
**STATE CORONER'S COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Dr Beata Vandeville |
| **Hearing dates:** | 1-2 March 2016, 4 July 2016 |
| **Date of findings:** | 24 November 2016 |
| **Place of findings:** | NSW State Coroner's Court, Glebe |
| **Findings of:** | Magistrate Derek Lee, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – propofol, fentanyl, midazolam, restricted substances, anaesthetist, Royal Australian College of Obstetricians and Gynaecologists |
| **File numbers:** | 2015/21976 |
| **Representation:** | Senior Sergeant S Harding, Coronial Advocate Assisting<br><br>Mr R Sutherland SC instructed by Mr N Hanna (for Dr S Kabir) |
| **Findings:** | I find that Beata Vandeville died on 18 January 2013 at Neutral Bay. The cause of death was acute mixed drug toxicity due to accidental drug overdose. There is insufficient evidence to support a finding that Dr Vandeville died as a result of actions taken by her with the intention of ending life. |

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## Introduction

1. Beata Vandeville's dream was to become a surgeon. She pursued that dream in her homeland of Poland and, later, in Australia. She eventually obtained her medical degree and sought to specialise as a gynaecologist and obstetrician. Despite being described as a gifted and skilled surgeon, Dr Vandeville encountered considerable adversity in pursuit of her dream. Sadly, it was one that she would never achieve.

## Why was an inquest held?

2. When a person's death is reported to a coroner there is an obligation on the coroner to make findings in order to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances in which that person died.

3. In Dr Vandeville's[1] case the answers to most of these questions can easily be answered from material contained in the brief of evidence which was submitted to the Coroner's Court by the police who investigated Dr Vandeville's death. However, the investigation raised questions about the manner of Dr Vandeville's death and certain issues surrounding it.

4. As a result, the inquest examined the following issues:

   (a) The cause of Dr Vandeville's death;

   (b) The circumstances in which a number of restricted substances and drugs of addiction came to be located in and around Dr Vandeville's home;

   (c) The circumstances in which these restricted substances and drugs of addiction came to be found within Dr Vandeville's system postmortem;

   (d) The events surrounding Dr Vandeville's discovery on 18 January 2013;

   (e) The nature and circumstances of Dr Vandeville's enrolment in the Royal Australian and New Zealand College of Gynaecologists Training Program, and whether any aspect of the program contributed to her death; and

   (f) Whether any recommendations are necessary or desirable in relation to any matter connected with Dr Vandeville's death.

5. Before going on to consider these issues in more detail it is necessary to firstly, remember and recognise Dr Vandeville's life, and secondly, recount some of the background events leading up to Dr Vandeville's death, as well as the events of 18 January 2013.

[1] During the inquest a close friend of Dr Vandeville, and the representative for Dr Vandeville's parents (who live overseas), indicated that Dr Vandeville's family preferred for her to be referred to by her professional title. In respecting their wishes, I shall do the same in these findings.

**Dr Vandeville's life**

6. Dr Vandeville was born in 1966 in Katowice, a city in the southwest of Poland, the only daughter of Zenon and Miroslawa Mara Swida. Dr Vandeville's mother described her as a quiet child who had a love of books and music from an early age. Dr Vandeville completed primary and high school with distinction, and during the course of her education she dreamt of becoming a surgeon.

7. In pursuit of this dream Dr Vandeville worked as a hospital attendant whilst completing her medical studies. She met her husband, an Australian citizen, whilst studying and they married in 1991. Dr Vandeville's husband returned to Australia and, about a year later, Dr Vandeville moved to Australia to join him.

8. Dr Vandeville took up English lessons upon her arrival in Australia. She returned to Poland to complete part of her internship and, later, also completed an internship in Australia. Dr Vandeville later divorced and subsequently began a relationship with Dr Shammi Kabir, an anaesthetist, who would later become her fiancé.

9. At this time Dr Vandeville was living in a unit in Neutral Bay. Dr Kabir lived with Dr Vandeville for the majority of the time although he sometimes stayed at his parents' house when he was working at hospitals close to where his parents lived. [2]

10. Dr Vandeville initially had a desire to specialise in plastic surgery. She later decided to pursue a speciality in obstetrics and gynaecology instead and commenced her training program with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (the College) in 2004.

11. During her medical training, both in Sydney and in rural areas of NSW, Dr Vandeville formed close bonds with her fellow trainees who admired her dedication and hard work, and valued her loyal and warm friendship. In the course of her studies she impressed many of her supervising physicians with her caring attitude and medical skill; some of these supervisors would later become Dr Vandeville's close mentors and friends.

12. Despite the demands of her work and studies, Dr Vandeville returned to Poland as often as she could to see her parents. It is distressing to know that Dr Vandeville's parents last saw her about two years before her death. No doubt the pain of their loss is more pronounced by their geographical separation from Dr Vandeville. Despite this physical separation, there is equally no doubt that the loving memories of their daughter will always be with them.

**What happened leading up to 18 January 2013?**

13. Dr Vandeville was found, unresponsive, in her unit in Neutral Bay on 18 January 2013. In order to place Dr Vandeville's death into context it is necessary to first understand the immediate events leading up to it.

14. On Friday, 11 January 2013 Dr Vandeville had lunch with a close friend, Virginia Clowes, who she had met several years earlier during their medical training. Dr Vandeville appeared drawn

[2] T3.40, 4/7/16.

and fatigued to Ms Clowes, and not her usual self. Ms Clowes felt that Dr Vandeville was severely stressed and not coping with the demands of her medical training.[3]

15. On Saturday, 12 January 2013 Dr Kabir returned from his parent's house to the Neutral Bay unit and found Dr Vandeville in bed. Dr Kabir saw that Dr Vandeville was very uncomfortable, was shivering, and that she had muscle aches.[4] He also noted that she had a temperature and low blood pressure.[5] Dr Kabir suggested to Dr Vandeville that she should go to the hospital and offered to call an ambulance, but she refused.[6] Instead Dr Vandeville asked for some intravenous fluids. Dr Kabir agreed as he was of the view that the next best option was to treat Dr Vandeville at home, noting that she would have been treated the same way at hospital, namely with intravenous pain relief and antibiotics.[7]

16. Dr Kabir inserted a cannula into Dr Vandeville's arm[8] and gave Dr Vandeville some antibiotics (Keflex and Cefazolin) as well as paracetamol intravenously.[9] This arrangement of being given intravenous fluids at home continued for the next several days[10] with the intravenous fluid bag being changed by Dr Kabir the following day.[11]

17. At some stage early in the week of 14 January 2013, Dr Vandeville was visiting her upstairs neighbour, Nena Gerloff, who lived in unit 74. Ms Gerloff noticed that Dr Vandeville did not look well and that she appeared to have no energy.[12]

18. Ms Gerloff saw Dr Vandeville again on 15 January 2013 when Dr Vandeville rang her and asked for a cup of tea. Ms Gerloff took the tea to Dr Vandeville's unit and noticed that Dr Vandeville took a long time to answer the door, that she was moving slowly and was using the wall to hold herself up.[13] Ms Gerloff helped Dr Vandeville back to bed and left her to sleep.

19. On Wednesday, 16 January 2013, Dr Kabir wrote Dr Vandeville a prescription for two oral antibiotics (Keflex and Rulide) and obtained them from a pharmacy in Neutral Bay.[14] According to Dr Kabir, Dr Vandeville's condition improved by Wednesday night and continued to improve the following day.[15]

20. On Thursday, 17 November 2013 Dr Kabir went to work late so that he could spend time with Dr Vandeville in the morning. Ms Gerloff saw Dr Kabir in the car park sometime that day and asked him how Dr Vandeville was. Dr Kabir said that Dr Vandeville was "a little bit better".[16] When later interviewed by the police Dr Kabir said that Dr Vandeville still had muscle aches and was feeling fatigued, and that she was still continuing with fluids and receiving antibiotics (Cefazolin) intravenously.[17]

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[3] Exhibit 1, p. 921.
[4] Exhibit 1, Volume 2, Record of Interview (ROI) dated 19/1/13, Q/A 328-329.
[5] ROI, Q/A 282-286.
[6] ROI, Q/A 331.
[7] ROI, Q/A 330-331.
[8] Exhibit 1, page 403.
[9] ROI, Q/A 286, 297, 302, 304, 312.
[10] ROI, Q/A 309.
[11] Exhibit 1, page 403.
[12] Exhibit 1, page 374.
[13] Exhibit 1, page 374.
[14] ROI, Q/A 369, 377.
[15] ROI, Q/A 404.
[16] Exhibit 1, page 374.
[17] Exhibit 1, page 404.

**What happened on Friday, 18 January 2013?**

21. Dr Kabir stayed at the Neutral Bay unit during the night of 17 January 2013. He woke up the next morning sometime before 7:00am. At this time Dr Vandeville was awake but still in bed. She told Dr Kabir that she had not slept well. When Dr Kabir left for work, Dr Vandeville remained in bed. On his way out, Dr Kabir took the rubbish from the kitchen and emptied it in an outside bin.[18] Dr Kabir drove to work, arriving at the St George Hospital car park at 6:58am.

22. Dr Kabir called Dr Vandeville at 10:10am. This call was not answered and Dr Vandeville returned the call at 12:18pm but it went to Dr Kabir's voicemail. Dr Vandeville called again at 12:21pm and spoke to Dr Kabir briefly. Dr Kabir called Dr Vandeville twice more, at 12:56pm and 12:59pm, with both calls going to voicemail.

23. At 1:08pm Dr Vandeville called Dr Kabir back. During the call, Dr Vandeville sounded teary and told Dr Kabir that she was feeling unwell, and asked him when he was going to finish work.

24. Dr Kabir left work later that afternoon, driving out of the hospital car park at 4:21pm. He called Dr Vandeville from his car at 4:25pm but the call went to voicemail. Dr Kabir continued to drive to Neutral Bay, stopping on the way at the Caltex service station on Military Road, Neutral Bay where he filled his car with petrol at 4:56pm. Electronic records from the hospital car park, Dr Kabir's mobile phone call records, and a transaction record from the service station confirm all of these times.

25. After arriving at the Neutral Bay unit, Dr Kabir spent a few minutes in his car checking his email before going to the mailbox. There he found a notice to collect a parcel from the post office. Dr Kabir took the notice and made his way upstairs to the unit. Once inside the unit, Dr Kabir saw that the bedroom door was closed and spent a short time searching for a cricket pass before entering the bedroom.[19]

26. Inside, Dr Kabir found Dr Vandeville lying on her back on the bed with the doona pulled up to her chest. Dr Kabir said that he was unsure but thinks that he possibly rang Dr Vandeville's mobile phone. Dr Kabir later explained that his reason for making this call was in order to prove a point to Dr Vandeville regarding some previous discussion that they had had about when a call goes to voicemail. Call charge records confirm that no call was made from Dr Kabir to Dr Vandeville's phone at this time.

