IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4738

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*
*Section 67 of the **Coroners Act 2008***

**Inquest into the Death of: DELTA DIAWO POKE**

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| Hearing Dates: | 1,2,3,4 and 5 September 2014, 8 September 2014 and 19 November 2014 |
| Appearances: | Mr Paul Halley of Counsel on behalf of Dr McAllister<br>Mr Sean Cash of Counsel on behalf of Dr Schulberg<br>Mr Michael Regos on behalf of Marie Stopes International |
| Police Coronial Support Unit: | Leading Senior Constable Tania Cristiano, Assisting the Coroner |
| Findings of: | AUDREY JAMIESON, CORONER |
| Delivered on: | 26 May 2016 |
| Delivered At: | Coroners Court of Victoria<br>65 Kavanagh Street<br>Southbank 3060 |

I, AUDREY JAMIESON, Coroner having investigated the death of DELTA DIAWO POKE

AND having held an inquest in relation to this death on 1,2,3,4 and 5 September 2014, 8 September 2014 and 19 November 2014

at Southbank
find that the identity of the deceased was DELTA DIAWO POKE
born on 30 November 1969
and the death occurred on 18 December 2011
at Eastern Health – Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria 3128
**from:**

1 (a) GLOBAL CEREBRAL ISCHAEMIA IN A SETTING OF ANAESTHESIA

**in the following summary of circumstances:**

1. Delta Diawo Poke suffered a cardiac arrest in the operating theatre while under anaesthesia for a late term termination of pregnancy. After sustained cardio-pulmonary resuscitation, she had the return of cardiac output. She was transferred to the Box Hill Hospital for management but had suffered global cerebral ischaemia from which she died four days later.

## BACKGROUND CIRCUMSTANCES

2. Delta Poke[1] was 42 years of age at the time of her death. She was a native of Papua New Guinea, temporarily living in Australia as an international student. She was married to Stanley Poke and they had four children, aged between eight and 22 years. From what has been able to be ascertained, Delta had normal births of all her children, save for her third child who was born premature at 26 – 27 weeks.
3. Delta was not known to smoke or use any form of illegal substance or drink alcohol. While she had undergone a cholecystectomy in August 2011, she otherwise appeared to be in good health. Her only prescribed medication was Depo-Provera®.[2]
4. On 9 December 2011, Delta attended general medical practitioner, Dr Salter at the Millennium

[1] During the course of the Inquest Delta Poke was referred to as Delta. For consistency, I have, in most part, avoided formality and also referred to her only as Delta throughout the Finding.

[2] Depo-Provera® is a hormone used for contraception; given by injection. Its effects last for three months at a time.

Medical Centre in Footscray. An ultrasound scan revealed her to be at 21 weeks gestation. Following the appointment at Millennium Centre, she went to the Melbourne Clinic for a termination. She was referred to the Croydon Day Surgery Centre (**the Centre**)[3], the only centre of its kind in Melbourne that performs late gestation terminations.

**SURROUNDING CIRCUMSTANCES**

5. On 9 December 2011, Delta attended the Centre located at 411 Dorset Road, Croydon, to provide personal information and obtain her booking details which were provided by the Manager of the Centre, Wendy Turner. Delta was booked in for a three day period commencing on 12 December 2011, involving two surgical procedures for a second trimester termination (21-22 weeks pregnant).
6. On 12 December 2011, at approximately 10.00am, Delta arrived at the Centre and was allocated a room at the Lodge, the accommodation facility attached to the Centre.[4] Delta's husband attended with her.[5] Delta met and liaised with several of the staff and received counselling[6] about her forthcoming procedures. No surgical procedures or medications were administered on that day.
7. On 13 December 2011 at approximately 7.00am, Delta presented at the Centre for her first procedure involving an anaesthetic. The procedure was a manual cervical dilatation and insertion of dilators. Anaesthesia was recorded on the *Serial Dilation Record* indicating that Delta was administered propofol 150 mg, midazolam 3.5 mg, fentanyl 80 mcg as well as metoclopramide 10 mg and cephalothin 1 g. No problems or complications were noted in the medical records on this day either preoperatively, in theatre, or in recovery where Delta also received tramadol 100 mg. The *Serial Dilatation Record* for 13 December 2011 also records Delta's oxygen saturation levels while in the operating theatre and Recovery.[7]

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[3] In March 2010 Marie Stopes International agreed to purchase the Centre with handover being 2015. At the time of the agreement Dr Schulberg was the owner operator of the Centre and the only practitioner in Victoria performing late term terminations.

[4] T @ p 15.

[5] T @ pp 48-49.

[6] Exhibit 5 – Statement of Wendy Turner dated 13 April 2013.

[7] Exhibit 7 - @ p 95 Inquest brief.

8. On 14 December 2011, Delta presented to the Centre at 0715 hours[8] for the final procedure. At 0730 hours her baseline observations were recorded as BP 120/77 mmHg, HR 81 beats per minute (bpm) and temperature as 35.5°C. At 0745 hours she was administered pethidine 30 mg intravenously and 70 mg intramuscularly (total 100 mg), metoclopramide 10 mg and cephalothin 1 g. Vaginal and sublingual misoprostol were administered and a syntocinon® infusion was commenced. At 1000 hours Delta was administered further misoprostol via the buccal mucosa.

9. In the afternoon of 14 December 2011, Ms Kathleen Ambrosio, a Central Sterilising Service Division ((CSSD) technician was in the operating theatre when Delta walked in,[9] accompanied by a nurse,[10] for her final procedure. Nurse Rebecca Harrison, assisting the Anaesthetist, Dr Peter McAllister also stated that Delta "*walked into the theatre*" and was assisted onto the operating table.[11] Ms Ambrosio entered Delta's details in the "ledger". The *Operating Room Record* reflects that Delta came into the operating theatre at 1335 hours.[12] Dr Mark Schulberg was the doctor performing the procedure and Nurse Sandra Croft was assisting him.

10. Nurse Harrison placed a Hudson oxygen mask[13] onto Delta's face and connected it to the oxygen supply. She also placed a blood pressure cuff on Delta's arm and the pulse oximeter probe onto Delta's finger. Delta was awake at this stage but Nurse Harrison could not get an oxygen saturation reading. She tried to warm Delta's fingers and moved the probe to a different finger. Nurse Harrison informed Dr McAllister who had proceeded with the anaesthesia. Dr McAllister was observing Delta's chest rising and falling while Nurse Harrison continued to attempt to obtain a reading. Nurse Croft was asked by Dr McAllister to get another mobile pulse oximeter from the Recovery Room. An oxygen saturation level was still unattainable with the

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[8] For the remainder of the Finding, I have used 24 hour time for reasons of consistency and to reflect the recording of times within the medical records.

[9] Wendy Turner stated that she had seen Delta "get onto a trolley to go into theatre" – Exhibit 5 – Statement of Wendy Turner dated 13 April 2013.

