AMENDED PURSUANT TO THE IMPLIED POWERS TO CORRECT A JUDGMENT AS SET OUT IN *ACHURCH V THE QUEEN* (2014) 253 CLR 141

CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Maureen Anne Smith
Hearing dates:	26, 27 and 29 October 2021; 6 June 2022; and 13 to 15 September 2022
Date of findings:	21 August 2023. Corrigendum issued 25 August 2023.
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Glen Innes District Hospital, Armidale Rural Referral Hospital, referral of medical practitioner to the ~~Australian Health Practitioner Regulation Agency~~ Medical Council of NSW, signs of clinical deterioration due to sepsis, septicaemia, septic arthritis, Between the Flags, inter-hospital transfer delays, systems for inter-hospital transfers in regional areas, vital signs observations
File Number:	2018/103054

Representation:	Ms K Edwards and Ms S Danne, Counsel assisting the Coroner instructed by Ms S Pickard, Department of Communities and Justice Mr B Bradley instructed by Ms L Blair, Crown Solicitor's Office, on behalf of Hunter New England Local Health District, NSW Ambulance, HealthShare and NSW Pathology Mr N Dawson instructed by Mr B Thompson, NSW Nurses and Midwives Association, on behalf of Ms A Cupitt, Ms J Murphy, Ms H Conyard, Mr R MacLean, Ms D Cox, Ms J Sillitoe, Ms J Mulvey, Ms A Pietsch, Ms E McLoughlin and Ms J Dijkstra Ms L Toose, NSW Nurses and Midwives Association, on behalf of Ms C Tierney Mr R Coffey instructed by Mr A Deards, Makinson d'Apice Lawyers, on behalf of Dr J Natukokona Mr J Harris instructed by Ms E Marel, Avant Mutual, on behalf of Dr M Manning Dr P Dwyer instructed by Mr E Hui, Mills Oakley, on behalf of Mr M Dunworth Parties who did not appear at oral hearing Ms A Lowe, unrepresented Ms D Jackson, MDA National, on behalf of Dr R Diebold Ms ~~G Wright, KC~~ Louise Jardim instructed by Ms S on behalf of Mr M Al-Amin
Findings	I make the following findings pursuant to s 81 of the *Coroners Act 2009* (NSW): **Identity** The person who died was Maureen Anne Smith **Date of death** She died on 1 April 2018 **Place of death** She died at Armidale Rural Referral Hospital, Armidale NSW **Cause of death** She died of septicaemia (*Staphylococcus aureus*) with the antecedent cause of septic arthritis. **Manner of death** There were systemic errors in the management of Maureen's condition which caused her transfer between hospitals to be delayed overnight. This had the cascading effect of delaying the commencement of

	antibiotic treatment and resulted in Maureen receiving sub-optimal care.
Recommendations	**To the ~~Australian Health Practitioner Regulation Agency (AHPRA)~~ Medical Council of NSW** 1. That Dr Jauncy Natukokona (also known as Robert Hakwa) be referred to the ~~Australian Health Practitioner Regulation Agency~~ Medical Council of NSW for investigation of his clinical conduct and that a copy of these findings be forwarded to assist with that investigation. **To Glen Innes District Hospital** 2. An audit process of appropriate nursing records should be undertaken at Glen Innes District Hospital, including the use of Standard Audit General Observation charts, fluid charts, recording of hourly rounding and recording of observations, with a view to improving these matters to attain an acceptable standard if the result of that audit were to demonstrate system issues. Such audit should be conducted at least twice yearly, for a trial period of two years and the capacity to be ongoing, in order to identify trends. **To Hunter New England Local Health District, NSW Ambulance and Patient Transport Services** 3. That communications between transport agencies in relation to a patient transfer should involve the treating doctor whenever possible, but especially in relation to any potential change to the medically agreed timeframe, to avoid incorrect information concerning the diagnosis or urgency being passed on second or third hand. **To Hunter New England Local Health District and Patient Transport Services** 4. That an inter-hospital booking for specialist treatment cannot be made with Patient Transport Services (via any method, whether directly or via Patient Flow Unit) unless a medically agreed timeframe has been agreed between the sending

	and receiving staff (by doctors unless unavailable) and recorded in the Patient Transport Services system. 5. That the Hunter New England Local Health District urgently consider and address the following issues as part of the pilot Medically Agreed Timeframe Project: a. provide a solution for obtaining a medically agreed timeframe where the three-way phone call between the Patient Flow Unit, the referring clinician and the accepting clinician is bypassed; b. provide certainty that a “force function” can be implemented in the Patient Flow Portal and the Patient Transport Services Computer Aided Dispatch when the booking does not come through the Patient Flow Portal; c. provide a mechanism to enforce the Local Health District updating changes to the medically agreed timeframe in the booking system; d. clarify the trigger for the proposed escalation pathway for notifying the Local Health District when Patient Transport Services does not have capacity to conduct a transfer including whether it is an automated or a human function; e. clarify whether the proposed notification system leaves time for the patient transfer to be reallocated to another service in order to meet the original medically agreed timeframe; and f. remove the time estimate pre-generated by the Patient Transport Services booking system as it risks confusing the medically agreed timeframe.

	To Hunter New England Local Health District 6. That Patient Flow Unit should record telephone calls in order to further improve training and performance, including to assist with accurate audits of the number of patients transferred within the relevant medically agreed timeframe. **To NSW Ambulance** 7. That NSW Ambulance consider undertaking an audit of outcomes from overflow transfer requests including: a. whether they were triaged through the Virtual Clinical Coordination Centre; b. whether NSW Ambulance undertook the transfer within 24 hours or otherwise; and c. whether (and the circumstances in which) the transfer request was sent back to Patient Transport Services.

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Introduction

1. This inquest concerns the tragic death of Maureen Anne Smith. Maureen was 75 years of age when she died at Armidale Rural Referral Hospital (**ARRH**) on 1 April 2018 after a delayed transfer from Glenn Innes District Hospital (**GIDH**) for specialist attention.

2. Maureen was described as a strong and independent woman. She had two sons, William and Craig Wilson, with whom she maintained regular contact. She often looked after her grandchildren when living close to them.

3. Maureen was a kind neighbour and formed a quick friendship with Leann Nixon when they lived on the same street. Maureen and Leann remained close friends long after Maureen moved away, with Leann visiting her nearly every day and assisting with Maureen's care when her health began to decline.

4. Up until she turned 50, Maureen was a fit and healthy woman who worked as a cleaner. In March 1994, Maureen suffered a fall at work and underwent back surgery. The surgery provided inadequate pain relief. Ongoing treatment included administration of Pethidine, Valium and Stemetil.

5. In July 2008, Maureen sustained further injuries when a motorbike fell on her. In 2009, she was referred to an orthopaedic surgeon for the treatment of her resulting hip ulcers and ongoing management of pain in her right knee, right shoulder and left hip. In 2011, Maureen was diagnosed with chronic methicillin-resistant staphylococcus aureus (**MRSA**) arising from the ulcer in her left hip. Specialist consultations continued until her death.

6. In March 2018, Maureen received steroid injections into her hip, knee and shoulder. It was around this time that William and Leann began to observe a decline in Maureen's health.

7. On 31 March 2018, Maureen was admitted to GIDH by Ambulance suffering uncontrolled pain. She was admitted under Dr Manning, a locum medical officer. A determination was made between Dr Manning and the accepting Orthopaedic Registrar at ARRH, Dr Natukokona, to transfer Maureen to ~~GIDH~~ ARRH for a knee aspiration. The systematic errors which caused Maureen's transfer to be delayed overnight had the cascading effect of delaying the commencement of antibiotic treatment. Maureen passed away shortly after her arrival at ~~GIDH~~ ARRH the following morning.

8. The transportation issues and subsequent decision-making of medical staff were important issues explored in this inquest and a series of improvements have been identified as a result.

The role of the coroner and the scope of the inquest

9. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

The evidence

10. Unfortunately, these proceedings occurred some time after Maureen's death, having been delayed for a number of reasons including COVID-19 restrictions. There were times when the passage of time affected the memory of a witness.

11. The court took evidence over 7 hearing days. The court also received extensive documentary material in seven volumes, as well as audio visual material. This material included witness statements, medical records and expert reports. The court heard oral evidence from doctors and nurses involved in Maureen's medical care and transport. The court was also assisted by expert evidence from:

    a. Professor William Rawlinson, Infectious Diseases Physician;

    b. A/Professor Anna Holdgate, Senior Staff Specialist in Emergency Medicine;

    c. Registered Nurse (**RN**) Eunice Gribbin, Expert Nursing Consultant; and

    d. A/Professor Nigel Hope, Orthopaedic Registrar.

12. A/Professor Hope's report was provided by representatives for Dr Natukokona during the hearing and was tendered, after A/Professor Holdgate and RN Gribbin had concluded their evidence and after Professor Rawlinson had been excused as no parties required his attendance. He was not called to give oral evidence. I note there was no request from any party to call him.

13. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

14. The following list of issues was prepared before the proceedings commenced:

    a. Whether the care and treatment provided to Maureen by GIDH from 31 March 2018 to 1 April 2018 was adequate and appropriate (having regard to her medical history and clinical condition), including:

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).

a. the manner in which her presenting condition and the risk of developing sepsis syndrome was identified;

b. the manner in which the sepsis pathway was implemented;

c. the application of the sepsis pathway to the circumstances of the regional Local Health District (**LHD**) having regard to (amongst other matters):

i. potential delays in transport and/or obtaining pathology results; and

ii. the decision to withhold antibiotics for a patient with possible sepsis or septic joint pending transfer to ARRH for a joint aspiration;

d. the decision to withhold antibiotics when it became clear that Maureen would not be transported to ARRH on 31 March 2018;

e. the frequency of monitoring and observation of Maureen, particularly overnight; and

f. the medical and nursing staff response to Maureen's deteriorating condition, particularly her increasing confusion/delirium.

b. Whether the advice provided by the Orthopaedic Registrar at ARRH was appropriate, particularly with respect to the provision of antibiotics, throughout the period of Maureen's treatment at GIDH and ARRH having regard to her medical history and clinical condition.

c. The circumstances in which Maureen's transfer to ARRH was delayed, including whether:

a. Maureen was appropriately triaged as a non-urgent patient;

b. urgent transport (by ambulance) should have been provided to ARRH on 31 March 2018 or 1 April 2018;

c. medical and nursing staff at GIDH should have responded differently when transport was refused or delayed (both in terms of her treatment and further attempts to ensure there was urgent transportation); and

d. the applicable policies, procedures and guidelines were appropriate?

d. The adequacy of pathology arrangements operative during after hours, on weekends and during public holidays in the Hunter New England (**HNE**) LHD, including in an emergency situation.

e. Whether any recommendations are necessary or desirable in connection with Maureen's death, including the advice provided to locum doctors at GIDH.

15. These issues guided the investigation. However, the inquest process tends to crystalize the issues in real contention and I intend to address those issues under several broad headings.

Fact finding and chronology

16. Prior to commencing the inquest, those assisting me prepared a summary of facts taken from the extensive available material. The document was circulated to the parties and agreement was reached in relation to the summary of facts contained. That document is annexed at Appendix A. It accurately sets out a chronology of events and for that reason I do not intend to repeat all those details here. It should be read in conjunction with these reasons.

17. Among other things it records the time, place and medical cause of Maureen's death. These matters, on which I must make findings pursuant to section 81 of the *Coroners Act,* were not in dispute. Maureen died at ARRH on 1 April 2018. I accept the forensic pathologist's opinion, which was supported by each of the independent experts, that her medical cause of death is appropriately recorded as septicaemia (*Staphylococcus aureus*) with the antecedent cause of septic arthritis. Further, I accept the opinions of both Professor Rawlinson and A/Professor Holdgate that it is most likely the joint injections which had occurred in March 2018 were the source of the septic arthritis which later became generalised sepsis. Given that these matters were essentially uncontested, the hearing focussed broadly on the *manner* of Maureen's death, which in turn included examination of her treatment and transfer between hospitals.

18. Further evidence was received in oral testimony relating to Maureen's medical care and the decisions made in relation to her transfer. There was also evidence relating to the procedures and processes now in place with respect to hospital transfers and expected levels of care. Counsel assisting have also summarised much of this material in their comprehensive closing submissions. I rely heavily on their submissions to set out further chronological details and aspects of the expert evidence in these reasons, where appropriate incorporating their words. I have also had the opportunity to consult comprehensive submissions from the each of the parties and I have adopted their submissions where appropriate.

19. Counsel assisting identified a number of key issues and it is efficient to deal with each in turn.

Standard of care

20. The inquest shed light on shortcomings in the standard of care provided to Maureen, including failures to identify cognitive deterioration and other "soft" signs of septicaemia

(referred to from this point onwards as sepsis); the inappropriateness of a decision to withhold antibiotics in respect of suspected sepsis when it was clear that Maureen would not be transferred on 31 March 2018; the lack of appropriate and timely observations; and failures to escalate transportation issues.

21. Despite the shortcomings, no expert identified a singular deficiency by any medical practitioner or agency that directly caused Maureen's death. Rather, as stated by A/Professor Holdgate, 'there were cumulative deficiencies which could have played a causative role'. Accordingly, I accept the submission of Counsel assisting that Maureen's death was not definitively avoidable. However, I also accept that her prospects of survival were diminished by the fact that she ultimately did not receive appropriate care. To this end, the inquest heard evidence on the standard of care provided by Dr Michael Manning (the referring clinician), Dr Jauncy Natukokona (the accepting specialist) and nursing staff, each of which is addressed below.

Factual findings in relation Dr Natukokona's evidence

22. Before considering the standard of care provided by the clinicians, it is necessary to resolve factual conflicts which arose from Dr Natukokona's evidence. At the time of Maureen's death, Dr Natukokona had been practicing as an Orthopaedic Registrar in Australia for 15 years and was the on-call orthopaedic specialist at ARRH.

23. Counsel assisting identified examples where Dr Natukokona contradicted his own evidence, the evidence of other staff, documentary evidence and expert opinions. Relevantly, where inconsistencies were put to Dr Natukokona, he was unwilling to make concessions on untenable positions or to concede the possibility that his recollection had been impacted by the passage of time.

24. On this basis, Counsel assisting submitted that Dr Natukokona was a poor witness whose evidence should be treated with caution and that it should be accepted that Dr Natukokona:

    a. had been told by Dr Michael Manning, during their first telephone conversation, that Maureen had a swollen and warm right knee, a cystic outpouring in her shoulder and had also been advised of point of care blood test results that Dr Manning had available to him at that time, including the white cell count and lactate results;

    b. had, at least by the time of his second call with Dr Manning, the point of care blood test results available to him on the Clinical Applications Portal system (**CAPS**), excluding the C-reactive protein results;

    c. did not seek to clarify Dr Manning's ability to perform a knee aspiration at GIDH (which Dr Natukokona conceded);

d. did not participate in a three-way telephone call between Dr Manning and the Patient Flow Unit (**PFU**) and only spoke to Dr Manning twice on 31 March 2018;

e. did not access CAPS a third time on 31 March 2018;

f. advised Dr Manning during both calls to withhold antibiotics; and

g. advised Dr Manning to administer paracetamol in the event Maureen developed a fever overnight.

25. Counsel for Dr Natukokona responded that he had been unfairly criticised by Counsel assisting and the court should make no finding that he was untruthful. In summary, it was submitted that no regard was given to the concerns raised or the subsequent observations of the court; that English is not Dr Natukokona's first language; that he was unfamiliar with the court environment and giving evidence; and that his evidence was substantially impeded by use of the audio-visual link (**AVL**).

26. In their submissions in reply, Counsel assisting responded that there was no application made for an interpreter and that counsel for Dr Natukokona had been expressly invited to alert the court of any concerns about Dr Natukokona's understanding of what was being asked. A presumption was also made in relation to the level of English language proficiency that is required to practice as an Orthopaedic Registrar in Australia, as Dr Natukokona had been doing for 15 years.

27. In respect of unfamiliarity with court and giving evidence, Counsel assisting stated that few witnesses are familiar with the circumstances of giving evidence in court and that questions were repeated where there were difficulties with AVL. It was also raised that Dr Natukokona was legally represented by counsel who could and did object at times where the evidence was impeded by AVL, and that Dr Natukokona was given multiple opportunities to address critical matters.

28. Counsel assisting reiterated that Dr Natukokona's unwillingness to concede that his memory may have lapsed due to the passage of time was an issue, noting for completeness that he was not deprived of the opportunity to prepare, review evidence or seek legal advice.

29. Having reviewed the evidence I accept Counsel assisting's submission that Dr Natukokona's evidence should be treated with caution. Where his recollection of events conflicted with the recollection of Dr Manning, I prefer Dr Manning's account. I do not accept that language difficulties might explain certain discrepancies in the accounts he gave. A number of his explanations were inherently implausible.

The standard of care provided by Dr Natukokona

30. Counsel assisting submitted that Dr Natukokona made the following unsafe decisions in Maureen's care and incorrect observations about her condition:

    a. the direction to withhold antibiotics in the second telephone call with Dr Manning after it was clear Maureen would not be transferred that day;

    b. the direction to Dr Manning to administer paracetamol in the event Maureen developed a fever overnight (despite agreeing this would be dangerous advice, Dr Natukokona denied giving it);

    c. maintaining during his evidence that there was no swelling or obvious drainable joint effusion when he examined Maureen's knee, despite evidence to the contrary from Enrolled Nurse Cupitt, Dr Manning, Dr Holdgate, the pathologist and photographs in which the swelling was clear to a layperson; and

    d. confusion of the suprapatellar and prepatellar bursa during his evidence, a matter which raised concerns from A/Professor Holdgate about his understanding of the skills required to act as an Orthopaedic Registrar.

31. In circumstances where patient care had resulted in a sub-optimal outcome, Counsel assisting raised concern about Dr Natukokona's apparent lack of honesty and his unwillingness to accept circumstances which could cause reviewers real difficulties in understanding clinical issues. It was submitted that this may not have impacted Maureen's care but caused ongoing concern in relation to his care of other patients and potentially his engagement with supervising clinicians and bodies.

32. Counsel assisting also posited that if Dr Natukokona's evidence was to be accepted (and contrary to Counsel assisting submissions), that his lack of clinical curiosity about important diagnostic information raised serious concerns about his conduct including his failure to follow up results where he stated that Dr Manning had told him that he was unsure of the results or that they were unavailable and failing to discuss with Dr Manning the possibility of a Maureen undergoing a knee aspiration at GIDH.

33. It was recommended that Dr Natukokona be referred to the Australian Health Practitioner Regulation Agency (**AHPRA**) for investigation into his unsafe practices.

34. Counsel for Dr Natukokona responded that a referral to AHPRA would be unnecessary, submitting that an orthopaedic expert should have, or should now be called; that A/Professor Hope's expert report should be wholly accepted; that A/Professor Holdgate's evidence should not be accepted without qualification; and that there was no explanation why Dr Natukokona's supervisor, Dr Diebold, was not called to give evidence.

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35. Counsel for the HNELHD, NSW Ambulance (**NSWA**), HealthShare and NSW Pathology (**the Health Agencies**) also stated that it was regrettable that evidence was not called from an orthopaedic specialist. It was added that criticisms of clinicians ought to be tempered by the challenges under which they operated on the day.

