STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of June Nutter
Hearing dates:	12 to 16 November 2018
Date of findings:	4 December 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – lymphangitic carcinomatosis, Campbelltown Private Hospital, High Dependency Unit, patient monitoring, Basic Life Support, Advanced Life Support, adrenalin, airway and ventilation
File number:	2015/373638
Representation:	Ms T Stevens, Counsel Assisting, instructed by Mr P Armstrong (Crown Solicitor's Office) Mr D Lloyd for Campbelltown Private Hospital, instructed by Ms R Hartwell (Kennedys) Mr M Lynch for Ambulance Service of NSW, instructed by Ms K Kumar (Hicksons Lawyers) Mr C Magee for Dr B Khialani, instructed by Mr R Li (Avant) Ms C Melis for Dr W Teoh, instructed by Ms C Watson-Kyme (Meridian Lawyers) Ms K Oldfield for the family of June Nutter, instructed by Ms K Nicholls (Kells Lawyers) Mr T Saunders for Dr R Rai, instructed by Ms N Brown (Meridian Lawyers)

Findings: I find that June Nutter died on 20 December 2015 at Campbelltown Private Hospital, Campbelltown NSW 2560. June died from lymphangitic carcinomatosis leading to hypoxaemic respiratory failure and cardiac arrest. June died from natural causes, as a consequence of natural disease process. Whilst not causally connected to June's death, the resuscitative efforts by Hospital staff following her cardiac arrest were not in accordance with optimal clinical practice.

Recommendations: ***To the General Manager, Campbelltown Private Hospital:***

1. I recommend that consideration be given to the implementation of robust, reliable and repeatable procedures to ensure that Career Medical Officers are informed of all relevant and current clinical and operational policies prior to the commencement of their first shift.

2. I recommend that consideration be given to the installation of appropriate signs and directions at access points and at the exit points of all elevators used by attending Ambulance Service of NSW personnel who have been called to assist with the care and treatment of a patient at Campbelltown Private Hospital, in order to allow such personnel to be able to independently determine the exact location of the patient.

3. I recommend that consideration be given to investigating the feasibility of providing simulation-based training in relation to airway management and ventilation to nursing staff and, in the event that it is deemed feasible to do so, that further consideration be given to incorporating such training in Basic Life Support and Advanced Life Support training provided to nursing staff as part of ongoing competency assessment.

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1. Introduction

1.1 On 19 December 2015 June Nutter was admitted for day surgery to Campbelltown Private Hospital so that a relatively low-risk and uncomplicated procedure could be performed. In the months leading up to this June had been experiencing health problems without a confirmed diagnosis. The intention was for the procedure to hopefully provide some diagnostic certainty, and for June to only remain in hospital for the day.

1.2 Although it was not known at the time of the procedure, June was suffering from a rare and aggressive form of stomach cancer. Almost 24 hours after the procedure, whilst June was still admitted to hospital, she suffered a sudden and unexpected deterioration as a result of the cancer. Despite attempts to resuscitate her, June later tragically died.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 In June's case, most of these questions could be answered from the evidence gathered as a result of the coronial investigation that followed her death. The coronial investigation, including the eventual inquest, was primarily concerned with examining the manner of June's death. In other words, the coronial investigation sought to better understand the circumstances surrounding June's death, the events which led up to it, and how these events ultimately affected the tragic outcome.

2.3 In the course of the coronial investigation certain issues, primarily associated with the care and treatment that June received at hospital, were identified. These issues formed the basis of the scope of the inquest.

2.4 It is with the benefit of hindsight, and with an opportunity for reflection, that an inquest is able to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. An inquest seeks to identify such shortcomings, not for the purpose of assigning blame or fault but, rather, for the purpose of learning lessons from them so that they are, hopefully, not repeated.

2.5 In this regard, inquests look backwards in time, but have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are usually made seeking to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

2.6 The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. The recommendations made by

Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

3. Recognition of June's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. A few brief words written by someone who never had the privilege of meeting June cannot possibly do justice to June's life, the person that she was, and how she positively affected so many people. However, it is hoped that these words, in some small way, honours June's life in a meaningful and respectful way.

3.3 June was, and still is, a beloved wife to her husband, Eric; a cherished mother to her four children, Melissa, Belinda, Crystal and Matthew; and an adoring grandmother to her 11 grandchildren at the time of her death.

3.4 June left school early in order to help her mother and later married her childhood sweetheart, Eric, when she was 18 years old and he was 20. Eric later made a home for himself and June and they lived there together up until June's death.

3.5 June was a devoted mother and was heavily involved in her children's school and sporting activities. June frequently gave up her time to volunteer at events related to her children's school, but also with other events in the wider community. This is reflective of the generosity of June's nature, the enormous time that she selflessly had for others, and her deep commitment to helping people.

3.6 June was no stranger to hard work and worked conscientiously throughout her life, no matter the job or task. June worked for many years as a cook in charge of a kitchen at an aged care facility. Like every job that she undertook, June was always meticulous with her work and took her responsibilities most seriously, often dedicating hours of her time to ensure that others were well looked after.

3.7 Despite her dedication to the needs of others, it was June's family who always came first in her life. When her first grandchild was born in 2004, and when others soon followed, June took a step back from work in order to spend more time with her grandchildren and children. Over time, it became an important family tradition for June to take a photo with each new grandchild. Her youngest grandchild, Cody, was born on 15 December 2015. Cody and his mother, Belinda, were visiting June in hospital on 20 December 2015, intending for a photo to be taken with June. Tragically, June was never able to take a photo with her grandson. Another family tradition that was dear to June was to give each of her grandchildren a one dollar coin in order to pass on to them her wishes for good luck, good life, and good wealth. Sadly, June was unable to fulfil this tradition in life with Cody either. However, although it was particularly for distressing for Melissa, shortly after June's death, Melissa wrapped June's hand around a coin and later gave it to Cody.

3.8 June and Eric typified the Aussie battler. They worked hard, lovingly raised their children, and had the modest dream of simply enjoying later life together. They enjoyed travelling, in particular cruising the oceans, and bought a motor home with plans to travel around Australia together. It is heart-rending to know that since June's death the motor home sits in the driveway of June and Eric's home, unused, and that the sight of a cruise ship brings Eric to tears.

3.9 Some of June's grandchildren were too young at the time of her death, or who were born after her death, will, tragically, never directly know of the love and devotion that June had for her family. To those who knew June the best and loved her the most, her life was enormously treasured, and her death equally devastating.

4. Background

4.1 On 2 June 2015 June went to see her general practitioner (**GP**), Dr Helen Corbett, at Camden Central Family Practice. June had been experiencing increased reflux, decreased appetite and some constipation for the previous few months. Dr Corbett prescribed June with medication (Nexium EC) to treat gastroesophageal reflex disease (**GERD**) and ordered pathology testing.

4.2 The test proved positive for Helicobacter pylori[1] and June returned to see Dr Corbett on 16 June 2015. On that occasion, Dr Corbett told June that she needed to continue with her existing medication regime, and prescribed further medication (Nexium HP7) to combat the Helicobacter pylori.

4.3 June later saw one of Dr Corbett's colleagues on 6 August 2015, who ceased the prescription for Nexium HP7. June subsequently returned to see Dr Corbett on 6 October 2015. On that occasion June again reported that she had decreased appetite and had lost up to 10 kilograms in weight. June also advised Dr Corbett that her reflux symptoms persisted when she stopped taking the Nexium EC. As a result Dr Corbett wrote a letter referring June to Dr Wun-Chung Teoh, a consultant gastroenterologist and Visiting Medical Officer (**VMO**) at both Campbelltown Private Hospital (**CPH**), as well as Campbelltown Hospital (**the Public Hospital**), a public hospital within the South Western Sydney Local Health District.

4.4 June next saw Dr Corbett again on 14 October 2015. On that occasion June reported that she was still experiencing decreased appetite and expressed anxiety about her symptoms being due to cancer. Dr Corbett encouraged June to see Dr Teoh as soon as possible. Dr Corbett also ceased all Nexium medication, and instead prescribed Somac, another type of medication to treat symptoms of GERD and eradicate Helicobacter pylori.

4.5 June first went to see Dr Teoh on 19 November 2015. On that occasion, June described her recent anorexia, weight loss and a possible change in bowel patterns. Dr Teoh also noted that there was persistent Helicobacter pylori which may have been the cause of her symptoms. Dr Teoh asked June to obtain an ultrasound in order to determine whether further investigations were required. In the meantime, Dr Teoh booked June in for a gastroscopy[2] and colonoscopy[3] (**the procedure**) on 19 December 2015 at CPH. In evidence during the inquest, Dr Teoh explained that the purpose of the procedure was to explore the reasons for June's symptoms, which he described as vague.

4.6 June underwent an ultrasound on 21 November 2015 and later spoke with Dr Teoh about the results on 24 November 2015. Dr Teoh noted that the ultrasound revealed sludge in the gallbladder and recommended that a magnetic resonance cholangiopancreatography[4] (**MRCP**) be performed. In evidence Dr Teoh explained that it was possible that the sludge had passed into the bowel ducts and caused an obstruction and so he wanted to get a clearer picture to see if that was the case.

4.7 The following day, 25 November 2015, June returned to see Dr Corbett and advised her that she had decided to proceed with the MRCP. This was performed on 11 December 2015 and indicated sludge

[1] A type of bacteria that infects the stomach and can cause inflammation and more serious conditions such as ulcers and cancer.
[2] A medical examination of the upper digestive tract using an endoscope (a thin, flexible tube containing a camera and light).
[3] A medical examination of the large bowel using an endoscope.
[4] A medical imaging technique that produces images of the hepatobilary (liver, gallbladder, bile ducts) and pancreatic systems.

in the gallbladder but no calculi, stricture or mass was identified. Dr Teoh regarded the findings to be non-specific with no evidence of any obstruction or intra-abdominal pathology.

4.8 On 14 December 2015 June experienced shortness of breath whilst walking uphill when going to visit her daughter, Melissa, at work. Melissa encouraged her mother to see a doctor and so June returned to see Dr Corbett on 16 December 2015. On this occasion, Dr Corbett noted that June's chest was clear on examination but that she was experiencing shortness of breath on exercise.

5. Overview of the events of 19 and 20 December 2015

5.1 Set out below is a factual overview of the events of 19 and 20 December 2015. The events will be described in greater detail later in these findings when specific issues are discussed and considered.

5.2 On 19 December 2015 Eric drove June to CPH, arriving at about 9:12am. Whilst she was seated on a couch in the reception area, and whilst Eric was speaking to a receptionist, June fainted, falling to her left onto the couch. Eric immediately went to attend to her and after several seconds, June was able to sit back up. The receptionist contacted Registered Nurse (**RN**) Eileen Stead to tell her what had occurred, and that June was experiencing shortness of breath.

5.3 RN Stead arrived in the reception area a short time later with a wheelchair to assist in moving June to the Day Surgery Unit (**the Unit**). RN Stead spoke with June, asking her if she had any breathing problems. June told RN Stead that she had been to see her GP recently and that she did not think that the salbutamol puffers she had previously been given were working. RN Stead helped June to the Unit, using the wheelchair.

5.4 June was subsequently admitted to the Unit and the admitting nurse, Enrolled Endorsed Nurse (**EEN**) Kerrie Curtis completed a pre-operative checklist. Dr Rakesh Rai, a specialist anaesthetist with intensive care training, was informed of June's arrival and her fainting episode in the reception. Dr Rai, who was to be the anaesthetist for the procedure that day, asked Dr Mohammad Pavel, a locum Career Medical Officer (**CMO**), to attend on June in order to review her. Dr Pavel later saw June, examined her, and inserted a cannula in order to start intravenous (**IV**) fluids. Following his examination, Dr Pavel did not relay any concerns to Dr Rai regarding going ahead with the procedure.

5.5 Dr Rai subsequently reviewed June in the pre-anaesthetic bay at 10:45am and again at 11:20am, shortly before the procedure commenced. The procedure began at 11:23am with Dr Teoh performing a gastroscopy first, and then a colonoscopy. June's vital signs, including her oxygen saturation levels[5], were monitored during the procedure. At one point Dr Rai noticed that June's oxygen saturations dropped to 80%.

5.6 During the course of the procedure Dr Teoh noted there was a hiatus hernia, severe erythema (redness) of the stomach lining, and a small polyp. Dr Teoh took gastric biopsies, a small bowel biopsy, and removed the sigmoid polyp[6].

5.7 Following the procedure June was transferred to the post anaesthetic care unit (**PACU**). Blood tests, as well as a chest x-ray (**CXR**) were ordered, with the latter being reported as being normal. A decision was made to admit June to the High Dependency Unit (**HDU**) overnight and for her to be reviewed that evening and again the following morning. The HDU was a 4 bed room located within the general surgical ward on Level 3 of CPH. June was later transferred to the HDU at 1:15pm.

5.8 According to a progress note entry in June's medical file, June's oxygen saturations dropped to 80-83% at one point overnight. However, on examination the following morning, 20 December 2015, it was noted that June's oxygen saturations had returned to 95%.

[5] A measure of the fraction of oxygen-saturated haemoglobin relative to total haemoglobin in the blood, with normal saturation levels considered to be between 95% to 100%.
[6] A small protrusion that grows out of the membrane, located in the end portion of the colon.

5.9 At around 11:00am on 20 December 2015 June asked the nursing staff in the HDU to help her to the bathroom. June was using a portable oxygen cylinder at the time. She told the nursing staff that she would be fine in the bathroom on her own and the nurses went to attend to other patients. At around this time, June's daughters, Belinda and Crystal, arrived in the HDU to visit her, with Eric arriving a short time later.