[10] Exhibit 1 – Statement of Kathleen Ambrosio dated 2 April 2013.

[11] Exhibit 8 – Statement of Rebecca Harrison dated 16 May 2013, T @ p 62.

[12] Exhibit 7 - @ p 93 Inquest Brief, T @ p 17.

[13] "The Hudson mask is for breathing spontaneously and at maximum can only ever deliver 60% oxygen" – T @ p 406 (Dr Falcone).

replacement machine. Dr McAllister positioned a guedel[14] airway into Delta's mouth to maintain her airway.[15] Nurse Harrison was getting anxious about Delta's breathing and worried that the pulse oximeter was not working.[16] Dr McAllister was unable to palpate a carotid pulse. No cardiac monitor was available in the operating theatre, therefore Delta's cardiac rhythm at that time was unknown.[17]

11. The *Operating Room Record* reflects that Delta's anaesthesia on this day involved propofol 100 mcg and 50 mg, fentanyl 100mcg and midazolam 5 mg. There are no times recorded indicating when these drugs were administered. Oxygen saturation levels were noted as difficult. Vital observations taken at 1335 hours and 1340 hours did not include oxygen saturation levels but she was noted to be pink and breathing.[18] There is no recording of the type of airway that Delta had or of the administration of oxygen.[19]

12. According to notes on the medical file, Delta suffered a cardiac arrest at 1340 hours. Staff commenced cardio-pulmonary resuscitation (CPR) and Emergency Services were contacted by Nurse Sharan Shahin.[20] Ms Ambrosio retrieved the "Crash Cart"[21] from Recovery. Ventilation of Delta was initially via a bag and mask and subsequently via endotracheal intubation which was achieved at 1352 hours. Three doses of adrenalin 0.5 mg were administered. Members of the Metropolitan Fire Brigade (MFB) and Ambulance Paramedics arrived at the Centre at 1358 hours and took over the management of the arrest.

13. Delta was subsequently transferred by ambulance to Box Hill Hospital (BHH). Dr McAllister

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[14] Guedel airway – also known as an oropharyngeal airway lifts the tongue off the posterior pharyngeal wall to prevent airway obstruction, prevents biting of the tongue, assists in oropharyngeal suctioning and promotes moulding of the face of a mask for manual ventilation.

[15] Exhibit 8 – Statement of Rebecca Harrison dated 16 May 2013.

[16] T @ p 79.

[17] T @ p 76.

[18] Confounding the facts of what and when Delta was administered the drugs for anaesthesia and the extent of her clinical state at the time there were two anaesthetic records –"one of them has no mention of the medications, the second one has the medications that were used and (sic) slightly more information but this as an anaesthetic record is deficient, it's not adequate." – T @ p 415 (Dr Falcone).

[19] T @ p 415.

[20] Exhibit 3 – Statement of Sharan Shahin dated 24 may 2013.

[21] A trolley equipped with resuscitation equipment and includes a defibrillator.

offered to accompany paramedics to Box Hill Hospital (BHH) to provide a clinical handover but this offer was declined. He provided paramedics with a transfer letter for the hospital which included information that Delta's 'downtime' was greater than 10 minutes.

14. Delta was subsequently admitted to the Intensive Care Unit (ICU) at BHH where she remained throughout her admission, until her death. Her admission diagnosis was attributed to severe hypoxic brain injury following out-of-hospital cardiac arrest. Delta was treated with therapeutic cooling, anti-convulsant therapy and received aggressive hemodynamic and respiratory support. Delta, however, failed to make any improvement and showed no neurological response. A computed tomography (CT) scan of her brain showed diffuse cerebral oedema and other changes consistent with severe hypoxic brain injury.
15. By 18 December 2011, Delta's condition had progressed to brain death. Her life support machines were turned off that day. Delta's time of death is recorded as occurring at 1135 hours.

**JURISDICTION**

16. Delta's death was determined to be a reportable death under section 4 of the *Coroners Act 2008*, because it occurred in Victoria, was unexpected and occurred following a medical procedure where the death was causally related to the medical procedure and death was not, immediately before the procedure was undertaken, reasonably expected.
17. The e-Medical Deposition Form completed by Dr Andrew Iliov HMO3 at BHH, ascribed the possible cause of death to *hypoxic brain injury following cardiac arrest leading to clinical brain death*. Dr Iliov also indicated within the form that the issues to be addressed by the forensic pathologist were *sequelae of events at Croydon Day Surgery Centre leading to cardiac arrest following her termination of pregnancy.*

**PURPOSE OF THE CORONIAL INVESTIGATION**

18. The Coroners Court of Victoria is an inquisitorial jurisdiction.[22] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[23] The cause of death refers to the medical cause of death, incorporating where

[22] Section 89(4) *Coroners Act 2008*.
[23] Section 67(1) of the *Coroners Act 2008*.

possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[24]

19. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[25] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[26] These are effectively the vehicles by which the prevention role may be advanced.[27]
20. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.
21. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.
22. Delta's identity was not in dispute, she was not a person placed in "*custody or care*" as defined by section 3 of the Act and her death was not considered to be a homicide. Therefore, it was not mandatory to conduct an inquest into the circumstances of her death. However, I exercised my discretion, pursuant to section 52(1) of the Act, to hold an inquest because I had identified matters of public health and safety that required further investigation.

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[24] This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[25] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, in contrast to the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[26] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[27] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

23. This finding draws on the totality of the material; the product of the coronial investigation of Delta's death. That is, the court records maintained during the coronial investigation, the Inquest brief and the evidence obtained at the Inquest, including submissions of legal counsel.

24. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

## STANDARD OF PROOF

25. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[28] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
    - the nature and consequence of the facts to be proved;
    - the seriousness of an allegation made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

26. The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

## FORENSIC INVESTIGATION

### Identification

27. A Statement of Identification was completed by Stanley Poke at Box Hill Hospital on 18 December 2011.

28. Delta's identity was not in dispute and required no further investigation.

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[28] (1938) 60 CLR 336.

**Medical cause of death**

Autopsy

29. On 21 December 2011, Dr Sarah Parsons (**Dr Parsons**), Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy on the body of Delta. Anatomical findings included global cerebral ischaemia, metastatic papillary carcinoma of the thyroid and placenta increta. Dr Parsons reported[29] that the cause of Delta's death was global cerebral ischaemia however because she had been unable to identify the cause of the global cerebral ischaemia through a full post mortem examination and ancillary tests, she ascribed the cause of death to unascertained. In addition, Dr Parsons stated that the cause of Delta's initial cardiac arrest had not been able to be determined at autopsy; there was no evidence of significant blood loss or of any evidence of amniotic fluid embolus and although there was evidence of placenta increta and retained products of conception, she stated that these were unlikely to have caused Delta's arrest.
30. In a supplementary report,[30] Dr Parsons explained that global cerebral ischaemia occurs when there is a lack of blood to the brain for any reason. However, no structural or pathological reason for the lack of blood flow to the brain had been identified through the full post mortem examination. In response to specific questions asked of Dr Parsons, she reported that she could not comment on whether Delta's death was avoidable or whether the lack of use of a pulse oximeter contributed to or increased the risk of global cerebral ischaemia. Dr Parsons also stated that the identification of a metastatic thyroid carcinoma was an incidental finding only and had not contributed to Delta's death.

