CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Nicholas Wells
Hearing dates:	22 May 2019 - 30 May 2019
Date of findings:	22 July 2019
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death from sepsis secondary to bowel perforation – was bowel perforation appropriately diagnosed and treated in hospital – adequacy of nursing care – subsequent action taken by hospital – are recommendations necessary or desirable?
File number:	2016**/**157430
Representation:	Counsel Assisting the inquest: J Downing of Counsel i/b Crown Solicitor's Office. Dr T Kusyk: K Burke of Counsel i/b Moray & Agnew Lawyers. Dr A Koshy: C Magee of Counsel i/b Avant Law. Dr R Yuen: C Jackson of Counsel i/b Browns Legal & Consulting. Dr D Campbell: R Sergi of Counsel i/b HWL Ebsworth Lawyers. Hunter New England Local Health District: M Lynch of Counsel i/b Hicksons. EN J Gardiner: N Dawson, New Law Pty Ltd. RN S Sawaki and RN M Locking: L Andelman i/b NSW Nurses and Midwives Association. Nicholas Wells' mother Sue Nakkan and step father Luis Feliu were unrepresented.

Findings:	**Identity** The person who died is Nicholas Wells born 18 June 1991. **Date of death** Nicholas Wells died on 23 May 2016 **Place of death** Nicholas Wells died at John Hunter Hospital, Newcastle NSW. **Cause of death** Nicholas Wells died of peritonitis secondary to a perforation of the small bowel. **Manner of death** Nicholas Wells died when the bowel perforation which he had sustained as a result of a motor vehicle accident did not receive adequate care and treatment from medical and nursing staff at the hospital to which he was brought.

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Recommendations

1. That Hunter New England Local Health District [the LHD] consider creating a policy document that reflects the current practice at John Hunter Hospital that no International Medical Graduate subject to Level 1 supervision (under the *Medical Council of Australia Guidelines – Supervised Practice for International Medical Graduates* or earlier versions) be appointed to a position beyond that of an intern, and distribute this to the Director of Medical Workforce and to all selection panels constituted to employ junior medical staff (interns, residents and registrars).

2. That the LHD consider creating a policy document specifying whether International Medical Graduates subject to different levels of supervision (under the *Medical Council of Australia Guidelines – Supervised Practice for International Medical Graduates* or earlier versions) are eligible to be appointed to intern, resident or registrar positions within the LHD.

3. That the LHD consider creating a policy framework to govern the way in which International Medical Graduates are supervised and monitored, including a system to ensure that their supervision requirements are communicated to the senior medical staff who provide their supervision.

4. That the LHD consider undertaking a review of the *Handbook and Guidelines for Junior Medical Staff and Trainees – John Hunter Hospital Surgical Services* with a view to revising Section 8.3, 8.4 and 15.6 in view of the findings made in this inquest.

5. That the LHD consider revising *Local Procedure JHH_0362 – Clinical Responsibilities of the Attending Medical Officer (AMO): John Hunter Hospital* so as to require that AMOs personally and fully assess patients within 24 hours of admission other than in exceptional circumstances.

6. That the LHD consider providing training and education to medical staff at John Hunter Hospital in relation to the need to complete the Standard Adult General Observation Chart where a medical officer wishes to prescribe a specific frequency of observations.

7. That the LHD consider including as part of its auditing of patient specialling performed under *Local Procedure JHH_0203 – Patients Requiring Additional Supervision/Special at JHH*:
    - whether the patient's respiratory rate has been documented 15 minutely; and
    - whether the patient's vital sign observations have been attended to at least every 30 minutes (in cases where the patient requires specialling due to acute/deteriorating medical condition).

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

These are the findings of an inquest into the death of Nicholas Wells.

Introduction

1. Nicholas Wells was 24 years old when he died at John Hunter Hospital, Newcastle in the early hours of 23 May 2016. He had been taken there by ambulance the previous morning following a motor vehicle accident near Bulahdelah on NSW's mid-north coast. Mr Wells suffered a bowel perforation as a result of the accident. He died seventeen hours after his hospital admission due to sepsis from faecal fluid entering his abdominal cavity.

2. The way in which Mr Wells' bowel perforation was diagnosed, monitored and treated at the John Hunter Hospital was closely examined at the inquest. The issues examined were:
    - Was bowel perforation a potential diagnosis for Mr Wells?
    - Was the management plan formed for him appropriate?
    - Should he have been reviewed by a surgical consultant?
    - Was the nursing care he received adequate?
    - The hospital's response to Mr Wells' death
    - Are any recommendations necessary or desirable?

Mr Wells' life

3. Nicholas Wells was born in Murwillumbah in northern NSW on 18 June 1991. He was raised by his mother Sue Nakkan and her partner Luis Feliu, both of whom attended the inquest.

4. As an adult Nicholas worked as a tiler, and in 2013 he and his then girlfriend Yasemine Eshelby had a daughter who is now aged 6 years. Ms Eshelby also attended the inquest.

5. In April 2016 Nicholas Wells moved to Brunswick Heads near the Queensland border, to live with his mother and step father Mr Feliu. He made regular car trips to Sydney to visit his daughter. It was while driving home from one of these visits that he suffered the car accident which led to his hospitalisation.

6. At the close of evidence at the inquest Ms Nakkan and Mr Feliu spoke movingly to the Court about their memories of Mr Wells. He was a loving son to them both and he adored his little daughter. They told the Court of his love

for his family, friends and for animals, and of the pain they continued to feel at his loss. It was plain that he was much loved and missed deeply. It was very important to Ms Nakkan and Mr Feliu to understand how their son came to die in hospital, and whether the risk of tragedies like this might be reduced in future.

The car accident

7. Early on the morning of Sunday 22 May Mr Wells left Sydney for his drive home to Brunswick Heads. At about 6.00am just south of Bulahdelah his car veered off the western edge of the Pacific Highway and collided heavily with two posts. The impact caused the car to spin around and continue for a short distance before it came to a stop.

8. Mr Wells was able to get out of his car and to contact emergency services. When police and ambulance officers arrived at about 7.00am Mr Wells was conscious and complaining of pain in his hip, right knee and ankle. He also told ambulance officers of pain in his lower left abdomen. He was taken by ambulance to John Hunter Hospital, Newcastle [JHH].