36. In reply, Counsel assisting clarified that A/Professor Hope's report could be accepted to the extent that it was consistent with the evidence of A/Professor Holdgate and Professor Rawlinson. It was identified that A/Professor Hope had been served with an incomplete set of medical records and was asked to make assumptions that were not capable of being established from the evidence at inquest. As a result, A/Professor Hope's report failed to address the critical issue of the advice to withhold antibiotics on the evening of 31 March 2018 based on the information provided by Dr Manning. Yet Dr Natukokona, A/Professor Hope, A/Professor Holdgate and Professor Rawlinson each accepted that it would have been inappropriate to give such advice.

37. I was also persuaded that A/Professor Holdgate's many decades of experience working with orthopaedic registrars gave her a sound basis to offer an opinion on this issue.

38. It should be remembered that I accept Dr Manning's evidence in relation to the conversations he had with Dr Natukokona and am satisfied that Dr Natukokona advised Dr Manning to withhold antibiotics during the second telephone call. A/Professor Hope's written report did not grapple with this evidence and there was no request for him to be called to provide an oral opinion.

39. Counsel assisting submitted that the only issue relevant to an orthopaedic specialist was whether Dr Natukokona should have followed up more proactively in relation to Maureen's transfer and care. This issue was dealt with in the report of A/Professor Hope and by Counsel assisting, without raising criticism of Dr Natukokona beyond his own concessions. By contrast, A/Professor Hope was not asked to comment on the evidence concerning the photographs of Maureen's knees in respect of his ability to identify an effusion. Nor did he identify any point of disagreement when he was expressly provided with an opportunity to identify aspects of the other experts' reports with which he disagreed.

40. I have considered the issue of referral carefully and am satisfied that a referral to the ~~AHPRA~~ Medical Council of NSW should be made in relation to Dr Natukokona. Leaving aside the evidence of A/Professor Holdgate and Professor Rawlinson about Dr Natukokona's ability to give appropriate orthopaedic care on the evening, I remain concerned about the doctor's honesty and capacity to engage with this inquiry with openness and insight.

The standard of care provided by Dr Manning

41. At the time of Maureen's admission, Dr Manning was a locum doctor attending GIDH for the first time over an Easter long weekend. He was a very junior doctor who was provided with limited assistance and relied upon the specialist advice he sought from the on-call orthopaedic registrar at ARRH. Dr Manning made an apology in court that demonstrated he had reflected deeply and had learnt from the events of Maureen's death. He also engaged with the HNELHD to improve the GIDH orientation guide in response to Maureen's death. The updates have now been implemented across all sites in the Tablelands sector.

42. I observed Dr Manning as he gave his evidence and he impressed the court as a thoughtful and compassionate doctor who did his best to assist the court with honesty and with insight. I had considerable sympathy for the position he found himself in on the evening he cared for Maureen. He was relatively inexperienced and had never worked at GIDH before. He was the only doctor at GIDH over the weekend and he had very limited training in the local systems.

43. Counsel for Dr Manning submitted, consistently with Counsel assisting, that there would be no criticism of Dr Manning beyond noting the following reasonable concessions:

    a. Dr Manning did not appreciate the significance of the point of care blood test lactate results on 31 March 2018, being unfamiliar with the machine and noting the sign which stated '*WBC & Diff estimate only*';

    b. his handwritten progress notes should have been timestamped;

    c. that, in retrospect, Maureen's raised heart rate in the afternoon of 31 March 2018 was clinically significant – though he had expected Maureen's observations would show a clear deterioration;

    d. that he was the clinician responsible for Maureen;

    e. that his primary diagnosis was for a condition beyond his scope of practice and that, when seeking advice, Dr Natukokona was relying on his clinical assessments and observations;

    f. that he had a greater responsibility for transfer and should have done more to advocate for Maureen's transfer, including speaking directly to NSWA – though he understood from RN Raymond MacLean that further deterioration would need to occur before NSWA would consider transfer that day;

    g. he may have been able to escalate his concerns about withholding antibiotics to a more senior staff member – though he was the only doctor on shift and did not know who to contact;

h. that he should have overridden the advice to withhold antibiotics – though he did not have the confidence to do so at the time and without a change to Maureen's observations;

i. that he expected Maureen would be kept under regular observation on the ward but should have specifically documented and advised nursing staff to conduct close observations overnight, at least four-hourly;

j. that he did not appreciate that increasing confusion or delirium indicated a clinical emergency when observations were otherwise "between the flags;"

k. that he did not think to contact Dr Natukokona about the clinical changes on the morning of 1 April 2018;

l. that he was facing other demands but should have checked on Maureen again in the morning of 1 April 2018, to ensure her transfer had occurred; and

m. he should have reviewed Maureen and taken observations when prescribing Morphine on 1 April 2018 – although he was busy in the emergency department at the time and was prioritising Maureen;s transfer.

44. I accept A/Professor Holdgate's opinion that Dr Manning correctly identified the relevant clinical issues during his first consultation with Maureen. He then correctly and promptly discussed her ongoing care with the orthopaedic on-call registrar at ARRH, who apparently agreed she should be transferred. Tragically a number of factors beyond Dr Manning's direct control delayed that transfer and Maureen's care was severely compromised.

45. It is very clear that Dr Manning has learnt from the events leading up to Maureen's death. In my view he has carefully considered what occurred and I offer no particular criticism of him, beyond the concessions he properly made.

The standard of nursing care

46. Statements were obtained from eleven nurses who provided care to Maureen during her admissions at GIDH and ARRH. Oral evidence was given by RN MacLean and by expert nursing consultant RN Gribbin, who had provided two reports in the matter. At the conclusion of the evidence, three issues remained with the standard of nursing care provided to Maureen.

47. Before dealing with the issues below, it is relevant to firstly consider the submission made by Counsel for ten of the nurses (**the nurses**)[3], that "no weight can be given to RN Gribbin's opinion." During her evidence, it came to light that aspects of RN Gribbin's CV were

[3] RN Amy Cupitt, EN Jeanette Murphy, RN Heather Conyard, RN Raymond MacLean, RN Dimity Cox, RN Joanne Sillitoe, RN Joanne Mulvey, RN Adriana Pietsch, RN Ebony McLoughlin and RN Jodie Dijkstra

incorrect and/or misleading. Evidence was led that she had relied upon outdated Standards and Codes of Professional/Ethical Conduct in her reports, claimed to be an expert on competencies and incorrectly applied Standards for Registered Nurses to Enrolled Nurses when separate Standards were in existence. While these concerns are clearly valid and somewhat concerning, I do not accept that *no* weight should be given to RN Gribbin's evidence. A/Professor Holdgate made similar conclusions.

48. The first issue related to the frequency of monitoring and observations. Between 8.45pm on 31 March 2018 and Maureen's transfer to ARRH at 2pm on 1 April 2018, only one set of observations were recorded, at 6.45am on 1 April 2018. Although RN Conyard stated that hourly rounds were performed on the patients overnight, including Maureen, no records and no fluid balance charts were kept. Dr Manning gave evidence that he instructed the nursing staff to contact him immediately upon any signs of deterioration overnight and, upon discovery that no observations had taken place on the morning of 1 April 2018, was advised by nursing staff there would be follow up. No effective follow up occurred.

49. I accept A/Professor Holdgate's evidence that no reliable conclusion can be drawn about what Maureen's observations would have revealed about her condition and whether earlier identification of her decline would have resulted in life-saving care. Nevertheless, I remain troubled by the omission.

50. Counsel assisting submitted that it be recommended that a twice-annual audit process of appropriate nursing records should be undertaken at GIDH, including the use of Standard Audit General Observation (**SAGO**) charts, the use of fluid charts, recording of hourly rounding and recording of observations; with a view to improving these matters to attain an acceptable standard if the result of that audit were to demonstrate system issues.

51. Counsel for the nurses supported the recommendation and proposed that it be expanded to include nursing staffing, nursing skill mix and medical coverage on nights, weekends and public holidays.

52. Counsel for the Health Agencies did not support the recommendation due to existing annual audits of SAGO charts/observations, ad hoc audits of fluid charts and GIDH's 97% compliance rate with a HNELHD Sepsis Audit performed in 2020. It was submitted that the diversion of resources was not necessary or desirable to improve public health and safety.

53. I disagree. I remain concerned about what was disclosed in the medical records in this case. An audit may assist in identifying whether the problem is ongoing. I intend to make the recommendation suggested by Counsel assisting and supported by the nurses in this matter.

54. The second issue related to the appropriate diagnosis and treatment of sepsis. In her evidence, A/Professor Holdgate identified "soft" signs of sepsis which may have been

detectable on 1 April 2018. These included an increased level of confusion and a drop in oxygen levels. Maureen's confusion was recorded by nursing staff at 6pm on 31 March 2018, at 7am on 1 April 2018 and she was described as "off with the fairies" at 7.28am on 1 April 2018. I accept the retrospective evidence of Dr Manning and the opinion of A/Professor Holdgate that doctors and nursing staff are jointly responsible for recognising the signs of sepsis and that the description of Maureen as "*off with the fairies*" indicated a clinical emergency.

55. The court heard evidence that HNELHD have taken steps to increase awareness of the signs of sepsis by providing a "Sepsis Kills" training course and to include sepsis education in the monthly mandatory training day for clinical staff. The Health Agencies also jointly proposed more frequent sepsis audits and further sepsis training. Counsel for the nurses welcomed the proposed training.

56. I am heartened by the approach to this important issue. Clearly Maureen's declining cognitive function should have been a red flag.

57. The third issue was that Maureen's transfer to ARRH should have been escalated. Specifically, in the afternoon of 31 March 2018, when it appeared that a same day transfer would not occur. Then again in the morning of 1 April 2018, when transport was delayed.

58. At the first opportunity for escalation, RN MacLean did not strongly advocate for Maureen's transfer. RN MacLean assisted the court by providing a detailed account of the challenges he had faced on at least two prior occasions when advocating for patient transport. I accept his evidence on this issue. His experiences included NSWA not accepting his views on risk of deterioration, NSWA not accepting risk of deterioration as a reason for ambulance transfer and NSWA not accepting patients who were "between the flags." RN MacLean appropriately conceded that he should not have provided a working diagnosis of "Osteomyelitis" when booking Maureen's transfer and that he may have been mistaken about his recollection of making a second call to NSWA.

59. At the second opportunity for escalation, nursing staff failed to notify Dr Manning of the delay and no action was taken to escalate her care despite her decline. Counsel assisting submitted that A/Professor Holdgate's evidence that these failures represented serious departures from an acceptable standard of care and were missed opportunities should be accepted. I accept this submission. However, I do not propose to make any criticisms of individual nursing staff in light of the resourcing issues and broader transfer recommendations set out below.

Transfer delay

60. The inquest heard evidence that the first attempt to arrange Maureen's transfer occurred at 1.22pm on 31 March 2021, when nursing staff called the Patient Flow Unit (**PFU**) requesting a same-day transfer for a "R septic knee joint." No booking was made at the time and, due to a subsequent series of system failures and human errors, Maureen's transfer did not commence until 2pm on 1 April 2018.

61. A conclave of institutional representatives from HNELHD, NSWA, PFU and Patient Transport Services (**PTS**)[4] gave evidence addressing some of the matters. I agree with the submission of Counsel assisting that the conclave evidence indicated a strong level of collaboration between the transport agencies and reduced the number of recommendations that may have otherwise been necessary or appropriate. I was heartened by the obvious desire of all parties to improve the relevant systems and do better in the future. However, in my view, the following issues remained outstanding following the conclave evidence and further documents produced in respect of pilot programs which were first referred to during their evidence.

Failure to seek or obtain a medically agreed timeframe (MAT)

62. The HNELHD and NSWA Inter-hospital Patient Transport Process dated December 2017, stated that the time to dispatch should be a MAT between the referring clinician (RN or medical officer) and the accepting medical officer. Three bookings were made for Maureen's transfer. The first, on 31 March 2018 at 2.17pm with PTS. Then at 3.13pm, when the booking was transferred to NSWA and finally, on 1 April 2018 at 7.28am, when the transfer was rebooked with PTS. A/Professor Holdgate concluded that there had been a breach of policy, as there was clearly no MAT given in any of the bookings when Dr Manning and Dr Natukokona wanted Maureen to be transferred on 31 March 2018, not the following day.

63. The conclave gave evidence that following Maureen's death the MAT issues have been addressed by the PTS no longer taking bookings with an urgency of less than 2 hours and with the introduction of a pilot program known as the "MAT Project." While the MAT Project represents a positive step towards addressing the issues, Counsel assisting identified several possible gaps in the MAT Project including:

    a. there is no solution to obtaining a MAT where the three-way phone call between PFU, the referring and the accepting doctors is bypassed;

    b. there is no certainty that the proposed "force function" stopping staff from entering a booking without a MAT will be implemented, given the evidence of PFU that no such

[4] PTS was known as Non-Emergency Patient Transport in 2018. Both organisations were part of HealthShare.

function currently exists, or whether a similar function would be used by the PTS Computer Aided Dispatch when the booking does not come through the Patient Flow Portal;

c. there is no enforceability mechanism to ensure that the LHD updates changes to the MAT in the system or to ensure that both doctors are consulted on the update;

d. a lack of clarity around the proposed trigger notifying a LHD where PTS does not have capacity to complete a booking, including whether it will allow time for transfer to another transport agency; and

e. there is no evidence that the PTS pre-generated time estimate based upon a service level agreement with the LHDs has been removed from the booking system.

64. Counsel assisting proposed three recommendations in respect of the MAT issues. First, that an inter-hospital booking for specialist treatment cannot be made with PTS via any method unless a MAT has been agreed between the sending and receiving physicians and recorded in the PTS system. Second, that the HNELHD urgently consider and address the issues raised in paragraph [63] as part of the pilot MAT Project. Third, that communications between the relevant transport agencies in relation to a patient transfer should involve the treating doctor whenever possible, but especially in relation to any change to the MAT, to avoid incorrect information concerning the diagnosis or urgency being passed on second or third hand.

65. Counsel for the Health Agencies did not support the recommendations. In respect of the first recommendation, it was submitted that there are circumstances, including at nurse led facilities, where patient transfer *must* be arranged with nursing staff at the sending facility or without a medical officer available. I accept the submission that the recommendation, as drafted, does not reflect the reality of nurse led facilities. Nevertheless, in my view, subject to a small amendment, it is an appropriate recommendation which arises from the evidence in this inquest.

66. It was submitted that second recommendation was unnecessary and will not improve public safety in circumstances where the pilot program is funded and designed to look at the subject matters. As I have stated I am heartened by the cooperative work that has gone into the pilot MAT project. Nevertheless, a recommendation provides some transparency in relation to the issues that may be considered. I accept the pilot program is likely to continue its work and I intend to recommend that issues directly arising from this inquest are specifically considered.

67. It was submitted that the third recommendation did not arise from Maureen's death, as no evidence had been led which suggested that nursing staff changed the MAT. Counsel for the Health Agencies also submitted that such a recommendation would be unnecessary

and treating doctors ought not to be involved "wherever possible" in the escalation pathway. In my view the recommendation is pertinent to the facts in this case. The importance of setting a MAT, with a clinician if possible, in order to avoid second or third hand information impacting transport critical decisions was revealed in the evidence in this inquest. I intend to make the recommendation for further consideration by the relevant agencies.

The coordination role of PFU

68. During Maureen's admission there were three telephone calls with PFU, none of which were recorded or resulted in a transportation booking. The inquest heard evidence that the role of PFU has subsequently changed, so that all inter-hospital transfers booked between 7am and 9pm should commence with a three-way conference call, providing for limited exceptions.

69. During the conclave evidence, Counsel assisting put forward the option for PFU to take on a bigger role in the patient transfer system. The conclave responded that this would be an unsuitable option due to resourcing issues, the exceptionally large geographical area of HNELHD and in circumstances where previous efforts to prevent bookings outside the system have been unsuccessful.

70. Counsel assisting also proposed that PFU should implement a telephone recording system, in-line with NSWA and PTS. The conclave raised resourcing issues as a barrier to implementation.

71. Counsel assisting submitted that the accountability and rigour of recording calls outweighed the resourcing limitations raised by the HNELHD witness and recommended that PFU should record telephone calls in order to further improve training and performance, including to assist with accurate audits of the number of patients transferred within the relevant MAT.

72. Counsel for the Health Agencies did not support the recommendation. It was submitted that HNELHD had considered and rejected recording calls on the basis that the PFU phone system is incompatible with recording devices, where HNELHD does not have capacity to store such information and, considering the cost and impracticalities, recording is unlikely to provide a public benefit.

73. In my view, further consideration should be given to this issue. Aside from resourcing constraints, no cogent reason was supplied to reject a recommendation which is likely to improve service delivery.

The disproportionate weight on "between the flags"

74. At the time of Maureen's admission, both NSWA and PTS had "between the flags" as clinical criteria in their booking policies and/or systems. Noting A/Professor Holdgate's evidence on

the “soft” signs of sepsis, there appeared to have been a disproportionate focus placed on whether Maureen was “between the flags” when booking and re-booking her transfer. In particular at 5.07pm on 31 March 2018, when NSWA deemed Maureen’s case unsuitable for ambulance transfer despite being advised that the referring and receiving clinicians wanted her transferred that day.

75. The HNELHD and NSW Inter-hospital Patient Transport Process (as at 31 March 2018 and the updated version of 2019) already require transport agencies to consider whether a patient is likely to deteriorate and whether they fall “between the flags.” The process does not permit selective priority between the two. In light of the MAT recommendations described above, and given that physicians are likely to be more confident and competent providing a MAT as a predictor for deterioration, it appears that no further recommendations are required in relation to this issue.

Failures in the making and transfer of bookings

76. The inquest heard examples of occasions where incorrect information was conveyed from the medical staff at GIDH to the transport services in relation to Maureen’s condition. Namely, that she had been diagnosed with osteomyelitis and that she did not have “MRO’s of infections”. At all relevant times, Dr Manning had advised staff that the transfer was for “investigations of a possible septic joint.” In other words, an infection but not one of contagion for the purposes of the safety of transport staff.

77. The provision of incorrect information, in turn, raised problems during the transfer of the initial PTS booking to the NSWA Electronic Booking System (**EBS**), as the incorrect diagnosis was passed on whereas the accurate note of “R septic knee joint” was omitted. Similarly, the lack of a MAT and the failure to contact either hospital to advise the medical staff of the booking change, meant NSWA received no indication of the urgency of the transfer.

78. Since Maureen’s death, the “Ways of Working” pilot program has been established between HNELHD and HealthShare. Where PTS cannot facilitate a booking, Ways of Working now requires PTS to contact the ward that made the booking and request a rescheduled time or to advise them to rebook through NSWA. I am satisfied that the Ways of Working program has alleviated some of the risks that misinformation will be passed between transport agencies and ensures the Hospital is notified when a transfer requires rescheduling/rebooking.

79. Counsel assisting identified a series of additional missed opportunities. These included the failure of NSWA call-taker, Mark Dunworth, to ask any follow-up questions about Maureen’s condition during the call with PTS to transfer the booking at 4.49pm on 31 March 2018; Mr

Dunworth's failure to interact with a treating doctor or accept that doctor's assessment of urgency; Dr Manning's failure to speak with NSWA directly when he became aware of the refusal to transfer; and an overarching failure to determine the real urgency of Maureen's clinical condition. Each matter was conceded by the individual and/or agency to which it related.

