



**CORONER'S COURT  
OF NEW SOUTH WALES**

**Inquest:** Inquest into the death of Adam Fitzpatrick

**Hearing dates:** 29 May 2023 to 31 May 2023; 1 to 2 June 2023; 5 to 9 June 2023

**Date of Findings:** 31 October 2023

**Place of Findings:** Coroner's Court of New South Wales, Lidcombe

**Findings of:** Magistrate Derek Lee, Deputy State Coroner

**Catchwords:** CORONIAL LAW – cause and manner of death, tracheostomy management, tracheostomy tube dislodgment, complex airway, bronchoscopy, monitoring of patient, rocuronium administration, blind instrumentation, resuscitation of patient, decompressive finger thoracostomy, tension pneumothorax, laryngeal mask airway, communication between hospital and family, open disclosure, access to patient records

**File number:** 2020/00249631

**Representation:**

Mr P Rooney, Counsel Assisting, instructed by Ms C Potocki (Crown Solicitor's Office)

Ms J Needham SC for the Fitzpatrick family

Ms A Horvath SC for South Eastern Sydney Local Health District, instructed by Makinson D'Apice

Dr P Dwyer SC for Dr A Dixit & Dr A Sharma, instructed by Unsworth Legal

Mr P Aitken for Dr A Jones, instructed by HWL Ebsworth

Ms B Epstein for Dr A van der Walt, instructed by Meridian Lawyers

Mr M Hutchings for Dr H Doshi, instructed by Avant Mutual

Ms K Kumar for Registered Nurse G Chan, instructed by Hicksons Lawyers

Ms T Berberian for Dr P Jain, instructed by HWL Ebsworth

Mr B Wilson for Dr P Clare, instructed by Meridian Lawyers

**Findings:**

Adam Fitzpatrick died on 25 August 2020 at St George Hospital, Kogarah NSW 2217.

The cause of Adam's death was hypoxic ischaemic encephalopathy secondary to displacement of tracheostomy and prolonged cardiac arrest from bilateral tension pneumothorax.

Adam died in circumstances where dislodgement of his tracheostomy was recognised or suspected by clinicians involved in his care. However, timely and definitive management of the clinical situation was not instituted to remove and replace the tracheostomy tube. This had the consequent effect of delaying effective management of Adam's airway and resuscitation efforts.

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## 1. Introduction

- 1.1 In the early hours of the morning on 8 August 2020, Adam Fitzpatrick, a 20-year old young man, was involved in a single motor vehicle collision in Hay, NSW. He suffered a number of facial and skull fractures and was initially treated at Hay Hospital before being transferred to St George Hospital in Sydney.
- 1.2 Over the next 13 days, Adam underwent surgery and various investigations and procedures were performed to treat his injuries. Significantly, a tracheostomy tube was inserted on 9 August 2020 to help Adam to breathe. Medical staff caring for Adam put in place plans to help manage Adam's tracheostomy and his airway.
- 1.3 On the morning of 22 August 2020, Adam was heard to be making gurgling noises and unusual noises were coming from his tracheotomy tube. By the afternoon, nursing and medical staff recognised that Adam was having difficulty breathing. Steps were taken to investigate the cause of these difficulties but Adam later went into cardiac arrest. Despite resuscitation efforts, Adam could not be revived and was later found to have suffered irreversible brain injuries that were not compatible with life. Adam was tragically pronounced deceased on the afternoon of 25 August 2020, just five days before his 21st birthday.

## 2. Why was an inquest held?

- 2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.
- 2.2 Adam's death was considered reportable because both the cause and manner of his death were not immediately clear. This is because the period of time between Adam's motor vehicle and his death, and in particular the events of 22 August 2020 raised questions about several aspects of the care and treatment provided to Adam. In addition, Adam's family also raised concerns about what they were told in the hours, days and months following Adam's death by those caring for and treating Adam, and by St George Hospital. For these reasons, it was determined that an inquest should be held. Accordingly, the coronial investigation gathered evidence from a number of health practitioners, St George Hospital and the South Eastern Sydney Local Health District (**SESLHD**), within which St George Hospital is located.
- 2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a

death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

- 2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated. Regrettably in Adam's case, this process has been particularly prolonged due in part to the impact of the COVID-19 pandemic.

### **3. Adam's life**

- 3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.
- 3.2 Adam was born on 30 August 1999 at Calvary Hospital, Wagga Wagga to Peter and Philippa Fitzpatrick. Adam was the youngest of three siblings with two sisters, Emma and Amanda.
- 3.3 As a boy, Adam attended preschool and primary school in Harden. He was a bright student, involved in the local community and took part in many sports including cricket, rugby league, soccer, swimming, basketball and archery, for which he won a silver medal at the NSW State Championships.
- 3.4 Adam later attended high school as a boarder at St Gregory's Catholic College in Campbelltown. He played rugby union for the college, was a member of the Agricultural Show Team and represented the Southern District in wool classing at the Royal Easter Show, and was well liked and respected by his peers.
- 3.5 Adam was very motivated and driven from a young age. After leaving high school Adam joined the local branch of the Rural Fire Service and found a position with a local farming contractor. Adam followed his passion for agriculture and was accepted into the University of New England at Armidale, later moving to St Alberts College.
- 3.6 Adam was very diligent and had a strong work ethic. He completed extra study units each semester for his degree in Agricultural Production and Management, which allowed him to almost complete his degree by the end of his second year. During university holidays Adam worked full-time to pay for his tuition and college fees as paying his own way was extremely important to him.
- 3.7 With his love of agriculture, Adam worked on the family property with his dad. Although the two men had different approaches to their work, with Adam's approach being less conventional, he was a hard worker and took great pride in his work.
- 3.8 By mid-2019, Adam had secured a position as a Biosecurity Support Officer with the Local Land Services in Armidale even though he had not yet graduated. In January 2020, Adam moved to Hay after being offered a position as a Biosecurity Support Officer with the Local Land Services in that area.
- 3.9 Outside of work, Adam was an avid reader of fiction and non-fiction alike and quickly absorbed knowledge on a wide range of topics. He enjoyed readily offering his opinion on many subjects but perhaps took the greatest enjoyment in what Amanda describes as stirring the pot and engaging in long political debates with Emma. Ever the larrikin, it seemed that Adam enjoyed seeing what reactions he could get out of Emma rather than being particularly invested in the debates themselves.

- 3.10 Adam's family describe him as a wanderer and a free spirit, the life of a party, extremely loyal, reliable, and an old soul at heart who moved through life at his own pace and in his own unique way. Adam lived by the motto, "*She'll be right, mate*". Nothing was ever a drama for Adam, he was never in a hurry and he always had time for a beer, a good story and time to drop in to see a mate or two on his way somewhere. He loved a good bargain, was a man of the people, and had a knack for drawing people around him.
- 3.11 It is truly heartbreaking to know that Adam died five days short of his 21<sup>st</sup> birthday, at a time when he had found his place in the world, the job of his dreams, the love of his life, and the town he wanted to call home. Ever since he has a child, Adam's family and friends meant the world to him. That love, admiration, trust and loyalty was no doubt reciprocated and makes the depth and enormity of Adam's loss even more painful to bear.
- 3.12 One lasting memory that Amanda has of her brother, amongst the many that Adam has left behind, is that of Adam driving down the road, with his windows down singing his heart out to his favourite country tunes and heading wherever the road took him next. Regardless of Adam's journey and destination, his family and friends will always be with him, and he with them.

#### **4. Summary of factual background**

4.1 Set out below is a factual summary of the events leading up to, and after, 22 August 2020, and the events on that day itself. It is not intended to be an exhaustive account of every aspect of Adam's care and treatment. Rather, it is intended to provide some background and context to the issues which the inquest considered and which are discussed in these findings.

##### ***Initial events***

4.2 On the evening of 7 August 2020, Adam attended the South Hay Hotel with a number of friends. He was last seen by his friends sometime between around 12:30am and 1:00am on 8 August 2020 when he said that he was returning home.

4.3 At around 2:00am on 8 August 2020, Adam was driving his vehicle when it became involved in single vehicle collision on Murray Street, Hay. He was later found at around 9:15am by local residents who contacted emergency services. Adam was subsequently extricated from his vehicle and found to have sustained a number of injuries including skull and facial fractures. Adam was still conscious and communicating at this time.

4.4 Adam was conveyed by NSW Ambulance (**NSWA**) to Hay Hospital where he arrived at around 10:26am. He was intubated at 1:21pm and given various medications. Following assessment and investigations, treating clinicians considered that Adam's injuries were not life-threatening but that he should be transferred to St George Hospital in Sydney for further investigations and treatment. During the transfer via NSWA helicopter, Adam was placed into an induced coma and an endotracheal tube was inserted. Adam departed Hay Hospital at 4:20pm and arrived at St George Hospital at around 6:21pm.

##### ***Transfer to St George Hospital***

4.5 On arrival, Adam was admitted to the Emergency Department (**ED**) where initial treatment was provided to repair lacerations on his face and left knee. At 1:06am on 9 August 2020, Adam was transferred to the Intensive Care Unit (**ICU**). At around 2:30am, Adam underwent emergency surgery for bifrontal craniotomy, debridement of anterior fossa floor, cranialisation of frontal sinus and pericranial graft placement.

4.6 At 10:04am, Adam was reviewed by Dr Arthur Jones, Ear Nose and Throat (**ENT**) Registrar, who recorded that Adam required (together with other treatment) a tracheostomy. A computed tomography (**CT**) angiography conducted later that day noted complex facial, left mandibular and skull base fractures.

4.7 On 10 August 2020, a surgical tracheostomy was performed which resulted in the insertion of a tracheostomy tube into Adam's neck to help him to breathe. Due to Adam's jaw and facial fractures, it was not possible to insert a breathing tube through his mouth or nose. Following surgery, Adam remained on a ventilator.

- 4.8 On 13 August 2020, Registered Nurse (**RN**) Eliza Dolatowski recorded in the progress notes that there were plans present in Adam's room to manage his tracheostomy and difficult airway. On 14 August 2020, a lumbar drain procedure was performed.
- 4.9 During the course of his admission, Adam was frequently visited by members of his family. From these visits, Adam's mother formed the view that Adam was not being sufficiently monitored due to staff being absent from Adam's room for periods of time, and staff needing to be alerted to Adams needs. Mrs Fitzpatrick recalls an occasion on 15 August 2020 when Adam woke and became agitated and no nursing staff member was in Adam's room at the time. Mrs Fitzpatrick was required to reconnect the tube connecting Adam's tracheostomy to a ventilator. A subsequent progress note entry made by RN Flora Cevalante at 7:08pm on 15 August 2020 noted that Adam had become agitated and almost self-extubated whilst RN Cevalante was away, was given a bolus dose of midazolam to calm him, and that he was kept comfortable.
- 4.10 Adam's progress notes record other instances when he was noted to become restless or agitated whilst in the ICU, including occasions when he was "*coughing and fighting ventilator*" and also producing sputum.
- 4.11 On 21 August 2020, Adam underwent further surgery for facial reconstruction. The Plastic and Reconstructive surgery team noted that whilst Adam's jaw was stiff and swollen, it was not wired shut. Further, according to Adam's mother, she was informed that the surgery had gone much better than anticipated. It appears that medical staff agreed that Adam would be weaned off the sedation that he had been provided with earlier during his treatment.
- 4.12 Following surgery, Adam was reviewed by Dr Ashima Sharma, and ICU staff specialist, and Dr Ajey Dixit, an ICU senior registrar, together with other members of Adam's treating team. The plan located in Adam's room for management of his airway and tracheostomy was updated. At 7:02pm on 21 August 2020, RN Peush Diwakaer noted that there was an emergency tracheostomy equipment at Adam's bedside.

#### ***The events of 22 August 2020***

- 4.13 During the morning ward round, Adam was reviewed by Dr Sharma and Dr Phoebe Clare, ICU Senior Resident Medical Officer. Adam's presentation was considered to be unremarkable and it was noted that he was stable, and not restless or agitated. The medical team made plans to reduce the extent of Adam's sedation.
- 4.14 However, Mrs Fitzpatrick visited and sat with Adam that morning. She noted that Adam would occasionally wake up and thrash around before falling back under sedation. Mrs Fitzpatrick also noted that Adam was gurgling throughout the morning and that strange noises were coming from his tracheostomy tube. Further, it appeared to Mrs Fitzpatrick that the tracheostomy tube had moved.
- 4.15 Mrs Fitzpatrick notified ICU RN Gary Chan, who was the nurse assigned to care for Adam that day. RN Chan observed that Adam was coughing intermittently at times and struggling with oral secretions. RN Chan suctioned the tracheostomy tube a number of times throughout the day.

- 4.16 In the early afternoon, Joseph Rianto, a physiotherapist, arrived and Mrs Fitzpatrick left to go to lunch. Mr Rianto noted that Adam's cough was productive of a large amount of yellow, thick secretions, and that he was coughing through his stoma at times.
- 4.17 At around 3:21pm, it was noted that Adam was having breathing difficulties and struggling with oral secretions. RN Chan attempted to suction the secretions but noted that they were pooling in Adam's mouth. He called for assistance from Dr Clare who attended Adam's room. The alarm on Adam's ventilator began sounding and Dr Clare activated the emergency alarm.
- 4.18 In response, a number of medical staff attended Adam's room, including Dr Dixit; Dr Paras Jain, ICU staff specialist; Dr Hemang Doshi, ICU Provisional Fellow; and Dr Alfred van der Walt, ICU Registrar. A number of interventions were attempted including the passing of a suction catheter. This was followed by a bronchoscopy, the insertion of a bronchoscope in Adam's tracheostomy tube to visualise his airway. During this procedure Adam's oxygen saturations began to fall and the bronchoscope was removed. A number of unsuccessful attempts were made to pass a bougie through the tracheostomy tube.
- 4.19 Adam subsequently went into cardiac arrest and resuscitation efforts were initiated including commencing chest compressions at 3:38pm. Attempts were made to ventilate Adam using a facemask and self-inflating bag via tracheostomy. However, a decision was subsequently made to cut the elastic bands in his mouth and attempt facemask ventilation orally.
- 4.20 Dr Jones was contacted and arrived a short time later. He noted that the tracheostomy tube had been dislodged and appeared to have entered the pre-tracheal space. Dr Jones removed and replaced the tracheostomy tube to secure Adam's airway but Adam remained in asystole.
- 4.21 Despite a return of spontaneous circulation, Adam's oxygen saturations did not improve. A needle thoracostomy was performed for a suspected pneumothorax. Following this, other investigations were performed in an attempt to identify a reversible cause of Adam's cardiac arrest. Adam was intubated and rocuronium, a muscle relaxant, was administered.
- 4.22 Dr Mary Langcake, Director of Trauma Services, arrived and performed bilateral finger thoracostomies. By this time Adam had been in cardiac arrest for approximately 46 minutes. Bilateral chest drains were inserted and
- 4.23 Return of spontaneous circulation was achieved and chest compressions were ceased at 4:21pm. Adam was intubated at 3:45pm and attempts were made to clear the blockage and secure the tracheostomy tube.
- 4.24 However, by this time Adam had been in cardiac arrest for approximately 46 minutes and his lungs had collapsed. Bilateral finger thoracotomies were performed and bilateral chest drains were inserted. After Adam was found to have a pulse, he was placed on a ventilator.

4.25 Adam was subsequently found to have sustained irreversible hypoxic brain injury. A cerebral perfusion scan was performed on 25 August 2020 which confirmed brain death and Adam was tragically pronounced deceased that afternoon.

## **5. The post-mortem examination**

5.1 Adam was later taken to the Department of Forensic Medicine where an external post-mortem examination was performed by Dr Kendall Bailey, forensic pathologist, on 28 August 2020. Dr Bailey noted Adam's history of surgery for head injuries which included skull and facial fractures. It was also noted that tracheostomy placement had occurred on 10 August 2020, and that there was reportedly tracheostomy dislodgement into the pre-tracheal space on 22 August 2020.

5.2 Having regard to the findings from the external examination only and toxicology results, together with the circumstances described in Adam's medical records, Dr Bailey opined that the cause of Adam's death was complications of multiple blunt force injuries, arising from the motor vehicle collision he was involved in on 8 August 2020.

5.3 It should be noted that at the time of the preparation of the autopsy report, Dr Bailey did not have available to her any of the witness statements and evidence, and the majority of the medical records, that were available to the inquest.

## 6. What issues did the inquest examine?

6.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

- (1) The statutory findings required by section 81 of the Act, including the cause and manner of Adam's death.
- (2) Whether Adam's sustained injuries, upon arrival at St George Hospital, were life-threatening and/or survivable.
- (3) Whether the care and treatment provided to Adam at St George Hospital was reasonable, appropriate, and adequate, including (but not limited to):
  - (a) the management of Adam's complex airway and airway risk assessment;
  - (b) whether nursing staff adequately monitored Adam;
  - (c) whether there was a failure by staff at St George Hospital to recognise that the tracheostomy tube that had been inserted had become dislodged;
  - (d) whether it is capable of being established when and how the tracheostomy tube that had been inserted became dislodged;
  - (e) whether it can be ascertained at what point in time there should have been suspicion (by either nursing staff, physiotherapy staff or medical staff) that the tracheostomy tube was dislodged;
  - (f) whether a bronchoscopy was appropriate in the circumstances;
  - (g) whether it can be ascertained that Adam was breathing adequately on his own up until the bronchoscopy;
  - (h) if sedation or a muscle relaxant was used and / or increased for the bronchoscopy, whether this was appropriate;
  - (i) whether it can be ascertained at what point Adam desaturated, and the relationship of that time to the various attempts to stabilize the airway;
  - (j) whether removal and replacement of the tracheostomy tube by the treating clinicians was contingent upon the arrival of the ENT Registrar, in circumstances where the Anaesthetics Registrar, ENT Registrar and Plastics Registrar had been contacted;
  - (k) whether it was appropriate and/or necessary that the ENT Registrar be contacted to come to St George Hospital to assist with the care and treatment of Adam;

- (l) whether the St George Hospital staff response to Adam’s cardiac arrest on 22 August 2020 was adequate;
  - (m) whether there was a delay by the St George Hospital staff in removing the tracheostomy tube and performing other resuscitative measures which contributed [to] Adam’s prolonged hypoxia and eventual cardiac arrest;
  - (n) whether there was a failure by nursing staff to adequately document and escalate parental concerns about positioning of the tracheostomy tube; and
  - (o) whether blind instrumentation (i.e. using a bougie or endotracheal tube) of the tracheostomy stoma was appropriate or worsened the airway obstruction.
- (4) Whether the procedures in place regarding Adam’s tracheostomy and airway management:
- (a) complied with applicable policies and guidelines; and
  - (b) were adequate to manage Adam’s condition.
- (5) Whether the resuscitation provided to Adam at St George Hospital was reasonable, appropriate, adequate, and timely including (but not limited to):
- (a) the choice of manual resuscitation device;
  - (b) the cause of any suspected tension pneumothorax;
  - (c) whether tension pneumothorax was suspected in a timely manner;
  - (d) the consequences (if any) of attempting decompression of pneumothoraces in relation to identifying a reversible cause of Adam’s cardiac arrest;
  - (e) whether decompressive finger thoracostomy was performed in a timely manner, and whether such timing materially affected the eventual clinical course; and
  - (f) whether decompressive finger thoracostomy was within the skill set and scope of practice of intensive care clinicians involved in Adam’s resuscitation.
- (6) Whether there was adequate communication and liaison between St George Hospital and Adam’s family?
- (7) Whether any recommendations are necessary or desirable in relation to any matter connected with Adam’s death.

6.2 For convenience, some of the issues are dealt with together and in chronological order below.

6.3 In order to assist with consideration of some of the above issues, opinions were sought from the following independent experts as part of the coronial investigation:

- (a) Professor Anne-Maree Kelly, Professor and Academic Head of Emergency Medicine and Senior Emergency Physician at Western Health in Footscray, Victoria;
- (b) Professor Carsten Palme, specialist in Otolaryngology, Head Neck Surgery and Head of Surgical Services and Director of Head Neck Surgery at the Chris O'Brien Lifehouse Cancer Centre;
- (c) Professor Ian Seppelt, Senior Staff Specialist, Department of Intensive Care Medicine, Nepean Hospital, and Anaesthetist and Director of Intensive Care, Nepean Private Hospital.

6.4 In addition, some of the sufficiently interested parties sought opinions from these additional independent experts:

- (a) Dr Keith Liyanagama, specialist anaesthetist, on behalf of Dr van der Walt; and
- (b) Clinical Nurse Consultant (**CNC**) Lachlan Tait, The Royal Melbourne Hospital, on behalf of RN Chan.

6.5 Each of the above experts provided one or more reports, which were included in the brief of evidence tendered at inquest. Each expert, with the exception of Dr Liyanagama also gave evidence during the inquest.

