STATE CORONER'S COURT
NEW SOUTH WALES

Inquest:	**Inquest into the death of SHONA HOOKEY**
Hearing dates:	27-29 June; 5-6, 14-15 December 2016
Date of findings:	22 December 2016
Place of findings:	State Coroner's Court, Glebe
Coroner:	Deputy State Coroner H.C.B. Dillon
File number:	2013/221800
Keywords	**CORONERS** – Cause and manner of death – Hospital death – Disabled patient unable to speak – Undiagnosed twisted bowel -- Whether response at care facility was appropriate – Whether response at hospital was appropriate -- Whether patient could have survived if response different – Improvements to systems
Representation:	Mr A Casselden SC (Counsel Assisting) instructed by Ms P Ava-Jones & Ms J Wardle (Crown Solicitor's Office) Mr M Fordham SC instructed by Curwoods Lawyers (NSW Ambulance Service) Mr J Brock instructed by Mr R Martig-Prym, Legal Aid Commission (Hookey family)

Mr N Dawson instructed by Ms J Graham, Nurses and Midwives Association (RNs Jordan & Jones)

Ms J Sandford instructed by Ms V Stojkova, Hicksons Lawyers, (Dr Mestrige)

Ms A Horvath instructed by Ms K Stewart & Mr John Vijayaraj, Henry Davis York (South West Sydney Local Health District)

Mr M Lynch instructed by Ms N Hali, Dept of FACS (Dept of Family and Community Services)

Mr D Barrow instructed by Ms C Williams, C Williams Legal (Mr K Pritchard)

Ms A Wood, Able Defence Lawyers (Ms R McCormick)

Mr H Chiu instructed by Mr L Bush, Makinson D'Apice (Ambulance Officers McAlpine, Gruar & Booth)

Findings: I find that Shona Hookey died on 19 July 2013 at the Campbelltown Hospital, New South Wales due to peritonitis, which was due to ischaemia of the bowel caused by gastrointestinal torsion (twisted bowel).

Recommendations: I recommend that the South Western Sydney Local Health District review record-keeping practice and procedure in the Campbelltown Hospital Emergency Department with a view to ensuring that contemporaneous clinical records are made by staff and that those staff are provided with the means to do so with a minimum of inconvenience.

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Reasons for Decision

Introduction

1. Shona Hookey was a young Aboriginal woman who died in the Emergency Department of the Campbelltown Hospital on 19 July 2013. She suffered from severe intellectual disability and had a history of epilepsy, stroke, right side hemiplegia and other conditions. Because of her conditions, she lived in a group home managed by the Department of Family and Community Services and her affairs were managed by the NSW Trustee and Guardian. Her death raises serious issues that are discussed in further detail below.

2. Although much of this inquest was spent exploring medical and social issues, Shona is not a mere statistic or a symbol of tragedy. All who participated in this inquest recognise that she was a person who left behind a family who loved her and who continue to mourn and miss her. They are, naturally, deeply saddened but also confused by the loss of Shona at such a young age.

3. It must also be acknowledged that Shona's death also deeply affected those who cared for her at the Plane Tree group home where she lived.

4. Although I make that acknowledgment, this case, unfortunately, raises serious issues concerning the quality of the care that Shona received at the group home and the hospital on the day of her death.

The coroner's functions

5. A coroner investigates sudden and unexpected deaths. This is one way that our society demonstrates its respect for human life and for the families who lose loved ones in such distressing ways. In carrying out such inquiries, coroners hope to provide some peace of mind to grieving families and distressed communities by reducing their confusion about how and why such a death occurred. If we understand what happened, we may have a chance of reducing the risk of it happening again.

6. The basic task of a coroner is to establish, if possible, the identity of the deceased person, the date and place of the person's death; and the cause and circumstances of the person's death.

7. There is no controversy in this case as to Shona's identity, the date or place of death. We also have clear evidence concerning the physical cause of her death.

8. The real questions in this inquest therefore concern the circumstances of Shona's death.

9. A secondary but equally important coronial function is to make any recommendations considered necessary or desirable in relation to any matter connected with this death. In formulating its recommendations, the court has had the benefit of the evidence of people involved in Shona's care, independent clinical experts and others.

10. The coronial process is not designed to find scapegoats to blame, nor to make judgments about legal liability or guilt or innocence, but to uncover the factors contributing to a sudden and unexpected death and to learn anything that might prevent such a tragic outcome in the future.

11. Nevertheless, in coming to such findings, in some cases it is necessary to identify human error or failures to perform adequately or appropriately. This is done not with the purpose of shaming or humiliating individuals, who are usually well aware of their mistakes, but so that the appropriate lessons can be learned and problems addressed. It is done with a view to mitigating the risks of such errors or failures causing further similar deaths in future. This is such a case.

The issues

12. The medical evidence that Shona died of peritonitis (infection in the abdomen) due to an ischaemic bowel (death of tissue in the bowel) caused by twisting of the bowel is not controversial. The circumstances of Shona's death raise the following questions:

- Did Shona receive appropriate care and treatment from Plane Tree Group Home?
- Are appropriate systems in place to escalate care at Plane Tree Group Home for residents showing signs of ill-health?
- Did the ambulance officers manage Shona appropriately?
- Did Shona receive appropriate care and treatment from Campbelltown Hospital?
- Are there any recommendations that are necessary or desirable to make in relation to any matter connected with the death?

Shona Hookey

13. Shona was the daughter of Victor and Robyn Hookey and she had eight siblings. Despite her disabilities, or even, perhaps, because of them, she was much loved by her family and it was evident that those carers who knew her well had a great deal of affection for her.

14. She was, unfortunately, so severely disabled that she was unable to speak. Her inability to speak had significant consequences on 18 and19 July 2013 because she was unable to provide a history that might have led to her ultimately fatal condition being recognised in time to save her life.

15. At earlier times in her life it seems that her condition had caused her frustration or suffering that resulted in what were described by some as 'behavioural problems'. But by 2013, according to evidence received in the inquest, these issues had subsided as they became better managed by an improved medical regime. Although this had not caused her serious harm in the past, Shona, had a history of ingesting foreign objects. Both these elements of her history became important on the day of her death. How they became so I discuss in greater detail below.

16. Shona's daily routine was to attend Macarthur Disability Services (MDS) in Camden from 9am to 3pm where she engaged in activities and programs suitable for her with other people before returning home to Plane Tree.

17. Shona's parents, in their personal statement about her, told the court that after Shona had gone into care they lost touch with her due to confusion as to where she had been taken and the complexities of the system they were dealing with. This was not known to me before the inquest and we did not explore the circumstances as they were not relevant to the circumstances of Shona's death. But it is another sad aspect of Shona's life and death.

What happened at Plane Tree?

18. As usual, on 18 July Shona attended MDS in the morning. Nothing unusual was noticed about Shona's behaviour or demeanour at MDS before she left for the day. At 1.30pm, she had a medical appointment with her neurologist, Dr Neil Griffith, in Campbelltown. She was accompanied by two carers, Mr Kenneth Pritchard and Ms Rosemary McCormick to this appointment. At the doctor's rooms she became distressed and began to cry. This was observed by both carers who brought it to the attention of Dr Griffith when he saw Shona.

19. Dr Griffith examined Shona and found that she was highly agitated and distressed, her shirt was ripped and she was drenched in sweat. He could not identify any physical or psychological trauma that might have caused this level of distress. Over the course of the consultation she settled partially. He recommended to the carers that if she did not improve within the next 30-60 minutes, they take her to the Campbelltown Hospital to be examined to exclude any physical cause of her agitation such as urinary tract infection or respiratory infection. Shona left with her carers and that plan.

20. According to Mr Pritchard and Ms McCormick, Shona appeared to calm down somewhat during the afternoon. The carers therefore became less concerned about her and did not take her to hospital.

21. At about 5.30pm, however, when Shona was about to have dinner, she became quite distressed and agitated again. She did not eat dinner and wandered around before lying on the floor on her back and banging her head. She was making noise and crying some of this time. She was given paracetamol for pain relief by Ms

McCormick. At one point Ms McCormick took some video of Shona because she was concerned but also puzzled by Shona's behaviour. She intended to show this to Ms Natasha McFarlane, the team leader, to explain Shona's behaviours that evening.

22. Ms McCormick went home at between 9 and 10pm. When she left, Ms McCormick Shona was still in much the same condition but Ms McCormick thought that the pain relief was having some effect. At about 10.20 pm, she called Mr Pritchard, who had remained at the group home waiting for the night shift. According to Ms McCormick, Mr Pritchard said that he would wait for the night shift before deciding what to do next for Shona.

23. The night shift worker was Ms June Hakiwai. She had cared for Shona for about 15 years. She arrived at Plane Tree at about 10.45pm. As she opened the door, she heard Shona crying. She saw Mr Pritchard in the kitchen and said, 'What's going on?'

24. Mr Pritchard replied, 'We've had a bit of a dilemma with Shona.' When Ms Hakiwai asked him why he had not called an ambulance for her, he told her that he had been waiting for a senior staff member to arrive to give direction. Ms Hakiwai called Ms Natasha McFarlane, the team leader, and told her that something was wrong with Shona. Ms McFarlane responded immediately and set off to Plane Tree. Ms Hakiwai then called '000' for an ambulance.

25. At this time, Shona was on the ground, banging her head, was very pale and could not support her own weight when standing. She was moaning and was very cold to the touch.

26. Soon afterwards, Ms McFarlane arrived and was shortly followed by an ambulance with two paramedics.

27. Mr Pritchard, although an experienced Disability Support Worker, was relatively new to Plane Tree on the day that Shona became fatally ill. He had known Shona only a few months and found her behaviours that day confusing and ambiguous. He sought information and guidance from Ms Rosemary McCormick, his fellow Disability Support Worker at Plane Tree during most of his shift. He relied on her to manage Shona during the afternoon and evening but, when she left, appears both to have felt concern for Shona and lost as to what to do.

28. Giving evidence, he was clearly upset and remorseful that his indecisiveness and inaction had contributed to Shona's suffering and possibly to her death.

29. Ms Rosemary McCormick knew Shona much better than Mr Pritchard did. She had greater depth of perception of Shona's state of mind and realised that Shona was suffering. Nevertheless, she failed to take effective action. By the time she left the group home at the end of her shift she had worked a double-shift of about 16 hours. In all probability by evening she was tired and her judgment may have been impaired as

a result. Evidence was given by her colleague Ms Hakiwai that Ms McCormick is a very good person and a thoroughly decent carer and I have no reason to doubt this.

30. Shona had been very agitated when she had seen Dr Griffith. She had then appeared to improve for some time but in mid- to late afternoon was once again very distressed. Dr Griffith's advice to the carers had been to take her to hospital if she did not improve. Whether the apparent improvement somehow confounded them and resulted in confusion and indecision is hard to know. But the evidence from carers who knew Shona best is that in July 2013 rolling around on the floor and banging her head and other such signs of distress were not normal behaviours for her. In any event, her distress was obvious and needed to be addressed urgently.

31. For reasons that are difficult to fathom, nothing was done to have her checked physically or even to provide fully effective pain relief for hours. Although the Panadol Shona was given seemed to have a slight effect, it clearly did not relieve her distress which was unusual. Although they both had concerns for Shona's well-being, and had been given advice to take her to hospital if she did not improve, Mr Pritchard and Ms McCormick failed to respond as they should have. While the situation was confusing for them, it was also obviously troubling enough for Ms McCormick to take a short video recording. This should have prompted a more urgent response.

32. This indecisiveness raises the question why good, experienced people acted so helplessly in Shona's crisis. A number of possible answers suggest themselves: first, Dr Griffith's examination of Shona may have planted the suggestion in Ms McCormick's mind that Shona's pain was emotional rather than physical. Her previous history may have also contributed to their misinterpretation of the gravity of Shona's situation.

33. Second, neither Ms McCormick nor Mr Pritchard had ever called an ambulance before. But they both knew that if they did and Shona was taken to hospital an on-call staff member would have to come to Plane Tree to relieve the Disability Support Worker who accompanied Shona to hospital and this would result in roster changes and consequent inconvenience. To what degree, if any, institutional inertia and pressure therefore affected their judgments is hard to say but it may have played a part.