80. In March 2020, the HNELHD issued an updated Clinical Policy Compliance Procedure "Inter-Facility Transfer for Patients requiring Specialist Care", which stated that the referring medical officer is to "[d]etermine the transport modality and level of clinical escort required in consultation with the receiving Specialist." I accept the submission of Counsel assisting that this policy, if complied with, operates to avoid practitioners being presented with similar inter-hospital transfer issues today.

NSWA culture of preserving resources

81. NSWA is mandated to provide an "overflow" service where PTS does not have the resources to conduct a transfer. Counsel assisting submitted that even in circumstances where NSWA considered the booking to be non-urgent, their initial reluctance to conduct Maureen's transfer, despite having ambulances available, demonstrated that the overflow service was ineffective.

82. During the conclave evidence, Mr Robert Fairey, Associate Director of Clinical Operations at the NSWA Western Control Centre, accepted that resource preservation was a cultural issue, whereby staff did not want to conduct non-urgent transfers and leave themselves unable to respond to more acute patients. However, Mr Fairey gave evidence that since 2018, new staff and improved education on MATs are contributing to a shift away from the resource preservation culture.

83. Separately, Mr Fairey gave evidence of a new Virtual Clinical Coordination Centre (**VCCC**) which was expedited to respond to COVID-19 surges. While still in the preliminary process of implementation, the VCCC's primary functions are to provide a secondary triage of low acuity incidents to reduce avoidable transfers by NSWA, improve ambulance availability for high acuity patients and provide linkages to community services.

84. Counsel assisting welcomed the VCCC and proposed a recommendation that NSWA consider undertaking an audit of outcomes from overflow transfer requests including whether they are triaged through the VCCC, whether NSWA undertook the transfer within 24 hours or otherwise, or whether (and the circumstances in which) the transfer request was sent back to PTS.

85. Counsel for the Health Agencies did not support the recommendation. It was submitted that auditing results of overflow patient transfers during a pandemic and before the complete

design and implementation of the VCCC would be of limited utility and an inefficient use of resources. It was further submitted that the parameters relating to transfers undertaken in less than 24 hours, and referrals back to PTS, either did not arise in the context of Maureen's death and/or are irrelevant to improving patient outcomes.

86. In my view the longstanding cultural issue of "*resource preservation*" was starkly in evidence in this case. Mr Robert Fairey described the phenomenon, but it was also indicated in the evidence given by RN Maclean when he was questioned about the possibility of escalating Maureen's transportation. His clear evidence of challenges and indeed "push back" when requesting assistance of NSWA was suggestive of the way (well motivated) resource guarding may affect patient care. In my view an audit is an appropriate way to assess the continued relevance of this factor. I intend to make the recommendation.

Determination of patient suitability and care provided by PTS

87. At the time of Maureen's death, PTS operated on the premise that patients were only booked with their service if they were within the service scope. The reason being that PTS staff were not trained to determine the suitability of patients for PTS transport. This may have led to some of the missed opportunities described above.

88. In March 2020, PTS introduced a new position of Clinical Assessment & Triage (**CAT**) nurse to assist with clinical triage, review of bookings and to deal with escalations and clinical questions. Since Maureen's death, PTS policy has also changed to require all patients with a MAT of under 2 hours to be booked with NSWA and the Ways of Working program has introduced daily meetings between the transport agencies to discuss transfer needs. I commend these changes and accept they are an improvement to public safety and reduce the risk of patients, such as Maureen, regrettably falling through the gaps.

89. In respect of the care provided by PTS, the medical records raised some concerns with Maureen's management. In particular, upon her arrival at ARRH, Maureen was left without medical or nursing staff for just over 10 minutes while handover occurred in a nearby triage room. Maureen went into cardiac arrest shortly after handover. I accept A/Professor Holdgate's opinion that it would have been more appropriate for handover to occur in Maureen's presence to improve chances of earlier recognition of her significant deterioration and consequently, earlier commencement of resuscitation. I also accept her opinion that the events following Maureen's arrival at ARRH had no impact on the manner or cause of Maureen's death.

The resourcing issues

90. I acknowledge that resourcing issues were a theme in the evidence concerning the challenges at GIDH, ARRH and in connection with transferring patients throughout the HNELHD. I accept that resourcing issues informed Maureen's care in multiple ways which were not limited to vehicle allocation, doctor availabilities and nursing coverage. However, these issues can and have been considered by specialist bodies, such as the "NSW Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales". I do not propose to consider the matters beyond noting their consistency with some of the evidence heard in this inquest.

The need for recommendations

91. Section 82 of the *Coroners Act 2009* (NSW) confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

Findings

92. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Maureen Anne Smith

Date of death

She died on 1 April 2018

Place of death

She died at Armidale Rural Referral Hospital, Armidale NSW

Cause of death

She died of septicaemia (*Staphylococcus aureus*) with the antecedent cause of septic arthritis.

Manner of death

There were systemic errors in the management of Maureen's condition which caused her transfer between hospitals to be delayed overnight. This had the cascading effect of delaying the commencement of antibiotic treatment and resulted in Maureen receiving sub-optimal care.

Recommendations pursuant to section 82 *Coroners Act 2009*

93. For the reasons stated above, I recommend:

To the ~~Australian Health Practitioner Regulation Agency (AHPRA)~~ Medical Council of NSW

1. That That Dr Jauncy Natukokona (also known as Robert Hakwa) be referred to the ~~Australian Health Practitioner Regulation Agency~~ Medical Council of NSW for investigation of his clinical conduct and that a copy of these findings be forwarded to assist with that investigation.

To Glen Innes District Hospital

2. An audit process of appropriate nursing records should be undertaken at Glen Innes District Hospital, including the use of Standard Audit General Observation charts, fluid charts, recording of hourly rounding and recording of observations, with a view to improving these matters to attain an acceptable standard if the result of that audit were to demonstrate system issues. Such audit should be conducted at least twice yearly, for a trial period of two years and the capacity to be ongoing, in order to identify trends.

To Hunter New England Local Health District, NSW Ambulance and Patient Transport Services

3. That communications between transport agencies in relation to a patient transfer should involve the treating doctor whenever possible, but especially in relation to any potential change to the medically agreed timeframe, to avoid incorrect information concerning the diagnosis or urgency being passed on second or third hand.

To Hunter New England Local Health District and Patient Transport Services

4. That an inter-hospital booking for specialist treatment cannot be made with Patient Transport Services (via any method, whether directly or via Patient Flow Unit) unless a medically agreed timeframe has been agreed between the sending and receiving staff (by doctors unless unavailable) and recorded in the Patient

Transport Services system.

5. That the Hunter New England Local Health District urgently consider and address the following issues as part of the pilot Medically Agreed Timeframe Project:

    a. provide a solution for obtaining a medically agreed timeframe where the three-way phone call between the Patient Flow Unit, the referring clinician and the accepting clinician is bypassed;
    b. provide certainty that a "force function" can be implemented in the Patient Flow Portal and the Patient Transport Services Computer Aided Dispatch when the booking does not come through the Patient Flow Portal;
    c. provide a mechanism to enforce the Local Health District updating changes to the medically agreed timeframe in the booking system;
    d. clarify the trigger for the proposed escalation pathway for notifying the Local Health District when Patient Transport Services does not have capacity to conduct a transfer including whether it is an automated or a human function;
    e. clarify whether the proposed notification system leaves time for the patient transfer to be reallocated to another service in order to meet the original medically agreed timeframe; and
    f. remove the time estimate pre-generated by the Patient Transport Services booking system as it risks confusing the medically agreed timeframe.

To Hunter New England Local Health District

6. That Patient Flow Unit should record telephone calls in order to further improve training and performance, including to assist with accurate audits of the number of patients transferred within the relevant medically agreed timeframe.

To NSW Ambulance

7. That NSW Ambulance consider undertaking an audit of outcomes from overflow transfer requests including:

    a. whether they were triaged through the Virtual Clinical Coordination Centre;

    b. whether NSW Ambulance undertook the transfer within 24 hours or otherwise; and

    c. whether (and the circumstances in which) the transfer request was sent back to Patient Transport Services.

Conclusion

94. I offer my sincere thanks to the assisting team, Kirsten Edwards, Sarah Danne, and Sian Pickard for their hard work and enormous commitment in the preparation of this matter and in drafting these findings.

95. Finally, once again I offer my sincere condolences to Maureen's family, especially her sons, Craig and William, and to her friend Leann.

96. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner, NSW State Coroner's Court, Lidcombe
21 August 2023

APPENDIX A

INQUEST INTO THE DEATH OF MAUREEN ANNE SMITH

Summary of evidence

as at 12 September 2022

Contents

A. BACKGROUND

1. Ms Maureen Anne Smith (previously known as Maureen Pettit) was born on 19 December 1942 and died on 1 April 2018 at Armidale Rural Referral Hospital (**ARRH**) aged 75 years. Ms Smith and her husband had divorced, and she had two sons, Mr Craig Wilson and Mr William Wilson aged approximately 51 and 56 respectively. Both sons were in contact with Ms Smith in the lead up to her death.

2. The autopsy report by Dr Hannah Elstub dated 3 October 2018, with reference to the autopsy undertaken on 6 April 2018 (**Autopsy Report**), concludes the direct cause of Ms Smith's death was "Septicaemia (Staphylococcus Aureus)" with antecedent cause of "Septic Arthritis of right knee" and other significant conditions contributing to the death being emphysema and osteoarthritis.[1] According to Professor William Rawlinson, the most likely cause of death was septicaemia, following the spread of a methicillin-sensitive staphylococcus aureus (**MSSA**), which is an organism that is sensitive to certain antibiotics such as flucloxacillin.[2]

3. Septicaemia is the presence of disease-causing bacteria in the blood. According to the Sepsis Toolkit, produced by the Clinical Excellence Commission,[3] sepsis is regarded as a medical emergency, being:

> A life-threatening condition that arises when the body's response to infection injures its own tissues and organs… Delayed treatment is associated with high mortality rates

4. Further, the Sepsis Toolkit explains that:

> Sepsis is a difficult clinical diagnosis that requires experience and a high index of suspicion for interpretation of history, signs and symptoms. Early senior clinician involvement is imperative to ensure that the required skills and knowledge are available to facilitate appropriate diagnosis and management. [4]

B. PRIOR MEDICAL ISSUES

Historic medical issues

5. Ms Smith had a complicated medical history spanning at least 15 years[5] including long-standing back pain, osteoarthritis, previous left femoral fracture with surgical fixation,

1 Tab 2 Autopsy Report, p.2
2 Tab 23 Expert Report of Professor Rawlinson, p.3 at [3.0] and p.4 at [4.0(4)]
3 Tab 26 Sepsis Toolkit, p.7
4 Ibid, p.18
5 Tab 4 Statement of Craig Wilson, at [4]

pressure ulcers, peripheral vascular disease, gastro-oesophageal reflux and iron deficiency anaemia.[6]

6. In March 1994, Ms Smith suffered a fall at work and subsequently had a lumbar laminectomy and a spinal fusion, which did not provide adequate relief from back pain.[7] Treatment continued for many years including administration of Pethidine, Valium and Stemetil.[8]

7. On 31 July 2008, Ms Smith was admitted to ARRH as a result of injuries sustained when a motorbike fell on her.[9]

8. On 5 November 2009, Dr Ee Kong Wong, Ms Smith's general practitioner, referred her to Dr Robin Diebold, Orthopaedic Surgeon, regarding pressure sores at both hips and various subcutaneous infections in both upper thighs following left inguinal abscess drained in Armidale in 2008 after the motorbike incident.[10]

9. During the period 2009 to 2018, Ms Smith had numerous consultations with Dr Diebold, during which time Dr Diebold arranged ongoing management for Ms Smith's hip ulcers and treatment for ongoing pain in her right knee, right shoulder and left hip. Dr Diebold notes that at examination of Ms Smith on 24 January 2018, the wounds and ulcers had healed. [11] The last such consultation was on 21 March 2018.[12]

10. On 10 January 2011, samples were taken from a swab of a wound on the left hip, showing "occasional" methicillin-resistant staphylococcus aureus (**MRSA**).[13] According to Professor Rawlinson, MRSA is a community strain which is resistant to certain antibiotics.[14] On 8 January 2015, further samples were taken and the resulting pathology showed "scanty" MRSA arising from a "L hip chronic ulcer" microbiology culture,[15] and a culture taken 17 March 2014 showed "profuse" MRSA.[16]

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6 Tab 2 Autopsy Report, p.2
7 Tab 19A Letter from Dr Lewis to Dr Wong, p.122
8 Tab 19A Letter to Dr Chowdhury, p.123
9 Tab 19A, ARRH Discharge Referral Notes from 2008, pp.23-26
10 Tab 19A, Letter from Dr Wong to Dr Diebold, p.49 and Response from Dr Diebold, p.51
11 Tab 8 Statement of Dr Diebold, at [45]
12 Ibid
13 Tab 19A Microbiology Report dated 13 January 2011, p.17
14 Tab 23 Expert Report of Professor Rawlinson, p.4 at [4.0(4)]
15 Tab 19A Microbiology Report dated 12 January 2015, p.5 and 23 April 2014, p.9
16 Ibid

11. On 6 July 2016, Glen Innes District Hospital (**GIDH**) medical records confirm that Ms Smith was monitored for sepsis[17] and then transferred to ARRH on 7 July 2016 for further management of pneumonia. ARRH records Ms Smith was admitted until 21 July 2016 for hospital acquired pneumonia and that Ms Smith suffered chronic MRSA arising from an ulcer in her left hip.[18]

12. A/Professor Anna Holdgate opines that the history of previous staphylococcus aureus infection did not have any major bearing on Ms Smith's treatment in 2018.[19] She states that while Ms Smith's history of chronic ulcers and positive MRSA swabs increased her risk of developing septic arthritis, she had both of conditions for many years without developing sepsis.[20]

13. Professor Rawlinson observes that the previous MRSA was not the causative organism involved in the sepsis presentation at the time of Ms Smith's death, although it is possible that Ms Smith had MRSA infection coexistent with the causative MSSA organism.[21]

Medical issues present in 2018

14. In or around December 2017, Ms Smith had a fall for which she was still seeking treatment in early 2018.[22]

15. On 27 February 2018, Ms Smith was reviewed by Dr Wong for "Pain. 4 weeks ago was wheeling out wheelie bin fell on RT knee … Tenderness medial patella WT bearing Likely sub periosteal haematoma". Dr Wong ordered X-ray right knee and prescribed Ordine.[23]

16. On 12 March 2018, Ms Smith attended at ARRH and had steroid injections into the hip and knee, performed by Dr Victor Petroff, specialist radiologist, upon referral by Dr Diebold. Dr Petroff used imaging guidance (CT guidance for the hip, ultrasound guidance for the knee) and an aseptic technique.[24]

17. A/Professor Holdgate confirms that intra-articular steroid injections carry a small risk of secondary septic arthritis which cannot be fully eliminated, even in the most expert

17 Tab 19A Adult Sepsis Pathway, Sepsis Management Plan from 2016, pp.128-131
18 Tab 19A ARRH ED Triage Notes from 2016, p.124
19 Tab 24A Expert Report of A/Professor Holdgate, at [2.1]
20 Ibid, at [2.1]
21 Tab 23 Expert Report of Professor Rawlinson, p.3 at [4.0(2)] and p.4 at [4.0(4)]
22 Tab 19A Letter from Dr Diebold to Dr Phillip Brownlie dated 24 January 2018, p.4
23 Tab 19A Clinical Notes dated 27 February 2018, p.84
24 Tab 19A INT Consultation with Patient Report, Armidale Radiology, p.3

hands. An aseptic technique is appropriate, requiring cleaning the skin and use of sterile equipment and medications.[25]

18. On 21 March 2018, Dr Diebold reviewed Ms Smith and noted that the recent injections of 12 March had provided her with partial relief of her symptoms, and he administered a steroid injection into Ms Smith's right subacromial bursa, in her right shoulder.[26] Dr Diebold's notes state that he has "not arranged to see her again at this stage".[27]

19. Ms Leanne Nixon, a long-time friend of Ms Smith's observed that in "[t]he days after the shots Maureen kept complaining of soreness and general unrest" and on or around 30 March 2018, Ms Nixon observed large blister on Ms Smith's right shoulder (the injection site for the cortisone), which "looked like a burn blister it was risen and appeared to be full of fluid".[28]

20. One of Ms Smith's sons, Mr William Wilson, went to stay with her 'around February to March 2018 and states that her health was on a rapid decline while he was there.[29] He states:

> I would often find her asleep at the kitchen table or on the floor asleep. She would walk around the kitchen talking to herself, I would say she was starting to become almost delirious. … she was barely eating…[30]

C. 31 MARCH 2018: ADMISSION TO GIDH

Ambulance to GIDH and initial patient assessments

21. At **9.58am**, an ambulance was called to attend Ms Smith.[31]

22. Mr William Wilson, states that he made that telephone call.[32] The ambulance records show "Caller Name" as "LEE NIXON".[33]

23. At **10.11am**, an ambulance was dispatched, and Ms Smith was taken to GIDH.[34]

24. The ambulance reports states:

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25 Tab 24A Expert Report of A/Professor Holdgate, at [7.3]
26 Tab 8 Statement of Dr Diebold, at [47]
27 Tab 19A Dr Diebold Patient Notes dated 21 March 2018, p.1; Letter from Dr Diebold to Dr Brownlie dated 21 March 2018, p.2
28 Tab 5 Statement of Leanne Nixon, at [7] and [10]
29 Tab 6 Statement of William Wilson, at [8]
30 Ibid
31 Tab 21 NSWA Records
32 Tab 6 Statement of William Wilson, at [9]
33 Tab 21 NSWA Records, Incident Detail Report, p.1
34 Tab 21 NSWA Records

> O/A pt 75yo female, c/o pain and weakness in bilateral arms and legs. Pt has chronic pain, usually controlled with own meds and cortisone injections
> Pt had cortisone injections 2/7 ago and has had uncontrolled pain since.
> Pt has raised, tight red lumps at injection sites.
> Not hot to touch.
> O/E pt alert and oriented, c/o pain. [35]

25. There are conflicting reports of Ms Smith's precise time of arrival at GIDH but it was some time after 11:00am. [36] GIDH Emergency Department (**ED**) Triage notes show that Ms Smith was assigned triage category 4: Semi-Urgent,[37] noting that Ms Smith:

> presents with Pain – Generalised, Pt BIBA i/c chronic pain Received cortisone injection in doctors rooms last week Right shoulder red and inflamed but not hot.

26. The nurse in charge at GIDH at the time (from 7.00am until 2.30pm) was Registered Nurse (**RN**), Dimity Cox.[38]

27. Enrolled nurse (**EN**) Amy Cupitt states that at the time of admission, Ms Smith 'was alert and orientated' and on presentation to the emergency department, was complaining of severe pain in her right knee. EN Cupitt confirmed in her statement that "[O]n inspection her knee was swollen, warm and tender to touch".[39]

28. According to Professor Rawlinson, Ms Smith did not present with generalised sepsis initially, noting the following:

> blood pressure was 120/73 mmHg …
>
> respiratory rate 20bpm consistent with a person of her age with her smoking history …
>
> heart rate of 95bpm – elevated, although again consistent with a woman with her condition …
>
> no fever, no urinary symptoms, and initially no altered cognition.[40]

First review by Dr Michael Manning at GIDH

29. Dr Michael Manning was a locum medical officer at GIDH, completing a locum placement over the Easter long weekend at the time.

