JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	22 - 24 February 2023
DELIVERED	:	18 OCTOBER 2023
FILE NO/S	:	CORC 1560 of 2020
DECEASED	:	KEELEY, CORAZON CONTRERAS

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
W Stops assisted the coroner
D Harwood (State Solicitors Office) appearing on behalf of the North Metropolitan Health Service and South Metropolitan Health Service
J Johnson (Julian Johnson Lawyers) appearing on behalf of Wilora Keeley
S Denman (Denman Lawyers) appearing on behalf of Dr Kasina
E Panetta (Panetta McGrath) appearing on behalf of Dr Lo

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Corazon Contreras KEELEY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, from 22 - 24 February 2023, find that the identity of the deceased person was* ***Corazon Contreras KEELEY*** *and that death occurred on 27 July 2020 at Fiona Stanley Hospital, Murdoch, from complications of metastatic endometrial carcinoma, treated palliatively in the following circumstances:*

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
AHPRA	Australian Health Practitioner Regulation Agency
Briginshaw principle	The accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
cm	centimetres
CST	cervical screening test
CT	computerised tomography
EMR	Electronic Medical Record
FH	Fremantle Hospital
the Framework	the Australian Disclosure Framework
FSH	Fiona Stanley Hospital
FTE	Full Time Equivalent
g\dl	grams per decilitre
GP	general practitioner
Hb	haemoglobin
HDC	Hysteroscopy Dilation and Curettage
KEMH	King Edward Memorial Hospital
the KEMH clinic	the gynaecology oncology clinic at KEMH
mm	millimetres
NICE guidelines	the National Institute for Health and Care Excellency guidelines (in England)
the panel	the panel of experts that prepared the SAC 1 report
PET	positron emission tomography
the SAC 1 report	the clinical incident investigation report
SCGH	Sir Charles Gairdner Hospital
SMHS	South Metropolitan Health Service
TCON	the Tumour Conference at KEMH

INTRODUCTION

"An expert is someone who knows some of the worst mistakes that can be made in his subject and who manages to avoid them."
Werner Heisenberg (1901-1976), mathematical physicist

1 The deceased (Ms Keeley) died on 27 July 2020, at Fiona Stanley Hospital (FSH), Murdoch, from complications of metastatic endometrial carcinoma.

2 Ms Keeley's death was a reportable death within the meaning of section 3 of the *Coroners Act 1996* (WA) (the Act) as it was unexpected. However, an inquest into her death was not mandatory as it did not fall within any of the circumstances set out in section 22(1) of the Act.

3 Nevertheless, on 11 November 2022, the Deputy State Coroner determined that an inquest into Ms Keeley's death was desirable pursuant to section 22(2) of the Act in order to investigate the standard of the medical care and treatment provided to Ms Keeley for her endometrial carcinoma.

4 I held an inquest into Ms Keeley's death at Perth on 22 - 24 February 2023. The following witnesses gave oral evidence:

(i) Dr Winnie Lo (Ms Keeley's general practitioner);
(ii) Dr Chandra Diwakarla (Consultant in Medical Oncology at FSH);
(iii) Dr Venkata Kasina (Consultant Obstetrician and Gynaecologist at FSH);
(iv) Dr Oley Dronov (Registrar, Obstetrics and Gynaecology at FSH);
(v) Associate Professor Emma Allanson (Consultant Gynaecologic Oncologist at King Edward Memorial Hospital);
(vi) Dr John Anderson (Deputy Director of Clinical Services for Fiona Stanley Fremantle Hospital Group);
(vii) Associate Professor Robert Rome (independent Consultant Gynaecological Oncologist); and
(viii) Dr Claire Hoad (Resident Medical Officer at FSH)

5 The documentary evidence at the inquest comprised of two volumes that were tendered as exhibit 1 at the commencement of the inquest, and a report from Associate Professor Peter Grant that was tendered during the inquest and became exhibit 2.

6 During the inquest, I requested two further documents from the South Metropolitan Health Service (SMHS) that were subsequently provided after the inquest had finished.[1] One document was Department of Health's Open

[1] ts 24/2/23, pp.328-329

Disclosure Policy regarding communication and disclosure requirements for health professionals in existence at the time of Ms Keeley's treatment (exhibit 3). The second document was the relevant Medical Professional Standards that applied at the time of Ms Keeley's treatment. This document was Fiona Stanley Fremantle Hospital Group's Medical By-Laws (exhibit 4). In addition, I was provided with a copy of the Australian Open Disclosure Framework that existed in 2020 (exhibit 5).

7 I also required a statement from Dr Padma Jatoth (Dr Padma), a Consultant Obstetrician and Gynaecologist at FSH, regarding her recollection of the conversations Dr Oley Dronov (Dr Dronov) said he had with her on 10 March 2020.[2] Dr Padma subsequently provided a statement dated 8 May 2023 to the Court which became exhibit 6.

8 On 26 September 2023, I was provided with a detailed electronic statement from Ms Keeley's daughter, Wilora Keeley, which addressed a broad range of matters.

9 My primary function has been to investigate the death of Ms Keeley. It is a fact-finding function. Pursuant to section 25(1)(b) and (c) of the Act, I must find, if possible, how Ms Keeley's death occurred and the cause of her death. Given the known circumstances in this matter, those findings can be made without difficulty.

10 The inquest particularly focused on the adequacy of the medical care and treatment provided to Ms Keeley during the period from 24 September 2019 to the end of March 2020.

11 Pursuant to section 25(2) of the Act, I may comment on any matter connected to Ms Keeley's death, including public health or safety or the administration of justice. This is an ancillary function of a coroner.

12 Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any civil liability or suggest a person is guilty of an offence arising from the death being investigated. It is not my role to assess the evidence for civil or criminal liability and I am not bound by the rules of evidence.

13 In making my findings I must be mindful of the standard of proof set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).

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[2] ts 24/2/23, pp.327-328

14 I am also mindful not to insert any hindsight bias into my assessment of the actions taken by health service providers in their treatment and care of Ms Keeley. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[3]

15 In addition, I must note that part of Ms Keeley's treatment took place during the emerging stages of the COVID-19 pandemic. This was a very difficult and challenging time for hospitals and their staff as they navigated the balancing act of providing optimal care for patients and preventing a potentially deadly outbreak of a virus within a hospital setting.

MS KEELEY [4]

16 Ms Keeley was born on 25 July 1949 in Manila, The Philippines. She was 71 years old at the time of her death.

17 Ms Keeley was married with one daughter. She met her husband in The Philippines after they had been pen pals together. They remained as a couple for 38 years. Ms Keeley moved to Western Australia in about 1982. She had a business degree and was employed as a translator before she retired.

18 Ms Keeley was an active churchgoer who enjoyed arts and crafts, pottery, gardening and socialising with friends. In her retirement, she had become a carer for elderly people, acting as their driver and spending time with them.

19 Towards the end of her life, Ms Keeley also became the primary carer for her husband who had early stage dementia and mobility issues.

OVERVIEW OF THE CARE AND TREATMENT PROVIDED TO MS KEELEY

24 September 2019 - 16 November 2019 [5]

20 In September 2019, Ms Keeley began experiencing vaginal bleeding. On 24 September 2019, she saw her general practitioner, Dr Winnie Lo (Dr Lo). After taking Ms Keeley's history, Dr Lo considered it might be thrush or post-menopausal bleeding. Dr Lo took some swaps for microbiology and requested a pelvic ultrasound. The results of the microbiology examination were normal, with no evidence of any infection.

21 The pelvic ultrasound scan was performed on 2 October 2019. Included in the findings was: "*The endometrium is thickened for post-menopausal status*

[3] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[4] Exhibit 1, Volume 1, Statement of Wilora Keeley dated 10/8/2020
[5] Exhibit 1, Volume 1, Tabs 9.1-9.11, GP Progress Notes and relevant Hospital Records Extracts between September 2019 and November 2019

and measures 18 mm. It is heterogeneous. Vascularity is demonstrated within the endometrium." The endometrium is the lining of the womb, and for a person of Ms Keeley's age it is normally less than 5 mm in thickness. The radiologist further noted: "*Heterogeneous and hypervascular with thickening of endometrium. Patient is post-menopausal. Suggest a gynaecologist review to further evaluate for endometrial neoplasia.*"[6] As was explained at the inquest, because the patient was post-menopausal, the thickening of the endometrium had to be further investigated in case it was a carcinoma.[7] In cases such as these, 10% turn out to be an endometrial cancer.[8]

22 On 4 October 2019, Ms Keeley saw Dr Lo to discuss the ultrasound findings. Dr Lo wrote a referral to the gynaecology clinic at Fremantle Hospital for further management of Ms Keeley's post-menopausal bleeding and the endometrium thickening. Due to computer issues at her practice, Dr Lo was not able to forward her referral until the next working day, which was 7 October 2019.

23 On 18 October 2019, Ms Keeley had another appointment with Dr Lo due to ongoing bleeding. As the gynaecology clinic at Fremantle Hospital had not replied to her referral, Dr Lo re-sent it.

24 On 5 November 2019, Ms Keeley was seen by Dr Ashleigh Evans (Dr Evans), a resident medical officer at the gynaecology clinic at FSH. Dr Evans obtained a history and performed an examination, and then had a discussion with Dr Rae Watson-Jones, an Obstetrics and Gynaecology Consultant. It was planned that Ms Keeley would have a Category 1 Hysteroscopy Dilation and Curettage (HDC) at Fremantle Hospital. A Category 1 classification meant that the procedure was urgent and was to be completed within 30 days. The procedure was booked for 29 November 2019 and was therefore within the timeframe.

25 On 15 November 2019, Ms Keeley presented to the emergency department at FSH with ongoing vaginal bleeding and anxiety regarding her upcoming procedure. Her haemoglobin (Hb)[9] level was normal and she was advised that the earliest date the procedure could be performed was the scheduled date of 29 November 2019.

26 On 16 November 2019, Ms Keeley saw Dr Lo and said that as her bleeding had been occurring for two months, she wanted an earlier HDC procedure. Dr Lo advised that if the bleeding became severe, Ms Keeley should reattend

[6] Exhibit 1, Volume 1, Tab 9.2, Perth Radiological Clinic Results
[7] ts 22/2/23, (Dr Lo), p.16
[8] ts 22/2/23, (Dr Kasina), p.73
[9] Abbreviation for haemoglobin, which is the protein in red blood cells that is responsible for oxygen delivery to body tissues.

an emergency department. However, unless she was admitted to a hospital, she would not be able to get the HDC procedure performed before 29 November 2019.

29 November 2019: Dr Kasina performs the first HDC procedure [10]

27 On 29 November 2019, Dr Venkata Kasina (Dr Kasina), a Consultant Obstetrician and Gynaecologist, performed the HDC procedure for Ms Keeley at Fremantle Hospital.

28 Dr Kasina documented the uterine cavity was "*smooth and regular*" and that samples had been taken of the endometrium for histopathology examination. Dr Kasina concluded that the HDC procedure was "*routine*", and noted the plan was to review the results of the histopathology with Ms Keeley at his clinic in three to four weeks.

29 On 4 December 2019, Ms Keeley had an appointment with Dr Lo and said she was still experiencing heavy vaginal bleeding intermittently. She also advised Dr Lo that she would be seeing the gynaecologist at his clinic for the histopathology results in three weeks.

Results from the first histopathology [11]

30 Four business days after the HDC procedure, the histopathology report was prepared (5 December 2019). The conclusion from the microscopic examination of the endometrial curetting stated: "*Endometrial curetting – Almost entirely infarcted polypoid tissue with possible atypical glandular epithelium. However, interpretation limited by the extensive necrosis and further sampling is necessary for diagnosis*" (underlining added). The presence of atypical glandular epithelium may indicate endometrial cancer and this was why it was recommended that further sampling was necessary.

31 Dr Lo's medical centre received a copy of the histopathology results on 13 December 2019. The medical centre advised Ms Keeley by text message to make an appointment with her GP to discuss the results.[12]

32 Ms Keeley saw Dr Lo on 16 December 2019. Dr Lo advised that the results from the histopathology showed a necrotic polyp but otherwise there were no obvious abnormalities. Ms Keeley said she was still experiencing intermittent heavy vaginal bleeding and that she was due to see Dr Kasina at the end of the month for a review and further management.[13]

[10] Exhibit 1, Volume 1, Tab 9.12, Post-Operation Report dated 29 November 2019
[11] Exhibit 1, Volume 1, Tab 9.14, PathWest Histopathology Report dated 5/12/2019
[12] Exhibit 1, Volume 1, Tab 9.15, Progress Notes for Ms Keeley dated 13/12/2019
[13] Exhibit 1, Volume 1, Tab 9.15, Progress Notes for Ms Keeley dated 16/12/2019

33 At this appointment, Dr Lo did not advise Ms Keeley that the histopathology results raised the possibility she may have endometrial cancer. Dr Lo's explanation for that is the results had not confirmed the polypoid tissue was cancerous, and given Ms Keeley's already high level of anxiety, she did not want to increase her concerns.[14] As Dr Lo said at the inquest, "*there's no evidence to say it is definite cancer.*"[15]

Dr Kasina's actions upon receipt of the histopathology results [16]

34 The histopathology results only came to the attention of Dr Kasina on 18 December 2019 when he reviewed Ms Keeley's file in his clinic. On that same day, he dictated and then electronically approved, a letter to Ms Keeley's GP. The letter was incorrectly addressed to a doctor at a medical centre in East Victoria Park. This doctor had been Ms Keeley's GP back in 2013.[17] This letter stated:

> Further to the follow-up of her hysteroscopy D & C and polypectomy at Corazon [sic] at Fremantle Hospital on 29 November 2019, her test results had come back as nil abnormal. It is benign polypoidal tissue, which is infarcted, hence she does not need any further gynaecology clinic appointments at Fiona Stanley Hospital.
>
> She will be attending you for further general care and follow-up. Thank you for your ongoing care.

