CORONERS COURT

NEW SOUTH WALES

Inquest:	Inquest into the death of Mervyn Douglas MORGAN
Hearing dates:	11-12 October 2021
Date of findings:	24 November 2022
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-death in custody- mandatory inquest-adequacy of treatment of liver disease-adequacy of clinical handover-adequacy of scan result follow up-adequacy of Advance Care Planning and Resuscitation Planning
File number:	2020/00004795
Representation:	Ms E Jones, Counsel Assisting instructed by Ms B Lorenc, Crown Solicitor's Office Mr A Jobe, instructed by Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Mr P Rooney, instructed by Makinson d'Apice Lawyers representing Justice Health and Forensic Mental Health Network and South Eastern Sydney Local Health District and Dr Mica Spasojevic

Findings:	I find that Mr Mervyn Douglas MORGAN died on 5 January 2020 at the Prince of Wales Hospital, NSW from complications of viral liver cirrhosis. He died as a result of natural causes while in the lawful custody of Corrective Services NSW.
Recommendations:	**To the Chief Executive Officer, Justice Health and Forensic Mental Health Network:** 1. I recommend that the standard paperwork utilised when transferring patients, incorporate a specific check for indicating whether a patient has an advance care directive or resuscitation plan in place.

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of Mr Mervyn Douglas Morgan who was born on 29 September 1960. Mr Morgan died on 5 January 2020, while in lawful custody.

2. The issues in the inquest are;
   a. The findings required by s 81(1) of the *Coroners Act 2009* (The Act), namely:
      i. the identity of the deceased;
      ii. the date and place of the death; and
      iii. the manner and cause of the death.
   b. Whether Mr Morgan received adequate and appropriate treatment between his entry into custody in September 2017 and his diagnosis of liver cancer in mid-2019, given his vulnerability to liver cancer and the need to monitor the condition of his liver.
   c. In particular, whether there was adequate clinical handover of Mr Morgan's care and treatment during this period.
   d. Following the ultrasound performed in July 2018, whether Mr Morgan was given sufficient and appropriate information about his medical condition, including to inform his decision(s) to refuse to undergo further testing until mid-2019.
   e. Whether appropriate steps were taken in December 2019 to act upon the requests of Mr Morgan to receive treatment and to re-consider or change his advance care planning, including his resuscitation plan and advance care directive.
   f. Whether there was adequate clinical handover of Mr Morgan to Prince of Wales Hospital (**POWH**) on 5 January 2020, including as to his advance care planning.

g. Whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death of Mr Morgan.

3. The Act requires a senior coroner to conduct an inquest where a death occurs in custody. In such cases the community has an expectation that the death will be properly and independently investigated.
4. This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. The primary focus in this inquest is whether there are any lessons that can be learned from Mr Morgan's death and whether anything should or could be done to prevent a similar death in the future.
5. Pursuant to section 37 of the Act a summary of the details of this case will be reported to parliament.

Mervyn Morgan

6. Mr Morgan grew up around Walgett and Coonabarabran. He completed high school and joined the Navy. He later undertook some tertiary study and worked as a community support worker.
7. Mr Morgan married, and he and his wife had a son who, sadly, died as a baby. Mr Morgan also had three stepchildren. Mr Morgan's wife died in 2012.
8. Mr Morgan suffered from a chronic Hepatitis C viral infection. Although the infection was successfully eradicated, he developed cirrhosis of the liver. It was recommended that Mr Morgan undergo regular monitoring for liver cancer, including by means of abdominal ultrasound every six months.[1] An ultrasound of Mr Morgan's abdomen was conducted on 4 May 2017 and showed a "echogenic lesion" that could "represent a dysplastic nodule". Further evaluation was recommended through a CT scan, MRI, or further ultrasound at "short interval".[2]
9. Mr Morgan was taken into custody on 18 September 2017. His earliest release date was 7 January 2027.[3]

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[1] Letter from Gastroenterologist Lay Gan to Dr Peter Ashley dated 26 April 2017: Exhibit 1 Vol 4, Tab 40, pp 486-487.
[2] US Upper Abdomen Report: Exhibit 1Vol 3, Tab 39, p 126.
[3] His initial sentence was reduced by the New South Wales Court of Criminal Appeal following an appeal against sentence: Exhibit 1 Vol 5, Tab 55.

Care and treatment between entry into custody and terminal diagnosis in mid-2019

10. During Mr Morgan's "Reception Screening Assessment" on 19 September 2017, cirrhosis of the liver was identified as an "Existing Active Health Condition".[4] On 20 September 2017, Mr Morgan was seen by a general practitioner and a note about his liver cirrhosis was made in his "Progress / Clinical Notes".[5]

11. On 9 October 2017, Mr Morgan was seen by another general practitioner, Dr Heather Rogers, who again made a note of his liver cirrhosis in his "Progress / Clinical Notes" and queried his "liver status".[6] Dr Rogers saw Mr Morgan again on 30 October 2017 and on 6 November 2017.[7] On the latter occasion, Dr Rogers made a request for information from John Hunter Hospital, including in relation to Mr Morgan's previous abdominal ultrasound.[8] By her next consultation with Mr Morgan on 13 November 2017, Dr Rogers had reviewed the requested information. In the "Progress / Clinical Notes" for 13 November 2017, Dr Rogers made a note that Mr Morgan needed "regular / lifelong liver cancer surveillance" with six monthly ultrasounds, including to evaluate the lesion shown on the previous ultrasound.[9] The entry concluded with the notation: "Referrals for U/S etc ... TBA next week".[10]

12. It appears that a referral for an ultrasound was not completed at this time. Dr Rogers has provided a statement in which she states that, due to the passage of time, she does not now have a recollection of her workload on 13 November 2017 or the steps taken by her following the consultation with Mr Morgan.[11] She recalls generally, however, that the clinic at which she saw Mr Morgan was often "very busy" and that she did not receive administrative support to complete entries on the Patient Administration System or to fax documents.[12]

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[4] Exhibit 1 Vol 4, Tab 40, pp 523-525.
[5] Exhibit 1 Vol 3, Tab 39, p 43.
[6] Exhibit 1 Vol 3, Tab 39, p 46. See also Statement of Dr Heather Rogers dated 8 October 2022 at [13]-[16].
[7] Statement of Dr Heather Rogers dated 8 October 2022 at [17]-[18], [20]-[21].
[8] Exhibit 1 Vol 3, Tab 39, p 47. See also the Consent to Obtain Health Information from External Agencies forms at Exhibit 1 Vol 3, Tab 39, pp 40-41.
[9] Statement of Dr Heather Rogers dated 8 October 2022 at [27].
[10] Exhibit 1 Vol 3, Tab 39, pp 47-48.
[11] Statement of Dr Heather Rogers dated 8 October 2022 at [29].
[12] Statement of Dr Heather Rogers dated 8 October 2022 at [7]-[8].

13. On 28 November 2017, Mr Morgan moved to the Metropolitan Special Programs Centre.[13] A comment of "cirrhosis" was made on Mr Morgan's "Transfer In and Out Form".[14]

14. Mr Morgan's next consultation with a general practitioner recorded in the "Progress / Clinical Notes" was on 17 January 2018. While the notes are difficult to read, it does not appear that Mr Morgan's liver cirrhosis was discussed.[15] On 8 February 2018, Mr Morgan was transferred to the South Coast Correctional Centre.