34. Third, their training appears to have failed them. The protocols they were meant to abide by were well-formulated and, had they been followed, would have resulted in Shona being taken to hospital much earlier in the day. If Disability Support Workers do not, under sudden pressure, know how to respond to a crisis that has been considered and planned for by departmental policy makers, this suggests a managerial or systems failure has occurred.

35. Fourth, it may also be that, due to years of exposure to 'behavioural problems' on the part of residents in group homes, these two workers had effectively become

desensitised to the potential significance of such behaviours and, perhaps, to signs of physical distress and suffering. One reason may have been that their experience had taught them that noisy and even self-damaging behaviours on the part of the people they were caring for usually concluded when the client had exhausted him- or herself. They may have been taking the approach that parents sometimes do when over-tired babies cry until they go to sleep.

36. Because in evidence they did not explain their own thinking very well the search for an explanation of what seems inexplicable behaviour on the part of the carers must remain to a large degree speculative. The explanation was not, however, callousness or some form of moral turpitude.

37. The failures by Mr Pritchard and Ms McCormick to make timely, effective decisions also raises the question of how decision-making by Disability Support Workers can be improved in such circumstances. The fundamental difficulty that they faced when confronted with a problem that was unfamiliar to them was that they could not recognise a pattern in Shona's behaviour that guided them towards the solution of the problem. Because they could not recognise the problem, they felt unable to work towards a solution. In such a situation, however, that very confusion should have triggered a better response – to call for help. I am advised that both Ms McCormick and Mr Pritchard are very conscious of this now.

38. The Department of Family and Community Services (FACS) has good protocols to guide Disability Support Workers in a structured way towards recognising problems that require action. In this case, however, there appears to have been a 'disconnect' between the policy document and the Disability Support Workers' response to Shona's grievous pain.

39. It is a common fallacy that providing information to people constitutes training. If the mere provision of information could impart skills, we could learn to drive a car or fly a plane by reading a manual. Information and skills are different things. Skills are learned by practising them so that experience is built and laid down as memory which can be drawn on in future. I understand that training and supervision have been carefully reviewed by FACS with this and other cases in mind.

40. Although the response of Mr Pritchard and Ms McCormick fell short, both Ms Hakiwai and Ms McFarlane's responses cannot be faulted. Once Ms Hakiwai was in control an ambulance was quickly on its way. Unfortunately, once the ambulance arrived, Shona's troubles were not over.

Paramedical and medical interventions

What was Shona's condition when the ambulance arrived?

41. Two paramedics, Ambulance Officers Sarah McAlpine and John Gruar, attended Plane Tree and managed her throughout most of the period she was at Campbelltown Hospital. The ambulance crew were alerted at 10.50pm by their control room and arrived at Plane Tree 16 minutes later.

42. Ms McAlpine had primary responsibility for patient care and Mr Gruar was the driver and had primary responsibility for logistics and communications with the Ambulance Service control room. Ms McAlpine made handwritten notes soon after the event. While during her oral evidence at the hearing her memory appeared in some respects to be defective, probably due to the passage of time, her written notes were made when the events were fresh in her mind. Some of her Ambulance Electronic Medical Record notes were made at an early stage and others were recorded later in the night. All, however, were made within a short time of the event.

43. She recorded a number of highly significant observations and impressions. She was told by a woman carer that Shona's behaviours were 'extremely unusual'. She palpated Shona's stomach and found it to be 'rock hard'. She noted that Shona was 'grey' in the face and that her limbs were 'yellow'. Shona had a sweet-smelling breath which Ms McAlpine thought from her experience was a sign of unwellness.

44. The observations that Shona was 'grey' in the face and cold, and that her abdomen was rigid when the ambulance arrived, is corroborated by the evidence of Ms McFarlane. In a file note made three days after Shona's death, Ms McFarlane recorded that when she got to Plane Tree 'Shona was a white grey colour and cold'. In her statement to the police investigators, she also said that on her arrival she had found Shona on the floor, rolling around attempting to sit up but unable to. In order to stop Shona from hurting herself, Ms McFarlane got down on the floor and hugged her. Shona was arching her back and Ms McFarlane noticed at this time that Shona's stomach was 'rock hard and looked swollen'.

45. As Shona was highly agitated and resisted being touched, it was not possible for Ms McAlpine to take a blood pressure reading. (Given her agitated state this may have been misleading anyway.) It was also impossible for Ms McAlpine to obtain a peripheral pulse for this reason. Shona was in 'obvious pain', she was passing wind, her limbs were cold to the touch, she had a coated tongue, and Ms McAlpine thought she may have been dehydrated. Her temperature was slightly low and Ms McAlpine thought she may be suffering from mild hypothermia. (It was winter time and Shona had been lying on the Plane Tree floor for hours so this may have contributed to her low temperature.)

What happened on arrival at the hospital?

46. Although Ms McAlpine was unable to remember this, on arrival and during the period she and Mr Gruar managed Shona, the evidence shows that there were a number of ambulances in the ambulance bay. The Emergency Department at Campbelltown Hospital that night was extremely busy, resulting in 'trolley block'. This is a back-up of patients on ambulance stretchers awaiting the availability of a bed in the hospital. 'Trolley block' is apparently a common phenomenon in Emergency Departments in all public hospitals during winter evenings. It is fundamentally a resource issue but it is also a management issue. Other terms for this phenomenon are 'access block' and 'bed block'.

47. The evidence suggests that this was, however, an exceptionally busy night at the hospital and that 'trolley block' was, therefore, unusually heavy. This is borne out by the fact that Shona remained on her trolley for nearly two hours and was only briefly examined by a doctor while she was on the trolley, not in the Emergency Department itself, until she 'crashed'.

48. The triage nurse on duty that evening was Registered Nurse K'sandra Jordan. On arrival of an ambulance, the triage nurse would attend the ambulance bay to speak to the paramedics and make her own assessment of the patient for triage purposes. RN Jordan saw the paramedics and spoke mainly to Ms McAlpine. She also conducted a brief examination of Shona.

49. Her triage notes record the following:

> From group home in Narellan. Severely developmentally delayed. [History] of ingestion of [foreign bodies]/substances. Today staff state unwell, crying out, ? in pain. [On examination] Appears to be in distress, abdomen tight, ?distended. Unable to attended observations due to distress.

50. RN Jordan initially assessed Shona as being in triage Category 3, meaning that she was not in immediate danger and should be seen by a doctor within 30 minutes. In her evidence at the inquest, however, she said that, because of Shona's distress, she in fact treated Shona as a Category 2 patient and that Shona was seen by a doctor within about 10 minutes. The triage category was never upgraded to Category 2 in the records.

51. Professor Sally McCarthy, Associate Professor Richard Cracknell and Associate Professor Randall Greenberg, emergency medicine consultants, provided expert reports and gave evidence concurrently before me regarding Shona's treatment. All the independent experts said that Shona should have been triaged as a Category 2 patient due to her pain and the fact that significant vital signs had not been recorded. There were, however, differences of opinion among the independent emergency specialists who gave evidence in the inquest as to the significance of this failure to upgrade the category.

52. Professor Sally McCarthy was critical. She emphasised that triage categories are not just about the time in which a patient should be first assessed by a doctor. Citing the Australian College of Emergency Medicine's guidelines, she stated that urgency in triage is about 'how quickly a patient needs to be seen in order to initiate treatment and prevent deterioration or further pain and suffering'. Associate Professor Richard Cracknell and Associate Professor Randall Greenberg both thought that Shona was in fact a Category 2 patient but placed less emphasis on the importance of getting the category right than Professor McCarthy. A/Professor Greenberg said that there is 'no magic' in the difference between Category 2 or 3.

53. While I accept that there may be, as A/Professor Greenberg says, 'no magic' in assessing a patient as being in Category 2, this seems to me to underestimate the subtle psychological influence of triage categories. All the experts agreed that cognitive biases, such as 'confirmation bias', 'anchoring' and so on, are well-known causes of misdiagnosis or inadequacy of medical response.[1] If a very busy emergency physician knows that an experienced triage nurse has looked at a patient and thinks that she is a Category 3 patient, might this not influence his own assessment of the patient? Might it not suggest to the physician that this person probably does not need as much attention or urgency of intervention as other patients triaged in Categories 1 or 2? Indeed, under cross-examination, Dr Dinusha Mestrige, the treating doctor, conceded that he had placed a certain amount of weight upon the triage category assigned to Shona. Triage categorisation, therefore, is not just a question of *when* a doctor looks at a patient but *how* he or she does so.

54. There were significant discrepancies between the evidence of Ms McAlpine and RN Jordan in relation to some observations and impressions of Shona on this evening. In particular, Ms McAlpine's evidence was that Shona's limbs were cold and that she was peripherally shut down. The ambulance record shows that Shona's temperature was slightly below the normal range. RN Jordan, who did not take a temperature, gave evidence that Shona's limbs were warm to the touch. She did not record this in her triage notes.

55. RN Jordan recorded in her notes, however, that she was able to find a palpable radial pulse. Ms McAlpine's evidence was that it had not been possible for her to find a

[1] See, for example, Tversky, A & Kahneman "Judgement under uncertainty: heuristics and biases: bias in judgments reveals some heuristics of thinking under uncertainty" *Science* Vol. 185, No.4157 (1974); Croskerry, Poovaiah "The Cognitive Imperative: Thinking about how we think" *Academic Emergency Medicine* Vol 7, No.11 (2000); Redelmeier et al "Problems for clinical judgment: introducing cognitive psychology as one more basis science" *Canadian Medical Association Journal* Vol 164, No.3 (2001); Groopman, J *How Doctors Think* Scribe, Melbourne, 2007; Redelmeier, D "The Cognitive Psychology of Missed Diagnoses" *Annals of Internal Medicine* Vol 142, No.2 (2005) 115-120; Weingart, S et al "Epidemiology of medical error" *British Medical Journal* Vol 320 18/03/2000 774-777; and Groopman, J, "Diagnosis: what doctors are missing" *New York Review of Books* Vol 56, No 17 05/11/2009.

pulse. RN Jordan was able to palpate Shona's abdomen but did not find it to be 'rock hard' as described by Ms McAlpine. She thought, however, that it may have been distended and noted this. In her evidence, she said that it was 'firm' but with a degree of softness.

56. RN Kelly Jones was the nurse in charge of beds that night. In a statement to police made in June 2015, she gave evidence that she had seen Shona on the trolley at the time that RN Jordan was conducting her triage assessment and also that she had been through the area in which Shona was being held a number of times later in the night.

57. She stated to police that at triage, Shona had appeared 'alert' and 'well-perfused' with 'no increased respiratory effort'. She said that Shona had been thrashing her arms around and stated that the carer had told her that this was Shona's 'normal behaviour'. She also stated that she had walked through the area where Shona was being held a number of times and that when she saw Shona she had appeared to be 'well-perfused' and 'settled'. In her oral evidence, RN Jones said that when she had walked through the Emergency Department she had looked at Shona and that she had reasonable colour. When asked about what she meant by 'settled', she said that Shona was quiet and appeared to be asleep.

58. My impression is that Ms McAlpine, RN Jordan and RN Jones were honest witnesses doing their best to give truthful, accurate evidence. Given, however, that it is now more than three years since the fatal events, it is unsurprising that memories have faded or become distorted or have been reconstructed in some respects. Human memory is not like a video recorder but is much more fragmentary. Eye-witnesses or participants tend to remember highlights or details of an event but usually cannot present a panoramic narrative or perspective. Indeed, if witnesses are able to present such a broad unbroken narrative, this suggests reconstruction rather than actual memory. Further, time quickly breaks short-term memory down. For this reason, contemporaneous records are usually much more accurate than oral evidence given months or years later.

59. On the question of whether there was a palpable pulse, Ms McAlpine explained that she had not been able to find a pulse due to Shona's agitation. Her recollection is that hospital staff were also unable to find a pulse. RN Jordan's record, however, shows that she did so, although she explained in evidence that this is all she was able to do. She was unable to take a blood pressure reading. The progress notes record that a palpable pulse was found but does not record the rate or any other details about it. In her oral evidence, RN Jordan stated that the pulse had been 'strong and regular'. For reasons I will come to, I am not convinced that the pulse was in fact 'strong and regular'.