30. In his statement, Dr Manning says that:

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35 Tab 21 NSWA Records, p.2

36 Tab 21 NSWA Records indicate, the ambulance was "@ destination" at **11.26am**, "Triage" was recorded at **11:28am** and "Off Stretcher" occurred at **11:32am**; Tab 19A GP Patient Notification from HNELHD to Dr Wong dated 31 August 2018, p.92 indicated an admission date and time of 31 March 2018 at **11.35am** citing "Problem / Procedure: fall"

37 Tab 19 GIDH Records

38 Tab 18C Statement of Lisa Ramsland, at [59]

39 Tab 10 Statement of EN Cupitt, at [6]-[7]

40 Tab 23 Expert Report of Professor Rawlinson**,** p.3 at [4.0(1)]

> Shortly after Ms Smith's presentation to ED, once I had finished reviewing the other patient in ED, I attended and reviewed Ms Smith. Ms Smith had been triaged and transferred to an ED bed.[41]

31. Upon examination, Dr Manning noted the following in relation to Ms Smith, without recording a time of review:

> 75♀ Multifocal Pain
>
> called ambulance for lower
> back pain and pain in
> all limbs
>
> - denies fevers
> - no n [?nausea] or v [?vomiting]
>
> R knee and lower lumbar
> back are foci of pain
>
> Increasing each day,
> on 5mg of oral ordine [?morphine] BD [?twice daily]
> but now no longer
> controlling pain.
>
> 10/7 interarticular cortisone
> – pain worsening since then
>
> B/D [?] chronic pain
> nicotine dependence
> PVD [?peripheral vascular disease]
>
> Meds
> Amitriptyline 20mg
> Morphine 5mg BD
>
> O/E 120/73 RR [?respiratory rate] 20 H95 [?heart rate 95]
> Cachetic
> C/O [?Complaining of] pain in lumbar back and knee
> Chest – reduced a/e [air entry] no creps [?crepitations]
> HSD [?Heart sounds dual]
> Abdo [?Abdomen] soft no mass
>
> R Knee
> warm and swollen
> Active movement 30 degrees
> Tender to palpation but not severe
> Feet perfused.
> Pulses weak,
> consistent with PVD [?peripheral vascular disease].
>
> R shoulder
> – non-tender large ganglion
>
> Imp [?Impression] Possible developing septic R knee
> missed courier for bloods / CRP
> AKI [?Acute kidney injury]

[41] Tab 7 Statement of Dr Manning, at [29]

> S/W Ortho @ Armidale
> - requests no abs
> - review in ED Armidale
> - fresh bloods
>
> S/W ED and advised of transfer
>
> Plan: For t/f to Armidale for
> ortho review
>
> Bloods
> Blood culture
> IV fluids
> - [chase] previous bloods for renal #
> analgesia
> given going for ortho review will not aspirate here.[42]

32. In his statement, Dr Manning recalled that:

> Ms Smith's right shoulder appeared to have a cystic outpouching from the joint capsule. This seemed to rise out from the joint and appeared quite prominent. It had the clinical appearance of a ganglion or out-pouching from the joint capsule of the shoulder. It was not warm or tender upon palpation and Ms Smith appeared to have reasonable movement and function of her right shoulder.[43]

33. According to Dr Manning, he had been informed that GIDH did not have any x-ray services available that day.[44]

34. Dr Manning states that he undertook Point of Care (blood) Testing (**PoCT**) on Ms Smith.[45]

35. At **11.55am**, PoCT device was processed by Operator ID 51005884, which identified neutrophils were $21x10^9/L$ and the white blood cell count was $26.6x10^9/L$.[46]

36. Professor Roger Wilson, Chief Pathologist and Executive Director Clinical Governance and Quality at NSW Health Pathology confirms in his statement that the monitoring of quality control testing and performance of the PoCT device located at GIDH was up to date for the expected testing intervals with results of those tests within the expected range, indicating reliable performance.[47] Professor Wilson also states that PoCT is reliable and replicate testing by a referral laboratory to confirm PoCT results should be avoided, except in the case of critical or spurious results.[48] He states that there were

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42 Tab 19 GIDH Records
43 Tab 7 Statement of Dr Manning, at [46]
44 Ibid, at [55]
45 Ibid, at [51]
46 Tab 19 GIDH Records [Note: Tab 19A contains a clearer copy of the PoCT test print]
47 Tab 15 Statement of Professor Roger Wilson, at [7]
48 Ibid, at [9]

protocols in place at GIDH for transporting pathology specimens by taxi for 'extreme emergencies'.[49]

37. A handwritten note was recorded as being taken at **12.10pm**, at the bottom of a form titled 'Emergency Department Triage Notes':

> Nursing: PT BIBA GENERALISED PAIN AND A RED INFLAMED R SHOULDER. HAD A CORTISONE INJ LAST WEEK IN DR'S ROOMS. SHOULDER SITE NOW RED AND [?] BUT NOT HOT. BLOODS (I-STAT)
>
> PTO
>
> (CONT) AND FORMAL, BLOOD CULTURES ATTENDED. IV FLUIDS COMMENCED AND PAIN RELIEF GIVEN. [RML] RN MacLean.[50]

38. At **12.10pm** PoCT device CG4+ test was processed by Operator ID 51005884, which identified lactate 2.29mmol/L.[51]

39. At **12.14pm** PoCT device CHEM8+ test was processed by Operator ID 51005884, which identified creatinine 196 mmol/L and urea 26.1 mmol/L.[52]

40. Results of bedside blood tests were attached to Dr Manning's notes, demonstrating, according to A/Professor Holdgate:

    a. "markedly" elevated urea and creatinine;

    b. a "markedly" elevated white cell count, (which A/Professor Holdgate notes was not commented upon); and

    c. a "mildly elevated" lactate level of 2.29mmol/L.[53]

41. According to A/Professor Holdgate:

    a. initial lactate levels of >2mmol/L along with worsening confusion are both in the "yellow zone" criteria of the NSW Health adult sepsis pathway (**Sepsis Pathway**);[54]

    b. no "red zone" criteria of the sepsis pathway were identified; and

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49 Tab 15 Statement of Professor Roger Wilson, at [11]
50 Tab 19 GIDH Records, commences pp.46-47
51 Ibid
52 Ibid
53 Ibid; Expert Report of A/Professor Holdgate, at [1.9] as to subparagraph (c), Tab 24C Second Supplementary Report of A/Professor Holdgate, p.3
54 Tab 26 Sepsis Toolkit, p.17 describes "Sepsis Pathways"

c. Ms Smith also had two recognised risk factors for sepsis, being the presence of the chronic wound on her left hip and her age, being over 65.[55]

42. While acknowledging certain limitations of the Sepsis Pathway, A/Professor Holdgate opines that Ms Smith demonstrated sufficient clinical signs to raise suspicion for sepsis at this stage.[56]

43. Professor Rawlinson states that Ms Smith had risk factors for sepsis but did not, using the Sepsis Pathway, have significant risk factors[57] including that she "did not demonstrate any red zone observations"[58] and did not have significant yellow zone observations under the Sepsis Pathway.[59] Professor Rawlinson observes that to be a "yellow zone observation", systolic blood pressure must be less than 100 mmHg and to be a "red zone observation", systolic blood pressure must be less than 90 mmHg; Ms Smith's was 120 mmHg.[60]

44. Neither A/Professor Holdgate nor Professor Rawlinson state that treatment pursuant to the Sepsis Pathway should have commenced at this point.

45. However, both those experts confirm that only a short delay is appropriate before administration of antibiotics in these circumstances, such delay being acceptable for the purpose of taking blood and other cultures. [61]

46. In this case, cultures were required to be taken from Ms Smith's knee joint, by an aspiration procedure. Dr Manning states that he had not aspirated a knee joint on his own prior to that time (although he had done so under supervision) and did not consider attempting that procedure in the circumstances.[62]

47. The Sepsis Toolkit does not recommend administration of antibiotics until recognition or diagnosis of sepsis, but states that commencement of antibiotic therapy should occur within the first hour of that recognition or diagnosis.[63]

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55 Tab 24A Expert Report of A/Professor Holdgate, p.8 at [4.1]
56 Ibid, at [4.3]
57 Tab 23 Expert Report of Professor Rawlinson, p.3 at [4.0(1)]
58 Ibid, p.4 at [4.0(3)]
59 Ibid
60 Ibid
61 Ibid, p.3 at [4.0(2)]; Tab 24A Expert Report of A/Professor Holdgate, p.6 at [3.1]
62 Tab 7 Statement of Dr Manning, at [78]
63 Tab 26 Sepsis Toolkit, pp.17-18; Tab 18 Statement of Peter Williams, Annexure D Sepsis Data Collection Tool Adult Inpatient (contemporaneous document)

48. A/Professor Holdgate states that diagnosis of a suspected septic joint is an orthopaedic emergency which requires orthopaedic intervention that was not available at GIDH.[64]

First contact with orthopaedic registrar at ARRH

49. At an unspecified time after his first review,[65] Dr Manning's notes confirm that he had a discussion with the Orthopaedic Registrar at ARRH, now known to be Dr Jauncy Robert Hakwa Natukokona, with notes as follows:

> Spoke with Orthopaedic Registrar at Armidale
> - requests no antibiotics
> -review in Emergency Department Armidale
> -fresh bloods.[66]

50. During their conversation, Dr Natukokona requested that Dr Manning not administer antibiotics. This is confirmed by both Dr Manning and Dr Natukokona.[67]

51. These conversations will be the subject of oral evidence.

52. Dr Manning's notes further document that he then spoke with ED, noting:

> Spoke with ED and advised of transfer
> Plan: For transfer to Armidale for orthopaedic review
> Bloods
>
> Blood Culture
> IV fluids
> -chase previous bloods for renal #
> analgesia
> given going for orthopaedic review will not aspirate here.[68]

53. In his statement Dr Manning confirms that he spoke with the on-call ED consultant at Armidale Hospital on the FACEM phone to advise of Ms Smith's impending transfer and her presentation generally. Dr Manning stated that he relayed the instructions from Dr Natukokona, including the x-ray to Ms Smith's right knee and new blood tests upon her arrival at ARRH ED, and that the consultant accepted the transfer and advised they would await Ms Smith's transfer.[69]

54. Dr Ronald Hawksford has provided a statement confirming that he was working in the ED at ARRH on 31 March 2018 between 7.30am and 5.30pm. Dr Hawksford further confirmed that a copy of a Clinical Handover, Advice and Transfer of Care Form for

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64 Tab 24A Expert Report of A/Professor Holdgate, at [2.4]
65 Tab 7 Statement of Dr Manning, at [54]
66 Tab 19 GIDH Records (extracted at paragraph [31] above, containing the full extract of related notes)
67 Ibid; Tab 9 Statement of Dr Natukokona, at [22(n)]; Tab 7 Statement of Dr Manning, at [57]
68 Tab 19 GIDH Records (extracted at paragraph [31] above, containing the full extract of related notes)
69 Tab 7 Statement of Dr Manning, at [59]-[60]

Maureen Smith from ARRH is in his writing, and that the form would have followed a telephone conversation from a doctor at GIDH regarding the transfer of Ms Smith. The form noted as 'Situation/Background': [70]

> Ortho
> ↑ swilling of ® knee
> post steroid injection

55. He further noted under 'Recommendation/Request' that Ms Smith was 'Accepted by Ortho'

56. Professor Rawlinson opines that where there is a likelihood of sepsis, particularly if a diagnosis of septic arthritis is made, it is inappropriate for no antibiotics to be given for an extended period. Where there is a provisional diagnosis of "sepsis syndrome" he opines that urgent antibiotic treatment is indicated. Professor Rawlinson notes that in this case, the provisional diagnosis was for localised sepsis i.e., not sepsis syndrome. However, in the circumstances of Ms Smith's age (>65 years), previous surgery to the knee and recent hydrocortisone injection, it was not appropriate to withhold antibiotics for any significant period of time.[71]

57. At **1.05pm** to **1.06pm**, Dr Natukokona accessed the Clinical Applications Portal (**CAP**) in relation to Ms Smith.[72] He states that CAP is a computer system which allows access to certain patient records (for example, previous x-rays and blood test results) within the Hunter New England Local Area Health District (**HNELHD**).[73] In his statement, Dr Natukokona referred to accessing CAP after his first discussion with Dr Manning, and again referred to accessing CAP at some time before 2pm.[74]

58. The CAP search results show that the following searches were undertaken using Dr Natukokona's user identification, and were the only searches concerning Ms Smith or the GIDH Emergency Department undertaken on CAP that afternoon:

    a. "consolidated patient schedule, ED Search" (an **ED Search**), commencing at 1:05:11 pm and ending at 1:05:11 pm;

70 Tab 17 Statement of Dr Hawksford, at [5]-[6]
71 Tab 23 Expert Report of Professor Rawlinson, p.5 at [4.0(5)]
72 Tab 22 Letter for Crown Solicitor's Office, Annexure 1 CAP Audit Report
73 Tab 9 Statement of Dr Natukokona, at [23]
74 Ibid, at [22]-[26] and [32]

b. immediately after, a patient search report relating to Ms Smith commencing at 1.05.19 pm to and ending at 1.06.38 pm;

c. about twenty one minutes later, an ED Search commencing at 1:26:37 pm and ending at 1:26:37 pm; and

d. immediately after, an ED Search commencing at 1:26:49 pm and ending at 1:26:49 pm.[75]

Further care and attempts to arrange transfer to ARRH

59. At **1.10pm**, blood samples were taken.[76]

60. Dr Manning states that he asked the ED Nurse in Charge how patients were transferred to ARRH and he was advised that the nursing staff would book an ambulance for transfer (Dr Manning said he understood the non-urgent patient transfer service was not operating that day). Dr Manning states he advised the nurse that the transfer was for "investigation of a possible septic joint".[77]

61. The Patient Flow Unit (**PFU**) notes show a PFU Request by "Michael" (also recording "Doctor: Michael Manning") at **1.22pm**.[78] In her statement, Nurse Manager Lisa Welfare at the PFU says "it appears" that at **1.22pm**, she received a telephone call from Dr Manning in relation to an inter-hospital transfer to ARRH for "R septic knee joint", although Ms Welfare also states that she has no independent recollection of her involvement.[79] Dr Manning states that, to his recollection, he never made a phone call to Ms Welfare.[80]

62. At **1.26pm**, PFU notes entitled "Transfer Request for Smith Maureen" (**the Transfer Request Record**) include a record of the following, as well as noting Ms Welfare as "PFU First Contact":

> (Lisa Welfare) R septic knee joint.
> Dr Manning has spoken to Robert Hakwa and also ED – t/port has been booked [81]

63. Ms Welfare says in her statement that the notes in the Transfer Request Record relating to the 1.26pm call also state in the Transport section "Dr Manning – RN att" and that

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75 Tab 22DDD Letter from the Crown Solicitor's Office regarding CAP dated 29 October 2021; Tab 22J Letter from the Crown Solicitor's Office regarding CAP dated 16 March 2022 and 22M Letter from the Crown Solicitor's Office regarding CAP dated 12 May 2022
76 Tab 19A Pathology Report, p.132
77 Tab 7 Statement of Dr Manning, at [62]
78 Tab 22 Letter from Crown Solicitor's Officer, Annexure 2a PFU Records
79 Tab 22A Statement of Ms Lisa Welfare, at [5] and [6]
80 Tab 7A Supplementary Statement of Dr Manning, at [37]
81 Tab 22 Letter from Crown Solicitor's Officer, Annexure 2a PFU Records, p.2

the "Transport Arranged" section is ticked and explains her understanding of this is that Dr Manning had informed her that a RN had attended to booking transport and further, that she would not have been involved in the planning or timeframe of the transport.[82]

64. At **1.32pm**, the Transfer Request Record includes a record of the following:

> (Lisa Welfare) R septic knee joint.
> Dr Manning has spoken to Robert Hakwa and also ED – t/port has been booked.
> Not through PFU[83]

65. On the first page of the Transfer Request Record, the timeframe selected against that transfer is "<24 hrs". The other options for timeframe are "<1 hr", "<12 hrs" and ">24 hrs".

66. Ms Lisa Ramsland, A/General Manager, Tablelands Sector, HNELHD, states that the selection of a timeframe ought to have been based on the medically agreed timeframe (**MAT**) communicated by the referring and accepting doctors at the time of referral.[84]

67. Ms Welfare says in her statement that, in accordance with her usual practice, this note would reflect that she telephoned the ED of ARRH to confirm they were aware of the booking.[85]

68. In relation to the contact made with PFU, Ms Ramsland makes both of the following statements:

    a. "it is my understanding that PFU were not asked to coordinate the booking";[86] and

    b. "The PFU were not asked to co-ordinate this transfer".[87]

69. At **1.40pm**, Morphine and paracetamol were administered and, according to the RN Raymond MacLean, intravenous fluids were also commenced at this time.[88]

70. At **2.05pm**, nursing records note an entry by RN Dimity Cox that blood samples were taken for formal pathology including blood cultures from "R) CF."[89]

71. At **2:17pm**, RN MacLean made a phone booking (reference 1481416) with Non-Emergency Patient Transport, HealthShare NSW. Non-Emergency Patient Transport is

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82 Tab 22A Statement of Lisa Welfare, at [7]-[8]
83 Tab 22 Letter from Crown Solicitor's Officer, Annexure 2a PFU Records, p.2; Tab 13A Statement of RN MacLean, at [15]
84 Tab 18C Statement of Lisa Ramsland, at [46]
85 Tab 22A Statement of Lisa Welfare, at [10]
86 Tab 18C Statement of Lisa Ramsland, at [39]
87 Ibid, at [42]
88 Tab 19 GIDH Records
89 Ibid

now called Patient Transport Service (**PTS**) and remains part of HealthShare NSW. It will be referred to as PTS throughout this Summary, although some of the contemporaneous notes refer to "Non-Emergency Patient Transport". The PTS booking form records the following information, among other things:

a. Patient Info – R septic knee joint

b. Transfer Comment –

"DX: Osteomyelitis
HX: Chronic Pain
Accepted by Ortho Registrar for Ward via ED"

c. "Is the Patient Between the Flags? / Yes"

d. Pickup Time 31/03 14:10-16:20

e. Delivery Time 31/03 15:50-19:00

f. Status – "Cancelled".[90]

72. Dr Manning states that he has reviewed the PTS booking form and that he had not been aware of the reference to "Osteomyelitis". He also states that osteomyelitis would have "been similar to my working diagnosis (septic arthritis) in terms of its implications and urgency".[91]

73. PTS has confirmed that Ms Smith was classed as a 'Class C transport" under the "Service Specifications for Transport Providers, Patient Transport Service" published 12 January 2018.[92] The summary of a 'Class C' transport includes:

a. patient is expected to remain within 'Between the Flags' criteria;

b. may require equipment monitoring (with the exception of cardiac);

c. observation and monitoring of an intravenous infusion;

d. behaviourally stable;

e. condition is not life threatening and is not likely to become life threatening during transport; and

90 Tab 18A, Annexure B
91 Tab 7A Supplementary Statement of Dr Manning, at [23]
92 Tab 22B Statement of Shubjeet Kaur, at [4]-[5]

f. patients have been assessed by a registered nurse or medical practitioner as having low risk of deterioration.[93]

74. PTS has advised that an automated message is audible when HNELHD makes a booking with PTS via telephone, which includes the following statement:

> All patients must be assessed by an appropriately qualified nurse or medical practitioner as suitable for patient transport service before making the booking.[94]

75. Any PTS call taker is required to complete a digital "Call Taking Form" by asking certain questions in relation to each transfer type.[95]

76. PTS telephone transcripts show a call from RN MacLean to PTS, in which RN MacLean spoke to "Stuart", now known to be Stuart Reeves a Booking Officer at Greater Metropolitan Booking Hub (**GMBH**), to organise the transfer of Ms Smith.[96] Some of the conversation is noted below (with ellipsis representing minor comments or interjections). After some introductory remarks, Mr Reeves confirmed his understanding of the booking as:

> … so what've we got, so is specialist care over to Armidale, hospital emergency … Who's the authorising doctor at Glen Innes

77. RN MacLean stated:

> The authorising doctor is Dr Manning

78. After some administrative matters, the conversation continued as follows:

Mr Reeves:	… and why did she present to Glen Innes Hospital?
RN MacLean:	Um, she presented with osteomyelitis by the looks of it
Mr Reeves:	osteomyelitis … Any other medical history with her?
RN MacLean:	Um, just um chronic pain
Mr Reeves:	chronic pain. Ok so transferring over to ED for investigations
RN MacLean:	No, she'll actually go in through ED, but she's been accepted by the orthopaedic reg down there, don't ask me his name, my doctor didn't give it to me mate
Mr Reeves:	That's fine. So, accepted by ortho registrar. So going for a ward via ED
RN MacLean:	via ED, yes mate
Mr Reeves:	ok that's fine mate, no problem at all. That patient's going today, and what time will that patient be ready?

