CORONER'S COURT

Name of Deceased:	Edna Beryl Whalen
File Number:	1449/2008
Hearing Dates:	21 – 24 May 2013 and 28 August 2013
Location of Inquest:	Coroners Court Glebe, NSW 2037
Date of Finding:	5 December 2014
Coroner:	Paul MacMahon Deputy State Coroner
Representation:	Ms K Rees SC – Counsel Assisting Mr A Black SC – Dr Z Darus-Mustapha Ms A Horvath – Dr M Hussein Mr S Gray – Mr H Johnston & Ms B Lennox

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

The residential address of any witness may not be published.

Findings made in accordance with Section 81(1) Coroners Act 2009:

Edna Beryl Whalen (born 24 October 1917) died on 1 February 2007 at the Port Macquarie Base Hospital, Wrights Road, Port Macquarie in the State of New South Wales. The cause of her death was Pulmonary Embolism due to Deep Vein Thrombosis with other significant conditions contributing to but not directly causing her death being the fractured of the neck of her left femur sustained on 8 January 2007, congestive heart failure, coronary heart disease and a prior myocardial infarction.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

Nil

Paul MacMahon

Deputy State Coroner

5 December 2014

Introduction:

Edna Beryl Whalen (who I will refer to as 'Edna' in these Reasons) was born on 24 October 1917. Edna died on 1 February 2007 at the Port Macquarie Base Hospital, Port Macquarie on the north coast of New South Wales. She was 89 years of age at the time of her death.

An autopsy undertaken by Dr G J Fuller on 5 February 2007 found that the cause of Edna's death was due to a pulmonary embolism which was due to deep vein thrombosis with other significant conditions contributing to but not causing her death as being a fractured neck of her left femur, congestive heart failure, coronary heart disease and previous myocardial infarction.

Edna's death was reported to the coroner on 1 February 2007.

Jurisdiction of Coroner;

The applicable coronial legislation at the time of Edna's death was the Coroners Act 1980 (the old Act). The Coroners Act 2009 (the new Act) repealed the old Act. The new Act commenced on 1 January 2010. The relevant legislation is therefore the Coroners Act 2009. All legislative references will be to that legislation.

Section 6 defines certain deaths as being a *"reportable death."*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the person who has died or is suspected to have died was ordinarily a resident of New South Wales.

The primary function of the coroner, when an inquest is held, is set out in Section 81(1). That section requires in summary that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, and the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 (1) provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

History of the coronial proceedings:

An inquest concerning Edna's death was commenced at Port Macquarie on 11 January 2012 before Deputy State Coroner Forbes. Evidence was taken by Her Honour between 11 and 13 January 2012. On 27 January 2012 Her Honour made findings and recommendations in accordance with Sections 81(1) and 82.

An application was subsequently made by Dr Zarlina Darus-Mustapha to the Supreme Court of New South Wales in accordance with Section 85 for an order that the inquest conducted by DSC Forbes be quashed and that a new inquest be conducted. Dr Darus-Mustapha was a party granted leave to appear at the inquest before DSC Forbes and gave evidence to Her Honour

during the course of that inquest. During the course of that inquest Dr Darus-Mustapha instructed solicitors and was represented by counsel.

Section 85 gives jurisdiction to the Supreme Court to make an order quashing an inquest where it is satisfied that it is necessary or desirable for it to do so for various specified reasons set out in that section.

On 30 July 2012 the then State Coroner, Magistrate Jerram, was advised of certain evidence that had been filed in the proceedings before the Supreme Court. Having regard to that evidence Her Honour invited Dr Darus-Mustapha to make an application in accordance with Section 83 that a fresh inquest be conducted.

Section 83 gives the State Coroner jurisdiction to order that a fresh inquest be conducted where she/he forms the opinion that: *'the discovery of new evidence or facts makes it necessary or desirable in the interest of justice to hold a fresh inquest.'*

An application was subsequently made by Dr Darus-Mustapha in accordance with Section 83 and that application was granted. Magistrate Jerram subsequently directed me, in accordance with Section 83(6), to conduct the fresh inquest.

Following the matter being allocated to me for inquest I considered it appropriate that I not read the Findings and Recommendations made by DSC Forbes and have no regard to the transcript of the evidence and the exhibits in the proceedings before her unless such transcript and/or exhibits were exhibited before me in these proceedings. The parties were advised of my decision and the proceedings were, in effect, conducted before me de novo.

Consistent with the above I considered that any Findings and Recommendations that I might make in these proceedings would, in accordance with Section 83(7), be expressed to be in substitution for those made by Deputy State Coroner Forbes. The parties were advised of as such and the inquest before me was conducted on that basis.

Section 81(1) Finding:

Edna's identity together with the date and place of her death were not issues of contention at inquest. I am satisfied that the evidence establishes that Edna Beryl Whalen, who was born on 24 October 1917, died on 1 February 2007 at the Port Macquarie Base Hospital, Wrights Road, Port Macquarie in the State of new South Wales.

The direct cause of Edna's death was not an issue of contention at Inquest either.

Dr Fuller, during the course of his autopsy examination, found, in part, that:

> *Sections of the lungs showed oedema together with a small pulmonary infarct in the mid zone of the right lung. An anti-mortem thrombus was present within a medium sized pulmonary artery in the right lung. On the left side a large embolus was present within the main trunk of the left pulmonary artery.*

Dr Fuller as a result of these findings recommended that the cause of Edna's death be recorded as being (using the current death registration protocols):

1. ***Direct Cause:***
   Disease or condition directly leading to death:
   (a) Pulmonary Embolism

Antecedent Causes:

Morbid conditions, if any, giving rise to the above cause,

stating the underlying condition last:

(b) Deep Venous Thrombosis.

2. ***Other significant conditions contributing to the death but not relating to the disease or condition causing it:***

   Fractured Neck of Femur, Congestive Cardiac Failure, Coronary Heart Disease, Previous Myocardial Infarction.

As well as accepting Dr Fuller's conclusions as to the direct cause of Edna's death the parties appearing at the inquest did not dispute that the fracture of the neck of her left femur was a contributing factor to the cause of her death.

