STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ricky Hampson
Hearing dates:	26 February to 1 March 2024 4 to 5 March 2024
Date of findings:	20 August 2024
Place of findings:	Coroners Court of NSW, Lidcombe
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – failure of diagnosis, perforated duodenal ulcer, insufficient medical investigations, necessity of identification of First Nations status when providing medical treatment, culturally appropriate treatment, natural causes, Dubbo Base Hospital, Western NSW Local Health District, First Nations advisory group, cultural induction training
File number:	2021/235863

Representation:	
Representation:	Counsel Assisting the Coroner: Mr Simeon Beckett SC, instructed by Ms C Dunn (Department of Communities and Justice) Ms Kellyann Murray and Mr Hampson's children: Ms H Fitzsimmons, instructed by Ms S Webb (Legal Aid NSW) Rick Hampson Snr and Lydia Chatfield: Mr Callan O'Neil of counsel, instructed by Mr G Newhouse, Ms A Raaj and Ms J Wright (National Justice Project) Western NSW Local Health District: Mr S Kettle of counsel, instructed by Ms H Allison and Ms E Ward (Crown Solicitor's Office) Dr Sokol Nushaj: Ms L McFee of counsel, instructed by Ms H Shiel (Barry Nilsson) Dr Lisa Hu: Ms M Gerace SC, instructed by Ms L Antonini (Avant Mutual) Dr Naveed Aziez: Ms K Burke of counsel, instructed by Ms K Poh (Moray & Agnew) Ms Maree Trow: Mr N Dawson (NEW Law), instructed by Ms L Toose (NSW Nurses and Midwives Association) Dr Jamee McBride: Mr G Gregg of counsel, instructed by Ms J Hayes (Meridian)

<table>
<tr><td>Findings:</td><td>Identity

The person who died was Ricky Douglas Hampson

Date of death

His date of death was on 16 August 2021

Place of death

His place of death was 6 Collins Avenue Dubbo, New South Wales

Cause of death

The cause of his death was a perforated duodenal ulcer

Manner of death

Mr Hampson died of natural causes in circumstances following presentation to hospital and the failure of hospital staff to diagnose and treat duodenal ulcer, discharging him home.</td></tr>
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Recommendations:	**To the Western NSW Local Health District:** **1.** That the Western NSW Local Health District (**LHD**) consider establishing a standing First Nations consultation and advisory group in liaison with the local Aboriginal community controlled health organisations, such as Dubbo Regional Aboriginal Health Service, to be consulted from time to time. **2.** That the LHD refer its training programs to that consultation group for review and recommendation for revision or additional modules if required. **3.** That the LHD ensure that cultural induction and recurrent training to medical and nursing staff at Dubbo Base Hospital involve face to face engagement with First Nations people from the community of Dubbo and the wider catchment area for the LHD. **3(a):** The LHD ensure that cultural induction training, including information specific to the local Aboriginal and Torres Strait Islander community, is provided to all medical and nursing staff who will be employed at the hospital for 6 weeks or more, including staff on a locum basis, as close to the start of their commencement as possible. This training should preferably include face to face engagement with Aboriginal and Torres Strait Islander people from the catchment area of the LHD. **3(b):** That the LHD consider whether recurring face to face training in the areas of cultural competence, responsiveness, awareness, humility and safety, can be provided to LHD staff regularly, preferably annually. **3(c):** That consideration be given to improving and enhancing mandatory training for staff in respect of:

	i. why First Nations patients are a high-risk, vulnerable community; ii. the scope of practice of Aboriginal Health Workers and Aboriginal Health Practitioners, including the ability of staff to make referrals to Aboriginal Health Workers and Practitioners; and iii. how Aboriginal Health Workers and Practitioners can be integrated into the clinical practice of doctors and nurses to improve patient experiences. **4.** That consideration be given to including the following information as mandatory when documenting a plan of management as referred to in Appendices A and C to Local Operating Protocol D23/11137: a. what outstanding investigations are to occur; b. whether there is a need for medical review; c. who is required to undertake the medical review; and d. when the medical review should be conducted during the patient's stay. **5.** That consideration be given to amending Appendix B of Local Operating Protocol D23/11137 to say: "A discharge from the EDSSU must be approved by a senior medical officer". **In relation to Dr Nushaj:** **6.** That Dr Sokol Nushaj is referred to the Health Care Complaints Commission for investigation and review as to whether he engaged in unsatisfactory professional conduct under the *Health Practitioner Regulation National Law (NSW) No 86a* in relation to his treatment of Ricky Douglas

	Hampson including the diagnosis of cannabinoid hyperemesis syndrome on 14 August 2021. **To NSW Health:** **7.** That NSW Health consider whether it should amend NSW Health Policy *Aboriginal and Torres Strait Islander – Recording of Information of Patients and Clients* PD2012_042 to ensure that all medical and nursing clinicians are advised of the Aboriginal or Torres Strait Islander status of a patient to ensure that it is considered in the treatment of such patients.

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Introduction and Focus of the Inquest

1. Ricky Douglas Hampson was a Kamilaroi-Dunghutti man. Dougie had undiagnosed perforated duodenal ulcers when he presented to Dubbo Base Hospital on 14 August 2021, admitted and discharged on 15 August 2021 and died the following day after being discharged home. At the time of his death Dougie was 36 years old, the father of eight children and the grandfather of one child.

2. At the request of family I will refer to Mr Hampson as Dougie, as he was at the inquest. He is also known to some as Ricky.

3. On 14 August 2021 at about 5.00pm Dougie felt something pop inside his abdomen and self presented to the Emergency Department of Dubbo Base Hospital in obvious pain. His heart rate and breathing rate were both high. His pain was recorded as being 10 out of 10.

4. He was examined by two nurses in the ED and by a doctor, Resident Medical Officer Dr Lisa Hu. Part of the history he provided was that he had smoked some cannabis that morning. An electrocardiogram (**ECG**) was done confirming that his heart rate was high (tachycardic), and blood tests were taken. Dr Hu's clinical impression was that he had undifferentiated abdominal pain. Dr Hu spoke about Dougie's case with emergency medicine physician Dr Sokol Nushaj who was the ED consultant that day. He quickly diagnosed Dougie with Cannabinoid Hyperemesis Syndrome (**CHS**). Dougie was given Morphine for the pain, and on Dr Nushaj's suggestion a sedative droperidol and fluids. At about 7.00pm he advised that Dougie should be given further fluids, reviewed and discharged. Dr Hu prepared the discharge summary.

5. There were no further investigations of the "popping" sensation or the cause of the pain such as by giving Dougie an x-ray or a CT scan. The blood tests revealed low sodium and potassium levels indicating some dehydration and a low-level infection, but no further blood tests were performed. Dougie was transferred to the ED's Short Stay Unit overnight where observations were taken. He felt more pain that night and was given oxycodone.

6. The next morning the observations taken revealed that Dougie's heart rate was still tachycardic and that his pain was fluctuating, but his other vital signs were within the normal range. Nursing staff provided him with treatment for constipation. He was not seen by any doctor during the remainder of his stay, and at about midday on 15 August 2021 he was discharged with ibuprofen and paracetamol and told to come back if the pain worsened. The nurse who

saw him last said that he was holding his lower abdomen and appeared to be in obvious discomfort. The discharge summary was the one written up the night before by Dr Hu, unchanged. It was addressed to the Justice Health doctor at Wellington Correctional Centre even though Dougie had been released from prison almost a year before.

7. Dougie returned to a friend's house, Mr Marshall Peachey in Dubbo, arriving by taxi. When he arrived Mr Peachey said that he got out of the taxi and walked over slowly holding his belly. Later when Dougie went outside for a cigarette on the veranda Mr Peachey observed that he appeared to be in pain and could not stand up straight, and he noticed that he only finished half of his cigarette. Mr Peachey last saw Dougie alive at about 3.30am sitting on or near the lounge.

8. At about midday on 16 August 2021, children at Mr Peachey's house reported that Dougie was not responding to them. Mr Peachey went to check and on finding Dougie near the lounge not moving, called the ambulance and started cardiopulmonary resuscitation. The ambulance officers arrived at just after 1.00pm and declared him deceased.

9. The primary issue for the inquest was how and why Dougie's perforated duodenal ulcers which were identified at post-mortem, were not identified and treated when he was in Dubbo Base Hospital on 14 and 15 August 2021.

The Autopsy and Investigation

10. Dougie's death was referred to the Coroner for inquiry and an autopsy was performed. Senior Forensic Pathologist, Dr Lorraine du Toit Prinsloo, was of the view that the direct cause of death was "perforated duodenal ulcer". In her report of 16 September 2021:

> Internal examination revealed approximately 4 litres of ascites (fluid within the abdominal cavity). There were two perforated ulcers inferior to the pyloric sphincter. Moderate coronary artery atherosclerosis was present in the right coronary artery.
>
> …
>
> The coronary arteries showed minimal coronary artery atherosclerosis in the left anterior descending coronary artery and moderate occlusion of the right coronary arteries. No acute coronary occlusion was identified. The opened stomach mucosa was normal. Directly inferior to the pyloric sphincter was two ulcers. There ulcers perforated and was present transmurally. The anterior ulcer measured 0.9cm in diameter and the posterior ulcer measured 1.5cm in diameter.
>
> …

> Causes for peptic/duodenal ulcers include smoking, H pylori [Helicobacter pylori] infection, alcohol use and use of non-steroidal anti-inflammatory medication. A perforated peptic ulcer is regarded as a serious complication of peptic ulcer disease. The mortality associated with peptic ulcer disease is between 1.3 - 20%.

11. Dr du Toit Prinsloo did not include atherosclerosis as a cause of Dougie's death. She ruled out the effect of non-toxic levels of metabolites of cannabis and methylamphetamine, as well as ibuprofen, paracetamol and pregabalin as contributing to his death. Despite Dougie testing positive to COVID-19 and some other viruses, she concluded that none contributed to the cause of his death.

12. Dr du Toit Prinsloo was concerned about the apparent absence of diagnosis at Dubbo Base Hospital and she recommended that the medical records be reviewed by a specialist in the field, such as an emergency physician/general surgeon to provide an opinion on the medical management of the Dougie. According to expert consultant gastroenterologist and hepatologist Dr Chris Vickers, the abdominal pain Dougie was experiencing on 14 August 2021 was caused by him suffering from two duodenal ulcers. No such diagnosis was made during Dougie's time in the hospital on 14-15 August 2021.

13. Constable Jake O'Malley from Dubbo Police Station is the officer-in-charge and took a large number of statements and prepared the coronial brief. In addition, a number of statements were received from the Western NSW Local Health District, which operates Dubbo Base Hospital, together with a number provided by doctors and nurses. That material was provided to both Dr Vickers and to an expert in emergency medicine, Associate Professor Anna Holdgate, to review the matter. Dr Vickers confirms that Dougie had perforated duodenal ulcers when he presented to Dubbo Base Hospital on 14 August 2021 and he also confirmed that he died as a result of the failure to treat those duodenal ulcers.