15. On 14 April 2018, the "Progress / Clinical Notes" made by a nurse noted "multiple chronic conditions" including liver cirrhosis.[16] Mr Morgan's "Chronic Disease Screen" took place on 16 April 2018. It did not occur earlier because he had been "frequently transferred". Again, liver cirrhosis was noted.[17]

16. Mr Morgan continued to be seen by "[n]ursing" for various things (for example, complaints about his hearing and eye-sight). It appears he was next seen by a general practitioner on 27 June 2018 when he consulted with Dr Linda Mayer. Dr Mayer has provided a statement in which she explains that her notations suggest that she reviewed the report from Mr Morgan's abdominal ultrasound in May 2017 and that she would have discussed this with Mr Morgan.[18] Dr Mayer ordered an ultrasound for Mr Morgan.[19]

17. On 10 July 2018, Mr Morgan was transferred from South Coast Correctional Centre to Parklea Correctional Centre and then to Hunter Correctional Centre on 13 July 2018. The "Transfer In and Out Form" for each of these moves did not refer to Mr Morgan's liver condition.[20]

18. An upper abdominal ultrasound, as ordered by Dr Mayer, was conducted on 20 July 2018 and additional lesions with a "suspicion of three nodules" were identified in Mr Morgan's liver. Further assessment with a CT scan or MRI was recommended.[21] Although Mr Morgan was no longer at South Coast Correctional Centre, the results of the ultrasound were provided to Dr Mayer by email.[22] Dr Mayer recalls that:[23]

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[13] See "Movements" recorded in Inmate Profile Document: Exhibit 1 Vol 1, Tab 18, p 3.
[14] Exhibit 1 Vol 3, Tab 39, p 18.
[15] Exhibit 1 Vol 3, Tab 39, p 48.
[16] Exhibit 1 Vol 3, Tab 39, p 49.
[17] Exhibit 1 Vol 4, Tab 40, pp 548-549.
[18] Statement of Dr Linda Mayer dated 27 September 2022: Exhibit 1 Vol 3, Tab 36A, p 2 [15].
[19] Referral Form: Exhibit 1 Vol 4, Tab 40, p 450.
[20] Exhibit 1 Vol 3, Tab 39, pp 27, 29.
[21] Report from Hunter New England Imaging: Exhibit 1 Vol 3, Tab 39, pp 124-125.
[22] Statement of Dr Linda Mayer dated 27 September 2022: Exhibit 1 Vol 3, Tab 36A, p 3 [20].
[23] Statement of Dr Linda Mayer dated 27 September 2022: Exhibit 1 Vol 3, Tab 36A, p 3 [21].

"While it is not routine practice for me to complete a referral for a patient in another correctional facility, noting the urgency and seriousness of the findings, I immediately completed a Justice Health Referral Form and ordered a "1 – urgent" MRI of [Mr Morgan's] liver."

19. That referral was dated 23 July 2018.[24] Dr Mayer sent the referral by email to a Health Centre Clerk at the Hunter Correctional Centre, while also requesting that Mr Morgan see a general practitioner on the next consultation day.[25] The Health Centre Clerk replied to that email, copying Julie Little, noting that the request would be forwarded to a registered nurse and that Mr Morgan would be placed on the "GP Waiting List".[26] Ms Little was the Nursing Unit Manager (**NUM**) at the Hunter Correctional Centre. She recalls that she had "only limited informal interaction with Mr Morgan" between July 2018 and March 2019.[27] Based on a supplementary statement provided by NUM Little, it appears that Mr Morgan was not added to the waiting list to see a general practitioner at this time.[28] NUM Little explains that she was on short course leave on 24 and 25 July 2018 and may not have seen the email 23 July 2018.

20. On 27 July 2018, Mr Morgan was seen by a nurse to complete a pre-appointment questionnaire with "nil issues" recorded.[29] But on 29 July 2018, Mr Morgan completed a "Patient Self Referral" form to see a nurse because he did not want to have the MRI.[30] On 3 September 2018, Mr Morgan cancelled his appointment. The "Progress / Clinical Notes" record that the "patient feels he doesn't need to go anymore and is happy to stay here".[31] The "Appointment Cancellation By Patient" form recorded the following information:[32]

"[My reason for cancellation is]: I feel in good health. No problems with my liver ... [I take the responsibility for any medical problem that might arise because of this cancellation. The clinical staff have advised me that:] It's been explained to me that I can't get an MRI locally – I have no wish to be transferred in the back of a truck for the long journey to Sydney."

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[24] Referral Form: Exhibit 1 Vol 3, Tab 39, p 32.
[25] Statement of Dr Linda Mayer dated 27 September 2022: Exhibit 1 Vol 3, Tab 36A, p 6.
[26] Statement of Dr Linda Mayer dated 27 September 2022: Exhibit 1 Vol 3, Tab 36A, p 5.
[27] Statement of Julie Little dated 19 August 2022: Exhibit 1 Vol 3, Tab 37, p 2 [8]-[9].
[28] Supplementary Statement of Julie Little, 10 October 2022, at [9].
[29] Progress / Clinical Notes: Exhibit 1 Vol 3, Tab 39, p 56.
[30] Exhibit 1 Vol 3, Tab 39, p 112.
[31] Exhibit 1 Vol 3, Tab 39, p 56.
[32] Exhibit 1 Vol 3, Tab 39, p 31.

21. From these documents, it is not clear whether Mr Morgan was made aware of the concerning results of the ultrasound conducted on 20 July 2018. It also appears that he was not seen by a general practitioner between 23 July 2018 and 3 September 2018 when he cancelled the MRI appointment. Indeed, although he saw nurses, including public health nurses, on a number of occasions, Mr Morgan is next recorded in the "Progress / Clinical Notes" as seeing a general practitioner on 2 May 2019 (see [28] below). In a general sense, however, Mr Morgan seems to have been aware, around this time, that his liver cirrhosis was a "significant medical concern". He expressed as much to Emma Harding, a Case Management Officer with Corrective Services NSW (**CSNSW**), in October 2018, but did not elaborate further.[33]

22. In January 2019, Mr Morgan again cancelled an appointment for an MRI. The "Progress / Clinical Notes" record:[34]

> "[Mr Morgan] [s]tates he does not require MRI and declines to complete paperwork. W/L for urgent MRI made 10/1/19. Patient declines to attend for imaging. Educated re risks to health. Patient maintains decision to refuse: consent not given."

23. Although there is a reference in the "Progress / Clinical Notes" to Mr Morgan completing "paperwork" to cancel this appointment, an "Appointment Cancellation By Patient" form has not been located. Additionally, the making of this request for an MRI in January 2019 is not recorded in the "Progress / Clinical Notes".

24. On 20 March 2019, Mr Morgan was seen by a public health nurse for "cirrhosis monitoring". The "Progress / Clinical Notes" record:

> "Last ultrasound July 18 - ? nil subsequent follow up as pt has refused MRI appointments. Email/phone call made to CNC re further plan. Pt needs URGENT follow up."

