# STATE CORONER'S COURT OF NEW SOUTH WALES

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| **Inquest:** | Into the death of Jimmy James |
| **Hearing dates:** | 11,12,18-22 May, 30 November 2015 |
| **Date of findings:** | 29 January 2016 |
| **Place of findings:** | State Coroners Court, Glebe |
| **Findings of:** | Magistrate Elaine Truscott |
| **Catchwords:** | Coronial Law-Cause and manner of death-hospital- pathway medicine-Sepsis Protocol-"Between the Flags"–record keeping- hospital review. |
| **File number:** | 2013/65777 |
| **Representation:** | Counsel Assisting Coroner:<br>Ms J Sandford instructed by Office of the General Counsel, Department of Justice<br><br>Western Sydney Local Health District:<br>Mr R Sergi instructed by Crown Solicitor's Office |
| **Findings:** | Jimmy James died on 2 March 2013 at Westmead Hospital, NSW due to pneumonia (with multiple left-sided rib fractures as the antecedent cause). |
| **Recommendations:** | **To the Western Sydney Local Health District**<br>That pending the full introduction of electronic medical record keeping at the emergency department of the Westmead Hospital, consideration be given to amending the 'Emergency department Adult Trauma Admission' form currently in use at the emergency department of the Westmead Hospital to incorporate a specific prompt for recording the results of Arterial Blood Gases (ABG) analyses. |

IN THE STATE CORONER'S COURT
GLEBE
NSW
SECTION 81 *CORONERS ACT* 2009

**REASONS FOR DECISION**

## Introduction

1 This inquest concerns the death of Jimmy James who died at the age of 44 whilst a patient in the Emergency Department of Westmead Hospital on Saturday 2 March 2013.

2 Three days previously, in the early hours of the morning of 27 February 2013 Mr James was involved in a physical altercation from which he incurred fractured ribs and bruising. He attended Westmead Hospital ("the hospital") at 3 am on 2 March. At about 9 am. he had the first of 3 cardiac arrests. Resuscitation attempts were unsuccessful and he died at about 10.45 am.

3 Pursuant to section 81 of the *Coroner's Act 2009*, a coroner's task holding an inquest is to make written findings in relation to the deceased's identity, date and place of death and the manner and cause of their death. A coroner may make recommendations as the coroner considers necessary or desirable in relation to any matter connected with the death.[1]

4 The issues in this inquest include a determination of the course of events on 27 February 2013 which led to the injuries incurred by Mr James. However, the predominant issues relate to the adequacy of the care and treatment provided to Mr James by the hospital. A further issue relates to the hospital's response to Mr James' death particularly in light of Mr James' death being reported to the coroner[2].

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[1] s82 *Coroners Act 2009*
[2] s6 *Coroners Act 2009*

5 Ultimately there is but one recommendation to make in this matter as the hospital has incepted a number of changes to meet the issues as they were identified during the course of the coronial investigation and proceedings.

6 In writing this decision I have predominantly adopted the narrative of Counsel Assisting's impeccable written submissions for fear of diminishing such accomplishment.

7 The evidence includes the brief prepared by the Officer in charge, which mainly related to the events leading up to Mr James' admission to hospital. Witnesses in relation to those events attended and gave evidence. The brief of evidence includes the Post Mortem Report of Dr R Irvine, Forensic Pathologist who also gave testimony during the inquest. Due to the hospital administration's refusal to provide but one short statement from one doctor to the Officer in charge, it was not until Counsel Assisting became involved and made numerous requisitions that the hospital provided statements shortly before and during the inquest. The remainder and bulk of the brief comprises medical and nursing staff statements and the hospital file. I was assisted by the evidence of Associate Professor David Bihari, an expert in intensivist medicine who provided a report and testimony. Numerous medical and nursing staff gave evidence further to their statements. Dr Crampton, the Chief Medical Advisor of Westmead Hospital gave evidence further to her correspondence which was tendered. Additional documents were tendered including those relevant to policy and procedure and medical literature.

## Background

8 Mr James, a Maori, was born in Kaikohe, New Zealand, and was later educated in Auckland. In 1989 he came to live in Australia. At the time of his death Mr James was working as a leading hand, employed by Neway Transport Pty Ltd (Neway), where he had worked since late 2005[3], and for some 7 years before that, as a labourer. He was well liked and respected by his colleagues at Neway, who described him, variously, as a genuine person[4], and a very good, reliable and professional worker[5].

9 Above all else, Mr James was a father and a grandfather, and he leaves behind a large and loving family. It was very evident at the inquest that Mr James was much loved, and that he is, and will continue to be much missed by all who were close to him. They include Ms Amelia Wolf, their

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3 In a residential tenancy application made by Mr James and Ms Wolf, dated 27.11.2011, it is stated that Mr James had then been employed at Neway Transport for 5 years, 3 months: Vol 1, Tab 26, p.230.

4 Statement of Michael Flahey, dated 5.3.13 at [4]: Vol 2, Tab 50, p.377.

5 Statement of Ian Hammond, dated 4.3.13 at [4]: Vol 2, Tab 48, p.370 [4]; Statement of Glen Rolfe, dated 4.3.13 at [4]: Vol 2, Tab 49, p.373.

daughter Julia, his father, Mr Jimmy James (senior), mother, Ms Eadie James, five siblings (Julia, Joy, Juanita, Ben and Joshua) and children Jessie, Jeweline, Jimmy Dean and Mahi.

10 Mr James (senior), together with Julia and Joy travelled from New Zealand to attend the inquest. Amelia, Ms Eadie James, Juanita, Jessie and Jeweline were also in attendance. Jimmy Dean was too upset to attend. At the inquest, and with the support of Mr James (senior), Amelia Wolf spoke eloquently and lovingly about the attributes of the man with whom she had shared a relationship over some eighteen years, and of the tremendous impact his tragic loss has had on their daughter, and on the family, generally. Mr James' work colleagues spoke highly of him consistent with the care and concern they showed to him in the days following the incident on 27 February. Mr James was plainly well regarded as a decent and hard-working member of the community, for whom family was all-important.

11 Mr James resided at a townhouse 13, 26-30 Elizabeth Street Granville from February 2011. Ms Wolf and Julia lived there with him until they moved to Parramatta for a short time before moving to the NSW north coast. They kept in touch with Mr James by telephone and visits.

12 In October 2012, 3 brothers, Selahi, Burak and Yusef Sivri moved into townhouse 7. Selahi Sivri had been the subject of a complaint made to police on 19 January 2013, by the occupant of Townhouse 14 (Mr Niraj Shrestha). On that day, police attended the complex in relation to an altercation between Mr Shrestha and Selahi Sivri[6], during which Mr James reportedly intervened at a point when Selahi Sivri allegedly pushed Mr Shrestha. In a statement he gave to police[7], Mr Shrestha made assertions to the effect that Selahi Sivri was the aggressor, and had made abusive and threatening statements toward him on this and on earlier occasions.

## Issue 1: The Events of 26-27 February 2013

13 On 26 February 2013, Mr James was due to commence his normal work shift at noon. He would normally cycle to work but on this day he telephoned Michael Flahey, a work colleague whose shift commenced at 4 pm and asked for a lift[8] explaining that he was not able to start work until later due to the real estate agent inspecting his premises.[9] When Mr Flahey attended in the afternoon he called Mr James on his mobile telephone but he could not locate

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6 see: COPS Report at Vol 1, Tab 20; Statement of Niraj Shrestha, dated 4.3.13 at [6]-[7]: Vol 2, Tab 38 at pp. 340-341.

7 Statement of Niraj Shrestha, dated 4.3.13 at [7]: Vol 2, Tab 38 at pp.340-341. See also: Statement of Selahi Sivri, dated 27.2.13 at [4]: Vol 2, Tab 35 at p.330; statement of Ben Harris, dated 3.3.13 at [6]: Vol 2, Tab 36, at p.335.

8 Statement of Michael Flahey , dated 5.3.13 at [6]: Vol 2, Tab 50 at p.377

9 Statement of John Rodger, dated 4.3.13 at [3]: Vol 2, Tab 47 at p.367

him. After Mr Flahey arrived at Neway another work colleague, Ian Hammond also made a number of unsuccessful attempts to call Mr James.

14 Mr Glen Rolfe, (National Trainer, Neway) said that Mr James was never late for work and it was very much out of character for Mr James to be absent. Mr Nasr, the real estate property manager gave a statement to the police to the effect that the townhouse was being sold and two weeks prior he and a photographer had attended the premises. He said Mr James had provided a spare key for inspections but Mr Nasr was not aware of an inspection that day[10].

15 It would appear that Mr James was dressed to attend work that day[11] but where he was or why he didn't answer his telephone when Mr Flahey attended or when Mr Hammond called has never been established.

16 There had been an incident during the afternoon when words were exchanged between Mr James and Selahi Sivri as Selahi drove his car out of the complex, past Mr James who was sitting outside his unit. The comment was in relation to Mr James' staring at Selahi.

17 Sunil Ghimire (occupant of townhouse 5)[12] said he heard Mr James yell out at about 5 pm *"Do you want to fuck or fight"*. This comment is consistent with a response to a remark made by Selahi Sivri to Mr James as he drove out of the complex at about that time. Mr Ghimire says in his statement that he heard Mr James yell out again *"do you want to fight"* intermittently every couple of hours between 9 pm and midnight at which time Mr Ghimire retired to bed.

18 Ben Harris, another resident of the townhouse complex, said that at about 11 pm he was woken by the sound of Mr James yelling out continuously every 20-30 minutes. Unable to sleep Mr Harris went to his study to work.[13] In his statement he said that between 2 and 2.50am[14] on 27 February he heard yelling and sounds of *"physical hitting...body to body contact"*, coupled with *"a scuffling sound"* on the concrete followed by a bang on the roller door. He said that it only lasted seconds.

19 Another resident in the Townhouse complex (Rosario Acuna[15]) was also woken by *"loud shouting"* around 2.30am on the morning of 27 February 2013. Ms Acuna did not recognise *"the[16] voice, only that it was a male voice ... walking up and down outside"*, which lasted for

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10 Statement of Joseph Nasr, dated 4.3.13 at [7]: Vol 2, Tab 37 at p.377-338

11 Statement of Burak Sivri, dated 4.3.13 at [15] (see also [5]): Vol 2, Tab 35 at p.365; 362; - Selahi Sivri at Q123-Q124: Vol 1. Tab 23 at p.141; - Yusuf Sivri at Q302-Q311: Vol 1, Tab 24 at pp.190-191.

12 Statement of Sunil Ghimire, dated 4.3.13 at [6]-[11]: Vol 2, Tab 39 at p. 343-344.

13 Statement of Ben Harris, dated 3.3.13 at [7]-[10]: Vol 2, Tab 36, at pp.335-336.

14 In his testimony he said between 2 – 3 am.

15 Statement of Rosario Acuna, dated 4.3.13 at [5]-[6]: Vol 2, Tab 45, at pp.360-361.

16 Suggestive that it was only one voice

*"about 15 minutes"*, and was then followed *by "four loud bangs...like someone was hitting something"*, and then *"everything went quiet"*.

20 Niraj Shrestha[17] was woken by his wife at about 1.30-2am. She informed him that: *"unit 13 and unit 7 are fighting"*. From his window he was able to see Townhouse 7 clearly. He observed all the lights to be on in Townhouse 7, and saw "Salam" (ie: Selahi[18]) starting up his car, and *"Salam's two brothers standing under the car port...looking towards unit 13"*. He next observed the three brothers *"drive off quickly"* in the car.

21 In his statement to police Mr Shrestha said that on Thursday 28 February, Mr Ghimire, with whom Mr Shrestha was *"very close"*, reportedly said to Mr Shrestha[19]:

> *"[Selahi] had an argument with Jimmy during the day. Then at night...Jimmy came out and was swearing at unit seven before he went back into his unit but he came back out and slammed the door at unit seven...after a while Jimmy banged on the door of [Selahi's] brother's car and as he was returning back to his unit...three guys came out of unit seven and...started bashing him in the common driveway"*.

22 That hearsay summary is consistent with what Mr James told Mr Flahey and Mr Rolfe. Mr Flahey said in his testimony that when he saw Mr James on 27 February Mr James said he had been given *"a hiding from a neighbour and some of his mates"*. On 1 March, Mr Rolfe visited Mr James and Mr James told him that *"he stuck his nose in where he shouldn't have...3 to 4 blokes came back a while later and they just gave it to me"*. Mr Rolfe said that Mr James said he was ashamed at what had happened. Amelia said Mr James' explanation to her was that he had been *"jumped at the park around the corner"*.[20]

23 After the incident the Sivri brothers drove to the police station and Selahi asked that a personal apprehended violence order be taken out against Mr James for Mr Selahi's protection. The brothers made statements to the police. They did not give evidence in the inquest about how Mr James was injured. Selahi Sivri was not served with a subpoena to give evidence at the inquest because he had left Australia.[21] However, both Yusuf and Burak Sivri attended the inquest under subpoena and were called as witnesses to give evidence. However, beyond confirming their place of residence at the material time, they each stated an objection on the ground set out in section 58(2) (a) of the *Coroners* Act 2009 which was upheld.

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17 Statement of Niraj Shrestha, dated 4.3.13 at [7], then: [9]-[10], Vol 2, Tab 38 at pp.340. then p.341.

18 see: COPS Report at Vol 1, Tab 20 (concerning Mr Shrestha's complaint to police on 19 January 2013, and as to identification of the person "Salam", as Selahi Sivri).

19 See: statement of Niraj Shrestha, dated 4.3.13 at [7] & [11]: Vol 2, Tab 38 at p.340 and 342.

20 Statement of Amelia Wolf, dated 2.3.13 at [22]: Vol 2, Tab 54 at p. 396. In her testimony she said she didn't think he was telling her the real story

21 Evidence of DSC Wilson that Selahi Sivri is not in the jurisdiction.

24 There are some disparities in the previous representations made by the brothers to the police, but in essence the version given is that Yusef went outside when he heard a bang and it was then that he saw damage to his car. Mr James attempted to punch him, but he ducked back and the punch just glanced his chin. Selahi who had been watching from his bedroom window came out and he and Mr James went to the ground until they both stood up and threw a couple of punches at each other until Mr James walked off and went back inside his townhouse. Selahi said that he punched Mr James in the face, he denied kicking him. Selahi received minor bruising to the left upper chest area.

25 Selahi said that Mr James was the aggressor. Selahi asserted that he acted in self-defence and at no time did he use excessive force. During the incident of 19 January, Mr Selahi was the aggressor and Mr James came to the rescue or support of his neighbour. Whilst there is some support from independent neighbours that it was Mr James who was making a repetitive commotion throughout the evening directed at the Sivri brothers there is a lack of independent evidence about how the incident in which Mr James was injured occurred – there is only the hearsay evidence referred to paragraph 21 above which was not adopted any further in the inquest. Accordingly, some scrutiny as to what the brothers told the police occurred is warranted.

26 Selahi said he was at home with Burak when he heard Mr James screaming out expletives from inside townhouse 13. This was accompanied by loud bangs. This would occur for 5 minutes every half hour. At about 11.30 pm Mr James was outside banging on their townhouse door, he did this intermittently and repeatedly until about 2.30 am. when there was a loud bang.

27 At about midnight, Selahi had sent a text message to Yusuf who was out. That message was shown to the police. It read *'the neighbour lost the plot his (sic) banging on the door and screaming and shit...come with a couple of boys when Ur coming home simdi I don't wanna go downstairs and get myself into shit".*

28 Yusuf told police that he arrived home alone and at that time he did not see Mr James. He later heard Mr James yelling outside, he heard *"glass noises"* and a *"banging noise"* at which point he ran downstairs and went outside. It was then that he had *"seen the damage"* to his car.

