JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	ROBYN HARTLEY, CORONER
DELIVERED	**:**	31 JULY 2025
FILE NO/S	**:**	CORC 3262 of 2021
DECEASED	**:**	FLYNN, DAVID KALUNDA

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Criminal Code Act Compilation Act 1913 (WA)
Medicines and Poisons Act 2014 (WA)
Medicines and Poisons Regulations 2016 (WA)

Cases:

Annetts v McCann (1990) 170 CLR 596

Counsel Appearing:

Ms T Weston appeared to assist the coroner.
Ms N Blumer (Blumers Personal Injury Lawyers) appeared for the Flynn family
Mr P Yovich SC (instructed by Ms M Smith, Avant Legal) appeared for Dr Hassan
Ms C Catto (Panetta McGrath lawyers) appeared for Nurse Mussa

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Robyn Mary Hartley, Coroner, having investigated the death of ***David Kalunda FLYNN*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 6 and 7 February 2025, find that the identity of the deceased person was* ***David Kalunda FLYNN*** *and that death occurred on 7 December 2021 at Armadale Kelmscott Memorial Hospital, 3056 Albany Highway, Mount Nasura, from cardiorespiratory arrest in a young child with opioid (morphine) toxicity in the following circumstances:*

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INTRODUCTION

1 David Kalunda Flynn (David[1]) was two years and eight months old when he died on 7 December 2021 following an elective circumcision procedure carried out by Dr Raad Hassan (Dr Hassan) at Gosnells Medical Clinic (the Clinic).

2 He was a happy, healthy child with no pre-existing medical conditions who never woke from the deep sedation administered for the circumcision.

3 A detailed examination of the circumstances leading to David's avoidable death provides an opportunity for a number of significant lessons to be learnt.

LEGISLATIVE FRAMEWORK

4 Given that David's death was unexpected, it fell within the definition of a reportable death under the *Coroners Act 1996* (WA) (the Coroners Act).[2]

5 Through their representative, Blumers Personal Injury Lawyers, David's family made an application pursuant to section 24 of the Coroners Act requesting that an inquest be held into his death.

6 Deputy State Coroner Linton granted the request for an inquest, noting that the primary focus would be the cause of death and an investigation into safe practices when administering anaesthesia to small children.

7 The Coroners Act requires that a Coroner who investigates a death must find, if possible, the identity of the deceased, the cause of death and the manner of death. Additionally, the Coroners Act empowers a Coroner to comment on any matter connected with the death, including public health or safety.[3]

8 Section 25(5) of the Coroners Act prohibits a Coroner from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

[1] David's family was consulted and expressed their preference that he be referred to by his first name.
[2] *Coroners Act 1996* (WA) s 3.
[3] *Coroners Act 1996* (WA) s 25(1) and (2).

THE INQUEST

9 The inquest into David's death was held over two days on 6 and 7 February 2025, in Perth.

10 The following witnesses were called to give expert evidence:

i. Dr Tanya Farrell
   Specialist Anaesthetist, Paediatrics
   Head of Department, Anaesthesia and Pain Medicine, Perth Children's Hospital
ii. Dr Parshotam Gera
   Consultant Paediatric Surgeon, Perth Children's Hospital
   Associate Professor, Curtin University
iii. Professor David Joyce
   Physician, Clinical Pharmacology and Toxicology
   Emeritus Professor, University of Western Australia
   Emeritus Consultant, Sir Charles Gairdner Hospital

11 The two witnesses of fact who gave evidence were Nurse Furqan Mussa (Nurse Mussa) and Dr Raad Hassan.

12 At the conclusion of the sworn evidence, David's parents, Mr and Mrs Flynn, accepted my invitation to speak about their son. They provided the Court with a series of beautiful pictures of David which we were able to display, along with a video that was played. Through their tears there were smiles as they remembered David.

13 In my role as a Coroner, I am committed to upholding the tenets affirmed by The Honourable Justice Toohey in ***Annetts v McCann*** (1990) 170 CLR 596 at 616, setting out the following passage:

> "Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends….".

14 From the outset, I made it very clear that the inquest into David's death was to be conducted in an inquisitorial, rather than adversarial, manner.

15 Counsel, expert witnesses, witnesses of fact and David's family all conducted themselves in an exemplary fashion with a clear awareness of the inquisitorial nature of the hearing.

Section 47 Certificate

16 Shortly after the commencement of Dr Hassan's evidence in chief, his counsel made an application for a certificate under s 47(1) of the Coroners Act. If granted, the certificate would result in Dr Hassan's answers to questions posed from that point onwards not being admissible in evidence in criminal proceedings (other than on a prosecution for perjury committed in the proceedings).

17 Given the importance of the fact finding exercise being undertaken, I determined it expedient for the ends of justice that Dr Hassan be compelled to answer questions.[4]

18 I addressed Dr Hassan directly at this early stage in his evidence and we had the following exchange:

> **CORONER:** I get the sense you want to tell the truth here today - - -?---Yes.
>
> - - - and help everybody understand what happened?---Yes, your Honour.
>
> Thank you?---I am transparent, and I don't think to hide – to hide anything.
>
> No?---Okay.
>
> And I'm glad to hear that?---Thank you.[5]

19 Dr Hassan provided his answers under statutory compulsion and, at the close of his evidence, I determined that he gave evidence to my satisfaction, meaning that his answers were responsive to the questions. I therefore granted Dr Hassan a certificate under s 47(2) of the Coroners Act.[6]

[4] Section 47(1) of the *Coroners Act 1996* (WA) empowers a coroner to compel a witness to answer any question even if the answer will incriminate or tend to incriminate the witness.
[5] T 176 (7/2/25).
[6] T 214 – 215 (7/2/25).

BACKGROUND

20 David's mother, Alice Flynn (Mrs Flynn), who is also known by her maiden name, Alice Kunda Chilekwa, was born in Zambia. She moved to Perth in 2007. Mrs Flynn met her husband Scott Flynn (Mr Flynn) in 2010 and they were married in Scotland in 2012. The Flynn's first child, their daughter Casmy, was born in Scotland in 2014. After moving back to Perth, they welcomed their second child, Phillip, in 2017. David was their third born and he arrived on 29 March 2019. David's younger brother Joseph was born on 11 April 2021.[7]

21 David was born at Fiona Stanley Hospital after Mrs Flynn was induced as a precaution due to her suffering from gestational diabetes. The birth was without complication and David was a healthy baby.[8]

22 The Flynn family's regular general practice was Seville Drive Medical Centre. David's medical records from that practice show that he received all his recommended vaccinations and was a healthy child with no serious health concerns.[9]

23 At the time of David's death, Mrs Flynn was working in aged care and studying nursing.[10]

CHRONOLOGY

24 In early November 2021 Mrs Flynn was studying at the library when she noticed Gosnells Medical Clinic across the road. She had been attempting to book her three sons in to be circumcised by a General Practitioner but the medical practice she was told to go to had referred her somewhere else.

25 Mrs Flynn attended at the Clinic and was advised that they performed circumcisions. When Mrs Flynn was interviewed by police not long after David's death, she recalled discussing with a staff member that she had three boys she wanted circumcised.[11]

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[7] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[8] Exhibit 1, Volume 1, Tab 19 Statement of Alice Kunda CHILEKWA dated 14 July 2022.
[9] Exhibit 1, Volume 1 Tab 26 Seville Drive Medical Centre Medical Records for Mr David Flynn.
[10] Exhibit 1, Volume 1, Tab 19 Statement of Alice Kunda CHILEKWA dated 14 July 2022.
[11] Exhibit 1, Volume 1, Tab 19.1 Transcript of Police Interview with Alice Chilekwa FLYNN dated 15 December 2021, p 6 – 7.

Pre-circumcision consultation 17 November 2021

26 An appointment was made with Dr Hassan on 17 November 2021 for David and his nine month old brother Joseph to have a pre-procedure consultation.[12]

27 Mrs Flynn recalls the reason for only taking her two youngest boys to the appointment on 17 November 2021 was because Phillip, who was four years old at the time, had school that day.[13]

28 Dr Hassan has recorded discussing the pros and cons of circumcision with Mrs Flynn at this appointment. He told her about possible complications like bleeding, infection and injuries. Dr Hassan's records state that Mrs Flynn was happy to proceed.[14]

29 In his evidence, Dr Hassan explained that he would have shown Mrs Flynn post-surgical pictures which look like an infection but, in fact, are examples of normal healing after the procedure. The standard photographs Dr Hassan provided to parents were contained in a document called 'Circumcision Photo Guide: What to expect after surgery'.[15]

30 During the appointment Dr Hassan examined David and Joseph and found that both had testicles that were high up and likely undescended. Dr Hassan referred David and Joseph for an ultrasound prior to the circumcision procedure.

31 Dr Hassan gave evidence about the standard discussion he had with parents prior to performing a circumcision on their child. Given Dr Hassan estimates he has performed around 4000 circumcisions in Iraq and more than 2000 in Australia[16] over a 30 year period I am confident that his standard discussion was well established. He explained that he would talk a patient's parent through the procedure, so it was as if they were watching it with their own eyes. Dr Hassan would tell them his plan was to perform a procedure that was as pain-free as possible. He would then tell the parent that the first step was to put Emla cream on the area to numb it. The next step is to "give the needle". Dr Hassan went on to assert that he would expressly refer to the fact that the needle contained

[12] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Attachment 1.
[13] Exhibit 1, Volume 1, Tab 19 Statement of Alice Kunda CHILEKWA dated 14 July 2022.
[14] Exhibit 1, Volume 1, Tab 24.1 Gosnells Medical Clinic records for Master David Flynn.
[15] Exhibit 1, Volume 1, Tab 23.3 Circumcision Photo Guide: What to expect after surgery.
[16] T 176 (7/2/25).

morphine. Then he would describe "the child will be tranquilised and asleep, and then we do the procedure".

32 Morphine is a prescribed Schedule 8 medication under the *Medicines and Poisons Regulations 2016* (WA) which means it is a controlled drug with strict regulations including specific requirements for prescribing, recording and supplying.

33 During his evidence, Dr Hassan was repeatedly questioned about whether he told Mrs Flynn that he would be using morphine to sedate David for the procedure and he answered in the affirmative each time.[17]

34 This is in contrast to Mrs Flynn's firm position that Dr Hassan never mentioned that he would be using morphine.[18]

35 In evidence, Dr Hassan was asked if he could elaborate on what, if any, other complications he would go into in addition to bleeding, infection and injuries. He said he could refer to possible anaphylaxis from Xylocaine and from other things, but he wouldn't expressly say that there was a possibility of death. Dr Hassan explained that, as he had never had a patient die following a circumcision procedure, he chose not to raise it during a pre-circumcision consultation.[19]

36 However, as Dr Hassan pointed out, the Gosnells Medical Clinic Medical Consent for Male Circumcision form included a reference to the fact that "death may occur".[20]

37 It is noted that the Consent form with the reference to the fact that death may occur was given to Mrs Flynn to read and sign on the day of David's procedure.

38 I will provide my assessment of the adequacy of the information provided to Mrs Flynn to enable her to give informed consent to the procedure later in my finding.

39 Mrs Flynn asserts that at the appointment on 17 November 2021 Dr Hassan told her to return with both boys at 11.00 am on Tuesday 7 December 2021 for the circumcision to take place. He also suggested that she bring her oldest son Phillip with her then.[21]

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[17] T 182 – 183; T 214 (7/2/25).
[18] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025; T 214 (7/2/25).
[19] T 184 (7/2/25).
[20] Exhibit 1, Volume 1, Tab 23.1 Gosnells Medical Clinic – Medical Consent for Male Circumcision dated 7 December 2021.
[21] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.

Ultrasound

40 As requested by Dr Hassan, Mrs Flynn took David and Joseph for ultrasounds on 19 November 2021. David's ultrasound report, dated 23 November 2021, confirmed Dr Hassan's clinical observation that both his testicles were undescended.[22]

41 Dr Hassan provided documents to the Court which show that the ultrasound report was received by him electronically via a network called HealthLink on 23 November 2021. Dr Hassan advised he receives results such as this into an account which can only be accessed by him. The software does not alert Dr Hassan when a test result is received into his account. It is Dr Hassan's usual practice to view and discuss a patient's test result the next time that patient presents for a consultation. Dr Hassan says that if a result is urgent, it is usually faxed or a call is made to alert him. Dr Hassan advised the Court that the medical imaging clinic did not contact him by telephone or fax about David's ultrasound.[23]

42 Dr Hassan did not go so far as to say that someone from the medical imaging clinic that performed the ultrasound on David should have contacted him to alert him to the result. Certainly, I am not aware of an ultrasound revealing undescended testicles being considered an urgent result warranting a fax or call to bring it to the requesting doctor's attention.

43 For the avoidance of doubt, I will record my view that a call or fax was not warranted and that it was appropriate for the medical imaging clinic to send Dr Hassan David's ultrasound result by the usual means. The responsibility to review the ultrasound rested with Dr Hassan.

