STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Makushla NIKOLAEVSKY
Hearing date:	13-15 October 2020
Date of findings:	27 November 2020
Place of findings:	NSW State Coroner's Court - Lidcombe
Findings of:	Magistrate Carmel Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death – care and treatment post hysteroscopy – pulmonary embolism
File number:	2017/208672
Representation:	Ms D Ward, Counsel Assisting, instructed by Ms C Potocki, NSW Crown Solicitor's Office Mr S Beckett representing Dr S Krishnan, instructed by Mr J Kamaras, Avant Law Mr G Gemmel representing Dr V Mansberg, instructed by Miss M Walsh of HWL Ebsworth Ms S Scott, representing Prince of Wales Private Hospital, instructed by Ms J Alderson of Minter Ellison lawyers

Findings:	Identity of deceased: The deceased person was Makushla Nikolaevsky Date of death: Ms Nikolaevsky died on 7 July 2017 Place of death: Ms Nikolaevsky died at Prince of Wales Private Hospital, Randwick, NSW Cause of death: The cause of her death was pulmonary embolism Manner of death: The manner of her death was as a result of a natural process in hospital following a hysteroscopy

INTRODUCTION

1. Mrs Makushla Nikolaevsky was a 43-year-old woman who died as a result of a pulmonary embolism in the Intensive Care Unit of the Prince of Wales Private Hospital on 7 July 2017. She had undergone a hysteroscopy at the hospital on 3 July 2017. The hysteroscopy was for the purpose of excluding a possible malignancy in her uterus. Her death was unexpected.

2. A coroner's primary role is to investigate and make findings as to the identity of the deceased person, the date and place of the death, and the manner and cause of death. A further role for a coroner is to assess whether there has been an appropriate response to an unexpected death and whether more needs to be done to protect others from a similar death.

3. This inquest was concerned primarily with the cause and manner of Mrs Nikolaevsky's death. Some of the issues originally identified for consideration fell away during the course of the hearing. In particular, the possibility of transcatheter embolization of the uterine arteries did not need to be further explored once it became clear that Dr Krishnan may have considered this option and discussed it with Mrs Nikolaevsky along with other treatment options once malignancy had been excluded.

4. The following issues emerged as the primary matters considered during the hearing:

    - Whether, on the material known to the treating team at the time, the Venous Doppler Ultrasound that was performed on 5 July 2017 should have extended above the inguinal ligament at the groin.

    - What was the most likely source of the pulmonary embolism leading to death?

    - Should Mrs Nikolaevsky have received the Clexane doses as prescribed to her?

    - The appropriateness of the prescribing of Cyclokapron (tranexamic acid).

Makushla Nikolaevsky

5. Mrs Nikolaevsky left behind a loving family including her husband Mark Nikolaevsky and his family, her mother Jeanette, her siblings Shannon, Natasha and Makaela and their families. Mrs Nikolaevsky's family referred to her affectionately as "Kush". Her sister Shannon described "Kush" as "*an eclectic, deep loving soul, passionate about life and everything it had to offer…a one of a kind human being who was loved and will be loved forever*".

6. Mrs Nikolaevsky and her husband married in January 2017. They first met in 1992 and had been together for many years prior to marrying.

7. Mrs Nikolaevsky had a long-term problem with heavy menstrual bleeding. Mr Nikolaevsky recalls this problem dating back to the late 1990s.

8. A pelvic ultrasound done in 2004 reported a history of irregular menstrual cycles. According to medical records within the coronial brief, low haemoglobin levels were evident on full blood counts taken in 2009, 2011 and 2013.

9. In 2013 Mrs and Mr Nikolaevsky attended upon an IVF specialist for diagnosed primary infertility. Mrs Nikolaevsky was noted to have iron deficiency anaemia. In 2014 pathology results again showed abnormally low haemoglobin. The records refer to severe microcytic, hypochromic anaemia.

10. In 2016 Mr Nikolaevsky recalls Mrs Nikolaevsky's periods became longer than usual and she was bleeding more than normal.