5.10 Whilst June was still in the bathroom she made call to the nurses to help her back to her bed. EEN Curtis helped June from the bathroom to a chair beside her bed and noticed that June was having difficulty breathing. EEN Curtis called the CMO on duty at the time, Dr Bharat Khialani, and asked him to review June.

5.11 Dr Khialani attended a short time later. He had a brief conversation with June, after which June collapsed in her chair and became unresponsive. An emergency call alarm was sounded, requesting assistance from other nursing staff, and a call was also made to Triple Zero. Nurses from other areas within the Hospital arrived in the HDU a short time later and Dr Khialani directed them to commence cardiopulmonary resuscitation (**CPR**).

5.12 In response to the Triple Zero call, three paramedic crews arrived at the Hospital a short time later. There was a delay in the paramedics gaining access to the Hospital as it was after hours and there was difficulty in identifying a code which would allow for access. Eventually the paramedics were granted access and made their way to the HDU. Upon arrival the paramedics took over the resuscitation attempts and continued treating June for about another 30 minutes. Tragically, June could not be revived and she was late pronounced deceased at 11:43am.

6. The postmortem examination

6.1 June was later taken to the Department of Forensic Medicine at Glebe where an autopsy was performed by Dr Othusitse Mokgwathi on 22 December 2015. Dr Mokgwathi noted that there was a tumour, measuring 60mm x 30mm in the stomach. Microscopic examination revealed poorly differentiated adenocarcinoma[7] of the stomach involving regional lymph nodes and beyond. There was also spreading to the lungs involving lymphatics[8].

6.2 In an autopsy report dated 10 August 2016, Dr Mokgwathi ultimately concluded that the cause of June's death was lymphangitic carcinomatosis (**LC**), with poorly differentiated gastric carcinoma being an antecedent cause.

[7] A type of cancer that forms in mucus-secreting glands throughout the body.
[8] The lymphatic system in the body is a network of delicate tubes that maintains fluid levels, reacts to bacteria, and deals with cell products that would otherwise result in disease.

7. What issues did the inquest examine?

7.1 The events of 19 and 20 December 2015 raised a number of questions about the care and treatment provided to June at CPH, and about certain decisions made by those caring for, and treating, her. The primary focus of the coronial investigation was to gather evidence in relation to these matters. Prior to the inquest a list of issues was drafted and circulated to the interested parties. This list raised the following issues:

(a) Whether it was reasonable and appropriate to proceed with gastroscopy and colonoscopy on 19 December 2015;

(b) Whether it was reasonable and appropriate for June to have been admitted to the HDU at CPH, rather than being transferred to the Public Hospital, following the procedure on 19 December 2015;

(c) Whether the monitoring and management of June from the time of her admission to the HDU on 19 December 2015 until her acute deterioration the following day was reasonable and appropriate;

(d) Whether the resuscitation attempts conducted on 20 December 2015, following June's acute deterioration, were reasonable and appropriate;

(e) Whether it was reasonable and appropriate for CPH staff to seek the assistance of Ambulance Service of NSW (**ANSW**) personnel;

(f) What factors contributed to the delay in ANSW paramedics being able to enter CPH; and

(g) What was the likely cause of June's acute deterioration and death, and could her earlier transfer to another hospital altered the outcome.

7.2 In order to examine the above issues, opinion was sought from a number of independent medical experts:

(a) Dr Philip Truskett, a senior general surgeon specialising in hepaticobilary, endoscopy and colonoscopy (on behalf of the Coroner's Court);

(b) Associate Professor Richard Lee, a senior staff specialist in intensive care and anaesthesia (on behalf of the Coroner's Court);

(c) Dr Steven Markowski, a senior Career Medical Officer specialising in intensive care (on behalf of Dr Khialani); and

(d) Dr Adrian Sultana, a specialist anaesthetist (on behalf of Dr Rai).

7.3 Each of the above experts, in total, prepared a number of reports which were tendered in evidence during the course of the inquest. Each of the experts also gave evidence, in conclave, during the inquest. Prior to the conclave, the experts were provided with a list of questions addressing the

issues above, along with a set of assumptions which they were asked to take into account in giving their answers.

7.4 Each of the above issues is examined in more detail below.

8. Was it reasonable to proceed with the gastroscopy and colonoscopy on 19 December 2015?

8.1 The evidence established that there were two matters which factored into the decision to proceed with the procedure on 19 December 2015:

(a) June's clinical presentation prior to the procedure; and

(b) The benefit of proceeding with the procedure, weighed against the risks associated with it.

8.2 After fainting in the reception area, RN Stead took June to the Unit by wheelchair and took her vital signs. RN Stead noted that June's oxygen saturations were 90% on room air and so she commenced June on 3 litres[9] of oxygen via nasal prongs[10]. RN Stead noted that within a few minutes June's oxygen saturations had risen to 98%.

8.3 RN Stead subsequently handed over June's care to EEN Curtis, told her that June had been experiencing shortness of breath, and asked her to request a medical review for June before the procedure. Whilst waiting for this to occur, EEN Curtis admitted June to the Unit and completed a Pre-Operative Checklist. June told EEN Curtis that she had been experiencing shortness of breath for just over a week. June also mentioned that her GP had arranged for a CXR and that it was clear. When EEN Curtis asked if June had any other symptoms that she should be aware of, June told her that she suffered from reflux.

8.4 Dr Rai later reviewed June in the pre-anaesthetic bay at 10:45am, and again at 11:20am shortly before the procedure began. Dr Rai noted that June had a history of vague abdominal symptoms of anorexia and weight loss, with shortness of breath and cough. Dr Rai also noted that June's respiratory symptoms had been previously investigated by her GP, where it was noted that a previous CXR was normal, and that June had been started on salbutamol[11] puffers.

8.5 On clinical examination Dr Rai noted that June's cardiovascular system was normal, and that her chest was clear with no crepitations[12] or wheeze. June's oxygen saturations were 98% with nasal prongs at 4 litres and 90% at room air. Dr Rai described the 90% level as being "*suggestive at best of mild hypoxemia*[13]".[14] In particular Dr Rai noted that June showed no sign of respiratory distress, no increased work of breathing, and a normal respiratory rate. In evidence, Dr Rai said that he considered that the oxygen saturations of 90% to be slightly low, but not enough to warrant considering cancelling or deferring the procedure.

8.6 Dr Rai also gave consideration to the fact that June had fainted in the reception area. He explained that June's dizziness could be attributed to dehydration, which is commonly observed in endoscopy patients. Dr Rai went on to explain that dehydration is the result of prolonged fasting and use of laxatives to prepare for the procedure. Further, Dr Rai noted that it was extremely hot that day (with the temperature at approximately 40 degrees) which also likely exacerbated the extent of dehydration. Ultimately, Dr Rai noted that June gradually improved after she was rehydrated with IV fluids.

[9] The measure of oxygen flow measured in litres per minute.
[10] A device placed in the nostrils used to deliver supplemental oxygen.
[11] Medication, marketed as Ventolin, used to treat asthma and open up the medium and large airways in the lungs.
[12] Abnormal lung sounds such as crackling or rattling.
[13] An abnormally low level of oxygen in the blood.
[14] Exhibit 1, Tab 12A at [8].

8.7 Dr Rai went on to discuss the anaesthetic plan with June which involved performing the endoscopy with "twilight", or minimum, sedation. June was agreeable with this and Dr Rai also discussed the risks of the procedure with her.

8.8 Apart from taking into account June's clinical presentation Dr Rai also formed the view that the benefit of going ahead with the procedure outweighed any inherent risks with it. In this regard, Dr Rai explained in evidence that whilst speaking with June in the pre-anaesthetic bay he formed the opinion that there was a high likelihood that she was a late presentation with gastric cancer. Dr Rai explained that his opinion was based on his 10 years of clinical practice as an anaesthetist, predominantly for gastric and oesophageal procedures. Having participated in excess of 6,000 such procedures, Dr Rai explained that he had become very familiar with the presentations of gastroesophageal cancers. On this basis Dr Rai said that June's symptoms of loss of appetite, weight loss, unresolved acid reflux disease, new epigastric pain, and reduced oxygen saturations on room air were suggestive of gastric cancer. Accordingly, Dr Rai emphasised that the possible diagnosis of cancer required urgent action and that the procedure was required to either rule out, or rule in, cancer.

8.9 Dr Rai ultimately summarised the decision to proceed in this way:

> "*The overwhelming benefits of a 15-minute diagnostic endoscopy procedure in a patient with a high degree of suspicion of having gastric cancer, performed under minimal sedation with easily reversible drugs and with a Consultant Anaesthetist present (this is often done without an Anaesthetist), clearly outweighed the relative minor anaesthetic risks. The presence of abdominal pain made it even more urgent for the procedure [to proceed]*".[15]

8.10 Further, Dr Rai noted that additional considerations such as June's anxiety, her and Eric's concerns about her symptoms, her preparation for the procedure, symptoms of abdominal pain, her presentation on 19 December 2015, and the thought that a diagnostic biopsy would facilitate urgent treatment before Christmas hospital closures all contributed to the decision to proceed.

8.11 Dr Teoh had a similar view to Dr Rai regarding the appropriateness of going ahead with the procedure. Although he did not examine June prior to the procedure, Dr Teoh said in evidence that he was aware that June's oxygen saturations were 90% at room air. Dr Teoh described this as an abnormal reading, but one which later improved after June was given supplemental oxygen.

8.12 Dr Teoh described the procedure as a "*frequently-performed, minimally invasive and generally low-risk*" one.[16] He said that June did not have any known absolute contraindications (such as shock or myocardial infarction) or relative contraindications (such as cardiac arrhythmia or recent myocardial ischaemia) for the procedure. Dr Teoh explained that although he was aware that June had been experiencing recent shortness of breath and fever he also did not consider these symptoms to be contraindications to the procedure. Overall, Dr Teoh was of the view that at the time of her admission, prior to and during the procedure, June "*did not have respiratory compromise which would have justified either cancelling or abandoning the procedure*".[17]

[15] Exhibit 1, Tab 12A at [13].
[16] Exhibit 1, Tab 10A at [5].
[17] Exhibit 1, Tab 10A at [7].

8.13 In evidence Dr Teoh agreed that June's shortness of breath in the four weeks preceding 19 December 2015 was a new and unexplained symptom. However he said that he was comfortable with the assessment made by Dr Rai and that there was nothing to suggest that there was any complication with proceeding with the procedure.

8.14 Like Dr Rai, Dr Teoh also took into account the benefits of going ahead with the procedure when compared to the relative risk associated with it. Dr Teoh said that June had already agreed to proceed and that in his opinion the risk was low compared to the benefit that the procedure would be diagnostic. Further, Dr Teoh emphasised that a diagnostic result could potentially be obtained, and a treatment plan commenced, before the approaching Christmas vacation period. However, in evidence, Dr Teoh agreed that he did not discuss the risks associated with the procedure with June personally, despite the fact that she was his patient. When asked why he had not done so, Dr Teoh again repeated that he considered the procedure to be low risk, and that there was a considerable benefit in proceeding without delay.

8.15 Given June's dyspeptic symptoms and the concern that June's symptoms of weight loss and change in bowel habit were attributable to a malignancy, Dr Truskett considered the procedure to be appropriate and a "*logical investigation*".[18] However, Dr Truskett explained that it would have been his preference for June's poor respiratory function to have been investigated more closely for the possibility of pulmonary embolus, before going ahead with the procedure. However, Dr Truskett noted that the possibility of pulmonary embolus was entirely excluded at the autopsy. Ultimately, Dr Truskett said that whilst he was "*therefore critical that a semi-elective procedure continued in the presence of significant short-term respiratory dysfunction…in reality it made no difference to the outcome*".[19] In evidence, Dr Truskett said that, on balance, he considered the decision to proceed to be a reasonable one. This was because a diagnosis was needed, and on the basis of June's discussion with Dr Rai on 19 December 2015, and her previous discussions with Dr Teoh, she was comfortable in proceeding and also keen to obtain a diagnosis.

8.16 Dr Sultana noted that June's oxygen saturations of 90% on room air prior to the procedure "*was out of keeping with her respiratory rate*" and that her presentation of fainting and shortness of breath was "*somewhat unusual for an elective endoscopy patient*".[20] Notwithstanding, Dr Sultana considered the decision to go ahead with the procedure to be reasonable due to the "*small but measurable improvement*" in June's clinical status pre-operatively (after she had been given oxygen, IV fluids, and bronchodilators), and the need for a diagnosis for a potentially treatable condition.[21] In evidence, Dr Sultana described June's respiratory dysfunction to be, at worst, "*moderate*" and that it was appropriate to reason that if the procedure did not go ahead, a potential diagnosis might not be obtained for another month due to the shutdown of CPH over Christmas. Dr Sultana described it as a weighted decision but ultimately said that there was not enough evidence to suggest that the procedure should have been cancelled outright.

8.17 Associate Professor Lee in evidence also referred to the fact that June's oxygen deficiency needed to be balanced against the aim of providing a diagnosis, in circumstances where her condition was deteriorating over time. Ultimately, Associate Professor Lee considered that, whilst there were risks associated with going ahead with the procedure, the decision to proceed, on balance, was a

[18] Exhibit 1, Tab 37, page 6.
[19] Exhibit 1, Tab 37, page 7.
[20] Exhibit 1, Tab 40, page 3.
[21] Exhibit 1, Tab 40, page 3.

reasonable one. In evidence, Associate Professor Lee said that there might have been safer alternatives to proceeding, although he did not specifically identify what these alternatives might have been.