60. In relation to other observations concerning Shona's colour, coated tongue, breath, perfusion and so forth, and the history in relation to Shona's behaviour, where there is a conflict between the evidence of Ms McAlpine and RN Jordan it is safer, in my

view, to rely primarily on the contemporaneous records or notes made close time to the events in question, including Ms McFarlane's notes concerning Shona's appearance and demeanour. This is important especially in relation to three particular pieces of evidence.

61. First, Ms McAlpine's notes record that she was told by a carer at Plane Tree that Shona's behaviour was abnormal. It therefore seems highly unlikely that she would have told or implied to RN Jordan, RN Jones or Dr Mestrige that Shona's behaviour at the home or the hospital was 'normal' due to a history of 'behavioural issues' as was claimed by hospital staff. Moreover, Shona was accompanied by Ms McFarlane who knew that Shona's behaviour that night was highly unusual. While it is possible and even likely that a past history of 'behavioural issues' may have been mentioned while hospital staff were trying to take a history, it is not likely that they suggested in any way that this was a normal behaviour for her. The reverse is much more likely.

62. Second, because Ms McAlpine took Shona's temperature and recorded her observations of Shona's facial and peripheral limb colours in her notes, and because she spent much more time with Shona than RN Jordan or RN Jones, and because Ms McFarlane was very familiar with Shona and thought she was very unwell, and because RN Jordan effectively upgraded Shona to a Category 2 patient, and because Dr Mestrige found it difficult to cannulate Shona, and because hindsight has demonstrated that Shona was, in fact, in extremis, in relation to Shona's appearance of unwellness, I prefer the evidence of Ms McAlpine to that of RN Jordan and RN Jones. In my view, when Shona arrived at the hospital, she very probably appeared not only to be distressed and in pain, but very unwell and possibly in shock.

63. The expert witnesses gave evidence that, while it is possible for a patient who is deteriorating to fluctuate in appearance or to the touch, this is not usual and the patient will, in any event, continue in a downward trend. Although it is possible that when RN Jordan and RN Jones saw Shona at triage she felt warm to the touch, and did not appear to be peripherally shut down, I think it is much more likely that she appeared unwell and that, due to Shona's agitation and distress, they were unable to make any accurate assessment of her real condition.

64. Third, Ms Jordan's evidence that Shona had a strong and regular pulse is difficult to accept. All that is recorded in the hospital notes is that the pulse was palpable. Due to Shona's agitation, the rate could not be counted nor a blood pressure taken. Shona was attempting to resist being touched. If RN Jordan was unable to count the pulse rate, she could only have been touching the point at which she felt the pulse for a very short time. Moreover, there is compelling evidence that she was deteriorating and possibly in shock at the time she was triaged. If that is so, and the clinical picture presented by the ambulance records certainly looks that way, Shona was deteriorating and her heart would have been working hard to maintain her circulation as she decompensated.

65. In a patient who is deteriorating the pulse rate tends to increase to maintain blood pressure and the strength of the pulse diminishes with falling blood pressure. Given both Ms McAlpine's contemporary observations, and what hindsight has revealed was Shona's fatal condition, it seems more likely that at triage Shona's pulse was faster and weaker than normal. Unfortunately, because of the difficulties in examining her, some very important vital signs – blood pressure and pulse in particular -- were not assessed at triage.

66. The evidence of RN Jones that she was told by a carer that Shona's behaviour was 'normal' and that she had appeared to be 'well-perfused' and 'settled' cannot be accepted. Where her evidence conflicts with the contemporaneous or near-contemporaneous records, I do not accept that it is reliable. For a number of reasons, her evidence strikes me as being largely a later reconstruction of events based on fragments of memory and her interpretation of the notes.

67. RN Jones was certainly very busy that night and she had a difficult job to perform. She, like all the Emergency Department staff, was under a great deal of pressure. Whatever her hasty observations may have suggested to her at the time, RN Jones was almost certainly mistaken in thinking that Shona did not appear unwell and was 'settled' during her two-hour wait for a bed.

68. Shona's behaviour was not 'normal' that night as Ms McFarlane has made clear. The fact that it was abnormal was noted, as we have seen, in the ambulance record. And Shona was in obvious pain – an abnormal condition in itself.

69. In relation to Shona's perfusion, I can place little weight on RN Jones's evidence. She did not examine the patient. She was not familiar with the patient. She spent very little time with the patient. She had a very busy department to organise and she had no particular reason, according to her understanding of Shona's condition, to pay any particular attention to Shona. An experienced paramedic who spent some hours with Shona had a very different impression of Shona's appearance. So did a carer who knew Shona very well. Those who were with Shona in the ambulance bay say that she remained agitated until she suddenly became quiet. This was not a 'settled' patient but a deteriorating one.

70. Ms Sharon Booth, a senior ambulance officer, was tasked that night with visiting hospital emergency departments to free up ambulances. She arrived at Campbelltown shortly before Shona was moved to the resuscitation bay. On her arrival she spoke to the paramedics minding Shona, quickly assessed Shona as being unwell and needing to be escalated, then went into the department to raise the paramedics' concerns. This too contradicts Ms Jones' fleeting observations and impressions.

71. Moreover, the objective evidence is that Shona died of peritonitis due to a twisted bowel. The onset of this condition was probably at about the time she was seen by Dr Griffith approximately 10 hours before her arrival by ambulance. She had not been

treated and the condition did not spontaneously resolve. She was therefore slowly deteriorating all afternoon and into the night, becoming more and more septic once the bowel became ischaemic and inflammation and infection set in. As this very dangerous condition was not treated, it seems likely that signs of deterioration, such as the coldness to the touch, and the grey and yellow colouring noted by Ms McAlpine, had not altered by the time she arrived at the ambulance bay and did not improve in the course of the night as she lay on the trolley with her pain unrelieved.

Dr Mestrige in the ambulance bay

72. According to RN Jordan, after triaging Shona, and after a conversation with Shona's carer, she spoke to Dr Mestrige because she was concerned about Shona's level of distress. When, exactly, RN Jordan spoke to Dr Mestrige, and he consequently examined Shona, is not clear from the records. RN Jordan believes that it was within about 10 minutes of her original triage assessment. RN Jones, in her witness statement, says that she saw Dr Mestrige with Shona inserting a cannula and take blood samples. She estimated this to have been about 10 minutes after RN Jordan had triaged Shona. In his witness statement to police Dr Mestrige did not provide a time at which he saw Shona in the ambulance bay and neither do his retrospective progress notes assist in this regard. Ms McFarlane, however, told the police investigator that the ambulance had not been long in the bay when a doctor attended on Shona.

73. It is common ground that Dr Mestrige quickly assessed Shona and, after a number of attempts, inserted a cannula in her foot. He took blood samples and ordered an x-ray. He did not, however, order pain relief or fluids at that time.

74. The failure to provide pain relief was strongly criticised by all the independent experts. Dr Mestrige was vague in his evidence concerning the degree of pain he thought Shona had been suffering at that time. He made no notes until a considerable time later, he did not know the patient and Shona was unable to express her degree of pain to him. When it was put to him that he could have provided pain relief he conceded that he may have been able to. He was adamant, however, that intravenous analgaesia would have been out of the question due to issues of patient safety. The experts all gave evidence that it would have been appropriate in the circumstances to relieve Shona's pain in the ambulance bay with a low dose of morphine or fentanyl. The latter drug does not reduce blood pressure the way morphine can. It can be given intra-muscularly.

75. The second main shortcoming of Dr Mestrige's performance identified by the experts in the ambulance bay is that, despite the fact that Shona was distressed – and he could take RN Jordan's word for that – and that it had been impossible to record important vital signs, especially blood pressure, Dr Mestrige did not escalate Shona's case so that the vital signs could be checked in a safe environment. Because of the lack of information concerning Shona's vital signs, he was not able to form anything like an accurate assessment of her condition.

76. Thirdly, although there is compelling evidence that Shona looked unwell, was distressed, was not behaving normally, and that Ms McFarlane had raised concerns with RN Jordan that Shona's condition required attention, Dr Mestrige appears to have given greater weight to a past history of ingestion of foreign bodies than to presentation of the patient in front of him and the carer's concerns.

77. In his evidence at the inquest, he said that the history he was given of Shona ingesting foreign objects and past 'behavioural issues' became his working diagnosis subject to further investigations that he commenced. As it turned out, this was a classic case of a cognitive error leading a physician down the wrong pathway. In the absence of Shona being able to provide her own history, this history was relied on. It was both true but misleading. It was probably because he fixed on this explanation for Shona's presentation that his assessment was not as thorough as it might otherwise have been. It may also be the explanation for his failure to provide pain relief there and then. But as Professor Sally McCarthy, one of the experts, pointed out, a diagnosis was not the important issue. An unwell patient had first to be properly assessed and the diagnostic pathways followed.

78. It is a medical cliché that those who know the patient best are able to tell when they are unwell and that their concerns ought to be given great weight. Probably because Dr Mestrige thought that the history he had been given provided a reasonable explanation of Shona's condition, he gave insufficient weight to Ms McFarlane's concerns or to Shona's physical presentation. This was a significant lapse of judgement.

79. Fourthly, although RN Jordan and Ms McAlpine had palpated Shona's abdomen, Dr Mestrige did not make an even rudimentary attempt to do so. His explanation was that to examine her abdomen was impossible because of the lack of privacy in the area in which he saw Shona. I accept that, for privacy reasons, he could not expose Shona but I find it surprising that he did not attempt to feel her abdomen through her clothing. RN Jordan evidently thought that this was important to do and that her findings were significant enough to record. It is not clear why it was possible and reasonable for RN Jordan to do so but not for him. In fairness, this omission is less significant than the others because he knew that RN Jordan had palpated Shona's abdomen and found that it was possibly distended.

80. In my view, the evidence that, on arrival and at the time Dr Mestrige saw her in the ambulance bay, Shona was obviously unwell and in pain, and probably exhibiting some of the signs of developing shock, as well as of a distended abdomen, is compelling.

81. The experts differed in the degree or intensity of their criticism of Dr Mestrige's performance at this point. But all agreed that his performance was sub-optimal.

82. Professor McCarthy identified a number of specific issues that she considered raised serious concerns about his performance at his first examination of Shona. In her view Dr Mestrige's performance at this point was poor because:

- He did not summon additional assistance and initiate early appropriate management for Shona;
- He did not commence the interventions and resuscitation required as soon as possible when he first saw Shona;
- He did not establish good intravascular access with an intraosseous needle to enable rapid early fluid resuscitation when faced with difficulties in establishing IV access in a patient with unrecorded blood pressure;
- He did not commence fluids once the IV access was established;
- He did not administer appropriate analgaesia to relieve Shona's distress and improve the capacity to obtain vital signs.

83. A/Professor Cracknell agreed with most of these points, although he was doubtful that Dr Mestrige should be criticised for failing to call for additional assistance. But he made the wider point that, in the circumstances, Dr Mestrige was 'very dependent on the whole clinical team'. He thought that Shona had been unwell on presentation but that the whole clinical team had failed to recognise how very unwell she was.

84. A/Professor Greenberg took a similar view. He made the point that this was 'not a straightforward case'. Dr Mestrige faced a number of considerable challenges, perhaps the most difficult of which was that Shona could not herself describe her symptoms. In his report he identifies things that could have been done much better by Dr Mestrige but stated, 'this is not necessarily a performance issue… but more likely his decisions were affected by "human factors" – multiple distractions, difficulty of cannulation and a lack of beds initially. These factors cannot be under-estimated.'

85. My impression is that Dr Mestrige's assessment of Shona was probably influenced by four external factors: (a) he was overwhelmed with work -- he had numerous cases to manage, only junior doctors to help him and a large number of decisions to make; (b) despite RN Jordan's notional re-categorisation of the case to a Category 2, he had been informed that she was a Category 3 case; (c) he had a possible (but, as it turned out, misleading) explanation for Shona's condition that suggested that it was unlikely to be life-threatening; and (d) if RN Jones is correct rather than the hospital census records, he did not have a bed for Shona at that time. (The hospital records indicate, I think probably incorrectly, that two resuscitation beds were available at about this time.)

