IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002175

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Dorothy Anne Simm
Date of birth:	16 March 1949
Date of death:	26 April 2023
Cause of death:	1a: Non traumatic intracerebral hemorrhage with further deterioration post medical intervention
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168

INTRODUCTION

1. On 26 April 2023, Dorothy Anne Simm was 74 years old when she died in hospital. At the time of her death, Dorothy lived in Sale with her husband, Geoffrey.

THE CORONIAL INVESTIGATION

2. Dorothy'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. Additionally, Dorothy's death was reported by Monash Health as *her death occurred following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.*[1]

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding 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.

5. 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.

6. This finding draws on the totality of the coronial investigation into the death of Dorothy Anne Simm. 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.[2]

[1] *Coroners Act 2008* (Vic) s 4(2)(b)(ii).

[2] 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.

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

Circumstances in which the death occurred

7. At around 6:30am on 17 April 2023, Dorothy experienced a sudden onset headache and left sided weakness. She was conveyed by ambulance to Sale Hospital where a computed tomography (**CT**) scan showed a right parietal intracranial haemorrhage.

8. Dorothy's case was discussed with the Victorian Stroke Telemedicine Service[3], and the decision was made for her to be transferred by helicopter to Monash Medical Centre, the closest hospital with both stroke and neurosurgical facilities.

9. Dorothy arrived at the Emergency Department at 10:04am. On arrival she was alert and oriented to time, place and person and had a Glasgow Coma Score (**GCS**)[4] of 15.

10. She was assessed by the stroke team as having a normal conscious state but had a dense left-sided hemiplegia and neglect. It was determined that she was a candidate for the Ultra-Early, Minimally inVAsive intraCerebral Haemorrhage evacUATion Versus Standard trEatment (EVACUATE) trial protocol[5]. She was consented for the trial by her husband, Geoffrey.

11. Dorothy was taken to theatre at about 6pm. A CT guided burr-hole and evacuation of the haematoma was performed using the trial endoscope, with some challenges. Neurosurgeon Chris Xenos explained:

    In principle, the endoscope works on a mirror system of delivering light into the cavity and a suction/clot evacuator instrument is used in addition for clot evacuation. It is these aspects of the procedure that were technically difficult from my perspective, with at times a poor view of the cavity contents, sub optimal evacuation of a tenacious clot by the provided suction system, and the need for frequent wiping and cleaning of the mirror to optimise visualisation.

[3] The Victorian Stroke Telemedicine connects regional hospitals with stroke specialists, enabling timely, expert care for acute stroke patients

[4] The Glasgow Coma Scale (**GCS**) is a neurological scoring system used to assess conscious level. The GCS is comprised of three categories; best eye response, best vocal response and best motor response. The GCS is scored out of 15, with a score of 15 indicating a normal level of consciousness.

[5] The EVACUATE trial was registered with the Australian and New Zealand Clinical Trials Registry and commenced on 15 November 2020. The hypothesis the trial is testing is whether patients with recent significant intracerebral bleed (defined as >20ml as estimated by CT scan) that do not have a significant underlying vascular abnormality (as determined by CT scan) but do have a significant neurological deficit (defined as a NIHSS score of >64) benefit from early (defined as within 12 hours) neurosurgical drainage of that bleed. The trial is randomized into standard care (non-surgical) and surgical care.

12. Mr Xenos recalled that during the surgery he noted likely entry into the ventricular system. Upon noticing this he endeavoured to optimise visualisation and attempted to withdraw out of the ventricle back into the clot cavity once he thought he had reasonable evacuation of clot material.

13. Upon completion of the surgery, Dorothy was taken for a CT brain scan. It showed *'partial evacuation of right parietal parenchymal haematoma. New tract containing acute haemorrhage and gas through the right thalamus and ventral midbrain with increased mass effect. Intraventricular haemorrhage has increased'*. There was associated hydrocephalus.

14. Dorothy was immediately returned to theatre and an external ventricular drain was inserted. Mr Xenos determined not to perform any further endoscopic evacuation or open craniotomy evacuation of the intracerebral haemorrhage in light of the deep extension of the bleeding.

15. Dorothy was slow to wake post-procedure. Within 36 to 48 hours, she was alert with a GCS of 15.

16. Dorothy's conscious state fluctuated over the following 48 hours, despite more aggressive drainage via the external ventricular drain.

17. At 2:57pm on 19 April 2023, Dorothy's GCS dropped to 8, resulting in a MET call[6]. A CT scan was performed, and surgeons lowered the drain to relieve intracranial pressure. Dorothy then remained stable with a GCS of 10.

18. Despite ongoing medical management, Dorothy's condition did not improve. On 25 April 2023, a family meeting was held by the neurosurgical team where Dorothy's family were advised of her very poor prognosis and that she was unlikely to ever return to independent living if she survived. The decision was made to transition her to comfort care.

