochemistry. Her weight was now 86 kilograms with a BMI of 30.467. Her blood sugars had improved significantly[9].

In evidence Dr Diamond indicated he did not expect to undertake post operative follow up with his patients when they had this type of surgery as he considered them to still be in the care of the specialist performing the surgery[10]. He did perform normal medical investigations for his patients to ensure their general health was consistent and, hopefully, improving where weight management surgery had been

[9] Exhibit 1, Tab 13
[10] Transcript 05.03.2013, pg 44

undertaken with a view to protecting patients from life threatening conditions.

It was his view the deceased was responding well to her surgery, and he only saw her one more time for review and a standard specialist referral for Mr Kierath to enable continued follow up and aftercare[11]. At the time Dr Diamond last saw the deceased she weighed 76 kilograms, had blood pressure well within the normal range and was planning to cease HRT.

The deceased's family GP, Dr Yeap, was completely uninvolved in either the deceased's pre or post operative care. He only discovered the deceased had undergone laparoscopic gastric banding as a result of his commenting upon her significant weight lose[12]. It was at that time the deceased informed Dr Yeap she had gastric banding but he was provided with no further information.

Mr Kierath saw the deceased for follow up, nine times in the remainder of 2008, with a steady weight loss over that time, other than in May 2008 when the deceased explained to him she had been to too "many weddings and christenings". They discussed further appropriate diet and food selection on that occasion as follow up education[13].

Mr Kierath saw the deceased another five times in 2009, with her last review being on 5 August 2009. A that time her

[11] Transcript 05.03.2013, pg 44
[12] Transcript 06.03.2013, pg 136
[13] Exhibit 1, Vol 1, Tab 15A

weight was 70 kilograms and she was able to wear size 10 clothing. Not unexpectedly the deceased was very happy with her progress as was Mr Kierath. He described her as a "star patient", someone who was doing the right things in terms of monitoring her progress after surgery and being extremely compliant with all management strategies. This included having some fluid removed in October 2008 when it was considered the band was too restricting and affecting her quality of life[14].

Mr Levissianos raised some concerns with his wife's aftercare. He believed the follow-up appointments were very short and that his wife was not physically examined[15].

Mr Kierath informed the court patients very quickly understood the workings of the gastric banding in their individual cases. He stated there was always an issue with the smaller stomach becoming blocked which patients would learn to regulate themselves, following education with respect to the types of foods they could eat and the need to eat slowly, chew thoroughly, avoid certain drinks and food types, and not eat too quickly or talk too much whilst eating which tended to trap air. On the occasion the lumen became blocked patients would sometimes need to regurgitate food or suffer a form of reflux.

There was also an issue of vomiting if too much was eaten, and there are concerns with vomiting. These concerns are

[14] Transcript 06.03 2013, pg 133
[15] Transcript 05.03.2013, pg 23

impressed upon patients prior to the surgery. Mr Kierath did not distinguish between reflux, regurgitation and vomiting, other than to say patients certainly became aware of the do's and don'ts whilst eating with a gastric band in place. Vomiting was always considered to be something patients needed to assess and report to their surgeon if there were any changes or concerns[16].

By the last review before the deceased's death (5 August 2009)[17]. Mr Kierath was quite positive the deceased understood the management of her band and that she was quite happy. He did not investigate the position of the band because it was not necessary. It was clear she was not in any form of discomfort and neither was the band causing her a problem. He and the deceased decided to do nothing further by way of either tightening or releasing the band and she was to be reviewed sometime in late 2009.

Mr Levissianos did not attend any of the appointments with his wife and had to rely upon her information with respect to her follow-up care. Occasionally her surgery was discussed with her cousin, an experienced Registered Nurse (RN), who had also had gastric lap banding with Mr Kierath[18]. Both women assured Mr Levissianos the fact of dry retching or vomiting following eating too much was normal, and had all been explained to her prior to surgery. The deceased also had a card provided to her at the time of her operation informing

[16] Transcript 06.03.2013, pg 124
[17] Exhibit 1, Tab 15
[18] Transcript 05.03.2013, pg 25

medical practitioners in general of the fact she was a person with a laparoscopic gastric band[19].