86. If I am correct, these four factors may have influenced Dr Mestrige to think (or hope) that Shona was not in immediate danger and could wait. To have escalated Shona's

case would have certainly created even more strain on an over-stretched department. In such circumstances, it would be natural for a very busy clinician, conscious of the burden he and his colleagues were already dealing with, not to add further to that strain immediately.

87. A twisted bowel, or more accurately, bowel volvulus, was one of the less likely diagnoses of Shona's condition. But, as Professor McCarthy pointed out, 'it is not necessary to know the definitive diagnosis to provide appropriate intervention, and the approach to any patient with acute abdominal pain and shock follows the same clinical pathway, with specific investigations and management occurring after initial resuscitation'.

88. To be fair to Dr Mestrige, while he was in the ambulance bay, he did initiate some investigations. But the key point here is that before those investigations have produced results that point to a more definitive diagnosis, emergency physicians are unwise if they jump to convenient conclusions based on incomplete information. As Professor Gordion Fulde has written, one of the 'laws' of emergency medicine that doctors should bear in mind is that 'All patients are trying to die before your eyes'[2]. Therefore, until the results come in, doctors should include worst-case scenarios in their approach to seriously unwell patients.

89. As I have noted, Professor McCarthy is more stringent in her criticisms of Dr Mestrige's performance than either of her colleagues. A/Professor Greenberg, very candidly, stated in his evidence that 'we have all been there'. The deeper question that this divergence of views among senior clinicians raises is not so much whether an individual doctor erred or failed but whether it is acceptable that when pressure mounts on emergency department clinicians, departments and hospitals that standards of performance decline.

The problem of escalating Shona's case

90. The evidence in relation to escalation of Shona's care while she was on the ambulance trolley after Dr Mestrige had seen her there sometime around midnight is in conflict. The nursing staff complained that the paramedics did not escalate Shona's case by bringing their concerns to their attention. RN Jones stated that she had walked through the ambulance bay several times while Shona was being held on a trolley and no one raised their concerns with her.

91. RN Jordan gave evidence that after 11pm the triage nurse is stationed at the front of the hospital near the waiting room dealing with patients who walked in. She said that she would go to the ambulance bay from time to time. Other evidence was given that, in 2013, arriving ambulances could use a bell to notify the triage nurse of their

[2] "The seriously ill patient: tips and traps" in Gordion WO Fulde, *Emergency Medicine: The principles of practice* (5th ed) (Sydney: Elsevier, 2009) p.352

arrivals. Evidence was also given that there is a telephone in that area that could be used. Paramedics also have radio contact with their control room and are able to call their control room, or presumably use their phones to call the hospital switch board.

92. The complaint that it was the paramedics who failed to escalate Shona's case was contradicted by Mr Gruar who gave evidence that Ms McAlpine had a number of times sought the attention of the nurses. Ms McAlpine in turn contradicted him and said that she had only tried once.

93. Her complaint, however, was that the nursing staff had effectively abandoned them. She said that because Shona was writhing on the trolley it had been too dangerous for the paramedics to leave and look for a nurse because Shona may have unbalanced the trolley and fallen. She said that the triage station near the ambulance bay was vacant and that 'no one came near us'. (This obviously contradicts Ms Jones's evidence that she walked through the area several times while Shona was on the trolley.) She also said that she could not ask Ms McFarlane to go to find a nurse or to assist Mr Gruar to hold Shona on the trolley because these were the responsibilities of the paramedics.

94. Whatever the explanation for the delay on that night, it appears to have been Ms Booth's intervention that resulted in Shona's case being escalated within the department. But for that, Shona may have died on the trolley.

95. That situation should not have arisen. If Shona was seen by the paramedics to be deteriorating, or if they had real concerns about the length of time it was taking for her to be moved to a bed, notwithstanding the ultimate responsibility of the hospital staff for Shona, it was incumbent on them to raise those concerns with the nursing staff. The picture presented at the inquest by the paramedics was of being left helpless and abandoned due to 'trolley block' in the ambulance bay. In my view, however, means were available to them to escalate Shona's case and it would be unfair to the nursing staff to find that Shona had been left to her own fate by them.

96. Ms McAlpine, in particular, appeared to me to be an experienced and intelligent professional with a genuine sense of compassion for Shona. I accept that she was concerned for Shona's welfare and was worried about aspects of the performance of the Emergency Department staff. It is therefore puzzling that more was not done by her or by Mr Gruar to bring their concerns to the attention of the nursing staff more urgently.

97. Professor McCarthy gave evidence that once a patient has arrived at an emergency department by ambulance, the hospital staff has ultimate responsibility for the care and management of that patient.[3] She noted that 'Ambulance officers have little

[3] NSW Health "Emergency Department Patients Awaiting Care" PD2010_075 22 December 2010 at [2]; "The Delayed Ambulance – Continuation of Care" SOP2009-066, File No 07/718 (D09/11414); and Australasian College for Emergency Medicine "Statement on Responsibility for Care in Emergency Departments" S18 (March 1999, updated 2012) at [3]-[4].

power in an ED, particularly in an ED where there is an expectation that they just have to wait and the hospital refuses to accept responsibility for the patients'.

98. Nevertheless, Mr Paul Tonge, the Acting Manager for Sustainable Access and Patient Flow in the NSW Ambulance Service stated in evidence that his expectation is that if paramedics have concerns about their patients, they would find ways of escalating cases. His evidence was that this is well understood by trained paramedics. I accept that this was the expectation of the nursing and medical staff at Campbelltown Hospital while patients were still on ambulance trolleys, and it was a reasonable one, especially on a very busy night in the Emergency Department.

99. In my view, however, there were shortcomings on both sides of this dispute. But, because the ultimate responsibility for care of patients lies with the hospital, including the responsibility of taking over the care of patients from paramedics in a timely fashion, the greater responsibility lies with the Campbelltown Hospital.

Shona crashes – the resuscitation effort

100. Ms McFarlane gave evidence at some point during the night she had observed Shona 'go quiet' on the trolley and stop moving around. She said that Shona would occasionally 'jolt' but otherwise lay still. She had stopped responding. Shortly afterwards, it seems, Shona's case was escalated. This was probably at about 1.20am.

101. In relation to the quality of the resuscitation effort, the evidence is once again in conflict and the hospital records are of uncertain reliability. Some of the evidence suggests that Shona received less than optimal or appropriate treatment; other aspects of the evidence suggests that a genuine and sustained effort was made to care for and resuscitate Shona after she 'crashed'.

102. Dr Mestrige's initial statement to police concerning the resuscitation provided only minimal information about what happened during the hours between Shona being taken to the resuscitation bay and her death. He told police that while Shona was in the ambulance bay 'she had apparently deteriorated' and he was asked to review her in the resuscitation area. She had appeared unwell and it was 'difficult to obtain her vital signs, including blood pressure and saturation'. She was gasping, had a 'very rigid abdomen' and appeared to be a surgical case. While he and the nurses were trying to stabilise her she went into cardiac arrest. He says that she was intubated, ventilated and CPR was 'continued'. He said that in this period Shona was reviewed by both the surgical and intensive care registrars and, 'after discussion with ICU/Emergency consultants, it was decided to continue resuscitation, but if she goes into cardiac arrest again not to recommence CPR'. He said that, using adrenaline, they were able to regain cardiac output but that Shona arrested a second time and the effort to resuscitate her ceased then.

103. In a second statement, Dr Mestrige provided further detail. He said that he estimated that he had been called urgently to the resuscitation bay at about 1.30am. The hospital computer system shows that she was moved there at 1.17am. The ambulance records suggest that she was moved off their trolley at 1.25am. According to the hospital computer records, x-rays were taken in the bay at 1.25am and a report was received at 1.44am.

104. He said that at this stage Shona was developing bradycardia (a slow heart rate), her breathing was irregular, her blood pressure was unrecordable and her oxygen saturation levels were difficult to obtain. She also had a low Glasgow Coma Score of 6-7 (down from 12 on arrival at the hospital).

105. He said that Shona went into cardiac arrest about two or three minutes after her arrival in the resuscitation bay. He says that CPR was immediately commenced and that he intubated Shona to provide oxygen and also that he inserted a femoral line because he did not think that the cannula in her foot was sufficient. He also requested the surgical and intensive care registrars to see Shona. At about this time he telephoned the on-call Public Guardian officer. He said that he did so to check whether there was any Advanced Care Directive for Shona. He also said that throughout this time the resuscitation effort continued.

106. His account was that after about 30 minutes of resuscitation, Shona's heart beat was regained but she remained unstable and could not breathe unaided. Her cardiac output remained low as did her blood pressure. In the manner in which this was account was written, it seemed to suggest that these various events took place soon after Shona was moved to the resuscitation bay. But the progress notes suggest something very different, namely that this vigorous effort did not really commence for about an hour after Shona was in the Emergency Department. His account is therefore somewhat confusing and does not seem to be a reliable guide to what occurred between about 1.30am and 2am.

107. Dr Mestrige said that about five to ten minutes after successfully resuscitating Shona, he reviewed the case with the surgical registrar, Dr Omar Mouline. Shona needed surgery for her blocked bowel but, in Dr Mouline's view, this could not occur until she had been stabilised. According to Dr Mestrige, Dr Mouline said that Shona's pupils were fixed and she was either dead or very close to it. The intensive care registrar, Dr Jorge Reyes, also reviewed Shona at that time. According to Dr Mestrige, Dr Reyes thought Shona was too sick to sustain in the Intensive Care Unit.

108. In his evidence, Dr Mouline stated that at about 2am he had been called to the resuscitation bay to urgently review a patient. He attended at 2.10am examined Shona and found that she had a rigid abdomen. He diagnosed a perforated or blocked bowel.

109. When he arrived, he noticed that Shona was not intubated although she had a GCS of 3, was suffering from Cheyne-Stokes breathing[4] and had no palpable pulse and no recordable blood pressure. He also noticed on the ECG machine (heart monitor) that she had a pulse rate of about 80 beats per minute. In his view, Shona was 'profoundly hypoxic'.

110. Dr Mouline stated that Shona's pupils remained fixed 'at all times' she was in the resuscitation bay. Ms McFarlane, in her notes made on 22 July 2013, recorded that when Shona deteriorated in the ambulance bay, 'her eyes (white parts) were starting to go black'. That, as Professor McCarthy remarked, appears to be a description of Shona's pupils becoming dilated.

111. Dr Mouline stated that he was in the resuscitation bay for about an hour. He had concerns that, given Shona's previous history of strokes, cerebral insults and other co-morbidities, she may not survive the resuscitation and become sufficiently stable for surgery. He said, however, 'Given the deceased's age, however, to my observation, all efforts were made to resuscitate and stabilise her with a view to her becoming a surgical candidate.'

112. In his evidence at the inquest, he stated that his recollection was that when he attended on Shona, she was being monitored but not receiving anything more than supplemental oxygen and possibly fluids. This is borne out by the progress notes.

113. The progress notes themselves are not a complete record or guide to what happened in the resuscitation bay. Although the evidence suggests that Shona was moved to the bay somewhere around 1.20am, the first note that is recorded is timed at 1.55am.

114. That note records that Shona had a GCS of 7; her abdomen was 'rock hard'; she was 'peripherally shut down'; she was having episodes of apnoea; she had unpalpable blood pressure; and was being monitored by ECG.

115. At 2.10am, the notes record that Shona was being hydrated with saline intravenously. RN McDonald also recorded that the Public Guardian had been called.

116. It was at about this time, when Dr Mestrige was on the phone to Ms Vyse, that Shona seems to have suffered her first cardiac arrest. Ms Vyse's file note states that the 'contact time' with Dr Mestrige was 2.11am and that he hung up because Shona was arresting.

117. At 2.18am, a further note recorded that Shona was still having episodes of apnoea and that the surgical registrar was present.