25. On 26 March 2019, a consultation occurred between Mr Morgan, a registered nurse and NUM Little.[35] The "Progress / Clinical Notes" record that his "management [was]

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[33] Statement of Emma Harding dated 5 September 2022: Exhibit 1 Vol 1, Tab 14, p 2 [8]; Case Note of Interview Assessment by Emma Harding on 10 October 2018: Exhibit 1 Vol 1, Tab 21, p 13.

[34] Exhibit 1 Vol 3, Tab 39, p 57.

[35] Exhibit 1 Vol 3, Tab 37, p 2 [10].

discussed" and that he was "[e]ducated re risks". Mr Morgan declined to attend a CT scan.[36]

26. It is useful to provide an extract from an entry in the "Progress / Clinical Notes" made on 10 April 2019 by a public health nurse.[37]

> "Pt seen in clinic re follow up URGENT MRI organised through Hepatitis CNC. Pt is refusing to attend this appointment. Pt is aware that a lesion was seen on his liver on an USS in May 2017. Pt then had an abdo USS in July 2018 but never received these results. Three subsequent appointments have been made for an MRI scan (Sept 18, January 19 & April 19) however pt has refused to attend. Pt needs to have a discussion with the GP re USS results from 2017/2018 & discuss the importance of the MRI scan. Pt booked for GP review 11/4/19. ..."

27. The evidence summarised above shows that between July 2018 and April 2019, Mr Morgan declined further imaging to investigate the condition of his liver. There appears to be no reason to doubt that Mr Morgan was competent to make decisions to refuse those recommended procedures. Yet three questions arise for consideration in this regard.

    a. The *first* is whether, in making these decisions, Mr Morgan had the benefit of a full explanation of the results of the ultrasound conducted in July 2018. The Justice Health & Forensic Mental Health Network (**Justice Health**) policy on "Consent to Medical Treatment – Patient Information" at the relevant time stated:[38]

    > "A competent adult patient is entitled to refuse medical treatment even if that treatment is necessary to keep them alive. A competent adult patient can refuse treatment, regardless of whether the reasons for making the choice seem to be irrational, unknown or even non-existent.
    >
    > Like consent to medical treatment, a refusal must be provided by a competent patient, be freely given, and specific to the proposed treatment or procedure. It is strongly recommended that the medical practitioner inform the patient of the consequences of refusing treatment."

    If Mr Morgan was to be properly informed of the potential consequences of his refusing further investigations, the results of the ultrasound conducted in July 2018 needed to be explained to him.

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[36] Exhibit 1 Vol 3, Tab 39, p 58.
[37] Exhibit 1 Vol 3, Tab 39, p 59.
[38] Exhibit 1 Vol 4, Tab 45, p 7 [3.3.5]. This remained relevantly the same in the more recent policy dated 14 November 2019: Exhibit 1 Vol 4, Tab 44, p 7 [3.3.5].

b. *Secondly*, it may be doubted that the "Progress / Clinical Notes" recording Mr Morgan's refusal to undergo further tests were sufficiently detailed in the circumstances. The same Justice Health policy referred to above continued:

> "A refusal can be express, implied or in writing, however, it is preferable that a refusal of treatment is recorded in writing and signed by the patient. Any discussions with patients about refusal of treatment should be recorded in detail in the health record.".

While some entries refer to Mr Morgan being "educated" about "risks" (see [22] and [25] above, none specifically refers to the ultrasound from July 2018 and the entry for 10 April 2019 states that Mr Morgan "never received" the results of that ultrasound (see [26] above). Accordingly, the record, on its face, leaves open the question of whether Mr Morgan was educated about the relevant magnitude of the risk of his refusal of treatment by reference to the most recent ultrasound results.

c. *Thirdly*, the involvement of a general practitioner in the kinds of decisions made by Mr Morgan to refuse further investigations is desirable. In respect of obtaining consent for medical treatments, the Justice Health policy specified that:[39]

> "Administrative and nursing staff cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and obtaining consent, where the procedure is to be performed by a medical practitioner. However in some cases, the medical practitioner may inform the patient and obtain verbal consent and subsequently ask a hospital staff member to have the patient complete the form."

28. Mr Morgan was seen by Dr Mary Foley, a general practitioner, on 2 May 2019. Dr Foley recalls:[40]

> "I was asked by [the Population Health] team to discuss the results of an ultrasound Mr Morgan had undergone in July 2018 which showed suspicion lesions, and to discuss why Mr Morgan had not attended previous imaging referrals as he had obtained an MRI referral through the Hepatitis Clinical Nurse ...
>
> As requested, ... I reviewed and discussed his ultrasound report from 20 July 2018 and noted the salient points that there were two nodules in the liver ... and that they had increased in size from previous imaging. I recall informing Mr Morgan that with the abnormal liver function test, growing nodules in the liver, and a

[39] Exhibit 1 Vol 4, Tab 45, p 6 [3.3.4].

[40] Statement of Dr Mary-Frances Foley dated 26 September 2022: EXHIBIT 1 Vol 3, Tab 36, pp 3 [3.5], 7 [3.10].

> history of hepatitis C and cirrhosis, that it would be important to have the follow-up MRI as organised by the Hepatitis Clinical Nurse Consultant. Mr Morgan told me that he would not have the MRI, and I was unable to find out why despite questioning. Despite me telling him about his results and their implications, he told me that he felt ok. I was able to convince Mr Morgan to agree to have a repeat ultrasound."

Dr Foley recalls that she had no concerns about Mr Morgan's capacity to understand the information provided and that he actively participated in the discussion.[41]

29. As arranged by Dr Foley, an ultrasound was performed on 13 May 2019. This showed that Mr Morgan's liver lesions had increased in size and were "highly suspicious for metastases".[42] On the same day, an "NLMC Advanced Liver Disease Clinical Assessment" was conducted by Jacqueline Clegg. A note was made in the field for "identified issues for follow up" which said: "had abdo USS 13/5/19 – previous abdo USS showed lesions in liver".[43] The "comment" field for "recommended monitoring" included the following:

> "For f/u with CNC when abdo USS result available. Pt seen re same – discussed re likely metastases – referred for CT Scan Chest and Liver. ..."

The "Medical Officer/Nurse Practitioner Assessment" part of that form was completed by Professor Andrew Lloyd on 6 September 2019.[44] The JHFMHN policy for "Management of Advanced Liver Disease Hepatocellular Carcinoma Screening" contemplates that this assessment will be completed for all patients who require regular monitoring of advance liver disease (including patients with cirrhosis) and/or screening for hepatocellular carcinoma.[45] Relevantly to Mr Morgan, the policy provides that:[46]

> "If a suspicious lesion is identified on the abdominal ultrasound [in regular screening], the patient must be referred for further imaging such as a triple phase CT or MRI scan, followed up specialist review."