27. Dr Kabir initially thought that Dr Vandeville was asleep but, on closer inspection, found that she was unresponsive. Dr Kabir started cardiopulmonary resuscitation (CPR), estimating that he had been in the unit for about 10 to 15 minutes by this time.[20] He continued CPR for approximately 20 minutes[21] until eventually calling triple 0 at 7:01pm. Dr Kabir subsequently made calls to his father's phone at 7:05pm. His mother answered the call and Dr Kabir spoke to her briefly, telling her what he had discovered. Dr Kabir called Ms Gerloff at 7:06pm and asked her to come to the unit.

[18] ROI, Q/A 1293, 1295.
[19] ROI, Q/A 958.
[20] ROI, Q/A 1015, 1341.
[21] ROI, Q/A 1146.

28. Paramedics received a notification at 7:03pm to attend the unit and arrived on the scene at 7:08pm.[22] Once inside the bedroom the paramedics applied defibrillator pads to Dr Vandeville but found that Dr Vandeville's cardiac rhythm was asystole. Dr Vandeville was declared deceased. One of the paramedics, Peter Rowe, heard Dr Kabir say a number of times, "This will have to go to the coroners".[23]

**What was found in and around Dr Vandeville's unit?**

29. The police conducted a search of Dr Vandeville's unit in the early hours of the morning on 19 January 2013. A large amount of over-the-counter medication and prescription medication was located in the kitchen.[24] Most of the prescription medication had been prescribed by Dr Kabir to Dr Vandeville between 4 January 2013 and 16 January 2013 and included Rulide and Ibilex (antibiotics), together with Eleva (an antidepressant) and Lorazepam (a benzodiazepine used to treat anxiety).

30. When Dr Vandeville's bedroom was searched a compression stocking was found under the bed and a 10ml syringe was found lodged in the carpet at the head of the bed.[25] A small amount of white liquid in the syringe was later analysed and no common drugs were detected. Further analysis however detected alfentanil[26], an opioid analgesic drug commonly used for anaesthesia in surgery.

31. When crime scene officers examined Dr Vandeville they found a small circular bruise on Dr Vandeville's right wrist with a hole in the centre, similar to an injection point.[27] On the bed sheet near her wrist was a small bloodstain.[28]

32. The police also searched a number of garbage bins outside the apartment block. Located inside one of the bins was a brown paper bag, labelled "Fourth Village Providore", which had been sealed closed with staples. Inside the bag was a needle wrap; tissues, a compression stocking, and antiseptic swab, all of which were blood-stained; an empty bottle of paracetamol with a needle tip in the top; and empty vials of lignocaine (a local anaesthetic), midazolam (medication used for anaesthesia and sedation), fentanyl (a potent opioid analgesic), and Rapifen (the trade name for alfentanil).[29]

33. Police conducted a further search several hours later at about 7:30am on 19 January 2013. Inside a set of bedside drawers to the right of Dr Vandeville's bed were 3 unopened bottles labelled Fresofol 500 mg and 3 syringes and needles.[30] Fresofol is one of the trade names for propofol, an agent used for the induction and maintenance of anaesthesia and also for general sedation.[31] These items were located behind perfume, books and other trinkets. Two of the syringes were unused, but one syringe had been used and contained a small amount of white liquid. Subsequent analysis of the liquid detected the presence of propofol.[32]

[22] Exhibit 1, page 755.
[23] Exhibit 1, page 756.
[24] Exhibit 1, page 453.
[25] Exhibit 1, page 462, 612.
[26] Exhibit 1, tab 4, page 70.
[27] Exhibit 1, page 456, 554
[28] Exhibit 1, page 553.
[29] Exhibit 1, page 459, 585-598.
[30] Exhibit 1, page 697.
[31] T13.19, 2/3/16.
[32] Exhibit 1, tab 4, pages 70, 652.

**What was the cause of Dr Vandeville's death?**

34. Dr Matthew Orde, forensic pathologist, attended the scene at about 3:00am on 19 January 2013. He noted that Dr Vandeville had minor bruises over her limbs which were in keeping with recent vascular access.

35. Later on the same day at 1:55pm Dr Orde performed an autopsy at the Department of Forensic Medicine in Glebe. In his autopsy report[33] Dr Orde concluded that there were two possible causes of death. Firstly, Dr Orde found that there was severe atherosclerotic narrowing of the coronary arteries supplying DR Vandeville's heart muscle, and also quite pronounced atherosclerotic narrowing of the left carotid artery supplying the brain. These findings suggested the possibility of coronary artery heart disease as being the cause of Dr Vandeville's death.

36. Secondly, the toxicological results revealed the presence of various drugs: propofol (which, at the time, could not be quantified[34]), lignocaine, and a possibly toxic level of sertraline (antidepressant medication). Low levels of lorazepam, midazolam and nordiazepam (all benzodiazepine antidepressant medication) were also found. A blood sample was later sent to another laboratory which was able to quantify the propofol as 0.6mg/L.[35] The overall toxicology results raised the possibility of mixed drug toxicity as being the cause of death.

37. Ultimately Dr Orde concluded that, given the circumstances in which Dr Vandeville was found and the evidence of "home hospitalisation", it was more likely that acute drug toxicity, rather than heart disease, was the cause of death. Dr Orde noted that the finding of multiple injection marks of different ages over Dr Vandeville's limbs suggested that some or all of the drugs may have been administered intravenously. Dr Orde also noted that several of the organs (lungs, liver, bowel) showed signs of damage which suggested that there had been previous incidents of prior sublethal drug toxicity which had compromised respiratory function.[36]

38. In order to examine the toxicology results in more detail, two specialist experts were engaged to consider the types, quantities, and effects of the various drugs found in Dr Vandeville's blood. Dr Judith Perl[37], a forensic pharmacologist, reach the following conclusions:[38]

    (a) the level of lorazepam found in Dr Vandeville was within the therapeutic range;

    (b) the level of midazolam would not be expected to have any serious adverse effects;

    (c) the very low level of nordiazepam (which is the primary metabolite of diazepam, a muscle relaxant used to relieve anxiety) suggested that diazepam had not been used within 24 hours of Dr Vandeville's death, and it would not have caused any impairment; and

    (d) the level of sertraline was above the normal expected therapeutic range[39] but not at a level where it would be expected to result in death.

[33] Exhibit 1, Volume 1, Tab 3.
[34] This is because methods to quantity the propofol were not available in the laboratory where Dr Vandeville's blood was analysed.
[35] Exhibit 1, tab 4.
[36] Exhibit 1, Volume 1, tab 3.
[37] At the time Dr Perl completed her report, the results of the quantification of the propofol were not available.
[38] Exhibit 1, Volume 1, tab 5.
[39] Dr Perl noted that it was possible the elevated level might have been partly due to the competition for metabolism between sertraline and the antibiotics and benzodiazepenes (diazepam, midazolam, lorazepam).

39. The laboratory which analysed Dr Vandeville's blood sample had no methods available to it to test for alfentanil. Therefore, Dr Perl concluded that it was not possible to say whether alfentanil was a factor in Dr Vandeville's death. However, Dr Perl also concluded that if Dr Vandeville had received a supratherapeutic level of alfentanil that this may have caused respiratory arrest and death.[40]

40. Dr Ross MacPherson[41], a senior staff specialist anaesthetist, was asked to specifically consider the effect of the quantity of propofol found in Dr Vandeville. Dr MacPherson prepared two reports which were tendered as exhibits during the inquest. In his first report, Dr MacPherson highlighted the extreme risk associated with use of propofol outside a controlled hospital environment. This is because when propofol is used in an anaesthetic setting, loss of consciousness is often accompanied by other physiological effects such as loss of upper airway reflexes, cessation of respiration and changes in heart rate and blood pressure. For these reasons, when it is administered, monitoring systems should be in place to measure blood pressure, heart rate and the degree of oxygen in the blood.[42] Further, equipment to maintain a patent airway (to enable spontaneous ventilation) and maintain suction, together with a supply of oxygen should also be available.

41. Dr MacPherson explained that while the dose of propofol found in Dr Vandeville was very low, being only one-tenth of the dose needed to produce unconsciousness, because of how rapidly the dosage level falls as it is redistributed throughout the body, it may have been the case that the dose that was administered to Dr Vandeville was significantly higher just a few minutes beforehand, prior to redistribution.[43]

42. Due to the very low level of lignocaine, Dr MacPherson thought it unlikely that this contributed to Dr Vandeville's death. He concluded that it was likely that the lignocaine was present to reduce the pain associated with the intravenous injection of propofol.[44]

43. Whilst the individual levels of lorazepam, midazolam, nordiazepam and sertraline were unlikely on their own to be sufficiently toxic to cause death, it is commonly understood in cases of drug overdose that the combined effect of such central nervous system depressant drugs is greater than their individual parts. Although the presence of alfentanil in the blood could not be confirmed via toxicological analysis I also conclude that it was administered to Dr Vandeville. The location of a syringe containing alfentanil is consistent with its recent use. Finally, the presence of propofol was a clear and significant contributory factor to respiratory depression and death. Due to the effects of redistribution, the quantity of propofol that Dr Vandeville used was much higher than the amount detected postmortem and therefore more potent than the quantified level would suggest. Taking all of the above into account, I conclude that the cause of Dr Vandeville's death was multi-drug toxicity.

[40] Exhibit 1, Volume 1, tab 5.
[41] Senior staff specialist, Department of Anaesthesia and Pain Management, Royal North Shore Hospital and Clinical Associate Professor, University of Sydney.
[42] Exhibit 1, Volume 1, tab 6.
[43] Exhibit 1, Volume 1, tab 6.
[44] Exhibit 1, Volume 1, tab 6.

**What was the manner of Dr Vandeville's death?**

44. As has already been noted, varying quantities of propofol, midazolam, lignocaine, lorazepam, fentanyl and alfentanil ("the restricted substances") were all found in and near Dr Vandeville's unit. Examination of the manner of Dr Vandeville's death raises two questions. Firstly, did Dr Vandeville administer the restricted substances herself or were they administered by Dr Kabir? Secondly, if Dr Vandeville administered the restricted substances herself, did she do so with the intention of ending her own life? As consideration of this second question requires an understanding of Dr Vandeville's participation in the College's Training Program, I will return to this question later in these findings.