35 Dr Kasina did not notice the letter was not addressed to Ms Keeley's current GP. However, the inquest heard evidence that for these letters, the GP and their address would be automatically populated from hospital records.[18] Dr Kasina did, however, leave a voicemail message on Ms Keeley's phone as telephone contact was standard practice for "non-concerning" histopathology results. Dr Kasina also copied his letter of 18 December 2019 to Ms Keeley.

36 On 30 December 2019, the medical centre in East Victoria Park forwarded Dr Kasina's letter to Dr Lo's medical centre via facsimile transmission.

31 December 2019: Ms Keeley's appointment with Dr Lo [19]

37 On 31 December 2019, Ms Keeley had a long consultation with Dr Lo. The histopathology results and the contents of the letter from Dr Kasina were discussed. However, Dr Lo noted the following:

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[14] ts 22/2/23 (Dr Lo), p.25
[15] ts 22/2/23 (Dr Lo), p.26
[16] Exhibit 1, Volume 1, Tab 9.19, Letter from Dr Venkata Kasina to Dr John Bourke dated 18/12/2019; Exhibit 1, Volume 1, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023
[17] Exhibit 1, Volume 1, Tab 15.1, Letter from Associate Professor Robert Rome dated 31/8/2022
[18] ts 24/2/23 (Dr Hoad), p.340
[19] Exhibit 1, Volume 1, Tab 9.20, Progress Notes dated 31/12/2019; Exhibit 1, Volume 1, Tab 9.22, Letter from Dr Winnie Lo to the gynaecology clinic at Fremantle Hospital dated 7/10/2019 (this letter has the incorrect date, the correct date was most likely 7/1/2020)

(i) Ms Keeley's vaginal bleeding was still ongoing;

(ii) she reported being tired; and

(iii) her Hb level of 118 g/dl[20] was "*borderline low*".

38 In those circumstances, Dr Lo decided to refer Ms Keeley back to the gynaecology clinic at Fremantle Hospital. The referral letter requested that Ms Keeley's post-menopausal bleed be reviewed and further management be undertaken to stop the bleeding.

39 Dr Lo's referral was classified as a Category 1 at the gynaecology clinic. However, due to the clinic's capacity issues, Ms Keeley was not seen until six weeks later. This was outside the 30 day period for Category 1 matters.

19 February 2020: Ms Keeley's appointment at FSH gynaecology clinic [21]

40 On 19 February 2020, Ms Keeley attended the gynaecology clinic at FSH. She was examined by Dr Claire Hoad (Dr Hoad), a resident medical officer at the clinic. Dr Hoad reviewed Ms Keeley and took her history. Dr Hoad had also reviewed the histopathology report dated 5 December 2019.

41 During her review of Ms Keeley, Dr Hoad held discussions with Dr Kasina. As set out in a letter to Dr Lo dated 19 February 2020, the following plan was formulated:

> Ms Keeley was discussed with Dr Kasina and it was decided she would have repeated hysteroscopy D & C at Fremantle Hospital. She has been booked as a Category 1 case and has been given a pathology form for bloods prior to the procedure. The procedure was discussed with Ms Keeley, she has consented and is happy with the plan. A plan for a follow-up will [be] made at the time of the procedure.

42 This letter from Dr Hoad, which had been reviewed by Dr Kasina before it was sent, did not refer to or explain the delay to follow-up the recommendation made in the earlier histopathology report that further sampling was required due to the finding of "*possible atypical glandular epithelium*".

28 February 2020: Dr Kasina performs another HDC procedure [22]

43 Ms Keeley's second HDC procedure took place on 28 February 2020 at Fremantle Hospital. Dr Kasina again performed the procedure, which was observed by Dr Dronov as part of his training. It was documented an

[20] The amount of haemoglobin in blood is expressed in grams per decilitre (g/dl)

[21] Exhibit 1, Volume 1, Tab 22, Letter from FSH gynaecology clinic to Dr Lo dated 19/2/2020;
Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023; Exhibit 1, Volume 2, Tab 7, Statement of Dr Claire Hoad dated 14/2/2023

[22] Exhibit 1, Volume 1, Tab 9.24, Discharge Summary dated 29/2/2020 and Operation Report dated 28/2/2020

ectocervical polyp was removed and that the uterine cavity was "*smooth and regular*". The endometrium was curetted for histopathology. The post operative period was reported as uncomplicated and Ms Keeley was discharged the next day.

44 Dr Kasina noted the plan was to review Ms Keeley's records at either of his outpatient clinics in three to four weeks. Ms Keeley advised that she wanted to be contacted on her mobile telephone for the histopathology results.

45 On 6 March 2020, Mr Keeley saw Dr Lo for another lengthy consultation. She complained of lower abdominal pain since the second HDC procedure and dizziness with headaches. It was noted she was waiting for a gynaecology follow-up.

Results from the second histopathology [23]

46 Although the histopathology report was dated 4 March 2020, it was not validated until 9 March 2020. The conclusion from the microscopic examinations of the ectocervical polyp and endometrial curetting taken during the second HDC procedure stated that both showed "*high grade undifferentiated malignancy*". In layperson's terms, this meant a fast progressing cancer.[24]

47 The report also said that further testing would be performed at another site for an opinion, and a supplementary report will follow when these tests were completed.

48 The findings of that supplementary report did not provide any additional information to the earlier conclusion of a high grade undifferentiated malignancy.[25]

Notifying Ms Keeley of the histopathology results [26]

49 Dr Dronov had a rostered day off on 9 March 2020 when he received a telephone call from PathWest advising that the histopathology results indicated Ms Keeley had cancer.

50 Dr Dronov forwarded an email to Dr Kasina advising him that Ms Keeley's "*pathology results were reported to be malignant*". Dr Dronov received an automated response from Dr Kasina's email address advising he was on leave

[23] Exhibit 1, Volume 1, Tab 9.28, PathWest Histopathology Report dated 4/3/2020
[24] ts 22/2/23 (Dr Lo), p.34
[25] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, attachment 6
[26] Exhibit 1, Volume 1, Tab 9.31, Progress Notes dated 17/3/2020; Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023 with attachments; Exhibit 1, Volume 2, Tab 8, Statement of Dr Oleg Dronov dated 16/2/2023 with attachments

and not returning to work until "*18/02/2020*"[sic]. This was an error as the date Dr Kasina was returning from leave was 18 March 2020.

51 Dr Dronov then called the on-call registrar and he was advised to:

(i) do an e-referral to the gynaecology and oncology service at King Edward Memorial Hospital (KEMH);

(ii) send a referral for CT scans of Ms Keeley's abdomen, pelvis and chest; and

(iii) arrange an urgent outpatient appointment for Ms Keeley.

52 Dr Dronov did not have remote access to BOSSnet,[27] and as referrals are generated through this system, Dr Dronov advised the on-call registrar he would perform those tasks when he attended work the next day. On 10 March 2020, Dr Dronov completed these tasks. The e-referral to KEMH also requested that it's gynaecology and oncology service takes over the management of Ms Keeley.

53 It is Dr Dronov's account[28] that on 10 March 2020, he also spoke to Dr Padma, the on-call Obstetrics and Gynaecology Consultant at FSH, about the histopathology results. As it is not a hospital's standard practice to advise a patient of a cancer diagnosis over the telephone, Dr Padma advised Dr Dronov to call Ms Keeley and ask her to attend the gynaecology clinic at FSH.

54 Dr Dronov subsequently telephoned Ms Keeley and said that she needed to attend the clinic to discuss the results of the histopathology. He advised Ms Keeley he had requested an appointment for the next day but that might not be possible, and an administrative staff member would contact her with a confirmed date and time. Dr Dronov also advised Ms Keeley he had made a referral to KEMH and that she would be contacted by KEMH regarding an appointment. He also mentioned the arrangements he had made for her to have the additional CT scans.

55 Dr Dronov's account is that he then had a further conversation with Dr Padma on 10 March 2020. In that conversation, Dr Padma indicated that as Dr Kasina was due back from leave soon, Ms Keeley should be given an appointment to see him personally. On the material before me, there is no evidence that an appointment was made for Ms Keeley to attend either the

[27] The Department of Health's digital health record system

[28] Certain aspects of conversations Dr Dronov says he had with Dr Padma on 10 May 2020 are not accepted by Dr Padma and this is dealt with later in my finding

gynaecology clinic at FSH or the one at Fremantle Hospital before Dr Kasina was due to return from leave on 18 March 2020.[29]

56 On 11 March 2020, Dr Dronov dictated a letter to Dr Lo. In that letter Dr Dronov included the operation report for the second HDC procedure and the histopathology results dated 5 March 2020. The letter also advised that Dr Kasina was currently on leave and that a telephone call had been made to Ms Keeley to attend the gynaecology clinic at FSH for a "*tentative appointment*" on 25 March 2020 when Dr Kasina had returned from leave.

57 Although a transcription service types up a letter such as this within a day or two, it is then sent back to the writer for review. In this instance, the letter then had to be forwarded to Dr Kasina, the authorising consultant, for approval before it is sent. As Dr Kasina did not return from leave until 18 March 2020, this letter was not sent to Dr Lo until the afternoon of 20 March 2020. It was sent by facsimile transmission.

58 Although Dr Lo's medical centre did not receive Dr Dronov's letter until 20 March 2020, Dr Lo was aware of the histopathology results before then. On 17 March 2020, Ms Keeley saw Dr Lo and the results of the histopathology were discussed, including the high grade undifferentiated malignancy.

59 Dr Lo was the first doctor who spoke to Ms Keeley about the diagnosis of her endometrial carcinoma.

Outcome of further CT scanning [30]

60 As it was through the public system, Dr Dronov's referral for CT scanning of Ms Keeley's abdomen, pelvis and chest was not scheduled until 1 April 2020.[31] Hence, it had not taken place by 17 March 2020. Dr Lo, however, requested this same scanning through the private system and that was performed by the Perth Radiological Clinic the next day, on 18 March 2020. The CT report stated:[32]

> 1. Large pelvic mass measuring up [to] 75 mm abutting both the fundus of the uterus and likely also the left adnexa, concerning for either an ovarian or endometrial malignancy.
> 2. Marked left para-aortic lymphadenopathy.

[29] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, pp.5-6
[30] Exhibit 1, Volume 1, Tab 9.32, Progress Notes dated 17/3/2020; Exhibit 1, Volume 1, Tab 9.33, Perth Radiological Clinic CT Scans on 18/3/2020
[31] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.6
[32] Exhibit 1, Volume 1, Tab 9.33, Perth Radiological Clinic CT Scans on 18/3/2020, pp.1-2

3. Partial obstruction of the left ureter with moderate left hydronephrosis. There is filling of the distal ureter on delayed images although with a slight lag compared to the right.
4. No demonstrated pulmonary metastasis.

61 At the inquest, Dr Lo summarised these findings as, "*the cancer is there and it is progressing and it has got to the lymph nodes.*"[33]

62 On 20 March 2020, Ms Keeley had another appointment with Dr Lo which involved a lengthy consultation. Dr Lo outlined and explained the results from the latest CT scanning. Dr Lo forwarded the CT report to the gynaecology clinic at FSH for follow-up at Ms Keeley's appointment with Dr Kasina on 25 March 2020.

25 March 2020: Ms Keeley's appointment with Dr Kasina [34]

63 The first appointment Ms Keeley had with any doctor from the genealogical clinics at FSH or Fremantle Hospital since the results became available from the second histopathology was with Dr Kasina on 25 March 2020. This was one week after Dr Kasina had returned from leave, eight days after Dr Lo had advised Ms Keeley of the results and 16 days after the histopathology results had been validated.

64 Dr Kasina told Ms Keeley what she already knew; namely, that she had an undifferentiated high grade malignancy. He did not disclose or apologise to Ms Keeley that he had failed to immediately recommend she undergo a second HDC procedure after he had seen the results from the first histopathology on 18 December 2019.

65 After reviewing imaging of the CT scans taken on 18 March 2020, Dr Kasina organised a CT intravenous pyelogram[35] and a positron emission tomography (PET) scan of the entire body for Ms Keeley. Dr Kasina was of the view that this would help with the ongoing management of Ms Keeley by the gynaecology oncology service at KEMH.

66 The above information was dictated by Dr Kasina on 31 March 2020 and the letter was then forwarded by facsimile transmission to Dr Lo on 2 April 2020. The final sentence of the letter read: "*I am discharging her from gynaecology clinic but will be closely following up.*" A copy of the letter was also sent to the gynaecology oncology service at KEMH.

[33] ts 22/2/23, (Dr Lo), p.37
[34] Exhibit 1, Volume 1, Tab 9.38, Letter from Dr Venkata Kasina to Dr Winnie Lo dated 31/3/2020
[35] An examination that uses an injection of contrast material into the veins followed by CT imaging to evaluate, in this instance, the ureter

67 On 30 March 2020, Ms Keeley had her last appointment with Dr Lo. Once more, it was a lengthy consultation and Dr Lo noted Ms Keeley was not sleeping well, that she continued to have abdominal pain and she was experiencing symptoms of depression and anxiety.[36]

The gynaecology oncology service at KEMH takes over Ms Keeley's treatment [37]

68 All patients with a pathologically confirmed gynaecological malignancy are referred to the gynaecology oncology service at KEMH. A malignancy is "pathologically confirmed" when a tissue diagnosis is obtained and reported as malignant by a histopathologist. Consequently, the e-referral by Dr Dronov to the gynaecology oncology clinic at KEMH (the KEMH clinic) on 10 March 2020 was appropriate.