8.18 **Conclusion:** The evidence establishes that, in general terms, the procedure was a low-risk one and often performed without the increased safety measures, such as having an anaesthetist present, that were available on 19 December 2015. There were two factors which impacted upon the decision of whether to go ahead with the procedure: June's pre-operative clinical presentation, and the desirability of obtaining a diagnosis.

8.19 So far as the first factor is concerned, it is evident that June was displaying respiratory dysfunction before the procedure and that her oxygen saturations of 90% on room air warranted further investigation. This clinical feature was known to both Dr Teoh and Dr Rai and it appears that appropriate consideration was given to it, with the decision ultimately being made that it did not represent a contraindication to performing the procedure.

8.20 Consideration of the second factor was important in reaching this decision. The evidence establishes that June was anxious to obtain a diagnosis for symptoms that had been causing her concern for the previous five months. Further, the timing of the procedure needed to be taken into account given the approaching Christmas period. Deferring the procedure would have created a delay in obtaining a potential diagnosis and, consequently, a delay in placing June on an appropriate treatment pathway.

8.21 Whilst reasonable minds may legitimately differ as to whether the procedure should have gone ahead or not, it could not be said that the risk-benefit analysis undertaken by Dr Teoh and Dr Rai was unreasonable. Although the measurement of June's oxygen saturations at 90% on room air was unusual, the evidence established that it improved with oxygen therapy and that June did not demonstrate any absolute or relative contraindications. Therefore, on balance, the decision to proceed was reasonable and appropriate. It should be noted that, as Dr Truskett explained, the decision ultimately made no difference to the outcome.

8.22 By his own acknowledgement, Dr Teoh did not personally examine June prior to the procedure, nor discuss the risks of it with her. Whilst there was no specific evidence adduced during the inquest to suggest that both of these things should have occurred, it might be argued that even a basic understanding of best clinical practice would suggest that both of these things should have occurred, particularly as June was Dr Teoh's patient. However, the evidence did establish that Dr Rai performed both of these tasks and conveyed the results of his examination to Dr Teoh. There is no evidence to suggest that the fact that Dr Teoh did not personally perform these tasks adversely affected the events that were to follow in any way.

9. Once started, was it reasonable to continue with the gastroscopy and colonoscopy on 19 December 2015?

9.1 June's intraoperative anaesthetic lasted from 11:22am to 11:40am. During the procedure June was monitored with intermittent, non-invasive blood pressure, oxygen saturation and electrocardiography (**ECG**). June was given oxygen via nasal prongs. Conscious sedation was commenced with fentanyl (for abdominal pain and as a cough suppressant), midazolam (an anxiolytic), and titrating doses of propofol[22] and ephedrine to augment her blood pressure for the insertion of the gastroscope, which occurred at 11:25am. The rest of the procedure, including the colonoscopy, was performed whilst June was partly awake.

9.2 The trend graph report[23], a printout of the electronic monitoring conducted during the procedure, indicates that June's oxygen saturations dropped to 80% during the procedure. In evidence Dr Rai estimated from looking at the trend graph that her oxygen saturations probably remained at this level for a few seconds. Dr Rai was asked in evidence whether he was concerned about this. He explained that oxygen saturations at this level are not uncommon in normal practice and that he was not concerned enough to suggest that the procedure should be abandoned. Overall, Dr Rai described June as having "*predictable desaturations during the procedure which resolved by the end*".[24] He went on to explain that if there was any concern that the oxygen saturations were remaining at, or dropping below, 80% then measures could be taken to address this by, for example, removing the endoscope or reversing the anaesthetic. However, Dr Rai ultimately considered that it was important to continue with the procedure in an attempt to obtain a diagnosis for June.

9.3 In evidence Dr Teoh was taken to the trend graph report and agreed that it was "*not a good graph*" and that it showed significant periods of desaturations. However, Dr Teoh expressed some scepticism about the accuracy of the graph on the basis that it seemed to demonstrate an unusual heart rate (of close to 200). Further Dr Teoh said that if June had suffered a period of prolonged desaturation he expected that he would have been told about it by Dr Rai, but had no recollection of this occurring. Dr Teoh considered a prolonged desaturation to be one lasting five to ten minutes, but emphasised that this was an unqualified statement on his behalf.

9.4 In evidence Associate Professor Lee said that June became hypoxaemic during the procedure and that this persisted during it. He considered that there was perhaps a point in the procedure where the anaesthetic given to June could be reduced and her oxygen delivery increased. Associate Professor Lee offered the opinion that if these measures were ineffective then consideration could be given to aborting the procedure. However, Associate Professor Lee was unable to reach a definitive opinion about whether the procedure should have continued on to completion on 19 December 2015, primarily because it was not possible to interpret the trend graph report with precision (as it is a printout, and not a dynamic electronic display on a monitor that would have been available to Dr Rai to visualise on 19 December 2015).

9.5 In evidence counsel for Dr Rai took Associate Professor Lee to the trend graph report. Associate Professor Lee said that in his estimation June's oxygen saturations dropped below 80%, he described the trend graph report in general as being "*extreme*", and said that it was very rare to see a chart of

[22] A short-acting medication that results in decreased consciousness and is used for starting and maintaining general anaesthesia.
[23] Exhibit 1, Tab 28, page 66.
[24] Exhibit 1, Tab 12 at [4].

this kind. Associate Professor Lee agreed that the combined use of the endoscope and three anaesthetic agents could potentially contribute to the drop in June's oxygen saturation levels, but maintained that it was the role of an anaesthetist in such a procedure to maintain a patient's oxygen saturations above 90%. Associate Professor Lee agreed with counsel for Dr Rai that June was anxious to obtain a diagnosis and that aborting the procedure would cause a delay in this being potentially achieved. In this regard, Associate Professor Lee acknowledged that he had tempered his position with this in mind, and that Dr Rai made manoeuvres to improve June's oxygen saturations by increasing the oxygen fraction and lightening the anaesthetic. Associate Professor Lee acknowledged that the question of whether the benefit of persisting with the procedure outweighed any risk was a decision to be made by Dr Rai. However, Associate Professor Lee ultimately agreed with counsel for Dr Rai that the decision to proceed appeared to be a reasonable one.

9.6 Dr Sultana also said that the identified difficulty in interpreting the trend graph report made it in turn difficult to answer the question of whether the procedure should have been aborted given June's low oxygen saturations. However, he explained that in general it was not unusual for patients to experience periods of oxygen desaturations during this type of procedure, which were temporary and reversible. Dr Sultana also took into account the fact that the procedure was completed over a short period of time (about 20 minutes) and with minimal sedation. Ultimately, Dr Sultana expressed the view that it would be "*almost inappropriate*" to abort the procedure because to do so would mean that June would have experienced the effects of anaesthesia with no possibility of obtaining a diagnosis.

9.7 **Conclusion:** The clinical evidence is insufficiently persuasive to allow for a conclusion to be reached that it was inappropriate to continue with the procedure. The evidence establishes that June's oxygen saturations dropped to 80% at one point during the procedure. Due to the limitations in interpreting a hard copy printout of the electronic monitoring that was occurring, as opposed to visualising a dynamic electronic display, it is not possible to definitely state for how long this period of oxygen desaturation lasted. On the best available evidence, provided by Dr Rai, it lasted a few seconds.

9.8 It should also be noted that the combined expert evidence indicated that periods of oxygen desaturations are not uncommon for the type of procedure that June was undertaking. Further, the evidence also established that if there was a concern that the oxygen saturation level was remaining at 80% for prolonged period, or was even dropping below this level, appropriate counter-measures could have been taken. Indeed, in order to address the drop to 80% Dr Rai increased the oxygen fraction and lightened the anaesthetic. Finally, the desirability of continuing with the procedure in the hope that it would produce a diagnostic result for June appears to have appropriately taken into account and given appropriate weight in any risk-benefit analysis. The general low-risk nature of the procedure, its relatively short duration, minimum sedation and having an anaesthetist present all factored into this equation. Having regard to all these matters, it could not be said that the decision to continue with the procedure was unreasonable or inappropriate.

10. What was the outcome of the procedure?

10.1 Dr Teoh explained that in view of June's symptoms he had a "*fairly high expectation*"[25] that some abnormality would be found. However, Dr Teoh noted that the only significant finding was the severe inflammation in the stomach lining. Dr Teoh explained that the procedures did not provide any indication that June was suffering from gastric cancer at the time.

10.2 In evidence Dr Teoh explained that he did not form any clear cut impression from the procedure. He said that it raised the possibility of cancer but that another impression that was open was that June had a severe case of gastritis. Dr Teoh explained that there were none of the usual hallmarks of gastric cancer and that in 10 years of practice post-fellowship, June's case was the only clinical case of LC that he had been involved in.

10.3 Dr Teoh was asked in evidence whether he believed he had taken a biopsy from the tumour site. He explained that he took multiple biopsies from sites that appeared abnormal. Dr Teoh was asked whether it was possible he did not visualise the tumour during the gastroscopy. Dr Teoh said that the more likely explanation was that the biopsy could not be taken deep enough. That is, from the autopsy it was discovered that June had a rare form of stomach cancer known as linitis plastica. Dr Teoh explained that this type of cancer infiltrates, and is notoriously difficult to diagnose, often not revealing itself on biopsy. Dr Truskett similarly emphasised that linitis plastic is a rare condition and "*frequently invisible to gastroscopy as there is no mucosal lesion*".[26]

10.4 Following the procedure June was transferred to the PACU and her oxygen saturations at that time were noted to be 92% on nasal prongs. Urgent blood tests, a CXR, PRN[27] paracetamol for pain, and salbutamol nebulisation for June's dry intractable cough were all ordered.

10.5 The salbutamol nebulisation was administered via a nebuliser mask with 10 litres oxygen. However this resulted in a drop in oxygen saturations to 90% when June was changed to nasal prongs after the nebulisation. Instead of increasing oxygen flow through the nasal prongs, June was switched to a Hudson Mask[28] with 10 litres oxygen (later reduced to 6 litres) which resulted in oxygen saturations increasing to 97%. Dr Rai decided against further weaning to nasal prongs as he felt that the non-humidified air would not be ideal for June who was dehydrated and experiencing a dry cough. At 12:30pm a CXR was performed which was later reported as being normal.

[25] Exhibit 1, Tab 10A at [17].
[26] Exhibit 1, Tab 37, page 6.
[27] Latin for *pro re nata* meaning, in medical terms, when necessary.
[28] A face mask used to deliver supplemental oxygen.

11. Was it reasonable and appropriate to admit June following the procedure?

11.1 As already noted above, June's procedure on 19 December 2015 was performed as a day surgery, which typically meant that a patient would be discharged home the same day as the procedure. However, following the procedure there was a joint decision made by Dr Teoh and Dr Rai to admit June to so that further investigations could be performed.

11.2 The relevant progress note written at 12:30pm by one of the nursing staff (RN Telford) records the following:

> "*NURSING: Pt arrived in recovery with Dr Rai and Dr Teoh present. Pt presented today as per above notes complaining of shortness of breath and with O_2 saturations on room air at 90%. On arrival into recovery pt tachycardic*[29] *as charted and O_2 saturations with nasal prongs supplementation at 4L 92%. Dr Rai and Dr Teoh requesting a ward bed for pt to be monitored overnight and further investigations into pts SOB*[30] *…*".[31]

11.3 Dr Teoh saw June in the PACU about 20 minutes after the procedure and explained that she was going to be admitted overnight to the HDU. Dr Teoh explained that the decision to admit June overnight "*was for abundance of caution, based on the reduced oxygen saturations*".[32] Dr Teoh ordered a CXR and blood tests and explained in evidence that the purpose in doing so was to see whether June's low oxygen saturations could be explained. He further explained that the plan was to admit June, perform further investigations, monitor June for any improvement overnight, and then determine if more investigation and referral to a respiratory specialist was required.

11.4 Dr Rai noted in evidence June's postoperative clinical state was considered to have remained unchanged from her preoperative state, and that her respiratory status postoperatively was similar to her preoperative state, or even slightly better with the salbutamol nebulisation. However, Dr Rai similarly agreed that a joint decision was made to admit June under Dr Teoh's care pending the results of the blood tests.

11.5 In evidence Dr Truskett described the decision to admit June as being a "*very sensible*" one, and that he strongly supported the decision. Dr Truskett explained that it was clear that June was experiencing an issue related to oxygenation, separate from the procedure, and which required further investigation. Associate Professor Lee agreed that given the inability to wean June off supplemental oxygen she could not be discharged home, and so the decision to admit her was appropriate. Similarly, Dr Sultana said that he thought it was "*essential*" for June to be admitted and expressed the view that he did not think any other specialist in Dr Teoh's position would have acted any differently.

11.6 **Conclusion:** Given the oxygenation issues encountered during the procedure, and the inability to wean June off supplemental oxygen after the procedure, further investigation to understand the nature of these issues was warranted. This meant that June needed to be admitted. Accordingly, the decision to admit June was entirely appropriate and reasonable in the circumstances.

[29] A heart rhythm disorder where the heart beats faster than normal while at rest.
[30] Shortness of breath.
[31] Exhibit 1, Tab 28, page 67.
[32] Exhibit 1, Tab 10A at [25].

