Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No:36/16

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Anna Maria WINTER****, with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 10 & 12 October 2016 find the identity of the deceased was* ***Anna Maria WINTER*** *and that death occurred on 20 May 2014 at St John of God Hospital, Subiaco, as the result of Sepsis Complicating Management of Vulval Carcinoma in an elderly woman with severe Coronary Artery Atherosclerosis in the following circumstances:-*

Counsel Appearing:

Mr T Bishop assisted the Deputy State Coroner

Mr G Bourhill (instructed by DLA Piper) appeared on behalf of Waikiki Private Hospital
Mr T Palmer (and with him Ms M Smith instructed by Avant Law) appeared on behalf of Dr Daryl Stephens

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INTRODUCTION

On 15 May 2014 Anna Maria Winter (the deceased) was transferred from Waikiki Private Hospital (WPH), where she had a suprapubic catheter inserted, to St John of God Hospital Subiaco (SJOGHS) for review of a squamous cell carcinoma of the vulva. Due to a mistake the transfer occurred by taxi instead of by ambulance, but the deceased appeared comparatively functional when leaving WPH and during the taxi journey.

On arrival at SJOGHS the deceased suddenly collapsed and arrested in the admissions department. A medical emergency team (MET) call occurred and she was resuscitated. The deceased was transferred to the intensive care unit (ICU) for management.

Initially the deceased seemed to improve but she did not recover and a decision was made with family to treat the deceased palliatively.

The deceased died on 20 May 2014. She was 94 years of age.

This is a discretionary inquest pursuant to section 22 (2) of the *Coroners Act 1996* (WA) and the evidence was heard at the same time as that of another deceased who was also treated by Dr Stephens in 2014. The inquests were heard

together to streamline the calling of the evidence for the purposes of examining the quality of the medical management and treatment provided to both deceased.

Dr Daryl Stephens is a consultant urologist who became a Fellow of the Royal Australian College of Surgeons Urology in 1981 and has worked as a proceduralist since then, both in Australia and overseas.[1] He is currently practicing in Mackay, Queensland, and is an adjunct professor at James Cook University. His career has been that of a generalist, of both primary and secondary referrals, in emergency urology and prostate cancer. The majority of his work has been clinical with only more recently an academic role.

Dr Stephens has worked in both the public and private systems, both in Australia and the UK. He practiced in Perth for 16 years increasingly in the private sector, prior to moving to Queensland where he consults, increasingly in the public sector.[2]

BACKGROUND

The Deceased

The deceased was born in Austria on 18 July 1919. She worked as a high school teacher in a small town until she retired. The deceased married and had two children, both

[1] t 12.10.16, p39
[2] t 12.10.16, p140

daughters, Anna and Stefanie, who were also born in Austria.

One of the deceased's daughters, Stefanie, moved to Australia in 1974 and had her children in Australia. Her sister, Anna, also moved to Australia, and in 1977 the deceased decided to move to Australia to be with her daughters and grandchildren.

The deceased originally lived with her daughter, Stefanie, and assisted in bringing up her children but eventually moved and lived independently with support from her family and Silver Chain.

The deceased was a very independent person and kept herself active and in touch with her community, both in Australia and overseas. It is clear that, despite living separately in Mandurah, the deceased was very well loved by her family and at the time of her death was still very mentally alert and engaged with her community.[3]

The deceased's medical general practitioner (GP) was Dr Vivien Dempsey of Mandurah Medical Centre. She reported the deceased as being in fairly good health, other than severe osteoarthritis in her hips and lower back, hypertension and deafness. The deceased was prescribed

[3] Personal communication, deceased's family to Mr Bishop

medications for her blood pressure and to control her pain and assist her with sleep.[4]

Dr Dempsey referred the deceased to Dr Stephens in March 2014 due to her concerns the deceased was complaining of severe pain on urination and on examination had a vulval carcinoma.[5] The deceased's GP considered that as a result of the vulval carcinoma it was necessary the deceased be provided with a catheter.

Dr Stephens reviewed the deceased and arranged for her to have a biopsy of the carcinoma. This was done at Peel Health Campus (PHC) on 11 April 2014 and diagnosed as a carcinoma in situ. Due to the deceased's pain on urination an indwelling catheter was also placed to assist her. The deceased found the indwelling catheter to be uncomfortable and Dr Stephens reviewed her on 24 April 2014 and arranged for the insertion of a suprapubic catheter. This was to be performed on 14 May 2014 at Waikiki Private Hospital under local anaesthetic with mild sedation.

