CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Brooke Tiddy
Hearing dates:	11 – 15 August 2025, Lidcombe Coroner's Court
Date of findings:	17 November 2025
Place of findings:	Lidcombe Coroner's Court
Findings of:	Deputy State Coroner, Magistrate Devine
Catchwords:	CORONIAL LAW – elective bariatric surgery - adequacy of pre-operative assessments – particularly pre-anaesthetic screening - rare condition - Sponastrime Dysplasia - communication between treating doctors - loss of anaesthetic information - manner and cause of death
File number:	2018/00290847
Representation:	Counsel Assisting: Geoffrey Gemmell, instructed by Valentina Markovina, Dawoud Ayache and Jillian Walshe, DCJ Legal St George Private Hospital: Richard Lee, instructed by Jehannah May and Ivan Li, MinterEllison Dr Michael O'Leary: Karen Kumar, instructed by Enoch Hui, Mills Oakley. Dr Vytauras Kuzinkovas: Lorna McFee, instructed by Neroli Martin, Barry Nilsson Lawyers Dr Vincent Da Silva: Richard Sergi, instructed by Hanna Shiel, Barry Nilsson Lawyers
Findings:	**Identity of deceased**: Brooke Tiddy

Date of death: 21 September 2018

Place of death: St George Private Hospital, Kogarah NSW

Cause of death: Cardiac arrest due to hypoxia caused by dynamic hyperinflation arising from complications related to subglottic stenosis

Manner of death: Complications arising from attempting to intubate and ventilate Brooke

Recommendations:

(1) That St George Private Hospital give consideration to reviewing and, if considered appropriate, amending its present Compromised Airway and Difficult / Awake Intubation Policy, in particular the section titled "COMPROMISED AIRWAY PROCEDURES" concerning the need for a pre-anaesthetic consultation by referring and the need for adherence to, the relevant ANZCA guidelines.

(2) That St George Private Hospital give consideration to reviewing and, if considered appropriate, amending its present Admission Policy, in particular the statement on page 1 of that policy, namely:

"Patients with chronic or complex medical conditions should be carefully worked up. Appropriate associated specialist may need to assess patient prior to admission."

with a view to making clear on whom the onus falls as to who it is who is to determine that the patient be carefully worked up.

(3) That St George Private Hospital give consideration as to how it may educate and inform Doctors with admitting rights or those Doctors who work at the hospital about the Hospital Policies applicable to their area of practice at the hospital.

(4) That St George Private Hospital give consideration to reviewing, and if considered appropriate, amending its present Anaesthetic Policy to require the anaesthetic technician to remind the anaesthetist to print the data from the anaesthetic machine where it has not otherwise been printed so as to ensure that it has been included within the patient's medical records.

Publication orders: Nil

FINDINGS

Introduction

1 This is the inquest into the death of Brooke Tiddy who tragically died, aged 32, at 3:00am on 21 September 2018 at George Private Hospital, Kogarah. I will refer to Ms Tiddy by her first name, Brooke, as is preferred by her family.

2 At the time of her death, Brooke had been admitted to St George Private Hospital since 18 September 2018 for elective bariatric surgery (Rou-en-Y gastric bypass) and hiatus hernia repair. The procedure was abandoned following cardiorespiratory arrest on induction of anaesthesia.

3 Brooke was resuscitated and transferred to the Intensive Care Unit (ICU), where she initially improved but subsequently deteriorated. Efforts at ventilation were unsuccessful, and she developed acute respiratory failure leading to cardiac arrest, from which she could not be revived.

4 Brooke is deeply missed by all those who loved and cared for her and I would like to begin these findings by expressing my sincere condolences to the family and friends of Brooke for their profound loss. As I was reminded during the inquest, Brooke is not just the reports I have read or a rare medical condition, she was a daughter, sister, aunty, cousin, grand-daughter and wife.

5 I also want to record my utmost respect for Brooke's family, recognising that the coronial process has been a protracted and significant intrusion by the State into what is a profoundly traumatic event in their lives. The impact that such a process has on family members (who have many unanswered questions regarding the circumstances in which a loved one has died) cannot be overstated.

6 It is also obvious to me that they wanted not just to understand the full circumstances of Brooke's death, but to be part of any positive change that could arise from her passing.

Legal Framework

7 Under the *Coroners Act* 2009 (the Act), a Coroner has the responsibility to investigate all reportable deaths. Reportable deaths are defined in section 6 of the Act.

8 Brooke's death was reported to the Coroner on 21 September 2018 as her death did not appear to be "the reasonable expected outcome of a health-related procedure carried out in relation to the person", or, in other words, was an unexpected consequence of her medical procedure.

9 The primary purpose of a coronial inquest is to make formal findings as to the following five aspects of a death pursuant to s81 of the Act: (1) the identity of the person who died, (2) the date they died, (3) the place they died, and what was (4) the cause and (5) the manner of that person's death. The inquest investigates the facts and circumstances of a death, places them on the public record, and in certain cases will examine recommendations that could be made to prevent similar deaths in the future.

10 Importantly, an inquest is not a forum where a Coroner sets out to prove any allegation or proposition or attribute blame or responsibility. Rather, an inquest is an inquisitorial exercise in fact finding, aimed at discovering what occurred, and it is this principle that steers the approach taken by a Coroner in evidentiary and procedural matters. It is also an opportunity for families to air concerns they have and to have relevant fears or suspicions allayed.

11 There is no controversy in this case in relation to the identity of the deceased nor the date, time and place of her death. The primary focus on this inquest is whether, in light of the circumstances that led to Brooke's death, there are any matters about which preventative recommendations might be made such as to reduce the likelihood of unnecessary deaths occurring in the future in similar circumstances.

The evidence

12 A coronial investigation precedes an inquest. During the investigation considerable evidence, in the form of witness statements, expert reports, medical records, hospital policies and more are obtained by, and provided to, the Coroner. A report as to the cause of death (a post-mortem report) is provided by a forensic pathologist.

13 In the case of the investigation into Brooke's death, a three volume brief of evidence complied by the Officer in Charge of the coronial investigation, Constable Steven Aubin, and extensively supplemented by the Assisting team, was tendered to the Court. Additional material was tendered during the course of the inquest.

14 I thank the Officer in Charge of the Investigation and the Assisting team for the thoroughness of their investigations and the work done by them because, to a very considerable extent, it brings to light the full facts surrounding Brooke's death.

15 The inquest also heard oral evidence over 5 days. The Court had the benefit of five expert witnesses who gave evidence at the hearing in conclave: two bariatric surgeons who gave concurrent evidence, as well as an intensivist, anaesthetist, and an Ear Nose and Throat (ENT) surgeon who gave evidence concurrently. The anaesthetist and surgeon involved in Brooke's surgery on 18 December 2018 also gave evidence at the hearing as did the intensivist who treated Brooke in the ICU. The Court also heard from a representative of St George Private Hospital. This evidence shone further light on the issues.

16 In receiving the entirety of the evidence referred to in paragraphs [13] and [15], making issues known as they developed and giving interested parties an opportunity to be heard and make submissions thereafter, the Court has sought to balance the obligation to afford procedural fairness to those whose reputation and interests are in question in a public forum with the need to confine, in an

appropriate manner, the scope of the inquest in order to meet the "primary duty" in s 81 of the Act.[1]

17 Given the volume of material before the Court, it is not possible (nor desirable) to refer specifically to all the available evidence but I want to assure Brooke's family that I have had the opportunity to thoroughly review and consider the entirety of the material and I have done so with the benefit of written submissions from all interested persons and I will touch on those aspects of the evidence that I consider most significant.

18 In deciding what matters to touch on I have also been guided by an Issues List that was circulated amongst the legal representatives appearing in the matter and which refers to the following matters:

(1) Determination of the statutory findings required by section 81 of the Act including: the deceased person's identity; the date and place of the deceased person's death, and the manner and cause of the deceased person's death;

(2) Whether Dr Kuzinkovas adequately and appropriately completed the Admission Referral Form and, in particular, the pre-operative instructions, in light of Brooke's condition of Sponastrime Dysplasia ("her condition");

(3) Whether Brooke received appropriate and adequate pre-operative assessments and, in particular, whether the pre-anaesthetic screening was sufficiently rigorous in light of Brooke's medical history;

(4) Linked to 2 and 3 above, what communication occurred between Drs Kuzinkovas and Dasilva prior to Brooke's admission concerning her condition;

[1] Conway v Jerram [2011] NSWCA 319 at [47]-[50] and citing X v Deputy State Coroner of New South Wales [2001] NSWSC 46 [60]. See also Commissioner of Police, New South Wales Police Force v Attorney General of New South Wales [2025] NSWSC 1119.

(5) If further pre-operative checks were undertaken by way of retrieval and consideration of prior medical records (particularly the 2002 and 2003 surgery), or by way of medical imaging or referral to an ENT surgeon, and if the subglottic stenosis had been detected what effect, if any, would that have had on the decision whether to proceed to surgery and, if so, the anaesthetic induction procedure?

(6) Given that Sponastrime Dysplasia is a rare condition and was disclosed on the Patient Health History Form and Admission Referral Form:

(a) Did Dr Dasilva read those forms and know that Brooke suffered from Sponastrime Dysplasia;

(b) Whether Dr Kuzinkovas and Dr Dasilva made adequate attempts by way of enquiries to understand Brooke's condition and other associated conditions.

(7) The circumstances surrounding the decision to remove the cartridge from the anaesthetic monitor prior to printing anaesthetic information and the failure to place the cartridge back in the anaesthetic monitor leading to the loss of the anaesthetic information.

(8) Whether there are any recommendations that are necessary or desirable in relation to any matter connected to Brooke's death pursuant to section 82 of the Coroners Act 2009.

19 I have also had the very considerable assistance of Counsel Assisting's submissions and have drawn extensively from those submissions in these findings including the format and headings employed by him.

Recognition of Brooke's life

20 Brooke was born 5 weeks premature at Camden Hospital on 18 April 1986 - the child of Glenda and John Russell and sister to Julie and Amanda.

21 Brooke suffered from Sponastrime Dysplasia. The word Sponastrime is an acronym for SPOndylar and NAsal changes, with STRIations of the MEtaphysis. It is an extremely rare condition. She was diagnosed with the condition at the age of 12.

22 Sponastrime Dysplasia is a bone disorder characterised by facial dysmorphism and skeletal abnormalities, notably short stature and short limbs.

23 In the family statement given by Mr Russell he touched on the qualities that made Brooke unique and much loved. From that I note the following:

(1) Mr Russell said Brooke's true calling was supporting people with disabilities through 'Wellways' and that she was respected and admired by colleagues. That drove her to make an even greater difference in the lives of others, she succeeded in obtaining a Bachelor of Social Work in Mental Health Services from the University of Queensland earning honours and distinctions as she did so.

(2) Brooke had a passion for baking and created stunning wedding and birthday cakes that delighted friends and family for being as beautiful as they were delicious.

(3) He described Brooke as smart, creative, happy, trusting and bright with an infectious laugh. He said that, whilst small in stature, she carried herself with a giant spirit that she used to meet the challenges in her life head on. He continued that she knew how to tell crude and rude jokes and drop the occasional F-bomb when the occasion demanded.

(4) Brooke's family have endured a great tragedy in losing her – none moreso than her parents - who still find her passing painful and who miss her profoundly at family celebrations. I also learnt of the special bonds Brooke shared with her sisters and (because of her unconditional love) her nieces.

24 The impression I gained is that Brooke was a wonderful individual and I hope that her memory has been honoured by the careful examination of the circumstances surrounding her death and the lessons that have been learned from the circumstances of her passing.

Factual matters not in dispute

25 Brooke was short of stature (123 centimetres tall) and very obese weighing 80.5kg.

26 On 24 August 2018, Brooke presented to Dr Vytauras Kuzinkovas at Advanced Surgicare against a background of weight management issues including unsuccessful attempts of various weight loss regimes. She was referred by Dr Wahida Parveen (GP) for consideration of surgical interventions.

27 According to Dr Kuzinkovas, Brooke's weight placed her in the "super, super obese" weight range. In view of her medical history, namely a large Hiatus Hernia and Gastroesophageal Reflux symptoms, Dr Kuzinkovas recommended "LapRoux en Y Gastric Bypass" with Hiatus Hernia repair as the most appropriate procedure for Brooke.

28 The procedure was to be performed at St George Private Hospital (the Hospital) with Dr Kuzinkovas as surgeon. The Admission Referral Form, completed by Dr Kuzinkovas on 26 August 2018, detailed Brooke's conditions as: "Obesity, ankle surgery, Sponastrime Dysplasia (genetic dwarfism), Gastro-oesophageal Reflux Disease and hiatus hernia" with allergies noted as "Maxalon".

29 The Admission Referral Form contains a number of tick boxes under the heading "Preoperative instructions (including tests required)". These are:

- Pre-admission clinic attendance required
- Pathology tests
- Investigations: Xray/ultrasound; ECG; Other

- Anaesthetic Consult
- Drug Order on Admission
- Special Instructions.

30 Of the above, “Drug Order on Admission” was ticked by Dr Kuzinkovas as well as “Special Instructions”, besides which the word “Teds” was written.

31 Pre-operative blood tests and a review by a dietician at Dr Kuzinkovas’ clinic formed the assessment process for the surgery.

32 The risks of the procedure explained to Brooke were bleeding, infection, risks related to general anaesthesia, blood clots, bowel injury, internal hernias, bowel obstruction, gallstones, dumping syndrome (or rapid gastric emptying), marginal ulcers, constipation or diarrhoea. No danger or concern regarding anaesthesia was related to Brooke.

33 Brooke completed the hospital patient admission details and patient health history forms which were then submitted to the Hospital. The forms were then placed in the patient's medical record prior to admission. Brooke completed her patient admission details and patient health history forms online. The hand writing that appears on this form was added later - either by the Preadmission nurse or the Admitting nurse.

34 Dr Kuzinkovas’ office sent the completed Admission Referral Form and the consent for treatment form to the Hospital. Precisely when that was done is unclear, but it is reasonable to assume it was within a business day after the consultation with Brooke. Those documents were placed in the patient's medical record prior to admission.

35 The preadmission nurse telephoned Brooke the day prior to admission to ensure the patient admission details, patient health history and consent for treatment forms were complete and to identify any issues of concern. Handwritten notes and ticks on the patient health history form were added either

by the preadmission nurse on 17 September 2018 or by the admitting nurse on 18 September 2018.

36 A handwritten note “Sponastrime Dysplasia” was written in the “any other medical conditions” section of Brooke’s patient health history form. The hand writing was a much larger size than the sections of the form completed online by Brooke.