69 On 19 March 2020, the KEMH clinic triaged Ms Keeley as Category 1. Ms Keeley was then allocated an appointment for 9 April 2020 at the KEMH clinic as a new referral patient. This was within the 30 day period.

70 On 2 April 2020, Ms Keeley's history and findings were discussed at the Tumour Conference at KEMH (TCON). TCON is a multi-disciplinary team comprising of gynaecological oncologists, medical oncologists, radiation oncologists, pathologists, radiologists, geneticists and nursing staff. All new cases are discussed at TCON for review and assessment of treatment plans.

71 The treatment plan for Ms Keeley was for a review of the metastatic workup at the forthcoming radiology meeting. After that, Ms Keeley would be seen and assessed for a total laparoscopic hysterectomy with bilateral salpingo oophorectomy and sentinel lymph node dissection.

72 On 3 April 2020, the PET scan organised by Dr Kasina showed activity within the uterus, left adnexa mass, right adnexal lesion and external iliac lymph nodes. As this scan showed highly metabolic active tissue, it confirmed the presence of cancer in these areas.

73 On 6 April 2020, the results from the CT intravenous pyelogram that was also organised by Dr Kasina became available. This scan showed left hydronephrosis due to a bulky mass partially occluding the mid-ureter and integral progression of disease.

74 A TCON review was undertaken for Ms Keeley on 9 April 2020. Ms Keeley was considered presently unsuitable for surgery due to the presence of the bulky nodal disease. Her unsuitability was because the degree of surgical morbidity was deemed to be unacceptably high. In such cases, it is standard

[36] Exhibit 1, Volume 1, Tab 9.35, Progress Notes dated 30/3/2020
[37] Exhibit 1, Volume 2, Tab 12, Statement of Associate Professor Emma Allanson dated 21/2/2023 with attachments

oncological procedure to administer chemotherapy to then enable possible surgical cytoreduction (surgery to decrease the amount of cancer).

75 The plan devised by TCON was for referrals to be made to medical oncology at Sir Charles Gairdner Hospital (SCGH) for chemotherapy, and for Ms Keeley to undergo interval imaging and review at TCON.

76 Given the findings of the latest scans, the specialists treating Ms Keeley noted that the overall survival rate for all endometrial cancers with para-aortic nodal disease was, at best, 30% at five years. Consequently, the intent of the treatment for Ms Keeley was considered to be palliative. This meant, while all attempts were made with the use of multi-model therapy (i.e. chemotherapy, surgery, radiotherapy), the likelihood of achieving a cure for Ms Keeley was considered low.

7 April 2020: Ms Keeley's admission to FSH [38]

77 On 7 April 2020, Ms Keeley attended the emergency department at FSH with suprapubic and lower back pain. She underwent a cystoscopy and ureteric stent insertion to unblock the ureter.

78 Whilst still an inpatient at FSH, Ms Keeley had a telephone consultation with a gynaecological oncologist at KEMH. Ms Keeley was advised that her disease was extensive and she was presently at Stage 4 uterine cancer. After three cycles of neoadjuvant chemotherapy, the possibility of surgery would be reconsidered.

79 On 17 April 2020, an e-referral was sent to radiology oncology at FSH for further management as Ms Keeley continued to have vaginal bleeding and her Hb levels had dropped. She was discharged on 19 April 2020, and was prescribed morphine for pain relief.

80 Ms Keeley's treatment plan was to commence outpatient chemotherapy at SCGH, undergo radiotherapy, and for Silver Chain Hospice to provide care in the community.

22 April 2020: Ms Keeley's second admission to FSH [39]

81 On 22 April 2020, Ms Keeley again attended the emergency department at FSH after a fall. Her vaginal bleeding and abdominal pain was still ongoing and she had confusion and drowsiness. X-rays revealed no fractures from her

[38] Exhibit 1, Volume 1, Tabs 9.39-9.42, FSH Emergency Medicine Summary, Letters to Dr Oleg Dronov dated 8/4/2020, 9/4/2020 and 15/4/2020

[39] Exhibit 1, Volume 1, Tab 9.43, FSH Emergency Medicine Summary; Exhibit 1, Volume 1, Tab 9.44, Amended Discharge Summary from FSH dated 6/5/2020

fall. Ms Keeley was admitted shortly after her attendance at the emergency department.

82 During her admission, Ms Keeley was reviewed by an oncologist and received palliative radiotherapy. She also commenced her first cycle of chemotherapy as an inpatient on 24 April 2020.

83 Ms Keeley was discharged from FSH on 6 May 2020.

Ms Keeley's chemotherapy [40]

84 On 5 June 2020, Ms Keeley completed her third cycle of chemotherapy. Although Ms Keeley had some difficulties tolerating her treatment, CT imaging on 17 June 2020 showed a significant response to the chemotherapy with a reduction in the size of the left para-aortic soft tissue density and the previous noted mass within the uterus had also decreased significantly. No new metastasis was identified.

85 In the circumstances, it was considered Ms Keeley could now be a suitable candidate for surgical intervention. Although no date had been scheduled, the plan was for this surgery to take place sometime over the forthcoming weeks. Regrettably, that plan was to be overridden by other factors.

EVENTS LEADING TO MS KEELEY'S DEATH

Hospital admissions from 5 July 2020 [41]

86 On 5 July 2020, Ms Keeley presented to the emergency department at KEMH with increasing lower abdominal pain. She was admitted and underwent surgery on 7 July 2020 that involved a laparotomy (removal of the womb), radical hysterectomy (removal of the fallopian tubes), bilateral salpingo oophorectomy (removal of the ovaries) and omentectomy (removal of omentum). Unfortunately, the tumour was noted to be invading the aorta and left psoas muscle which could not be surgically removed.

87 Post operatively, Ms Keeley's condition deteriorated and she developed numerous complications. These included ileus, anaemia (which required blood transfusions), abnormal liver functioning, fever (for which she was commenced on intravenous antibiotics), delirium, hypertension, obstruction of the duodenum and significant pain.

88 As there was no CT scanning machine at KEMH, Ms Keeley was taken to SCGH for a CT scan on 15 July 2020. This was because her Hb levels had

[40] Exhibit 1, Volume 1, Tab 9.52, Letter from Dr Chandra Diwakaria to Dr Winnie Lo dated 25/6/2020
[41] Exhibit 1, Volume 1, Tabs 9.53-9.58, Various Hospital Records Extracts; Exhibit 1, Volume 2, Tab 12, Statement of Associate Professor Emma Allanson dated 21/2/2023

dropped and there were concerns she may have internal bleeding. The CT scan did not show active intra-abdominal bleeding. However, it did confirm further progression of the cancer due to the increase of the size and number of the para-aortic nymph nodes.

89 By mid-July 2020, it was confirmed Ms Keeley's diagnosis was now at stage 4B on the endometrial cancer staging. This was the highest stage and indicated the presence of distant metastasis, including abdominal metastases. It meant that Ms Keeley's cancer was rapidly progressing and that further surgical intervention was not going to provide a cure. As Associate Professor Emma Allanson, Consultant Gynaecologic Oncologist at KEMH, noted: "*The teams caring for Ms Keeley were ultimately outrun by the biology of a histologically aggressive disease*".[42]

90 On 17 July 2020, the gynaecology oncology team had a detailed discussion with Ms Keeley's daughter which included explanations as to the high grade of Ms Keeley's tumour and that her treatment plan was to include palliative care.

91 On 20 July 2020, Ms Keeley developed increased confusion and abdominal distention with vomiting. She was taken by ambulance from KEMH to SCGH for another CT scan which identified a bowel obstruction.

92 On 21 July 2020, Ms Keeley reported that she knew she could not be cured and expressed a wish that she did not want to be in hospital when she died.

93 On 23 July 2020, a family meeting, including Ms Keeley, was held with the gynaecologic oncology consultants. It was explained there were very limited treatment options and that Ms Keeley needed to be reviewed by radiation oncology to consider whether palliative radiotherapy to relieve her gastric obstruction was possible. The family was informed that even with radiation, Ms Keeley's tumour would continue to progress, and the option of further chemotherapy was considered unsuitable given Ms Keeley's physiological condition.

94 Ms Keeley subsequently advised that she wanted to proceed with palliative radiation therapy.

24 July 2020: Ms Keeley is admitted to FSH [43]

95 On 24 July 2020, Ms Keeley was transferred from KEMH to FSH to explore the use of palliative radiotherapy.

[42] Exhibit 1, Volume 2, Tab 12, Statement of Associate Professor Emma Allanson dated 21/2/2023, p.12
[43] Exhibit 1, Volume 1, Tab 9.59, Discharge Summary from FSH dated 27/7/2020

96 Ms Keeley's management options were considered by her treating medical oncologist and radiation oncologist at FSH. Both oncologists agreed that Ms Keeley was too frail to benefit from palliative radiotherapy.

97 In consultation with her family, Ms Keeley was commenced on end-of-life care at FSH. She was kept comfortable with palliative medications that were administered via a continuance subcutaneous infusion.

98 In the presence of her family, Ms Keeley died at 3.44 pm on 27 July 2020 at FSH.[44]

CAUSE AND MANNER OF DEATH [45]

99 On 29 July 2020, Dr Victoria Kueppers (Dr Kueppers), a forensic pathologist, conducted an external post mortem examination of Ms Keeley's body. Dr Kueppers was of the view that an external examination and a review of hospital medical records would allow a cause of death to be given without an internal post mortem examination.

100 Dr Kueppers noted that Ms Keeley was diagnosed with a high grade undifferentiated malignancy in March 2020 following post-menopausal bleeding. Further imaging showed that the cancer had spread beyond the uterus, consistent with Stage 4 malignancy. Dr Kueppers also noted that following her surgery on 5 July 2020, Ms Keeley's tissue diagnosis was, "*high grade endometrial carcinoma with neuroendocrine differentiation*". Extensive intra-abdominal disease was present and disease progression was noted on post-operative CT imaging.

101 Toxicological analysis detected multiple medications, including terminal palliative care medications. Dr Kueppers recorded that all medications were in keeping with Ms Keeley's clinical history.

102 At the conclusion of the external post mortem examination, and after reviewing the hospital medical records and the results of the toxicological analysis, Dr Kueppers expressed the opinion that the cause of Ms Keeley's death was complications of metastatic endometrial carcinoma, treated palliatively.

103 I accept and adopt that conclusion expressed by Dr Kueppers as to the cause of death.

[44] Exhibit 1, Volume 1, Tab 3, Death in Hospital Form dated 27/7/2020

[45] Exhibit 1, Volume 1, Tabs 5.1-5.4, Supplementary Post Mortem Report, Full Post Mortem Report, Letter from Dr Victoria Kueppers dated 29/7/2020, Interim Post Mortem Report; Exhibit 1, Volume 1, Tabs 6.1-6.2, Final Toxicology Report and Interim Toxicology Report

104 Accordingly, I also find that Ms Keeley's death occurred by way of natural causes.

THE CLINICAL INCIDENT INVESTIGATION (SAC 1) REPORT [46]

105 Ms Keeley's death was investigated through a Root Cause Analysis inquiry process. These internal inquiries by hospitals include cases where there is a clinical incident that has, or could have, caused serious harm or death that was attributable to the provision of health care (or lack thereof), rather than the patient's underlying condition or illness. These clinical incidents are categorised as Severity Assessment Code 1 (SAC 1). The circumstances of Ms Keeley's death were felt to fall within SAC 1 and a clinical investigation was conducted into the delayed diagnosis of Ms Keeley's endometrial cancer.

106 A clinical incident investigation report (the SAC 1 report) was subsequently prepared by a panel of experts (the panel). The panel comprised Director of Clinical Services, external Consultant Oncology, Consultant Medical Oncology, the Head of Department (Obstetrics and Gynaecology), Medical Director, Coordinator (Nursing and Midwifery) and Manager (Quality, Systems and Performance).

107 Relevant to the inquest, the SAC 1 report made the following findings:[47]

Actions taken after the first histopathology

(i) The histopathology dated 5 December 2019 was misinterpreted[48] by Dr Kasina when he reviewed it and this incorrect information was provided to Ms Keeley and her GP.

(ii) Ms Keeley was re-referred by her GP for continued bleeding. She was seen at the gynaecology clinic on 19 February 2020 when she was booked for a second HDC procedure later that month. The misinterpreted result from the first HDC procedure was not identified at this clinic appointment, or during Ms Keeley's overnight stay in hospital for the second HDC procedure.

(iii) The misinterpretation of the first histopathology was subsequently identified during Ms Keeley's hospital admission in April 2020 after she was reviewed by other consultants. The incident was appropriately reported at that stage.

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[46] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023; Exhibit 1, Volume 2, Tab 11.1, Clinical Incident Investigation Report dated 3/6/2020

[47] Exhibit 1, Volume 2, Tab 11.1, Clinical Incident Investigation Report dated 3/6/2020, pp.15-19

[48] The word "misinterpreted" was used by the panel (as well as "misinterpretation") to describe Dr Kasina's review of the first histopathology. As will be seen later in my finding, it is not the description I have used.