9. Mr Wells told paramedics he had taken some crystal methamphetamine earlier that morning. This was confirmed in blood samples which showed the presence of methamphetamine, amphetamine and cannabis metabolites.

At JHH Emergency Department: the trauma call

10. At 7.35am while on route to hospital the ambulance contacted the hospital's Emergency Department. This prompted the ED Nurse Team Leader to make what is known as a trauma call. The Court heard that in accordance with JHH protocols, trauma calls summon the attendance to ED of doctors from the hospital's Acute and General Surgical Unit [the AGSU], the Intensive Care Unit, and the ED. The purpose is to provide a prompt assessment of a newly arrived trauma patient and to collectively determine a management plan. Doctors who are required to attend a trauma call are notified by means of text messages sent on what are known as DECT phones.

11. Soon after Mr Wells arrived at JHH he received a primary and secondary review from ED Registrar Dr Amy Owen and ICU Registrar Dr Cynthia Bierl, both of whom had responded to the trauma call. The evidence is that the trauma call had been made at some time between 7.35am and 8.10am.

12. That morning, surgical registrar Dr Taryn Kusyk had the responsibility within the AGSU of responding to any trauma calls. However neither Dr Kusyk nor any other member of the AGSU team attended in response to the trauma call, or participated in the primary and secondary assessments of Mr Wells' condition.

The primary and secondary assessment in ED

13. ED Registrar Dr Owen recorded that Mr Wells had abdominal pain, abrasions over the left lower abdomen, and leg pain. Dr Owen also identified possible free fluid in the area between his liver and kidney. Because of this she ordered a CT scan of his abdomen.

14. The CT scans of Mr Wells' abdomen, chest and pelvis were undertaken by 9.59am, and showed a compression fracture of the L2 vertebral body and free fluid in the pelvis '*more than would be expected normally'*, with no apparent source. This prompted Dr Owen to order that Mr Wells receive a review by a member of the surgical team. Meanwhile, x-rays of Mr Wells' right lower leg had confirmed two separate fractures of the fibula shaft.

15. Mr Wells next received an assessment by Orthopaedic Registrar Dr Andrew Caterson. He determined that Mr Wells' ankle would require operative fixation and ordered that he be kept nil by mouth in anticipation of surgery the next day.

16. I should note that at the inquest, no criticism was made of the medical assessments and decisions made by Dr Owen, Dr Bierl and Dr Caterson.

17. Until approximately 11.00am there was no review of Mr Wells by any member of the hospital's surgical team. This delay was the subject of enquiry at the inquest. The Court heard that as a designated Major Trauma Centre, JHH would be expected to provide an immediate response by a surgical registrar to a newly arrived trauma patient. As noted, that morning the responsibility for providing this lay with Dr Taryn Kusyk.

18. At that time Dr Kusyk was employed at JHH as an unaccredited surgical registrar. Dr Kusyk was an International Medical Graduate [IMG], having qualified in medicine in the Ukraine in 1996 and undertaken postgraduate study and training there and in Germany. For a number of years he worked in NSW hospitals as an unaccredited surgical registrar. He commenced employment in this role at JHH in August 2015.

19. As an unaccredited surgical registrar, Dr Kusyk had only provisional registration. He had been assessed by the Medical Board of Australia as a first year medical graduate on the basis of his knowledge, skills, attitude and performance. The Medical Board had determined that he required what is known as Level 1 supervision. This meant that his supervisor, a senior doctor, was required to be physically present at his workplace at all times when he was providing clinical care. Importantly, Dr Kusyk was required to consult his supervisor about the management of all patients at the time of their consultation. As will be seen, surgical consultant Dr Anil Koshy, who was Dr Kusyk's supervisor for that day, was quite unaware that he was subject to Level 1 supervision requirements. The reasons for this are addressed later in these findings.

20. As to why Dr Kusyk did not attend the trauma call that morning, Dr Kusyk denied having received the call. He suggested that at the time the call went out the DECT phone was still in the possession of his AGSU shift predecessor. However the court heard some evidence to the contrary, namely that the phone had been handed to Dr Kusyk between 7.45 and 8.00am. Unfortunately the DECT phone records are of limited assistance in resolving this factual issue. I have concluded that given the lack of factual clarity it is not open to criticise Dr Kusyk for his failure to attend and participate in the initial surveys of Mr Wells' condition. The result however was that an opportunity was missed for a collective diagnosis of bowel injury to be made, and a collective decision to seek a senior clinical review.

The examination by Dr Kusyk

21. During the morning Dr Kusyk accompanied the paediatric consultant Dr Aniruddh Desphande on ward rounds in the paediatric surgical unit. According to Dr Kusyk, he received a call at 10.20am asking him to review Mr Wells in ED which, Dr Kusyk said, was the first notification he received of Mr Wells. This was succeeded by another call at about 10.30am, asking him to review a second trauma patient. Dr Kusyk told the Court that Dr Deshpande would not allow him to leave until the ward rounds had completed. However this evidence is disputed by Dr Desphande. He provided a statement that he could not recall any such request from Dr Kusyk, and that his usual practice would be to allow the Registrar to return to ED immediately.

22. Once back in the ED, Dr Kusyk conducted a medical review of Mr Wells at around 11.00am. Based on his oral and documentary evidence it can be established that Dr Kusyk identified the following about Mr Wells' condition:

- that he had consumed methylamphetamine earlier that morning
- that according to the CT scans he had an L2 fracture and free fluid in the pelvis
- that although his abdomen was soft there was guarding and tenderness in the lower abdomen.

23. Dr Kusyk recorded a possible diagnosis of small bowel injury. He documented a management plan of:

- admitting Mr Wells to hospital
- giving him IV fluids and keeping him nil by mouth
- organising a neurosurgical review.

Following Dr Kusyk's attendance, Mr Wells was admitted to JHH under the care of Dr Koshy who was the surgical consultant on duty that day.

24. In light of Dr Kusyk's suspicion of a small bowel injury, the adequacy and appropriateness of this management plan was closely examined at the inquest. As will be seen, it was the subject of expert criticism in its failure to direct further surgical assessment, investigation and treatment of what was a suspected life-threatening condition.

25. Dr Kusyk did not immediately discuss his diagnosis and management plan with Dr Koshy. I have noted that this was a requirement of his registration as an unaccredited surgical registrar. At the inquest Dr Kusyk said that he phoned Dr Koshy at about 12.30pm to discuss Mr Wells and other patients; however Dr Koshy told him he was on his way to surgery and would discuss patients after he had finished operating.