[4] An abnormal pattern of breathing that results in temporary stoppage of breathing -- apnoea. It is associated with significant brain injury.

118. At 2.20am, Dr Mouline recorded his notes. In addition to his observations of Shona's physical condition, he recorded that Dr Mestrige had discussed resuscitation with the Public Guardian and that her resuscitation status was 'at [the] discretion of [the medical] staff'. He also noted that Dr Mestrige had had a discussion with the Emergency Department staff specialist and that Shona was for 'full resuscitation/CPR/intubation'.

119. At 2.22am, the notes record that the resuscitation team was called. Shona had a GCS of 3; her pupils were fixed and dilated; she had a heart rate of 75; the medical officer (Dr Mestrige) was bagging the patient [to support her breathing]; there was a plan to intubate her; intravenous fluids were in progress and Shona's blood pressure was unable to be obtained.

120. At 2.30 Shona's heart rate was recorded as 55 and Dr Mestrige was told this by the nurses. Two minutes later it had declined to below 30 beats per minute and was irregular. She was being bagged at this stage but had not been intubated.

121. At 2.34 her heart rate was recorded on the ECG monitor as zero and CPR was commenced. At 2.35 she was given adrenalin and bagging continued. At 2.36 defibrilator pads were placed on Shona, she was given more fluids and CPR continued. At 2.37 CPR continued with more adrenalin being administered and at 2.38 Shona was intubated. CPR continued. All this time she remained asystole. At 2.42 more adrenalin was administered. These efforts continued but it was not until 2.52 that a pulse returned.

122. From about 2.30am until 3.30, the progress notes record a sustained and vigorous resuscitation effort. It seems that the effort continued until about 4.44am. Dr Mestrige's evidence suggests that from the outset the resuscitation effort was urgent and sustained. The progress notes, however, do not support this. One troubling and unexplained feature is that, according to Ms Vyse's account of her conversation with Dr Mestrige, Shona arrested at 2.11am. This is not recorded nor is anything that suggests CPR was started at that time.

123. Whether that is a flaw in the note-taking or Dr Mestrige's recollection is faulty is difficult to determine with precision. Some of the notes appear to have been made at the time actions were taken; others may have been made later; some actions may not have been recorded at all.

124. Ms McFarlane was present throughout some of the time Shona was in the resuscitation bay and fills in some of the missing picture. In the file notes recorded three days afterwards, she said that Shona was taken to the resuscitation bay where an x-ray was taken. She said that at about 2.00am the doctor said that Shona was dying. She said that she had been telling him during the night to speak to the Public Guardian and that she saw him make a telephone call. She said that was asked to leave the bay at about 2.15am and that thereafter she waited in another room. She did not go back to

the resuscitation bay until about 3.30am when she was told by a nurse that Shona had been resuscitated for about 30 minutes and that the medical team was now 'manually pumping oxygen into her'.

125. In her statement to the police investigator, Ms McFarlane added further detail. She said that once Shona was taken to the resuscitation bay, she went to the toilet. When she came back, Shona had an oxygen mask on. She also cleaned Shona up because she had become incontinent of faeces. She thought that Shona had no muscle tone around her anus.

126. According to Ms McFarlane, she then had a conversation with Dr Mestrige concerning Shona's further treatment. The terms of that conversation are controversial and are disputed by Dr Mestrige. This is discussed in detail further below. For present purposes, it suffices to say that Ms McFarlane states that, after the x-ray was taken, Dr Mestrige told her that the medical team did not know what was wrong with Shona, he made the disputed remarks, and said that he would need to take legal advice. She said that shortly after Dr Mestrige spoke on the phone she was asked to leave. Apart from describing Shona being x-rayed and given oxygen by mask, Ms McFarlane did not describe anything else being done to resuscitate Shona.

127. RN Brooke Anderson gave a statement to police investigators in February 2015. She relied principally on the progress notes to refresh her memory. She stated that 'I have only written what I know to be true and have a clear memory of.' She said that her first contact with Shona was in the resuscitation bay at about 1.50am. (That timing is clearly based on the progress notes annotation of time.) Her evidence was that at this time Shona was receiving fluids and oxygen. After the surgical registrar arrived, she left to reassess other patients in the resuscitation area. She did not return until about 2.21am when she was told that Shona's GCS had fallen to 3 (from 7 when she was brought to the bay). Shortly after this time that CPR was started and two more cannulas were inserted. RN Anderson was unable to recall any of her conversations with the carers and made no mention of any conversations between Dr Mestrige and others.

128. RN Kellie McDonald also gave a statement to police. She made the observations that are recorded in the progress notes at 1.50am. Her recollection is that Shona was moved to the resuscitation bay at about that time. In essence, her statement simple puts into plain English those matters that are recorded in the progress notes. She noted that carers were present on and off during the time she was caring for Shona in the resuscitation bay. She was unable to recall specific conversations that were held during the period Shona was in the bay.

129. RN Danielle Zobouian was the Clinical Initiatives Nurse on duty that night. She attended the resuscitation bay at 2.20am and was the scribe who wrote up the progress notes from that time. She said that when she arrived at the bay several medical and staff members were present: Dr Mestrige, two other emergency department doctors,

the surgical and intensive care registrars, the nurse manager, the nursing team leader and three other nurses.

130. Professor McCarthy was critical of Dr Mestrige's resuscitation work. She noted that, according to the records, resuscitation had started nearly an hour after Shona is recorded as being offloaded from the ambulance trolley. She also noted that, according to the records, there was a delay of at least 32 minutes between a finding of there being no palpable pulse and CPR being commenced. A failure to reposition the endotracheal tube for 23 minutes after poor ventilation was detected was another criticism she made. And she was critical of the failure to recognise and treat profound hypoglycaemia evident on the blood gas result available to the medical team at 2.55am.

131. She was highly critical of Dr Mestrige's apparent failure to initiate resuscitation immediately Shona was brought to the resuscitation bay and of his calling the Public Guardian prior to initiating full resuscitation or CPR.

132. Dr Mestrige's colleagues and other experts were not so critical. A/Professor Cracknell's opinion was as follows:

> Based on my clinical experience, knowledge of the autopsy diagnosis of peritonitis secondary to ischaemic bowel, and the comments from the surgical registrar [Dr Mouline], it is my opinion that from the time [Shona] was moved into the Resuscitation Bed she had no meaningful chance of survival as she could not survive without surgery and yet was already too compromised to survive such an operation. She had an active resuscitation in the Resuscitation Bed and in hindsight some of the elements could have been improved. However I do not believe that these elements contributed to the eventual outcome of death.

133. He also cautioned against over-reliance on the progress notes as a record of the sequence of events. Time stamps on computer records are not necessarily imprinted at the time of the event. They may simply reflect the time a record is made of an earlier event. He also noted that an entry in the record 'is a description of events in progress rather than the commencement of any specific action' and that 'events in and of themselves take time to occur'.

134. A/Professor Greenberg took the view that 'whilst, with the benefit of hindsight, Ms Hookey's treatment in ED at Campbelltown could have been improved… the care given was appropriate given the challenges facing the clinical staff.' He disagreed with aspects of Professor McCarthy's criticisms of the resuscitation effort. In particular, he thought that it was appropriate that CPR was not commenced until 2.34am when her heartbeat ceased. He noted that she was intubated at 2.38am and commented, 'This aspect of the resuscitation shows efficiency'. He also noted that fluids had been commenced even before Shona was moved to the resuscitation bay.

135. The standard emergency medicine approach to management of a deteriorating patient is 'ABCD'. The patient's *airway* must be checked and any obstruction cleared. Airway obstruction can cause hypoxic brain injury. High concentration oxygen may be needed. The patient's *breathing* must be assessed. Respiratory distress must be addressed urgently and the patient's breathing supported by, for example, bagging with a mask. Oxygen saturation levels must be monitored. *Circulation* must be assessed and monitored. Intravenous fluids must be administered if a patient is in shock to support maintenance of adequate blood pressure. *Disability*, that is, unconsciousness or unresponsiveness on the part of the patient must assessed and responded to appropriately.

136. It appears that shortly after Shona 'crashed' fluids were started and efforts were made to support her breathing. The main point of difference between the experts was in relation to the commencement of chest compressions. Professor McCarthy's evidence was to the effect that CPR was not commenced when it should have been. In her view, chest compressions ought to have commenced when Shona became apnoeic. She said that, in a setting in which the clinical team were unable to obtain a blood pressure or pulse and intravenous fluids had been started, there should have been immediate commencement of chest compressions and assistance of respiration. In her view, this should probably have started while Shona was on the trolley because it was at that point that Ms McFarlane saw Shona's pupils dilate, indicating that she was hypoxic.

137. In support of her view, Professor McCarthy referred to the Australian resuscitation guidelines. Those guidelines were not in evidence but she said that they advise that chest compressions should be started if a patient is unresponsive and not breathing normally. That was when Shona was having apnoeic episodes, much earlier than 2.34am and probably at about 2.11am.

138. A/Professor Greenberg, on the other hand, was of the view that until Shona's heart had stopped beating, chest compressions would have had little or no beneficial effect. His evidence was that Shona's heartbeat was being monitored in the resuscitation bay and that, according to the progress notes, it was not until 2.34am, when nil heartbeats were registered, that chest compressions were going to be of any use.

139. A/Professor Cracknell, while agreeing that Shona needed treatment, was of the view that the records do not allow us to understand precisely what was happening during the period shortly after Shona 'crashed' and therefore found it impossible to assess whether or not there were deficiencies in the early resuscitation effort.

140. On four things, however, all the experts were agreed. Shona was very ill by the time she arrived at the hospital. She needed urgent treatment. The severity and urgency of her condition was not recognised by the hospital staff. But that, regardless of whatever action the staff took or might have taken, she had very little chance of survival.

141. While Professor McCarthy's criticisms of the standard of the resuscitation effort raise obvious concerns, given the divergence between the experts on the standard of care provided to Shona during the resuscitation period, I am not able to say categorically whether or not it was sub-standard.

142. If the clinical picture was that Shona was dying and had little or no chance of survival, it may, in those circumstances, have been reasonable not to undertake heroic measures to resuscitate her. On the other hand, Dr Mestrige had been given advice that if she could be stabilised she could be a surgical candidate, her only chance of survival. The experts all emphasised that in medicine there are 'no absolutes'. What is troubling here is that the progress notes appear to show that a concerted resuscitation effort was only made after Dr Mestrige took advice from the Public Guardian and Dr Ung to the effect that if her medical condition was such that Shona could be saved, that ought to be done.

143. My concerns are heightened by evidence suggesting that Dr Mestrige may not have been willing to make a full effort due to the fact that Shona was severely disabled. That question will be discussed further below. Before doing so, however, it is important to address another important difference between the experts.

Do circumstances govern the standard of care provided in emergency departments?

144. A/Professor Cracknell's view of Dr Mestrige's overall performance was that:

> … Dr [Mestrige] initially failed to recognise the seriousness of [Shona's] condition but after the point of deterioration there was a co-ordinated resuscitation which included fluids, CPR, antibiotics, referrals to consultants and the surgeons and the [Public Guardian]. Dr [Mestrige] shares the failing with the whole clinical team and you would have to remove all the surrounding circumstances to conclude that he personally performed in a substantially substandard manner.

145. A/ Professor Greenberg was largely in agreement with this view. It does both of those physicians credit that they feel sympathy for a clinician trying to work under the enormous strain that Dr Mestrige and his team were on that fateful night. Most thoughtful people would feel the same. But I have two difficulties with A/Professor Cracknell's opinion. The first is that he appears to accept a sliding scale of standards which depend on how much pressure a clinician is under at the time of a critical event. Professor McCarthy's attitude appears to be that pressure and circumstances cannot be allowed to erode standards or there is no firm benchmark against which performance can be measured.

146. Secondly, I acknowledge that there is a high degree of inter-dependency and teamwork in an emergency department. But it does not appear to me to be acceptable

to share out the responsibility for a catastrophic failure equally among all the members of the team. Team leaders and senior clinicians must bear a greater burden of responsibility than less experienced, or less qualified, members of staff.