44 Regrettably, in this instance, Dr Hassan did not follow his usual practice. In an unintentional oversight, he did not review the ultrasound result prior to proceeding with David's circumcision procedure on 7 December 2021. He has informed the Court that he first viewed David's ultrasound report on 10 December 2021, three days after his death.[24]

45 The significance of this omission will be addressed further on in this finding.

[22] Exhibit 1, Volume 1, Tab 23.4 Ultrasound Scrotum Mr David Flynn exam date 19/11/2011 reported 23/11/2011.
[23] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Attachments 13 and 14.
[24] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024.

Circumcision procedure 7 December 2021

46 On Tuesday 7 December 2021 David was in good health.[25] He was his normal happy self, playing and dancing.[26]

47 Mrs Flynn arrived at Gosnells Medical Clinic just before 11.00 am with Phillip, David and Joseph. A still from the CCTV footage of the reception area at 10.56 am shows the receptionist holding up one finger during his initial interaction with Mrs Flynn.[27]

48 The Court has been provided with a copy of the Clinic's electronic appointment book for 7 December 2021 and it shows an 11.00 am appointment with Dr Hassan for just David Flynn.[28]

49 It is a fair assumption that the CCTV still has captured the point at which the receptionist was explaining to Mrs Flynn that the electronic appointment system only had a booking for one of her sons, David, to be circumcised that day.

50 Mrs Flynn was given a form for Medical Consent for Male Circumcision to sign.[29] While she was completing the paperwork David is captured on the CCTV footage drinking from a bottle.[30]

51 CCTV footage shows that Nurse Mussa called Mrs Flynn and her three boys into the treatment room at 11.18 am. Mr Flynn arrived at the clinic at 11.19 am and joined the family in the treatment room.[31]

52 Mrs Flynn says that at some stage she asked Dr Hassan if Phillip could be checked that day. Dr Hassan said that Phillip couldn't be checked, but that she could bring him when she came back for David's post-procedure check the following week.[32]

53 Dr Hassan provided a different recollection of what occurred after Mrs Flynn arrived at Gosnells Medical Clinic on 7 December 2021. In his first statement to the Court he asserted that:

[25] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[26] Exhibit 1, Volume 1, Tab 20, Statement of Moseka Eduige MASHAURI.
[27] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 1A CCTV still 10.56am.
[28] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 2 Gosnells Medical Clinic electronic appointment book dated 7 December 2021.
[29] Exhibit 1, Volume 1, Tab 23.1 Gosnells Medical Clinic – Medical Consent for Male Circumcision dated 7 December 2021.
[30] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.
[31] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.
[32] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.

> "Mrs Flynn presented with her three children in the treatment room and asked me to circumcise them all. I explained to her that she booked only one child and I could not do all three. She insisted I add Phillip but then indicated David was to be done first. That day was busy. My usual practice was only to do what is booked for circumcision, but I complied with Mrs Flynn's request at her insistence to circumcise one of her other children".[33]

54 In his supplementary statement Dr Hassan stated:

> "Mrs Flynn spoke to me in the treatment room, she asked me to circumcise all three children. Despite her booking one child for circumcision, after begging me I agreed to add one extra child. She chose Joseph".[34]

55 Later I will comment on the appropriateness of Dr Hassan's decision to add Joseph's circumcision to the procedure list on 7 December 2021.

56 It was Dr Hassan's practice to administer subcutaneous morphine to patients over 12 months of age to sedate them for the circumcision procedure. The calculation of the appropriate amount of morphine was done using the patient's weight. Dr Hassan calculated morphine dosage using the following clinically accepted formula:

body weight (kg) x 0.2mg.[35]

57 The established procedure at Gosnells Medical Clinic was for the nurse assisting Dr Hassan with a circumcision procedure to apply Emla cream to the patient's penis and then weigh them if they were being administered morphine.

58 During her evidence, Nurse Mussa explained that she would either weigh a patient at the same time as she applied the Emla cream or she would weigh them just before the doctor came in to give the morphine.[36]

59 At approximately 11.40am Nurse Mussa applied the Emla cream to David.

60 As she had been taught to do, Nurse Mussa then weighed David and wrote the result down on a Post-it note which she stuck on the door of the cupboard where the Schedule 8 medication register was kept. The Post-it note was discarded and Dr Hassan did not record David's weight in his records of the procedure.

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[33] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[34] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024.
[35] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[36] T 105 (7/2/25).

61 The process of applying Emla cream and weighing David took a few minutes. CCTV footage captured the Flynn family leaving the treatment room at 11.46 am. A still image of the footage shows David drinking from a bottle or sucking on a yoghurt pouch.[37]

62 Mrs Flynn does not recall being told by Dr Hassan or Nurse Mussa that David should be fasting before the procedure.[38]

63 Both Nurse Mussa[39] and Dr Hassan[40] gave evidence that at no stage did they advise Mrs Flynn that David should not eat or drink for a specified period of time in the lead up to the circumcision procedure.

64 There was a wait time of 45 minutes for the Emla cream to take maximum effect.[41]

65 The family left the Gosnells Medical Clinic at 11.52 am[42] and went to Hungry Jacks where David ate a kids meal comprising chicken nuggets, fries and a small Fanta.[43]

66 After finishing their meal at Hungry Jacks, Mr Flynn went home with Phillip and Mrs Flynn returned to the Clinic with David and Joseph, arriving back in the waiting room at 12.33 pm.[44]

67 At 12.36 pm, Nurse Mussa called Mrs Flynn and David back into the treatment room.[45]

68 Nurse Mussa unlocked the double locked safe where the morphine was kept with the other Schedule 8 medication held by the Clinic.[46]

69 Generally, if Nurse Mussa was in the treatment room preparing everything for the procedure, she would access the morphine from the safe and put it on the bench ready for the doctor.[47]

70 In her witness statement given to police shortly after David's death, Nurse Mussa explained that once a new ampoule of morphine was

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[37] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 2A CCTV still 11.46 am.
[38] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[39] T 111 (7/2/25).
[40] T 190 – 192 (7/2/25).
[41] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[42] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 3 CCTV still 11.52 am.
[43] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[44] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 4 CCTV still 12.33 pm.
[45] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 5 CCTV still 12.36 pm.
[46] A picture of the safe can be found at Exhibit 1, Volume 1, Tab 8.1 Selection of 10 photographs taken by police officers, Photograph 5.
[47] Exhibit 1, Volume 2, Tab 6 Further statement of Furqan MUSSA dated 16 July 2024.

opened it would be recorded in the Clinic's "red book" along with two authorised medical staff signatures as well as being recorded in the patient's file.

71 However, in this instance, the remaining morphine left over from a previous patient was used for David. This was not documented in the red book but was documented in his patient file.[48]

72 This was the established practice for recording the use of Schedule 8 medication at Gosnells Medical Clinic. Nurse Mussa was taught the processes and procedures involved in a circumcision procedure, including the record keeping, by Dr Hassan and another practice nurse who was already working at the clinic when she started there. That nurse left the Clinic a few months after Nurse Mussa commenced.[49]

73 Dr Hassan entered the treatment room at 12.42 pm[50]. He checked David's weight written on a Post-it note by Nurse Mussa. Dr Hassan then calculated the amount of morphine David needed as follows - 16.25kg x 0.2mg = 3.25mg. In order to administer David 3mg of morphine Dr Hassan knew he had to draw up 0.1ml of the 30mg/ml morphine sulfate concentration in the opened ampoule.[51]

74 Dr Hassan drew up what he asserts was 0.1ml of morphine in a 1.0ml syringe. He then injected it subcutaneously in David's left arm.

75 Mrs Flynn states that Dr Hassan did not tell her what was in the syringe at the time of administration, and he did not say it was morphine.[52]

76 The morphine Dr Hassan injected into David was drawn from an ampoule opened on 2 December 2021 when he conducted two circumcision procedures. Dr Hassan used a total of 10.5mg of morphine for the two procedures conducted on 2 December 2021. He explained that the used morphine ampoule was securely closed by covering the top with three layers of micropore tape and stored in the drug safe. This was done to prevent it becoming crystalized or contaminated. The maximum time Dr Hassan says he stored morphine was five to seven days and, in

[48] Exhibit 1, Volume 1, Tab 21, Statement of Furqan MUSSA dated 13 December 2021.
[49] T 101 – 102 (7/2/25).
[50] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 6 CCTV still 12.42 pm.
[51] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[52] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.

most cases, he would use it within a day or two. Dr Hassan adopted the practice of reusing opened ampoules of morphine to save resources.[53]

77 After the morphine injection was given, Dr Hassan's standard practice was to wait about 10 minutes for it to start taking effect and that practice was followed with David.

78 CCTV footage shows Mrs Flynn carrying David as they left the treatment room at 12.45 pm and returned to the waiting room. David can be seen rubbing his left arm where he was given the morphine injection.[54]

79 When they were back in the waiting room after the morphine injection, Mrs Flynn shared a pouch of yoghurt (or similar) between David and Joseph with the majority being consumed by David. Mrs Flynn also gave David a bottle of water to drink. At one point, David can be seen walking off down the corridor of the Clinic.[55] Mrs Flynn recalls singing to David to distract him.[56]

80 During this time Nurse Mussa prepared the procedure bed and the trolley.[57] While giving evidence Nurse Mussa explained that she would set up the trolley with all the things needed for the circumcision procedure including instrument packs, dressing packs, saline and betadine.[58]

81 At 12.55 pm Dr Hassan returned to the treatment room[59] and at 12.56 pm he called David and Mrs Flynn to come back in.[60]

82 Mrs Flynn carried an awake and alert David back into the treatment room for his procedure.[61] She helped him onto the bed and removed his pants and shoes.

83 At this point, David started getting sleepy and Dr Hassan told her the medication was working. Mrs Flynn settled David before returning to the waiting room to look after Joseph who was in his pram.[62]

84 Dr Hassan recalled that when David came into the treatment room, he was drowsy and quiet but his eyes were open. This was the same

[53] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[54] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.
[55] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.
[56] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[57] Exhibit 1, Volume 1, Tab 21, Statement of Furqan MUSSA dated 13 December 2021.
[58] T 121 (7/2/25).
[59] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 8 CCTV still 12.55 pm.
[60] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.
[61] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.
[62] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.

presentation at this point in the process as all the other children he had circumcised before David.

85 Before proceeding with the circumcision, Dr Hassan marked the skin where he planned to cut, and the area was disinfected with Betadine. He administered 1ml of plain xylocaine 2% (a local anaesthetic) to the base of the penis and around the skin that had been marked to be cut. He then injected 0.3ml of xylocaine with adrenaline around the marked skin that was going to be cut to prolong the effect of the local anaesthesia and produce more haemostasis (the body's natural process to stop bleeding). While the xylocaine was taking effect, Dr Hassan pulled down the skin to clean the glans.

86 Dr Hassan then placed mosquito artery forceps to hold out the foreskin before cutting it with high frequency cautery. Once the cutting was completed, Dr Hassan placed a dressing on David's penis.

87 Dr Hassan described David as semi sleepy but conscious during the procedure. He does not recall observing anything unusual as far as David was concerned.[63]

88 Dr Hassan made a record of the circumcision in David's patient record including the following[64]:

> Circumcision under LA and aseptic measures
> Morphine 3mg S/C left over
> Circumcision performed Bleeders haemostasis
> Wound closed by Floxmil strips around wound
> Dressing Written instruction print it out
> Warning verbally given
> Any concern dial 000 Return or go to any closest ED hospital.

89 At 1.16 pm, Nurse Mussa went to the waiting room and asked Mrs Flynn to bring her younger son Joseph into the treatment room.[65]

90 Dr Hassan states that when the procedure was finished and Mrs Flynn came into the treatment room she spoke to David as she took him off the bed.[66]

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[63] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[64] Exhibit 1, Volume 1, Tab 24.1 Gosnells Medical Clinic records for Master David Flynn. NOTE: obvious typographical errors have been amended.
[65] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 9 CCTV still 1.16 pm.
[66] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.

91 However, Mrs Flynn recalls seeing David lying on the bed asleep when she got to the treatment room. She was expecting him to be screaming but says Dr Hassan told her everyone was different. She put David's clothes back on and moved him to the bed in the adjoining bay in the treatment room so that Joseph could be prepared for his procedure.[67]

92 Dr Hassan told Mrs Flynn that David would fall deeply asleep in the car and should wake up in about two to three hours. He explained that David might vomit due to the effect of the morphine and that if that happened, she should give him salt and water to stop the vomiting.[68]

93 Mrs Flynn's recollection of the conversation with Dr Hassan straight after David's procedure is that he told her that if David vomits, give him water with a little salt. He also said that David may be itchy and that he was likely to wake up in the car on the way home.[69]

94 Mrs Flynn held Joseph while he underwent the circumcision procedure. In accordance with Dr Hassan's established practice, Joseph was not given morphine due to his age.