37 The usual practice was that if the preadmission or admission nurse identified any significant issues of concern, they directly contacted the surgeon or anaesthetist by telephone. Any discussion with the surgeon or anaesthetist would then be documented in the “clinical/preadmission notes” section of the patient health history form.

38 Neither the preadmission nurse nor the admitting nurse made any entries in the section of the patient health history form. Amelia Bulmer thereby concludes that neither of the nurses had any particular concerns in relation to Brooke’s health history. There is no evidence that any inquiries were made by the preadmission nurse or the admitting nurse as to the meaning or significance of Sponastrime Dysplasia.

39 The Hospital’s Admission and Preoperative Care of Day Surgery Patients and Day of Surgery Patients Policy required that comorbidities be communicated to all relevant personnel and documented on the preoperative checklist. The preoperative checklist is another means of communication and handover between the admitting nurse and the receiving operating theatre staff.

40 At the time of Brooke’s admission, patient handover between the admission nurse and the receiving nurse was not always face to face or verbal. However, it is now a requirement at the Hospital for a verbal handover to take place between the admissions nurse and the receiving nurse.

41 Dr Dasilva received via email on 17 September 2018 the operating list for the following day. The list identified Brooke as the first patient scheduled on 18 September 2018.

42 That Brooke suffered from Sponastrime Dysplasia was not communicated to Dr Dasilva prior to her admission and Dr Dasilva was not told of and was not aware of, Brooke having the condition before proceeding to anaesthesia. Dr Kuzinkovas did not provide Dr Dasilva with a clinical history of Ms Tiddy prior to surgery commencing.

43 On 18 September 2018, Brooke was admitted to St George Private Hospital for the planned elective surgery scheduled for 7am. Prior to arrival, Brooke self-administered Valium at home at 4:30am but was reportedly still very anxious. Dr Dasilva, Anaesthetist, directed that she still be administered the usual standing order pre-medication of Lyrica (150mg) and Diazepam (5mg). Dr Dasilva's standing orders have since changed in that whilst his practice of ordering diazepam 5mg continues, he no longer orders Lyrica.

44 Dr Dasilva consulted with Brooke for the first time prior to surgery in the theatre holding bay and noted her admission observations, heart rate, blood pressure and oximetry to be within normal limits. Dr Dasilva asked Brooke a series of questions. None of the questions included a reference to Sponastrime Dysplasia. Brooke told Dr Dasilva that she did get a croup-like cough whenever she had a bad cold, that she was taking Lexapro and Valium and that she was allergic to Maxolon which made her vomit.

45 Dr Dasilva was satisfied that Brooke did not currently have croup and did not present with any respiratory compromise on auscultation. He was further satisfied that the pre-operative administration of medication on 18 September 2018 did not impair Brooke's capacity to engage in the pre-anaesthetic assessment.

46 Dr Dasilva observed Brooke had "a very short neck but adequate thyromental distance, mouth opening and neck extension".

47 Dr Dasilva considered that there may be a difficulty with intubation and accordingly requested his anaesthetic assistant prepare a size 6 endotracheal tube (ETT) and to have the CMAC video laryngoscope available. Dr Dasilva says that he noted that Brooke had a normal sized head and torso.

48 At 7:00am, induction of anaesthesia commenced. Attempts at establishing peripheral venous (IV) access to administer the anaesthetic medications were unsuccessful as Brooke was "very difficult to cannulate". As such, Dr Dasilva commenced anaesthesia via inhalation induction by administering 6 litres of 100% oxygen and Sevoflurane by facemask.

49 Anaesthesia was deepened with Sevoflurance until Brooke was fully anaesthetised. A size 3 laryngeal mask was then inserted, and Brooke was said to have maintained spontaneous respiration. All monitored parameters remained stable. A right internal jugular central venous line was inserted under ultrasound guidance.

50 Dr Dasilva administered the following medications intravenously: 50mg Propofol, 1 Mg Midazolam, 50mg Lignocaine, 10mg Magnesium, 2mcg Dexmedetomidine, 10mg Ketamine and 100mg Rocuronium (a muscle relaxant/paralytic).

51 The laryngeal mask was removed, and Brooke was intubated with a size 6 ETT under direct laryngoscopy. Endotracheal intubation was confirmed by capnography (monitoring CO2 output). According to Dr Dasilva, it then became "immediately apparent" that Brooke's lung compliance became abnormally decreased.

52 At 7:45am, a call was raised for the Medical Emergency Team (MET) and CPR was commenced as blood pressure was not recordable and there was pulseless electrical activity (PEA).

53 The progress notes indicate that cardiogenic shock and anaphylactic shock were considered in the differential diagnosis for the cardiac arrest.

54 At 8:30am, bloods were collected for Tryptase testing, to assess for anaphylaxis.

55 At 8:46am, Brooke was transferred to the ICU under the care of Dr Michael O'Leary (Intensivist). Mechanical ventilation proved difficult, and Dr Dasilva assisted with hand ventilation for a further 20 minutes until adjustments were made to the mechanical ventilator.

56 On admission to the ICU, Brooke's pupils were observed to be dilated and poorly reactive to light.

57 At 3:50pm, repeats of Tryptase blood testing were ordered.

58 A progress note by Dr O'Leary at 4.30pm indicated gradual improvement in Brooke over the course of the day, though gas exchange remained "problematic".

59 On 19 September 2018 at 8:50am, Dr O'Leary and Dr Vaswarmi examined Brooke and noted "Eyes open to voice; following commands, abdomen soft, UOP OK, afebrile. Plan: Extubate when appropriate. Restart regular medications".

60 By 1:15pm, Brooke was successfully extubated. Post-extubation, Brooke's breathing had become tighter. However, she remained haemodynamically stable.

61 At some time on the afternoon of 19 September 2018, Dr O'Leary learnt for the first time that Brooke had Sponastrime Dysplasia. He was told this by Brooke's family.

62 On 20 September 2018 the progress notes indicate that Brooke had been desaturating over the course of the previous night. Following a review by Dr O'Leary and Dr Vaswarmi at 8:50am, Brooke was commenced on high flow nasal prong (HFNP) for respiratory support.

63 At 11:20am, Brooke was noted to complain of headaches which exacerbated upon movement and coughing episodes. At 12:10pm, Dr O'Leary again reviewed Brooke and recommended commencement of BiPAP (non-invasive ventilation).

64 At 1:00pm, an interim ECG report, sought by Dr George Youssef, recorded Brooke's cardiac valves, right heart size and left ventricular size and systolic function all within normal parameters with no pericardial effusion noted. Dr Youssef was not told that Brooke had Sponastrime Dysplasia.

65 At 2:50pm, Brooke was reported to remain stable on BiPAP and resting in a chair. At 4:45pm, Dr O'Leary reviewed Brooke and noted that the BiPAP was not well tolerated and suggested intermittent BiPAP use if she worsened.

66 At 6:25pm, Brooke's condition had deteriorated, and she was returned to BiPAP. A nursing note stated that she complained of chest and back pain and was unable to tolerate remaining in bed for longer than 10 minutes. She was given Valium as she was noted to be "anxious +++".

67 Dr Waheed Shahidullah, a CMO in the position of ICU Registrar, contacted Dr O'Leary and an elective intubation was discussed for which Dr O'Leary came to the Hospital at approximately 11pm.

68 Dr O'Leary inserted a size 6 ETT and immediately ventilation was problematic, requiring increasing pressure to obtain tidal ventilation. The mechanical ventilator would not ventilate at all. Dr O'Leary was concerned that the tube was too small and had blocked, so he tried to change to a larger ETT. After inserting a bougie, Dr O'Leary withdrew the size 6 ETT and attempted unsuccessfully to insert an 8, then a 7 and then a 6 ETT. Brooke could not be intubated.

69 CPR was commenced and Dr O'Leary performed an emergency cricothyroidotomy. Brooke remained impossible to bag ventilate, in bradycardia but with a cardiac output. She had gross whole-body subcutaneous

emphysema. As it was clear to Dr O'Leary that the situation was now irretrievable, he decided to stop attempts at resuscitation.

70 At 3:00am on 21 September 2018, Brooke was pronounced deceased.

71 On autopsy, it was revealed that Brooke had a circumferential bank of mucosal ulceration just below the vocal cords, where there was observed a marked narrowing of the airway to a diameter of 7mm. Microscopic examination of intra-thoracic tissues confirmed chronic tracheal stenosis. Dr Irvine, Forensic Pathologist, noted that it was not entirely clear how the subglottic stenosis was related to the cardiopulmonary arrest during anaesthetic induction, but that "it certainly explains many of the clinical observations, and ultimately explains the death of the deceased". In her view, the stenosis was "almost certainly pre-existing".

72 Dr Irvine details that given that the larynx and trachea contain cartilage, it is not unreasonable that these could be affected by a bone disorder (congenital stenosis).

73 On examination, the stenotic area in Brooke showed "gross ulceration". Ulcers were also apparent on the surface of the epiglottis. According to Dr Irvine, while stenosis is not an unusual finding in individuals who have had prolonged intubation (several days to weeks), it is unusual in an individual intubated for "only a little over a day". In Dr Irvine's view, the observed ulceration suggests that the tissue on the surface of the stenotic region was quite tight around the endotracheal tube – and swelling of the ulcerated tissue would have made subsequent intubation more difficult.

74 The narrowing of the airway was found to be severe, comparable to the diameter of a drinking straw. Dr Irvine noted that the normal tracheal diameter in an adult is approximately 15 to 25mm, although Brooke was within the smaller range.

75 In the four years prior to her death, Brooke suffered generalised anxiety disorder and major depressive disorder for which she was prescribed Escatilopram (Lexapro 20mg daily), Propranolol (40mg daily), Agomelatine (Valdoxan 25mg daily) and Diazepam (Valium 5mg PRN). On two occasions, Brooke presented to Campbelltown Hospital with suicidal ideations and underwent mental health assessments. At the time of her death Brooke had also been taking Esomeprazole (Nexium 20mg daily) for gastric acidity and was prescribed a bronchodilator and steroid inhalers for asthma.

76 There was no hospital policy requirement for a patient with chronic or comorbid conditions to undergo a "work up" prior to admission.

77 Professor Goh is a specialist radiologist who was asked to review a number of X-rays performed on 18, 19, 20 and 21 September 2018. His unchallenged findings included the following:

(1) The chest X-ray of 18 September 2018 at 8:42 AM shows that the ETT tip lies approximately 5.5 centimetres above the carina which would be in a satisfactory position and that it was well below the site of the glottic stenosis lying at least 3.5 centimetres below the glottic stenosis;

(2) The chest X-ray of 18 September 2018 at 11:38 AM shows the ETT tip lying 4 centimetres above the Carina in a satisfactory position and that it was well below the site of the glottic stenosis and is thought to lie 4 centimetres below the glottic stenosis;

(3) The chest X-ray of 18 September 2018 at 2:41 PM shows the ETT tip lying 3.8 centimetres above the carina which is in a satisfactory position, that the ETT tip was well below the site of the glottic stenosis and that it is thought to lie 4.2 centimetres below the glottic stenosis;

(4) In relation to the chest X-ray of 19 September 2018 at 8:12 AM Professor Goh is of the view that the ETT tip lies 2.1 centimetres above the carina and 5 centimetres below the glottic stenosis;

(5) The chest X ray of 20 September 2018 at 8:19 AM indicates that no ETT is identified;

(6) The same is true of the chest X-ray taken at 9:37 PM on 20 September 2018;

(7) In relation to the chest X-ray of 21 September 2018 at 00:10 AM Professor Goh says that the ETT tip is within the right main bronchus, approximately 2.1 centimetres into the right main bronchus but the left lung is inflated;

(8) The chest X-ray taken 21 September 2018 at 1:38 AM shows the ETT tip within the right main bronchus, approximately 1.2 centimetres into the right main bronchus and the left lung is inflated. A small left sided pneumothorax has developed;

(9) In relation to the chest X-ray dated 21 September 2018 at 2:20 AM Professor Goh is of the view that the ETT tip is within the right main bronchus, approximately 1.4 centimetres into the right main bronchus and that the left lung is inflated. A small left sided pneumothorax which was indicated on the previous X-ray appears unchanged. The left chest/ pleural drain tubing is kinked 4.3 centimetres from the end of the tube. Pneumomediastinum has slightly progressed.

78 Professor Goh comments that Brooke's body habitus and short neck in combination with the subglottic stenosis would have been challenging for airway access.

79 Dr O'Leary's attempts to insert the 8, 7 and 6 size ETTs occurred after the last X-ray at 2.20AM.

Matters that are factually contentious

80 There are eight matters that are factually contentious relevant to the manner and cause of Brook's death. The matters are:

(1) Ought Brooke have been referred for a preoperative assessment?;

(2) If Brooke had been referred for a preoperative assessment, what would have been learnt about her medical history, in particular Sponastrime Dysplasia?;

(3) Did Dr Dasilva read the words “Sponastrime Dysplasia” on the Admission Referral Form or the Patient Health History - General Form?

(4) Did Brooke suffer an anaphylactic reaction on anaesthesia on either 18 or 21 September 2018?;

(5) What were the circumstances surrounding the loss of the information from the anaesthetic cartridge?;

(6) Why did ventilation fail immediately after intubation on each of 18 and 21 September 2018?;

(7) Why did Brooke arrest on 18 and 21 September 2018?; and

(8) Why did Brooke deteriorate in ICU 20 September 2018?

81 The Hospital does not seek to be heard in respect of the factual findings proposed by Counsel Assisting.

82 Determination of these matters necessarily informs the issues identified in paragraph [18].

Matter 1 Ought Brooke have been referred for a preoperative assessment?

The evidence of Dr Kuzinkovas

83 The pre-operative assessments undertaken by Dr Kuzinkovas at his clinic consisted of blood tests and a dietician review. The pathology tests he ordered showed signs of metabolic syndrome, insulin resistance, pre-diabetes, fatty

liver disease, and high cholesterol/triglycerides – however these did not cause him to consider the need for a specialist preoperative assessment as “that was part of pre-operative assessment already. So she needed treatment”.

84 Dr Kuzinkovas said that he applied his clinical judgement to the question of the level of work up required for Brooke prior to surgery, to the best of his knowledge and skills.

85 Dr Kuzinkovas did not accept that Brooke’s presentation with her comorbidities should have initiated a process of pre-admission assessment, saying “not necessarily so”. According to him, Brooke did not have symptoms which affected her day-to-day life. She did not say anything about breathing problems or anything related to her heart which could raise alarms bells to him saying “okay you might be an anaesthetic risk” and trigger a more thorough pre-operative assessment.

86 Despite Brooke’s presentations and her short stature, he did not consider pre-admission assessment was required, stating that “If a patient highlights any significant medical comorbidities, then I escalate and - escalate to my colleagues who perform further assessments”. In this context he referred to patients disclosing specific issues or “red flags” like being a heavy smoker, having shortness of breath or being unable to walk up a flight of stairs.