45. The possibility that Dr Kabir may have administered the restricted substances to Dr Vandeville arises because of certain things that Stephen Morton told the police.[45] Mr Morton was a neighbour of Dr Vandeville who lived in the same unit block as her. After encountering each other in the common areas of the block, Mr Morton received a Facebook friend request from Dr Vandeville on 23 November 2012. They sent each other messages via Facebook for several days before exchanging mobile phone numbers. From 27 November 2012, they sent each other text messages. This communication eventually led to Dr Vandeville and Mr Morton forming a casual intimate relationship.

46. Mr Morton told the police that Dr Vandeville regularly said that she had injections, and that at times Dr Kabir injected her with drugs.[46] She did not mention the name of any drug apart from valium and said that Dr Kabir sat with her to make sure that she was alright while under the effects of the drug.

47. Mr Morton saw Dr Vandeville inject herself on two occasions with drugs that came from small vials of clear liquid. On each occasion Dr Vandeville used a syringe to inject the drugs into a cannula.[47] The first occasion was in Mr Morton's unit where he saw that Dr Vandeville had a cannula in her leg. Mr Morton said that Dr Vandeville went into a semi-conscious state and her eyes rolled back in her head. Dr Vandeville attempted to talk but Mr Morton could not make sense of what she was saying.

48. The second occasion was on 12 January 2013 in Dr Vandeville's unit when she had a cannula in her arm. Mr Morton says that Dr Vandeville asked him to inject the drugs for her but he refused. Dr Vandeville said that she understood, apologised and said words to the effect of, "Don't worry, I'm going to be OK. You're not going to end up with a dead body on your hands".[48] Mr Morton explained that after injecting herself, Dr Vandeville lay back and went into a daze for about five minutes but she told Mr Morton that she was OK and that the drugs were working. It appeared to Mr Morton that Dr Vandeville was less affected on this occasion than on the first occasion.

49. On 17 January 2013 Dr Vandeville sent Mr Morton a photo of her right arm with a cannula inserted near the wrist.[49]

[45] Another witness, Jolanta Barbara Zbieg, also told the police (Exhibit 1, page 946) that Dr Vandeville had told her that Dr Kabir injected Dr Vandeville with drugs via a cannula. Due to Ms Zibet's unavailability she was not called as a witness at the inquest.
[46] Exhibit 1, page 1054.
[47] Exhibit 1, pages 1054-1055.
[48] Exhibit 1, page 1055.
[49] Exhibit 1, page 1057.

50. The above evidence raises both the possibility that either Dr Kabir administered the restricted substances on 18 January 2013, or Dr Vandeville administered the substances herself. However, I conclude that the former can be excluded and that the latter occurred. This is for several reasons.

51. Firstly, there is reason to doubt the comments made by Dr Vandeville to Mr Morton regarding Dr Kabir having previously injected her with drugs. This is because the police investigation revealed that Dr Vandeville told Mr Morton things, some of which were about Dr Kabir, which were later found to be untrue. For example, on 22 December 2012 Mr Morton said that Dr Vandeville told him that Dr Kabir became angry and abused her after she said that she no longer wanted to participate in a drug trial that Dr Kabir was conducting as part of a PhD project.[50] Police enquiries with the Therapeutic Goods Administration, the Federal government body responsible for oversight of clinical drug trials, revealed no record of Dr Kabir ever conducting any such trial.[51]

52. Further, Dr Vandeville told Mr Morton that around 29 December 2012 she was called into St Vincent's Hospital to assist in an operation concerning a female person who had been stabbed. Police enquiries revealed that Dr Vandeville did not have accreditation to work at St Vincent's Hospital after 31 July 2012.[52] Further, the hospital had no record of any female person being treated on 29 December 2012 for a stab wound.[53]

53. The above matters are not intended in any way to portray Dr Vandeville in a negative way or to denigrate her character. They are merely used to examine whether Dr Vandeville's comments to Mr Morton can be regarded as being reliable and cogent evidence.

54. Secondly, the two occasions when Mr Morton saw Dr Vandeville self-administer a drug, or drugs, were proximate to her death, both occurring within a span of about 2 months prior to her death. It can also be inferred from the photo which Dr Vandeville sent on 17 January 2013 that this was a third occasion of self-administration. All of these occurrences are consistent with self-administration of the restricted substances by Dr Vandeville on 18 January 2013.

55. Thirdly, the circumstances of Dr Vandeville's discovery by Dr Kabir are also consistent with self-administration. That is, there is no reason to doubt Dr Kabir's evidence that he removed the cannula from Dr Vandeville (which was an admission potentially adverse to his own interests) and no reason to doubt that the location of the bruise on Dr Vandeville's wrist and the bloodstain on the bed sheet were consistent with recent intravenous self-administration.

56. For all of the above reasons, I conclude that the restricted substances were self-administered by Dr Vandeville on 18 January 2013.

**What were the circumstances in which a number of restricted substances and drugs of addiction came to be located in and around Dr Vandeville's home?**

57. The fact that the restricted substances were found in a private home where both Dr Vandeville and Dr Kabir lived (even if only on a part-time basis in the case of Dr Kabir) and the fact that

[50] Exhibit 1, page 1055.
[51] Exhibit 1, page 2187.
[52] Exhibit 1, page 2068.
[53] Exhibit 1, page 2065.

both Dr Vandeville and Dr Kabir were doctors, immediately raises the question of whether either of them had obtained the restricted substances.

58. In order to examine how the restricted substances came to be where they were eventually found, an understanding of what laws apply in relation to how these substances are to be stored and who has legal access to them is needed. It will then be necessary to consider whether Dr Vandeville or Dr Kabir (or possibly an unknown third party) had access to these items and whether it is probable that they did in fact obtain them.

***(a) The relevant legislation***

59. Regulation of pharmaceutical drugs in NSW is governed by the *Poisons and Therapeutic Goods Act 1966* (the Poisons Act) and the *Poisons and Therapeutic Goods Regulation 2008* (the Poisons Regulation). Drugs and substances are classified in the NSW Poisons List according to a number of different schedules.[54] The relevant schedules are:

(a) **Schedule 4:** this contains substances which in the public interest should only be supplied upon the written prescription of a medical practitioner, or other practitioner with appropriate authority. Lignocaine[55], lorazepam, midazolam and propofol are all listed in Schedule 4.

(b) **Schedule 8:** this contains substances which are addiction-producing, or potentially addiction-producing. Alfentanil and fentanyl are both listed in Schedule 8.

60. Within hospital wards, Schedule 4 substances must be stored apart from all other therapeutic goods (other than drugs of addiction) in a separate room, safe, cupboard or other receptacle securely attached to a part of the premises. They must be kept securely locked when not in immediate use. However, these storage requirements do not apply when they are kept on an emergency trolley, anaesthetic trolley or operating theatre trolley.[56]

61. Schedule 8 substances must also be stored in an identical way to Schedule 4 substances in hospital wards. However there are additional restrictions concerning who has access to the secured area where the substances are stored.[57] There is also a requirement that a drug register be kept to record certain details such as the quantity of the drug administered, when it was administered and the name of the patient to whom it was administered.[58] The entry in the register must be signed by the person who made it and, in the case of drugs of addiction, countersigned by a person who directed, or witnessed, its administration. There are further requirements in relation to the destruction of unusable drugs where the destruction must be recorded and signed by the person who witnessed the destruction.[59]

[54] Poisons Act, section 8.
[55] In certain applications (such as in aqueous gel preparations and preparations for topical use other than eye drops), lignocaine is also listed in Schedules 2 and 5 of the Poisons List.
[56] Poisons Regulation, clause 30.
[57] Poisons Regulation, clause 75.
[58] Poisons Regulation, clause 117.
[59] Poisons Regulation, clause 127.

***(b) What type of access did Dr Vandeville have to the restricted substances?***

62. Dr Vandeville was not an anaesthetist and therefore did not have direct access to any of the restricted substances, which are commonly used in an anaesthetic setting. However, between June 2012 and December, Dr Vandeville did work at three medical facilities where some of the restricted substances were stored. Those three facilities were Kingsgrove Day Hospital, The Cosmetic Institute (TCI) in Parramatta, and St Vincent's Hospital.

63. Dr Vandeville undertook some training at Kingsgrove Day Hospital between June 2012 and August 2012. Fentanyl, midazolam and propofol are all used at the hospital. According to the director of nursing at the hospital, propofol and midazolam were stored in accordance with the Schedule 4 requirements, and fentanyl was stored in accordance with the Schedule 8 requirements.[60] However, the hospital did not have propofol in the 500mg quantity found in Dr Vandeville's bedside drawers.

64. Midazolam, fentanyl, and propofol were all used at TCI. However, like Kingsgrove Day Hospital, TCI also did not use the large 500mg vials of propofol that were found in Dr Vandeville's bedside drawers.[61] Dr Vandeville began working at TCI shortly after it commenced operation in September 2012. By the time of the police investigation, Dr Vandeville's name had been removed from the electronic records and so it was not possible to identify every day that she worked there. However, other records confirmed that Dr Vandeville worked there on 21 and 22 September 2012 and also on 13 and 21 November 2012.[62] She also consulted on two other days before November 2012, but the exact dates are unknown.

65. As TCI had only recently commenced operation, initially there was non-compliance with the Schedule 4 storage requirements. According to Alfred Lombardi, the Director of Nursing, up until mid-November 2012 both midazolam and propofol were kept in anaesthetic trolleys but left unlocked on days when there was no surgery.[63] This of course meant that both substances were readily accessible to someone like Dr Vandeville who had access to the procedure rooms where the trolleys were kept. Further, Mr Lombardi explained that there were times during the day (such as lunchtime) when the procedure rooms were unstaffed thereby increasing the possibility of the restricted substances being diverted. Schedule 8 substances were, however, stored in accordance with the Poisons Regulation. Overall, Mr Lombardi explained that whilst both midazolam and propofol would have been accessible to Dr Vandeville, fentanyl would have been very difficult for her to access.[64]

66. As part of her College training Dr Vandeville assisted in two surgeries at St Vincent's Private Hospital (SVPH) in December 2012.[65] According to Adjunct Professor Jose Aguilera, Director of Nursing and Clinical Services, SVPH did stock the type and quantities of restricted substances that were found in and around Dr Vandeville's home, except for the type of midazolam.[66] Professor Aguilera also explained that the restricted substances were all stored in accordance

[60] Exhibit 1, page 2394.
[61] T63.1, 1/3/16.
[62] Exhibit 1, page 2439.
[63] Exhibit 1, page 2438.
[64] T65.42, 1/3/16.
[65] Exhibit 1, page 1002.
[66] Statement of Adjunct Professor Jose Aguilera, pares 5-7.

with their respective Schedule 4 and Schedule 8 requirements and that unauthorised diversion of the Schedule 4 substances was highly unlikely.[67]

***(c) What type of access did Dr Kabir have to the restricted substances?***

67. According to Dr Kabir's diary, he worked at 11 hospitals across Sydney between 1 July 2012 and 18 January 2013. All of the hospitals used the restricted substances in the type and quantity found in and near Dr Vandeville's unit.