14. The primary focus for the inquest is to determine why and how Dougie's perforated duodenal ulcers were not identified and treated when he was in Dubbo Base Hospital on 14 and 15 August 2021.

Statutory Role of the Coroner

15. Jurisdiction is found under s. 21(1) of the *Coroners Act 2009* to conduct this inquest because the death was a reportable death or there is reasonable cause to suspect that the person's death is a reportable death. The term "reportable death" is defined in s 6(1) of the *Coroners Act 2009*

and includes where the reason for the person's death is unknown or the circumstances of the death are unusual. The Coronial Checklist completed for Dougie at the hospital on 16 August 2021 records that "the cause of death is unknown".

16. The Act requires findings to be made pursuant to s. 81(1) of the *Coroners Act 2009* as to:

    a. the occurrence of the death;

    b. the identity of the deceased;

    c. the date and place of the death; and

    d. the manner and cause of the death.

17. Manner and cause of the death permits an inquiry into more than the medical cause of the death. The term "manner" includes the circumstances surrounding the death and, in this case, the actions of those responsible for Dougie's care at Dubbo Base Hospital.

18. Section 82 of the *Coroners Act 2009* makes provisions for the making of recommendations considered necessary or desirable in relation to any matter connected with the death. One of the matters on which recommendations may be made is in the area of public health and safety.

19. Another matter upon which recommendations may be made is that "a matter be investigated or reviewed by a specified person or body under s. 82(2)(b)". The *Health Practitioner Regulation National Law (NSW) No 86a* governs the conduct of medical practitioners and nurses. If there has been conduct that *may* amount to unsatisfactory professional conduct or, indeed, professional misconduct under that statute, then a recommendation may be made that the conduct be investigated by the Health Care Complaints Commission.

20. It is not the role of the inquest to determine at law whether there has been negligence or whether damages should be paid or whether any individual is guilty of a criminal offence. Those are matters which may be the subject of separate proceedings in other courts.

21. The statutory focus of this inquest is on determining manner and cause of death, making formal findings of fact and deciding whether to make recommendations.

Background to Dougie and his life

22. The inquest focused on events occurring during a 48-hour period between 14 and 16 August 2021. This inquest was reviewing only hours of his life, as opposed to the many years of joy

that he brought to his parents, siblings, partner, friends and importantly to his children and grandchild.

23. However, it is important to reflect upon the life of Dougie. He held a pivotal role in his family, and his family are bereft at the loss of the joy and energy he brought to their lives. His inquest was closely followed and attended by many, a tribute to the person who he was.

24. Dougie was born in 1984 in Camden to Ricky Hampson Senior and Lydia Chatfield and grew up in Sydney and Canberra. He maintained a strong connection throughout his life with his parents.

25. Ricky Douglas Hampson, 'Dougie', was a Kamilaroi-Dunghutti man. Kamilaroi country is to the Northeast of Wiradjuri country and is one of the biggest First Nations in Eastern Australia. Dunghutti country is on the NSW north coast and includes Port Macquarie.

26. He met Kellyann Murray in Yass and they started a relationship in about 2001. They had two children while they were both quite young. Later they moved to Dubbo where Kellyann was originally from. They then moved to Wongarbon with the children, a small town between Wellington and Dubbo. Dougie and Kellyann lived together with the kids on and off, with periods of time living separately.

27. Dougie worked in various jobs and, according to the medical notes, this included working as a truck driver, a cleaner, a landscaper, and in a warehouse.

28. Dougie struggled with drug use from his twenties and this exacerbated his mental health. He had a history of using cannabis, ice (methylamphetamine) and drinking excessive amounts of alcohol. There is evidence of a number of occasions where his mental health was adversely affected by drugs leading to him being taken to the hospital by police or ambulance for treatment. In 2014 he reported using cannabis daily and he appears to have used cannabis at varying levels until 2021. He also took anti-depressants to address his mental health.

29. Although only indirectly relevant to the inquest, Dougie did spend some short periods of time in prison. In 2015 he was in prison for 5 months for property offences and contravening an AVO. In September 2017 he was arrested and imprisoned until January 2018. A pre-sentence report said he was using cannabis daily and ice when available, although not alcohol, and his

family unit had broken down. He served a further period in prison from July to November 2018.

30. He was arrested and bailed a number of times in 2019 and eventually commenced a sentence in August 2019. He was sentenced to 1 year and 5 months and 1 year and 2 months respectively for a series of offences.

31. Just before his release, his community corrections officer spoke with Kellyann who provided her support for Dougie's release and said that she would take him to any necessary appointments and treatment for drug counselling, being very supportive of him attending. His non-parole period expired on 9 September 2020 and he was released that day. He returned to live with Kellyann and their kids. This was the last time he was in gaol before his death.

32. In January 2021, his community corrections officer recorded Dougie as saying "family is important to me – my family is everything. … I am just staying clean and I have only been out for 3 months, everything is finally good". In March 2021, at the end of his parole, the officer noted that his supervision had been successful. He had not relapsed nor re-offended while on supervision. His attitude towards supervision was noted as being always positive and he was happy to complete programs.

33. However, on 21 May 2021 Dougie had a car accident early in the morning which was recorded as an attempt at having tried to self-harm. He reported that he had consumed alcohol and some marijuana following which he became emotionally overwhelmed and lost his temper, getting into the vehicle with some intention of self-harming. He told the ambulance officers he was "regretful of his actions", stating he "made a mistake in the heat of the moment". He called his mother while at the hospital and left the hospital later that morning with only minor abrasions.

34. It is clear that he had mental health and substance abuse issues which led to troubles with the law. However, these were all challenges that he faced and was trying to address. It was very clear from the evidence and the family statements that he brought so much fun and love to those who he kept close. He was much admired, and his company sought after. He wanted to support his children, friends and family. He was continually trying to self-improve, and as with any such process, it was ongoing.

35. The family gave a series of family statements, providing accounts of a vivacious and lively boy who grew into a charismatic man. He was clearly a precious part of his family, and brought

great joy to his parents and siblings. His parents have been left devastated by his loss. The photos and words shared with the inquest painted the picture of a person who held family close and dear to him. He was able to rely upon his parents during hard battles that he fought with substance use over the years, and they were always there to help him when he needed. Equally however he was always keeping his family close and could be relied on at family functions to bring fun and laughter.

36. His eight children also presented a most moving reflection, both inside and outside the courtroom at Dubbo. The family statement commenced with the children painted with ochre, gathered around the bar table, united and together, as they reflected on the man they call dad. Eloquently they expressed how much he loved his children and their mother. They told stories about his love of dancing around. They reflected that his family was critically important to him, and that he was working hard on himself to bring his family back together.

37. The children performed a breathtakingly beautiful Aboriginal dance in honour of their father, it was heartfelt, spectacular and deeply personal, touching I am sure all those present privileged to witness in such an event. Their song and dance demonstrated in what perhaps words can't their love and loss. This generous demonstration spoke volumes of the regard in which he was held and was a touching and extraordinarily special memorial through this very uniquely presented family statement. I acknowledge and thank them and those who participated and helped them perform this very special and culturally beautiful reflection.

38. From all of this it was evident to those at the inquest that Dougie was vibrant and a real personality, and subsequently a great void is felt in their lives where he once was.

Factual Analysis of evidence

39. I am indebted to my instructing solicitor and Senior Counsel Assisting for uncontroverted factual details in submissions which I have utilized extensively through the findings.

The days before the admission

40. It was clear that Dougie was beginning to experience symptoms prior to the lead up to the hospital admission. A fortnight before Dougie died, Kellyann remembers him having a bad tooth ache, and that he had been vomiting and felt unwell.

41. Dougie's relative Lizzie Toomey said that about this time he had been staying with Gloria Fernando and Paul Peachey and she saw him frequently. She said in a statement:

> I recall that during this time he had ongoing pain in his chest and stomach and he would often bend over holding his stomach. He said that he had "a burning feeling" under his ribs near his sternum in a particular spot.

42. Around the same time Dougie's daughter Jasmine stayed with Dougie at Mr Peachey's place. She remembers Dougie saying he felt sick and being unable to eat. She said he needed to go to the toilet but told her he was unable to.

43. Both Kellyann and Jasmine say that, in their experience, Dougie was generally reluctant to go to the doctor. Lizzie Toomey also agreed that Dougie did not like going to the hospital.

44. This was an important piece of evidence. The very fact that Dougie self-presented at the hospital was very significant and further supported the fact that he was very unwell at the time of presentation.

The admission and treatment on 14-15 August 2021

45. Mr Peachey recalled Dougie explaining why he went to hospital:

> [Dougie] explained that he was walking to Geraldine Carr's place on Gregory Court. On the way, [Dougie] said he got to Braun Ave and felt a popping noise in his belly and was in a lot of pain following this. He said it was bad enough to make him fall to the ground. That incident I believed happened on the 14th as he was walking from my house.

46. Dougie was consistent in his account that he felt a popping noise or feeling in his stomach, and I accept that he reported this to a friend and also to the hospital, and it made its way into the hospital records.

Admission and triage

47. At about 5.00pm Dougie entered the Emergency Department of Dubbo Base Hospital. The admission form correctly recorded his name and his address in Wongarbon, and noted that his presenting problem was abdominal pain. The Attending Medical Officer was Dr Naveed Syed Aziez. However, the admission form incorrectly stated that his "person to contact" was the Governor of Wellington Correctional Centre, with an address of Wellington Correctional Centre, and the "local medical officer" being Dr Michael Ferres, a Justice Health doctor at the

gaol. Dougie had left gaol 11 months before and was clearly not a correctives patient. The records noted from 2017 included that he had "acute alcohol intoxication" at that time.

48. Dougie was seen by Registered Nurse (**RN**) Kerri Daniels in the waiting room and triaged at 5.12 pm. RN Daniels noted that he was "writhing in pain" and he told her that it "felt like something tore". She noted that "self-presented with abdo pain … pain radiating generally". She also recorded that Dougie had "frequent cannabis and infrequent ETOH [alcohol]". He was allocated a Triage Category 3, a category which required that he be attended to within 30 minutes of his presentation. This assessment was reviewed by expert evidence and RN Daniels.

49. In August 2021 Dubbo Base Hospital was in the midst of the COVID-19 pandemic. Most staff were required to wear PPE during this time. Dougie had been tested for COVID that morning but no result had been received, and as such the required assumption was to treat him as COVID positive until it could be shown otherwise. As a result the COVID protocol was followed and he was taken to Bed 13, an isolation room 2-3 minutes walk from the ED waiting room. At 6.57pm that night the results revealed this to be in fact the case.