EXPERT OVERVIEW

The court asked Professor Jeffrey Hamdorf, an experienced General Surgeon with a speciality in gastro intestinal surgery for an overview of the deceased's operation and follow-up[20]. Professor Hamdorf is also currently the Director of Clinical Training and Education at the School of Surgery at University of Western Australia, and Professor of Surgical Education.

Professor Hamdorf indicated Mr Kierath was known to him, as would be the normal situation in the WA Medical community, and that Mr Kierath had been performing gastro intestinal surgery in the bariatric area for a long time. He considered Mr Kierath to be very experienced.

Professor Hamdorf reviewed the medical information with respect to the deceased prior to her decision to have laparoscopic gastric lap banding. He agreed it was appropriate surgery for the deceased. She was morbidly obese and there were definite risks to her continuing to remain at the weight she was, or indeed run the risk of increased weight. The fact it was becoming a problem was emphasised by her elevated blood sugars indicating borderline diabetes prior to her decision to undertake surgery. Professor Hamdorf's preference was a team approach to bariatric surgery, followed by multi-disciplinary follow-up.

[19] Transcript 06.03.2103, pg 124
[20] Exhibit 1, Tab 12; Transcript 06.03.2013, pg 66

Mr Kierath pointed out in evidence that by the time patients were considering bariatric surgery they had been reviewed by their GP's and usually referred to many relevant disciplines which would constitute the same input as that from a multi-disciplinary team. He believed by the time a patient was referred to him they were both psychologically and medically prepared for the considerations he also covered with them with respect to specific surgery. Both Professor Hamdorf and Mr Kierath agreed follow-up visits with surgeons were usually short and did not involve a physical examination, other than the use of the port at the time of tightening or loosening the band.

Both Professor Hamdorf and Mr Kierath agreed they would rely on patients to tell them about any problems they were having and they would follow-up on any problems more closely as appeared necessary[21].

Both Professor Hamdorf and Mr Kierath were adamant pain with respect to the lap band would always be a concern and patients would certainly be expected to advise them if there was any pain associated with either eating or positioning of the band. In addition both surgeons were adamant patients are well educated with respect to the significance of excessive vomiting. Professor Hamdorf instructed patients he was to be contacted if they vomited more than three times in any 24hour period, while Mr Kierath advised his patients to contact him in

[21] Transcript 06.03.2013, pg 78, pg 128,

the event there was persistent vomiting of any description. Both surgeons agreed their patients were provided with emergency telephone numbers and both surgeons are always available to patients by way of mobile telephone numbers.

Other than his concern his wife appeared to be still vomiting frequently, Mr Levissianos reported no difficulties with his wife following her surgery and she seemed to be enjoying life.

EVENTSSURROUNDINGDEATH

On Saturday 31 October 2009 the deceased and her husband attended their niece's birthday party. According to Mr Levissianos there was Greek dancing and the deceased joined in with that enthusiastically and had a really good night. He estimated she was dancing for approximately four hours[22].

The following morning the deceased told her husband she was feeling dizzy and unwell. She thought it would be better if she stayed in bed and believed she was developing a viral infection of some type[23].

On Monday, 2 November 2009 the deceased was still unwell. She had been dry retching and her husband was concerned her dizziness was increasing. He thought it advisable he contact the family GP to visit her at home to see how she was.

[22] Transcript 05.03.2013, pg 19
[23] Exhibit 1, Tab 5, para 12 & 20

Mr Levissianos contacted Dr Yeap who came to visit the deceased on Monday afternoon[24].

The deceased complained of fever and vomiting relating back to the Sunday but reported no other symptoms. The deceased did not at any time advise Dr Yeap she was experiencing pain. Dr Yeap examined the deceased and noted she had a normal abdomen and normal heart and lung sounds. She had a temperature and he gave her some Stemetil to control her vomiting. He told her to take two Panadol tablets as required. Dr Yeap recommended the deceased be reviewed if she did not improve.

Mr Levissianos was advised by his wife the doctor had also advised her to remain in bed.[25]

In evidence Dr Yeap advised on both occasions he had visited the deceased she had been alone in the house and she had been well enough to come to the door to answer his call.

On 3 November 2009 the deceased asked Dr Yeap to return because she was still feeling unwell. On this occasion the deceased complained of having an ear ache and of persistent vomiting.