26. The above evidence is disputed by Dr Koshy, who denied having had any conversation with Dr Kusyk about Mr Wells until 7.00pm that night. The content of the 7.00pm discussion is addressed later in these findings.

27. Again the phone records are of limited assistance in resolving this factual issue. They do however disclose a sixteen second call made to Dr Koshy's mobile phone at 12.46pm. This may well have been the phone call alluded to by Dr Kusyk. It is not possible to identify whether the call involved an actual conversation with Dr Koshy, or whether a message was left. The short duration of the call suggests that if there was an actual conversation, it involved little detail.

The transfer to surgical ward

28. Mr Wells remained in the ED until 3.20pm that day, awaiting transfer to the surgical ward. During this time nurses recorded his vital signs at approximately 1.5 hour intervals. When he was transferred to the surgical ward the nurse in charge RN Melanie Locking was informed that he had a possible small bowel injury and that he was thought to be drug-affected.

29. Mr Wells' condition began to deteriorate. On arrival at the surgical ward he was observed to be confused, plucking at the air and mumbling to himself. RN Locking attributed his disturbance to his being significantly drug-affected. She moved him to a single-bed room close to the nurses' station and as it was the weekend, contacted the After Hours Manager RN Ian McQualter.

30. To RN McQualter RN Locking expressed concern that Mr Wells needed more acute care due to the risk that in his confusion and agitation he would harm himself or others. RN McQualter's recollection is that RN Locking was also concerned that the treatment plan for Mr Wells was inadequately documented, but RN Locking did not recall this in her oral evidence.

31. By 4.30pm Mr Wells' agitation had increased and he was complaining of very severe testicular pain. Unable to obtain contact with Dr Kusyk (who was by then assisting with surgery in the operating theatre) RN Locking arranged for Mr Wells to be reviewed by the surgical resident medical officer, Dr Daniel Campbell.

The review by Dr Campbell

32. At that time Dr Daniel Campbell was a first year resident medical officer. He attended Mr Wells sometime between 4.30 and 5.15pm, and was told by RN Locking that Mr Wells had been in a car accident and was *'coming down from*

heroin'. RN Locking was concerned that Mr Wells was aggressive and verbally abusive to staff.

33. Dr Campbell examined Mr Wells and recorded in his notes that he was suffering left sided testicular pain and lower abdominal pain, although he did not note any guarding. Dr Campbell also observed a visible seat belt bruise across Mr Wells' lower abdomen.

34. Concerned about Mr Wells' condition, Dr Campbell decided he needed to be reviewed by a more senior surgical doctor. He explained this was because his symptoms suggested an intra-abdominal injury, he was tachycardic, and he had a tender abdomen with fluid lacking any defined source. Dr Campbell first attempted to contact Dr Kusyk on the DECT phone, but could not get through. Nor could he reach the AGSU consultant Dr Koshy, who was also operating in a second theatre, assisted by the second AGSU registrar Dr Ronald Yuen.

35. Dr Campbell decided to personally bring his concerns to the attention of the senior doctors. He went to the operating theatres and started to describe Mr Wells' condition to Dr Koshy and Dr Yuen. However both were preoccupied with the surgery they were performing, so Dr Campbell told them he would leave a note setting out the relevant details and his request for a senior medical review. This he did, leaving the note on the work bench of the operating theatre.

36. According to Dr Campbell, he then encountered Dr Kusyk in the changing rooms of the operating theatres. Dr Campbell expressed concern to Dr Kusyk that Mr Wells did not have a sufficient treatment plan, to which Dr Kusyk replied *'That's fine, I'll sort it out'.* I note Dr Kusyk said he had no recollection of this discussion.

37. At about 6.00pm Dr Campbell completed his shift and left the hospital, believing he had done what he could to escalate his concerns about Mr Wells to the senior doctors.

38. At the inquest no criticism was expressed of Dr Campbell's care and treatment of Mr Wells. I respectfully adopt expert opinion provided to the inquest that Dr Campbell performed his duties in relation to Mr Wells in a careful and diligent manner, in particular in his attempts to bring his condition to the attention of senior medical staff.

39. It is to be noted that apart from the above review undertaken by Dr Campbell, Mr Wells was not seen by any member of the AGSU team between the time of Dr Kusyk's review at 11.00am that day, and when he was found unresponsive fourteen hours later.

The discussion between Dr Kusyk and Dr Koshy at 7pm

40. Dr Koshy and Dr Yuen finished in the operating theatre at about 6.45pm. They searched for the note about Mr Wells which Dr Campbell had left, but could not

find it. Dr Koshy did not attempt to call Dr Campbell, stating he assumed one of the surgical registrars would have attended to Dr Campbell's concern.

41. At 7.00pm Dr Kusyk met with Dr Koshy to provide a hand over of the patients admitted under Dr Koshy's care that day, including Mr Wells. It should be noted that this discussion represents the first and only occasion (excluding the possible brief phone conversation alluded to in paragraph 25 above) on which Dr Kusyk consulted with Dr Koshy about the patients whom he had attended that day.

42. There is some dispute between the two doctors as to what exactly was communicated about Mr Wells. They agreed that Dr Kusyk told Dr Koshy the following:

- that he had been involved in a motor vehicle accident
- that he had a seat belt injury
- that his abdomen CT scan showed free fluid
- that he may have been suffering drug withdrawal.

43. In contrast with Dr Kusyk's evidence,Dr Koshy denied that he was informed of a suspected small bowel injury, and could not recall if Dr Kusyk had told him of the L2 fracture. The latter would have been evident on the CT scans, but when they attempted to view these they found the scanner in that location wasn't working correctly.

44. Following this discussion Dr Koshy did not see the need to personally review Mr Wells. Nor did Dr Kusyk suggest that he do so. After the meeting Dr Koshy reviewed some patients (who did not include Mr Wells) then left the hospital on completion of his shift at about 8.00pm. No changes were made to the management plan which Dr Kusyk had documented at 11.00am that morning.

45. At the inquest Dr Koshy sought to explain his decision not to personally review Mr Wells. He identified two features which he said would have prompted him to do so had he been informed of them. These were the presence of the L2 fracture, and the persistence of Mr Wells' abdominal pain since admission that morning. In his view, either one of these features would be highly indicative of small bowel injury.