Neuropathology examination

31. A neuropathological examination of Delta's brain was performed by Dr Linda Iles, Forensic pathologist at the VIFM. The findings of Dr Iles' examination were consistent with global cerebral ischaemic injury.

Toxicological analysis

32. Toxicological analysis of an ante mortem blood sample taken from Delta on 14 December 2011 identified a range of drugs consistent with being administered by emergency/hospital staff.

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[29] Exhibit 32 – Medical Examiner's Report – Dr Sarah Parsons dated 7 June 2012.

[30] Exhibit 33 – Supplementary report of Dr Sarah Parsons dated 24 January 2014.

Independent Expert opinion

33. Dr Ginette Falcone, Consultant Anaesthetist at the Royal Women's Hospital provided an independent expert opinion report to the Court dated 7 January 2014. *Inter alia*, Dr Falcone opined that the General Practitioner anaesthetist Dr McAllister:

a) did not act in accordance with the Professional Standards as enunciated by the Australian and New Zealand College of Anaesthetists (ANZCA). Anaesthesia was induced without mandatory monitoring of oxygen saturation levels. The anaesthetic record was deficient in documentation of medications, monitoring and airway device used.

b) The anaesthetic medications administered can cause significant hypoventilation (low respiratory rate) or apnoea (not breathing) leading to hypoxaemia.[31]

c) The anaesthetic record is very poorly documented and as this is the only testament (apart from witness statements after the fact) it is difficult to ascertain the sequence of events during the administration of the anaesthetic.

d) To embark on an anaesthetic without adequate monitoring (pulse oximeter, capnography[32]) negates patient safety. These cases are elective or semi-elective and the anaesthetic should not commence until adequate monitoring is established.

e) The lack of monitoring with continuous pulse oximetry, pulse rate and capnography ensured that deterioration in her physiological markers went undetected until she arrested and hypoxic brain damaged occurred.[33]

## Inquest brief

34. Detective Leading Senior Constable Simonne Corin (**DLSC Corin**) was nominated to be the coroner's investigator[34] and she prepared the Inquest brief.

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[31] Dr Falcone amended her report at the time of giving her *viva voce* evidence – the "cyanosis" was used in her Report but amended to "hypoxaemia" prior to confirming the contents to be true and correct.

[32] Capnography measures exhaled carbon dioxide, indicative of adequate ventilation.

[33] Exhibit 34 – Independent expert report of Dr Ginette Falcone dated 7 January 2014.

[34] A coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner. LSC O'Sullivan commenced as the coroner's investigator on 21 December 2010, after it was determined that another police member had a personal conflict and could not act as coroner's investigator.

35. The Inquest brief included a statement[35] by Dr David Charlesworth, Director of Intensive Care at Eastern Health, dated 10 October 2011. Within the body of his statement, Dr Charlesworth made reference to a previous case that he had managed, involving patient 'S'; a 40 year old who was at 23 weeks gestation, who presented critically unwell at BHH following a termination procedure at the Centre. Dr Charlesworth stated that his concerns regarding the management of this patient at the Centre were such that he made a notification to the Australian Health Practitioner Regulation Agency and contacted the Department of Health[36], and that the notification included his concerns about Dr Shulberg's management of patient 'S'. In particular, Dr Charlesworth stated that his concern related to a common theme of poor monitoring, applicable to the circumstances of both patient 'S' and Delta. Dr Charlesworth stated *"this in particular relates to the monitoring during surgical procedures at the Croydon Day Clinic. Of equal concern is the risk and incident assessment framework for this facility."*

**THE INQUEST**

**Direction Hearings**

36. On 25 November 2013, I conducted a Directions Hearing.

37. On 25 March 2014, I conducted a Directions Hearing wherein, *inter alia*, the Australian Health Practitioners Agency (**AHPRA**) provided me with documents in response to a Form 4 pursuant to section 42 of the Act (Form 4) signed by me on 8 November 2013 and a Form 4 signed by me on 18 March 2014.

38. On 10 April 2014, I conducted a Directions Hearing to hear submissions from interested parties in relation to the documents provided to me by AHPRA pursuant to both Form 4 requests. The interested parties present at the Directions Hearing were:

- AHPRA, represented by Ms Sara Hinchey of Counsel (as she then was);
- Dr McAllister and Dr Schulberg, represented by Mr Tim McEvoy of Counsel; and
- Marie Stopes International Australia, represented by Mr Michael Regos, partner of DLA Piper Australia.

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[35] Inquest brief @ p 45, Exhibit 29 – Statement of David Charlesworth dated 18 December 2011.

[36] The Department of Health is now known as the Department of Health and Human Services.

- Leading Senior Constable (**LSC**) Tania Cristiano of the Police Coronial Support Unit was Counsel Assisting.

39. On 11 April 2014 I handed down my "Ruling on Applications under the *Coroners Act 2008.*" The Ruling is published on the Court's website.

40. On 11 August 2014 an Application was made by Counsel on behalf of Dr McAllister to recuse myself. Mr Tim McEvoy of Counsel appeared on behalf of Dr McAllister and Dr Schulberg. Mr Guy Gilbert of Counsel appeared as Counsel Assisting.

41. On 14 August 2014, I handed down my "Ruling on Application by interested parties for Coroner to recuse herself." The application was refused and I stated in the Ruling that I would remain the investigating Coroner in relation to the death of Delta Poke. The interested parties indicated that they would not appeal my Ruling to the Supreme Court. The Ruling is published on the Court's website.

**Evidence at the Inquest**

42. *Viva voce* evidence was obtained from the following witnesses at Inquest:

a) Kathleen Ambrosio – Central Sterilising Service Division (CSSD) technician

b) Sharan Shahin – Registered Division 2 Endorsed Nurse (now Endorsed Enrolled Nurse)

c) Wendy Turner – Practice Manager, Croydon Day Surgery Centre

d) Rebecca Harrison – Registered Nurse Division 1

e) Sandra Croft – Registered Nurse Division 1

f) Dr Mark Schulberg – medical practitioner/surgeon[37]

g) Simon Fraser – MICA paramedic

h) Edda Courtney – MICA paramedic

i) David Murray – Advanced Life Support (ALS) paramedic

j) Keith Willison – Senior firefighter, MFB

k) Dr Peter McAllister – GP Anaesthetist

[37] Dr Schulberg's medical registration was cancelled by the Victorian Civil and Administrative Tribunal (VCAT) on 24 May 2013 for matters unrelated to the death of Delta Poke. Consequentially his Counsel, Mr Cash referred to him as "Mr Schulberg" and not "Doctor" in the course of his *viva voce* evidence. I have referred to him as "Doctor Schulberg" throughout the Finding as he was a registered medical practitioner at the time of his involvement with Delta.