Attendances at the Emergency Department of St Vincent's Hospital

11. In May 2017 Mrs Nikolaevsky attended for a blood test ordered by her GP which revealed a haemoglobin level of Hb32, indicating severe anaemia. Mr Nikolaevsky recalls being told that it was very unusual for a person with such low haemoglobin to be able to walk around and Dr Krishnan (later Mrs Nikolaevsky's treating gynaecologist) gave similar evidence at hearing. It is

likely Mrs Nikolaevsky had become habituated to very low haemoglobin levels that would have rendered other people unconscious.

12. As a result Mrs Nikolaevsky was referred to St Vincent's Hospital where she was admitted for a blood transfusion and was prescribed Provera and Cyclokapron (tranexamic acid). Provera is a medication given to women to re-establish a regular menstrual cycle and Cyclokapron is an antifibrinolytic agent, a medication used to treat excessive blood loss. Given her long term history of heavy menstrual bleeding and anaemia, Mrs Nikolaevsky was also referred to see a gynaecologist but for unknown reasons she had not yet attended an appointment by the time of her next presentation at hospital.

13. In mid-June 2017 Mrs Nikolaevsky began to feel lightheaded and her lips were going off colour. She went to the Emergency Department at St Vincent's and was readmitted with menorrhagia (abnormally heavy and prolonged menstrual bleeding). Her haemoglobin level was at Hb36, still extremely low.

14. Dr Surya Krishnan, consultant obstetrician and gynaecologist, received a telephone call from the gynaecology surgical fellow at St Vincent's to discuss Mrs Nikolaevsky's presentation. Dr Krishnan recommended a blood transfusion and treatment with Provera and Cyclokapron. Mrs Nikolaevsky received 3 units of blood and an iron infusion.

15. During this admission Mrs Nikolaevsky was recorded as having a 22-week, bulky, tender uterus. Mrs Nikolaevsky was not pregnant; the reference to a "22 week" uterus is a way of measuring the size of a uterus by comparison to a woman carrying a 22-week foetus.

16. Mrs Nikolaevsky was referred for a consultation with Dr Krishnan after discharge from hospital. He made arrangements to see her in his rooms for an urgent appointment. The appointment was late in the day so that there would be no time pressure to get through the consultation quickly.

17. As at this consultation on 23 June 2017 Mrs Nikolaevsky was still on Provera and Cyclokapron as prescribed at St Vincent's Hospital the previous week. She told Dr Krishnan she had seen many other gynaecologists in the past who had recommended a hysterectomy, but Mrs Nikolaevsky wished to pursue IVF treatment.

18. Dr Krishnan reviewed her and noted a very large 24-week size uterus that was palpable. He gave evidence that he told Mrs Nikolaevsky that given her age and history he did not believe IVF would be successful and strongly recommended a hysterectomy to treat the chronic menorrhagia and anaemia. He says that Mrs Nikolaevsky was not happy with this medical advice but agreed to proceed with a hysteroscopy to exclude malignancy as a cause for her heavy bleeding. Dr Krishnan gave further evidence that this was to be the first investigatory step and he anticipated then having later robust discussions with Mrs Nikolaevsky about treatment options once a malignancy had been excluded.

The procedure at Prince of Wales Private Hospital

19. On Monday 3 July 2017 Mrs Nikolaevsky was admitted to the Prince of Wales Private Hospital for her elective hysteroscopy procedure. By this time she had ceased the Provera and Cyclokapron prescribed during the June attendance at St Vincent's Hospital.

20. Dr Krishnan anticipated the hysteroscopy would be a relatively short procedure performed as day surgery. Unfortunately, unexpected complications led to Mrs Nikolaevsky having to be admitted into the hospital in circumstances set out below. For this reason, Dr Krishnan did not prescribe Clexane (an anti-coagulant) prior to the procedure.