46. Furthermore, according to Dr Koshy, Dr Kusky had told him that Mr Wells was '*stable'* and that he (Dr Kusyk) wasn't worried about him. On that basis, Dr Koshy appears to have accepted that the conservative management plan which Dr Kusyk had formulated was appropriate and that there was no need for him to undertake any further action in relation to Mr Wells that evening.

47. This also was Dr Kusyk's assessment of the situation. During the remainder of his shift he reviewed other trauma and surgical patients. He then provided a handover of his patients to the incoming AGSU registrar, advising the registrar that Mr Wells was stable, and left the hospital shortly after midnight. At no time after 11.00am that day had he reviewed Mr Wells personally, enquired as to his progress or looked at his clinical notes.

Events during the evening

48. In the surgical ward Mr Wells' condition continued to worsen. In the course of the afternoon and evening he became extremely thirsty and reacted angrily when told he was not allowed to drink. Nursing staff were unable to obtain contact with any member of the AGSU medical staff. Meanwhile they attempted to take Mr Wells' observations at four hourly intervals, which was the standard frequency in the surgical ward in the absence of a direction for greater frequency. This proved difficult due to the level of his agitation.

49. At about 7.30pm RN Locking was sufficiently concerned about Mr Wells' behaviour to activate a 'Code Black' call. This is an emergency call where there is a concern of physical harm from acts of aggression. A medical registrar, Dr Jeff Anh, attended in response. He concluded that Mr Wells was not receiving sufficient pain relief and was also experiencing drug withdrawal symptoms. He ordered morphine and diazepam. The activation of the Code Black was not made known to Dr Kusyk or Dr Koshy.

50. It had been decided that during the evening Mr Wells should be nursed on a 1:1 basis, an arrangement known as 'specialling'. From 9.30pm onwards Mr Wells' care was assigned on this basis to Enrolled Nurse Jane Gardiner.

51. EN Gardiner had been an Enrolled Nurse for about 18 months, and had not received any training or instruction on what is required with this kind of nursing. She had undertaken 'specialling' nursing only once before. Her understanding was that the 'specialling' order had been made in Mr Wells' case not because he needed to be monitored for clinical deterioration, but rather because he may harm himself by getting out of bed and putting weight on his injured ankle. At the inquest she said that her impression of his main clinical problem was his fractured ankle and L2 fracture. She could not recall being told of a suspected bowel injury.

52. Throughout the evening EN Gardiner seated herself with a book just outside Mr Wells' room. She kept the door open and looked into the room from time to time to observe him. She told the court that Mr Wells' severe agitation made it too difficult to obtain observations, although she assessed his pain level as severe. By 11.30pm he appeared to be more settled and she decided not to disturb him with any further attempts.

53. Shortly after 1.00am EN Gardiner entered Mr Wells' room and saw that he was lying with his eyes open, faced away from the door. His colour was unhealthy and his body rigid. The nurse in charge immediately called a rapid response and commenced CPR. However Mr Wells could not be revived, and he was pronounced deceased at 1.40am.

The post mortem report

54. An autopsy was conducted by forensic pathologist Dr Jane Vuletic. She found the cause of Mr Wells' death to be faecal peritonitis, due to a leak of faecal contents from a perforation in the small bowel. The appearance of the bowel

surface indicated the perforation had occurred many hours prior to death, and most likely around the time Mr Wells had suffered abdominal trauma in the motor vehicle accident.

55. Dr Vuletic also noted abdominal wall bruising and a fracture of the L2 vertebra, both indicative of abdominal trauma. She commented that bowel perforation is a recognised complication of blunt abdominal trauma.

Issues at the Inquest

56. I turn now to address the issues raised at the inquest. The Court's determination of these was assisted by the evidence of the following expert witnesses, who each provided statements and gave evidence in conclave at the inquest:

- Associate Professor Anna Holdgate, Senior Staff Specialist in Emergency Medicine, Sutherland and Liverpool Hospitals. She has over 22 years of clinical experience as a specialist in Emergency Medicine.
- Dr PhillipTruskett, General and Upper Gastrointestinal Surgeon with thirty years' experience in private and public hospitals.

57. The Court also heard evidence as to JHH procedures and policies, and changes that have since been made, from Professor Michael Hensley, Director of Medical Services at JHH and Ms Debbie Bradley who is the General Manager of JHH.

Was bowel perforation a potential diagnosis for Mr Wells?

58. The unanimous expert opinion was that the suspicion of a small bowel injury which Dr Kusyk formed at his 11.00am examination was well founded. The combination of the history of a motor vehicle accident, abdominal tenderness, and the presence of free fluid in the abdomen were all highly suggestive of such an injury. The existence of an L2 fracture increased the level of suspicion, as it indicated a severe impact capable of compressing and perforating the bowel.

Was the management plan appropriate?

59. Expert opinion was unanimous that the management plan which Dr Kusyk documented at 11.00am was wholly inadequate and demonstrated poor clinical judgement, in that it failed to reflect the seriousness of the suspected injury.

60. The Court heard that in cases of traumatic bowel injury the only accepted treatment is surgical repair. The injury is a life-threatening one with the risk of death from sepsis increasing with each hour of delay. That being the case, there were only two management options for patients with a suspected bowel injury. These were proceeding to exploratory surgery, or (more conservatively) a defined period of close observation. In the latter case if abdominal pain and tenderness did not improve within a few hours then exploratory surgery was required.

61. In A/P Holdgate's opinion, with which Dr Truskett agreed, if Dr Kusyk had decided upon a plan of assessment for a period of time then the treatment plan required clear details of the period of assessment and the frequency of observations. There also needed to be medical reviews on an hourly basis. Dr Kusyk's treatment plan documented none of these features.

62. In any event both experts cast doubt on the appropriateness of a plan of observation in Mr Wells' case, in circumstances where he was known to have ingested drugs prior to the car accident. Close observations could not reliably be taken where a person was intoxicated, making it difficult to assess the accuracy of the provisional diagnosis. This increased the balance in favour of a surgical response.

63. Criticism was also expressed of Dr Kusyk's failure to immediately discuss his findings with Dr Koshy after his review. This was the case regardless of whether Dr Kusyk was subject to Level 1 supervision requirements. The seriousness of the diagnosis warranted prompt discussion with a consultant to obtain a definitive diagnosis and settle a treatment plan. At the inquest Dr Koshy too agreed that given Mr Wells' history and presentation, Dr Kusyk ought to have consulted with him almost immediately.