RN Alison Sayers and Dr Lisa Hu attend on Dougie

50. RN Alison Sayers then took over Dougie's care. Her progress notes were made after the fact. RN Sayers recorded that Dougie had self-presented with sudden onset generalised abdominal pain. He told her that he had smoked marijuana that day. She noted he was warm to touch, and that he was maintaining his breathing, speaking in full sentences, Glasgow Coma Scale of 15 and both alert and oriented. She did note the following: "some distress regarding pain, very vocal moaning and groaning" and "tachycardiac and tachypneic, pt very distressed with pain at this time".

51. An ECG was performed at 5.20pm by RN Sayers which confirmed that he had sinus tachycardia, being a fast heart rate.

52. The Resident Medical Officer Dr Lisa Hu was assigned to Dougie's care. She was a relatively inexperienced medical officer and reported to the two specialists in charge of the ED that day, Dr Aziez and Dr Sokol Nushaj. Dr Hu wrote some notes contemporaneously and some were recorded later. Her note at 5.19pm indicates that Dougie is Aboriginal and at 5.22pm she ordered Endone every 4 hours and PRN to be dispensed as needed.

53. At 5.29pm RN Sayers took Dougie's vital signs. His heart rate was high at 125 bpm, his blood pressure was 114/99, his breathing was also high at 28 brpm and his temperature was normal. His pain was recorded as 10 on rest and 10 on movement, on a scale of 1 to 10.

54. At about 5.45pm an intravenous catheter or IVC was inserted by Dr Hu as noted by RN Sayers and Dr Hu, and medications were given at 5.50pm.

55. At 5.48pm Dr Hu ordered a number of tests including liver function, lipase level, full blood count, electrolytes/urea/creatinine levels and C-Reactive Protein (infection marker).

56. Dr Hu recorded a detailed note of her examination of Dougie after the fact at 6.11pm. She recorded at that time that the pain came on suddenly at about 5.00pm and that he felt something pop inside and that the pain was radiating all over his abdomen and sometimes down to his testicles. He described the pain to her as a sharp pain, like being stabbed, waxing and waning. At better times he rated the pain at 8/10 and 10 plus when bad. He reported it worsened with movement and better on rest.

57. Dr Hu recorded that Dougie had reported no nausea and no vomiting. She recorded that he reported smoking a small amount marijuana that day, and amphetamines 2 days prior. On examination he was: "Alert, intermittently writhing and yelling in pain and clutching at abdomen. [His] Abdo - non distended … tender all over, voluntary guarding, no rigidity/rebound/percussion tenderness, bowel sounds were present and no renal angle tenderness". Her impression was "undifferentiated abdo pain" and the plan was for analgesia, bloods and "repeat [observations] when more settled".

58. What is evident is that Dougie provided a clear account to the hospital that he had no nausea and no vomiting. While he had reported smoking marijuana that day, there appears no other history given of marijuana use. He presented in intense pain. He reported that he was Aboriginal. This information was all available to the treating team, and known to the hospital.

59. Dr Hu completed her progress note at 7.00pm and recorded in that note that Dougie was given droperidol 5mg and morphine 2.5mg intra-venously at 5.50pm. While the morphine was ordered and given at 5.50pm, the droperidol was not recorded in the medication chart as either ordered or administered.

60. In her statement Dr Hu said that after her first review she discussed Dougie with her supervisor Dr Nushaj. She says in her statement:

> During that discussion my supervisor advised me that, with his presentation and his history of smoking marijuana earlier that day, he should have a provisional diagnosis of Cannabinoid Hyperemesis Syndrome (**CHS**).

61. She had not heard of CHS before and relied on her supervisor to make that provisional diagnosis. She said that the droperidol was recommended by Dr Nushaj to treat Dougie's CHS.

62. According to Dr Hu's note recorded at 7.00pm, she says that Dougie was "asleep, not in distress, [but] upon waking up he started screaming in pain. Once [I] left the room, Ricky [was] observed to immediately settle and was sleeping again". He was noted to have respiratory alkalosis (from rapid breathing), lactate of 1.9mmol/L and low sodium, chloride and potassium with a raised CRP of 23 which although high, was not critically so. She records that she discussed Dougie with Dr Nushaj and he recommended IV fluids and then a review and discharge. This was the last recorded entry of any doctor having reviewed Dougie.

63. By 7.12pm Dougie's heart rate had come down to 112 bpm but was still tachycardic, his blood pressure was raised at 132/96, his breathing had settled to 19 brpm. He still had pain of 5 on movement and 2 on rest.

Transfer to the short stay unit

64. At about 8.00pm Dougie was transferred to the ED Short Stay Unit (**SSU**) where RN Emily Berry took over his care. His observations including his heart rate and breathing, which were normal. He was on IV fluids until about 9.20pm that evening when RN Berry disconnected the fluids.

65. In her progress note for the period 8.31pm to 9.20pm, RN Berry remarked that Dougie was sleepy and drowsy but also noted that he was alert and orientated, and his observations at 8.18pm were between the flags. He was not complaining of pain and was not nauseous.

66. At 9.30pm at shift change, RN James Watson took over Dougie's care until the next morning. At the handover RN Berry said to RN Watson that Dougie had been admitted to the SSU with "generalised abdominal pain, dehydration and possible cannabinoid hyperemesis syndrome". RN Kate Butler, the nurse-in-charge overnight, also received a handover that Dougie had "abdominal pain and vomiting with no clear source, and consideration was given to whether

he may have cannabis induced hyperemesis." Neither handover was recorded; this evidence was provided from recollection. Again there is no evidence that Dougie told anyone that he vomited or was nauseous, in fact he had stated that he had not, and did not have these symptoms.

67. At 10.30pm RN Watson noted that Dougie was 'between the flags', not febrile however remained tachycardic. He was noted to be drowsy but able to be roused. He was reporting no pain on rest but 5/10 on movement. It was noted that he could be discharged when no longer drowsy "As per FACEM Koli" (i.e. Dr Nushaj).

68. At about the same time, 10.26pm, Dr Hu completed the discharge summary which was addressed to the Justice Health doctor, Dr Michael Ferres, at Wellington Correctional Centre.

69. At 11.46pm Dougie complained of pain and was given Endone by RN Watson as charted earlier by Dr Hu. Dr Nushaj and Dr Hu were due to finish their shifts at midnight.

The overnight shift

70. Dr Jamee McBride took over for the overnight shift from Dr Nushaj commencing at 8.30pm on 14 August 2021. In 2021 he was a first-year emergency medicine registrar but was responsible for all the patients in the ED overnight. As a registrar he was training to be a Fellow of the Australian College of Emergency Medicine (**FACEM**) which would qualify him to be an emergency medicine consultant. He was assisted by a junior doctor only two years out of medical school.

71. To be in the ED SSU, patients have to be medically stable. A nurse is assigned to each patient and the nurse will escalate to the nurse-in-charge and the doctor-in-charge if the patient's clinical condition deteriorates.

72. Dr McBride received a handover from Dr Nushaj. Again he relied upon his memory and recalled as follows:

> Dr Nushaj told me that Mr Hampson's working diagnosis was cannabinoid hyperemesis syndrome. I remember he told me "his sister is picking him up tomorrow". The plan was for Mr Hampson to stay overnight, under observation with a view to him being reviewed in the morning and then discharged into the care of his sister, if he was clinically stable.

73. The handover did not include a review of the clinical records. Dr McBride said he was not told that Dougie had been given droperidol or that he was tachycardic. Dr McBride did not see Dougie at handover or during the remainder of his shift. It should be noted at this point that Dougie's admission was during COVID and so some practices of handover differed from usual processes.

74. Meanwhile at 12.48am, Dougie's relative Lizzie Toomey rang the hospital and, according to her, spoke to a doctor who said he was looking after Dougie. In an email recorded 7 days after Dougie's death, she recalls asking the doctor whether the pain had been caused by his appendix or gallstones. She says she was told by the doctor: "Well we have done some test on your brother and they have all came back negative". She further recorded the doctor saying: "Well I'll say that, it's nothing acute, its nothing severe. So there is no underlying problems". The doctor was not able to be identified, and Dr McBride certainly had no recollection of this conversation.

75. RN Watson recorded Dougie's tachycardia worsening during the night. He was 114 bpm at 2.49am, 131 at 5.49am and 126 at 6.57am. His pain was recorded as 5 on movement at 5.49am. The 'between the flags' protocol required the nurse looking after Dougie to raise the tachycardia with medical staff. RN Watson escalated the tachycardia to Dr McBride, according to his notes, at 5.54am and at 7.03am.

76. Dr McBride recalls RN Watson raising Dougie's tachycardia with him towards the end of his shift:

> James [Watson] told me that Mr Hampson was tachycardic. He told me that Mr Hampson's other observations being his blood pressure, oxygen saturations, respiratory rate and temperature, were all within the flags.

77. Dr McBride says that:

> As Mr Hampson's other observations were normal, I formed the view that that his tachycardia was due to pain. … Pain is a symptom of cannabinoid hyperemesis. I knew that Mr Hampson would be assessed prior to his planned discharge, and, if his tachycardia had not resolved, he would not be cleared for discharge.

78. RN Watson records the conversation as "not for further intervention currently". Dr McBride assumed that the diagnosis of CHS was correct and that an abdominal examination had been performed.

79. At 5.55am Ms Toomey called the hospital again and asked RN Watson for a call when Dougie was ready to be discharged so she could collect him.

The morning shift

80. At about 7.30am on 15 August 2021, RN Watson handed over responsibilities for Dougie to RN Maree Trow. RN Watson recalls that he informed her that Dougie was for review by the morning team. RN Trow recalls being told that Dougie had tachycardia overnight and it had been escalated to the ED Medical Officer who was said to be "not concerned about the tachycardia".

81. At about 8.00am, Dr Naveed Syed Aziez commenced his shift as the ED consultant and was responsible for patients in both the ED and in the ED SSU, including Dougie.

82. There was a handover from Dr McBride to Dr Aziez which was not recorded. Dr McBride says that he handed over the fact that Dougie had been tachycardic overnight, that his sister was coming to pick him up but he was not sure whether he told Dr Aziez of the Endone given to Dougie. By contrast, Dr Aziez says that he was not told that Dougie had tachycardia or ongoing abdominal pain or that he had received Endone the night before.

Discharge from Dubbo Base Hospital

83. Dr Aziez accepts that he did not review Dougie prior to discharge:

> As Mr Hampson had been discharged and no concerns were raised with me, I did not list him on my patient list as a patient for me to review.

84. Dr Aziez says that:

> Mr Hampson's discharge summary on file was signed and finalised, and accordingly it appeared to me that Mr Hampson had been discharged.