Waikiki Private Hospital (WPH)

WPH is a small hospital situated in Willmott Drive, Waikiki. Dr Stephens had visiting rights at WPH where he conducted some of the procedures for the purposes of his consultancy. The deceased was recorded as arriving at WPH just before 1

[4] Ex 1, tab 14/19
[5] Ex 1, tab 14

pm on 14 May 2014 ready for the insertion of her suprapubic catheter later that afternoon.

The procedure was booked to be under local anaesthetic with intravenous sedation. Her preoperative observations at 1.10 pm were temperature 36.4°C, pulse 55 bpm, blood pressure 181/81mmHg and oxygen saturation of 98%.[6] Her current medications were noted, and that the deceased had brought some Panadol Osteo and aspirin with her. The deceased was then transferred to the operating theatre for the procedure with Dr Stephens and an anaesthetist.

The procedure from the hospital's perspective was short, taking ten minutes of theatre time. There is no operative record in the hospital notes, however, Dr Stephens pointed out there must have been one because it was necessary it be filled out for the purposes of recovery and later ward treatment.[7] It was his practice to complete operative records and a requirement for post procedure care at any hospital. Ms Mincherton, Nursing Director of WPH, confirmed in evidence, there was no post-operative record in the deceased's notes.[8] Both the operating schedule and the post-operative record are the responsibility of the doctor.[9]

[6] Ex 1, tab 19
[7] t 12.10.16, p143, 165
[8] t 10.10.16, p58
[9] t 10.10.16, p60

INSERTION OF THE SUPRAPUBIC CATHETER

Dr Stephens provided a report to the inquest in which he recalled the deceased as being very thin, but in his view the insertion of the suprapubic catheter was straight forward and without any complications. Dr Stephens provided a supplementary report to the court prior to the inquest outlining his normal practice when inserting a suprapubic catheter, and that used for the deceased.[10]

Dr Stephens outlined the position of the patient (deceased) was to be tilted, head down, to ensure the sigmoid colon loops fall back and away from the bladder. The sigmoid colon is within the peritoneum, while the bladder is completely outside the peritoneum, which folds over the front of the bladder wall. In the head down position that falls away from the distal two thirds of the bladder wall and allows the insertion of the suprapubic catheter directly into the bladder without coming into contact with the peritoneum or organs inside it. In addition it is necessary the bladder be full to allow clear, safe access to the bladder without complication from the peritoneum or bowel.[11] This is done under appropriate sedation to prevent discomfort to the patient but leaves them comfortable and conscious but sedated.

[10] Ex 1, tab 20
[11] t 12.10.16, p147

The bladder is inflated to ensure part of it is clear of the peritoneal folds and a flexible cystoscope is passed in, through the abdominal wall to allow a direct view of the dome of the inflated bladder ready for the insertion of the suprapubic cannula under vision. This was done with one pass directly into the bladder which was free of the sigmoid colon and other organs within the peritoneal cavity. Once passed, the suprapubic catheter was secured with dressings and held in place, with the knowledge of the patient.

During the procedure Dr Stephens noted the lesion on the deceased's vulva was totally obstructing her urethra. He was very concerned that, despite the biopsy, the lesion was a squamous cell carcinoma which needed specialist surgical management, under both a plastic surgeon and gynaecological oncologist.

Dr Stephens was concerned enough that he asked a plastic surgeon in the adjacent theatre to observe the lesion for his opinion. That plastic surgeon agreed with Dr Stephens assessment of the deceased's lesion and suggested a gynaecological oncologist be asked to review the deceased urgently.[12]

Post operation the deceased observations were taken in the recovery bay at 1.55 pm and recorded as a pulse of 80bpm, blood pressure 159/76mmHg, respiration rate of 12 and

[12] t 12.10.16, p146

oxygen saturation of 99% on 6L oxygen via Hudson mask. These observations were within acceptable limits and the deceased's observations remained within acceptable limits for the remainder of that afternoon. The deceased was transferred to the Peninsular ward at 2.10 pm and continued to be monitored to ensure her observations were within acceptable limits.