147. In relation to both A/Professor Cracknell's and A/Professor Greenberg's umbrella assessments, I concede that it is perhaps realistic to reduce expectations when clinicians are under great pressure. Nevertheless, I prefer the higher aspirations of Professor McCarthy's approach. If her approach is adopted, a sliding scale of standards according to circumstances is unacceptable. Although her approach may be the counsel of perfection, for the sake of public health and safety, and confidence in our hospital system, this must surely be the goal at which emergency departments take aim.

148. While it is understandable and, indeed, in some respects laudable for experts to be relatively forgiving of lapses of judgment or performance by individual clinicians under great pressure, the stringency of Professor McCarthy's approach has much to recommend it from a policy perspective. If Dr Mestrige made mistakes, they are valuable not so much so that they can be used to humiliate or punish him, but so that lessons can be learned and his and his team's performance improved in future. The alternative is what Professor McCarthy called a 'culture of acceptance' of low or declining standards of care and treatment.

149. If that is so, the questions then become: (a) how can systems be designed to support the clinicians to perform to their normally high standards when an emergency department comes under severe pressure? And (b), how do we prepare clinicians to operate under pressure at a high standard that does not decline as pressure increases? These are questions the answers to which are beyond the scope of my expertise and, indeed, beyond the scope of this inquest to resolve. They are for the College, the emergency medicine profession, the policy makers and administrators of the health system and, of course, the Campbelltown Hospital to address. While these are large questions, as I remarked to Shona's parents at the end of the inquest, I hope that her death will leave a legacy of life-saving improvements at Campbelltown Hospital.

Emergency treatment and the Public Guardian

150. One matter of separate concern is that Dr Mestrige appears to have been unaware that the law and NSW Health policy did not require him to get legal advice from, or to consult, the NSW Public Guardian concerning the provision of emergency treatment for Shona. It is true that Ms McFarlane was urging the doctor to do so. He may also have been getting similar advice from others. But the law is quite explicit. Section 37(1) of the *Guardianship Act 1987* provides:

> Medical or dental treatment may be carried out on a patient to whom this Part applies without consent given in accordance with this Part if the medical

practitioner or dentist carrying out or supervising the treatment considers the treatment is necessary, as a matter of urgency:

(a) to save the patient's life, or

(b) to prevent serious damage to the patient's health, or

(c) except in the case of special treatment-to prevent the patient from suffering or continuing to suffer significant pain or distress

151. Shona was a patient under the care of the Public Guardian but, given the urgency of her situation, it was unnecessary for Dr Mestrige to seek consent from the Public Guardian to treat Shona. As an experienced emergency doctor, it is surprising that he was unaware of this.

The allegation of differential treatment

152. A number of witnesses have asserted that while Shona was being treated by Dr Mestrige at Campbelltown Hospital, he made statements or asked questions that suggested that he thought that Shona, because of her intellectual disability, should receive a lesser standard of care and treatment than would be given to 'normal' patients. He has vigorously denied that this was so and, indeed, claims that Shona, because of her disability, received a higher priority for treatment than might otherwise have been the case.

153. Given the potentially damaging effect of a finding against Dr Mestrige on this point, it should not be made without strong evidence[5]. I am conscious of the fact that Dr Mestrige's colleagues hold him in high regard, and that they believe that it would be out of character for him to discriminate against or treat a disabled person less thoroughly or favourably than he would any other patient. He is a senior doctor and has worked, as far as I am aware or his colleagues are aware, without any complaint of this nature ever before being made against him.

154. If this were a case of word against word, it would not be possible to make a finding adverse to Dr Mestrige. But in this case, four independent witnesses, some of whom made notes of their conversations with him close to the time of the conversations, have given evidence that is consistent with the tenor of the allegation or which corroborates the fact that he took the fact that Shona was intellectually disabled into account in his decision-making. The statements that they say Dr Mestrige made were voiced at different times in different circumstances. Those statements are like separate strands in a cable. Woven together their effect is much stronger than each taken singly.

[5] *Briginshaw v Briginshaw* [1938] HCA 34.

155. In her notes made shortly after the event, Ms McAlpine recorded that, after Shona had been taken to the resuscitation bed, she had 'apnoeic moments'. She noted that the nurses there gave Shona oxygen and asked the doctor to resuscitate her. She recorded that his response was 'Given her Hx [history] should we Rx [treat] her'. In her statement to police, Ms McAlpine gave a slightly different version of this response: 'Given her history should we really bother'. She also stated to police that she had told the doctor, 'If you don't you'll have the public guardian to deal with'.

156. In her oral evidence, Ms McAlpine stated that the doctor had used the word, 'treat' rather than 'bother' and explained that when she was being interviewed by police there was pressure to get out on the road. She thought that this had resulted in an inaccurate recording in the statement of her evidence by the police investigator. She stood by her evidence that she had mentioned the Public Guardian to the doctor but said that he did not respond to her comment. Not long afterwards, Dr Mestrige made a telephone call to the duty Public Guardian.

157. Ms McFarlane gave evidence in a similar vein. Her account is that in the resuscitation unit Dr Mestrige said 'Look at her, she's 29, if she was normal we'd treat her differently'. She said that the doctor then made a phone call. This may have been the call he made to the Public Guardian. It could also have been a call he made to Dr Setty Ung, the on-call staff specialist, for advice.

158. Both these witnesses maintained that they heard Dr Mestrige say these things. Of course, it could be argued that, in the stress of the situation, they misheard or misunderstood what Dr Mestrige had said to them. But he flatly denied having said anything of this kind.

159. The duty officer of the NSW Trustee and Guardian who received the call from Dr Mestrige was Ms Gowan Vyse. Ms Vyse took contemporaneous notes, some during the call itself and some after the call concluded. Her note records the following:

> Dr Danusha [Mestrige] called to advise that Ms [Hookey] had been admitted to hospital yesterday afternoon. She has had an [intellectual disability] and history of ingesting objects. Dr Danusha advised that she was very unwell and dying. He advised that scans did not reveal anything had been ingested but that she was septic. *Dr Danusha requested advice as to [whether] or not to resuscitate given her intellectual disability and quality of life. I advised that he should not be making decisions based on her disability but on her presenting condition and his clinical opinion. Dr Danusha asked if I was a medical practitioner. I said no. He said well you can't help me.* I attempted to explain the [Public Guardian] decision-making role in relation to end of life matters and that he needed to make a clinical judgment based on her condition as to [whether] resuscitating was indicated or [whether] it was futile. As I was speaking to the [doctor] he indicated that Ms [Hookey] was arresting as we were speaking. He thanked me and hung up. (Emphasis added).

160. Dr Ung was a staff specialist in emergency medicine at the hospital in 2013. He stated to police that between 1am and 2am he had received a call from Dr Mestrige who said words to the effect of, 'Shona Hookey has arrested and we are administering CPR. Given her developmental delay how long should the resuscitation attempts go on for?'

161. Although he had no independent memory of the conversation or its precise context, Dr Ung ventured that Dr Mestrige may have been concerned that Shona did not have a parent or guardian available acting as advocate for her and that the reference to her disability was in relation to this. It is, of course, possible that Dr Mestrige had this concern, although he did not say so in his evidence. But this would not be a literal or natural interpretation of his question to Dr Ung. It implies that, as far as Dr Mestrige was concerned, Shona's disability was a relevant factor in the decision as to how much effort should be made to save her life. Dr Ung, quite correctly, responded, 'If the patient's medical condition is reversible then resuscitation should continue until such time as the surgical team can come in and assess her'. In saying this, Dr Ung effectively dismissed the question of disability from consideration. It was Shona's medical condition only that counted in this situation.

162. It was submitted on behalf of Dr Mestrige that, for a number of reasons, I could not be satisfied that he had said anything that could be construed as indicating discriminatory conduct or a discriminatory attitude on his part. It was argued that he is a well-trained, skilful doctor who is highly regarded by his colleagues and that it would be so out of character for him to have said the things he is alleged to have said that it is implausible and unlikely that he did say them. On the issue of character, it was also said by Dr Ung that Dr Mestrige takes his Hippocratic Oath seriously.

163. I have no reason to doubt that Dr Mestrige is highly esteemed by his colleagues and that, if he did say the things alleged, it was out of character for him. On the other hand, courts are full of people who have done things out of character. There are very few faultless human beings or people who are impervious to great pressure. With nursing and medical staff under great stress in a very busy and over-extended Emergency Department, I do not find it inherently improbable that a doctor who has many calls on his attention and is severely overloaded, might make remarks of the kind attributed to Dr Mestrige. Under great pressure, it is quite plausible that Dr Mestrige, or, indeed, anyone, might say or do things that are out of character.

164. It is not implausible, in my view, that a doctor who does not work closely and regularly with intellectually disabled people might think that a severe intellectual disability is an unfortunate condition for a human being to live in. If Dr Mestrige thought Shona was dying, as he apparently did, I do not find it implausible that he might have wondered aloud whether it was worthwhile treating her.

165. It was also submitted on his behalf that I should be very cautious in accepting the various accounts given by the four independent witnesses because of the well-known phenomenon of fallibility of memory. Counsel for Dr Mestrige referred me to

observations of McClelland CJ in Eq in *Watson v Foxman* on the potential unreliability of recollections of critical conversations. His Honour said[6]:

> Furthermore, human memory of what was said in a conversation is fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time, particularly where disputes or litigation intervene, and the processes of memory are overlaid, often subconsciously, by perceptions of self-interest as well as conscious considerations of what should have been said or could have been said. All too often what is actually remembered is little more than an impression from which plausible details are then, again often subconsciously, constructed. All this is a matter of ordinary human experience.

166. I agree entirely with those comments. In some respects, the recollections of Ms McAlpine and Ms McFarlane were found to be faulty or inaccurate when tested by Counsel Assisting and in cross-examination by interested parties. Three years after Shona's death this is unsurprising. If all they had to rely on were their three year old memories of an event which occurred in very stressful circumstances, the reliability of their recollections would indeed be questionable. But, of course, it was not.

167. Although His Honour did not refer in that passage to contemporaneous records, it is self-evident that his observations underline the evidentiary significance of contemporaneous records or records made shortly after an event when memory is at its freshest. All other things being equal, it is generally preferable to rely on a contemporaneous or nearly contemporaneous record made by an independent witness than a version of events that is produced long after the events in question.

168. This is borne out in comments made by Hely J in *Port Kembla Coal Terminal Ltd v Braverus Maritime Inc*[7]:

> I agree with the plaintiff's submission that in this very difficult context, the Court should, where possible, base its fact findings on the objective or contemporaneous documentary evidence augmented by the testimony of the relevant witnesses to the extent that these witnesses are not in conflict. Where there is conflict the Court should, where possible, seek to resolve it by determining, on the objective evidence, what is inherently probable supplemented by admissions against interests made by the crew, on the one hand, or the Pilot on the other.

169. This passage outlines the usual judicial method of resolving difficult conflicts of evidence. His Honour there gave evidentiary primacy to 'the objective or contemporaneous documentary evidence'. While independent witnesses can, of

[6] (1995) 49 NSWLR 315 at 319.

[7] [2004] FCA 1211 at [40]

course, make mistakes, they are generally to be considered more objective than interested parties. Both Ms McAlpine and McFarlane are, in my view, independent witnesses. And both, of course, like Ms Vyse, made contemporaneous or near-contemporaneous notes. Their evidence, on the face of it, is therefore compelling.

170. As Hely J also noted, the inherent probability or improbability of one version of events is a factor that may help resolve a conflict in evidence. Ms Sandford submits that it is inherently improbable that a doctor with the reputation he enjoys among his peers at Campbelltown Hospital would make such remarks as are alleged. Dr Ung, for example, was 'shocked' to hear the allegations.

171. The difficulty I have with that submission, however, is the objective fact that four independent witnesses gave accounts that, taken together, contradict Dr Mestrige's absolute denial of having said anything that could be construed as discriminatory against a disabled patient.

172. It is also an objective fact that three of those witnesses took notes contemporaneously or shortly after the events in question but Dr Mestrige did not. It is inherently improbable, in my view, that four independent witnesses could be so wrong in their recollections when they are so consistent, especially when, in two cases, the very reason they recorded their notes was because they were offended and horrified by what they had heard.

