IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000988

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Abraham Sleiman Transcendo
Date of birth:	24 August 1989
Date of death:	19 February 2023
Cause of death:	1(a) Complications of subarachnoid haemorrhage secondary to a ruptured aneurysm.
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084

INTRODUCTION

1. On 19 February 2023, Abraham Sleiman Transcendo was 33 years old when he passed away at the Austin Hospital. At the time of his death, Mr Transcendo lived at Wyndham Vale with his partner.

THE CORONIAL INVESTIGATION

2. Mr Transcendo's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. This finding draws on the totality of the coronial investigation into the death of Abraham Sleiman Transcendo. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

6. On the evening of 14 February 2023, Mr Transcendo was at home with his partner, David Transcendo. He experienced a sudden onset severe frontal headache and nausea, after consuming twice his 100mg prescribed dose of sildenafil. Mr D Transcendo called 000 at

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8.43pm and requested an ambulance. An ambulance was dispatched Code 2 at 8.55pm and arrived at 9.11pm.

7. After assessing Mr Transcendo at the scene, paramedics transported him to the nearest stroke capable hospital, being Werribee Mercy Hospital (**WMH**) emergency department (**ED**) and arrived at about 9.48pm. He was triaged by staff at about 9.55pm. Due to ramping at WMH, Mr Transcendo remained with paramedics until about 11.02pm, when he was formally transferred into WMH's care. Whilst waiting, paramedics continued to monitor Mr Transcendo's condition. About 30 minutes after the initial triage (i.e., at about 10.25pm), Mr Transcendo experienced two episodes of bradycardia and reduced consciousness. The paramedics notified WMH staff to escalate his care.

8. Mr Transcendo underwent an urgent CT brain scan at about 12.16am on 15 February 2023, which showed a severe diffuse subarachnoid haemorrhage, intraventricular haemorrhage secondary to an aneurysm of the anterior communicating artery at the origin of the anterior cerebral arteries. This was communicated to the referring ED medical officer (**MO**), who discussed the case with a neurosurgical registrar at St Vincent's Hospital, to facilitate a possible transfer. Unfortunately, St Vincent's Hospital did not have an available bed for Mr Transcendo, so the MO also contacted Adult Retrieval Victoria (**ARV**) to facilitate an urgent transfer to another appropriate facility.

9. ARV then contacted a range of hospitals attempting to facilitate a transfer. The Royal Melbourne Hospital, Alfred Hospital and Monash Medical Centre Intensive Care Units (**ICU**s) did not have an available bed. However, at about 1.57am, the Austin Hospital confirmed an available bed for Mr Transcendo. Conversations continued between ARV, WMH and Austin Hospital to facilitate immediate surgical intervention for Mr Transcendo upon his arrival at the Austin Hospital.

10. The ARV coordinator initiated the transfer by requesting a Mobile Intensive Care Ambulance (**MICA**) to attend WMH. The MICA was dispatched Code 1 at 2.33am and arrived at WMH at 2.54am. The MICA team loaded Mr Transcendo into the ambulance at 3.37am and transported him under 'lights and sirens' to the Austin Hospital, arriving at 4.50am.

11. Upon arrival at the Austin Hospital, Mr Transcendo was noted to have bilateral non-reactive pupils and had a Glasgow Coma Scale (**GCS**) score of three. The treating neurosurgeon noted that given Mr Transcendo's young age, he would attempt to insert bilateral external ventricular drains (**EVD**s), which was an attempt to save his life, however there was still a high chance

of mortality or significant deficit regardless. Mr Transcendo's partner provided consent to proceed with the surgery.

12. Following the procedure, Mr Transcendo received neuroprotective measures in the ICU, however his intracerebral pressures were unable to be controlled. Brain death was confirmed on 19 February 2023. He was extubated on 22 February 2023 and passed away shortly thereafter.

Identity of the deceased

13. On 20 February 2023, Abraham Sleiman Transcendo, born 24 August 1989, was visually identified by his partner, David Transcendo.