30. On 22 May 2019, Mr Morgan consulted with Ms Clegg about the results of his ultrasound. The need for a follow up CT scan to confirm the diagnosis was discussed.[47] It appears Mr

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[41] Statement of Dr Mary-Frances Foley dated 26 September 2022: Exhibit 1 Vol 3, Tab 36, pp 3 [3.1], 8 [3.16(i)].
[42] Ultrasound Report: Exhibit 1 Vol 3, Tab 39, p 123.
[43] Exhibit 1 Vol 4, Tab 40, p 567-571.
[44] Exhibit 1 Vol 4, Tab 40, p 572.
[45] Exhibit 1 Vol 5, Tab 47, p 4-5 [3.3]-[3.5].
[46] Exhibit 1 Vol 5, Tab 47, p 5 [3.4]. This requirement was relevantly the same in the earlier version of the policy: see Exhibit 1 Vol 5, Tab 48, p 4 [3.4].
[47] "Progress / Clinical Notes": Exhibit 1 Vol 3, Tab 39, p 65.

Morgan understood the information conveyed during this consultation as, on 23 May 2019, Mr Morgan told Ms Harding that he would be attending a specialist medical appointment to confirm a cancer diagnosis.[48]

31. Professor Lloyd, an infectious diseases physician, consulted with Mr Morgan on 24 May 2019. In his notes, Prof Lloyd observed "2 years of lack of [follow up] of liver lesions?" with lesions larger between ultrasounds.[49] Prof Lloyd arranged a CT scan for Mr Morgan in Maitland. The scan was conducted on 3 June 2019 and revealed concerns for "multifocal HCC" (i.e. hepatocellular carcinoma) and "metastatic lesion".[50]

Care and treatment subsequent to terminal diagnosis

32. On 7 June 2019, Mr Morgan discussed the results of the CT scan with Prof Lloyd. At that time, Mr Morgan declined treatment. The "Progress / Clinical Notes", taken by NUM Little, record that the implications of declining treatment were discussed.[51] Prof Lloyd has provided a statement in which he offers the following description of the consultation on 7 June 2019:[52]

> "... I discussed the likely diagnosis of metastatic HCC and the poor prognosis (which is a median survival of less than 12 months) and the relatively poor probability of a partial (non-curative) response (approximately 20%) to the existing HCC treatments (sorafenib and levatinib). Following this discussion, as he was largely asymptomatic, Mr Morgan opted not to have treatment. I described to him the way in which he would be provided with palliative care – notably with analgesia for pain if needed. We opened discussion about an Advanced Care Directive to allow him to outline his palliative care wishes. As palliative care for HCC may involve active management of the manifestations of liver failure, Mr Morgan agreed to have regular nursing observations (e.g. monthly weight and abdominal girth measurements to detect fluid accumulation or ascites) as well as 3 monthly blood tests of his liver function."

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[48] Statement of Emma Harding dated 5 September 2022: Exhibit 1 Vol 1, Tab 14, p 2 [9]; Case Note of Interview Assessment by Emma Harding on 10 October 2018: Exhibit 1 Vol 1, Tab 21, p 20.
[49] Statement of Professor Andrew Lloyd dated 18 August 2022: Exhibit 1 Vol 3; Tab 38, pp 2-3 [7].
[50] CT Scan Report: Exhibit 1 Vol 3, Tab 39, p 121. See also Statement of Professor Andrew Lloyd dated 18 August 2022: Exhibit 1 Vol 3; Tab 38, p 3 [9].
[51] Exhibit 1 Vol 3, Tab 39, p 69. See also Statement of Julie Little dated 19 August 2022: Exhibit 1 Vol 3, Tab 37, p 2 [12].
[52] Statement of Professor Andrew Lloyd dated 18 August 2022: Exhibit 1 Vol 3, Tab 38, p 3 [10].

33. Mr Morgan later discussed his decision to decline treatment with an Aboriginal Health Care Worker.[53]

34. On 9 July 2019, Mr Morgan was seen by Dr Foley. In her statement, Dr Foley recalls that:[54]

> "I asked Mr Morgan what his understanding of his condition was. He told me that Prof Lloyd had told him that he had a life expectancy of six months to two years and asked me what I thought. I told him that I agreed with Prof Lloyd's assessment. We discussed the carcinomas and cirrhosis, and Mr Morgan told me that he did not want treatment, except to make him more comfortable. Mr Morgan appeared to have understood and come to terms with his prognosis and his decision about his healthcare. ...
>
> We again discussed his decision to not undertake active treatment. He confirmed that he had discussed this with Prof Lloyd as well, and that this was his decision. I made sure that he understood that he could change his mind if he decided to."

35. On 8 August 2019, Mr Morgan signed a 'not for resuscitation' (**NFR**) request. The "Progress / Clinical Notes" record that he "wishes to be comfortable / does not want CPR, intubation, mechanical respirator".[55] His Advance Care Directive (**ACD**) stated that he did not wish to receive intensive, active, or surgical treatment, and wished to be transferred to hospital for palliative care only.[56]

36. Prof Lloyd consulted with Mr Morgan again on 6 September 2019. The plan discussed was to continue palliative care. Prof Lloyd noted that an ACD was in place and commented that it "needs regular review as [disease] progresses".[57] On the same day, Prof Lloyd endorsed the "NLMC Advanced Liver Disease Clinical Assessment" prepared by Ms Clegg in May.[58]

37. A further CT scan conducted on 21 October 2019 showed findings "consistent with progression of the multifocal bilobar hepatocellular carcinoma".[59] These results were discussed with Mr Morgan on 1 November 2019, and he stated he was "happy [with] current management plan" and did not "want any further interventions".[60]

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[53] "Progress / Clinical Notes" for 30 July 2019 and 15 August 2019: Exhibit 1 Vol 3, Tab 39, p 78, 81.
[54] Statement of Dr Mary-Frances Foley dated 26 September 2022: Exhibit 1 Vol 3, Tab 39, p 14 [3.30], [3.33].
[55] Exhibit 1 Vol 3, Tab 39, p 79.
[56] Exhibit 1 Vol 3, Tab 39, p 12.
[57] Statement of Professor Andrew Lloyd dated 18 August 2022: Exhibit 1 Vol 3, Tab 38, p 5 [15].
[58] Statement of Professor Andrew Lloyd dated 18 August 2022: Exhibit 1 Vol 3, Tab 38, p 5 [16].
[59] Exhibit 1 Vol 3, Tab 39, p 120.
[60] Exhibit 1 Vol 3, Tab 39, p 86.