12. Was it reasonable and appropriate for June to have been admitted to the High Dependency Unit at Campbelltown Private Hospital, or should she have been transferred to Campbelltown Hospital?

12.1 In order to understand the underlying basis of the decision to admit June to the HDU at CPH, it is convenient to first examine the contemporaneous records.

12.2 The CXR was performed at 12:45pm. Dr Rai and Dr Teoh reviewed the results at about 1:00pm and considered them to be normal. The CXR was later reported on by a radiologist as also being normal. A progress note entry at 1:00pm records the following:

> "*NURSING: Chest xray reviewed by Dr Rai and informed of pts current vital signs. Dr Rai happy with same and requesting pt be transferred to ward bed for further monitoring*".[33]

12.3 This review by Dr Raid was the last time that he saw June before the end of his shift. June was subsequently transferred to the HDU at about 1:15pm. There, she was later reviewed by Dr Teoh at about 1:48pm. A progress note entry made at that time records the following:

> "*R/V by Dr Teoh. He want [sic] blood result informed by [sic] CMO*".[34]

12.4 It appears that the blood results became available at around 6:15pm. A progress note entry at that time notes:

> "*Blood results came, CMO aware and he will give ring [sic] to Dr Teoh*".[35]

12.5 Finally, a progress note entry made by Dr Pavel records the following:

> "*D/W Dr Teoh about blood result & pt. Happy to keep in hospital overnight and will decide tomorrow regarding…CTPA*[36]".[37]

12.6 In a statement made prior to the inquest, Dr Rai said that the decision was to admit June to the HDU on an interim basis for a few hours whilst awaiting the results of the blood tests. He explained that the timing of any eventual transfer to the Public Hospital was to be made by Dr Teoh after the blood test results were available.

12.7 Dr Rai said that he discussed with Dr Teoh whether June should about transferring June to the Public Hospital to further investigate her cough and shortness of breath. It was likely that this would involve further imaging and a respiratory consult. However, Dr Rai explained that it was thought appropriate to not transfer June having regard to it "*being the weekend and with a high level of care available in the High Dependency Unit at Campbelltown Private Hospital with continuous ECG, non-invasive blood pressure (NIBP), oxygen saturation (SpO_2), respiratory rate monitoring done on a Healthscope Adult observation chart*".[38]

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[33] Exhibit 1, Tab 28, page 68.
[34] Exhibit 1, Tab 28, page 68.
[35] Exhibit 1, Tab 28, page 69.
[36] Computed Tomography Pulmonary Angiogram: a diagnostic test to obtain an image of the pulmonary arteries to look for pulmonary embolus (blockage in the arteries caused by blood clots).
[37] Exhibit 1, Tab 28, page 69.
[38] Exhibit 1, Tab 12 at [5].

12.8 Dr Teoh said that his intention was for June to be admitted to the HDU but agreed that this was not documented by him in the progress notes. However, in evidence Dr Teoh agreed with the progress notes entry made at 1:48pm and confirmed that he wanted the CMO, Dr Pavel, to inform him of June's blood test results. Dr Teoh explained that once the results became available his intention was to discuss June's condition and formulate an assessment of her clinical situation. Further Dr Teoh said when her later spoke to Dr Pavel he asked Dr Pavel to review June's stability and oxygen saturations in order to decide if there was any change to her status which necessitated action or a further management plan. Dr Teoh explained in evidence that if June did not spontaneously improve by the following morning that help would have to be sought from a respiratory specialist.

12.9 Dr Teoh agreed in evidence that he did not document this plan in the progress notes and agreed, in hindsight, that it would have been useful if he had. Dr Rai agreed that, in hindsight, the absence of documented plan created confusion. Dr Teoh explained that at the time he felt that his instructions had been clear, that the nursing and medical staff understood the plan, and that everything that had been requested by him had occurred. However, Dr Teoh said that, as a result of June's death, it is now his practice to document management plans in a patient's progress notes.

12.10 Like Dr Rai, Dr Teoh also took into account a number of factors in deciding to admit June to the HDU. In evidence Dr Teoh explained that he thought June would receive better care in the HDU, rather than being moved to the public hospital on Saturday night. Dr Teoh went on to explain that he was also conscious that as it was weekend, June would have likely had poorer nurse-to-patient ratios in an unmonitored bed in the public hospital. Dr Teoh expressed the view, on the basis that he worked at both hospitals, that he did not think that June would have met the criteria for HDU admission in the public hospital and would have been placed in a standard ward bed. On this basis he considered that there would be better monitoring of June, and a more comfortable experience for her, in the HDU at CPH.

12.11 In evidence, Dr Teoh was asked about Dr Rai's statement that June was admitted to the HDU on an interim basis awaiting blood results. Dr Teoh said that he did not know what was meant by this but that the plan was to examine the blood results to explain what was occurring. He said that if June improved overnight she could be discharged home. However, Dr Teoh explained that if June did not improve then the plan was to transfer her to the Public Hospital under his care where a specialist could review her on Sunday, rather than wait until Monday.

12.12 Given the progress note entry made at 6:30pm both Dr Teoh and Dr Rai were asked whether any consideration was given to performing a CTPA which, if it was to be performed, would have necessitated June's transfer to the Public Hospital. Dr Teoh said that there was a discussion between himself and Dr Rai and, later, Dr Pavel about a differential diagnosis and that consideration was given to an angiogram. However, Dr Teoh explained that a pulmonary embolus was not high on a differential diagnosis because June had no risk factors. Dr Rai similarly agreed that he discussed a differential diagnosis of pulmonary embolus with Dr Teoh and agreed with him that the probability was low.

12.13 The issue regarding the absence of a management plan documented by either Dr Rai or Dr Teoh was explored in evidence with Susie Cicuto, the Director of Clinical Services at CPH. Ms Cicuto agreed that

it was concerning that neither VMO had documented a management plan for June in the progress notes. In evidence Ms Cicuto explained that the issue regarding documentation by VMOs has been assessed several times by the Medical Advisory Committee (**MAC**) at CPH with the result that nursing staff frequently encourage VMOs to document management plans themselves for patients. When this is not done, then nursing staff take on the responsibility to perform such documentation. Ms Cicuto explained in evidence that, in her own personal experience as a RN for more than 30 years at five different public and private hospitals, the issue regarding documentation exists more broadly and is not limited only to practice at CPH. However, Ms Cicuto explained that according to the CPH Hospital By-Laws (both in force as at December 2015, and currently), the routine failure by a VMO to perform appropriate documentation may impact on a VMO's re-accreditation.

12.14 In this regard it is noted that clause 236 of the *Healthscope Limited Hospital By-Laws Adopted 1 July 2018*[39] (**the 2018 By-Laws**) provides:

> *An Attending Health Practitioner must maintain full, accurate and legible medical records for all patients treated by him or her at a Healthscope Hospital.*

12.15 Further, clause 258 of the 2018 By-Laws[40] provides:

> *Pertinent progress notes must be recorded at the time of observation sufficient to permit continuity of care, communication of clinically relevant information to nursing and other staff and transferability of the Patient. Wherever possible, each of the Patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders and the results of and tests and treatments undertaken.*

12.16 In his report, Dr Truskett said that the decision to admit June to the HDU "*for further observation and potential investigation was entirely appropriate*".[41] However, Dr Truskett qualified this by stating that it would have been his preference, even before the procedure, to perform a CTPA in order to exclude the possibility of pulmonary emboli. However, in expressing this preference Dr Truskett noted that performing a CTPA would not have altered the outcome. In evidence Dr Truskett said that he was unsure if June should have been transferred to the Public Hospital immediately after the procedure. He considered that it was reasonable for some investigation to be conducted to more fully understand the reason for June's condition.

12.17 In general terms Associate Professor Lee described a HDU as "*providing a level of care intermediate between intensive care and general ward care*".[42] He explained that patients are typically admitted to a HDU because they are at high risk of developing complications. Accordingly, Associate Professor Lee explained that a HDU should have resources to manage critically ill patients who may experience short-term emergencies, and manage more stable patients by way of monitoring and support. Associate Professor Lee described the decision to admit June to the HDU as not appropriate and explained that for June to be admitted Dr Teoh and Rai "*would have needed to have a reasonable expectation that*":[43]

[39] Exhibit 7.
[40] Exhibit 7.
[41] Exhibit 1, Tab 37, page 7.
[42] Exhibit 1, Tab 38, page 4.
[43] Exhibit 1, Tab 38, pages 6-7.

(a) They had a clear working diagnosis for June's increasing oxygen requirements;

(b) June would respond to therapy;

(c) They had a backup plan if June deteriorated; and

(d) The Hospital would be able to respond to a rapid deterioration.

12.18 Associate Professor Lee considered that none of these prerequisites were present, and that June needed further investigation in a facility, such as the Public Hospital, where advanced life support was available.

12.19 In evidence Associate Professor Lee explained that the clear CXR (both in the weeks preceding, and immediately following, the procedure) may have given Dr Teoh and Dr Rai "*false security*". Associate Professor Lee said that because June had severe hypoxaemia, which was undiagnosed and undifferentiated, she needed to be in a hospital where she could be closely monitored and her hypoxaemia could be differentiated with appropriate investigation. Associate Professor Lee opined that the HDU of a small, private hospital was not the appropriate facility for this to occur. Instead, Associate Professor Lee said that June's presentation suggested, statistically, that it was most likely that she was suffering from pulmonary embolus. In order to exclude this, a CTPA needed to be performed, which would have involved transferring June to a major acute public hospital. Associate Professor Lee suggested that June should have been transferred to the Public Hospital as soon as an ambulance could be arranged after she had recovered from the anaesthetic.

12.20 Dr Sultana offered the opinion that it was reasonable for Dr Rai to attempt to resolve June's issues on site at the Private Hospital with the information available to him at the time. Dr Sultana expressed doubt that "*any other colleagues of similar expertise would have acted differently*".[44] Further, Dr Sultana said that even if June had been transferred to a tertiary facility such as Liverpool Hospital, there was no guarantee that the type of care envisaged by Associate Professor Lee would be available to her due to overwhelming demands for critical care facilities. In evidence, Dr Sultana elaborated by hypothesising that if June had been transferred she may have ended up in an emergency department where resolution of her hypoxaemia might be further delayed.

12.21 Dr Markowski shared a similar view to Dr Sultana. In his report he expressed the view that even if June had been transferred to the Public Hospital, her presenting symptoms would have made her likely for admission to a Level 1 ward for investigation. Dr Markowski considered that June would not have met the requirements for a HDU Level 2 bed and "*almost certainly*" would not likely have been admitted to any form of intensive care unit.[45]

12.22 Counsel for Dr Teoh explored the opinions expressed by Dr Sultana and Dr Markowski with Associate Professor Lee. In response to Dr Sultana's opinion, Associate Professor Lee said that he did not think that the possibility of a poorer nurse-to-patient ratio (in an emergency department as opposed to a HDU) should ever be a consideration in general, and should not be a reason for a patient not to be transferred. Further, Associate Professor Lee considered the opinion expressed by Dr Markowski to be wrong. Associate Professor Lee offered the contrary view that June's history of hypoxaemia on a

[44] Exhibit 1, Tab 40, page 4.
[45] Exhibit 1, Tab 39, page 11.

background of clear chest x-rays, with fluctuating oxygen saturations, suggested that it was more likely that her condition would be taken seriously and meant that it was more likely that she would be admitted to a HDU.

12.23 **Conclusion:** The evidence establishes that Dr Teoh and Dr Rai gave appropriate consideration to the fact that June's hypoxaemia warranted further investigation. To this extent, a CXR and blood tests were ordered. It is also evident that consideration was given to performing a CTPA in order to rule in or rule out the possibility of pulmonary embolus, although both doctors considered this to be low on the likely list of possibilities.

12.24 By 1:00pm the results of the CXR were known and were clear. By 6:30pm the blood test results were also known and they did not provide further clarity regarding June's hypoxaemia. Although there was some disagreement between the experts as to whether June should have remained in the HDU at CPH or whether she should have been transferred to the Public Hospital, there was general agreement that if any transfer was to occur, it did not need to occur immediately and that it was reasonable to conduct some initial investigation. By 6:30pm that initial investigation had concluded, and had been unable to resolve June's symptoms.

12.25 The management plan instituted by Dr Teoh amounted to having June admitted overnight and then reviewed by the CMO in the morning for any signs of improvement. In the absence of any improvement, Dr Teoh's intention was to transfer June for specialist respiratory assessment. Associate Professor Lee described June as having "*been admitted to the HDU in a blind hope that she would improve with time*".[46] Whilst this characterisation is perhaps unnecessarily pejorative, the evidence established that no management plan had been implemented, in accordance with the perquisites described by Associate Professor Lee, which would have allowed for June's admission to the HDU.

12.26 It is evident that the likely level of care that June would receive in the Public Hospital on a Saturday night, if transferred, was a factor relevant to Dr Teoh's decision-making process. In this regard, counsel for Dr Teoh submitted that Dr Teoh's direct experience of working in both hospitals and his experience of ward environments, together with the opinions expressed by Dr Sultana and Dr Markowski, should be accepted in preference to that of Associate Professor Lee who, it is submitted, works primarily in an intensive care setting in a tertiary hospital environment.

12.27 It is, of course, not possible to definitively state what level of care would have been provided to June if she had been transferred, and what ward she would have been assigned to. However, it would appear that the more important consideration is whether the facility that June was in had the potential to meet her needs, particularly in the event of a sudden and unexpected deterioration. To this extent, by 6:30pm on 19 December 2015 the initial investigations conducted at CPH were all non-diagnostic. This alone suggests that a higher level of management, and ability to investigate, was required. This in turn leads to a conclusion that it would have been more appropriate for June to have been transferred to the Public Hospital on 19 December 2015.