l) Maria Deveson Crabbe – Chief Executive Officer Marie Stopes International for Asia Pacific and Australia

m) Dr David Charlesworth – Executive Clinical Director, Eastern Health, Clinical Director of ICU Box Hill Hospital

n) Dr Sarah Parsons – Forensic Pathologist, VIFM

o) Dr Ginnette Falcone – Consultant Anaesthetist - Independent Expert Opinion

43. At the opening of the Inquest, Counsel Assisting indicated that the areas to be explored in the Inquest included:

- the qualifications, experience and training of both the anaesthetist and the surgeon;
- the policies and procedures at the Croydon Day Centre;
- the use and the working condition and the maintenance of the pulse oximeters;
- the care and management of Delta at the Croydon Day Surgery Centre;
- documentation and record keeping at the Croydon Day Surgery Centre; and
- the cause of death, noting that it had been ascribed to an unascertained cause by Forensic Pathologist, Dr Parsons.

**Qualifications, experience and training of Dr Schulberg and Dr McAllister**

44. Dr Schulberg held the appropriate medical qualifications to perform the surgical procedures on Delta and was recognised as the only medical practitioner in Victoria performing late term termination of pregnancy procedures. His experience in performing termination procedures commenced in the early 1990s while working in Queensland in the area of women's health. He commenced working at the Centre, of which he was owner and Director, in 1998. At the time of performing the procedures on Delta, Dr Schulberg was performing approximately 75 pregnancy termination procedures per week at the Centre, with approximately five to ten each week which would be late term terminations.[38]

45. Dr McAllister graduated as a medical practitioner in 1985 and obtained a Diploma of

[38] T @ p 173.

Anaesthetics in the United Kingdom from the College of Anaesthetists in 1991.[39] He completed his training at the Royal Australian College of General Practitioners in 1994 and was subsequently accredited by the Joint Consultative Committee of Anaesthesia (JCCA) to be a GP Anaesthetist. He was appropriately qualified with current accreditation to practice as a GP Anaesthetist at the time he administered an anaesthetic to Delta on 14 December 2011.

**Care and management of Delta at the Croydon Day Surgery Centre**

46. Delta was booked into the Centre for three days to undergo two surgical procedures[40] scheduled for 13 and 14 December 2011, for the purposes of completing a late term termination of her pregnancy.

47. The procedure undertaken on 13 December 2011 involved the administration of an anaesthetic. The Anaesthetist was Dr Colin Duncan. The medical records, including the anaesthetic record and the evidence of witnesses, support that the anaesthetic and the procedure were undertaken and completed as anticipated and without incident.[41]

48. On 14 December 2011, Dr Peter McAllister was the Anaesthetist for the Centre's surgical list. The *Register of Surgical Operations* reflects that Delta was in the operating theatre at 1328 hours. The *Recovery Room Record* reflects the time Delta came into the operating theatre to be 1335 hours. There is no record to reflect Delta's conscious state on arrival or any record of concern about her wellbeing. Nurse Harrison, assisting Dr McAllister, attached the finger probe of the pulse oximeter to Delta but was unable to obtain an oxygen saturation level. The *Operating Room Record* reflects that Delta's anaesthesia on this day involved propofol 100 mcg and 50 mg, fentanyl 100mcg and midazolam 5 mg. Oxygen saturation levels were noted as difficult. Vital observations taken at 1335 hours and 1340 hours did not include oxygen saturation levels but she was noted to be pink and breathing.

49. On 14 December 2011, when Dr Schulberg entered the operating theatre to perform the final

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[39] "Australian doctors who have undertaken anaesthesia training in the UK, including those who have a Diploma of Anaesthetics are automatically accredited by the Joint Consultative Committee of Anaesthesia (JCCA)." – Exhibit 34 - Dr Ginette Falcone dated 7 January 2014.

[40] T @ p 173.

[41] Exhibit 3 – Statement of Sharan Shahin dated 24 May 2013, Exhibit 8 – Statement of Rebecca Harrison dated 16 May 2013.

operative procedure on Delta, he had no grounds or basis on which to deviate from the schedule as he not been alerted to any issues or concerns. Delta was already in the operating theatre, had been anaesthetised and had been placed in the lithotomy position[42] in preparation for Dr Schulberg's arrival in the theatre. Dr McAllister agrees that this was likely the sequence of events[43] and according to Nurse Croft, consistent with Dr Schulberg's practice.[44] Ms Ambrosio similarly agreed that this was not unusual for Dr Schulberg to enter the theatre after the patient was anaesthetised.[45] It thus follows that Dr Schulberg was not present when Nurse Harrison first attached the finger probe of the pulse oximeter to Delta's finger when she was awake. From Dr Schulberg's own knowledge of the procedure he performed the previous day, and in the absence of any contemporaneous information either known or conveyed to him by nursing and/or other medical personnel present, Dr Schulberg commenced the final operative procedure. On 14 December 2011, the patient monitor was positioned in the theatre such that it was obscured from Dr Schulberg's direct sight while he was himself positioned to perform the procedure. As a consequence, Dr Schulberg was unable to visualise any of the patient's parameters for himself.[46] Dr McAllister concedes that he did not tell Dr Schulberg when he entered the operating theatre to commence the procedure that he had been unable to obtain an oxygen saturation level reading,[47] because he *"fully expected to (sic) get a reading in the near future"*.[48] But Dr McAllister did not obtain an oxygen saturation level reading for the duration of the procedure, which Dr Schulberg originally estimated took between 5-10 minutes[49] and later considered that *"it may have taken even less time."*[50] Dr Schulberg stated that during the procedure he heard occasional mumblings between Dr McAllister and the anaesthetic nurse, Nurse Harrison about

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[42] The lithotomy position is a supine position of the body with the legs separated, flexed and supported in raised stirrups.

[43] T @ p 299.

[44] T @ p 118.

[45] T @ p 18.

[46] T @ p 200.

[47] T @ p 299.

[48] T @ p 300.

[49] Exhibit 12 – Statement of Dr Mark Schulberg dated 2 August 2013.