87 The only logical conclusion from the evidence of Dr Kuzinkovas is that he was relying on his patient to highlight his or her “significant comorbidities”. On that basis, Dr Kuzinkovas did not consider “super super obesity,” the condition of Sponastrime Dysplasia (about which he knew nothing other than what Brooke told him about it) and her croup were such that he should have escalated the matter to his colleagues, that is, for Brooke to have a pre-operative assessment.

88 Dr Kuzinkovas agreed in hindsight that Brooke was an unusual and high-risk patient, and he accepted, with the benefit of hindsight, that Brooke did require a pre-operative assessment, at least by an anaesthetist and possibly a respiratory physician.

89 Dr Kuzinkovas accepted that Brooke's proposed bariatric surgery was totally elective with no reason to rush the workup.

The evidence of Dr Dasilva

90 Over and above the agreed factual matters, Dr Dasilva said, "I can only assume that he [Dr Kuzinkovas] didn't think there were any anaesthetic issues relevant to communicate with me". He accepted that the only time he would receive information regarding clinical history from Dr Kuzinkovas for a patient would be if Dr Kuzinkovas was of the view that the information was relevant from an anaesthetic point of view. He accepted that he was reliant on Dr Kuzinkovas.

91 Later in his evidence, Dr Dasilva stated: "I'm not sure what you mean by relying. I mean, I talk to and take a history and examine all my patients myself as well, so I'm not relying on [Dr Kuzinkovas] to deliver me all the information". He added "…I wasn't relying on him, because I think that information – ultimately, I have to obtain that, but of course, if he knew something, then it was helpful for him to share that with me".

92 Counsel Assisting made the submission that it is difficult to reconcile this aspect of Dr Dasilva's evidence.

93 Dr Dasilva confirmed that because he had not received any information from Dr Kuzinkovas in relation to Brooke from an anaesthetic point of view that he had no concerns about proceeding to anaesthesia, "after I had spoken to her and examined her myself." His only concern with anaesthesia was that she had a very short neck – "people with short necks can be difficult to intubate sometimes".

94 To his credit, Dr Dasilva agreed that given Brooke had Sponastrime Dysplasia, the pre-anaesthetic screening she received was insufficient. He agreed that being informed by Dr Kuzinkovas about Sponastrime Dysplasia prior to her admission would have been "desirable" and "beneficial."

95 Had he been told the day before the operation that Brooke had Sponastrime Dysplasia, Dr Dasilva said “I would've looked up what the condition was because I was unaware of the condition and then referred her on appropriately prior to the procedure.”

96 Dr Dasilva agreed that had he discovered the day before the operation that associated with Sponastrime Dysplasia was subglottic stenosis and/or tracheobronchomalacia it would be a reason to refer her and he would have cancelled the surgery and referred her on appropriately.

97 Dr Dasilva could not recall ever being contacted by a nurse from the hospital in relation to an anaesthetic issue prior to admission; he said, “Not that I can recall”.

98 He accepted that croup in an adult is unusual but did not think it gave rise to a concern about capacity to anaesthetise a patient because “croup is usually a transient process, and if the patient doesn’t have Croup at the current time, then it’s usually not a concern.” It does not indicate difficulty to intubate. He did not have any concern that Brooke’s airway might be problematic from the point of view of intubating in respect of the croup. He agreed that his concern was the fact that Brooke had a short neck.

99 When asked whether he considered, as at 18 September 2018, that an adult with croup was an indication of airway difficulty, he said “not necessarily airway difficulty, but it would be a respiratory symptom. Croup generally means some form of tracheomalacia, but it may mean other things as well…”

100 Dr Dasilva recorded that she had “croup-like cough whenever she had a bad cold,” then auscultated her chest “to ascertain that she did not have any wheeze or any asthma related issues.”

101 He agreed with Professor MacPherson’s proposition that a person of Brooke’s age at the time suffering croup would suggest “abnormal airway architecture”,

but in respect of “possibly critical airway narrowing” he said that would be more difficult to ascertain.

102 Dr Dasilva agreed that had Brooke had a pre-operative assessment, it may have uncovered Brooke's significant anaesthetic complications during her previous surgery in March 2003 and accepted that it would have given a greater opportunity for that information to be uncovered.

103 He accepted that had that information in relation to Brooke’s previous surgery in 2003 been forthcoming days before the operation “then certainly, I would have proceeded differently”.

104 He agreed with the opinion of Professor Seppelt that Brooke was an unusual and high-risk patient who warranted a pre-operative assessment, and pre-operative in the sense of the days or weeks leading up to the operation, not on the morning of the operation.

The evidence of Dr Garrett Smith

105 Dr Smith said the starting point for a pre-operative assessment would have been the anaesthetist. Any investigations or recruitment of other specialists such as an ENT surgeon falls within the remit of the anaesthetist. Had the anaesthetist spoken to Brooke “in the weeks leading up to the surgery they would have had the opportunity to recruit specialists as required, and perform investigations as required”.

The evidence of Dr David Greenberg

106 Dr Greenberg stated that after learning that Sponastrime Dysplasia is associated with mid-face dysplasia, which can be associated with airway problems, he considered this a “red flag” which is “clearly a very significant indicator for the anaesthetist”. His view was that mid-face hypoplasia has “anaesthetic implications,” which is important information of which the clinicians (surgeon or anaesthetist) should be aware. He stated: “Seeing the patient on

the day of the procedure, I couldn't see how that could be ideal in this setting" and that "some form of assessment prior to anaesthetic would have been appropriate and reasonable practice."

107 Dr Greenberg stated that on the admission form, "Pre-admission clinic attendance required" should have been ticked and the fourth box down (anaesthetic consult) should also have been ticked. He maintained his opinion that if discussion by Dr Kuzinkovas with the anaesthetist was not possible then Brooke should have been referred to a pre-anaesthetic clinic prior to her surgical procedure.

108 Dr Greenberg suggested that Brooke appears to have gone from the surgeon's rooms onto the operating list with the anaesthetist only seeing her on the day, leaving her various comorbidities with the dysplasia "not… addressed." In his view "there doesn't seem to have been a connect with Dr Kuzinkovas and Dr Dasilva."

109 Looking at the matter prospectively, he said there should have been consultation between the surgeon and the anaesthetist prior to the surgery.

The evidence of Professor MacPherson, Dr Gallagher and Professor Seppelt

110 Each of Professor MacPherson, Dr Gallagher and Professor Seppelt was of the view that Brooke should have had a pre-operative work-up, namely she should have been seen by an anaesthetist or another specialist in advance of the operation.

111 Each of Dr Gallagher and Professor Seppelt commented on the rarity among adults of croup, which Brooke had. It was "extremely unusual" - a "red flag."

112 Professor Seppelt disagreed with the view that Brooke was at the "lower end" of bariatric risk because she was "a very unusual person presenting for bariatric surgery" with a syndrome of uncertain implications. In his view, "there was a missed opportunity to initiate a series of investigations that could well have led

to the conclusion that there was an underappreciated or underdiagnosed problem, which was the subglottic stenosis".

Counsel Assisting's submissions

113 Counsel Assisting submits that having regard to the evidence canvassed in paragraphs [83] to [112] the Court would be comfortably satisfied that Brooke ought to have been referred for a preoperative assessment in the days or week leading up to her surgery on 18 September 2018. That submission is made looking at the matter prospectively.

Dr Kuzinkovas' submissions

114 Dr Kuzinkovas submits generally that, in circumstances where a witness whose reputation and interests are in question in a public forum, it is essential that all the evidence on a particular contentious issue is identified, referred to and reconciled, with and in the context of any concession made. He submits that relevance, cogency and overall fairness are all factors that must bear upon the decision to make use of evidence to support a proposed factual finding.

115 On this particular factual matter, Dr Kuzinkovas submits to the effect that:

(1) the type of assessment or the symptom profile necessitating assessment has not been identified;

(2) the implicit criticism that he relied on the history provided by Brooke when assessing the need for referral is without foundation; and

(3) the submission that the evidence supports a finding that Dr Kuzinkovas ought to have referred Brooke for pre-operative assessment is misconceived and fails to address other evidence before the Court.

116 In support of his submissions Dr Kuzinkovas draws upon the following evidence and contentions:

(1) The GP referral letter dated 24 August 2018 from Dr Paveen outlined a past medical history, relevantly, the Sponastrime Dysplasia diagnosis, moderate chronic anxiety (2016), breathing difficulty (2017).

(2) Dr Kuzinkovas has considerable experience in assessing the suitability of patients for surgery. His clinical expertise was not questioned.

(3) Brooke presented as a mature adult, 32 years of age affected by obesity. She was studying social work part time and working fulltime in the community. Brooke engaged in the consent process and understood the nature of the surgery proposed. Her family obesity history is disclosed in the clinical records, her sister had undergone bariatric surgery by Dr Kuzinkovas, and her mother had suffered a myocardial infarction at age 38 because of obesity.

(4) Dr Kuzinkovas had no concerns regarding Brooke's intellectual capacity to understand the matters discussed; he had no concerns regarding her cognition and her ability to communicate effectively. He rejected any suggestion she had low health literacy.

(5) Regarding the Sponastrie Dysplasia diagnosis, (referred to by Dr Kuzinkovas as 'genetic dwarfism' in the Admission Referral Form (ARF), Brooke informed Dr Kuzinkovas that the effect of it for her was orthopaedic, requiring ankle surgery, that her Sponastrime Dysplasia was associated with musculoskeletal problems. He was not informed of any anaesthetic issues in relation to her previous ankle surgery and endoscopy.

(6) Regarding breathing difficulty, prior to the consultation, Brooke had completed a Patient Medical History and in response to the question as to 'Whether you have ever suffered from the following problems: Respiratory Problems', Brooke ticked No. At the consultation, Brooke informed Dr Kuzinkovas that she had occasional asthma, mild, moderate, light.

(7) Dr Kuzinkovas was not informed by the GP nor by Brooke, of any treatment medication or preventative medication for asthma, recurrent respiratory problems requiring hospital admissions as a child, recurrent episodes of adult croup, recent episodes and consultations for a barking type of cough, wheeze and shortness of breath. It may be inferred that, consistent with the GP's omission of reference to this history in the referral letter, Brooke did not consider the symptoms uncommon.

(8) If he had been so informed, Dr Kuzinkovas would have organised a referral to a respiratory specialist.

(9) Regarding Brooke's mental health, she informed Dr Kuzinkovas that her depression was well controlled with treatment, she made no reference to previous hospital admissions for acute presentations and suicidal ideation.

(10) According to Dr Kuzinkovas, she did not present as depressed, and he understood she was consulting a psychologist. There is no psychiatric evidence of major depressive disorder being diagnosed.

(11) There is no pre-anaesthetic clinic or preadmission clinic at St George Private Hospital. Dr Kuzinkovas applies his surgical clinical judgment to his preoperative assessment, and if there are red flags of surgical significance, he consults with the anaesthetist. His professional relationship with Dr Da Silva was longstanding, the blood tests disclosed a metabolic syndrome confirming the need for surgery, they had shared experience involving complex surgery with obese patients with significant comorbidities. The "super super" descriptor of her obesity in comparison with many of his patients was not considered high risk.

(12) From a surgical perspective, Brooke did not present with any significant respiratory or cardiac red flags. Dr Kuzinkovas was not informed of the croup history, and the gastric surgeons, Dr Greenberg and Dr Smith considered that there was no need to refer Brooke to a respiratory

specialist or ENT on the history known by Dr Kuzinkovas. There were no clinical findings suggestive of any cardiac pathology which was confirmed on autopsy. Contrary to Professor Seppelt's opinion, that a 'bare minimum workup would have included an echocardiogram' (ECG), Dr Kuzinkovas considered there was no clinical basis for a cardiac referral, Dr Da Silva confirmed there was no need for an ECG and on consideration of the clinical assessment, the ECG in hospital on 20 September 2025 and the autopsy report, Dr Smith stated that no cardiac referral was necessary.

(13) Lack of information meant that Dr Kuzinkovas was not aware of Brooke's earlier surgery airways history, that could have influenced her management. In view of Brooke's presentation, it must be inferred that she did not know of that history.

(14) The concession by Dr Kuzinkovas that Brooke was an unusual and high-risk patient requiring a preoperative assessment, was made after analysing information as to past events and material not available to him at his preoperative assessment.

(15) According to Dr O'Leary, access to a patient's previous history is problematic and he was unsure that a preoperative assessment would have necessarily prevented the outcome as the previous airways issues were not communicated to the family, 'if the information is not searchable and not available and not known… it could be very difficult to tease that out in a patient'

(16) Dr Da Silva was not sure that information regarding previous anaesthetic complications would have been forthcoming, and Dr Smith considered it was unlikely that any meaningful information would be available by contacting former paediatricians.

(17) The basis for Professor Seppelt's opinion that there should have been a referral to a respiratory specialist or cardiologist is the unusual nature of

Brooke's dwarfism. His reasoning process suggests a belief of vulnerability which is inconsistent with her presentation to Dr Kuzinkovas and Dr Da Silva. In cross examination, however Professor Seppelt was unable to respond to a question as to the type of further information that might be obtained on referral, nor did he identify the relevant assessor.

(18) Professor Seppelt, somewhat reluctantly, agreed to defer to the opinion of a bariatric surgeon with experience in surgery on patients with dwarfism regarding the necessity for referrals, from a surgeon's point of view.

(19) According to Dr Smith, Brooke was a suitable patient to undergo the weight loss surgery proposed, which was complex, but predictable in the sense that the steps are identical in each case. There were no surgical comorbidities that made the surgery high risk surgery, all patients undergoing bariatric surgery are morbidly obese, having operated on patients with dwarfism, he did not consider Sponastrime Dysplasia was a contraindication.

(20) The bariatric surgeon's role is to assess a patient based on whether there will be a benefit to their metabolic problems. In his opinion, any preoperative assessment should have been initiated by Dr Da Silva after an initial anaesthetic review, that generally, direct communication between the surgeon and the anaesthetist prior to admission is not required as it is recommended and common practice for anaesthetists to contact patients prior to an elective operating list. It is not the surgeon's responsibility to take stewardship of anaesthetic assessment by way of further investigations or enquiry. Dr Greenberg agreed, stating that the surgeon's role involved choice of procedure and holistic review for obvious red flags.

(21) There was no need for a mental health referral prior to surgery. According to Dr Smith, psychiatric history is only relevant if there is a florid major psychiatric illness that plays into decision making about the

surgery, and whether the patient can comply with post operative dietary instructions, that recent research from Monash established there was no evidence supporting the contention that patients undergoing bariatric surgery should be referred to a psychologist.

