QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robyn Ann Beale**
TITLE OF COURT:	Coroners Court
JURISDICTION:	MACKAY
FILE NO(s):	2021/3543
DELIVERED ON:	31 March 2026
DELIVERED AT:	Brisbane
HEARING DATE(s):	25 – 28 August 2025
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS: Inquest; Health Care Related Death; Performance of Hemithyroidectomy at Regional Private Hospital; After-hours Management of Post-surgical Complication; Whether Health Care was adequate and appropriate.

REPRESENTATION:

Counsel Assisting:	Mr David Schneidewin and Ms Carolyn McKeon.
Mater Private Hospital Mackay:	Mr Damien Atkinson KC, instructed by Minter Ellison.
Queensland Ambulance Service:	Ms Melanie Morris, Gilshenan & Luton
Dr Cody Fitzgerald:	Mr Sean Farrell, instructed by Meridian Lawyers.
Dr Adam Hatherly:	Ms Amelia Hughes, instructed by Barry Nilsson Law.
Dr Richard Cooper:	Ms Katherine McGree, instructed by Avant.

Contents

Introduction

1. At the relevant time, Robyn Ann Beale (**Mrs Beale**) was aged 78; having been born on 25 January 1943. She resided in Mackay with her husband of 50 years and was a mother to two sons, and grandmother and great grandmother to four and five children respectively.

2. Mrs Beale had a medical history significant for multinodular goitre (multiple lumps causing thyroid enlargement) and underwent hemithyroidectomy (removal of half the thyroid gland) on 2 August 2021 (**thyroid surgery**) at Mater Private Hospital Mackay (**MPHM**).

3. Mrs Beale died in the Intensive Care Unit (**ICU**) of the Mackay Base Hospital (**MBH**) on 3 August 2021.

4. According to the Autopsy Certificate of 29 July 2021[1], the forensic pathologist opined that the cause of death was:

    1(a) Hypoxic ischaemic encephalopathy

    1(b) Compression of the neck

    1(c) Post-surgical bleed (right hemithyroidectomy).

5. The coronial jurisdiction was enlivened because Mrs Beale's death was a 'reportable death' under the *Coroners Act* 2003 (**CA**).

6. The issues I have to determine are:

    a. The findings required by s 45(2) of the CA – the identity of the deceased person, when, where and how she died and the cause of her death.

    b. Having regard to the well-known albeit uncommon incidence of post-operative thyroidectomy wound haematoma (**the bleeding**

[1] An autopsy was performed on 19 August 2021. It comprised an external and internal examination (to the extent an internal examination was required to determine the cause of death), imaging, document review and toxicology studies.

complication), and the limitations in respect to the after-hours care available to patients at MPHM, whether it was appropriate to perform the thyroid surgery upon Mrs Beale at MPHM on 2 August 2021 at the time it was performed, or at all?

c. Whether the post-operative care provided to Mrs Beale at MPHM following the thyroid surgery was adequate and appropriate, including a consideration of the following:

    i. Whether the bleeding complication was due to an arterial bleed or a venous bleed?

    ii. Whether the nursing care of Mrs Beale at MPHM was adequate and appropriate including with respect to the frequency of the observations taken and record keeping?

    iii. Whether the nursing staff and the model of after-hours nursing care at MPHM otherwise provided the necessary skill-set and coverage to detect and manage the bleeding complication (or other emergent and serious post-operative complications in a patient) in a manner that was timely and so as to reduce the risk of catastrophic injury or death of the patient?

    iv. Whether Dr Hatherly's management and treatment of the bleeding complication was adequate and appropriate having regard to his skill-set, training, qualifications and experience?

    v. Whether the medical staff and the model of after-hours medical coverage at MPHM otherwise provided the necessary skill-set and experience to assess and manage the bleeding complication (or other emergent and serious post-operative complications in a patient) so as to reduce the risk of catastrophic injury or death of the patient?

vi. Whether the treatment and management of the bleeding complication by the attending medical staff, including Dr Fitzgerald and Dr Cooper, was otherwise adequate and appropriate?

d. Whether any aspect of the treatment and management provided to Mrs Beale at MPHM caused or hastened her death?

e. Whether any failure to provide treatment and management to Mrs Beale at MPHM caused or hastened her death?

f. Whether the response to Mrs Beale's death on the part of MPHM has been adequate and appropriate?

7. In addition to the evidence contained in the brief of evidence (**BOE**), the following witnesses provided oral evidence at the Inquest:

a. Dr William Joseph Fitzgerald, General Surgeon;[2]

b. Dr Richard Cooper, Anaesthetist;[3]

c. Dr Robert Adam Hatherly, Overnight Medical Officer (**OMO**);[4]

d. Enrolled Nurse (**EEN**) Helen Buekes;[5]

e. Registered Nurse (**RN**) Jasmine Connell;[6]

f. RN Anne Venton;[7]

g. RN Susan Deane;[8]

h. Mitchell Reece Zaini, Queensland Ambulance Service (**QAS**) paramedic;[9]

i. Sam William Streeter, QAS paramedic;[10]

j. Gracyn Ashley Butler, QAS paramedic;[11]

[2] Ex C1; C1.1, C1.2 BOE; T1-5 – T1-33.
[3] Ex C4, C4.1 BOE; T1-34 – T1-48.
[4] Ex C11, C11.1 BOE; T2-3 – T2-54.
[5] Ex C5, C5.1 BOE; T2-54 – T2-73.
[6] Ex C6, C6.1 BOE, T2-73 – T2-85.
[7] Ex C7, C7.1 BOE; T3-2 – T3-13.
[8] Ex C9, C9.1 BOE; T3-14 – T3-27.
[9] Ex C14 BOE; T3-29 – T3-36.
[10] Ex C15 BOE; T3-37 – T3-46.
[11] Ex C12 BOE; T3-46 – T3-52.

k. Professor Christopher Francis Perry, Otolaryngologist, Head and Neck Surgeon (expert witness);[12] and

l. Ms Christine Went, Executive Director, Mater Hospitals.[13]

8. The role of the Coroner is limited to ascertaining what happened, not to ascribe guilt, attribute blame or apportion liability. A Coroner must not include in the findings any statement that a person is, or may be, guilty of an offence or civilly liable for something.

9. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[14] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the Coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer…In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*[15]

10. In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[16] As outlined in 'The Australasian Coroners Manual':

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation. … Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there. … Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for*

[12] Ex D1 BOE; T4-3 – T4-30.
[13] Ex C16 BOE; T4-32 – T4-47.
[14] *Briginshaw v Briginshaw* (138) 60 CLR 336.
[15] Ibid at 362 – 363 (Dixon J).
[16] Findings of the inquest into the death of Pasquale Roasario Giorgio (https://www.courts.qld.gov.au/__data/assets/pdf_file/0005/581720/cif-giorgio-pr-20180911.pdf) [140] – [142].

> *understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[17]

11. Additionally, a Coroner may, whenever appropriate, comment on matters connected with a death investigated at an Inquest and make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

12. A Coroner may also give information about a person's conduct in a profession or trade to a disciplinary body for the person's profession or trade, if the Coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

13. For reasons that appear later in these findings, I have made one recommendation about improving the after-hours health care provided at MPHM subject to the qualification indicated. Otherwise, I make no referrals of health care providers involved in Mrs Beale's health care at MPHM to their professional regulatory bodies.

14. I thank Counsel Assisting and the parties' representatives for their assistance during the Inquest and their comprehensive submissions following the hearing[18].

Coronial issues

Background factual findings

15. Mrs Beale also had a past medical history significant for ischaemic heart disease, hypertension and high cholesterol. She had undergone numerous prior surgeries and was taking various prescribed medications for her pre-existing conditions.

[17] Hugh Dillon and Marie Hadley, The Australasian Coroner's Manual (The Federation Press, 2015).
[18] The last of which was received on 25 February 2026.

16. Mrs Beale signed a generic consent form for the thyroid surgery on 21 July 2021. Included was an acknowledgement that the surgery carried some risks and complications which had been explained to her, and that she understood that aspects of her general health may contribute to, and possibly add to, the risks and increase the chances of complications. It was noted that Mrs Beale was on Aspirin, which was ceased a week or more prior to the thyroid surgery to reduce her bleeding risk.

17. Mrs Beale was admitted to MPHM on the morning of the thyroid surgery and, according to the operation report and anaesthetic record, the thyroid surgery was performed in theatre between 14.05 hours and 16.27 hours on 2 August 2021. The thyroid surgery was performed by Dr William Fitzgerald (**Dr Fitzgerald**), General Surgeon.

18. Following the thyroid surgery, Dr Fitzgerald reviewed Mrs Beale at 16:40 hours, with normal breathing, swallow and cough documented at that time.

19. At 16:49 hours, nasal prongs (**NP**) for the administration of oxygen, were put in place.

20. At 16:52 hours, it was noted that Mrs Beale was able to state her name, could cough and had spontaneous breathing with no excessive effort.

21. At 17:00 hours, Mrs Beale was ready for discharge from the Post Anaesthetic Care Unit (**PACU**) to the ward. She was hemodynamically stable. Her post-operative pain score was scored as 2. Both the Dr Fitzgerald and Dr Zaja, the Anaesthetist for the thyroid surgery, agreed to Mrs Beale being discharged from PACU to the ward.

22. Mrs Beale was discharged from the PACU at 17:28 hours and the vital observation chart on the ward indicates she was received shortly thereafter.

23. At 17:30 hours, there was RN handover to the receiving ward RN. Mrs Beale was noted to be uncomfortable, and a towel was placed behind the neck for support and comfort with good effect. The dressing was taken down, noting the presence of wound staples. The neck was soft and the drain empty. It was noted that the surgeon had placed staples rather than sutures to close the wound and the RN ensured that the bedside stitch cutter was replaced with a staple remover (gauze was also at the bedside).

24. At 18:00 hours, the RN administered Mrs Beale 1g oral Paracetamol and offered oral Paracetamol liquid as Mrs Beale had declined the Tramadol offered. Q-ADDS[19] observations were stable: On room air (**RA**); Alert. The nurse recalled the patient had no swallowing difficulties.

25. Dr Fitzgerald reviewed Mrs Beale at 18:30 hours, but this is not documented. His evidence about this attendance was:[20] "*It's not my practice to make a note if everything is absolutely stable and fine with the patient, as it was. I had no concerns. She spoke to me. She thanked me for the surgery. I asked her if she had any pain. She had none. She was able to swallow and cough. I always check those two things. And her voice was normal, which is the indication that the nerves were intact. And so I was very happy with her at that time."*

26. At 18:50 hours, the RN attended to Q-ADDS observations of Mrs Beale, which were stable.

27. At 20:10 hours, the RN attended Q-ADDS observations of Mrs Beale: Score (2)[21], BP approx. 110/70; Oxygen Saturations 90-94%; RA; Alert.

28. At 21:00 hours there was a shift changeover to evening/night duty. The surgical department night shift had two RN's and one EEN on shift. The second RN had been rostered that day for night shift, following

[19] The Queensland Adult Deterioration Detection System: an early warning tool used to identify clinical deterioration.
[20] T1-14, LL33-38.
[21] According to the Q-ADDS scoring system, this was normal.

assessment of patient numbers and acuity. There was no designated team leader; the staff themselves allocated a patient load based on acuity. The Team elected to divide the 24 patients into blocks of eight. The EEN was effectively responsible for eight patients, with the normal practice being the EEN referred to either RN if they required assistance. This gave the EEN flexibility to choose the most available RN (usually the less busy RN) as the night shift progressed.