29 Yusuf says that Mr James *"ran up to [him]...throwing a punch... [and] nicked [him]...across the chin".*[22] Selahi, who had been watching from his bedroom window ran down outside. Despite Yusuf saying that he stepped back and was no longer involved[23], Selahi said he intervened to

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22 ROI - Yusuf Sivri: Vol 1, Tab 24 at Q50 p.168; Q201 p. 180; Q211-212 p.181-182;

23 *Ibid* Q389 at p.200;Q493 at p.201

*"separate"* Yusuf from Mr James[24], that he *"pushed"* or *"pulled"* Mr James away[25] or Mr James *"went to"* Selahi as soon as he saw him.[26] Yusuf said that he saw Mr James tackle Selahi to the ground.[27] Selahi said Mr James grabbed him and dragged him down, in response to which he *"started defending [himself]"*, and *"palmed him a few times in the face maybe and...hit...him a few times"..."with a closed fist".*[28]

30 Yusuf claimed to have not laid hands on Mr James[29]except to pull him and Selahi apart.[30] Yusuf denied seeing anyone kick Mr James[31]. Both brothers said that the incident was of a short duration and Mr James just walked back to his townhouse like normal.[32] They both said Mr James smelt strongly of alcohol.[33]

31 Burak Sivri said that he had stayed in his room until going outside due to curiosity. He said that he saw Selahi and Mr James grappling on the ground in the driveway about 10 m away. He said he did not see any punches being thrown.[34]

32 Mr James' injuries included multiple left sided rib fractures[35] a bruised and swollen right eye[36] and probably some injury causing bleeding, perhaps a bloody nose.[37] How the injuries were caused and regardless of whether Selahi was acting alone and initially or ultimately in self-defence, it can be said injury-wise that Mr James came off significantly second best. The injuries to Selahi were "some bruising on his upper left chest" which was photographed by the police. The injuries to Mr James were such that he was unfit to attend work.

***Wednesday 27 February 2013***

33 On 27 February 2013, Mr James did not attend work. Mr Rodger, a work colleague, unsuccessfully tried to contact Mr James' mobile telephone, so he visited Mr James' home at

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24 ROI- Yusuf Sivri: Vol 1, Tab 24 Q230 at p.183; ROI - Selahi Sivri: Vol 1, Tab 23 Q59 at p.133...
25 ROI - Yusuf Sivri: Vol 1, Tab 24 Q234-235 at p. 184; Q397 p.201.
26 *Ibid.* Q400 at p.201.
27 Ibid Q234-237 at p.184
28 ROI Selahi Sivri: Vol 1, Tab 24 Q 59 at p.133 and Q107-Q108 at p. 139
29 ROI Yusuf Sivri : Vol 1, Tab 24 at Q387-Q389 at p.200; Q493 at p.201.
30 *Ibid.* Q430-Q436 at p.204.
31 *Ibid.* Q402 at p.201.
32 ROI- Yusuf Sivri: Vol 1, Tab 24 Q279-Q280 at p.188; ROI - Selahi Sivri: Vol 1, Tab 23 Q103 at p.139.
33 Statement of Selahi Sivri, dated 27.2.13 at [17]: Vol 2, Tab 35 at p.332. ROI - Yusuf Sivri: Vol 1, Tab 24 at Q249-Q252 at p.185; Q255 at p.186.
34 Statement of Burak Sivri, dated 4.3.13 at [15]-[16]: Vol 2, Tab 35 at p.365.
35 As evident from hospital records and the post mortem report of Dr Irvine, forensic pathologist
36 see: Statement of Martin Allred, dated 3.3.13: Vol 1, Tab 9 at pp.68-71.
37 Blood was found on his work vest which he was reportedly wearing at the time and blood drops were seen on the floor at the door entry by witnesses and which was photographed by police. He told Ms Wolf on 2nd March he had a broken nose and he had been coughing up blood.

about 4.30pm[38]. Mr James' vehicle and pushbike were in the carport. Mr Rodgers knocked on the front door for about ten minutes (the screen door being open) without receiving a response. He saw blood speckles near the door handle of the wooden (front) door. Mr James later informed Mr Flahey that he was at home when Mr Rodger visited, but that he (Mr James) was upstairs and *"was in too much pain to come down."*

34 Having been informed of Mr Rodger's (unsuccessful) efforts to locate Mr James, Mr Flahey decided to go to Mr James' home after work on 27 February 2013[39]. He did so, arriving at around 8.30pm. He saw *"blood spattered in a number of small drops"* directly inside the front door. In his testimony, Mr Flahey confirmed that Mr James *"did not want to go into the details"* of what had occurred the previous evening, save to state that he got a *"hiding from a neighbour and some mates"*. Mr James stated that he thought he had broken ribs. He also told Mr Flahey that he had *"lost"* his phone. On noticing that Mr James was holding his side as he walked, Mr Flahey expressed concern that Mr James may have a collapsed lung or internal injuries, and urged Mr James to go to hospital. In his testimony, Mr Flahey confirmed that he offered to take Mr James to hospital, but that the more he *"pushed"* the more Mr James voiced his resistance.

35 At 10pm on 27 February 2013, Constable Allred attended Mr James home and served a provisional apprehended personal violence order on him. Constable Allred observed Mr James to have a bruised and slightly swollen eye, and to be holding his chest around the lower ribs, with his hand. Constable Allred offered to call an ambulance. Mr James asked whether Constable Allred could drive him to a doctor. Constable Allred explained he could not do so, but again offered to call an ambulance but Mr James declined stating that he would go to the doctor the next day. Mr James also declined to engage in discussion with Constable Allred about the events of the previous evening, stating: *"We've had issues for ages, but it's sorted now, it's all good"*.

***Thursday 28 February 2013***

36 There is no evidence relating to Thursday 28 February 2013. Presumably Mr James stayed at home resting.

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38 Statement of John Rodger, dated 4.3.13 at [6]-[7]: Vol 2, Tab 47 at p.368.

39 Statement of Michael Flahey, dated 5.3.13 at [9]-[10]: Vol 2, Tab 50 at pp.378-379.

***Friday 1 March 2013***

37 Investigations conducted by the police reveal that Mr James left his home on Friday 1 March 2013 and at 10.25 am he withdrew money from a Westpac ATM in South Street, Granville and at 10.39 am. he purchased a packet of 20 tablets of Voltaren and anti-inflammatory gel from a pharmacy. At 11.44 am. Mr James placed $150 to recharge a mobile phone Ms Wolf had given him.[40] It is unlikely he attended a doctor[41].

38 Between 12.45 and 1.54pm Mr James and Ms Wolf exchanged texts in relation to Julia visiting over the weekend. Mr James initially sought to postpone the arrangement but in the end, it was agreed for her visit to take place around noon on Saturday 2 March 2013.

39 At about 2.15-2.30 pm Mr Rolfe attended Mr James' home.[42] Mr Rolfe observed him to have bruising covering the entire right eye, and to be hunched over and holding his ribs on the right side. His impression was that Mr James was *"a bit vague"*, and appeared dehydrated, thin and gaunt. He otherwise confirmed that Mr James told him that *"he stuck his nose in where he shouldn't have"*, and *"was ashamed of what had happened"*, but that Mr James did not elaborate, save to reiterate *"three to four guys gave it to [him]"* (viz. per his statement, Mr James said to him: *"This is what happened as a result of [Mr James sticking his nose in]. Three or four blokes came back a while later and they just gave it to me"*). He too urged Mr James to go to hospital, but Mr James almost *"begged"* him not to call an ambulance. Mr James told him that he'd lost his wallet and *"his phones were smashed up by these blokes"*.

40 Mr Rolfe departed the premises to purchase some food for Mr James. Upon his return, Mr James was *"talking, coherent and had an appetite"*. Mr James had also told him that he felt better than he was two days ago. Mr Rolfe's impression was that Mr James would be okay. He left the premises on the understanding that he would cook up some stews for Mr James, and return to deliver the stews, and see Mr James the following day. In fact, to his very great credit, Mr Rolfe did return to deliver the stews at about 9.30am the following morning, when unbeknownst to him, Mr James was in extremis at the Westmead Emergency Department (ED). He returned to Mr James' residence at about midday that day, to be greeted by Mr James' son, Jimmy Dean, who told him of the tragic outcome.

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40 see: Statement of DSC Mennilli, dated 4.4.13 at [10.2]-[10.3]: Vol 1, Tab 7, at p.65.
see: Vol 1, Tab 32, p.272.

41 The inquest received evidence from Dr Watik Latif, a general practitioner whom Mr James had attended since August 2003. That evidence demonstrates that Mr James last attended upon Dr Latif on 21 January 2013 (see: statement of Dr Latif, dated 1.5.15 at [4]: Vol 2, Tab 53 at p.390).

42 In his testimony Mr Rolfe confirmed the date, his statement incorrectly citing Friday 28 March

***Saturday 2 March 2013***

41 At 2.17am on 2 March Mr James telephoned Ms Wolf. He told her that he had been *"jumped"* on Tuesday night *"at the park around the corner"*[43], and that he had broken ribs, a broken nose and a black eye, had been coughing up blood, and his legs had *"gone numb"*. He accepted Ms Wolf's offer to take him to hospital. For reasons including those set out in the statement she gave to police[44], Ms Wolf did not believe Mr James' story about having been jumped in the park. In her testimony, she elaborated, stating that Mr James was *"evasive"* and *"grumpy"* and *"shut [her] down"* when she pressed him for information. She added that in all the years she had known Mr James (since 1997) he *"only ever got into two fights"* and she did not think he started them.

42 Ms Wolf and Julia arrived at Mr James' house about 2.30am. Ms Wolf observed blood on the floor in the lounge room and kitchen. Mr James was showering at the time of her arrival. She helped him to dress. He insisted upon retrieving his sandals from the garage, but Julia followed him, and later told Ms Wolf that the interior of the garage was in a mess. Her testimony was that Julia told her the garage was *"trashed"*[45].

43 Ms Wolf's testimony was that Mr James complained that his legs were *"numb"*, and that it was a *"struggle"* to get Mr James downstairs. She also described how, en route to Westmead Emergency Department, Mr James appeared to be *"struggling to breathe"* and *"gasping and struggling to talk to Julia"*. In her statement to police[46], she also gave a description that Mr James was *"wincing in pain"*.

44 Ms Wolf's testimony was that at the Westmead ED, Mr James told staff that he had been *"kicked in the head and ribs"*, and mentioned to her that he had been *"stomped in the balls"*.

45 Dr Tran, who saw Mr James soon after he was triaged, stated that Mr James told him that he had been *"assaulted in a park"*[47]. Dr Samra documented a history that Mr James had been *"kicked"* in the head, face, chest, abdomen and groin[48]. Nurse Copeland documented a history that Mr James had been *"kicked"* to the chest and stomach[49]. Dr Lorenzo documented a history that Mr James had been *"punched"* in the face, chest and abdomen[50].

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43 Statement of Amelia Wolf, dated 2.3.13 at [22]: Vol 2, Tab 54 at p. 396.
44 *Ibid.* at [35]-[36] & at p.398 and see also at [30] p.397.
45 Little can be made of this evidence where the forensic examination conducted by police (of the inside of the garage) did not, apparently, expose anything suspicious: see statement of SC Jones, dated 7.5.15 at [17]: Vol 1, Tab 20 at p.95f.
46 Statement of Amelia Wolf, dated 2.3.13 at [27]: Vol 2, Tab 54 at p.397.
47 Statement of Dr Tran, dated 15.5.15 at [6]: Vol 2, Tab 65d at p.449g.
48 Vol 2, Tab 66 at p.458.
49 Vol 2, Tab 66 at p. 485.
50 Vol 2, Tab 66 at p. 460.

46 On CT performed at Westmead ED on 2 March 2013[51]:

a) No acute facial bone fracture, or intra-cranial injury, was identified.

b) Displaced rib fractures in the left 5th to 9th ribs laterally, were identified.

c) A *"tiny"* pneumothorax was seen in the left lung.

*d)* No injury to the abdominal viscera was identified.

47 In view of the history of recent trauma the consolidation in the right lung was *"favoured"* by the reporting radiologist *to represent blood and less likely infection"* while other findings throughout both lungs were considered to be *"in keeping with pulmonary contusion and/or oedema".*

48 *Various superficial injuries, including multiple contusions to the forehead* and peri-orbital area[52], were noted by treating medical attendants. Dr Samra noted that Mr James was tender all over the chest and abdomen[53]. Dr Lorenzo noted four contusions on the anterior abdominal wall[54]. Mr James complained to Dr Samra of tenderness in the groin (but no redness or bruising was seen on examination[55]). Dr Tran discerned no tenderness on palpation of the testes[56].

49 At Post Mortem, Dr Irvine, forensic pathologist, identified fractures of the left anterolateral 4th through 6th ribs, left lateral 9th rib, and *"possibly"* left lateral 8th rib (Dr Irvine commented on the possibility that this fracture may have been related to the autopsy process[57]). A nasal fracture of unknown age was also identified[58]. Various non-contributory blunt force injuries (comprising contusions and abrasions) were also identified[59]. No blunt force injury to the abdomen/abdominal organs was identified.

50 Mr James' injuries are consistent with Mr James' report of being kicked and punched by several persons. The evidence supports a version that at some stage Mr James was on the ground[60] and if he was kicked to the chest it was likely to have occurred whilst he was on the ground. Whether Mr James' received any rib fractures from falling on the ground and or from being kicked or punched or a combination of both is not possible to determine. Mr James was likely

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51 Report of CT Trauma Study: Vol 2, Tab 66 at p.505-506.
52 Vol 2, Tab 66 at p. 460 (Dr Lorenzo's note).
53 Vol 2, Tab 66 at p. 411/459.
54 Vol 2, Tab 66 at p. 461.
55 Vol 2, Tab 66 at p.411/459.
56 Vol 2, Tab 66 at p. 481(and see Vol 2, Tab 65d at p.449h[8]-[10]).
57 Autopsy Report for the Coroner: Vol 1, Tab 6 at p.36.
58 *Ibid.* at p. 30.
59 *Ibid.*
60 Selahi's shirt was torn and dirty.

intoxicated[61] and it was likely that he had been drinking over the course of the night as his agitation was increasing into the early hours of the next morning. It may be that his level of intoxication played a part in his ability to fend for himself when involved in the physical altercation. It is not possible to determine whether Mr James was confronted as he was walking back to his unit or outside his unit or in the terms described by Yusuf and Selahi Sivri. However, it does appear that the altercation occurred near the townhouse 7 carport.

***Conclusion about the Physical Altercation***

51 Mr Selahi was barely injured (he had "*some bruising to his right upper chest*") and his version of what occurred does not satisfactorily account for the extent of Mr James' injuries. This, together with Mr James' report of several people, make it more likely that Mr James' injuries were inflicted by a person or persons in addition to Mr Selahi, the identity of whom is unable to be ascertained. Selahi Sivri claimed his acts were in self-defence. The evidence does not allow for a determinative resolution of this issue, other than to say if Mr Selahi was not acting alone as he claimed it is unlikely he was acting in self-defence.

## Issue 2: The Care and Treatment - whether Mr James received Timely and Appropriate Management at Westmead Emergency Department

### (i) The Physical and Medical condition of Mr James on Presentation to the Westmead ED

52 The nature of Mr James' *physical* condition when he presented to the hospital was as summarised above [46-49]. The following clinical signs indicate his *medical* condition:

a) **Shortness of breath**

Ms Wolf had noticed that Mr James was struggling to breathe[62], and his shortness of breath (SOB) was documented by RN Doherty[63] (at 03.34hrs), and by RN Copeland[64] at (03.40hrs), the latter noting "*presents with increasing SOB*". On examination at

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61 Selahi and Yusuf both report a strong smell of alcohol on Mr James. Ms Wolf gave testimony that Mr James drank too much alcohol and Mr Hammond (Neway) said Mr James liked a drink. Mr James' treating doctors (see for example: report of Dr Patullo, dated 19.7.2007: Vol 2, Tab 72 at pp.615-616.