(22) On review of Dr Kuzinkovas' evidence concerning Brooke's presentation and the psychiatric history provided by her and the GP, Professor Seppelt conceded that a referral for a mental health assessment would not be expected.

117 Dr Kuzinkovas concludes his position on this disputed factual matter with the submission that the proposed finding in so far as it relates to Dr Kuzinkovas is not supported by the evidence, which negates Professor Seppelt's requirement for a referral to a respiratory specialist, particularly in circumstances where Dr Kuzinkovas was not informed by the referring GP or Brooke of her croup, 'the extremely unusual… red flag'. He says the evidence also negates the assertion that Dr Kuzinkovas should have referred Brooke for cardiac and mental health assessments.

118 It is further submitted that the evidence of Dr Smith and Dr Greenberg as to a surgeon's role is persuasive and supports a finding that any preoperative anaesthetic assessment was not within the surgeon's role but that if Counsel Assisting's proposed prospective finding is made in relation to Dr Kuzinkovas, the terms of that finding should be qualified by reference to the evidentiary material outlined and this provides the basis for a finding which excludes any adverse criticism of Dr Kuzinkovas.

Dr Dasilva's Submissions

119 Dr Dasilva does not make any submission that Brooke ought *not* to have been referred for pre-operative assessment so far as that concerns him. He makes three submissions in response to those of Counsel Assisting.

120 Firstly, he takes issue with Counsel Assisting's submission that he relied upon the information provided to him pre-operatively by Dr Kuzinkovas in *"any material way"*. He maintains that his pre-operative assessment of Brooke was informed by his own consultation with, and examination of, Brooke.

121 He says that when viewed in the context of other oral evidence given by him, his acceptance of Counsel Assisting's proposition that he was reliant on Dr Kuzinkovas should be understood as meaning he *"accepted"* what was conveyed to him by Dr Kuzinkovas.

122 Dr Dasilva goes onto submit that any information provided pre-operatively by Dr Kuzinkovas was merely a *"component part"* and *"lesser element"* part of his pre-operative assessment of Brooke which was informed by Dr Dasilva's own consultation with, and examination of, Brooke.

123 Secondly, he submits that Counsel Assisting's submission that his only concern in relation to proceeding with anaesthesia was Brooke's short neck does not take into account his evidence that in addition to that there remained risks of intubating and as a consequence he ordered that a C-MAC video laryngoscope and smaller ETT be available in theatre.

124 Thirdly, as regards the issue of croup he submits:

(1) No submission is made by Counsel Assisting to the effect that in the course of undertaking his pre-anaesthetic assessment of Brooke Dr Dasilva did not consider the history of croup.

(2) The evidence demonstrates that he appropriately elicited a relevant history of the circumstances in which Brooke experienced croup from time to time: viz. whenever she had a bad cold.

(3) He accepted that the existence of croup generally indicated a form of tracheomalacia but may indicate other issues. Relevantly, Dr Dasilva

accepted the proposition that croup can suggest abnormal airway architecture.

(4) As a result of, and in addition to, eliciting the history of intermittent croup, Dr Dasilva carried out an examination of Brooke's chest by auscultation and found on examination that Brooke did not have a wheeze or asthma related issue.

(5) Having elicited the history of croup, Dr Dasilva quite appropriately satisfied himself that croup was not extant at the time of the preoperative assessment. In that circumstance, Dr Dasilva properly excluded the presence of croup (and a possibly compromised airway) indicating a possible difficulty intubating Brooke.

(6) The detail of Dr Dasilva's pre-anaesthetic assessment is set out in Dr Dasilva's second and third statements. The significant additional detail provided by Dr Dasilva in his oral testimony reflects experienced, expert and careful anaesthetic practice.

Conclusion

125 I accept the submission of Counsel Assisting that, looking at the matter prospectively, Brooke ought to have been referred for a pre-operative assessment in the days or week leading up to her surgery on 18 September 2018.

126 In reaching that conclusion, I note the following matters:

(1) Dr Kuzinkovas' submissions that (i) the type of assessment or the symptom profile necessitating assessment "has not been identified" and (ii) the implied criticism of Dr Kuzinkovas for reliance on the history provided by Brooke was "without foundation" are not reasonably arguable given the evidence referred to on this matter at paragraphs [83] to [90].

(2) I acknowledge the additional evidentiary matters put forward by Dr Kuzinkovas but reject the submission that such a finding is misconceived and fails to address this evidence. In this context it is sufficient to note that each of the expert medical witnesses who assisted this inquest has substantial qualifications and experience in the specialties relevant to the case. Each of them brought an independent mind to the issues, evidenced by the fact that they did not concur on all points. On the basis of their qualifications, experience and objectivity the Court considers their opinions reliable and places significant weight upon them and the overwhelming weight of the expert evidence is that Brooke ought to have been referred for a pre-operative assessment in the days or week leading up to her surgery on 18 September 2018.

(3) I prefer the evidence of Dr Greenberg where it conflicts with that of Dr Smith on this issue. I do so because:

(a) Initially, Dr Smith sought to downplay Brooke's disclosure of her Sponastrime Dysplasia to Dr Kuzinkovas, contending that, whilst he would have researched the condition (because like all the experts he had not heard of it before this case) he would have done so merely for "interests' sake". To his credit, he withdrew that contention when questioned by the Court.

(b) Later, Dr Smith sought to contend that, despite the complex nature of the surgery and Dr Kuzinkovas' not having previously heard of Sponastrime Dysplasia, Dr Kuzinkovas need not have done any research or inquiry on the condition – that he was entitled to rely on what Brooke told him and that otherwise it was a matter entirely for his anaesthetist.

With unfeigned respect to Dr Smith I think it untenable that complex (albeit predictable) bariatric surgery proceed without the surgeon having accurate information and a proper understanding of a

patient's presentation. In this regard I note the following evidence of Dr Greenberg:

> "I see the surgeon's role as not just doing the surgery. We're doing the surgery in a patient, and that doesn't always mean that that's all you're going to do…"[2]

(4) As regards Dr Dasilva's submissions, I do not understand it be contended by Counsel Assisting that Dr Dasilva was entirely reliant on the provision of information (or the lack thereof) by Dr Kuzinkovas, merely that he placed *some* reliance on it.

(5) Nor do I accept that Dr Dasilva meant "accepted" when he agreed he had "relied" upon the information provided by Dr Kuzinkovas. Even when that concession is viewed in the context of his other evidence the contention cannot be accepted. Indeed, Dr Dasilva's submission that information provided pre-operatively by Dr Kuzinkovas was merely a "component part" and "lesser element" of his pre-operative assessment concedes exactly that which he argues against.

(6) I accept that in proceeding with anaesthesia, Dr Dasilva was concerned with more than merely Brooke's short neck. His evidence that he ordered a C-MAC video laryngoscope and smaller ETT be available in the operating theatre supports the submission that he was alert to the fact that there remained risks of intubating.

(7) The submission that the details of Dr Dasilva's pre-anaesthetic assessment and his oral testimony reflect experienced, expert and careful anaesthetic practice must be read in the context that, in this instance, his practice was fundamentally compromised to the extent that he did not have a complete picture of Brooke's history, in particular, any knowledge of Sponastrime Dysplasia.

[2] T188.8-10

Matter 2 – If Brooke had been referred for a preoperative assessment, what, on the balance of probabilities, would have been learnt about her medical history, in particular, Sponastrime Dysplasia?

127 Dr Kuzinkovas accepted that a pre-operative assessment with a full medical history could have discovered that Brooke suffered from laryngotracheomalacia, subglottic stenosis, and that croup would have been revealed. He also accepted that had there been a pre-operative assessment conducted, more information would have been ascertained in relation to the extent of Brooke's depression.

128 Dr Dasilva agreed that had he seen Brooke in a pre-operative assessment in the days or weeks leading up to the operation that it would have increased the opportunity for more information to be elicited in respect of her previous hospital admissions. Similarly, it would have provided him time to consider the diagnosis of Sponastrime Dysplasia. It would also have given him the opportunity to question Brooke more closely in relation to her airway, and in light of her recent shortness of breath and wheeze on a background of croup.

129 Professor MacPherson was of the view that had Brooke been referred for a pre-operative assessment, Brooke's current and past medical history, which may impact on the upcoming surgery, would have been uncovered and investigated and, in particular, Brooke's "unusual condition" which was critically associated with a range of pathophysiologies, which are of direct impact to the anaesthetist and involved the upper airway, would have been discovered and investigated.

130 Dr Gallagher was of the view that if Brooke had a pre-operative assessment the recurrent croup would have been questioned more closely, and a better understanding of that gained, and that would have led to an investigation of what Sponastrime Dysplasia represented.

131 Professor Seppelt was of the view, regardless of who started the process, Brooke would ultimately have been referred for more detailed airway investigation, whether that be by a respiratory physician or by an ENT surgeon, the subglottic stenosis identified, and hypothetically, even referred to Dr

Gallagher for treatment of the subglottic stenosis, which probably would have taken precedence over the bariatric surgery.

Counsel Assisting's submissions

132 Counsel Assisting submits that in light of the expert evidence of each of Professor MacPherson, Dr Gallagher and Professor Seppelt, the Court would be comfortably satisfied that had Brooke had a pre-operative assessment in the days or weeks leading up to 18 September 2018 Brooke's pathophysiologies, including her unusual airway architecture viz. her subglottic stenosis which had a direct bearing on her being anaesthetised, would have been discovered. This would have led to referral to an ENT Surgeon or respiratory physician for further evaluation.

Dr Kuzinkovas' submissions

133 Dr Kuzinkovas submits that so far as the concessions made by him on this issue are concerned they are made with the benefit of hindsight, with no reliable evidence of what material may have been uncovered and what material findings would have inevitably been made available.

134 He says the other evidence referred to by Counsel Assisting relates to retrospective assessment from an anaesthetist perspective and, with reference to the demarcation of roles and the different skill sets of surgeon and anaesthetist, airway architecture is not a matter for referral by a surgeon.

135 He says that if he had conducted research in 2018 regarding the Sponastrime Dysplasia diagnosis, it cannot be stated with any degree of certainty that he would have been informed of the association with subglottic stenosis and tracheobronchomalacia. In this regard he relies on his limited recollection of researching the condition after Brooke's death. Specifically, that he recalls reading about Sponastrime Dysplasia's association with musculoskeletal problems and metaphysis development but had no recollection of a reference to subglottic stenosis.

136 He also notes in support of his submission that according to Dr O'Leary, nothing about Brooke's presentation disclosed an airways problem and when Dr O'Leary conducted a forensic search, the search required entry of specific terms such as Sponastrime Dysplasia and anaesthesia/intubation.

137 Dr Kuzinkovas continues the submission with reference to Prof MacPherson's concession that what was seen in his Wikipedia search in 2021 may be different to a search in 2018 and Prof MacPherson's acknowledgement that Wikipedia may not be reliable, stating 'when I'm writing a professional document, I go to the highest level of sources': something Dr Kuzinkovas submits is inconsistent with him having searched Wikipedia for the purposes of his opinion.

138 Dr Kuzinkvoas also relies on the evidence of Dr Smith that just prior to giving evidence, he conducted a Pubmed search of Sponastrime Dysplasia and that the full text search results disclosed 33 references, of which 11 were available in September 2018. Those 11 references were reviewed and do not disclose reference to subglottic stenosis or tracheobronchomalacia.

139 When Dr Smith conducted a wider search, Sponastrime Dysplasia and subglottic stenosis, 1 reference, Langer et al (1996) was disclosed, a paper about which Professor Seppelt said 'didn't immediately strike me as the most relevant'.

140 Dr Kuzinkovas says that as a consequence of all the above, there is no evidentiary basis to suggest that any internet search in 2018 of Sponastrime Dysplasia would have alerted him to refer Brooke for an assessment of her airway pathology and there was no basis for a pre-operative assessment from a surgeon's perspective.

141 Dr Kuzinkovas continues that the assertion by Counsel Assisting that the subglottic stenosis 'would have been discovered' inappropriately conflates hindsight and cognitive bias, potential sources of information, and a possible relevant referral as predictable and inevitable and concludes by submitting that

there is no basis for adverse criticism of Dr Kuzinkovas regarding the second matter in dispute.

Dr Dasilva's submissions

142 Dr Dasilva submits that on a consideration of the whole of the evidence, one could not be confident that an assessment in the days or weeks prior to surgery would have revealed the fact that Brooke had "unusual airway architecture".

143 He submits that the premise to Counsel Assisting's submission as to such a finding is that an investigation of the term Sponastrime Dysplasia would have revealed that Brooke had subglottic stenosis. That finding in turn relies on assumptions as to what might have been discovered whether by independent internet search such as PubMed, Google or some other source.

144 In support of the submission that the evidence falls short of making a finding that Brooke's subglottic stenosis would have been discovered, he submits that four aspects of the evidence are relevant.

145 One, in addressing the Wikipedia search annexed to his report, Prof Greenberg conceded he could not say what a search may have disclosed as at September 2018. To be clear, there was no evidence at the hearing as to what in fact might have been disclosed as at 2018. This is fundamental.

146 Two, it was Dr Smith's evidence that a PubMed search conducted by him at the date of the hearing revealed just 33 articles relevant to Sponastrime Dysplasia, only 11 of which were available as at 2018. A refined search for articles relating to both Sponastrime Dysplasia and subglottic stenosis produced just a single article.

147 Three, upon closer consideration of the references contained in the Wikipedia annexure to Prof Gallagher's report, it is apparent that the source article referred to in the footnote did not itself include any reference to the terms subglottic stenosis or tracheobronchomalacia.

148 Four, in considering what might likely have occurred had a pre-operative assessment occurred prior to 18 September 2025, it is submitted that one should not lose sight of the fact that Sponastrime Dysplasia is an exceptionally rare condition. Of all the expert witnesses who gave evidence at the hearing, none had heard of Sponastrime Dysplasia prior to them being involved in the Inquest.

149 For these 4 reasons it is submitted that the Court could not confidently find (as submitted by Counsel Assisting) that had a pre-operative assessment been carried out in the days or weeks prior to the surgery on 18 September 2018, Brooke's pathophysiology (including her unusual airway architecture) would have likely been discovered. It is submitted such a finding requires a considerable degree of speculation.

Counsel Assisting's submissions in reply

150 In answer to Dr Kuzinkovas' submissions concerning hindsight bias and Dr Da Silva's submissions on this issue generally, Counsel Assisting submits that whilst the Court should be careful to avoid hindsight bias in judging the actions of any particular person in the process of making a finding which results in adverse criticism of that person's conduct, it cannot be avoided that the coronial process is conducted with the benefit of hindsight. The reality is that the Coroner looks back at what happened in respect of a particular death with the benefit of the facts available to him or her and determines what findings should be made about the manner and cause of death and what recommendations should be made arising out of the death of a person.