29. At 21:15 hours, there was a ward shift handover where the night shift EEN (EEN Beukes) received handover from the RN on the evening shift, who noted Mrs Beale had been complaining of some neck pain relieved by placing a rolled towel behind her neck. During the shift Mrs Beale had no swallowing difficulties and her husband had fed her some jelly and custard, although this was not witnessed by the RN. The evening shift RN had signed off the drain as patent and the amount and consistency of drainage was of no concern. The retrospective progress note indicated 20mls of fluid drained. The RN recalled no swelling around the neck staples at this time.

30. At 21:30 hours, Q-ADDS observations of Mrs Beale were performed: Score (2); BP 115/70; Oxygen Saturations 95 - 97% with NP oxygen support; Alert.

31. At 21:35 hours, the RN administered to Mrs Beale 4 mg IV[22] Ondansetron for nausea with some effect.

32. At 22:00 hours, the RN administered to Mrs Beale 25 mg Cyclozine IV and the nausea settled. Mrs Beale declined an offer of a Tramadol 50mg tablet.

33. At 22.10 hours, Q-ADDS observations of Mrs Beale were performed: Score (2); BP 110/65; Oxygen Saturations 95 - 97% NP; Alert.

[22] Intravenous.

34. At 22.31 hours, a nurse call was activated by Mrs Beale. The RN attended. The reason for attendance is recorded as: "*neck pain".*

35. At 22.45 hours, Mrs Beale was administered 5mg oral Endone, and 1g oral Paracetamol. By her statement,[23] EEN Beukes refers to this attendance as follows:

> *"I remember attending to Mrs Beale around 22.45 after she had pressed the call button. At this time Mrs Beale again complained of neck pain. I suggested to her that we could remove the towel roll and asked if she would like some pain relief. The patient replied in the affirmative but asked if it could be in liquid form as she was having difficulty in swallowing. I complied with this request returning with a dose of liquid Endone with RN Debbie Ballinger-Oches. Debbie and I checked Mrs Beale's details against her armband and with Mrs Beale. We confirmed her name/ date of birth and UR prior to handing her the medication. At this point Mrs Beale was "perfectly normal" and able to talk to Debbie and I confirming her details with no hints of the subsequent events. I also recall that Mrs Beale had been drinking water and orange juice with no problems earlier on the shift."*

36. At 23.30 hours, Q-ADDS observations of Mrs Beale were performed: Score (0); BP 130/75; Oxygen Saturations 97% RA; Alert.

37. No further observations were recorded until 01.30 hours on 3 August 2021.

38. Between 01.23 hours and 01.30 hours, Mrs Beale activated a nurse call and the EEN Beukes attended. The reason for the call is recorded: "*Patient had difficulty breathing and requested oxygen via NP. NP oxygen applied*." Q-ADDS observations of Mrs Beale were performed: Score (1); BP 130/80; Oxygen Saturations 95% RA.

39. At 01.40 hours Mrs Beale was recorded by EEN Beukes as stating "*Patient states she can't breathe*."[24] At Inquest, EEN Beukes evidence about this recording was:[25]

[23] Ex C5 BOE, paragraph 3.
[24] Noted in progress notes in line with observations noted on Q-ADDS.
[25] T2-59, L41 – T2-61, L15.

"Okay. Well, let's just have a look at the obs charts for completion. Again, going back to page 44. You took obs at 1.30. Is that – that's your entry?---It is.

And again, what would you say about those obs?---I would say that they were normal for a post-op patient.

Okay. And now reflecting, you think it was at that time perhaps the issue that's referred to in the note of 1.40 was raised with you by Mrs Beale?---While I was in that room, yes, I would say so.

Okay. Now, you've recorded that what she complained of at that time was that she couldn't breathe?---Well, she was struggling to breathe.

Okay?---Not that she couldn't. Yeah.

Well, I'm just going off your note says?---Yeah. No. I – yeah, I know what she said.

"Patient states she can't breathe"?---Mmm-hmm.

But you now recall that a better description would be that she was struggling to breathe?---Was struggling to breathe, yes.

Okay. Was there any other information conveyed to you about her breathing at that time that isn't recorded in your note?---No.

For how long she had been - - -?---I would have done her obs, her sats were normal. I would have taken it as just discomfort.

Okay. I see that you've recorded that her sats were 95 at that stage?---Yeah.

So that's normal for a post-operative patient?---In a normal range. It's – it's certainly a normal range, yes.

Okay. So the reference to her or the complaint of her being – having – struggling to breathe, you considered in the context you considered that in the context of what her oxygen saturations were?---Yes. If – if I'd – if her sats were very low, I would have obviously done something else, but her sats were normal.

Okay. If her sats were very low, what would you have done?---I would have got a – a registered nurse - - -

Okay?--- - - -to come and check.

Okay. If it were the case – this is, I appreciate this isn't what you now recall, but if it were the case that she couldn't breathe, would

that be something that would be - - -?---I would have pushed the code button if she couldn't breathe.

Okay. So you didn't push the code button. We can proceed on the basis that it wasn't that wasn't the situation at that point in time?---No, she was clinically stable.

Okay. And you've noted that the patient made a request about oxygen?---She asked to have oxygen, yes.

Okay. Is that something that you can make a decision about as an EEN?---Just a – well, yes, technically. Um – just not a – not a large dose of oxygen, just a sort of a – just a one would be fine. I wouldn't give her a 6 litre or anything like that without sort of getting some permission somewhere.

Okay. And was there any complaint to you about pain levels at that stage?---I don't recall. I don't recall.

Is that something that you would have noted if there had been a complaint?---Yes, I would have, because we would have done something about it.

Okay. So you adjusted the oxygen levels?---Yeah.

And she returned to – she had some improvement in her oxygen saturation?---She did.

Okay. And what did that mean to you in terms of her stability?---Well, she was still talking, drinking, everything, so clinically, she looked fine to me. And obviously, I was gonna go back there all the time. And ten patients and you just kind of go from one to the other."

40. As stated, Mrs Beale requested NP's. 2L of Oxygen was delivered by NP's, following which the observations were: Oxygen Saturations 97% NP; Alert; no pain score recorded.

41. This variance was recorded in the progress notes without escalation to the RN or Dr Fitzgerald as treating surgeon at this time. The Q-ADDS observations had not fallen into the purple zone to trigger an emergency call.

42. The timing of the sequence of events is somewhat unclear from this point.

43. According to the Chronology in Ex B2.1 BOE:

> *"At 02.27 hrs, Mrs Beale activated a nurse call. The EN responded. The reason for the call was noted as: "neck pain." The IVAC was alarming - IVC[26] was partially dislodged from Mrs Beale's hand. Mrs Beale requested pain relief for her neck pain. The EN recalled Mrs Beale was speaking without difficulty. Following RN/EN discussion, a decision was made to remove the cannula given Mrs Beale's adequate oral intake. Mrs Beale was administered an oral tablet of Endone. After swallowing the tablet, Mrs Beale tried to clear her throat with a gentle cough and became cyanotic."*

44. EEN Beukes' evidence at Inquest was:[27]

> *"You say there that the bell call was at about 2.30 am, the bell call but from the patient?---Yeah*
>
> *Could I suggest to you that it might have been a bit earlier than 2.30 am?---I don't recall. I really don't. I – I don't remember.*
>
> *Okay. She was seeking pain medication at the time that that bell call was made' is that correct?---Yes.*
>
> *Okay. And you responded by going and speaking to Jasmine Connell about that?---Yeah. She also had dislodged her IV cannula, and I think that is why she rang - - -*
>
> *Okay?--- - - -if I'm trying to remember it right.*
>
> *Okay. And is that the reason you went and spoke to RN Connell?---No, and for the pain relief.*
>
> *Okay?---And then while we were doing the pain relief, I spoke to her about the cannula.*
>
> *Okay. And you say that you retrieved another dose of the Endone or oxycodone - - -?---Yes.*
> *- - - from the drug cupboard?---Yeah*
>
> *And you say that you were taking additional time, I assume in returning to the patient, to speak to RN Connell about that?---Well we – I – we spoke about it while we were getting the drugs out of the cupboard.*

[26] Intravenous cannula.
[27] T2-61, L 21 – T2-63 – L45.

Okay. All right. So, can I take you to the medication chart? I'm just trying to nail down the timing. And you'll see there that there's a second entry for – so this is on page 61.

You'll see there that there's a second entry for the administration of oxycodone?---Yeah.

That's the Endone that we're talking about in that paragraph?---Yes.

And you see the time that it's recorded as being administered?---Yes.

Am I reading it correctly; 2.25?---Yes.

Can we proceed on the basis if that's accurate, that the bell call must have been sometime before 2.25?---I would say so, yes.

Okay. When you saw her in response to that bell call at some time earlier than 2:25 am, how did she present to you clinically at that time?---Fine. She was talking, she was drinking. She was sitting on the side of the bed and showed me her cannula which had partially come out. So she was clinically all right.

Okay. All right. So you left to retrieve the Endone in the way that we've described?---Yeah.

You spoke to RN Connell about that and the cannula?---Yeah.

And you returned to the room with the medication?---Yes.

And did RN Connell return with you?---Yes.

Okay. Can you tell me what happened from there?---We – um – checked her name, date of birth. We took out that cannula – um – because they – um – Jasmine didn't think it was necessary because she had no IV medication. We – um – checked her name, date of birth with her armband. She told us her name and date of birth and we gave her the Endone.

Okay. Can I pause there?---Mmm-hmm.

When you fill in the medication chart, do you do that recording the administration after the medication is administered or before the medication is administered?---While we're doing it

Okay. So we can proceed on the basis that at that time it was about 2.25 am when you provided the medication to her?---Yeah.

Okay. How did she proceed from there?---She was good. Well – um – she had her Endone, swallowed it. Jasmine left and I was still busy doing stuff around the room, making sure she was okay. And that was basically – she looked clinically well. She was talking, she drank her tablet with no problem. She looked fine.

Okay. Can I just take you to paragraph 6 on page 2 of your statement?---Mmm-hmm.

If you can just read that to yourself again?---Yep.

So she took the tablet, she swallowed it. Then what happened?---Well, Jasmine left and she was fine. I was – I think I was just tidying up or putting something away. I can't really recall what I was doing, but I was still in the room, and then she – um – did that and I turned around to see if she was trying to talk to me or something and she just – her eyes went huge and she started to turn blue and it was instant.

Instantly turned blue?---Well, she literally, just within seconds, went from sitting talking to me to not being able to talk.

Okay. So within seconds, sitting and talking to you, and then not being able to talk, that was after she attempted to clear her throat?---Yeah. Yes.

Okay. You've described her as turning blue?---Yeah.

Did that happen at the same time or - - -?---All – all within seconds of – of her sort of making that little cough.

Okay?---Because I literally just turned around and saw the reaction.

Okay. You were in the room alone with her at that time?---Yes.

Okay. What did you do?---I pushed a code.

Okay. And do you have any idea of when that might have been?---No

Okay. Can we proceed on the basis that it was sometime after 2.25 am when the medication was administered and perhaps sometime between 2.30 am? Would that be fair estimate?---Yes. It – it was minutes.

Okay?---It wasn't – it wasn't 20 minutes, it was maybe five.

Okay?---Yeah.

So within five minutes of administering the medication?---I – I would say so yes.

Okay. And what happened – apart from Mrs Beale turning blue, did – was there anything else that happened?---I just pushed a code immediately because I knew we were going to need help."