62 see: paragraph [43]

63 ED Nursing Progress Note, entered at 03.28 hrs on 2.3.13: Vol 2, Tab 66, at p.484.

64 Trauma Sheet, Nursing Progress Notes: Vol 2, Tab 66, at p.485.

about 03.15hrs[65] Dr Samra elicited a history that Mr James had been assaulted 4 days ago, and *"developed SOB on Day 1"*.

b) **Low saturation of oxygen**

At triage, RN Canete[66] found Mr James' saturation of oxygen (on room air) to be 93%. Oxygen given via a non-rebreather facemask achieved some transient improvement. Thereafter, as acknowledged by Dr Moulden in her testimony, saturations declined[67].

c) **Respirations**

At triage, Mr James' was tachypneic (abnormally rapid breathing). His respiratory rate was abnormally rapid at 30 bpm (breaths per minute), and rose to 35bpm at 03.34hrs[68]. As acknowledged by Dr Moulden in her testimony, respirations recorded after 03.34hrs until approximately 06.45 (this being the last time at which respirations were recorded) show that Mr James remained tachypneic. That his tachypnoea had worsened by 07.00hrs is evident from the notes made, and the measures taken by RN Cunynhame once she came on duty at 07.00hrs[69].

d) **Temperature**

Mr James' temperature, which was not recorded before approximately 03.40hrs (and was then found to be 35.1C), showed that he was hypothermic[70]. This was the first and only occasion when temperature was recorded before 08.10hrs, at which time RN Cunynhame noticed that Mr James was *"cold"*.[71]

e) **Blood pressure**

Mr James' blood pressure, which was not recorded before approximately 03.15hrs (and was then found to be 98/90), showed that he was hypotensive (ie: systolic blood pressure less than 100mmHg) and had a narrowed pulse pressure[72] (ie: a low numeric difference between systolic and diastolic blood pressure). In his testimony, A/P Bihari explained that this narrow pulse pressure was indicative of vasoconstriction and loss of blood volume due to hypovolaemia.

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65 Statement of Dr Samra, dated 1.5.15 at [8]: Vol 2, Tab 58A, at p.420b.
66 Triage presenting information: Vol 2, Tab 66, at p.457.
67 See: *Schedule of Observations*, handed up at inquest
68 *Ibid.* See also *Schedule of Observations.*
69 Vol 2, Tab 66 at p. 486.
70 Report of A/P Bihari: Vol 3, Tab 76 at p. 780. In her testimony, Dr Moulden agreed that Mr James was hypothermic at 03.40hrs and added that, because temperature is a marker of perfusion, she would have expected it to be monitored.
71 per testimony of RN Cunynhame.
72 *Ibid.*

f) **Heart rate**

Mr James' heart rate, which was not recorded before approximately 03.20 hrs (and was then found to be 120), showed that he was tachycardic (ie: he had a rapid heart rate). As acknowledged by Dr Moulden in her testimony, Mr James remained tachycardic. In his testimony, A/P Bihari pointed to the measurements of heart rate recorded following Mr James' admission as indicative of hypovolaemia[73].

g) **Elevated lactate (12.7mmol/L) and deranged pH (7.22)**

Arterial blood gases (**ABG**) processed at 03.35hrs (**03.35 ABG**) showed a severe lactic acidosis[74]. The testimony of A/P Bihari was that a blood lactate of 4.0mmol/L or more is a *"red flag"*, with sepsis being *"the first thing that comes to mind"*, for which *"time to first antibiotics is critical"*.

h) **Abnormal serum creatinine of 302 mmol/L**

The 03.35 ABG also showed that Mr James had an *acute* kidney injury (serum creatinine of 302 mmol/L)[75]. In his testimony A/P Bihari reiterated that Mr James' renal impairment was a *consequence* of the shock from which he was suffering (ie: it was ***not*** a co-morbidity).

Mr James' renal function was also demonstrated by *laboratory* blood chemistry results for creatinine and estimated glomerular filtration rate (**eGFR**)[76], derived from blood samples processed by Dr Tran at 03.45hrs. These results were available on the electronic record at about 04.45 am.[77]

i) **Profound leukopaenia (low white cell count)**

Full blood count (**FBC**) results (derived from blood samples processed by Dr Tran at 03.45hrs) showed a very low white cell count (**WCC**) of 0.7. This result was available

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73 A/P Bihari discounted the heart rate of 80bpm, recorded by Dr Lorenzo at approximately 05.30-05.45, as *"spurious"* (see also, paragraph [113], below).

74 Vol 2, Tab 66 at p. 470; Expert report of A/P Bihari: Vol 3, Tab 76 at p. 780 (5th paragraph).

75 Vol 2, Tab 66 at p. 470; Expert report of A/P Bihari: Vol 3, Tab 76 at p.781 (3rd paragraph).

76 Vol 2, Tab 67 at p. 507.

77 see: Statement of Nadine Thompson, dated 23.4.15 at [9]-[16]: Vol 2, Tab 61 at p. 429. Her testimony was that although these results were not available on "Firstnet" when she checked before administering contrast, they were available when she checked at approximately 04.45hrs, after performing the scan (see also, paragraph [125], below). Vol 2, Tab 68 at p. 521.

no later than 04.54hrs[78]. A/P Bihari remarked that the WCC was *"of particular concern"* and was suggestive of *"profound toxic bone marrow suppression"*.[79]

Dr Samra knew of the WCC when he reviewed Mr James at or *"about 05.15hrs"*[80]. The testimony of Dr Lorenzo (who commenced to assess Mr James between 05.30-05.45hrs) was, ultimately, to the effect that the WCC did **not** come to his attention. (See below, at paragraphs [106] & [109]). Yet, Dr Cao made a note of the WCC in the ED Trauma Admission sheet[81], and agreed that the result (ascertained from a computer) would have been available to Dr Lorenzo. Her evidence was that she and Dr Lorenzo generally reviewed the records together.

j) **Deranged liver function indicative of *acute* hepatic necrosis**

Blood chemistry results (derived from blood samples processed by Dr Tran at 03.45hrs) showed hepatic derangement, demonstrated by an aspartate transaminase (**AST**) of 3242, an alanine transaminase (**ALT**) of 1064, Bilirubin of 55, and an abnormal liver synthetic (**INR**) of 1.5.

It is likely these blood chemistry results were available at a 04.45hrs, when the other blood chemistry results, specifically, those indicative of renal impairment, (see h) above) were seen by Ms Thompson when she accessed the Firstnet database. The testimony of Dr Arunanthy was that it is likely that all of the blood chemistry results became available at the same time (although this is not always the case).

Dr Irvine (forensic pathologist) attributed the centrilobular necrosis of the liver to *"shock within the hours prior to death"*, *"probable sepsis"* and *"possibly a toxic effect of overuse of paracetamol"*[82]. A/P Bihari also considered the liver necrosis to be *acute*[83] (as opposed to chronic) and felt it was probably due to ischaemia coupled with continuous use of low dose paracetamol, on the background of a damaged liver due to hepatitis C infection and chronic alcohol abuse.

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78 Vol 2, Tab 67 at pp. 515 & 519.
79 Expert report of A/P Bihari: Vol 3, Tab 76 at p.780 (3rd paragraph).
80 As to time of review see: Statement of Dr Samra, dated 1.5.15 at [13]: Vol 2, Tab 58A, at p.420c-420d.
81 Vol 2, Tab 66 at p.482.
82 Autopsy Report for the Coroner, dated 24.4.2014: Vol 1, Tab 6, at p.29 & 31.
83 Expert report of A/P Bihari: Vol 3, Tab 76 at p.779 (at point 7); see also at p. 780.

k) **Skin discolouration**

RN Canete observed Mr James to be jaundiced at presentation[84]. Shortly thereafter, Dr Tran noted *"widespread ecchymosis"* across Mr James' abdomen[85]. In his testimony, Dr Tran clarified that he used this term to describe *"uniform discolouration across [Mr James'] abdominal wall"* but *"was not sure what it might have been"*. In her testimony, Ms Wolf said Mr James' skin was *"all patchy from the top of his ribs to his knees"*, adding that it was *"very strange"* and *"blotchy"* and *"purplish in colour"*. She did not think it looked like bruising. She raised her concern with medical staff and was told *"it was probably bruising"*[86]. In his testimony, Dr Samra could not comment upon the note made by Dr Tran (as to the presence of ecchymosis), and did not recall being alerted by Ms Wolf to what she had observed, but agreed that skin mottling can be indicative of septic shock[87]. Dr Lorenzo expressed the opinion that ecchymosis is distinguishable from mottling, and speculated that the note (made by Dr Tran) in the ED Trauma Admission sheet *"tells us that the patient may have internal bruising"*. As noted above, Dr Tran was not sure what the discolouration he saw was. Otherwise, Dr Lorenzo accepted that mottling is consistent with sepsis, and is indicative of hypo-perfusion.

53 Mr James also had underlying (pre-morbid) medical and other conditions, specifically:

a) A history of alcohol overuse.

b) Hepatitis C virus infection.

c) Moderate hepatitis with early cirrhosis[88].

d) A history of anal carcinoma (successfully treated in 2007, with no abnormality detected on follow up between 2007 and 2012[89]).

e) Moderate chronic lung disease[90].

54 Notwithstanding his concurrent *chronic* medical conditions, the picture painted by the evidence is that Mr James was not a sickly man; rather he was a man who struck those who saw him day to day as *"a fairly fit individual"*, who up until the 27 February 2013 appeared to be *"healthy and well"* (per Mr Hammond of Neway[91]). According to Ms Wolf, Mr James had lost weight, but she did not attribute this to any medical condition[92]. Mr James was not apparently in need of any

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84 Vol 2, Tab 66 at p. 457.
85 Vol 2, Tab 66 at p. 481 (and see Vol 2, Tab 65d at p.449h[6]-[10]).
86 Bruising was not indicated at autopsy
87 Ex. 4 H. Ait-Oufella, et.al *Mottling score predicts survival in septic shock*, Intensive Care Med (2011) 37:801-807.
88 Autopsy Report for the Coroner, dated 24.4.2014: Vol 1, Tab 6, at p. 29 & p. 31.
89 see: Radiation Oncology Network Follow-Up notes at Vol 2, Tab 73 at pp. 620-622.
90 Autopsy Report for the Coroner, dated 24.4.2014: Vol 1, Tab 6, at p. 29.
91 Statement of Ian Hammond, dated 4.3.13 at [4] & [10]: Vol 2, Tab 48 at p. 372.
92 Rather, Ms Wolf, believed Mr James' *"significant"* weight loss of *"probably about 10 kilograms"* to be due to *"drinking...because of associated stress"* (see: Statement of Amelia Wolf, dated 2.3.13 at [34]: Vol 2, Tab 54 at p.398).

form of regular medical treatment[93], and had been in the habit of riding his bicycle over some considerable distance between his home and his work at Neway (according to Mr Flahey, for about six months[94]). Mr James was very rarely absent from work. Indeed, according to Mr Rodger *"he was always after overtime and disappointed if he didn't get it"*[95].

55 With the benefit of Dr Irvine's autopsy report, and in the light of the objectively ascertainable clinical signs identified above (at paragraph [52]a)-j)), A/P Bihari opined that, Mr James presented to the Westmead ED with multi-organ failure secondary to septic shock, originating from pneumonia, and was *"clearly a very sick man"* [96]. His opinion was that *"more aggressive resuscitation"* following the analysis of blood gases at 03.35hrs *"may have changed the hospital outcome"*[97]. Indeed A/P Bihari concluded that, if appropriate intervention had occurred at about that time, Mr James' death might have been prevented[98].

56 In his testimony, A/P Bihari reiterated that, Mr James was a *"very sick man"*, who exhibited *"signs associated with a poor outcome"* (specifically, Mr James was hypovolemic and had a low WCC). Citing statistical data (the "ARISE" study), A/P Bihari's testimony was that 40-50% of such patients do not survive, while four in six do. In response to a proposition put in cross-examination (viz. that A/P Bihari could only say that Mr James' death *"might"* have been prevented because of what, it was asserted, were Mr James' asserted *"serious co-morbidities"*) A/P Bihari frankly acknowledged that *"we don't know what might have happened"*, but pointed to the statistical evidence showing that *"at least half and possibly 60% of patients with such presenting signs would have survived"*. A/P Bihari did not intimate, and it was not suggested to him under cross-examination that, any features of Mr James' presentation were such that, even with appropriate treatment, Mr James was destined to fall within the cohort that would not survive.

57 Mr Sergi, on behalf of the hospital, does not take issue with a finding that Mr James' medical condition was multi-organ failure secondary to septic shock originating from pneumonia attributable to his rib fractures. Mr Sergi takes issue that the Court would find that the time at which the need for *aggressive medical treatment* was **indicated to** Mr James' treating doctors

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Possible sources of stress at that time, may have included recent events concerning his grandchildren, in respect of which he had taken leave, to which Mr Rodger alluded (Vol 2, Tab 47 at p.368 – see also Mr Hammond at Tab 48, p. 370), and, the distance that separated him from Julia following Ms Wolf's recent move to the north coast of NSW (see: Statement of Amelia Wolf, dated 2.3.13 at [10]: Vol 2, Tab 54 at 394).

93 The notes of Dr Latif, Mr James' GP, confirm that Mr James attended on very few occasions, largely in respect of routine ailments only (eg: cough, flu, diarrhoea and vomiting), and did not require any regular prescription or other medication (see: Vol 2, Tab 75).

94 Statement of Michael Flahey, dated 5.3.13 at [5]: Vol 2, Tab 50, p.377.

95 Statement of John Rodger, dated 4.3.13 at [4]: Vol 2, Tab 47 at p. 367.

96 Expert report of A/P Bihari: Vol 3, Tab 76 at p.779 (point 2) & at p. 780 (2nd paragraph).

97 *Ibid.* at p.780 (9th paragraph).

98 *Ibid.* at p. 784 (6th paragraph).

was any earlier than about 05.15-05.30 when Dr Samra had all the results from the investigations and attended Mr James for second review.

58 Mr Sergi submits that the trauma investigations carried out by the hospital were reasonable given the history Mr James provided of being assaulted. Indeed Mr Sergi submits that the hospital would be criticised if Mr James hadn't been sent to radiology for CT scans. Mr Sergi says that given the need to have those tests performed, Dr Samra's review at 05.15-05.30 was the earliest time at which he could properly consider all the results and at which time he did query sepsis and ordered antibiotics to address that issue. Accordingly, an understanding of the sequence of events and then the doctors' responses to those investigations is necessary.

### (ii) Sequence of Medical Attention, Investigation and Treatment at Westmead Emergency Department

59 Mr James arrived at ED at 03.02[99] and was triaged at 03.06[100]. Mr James was seen by Dr Samra, one of the two Registrars on duty at 03.15. Dr Samra who had care of Mr James throughout his admission in ED, ordered blood tests including ABG, he ordered a CT scan of head/neck and chest/abdomen, he ordered the commencement of patient pain relief and fluids stat and he requested an acute surgical review[101].

60 At 03.34 a mobile chest x-ray was performed[102] after which Mr James was moved to a bed in the resuscitation bay[103]. At 03.35 the ABG results were processed.[104] (The results of which are known at that time as they are printed out into the hand of the doctor who processes them). At 03.40 RN Copeland commenced IV fluids and a nurse trauma flowsheet.[105]

61 Dr Tran (a resident (junior doctor to Dr Samra)) processed various orders for blood tests at 03.45 and at 03.48 entered a request for CT Chest and CTA abdomen onto the RIS system. At 04.00 Dr Tran made further observations of Mr James and partially completed the ED Trauma Admission Sheet[106] At 4.06 Dr Samra processed his order for CT Facial bones and brain[107]

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99 Medical records Vol 2, Tabs 66-68 p 457
100 *Ibid* p 457, however RN Canete failed to take Blood Pressure, temperature and pulse rate
101 *Ibid* pp 458, 489,497
102 *Ibid* p 504
103 Dr Samra's evidence.
104 Medical records Vol 2, Tabs 66-68 p 470
105 *Ibid* p 480, 480A, 490C, 485
106 *Ibid* pp 519, 480, 480E and 481.
107 *Ibid* p 522

62 At 4.20 the CT trauma study was completed. Prior to commencing the study, radiographer Ms Thompson noted that creatinine and eGFR results were not on the Firstnet system (computer system) and at 04.15 she telephoned ED and was advised by a registrar to conduct the study anyway as Mr James was *"youngish and we don't need bloods to do a scan".*[108] The ABG results taken 40 minutes earlier showed the serum creatinine level of 302mmol/L[109] but those results were not available electronically.[110] It is likely that the registrar with whom Ms Thompson spoke was Dr Samra as having reviewed Mr James, he was in a position to give the advice she was given. There was only one other ED registrar on duty, Dr Malik who says, and I accept, he had no involvement with Mr James.