Associate Professor John Raftos described that contribution in the following terms:

> *Hip fracture in the elderly has a high mortality, mostly as a result of immobility caused by the fracture and the immobility and physiological stress associated with its anaesthetic and surgical treatment, Studies over the years have shown that delays in surgical treatment of hip fracture increase mortality. A recent study showed a 30 day mortality of 9.7% in patients who had surgical treatment within 24 hours of admission to hospital with hip fracture compared to a mortality of 13% in patients whose surgical treatment was provided more than 24 hours after admission. Patients whose operation is delayed are about 50% more likely to die than those whose operation is performed within 24 hours of admission, In general, the longer the delay between the fracture and its surgical treatment, the higher the mortality. The common causes of death in patients with hip fracture are associated with immobility and include:*
>
> - *Thromboembolic disease (deep venous thrombosis and pulmonary embolism),*
> - *Pneumonia,*
> - *Urinary infection.*
>
> *Deep venous thrombosis forms in the veins of the legs when an individual is immobile in bed. The main reason for early surgical treatment of patients with hip fracture is to allow early mobilisation and so minimise the period of immobility in bed and reduce the likelihood of deep venous thrombosis and pulmonary embolism associated with immobility.*

Another aspect associated with hip fractures that add to the complexity associated with caring for persons suffering from such conditions, in particular the elderly, is whether or not the fracture is impacted, non-displaced or displaced. Impacted and non-displaced fractures are not exactly the same however have similar characteristics.

Fractures of the femoral neck that are found on initial x-rays to be in normal, or near-normal, alignment are called non-displaced. The treatment of non-displaced femoral neck fractures is fairly uncontroversial and generally involves internal fixation. Multiple stabilizing screws are placed from the outside (lateral) position of the proximal femur through the fractured neck, and anchored into the bone of the femoral head. With the fracture aligned and stabilised with screws, these fractures commonly heal without complications. The repair of am impacted fracture is similar.

Fractures of the femoral neck that are found to be moderately to severely misaligned on initial x-ray are called displaced femoral neck fractures. More controversy surrounds the treatment for displaced neck fractures. Elderly patients with displaced femoral neck fractures may be treated with internal fixation by screws or, more usually, by a surgical restoration of the integrity of the femur which can include the use of prosthesis.

There are thus more significant physiological and psychological stresses associated with the repair of a displaced fracture than that associated with an un-displaced fracture. Added to this are the secondary consequences described by Associate Professor Raftos that result from longer periods of immobility particularly in elderly patients.

Non-displaced fractures are, however, recognised as being harder to detect because there are fewer clinical signs. They can be elusive to identify and easily missed. Indeed Associate Professor Raftos gave evidence that he had

seen older people walk on non-displaced hip fractures for days; weeks or months with or without dementia as doing so may not be too painful. In a person with mild to moderate dementia that condition may also mask any pain experienced by the patient.

It is however accepted that non-displaced fractures are inherently unstable and will displace after a period of time. Dr Drummond's evidence was that this tended to occur by 28 days after the occurrence of the fracture.

I accept the recommendation of Dr Fuller as to the direct cause of Edna's death. I also accept that the fracture that she suffered to the neck of her left femur was a significant contributing factor to the cause of her death. I accept the description (which was uncontroversial) given by Associate Professor Raftos of the mechanism by which the fracture that she sustained to the neck of her left femur contributed to the cause of her death.

I accept that in an elderly person, such as Edna, a fractured neck of femur has a high mortality rate and that mortality rate is increased significantly if there is a delay in identifying and repairing the fracture, particularly where the fracture is displaced, due to the more significant physiological and psychological stresses that are associated with the repair of a displaced fracture and the secondary consequences that result from the restrictions on mobility that results from the fracture.

In the circumstances at Inquest the investigation sought to determine when Edna suffered the fracture of the left neck of her femur.

Factual background:

Since March 2002 Edna had been a resident of 'Vincent Court', an aged care facility, at Kempsey on the mid-north coast of New South Wales. Edna suffered from a number of medical conditions including dementia, incontinence of the bladder and bowels and hypertension. She was otherwise active and mobile.

At About 3.10pm on 8 January 2007 Edna became involved in a physical altercation with another resident. Edna and the other resident were separated. Edna was found to have suffered no injuries other than a scratch to her hand which was treated with 'Steri' strips. Edna was then taken to her room.

At about 4.45pm the same day RN Julie Davis entered Edna's room and asked her to come for tea. Edna stated 'I fell in my room and hit my head.' When RN Davis asked for more information Edna said that she felt dizzy and 'I have a sore leg up here.' Edna is reported to have indicated her upper leg area.

Edna subsequently walked to meal room had dinner and thereafter returned to her room where she was observed walking around her room.

At about 9.00am on 9 January 2007 Edna was noted by staff as being breathless and appeared unwell. When her condition had not improved by 11.00am an ambulance was called and she was transported to Kempsey District Hospital (KDH).

When Edna was transported to KDH a letter was sent with her by Vincent Court that identified the reason for her transfer as being:

> *'C/O (R) sided headache, (L) hip pain, cannot weight bear (sudden onset).'*

Edna arrived at KDH at 12.10pm on 9 January 2007 and remained there as an inpatient until her discharge on 25 January 2007. On discharge Edna was transferred to the Amity Nursing Home (Amity).

On 30 January 2007 at Amity Edna suffered a rapid deterioration in her health including not taking fluids. Her general practitioner, Dr Smith, was asked to review her. Dr Smith noted that Edna's left foot was externally rotated and her hip was tender to touch. He considered that her left hip should be X-Rayed.

On 31 January 2007 Edna transferred to KDH for an X-Ray of her left hip. Dr Smith attended KDH with her. The X-Ray revealed that Edna was suffering from a fractured left neck of her left femur. As a result Edna was admitted to KDH as an inpatient at 1.15pm that day. It was subsequently decided that she should be transferred to Port Macquarie Base Hospital (PMBH). Edna was admitted to PMBH at 4.40pm the same day.

At PMBH a decision was made to 'fix' the fracture of her left hip by undertaking hip replacement surgery. At 2.35pm on 1 February 2007 Edna was taken to theatre. During surgery, as the prosthesis was being cemented into place, Edna suffered a cardiac arrest. Efforts to revive her, unfortunately, were not successful. She was declared deceased at 5.20pm on 1 February 2007.