(iv) In light of the misinterpretation of the pathology findings, the experts on the panel agreed that there was no information in the operation report from the first HDC procedure which indicated any macroscopic abnormality of the endometrium. Upon independent review of the video hysteroscopic findings, differences were noted between what was documented in the operation report and what was visible when the images were reviewed.

(v) The histopathology results from the first HDC procedure were validated and available four business days after the procedure. It was identified that there was no clear system for notifying clinicians that pathology results are available.

(vi) The misinterpretation of the histopathology led to Ms Keeley being discharged from the gynaecology clinic without a follow-up plan.

(vii) The experts on the panel noted that a comparison of the operation report and the histopathology result would have identified discrepancies and that the presence of infarcted material would have been questioned. The presence of atypical tissue would also raise suspicion and would have led to a second pathology opinion from a specialist centre. This did not occur.

(viii) The identified action from the histopathology should have been to either offer conservative management, which would include a follow-up appointment and a clinical review, or refer for further specialist advice or treatment. It was agreed that the discharge from the gynaecology clinic was not the appropriate outcome for Ms Keeley. It was also noted that she had not been seen, nor had she been given any advice, about the severity and proposed management of her vaginal bleeding.

Actions taken after the second histopathology

(ix) The panel considered that arrangements for periods of leave by consultants should be made for the follow-up of ongoing cases. Had this occurred, Ms Keeley would have been reviewed earlier.

(x) Ms Keeley was seen by the treating consultant three weeks following the validated result of a high grade malignancy being available.[49] During this period of delay there had been significant disease progression.

(xi) The difficulties in managing an unwell patient who is an inpatient at one site and who requires specialist care at another site were discussed by the panel. This resulted in fragmented care and delay to timely definitive

[49] I note that it was actually 16 days, not three weeks

treatment, particularly for patients who need urgent gynaecological chemotherapy or surgery and who are admitted to FSH.

Further issues considered

(xii) Two issues were also identified by the panel that were not contributory to Ms Keeley's outcome. The first was the delay in the reporting of the incident which subsequently delayed the SAC 1 investigation. The second issue was the delay regarding the open disclosure with the patient and her family of Dr Kasina's misinterpretation of the first histopathology.

(xiii) This misinterpretation was only identified upon review of Ms Keeley's notes by the on-call consultants who identified it during her inpatient hospital admission in April 2020. The incident was then reported for investigation, which was four months after the misinterpretation. Once the incident was identified, open disclosure occurred. However, incomplete information was relayed and so a second meeting had to be arranged with the family for details to be clarified.

108 Although I have considered the above findings of the panel and have generally agreed with them; ultimately, my own findings have been determined by the documentary and oral evidence presented at the inquest. I will now address those findings.

ISSUES RAISED BY THE EVIDENCE

Did Dr Kasina give appropriate consideration to what the hysteroscopy instrument displayed during the first HDC procedure?

109 Dr Kasina's operation report following the first HDC procedure noted that the uterine cavity was "*smooth and regular*", and that it was a "*routine HDC.*"[50]

110 During the HDC procedure, Dr Kasina took some still images using the hysteroscopy instrument. These images were attached to Dr Kasina's statement.[51] Given what it depicted, it was the image that was subsequently numbered 6 at the inquest that was the subject of some scrutiny.

111 Referring to this image, Associate Professor Robert Rome (Associate Professor Rome), an independent consultant gynaecologist and oncologist,

[50] Exhibit 1, Volume 1, Tab 9.12, Post-Operation Report dated 29/11/2019
[51] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, attachment VK4

noted that this, "*showed a lesion of concern in the uterine cavity which was an irregular mass on the posterior wall with some abnormal vessels.*"[52]

112 At the inquest, Associate Professor Rome identified that the red dots that appeared in image 6 were concerning. He was asked:[53]

> Why would the red dots be concerning? What would that suggest? --- A totally benign polyp might have a little bruising on the surface. If it has got a totally smooth surface, it's often on a stalk. Sometimes it's what's called sessile, which there isn't a stalk. But this – the red dots represent haemorrhage, and the reason there's haemorrhage is that it's a neoplasm or a malignancy with abnormal vessels, which lack a significant vascular wall. It's – these are produced in cancers by tumour angiogenesis factors which stimulate growth of new blood vessels. And that's what's showing on that scan. The red dots are, in fact, little haemorrhages from abnormal blood vessels. The alarm was given in the ultrasound which said that it was a 19 millimetre endometrium, was heterogenous, in other words, of mixed solid and cystic construction, and also hypervascular. In other words, there was increased blood flow. So warning signs were there. It was a significant abnormality.

113 As Dr Kasina had earlier given evidence that image 6 was taken at the junction of the endocervical canal and the lower uterine segment,[54] Associate Professor Rome was asked whether it made a difference diagnostically if it was in the endocervical canal or the uterine cavity. He answered, "*No. There was an abnormality there and it needed sorting out*."[55]

114 Associate Professor Rome was also asked:[56]

> And would you agree that somebody who has seen what is shown on those images during the course of the hysteroscopy should have appreciated the abnormality when they saw that on the monitor during the procedure? - - - Yes.

115 As to what had been identified by Associate Professor Rome in image 6, Dr Kasina explained:[57]

> I had been primarily focused on looking for any concerning endometrial lesions in the uterine cavity, which I did not find. Whilst I thought at the time that the endocervical canal did not have any unexpected features, I must admit that I wasn't expecting there to be any, given the CST[58] result and the absence of any cervical lesions being identified by the initial ultrasound report.
>
> Whilst I don't know whether that influenced my perceptions on the day of the initial procedure, on closer examination, and with the benefit of hindsight, I can see that the

[52] Exhibit 1, Volume 1, Tab 15.1, Report from Associate Professor Robert Rome dated 31/8/2022, p.1
[53] ts 24/2/23 (Associate Professor Rome), p.294
[54] ts 22/2/23 (Dr Kasina), p.114
[55] ts 24/2/23 (Associate Professor Rome), p.295
[56] ts 24/2/23 (Associate Professor Rome), p.303
[57] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.5
[58] The cervical screening test in the initial referral

> images (and in particular the sixth image) do show a lesion of possible concern (in the endocervical canal). That was not, however, something that I had identified as being of any concern on the day in question. If I had, I certainly would not have ignored it.

116 Associate Professor Rome also agreed that the doctor performing the procedure should have been eager to see the histopathology based on what ought to have been their concerns from what was depicted on the images.[59]

117 Unfortunately, it would appear that Dr Kasina in this instance had, what Mr Denman described in his closing submissions with respect to another matter, as a "*perception bias*".[60] As he did not perceive there would be any abnormalities in or near the endocervical canal, it would appear he did not pay adequate attention to this area during the HDC procedure.

118 I also note that Dr Kasina did not review any of the images from the hysteroscopy instrument either before or after he had received the first histopathology report. He was asked at the inquest:[61]

> With that image, the sixth image, looking at that now if you saw that or reviewed that after the HDC would that have given you significant concern on its own? - - - Not immediately after hysteroscopy, Mr Stops.
>
> Yes? - - - But in conjunction with the pathology report, yes, Mr Stops.

119 I am satisfied to the required standard, and being mindful not to insert hindsight bias, that Dr Kasina failed to give appropriate consideration to the lesion in the uterine cavity that was visible during the hysteroscopy. As a consequence, he did not appreciate the possibility that this lesion was malignant. I am also satisfied to the required standard that a consultant obstetrician and gynaecologist of Dr Kasina's experience ought to have done so.

Did Dr Kasina give appropriate consideration to the first histopathology report?

120 As already noted, the conclusion from the first histopathology report identified, "*possible atypical glandular epithelium*" and that, "*further sampling is necessary for diagnosis*".[62]

121 After looking at the histopathology report, Dr Kasina did not arrange to see Ms Keeley to discuss the findings and did not recommend another HDC to obtain a further sampling. Instead, he advised that the test results had come

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[59] ts 24/2/23 (Associate Professor Rome), p.305

[60] It should be noted Mr Denman used this description in the context of the inaccurate conclusions made by Dr Kasina from the first histopathology report. Nevertheless, I am of the view that the phrase can also be applied to Dr Kasina's failure to appreciate the significance of what the images from the hysteroscopy were depicting.

[61] ts 22/2/23 (Dr Kasina), p.78

[62] Exhibit 1, Volume 1, Tab 9.4, PathWest Histopathology Report, dated 5/12/2019

back as "*nil abnormal*" and no further appointments were required at the gynaecology clinic.[63]

122 The unanimous opinion of those experts who provided reports to the Court was that this action taken by Dr Kasina was inappropriate.

123 Associate Professor Rome stated:[64]

> The communication of an incorrect result and the discharge back to her GP was substandard practice. Dr Kasina indicated that there was no abnormality. This was clearly erroneous given the hysteroscopic findings and the pathology report that recommended there should be further sampling.

124 Associate Professor Peter Grant, a gynaecological oncologist, expressed a similar view:[65]

> This misinterpretation of the histopathology report and subsequent management recommendation is inappropriate and falls below the standard of performance that could be reasonably expected from someone of a similar level of training and experience.

125 Dr John Anderson, Deputy Director of Clinical Services for Fiona Stanley Fremantle Hospital Group, was of the view that Dr Kasina's failure to have a second HDC performed was "*inappropriate care*".[66]

126 Unsurprisingly, Dr Kasina did not take issue with these opinions:[67]

> Although I now accept without hesitation that the initial histopathology report raised a number of red flags that should have concerned me, at the time of my review I did not notice, or at least adequately appreciate, these red flags. … I accept without question that that was inexcusable …

127 That concession by Dr Kasina was entirely appropriate. As was the closing submission by his counsel at the inquest that, "*it's patently obvious that he didn't read it* [the first histopathology report] *properly*".[68]

128 Dr Kasina assumed that he believed there was "*a normal endometrial cavity*" and that he was not expecting "*an abnormal or concerning histopathology report*". Consequently, he "*only therefore very quickly skimmed over the initial histopathology report, and was unduly influenced by the reference to non-contributory immuno-staining*".[69]

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[63] Exhibit 1, Volume 1, Tab 9.19, Letter from Dr Kasina to Dr John Bourke dated 18/12/2019
[64] Exhibit 1, Volume 1, Tab 15.1, Letter from Associate Professor Robert Rome dated 31/8/2022, pp.1-2
[65] Exhibit 2, Letter from Associate Professor Peter Grant dated 29/10/2021, p.3
[66] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.3
[67] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.6
[68] ts 24/2/23, (closing submissions by Mr Denman), p.396
[69] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.6

129 I am satisfied to the required standard that the failures by Dr Kasina to note the significance of a possible atypical glandular epithelium and to follow the recommendation for a further sampling by the pathologist were inexcusable. I accept Dr Kasina did not make a deliberate decision to ignore these parts of the histopathology report; however, these failures remain inexplicable. Accordingly, I make that finding. I am not surprised Dr Kasina has stated it was "*a failing I will forever regret*".[70]

130 Although I agree with the finding of the SAC 1 report with respect to this aspect of Ms Keeley's care, I do not agree with the panel's description that the histopathology report was "*misinterpreted*" by Dr Kasina. Upon reading the phrases, "*possible atypical glandular epithelium*" and "*further sampling is necessary for diagnosis*", there can be no misinterpretation by the reader (particularly if that person is a consultant obstetrician and gynaecologist) of what they mean.

131 I am also satisfied to the required standard that Dr Kasina's description of Ms Keeley's first histopathology results having come back as "*nil abnormal*"[71] was incorrect and misleading. It ignored the fact that the histopathology report had said there was "*possible atypical gradual epithelium*". As this epithelium may have indicated endometrial cancer, it was entirely inaccurate to include this part of the results as being "*nil abnormal*".[72]

132 Accordingly, I make that finding. I also agree with Associate Professor Rome's opinion that this "*represented substandard practice.*"[73]

133 After Dr Kasina stated at the inquest that he did not see any abnormality during the first HDC procedure, I asked the following questions:[74]

> **CORONER:** Well, you might not have been able to see any abnormality, Doctor, but the histopathology report isn't supporting you 100 per cent - - -?---Yes, your Honour.
>
> - - - on that conclusion you've drawn?---Yes, your Honour.
>
> And the histopathology report is saying another sample is required?---Yes, your Honour. That is what I have missed and I ignored, and I am sorry about that.
>
> I'm at a bit of a loss as to how you missed reading that 'further sampling is necessary for diagnosis'. At this stage this report has not ruled out cancer, has it?---Yes. Yes, your Honour.

[70] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.7
[71] Exhibit 1, Volume 1, Tab 9.19, Letter from Dr Venkata Kasina to Dr John Bourke dated 18/12/2019
[72] At the inquest, Dr Kasina acknowledged that atypical glandular epithelium *"could be a predecessor for a cancer"*: ts 22/2/23 (Dr Kasina), p.8
[73] Exhibit 1, Volume 1, Tab 15.1, Letter from Associate Professor Robert Rome dated 31/8/2022, p.2
[74] ts 22/2/23 (Dr Kasina) pp.81-82

> Yes. And so therefore the pathologist is saying, "We need another sample"?---Yes, your Honour. In hindsight, yes, your Honour. I did not appreciate it on the day unfortunately.
>
> Well, how much attention did you actually pay to that final sentence?---I should have at least called the pathologist and spoken to him, Mr – your Honour.
>
> Are you accepting that - - -?---It is a failure on my part.
>
> - - - you did not pay enough attention to that last sentence?---It is a failure on my part to recognise the significance, your Honour.
>
> Because it's clear, isn't it, when you look at it that what the pathologist is saying is 'another sample is necessary'. - - -?---Yes, your Honour.