173. The passage from *Watson v Foxman* referred to above also highlights another factor that can, in some circumstances, be significant. When assessing the credibility or reliability of witnesses, the fact that their recollections may be 'overlaid, often subconsciously, by perceptions of self-interest as well as conscious considerations of what should have been said or could have been said' may, in some circumstances, be significant.

174. This became the subject of an argument put on behalf of Dr Mestrige. His counsel submitted that the recollections of the carer, Ms McFarlane and the ambulance officer, Ms McAlpine, may have been motivated by self-interest. She raised the possibility that their complaints against Dr Mestrige may have been motivated by a consciousness that Shona's death would be investigated and they may be criticised as a result.

175. The implications of that submission are very serious. At one level, it could imply that both Ms McAlpine and Ms McFarlane may have fabricated evidence against Dr Mestrige for some ulterior motive. Or, less damningly, it could imply that, because they were aware of Shona's death and may have been affected by fear of the consequences of an investigation, their recollections of things said may have been subconsciously reconstructed in a way that paints them in a favourable way and Dr Mestrige in an unfavourable light. This was never put to either of them during their evidence.

176. Indeed, such a proposition was never put to any witness by Counsel Assisting or any of the representatives of interested parties. For it to be put, the Bar Rules require that there be a proper basis for doing so. I am unaware of any basis for such a proposition being put to any witness.

177. Moreover, if that argument for Dr Mestrige were permissible at all, it could be made equally against the nurses and Dr Mestrige himself. The hospital staff would certainly have been conscious of the fact that a Root Cause Analysis investigation always follows an event like Shona's death and sometimes an inquest does too.

178. As I explained to counsel for Dr Mestrige, while the rules of evidence and the rule in *Browne v Dunn* do not apply in an inquest, without the proposition being put to the witnesses, I could not accept the submission. Just as it would be unfair to take that approach to Dr Mestrige or any of the hospital staff, it would be grossly unfair to do so in respect of Ms McAlpine and Ms McFarlane.

179. It was also submitted for Dr Mestrige that the two nurses who were working with him in the resuscitation bay were not called to give oral evidence. The suggestion appeared to be that, because those witnesses were not called, it would be unfair for a finding to be made that Dr Mestrige made the statements alleged by Ms McFarlane and Ms McAlpine. I do not accept that submission.

180. Each of them gave a statement during the police investigation. They did not mention hearing any comment of the type alleged by Ms McFarlane and Ms McAlpine in their statements. They were unable to recall any conversations they had in the resuscitation bay. Two years after stressful events, during which they had been focussed on monitoring and resuscitating Shona, this is unsurprising.

181. It is not the practice of this jurisdiction to call all witnesses who give statements. An inquest is not a trial in which the coroner or Counsel Assisting has a duty to call all relevant witnesses regardless of whether or not they add significantly to the evidence. No *Jones v Dunkel* [8] inferences arise if a witness is not called by a coroner.

182. In any event, interested parties can, if they wish, request the coroner or Counsel Assisting to call witnesses who do not appear on the coroner's witness list. If parties make such requests, they are rarely rejected by coroners. No such request was received from those representing Dr Mestrige. In my view, the evidence of the nurses on this topic was effectively neutral.

183. I should note also for completeness that Dr Mouline's evidence on this issue is also, in effect, neutral. Dr Mouline did not recall any of the medical staff making statements of the kind alleged by Ms McFarlane and Ms Alpine. It appears to me, however, that if such statements were made, the one said to have been made in Ms McAlpine's

[8] [1959] HCA 8; (1959) 101 CLR 298 at 320.

presence was uttered before Dr Mouline attended the resuscitation bay. Any conversation between Dr Mestrige and Ms McFarlane may not have been heard by or listened to by Dr Mouline.

184. In summary, there was no collusion between these four independent witnesses. Both Ms McFarlane and Ms McAlpine recorded their recollections of what Dr Mestrige had said while they were fresh in their minds because they were offended by the implications. These four accounts, taken together, give rise to an irresistible inference that Dr Mestrige took Shona's disability into account in his decision-making process concerning her treatment. In my view, it is more likely than not that he made the remarks attributed to him or made statements to similar effect.

185. Because he denied doing so, it is difficult to understand his motivation. Those who know him think highly of him and his general character and his professional attitudes. If that is so, it seems unlikely that he was being callous or deliberately discriminating against a severely disabled person. The most benign interpretation that can be placed on his comments is that he thought that Shona was dying and that her quality of life was so poor that it would be a mercy for Shona not to be resuscitated.

186. But the law and ethical medical practice are not discriminatory in that fashion. Shona's life was no more nor less valuable to her than anyone else's is to him or her. It needs to be remembered that one of the great lessons of the 20th century is that the principle of a right to life does not distinguish between individual human beings. Taken to its logical conclusion, the alternative to a principle of equality of right to life is a descent into discrimination, social Darwinism, eugenics, and even, in extreme cases, ethnic cleansing, 'euthenasia' of the vulnerable and weak, and genocide. I do not for a moment suggest that Dr Mestrige's outlook was at the extreme end of this spectrum. As I have said, his attitude may have been merciful. But the logical implications of even such an attitude must be considered.

187. None of this requires heroically futile efforts to be taken to keep disabled people alive when they would not be for others. Only that they should not be treated with a lesser standard of care than any other patient could reasonably expect to receive in the same circumstances.

188. This jurisdiction is not a disciplinary tribunal. It is not for me to say whether Dr Mestrige's remarks and performance on the fatal night deserve professional disciplinary sanction. But it is appropriate, in my view, that the case be referred to the Health Care Complaints Commission for investigation of the questions whether Dr Mestrige discriminated against Shona Hookey; if so, why and how; and, if it is found that he did so, whether it is appropriate to take disciplinary action in respect of that conduct. The papers will be referred to the Health Care Complaints Commission for its consideration of those questions.

The critical significance of good record-keeping

189. Good record-keeping is a critical element of sound, safe medical practice. I have made this observation in a number of inquests, and in a number of professional development talks I have given in hospitals. I have been invited to give these talks because hospital administrators are acutely aware of the critical importance of good record-keeping. This is, in truth, a statement of the obvious.

190. The keeping of good records should not be driven by a fear of lawyers or a 'tidy town' mentality, but by recognition of the urgency of patient safety. Observations of vital signs and progress notes are an emergency department's systemic short-term memory. Taking and recording observations of vital signs is probably the most important of the records that must be kept up to date, but progress notes are almost equally important. Progress notes are slices in time that enable clinicians to monitor patients as they improve, stabilise or deteriorate.

191. Without a baseline against which these things can be checked, clinicians are working half-blindly. It is at times when the pressure is greatest, and the danger of cognitive overload is highest, that good record-keeping is most important. This is so that critical things, the absence of which may endanger patients, such as vital signs observations, pain relief or fluids, are not overlooked or forgotten in the flurry of activity.

192. Good contemporaneous records were not kept by the nursing and medical staff throughout the night of 18 and 19 July 2013 in respect of Shona. The picture presented in this inquest is that the Campbelltown Hospital was creaking under the pressure of a shortage of resources and inefficiencies in the management of the emergency department. This was, by all accounts, a particularly busy night but winter nights are frequently busy in all hospital emergency departments. The fact that significant improvements have been made in the operation of the Campbelltown Hospital emergency department since July 2013 demonstrates a recognition of how potentially dangerous, due to systemic inadequacies, the emergency department was to critically ill patients on the night of Shona's death.

193. In such situations, human error is virtually inevitable. It is also inevitable that, unless robust and effective systems are operating, risk to patients will increase as pressure does. The greater the pressures on emergency department staff, the higher the level of risk of human error and therefore the greater the need for their systems to be secure defences against the inevitable errors that will occur.

194. Errors under pressure are not moral failings. If human error was a function of character, it would be relatively easy to eliminate: the "bad" could be identified and excluded from practising in areas in which they might harm to others. In truth, all competent professionals make mistakes from time to time even, improbable as it may seem, barristers and judicial officers. Cognitive overload, incomplete information and

inexperience are three of the more usual explanations for those mistakes. Recklessness and deliberate flouting of proper procedures is far less common. Hence the need for a culture of diligence in relation to proper procedures and, in this instance, good record-keeping. It is a basic issue of risk management and patient safety. The Hippocratic Oath requires physicians first to do no harm. Good record-keeping is one significant practical aspect of that philosophy.

195. Dr Mestrige gave evidence that, due to the large number of patients that doctors and nurses were seeing in the emergency department on this evening, patient records were not noted up sometimes for hours afterwards. If a doctor has seen a number of patients in a relatively short space of time, and has made or is making numerous decisions in relation to that large body of patients, and is not recording notes from which memory can be refreshed as he or she goes, common sense (and neuroscience) suggests that the probability of errors being made is high. Dr Mestrige conceded this during his evidence. He also gave evidence to the effect that making contemporaneous progress notes on the computer system was inconvenient and was given a lesser priority than dealing urgently with patients. Understandable as this may be, for the reasons outlined above, I do not accept that this is appropriate practice.

196. Therefore, can a simple method of ensuring that contemporaneous notes are made each time a nurse or doctor attends upon a patient be found? If updating electronic records at the time of each attendance is time-consuming or inconvenient while patients are being treated, it cannot be beyond the ingenuity of the hospital's administration or the Local Health District or NSW Health to come up with a simpler system for ensuring that this happens. Notebooks, dictaphones and smart phones are three common ways of taking notes that spring immediately to mind. Although there may be a degree of double-handling involved, if the choice is between taking no notes and some double-handling, the preferable option is starkly simple. Transferring the information without difficulty to the patient record system at the end of a shift should be technically feasible and relatively simple, such as scanning in the notes taken in notebooks or other media.

197. The problem of poor record-keeping has wider implications also for the management of the hospital. Not only are patients placed at immediate risk but, when cases are reviewed in the hope of learning the necessary lessons, serious difficulties arise if the records are incomplete or inaccurate. How are systems to be improved if the records do not reflect how they work? This case is a good illustration of how difficult it is to work out exactly what was happening if records are inadequate. Two examples will suffice.

198. First, there is an irreconcilable discrepancy between the evidence of RN Jones who was managing the beds in the emergency department and the hospital records drawn from its computer system concerning the availability of resuscitation beds while Shona was on the ambulance trolley. The nurse says that there were no beds available

throughout that time. The records, however, show that two beds became available in that time. It seems doubtful to me that two beds would have been left vacant while patients were queued up due to 'trolley block' but that is what the records appear to show.

199. Second, what happened to Shona between the time she 'crashed' and was seen by Dr Mouline sometime after 2am is quite unclear because records do not seem to reflect the timings of some things done between about 1.25am and 1.50am. Nor, it seems, do they record all that was done. On Dr Mestrige's version, vigorous and sustained efforts were being made throughout that time to manage Shona. On the other hand, other evidence, such as Dr Mouline's account, suggests that this may not have been the case. Good written documentation is evidence of what was done and why.

200. Far less importantly, but perhaps an incentive to improve individual diligence in this respect, good record-keeping is also a clinician's best defence against later criticism. As we have seen, this case has thrown up several examples where contemporaneous records would have resolved conflicts of evidence had they been made by medical and nursing staff.

201. How the record-keeping problem is solved, however, is a matter for the Local Health District. (The Ministry of Health may also have a concern that there may be cultures of poor record-keeping in other hospitals.) I propose to make a recommendation to the Minister for Health concerning this question.

A cluster of errors and systems failures

202. In summary, Shona's death was the tragic conclusion to a cluster of mistakes and failures in systems intended to care for her:

- Her carers at Plane Tree during the afternoon and evening were indecisive and failed to take necessary action. If there had not been a changing of the guard that night, and prompt and decisive action taken by Ms Hakiwai, Shona would have died there.

- The Campbelltown Hospital Emergency Department was overcrowded and the staff were under intense pressure, at one point having to manage 58 patients with only 33 beds available. The hospital's systems for managing this degree of pressure were inadequate.