## 7. What was the cause of Adam's death?

- 7.1 Professor Kelly opined that the cause of Adam's death was hypoxic brain injury caused by cardiorespiratory arrest. Professor Kelly expressed some doubt that displacement of the tracheostomy tube alone resulted in the cardiac arrest as Adam had been breathing on his own through the tracheostomy tract and maintaining acceptable oxygen levels for at least some period of time. Professor Kelly therefore considered that sedating Adam for a bronchoscopy was "*the most likely contributor to the advent of hypoxaemia which led to cardiac arrest and fatal hypoxic brain injury*".
- 7.2 Professor Palme opined that the cause of Adam's death was irreversible brain injury due to hypoxic cardiac arrest caused by a dislodged tracheostomy tube.
- 7.3 Professor Seppelt opined that the immediate cause of Adam's death was hypoxic ischaemic encephalopathy secondary to prolonged hypoxic cardiac arrest, with the underlying cause of death being severe facial and skull base injuries with associated traumatic brain injury. Professor Seppelt expanded on this opinion by explaining that Adam's hypoxia was initially due to displacement of the tracheostomy and finally due to prolonged cardiac arrest from bilateral tension pneumothorax. Professor Seppelt ultimately concluded:

As one led in to the next it is impossible to say precisely which was most significant as a cause of [Adam's] hypoxic ischaemic encephalopathy.

- 7.4 **Conclusions:** The expert evidence establishes that the cause of Adam's death was hypoxic ischaemic encephalopathy secondary to displacement of his tracheostomy and prolonged cardiac arrest from bilateral tension pneumothorax.

**8. Were Adam’s sustained injuries, upon arrival at St George Hospital, life-threatening and/or survivable?**

8.1 Professor Kelly utilised the Trauma Injury Severity Score (**TRISS**), a method for estimating the probability of a patient’s survival following a traumatic injury. Having regard to Adam’s age and the nature of his severe head injury, serious facial injury and minor leg injury, together with his vital signs at presentation at Hay Hospital, Professor Kelly noted that a TRISS calculation estimated Adam’s probability of survival at 97%. Professor Kelly noted that if Adam’s head injury was to be graded as serious (and not severe) then his probability of survival would exceed 98%.

8.2 Professor Kelly expanded on this opinion during her evidence:

The life threat was in the early phases, where the damage to [Adam’s] face and airway, if no[t] correctly treated, could have been fatal. And so the treatment by the paramedics in Hay was good. And so once that part is over, then it’s – then the – it’s the – the manage – the further management thereafter, and that’s where the survivability comes in.

8.3 Professor Palme noted that Adam’s injuries predominantly involved the facial skeleton, skull base and associated soft tissues, with no evidence of any significant injury to his brain or other critical organs. As a result, Professor Palme opined that Adam’s injuries were potentially life-threatening but survivable.

8.4 Professor Seppelt similarly acknowledged that Adam’s injuries were life-threatening but opined that “*a severe facial and skull base injury in a healthy young man is usually survivable*”. Professor Seppelt went on to explain that the determining factor was the severity of Adam’s underlying brain injury but as this did not appear to be severe, there would have been hope for a “*good outcome*” following a prolonged period of treatment and rehabilitation.

8.5 **Conclusions:** The expert evidence establishes that the injuries that Adam sustained on 8 August 2020 were, at that time, life-threatening. However, having regard to Adam’s age, the severity of particular injuries, and the quality of the initial treatment provided to Adam and his management up to 22 August 2020, a conclusion can be reached that Adam’s injuries were survivable. Indeed, applying the TRISS method of estimating survivability produces a result that by 22 August 2020 Adam would have almost certainly survived his injuries.

9. Was the management of Adam's complex airway and airway risk assessment reasonable, appropriate and adequate?

9.1 Two documents are relevant to consideration of this issue:

(a) the Difficult Airway Management Plan (**Airway Plan**); and

**DIFFICULT AIRWAY MANAGEMENT**

BED 48

Airway Grade & Anatomy	POST FIXATION LE FORTE III FACE & NECK SWELLING C MO IFB
Current Airway	TRACHE 8.0

**AIRWAY PLAN**

CALL FOR HELP \*8009  
List Mobile numbers  
1W SR Anaesthetics + ENT

PLAN A Initial Strategy	REPLACE TRACHEOSTOMY UNDER BRONCH
PLAN B Alternative Strategy	RESCUE OXYGENATION BAG MASK
PLAN C Rescue Techniques	Anaesthetics   ENT prepare for FONA Cricothyrotomy

**ICU** INTENSIVE CARE UNIT - ST GEORGE HOSPITAL

(b) the Services Tracheostomy Emergency Management Plan (**Tracheostomy Plan**).

1120-87-25 St George Hospital  
**FITZPATRICK, Adam**  
 57 Widgeongully Road Jugiong 2726  
 DOB: 30-Aug-1999 20y Sex: M Ph: 0452692829 MC: 22690906724  
 AMO: Dr Peter Campbell! Fin: V4

NSW GOVERNMENT Health South Eastern Sydney Local Health District  
**Services Tracheostomy Emergency Management Plan.**

12/08/20

Does the patient have a patent upper airway?

**YES**

**NO**

**Airway information:**  
 1. Grade of Airway - On scene  
 2. Method of ventilation (circle) - BVM/LMA  
 3. Method of intubation - MAC 3  
 4. Equipment needed (circle) - MAC/C-MAC/FOB 4/D  
 5. Number of attempts -

**Tracheostomy information:**  
 DATE OF INSERTION: 10/08/20  
 1. Tracheostomy technique (circle): Surgical  
 2. Level of tracheostomy:  
 3. Size of tracheostomy: 8 PORTEX  
 4. Type of tracheostomy: PORTEX  
 5. Inner cannula (circle) in / out  
 6. Stay Sutures (circle): Yes / No  
 7. If Yes, direction of pull:

**Additional information / Plan:**  
BOUGIE through tracheostomy  
Railroad new trache over bougie

**CALL FOR HELP:**  
 \* Check ETCO<sub>2</sub>, trace  
 \* Can you pass suction catheter?

**CALL FOR URGENT HELP:** (ICU SS/ICU SR Anaesthetic Fellow pg. 999/ENT via switch)  
 \* CAN'T INTUBATE  
 \* CAN'T VENTILATE ORALLY OR NASALLY

1. \* Remove or replace inner cannula (if present) and consider replacing tracheostomy  
 2. \* Cricothyroidotomy  
 3. \* Consider Sub-stomal airway approach

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_ Page 16 of 17  
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- 9.2 Dr Sharma was a VMO staff specialist in intensive care at St George Hospital. She first saw Adam on 21 August 2020 and recognised that by virtue of his tracheostomy and facial injuries he had a difficult airway which required a management plan. Dr Sharma accepted that as the ICU consultant it was her ultimate responsibility to devise such a plan.
- 9.3 Sometime between around 5:00pm and 6:00pm on 21 August 2020, during the evening ward round, Dr Sharma assessed Adam for the first time with Dr Dixit. Dr Sharma gave evidence that during the assessment she instructed Dr Dixit to write, “*Replace tracheostomy under bronch*” on the Airway Plan in relation to Plan A - Initial Strategy. Dr Sharma gave evidence that Plan B (Alternative strategy) and Plan C (Rescue techniques) “*were already in place*” and that she made no changes to those sections of the Airway Plan.
- 9.4 However, Dr Sharma indicated that, on reflection, she should have looked at Plans A, B and C, and could have made changes to Plan C which referred to “FONA” (front of neck access) and a cricothyroidotomy. In particular, Dr Sharma gave evidence that:
- (a) as Adam already had a tracheostomy, front of neck access was not applicable, and neither was a cricothyroidotomy;
- (b) Plan C was “*not applicable in this setting*”; and

- (c) she ought to have looked at Plan C and thought about whether it needed to be on the Airway Plan, and made any necessary changes.
- 9.5 Dr Sharma gave evidence that there was a discussion amongst the team members, including Dr Dixit, about Adam's difficult airway. According to Dr Sharma, the team members had an opportunity raise any concerns with the management plan for Adam but no one did so. Despite this, Dr Sharma acknowledged in her evidence that she should have clarified with the team members whether they held any concerns with her plan for management of Adam's airway.
- 9.6 Dr Sharma gave evidence that that if an emergency scenario developed following her departure from the hospital at the end of her shift, it was her expectation that junior medical staff would immediately seek assistance from ENT and anaesthesia medical staff. Dr Sharma gave evidence that she also expected that Plan A would be followed, namely that the tracheostomy would be replaced under bronchoscope (as opposed to blind instrumentation), with the second option being use of a bougie if a team member was not comfortable with using a bronchoscope.
- 9.7 In addition, Dr Sharma gave evidence that:
- (a) whilst team members "*should definitely look at the plan*", they were under no obligation to strictly follow it;
  - (b) she always teaches junior medical staff to use their clinical judgement; and
  - (c) in a dynamic situation, the plan could be modified if required "*based on their skills, their level of seniority and [their] expertise*".
- 9.8 Dr Dixit gave evidence that:
- (a) it was his understanding that he was required to follow the Airway Plan; and
  - (b) if no such plan existed then he would have used his clinical judgement and deflated the tracheostomy cuff to remove it and replace it with another tracheostomy tube.
- 9.9 Dr Dixit acknowledged that as the most senior medical officer present in Adam's room shortly after the emergency alarm sounded, it was his decision to carry out a bronchoscopy. However, Dr Dixit gave evidence that, based on his training and experience, he was of the view that performing a bronchoscopy would not add "*much information other than in an emergency clinical situation*". Dr Dixit said that he would not necessarily agree that a bronchoscopy would be needed to replace a tracheostomy and that, on reflection, he would have liked to have had a further discussion with Dr Sharma regarding this aspect of the Airway Plan. To this extent, Dr Dixit also acknowledged the following:

I think it was my duty, when a plan was devised by the consultant the night [before], to confirm with the consultant what was it [sic] meant by replacing the tracheostomy [under] bronchoscopy.

9.10 In addition, Dr Dixit gave evidence that whilst as at 22 August 2020 he knew how to replace a tracheostomy, he had no experience of having ever replaced one under bronchoscopy and did not know how to do so.

9.11 Dr Doshi gave evidence that upon arriving in Adam's room he saw the Airway Plan but not the Tracheostomy Plan. He gave the following evidence regarding following the Airway Plan:

[...] there is a difficult airway management plan on the door which, again, [Dr Dixit] reminded me, which was - I assume was prepared by the consultant because that's how it is to be done at St George. So I thought that I'm obliged to follow that, however, if I were to choose, I probably wouldn't put in [sic] bronchoscopy straight away.

9.12 Dr Doshi gave evidence that in the absence of the Airway Plan he would have, in essence, followed the algorithm set out in the Tracheostomy Plan. Dr Doshi gave evidence that he disagreed with Plan A of the Airway Plan regarding use of bronchoscope because setting it up "*takes some time*" and it would have been challenging to negotiate it. Instead, Dr Doshi gave evidence that he would have deflated the cuff, removed the tracheostomy tube, and provided oxygenation whilst preparing to insert a new tracheostomy tube.

9.13 Dr Doshi acknowledged that he did not voice his concerns regarding Plan A for the following reasons:

(a) he was confronted with what he described as a "*crisis situation*";

(b) Dr Dixit was more senior and had been involved in Adam's care for the previous six days; and

(c) Dr Jain, who was a consultant and also more senior, indicated that he should "*carry on*" prior to inserting the bronchoscope in the trachea.

9.14 Ultimately, Dr Doshi gave evidence that the presence of both the Airway Plan and the Tracheostomy Plan and "*having two different plans is not an ideal thing*". Dr Doshi sought to explain this challenging circumstance in this way:

So if there is a senior colleague who knows the patient or consultant present in the room who is a supervisor, we are obliged to follow the instruction unless and until - it's clearly conflicting and clearly doesn't make sense, but there was, like, one can argue either way I would say in this case.

9.15 Dr Jain gave evidence that he also saw the Airway Plan, but not the Tracheostomy Plan, on 22 August 2020. He said that it was incumbent on medical staff arriving in response to the emergency situation to follow the Airway Plan and described this as unfortunate because, in his usual practice, he would not have performed a bronchoscopy to start with.

9.16 Notwithstanding the above, Dr Jain gave evidence that he felt obliged to follow the Airway Plan despite disagreeing with it because:

I met Adam less than a minute ago, just - it's difficult to then change, suddenly, the plan in that way.

9.17 During his evidence Professor Seppelt said he found Plan C “*rather odd*”. He went on to explain the following about Plan C:

It says, “Prepare for FONA”, that stands for front of neck access or cricothyrotomy. Adam already had a tracheostomy, that is front of neck access. Cricothyrotomy is an emergency procedure where access to the airway is through the cricothyroid membrane which is higher. So, it strikes me as pretty weird that you would want to go higher if you’ve already got a problem lower in the airway. So, whoever wrote the plan C, I’d suspect was doing it kind of as a reflex response, rather than a considered response.

9.18 Professor Seppelt gave evidence that in an emergency scenario, it was not incumbent upon medical staff to follow the Airway Plan. He explained:

You need to do the right thing for the patient at the time. The plan is just an opinion, whether it's a good or a bad plan. It's neither legislation nor even policy or protocol. It's just a plan. Patients haven't read the plan and things can evolve and be different at the time. So, your responsibility is to assess the situation and deal with the situation.

9.19 Professor Seppelt went on to offer the following opinion as to the obligation that the clinicians on 22 August 2020 felt with respect to following the Airway Plan:

I can see where that has come from. It comes down to the confidence and experience of the individuals. But ultimately there is still an obligation to take the situation as it is. It is always easier if you know the patient. If you are walking in on something new and you don't know the situation at all, then you have to very rapidly work out what the situation is. But a written plan like that might be a guide, but you ultimately have to do what you perceive to be best, based on your own training, experience and the situation in front of you.

9.20 Although Dr Dixit had the benefit of being present when Dr Sharma formulated the Airway Plan, and having seen Adam prior to 22 August 2020, Professor Seppelt maintained that the Airway Plan was still a guide and that Dr Dixit ought to have exercised clinical judgment to take any necessary steps in response to the emergency scenario, consistent with his training and competencies.

9.21 When asked to comment on Dr Dixit’s evidence that he did not know how to replace a tracheostomy under bronchoscopy, Professor Palme gave this evidence:

I’m actually unfamiliar with that technique.

[...]

I’m not exactly familiar with this, and whoever wrote [Part A of the Airway Plan], I’d be very interested to see them show me how to do it.

9.22 Dr Heidi Boss, Director of Medical Services at St George Hospital, gave the following evidence with respect to the exercise of clinical judgment and use of clinical skills even in the presence of a management plan formulated by a consultant:

I can tell you what they espouse now and what the ICU teach now, which is that the plan is a guide to guide conversation amongst the team that may involve changes to the plan but, ultimately, the plan is a guide, and at the point that there becomes an emergency, the clinical situation, the patient

clinical factors, and the skills and clinical judgement of the clinicians need to be what forms how they respond.

So do all the work before there's an emergency to make sure that they know what various algorithms might be for various emergency situations and how to respond, practise it in simulation situations, talk about it on a daily basis in the ward rounds within the team to understand who has the skills to do what so that, in the event of an emergency, they are a team that can respond without having to look at a plan on a wall.

9.23 Dr Boss gave further evidence that the approach taken above is the subject of training and education for clinicians, particularly with respect to how they approach patients and emergencies. In addition, Dr Boss gave evidence regarding education and training provided with respect to the particular challenges confronting the clinicians on 22 August 2020:

There have been a number of workshops and simulation sessions designed around tracheostomy emergencies and, again, they have a two-pronged approach. One is the technical skills around recognising and then being able to remove and reinsert a tracheostomy tube in an emergency situation, but it's done in conjunction with teaching and training, and practising the non-technical skills in that team emergency environment.

9.24 It was submitted on behalf of the Fitzpatrick family that:

- (a) the Airway Poster "*was grossly inadequate and Dr Sharma may be criticised for failing to provide an adequate plan to manager Adam's airway in the event of an emergency*";
- (b) "*as the most senior clinician involved, Dr Paras Jain in particular should be criticised*"; and
- (c) both Dr Sharma and Dr Jain should be referred to the Medical Council of New South Wales (**Medical Council**) or to the Australian Health Practitioner Regulation Agency (**AHPRA**).

9.25 The issue of whether any health practitioner involved in Adam's care should be referred to any organisation is dealt with in more detail later in these findings.

9.26 Senior counsel for Dr Sharma submitted that:

- (a) "*there is no suggestion that Dr Sharma is not competent to practise as an intensive care specialist*";
- (b) it was not suggested to Dr Sharma that "*there was a continued gap in her knowledge and training*"; and
- (c) "*members of the medical profession are human and even the best professionals are therefore subject to human error*".

9.27 Counsel for Dr Jain submitted that a distinction should be drawn between Dr Dixit, who was the "*only clinician with personal knowledge of Adam's condition*" and who had been "*involved in the preparation of the [Airway Plan] the night before*". It was further submitted that in circumstances where Dr Dixit, Dr Doshi and Dr Jain were "*working in a dynamic and chaotic emergency felt obliged*

to follow the [Airway Plan], the Court should be cautious in not being overly critical” of each clinician for following the Airway Plan.

- 9.28 According to Dr Sharma’s own evidence she recognised that there was a missed opportunity on 21 August 2020 to clarify with the clinicians caring for Adam that they understood the particulars of the Airway Plan. This recognition is particularly significant in circumstances where Dr Dixit had never before performed Part A of the Airway Plan, and Dr Sharma herself acknowledged that Plan C was not applicable and that she should have thought about whether it required amendment. Further, the evidence of Professor Palme and Dr Dixit suggests that Plan A was uncommon and therefore potentially unfamiliar to clinicians involved in Adam’s care.
- 9.29 Dr Boss’ evidence establishes that clinicians working in the ICU at St George Hospital are now taught that management plans for a patient are only guides and that clinicians must use their clinical skills and judgement when dealing with the patient in front of them, particularly in an emergency situation. However, Professor Seppelt’s evidence as to the obligation of clinicians to assess and deal with the clinical situation in front of them did not distinguish between what clinicians were taught prior to 22 August 2020 and what they are taught now.
- 9.30 Similarly, Professor Seppelt’s evidence did not distinguish between differences in seniority amongst clinicians. Instead, Professor Seppelt’s evidence was that regardless of the confidence and experience of an individual clinician, the same obligation to deal with the situation in front of them remained.
- 9.31 In this regard it is interesting to observe that whilst it was submitted on behalf of the Fitzpatrick family that Dr Jain “*in particular should be criticised*” by virtue of his seniority relative to Dr Dixit and Dr Doshi, no similar submission is made with respect to Dr Dixit. As counsel for Dr Jain correctly submitted, Dr Dixit was not only more familiar with Adam, but he also had an opportunity on 21 August 2020 to clarify Part A of the Airway Plan with Dr Sharma in circumstances where he knew he had never performed Part A before. As to the first of these matters, it is acknowledged that the only distinction which Professor Seppelt’s evidence sought to draw between a clinician familiar with a patient and a clinician “*walking in on something new*” is that the later would have to “*very rapidly work out what the situation is*”.

9.32 **Conclusions:** Whilst Dr Sharma had an expectation that clinical staff involved in Adam’s care should consider the Airway Plan in an emergency situation, she did not expect them to strictly adhere to it. Rather, Dr Sharma expected that, consistent with her training of junior medical staff, clinicians involved in Adam’s care should exercise their own clinical judgement and apply their own clinical skills to the situation in front of them. This evidence is entirely consistent with the evidence of Professor Seppelt and Dr Boss.

9.33 Notwithstanding the above, each of Dr Dixit, Dr Doshi and Dr Jain felt obliged to follow the Airway Plan in circumstances where there was disagreement with it, and an indication that the algorithm set out in the Tracheostomy Plan would have been followed in the absence of the Airway Plan. The existence of a management plan formulated by a consultant, their unfamiliarity with Adam, and differences in seniority amongst the medical staff themselves were all contributing factors to this mistaken belief.

9.34 Notwithstanding, the expert evidence establishes that clinicians are obliged to use their training and experience to treat the patient in front of them. In other words, regardless of the differences in seniority between them, Dr Dixit, Dr Doshi and Dr Jain ought to have used their clinical judgment, skills and experience rather than rigidly following the Airway Plan, despite feeling obliged to do so. The Airway Plan should only have been regarded as a guide, rather than mandating a particular clinical course of action. In this regard, the expert evidence establishes that each of Dr Dixit, Dr Doshi and Dr Jain had a misplaced obligation in following the Airway Plan instead of recognising their obligation to treat the patient in front of them.

9.35 The Airway Plan formulated by Dr Sharma was deficient for two reasons. First, Dr Sharma recognised that there was a missed opportunity on 21 August 2020 to clarify with the clinicians caring for Adam that they understood the Airway Plan and had no concerns with it. This was of critical significance given Dr Dixit's unfamiliarity with Part A of the Airway Plan and his evidence that in the absence of Part A he would have, consistent with the opinion expressed by Professor Seppelt, exercised his own clinical judgement and managed Adam's airway in a different manner. Second, Dr Sharma also recognised that she ought to have given consideration to the efficacy of Plan C of the Airway Plan having regard to Adam's particular clinical situation.

9.36 Since August 2020, education and training has been provided to clinical staff, particularly those that work in the ICU at St George Hospital, to reinforce a clinician's obligations to a patient regarding their management, as described by Professor Seppelt and Dr Boss. In addition, a greater degree of more specific education and training has been provided to ensure that clinical staff appropriately utilise both technical and non-technical skills in a team emergency environment.

**10. Was Adam adequately monitored by nursing staff? Was there a failure by nursing staff to adequately document and escalate parental concerns about positioning of the tracheostomy tube?**

10.1 In her statement of 25 November 2020, Mrs Fitzpatrick recorded some general observations of monitoring of Adam prior to 22 August 2020:

Adam was supposed to be on 1 to 1 supervision but this was not always the case as when the nurses took breaks there was only one nurse to 2 patients and if the other patient needed something or the nurse moved off, Adam was left unsupervised.