The deceased was given temazepam at 7 pm, and at 9 pm she was resting in bed with her suprapubic catheter draining well.[13]

Observations later that night reflected a normal temperature, pulse rate, respiration rate and oxygen saturation with normal blood pressure. Her pain score was recorded as 0/10 and her wound dressing noticeably dry and intact.

The intention for the admission had been the deceased would have the suprapubic catheter inserted and then be discharged home with her family. This plan was altered by Dr Stephens' concern the deceased be reviewed by a gynaecological oncologist for the management of her lesion.

Unfortunately the notes for WPH, Dr Stephens' recall and that of the deceased's family do not correspond in chronology, although the intent the deceased be reviewed by

[13] Ex 1, tab 19

a specialist gynaecological oncologist remained the consistent thread of expectations. The WPH notes are scant and, I have to assume, incomplete but there is no issue with the nursing itself.[14]

Dr Stephens' evidence was he had contacted Dr Stuart Salfinger at SJOGHS on the afternoon of 14 May 2014 and expected the deceased to be transferred directly from WPH to SJOGHS that afternoon because Dr Salfinger had advised him there was a bed available for the deceased.[15] Dr Salfinger's report indicated the deceased was referred to him on 15 May 2014, but I have no issue with the fact that is what SJOGHS's notes would reflect.[16]

The outcome was the deceased remained in WPH overnight and was transferred to SJOGHS the following day.

The WPH notes indicate very little about what the intention was, other than the fact the deceased remained in WPH overnight with normal observations, but some complaint of pain.

The hospital progress notes show entries by the nursing staff at 9 pm on 14 May 2014, 5.30 am and 11.45 am on 15 May 2014, aside from the post-operative and medication charts.

[14] t 10.10.16, p13
[15] t 12.10.16, p155
[16] Ex 1, tab 13

The notes reflect the deceased as experiencing left sided lower abdominal pain overnight which was treated with Panadol Osteo and her own aspirin.

There was concern expressed about a low urine output overnight although the deceased appeared to be tolerating water well, and blood staining about which Dr Stephens was unconcerned when it was communicated to him. His main concern was the deceased be transferred to SJOGHS as he had arranged.[17]

Following handover from the night staff, at 7:30am registered nurse Mark Crook (RN Crook) observed the deceased's catheter bag as containing approximately 100-150mls of concentrated urine with, what he believed was, dark, old, blood staining.[18] The deceased appeared alert and well and was not complaining of pain or discomfort, but due to his unease about the low urine output and blood stained urine he contacted Dr Stephens.

Dr Stephens stated in evidence he was very surprised when he understood the deceased was still at WPH on the morning of 15 May 2014 because his understanding was that she had been transferred the previous afternoon. He believed his secretary had arranged a bed under the care of Dr Salfinger at SJOGHS.

[17] t 12.10.16, p149
[18] t 10.10.16, p12

In any event, Dr Stephens was unconcerned as to RN Crook's description of the deceased, he considered RN Crook to be a very competent nurse and the deceased's other observations indicated she was clinically well. They agreed the deceased was to be reviewed by a specialist later that day and neither were concerned about the low urine output or the blood staining in the urine in the short term.[19]

The deceased's family, with whom Dr Stephens believed he had discussed his plan for the deceased, believed it was due to their instigation the deceased remained in hospital overnight. There is no record in the notes that this was the case, and does not fit with the note RN Crook was asked to find a bed for the deceased on the ward, following recovery, prior to transfer. The only conclusive outcome was the deceased was to be reviewed by a specialist gynaecological oncologist at SJOGHS as soon as it could be arranged pending which she remained at WPH.

RN Crook said in evidence he was not experienced with the after care of the insertion of a suprapubic catheter which was why he had rung Dr Stephens with his concerns on 15 May 2014. It was RN Crook's understanding the deceased was for discharge, and review later that day by Dr Salfinger at SJOGHS. Due to his belief is was a discharge, rather than a transfer, he did not arrange an ambulance for the

[19] t 10.10.16, p15

transfer, nor had an ambulance been arranged by anyone else.