95 Mrs Flynn recalls David sleeping on the other bed throughout Joseph's procedure.

96 Dr Hassan left the treatment room after Joseph was circumcised to prepare the aftercare paperwork. It was standard for Dr Hassan to do this after each circumcision procedure. He would then bring the paperwork back into the treatment room for Nurse Mussa to go through with the parent in detail and highlight the date they needed to come back for a dressing change.[70]

97 Mrs Flynn recalls Nurse Mussa speaking to her about aftercare. She told Mrs Flynn to send photos to the clinic phone if the wound looked infected or she was concerned. She gave her the Gosnells Medical Clinic - Post Circumcision Instructions and a prescription for antibiotics. Nurse Mussa also confirmed that they should come back the following Monday for a check-up.[71]

98 The version of the Post Circumcision Instructions given to Mrs Flynn contained an incorrect check-up date of 13 July 2021.[72]

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[67] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[68] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[69] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[70] Exhibit 1, Volume 2, Tab 6 Further statement of Furqan MUSSA dated 16 July 2024.
[71] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[72] Exhibit 1, Volume 1, Tab 23.2 Gosnells Medical Clinic – Post Circumcision Instructions.

99 Dr Hassan has explained that the Post Circumcision Instructions are a document he created. It is a template that had a default date of 13 July 2021 for the follow up appointment. Dr Hassan was confident that Nurse Mussa went through the Instructions with Mrs Flynn and hand corrected the date on the typed instruction sheet before she left.[73] Whether or not the date was amended by hand, Mrs Flynn recalls being told by Nurse Mussa to return the following Monday.

100 Mrs Flynn requested a medical certificate as she had taken leave from work to look after David and Joseph.[74]

101 The medical certificate that Dr Hassan produced in response to Mrs Flynn's request was photographed by Coronial Investigation Squad officers during the course of their investigation. The photograph shows that the medical certificate was made out for "Master Philip Flynn DOB 1/5/2017".[75]

102 Counsel Assisting the Coroner questioned Dr Hassan about the incorrect patient name on the medical certificate. He explained that it was an honest mistake likely brought about by the fact that Phillip's medical notes were probably open due to him having been brought into the Clinic with David and Joseph initially.[76]

103 At 1.56 pm Mrs Flynn left the treatment room carrying paperwork and pushing Joseph in his pram.[77] She left Joseph in the pram while she paid the account and then went back into the treatment room to collect David.

104 At 2.07 pm Mrs Flynn carried David, who looked to be sound asleep in her arms, to the car.[78]

105 Mrs Flynn returned to the waiting room at 2.09 pm to collect Joseph and then left the clinic.[79]

106 When Mrs Flynn arrived home Joseph was crying persistently. She carried David inside and laid him on her bed before turning on the air-conditioner.

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[73] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[74] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[75] Exhibit 1, Volume 1, Tab 8.1 Selection of 10 photographs taken by police officers, Photograph 10.
[76] T 196 – 198 (7/2/25).
[77] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 10 CCTV still 1.56 pm.
[78] Exhibit 1, Volume 1, Tab 22.3 Supplementary statement of Dr Raad HASSAN dated 4 December 2024, Document 11 CCTV still 2.07pm.
[79] Exhibit 1, Volume 2, Tab 7 CCTV from Gosnells Medical Clinic on 7 December 2021.

107 Mrs Flynn went back to the car and carried Joseph into the room. David was fast asleep on the bed. Joseph continued to cry so Mrs Flynn gave him some baby Panadol.

108 Mrs Flynn had been told to take off David and Joseph's shorts and nappies and just leave them in tops with the cups in place over their penises. When she looked in Joseph's nappy there was a small amount of blood in it.

109 Mrs Flynn recalls that as she was changing David he moved as if he was trying to sit up. He did not open his eyes or cry. It was like he was doing it while he was still asleep. David was still warm at that point.[80] This description will become vitally important later in this finding.

110 The P98 Mortuary Admission Form completed by attending Coronial Investigation Squad officers, who spoke to Mrs Flynn shortly after learning that David had died, included the following description[81]:

> The family returned to their home address somewhere between 1400 – 1500 hours. Both children were drowsy. Mother Alice went to bed with both children to rest and watch TV. *At one stage the deceased tried to get out of bed, and Alice encouraged him to lie back down and relax*. [emphasis added]

111 The information recorded on P98 Forms is a useful means of capturing as much relevant information as possible in the period straight after a reportable death. While every effort is made to ensure accuracy, further investigations are intended to elaborate upon and sometimes refine the initial snapshot captured in the P98 Form during the time just after an unexpected death.

112 In so much as the description of David's level of consciousness varies between that recorded in the P98 Form and Mrs Flynn's statement made on 2 February 2025 I accept the latter as being the most accurate. The P98 Form was completed by attending police officers and would not have been read back to Mrs Flynn for her to verify before completing, as a witness statement is. Further, the clinical significance of the exact nature of David's conscious state when he moved while Mrs Flynn changed him in the afternoon on 7 December 2021 would not have been apparent to the attending officers or Mrs Flynn at the time information was being incorporated in the P98 Form.

[80] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[81] Exhibit 1, Volume 1, Tab 2 Mortuary Admission Form – P98 for David FLYNN.

113 While David slept, Joseph continued to cry and Mrs Flynn was becoming increasingly concerned about the baby.

114 Mrs Flynn called her friend with older sons who had been circumcised. Her friend ran a home daycare and looked after all four Flynn children.

115 On 7 December 2021 Mrs Flynn's friend looked after Casmy, Phillip, David and Joseph from 7.00 am when Mr Flynn dropped them off to her home. The friend took Casmy to school at about 8.30am. Later in the day, after collecting Casmy from school, the friend was looking after Phillip and Casmy and expected either Mr or Mrs Flynn would be coming to collect their two eldest children.

116 Both Mr and Mrs Flynn arrived at the friend's house at about 4.45 pm with David and Joseph. She recalls seeing Mr Flynn come into her house through the garage carrying David, who was asleep in his arms.[82]

117 Mr Flynn placed David on the couch in the living area. He laid David on his side with his head facing up.

118 Mrs Flynn put Joseph on the playmat in the living area. He was crying on and off. When Mrs Flynn checked Joseph's nappy there was a lot of blood in it. She took photographs of the blood.

119 Tuesday night is prayer night at the church the Flynn family attends so Mr Flynn went to church and took Casmy and Phillip with him.

120 Mrs Flynn's friend made some porridge for Joseph and Mrs Flynn fed him. Joseph was crying and then urinating, repeatedly. He was bleeding heavily and had blood on his leg. Mrs Flynn felt that Joseph was in pain.[83]

121 Understandably, Mrs Flynn was focused on Joseph from the time she arrived at her friend's house. It is clear he was in distress and the problem in terms of his bleeding and pain was only getting worse.

122 At about 6.30pm Mrs Flynn checked on David on the couch. His legs were cold to touch. Working in a nursing home Mrs Flynn knew that his legs shouldn't be that cold. She felt for a pulse on his wrist but could not feel one. Her friend's son, who is a nurse, came into the living room and checked David but he could not feel a pulse either. David was not breathing.

123 Mrs Flynn called for an ambulance at 6.32 pm.[84] She checked David's mouth for vomit, but it was clear. The emergency services call taker told

[82] Exhibit 1, Volume 1, Tab 20, Statement of Moseka Eduige MASHAURI.
[83] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025.
[84] Exhibit 1, Volume 1, Tab 18 St John Ambulance Patient Care Record 21240380.

Mrs Flynn to put David on the floor so CPR could be administered. She followed the instructions and started CPR under the guidance of the call taker.

124 Police were contacted by St John Ambulance at 6.38 pm. The first police officers arrived at the home at 6.42 pm[85] and took over CPR from Mrs Flynn.

125 St John Ambulance were on the scene by 6.44 pm. Ambulance officers took over care of David and resuscitation efforts continued. The ambulance officers found that David was not breathing or responding and his pupils were fixed and dilated. They continued compressions and attached paediatric defibrillator pads in the hope of being able to administer a charge, but David remained asystole. Three doses of adrenaline were administered at the scene to nil effect. It was decided to transfer David to Armadale Hospital Emergency Department. The ambulance departed at 7.09 pm.[86]

126 While ambulance officers were working on David a family member brought Joseph out to show them. He had blood on his foot and was observed to be flat, clenching his jaw and hard to rouse. One of the ambulance officers called for a priority one ambulance to attend for Joseph. That officer stayed at the scene to care for Joseph until the other ambulance arrived.[87]

127 The ambulance carrying David arrived at Armadale Hospital at 7.14 pm. Maximal resuscitation efforts continued in the Emergency Department for over 45 minutes. Sadly, despite the best efforts of all involved, David was declared life extinct at 8.03 pm.[88]

128 Mrs Flynn was comforting Joseph in the bay next to the one where David was being worked on. A doctor came to tell her that they had been unable to save David. She could not believe it. Mrs Flynn had thought that David was going to recover. While she was trying to come to terms with David's death, she was told Joseph needed to be transferred to Perth Children's Hospital.

[85] Exhibit 1, Volume 1, Tab 13 Police Incident Report LWP21120700913681.
[86] Exhibit 1, Volume 1, Tab 18 St John Ambulance Patient Care Record 21240380.
[87] Exhibit 1, Volume 1, Tab 18 St John Ambulance Patient Care Record 21240380.
[88] Exhibit 1, Volume 1, Tab 25 Medical notes for David Flynn from Armadale Health Service.

129 Mrs Flynn went with Joseph in the ambulance to Perth Children's Hospital where he underwent emergency surgery to control bleeding from his frenular artery.[89]

EXPERT REPORTS AND EVIDENCE

DR FARRELL

130 Dr Tanya Farrell is a Specialist Anaesthetist with 20 years consultant level experience both anaesthetising and sedating children for surgical procedures and pain conditions. She has been the Head of Department for Anaesthesia and Pain Medicine at Perth Children's Hospital for approximately 6 years and is the President Elect for the Society for Paediatric Anaesthesia for New Zealand and Australia.

131 Dr Farrell provided the Court with a report dated 6 June 2024[90] and gave measured and very helpful evidence at the inquest.[91]

Circumcision procedures under sedation in general practice setting

132 On the question of the appropriateness of performing David's procedure in a general practice setting, Dr Farrell began by pointing out that elective circumcision in healthy children is a safe and common practice despite the known risk of complications. Further, it is a procedure that has been performed for thousands of years for a range of reasons.

133 Dr Farrell cited the Royal Australasian College of Physicians' 2022 Position Statement on Circumcision of Infant Males which advises that circumcision be undertaken under general anaesthesia by appropriately qualified specialists. During evidence she was careful to confirm that she would not recommend having a circumcision without a general anaesthetic.[92]

134 However, taking a pragmatic view, she understood that Dr Hassan is a registered medical practitioner with extensive experience performing elective circumcisions in general practice such that the procedure could be considered within his scope of practice. The crucial caveat to this

[89] Exhibit 1, Volume 2, Tab 4 Perth Children's Hospital Medical Records for Joseph Flynn.
[90] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA.
[91] T 16 – 48 (6/2/25).
[92] T 29 – 30 (6/2/25).

acknowledgement by Dr Farrell is that the procedure must occur with requisite monitoring of the incident and outcomes.

135 Dr Farrell went on to inform the Court that elective circumcisions could conceivably be carried out in a general practice setting with a series of safeguards in place. However, she observed that it is difficult and onerous for a general practice to put in place all the necessary measures with respect to personnel, training, assistance, equipment, monitoring, medication management, documentation, procedures for resuscitation and rescue, and the physical space required to perform safe procedural sedation.

136 Further, paediatric sedation carries the additional burdens of behavioural management, the requirement for size appropriate monitoring and resuscitation equipment, the cognitive load for drug calculation based upon weight and finally, and importantly, maintaining a volume of practice to retain competence in sedation and performing procedures in small children. It is accepted that children under the age of six years are not only at higher risk for sedation related adverse events but, due to being less mature and therefore less cooperative than an older cohort, these younger patients are also more at risk of deeper than intended sedation. Dr Farrell explained that, due to these reasons, procedural sedation for surgical procedures, particularly involving children, has largely been abandoned in the general practice setting.

137 Dr Farrell drew from a number of eminent publications in support of the opinion she provided to the Court in this matter. Of particular relevance was the Australian and New Zealand College of Anaesthetists PG09(G) Guideline on Procedural Sedation 2023 (the PG09(G) Guideline) which is endorsed by the Royal Australian College of General Practitioners.

138 The PG09(G) Guideline defines sedation levels as follows:

> **Minimal**: A drug-induced state of diminished anxiety, during which patients **are conscious** and respond purposefully to verbal commands or light tactile stimulation.
> **Moderate**: A drug-induced state of **depressed consciousness** during which patients retain the ability to respond purposefully to verbal commands and tactile stimulation.
> **Deep**: A drug-induced state of **depressed consciousness** during which patients are not easily roused and may respond only to noxious stimulation.