134 With these concessions made by Dr Kasina in mind, I have noted that his letter to Ms Keeley's GP only summarised the contents of the histopathology report that appeared under the heading, "*Microscopic*".[75] It may therefore be contended that Dr Kasina did not even read what had been written under the heading, "*Conclusion*". After careful consideration, and applying the ***Briginshaw*** principle, I will not make a finding that Dr Kasina failed to read this part of the histopathology report.

135 Nevertheless, as the late Chief Judge Kevin Hammond AO would have said, I have only done so "*by the merest of margins*". Instead, I will simply agree with that part of the closing submissions from Dr Kasina's counsel when he said his client had "*made an atrocious and unjustifiable mistake*".[76]

Did Dr Kasina provide appropriate management of Ms Keeley's bleeding?

136 One of the reasons given by Dr Kasina as to why he discharged Ms Keeley back to her GP on 18 December 2019 was because he had seen no vaginal bleeding during the first HDC procedure and he had been told by Ms Keeley that her bleeding had stopped.[77] Dr Kasina could not recall how long Ms Keeley said it was since her bleeding had stopped.[78] The question was raised at the inquest as to whether this was appropriate management of Ms Keeley's post-menopausal bleeding.

137 Dr Lo consistently noted that Ms Keeley's bleeding was intermittent. However, I have also noted that Dr Lo's first referral to the gynaecology clinic did not specifically refer to the bleeding in that way.

138 Nevertheless, Dr Anderson noted in his report: "*Post-menopausal bleeding should always raise concerns of possible cancer as indicated in the relevant*

[75] Exhibit 1, Volume 1, Tab 9.19, Letter from Dr Kasina to Dr John Bourke dated 18/12/2019
[76] ts 24/2/23, (closing submissions by Mr Denman), p.370
[77] ts 22/2/23 (Dr Kasina), p.133
[78] ts 22/2/23 (Dr Kasina), p.135

guidelines."[79] He also stated that, "*management of post-menopausal bleeding is an expected knowledge set for consultants.*"[80]

139 Associate Professor Rome provided these answers to questions he was asked at the inquest:[81]

> And would the need for that follow-up be changed if you had not seen blood during the course of the hysteroscopy?---Well, I think she should have been asked to report any ongoing symptoms and bleeding; given the opportunity to make contact or keep contact with the specialist.
>
> Yes?---I don't think the GPs can handle problems like this, really. … I think the specialist owes a duty of care to the patients to see the gynaecological problem through to its completion.
>
> Yes. The referral said that she was being referred for management, and what you're describing is management, isn't it?---Yes.

140 Associate Professor Rome later explained:[82]

> … postmenopausal bleeding is usually on and off, and I don't think it's always continuous. If it was always continuous you would be having all these women coming in with extremely low haemoglobins needing transfusions but that's not a common scenario. It's usually on and off.

141 I accept this evidence from Dr Anderson and Associate Professor Rome. Accordingly, I am satisfied to the required standard it was not a valid reason for Dr Kasina to discharge Ms Keeley on 18 December 2019 because her bleeding had stopped at or about the time of her first HDC procedure.

Should Dr Kasina have identified the mass in the endometrial cavity during the second HDC procedure?

142 Associate Professor Rome was of the view that the hysteroscopic images from the second HDC procedure showed, "*a very suspicious lesion in the endometrial cavity.*"[83] The question was raised at the inquest as to whether Dr Kasina should have identified this mass at his examination of Ms Keeley when she was under anaesthetic during the HDC procedure.

143 A CT scan performed on 18 March 2020 (i.e. 19 days after the HDC procedure) found that this mass measured up to 75 mm.[84] Notwithstanding

[79] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.3
[80] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.4
[81] ts 24/2/23 (Associate Professor Rome), p.307
[82] ts 24/2/23 (Associate Professor Rome), p.317
[83] Exhibit 1, Volume 1, Tab 15.1, Letter from Associate Professor Robert Rome dated 31/8/2022, p.2
[84] Exhibit 1, Volume 1, Tab 9.33, Perth Radiological Clinic SC scans on 18/3/2020

this mass, Dr Kasina, in his operation report, described the uterine cavity (with the exception of an anterior wall polyp) as "*smooth and regular*".[85]

144 Associate Professor Rome testified that "*the upper part of the uterine cavity might have been smooth, but there is something going on lower down than that.*"[86]

145 At the inquest, Dr Kasina's explanation for not seeing this lesion at the time of his examination under anaesthetic was that it was a very rapidly growing cancer and that a mass size of smaller than 5 cm (i.e. 50 mm) "*can be really hard*" to pick up.[87]

146 Although it is common ground that this cancer can rapidly grow, Associate Professor Rome was of the view that given the size of the mass on 18 March 2020, it would have been "*easily palpable on examination under anaesthesia*" 19 days earlier.[88] Associate Professor Rome also noted that given Ms Keeley's weight, obesity was not an excuse for missing this mass.[89]

147 Associate Professor Allanson's opinion differed from Associate Professor Rome. When she was asked whether it was reasonable that a mass of the size it was on 18 March 2020 could be reasonably missed by a competently performed examination under anaesthesia 19 days earlier, she answered: "*It's within the realm of possibility. Absolutely.*"[90]

148 As there is no way of determining the exact size of the mass on 28 February 2020, and given the two differing opinions from the experts, I cannot be satisfied to the required standard that Dr Kasina should have identified this mass in the endometrial cavity during his examination under anaesthesia on 28 February 2020.

The delay advising Ms Keeley of the cancer diagnosis by the gynaecology clinic

149 As already outlined above, the gynaecology clinic was advised of Ms Keeley's confirmed malignancy in a telephone call to Dr Dronov from PathWest on 9 March 2020. Although I am satisfied that the treatment provided to Ms Keeley thereafter was carried out in an appropriate and timely fashion, there was an inappropriate and unjustified delay in relaying the malignancy diagnosis to her. It should never have happened that it was

[85] Exhibit 1, Volume 1, Tab 9.24, Operation Report dated 28/2/2020
[86] ts 24/2/23 (Associate Professor Rome), p.307
[87] ts 23/2/23 (Dr Kasina), pp.145-146
[88] ts 24/2/23 (Associate Professor Rome), pp.307-308
[89] ts 24/2/23 (Associate Professor Rome), p.308
[90] ts 23/2/23 (Associate Professor Allanson), p.243

Ms Keeley's GP who first informed her of her cancer diagnosis on 17 March 2020, some eight days later.

150 In his closing submissions, Mr Harwood, counsel for SMHS, properly made the following concession: "*Ms Keeley should have been informed of her cancer diagnosis within a few days of 9 March, and then a delay of 15 days in advising Ms Keeley of her diagnosis was inappropriate.*"[91] Mr Harwood subsequently submitted: "*South Metropolitan Health Service accepts that there was an unreasonable delay in advising her of the cancer diagnosis.*"[92]

151 It was Dr Dronov's evidence that his initial plan was for the gynaecology clinic to advise Ms Keeley of her diagnosis shortly after 10 March 2020. However, this was changed following a discussion he had with Dr Padma on 10 March 2020, who was the on-call obstetrics and gynaecology consultant. Dr Dronov's account was: "*After I spoke with Dr Padma, she indicated that as Dr Kasina was due back to work soon that Ms Keeley should see him personally.*"[93]

152 In light of this account from Dr Dronov, and having not had a statement from Dr Padma or having heard her give evidence at the inquest, Dr Padma was given the opportunity of providing a statement with respect to her version of events regarding 10 March 2020 and any interactions she had with Dr Dronov. Dr Padma subsequently provided the Court with a statement dated 8 May 2023.[94]

153 Dr Padma did not have any independent recollection of having a conversation with Dr Dronov about Ms Keeley on 10 March 2020. Specifically, she stated:[95]

> I do not recall ever speaking to Dr Dronov about this patient, or about Dr Kasina returning from leave. As such I cannot accept that I spoke to Dr Dronov and advised him that Dr Kasina was due back to work soon, and that Ms Keeley should see him personally.
>
> It is considered proper practice, and has always been my practice over the many years I have been a medical practitioner, to ensure the patient is called immediately and told to come into the clinic as soon as possible to receive the news in person.
>
> …
>
> It would also not be appropriate in these circumstances to wait until a consultant is back from leave to book in an appointment if that is some time away.

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[91] ts 24/2/23 (closing submissions by Mr Harwood), p.375
[92] ts 24/2/23 (closing submissions by Mr Harwood), p.375
[93] Exhibit 1, Volume 2, Tab 8, Statement of Dr Oleg Dronov dated 16/3/2023, p.8
[94] Exhibit 6, Statement of Dr Padma Jatoth dated 8/5/2023
[95] Exhibit 6, Statement of Dr Padma Jatoth dated 8/5/2023, pp.4-5

154 Dr Padma concluded her statement with the following:[96]

> Again, as set out above, I would never advise a registrar to wait until a consultant returns from extended leave before booking an appointment to ensure a patient is told of their cancer diagnosis. This needs to happen as soon as possible, and an appointment needs to be made and confirmed with the patient immediately so they can attend [the] clinic in the next few days and receive the diagnosis in person.

155 There is an inconsistency in the accounts from these two doctors. I was able to see and hear Dr Dronov give evidence about this matter and other areas at the inquest. I found him to be a very reliable and credible witness.

156 I also note there is a contemporaneous record by Dr Dronov regarding the conversation he had with Dr Padma on 10 March 2020. This record is an email he sent to Dr Kasina at 4.13 pm on that day. That email read:[97]

> Dear Dr Kasina,
>
> I hope you are well. Sorry for writing to you in your leave. <u>I have spoken with Dr Padma about this patient</u> Keeley Corazon [sic]. I had an advice to do e-referral to KEMH Gynaecology Oncology, refer for CT chest\abdomen\pelvis and inform patient by phone to come to see you in Gynae clinic when you come back to work. I have called her to say that she will be mailed to KEMH and invited for CT.
>
> Kind regards,
>
> Oleg Dronov
>
> *(underlining added)*

157 I am therefore satisfied to the required standard that Dr Dronov did have a conversation with Dr Padma on 10 March 2020 and that the outcome of this conversation was Dr Kasina would personally advise Ms Keeley of the cancer diagnosis when he returned from leave. I am also satisfied that this course of action was proposed by Dr Padma. Accordingly, I make that finding.

158 This finding should not be regarded as adverse in nature with respect to Dr Padma. That is because I am satisfied this decision was made because of a misunderstanding as to when Dr Kasina was returning from leave, and that there was an incorrect belief it was going to be shortly after 10 March 2020.

159 I am satisfied of this for two reasons. The first is what Dr Padma outlined in her statement:[98]

> If the patient's treating consultant, such as Dr Kasina, was going to be running a clinic in the very near future (for example in the next few days) and there is an available spot in their list that the patient could be booked into, then it would be appropriate to

[96] Exhibit 6, Statement of Dr Padma Jatoth dated 8/5/2023, p.7
[97] Exhibit 1, Volume 2, Tab 8, Statement of Dr Oleg Dronov dated 16/3/2023, attachment OD6
[98] Exhibit 6, Statement of Dr Padma Jatoth dated 8/5/2023, p.6

> do so given they have knowledge of the patient's history and have that relationship with the patient.
>
> However, this would only be appropriate if the consultant had a list the next day, or at the very most that same week. It would not be at all appropriate to wait longer than this for a consultant to return from leave.

160 The second reason is Dr Dronov said Dr Padma had indicated Dr Kasina, "*was due back to work soon*".[99] As Dr Dronov recounted at the inquest:[100]

> So after I got the advice from Dr Padma that it should happen when Dr Kasina is coming back, but she didn't mention when, exactly, he is coming. She didn't [sic] aware, and I don't remember if I was told, you know, the exact dates of that. But I was told – and I remember it clearly – that I was told he was coming just in a few days.
>
> Okay? - - - So it was going to happen very soon.
>
> Okay? - - - Probably not tomorrow, but the nearest dates. Yes.

161 Finally, I am satisfied to the required standard that Dr Kasina did not make appropriate arrangements to hand over Ms Keeley's case to another consultant prior to commencing his leave. The following assumption he made that Ms Keeley's histopathology results would be appropriately managed in his absence was misguided:[101]

> I assumed that any concerning histopathological results would be managed appropriately in my absence, although I accept with the benefit of hindsight that it would have been appropriate to formally hand over the patient's case to one of my colleagues.

162 I am at a loss to understand why Dr Kasina required the benefit of hindsight to accept it was appropriate to arrange a hand over of Ms Keeley's care to another consultant. Barring an unanticipated delay, he should have expected the histopathology results would become available during his leave. He would have also known those results may contain a cancer diagnosis. In those circumstances, a hand over ought to have been arranged by Dr Kasina before he went on leave.

The delay and adequacy of Dr Kasina's open disclosure

163 As at the time of Ms Keeley's treatment and care, the Department of Health's Open Disclosure Policy was to adopt the Australian Open Disclosure Framework (the Framework).[102] Fiona Stanley Fremantle

[99] Exhibit 1, Volume 2, Tab 8, Statement of Dr Oleg Dronov dated 16/3/2023, p.8
[100] ts 23/2/23 (Dr Dronov), p.210
[101] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.8
[102] Exhibit 3, Department of Health's Open Disclosure Policy, p.1

Hospitals Group also had a section in its Medical Professional Standards 2020 that dealt with open disclosure.[103]

164 Clause 1.1 of the Framework provided the following definition of open disclosure:[104]

> Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers. The elements of open disclosure are:
>
> - An apology or expression of regret, which should include the words, “I am sorry” or “we are sorry”.
> - A factual explanation of what happened.
> - An opportunity for the patient, their family and carers to relate to their experience.
> - A discussion of the potential consequences of the adverse event.
> - An explanation of the steps being taken to manage the adverse event and prevent recurrence.