64. A/P Professor Holdgate and Dr Truskett noted Dr Kusyk's evidence that he had attempted to call Dr Koshy at 12.30pm but had been told to wait until after Dr Koshy had performed surgery. They agreed however that in a case such as that of Mr Wells, it was imperative to escalate to a consultant and that a degree of assertiveness may well be required.

65. The evidence leaves no room for doubt that the management plan documented by Dr Kusyk was not an appropriate or adequate clinical response to his condition. It provisionally diagnosed a serious and life-threatening condition, but failed to direct the necessary surgical follow up. The manifest deficiency of the plan, combined with other deficiencies in care which followed, resulted in Mr Wells being left to deteriorate without the treatment he needed to save his life.

Should Mr Wells have been reviewed by a surgical consultant? If so, why didn't this happen?

66. The failure to escalate Mr Wells' case to a surgical consultant was a significant failure in his care and contributed to his tragic death. The Court heard unanimous expert evidence (with which Dr Koshy agreed) that the serious nature of his provisional diagnosis required almost immediate review by a senior surgical clinician. This would have ensured that a definitive diagnosis was reached, and would have made more likely the early intervention which was needed to avert Mr Wells' deterioration and death. I accept the expert evidence on this point.

67. The Court examined how it was that Mr Wells, having been provisionally diagnosed at 11.00am with a small bowel injury, did not receive any further

attention from AGSU medical staff thereafter. I have referred above to Dr Kusyk's evidence of his attempt at around 12.30pm to advise Dr Koshy of the newly admitted trauma patients. As noted A/P Holdgate and Dr Truskett were of the view this was not an adequate response to the requirements of the situation.

68. Clearly the subsequent review which took place between the two doctors at 7.00pm that evening represented a further, if belated, opportunity for senior surgical intervention. Again this did not happen. It would appear each doctor left the meeting with the impression that he was not required to take any action in relation to Mr Wells that night.

69. I have outlined above Dr Kusyk's evidence as to what he told Dr Koshy about Mr Wells at the 7.00pm meeting. At the inquest Dr Kusyk stated he believed he had told Dr Koshy all that was necessary about Mr Wells, and that it was up to Dr Koshy as the senior consultant to decide whether to review him and make any changes to the treatment plan.

70. For his part Dr Koshy claimed that Dr Kusyk had not informed him of two features which he identified as critical to Mr Wells' condition: his L2 fracture and the persistence of abdominal pain. Further, Dr Kusyk had assured him Mr Wells' condition was '*stable'.* On this basis he saw no need to make any changes to the conservative treatment plan, or to personally review Mr Wells.

71. Dr Kusyk agreed that he had told Dr Koshy that Mr Wells was stable. He was asked how he knew this, given that he had neither sought nor received any updating information about his condition since 11.00am. He offered the explanation that he had meant Mr Wells had been stable *as at 11.00am* and not at 7.00pm, eight hours later. Similarly, he asserted that when he outlined Mr Wells' management plan to Dr Koshy and Dr Koshy agreed with it, Dr Koshy was agreeing with a management plan that was suitable for Mr Wells' condition *as at 11.00am*. Dr Kusyk told the Court that he'd informed Dr Koshy he had not reviewed Mr Wells since 11.00am, or received any information about his progress.

72. Dr Kusyk's evidence on the above matters strains credulity. It requires acceptance of the following:

- that Dr Koshy understood the management plan he was approving at 7.00pm was not an ongoing one, but was based only upon Mr Wells' condition eight hours earlier; and
- that he nevertheless approved the management plan, knowing that Dr Kusyk had received no information about Mr Wells' condition since 11.00am.

73. It also involves acceptance of the ludicrous proposition that when Dr Kusyk advised Dr Koshy at 7pm that Mr Wells was stable, he was to be understood as meaning that he had been stable *eight hours earlier*.

74. I note that in the statements which Dr Kusyk provided to the inquest, he did not refer to informing Dr Koshy that he had not reviewed Mr Wells since 11.00am. Nor did he clarify in his statements that his recommendation for conservative

management was a recommendation applicable to Mr Wells' condition only at 11.00am.

75. For the above reasons, I do not accept Dr Kusyk's evidence that he informed Dr Koshy that he had not reviewed Mr Wells since 11.00am that morning, and that he had not received any updating information about him. Nor do I accept as credible that Dr Kusyk represented to Dr Koshy that Mr Wells' management plan was to be understood as one applicable to his condition as at 11.00am.

76. It is difficult to comprehend how Dr Kusyk could have understood the outdated information he provided to Dr Koshy to be adequate, or indeed his overall management of Mr Wells to be appropriate, without reaching the conclusion that he lacked the clinical acumen to appreciate the seriousness of Mr Wells' situation. This indeed was the conclusion reached by A/P Holdgate in her evidence to the inquest.

77. It is important to note that A/P Holdgate and Dr Truskett were also critical of Dr Koshy for not personally reviewing Mr Wells following this meeting. In their opinion even on the basis of the limited information provided by Dr Kusyk, Dr Koshy ought to have been concerned about the possibility of a small bowel injury. Furthermore, knowing as he did that Mr Wells was showing symptoms of drug withdrawal, he ought not to have considered the conservative plan of observation to have been feasible. In these respects his clinical management of Mr Wells, a patient admitted under his care, was deficient. In their opinion this was also the case with his failure when surgery completed that evening to follow up on Dr Campbell's concerns about Mr Wells.

78. At the inquest Dr Koshy conceded that he ought to have asked more questions about Mr Wells' progress, and should have tried to get a better CT scan picture which would have established the presence of Mr Wells' L2 fracture. However he disagreed with the proposition that even on the basis of what he said Dr Kusyk had told him, this was sufficient to suspect Mr Wells had a small bowel injury. He stated further, and the evidence establishes, that he was unaware that Dr Kusyk required Level 1 supervision. On the contrary, Dr Koshy said that at that time he had confidence in Dr Kusyk, having worked with him some years previously and formed the opinion that he was a capable practitioner.

79. I accept the consensus of the independent expert opinion that Dr Koshy did not do enough to satisfy himself that Mr Wells did not require personal review. Nor did he do enough to satisfy himself that the management plan was appropriate. These failures in care contributed to the tragic outcome.