Dr Yeap examined her ear drums and they were normal. On examination she was not dehydrated and her throat and tongue were normal. The deceased did not advise Dr Yeap she

[24] Submissions filed on behalf of Dr Chai Teng Yeap
[25] Exhibit 1, Vol 1, Tab 5 para 15; Exhibit 1 Tab 8, pg 3; Exhibit 1, Tab 14, Note 02.11.2009

was in any pain and furthermore Dr Yeap said in evidence, she had assured him on the first visit the difficulty was not her lap band[26]. Dr Yeap advised the court the deceased was fairly strong willed and would effectively not take advice unless it accorded with what she thought was correct.

Mr Levissianos described his wife as being "in tune with her body" and generally would self diagnose and only accept advice when that was consistent with her own views.

Dr Yeap could not find anything wrong with the deceased and suggested she went to hospital but she declined. The deceased was convinced she had an ear infection and asked for antibiotics. Dr Yeap came to an agreement with the deceased that he would prescribe her some broad spectrum antibiotics, which he did, on the understanding she would go to hospital if she did not improve. Dr Yeap was not aware of a possible link between ear and stomach pain due to the position of the vagus nerve in some patients as described by Professor Hamdorf[27].

Dr Yeap noticed a bucket with some vomit, although he could not recall the colour of the residue by the time of the inquest. He did not make a note of the colour of the residue which inclined him to believe it had not been discoloured, or he would have made a note to that effect, it being a significant observation.

[26] Transcript 06.03.2013, pg 143
[27] Transcript 06.03.2013, pg 90

Mr Levissianos advised the court his wife was not eating solid food and was drinking soup or cordial. When Mr Levissianos commented on the colour of the phlegm in the bucket his wife assured him it was because of the cordial. Neither Dr Yeap nor Mr Levissianos noted any unpleasant smell emanating from the deceased's mouth in conjunction with the vomit[28].

Mr Levissianos was concerned about his wife but was reassured by her belief she had an infection. At no time did she advise him she was in any sort of pain.

On Wednesday 4 November 2009 Mr Levissianos went to work as normal, but because his wife was still so unwell he arranged for her mother to come and look after her. At about 11:00am the deceased's son rang her and when she answered the telephone, her son considered she sounded muddled and a little disorientated. He asked whether his grandmother had arrived, but his mother told him she had not. At about 11:30am the deceased's mother arrived to care for her but found her in bed and unresponsive[29]. A black substance was over her mouth and down her neck and there was also black fluid on the bed clothes.

The St John Ambulance Service was called and on the arrival of the paramedics they were unable to revive the deceased. She was declared deceased at approximately midday on 4 November 2009.

[28] Transcript 06.03.2013, pg 145
[29] Exhibit 1, Tab 5, para 18

POSTMORTEMEXAMINATION[30]

On 6 November 2009 Dr Jodi White, Forensic Pathologist, conducted a post mortem examination of the deceased. She found the stomach of the deceased revealed significant necrosis. Approximately two thirds of the deceased's stomach had herniated through the gastric band device and caused an obstruction at the gastric band. This had constricted the blood supply to the stomach above the device which had become necrotic[31].

Dr White described black fluid in the oesophagus and upper airways as well as all over the inner surface of the lungs. There was also patchy discolouration of the lungs which may have been indicative of earlier aspiration. These observations were consistent with a terminal aspirational event[32].

Dr White indicated all of the stomach which had herniated through the lap band was necrotic. The degree of necrosis and inflammation would indicate the deceased was likely septic, although this was not confirmed by microbiology. Dr White believed it would have taken approximately 4-5 days for the deceased's stomach to have reached that stage of necrosis. She could not be more precise than 4-5 days. In her view the final event of aspiration would have resulted in death in 3-4 minutes[33]. The aspiration would have resulted in respiratory arrest. There were no illicit substances detected in the deceased's blood and there was no alcohol present.

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30 Exhibit 1, Tab 6
31 Transcript 05.03.2013, pg 55 & 58
32 Transcript 05.03.2013, pg 57
33 Transcript 05.02.2013, pg 57

In Dr White's opinion the deceased death was caused by aspiration of her gastric contents, in association with her gastric necrosis, in a lady with a gastric band device.

Neither Dr White, Professor Hamdorf nor Mr Kierath could believe the deceased had experienced the extent of necrosis observed in the post mortem photographs without experiencing excruciating and over whelming pain.