Dr Stephens said in evidence that if he had known earlier the deceased was still at WPH on 15 May 2014, he considered her his patient and would have reviewed her.[20]

RN Crook liaised with SJOGHS bed manager and was advised there would be a bed ready for the deceased at 2 pm for her review. The deceased's family were present and indicated it was not possible to transfer the deceased in either of their vehicles in her current condition. RN Crook considered the deceased to be well at the point of discharge and took observations which he did not record, over and above the earlier observations, which were all within a normal range. The deceased had eaten her breakfast and was not reported as being unwell although, obviously at 94, she was experiencing some discomfort with the whole process.[21]

It is common ground the deceased should have been transferred by ambulance and that RN Crook was mistaken the deceased was being discharged for review, rather than being transferred from hospital to hospital.[22]

[20] t 12.10.16, p148, 169
[21] t 10.10.16, p16
[22] t 10.10.16, p59

Nevertheless, the evidence is the deceased was placed in a taxi, and the taxi driver, when interviewed by police with respect to that journey, indicated he took the deceased from WPH to SJOGHS on 15 May 2014. The booking was for 12 pm. The deceased was assisted into the taxi by her son-in-law just after noon. She travelled in the front passenger seat, and according to the taxi driver, Navdeep Singh, appeared to be a normal passenger about whom he had no concerns.

The deceased did not speak directly to Mr Singh, but did respond by smiling when he spoke, she was not unwell in his taxi and had something to eat while travelling.[23]

On arrival at SJOGHS the deceased's son-in-law and a member of staff helped the deceased out of the taxi and placed her in a wheel chair. That was the last time Mr Singh saw the deceased and he did not report any concerns over her journey in his taxi.

ADMISSION TO SJOGHS

A report from Dr Stuart Salfinger indicated he had received a telephone call from Dr Stephens expressing concern over the deceased who had what was *"clinically a squamous cell carcinoma of the vulva"*. Dr Salfinger understood the deceased initially had a normal indwelling catheter and that

[23] Ex 1, tab 10

the lesion had been biopsied, but was recorded as a carcinoma in situ. Dr Stephens was concerned when he later placed a suprapubic catheter that the lesion was a squamous cell carcinoma and he wished Dr Salfinger to review her.[24]

Dr Salfinger, in his report, understood the deceased had been at Peel Health Campus, not WPH, but agreed the deceased should be transferred to his care at SJOGHS, when a bed was available. It was up to Dr Stephens and the referring hospital to organise the transfer.

He understood that when the deceased arrived at SJOGHS she was acutely unwell and vomited in the admissions department. She was immediately transferred to the ward where a MET call was made. The deceased had no recordable blood pressure and had to be resuscitated by the ICU team. There was no documentation with her transfer referring to any other problems. The deceased was aggressively resuscitated and transferred to ICU for ongoing management.

The working diagnosis was the possibility of damage to a viscus from the suprapubic catheter when placed, however, an abdominal CT showed no evidence of any bowel injury and therefore it was not considered there had been any surgical error. The deceased was treated with ionotropic

[24] Ex 1, tab 13

support and intravenous antibiotics and appeared to initially improve, clinically, but did not recover from her initial collapse at admission.

Dr Salfinger reported that urinary culture taken on her admission on the 15th confirmed a UTI with *Klebsiella pneumoniae* and the team at SJOGHS worked with the diagnosis the deceased had severe urosepsis, which had resulted in septic shock and collapse. It was decided, in consultation, with the family, there not be aggressive management of the deceased, but that she receive palliative care and support only. The deceased was transferred to palliative care unit and managed until she died on 20 May 2014.[25]

POST MORTEM EXAMINATION

The post mortem examination of the deceased was carried out by Dr Amy Spark, Forensic Pathologist, on 26 May 2014.

On examination Dr Spark found the deceased had a large lesion in keeping with cancer on her vulva and that there were outpouchings of the bowel wall (diverticular disease) with evidence of infection and pus within the surrounding fatty tissue and throughout the abdomen.

[25] Ex 1, tab 13

Dr Spark noted severe hardening and narrowing of the vessels of the heart, multi-cystic and scarred kidneys with heavy congested lungs with changes of possible pneumonia. Dr Spark said she initially believed the pus surrounding the bowel and within the abdomen represented a ruptured diverticular abscess, however, it was possible it was iatrogenic infection complicating the placement of the suprapubic catheter.