[50] T @ p 144.

the pulse oximeter monitor and the patient's colour and respiration,[51] but this did not cause him any concern because it was not unusual for there to be some issue with a pulse oximeter and no one conveyed to him any concerns about the patient, Delta. Dr Schulberg stated:

> *If anything, I heard in conversation with the mumblings Peter reassuring that there was nothing to worry about. She was breathing, she was pink, all was good and clinically, it's more important to be, you know, confident about what the clinical picture is than the machines.* [52]

50. According to Dr Schulberg, he had for all intents and purposes completed the final procedure before he became aware and/or was alerted to a concern about Delta's condition. Ultimately, he conceded that it was likely to have been almost immediately before the end of the procedure when he and Dr McAllister both happened to notice, at almost the same time, something untoward with Delta.[53] Dr McAllister mentioned some difficulty obtaining a pulse while Dr Schulberg noticed that Delta's blood looked dark in colour which is an indication of de-oxygenated blood. His own entry in the Operating Room Record indicates *"Cardiac arrest with de-oxygenation during the procedure (towards the end)."*[54]

51. Dr Schulberg assisted in the resuscitation process. At no time either during or after the procedure, or during resuscitation of Delta, or after the return of cardiac output did he notice any haemorrhaging.[55]

**The use and the working condition and the maintenance of the pulse oximeters**[56]

52. Dr Schulberg stated that approximately seven – 10 days prior to 14 December 2011, a monitor from the Recovery Room had been brought into the operating theatre to replace the pulse

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[51] Exhibit 12 – Statement of Dr Mark Schulberg dated 2 August 2013, T @ p 148.

[52] T @ p 149.

[53] T @ p 159.

[54] Medical records @ p 93 Inquest Brief (Exhibit 7 comprises pp 89 – 146 Inquest Brief). (see also: Exhibit 30 – Original Medical Records).

[55] T @ pp 198-199.

[56] "The pulse oximeter is a machine that reads the patient's pulse rate and oxygen saturations. The pulse oximeter goes on the patient's finger and it is plugged into the blood pressure machine which reads on the screen the patient's blood pressure, heart rate (sic) and oxygen saturations." – Exhibit 6 – Statement of Wendy Turner dated 21 August 2014.

oximeter because it was faulty and had been sent off for repairs.[57] The monitor was not, according to Dr Schulberg, a stand-alone pulse oximeter but in addition to measuring oxygen saturation rates it also monitored blood pressure and heart rate.[58] When Dr McAllister arrived at the Centre on the morning of 14 December 2011, the machine for measuring oxygen saturation levels was different from the one that was usually on the Boyle's machine but it was not a complex machine that necessitated anything more than checking it by putting it on your own finger.[59] On 14 December 2011, this monitor had been used in the operating theatre for the 18 procedures that preceded Delta's without concern about its functioning capability.[60] According to Nurse Harrison, it was also the same machine that had been used during the operations/procedures listed on 13 December 2011[61] and it had been working without problem.[62]

53. There was no definitive evidence to support the contention/speculation that on 14 December 2011 the pulse oximeter machine in the operating theatre was faulty. No maintenance records were provided to the Court. Ms Turner stated that she recalled being requested to bring an alternative pulse oximeter from the Recovery Room into the operating theatre because doctors were having difficulty getting oxygen saturation levels from Delta but that she was not otherwise aware if there were any faulty machines or equipment around the time Delta was at the Centre[63] which she clarified in her *viva voce* evidence to mean on that day.[64]

54. Maintenance of the Centre's medical equipment was undertaken by Chemtronics Biomedical Engineering[65] who were contracted to conduct regular maintenance/safety checks/repairs.[66] Ms

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[57] Exhibit 12 – Statement of Dr Mark Schulberg dated 2 August 2013, T @ pp 137 -138.

[58] T @ p 138. 2011,

[59] T @ pp 319-320.

[60] Exhibit 12 – Statement of Dr Mark Schulberg dated 2 August 2013.

[61] T @ pp 65 – 66.

[62] T @ p 76, p 80.

[63] Exhibit 6 – Statement of Wendy Turner dated 21 August 2014.

[64] T @ p 33.

[65] Exhibit 6 – Statement of Wendy Turner dated 21 August 2014.

[66] T @ p 26.

Ambrosio believed that the medical equipment was checked yearly.[67] Any identified problems/malfunctioning equipment was reported to either the Centre's Manager, Ms Turner or the Director of Nursing, Jeanene Aldridge.[68] Replacement of equipment was the responsibility of the Director of Nursing.[69]

**The policies and procedures at the Croydon Day Surgery Centre**

55. In March 2010, Marie Stopes International[70] entered into an agreement to purchase the Centre from the then owner operator, Dr Schulberg with handover scheduled for 2015. The role of Marie Stopes was dictated by the terms of the agreement, which stipulated that Dr Schulberg would remain the full legal and beneficial owner of the business and the assets until the completion date in 2015.[71] Although in full control of the business, Marie Stopes extended to Dr Schulberg the right to use and access its know-how and expertise, and to provide support in the areas which included branding, marketing, referral generation, advocacy and education, and research related services however, access to these was not imposed on the Centre. Following the termination of its previous Director of Nursing, Ms Jeanene Aldridge, employed by Marie Stopes International, was appointed as the Centre's clinical manager/Director of Nursing.[72] Marie Stopes also provided assistance to Dr Schulberg in securing employees to work at the Centre.

56. In order for the Centre to retain a private health facility licence, the Centre had to maintain accreditation, which it did do. The Centre was also annually audited by the Department of Health. Auditing involved an examination of its policies and procedures. The policies and procedures of the Centre continued to be used until the business formally transferred to Marie Stopes in April 2012, and were the ones in place at the time of Delta's admission.[73] These

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[67] Exhibit 2 – Statement of Kathleen Ambrosio dated 19 August 2014. This was also Wendy Turner's evidence – T @ p 34.

[68] T @ p 32.

[69] T @ p 13, Exhibit 4 – Statement of Sharan Shahin dated 21 August 2014, T @ p 26.

[70] Marie Stopes is a worldwide organisation with a primary focus on women's reproductive and sexual health.

[71] T @ p 443.

[72] T @ p 132.

[73] Exhibit 28 - Statement of Marie Crabbe dated 20 December 2013.

policies required pulse oximetry as part of routine monitoring in the operating theatre.[74]

57. Mr Cash, in his final submissions on behalf of Dr Schulberg, stated that there was no confusion about which policies or procedures were in place by virtue of the transition towards the 2015 transfer of ownership of the business. He also said that had there been compliance with the Centre's "Functional Procedures" and pulse oximetry monitoring conducted before and throughout the procedure on 14 December 2011, "*Delta's hypoxic state may have been detected earlier*".[75]

**Documentation and record keeping at the Croydon Day Centre**

58. The record keeping of Delta's times in the operating theatre did not reflect a culture that encouraged attention to detail. The *Register of Surgical Operations*[76] records a different date of birth for Delta on 13 December 2011 from the one recorded on 14 December 2011. The "total time" of the procedure for 13 December 2011 has not been recorded in this Register but is recorded in the *Operating Room Record*. The time at theatre recorded for 14 December 2011 differs between the *Register of Surgical Operations* (1328 hrs) and the *Operating Room Record* (1335 hrs), leading Dr Schulberg to offer an explanation that the difference may come about because the *Operating Room Record* may reflect when the anaesthetic was given or the procedure commenced, whereas the *Register of Surgical Operations* likely reflects when Delta entered the operating theatre.[77]

59. The *Serial Dilation Record* for 13 December 2011 contained thorough details of the procedure, whereas no details were added to the record for the procedure performed on 14 December 2011. Similarly the "remarks" section in the *Register of Surgical Operations* for 14 December 2011 was blank, despite the fact that something out of the ordinary did occur on that day. Dr Schulberg acknowledged that one would expect to see something noted in that section of the Register given the events that unfolded on that day in the operating theatre.[78]

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[74] See Appendix 8 Inquest brief - *Functional Procedures* – 4. Patient Admission –@ p 328, and 8. Anaesthesia – Patient Preparation –@ p 342.