38. Around this time, Mr Morgan appears to have spoken about his terminal diagnosis with staff members of CSNSW.[61] Ms Harding formed the view that he was "open and comfortable talking about his terminal prognosis" and "appeared to understand his diagnosis".[62] Ms Harding also recalls that Mr Morgan was "aware of options for self-referrals to Justice Health and Psychology services".[63] But it may be noted that Mr Morgan did not have contact with psychology services in 2019.[64]

39. Due to a deterioration in his condition, a determination was made to transfer Mr Morgan to Long Bay Hospital in late November 2019.[65] The "Transfer In and Out Form" recorded that Mr Morgan was a "palliative care patient" with "multiple liver CA" and that there was a "current ACD".[66]

Time at Long Bay Hospital (5 – 12 December 2019)

40. On 5 December 2019, Mr Morgan was admitted to Long Bay Hospital under the care of Dr Mica Spasojevic.[67] The next day (6 December 2019), Mr Morgan was seen by Dr Spasojevic and Dr Ronnachit, an infectious diseases fellow. During these consultations, Mr Morgan expressed a wish to receive treatment for his cancer.[68] Dr Spasojevic recalls being aware that Mr Morgan had completed an ACD which outlined that he did not wish to be provided with intensive treatment, active treatment, surgical treatment, or CPR. She recalls formulating a plan that Mr Morgan would be reviewed by a palliative care team and that there would be a follow up with Professor Lloyd about treatment options.[69] A referral for a palliative care review, which would usually occur at POWH, was completed.[70]

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[61] In addition to speaking with Ms Harding, Mr Morgan spoke with another officer about his diagnosis in June 2019: see General Case Note by Chris Hughes dated 11 June 2019: Exhibit 1 Vol 1, Tab 21, p 21.
[62] Statement of Emma Harding dated 5 September 2022: Exhibit 1 Vol 1, Tab 14, p 2 [11]-[12].
[63] Statement of Emma Harding dated 5 September 2022: Exhibit 1 Vol 1, Tab 14, p 3 [17].
[64] Psychological Services Report: Exhibit 1 Vol 1, Tab 26, p 1.
[65] See Case Note of Placement Matters by Marcel Vernier dated 29 November 2019: Exhibit 1 Vol 1, Tab 21, p 23; "Progress / Clinical Notes" for 29 November 2019: Exhibit 1 Vol 3, Tab 39, pp 87-88.
[66] Exhibit 1 Vol 3, Tab 39, p 350.
[67] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 2 [8]-[9].
[68] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 2 [11]-[13]. See "Progress / Clinical Notes": Exhibit 1 Vol 4, Tab 40, pp 511-512.
[69] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 2 [13]. See also "General Note": EXHIBIT 1 Vol 4, Tab 40, pp 603-604.
[70] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 3 [16], [19]. See also "PAS Referral Form": Exhibit 1 Vol 3, Tab 39, p 347.

41. Because of a further deterioration in his condition, Dr Spasojevic arranged for Mr Morgan to be transferred to POWH on 12 December 2019.[71] The referral letter recorded that Mr Morgan had previously declined treatment, but was now keen to receive treatment.[72] Dr Spasojevic "anticipated that [Mr Morgan] would undergo any necessary investigations and would be reviewed by the Palliative Care Team" at POWH.[73]

Admission to POWH (12 – 20 December 2019)

42. Mr Morgan was admitted under the care of Professor Stephen Riordan, a gastroenterologist/hepatologist, between 12 and 20 December 2019. On his arrival at the Emergency Department, a Registrar described Mr Morgan's symptoms as being dyspnoea, abdominal pain and headaches. The Registrar also recorded in the "Progress Notes" that Mr Morgan had changed his mind about previously declining treatment.[74] Prof Riordan has provided a statement in which he recalls that Mr Morgan:[75]

> "was managed with supplemental oxygen as required for dyspnea along with dexamethasone for the liver capsular pain. The Palliative Care team was consulted and directed other pain control and comfort measures, which proved effective. He commenced sorafenib as a strategy to potentially slow the rate of intrahepatic tumour progression to also help with pain control. He also commenced sertraline for pruritis related to the intrahepatic cholestasis with good effect."

43. In a supplementary statement, Prof Riordan has confirmed his recollection that Mr Morgan's "wishes for treatment" were discussed with the team at POWH and relayed to him (Prof Riordan). "As a consequence", a number of investigations were conducted "in order to ascertain the cause of Mr Morgan's symptoms".[76] A CT scan showed "innumerable hypervascular lesions throughout the liver ... favoured to reflect metastatic HCC."[77] Prof Riordan explains:[78]

> "both sorafenib, the gold standard systemic treatment for hepatocellular carcinoma at the time, and sertraline, for management of pruritis, were

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[71] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 3 [20]. See also "General Note": Exhibit 1 Vol 4, Tab 40, p 628-629; "SOAP": Exhibit 1 Vol 4, Tab 40, p 631.
[72] Exhibit 1 Vol 2, Tab 34, pp 81-82.
[73] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 3 [20].
[74] Exhibit 1 Vol 2, Tab 34, p 137.
[75] Statement of Prof Stephen Riordan dated 9 December 2021: Exhibit 1 Vol 2, Tab 30, p 3 [5].
[76] Supplementary Statement of Prof Stephen Riordan dated 6 October 2022.
[77] Exhibit 1 Vol 2, Tab 34, p 58.
[78] Supplementary Statement of Prof Stephen Riordan dated 6 October 2022.

commenced. The aim of treatment with sorafenib was to try to achieve even a minor reduction in the extensive intrahepatic tumour burden that might aid in pain control and improve dyspnoea."

44. While this treatment was administered, the "goals of care" were described variously in the "Progress Notes" during Mr Morgan's admission to POWH as being for comfort.[79] On 12 December 2019, a Resuscitation Plan for Mr Morgan was partially completed, whereby he requested no CPR and limited respiratory support.[80] Mr Morgan was subsequently marked "NFR" on the "Nursing Care Plan".[81] On 13 December 2019, a palliative care medical officer recorded a "Progress Note" stating:[82]

> "**Goals of Care:**
>
> Treat reversible pathology
>
> Ensure comfort
>
> **Ceilings of intervention**
>
> Ward based as per treating team
>
> Discussion ...
>
> [Mr Morgan] brought up he would not want to be brought back if dying – not for CPR or intubation as [this] is against patient wishes."

45. Prof Riordan opines that:[83]

> "Mr Morgan was suffering from a very advanced, irreversible malignancy and his death was not preventable. The goal of therapy during his admission under my care, in collaboration with my Palliative Care and Respiratory Medicine colleagues in a multidisciplinary approach, was to ensure Mr Morgan's comfort."

46. Prior to Mr Morgan being discharged back to Long Bay Hospital on 20 December 2019, Dr Muggleton, a gastroenterology registrar basic physician trainee, spoke with Dr Spasojevic about Mr Morgan.[84] The "Discharge Referral" stated:[85]

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[79] See "Progress Note" by Registrar Kostas Brooks on 15 December 2019 and 14 December 2019: Exhibit 1 Vol 2, Tab 34, pp 146-148.
[80] Exhibit 1 Vol 2, Tab 34, pp 9-10.
[81] Exhibit 1 Vol 2, Tab 34, pp 85, 87.
[82] Exhibit 1 Vol 2, Tab 34, pp 161-162. See also the "Progress Notes" on later days: Exhibit 1 Vol 2, Tab 34, pp 153-154, 156-157, 158-159, 160.
[83] Statement of Prof Stephen Riordan dated 9 December 2021: Exhibit 1 Vol 2, Tab 30, p 3 [5].
[84] Statement of Dr Adam Wilkinson dated 29 September 2022: Exhibit 1 Vol 2, Tab 31, p 4 [31]. See also "Progress Note": Exhibit 1 Vol 2, Tab 34, p 141.
[85] Exhibit 1 Vol 2, Tab 34, pp 63-64.

"Discharge Plan

1. Discharge back to Long Bay Hospital
2. Medication changes

-NEW Sorafenib ...