165 The Framework sets out eight guiding principles. Of relevancy to the open disclosure provided to Ms Keeley by Dr Kasina, I note the first three of these guiding principles:[105]

> **1. Open and Timely Communication**
>
> If things go wrong, the patient, their family and carers should be provided with information about what happened in a timely, open and honest manner. The open disclosure process is fluid and will often involve the provision of ongoing information.
>
> **2. Acknowledgement**
>
> All adverse events should be acknowledged to the patient, their family and carers as soon as practicable. Health service organisations should acknowledge when an adverse event has occurred and initiate open disclosure.
>
> **3. Apology or Expression of Regret**
>
> As early as possible, the patient, their family and carers should receive an apology or expression of regret for any harm that resulted from an adverse event. An apology or expression of regret should include the words, “I am sorry” or “we are sorry”, but must not contain speculative statements, admission of liability or apportioning of blame.

166 I note that each of these principles stress the importance of providing open disclosure in a timely manner. Unfortunately, Dr Kasina’s apology for the mistake he made advising there were no abnormalities arising from the first histopathology was anything but timely or, at least initially, adequate.

[103] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, attachment 3, pp.22-23
[104] Exhibit 5, Australian Open Disclosure Framework, p.11
[105] Exhibit 5, Australian Open Disclosure Framework, p.12

167 As I have already outlined above, Ms Keeley had an appointment with Dr Hoad at the FSH gynaecology clinic on 19 February 2020. It was during that appointment, Dr Hoad became aware that there had not been a second HDC procedure as recommended in the first histopathology report. As a result of that, Dr Hoad discussed the matter with Dr Kasina that same day. It was clear from Dr Hoad's evidence at the inquest that she conferred with Dr Kasina as he was the consultant at the gynaecology clinic that day, and not because he had performed the first HDC procedure.[106]

168 The histopathology report stated that it was requested by Dr Kasina and that the report was to be provided to him. He is named three times on the first page of the report.[107] Nevertheless, Dr Hoad was uncertain as to whether she had noticed Dr Kasina's name on the histopathology report, stating: "*I might have realised it was him. I don't know. I just didn't write it in my notes*."[108]

169 To the best of Dr Kasina's recollection, he did not personally review any of the records relating to Ms Keeley on 28 February 2020.[109]

170 Dr Hoad's progress note of her consultation with Ms Keeley does not disclose that Dr Kasina had performed the first HDC procedure.[110] Nor does Dr Hoad's letter to Dr Lo dated 19 February 2020 (which was reviewed by Dr Kasina) refer to Dr Kasina having performed the earlier HDC procedure.[111]

171 Dr Kasina did not accept that as of 19 February 2020, he was aware he had performed the first HDC procedure. Given the large number of HDC procedures Dr Kasina would have performed in the intervening period, I must also pay heed to the unlikelihood that he would be able to recall, after a period of more than two and a half months, the name of each patient he has performed what he regarded as a routine HDC procedure.

172 In light of the above evidence, I am not able to find to the required standard that on 19 February 2020, Dr Kasina was aware he was responsible for failing to arrange another HDC procedure for Ms Keeley in December 2019.

173 In preparation for the second HDC procedure on 28 February 2020, Dr Kasina gave evidence that he would have only looked at the progress note

[106] ts 24/2/23 (Dr Hoad), pp.336-337
[107] Exhibit 1, Volume 1, Tab 9.14, PathWest Histopathology Report dated 5/12/2019
[108] ts 24/2/23 (Dr Hoad), p.338
[109] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.7
[110] Exhibit 1, Volume 2, Tab 7, Statement of Dr Claire Hoad dated 14/2/2023, attachment CH2
[111] Exhibit 1, Volume 2, Tab 7, Statement of Dr Claire Hoad dated 14/2/2023, attachment CH1

prepared by Dr Hoad on 19 February 2020, and not at any other records for Ms Keeley.[112]

174 If that is correct, and I have no evidence to the contrary, then Dr Kasina was also not aware at that stage he was responsible for there not being an earlier HDC procedure.

175 However, I can be certain that by 25 March 2020, Dr Kasina was aware he was responsible for the error. He gave the following evidence at the inquest:[113]

> So did you not on the 18th of March appreciate that you had failed to act on the original histopathology?---I cannot recollect that, Mr Johnson.
>
> That you had then done a second procedure and now you had a confirmation that your patient had cancer. You didn't appreciate all of that on the 18th of March?---On the 18th, no Mr Johnson. I - highly unlikely - but on the 25th, yes, it would be.
>
> Thank you. Okay. So by the 25th you understood that, that that's what had happened?---Yes, Mr Johnson.
>
> And you didn't tell the patient and the family about that at that time did you?---I did not tell the pathology – the pathologist has asked for a second - - -
>
> A further sample?---Further sampling, yes.

176 Dr Kasina's explanation as to why he did not disclose his mistake was because the family and he were more focused on the current situation and the future.[114]

177 I find, in accordance with the open disclosure policies at the time, it was incumbent upon Dr Kasina to provide a full disclosure to Ms Keeley and her family with respect to the serious errors he had committed. These errors comprised of failing to act on the recommendation contained in the first histopathology report and discharging Ms Keeley from his care because the histopathology results were "*nil abnormal*". The Framework not only clearly required him to do that but required him to do so "*as soon as practicable*" and to apologise "*as early as possible*".[115] Accordingly, that should have occurred on 25 March 2020 when Dr Kasina saw Ms Keeley.

178 This failure by Dr Kasina to have the open disclosure in a timely manner meant that Ms Keeley and her family were left for an unnecessary period of time having the mistaken belief the cancer only commenced after the first HDC procedure. That was clearly not the case.

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[112] ts 23/2/23 (Dr Kasina), p.141
[113] ts 23/2/23 (Dr Kasina), p.151
[114] ts 23/2/23 (Dr Kasina), p.151
[115] Exhibit 5, Australian Open Disclosure Framework, p.12

179 As Ms Keeley's daughter sets out in her statement, she was becoming increasingly worried about her mother's declining health following her admission to FSH on 7 April 2020. Wilora Keeley's desperation for answers led to contact with not only Dr Kasina but also with nurses and doctors at KEMH and SCGH, patient liaison services, politicians, media and the Department of Health.[116] On 14 April 2020, and at her request, Ms Keeley's daughter recalls she had a face-to-face meeting with Dr Kasina and two other doctors. Although her complaint about the slow response to her mother's treatment was discussed, the error committed by Dr Kasina in December 2019 was not. Ms Keeley's daughter is not to blame for that as Ms Keeley was still unaware the error had occurred.[117]

180 Dr Kasina's first attempt at open disclosure took place on 17 April 2020. As I have already found, this was over three weeks after it should have been done. However, what has caused me even further disquiet is that Ms Keeley was the person who initiated the conversation. On that day she had "*sought an explanation of the timeline of events with her family*".[118] Ms Keeley was too drowsy to be able to participate; however, she gave consent for Dr Kasina to speak to her daughter and her daughter's partner.[119]

181 The discussion at this meeting was the subject of a progress note completed by Dr Kasina's registrar who was also in attendance. The progress note stated that apologies were made by Dr Kasina for the "*delays*". However, it is unclear what delays the apologies related to as the progress note mentions three delays. Two of these were noted as being concerns Ms Keeley's daughter and her partner had raised about the delay in being informed of the cancer diagnosis, and the delay in obtaining imaging in the public system and having the results reviewed.[120] The third delay mentioned in the progress note refers to the delay in undertaking the second HDC procedure. This was described as "*a slight delay*".[121] I also note the progress note does not specifically record that Dr Kasina acknowledged he was personally responsible for that delay.[122]

182 However, at the inquest, Dr Kasina was emphatic he had said at the meeting it was his mistake for the delay in the scheduling of the second HDC

[116] Exhibit 1, Volume 1, Tab 16, Statement of Wilora Keeley dated 10 August 2020, p.5
[117] Exhibit 1, Volume 1, Tab 16, Statement of Wilora Keeley dated 10 August 2020, p.6
[118] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.11
[119] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.11
[120] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, attachment VK27
[121] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, attachment VK27
[122] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, attachment VK27

procedure.[123] Dr Kasina also said at the inquest that he did not use the word "*slight*" when explaining that delay.[124]

183 Ms Keeley's daughter has a very different account of what was discussed at this meeting:[125]

> There was no mention of the mistake at this stage either. I mentioned "no cancer in November and now advanced cancer, it's so aggressive, mum needs help now". The doctor did not admit to misdiagnosis, instead agrees with my timeline and writes down how unhappy we were with how things were progressing. He mentioned that it was open disclosure, but does not explain what that was.

184 Wilora Keeley also recalls there was a doctor taking notes as Dr Kasina was talking.[126]

185 As can be seen from the above summary, Dr Kasina's account of what was said at this meeting is not only inconsistent with the recollection of Ms Keeley's daughter, it also does not accord with aspects of the progress note. Most notably, there is no record in the progress note that Dr Kasina acknowledged he was personally responsible for the erroneous response to the first histopathology report and that he had apologised for this mistake.

186 Although I accept that it is never possible to write down everything that is said at a meeting, one has an expectation a note is to be made of the most important parts of the discussions in the meeting. In my view, an acknowledgement of his personal responsibility and an apology from Dr Kasina regarding his failure to properly respond to the results of the first histopathology report would have been the most significant part of a meeting that was supposed to be about open disclosure.

187 Dr Kasina was unable to recall what the reaction was when he told Wilora Keeley and her partner he had personally made this mistake. I asked Dr Kasina these questions at the inquest:[127]

> Can you recall their reaction when you told them that? --- I cannot, your Honour. Yes.
>
> I gather if you told them that, they would have been extremely angry? --- Yes, look, they were more anxious about what's happening and I'm there to help them as – I had to coordinate the care of them as a leading oncologist at that point of time.
>
> Are you absolutely certain you told them --- ? --- Yes. Yes, sure.
>
> --- that you had made a mistake? --- Yes, your Honour.
>
> But you can't recall their reaction? --- At that – no, unfortunately

[123] ts 23/2/23 (Dr Kasina), p.155
[124] ts 23/2/23 (Dr Kasina), p.161
[125] Exhibit 1, Volume 1, Tab 16, Statement of Wilora Keeley dated 10 August 2020, p.6
[126] Exhibit 1, Volume 1, Tab 16, Statement of Wilora Keeley dated 10 August 2020, p.6
[127] ts 23/2/23 (Dr Kasina), p.155

188 I would expect that had Dr Kasina told Ms Keeley's daughter he was personally responsible for the error that delayed the cancer diagnosis and had apologised for that error, there would have been an understandable emotional reaction that would not be easily forgotten. I would also expect emotionally charged follow-up questions as to how Dr Kasina could have made such a mistake, in addition to expressions of concerns about the delay (which necessarily flowed onto the commencement of the cancer treatment). Yet Dr Kasina cannot recall the reaction.

189 In addition, whilst the progress note does record Wilora Keeley and her partner having concerns about other delays, there is no note they were concerned about the delay in confirming the cancer diagnosis after the first histopathology. That is actually consistent with them being advised, as recorded in the progress note, that there was only "*a slight delay*" with respect to that matter.

190 I have also noted the submission made by Mr Denman, counsel for Dr Kasina, regarding his client's conduct at this meeting: "*He should have more directly conceded his failure to properly action the histopathology result recommendation, rather than just focusing on consequential delays.*"[128] Although this is not a concession that Dr Kasina did not acknowledge his failure, it is an acknowledgement that he did not give the matter the necessary consideration that was required for an open disclosure meeting.

191 After careful consideration of the evidence, and being mindful of the ***Briginshaw*** principle, I am satisfied that at the meeting on 17 April 2020, Dr Kasina did not make a full and open disclosure that he was personally responsible for the delay in having the second HDC procedure performed. I am also satisfied that no specific apology was made regarding that delay or for the fact that Dr Kasina had inappropriately discharged Ms Keeley from his care. Accordingly, I make those findings. In doing so, I have accepted the account given by Ms Keeley's daughter and note it is more consistent with the contents of the progress note when compared to Dr Kasina's account.

192 On 20 April 2020, Dr Kasina was informed by his Head of Service at FSH that a detailed formal open disclosure with the patient and her family was necessary. Due to the impact of the COVID-19 pandemic at the time, it was agreed that this process would take place by telephone, rather than in person.[129]

[128] ts 24/2/23, (closing submissions by Mr Denman), p.369
[129] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.11

193 This formal open disclosure took place on 21 April 2020 and involved Ms Keeley, her daughter and her daughter's partner. On this occasion Dr Kasina completed a document titled "*Open Disclosure Discussion Record*".[130]

194 It is agreed that during this telephone link-up Dr Kasina admitted his mistake regarding the first histopathology report and apologised.[131]

195 Unfortunately, the whole process regarding the open disclosure to Ms Keeley and her family had its shortcomings. As conceded by Dr Kasina:[132]

> Although I then attempted to provide formal open disclosure by telephone to the patient and her family on 21 April 2020, I accept with the benefit of hindsight that I could have managed that process better (it was the first occasion on which I had to perform formal open disclosure, and I did not fully appreciate what I was supposed to be doing). The family expressed disappointment about what had occurred (in respect of which they asked for a different contact point to discuss their concerns further), but agreed to me providing ongoing logistical support.