68. However, with respect to storage and record-keeping associated with the restricted substances, there were slightly different practices within the hospitals. All the hospitals kept a register of the Schedule 8 substances. However it appears that some hospitals (Sydney South West Private Hospital[68], Nepean Private Hospital[69], Westmead Private Hospital[70], Norwest Private Hospital[71], St George Private Hospital[72], and Kareena Private Hospital[73]) had an extra-level of safekeeping by also keeping a register for midazolam, even though this was not a Schedule 4 requirement. It also appears that whilst most hospitals stored propofol in accordance with the Schedule 4 requirements, these requirements were not followed at some hospitals (St George Private Hospital[74], Liverpool Hospital[75]). However, even if propofol was not kept in a secure area it was generally kept in areas that were inaccessible to members of the public.

69. It appears that, generally, there was compliance with the storage and record-keeping requirements of the Poisons Regulation with respect to both Schedule 4 and Schedule 8 restricted substances. The comprehensive police investigation did not identify any discrepancies in any of the registers that indicated that either Dr Vandeville or Dr Kabir diverted any of the Schedule 4 or Schedule 8 substances. However, despite such compliance, it was commonly accepted, by the various directors of nursing, clinical services and pharmacy from whom statements were taken, that removal of Schedule 4 substances would not be difficult in a busy hospital environment. If the amounts removed were small and they were removed infrequently, they would not be missed. The various directors also agreed that because of the record-keeping requirements and increased security measures associated with Schedule 8 substances, that it would be more difficult, but by no means impossible, to divert these substances. Indeed it was noted that the substitution of a drawn syringe or the secretion of residual amounts were some diversionary methods that could be used.[76]

70. Dr MacPherson's evidence was consistent with the views expressed by the above directors. He also explained that in a busy hospital setting, with clinical staff focused on different individual tasks, it is possible for even Schedule 8 substances to be diverted. Dr MacPherson acknowledged that even though secure storage may reduce the risk of diversion, this will not entirely frustrate the attempts of a determined person intent on doing so.[77]

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[67] Aguilera, para 8.
[68] Exhibit 1, p. 2453.
[69] Exhibit 1, p. 2464.
[70] Exhibit 1, p. 2516.
[71] Exhibit 1, p. 2544.
[72] Exhibit 1, pp. 2583-2584.
[73] Exhibit 1, pp. 2646-2647.
[74] Exhibit 1, pp. 2583-2584.
[75] Exhibit 1, pp. 2403-2404.
[76] Exhibit 1, p. 2404.
[77] T18.9, 2/3/16.

***(d) Did Dr Vandeville obtain the restricted substances?***

71. The evidence reveals several instances from which it can be inferred that, from about June 2012, Dr Vandeville intended to obtain the restricted substances.

72. Firstly, according to Dr Kabir, in the 6 months preceding her death Dr Vandeville asked him about different types of anaesthetic drugs and their effects.[78] Dr Kabir told the police that Dr Vandeville had asked for midazolam[79], fentanyl[80] and propofol.[81] In response, Dr Kabir said that he told Dr Vandeville that what she was asking about was "ridiculous" and that these drugs would not help with the conditions (migraines, insomnia, depression) that Dr Vandeville was experiencing at the time.[82] Dr Kabir told said that he told Dr Vandeville that propofol was a dangerous drug only for use in a hospital setting.[83]

73. Secondly, it appears that Dr Vandeville *attempted* to obtain the restricted substances from TCI. On 21 November 2012, Dr Vandeville asked Mr Lombardi on multiple occasions for a fob key to access the internal areas of TCI. Mr Lombardi thought this was an unusual request because there was no need for Dr Vandeville to have such access.[84] This is because a fob key was only needed to open and close the premises and the premises would have been opened by the time Dr Vandeville arrived. The only other doctor who had a fob key was the owner of TCI.

74. Thirdly, Mr Lombardi also explained that on two days when Dr Vandeville was working at TCI there were temperature changes in a fridge where a number of muscle relaxant drugs were stored.[85] The temperature changes indicated that the door to the fridge had been opened for an unusually long time (30 to 60 seconds). This suggested to Mr Lombardi that fridge had not been opened as part of routine practice to obtain the drugs (which would have only taken a few seconds), but instead that someone may have been searching through the fridge looking for other types of drugs.

75. Dr Vandeville's unusual request for a fob key, together with the unlikely coincidence that the only two instances of the drug fridge being opened for unusual periods of time occurred on the few occasions that Dr Vandeville worked at TCI, lead me to conclude that Dr Vandeville was actively attempting to obtain the restricted substances from TCI.

76. However, whether Dr Vandeville was *actually* successful in her attempts (whether at TCI or the other 2 hospitals where she worked in 2012), resulting in the restricted substances being found in her unit on 18 January 2013, is an entirely separate matter.

77. As already noted above, the 500mg vials of propofol could not have come from either TCI or Kingsgrove Day Hospital as neither hospital kept propofol in this quantity. The evidence also establishes that the vial of fentanyl found in the garbage bin in Dr Vandeville's unit block could not have come from Kingsgrove Day Hospital and it is highly unlikely that it came from TCI.

[78] T15.1, 4/7/16.
[79] ROI, Q/A 1259.
[80] ROI, Q/A 1266.
[81] ROI, Q/A 1276.
[82] T15.14-41, 4/7/16.
[83] T16.15, 4/7/16.
[84] Exhibit 1, p. 2439.
[85] Exhibit 1, page 2438.

78. This is because as part of the police investigation enquiries were made with the various manufacturers and distributors of the restricted substances.[86] The substances are typically delivered to distributors in bulk batches, numbering in the tens of thousands. These enquiries revealed that whilst it was possible to identify the batches where some of the substances originated, because individual bottles or ampules are not identifiable, it is not possible to trace individual items. Overall, the batch enquiries were unable to identify which hospitals the restricted substances came from. However, because one of the vials of fentanyl found in the garbage bin came from a batch (numbered 224089) that was not delivered to the distributor until 7 November 2012[87], the fentanyl could not have been obtained by Dr Vandeville from either Kingsgrove Day Hospital or The Cosmetic Institute (on 21 and 22 September 2012) because Dr Vandeville did not work at these hospitals after 7 November 2012.

79. As the restricted substances are commonly used in an anaesthetic setting, the evidence established that it would be more difficult for a person outside this setting to divert the substances. Dr MacPherson described anaesthesia as "a one-man show basically"[88] where the anaesthetist is responsible for drawing, administering, and then destroying the drug of anaesthesia. In such circumstances, Dr MacPherson explained that this created both the opportunity and the means for a drug to be diverted. Dr MacPherson further explained that it would be unusual for person not associated with anaesthetic procedure to access an anaesthetic trolley, and that because propofol is used almost exclusively in an anaesthetic (or intensive care) setting, it would be "very hard" for such a person to easily access a large 500mcg dose of propofol.

80. I acknowledge that by virtue of her work at the Kingsgrove Day Hospital, TCI, and St Vincent's Hospital, Dr Vandeville had the *opportunity* to divert the restricted substances. However, I conclude that the opportunity did not become actual diversion. This is because, firstly, the opportunity was very limited, essentially amounting to a 2-month period in the case of Kingsgrove Day Hospital and a matter of days in relation to the other two hospitals. Secondly, the opportunity was further diminished as a result of Dr Vandeville not working in an anaesthetic setting. Even Dr Kabir agreed that it would have been extremely difficult for Dr Vandeville to access fentanyl[89] and that he would have been very surprised if she had been able to access any of the restricted substances.[90] Dr Kabir repeatedly said in evidence[91] that he had no idea how Dr Vandeville could have accessed the substances.[92]

***(e) Did Dr Kabir obtain the restricted substances?***

81. The evidence clearly establishes that because of Dr Kabir's work as an anaesthetist, and given the number of hospitals that he worked at and the frequency with which he attended them, he had far greater opportunity than Dr Vandeville to divert the restricted substances. But the question to be asked again is whether this opportunity became actual diversion.

[86] Exhibit 1, pages 181-184.
[87] Exhibit 1, page 182.
[88] T18.22, 2/3/16.
[89] T17.19, 4/7/16.
[90] T18.18, 4/7/16.
[91] T18.37, T20.5, 4/7/16.
[92] T20.9, 4/7/16.

82. In Dr Kabir's case I conclude that actual diversion occurred. That is, he was responsible for obtaining the restricted substances that Dr Vandeville self-administered on 18 January 2013. I have reached this conclusion for a number of reasons.

83. Firstly, whilst I acknowledge that Dr Kabir consistently maintained in his evidence that he denied obtaining midazolam[93], fentanyl[94] and fentanyl[95] for Dr Vandeville, there were other aspects of his evidence which were troubling and which adversely affected the reliability and cogency of his denials. These aspects are:

(a) In both his record of interview with the police and in evidence, Dr Kabir provided an implausible account of the events between 4:56pm and 7:01pm on 18 January 2013. Dr Kabir initially told the police that he arrived at Dr Vandeville's unit at about 5:00pm[96] but later changed this time to about 6:00pm.[97] When questioned further, Dr Kabir reverted to his initial position, stating that he arrived at the unit at about 5:00pm but, after finding the post office collection notice in the mailbox, he returned to his car and drove to Neutral Bay post office, approximately one kilometre away.[98] Dr Kabir said that he parked, walked to the post office, but found it closed.[99] He said that he then drove back to the unit, parked his car and went upstairs. However, in evidence Dr Kabir changed his position again and said that he probably never drove to the post office.[100] The three separate versions of events given by Dr Kabir regarding his movements around 5:00pm on 18 January 2013 undermines the reliability of his denials.

(b) If it is accepted that Dr Kabir never drove to the post office then this means that he discovered Dr Vandeville in bed, unresponsive, within minutes of entering the unit. This places the discovery of Dr Vandeville at just after 5:00pm. The evidence establishes that a triple 0 call for an ambulance was not made until 7:01pm, meaning that a period of approximately 2 hours elapsed between Dr Vandeville's discovery and the ambulance being called. Dr Kabir agreed in evidence that it was "ridiculous" that he did not immediately call for an ambulance upon discovering Dr Vandeville and that he should have immediately done so.[101] But when asked why he did not act accordingly he said that he had no idea why he did not do so.