14. Identity is not in dispute and requires no further investigation.

Medical cause of death

15. Forensic Pathologist Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 23 February 2023 and provided a written report of her findings dated 7 March 2023.

16. The post-mortem examination revealed findings consistent with the reported circumstances.

17. Examination of the post-mortem CT scan showed a subarachnoid haemorrhage, intraventricular haemorrhage, bilateral external ventricular drains and bi-basal pneumonia.

18. Toxicological analysis of ante-mortem samples (taken at 11.00pm on 14 February 2024) identified the presence of sildenafil.[2] Ethanol (alcohol) was not detected.

19. Dr Parsons provided an opinion that the medical cause of death was "*1(a) Complications of subarachnoid haemorrhage secondary to a ruptured aneurysm.*"

20. I accept Dr Parsons' opinion.

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[2] Sildenafil is a phosphodiesterase 5 inhibitor that is indicated for pulmonary arterial hypertension and erectile dysfunction.

FAMILY CONCERNS

21. Lawyers representing Mr Transcendo's partner wrote to the Court and expressed concerns on his behalf about the treatment Mr Transcendo received at WMH and delays in organising further investigations and transfer to a suitable medical facility.

FURTHER INVESTIGATIONS AND CPU REVIEW

22. As part of the coronial investigation, I directed statements be provided by WMH and Ambulance Victoria (**AV**), who provide ARV services. I also referred this matter to the Coroners Prevention Unit (**CPU**)[3] to provide an independent review of the medical treatment and care provided to Mr Transcendo, and to specifically consider the concerns raised on behalf of Mr Transcendo's partner.

Transfer time between WMH and Austin Hospital

23. Dr Christopher Perry, Retrieval Consultant and Quality and Safety Lead at ARV, provided a statement outlining the specific timeline of events pertaining to Mr Transcendo's care on 14 and 15 February 2023. Dr Perry noted that more than four hours elapsed between the time of the initial ARV referral to the time Mr Transcendo arrived at the Austin Hospital. Dr Perry noted that in an 'ideal world' with no delays or other competing time pressures, the timeframe would be about 145 minutes. He noted that given that unavoidable delays can and do occur, this timeframe is simply not always achievable.

24. Dr Perry noted the numerous attempts made to secure a bed for Mr Transcendo at various hospitals, however only the Austin Hospital were able to facilitate a neurosurgery bed. Given the physical distance between the two hospitals, the drive itself took approximately one hour. A transfer from WMH to St Vincent's Hospital (as originally intended) would have been quicker.

25. Dr Perry also noted that from 12.48am to 3.39am on 15 February 2023, ARV was managing a total of nine complex and time-critical referrals. As a result, there was no retrieval doctor available for Mr Transcendo's transfer. Therefore, MICA paramedics were dispatched instead

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

to transport Mr Transcendo to the Austin Hospital, as per ARV protocol when ARV clinicians are unavailable. He noted that this did not cause or contribute to Mr Transcendo's death but was evidence of the significant demand placed on the service at the time.

26. Dr Perry further commented that with the benefit of hindsight, ARV identified some system issues that could improve the care of a similar patient in the future, namely:

    a) Early dispatch of paramedics for time-critical cases whilst sourcing and/or confirming the appropriate destination or hospital may have expedited the transfer.

    b) For time-critical neurosurgical cases, an early decision to define the transfers to the closest geographical centre, especially whilst experiencing access block, regardless of its bed status, potentially could have expedited the transfer.

    c) Support of a business case for more available ARV resources and a 24-hour ARV ambulance and crew could have reduced on-scene time.

    d) Development of clear criteria for ARV coordinators to define time-critical neurosurgical emergencies to the closest centre without having to call for bed availability.

    e) Encourage the referrer to contact ARV initially for time-critical neurosurgical cases as ARV have oversight of ICU beds and other high-acuity neurosurgical demands.