Mr Levissianos confirmed his wife never complained of pain and the only symptoms she described were a feeling of un-wellness, coming down with an infection, and dizziness.

CONCLUSIONASTOTHEDEATHOFTHEDECEASED

I am satisfied the deceased was a 55 year old woman who had gained a considerable amount of weight in the last few years of her life. This severely affected her quality of life and she made a decision she would undertake bariatric surgery, after having consulted a GP she trusted in the area of weight control, and a surgeon to whom she was referred, Mr Kierath.

The deceased had surgery by way of a laparoscopic gastric band insertion on 5 February 2008 and thereafter underwent regular follow-up with her surgeon, with some overview by Dr Diamond with respect to her general medical health. At no time did the deceased involve her normal family doctor, Dr Yeap, in her weight control program.

The deceased's weight fell from approximately 108 kilograms to 70 kilograms by the time of her death. She was very happy with her reduction in size and, other than dry retching or vomiting on occasion, experienced no problems. She was reassured by others, and so reassured her husband, vomiting from time to time was an expected outcome from the gastric band insertion.

Expert evidence during the course of the inquest advised the court gastric lap banding is a procedure which, while initially less intrusive than other forms of bariatric surgery, does require life long regard to the fact of the placement of a gastric band device. Vomiting is always seen as a feature which needs to be monitored. In the event of excessive vomiting the stomach structure may move through the device aperture by way of reverse peristalsis. This needs to be surgical corrected by either removing or loosening of the gastric device. All patients are advised of the difficulties with excessive vomiting, and certainly all the literature is clear in explaining patients must consult their surgeons if there is a concern over and above their normal experience with vomiting.

The deceased reported no problems with her device and did not at any stage complain of pain.

On 31 October 2009 the deceased attended a party with her husband and thoroughly enjoyed the evening by dancing extensively. She would not have been able to participate in such a way prior to her weight loss.

On the day following the party the deceased experienced some dizziness and un-wellness. She did not complain of pain.

The deceased's husband contacted the family GP on 2 November 2009 who conducted a home visit. He was advised by the deceased there was not a problem with her lap band and she considered she had developed an infection. Dr Yeap provided the deceased with a Stemetil injection to control her vomiting.

Professor Hamdorf advised the inquest patients and GPs needed to understand that when a patient was experiencing vomiting to the extent an injection was required to control vomiting, then there were likely to follow problems with the lap banding device, and the relevant Consultant Surgeon should be contacted.

It is the vomiting which causes migration of the stomach through the device aperture and it is the vomiting which is of concern with this complication. Once that has occurred then vomiting can also become an outcome of the complication because of obstruction of the lumen through the band aperture.

On 3 November 2009 the deceased was still unwell and recalled Dr Yeap. He was unable to diagnose a condition for the deceased and attempted to persuade her to visit a hospital. The deceased was adamant she required antibiotics

and Dr Yeap provided her with antibiotics on the understanding she would go to hospital if they proved to be ineffective.

The following day the deceased's husband arranged for his mother-in-law to care for his wife because she was still unwell.

At approximately 11:00am the deceased's son rang her and she responded to the telephone although she did not seem to be particularly well.

The deceased's mother arrived at 11:30am at which time she found the deceased collapsed and unresponsive in bed.

The deceased could not be resuscitated.

A post mortem examination revealed the deceased's stomach had herniated through her lap band device and cut the blood supply to her stomach. Her stomach above the device had become necrotic and formed an obstruction so she was unable to process food. As a result of the obstruction she had aspirated, which appears to have been light at first, but there then appears to have been a terminal aspiration which resulted in respiratory arrest and death.

I find death arose by way of Misadventure.

LESSONSTOBELEARNED

The case of the deceased highlights difficulties GPs face when patients attend more than one GP and there is a lack of communication between the various medical practitioners and the patient. It also highlights the importance of GPs receiving education in the identification and management of complications arising out of gastric band placement.

The deceased's death was likely preventable and should not have resulted in her death had she advised Mr Kierath of her excessive vomiting, or had her GP understood vomiting itself can cause, as well as reflect, a problem with a gastric band device. Had the deceased contacted Mr Kierath on 2 November 2009 or perhaps even the following day, it is possible her death may have been prevented by removal of the band. In view of the extent of the necrosis by the time of death she would also have required surgical intervention to remove the necrosed tissues. Immediate loosening of the device would have reduced the complete obstruction of her intestinal tract which ultimately led to death due to the resulting aspiration of her gastric contents[34].