On further investigation via histology and microscopy Dr Spark indicated the deceased showed extensive scarring throughout the heart, acute pneumonia throughout the lungs, scarring of the kidneys, carcinoma of the vulva and abscess material within the suprapubic catheter site, with organising and acute pus on the surface of the small and large intestine. The out-pouching of the large bowel was, as far as she could see, intact.[26]

Toxicology indicated normal hospital care[27] and microbiology grew *Klebsiella pneumoniae* in the abdominal cavity, vagina and rectum, the suprapubic catheter site, the kidneys and spleen.[28]

Dr Spark gave her opinion death was caused by sepsis complicating management of vulval carcinoma in an elderly woman with severe coronary artery atherosclerosis.

[26] Ex 1, tab 4
[27] Ex 1, tab 5
[28] Ex 1, tab 6

Dr Spark could not find any evidence of rupture of the peritoneal cavity as a result of the insertion of the suprapubic catheter, nor could she find evidence of rupture of the sigmoid colon diverticulum.

The family of the deceased expressed concern, particularly over the deceased's transfer from WPH to SJOGHS by way of taxi, and were concerned the management of the deceased's transfer had caused her death. They believed that had she been monitored in an ambulance during transfer a deterioration in her condition would have been evident before her sudden collapse.

EVIDENCE OF DR RUTHVEN

Dr Stephen Ruthven was asked to independently review the deceased's management and her resulting death, both by Dr Stephens and SJOGHS. Dr Ruthven is an independent consultant urologist and he indicated that diverticular disease can spontaneously rupture and so introduce gas, caused by localised or generalised bacterial peritonitis, into the peritoneal cavity. He outlined that inadvertent perforation of the colon during the insertion of a suprapubic catheter could also cause this problem.

It was as a result of Dr Ruthven's query Dr Stephens was asked for an outline of how the suprapubic catheter had

been inserted. In evidence Dr Ruthven indicated the description of the method of insertion, with the patient's head down and a clear view of the bladder dome, free of the peritoneal folds, persuaded him the colon had not been perforated during the procedure for inserting the suprapubic catheter and it was for this reason there was no perforation of the colon observable at post mortem.[29]

It was the presence of gas under the deceased's diaphragm, indicated on the CT scans from SJOGHS, which persuaded Dr Ruthven the event which had caused the deceased's collapse on admission to SJOGHS was the rupture of the diverticular within the peritoneal cavity. He discounted the pathologist's view the insertion of the catheter had caused the sepsis observed in the peritoneal cavity, as an impossibility, due to the fact the catheter tract to the bladder was external to the peritoneal cavity but the presence of gas within the peritoneal cavity at the time of the deceased's collapse indicated the source of infection was within the peritoneal cavity.[30]

Further, the fact the deceased had been relatively well following insertion of the suprapubic catheter up until the time of her sudden and quite obvious collapse on admission to SJOGHS was much more supportive of the spontaneous rupture of one of the diverticular abscesses and thus the source of the sepsis, which then spread significantly over

[29] t 10.10.16, p37
[30] t 10.10.16, p36

the following days and caused the death of the deceased by way of sepsis.[31]

Dr Ruthven was not concerned as to the lack of any apparent rupture at the time of post mortem as the time between the rupture on admission to SJOGHS and death was long enough for any rupture to have sealed.

Dr Ruthven did not believe the deceased was suffering as the result of a bowel perforation, as a result of the procedure for insertion of the suprapubic catheter, due to the fact she was apparently comfortable enough to eat and drink following that procedure.[32] Dr Ruthven commented, at the time of the deceased's discharge from WPH, and transfer via taxi, there was no indication she was acutely unwell.

It was Dr Ruthven's view there was clear evidence of intraperitoneal gas on the CT scan following admission to SJOGHS. It would have been from a large bowel perforation had that been the way it occurred, which was not consistent with the deceased's condition prior to her rapid collapse. It was far more likely to have originated from a spontaneous rupture of a diverticulum of the sigmoid colon which resulted in immediate collapse, subsequent bacterial peritonitis, sepsis and death.