93 Ibid, at [6]
94 Ibid, at [9] [Note: includes a transcript of the full automated message]
95 Ibid, at [10] and Annexures 3 and 4
96 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, Annexure H, p.1

RN MacLean: be ready from now

Mr Reeves: sorry from now?

RN MacLean: yep

Mr Reeves: ok sweet

RN MacLean: and if you're really quick, I've got two ambo's sitting here doing nothing [laughter]

79. In some further exchanges, RN MacLean confirmed that Ms Smith is "between the flags" and responds "no" when Mr Reeves asks if she has any "MRO's or infections".

80. Mr Reeves then confirmed the booking in the following terms:

> Ok, sweet, alright so I'll just send that one through to despatch for you now. So I confirm it's from Glen Innes Hospital at Emergency Department to Armidale Emergency Department, accepted by ortho registrar, and patient is ready from now… booking number is 1481416. So the guys at despatch will look at it and get it planned in as soon as we possibly can for you mate

81. Mr Mohammad Al-Amin was a PTS Floor Operations Co-ordinator at GMBH. His statement explains that the PTS is used for patients who are clinically stable and within the scope and capabilities of the PTS. Mr Al-Amin is not clinically trained and explains that staff at PTS do not have access to patient notes. He states PTS staff do not determine whether a patient requires urgent transport as PTS staff are not trained to make such an assessment.

82. Mr Al-Amin states the relevant details for the transfer, including patient requirements, are provided by the person making the booking. If the booking is for an urgent transfer, the PTS staff are informed by the person making the booking and the booking request will contain a notation such as "urgent booking", "booking is for ambulance", "ambulance required" and/or "within 60 minutes". The PTS booking form does not include any of these phrases.[97]

83. Mr Al-Amin further explains in his statement:

> 13. I interpret the Booking Sheet as follows:
>
> a. at 1417 on 31 March 2018, Glen Innes Hospital requested transport to collect Maureen Smith, with a patient ready time at Glen Innes Hospital of 1420hrs on 31 March 2018;
>
> b. the transport was not booked as urgent; and
>
> c. the patient was to be admitted to the ward of the Armidale Hospital, via its Emergency Department.

[97] Tab 14B Statement of Mohammed Al-Amin, at [9]-[10]

> 14. The middle row of boxes on the Booking Sheet shows a pickup time of between 1410hrs and 1620hrs and a delivery time of 1550hrs to 1900hrs. This is an estimate only that is pre-generated by the booking system. It does indicate that the PTS vehicle will pick up the patient in that time. To the best of my understanding the estimate reflects a service level agreement between PTS and hospitals.[98]

84. Mr Al-Amin later notes that if the Booking Sheet indicated the patient was not suitable for PTS or required an urgent transfer the usual practice of PTS would be for the dispatcher to book an ambulance.[99]

85. At **2.30pm** ED Triage notes taken by RN MacLean state:[100]

> "NURSING. PT CARE ACCEPTED BY ARRH ORTHO. TRANSPORT BOOKED REF NO. 1481416. RN MACLEAN"

86. In his statement, RN MacLean confirms that at around **2.30pm** he had been informed by Dr Manning that Ms Smith was to be transferred to ARRH and that RN MacLean immediately contacted PTS to make a phone booking. He states he was informed by the PTS booking officer that they had no vehicle available at that time, but that one would be dispatched as soon as it became available.[101]

87. Dr Manning handwrote a referral to Armidale ED / Orthopaedics Registrar noting:

> Problem list:
>
> 1. Increasing pain. Multifocal but worse in R knee & sacrum.
> 2. R Knee swollen & warm
>
> – 10 days post cortisone injection
>
> – I-STAT white cell count ↑ Neuts [?neutrophils] 21.0
>
> 3. Acute kidney injury
>
> …
>
> Her R knee has worsening swelling and is warm to touch. Her point of care FBC shows a significant neutrophilia. Whilst we haven't documented a fever, given the above she was discussed with the Orthopaedic Registrar for ? septic joint. He has asked that we transfer her to Armidale Emergency Department for further assessment. He has asked for fresh bloods and X-ray. The cultures and bloods we have taken here in Glen Innes will be sent with her. [102]

98 Ibid, at [13]-[14]
99 Ibid, at [15]
100 Tab 19 GIDH Records
101 Tab 13A Statement of RN MacLean, at [17]
102 Tab 19 GIDH Records

88. The nurse in charge at GIDH between 2:30pm and 11:00pm was RN Adrianna Peitsch, having taken over from RN Cox who finished at 2.30pm.[103]

89. At **2:32pm**, according to the joint statement on behalf of HNELHD, NSW Ambulance (**NSWA**) and HealthShare NSW (**the Joint Response**), the notation of "R septic knee joint" was added into booking 1481416 under the "Patient Comment" field in the Patient Flow Portal by HNELHD.[104]

90. Dr Manning notes that there was a rise in Ms Smith's heart rate, recorded between 2.45pm and 4.30pm, which remained between the flags and while he was aware of this, he did not consider it sufficient to require a change of approach.[105]

91. At around **3-4pm**, Dr Natukokona states that he checked CAP and it indicated that Mr Smith had not left GIDH so he telephoned PFU to enquire about the reason for Ms Smith's delay. He states his impression from that conversation was that she would be arriving within the next few hours but that she had not yet left GIDH.[106] The CAP search results do not appear to show this check having been undertaken by Dr Natukokona under his login,[107] nor do the CAP search results show any CAP searches (under any login) relating to either GIDH or Ms Smith during that time.[108]

92. Mr Al-Amin states that the log shows that he and two dispatchers searched for a vehicle for the transport and could not find one. He states he adopted normal practice when there was no PTS vehicle available and transferred the booking through the Electronic Booking Service (**EBS**) to NSWA. The EBS uses an online portal to manually transfer the booking to NSWA.[109]

93. The booking information forwarded to NSWA noted:

> PT 75YO F WGHT: <=150KG NON INFECTIOUS
> STRETCHER DIAGNOSIS: OSTEOMYELITIS .. RCV LOCN:
> ED, EBS: DX: CHRONIC PAIN
> ACCEPTED BY ORTHO REGISTRAR FOR WARD VIA ED

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103 Tab 18C Statement of Lisa Ramsland, at [59]
104 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, at [12]
105 Tab 7A Supplementary Statement of Dr Manning, at [13]
106 Tab 9 Statement of Dr Natukokona, at [35]
107 Tab 22 Letter from the CSO, Annexure A CAP Audit Report
108 Letter from the Crown Solicitor's Office regarding CAP dated 29 October 2021; Tab 22J Letter from the Crown Solicitor's Office regarding CAP dated 16 March 2022 and 22M Letter from the Crown Solicitor's Office regarding CAP dated 12 May 2022
109 Tab 14B Statement of Mohammed Al-Amin, at [16]-[17]

PATIENT IS READY FROM 1420[110]

94. The forwarded information did not include the note "R septic knee joint". This information was contained within an additional comments field and was not forwarded via the EBS. The Joint Response accepts that this was relevant information which should have been forwarded to NSWA.[111]

95. Mr Al-Amin states the EBS booking was made at **3:13pm** and that he notified the Western Control Centre at NSWA of the transfer at **3:15pm**, which is confirmed by the transcript of calls from PTS in which Mr Al-Amin is recorded as speaking to "Juanita" at NSWA to advise that PTS had "EBS'd, a patient going from Glen Innes ED to Armidale ED" before confirming that patient was Maureen Smith.[112] The PTS log annexed to Mr Al-Amin's statement confirms EBS at 1513 hours, and 'WESTERN ACCEPTED. MA at 1515 hours'.[113]

96. PTS telephone transcripts show that Mr Al-Amin then called GIDH at **3:22pm** and spoke to "Amy"[114] and advised the booking had been transferred to NSWA.[115] In his statement, Mr Al-Amin says he then cancelled the booking at **3:22pm** as Ms Smith's transport had been transferred to NSWA (and that this was the usual process when a booking is transferred via EBS).[116]

97. Since that time, HNELHD and HealthShare NSW have commenced a pilot programme called 'Ways of Working', pursuant to which, if PTS cannot facilitate a booking, the PTS officer contacts the ward that made the booking and requests them to either reschedule the non-emergency transfer to another suitable time, or, if the patient must be transferred via NSWA, the PTS officer will advise them to contact NSWA directly.[117] In a statement

110 Tab 21A Statement of Lauren Mansell, Annexure J Incident Detail Report 60050

111 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, at [14] [Note: CSO commented that "(a) the medically agreed timeframe is provided by the hospital at the time of booking; and (b) the information provided by the hospital was that the patient was ready from 1420 with no medically agreed timeframe requested at the time of booking, in the markup of this Summary of Evidence on 7 September 2021]

112 Tab 22B Statement of Shubjeet Kaur, at [18]-[19] and [27]; Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, Annexure H Transcripts, p.4

113 Tab 14B Statement of Mohammed Al-Amin

114 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, p.15 the PTS transcript of that phone call states that it was between Mr Al-Amin and RN Cupitt; Tab 10 Statement of RN Cupitt does not mention that call or any other related call that RN Cupitt was personally involved in

115 Tab 14B Statement of Mohammed Al-Amin, at [20]; Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, Annexure H Transcripts, p.5

116 Tab 14B Statement of Mohammed Al-Amin, at [21]

117 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, at [38]-[41]; Tab 22B Statement of Shubjeet Kaur, at [25]-[26] and Annexure 6

on behalf of PTS and HealthShare NSW, Shubjeet Kaur states that this is "significant change", noting:

> PTS does not have access to patient records and therefore is not the most effective source of information for any booking being forwarded to NSWA. The new programme ensures direct communication between the requesting agency (HNELHD) and the transfer agency (NSWA).[118]

98. At **4:49pm**, Mr Mark Dunworth of NSWA called Mr Al-Amin from PTS concerning a booking "from you guys" (i.e. from PTS) and Mr Dunworth stated:

> I was just wondering why we got that, there didn't seem to be anything in the job to indicate why it would have to go with Ambulance, other than if you just didn't have a crew.

99. Mr Al-Amin responded that Ms Smith was suitable for PTS but that "we do not have anyone in the area … until tomorrow". Mr Dunworth confirms he was aware of the policy that NSWA was to provide support to local health districts to achieve timeframes for inter-facility transport for specialist review within 24 hours, where there was insufficient PTS crew available to do so and says he "thought that Ms Smith would be transported by PTS within a 24-hour period".[119]

100. Mr Dunworth said that he had a crew out of town doing a transfer and could not send an emergency crew out of town simply because there was no patient transport vehicle available, he said "like if they are going to ED because they need treatment for something straight away there is a good case to do that" but not if they were going to pass through ED to "sit on the ward at Armidale until someone could do something". Mr Dunworth said he would put the job "on the back burner and it may come back to you tomorrow". Mr Al-Amin replied "ummm, no problem, cool, cool".[120] Mr Al-Amin states that the "Log" shows he advised his senior supervisor, the team leader of GMBH, of the conversation with Mr Dunworth.[121] A copy of the "Log" is annexed to Mr Al-Amin's statement and includes a notation stating at 1654 hours "ADVISED TL [Team Leader]. MA."[122]

101. Mr Dunworth accepts that he implied there was limited NSWA capacity to conduct Ms Smith's transfer and suggested that he did not have a "spare" crew.[123]

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118 Tab 22B Statement of Shubjeet Kaur, at [27]
119 Tab 14AB Third Supplementary Statement of Mark Dunworth, at [8]
120 Tab 14 Statement of Mark Dunworth, Annexure A
121 Tab 14B Statement of Mohammed Al-Amin, at [22]-[23]
122 Ibid
123 Tab 14AB Third Supplementary Statement of Mark Dunworth, at [10]

102. Mr Robert Fairey, A/Chief Superintendent (Western Control Centre NSWA) confirms that there was capacity for a NSWA transfer at that time.[124] In terms of NSWA crew availability at around that time, Mr Fairey confirms that:

    a. as at 3:15pm that day:

        i. there were at least seven crewed NSWA vehicles within 100km of GIDH that were not then allocated to a job, including one at Glen Innes Station;

        ii. a further crew from Armidale Station had just completed a job and was returning to the station; and

        iii. another crew from Tenterfield Station had been assigned to an inter-hospital transfer but was called off that job shortly after.[125]

    b. as at 4:49pm that day, at least seven crewed NSWA vehicles remained within 100km of GIDH that were not then allocated to a job, including one at Glen Innes Station;[126] and

    c. as at 5:07pm that day, at least four crewed NSWA vehicles remained within 100km of GIDH that were not then allocated to a job, including one at Glen Innes Station, with a further two who "did not attend a case" at that time.[127]

103. The PTS phone transcript confirms that GIDH called PTS at **5:03pm** on 31 March 2018. According to the transcript, "Ray" from GIDH spoke to "Shevin" at PTS about the booking for Ms Smith's transfer, citing booking number 1481416.[128] This may be the same call RN MacLean refers to in his statement, which he says he made at around **5.00pm** to PTS for a status update on Ms Smith's transfer.[129] The transcript shows that "Ray" asked:

> Yeah, just want to know how it's going, I haven't heard anything from anybody, other than I've been told it's been booted to Ambulance. Just want to know how long it's going to be, we need to get this patient down there[130]

104. "Shevin" responded:

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124 Tab 21B Statement of Robert Fairey, at [62]
125 Ibid, at [58]
126 Ibid, at [59]
127 Ibid, at [60]
128 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, Annexure H Transcripts, p.6
129 Tab 13A Statement of RN MacLean, at [18]
130 Audio is available at Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, Annexure E

> Yep, so it has been moved to Ambulance, so I no longer have umm access to what time they'll be picking her up. But I can give you the phone number to call to make the enquiry.[131]

105. Mr Al-Amin states that this call is reflected in the Log attached to his statement but that he was not involved and "did not do anything in relation to the patient for the rest of my shift".[132] The Log attached to his statement confirms a notation at **5.05pm**:

> ADV. PT TO CALL AMBULANCE IN RELATION TO ETA AS BOOKING WAS NO LONGER WITH US – CB.[133]

106. RN MacLean states that he then contacted NSWA and spoke to the Western District Co-ordinator.[134] At **5:07pm** RN MacLean spoke to Mr Dunworth of NSWA. RN MacLean said to Mr Dunworth that he had "booked or we rang for transport for a patient to transfer into Armidale a few hours ago".[135] Mr Dunworth told RN MacLean:

> I was talking to Non-Emergency patient transport and they suggested suitable for them to take. They just don't have a vehicle and probably won't have one till tomorrow morning, so they're keeping that booking and then once they get a crew tomorrow they'll be taking her down to Armidale. So it'll be tomorrow I'd say.[136]

107. RN MacLean asks Mr Dunworth to "hang on for a minute", there is talking in the background, after which RN MacLean states:

> …Mark I've just been speaking to the doctor up here, mate, he wants her to go today

108. Mr Dunworth responds:

> Yeah, that's fine, I can't send my emergency ambulance out of town to transfer, they're actually going to be assisting Tenterfield with a very sick patient coming down to go to Armidale … so yeah, look, patients that are suitable to go with patient transport have to go with them, we can't, we'll get … anyway, the thing with it is if they are suitable to go with patient transport, they go with patient transport, not in an emergency ambulance because we can't take our emergency resources out of the town for something that isn't an emergency because someone who does need it and we're not there and we're transporting a non-emergency case, yeah we can't explain that so it'll be, yeah… If the patient develops any condition that, you know, would then put her outside the flags and needing immediate transport, it's only a phone call back to us with all the details and we can work something out but while they are quite stable and meeting the transport criteria for non-emergency transport, we can't put them in an emergency vehicle.