4. Follow-up in Palliative Care clinic at POWH – Long Bay will be contacted by Pall Care to arrange
5. Follow-up with Gastro/Prof Riordan Feb 2020 ...
6. Return to GP/Ed if any new or concerning symptoms.

Issues During Admission

Dyspnoea and abdominal pain

-Diagnosed with hepatocellular carcinoma in September 2019

-Potentially metastatic with lung lesions noted on imaging at the time

-Decline treatment for the same and was transferred to Long Bay Hospital in past few weeks for palliation

-Since this time has developed increasing symptoms & has changed mind about treatment

-Linked in with palliative care for management of pain (as per medication plan above) ...

-Commenced on Sorafenib for control of HCC".

Dr Adam Wilkinson prepared this discharge summary but has no independent recollection of Mr Morgan.[86]

Transfer back to Long Bay Hospital (20 December 2019 – 5 January 2020)

47. When Mr Morgan was transferred back to Long Bay Hospital on 20 December 2019, a medical officer made a "General Note" that Mr Morgan "initially refused treatment, now on Sorafenib" and that referrals "to cancer care nurse and palliative care team (TBA)".[87] For a number of days thereafter, the "SOAP" notes completed by nurses at Long Bay Hospital record Mr Morgan's care as continuing in accordance with this plan for palliation and comfort care.[88]

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[86] Statement of Dr Adam Wilkinson dated 29 September 2022: Exhibit 1 Vol 2, Tab 31, pp 1 [4], 4 [28], 5 [34].
[87] Exhibit 1 Vol 4, Tab 40, p 634.
[88] For example, Exhibit 1 Vol 4, Tab 40, p 636.

48. On 29 December 2019, a registered nurse recorded that Mr Morgan was "requesting to come off NFR order". This was said to be "handed over for MO review tomorrow 30/13 due to no NFR status within notes".[89] As outlined above, Mr Morgan completed a ACD on 8 August 2019. A Resuscitation Plan had also been discussed at POWH on 12 December 2019. The "SOAP" note for 29 December 2019 suggests the registered nurse did not have access to these documents. Additionally, it is noted that the Justice Health policy for "End of Life Care, Resuscitation Plans and Advance Care Directives" stated that:[90]

> "Resuscitation Plans must be reviewed, updated and re-signed on transfer to another centre or after a three month period from the date of the last update by the MO [i.e. medical officer]."

49. On 30 December 2019, Dr Spasojevic saw Mr Morgan and recorded the following "General Note":[91]

> "... wants to revoke no CPR order
>
> understand his poor prognosis, told by POWH life expectancy 6 months to 2 years
>
> ...
>
> Plan:
>
> -for full resuscitation until Palliative review
>
> -cont current management
>
> -palliative follow up TBA
>
> -gastro follow up"

50. Of this consultation, Dr Spasojevic recalls:[92]

> "[Mr Morgan] indicated that he wanted to revoke the previous 'not for resuscitation order'. He indicated to me that he had been advised by the Prince of Wales Hospital team that he had a life expectancy of 6 months to 2 years.
>
> I recorded a plan that included that Mr Morgan was for full resuscitation until he had undergone palliative review. It was my usual practice when a patient requests a change to a previously expressed Advance Care Directive / Resuscitation Plan to

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[89] Exhibit 1 Vol 4, Tab 40, pp 673-674.
[90] Exhibit 1 Vol 5, Tab 46, p 5 [3.3.3].
[91] Exhibit 1 Vol 4, Tab 40, p 677.
[92] Statement of Dr Mica Spasojevic dated 25 August 2022: Exhibit 1 Vol 3, Tab 35, p 4 [24]-[25].

note this in the clinical records and also to complete and update a Resuscitation Plan."

51. A new ACD and/or Resuscitation Plan is not contained in the medical records for Mr Morgan.

52. Dr Spasojevic gave evidence that it is her usual practise to complete a Resuscitation Plan at the time of documenting a patient's wishes. She does not now have an actual recollection of undertaking that process. She has given evidence that she expects she would have completed a Resuscitation Plan for Mr Morgan after the 30th of December 2019 discussion but that she is not sure whether the plan has now been misplaced. It is submitted by JHFMHN that this is a possibility.

53. On 31 December 2019, a registered nurse recorded in the "plan" field of a "SOAP" note to "[a]wait Pall care review in light of patients request to revoke his NFR status".[93] On 2 January 2020, a registered nurse noted that Mr Morgan's skin was "yellowing" and recorded a plan for the medical officer to review Mr Morgan.[94] On 3 January 2020, a registered nurse recorded in the "plan" field: "MO please advise regarding NFR ... and ACD".[95] On 4 January 2020, which was a Saturday, a registered nurse requested that Mr Morgan be reviewed by a medical officer on "Monday".[96]

54. Under the "End of Life Care, Resuscitation Plans and Advance Care Directives" policy, staff at the Long Bay Hospital bore responsibilities in connection with Mr Morgan's advance care planning, as reflected in an ACD or Resuscitation Plan. The policy stated:[97]

> "All healthcare staff with a direct caring role for patients, health records staff and patient related administrative staff should:
>
> - Understand what ACP [i.e. advance care planning] is
> - Be able to explain ACP to patients in general terms
> - Be able to locate and provide information about ACP to patients
> - Be able to recognise and manage ACP forms within the health record system

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[93] Exhibit 1 Vol 4, Tab 40 pp 683-684.
[94] Exhibit 1 Vol 4, Tab 40, pp 689, 691.
[95] Exhibit 1 Vol 4, Tab 40, p 693.
[96] Exhibit 1 Vol 4, Tab 40, p 702.
[97] Exhibit 1 Vol 5, Tab 46, pp 2-3 [2.1].

Staff with a clinical role, such as Medical Officers (MO), nurses, social workers and allied health staff should comply with the above in addition to the following:

- Initiate and facilitate discussions with the patient and/or their 'person responsible'
- Fully document outcomes of ACP discussions in the health record, this includes the use of forms JUS060.091 Advance Care Directive: Patient, ... and SMR020.056 Resuscitation Plan – Adult
- Take responsibility for knowing if a patient has an ACD or Resuscitation Plan
- Make reference to ACDs or Resuscitation Plans during clinical handovers to the multidisciplinary team
- Ensure reference to ACDs or Resuscitation Plans are made in all transfer and/or discharge documentation
- Ensure the Resuscitation Plans are completed by the treating, or delegated, MO responsible for the patient; and reviewed, updated and resigned on transfer to another centre or after a three month period from the date of the last medical update
- Enter PAS alert "Advance Care Directive" for every patient with an ACD or Resuscitation Plan
- Ensure the appropriate Clinical Director is aware of any patient with [an] ACD or Resuscitation Plan."