10.2 As to her observations on 22 August 2020, Mrs Fitzpatrick goes on to state that when she arrived at Ste George Hospital on that day she found Adam to be unattended, with one of the nurses indicating that the nurse assigned to Adam was on a break. Following this, Mrs Fitzpatrick goes on to state:

In the nearly 4 hours I sat with Adam on the morning of the 22/08/2020 Adam's nurse Gary Chan never once addressed or spoke to Adam, made no attempt to calm him, did not support the tube when Adam was moving and moved him quite roughly back into position when I pointed out that the tracheostomy tube was at a very strange angle. If Adam moved too much, he gave him a bolus of propofol to re-sedate him but gave him no reassurance. During the day Gary left the room frequently to get things, leaving me alone with Adam.

On several occasions, I supported Adam's head and tracheostomy tube while he moved around as the nurse ignored this. As the sedation was reduced Adam was beginning to breathe on his own and also began to cough. The nurse Gary suctioned Adam's mouth and through the tracheostomy tube with little effect.

[...]

I remained at the hospital while both Adam's nurse and the nurse for the adjoining room had their lunch breaks as I did not feel comfortable leaving him with reduced supervision.

10.3 In a progress note entry written retrospectively at 8:17pm on 22 August 2020, RN Chan relevantly recorded the following:

V/B mother this morn [sic] who appeared to be in distress about the pt's condition  
She raised concerns regarding the placement of Portex trache  
From my initial assessment, the stoma was clean with minimal ooze. No air leak was present  
I attempted to reassure the pt's mother and told her I would notify the team. I also suggested she raise her concerns with the medical team on the WR. She appeared agreeable at the suggestion

During the AM WR, Propofol was reduced from 20ml/hr to 15ml/hr as per ICU. Midazolam reduced to 5ml/hr and Fentanyl reduced to 6ml/hr

The pt appeared in distress following the WR requiring boluses of Propofol to settle  
At one stage the pt's mother felt the need to support the TT during the pt coughing. I bloused [sic] Fentanyl 2ml and Propofol 2ml with good effect. I checked the pt's trache for secretions and gave some oral suctioning

I had assisted Plastics earlier in the afternoon by supporting the pt's head and opening the pt's lips for Plastics to insert rubber bands to the exterior of the pt's teeth.

The pt appeared to be saturating well on the monitor and ventilating with good tidal volumes as set.

10.4 During his evidence RN Chan accepted that there were occasions when he was not in Adam's room for varying amounts of time. RN Chan gave evidence that when he was on a morning tea break (20 minutes) or lunch break (30 minutes), Adam would have been supervised by an **ACCESS** (Assistance, Coordination Contingency, Supervision and Support) nurse, and that if an ACCESS nurse was not available, Adam would have possibly been supervised by another nurse who was not attending to a patient. Apart from these longer periods of time, RN Chan suggested that he may have been absent for the following reasons:

I may have been on the other side of the glass room, sitting at the desk, typing notes, making the notes. I may have been grabbing equipment. I may have been on a break. I may have been at the toilet. I may have been getting medication with a second RN, with supervision from another R – A RN with Adam. I may have been speaking to the team, the RMOs in the office.

10.5 However, RN Chan had no recollection as to how frequently he may have been absent from Adam's room for any of the reasons described above. Notwithstanding, RN Chan gave evidence that he was required to inform someone whenever he was absent from Adam's room so that they could assist with monitoring Adam.

10.6 RN Chan gave evidence that prior to going on his morning tea break at around 9:10am, he informed both the pod coordinator (RN Lawrence Keating) and the medical team that Adam had been coughing.

10.7 Professor Seppelt expressed the following opinion on this issue:

I can only comment on what is in the documentation and the various statements, where it appears the nursing staff certainly were adequately monitoring [Adam]. My expectation is predominantly 1:1 nursing [a 1:1 nurse patient ratio] consistent with standards from the College of Intensive Care Medicine of Australia and New Zealand (CICM) and the Australian College of Critical Care Nurses (ACCCN). Even a 1:1 nurse needs breaks, however, for meals or toilet breaks. In an ideal world a supernumerary nurse is available to cover for breaks. In the real world nurses have to cover for each other, so at times one nurse will be watching two patients while the other nurse is on a break, even though both patients are designated "1:1 nursing". The other unknown is what else is going on at the same time in a busy ICU.

It is clear from their statements that the Fitzpatrick family felt there were lapses in monitoring at times, but this is not reflected in the records provided in my brief.

10.8 RN Chan gave evidence that at the start of his shift, he observed that Adam was moving his limbs spontaneously and frequently, which could potentially result in dislodgement of the tracheostomy tube. RN Chan gave evidence that his observations suggested to him that the extent of Adam's sedation was insufficient. RN Chan gave evidence that he:

(a) he told RN Keating about this;

(b) could not recall the details of what he said but considered it more likely than not that he mentioned his concerns regarding the length of the tracheostomy tube (in other words, that it was protruding from the tracheostomy stoma);

- (c) expected that what he disclosed would be raised with the medical team;
- (d) could not recall whether RN Keating or any member of the medical team provided him with a response;
- (e) could not recall whether he chased up RN Keating; and
- (f) had a separate conversation with a member of the medical team regarding his concerns, but could not recall any further details regarding this interaction.

10.9 When asked whether he took any steps in response to Adam’s presentation, RN Chan gave evidence that he “*made sure Adam was safe*” but could not recall how he did so apart from holding the tracheostomy tube although he could not provide any further detail about his actions.

10.10 CNC Tait gave evidence that it would not have been reasonable if RN Chan did not chase up the pod coordinator, did not speak to a member of the medical team regarding his concerns, and if he left Adam’s room for more than 30 seconds whilst not on his morning tea or lunch break.

10.11 The submissions on behalf of the Fitzpatrick family referred to three additional aspects of the evidence:

- (a) Mrs Fitzpatrick reported an incident on 15 August 2020 to RN Clare Loveday, the ICU Nurse Manager, during which Mrs Fitzpatrick observed Adam to cough, causing the tube connecting his tracheostomy to the ventilator to become dislodged. At the time, Mrs Fitzpatrick was in the room alone with Adam as the nurse monitoring Adam had left to go on a break;
- (b) On 22 August 2020, Mrs Fitzpatrick arrived at Adam’s room at around 10:05am and found no nurse present in the room. According to Mrs Fitzpatrick, RN Chan did not arrive until about 15 minutes later;
- (c) St George Hospital conducted a review of its intensive care services nursing staff model after August 2020 which relevantly found that the number of ACCESS nurses per shift did not meet Australian College of Critical Care Nurses (**ACCCN**) standards .

10.12 From the above, it was submitted on behalf of the Fitzpatrick family that although there is no positive evidence that RN Chan was absent from Adam’s room shortly before Adam experienced an airway emergency on 22 August 2020, “*it can be inferred that **it is possible** [RN] Chan was not adequately supervising Adam in the moments leading up the emergency*” (original emphasis) and that “*it is open to the Court to criticise the supervision provided by [RN] Chan during the course of the day on 22 August 2020*”. In addition, it was submitted on behalf of the Fitzpatrick family that RN Chan should be referred to the Nursing and Midwifery Council of New South Wales (**Nursing Council**) and/or to AHPRA. Again, this last submission is dealt with later in these findings.

10.13 The St George Hospital medication administration records indicate that on 22 August 2020, RN Chan paused Adam’s midazolam and fentanyl infusions at 10:05am and administered furosemide to Adam

at 10:09am. RN Chan made a progress note entry at 12:47pm on 22 August 2020 in which he recorded reductions to the midazolam and fentanyl that were being administered to Adam. These contemporaneous records suggest that RN Chan was attending to Adam at around the time that Mrs Fitzpatrick states that she arrived at Adam's room at approximately 10:05am. Whilst it is possible that RN Chan may have left Adam's room at around this time, there is no direct evidence as to whether this occurred, when it may have occurred, or for how long.

10.14 In his statement, RN Chan said that at approximately 3:25pm he was using a Yankauer tool to suction oral secretions that Adam was struggling with and heard that Adam "sounded gurgly". Adam was struggling with oral secretions. RN Chan said that he felt that he "*needed urgent assistance as the secretions were pooling into Adam's mouth and [he] was unable to reach the back of [Adam's] oral cavity*". RN Chan gave evidence that he called Dr Clare who was "*two bed spaces from Adam's bedside*". Dr Clare gave evidence that at around 3:22pm on 22 August 2020 she heard RN Chan calling out from inside Adam's room that Adam was making unusual noises. Dr Clare said that she could hear the alarm from Adam's ventilator also sounding at the same time.

10.15 As to the review of intensive care services nursing staff model conducted by St George Hospital the executive summary of the review stated the following:

It was noted from the benchmarking exercise of Level 6 ICU's [sic] across the State that the ACCCN standards were not able to be consistently applied in all domains at all facilities. [St George Hospital] sat above the baseline of many of the peer sites.

10.16 The findings of the review referred to above are of limited assistance. They do not refer to the actual availability of ACCESS nurses in the ICU at St George Hospital on 15 or 22 August 2020, nor provide any additional data as to how far above St George Hospital may have sat above a baseline set by the ACCCN and in respect of which of the ACCCN standards. Accordingly, whilst the submissions on behalf of the Fitzpatrick family correctly acknowledge that it can be inferred that it is possible RN Chan was not adequately supervising Adam on the afternoon of 22 August 2020, such an inference is not reasonably open on the available evidence.

10.17 **Conclusions:** The evidence establishes that there were a number of legitimate reasons for RN Chan to have been absent from Adam's room on 22 August 2020. RN Chan gave evidence that when this occurred for anything other than a very short period of time, arrangements were made for another nurse to provide cover by monitoring Adam. However, Professor Seppelt recognised that in a practical sense, it can often be the case that one nurse may be covering two patients.

10.18 The expert and documentary evidence does not identify any deficiencies with the monitoring of Adam on 22 August 2020. It is recognised that the evidence as to the movements of RN Chan and his reporting of concerns to the pod coordinator and medical team regarding his observations of Adam derive almost entirely from RN Chan's own evidence. The expert evidence establishes that if RN Chan did not chase up the pod coordinator and did not speak to medical officers about his concerns then this would have been unreasonable. However, there is no other evidence which establishes that RN Chan did not do either of these things, and no independent evidence which directly contradicts the account provided by RN Chan. Therefore, a conclusion cannot be reached that RN Chan failed to escalate Mrs Fitzpatrick's concern regarding the positioning of Adam's tracheostomy.

10.19 There is also no independent evidence that the circumstances which led to Adam being unattended for a period of time on 15 August 2020, when the tube connecting his tracheostomy to a ventilator became dislodged, were also present on 22 August 2020. Indeed, Dr Clare's evidence corroborates the account provided by RN Chan that he was inside Adam's room (and suctioning Adam's oral secretions) at around 3:35pm shortly before Adam's airway emergency. Further, there is no evidence as to the actual availability or otherwise of ACCESS nursing staff on 22 August 2020 to provide cover for RN Chan in the event that he was absent from Adam's room. In these circumstances, a positive conclusion cannot be reached that Adam was not adequately monitored.

**11. Did medical and nursing staff fail to recognise that Adam's tracheostomy tube had become dislodged?**

11.1 Professor Palme explained the clinical significance of a blocked tracheostomy tube in a patient:

An anteriorly dislodged tracheostomy tube does not only fail to allow the normal flow of oxygen to the lungs but it also causes posterior displacement of the anterior tracheal wall and narrowing of the airway. The surgically created anterior tracheal opening is not protected by the tube and potentially allows soft tissue and[/]or blood to enter the airway causing further obstruction.

[...]

Definitive treatment [for Adam] required immediate removal and replacement of the dislodged tube to prevent prolonged hypoxaemia and its life-threatening sequelae.

11.2 In his first report, Professor Seppelt expressed the following:

My interpretation of events is as follows: I suspect the tube had been partially dislodged in the morning, and that Mrs Fitzpatrick was right to express concern. It is possible that the tip of the tube was still in the airway but the cuff had been dislodged or was outside the airway. That would explain both the unusual noises described, and the increased coughing and discomfort.

11.3 As noted above, RN Chan gave evidence that on 22 August 2020 he considered that Adam's spontaneous coughing and limb movements could potentially cause tracheostomy tube dislodgement. However, although RN Chan considered that whilst Adam was "at high risk", he did not think that the tracheostomy tube had actually dislodged during the time that he was caring for Adam.

11.4 Dr Dixit was asked about the issue of tracheostomy dislodgment and gave the following evidence:

Q. So to limit that a little bit, the times that you did see Adam leading up to the events of the afternoon of 22 August, on those occasions, you didn't see anything that was of concern to you about his breathing or about a possible dislodgement of the tracheostomy tube.

A. That's correct.

11.5 In somewhat of a contrast, Dr Doshi gave the following evidence as Dr Dixit was attempting to pass the suction catheter, and before Dr Dixit asked him to perform the bronchoscopy:

Q. So Dr Dixit is, in effect, carrying out this step, he's attempting to pass a suction catheter through Adam's tracheostomy tube, and he's talking to you at the same time.

A. That's correct.

Q. What do you recall him saying?

A. So he mentioned to me that he's been [sic] trauma patient and he's looking after him for previous six days, and the tracheostomy has been here around 10 days. And he told me that he's trying to pass suction [sic] catheter, which is obviously visible to me, and he definitely mentioned that he's unable to do that. And either tracheostomy is blocked or it's dislodged.

Q. I was going to ask you that. So your recollection of what he said as he was carrying out this procedure was that the tracheostomy was likely blocked or dislodged.

A. That's correct.

Q. Then you say that Dr Dixit asked you to perform a bronchoscopy.

A. Yup

11.6 Dr Jain gave the following evidence that upon entering Adam's room (and observing Dr Doshi inserting the bronchoscope through the tracheostomy tube):

Q. At this stage, had you formed any views about whether the tube was blocked or dislodged or something else?

A. No.

Q. Is it also your evidence that on one view, it doesn't matter whether it's blocked or dislodged or something else--

A. That's correct.

Q. --because your thought process is that this tube has to be removed.

A. That's correct.

11.7 In his supplementary report, Professor Seppelt expressed the view that the 56 second video of the bronchoscopy (**Bronchoscopy Video**) confirmed his "*previous diagnosis that the tracheostomy tube had been dislodged into the pre-tracheal space*". Further, Professor Seppelt noted that the Bronchoscopy Video showed:

(a) Adam to be breathing spontaneously and not being mechanically ventilated;

(b) the attending medical personnel to be "*relatively calmly trying to deal with the situation*"; and

(c) that whilst it was clear that there was an airway problem, there was no life threatening emergency at the time.

11.8 However, Professor Seppelt ultimately expressed this view:

Unfortunately the doctors involved misinterpreted what they were looking at – from their conversation they believed they were looking at a partially obstructed trachea from some sort of flap. I believe the video shows reasonably clearly the tip of the tube was in the pre-tracheal space, showing an intermittent view of the trachea.

[...]

It is clear the staff looking at the bronchoscopic images did not appreciate what they were looking at, and this may have distracted them from making the diagnosis that the tube had been dislodged, and promptly reinserting a new tube down the established tract which may have prevented the disaster.

11.9 The possible contributors to this misinterpretation was explored in evidence with each of the clinicians.

(a) Dr Dixit gave evidence that he knew how to replace a tracheostomy tube (in an elective, but not an emergency, situation), but had no experience of replacing a tracheostomy tube under bronchoscopy. He said that he saw "*something moving up and down*" and "*interpreted it as a flap*". When asked what he thought this meant, Dr Dixit gave evidence that he was unsure what was happening and where the tip of the bronchoscope was. Accordingly, he was unable to "*identify the tissues that were coming up and down*". Dr Dixit also gave evidence that there was consensus amongst the clinicians that the tracheostomy tube had to be replaced, and discussion about differential diagnoses as to the reason why Adam's airway was compromised.

However, none of the clinicians expressed with certainty that tube dislodgement was the cause of Adam's airway difficulties.

- (b) Dr Jain gave evidence that from the outset, a "*clinically dislodged [tracheostomy] is always on the card[s]*". This, together with a blocked tracheostomy tube, "*are the two topmost causes of a higher way [sic] pressures*". His primary differential diagnosis was granuloma, with a dislodged tracheostomy tube being "*one of the different shared diagnoses was [sic] present*". In hindsight, he accepted that the bronchoscopy findings were misinterpreted because "*we thought it is a flap*" and "*moving with spontaneous breathing*". Dr Jain explained that the view from the bronchoscope created a "*distraction*" as it raised the possibility of a granuloma or some other cause of Adam's airway distress. As a result, this delayed Adam's management in the sense that the bronchoscope should have been withdrawn and the existing tracheostomy tube replaced with a new tube.

In a supplementary statement, Dr Jain indicated that he had reflected on the events of 22 August 2020 and made a reference to the contents of his first statement:

I set out my discussion with Dr Dixit and Dr Doshi about our decisions at crucial times during the resuscitation and how following a different path may have provided Adam with a better chance of survival. For my own part, I deeply regret as the most senior practitioner present not recognising the dislodged tracheostomy tube earlier and not attempting to replace the tracheostomy tube with the Portex blue line 8 or 7 tube which was available at Adam's bedside.

- (c) Dr Doshi gave evidence that "*within [the] first minute of [the] bronchoscopy*" he came to the view that the tracheostomy tube had become dislodged. Despite this, Dr Doshi did not voice, or otherwise convey, his view to anyone else in the room at the time. Dr Doshi gave evidence that he could not recall why he did not do so (but sought to explain that during the second part of the bronchoscopy he mentioned that he was attempting "*to negotiate that bronchoscope into the trachea in order to get access*"). Dr Doshi gave evidence that in hindsight, he ought to have done so. Dr Doshi also gave evidence that despite coming to this view he did not remove the tracheostomy tube because the bronchoscope was already in situ:

And the thought process was that the bronchoscopy is already inside and tracheostomy tube is already inside the bronchoscope, but there's no point taking everything out and putting a new [sic] rather than attempting to negotiate the same bronchoscope inside the tracheal opening, and then just railroad the same tracheostomy tube inside the trachea as a temporising measure.

Even after the bronchoscope was removed, Dr Doshi gave evidence that he was asked to assume the role of team leader and following this, Dr Jain and Dr Dixit took over management of Adam's airway and the tracheostomy. As a result, Dr Doshi gave evidence that he "*left it at their discretion to decide the next course of action*".

11.10 As to the failure by Dr Doshi to verbally articulate his thought process, Professor Seppelt expressed this view:

That worries me. If he suspects the tube is dislodged, that's life-threatening. I think he's got an obligation to at least speak up. Either that, or for whatever interpersonal reasons he doesn't feel able to speak up, that's a problem as well. But anyone who thinks, whether rightly or wrongly, that the tube is dislodged, I think has to at least articulate that.

11.11 The evidence given by Dr Doshi regarding not communicating his views about the tracheostomy to any other person in Adam's room raises for consideration the concept of crisis resource management (**CRM**). It was submitted on behalf of the Fitzpatrick family both in relation to the present issue, and other issues below which involved consideration of the dynamics, experience, and need for leadership within clinical teams responding to an emergency situation, that "*additional training in communication and non-clinical skill ie. crisis resource management training should be mandatory for ICU staff*".

11.12 Professor Seppelt was asked whether he had any opinion as to whether "[crisis] resource management would assist in managing" a "Can't Intubate, Can't Oxygenate" (**CICO**) scenario. This describes a situation where there is an upper airway obstruction that exists in the upper airway that cannot be relieved by airway management interventions which results in an inability to oxygenate a patient with low or falling oxygen saturations. Professor Seppelt gave evidence that the "[s]imple answer is – is totally yes and absolutely". He went on to explain:

[I]t's learning how to function as a team in an emergency situation and particularly for the team leader to be conscious of the human resources available, so it's not just me doing everything while these people stand by doing nothing. It's trying to use the team effectively. But also the – the great assertiveness where someone who may be lower down the hierarchy is able to express an opinion which is heard, which again is one of the big CRM lessons that's come from aviation.

11.13 In her first statement, Dr Boss explained that since August 2020, St George Hospital has developed a multidisciplinary team training program which is mandatory for all ICU staff. This involves the conduct of a variety of weekly Routine Interdisciplinary Simulation in Critical Care (**RISC**) scenarios and incorporates technical and non-technical skills identified as "*essential for all deteriorating patient scenarios*". The non-technical skills component "*incorporates situational awareness, decision-making, team-work and leadership and task management*". Further, the training program has been incorporated into the ongoing education and training plan for the ICU, and the RISC has received Continuing Professional Development accreditation from the College of Intensive Care Medicine.

11.14 Dr Boss gave evidence that the approach by St George Hospital to education and training provided since August 2020 to ICU staff has been "*very much in line*" with CRM principles. Dr Boss went on to explain:

[T]he training is not just about the technical skills and the – the – the clinical skills, the technical skills that the doctor has but around those non-technical skills around team work, around leadership, around situational awareness, around that graded assertiveness and speaking together as a team, so there has been a lot of work that ICU have done in setting up their education and training program with a very large emphasis on those non-technical skills in combination with the technical skills.

[...]