63 At about 04.45 Ms Thompson noted that the **serum** creatinine and eGFR results were on Firstnet.[111] At 04.59 Ms Thompson made a procedural note on the RIS system indicting that she had contacted the radiology registrar to speak with the ED registrar to ensure that Mr James was given more hydration.[112] At 05.20 RN Copeland signed for the administration of 2 x 1L Normal saline.[113]

64 At 04.54 the full blood count was available on FirstNet and the laboratory notified ED of the very low WCC.[114] The CT Trauma study was reported at 05.13[115] Dr Samra then reviewed Mr James, (05.15-05.30). Dr Samra noted the WCC and deranged renal function and in his notes he queried whether Mr James had an underlying sepsis. He ordered intravenous antibiotics, and sought a High Dependency Unit Admission and review by the acute surgical team.[116] At 05.30 am. antibiotics Ceftriaxone 1g IV and Azithromycin 500mg were charted and given (once only).[117]

65 Between 05.30 and 05.45 Dr Lorenzo, surgical registrar, accompanied by Dr Cao (resident – junior to Dr Lorenzo) attended the ED resuscitation bay to review Mr James. (They had come earlier at which time Mr James was in radiology for his CT scans).[118] At 06.00 RN Copeland charted observations and at 06.10 gave Mr James 5 mg Endone (PO) for his complaint of leg pain.[119]

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108 Statement of Thompson Vol 2 Tab 61, p.429 [10].
109 Medical records Vol 2, Tabs 66-68 p470
110 Crampton Tab 102, p.10
111 Statement of Thompson Vol 2 Tab 61, p.429 [16]
112 Medical records Vol 2, Tabs 66-68 p21; Statement of Thompson Vol 2 Tab 61, p.429 [16]
113 Medical records Vol 2, Tabs 66-68 p489 and testimony of RN Copeland. It is likely that this entry was retrospective for the first fluids provided at 0340 before Mr James was taken to radiology (see para 60 above) See FN 106 and 126
114 Medical records Vol 2, Tabs 66-68 p515, 521
115 *Ibid* pp505-506
116 *Ibid* pp464, Statement of Dr Samra Vol 2 Tab 58a, p.420c-420d [13]
117 Medical records Vol 2, Tabs 66-68 p496
118 *Ibid* p 460 -461 and testimony of Drs Lorenzo and Cao.
119 *Ibid* pp 480A, 485, 496

66 Dr Lorenzo did not make any notes of any diagnosis. Rather, at 06.15 Dr Lorenzo documented his management plan which included admitting Mr James into the High Dependency Unit, assist his breathing with high flow oxygen nasal prongs, provide patient controlled analgesic, free fluids and DVT prophylaxis, a urine dip test to assess alcohol withdrawal scale and give Thiamine 100mg IV stat. He ordered that an indwelling catheter be placed, blood tests be repeated, another chest X-ray be performed later that day and a hepatitis profile be taken.[120] Dr Cao completed the ED Trauma Admission Sheet that had been commenced by Dr Tran.[121]

67 At 06.45 Dr Tran completed an ED Ward Transfer Form to be signed off by a senior medical Officer[122]. This form is usually completed at the request of the ED registrar.

68 At 07.00 the nursing night shift handover to morning shift occurred. RN Cunynhame commenced care of Mr James who was still in the resuscitation bay in ED. At 7.30 panadol 1g charted by Dr Samra was given by RN Cunynhame and at 7.35 Fentanyl IV 50 mcg was given.[123]

69 At 7.40 RN Cunynhame made a note of her observations of Mr James at 07.00. She wrote that he was in respiratory distress – tachypoeneic and hypoxic. The high flow nasal prongs rate of $FiO_2$ 28% was increased to 30% but Mr James remained hypoxic at 85%. RN Cunynhame requested that a doctor review Mr James and she wrote she was awaiting same. [124] At 07.50 RN Cunynhame put up a third litre of normal saline to run over 4 hours.[125] Another dose of Fentanyl was given at 07.55.[126]

70 At 08.00 the medical staff handover to morning shift commenced. Dr Arunanthy was the consultant ED doctor. She attended Mr James in the first 10 minutes of her arrival. She ordered that the $FiO_2$ be increased to 60% and that a repeat ABG be performed. RN Cunynhame wrote this in her progress notes including *"discussion made for arterial line insertion (for regular ABG's) and ? for intubation"*. Dr Arunanthy continued her rounds of the ED[127]

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120 *Ibid* p 461, Statement of Dr Lorenzo Vol 2 Tab 60 p 425 [11]-[12]
121 Medical records Vol 2, Tabs 66-68 p480E-483; Dr Cao testimony
122 Medical records Vol 2, Tabs 66-68 p456, Statement of Dr Tran Vol 2 Tab 65D, p.449H [14]-[15]
123 Medical records Vol 2, Tabs 66-68 p497
124 *Ibid p 486*
125 *Ibid* pp 489-490; Testimony of RN Cunynhame. See FN 114.
126 Medical records Vol 2, Tabs 66-68 p497
127 Testimony and statement of Dr Moulden Tab 64 p 442 [6], Dr Arunanthy Tab 63, p 436 [16] and RN Cunynhame Tab 62, p 432 [14] % p 433 [24] and Medical Records Vol 2 Tabs 66-68 p 486

71 At 08.20 RN Cunynhame noted that Mr James was *"spitting out brown type liquid and he was sounding more congested in upper respiratory tract. Audible wheeze. Decision made to intubate".*[128]

72 At 08.35 Intensive Care Unit was paged to attend and Dr Thomas and Dr Kamaraju arrived about 08.45.[129] At about 08.55 Mr James had a seizure with nil pulse and at 8.58 CPR was commenced and by 09.00 he was intubated (with difficulty). An ABG was processed at 09:18 and bilateral chest drains were inserted sequentially. A carotid pulse was detected at 10.01 and CPR was ceased, an arterial line and central venous catheter was placed and another ABG processed at 10.13, CPR was recommenced however Mr James had a second cardiac arrest lasting about 20 minutes and then a third. A final ABG was processed at 10.31 and Mr James was pronounced deceased at 10.43[130]

### (iii) Issues about the Medical Treatment at Westmead Emergency Department

73 In his report of 24 July 2014 A/P Bihari suggests :

*"The only way to improve the system so as to prevent a similar course of events in the future is to have* ***more senior medical staff present on the floor at night time in a busy emergency department/trauma unit such as Westmead Hospital***"

He identified critical errors as follows:

a) Mr James was triaged as a **trauma** patient and remained on this **"pathway"**,

b) an ABG (Arterial Blood Gas) result taken within half an hour of Mr James being reviewed by Dr Samra showed that Mr James had marked **lactic acidosis** which was not commented on in the medical notes (suggestive that it was either not seen or not understood).

c) Early blood test results identified that Mr James had profound **leukopenia**; this was (incorrectly) not considered of any great importance by the doctors.

d) the ABG result showed **acute kidney injury** which was either not seen or was misunderstood before contrast CT was given and in any event there was no attempt at

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128 Medical Records Vol 2 Tabs 66-68 p 486
129 Testimony of Dr Thomas that it is a 5-10 minute walk from ICU to ED
130 Medical Records Vol 2 Tabs 66-68 pp, 462-479.

**"renal protection"**(monitoring of urine output with a urinary catheter and adequate intravenous fluid loading) before (or after) Mr James was given contrast CT.

e) despite the doctor noting that Mr James was suffering **acute hepatic necrosis** he prescribed paracetamol

f) no attempts were made to monitor the **adequacy of his circulation** (no arterial line, no central venous line inserted)

g) a decision had been made to transfer Mr James when he was obviously unstable from his vital signs observation chart

h) despite being seen by an ED staff specialist at morning handover he was allowed to suffer **hypovolemic cardiac arrest**

i) one of the bilateral chest drains inserted during pulmonary resuscitation pierced the right lung into the trachea which probably made it **impossible to ventilate the patient adequately.**

74 The inquest identified a number of (uncontested) shortfalls concerning the following :

a) standards for documentation,

b) fluid administration and monitoring,

c) prioritising of patients at handover,

d) ED Sepsis Protocol,

e) ABG accreditation,

f) compliance with policy relating to "Recognition and Management of Patients who are Clinically Deteriorating",

g) senior medical review of patients prior to transfer out of ED,

h) morbidity and mortality reviews,

i) reporting and investigation of critical incidents,

j) provision of evidentiary statements requested on behalf of the Coroner

***Designation and Management as a Trauma Patient***

75 The doctors treating Mr James' failed to identify Mr James' medical condition (septic shock secondary to his pneumonia) which resulted in a failure to provide aggressive resuscitation and monitoring as required. A/P Bihari opined that *"pathway medicine"* was a factor that contributed to the lack of recognition of Mr James' medical condition whereby he received suboptimal treatment. He was of the view that Mr James should not have been placed on the trauma pathway but even if he was he should not have stayed on it.

76 Though Mr Sergi does not contest that ultimately the doctors did fail to recognise Mr James condition he does submit that the trauma investigation was appropriate however, his submission does not seem to dispute A/P Bihari's opinion as to the role the "pathway" played in the doctors' inability to recognise Mr James' condition.

77 RN Canete triaged Mr James as a 'category 2', but omitted to take or record important vital signs, specifically, blood pressure, temperature, and heart rate. His evidence was that the allocation of a triage category 2 was in part based upon Mr James' trauma presentation, and in part based upon his respiratory presentation[131].

78 Dr Crampton, who gave evidence based on her recent review of the medical record coupled with *"information...obtained...from meetings with (unidentified) staff at Westmead"*[132], postulated that the decision to commence Mr James on a trauma pathway was *"precipitated at triage and not overruled"*.

79 The evidence of RN Copeland, who was assigned to the Resuscitation Bay, was that an ED Nursing Trauma Flowsheet was usually only commenced for a patient who had suffered trauma within 24 hours of presentation (ie: fresh trauma). Although her evidence was that she commenced the ED Nursing Trauma Flowsheet *"because of [Mr James'] history of assault"*[133], she expressed uncertainty in her testimony as to whether a medical Officer or a member of nursing staff commenced Mr James on the trauma pathway. It may well be that she followed the triage determination that Mr James was a trauma patient.

80 Dr Tran's evidence was that once Mr James had been moved to the Resuscitation Bay, he commenced making notes in the ED Trauma Admission sheet[134]. In his testimony, he explained that the ED Trauma Admission sheet is a *"template"* for medical Officers, in which information

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131 Statement of RN Canete, dated 8.5.15 at [7]: Vol 2, Tab 65A, p.449a
132 Letter Dr Crampton, dated 18.5.2015: Vol 4, Tab 102, p.1255.
133 Statement of RN Copeland, dated 24.4.15 at [7]: Vol 2, Tab 56, p.401.
134 Statement of Dr Tran, dated 15.5.15 at [8]: Vol 2, Tab 65d at p.449h.

can be *"consolidated"* and *"was next to [Mr James'] resus bed"*. This was why he commenced to write in it. When he was asked to identify the preconditions for designation as a trauma patient, Dr Tran said: *"As Mr James...verbalised concerns about injuries sustained in an assault...**we** categorised him as a trauma [patient/pathway]"*.

81 In his statement and evidence, Dr Samra did not address the issue of who, on the night, determined that Mr James was a trauma patient, but as the senior doctor involved in Mr James' care Dr Samra must have either considered and endorsed it or simply failed to question it.

82 Dr Samra acknowledged in his testimony that Mr James was *"unduly concentrated on as a trauma admission"*. He suggested that a *"fixation with trauma"* led to a *"blind spot"*. Ultimately, Dr Samra conceded that Mr James' presentation was indicative of septic shock, but that the trauma presentation *"put us off"*.

83 The *"fixation with trauma"* was evidenced by, amongst other things, the decision in the first instance, to obtain a CT Trauma Study. A/P Bihari opined that the CT Trauma study was *"not the correct investigation"* and was *"unnecessary and dangerous"* because *"the risk of doing it outweighed the risk of not doing it"*. This fixation with trauma seemingly also influenced the radiologist's *"favoured"* interpretation of the findings made on CT (see: paragraph [47], above), which interpretation was (apparently) not revisited by medical staff once the clinical picture presented by the results of blood tests was known.

84 From the outset Dr Samra had identified Mr James as a suitable candidate for review by the acute surgical unit and even at 0530 he re-iterated that request. Upon that review, despite not requiring surgical intervention, Mr James was identified as a suitable candidate for transfer to the surgical High Dependency Unit (**HDU**). This further evidences the ongoing 'trauma bias'. Dr Tran commenced to write up the ED Ward Patient Transfer Form[135] at or about 06.45hrs, probably at the request of Dr Samra. (Dr Arunanthy said that an ED Ward Patient Transfer Form is commenced when *"a decision is made to admit"* (but is not completed until a bed becomes available).

85 Mr James was deteriorating dramatically (per A/P Bihari[136]) at the time when this decision was made. This is confirmed by the observations documented by RN Cunynhame, when she came on duty at 07.00hrs[137]. The provisional diagnoses and other information contained in ED Ward Patient Transfer Form, coupled with the fact that its preparation was directed at a time when

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135 Vol 2, Tab 66 at p.456. See also: Statement of Dr Tran, dated 15.5.15 at [14]-[16]: Vol 2, Tab 65d at pp.449h-449i.
136 Expert report of A/P Bihari: Vol 3, Tab 76 at p. 782 (9th paragraph).
137 Vol 2, Tab 66 at p. 486. Her testimony was to the effect that her notes contained a summary of her observations and actions up to the time when she made each note.

Mr James remained outside the 'flags', lends considerable force to A/P Bihari's testimony that the 'focus' on trauma did not merely cause staff to 'take their eyes off the sepsis ball' (as was suggested to him in examination); rather, *"they never had their eyes on sepsis"*.

86 Finally, as A/P Bihari explained, the placement (later) of chest drains was also indicative of the ongoing trauma bias, in that *"doctors [were] treating [Mr James] as a fresh trauma patient"* (when the small pneumothorax was *"not relevant"*).

87 Although Dr Lorenzo made an assessment that Mr James was not a candidate for surgery, he documented no diagnosis. Specifically, his note and plan of management plan are not consistent with him having postulated a diagnosis of pneumonia at the time of his assessment[138]. For reasons that were unexplained, Mr James remained on the trauma pathway, and was handed over by Dr Lorenzo to one of the surgical registrars, in anticipation that Mr James would be transferred to the surgical HDU.

88 Ultimately, Dr Lorenzo accepted (in retrospect) that his approach to assessing Mr James was influenced by his *"assumption"* that Mr James was a trauma patient, and may have been less than ideal. Further, he surmised that there were results that he did not have[139], or did not assess.

89 In the light of the testimony of Dr Cao, and having regard to the content of the Dr Lorenzo's contemporaneous note, it appears likely that Dr Lorenzo acted on verbal reports only concerning the findings made on CT (as opposed to calling for, and viewing the films for himself, in order to evaluate the *"favoured"* interpretation offered by the radiologist[140] against the clinical picture presented by the results of blood tests, including those obtained *after* the CT study had been performed[141]). Dr Cao's testimony was that the note she made on the ED Trauma Admission sheet[142] indicates that the written report of the CT was not then accessible on the computer. She said that in such circumstances, results are generally ascertained over the phone, but she could not recall whether she and Dr Lorenzo called radiology together. It is also likely that Dr Lorenzo did not review Dr Samra's notes at second review which included his query of sepsis.

90 That Dr Lorenzo did not properly assess, and/or was distracted by his focus on Mr James' status as a trauma patient is borne out by, amongst other things, the fact that while he made a

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138 Vol 2 Tab 66, at pp. 460-461; *cf.* paragraph [10] of Dr Lorenzo's statement of 24.4.15: Vol 2, Tab 60 at p.424
139 see further at paragraphs [115]-[119], below.
140 see: paragraph [59], above.
141 see also: paragraph [143], below.
142 viz. *"CT-SCANS (please document) verbal reports"* at Vol 2 Tab 66, at p.482.

note of certain of the significant results returned from the laboratory, including results indicative of an acute kidney injury and hepatic derangement, he did not turn his mind at the time, to what those results signalled. Nor did his management plan include treatment targeted to addressing either condition.