45. According to RN Connell, the recording of the Endone being administered to Mrs Beale (at 02:25 hours) would have been entered in the drug book at the time it was signed out, i.e. prior to the administration of the drug to Mrs Beale.[28] She accepted that she must have attended with EEN Beukes to administer the drug (sometime after 02.25 hours), but had no recollection of doing so and could not recall how Mrs Beale presented at that point in time.[29] If there was anything adverse about Mrs Beale's clinical presentation at the time the Endone was administered, I consider it likely RN Connell would have recalled that.

46. According to the Chronology in Ex B2.1 BOE, at or about 02:28 hours EEN Beukes "*activated the staff assist call button and the two Unit RNs* [RN Connell and RN Venton] *attended immediately. Mrs Beale became non-responsive and was laid down. A Code Blue call was activated. The nursing staff commenced emergency resuscitation management*."

47. According to RN Connell:[30]

"Now, please tell me what you can recall about Mrs Beale's clinical presentation when you attended in response to the emergency alarm?---When I – um – presented into the room, she was sitting on the side of the bed and she was – I remember her talking to us just saying that she was having – saying that she couldn't breathe – um – and that's when we put the Hudson mask on her face, and just told her to sit back down onto the bed. And then we – that's when we called the code.

All right. Can I – I just want to be clear about what you've said in this statement. When you first saw her, to be clear, you say that she said words to the effect, I can't breathe, so she was still speaking at that time?---Yes.

[28] T2-75, LL 32-46.
[29] T2-76, LL 1-9.
[30] T2-76, L28 – T2-78, L13.

Can we proceed on the basis that what that indicates that she was having difficulty breathing, when you first arrived?---Yes.

Okay. Later in that paragraph you say, "It was obvious Mrs Beale was not breathing". Do you see that?---Yes.

Does that mean that she progressed from having difficulty breathing, to not breathing?---Yes, or until yeah, having difficulty breathing. Yep.
So which – what does it mean?---I guess, indicating that she's having difficulty breathing.

Okay. As opposed to not breathing, at that point in time?---Yes.

Okay. You said that you placed the Hudson mask on her face?---Yep.

Is that right?---Yes.

Was she having difficulty breathing at that time, or was she not breathing at that time?---I'm sorry, I can't fully recall.

Is there any scenario whereby you might place a Hudson mask on a patient's face if they are just having – sorry, not just, but having difficulty breathing as opposed to not breathing?---Yes. Yep.

Okay. All right. So you can't recall whether she was having difficulty breathing or not breathing at the time you placed the Hudson mask on her face, is that where we're at?---Yeah. I can recall that she was having difficulty breathing, because when we had the Hudson mask on her, I remembered it was fogging up because she was really trying hard to breathe. I do remember that. Yes.

Okay. But still breathing?---Yes.

All right. And what did she look like from a clinical point of view, her colour in particular?---Yeah, I remember she was grey – um – her neck looked very distended. I do remember that.

Okay. Well, just in terms of her colour, would you describe her as cyanotic at that time?---No. No.

Just in terms of what you observed about her neck, can you describe that a bit more fully for us, please?---Um – there was no blood coming out of the wound itself, but it was very distended. I do remember that. Yes.

Okay. Did that indicate anything to you?---Yes. Yep.

What was that?---Well, I just felt my judgment was that, obviously, she's having a bleed there, and that's causing, yeah, airway breathing difficulties. Yep.

What made you think she was having a bleed there?---Because of the distention in the – in her neck.

….

And in terms of the urgency, or otherwise, of that presentation, what was your assessment?---Um – that, yeah, we needed to call the code straight away. Yes.

Was it because of that presentation, that is the swelling and the breathing – the swelling on its own that caused you to call the code?---And also the breathing difficulty.

Okay. It was the swelling in the context of the breathing difficulty that caused you to call the code, is that correct?---Yes.

All right. And did you have any view, or understanding of what would be required to manage that situation beyond calling the code?---No."

48. According to RN Venton:[31]

"Okay. And did you observe anything about Mrs Beale when you entered the room?---She was having difficulty breathing.

Okay. And what made you come to that conclusion?---I don't recall the actual signs and symptoms but she was having difficulty breathing at the time.

Okay. Was – how was she presented in the room?---She was sitting on the side of the bed.

Okay. Was she saying anything at that time?---I don't recall if she was talking at the time.

Okay. Sorry, I'll just go back. Ms O'Connell and Ms Beukes were already in the room when you – when you arrived; is that correct?---I'm – don't recall the actual order that we all got there but all three of us were eventually in the room.

Okay. And was there any discussion amongst the three of you about what you were confronting at that point?---Well, looking on my statement I think I recall that we noted she was having difficulty and we assessed her and noted she didn't have a pulse.

[31] T3-6, L17- T3-8, L20.

Okay. And how did you assess or look for a pulse?---I'm not sure who did but I think her pulse was checked.

Okay. She wasn't wearing an oximeter; is that right? Was not - - -?---I don't recall.

Okay. But someone checked her pulse in – by some way?---Yes. And the finding was no pulse?---Yes.

Okay. And was she still breathing when that assessment was made?---I don't recall.

Okay. All right. Now, if I can just take you to paragraph 10 of your statement?---Yes.

You mentioned something before about Mrs Beale's neck. What observation – did you make an observation about the state of her neck when you entered the room?---Yes. It was short and thick.

Okay?---Yeah.

Anything else about the neck which was – that you're able to describe?---I think I noticed there was some swelling but I don't – yeah, bit hard to remember exactly over time.

Okay. I think when you wrote your statement on the 23rd of July you said, "I recall that I thought the neck looked swollen from the time I first saw the patient"?---Mmm.

Is that accurate?---From what I can recall, yes.

Okay. And the swelling that you observed was something, if I can put it this way, abnormal even in the context of Mrs Beale having a short and thick neck? Is that what you mean to convey?---Yes.

Okay. And did you make any assessment or – sorry, I'll withdraw that. Did you draw any connection between the swelling of the neck and the difficulty breathing at that stage?---I don't think so, no.

Okay. Reflecting on what you knew or what you'd learnt from the seminar with Dr Westcott, that didn't come to mind at that point in time that there may be a connection between the swelling and the shortness of breath?---Well, in the rush of time, no. Yes. Yes.

Okay. That's fine. All right. So what happened after that initial attendance? Can you describe what happened next?---We had checked for the pulse and we started – we hit the CPR button and we had assistance to commence CPR.

And the CPR button is sometimes referred to as the code button?---The code button, yes.

Yes. And the reason for hitting the CPR button is what?---To get – grab more assistance and to have a team there to – so we can perform CPR.

Can I suggest to you it's also to call the medic – for the medical practitioner on site to attend at the scene?---Correct.
….

Okay. When you describe commencing CPR, was there chest compressions as well as ventilation started or just chest compressions?---Both.

Both?---If I remember, yes.

Okay. And how was the patient's ventilation being managed at that point?---With a bag mask, yeah.

Okay. And so a nurse, one of the nurses, was performing chest compressions and one of the nurses was performing the bagging at that point in time. Is that your recollection?---If I – yes.

Okay?---From what I can remember, yes.

All right. And do you have any recollection of how long it took before Dr Hatherly arrived?---No, I don't recall. A few minutes, I think, yes."

49. Doing the best that I can on the evidence available, I find that:

a. Between 02:25 hours and 02:27 hours Mrs Beale was administered an oral tablet of Endone and, after swallowing the tablet, Mrs Beale tried to clear her throat with a cough;

b. Mrs Beale immediately exhibited difficulties with breathing and rapidly progressed to respiratory arrest at some time between 02:28 hours and 02:30 hours;

c. A Code Blue was called at some time between 02:28 hours and 02:30 hours.

50. The precise time of Dr Hatherly's arrival to Mrs Beale's room is unknown, but at Inquest he thought it was likely around 02:30 hours.[32] It could have been up to 02.31 hours, but in any event I find that he immediately responded to the Code Blue and attended Mrs Beale's room as expeditiously as he could.

51. In respect of the situation upon his arrival, Dr Hatherley's evidence at Inquest was:[33]

> *"Okay. So you're moving towards the room where Mrs Beale was situated?---Yes. So – ah – so when I arrived – ah – so thinking back, I mean I – I probably received information that she had stopped breathing, or said something like, "I can't breathe" and she had collapsed. So – ah – on arrival to her room, and I'm standing in the doorway, I could see a lot of activity around her. Ah – she was lying in the bed. Ah – there were already paddles on her, defibrillation paddles.*
>
> *Yes?---Her eyes were open.*
>
> *Yes?---And there was no obvious movement or response from her with – with a great deal of activity around. So that – and she was a terrible colour, and I remember my first impression thinking that she looked dead. So that was my – my first impression as I arrived. So I immediately turned to Sue and said, "We need to call everybody, so you need to get the ambulance here and the surgeon and the anaesthetist." And then I moved into the room to begin the ALS[34] protocol.*
> *…*
>
> *All right. Now, can I – you undertook an initial assessment, the one you've just described, and you identified that Mrs Beale's eyes were open?---Yes.*
>
> *What did you notice about her eyes at that point in time, if anything?---Well, that they – that they were not moving. So – so with all the activity going around, she wasn't blinking, she was perfectly still and just lying there with her - - -*
>
> *Were they fixed and dilated?---Well, when I approached the patient and went up to her head, yes, I could see as I looked down at her that there was just – they were – yes, there was no movement, her pupils were fixed and dilated.*

[32] Starting a T2-17, L4.
[33] T2-17, L34 – T2-20, L 20.
[34] Advance Life Support.

Okay?---She had an enormously swollen neck.

Okay. An enormously swollen neck?---Mmm.

You noticed that from the outset?---No, not from the outset. So from the outset I'm standing at the doorway.

Sure?---So – ah – would you like me to – as I've asked Sue to call everybody, I've then moved into the room to get close to the patient.

Yes?---Continuing to get some history, so I think I learned that she had coronary artery disease. I asked her whether she had – I think I would have asked her if she had any airway disease or just – just trying to get – because at the moment I've got a patient who's stopped breathing, so you sort of think, "Could it be their lungs? Could it be their heart? Could it be they were in fluid overload? Was it an allergic reaction?" So I'm trying to work out is this heart or lung. I know she's had a thyroid operation, but she's just collapsed, so I'm not coming at it from a – that she's had a bleed and she can't breathe because of that. At this point I'm thinking of medical things, okay.

Okay?---So I was very surprised when I approached the patient because there were – on the monitor, because she had the pads on, she had what looks like organised – like a normal heart beat.

Rhythm?---Yeah, so that's what it looked like to me, and so I was very surprised at that given that she was very unresponsive. So I slightly broke the ALS protocol just from the point of view as I moved up to the head, I just put my fingers on her radial pulse as I was moving up, and I felt a pulse, which I found surprising. I then put my stethoscope into my ears as I moved up and placed that on her chest. I could not hear a heartbeat, so I immediately checked again and there was nothing and then I've moved up to the head, asked for a – sort of moved up to the head, started to manage her airway. I made the decision to get a nasopharyngeal away[35] [sic] *to just help me bag her. It might have been I started bagging her and then asked for it. I'm not certain. And at that point I real – I could see how swollen her neck was. I also received information at this time that the patient had no cannula, and so at this point I'm the only person in that room who can – who has any airway skills, surgical skills or can cannulate. Given what was on the monitor and that she had no pulse, she was having 5 a pulseless electrical activity arrest, so regardless of the cause of that, the treatment for that is adrenaline. So she has no intravenous access. So I then had to start making decisions about what to do.*

[35] Presumably 'airway'.