[T]here is a very strong focus on simulation. So being able to test out how the team work under pressure in a safe environment so that they can practice, practice, practice so that in the event that they have a real emergency, they know what to do, as opposed to trying to teach that in a real scenario.

11.15 **Conclusions:** Dr Dixit and Dr Jain both failed to recognise that Adam's tracheostomy tube had become dislodged. This is primarily because the view from the bronchoscopy led the clinicians to conclude that there was a partially obstructed trachea from what was described as some sort of flap. This caused the clinicians to become distracted and delayed effective management of Adam's airway, which required removal of the tracheostomy tube and insertion of a new tube.

11.16 According to his own evidence, Dr Doshi was the only clinician who recognised that the tracheostomy tube had become dislodged. Despite this, Dr Doshi did not communicate his views to the other clinicians. It appears that this was because Dr Doshi and the other clinicians became anchored in their thinking to the bronchoscopy and what they believed they were visualising at the time. Even after the bronchoscope was removed, an opportunity existed for Dr Doshi to communicate his views to the other clinicians in the room. However, this opportunity was again not taken because Dr Doshi deferred to his colleagues, by virtue of their seniority and his role within the clinical team, with respect to management of Adam's airway. Again, this delayed effective management for Adam.

11.17 The inability of the clinicians to communicate and work effectively as a team to provide appropriate management of Adam's condition highlights the importance of non-technical and non-clinical skills, particularly in an emergency situation. The absence, or inadequacy, of such skills contributed to the events of 22 August 2020 after Adam began experiencing airway distress. The expert evidence establishes that Dr Doshi was at least obliged to communicate his views regarding dislodgement of the tracheostomy to the other clinicians in the room at the time. This is particularly so given that he arrived at this view within the first minute of the bronchoscopy.

11.18 Since August 2020, St George Hospital has developed a mandatory training program for ICU staff which embraces, teaches and reinforces CRM principles. This program is simulation-based and provides opportunities for ICU staff to develop and enhance non-clinical skills centred on communication within a clinical team during an emergency situation. Accordingly, it is neither necessary or desirable for any recommendation to be made to St George Hospital regarding CRM training in this regard.

## 12. How and when did the tracheostomy tube become dislodged?

- 12.1 On 22 August 2020, Adam was subject to monitoring of his vital signs, including End Tidal CO<sub>2</sub> (ETCO<sub>2</sub>) monitoring. ETCO<sub>2</sub> is the level of carbon dioxide released at the end of an exhaled breath. ETCO<sub>2</sub> monitoring provides a breath-by-breath analysis and recording of a patient's ventilatory status, and gives early warning of respiratory compromise. It is measured in millimetres of mercury (mmHg) with normal levels of ETCO<sub>2</sub> ranging from 35 to 45 mmHg.
- 12.2 Minute-by-minute ventilation records indicate that Adam's ETCO<sub>2</sub> readings were consistently at 30 mmHg or below from 3:00pm on 22 August 2020. At 3:22pm, Adam's ETCO<sub>2</sub> dropped from 21 mmHg to 0 mmHg.
- 12.3 Dr Dixit expressed the view, based on the above records, that Adam's tracheostomy tube dislodged at or around 3:22pm. Dr Doshi similarly was of the view that a ETCO<sub>2</sub> reading of 0 mmHg at 3:22pm meant that the tracheostomy tube was either blocked or dislodged.
- 12.4 Professor Palme indicated that he was unable to comment "*on the exact moment that the tracheostomy tube became dislodged*" but opined that the tracheostomy tube became dislodged sometime between 2:25pm, which is when a progress note entry was made recording no significant issues with Adam's ventilation or the tracheostomy tube, and 3:25pm.
- 12.5 As noted above, Professor Seppelt opined that the tracheostomy tube had become partially dislodged sometime during the morning of 22 August 2020. He explained:

[M]y suspicion and I can't prove this, is that in the morning when Mrs Fitzpatrick perceived that the tube was out at a slightly funny angle and there were unusual noises, is that this cuff may have either fully or partially come out of the airway. The tip was still sitting in the airway, which is why Adam was still being ventilated, but it was a very unstable position with the cuff partly out.

- 12.6 According to Professor Seppelt, this would explain the unusual noises that Adam was making and his increased coughing and discomfort. Professor Seppelt went on to opine that at 3:25pm the tube was dislodged a millimetre further, with the tip no longer in the airway but in the pre-tracheal space.

12.7 **Conclusions:** It is most likely that the tracheostomy tube became dislodged at or about 3:25pm on 22 August 2020. Adam's presentation at different points in time prior to 3:25pm are consistent with partial dislodgment. However, even with the benefit of all the available documentary evidence and medical records, Professor Seppelt was only able to surmise about the possibility of partial tube dislodgment at some time prior to 3:25pm and was unable to demonstrate any precise time of dislodgment. The available evidence does not allow for a conclusion to be reached as to how the tracheostomy tube became dislodged.

### 13. When should the tracheostomy tube have been suspected to have been dislodged?

13.1 As noted above, in his first report Professor Seppelt indicated his suspicion that Adam's tracheostomy tube had become partially dislodged during the morning of 22 August 2020. Professor Seppelt went on to indicate the two ways that the outcome could have been different were if the partially dislodged tracheostomy tube had been recognised and a clinician "*dealt with it*", or if the tube could have been reinserted before the development of hypoxaemia and cardiac arrest.

13.2 As to the first of these matters, Professor Seppelt described "*some subtle indicators of a developing problem*" being present, such as Mrs Fitzpatrick's observations that there were gurgling and strange noises coming from the tracheostomy tube, and it appeared that it had moved. However, Professor Seppelt explained that these indicators or "*red flags*", as he described them, were only apparent in retrospect. Relevantly, Professor Seppelt noted that despite his suspicions about the partially dislodged tube, it was still possible to ventilate Adam, and for Mr Rianto to suction through the tracheostomy tube.

13.3 **Conclusions:** Although there were subtle indications on the morning of 22 August 2020 that Adam's tracheostomy tube had become partially dislodged, the expert evidence establishes that such indications were only apparent in hindsight. Therefore, the evidence does not establish a particular time when a suspicion should have arisen that the tracheostomy tube had become partially dislodged.

#### 14. Was a bronchoscopy appropriate in the circumstances?

14.1 In his supplementary report, Professor Seppelt opined that a bronchoscopy was appropriate because:

- (a) a “*bronchoscopy by a skilled practitioner will rapidly identify the problem and confirm the appropriate next action*”; and
- (b) at the time it was performed on 22 August 2020, Adam was attempting to breathe spontaneously and not yet hypoxic.

14.2 However, Professor Seppelt placed one important qualification on his opinion regarding the appropriateness of the bronchoscopy:

The bronchoscopy was carried out adequately but the findings misinterpreted, which may have distracted from an attempt to replace the tube down the established tract.

14.3 This opinion was confirmed by the evidence of both Dr Dixit and Dr Jain. Dr Dixit gave evidence that he did not know what the flap that the bronchoscopy showed was, and accepted a description that the findings had been misinterpreted. Dr Jain acknowledged that he was “*immediately distracted towards the bronchoscopy view*”, which led to hypoxaemia and delayed management of Adam’s airway.

14.4 Professor Palme was of a slightly different view. First, he gave evidence that what was being performed on 22 August 2020 was not, in fact, a bronchoscopy. Professor Palme described this as a procedure involving “*looking all the way into the bronchi, which are at the end of the trachea*”. Instead, Professor Palme considered that what was occurring on 22 August 2020 was “*a fiberoptic examination of the intratracheal tube*”.

14.5 Professor Seppelt acknowledged that, strictly speaking, a bronchoscopy is looking inside the bronchi, but considered that Professor Palme may have been being “*very semantic*”. Professor Seppelt opined that “*everybody would refer to [the procedure on 22 August 2020] as an attempted bronchoscopy*”.

14.6 Second, Professor Palme considered that bronchoscopy is an appropriate procedure to confirm that a tracheostomy tube is correctly placed within the tracheal lumen in the circumstances of Adam’s case on 22 August 2020. However, Professor Palme opined that a bronchoscopy (or what he described as fiberoptic endoscopic visualisation of the tracheostomy tube) “*did not provide any extra information not already clear on clinical history and examination*”. In other words, as Professor Palme noted, “[e]stablishing the diagnosis of a blocked or mal-positioned tracheostomy tube is based on symptoms, physical examination and failure to pass a suction catheter”. In addition, Professor Palme opined that bronchoscopy can be considered in a stable patient “*when performed by an expert in a controlled setting*”.

14.7 Professor Palme gave evidence that it is the clinical picture which should drive the management of a patient and explained this further opinion about the bronchoscopy on 22 August 2020:

I don't think it's helpful. For the simple reason, again, the diagnosis of a blocked or dislodged tracheostomy is a clinical diagnosis. Signs of airway obstruction and the failure to catheter will tell you that the tracheostomy is not in the correct position. If you want to go to the point where you put a telescope into the trachea and confirm that there is a flap or it's not in the right spot, you can do that. But that's not a bronchoscopy; that's just like inspecting the endotracheal tube from the inside for the length of the tracheostomy. And I do not believe that a bronchoscope is going to be helpful in reinserting that tracheostomy in that scenario because it is akin to a bougie. It is only going to make things worse.

14.8 **Conclusions:** The expert evidence establishes that the procedure performed on Adam on 22 August 2020 should most accurately be described as an attempted bronchoscopy or fiberoptic examination of an intratracheal tube. The expert evidence also establishes that whilst it is most likely appropriate for this procedure to have been performed, it was unnecessary to diagnose that Adam's tracheostomy was blocked or dislodged. This is because this is a clinical diagnosis. Adam's clinical history, his presentation on 22 August 2020 and the available information regarding the inability to pass a suction catheter was sufficient to diagnose an incorrectly positioned tracheostomy tube.

14.9 Further, there is one aspect of the evidence which raises doubt about whether performance of the bronchoscopy was entirely appropriate. Whilst Professor Seppelt noted that Adam was not yet hypoxic when the bronchoscopy was performed, Professor Palme's view is that it should only have been considered for a stable patient. In addition, notwithstanding the above, the more critical issue is that the results of the bronchoscopy were misinterpreted by the clinicians, namely Dr Dixit and Dr Jain. This in turn distracted the clinicians from appropriately managing Adam's airway.

## 15. Was Adam breathing adequately on his own up until the bronchoscopy?

- 15.1 Professor Kelly explained that the meaning of the term “*breathing adequately*” is open to subjective interpretation but considered that that this meant that Adam had oxygen saturations of more than 90% (irrespective of respiratory rate or tidal volume). Professor Kelly noted that Adam’s oxygenation saturation was 100% at 3:22pm (when Dr Clare arrived) and still at that level at 3:28pm (when Dr Doshi arrived). However, Professor Kelly noted that Adam desaturated after the bronchoscopy commenced.
- 15.2 Having regard to the above, Professor Kelly considered that Adam was “*maintaining reasonable oxygen saturation*” at least until the commencement of the bronchoscopy, most likely due to a combination of increased inspired oxygen concentration and Adam’s spontaneous respiratory efforts.
- 15.3 During her evidence, Professor Kelly was shown Adam’s minute-by-minute ventilator records. Professor Kelly noted that between 3:22pm and about 3:20pm or 3:21pm, the records show that Adam had oxygen saturations of 100% meaning that he was “*adequately oxygenating*”. Professor Kelly also noted that at 3:31pm, Adam’s oxygen saturations dropped from 100% to 74%, and then to 6% at 3:33pm, indicating that he was not adequately breathing on his own.
- 15.4 Professor Palme also noted that before the bronchoscopy was commenced, Adam had reported oxygen saturations of 100% and was haemodynamically stable. However, Professor Palme was unable to comment on whether Adam was “*breathing adequately*”.
- 15.5 Professor Seppelt opined that the Bronchoscopy Video showed Adam’s respiratory movements and that he was breathing spontaneously at that time.

15.6 **Conclusions:** Having regard to the observations of Adam’s oxygen saturations, Adam was breathing adequately up until the commencement, and during the initial stages, of the bronchoscopy. However, between 3:31pm and 3:33pm, Adam’s oxygen saturations decreased precipitously, meaning that he was no longer breathing adequately at this time.

**16. Was sedation used for the bronchoscopy and was this appropriate?**

16.1 As noted above, Professor Kelly considered that as Adam was breathing on his own and maintaining reasonable oxygenation, displacement of the tracheostomy tube would not have been “*the critical problem*”. Professor Kelly noted that some other factor would have reduced the effectiveness of Adam’s breathing, namely: sedation or paralysis, or the development of a condition in or around the lungs. Professor Kelly went on to explain:

So something else must have happened, to – to – to stop him breathing adequate, like, like, adequately on his own, and those likely things would have been some sedation. And there was some mention, in some of the original statements, about some – some suggestion that sedation might have been given. In the later statements I received, then the question of rocuronium came up.

16.2 In his statement, Dr van der Walt said the following:

An attempt at oral intubation was suggested, although I do not specifically recall who suggested this. I called out to Gary Chan, Registered Nurse, who was at the doorway on the other side of the room, to administer 100mg of rocuronium. This is standard practice in order to relax the vocal chords to allow intubation through the airway. This order was not contradicted or commented on by any other practitioner. I recall RN Chan administered the rocuronium as ordered, but cannot recall exactly when this occurred.

16.3 In evidence, Dr van der Walt was less certain that it was RN Chan who administered the rocuronium. He explained:

I think - that’s - that’s not 100% clear. I think - I - I think it was him. I think it was him. I think, but I don’t have a clear recollection of it being closed loop like that. But in my memory, when I was writing the statement, that’s how I remembered it.

16.4 In addition, Dr van der Walt gave evidence that in ordering the rocuronium he spoke “*out of turn*” and that it “*would have been more appropriate*” for him to instead suggest the administration of rocuronium to the team leader and ask for confirmation. On reflection, Dr van der Walt gave evidence that he would have instead made a suggestion for the administration of rocuronium as if to invite comment from the other clinicians in the room.

16.5 The administration of rocuronium was explored in evidence with the other clinicians who were in Adam’s room at the time:

(a) Dr Dixit gave this evidence:

I remember someone calling out. I don't know whether it was asking for it to be given or whether it was announcing to the team that it has been given, but I heard rocuronium. At that time, I didn't understand the significance or I didn't have any view or I didn't object to it. I didn't say anything.

[...]

I understand it was in the context when they were attempting to intubate him orally. That is our usual practice to give rocuronium to intubate orally. So I didn't attach any significance or I didn't have any - I didn't object or I didn't say anything.

- (b) Dr Doshi gave evidence that he heard Dr van der Walt say words to the effect of, “*I have given rocuronium*”, but no memory of Dr van der Walt saying, “*I’m about to give rocuronium*”. Dr Doshi also gave evidence that he had an expectation that Dr van der Walt would have verbalised an intention to administer rocuronium because “*it’s part of the closed loop communication*” and “*requires approval from the team leader*”. Dr Doshi went on to explain that he would not administer rocuronium in a situation like the one on 22 August 2020, and that if he had heard Dr van der Walt express an intention to do so he “*would have said that we must not give it*”. Dr Doshi went on to express the following view about the use of rocuronium for oral intubation:

We can still attempt the oral intubation without giving rocuronium, if that's the last resort.

[...]

Based on the laryngoscopic view, but it does not absolutely require administration of rocuronium, especially in this case where the risk of giving rocuronium clearly outweighs the benefit.

- (c) Dr Jain gave the following evidence:

I think – I can’t be sure that whether he was organising or what time. But I definitely heard rocuronium medication. Whether it was after administration or before that, I can’t be sure. It was a bit chaotic and bit noisy.

[...]

And when this rocuronium administration, my recollection was done when [sic] anaesthetic fellow had already arrived and he had cut the elastic band. He had already bag mask with the nasal-pharyngeal and oral-pharyngeal airways and the maximum oxygen saturations we could able [sic] to get in the range of a high-30s to 40s. At that time, my understanding that [the anaesthetic fellow] tried to intubate it. So my understanding that Doctor Van Der Walt ordered or was organising rocuronium, my understanding that it was requested by [the anaesthetic fellow] to give a best chance of oral tracheal intubation.

- 16.6 After having been provided with the expert reports of Professor Kelly, Professor Palme and Professor Seppelt, Dr van der Walt prepared a supplementary statement in which he said the following:

With the benefit of hindsight, the additional information now available and the greater intensive care experience I have gained in the interim, I agree that the administration of rocuronium was not appropriate for the situation. I can see that this is also the opinion expressed by the experts.

My decision to order rocuronium was the result of a clinical judgment I made under the exigencies of the situation based on my contemporaneous abilities and with particular reference to [Adam’s] prior desaturation and the failure of the attempted ventilation through the tracheostomy. At the time, I considered the administration of rocuronium to be justified in the context of a last resort effort at resuscitation and my decision in this regard was not contradicted.

- 16.7 In his evidence, after being shown the ventilation records which showed Adam’s oxygen saturations decreasing between 3:23pm and 3:25pm, and again at 3:31pm, Dr van der Walt agreed with the opinion expressed by Professor Palme that the use of sedation and muscle relaxant when managing a patient with an unstable or unsecured airway is an “*absolute contraindication*”.

- 16.8 In evidence, Professor Palme explained this contraindication:

When you have an acute airway obstruction, there is a period where a patient can maintain their ventilation and their saturation through their own efforts of breathing and that is the period in time where you have the opportunity to correct the problem and manage the patient safely. So this person is giving you the opportunity to save their life.

[...]

Now the problem with giving sedation or other types of drugs, it will only impair the person's respiratory drive, so you are actually taking away that person's compensatory mechanism in - you know - that are necessary to sustain saturation and ventilation. So unless you've already instituted a way to secure the airway, that is a very unsafe and dangerous thing to do.

16.9 Professor Palme went on to explain that a muscle relaxant blocks the receptors and paralyses neuromuscular junctions. This has the effect of taking away a person's respiratory drive; in other words, although the person may want to breathe they simply cannot. Professor Palme noted that for a patient such as Adam, whose tracheostomy tube had not been replaced with a new one, there was no way of ventilating him. In this scenario, use of a muscle relaxant such as rocuronium "*would be incorrect*".

16.10 In her supplementary report, Professor Kelly agreed with Professor Palme. She expressed the view that the use of sedation or muscle relaxation (such as the administration of rocuronium) was not appropriate as it risked inhibiting or blocking any spontaneous breathing "*which, even if suboptimal, may be sufficient to buy time for additional specialised personnel to arrive or additional equipment/procedures to be available*". Professor Kelly gave the following evidence:

[T]he generally accepted principles, among critical care and ear, nose and throat and faciomaxillary specialists, is that if a patient is breathing on their own enough, and "enough" is a saturation above about 85 or 88%, so it's not perfect, it's enough.

[...]

[C]onverting that into a situation where they can't oxygenate themselves at all, runs - runs the risk of basically them - them dying, from hypoxia.

16.11 In his supplementary report, Professor Seppelt explained that sedation is not necessary for bronchoscopy through an already established airway, but in an airway emergency there is also no need for sedation for the bronchoscopy. Indeed, Professor Seppelt noted that "*anything that may stop the patient from breathing is potentially catastrophic*".

16.12 When asked about his opinion of the use of sedation in these circumstances, Professor Seppelt expressed the following view:

I don't think there's any place at all to be honest. The point of sedation is to relieve distress. I think this far into an emergency Adam's unconscious. It both distracts from the need to deal with the emergency and depending on drugs you use they can - they can have some consequences as well.

16.13 As to the specific use of rocuronium, Professor Seppelt explained:

The word I used in my first report was unwise.

[...]

So, while [Adam] may not have been breathing well enough for pure spontaneous ventilation, he was making some spontaneous breaths, and while he was breathing he was managing to at least

some extent to oxygenate himself. [Giving] a neuromuscular blocker stops that. It paralyses all the skeletal muscle. He's not breathing. While that is a standard technique in anaesthesia, in order to place a tube from above it also commits you to doing that and to dealing with the consequences of it.

16.14 In his evidence, Dr van der Walt appeared to express some doubt regarding Professor Seppelt's opinion. Dr van der Walt said the following:

I agree that that could be the situation if he was breathing spontaneously before and then the - the muscle relaxant was given. I think looking at the timing and when the muscle relaxant was given, he was already not breathing adequately to maintain his oxygen levels. Cause they had already dropped. So I don't think in that instance - I don't think it was the neuromuscular blocker that converted the stable situation into an unstable situation.

16.15 Instead, Dr van der Walt offered the following hypothesis:

I have a theory but that's - it's not - it's not a recollection, it's just what I think. And I think it could have been when the bag mask was removed from his face. So that whatever assisted breathing that happened with the bag masking through the upper airway was then lost and then led to a desaturation, followed by ventilating through the tracheostomy which then caused a pneumothorax, which was the - which was the reason for the persistent hypoxia and ultimate arrest and delay of getting things back to where it should be.

16.16 In his evidence, counsel for Dr van der Walt took Professor Seppelt to Adam's minute-by-minute ventilation records for 22 August 2020 and particular records regarding Adam's medication management. Neither of these records were available to Professor Seppelt at the time of his first report. Professor Seppelt gave the following evidence regarding the ventilation records:

[3:31pm] with a peripheral saturation of 74%, [Adam]'s now starting to deteriorate quite rapidly. And from then on, the pulse oximetry is - is basically meaningless but very, very low. These things have never been validated below saturation of - of about 60% but what you do know from then on is that there's - there's no meaningful oxygenation until you get return of spontaneous circulation much later.