There was no "bad decision making" on the part of the deceased, Dr Diamond or Mr Kierath in the placement of the gastric band device. The deceased saw an accredited practising dietician and consulted her GP a number of times before being referred to Mr Kierath. The surgery went well and

[34] Transcript 06.03.2013, Prof Hambdorf pg 99-100

there were no issues following surgery. The purpose of the surgery was well met with her considerable weight loss and improvement in quality of life.

The deceased did not complain of any usual problems related to her vomiting and did not mention pain although I am satisfied she must have experienced some level of pain. She was aware of being unwell, but apparently did not, or was reluctant to, relate that to an issue with her gastric band device.[35] The medical care she received in those days is not the subject of criticism in view of the deceased's lack of expressed concern. It would have been preferable had the deceased agreed to go to hospital, however, she did not and there was no reason apparent to Dr Yeap to refer her to hospital over her wishes[36].

It does, however, raise the issue as to the education of GPs about complications arising from the various bariatric surgeries. There is a significant issue in the West Australian community about obesity and considerable numbers of bariatric operations performed in an effort to provide some weight control measures to those suffering obesity.

Although a common procedure gastric banding surgery is always associated with a certain level of risk for the life of the band. The surgery itself can have life threatening consequences as does any form of surgery. The deceased's complication in this case arose at a time well after

[35] Transcript 06.03.2013, pg 114
[36] Transcript 06.03.2103, pg ?

complications are normally expected to arise as the result of lap banding.

It appears to have been a complication that arose as a result of excessive vomiting. It may be the deceased did have an illness of some description which caused her excessive vomiting, which led to the herniation of her stomach through the device, which in turn led to the problems she experienced with necrosis, obstruction, and aspiration. Certainly the extent of the herniation and necrosis must have been a recent development in relation to the time elapsed since the placement of the device.

In view of the frequency with which gastric banding is performed there is a real need to ensure patients and GPs are well informed about the risks and side effects. It is necessary for the fact of the placement of the device to be taken into account at the time of any later gastric difficulties which may arise, to ensure patients receive the care necessary after the placement of such a device.

In the circumstances of this case developing education programs designed to inform junior doctors and GPs about the potential risks of bariatric surgery and other facts critical to the long-term management of patients who have had such surgeries could, in my view, only serve to improve the level of care for many gastric band patients in the longer term.[37]

[37] Transcript 06.03.2013, pg 85

Certainly patients must take responsibility for their own health care. However, part of that care, will usually involve consultations with GPs, whether that consultation involves a known problem experienced with the band, or not. In the current case had Dr Yeap fully understood vomiting itself could lead to the problem experienced with the band, as opposed to the deceased's apparent understanding vomiting was to be expected, without considering the outcome which can arise, then the fact of the administration of medication to prevent vomiting should have alerted both the deceased and the GP a review of the device by the relevant surgeon was necessary.

This would require a level of awareness about the potential life long risks associated with the banding device surgery and, more specifically, GPs need to understand repetitive vomiting, or strenuous retching mandates urgent review to allow the band to be loosened or removed, if necessary. Raising awareness by way of GP education could be achieved by developing educational programs directed towards identifying and managing risk factors, which can be directly related to the banding, and which may arise throughout life. It should be part of the education necessary for GPs to refer patients for bariatric surgery in the first place. Such educational programs would need to reach experienced doctors in private practice as well as junior hospital doctors.

RECOMMENDATIONS

I recommend a Specialist General Practice Group look at the development and extension of training programs to raise awareness about the common and life long concerns and complications associated with gastric banding surgery (GBS) including the significance of prolonged vomiting in a patient with prior GBS.

I intend a copy of this finding be circulated to:

(i) WA Branch of AMA
14 Stirling Highway
NEDLANDS WA 6009

(ii) The WA Division State Office of the Australian Divisions of General Practice
South Street
MURDOCH WA 6150

(iii) Royal Australian College of General Practitioners
34 Harrogate Street
WEST LEEDERVILLE WA 6007

EF VICKER
DeputyState Coroner

16 May 2013