- Shona was triaged, seen briefly by a doctor, but left on an ambulance trolley for two hours despite the fact that the hospital's records indicate that a bed became available shortly after her arrival. (Whether a bed was in fact available is disputed but this is an instance either of poor bed management or poor record-keeping.)

- Her condition was not correctly assessed by nursing or medical staff while she was in the ambulance bay.

- The doctor's tentative diagnosis, based on a misleading history, was incorrect.
- Shona was not provided pain relief or fluids while she was on the ambulance trolley.
- Shona was not sedated so that observations of her vital signs could be taken with reasonable accuracy.
- Record-keeping in the department, under the degree of pressure being experienced, was poor.
- The doctor appears to have taken the fact that Shona was severely intellectually disabled into account in an irrelevant way that was disadvantageous to Shona.
- The ambulance crew, while willing to escalate Shona's case, were unfamiliar with the arrangements at Campbelltown Hospital and felt unable to leave her to find a nurse. They did not call their control room but waited for someone to attend on Shona.
- The hospital did not have a routine of regular checks being made by a senior clinician on patients being held in the ambulance bay but relied on the ambulance officers to escalate cases.
- When Shona crashed and was taken to a resuscitation bed, the doctor wasted time unnecessarily calling the Public Guardian for instructions concerning resuscitation. This was entirely unnecessary because he had the statutory authority to treat a disabled person without consent in a medical emergency.
- The resuscitation effort may have been less than optimal. This was probably due to a combination of heavy pressure on the Emergency Department and the doctor's views concerning Shona's severe intellectually disability and the efficacy of the effort.

203. The American journalist, H.L. Mencken, once wrote that 'For every complex problem there is a solution that is clear, simple and wrong.' A clear, simple and wrong approach to Shona's death would be simply to 'name and shame' a few people and walk away.

204. Such an approach – possibly satisfying to some – is an inadequate response to this tragedy. To their great credit, Shona's parents have not expressed such an attitude. They were remarkably forgiving and generous-spirited. They recognise that the real issues of health and safety are far more complex and that decent people can and do make mistakes.

205. Professor James Reason, an expert on human error and systems failure, has remarked, 'When an adverse event occurs, the important issue is not who blundered but how and

why the defences failed.'[9] The most fruitful approach to a tragedy like Shona's is to fix the problems.

Changes and reforms since 2013

The Department of Family and Community Services

206. In a report prepared for this inquest in June 2016, the Department of Family and Community Services outlined the internal investigations, reviews and improvements that the department made following Shona's death (and other deaths of people for whom it is responsible). It also provided information concerning recommendations made by the Ombudsman and its own internal reviewers.

207. It has addressed five categories of systemic issues: the recognition and response to critical situations; management of individual risks; internal review by FACS services; inconsistency in documentation standards; and inconsistent staff, orientation, training and supervision.

208. In June 2015, FACS implemented a 'Continuous Improvement Review Tool' which is intended to promote a culture of continuous improvement and review in group homes. Action plans based on FACS policy are being developed and monitored.

209. Other broad programs being rolled out and implemented include the 'Employee Development Program' for training support and professionally developing support workers; the 'Good to Great Policy Framework' which is a strategic policy framework intended to ensure that best practice prevails in the disability support sector; the Clinical Governance Review Panel for Client Deaths, a committee which seeks to learn the lessons that the death of client may teach; and the 'Support in Accommodation Services Project'.

210. The Ombudsman made a large number of recommendations for improving FACS's internal processes and programs as did the internal reviews. Those recommendations concerned responses to emergencies or critical situations; induction and training of staff; improving internal reviews; better record-keeping; and enhanced induction, training and supervision of staff.

211. Given that these necessary or desirable changes have been made, I do not propose any recommendations to the Minister for Family and Community Services.

The NSW Ambulance Service

212. Mr Paul Tonge gave evidence that due to work done since 2013, delays in paramedics handing over care to emergency staff at Campbelltown had significantly reduced. The

[9] James Reason, "Human Error: Models and Management", *British Medical Journal* 2000;320;768-770 at 768.

overall improvement in off-loading ambulance stretchers was in the order of five minutes (nearly a 14% reduction in delay). NSW Ambulance has introduced several policies aimed at minimising the numbers of patients held on ambulance stretchers in emergency departments for 30 minutes or more. That work is being done collaboratively with hospital managements and NSW Health.

213. The most recent Work Instruction issued by NSW Ambulance to paramedics requires ambulance crews to keep their control room informed of their situation. It also requires paramedics to alert hospital staff of any change of condition in the patient. And it makes provision of dealing with unforeseen events in which operational workload exceeds resources.

214. Where there are unforeseen delays of significance, NSW Ambulance, hospital and Local Health District management are required to work together to find ways of resolving the problems. If this system works as it is intended, it is unlikely that a patient like Shona would now be kept on an ambulance trolley for two hours.

215. Professor McCarthy said that she was concerned that, unless significant changes were made within overloaded emergency departments, offloading ambulance trolleys more quickly simply transfers the problem from the Ambulance Service to hospitals. I share that concern but, insofar as the Ambulance Service is concerned, I do not see the need for any recommendation to be made. The primary question is how hospitals deal with the loads brought to them by ambulances.

Campbelltown Hospital

216. Dr Sellapa Prahalath, the Director of Medical Services at Campbelltown Hospital, and previously a joint co-ordinator of the Emergency Department, gave evidence of a number of measures that, since 2013, have been taken to improve the overall performance of medical services at the hospital. He outlined 15 specific changes that had been made or were in the process of being introduced.

217. Perhaps the most important point he made was that it is not possible to improve the performance of the Emergency Department without taking a 'whole hospital' approach, because 'trolley block' or 'bed block' is caused to a significant extent by slow discharge of patients from wards. This in turn slows the progress of patients out of the Emergency Department into the wards and therefore delays transfer of patients into the Emergency Department from ambulances.

218. It is unnecessary here to list all the changes outlined by Dr Prahalath. Four important examples, however, should be highlighted.

219. First, the number of beds in the hospital is being increased. A further 30 beds will open in 2017.

220. Second, the Emergency Department now has an additional doctor on night shift and a second triage nurse has been allocated to the ambulance bay area.

221. Third, the hospital has introduced a Rapid Ambulance Assessment Area (RAAA) with staffed Emergency Department beds to provide care shared by paramedics and hospital staff as a kind of halfway house between the ambulance bay and a bed proper within the Emergency Department. This enables quicker release ambulances and a degree of care for patients that is an improvement on them lying on ambulance stretchers.

222. Finally, and perhaps most importantly, an additional position of 'Medical Navigator' has been created. The Medical Navigator is a reasonably senior doctor with at least two years of Emergency Department experience and five years post-graduate experience. The Medical Navigator's primary responsibility is to rapidly assess incoming patients in the ambulance bay and the sub-acute area and, if required, escalate cases to a doctor immediately. At present, the Medical Navigator is rostered on between 10am and 8pm only.

223. The overall performance of the Campbelltown Emergency Department appears to have improved quite significantly since Shona's death. In 2013, less than half the patients arriving by ambulance were cleared from their trolleys within thirty minutes. Now it is about 90%. Most patients now spend somewhat less time in the Emergency Department. More significantly, the number of patients staying in hospital for 24 hours or more has also reduced by about 50% since 2013. The use of the RAAA has declined despite reduced delay in transferring patients from ambulances.

224. These are not reasons for complacency but they do show serious intent in improving systems, taking a 'whole hospital' approach and enhancing public health and safety in one of the busiest emergency departments in the State.

225. In Dr Prahalath's list of improvements, he noted that the 'existing safe operating capacity for the ED is revised every 12-18 months and the ED has an escalation plan that relates to the activity of the ED and dictates the responses from different parts of the hospital'. Due to an oversight on my part, this was not further explored with him. It suggests, however, that the hospital has a regular review of managing surges in demand placed on the Emergency Department. If that is so, I would expect that it considers the issue of high demand in winter months and has a plan for dealing with nights like 18 July 2013 when there were approximately 20 more patients than beds available.

226. If it does not, in my view, hospital management ought to develop such a plan as a matter of priority. Because, however, I did not raise this issue with Dr Prahalath I do not propose to make a formal recommendation under the Coroners Act. I hope, nevertheless, that serious consideration will be given to this question.

Conclusions

227. Professor McCarthy made a very telling comment about the significance of culture in an emergency department. With a poor culture, that is, a 'culture of acceptance', when an emergency department is placed under severe pressure, its standards of care will decline. This does not have to be the case.

228. The American surgeon and author Dr Atul Gawande has written perceptively on the issue of individual performance and systems[10]:

> When medical practice goes wrong, who is to blame? The traditional answer in journalism has been unambiguous: the doctor. If the press found out a person had died from improper care or had had the wrong leg cut off, the reaction was predictable. A clamor went up for the incompetent physician's head--or at least his license. And doctors everywhere cringed. There but for the grace of God go I, each of us would say. For all of us make terrible mistakes. Only the unlucky few are publicly exposed.
>
> So I've been intrigued by the increasingly popular alternative explanation--"the system did it." In many cases, this is the right way to go. Bad systems are more often at fault than bad doctors. I worry, however, that we have already begun to take this explanation too far--so far that we are introducing a dangerous murkiness into the question of who is ultimately in charge when it comes to taking care of patients.

229. Clearly, good systems and diligent, skilful individual performance go hand in glove. In his book *Better: A Surgeon's Notes on Performance,* Gawande describes working in an under-resourced Indian hospital overflowing with patients and how the impressive surgeons there not only coped with their conditions but improved them. Gawande wrote of the lessons his experience there taught him. They were the antithesis of a culture of acceptance of mediocrity[11]:

> True success in medicine is not easy. It requires will, attention to detail, and creativity. But the lesson I took from India is that it was possible anywhere and by anyone. I can imagine few places with more difficult conditions. Yet astonishing successes could be found. And each one began, I noticed, remarkably simply: with a readiness to recognise problems and a determination to remedy them.

[10] "The Buck Stops with the Doc" Slate.com July 23, 1998; see also Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (London: Profile Books, 2002) especially chapters 3 ("When Doctors Make Mistakes") and 5 ("When Good Doctors Go Bad"); Atul Gawande, *Better: A Surgeon's Notes on Performance* (London: Profile Books, 2007) especially Ch 11, ("For Performance").

[11] Gawande, *Better* (2007), 246.

> Arriving at meaningful solutions… does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.

230. If this inquest achieves anything of significance, I hope it will be to prompt thoughtful, caring people in the organisations involved in this case to reject any signs of a 'culture of acceptance' of sliding or mediocre standards and to aim continually for excellence in their personal and organisational standards.

231. The changes made and being made in the Department of Family and Community Services, the Ambulance Service and the Campbelltown Hospital suggest that thoughtful people in those organisations are seeking to arrive at 'meaningful solutions' to the complex problems that Shona's case illustrates.

232. To lose a daughter, twice in Mr and Mrs Hookey's case, must be an unimaginably heart-breaking experience. Counsel for the Department of Family and Community Services, for carers and for the Local Health District all offered condolences and apologies to Mr and Mrs Hookey. Those apologies were graciously accepted by them.

233. An inquest is one way our society shows respect for a person who has died a sudden, unexpected and perhaps preventable death. It is a way our society shows that individual lives are precious no matter who you are. And it is a way our society learns from tragic deaths. I hope that Mr and Mrs Hookey will accept the very sincere condolences and respects of the coronial team and the staff of the Coroners Court.

Findings s 81 Coroners Act 2009

234. I find that Shona Hookey died on 19 July 2013 at the Campbelltown Hospital, New South Wales as a result of peritonitis, which was caused by ischaemia of the bowel due to gastrointestinal torsion (twisted bowel).

Recommendation s 82 Coroners Act 2009

To the Minister for Health:

235. I recommend that the South Western Sydney Local Health District review record-keeping practice and procedure in the Campbelltown Hospital Emergency Department with a view to ensuring that contemporaneous clinical records are made by staff and that those staff are provided with the means of doing so with a minimum of inconvenience.

Magistrate Hugh Dillon
Deputy State Coroner