16.17 Professor Seppelt gave evidence (consistent with earlier evidence by Dr van der Walt) that the process involved in accessing the machine where rocuronium is stored by entering a code, removing the drug, and preparing it for administration could take "*at least a couple of minutes*".

16.18 During his evidence Professor was asked to:

- (a) have regard to the fact that the ventilation records showed Adam in severe hypoxemia from 3:31pm;
- (b) assume that Adam was administered rocuronium sometime after 3:35pm; and
- (c) then express an opinion as to any contribution which rocuronium administration likely made to Adam's clinical picture.

16.19 Professor Seppelt gave this evidence:

If those timings are correct, then yes, I accept that [Adam]’s already in cardiac arrest and it’s not going to have made a difference.

My concern when I first saw that information at the time I wrote the second report is that he had been breathing spontaneously and I – I think my – my words were that – to give something that takes that away was unwise. I – I certainly accept your premise that if this is already several minutes after the cardiac arrest, it was not going to make a difference.

16.20 It was submitted on behalf of the Fitzpatrick family that “*Dr van der Walt may be criticised for ordering the administration of rocuronium*” and that “*Dr Doshi and Dr Jain may be criticised for their respective roles in failing to take steps to prevent the administration of the rocuronium. Dr Jain as the most senior clinician in attendance, in particular, may be criticised*”. It was further submitted that Dr Jain should be referred to the Medical Council or to AHPRA. Again, this last submission is discussed further below.

16.21 As noted above, Dr Doshi gave evidence that he did not hear Dr van der Walt vocalise his intention to administer rocuronium and that if he had such an intention he would have advocated against its administration. Dr Jain’s evidence is that he could not recall when the order for rocuronium was mentioned but was of the understanding that its administration had been ordered by an anaesthetic fellow. The evidence of both Dr Doshi and Dr Jain on these matters was not challenged during the inquest.

16.22 **Conclusions:** There is a distinction between a sedative and a muscle relaxant such as rocuronium, although both decrease a patient’s respiratory drive. In the context of an emergency situation involving a patient in respiratory distress or with an unsecured airway, the administration of either drug is contraindicated.

16.23 There is no evidence that Adam was administered a sedative or a muscle relaxant for the purpose of performing the bronchoscopy. Rather, rocuronium was administered for the purpose of oral intubation as a “*last resort*” effort to resuscitate Adam. There is no doubt on the evidence that Dr van der Walt ordered the administration of rocuronium but it is unclear on the evidence who administered it.

16.24 The evidence establishes that Dr Dixit heard rocuronium mentioned but it is unclear if this was before or after its administration. In any event, Dr Dixit did not appreciate the significance of its administration other than it was for the purpose of oral intubation. The evidence also indicates that Dr Doshi did not hear Dr van der Walt’s order, and that Dr Jain was of the understanding that the rocuronium had been ordered by an anaesthetic fellow to assist with oral intubation. Notwithstanding any of these matters, the evidence establishes that Dr van der Walt ought to have sought approval from the team leader before rocuronium was administered to Adam.

16.25 The contemporaneous records indicate that rocuronium was administered after Adam's oxygen saturations had fallen to 74% and were continuing to fall, meaning that he was no longer breathing spontaneously and able to oxygenate himself. Professor Seppelt's evidence establishes that the administration of rocuronium at this time would not have made a material difference to the eventual outcome.

## 17. At what point did Adam desaturate?

17.1 In his supplementary statement, Dr Dixit said the following:

[Adam] started to desaturate at 3:31pm. At that time, the team was performing the bronchoscopy and awaiting the arrival of the longer tracheostomy tube which had been requested. Other practitioners were attempting to ventilate [Adam] manually via his upper airway at the time.

17.2 Dr Dixit confirmed this timing in his evidence and said that he thought Adam desaturated after the bronchoscopy commenced, although he could not recall how many minutes from commencement. Dr Dixit went on to say that as he formed the intention to remove the tracheostomy, Adam began to desaturate. He explained:

So I think [Adam] started desaturating. We noticed and someone said, "He's desaturating" - "Adam's desaturating" then actually, we then started - I think we removed the bronchoscope immediately and then soon after that, I think we removed the tracheostomy tube as well.

17.3 In his evidence, Dr Doshi did not accept that Adam desaturated during the initial bronchoscopy. Instead, Dr Doshi estimated that the duration of the bronchoscopy was between two and half to 3 minutes, and that Adam "*desaturated during the end [of the] bronchoscopy*" at which time, Dr Doshi removed the bronchoscope.

17.4 Dr Jain gave evidence that Adam "*started desaturating just around 3:31[pm] or so*", after which he asked Dr Doshi to remove the bronchoscope. Dr Jain went on to explain what then happened:

So that - and then we disconnected from the ventilator and removed the tracheostomy tube but Dr Dixit at that time inserted a bougie through the tracheostomy tube and removed the tracheostomy tube. That happened within the next one minute, around 3.32, 3.33, tracheostomy tube came out.

17.5 Dr van der Walt gave evidence that, he could not exactly recall, he thought that the bronchoscope had not yet been removed when Adam began to desaturate.

17.6 This is consistent with the expert evidence. As noted above, Professor Kelly expressed the view, based on available records, that Adam desaturated during the initial bronchoscopy. Similarly, Professor Palme was of the view that Adam desaturated sometime between 3:22pm and 3:38pm after the bronchoscopy had commenced.

17.7 **Conclusions:** The evidence establishes that Adam desaturated during the bronchoscopy and that attempts had not been made to stabilise his airway. After the bronchoscope was removed it appears that Dr Dixit inserted a bougie through the tracheostomy tube.

**18. Was removal of the tracheostomy tube by the treating clinicians contingent on the arrival of the ENT Registrar? Was there a delay in removing the tracheostomy tube and performing other resuscitative measures?**

18.1 Dr Doshi gave evidence that he had the necessary training, and it was within his skill set, to remove a tracheostomy tube. Dr Doshi went on to explain that he had performed this procedure “[a]t least five to seven times a year”. Dr Doshi also gave evidence that it is common practice to remove a tracheostomy without a bronchoscopy, and that he had done this before. Further, Dr Doshi gave evidence that it is less common to replace a tracheostomy under bronchoscopy but that he could also perform this.

18.2 Dr Doshi gave evidence that on arrival at Adam’s bedside, the fact that Dr Dixit was unable to pass the suction catheter was a clear indication that the tracheostomy tube was either blocked or dislodged, and that regardless, it needed to be removed and replaced. Dr Doshi gave evidence that he should either have removed the tracheostomy tube himself at this point, or suggested to Dr Dixit that he remove it, notwithstanding the contents of the Airway Plan.

18.3 For his part, Dr Dixit gave evidence that he possessed the necessary skills and training to remove the tracheostomy tube, and that he had done so in elective situations, but not in an emergency situation. Dr Dixit gave evidence that the tracheostomy tube should have been removed “[a]s soon as we had the clinical indicators”; in other words, when the suction catheter could not be passed and the ETCO<sub>2</sub> trace “was gone”.

18.4 When asked why he did not remove the tracheostomy tube at this point, despite recognising that it needed to occur, Dr Dixit offered the following explanation:

For a split second, I thought about this when I arrived initially, but then there was set plan to do a replacement under bronchoscopy and also, it is - there is a mental block when somebody has a difficult upper airway. I felt it was very difficult to overcome because knowing that I - in the back of my mind, I knew that upper airway could be difficult. There was a certain mental block in my - within me which I found it very hard to overcome.

18.5 Dr Dixit went on to acknowledge that, on reflection, he should have taken the lead in Adam’s management on 22 August 2020. Dr Dixit also referred to a degree of confidence bearing upon his actions and gave evidence that since August 2020, he has completed a number of courses to gain more experience “and to be comfortable to make those decisions in critical moments”.

18.6 Dr Jain similarly gave evidence that he too had the necessary skills and training to remove the tracheostomy tube. He gave evidence that he had performed three to five elective tracheostomy changes, with the last occasion being “just a few months” prior to August 2020 (at a different hospital). Dr Jain also gave evidence that he had experience in replacing a tracheostomy under a bronchoscopy in a simulation scenario. Dr Jain gave evidence that he considered this should occur shortly after Dr Dixit was unable to pass the suction catheter, despite not yet reaching any view as to whether the tube had become dislodged or blocked:

Because difficult [sic] high airway pressures, so clearly it shows that tracheostomy is compromised, and difficulty in passing the suction, so just if you go through the algorithm in my mind that tracheostomy is compromised.

- 18.7 Dr Jain expressed regret, on reflection, that he did not stop the bronchoscopy at this point in time and remove the tracheostomy tube. Dr Jain also agreed in evidence that there was no need to wait for an ENT registrar to arrive to remove and replace the tracheostomy tube, and that this should have occurred before Dr Jones arrived.
- 18.8 Professor Kelly opined that “*emergency tracheostomy replacement should be a core [skill] of critical care physicians*”. In his first report, Professor Palme opined that “*all senior medical staff in ICU caring for patients with a long-term tracheostomy needed to be able to confidently change a non-functioning tube*”. Professor Seppelt, in his supplementary report, agreed with this opinion .
- 18.9 In evidence, Professor Palme appeared to expand on his opinion by stating that “*any person managing a tracheostomy should be capable in [sic] changing a tracheostomy tube*”. When asked which clinician in particular has the responsibility to ensure this occurs, Professor Palme expressed the following view :

So, there are circumstances where these scenarios occur on the ward. There are circumstances where this occurs in high dependency. There are circumstances where this occurs within the intensive care. And the reality is whoever is the most comfortable and most competent person to do it should do it because the problem with airway obstruction is you only have a short period of time. We are talking a matter of minutes. It is not something that we can remedy by calling in somebody from 10, 15, 20, 30 minutes away. It needs to be done right now otherwise the outcomes are catastrophic.

- 18.10 In his evidence, Professor Seppelt expressed a similar opinion:

My point, which I addressed in one of the reports about the ENT registrar on call - I was pleased and surprised how quickly the ENT registrar arrived, but I think by definition, anybody who is on call from home cannot be relied on showing up for at least half an hour or so, even if they live close to the hospital. So you can't rely on outside help in a life-threatening emergency. You need to have facilities in house.

- 18.11 As to the question of timing, Professor Seppelt opined that the tracheostomy tube should have been removed and replaced “*as soon as it became clear that Adam was not being ventilated*” and “*the tube wasn't in the airway*”. Professor Seppelt went on to note that the bronchoscopy findings showed that the tracheostomy tube was not in the airway but that the clinicians did not appreciate what they were looking at and misinterpreted the findings. Indeed, Professor Seppelt expressed the view that the 55 second duration of the Bronchoscopy Video was longer than what was required to arrive at a diagnosis:

Because that should really have only been a 10-second procedure to go, "This is not in the airway, pull everything out".

18.12 Professor Seppelt went on to explain that the tracheostomy should have been removed at that time by “[t]he most senior person there or whoever was actually standing at the airway”, and that other persons have the necessary skill set to do this then “it doesn’t matter who does it”.

18.13 Professor Seppelt opined that the tracheostomy tube should have been removed before Dr Jones arrived and could not offer an explanation for why this did not occur. He noted the following:

I can certainly speculate on being task-focused and certainly trying to visualise a scenario. There are a large number of people in a very chaotic situation, and while training is to try and not get this problem but certainly recognised phenomenon [sic] and if - if you’re fixated on a particular pathway it - it’s difficult to deviate from that.

18.14 Relevantly, Professor Seppelt offered this view of the mood in Adam’s room at the time of the bronchoscopy:

So on the video, there was at least two people speaking. They were having a conversation and it was literally, “I’m not sure what I’m looking at. Isn’t this interesting?” There’s a sense of calm and a lack of emergency at the time. This certainly evolved into an emergency a few minutes later, but at that time, Adam was breathing. He was well oxygenated and all that was needed was to put the bronchoscope in, diagnose the problem, which was a dislodged tube, remove the tube, and then go from there.

18.15 **Conclusions:** The evidence establishes that the tracheostomy tube should have been removed at the time that the suction catheter could not be passed. This did not depend upon any of the clinicians forming a view as to whether the tracheostomy tube was actually dislodged or blocked. It was within the skill set of Dr Doshi, Dr Dixit and Dr Jain to remove the tracheostomy tube at this point in time. In addition, there was at least one further opportunity to remove the tracheostomy tube during the initial stages of the bronchoscopy. At this time, the bronchoscopy findings showed that the tracheostomy tube was not in the airway, and it should have been removed.

18.16 Removal of the tracheostomy tube at the above points in time could have been performed by any of Dr Doshi, Dr Dixit or Dr Jain. The expert evidence establishes that it did not matter who actually removed the tube, and that removal was not contingent upon the arrival of Dr Jones.

18.17 The evidence establishes that the terms of Plan A of the Airway Plan, the confidence of some of the clinicians, the differences in seniority between the clinicians and their roles within the team and what has been described as the chaotic nature of the situation all contributed to the delay mentioned above. However, as noted above, the clinicians were under an obligation to use their clinical skills and judgment to treat the patient in front of them rather than rigidly adhere to a management plan.

18.18 Further, whilst it can be accepted that the environment in which the clinicians were in became increasingly chaotic, this was not the case at the time that Dr Dixit, Dr Doshi and Dr Jain came to the view that the tracheostomy tube ought to have been removed and replaced. These views were formed at the time the suction catheter could not be passed prior to bronchoscopy. As the Bronchoscopy Video shows, there was still a sense of calm in Adam's room at the time and the situation did not evolve into an emergency scenario until several minutes later when Adam's oxygen saturations began to fall.

18.19 It follows from the above that there was an unreasonable delay in removing and replacing the tracheostomy tube. As conceded by the clinicians, this in turn delayed the management of Adam's airway and contributed to his prolonged hypoxia and eventual cardiac arrest.

**19. Was it necessary or appropriate for the ENT Registrar to be contacted to assist with Adam's care and treatment?**

19.1 Dr Clare gave evidence that upon entering Adam's room, she heard Adam making what she described as abnormal "*obstructed breathing noises*". After activating the emergency alarm at Dr Dixit's instruction, Dr Clare began making phone calls based on her reading of the Airway Plan which referred to calling ENT. As a result, Dr Clare made four phone calls: first to the ENT Registrar, the anaesthetics Registrar, the plastics Registrar, and a second call to the ENT Registrar.

19.2 Dr Jones described the call that he received in this way:

I was informed that there was an issue with the tracheostomy tube. I asked standard questions including what measures had been taken, what they thought the issues were and whether they would like me to attend. I was informed that Mr Fitzpatrick's oxygen saturations were still good and he was breathing spontaneously, that ICU would continue to trouble shoot and would call me back if they had ongoing problems. The [caller] was not at Mr Fitzpatrick's bedside and was relaying information from others who I could faintly hear in the background.

19.3 Dr Jones gave evidence that he was at home on the afternoon of 22 August 2020 when he received two phone calls from a female medical officer (believed to be Dr Clare), with the first call at around 3:25pm. Dr Jones gave evidence that from this first phone call he formed the impression that there was a situation unfolding at the hospital and that he might be requested to attend at some stage. Dr Jones gave evidence that he was not asked to attend but after the call finished, he felt concerned to the point where he was anticipating a second phone call.

19.4 Dr Jones described the urgency of the second phone call as being of "*far greater than the urgency of the first*" phone call, and that he was requested to attend the hospital. When asked if he would have taken it upon himself to attend the hospital if this same urgency had been present during the first phone call, Dr Jones explained:

I think there's a certain level of professional courtesy that if you're not specifically requested, unless you had, like, grave concerns about patient safety, that you wouldn't voluntarily attend if the team had said, "It's okay. We will troubleshoot and get back to you." I think if you're not specifically asked, you wouldn't necessarily attend but certainly, yeah, if I had any concerns or as you said, if the urgency of the original phone call had been greater than I may have left earlier.

19.5 In evidence, Dr Clare agreed that Dr Jones' account of the first phone call that he described in his statement was accurate and in particular agreed that she did not ask him to attend. Instead, Dr Clare gave evidence that Dr Jones told her that he was 30 minutes away and she assumed that because Adam had oxygen saturations of 100% and the clinicians in the room had just started troubleshooting, that "*they would be able to solve this in half an hour*".

19.6 Dr Clare gave evidence that approximately 5 to 7 minutes later, she called Dr Jones a second time. Dr Clare explained the reason for this call in this way:

[I]n the interim I was calling the anaesthetics registrar, who was in the hospital, and the plastics registrar, so that took up a few minutes of my time making the other two phone calls, and then after

the responding calls I checked to see whether we wanted to wait - whether we wanted to get ENT to come in from home. Adam was still stable with saturation of 100% even at the time of the second phone call. I called the ENT registrar back and said we do need you to come.

[...]

I was going to check with the doctors inside the room. They were all actually very focussed on what they were looking at and I ended up checking with the in-charge nurse and asking the nurse whether I should get him – get ENT to come in and the in-charge nurse said yes, so then I called ENT and told him to come in.

- 19.7 Upon arriving in Adam’s room, Dr Jones reviewed the footage from the bronchoscopy and described in his statement that he then proceeded in this way:

I could see a size 8.0 Uniper adjustable flange tube was at the bedside. I proceeded to immediately place this via the mature tracheostomy tract (now day 12). There was no resistance, and the tube went in without any complications. I inflated the cuff which helps secure the tube and attached it to the bag so ventilation could continue with an end tidal CO2 reading. I passed the bronchoscope via the tube to confirm the position. I could see the carina, there was no blood, no granulation and no mucus. The airway was secured.

- 19.8 Professor Seppelt opined that generally speaking, calling an ENT Registrar should not have been necessary in order to replace a patient’s tracheostomy tube. In evidence, Professor Seppelt said the following in relation to the speed and ease with which Dr Jones was able to replace the tube:

So from what I read in [Dr Jones’] statement, it was literally a matter of picking up a tube, putting some lubricant, sliding it into the airway. That’s all it is.

19.9 **Conclusions:** As described above, it ordinarily would not have been necessary for Dr Clare to call Dr Jones. This is because the need to replace Adam’s tracheostomy tube should have been recognised by the clinicians in the room at the time, all of whom had the necessary skills and training to remove and replace it. However, given the circumstances on the afternoon of 22 August 2020, it became both necessary and appropriate for Dr Clare to call Dr Jones.

19.10 There is no evidence to suggest that Dr Jones should have left for the hospital at any earlier point in time. This is because of the difference in urgency between the first and second phone calls that he received, and because Dr Jones was advised during the first phone call that the treating team were still troubleshooting the clinical situation with no specific request made for him to attend.

**20. Did St George Hospital staff respond adequately to Adam's cardiac arrest?**

20.1 This issue has been encompassed in the issues already considered in detail above, and is discussed further below with respect to the resuscitation efforts provided to Adam. However, it is worth noting that in addition, in his first report Professor Seppelt provided this opinion:

The staff response was prompt and rapidly escalated, and the numerical response was more than adequate, bordering on 'too many'. What was needed was one person experienced in complex airways and tracheostomy management, to reinsert the tube.

20.2 Therefore, the evidence establishes that the response to Adam's cardiac arrest was adequate except for the failure to recognise that Adam's tracheostomy tube required removal and replacement, irrespective of whether it was blocked or dislodged. Further consideration of this issue is dealt with in more detail below.

## 21. Was blind instrumentation of the tracheostomy stoma appropriate?

21.1 In his retrospective progress note entry written on 23 August 2020, Dr Jain relevantly recorded the following:

Attempt to pass bougie with ETT through stoma was unsuccessful. Anaesthetics fellow joined at this point to assist with the airway.

[...]

Attempt to pass ETT without bougie was also unsuccessful

Large blood clot came out of tracheostomy stoma with subsequent blood stained fluid.

21.2 In his supplementary report, Professor Palme explained that blind instrumentation will potentially cause the following:

- (a) The bougie to enter the pre-tracheal space leading to further collapse of the anterior tracheal wall and/or soft tissue with worsening obstruction;
- (b) trauma leading to bleeding further obstructing the distal airways and impair gas exchange; and
- (c) trauma to the stoma and further complicate tracheostomy tube insertion.

21.3 Accordingly, Professor Palme expressed the following opinion:

[B]lind insertion of a bougie through the tracheostomy tube in the hope that it ends up in the trachea, is dangerous and an absolute contraindication. It is difficult to understand the rationale behind why this was performed when prior endoscopy identified the tube to be in a false passage.

21.4 As to this issue, Professor Palme expressed the following opinion:

Blind instrumentation in a blocked tracheostomy just doesn't make sense and it will worsen the scenario because it's going to cause trauma to the surrounding tissue, to the trachea. It's going to cause bleeding and it is not going to achieve the aim of what you're trying to do. You know, that would be my opinion and I really can't think of deviating from that.

21.5 It appears that Dr Dixit was not aware of this contraindication. He gave this evidence:

I've seen his explanation. I didn't know that explanation before he mentioned it. I have seen a number of algorithms for the troubleshooting the tracheostomies including UK's national project and also, ACI from New South Wales Health which say bougie can be used. I didn't - I've seen other algorithms as well. So I've seen this algorithms, UK's - especially UK's. So it says bougie, but I didn't know about the significance of this - problems with this until I saw [Professor Palme]'s report.