151 Further, the non-use of hindsight analysis would limit the coronial process if it were to be confined to assessing all the facts prospectively, because it would deprive the Coroner of the ability to formulate sensible recommendations or generate learnings from the tragic circumstances of, in this case, Brooke's death.

152 On this matter, Counsel Assisting relies on the observations of State Coroner Barnes in the findings of the Inquest into the deaths arising from the Lindt Café Siege (2017) at [25] and the findings of State Coroner O'Sullivan at [10]-[11] of the Inquest into the death of CS (2022):

> "A coronial inquest takes places, necessarily, after the event. It follows that, unavoidably, a coronial inquest is conducted with the benefit of hindsight. However, in performing the role set out in ss. 81 and 82 of the Act, it is accepted that a Coroner must judge the appropriateness of steps taken or not taken by an involved person or organisation against the information that was available to that individual or organisation at the time, and not, as has been pointed out in submissions, through the prism of the tragic outcome of the case. Indeed, coronial inquests routinely examine whether, armed with the knowledge available to the relevant individual or organisation at the time, a party could have or should have acted differently in the particular circumstances that presented themselves. This is, in my view, entirely appropriate, and indeed a fundamental aspect of the coronial jurisdiction."

153 He submits therefore, that, in the circumstances of this Inquest, the Court should ensure that any finding involving the criticism of a person or person's conduct of a particular matter is not infected with hindsight bias. In that way an unfair criticism can be avoided. However, the Court should not be reluctant to make findings with the benefit that hindsight may bring to the Inquest. Such findings may pertain to the appropriateness or otherwise of a person's conduct and/or to making recommendations arising out of the Inquest. Such a finding is not unfair. The formulation of the finding can be expressed in such a way so as to recognise the particular circumstances that existed at the relevant time.

154 Counsel Assisting continues: the Inquest proceeded to examine what searches could or should have been made of Brooke's extremely rare condition. That approach was adopted by Counsel Assisting and by those representing Dr Kuzinkovas and Dr Dasilva. To that end, a considerable focus of the second

factual matter in dispute is concerned with what a contemporaneous electronic search, whether Wikipedia, Google or Pubmed, may have revealed.

155 He says that to a large extent, if not entirely, the point seems to have been missed that the failure to refer Brooke for a pre-operative assessment resulted in the loss of opportunity for more information relevant to the manifestations of Brooke's condition of Sponastrime Dysplasia, which directly impacted on her anaesthetization, being discovered. Her proceeding to being anaesthetized was an essential element of her proceeding to the bariatric surgery, for which Dr Kuzinkovas consented her.

156 He continues that both Dr O'Leary and Dr Dasilva accepted, without equivocation, that a preoperative assessment provided the opportunity for a more thorough examination of a patient's medical history and the obtaining of information. Dr Kuzinkovas accepted there was no reason to rush the work up and Brooke's surgery was totally elective and with the benefit of hindsight Brooke required a pre-operative assessment by at least an anaesthetist and a respiratory physician, and accepted that had she had a preoperative assessment that Brooke's laryngotracheomalacia and subglottic stenosis could have been discovered.

157 Counsel Assisting also notes that of the various published papers comprising Exhibit 8, tendered by Counsel Assisting at the request of Dr Kuzinkovas' Counsel, three (that by Offiah et al, that by Cooper et al and that by Gripp et al) specifically refer to the paper authored by Langer et al in 1996 (Exhibit 6) whilst three others (that by Jeong et al and two by Hall et al) refer to a 1997 paper by Langer and two of the same authors of the 1996 paper with the not dissimilar title "Sponastrime dysplasia: diagnostic criteria based on five new and six previously published cases".

158 The 1996 paper by Langer et al was the paper referred to by Dr Smith in his evidence and the second hit on page 2 of the search done by Professor MacPherson. The headnote, that is the first text of the paper, specifically states in bold print:

“Previously undescribed complications of this condition are subglottic stenosis and tracheo-broncho-malacia (sic)….”

159 Counsel Assisting submits that what this highlights is the very matter which arose repeatedly in this Inquest, and is perhaps best summarized by Professor Seppelt:

> “there was a missed opportunity to initiate a series of investigations that could well have led to the conclusion that there was an underappreciated or underdiagnosed problem, which was the subglottic stenosis, and potentially even say, "We shouldn't be doing major obesity surgery right now….”

Consideration

160 Dr Kuzinkovas describes his recollection of what he read about Sponastrime Dysplasia’s after Brooke’s death as “like a blur”. He says he is “pretty sure” he did not see a reference to subglottic stenosis. He is uncertain whether he researched the term before or after the bariatric department meeting and may have researched the term after the autopsy report was available. I am not critical of Dr Kuzinkovas’s recollection some 7 years after events took place but clearly his evidence on this matter is of limited evidentiary value.

161 As to what internet searches should have been made of Brooke’s extremely rare condition and what they might have revealed about it, I accept the fundamental submissions of Dr Kuzinkovas and Dr Dasilva that there was no evidence at the hearing as to what a Google, Pubmed or Wikipedia search would have disclosed as at September 2018. Having said that, the second factual matter in dispute is not concerned merely with Internet searches. The larger question is what would have been learnt about her medical history, in particular, about her Sponastrime Dysplasia, if she had been referred for a pre-operative assessment.

162 On this larger question, given the evidence at paragraphs [127] to [131] I accept Counsel Assisting's submissions that a preoperative assessment would have provided the opportunity for a more thorough examination of Brooke's medical history and the obtaining of information and that, more likely than not, if she was assessed by an anaesthetist or respiratory physician Brooke's laryngotracheomalacia and subglottic stenosis would have been discovered. It was indeed a missed opportunity.

Matter 3 Did Dr Dasilva read the words "Sponastrime Dysplasia" on the Admission Referral Form or the Patient Health History – General Form?

Dr Dasilva's evidence

163 Initially Dr Dasilva's evidence was that he could not remember if he had read the words "Sponastrime dysplasia" on the Patient Health History – General Form. Next, Dr Dasilva said it was "possible" that he had not, in fact, read the words "Sponastrime dysplasia" on the Patient Health History – General Form.

164 The next iteration of Dr Dasilva's evidence on this issue was that it was "unlikely" that he read the words "Sponastrime Dysplasia", that he did not recall reading them, and as the words were hand written, that is in different font from the typed words on the form, that it was "very likely" that he may have not seen the words. Dr Dasilva did not suggest the words were not written on the form at the time he (otherwise) read the form.

165 That Dr Dasilva did not read the words "Sponastrime Dysplasia" on either the Admission Referral Form or the Patient Health History – General Form is consistent with his evidence that he first became aware of Sponastrime Dysplasia after the surgery on 18 September 2018, vaguely recollecting that it was when he went back into the ICU to check on Brooke.

166 To his credit, Dr Dasilva accepted that the assessment that he was required to undertake in relation to Brooke included properly informing himself of any

relevant diagnosis which, in this case, was Sponastrime Dysplasia and that he did not do so.

Submissions

167 Based on the above, Counsel Assisting submits that the Court would be comfortably satisfied that Dr Dasilva did not read the words Sponastrime Dysplasia on either the Admission Referral Form or the Patient Health History – General Form.

168 Dr Dasilva accepts that such a finding is open to the Court.

Consideration

169 Dr Dasilva did not read the words Sponastrime Dysplasia on either of the Admission Referral Form or the Patient Health History – General Form.

Matter 4 Did Brooke suffer an anaphylactic reaction on anaesthesia on either 18 or 21 September 2018?

170 Dr Dasilva was of the view that Brooke suffered an anaphylactic reaction on 18 September 2018, caused by rocuronium, that the interpretation of the tryptase level had been slightly overlooked in Brooke's case and that the tryptase level has not been interpreted correctly in Brooke's context.

171 Professor Seppelt was of the view that looking at the matter prospectively, an anaphylactic reaction was a reasonable hypothesis, indeed "perfectly reasonable".

Counsel Assisting's submissions

172 Counsel Assisting submits that whilst the hypothesis of Brooke suffering an anaphylactic reaction on the morning of 18 September 2018 was a reasonable hypothesis when considering the matter prospectively, the overwhelming evidence is that Brooke did not suffer an anaphylactic reaction when

administered rocuronium or indeed at any time that she was admitted to St George Private Hospital.

173 He says Dr Dasilva's anaphylaxis' theory faces a number of evidentiary difficulties.

174 Firstly, there was no "baseline" test taken at 24 hours after onset of Brooke's supposed anaphylactic reaction. Dr Dasilva could "only propose" it would have been less than the level obtained 8 hours after the initial supposed anaphylactic reaction, thereby fulfilling the "criteria of having an anaphylactic reaction based on the tryptase levels obtained."

175 Notwithstanding the absence of this baseline result, Dr Dasilva was "quite confident" that Brooke's tryptase level would have trended in the manner he expected. It was, he said, "a scientific assumption".

176 Secondly, according to Professor MacPherson, the treatment Brooke underwent "was textbook for anaphylaxis, yet there was no improvement." This was unusual and it would be expected that Brooke would get better within half an hour, but she did not.

177 Thirdly, Brooke did not have cardiovascular collapse or hypotension which was found in a major UK study as the most common sign that occurred in over or around about 50% of all patients that had anaphylaxis. Also, Dr O'Leary noted that Brooke had no rash.

178 Fourthly, according to Professor Seppelt, Dr O'Leary deliberately used different anaesthetic drugs, still working on presumed anaphylaxis, thereby making a decision to not use the possible triggering agents used in the operating theatre, but to use drugs that were chemically quite different, but still had exactly the same problem with ventilation as did Dr Dasilva on 18 September 2018.

179 In summary, neither Professor MacPherson, Dr Gallagher nor Professor Seppelt considered Brooke suffered an anaphylactic reaction.

Dr Dasilva's submissions

180 Dr Dasilva adopts Dr Seppelt's evidence that anaphylaxis was the most likely diagnosis prospectively and that the treatment thereafter was "textbook". He adopts Counsel Assisting's submission that the hypothesis Brooke suffered an anaphylactic reaction on 18 September 2018 was, prospectively speaking, a reasonable hypothesis.

181 It is submitted that, notwithstanding the expert opinions of Prof MacPherson, Dr Gallagher and Prof Seppelt, the available evidence is not sufficiently conclusive as to whether Brooke suffered an anaphylactic reaction on 18 September 2018. In the absence of a baseline tryptase, anaphylaxis cannot be ruled out as a cause of the arrest Brooke suffered on 18 September 2018.

Consideration

182 Looking at the matter prospectively, I accept that an anaphylactic reaction was a reasonable hypothesis, indeed it was "perfectly reasonable".

183 Looking at the matter retrospectively, Prof MacPherson, Dr Gallagher and Prof Seppelt were asked to consider Dr Dasilva's contention and ultimately rejected it as implausible.

184 The evidence set out in paragraphs [174] to [179] permits of no uncertainty. I am satisfied that Brooke did not suffer an anaphylactic reaction when administered rocuronium or indeed at any time that she was admitted to St George Private Hospital.

Matter 5 What were the circumstances surrounding the loss of the information from the anaesthetic cartridge?

185 Dr O'Leary stated that the information could have been important, such information would have included the exact time of Brooke's deterioration, changes to oxygen levels, CO2 levels, the latter being helpful information if a person is being ventilated.

186 According to Dr Dasilva, the information collected would have included Brooke's heartrate, blood pressure, oxygen saturation, and carbon dioxide output.

187 Dr O'Leary made the point that "obviously, in any situation, any clinical emergency, any unanticipated change in a patient, the more information that you have about what happened, the more likely you are to be able to work out what the cause might be, and losing information is never going to be a good thing," whilst accepting that it was hard to say whether it would have definitely assisted him much at the time.

188 Dr Dasilva, on the other hand, did not think that the information lost would have added anything more to Brooke's treatment as he expressed the view that he gave Dr O'Leary a very good hand over.

189 It was necessary during the hearing to piece together various sources of information as to the precise circumstances as to how the information from the cartridge was lost. There were numerous inconsistencies in the evidence.

190 Dr O'Leary gave evidence that it was Dr Dasilva who stated at the Anaesthetic Department Meeting held on 7 November 2018 that it was in discussion with GE (General Electric) that it was noted there was a 24-hour window when the cartridge could have been placed back in the anaesthetic monitor to retrieve the information which had been erased. The minutes of the meeting also state that it was due to the removal of the cartridge from the anaesthetic monitor and use in ICU prior to printing the anaesthetic information that whole details were lost in relation to the anaesthetic given.

191 Dr O'Leary was not aware that each time a new procedure was started, the information was lost, such information being provided by the Hospital's Ms Tanevska in her statement dated 19 June 2025.

192 Dr Dasilva's evidence was that when he left the ICU, the anaesthetic cartridge was still in the ICU. He said that one of the senior nurses told him that attempts

had been made to print out the record in the ICU but that was not possible and, on asking if the cartridge could be removed and brought back to the operating theatre “they were told that they weren’t allowed to remove it”.

193 Dr Dasilva also said that the cartridge was connected to leads that were directly connected to Brooke and it was not wanted to disconnect the cartridge from Brooke. Dr Dasilva also said that he was told by Margaret Troy that the module only held data for 24 hours, according to General Electric.

194 Dr Dasilva did not recall being told that the information from the cartridge was cleared because the machine was prepared for the next surgery. He also said that he was “absolutely” sure that the cartridge remained in the ICU and that it remained in the ICU and was not brought back to the operating theatre until Brooke was extubated, which was on 19 September 2018. Dr Dasilva said that his understanding of that information came from Margaret Troy.

195 Dr Dasilva admitted that he and the operating team overlooked printing the anaesthetic records, the usual practice being that in the event that someone were to be transferred from the operating theatre to the ICU, before doing so, the information from the anaesthetic cartridge would be printed out. That did not occur on this occasion.

196 Dr Dasilva did not think it was the case that a subsequent operation taking place in the operating theatre would result in information in the anaesthetic cartridge being automatically wiped. Rather, it was his understanding that if there were two operations using the same cartridge on the same day the cartridge would store each of those operations’ information and that “most machines work like that”.

197 Ms Russell-Green, Director of Clinical Services at the Hospital, admitted, understandably, that she was “concerned” about the events of the information being lost. Ms Russell-Green’s evidence in many material respects was the opposite to that of Dr Dasilva on the circumstances of the information being lost from the anaesthetic monitor.