27. The CPU review noted that a subarachnoid haemorrhage is a neurologic emergency with a mortality rate of about 60% in the first six months. In Mr Transcendo's case, he had a severe diffuse subarachnoid haemorrhage with intraventricular haemorrhage and the CPU opined that it was difficult to assess whether the outcome would have differed with a shorter transfer timeframe.

28. The CPU review noted that that the ARV workload was unexpectedly very high due to factors beyond its control, and that in such circumstances the response by ARV was reasonable. The CPU commented that the suggested improvements seemed reasonable, but stressed that the delay was caused by ARV experiencing a very high workload at the time. I also note that AV's comments and suggestions were made with the benefit of hindsight, and in my view the identification of general suggested improvements does not detract from the CPU advice that the transfer time experienced on 14 and 15 February 2023 was reasonable, given the

unavoidable delays that occurred as a result of a high workload, and which were outside the control of AV having regard to current resourcing.

Investigations at WMH

29. The CPU reviewed Mr Transcendo's treatment at the WMH ED and noted that the timing of his treatment was appropriate and reasonable. They noted that he promptly underwent a CT scan, which is the 'gold standard' test for patients with a suspected subarachnoid haemorrhage. They opined that given Mr Transcendo's condition, with a GCS of 13-14 that was not decreasing, an urgent (but not immediate) CT brain scan was appropriate. The CPU did not identify any prevention opportunities in relation to Mr Transcendo's care and treatment at WMH.

Conclusion regarding family concerns

30. The concerns raised regarding delay are understandable. There was clearly delay in organising the transfer to an appropriate hospital, and therefore delay to necessary medical treatment in Mr Transcendo's case. However, I am satisfied that the primary cause of the delay was an unexpectedly heavy workload and broader resourcing issues. The efforts that were made to facilitate appropriate and timely medical treatment within those constraints were reasonable. Furthermore, having regard to the serious nature of the medical emergency, the evidence does not support a finding that Mr Transcendo would have survived his medical emergency if the delay had not occurred.

FINDINGS AND CONCLUSION

31. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Abraham Sleiman Transcendo, born 24 August 1989;

    b) the death occurred on 19 February 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084, from complications of subarachnoid haemorrhage secondary to a ruptured aneurysm.; and

    c) the death occurred in the circumstances described above.

I convey my condolences to Mr Transcendo's family for their loss.

COMMENTS AND RECOMMENDATIONS

32. Whilst the death of Mr Transcendo was not preventable, the system issues identified by ARV may assist in reducing delay in future similar cases and therefore potentially improve patient care. I commend ARV for their thorough response to the request for information and their identification of systems issues demonstrated by this case. It is appropriate to adopt the suggested changes as recommendations, such that there will be a requirement pursuant to s 72(3) of the Act for a written response within 3 months. That response must include a statement of what action (if any) has, is or will be taken in response to the recommendations.

33. Having regard to the role of the Coroners Court in contributing to the reduction of the number of preventable deaths, and the desirability of promoting public health and safety, pursuant to s 72(2) of the Act, I make the following recommendations:

Recommendation 1

That Adult Retrieval Victoria implement policy and procedure which will achieve the following outcomes:

a) Early dispatch of paramedics for time-critical cases whilst sourcing and/or confirming the appropriate destination or hospital to expedite transfer.

b) Development of clear criteria for ARV coordinators to define time-critical neurosurgical emergencies to the closest centre without having to call for bed availability.

c) Development of processes which will ensure a referrer contacts ARV initially for time-critical neurosurgical cases.

Recommendation 2

That Adult Retrieval Victoria consider the submission of a business case for more available ARV resources and a 24-hour ARV ambulance and crew.

Pursuant to s 73(1) of the Act I order that this finding be published on the Internet.

I direct that a copy of this finding be provided to the following:

David Transcendo, Senior Next of Kin

Ambulance Victoria

Austin Health

First Constable Josh Bagdadi, Victoria Police, Notifying Member

Signature:

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Coroner Catherine Fitzgerald

Date : 20 September 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.