The adequacy of the nursing care provided to Mr Wells

80. The evidence at the inquest established that ineffective communication on the surgical ward, and inadequate nursing care under the 'specialling' arrangement, also contributed to Mr Wells' death.

81. It was identified as a matter for concern that during the afternoon and evening clinical staff too readily interpreted his increasing agitation, thirst and pain as

the symptoms of drug withdrawal rather than, as in A/P Holdgate's opinion was more likely, the signs of developing peritonitis and sepsis secondary to his untreated bowel injury.

82. The evidence establishes that as the afternoon wore on and Mr Wells became increasingly confused and agitated, RN Locking made a number of attempts to obtain assistance with his care. She spoke with the After Hours Manager; called for the attendance of Dr Campbell when Mr Wells developed severe testicular pain; attempted several times without success to secure the attendance of Dr Kusyk (attempts which he stated he could not recall); and summoned the medical registrar Dr Ahn, who was not qualified to identify the likelihood that Mr Wells' deteriorating condition had a surgical cause. With the exception of Dr Campbell, the focus of these clinicians' response was to seek ways of managing Mr Wells' behaviour.

83. In her report and evidence, A/P Holdgate conceded that the management of agitated and confused patients is very challenging and makes assessment and treatment more difficult. She also noted the attempts made by RN Locking to obtain a surgical review of Mr Wells. In my view it ought also to be noted that the deficiencies of the management plan prepared earlier by Dr Kusyk would not have assisted in communicating the need to closely monitor Mr Wells for signs of clinical deterioration.

84. A/P Holdgate was nevertheless of the view that greater consideration should have been given to the possibility of a surgical cause for Mr Wells' pain, agitation and thirst. As a result of an internal review of systemic issues arising from Mr Wells death JHH likewise acknowledged that his care while on the surgical ward was deficient, as it was impaired by the readiness to attribute his behaviour and symptoms to drug withdrawal.

85. I accept that on the surgical ward, misinterpretation of Mr Wells' symptoms occurred which contributed to his death.

The nursing care provided under the 'specialling' arrangement

86. A further feature identified as contributing to Mr Wells' death was the standard of care provided to him under the 'specialling' arrangement. The evidence clearly establishes that EN Gardiner's management of Mr Wells did not comply with critical requirements which then applied to such arrangements [refer *HNELHD Clinical Guideline16_03*]. Specifically:

- she did not undertake at least hourly assessments and observations of his condition
- she did not remain in the room with him.

Instead as noted, she appears to have been for the most part stationed outside his room, only occasionally observing him, and recording only a limited number of vital signs. I accept the conclusion of A/P Holdgate and that of the hospital itself following the internal review, that Mr Wells did not receive constant supervision as required while he was under EN Gardiner's care.

87. Notwithstanding this conclusion, in my view the deficiency ought properly to be regarded as attributable to systemic failures within the hospital. It emerged that RN Locking, EN Gardiner and RN Sawaki (who was the nurse in charge who succeeded RN Locking) had not received any training or instruction in the LHD's own guidelines for specialling. In her evidence RN Gardiner said she was unaware of the above two requirements. She has since received one-on-one instruction on the LHD's updated Clinical Guideline for specialling. In addition the Court heard that all nursing staff have received the updated Guideline and been required to acknowledge that they have read it and understand its obligations.

88. It must have been very distressing for Mr Wells' family to learn that despite being under 1:1 nursing care, his deterioration and collapse were not noted until it was too late to save him. Similarly it must have added to their distress to learn that clinical staff did not identify the likelihood that his behaviour throughout the afternoon and evening was a sign of evolving surgical emergency.

89. Nevertheless, I am not of the view that explicit criticism of individual nurses on the surgical ward would be appropriate or productive. In relation to the misinterpretation of Mr Wells' symptoms, it is fair to take into account the context within which this occurred, aspects of which are referred to in paragraphs 83 and 84 above. I note further that the hospital has taken steps to address these features, which are described further below.

90. The hospital has also taken appropriate steps to improve the awareness of EN Gardiner, and of nursing staff more widely, of what they are required to do when undertaking 'specialling'. These too are described below.

Appropriate action regarding the conduct of Dr Kusyk

91. It will be evident from the conclusions reached above regarding Dr Kusyk's care and treatment of Mr Wells, that he displayed poor clinical judgement and lacked the ability to appreciate the seriousness of Mr Wells' condition. This was evidenced in the inadequacy of the management plan he formed, in his failure to escalate Mr Wells' care to a senior consultant, in his failure to take any steps to review Mr Wells throughout the day, and in his failure to properly brief Dr Koshy at the 7.00pm meeting. These deficiencies meant that Mr Wells did not receive the surgical intervention he needed to save his life.

92. Dr Kusyk gave lengthy evidence at the inquest. At the close of his evidence he expressed regret to Mr Wells' family that their son had died. In addition, in closing submissions made on his behalf Ms Burke told the Court that Dr Kusyk accepted that criticism of his care of Mr Wells was appropriate. Despite this there was little sign in Dr Kusyk's evidence that he acknowledged any shortcomings in his care of Mr Wells, or their role in the tragedy. This apparent lack of insight was a source of concern for me, and I gave serious consideration to whether it would be appropriate to refer the evidence heard at the inquest to the Medical Council of NSW. A Coroner is able to do this

pursuant to section 151A(2) of the *Health Practitioners Regulation National Law (NSW)*, if the Coroner has:

'...reasonable grounds to believe the evidence given … in proceedings conducted before the coroner may indicate a complaint could be made about a person who is registered in a health profession…'

93. On careful consideration of the evidence as a whole I have decided against this course. I adopt the submissions of Counsel Assisting the inquest that while referral of Dr Kusyk's conduct would be open on the evidence, other factors argue against doing so. My reasons follow.

94. First, on 12 October 2016 Dr Kusyk made a self-notification to the Australian Health Practitioner Regulation Agency [AHPRA] regarding his clinical treatment of Mr Wells. Following consideration of the circumstances, it appears that AHPRA concluded the incident was a 'one-off', recording that no other issues had been raised in relation to Dr Kusyk's practice. AHPRA imposed a condition on Dr Kusyk's registration requiring him to undertake and successfully complete an education course in communication. In the view of AHPRA, this condition would mitigate the risks it had identified in relation to his conduct. In light of this action, it appears unlikely that a referral to AHPRA arising out of this inquest would be productive.