198 She said it was “incorrect” to say that the reason the anaesthetic monitor could not be brought back to the operating theatre was because there were leads or cords attached to Brooke. Moreover, based on her conversation with Margaret Troy:

(1) The module never left the operating theatre;

(2) The anaesthetic cartridge was not in the ICU;

(3) Margaret Troy did not tell Dr Dasilva that an attempt was made to print out the record in the ICU which could not be done;

(4) Margaret Troy did not tell Dr Dasilva that the cartridge could not be removed from the ICU and taken back to the operating theatre; and

(5) The leads remain with the patient and are detached from the monitor in the operating theatre and then reattached to the monitor in the ICU.

Counsel Assisting’s submissions

199 Counsel Assisting submits that the number of versions of events as to the precise circumstances of what happened to the information in the anaesthetic cartridge and why it was not able to be, or was not in fact printed out, are regrettable and cause for concern.

200 He submits that the evidence also makes it challenging to make submissions as to precisely what were the circumstances leading to the information being lost but that nonetheless, there is a preponderance of evidence that supports the proposition that when Brooke was taken to ICU from the operating theatre the cords or leads were detached from the monitor, but the monitor and the cartridge or module stayed in the operating theatre.

201 Counsel Assisting continues that although it may be submitted that the minutes of the Anaesthetic Department Meeting on 7 November 2018 recorded what was said quite near in time to what occurred, it needs to be remembered that,

according to Dr O'Leary, it was Dr Dasilva who told the Anaesthetic Department Meeting of the removal of the cartridge from the anaesthetic monitor and use in ICU prior to printing the anaesthetic information, such that all details were lost in relation to the anaesthetic.

202 He continues that given Dr Dasilva's evidence on this issue is largely contradicted by Margaret Troy (through Ms Russell-Green) and given the evidence of Ms Russell-Green as to the leads remaining with the patient and the monitor and cartridge remaining in the operating theatre, the Court would not accept Dr Dasilva's version of events on the loss of the information from the anaesthetic cartridge.

203 Moreover, Ms Tanevska, who is responsible for overseeing the maintenance of equipment and machines used in operating theatres at the Hospital stated that after Brooke was transferred to the ICU the operating team, on returning to the operating theatre realised they had not printed out the information and it was cleared in preparation for the next surgery.

204 In summary, Counsel Assisting submits that the information in the anaesthetic cartridge was lost because the person or persons responsible for printing out the information from the anaesthetic cartridge failed to do so before detaching the leads from the monitor in the operating theatre and taking Brooke to the ICU and, on returning to the operating theatre the cartridge had its information in relation to Brooke's anaesthetisation wiped as the cartridge was prepared for the next patient to be operated on.

205 Despite the efforts of the Hospital to liaise with General Electric, the manufacturer of the relevant machine, it was not possible to retrieve the information.

Dr Dasilva's submissions

206 Dr Dasilva agrees with Counsel Assisting's characterisation of the loss of the data contained on the cartridge as regrettable. He concedes it is not reasonably

contestable that the nature of the data lost including Brooke's heartrate, blood pressure, oxygen saturation and carbon dioxide output was potentially important.

207 To his credit, he also accepts that the anaesthetic team failed to print the anaesthetic record prior to commencing resuscitation efforts and moving Brooke to the ICU and that that the inconsistent versions of events surrounding the loss of the data from the ventilation monitor makes any findings as to what occurred problematic.

208 Dr Dasilva makes essentially 3 further submissions.

209 Firstly, that he should not be criticised in relation to the loss of data from the cartridge, particularly in light of the fact that at the relevant time Dr Dasilva's attention was directed entirely to the medical emergency of resuscitating Brooke after her arrest.

210 He notes in support of this contention that, having regard to the circumstances, Prof MacPherson was not critical of the failure to print an anaesthetic record. Indeed, even absent a medical emergency, Prof MacPherson volunteered that the inability to print out an anaesthetic record has "happened to all of us".

211 Secondly, it is plain from a consideration of the whole of Dr Dasilva's evidence that he was unaware of the fact that the data could be lost in the way in which occurred. In this context he notes that Dr O'Leary too was unaware that data was lost on commencement of a new operative procedure.

212 Thirdly, that in relation to the manner in which the data was lost, given the inconsistent versions of events surrounding this matter, the Court would be slow to accept any particular version of what took place and definitive findings may not be possible.

213 In support of this third contention Dr Dasilva says:

(1) Ms Russell-Green's oral testimony was not based on her direct knowledge but upon hearsay communications with another person, RN Margaret Troy.

(2) In her statement, RN Tanevska provided a different explanation to that provided by others as to the precise sequence of events that led to the loss of the data.

(3) Given (1) and (2), the indirect evidence of Ms Russell-Green and the statement of RN Tanevska should not be preferred to the direct evidence of Dr Dasilva (as Counsel Assisting argues).

(4) No person made any contemporaneous record or account of the chronology of relevant events. Rather, attempts were made to reconstruct events post ipso facto.

(5) Neither RN Troy nor RN Tanevska were called to give evidence, neither had their respective accounts tested.

Consideration

214 The anaesthetic team failed to print the anaesthetic record prior to commencing resuscitation efforts and moving Brooke to the ICU and important information in the anaesthetic cartridge was subsequently lost.

215 The failure to print the information contained in the anaesthetic cartridge and the subsequent loss of that data altogether is indeed regrettable and concerning. I am not however critical of Dr Dasilva directing his attention entirely to the medical emergency of resuscitating Brooke after her arrest.

216 I accept, for the reasons advanced by Dr Dasilva, that the inconsistencies in the evidence surrounding the loss of the data from the ventilation monitor (and the untested hearsay say nature of some of it) is not merely challenging: it makes findings on how the data was lost, even on the balance of probabilities, not possible.

Matter 6 Why did ventilation fail immediately after intubation on each of 18 and 21 September 2018?

217 Dr O'Leary was of the view that Brooke's subglottic stenosis or her tracheobrochomalacia "has to" account for the difficulty that RN Quita had in advancing a suction catheter through the ETT. He went on to say that the stenosis and the tracheobrochomalacia would act together to be bad, indeed it would be a very serious situation for a patient. He said:

> "I would imagine - it's not in my exact area of expertise - but is a fairly fixed thing. So it's a tightness. So the two things would - would act together to be bad. Certainly if you have a stenosis that's occluding your tube or occluding your airway and you've got the collapse of airways beyond that. That would be a very - very serious situation for a patient." Indeed, the ulceration would "would no doubt make the stenosis tighter and more difficult for the patient."

218 However, Dr O'Leary also posed two questions: why did Brooke get better the first time, that is on 19 September 2018, the day after the first intubation when Brooke was still intubated and how did she get better, if the problem is the compression of the tube. Dr O'Leary said that it doesn't make sense.

219 Another factor militating against the subglottic stenosis or tracheobronchomalacia causing pressure on the ETT such as to cause the ventilation to fail is that Dr O'Leary was adamant that he had no difficulty inserting the tube, which one would expect if such pressure was exerted to the outside of the tube by the stenosis or tracheonbronchomalacia.

220 Having said all that:

(1) Dr O'Leary agreed with the proposition that the tension pneumothorax in the right lung was consistent with a diagnosis of dynamic hyperinflation and that the right sided pneumothorax was likely due to the very high airway pressures required for ventilation. Dr O'Leary's view of dynamic

hyperinflation being the cause of Brooke's problems with ventilation was reinforced by his reading of Dr Gallagher's report in that it caused him to recall that after he had reintubated Brooke, he had the impression that when the bag was having to be squeezed incredibly forcefully to get air into her lungs, the air was not escaping and the chest was rising, but not falling, so gas was being trapped within the lungs.

(2) It remains puzzling as to why Brooke recovered in the ICU on 19 September 2018 if she had suffered dynamic hyperinflation immediately after being intubated on 18 September 2018. Dr O'Leary accepted that dynamic hyperinflation could well have been relevant in the lead up to the cardiac arrest and during the period of cardiac arrest in the operating theatre on 18 September 2018, but it was not an issue when Brooke was recovering in the ICU. Dynamic hyperinflation was not something that he had turned his mind to when he was in the operating theatre on 18 September 2018.

221 Of course, Dr Dasilva was of the view that the failure to ventilate Brooke was brought about by an anaphylactic reaction but that can be discounted (see above).

222 Professor MacPherson's view initially, considering the matter retrospectively, was that Brooke's subglottic stenosis was causing the tube to be occluded. Indeed, he thought there was "a high likelihood that the endotracheal tube was being occluded".

223 On being taken to Professor Goh's report of the subject x-ray, Professor MacPherson was somewhat less certain but did conclude that the tissue of Brooke's subglottic stenosis could have compressed the endotracheal tube.

224 Dr Gallagher was of the view that ventilation failed either due to dynamic hyperinflation or compression of the endotracheal tube as a result of Brooke's subglottic stenosis, but the more likely explanation was compression of the tube.

225 Professor Seppelt's view was that the cause was either dynamic hyperinflation with compression of the tube due to tight subglottic stenosis, or it was related to the tracheobronchomalacia and airway collapse with positive pressure. Professor Seppelt accepted that there was a degree of speculation. In fact, he said: "we're speculating as to the mechanism". However, he came to the conclusion that on each occasion of attempted ventilation (i.e. 18 September 2018 and the early hours of 21 September 2018), the problems "ultimately came down to subglottic stenosis and the tracheobronchomalacia ….. but in the ICU, it - things just snowballed. One thing went wrong, then another thing, and she developed a pneumothorax."

Counsel Assisting's submissions

226 Counsel Assisting submits that the weight of the evidence supports the conclusion that on 18 and 21 September 2018 Brooke could not be ventilated due to her subglottic stenosis exerting pressure on the endotracheal tube so as to restrict airflow through the tube, leading to dynamic hyperinflation. In this regard Counsel Assisting relies on the evidence of Dr O'Leary, Professor MacPherson, Dr Gallagher and Professor Seppelt referred to above. He accepts that if the Court adopts this as the reason for the difficulty in ventilating Brooke on 18 September 2018, it leaves unexplained why Brooke recovered in ICU on 19 September 2018, to the point where Dr O'Leary thought it appropriate to extubate Brooke, which he did.

Dr Dasilva's submissions

227 Dr Dasilva submits that the available factual and expert evidence does not allow definitive findings to be made as to why ventilation failed immediately after ventilation commenced on both 18 and 21 September 2018. More specifically, a finding of fact cannot be made that more likely than not the ETT placed in Brooke's airway on both 18 and 21 September 2018 was so distorted by the subglottic stenosis as to prevent any air passing through the airway so resulting in dynamic hyperinflation.

228 The submission continues that in the evidence there were various postulations on the matter: that the ventilation failed as a result of dynamic hyperinflation, the effect of subglottic stenosis (causing compression of the ETT), use of a mis-sized ETT, misplacement of the ETT or tracheobronchomalacia and that the evidence does not disclose which of the potential hypotheses, either alone or in combination, caused ventilation to fail. It is said that none of Dr O'Leary, Prof Goh, Prof Greenberg, Dr Gallagher or Prof Seppelt were "in comfortable agreement".

229 Turning to the evidence in detail, Dr Dasilva makes the following submissions:

(1) Given that Dr O'Leary treated Brooke over a two day period, he had the advantage of personal examination and observation over others who gave evidence. In his oral testimony, Dr O'Leary postulated that subglottic stenosis and tracheobronchomalacia were relevant pathophysiologies but this opinion should be considered in light of other matters.

Firstly, Dr O'Leary conceded that the matter was not his area of expertise. Secondly, Dr O'Leary's opinion as to the existence or otherwise of tracheobronchomalacia, should be considered in the context of Prof MacPherson's agreement that the autopsy report did not include findings that were consistent with tracheobronchomalacia. Thirdly, as Dr O'Leary himself asks rhetorically, if stenosis and tracheobronchomalacia played a role in the initial airway compromise, why did Brooke appear to recover so well and so quickly in ICU while she remained intubated? Fourthly, as Counsel Assisting submits, and contrary to Dr O'Leary's expectation, if stenosis and tracheobronchomalacia were present, what is to be made of Dr O'Leary's adamant evidence that he had no difficulty intubating Brooke?

(2) On its face, Prof Goh's opinion that the tip of the ETT was "well below the site of the glottic stenosis" is not consistent with the proposition that the subglottic stenosis either prevented the ETT being sufficiently

inserted into Brooke's airway or, to a lesser extent, caused sufficient constriction of the tube to result in complete occlusion of the ETT.

(3) While Prof MacPherson ultimately opined that that it was the existence of a subglottic stenosis which was likely the cause of the occlusion of the ETT, he conceded that the expert radiological opinion of Prof Goh (that the tube had passed the point of the subglottic stenosis) had tempered his opinion. Dr Dasilva observes that Prof Gallagher and Prof Seppelt also modified their opinions on the basis of Prof Goh's subsequent report.

(4) Like all experts retained in the matter, Prof MacPherson had to formulate his opinion on certain presumptions. One example is an assumption about the diameter of Brooke's trachea being "very narrow". Prof MacPherson agreed in his oral testimony that in his written report he used the word "presumably" in his written opinion because he could not be certain of the diameter of the trachea. Likewise, Prof MacPherson agreed that he opined that the narrow trachea "*may* [emphasis added] have occluded outflow of oxygen from the machine to the lungs" because he could not be sure of that premise. It is submitted that this concession is an appropriate recognition of the inherent uncertainty of the facts.

(5) Dr Gallagher in his oral evidence postulated a number of causes for the failure of the ventilation. He considered possibilities to include hyperinflation and compression of the ETT due to the firmness of the subglottic stenosis (shown on autopsy). That said, Dr Gallagher also referred to a number of imponderables including the degree to which the ETT had been passed in the airway (relative to the incisors), the measure of Brooke's airway and the dimensions of the subglottic stenosis. Ultimately, Dr Gallagher opined that the more likely possible cause, of all possible causes, was that the ETT was compressed in some way. Dr Gallagher was not able to provide an opinion on how and in what way the more likely possibility of ETT compression occurred.

(6) Prof Seppelt agreed in general terms with the assessment of Dr Gallagher. Of significance, however, Prof Seppelt neatly encapsulated why the forensic position regarding the mechanism of injury was speculative, even with the benefit of hindsight and time to consider the matter:

> "Yeah. It's the same retrospectively. There's got to be some degree of speculation. We know the findings at autopsy, we know some of the other information that wasn't available on the day, but ultimately, we're speculating as to the mechanism."

Consideration

230 In their evidence Dr O'Leary, Professor MacPherson, Dr Gallagher and Professor Seppelt canvassed a number of mechanisms to explain why ventilation failed. In the course of that evidence they were made aware of Professor Goh's conclusions on placement of the ETT. They made appropriate concessions in light of that evidence and other evidence that suggested Brooke's ventilation failed for reason(s) not connected with her subglottic stenosis. Prof Seppelt did indeed speak of the speculative nature of this evidence.