Issues for Inquest:

The primary issue at inquest revolved around the question of when Edna sustained the fracture to her left hip and whether or not the care and treatment provided to Edna at KDH was appropriate. To assist me in this

regard a substantial brief of evidence was tendered and, in addition, I received oral evidence from:

- Dr Darus-Mustapha – the doctor who first examined Edna in the Emergency Department of KDH and ordered her admission as an inpatient,
- Dr Hussein – the doctor in charge of the medical ward that Edna was admitted to at KDH and who was responsible for her medical care whilst an inpatient in that ward,
- Ms Brooke Lennox (nee Bowland) - a physiotherapist who sought to mobilise Edna whilst she was a patient at KDH,
- Mr Hamish Johnston – another physiotherapist who sought to mobilise Edna whilst she was at KDH,
- Associate Professor John Raftos, an Emergency Medicine specialist,
- Dr Robert Drummond, an Orthopaedic Specialist,
- Associate Professor Tuly Rosenfeld, a consultant Geriatrician and Physician, and
- Mr Michael Ryan, a specialist Musculoskeletal Physiotherapist.

The evidence:

Prior to 8 January 2007 Edna was assessed by her general practitioner Dr Smith as being:

> *'previously well, fully mobile with a mild dementia.'*

Rosemary Farly, who cared for her at Vincent Court, described her condition as being:

> *'physically she was quite mobile. She was able to walk freely and did not use any walking aids…during the night she would get up and strip her bed… signs of the dementia she was suffering.'*

Immediately following the altercation with another resident on 8 January 2007, Rosemary Farly stated that Edna:

> *'walked back to her room unaided. She sat on the chair of her room...at no time did she show any signs of pain in any of her limbs other than the scratch on her hand.'*

I accept the evidence of Dr Smith and Ms Farly and am satisfied that prior to the afternoon of 8 January 2007 Edna did not suffer from any physical injuries that are directly relevant to the matters that I am required to determine at this inquest.

The Vincent Court Hostel notes at 4.45pm on 8 January 2007 record that Edna:

> *'said that she fell over in her room and hit her head. There were no apparent injuries but when attempting to walk she had pain in her left leg (top area). She also said that she felt breathless as if she had a touch of asthma, with pain in her chest and also dizziness. She also had a vomit.'*

These notes were confirmed by the evidence of RN Julie Davis.

The Vincent Court Hostel notes at 8.00am on 9 January 2007 record that Edna was:

> *'breathless and unwell, unable to weight bear.'*

At 11.00am the notes record that she:

> *'had not improved. Unable to weight bear. Complaining of pain L hip and R head and temple. States she had a fall last night. BP 114/70 P12 T38.5. Pupils ECCRTL. Ambulance called.'*

At 11.45am on 9 January 20107 NSW Ambulance officers transported Edna to KDH. The officer made the following record:

> ***Chief complaint:*** *P.O.O. + pain behind left eye*

Patient history: *C/T patient unwell, on arrival elderly female patient lying in bed, recent history of increasing temperature over last 24/48 hours. Patient complaining of pain around left eye. Carer states that all new symptoms, patient now not ambient.*

On her arrival at KDH at 12.08pm on 9 January 2007 the notes record Edna's condition as follows:

Presenting health problem: *hip pain, headaches*
Relevant coexisting conditions: *dementia.*

At 12.10pm on 9 January 2007 the triage nurse at KDH (EN Rae Pope) recorded as follows:

Priority 4, BIBA with right sided headache, left hip pain and fever.

I am satisfied that the evidence establishes that between 3.00pm and 4.45pm on 8 January 2007 Edna suffered an unwitnessed fall in her room at the Vincent Court Hostel as a result of which she subsequently reported pain to her head and left hip.

At 12.15pm on 9 January 2007 Edna was seen by Dr Darus-Mustapha who also reviewed her again at 7.00pm that day. Dr Darus-Mustapha recorded her observations and actions in the KDH notes, made a statement dated 12 January 2012 and gave evidence before DSC Forbes on 12 January 2012 and myself on 21 May 2013. Following the conclusion of the taking of evidence by me Dr Darus-Mustapha was granted leave to file a further statement on a particular issue. That statement was dated 27 May 2013 and became Exhibit 5.

In her statement of 12 January 2012 Dr Darus-Mustapha stated that she was unable to get a clear history from Edna as she found her 'pleasantly confused.' She contacted the nursing home and was informed that Edna may

have had an unwitnessed fall after which she had refused to weight bear and was complaining of a headache and was suffering from a fever.

Having obtained this history Dr Darus-Mustapha said that she undertook a physical examination of Edna. She said she asked Edna if she was experiencing any head, chest, and hip or leg pain. She said Edna did not *'complain of any pain to me.'*

Dr Darus –Mustapha then said that she performed a physical examination of Edna. She described that examination at the time as follows:

> *'I then proceeded to a physical examination. The only abnormality that I noted was some pitting oedema up to her mid shin on her left leg. I then helped her to stand up at the side of the bed. She was able to weight bear and take a few steps with minimal assistance. She was a bit unsteady during these few steps, however, did not appear in any discomfort or pain. Ms Whalen was smiling throughout the examination.'*

Following that examination Dr Darus-Mustapha concluded:

- *Her presentation of fever, increased confusion and leucocytes in the urine was consistent with a urinary tract infection,*
- *She did not think hip fracture was likely because Edna was able to weight bear without any sign of discomfort or pain, and that*
- *Following the prescription of antibiotics Edna was safe to be discharged back to her nursing home.*

Dr Darus-Mustapha re-examined Edna at 7.00pm that day. She said that at that time she found Edna to be *'restless, not tolerating any food or fluid (and that) her temperature had spiked at 38.4 degrees'.* As a result Dr Darus – Mustapha arranged for Edna to be admitted to KDH and requested that a physiotherapist see her concerning her mobility difficulties.

When Dr Darus-Mustapha gave evidence before DSC Forbes on 12 January 2012 she confirmed that in preparing her statement she had reviewed the

notes that she had made in the KDH records. She subsequently indicated in her statement of 27 May 2013 that that she was also assisted by her legal advisors in the preparation of that statement.