[75] T @ p 436.

[76] Exhibit 15.

[77] T @ p 196.

[78] T @ p 197.

**The cause of death**

60. In her *viva voce* evidence, Dr Parsons stated that the global cerebral ischaemia identified at post mortem examination was a secondary phenomenon, the cause of which was not found. She said the brain had not had enough blood to it and had been deprived of oxygen and the reason for that was undetermined.[79] Possible causes had been excluded, such as there was no evidence of post-partum haemorrhaging or of amniotic fluid embolus.[80] Dr Parsons said this is why she felt more comfortable with the cause of death being unascertained, but conceded that other pathologists may have put it as global cerebral ischaemia.[81] Dr Parsons agreed that it was the cause of the global cerebral ischaemia that was unknown, not what the medical cause of death was and stated that she could have ascribed the cause of death to "global cerebral ischaemia – cause unknown" which is the same as saying "unascertained".[82]

**Reflections of Dr Peter McAllister**

61. Dr McAllister stated that he did not, on reflection, have an appreciation of the complexity of follow-on procedures, that is, the second procedure in the late term termination process. He now acknowledges that these procedures are more difficult and more complicated than the "straight-forward" anaesthetic procedures. Dr McAllister stated that he no longer performs anaesthesia in these procedures or in any other gynaecological procedures.

62. Dr McAllister accepted that he should have done a pre-anaesthetic assessment prior to Delta coming into the operating theatre, and this is particularly so because communication was poor. He said that he put it down to language difficulties, although he had no basis on which to make that assumption other than the colour of Delta's skin. He made no enquiries with any other members of staff about Delta's ability to communicate in English, nor is there anything in the medical records that would reflect that communication had been difficult. A *Consent to Second Trimester Termination of Pregnancy*[83] which is contained within the medical records is signed

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[79] T @ pp 394-395.

[80] T @ p 396.

[81] T @ p 395.

[82] T @ p 395.

[83] Exhibit 7 - @ p 107 Inquest Brief.

by Delta in the presence of a witness, and makes no reference that an interpreter was required for the obtaining of consent for the procedure. Similarly, Delta signed the *Anaesthetic Risk Information Sheet* on 12 December 2011 which was witnessed by K. Collins, a nurse at the Centre. According to Ms Turner, this document is discussed with the patient at the time of consultation and the signatures signify that it has been discussed.[84] Again, there is no reference to any communication difficulties, even within this document which I presume would be of particular relevance to the anaesthetist. There is nothing in the medical records about what, if anything, was difficult about the communication with Delta. Ms Turner, the Practice Manager who was with Delta on a number of occasions, stated that Delta had no difficulties understanding or speaking English.[85] Nurse Harrison stated that Delta may have had an accent *"but I don't think there was a massive difficulty with communication"*.[86]

63. Dr McAllister now accepts that there was not good communication between himself and Delta before he administered the anaesthetic to her.

64. Dr McAllister also accepts that a full set of observations, including pulse oximetry, should have been obtained prior to the administration of the anaesthetic.

65. Dr McAllister's use of midazolam in anaesthesia has also been the subject of his reflective actions/responses. The administration of 5 mg of midazolam as a part of the anaesthetic was the subject of comment by the Court appointed independent expert, Dr Falcone and by Dr Charlesworth.[87] Dr Falcone in her *viva voce* evidence stated that the anaesthetic administered to Delta was *"heavy handed"*. She explained that the midazolam is called a co-induction agent because it *"acts with the propofol to make you more sleepy, to obtund your upper airway reflexes and to effectively stop you breathing as does the fentanyl"*.[88] She said the amount of midazolam is significant when administered with the fentanyl and propofol. This is because there is no titration of the sedation; that is, giving small increments to see what the response is

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[84] T @ p 50.

[85] T @ pp 54 - 55.

[86] T @ p 67.

[87] T @ p 369.

[88] T @ p 408.

with the aim of keeping the patient breathing, and the result being that you can just "*stop the patient breathing or they can lose their upper airway reflexes and obstruct their upper airway*".[89] Furthermore, Dr Falcone stated that when you give the propofol, fentanyl and the 5 mg midazolam all at once "*you actually create high plasma levels of those drugs which actually (sic) obtunds your airway, it can also cause quite significant cardiovascular effects*".[90]

66. At the time, Dr McAllister did not consider the dose of 5 mg midazolam to be a high dose given Delta's size, which was recorded in the medical record as being 94 kg.[91] Nevertheless, Dr McAllister stated that his current practice is to now use smaller doses of midazolam in the range of 2-3 mgs.

67. In addition to Dr McAllister's acknowledgements about his shortcomings in his management of Delta as her Anaesthetist and his cessation of work as a GP Anaesthetist in gynaecological or termination procedures, he has engaged in other restorative activities indicative of reflective practice according to his Counsel, Mr Halley.[92] Dr McAllister initiated and has been receiving mentoring from a Consultant Anaesthetist at the Austin Hospital. He has also been undertaking continuing professional development (CPD) activities although they are not specifically required for him to practice as a GP Anaesthetist or for him to receive re-accreditation of the same every three years.

**COMMENTS**

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

1. I do not accept the conclusions of Dr Parsons that because the cause of the global cerebral ischaemia cannot be determined following the full post mortem examination, the cause of death is in itself "unascertained". There are many instances where no actual or determinative cause can be identified from a full post mortem examination. For example, in situations where a young person with no known medical history may have experienced a sudden unexplained

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[89] T @ p 409.

[90] T @ p 410.

[91] Exhibit 7 – p 92 Inquest Brief. The Medical Examiner's Report of Dr Sarah Parsons (Exhibit 32) records Delta's weight as 97 kilograms with a Body Mass Index (BMI) of 37.89. BMI is an index for assessing overweight and underweight, obtained by dividing body weight in kilograms by height in meters squared: a measure of 25 or more is considered overweight.