Okay. So it's very dynamic and fluid, I am sure, and it was a high pressure environment, I am sure, and all of this is happening very rapidly, I am certain of that. I'm just trying to get a handle on how far into your management you observed that her pupils were fixed and dilated?---Oh, the second I got up to her head and looked down at her.
Within 30 seconds of entering the room, one minute?---I would say a minute.

Okay?---So yeah, a minute, maybe 75 seconds or a minute. Yeah. Somewhere - - -

But very soon upon entering the room, that was apparent to you - - -?---Yes.

that her eyes were fixed and dilated?---Yes.

And does that go also for the very swollen neck?---Yes. So the second I got up to her neck and looked down, I could see that her neck was very swollen and her pupils were unresponsive.

Okay. And what does a patient who's got fixed and dilated – what does fixed and dilated pupils in a patient indicate to you?---That their brain is dead, that it's not working. Yeah.

Okay. Is that part of the reason why you thought she was dead at that point?---My impression initially was just based upon her total lack of responsiveness and her colour. I mean, I have seen a lot of – ah – dead people during – during my career. Um – so just – just her colour and the way she was, I just thought that that was the – that's just how she looked. I mean, when I came up and saw her – ah – pupils and how unresponsive she was, I thought that – I thought that her brain had probably already been – um – hadn't received enough oxygen. Um – and I guess, you know, following on from that the nursing assessment for her, I mean, I would probably add – it was probably two minutes before they based it on the nursing notes that I read before they sort of hit the button. So I would assume by the time I got up to the head, we're already at the sort of five to six-minute mark total – um – which….

And how long – how long – sorry, you go on?---Yeah. So – and in someone of that age with coronary artery disease, I mean, it just – that's probably not going to be a good outcome, but because it's an observed duress, it doesn't change what I'm going to do. We're just going to do our best.

So in your experience, I think you've touched on it already having regard to her age and her medical history, et cetera, how long

might a patient have from the time that they have airway occlusion before they are in the situation where they've suffered brain death?---I would say around five minutes. I mean, I have been involved in resuscitation which was attended to by a very experienced emergency physician who helps out the – the ambulance and we – ah – he – he called it at about eight or nine minutes. So as in he's – he said they're generally in this age group, they're just not going to do well. Ah – the patient – we got the patient's pulse back, but they then passed away a few hours later. So once you get to five minutes, it just – every 60 seconds after that you're - - -

Okay. So I think your evidence was that from that very early point in time, and this is before CPR commenced - - -?---It – so - - - you'd formed the view that the outcome wasn't going to be particularly good for Mrs Beale?---Yes.

Because of the brain death – likely brain death?---Yes.

Okay. But just to be clear, notwithstanding that – as I understood your evidence, that didn't inform what you then did?---Absolutely not, no."

52. After assessing the situation, Dr Hatherly inserted a nasopharyngeal airway (a small tube intended to pass from the nose to the back of the mouth) and performed CPR.

53. There are no contemporaneous notes covering the initial resuscitative efforts, but Dr Hatherly's retrospective note indicates the skin staples were removed, that there was neck swelling, and that Mrs Beale had an initial pulse post respiratory arrest before losing the detectable pulse and having chest compressions commenced.

54. Dr Hatherly did not attempt endotracheal intubation at that time.

55. At of about 02.38 hours, RN Deane telephoned Dr Fitzgerald.

56. I find that RN Deane telephoned Dr Cooper sometime between 02.32 hours and 02:39 hours. Otherwise, I do not consider it necessary to resolve the discrepancy in the evidence as to when Dr Cooper was called because nothing turns on that issue given my findings below.

57. At or about 02.40 hours, RN Deane commenced scribing in the clinical record. Adrenalin 1:1000 was administered.

58. At 02:42 hours, there was no shockable rhythm and CPR was continued.

59. From at or about 02.45 hours, QAS Paramedics arrived.

60. At or about 02.50 hours to 02:53 hours QAS Critical Care Paramedic, Sam Streeter (**CCP Streeter**), attempted direct laryngoscopy but could not obtain a laryngeal view. I note that the resuscitation documentation[36] records that endotracheal intubation was commenced at 02:53 hours but was unsuccessful due to "*bad airway. Can't pass bugie (sic) lots of swelling*". By his statement[37] CCP Streeter states:

> *"The Doctor appeared to be having difficulties managing the airway because the bed was up against the wall. I moved the bed, so the head end was more accessible. I asked the Doctor what specialty he was and what his airway management experience was. I remember him telling me he was a General Medical doctor and [he] had some airway management experience, but not for some time. I asked the doctor if I could assist in managing the airway.*
>
> *I tried to ventilate the patient with bag-valve-mask (BVM) but was unable to do so. I had one attempt at laryngoscopy and had difficulty making out the airway anatomy due to swollen anatomy on direct view."*

61. Dr Hatherly then attempted endotracheal intubation on Mrs Beale but was not successful.

62. Bag valve mask ventilation was continued however, the bag-mask ventilation was not effective.

63. At 02.52.58 hours[38], Dr Fitzgerald arrived. By his statement[39] Dr Fitzgerald stated:

[36] Ex B2.10 pp. 68-73.
[37] Ex C15 BOE.
[38] Time taken from the swipe card records.
[39] Ex C1 BOE.

"*On my arrival to the Surgical Ward Mrs Beale was unconscious. Active CPR was being given by Dr R Hatherly – the House Medical Officer on call- and nursing staff. He told me her pupils were fixed and dilated from when he arrived from when the Code Blue was called. He said the arrest was called at about 0200 hours. A bag and mask was being used for ventilation with no endotracheal tube in place. I noted that the neck wound clips had been removed but that her neck was swollen. I immediately manually opened the entire neck wound and evacuated approximately 200-300mls of dark blood and clot from the thyroid bed. There was no active bleeding at that time*."

64. At Inquest, Dr Fitzgerald's evidence was:[40]

> *"Was there any other clinical presentation that you observed?---Well, her face was ashen. I wouldn't say cyanotic or blue, but she certainly appeared pale. And there were no breathing efforts, there was no rising of her chest. And I didn't specifically observe this, but I was told by Dr Hatherly, who was conducting the CPR, that her pupils were fixed and not responding to light.*
>
> *And for the lay people in the room, what does that indicate?---Brain death.*
>
> *All right. Now, I interrupted you. Having observed the state of Mrs Beale's swollen neck, you took some measures. Can you describe what that involved?---Well, I went to her side, I put my fingers, both hands, into the muscle in the midline of the neck and pulled with all my might to open those muscles and then evacuated the clot that was within the thyroid bed. And I could see that the trachea was compressed by that, the trachea was on view. When I removed that clot, as I recall, Dr Cooper, the on-call anaesthetist, came, arrived, and attended to trying to obtain an airway pretty much in the middle of me removing the clot. And he had difficulty, as you know in his statement, obtaining an airway. And he did, though, after a few minutes, I can't say exactly how long, he was able to insert an endotracheal tube and ventilate the patient and restored her heartbeat. And her blood pressure came up, because when I arrived they had no blood pressure. And that's when there was some active bleeding occurring then, once her blood pressure and pulse were restored, from the wound where I had put my fingers, because it was a rather hasty and rapid-fire removal of the clot, and it's not surprising that there was some bleeding then, once her blood pressure had been restored."*

[40] Starting at T1-19, L13.

65. Dr Cooper arrived at 02:56 hours. According to his statement:[41]

> *"I arrived at the Mater and attended the patient in their room at 0256. The patient was receiving cardiopulmonary resuscitation ('CPR'). The surgeon (Dr William 'Cody' Fitzgerald), night-time hospital Senior Medical Officer ('SMO') (Dr Adam Hatherly), nurses, and Queensland Ambulance Service ('QAS') staff were in attendance. QAS were ready to transfer the patient to MBH and the MBH Intensive Care Unit ('ICU') were aware and accepting of the patient pending bed availability.*
> *….*
>
> *Management included:*
>
> - *I immediately took over airway management and was able to effectively bag-mask ventilate (BMV) the patient (confirmed by chest rise, mask fogging, EtCO2). Significant soiling of the airway with stomach contents was suctioned.*
> - *I requested a fluid bolus, additional IV access, and a venous blood gas (to look for further reversible causes of the arrest).*
> - *CPR continued. I attempted to secure the airway with an endotracheal tube ('ETT') at a rhythm/pulse check. Direct laryngoscopy with a Macintosh 4 laryngoscope revealed a Cormack-Lehane ('CL') grade 4 view. The airway was distorted and swollen called for a video laryngoscope and the difficult airway trolley from theatre. Effective BMV continued.*
> - *Return of spontaneous circulation ('ROSC') occurred, likely in response to improved ventilation/oxygenation.*
> - *On the 2nd attempt to secure the airway a glidescope videolaryngoscope was used, revealing a CL grade 3b view of only the tip/most cranial part of epiglottis with swollen tissue displacing larynx to left and crowding airway with red/swollen tissue from anteriorly. I attempted to pass a Frova intubating introducer under the epiglottis and into the trachea but was unable to do so. I was still able to effectively BMV the patient.*
> - *A 3rd attempt to secure the airway was made using the glidescope (CL grade 3b view) and a size 6 ETT with malleable stilette inserted, which was able to slip under and lift the epiglottis and enable me to see the arytenoids*

[41] Ex C4 BOE.

and a small posterior part of the vocal cords. The ETT was passed into the trachea, and was noted to be a tight fit. The position of the ETT was confirmed with bilateral breath sounds and chest expansion, EtCO2, and later chest x-ray. Midazolam was given for sedation."

66. The resuscitation documentation[42] indicates that there was a return of circulation at or about 03.13 hours. Dr Cooper stated that this was achieved in response to effective bag-mask ventilation.[43] Successful endotracheal intubation was achieved by Dr Cooper at 03:20 hrs, after the third attempt referred to above.

67. Dr Fitzgerald stated:[44]

"*Dr Cooper inserted an endotracheal tube and maintained CPR until the pulse and blood pressure were restored. Her pupils however remained fixed and dilated. Active bleeding occurred from the neck wound when blood pressure was restored and I called in operating theatre staff so as to perform operative haemostasis. Bleeding vessels were noted in the platysma and strap neck muscles but there was no active bleeding from the thyroid bed. The bleeding vessels were ligated with successful haemostasis and he neck wound was closed with loose skin sutures*."

68. At Inquest, Dr Fitzgerald's evidence was:[45]

"*And fairly soon after Dr Cooper intubated Mrs Beale, her heartbeat was restored and her blood pressure was restored, and I noticed – somebody else took over the compressions – that there was some active bleeding occurring in the wound, which appeared to me to be mostly coming from the muscles, the vessels and the muscles where I had had to open up physically to get the blood clot out. I put a combine over that area to put a bit of pressure on those vessels while the CPR was continuing, and then I said to Dr Cooper, "I think we need to take her to the operating theatre so I can tie off these vessels". Both of us knew that it was unfortunately very unlikely that, given her fixed, dilated pupils, that this was going to help in any way, but I didn't want a patient to have an actively bleeding neck wound until we absolutely had excluded the chance that she may have a recovery. I felt that I needed to do that, and Dr Cooper agreed*."

[42] [42] Ex B2.10 pp. 68-73.
[43] T1-39, LL33-50.
[44] Ex C1 BOE.
[45] T1-20, LL 27 – 38.