21.6 In his evidence, Dr Doshi declined to answer a question posed to him as to whether he accepted that blind instrumentation of the stoma caused further airway obstruction. Instead, Dr Doshi indicated that he “*would leave that to experts to comment on that*”.

21.7 In evidence, Dr Jain described the blind instrumentation in this way:

[W]e attempted to replace the tube, but with attempted [sic] with the endotracheal tube which is the part of the algorithm. We attempted to insert endotracheal tube six and a half with bougie and without bougie. So, we made two attempts to pass that, but unfortunately, I regret that I - we should have used other tracheostomy whatever was available at the bedside. Even standard trachy size 8 or size 7. But in that stressful moment I think we already had - it looks like more of a mental block or cognitive load that caused not thinking of [sic] attempting whatever is available at that time.

[...]

So after cutting 3.35 [sic], it became after we had two failures with the putting of [sic] bougie, endotracheal tube with bougie or without bougie through the tracheostomy stoma, I think there was a bit of panic and chaotic situation there when Adam had a low oxygen level.

21.8 There then followed in the evidence this exchange between Counsel Assisting and Dr Jain:

Q. Notwithstanding what you said about who the team leader was, do you think that given your level of expertise and seniority you perhaps could have taken control of the situation differently?

A. Yes, I agree, and I regret that. Yeah, I should have taken that lead - leadership role or, at least, coordinate better.

21.9 **Conclusions:** Blind instrumentation of the tracheostomy stoma was not appropriate. The expert evidence establishes that this can cause complications such as trauma to the surrounding tissue and lead to obstruction of the distal airway. Indeed, Dr Jain's retrospective progress note entry records that following two unsuccessful attempts to pass the bougie a large blood clot came out of the tracheostomy stoma with subsequent blood stained fluid.

21.10 Dr Dixit, based on his understanding of a number of algorithms (primarily from the United Kingdom) associated with troubleshooting tracheostomies, did not on 22 August 2020 appreciate that blind instrumentation was a contraindication. Dr Jain gave evidence that panic and chaos within Adam's room at the time contributed to cognitive overload which prevented the clinicians from recognising the most appropriate course of management, which was to simply remove and replace the tracheostomy tube. Dr Jain accepted that as the most senior clinician he should have taken more of a leadership role in this respect, and expressed regret for not doing so.

**22. Did the procedures in place regarding Adam’s tracheostomy and airway management comply with applicable policies and guidelines, and were they adequate to manage Adam’s condition?**

22.1 In his first report, Professor Seppelt considered that all applicable policies and guidelines from NSW Health and SESLHD were complied with, they were not adequate to manage Adam’s condition. However, in expressing this view, Professor Seppelt also expressed doubt that “*any more policies or procedures would have made a difference*”.

22.2 Professor Seppelt qualified this opinion in his further supplementary report when referring to the failure to use a laryngeal mask airway (**LMA**) during the resuscitation attempts. This is a matter which is discussed in more detail below. Professor Seppelt explained that “*use of the LMA as an emergency airway is explicitly mentioned*” in the NSW Health Policy Directive *Tracheostomy Clinical Management (Adult)* (PD2010\_066) (**Tracheostomy Policy Directive**) and “*was considered standard practice in 2020*”.

22.3 Professor Palme considered that the relevant policies and guidelines appeared to be “*broadly adequate and consistent with standard of care in a patient with a tracheostomy*”, and that the bronchoscopy was performed according to hospital policy. In evidence, Professor Palme elaborated further:

Well, it was - that was their policy, so I guess they followed the – their policy. Was it necessarily correct? I mean, that’s open to debate, and as I said, I would find it difficult to defend that.

22.4 However, he noted that the bronchoscopy worsened Adam’s airway obstruction. Instead, Professor Palme opined that the following should have occurred:

Best practice management would have included retraction of the edges of the tracheostomy stoma, direct inspection of the stoma with appropriate illumination, perform careful suction and insertion of an airway into the trachea under direct vision.

22.5 It was submitted on behalf of the Fitzpatrick family that clause 5.7 of the SESLHD *Tracheostomy Clinical Management Procedures for Adult Inpatients* (SESLHDPR/298) (**Tracheostomy Procedure**) provided that, amongst other things, a “[t]racheostomy emergency response plan specific to critical [sic] nature of patient airway” is considered essential bedside equipment. It was further submitted that the Airway Plan was not specific to the critical nature of Adam’s airway and that regard should be had to two aspects of the expert evidence:

(a) Professor Palme, when referred to the references in both the Airway Plan and the Tracheostomy Plan for the potential need to prepare for a cricothyroidotomy opined:

I think it’s probably just a simple cut and paste from other types of airway management plans, and it actually doesn’t make logical sense;

(a) Professor Seppelt in his further supplementary report described the Airway Plan as “*fine but whoever filled it was on reflex and not thinking about this specific patient*”.

- 22.6 It should be noted that the Tracheostomy Procedure was published in October 2020 and therefore not in force as at August 2020 and irrelevant to the present issue. However, the opinions expressed by Professor Palme and Professor Seppelt regarding aspects of the Airway Plan remain relevant in relation to the adequacy of the Airway Plan which has already been discussed above.
- 22.7 It was also submitted on behalf of the Fitzpatrick family that the Tracheostomy Plan was “*not compliant with the [Agency for Clinical Innovation (ACI)] guidelines at the time*”. This is a reference to the ACI clinical practice guide, *Care of adult patients in acute care facilities with a tracheostomy (ACI Guide)*. Professor Seppelt explained that the ACI Guide was published in October 2021 but “*summarises the evidence and best practice in 2020*”. In addition, Professor Seppelt described the algorithms for the emergency management of tracheostomies in the ACI Guide as being “*extremely clear and well written*” with “*the same information [...] present in the [Tracheostomy Policy Directive] though not as well expressed*”. The algorithms referred to by Professor Seppelt include the LMA as a “*‘bail out’ option which allows oxygenation and restores control in the vast majority of cases*”.
- 22.8 It was submitted by senior counsel for SESLHD that the opinions expressed by Professor Seppelt related to the ACI Guide published in 2021. This is indeed correct. However, the explanation provided by Professor Seppelt above suggests that there are material similarities between the relevant content of the ACI Guide and the relevant policy which existed as at August 2020, namely the Tracheostomy Policy Directive. Notwithstanding, in the absence of evidence regarding the exact content of the Tracheostomy Policy Directive it is difficult to reach a more precise conclusion regarding its adequacy and the extent to which it may have been complied with.

22.9 **Conclusions:** The evidence establishes that whilst, strictly speaking, the relevant policies for tracheostomy management were largely complied with in the sense that the Airway Plan was followed, they were not adequate to manage Adam’s condition because the clinicians involved did not apply their clinical judgement to Adam’s particular clinical situation.

22.10 The one discrete exception concerns the failure to use a LMA as what Professor Seppelt described as a “*bail out*” option during Adam’s resuscitation attempts. Whilst the evidence of Professor Seppelt is that relevant algorithms for the use of LMA were available in applicable policy material as at August 2020, there was no evidence before the inquest as to the actual algorithms in use at the time. Accordingly, it is not possible to reach any further conclusion regarding the adequacy of this policy material or the degree to which it may have been complied with. It should also be noted that whilst neither the Airway Plan or the Tracheostomy Plan referred to the use of an LMA, the evidence establishes that none of the clinicians on 22 August 2020 had regard to the Tracheostomy Plan.

### 23. Was the choice of manual resuscitation device appropriate?

23.1 In his statement, Dr van der Walt described the following after Adam's oxygen saturations fell to 80%:

I went to the head of the bed to assume the conventional airway management role while the senior medical officers attended to troubleshooting the tracheostomy tube. I retrieved the self-inflating bag-valve-mask ventilator (BVM) from behind the bed to commence bag mask ventilation (BMV) [sic]. I held a two-handed seal over Mr Fitzpatrick's mouth and asked for assistance to squeeze the bag, which was provided by Lawrence Keating, Registered Nurse. Mr Fitzpatrick's oxygen saturation increased back to 100%.

23.2 After noting that Dr Doshi was able to pass the bronchoscope through the tracheostomy tube, Dr van der Walt described the next sequence of events:

The trachea tube was still connected to the ventilator. At this point Dr Doshi advised that there was no need to BMV from the mouth, as the tracheal tube was believed to be in the trachea with the cuff inflated, so I removed the BVM from Mr Fitzpatrick's mouth.

Dr Jain requested a longer tracheostomy tube. This was not available at the bedspace and had to be sourced from an operating theatre or the ear, nose and throat (ENT) unit. While this was being sourced Mr Fitzpatrick's oxygen started to desaturate again. Dr Doshi attached the BVM to the tracheostomy and bagging was recommenced, but the oxygen saturation did not improve. We noted neck swelling while bagging from the end of the tracheostomy tube and the tracheostomy ties had to be cut due to the swelling. The tracheostomy cuff was deflated and BVM over the mouth was recommenced, I held the two-handed seal while someone else squeezed the bag.

23.3 Following this, Dr van der Walt described encountering resistance, and expressing difficulty, after taking over squeezing the BVM, with Adam's oxygen saturations continuing to drop.

23.4 In his further supplementary report, Professor Seppelt considered that initially it was reasonable and appropriate for a BVM to have been used "*very carefully*" on the tracheostomy tube. However, Professor Seppelt explained that this was conditional upon the tracheostomy being in the airway. Professor Seppelt went on to explain the following:

If anything does not [feel] 'right' however, and especially once a dislodged tube is suspected, it is **very important to not try to ventilate through the tube** as gas will be forced under pressure in to the mediastinum [the structures in the centre of the chest outside the airways] and this is potentially lethal. [original emphasis]

23.5 Professor Seppelt explained that once BVM ventilation is unsuccessful, there are two options:

- (a) a transglottic airway, which involves an endotracheal tube being passed through the glottis; or
- (b) a supraglottic airway, which involves a tube (with the most common of these being a laryngeal mask airway (**LMA**)) sitting in the pharynx above the glottis to provide an airway.

23.6 Professor Seppelt gave evidence that if the tracheostomy tube was correctly positioned in the trachea with the cuff inflated then there was no need to use the BVM from the mouth. However, Professor Seppelt was asked for his view if the tracheostomy tube was not correctly positioned:

Well, it clearly wasn't. The way [sic] a very chaotic situation would have been evolving - I don't have a problem with that statement, but to then - there should have been rapid recognition that wasn't the right thing to do.

23.7 Professor Seppelt opined that whilst it was reasonable for the BVM to have been used first, this should not have been use as an alternative to a LMA. Professor Seppelt also expressed this view:

It is unfortunate that an LMA was not inserted in [Adam]'s case as I think there was a good chance it would have allowed control to be restored.

23.8 Dr van der Walt gave this evidence regarding the use of the BVM and not the LMA:

I think at the time I would have thought that with [Adam's] facial fractures and the swelling and everything that I wouldn't be able to put in an LMA. I accept that, you know, thinking back about it now it's the glaring obvious thing - why didn't we do that. I think we were a bit tunnel visioned. A little bit a lot tunnel visioned at that stage. But certainly, I think an LMA would have been a more appropriate step to attempt before endotracheal intubation which would have been - which we anticipated to be very difficult in any case.

23.9 For completeness, it should be noted that the position of the pressure limiting valves override on the BVM was relevant and made no difference. This is a device found on some models of resuscitation bags to allow the deliberate application of a higher pressure than can generally be achieved . Professor Seppelt explained that this is because ventilation into the pre-tracheal space will always be harmful and oral ventilation was never effective, regardless of the position of the override.

23.10 **Conclusions:** Whilst it was initially appropriate and reasonable to use a BVM for ventilation, its continued use was not appropriate once tube dislodgement was suspected. At that time, a LMA should have been used. Dr van der Walt considered that due to the nature of Adam's injuries there may have been some difficulty with using a LMA. Dr van der Walt sought to explain that other ventilation options were not considered due to what he described as "*tunnel vision*" on the part of the clinicians in the room.

23.11 The expert evidence establishes that whilst the events in Adam's room were chaotic and stressful, it should still have been recognised that use of the BVM was no longer appropriate. The expert evidence also establishes that if a LMA had been used there was a "*good chance*" that Adam's airway could have been effectively managed.

## 24. What was the cause of any suspected tension pneumothorax?

24.1 Professor Seppelt described the significance of a tension pneumothorax in this way:

[T]he word tension means is that there's an increased pressure so - so a simple pneumothorax can be well tolerated. There's air in the plural space but provided there's not too much you can still walk down the street with it. A small to moderate sized pneumothorax. Tension means that there's an increased pressure and specifically the - the pressure is high enough to obstruct the venous return.

So, blood flows back to the heart. There's two big veins, the superior and inferior vena cava from upper and lower parts of the body. That passes through the mediastinum. If the pressure in the plural space is higher than the venous pressure than there's no blood flow back to the heart. If no blood is flowing back to the heart then no blood can come out the other side and that's what a tension pneumothorax is.

24.2 Professor Seppelt explained that as a BVM was being used to attempt to ventilate Adam through a displaced tracheostomy tube that was sitting in the pre-tracheal space, this caused positive pressure ventilation of the mediastinal space. This in turn resulted in tension pneumothoraces.

24.3 **Conclusions:** Adam's tension pneumothoraces were caused by the use of a BVM to attempt to provide ventilation when the tracheostomy tube was incorrectly positioned in the pre-tracheal space. This had the effect of causing positive pressure ventilation of the mediastinal space eventually resulting in tension pneumothoraces.

**25. Were tension pneumothoraces suspected in a timely manner? Was decompressive finger thoracostomy performed in a timely manner, and was this within the skill set and scope of practice of the clinicians involved?**

25.1 As referred to above in Dr van der Walt's statement, after Dr Doshi attached the BVM to the tracheostomy tube, swelling was observed in Adam's neck. Professor Kelly considered this to be of significance and explained:

There were – there were actually two reasons to be suspicious about a pneumothorax. One was that we now had - had a proven secure airway, that was – but was not solving the problem.

[...]

The oxygenation was not improving. So the usual process is to go through the potential causes for that, and in this course a prime potential cause was a pneumothorax. And – and the signs, that there was – there was swelling of the neck as well. So there was the – the two – that there was the – going through the causes that could cause this, and then there was the – there is evidence of a neck swelling.

[...]

In the situation where we don't have – yet have a secure airway, I would've been thinking I would've been suspicious of a pneumothorax. But when we have a confirmed airway and we're not getting better, a tension pneumothorax has jumped right to the top of my list

25.2 Professor Kelly went on to describe three interventions in response to a tension pneumothorax: needle thoracostomy, finger thoracostomy and microcatheter placement (whilst acknowledging that this third intervention is more commonly used by emergency physicians). As to the timing of intervention when Adam's airway had been re-established (with no return of spontaneous circulation but evidence of neck swelling) Professor Kelly gave the following evidence:

I might even, admitting that I have the benefit of hindsight, if I had been aware that there was neck swelling, even though we didn't have an airway yet confirmed, I would have been filing in my mind that we need to get the airway and then I was suspecting a pneumothorax and I would probably have been saying, "Let's prepare to intervene as soon as we get the airway sorted".

[...]

In a patient that you're going to mechanically ventilate, in mechanical ventilation, you deliver higher airway pressures. And so in a patient in whom is suspected any pneumothorax that you're going to ventilate, my personal approach would be saying, "Actually, I don't want to run the risk of developing tension. Let's make sure that we can't be having – by doing the intervention".

25.3 Professor Kelly agreed that there was no need to wait until the suspicion was greater for a tension pneumothorax, or that it was clear that one was present. She explained:

[E]specially a situation like this where Adam was now so unstable and critically ill. There's a risk balancing, and that risk balancing comes with experience obviously, but, you know – and it's well known that clinicians find it harder to do things than to not do things in terms of interventions. But, you know, I would've been going, "Actually, that's suspicious of a pneumothorax". I would be – if I couldn't get a quick chest x-ray, I would be having a feel of the neck and going, "Yeah, that's gas to me. Let's go ahead and put the" – in my case, it would be the microcatheters in.

25.4 Professor Seppelt gave evidence that when Adam's oxygen saturations began to drop after his airway had been re-established this, together with the neck swelling confirmed that the

tracheostomy was outside the airway and some gas was being forced into the mediastinum. Professor Seppelt gave evidence that this “possibly” represented the starting point of the commencement of pneumothorax. Professor Seppelt went on to explain that Adam’s neck swelling and the absence of a return of spontaneous circulation more likely than not represented a tension pneumothorax. He explained:

So, having thought of that as a possibility then you’ve got an obligation to either deal with it or rule it out.

25.5 Professor Seppelt considered a needle thoracostomy and a finger thoracostomy to be “both valid techniques”. As to when either should have been performed, Professor Seppelt opined:

In terms of the timing, the right time to have attempted one of them was, I think, within a few minutes of re-inserting the tracheostomy. Allowing a bit of time for that whole diagnostic process of - “There’s no return of spontaneous circulation. What’s the reason? Is it this? Is it this? Is it this? Okay, we better decompress the chest.”

25.6 In his statement, Dr Jain described the following after the tracheostomy tube was replaced and Adam’s airway was re-established:

Around this time I performed a physical examination of Mr Fitzpatrick since he was difficult to bag mask, and noted that he had subcutaneous emphysema around his neck and upper chest with poor breath sounds on both sides of his chest. He also displayed significant abdominal distension.

25.7 In evidence, Professor Seppelt was asked whether the observations made by Dr Jain described above should have led to a reasonable suspicion of pneumothoraces at that time. He said:

Quite possibly, yes. That’s certainly difficult to answer without actually being there and it’s a – a judgement thing at the time.

[...]

All of the signs there are – are definitely consistent with pneumothorax. In this sort of emergency, clinical examination is incredibly hard so while you might try – try and listen for breath sounds with a stethoscope, if you can imagine doing that in a very noisy room with a lot of other things happening, it’s pretty – pretty hard to be sure. But what – what is described certainly is consistent. The comment about abdominal distension, that could also relate to attempts to mask ventilate if during attempts to mask ventilate gas passes down to the stomach, you can actually cause abdominal distension doing that.

25.8 Dr Dixit gave evidence that at some point prior to the arrival of Dr Langcake, he recalled hearing Dr Doshi ask Dr Jain whether tension pneumothorax might be the cause of Adam’s cardiac arrest. Dr Dixit said that a number of further steps were then taken including bilateral needle decompression, a bedside lung ultrasound, an echocardiogram (to rule out cardiac tamponade or dilated right ventricle), an orogastric tube was used to decompress the distended abdomen. These further steps took around 25 to 30 minutes from the time that Adam went into cardiac arrest and were completed shortly before Dr Langcake arrived at 4:00pm.

25.9 Dr Doshi gave evidence that after Adam's airway was secured, and having regard to Adam's neck swelling, he considered tension pneumothorax to be the cause of the cardiac arrest. Dr Doshi gave evidence that he had the necessary skills and training to perform a bilateral finger thoracostomy, considered that he could have performed it, and suggested on more than occasion that it be performed. When asked why he did not do so, Dr Doshi gave evidence that Dr Jain expressed his opinion that "*it was not required*". Dr Doshi also explained:

I was a team leader and as a team leader - the role of the team leader is to direct the team members to do the procedures and monitor the entire - monitor and manage the entire resuscitation scenario, rather than actively participating in any procedure.

25.10 Dr Doshi was asked whether any explanation was given as to why Dr Jain overruled his views regarding whether a tension pneumothorax had been ruled out. He said:

What I can recall and, again, looking at my contemporaneous notes, I was told that we already did the needle thoracostomy and there was no air gush, so let's look at the other causes.

25.11 As to the question of timing, Dr Doshi gave the following evidence:

So once Dr Jones secured the tracheostomy, confirmed the position of the tracheostomy with bronchoscope, and then what's the usual sequence of CPR we continue CPR and at the end of two minute at next rhythm check, what we call it, we see what's the rhythm and we see the pulse which was not there, it means Adam is in persistent cardiac arrest. For the next step was done as putting a bilateral long needle which is the first step in relieving tension pneumothorax. And after that, if still he is in cardiac arrest then next step would be to do a finger thoracostomy.

25.12 In evidence, Dr Doshi was asked whether he had an obligation as team leader to drive certain steps in Adam's management. He said:

[The t]eam leader has obligation [sic] to make decisions but in such situation [sic] in a hospital setting, especially in tertiary care, when there is a consultant who is present, who was also my supervisor of training who is senior to me in experience and in designation, I'm obliged to follow their advice, especially in such complex situation.

25.13 Dr Doshi agreed with counsel for Dr Jain that other than the question of whether a tension pneumothorax had been ruled out, there was no other disagreement about the steps taken in management between when Adam's airway had been re-established and the arrival of Dr Langcake.

25.14 Dr Langcake gave evidence that the absence of a hiss during a needle thoracostomy would possibly suggest that a tension pneumothorax was not present but that this is "*never an absolute*". Dr Langcake explained that the absence of a hiss may be due to a number of reasons including blood being present which might block the end of a needle, or the needle not being long enough to enter the chest cavity. Dr Langcake gave evidence that she did not consider it unreasonable for a clinician who, having carried out a needle thoracostomy and not hearing a hiss, to form a view that a tension pneumothorax is not present. Dr Langcake explained:

I think they were working on the evidence they had and so it would not be unreasonable for them having performed that procedure with the needle that was done and not hearing a hiss, it would not be unreasonable for them as they're working through the algorithm, to say it doesn't appear to be a tension pneumothorax.