85. During the morning RN Trow recorded Dougie's tachycardia and pain worsening. At 7.48am RN Trow recorded his heart rate was 126 but his pain was recorded as a 0. At 10.11am she recorded his heart rate was 124 and his pain was 3 on rest and 3 on movement.

86. At 10.14 that morning RN Trow spoke with Dougie who reported not having his bowels open and that Dougie "feels pain is due to same". She then recorded that she prescribed laxatives coloxyl and senna which were administered to Dougie at 11.00am.

87. At 11.59am that day she recorded his heart rate as 89 but his pain was 5 on rest and 5 on movement. His blood pressure, breathing rate and temperature were within the normal range.

88. RN Trow says in her statement that she spoke to Dr Aziez about the complaint of constipation and he ordered Movicol. Dr Aziez says he does not recall such a conversation and says Movicol is not a medication he would normally order. RN Trow noted that she gave Dougie Movicol at 12.06pm and that his sister "will pick him up in 15 minutes".

89. Dr Aziez says he recalls that "the nursing staff contacted me to confirm that Mr Hampson's vitals were between the flags and that he was ready to be picked up by his sister". This accords with RN Trow's progress note of 12.19pm that: "Pt cleared for D/C [discharge] by EDMO pt walked out front to await sister to arrive".

90. However, RN Trow also said:

> I witnessed that Mr Hampson was in discomfort holding his lower abdomen. He stated that it was only constipation and that he wanted to go home. I asked him if he was sure he didn't want to wait to see if the medication worked and he said no that he just wanted to go home. Mr Hampson was in obvious discomfort whilst I walked out to the front foyer of hospital with him, again I asked if we could help him more. He declined stating its only constipation.

91. The discharge summary remained as it had been completed the night before and did not mention the worsening symptoms on 15 August 2021 or that Dougie had been found to be COVID positive.

92. During 14 and 15 August 2021, Dougie was not seen by any Aboriginal health worker.

93. Ms Toomey then gave evidence that although she went to her car to pick Dougie up from hospital, her car would not start. She was unable to otherwise pick him up and rang the hospital to tell them. When she did so she was told by reception that he had been discharged. She called but could not reach his mobile.

Dougie's vital signs

94. It is apparent from the recorded evidence that on 15 August 2021, Dougie's heart rate was persistently tachycardic (above 120) until the reading taken at 11.59am and that his pain level was increasing. His temperature and breathing remained within a normal range.

Events after Dougie left hospital

95. Dougie arrived in a taxi back to Mr Peachey's house. It is not known when or where Dougie ordered the taxi, or how much time passed between leaving the hospital and arriving at Mr Peachey's place. Mr Peachey says:

> [Dougie] got out of the taxi after being at the hospital. I was on the veranda and saw him bent over in pain. [He] was walking over slowly and holding onto his belly. [He] came over and asked me to pay for the taxi, which I did.

96. Mr Peachey asked him if he had tested positive to COVID and Dougie said "it came back negative". Mr Peachey and Dougie discussed his pain:

> I asked [Dougie] if the hospital did any scans and [Dougie] said they didn't and they just gave him Panadol. As [Dougie] spoke, I could tell he was in pain leaning over the [rail] on the veranda. I could see [Dougie] could not stand up straight and only finished half his smoke.
>
> I remember saying to [Dougie] that he shouldn't have left the hospital and they shouldn't have discharged you. After we went inside to the loungeroom and [Dougie] sat on his knees on the floor while leaning over the lounge.

97. Mr Peachey says they stayed in the lounge room until about 3.30am the following morning, 16 August 2021, until Mr Peachey went off to bed.

98. Mr Peachey says he thought he saw Dougie sleeping at 9.30am as he headed outside. However, when some of the children living there couldn't wake him they told Mr Peachey. Mr Peachey tried to wake him and realised he wasn't breathing so began cardiopulmonary resuscitation, and called an ambulance who arrived, however he could not be resuscitated.

99. It is understandable that after presentation and admission to hospital that Dougie would not return there. There was no evidence of anyone explaining to Dougie what they believed he had, how it evolved and how it should be treated. There was a lacuna in the evidence on this issue. We are left not knowing what Dougie had been made aware of, if anything at all, in relation to his own condition.

Consideration of witnesses

Treatment by Dr Hu

100. Dr Hu examined Dougie, spoke with him, took a thorough history and obtained relevant information which she noted. Her provisional diagnosis was considered appropriate, and she then went to her supervisor with his case. She was then presented with a diagnosis and instructions from her supervisor Dr Nushaj, and she was entitled to rely on these. It was not a situation where she had formed a different view, or indeed was even familiar with the diagnosis.

101. The issue of the transposing of incorrect personal information about Dougie in relation to his contact information, being Wellington Correctional Centre, was troubling. This error was concerning and largely unexplained prior to inquest, and it raised issues in relation to any preconceptions that might have occurred as a result of his Aboriginality. Dr Hu said that when she wrote the discharge summary this information was self-populated, and it appears that it had not been changed from the new information provided by him at admission. It wasn't clear that Dr Hu could even review this information as she made her notation on the system, but in any event I accept that there was no independent turning of the mind to this detail. She noted that she would have completed the content part of the letter, without regard to the address. I was satisfied on this evidence that the prison information did not reach the treating team, and therefore did not have any influence on the way Dougie was treated. It was a system error. It was not a detail discussed by any doctor treating Dougie, and I am satisfied that this misinformation had no part to play in relation to assumptions made about him or his treatment. The importance of this error was that if the discharge information had been sent out to his treating doctor, it would have been sent to the wrong location for ongoing follow up.

102. In evidence Dr Hu was uncertain as to why the discharge letter was created by her well before discharge had been finally determined. There was also some evidence that this letter should be overseen by the senior doctor, however that was not her experience at the time.

103. It was problematic that the letter discharging Dougie was pre-written and signed. This suggested to the future carers that he was intended for discharge and this fact did influence his future care. I accepted that in her experience while at the hospital, Dr Hu was of the belief that she could write and sign the discharge letter, however it is clear that a senior doctor should oversee this process.

104. Dr Hu says that "after discussion with my supervisor [Dr Nushaj] we reviewed him together again and it was decided he was to remain overnight as he reported he did not have a phone or wallet and did not have anyone to take him home". That was her recollection of why he was to stay overnight. The creation of the discharge letter is support for that position. I preferred her account on this point. The firm decision had been made that Dougie was there for pain management only, a discharge letter created and he was moved to the SSU. This also aligns with Dougie's relative's evidence that she called the hospital and had a conversation about his health, and was going to pick him up. On evidence of Dr McBride, he was also made aware that Dougie's sister would collect him the following day.

105. The content of the discharge letter is contemporaneous evidence of what was occurring at the time, including that he was there for pain management only, and that he was being kept in the SSU for social reasons as opposed to medical. The letter had the following features:

a. the diagnosis stated was "undifferentiated generalised abdominal pain";

b. a diagnosis of CHS was not included in the letter;

c. a reason for the giving of droperidol was not stated;

d. there is no mention of tachycardia;

e. his abdomen is said not to be "peritonic"; and

f. there is no mention of the level of pain he had experienced or was experiencing other than a need for paracetamol and ibuprofen.

106. The discharge summary ends with the following words:

> If your symptoms persist [or] worsen, you have black or bloody stool or you are otherwise concerned please seek medical attention from your GP or return to the Emergency Department.

107. This plan noted was in place as a result of the incorrect diagnosis, and influenced the treatment thereafter.

Dr McBride

108. Dr McBride was able to give some very important and significant evidence which I will discuss below in relation to the issue of the treatment of First Nations patients. He said that had he been aware that Dougie was Aboriginal, he would have reviewed him personally.

109. There was no criticism made of Dr McBride. He was on a busy shift, he received a handover and would have preferred to see Dougie but did not. He was relying upon further monitoring of Dougie and a review that would take place prior to discharge. He also relied upon the diagnosis of CHS which in his mind explained the pain and the reported tachycardia.

Nurse Trow

110. In evidence she noted her great concern for him, and expressed that she had not wanted him to leave hospital. She indicated that during COVID she was not permitted to physically leave the hospital, and so instead watched him leave from the door, and that she really tried to encourage him to stay, but could not convince him. RN Trow said she then returned to her duties in the SSU where she was the sole nurse on duty.

111. RN Trow was also questioned about failing to report his vital signs that were not between the flags to the doctor, however she also relied upon the doctor to determine discharge, and did report to the doctor his need for treatment for his constipation. She was entitled to rely upon the review process. There was no criticism made of RN Trow. It would have been preferable, however, if Dr Aziez had been informed of the tachycardia and the ongoing pain Dougie was experiencing.

Dr Aziez

112. Associate Professor Holdgate is critical of the failure to review Dougie prior to discharge. Dr Aziez accepts that, and with the benefit of hindsight would have seen him, and he indicated that he makes that his practice now.

113. Dr Aziez says that he was not advised "at handover or by nursing staff" that Dougie had been tachycardic or had ongoing pain and that if he had, he would have reviewed Dougie and personally examined him. Again this may have assisted him to be specifically made aware of these matters, although nursing staff would have anticipated that Dougie would be reviewed by a doctor prior to discharge.

Discussion of the CHS diagnosis by Dr Nushaj, subsequent treatment and its consequences

What information did Dr Nushaj have to form his diagnosis of CHS?

114. Dr Nushaj could recall that Dr Hu said that Dougie was experiencing abdominal pain, agitation and difficult to control symptoms, but was firm in his evidence that he was not informed that he described that something "popped" inside. He said that he would have remembered that information. He did recall Dr Hu telling him that Dougie had no nausea or vomiting. That was considered significant because Associate Professor Holdgate's evidence was that nausea or vomiting is a required symptom for a diagnosis of CHS.

115. He agreed that he did not review the triage note that referenced the popping report. He did not review Dr Hu's documentation, and could not explain why. Dr Hu did not recall all aspects of the conversation she had with Dr Nushaj where Dougie's diagnosis was discussed, but she said it was her usual practice to go through all aspects of those matters included in her notes. I prefer the account of Dr Hu on this point, as she had the benefit of a contemporaneous notation recording the popping, she had made that obvious enquiry and I accept she would have, on balance, transferred that information to Dr Nushaj.

116. Whether he failed to hear or absorb this statement may be another issue. He had no recollection of being told of that fact. He says that this would have better informed him. An obvious issue arising from evidence is why Dr Nushaj seems to have made no inquiry and therefore had no information about the onset of the condition, which does seem unusual, to then have proceeded with no information about the onset.

117. RN Sayers was a relatively inexperienced nurse who recalls raising whether the CHS diagnosis was correct with no vomiting or nausea, although Dr Hu and Dr Nushaj do not recall such query. This interaction was said to have occurred at the nurses station, and that is where Dr Hu recalls relaying the history of her findings of her examination to Dr Nushaj. I accept that if this was said at the time, neither doctor heard or absorbed the comment.