69. On return to theatre, Dr Fitzgerald discovered two arterial bleeding points in the superior aspect of the platysma muscle (thin broad muscle at front of neck) but no active bleeding from the thyroid bed. The bleeding vessels were ligated with successful haemostasis.

70. Arrangements were the made to transfer Mrs Beale to the ICU at MBH by the QAS . Upon her being received at MBH, Mrs Beale was suspected as having a severe brain injury.

71. Despite intensive care support provided to Mrs Beale, she made no meaningful recovery, ultimately passing away after being extubated with family consent late in the afternoon of 3 August 2021.

72. I proceed on the basis of factual findings in accordance with the above summary of the evidence.

Issue 2

Whether it was appropriate to perform the thyroid surgery at MPHM on 2 August 2021, or at all?

73. According to the licence issued by the Private Health Regulation Unit within Queensland Health. MPHM held a Level 3 Service Capability in Surgical Services, Close Observation Services and Emergency Services[46].

74. At the time of the thyroid surgery, MPHM did not have an ICU, nor did it have a High Dependency Unit (**HDU**) (although up until the morning Ms Went gave evidence at the Inquest, MPHM had represented on its website that the facility had the latter capability).

75. Mrs Beale presented to Dr Fitzgerald with a 5cm mass in her right thyroid gland which was pushing on her trachea across the midline.

76. According to Professor Perry:[47]

[46] Ex B2.3.
[47] Ex D1, p.5.

> "*Being a Bethesda IV mass, it had a 25% chance of being cancer. 90% of thyroid cancers are relatively slow growing but the other 10% are not slow. Also, in the elderly, more benign thyroid cancers are well known to be prone to de-differentiation and become rapidly untreatable and fatal…..the hemi-thyroidectomy was an appropriate operation for somebody who anticipated that they would still be alive for a further five or 10 years in the normal unfolding of her life…..I cannot find any reason that the surgery was not indicated. Most surgeons would offer this procedure to a 78-year-old person*."

77. Dr Fitzgerald had experience performing thyroid surgery. By his statement[48] he stated that: *"*[he has] *performed many thyroidectomies approximately 250-300 over the past 26 years*."

78. However, in the more recent years prior to Mrs Beale's surgery, Dr Fitzgerald had performed relatively few thyroidectomies. He performed only one thyroid surgery in 2020, on 26 October 2020, that being the last thyroid surgery he performed before Mrs Beale's surgery on 2 August 2021.[49]

79. Notwithstanding Dr Fitzgerald having performed relatively few thyroidectomies in the years prior to Mrs Beale's surgery, I find that he was appropriately skilled by reason of training and experience to perform the thyroid surgery on 2 August 2021. Indeed, the evidence of Professor Perry was to the effect that he advanced no criticisms at all about the care provided by Dr Fitzgerald, including as to the performance of the thyroid surgery.

80. Additionally, there was no restriction on Dr Fitzgerald's clinical privileges or scope of clinical practice specifying that he was not to perform thyroid surgery (or other endocrine surgery) at MPHM at the subject time, nor since.

[48] Ex C1.2.
[49] T1-6, L41 – T1 -L47.

81. Otherwise, there is no evidence before me to establish that, in allowing thyroid surgery to be performed at the facility, MPHM acted outside the Clinical Services Capability Framework[50].

82. Subject to the matters discussed below, I find that it was appropriate for Dr Fitzgerald to perform the thyroid surgery upon Mrs Beale at MPHM on 2 August 2021.

83. Albeit uncommon, the incidence of post-operative thyroidectomy wound haematoma (the bleeding complication) is well known according to Professor Perry and is referred in material published by the Royal Australasian College of Surgeons.[51]

84. The issue remaining is whether it was appropriate for MPHM (as an institution), in the context of the known risk of the bleeding complication following thyroid surgery, to permit the surgery to proceed at MPHM on 2 August 2021 having regard to the limitations of the after-hours care available at MPHM?

85. MPHM was evidently aware of the risk of postoperative bleeding (i.e. the formation of haematoma compromising the airway) following thyroid surgery and the medical emergency it presented.

86. Prior to Mrs Beale's surgery, on 30 January 2021, MPHM conducted an "in-house" tutorial, presented by Dr Adrian Westcott, entitled "*Post-Op Care of Thyroidectomy Patients*" with the object of the session being "*How to respond to post-op complications*." A video of the tutorial is in evidence at Exhibit B2.8.1. The tutorial was attended by a number of the nursing staff of MPHM[52] and was directed to nursing staff accordingly. No medical practitioners were in attendance.

[50] https://www.health.qld.gov.au/__data/assets/pdf_file/0021/444423/cscf-fs-2-service-levels.pdf
[51] Ex D1.
[52] Including RN Venton, who was involved in the resuscitation of Mrs Beale on 3 August 2021 - see Ex B2.8.2. The video of the tutorial was also subsequently viewed by RN Connell.

87. In the video, Dr Westcott is seen to describe the anatomy of the neck where the thyroid is located, what is involved in performing thyroid surgery, and he explains the mechanism by which the formation of postsurgical haematoma occurs. He also explains the emergent nature of the bleeding complication and what is required to manage it.

88. Essentially, in the event of the occurrence of the bleeding complication, what is necessary is to open the wound by removal of the sutures (or staples) through three layers (skin, platysma and strap muscles) using the suture cutter or staple remover.

89. In the video Dr Westcott explained that in the case of sutures, they will be continuous and all that is required is to cut one suture at each layer and the pressure of the haematoma will cause the remaining sutures to release, opening the layer. Dr Westcott explains that once this is done "*the patient is safe…and I should say that it [the incidence of the complication] is less than 1%, so you should never see it."*

90. On the video, a nurse (not identified) is heard to ask a question about when to release the sutures, referring to the signs of neck swelling and "*airway occlusion*", to which Dr Westcott responded: "*if you've got airway occlusion, you're probably too late*." Dr Westcott goes on to explain that "*if you have got an expanding haematoma and airway issues, you've just got to split it on the ward*." He essentially confirms that opening the wound in those circumstances should be done immediately, and before calling medical staff to attend. He qualifies this by saying that "*but if you've got a haematoma there and they're talking normally and breathing normally and their stats are normal, leave it alone*", the implication being that medical staff should be requested to urgently attend. It is confirmed that "*only if the airway is compromised*" should the nursing staff open the wound as described above.

91. Despite the MPHM being aware of the risk of the bleeding complication prior to the performance of the thyroid surgery, on the evidence before me it is clear that the nursing staff and the medical officer, Dr Hatherly,

who were presented with the bleeding complication in the case of Mrs Beale in the early hours of 3 August 2021 did not do what was necessary to manage the complication.

92. In this regard, the MPHM has appropriately acknowledged and accepted that the care provided by the MPHM to Mrs Beale on 3 August 2021 was not optimal. Indeed, I find that the care provided by the MPHM to Mrs Beale on 3 August 2021 in managing and treating the bleeding complication was not adequate, nor appropriate.

93. In particular, whereas the treatment Mrs Beale required was (a) the removal of the obstruction to her airway and/or (b) the insertion of an endotracheal tube, it is clear from his own evidence that Dr Hatherly did not possess the necessary skills to perform either procedure.[53]

94. Additionally, it is clear that the nursing staff present who had received some instruction from Dr Westcott's tutorial about how to manage the bleeding complication had an incomplete understanding of what was required and/or a lack of confidence to do what was required.[54]

95. At Inquest, Professor Perry was guarded in responding to questions around whether it was appropriate for MPHM to allow thyroid surgery to be undertaken at the facility given the limitations in respect to the after-hours care available.[55]

96. Specifically, Professor Perry's evidence was that "*you can't cover every eventuality*" and he opined in oral evidence that:[56]

> *"And I really hope that, as a result of this, we're not going to be restricting thyroidectomies to public hospitals with massive intensive care units because the intensive care units are already full – uh – so unfortunately, people have to do things which are a bit risky. They can't be a hundred per cent safe. Uh – and –uh – it would be a shame to stop thyroidectomies being done in*

[53] See Dr Hatherly's evidence extracted in Counsel Assisting's Submissions at paragraphs [52] – [53].
[54] See RN Connell's evidence extracted at paragraph [57] of Counsel Assisting's Submissions.
[55] See Professor Perry's evidence extracted at paragraph [62] of Counsel Assisting's Submissions.
[56] T4-10, L12.

provincial cities with good hospitals and well-trained staff – uh – who can't have, you know, a Royal Brisbane Hospital intensive care unit right next door to them. Or right in – in their ca – in their campus."

97. In summary, Professor Perry's evidence was:

Q. "Yeah. All right. So I think I understand your evidence is that perhaps in an ideal theoretical world, having someone onsite who's capable of intubation would be a good idea, but from a practical perspective, there are limitations. Is that what you're saying in terms of being able to provide that support? --

A. That's exactly right. Yes."

98. I acknowledge and accept the submissions of King's Counsel for the MPHM to the following effect:

a. There is no suggestion that in permitting the thyroid surgery to proceed, MPHM acted outside the Clinical Services Capability Framework;
b. The bleeding complication was a very rare complication (less than 1% as described by Dr Westcott in the tutorial video);
c. There is no evidence of there being any other deaths arising from such a complication at MPHM;
d. It would be expensive to have an emergency physician, surgeon or anaesthetist on site after hours;
e. Implementing an ICU would also be expensive and strain resources;
f. There is very real benefit in patients being treated locally; and
g. There are important social and economic questions going to the availability of public and private care in regional Queensland.

99. I also acknowledge and accept that there may be some logistical issues in ensuring that the medical officer providing the onsite after-hours care at the MPHM maintains current and regular experience in endotracheal intubation, but there is no evidence before me that any such difficulties have been given close consideration by MPHM in response to Mrs Beale's death, or that they are insurmountable. Otherwise, I note that Dr Cooper would have expected the after-hours medical cover at MPHM

would involve practitioners who were capable of performing endotracheal intubation.[57] Ms Went also agreed that MPHM "*should have in their toolbox*" after- hours doctors competent in performing endotracheal intubation on-site in the event the need arises.[58]

100. In terms of whether it was appropriate for MPHM (as an institution), in the context of the known risk of the bleeding complication following thyroid surgery, to permit the surgery to proceed at MPHM on 2 August 2021 having regard to the limitations of the after-hours care available at MPHM, there is clearly a balance to be considered between depriving residents of regional centres from undergoing common surgery (including thyroid surgery) in those centres and ensuring adequate and appropriate cover in the context of the practical limitations Professor Perry was referring to.

101. However, in this instance, whilst I find it was appropriate to perform the thyroid surgery at MPHM on 2 August 2021, and regardless of the rarity of the bleeding complication arising, where MPHM was clearly aware of the risk of the bleeding complication and the need to educate at least its nursing staff accordingly, I find that MPHM should have done more than it did to provide after-hours medical cover capable of managing the bleeding complication if it arose, including by taking steps directed to:

    a. Ensuring that the medical officer providing the after-hours medical cover was appropriately and adequately trained and skilled in:

        i. Identifying and understanding the bleeding complication of a surgical procedure that was being undertaken at MPHM;

        ii. Understanding the pathological mechanism of the airway compromise caused by post-operative haematoma;

[57] T1-47, L48 – T1-47, L4.
[58] T4-40, LL39-41.

iii. Knowing what was required to be done to adequately restore airway patency, including the need to remove the three layers of sutures (or staples) for the purposes of releasing the haematoma;

iv. Understanding the urgent nature of the complication including the short timeframe in which hypoxic brain injury will be suffered if the airway is not restored;

v. Appreciating the need to escalate through the ASL algorithm including to endotracheal intubation given the mechanism of the airway compromise and the short time available to restore the airway before hypoxic brain injury is suffered; and

vi. Undertaking endotracheal intubation confidently;

b. Ensuring that the nursing staff were appropriately and adequately trained and skilled in:

i. Identifying and understanding the bleeding complication of a surgical procedure that was being undertaken at MPHM;

ii. Understanding the pathological mechanism of the airway compromise caused by post-operative haematoma;

iii. Knowing what was required to be done to adequately restore airway patency, including the need to remove the three layers of sutures (or staples) for the purposes of releasing the haematoma and being confident to do so, at least where a medical officer is not available.