21. Dr Krishnan performed the hysteroscopy with Mrs Nikolaevsky under general anaesthetic. He described in evidence that during the procedure torrential bleeding occurred, "an explosion of blood". Dr Krishnan had never experienced anything like it before; the blood hit him in his chest forcing him to briefly move back from the surgical field. Dr Krishnan trialled different intrauterine balloons to try and stem the bleeding. Eventually two intrauterine balloons were inserted and expanded to stop the bleeding. Mrs Nikolaevsky was administered tranexamic acid intravenously and an urgent request was made for packed cells from the blood bank.

22. The procedure had taken longer than expected and Dr Krishnan remained with Mrs Nikolaevsky for an additional hour whilst she was in recovery to ensure the bleeding did not recur.

23. As a result of these unanticipated developments Mrs Nikolaevsky needed to remain in hospital.

24. Dr Krishnan ordered an ultrasound pelvic and CT abdo/pelvis be performed the next day to ensure that the intrauterine balloons had not perforated the uterus (ultimately only the transabdominal scan was performed because the presence of two transvaginal intrauterine balloons precluded using the vaginal probe).

25. Dr Krishnan had a discussion with Mrs Nikolaevsky and Mr Nikolaevsky and warned them that if bleeding reoccurred overnight Mrs Nikolaevsky would likely need a hysterectomy as a lifesaving procedure.

26. The histopathology from the curette ultimately demonstrated chronic endometritis in a progesterone affected endometrium with breakdown and a possible endometrial polyp with abundant blood clots. There was no malignancy.

27. On Tuesday 4 July 2017 Dr Krishnan again discussed the matter with Mrs Nikolaevsky. She had been successfully transfused overnight and was haemodynamically stable when seen on ward rounds. Dr Krishnan told her that the bleeding during her hysteroscopy was like nothing he had seen before and that he hoped to remove the intrauterine balloons on 5 July 2017. He says he again told Mrs Nikolaevsky that a hysterectomy would be necessary one day and that he didn't think IVF would work for them. Dr Krishnan says Mrs Nikolaevsky wanted a second opinion from Dr Jenny Cook. This was arranged for Thursday 6 July 2017 but sadly Mrs Nikolaevsky collapsed before this review could take place.

28. On Tuesday 4 July 2017 Dr Krishnan also prescribed continuous calf compressors with TEDS stockings and Clexane at the rate of 20mg/day.

29. As referred to above, Clexane is an anticoagulant. It deactivates a protein the body uses to form clots. It can be prescribed at a therapeutic rate for the treatment of thrombosis and can also be prescribed as a prophylactic to try and prevent clots developing.

30. These measures were considered important in Mrs Nikolaevsky's case for reasons including the extent of her bleeding, and the fact that she had the transvaginal intrauterine balloons in place and was going to be largely confined to bed whilst on the ward.

31. In his oral evidence Dr Krishnan said that he had taken some time to think about the level of prescribing of the Clexane. He was conscious that the bleeding was still fresh and whilst he would normally prescribe a prophylactic dose of 40mg, he determined to trial a 20mg dose in the circumstances of this case.

32. Dr Krishnan further ordered the antifibrinolytic tranexamic acid be administered. As referred to earlier, Mrs Nikolaevsky had already received tranexamic acid intraoperatively on 3 July 2017 with two further oral doses of 100mg ultimately administered on the ward on 4 July 2017 (at 1600 and 2200).

33. Dr Krishnan asked for the results of the CT abdo and pelvis be sent to his office when available.

34. Amongst other things the CT report referred to the presence of the transvaginal intrauterine balloon catheters and a urethral bladder catheter, a bulky and anteverted uterus and no evidence of extravasation of fluid in the subserosal region nor any pelvic fluid seen to suggest uterine rupture. There was no acute arterial or venous bleed demonstrated and no haematoma demonstrated.

35. Although not referred to in the radiologist report, Dr Krishnan understands he was also informed there was compression of Mrs Nikolaevsky's common iliac vein. This is referred to in a letter from Dr Krishnan to Mrs Nikolaevsky's GP on 13 July 2017 and Dr Krishnan believes it is information that must have been provided in a discussion he had with the reporting radiologist.