[92] T @ p 456.

collapse and the circumstances surrounding death give no clue as to cause. In cases such as this, the cause of death may be due to or likely to be from a fatal cardiac arrhythmia, but in the absence of any post mortem findings the cause might appropriately be ascribed to "undetermined" or "unascertained". In other words, there are no forensic findings to support the presumption of the cause of death. In circumstances, however, when the medical cause is identified through a post mortem examination, it should be so stated on the Certificate of Death. Pieces missing from the medical puzzle are often explained through the finding of facts by a Coroner, on the balance of probabilities, about the circumstances surrounding the death. Similarly, it is not unusual for a cause of death to be depicted in a narrative form to encapsulate a number of medical possibilities that may have contributed to death; for example where an elderly person with a number of medical comorbities fractures what is commonly referred to as the "hip". It may be accepted that the fracture set off a chain of other medical events or complications which had a cumulative effect leading to death, but medically it was not the fracture *per se* that caused the actual death. Nevertheless, "Complications of a fractured neck of femur" is often given in these circumstances as the cause of death either with or without a full post mortem examination. Global cerebral ischaemia depicts a situation where the brain has been deprived or starved of oxygen. Delta's brain was deprived of oxygen after she was administered an anaesthetic for the purposes of an operative procedure. The circumstances support that sequence.

2. There was speculation by witnesses that some medical event may have already occurred or have been in the process of occurring to Delta even prior to the administration of the anaesthetic. Some of this speculation arose from Dr McAllister's "reflection" on the events, which I am advised he has "*trawled through for a number of years.*"[93] His *viva voce* evidence was that Delta seemed not to be fully well, even when she came into the operating theatre, "*that her conscious state may not have been as good as it should have been prior to me anaesthetising her.*"[94] The records from the Recovery Room however reflect that as late as 1315 hours on 14 December 2011, Nurse Shahin recorded that "*increased pain continues*"[95] which indicates that Delta was capable of communicating at that time. This timeframe and level of consciousness/awareness is supported by the evidence of Ms Turner who stated that she saw

[93] T @ p 450.

[94] T @ p 318.

[95] Exhibit 7 – p 94 Inquest Brief, T @ p 23.

Delta in the Recovery Room and that *by 1:00 pm her pain had increased and I saw her get onto a trolley to go into theatre.*[96]

3. Dr McAllister's "reflection" of the events may equally amount to hindsight bias. The possibility of the accuracy of this reflection is concerning because it takes his decision to proceed to anaesthetise a woman who had otherwise completed an uncomplicated procedure the previous day, to a different dimension. Dr McAllister does however acknowledge that it was his duty to ensure that Delta was adequately prepared for anaesthetic and that if some medical event was occurring beforehand, he should have picked it up and not continued with the anaesthetic.

4. The circumstances of Delta's death have raised the question about the suitability of GP Anaesthetists performing anaesthesia in complex surgical procedures, albeit that fall into the category of "day procedures". Dr McAllister's own acknowledgements include that he did not appreciate the complexity of the procedure Delta was undergoing on 14 December 2011 and that he had not kept up with any CPD in this specialist area because he was not required to do so. Dr McAllister indicated through his Counsel, Mr Halley, that he supported a recommendation from me that such CPD for GP Anaesthetists be compulsory and that this specialist group should also be compulsorily required to have mentoring and that such mentoring should be specific to a minimum number of sessions within the tri-annum, that is, the period which is associated with re-accreditation of the GP Anaesthetists from the Joint Consultative Committee of Anaesthesia.[97]

5. I accept that the identified shortcomings in the Centre's documentation in the operating theatre on 13 December 2011 and 14 December 2011 are not relevant to the cause of death. However, scrutiny of the record keeping cannot be avoided in a coronial investigation into a reportable death which has occurred in the context of a medical procedure. Record-keeping/documentation is contextually relevant; that is, it is unavoidably relevant to understanding the circumstances which are the subject of my investigation. Accurate and appropriate record keeping/documentation made contemporaneously can support hindsight recall and dismiss uncertainty about the sequence of events and responses to the same. Such record

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[96] Exhibit 5 – Statement of Wendy Turner dated 13 April 2013.

[97] The Joint Consultative Committee on Anaesthesia (JCCA) is a tripartite committee with representatives from the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australian College of General Practitioners (RACGP) (RACGP Rural) and the Australian College of Rural and Remote Medicine (ACRRM). The current membership of the JCCA is four specialist anaesthetists from ANZCA, two rural GP anaesthetists nominated by RACGP Rural, and two rural GP anaesthetists nominated by ACRRM.

keeping/documentation reflects positively on the professional clinicians. To the contrary, inaccurate, incomplete and even "record-keeping imperfections" that Mr Cash referred to, impact not only upon the line of enquiry of a coronial investigation but can adversely reflect upon systemic and at times individual professional standards. Compliance with record keeping/documentation was ultimately the responsibility of the Centre's owner and operator of the time, Dr Schulberg.

6. The circumstances of the incident at the Centre involving patient "S", a 40 year old 23 week gestation termination were not the subject of my investigation and indeed outside my jurisdiction, but drawn to my attention by Dr Charlesworth in his statement dated 18 December 2011. Dr Charlesworth articulated his concerns about how the circumstances of patient S's presentation to Box Hill Hospital, as well as that of Delta's, identified a common theme of poor monitoring at the Centre. Dr Charlesworth reported both matters to AHPRA. Without commenting on the matter relating to patient S, I concur with Dr Charlesworth's concerns when considered in light of additional evidence heard during the course of this Inquest about the continuation with Delta's operation in the absence of recordable vital signs, in particular, oxygen saturation levels. There was also evidence depicting a concerning approach to the running of the Centre; including the use of untrained staff in the operating theatre to monitor vital signs[98], and suspended-from-practice nursing personnel providing ongoing education and writing nursing policies.[99] Documentation pertinent to the operation of the Centre at the time of Delta's admission was missing/not able to be located, despite the then owner and medical director being aware that Delta's matter would be the subject of a Coronial investigation. While the issues relating to patient "S" are not germane to my investigation into the circumstances of Delta's death, it is nevertheless understandable why Dr Charlesworth raised his concerns to me, AHPRA and the Department of Health. Nevertheless, save for acknowledging that the matter of patient S was brought to my attention and these comments in respect of the same, the circumstances of patient S were not explored and not in any way germane to my Findings in this investigation.

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[98] The evidence of Kathleen Ambrosio who was employed in the Central Sterilising Department (CSSD) and who had no nursing qualifications, was that she would assist during operative procedures on occasion. (Exhibit 1 & 2, T @ p 8

[99] In her *viva voce* evidence Wendy Turner stated that at the time of Delta's admission to the Centre her professional qualifications as a Registered Nurse, Division 1 had been suspended while the Nurses Board of Victoria (as it then was) was investigating a matter involving her – T @ p 54. According to the *viva voce* evidence of Nurse Harrison, Wendy Turner was continuing to work in Recovery – T @ p 60.

**FINDINGS**

1. I find the identity of the deceased is Delta Diawo Poke born 30 November 1969 and that her death occurred on 18 December 2011 at the Box Hill Hospital, Box Hill.

2. I find that Delta Poke died from global cerebral ischaemia in a setting of anaesthesia.

3. I find that at all relevant times during Delta's contact, admission and medical and surgical procedures at the Croydon Day Surgery Centre, Dr Schulberg was the owner and operator of the Centre and thus the person with the responsibility and control of the policies and procedures and implementation of the same.