118. Dr Hu does recall a conversation about the blood results, and her note records consideration of the blood results.

119. As previously stated, Dr Nushaj had not taken any note of his examination or review, and did not dictate anything concerning history, examination, diagnosis or treatment. He indicated in evidence that he developed an impression of CHS when he saw Dougie being brought in, and

recalled that when he examined Dougie there was an absence of involuntary guarding, rebound tenderness and rigid abdomen and learned that Dougie had used cannabis that day. He also recalled a level of agitation in Dougie's presentation. He said his diagnosis was confirmed on his receipt of the blood results. Dr Nushaj relied on certain blood results to support and it seems strengthen his view that the combined results could indicate CHS (loss of potassium and sodium by vomiting stomach acid).

120. On the question of what it was that caused him to immediately consider CHS, Dr Nushaj said:

> … it was just the body pattern, the movements and the agitation that triggered the first thought that the first impression that this could be a cannabis induced hyperemesis. Whether that's also made me think that he's a regular cannabis user I can't make that comment, sorry.

121. Dr Nushaj accepted that he had a cognitive bias that was created by his first impression which anchored his determination of CHS. He agreed that he did not order imaging to exclude more serious diagnoses, and that if he had not formed the diagnosis of CHS that he would have.

122. Dr Nushaj says that he entered Dougie's cubicle and examined him and had a recollection that he did so, but there was no note taken of that examination. I accepted that he did in fact examine Dougie, he did have a recollection of doing so. However, there was no note and no clarity around what precisely happened during that examination. This was an opportunity to speak to him about the nature of the pain, how it started, his marijuana use, and whether he had been vomiting. Whatever occurred during that examination it is clear that an opportunity to traverse these facts was not taken.

123. The CHS diagnosis is puzzling, and after hearing all of the evidence there was simply no proper basis for making it. I was satisfied on the evidence of Dr Nushaj that he remained unaware of Dougie's First Nations status at the point of making the initial diagnosis, and it was unclear when he was made aware of his identification, and that this therefore had no impact on the diagnosis or subsequent treatment.

124. What is concerning is that all of the information needed for Dr Nushaj to inform himself was available to him. He did not rely on the information noted at admission nor the notes made by Dr Hu. He did not avail himself of the opportunity he had to converse with Dougie about when he first noted the pain, whether he had been vomiting or his marijuana habits. It appeared he had very limited information on which to make such a specific diagnosis. There was also no

differential diagnosis, and an acceptance of the diagnosis to the exclusion of all other possibilities.

125. Dougie's reported symptom that he felt like something internal had torn or popped was recorded within the notes and was important information referred to by Dr Vickers and Associate Professor Holgate as it required further investigation to determine the cause of tearing or popping, being a hallmark of a perforated viscous.

126. The evidence of Associate Professor Holgate that a diagnosis of CHS requires the presence of "hyperemesis" which, by definition, is excessive vomiting. There was no evidence to support a finding at the time that Dougie had been vomiting or even feeling nauseous, quite the contrary, he indicated that he was not, as noted by Dr Hu. The experts in this case, Dr Vickers and Associate Professor Holdgate, both confirm that Dougie's symptoms did not justify the diagnosis of CHS. I am satisfied therefore that this was not a diagnosis available to Dr Nushaj. I also accept that Dr Hu was reliant on Dr Nushaj as her supervisor, and that it was appropriate for her in this case to defer to him, particularly in a case where she was not at all familiar with CHS.

127. There is no reflection in the medical notes at all of the diagnosis of CHS being made, let alone any explanation as to how this was arrived at. This absence is testament to why the taking of contemporaneous notes is essential, and has been detrimental to Dr Nushaj's recollection who has needed to rely on his memory for most of the events.

128. The diagnosis of cannabinoid hyperemesis syndrome was incorrect and should not have been made on what little information was known at the time it was made. It was premature, no scan or imaging was performed of Dougie's abdomen and no differential diagnosis was identified. The diagnosis then governed the approach of the doctors who took over his treatment.

129. Dr Nushaj admits this in his statement of 24 November 2022:

> I acknowledge, without reservation that CHS was an erroneous impression, and that the management plan should have included a need for review to consider and exclude other diagnoses in the event of deteriorating symptoms.

Dr Nushaj's explanation of the CHS diagnosis

130. Dr Nushaj's explanation of the exact nature of CHS in his evidence also did not sit with the expert opinion of Associate Professor Holdgate. He said: "If you've got highly concentrated

pure marijuana, that could trigger the cannabinoid hyperemesis syndrome”. This statement was not agreed to by Associate Professor Holgate. She said the patient must have regular and/or long term use of cannabis and the vomiting is cyclical, and CHS cannot be resultant from ‘highly concentrated’ cannabis as described by Dr Nushaj.

131. Associate Professor Holgate opined in her report: "Cannabinoid Hyperemesis Syndrome is typically seen in patients with regular cannabis use and presents as cyclical episodes of severe nausea and vomiting associated with abdominal pain”. Further, she said:

> It is by definition, a diagnosis of exclusion when other organic causes of these symptoms have been rules out by appropriate history, examination and investigation. Mr Hampson did not have features of CHS in that he described no nausea or vomiting which is the hallmark of this condition.

Prescription of droperidol

132. I accept on the evidence that Dr Nushaj ordered the droperidol and that it was administered by an unknown person to treat the CHS symptoms. It also appears that Dr Nushaj ordered droperidol even prior to examining Dougie. He did not recall administering droperidol, nor would that be his usual practice to administer the drug.

133. As a result of the fact of the misdiagnosis, what follows is that Dougie should not have been administered droperidol. Droperidol, is a sedative and anti-nausea drug. The resultant outcome of this administration according to Associate Professor Holdgate would have been to evoke a sedative effect from the drug, masking the pain experienced by Dougie and rendering later clinical assessments “unreliable”.

Impact of Dougie identifying as Aboriginal on the diagnosis and treatment by Dr Nushaj

134. Counsel Assisting referred to one exchange in evidence:

> Q. What I'm suggesting to you [is] that one of the things you, not the main thing, perhaps, but one of the things you took into account in that process was because he was an Aboriginal man with cannabis use and you'd seen plenty of other Aboriginal people with the same syndrome?
>
> A. Correct. I've seen cases with cannabis induced hyperemesis and Aboriginal.

> Q. I need to go to the next step. You'd seen those. That was something that you took into account or influenced your decision to come up with a diagnosis of CHS?
>
> A. Absolutely, early on, I would say yes.

135. It was not apparent as the evidence was given that this was understood by Dr Nushaj to be specifically directed to his knowledge that Dougie was Aboriginal, but came across in evidence as a general observation that of the presentations of CHS, a reasonable percentage of these presentations related to First Nations persons.

136. I am not satisfied on the evidence that Dr Nushaj was saying that as a result of Dougie being Aboriginal that it factored into his diagnosis, because on the evidence it was unclear when he became aware of this fact. What I do accept is that Dr Nushaj was indicating that a large number of patients that he had diagnosed with CHS were Aboriginal, and the fact that he was seeing CHS in waves influenced his quick decision to diagnose Dougie.

137. The result for Dougie of course was the same, and the evidence is that a large percentage of CHS diagnosis were being made on First Nations persons. I am not satisfied that any racial bias conscious or unconscious played a part in any diagnosis or treatment of Dougie by Dr Nushaj. I accept therefore as submitted that the part it did have to play was, on his own evidence, one of the reasons that Dr Nushaj reached his erroneous diagnosis was that he had seen plenty of Aboriginal people in the ED with CHS. However, there was no link made by Dr Nushaj of Dougie's Aboriginal status because, at the point of diagnosis and initial treatment, he did not inform himself as to Dougie's nominated status. The evidence remained very unclear as to when he did become aware of his Aboriginal status, although his account was that at some point he did.

Impact of the diagnosis of CHS by Dr Nushaj

138. The evidence at the inquest supported the following conclusions in relation to Dr Nushaj's treatment of Dougie:

    a. an incorrect diagnosis of CHS had been reached;

    b. the diagnosis of "undifferentiated abdominal pain" was not to be further investigated by x-ray or CT;

c. no further bloods were to be sought notwithstanding some results which required monitoring; and

d. subject to a further review, Dougie was to be discharged.

139. The impact of this diagnosis was very significant. It affected the drugs Dougie was given for pain, which would have, at least to some extent, masked the full nature of his urgent illness. It meant that the continued treatment was consistent with that diagnosis by subsequent medical practitioners, and precluded Dougie from other investigations which would likely have unearthed the serious underlying illness.

140. Dr Vickers gave evidence that if Dougie had properly been diagnosed at the ED after he presented, it is likely an operation and treatment would have successfully addressed his illness, and that if treated properly and promptly he had a good prospect of survival. A submission on behalf of the LHD also raised that Dr Vickers indicated that Dougie's survival prospects would have been affected by delays in treatment. It is accepted that investigations would have taken a period of time necessarily, and that further testing and imaging may have meant that proper treatment might not have occurred immediately.

141. Dr Vickers noted the management of Dougie's condition would have required a referral to a surgeon, and the patient would be prepared for surgery on their advice. The surgeon would then repair the injury. He noted: "The longer one leaves peritonitis, the increasing risk of mortality". He noted that as delay continued, Dougie's chances of survival would have decreased. However, it was properly noted in submissions for the LHD that he was not given the chance that he should have been afforded to undertake the appropriate treatment.

Consideration of referral of Dr Nushaj

142. The submission was made that there should be no referral of Dr Nushaj. It was said that the relevant evidence from Dr Vickers and others of Associate Professor Holgate were not fairly provided to nor put to Dr Nushaj for comment. It was submitted that he would have an expectation that the substance of critical allegations would have been explored in evidence, and that the Counsel Assisting has the responsibility to elicit evidence that either supports or contradicts a matter or issue on which a decision is likely to turn. In essence, there is a suggestion of unfairness, to rely on evidentiary conclusions from material which was not explored with Dr Nushaj nor with Associate Professor Holgate, including the clinical use of

droperidol for sedation, Dr Nushaj's interpretation of blood gases and examination findings and relevance to diagnosis.

143. In reply Senior Counsel Assisting submitted that natural justice has been afforded in the situation where Dr Nushaj was a person of sufficient interest, was invited to make a statement and gave evidence. He was provided in advance the brief of evidence, including the expert evidence. Additional evidence was not submitted on his behalf in the form of expert evidence. However, he was represented and offered the opportunity to examine all witnesses as they gave evidence. He was also examined at length, with the opportunity for re-examination. He expanded considerably in oral evidence. Associate Professor Holgate was not challenged in any real sense about her adverse opinion about Dr Nushaj's treatment. Dr Nushaj agreed that the diagnosis of CHS was wrong. He also agreed that nausea and vomiting was a crucial element of hyperemesis.