25.15 Dr Langcake was asked whether performing a finger thoracostomy would be the next step following the needle thoracostomy. She gave this evidence:

No. That wouldn't be an assumption I could make because that's a surgical skill and that might not be in the skillset of the attending doctors. It's a skillset that we as surgeons have that the emergency doctors have that the prehospital personnel do, but it isn't in the skillset of any doctor in the hospital

25.16 Dr Langcake went on to explain that her expectation of ICU personnel being able to perform a finger thoracostomy would be dependent on their training.

25.17 Relevantly, Dr Jain gave evidence that he had performed more than 100 intercostal drain insertions (also known as tube thoracostomies) in an elective setting but had only done one emergency chest drain insertion in 2015. Dr Jain gave evidence that he had also performed finger thoracostomies as part of an elective procedure but never in an emergency situation.

25.18 Professor Seppelt considered this issue in his further supplementary and opined:

It should not be necessary to call outside staff to decompress a tension pneumothorax and this falls within the skill set of an intensive care specialist. All intensivists should be able to do (non-emergency) tube thoracostomies, and the incision and initial decompression of pleural space (whether with finger or forceps) is the first step before subsequent placement of a chest tube.

25.19 Dr Jain's view was that "*tension pneumothorax hypoxia was always [the] highest cause for ongoing [...] cardiac arrest at that time*". He said that he came to this view about four or five minutes after the tracheostomy tube had been replaced.

25.20 Dr Jain was asked what he would have done next if Dr Langcake had not been, or could not be, contacted. He said:

Probably we would have proceeded with the finger thoracostomy, it is just the time I was reaching to the time that probably we have to proceed. Dr Langcake arrived. If I would have or Dr Dixit would have performed the procedure, probably we would have taken more time to perform that procedure than Dr Langcake performed it because she performs that procedure more regularly especially in emergency situation. Probably I would have taken more time than the surgeon or any of them. There were two surgical trainees outside standing out of that room. There was an ENT surgeon. ENT registrar was standing outside the room, and there was a plastic registrar, both are competent to do the finger thoracostomy. But by then I think I was just thinking of other causes or whether there were any other process that needs to be ruled out.

25.21 In his further supplementary report, Professor Seppelt recognised that it is difficult to ascertain the precise timing of certain events from the available medical records and statements. Notwithstanding, he expressed this opinion:

There is no doubt there was an avoidable delay before Dr Langcake [a trauma surgeon] attended and performed the decompressive finger thoracostomies, and overall it has been estimated Mr Fitzpatrick had been in cardiac arrest for 46 minutes.

25.22 **Conclusions:** The expert evidence establishes that the clinicians on 22 August 2020 ought to have suspected the possibility of a pneumothorax even before Adam's airway was secured. This suspicion ought to have been confirmed in the minds of the clinicians once the airway was secured, and with recognition of neck swelling and no return of spontaneous circulation.

25.23 Therefore, within a few minutes at most of the tracheostomy tube being removed and replaced, intervention in form of needle or finger thoracostomy ought to have been performed. The expert evidence establishes that both interventions were within the skill set and scope of practice of the clinicians present in Adam's room. Although a needle thoracostomy was performed, the absence of a hissing sound (representing a gush of air) provided a false sense of reassurance at least to Dr Jain that a pneumothorax was not present. The expert evidence establishes that the clinicians were obliged to rule out the possibility of a pneumothorax completely before proceeding to consider other possible reversible causes of Adam's cardiac arrest.

25.24 Indeed, Dr Doshi's evidence was that the next step in Adam's management was to perform a finger thoracostomy. Dr Doshi suggested more than once that this be done but deferred to Dr Jain, due to his seniority, who was of the view that it was not required. This is despite Dr Doshi accepting that as the team leader he was obliged to make such decisions regarding a patient's management.

25.25 The performance of further investigations to rule out other reversible causes of Adam's cardiac arrest further delayed the performance of a finger thoracostomy. Dr Jain eventually gave consideration to this being performed only several minutes before the arrival of Dr Langcake who almost immediately performed the procedure.

**26. Was there adequate communication and liaison between St George Hospital and Adam's family?**

26.1 In her evidence, Mrs Fitzpatrick was asked directly by senior counsel for the Fitzpatrick family to provide a synopsis of this issue from 22 August 2020 onwards. Mrs Fitzpatrick gave the following evidence:

It would have been I think far easier for us as a family to accept what had happened and to be able to grieve and not be fighting all this time to get answers had the communication been honest at the start, had doctors or nurses or something admitted mistakes, had we been told the truth right from the start. I think it would have been just so much easier for us. Instead we've spent, you know, close to three years now just still waiting to get the answers which could have been provided to us right at the start.

26.2 In his first report, Professor Seppelt considered this question and acknowledged it to be a difficult one to answer based upon the medical records. However, Professor Seppelt opined that from the records and statements that he had reviewed, it appeared that "*there had been adequate communication and liaison*".

26.3 In her first report, Professor Kelly also considered this issue and expressed the following views:

[T]he various versions of events make it clear to me that there was miscommunication and mistrust between the clinicians and the family. The variations in the accounts of the clinicians that the family perceive to have heard did not help this.

In my experience, it is not uncommon for there to be slight variations in recall of events in unexpected emergencies such as this, especially events that have multiple phases and a poor outcome. Also, in my experience, soon after such events the involved clinicians are also stressed and often undertake a self-critical period of reflection on their actions that can be perceived badly if expressed to others at that time (clinicians or non-clinicians). This to some extent explains, but does not excuse, the miscommunication that appears to have occurred.

26.4 In Adam's case a "*hot debrief*" was conducted following the resuscitation attempts to examine the events that unfolded and identify any concerns that those involved might have about the process. Dr Langcake, who was invited to attend the debrief, gave evidence that it is an emotional event given the need for it to occur contemporaneously. The family meeting followed shortly after this debrief.

26.5 Professor Kelly went on to offer a number of ways which she considered that such communication issues could be improved:

- (a) Having a designated clinician leader at the initial family meeting with specific training and experience in communicating unexpected emergency events;
- (b) Having a smaller, rather than larger, team at the initial family meeting that possesses sufficient information to answer a family's main questions and "*undertake to obtain timely answers for additional questions that arise*";

- (c) Having the leader from the initial meeting address all subsequent communications in a frequent, open and honest manner;
- (d) Advising families that “*a review of the events will be undertaken by a defined process and that, where possible, the outcomes of that review will be shared with them*”;
- (e) Being clear with families about likely outcomes and using language that is clear and accessible.

26.6 Specifically in relation to Adam’s case and his prognosis, Professor Kelly expressed the following view:

In my opinion, the ICU clinicians knew or ought to have known that, due to a very long period of cardiac arrest, [Adam] was very unlikely to make a good neurological recovery and that it was probable that he would die. This could have been better communicated. Although it is true that we sometimes get surprises about a patient’s recovery, the practice I have seen of saying that 48 hours will be needed after a cardiac arrest for the prognosis to be clearer is not one that families readily comprehend.

26.7 The last of these matters was acknowledged by Dr Sharma in her evidence when she said:

So in the [sic] hindsight, I would reflect. The open disclosure meeting should have been conducted better. And probably at a different time. Not at a time when the family understandably was emotionally distressed. And as a medical team leader, myself, and the other team members were in a shocked state. I should have allowed the family members to come and spend time with Adam. And then followed the process of open disclosure discussion.

26.8 The matters raised by Mrs Fitzpatrick and Professor Kelly were acknowledged by Dr Boss in her evidence, who said:

I agree entirely with that and, certainly, one of the things that I took away from that first conversation with the Fitzpatrick family was that we let the family down around that communication early on. We have done some work at the executive level around that.

When we identify an incident now, one of the first things that we do is appoint a dedicated family contact that’s at the executive level. In the past, that might have been one of the clinicians involved, or one of the clinicians in the unit. Now we make sure that the dedicated family contact, right from the very beginning, is an executive member because we have the capacity to make sure that the family’s concerns can be passed onto the right people, and also have the capacity to make decisions that might assist the family. We really failed you in that regard, and I am very sorry for that. So that’s one thing that we have tried to do that we took away as a learning, out of Adam’s death; that we need to do better.

26.9 Dr Boss gave evidence that the above changes are not intended to replace communication between clinicians and family members. However, Dr Boss explained that apart from training provided by the Health Education and Training Institute, St George Hospital has provided additional open disclosure training packages on a regular basis that use case studies relevant to the ICU. In addition, other training has been provided to educate clinicians outside of the ICU more broadly regarding the importance of open disclosure.

26.10 Mrs Fitzpatrick also gave evidence regarding an incident which occurred on the morning of 26 August 2020:

So Adam had gone to organ donation and we were waiting for the records to be delivered. Theresa Jacques came up and she took the [Airway Plan] off the doorway and she and one of the other documents were discussing it. I pulled down [the Tracheostomy Plan] and I handed it to her and said, "If you're going to look at that one, you know, maybe you should take this one too" because they were both similar sort of plans, and she basically ripped it out of my hands and said, "That's evidence, you can't take that and it's got, it's got to go back on the wall", and she basically sort of - you know, it was quite affronting. And she insisted that [the Tracheostomy Plan] was put back on the whiteboard, and she just walked off with the [Airway Plan].

26.11 Mrs Fitzpatrick gave evidence that during the family meeting which Dr Jacques attended, she enquired why the steps in the Airway Plan were not followed, and in particular why a cricothyroidotomy was not performed. Dr Jacques gave evidence that she was "*a little bit puzzled*" by the perspective of both Adam's family and the ICU staff with reference to the Airway Plan. In her statement, Dr Jacques said that she told Adam's family that she did not consider a cricothyroidotomy to be appropriate because Adam had a tracheostomy. Dr Jacques said that she "*sought to give a clear, brief and honest answer to the question posed based on Adam's particular circumstances*". However, Dr Jacques went on to state:

In hindsight, I recognise that my response may have been too brief and that Mrs Fitzpatrick was left with further questions. I deeply regret any concern I may have caused as a consequence .

26.12 Dr Jacques gave evidence that she focused, at that point in time, on the Airway Plan as she was aware that the clinical staff were relying upon that document as opposed to the Tracheostomy Plan. As to why she did not take both documents, Dr Jacques gave this evidence:

My focus was genuinely on trying to keep all the information together and for things, it was a loose piece of paper and I didn't want it to get [sic] missing.

26.13 Mrs Fitzpatrick also gave the following evidence regarding attempts made by Adam's family to obtain information relevant to his care and treatment:

We requested all Adam's medical records at the time of the incident and some were provided. Closer examination of these, found that numerous items were missing, including but not limited to the ICU records, the medication charts, scans taken at Adam's bedside during the incident, the bronchoscopy video, the records of rocuronium being given, the diagnostic ultrasound taken during the event and the cardiac arrest code summary that we had specifically requested.

Over the following months I continued to request these records, initially from the social worker who helped us obtain the first set, then from the Medico-legal Department, the Patient Safety Manager, and finally from the St George Hospital Executive, Director of Medical Services.

I made numerous phone calls and sent over thirty emails requesting specific medical records during the six months following Adam's death with records promised but only some provided.

It was found that the Emergency Airway Plan and the Tracheostomy Management Plan, that Theresa Jacques had called evidence, had been destroyed.

[...]

On 24 February 2021, 6 months after Adam's death, the Patient Safety Manager advised that the Biomedical Engineering team had advised her that unfortunately the technology does not store historic information - the logs don't usually go back for more than 3 months. They are not able to get any data/reports from the resuscitation machine or the scanning equipment used during Adam's resuscitation.

The stress of having had to continually fight to receive these records significantly added to our family's distress at a time when we most needed support from the hospital. To be told that the records were destroyed three months prior is appalling.

26.14 In response to the above, both in her statements and in evidence, Dr Boss explained the following:

- (a) Since August 2020, St George Hospital has implemented the **REACH** (Recognise, Engage, Act, Call, Help) program, developed by the Clinical Excellence Commission in collaboration with Local Health Districts and consumers, across the entire hospital. REACH is a system that helps family members and carers of a patient to escalate their concerns with staff about worrying the changes in a patient's condition.
- (b) St George Hospital was unable to adequately address the matters raised by the Fitzpatrick family due to the need to conduct an independent fact-finding investigation (which was later delayed by the effects of the COVID-19 pandemic), assist an active coronial investigation, and manage complaints made to the Health Care Complaints Commission (**HCCC**) about individual staff members.
- (c) When she initially attempted to obtain electronic data from the ventilator and other electronic equipment used in Adam's case she was informed that the data is recorded on a continuous loop which recycles every three months. Dr Boss was unaware until the time of the inquest that the data is in fact uploaded and stored on the Electronic Record for Intensive Care (**eRIC**) information system indefinitely. Dr Boss explained:

It was as simple that I had asked the question in the wrong way in the first place, and [during the inquest], prompted by some of the questions that had come out, I asked the question in a different way to somebody who said, "I'll look up the 45 minute-by-minute data", and I said, "I don't know what you're talking about", and then it was explained, and then I said, "Get it for me now".

- (d) Dr Boss referred to the announcement made by NSW Health to introduce a Single Digital Patient Record (**SDPR**), with SESLHD being one of the first Local Health Districts being asked to develop and implement the SDPR for NSW. Dr Boss explained the significance of the SDPR in this way:

The value of a single digital patient record is that you go into one system and then you will have access to all of the various electronic platforms that contain all of the various patient medical records that you might need to use, so that will make it easier for clinicians, and it will be just one place that you will have to go to, to be able to download all of the patient's medical records in the event of a medical, legal, or a coronial inquest.

26.15 It was submitted on behalf of the Fitzpatrick family that the REACH program “*deals with the escalation of concerns to prevent an incident like occurred [sic] to Adam from happening in the first place [but] it does not address problems of the kind that occurred after the incident on 22 August 2020*”. This submission is indeed correct. However, it appears that the other improvements made by St George Hospital, namely additional open disclosure training for ICU clinicians in particular and the appointment of a dedicated family contact at the executive level, do address the concerns raised by and on behalf of the Fitzpatrick family.

26.16 **Conclusions:** The manner in which St George Hospital staff communicated with Adam’s family was not entirely adequate. In particular, Adam’s family were not immediately provided with a clear understanding of his prognosis following his cardiac arrest or the contributing factors to this outcome. Further, legitimate queries held by Adam’s family about the clinical decision-making involved in managing his airway before and during the emergency on 22 August 2020 were not addressed in a clear and forthright manner.

26.17 It appears that the stress and emotional toll involved with the events of 22 August 2020 contributed to the first matter, whilst ambiguous aspects of the Airway Plan and Tracheostomy Plan contributed to the second matter. However, the expert evidence establishes that whilst this may explain the miscommunication with Adam’s family, it does not excuse it.

26.18 The evidence also establishes that the Fitzpatrick family encountered significant obstacles and delays in being provided with relevant information and records related to Adam’s care. Whilst much of this can be explained by a legitimate misunderstanding of technical aspects of record-keeping and the need for St George Hospital to follow certain processes to allow for an informed and considered response to be provided to the Fitzpatrick family, it does not diminish the understandable distress and frustration felt by them.

26.19 Since August 2020, improvements have been made to the processes described above which appear to mitigate against the possibility of similar inadequacies in communication between a hospital and a patient’s family. At the local level, there has been additional open disclosure training provided to clinicians to assist with more meaningful interactions with family members and dedicated personnel to ensure accurate and helpful information sharing. At a broader level, technological improvements to the ways in which patient records are stored and accessed will hopefully make this information sharing more timely, effective, and accessible.

## 27. Is it necessary or desirable for any recommendations to be made pursuant to the Act?

### ***Amendment of Adam's clinical record***

27.1 Following on from the issues regarding communication described immediately above, it was submitted on behalf of the Fitzpatrick family that a recommendation ought to be made that St George Hospital “take steps to amend Adam’s clinical records to accurately reflect what occurred on 22 August 2020”. Reliance was placed on the following aspect of Dr Boss’ evidence in this regard:

Q. [...] As I understand, part of the purpose of the inside investigation was to correct Adam’s clinical records. And as a mark of respect for Adam, the family would ask whether that’s something that St George Hospital would consider doing.

A. Yes, I will - I will absolutely look at how I can best do that.

27.2 It was submitted by senior counsel for the SESLHD that:

The SESLHD has already confirmed that an addendum will be added to Adam’s clinical records to accurately reflect what occurred on 22 August 2020. This will be done by [St George] Hospital adding an entry to Adam’s electronic medical record to retrospectively amend it after [the] Court hands down its findings.

27.3 **Conclusions:** As the submissions on behalf of the SESLHD confirm the evidence given by Dr Boss, it is neither necessary or desirable to make a recommendation regarding this matter.

### ***State-wide review of tracheostomy management***

27.4 During Professor Palme’s evidence he was asked whether he could articulate any system improvements that might be made to mitigate against the possibility of another event like the one involving Adam from occurring again. Professor Palme gave this answer:

I think this is a very sad and tragic case and I really want to pass on my condolences to the family because, you know, this is just awful. But unfortunately, it’s not an isolated scenario. We see this, you know, not too infrequently, and why? Because people die from airway obstruction very, very quickly. And in terms of tracheostomies, I’m an ear, nose and throat surgeon, so this is my domain, I guess, and I find there is a fundamental misunderstanding or lack of understanding of tracheostomies amongst many specialists, and particularly specialists you would feel should know about tracheostomies, and I think this is what leads to some of these scenarios, and particularly this tragic scenario that we see in front of us.

And the problem is that I think there is just no consistent education, no consistent training, and as we can see by these emergency management plans, they’re complex; they’re inconsistent; they’re not correct; they vary from hospital to hospital, and I think that really complicates how we manage these patients. And I think it would be a great outcome from this - from this hearing that we would look at reviewing tracheostomy management data in the state, develop a consistent management strategy that is - that is constant across all public health institutions, create standardised training and mandate them.

27.5 During her evidence Dr Boss was asked to comment on, and offer her thoughts regarding, Professor Palme's evidence. Dr Boss gave this evidence:

Yes, absolutely would welcome that at a state level. As I said, we're a training hospital, we have trainees that are moving around, and so having consistency for the hospital, the hospital is absolutely critical.

27.6 It was submitted on behalf of the Fitzpatrick that, having regard to the above evidence (and the absence of a standardised emergency algorithm for tracheostomy management), *"it is within the power of the Coroner to recommend that a review of tracheostomy management is undertaken at the state level by the Ministry of Health. Further, the family submits that at the finalisation of this review all hospitals in New South Wales should adopt a standardised emergency algorithm for tracheostomy airway emergencies"*.

27.7 It is acknowledged that Professor Palme is sufficiently skilled, knowledgeable and experienced to provide the evidence set out above. Whilst Professor Palme's evidence indicates that many of the issues which this inquest examined are evident at a broader level, examination of these matters are beyond the scope of this inquest. Apart from Professor Palme's evidence, the inquest did not receive or consider any other evidence of similar incidents that would allow a conclusion to be reached about the occurrence or otherwise of such incidents. As senior counsel for the SESLHD correctly submitted, it is expected that data regarding such incidents would be held by organisations such as NSW Health and the NSW Clinical Excellence Commission who are not parties to the inquest.

27.8 **Conclusions:** In any inquest examining a death in a hospital setting, there are obvious challenges in making a recommendation at a State-wide level following a single adverse event. There is often little evidence about whether systems factors which contributed to the event exist at the level of a Local Health District (where several other hospitals may be situated), let alone at a State-wide level. Similarly, there is often little evidence about the resource and practical implications that are involved in seeking to put into effect any such recommendation.

27.9 On one view, rather than advocating for generalised and widespread change, the evidence of Professor Palme and Dr Boss is primarily directed to ensuring that adequate education and training exists for clinicians involved in tracheostomy management, particularly in an emergency situation. Adequacy in this sense is reflected in such training being effective, consistent, and mandatory. This inquest has already considered such issues as they relate to St George Hospital and Adam's case. Within the limited scope of the inquest and the provisions of the Act, the inquest has not been able to consider any evidence more broadly. Accordingly, it is neither necessary or desirable to make the recommendation which the Fitzpatrick family submits ought to be made.

## 28. Operation of section 151A(2) of the Health Practitioner Regulation National Law (NSW)

28.1 It was submitted on behalf of the Fitzpatrick family that the following health practitioners “*should be referred*” to the Medical Council, the Nursing Council of New South Wales (**Nursing Council**) or AHPRA:

(a) Dr Sharma;

(b) Dr Jain; and

(c) RN Chan.

28.2 Having regard to the evidence available to the inquest and the conclusions reached above, it is appropriate to also give consideration to the conduct of Dr Dixit and Dr Doshi.

28.3 In support of the above submissions, it was further generally submitted on behalf of the Fitzpatrick family:

Aside from criminal charges, if a driver is at fault their licence is removed to prevent further harm. If a builder fails to make a safe building they also have licences revoked until they have proven safety measures in place, yet in our medical system there is no mandatory removal of licence, or penalty involved when doctors are involved in incidents like this one.

An apology is not enough, nor is mandatory training, as this had also supposedly been completed before the incident and the doctors involved professed to have the necessary skills, yet failed to use them. Measures need to be put in place to ensure that not only do the medical practitioners have the skills, but that until they are competent and confident enough to use them they are adequately supervised. For this reason we request that various practitioners are referred to AHPRA.