[46] Exhibit 1, Tab 38, page 7.

12.28 It was conceded by Dr Teoh that he did not document his management plan for June, and that it would have been useful if he had done so. If this had occurred it would have provided clarity for the clinical staff involved in June's care. It is accepted that Dr Teoh's management plan was documented in part by the nursing staff. However, this still led to a degree of confusion, as acknowledged by Dr Rai who considered June's admission to the HDU to be on an interim basis (until the results of the blood test were known), which was contrary to the intention of Dr Teoh.

12.29 Notwithstanding, there is no evidence to suggest that the absence of a management plan documented by Dr Teoh adversely affected June's care. Dr Teoh's intention was for June to be admitted to the HDU overnight, where she would receive continuous electronic monitoring, which, as will be discussed further below, occurred.

12.30 The evidence established that the absence of a documented management plan was not unique to the events of 19 December 2015 or, indeed, to general practice at CPH. Whilst it could not be said that this represents clinical best practice, the evidence established that it is an area that CPH is aware of and which it seeks to regularly address. The current version of the CPH By-Laws specifically and appropriately provide for the need for all health practitioners to properly document adequate progress notes. Further the 2018 By-Laws also provide for the routine failure to do so to be taken into account in the process of re-accrediting a health practitioner.

13. Was the monitoring that June received overnight appropriate?

13.1 Dr Teoh said in evidence that he did not document his recommendation that June be continuously monitored during her admission overnight but said that logic would suggest that she would have to be in order to observe any change overnight. He said that he assumed that the HDU had the ability to continuously monitor a patient given the number of surgical cases performed at CPH, and the need for a HDU to allow patients to recover following surgery.

13.2 Dr Rai said in evidence that he specifically asked for a HDU bed where he had an expectation that June would be continuously monitored. He explained that the overwhelming reason for a HDU bed was the high likelihood of gastric cancer and the need to have blood tests done and a chest x-ray performed.

13.3 At 7:00pm, Dr Khialani commenced his shift as the overnight CMO on duty. At 9:00pm Dr Khialani made an alteration to June's calling criteria, requiring that he be notified in the event that June's oxygen saturations fell below 94%. Without an alternation the usual threshold for notification would be if a patient's oxygen saturations fell below 90%. In evidence Dr Khialani said that he had spoken to one of the nursing staff in the HDU at about 8:30pm or 9:00pm about June's oxygen requirements and the need for an ongoing plan in the event of a sudden deterioration. Therefore, Dr Khialani explained that he made the alteration to the calling criteria to provide a "*buffer*" and opportunity to reassess June and instigate management in the event that her condition deteriorated.

13.4 In relation to June's overnight monitoring whilst in the HDU, the parties in the inquest agreed to the following facts[47]:

(a) June's oxygen saturations were 98% at 10:00pm on 19 December 2015 on Hudson Mask;

(b) According to a progress note entry made at 10:20pm on 19 December 2015, Dr Khialani ordered that June's oxygen delivery be changed to be via nasal prongs (to make her more comfortable so that she could sleep), but that if her oxygen saturations fell below 94% the method of oxygen delivery was to revert back to Hudson Mask;

(c) Between 10:20pm on 19 December 2015 until 5:00am on 20 December 2015, no observation of June's oxygen saturations were recorded;

(d) At 5:00am on 20 December 2015, June's oxygen saturations were recorded at 95%;

(e) At 5:30am a progress note entry recorded that between 10:20pm on 19 December 2015 and 5:30am on 20 December 2015 at a time, or at times, unknown:

(i) June's oxygen saturations were between 90% and 97% on Hudson Mask;

(ii) At some point June's oxygen saturations dropped to 80-83% when on nasal prongs; and

(iii) In response to the drop in oxygen saturations, the nasal prongs were replaced with a Hudson Mask.

[47] Exhibit 5.

(h) At all times whist June was in the HDU she was constantly monitored by a wall monitor which recorded a number of matters including her oxygen saturation levels, blood pressure, ECG and heart rate;

(i) The wall monitor was set so that if June's oxygen saturations fell below 90% an alarm sounded. It is likely that it was in response to an alarm sounding that June's oxygen saturations were recorded at 80-83%. It is also likely that the change in oxygen delivery from nasal prongs to Hudson Mask was effective to bring June's oxygen saturation levels to over 94%.

(j) June's oxygen saturations were recorded at 95% at 8:00am, and again at 11:00am, on 20 December 2015;

(k) At the time of Dr Khialani's arrival, June's oxygen saturations were at 96%.

13.5 Having regard to the agreed facts above, CPH made the following concessions:

(a) the drop in oxygen saturation levels to 80-83% ought to have been brought to Dr Khialani's attention;

(b) the fact that the drop in oxygen saturations was not brought to Dr Khialani's attention represented a missed opportunity for Dr Khialani to assess June; and

(c) observations should have been recorded more regularly during June's time in the HDU.

13.6 Ms Cicuto agreed in evidence that as at 19 and 20 December 2015, there were a number of policies within CPH which referred to the observation of patients. However, at that time CPH did not have a comprehensive observation policy. Accordingly, in February 2016 CPH issued *Policy 8.45b Vital Signs Observation – Adult Patient*. The purpose and scope of this policy is to provide "*clinicians at Campbelltown Private Hospital a standardised approach for monitoring vital sign observations and early detection and treatment of the deteriorating patient via the facility Clinical Emergency Response System (CERS) in a timely and effective manner*".[48]

13.7 The Clinical Emergency Response System (**the CERS policy**) is a further policy (Policy 8.45a) that was issued by CPH in June 2015. It provides for "*a two-tiered system that provides early recognition, intervention, timely management and appropriate treatment to the deteriorating and/or seriously ill patient in the hospital, 24 hours a day*".[49] In evidence Dr Khialani was taken to the CERS policy and advised that he had not seen it before. Dr Khialani further explained that as at December 2015 the CERS policy had not been provided to him either by CPH, or by the locum agency through which his work as a CMO was arranged.

13.8 This issue was explored with Ms Cicuto in evidence. She explained that whilst the policy documents such as the CERS policy are referred to during the induction process involving a CMO, copies of the relevant policies are not physically given to a CMO. Ms Cicuto agreed that this could potentially lead

[48] Exhibit 1, Tab 32.
[49] Exhibit 1, Tab 36, page 17.

to a situation where a CMO performs their first shift without having seen relevant policy documents, and agreed that this type of potential occurrence should not continue.

13.9 Dr Khialani said in evidence that a drop in oxygen saturations to 80-83%, without reference to the agreed facts above, would represent a clinical deterioration and the need for medical review and potential escalation. He explained that if he had been provided with such information, he would have reviewed June and, depending on the outcome of the review, spoken to Dr Teoh about the next steps to be taken. Dr Teoh similarly agreed in evidence and said that he expected that the mere observation of oxygen saturations at 80-83%, again without reference to the agreed facts above, would have triggered a review by a CMO and that the CMO would in turn ring him about the result of that review.

13.10 However, having regard to the agreed facts set out above, Dr Truskett, Associate Professor Lee and Dr Markowski all agreed with questions put by counsel for CPH that the response of the nursing staff to June's drop in oxygen saturations to 80-83% at some point overnight was reasonable.

13.11 **Conclusion:** June's oxygen saturations (and blood pressure and heart rate) were recorded on her general observation chart initially at 1:30pm and then hourly between 2:00pm and 4:00pm on 19 December 2015. However, apart from an entry made at 10:00pm on 19 December 2015, no other observation was recorded until 5:00am on 20 December 2015. CPH appropriately conceded that, despite the existence of continuous electronic monitoring of vital signs provided by the wall monitor in June's room, the observations should have been more regularly recorded between 10:20pm on 19 December 2015 and 5:30am on 20 December 2015. The gap of some seven hours with no observations recorded in the June's general observation chart cannot be explained on the available evidence.

13.12 CPH has taken appropriate steps to introduce a comprehensive patient observation policy which did not exist in December 2015. Such steps are commendable and in keeping with a commitment to clinical best practice. However, the evidence demonstrated that difficulties may still exist in ensuring that CMOs are appropriately informed of such policies prior to their first shift. To this extent, the following recommendation is necessary.

13.13 **Recommendation 1:** I recommend to the General Manager, Campbelltown Private Hospital, that consideration be given to the implementation of robust, reliable and repeatable procedures to ensure that Career Medical Officers are informed of all relevant and current clinical and operational policies prior to the commencement of their first shift.

13.14 Dr Khialani and Dr Teoh both agreed, in general terms, that a drop in oxygen saturations to 80-83% would have warranted review by a CMO followed by potential discussion with a consultant depending on the outcome of that review. However, on the basis of the facts agreed to by the parties it is most likely that HDU nursing staff appropriately responded to the drop in June's oxygen saturations by changing the method of oxygen delivery so as to bring June's oxygen saturations back above 95%. It is not possible to conclude on the available evidence that if Dr Khialani had been informed of the drop in oxygen saturations that this would have resulted in June's transfer from CPH to the Public Hospital. Rather, as CPH appropriately conceded, there was a missed opportunity for Dr Khialani to have reviewed June overnight.

14. Was June appropriately monitored on 20 December 2015?

14.1 EEN Curtis and RN Kalpana Basnet started their shift in the Level 3 General Surgical Ward at 7:00am on 20 December 2015. The two nurses first attended on June at about 9:00am or 9:30am. They made June's bed whilst she sat in a chair nearby.

14.2 At some time before midday, June called for nursing assistance as she needed to go to the toilet. RN Basnet and EEN Curtis responded to the call and helped June to the bathroom. At this time June was receiving oxygen from a portable cylinder. June told both nurses that she was fine to use the toilet on her own and they waited outside the bathroom for her. From inside the bathroom June later told RN Basnet that she was fine and that she would call when she was ready to be taken back to her room. RN Basnet said even though June was in the HDU, her understanding was that she could leave June alone for brief periods. Further, RN Basnet explained that she was also busy attending to other duties. RN Basnet left June and returned to the general ward where she had been performing duties with Dr Khialani, completing discharge documents for patients. As this was occurring, June's husband and daughters arrived to visit her. Belinda and Crystal arrived whilst June was in the bathroom, with Eric arriving a short time later.

14.3 EEN Curtis returned to June's room sometime later in response to a buzzer which June had activated whilst in the bathroom. June told EEN Curtis that she needed help returning to her bedside chair as she did not have the strength to walk back herself. EEN Curtis helped June back to her bedside chair and noticed that she had difficulty breathing. In response, EEN Curtis switched June's oxygen supply from the portable cylinder to the wall-mounted supply. June told EEN Curtis that she wanted to sit in the chair as it made it easier for her to breathe than when lying in bed.

14.4 In evidence, RN Basnet said that it was her understanding that it was not essential for a nurse to be present in the HDU at all times when a patient was there. She initially said that she could not recall how long she was waiting outside the bathroom for June, but later estimated that June had been in the bathroom for a "*few minutes*". According to June's daughters, Belinda and Melissa, June was left alone in the bathroom for at least 10 minutes.

14.5 In evidence Dr Teoh initially said that it was his expectation that a patient in the HDU would never be left alone without a nurse present. However, during questioning by counsel for CPH Dr Teoh was asked to make the following assumptions:

(a) that the HDU is located within the general surgical ward;

(b) that June was the only patient in the HDU on 19 and 20 December 2015;

(c) that there was a maximum of 12 other patients in the general surgical ward;

(d) that there was a RN, EEN and CMO on duty covering the surgical ward; and

(e) that at all times June was connected to a wall monitor of monitoring oxygen saturations and blood pressure.

14.6 On this scenario, Dr Teoh agreed that it was not necessary to have a RN or EEN present with a patient in the HDU at all times.

14.7 In his report, Dr Truskett noted that it appeared that June deteriorated significantly whilst in the bathroom. He noted that "*it would be usual in a HDU setting that a patient requiring such care would be supported when attending toilet [sic] and accompanied by nursing staff*".[50] However, in evidence Dr Truskett considered it reasonable for June to have been left alone in the bathroom momentarily. Given that June was well enough to mobilise to the bathroom and speak with the nurses, Dr Truskett considered that it was not outside expected clinical practice for her to have been left alone for a short time. Ultimately, Dr Truskett offered the view that even if nursing staff had been present continuously whilst June was in the bathroom, this would not have altered the eventual outcome.

14.8 **Conclusion:** It is difficult to make a meaningful assessment of whether June was appropriately monitored on the morning of 20 December 2015. This is because the opinion expressed by Dr Truskett was premised on the fact that it was perfectly reasonable for nursing staff to have left June alone *momentarily*. However, on the available evidence it is not possible to determine the time that June was alone in the bathroom, and whether this length of time accords with Dr Truskett's assessment of her management.

14.9 What the evidence does establish is that June told the nursing staff that she could manage on her own, and that the nursing staff made an enquiry with her when she was in the bathroom. Further, the nursing staff responded to a call for assistance when June activated the call buzzer. June's daughters noticed that their mother was visibly unwell when she left the bathroom. It would therefore seem logical to conclude that if nursing staff had been present with June they would have been able to similarly observe her deterioration and, consequently, make an earlier call to Dr Khialani. However, as Dr Truskett explained this would not have altered the eventual outcome.