95. Secondly the evidence establishes, and I accept, that Dr Kusky ought not to have been appointed to the position of surgical registrar at JHH in April 2015. The reasons for this are explained in paragraph 107 below. To its credit the LHD and the hospital have acknowledged their role in the error of his appointment, and its consequences.

96. Related to the above, it is appropriate to take into account that on 22 May 2016 Dr Kusyk was working in a position whose responsibilities exceeded those for which he was capable, according to the assessment of the Medical Board of Australia. I have noted at paragraph 19 above that he had been assessed by the Board as a first year medical graduate on the basis of his knowledge, skills, attitude and performance. Arguably the clinical deficiencies in his management of Mr Wells ought to be assessed within that context.

97. I accept the submission of Counsel Assisting that on the evidence, it would be open to refer Dr Kusyk's conduct to the Medical Council. Taking into account the above factors however, I have concluded that this would not be a productive course of action.

98. I should note that after the determination of AHPRA Dr Kusyk successfully completed the communication course. On 24 August 2018 he was notified that he was eligible for general registration. He is currently employed as a surgical registrar in a hospital in metropolitan Sydney.

Appropriate action regarding the conduct of Dr Koshy

99. I accept the evidence that deficiencies in Dr Koshy's care of Mr Wells contributed to his death. Dr Koshy did not do enough to satisfy himself that Mr Wells did not require personal review, or to be confident that the management plan was appropriate. In closing submissions Counsel Assisting submitted that it would be open to refer Dr Koshy's conduct to the Medical Council, but that this course was not pressed.

100. In his evidence Dr Koshy conceded he ought to have done better in his care of Mr Wells. The Court learnt that after Mr Wells' death, Dr Koshy was required to receive specific performance feedback from the Medical Lead for Surgery in relation to his conduct. Considering the evidence overall including Dr Koshy's acknowledgement and the follow up action taken by the hospital, I have concluded that the circumstances do not require referral of Dr Koshy's conduct to the Medical Council.

Is there a need to propose any recommendations?

The response of JHH to Mr Wells' death

101. I turn now to consider what changes have been made to policies and practices at the hospital as a result of Mr Wells' tragic death. I will then consider whether any further changes should be recommended which would feasibly reduce the risk of such deaths in the future.

102. It was evident that Mr Wells' death was treated with great seriousness by the hospital, as it deserved to be. In addition to giving evidence, General Manager Bradley and Professor Hensley attended each day of the inquest. On behalf of the hospital they acknowledged to the Court and to Mr Wells' family that he did not receive the level of care that he deserved, and they expressed their sincere apology for this. Both expressed a strong commitment to addressing for the future the many shortcomings in the care he received.

103. The Court heard evidence from both witnesses that a detailed review into the care provided to Mr Wells had been conducted. The review identified a number of factors that had contributed to his death. It also made several recommendations for improvements, the majority of which have been implemented. These include:

- new procedures for trauma calls, to ensure that an alternative clinician responds if the doctor with primary responsibility does not do so.

- specific nursing education to reduce the risk that signs of clinical deterioration are misinterpreted as symptoms of drug withdrawal.

- an updated Clinical Guideline for 'specialling' arrangements, containing increased requirements for the recording of vital signs. All nursing staff have

received the updated guideline and have been required to sign that they have read it.

- a new system to improve the way information is relayed to surgeons who are otherwise unavailable because they are performing surgery.

- reinforcement to junior doctors of the need to use 'ISBAR' systems to improve the clarity of their communications with senior medical staff about patient care.

- reinforcement to medical staff of the need to clearly document frequency of observations for a patient, where there is a need to depart from the standard frequency.

104. These changes are welcome, and evidence the commitment of the LHD and the hospital to increasing the safety of their patients.

Proposed recommendations

105. I now discuss those specific systemic failures which contributed to Mr Wells' death, in relation to which in my view it is necessary and desirable to make recommendations.

Appointment and supervision of IMGs

106. A key systemic failure which contributed to Mr Wells' death was the appointment of Dr Kusyk to the surgical registrar role in 2015. Professor Hensley acknowledged that this appointment ought not to have been offered to him, nor should he have accepted it. This was because the responsibilities which a surgical registrar is required to discharge, in particular in an area of the hospital such as ED or trauma, are not compatible with the onerous requirements of Level 1 supervision. In Professor Hensley's firm view, the LHD needed to ensure that in future, a doctor assessed as requiring such a level of supervision is not offered employment to a position carrying responsibilities beyond those of an intern. This was a change he had implemented at JHH since Mr Wells' death.

107. I agree with Professor Hensley's opinion, with which A/P Holdgate concurred, that the inappropriate appointment of Dr Kusyk to the position of surgical registrar was a major contributor to Mr Wells' tragic death. In my view there can be no room for doubt of the necessity to implement across the HNELHD the change which Professor Hensley has introduced at JHH. It is the subject of Recommendation 1 in these findings. It is encouraging that in written submissions the HNELHD gave its support to this proposed recommendation.

108. A related systemic failure was the lack of a formal process whereby Dr Koshy was made aware of Dr Kusyk's supervision requirements. At the inquest Professor Hemsley told the Court the hospital was permitted to appoint co-supervisors for the day-to-day supervision of unaccredited registrars. This role was typically filled by the relevant on-call specialist for that day. As the Court

heard, on 22 May this person was Dr Koshy who had not been informed that Dr Kusyk was subject to Level 1 supervision. It emerged that JHH had no formal arrangements whereby the supervision requirements of IMGs such as Dr Kusyk were communicated to the senior medical staff providing supervision.

109. Professor Hensley readily acknowledged the need for such arrangements. Accordingly Counsel Assisting the inquest proposed a recommendation that the LHD consider developing a system of notifying doctors responsible for the supervision of junior medical staff of their supervision levels.

110. In response the LHD noted that the administrative requirements for IMG supervision are different to those for other categories of junior medical staff. The LHD therefore proposed an amended proposal, that a policy framework be developed to govern the way in which IMGs are supervised '*and how the supervision requirements of [IMGs] are communicated to the senior medical staff who provide their supervision'.*

111. Since the evidence heard in this inquest concerned supervision failures in relation to an IMG, I accept it is appropriate to confine the proposed recommendation to this category of medical staff. I accept also that the mechanism whereby supervision requirements of IMGs are notified must be a matter for the LHD and the hospital to determine. In my view however given the tragic outcome in Mr Wells' case, it is in the interests of patient safety that the proposed policy framework document that such notification must take place. I have reflected this in the wording of Recommendation 3.