28.4 Several points should be made regarding the above submissions.

28.5 First, according to its website, AHPRA (in partnership with a number of National Boards) “*ensures the community has access to a safe health workforce across all professions registered under the National Registration and Accreditation Scheme*”. One of the core regulatory functions of AHPRA is to “*manage complaints and concerns raised about the health, performance and conduct of individual health practitioners on behalf of the National boards, except in New South Wales and in Queensland*”. In these States, the role of AHPRA is to manage notifications which are referred to it. The AHPRA website provides that in NSW, concerns about registered health practitioners should be directed to the NSW Health Professional Councils Authority (**Councils Authority**) or the HCCC.

28.6 Second, the Councils Authority lists both the Medical Council and Nursing Council in its list of health professional councils of NSW. It appears then that, in the present context, both of these Councils are best placed to potentially consider the matters advanced in the submissions on behalf of the Fitzpatrick family regarding the conduct of Dr Sharma, Dr Jain and RN Chan.

28.7 Third, the Act does not provide for legislative pathway for a person “to be referred” to the Medical Council, Nursing Council or AHPRA. Instead, section 82 of the Act provides:

**82 Coroner or jury may make recommendations**

- (1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.
- (2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation –
  - (a) public health and safety,
  - (b) that a matter be investigated or reviewed by a specified person or body.

28.8 Therefore, in the present context, a Coroner may recommend that the Medical Council or Nursing Council (or indeed the HCCC) investigate or review the conduct of a registered health practitioner if the Coroner considers it necessary or desirable to do so. It is understood that where the submissions on behalf of the Fitzpatrick family invite consideration of whether a registered health practitioner is to be “referred”, this is an allusion to section 151A(2) of the Health Practitioner Regulation National Law (NSW) (**National Law**). Given that section 151A(2) explicitly provides for the mechanism by which, in the context of actual or contemplated coronial proceedings, the Medical Council and Nursing Council may consider the conduct of a registered health practitioner, this appears to be the most appropriate legislative pathway to follow, and not section 82(2)(b) of the Act. The legislative framework provided by the National Law is discussed in more detail below.

28.9 Fourth, to the extent that the submissions on behalf of the Fitzpatrick family may suggest that consideration of issues relating to fault or the imposition of a penalty has any bearing on the question of “referral”, these submissions ought to be rejected. The Act does not provide for the attribution of fault or blame, or the imposition of penalties on individuals. Indeed, these concepts are incongruous with the purpose and functions of the coronial jurisdiction.

**Legislative framework of the Health Practitioner Regulation National Law (NSW)**

28.10 Part 8, Division 3 of the National Law deals with the making of complaints about registered health practitioners (Subdivision 1), how complaints are to be dealt with (Subdivision 2), and the powers that may be exercised by a Tribunal, Council or Committee when dealing with a complaint (Subdivisions 3, 4, 5, 6 and 7). Section 151A of the National Law is found within Subdivision 8. It sets out the “[d]uty of courts etc to refer matters to [an] Executive Officer” of a Council for the health profession.

28.11 Sections 151A(2) and (3) provide:

**151A Referral of matter by Courts**

- (2) If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession.
- (3) If a notice or a transcript of evidence is given to the Executive Officer under this section –

- (a) a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates; and
- (b) the Executive Officer must give written notice of the notice or transcript of evidence to the National Board for the health profession in which the person is or was registered.

28.12 Relevantly, the Medical Council and Nursing Council of New South Wales are both Councils established under section 41B of the National Law.

28.13 Section 151A does not explicitly define, or otherwise provide guidance as to, what may constitute “reasonable grounds”. However, it is noted that the guiding principles set out at section 3A of the National Law provides the following:

- (1) The main guiding principle of the national registration and accreditation scheme is that the protection of the health and safety of the public must be the paramount consideration.

28.14 Similarly, section 3B of the National Law provides:

**Objective and guiding principle**

In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.

28.15 Section 144 of the National Law sets out a number of grounds for complaint about a registered health practitioner and provides:

The following complaints may be made about a registered health practitioner –

(a) **Criminal conviction or criminal finding**

A complaint the practitioner has, either in this jurisdiction or elsewhere, been convicted of or made the subject of a criminal finding for an offence.

(b) **Unsatisfactory professional conduct or professional misconduct**

A complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct.

(c) **Lack of competence**

A complaint the practitioner is not competent to practise the practitioner’s profession.

(d) **Impairment**

A complaint the practitioner has an impairment.

(e) **Suitable person**

A complaint the practitioner is otherwise not a suitable person to hold registration in the practitioner’s profession.

28.16 It is understood that the submissions on behalf of the Fitzpatrick family suggest that a complaint could be made about the professional conduct and/or competence of Dr Sharma, Dr Jain and RN Chan.

28.17 Section 139 of the National Law provides:

**139 Competence to practice health profession [NSW]**

A person is **competent** to practise a health profession only if the person –

- (a) has sufficient physical capacity, mental capacity, knowledge and skill to practise the profession; and
- (b) has sufficient communication skills for the practice of the profession, including an adequate command of the English language.

28.18 Section 139B of the National Law relevantly provides:

**139B Meaning of “unsatisfactory professional conduct” of registered health practitioner generally [NSW]**

- (1) **Unsatisfactory professional conduct** of a registered health practitioner includes each of the following –
  - (a) **Conduct significantly below reasonable standard**  
Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner’s profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

28.19 Therefore, having regard to the legislative framework described above, if there are reasonable grounds to believe that evidence given during the inquest may indicate a complaint could be made about Dr Sharma, Dr Jain or RN Chan (all of whom are registered health practitioners) then a transcript of that evidence may be given to the Executive Officer of the Medical Council or the Nursing Council.

28.20 It is noted that the use of the words “believe”, “may indicate” and “could” in section 151A(2) of the National Law individually and collectively impose a relatively low threshold by which that provision might be engaged. Therefore, section 151A(2) does not impose any requirement that the evidence in actual or contemplated coronial proceedings establishes a complaint. Instead, section 151A(2) may be engaged if a coroner has reasonable grounds to believe that the evidence may indicate that a complaint could be made.

***Matters to be taken into account when considering the application of section 151A(2)***

28.21 As a general matter, inquests which examine the cause and manner of a person’s death in a health care setting frequently consider issues relating to the adequacy, appropriateness and reasonableness of the health care provided to that person by a registered health practitioner. Consideration of such issues can in turn give rise to consideration of whether section 151A(2) of the National Law is enlivened.

28.22 Traditionally, the question of whether this provision is enlivened seems to have turned on a number of considerations, such as whether a registered health practitioner:

- (a) has engaged with the coronial investigation and inquest process;
- (b) has demonstrated appropriate insight and reflection;
- (c) has issued a personal apology to the family members of the deceased person that the inquest is concerned with;
- (d) has demonstrated contrition and/or remorse; and
- (e) has undertaken additional education and training since the event which is the subject of an inquest aimed at continued professional development and personal development.

28.23 In this regard, the inquest into Adam's death has been no different. By way of example:

- (a) It was submitted by senior counsel on behalf of Dr Sharma that enlivenment of section 151A(2) of the National Law is *"not an appropriate way to deal with a situation where there is evidence of an isolated incident, after which a competent medical professional shows the ability to reflect, and to articulate ways in which they might have assisted with better care"*;
- (b) It was submitted by counsel for Dr Jain that section 151A(2) of the National Law should not be engaged because, *inter alia*, *"Dr Jain presented as an honest and cooperative witness who demonstrated clear insight as to what went wrong during the airway emergency. He is an intelligent and compassionate doctor who cares deeply about his patients. He never sought to deflect blame or responsibility and gave evidence with integrity which demonstrated deep respect for all his colleagues from the Hospital"*;
- (c) In response to a submission on behalf of the Fitzpatrick family that RN Chan gave evidence that he *"could see no way that he could have done anything better"*, it was submitted by counsel for RN Chan that this *"should be considered in light of his reflections offered at the commencement of his evidence"*;
- (d) It was submitted by counsel for Dr Doshi that *"[t]he evidence establishes that the overwhelming response of the clinicians involved in Adam's care has been of reflection and introspection. Dr Doshi responded to these events as 'a life lesson' which led him to engage in further training and a dedication to patient safety and quality care"*;
- (e) Whilst it was submitted on behalf of the Fitzpatrick family that Dr van der Walt *"may be criticised for ordering the administration of rocuronium"*, Dr van der Walt was not included amongst the registered health practitioners that the Fitzpatrick family submit *"should be referred"*. It appears that this is because, according to the submissions, *"Dr van der Walt has engaged with the inquest in a way that demonstrated openness, honesty and insightfulness"*; and

- (f) It was submitted by counsel for Dr van der Walt that no criticism should be made of him because, *inter alia*, “[h]e has generally reflected, sought counselling and endeavoured to learn and develop through the experience. His evidence all along, including at the hearing, was considered, truthful and made against his own interest [...] Dr van der Walt has expressed remorse for his role in Adam’s failed resuscitation and again, has reflected deeply on that matter”.

28.24 The websites for the Medical Council, Nursing Council and Councils Authority all describe in identical terms how a complaint about a registered health practitioner will be assessed by the respective Council:

When we assess the complaint, we consider:

- what happened
  - **practitioner’s response to the complaint**, and any other relevant information (including information from other parties and previous complaints)
  - the seriousness of the incident
  - the **practitioner’s ability to reflect on what happened and show that they understand expected standards**
  - **what the practitioner has done to ensure that a similar incident does not recur**
  - the impact of the practitioner’s health on their practice
- [emphasis added]

28.25 Five conclusions can be reached about the above:

- (a) First, matters such as whether a registered health practitioner has demonstrated appropriate reflection or undertaken any additional education, training or personal and professional development following an adverse event are subjective factors (**Subjective Factors**);
- (b) Second, these Subjective Factors are, in essence, identical to those which various counsel for sufficiently interested parties have made submissions about in this inquest, as described above;
- (c) Third, these Subjective Factors are considered by the Medical Council and Nursing Council after a complaint has been made about that health practitioner;
- (d) Fourth, section 151A(2) imposes no requirement that these Subjective Factors are to be taken into account by a coroner before a transcript of evidence is given to an Executive Officer of the Medical Council or Nursing Council; and
- (e) Fifth, as a consequence, consideration of such Subjective Factors has no bearing on whether section 151A(2) of the National Law is enlivened in the context of coronial proceedings.

28.26 Support for the above conclusions can be found in Part 8, Division 3, Subdivision 1 of the National Law, which deals with the making of complaints and relevantly provides that:

- (a) any person can make a complaint (section 144B(1));
- (b) a complaint may be made on the grounds set out in section 144 (described above);

- (c) a complaint must be in writing (section 144D(1)(a));
- (d) a complaint must contain particulars of the allegations on which it is founded (section 144D(1)(b)); and
- (e) a complaint need not be made in terms that are strictly consistent with the terms of section 144 (section 144D(2)).

28.27 It can be seen from these provisions that the making of a complaint is not fettered by any consideration as to whether a registered health practitioner has, for example, demonstrated appropriate reflection or undertaken any additional education, training or personal and professional development following an adverse event which is the subject of a complaint. These matters are, in essence, matters which may bear upon how the Medical Council or Nursing Council may assess and deal with a complaint, utilising the powers available to the respective Councils.

28.28 Section 145B of the National Law sets out different courses of action available to a Council on complaint, including that a Council may:

- (a) make any enquiries about the complaint the Council thinks appropriate;
- (b) refer the complaint to the HCCC for investigation;
- (c) refer the complaint to a Professional Standards Committee or the Civil and Administrative Tribunal, both of which have disciplinary powers available to them (pursuant to Subdivisions 3 and 6 respectively of Part 8, Division 3 of the National Law);
- (d) direct a health practitioner to attend counselling; and
- (e) determine that no further action should be taken in respect of the complaint.

28.29 From this it can be inferred that section 151A(2) of the National Law merely provides a mechanism by which evidence in coronial proceedings may ground a complaint to the Medical Council or Nursing Council. It does not provide for how such a complaint is to be assessed, investigated or considered, or what course of action is to be taken.

28.30 Similarly, section 151A(2) does not provide for whether any disciplinary or regulatory action ought to be taken against a health practitioner. It can be inferred that in circumstances where the Medical Council or Nursing Council determines that a complaint is made out, there may be relevant mitigating factors which bear upon what course of action (regulatory, disciplinary or otherwise) a Council may take. Such mitigating factors may include the Subjective Factors described above and which have been referred to by various counsel for the sufficiently interested parties in their submissions.

28.31 In this way, the principles underpinning section 151A(2) of the National Law are not dissimilar to those that underpin sections 78(2) and (3) of the Act. Sections 78(2) and (3) also provide a mechanism by which a Coroner may refer a matter to the Director of Public Prosecution where the Coroner is of

the opinion that the evidence in coronial proceedings may, in essence, support the commencement of criminal proceedings. These sections seek to ensure that there is an important separation between the coronial proceedings on the one hand, and potential criminal proceedings on the other. They do so in recognition that whilst there may be degrees of overlap it is critical to preserve the integrity of both the coronial and criminal jurisdictions.

28.32 For possible avoidance of doubt, one additional matter should be noted. Consideration of the Subjective Factors is akin to consideration of mitigating factors in a sentencing exercise in criminal proceedings. Such consideration is concerned with the penalty phase of criminal proceedings and not with the commencement phase. In the same way, the Subjective Factors would appear to have no relevance in the equivalent commencement phase provided by section 151A(2) of the National Law for possible eventual courses of action that may be taken by the Medical Council or Nursing Council.

28.33 All of the above it not to say that the Subjective Factors are inconsequential in coronial proceedings. The willingness of witnesses and sufficiently interested parties to be frank and engage with the coronial process assists the fact-finding task of coroners. In addition, the Subjective Factors often have a role to play in the therapeutic jurisprudence aspect of the coronial jurisdiction, and in potentially minimising counter-therapeutic outcomes for families of deceased persons and sufficiently interested parties.

28.34 It is recognised that section 151A(2) of the National Law is bipartite. Even if a coroner has reasonable grounds to believe the evidence in actual or contemplated proceedings may indicate a complaint could be made about a registered health practitioner, it does not mandate a particular course of action. Rather, section 151A(2) affords a coroner a discretion as to whether such a complaint may be made (by the giving of a transcript of evidence to a relevant Council).

28.35 Section 151A(2), and the balance of the National Law, do not set out or otherwise provide guidance as to what matters a coroner may take into account in exercising such a discretion. On one view, the Subjective Factors described above may factor into the exercise of discretion by a coroner. However, for the reasons set out above it appears that consideration of the Subjective Factors should not form part of this discretionary exercise.

28.36 Rather, it appears that regard is to be had to whether the evidence which may ground a complaint is relevant to the objective and guiding principles of the National Law, namely the protection of the health and safety of the public. By way of example:

(a) whether a registered health practitioner has demonstrated appropriate reflection or insight following an adverse event which may be the subject of a complaint is a matter that may be relevant to a course of action available to a Council to direct the practitioner to attend counselling (section 145B(1)(g) of the National Law);

(b) whether a registered health practitioner has undertaken any additional education, training or personal and professional development following an adverse event may be the subject of a complaint is matter that be relevant to the powers of a Council to:

- (i) direct an Assessment Committee to require the practitioner to undergo skills testing (section 147C(1) of the National Law); or
- (ii) order that the practitioner complete an educational course specified by the Council (section 148E(1)(e) of the National Law).

28.37 Having regard to all of the above, consideration of the application of section 151A(2) of the National Law in the present matter will be limited to the evidence given in the proceedings.

***RN Gary Chan***

28.38 As set out above, the available evidence:

- (a) establishes that there were legitimate reasons for RN Chan to have been absent from Adam's room on 22 August 2020;
- (b) does not positively establish that RN Chan did not escalate Mrs Fitzpatrick's concerns regarding the positioning of Adam's tracheostomy;
- (c) establishes that RN Chan was inside Adam's room on 22 August 2020 shortly before the airway emergency; and
- (d) does not positively establish that Adam was not adequately monitored.

28.39 Therefore, there are no reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about RN Gary Chan, who is a person registered in a health profession, namely that RN Chan has engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practise in a health profession.

***Dr Ashima Sharma***

28.40 As set out above, the available evidence establishes that Dr Sharma:

- (a) did not clarify with the clinicians caring for Adam that they understood the Airway Plan and had no concerns with it; and
- (b) did not give consideration to Part C of the Airway Plan given Adam's particular clinical situation and needs.

28.41 Having regard to the above, there are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about Dr Ashima Sharma, who is a person registered in a health profession, namely that Dr Sharma has engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practise in a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of this evidence is to be given to the Executive Officer of the Medical Council of New South Wales.

**Dr Ajey Dixit**

28.42 As set out above, the available evidence establishes that Dr Dixit:

- (a) did not exercise appropriate clinical judgement in managing Adam's tracheostomy; and
- (b) did not remove and replace Adam's tracheostomy tube once the suction catheter could not be passed, or at any time afterwards.

28.43 Having regard to the above, there are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made that Dr Ajey Dixit, who is a person registered in a health profession, namely that Dr Dixit has engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practise in a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of this evidence is to be given to the Executive Officer of the Medical Council of New South Wales.

**Dr Hemang Doshi**

28.44 As set out above, the available evidence establishes that Dr Doshi;

- (a) did not exercise appropriate clinical judgement in managing Adam's tracheostomy;
- (b) did not communicate his view that Adam's tracheostomy had become dislodged to the other clinicians in Adam's room at the time;
- (c) did not remove and replace Adam's tracheostomy tube once the suction catheter could not be passed, or at any time afterwards; and
- (d) did not, as the team leader at the time, perform a finger thoracostomy upon suspecting a tension pneumothorax.

28.45 Having regard to the above, there are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about Dr Hemang Doshi, who is a person registered in a health profession, namely that Dr Doshi has engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practise in a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of this evidence is to be given to the Executive Officer of the Medical Council of New South Wales.

**Dr Paras Jain**

28.46 As set out above, the available evidence establishes that Dr Jain:

- (a) did not exercise appropriate clinical judgement in managing Adam's tracheostomy;

- (b) did not remove and replace Adam's tracheostomy tube once the suction catheter could not be passed, or at any time afterwards;
- (c) inappropriately performed blind instrumentation of the tracheostomy stoma; and
- (d) did not perform a finger thoracostomy upon suspecting a tension pneumothorax.

28.47 Counsel for Dr Jain submitted that as Dr Jain has previously been the subject of a complaint by the Fitzpatrick family to the HCCC (with no further action taken), it is "*difficult to envisage what the utility of Dr Jain's referral would be other than as a punitive measure*". Three points should be made regarding this submission:

- (a) as explained above, the concepts of penalty or punishment are entirely inconsistent with the purpose and functions of the coronial jurisdiction and have no part to play in consideration of whether section 151A(2) of the National Law is engaged;
- (b) section 151A(2) provides only the mechanism by which a complaint may be made to the Medical Council for it to consider an available course of action, and is not concerned with any concepts of penalty or punishment; and
- (c) evidence available to the inquest may not have been available to the HCCC.

28.48 Having regard to the above, there are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about Dr Paras Jain, who is a person registered in a health profession, namely that Dr Jain has engaged in unsatisfactory professional conduct and/or demonstrates a lack of competence to practise in a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of this evidence is to be given to the Executive Officer of the Medical Council of New South Wales.

## 29. Findings

29.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Patrick Rooney, Counsel Assisting, and his instructing solicitor, Ms Clara Potocki from the Crown Solicitor's Office. The Assisting Team has worked tirelessly to assist the conduct of the coronial investigation, gather and scrutinise the evidence, and ensure that all relevant issues have been examined. I am extremely grateful for their meticulousness, and for the sensitivity and empathy that they have shown during all stages of the coronial process.

29.2 I also thank Constable Matthew Christensen for his role in the police investigation and for compiling the initial brief of evidence.

29.3 The findings I make under section 81(1) of the Act are:

### ***Identity***

The person who died was Adam Fitzpatrick.

### ***Date of death***

Adam died on 25 August 2020.

### ***Place of death***

Adam died at St George Hospital, Kogarah NSW 2217.

### ***Cause of death***

The cause of Adam's death was hypoxic ischaemic encephalopathy secondary to displacement of tracheostomy and prolonged cardiac arrest from bilateral tension pneumothorax.

### ***Manner of death***

Adam died in circumstances where dislodgement of his tracheostomy was recognised or suspected by clinicians involved in his care. However, timely and definitive management of the clinical situation was not instituted to remove and replace the tracheostomy tube. This had the consequent effect of delaying effective management of Adam's airway and resuscitation efforts.

29.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Philippa, Peter, Emma and Amanda; to Adam's partner, Lucinda; to Adam's family, many friends and loved ones; and to the many people that Adam touched in his all-too-brief, but meaningful, exuberant and remarkable, life.

29.5 It is fitting to end with the words shared by Amanda at the end of the evidence in the inquest:

We'll see you again. Keep the engine running and the passenger seat warm for me. All the time in the world would never have been enough with you.

They say the greatest tribute to the dead is not grief but gratitude. We are eternally grateful for the 20 sweet years we got with Adam.

Adam John Fitzpatrick; the man, the myth, the legend.

29.6 I close this inquest.

Magistrate Derek Lee

Deputy State Coroner

31 October 2023

Coroners Court of New South Wales