91 Dr Lorenzo's testimony also suggested that he did not appreciate the significance of certain results he did document. By way of example, one obvious 'marker' of Mr James' condition was his elevated haemoglobin, which as A/P Bihari observed, was indicative of haemo-concentration[143] (ie: caused by fluid deficit). Yet Dr Lorenzo said he was *"unsure"* if this result was in the upper limit of normal, or, abnormal. Conversely, Dr Arunanthy acknowledged that the haemoglobin result *was* abnormal, and agreed that such abnormality is commonly caused by fluid deficit, and should have contributed to concern that Mr James was hypovolaemic.

92 In his testimony, A/P Bihari spoke of the dangers inherent in pathway medicine when administered without supervision by senior medical Officers. I accept Ms Sandford's submission that the inadequacy of Dr Lorenzo's response to the results of blood tests known to him at the time of his assessment of Mr James underscores such an opinion.

***The results of the 03.35 Arterial Blood Gases***

93 One of the first investigations ordered by Dr Samra was to test Mr James' blood. One of those tests was an ABG. The results show that Mr James had a very high lactic acidosis and an acute kidney injury.[144] Unlike the other blood tests which are sent to a laboratory, the ABG is carried out on the spot by a staff member. Once the blood sample is taken, the staff member walks to the machine, logs on so that their staff identity is recorded, the sample is placed in the machine and the patients identity is entered, the analysis proceeds whilst the staff member stands there and within about a minute the machine ejects a paper docket which sets out the name of both patient and staff member and of course the ABG test results. That docket is on Mr James' file but there is no evidence that any staff member read it prior to ED handover at morning ward rounds - some 4 ½ hours after it was obtained.

94 The docket indicates that a Dr Woods was responsible for processing the sample. Dr Woods denied any involvement, for the reasons set out in his statement[145]. His evidence, which I accept, was that he was not the operator of the *"point of care"* machine from which the 03.35

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143 Expert report of A/P Bihari: Vol 3, Tab 76 at p.782 (7th paragraph).
144 See paragraph 52 g) and h) above
145 Statement of Shane Woods, dated 23.4.15 at [8]: Vol 2, Tab 61 at p.428.

ABG was processed. Dr Woods, explanation is that he must have processed an ABG from another patient shortly prior to Mr James' ABG process. He said that after a member of staff has logged in to use the machine, and until the log in timed out, any other member of staff with authority to perform an ABG could use the machine without having to log in, with the consequence that, strips generated in respect of such analyses would identify as the operator, the previous member of staff whose log in details had not timed out in the interim. In his testimony, Dr Woods described this as a *"problem"*, although he had not discussed it with colleagues. In spite of the significance of the results of the 03.35 ABG, the WSLHD was unable to identify the member of staff who attended to that task. The time lapse from the 2 March 2013 to when that inquiry was made (shortly before inquest) is probably the reason that identification has not been possible.

95 The testimony of Dr Tran, who either took, or was given the blood samples he processed at 03.45hrs for laboratory analysis[146], was that *"any number of people"* could have been involved in processing and reporting the results of the 03.35 ABG. He had no recollection of processing it himself nor of being informed, or of being made aware of the results of the 03.35 ABG

96 The testimony of RN Copeland was to the effect that, while nurses can perform ABG's she was not *"signed off"* to do so, but nonetheless understood the significance of ABG readings. She could not recall seeing the results of the 03.35 ABG, but agreed that such results would ordinarily come to her attention. She remarked that, had the lactate and pH levels returned on the 03.35 ABG come to her attention, she would have alerted a doctor.

97 The testimony of RN Cunynhame was that she now does, but did not, in March 2013, perform ABG analyses.

98 The testimony of Dr Samra was that he normally takes blood from his patients, but that an ABG is often performed by a junior doctor, and sometimes by nursing staff, and the strip is sticky taped to the paper record (Dr Arunanthy's testimony was that the strip is usually stuck in the clinical record, but she could not recall how she learned of the results of the 03.35 ABG).

99 Dr Samra claimed no actual recollection of what occurred in the present case. Nonetheless, in a statement he made more than two years after the events in question, but a few weeks before the inquest commenced, he asserted that he *"was very focused on Mr James' high lactate"*[147].

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146 Statement of Dr Tran, dated 15.5.15 at [11]: Vol 2, Tab 65d at p.449h.
147 Statement of Shalinder Samra, dated 1.5.15 at [16]: Vol 2, Tab 58a at p.420d.

100 The inference from this assertion is that Dr Samra was, at the time of his treatment of Mr James, aware of the ABG results produced at 03.35. Although the Court does not question Dr Samra's honesty as a witness, I cannot accept this evidence as reliable or accurate. The analysis of the events and records indicate that Dr Samra was not aware of the ABG results until, if at all, Dr Arunanthy ordered that another ABG be performed. That was about 08.10 am.

101 As A/P Bihari observed, the medical record contains no mention (until much later) of the *"profound metabolic abnormality"* shown on the 03.35 ABG[148]. Nor do the notes made by Dr Samra[149] otherwise suggest that Mr James' high lactate was the 'focus' of his management. Indeed neither the blood lactate result, nor the *arterial* creatinine result that was returned at the same time, are mentioned in the notes made by Dr Samra.

102 The most plausible explanation for the absence of any contemporaneous documentation concerning the 03.35 ABG is that the results were not communicated at the time, and/or not followed up. That Dr Samra did not, in fact, become aware of those results is consistent with the course of his management of Mr James after 03.35hrs. That is, if Dr Samra had been aware of the ABG results at 03.35 causing him to be *focussed on Mr James' high lactate* he would not have or at least should not have allowed 2 hours to lapse so that CT scans were taken before reviewing Mr James and administering antibiotics. That Dr Samra was not focussed on Mr James' high lactate is further evidenced by the fact that he did not order that another ABG be taken when he reviewed Mr James at 05.15-05.30.

103 Likewise Dr Lorenzo was unaware of the ABG result. He said that his practice was to take blood (from the patient), and have a junior doctor process an ABG (and he would expect a junior doctor to appreciate the significance of abnormal results). Ultimately, Dr Lorenzo surmised that he did not see, and was not alerted to the results of the 03.35 ABG.

104 Although Dr Lorenzo initially stated (in answer to questions put by Counsel for the WSLHD) that there was nothing in the report of the 03.35ABG that would have caused him to change the management plan he formulated after seeing Mr James, under re-examination he stated that if he had been aware of the results of the 03.35 ABG, he would have ordered fluids and analgesia and *"sent Mr James to ICU"*. Likewise, his testimony was that he did not see Dr Samra's note querying *"underlying sepsis"*, for if he had, he would have ordered antibiotics. As to the WCC, Dr Lorenzo agreed that it was indicative of sepsis, but stated that it was also possibly referable to liver failure. Having initially expressed uncertainty as to why he did not note that result, Dr

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148 Expert report of A/P Bihari: Vol 3, Tab 76 at p.780 (6th paragraph).

149 Having ordered arterial blood gases (Vol 2, Tab 66 at p. 459) Dr Samra made no further note before his "post fluids" review (Vol 2, Tab 66 at p. 464), which he stated was performed at "*at about 05.15hrs*". In that note he made no reference to the lactic acidosis evident on the 03.35 ABG.

Lorenzo conceded under re-examination that he would have documented the WCC if it had come to his attention. Yet his resident did document the WCC[150].

105 Dr Lorenzo stated that it was his practice to speak to the clinician requesting surgical review, and to obtain information from that clinician, including background, and investigations performed. He said that when he returned to assess Mr James, at a time he estimated to be between 05.30 and 05.45hrs, another doctor (who he thought was an *"ED physician")* was present. *If* Dr Lorenzo followed his stated practice on this occasion, the probabilities are that he spoke with Dr Samra (and Dr Samra accepted as much). Neither doctor had any recollection of speaking with each other. If they did, and *if* Dr Samra was indeed *"very focused on Mr James high lactate"*, it is improbable that the 03.35ABG would not have been discussed. Equally, it is unlikely that the WCC, about which Dr Samra was certainly aware, would not have been mentioned. Against that, the testimony of Dr Lorenzo noted above, suggests that the WCC was not raised in any discussion he may have had with Dr Samra.

106 In a statement he made in August 2013, Dr Lorenzo asserted that, when he saw Mr James *"He was...in respiratory acidosis (sic.)"*[151]. However, it seems doubtful that this comment was intended, as the sentence in which it appears would make better sense if the word "*distress*" was substituted for *"acidosis"* (Mr James' observations at that time being indicative of respiratory distress). In any case, it was accepted by Dr Lorenzo that because the 03.35 ABG contained no reading for $PCO_2$ (partial pressure of carbon dioxide), it would not have been possible for him to conclude, at the time of his assessment, that Mr James had *respiratory* acidosis (because, as he explained, the level of carbon dioxide derived on blood gases is important in determining whether acidosis is respiratory or metabolic). The reference to "*respiratory acidosis"* is best explained as an error.

107 The same can probably be said of Dr Lorenzo's reference in his statement to *"repeat blood gases"*. An instruction for repeat blood gases infers that an analysis had already been done. However, Dr Lorenzo eschewed any knowledge of the 03.35 ABG in his testimony, and did not, in fact, document an order for repeat blood gases[152]. A further example of the imprecision that is a feature of the statement made by Dr Lorenzo in August 2013 is the inconsistency between the comment that Mr James was *"tachycardic"* juxtaposed against Dr Lorenzo's

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150 Refer paragraph [52]i), above.

151 *cf.* Statement of Aldenb Lorenzo, dated 2.8.13: Vol 2, Tab 59, at p.422 where Dr Lorenzo states that when he saw Mr James *"He was...in respiratory acidosis"*.

152 The note made by Dr Lorenzo was *"Rpt **bloods** today"* (see. Vol 2, Tab 66, at p.461).

contemporaneous note that Mr James' heart rate was 80bpm[153]. This anomaly simply bears out A/P Bihari's observation as to the *"spurious"* nature of that reading.

108 Although the ED Trauma Admission Sheet[154] did not contain a template for inclusion of blood results, other than *"Laboratory Test Results"*[155] (and ABG analyses were not then, and are not now, processed through the pathology laboratory[156]), it seems unlikely that Dr Cao would *not* have documented the results of the 03.35 ABG if those results had come to her attention. In any case, that Dr Lorenzo was unaware of the 03.35 ABG when he assessed Mr James is strongly suggested by the fact that he did not document those results in the note he made at that time of his assessment. That Dr Lorenzo *did* document the results of the 03.35ABG in the retrospective note he made at 10.25hrs[157] only reinforces this conclusion. Whether Dr Lorenzo was unaware of the WCC, as he (ultimately) asserted in his testimony, or, was aware of the WCC, but simply did not recognise its significance, cannot be determined on the evidence.

***Medical Records***

109 Dr Lorenzo suggested that that he did not have all of the medical records and test results available to him when he assessed Mr James. He explained that the notes were maintained in loose form before being compiled by a nurse. An examination of the records demonstrates that various staff complete different forms Dr Lorenzo's notes and a staff member from radiology were written on a form titled 'Progress/Clinical Notes'. Dr Samra and others wrote on a form bearing the title (in the margin) 'Emergency Department Continuation Sheet'.

110 For the most part, the record is not sequential. Rather, it appears that staff made notes on separate pieces of paper, rather than in one continuous and uniform paper record. The lack of sequentiality is demonstrated by Dr Samra's final entry. In point of time, it was made *before* Dr Lorenzo's attendance, yet it appears *after* Dr Lorenzo's note (and this supports Dr Lorenzo's testimony that he did not see the note *"? underlying sepsis")*.

111 In the light of the progress note made by RN Doherty in the electronic medical record[158], and in the paper record[159], it appears that no consistent approach to record keeping was adopted by nursing staff. While a 'hybrid' medical record is countenanced by applicable NSW Health

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153 In his testimony, Dr Lorenzo confirmed that his note "CR" was intended to refer to heart rate, and that the reading obtained (80 bpm) was within normal limits.

154 Vol 2, Tab 66 at p.482.

155 *Ibid.*

156 While the evidence was that the ED Nursing Trauma Flowsheet was withdrawn from use in the Westmead ED on a date coinciding with the commencement of the inquest, the ED Trauma Admission Sheet (it being a document used by medical, as opposed to nursing staff) remains in use.

157 Vol 2, Tab 66 at p. 462.

158 Vol 2, Tab 66 at p. 484.

159 Vol 2, Tab 66 at p. 457.

policy[160], sequentiality is unlikely to be achieved at the time when care is being provided if nursing staff (or for that matter, medical staff) record progress notes in different mediums

112 In the context of a busy emergency department, a consistent approach to the choice of medium in which progress notes are documented would be more in keeping with the objective of facilitating the safe care and treatment of patients (see below, at paragraphs [114] & [116]).

113 Finally, and perhaps of most significance, the 03.35 ABG strip does not appear in the record between the entry first made by Dr Samra, and the note made by a member of staff in radiology. Rather, it appears after the retrospective notes made by Dr Arunanthy and the ICU registrar, together with each of the strips for ABG's that were processed after Mr James arrested. This strongly suggests that the 03.35 ABG strip was not 'stuck' in the record contemporaneously.

114 One consequence of this (apparently) haphazard method of record keeping is to defeat the purpose for which notes are made. As at 2 March 2013, NSW Health PD2012_069 *Health Care Records – Documentation and Management* (which remains current) provided (at p.2):

> *The main purpose of a health care record is to provide a means of communication to facilitate the safe care and treatment of a patient / client.*

115 This objective was not achieved in Mr James' case.

116 The Policy Directive provides (at p.6):

> ***2.2 Standards for documentation***
> *Documentation in health care records must comply with the following:*
>
> *(o) Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.*

117 Further, Mr James' case demonstrates a failure to comply with this mandate.

***<u>The Treatment Mr James Should have Received</u>***

118 A/P Bihari identified the treatment that Mr James should have been given to address his medical condition. He opined that the arterial creatinine result (indicative of acute kidney injury) called for *"intravenous volume resuscitation, the placement of a urinary catheter and*

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[160] Ex. 5: NSW Health PD2012_069 *Health Care Records – Documentation and Management*, at p.3

*invasive haemodynamic monitoring"* [161]. His testimony was that fluid loading in the order of 300ml per kilo 'stat' (ie: 2.5-3L in a patient weighing 90kg) should have been delivered in the first instance, before reassessment, and further fluid.

119 The need for aggressive fluid loading was only heightened in the circumstance where it was proposed to perform a CT study with contrast (Omnipaque 300). This and other of the measures identified by A/P Bihari [162] were necessary to provide protection against the risk of contrast induced renal failure.

120 Had the creatinine result identified by the 03.35 ABG come to the attention of Dr Samra, it is to be expected that, shortly thereafter, but certainly no later than 04.06hrs[163] (at which time Dr Samra was obviously revisiting Mr James' management), orders would have issued to ensure that appropriate measures for renal protection were taken *before* Mr James was transferred to radiology. At the very least, it is to be expected that Dr Samra would have documented the *arterial* creatinine result at this time.

121 Given that the note he made following his review of Mr James *after* the laboratory creatinine and other blood chemistry results became available expressly refers to the deranged renal function demonstrated by those results (together with the WCC returned on the full blood count results)[164], it stands to reason that, had he been aware of it, Dr Samra would have made a note (earlier) of the *arterial* creatinine result. Logic dictates that he would also have documented the blood lactate and pH results derived from the 03.35 ABG, had he been aware of them. Suffice it to say, those results provided a further reason to commence aggressive fluid resuscitation, without delay.

122 As indicated earlier, I am satisfied that the ED registrar with whom the radiographer Ms Thompson spoke in relation to the unavailability of creatinine results at 04.15 was Dr Samra[165]. Had Dr Samra reviewed the ABG result he would have been aware of the arterial creatinine and presuming he understood the significance of such result or at least appreciated the reason for Ms Thompson's call, he would have conveyed that result to Ms Thompson rather than telling her that Mr James was *"youngish and we don't need bloods to do a scan".*[166]

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161 Expert report of A/P Bihari: Vol 3, Tab 76 at p.780 (8th paragraph).

162 Expert report of A/P Bihari: Vol 3, Tab 76 at p. 779 (point 5) and at p.781 (5th paragraph).

163 ie: the time at which Dr Samra ordered a CT scan of the facial bones and of the brain, to be performed in conjunction with other studies he had requested at the time of his initial assessment of Mr James, and which had been logged at 03.48, by Dr Tran (see: Statement of Nadine Thompson, dated 23.4.15 at [8]:Vol 2, Tab 61 at p.428).