These responsibilities are facilitative of the patient's right to cancel or amend any ACD or Resuscitation Plan at any time.[98]

Events of 5 January 2020

55. At 5:45am on 5 January 2020, Mr Morgan was found on the floor. He was "very weak" and "breathless". An ambulance was called for "urgent transfer".[99] Ambulance officers recorded that Mr Morgan appeared to be severely distressed and he was speaking with words only.[100]

56. The "Emergency Response Form" which was sent with Mr Morgan from Long Bay Hospital to POWH did not record information about Mr Morgan's advance care planning; in particular, it did not record that Mr Morgan wished to be resuscitated.[101] There is no obvious field for information about a patient's advance care planning on that form. Yet, as

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[98] Exhibit 1 Vol 5, Tab 46, pp 3 [3.2], 4 [3.3].
[99] "SOAP": Exhibit 1 Vol 4, Tab 40, p 705; "Emergency Response Form": Exhibit 1 Vol 4, Tab 40, pp 377-378.
[100] Ambulance Electronic Medical Record: Exhibit 1 Vol 1, Tab 29, p 3.
[101] Exhibit 1 Vol 4, Tab 40, pp 377-378.

noted above, Justice Health policy seemed to contemplate that reference would be made to ACDs or Resuscitation Plans in transfer documentation.

57. On arrival at the Emergency Department at POWH, Mr Morgan was seen by Dr Katrina Clark, a registrar. She recalls that Mr Morgan appeared "critically unwell". He was, however, responsive, "speaking in words only" and "obeying simple commands".[102] Importantly, Dr Clark reviewed Mr Morgan's clinical file, but considered that his ceiling of care was unclear.[103] She initiated active treatment and proceeded to make enquiries of the Gastroenterology Team at POWH and of Long Bay Hospital.[104] In her statement, Dr Clark recalls that:[105]

> "I spoke to the gastroenterology Advanced Trainee Registrar (AT), Dr Akalya Mahendran, who had been involved in [Mr Morgan's] prior admission to POWH.
>
> Dr Mahendran noted she was surprised [Mr Morgan] had been transferred back to POWH, as [he] had been transferred from POWH to Long Bay Hospital to receive palliative care. Dr Mahendran advised me that [Mr Morgan] was for 'comfort care' only, that is, to make him comfortable, as opposed to administering active treatment. ...
>
> I then telephoned the Long Bay Hospital on the number listed on the Justice Health Emergency Response Form, dated 5 January 2020, and spoke to a Registered Nurse (RN) to see whether they would be able to accept transfer of [Mr Morgan] for palliative care and whether they were aware that [he] was not to be transferred to hospital for active treatment. I recall the RN I spoke with indicated there was no medical officer on site, and that they were not aware he was not for transfer or that [Mr Morgan] was for comfort care only."

58. Dr Clark also made a "Progress Note" which reflected the enquiries she made.[106] In particular, she recorded the following notations:

> "Unclear ceiling of care from documentation from LBJ
>
> ...
>
> D/W LBJ RN

[102] Statement of Dr Katrina Clark dated 6 October 2022: EXHIBIT 1 Vol 2, Tab 31A, p 3 [17].
[103] Statement of Dr Katrina Clark dated 6 October 2022: EXHIBIT 1 Vol 2, Tab 31A, p 4 [20]-[21].
[104] Statement of Dr Katrina Clark dated 6 October 2022: EXHIBIT 1 Vol 2, Tab 31A, p 5 [22].
[105] Statement of Dr Katrina Clark dated 6 October 2022: EXHIBIT 1 Vol 2, Tab 31A, p 5 [23], [24], [26].
[106] Exhibit 1 Vol 2, Tab 34 p 97.

-was unaware of his ceiling of care and plan for comfort care ..."

59. Dr Clark observed that Mr Morgan was not tolerating the "BiPap machine", being a treatment used to remove fluid from the lungs. Dr Clark recalls discussing the removal of the machine with Mr Morgan and explaining that medication could be given to make him more comfortable. Around this time, shortly after 8am, Dr Clark handed-over to Dr Laura Brown and another Registrar.[107] Dr Clark informed them that Mr Morgan had not tolerated the BiPap machine and that "he was known to the gastroenterology team, who had advised that he was for comfort care only".[108] Dr Brown recalls the conversation similarly.[109] Registered Nurse Eloise Berry also obtained information about the level of care to be provided to Mr Morgan from Dr Clark.[110] At around 8:30am, RN Berry made a "Progress Note" which stated:[111]

> "Decision made at 0805 by EDSS in conjunction with known Pall Care and other teams that patient is to be made comfortable during this time."

60. Dr Brown recalls that Mr Morgan indicated that he wanted the ventilator and oxygen mask to be removed.[112] To similar effect, RN Berry recalls that Mr Morgan asked that the ventilator and mask be removed and indicated that he did not wish for nasal prongs to be applied. In her statement, RN Berry explains that she would have asked Mr Morgan "a number of questions to confirm his wishes" and that he "indicated that he wanted to be made comfortable".[113] She also recalls that Mr Morgan would occasionally give a "thumbs up" and "nod when [she] asked him if he was feeling more comfortable".[114]

61. Dr Brown charted certain palliative medications, with input from the palliative care team. At around 9am, Dr Brown made a "Progress Note", recording:[115]

> "-end stage metastatic HCC, has declined treatment
>
> -known to pall care

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[107] Statement of Dr Laura Brown dated 16 September 2022: Exhibit 1 Vol 2, Tab 32, p 2 [10].
[108] Statement of Dr Katrina Clark dated 6 October 2022: Exhibit 1 Vol 2, Tab 31A, p 6 [28]-[30].
[109] Statement of Dr Laura Brown dated 16 September 2022: Exhibit 1 Vol 2, Tab 32, p 2 [12], [15].
[110] Statement of Eloise Berry dated 2 October 2022: Exhibit 1 Vol 2, Tab 33, p 2 [11].
[111] Exhibit 1 Vol 2, Tab 34, p 104.
[112] Statement of Dr Laura Brown dated 16 September 2022: Exhibit 1 Vol 2, Tab 32, p 2 [14].
[113] Statement of Eloise Berry dated 2 October 2022: Exhibit 1 Vol 2, Tab 33, p 2 [12].
[114] Statement of Eloise Berry dated 2 October 2022: Exhibit 1 Vol 2, Tab 33, p 3 [18]. See also "Progress Note": Exhibit 1 Vol 2, Tab 34, p 100.
[115] Exhibit 1 Vol 2, Tab 34, p 101.

-for comfort measures

...

-asking to be made comfortable"

62. Mr Morgan became unresponsive shortly after being seen by a priest, whose visit Mr Morgan had requested.[116]

63. In her statement, Dr Brown records that:[117]

> "In light of Mr Morgan's critical presentation, the fact that the Gastroenterology Team had indicated that he was for comfort care and that Mr Morgan had expressed that he wished to be made comfortable, a determination was made to move Mr Morgan toward palliation."

64. To similar effect, the "Report of Death" completed by Dr Brown on 5 January 2020 recorded that Mr Morgan was treated for "comfort care" and managed "with [a] palliative approach as per patient wishes".[118] The "Discharge Referral" which was also completed by Dr Brown stated that Mr Morgan was "treated with comfort measures" "[i]n accordance with his previous advance care discussions and his expressed wishes".[119]

ISSUES

Adequacy and appropriateness of treatment between September 2017 and mid-2019

65. Mr Morgan's liver cirrhosis was appropriately identified and recorded as a health condition at the time of his entry into custody in September 2017.