196 In light of all of the above, I have found that the open disclosure to Ms Keeley and her family was substandard and fell well short of the relevant principles of the Framework. The responsibility for that should not just lie with Dr Kasina. SMHS must also shoulder some of the responsibility as it was clear to me that, at least initially, Dr Kasina did not understand what he was required to do in the open disclosure process.

197 The Framework's fifth guiding principle states that health service organisations, "*should create an environment in which all staff are ... prepared through training and education to participate in open disclosure* [and] *supported through the open disclosure process.*"[133] Dr Kasina had clearly not been prepared for the open disclosure on 17 April 2020.

Was there a fragmenting of the treatment and care provided to Ms Keeley?

198 Associated Professor Rome made this observation in his report:[134]

> In my experience patients with complex medical problems can come to harm when care is provided at multiple hospitals. At least three hospitals have provided care in Ms Keeley's case – viz. FSH-FH,[135] KEMH and SCGH. Breakdowns in communications,

[130] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, attachment VK30
[131] Exhibit 1, Volume 1, Tab 16, Statement of Wilora Keeley dated 10 August 2020, p.6; Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, attachment VK30, p.1
[132] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.12
[133] Exhibit 5, Australian Open Disclosure Framework, p.13
[134] Exhibit 1, Volume 1, Tab 15.1, Letter from Associate Professor Robert Rome dated 31/8/2022, p.3
[135] FH is an abbreviation for Fremantle Hospital

delays in diagnosis, and treatment and fragmentation of care by different teams are just some of the things that can increase the risks to patients.

199 Associate Professor Allanson acknowledged that the involvement of several hospitals creates, from a lay person's viewpoint, a perception there was fragmentated care and a lack of continuity of care for Ms Keeley.[136] However, she went on to say:[137]

> But we have a long history of providing multidisciplinary care coordinated by the gynae-oncology service, and lots of systems in place that mean all of our patients have care across Genesis, Fiona Stanley for their radiation, Charlies for their chemo, and with us [i.e. KEMH] as a standard thing. The care is coordinated by clinical nurse coordinators, so we do have central points of contact, and we do have continuity from that point of view. But I do appreciate from the outside it probably looks fragmented.

200 When I asked Associated Professor Allanson whether the fragmented care was working effectively, she responded:[138]

> Yes, we have lots of systems in place, and I would say that we deliver high-quality oncological care to our patients. The capacity to move to a single site and have everyone in one site is well above my pay level.
>
> All right. But that would be ideal? --- The strategic planning, I think, of the women and newborns with the move of Kind Edward to Charles Gairdner site includes the capacity for patients to have access to things at the same site.

201 I am therefore satisfied that there was a fragmenting of the care and treatment provided to Ms Keeley. However, I am also satisfied that this did not negatively impact on the level of that care and treatment.

Was Ms Keeley's death preventable with an earlier cancer diagnosis?

202 As to this question, Associate Professor Rome provided the following:[139]

> In my opinion, it is highly likely that Ms Keeley's cancer had already spread when she was referred to the FSH on 7 October 2019, although the left ovary was not enlarged at that time. It is noteworthy that soon after the diagnosis of her cancer a staging CT scan was done on 6 April 2020. This showed a large left-sided ovarian mass which measured 9.2 cm in maximum dimension, indicating that the cancer was rapidly growing. In my opinion, it is unlikely that an earlier diagnosis of her cancer in October or November 2019 would have changed the eventual outcome.

203 Associate Professor Allanson agreed with this opinion.[140] She added:[141]

[136] ts 23/2/23 (Associate Professor Allanson), p.230
[137] ts 23/2/23 (Associate Professor Allanson), p.230
[138] ts 23/2/23 (Associate Professor Allanson), p.231
[139] Exhibit 1, Volume 1, Tab 15.1, Letter from Associate Professor Robert Rome dated 31/8/2022, p.3
[140] Exhibit 1, Volume 2, Tab 12, Statement of Associate Professor Emma Allanson dated 21/2/2023, p.12
[141] Exhibit 1, Volume 2, Tab 12, Statement of Associate Professor Emma Allanson dated 21/2/2023, p.12

> Neuroendocrine tumours of the endometrium are highly aggressive tumours and have a poor prognosis. Should this diagnosis have been made in November 2019, it is unlikely that the outcome (i.e. death from disease) would have been altered. It is difficult to postulate on disease progression in the interval between November 2019 and March 2020 and expert opinions may vary on this. In the absence of metastatic work (i.e. CT) in November 2019, it is difficult to know whether we would have been able to offer upfront surgery prior to adjuvant therapy.

204 In light of the opinions of these two highly credentialed experts, I am satisfied that it was very unlikely Ms Keeley's death would have been prevented had Dr Kasina responded appropriately to the first histopathology report on 18 December 2019.

Would Ms Keeley's life been prolonged with an earlier cancer diagnosis?

205 The timing of the cancer diagnosis turns on when the second HDC procedure would have been performed had Dr Kasina followed the recommendation in the first histopathology report. This exercise involved a degree of speculation, particularly given the intervening Christmas period.

206 In closing submissions, Mr Denman posited that the procedure would not have been performed before the end of January 2020. In contrast, Mr Johnson submitted that if Dr Kasina had properly taken note of the concerning nature of the hysteroscopy images, particularly image 6, then he ought to have been looking out for the histopathology result as soon as it was available. He therefore submitted the procedure could have been performed in early January 2020.

207 For the purposes of this exercise, I have taken the middle ground and formed a view that it was most likely this procedure would have been performed sometime in the middle of January 2020. That would have meant the histopathology result confirming the cancer would have most likely been available approximately one week later. This means a referral would have been made to the gynaecology oncology service at KEMH roughly six or seven weeks before it actually was.

208 At the inquest, Associate Professor Allanson was asked that if the cancer had been diagnosed in January 2020 was there "*more than a 50% probability*" Ms Keeley would have survived longer than she did. Associate Professor Allanson answered:[142]

> No, I don't think you can say that. I don't think you've got any evidence to be able to say that one way or the other. Because you don't have any evidence about what was going on in January.

[142] ts 23/2/23 (Associate Professor Allanson), p.239

So it's impossible to say that?---Yes.

209 Associate Professor Allanson was also asked this question:[143]

> Is it likely that the suffering and the pain that she's experienced would have been reduced with an earlier diagnosis, if that had been managed from January, rather than when it was?---Not necessarily. Suffering and pain with a cancer diagnosis are awful, and we do everything to try and avoid them. They're not necessarily a result of when it was diagnosed.
>
> So, again, is the answer - - -?---You can't say one way or the other because you don't have the information.
>
> - - - no one can say; it's equally likely again?---Yes. Yes.

210 Associate Professor Rome expressed a different view with respect to this matter. He was asked:[144]

> Do you think that with a diagnosis in December or January that it is likely that she would have survived longer than she did?---Yes, I do. And probably in December or January, surgery – upfront surgery would have been feasible, and adjuvant radiotherapy and/or chemotherapy would have been appropriate. What she had, of course, is the other way around. She had gross disease which required neoadjuvant chemotherapy to try to get it to shrink.
>
> Yes?---These cancers are not very chemo-sensitive at all.
>
> …
>
> And so if she had had surgery as the first line of treatment before chemo, it's likely that that would have been successful in debulking?---Yes, removing the uterus.
>
> Yes?---They probably would have found small volume disease in the lymph nodes.
>
> Yes?---That's a best guess on my part.
>
> Yes, I understand?---In the absence of a CT scan in October 2019 we will never know.

211 Mr Harwood, in his closing submissions, invited me to accept the opinion of Associate Professor Allanson on this point. Mr Johnson, on the other hand, submitted that Associate Professor Rome's opinion should be preferred.

212 I am unable to prefer one opinion from an expert over the other in this instance. I accept Mr Johnson's contention that Associate Professor Rome has more experience than Associate Professor Allanson. Nevertheless, Associate Professor Allanson remains a highly qualified and experienced gynaecologic oncologist.

213 One reason why I am not persuaded to accept Associate Professor Rome's opinion over Associate Professor Allanson's more cautious approach is that

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[143] ts 23/2/23 (Associate Professor Allanson), p.239
[144] ts 24/2/23 (Associate Professor Rome), pp.311-312

it remained somewhat speculative. Associate Professor Rome qualified his answer as to what would have been found if surgery had taken place, saying it was "*a best guess on my part*". He also said that in the absence of a CT scan in October 2019, it was not known whether there was only a small volume of disease in the lymph nodes.

REMEDIAL ACTIONS TAKEN WITH RESPECT TO DR KASINA [145]

Management of Dr Kasina

214 The Head of Service of obstetrics and gynaecology provided supervision and mentoring to Dr Kasina after his erroneous response to the first histopathology came to light in April 2020. As part of this review, a retrospective review of all hysterectomy procedures performed by Dr Kasina was completed from 2018 to 2020. No missed cancer diagnosis was identified. A review was also undertaken of all the hysteroscopies performed by Dr Kasina since 2020. This review was still ongoing as of February 2023. Again, there was no missed cancer diagnosis found.

215 Dr Kasina has estimated that he has performed close to 2,000 hysteroscopies that have involved the interpretation of subsequent histopathology results. He noted the clinical errors that he made regarding the first histopathology from Ms Keeley's initial HDC procedure was the only time. Although that is reassuring, as were the results of the reviews outlined above, it makes it even more perplexing that Dr Kasina would commit such a serious oversight with respect to the first histopathology report for Ms Keeley.

216 From 15 May 2020, all cases seen in Dr Kasina's clinic were reviewed by the Head of Department. In the initial phase, it was direct supervision for four weeks and then it became indirect supervision with cases being reviewed within four weeks.

217 Dr Kasina's performance management has been in accordance with Phase 2 of the Department of Health's "*Managing Unsatisfactory and Substandard Performance Policy.*"[146]

218 Dr Kasina's gynaecology involvement has been limited. As of 21 February 2023, he has had no gynaecology elective clinics since 13 September 2021, no elective gynaecology theatre since 22 December 2021 and no colonoscopy procedures from 12 January 2022.

[145] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023; Exhibit 1, Volume 2, Tab 11, Report of John Anderson dated 21/2/2023
[146] ts 23/2/23 (Dr Robinson), p.254; Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, attachment 12, p.3

219 Dr Kasina's contract was also limited to 0.5 FTE[147] from October 2022 and was mainly obstetric-based with no gynaecology clinic commitments, apart from being the on-call consultant. When he has been the on-call consultant, there is a second backup consultant available to cover gynaecology. If that consultant is unavailable, there is a default to the Head of Department.

Action taken by Australian Health Practitioner Regulation Agency (AHPRA)

220 On 25 May 2020, the FSH Director of Clinical Services notified AHPRA of Dr Kasina's failing in respect to his response to the first histopathology report. On 29 May 2020, Dr Kasina submitted a self-notification to AHPRA. In addition, Ms Keeley's family also submitted a notification to AHPRA.

221 At the conclusion of a lengthy AHPRA investigation, various conditions were imposed on Dr Kasina's registration which took effect on 12 April 2022. These conditions required Dr Kasina to practice gynaecology under supervision and undertake further education.

222 I am satisfied with the performance management process that Dr Kasina has been subjected to and also the outcome of the AHPRA investigation. I am also satisfied that Dr Kasina's response to the results of the first histopathology was an aberration, albeit a very serious one, of what has otherwise been an appropriate level of care and treatment of his patients. I have no doubt at all Dr Kasina has learnt from the errors he made in his treatment and care of Ms Keeley, and that it is extremely unlikely he will ever commit those errors again.

QUALITY OF MS KEELEY'S TREATMENT AND CARE

223 The treatment and care provided to Ms Keeley by her GP, Dr Lo, is deserving of high praise. It was clear to me from the documentary evidence and the oral evidence of Dr Lo at the inquest that she did everything expected of a GP. In particular, I note the lengthy consultations she had with Ms Keeley which, no doubt, involved a careful and empathetic explanation to her patient of the results and progression of her cancer.

224 Similarly, I am satisfied that the treatment and care Ms Keeley received from 10 March 2020 was appropriate, apart from the delayed advice to her regarding the cancer diagnosis and Dr Kasina's delayed initial attempts at open disclosure. I note that Ms Keeley's family hold a similar view. In his closing submissions, Mr Johnson stated: "*There's no issue from the family's*

[147] FTE is an abbreviation for Full Time Equivalent

perspective that everything that was done from then onwards [10 March 2020] *was done in an appropriate, timely fashion.*"[148]

225 However, as I have already made abundantly clear in this finding, there were aspects of Dr Kasina's care and treatment of Ms Keeley that were sadly lacking. These involved his failure to give appropriate consideration to the lesion that was visible during the hysteroscopy at the first HDC procedure, his failure to respond appropriately to the first histopathology report, and the delay and initial inadequacy of his open disclosure in April 2020.