144. It is submitted by Senior Counsel Assisting that the error was a substantial error. He referred to the facts of the case being that the cognitive bias meant that Dr Nushaj formed an impression of CHS on merely seeing Dougie being wheeled into the Emergency Department. Further, the early diagnostic closure meant that the impression of CHS was never questioned or investigated by reviewing the patient or by obtaining a CT scan, and therefore Dr Nushaj was anchored by this early diagnosis. It is submitted that while Dr Nushaj admits that such errors occurred, this makes the gravamen of the errors more serious, given that he is a senior medical practitioner and such errors should be well known categories of potential errors. I accept this submission.

145. Finally, Ms Edwidge and Professor Paradies gave evidence of the racial bias in the provision of health care in Australia based on research and anecdotal evidence. On the facts of this particular matter, there is no basis for a finding that Dr Nushaj diagnosed Mr Hampson with CHS because he was Aboriginal. At its highest the evidence was that Dr Nushaj had seen a number of Aboriginal people in the Emergency Department presenting with CHS, and CHS in his opinion was found in greater number in Aboriginal patients in emergency.

146. It was submitted that Dr Nushaj's diagnostic error was a mistake, and that a referral is neither necessary or desirable in relation to public health and safety. The discretion involves an assessment of the benefits or disadvantages of the proposal and a procedural fairness requirement if a recommendation impacts on an individual's interests, including their reputation. It was further submitted that most omissions of care identified in the evidence are

the consequences of hindsight, which is a factor that weighs against being overly critical and negates the need for negative comment. Further it is said that Dubbo Base Hospital, Western NSW Local Health District and individual clinicians have appropriately reflected on the contributory factors, and organisational and individual changes have been subsequently introduced to mitigate against a death of a similar nature, thus it is submitted these factors weight against the referral.

147. It was submitted that although Dr Nushaj accepts that he exhibited cognitive bias, early diagnostic closure and anchoring bias, this was not addressed or explored with him in the evidence by Senior Counsel Assisting.

148. Fairness in my view in this matter remained at the forefront of the inquest. The matter of referral was raised as a specific issue in the issues list and Dr Nushaj was put on notice as a person of sufficient interest.

149. I agree with the submissions that there is no mandate that a referral must be made even if there are reasonable grounds to believe the evidence may indicate that the conduct amounted to unsatisfactory professional conduct or professional misconduct. A discretion remains.

150. There is no issue that Dr Nushaj and indeed all of the medical practitioners and nurses involved in the treatment of Dougie were not wanting the best outcome for him. We explore these issues in the courtroom environment, spending time delving into the individual decisions made, the many clinical observations taken and noted, we have experts review the material and the benefit of hindsight to consider what may have been done better. The reality of the working environment painted by various witnesses in this matter describe the environment in which these decisions were being made. This was a very busy emergency department, with some very junior doctors, limited staffing and the complication of COVID. Dr Nushaj was making this decision under those conditions, in a department that had been seeing waves of CHS. Some of the latter doctors did not even see Dougie while on shift. An emergency department is a place where one goes for just that, emergency treatment, and the doctors and nurses are constantly considering who is the more urgent patient. I mean no criticism of the hospital nor its staff in making these comments, but merely that the prism of the courtroom can sometimes lose the reality of the conditions that we are asking our doctors and nurses to make sometimes life determining decisions.

151. The point of this inquest is not to appropriate or attribute blame, which had been submitted on Dr Nushaj's behalf as being incongruous with the purpose and function of this jurisdiction. This was a very serious and fundamental error made by Dr Nushaj, and Dr Nushaj has expressed his deep regret and made an apology.

152. There were further subsequent errors made by others following the diagnosis of CHS. Some of these included the early preparation and signing of the discharge letter, the inclusions of a custodial address in that letter, the failure of any further doctor to assess Dougie personally, the failure to assess Dougie prior to discharge, the failure to investigate the ongoing tachycardia and pain levels prior to discharge, failure to escalate the ongoing tachycardia to a treating doctor and overall failure to give attention to Dougie's Aboriginal status. These types of matters were relied on to urge for non-referral of Dr Nushaj. I accept that these were additional matters relating to inadequacies in Dougie's treatment, however these do not detract from the initial error by Dr Nushaj in his diagnosis and treatment.

153. The view of Associate Professor Holgate was that the treatment, including diagnosis of CHS by Dr Nushaj was below the peer professional standard. The failure to take notes was also considered to be below the peer professional standard.

154. The misdiagnosis by Dr Nushaj was but one of the concerning features. It was not a case where that diagnosis was even available to him in the circumstances of this case. He did not take or ensure appropriate notes were taken to reflect his interactions with Dougie. He did not consider a differential diagnosis. He did not review the intake notes, nor those of Dr Hu that contained within them valuable and critical information. He did not inform himself of Dougie's identification as an Aboriginal man from the outset. He made the diagnosis prior to examination of Dougie. He failed to organise further imaging where the circumstances required that he did. He, on his own admission, experienced cognitive bias and anchoring as a senior doctor.

155. The purpose of this inquest is not to look behind why he made significant errors, however in my view given the state of the evidence it is both necessary and desirable that the appropriate body be provided with the material generated in this inquest. It is for the proper authority, being the HCCC, with the experience and powers to consider the complaint, and to make appropriate determinations according to its functions. I make no finding as to that issue, as I should not, other than to acknowledge this evidence demonstrates that this treatment may be

significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience, and that in this case that warrants the appropriate body to now be given the opportunity to consider it more fully. The inquest has the benefit of expert review indicating that this was a concerning departure from expected standards.

Provision of health services to Aboriginal people in regional NSW

156. Dougie's death occurred in the context of the provision of health services to First Nations people in regional NSW. The inquest considered whether there were failings in the provision of health services to Dougie, and if so whether those failings should be seen in light of the provision of health services to First Nations people in NSW. Counsel Assisting provided some very helpful statistics and principles set out below.

157. The Australian Bureau of Statistics recorded in 2021 that 15.7% of the population of Dubbo is First Nations. Part of the catchment area for Dubbo Base Hospital is North-Western NSW where the First Nations percentage of the population is 18.6%. Dr Stewart, the Head of ED at Dubbo Base Hospital, estimates that 29% of the patients seen in his ED in 2022 were Aboriginal.

158. It is well known that First Nations people experience poorer health outcomes and have a lower life expectancy than non-First Nations Australians. This is the foundation for NSW Health's policies and procedures on Aboriginal health. Both health and life expectancy are measured as part of the Closing the Gap strategy which is a formal agreement between the Federal and State and Territory governments and the Coalition of Aboriginal and Torres Strait Islander Community Controlled Peak Organisations. Target 1 is that "everybody enjoys long and healthy lives" and that the gap in life expectancy be closed by 2031.

159. The Prime Minister reports annually to the Commonwealth parliament on progress. While the gap has narrowed over the last 10 years, the most recent report is that there is "improvement but not on track".

160. The Key Actions for 2024 identified by the Commonwealth, other than those which concern community-controlled health organisations, and are relevant to this inquest include:

    a. The Minister for Health and Aged Care is to develop measures that report on institutional racism within the health system and measure access by First Nations people to culturally safe health services; and

b. Continue to support and develop the First Nations health workforce.

161. There has been a focus on the improvement of First Nations health care in NSW. An inquiry was conducted by a committee of the NSW Legislative Assembly in a May 2022 Report entitled *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*. The inquiry considered health services for First Nations people at Chapter 6.

162. At that inquiry numerous witnesses described to the committee the impact of discrimination on an individual's choice to seek treatment, including witnesses from Dubbo Regional Aboriginal Medical Service and Moree. What can be seen from this is evidence that a number of concerns were made by a number of witnesses.

163. A specific suggestion for the delivery of culturally safe health services was made to the committee:

> Local Health Districts and/or the local facilities engaging with Elders and community members about their experiences and seeking their advice and guidance about what strategies need to be put in place, as well as incorporating local content into their training programs. A positive example of this is the Waminda cultural immersion program for staff from the Illawarra Shoalhaven Local Health District.
>
> To support First Nations people to feel more comfortable in healthcare facilities, employing Aboriginal people in front of house roles like reception staff, and including Aboriginal artwork and acknowledgements and welcome to country protocols.

164. Finding 17 of the inquiry was:

> *Finding 17* That it is unacceptable that some First Nations people still experience discrimination when seeking medical assistance in some rural, regional and remote hospitals in New South Wales.

165. The Committee made the following recommendation:

> In order to make health services, particularly those in rural, regional and remote New South Wales more culturally safe for First Nations people, the committee recommends that NSW Health and the Local Health Districts improve the cultural safety of health services and facilities by engaging with Elders and local communities to revise and incorporate local content into staff cultural awareness training, to listen to their experiences of the healthcare system and seek the guidance around what cultural safety strategies should be applied in their areas, and to include prominent Acknowledgements of Country in all NSW Health facilities as a starting point.

166. Earlier this year the Productivity Commission released an important report concerning Federal, State and Territory governments' ability to meet the Closing the Gap targets. Its language is unapologetic on the role of institutional racism:

> Priority Reform 3 commits governments to systemic and structural transformation of mainstream government agencies and institutions to ensure that governments are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people. This commitment applies to government organisations without exception – to government departments, statutory bodies, commissions, hospitals and health services, government-owned companies, local governments and every other type of government organisation.
>
> …
>
> [The six transformation elements] require governments to: identify and eliminate racism; embed and practice meaningful cultural safety; deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and people; increase accountability through transparent funding allocations; support Aboriginal and Torres Strait Islander cultures; and improve engagement with Aboriginal and Torres Strait Islander people.

Expert reports on culturally safe provision of health care

167. This may be seen by some as an uncomfortable topic, but it should not be. The reality is that health care professionals are committed to best outcomes for all patients. Government both Federal and State recognise it as an important issue, and this was a valuable opportunity to explore the topic. One of the important issues in this case was whether the medical treatment that Dougie received was influenced by racial bias, racism or institutional racism. This is not an easy matter to traverse. However, everyone has the right to health care no matter what race they might be or the condition they suffer and is a right is protected by Federal and State laws such as the *Racial Discrimination Act 1975* (Cth) and the *Anti-Discrimination Act 1977* (NSW).