[31] t 10.10.16, p40
[32] Ex 1, tab 15

CAUSE AND MANNER OF DEATH

I am satisfied on whole of the evidence as assessed by Dr Ruthven, following receipt of Dr Stephens' description of the procedure for the insertion of the suprapubic catheter and the medical record of the deceased, both at WPH and SJOGHS, the deceased had a large carcinoma on her vulva which was obstructing her urethra and affecting her ability to urinate. The lesion was biopsied and said to be a carcinoma in situ, which was not of particular concern, although due to the discomfort for the deceased, required the placement of an indwelling catheter to assist her with urination.

This became uncomfortable and difficult for the deceased to manage and it was decided a suprapubic catheter would be placed directly into the bladder to bypass the difficulty for the deceased with urination. The intention was for the deceased to be discharged home following that procedure.

This was undertaken at WPH on 14 May 2014 at which time Dr Stephens was concerned the carcinoma was more serious than had been revealed by the biopsy, and should be reviewed by a consultant oncologist experienced in gynaecology. Arrangements were made for Dr Stuart Salfinger to review the deceased at SJOGHS.

It is clear this was the intention, but the lack of clear documentation in WPH notes for the deceased makes any clear direction or expectation impossible to define.[33] Certainly there was little by way of guidance for hospital staff.

Following the insertion of the suprapubic catheter the deceased was not clinically unwell on her observations, or showing signs of an elevated temperature or respiratory rate. It is accepted the presence of an indwelling catheter would have fostered bacteria in the bladder, but the fact the suprapubic catheter was inserted with one pass makes that as a reason for the subsequent development of sepsis highly unlikely.

The following day the deceased was transferred to SJOGHS by way of taxi rather than ambulance, which was a genuine mistake on the part of RN Crook, who understood it was a discharge rather than transfer. He has explained this and the evidence of the taxi driver indicated the deceased was not unwell during that journey.

I am satisfied that on arrival at SJOGHS the deceased experienced an immediate response to the rupture of a diverticular abscess in her sigmoid colon which gave her instant pain and caused an immediate deterioration in her health, as recorded by her observations in admissions when

[33] t 10.10.16, p57-61

she started to vomit. The rupture of the diverticular abscess released bacteria, colon material and gases into the peritoneal cavity. This caused the deceased to experience an immediate spread of bacteria within her peritoneal cavity and she became septic and suffered from septic shock from which she ultimately died. She had significant co-morbidities which would have lessened her ability to compensate for additional insults to her physiology.

I am satisfied the deceased died on 20 May 2014 from sepsis originating from a ruptured diverticulum at approximately 1 pm on 15 May 2014. Although she received aggressive treatment and resuscitation her condition remained unwell and a decision was made to treat her palliatively. She died on 20 May 2014 as a result of septic shock arising out of her sepsis.

I find death occurred by way of Natural Causes.

CONCLUSION

I am satisfied the deceased was a very well loved family member and her loss to her family was unexpected in its rapidity. The family understood the deceased had an apparently non aggressive cancerous growth and appeared to be otherwise relatively well. The location of her carcinoma made urination difficult and painful, which was not particularly relieved by an indwelling catheter.

In an attempt to remove that difficulty for the deceased a decision was made to locate a suprapubic catheter to bypass the urethra. During that insertion Dr Stephens was concerned the biopsy result for the carcinoma may be inaccurate. It appeared to him the carcinoma was very aggressive and he was concerned it needed proper gynaecological oncological review. That was arranged and Dr Stuart Salfinger was to assess the deceased's carcinoma on 15 May 2014 following transfer to SJOGHS.

The deceased appeared relatively well between WPH and SJOGHS, but unfortunately collapsed suddenly and seriously on admission to SJOGHS. The fact of the deceased's sudden deterioration in this way was inevitably going to cause her family great distress as they had believed she was managing well.

I am satisfied, on all the evidence, that collapse was due to a naturally occurring rupture of the deceased's diverticulum into her peritoneal cavity spreading bacteria, followed by sepsis throughout the deceased's abdominal organs. Due to her age and underlying heart disease the deceased's ability to compensate this insult on her system was severely compromised and despite aggressive treatment she developed septic shock and multi-organ failure.

Despite antibiotics and full ionotropic support the deceased died in SJOGHS on 20 May 2014 leaving behind a shocked and distressed family. While the management of the deceased's transfer from WPH to SJOGHS was not optimal, it did not cause or contribute to her sudden collapse and death.

E F Vicker
Deputy State Coroner
31 March 2017