139 It is not in dispute that the level of sedation sought to be achieved by Dr Hassan when he performed circumcisions was greater than minimal.

140 Dr Farrell explained that sedation is best understood as occurring on a continuum from mild sedation, where someone may be relieved of the symptoms of anxiety with medications, through to general anaesthesia. Practitioners use a range of agents to produce the intended level of sedation and it is very easy to slip from one part of the continuum to another. So as a general precaution, if sedation is planned, it is recommended that the preparatory and emergency response measures taken accord with those of a level of sedation greater than is intended to be achieved.[93]

Facilities, equipment and personnel

141 For safe sedation of small children to occur in an outpatient setting the clinic needs to be equipped with the facilities required to deal with an emergency. The procedure should take place in a room with access to oxygen, suction and a means of ventilating a patient who stops breathing. Importantly, there must be face masks, airway devices and self-inflating bags in a range of sizes suitable for paediatric patients. Monitoring equipment (set out in detail further on) needs to be compatible with various child-sized accessories. The clinic must stock resuscitation and emergency medication with doses of these rescue agents pre calculated in accordance with the weight of the child undergoing the procedure.

142 Dr Farrell stated during her evidence that sedation of this kind must take place in a space where it can be done safely with the right equipment by people with the requisite knowledge, competence and training.[94]

143 Children undergoing procedural sedation would ideally be attended to by at least two, preferably three, personnel all with current training in paediatric specific life support.

144 During her evidence Dr Farrell explained that the ability to rescue situations when they get out of control is paramount to any undertaking with regard to sedation, particularly in children where things can get out of control very quickly. The personnel involved should be people who

[93] T 19 (6/2/25).
[94] T 32 – 33 (6/2/25).

have experience with resuscitation and care of children as well as managing the different behavioural aspects of sedating children.[95]

Fasting

145 As prescribed in the PG09(G) Guideline, children undergoing anything more than minimal sedation should be fasted from solids for six hours prior to the procedure and may drink clear fluids up to an hour before.

146 Dr Farrell gave evidence that there is some literature coming out now to suggest that sipping small amounts of clear fluids such as water, apple juice or lemonade up until the procedure is safe.[96]

147 It is noted that opioid medication such as morphine is a known emetic, making adherence to the fasting protocol in David's case even more important.

Morphine as a sedating agent, strength of solution, size of syringe and mode of administration

148 Dr Farrell explained that, in her experience, opioid drugs are more commonly used for pain relief as opposed to sedation. While not going so far as to say that morphine is not suitable for use as a sedating medication, she stated that opioids aren't great sedative agents.[97]

149 When a medication like morphine is being used for pain relief it would be the expectation that the patient would remain conscious and, therefore, be able to protect their airway if they were to vomit. Once a patient loses consciousness, their ability to maintain their airway is removed.

150 Subcutaneous administration of morphine is common in palliative care but is rarely used in an acute care setting due to the unreliable onset and offset of the drug's effect. Dr Farrell advised that the peak effect for subcutaneous dosing of morphine is expected to occur about 50 to 90 minutes post administration. The effects of morphine can last up to three to four hours.

[95] T 32 (6/2/25).
[96] T 20 (6/2/25).
[97] T 26 (6/2/25).

151 Due to morphine's long-lasting effect, Dr Farrell believes there are other sedating medications better suited for use for a short procedure such as circumcision. Morphine administered subcutaneously is too unpredictable and has a long duration of action, making it a suboptimal medication selection in this instance.

152 The choice of a 1ml hollow bore needle, combined with the strength of the morphine solution (undiluted 30mg/ml) Dr Hassan elected to use, increased the likelihood of inaccuracy in dosing.

153 Dr Farrell pointed to the fact that the type of syringe that Dr Hassan used has a dead space in the needle containing a volume you can't reliably predict. So that when you push the plunger down to empty you will always have a small amount of unmeasurable fluid left behind, eroding the accuracy of the dosing.[98]

154 Dr Farrell informed the Court that she would not administer undiluted morphine in the concentration used by Dr Hassan when anaesthetising children. Rather, she would use a concentration of 10mg per ml and dilute 1ml up to 10ml. So that to administer 3mg of the drug she would give the child 3ml of the solution.

155 This can be contrasted with the volume of 0.1ml required to be measured by Dr Hassan to accurately administer 3mg of morphine to David.

156 Dr Farrell explained that, using her method, 3ml would not be given by injecting three full 1ml syringes of the solution. Rather, she would use a 10ml syringe to draw up 3ml. She noted that this would be a large volume to administer subcutaneously which is another reason anaesthetists don't routinely use subcutaneous injections to provide medication.[99]

Monitoring

157 Continuous and multi-faceted monitoring of a patient undergoing the level of sedation used in David's case is essential to ensure patient safety.

158 According to the PG09(G) Guideline, whenever greater than minimal sedation is achieved for the purpose of conducting a procedure, the following level of monitoring should be maintained:

[98] T 28 (6/2/25).
[99] T 25 (6/2/25).

i. Continuous monitoring of oxygen saturation with pulse oximetry that alarms when pre-set limits are transgressed is essential in all patients undergoing procedural sedation. When alarms are triggered signifying presence of hypoxaemia then staff should devote their whole attention to correcting this situation, which may include ceasing the procedure until the hypoxaemia is corrected.
ii. Continuous waveform capnography is recommended for sedation where verbal contact is lost or difficult to monitor. Capnography should be available for minimal and moderate sedation and is strongly advised for moderate sedation in both adults and children.
iii. Regular monitoring of pulse rate, oxygen saturation and blood pressure throughout the procedure and recovery phase, using equipment suited to patient size, is essential. Regular observation of a child's breathing pattern and monitoring of respiratory rate is essential for children. For those patients in whom monitoring prior to commencement of sedation may not be practical, such as small children or patients with intellectual disabilities or cognitive impairment, regular monitoring should commence as soon as possible and continue throughout the episode of sedation and the early recovery phase of care.
iv. According to the clinical status of the patient, other monitors such as ECG may be required.

Discharge

159 Dr Farrell advised that discharge from a clinical setting following sedation should only occur after the following stringent discharge criteria have been met:

i. Cardiovascular function and airway patency are satisfactory and stable.
ii. The patient is easily arousable, and protective airway reflexes are intact.
iii. The patient can talk (if age appropriate).
iv. The patient can sit up unaided (if age appropriate).
v. For a very young child or a child with disability who is incapable of the usually expected responses, the pre sedation level of responsiveness or a level as close as possible to the normal level for that child should be achieved.
vi. The state of hydration is adequate.[100]

160 In evidence Dr Farrell explained that David should only have been discharged from Gosnells Medical Clinic once he had achieved his pre-sedation or baseline level of consciousness. He should have been awake, able to walk and able to eat and drink something before he went home.[101]

[100] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA, p 8.
[101] T 31 (6/2/25).

Informed consent

161 On the issue of informed consent, Dr Farrell drew on her own experience in explaining that, prior to a procedure such as the one performed on David, most of the discussion with the parents would be focussed on the circumcision itself. She would expect the person performing the procedure to detail complications such as bleeding and infection.

162 On the sedation front, she would always ensure that parents were aware that sedation itself poses risks. Dr Farrell would explain to them that cardiovascular or respiratory issues become undisguised under sedation and that the patient might have a reaction to the medications used. Given the settings that Dr Farrell conducts sedation in, she would go on to reassure parents that they have the people that are trained and are in the right place with the right equipment to cope with most of the possible complications if they were to arise.[102]

163 Dr Farrell was asked by counsel for the family whether, during the course of obtaining informed consent, she would tell a parent that she was intending to use morphine to sedate their child. She responded that she would not necessarily name the medication but would refer to the fact that a sedative agent would be used. Dr Farrell explained that anaesthetists don't often go through and name every medication they're planning to use during a procedure. Rather, she would describe a medication by the effects she was hoping to achieve by using it and how long she expected it would take for recovery to occur.[103]

Ultrasound result

164 Dr Farrell was asked about the ultrasound result that showed David had undescended testicles. She explained that there is a condition where testicles can be undescended and that can be an indication for a surgery called orchiopexy. Dr Farrell is aware that testicles can be quite mobile meaning this condition can be over diagnosed. An initial presentation like David's would require further investigation by a surgeon.

[102] T 33 – 34 (6/2/25).
[103] T 35 (6/2/25).

165 While Dr Farrell doesn't perform the surgery, she has administered the anaesthesia for many boys undergoing an orchiopexy.[104] Further, she has anaesthetised a significant number of patients who have had a circumcision procedure performed while under general anaesthetic for an orchiopexy.[105]

Conclusion

166 Dr Farrell summarised her assessment of David's circumcision procedure under sedation as follows:

> …although it is difficult to determine if the environment and equipment available might render the sedation and procedure appropriate in this setting for this patient, there exist significant issues and concerns with medication selection, management and administration, monitoring and conduct of sedation, recovery and documentation such that it is my opinion that sedation for children in this setting is not appropriate.[106]

DR GERA

167 Dr Parshotam Gera has been a Consultant Paediatric Surgeon in Western Australia for the last 12 years. He has 23 years' experience in Paediatric Surgery and worked as the head of the Paediatric Surgery Department at Perth Children's Hospital from 2018 to 2021. Dr Gera currently works as a Consultant Paediatric Surgeon at Perth Children's Hospital and is an Associate Professor at Curtin University. He is also a senior instructor and supervisor with the Royal Australasian College of Surgeons.

168 Dr Gera was involved in the emergency surgery performed on David's younger brother Joseph in the early hours of 8 December 2021 to repair his frenular artery which was damaged during his circumcision procedure.[107]

169 Dr Gera provided the Court with a report on 24 July 2024[108] as well as giving insightful oral evidence.[109]

[104] T 18 (6/2/25).
[105] T 32 (6/2/25).
[106] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA, p 9.
[107] Exhibit 1, Volume 2, Tab 4 Perth Children's Hospital Medical Records for Joseph Flynn.
[108] Exhibit 1, Volume 1, Tab 28 Report of Dr Parshotam Gera MBBS, M.Med.Sc., FRACS.
[109] T 49 – 64 (6/2/25).

Appropriateness of decision to carry out an elective circumcision in a general practice setting

170 Like Dr Farrell, Dr Gera commenced his response to this question in his report by pointing out that circumcision is a common procedure in male children which has been practised for thousands of years for cultural, religious and health reasons.

171 It is Dr Gera's view that circumcision can be done in the general practice setting so long as there is appropriate support and training of personnel, accurate documentation of the dose of procedural analgesia and established protocols for management of sedated patients.

172 In his report, Dr Gera cited the Clinical Practice Guidelines for Procedural Sedation issued by the Royal Children's Hospital Melbourne for guidance as to best practice when sedating children:

- there must be adequate assessment of various factors before administering sedation to a child;
- the clinician must have adequate experience with the medication;
- there must be the presence of a skilled airway clinician to respond to an emergency;
- ensure appropriate airway and resuscitation equipment;
- use appropriate monitoring including pulse oximetry, cardiac monitoring and blood pressure;
- maintain close observation of the airway and chest movements if needed;
- care by appropriate skilled staff until recovery is well established; and
- the child should not be discharged home until they have established their pre-procedure neurological baseline.

173 Dr Gera performs circumcisions and it is his practise to perform the procedure in day operating theatre under general anaesthesia administered by a paediatric anaesthetist for all children over 6 months of age.

Informed consent

174 While parental consent with knowledge of the procedural complications was documented by Dr Hassan, Dr Gera noted that a discussion of sedation or anaesthetic risk was not recorded.

Ultrasound result

175 During his evidence, Dr Gera advised that the appropriate action for a general practitioner to take upon receiving an ultrasound result like the one David got would be to refer the patient to a paediatric surgeon to determine if surgical correction of the undescended testicles was required. He also confirmed that, if David had needed surgery under general anaesthetic to correct undescended testicles, he could have had a circumcision at the same time. However, surgeons operating in public hospitals are not permitted to perform a circumcision procedure unless it is medically indicated.[110]

176 Counsel for David's family put to Dr Gera that, given Dr Hassan conducted a physical examination of David's testicles during the pre-circumcision appointment on 17 November 2021 and noted they were high up, he should have explained to Mrs Flynn the significance of confirming whether the testicles were undescended given corrective surgery for that condition could include a circumcision procedure. Dr Gera agreed with this proposition and confirmed counsel's position that a conversation of that nature should have occurred at the pre-circumcision consultation.[111]

Conclusion

177 Dr Gera concluded his report as follows:

> In summary, there are significant issues in the current case in terms of medication management, monitoring and discharge of a sedated child. In my opinion the current setting was not appropriate to perform the procedure (circumcision) under anaesthesia.[112]

CAUSE AND MANNER OF DEATH

Post mortem

178 Forensic pathologists Dr Vagaja and Dr Patton conducted a full post mortem examination on 10 December 2021.

[110] T 56 - 57 (6/2/25).
[111] T 57 – 58 (6/2/25).
[112] Exhibit 1, Volume 1, Tab 28 Report of Dr Parshotam Gera MBBS, M.Med.Sc., FRACS, p 6.