(c) Dr Kabir was extremely vague regarding his movements between discovering Dr Vandeville and calling triple 0 at 7:01pm. During his interview with the police, Dr Kabir said that most of the substances that Dr Vandeville might have used should still be in the apartment but declined to answer when asked if he had disposed of, or hidden, anything.[102] However, later in the interview, Dr Kabir told police that he removed a packet "that had stuff in it which was syringes and all that" and threw it in a rubbish bin whilst driving around.[103] Dr Kabir could not recall exactly where he disposed of the packet and said he did so because he did not want Dr Vandeville "implicated".[104] In evidence Dr Kabir maintained that he pulled the

[93] T16.42, 4/7/16.
[94] T18.21, 4/7/16.
[95] T19.5, 4/7/16.
[96] Exhibit 1, page 367.
[97] Exhibit 2, page 357.
[98] ROI, Q/A 848, 850, 856-860.
[99] ROI, Q/A 900.
[100] T47.25, 4/7/16.
[101] T49.2,4/7/16.
[102] ROI, Q/A 1298.
[103] ROI, Q/A 1347-1348.
[104] ROI, Q/A 1347.

cannula from out of Dr Vandeville's arm and that he left the unit because he "just wanted to get out of there".[105] It is not known what time Dr Kabir left the unit and what time he returned. However, if Dr Kabir's evidence that he performed CPR for approximately 20 minutes is accepted this means that he may have been absent from the unit and driving around "trying to process what was happening"[106], for up to 90 minutes. I acknowledge that Dr Kabir was most likely shocked and traumatised by discovering Dr Vandeville to be unresponsive. However, even allowing for this, the significant length of time that Dr Kabir was absent from the unit, which is both lacking in detail and incapable of coherent explanation, is difficult to reconcile. This is particularly so bearing in mind Dr Kabir's own acknowledgement that he should have called an ambulance immediately upon discovering Dr Vandeville.

(d) Call charge records establish that Dr Kabir received a call from his architect, Daryl Neil, at 5:41pm and that the call lasted 1 minute and 40 seconds. If the above timeline is correct then this means that Dr Kabir received the call after he left the unit and whilst he was driving around. Dr Kabir sought to explain in evidence that he was mostly just listening during the call and made no mention of his discovery of Dr Vandeville. However, Mr Neil said that Dr Kabir "appeared to be his normal self" and "spoke quietly and only about the matters at hand (which concerned a local council application)".[107] This version of events is inconsistent with what Dr Kabir told the police in his record of interview. In the interview, Dr Kabir said that he received the call from Mr Neil either when he was driving to Vandeville's unit or when he was still in his car after he had arrived there.[108] Also, it is again difficult to reconcile the answering and content of the phone call with Dr Kabir's discovery of Dr Vandeville.

(e) In evidence Dr Kabir agreed that by not calling an ambulance and by disposing of the syringe that it appeared that he was trying to hide something. However, after acknowledging this, Dr Kabir maintained that this was not in fact what he was doing[109], but could offer no other explanation for why he had acted in the way that he did other than to describe that his "brain didn't sort of accept what had happened".[110]

84. Secondly, Dr Kabir denied injecting Dr Vandeville with any drugs and claimed that she never asked him to.[111] However, in the autopsy report Dr Orde found that Dr Vandeville had multiple superficial injuries consistent with recent vascular access, and opined that several of the injuries were in locations which would have been difficult for Dr Vandeville to gain vascular access on her own.[112] Although Mr Morton said that Dr Vandeville asked him to inject her with drugs, there is no evidence to suggest that he ever did so. Even though I have already concluded that Dr Vandeville's assertion to Mr Morton that Dr Kabir injected her with drugs cannot be accepted, then the available evidence does not identify any person, other than Dr Kabir, with sufficient skill and opportunity to assist Dr Vandeville to gain access to the inaccessible sites identified by Dr Orde.

[105] T49.8, 4/7/16.
[106] T48.48, 4/7/16.
[107] Exhibit 1, page 1255.
[108] ROI, Q/A 794.
[109] T49.30, 4/7/16.
[110] T35.35, 4/7/16.
[111] T26.20, 4/7/16.
[112] Exhibit 1, Volume 1, Tab 3.

85. Thirdly, Dr Kabir agreed to writing repeat prescriptions for Dr Vandeville for antidepressant medication that had originally been prescribed by a psychiatrist.[113] Examination of the prescription medication found inside Dr Vandeville's unit indicated that Dr Kabir wrote the prescriptions between 4 January 2013 and 16 January 2013. The Australian and New Zealand College of Anaesthetists Code of Conduct[114], the Medical Board of Australia Code of Practice[115], and Medical Council of Australia guidelines[116] all advise medical practitioners, except in emergencies, to avoid providing medical care to any person that a practitioner has close personal relationship with. It is clear that not only did Dr Kabir write repeat prescriptions but that he also assisted Dr Vandeville with a significant degree of "home hospitalisation" in the week preceding her death. Such an apparent error of professional misjudgement diminishes Dr Kabir's credibility and points towards diversion of the restricted substances as being more likely.

86. Fourthly, Dr Kabir said that the only time that he suspected that Dr Vandeville may have been using medication without his knowledge was in January 2013, about a week before Dr Vandeville's death. On this occasion, Dr Kabir said that he discovered Dr Vandeville with a syringe in her hand, which she then tried to hide.[117] When Dr Kabir enquired what it was for, Dr Vandeville told him it was nothing, to not worry, and asked him to leave. Given the large volume of medication that was found in the kitchen of Dr Vandeville's unit[118] it is difficult to accept that the January 2013 incident was the only occasion when Dr Kabir suspected that Dr Vandeville was using medication without his knowledge. The medication found on 18 January 203 was not hidden and was in plain sight. It has been submitted on behalf of Dr Kabir that the three proposals were found hidden in Dr Vandeville's bedside drawer and that Dr Kabir was unaware of them, which in turn means that he did not obtain them. However, the weight that can be given to this submission is diminished by the unlikelihood that Dr Vandeville had any opportunity to obtain these bottles of propofol for the reasons which have already been set out above. Furthermore, even though Dr Kabir denied having any knowledge of the contents of the paper bag that he disposed of on the morning of 18 January 2013, the probability that Dr Kabir was aware of the contents of the paper bag cannot reasonably be excluded having regard to the other evidence that I have referred to. If Dr Kabir had acted with such knowledge, then his actions would be consistent with his subsequent disposal of the cannula from Dr Vandeville's arm.

87. Finally, Dr Kabir himself said that he was unaware of any third party supplying Dr Vandeville with the restricted substances[119], that most of Dr Vandeville's friends were obstetricians and gynaecologists who would not have easy access to the restricted substances and that he was unaware of Dr Vandeville attempting to obtained the substances by unlawful means.[120] Having already concluded that Dr Vandeville herself did not obtain the substances, by a process of elimination, the only logical conclusion is that Dr Kabir is the only remaining person with sufficient opportunity to have obtained the substances.

88. Having regard to all of the above, I conclude that Dr Kabir was responsible for obtaining the restricted substances that Dr Vandeville self-administered on 18 January 2013.

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[113] T5.37, 4/7/16.
[114] Exhibit 1, Volume 1, Tab 19.
[115] Exhibit 1, Volume 1, Tab 20.
[116] Exhibit 1, Volume 1, Tab 21.
[117] T21.18, 4/7/16.
[118] Exhibit 1, page 453.
[119] T20.43, 4/7/16.
[120] T42.8, 4/7/16.

**Did any aspect of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Training Program contribute to Dr Vandeville's death?**

89. The police investigation revealed evidence that Dr Vandeville felt that she had been subjected to bullying and unfair treatment during her attempt to become a Fellow of the College. This in turn raised questions about whether Dr Vandeville's participation in the College's Fellowship Training Program (the Program), or any aspect of it, contributed to Dr Vandeville's death.

90. In order to answer these questions it is necessary to understand the nature of the Program and the relevant parts of Dr Vandeville's participation in it.

***(a) Overview of the Training Program***

91. The College is accredited to train and accredit doctors in the speciality of obstetrics and gynaecology. To do so, it conducts the Program which is a 6 year program divided into two parts: a 4-year Integrated Training Program (ITP)[121], which must be completed by Program candidates within 8 years; and a 2-year Elective Training.[122] Completion of the Program culminates in Fellowship of the College, enabling a doctor to be registered and practice as a specialist obstetrician and gynaecologist.

92. As part of the Program, candidates are required to achieve satisfactory mid-semester (every 3 months) and end of semester (every 6 months) assessment reports.[123] A review of Dr Vandeville's Program records indicates that she consistently achieved satisfactory reports from January 2004 until January 2008. At that time Dr Vandeville began to receive several borderline ratings, eventually resulting in a borderline assessment at the end of the first semester in 2009. Following this, Dr Vandeville continued to achieve satisfactory assessments until Semester 2 of 2011 during which she was given a warning during the mid-semester assessment and a fail mark at the end-of-semester assessment.

***(b) Overview of the Program's examination process***

93. The Program has two major examinations: a written and an oral examination, with a pass required in the written examination before sitting the oral examination. The examinations are held twice per year. During Dr Vandeville's enrolment, the written examinations were held in February and August, whilst the oral examinations were held in May and October. Program candidates are permitted to attempt each examination four times.

94. The oral examination consists of a 10-station examination. At each station students are allowed 4 minutes of reading time with each examination taking 12 minutes. At each station there is a different examiner. The stations are scenario-based and often use actors and medical students to conduct the scenarios. The examiners are involved in the development of the station which they are marking and use a previously agreed marking scheme to evaluate each trainee. Examiners are unaware of the pass mark for the station, nor how a candidate has performed at other stations.[124] One of the Examination coordinators or the Chair of the Board of Examiners may also

[121] The Integrated Training Program is now known as the Core Training Program.
[122] Elective Training is now known as the Advanced Training Program.
[123] The 3 month and 6 month assessment reports are now known as formative appraisal and summative assessment, respectively.
[124] Statement of Professor Ian Symonds dated 4 May 2016, paragraph 9.

randomly select a station and observe candidates to ensure that the marking schemes are being applied consistently by the examiners.[125]

95. After each examination, candidates are advised if they have been successful or unsuccessful. Following two unsuccessful attempts a candidate may request verbal feedback from a nominated member of the Board of Examiners. When this occurs, the College collates all mark sheets from each station (which includes the examiner's comments) and sends the material to the member of the Board to meet with the candidate in person or via teleconference. The candidate is encouraged to have their training supervisor, mentor, or support person at the session. The examiner is not permitted to give the candidate their actual marks or show the candidate their mark sheets, but they are allowed to point out any areas of insufficient knowledge, or areas of improvement, and to suggest strategies to address these areas. The aim of the feedback session is not to provide a detailed analysis of the scoring for each failed station as it is unlikely that a candidate would be examined on the same subject in subsequent examinations.[126]

96. According to the College's policies and guidelines, candidates are only provided with one formal verbal feedback session after two unsuccessful examination attempts. It appears that this is because the sessions are provided by the nominated examiner in his or her own time, preparation by the examiner for the session takes a considerable amount of time, and the College does not have the resources to offer sessions to each candidate after every unsuccessful attempt.