164 Vol 2, Tab 66 at p. 464.

165 See para 62 above

166 There is no evidence that the only other ED registrar Dr Malik had any involvement with Mr James and it is implausible that he had spoken with Ms Thompson.

123 That the volume of fluids initially charted by Dr Samra was not revisited in response to the 03.35 ABG, or at about 05.15-05.30 (when Dr Samra documented the deranged renal function shown on the laboratory results), or indeed at any time during his shift, and, that Dr Samra gave no order(s) for monitoring of fluid output, or for cardiovascular and metabolic monitoring (ie: arterial line, central venous catheter, repeat ABG's and lactate[167]), are further objective facts that do not sit comfortably with the contention that Mr James' high blood lactate was recognised, let alone focused upon.

124 Equally, that these steps were not taken when renal derangement *was* recognised (on the laboratory results) is indicative of a lack of appreciation of the nature and seriousness of Mr James' medical condition. This is also demonstrated by the fact that once the AST and ALT results (indicative of hepatic necrosis) were available, Dr Samra did not revisit the prescription for PRN Panadol he had charted[168] when he first saw Mr James at about 03.15 hrs. In the result, Mr James was given 1 gram of Panadol at 07.30hrs. Dr Samra conceded in his testimony that it was *"a mistake"* to give Panadol in the circumstances. These omissions were multiplied by the failure to institute appropriate antibiotic therapy promptly after 03.35hrs, and, in response to the WCC.

125 The expert opinion of A/P Bihari was that: *"the fluid resuscitation of [Mr James] was totally inadequate"* [169] (and see paragraph [118], above). This was borne out by the evidence.

126 The testimony of RN Copeland was to the effect that, 1 litre of Normal Saline was put up and administered over ten minutes between 03.40 and 03.50hrs[170], and a second litre commenced at 03.50hrs, which was running when she escorted Mr James to radiology. RN Copeland acknowledged the discrepancy between entries she made in the IV Fluid Chart that formed part of the ED Nursing Trauma Flowsheet[171], and the entries she made in the IV Fluid Orders sheet[172] (the latter indicating that both litres of fluid ordered by Dr Samra were not commenced before 05.40hrs). She surmised that the chart contained in the ED Nursing Trauma Flowsheet *"would be correct"*, and speculated that the entries she made in the Fluid Orders sheet could reflect the time when she made those entries. The note made by RN Copeland at 03.40hrs in the ED Nursing Trauma Flowsheet[173] supports her testimony that IV fluids were commenced at that point. Likewise, the note she made at 05.00hrs supports her testimony that

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167 see: Supplementary expert report of A/P Bihari, dated 23.4.15 at p. 486b (4th bullet point).
168 see: PRN Medication chart: Vol 2, Tab 66 at p. 497.
169 *Ibid.* at p. 782 (9th paragraph).
170 see: para 60 above.
171 Vol 2, Tab 66 at p. 480C.
172 Vol 2, tab 66 at p. 489.
173 Vol 2 Tab 66 at p. 485.

IV fluids were running when Mr James was escorted (by her) to radiology, the timing of which, according to Ms Thompson, was after 04.16hrs, and before 04.20hrs[174].

127 The only explanation offered by RN Copeland for not having made any record of output in the IV Fluid Chart that formed part of the ED Nursing Trauma Flowsheet was that Mr James had no urine output for the duration of her shift. The testimony of RN Cunynhame was that she commenced a Fluid Balance chart[175] because it is *"easier to use a separate chart"* (ie: separate to the IV Fluid chart attached to the ED Nursing Trauma Flowsheet).

128 In respect of the administration of fluid from 03.40hrs, as A/P Bihari remarked in his testimony, gravity alone would not permit the infusion over ten minutes of 1L of fluid without the use of a *"rapid infusion device"*. Although the contemporaneous note made by RN Copeland at 03.40hrs makes no mention of the placement of any such device, RN Cunynhame documented the presence of two peripheral IV cannulae when she came on duty at 07.00hrs[176]. It is certainly possible that the size/diameter of one or other of the cannula was sufficient to effect rapid fluid infusion. However, by reason of the scant and inadequate documentation concerning fluid administration, the evidence only allows a conclusion that two litres of fluid were probably administered over the four or so hours that elapsed from 03.40 until RN Cunynhame commenced a third litre of fluid (over 4 hours) at 07.50hrs[177].

129 That Dr Samra did not direct the placement of an in dwelling catheter (**IDC**) is inconsistent with the notion that he was *"focused on Mr James' high lactate"*. In the event, and in spite of the order written up by Dr Lorenzo at about 06.15[178], no steps were taken thereafter to place an IDC[179]. Consequently, Mr James' fluid output was not monitored, appropriately, or at all, there being but one reference in the nursing notes to a statement made by Mr James to RN Cunynhame (who came on duty at 07.00hrs) that *"he has voided"* [180].

130 The expert opinion of A/P Bihari, concerning what was signalled by the blood lactate level shown on the 03.35 ABG, and, by various of the blood results derived from samples taken at 03.45hrs, is noted above, at paragraph [52] i)-j). His opinion was that, in addition to aggressive fluid resuscitation and monitoring of output (addressed above):

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174 Statement of Nadine Thompson, dated 23.4.15 at [15]:Vol 2, Tab 61 at p.429.

175 Vol 2 Tab 66 at p. 490.

176 Vol 2, Tab 66 at p. 486.

177 see: Vol 2, Tab 66 at pp. 489-490. The testimony of RN Cunynhame was that she commenced the third litre of fluid at 07.50hrs.

178 ie: *"IDC pls"* see: Vol 2, Tab 66 at p. 461; and see also at p. 483 (point 7).

179 The testimony of RN Copeland was that the task of placing an IDC in Mr James fell to a doctor, as she would not have been *"allowed"* to place it, because nurses may only perform this procedure in stable patients (and Mr James was not within this criteria, by reason of his medical history, including Hepatitis C).

180 Vol 2, Tab 66 at p. 486 (entry made at 07.40hrs).

a) Blood cultures should have been taken[181].

b) High doses of broad-spectrum antibiotics should have been given in the first instance (with targeted antibiotics substituted once the results of blood cultures were known).

c) The intensive care unit should have been involved, and infectious diseases consulted.

d) Arterial and central venous lines should have been placed to enable invasive cardiovascular/ haemodynamic monitoring.

e) Loading with N-acetyl cysteine was required to treat Mr James' hepatic derangement (and renal impairment).

f) Blood gas sampling should have been repeated (in order to check whether the blood lactate level contracted in response to fluid resuscitation and associated measures). It is noted that blood gases were never repeated during Dr Samra's shift. As A/P Bihari remarked in his testimony:

> *"If someone had known of the lactate result of 12.7, the test would have been repeated to make sure it [the level of lactate] was coming down."*

131 Dr Moulden who accompanied Dr Arunanthy on the handover ward round agreed that the high lactate evidenced by the ABG result at 03.35 indicated that Mr James required aggressive fluid resuscitation, blood cultures and antibiotics within 60 minutes, with repeat blood gases every half to one hour to monitor response to treatment. Further, she identified that as the ABG result did not show the carbon dioxide and bicarbonate values it was important to obtain those values.

132 Dr Moulden agreed that the trend of Mr James' observations, coupled with the results of investigations (particularly once the WCC was known) was indicative of septic shock, and conceded that there was no time to waste in administering antibiotics. However, Dr Moulden

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181 The imperative to take blood cultures before administering antibiotics, where blood lactate is equal to or greater than 4mmol/L was mandated by the Adult Sepsis Pathway reproduced in the *WSLHD ED Sepsis Protocol: Adult First Dose*, which Protocol was (apparently) in existence as at 2 March 2013 (see: Vol 4, Tab 93, at p. 1135; p. 1137-1139).

explained that, in March 2013 the 'Sepsis pathway[182] was ***"not something that was pushed on us to use"*** (in the Westmead ED).

133 The testimony of Dr Arunanthy was that the lactic acidosis evident at 03.35hrs required aggressive fluid resuscitation, frequent observations of blood pressure every 15 minutes, frequent repeat blood gases to monitor and assess the response to the acidosis, and, *"early"* placement of an IDC in order to monitor urine output and guide fluid resuscitation. She acknowledged that there could be no effective resuscitation if an IDC was not placed.

134 While Dr Arunanthy did not concede that the renal impairment evidenced by the 03.35 ABG (and by the laboratory results received later) was acute (as opposed to acute on chronic), she nonetheless accepted that the results were significant, and called for *"swift action"*.

135 Equally, although Dr Arunanthy placed emphasis on Mr James' history of trauma as a potential cause of multi-organ failure and morbidity if not treated, she accepted that his shortness of breath, high respiratory rate, low saturation of oxygen, low systolic blood pressure and hypothermia on presentation, dictated that he had more than two 'yellow zone' criteria (per the Sepsis Pathway). Similarly, while Dr Arunanthy pointed to trauma as within the possible differential diagnoses for lactic acidosis, she accepted that, in the light of Mr James presenting signs, coupled with the blood lactate result, treatment should have been commenced on the assumption that Mr James had sepsis until proven otherwise, consistent with the Sepsis Pathway.

136 In any case, as Dr Arunanthy acknowledged, the result of the WCC simply confirmed that septic shock was the probable cause of Mr James' condition. Her testimony was that she would have given double the dose of Ceftriaxone administered to Mr James. Ultimately, with the benefit of reviewing the trend of Mr James' observations, and in the light of the results of the 03.35 ABG and the WCC, Dr Arunanthy expressed the opinion that, in view of Mr James' respiratory dysfunction, intubation should *"at least"* have been considered, subject to the response gauged on repeat ABG's.

137 In answer to questions put by Counsel for the WSLHD Dr Arunanthy explained that her hesitation (ie: both in conceding that Mr James ought to have been put on the Sepsis pathway, and, in relying on pathways more generally) was not because Mr James did not *"fit"* in that pathway, but rather, because in the presence of a constellation of signs and symptoms, a patient may also fit into other pathways. As she put it, the typical problem in an ED is that the

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182 Dr Moulden was shown the Sepsis Pathway behind Vol 3, Tab 87 at pp.1018-1019, which pathway is reproduced in the *WSLHD ED Sepsis Protocol: Adult First Dose* (see: Vol 4, Tab 93, at p. 1135; p. 1137-1139).

clinician has to *"discover a diagnosis"*. Her testimony in this regard only serves to highlight the shortcomings of management in Mr James' case, in that, staff did not approach his care with the objective of *discovering* a diagnosis, but instead seemingly assumed that his presentation was due to trauma.

138 The absence of carbon dioxide and bicarbonate readings on the 03.35 ABG was a further matter about which Dr Arunanthy expressed *"concern"*. She explained that the point of care machine does not always produce such readings (or can otherwise produce incomplete readings), but that when an incomplete reading is obtained, the ABG should be repeated, and she was not sure why this had not occurred in Mr James' case. She agreed that carbon dioxide and bicarbonate levels assist in identifying whether acidosis is metabolic or respiratory, and for how long a patient has been acidotic (by reference to any evident compensatory response – for example: a $CO_2$ reading indicative of *"blowing off"* $CO_2$[183]).

***Information given at Handover***

139 Dr Arunanthy described her ward handover routine was to attend patients one side of the room and then the other side. The most unwell patients were placed in the resuscitation bay which was in the middle of the ED. Accordingly, though Mr James was in fact critically ill in the resuscitation bay, he was not the first patient reviewed that morning. Dr Arunanthy would receive a verbal account from the treating doctor for each patient. When she had completed handover she would then determine the order in which she would further review her patients. A/P Bihari suggested that given patients in the resuscitation are the most unwell it would be preferable that ward rounds commenced at that location. I agree.

140 It was only shortly before the commencement of the inquest that staff were asked for their recollections of Mr James[184] and unsurprisingly they have little to no independent recollection, of what information was handed over at the ward round. Dr Arunanthy said that other than being made aware of the 03.35 ABG, and of being informed that Mr James had pulmonary contusions, fractured ribs and a small pneumothorax[185], she could not recall what, if any,

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183 The testimony of Dr Arunanthy was that the *"very low"* $CO_2$ reading of 15 (normal reading being 5) charted by RN Copeland at 04.50hrs (see: Observations Chart, Vol 2, Tab 66 at p. 480A) would have been ascertained by capnography, and was indicative of a compensatory response to metabolic acidosis. She would have expected the nurse to inform the ED registrar of such a low reading, and *"at a minimum"*, for an ABG to be performed to confirm what the $CO_2$ reading was. RN Copeland's testimony was that she measured the $CO_2$ level via nasal prongs attached to the monitor, and likely alerted the doctor to the reading she recorded.

184 Despite an early request for statements the hospital refused to provide them. See statement of DSC Mennilli dated 4.4.13 at [7.9]: Vol 1, Tab 7 at pp 55-56

185 see" Statement of Shalini Arunanthy, dated 24.4.15 at [12]: Vol 2, Tab 63 at p.436.

additional information she was given by Dr Samra. Specifically, she could not recall whether she was made aware of the trend demonstrated by Mr James' recorded observations since his admission, or of the WCC. The handover information provided to Dr Arunanthy by Dr Samra could only have been that which was consistent with his (lack of) understanding of Mr James' medical condition.

141 In respect of the CT findings Dr Arunanthy accepted that pneumonia due to infection *should* have been considered, particularly in the light of the WCC, but that at the ward round, she had been informed only that Mr James had pulmonary contusions. As she explained, she relied on verbal information provided to her at the ward round. She agreed that the information she received at handover about the CT findings indicated that staff had attributed Mr James' condition to trauma, rather than infection.

142 The testimony of RN Cunynhame was that she raised her concerns about Mr James' evident respiratory distress with the night ED registrar *before* the ward round, and was then awaiting medical review[186]. She also confirmed that Mr James was *"cold"* when she took observations recorded at 08.10hrs, and that the note she made at 08.10hrs was documented *after* there had been a discussion with the registrar (and Dr Arunanthy) in which the need for intubation had been raised. Her testimony was to the effect that by 08.20hrs a decision to intubate had been made, and a registrar was present in the resuscitation bay.

143 Dr Moulden could not recall *"the specifics"* of what was handed over, including whether she was informed of the WCC. Her testimony was to the effect that the *"consensus"* to which she referred in her evidentiary statement[187] was based on the appearance of Mr James at the ward round. She said it was not then *"obvious"* that Mr James required intubation.

144 What ultimately emerged in the testimony of Drs Moulden and Arunanthy was that an incomplete clinical picture was conveyed at handover. Simply stated, the handover was inadequate. In that context, Dr Moulden surmised *"possibly better information about [Mr James'] decline would have changed the decision [to carry on with the ward round]"*. Similarly, Dr Arunanthy assumed that if she had been aware of the *"full picture"* she would have taken a different course. Specifically, her testimony was that had she known all of the facts (objectively) available at the time handover, she would have considered whether Mr James should have been intubated at that time rather than proceeding with the ward round.

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186 The evidence of RN Cunynhame and of RN Barbosa, touching on the administration, contrary to the order charted by Dr Samra, of Fentanyl 50mcg at 07.35 and at 07.55, is noted as is the expert opinion of A/P Bihari that this medication error did not contribute to the death of Mr James.

187 see: Statement of Eleanor Moulden, dated 23.4.15 at [9]: Vol 2, Tab 63 at p.442.

145 In the event, Dr Arunanthy determined that further treatment of Mr James could be deferred until she had completed the ward round. She requested a repeat ABG and directed nursing staff to increase the rate of oxygen being given. In respect of the latter, in answer to questions put by Counsel for the WSLHD, Dr Arunanthy explained that, in the light of Mr James' circumstances as she saw them at the time of the ward round, *"we wanted to try and pre-oxygenate him...[and] maximise his oxygenation and metabolic parameters"*.

146 Dr Arunanthy added that, when Mr James arrested, she was still *"not happy"* with the level of oxygenation, but was reluctant to put him on a mask because of the presence of a pneumothorax. The expert opinion of A/P Bihari (who had the benefit of hearing the testimony of Dr Arunanthy) was that the decision to defer treatment of Mr James was an error of judgment. On the basis that the sickest patients are located in the resuscitation bay, (and because *"the severity of Mr James' illness"* needed to be addressed), he did not resile from his opinion, notwithstanding the deficient handover.