19. Dorothy died at 4:17am on 26 April 2023.

Identity of the deceased

20. On 26 April 2023, Dorothy Anne Simm, born 16 March 1949, was visually identified by her daughter, Andrea Simm, who completed a Statement of Identification.

[6] The Medical Emergency Team call is a hospital-based emergency medical call system, designed for a nurse (or other staff member) to alert and call other staff for help. A major trigger for calling at MET is when a patient's vital signs have fallen outside set criteria.

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

Medical cause of death

22. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Dorothy Simm on 27 April 2023. Dr Bedford considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from Monash Health and provided a written report of his findings dated 28 April 2023.

23. The findings at external examination were in keeping with the history.

24. The post mortem CT scan showed the following:

- Right parietal burr hole
- Right parietal, left parietal and right thalamic haemorrhages with intraventricular spread
- Distended stomach
- Bilateral pleural effusions
- Mitral valve annular calcifications

25. Dr Bedford provided an opinion that the medical cause of death was 1(a) NON TRAUMATIC INTRACEREBRAL HEMORRHAGE WITH FURTHER DETERIORATION POST MEDICAL INTERVENTION.

MONASH HEALTH REVIEW

26. Dorothy's case was reviewed as part of the Neurosurgical Unit's weekly audit, the Morbidity and Mortality meeting, and at the neurosurgical business consultant meeting. Following the Morbidity and Mortality meeting, it was classified as a 'Class 3'[7] death.

[7] Death classifications are different to Incident Severity Ratings. Monash Health classifies deaths as follows:
1. Death which may have resulted from treatment (commission error)
2. Death which may have been prevented with further treatment (omission error)
3. Death which would NOT have been prevented with further treatment
4. Anticipated death due to terminal illness
5. Death following cardiac or respiratory arrest which occurred before arrival to hospital

27. Dorothy's was the second case via the EVACUATE trial performed at Monash Health. Some of the same technical issues experienced by Mr Xenos were noted in the first case – including poor suboptimal visualisation and clot aspiration – but there was no poor outcome in that case.

28. As part of the reviews/discussions, members of the Neurosurgical Unit raised concerns with continuing as part of the EVACUATE trial, in utilising the provided endoscope and suction equipment. The specific concerns related to suboptimal vision during the case, suboptimal suctioning of tenacious thick clot, and the need for frequent wiping of blood and fluid off the endoscope mirror for better visualisation.

29. Following discussion of the issues, it was decided that the Monash Health Neurosurgical Unit would pause further involvement in the EVACUATE trial.

30. Monash Health did not report Dorothy's case to Safer Care Victoria as a sentinel event[8] and a Serious Adverse Patient Safety Event (**SAPSE**)[9] review was not conducted. Her death was also not assigned an ISR (incident severity rating)[10].

CORONERS PREVENTION UNIT REVIEW

31. Having regard to the circumstances of Dorothy's death, I asked that a clinician from the Coroners Prevention Unit (**CPU**)[11] review the case and advise me whether she was an appropriate candidate for the EVACUATE trial.

32. In doing so, the CPU considered the medical record and statements from the following:

- Mr Leon Lai, Consultant neurosurgeon, Monash Health
- Mr Chris Xenos, Consultant neurosurgeon, Monash Health

[8] Safer Care Victoria describes a sentinel event as when something goes wrong with a patient's care that causes them serious harm or death. Safer Care Victoria provides 11 categories of sentinel event.

[9] A SAPSE is an event that has resulted in, or is likely to result in, unintended or unexpected moderate or severe harm or prolonged psychological harm being sustained by the patient.

[10] ISR is a tiered incident severity rating system for adverse events:
ISR 1 – Severe impact or death
ISR 2 – Moderate impact
ISR 3 – Mild impact
ISR 4 – No harm/near miss

[11] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

- Dr Carlos Scheinkestel, Director of Quality and Safety, Monash Health

33. On Dorothy's presentation to the Emergency Department, her case was discussed with multiple clinicians who agreed that her presentation and haemorrhage fulfilled the criteria for the trial.

34. Dorothy was consented for the trial by her husband who provided consent for a right frontal parietal intracerebral haematoma evacuation. The risks were raised during the consent process, including bleeding, infection, cerebrospinal fluid leak, nil improvement in symptoms, anaesthetic complications and death.

35. The CPU advised me that Dorothy's participation in the trial was appropriate and the neurosurgical team acted reasonably and appropriately in terms of both the trial surgery itself and their response to complications. They further advised that the decision to withdraw from the trial due to technical difficulties with the trial equipment was appropriate.

36. The CPU noted with concern that Dorothy's death was not given an ISR or considered a sentinel event, particularly as it was reported to the Coroner by Monash Health as a death that '*occurred following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not … have reasonably expected the death'*.