In her evidence before DSC Forbes Dr Darus-Mustapha was questioned extensively about her conclusion that Edna was unlikely to have suffered a hip fracture and why she did not order a hip X-ray. She stated that, at that time, she was still of the opinion that Edna had not suffered a hip fracture. She said:

> *'..if it's still the same patient with the same presentations and with my clinical finding I will unlikely do the hip – the hip X-ray because I think the hip fracture is unlikely'.*

Dr Darus-Mustapha gave evidence before me on 21 May 2013. She stated that at the time of her examination of Edna on 9 January 2007 she was working as a locum career medical officer at the KDH. She stated that she had at that time treated patients with hip fractures, knew that a sub-capital fracture involving the neck of a femur was a highly common reason for elderly women to be admitted to hospital. She was asked by Counsel Assisting about her state of knowledge of hip fractures at the time and asserted that on 9 January 2007 she knew:

- that hip fractures can be impacted or displaced,
- that in the case of an impacted hip fracture pain can be caused to the hip joint,
- that a person with an impacted hip fracture can stand or walk, although with pain, because of the relatively stable nature of the fracture,
- that if an impacted hip fracture is not detected and treated, then the impacted fracture would displace over time,
- that such displacement would occur in the period of up to a month after the initial fracture,
- that once an impacted fracture is displaced it required greater surgical intervention to treat it, and

- that if there was a delay in detecting an impacted fracture there would be greater risks to the patient because of the nature of the greater surgical intervention and the consequence of immobility in the development of blood clots.

In her evidence before me Dr Darus- Mustapha agreed:

- that the test to confirm or exclude a hip fracture was a hip X-ray,
- that her provisional diagnosis of urinary tract infection would not have accounted for the left hip pain that Edna was reported to have experienced on 9 January 2007,
- that it was possible that the fact that Edna, as a person with dementia, did not report pain did not mean that she was not actually experiencing pain at that time, and
- that it was possible the pitting oedema she observed to Edna's left leg may have been caused by an injury or fracture in the hip.

Dr Darus-Mustapha also confirmed the evidence that she gave before DSC Forbes that, not having observed any indication that Edna was in pain during the course of her examination, she concluded that a hip fracture was unlikely. She considered that this was the case whether or not the fracture was impacted or displaced. She said that in her opinion it was:

> *'uncommon for people that having a fracture of the hip, whether it is displaced or non-displaced, to be able to weight bear or to be able to take a few steps without any evidence of discomfort or pain'.*

Dr Darus-Mustapha during the course of her evidence before me remained of the opinion that, at the time she examined her, Edna was not suffering from a fracture to her hip. She indicated that she was confident that the physical examination she had undertaken on 9 January 2007 would have revealed whether or not Edna was suffering from a fracture of the hip. As that

examination did not suggest that was the case she was adamant it was not necessary to order an X-ray of her hip.

It was during the evidence before me that it was suggested, by Mr Black SC who appeared for her, that Dr Darus-Mustapha had never been asked what the physical examination she had undertaken of Edna consisted of. Counsel Assisting, in response, asked that she describe the examination that she had performed. Dr Darus-Mustapha in response described the examination in these terms:

> *My physical examination are with my observations, looking at the patients, looking at any obvious deformity form her face down to her leg at the first instant. And then I proceed with studying of –asking her whether she have any pain at any part of her body, and at the same time looking at her eyes, whether she have pain in the eyes, and also asking whether she have any pain in the ears, and looking into the ears with the orthoscope. And then I proceed with listening to her chest, the front part of the chest, listening to the heart and listening to the lung from the front.*
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> *I then proceed with looking at her lower body. She was wearing a nightie so I lift up the nighties, I was looking at the hip, both sides, right and left, and I couldn't – I couldn't see any deformity apart from the swelling or the pitting oedema on the left lower legs. And then proceeded with feeling, palpation of the hip, mainly at the top of the hip starting at the right side, then to the left, and also palpations on both of the hip at the pelvic level, eliciting any pain, and at that stage she did not complain of any pain.*
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> *I then proceed with the hip examination with the right hip because the complaining leg was the left, and I flex her-I ask her if she can lift up her leg, and she did, and she did not – again did not complain of any pain and she did not show any discomfort. I then do the hip examination which is flexing the leg which is bending the knee and pushing the knee right toward the body, and to try to elicit any pain or to try and see whether there is any evidence of discomfort. Again, this patient did not show any sign of that. And I did the same one with the left. Again she did not show any sigh of discomfort.*
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> *I then check for the internal and external rotations of the hip on both sides. Starting with the right again. It involves you flexing your knee to stabilise the hip pretty much – and rotating the leg at the joint of the hip, and if patients have any impacted or dis-impacted fracture or any pathology underlying fracture on the hip, they will show some evident sign of discomfort, and I did not see this in Mrs Whalen. I then help to – I ask her whether she can walk. She – I think she was in – I don't know*

whether she replied, but I believe that she agreed to do that, but I help her standing up to the side of the bed.

I was standing on her right-hand side to support her, making sure that she did not fall, and she was able to take a few – take several step, again without any evidence of discomfort or pain, and we were able to come back to the bed. She did, however, seem unsteady on the feet. There was no sigh – again, there was no sign of discomfort or pain, and she did not voice it to me either.

Dr Darus-Mustapha agreed that she made almost no notes of the examination that she had now described in detail and had not outlined that examination in her statement of 12 January 2012 or in her evidence before DSC Forbes on 12 January 2012. She said by way of explanation that she had never been asked to do so notwithstanding that in a letter dated 26 March 2013 (Exhibit 4) to her solicitors from the Crown Solicitor's Office she was asked to provide any evidence, additional to that contained in the brief of evidence, that she wanted considered at inquest.

She was given leave to file a further statement on the matter which she did by affidavit of 27 May 2013 (Exhibit 5). In that affidavit Dr Darus-Mustapha stated that following Edna's death there was a 'Root Cause Analysis' investigation undertaken at the KDH during which she was interviewed by a doctor and that during the course of that interview she referred to the detail of the physical examination she had undertaken however thereafter, until Monday 20 May 2013 when Mr Black SC did so, no one else had asked her to describe the physical examination.