168. Two experts were asked to review Dougie's treatment and provide reports:

    a. Professor Yin Paradies is he Alfred Deakin Professor of Race Relations at Deakin University who is a Master of Public Health (University of California, Berkeley) and a Doctor of Philosophy in social epidemiology (University of Melbourne) and has conducted research on the health, social and economic effects of racism as well as racism theory, policy and practice for over 20 years. Professor Paradies is the Chair in Race Relations at Deakin University. He has a Masters of Medical Statistics from the

University of Newcastle. He has a Masters of Public Health from the University of California, Berkeley from 2004. He has a PhD in Social Epidemiology. He has conducted research in to health, social and economic effects of racism, as well as anti-racism theory, policy and practice. He has presented a large number of papers and reports. He has written on a number of indigenous health-related matters, and has considered the impacts of the Australian health system on First Nations people extensively.

i. Professor Paradies indicated some of the areas of disparities between non-Indigenous and Indigenous patients, including the fact Indigenous patients are less likely to receive early diagnosis, are reluctant to go to hospitals or doctors, may suffer greater accessibility, cultural barriers, longer waiting times, early leaving incidents. I mention these without mentioning the multifaceted reasons he provides as impacting these outcomes.

ii. Specifically in relation to leave events and being two and half times more likely to have leave events, Professor Paradies indicated that some leave events are to do with: a past negative experience in the health care system; a generalised mistrust of health care and western health care systems; and the impact of intergenerational trauma, cultural safety and racism within health care systems that might have been personally experienced or experienced and relayed by family and friends. Other issues he raised can be affordability, other family and cultural responsibilities and obligations, and he noted that there are many factors.

b. Ms Vanessa Edwidge is a Ngarabal woman from Emmaville, a registered psychologist and is the current Chair of the Australian Indigenous Psychologists Association. She is a director on the board of Gayaa Dhuwi (Proud Spirit) Australia, a national peak body for Aboriginal and Torres Strait Islander people, particularly around governance, social and emotional wellbeing. She notes that a significant part of her practice and work is to incorporate all aspects of cultural competence, ensuring that Aboriginal and Torres Strait Islander people feel safe in the counselling process and assessments that she does. She said that it is absolutely integral to achieving the best outcomes for Aboriginal and Torres Strait Islander people to practice in a way that is safe and responds to their needs.

i. She gave evidence of the need for cultural safety, particularly within health settings. Historically she notes that some such places were not safe. She noted in her report that apart from being welcomed and respected, she would expect experiences of Aboriginal and Torres Strait Islander people to be believed and validated. She noted that "our culture is centre to our wellbeing, so it's important that culture is valued and centred in terms of, you know, our mental, our physical wellbeing, culture plays a huge part in how we choose to-to heal … and the way we would like to be treated".

ii. When she was asked about cultural safety, she said as follows:

> I think it's imperative that anyone working with Aboriginal and Torres strait Islander people, irrespective of where that is, needs to have a very sound understanding of intergenerational trauma, the impacts of that trauma, and how that impacts on Aboriginal and Torres Strait Islander people access services, whatever those services may be.

iii. She went on to indicate that training, particularly face to face cultural training, is essential to addressing these issues to get better outcomes. Ms Edwidge said: "Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."

169. Both experts had concerns that the treatment Dougie received was influenced by racism or institutional racism. This was based on the brief of evidence provided to them, and some particularly concerning features such as these facts:

a. Dougie identified at the hospital as being Aboriginal;

b. the discharge documentation relevant to Dougie was incorrectly addressed to the prison and prison medical services;

c. Dougie's records noted that he had previously been intoxicated upon presentation to hospital;

d. the diagnosis of CHS was made with seemingly no or limited basis;

e. the type of diagnosis that was made;

f. the fact he was triaged as a category 3 patient (to be attended to within 30 minutes) rather than a category 2 which would have required more prompt treatment; and

g. seemingly no Aboriginal specific services being provided for his assistance.

170. Professor Paradies made reference to colour-blind racism. He said that one systemic or institutional form of racism can be the ideology that "I'm not racist, I don't see colour" and other forms of neutrality. He notes in his view it is problematic that senior medical staff did not know about Dougie's Aboriginality. He noted that a failure to create environments where that knowledge is disseminated to people who need to know is a form of systemic, colour-blind racism. He notes that the research does not support this approach. A person comes to the hospital with a social and community history, and potentially issues of intergenerational trauma. There may be a belief or discomfort in the community towards hospital, and cultural factors, such as a reluctance to put forward medical history.

171. He gives his support for the Aboriginal hospital liaison officers, as well as other Aboriginal specific staff, health workers and interpreters. He indicated that having them present tends to result in better outcomes for Aboriginal patients, through having someone who understands Aboriginal culture well, and at the same time assist in navigation of the medical system. This acts as an advocate for treatment and discharge planning.

172. For a finding of racial discrimination to be made under the *Racial Discrimination Act 1975* (Cth) and the *Anti-Discrimination Act 1977* (NSW), the relevant conduct must have been "based on race" or "on the ground of" race. Both of those statutes prohibit conduct based on race whether or not race is the only reason for the conduct. This is helpful because although not hearing a case of racial discrimination under either of those statutes, it assists while considering whether the evidence substantiates a finding that any adverse health services received by Dougie were based on race.

173. Much of this determination requires analysis of the totality of the evidence. As previously set out, I am satisfied that Dr Hu knew that Dougie was Aboriginal, but I accept that no other medical professional appeared to have become aware of that fact during Dougie's admission. Dr Nushaj became aware but was unsure when. There was no overt mention of this, nor in evidence was there any suggestion that anyone had reflected upon this fact. It did not on the evidence play a conscious part in the treatment of Dougie.

Dr McBride

174. Dr McBride moved to Dubbo as a Senior Resident Medical Officer, and has commenced FACEM training. In 2021 he was in his first year as an emergency medicine trainee registrar. This means that he was an experienced doctor, and had begun his specialist training. His role was as the most senior doctor with responsibility for all patients within the Emergency Department that night, and that may have been around 65 patients. It was Saturday night, which he expressed is generally very busy.

175. Dr McBride also noted that he did have discussions with RN Watson on 15 August 2021 about how Dougie was. He indicated that he was relying on the senior medical officer coming on shift to review Dougie after overnight and consider such things as tachycardia and pain. He was not aware that there was a discharge plan at the time of being on duty.

176. He noted that he had not become aware that Dougie was First Nations, but if he had he would have gone to his bedside to review and examine him. He also noted that he was not approached by any Aboriginal liaison officer.

177. He noted:

> We're all taught and aware that Indigenous people are a more vulnerable population, but more so personally for me, being Indigenous myself I understand the complexities of an Indigenous person and going and seeking healthcare.

178. He also noted that there is a well known fear within the First Nations community of presenting to hospital or seeking healthcare. In response to a question about how he manages that in a practical sense, he noted that "just having the understanding that fear exists, and just being aware of that and relating and understanding and being able to at times try and relieve that fear".

179. He talked in detail about building rapport and settling fear being important strategies to get to the root of why a First Nations person presented. He raised the important issue of a presentation of agitation, that is a person may present agitated if they find themselves in a space where they do not feel safe or are in fear.

180. Dr McBride was able to discuss some of the positive changes that have occurred since that time. Importantly an admission checklist, together with an icon that appears on the screen alerting a practitioner to the fact that a person is First Nations. Dr McBride noted that this

raises a level of awareness and caution. In clinical terms he noted this might alter history taking, spending more time being aware of cultural sensitivity.

181. Dr McBride is a doctor in a regional setting who is himself First Nations. We had the great benefit of his insight as a medical professional and from a cultural perspective. The evidence from those working at the hospital, particularly that of Dr Stewart, was that Dr McBride is a highly valued member of the team. It is also apparent that he has been heavily relied upon and consulted about First Nations issues.

182. The evidence supports that there is a continued lack of understanding and awareness of what it means for an Indigenous person to present to hospital, and the level of fear that exists in the community. Dr McBride spoke eloquently about the mistrust or luck of trust or indeed no trust from the Indigenous community in the hospital system that needs to be addressed. His focus was on improving cultural safety and understanding of the impact of culture on First Nations persons. Importantly, Dr McBride expressed how he felt a lot of support from the department in regards to being a First Nations trainee.

183. He noted:

> I did mention briefly that the specific fears that our community have is they have a fear that if they go to hospital they're not going to be taken seriously. If they go to hospital, they're going to encounter prejudice and racism. If they go to hospital, they may not get the treatment that they deserve and can have adverse health outcomes.

It was clear that his observation was that there is still much work to do in this area.

184. What he was identifying was the elevated risk that a First Nations person faces once they present to hospital. Professor Paradies says not to become colour-blind in the treatment of First Nations persons. That is, a First Nations person presents statistically as a higher risk patient merely by virtue of being First Nations. It is a medical fact that should feature in the taking of history, assessment of presentation and subsequent investigations. This is not about special or preferential treatment, it is about individualised and proper medical diagnosis and treatment for First Nations people.

185. It further impacts on the cultural sensitivities required as part of the treatment given the fear of government, generational trauma and exposure, stereotyping and generalisation that can lead

to poor outcomes. The mere presentation may be relevant to the determination of the level of illness experienced, given the competing fears.

186. Dr McBride's evidence was extremely valuable and was further support for the experts. He spoke of the realities of the cultural barriers, the poorer health outcomes that statistically befall First Nations people and the need to recognise that if an Indigenous person presents to a hospital, that in itself is a powerful statement of the level of need in many cases.

187. His evidence also supported the issue of unconscious bias and colour-blindness. There was much reliance placed on him by the hospital for cultural education and support, which he has willingly provided, but this must also be recognised as an enormous added cultural load on Dr McBride. The processes in place should be independent of any one doctor, and should stand regardless of who is present in the workplace. His evidence was courageous, he clearly felt the loss of Dougie as another loss of a First Nations person deeply. Yet this is not his burden to bear, and instead he should be celebrated not only as another young doctor, but as a successful First Nations doctor who has made a choice to work within a First Nations community which is more than enough giving to the community. He should be applauded for the additional work that he does in education and training on a cultural level.

Response from the Local Health District as to proposed recommendations

188. The LHD has engaged with the process of cultural sensitivity. It is clear that some steps have been taken by Dubbo Base Hospital, but the evidence indicates that more needs to be done.

189. The LHD urges the position that Dougie's treatment was not hampered by his Aboriginal status and that there was no actual or unconscious bias in that regard. It accepts that that there are constraints due to budget and staff and that needs to be acknowledged. Dubbo Base Hospital plays an essential role in the provision of health services to this important and very special community within NSW. Boasting support for its significant First Nations consumers, it has approximately 30% of all presentations being First Nations. The paediatric presentations are around 40% First Nations. It is agreed that these are the largest numbers seen anywhere. It is uniquely placed to lead NSW in best practice both in cultural sensitivity and treatment provision.