147 The testimony of A/P Bihari was to the effect that, at the time of the ward round, *"oxygenation of [Mr James] was not the issue"* [188]. Rather, *"the key issue was to give more fluid at 08.00hrs"*, and had it been given, Mr James may not have had a seizure. He opined that Mr James *"had a seizure because of low cardiac output"* caused by *"hypovolaemia +/-myocardial suppression associated with sepsis"* [189]. A/P Bihari emphasised in his testimony that Mr James' low cardiac output state was evident *"not from looking back over the record"*, but from Mr James' vital signs.

148 The testimony of Dr Moulden was that *"certainly looking at it now"* Mr James required fluid resuscitation, but that the focus of staff at the time was *not* on hypovolaemia. Her evidence was that she continued on the ward round, and did not return to prepare to take another ABG until the ward round was completed[190]. In the event, Mr James deteriorated before she could place an arterial line[191].

149 Given that no medical practitioner made contemporaneous notes, the precise sequence and timing of events that transpired after Mr James was seen on the ward round, and when he suffered a seizure (at approximately 08.55) remains unclear. This lack of precision is exasperated by a lack of recollection caused by a refusal of the hospital to provide statements to the Officer in charge for the coroner or any referral to the hospital's morbidity and mortality

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188 see: Statement of Shalini Arunanthy, dated 24.4.15 at [17], [19] & [24]: Vol 2, Tab 63 at pp.436 & 438.

189 Expert report of A/P Bihari: Vol 3, Tab 76 at p.783 (1st paragraph).

190 see: Statement of Eleanor Moulden, dated 23.4.15 at [9]: Vol 2, Tab 63 at p.442; *cf.* the testimony of Dr Arunanthy, which was that she continued on the ward round and left Dr Moulden to take an ABG. Given the time that elapsed (at least 40 or so minutes) after Mr James was seen on the ward round, and when he suffered a seizure (at approximately 08.55), Dr Moulden's recollection of having continued on the ward round seems more reliable.

191 *Ibid.* at [13].

review process. Had that occurred, the details of the events when they were fresh in the memory of the witnesses would have been properly recorded; thus they would have been not only available but far more reliable than when a witness is asked to recollect them 2 years later.

150 According to Dr Samra, upon requesting a repeat ABG when Mr James was seen on the ward round, Dr Arunanthy *"indicated that we should prepare to intubate Mr James if the $PCO_2$ was poor"*[192]. In the event, no ABG was taken before Mr James suffered a seizure. According to the testimony of RN Cunynhame, the decision to intubate had been made by 08.20hrs, when a registrar was in the resuscitation bay. Conversely, the evidence of Dr Arunanthy and of Dr Moulden was to the effect that a decision to intubate was not made before Dr Arunanthy returned to the resuscitation bay after completing the ward round (which according to the retrospective note she made, was 30 minutes later[193]). As noted above, Dr Moulden was in the process of preparing to place an arterial line when Mr James suffered a seizure. According to Dr Arunanthy, it was then that she made a plan for *"a difficult intubation"* [194].

151 The evidence of Dr Thomas was that he and his colleague (Dr Kamaraju) were paged by the ED team *"at around 08.35 hrs"* [195], his belief being that the ED Team were planning to intubate Mr James (and transfer him to ICU)[196]. His testimony was that it took about 5-10 minutes to walk between the ICU and the ED. He confirmed that the request for ICU assistance was made because the ED was *"worried about [Mr James' condition]"*. He explained that the concern expressed by the ED related *"mainly"* to abnormalities in the blood results, but that no concern was expressed to the effect that a difficult intubation was anticipated.

152 In his testimony, Dr Thomas clarified that, in stating that he did not see Mr James while he was conscious[197], he meant that because staff were preparing to intubate Mr James when he arrived in the ED, he did not *assess* Mr James (not that Mr James was unconscious). He also confirmed that he wished to revise his statement that Mr James arrested *during* intubation, explaining that the process of intubation includes preparation, and, that an endotracheal tube had not been placed before Mr James arrested. In any case, the retrospective note[198] and evidence of Dr Arunanthy[199], coupled with the retrospective notes made by Dr Kamaraju[200] and by RN

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192 see: Statement of Shalinder Samra, dated 1.5.15 at [19]: Vol 2, Tab 58 at p. 420d.
193 Vol 2, Tab 66 at p. 466.
194 see: Statement of Shalini Arunanthy, dated 24.4.15 at [22]-[26]: Vol 2, Tab 63 at p. 438.
195 The retrospective note made by Dr Kamaraju times the "call" at 08.35hrs: Vol 2, Tab 66 at p.448.
196 Statement of Rojan Thomas, dated 22.4.15 at [5]-[6]: Vol 2, Tab 65 at p.448.
197 *Ibid.* at [7].
198 Vol 2, Tab 66 at p.466.
199 Statement of Shalini Arunanthy, dated 24.4.15 at [26] Vol 2, Tab 63 at p. 438.
200 Vol 2, Tab 66 at p.468.

Barbosa[201] respectively, and, the history documented by the cardiothoracic registrar[202] suffice to confirm that the (first) arrest occurred *prior* to intubation. According to the retrospective note made by RN Barbosa, intubation was achieved at 09.00hrs.

153 Subsequent events are summarised in para [72] and there are three issues commented upon by A/P Bihari in relation to the attempts to resuscitate Mr James:

a) the entry in the 'Once Only, Pre-medication Chart & Nurse Initiated Medicines' Chart for 125mg IV of Thiopentone;

b) the absence of documentation evidencing the administration of fluids during the resuscitation,

c) the mechanism whereby chest drains were inserted.

154 In his report[203] and testimony, A/P Bihari expressed strong criticism of the (apparent) use of Thiopentone. In summary, his testimony was to the effect that:

a) The medical chart speaks for itself (and indicates that Thiopentone was given).

b) Thiopentone is not commonly used (as an anaesthetic agent).

c) In the setting of a hypovolaemic patient Thiopentone produces hypotension.

d) When Thiopentone is used, it is recommended that 40mg doses be given gradually.

e) *"Most of us have given up using [Thiopentone]".*

f) Thiopentone 125mg was *"dangerous".*

g) He would have used Ketamine and Fentanyl in bigger doses.

155 Dr Moulden confirmed in her testimony that the entries in the medication chart for Thiopentone were made by her, but explained that because the chart had not been signed by a member of nursing staff; Thiopentone may not have been administered, adding that *"it does happen that drugs are drawn up, signed for, but never used".*

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201 Vol 2, Tab 66 at pp.478-479.
202 Vol 2, Tab 66 at p.476.
203 *Ibid.* at p. 784 (2nd paragraph).

156 Although Dr Arunanthy accepted that the medication chart suggests that Thiopentone was given, her testimony was that in the circumstance where Mr James had arrested before he could be intubated it was unlikely that Thiopentone was, in fact, given. Otherwise, Dr Arunanthy defended her choice of anaesthetic agent on the bases that she prescribed a low dose, and was comfortable using Thiopentone. Further, she explained that in *"really sick patients who arrest pre-intubation whatever medication you give them will cause decompensation"*. Although she acknowledged that Ketamine may not have that effect, she expressed the opinion that in Mr James' case, it too would have caused him to decompensate.

157 Given that the medication chart is incomplete, and, in the light of Dr Arunanthy's testimony I accept that Thiopentone was not administered. In any event, given Dr Arunanthy's seniority and experience as an emergency physician[204] her choice of Thiopentone as an anaesthetic agent is probably a matter of judgment about which reasonable minds can legitimately differ.

***Fluid administration during resuscitation***

158 In his report[205] A/P Bihari expressed surprise that *"large volumes of intravenous fluids were not administered during the CPR..."*

159 Although Dr Arunanthy accepted that the medical record contains no documentation evidencing the administration of fluids during the resuscitation, her testimony was that her practice is (and was) to give fluids during a resuscitation effort. Further, she pointed to the Autopsy report in which reference is made to the presence of bags of fluid (amongst other medical intervention equipment[206]). She surmised that fluids were given, but that fluid administration was not documented.

160 Given that it is inherently improbable that fluids would not be administered during the course of a resuscitation effort (particularly when led by a senior doctor, as was the case here) there is no basis on the evidence to suppose that Dr Arunanthy departed from her usual practice. Accordingly, I am satisfied that fluids were administered albeit not documented.

***The chest drains***

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204 see: Statement of Shalini Arunanthy, dated 24.4.15 at [2] Vol 2, Tab 63 at p. 435.
205 Expert report of A/P Bihari: Vol 3, Tab 76 at p. 784 (1st paragraph).
206 see: Autopsy Report for the Coroner, dated 24.4.2014: Vol 1, Tab 6, at p.34.

161 A/P Bihari was critical both of this intervention[207], and, of the technique of insertion[208]. He opined that the iatrogenic injury to Mr James right lung was likely caused by a trocar, used within the chest tube, to place the drain. He explained that, in the presence of this injury, it would have been impossible to achieve normocarbia (i.e.: normal arterial $CO_2$ pressure) in spite of positive pressure ventilation.

162 The standard technique of 'finger thoracotomy' (used to place a chest drain), is described in the evidentiary statement made by Dr Lorenzo on 24.4.2015[209], in which he claimed no recollection as to which drain (right or left) he inserted. His testimony was to the effect that two people *"always"* perform this procedure, but that he could not recall the identity of the other doctor involved. He said that he was not previously aware that the right lung had been punctured, and expressed surprise that the chest tube penetrated the trachea, remarking that *"the trachea is rigid and the tube not stiff enough"*. Upon being appraised of the opinion expressed by A/P Bihari, Dr Lorenzo agreed that a trocar must have been used, but stated it was not his practice to use a trocar. Otherwise, on the basis of the retrospective note he made, he surmised (unconvincingly) that he placed the left drain.

163 Neither Dr Arunanthy nor any other witness could identify how many, or which members of staff attended to placement of the chest drains in Mr James. The uncertainty generated by other of the evidence, as to whether Dr Malik was involved, was clarified in a statement he provided, made on 8 May 2015[210].

164 The testimony of Dr Arunanthy was that chest drains are usually inserted simultaneously, by two doctors. She was unable to recall if the procedure was performed sequentially in Mr James, but was *"almost 100% sure"* that a trocar was not used (on the basis that for ten years or more, chest drains have not come with trocars). Dr Moulden was *"not sure"* what a trocar was, explaining that a drain is inserted with a device that comes with the chest drain.

165 Dr Arunanthy opined that in Mr James' case, the procedure would have been made more difficult because Mr James was having CPR concurrently, and was not optimally positioned, he being supine (which *"changes the anatomy"*). She also remarked that in the presence of blood and air in the space, the doctor performing the procedure may not have realised that the lung had been breached.

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207 see: paragraph [97], above.

208 Expert report of A/P Bihari: Vol 3, Tab 76 at p. 779 (point 10); p. 783 (penultimate and last paragraphs); p.784 (3rd paragraph).

209 Statement of Aldenb Lorenzo, dated 24.4.15 at [18]: Vol 2, Tab 60, at p.426.

210 Statement of Rajesh Malik, dated 8.5.15 at [6]: Vol 2, Tab 65C, at p.449f.

166 In the result, the unsatisfactory state of the evidence does not permit any finding to be made as to who placed the right chest drain, and by what technique, albeit that the testimony of Dr Arunanthy suggests that a trocar is unlikely to have been used. In any event, and despite the fact that the resuscitation effort was plainly comprised as a result of the penetration injury occasioned by the incorrect placement of the right chest drain, the expert opinion of Dr Irvine was that this injury occurred when Mr James was agonal, and likely did not contribute substantially to his death[211].

167 Mr Sergi submits in relation to findings that *"insofar as trauma was concerned, the triage of Mr James, the investigations undertaken and the findings on investigations were entirely appropriate"*. That submission is somewhat disingenuous.

168 I note Dr Irvine's remarks in the Autopsy Report:[212]:

> *"The rib fractures were almost certainly a major contributing cause to the development of, or worsening of, the pneumonia; rib fractures not only diminish chest wall excursion to some degree but also cause the injured patient to "splint" the painful ribs, resulting in further decreased aeration of the lungs and expectoration of material. The rib fractures are allegedly the result of an assault. That said [Mr James] had other factors that put him at risk for pneumonia, including alcoholism, chronic lung disease and underlying medical conditions"*
>
> *It is recommended that the medical records be reviewed by an appropriate clinician...in order to determine if [Mr James'] care and treatment was appropriate and timely,* ***especially given that pneumonia is a likely consequence of rib fractures,*** *and the deceased had underlying medical conditions. While the right chest tube was obviously incorrectly inserted[213], this occurred when [Mr James] was agonal, and likely did not contribute substantially to his death."*

169 In support of his submission that there is insufficient evidence to find that with timely and appropriate intervention and treatment Mr James would have survived, Mr Sergi raises a number of points[214].

170 The first is Mr James' co-morbidities – however, I am not persuaded that they were so significant as to place Mr James outside the survivor cohort. Secondly, that at the time of his triage Mr James was clearly a sick man and that in Mr A/P Bihari's opinion aggressive

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211 see: Autopsy Report for the Coroner, dated 24.4.2014: Vol 1, Tab 6, at p.29 (last paragraph).

212 *Ibid.* at p.29.

213 At p. 3 of her report [Brief of Evidence p.28], Dr Irvine noted:

> *"The right...(chest) tube had been inserted completely through the parenchyma of the middle lobe of the right lung; the tube entered the right mainstem bronchus and extended into the trachea. There was, however, minimal haemorrhage associated with this iatrogenic injury."*

214 Para [58] and [59] above

treatment would only be successful if it was commenced at 3.00. That time was not A/P Bihari's evidence. As Dr Moulden said, aggressive treatment should be commenced within 60 minutes when signs of sepsis are evident. It is trite to say that prospects of survival are increased the sooner treatment is commenced. However, there is no evidence that unless treatment was provided at 03.00 or 03.45 Mr James would not survive.

171 Mr Sergi points out that even A/P Bihari's testimony was no higher than Mr James "may" have survived. A/P Bihari posited that Mr James may have required several weeks in ICU to recover. Mr Sergi cavils with a 60% survival rate preferring A/P Bihari's concession that the ARISE study gave a "little over" 50%. The evidence shows that prior to the 27 February 2013 Mr James was fit and healthy and at age 44 the missed opportunity to receive the appropriate and timely treatment resulted in him being unable to survive the sepsis with which he presented.

172 Mr Sergi seeks to undermine A/P Bihari's evidence suggest that his opinion was affected by hindsight bias or he was simply unreasonable in matters such as criticising the placement of chest drains or that as an intensivist rather than an emergency physician he didn't appreciate the need for a trauma study to be carried out. I don't think that they were salient points germane to A/P Bihari's overall opinion that the treating doctors failed to diagnosis that Mr James not only had pneumonia but was in septic shock from it. That issue has not been contested in Mr Sergi's submissions.

173 I do not agree with Mr Sergi's suggestion that the fact that A/P Bihari is an intensivist rather than an emergency physician has influenced his opinion in being critical of the doctors' trauma investigations. A/P Bihari's opinion in relation to the impact of the trauma pathway and how it blinkered both Dr Samra and Dr Lorenzo contributing to their inability to discover a diagnosis was conceded by those doctors in any event. At least Dr Samra queried sepsis as a provisional diagnosis however he neither adequately determined nor treated it.

## ***The Existence and Adequacy of Policies, Procedures and Protocols at the Westmead Emergency Department on 2 March 2013***

### ***ED Nursing Trauma Flowsheet***

174 The evidence was that, as at 2 March 2013, the Adult Emergency Department Observation Chart (**AEOC**), which was rolled out by the Clinical Excellence Commission (**CEC**) in early

October 2012[215], was not used by nursing staff in the Westmead ED for patients designated as 'trauma' admissions. Instead, the ED Nursing Trauma Flowsheet was used. The testimony of RN Copeland (given on 18 May 2015) was to the effect that an email had recently been circulated to nursing staff that had *"something to do with observations and trauma"*.