Following Edna's admission to KDH she was transferred from the Emergency Department to the Medical ward of the hospital where she came under the care of Dr Muhammad Hussein, who among other duties, was responsible for the in-patient care of patients admitted to the medical ward and the high dependency unit of the hospital. Edna was an in-patient in the medical ward between 10 January 2007 and 25 January 2007 when she was discharged to the Amity.

A broad summary of the period of Edna's admission to the medical ward at KDH is as follows:

- On 11 January 2007 it is noted that because of her dementia Edna was not for CPR/ICU in the event of an arrest, an X-ray of her chest and cervical spine was ordered,
- On 12 January 2007 physiotherapy was asked to endeavour to mobilise her. An attempt was made however that attempt was unsuccessful due to *'low compliance'*,
- On 13 January 2007 Edna was requesting oral analgesia,
- On 15 January 2007 a request was made for an Aged Care Discharge Planner to be obtained , a CT scan of the brain was ordered,
- On 16 January 2007 there was a further attempt to mobilise Edna by physiotherapy. Once again this was unsuccessful. The reason given was *'Patient unwilling to participate in treatment.'*
- On 18 January 2007 Edna's condition had deteriorated significantly and her family were contacted and advised that they should come to see her ASAP. Edna was placed on *Palliative / Comfort care only.*
- On 19 January 2007 Edna's condition began to improve however she was *'stiff and restive when repositioning'.*
- On 23 January 2007 Edna was again seen by physiotherapy with a view to mobilising her. This was once again unsuccessful. It was suggested that *'Patient will require highest level (nursing home) care. Patient cannot be discharged back to Vincent Court.'*
- On 24 January 2007 Edna underwent ACAT assessment for high care. It was recommended that it was necessary for a *'Sit / stand lifter – 2 staff required with all transfers.'*
- On 25 January 2007 Edna was discharged to the Amity Nursing Home. At the time the Nursing Assessment for Patient transferring to Nursing

Home recorded her mobility as being *'Immobile, Unable to stand / weight bear.'*

Dr Muhammad Hussein made two statements (23 July 2011 and 6 May 2013) and gave evidence before DSC Forbes on 13 January 2012 and myself on 22 May 2013. He outlined in detail the treatment Edna received under his care. It was clear that for the most part the focus of his care of Edna was on issues other than her immobility and the reason for it. He did not order a hip X-ray although he arranged for X-rays of other parts of her body and a brain scan.

Dr Hussein said that on Edna's admission to the ward he *'probably'* did an examination of her hips although there was no documentation of such an examination. He said that he was however confident that he *'would have'* done one and on that basis of that physical examination he would have identified any fracture that was present. Had he considered it necessary he would have ordered an X-ray of the hips however the examination that he believed he would have undertaken must have not suggested one was necessary.

Dr Hussein stated that following Edna's death he had reflected on the case and had since changed his practice in a number of ways including in relation to the issues of unwitnessed falls and of patients not being able to adequately express themselves. He also said that his *threshold to order X-ray of the pelvis/hip in elderly patients is now much lower.*

Ms Brooke Bowland (now Mrs Lennox) was a physiotherapist in her first year of practice at the time she examined Edna. In January 2007 she was on a 10 week secondment to the KDH. She had no independent recollection of her examination of Edna. She made a statement date 29 April 2013 and gave evidence before me on 22 May 2013.

On 12 and 23 January 2007 she was asked to assess Edna's mobility. Ms Bowland, to her credit, candidly acknowledged that her notes of her examination on Edna were inadequate. As at January 2007 she also acknowledged that she had an incomplete understanding of the nature of hip fractures and issues relating to the effects of dementia. As she had no independent knowledge of her examination her statement recorded what she would have expected she would have done during the course of those examinations and not necessarily what in fact happened.

Ms Bowland's notes of the examination on 12 January 2007 record:

> *'patient reluctant to mobilise but did agree to try. Mobilisation unsuccessful. Patient unable/unwilling to take any steps to assist with moving up the bed. Mobilisation difficult due to low compliance'.*

On the basis of these notes it is hard to accept that Edna left her bed during the course of the examination. If she was not prepared to 'move up the bed' it is unlikely that she left it.

On 23 January 2007 Ms Bowland recorded her examination as follows:

> *ATSP re mobility (again)*
>
> *No patient input. Explained to patient reasoning behind mobilization, patient understood however no physical input on patient's behalf on attempt to stand from chair. Therapists used absolute maximal assistance x 2 to stand patient but had to sit patient down against (sic) immediately as patient was not providing any physical input to stand.*
>
> *Plan: patient provides no physical/compliance with attempting to mobilise even when patient appears to understand purpose. Patient will require highest level (nursing home) care. Patient cannot be discharged back to Vincent Court.*

These notes make it clear that at the time of the second examination by Ms Bowland Edna had no mobility whatsoever. It is reasonable to infer that Edna left her bed on this occasion however only with the assistance of 2 staff members. It is also clear that Edna sat in a chair however that was with the assistance of the staff. She did not do so herself. Ms Bowland in her notes

makes it clear that Edna did not contribute at all. Unfortunately apart from concluding that Edna had no mobility and would require the highest level of nursing home care she did not undertake any investigation as to why Edna was immobile.

Ms Bowland stated that before she examined Edna she reviewed the hospital medical notes so that she was aware of her history. She relied on the medical staff to undertake such examinations and order such tests as they considered were warranted. She assumed that if a hip X-ray was warranted then it would have been ordered. She did not see it as her role to clarify the cause of her immobility but only to assess her mobility.

Mr Hamish Johnston was the physiotherapist who assessed Edna on16 January 2007. Mr Johnston, who was a more experienced physiotherapist than Ms Bowland, gave evidence before DSC Forbes on 11 January 2012 and me on 23 May 2013. Mr Johnston thought that the notes of his examination of Edna were reasonable by 2007 standards but acknowledged that were inadequate by contemporary standards.