4. And I further find that the evidence affords me a comfortable level of satisfaction that there is a causal link between the failure to detect Delta's oxygen saturation levels/baseline pulse oximetry before the commencement of anaesthesia, her hypoxic state and the cause of her death.

5. And I further find that the evidence affords me a comfortable level of satisfaction that there is a causal link between the failure to detect Delta's oxygen saturation levels subsequently during the prolongation of the anaesthesia for the purposes of the operative procedure, her pronounced hypoxic state and the cause of her death.

6. I find that Dr McAllister failed to detect Delta's hypoxic state on 14 December 2011 because he failed to obtain an oxygen saturation reading through the application of pulse oximetry before commencement of the anaesthetic and hence the operative procedure, and failed to ensure the pulse oximeter was working and that these failures were in contravention of the Centre's *Functional procedures*[100].

7. While I acknowledge the reflections and concessions of Dr McAllister provided during the course of the Inquest, including that he should have ensured that he had communicated with Delta before administering an anaesthetic agent(s) to her and that he should have completed a full set of vital signs including obtaining an oxygen saturation level prior to administering an anaesthetic agent(s), I find that the evidence affords me a comfortable level of satisfaction that the actions of Dr McAllister represent a gross departure from accepted clinical practice standards expected of a reasonable medical practitioner practising in the area of Anaesthesia and that these departures contributed to the cause of Delta's death.

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[100] Appendix 8 – Inquest Brief.

8. AND in turning my mind to the question of whether Delta's death was preventable, I am mindful of the momentum that has been created about whether Delta was already experiencing some medical event when she was brought into the operating theatre. This momentum occurred in part because the actual cause of the global cerebral ischaemia was not identified at autopsy but that possibility has been enhanced by Dr McAllister's reflections about why a pulse oximeter reading could not be obtained. I find, on the weight of the evidence, and on the balance of probabilities, that if some medical event was occurring, it was nevertheless occurring in the operating theatre when Delta was under the care of Dr McAllister. As late as 1315 hours, Delta reported increased pain to Nurse Shahin. There is no evidence of anything untoward occurring in the Recovery Room where she was being monitored prior to entering the theatre for her scheduled final procedure. At 1328 hours, Delta was brought into the operating theatre – either walking with a nurse or on a trolley. Thereafter and within a space of seven minutes at 1335 hours, Delta's heart rate was recorded as 50bpm and an oxygen saturation level was unattainable. Baseline observations were not obtained[101] before the anaesthetic was administered by Dr McAllister. It was at this time that a more fulsome and professionally responsible assessment of Delta should have been done, but anaesthesia proceeded which also included a dose of midazolam considered to be "heavy handed". At that time her airway was not protected. In conclusion, I find that the evidence on the balance of probabilities provides me with a comfortable degree of satisfaction that her death could have been prevented if reasonable and appropriate medical management had occurred at that time. I cannot however say with the same degree of comfort that her death was capable of being prevented from beyond that point in time.

9. I have not identified any other clear and cogent evidence of contributing factors to Delta's death, either of a systemic or individual nature.

10. Save for the comments I have made above in respect to the owner and medical director of the Centre, I make no adverse comment about Dr Schulberg in respect to his professional capacity as the surgeon involved with Delta on 14 December 2011.

11. I direct that pursuant to section 49(2) *Coroners Act 2008* that the Principal Registrar notify the Registrar of Births, Deaths and Marriages of the prescribed particulars of my Findings following

[101] T @ pp 97, 98

my investigation and accordingly that the Registrar amend the currently registered cause of death to reflect my Findings into the cause of death of Delta Diawo Poke.

**RECOMMENDATIONS**

I make no recommendations directed at the Croydon Day Surgery Centre pursuant to section 72(2) of the *Coroners Act 2008*, in connection with the death of Delta Poke because I am satisfied that there have been a number of changes implemented of both a restorative and preventative nature since the completion of the agreement in April 2012, whereby Marie Stopes International took over the ownership and operation of the Centre in its entirety, which is now known as the *Dr Marie Maroondah* clinic. Matters of governance, the introduction of policies and procedures that meet evidence-based best practice and national standards, the introduction of new equipment and equipment processes, and the employment of specialist anaesthetists who all hold Fellowship at the Royal Australian College of Anaesthetists,[102] reflect that the issues identified through the investigation into the death of Delta Poke along with the concerns identified by Dr Charlesworth have been addressed by the new owner and operator, Marie Stopes International.

I make the following recommendations pursuant to section 72(2) of the *Coroners Act 2008* in connection with the death of Delta Poke:

1. With the aim of reducing harms and preventing like deaths **I recommend** that the Joint Consultative Committee on Anaesthesia (JCCA), a tripartite committee with representatives from the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australian College of General Practitioners (RACGP) (RACGP Rural) and the Australian College of Rural and Remote Medicine (ACRRM), review the training required by general medical practitioners necessary for attaining accreditation from the JCCA to practice as a GP Anaesthetist.

2. With the aim of reducing harms and preventing like deaths and promoting the professional standing and development of GP Anaesthetists by ensuring that they remain informed, appraised of and proficient in current practice and current practice standards in the area of anaesthesia, **I recommend** that the JCCA implement a compulsory continuing professional development (CPD) scheme for GP Anaesthetists.

3. With the aim of reducing harms and preventing like deaths and promoting the professional standing and development of GP Anaesthetists by ensuring that they remain informed,

[102] T @ pp 335-337.

appraised of and proficient in current practice and current practice standards in the area of anaesthesia, **I recommend** that the JCCA link the provision of ongoing or triennium accreditation to practice as a GP Anaesthetist only on the completion of compulsory CPD points as determined within the stated period.

4. With the aim of reducing harms and preventing like deaths and promoting the professional standing and development of GP Anaesthetists and assisting them to remain informed, appraised of and proficient in current practice and current practice standards in the area of anaesthesia through the provision of professional support, encouragement and access to consultant anaesthetists, **I recommend** that the JCCA investigate and examine the feasibility of introducing a formal but accessible mentoring program for GP Anaesthetists.

To enable compliance with sections 72(5) and 73(1) of the *Coroners Act 2008* (Vic), I direct that these Findings will be published on the internet.

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

Mr Stanley Poke

Mr Steven Stanley

Mr Michael Regos, DLA Piper Australia.

Mr Andrew Smith, John W Ball & Sons

Mr Chris Spain, Tresscox Lawyers

Joint Consultative Committee on Anaesthesia

Australian and New Zealand College of Anaesthetists

Royal Australian College of General Practitioners

Department of Health and Human Services

Australian Health Practitioners Regulation Agency

Dr David Charlesworth

Dr Ginette Falcone

Detective Leading Senior Constable Simonne Corin

Signature:


AUDREY JAMIESON
CORONER
Date: **26 May 2016**