36. Mrs Nikolaevsky remained in hospital for a second night with plans to attempt to remove the transvaginal intrauterine balloons on Wednesday 5 July 2017.

37. There was a development on Wednesday morning. A nursing entry in the progress notes at 0500 summarising events overnight recorded "Pain 7/10 but comfortable Pt states." An addition to that progress note observes "patient has calf compressors in situ overnight." There was no complaint from Mrs Nikolaevsky or observation by nursing staff of any swelling, hardness or tenderness in her leg at this point.

38. A nursing entry in the progress notes at about 0800 referred to Mrs Nikolaevsky having asked if her calf compressors could be removed. Nurses at this time noted that her left leg was very swollen and hard and tender to touch calf and thigh. The right thigh was not swollen.

39. Nursing staff immediately contacted Dr Krishnan and he ordered an urgent Venous Doppler Ultrasound (VDU). The concern was that the left leg symptoms were due to a deep venous thrombosis or blood clot having formed in one of the deep veins of the leg.

40. The Urgent Inpatient Medical Imaging Referral completed on behalf of Dr Krishnan included an entry in the clinical note section reading "Left lower limb Doppler required for swelling."

41. Whilst waiting for the VDU to be performed, Dr Krishnan ceased the tranexamic acid due to concerns about a possible DVT and spoke to the anaesthetist about potential review and management by a vascular surgeon prior to attempting to remove the balloons.

42. The VDU was performed that morning. The sonographer's worksheet included a comment "No evidence of DVT seen in L leg, all veins patent and comprehensive."

43. Dr Victor Mansberg, supervising and reporting radiologist, reviewed the digital images and the sonographer's worksheet and dictated a report to Dr Krishnan. He observed all the deep veins were clear and patent, the long and short saphenous veins were also clear and patent. No evidence of a Baker's cyst. No evidence of deep venous thrombosis or superficial thrombophlebitis.

44. Dr Mansberg did not see and was not asked to assess the patient, did not have access to patient records (or if he had access to the imaging records from 5 July 2017 nothing in the VDU imaging or sonographer worksheets he reviewed triggered any need for him to look for prior imaging) and was not aware of the nature of Mrs Nikolaevsky's treatment nor current condition.

45. Dr Krishnan was reassured by the results of the VDU that revealed no DVT in the left leg. He gave evidence that he ascribed the source of Mrs Nikolaevsky's swollen leg to the compressed common iliac vein that had been seen on the CT on 4 July 2017. He was of the opinion that the compression was due to the size and location of Mrs Nikolaevsky's 24-week uterus following the manipulation of her uterus during the hysteroscopy. For instance Dr Krishnan referred to having

to manipulate Mrs Nikolaevsky's uterus and physically using his thumb to stem the bleeding whilst calling help into theatre, and that that type of manipulation can contribute to movement of the position of the uterus.

46. Dr Krishnan gave evidence that common iliac vein thrombosis is so unexpected, and such a rare occurrence for an Obstetrician and Gynaecologist to encounter that he did not consider that Mrs Nikolaevsky might have a left common iliac vein thrombosis.

47. Once Dr Krishnan received the negative VDU result, he determined to go ahead with the procedure to remove the intrauterine balloons. He discussed the gravity of the situation with Mrs Nikolaevsky and Mr Nikolaevsky in advance. He told them that if the bleeding reoccurred, he might need to re-instate the balloons or consider uterine artery embolization or a hysterectomy.

48. The balloons were however successfully removed. Whilst there was an immediate bleed this was thought to be consistent with old blood and no balloon needed to be reinserted. Once again Dr Krishnan accompanied Mrs Nikolaevsky in recovery before it was considered appropriate and safe for her to be returned to the ward.

49. Having been ceased earlier in the day, tranexamic acid was prescribed intraoperatively and was administered orally at 2400 and the next morning at 0800. Ongoing Clexane and calf compressors continued.