97. Since the start of 2013, the College gives all candidates written information about each oral examination station and how they scored in relation to the Minimal Acceptable Passing Standard (MAPS). That is, candidates are told whether they scored well below, below, at, above, or well above the MAPS.[127] Candidates are also told whether their score is at the MAPS, within 2 marks of the MAPS, or more than 2 marks above or below the MAPS.[128] The MAPS is calculated through a separate standard setting process. It should be noted that during the time of Dr Vandeville's candidature, the written information that I have just referred to was not routinely provided to candidates.

***(c) Dr Vandeville's examination chronology: 2010-2011***

98. Dr Vandeville **first** sat the oral examination on 23 May 2010 and was unsuccessful, passing only 1 out of the 10 stations. She sat the examination a **second** time on 17 October 2010 and was again unsuccessful, passing 2 out of the 10 stations. Following this attempt, on 25 January 2011, Dr Vandeville requested feedback on her performance and specifically asked that Professor Ian Symonds, the Chair of the Board of Examiners, provide the feedback. This was arranged and Professor Symonds conducted a feedback session with Dr Vandeville in February 2011 via teleconference. The session took about an hour and Dr Christopher Bradbury, one of Dr Vandeville's mentors, was present as a support person. According to Professor Symonds, Dr Vandeville "expressed her thanks at the time and indicated that she found the session helpful".[129]

[125] Second statement of Lynette Johnson (undated), paragraph 5.
[126] Statement of Professor Ian Symonds dated 4 May 2016, paragraph 16.
[127] Statement of Lynette Johnson dated 11 February 2016, page 4.
[128] Second statement of Lynette Johnson (undated), paragraph 6.
[129] Statement of Professor Ian Symonds dated 4 May 2016, paragraph 17.

99. Dr Vandeville sat the oral examination for a **third** time on 22 May 2011 and was unsuccessful, passing 3 out of 10 stations. Following the examination Dr Vandeville applied for special consideration to be given to her, citing painful mouth ulcers, severe migraines and her mother falling ill which, collectively, placed her under high stress.[130] On 3 June 2011 the College advised Dr Vandeville that special consideration would been given and that the third examination would not be counted as one of her four attempts. This meant that Dr Vandeville had only exhausted two examination attempts and had two more attempts available to her.

100. At about the same time, Dr Vandeville made a request for another verbal feedback session to be provided. Dr Bradbury intervened on Dr Vandeville's behalf and wrote to Professor Symonds on 23 June 2011 requesting that special consideration be given for a further feedback session. This request was initially declined. However, on 1 August 2011 Professor Symonds wrote to Dr Bradbury to confirm that whilst Dr Vandeville's one allotted verbal feedback session had already been provided consideration would be given for a further feedback session.[131] Dr Vandeville was advised of this in writing but Dr Vandeville never contacted the College or Professor Symonds[132] to arrange for such a second feedback session, and so none was ever conducted (at this time).

101. On 12 September 2011 Dr Charles McCusker wrote to the President of the College. In his letter Dr McCusker indicated that he considered Dr Vandeville to be a "dedicated and gifted surgeon" and expressed difficulty in understanding how Dr Vandeville could have been unsuccessful in her three examination attempts. Later in his letter Dr McCusker wrote:

> "*Proper process does not appear to have occurred and in my opinion [Dr Vandeville] is being denied natural justice. My personal enquiry from various examiners has included throwaway lines that smack of racism and misogyny. If she passes her resit in October then all will be fine but if she fails again I will support her contention that she has not been afforded the same treatment as other candidates*".[133]

102. By letter dated 7 October 2011, the President of the College, Dr Rupert Sherwood indicated that due process had been given to Dr Vandeville. In relation to the alleged unprofessional behaviour from examiners, Dr Sherwood indicated that such matters were taken very seriously and invited that written examples of such behaviour to be provided.[134] It does not appear that Dr Sherwood's letter was ever replied to.

103. On 23 October 2011 Dr Vandeville sat the exam for a **fourth** time, passing 1 out of 10 stations. Although this was Dr Vandeville's fourth actual attempt, it was officially only recorded as being her third attempt due to the special consideration given to her in June 2011.

104. On 19 November 2011 Dr Vandeville applied for an extension of time to complete the ITP. This application was necessary because candidates were required to complete the ITP within 8 years of starting it. As Dr Vandeville had started the Program in 2004, she was required to complete it by the end of 2011. On 28 November 2011 the College granted Dr Vandeville's application, giving her until 31 May 2012 to complete the ITP. This in turn meant that Dr Vandeville could sit the next scheduled oral examination in May 2012.

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[130] Statement of Lynette Johnson dated 11 February 2016, page 8.
[131] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4.
[132] Statement of Professor Ian Symonds dated 4 May 2016, paragraph 21.
[133] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4.
[134] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4.

105. Following this most recent examination, Dr Vandeville again requested a verbal feedback session. This was granted and took place on 21 November 2011 with Professor Symonds and Dr McCusker, as a support person, in Newcastle. The session was recorded on video and a copy of the video, together with a written summary of the main points of the session, were sent to Dr Vandeville on 2 February 2012. In a letter dated 16 October 2012 (that was submitted to the College as part of Dr Vandeville's later request for a further extension of time to complete the ITP), Dr McCusker described the feedback session as being "most unhelpful".

***(d) Dr Vandeville's examination chronology: 2012***

106. On 21 April 2012 Dr Vandeville wrote to the College requesting that she given an extension of time to sit her fourth examination (but her actual fifth attempt) in October 2012, rather than in May 2012. Dr Vandeville cited frequent migraine attacks and emotional and psychological stress as the reasons for her request. By letter dated 24 April 2012, the College refused Dr Vandeville's application and indicated that failure of the fourth examination would result in her removal from the Program. However, the College indicated that in the event of a fourth unsuccessful attempt Dr Vandeville could still ask for special consideration to be given allowing her to sit the exam for a fifth time (which would be her sixth actual attempt).

107. Prior to the May 2012 examinations, the Board of Examiners became aware that Dr Vandeville had made a number of complaints (which are discussed in more detail below) against some of the examiners. It was not possible to structure the examination in a way to prevent Dr Vandeville from encountering any of the examiners that she had made complaints about. Instead, both Professor Symonds and Professor Stephen Robson, the Examination coordinator, acted as independent observers at each examination station. Professor Robson could not identify any adverse issue arising from any of the stations or with any of the examiners.[135]

108. On 20 May 2012 Dr Vandeville sat the examination for a **fifth** time (but which was considered to be her fourth and final attempt because the earlier special consideration) and was unsuccessful, passing 2 out of 10 stations. The following day she applied for special consideration to be given, citing debilitating migraine attacks during the period leading up to the exam, and on the day of the exam itself, and requested an opportunity to sit the exam for a fifth time (which would be her actual sixth attempt). This application was refused by the College on 1 June 2012 on the basis that Dr Vandeville's circumstances did not constitute grounds for special consideration. On 2 June 2012 Dr Vandeville sent an email to the College requesting an informal review of both her most recent examination result and the refusal of her application for an extension of time. Dr Vandeville requested copies of her mark sheets for each station, information regarding the MAPS, details on how the MAPS was determined, and similar information from her previous examinations. On 4 June 2012 Dr McCusker wrote to the College on Dr Vandeville's behalf asking that re-consideration be given to permitting Dr Vandeville to sit the exam for a fifth time.

109. From an examination of the material produced to the Court by the College, pursuant to an order for production, it is unclear whether any material was ever provided to Dr Vandeville. There is, however, correspondence within the produced material indicating that, following legal advice, the College determined that Dr Vandeville could be provided with publicly available information

[135] Statement of Professor Stephen Robson dated 9 May 2016, para 8.

relating to the examinations, a summary of her marks (without identifying any third parties) but not the marks sheets themselves, but not any material relating to her previous attempts.[136]

110. It appears that between 2 June 2012 and 17 July 2012 further material was forwarded to the College in support of Dr Vandeville's request for a fifth examination attempt. Amongst this material was a report from Dr Usman Malik, psychiatrist, dated 8 June 2012 in which Dr Malik opined that Dr Vandeville was suffering from Adjustment Disorder and Depressed Mood at the time of the May 2012 examinations.

111. In a letter sent to the College dated 12 June 2012 Dr Vandeville said that the only feedback she received from the first feedback session was that she "needed to be more organised when presenting".[137] In relation to the second feedback session Dr Vandeville wrote that it "was again quite unhelpful, as it did not specify where I had not scored the required marks to pass". Later in the letter Dr Vandeville wrote:

> "*I was very confused and angry at the lack of transparency with the exam feedback. It did not really give me any more direction or guidance on how to change my preparation with the next exam*".

112. In her letter Dr Vandeville said that she had been "emotionally and psychologically traumatised" by the examination process, that she suffered frequent debilitating migraines that left her bedbound for entire days, that she had trouble sleeping, had lost weight, and was depressed. Dr Vandeville also said that two consultants at St Vincent's Hospital had "began to bully and harass" her when they learned of her failed examination attempt.

113. On 17 July 2012 the College granted Dr Vandeville an extension until 30 November 2012 to complete the ITP, allowing her to sit the oral examinations on 21 October 2012. On 31 July 2012 Dr Vandeville sent an email to the college acknowledging the extension of time and requested a third verbal feedback session. After some discussion within the College it was decided that there would be little utility in Professor Symonds conducting a third feedback session as it was expected that his feedback would be the same and that his previous feedback had been ineffective in improving Dr Vandeville's exam performance.[138] Instead, Dr Vandeville was advised on 3 August 2012 that a third feedback session would be conducted by Professor Robson.

114. The feedback session took place on 31 August 2012 during a face-to-face meeting with Dr Robson in Canberra. Dr McCusker attended as a support person and the session lasted almost 2 hours. Prior to the session, on 20 August 2012, Dr Vandeville asked for copies of all her previous mark sheets to be provided to her. It appears that this request was made after Dr Vandeville sought legal advice from solicitors in relation to obtaining the information that she was seeking. On the same day as her letter the College wrote to Dr Vandeville advising her that it was not College policy to release individual mark sheets but that instead a summary of her previous examination results would be provided to Professor Robson, along with the results from her fourth attempt.