102. In the case of Dr Hatherly, a formal interview and more rigorous enquiry about his skills and competency at the time he was contracted to perform the OMO role likely would have revealed the limitations in his

capability to adequately deal with the bleeding complication, with any necessary education and training to be provided.

103. In the case of the nursing staff, whilst Dr Westcott's tutorial was obviously well intended and directed specifically to the complication Mrs Beale suffered, follow-up after the tutorial with practical hands-on exercises likely would have consolidated the learning and improved confidence in the nursing staff to do what was necessary when the complication arose.

104. Additionally, not all of the nursing staff had attended the tutorial, watched the video or had been directed to watch it. That was the case with EEN Beukes, who was caring for Mrs Beale at the time she suffered the bleeding complication.[59] Although she gave evidence at the Inquest to the effect that she observed Mrs Beale's neck to be swollen and that she was having difficulty breathing, it was evident that she had no appreciation of the nature of the complication and what was required to be done to manage it.[60]

Was there an unexpected and concerning intra-operative bleed?

105. This was not a formal issue for Inquest.

106. Although the question took up some considerable time in evidence at the Inquest, I propose to deal with it economically.

107. For ease of reference, paragraph [32] of Mr Atkinson KC's submissions on behalf of MPHM states (in part):

> *"It will be recalled that EEN Beukes gave evidence that she met Dr Fitzgerald when he attended the Hospital during the event. She said she recalled him saying that there had been a bleed during surgery. EEN Beukes gave very forthright and comfortable evidence on this point, particularly in response to cross-examination from Dr Fitzgerald. She was impressive, certain and dispassionate at the same time. It is entirely unlikely that she would make up such a specific recollection and no motive was*

[59] Ex C5.2 BOE.
[60] T2-64 L45 -T2-65, L8.

suggested for her doing so. Dr Fitzgerald, on the other hand, could not recall whether or not he made the comment."

108. It is not clear on the face of Mr Atkinson KC's submissions what I am to make of EEN Beukes' recollection of her exchange with Dr Fitzgerald. However, I gather I am to consider the submission in the context of the line of questioning of Dr Fitzgerald by Counsel Assisting and Mr Atkinson KC at the Inquest. For the sake of brevity, I refer to Mr Atkinson KC's examination only:

> *"And then you said words to her to the effect of, "This lady had a bleed in theatre but I tied it off"?---I don't recall saying anything of that – with that wording to anybody prior to entering her room in the surgical ward.*
>
> *And can I ask you whether it's true though that this lady had a bleed in theatre and did you tie it off?---She had a number of vessels, as I described, which I had to tie off. I don't recall any particular vessel heavily bleeding during the procedure. I did not make a note of that, and I don't recall any specific major concern with bleeding during the procedure.*
>
> *I understand from what we discussed earlier, Dr Fitzgerald, that it's of the nature of the operation that necessarily you are tying off vessels. But when you tie them off, if it all goes well, they don't bleed?---Correct.*
> *And it would only be of significance to say, "I tied it off but there was a bleed", if it was a bleed of some significance?---Yes.*
>
> *And certainly you accept the possibility that it was 150 mils*[61] [sic], *in this case, the bleed?---During the course of the operation, yes.*
>
> *If the patient had a bleed of some significance in theatre, I think you agreed with Mr Schneidewin that is something that it would be important to tell the staff, the nurses subsequently?---Yes.*
>
> *Because you'd be more vigilant in the care if there had been an intraoperative bleed?---Yes. If there was bleeding which was particularly difficult to control, which took time, and resulted in a volume of blood being lost of concern, yes, I would speak with the nurses in the ward."*

109. I also gather that the inference to be drawn from this is that if the nursing staff on the ward had been informed about a significant intraoperative bleed, they might have been more vigilant or done something differently

[61] Presumably 'mls'.

in terms of their care of Mrs Beale on the ward, although what any change in the level of care might have been, and whether that would have made a difference to Mrs Beale's outcome, was not explored in the evidence.

110. In addition, it was suggested that the recorded blood loss during the surgery, Dr Fitzgerald's use of Surgicel, the number of swabs used during the surgery, and additional ligature reels recorded in the operation report were indicative of an unexpected and significant intraoperative bleed.

111. Given the evidence of Professor Perry about the latter suggestion, I do not consider it necessary for me to decide whether EEN Beukes is correct in her recollection of her exchange with Dr Fitzgerald, or what might have been meant by Dr Fitzgerald in making any such statement.

112. Professor Perry's evidence about the latter suggestion was to the following effect:[62]

    a. Noting that 30 swabs were accounted for as having been used in the surgery, that suggested a relatively normal amount of bleeding for a hemithyroidectomy;

    b. Losing up to 150mls of blood in a thyroid operation is not uncommon; "*that's a normal, average thyroidectomy blood loss";*

    c. The use of 30 swabs is consistent with the recorded intraoperative blood loss of 150mls;

    d. "*maybe 20 or 30 or 40 per cent of thyroids would have a – a – about a 150 ml blood loss*."

    e. The number of ligature reels recorded as being used was not indicative of unexpected bleeding or difficulties achieving haemostasis; "*some surgeons use a lot of suture – a – a large*

[62] T4-4, L40 to T4-7, L28.

length to tie a small knot. Uh – and others use a small amount. Um – you can't tell the blood loss on this – the blood – on – on the four ligatures – um – the – the blood loss, the more accurate thing are the sponges, and the estimate of an honest person at the end of the operation saying – uh – and it would have been a nurse – uh – we – we – about 150 mil[63] [sic]*, and I'd be happy to accept that. It doesn't mean anything";*

f. In terms of whether or not there was an unexpected intraoperative bleed, the recorded use of Surgicel means "*nothing, really. Uh – surgicel is a gauze – um – which has a – a – a vessel – uh – clotting – uh – agent in it, and – uh – it's often cut down – so it comes out of a packet, so it looks like a packet of 10 centimetres by 20 centimetres, which is, you know, al – al – almost a – a fool's cup*[64] [sic] *sized piece of paper – uh – was taken, it was probably cut down to a smaller amount. Uh – I use it with every thyroid. I put it on the thyroid bed because it's – can be fairly oozy – uh – and the main nerve of the voice box can be in amongst that ooze, and then you've got to put a sucker in which is a – a – sorry, a drain in which is a sucking drain, and if – if it sucks the vocal chord*[65] [sic] *nerve into it, it could paralyse that nerve which is very, very easily damaged and so I think it's fair to say that the majority of thyroid surgeons whether they're from the head or neck branch that I am, or from the general surgery branch that Dr Fitzgerald is from, I think you'd find the vast majority of people put – uh – one or two or three layers of surgicel – um – over the top of the nerve on the bed to help in the haemostasis from the small, small blood vessels and stop damage to the recurrent laryngeal nerve with the drain."*

113. Given Professor Perry's evidence, regardless of the accuracy or otherwise of EEN Beukes' recollection of her exchange with Dr

[63] Presumably 'mls'.
[64] Presumably 'cap'.
[65] Presumably 'cord'.

Fitzgerald, I am not satisfied, having regard to the weight of the evidence, including contemporaneous intra operative documentation, that there was an unexpected and concerning intraoperative bleed that should have been recorded and reported to nursing staff on the ward.

Issue 3(a)

Whether the bleeding complication was due to an arterial bleed or a venous bleed?

114. At the Inquest, there were a range of opinions expressed as to whether the bleeding complication was due to an arterial bleed or a venous bleed. These have been thoroughly summarised by Counsel Assisting at paragraphs [132] to [136].

115. Clearly, reasonable minds may differ in considering a hypothesis for the cause of the haematoma and there is no good reason why I should prefer one of the hypotheses advanced over others. Further, for the reasons advanced by Counsel Assisting in his submissions, I do not consider it necessary that I should do so.

116. Nevertheless, I accept Professor Perry's hypothesis as the most plausible. That is, that Mrs Beale most likely suffered a major arterial bleed following a ligature coming off when she coughed after taking the oral Endone tablet.[66]

Issue 3(b)

Whether the nursing care of Mrs Beale at MPHM was adequate and appropriate including with respect to the frequency of the observations taken and record keeping?

117. After 23:30 hours on 2 August 2021, no further observations were taken and recorded until 01:30 hours on 3 August 2021. This was put down to workload on the ward.

[66] T4-19.

118. Additionally, at 01:30 hours when observations were taken, that was in response to Mrs Beale reporting that she was having difficulty breathing and requesting oxygen. She was administered 2L of oxygen with improvement, however the variance was recorded in the progress notes without escalation to the RN or Dr Fitzgerald at that time.

119. Thereafter, no further observations are recorded and the only note prior to the arrest is the 01:40 hours note recorded by EEN Beukes stating: "*Patient states she can't breathe."*

120. This is not what was required of EEN Beukes and on that basis, I find that the frequency of the observations taken by EEN Beukes and her record keeping was not adequate, nor appropriate.

121. However, given the critical findings of fact outlined later in these findings, these deficits in the taking of observations and the record keeping are unlikely to have contributed to Mrs Beale's outcome.

122. It is hoped however, that this tragic case causes EEN Beukes, and indeed all nursing staff involved in Mrs Beale's care that night, to reflect on their professional practice in this respect.

Issue 3(c)

Whether the nursing staff and the model of after-hours nursing care at MPHM otherwise provided the necessary skill-set and coverage to detect and manage the bleeding complication (or other emergent and serious post-operative complications in a patient)?

123. Given the approach taken to the evidence at Inquest, this Issue can only be considered in the context of the bleeding complication.

124. In this regard, despite the training that some of attending RN's had received (by attending or watching the video of Dr Westcott's tutorial), for reasons canvassed in consideration of Issue 2 above, I find that the nursing staff and the model of after-hours nursing care at MPHM did not otherwise provide the necessary skill-set and coverage to detect and

manage the bleeding complication because those nursing staff who had attended Dr Westcott's tutorial were not capable of doing what was necessary to manage the bleeding complication and/or were not confident to do what was necessary to manage the bleeding complication.

125. Moreover, regardless of the rarity of the incidence of the bleeding complication (less than 1%, according to Dr Westcott), it was neither adequate nor appropriate for Mrs Beale to be cared for post-operatively by an EEN, particularly one who had not attended or watched the video of Dr Westcott's tutorial, and who otherwise lacked the necessary skill-set to detect and manage the bleeding complication should it arise.

Issue 3(d)

Whether Dr Hatherly's management and treatment of the bleeding complication was adequate and appropriate having regard to his skill-set, training, qualifications and experience?

126. Counsel for Dr Hatherly has provided detailed written submissions, which I have considered carefully.

127. In brief, Counsel for Dr Hatherly submits that Counsel Assisting has considered Issue 3(b) out of context and that consequently the findings urged by Counsel Assisting about Dr Hatherly's management and treatment of the bleeding complication are not open on the evidence.