50. The plan was for discharge the next day being Thursday 6 July 2017.

51. Sometime between 9 and 10am on 6 July as Mrs Nikolaevsky was getting ready for Mr Nikolaevsky to come and take her home, she was assisted back to her bed after a wash. She complained of feeling awful and hot and said she couldn't breathe. She was seen by nursing staff to look grey, to be sweaty and cold. Mrs Nikolaevsky collapsed on the ward. A MET call was made, CPR commenced, and she was placed on extracorporeal membrane oxygenation (ECMO). Mrs Nikolaevsky was taken to the cath lab where a massive bilateral pulmonary embolism was confirmed. This meant that despite CPR and ECMO there had been no effective blood flow and hence catastrophic organ damage.

52. Mrs Nikolaevsky moved to the Intensive Care Unit and sustained another massive per vaginum bleed whilst there.

53. Mr Nikolaevsky and Mrs Nikolaevsky's family were informed that she would not recover.

54. The hospital ceased life-support and Mrs Nikolaevsky was pronounced deceased on Friday 7 July 2017.

55. Mrs Nikolaevsky's death was reported to the coroner as an unexpected death. The forensic pathologist determined from the hospital medical records and available scans that the cause of death was a pulmonary embolism following hysteroscopy and uterine biopsy. A coroner's death certificate was issued, and no autopsy was conducted. I accept the evidence of Associate Professor Paul Myers that even if an autopsy had been performed, it might not have revealed the site at which the embolism formed.

56. Mrs Nikolaevsky's family requested the coroner to investigate the circumstances surrounding her death.

57. Independent medical reviews of her care and treatment were conducted by the following experts:

    - Associate Professor Paul Myers, Vascular Surgeon
    - Professor Kenneth Thomson, Diagnostic and Interventional Radiologist
    - Professor Andrew Korda, Conjoint Professor of Obstetrics and Gynaecology

58. Dr Krishnan arranged for an expert review of his care and treatment of Mrs Nikolaevsky by Dr Robert Ford, Obstetrician and Gynaecologist.

59. Dr Mansberg arranged for an expert review of his interpretation of the VDU of 5 July 2017 by Dr Michael Jones, Specialist Radiologist.

60. All of the five experts reviewed Mrs Nikolaevsky's clinical notes and had available to them the relevant scans and ultrasounds. They all appeared in the inquest and provided opinions in

relation to the matters within their expertise on issues that they considered were relevant to Mrs Nikolaevsky's care and treatment.

61. I will now turn to the issues that were considered significant in her care and treatment.

On the material known to the treating team at the time, should the Venous Doppler Ultrasound that was performed on 5 July 2017 have extended above the inguinal ligament at the groin?

62. The failure to consider the possibility of a Left Common Iliac Vein thrombosis above the thigh was criticised by Associate Professor Myers, Vascular Surgeon and by Professor Thompson, Diagnostic and Interventional Radiologist. They emphasised that the acute onset of the swelling, hardness and pain in her leg (despite the fact the uterus had been enlarged for at least the preceding weeks), the fact that only one leg was affected and the absence of a DVT on the VDU suggested that the most likely cause of the left leg symptoms was a thrombosis somewhere above the thigh. They considered that a VDU should have interrogated above the inguinal ligament at the groin.

63. Dr Krishnan stated that a common iliac vein thrombosis is so unexpected, and such a rare occurrence for an Obstetrician and Gynaecologist to encounter that he did not consider it. He said that the swollen left leg was readily accounted for by uterine pressure on the iliac vein that had been observed in the CT on 4 July. He was aware that he had manipulated the uterus during the hysteroscopy procedure, and he was aware that the uterus was very large. He had seen pregnant women during his professional career with only one leg affected by swelling as a result of a large uterus compressing either the left common iliac vein or right common iliac vein.