179 Their preliminary determination as to the cause of death as set out in the initial post mortem report was undetermined (pending investigations).[113]

180 Following the initial post mortem report, the forensic pathologists received and reviewed clinical notes from Gosnells Medical Clinic.

181 As the results became available, they also considered microscopic examination of tissues, macroscopic and microscopic examination of the brain by a neuropathologist, vitreous fluid biochemistry, microbiology, virology, immunology and toxicology testing.

182 Immunology testing was not supportive of David having suffered an anaphylactic reaction to morphine.[114]

183 In terms of toxicological analysis, given the significance of the interpretation of these results, the forensic pathologists were informed by the expert opinion of eminent toxicologist Professor David Joyce dated 2 November 2023 which they cited as being "…supportive of death occurring due to toxic effects (opioid effects) following the administration of morphine on 7 December 2021".

184 In their supplementary post mortem report the forensic pathologists formed the opinion that, taking into account the further investigations, the cause of death was cardiorespiratory arrest in a young child with a likely opioid (morphine) toxicity.[115]

PROFESSOR JOYCE

185 Professor David Joyce is an Emeritus Professor at the University of Western Australia and Emeritus Consultant at Sir Charles Gairdner Hospital. He remains in practice at the Clinical Pharmacology & Toxicology Laboratory at PathWest and in forensic toxicology.

186 Graduating from medicine at the University of Western Australia in 1975 (MBBS), Professor Joyce was admitted to fellowship of the Royal Australasian College of Physicians (FRACP) in 1983 and was awarded a Doctorate of Medicine (MD) by the University of New South Wales in 1988.

187 In addition to practicing in acute general medicine and clinical pharmacology, Professor Joyce headed the Clinical Pharmacology

[113] Exhibit 1, Volume 1, Tab 5.1 Post Mortem Report of David FLYNN.
[114] Exhibit 1, Volume 1, Tab 5.2 Supplementary Post Mortem Report of David FLYNN, p 2.
[115] Exhibit 1, Volume 1, Tab 5.2 Supplementary Post Mortem Report of David FLYNN.

service at Sir Charles Gairdner Hospital and the Clinical Pharmacology and Toxicology Laboratory at PathWest (and its predecessors) from 1986 to 2023.

188 Professor Joyce has published over 100 papers in basic and clinical pharmacology and, most recently in 2022, the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists recognised Professor Joyce's contributions to education, practice and research with a lifetime achievement award.

189 Professor Joyce provided the Court with a report dated 2 November 2023[116] and a supplementary report dated 17 May 2024[117]. His evidence at the inquest was characteristically meticulous and illuminating.[118]

Inherent limitations of calculations

190 Before embarking upon an examination of whether the likely dose of morphine administered to David was 3mg as intended, Dr Joyce was careful to point out that most reported interpretations of drug concentrations are based on samples taken from living adults. The interpretation of blood concentrations of drugs in specimens collected during a post-mortem examination of a child must be considered with an awareness that there will be differences. They are:

- Blood plasma or serum is the conventional medium for most clinical drug analysis, while whole blood (which includes both cells and plasma) is the conventional medium for post-mortem toxicology. Drug concentrations in blood cells are not necessarily the same as concentrations in blood plasma. This has to be accounted for when experience from measuring plasma concentrations is applied to interpreting blood specimens.

- A further impediment to direct comparison of ante-mortem and post-mortem drug concentrations is post-mortem redistribution of drugs. Post-mortem redistribution describes a process of drug diffusing passively across biological barriers after death, artificially raising or lowering the concentration in blood. In this case, the blood specimen that was analysed for morphine was collected from the aorta, which is a central vessel liable to post-mortem redistribution. A request was therefore made to Chemistry Centre to

[116] Exhibit 1, Volume 1, Tab 27 Report of Professor David A Joyce MBBS MD FRACP dated 2 November 2023.
[117] Exhibit 1, Volume 1, Tab 27.1 Addendum Report of Professor David A Joyce MBBS MD FRACP dated 17 May 2024.
[118] T 66 – 93 (6/2/25).

measure free and total morphine in liver tissue, to provide further independent guidance on the amounts of morphine present in the body at the time of death.

- Young children have different susceptibilities to some drugs than adults, importantly including drugs that affect respiratory efficiency.

- For many drugs, there is little guiding data on blood concentrations in children because they are not prescribed much for children and have not attracted much research.[119]

191 During his evidence, Professor Joyce confirmed that for morphine, in particular, the available data capturing the adult experience is much greater than data detailing how children respond to the drug.

192 He also elaborated on the issue of younger children having different susceptibilities to some drugs when compared with adults. Professor Joyce explained that by the time a child is David's age they are becoming more like adults. So this consideration isn't as important as it would be for a younger child but it does need to be kept in mind so that interpretations are not made too prescriptively.[120]

The administered dose of morphine – intentions, records and concentration

193 It is uncontroversial that the intended dose of morphine for David was 3mg given subcutaneously. This was a clinically appropriate dose given he weighed 16kg.

194 Professor Joyce raised the fact that it is a requirement that records are made and kept for Schedule 8 medication including patient name, dose administered to the patient, residual amount of that dose discarded and a running total of dose units held by a practice.

195 Due to deficiencies in record keeping for Schedule 8 medication at Gosnells Medical Clinic, the only documentation that Professor Joyce could rely on to verify the dose administered was the record made by Dr Hassan in David's Progress Notes on 7 December 2021.

196 Without a record of the real source of the morphine administered to David, the actual dose administered was not actually documented. All that was recorded was a statement of an intended amount.

[119] Exhibit 1, Volume 1, Tab 27 Report of Professor David A Joyce MBBS MD FRACP dated 2 November 2023, p 5 – 6.
[120] T 68 – 69 (6/2/25).

197 Professor Joyce stated that this was extremely important missing information where the possibility of opioid toxicity is being considered.

198 As with Dr Farrell, Professor Joyce pointed out that the 30mg per 1ml formulation of morphine used by Dr Hassan placed demands on the operator because drawing up 3mg in a 1ml syringe requires the accurate extraction of just one-tenth of a millilitre into the syringe followed by complete injection of the drawn-up solution.

Estimations of the administered dose of morphine from concentrations in post-mortem specimens

199 Professor Joyce calculated the likely administered dose of morphine in three different ways.

200 When completing his calculations, Professor Joyce used four hours as the time between the administration of morphine and David's death.[121]

201 In David's case, four hours is the shortest possible time that could have elapsed between administration and death given the morphine was injected at about 12.45 pm and David was carried into a family friend's home by his father at approximately 4.45 pm without any concern or suggestion he was cold to the touch or wasn't breathing.

202 David's mother felt his legs at about 6.30 pm and it was at this time she realised he was cold and had stopped breathing. As acknowledged by Professor Joyce, the time between administration of the medication and David's death may have been longer than four hours[122] but, without certainty as to the exact time of his passing, he did his calculations on the basis of this timeframe. If David's time of death was, in fact, later than 4.45 pm then the results for at least one of the following methods of calculation would have suggested an even higher administration dose.

203 The first method of calculation saw Professor Joyce conduct a comparison of David's post mortem blood concentrations of free morphine with published studies of what occurs after morphine administration to children where the outcome was not fatal. This calculation method operated on the accepted premise that the estimated half-life for free morphine is 1.325 an hour.

[121] T 83 (6/2/25).
[122] Exhibit 1, Volume 1, Tab 27 Report of Professor David A Joyce MBBS MD FRACP dated 2 November 2023, p 8.

204 Using this measure, the expected free morphine concentration in blood four hours after administration of 3mg was significantly less than the amount found in David's post mortem samples. While the calculations made no provision for post mortem redistribution of the drug, thereby weakening their reliability, Professor Joyce was willing to state that the results point towards David having received a dose of morphine greater than 3mg.

205 The second method involved estimating the total amount of morphine remaining in the body at the time of death and comparing it with what might be expected from the intended dose. In his evidence Professor Joyce described this as a rather more convoluted method which turns on data as to how widely morphine distributes in the body after administration. However, there is guiding data which is good enough to base a calculation on. As with the first method, this calculation produced a result that is indicative of Dr Hassan administering a dose of morphine in excess of 3mg.[123]

206 Using the third method, Professor Joyce adopted the concentrations of free and total morphine found in post mortem liver tissue as representative of the concentrations in body tissue generally. During his evidence, Professor Joyce confirmed that liver tissue has a greater likelihood of maintaining a stable concentration after death than blood does. By taking the concentrations in liver tissue and multiplying by body weight, Professor Joyce worked out an estimated total amount of morphine in the body. Again, this method of calculation came up with an administration dose greater than 3mg.[124]

207 While conceding that none of these estimation methods can be considered infallible for reasons related to post mortem distribution and unproven underlying assumptions, Professor Joyce asserted that, "…as rough as they are, all three approaches are suggesting that the administered dose was higher than the prescriber intended".[125]

208 Professor Joyce was asked if he was able to be more precise than "greater than 3mg" when estimating the amount of morphine administered to David by Dr Hassan. He responded by saying that he deliberately

[123] T 70 - 71 (6/2/25).
[124] T 71 (6/2/25).
[125] Exhibit 1, Volume 1, Tab 27 Report of Professor David A Joyce MBBS MD FRACP dated 2 November 2023, p 9.

avoided making a specific numerical estimate because that would tend to confer a credibility on his calculation processes beyond what they actually possess.[126]

Clinical course

209 Professor Joyce carefully considered Mrs Flynn's witness statement dated 14 July 2022 and Nurse Mussa's statement of 13 December 2021 along with the medical records from Gosnells Medical Clinic in a bid to establish the onset of David's sedation on 7 December 2021. Given no formal observations were conducted or recorded, Professor Joyce relied upon the witness accounts to conclude that there was approximately 10 to 15 minutes between the administration of the morphine and the commencement of the circumcision procedure, by which time David was described as getting sleepy. This accords with the timing captured on CCTV footage from the Clinic. Professor Joyce considered that the onset of narcosis after subcutaneous injection seemed to have taken around 10 minutes.

210 Relevantly, Dr Farrell observed that the onset of sedation just an estimated 10 minutes after Dr Hassan administered the morphine to David, is rapid for the subcutaneous route and supports the possibility of the dose being higher than intended. Peak effect for subcutaneous dosing of morphine is expected 50 to 90 minutes post injection.[127]

Conclusion

211 In concluding his report, Professor Joyce stated:

> The clinical history, the deficiency in contemporary dosage record-keeping, the lack of peri-procedural observations that argue against opioid toxicity, blood concentrations of morphine species that appear high for the intended dose, blood concentrations in the range that has been associated with lethal toxicity and lack of apparent other explanations for the death therefore make it likely that opioid toxicity was the cause of death.[128]

[126] T 71 (6/2/25).
[127] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA, p 7.
[128] Exhibit 1, Volume 1, Tab 27 Report of Professor David A Joyce MBBS MD FRACP dated 2 November 2023, p 12.

Likely opioid toxicity

212 In his report, Professor Joyce made multiple references to the line in the P98 Form that reads "At one stage the deceased tried to get out of bed, and Alice encouraged him to lie back down" before noting that this single mention of a transient return to consciousness was not reflected in Mrs Flynn's statement to police.[129]

213 Professor Joyce completed his first and supplementary reports prior to Mrs Flynn preparing her second statement of 3 February 2025 where she described, as she was changing David in the afternoon on 7 December 2021 "…he moved as if he was trying to sit up. He didn't open his eyes or cry. It was like he was doing it while still asleep. He was still nice and warm then".[130]

214 During his evidence Professor Joyce explained that his report was supportive of David probably dying from opioid toxicity and that the use of the word "probably" and, later, "likely" in describing the cause of death was because the P98 Form included those few words that implied that there had been a period of consciousness during the day.

215 Having advised Professor Joyce of the description of David's movement as detailed by Mrs Flynn in her supplementary statement, he informed the Court that this information allowed him to move to the position of saying that David's death was caused by opioid toxicity.[131]

Cause of death

216 In my closing remarks at the inquest, I informed the parties that I had formed the preliminary view that the cause of death was cardiorespiratory arrest in a young child with opioid (morphine) toxicity. I referred to Professor Joyce's evidence that he had incorporated the word "likely" in front of opioid toxicity in his report on the basis of an understanding of information contained in the P98 Form which had since been superseded by a description set out in Mrs Flynn's supplementary statement.[132]

[129] Exhibit 1, Volume 1, Tab 27 Report of Professor David A Joyce MBBS MD FRACP dated 2 November 2023, p 3 and 10.
[130] Exhibit 1, Volume 1, Tab 19.2 Statement of Alice Kunda CHILEKWA dated 3 February 2025, p 5.
[131] T 73 (6/2/25).
[132] T 216 (7/2/25).