231 Notwithstanding these matters, Dr Dasilva's submissions conflate medical certainty, which is lacking, with the civil standard of proof the Court is required to apply in an inquest, that is proof, on the balance of probabilities.

232 The weight of the evidence from Dr O'Leary, Prof MacPherson, Dr Gallagher and Prof Seppelt is that, more likely than not, Brooke could not be ventilated immediately after intubation on each of 18 and 21 September 2018 due to her subglottic stenosis exerting pressure on the endotracheal tube so as to restrict airflow through the tube, leading to dynamic hyperinflation. I accept that evidence and make that finding on balance.

Matter 7 Why did Brooke arrest on 18 and 21 September 2018?

233 Counsel assisting submits that given the preceding matter, there is little need for extensive consideration of this matter and that the cause of Brooke's arresting is related to the difficulty of her being ventilated. No submission is made to the contrary.

234 Dr Gallagher and Professor Seppelt expressed the view that the cause of Brooke arresting on 18 September 2018 was due to dynamic hyperinflation, with Professor Seppelt adding due to hypoxia. Professor MacPherson also expressed the view that Brooke arresting was caused by hypoxia, which was due to "failure of intubation due to dynamic airway collapse."

235 Professor MacPherson, Dr Gallagher and Professor Seppelt were unanimous in their view that the cause of Brooke arresting on 21 September 2018 was due to dynamic hyperinflation together with "a pneumothorax present and increasing emphysema, so air outside of the tissues contributing to the problem."

Consideration

236 I accept the evidence that Brooke arrested due to dynamic hyperinflation and am further satisfied that hypoxia, a pneumothorax and increasing emphysema contributed to the arrest.

Matter 8 Why did Brooke deteriorate in ICU 20 September 2018?

237 Dr O'Leary expressed the view that Brooke's deterioration in ICU was slow, rather than "rapid" as was stated in the Anaesthetic Department Meeting Minutes.

238 Professor Seppelt said one could "speculate" as to a number of causes. He went on to say that one "possible explanation" was pulmonary oedema, where there's back pressure from the left ventricle into the lungs, and fluid into the lungs".

239 Another possible explanation which Professor Seppelt admitted was speculative was an inflammatory response which led to Brooke developing fluid in her lungs leading to a respiratory deterioration.

240 Professor Seppelt did not consider that the result of Brooke's echocardiogram altered his view about pulmonary oedema, stating that an echocardiogram "is a picture in time" whereas what he was referring to is a dynamic process.

241 Dr Gallagher implies, without stating it to be the case, that it was Brooke's subglottic stenosis that gave rise to her documented desaturation. He said:

> "….the nurses were concerned because she had these episodes of desaturation, which were fairly significant…….one of the big problems with subglottic stenosis is that people don't recognise it for what it is, ……so I think the deterioration, and the fact that she kept deteriorating over a long period of time should really have sort of started to push you along the lines of, well, look, we need to have a look at her larynx and see what's going on."

242 Support for Dr Gallagher's implied view of Brooke's subglottic stenosis giving rise to her deterioration comes from Dr O'Leary. He states:

> "With the benefit of hindsight, a subglottic stenosis would have made Mrs Tiddy's spontaneous breathing more difficult (particularly in the face of increased respiratory demands)."

243 In this regard Dr O'Leary changed his opinion from that which he considered at the time Brooke was deteriorating.

Counsel Assisting's submissions

244 In light of Professor Seppelt's use of the word "speculate" Counsel Assisting does not submit that I would find proven, on the balance of probabilities, either of Professor Seppelt's theories as to the cause of Brooke's deterioration.

245 Rather, Counsel Assisting submits that I could find that Brooke's deterioration in the ICU on 20 September 2018 arose due to breathing difficulties brought about by Brooke's subglottic stenosis.

246 He submits that another reason to accept this view is that at the time of Brooke's deterioration she was likely to have a degree of ulceration brought about by the initial intubation and the duration of that intubation, being about 28 hours. The effect of the ulceration would be to exacerbate the effect of the stenosis. In this regard Counsel Assisting relies on Dr Irvine's view that the ulceration suggested "the tissue on the surface of the stenotic region was quite tight around the endotracheal tube" and her description that the narrowing was "quite severe".

247 No submission is made against that made by Counsel Assisting.

Consideration

248 I accept the submission of Counsel Assisting for the reasons advanced by him and find that Brooke's deterioration in the ICU on 20 September 2018 arose due to breathing difficulties brought about by Brooke's subglottic stenosis.

Issues Dr O'Leary

249 The Issues List that was circulated amongst the legal representatives appearing in the matter and which is set out at [18] was the final iteration of a document that evolved over time and upon receipt of evidence. Earlier iterations included issues that related specifically to Dr O'Leary and his care and management of Brooke.

250 Dr O'Leary submits that in such circumstances it is appropriate to note that Prof Seppelt was his only peer that gave evidence at the inquest and that Prof Seppelt has "no specific criticisms of Dr O'Leary's post-operative management". More specifically, Prof Seppelt considered that:

(1) It was "a perfectly reasonable decision" to extubate Brooke on the morning of 19 September 2018 in circumstances where she was awake,

breathing spontaneously on low levels of support and indicating that she wanted the endotracheal tube removed.

(2) The re-intubation on 20 September 2018 was handled appropriately and the decision to change the ETT was understandable.

(3) Dr O'Leary's response to the difficulty ventilating Brooke and his management of her overnight on 20 September 2018 and into 21 September 2018 could not be criticised: everything was done in a "catastrophic and ultimately fatal situation".

(4) Important information available from 2003 when Brooke was 17 years of age and underwent a right ankle arthroscopy, at which time the anaesthetist noted subglottic narrowing and being unable to pass a 6.0 or 5.5 uncuffed tube below the subglottis, was not available to Dr O'Leary or Dr DaSilva. In the absence of this information, when it was not possible to ventilate Brooke with a 6.0 tube and there were concerns about possible obstruction, it was a reasonable thing to attempt to increase the size of the ETT.

(5) Brooke's treatment in the ICU was appropriate, she was ready for extubation at the time she was extubated and after further deterioration an appropriate decision was made to reintubate her.

251 No criticism is made of Dr O'Leary and no submission is made against the matters raised on his behalf. In those circumstances I am satisfied that the treatment and care Dr O'Leary provided Brooke was entirely reasonable.

Issue 1 Statutory Findings

252 Counsel Assisting submits that the following findings are open to be made under s81(1) of the Act. No submission is made against that.

Identity of deceased: Brooke Tiddy

Date of death:	21 September 2018
Place of death:	St George Private Hospital, Kogarah, NSW
Cause of death:	Cardiac arrest due to hypoxia caused by dynamic hyperinflation arising from complications related to subglottic stenosis
Manner of death:	Complications arising from attempting to intubate and ventilate Brooke

Issue 2 Whether Dr Kuzinkovas adequately and appropriately completed the Admission Referral Form, and in particular the pre-operative instructions, in light of Brooke's condition of Sponastrime Dysplasia ("her condition")

Counsel Assisting's submissions

253 Counsel Assisting submits that Dr Kuzinkovas neither adequately nor appropriately completed the Admission Referral Form, and in particular the pre-operative instructions, in light of Brooke's condition of Sponastrime Dysplasia. This submission is made relying on the same evidence canvassed in determining the first factual matter: ought Brooke have been referred for a pre-operative assessment?

254 The submission is that Dr Kuzinkovas ought to have ticked the boxes "Pre-admission clinic attendance required" and "Anaesthetic Consult" because Sponastrime Dysplasia was a highly unusual condition, which Dr Kuzinkovas had never heard of, and thus it was incumbent upon him to take reasonable steps to have Brooke examined prior to the day of the operation. That submission is said to be reinforced by the fact that none of the doctors who gave evidence in the Inquest had ever heard of Sponastrime Dysplasia prior to their involvement in this matter.

Dr Kuzinkovas' submissions

255 Dr Kuzinkovas relies on the same evidentiary material already canvassed in determining the first factual matter to explain the omission to of an anaesthetic consultation. He notes that there is no pre-admission or pre-anaesthetic clinic at St George Private Hospital to explain why he did not tick the anaesthetic consult box in the Admission Referral Form.

256 He further notes the evidence of Dr Smith to the effect that, in the circumstances, the Admission Referral Form was appropriately completed and that opinion was not the subject of comment by Dr Greenberg.

Consideration

257 Consistent with my findings for the first factual matter and based on the same evidence, I am satisfied that Dr Kuzinkovas neither adequately nor appropriately completed the Admission Referral Form, and in particular the pre-operative instructions, in light of Brooke's condition of Sponastrime Dysplasia.

258 The failure to tick either of the boxes for Pre-admission clinic attendance required or Anaesthetic Consult Completion is capable of being understood on the basis there is no pre-admission or pre-anaesthetic clinic at St George Private Hospital but given that Sponastrime Dysplasia was a highly unusual condition which Dr Kuzinkovas had never heard of, and about which he knew nothing more than Brooke had disclosed, it was incumbent upon him to take reasonable steps to have Brooke examined prior to the day of the operation. Again, this was a missed opportunity to ensure that happened.

Issue 3 Whether Brooke received appropriate and adequate pre-operative assessments and, in particular, whether the pre-anaesthetic screening was sufficiently rigorous in light of Brooke's medical history

Counsel Assisting's submissions

259 Counsel Assisting submits that Brooke did not receive appropriate and adequate pre-operative assessments and, in particular, submits that the pre-anaesthetic screening was not only insufficiently rigorous, but totally insufficient in light of Brooke's medical history. This submission is made relying on the evidence set out when dealing with factual matters 1 and 2.

260 He says the fact is the only pre-anaesthetic screening Brooke received was on the morning of the operation when Dr Dasilva did not even read the words "Sponastrime Dysplasia" on the Admission Referral Form or the Patient Health History – General Form. In the circumstances, it was wholly inadequate.

Dr Kuzinkovas' submissions

261 Dr Kuzinkovas relies upon the same factual matters and submission relating to determining the first factual matter.

Dr Dasilva's submissions

262 Dr Dasilva does not dispute that in all the circumstances of Brooke's presentation, the pre-operative assessments including the pre-anaesthetic assessment was inadequate.

263 He says that, in considering the circumstances in which the pre-anaesthetic assessment was undertaken by Dr Dasilva, the following matters should be taken into account:

(1) The fact that the pre-anaesthetic assessment occurred on the morning of the planned procedure was, of itself, not inappropriate. In his oral testimony, Prof Seppelt agreed with the proposition that in the private hospital setting in New South Wales it is common (ie. every day) for pre-anaesthetic assessments to be carried out on the morning of the procedure. The absence of a pre-admission clinic at St George Private Hospital is consistent with a widespread practice of conducting a pre-

anaesthetic assessment on the morning of a procedure in the private hospital setting.

(2) Prof MacPherson, Dr Gallagher and Prof Seppelt agreed that the ANCOA guidelines did not, and do not, include guidance or direction to the effect that pre-anaesthetic assessment should not occur on the morning of a procedure.

(3) In Dr Dasilva's long experience of anaesthetising bariatric patients, Brooke presented at the low end of the range of risk: viz. she did not present with significant comorbidities including coronary disease, chronic obstructive pulmonary disease, diabetes. Prof Macpherson agreed that when comparing what was known to Dr Dasilva of Brooke's presentation, Brooke was at the lower end of the scale of risky patients. Prospectively, from the point of Dr Dasilva, Prof Macpherson summed up the position as follows:

"Let's be clear here. Just putting outcome bias out of the way, there is definitely a situation here in favour of Dr Dasilva, where he was confronted with a person who seemingly gave a very nice, clean bill of health, non-smoking, you know, "I don't have asthma", apart from the occasional croup she gave no history of this - of shortness of breath on exertion. I mean, you'd be ticking [these] squares and saying that, "This doesn't sound too bad". And indeed, if you just look at that, her respiratory history, as I said there, was quite remarkably NAD, apart from the business about the recurrent cough and the croup. So yes, there are a lot of issues there that would make you think, "This isn't too bad".

(4) In undertaking his pre-operative assessment, Dr Dasilva did not deviate from bearing the responsibility of satisfying himself that it was safe to proceed to anaesthesia. The evidence discloses that Dr Dasilva sought information and undertook examination to satisfy himself of fundamental matters.

264 In relation to the issue of croup, Dr Dasilva submits that he appropriately sought, obtained and interrogated a history from Brooke. From the point of view of Brooke, the history she provided of occasional croup was not a history consistent with a difficult airway including, for example, breathing difficulty on exertion. He says Prof Macpherson's oral testimony affirms the contention:

> "So I would have thought that, if Mrs Tiddy [was] involved in any sort of significant exercise, like running up a couple of flights of stairs, or running for a bus, that she might be aware of some shortness of breath. It was never brought up. She never brought it up herself, and she was asked about it multiple times."

265 Dr Dasilva further submits that it is uncontroversial that Brooke and her family were unaware of the significant anaesthetic issues that arose when Brooke underwent surgery at the Children's Hospital Westmead when aged 17. For reasons that were not discovered at the inquest, Brooke and her family had no knowledge of the significant and relevant difficulties encountered when intubating Brooke years prior at this hospital.

266 He says those difficulties were inevitably material to any subsequent attempted intubation including that which was attempted by Dr Dasilva on 18 September 2018 and by Dr O'Leary on 21 September 2018 and that, through no fault of her own, when Dr Dasilva sought from Brooke relevant prior history of anaesthetic difficulty, Brooke was not able to provide that information and, as such, an accurate history.

267 Reference is then made to Dr O'Leary's observation as to whether Brooke's ignorance of the history of airway difficulty could have ever been discovered regardless:

> "[I]f the information is not searchable and not available and not known to the family or to the patient, it could be very difficult to tease that out in a pre-operative assessment."

Consideration

268 Whilst (a) there is no criticism made of Dr Dasilva to the effect that conducting a pre-anaesthetic assessment on the morning of the planned procedure was "of itself" inappropriate and (b) I accept the evidentiary matters raised by Dr Dasilva should be taken into account in assessing the adequacy of his pre-anaesthetic assessment, consistent with my findings on the first factual matter and based on the same evidence, Brooke did not receive appropriate and adequate pre-operative assessments from Drs Kuzinkovas and Dasilva.

269 The pre-anaesthetic screening particularly, was totally insufficient considering Brooke's medical history. The evidence permits of no other conclusion.

Issue 4 Linked to 2 and 3 above, whether communication should have occurred between Drs Kuzinkovas and Dasilva prior to Brooke's admission concerning her condition.

Counsel Assisting's submissions

270 Counsel Assisting submits that communication should have occurred between Drs Kuzinkovas and Dasilva prior to Brooke's admission concerning her condition. This submission is made relying on the evidence already canvassed, largely that referred to in the context of the first factual matter; ought Brooke have been referred for a pre-operative assessment.