66. By mid-November 2017, the results of an ultrasound conducted on 4 May 2017 (which showed a lesion and possible nodule in Mr Morgan's liver) had been obtained and the need for Mr Morgan to have regular monitoring, in the form of six-monthly abdominal ultrasounds, had been identified and recorded in Mr Morgan's clinical notes.

67. Mr Morgan was not referred for an abdominal ultrasound until Dr Mayer completed a referral on 27 June 2018. That ultrasound was conducted on 20 July 2018. It showed additional lesions with suspicion of multiple nodules.

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[116] Statement of Eloise Berry dated 2 October 2022: Exhibit 1 1 Vol 2, Tab 33, p 3 [18]-[19].
[117] Statement of Dr Laura Brown dated 16 September 2022: Exhibit 1 Vol 2, Tab 32, p 2 [16].
[118] Report of Death of a Patient to the Coroner (Form A): Exhibit 1 Vol 1, Tab 2, p 1.
[119] Exhibit 1 Vol 2, Tab 34, p 92.

73. Mr Shaun Connolly, the Network Nurse Manager Operations, Access and Demand Management, gave evidence during the inquest. He gave evidence that there is now a newer network policy, 1.175 Management of Advanced Liver Disease and Hepatocellular Carcinoma [123] which outlines a process where patients that have liver disease can access the most appropriate clinician at the earliest possible time. He said that since Mr Morgan's death a referral in his case would now be made to a specific clinician rather than to a clinic. Mr Connelly is of the opinion that this would have made a difference in Mr Morgan's case and that there will no longer be the risk of a near 12-month delay in treatment as occurred from 2018 to 2019.

74. Mr Connolly explained that there should have been a General Practitioner waitlist entry made for Mr Morgan to be reviewed by a General Practitioner after the July 2018 ultrasound results were available. Mr Connolly accepted that this was an absolute missed opportunity by Justice Health. Mr Connelly stated that now, when results are received, a waitlist entry is made for the patient to be seen. He explained that a general practitioner now creates, on the electronic Patient Administration System, referrals and waitlist entries, even if the patient is no longer housed at the correctional centre at which the General Practitioner works.

75. He also explained that there are escalation pathways available for nursing staff to utilise if a patient is refusing treatment, including group email addresses that go to a number of different staff within Justice Health. He indicated that over the last few years there has been a much more consistent response around escalation procedures for patients refusing care. I do not propose to make any recommendations in relation to this issue

Sufficiency of steps in December 2019 to act upon requests to receive treatment and change advance care planning

76. While Mr Morgan had previously declined treatment for his liver cancer, Mr Morgan expressed a wish to receive treatment on 6 December 2019. That wish was recorded in Mr Morgan's clinical notes at Long Bay Hospital and in the documents sent to Prince of Wales Hospital (**POWH**) when Mr Morgan was transferred there on 12 December 2019.

77. While at POWH, Mr Morgan commenced certain treatment for his liver cancer.

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[123] Exhibit 1, Tab 47.

78. On 29 December 2019 (after he had been discharged back to Long Bay Hospital), Mr Morgan requested to revoke a previous decision that he not be resuscitated. The nurse receiving that request:

   a. appears not to have had access to Mr Morgan's advance care directive completed on 8 August 2019;
   b. appears not to have had access to Mr Morgan's resuscitation plan discussed at POWH on 12 December 2019; and
   c. could not locate a resuscitation plan that had been completed at Long Bay Correctional Centre within the last three months, as contemplated by [3.3] of Justice Health's 'End of Life Care, Resuscitation Plans and Advance Care Directives Policy'.[124]

79. On 30 December 2019, the same request (to revoke a previous decision not to be resuscitated) was made of Dr Spasojevic, who noted a plan in Mr Morgan's clinical notes that he be "for full resuscitation until Palliative review".

80. There was a failure to properly file, facilitate and fully document the advance care planning discussions Mr Morgan sought to have with staff at Long Bay Hospital between 29 December 2019 and 5 January 2020.

81. No documentation of Mr Morgan's advance care planning was provided by Long Bay Hospital to POWH. It was a requirement of Justice Health's 'End of Life Care, Resuscitation Plans and Advance Care Directives Policy' that reference be made to any advance care directive or resuscitation plan in clinical handovers and/or transfer documentation. The omission of that information in the material conveyed to POWH on 5 January 2020 should, however, be understood in the context of the urgency of the transfer to POWH.

82. Upon enquiry by Dr Katrina Clark from POWH, a registered nurse at Long Bay Hospital was unable to indicate or confirm Mr Morgan's "ceiling of care". All staff with a clinical role were required by Justice Health's 'End of Life Care, Resuscitation Plans and Advance Care Directives Policy' to "[t]ake responsibility for knowing if a patient" has an advance care directive or resuscitation plan.

83. More could have been done by the staff at Long Bay Hospital to facilitate Mr Morgan's advance care planning and to fully document his wishes. While Dr Spasojevic made a note

[124] Exhibit 1 Vol 5, Tab 46, pp 4-5 [3.3].

that Mr Morgan would be for full resuscitation pending review, an ACD or Resuscitation Plan is not in the records. Dr Spasojevic's note appears to have been insufficient to make clear to the nurse on staff on 5 January 2020 what Mr Morgan's wishes were.

84. While any inadequacy in the handover from Long Bay Hospital to POWH on 5 January 2020, in terms of information about Mr Morgan's advance care planning, did not ultimately impact the course of Mr Morgan's treatment, it could have.

85. Mr Connolly stated that in relation to transferring of patient inmates that it would be appropriate for paperwork dealing with transfers to include specific questions about Advance Care Directives and Resuscitation Plans. I propose to make a recommendation in that regard.

86. He gave evidence that a transfer is now done on an electric form when a patient is being sent to an external hospital. He says that it provides information as to the reason for admission together with general patient information. He said that it provides a clinician handover of the patient. He said that since 2019 there has been considerable work done in relation to the functionality of the Long Bay Hospital Medical Sub Acute Unit. He gave evidence that there is a new Nurse Unit Manager that drives a comprehensive clinical review process. He says that safety huddles in clinical handover processes have improved. He stated that the Resuscitation Plans and Advance Care Directives remain hard copy forms but that they are also now scanned into the electronic health system.

87. I note that many relevant processes, policies and technology have changed since Mr Morgan's death.

88. I now make the following findings and recommendation.

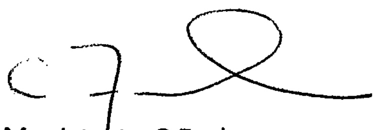
Findings:

I find that Mr Mervyn Douglas MORGAN died on 5 January 2020 at the Prince of Wales Hospital, NSW from complications of viral liver cirrhosis. He died as a result of natural causes while in the lawful custody of Corrective Services NSW.

Recommendations:

To the Chief Executive Officer, Justice Health and Forensic Mental Health Network:

1. I recommend that Justice Health amend the standard paperwork utilised when transferring patients to incorporate a specific check for indicating whether a patient has an advance care directive or resuscitation plan in place.



Magistrate C Forbes

Deputy State Coroner

November 2022

Coroners Court of New South Wales