109. NSWA confirms that despite the reference to PTS "keeping that booking", the booking was with NSWA as at the time of the call and was not closed with NSWA until 7:38am the following day.[137]

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131 CSO has advised that 'Shevin" is a reference to Charvind Bains
132 Tab 14B Statement of Mohammed Al-Amin, at [24]-[25]
133 Ibid
134 Tab 13A Statement of RN MacLean, at [19]
135 Tab 14 Statement of Mark Dunworth, Annexure A
136 Audio of the conversation is available at Tab 21A, Annexure G
137 Tab 21B Statement of Robert Fairey, at [38]-[39]

110. Mr Dunworth subsequently stated that, the mention of "sepsis" is "an alarm bell for me". [138] He stated that if "sepsis" had been mentioned in his conversations with Mr Al-Amin or RN Mclean, or if had been contacted later and been advised that the patient's condition had deteriorated, he would have reallocated NSWA resources and sent an ambulance as soon as possible.[139] Mr Dunworth also observed that, in the "Incident Detail Report" related to the booking, there was similarly no mention of "septic joint" or "sepsis", instead there was a statement that Ms Smith was "NON INFECTIOUS". Separately, the "Incident Detail Report" also described Ms Smith's condition as "osteomyelitis" (an infection of the bone which can develop into sepsis), which was also mentioned by Mr Dunworth to Mr Al-Amin in the telephone call at 4.49pm.[140]

111. Dr Manning states that he was present in ED at the time of a phone call to the Ambulance service, handwriting the initial referral letter to Armidale ED, but does not specify the time of that call or who from GIDH made that call.[141] Dr Manning states that he had the impression that "the Ambulance service was pushing back and did not want to divert Ambulance officers to transfer Ms Smith", although he also stated his recollection that "it was not an immediate "*no"* from the Ambulance services at that time and I understood the Ambulance service might still be able to transfer Ms Smith that day".[142] Dr Manning states that he instructed the nursing staff at some point during discussions to advise the Ambulance service that Ms Smith required immediate transfer that day.[143]

112. RN Pietsch was the nurse in charge at GIDH that afternoon and evening. She states that in her experience "it was not unusual around that time to encounter difficulties at GIDH securing transport for patients who needed transfer between hospitals".[144] RN Alyssa Lowe was a locum nurse working at GIDH at the time and stated "patient transport and booking ambulances was always difficult in Glen Innes. It was always a long wait to have ambulances retrieve your patients".[145]

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138 Tab 14 Supplementary Statement of Mark Dunworth, at [5] and Annexure A, p.3
139 Ibid, at [10]
140 Ibid, at [6], Annexure B, p.1 and Annexure A, p.1
141 Tab 7 Statement of Dr Manning, at [64]
142 Ibid, at [64]-[65]
143 Tab 7 Statement of Dr Manning, at [67]
144 Tab 13G Statement of RN Adriana Pietsch, at [9]
145 Tab 13H Statement of RN Alyssa Lowe, at [16]

113. Ms Lauren Mansell, Deputy Director Western Control Centre, NSWA states that NSWA complied with all policies and procedures in relation to the transfer of Ms Smith.[146] However, she states that:

    a. there was a potential system issue that arose during the call at 5.07pm, in which NSWA was informed that a medical practitioner had requested transfer that day;[147] and

    b. there may have been a lost opportunity on the call between Mr Dunworth of NSWA and GIDH, "or escalation pathways", to question why Dr Manning wanted the transfer to occur on Saturday 31 March 2018 (the same day).[148]

114. A/Professor Holdgate observed, in connection with the 5:07pm telephone call transcript, that Mr Dunworth "essentially dismisses the doctor's request", also noting it is "very unfortunate" that Mr Dunworth did not seek further information regarding why the doctor wanted Ms Smith to be transferred that day.[149]

115. Mr Dunworth states that he regrets not making any further enquiry as to why the doctor wanted Ms Smith transported.[150]

116. A/Professor Holdgate refers to the HNELHD and NSWA Interhospital Patient Transport Process dated December 2017, in particular, the matrix on page two which states the time to dispatch should be a MAT between the referring clinician (RN or medical officer) and the accepting medical officer.[151] A/Professor Holdgate concluded there was clearly no MAT, as both Dr Manning and Dr Natukokona wanted Ms Smith to be transferred on 31 March 2018, not the following day, and that the failure to consider the opinions of the referring and accepting doctors with respect to the timeframe for Ms Smith's transfer was a breach of policy.[152]

117. According to nursing expert RN Eunice Gribbin, there was a failure by nurses to escalate Ms Smith's care up the chain of command (to the nurse in charge and/or the hospital manager covering GIDH over the long weekend) to action a call to NSWA to explain

146 Tab 21A Statement of Lauren Mansell, at [20]
147 Ibid, at [21]
148 Ibid, at [23]
149 Tab 24C Second Supplementary Report of A/Professor Holdgate, p.2
150 Tab 14AB Third Supplementary Statement of Mark Dunworth, at [9]
151 Tab 21A Statement of Lauren Mansell, Annexure O Joint Inter-Hospital Patient Transport Process, p.2
152 Tab 24C Second Supplementary Report of A/Professor Holdgate, p.3

the urgency of the request.[153] She opines that nurses should have contacted Dr Manning and asked that he personally call the NSWA to explain the situation and insist upon transfer by ambulance that day.[154]

118. In his statement, RN MacLean says that after his call with NSWA (i.e. after **5:07pm**), he then called PTS again who told him that Ms Smith would be transferred on the morning of Sunday 1 April 2018.[155] The telephone call transcripts from PTS do not include a record of this call and PTS has subsequently advised from its review, there is no further telephone call identified from GIDH on 31 March 2018 after 5:07pm.[156] RN MacLean states that he then informed Dr Manning of the updates concerning NSWA and PTS.[157]

119. Dr Manning states that he did not know until 5:00pm that "the Ambulance service had categorically refused to take Ms Smith that day, particularly while her observations were within normal limits", and confirms that it was RN MacLean who informed him that NSWA "had finally categorically said no to Ms Smith's transfer. I understood they would only consider taking Ms Smith if she was to deteriorate in her observations (to fall outside the flags)".[158] Dr Manning accepts that he should have directly spoken with NSWA to express the urgency of her transfer.[159]

120. At **5.20pm** GIDH nursing records document (apparently an entry by RN MacLean):[160]

> SPOKE TO NSW AMB WESTERN CO-ORD RE TRANSFER OF PT TO ARRH ED. THEY ADVISE THAT PT IS NOT SUITABLE FOR AND DOES NOT REQUIRE AMBULANCE TRANSFER THEY HAVE HANDED TRANSFER BACK TO PT TRANSPORT WHO HAVE NOTHING AVAILABLE UNTIL TOMORROW 01/4/18. I ALSO SPOKE WITH LEE NIXON WHO IS LISTED AT PT'S NOK SHE IS UNWILLING TO DRIVE PT TO ARRH TODAY [RN MacLean].

121. The Crown Solicitor's Officer (**CSO**) has confirmed that "NSWA kept [the] booking on its system until the following morning".[161]

122. The Inter-Hospital Patient Transport Process policy of HNELHD and NSWA sets out the policy and guidelines to be followed in relation to transfers such as that of Ms Smith

153 Tab 25 Expert Report of RN Gribbin, p.4
154 Ibid, pp.22-23
155 Tab 13A Statement of RN MacLean, at [20]
156 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare; Tab 22B Statement of Shubjeet Kaur, at [99]
157 Tab 13A Statement of RN MacLean, at [21]
158 Tab 7A Supplementary Statement of Dr Manning, at [19]
159 Ibid, at [22]
160 Tab 19 GIDH Records
161 Tab 21A Statement of Lauren Mansell, Annexure J Incident Detail Report 60050, at [25] states incident closed at **0738** hours on 1 April 2018 [Note: CSO comments in relation to this Summary of Evidence dated 7 September 2021]

between GIDH and Armidale Hospital.[162] Among other things, it states that the recognition of the need for NSWA to transfer a patient is outlined against three clinical criteria,[163] being:

1. The patient has a life-threatening condition that requires emergency transport.
2. The patient is behaviourally unstable requiring mechanical restraint.
3. A patient is assessed as likely to deteriorate and fall outside of "Between the Flags" criteria.

123. In his supplementary statement, Mr Peter Williams, General Manager, Tablelands Sector, HNELHD confirmed that HNELHD has reviewed its guidelines around inter-hospital patient transport, and that the Inter-Hospital Patient Transport Process policy of HNELHD and NSWA was updated in August 2019, however the criteria for ambulance versus non-emergency patient transport for inter-hospital transfers did not require change.[164]

124. In March 2020, the HNELHD issued an updated Clinical Policy Compliance Procedure "Inter-Facility Transfer for Patients requiring Specialist Care", which states that the referring medical officer is to "[d]etermine the transport modality and level of clinical escort required in consultation with the receiving Specialist".[165]

125. Mr Williams states that a medical officer orientation manual has been improved since the death of Ms Smith.[166] That manual is dated April 2021 and is annexed to Mr Williams' further statement and contains a section titled 'Policies and Guidelines', which states that: 'Hard copies of MoH and NHE policies and Guidelines exist within departments; however these may also be accessed through the HNE intranet" and includes a link to a number of policies.[167]

126. The April 2021 manual:

    a. does not include reference to the Clinical Policy Compliance Procedure "Inter-Facility Transfer for Patients requiring Specialist Care"; and

[162] Tab 21 NSWA Records, Inter-Hospital Transport Process dated 21 December 2017 (also located at Tab 21A Statement of Lauren Mansell, Annexure Y and Tab 18 Statement of Peter Williams, Annexure Q2)
[163] Tab 21 NSWA Records
[164] Tab 18B Supplementary Statement of Peter Williams, at [17]
[165] Ibid, at [18] (also located at Tab 18 Statement of Peter Williams, Annexure P2, p.407
[166] Ibid at [2] and Annexure A Medical Officer Orientation Manual, p.12
[167] Ibid

b. includes no other reference describing the obligation on the medical officer described in the above paragraph.

127. Mr Williams identifies the following as improvements to the April 2021 manual:

a. inclusion of a protocol for suspected septic joint;

b. PFU call protocol;

c. NSWA Escalation Process;

d. clarification concerning the RN in Charge and PFU; and

e. moving the escalation flowcharts into the body of the document.[168]

128. In October 2021, a further edition of the medical officer orientation manual was issued.[169] The manual includes the following relevant additions:

a. a detailed contacts list with a subheading "Interhospital Transfer Key Contacts";[170]

b. reference to an acute care pathway for sepsis available in hardcopy in the ED;[171]

c. addition of a section entitled "Escalation of Patient Care to Speciality Services" outlining the formal network for accessing support and advice;[172]

d. addition of a section entitled "Interfacility Transfer for Patients requiring Specialist Care" which states:

i. the PFU is required to coordinate transfers between **7.00am** and **9.00pm** and involves all relevant clinicians;

ii. at all other times the referring clinician co-ordinates the transfer themselves, directly with the specialist service medical officer;

iii. that once transfer is confirmed, it is the responsibility of GIDH staff (not PFU) to make the booking; and

iv. includes a reference to the "Inter-facility Transfer for Specialist Care" policy.[173]

168 Tab 18B Supplementary Statement of Peter Williams, at [6]-[7]
169 Tab 22I GIDH Medical Officer Orientation Manual dated October 2021
170 Ibid, p.5
171 Ibid, p.9
172 Ibid, p.10
173 Ibid, pp.10-11

e. addition of a section entitled "Role and Responsibilities of the Referring Medical Officer for InterFacility [sic] Care" which states:

- "Perform a clinical assessment of the patient's condition, including identifying any pathology or imaging required to assist in determining clinical status and need for transfer
- Contact the PFU or specialist service to refer the patient and discuss the plan of care with the senior specialty clinician
- This includes determination of the Medical Agreed Timeframe (MAT). The MAT is the time that the patients needs to be at the receiving facility from a clinical perspective. The referring and accepting medical officers, together, identify the MAT.
- Determine the transport modality and level of clinical escort required in consultation with the receiving Specialist
- Contact the PFU/accepting specialist service in the event of clinical deterioration while awaiting transfer for, updated treatment advice and reassessment of the urgency for transfer
- Maintain responsibility for the patient while patient transfer is pending
  Exception: Responsibility is transferred to the Retrieval Service when they take over patient care"[174]

f. addition of a section entitled "Patient Transport Delays" prompting the use of the existing NSWA escalation flowchart;[175]

g. addition of sections outlining the availability of radiology and pathology;[176]

h. inclusion of a PFU three-way conference call visual aide;[177] and

i. inclusion of the Adult Sepsis Pathway tool.[178]

129. The October 2021 manual does not include copies of the policies identified within the body of the manual as annexures. Alternatively, the policies appear to be hyperlinked to a NSW Health intranet page.

Ms Smith's care after it was clear there would be no transport on 31 March 2018

130. Having been advised that Ms Smith was not going to be transported to ARRH that day, in A/Professor Holdgate's opinion:

a. the advice given by Dr Natukokona to Dr Manning at this point to withhold antibiotics was inappropriate as it meant that, even with a transfer early the

[174] Tab 22I GIDH Medical Officer Orientation Manual dated October 2021, p.11
[175] Ibid, pp.12-13
[176] Ibid, p.14
[177] Ibid, p.20
[178] Ibid, pp.22-25

following morning, the patient would face a delay of nearly 24 hours prior to diagnosis and treatment which is not clinically acceptable;[179]

b. the most appropriate advice to Dr Manning would have been to aspirate the knee at GIDH and then commence antibiotics;[180]

c. in circumstances where Dr Manning did not have the skill or experience to perform a knee aspiration, Dr Manning and Dr Natukokona should have liaised with NSWA to arrange an urgent ambulance transfer to ARRH;[181]

d. it was not appropriate for family or friends to transfer Ms Smith;[182] and

e. if an ambulance transfer still could not occur, antibiotics should have been commenced.[183]

131. Further, A/Professor Holdgate opines that, upon learning that Ms Smith was not to be transferred that day, Dr Natukokona should have: [184]

a. discussed with Dr Manning his ability to perform an aspiration of the knee joint and, failing the ability to execute of that procedure by Dr Manning, Dr Natukokona should have advocated strongly for Ms Smith to be transferred to ARRH that day;

b. recommended that antibiotics be commenced at GIDH; and

c. at a minimum, discussed the case with his consultant orthopaedic surgeon to get further advice in relation to Ms Smith's care.

Second review by Dr Manning

132. RN Mclean states that, at Dr Manning's instruction, he arranged for Ms Smith to be transferred to a ward bed overnight and handed over to one of the ward nurses at about **5:50pm**.

133. At **6.00pm**, GIDH nursing records (apparently an entry by EN Amy Cupitt):[185]

> Admission attended in ED. High Falls Risk. Handed over to evening staff – please attend FRAMP. Pt also confused @ times. IV in progress. Transferred to ward at 18.10hrs.

179 Tab 24A Expert Report of A/Professor Holdgate, p.7 at [3.3]
180 Ibid
181 Ibid
182 Ibid, p.6 at [2.6]
183 Ibid, p.7 at [3.3]
184 Tab 24B Supplementary Report of A/Professor Holdgate, p.4 at bullet point 1
185 Tab 19 GIDH Records

134. According to the statement of EN Cupitt, at approximately **6.00pm**, EN Cupitt completed the Adult Inpatient Admission Form and Risk Assessment Form and in doing so, asked Ms Smith if she had a current history of MRSA, vancomycin-resistant enterococcus (**VRE**), to which Ms Smith answered 'No'.[186]

135. Also at **6.00pm,** clinical notes reflect that Dr Manning had reviewed Ms Smith again noting:

> 75♀ ? Septic R knee
>
> accepted for transfer to armidale
>
> Ambulance unable to transport
> Patient flow aware
>
> No family or friends available or willing
>
> One friend who rang in to enquire declined as they had spent the last 3 days with her
>
> R knee remains tender, swollen and warm to touch
>
> Confusion more noticeable[187]

136. Dr Manning clarifies that his reference to "patient flow" was a general term for the administration that co-ordinated the interhospital patient transfers either by ambulance or by PTS.[188]

137. Further, Dr Natukokona says in his statement that at 6.00pm, Dr Manning and PFU rang his mobile telephone in a three way link, in which PFU advised him that Ms Smith would be admitted overnight at GIDH and transferred to ARRH first thing the following morning, a decision which Dr Natukokona says he questioned before advising that Ms Smith should be transferred immediately to ARRH.[189] Dr Manning says that he does not recall any "three way" phone call.[190] Ms Welfare says in her statement that if a three way conference call had taken place it would have been documented in the PFU database progress notes.[191]

[186] Tab 10 Statement of Amy Cupitt, at [14]
[187] Tab 19 GIDH Records
[188] Tab 7A Supplementary Statement of Dr Manning, at [15]
[189] Tab 9 Statement of Dr Natukokona, at [37]
[190] Tab 7 Statement of Dr Manning, at [122(a)]
[191] Tab 22A Statement of Lisa Welfare, at [6]

Second contact with orthopaedic registrar at ARRH

138. Further notes by Dr Manning on 31 March 2018 appear to be the final entry in the GIDH Clinical Notes before 1 April 2018 and document a discussion with Dr Natukokona. Those notes read:

> …
>
> Patient flow advise transport available tomorrow
>
> Plan. Admit here.
> D/w Ortho Registrar
>
> -request no abs
> -monitor o'night
> -they want to tap knee
>
> Continue IV fluids
> analgesia
> reculture if febrile
> repeat POC FBC + Chem 8
> tomorrow[192]

139. Dr Manning states that at no point in either discussion with Dr Natukokona did Dr Natukokona ask Dr Manning to "perform the joint aspiration procedure, as he did not agree with my assessment of a septic process. Dr Natukokona wanted to see Ms Smith and perform the aspiration himself if he felt it was necessary".[193]

140. The noted conversation with the "Ortho Registrar" was the subject of oral evidence.

141. An explanation of the records was sought in oral evidence along with what was conveyed to nursing staff.

142. In his statement, Dr Manning said that he told [unnamed] nursing staff that if, at any time during the evening, they were worried about Ms Smith, or if Ms Smith deteriorated, developed a fever/temperature, to contact him immediately. He stated that he expected Ms Smith would remain under close and regular observation by nursing staff but accepts in hindsight he should have specifically documented and advised nursing staff to keep Ms Smith under close observation, at least 4 hourly.[194]

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[192] Tab 19 GIDH Records [Note: these notes begin at the top of a page without specifying the exact time, although they appear to be a continuation of Dr Manning's 6.00pm notes mentioned in paragraph [133] of this Summary of Evidence]
[193] Tab 7A Supplementary Statement of Dr Manning, at [29]
[194] Ibid, at [82]-[84]

143. At **7.20pm**, an "Afterhours Admission / Transfer / Discharge Form" was completed in relation to Ms Smith, noting admission at GIDH and transfer to ward at 1900hrs, "Admission Reason: Fall".[195]

144. At **9.15pm** nursing recorded (apparently an entry by RN Alyssa Lowe):[196]

> Analgesia given with good effect. Pt refused to be turned @ 2030. IVF in progress for tx to armidale tomorrow for ortho review. Vitals stable, afebrile.