128. I respectfully disagree.

129. Having regard to his skill-set, training, qualifications and experience, it is patently clear that Dr Hatherly was not equipped and not capable of doing what was required to manage and treat the bleeding complication in that,[67] whereas the treatment Mrs Beale required was (a) the removal of the obstruction to her airway and/or (b) the insertion of an endotracheal tube, it is clear from his own evidence that Dr Hatherly did not possess the necessary skills to perform either procedure.

[67] As is also submitted by King's Counsel for MPHM in addition to Counsel Assisting.

130. It therefore follows that, having regard to his skill-set, training, qualifications and experience, Dr Hatherly's treatment and management of the bleeding complication was neither adequate nor appropriate, and I find accordingly.

131. To find to the contrary in respect of Dr Hatherly's treatment and management of the bleeding complication, as pressed by his Counsel, would be inconsistent with the only finding I consider is open on the evidence (and which is supported by the expert opinion of Professor Perry), that finding being that the treatment and management of the bleeding complication in the early stages of the resuscitation efforts was not adequate and appropriate because, quite simply, what was required to be done was not done.

132. Having made this finding, I otherwise have no hesitation in making the following findings:

    a. Dr Hatherly responded to the Code Blue promptly;
    b. Mrs Beale's arrest involved a very rare post-operative complication in a field outside Dr Hatherly's training and experience;
    c. Upon his arrival to Mrs Beales' room, Dr Hatherly undertook an immediate assessment of the situation and called for assistance from QAS, the treating surgeon and the on-call anaesthetist, which was appropriate;
    d. Dr Hatherly took on the leadership role in the early resuscitation efforts, which was appropriate;
    e. Dr Hatherly did not act or fail to act in way that was contrary to the express requirements of the OMO role;
    f. Regardless of the rarity of the incidence of the bleeding complication, Dr Hatherly should have, in my view, been provided with the training referred to in paragraph 101(a) of these findings;
    g. Dr Hatherly employed maximal effort during the early resuscitation efforts to treat and manage the bleeding

complication to the limits of what his then skill-set, training, qualifications and experience allowed;

h. Due to systemic shortcomings in respect of the after-hours medical cover at the MPHM, Dr Hatherly was placed in a position that required him to do something which he was not equipped or capable of doing. That said, regardless of the express requirements of the OMO role, Dr Hatherley is a medical practitioner sufficiently qualified to understand the level of service capability of the MPHM and that post-surgery complications could potentially arise in the after-hour period requiring a level of intervention on his part that exceeded the limits of his own capabilities; and

i. For the reasons discussed in response to Issue 4 and 5 below, even if Dr Hatherly had been capable and/or confident of doing what was immediately necessary to treat and manage the bleeding complication, given the rapidity of the onset of the complication and the fact that her pupils were fixed and dilated very shortly after she arrested, it is not likely Mrs Beale could have been saved.

133. Leaving aside the systemic shortcomings identified above, it is unexplained on the evidence why Dr Hatherly elected to put himself in the position of working at MPHM with its level of service capability, knowing the limits of his own capabilities. It is hoped that this tragic case causes him to reflect on his professional practice in this respect.

Issue 3(e)

Whether the medical staff and the model of after-hours medical coverage at MPHM otherwise provided the necessary skill-set and experience to assess and manage the bleeding complication (or other emergent and serious post-operative complications in a patient)?

134. Given the approach taken to the evidence at Inquest, this Issue can only be considered in the context of the bleeding complication.

135. In that regard, I find that the medical staff and the model of after-hours medical coverage at MPHM did not otherwise provide the necessary skill-set and experience to assess and manage the bleeding complication because after-hours there were no on-site medical practitioners capable of doing what was required to assess and manage the bleeding complication within the very short period of time that was necessary to salvage Mrs Beale.

Issue 3(f)

Whether the treatment and management of the bleeding complication by the attending medical staff, including Dr Fitzgerald and Dr Cooper, was otherwise adequate and appropriate?

136. I acknowledge the detailed submissions of Counsel for each of Dr Fitzgerald and Dr Cooper and appreciate the assistance they each provided.

137. However, it is not necessary for me to summarise those submissions here because there is no evidence before me that is critical of the treatment and management of the bleeding complication by either of Dr Fitzgerald or Dr Cooper.

138. On the contrary, it is clear on the evidence that each managed the bleeding complication in the way that was required and consistent with their respective disciplines:

    a. In the case of Dr Fitzgerald, by immediately evacuating the haematoma upon his arrival, amongst other things, and by taking Mrs Beale back to theatre to achieve surgical haemostasis; and

    b. In the case of Dr Cooper, by persisting with ventilation efforts until he successfully restored Mrs Beale's circulation after intubating her, amongst other things.

139. I find that the treatment and management of the bleeding complication by each of Dr Fitzgerald and Dr Cooper was adequate and appropriate in all respects.

Issues 4

Whether any aspect of the treatment and management provided to Mrs Beale at MPHM caused or hastened her death?

Issue 5

Whether any failure to provide treatment and management to Mrs Beale at MPHM caused or hastened her death?

140. It is convenient to deal with these Issues together.

Fixed and dilated pupils

141. The evidence of Dr Hatherly and others was that the finding of fixed and dilated pupils in Mrs Beale was indicative of brain death.

142. As to when that might occur following cardiac arrest without adequate ventilation, Professor Perry opined to the following effect:[68]

    a. If an adult is held under water for 5 minutes (i.e. such that their brain is deprived of oxygen), they will normally suffer brain death;

    b. Brain injury could be suffered within two to three minutes of cardiac arrest;

    c. Following cardiac arrest, although it depends on the individual, it will take five minutes, possibly up to 8 minutes before they suffer brain death without adequate ventilation; and

    d. Once the individual has fixed and dilated pupils, although some survive the cardiac event, that is very uncommon; the chance of survival is very low.

[68] T4-12, L30 – T4-13, L16.

143. In the event of Mrs Beale arresting at or around 02.28 hours (or shortly before) when the Code Blue call was made, taking into account a reasonable period of time for Dr Hatherly to respond and reach Mrs Beale's room, it is conceivable that she had already suffered brain death (or, at least, severe hypoxic brain injury) when he observed that she was unresponsive with fixed and dilated pupils at some point in the first minute or so after he arrived.

Critical findings of fact

144. Having regard to all of the evidence, I make the following critical findings of fact:

a. At or about 02:25 hours to 02:27 hours on 3 August 2021, Mrs Beale was administered an oral tablet of Endone;[69]

b. Mrs Beale likely suffered an acute arterial bleed on the ward when she coughed after taking the Endone tablet and this resulted in the rapid formation of a haematoma and swelling in her neck, with the consequence of airway compromise. This likely occurred in the period 02:25 hours to 02:27 hours on 3 August 2021;

c. There is no evidence of Mrs Beale having any observable swelling in her neck prior to this time;

d. It is likely Mrs Beale arrested in the period 02:27 hours to 02:28 hours on 3 August 2021;

e. EEN Beukes and RN Connell responded appropriately by calling the Code Blue at or about 02:28 hours;

f. Dr Hatherly and the other RN's responded swiftly to the Code Blue and attended Mrs Beale's room as soon as possible. I estimate that Dr Hatherly arrived at Mrs Beale's room at or about 02:30 hours to 02:31 hours;

[69] Counsel Assisting's Submissions at [108].

g. Mrs Beale's pupils were observed to be fixed and dilated within (1) minute of Dr Hatherly's arrival at the room, with a poor prognosis for survival from very early in the resuscitation efforts.

Prognosis for survival following arrest

145. At Inquest, Professor Perry gave the following opinion evidence:

> "*Okay. Can I then just recap so that we know where we're at. We've got between – perhaps, between five and eight minutes before we – Mrs Beale would have suffered brain death from the time that the cardiac arrest commenced?---Yep.*
>
> *We – the person who was attending to deal with this particular arrest with this particular complication – that is the swelling of the neck causing a compressive obstruction of the windpipe – would need to understand that that was what was unfolding in front of them. They would then need to deduce that they needed to get past that obstruction to provide effective ventilation. And they would need to deduce that that would require rapid invasive management of the airway even if we are following the ALS algorithm, rapid movement through the algorithm to get to that point. And this person would need this skill to training to be able to intubate the patient?---Exactly right. Yes. And – and that is – you know, pretty available in a public hospital intensive care unit and good private hospital int – inte – intensive care units. You're not going to have all that available at fingertips in a regular post-surgery ward*."[70]
>
> ….
>
> "*Okay. Now, one further question in relation to that. If we assume that the arrest occurred at 2.28 am or thereabouts - - -?---Mmm-hmm.*
>
> *- - - and let's say I – the evidence seems to be that Dr Hatherly was there within a couple of minutes of responding to the emergency call - - -?---Mmm-hmm*
>
> *- - - and let's proceed on the basis that there would've been some passage of time, perhaps, minutes before his made those observations of Mrs Beale - - -?---Mmm-hmm.*
>
> *- - - having - - -?---Mmm-hmm.*
>
> *- - - fixed and dilated pupils - - -?---Mmm-hmm. Mmm-hmm.*

[70] T4-17, LL 26 – 41.

- - - does that fit with your timeframes in terms of hypoxic brain death, that is, she - - -?---Yeah, it does.

- - - could have presented in that way within about five minutes?---Yeah, it – it – it – it's true. We're looking at two minutes before the doctor gets there, which is pretty quick. You know, he wasn't down the road. Uh – an assessment does take time. It's not, you know, instantaneous. Uh – so, you know, a five-minute time, fixed dilated pupils, trying to get tubes, trying to call people to bring equipment over – uh – a – assessing the patient, looking at their obs, and a patient you haven't seen before – uh – yeah, it's – 300 mils of blood obstructing the airway in a very quick period of time – by the sounds of it, it was 10, 20, 30 seconds – it's all very consistent that she was probably not salvageable by the time he was able to think about letting the blood out of the neck."[71]

146. Professor Perry's evidence, which I accept, can otherwise be summarised as follows:

a. Where a person suffers a post operative arterial bleed after thyroid surgery there will be a buildup of retrosternal blood that, if unrelieved, causes airway obstruction leading to hypoxia and irreversible brain damage, which can be sustained after only 5 minutes;[72]

b. Professor Perry agreed that the period of five minutes that can lead to irreversible brain damage might be even shorter for an elderly person like Mrs Beale "*with known coronary artery disease and that disease can also be going up into the brain*";[73]

c. If – as appears to be the case – Dr Hatherly arrived at the room at 02.31 hours, Mrs Beale may have already suffered irreversible brain damage;[74]

147. Professor Perry also said:[75]

Q. "Can you first of all indicate how long might the patient have before they would suffer irreversible hypoxic injury?

[71] T4-19, L 45 – T4-20, L 23.
[72] T4-27, L22 T4-12, L30.
[73] T4-27, L5.
[74] T4-27 – T4-28.
[75] T4-12 at 35.

A. Uh – it doesn't take long. Um – if – if an adult is held under water for five minutes, they're normally brain dead. Um – there is normally a little bit of – an output despite, you know, not – so it's not normally – they're not – is a bit of oxygen getting in. Uh– talking to intensive care physicians they – on – on – in the medical notes, it says that somebody saw that by that stage Mrs Beale had fixed dilated pupils which normally means there's very, very serious brain injury."