Mr Johnston's record of his examination on 16 January 2007 was:

> *Physio: Patient unwilling to participate in treatment even after explaining need to mobilise as discharge criteria for returning home. Facilitated with mobility*
>
> *...Would not take any steps.*
>
> *Plan: low compliance and not concerned regarding current lack of mobility. With all probably high level care, physio is no longer needed. Patient discharged.*

Once again it is clear that at the time of Mr Johnston's examination of Edna on 16 January 2007 she had little or no mobility.

Surprisingly Mr Johnston acknowledged that in 2007 he had a somewhat limited knowledge of the pathology of hip fractures. He said that as Edna's medical notes did not have a focus on her hip it was not a matter to which he gave any consideration. His notes suggest that his conclusion was that Edna was being uncooperative and he acknowledged that that was so. He did not think it was his function to try and find out why Edna was being uncooperative. He did not see it as his role to question the decisions of the medical staff as to what investigations should be undertaken.

Edna was admitted to the Amity Nursing Home 26 January 2007. Edna's gait and mobility was recorded at that time as being:

'none (sic) weight bearing'

The Manual handling assessment / plan recorded a functional diagnosis at the time of:

'non- weight bearing immobility'.

Between her admission to Amity on 26 January 2007 and the examination of her by Dr Smith on 30 January 2007 the records of the Amity do not contain any record that suggests Edna's mobility was regained or that she suffered a fall witnessed or otherwise.

Associate Professor Raftos prepared a review dated 24 September 2010 of Edna's care and treatment whilst in the KDH. Having undertaken that review he stated that in his opinion:

> *This history clearly indicated that Mrs Whalen was presenting to hospital following a fall after which she had pain in her left hip and was unable to stand or walk. The only reasonable medical response to such a history would have been to suspect the possibility of hip fracture and perform x-rays of the pelvis and left hip to confirm or exclude that possibility.*

Associate Professor Raftos was also of the opinion that the course of care by both the medical and physiotherapists was such that the diagnosis of the fracture of her hip was unnecessarily delayed. He concluded that;

> *The diagnosis of Mrs Whalen's left hip fracture was unnecessarily delayed by about three weeks. The immobility during this delay significantly increased the likelihood that she would develop a complication of hip fracture, such has pulmonary embolism, and significantly increase the likelihood that she would die as a result of the hip fracture.*

Following DSC Forbes delivering her findings and recommendations on 27 January 2012 Dr Darus-Mustapha commenced proceedings in the Supreme Court of New South Wales seeking to quash the inquest conducted by her. In support of that application an affidavit of Associate Professor Raftos was filed. It was that affidavit that led the then State Coroner Magistrate Jerram to invite Dr Darus-Mustapha to request a fresh inquest.

Associate Professor Raftos was asked by those acting for Dr Darus-Mustapha to make a number of assumptions and having done so review the opinion he had previously expressed. Having accepted the assumptions given to him Associate Professor Raftos formed a reviewed opinion that:

> *it was unlikely that Mrs Whalen had a fractured hip when she attended the Emergency Department at Kempsey District Hospital (on 9 January 2007)*

and that (consequentially)

> *he was no longer able to say that there was an unnecessary delay in diagnosis of Mrs Whalen's fractured hip.*

Associate Professor Raftos gave evidence before me as did Dr Robert Drummond, an Orthopaedic Specialist, Associate Professor Tuly Rosenfeld, a consultant Geriatrician and Physician, and Mr Michael Ryan, a specialist Musculoskeletal Physiotherapist each of whom had reviewed the care and treatment afforded to Edna whilst she was in KDH.

Consideration:

The primary issue for determination at inquest was whether or not Edna suffered the fracture of her hip at Vincent Court on 8 January 2007 or at some other time. This led to a detailed examination of the care that she received whilst a patient at KDH and in particular the assessment initially undertaken by Dr Darus-Mustapha.

The revised opinion of Associate Professor Raftos was helpful in focusing on these issues however, as he acknowledged, his revised conclusion was founded on the assumptions that he was given. If those assumptions were not accepted individually or as a whole then Associate Professor Raftos's opinion may or may not be varied again. In forming my opinion I have the opportunity of the assistance of each of the specialists who gave evidence before me and assessed the evidence of those who treated Edna during her admission to KDH.

Counsel Assisting has submitted that on the balance of probabilities Edna suggested the fracture to her hip on 8 January 2007 following a fall that occurred in her room at Vincent Court. Counsel Assisting submits that there are seven findings of fact that support that conclusion. Those findings of fact are:

- Edna had a fall on 8 January 2007,
- After 8 January 2007 there was a sudden change in her mobility,
- On 8 and 9 January 2007 she displayed symptoms consistent with a fractured hip,
- Nothing that Edna did after the fall on 8 January 2007 was inconsistent with an impacted fractured hip,
- There was no evidence that a fall occurred on any other occasion between 8 and 30 January 2007,
- A fracture on 8 January 2007 is consistent with the X-ray that ultimately disclosed it,

- It is consistent with the time frame in which impacted fractures displace.

Mr Black SC, Counsel for Dr Darus-Mustapha, has submitted that the evidence available does not support the conclusion that Edna suffered a fracture to her hip on 8 January 2007. He argues that I would be careful to make such a finding as for a number of reasons each of which I will deal with in order.

Mr Black accepted that although Edna complained of a fall on 8 January 2007 she was subsequently seen to walk to and from her meal room and around her room. I accept that this occurred however I also accept the evidence before me from Associate Professor Raftos and others that a person suffering from an impacted or non-displaced fracture of the hip will not necessarily be prevented from walking or standing.

Although Mr Black accepted that there was a change in Edna's mobility after 8 January 2007 he pointed out that that change was consistent with other conditions from which she was found to be suffering and that the fracture of the hip was inconsistent with the physical examination undertaken by Dr Darus-Mustapha. I accept that Edna was at the time suffering from other conditions that may have affected her mobility and will return to the physical examination undertaken by Dr Darus-Mustapha.