175 The AEOC incorporates the 'between the flags' principles which enables the ready identification if a patients deteriorates and the observations place them 'outside the flags' necessitating a prompt medical review and intervention.

176 Evidence received from Dr Crampton confirmed that the ED Nursing Trauma Flowsheet had been withdrawn on 11 May 2015, and, that the use of AEOC's has since been extended to trauma patient care[216]. Although the evidence of Dr Crampton was that this action had been taken *"as a result of Mr James' death"*, it is noteworthy that the withdrawal of ED Nursing Trauma Flowsheet coincided with the first day of the inquest.

***ED Trauma Admission Sheet (Medical Officers) and ABG analysis***

177 The testimony of Dr Crampton was that the ED Trauma Admission sheet[217] (used by medical staff) is designed *"to ensure that no trauma issues are missed"*. Dr Crampton's evidence is that this sheet will remain in use until the introduction of the electronic Medical Record (eMR) which is anticipated to be July 2016.[218]

178 The ED Trauma Admission contains no 'prompt' for staff to document the results of ABG analyses. Rather, it makes (express) provision for *Laboratory* test results only. In the circumstance where ABG analyses performed at the Westmead ED continue to be generated in paper form only, the risk that the strip may not make its way into the record (which, is likely to have occurred in Mr James' case) remains extant.

179 Ms Sandford submits that *"to guard against that risk, the inclusion in the ED Trauma Admission sheet (or whatever iteration of that document may remain in current usage) of a specific section designed to prompt staff to check the medical record and/or consult with the clinician having primary care, to ascertain whether an ABG has been ordered, and if so, to obtain and document the results, may be prudent"*.

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215 see: Memorandum at Vol 3, Tab 64 at pp. 1012-1013.
216 see: letter Dr Crampton, dated 18.5.2015: Vol 4, Tab 102 at p.2 (penultimate paragraph) and at p. 5 (2nd paragraph) of letter.
217 Vol 2, Tab 66 at pp. 480E-483.
218 Ex 3: Dr Cramption letter of 9 October 2015 p.1

180 The testimony of Dr Crampton was to the effect that, in March 2013 and at the time of the inquest, *"issues related to quality control"* of the point of care ABG machine located in the ED were such that results generated by the machine are not suitable for inclusion on the electronic database operated by the separate service provider responsible for the operation of the pathology Laboratory. Dr Crampton explained that while the machine is not faulty, it was not *"accredited by the National accrediting standard"*, but that resources were then *"under discussion"*. Otherwise, Dr Crampton acknowledged the problem demonstrated by the evidence received from Dr Woods, and confirmed that this difficulty was being addressed.

181 Dr Crampton addressed this issue in her letter of 9 October 2015, advising that she expected the ABG machine to receive NATA accreditation (by end of 2015) and that once it was obtained *"the full suite of ABG orders made and results carried out in ED will be available electronically to all ED medical and nursing staff on the Westmead CERNER pathology screen...it is anticipated that the eMR will include an electronic pathway that provides for the recording of ABG test results...The current ED Adult Trauma Admission form contains a prompt for laboratory test results. It does not, however, currently provide a prompt for the recording of the results of ABG analysis. This form can be reprinted to include this addition"*.

182 I agree with Ms Sandford's submission that, for the ED of a busy major tertiary referral centre not to be equipped with accredited equipment necessary for the conduct of essential investigations, and for the results of such investigations not to be available electronically, is at least unsatisfactory, and is worthy of comment. However, having regard to the matters set out in Dr Crampton's letter of 18 May 2015[219] and her letter of 9 October no recommendation is necessary.

183 Ms Sandford submits that I make a recommendation that until the eMR is fully implemented that the hospital does amend the paper ED Trauma Admission sheet to incorporate a specific prompt for the recording of ABG results. Mr Sergi does not oppose such a recommendation. I agree that it is an appropriate and necessary recommendation given the potential for the docket ABG result to "go missing" in the loose papers which, as shown in this case, can lead to a very adverse outcome.

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[219] see: letter Dr Crampton, dated 18.5.2015: Vol 4, Tab 102 at p.10 of letter.

***The Sepsis Protocol***

184 As noted at paragraph [132], above, the evidence (of Dr Moulden) was that the 'Sepsis pathway' was *"not pushed"* in the Westmead ED in March 2013.

185 Dr Crampton's evidence was that given the currency in March 2013, of a specific ED Sepsis Protocol[220], it was not clear (to her) why staff did not consider sepsis. The testimony of Dr Arunanthy was to the effect that currently, the 'Sepsis Kills' program is *"pushed very aggressively"* at the Westmead ED. When Dr Crampton gave evidence in May 2015 she was unable to shed light upon what would appear, then, to be the absence of a "valid" Sepsis protocol in place at the Westmead ED. As Dr Crampton acknowledged in her testimony, the Protocol did not provide a clear or concise guide as to the type and dosage of antibiotics that ought to be used in any given circumstance[221]. Dr Crampton's letter of 9 October 2015 sets out that changes are now in place which address this issue:

*"The Western Sydney Local Health District (WSLHD) ED Sepsis Guideline: Adult First Dose Antimicrobials* ***(the Sepsis Guideline)*** *has been updated by the Antimicrobial Stewardship Infectious Disease Physician approved by the WSLHD Drug Committee. The sepsis Guideline was modified on 1 February 2015. It was valid from 27 May 2015...*

*The Sepsis Guideline includes the adult sepsis pathway. It also sets out the type, dosage and route of antibiotics to be administered. The document is readily available on the ED Intranet site which is the principle reference point for all medical staff working and attending the ED.*

*The implementation of the Sepsis Guideline is currently supported by the eMR That support commences at the triage screen of the eMR The Sepsis Guideline is also supported on the Department Overview screen so that action taken can be monitored at all times on the ED management list."*

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220 See: Vol 4, Tab 93.

221 See: Vol 4, Tab 93. The pathway at p. 1138 instructs "Start antibiotics within 60 minutes", yet the 'Intravenous First Dose Guideline' at pp. 1143 does not provide guidance with respect to, by way of example, whether 1g or 2g of Ceftriaxone should be administered, and if so, in what circumstances (save that in the text of the Protocol, at p. 1139, it is stated: *"Contact the ID Physician/Microbiologist on call...to seek advice as needed."*

***Compliance with PD2011 077 (published 6.12.2011) and PD2013 049 (published 9.12.2013): Recognition and Management of Patients who are Clinically Deteriorating***

186 As acknowledged by Dr Crampton[222], the management of Mr James *"underscored practical failures of the application of relevant principles of care"*. In her letter of 18 May 2015, Dr Crampton stated, that:

a) at the time of Mr James' admission, 'escalation processes' in place within the general hospital for clinically deteriorating patients[223] had limited implementation in the ED[224] ;
b) a review is currently underway to determine the most appropriate escalation processes within the ED for a clinically deteriorating patient, and;
c) the Westmead ED is yet to implement a policy compliant with PD2013_049[225].

187 In her testimony, Dr Crampton confirmed that a policy compliant with PD2013_049 had, in fact, been drafted, and was in the process of being 'signed off'. In her letter of 9 October 2015 Dr Crampton advises:

> *"The ED at Westmead has designed a Policy Compliance Procedure (to implement PD2013_049)...the document is the* ***Management of the Deteriorating Patient Procedure "Between the flags" Emergency Department Clinical Emergency Response System (EDCERS): Westmead Hospital.***

188 Dr Crampton explains that the aim of the system is to ensure that where a patient's condition is clinically deteriorating, their care is escalated directly to the most senior ED medical Officer on duty.[226] If the patient's condition fails to improve the patient is to be transferred to a bed in the resuscitation bay for a review by the Intensive Care Unit. The system empowers the ED Nurse Unit Manager (rather than a medical Officer) to request ICU consultation when a patient's response to treatment is not as anticipated

189 This policy is intended to address particular concerns articulated by A/P Bihari, specifically, the need for input from senior medical Officers, including external sources of advice (ie: ICU). In this context, it is noted that since January 2015, staffing levels (relevantly, of consultants) have

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222 *Ibid.* at p.5 of letter.
223 see: WSLHD Policy Compliance Procedure created 12.4.2006, modified 1.4.2015, *Management of the Deteriorating Patient. "Between the Flags" Clinical Emergency Response System (CERS): PACE/ALS Westmead Hospital*: Vol 4, Tab 92.
224 see: letter Dr Crampton, dated 18.5.2015: Vol 4, Tab 102 at p.2 (3rd paragraph) of letter.
225 *Ibid.* at p.5 (6th paragraph) of letter.
226 Which, if after midnight will be a registrar.

been increased in response to workload and supervision requirements, although the position remains that no consultant is 'on the floor' after midnight[227].

***Fluid Monitoring and medical record keeping***

190 The inadequacy of nursing documentation concerning fluid administration, coupled with the failure to record fluid output during Mr James' admission, is a further issue of significant concern, particularly in the setting of a hypovolaemic patient with septic shock. The introduction (from 11 May 2015) of the AEOC for *all* ED admissions should reduce the potential for oversight in documentation of fluid administration/balance, such that the irregularities seen in Mr James' case may best be addressed by education and training, coupled with periodic auditing of AEOC's. In this regard, the matters set out in Dr Crampton's letter of 18 May 2015 (under the heading 'Training of Staff'), are noted.

191 Dr Crampton writes in her letter of 9 October 2015 that as a direct consequence of realising the shortcomings in contemporaneous and sequential medical record keeping in Mr James' case, the hospital has carried out staff orientation, audits and feedback. Audit Data Entry forms for Observation Charts, Clinical Handover and Clinical Documentation have been designed and implement. The key audit for fluid monitoring occurs at every shift. It is anticipated that the introduction of the electronic medical records system to the ED in July 2016 will address some of the difficulties.

***Transfer of patients out of the ED***

192 It is noted that steps were introduced in the Westmead ED in October 2014 to provide for senior medical review before a patient is transferred out of the ED to a ward, to guard against the risk (which eventuated here) of unrecognised clinical deterioration. The testimony of Dr Crampton was to the effect that this corrective measure was implemented because it was clear that patients *"outside the flags"* were being transferred out of the ED. Dr Crampton, who evidently became aware of the circumstances of Mr James admission only shortly prior to the inquest, was unable to say whether the introduction of this measure in October 2014, was informed by the death of Mr James.

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227 *Ibid.* at p. 7 (final paragraph) – p.8 of letter.

## Issue 3: Westmead Hospital's Response to Mr James Death

### *Morbidity and mortality reviews*

193 Contrary to previous policy in place at the Sydney West Area Health Service[228], which Dr Crampton confirmed was *"carried over"* following the establishment of Local Health Districts, no morbidity and mortality (M&M) meeting concerning the death of Mr James was conducted by the Westmead ED. Nor did any member of staff involved in the treatment of Mr James participate in an M&M conducted by the Trauma Service, on 22 July 2013, the minutes of which were obtained by Dr Crampton, who confirmed that the outcome was that the death of Mr James was *"not trauma related"*. No further comment was provided. The testimony of Dr Arunanthy was to the effect that, she would have expected to have been consulted and invited to contribute to an M&M convened in respect of the death of Mr James, but was not invited to attend the M&M conducted by the Trauma Service.

194 Dr Crampton confirmed that the ED should have conducted an M&M, but was unaware why it did not.

195 While the failure to conduct an appropriately constituted M&M into Mr James' death constituted a departure from standards in place at the Westmead Hospital in March 2013, having regard to the matters set out in Dr Crampton's letter of 18 May 2015[229], no recommendation is now necessary.

### *Reporting and Investigation of Critical Incidents*

196 The testimony of Dr Arunanthy was to the effect that she reported Mr James' death to the Director of the Westmead ED, and, while she could have made a notification in the Incident Information Management System (IIMS) herself, and did regard Mr James' death as a critical incident that required reporting, she did not. In the circumstance where Dr Arunanthy considered it unnecessary to take the matter further once a report to the Coroner had been made, she surmised that her omission was an oversight. It is, however, a matter of some concern that a senior ED physician was (apparently) unfamiliar with mandatory reporting requirements dictated by applicable NSW Health policy concerning incident management, which requirements were reproduced in local WSLHD policy current as at March 2013[230].

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228 see: Vol 4, Tab 99: *SWAHS Conduct of Morbidity and Mortality Meetings – Clinical Guidelines*, dated April 2008.
229 see: letter Dr Crampton, dated 18.5.2015: Vol 4, Tab 102 at pp.8-9of letter.
230 see: WSLHD *Incident Information Management System (IIMS) policy (Clinical Incidents)*: Vol 4, Tab 95.

197 In her testimony, Dr Crampton confirmed that, in accordance with WSLHD policy in place as at March 2013 the death of Mr James should have been notified on IIMS This oversight was first remedied on 12 February 2015[231], when an IIMS notification was made as a result of a file review conducted by the WSLHD Clinical Governance Unit following notification that an inquest was to be conducted. It is submitted that the steps proposed in Dr Crampton's letter of 18 May 2015[232], with respect to mandatory reporting of deaths in the ED that are referred to the Coroner, will bring practice at the Westmead ED into line with applicable NSW Health policy concerning incident management.

***Staff Training in Incident Management***

198 The need for staff training was a separate matter canvassed with Dr Crampton, during her testimony. In her letter of 9 October 2015 Dr Crampton writes *"Since Mr James' death, the process in place in the ED regarding deaths reportable to the Coroner has been made clearer. Where there has been a report of a death to police, such report is included in the shift report of every Senior Medical Officer... the SMO who is on duty is then responsible for entering the death into IIMS".*

199 In the event the incident is not entered it is anticipated that it will be entered into IIMS by the Emergency Medicine Administration Registrar who is responsible for reconciling the shift reports. In addition to that procedure the Clinical Governance Unit (CGU) requires that all deaths across WSLHD are reported to the Unit. It is anticipated that when the police advise Westmead Hospital or WSLHD that a death has been referred to the coroner, that will be reported to CGU who, if there has been no IIMS conduct a file review of the medical record. The LHD has created a new position of Clinical Risk Officer who will ensure that the relevant cases receive the appropriate level of review and/or investigation.

200 As noted at paragraph [140] above, that an early request made by the OIC on 18 April 2013, for the provision of evidentiary statements, was not met with any satisfactory response, has compromised the fact finding process in this inquest. The background and steps taken by the CGU since December 2013, to implement processes to ensure that such requests are actioned in a timely fashion in the future, have been addressed by Dr Crampton. In light of the improvements there is no recommendation necessary.

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231 see: IIMS notification: Vol 2, Tab 68A.
232 *Ibid.* at p.8.

201 Mr Sergi's submissions address the remainder of the issues on the basis that changes have been effected by the hospital and accordingly recommendations are not necessary, with which I agree.

202 Westmead Hospital has addressed the concerns which this coronial investigation and inquest has raised. However, it is regrettable that the need for those changes was not identified earlier. I suspect that would have occurred had Mr James' death been appropriately reported to the hospital's governance as it should have been at the time and had the hospital's representative taken a different attitude to the provision of medical and nursing staff statements requested by the Officer in charge on behalf of the coroner a few weeks after Mr James' death.

203 At least I hope the outcome of this inquest brings some comfort to Mr James' family in that they have now an understanding about what happened to Mr James who was their son, brother, father and partner and that the changes prevent another family from suffering such loss.

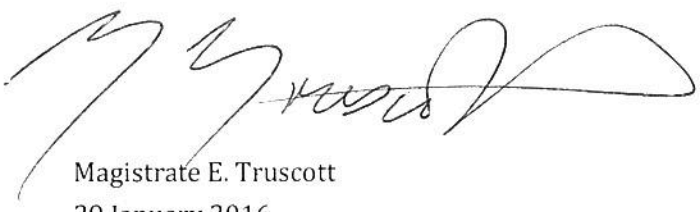
**Formal Findings**

Jimmy James died on 2 March 2013 at Westmead Hospital, NSW due to pneumonia (with multiple left-sided rib fractures as the antecedent cause).

**Recommendation**

**To the Western Sydney Local Health District**

That pending the full introduction of electronic medical record keeping at the emergency department of the Westmead Hospital, consideration be given to amending the 'Emergency Department Adult Trauma Admission' form currently in use at the emergency department of the Westmead Hospital to incorporate a specific prompt for recording the results of ABG analyses.



Magistrate E. Truscott
29 January 2016