64. Professor Korda and Dr Ford both agreed with Dr Krishnan. They both stated that they had never seen a thrombus in the common iliac vein in their long professional lives. They agreed with Dr Krishnan that they had observed unilateral leg swelling in pregnant women as a result of compression from a large uterus. They agreed that the circumstances of Mrs Nikolaevsky's case were truly rare. They were not critical of the opinion of Dr Krishnan that the swollen left leg was attributable to the compression of the common iliac vein. From their perspective as gynaecologists, they were not critical that a VDU was not performed above the inguinal ligament at the groin.

65. Turning then to the perspective of Associate Professor Myers (vascular surgeon), Professor Thomson (interventional radiologist) and Dr Jones (radiologist).

66. The criticism and opinion of Associate Professor Myers and Professor Thomson that the VDU should have extended above the inguinal ligament must be seen in the context that a VDU whilst the "gold standard" investigatory technique to look for thrombosis in the deep veins of the legs, is not necessarily as accurate when interrogating above the inguinal ligament. Professor Thompson gave evidence that it can be very difficult to examine in the setting presented, in particular where there was a large uterus present. Further one would need to allow for the presence of the bowel together with gas and for the fact that Mrs Nikolaevsky was overweight. Associate Professor Myers agreed with the potential difficulties in this setting. Dr Jones also agreed with the potential difficulties and stated that the further examination would not have occurred in general radiology practice, as here.

67. Notwithstanding this, Associate Professor Myers and Professor Thomson each would expect that in a similar situation the VDU would extend above the inguinal ligament because the left leg symptoms were not explained by the VDU of the left leg. They each expected that a vascular sonographer (in the case of Associate Professor Myers) or a sonographer working with an interventional radiologist (in the case of Professor Thomson) would speak to the consultant in circumstances where there was no explanation for the symptoms below the inguinal ligaments. As Associate Professor Myers said if the imaging doesn't look above the inguinal ligament it won't find anything above the inguinal ligament.

68. Dr Jones took a different approach and said that in general radiology and in the circumstances of what Dr Mansberg knew, it was understandable that the VDU did not extend above the inguinal ligament.

69. I accept that the swollen left leg might have been the result of <u>both</u> the uterus compressing on the common left iliac vein and a thrombosis above the inguinal ligament.

70. Acknowledging the invidious situation confronting Dr Krishnan, Associate Professor Myers went on to say that even if a thrombus was detected, Mrs Nikolaevsky would have been in a very serious and critical situation and any treatment would have been difficult.

71. In the difficult circumstances of this case I accept that the failure to extend the VDU interrogation above the inguinal ligament at the groin was not unreasonable.

What was the most likely source of the pulmonary embolism leading to death?

72. Associate Professor Myers and Professor Thomson are of the opinion that a thrombus in the iliac vein would have been the most likely source of Mrs Nikolaevsky's pulmonary embolism. They each rely upon the onset of the left leg symptoms (not just the swelling but also the pain and tenderness), the negative result from the VDU and the subsequent discovery of a pulmonary embolism.

73. Associate Professor Myers suspects that Mrs Nikolaevsky was already forming a clot, possibly in the external iliac vein on 4 July 2017 and that on the night of 5 July 2017, it clotted in the common iliac vein which caused the swelling symptoms.

74. Both Associate Professor Myers and Professor Thomson accept however, that the precise source of the embolism cannot now be accurately determined.

75. In my view, it is not necessary for me to make a finding as to the source of the pulmonary embolism. All of the experts agree that Mrs Nikolaevsky's case was a rare and difficult presentation. All of the experts agree that we will never be 100% sure of the source of the pulmonary embolism.

Should Mrs Nikolaevsky have received the Clexane doses as prescribed?

76. As outlined earlier, Dr Krishnan gave evidence that he took some time to consider the appropriateness of prescribing Clexane. His concern was the heavy bleeding. He was concerned that Clexane might increase the risk of further bleeding. As a result he prescribed 20 mg rather than the usual 40 mg as a prophylactic dose.

77. Associate Professor Myers stated that 20 mg was unlikely to be effective and said that if prescribing at that dose, there was probably no point in prescribing Clexane at all. That said,

Associate Professor Myers also fairly acknowledged that Dr Krishnan was "between the devil and the deep blue sea" and that he (Associate Professor Myers) was speaking from his perspective as a vascular surgeon.