Although Mr Black accepted that after 8 and 9 January 2007 Edna displayed symptoms consistent with a fractured hip he submitted that she also displayed behaviour which was inconsistent with that being the case that being her movement at Vincent Court and the observations by Dr Darus-Mustapha. As far as the movement observed is concerned, as indicated above, I do not accept that submission. I am satisfied that the movement observed is not inconsistent with an impacted or non-displaced hip fracture. I will return to Dr Darus-Mustapha's examination

The suggestion that nothing Edna did after the fall was inconsistent with an impacted hip fracture was disputed by Mr Black. Leaving aside the physical examination undertaken by Dr Darus-Mustapha to which I will return I do not accept that this is the case. In my view Edna's walking around Vincent Court on 8 January 2007 is not inconsistent with an impacted hip fracture.

Mr Black suggested that I should be careful about accepting that there was no evidence of a fall on any other occasion between 8 January 2007 and 30 January 2007 other than the one complained of by Edna. It was suggested that the reason there was no evidence was because there was no investigation.

I do not accept that this is the case. I am satisfied that there was a thorough investigation of the circumstances of Edna's care from 8 January 2007 until the date of her death. The available evidence overwhelmingly leads to the conclusion that there was no such fall. From the time of her admission to KDH on 9 January 2007 to the date of her readmission on 31 January 2007 Edna's mobility was severely compromised. Had she had another fall during that period it is reasonable to infer that she would have been found by staff and had to be assisted. Reporting requirements for such incidents would have required that such an incident would be documented. There was no such incident report. I am satisfied that on the balance of probabilities there was no such incident.

Mr Black notes that there are notes in the Amity records for 28 January 2007 which refer to observed bruising are unexplained. I do not accept this suggests Edna had experienced a fall. It is well known that elderly people bruise easily and the bruises referred to are of a relatively minor nature and were more likely to have been suffered by the efforts of staff to undertake regular care of Edna.

To suggest that the statement setting out the review of the Amity records is self-serving evidence from the staff of that Nursing Home amounts to nothing more than a suggestion that such staff engaged in a conspiracy to cover up their failure to care for Edna. There is absolutely no evidence whatsoever before me to suggest that this is the case and I reject the suggestion.

Mr Black submits that the X-ray that identified Edna as having suffered from a fracture to her hip was consistent only with her having suffered a fracture to her hip in the 28 days prior to the X-ray having been performed. I accept that that is the case. It is however consistent with the fracture having occurred on 8 January 2007.

Counsel Assisting submitted in her seventh point that the circumstances of this case were consistent with the time in which an impacted fracture would displace. She relied on the evidence of Dr Drummond which was accepted, for the most part, by Dr Darus-Mustapha. This was not challenged by Mr Black. I accept that this is the case.

This brings me to the physical examination performed by Dr Darus-Mustapha on Edna on 9 January 2007. Counsel assisting submits that I should not accept Dr Darus-Mustapha's evidence as to the nature of that examination as given in evidence before me.

The physical examination outlined in her evidence before me was the subject of comment by the experts that gave evidence in the inquest. It was generally accepted that some aspects of that examination would be sufficient to identify whether or not, at the time, Edna was suffering from a fracture to her hip. I accept that this is the case and that had Dr Darus-Mustapha undertaken the examination she has described and obtained the results she has outlined Edna did not have a fracture of her hip at the time of the examination and the fracture must have occurred at some later unidentified time.

Counsel assisting submits however that I would not accept Dr Darus-Mustapha' evidence as to the nature of that physical examination because that evidence described was, in effect, of recent invention. It was put that the physical examination was not as extensive as claimed and that it was more likely at the time Edna was suffering from an impacted or non-displaced fracture that would not necessarily have been identified by clinical examination alone particularly in a patient such as Edna who was suffering from dementia.

In forming a view on this matter it is necessary for me to look at the evidence available and have regard to the opinion I formed of Dr Darus-Mustapha when she gave evidence. As far as the latter is concerned it was clear to me that she was a highly intelligent and articulate professional, although somewhat arrogant, and a person who was able to identify with clarity the issues that needed to be resolved in the examination of the treatment afforded to Edna.

In these circumstances it came somewhat as a surprise when giving evidence before me when she suddenly outlined for the first time an examination she said she undertook of Edna that all would have conclusively resolved the issue of whether or not Edna suffered a fracture of the hip on 8 January 2007.

It was also surprising that she had not provided this detail when she made her statement of 12 January 2012 and gave her evidence before DSC Forbes on 12 January 2012. It was also somewhat surprising that she did not provide that detail when she qualified Associate Professor Raftos to obtain his reviewed opinion for the Supreme Court proceedings that she commenced to quash the inquest conducted by DSC Forbes. Clearly it was an important assumption that ought reasonably been put to Associate Professor Raftos for his consideration.

It was also surprising that when invited by those assisting me in preparing for the inquest, which I was directed to conduct by the then State Coroner Magistrate Jerram following her request for a fresh inquest, to provide any additional evidence she wished to be considered she did not provide a further statement outlining such important and relevant facts to the issue that was clearly going to be addressed at that inquest. Other witnesses involved in the inquest did just that.

There can be no dispute that Dr Darus-Mustapha did not instruct her lawyers in the first inquest about the detail of the physical examination she now says she conducted – it is reasonable to infer that had she done so it would have been recorded in her statement or at least drawn from her in evidence before DSC Forbes.

There can be no dispute that Dr Darus-Mustapha did not instruct her lawyers about the detail of the about the detail of the physical examination she now says she conducted when she commenced the Supreme Court proceedings - it is reasonable to infer that had she done so it would have been an assumption that was put by them to Associate Professor Raftos.

There can be no dispute that Dr Darus-Mustapha was well aware of the significance of the detail of the physical examination to the issue of whether or not Edna had suffered a hip fracture on 8 January 2007. She says in her affidavit of 27 May 2013 that during her Root Cause Analysis interview she was asked questions about the detail of her examination. It was clearly a matter that was of importance to the interviewer who, it is clear, was examining the same issue as I am examining. That interview it would seem occurred prior to the inquest conducted by DSC Forbes.

Dr Darus-Mustapha thus must have been well aware in preparing for the inquest before DSC Forbes, and at all times since, that this was an important

matter of fact. If it were true it was in her interest to make it known. The fact that she did not do so suggests that it did not occur as she now says.