217 All parties to this matter were given the opportunity to file written submissions in response to the preliminary determinations outlined in my closing remarks.

218 Submissions filed on behalf of Dr Hassan expressly stated that my proposed finding as to David's cause of death was not disputed.[133]

219 I find that the cause of death was cardiorespiratory arrest in a young child with opioid (morphine) toxicity.

Manner of death

220 As foreshadowed in my closing remarks, I find that the manner of death was misadventure.[134]

DR HASSAN'S CLINICAL PRACTICE AND DECISION MAKING

Circumcision under sedation in general practice setting

221 Both Dr Farrell and Dr Gera informed the Court that it was appropriate, in theory at least, for Dr Hassan to perform procedural sedation on a child of David's age in a general practice setting. However, both were at pains to point out that it was only appropriate if an onerous list of requirements in relation to training and number of personnel, equipment, monitoring, medication management, procedures for resuscitation and rescue and discharge criteria could be met.

222 During his evidence at the inquest Dr Hassan was asked by his counsel whether, as at 7 December 2021:

> there was naloxone[135] in the surgery available for him to use if needed
>
> he had the expertise to use naloxone if required
>
> he had the equipment available for paediatric resuscitation
>
> he had current paediatric CPR training

[133] Submissions on behalf of Dr Raad Hassan prepared by Paul Yovich SC filed 7 March 2025.
[134] Misadventure applies where some deliberate, appropriate and lawful act takes an unexpected turn which leads to death.
[135] Naloxone is an opioid antagonist used to treat opioid overdoses.

and Dr Hassan answered yes to all four questions.[136]

223 In submissions filed with the Court by counsel for Dr Hassan it was asserted:

> If the procedure had been done following the guidelines recommended for the use of procedural anaesthesia by the Australian and New Zealand College of Anaesthetists, and in particular those relating to peri– and post-operative monitoring, the Gosnells Medical Clinic had the equipment necessary to monitor and revive David (including, importantly, naloxone), as well as the equipment available for paediatric resuscitation, and Dr Hassan had current paediatric CPR training.[137]

224 I agree wholeheartedly with Dr Hassan's counsel that the Australian and New Zealand College of Anaesthetists PG09(G) Guideline on procedural sedation 2023, which Dr Farrell relied upon in formulating her expert opinion in this matter, should have been followed in the performance of David's circumcision procedure.

225 The PG09(G) Guideline is comprehensive and clearly created with patient safety as the paramount concern. I am of the strong view that it should guide general practitioners, such as Dr Hassan, performing procedural sedation.

226 I have been advised by the Royal Australian College of General Practitioners (RACGP), Western Australia that they were involved in the development of the PG09(G) Guideline and believe it should apply to all sedationists.[138] I note that the crest of the RACGP appears on the front page of the PG09(G) Guideline along with the 22 other colleges and societies who have endorsed the document.

227 In Appendix IV of the PG09(G) Guideline entitled 'Safe procedural sedation competencies' it states:

> The risks associated with procedural sedation are proportional to the depth of sedation. The major risks are airway management followed by patient comorbidities. Consequently, a graded approach to skills, staffing and technique may be appropriate. For example, **basic life support skills suffice for minimal sedation** achieved solely by a single oral dose of an anxiolytic or alternatively by the sole administration of nitrous oxide/oxygen or methoxyflurane. However, for intravenous sedation, or where multiple sedative agents are administered, or

[136] T 210 (7/2/25).
[137] Submissions on behalf of Dr Raad Hassan prepared by Paul Yovich SC filed 7 March 2025, p 5.
[138] Letter to Coroner's Court of Western Australia from Mr Hamish Milne, WA State and GP Training Manager, dated 30 April 2025.

> **for deeper levels of sedation where the risks are greater the higher skills of advanced life support are necessary**.[139] [emphasis added]

228 Of particular relevance to this matter, the PG09(G) Guideline also provides:

> It is essential that a practitioner with the required airway and life support skills is immediately available for all procedural sedation. This will be basic life support for minimal sedation and age-appropriate advanced life support for moderate sedation for children and adults.[140]

229 I interpret the PG09(G) Guideline as requiring Dr Hassan, as the sedationist, to be trained in Advanced Paediatric Life Support in order to safely administer moderate to deep sedation to children, such as David, undergoing a circumcision procedure at Gosnells Medical Clinic.

230 Following the inquest I sought, and was provided with, copies of Dr Hassan's paediatric CPR training credentials current as at 7 December 2021. The information received confirmed that Dr Hassan had up to date triennial Basic Life Support and Provide CPR competencies on the day of David's procedure.

231 I am aware that Basic Life Support and Provide CPR training likely include components of child specific emergency responses but I am not satisfied these competencies are sufficient to properly train a sedationist to the standard required to safely administer anything more than minimal sedation to a patient as young as David.

232 On the question of access to rescue agents such as naloxone, I accept the evidence of Dr Hassan, that there was access to this medication at Gosnells Medical Clinic.

233 However, I note Dr Farrell's report stated that, to ensure procedural sedation was conducted safely in an outpatient setting, "resuscitation and emergency medications would be readily available, and **doses of these rescue agents appropriate for the weight of the child calculated ahead of time** for all but the most experienced paediatric practitioner"[141] [emphasis added].

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[139] Australian and New Zealand College of Anaesthetists PG09(G) Guideline on procedural sedation 2023, p 18.

[140] Australian and New Zealand College of Anaesthetists PG09(G) Guideline on procedural sedation 2023, p 6.

[141] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA, p 6.

234 In the detailed evidence provided by Nurse Mussa as to the step by step preparation for David's circumcision procedure, there was no mention of preparing naloxone for Dr Hassan to pre-calculate an appropriate dose for David based on his weight. Similarly, Dr Hassan's evidence about what actions he took in the lead up to David's procedure did not include any reference to preparing a dose of naloxone or any other rescue agents so that they were readily available for use.

235 Given David was not monitored in the manner required under the PG09(G) Guideline and was discharged from the Clinic while still deeply sedated there was never an opportunity to consider the administration of rescue agents.

Morphine as a sedating agent, mode of administration, concentration of solution and size and type of syringe

236 Dr Farrell and Professor Joyce both expressed concern about the choice of morphine as the sedating agent for David's procedure.

237 Morphine is more commonly used for pain relief when patients are likely to remain conscious and, thereby, able to maintain their airway. It is slow acting, with the peak effect for morphine given subcutaneously occurring about 50 to 90 minutes after administration. Additionally, it is long lasting, taking up to four hours to wear off. For a short procedure like circumcision, a sedating agent with a more rapid onset and offset would be more suitable.

238 Dr Farrell explained that subcutaneous administration of morphine results in a less reliable onset and offset of the drug's effect when compared with intravenous administration

239 Both Dr Farrell and Professor Joyce provided detailed written and oral evidence about the much higher degree of difficulty Dr Hassan imposed upon himself by using such a concentrated morphine solution drawn up in a small syringe.

240 Dr Hassan explained in evidence that he had observed some of his young patients experiencing pain when he injected larger volumes of a more diluted solution of morphine so he moved to using the more concentrated solution and his patients no longer suffered.[142] He was also adamant that

[142] T 192 (7/2/25).

he had a lot of experiencing accurately drawing up the correct dose of morphine using the 30mg/ml solution and a 1ml syringe.[143]

241 Finally, the two experts identified difficulties in achieving accurate dosing given the dead space in the type of syringe used by Dr Hassan.

242 With the margin for error so great, and the consequence of an intentional overdose being potentially fatal, I believe Dr Hassan made a series of poor decisions in his choice of sedating agent, mode of administration, concentration of solution and the size and type of syringe used.

Informed consent

243 I agree with Dr Gera's assessment that Dr Hassan obtained adequate informed consent from Mrs Flynn in relation to the circumcision procedure itself but should have been more prescriptive in his explanation of the risks associated with sedation.

244 Dr Hassan gave evidence that he chose not to refer to the possibility of death when discussing circumcision procedures with parents because, in performing thousands of circumcisions over almost 40 years, he had never had an adverse outcome, let alone a fatal one. He also pointed out that the risk of death was set out in the Gosnells Medical Clinic – Medical Consent for Male Circumcision which Mrs Flynn signed on the day of David's procedure.[144]

245 I believe Dr Hassan should have had a full and frank conversation with Mrs Flynn on 17 November 2021 detailing the very real, albeit rarely occurring, risks associated with moderate to deep sedation of a child of David's age. I do not think that a reference to possible death on a form signed shortly before the procedure suffices.

246 Mrs Flynn maintains Dr Hassan never expressly stated that he would be using morphine as the sedating agent for David's circumcision, either at the pre-circumcision consultation on 17 November 2021 or on the day of the procedure. Dr Hassan insists he did.

247 On this issue I was assisted by Dr Farrell's evidence that she would not necessarily name every medication she was intending to use when obtaining informed consent from parents before anaesthetising or sedating their child. She explained that she would be more likely to focus

[143] T 211 – 212 (7/2/25).
[144] T 182 (7/2/25).

on the intended effect of the drugs in her arsenal when discussing them with parents. I note, however, that the list of medication a paediatric anaesthetist like Dr Farrell would use is very likely a lot longer than the three drugs (morphine, xylocaine and adrenaline) administered by Dr Hassan in performing David's circumcision procedure.

248 Without making a finding as to whose recollection of the reference to morphine I prefer, I will simply state that when a small number of drugs are being used by a sedationist it would be best practice to name the medication when obtaining informed consent.

249 I have viewed the Royal Children's Hospital Melbourne Parent Information Sedation for procedures handout[145] which sets out various types of sedation medication and explains what they're used for, their effect and onset and offset. I am conscious of the need to strike a balance between informing and overwhelming a parent but can understand why Mrs Flynn could have expected to be told that David was going to be given morphine as a part of the circumcision procedure.

Ultrasound result

250 In my closing remarks at the end of the inquest I foreshadowed the fact that, unless otherwise convinced, I would find that Dr Hassan should have followed his usual practice and checked David's ultrasound results prior to proceeding with his circumcision procedure. Had Dr Hassan checked the results he would have been in a position to inform Mrs Flynn that David would need to be referred to a paediatric surgeon for advice as to whether he required surgical correction of his undescended testicles. As part of any conversation about the ultrasound results, Mrs Flynn should have been told that, if surgery was needed, David could have been circumcised at the same time while under a general anaesthetic.

251 In submissions filed on his behalf, counsel for Dr Hassan did not oppose my proposed finding on this point.[146]

252 I accept that Dr Hassan's failure to check David's ultrasound result until after his death was an inadvertent mistake however, this was clearly a missed opportunity for Mrs Flynn to be armed with all the information

[145] www.rch.org.au/clinicalguide/guideline_index/Procedural_sedation/.
[146] Submissions on behalf of Dr Raad Hassan prepared by Paul Yovich SC filed 7 March 2025, p 4.

necessary to make a fully informed decision about the merits of having David circumcised by Dr Hassan in a general practice setting.

253 In response to a question from counsel for David's family, Dr Gera agreed that, ideally, Dr Hassan should have raised the possibility of David having undescended testicles after he did a physical examination at the pre-circumcision consultation. If Dr Hassan had explained why he was referring David for an ultrasound prior to the circumcision procedure, it would have allowed Mrs Flynn to consider and discuss with her husband whether they would go ahead with David's circumcision if the ultrasound result confirmed the need for a referral to a paediatric surgeon. It would also likely have prompted Mrs Flynn to ask about the ultrasound result on the day of David's procedure, thereby reminding Dr Hassan to go over it with her.

254 I must stress that this is in no way suggesting that Mrs Flynn bore any responsibility to raise the issue of David's ultrasound results with Dr Hassan. It is completely understandable that, having not heard anything from the Clinic following the ultrasound and, in the absence of Dr Hassan discussing the results with her on 7 December 2021, Mrs Flynn would have assumed that the ultrasound had not revealed anything of consequence.

255 I do not intend to go so far as to find that Dr Hassan erred on 17 November 2021 by not going into detail with Mrs Flynn in terms of the full extent of the ramifications if David's ultrasound revealed he had undescended testicles. There was a lot of important information for him to get through at that pre-circumcision consultation and I am conscious of the time constraints general practitioners work under. It is easy to impose unrealistic expectations on them when going over a coronial matter in detail, with the benefit of hindsight and in the knowledge of the devastating outcome.

256 It may be that the realities of running a busy general practice mean that a standard consultation does not provide the time to physically examine a patient (in this case two patients), obtain informed consent from the parent in terms of the circumcision procedure as well as the sedation and discuss the significance of a possible diagnosis of undescended testicles. It provides further insight into Dr Farrell's observation that "…procedural sedation for surgical procedures, particularly for children,

has largely been abandoned in the general practice setting and deferred to ambulatory care settings".[147]

Decision to add Joseph to procedure list

257 There was conflicting evidence between Mrs Flynn and Dr Hassan in terms of how many of her sons the Clinic expected to attend for a circumcision procedure on 7 December 2021.