Other proposed recommendations

112. Counsel Assisting proposed four other recommendations, in relation to all of which the HNELHD indicated its support. The need for these recommendations is supported by the evidence, and I propose to make them in these findings. These are:

- That JHH's *Handbook and Guidelines for Junior Medical Staff* be reviewed, in particular those areas which advise junior doctors how to locate and consult with senior medical staff. A/P Holdgate remarked in the second of her expert statements that the existing language suggested *'a level of excessive deference'* to consultants, and placed too much onus on the junior doctor to find his or her senior. As consultants were ultimately responsible for patients admitted under their care, they needed to ensure that junior doctors knew how to contact them.

- That JHH's Local Procedure setting out the clinical responsibilities of senior medical officers be revised, so as to require that they personally and fully assess patients within 24 hours of admission other than in exceptional circumstances.

- That medical staff at JHH better understand the need to document a specific frequency of observations in cases where this is to deviate from the standard frequency.

- That compliance with the new 'specialling' arrangements at JHH be audited.

Concerns of Mr Wells' family

113. In her statement prepared for the inquest, Mr Wells' mother Sue Nakkan described how her initial contact with JHH was a source of distress for her. At about 10am on the morning of 22 May she received news that her son had been taken to JHH after a car accident. Ms Nakkan, who was at that time staying in Melbourne, immediately rang the hospital and was put through to Dr Owen in ED. Unfortunately it appears Dr Owen did not have information before her identifying Ms Nakkan as Mr Wells' next of kin, and was unable to provide any details. Ms Nakkan says that Dr Owen told her '*he looks ok'*, and believing that his condition was not serious Ms Nakkan and Mr Feliu then flew home to Brunswick Heads. It was evident that Ms Nakkan wishes deeply that she had been given details of Mr Wells' condition, as she would have travelled to Newcastle from Melbourne to be with him.

114. Later that day Ms Nakkan was able to speak to Mr Wells on the phone and was shocked to learn from him that he couldn't walk. She did not learn of his death until 8.00am the following morning, when police came to her home to inform her. These communication issues added greatly to her distress and grief at the sudden loss of her son.

115. At the inquest Dr Owen was unsure whether, at the time of Ms Nakkan's call to her on the morning of 22 May, Mr Wells' papers recorded his mother as his next of kin. The evidence was unclear as to when this information was recorded. Accordingly it would not be appropriate to suggest that Dr Owen acted inappropriately or insensitively in her dealings with Ms Nakkan, although Ms Nakkan's distress about this situation is very understandable.

116. Ms Nakkan and Mr Feliu have generously offered their assistance to LHD educators so that a family focus can be incorporated into the training and education programs developed as a result of the tragic death of their son. It seems to me that integrating a family perspective into such learning programs could be a powerful and effective way of helping clinicians to develop a deeper understanding of patient care. I am pleased to note that this open hearted offer has been acknowledged by the LHD, who have responded that they will seek ways of working with Mr Wells' family to develop this idea.

Conclusion

117. In conclusion, and on behalf of us all at the Coroner's Court, I offer to Mr Wells' family my sincere sympathy for the loss of Nicholas. I hope that the process of the inquest, painful as it is for family members, has answered some of their questions and given them some reassurance for the future.

118. I express my deep appreciation of the excellent assistance I received from Mr Downing, Counsel Assisting, and from Ms Hainsworth of the Crown Solicitor's Office. My thanks also to all the representatives who assisted with the inquest.

I close this inquest.

E Ryan
Deputy State Coroner
Lidcombe

Date
22 July 2019

Findings required by section 81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is Nicholas Wells born 18 June 1991.

Date of death
Nicholas Wells died on 23 May 2016.

Place of death
Nicholas Wells died at John Hunter Hospital, Newcastle NSW.

Cause of death
Nicholas Wells died of peritonitis secondary to a perforation of the small bowel.

Manner of death
Nicholas Wells died when the bowel perforation which he had sustained as a result of a motor vehicle accident did not receive adequate care and treatment from medical and nursing staff at the hospital to which he was brought.

Recommendations pursuant to section 82

1. That Hunter New England Local Health District [the LHD] consider creating a policy document that reflects the current practice at John Hunter Hospital that no International Medical Graduate subject to Level 1 supervision (under the *Medical Council of Australia Guidelines – Supervised Practice for International Medical Graduates* or earlier versions) be appointed to a position beyond that of an intern, and distribute this to the Director of Medical Workforce and to all selection panels constituted to employ junior medical staff (interns, residents and registrars).

2. That the LHD consider creating a policy document specifying whether International Medical Graduates subject to different levels of supervision (under the *Medical Council of Australia Guidelines – Supervised Practice for International Medical Graduates* or earlier versions) are eligible to be appointed to intern, resident or registrar positions within the LHD.

3. That the LHD consider creating a policy framework to govern the way in which International Medical Graduates are supervised and monitored, including a system to ensure that their supervision requirements are communicated to the senior medical staff who provide their supervision.

4. That the LHD consider undertaking a review of the *Handbook and Guidelines for Junior Medical Staff and Trainees – John Hunter Hospital Surgical Services* with a view to revising Section 8.3, 8.4 and 15.6 in view of the findings made in this inquest.

5. That the LHD consider revising *Local Procedure JHH_0362 – Clinical Responsibilities of the Attending Medical Officer (AMO): John Hunter Hospital* so as to require that AMOs personally and fully assess patients within 24 hours of admission other than in exceptional circumstances.

6. That the LHD consider providing training and education to medical staff at John Hunter Hospital in relation to the need to complete the Standard Adult General Observation Chart where a medical officer wishes to prescribe a specific frequency of observations.

7. That the LHD consider including as part of its auditing of patient specialling performed under *Local Procedure JHH_0203 – Patients Requiring Additional Supervision/Special at JHH*:
    - whether the patient's respiratory rate has been documented 15 minutely; and
    - whether the patient's vital sign observations have been attended to at least every 30 minutes (in cases where the patient requires specialling due to acute/deteriorating medical condition).