14.10 Counsel for June's family submitted that a number of recommendations ought to be made to CPH mandating, in effect, increased (2-to-1) and continuous nurse-to-patient ratios in the HDU. Further, it was submitted that CPH should be required to advise all medical practitioners admitting patients to the HDU of the level of monitoring available and the expected nurse-to-patient ratio. This submission appears to be based in part on a reference in Associate Professor Lee's first report[51] in which he expressed an opinion regarding the composition of a HDU in general terms. However, in evidence Associate Professor Lee agreed with counsel for CPH that he was simply an expressing an unqualified opinion. Further, Associate Professor Lee acknowledged that he was not suggesting that the HDU at CPH in particular should be continuously staffed with a minimum of two nurses if only one patient was admitted there.

[50] Exhibit 1, Tab 37, page 8.
[51] Exhibit 1, Tab 38, page 4.

14.11 Given finite resources, it can be concluded that any mandated increase in nurse-to-patient ratios in the HDU at CPH would likely affect resourcing in other wards. Further, it would appear that the constant admission and discharge of patients to the HDU would likely make any obligation on CPH to advise medical practitioners of expected nurse-to-patient rations an unworkable one. As these matters were not raised with Ms Cicuto, would have been best placed to address them, in evidence it is difficult to conclude that there is an appropriate evidentiary basis for to make such recommendations. Finally, it should be noted that although neither Dr Teoh nor Dr Rai were specifically aware of the type of monitoring that June would be provided with in the HDU, their expectation was that her vital signs would continuously electronically monitored. This, in fact, occurred.

15. The initial resuscitation attempts by Hospital staff

15.1 After June was observed to have difficulty breathing following her return from the bathroom, EEN Curtis notified Dr Khialani, who arrived a short time later with RN Basnet. Dr Khialani had a brief conversation with June, asking if she was currently feeling any pain. June said that she had pain in her chest. As this occurred EEN Curtis attached a salbutamol nebuliser mask to June whilst RN Basnet checked June's blood pressure. RN Basnet saw that June was losing consciousness and heard her say that she "had a tightness".[52] At this point, June collapsed in her chair.

15.2 EEN Curtis pressed the emergency call alarm button and Dr Khialani instructed her to also call Triple Zero, which she did. With the help of Eric, RN Basnet moved June from the chair onto her bed.

15.3 EEN Jessica Edwards was working in the rehabilitation ward on level 2 with RN Rhoda Gamildien. Upon hearing the emergency call alarm EEN Edwards ran upstairs to the HDU. When she arrived Dr Khialani instructed her to commence chest compressions whilst EEN Curtis began using a bag valve mask (BVM) to ventilate June. RN Gamildien arrived a short time later and Dr Khialani instructed her to measure June's blood sugar level.

15.4 RN Mary D'Silva was in the tea room on a break when she heard the emergency call alarm. She immediately made her way to the HDU and found that Dr Khialani, EEN Edwards, and EEN Curtis were already in the process of attempting to resuscitate June. RN D'Silva saw that June's daughters were still in the room and asked if they wanted to come with her to a quiet room so that they did not have to observe the distressing events that were unfolding. However, June's daughters chose to remain with their mother.

15.5 Dr Khialani instructed RN D'Silva to attach a defibrillator, which was located on an emergency trolley in the HDU, to June. However, RN D'Silva was unfamiliar with the monitor on the HDU emergency trolley because it was different to the monitor on the emergency trolley in the rehabilitation ward where she usually worked. As a result, RN D'Silva had difficulty in applying the defibrillator pads to June. Eventually RN Basnet took over this task and attached the pads. When the monitor was turned on RN D'Silva saw that there was no heart rhythm. Dr Khialani said that he also noticed the initial rhythm was asystole and that this did not change during the entire resuscitation attempt.

15.6 Following the first cycle of CPR Dr Khialani directed the nurses to swap roles as he noted that EEN Edwards was becoming tired from performing compressions. This resulted in RN D'Silva performing compressions, EEN Curtis began administering oxygen, EEN Edwards began to scribe, and RN Basnet was using the defibrillator to monitor for any heart rate. As this was occurring, Dr Khialani asked for a pause so that the defibrillator could be checked, which indicated that the rhythm was still asystole.

15.7 Following this, EEN Edwards took on the role of scribe. In evidence she was taken to the record of the resuscitation attempt[53] and explained that she recorded entries from 11:13am through to 11:40am. The record also contains two entries marked at 11:10am. In evidence EEN Edwards said that she did not make either 11:10am entry and also could not recall whether the entries were already present when she commenced scribing. In any event, EEN Edwards explained that she did not record the word "*Asystole*" next to the two 11:10am entries and the entries at 11:13am and 11:17am.

[52] Exhibit 1, Tab 20 at [15].
[53] Exhibit 1, Tab 28, page 25.

15.8 Next to the entry for 11:13am, EEN Edwards wrote the following: "*Rhythm assess → HR 28*". In evidence she explained that "*Rhythm assess*" meant that CPR was stopped so that June's heart rate could be assessed on the monitor by Dr Khialani. EEN Edwards was asked whether she simply wrote what she had been told. She said that she could not see any heart rate on the monitor and did not recall a heart rate being mentioned to her. Ultimately EEN Edwards could provide no explanation to reconcile the 11:13am entry showing asystole on the one hand, and also showing a heart rate of 28 on the other. EEN Edwards said she could not recall whether the entry of asystole was present at the time she wrote heart rate. In any event, EEN Edwards said that she did not recall being told about any heart rate or seeing a heart rate on the monitor.

15.9 Dr Khialani said that during the second cycle of CPR he noticed that RN D'Silva, who was ventilating June, was not forming a seal around June's airway with the BVM. As a result Dr Khialani said that he could hear air disperse and saw no chest wall movement. As a result, Dr Khialani said that he moved from his position at the side of the bed to the head of the bed and inserted a Guedel airway. Afterwards Dr Khialani said that he performed a jaw thrust to open June's airway, and used both hands to form a seal with the BVM, whilst asking RN D'Silva to continue ventilation. Dr Khialani said that this method appeared to work better as he saw chest wall movement.

15.10 Since December 2015 CPH has taken steps to address the issue encountered by RN D'Silva by ensuring that monitors on each emergency trolley throughout CPH are now identical. Further, equipment checklists are now included with each trolley, with a requirement that each trolley be checked once per shift.

16. The arrival of Ambulance NSW paramedics

16.1 As a result of the Triple Zero call made by EEN Curtis, NSW Ambulance were tasked at 11:04am to attend the Hospital. Three paramedic crews arrived at the Hospital at 11:09am and parked at the designated ambulance entrance at the rear of the hospital. As it was a Sunday, and therefore regarded as being after hours, the rear entrance doors were locked and the paramedics could not immediately enter the hospital. Instead, an access code needed to be entered into a keypad in order to unlock the entrance doors.

16.2 Although some of the paramedics were aware that there was an access code at the Hospital to allow for afterhours access, none of them knew what the code was. This is because the paramedics attending on 20 December 2015 had only previously attended CPH on a limited number of occasions, or only during usual operating hours. The use of an access code to gain entry after hours was not unique to CPH. Similar codes are used at other facilities, such as private hospitals and nursing homes, that ANSW personnel are required to attend. In these situations, ANSW relies on these facilities to inform ANSW of the means by which access can be gained.

16.3 According to facts[54] agreed to by the parties, enquiries made by both the CPH and ANSW have failed to ascertain:

(a) whether any information at all was provided by CPH to ANSW prior to 20 December 2015 regarding the access code; and

(b) the exact nature of any information that might have been provided by CPH to ANSW prior to 20 December 2015 regarding the access code .

16.4 There was a brief discussion amongst the paramedics as to whether the access code was 1987 or 1978. Both codes were tried but neither allowed entry. One of the paramedics, Karen Pople, entered a number of other codes without success, and even attempted to guess the code by pressing numbers on the keypad that were faded.

16.5 The Duty Operations Manager, Inspector Alessandro Simeoli, had arrived at the hospital in one of the three paramedic crew vehicles. After encountering the difficulty with the access code, Inspector Simeoli made call to NSW Ambulance dispatch in an attempt to make contact with staff from the Hospital so that access could be granted. Inspector Simeoli also made his way to the front entrance of the Hospital in an attempt to gain access.

16.6 After waiting between approximately six or seven minutes[55] and ten minutes[56] one of the nurses (most likely RN Gamildien) arrived at the rear entrance to let the paramedics into the hospital. The senior NSW Ambulance clinician on site, Linda Lodge, explained that the nurse directed the paramedics to make their way to Level 3 via a goods elevator. It appears that this elevator was used so that the paramedics were able to fit a stretcher and their equipment into the elevator. However, the nurse did not accompany the paramedics in the goods elevator. As a result, Paramedic Lodge explained that when the paramedics arrived on Level 3 they were unaware of where to go, where the

[54] Exhibit 4.
[55] Exhibit 1, Tab 21 at [6].
[56] Exhibit 1, Tab 22 at [9]; Tab 23 at [7].

HDU was and, most importantly, where June was. Eventually one of the nurses, who had made their way separately to Level 3 in a different elevator, directed the paramedics to the HDU.

16.7 At around this time Inspector Simeoli was eventually able to gain access to the front foyer of the Hospital and spoke to a hospital staff member, asking where June was. It became apparent to Inspector Simeoli that the staff member was unaware of the reason for attendance of the paramedics. At this time, Inspector Simeoli received a radio message that the paramedics at the rear entrance had been granted access.

16.8 According to facts agreed to by the parties certain improvements have been made since December 2015 to mitigate the possibility of any delay in ANSW personnel attending to the care of patient at CPH. These improvements include:

(a) From 22 February 2016 ANSW recorded the access code to CPH in its Computer Aided Despatch database – this code has remained unchanged up to 8 November 2018;

(b) Whenever ANSW personnel are tasked to attend CPH, the access code is automatically sent to a mobile data terminal and relayed to the attending ANSW vehicle(s); and

(c) There is now a dedicated access keypad at CPH solely for the use of ANSW personnel with the access code not being subject to change.

16.9 Further, in November 2018 CPH issued a policy to facilitate access by ANSW personnel to CPH in a timely manner. Apart from referring to a universal access code sent by CPH to ANSW, the policy also provides that when access is required after hours:

(a) the exact location (including department, floor level and bed number) of a patient that is requiring transfer or care will be communicated to ANSW; and

(b) if staff numbers permit, a junior staff member will meet attending ANSW personnel at the rear access door and escort them to the patient.

16.10 Paramedic Lodge was asked by Counsel for CPH whether there was anything else CPH could do to assist ANSW paramedics responding to an emergency call for assistance. Paramedic Lodge explained that attending paramedics are required to use the goods lift at CPH in order to fit their patient stretchers and other equipment. However, she explained that on each level there is no signage at the exit points from the goods life to assist in directing paramedics to the location of a patient.

16.11 **Conclusion:** It appears that an administrative oversight sometime prior to 20 December 2015 led to a situation where the attending paramedics could not immediately gain access to CPH. Enquiries made by both CPH and ANSW have not been able to elicit information that provides an understanding of what contributed to this apparent oversight. It should be noted that whist Dr Truskett noted that criticism could be made regarding the access issues encountered by the paramedics, it was his opinion that June's death was "*most unlikely to have been responsive to resuscitative effort*" and that the delay in access did not have any material impact on June's death.[57]

[57] Exhibit 1, Tab 37, page 10.

16.12 It is evident that since 20 December 2015 a more robust system has been implemented to mitigate against the possibility of difficulties with physical access to CPH contributing to a delay in ANSW personnel attending on a patient. One of the improvements made provides for attending ANSW personnel being escorted to a patient by a CPH staff member. However, this is dependent on a staff member being available. In the event that attending ANSW personnel are required to independently locate a patient after gaining access to CPH, it appears that potential delays may be encountered due to the absence of signs and directions at the access points used by ANSW personnel. To this extent, the following recommendation is necessary.

16.13 **Recommendation 2:** I recommend to the General Manager, Campbelltown Private Hospital, that consideration be given to the installation of appropriate signs and directions at access points and at the exit points of all elevators used by attending Ambulance Service of NSW personnel who have been called to assist with the care and treatment of a patient at Campbelltown Private Hospital, in order to allow such personnel to be able to independently determine the exact location of the patient.

17. Were the resuscitation attempts by Hospital staff reasonable and appropriate?

(a) Administration of adrenalin

17.1 Upon entering the HDU Paramedic Lodge saw that Dr Khialani and the nursing staff were surrounding June who was on her bed. Paramedic Lodge saw that June had a cannula in her hand and asked Dr Khialani how much adrenalin June had been given. Dr Khialani told her that none had been given and Paramedic Lodge asked one of the other paramedics to administer adrenalin to June.

17.2 Paramedic Lodge said that she was surprised that adrenalin had not been given in accordance with the Australian Resuscitation Council Guideline regarding Protocols for Advanced Life Support (**the Guideline**). The Guideline provides that where Advanced Life Support (**ALS**) is provided to a person with a non-shockable rhythm, 1 mg of adrenalin is to be administered immediately, and then every three to five minutes, or during every second loop or cycle of the resuscitation algorithm. Associate Professor Lee noted that by the time of the arrival of the paramedics in the HDU, resuscitation had been continuing for approximately 22 minutes. This meant that that, applying the Guideline, a total of 4mg of adrenalin in four doses should have already been administered to June.