271 He says the fact is there was no communication between Dr Kuzinkovas and Dr Dasilva concerning Brooke's condition. The only information sent by Dr Kuzinkovas to Dr Dasilva was Brooke's name, date of birth and mobile phone number. In Professor Seppelt's opinion:

> "I do think it's remiss that the surgeon mentioned the Sponastrime Dysplasia in writing, but that wasn't communicated, because if that had been noticed….that would have prompted a few questions"

272 Dr Dasilva makes no submission on this issue.

Dr Kuzinkovas' submissions

273 Dr Kuzinkovas' repeats his submissions on the first and second issues. Further, he says that consistent with usual practice, he was entitled to assume that the Admission Referral Form, documents completed by Brooke and admission staff were available for Dr Dasilva's review and consideration.

Consideration

274 I will not restate the evidence already referred to in these findings. It is sufficient to note for the purpose of determining this issue that (1) Dr Dasilva said he had worked in the bariatric list with Dr Kuzinkovas for about 15 years, (2) Dr Dasilva relied, at least in part, on information provided to him by Dr Kuzinkovas, (3) in Dr Dasiva's view it would have been desirable and beneficial for Dr Kuzinkovas to have informed him of Brooke's Sponastrime Dysplasia, (4) according to Dr Greenberg bariatric surgery is a "team game" where the anaesthetist is a "major player", (5) Brooke was an unusual patient and (6) I accept the evidence of Prof Seppelt on this issue.

275 Additionally, Ms Russell-Green gave evidence as an experienced senior nurse practitioner and the Director of Clinical Services at the Hospital that there should have and (would normally be) communication between a VMO and anaesthetist prior to admission where a patient had a rare or potentially complex condition.

276 Given the totality of this evidence and the evidence canvassed in dealing with factual matters 1 and 2, communication beyond what took place should have occurred between Drs Kuzinkovas and Dasilva prior to Brooke's admission. That there was no communication was a lost opportunity for investigation of her condition and an informed decision being made as whether the surgery should proceed.

Issue 5 If further pre-operative checks were undertaken by way of retrieval and consideration of prior medical records (particularly the 2002

and 2003 surgery), or by way of medical imaging or referral to an ENT surgeon, and if the subglottic stenosis had been detected what effect, if any, would that have had on the decision whether to proceed to surgery and, if so, the anaesthetic induction procedure?

Counsel Assisting's submissions

277 Counsel Assisting submits that this issue proceeded on the assumption that there was a manner in which Brooke could have proceeded to anaesthetisation if the subglottic stenosis had been detected. He concedes that assumption is not made out on the evidence.

278 Rather, what Counsel Assisting submits is as stated by Prof Seppelt, namely that "… the key is understanding the pathophysiology pre-operatively, and surgeon and anaesthetist jointly coming up with a management plan that addresses the physiological problems." Prof Seppelt further said that a thorough pre-operative assessment would have led to a joint decision between the surgeon and the anaesthetist as to how to perform the procedure most safely, or indeed whether to proceed at all.

279 Counsel Assisting continues that the specifics of the safest procedure were not explored during the hearing because how the anaesthesia ought to have been performed depends "a lot on the outcome of the investigations". Nonetheless, Counsel Assisting submits that the weight of the evidence does not support the views expressed by Professor Seppelt in his report dated 18 September 2024 of the procedure being performed with the patient awake or sedated with a regional anaesthetic.

280 Dr Kuzinkovas does not cavil with these submissions.

Dr Dasilva's submissions

281 Dr Dasilva notes the submissions made by Counsel Assisting on this issue are couched in terms that include the phrase “if the subglottic stenosis had been detected”.

282 As with the second factual matter; if Brooke had been referred for a pre-operative assessment, what have been learnt about her medical history, in particular Sponastrime Dysplasia, Dr Dasilva submits the Court could not be confident that the premise upon which this issue is founded could be made out: viz. that an assessment in the days or weeks prior to surgery would have revealed the fact that Brooke had subglottic stenosis.

283 On the assumption that the premise could be made out (contrary to his submission), Dr Dasilva agrees with Counsel Assisting’s submission that the evidence did not traverse in any meaningful way what alternative anaesthetic course may have been adopted at surgery.

284 He continues that, as was properly conceded by Counsel Assisting, the evidence did disclose that the approach postulated by Prof Seppelt (performing the surgery with the patient awake or anaesthetised regionally only) was not realistic.

Consideration

285 I accept Counsel Assisting’s submissions on this issue noting that an assessment in the days or weeks prior to surgery would most likely have revealed the fact that Brooke had a subglottic stenosis but the evidence does not support the approach postulated by Prof Seppelt and does not disclose what anaesthetic alternatives, if any, could have been adopted had Brooke’s subglottic stenosis been detected.

Issue 6 Given that Sponastrime Dysplasia is a rare condition and was disclosed on the Patient Health History Form and Admission Referral Form:

(1) Did Dr Dasilva read those forms and know that Brooke suffered from Sponastrime Dysplasia;

(2) Whether Dr Kuzinkovas and Dr Dasilva made adequate attempts by way of enquiries to understand Brooke's condition and other associated conditions.

286 In response to the first subparagraph, Counsel Assisting submits it is patently clear that Dr Dasilva did not read the words Sponastrime Dysplasia on the Patient Health History Form and Admission Referral Form and therefore did not know that Brooke suffered from Sponastrime Dysplasia before proceeding to anaesthetise Brooke.

287 In answer to the question as to whether Dr Dasilva read the Patient Health History Form and Admission Referral Form, Counsel Assisting does not submit that Dr Dasilva did not read the Patient Health History Form, albeit that he did not read it in its entirety, specifically did not read the words "Sponastrime Dysplasia" on that form.

288 Counsel Assisting submits that the evidence does not establish that Dr Dasilva read the Admission Referral Form. If he did do so, he did not read the words "Sponastrime Dysplasia" written by Dr Kuzinkovas as he was unaware of Brooke having that condition until after his anaesthetisation of Brooke on 18 September 2018.

289 In answer to the second subparagraph, Counsel Assisting submits that Dr Kuzinkovas did not make adequate attempts by way of enquiries to understand Brooke's condition and other associated conditions. The only question Dr Kuzinkovas asked Brooke about Sponastrime Dysplasia, a condition which he had never heard of before, was "how does it affect you?" to which she informed him that it was "merely a bone problem" and that she had had some surgeries in relation to it.

290 Dr Kuzinkovas had asked when it was that she had undergone ankle surgery, eliciting that it was in the past.

Dr Kuzinkovas's submissions

291 No submission is made in relation to the first subparagraph. In relation to the second subparagraph Dr Kuzinkovas relies on the same evidence and submissions put forward in relation to the first and second factual matters (ought Brooke have been referred for a pre-operative assessment and if she had been referred for a pre-operative assessment what would have been learnt about her medical history, in particular Sponastrime Dysplasia).

Dr Dasilva's submissions

292 On behalf of Dr Dasilva, two submissions are made. Firstly, it is not contested that Dr Dasilva first became aware of the condition of Sponastrime Dysplasia after Brooke had arrested on 18 September 2018. Secondly, it is not contested that Dr Dasilva likely did not read that part of the admission documents containing the words "Sponastrime Dysplasia".

293 It is said that otherwise the submission by Counsel Assisting relies on the premise "if the subglottic stenosis had been detected" and that consistent with his submissions on the second factual matter the Court the Court could not be confident that this premise is made out, that is that an assessment in the days or weeks prior to surgery would have revealed the fact that Brooke had subglottic stenosis.

Consideration

294 I accept Counsel Assisting's submission that Dr Dasilva did not read the words Sponastrime Dysplasia on the Patient Health History Form and Admission Referral Form and therefore did not know that Brooke suffered from Sponastrime Dysplasia before proceeding to anaesthetise Brooke.

295 No lesser conclusions are possible given the concessions made by Dr Dasilva on his knowledge (or lack thereof) of the condition until after Brooke's passing.

296 Having regard to the evidence referred to in paragraphs [289] and [290], the further evidence canvassed in the first and second factual matters and consistent with my factual findings on those matters, I accept Counsel Assisting's submission that Dr Kuzinkovas did not make adequate attempts by way of enquiries to understand Brooke's condition.

Issue 7 The circumstances surrounding the decision to remove the cartridge from the anaesthetic monitor prior to printing anaesthetic information and the failure to place the cartridge back in the anaesthetic monitor leading to the loss of the anaesthetic information.

297 Counsel Assisting relies on the same evidence and submissions he made concerning matter 5: what were the circumstances surrounding the loss of information from the anaesthetic cartridge.

298 He says the Court would be comfortably satisfied, on the balance of probabilities, that the information from the anaesthetic monitor was lost as a result of the cartridge on which the anaesthetic information was recorded being wiped when the same cartridge was prepared for the next operation in the operating theatre. That occurred in circumstances where Dr Dasilva had accompanied Brooke to the ICU before attending to or giving instructions to, print the information from the cartridge. By the time he returned to the operating theatre, the information had been wiped from the cartridge as it was being prepared for the next operation. Despite the Hospital's removal and isolation of the cartridge after learning of the information having been wiped and its contact with General Electric, the manufacturer of the cartridge, the information could not be retrieved.

Dr Dasilva's submissions

299 As with matter 5, Dr Dasilva submits that the evidence is such that there are insuperable obstacles to making factual findings.

Consideration

300 The failure to print the information contained in the anaesthetic cartridge and the subsequent loss of that data altogether is regrettable and concerning as previously stated. Again, I am not critical of Dr Dasilva directing his attention entirely to the medical emergency of resuscitating Brooke after her arrest and I accept, for the reasons advanced by him on factual matter 5, that findings on how the data was lost are not possible to the requisite standard.

301 For the sake of completeness the evidence does not allow for a conclusion to be reached as to whether this materially affected the eventual outcome in Brooke's case.

Issue 8 Whether there are any recommendations that are necessary or desirable in relation to any matter connected to Brooke's death pursuant to section 82 of the Coroners Act 2009.

302 Ms Russell-Green said that at the time of Brooke's passing, there was no hospital policy requirement for a patient such as Brooke to undergo a work-up but that there had since been a change to the Hospital's policy in that regard. She also spoke of change in the Hospital's nurse to nurse handover policy, the Hospital's anaesthetic machines and, consistent with the recommendations set out below, a willingness to review the Hospital's policies and procedures further in light of the evidence given during the inquest.

303 I am satisfied that the Hospital has, as an organisation, appropriately reflected on the contributing factors to Brooke's death and this had led to some improvements instituted at an organisational level to ensure what happened in Brooke's case is not repeated. I am satisfied the Hospital will continue to review its policies and procedures in light of the evidence given at the inquest.

304 Dr O'Leary gave the following oral evidence:

> "I think the main thing right from the beginning that I regretted terribly is the fact that I allowed myself to deal with this problem all on my own that night. I have to say to Brooke's family that this was the worst experience I've ever had in my career, I felt very lonely that night. And when Brooke was dead, I remember standing there and just could not believe what had happened and why it had happened. And when I thought about what I did, and I spoke to Professor Skowronski, who was a mentor of mine, and we talked about the case, and I just wish I had said to him, "George, mate, I'm sorry, I know it's 2 am, but I need you to come in and give me a hand, I'm struggling here, I don't know what to do. I can't work this one out…"

305 I am satisfied that Dr O'Leary has indeed reflected deeply on his involvement in Brooke's death and it has had a significant impact upon him.

306 Consistent with the position he took during the inquest, Dr Kuzinkovas did not make any acknowledgement of having contributed to Brooke's passing. He did say, however, regarding changes to his practices after Brooke's death, that he is now "extremely careful in collecting medical history" and he now escalates referrals to specialists more readily "sometimes maybe even unnecessarily".

307 Dr Kuzinkovas and Ms Russell-Green also acknowledged the grief and tragic loss Brooke's family have suffered from her loss and made what I believe to be genuine statements of sympathy during the inquest.

308 Dr Dasilva gave evidence that since Brooke's passing, he has changed his standing orders in relation to the administration of anxiolytic medications, specifically Lyrica, but it was not obvious this was directly related to what happened in Brooke's case.

309 It was submitted on his behalf that given his acceptance of criticisms, he had reflected on the clinical circumstances of Brooke's death in a proper and

appropriate manner and that he has learnt some difficult lessons. That is certainly to be hoped.

310 Counsel Assisting suggested that 4 recommendations be given to St George Private Hospital pursuant to s82 of the Act. The Court notes that the hospital will consider those 4 recommendations, that the recommendations are supported by Dr O'Leary and that there are no submissions made opposing the proposed recommendations.

Recommendations

311 The recommendations are a measured and appropriate response to the evidence in this inquest. It follows that I have no hesitation in making the following recommendations:

(1) That St George Private Hospital give consideration to reviewing and, if considered appropriate, amending its present Compromised Airway and Difficult / Awake Intubation Policy, in particular the section titled "COMPROMISED AIRWAY PROCEDURES" concerning the need for a pre-anaesthetic consultation by referring and the need for adherence to, the relevant ANZCA guidelines.

(2) That St George Private Hospital give consideration to reviewing and, if considered appropriate, amending its present Admission Policy, in particular the statement on page 1 of that policy, namely:

> "Patients with chronic or complex medical conditions should be carefully worked up. Appropriate associated specialist may need to assess patient prior to admission."

with a view to making clear on whom the onus falls as to who it is who is to determine that the patient be carefully worked up.

(3) That St George Private Hospital give consideration as to how it may educate and inform Doctors with admitting rights or those Doctors who

work at the hospital about the Hospital Policies applicable to their area of practice at the hospital.

(4) That St George Private Hospital give consideration to reviewing, and if considered appropriate, amending its present Anaesthetic Policy to require the anaesthetic technician to remind the anaesthetist to print the data from the anaesthetic machine where it has not otherwise been printed so as to ensure that it has been included within the patient's medical records.

Concluding remarks

312 I will close by again conveying to Brooke's family my sympathy for the tragic loss of Brooke. I acknowledge that she is forever lost to them.

313 I thank the Assisting team, particularly Mr Gemmell and Valentina Markovina, Dawoud Ayache and Jillian Walshe, DCJ Legal, for their outstanding support in the conduct of this inquest.

Statutory findings required by s 81(1)

314 I make the following findings:

Identity of deceased:	Brooke Tiddy
Date of death:	21 September 2018
Place of death:	St George Private Hospital, Kogarah, NSW
Cause of death:	Cardiac arrest due to hypoxia caused by dynamic hyperinflation arising from complications related to subglottic stenosis
Manner of death:	Complications arising from attempting to intubate and ventilate Brooke

I close this inquest.

Magistrate Stuart Devine

Deputy State Coroner

Lidcombe Coroner's Court

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