145. Observations were recorded on seven occasions between **11.40am** and **8.45pm** on 31 March 2018 and most signs remained within normal limits although, according to A/Professor Holdgate, the "heart rate was persistently at the upper end of the normal range".[197]

146. In her expert nursing reports, RN Gribbin states that there was a failure to closely observe and monitor Ms Smith. RN Gribbin was only able to identify two partially entered, hourly rounding checks overnight on 31 March 2018. RN Gribbin opines that nurses would or should have known to closely monitor Ms Smith's observations overnight every hour and that this was particularly important in Ms Smith's case, in light of her suspected septic right knee and acute kidney injury, which a reasonably competent nurse would have identified as issues which can lead to rapid deterioration requiring close and regular monitoring.[198]

147. The nurse in charge at GIDH from 10.45pm to 7.15am the next morning was RN Heather Conyard, having taken over from RN Adrianna Peitsch who finished at 11.00pm.[199]

148. In her statement, RN Conyard recounted that at 11pm, during her first round of the patients following handover, she observed Ms Smith to be sleeping, and that hourly rounds continued to be performed on the patients, including Mrs Smith throughout the shift.[200]

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195 Tab 19 GIDH Records, ARRH Afterhours Admission / Transfer / Discharge Form dated 31 March 2018
196 Tab 19 GIDH Records
197 Ibid; Tab 24A Expert Report of A/Professor Holdgate Report, at [1.13]
198 Tab 25 Expert Report of RN Gribbin, pp.4-5, 21
199 Tab 18C Statement of Lisa Ramsland, at [59]
200 Tab 12 Statement of RN Conyard, at [10]

D. 1 APRIL 2018: GIDH CARE

149. At **6:45am** vital signs were taken and at **7.00am** on 1 April 2018 EN Jeanette Murphy who recorded:

> Pt observed to be talking in sleep overnight. Obs attended and remain between the flags as per SAGO chart. Pt is unable to swallow paracetamol this am, not able to use straw for fluids -not understanding what to do with this action. Reported to RN Conyard (Murphy EEN)[201]

150. Observations recorded at 6:45am are recorded as follows:

> RR 18bpm, SpO2 98% on nasal prongs, BP 128/63, HR 100bpm and regular, neurological observation level was alert, T = 36.9, pain level "R" for resting.[202]

151. In her statement, EN Murphy stated that:

> I was not sure why Mrs Smith could not use the straw, and considered that it was possibly because I had woken her or because her mouth was too dry[203]

152. RN Conyard said, in her statement, that:

> Ms Smith was orientated as to person and place but had difficulty sucking water through a straw so she could take her medication. This was overcome by EN McDonald assisting Mrs Smith to drink from a glass[204]

153. A/Professor Holdgate opines that the above note recorded by EN Murphy indicates that Mrs Smith was confused and unable to coordinate drinking from a straw.[205]

154. RN Gribbin observes that no fluid balance chart was maintained in relation to Ms Smith, and the above entry (which she notes to have been recorded at 6.45am) was the only observation recorded since 8.45pm on 31 March 2018. No further observations were recorded for the remainder of Ms Smith's time at GIDH, constituting a delay of ten hours overnight without recorded observations and a further delay of eight hours after the single recorded observation referred to above,[206] which RN Gribbin states would have made early detection difficult.[207]

155. RN Gribbin also states that Ms Smith's decline on this morning required an immediate response by way of escalation up the chain of command to expedite an appropriate

[201] Tab 19 GIDH Records, p.28; Tab 13 Statement of RN Murphy, at [15]
[202] Tab 13 Statement of RN Murphy, at [13]; Tab 19 GIDH Records, p.28
[203] Tab 13 Statement of EN Murphy, at [16]
[204] Ibid, at [12]
[205] Tab 24A Expert Report of A/Professor Holdgate, at [1.14]
[206] Tab 25 Expert Report of RN Gribbin, pp.4 and 17
[207] Tab 25A Supplementary Report of RN Eunice Gribbin, at [1.1]

response[208] but states that, despite Ms Smith's apparent decline in condition, the nurses failed to call Dr Manning or escalate Ms Smith's care up the chain of command.[209]

156. The nurse in charge at GIDH from 7.00am was RN Cox, taking over from RN Conyard who finished at 7.15am.[210]

157. At **7.22am**, nursing recorded:

> Phone call from Mark, After Hours Bed Manager in Armidale Hospital, received 0655 hrs. Advised that on Pt being transported to ARRH today – pending transport confirmation – for staff to contact ARRH ED to hand Pt over as it is unclear if any handover to ARRH staff has been attended from nursing staff[211]

158. Around this time, PFU called GIDH to advise that there was no booking. A notation at **7.41am** in the PFU notes states the following (which may be a later entry for that call, not reflecting the actual time of the call):

> "(Stacey Greentree) Pt not moved overnight-ward following up"

159. At **7.30am**, GIDH nursing recorded:[212]

> Pt flow manager Stacey called regarding no booking. Booking confirmed – rebooked for today. Booking # 1481727 ?10am, not confirmed time at this stage but will be transferred today

160. At **7:28am**, PTS telephone records show a call from GIDH to PTS in which it appears that "Hannah McCarthy" who identifies herself as a nurse from GIDH, speaks to "Stu" (understood to be Mr Stuart Reeves) at PTS. Some of that conversation is set out as follows (with minor interjections and comments represented by ellipses). Ms McCarthy said:

> I've got a patient here that we've got written down for transfer, er, transport to Armidale Hospital today. I've just been contacted through Patient Flow saying that no booking has been made for the same … and I was wondering if it is possible if we could try and organise something[213]

161. After some discussion to ensure identification of the patient and locations, Mr Reeves confirmed:

> yes there was a booking made, um it was created on the 31st which was yesterday at 2:17 in the afternoon by myself from Ray … um, I made that booking, and she was getting accepted by the ortho registrar down at the ward via ED … and it was transferred to NSW Ambulance

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208 Tab 25A Supplementary Report of RN Eunice Gribbin, at [1.2]
209 Ibid, p.5
210 Tab 18C Statement of Lisa Ramsland, at [59]
211 Tab 19 GIDH Records
212 Ibid
213 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, Annexure H Transcript, p.7 and Annexure F Audio

162. The transcript then refers to "GI" (which may be a reference to GIDH and therefore to Ms McCarthy), who said:

> Well, NSW Ambulance had actually rung back, and this was documented at 1720 …

163. Ms McCarthy continued:

> … and Ray's written this, that spoke to NSW Ambulance, Western Coord, retransfer of patient to Armidale. They advised that the patient is not suitable and does not require Patient Transfer … and they have handed patient to Patient Transport, who have nothing available until tomorrow … you can redo that one?

164. Mr Reeves replied:

> yeah I can certainly re-book it, I'm just having a look at the log notes here. Yeah the booking was forwarded at 3:13 … so they've obviously sent it over. There might have been a capacity situation, as to why they couldn't, why we couldn't actually do it at that time … so I'll create a new form …

165. Ms McCarthy informed Mr Reeves:

> Um, she does have MRSA … and she is quite off with the fairies

166. Mr Reeves asked:

> Is that delirium that she has, is it a delirium or is she cognitively impaired?

167. Ms McCarthy replied:

> It seems to be more of a delirium at this point, and it has been noted that she's had this on admission

168. Mr Reeves responded:

> Ok, no worries at all, that's fine, MRSA, chronic pain, delirium. [inaudible] got osteomyelitis. And there's no other history with her?

169. Ms McCarthy replied:

> no, I think um the reason why she's got chronic pain and everything stems from having a car accident quite a few years ago, and she's had that sort of, um, then medication like dependency from there…

170. After some formalities, Mr Reeves confirmed:

> so I've got that in, and that's booked in patient ready from now, and the booking number is 1481727 [repeated]. Yep so, in that region, the earliest vehicle we can put her on is a 10 o'clock car

171. Dr Manning agrees, with the benefit of hindsight and with reference to RN McCarthy's reference to Ms Smith being "off with the fairies", that Ms Smith's level of confusion at that time indicated a clinical emergency. He states that at the time, he did not appreciate the significance of the delirium in the context of observations otherwise being "between the flags".[214]

[214] Tab 7A Supplementary Statement of Dr Manning, at [35]

172. Ms Ramsland confirms that:

> The *Delirium Clinical Care Standards policy and the Prevention, Recognition and Management of Delirium* policy compliance procedure (**PCP**) require for patients at risk of delirium to be screened using the assessment tool. All patients over the age of 65 years who present to hospital and have a cognitive impairment or recent change in behaviour or thinking are to undergo early screening using one of the multiple tools listed in the PCP. Infection and pain are listed in the PCP as precipitating factors for delirium. The patient met the criteria for being at risk, and therefore should have undergone assessment for Delirium using the *Delirium Risk Assessment Tool* (DRAT) within 24 hours of presentation/admission. This tool subsequently recommends further investigations if there is a change in behaviour and ongoing daily monitoring of a patient's condition using the Confusion Assessment Method tool.[215]

173. NSWA confirms that the booking was not transferred from NSWA to PTS but states that "at 0728 hours on 1 April 2018, HNELHD rebooked the transfer with PTS".[216]

174. At **7:31am**, PTS Booking Form 1481727 shows that a booking was made by "Hannah" to transfer Ms Smith from GIDH to ARRH. The Joint Response states that this telephone call was made at **7:28am**.[217] Booking Form 1481727 notes, among other things:

> (MRSA) Methicillin Resistant Staphylococcus Aureus
> Is the Patient Between the Flags? / Yes
> DX: OSTEOMYELITIS
> HX: MRSA // CHRONIC PAIN // DELIRIUM
> ACCEPTED BY ORTHO REGISTRAR FOR WARD VIA ED
> R septic knee joint
> Pickup Time 01/04 07:20 – 09:30
> Delivery Time 01/04 09:00 – 12:10

175. The booking form does not make any reference to the booking being "urgent" or any similar statements.

176. At **7:32am**, transfer 1481727 was allocated to a PTS vehicle.[218]

177. At **7.36am**, Mr Mark Dunworth of NSWA called PTS and spoke to someone he called "Tooba", concerning Ms Smith's transfer.[219] Mr Dunworth said:

> "got a job that we got from you guys yesterday only because you had no vehicles. It was a Glen Innes to Armidale and I know the guys were going out – they were doing a Glen

[215] Tab 18C Statement of Lisa Ramsland, at [60]
[216] Tab 21B Statement of Robert Fairey, at [40]-[41]
[217] Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, at [21] and Annexure G Booking 1481727
[218] Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, at [23]
[219] Tab 14 Supplementary Statement of Mark Dunworth, Annexure A Transcript, pp.5-6

> Innes out to Vegetable Creek and then bringing a Vegetable Creek back into Glen Innes umm and so I thought this one might just umm fit in perfectly. It's - "

178. "Tooba" interrupted to say:

> "just before you go on, maybe I've got it already because that car is full now"

179. Mr Dunworth and "Tooba" then confirmed that they were both talking about "Maureen Ann Smith" and ended the conversation.

180. At **7:38am**, NSWA Incident Report Details records "CONFIRMED GOING WITH NEPT".[220]

181. Also at **7:38am**, NSWA Incident Report Details further records "Incident has been closed."[221]

182. The next apparent notation after **7:30am** in the GIDH Clinical Notes is by Dr Manning, showing that at an unspecified time on 1 April 2018 he reviewed Ms Smith and recorded:

> 75♀ ↑ pain
>
> confusion
>
> swollen R knee post
> cortisone injection
> AKI [acute kidney injury]
>
> ?Septic R knee
>
> no transfer options to Armidale
>
> Ortho has requested no abs pending their review
>
> Full bloods +cultures taken here
> But unable to transfer for analysis
>
> on slow IV fluids …[222]

183. Also, at an unspecified time on 1 April 2018, possibly at the same time and as the remainder of the notes immediately above, Dr Manning's notes record in relation to Ms Smith:

> … O/E HR 100 128/63
>
> Clear HSDNA
>
> Soft
> no mass
>
> R Knee ↑ swelling
> tender
> warm

---

220 Ibid, Annexure B Transcript, p.2; Tab 21A Statement of Lauren Mansell, Annexure J Incident Detail Report 60050

221 Ibid

222 Tab 19 GIDH Records

> Imp: Delirium
> + raised WCC
>
> ? Septic knee
> (not clear cut but no other source)
> limit investigations available locally to progress diagnosis and were unable to transfer
>
> Plan: T/F today
> Urine MCS
> CXR to complete septic screen
> await bloods
> if unable to transfer will need MX [management] soon[223]

184. A further note by Dr Manning was added to the handwritten referral prepared for ARRH that morning also at an unspecified time, which reads:

> Maureen has remained afebrile but increased delirium and the swelling in the right knee has increased.
>
> She is having CXR [?chest X-Ray] & urine studies but without formal bloods our ability to further identify the source has been limited.
>
> As per orthopaedics we have held off antibiotics.[224]

185. Dr Manning states that he recalls looking at the Standard Adult General Observation chart (**SAGO chart**) during his ward round that morning and noticed there were no observations performed overnight. He recalls the nurse with him also commenting on this and informing him it would be followed up.[225] Dr Manning accepts that he should have recorded the frequency of observations into Ms Smith's patient file.[226]

186. A/Professor Holdgate states that given the ongoing delays in the transfer, antibiotics should have been administered on the morning of 1 April 2018 and that this would have probably increased Ms Smith's chances of survival,[227] although it is not possible to quantify that increase.[228]

187. A/Professor Holdgate further opines that when Ms Smith did not arrive at ARRH during the morning, Dr Natukokona should have actively pursued her whereabouts given his awareness of her possible septic arthritis and given that he had advised (at least, according to Dr Manning's contemporaneous notes) that antibiotics should not be administered. A/Professor Holdgate also opined that it was not Dr Natukokona alone who was responsible for pursuing the progress of Mrs Smith's transfer.[229]

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223 Tab 19 GIDH Records
224 Tab 19 GIDH Records
225 Tab 7A Supplementary Statement of Dr Manning, at [32]
226 Ibid, at [33]
227 Tab 24A Expert Report of A/Professor Holdgate, at [3.4]
228 Ibid, at [8.1]
229 Tab 24B Supplementary Report of A/Professor Holdgate, p.4 at bullet point 2

188. At **9.30am**, x-rays were taken of Ms Smith's chest and right knee.[230]

189. At **10.00am**, according to her statement, RN Carol Tierney from PTS arrived with Rachel Margery, Patient Transport Officer (**PTO**), at GIDH for the purpose of transferring a different patient to Emmaville Multipurpose Service and during that attendance, became aware of the transfer of Ms Smith to ARRH.[231] In the Joint Response, it is stated that the PTS crew "first transferred a patient from GIDH to Vegetable Creek Multipurpose Service at Emmaville on the morning of 1 April 2018" in response to a booking that was made the previous morning at 11:31am.[232]

190. At **11.00am** Ms Smith was documented by EN Cupitt as confused and incontinent of urine. A Mid-Stream Urine test was collected.[233]

191. At **12.15pm** nursing records noted (apparently by RN Jodie Dijkstra):[234]

> Ice applied to pt's R) knee helping with pain & inflammation. Pt says that her left arm & leg felt "heavy" Pt also complained of painful heels. Heel pads & bandages applied. Remains awaiting T/F – resting comfortably otherwise.

192. Dr Manning states that he was passing by Ms Smith's room at around 12:30pm to review another patient and was surprised and frustrated to see that she had not been transferred earlier that day. He states he expected to be notified by nursing staff if she was not transferred as planned. Dr Manning said he was told by the ward nurse that there was a higher priority patient that required transfer that morning but that the transport officer was back on site at the hospital having a short mandated break.

193. RN Gribbin states that the failure by nursing staff to have engaged in close monitoring and recording of observations, along with failing to make Dr Manning aware of the delayed transportation and refusal of NSWA to accept Ms Smith's transfer, was a missed opportunity for urgent action to be taken by Dr Manning.[235]

E. 1 APRIL 2018: PTS ARRIVAL AT GIDH AND TRANSFER TO ARRH

194. According to the Joint Response, the PTS crew returned to GIDH at **1:25pm** and commenced a mandated break.

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230 Tab 19 GIDH Records
231 Tab 16 Statement of RN Tierney, at [7]
232 Tab 18A Joint Statement of HNELHD, NSWA and HealthShare, at [26]
233 Tab 19 GIDH Records
234 Ibid
235 Tab 25A Supplementary Report of RN Eunice Gribbin, at [1.3]

195. According to her statement, at an unspecified time RN Tierney and her colleague returned to GIDH from two other jobs involving Emmaville Multipurpose Service.[236] Upon arrival, she observed Ms Smith sitting up in bed, she was pale, "a little bit restless and rubbing her ankle". RN Tierney states that the nursing staff advised her that Ms Smith's diagnosis appeared to be sepsis.[237]

196. RN Gribbin states that a full set of observations is required prior to any form of patient transfer but that this was not done in relation to Ms Smith prior to her transfer.[238]

197. RN Tierney states she reviewed Ms Smith's paperwork upon arrival and noticed that observations had not been recorded since around 6.30am and requested that those be performed noting in her statement that temperature, blood pressure and pulse were within normal limits, but her oxygen saturation was low.[239] The observations do not appear to be recorded in the medical notes. RN Tierney requested oxygen to be given to Ms Smith and recalls that this was applied by simple face mask and that, prior to leaving the ward, her oxygen saturation had gone up over 90%.[240]

198. At **1.40pm** Morphine was administered.[241] In transferring Ms Smith to the stretcher, RN Tierney states that Ms Smith remained a little restless and as a result, RN Tierney asked if it was possible to have a bit more pain care for Ms Smith. RN Tierney further states that the "nurses consulted with the doctor in the ED, and 2.5mg morphine IV was ordered and given".[242] Dr Manning states that he ordered the morphine without reviewing Ms Smith because he was with another patient in the ED and unable to leave the ED. He states that, with the benefit of hindsight, he should have gone to review Ms Smith and taken her observations before doing so.[243]

199. Patient transport officer (**PTO**) Rachel Margery recalls that RN Tierney said of Ms Smith as they prepared for transfer, "she's not well" and words to the effect for Ms Margery to get to Armidale as quickly as possible.[244]

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236 Tab 16 Statement of RN Tierney, at [8]
237 Ibid, at [9]
238 Tab 25 Expert Report of RN Gribbin, p.17
239 Tab 16 Statement of RN Tierney, at [9]
240 Ibid, at [9] and [13]
241 Tab 19 GIDH Records
242 Tab 16 Statement of RN Tierney, at [11]
243 Tab 7A Supplementary Statement of Dr Manning, at [34]
244 Tab 16B Statement of Rachel Margery, at [8]

200. According to GIDH records, Ms Smith's transfer to ARRH commenced at **2.00pm**.[245]

201. The handover information provided (**Handover Printout**)[246] confirms that the transfer at "pickup" was affected as between nurse "Amy" (understood to be EN Amy Cupitt) and PTS staff "Carol" (understood to be RN Carol Tierney). The Handover Printout included the following information:

   a. in response to "Are there any concerns regarding clinical deterioration for this patient during transport?", "No";

   b. confirmation of an altered cognitive state (e.g. Confusion), and "anxious reassurance given";

   c. confirmation of infection risk;

   d. confirmation that the PTS crew had assessed Ms Smith as suitable for transport with PTS; and

   e. most recent observations were between the flats "YES".

202. At **2.00pm**, nursing records (by RN McLoughlin) note that blood results were returned by telephone from Tamworth pathology in relation to samples collected the previous day, demonstrating:

   a. a white cell count (**WCC**) of 29.6 which was, according to A/Professor Holdgate, "very high";[247]

   b. high C-reactive Protein (**CRP**), later determined to be 403: also "very high" according to A/Professor Holdgate[248];

   c. potassium of 6.1: according to A/Professor Holdgate "moderately elevated";[249]

   d. creatinine of 196: according to Professor Rawlinson[250] "raised Creatinine"; and

   e. GFR at 23 ml/min: according to Professor Rawlinson, "decreased".[251]

203. A/Professor Holdgate confirms that both WCC and CRP are general tests, results of which can be raised for many reasons but most commonly in the presence of infection.