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[136] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4.
[137] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4.
[138] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4, email from Professor Symonds to Kylie Grose dated 2 August 2012.

115. During the session, Professor Robson discussed each of the examination stations, pointing out areas where Dr Vandeville had performed well and other areas where she had not performed as well, giving her advice on how to better handle the stations in the future and what type of answers and actions would attract marks. Professor Robson stated that he did "not recall any particular adverse reactions responses by Dr Vandeville" to the session and that at the end of the session Dr McCusker remarked that "it had been a very valuable exercise and well worth the drive from Sydney".[139] In a letter dated 16 October 2012 (that was submitted to the College as part of Dr Vandeville's request for a further extension of time), Dr McCusker described the feedback session as being "most insightful".

116. By letter dated 15 October 2012 Dr Vandeville wrote to the College requesting a further extension of time to sit her fifth exam and complete the ITP. Dr Vandeville again cited her migraine attacks and depression as reasons for her request, along with the earlier "unhelpful" feedback sessions provided by Professor Symonds, and the College's refusal of her request for her mark sheets.

117. On 17 October 2012, the College advised Dr Vandeville that her application had been granted with an extension allowed until 30 June 2013, meaning that Dr Vandeville could sit her fifth examination attempt (but which would have been her **sixth** attempt overall) in May 2013.

118. On 22 November 2012 Dr Vandeville's solicitors wrote to the College requesting copies of all of Dr Vandeville's mark sheets together with all marking guides provided to examiners. On 4 December 2012 solicitors acting for the College wrote to Dr Vandeville's solicitors indicating that it was not College policy to disclose the material requested in order to ensure security and integrity in the examination process, to ensure the privacy of the examiners and other third parties, and to ensure that all candidates obtain appropriate and formal feedback. However, the College extracted information in relation to Dr Vandeville's most recent (fourth) examination attempt which indicated whether she was well below, below, at, above, or well above the MAPS, and whether within 2 marks. As already noted above, since January 2013, the College now provides such information to all candidates.[140]

***(e) Other aspects of the Program***

119. Apart from her dissatisfaction with the examination process and her inability to given the marking information that she sought, it also appears that Dr Vandeville felt aggrieved by other aspects of the Program unrelated to the examinations. On 4 April 2012 Dr Vandeville sent an email to Dr Vincent Lamaro, who was one of three consultants involved in Dr Vandeville's clinical supervision at St Vincent's Hospital. In the email Dr Vandeville alleged that she had been intimidated by Dr Lamaro into signing a blank end of semester assessment form. In a letter of the same date, Dr Lamaro forwarded a copy of the email to the College and denied Dr Vandeville's allegation.

120. It also appears that there was some friction between Dr Vandeville and her professional colleagues both in late 2009 and again in late 2011. The 2009 issue appears to arise from some allegations made by Dr Vandeville regarding unfair treatment that occurred whilst she was a trainee at Liverpool Hospital. Although a police examination of Dr Vandeville's laptop in

[139] Statement of Professor Stephen Robson dated 9 May 2016, para 13.
[140] Statement of Lynette Johnson dated 11 February 2016, page 9.

December 2013 discovered a draft letter to the College outlining Dr Vandeville's allegations[141], it does not appear that any formal complaint was ever lodged with the College.

121. The 2011 issue appears to have arisen following Dr Vandeville's fourth unsuccessful examination attempt in October 2011 which had an adverse impact on her mental well-being. This in turn adversely affected Dr Vandeville's work performance in which she found it difficult to perform her clinical duties, leading to a request for a period of leave. It appears that this situation caused disharmony amongst Dr Vandeville's colleagues.[142] Again, no formal complaint about this issue was ever made to the College.

***(f) Conclusions regarding Dr Vandeville's participation in the Program***

122. From all of the above it can be seen that Dr Vandeville felt aggrieved by several aspects of the College's Program. Dr Vandeville's two main grievances concerned the College's refusal to provide her with her examination mark sheets, and the perceived usefulness of her first two verbal feedback sessions, which she regarded as being unhelpful.

123. The totality of evidence concerning Dr Vandeville's participation in the Program reveals that she attempted the oral examinations five times between May 2010 and May 2012, and that a total of 26 different examiners were involved in examining her.[143] According to Dr Vandeville's examination results she reached the MAPS in only 9 out of a total of 50 stations.

124. Firstly, given the number of different examiners involved in examining Dr Vandeville and the fact that both Professor Symonds and Professor Robson acted as independent observers during the May 2012 examinations, there is no evidence that Dr Vandeville was treated unfairly or inappropriately during any of her five examination attempts. There is also no evidence to support Dr McCusker's assertion in September 2011 (at which time Dr Vandeville had attempted the examinations twice) that Dr Vandeville had been subjected to any racist or misogynist behaviour from any of the examiners. I note that no response was ever sent to the College when an invitation was made to provide examples of such behaviour. Further, in his statement to the police Dr McCusker made no further reference to the contents of his September 2011 letter.[144]

125. Secondly, although Dr Vandeville was dissatisfied with the overall examination process, the evidence establishes that each of her requests for extensions of time and additional feedback sessions were granted by the College. It is also clear that the opportunities extended to Dr Vandeville exceeded the College's usual procedures and exceeded what was typically offered to the Program's candidates:

    (a) Dr Vandeville was given a total of three verbal feedback sessions when College guidelines typically only allow for one session;

    (b) Dr Vandeville was granted three extensions of time to complete the ITP, meaning that the date for completion was extended from December 2011 to June 2013;

[141] Exhibit 1, page 2079.
[142] Exhibit 1, page 938.
[143] Second statement of Lynette Johnson (undated), paragraph 5.
[144] Exhibit 1, page 963.

(c) Dr Vandeville was given special consideration following her third examination attempt so that it was not counted against the four attempts that candidates are typically allowed; and

(d) Overall, Dr Vandeville was given five attempts to sit the oral examinations where College guidelines typically only allow candidates four attempts.

126. Thirdly, although Dr Vandeville regarded her first two feedback sessions with Professor Symonds to be have been unhelpful, there is no evidence to support this. Neither Dr Bradbury, who was present at the first session, nor Dr McCusker, who was present at the second session, make any mention in their statements that the sessions were unsatisfactory in any way. In particular, Dr McCusker did not explain why he made the assertion in October 2012 that the second feedback session was unhelpful. Further, although the sessions were conducted, respectively, in February 2011 and November 2011, no issue was raised about the sessions being allegedly unhelpful until June 2012 and October 2012. Finally, even if it could be established that the first two feedback sessions were deficient in any way, the evidence unequivocally establishes that the third feedback session was both worthwhile and insightful.

127. Fourthly, although Dr Vandeville was clearly frustrated by the College's refusal to provide her with her examination mark sheets, to the extent that Dr Vandeville was considering legal action, there is no evidence to suggest that Dr Vandeville was treated any differently from other Program candidates. That is, the College's policy in relation to not providing candidates with copies of their mark sheets was applied universally to all candidates, with Dr Vandeville being no exception. Whilst an inquest is not the suitable forum to consider the appropriateness of the College's policy in this regard, the evidence would appear to indicate that the policy is soundly based on the need to ensure the integrity of the examination process. Since January 2013 it is now the case that College policy allows for candidates to be provided with written information in relation to how they have scored relative to the MAPS. Although this change in policy occurred after Dr Vandeville's death, this information was actually provided by the College to Dr Vandeville in December 2012.

128. Fifthly, there is no evidence to support Dr Vandeville's assertion that she was intimidated into signing a blank assessment report. The report itself is dated 20 February 2012 and bears both Dr Vandeville's and Dr Lamaro's signatures.[145] Dr Lamaro's evidence is that the signing of the report was witnessed by other hospital staff.[146] If Dr Vandeville's assertion is correct then it is difficult to understand why there was a 2 month delay in the issue being raised with Dr Lamaro (but not with the College) until April 2012.

129. Finally, there is also no evidence that any aspect of Dr Vandeville's practical training in the workplace contributed to her death. Dr Vandeville's allegations in relation to the periods in late 2009 and late 2011 are difficult to assess because no formal complaint was ever lodged with the College. It would appear that the 2009 allegations stemmed from Dr Vandeville being given a borderline end-of-semester assessment result. This was the first borderline assessment that Dr Vandeville had received after previously receiving only satisfactory assessments in her first four years of the Program between 2004 and 2008. Dr Vandeville's Program participation history reveals that in 2010 (whilst at a different hospital) Dr Vandeville received an overall satisfactory assessment report at the end of her first semester, but it was noted that she had received two

[145] Exhibit 1, material produced by the RANZCOG pursuant to a s 53 order, Tab 4.
[146] Statement of Dr Vincent Lamaro dated 16/6/16, page 3.

borderline ratings during that semester.[147] Then in her second semester of 2011 (at a third hospital) Dr Vandeville received a warning in her mid-semester assessment report and a fail mark in her end-of-semester assessment report, with it being noted that she had received borderline ratings in multiple assessment categories.[148]

130. Given this chronology it would appear that Dr Vandeville's unsuccessful examination attempts were adversely cyclical; that is, her unsuccessful results created additional stress for Dr Vandeville, leading to a reduction in the standard of her clinical work, which in turn created further stress that negatively affected her examination performance. I can find no evidence that Dr Vandeville was treated inappropriately in the workplace or, more importantly, that any aspect of her clinical training contributed to her death. As the 2009 and 2011 issues were also not relevantly proximate to the time of Dr Vandeville's death they cannot be regarded as having contributed to it.

131. Overall I conclude that there is no evidence to suggest that Dr Vandeville's participation in the Program, or any aspect of it, directly contributed to Dr Vandeville's death.

**Did Dr Vandeville intentionally end her life?**

132. Although I have concluded that no aspect of the Program directly contributed to Dr Vandeville's death it is clear that Dr Vandeville herself believed that she was being treated unfairly by the College, and also believed that her grievances with the College were valid. It is also clear that these factors, combined with her repeated unsuccessful examination attempts, adversely affected Dr Vandeville's physical and mental well-being.[149]

133. As I have already referred to in paragraph 44 above, this fact alone raises a question regarding the manner of Dr Vandeville's death and whether she acted on 18 January 2013 with the intention of ending her life. Apart from the circumstances surrounding that day, other evidence was discovered during the police investigation which suggested that Dr Vandeville may have been contemplating self-harm.