During the course of her evidence before DSC Forbes, whilst there is no specific question put to her in where she was asked to detail her physical examination, there were many questions that were put to her dealing with the question of why she did not order an X-ray of Edna's hip. Had she described the physical examination that she now asserts she undertook she would have been providing a direct and relevant explanation of her reasons for not ordering a hip X-ray. She did not do so

It would appear to me that, at this stage, for Dr Darus-Mustapha's to try and explain her not telling anyone prior to her giving her instructions to Mr Black that *'no one had previously asked her'* is a somewhat facile excuse. It is really an offence to a person of her intelligence. It is an explanation that judges and magistrates here in various forms on a regular basis. It is invariably rejected. I do not accept that Dr Darus-Mustapha undertook the physical examination of Edna that she says she did. I am satisfied that the description of the examination given by Dr Darus-Mustapha to me is one of recent invention.

In addition to the above there are other reasons to reject Dr Darus-Mustapha's evidence as to the nature of the physical examination she undertook of Edna on 9 January 2007. One example is that she says that during the course of her examination she got Edna to raise both of her legs, one at a time, unassisted. Professor Rosenfeld considered that for this was 'unlikely' given Edna's dementia. I accept Professor Rosenfeld's evidence on this issue.

I am satisfied that the physical examination Dr Darus-Mustapha undertook of Edna on 9 January 2007 was insufficient to exclude the possibility of a hip

fracture and that, given the history she had received, she should have ordered an X-ray of Edna's pelvis and hip to confirm or exclude that diagnosis.

I am satisfied that on the balance of probabilities that Edna suffered a fracture of her left hip on 8 January 2007 and that fracture was initially impacted or non-displaced. I am satisfied that it is likely that any mobility of Edna observed by Dr Darus-Mustapha in her examination on 9 January 2007 was available because the fracture at the time was non-displaced. I am also satisfied that at some later date, and prior to the examination conducted by Dr Smith on 31 January 2007, the fracture displaced. I am satisfied that on the balance of probabilities had an X-ray of Edna's hip been undertaken on 9 January 2007 it would have revealed the hip fracture she had suffered.

I am satisfied on the balance of probabilities that had an X-ray of the Edna's hip been undertaken following the examination by Dr Darus-Mustapha, or whilst she was a patient at KDH, it would have disclosed a fracture to her hip and that the delay in diagnosing that fracture increased the likelihood that she would develop a complication of hip fracture, such as pulmonary embolism, and significantly increase the likelihood that she would die as a result of the hip fracture.

Counsel Assisting also criticises Dr Hussein and the two physiotherapists for not seeking to identify what was the cause of Edna's immobility and, in the case of Dr Hussein, for not requesting a hip X-ray to exclude a hip fracture as the cause of that immobility.

In the case of Dr Hussein I am satisfied that on the balance of probabilities the care he provided to Edna whilst was not focused on the issues associated with her immobility. He ordered chest and cervical X-rays following complaints of neck pain and a subsequent brain scan and appears to have delegated the issues of immobility to the physiotherapists. Although he says that he

'probably' undertook a physical examination on her admission to the Ward I am not satisfied that this occurred in a manner designed to identify a hip fracture. There are no records to suggest that it did. It would appear more likely that he relied on the assessments undertaken whilst Edna was in the Emergency Department as setting the focus of his care plan for Edna and that nay physical examination undertaken was cursory.

When Edna's condition began to deteriorate the issues focused on were palliative care, her comfort and her relationship with her family. When she then began to recover the focus then turned to the nature of nursing care required following her discharge. I am satisfied that at no relevant time was any serious consideration given to the cause of Edna's immobility and the possibility of her having suffered a fracture to her hip. This lack of focus on the reasons for Edna's immobility deprived her of the possibility of the hip fracture being diagnosed at an early time and significantly increased the risks that she was exposed to when an attempt to repair the fracture was undertaken.

As I have already found in the case of the two physiotherapists their focus, which was candidly acknowledged, was on the assessment of the degree of Edna's mobility and not the reasons for that immobility. Their lack of understanding of the nature and manifestations of hip fractures as well as their reticence to try and identify the reason for Edna's immobility and to question the decisions of medical practitioners was, for Edna, unfortunate.

Comment:

I consider that it is necessary to make an additional comment about the professional attitude of Dr Darus-Mustapha. It is troubling that at no stage in the evidence before DSC Forbes or myself was she prepared to accept that, notwithstanding whatever physical she undertook of Edna, in it would have been preferable for her to order a pelvis and hip X-ray in order to exclude the

possibility that her clinical assessment was wrong. This shows a very troubling arrogance for a relatively young and inexperienced medical practitioner.

The attitude of Dr Darus-Mustapha is to be contrasted with the attitude expressed by the more senior practitioners who gave evidence.

Professor Rosenfeld said that clinical judgement is imperfect and that is why one relies on radiological tests.

Dr Drummond agreed that it was prudent medical practice to get an X-ray. He said:

> *The first thing you do is have a hip x-ray of a little old lady with a sore hip.*

Associate Professor Raftos was most eloquent on the subject. He said;

> *I would have done a hip x-ray because I don't trust physical examination. You can have a normal physical examination and still have pathology. My experience is that I trust physical examination less and less. The only definitive test is an x-ray. Physical examination is helpful ...If it's negative, it doesn't necessarily rule out the pathology...I would have done an x-ray anyway.*
>
> *I'm old enough to know that physical examination isn't always correct...*

Section 82 Recommendations:

Given my findings in this matter it is appropriate that I give consideration to whether or not the making of recommendations is necessary or desirable. In summary I have found that the care provided to Edna whilst a patient at KDH was less than what might reasonably be expected and that it is more probable than not that those failings that occurred contributed significantly to her death. Correcting the failings that have been identified would be in the public interest.

It is comforting to note the evidence of Dr Michael Ryan, Network Director Medical Services for the Mid North Coast Local Health District (MNCLHD). KDH is a hospital within the jurisdiction of the MNCLHD. Dr Ryan sets out in his evidence the changes in policy and the education undertaken that the MNCLHD has implemented since Edna's death. Having regard to that evidence and the time that has elapsed since Edna's death I do not consider that it is necessary or desirable for me to make any recommendation to the MNCLHD.

Paul MacMahon

Deputy State Coroner

5 December 2014