CHANGES AND IMPROVEMENTS SINCE MS KEELEY'S DEATH

226 The SAC 1 report made a number of recommendations following the panel's investigation of this matter. These recommendations included addressing the delays in notification of normal pathology results, the hand over process for when a consultant is on leave, the variation in the practice of chart out requesting, and the fragmentation of care for gynaecology oncology patients that may result in a delay of treatment. The panel also recommended that if there was an electronic system notifying clinicians that a histopathology result was available, then a review of the result from Ms Keeley's first histopathology could have been done earlier.[149]

227 Dr Anderson reported that the recommendations from the SAC 1 report have been implemented.[150] In addition, a service improvement project was initiated in the Gynaecology and Obstetrics Department. As a result of that, the following changes have also been implemented:[151]

- A weekly clinic is now conducted by registrars during which all gynaecology outstanding results or chart outs are dealt with, the patients are contacted to inform them with a letter sent, and the relevant consultant is contacted.
- A Gynaecology Multi-Disciplinary Team comprising of gynaecology consultants, a radiologist, a pathologist and other specialities as needed meets fortnightly to review complex cases.
- A Gynaecology Mortality and Morbidity meeting has been established to discuss all complications and trended data.
- A hysteroscopic specific outpatient clinic has being created where all patients with post-menopausal bleeding are reviewed by dedicated nurse coordinators within one month.

[148] ts 24/2/23 (closing submissions by Mr Johnson), p.393
[149] Exhibit 1, Volume 2, Tab 11.1, Clinical Incident Investigation Report, pp.25-26
[150] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.10
[151] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.11

- With respect to management, all cases where results are pending have a chart out in place, any abnormal results are discussed with the requesting consultant and the patient is advised.
- Leave arrangements must conform to the guideline for notification of cover arrangements to the Head of Service (Medical Professional Standards).
- With respect to clinical guidelines, an orientation pack has been created which includes information regarding local and KEMH guidelines.

228 I commend these changes that have been made which I expect will reduce the prospect of the shortcomings that existed in the care and treatment of Ms Keeley from occurring to other patients.

POTENTIAL RECOMMENDATIONS

Establishing an Electronic Medical Record for public hospitals

229 One matter that involved extensive evidence at the inquest was Dr Kasina's failure to properly action the recommendation in the first histopathology report.

230 In his oral evidence, Dr Anderson identified this failure as an example "*of the problems associated with results acknowledgment.*"[152] Dr Anderson added that he has been leading a steering group to address this issue and had been involved in multiple discussions to try and resolve it. However, he did not see a resolution of the problem without the introduction of an all-encompassing Electronic Medical Record (EMR) for the Department of Health. Dr Anderson noted that Western Australia was making moves in that direction as was the Federal Government; however, he added that a recommendation supporting the introduction of an EMR from the Coroners Court would assist.[153]

231 As Dr Anderson explained, the current system is not an electronic health care system. Rather, "*it is merely scanned documents and some information coming in by e-forms.*"[154] Dr Anderson acknowledged that a State-wide distribution of an EMR would have to connect with a number of existing systems and that it would be "*a big deal*".[155] Dr Anderson could not estimate what the timeline was going to be for the implementation of an

[152] ts 23/2/23 (Dr Anderson), p.282
[153] ts 23/2/23 (Dr Anderson), pp.282-283
[154] ts 23/2/23 (Dr Anderson), p.265
[155] ts 23/2/23 (Dr Anderson), p.269

EMR; however, the general consensus was that it would take seven to ten years.[156]

232 I had contemplated making the recommendation that Dr Anderson had suggested. The benefits of an EMR that has a system of checks and balances inbuilt into it that ensured proper and timely attention was given to pathology results are obvious. It would have likely led to the introduction of an earlier treatment path for Ms Keeley had it existed in December 2019.

233 However, unbeknown to myself or Dr Anderson at the time, the Deputy State Coroner had already made a recommendation regarding the funding of an EMR in her findings from the inquest into the death of Aishwarya Aswath Chavittupara. This finding was delivered in the same week as the inquest into Ms Keeley's death. Recommendation 4 from the Deputy State Coroner states:[157]

> I recommend that the State Government prioritise funding the Department of Health's EMR program to ensure that as soon as practicable, all public hospitals in WA, and in particular PCH, have access to digital tools that make it easier for all staff to record information, access medical records and be supported in their clinical assessments. This will significantly enhance patient safety in our public hospitals.

234 By email dated 24 March 2023, Mr Cooney, from the State Solicitor's Office which appeared for SMHS, advised:[158]

> SMHS instructs that SMHS endorses the substance of recommendation 4 of the Deputy State Coroner in the inquest into the death of Aishwarya Aswath Chavittupara.
>
> …
>
> SMHS further instructs an Electronic Medical Record (EMR) is one of the highest priorities of the WA Health Sustainable Health Review. WA Health is undertaking a staged approach to the goal of implementing an EMR for the State. Stage 1, which involves transitioning all hospitals from paper records to a digital clinical record system, is underway across WA. Stage 2, which involves implementing the core features of an EMR, is currently under discussion. The Stage 2 Business Case is due to be completed by December 2023, with the first site implementation planned for 2027.

235 In light of this advice, and noting that the type of recommendation I contemplated has already been made by the Deputy State Coroner, I do not consider it necessary to make a further recommendation that would be along very similar lines.

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[156] ts 23/2/23 (Dr Anderson), p.269
[157] Inquest into the death of ***Aishwarya Aswath Chavittupara*** [2023] WACOR10 delivered 22 February 2023, p.113
[158] Email from Henry Cooney to counsel assisting dated 24/3/2023

236 I will simply note that it is reassuring to know that work is underway towards the implementation of an EMR within our public hospitals. I would expect the State Government would see the considerable merits of this project and would make the appropriate financial commitments to ensure it can be implemented in a timely manner.

Establishing a stand-alone gynaecology/oncology medical facility

237 The fragmented care that Ms Keeley received following her cancer diagnosis was not unexpected. Currently, surgery for gynaecologic cases is typically performed at KEMH. If chemotherapy and/or radiotherapy is required, this is generally provided by SCGH. FSH also has the ability to provide chemotherapy in its oncology unit, and provide radiotherapy by Genesis Care.[159] As KEMH does not have a CT scanning machine, its patients who require a CT scan need to be taken to SCGH.[160]

238 When Associate Professor Allanson was asked why this fragmented system existed, she explained: "*The set-up in Western Australia is that we don't all exist in the same place, and that's historical and resource-driven, and, you know, unit-driven.*" [161]

239 Nevertheless, Associate Professor Allanson was of the view that this system of care was working effectively.[162]

240 I am not minded to make a recommendation for a stand-alone gynaecology/oncology medical facility for the reason that there is already a fully funded commitment from the State Government to build a new maternity hospital at the FSH precinct and to close the maternity section at KEMH. It has been reported since the inquest that the Health Minister has said this will allow a greater capacity to treat gynaecology patients at KEMH.[163] Consequently, it would seem there is every likelihood the relocation of the maternity hospital will have a flow-on effect of creating the opportunity for a less fragmented system for patients requiring treatment for gynaecology/oncology matters.

Implementing a fast-track referral system for suspected endometrial cancer

241 In her electronic statement provided to the Court on 26 September 2023, Wilora Keeley made well-researched and articulate submissions that I implement several recommendations. I reached the view that one of these

[159] Exhibit 1, Volume 2, Tab 11, Report of Dr John Anderson dated 21/2/2023, p.6
[160] ts 23/2/23 (Associate Professor Allanson), p.231
[161] ts 23/2/23 (Associate Professor Allanson), p.230
[162] ts 23/2/23 (Associate Professor Allanson), p.231
[163] watoday.com.au/national/western_australia/site-challenges-push-news-perth-women-s-and-children-s-hospital-south-p5czo7.html

recommendations had particular merit. It concerned the implementation of a fast-track referral system for women with suspected endometrial cancer. Because of the rapid progress of these cancers when they are undifferentiated, Ms Keeley's daughter proposed that I make a recommendation for a two-week timeframe for a hysteroscopy to be performed for women with suspected endometrial cancer. In her submissions, Wilora Keeley referenced articles that cited the National Institute for Health and Care Excellence (NICE) guidelines, which are evidence-based recommendations for healthcare in England.

242 It is my practice to invite those parties with an interest in a potential recommendation to make submissions regarding its feasibility. In this instance, that invitation was extended to SMHS.

243 I received a submission dated 16 October 2023 from the Head of Department, Obstetrics and Gynaecology, Fiona Stanley and Fremantle Hospital Group, Mr Arisudhan Anantharachagan (Mr Anantharachagan). Although Mr Anantharachagan accepted that the proposed recommendation's "*sentiment is laudable*", he added, "*it is not feasible in the short to medium term*".[164]

244 In his detailed submission to the Court, Mr Anantharachagan outlined the difficulties that would arise should attempts be made to implement the proposed recommendation. He also referred to (and attached) a more updated version of the NICE guidelines that was only released this month.[165] These NICE guidelines have a lesser target of a hysteroscopy within two weeks after it was demonstrated that the former target was not feasible.[166]

245 Mr Anantharachagan concluded his submission with the following:[167]

> In summary, the WA public health system currently aims to provide an appointment with a gynaecologist within four weeks, and the hysteroscopy performed no later than eight weeks after a referral from a GP. In England, the process aims for no more than four weeks between GP referral and gynaecology clinical appointment with hysteroscopy to follow thereafter. Outcomes from these two systems are likely to be similar i.e. hysteroscopy within eight weeks. At FSH, the current target is no more than four weeks from GP referral to (outpatient) hysteroscopy. So FSH is arguably the most expedited approach of the three with the standard WA approach being basically on par with England. SMHS is not aware of any public health service that targets GP referral to hysteroscopy within two weeks.

[164] Letter from Mr Arisudhan Anantharachagan dated 16/10/2023, p.1
[165] NICE Guidelines, Suspected Cancer: Recognition and Referral, 2 October 2023
[166] Letter from Mr Arisudhan Anantharachagan dated 16/10/2023, p.1
[167] Letter from Mr Arisudhan Anantharachagan dated 16/10/2023, p.3

246 In light of the submission from Mr Anantharachagan, I am satisfied a recommendation for a two-week fast-track referral system for hysteroscopy for patients with suspected endometrial cancer could not be effectively implemented, not at least in the short term.

247 Furthermore, I am satisfied with the improvements that have been made since Ms Keeley's death regarding the timing of a hysteroscopy. The creation of the specialist gynaecology clinic dedicated to post-menopausal bleeding now allows for an outpatient hysteroscopy (performed without anaesthesia and a theatre). As noted by Mr Anantharachagan, "*this approach has the benefit that it could save up to 30 days which might otherwise be spent waiting for a traditional hysteroscopy.*"[168]

CONCLUSION

248 In September 2019, Ms Keeley began experiencing post-menopausal bleeding. She reported this to her GP who, amongst other investigations, requested a pelvic ultrasound. That ultrasound found a thickening of the endometrium and the radiologist suggested a gynaecology review to evaluate this for possible endometrial carcinoma.

249 Ms Keeley was to become the one in ten post-menopausal women whose thickening of the endometrium is cancerous. Sadly, her cancer was also undifferentiated with neuroendocrine features, which is very rare and occurs in less than one percent of all endometrial cancers.[169] These neuroendocrine tumours of the endometrium are aggressive and progress rapidly, and the five-year survival rate is very low.[170]

250 On 29 November 2019, Dr Kasina, Ms Keeley's gynaecologist, performed the first HDC procedure. I have found he initially erred in failing to give appropriate consideration to a lesion in the uterine cavity that was visible during the hysteroscopy at this HDC. I have also found Dr Kasina failed to perform a repeat HDC procedure in a timely manner after a pathologist recommendation to determine whether Ms Keeley had endometrial cancer. Dr Kasina then compounded these errors by prematurely discharging her from his care.

251 These mistakes meant that Ms Keeley's cancer diagnosis was delayed for an estimated six to seven weeks.

252 I accept that surgeons such as Dr Kasina who work in the public sector have extremely heavy workloads. I also have no doubt that every surgeon,

[168] Letter from Mr Arisudhan Anantharachagan dated 16/10/2023, p.2
[169] ts 24/2/23 (Associate Professor Rome), p.300
[170] Exhibit 1, Volume 2, Tab 12, Statement of Associate Professor Emma Allanson dated 21/2/2023, p.11

including Dr Kasina, goes to work intending to do their utmost to provide the very best standard of care for their patients.

253 Unfortunately, whether it was from his workload and/or other factors, Dr Kasina failed to pay due and proper attention to the concluding remarks in the first histopathology report. I expect that this error has weighed heavily on Dr Kasina since it happened nearly four years ago. Although it is very unlikely Ms Keeley would have survived had her endometrial carcinoma been diagnosed in a more timely manner, Dr Kasina has expressed, "*I will forever regret that I denied her and her family that possibility*."[171]

254 Since Ms Keeley's death, SMHS have implemented a number of strategies that are aimed at improving the care offered to patients requiring gynaecology/oncology health services and, more specifically, to avoid the mistakes that occurred in Dr Kasina's care of Ms Keeley. I genuinely hope these changes achieve their desired aim.

255 It is also evident that the Department of Health is committed to the implementation of an EMR system that should have mechanisms in place to ensure pathology results are acted upon in a timely manner.

256 Nevertheless, whilst the changes that have already been made are welcome, I am very much aware that Ms Keeley's family must continue to deal with the sadness and grief caused by her death and the circumstances surrounding it. I am also acutely aware of the heavy toll this has had on Wilora Keeley.

257 On behalf of the Court, and as I did at the conclusion of the inquest, I extend to Wilora Keeley, and to other family members and friends of Ms Keeley, my sincere condolences for their loss.

P J Urquhart
Coroner
18 October 2023

[171] Exhibit 1, Volume 2, Tab 2, Statement of Dr Venkata Kasina dated 8/2/2023, p.13