148. He also said:[76]

> *"About 20 to 25 per cent of people survive that if they've got an intensive care physician and anaesthetists around, they got lines in place, got a laryngoscope next to the bed, they got three or four intensive care trained registered nurses. Um – so this lady, you know, three, four, five minutes in a ha – with a ward, fixed dilated pupils, her chances of surviving was way less than 20 per cent and probably down towards 10 per cent… or less with the fixed dilated pupils."*;

149. Mr Atkinson KC submits that this presents a "huge problem" in terms of survival for a patient in the position of Mrs Beale in that:

a. Five minutes may already have passed since Mrs Beale stopped breathing (02:25 to 02:31 hours);
b. Two minutes might well be spent by the doctor in assessing the situation, and reaching a diagnosis;
c. Two more minutes might be spent in placing the endotracheal tube; and
d. Up to 9 minutes might have elapsed since a patient in the position of Mrs Beale stopped breathing.

150. When Mr Atkinson KC put this hypothetical timing scenario to Professor Perry, the following exchange occurred:[77]

Q. "And now you might ?---But that might be up to nine minutes?

A. That – that – that's why – that's why the – yep. That's the explanation of why it would [indistinct] normal ward and normal public hospital – uh – the – the survival rate's about 14 per cent with everything there, not in the early

[76] T4-28, L18.
[77] T4-29.

hours of the morning, lots of doctors around, an – anaesthetic registrars, consultants two minutes away in the operating theatre."

151. That is, it is very likely Mrs Beale would have passed away regardless of the hospital in which the bleeding complication occurred.

152. Consequently, despite the inadequate and inappropriate treatment and management of the bleeding complication early in the resuscitation efforts, on account of the critical findings of fact, I find that it is unlikely Mrs Beale would have survived in any event. That is, even if Dr Hatherly and the attending nursing staff had been capable and/or confident of doing what was immediately necessary to treat and manage the bleeding complication, given the rapidity of the onset of the complication and the fact that her pupils were fixed and dilated very shortly after she arrested, I find that it is not likely Mrs Beale could have been saved.

153. Tragically, as detailed above, the timeframe for intervention of the bleeding complication was further compromised by Mrs Beale's pre-existing ischaemic heart disease; the nature and extent of which was identified at autopsy[78].

154. The finding in respect of Issues 4 and 5 is therefore in the negative.

Issue 6

Whether the response to Mrs Beale's death on the part of MPHM has been adequate and appropriate?

155. The MPHM acknowledges that Mrs Beale's death has brought to light certain systemic issues and it has worked subsequently to address them. It is noted that the Executive Director of Mater Hospitals, Chris Went, gave evidence in person in Mackay, and that, by paragraph 6 of her statement to the Inquest, [79] she was transparent and made very specific admissions as to the quality of care. She also noted (as was the case) that, very soon after the death, the Mater undertook a

[78] Ex A6.
[79] Ex C16 BOE.

comprehensive review of Mrs Beale's clinical management after the death and the review made 12 recommendations, which have subsequently been addressed.

156. Professor Perry noted that he considered "*the Mater's … been quite frank and open and transparent with this*".[80]

157. The improvements which have been made are set out in detail in Ms Went's statement and include the following:
    a. All hemithyroidectomy cases are now scheduled on morning operation lists, the intention being that any complications are more likely to arise in the afternoon, when the MPHM will be fully staffed;
    b. Because the Emergency Department is open until 22:00 hours, this should ensure that, at least until that time, there are physicians close by with experience in emergency airway management;[81]
    c. There remain anaesthetists on call for 24 hours a day 7 days per week;[82]
    d. Where a thyroidectomy is performed, the patients are always taken directly to the Close Care Observation Unit where there are only 5 patients and there are 2 RN's monitoring those patients. The Unit is designed so that the nurses at all times have clear visibility over the patients, the intention being that in the event of patient deterioration post-operatively, it is very likely that any symptoms will be detected at an early stage and appropriate action taken;
    e. Whereas Mrs Beale was cared for in the early morning by an EEN, RN's are now the primary caregivers for thyroidectomy patients;
    f. The scope of practice as between EEN's and RN's is now the subject of a clear policy which has been reduced to a booklet;
    g. This role delineation has been reinforced with uniform changes;

[80] T4-30.
[81] T4-40, L7.
[82] T4-40, L8.

h. There has been ongoing training in relation to post-thyroidectomy care;

i. The Mater is considering the feasibility of an ICU at MPHM;

j. ALS training is provided to doctors and clinical nurses every 2 years; and

k. The Mater is consulting with anaesthetists to provide more frequent follow-up training for after-hours doctors to maintain endotracheal intubation competence.

158. Having regard to these changes and improvements implemented at MPHM, I am satisfied that MPHM's response to Mrs Beale's death to minimise the risk of similar events occurring in the future has been adequate and appropriate.

159. The only point of concern that was raised with Ms Went at Inquest was that the ALS training that had been reviewed and implemented did not include training of medical officers in endotracheal intubation (including Dr Hatherly and others holding similar positions).

160. The examination of Ms Went in this regard was as follows:[83]

> *"And we've heard a lot about the stepwise process that one goes through when undertaking advanced lifesaving procedures, starting with the least invasive, airway management, and moving through each of the steps as it becomes apparent – I'm using very layman terms – as it becomes apparent that the approach that might be being adopted isn't achieving adequate ventilation. And as I understand it, those steps could lead to, ultimately, the need to intubate a patient.*
>
> *Now, I don't – I can't point to any particular examples, but it seems to me that if a patient arrests and if ALS is required in order to manage that patient, that there may be a scenario where the patient ultimately requires intubation and may do so in a relatively short period of time. How is that being managed, if at all, at the Mater Private Hospital in the absence of an ICU or an HDU?---So we have anaesthetists that are on call 24/7 to come in, and they come quite quickly. Uh – we also have general physicians on call – um – 24/7. Um – during the hours of 8 'til 10 pm, we have an emergency department opened as well with [indistinct] um – so you know, we do have coverage for that type of event. Um – I*

[83] T4-39, L 44 – T4-41, L 43.

guess the training and good bal – bag valve masking is – until they get there – is really important - - -

Yep?--- - - - um – and being able to, you know, insert a [indistinct] airway to be able to do that. Uh – we train our nurses really well on how to do that and how to maintain the seal until that – um – anaesthetist can come. Mmm.

And in the case of Ms Beale, I think the anaesthetist was called not a long time after the CPR commenced but sometime after CPR commenced, and then took some time to arrive. And in the case of Ms Beale, quite obviously, it was too late by the time he arrived. That's no criticism of anybody necessarily except that, on that particular occasion, the on-call anaesthetist that was relied upon couldn't get there - - -?---Mmm.

- - - in the time that was required. Would it not be better to have a doctor in the hospital 24/7 who could intubate a patient to avoid those circumstances?---It would be granted; however, it's really hard to maintain competence in that if you're not doing it all the time. So we are thinking more around the competence of doing it and the frequency of doing that. So we are going to be talking to our anaesthetists around doing some follow-up training more frequently with our after-hours doctors to try and help them and support them to maintain a competence in it.

And it's not that it's – there are two things – two general things about it, if I could put it that way. First of all, there's the ability to achieve intubation?---Mmm.

And secondly, there's risks associated with attempting intubation if you're not confident, and the greatest risk being that you intubate the oesophagus rather than the trachea; is that correct?---Yes.

All right. So moving forward, you're still considering or looking at the prospect of improving competency for after-hours doctors to perform intubation at site?---Oh – look, I think it's – it's – should be in their toolbox - - -

Yep?--- - - - um – it's just the maintenance of that is really important.

think that's the point I'm making. It should be in the toolbox because it may be necessary - - -?---Yes.

- - - in a particular emergency situation. You would agree with that?---Yes

Okay. All right. I was going to take you to the ALS material, but I don't think I need to have any regard to that. Just bear with me for a moment. You mentioned earlier in your evidence about rescheduling times for thyroidectomies and other thyroid procedures so that they don't occur in the afternoon – that they are undertaken in the morning, and you have addressed this to some extent in your statement. The idea of doing so, I take it, is to have more people on the ground in the event that such a complication arises as occurred in the case of Ms Beale. Is that correct?---That's correct.

Including those who may be able to intubate in a rapid way that didn't occur on this particular occasion; is that correct?---Correct.

But you would accept that it's still possible that a complication might arise in the after-hours period even if the surgery is performed in the morning?---It's still possible, yes.

Yep. And for that – and that is also a reason why after-hours cover should have it within their toolbox. The ability to intubate in their toolbox?---Mmm

….

Yes?---Yes. Sorry. We have – um – emergency physicians that run our emergency department that's open between 8 and 10 pm every day.

And those emergency physicians have the capability to intubate?---Yes."

161. As at the date of the Inquest, MPHM could not be assured that it had on-site medical practitioners competent in performing endotracheal intubation between the hours of 22:00 hours and 08:00 hours and continued to rely on the on-call Anaesthetist to attend if required during those hours. As demonstrated to Ms Went by Counsel Assisting, that arrangement was not of assistance in the case of Ms Beale (although, I accept that endotracheal intubation very early in the resuscitation efforts probably would have been difficult and may not have been immediately successful in any event). Consequently, if confronted with a similar emergency between the hours of 22:00 hours and 08:00 hours, as matters stood at the Inquest, MPHM could be at risk of having another adverse outcome.

162. Ensuring continued competency in performing endotracheal intubation in medical practitioners who do not do so regularly is no doubt challenging, however, in my view, efforts should be directed to achieving that in light of the service capability of MPHM, as Ms Went indicated was proposed. In this regard, I consider it appropriate that I make the recommendation below.

Recommendations

163. I recommend that MPHM take steps to ensure ongoing competency (and confidence) in performing a level of advanced airway management consistent with its Clinical Services Capability and in particular, endotracheal intubation in those medical practitioners who are employed and/or contracted to provide on-site after-hours medical cover, in particular between the hours of 22:00 hours and 08:00 hours, if such measures to achieve that have not already been initiated and undertaken.

Findings required by s. 45

Identity of the deceased – Robyn Ann Beale

How she died – Following a right hemithyroidectomy performed at Mater Private Hospital Mackay, Mrs Beale suffered an acute post-surgical arterial bleed in her neck when she coughed after swallowing an Endone tablet administered for pain relief, which resulted in rapid obstruction of her airway.

Place of death – Mackay Base Hospital MACKAY QLD 4740 AUSTRALIA

Date of death– 3 August 2021

Cause of death – Hypoxic ischaemic encephalopathy as a result of the obstruction of her airway caused by a post-surgical arterial bleed in her neck following right hemithyroidectomy.

Concluding comments

Mrs Beale suffered from a rare but recognised complication of surgery she electively underwent in a regional private facility to treat a potentially serious pre-existing condition. Tragically, as the evidence has borne out, she would have likely passed away from the complication regardless of the facility in which it occurred. Nevertheless, MPHM has been transparent about its shortcomings and has implemented substantial changes since Mrs Beale's death, to prevent a similar incident from occurring again in the future.

In Mrs Beale's memory, a family statement was read out at the conclusion of the evidence. Suffice to say the sentiments expressed were heartfelt and sincere, and it is quite clear that the loss of Mrs Beale has had a profound impact on those that loved and cherished her.

I offer my sincere condolences to Mrs Beale's loved ones. To the extent that it is able, it is hoped that these proceedings have addressed any questions or concerns and assists in bringing a measure of healing.

I close the inquest.

Carol Lee
Coroner
SOUTH EAST QUEENSLAND