78. Both Professor Korda and Dr Ford also gave evidence that Dr Krishnan had a difficult problem to navigate. He was faced with the extraordinary situation of heavy bleeding during the hysteroscopy, chronically very low haemoglobin levels and the presence of a very large uterus, all to be balanced against the risk of clotting. They both assessed that from the perspective of a treating gynaecologist, Dr Krishnan's judgement to prescribe 20 mg was a reasonable compromise.

79. In my opinion the decision to prescribe Mrs Nikolaevsky with 20 mg Clexane was reasonable in the circumstances known at the time.

The appropriateness of the prescribing of Cyclokapron (tranexamic acid).

80. Associate Professor Myers did not support the use of tranexamic acid because he said it would increase the risk of a DVT, albeit not by a large amount (there being insufficient studies of sufficient numbers and statistical power to enable the risk to be quantified) Associate Professor Myers also observed that given his vascular speciality he may be specifically attuned to the risk of tranexamic acid to an extent not shared by the gynaecological specialty.

81. Dr Krishnan and Professor Korda and Dr Ford gave evidence that tranexamic acid is a standard medication administered together with progesterone to stop heavy menstrual bleeding. Contrary to Associate Professor Myers, they were of the opinion that there was no association between the use of tranexamic acid and the experience of thrombosis.

82. Dr Krishnan said that the drug had been used for some decades to good effect.

83. In the circumstances of this case, I make no criticism of Dr Krishnan's attempt to treat Mrs Nikolaevsky with Cyclokapron (tranexamic acid).

Are recommendations necessary?

84. Mrs Nikolaevsky gave much joy and happiness to her family. They spoke lovingly about their wife, daughter and sister at the close of the evidence. To them, she was unique and irreplaceable, and it is very important that her untimely death should not be in vain.

85. I hope that her family understand that their legitimate concerns have been taken seriously by everyone involved in the Inquest.

86. It is true that the unusual circumstances of Mrs Nikolaevsky's death provide an opportunity to consider the desirability of treatment protocols to guide further similar cases, including around the use of tranexamic acid and VDU extending above the inguinal ligament.

87. Balanced against this is the fact that the gynaecologists here were unanimous in describing how rare these types of presentations are. This is not to say that Mrs Nikolaevsky's case was unprecedented, but it was certainly rare.

88. Long experience in this jurisdiction, plus the specific evidence of Professor Korda and Dr Ford in this case, cautions against making general recommendations about practice, procedure and treatment protocols based upon the outcome of rare cases. I am mindful that any recommendation the Court made would be made without notice of competing priorities for training and research in the relevant specialties.

89. This does not mean that the inquest into Mrs Nikolaevsky's death has not been important. To the contrary, this in-depth analysis of the manner and cause of her death has clearly prompted careful consideration by the practitioners involved in her treatment and has allowed the Court to understand the complexities her case presented, notwithstanding the fact that I will not make any recommendations.

Conclusion

90. I would like to acknowledge and express my thanks to the officer in charge, Senior Constable Barry for his thorough investigation of this matter.

91. I also thank my counsel assisting, Ms Donna Ward and her instructing solicitor, Ms Clara Potocki for the work they put into assisting me in this inquest.

92. I extend my sympathies to all of Mrs Nikolaevsky's family.

Findings pursuant to section 81(1) Coroner's Act 2009

The identity of the deceased

The deceased person was Makushla Nikolaevsky

Date of death

Ms Nikolaevsky died on 7 July 2017

Place of death

Ms Nikolaevsky died at Prince of Wales Private Hospital, Randwick, NSW

Cause of death

The cause of her death was pulmonary embolism

Manner of death

The manner of her death was as a result of natural disease process in hospital following a hysteroscopy

93. I close this inquest.

Carmel Forbes

Deputy State Coroner

NSW State Coroner's Court, Lidcombe

Date: 27 November 2020