258 What is not in dispute is the entry in the Clinic's appointment book which shows just David booked in at 11am on 7 December 2021.

259 Ultimately, Dr Hassan elected to add Joseph to the list and circumcised both him and David despite it being what he described as a busy day.

260 As I stated during the inquest, it was Dr Hassan's responsibility, as an experienced medical practitioner, to only agree to perform as many circumcision procedures as he could safely do within the allocated time on 7 December 2021.[148] Any reference to parental pressure to add a child to the list is unhelpful in my view.

Fasting

261 The unrefuted evidence before me in this matter is that David should have been fasted prior to the circumcision procedure.

262 This is because sedated patients have diminished protective laryngeal reflexes, making the consequences of regurgitation of stomach contents far more serious than for fully conscious patients.

263 Fasting protocols were never discussed with Mrs Flynn and David ate and drank right up until just before he slipped into a sedated state.

264 Fasting was particularly important in this instance due to the fact that morphine is a known emetic.

265 It should be noted that the fact David wasn't fasted before the circumcision procedure ultimately had no bearing on his death.

266 Nevertheless, it is absolutely clear that fasting protocols should have been observed given the intention to achieve moderate to deep sedation. The failure to ensure that fasting protocols were observed was a significant error on the part of Dr Hassan.

[147] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA, p 6.
[148] T 208 – 209 (7/2/25).

267 This was conceded in submissions filed by counsel for Dr Hassan.

268 During his evidence, Dr Hassan stated that David's parents "…didn't report to us that they went out and gave him food, so we don't know". As I pointed out at the time, I do not think it is fair to suggest that a parent should be reporting back to a doctor that their child had eaten when they were never told to ensure their child adhered to fasting protocols.[149]

Failure to record David's weight in patient record

269 In response to an enquiry from WA Police on 10 December 2021, Dr Hassan said that David was measured as weighing 16.25kg on 7 December 2021.[150]

270 Given that morphine dosage is calculated based on a patient's body weight, accuracy of measurement, communication of the weight between the nurse and the doctor and recording of it in a patient's medical record are all very important.

271 Without Dr Hassan recording David's weight in his patient records, the Post-it note technique relied upon at Gosnells Medical Clinic was clearly not best practice from a record keeping point of view.

272 David's weight was measured during the post mortem examination process and found to be 16kg.[151] Accordingly, concerns about a possible mistake by Nurse Mussa in taking his weight or a miscommunication between the nurse and Dr Hassan as to the measurement are not borne out.

Monitoring

273 Through his counsel, Dr Hassan accepted that David should have been monitored during and after his circumcision procedure in accordance with the PG09(G) Guideline on procedural sedation.[152]

274 The evidence of the experts in this matter was unequivocal and there is no doubt in my mind that monitoring should have taken place.

275 As asserted by Dr Farrell in her evidence, at a bare minimum David's baseline observations, taken before the procedure commenced, should

[149] T 191 – 192 (
[150] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024.
[151] Exhibit 1, Tab 5.1 Post Mortem Report of David FLYNN.
[152] Submissions on behalf of Dr Raad Hassan prepared by Paul Yovich SC filed 7 March 2025 p 5 – 6.

have included auscultation of the chest, listening to the heart and an oxygen saturation and heart rate reading. Once he was settled they might have also tried to get a blood pressure reading and respiratory rate.[153]

276 In accordance with the PG09(G) Guideline, the monitoring required during the procedure included continuous monitoring of oxygen saturation with pulse oximetry that alarms when pre-set limits are transgressed and continuous waveform capnography. There should also have been regular monitoring of pulse rate, oxygen saturation, blood pressure and respiration rate throughout the procedure and recovery phase.

Discharge

277 The most concerning of all Dr Hassan's clinical decision making in this matter was allowing Mrs Flynn to take David from Gosnells Medical Clinic while he was still deeply sedated.

278 Given that the peak effect for subcutaneous dosing of morphine is expected at 50 to 90 minutes post injection and the effects of morphine can last up to three to four hours, it is hard to comprehend the fact that David was discharged from the Clinic less than an hour and a half after he was administered the drug.

279 The inadequacy of Dr Hassan's conduct in not adhering to the discharge criteria set out in the PG09(G) Guideline has been accepted by him through his counsel.[154]

280 It is clear that David should have stayed at the Clinic until his cardiovascular function and airway patency were satisfactory and stable, he was easily arousable with his protective airway reflexes intact, he could talk and sit up unaided, and his state of hydration was adequate.[155]

281 Unfortunately, none of these discharge criteria were met when Mrs Flynn carried her deeply sedated child to the car at 2.07pm on 7 December 2021 and the consequence was devastating.

[153] T 22 (6/2/25).
[154] Submissions on behalf of Dr Raad Hassan prepared by Paul Yovich SC filed 7 March 2025, p 5.
[155] Exhibit 1, Volume 1, Tab 29 Report of Dr Tanya R Farrell MBBS FANZCA MBA, p 8.

Preventable death

282 I agree with the submissions filed on behalf of David's family that his death could have been avoidable if appropriate guidelines were followed.[156]

283 The three highly qualified medical practitioners who gave expert evidence at the inquest all agreed that, if David had been kept at Gosnells Medical Clinic after the procedure and monitored appropriately prior to discharge, his deterioration would have been identified and reversal of the developing opioid toxicity could have occurred. This would very likely have saved his life.[157]

Record keeping for Schedule 8 Medication

284 Pursuant to the *Medicines and Poisons Regulations 2016* (WA) (the Regulations) Dr Hassan was required to keep a Register recording each time he administered morphine to a patient at Gosnells Medical Clinic.

285 It has been conceded by Dr Hassan[158] that the Schedule 8 Register in use at the Clinic at the time of David's death did not comply with these record keeping obligations. It was the practice at the Clinic to only record newly opened ampoules of morphine in the Register. When morphine was drawn from opened ampoules for subsequent patients it was not recorded in the Schedule 8 Register but would be recorded in that patient's medical record. This is what occurred in David's case.

286 It is clear that Dr Hassan, as the health professional authorised to administer morphine and the holder of the required health service permit on behalf of Gosnells Medical Clinic, was in breach of the record keeping obligations imposed by the Regulations by maintaining an incomplete Schedule 8 Register.

287 While this breach is concerning, it must be acknowledged that it in no way contributed to the tragic outcome in this matter.

288 During the course of the inquest there was a significant focus on Dr Hassan's failure to comply with the section of the Department of Health's Guideline on administration and record keeping for Schedule 4

[156] Closing submissions on behalf of David's family prepared by Blumers Personal Injury Lawyers filed 7 March 2025 p2.
[157] T 36 Dr Farrell, T 58 Dr Gera, T 77 Professor Joyce (6/2/25).
[158]

Restricted and Schedule 8 medicines that advises that unused portions of ampoules of Schedule 8 medication should be discarded.[159]

289 This issue was raised with the Department of Health after the inquest and their response is detailed further on in this finding.

290 Following David's death, Dr Hassan requested that the Department of Health revoke his authorisation to possess and administer morphine.[160]

291 Dr Hassan no longer performs circumcision procedures.

REFERENCE TO DISCIPLINARY BODY

292 Section 50(1) of the Coroners Act, empowers a coroner to refer evidence to a body which has jurisdiction over a person carrying out a profession, if the evidence concerns the conduct of that person in carrying out their profession and, in the opinion of the coroner, the evidence is of such a nature as might lead the body to inquire into the person's conduct.

293 The Australian Health Practitioner Regulation Agency (AHPRA) is the body with oversight of medical practitioners.

294 I am satisfied that the evidence I have received in this matter concerning Dr Hassan's professional conduct warrants referral to AHPRA.

CONSIDERATION OF POSSIBLE CRIMINALITY

Consideration of criminal charges by Western Australia Police Force

295 Pursuant to section 53 of the Coroners Act, an inquest cannot proceed where a person has been charged with an offence in which the question as to whether the accused person caused a death is in issue. Therefore, it was important for the Court to know whether there was any likelihood that Dr Hassan would be charged with a criminal offence as a result of the investigation into David's death.

296 At the request of the State Coroner, Detective Senior Sergeant Hugh Le Tessier from the Western Australia Police Force Homicide Squad

[159] Exhibit 1, Volume 2, Tab 2 Department of Health Guideline on administration and record keeping for Schedule 4 Restricted and Schedule 8 medicines, p 4.
[160] Exhibit 1, Volume 1, Tab 22 Statement of Dr Raad HASSAN dated 24 April 2024, p 6.

undertook a review of whether there was any criminality in respect of Dr Hassan's involvement in David's death.[161]

297 Possible breaches of the *Criminal Code Act Compilation Act 1913* (WA) were considered. Given David's death occurred following a medical procedure, the review focussed on sections 259 and 265:

> **259 Surgical and medical treatment, liability for**
>
> (1) A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) —
>
> (a) to another person for that other person's benefit; or
>
> (b) to an unborn child for the preservation of the mother's life,
>
> if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.
>
> **265 Duty of person doing dangerous act**
>
> It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment (including palliative care) to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.

298 Detective Senior Sergeant Le Tessier undertook a comprehensive assessment of all the available materials and ultimately determined that, based on current legislation and case law, the criteria set out in the WA Police Prosecution policy and guidelines could not be met and charges would not be laid against Dr Hassan.

Possibility of report at the conclusion of the inquest

299 Under section 27(5) of the Coroners Act a coroner may make a report to the Director of Public Prosecutions if they believe an indictable offence has been committed, or to the Commissioner of Police if they believe a simple offence has been committed, in connection with a death which they have investigated.

[161] Exhibit 1, Volume 1, Tab 12 Memorandum from Detective Senior Sergeant Hugh Le Tessier 6552 Homicide Squad to State Coroner 'Review of reportable death investigation relating to child David Kalunda FLYNN'.

300 At the conclusion of the inquest, I advised the parties that the evidence I had heard over the course of the preceding two days did not cause me to change the preliminary view I held going into the inquest that I did not believe a report was warranted in this matter.[162]

COMMENTS IN RELATION TO NURSE MUSSA

301 Nurse Mussa's first job following graduation from her nursing studies was as a practice nurse with Gosnells Medical Clinic.[163]

302 When Nurse Mussa started at the Clinic in 2015 she was given on the job training by Dr Hassan and the more experienced practice nurse who already worked there. Given he was the only doctor at Gosnells Medical Clinic who performed the procedure, Dr Hassan taught her about her role in assisting him with circumcisions. It was the practice nurse who trained her and showed her how to set up the trolley for the procedure. However, that nurse left the Clinic a month or two after Nurse Mussa started. For a period after her departure, Nurse Mussa was the only practice nurse at Gosnells Medical Clinic[164]

303 As set out previously, record keeping obligations imposed by the *Medicines and Poisons Regulations 2016* (WA) in terms of maintaining a centralised register of administration of Schedule 8 medications at the Clinic was the responsibility of the authorised medical practitioner, Dr Hassan. Ideally, a registered nurse such as Nurse Mussa would have been aware of this record keeping obligation and considered raising it with Dr Hassan. However, I do not believe Nurse Mussa's failure to do so warrants harsh criticism in this instance.

304 I am heartened to learn about the lengths Nurse Mussa has gone to following David's death to inform herself in relation to Schedule 8 medications.[165]

[162] T 225 (7/2/25).
[163] Exhibit 1, Volume 1, Tab 21, Statement of Furqan MUSSA dated 13 December 2021.
[164] T 101 – 102 (7/2/25).
[165] Closing submissions on behalf of Nurse Furqan Mussa prepared by Panetta McGrath Lawyers filed 7 March 2025 p 3 – 4.

305 I will also reiterate the fact that the record keeping failures at Gosnells Medical Clinic when it came to morphine did not play in a role in David's death.

306 Turning to potential missed opportunities for Nurse Mussa to intervene in aspects of David's care on 7 December 2021, I am conscious of the context within which she was practising.

307 As set out by Nurse Mussa's counsel in written closing submissions, at a general practice such as Gosnells Medical Clinic, a practice nurse assumes responsibility for a wide range of nursing duties with on the job training and, often, minimal supervision. This can be distinguished from a hospital environment where nurses generally work in teams with defined areas of responsibility, more structured supervision and codified monitoring and discharge protocols.[166]

308 Nurse Mussa was also working in a hierarchical structure where established procedures went unquestioned. Given this was her first job as a registered nurse, she lacked knowledge of and exposure to other clinical settings that might have enabled her to identify and raise concerns about deficiencies with the procedures at Gosnells Medical Clinic[167].