245 Tab 19 GIDH Records
246 Tab 22E HealthShare Handover Printout
247 Tab 19 GIDH Records; Tab 24A Expert Report of A/Professor Holdgate, at [1.16]
248 Ibid
249 Ibid
250 Tab 23 Expert Report of Professor Rawlinson, p.8 at bullet point 4
251 Ibid

Raised WCC and CRP indicates significant infection but does not differentiate between localised or generalised infection. Ms Smith's results were consistent with both septic arthritis (restricted to the joint) or generalised sepsis (throughout the body). However, she states that, in conjunction with her increased confusion during the morning, the significantly raised WCC and CRP would be supportive of the presence of generalised sepsis.[252]

204. Dr Manning states that he was not made aware of these pathology results at the time they arrived and did not learn of them until between 5.30 to 6pm that day. As he did not have access to Auslab, he requested the RN MacLean access Auslab on his behalf to access the results at or around that time.[253]

205. Dr Manning states:

> Had I known that Ms Smith had a CRP of 403, at any stage, I would have immediately changed my approach, as a CRP that high would have supported a diagnosis of sepsis. I would have commenced Ms Smith on antibiotics immediately, regardless of other circumstances.[254]

206. At **3.00pm** nursing notes state (apparently a note by EN Cupitt): [255]

> Pt transferred to ARRH via pt t/p @1400hrs. Analgesia & anti-emetic given prior to leaving. Pt extremely anxious – IVF in progress. Handover given to ARRH ED staff on departure

207. RN Tierney states that:

    a. Ms Smith was alert and conversing throughout the trip, apart from being "a little confused" when talking about her children at one stage, but otherwise alert;[256] and

    b. about 10 minutes from ARRH, Ms Smith was a little bit restless and said she had a backache.[257]

208. RN Gribbin notes that clinical observations where not documented during the transfer and this is not consistent with peer professional opinion as competent clinical practice at the time.[258]

252 Tab 24B Supplementary Report of A/Professor Holdgate, p.2
253 Tab 7A Supplementary Statement of Dr Manning, at [7]
254 Ibid, at [8]
255 Tab 19 GIDH Records
256 Tab 16 Statement of RN Tierney, at [16]
257 Ibid, at [17]
258 Tab 25A Supplementary Report of RN Eunice Gribbin, at [2.2]

F. 1 APRIL 2018: ARRIVAL AT ARRH, HANDOVER AND TREATMENT

Arrival at ARRH

209. ARRH records show that Ms Smith arrived at **3.14pm** and was triaged as ATS2.[259]

210. At **3.15pm**, ARRH ED Triage Nurse Notes state in typeface:[260]

> Pt BIB Community transport, presented last night with chronic right shoulder and knee pain.
>
> Pt for admission via ortho reg for ? septic right knee post cortoissone [sic] injection last week.
>
> OE: Pt not abke [sic] to answer questions, cold perioherally [sic], looks very unwell, offloaded to be for further assessment, appears delusional to community nurse.

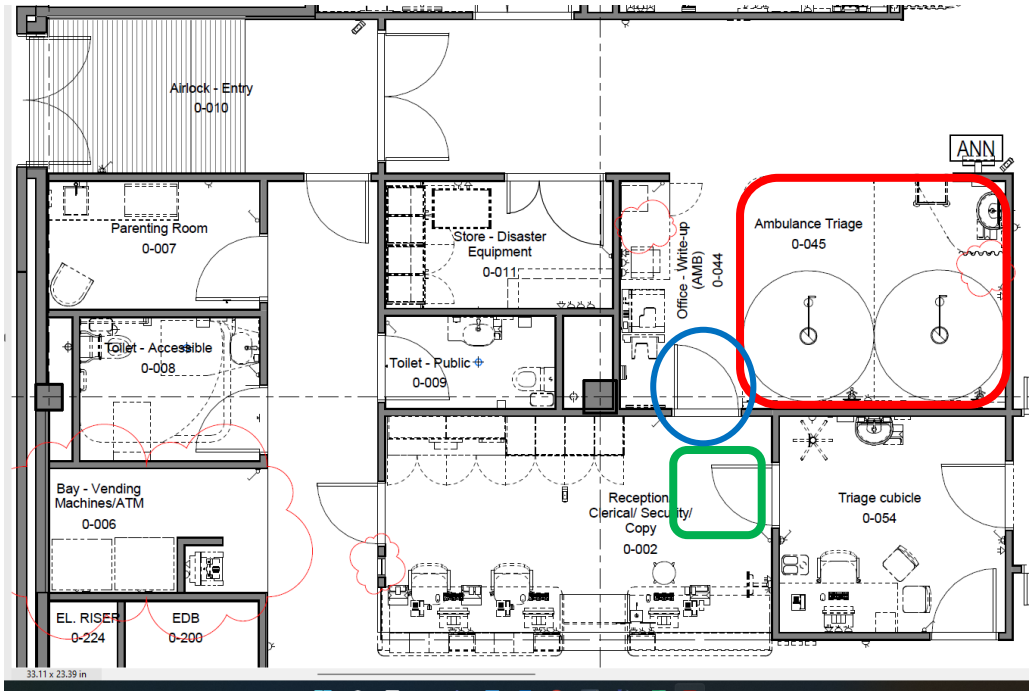
211. And in handwriting:

> "T/F from Glen Innes Hospital with ? septic (R) knee
> On arrival to ED pt was pale and nonresponsive
> Offloaded to resus, seen by Dr Young
> Warm to touch, cap refill 4 sec …"

Handover / Triage – timing and location

212. At or shortly after the time of arrival, RN Tierney executed handover with the triage nurse, RN Joanne Mulvey, in the location RN Mulvey identified as the green boxed area on the map below. While handover occurred, Ms Smith was in the "Ambulance Triage" area, outlined in red below, with PTO Rachel Margery and without any medical staff in attendance.

[259] Tab 20 ARRH Records, pp.6, 11
[260] Tab 20 ARRH Records, p.11



213. PTO Margery states that Ms Smith was placed "to the right of the words "Ambulance Triage 0-045" on the above map, within the red outline."[261] RN Mulvey states, by marking on a map, that Ms Smith was left within the outlined Ambulance Triage area but to the left of the central dotted line.[262]

214. In the PTS incident report, the 'notifier' is identified as RN Tierney and the following note is recorded under 'incident description':[263]

> I left Mrs Smith, on the stretcher in the triage bay after we made her comfortable rearranging her position, with our Driver at 1514hrs and went the separate room to give handover to the triage nurse Jo. The time of 1514hrs is the record on the triage notes.

215. The PTS incident report recorded that PTO Margery had stayed with Ms Smith during the time in which RN Tierney had conducted the handover.[264] PTO Margery confirms this in her statement.[265]

216. PTO Margery recalls that RN Tierney did a set of observations on Ms Smith upon arrival, before leaving the patient through the door between "Office Write-up (AMB) 0-044"

261 Tab 16B Statement of Rachel Margery, at [12]
262 Tab 11B Supplementary Statement of RN Mulvey, at [5]
263 Tab 22F Patient Transport Services Incident Report
264 Ibid, p.3 under the heading "Senior staff member"
265 Tab 16B Statement of Rachel Margery, at [13]

and "Reception/Clerical/Security/Copy 0-002" (that door is circled in blue on the map of ARRH above) to undertake the handover.[266]

217. RN Mulvey has indicated that the handover occurred at the location of the green outline in the map above.[267]

218. According to RN Mulvey, the handover commenced at **3:15pm.**[268] It continued for a "short period of time" but she does not recall how long the handover had been going for before she and RN Tierney returned to the Ambulance Triage area to see Ms Smith because "it became evident that [she] needed clarification on Ms Smith's current condition".[269]

219. According to RN Tierney, the handover commenced at **3:14pm** and ended at **3:25pm** or **3:26pm**. RN Tierney states that she is aware of the timing of the handover having had reference to the incident report (which records the time of Ms Smith's arrival at ARRH as **3:14pm**) and the audio of a subsequent telephone call she made to PTS Sydney hub.[270] In that telephone call, RN Tierney reported back to PTS that she had been in triage for 12 minutes while PTO Margery was with Ms Smith.[271]

220. PTO Margery states that RN Tierney returned to Ms Smith at **3:26pm** with a nurse from ARRH.[272]

221. RN Tierney states that, when she and RN Mulvey returned, Ms Smith appeared to be sleeping and responded only with "a noise that sounded like a grunt or a groan" when the triage nurse (presumably RN Mulvey) addressed her.[273] The PTS incident report includes the following related note:[274]

> Around 1525hrs the triage nurse and I came out of the room to speak to Mrs Smith. Mrs Smith only grunted to Jo then there was no more response from her. Mrs Smith face was very pale in colour.

266 Tab 16B Statement of Rachel Margery, at [13]
267 Tab 11B Second Supplementary Statement of RN Mulvey at [6] and Annexure A
268 Tab 11A Supplementary Statement of RN Mulvey, at [5]; Tab 11B Second Supplementary Statement of RN Mulvey, at [6]
269 Tab 11B Second Supplementary Statement of RN Mulvey, at [6]
270 Tab 16A Supplementary Statement of RN Tierney, at [20A] and Annexure E Transcript
271 Ibid, Annexure E Transcript, at p.2
272 Tab 16B Statement of Rachel Margery, at [15]
273 Tab 16 Statement of RN Tierney, at [21]
274 Tab 22F Patient Transport Services Incident Report

222. RN Mulvey states that it is not possible to bring a patient on a stretcher into the "Patient Transport and Triage Area".[275]

223. RN Sillitoe states that normal practice for a patient arriving to ED via inter-hospital transfer "would have been to triage them in the designated Ambulance Bay within the department."[276] RN Gribbin states that handover ought to have been conducted at the bedside.[277]

224. The "Clinical Handover – Standard Key Principles" policy in place at the time of the handover states the handover place should be:

> "In the patient's presence, where appropriate (bedside handover)."[278]

225. That policy also states:

> "Where the condition of a patient is deteriorating: Escalate the management of these patients as soon as a deterioration in condition is detected."[279]

Handover / Triage – notes

226. The Handover Printout confirms that the transfer at "destination" was affected as between PTS staff "Carol" (RN Carol Tierney) and nurse "Jo" (RN Joanne Mulvey). The Handover Printout included the following information: [280]

   a. the "current diagnosis" provided was "chronic pain". RN Tierney has stated she acknowledges she should have instead recorded the diagnosis of "R septic knee joint" as had been written on the electronic booking information;[281]

   b. the most recent clinical observations were confirmed as between the flags, and a further note at the end of the Handover Printout states:

      > Re: Are the most recent clinical observations between the flags? Crew noted the following: 'Between the flags prior to leaving and during trip pulse 86';

   c. no "relevant medical history" of the patient was recorded as being handed over;

   d. "MRSA" was recorded as an infection risk;

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275 Tab 11A Supplementary Statement of RN Mulvey, at [5]
276 Tab 13F Supplementary Statement of RN Sillitoe, at [6]
277 Tab 25A Supplementary Report of RN Eunice Gribbin, at [3.3] and [4.2]
278 Tab 22O Letter from the Crown Solicitor's Office regarding transfer, triage and handover, Annexure A, at p.8
279 Ibid
280 Tab 22E HealthShare Handover Printout
281 Tab 16A Supplementary Statement of RN Tierney, at [9A]

e. PTS crew assessment of the condition of the patient at the end of the transfer was "unchanged", however a note following this states:

> Re: Advise if the patient has an altered cognitive state (e.g. confusion)? Crew noted the following: 'delirious which became worse in the last 20 minutes'

227. RN Mulvey confirms that RN Tierney had told her that Ms Smith had become delusional in the last twenty minutes of the journey.[282]

228. RN Mulvey states that when she observed Ms Smith she "looked very unwell. She was peripherally cold and unable to answer questions when asked, and only mumbled in response. Her mouth was dry, her eyes were only slightly opened and she was moving her dentures with her tongue. She did not respond to verbal commands." and that as a result of this, RN Mulvey immediately alerted the RN in charge and informed the Chief Medical officer of Ms Smith's condition, after which Ms Smith was transferred to the resuscitation bay.[283]

Transfer of Ms Smith to resuscitation bay

229. PTO Margery states that when the two nurses returned to Ms Smith on the stretcher, the ARRH nurse (known to be RN Mulvey) said "let's go to bed 5",[284] and PTO Margery started moving Ms Smith there accordingly but after a few steps the ARRH nurse said that they should instead go straight to Resus Bay 2 (marked as Patient Bay – Resuscitation 0-014 on the map of ARRH).[285]

230. RN Tierney describes in her statement that while transferring Ms Smith on a stretcher to her designated bed, the ED nurse-in-charge (known to be RN Sillitoe) approached and attempted but could not rouse Ms Smith and redirected RN Tierney to a bed in the resuscitation bay at **3.30pm**.[286]

231. PTO Margery recalls Ms Smith was transferred to the bed in Resus Bay 2 before PTO Margery departed with the stretcher prior to CPR commencing.[287]

232. The PTS incident report records the 'initial action taken' as follows:

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[282] Tab 11 Statement of RN Mulvey, at [6]
[283] Ibid, at [7]; Tab 16B on the PTO Rachel Margery states that Bed 5 is marked as "Patient Bay Acute Treatment 0-048" on the map of ARRH at Annexure A

[285] Tab 16B Statement of Rachel Margery, at [16] and [17]
[286] Tab 16 Statement of RN Tierney, at [23]-[24]
[287] Tab 16B Statement of Rachel Margery, at [18]

> We immediately transferred Mrs Smith off the trolley to a bed in the Resus Bay under the care of the Emergency Nurses.

Resuscitation attempt

233. RN Tierney states that the ED nurse-in-charge commenced chest compressions after checking for a heartbeat and requested RN Tierney to press the red emergency button, which she did.[288]

234. ARRH Progress / Clinical Notes set out a timeline of CPR commencing at **3.35pm**[289] and ARRH ED Triage Notes, at **3.15pm** record:

> -not responding to voice or painful stimulus
> -monitor connected, found pt to be in ventricular fibrillation, no carotid pulse palpated
> -pads applied, shocked [with] 200J
> -CPR started immediately
> -MET call activated
> On airway – Dr young – [Guedel] + BVM – ready to bag
> TL: Dr Hawksford
> Medical team from ward arrived quickly to assist
> Continue on for 30 minutes [with] ALS [Advanced life support]-asystole[290]

235. At **4.07pm** the decision was taken to stop resuscitation. Ms Smith was declared deceased.[291]

Dr Natukokona's involvement in Ms Smith's treatment at ARRH

236. Dr Natukokona confirms that he had no communication or information about Ms Smith on 1 April 2018 until he met her at **3.14pm** when she arrived at ARRH and was brought into the Resuscitation Bay.[292]

237. Dr Natukokona states that he reviewed Ms Smith's right knee at that time and states that he found it to be normal, with no erythema, no warmth, no swelling and no obvious drainable joint effusion".[293]

238. Dr Hawksford, who was involved in the resuscitation of Ms Smith, recalls Dr Natukokona standing by the bed of Ms Smith during the attempted resuscitation and holding a syringe.[294]

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288 Tab 16 Statement of RN Tierney, at [23]-[24]
289 Tab 20 ARRH Records, p.13
290 Tab 20 ARRH Records, p.12
291 Ibid, p.13
292 Tab 9 Statement of Dr Natukokona, at [45]
293 Ibid, at [46]
294 Tab 17A Supplementary Statement of Dr Hawksford, at [4]

239. A/Professor Holdgate has reviewed clinical photographs of Ms Smith's right knee, which were taken on 6 April 2018 at the autopsy of Ms Smith, and states that those photographs confirm the clinical impression of Dr Manning, including a large effusion in the knee joint.[295]

Subsequent events that day

240. At **6.30pm** Dr Manning made the following entry into clinical notes after having been advised of Ms Smith's death:

> Reviewed notes after contact from Constable Matt Lee-Winser of Armidale Police – advised of Maureen Smith's death at the Armidale emergency.
> Please note results as listed above were not relayed to myself, was reviewing bloods with RN Raymond MacLean immediately before notification.[296]

241. At **11.30pm** NSW Pathology telephoned blood culture results to Dr Mazen Ashour ED ARRH informing them that both blood cultures and a midstream urine test confirmed staphylococcus aureus.[297]

242. Dr Manning states that, upon review of those records, the blood culture results detected gram positive cocci and that:

> had I known of the gram positive cocci blood culture results, at any stage, this would have confirmed a diagnosis of sepsis, as a complication of my working diagnosis of septic arthritis.[298]

G. POST MORTEM RESULTS AND EXPERT ANALYSIS

243. The Autopsy Report concludes that:

> The findings are consistent with death due to *Staphylococcus aureus* septicaemia due to septic arthritis of the right knee. The corticosteroid injections performed 10 days prior to her death are a likely source of infection. A contributing factor in the death may be the management of this case at Glen Innes and Armidale Hospitals, specifically the delays in transport of the deceased and the subsequent commencement of appropriate management.[299]

244. Results from testing on 31 March 2018 demonstrated MSSA[300] (which was different to the MRSA organism colonizing Ms Smith's ulcers chronically over earlier years)[301] and results from testing the following day measured staphylococcus aureus at >10^8/L,

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295 Tab 24C Second Supplementary Report of A/Professor Holdgate, p.5
296 Tab 19 GIDH Records
297 Tab 19A Pathology North Blood Culture Report, p.13; Tab 15 Statement of Professor Wilson, Annexure H Specimen Audit History
298 Tab 7A Supplementary Statement of Dr Manning, at [9]-[10]
299 Tab 2 Autopsy Report, p.5 at [7]
300 Tab 19A Microbiology Report dated 3 April 2018, p.94
301 Tab 23 Expert Report of Professor Rawlinson, p.4 at [4]

which **was not** sensitive to Methicillin but **was** sensitive to Flucloxacillin, (or, according to A/Professor Holdgate, sensitive to "standard antibiotic therapy").[302] Professor Rawlinson opined that there were "a number of antibiotic choices for Ms Smith at that time".[303]

245. According to A/Professor Holdgate, it is "almost certain that the joint injections on either 12 or 21 March were the cause of Mrs Smith's septic arthritis and subsequent generalised sepsis" with the more likely source being the shoulder injection on 21 March.[304]

246. A/Professor Holdgate opines that there is no doubt that administration of antibiotics on the afternoon of 31 March 2018 (and probably even on the morning of 1 April 2018) would have increased Ms Smith's chances of survival, however, in her view, it is impossible to quantify that increase.[305] A/Professor Holdgate opines that without any antibiotics, risk of death was very high; with antibiotics, the risk would have been substantially lower but still in the order of 30%.[306]

247. Professor Rawlinson opines "[i]t is uncertain what the cause of sepsis for Ms Smith was" but that it was "likely" that the corticosteroid injections in March 2018[307] could have contributed to Ms Smith's acute infection.[308]

248. Professor Rawlinson states "Ms Smith was at high risk of death … from an acute septic or other inflammatory event". He opines that it is not possible to give a definitive opinion regarding Ms Smith's chance of survival had she been given antibiotics to which the MSSA was susceptible but does state that providing "appropriate" antibiotics would have led to a better chance of survival, particularly if administered within 24 to 36 hours prior to her demise. He states that the antibiotic likely to be administered would be broad spectrum antibiotics such as ceftriaxone, "which would not have been as appropriate as specific antibiotics such as flucloxacillin or clindamycin, although they would to some extent have reduced progression of her MSSA infection." [309]

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302 Tab 19A Microbiology Report dated 3 April 2018, p.94; Tab 24A Expert Report of A/Professor Holdgate, at [1.1], [1.18], [5.1]-[5.3]; Tab 23 Expert Report of Professor Rawlinson, p.4 at [4.0(4)]
303 Tab 23 Expert Report of Professor Rawlinson, p.4 at [4.0(4)]
304 Tab 24A Expert Report of A/Professor Holdgate, at [7.2]
305 Ibid, at [8.1]
306 Ibid, p.12 at [8.3]
307 Professor Rawlinson refers to the injections "administered by Dr Diebold on 14 March 2018 and 21 March 2018", however other material evidences the first injection to have been administered by Dr Petroff on 12 March 2018 (see paragraphs [16] and [18] of this Summary of Evidence)
308 Tab 23 Expert Report of Professor Rawlinson, p.6 at [6]
309 Ibid, at [7]