17.3 Dr Khialani agreed in evidence that, as at 20 December 2015, he had been trained in ALS and was aware of the Guideline and the algorithm which applied regarding the provision of ALS.[58] In these circumstances he was asked why no adrenalin was administered to June at any point prior to the arrival of the paramedics. Dr Khialani explained that the initial period during the resuscitation of a patient is very challenging and that in June's case he encountered a number of particular issues, namely:

(a) difficulty in attaching the defibrillator pads;

(b) challenges with maintaining June's airway;

(c) being removed from the role of team leader and being required to directly assist with ventilation;

(d) being required to speak to Dr Teoh during the resuscitation with a phone held up to his ear by one of the nurses; and

(e) having to despatch some of the nurses in order to locate the paramedics and ensure that they were able to enter the Hospital.

17.4 Having regard to all of the above and with the events unfolding, Dr Khialani said that he simply just never got around to giving adrenalin to June. Additionally, Dr Khialani said that he did not recognise that June had a working cannula. He went on to explain that he was aware of the Guideline but described the situation as "*chaotic*", and that he was trying to remain as calm as possible in order to think through the steps that were required to keep June alive. Dr Khialani said that he placed emphasis on compression and airway management and that when he heard the ambulance sirens he assumed that help was "*just around the corner*", and that the arriving paramedics would be able to establish an airway and deliver the intensive care that June needed. Overall, Dr Khialani described

[58] Exhibit 1, Tab 31, page 21.

the event as one of the most challenging of his career, being unsupported with minimal resources and in an environment and personnel unfamiliar with trying to save a patient in asystolic rhythm.

17.5 Paramedic John Harold said that when he walked into the room he formed the impression that "*there was no urgency in what was being done and [the resuscitation team] were very casual. There was no panic in their actions despite the situation and them having to call [paramedics]*".[59] Dr Khialani said that the description provided by Paramedic Harold did not fit well. Dr Khialani said that he knew how he was feeling and that he tried to stay as calm as he could, but whether he externalised it or not he was not sure.

17.6 Dr Truskett agreed with Dr Khialani's description of the event as being "*chaotic*". Dr Truskett described Dr Khialani as being in the position of, effectively, "*holding the fort*" in circumstances where he was aware that a highly skilled intensive care team was on their way. Dr Truskett emphasised that the Guideline is simply that; a guideline, and not a standard, to assist with decision-making during ALS. Dr Truskett opined that it was correct for Dr Khialani to focus on maintaining June's airway. Dr Truskett went on to say that to stop to administer adrenalin, with what Dr Truskett described as "*variable outcome*", and potentially lose the airway would be a "*flawed decision*". Overall Dr Truskett considered Dr Khialani's conduct to be "*perfectly reasonable*" in the circumstances, even though the Guidelines were not complied with. Similarly, Dr Sultana considered Dr Khialani's efforts to be reasonable, whilst also noting that his actions fell short of the Guidelines.

17.7 Dr Markowski also agreed that not administering adrenalin was a breach of the Guidelines and that not following the Guidelines "*is certainly not a pathway [he] would advocate*".[60] However, both in his report and in evidence Dr Markowski sought to highlight (in reference to academic studies) that there is ongoing debate in the medical community regarding the value of using adrenalin in a cardiac arrest setting.

17.8 Associate Professor Lee agreed generally that Dr Khialani was faced with a difficult situation. However he emphasised that compliance with the Guideline is standard procedure in a cardiac arrest setting and that it would have been an easy matter for Dr Khialani to instruct one of the nurses to administer adrenalin whilst he concentrated on maintaining June's airway. In this regard, Associate Professor Lee considered that paramedics were correct to be surprised that adrenalin had not been given to June prior to their arrival.

17.9 **Conclusion:** The evidence establishes that the resuscitation of June was a challenging situation. Whilst Dr Khialani was aware of the Guideline, and that adrenalin was to be administered in accordance with it, the dynamic events that were unfolding on 20 December 2015 meant that he simply did not get around to doing so. The inquest was not the appropriate forum to consider the broader issues raised by Dr Markowski regarding the value of administering adrenalin in a cardiac arrest setting. However, notwithstanding any debate or controversy that may surround this issue, all of the experts agreed that the Guideline should have been followed.

[59] Exhibit 1, Tab 24 at [9].
[60] Exhibit 1, Tab 39, page 20.

17.10 However, it is acknowledged that the particular circumstances of June's resuscitation presented Dr Khialani with a number of challenges above what might typically be encountered in what can be regarded as a confronting situation for any health care professional. Therefore, whilst compliance with the Guideline would have represented optimal clinical practice, Dr Khialani's failure to do so is perhaps understandable given the opinions expressed by Dr Truskett.

(b) Airway and ventilation

17.11 As at 20 December 2015 all of the nursing staff involved in June's resuscitation attempt had been trained in Basic Life Support (**BLS**). According to the Australian Resuscitation Council this involves the establishment and maintenance of airway, breathing and circulation, and related emergency care.

17.12 After instructing one of the paramedic team to administer adrenalin to June, Paramedic Lodge made her way to the top of the bed where June's head was positioned. As she did so she saw that Dr Khialani was holding June's head with her chin close to chest and described this as being "*the opposite way it should've been to clear her airways*".[61] In evidence Paramedic Lodge said that she saw Dr Khialani with one hand on June's chin and believed his other hand was on the top of her head, and that he was not holding the BVM.

17.13 Paramedic Pople said that when she first walked into the room she "*could tell that CPR had been ineffective*".[62] She referred to the fact that June's head was cyanosed (which conveyed to Paramedic Pole that ventilation was ineffective) and that her head was tilted downwards, thereby restricting airflow.

17.14 During questions from counsel for Dr Khialani, Paramedic Lodge said it was not unexpected that Dr Khialani, as the team leader and with the understanding that paramedics would be attending within minutes, would focus the initial resuscitation attempts on compressions and ventilation. Paramedic Lodge also agreed that there were two methods to maintain a patent airway during CPR: the chin or jaw thrust, and the pistol grip. Paramedic Lodge agreed that she observed Dr Khialani attempting to perform the pistol grip, but that June's chin was closer to her chin than expected, but that she only saw this positioning for a short period of time.

17.15 Paramedic Lodge also observed that one of the nurses was holding the BVM and that "*it had not been expanded to facilitate proper air movement*".[63] Paramedic Lodge described this as being "*ineffective due to the large amount of fluid obstructing the airways*".[64] In evidence Paramedic Lodge described part of the BVM as being "*concertinaed up*" and not expanded, resulting in air not fully going in the bag. At this time Paramedic Lodge said that she did not notice any chest wall movement.

17.16 Paramedic Chris Angus also formed the impression that there was not a good seal with the BVM and that it looked as though the nurse holding the mask "*was just holding it there and not checking the mask as she held it*".[65] Paramedic Angus also described Dr Khialani and one of the nurses as "*doing a one persons [sic] job*".[66] Paramedic Angus went on to explain that paramedics are trained to hold a

[61] Exhibit 1, Tab 21 at [8].
[62] Exhibit 1, Tab 23 at [10].
[63] Exhibit 1, Tab 21 at [9].
[64] Exhibit 1, Tab 21 at [9].
[65] Exhibit 1, Tab 22 at [13].
[66] Exhibit 1, Tab 22 at [13].

patient's head and the BVM in order to achieve good visualisation and grip on a patient's head and the BVM.

17.17 RN D'Silva agreed that she was responsible for ventilation when the paramedics entered the room. She said that she was aware of the comments made by the paramedics and said that she believed she had achieved a good seal with the BVM, and was not aware of any obstruction to the airway. She said that she did not notice that the BVM was not fully expanded until one of the paramedics tugged on the mask. She described Dr Khialani as holding June's jaw up and her head back to open her airway, with his fingers on either side of her jaw bone, thrusting her chin out. Dr Khialani said that he saw no suggestion that June's airway might be blocked as he saw chest wall movement and on that basis he believed that June was being ventilated appropriately.

17.18 At the same time that Paramedic Lodge made her observations regarding the BVM, she also recalled that Dr Khialani said to her, "*You're gonna need suction*".[67] Paramedic Lodge took the suction tube from the wall and observed that June's head was already cyanosed and that her airway was full of fluid. Paramedic Lodge said that in her opinion the fact that June was cyanosed indicated that oxygen exchange was not effective and that she believed that this was due to fluid preventing oxygen transfer. Paramedic Lodge used the suction to clear June's airway of what she described as "*a combination of probably vomit, fluids and gastric contents*".[68] Paramedic Lodge described the volume as being more than she had ever seen in a patient in cardiac arrest. After completing the suctioning, Paramedic Lodge intubated June.

17.19 Dr Khialani said that although the BVM was transparent, with the mask over June's face, he could not see whether there was any fluid obstructing the airway. Dr Khialani agreed that he may have said to Paramedic Lodge that the paramedics were going to need suction, but did not recall doing so.

17.20 Dr Khialani was asked if he considered using suction to ensure that the airway was not blocked. He explained that because there was chest wall movement he believed ventilation had been achieved and felt that there was no airway obstruction. Dr Khialani explained that if any further difficulties with ventilation were encountered he would have next considered using a laryngeal mask airway (**LMA**). Dr Khialani indicated that whilst he had received ALS training he had not received any formal anaesthetic training in intubation. He said that he knew that a more secure airway was required but said that he did not have the resources to do so and hoped that paramedic arrival could achieve this.

17.21 Dr Truskett said that it was clear that ventilating June proved to be difficult and in this situation Dr Khialani reverted to using a BVM and Guedel airway which was appropriate in circumstances where the members of the resuscitation team were not skilled in intubation and where the imminent arrival of paramedics was expected.

17.22 Associate Professor Lee noted that regarding Paramedic Lodge's observation that Dr Khialani was holding June's chin in a way so that it was titled downwards towards her chest that "*it is difficult to draw conclusions from observations at a particular point in time in the process which had been going on for many minutes*".[69] Associate Professor Lee noted that Paramedic Lodge may have made her observation at the time that Dr Khialani was releasing his jaw thrust and that this may have in turn created a false impression of Dr Khialani's actions.

[67] Exhibit 1, Tab 21 at [8].
[68] Exhibit 1, Tab 21 at [10].
[69] Exhibit 1, Tab 38, page 9.

17.23 In evidence Associate Professor Lee agreed that two-person ventilation was appropriate and that the decision not to use a LMA was acceptable and consistent with the Guideline. In this regard Associate Professor Lee noted that the focus should have been on oxygenation using the most appropriate methods, which in this case was using the BVM. However, Associate Professor Lee opined that Dr Khialani lacked situational awareness due to his failure to use suction, which was readily available, to clear June's airway of fluid.

17.24 Overall Dr Truskett emphasised that there was a vast difference between competence and performance and that June's resuscitation was attended by what he described as "*a lot of human factor issues*". In relation to the conduct of the nursing staff, Associate Professor Lee noted that their level of expertise was acceptable but that they were not adept, and were not expected to be. Dr Sultana said that adequate BLS was in progress at the time of the arrival of the paramedics. Dr Markowski considered that the nursing team had done a "*reasonable job*" and noted that they were not an intensive care team in a tertiary hospital. He noted that in any resuscitation there are often minor errors which are corrected and that, in June's case, these did not influence the outcome.

17.25 Ms Cicuto explained that BLS training at CPH now includes simulation-based training. The advantage of using a simulator, which had previously not been available in training packages, allows for nursing staff to determine if effective compressions are being performed. Further, Ms Cicuto also advised that as at November 2018, approximately 41% of nurses employed by CPH have received ALS training. In evidence Ms Cicuto was asked whether a simulator to assist with airway management and use of a BVM could also be incorporated into staff training packages. Ms Cicuto said that she was unsure whether such a training method existed but considered that it would be a good idea to pursue if one was available.

17.26 **Conclusion:** It is not possible to conclude that the observations made by paramedics arriving at a certain point in time during the resuscitation equates to some deficiency on the part of Dr Khialani in maintaining June's airway and providing ventilation. The evidence leaves open the fact that at the relevant time Dr Khialani may have been releasing or adjusting his grip whilst attempting to maintain a patent airway for June. It should also be noted that when RN Gamildien arrived in the HDU she saw Dr Khialani performing a "*jaw lift*"[70] so that oxygen could be administered by RN Basnet using the BVM. This observation tends to suggest, on balance, that Dr Khialani was appropriately maintaining June's airway.

17.27 The issue regarding ventilation and suctioning is more difficult to resolve. The evidence from Paramedic Lodge establishes that there was a large amount of fluid which required suctioning. Although Dr Khialani said that he could not visualise any fluid, his concession in evidence that he may have told the paramedics that June needed suctioning suggests that he was aware of the need to do so. Therefore, it is most likely that Dr Khialani was aware of this need but, perhaps similar to the omission to administer adrenalin, simply did not do so because of the challenging nature of the situation that he was confronted with.

[70] Exhibit 1, Tab 17 at [10].

17.28 The issue regarding the use of the BVM is also difficult to reconcile. Dr Khialani recognised that there was a difficulty with maintaining a seal on the BVM which is why he initiated two-person ventilation. On the one hand, RN D'Silva said that she thought good ventilation was being achieved but agreed that she was unaware that the BVM was not fully inflated until one of the paramedics drew this to her attention by pulling on it. On the other hand, Dr Khialani said that he was able to observe chest wall movement which suggested to him that June was being effectively ventilated. Given the initial difficulty with ventilation recognised by Dr Khialani, and the observations of the attending paramedics, it is most likely that June's ventilation was attended by some difficulty. The evidence establishes that consistent and effective ventilation was likely not maintained by CPH staff throughout their involvement in June's resuscitation.