309 When it came to David's circumcision procedure, Nurse Mussa did precisely as was asked of her by Dr Hassan and followed the exact procedure she had been taught and followed countless time before 7 December 2021.

310 I concur with the submission from Dr Hassan's counsel that Nurse Mussa:

> …followed the procedure laid down for circumcisions at the Gosnells Medical Clinic, including carefully weighing David, and accurately conveying David's weight to Dr Hassan before Dr Hassan administered the morphine to David".[168]

311 It has been conceded that Dr Hassan did not ensure the required observance of fasting protocols, implementation of peri and post-operative monitoring and compliance with discharge criteria when administering moderate to deep sedation to children undergoing

[166] Closing submissions on behalf of Nurse Furqan Mussa prepared by Panetta McGrath Lawyers filed 7 March 2025, p 2.
[167] Responsive submissions on behalf of Nurse Furqan Mussa prepared by Panetta McGrath Lawyers filed 25 March 2025, p 1.
[168] Submissions on behalf of Dr Raad Hassan prepared by Paul Yovich SC filed 7 March 2025, p 6.

circumcision procedures at Gosnells Medical Clinic. It follows that Nurse Mussa was not trained to comply with these three crucial aspects of safe procedural sedation in assisting Dr Hassan.

312 Nurse Mussa understands that her primary responsibility as a nurse is patient safety. She has demonstrated insight in identifying areas of her practice in relation to this matter which could have been better. They include, enforcing fasting protocols prior to the circumcision procedure (had she known they applied) and conducting post-operative monitoring of David prior to discharge. Nurse Mussa accepts that, while she was never directed to observe patients following a circumcision, there was no specific impediment which would have prevented her from performing her own observations.

313 Counsel for Nurse Mussa submitted the following contextual considerations to be borne in mind when assessing her professional conduct in this matter:

- she had limited clinical involvement in the treatment and care provided to David.
- she was never instructed by Dr Hassan or other Gosnells Medical Clinic staff about the need to perform postoperative observations on patients following morphine administration for circumcision procedures. Whilst she knew how to conduct postoperative observations, and had done so in respect of other procedures at Gosnells Medical Clinic, she had never been instructed to do so for these specific procedures.
- she has demonstrated significant insight into practice deficiencies and has actively pursued remedial education and practice improvements.
- she has applied these improved practices in her subsequent employment, demonstrating sustained commitment to practice improvement.[169]

314 Nurse Mussa left Gosnells Medical Clinic shortly after David's death and no longer works in a clinical setting. Her current role is predominantly administrative. I was left with no doubt as to the deep remorse and regret she feels in relation to David's death. She has clearly taken personal responsibility for her involvement. I am satisfied Nurse Mussa has reflected on her role in the care provided to David that day and will learn from and live with the missed opportunities forever.

[169] Closing submissions on behalf of Nurse Furqan Mussa prepared by Panetta McGrath Lawyers filed 7 March 2025, p 4 – 5.

PROPOSED RECOMMENDATIONS PUT FORWARD BY COUNSEL FOR DAVID'S FAMILY

315 Counsel for David's family proposed the following recommendations for consideration:

i. Clinical safety and quality standards should be monitored and enforced for primary health care providers performing surgical or other procedures involving opioid sedation of children.

ii. General practices using Schedule 8 medication on a regular basis should be subject to clinical audits.

iii. Clinicians involved in dispensing, witnessing and administering Schedule 8 medication should undergo mandatory regular training and certification.[170]

Consideration of first proposed recommendation with input from the Royal Australian College of General Practitioners

316 In terms of the first proposed recommendation, monitoring of clinical safety and quality standards for the vast majority of general practices in Australia occurs by way of triennial accreditation. This process requires practices to be assessed by an independent third party against the Royal Australian College of General Practitioners standards.

317 Following the inquest I sought the view of the RACGP, Western Australia as to whether the PG09(G) Guideline on procedural sedation applied to general practitioners, like Dr Hassan, performing procedural sedation.

318 In a letter from their WA State and GP Training Manager, it was confirmed that the RACGP was involved in the development of the PG09(G) Guideline which is intended to apply to all sedationists, including general practitioners.

[170] Closing submissions on behalf of David's family prepared by Blumers Personal Injury Lawyers filed 7 March 2025.

319 While endorsing the use of the PG09(G) Guideline use by their members, the RACGP noted:

> …that guidelines only provide a synthesis of evidence at a point in time and an opinion of the guideline leadership group in the form of recommendations. Guidelines do not define a set of rules that must be followed.

320 I understand and appreciate the response provided by the RACGP and do not intend to make a recommendation relating to this issue.

321 However, given the tragic, avoidable outcome in this matter I will forward this Finding to the RACGP, Western Australia and ask that they consider circulating it to their members along with a link to the Australian and New Zealand College of Anaesthetists PG09(G) Guideline on procedural sedation 2023.

Consideration of second and third proposed recommendations with input from the Department of Health

322 Proposed recommendations two and three were provided to the Department of Health (the Department) for their response.

323 In a letter from the Director General of the Department of Health dated 6 May 2025 the following information was provided:

> Registration in Australia with the Australian Health Practitioner Regulation Agency (AHPRA) requires health practitioners to meet minimum requirements of training and competence. For medical practitioners and nurses, this includes the storage, handling and use of Schedule 8 (S8) medicines.
>
> The *Medicines and Poisons Regulations 2016* authorise medical practitioners to possess, prescribe and administer medicines in S8 in the lawful practice of their profession. The authority allows individual medical practitioners to procure S8 medicines for the treatment of their patients but does not allow medicines to be shared across different practitioners in a clinic. Where a medical practice, such as Gosnells Medical Clinic has multiple practitioners, they require a permit, known as a health service permit, to procure medicines, including S8 medicines, for use by any prescribing practitioner within the practice.
>
> Assessment of applications for a health service permit to procure, store and use S8 medicines includes ensuring the proposed permit holder has knowledge of the requirements for storage and record keeping. As medical practitioners are permitted to conduct these activities under the regulations

> without a permit, they are considered equally suitable to hold a permit for a medical practice.

324 The Department's records in terms of permits held by Gosnells Medical Clinic are:

> On 7 February 2012, Dr Hassan applied for a health service permit on behalf of Gosnells Medical Clinic. This was initially granted for medicines up to Schedule 4 (S4) due to the lack of a compliant safe and was reissued to include S8 medicines in September 2012. The permit included a condition that S8 medicines are to be stored, recorded, and accessed in compliance with the Poisons Regulations. Advice was provided to Dr Hassan in November 2012 regarding sourcing a compliant S8 register for recording purposes.
>
> Each subsequent year, Dr Hassan signed a declaration requesting renewal and agreeing to comply with the requirements under the relevant legislation.
>
> In February 2022, Dr Hassan requested the removal of S8 medicines from the permit and completed the relevant paperwork to enact the change

325 It is clear from this information that Dr Hassan was on notice as to the requirement that Schedule 8 medications used at Gosnells Medical Clinic needed to be stored and recorded in accordance with the applicable legislation.

326 The Department was able to inform the Court that from January 2017, following the enactment of the *Medicines and Poisons Act 2014* (WA) (Medicines and Poisons Act), application forms for permits were revised to request detailed information from the applicant about how they intended to comply with the requirements under the Regulations in terms of storage and recording of medicines.

327 Interestingly, the response from the Department advised that the Guideline on administration and record keeping for Schedule 4 Restricted and Schedule 8 medicines:

> **is not intended for privately operated medical practices**. This Guideline is part of a suite of guidelines to support the Department of Health's Medicines Handling Policy, which is applicable to health care facilities operated by WA Health, such as public hospitals. **Although the Guideline is publicly available, general practices are not routinely advised of it.** [emphasis added]

328 This means that concerns raised in this matter about the failure to comply with Department's Guideline fall away.

329 In its response, the Department went on to explain:

> The Australian Commission on Safety and Quality in Healthcare (ACSQH), in collaboration with the Royal Australian College of General Practitioners (RACGP), provide the National General Practice Accreditation Scheme. This includes a series of self-assessments and independent assessments against the RACGP Standards for general practice. These standards include requirements to meet acquisition, use, storage and disposal of S4 and S8 medicines contained in legislation, although detail of the specific requirements is lacking. Gosnells Medical Clinic is listed as being accredited under this scheme.

330 Accredited general practices, such as Gosnells Medical Clinic, are tested against standards that include an understanding of and compliance with legislative obligations in relation to record keeping for Schedule 8 medication.

331 In response to the suggestion that a recommendation be made to ensure general practices using Schedule 8 medication on a regular basis are subject to clinical audits, the Department stated:

> The purpose of the *Medicines and Poisons Act 2014* is to regulate and control the manufacture and supply of medicines and poisons. It is outside the scope of the Act to assess the clinical practices of clinicians.
>
> The Department of Health does conduct audit and compliance activities regarding the Act, which can extend to those practices that hold a health service permit. Audits are scheduled according to the risk associated with the specific licence or permit type. The Department does conduct investigations in response to any notification of non-compliance, or concern regarding public safety.
>
> Medical practices are not otherwise required to seek a licence or permit to operate as a practice under State legislation.
>
> As outlined, the national accreditation scheme through ACSQH does provide a program of quality assurance, however, this is not a mandatory requirement to operate as a general practice.
>
> For these reasons, it is not considered reasonably practical or possible, under the current regulatory scheme, to conduct regular audits of all general medical practices in Western Australia.

332 The Department's response to the proposal that it be recommended that clinicians involved in dispensing, witnessing and administering Schedule 8 medication should undergo mandatory regular training and certification was as follows:

> Under the *Medicines and Poisons Act 2014,* health practitioners are not required to obtain additional qualifications or training to manage S8 medicines. AHPRA registration of health professionals is a National scheme, and it is not feasible to require practitioners to undergo training specific in order to practice in WA.
>
> Online resources are provided to support the practice of health practitioners which includes guidance for medical practitioner and nurses in the purchasing, storage and recording of S8 medicines. Witnessing administration of S8 medicines is not a requirement under the Act or Regulations.

333 On the basis of the comprehensive and compelling information provided by the Department, I do not intend to make proposed recommendation II and III.

334 The current system whereby the Department issues and renews health service permits for the possession, prescription and administration of Schedule 8 medicines ensures medical practitioners are aware of their obligations under the Medicines and Poisons Act and associated Regulations. The duty to uphold those obligations rests with the practitioner themselves.

REMEMBERING DAVID

335 After sitting through two days of very difficult evidence, Mr and Mrs Flynn were gracious enough to share an insight into their cherished, cheeky son David.

336 While a series of photographs of him with his siblings were shown to the Court, Mrs Flynn told us of the special bond David shared with older sister Casmy, older brother Phillip and younger brother Joseph. She also gave us the bittersweet news that David now has a younger sister who he will never meet in this life. Joseph, who is three years old, shows his baby sister photographs of David all the time. Phillip is seven and prays every day, looking forward to being reunited with David one day. Casmy has told her mother she thinks David went away because they used to fight too much over the remote control.

337 Mr and Mrs Flynn have been supported through their loss by the Zambian community they know through their church. David was loved by the community and he was a star performer when he attended church – singing and dancing and bringing joy. He loved going to church so much that he had to be bribed with the promise of ice cream to get him to leave.

338 Mr Flynn explained that David was a two year old who carried himself like a much older person. He was full of love and life and he is dearly missed.

339 A heartwarming video of David provided by the Flynns showed him playing the role of a pint-sized preacher delivering a pitch perfect sermon using his toothbrush as a microphone.

340 David lives on through his parents and his siblings who talk about him often and love to look at photographs and watch videos of him. David's family provided the Court with a picture of David and permission to include it in this finding.

341 David will never be forgotten. Nor should the lessons arising out of his death.

CONCLUSION

342 David was a much-loved child taken from his family in devastating circumstances.

343 He underwent a simple, elective procedure that is generally considered to be safe when performed on healthy children.

344 The critical issue in David's case arose out of to the administration of sedation in the form of morphine.

345 Procedural sedation, particularly in children, comes with significant known risks. These risks can be mitigated if the sedationist complies with requirements aimed at ensuring patient safety. Of particular relevance in this instance, is the need to ensure the setting in which the procedure occurs is appropriately staffed, equipped and set up, the patient is monitored peri and post-operatively and discharge criteria are strictly adhered to.

346 Dr Hassan failed in his professional duty to take the necessary measures to ensure David's safety on 7 December 2021. His oversights were inadvertent and he has acknowledged his shortfalls and expressed deep remorse for the catastrophic consequences.

347 I am acutely aware of the fact that general practitioners and practice nurses like Dr Hassan and Nurse Mussa work in busy environments with many competing demands. I also have no doubt that they entered their respective professions with a desire to help others and that David's death has impacted them profoundly.

348 To honour David's memory we must ensure that the lessons learnt from his death are shared and acted upon in the hope that no other family has to endure a loss like the one the Flynns must live with.

RM Hartley
Coroner
31 July 2025