37. Mr Lai explained the rationale for not assigning an ISR or categorising the death as a sentinel event.

38. He noted that Dorothy had a very poor presenting condition, and if she had not been a candidate for the EVACUATE trial, the only alternative treatment option would have been conservative management. A craniotomy would not be standard practice for her condition.

39. Dorothy initially woke from the surgery with a good outcome, indicating that the partial evacuation surgery and insertion of the extra ventricular drain was successful. Unfortunately, she began to deteriorate.

40. CT imaging on 24 April 2023 demonstrated that Dorothy experienced a new contralateral spontaneous intracerebral haemorrhage, which Mr Lai noted typically carries a poor prognosis and was not considered to be related to the surgery, but a result of her underlying bleeding pathology.

41. As noted above, the death was classified at the Morbidity and Mortality meeting as a Class 3 death. Mr Lai explained that whilst there were some concerns about the EVACUATE trial equipment, the equipment did not impact on Dorothy's surgical outcome, and her death was the result of the severity of her underlying pathology. He said *'there was no instrument failure intraoperatively directly contributing to Mrs Simm's delayed poor outcome following surgery.'*

42. It was discussed at the Morbidity and Mortality meeting[12] that whilst possible entry into the ventricle was not optimal, it did not cause any significant harm or injury that increased the likelihood of, or caused the death, and any potential issues were appropriately managed by insertion of the external ventricular drain.

43. Mr Lai concluded:

> *Therefore, whilst there were concerns about whether the surgical equipment used in the Evacuate trial functioned optimally, it was considered at the [Morbidity and Mortality meeting] that these concerns did not impact on Mrs Simm's surgical outcome and did not cause harm to support a death classification of Class 1 or a clinical incident requiring review in accordance with ISR classification or SAPSE review.*

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. I consider that at all times, Monash Health clinicians acted reasonably and appropriately in providing Dorothy's care.

2. I accept that Dorothy's presentation on arrival at Monash Health was poor, and that she would have been for conservative management if not for her eligibility for the EVACUATE trial. I also accept that the surgery did not cause or contribute to her death, and that following the surgery she experienced a new contralateral spontaneous intracerebral haemorrhage with a very poor prognosis.

3. It follows that I should therefore accept the reasons for Monash Health not classifying Dorothy's death as a sentinel event or requiring a SAPSE review.

[12] Mr Lai clarified that at least six Consultant Neurosurgeons were in attendance at the meeting.

4. However, I consider that Dorothy's death should have been given an ISR.

5. Safer Care Victoria advises that once an Adverse Patient Safety Event (**APSE**) has been identified, it should be assigned an incident rating that classifies the severity of the adverse event and informs the type of review and external notification requirements. Essentially, the ISR classification determines the type of investigation required into the incident.

6. The Australian Commission on Quality and Safety in Health Care defines an APSE as *'An incident that results, or could have resulted, in harm to a patient or consumer'*. It seems clear to me that intraoperative equipment difficulties, and the possible entry into the ventricle (described by Mr Lai as *'not optimal')* could have resulted in harm, and therefore Dorothy's case was an APSE requiring an ISR.

7. The death classification system applied by Monash Health is, by contrast, a classification system for the findings of a review or investigation. The classification of a death cannot be used retrospectively to determine the type of review as this risks an inappropriate review.

8. Despite my criticisms, I acknowledge that the Monash Health did perform open disclosure with Dorothy's family and did take steps to decrease the chance of recurrence by withdrawing from the EVACUATE trial.

9. I do acknowledge that even had an ISR been assigned and that review process follows, Dorothy's death would have been classified as Class 3. Ultimately, Monash Health's review processes are just that – a review after the fact – and therefore had no bearing on Dorothy's sad outcome. However, following the appropriate process as set out by Safer Care Victoria provides the best opportunity for a thorough review and subsequent learnings. I intend to make a pertinent recommendation to ensure this is done in future.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Director of Quality and Safety at Monash Health educate the Quality and Safety leads of each clinical unit about the difference between Riskman's death audit functionality and the Adverse Patient Safety Event functionality to ensure there is an appropriate reporting culture.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Dorothy Anne Simm, born 16 March 1949;

   b) the death occurred on 26 April 2023 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168;

   c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that Dorothy Anne Simm died from a non-traumatic intracerebral haemorrhage with further deterioration following surgical intervention;

2. AND, having considered the available evidence, I find that the medical management provided to Dorothy Anne Simm by Monash Health was at all times reasonable and appropriate, and I find that her death could not have been prevented.

I convey my sincere condolences to Dorothy's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

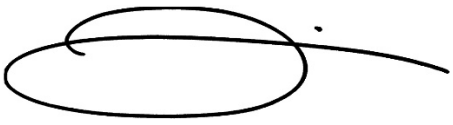
Geoffrey Simm, Senior Next of Kin

Monash Health

Safer Care Victoria

Senior Constable Anh Do, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 23 January 2026

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.