17.29 Whilst Dr Khialani was trained in ALS and all the nurses involved in the resuscitation were trained in BLS, it is useful to recall Dr Truskett's observation that a gap exists between competence and performance. The introduction of simulation-based training for the performance of effective compressions is a positive step to bridging this gap. If similar simulation-based training can also be provided with respect to airway management and ventilation then that would only assist to further bridge this gap. Therefore, it is desirable to make the following recommendation.

17.30 **Recommendation 3:** I recommend to the General Manager, Campbelltown Private Hospital, that consideration be given to investigating the feasibility of providing simulation-based training in relation to airway management and ventilation to nursing staff and, in the event that it is deemed feasible to do so, that further consideration be given to incorporating such training in Basic Life Support and Advanced Life Support training provided to nursing staff as part of ongoing competency assessment.

18. Was it reasonable and necessary for Hospital staff to call NSW Ambulance to assist with the resuscitation attempts?

18.1 The CERS policy at CPH provides for different escalation protocols depending on the type of rapid response required in different clinical situations. The protocols identify that the medical officer responsible for managing the rapid response makes the determination for ANSW to be called as clinically indicated.

18.2 In evidence, Dr Khialani explained that one of the primary reasons for calling Triple Zero was the need for a patient in cardiac arrest to be transferred to a tertiary hospital to receive the care needed after being revived. Dr Khialani explained that by describing his involvement in the resuscitation attempt as being unsupported and with minimal resources (referred to above) he was referring to the fact that the nursing staff were not comfortable or not familiar with the defibrillator pads and use of the BVM, and that if they were more comfortable he would have felt more supported in managing the resuscitation team.

18.3 However, Dr Khialani agreed with counsel for CPH that he had five nurses available to him for several minutes before any left the room and that, in terms of numbers, this was sufficient to assist in a resuscitation of the kind attempted. Dr Khialani also accepted that it was sufficient, staffing-wise, for CPH to have a doctor with his skills on duty at the time, and that there was no need for an extra medical officer to be on duty. Finally, Dr Khialani agreed that the load on 20 December 2015 was about 30 patients and that this was not a particularly heavy patient load for a CMO.

18.4 Dr Truskett noted that the protocol at CPH was for ANSW to be called in the event of a rapid response such as the one June required, and considered this to be reasonable given the staff that was available. He explained that even if the resuscitation had been successful, it would have been mandatory to transport June by ambulance to a facility with an appropriate level of care. Associate Professor Lee agreed with Dr Truskett that CPH would not be expected to provide intensive care in such a situation in order to maintain June's condition. He also noted that the transfer of patients between hospitals, according to their needs, is constant and that a private hospital, which may see one or two incidents of cardiac arrest a year, would be unable to continue to provide the support necessary. Dr Markowski also agreed that it was appropriate for CPH staff to call ANSW for assistance. He referred to the fact that a large number of facilities do not have highly trained tertiary-level staff to mount a resuscitation team, and that in these instances reliance is placed on services provided by ANSW.

18.5 **Conclusion:** The evidence establishes that it was appropriate for CPH staff to seek assistance from ANSW. Whilst there was a sufficient number of staff to perform a resuscitation attempt, the evidence has already established that there was not a direct correlation between training and performance. That said, it was appropriate to seek assistance from NSW Ambulance given that the staff were not specialised staff working in an intensive care setting. Further, in the event that June could have been resuscitated, transfer to a tertiary hospital to continue care would have eventually been required.

19. Was there a causal relationship between the procedure and June's acute deterioration?

19.1 In his report, Dr Truskett opined that the procedure was incidental and not causal of June's rapid deterioration on 20 December 2015. In evidence he described both events as coincidental. In particular Dr Truskett noted that the procedure took place with only light anaesthetic, that June recovered afterwards, and that she then suffered an acute deterioration some 20 hours later. Overall Dr Truskett considered the deterioration to be inevitable and did not think that any aspect of the procedure precipitated the arrest. Rather, it was reflective of the disease that June was suffering from.

19.2 Associate Professor Lee similarly noted that it was difficult to find any causal relationship between the procedure and June's acute deterioration. He noted that there was only evidence of a temporal relationship between the two events and could not make any comment as to cause and effect.

19.3 Dr Sultana similarly noted that although June's oxygen saturations were fluctuating during the procedure, she appeared to make a full recovery in the PACU. On this basis, it appeared to Dr Sultana that June's deterioration was sufficiently removed in time from the procedure to indicate that there was no causal connection and that the clinical course up to 20 December 2015 was unrelated to the events on that day. Further, Dr Sultana placed great weight in the autopsy which demonstrated no evidence of myocardial infarction, pulmonary embolus or stroke (cerebrovascular accident). On this basis, he opined that there was no causal relationship.

19.4 **Conclusion:** The combined expert opinion establishes that there was only a temporal, and not a causal relationship between the procedure and June's acute deterioration. As noted by Dr Truskett, June's acute deterioration on 20 December 2015 can be accurately regarded as reflective of the disease that she was suffering from, and not as a result of the procedure performed a day earlier. To reinforce this conclusion, no evidence was demonstrated at autopsy which supported the cause of June's death as being attributable to any complication arising from the procedure.

20. What was the cause of June's death and would transfer prior to her acute deterioration have altered the eventual outcome?

20.1 Dr Truskett opined that June died of LC. He described this as a rare and aggressive disease which is a subtle condition to diagnose, as demonstrated by the absence of any evidence of the disease in imaging performed a month before June's death. Dr Truskett explained that it is typical for a biopsy to not demonstrate any malignancy because the tumour is usually located so deep below the stomach lining that any sampling is usually negative. Dr Truskett further explained that in 30 years of practice he had only ever seen one previous case of LC, which also was not diagnosed ante mortem. Dr Truskett opined that June's cardiac arrest was due to the end stage effects of LC and not to other events.

20.2 Dr Sultana agreed with Dr Truskett and opined that the cause of death was LC resulting in infiltration by metastatic cells leading to respiratory failure and in turn leading to cardiac arrest. Dr Sultana emphasised that the rarity of the disease was worth repeating and referred to the fact that a major academic textbook of respiratory medicine referred to the fact that a diagnosis of the disease is never made ante mortem.

20.3 Associate Professor Lee opined that the direct cause of death was hypoxaemic respiratory failure leading to bradycardia and asystole. He explained that the asystole was a result of an insult to the heart caused by low oxygen, and that the direct cause of this was the LC.

20.4 In evidence counsel for the Hospital took Dr Truskett to his report in which he expressed the opinion that June's death was inevitable, most unlikely to have been responsive to resuscitative effort, unlikely to have been contributed to by the procedure, and where the deficiencies associated with the resuscitative effort had no material impact on the death. Dr Truskett indicated in evidence that he adhered to the opinion expressed. In evidence Dr Sultana agreed with Dr Truskett.

20.5 In evidence Associate Professor Lee indicated that he, however, did not agree with Dr Truskett's opinion and indicated that his disagreement was on the basis that June should have been transferred to the Public Hospital prior to her acute deterioration. If this had occurred, Associate Professor Lee opined that it was more likely than not that June's cardiac arrest "*could have been avoided by appropriate respiratory support and monitoring*", and that a comprehensive physical examination and a CTPA or high resolution CT scan "*would have confirmed the diagnosis of lymphangitic carcinomatosis due to gastric cancer*".[71] If a diagnosis had been made Associate Professor Lee opined that it is likely June "*would have been given palliative care after treatment options had been explored and it is most likely she would not have left hospital alive*" unless the "*underlying cancer [was] highly sensitive to chemotherapy*".[72] Ultimately, Associate Professor Lee concluded that June's life "*was sadly going to be limited by her spreading cancer and would not have been greatly extended or improved by appropriate and better management*".[73]

20.6 In evidence Associate Professor Lee further indicated that if June had responded to chemotherapy, which would be rare, then she might have survived weeks to months. The intention then would be to improve her respiratory function enough so that she could be taken off a ventilator. However,

[71] Exhibit 1, Tab 38, page 10.
[72] Exhibit 1, Tab 38, page 10.
[73] Exhibit 1, Tab 38, page 10.

Associate Professor Lee agreed that it was more likely that June would not respond to chemotherapy but that she may have made a short term response to supportive therapy which might extend her lifespan by a matter of days.

20.7 Dr Truskett in evidence expressed the view that even if June had been transferred to the Public Hospital it would have made no difference to the eventual outcome. He repeated the fact that in the vast majority of cases LC is only diagnosed at autopsy and that if June had been capable of being intubated and ventilated then her best hope was dying on a ventilator which Dr Truskett expected would occur within a matter of days. Dr Truskett also pointed out that whether June would have received chemotherapy is highly debatable given how advanced her disease was and that it may not have been provided in recognition of the futility of offering any further treatment.

20.8 Dr Sultana expressed the frank view that having regard to reported cases in academic literature, to expect a positive response to chemotherapy would be, as he described it, "*in the realms of science fiction*". He explained that looking at the confluence of rare positive outcomes and agreeing with Dr Truskett that June's condition demonstrated the worst kind of pathology, to extend even a slim hope to June's family, even with presumed escalation therapy and aggressive chemotherapy, would be flawed.

20.9 **Conclusion:** The combined weight of the medical expert opinion establishes that the overriding natural disease process which caused June's death was lymphangitic carcinomatosis. Progression of this disease process ultimately led to June's hypoxaemic respiratory failure and cardiac arrest. The cause of June's death was, therefore, lymphangitic carcinomatosis leading to hypoxaemic respiratory failure and cardiac arrest. The available expert evidence, on balance, does not support a conclusion that any deficiency associated with the June's resuscitation attempt played a causative role in her death.

20.10 The opinions expressed by Associate Professor Lee raise the possibility that if June had been transferred prior to her acute deterioration that her cardiac arrest might have been avoided, and that the LC could have been diagnosed. However, the experience of Dr Truskett, and the academic literature which has been referred to, suggests that it is most likely that a diagnosis could not have been made. Even if it had been made, there is considerable uncertainty about whether further treatment, such as aggressive chemotherapy, would have been provided to June. Finally, even if such treatment had been provided, June's prognosis in terms of future life expectancy remained dire. The combined expert evidence establishes that it is most likely that even if June's resuscitation had been successful any further care provided to her would have been palliative rather than therapeutic.

20.11 Counsel for June's family submitted that if June had been transferred to the Public Hospital prior to 11:00am on 20 December 2015, this may have prevented her sudden and obviously distressing deterioration whilst her family were present. It was submitted that if this had occurred, and June had responded positively to the resuscitation attempts, then it would have at least allowed her family some opportunity, however brief, to come to terms as best as possible with the gravity of her condition and prognosis. Although dependent on a number of variables which cannot be quantified, the possibility of such an outcome cannot, of course, be entirely discounted. However, as upsetting as this must be for June's family, the combined weight of expert evidence, even according to Associate Professor Lee, suggests that it is most likely that this outcome would not have occurred.

21. Acknowledgements

22.1 The inquest into June's death took place almost three years after her death. It is not unusual for there to be a relatively lengthy period of time between the reporting of a death to the Coroner's Court and an eventual inquest. Whilst legal, and other, professionals who work within the coronial and courts system are accustomed to such timeframes, it is acknowledged that such timeframes are difficult to understand and accept by those who do not. However, this time is required to ensure that a comprehensive coronial investigation is conducted to examine all relevant issues. Such an investigation would not have been possible in this case without the dedication, skill and tireless efforts of Counsel Assisting, Ms Tracey Stevens, and her instructing solicitor, Mr Paul Armstrong. Their tremendous assistance both prior to, and during, the inquest must be acknowledged with great appreciation on behalf of the NSW community.

22.2 Thanks and appreciation must also be expressed to the police officer-in-charge, Detective Senior Constable Derek Kennedy, for compiling the initial brief of evidence. Finally, the assistance provided by the various legal representatives who participated in the inquest should also be recognised and acknowledged as in keeping with the fundamental non-adversarial principles of the coronial jurisdiction.

23. Findings pursuant to section 81 of the Coroners Act

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

Identity
The person who died was June Nutter.

Date of death
June died on 20 December 2015.

Place of death
June died at Campbelltown Private Hospital, Campbelltown NSW 2560.

Cause of death
June died from lymphangitic carcinomatosis leading to hypoxaemic respiratory failure and cardiac arrest.

Manner of death
June died from natural causes, as a consequence of natural disease process. Whilst not causally connected to June's death, the resuscitative efforts by Hospital following her cardiac arrest were not in accordance with optimal clinical practice.

24. Epilogue

24.1 I am most conscious of the fact that these findings are being delivered at a time of year when June and her family would have been looking forward to the simple pleasure of being together, and enjoying each other's company and their love for one another. No doubt, there will be an enormous

emptiness present for June's family despite other reasons to celebrate and be festive over the holiday season.

24.2 At the end of the inquest, Eric was kind enough to distribute roses to the parties participating in the inquest, and to the staff at the Coroner's Court, in memory of June. That gesture most exemplifies June's generosity of spirit, and her compassion and empathy for others.

24.3 On behalf of the NSW State Coroners Court and the counsel assisting team, I offer my deepest heartfelt sympathies, and most respectful condolences, to Eric, Belinda, Melissa, Crystal and Matthew; to June's grandchildren; and to the other members of June's family for their devastating and tragic loss.

24.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
4 December 2018
NSW State Coroner's Court, Glebe