134. One of the primary pieces of evidence in this regard comes from October 2010. At this time Dr Vandeville had just completed her second unsuccessful examination attempt. Dr Vandeville sent a text message to a friend and medical colleague, Dr Nasreen Shammas, in which she wrote:

> "*…that's it the exam I could not pass, this life for me, I am done with the life (sic), I don't need this life. I have nothing more to do with the life (sic). Goodbye my friend I will love you forever*".[150]

135. After reading the message Dr Shammas, out of concern for Dr Vandeville, notified the police. At about 8:20pm on 28 October 2010, the police went to Dr Vandeville's unit and spoke to her and Dr Kabir. Dr Vandeville explained that the message had been misinterpreted and that she was simply concerned about failing her exams.[151] Ambulance officers checked Dr Vandeville's health and found no evidence of self-harm. Dr Kabir confirmed with police that Dr Vandeville had never attempted self-harm and that he would stay and look after her whilst she slept. In his later

[147] Statement of Lynette Johnson dated 11 February 2016, page 7.
[148] Statement of Lynette Johnson dated 11 February 2016, page 8.
[149] Exhibit 1, pages 926, 967.
[150] Exhibit 1, page 1005.
[151] Exhibit 1, page 1220.

interview with the police after Dr Vandeville's death, Dr Kabir was asked about the October 2010 incident. Dr Kabir told the police that Dr Vandeville had taken an unknown quantity of sleeping tablets, possibly Xanax, and that she wanted to "sleep it off".[152]

136. The evidence indicates that the October 2010 incident was not an isolated one. In June or July 2011 Dr Vandeville called Dr Yasser Diab, a friend who she had completed part of her medical training with. Dr Vandeville told Dr Diab that she was not eating or sleeping, losing weight, feeling bad, and that she was going to die.[153] Dr Diab said that he would call the police but Dr Vandeville told him not to.

137. On 7 November 2011 Dr Vandeville sent Dr Kabir a text message which read: "*I want to say goodbye. I want you to know that I'll look after you from above the sky. No purpose to continue to live. Hugs and kisses, Beata. PS. Sorry to upset you. This is way better for both of us*". Dr Vandeville sent similar messages to Dr Kabir on 8, 9 and 20 November 11. Further similar messages were also sent by Dr Vandeville to Dr Kabir on 26 April 2012, 16 May 2012, and 18 August 2012.

138. Mostafa Anbarteh, a friend of Dr Vandeville's, visited her sometime in late 2012. Dr Vandeville had recently failed an exam and asked to see Mr Anbarteh. Whilst Mr Anbarteh and Dr Kabir were trying to comfort her, Dr Vandeville said to him, "*When I die Mostafa, I will be your angel. I will take care of you*".

139. In both his interview with police and in evidence, Dr Kabir was asked about these previous comments made by Dr Vandeville suggesting that she was contemplating self-harm. Dr Kabir told the police that he thought that Dr Vandeville's comments may have been made in order to draw attention to her struggles with her exams.[154] Dr Kabir also explained in evidence that Dr Vandeville would sometimes become emotional and send such messages which he felt were her way of seeking some attention.[155] At no stage did Dr Kabir feel that Dr Vandeville was expressing any genuine intention to end her life.[156]

140. There is support for Dr Kabir's conclusions. Jarrod Linsell, a former medical colleague who Dr Vandeville was briefly in a relationship with, told the police that Dr Vandeville had previously made comments to him about dying. However, Mr Linsell's opinion is that "emotionally [Dr Vandeville] was unstable at times and would say things to make people feel sorry for her".[157]

141. Notwithstanding the above, the combined evidence from Dr Vandeville's close friends, mentors and colleagues is that they do not believe Dr Vandeville ever seriously contemplated self-harm and that they never observed her act, or attempt to act, on any such possible contemplation.[158] There is also positive evidence which mitigates against any finding that Dr Vandeville intended to end her life on 18 January 2013:

    (a) Dr Kabir said in evidence that when he spoke to Dr Vandeville on the phone during the day on 18 January 2013, she did not express any intention to harm herself;[159]

[152] ROI, Q/A 657, 671
[153] Exhibit 1, page 926.
[154] ROI, Q/A 641.
[155] T10.7, 4/7/16.
[156] T14.10, 4/7/16.
[157] Exhibit 1, page 918.
[158] Exhibit 1, pages 922, 939, 947, 968.
[159] T54.32, 4/7/16.

(b) On 17 December 2012 Dr Vandeville's solicitors wrote to her inviting her to discuss the response letter from the College dated 4 December 2012 with Dr McCusker in order to determine whether anything was to be served by pursuing further information from the College. There is evidence that Dr Vandeville planned to pursue her issues with the College by taking legal action;[160]

(c) According to Dr Kabir, Dr Vandeville was adamant that she would complete her training and the Program;[161]

(d) There is no evidence to suggest that Dr Vandeville did not intend to sit the examinations in May 2013;

(e) In the week before her death Dr Vandeville had made plans to visit a good friend who lived in Lightning Ridge[162];

(f) According to one of Dr Vandeville's close friends, Robert Sztormowski (who acted as the Australian representative of Dr Vandeville's family during the inquest), Dr Vandeville was "looking forward to the future for many reasons".[163]

142. Having considered all of the above evidence I conclude that the manner of Dr Vandeville's death was accidental drug overdose. There is insufficient evidence to support a finding that Dr Vandeville died as a result of actions taken by her with the intention of ending her life.

**Should any recommendations be made?**

143. Section 82 of the Act allows a coroner to make recommendations in relation to any matter connected with a person's death. Such recommendations may be made if a coroner considers them to be necessary or desirable. Issues of public health and safety can be, and often are, the subject of recommendations.

144. This inquest has raised issues regarding the diversion of restricted substances and drugs of addiction from hospitals by medical professionals. An inquest in Western Australia in 2013 investigated a death arising from the diversion of propofol from a hospital by a nurse for recreational use.[164] The coroner in that inquest recommended that, if reasonably practical, the Department of Health and all hospitals in the Western Australian health system implement a means of restricting the unauthorised use of propofol without placing patients at risk.

145. Unauthorised diversion of drugs and restricted substances from hospitals is not a novel issue. In relation to drugs of anaesthesia, Dr MacPherson acknowledged that the diversion of propofol and its misuse has become a general problem in recent years with some academic studies focusing on its misuse within the Australian medical community.[165] Some of these academic

[160] Exhibit 1, pages 921-922.
[161] T52.29, 4/7/16.
[162] Exhibit 1, page 942.
[163] Exhibit 1, page 956.
[164] *Inquest into the death of Craig James Doherty*, Perth Coroner's Court, 15-17 July 2013.
[165] Exhibit 1, Volume 1, Tab 6.

studies formed part of the brief of evidence that was tendered during the inquest.[166] From the academic literature the following can be gathered:

(a) Both internationally, and within Australia, propofol has increasingly become the agent of choice for abuse amongst anaesthetists, despite educational programs and increased vigilance[167];

(b) Propofol abuse and recreational use can often lead to death because of the rapid onset of unconsciousness and apnea (temporary cessation of breathing) following injection[168];

(c) The narrow margin for safety makes propofol a lethal drug with studies suggesting propofol abuse has the highest mortality rate[169];

(d) Anaesthetists have a higher rate of propofol abuse that other medical practitioners because this drug is widely used in their clinical practice[170];

(e) The majority of cases of propofol abuse involve its use for recreational purposes, stress relief and to alleviate insomnia[171].

146. From the above it is apparent that there is an increasing tendency for propofol to be diverted and misused. On the surface, it would appear that tighter restrictions in relation to its storage and distribution within hospitals are called for. However, Dr MacPherson explained, both in his supplementary report and in evidence[172], that in a surgical setting propofol is often required urgently. Any delay in access, such as a nurse (who has the keys to the safe where propofol might be securely kept) not being immediately available, could have catastrophic implications for a patient under anaesthesia.

147. It is also clear that the Department of Health already has in place a policy directive for the handling of medication in NSW public health facilities.[173] The Australian and New Zealand College of Anaesthetists (ANZCA) has also produced recommendations on minimum facilities for safe administration of anaesthesia in surgical settings.[174] It appears that both documents appropriately balance the need for patient safety against the need to securely store and manage drugs of anaesthesia in a way to minimise the risk of unauthorised diversion.

148. As neither the Department of Health nor the ANZCA were involved in the inquest, the issue regarding storage and management of propofol in a hospital setting was not sufficiently canvassed to allow any formal recommendation to be made. However, whilst acknowledging the practical difficulties highlighted by Dr MacPherson[175], it would seem worthwhile for further consideration to be given, by both the Department and the ANZCA in collaboration, to possible ways in which potential unauthorised diversion of propofol might be minimised without compromising patient safety.

[166] Exhibit 1, Volume 1, Tabs 9-16.
[167] Exhibit 1, Volume 1, Tab 9.
[168] Exhibit 1, Volume 1, Tab 12.
[169] Exhibit 1, Volume 1, Tab 9.
[170] Exhibit 1, Volume 1, Tabs 10 & 11.
[171] Exhibit 1, Volume 1, Tab 12.
[172] T20.19, 2/3/16.
[173] Exhibit 1, Volume 1, Tab 17.
[174] Exhibit 1, Volume 1, Tab 18.
[175] T21.33, 2/3/16.

149. In evidence Dr MacPherson indicated that within the ANZCA a group has been established to look after the personal welfare of anaesthetists in order to minimise the risk of diversion of anaesthetic drugs for recreational use or abuse.[176] According to Dr MacPherson the ANZCA has recommended that hospitals should also have a designated anaesthetist to look after the welfare of other anaesthetists at the hospital. It seems that this is also an issue worthy of consideration for implementation within local health districts in NSW.

**Findings**

150. Before turning to the findings that I am required to make, I would like to acknowledge and thank Senior Sergeant Sasha Harding, Coronial Advocate, and Detective Sergeant Richard Gaut, the officer-in-charge of the police investigation, for their hard work, assistance and valuable contributions both before, and during, the inquest.

151. The findings I make under section 81(1) of the Act are:

***Identity***
The person who died was Beata Vandeville.

***Date of death***
Dr Vandeville died on 18 January 2013.

***Place of death***
Dr Vandeville died at Neutral Bay NSW 2089.

***Cause of death***
The cause of Dr Vandeville's death was acute mixed drug toxicity.

***Manner of death***
Dr Vandeville died from an accidental overdose of multiple drugs that were self-administered, without the intention of ending life.

**Epilogue**

152. Dr Vandeville was, sadly, never able to fulfil her dream. However, despite considerable adversity, she never wavered in the pursuit of it. Her medical skills, dedication, industrious nature, warmth, caring attitude, and loyal friendship will be missed by the many people who knew her best.

153. On behalf of all the coronial team I would like to offer my condolences to those people and to Dr Vandeville's parents and family in particular.

154. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
24 November 2016
NSW State Coroner's Court, Glebe

[176] T20.50, 2/3/16.