190. It is agreed that there was an omission to take into account Dougie's indigeneity. Dr Geoff Hardacre, the Director of Medical Services, reflected on the fact that there were system errors,

not attributable to Dougie being an Aboriginal man. Dr Hardacre went on to say that he would have hoped that Dougie had received a further medical review during his stay, whether he was Indigenous or not. It rejects that this is a form of colour-blind racial bias, but rather a hope that Dougie would have received a review. It proffers caution therefore in imposing recommendations drafted prior to hearing the evidence of Dr Stewart and Ms Bickerton.

191. The recommendations are submitted to not be necessary and ought not be formally adopted, or in a number of cases some amendments are proposed. It is said that generally actions and policies with similar intentions are either in train or have been adopted. There is an extensive network of governance structures that exist within DBH with deep ties to the local Aboriginal community.

192. The Western NSW Local Health District provided a number of statements about its response to Dougie's death, its contact with his family following the death, and its policies and procedures. Dr Hardacre undertook to meet directly with Dougie's parents after his death. The General Manager of Dubbo Health Service, Ms Debra Bickerton, gave evidence about policies, procedures and training since Dougie's death. There have been a number of changes to procedures in the SSU, with Aboriginal Health Workers and training. Dr Daniel Stewart addressed changes within the ED following Dougie's death since 2021.

193. Dr Stewart gave very comprehensive evidence of his commitment to embrace learning and teaching culture awareness. He has actively pursued this and continues to do so in a positive way. The hospital clearly supports his approach, and its commitment to the employment of First Nations persons to be part of its core staff is also a very positive step.

194. However the hospital needs support and financial backing to encourage growth in this area. It is willing, it acknowledges the need, but the addressing of the issue should not place reliance on individuals who are presently at the hospital and taking on this impressive task.

195. This inquest heard from four First Nations persons directly. Two experts in the area, one professional and experienced doctor, and a friend of Dougie's (Mr Peachey) who lives in the local area. Steps are being taken, but much more can be done to address unconscious bias, to increase trust within the First Nations community and establish ways to achieve the best outcomes for all consumers of the local hospital services, including First Nations consumers.

196. It is also worth noting that although the First Nations population sits at around 3.4%, this community represents around 30% of all presentations to Dubbo Hospital. On that basis alone Dubbo Hospital should be supported in its efforts to become a centre of cultural excellence. The evidence was that experience at Dubbo Hospital is sought after by doctors to give exposure to the treatment of First Nations persons, which is an opportunity for best practice to be demonstrated and shared to wider NSW health.

197. In response to the recommendations proposed, the concern was raised that there may be duplication of existing structures and possible disruption of existing connection with the local Aboriginal community leaders and organisations. They raise that local Aboriginal community leaders were not heard in the course of the inquest. The point and focus of many of these recommendations is to ensure the opportunity is extended in a formally acknowledged way to involve the local community in the development of cultural improvements. The ultimate outcome being sought is to improve outcomes for First Nations people. Engaging expert evidence on this issue, as with any expertise, is to gather a better understanding of what will improve the existing relationship between the hospital and its consumers. The LHD raised that they are seeking to improve the model of care to reduce the proportion of Aboriginal patients who leave without being seen, and that the Emergency Department work towards setting the standard for what can be achieved for Aboriginal health in such Departments.

198. The recommendations below are being promoted to encourage just that. The expert evidence adduced, together with the factual evidence of this case involving Dougie, in particular the considered views of Dr McBride, provide sufficient evidentiary basis for the making of improvements. Indeed, this evidence supports that it is both necessary and desirable to do so.

199. The evidence reflects on an historical loss of trust in governmental institutions by First Nations people, and that trust needs to rebuild, or indeed, build. The tenor of the evidence was in some ways clear and simple. Engage in a culturally respectful way, connect, build rapport, be mindful of the barriers and historically poor outcomes and factor that into the medical process.

Discussion of recommendations proposed

200. There were recommendations proposed in the submissions of Senior Counsel Assisting, submissions for Ms Murray and for Mr Hampson and Ms Chatfield. The responses on behalf of the interested parties were then provided and have been taken into account. There is overlap

in relation to some of proposed submissions, and ultimately Senior Counsel Assisting has proposed a consolidation of a number of the recommendations.

To the Western NSW Local Health District:

(1) That the Western NSW Local Health District (LHD) consider establishing a standing First Nations consultation and advisory group in liaison with the local Aboriginal community controlled health organisations, such as Dubbo Regional Aboriginal Health Service, to be consulted from time to time.

201. The first matter relates to the consultation process with the local First Nations community.

202. This recommendation is to support the establishment of a First Nations consultation and advisory group. This was not supported by the LHD, given there is already an advisory group that has been established in the region. We did not hear from any First Nations person who is involved in this process, and it was not entirely clear the role that is played by the existing consultation group. The submission from the LHD is that this would replicate pre-existing structure, however given there is no evidence to support that a group exists of the nature proposed.

203. This recommendation supports the LHD creating an open and transparent conversation with the local First Nation community, allowing for a wide input from those who culturally understand the local community issues. The LHD currently does seek consultation from the Aboriginal community in respect of policy and projects, however that is a different concept to the establishment of a First Nations controlled consultation group that is an ongoing group. The LHD appears to determine when to engage with the Aboriginal community on what appears to be more of an ad hoc basis. Witnesses described the process to be informal.

204. Various witnesses in the proceedings from the hospital all accepted that it would be a good situation to have formalised the process, and that frequent consultation with the Aboriginal community would be of benefit. The overall tenor of the evidence was supportive of a more formalised process.

205. Dougie's parents proposed that this body consider and implement feedback, training, referral relationships, quantitative and qualitative measurements for analysing institutional racism and establish a robust and prescriptive framework for culturally safe care. In relation to the specific roles and responsibilities of the Aboriginal consultation group, it is important to allow the

hospital and consultation group to determine the nature and role of the group, and in my view I do not need to specify these matters. The submissions on behalf of Ms Murray support the concept, and make proposals for the makeup of the group and the frequency of meeting. Again, these are matters that should form part of the advisory group in conjunction with the hospital to determine.

206. The evidence supports the need for this consultation group, and I intend to make this recommendation. This would be a formalisation of what the DBH is currently undertaking in a less structured way, and would also be a mechanism of gaining support and confidence within the local First Nations Community. Rather than confounding current arrangements, it would seem that there are some established relationships which could be drawn upon in the development of an advisory group.

(2) That the LHD refer its training programs to that consultation group for review and recommendation for revision or additional modules if required.

207. The evidence of Dr McBride and others demonstrates the utility in education stemming from the community for the benefit of the community. On that basis after reviewing the reasoning in the submissions, I am of the view that this recommendation is both necessary and desirable and will be made. I also note that these are opportunities and practical solutions for bridging the gap in accordance with general government policy, and this recommendation provides a perfect example of how this can be done in a productive way. It seeks help and assistance from the local community of First Nations people to have an input on training programs that will have a real impact on the future treatment of First Nations people. Although not agreeing with the proposed recommendation, the LHD have helpfully indicated that this proposal is reasonable.

208. Submissions on behalf of Ms Murray also proposed a recommendation in very similar terms. Those submissions also urged for the use of Dougie’s case study and specific details of some training sessions, however as stated previously the ambit and design of programs ought be left to conversation between the DBH and the consultation group.

(3) That the LHD ensure that cultural induction and recurrent training to medical and nursing staff at Dubbo Base Hospital involve face to face engagement with First

Nations people from the community of Dubbo and the wider catchment area for the LHD.

3(a): The LHD ensure that cultural induction training, including information specific to the local Aboriginal and Torres Strait Islander community, is provided to all medical and nursing staff who will be employed at the hospital for 6 weeks or more, including staff on a locum basis, as close to the start of their commencement as possible. This training should preferably include face to face engagement with Aboriginal and Torres Strait Islander people from the catchment area of the LHD.

3(b): That the LHD consider whether recurring face to face training in the areas of cultural competence, responsiveness, awareness, humility and safety, can be provided to LHD staff regularly, preferably annually.

3(c): That consideration be given to improving and enhancing mandatory training for staff in respect of:

a. **why First Nations patients are a high-risk, vulnerable community;**

b. **the scope of practice of Aboriginal Health Workers and Aboriginal Health Practitioners, including the ability of staff to make referrals to Aboriginal Health Workers and Practitioners; and**

c. **how Aboriginal Health Workers and Practitioners can be integrated into the clinical practice of doctors and nurses to improve patient experiences.**

209. The next recommendation is the consideration of training being delivered in a face to face manner, and to include staff who are with the hospital for more than six weeks. Again, this is not supported, on the basis that there has been face to face training in the past, and its resumption may occur.

210. The opinion of the Ms Edwidge was that there is significant value and a need for increased focus on cultural face to face training. Dr Stewart also spoke of the great benefit and understanding that he had received by just talking, one on one. He gave some very compelling

evidence of the ability to ask sometimes difficult questions, or explore ideas to gain a deeper understanding of cultural issues.

211. Ms Murray proposed 3(a) pressing for cultural training for new staff. Dr Stewart gave evidence that upon arrival at DBH, staff may have had little if any specific training on cultural safety or competence, let alone specific training relevant to the Dubbo local area. This is an example of where a culturally designed and led training program would be significant. Dr Hu had never heard of CHS. Dr Nushaj said that it was a common presentation of First Nations people at DBH. There was no Aboriginal identified liaison officer to visit with Dougie, and the experts together with Dr McBride set out what should and would have been different had his background been recognised and understood, at least at that time by Dr McBride. Dubbo Hospital agrees that it should be the leader in Aboriginal Health, and says that it is sought out by medical professionals on that basis. The fact that the local First Nations population is so high and represents 30% of the patients presenting, it seems a valuable recommendation to ensure the opportunity for the specialist cultural training to be provided for the community.

212. Recommendation 3(c) is particularly powerful in its simplicity, particularly opening up the question of why First Nations patients are a high-risk, which leads into much of the discussion of the experts on this issue, and the experience of Dr McBride.

213. Dougie's parents suggested in relation to the reformulated recommendation that the cultural training be delivered quarterly. The LHD have indicated that it is not aware that this type of training proposed exists.

214. The LHD indicates there is no evidence to suggest whether training in respect of racial bias, colour-blind racism and cultural safety would improve outcomes. It is hoped that the findings of this inquest will assist in demonstrating that an improved service would include generating cultural awareness and knowledge among staff. Many non-Indigenous people had the opportunity and benefited greatly from the knowledge and awareness that was highlighted from the evidence given in this inquest alone.

215. Ms Bickerton gave evidence that she completed the "Respecting the Difference" training delivered, she understood, every eight years. She recalled that her training was presented by an Aboriginal man who had travelled from out of area, however this was an example of a training that she was able to readily recall as positive. There was evidence of cultural tours facilitated by DBH staff, led by Dr Stewart and Dr McBride, but this training again appeared

to be of infrequent delivery, and several witnesses could not recall when they had last engaged in cultural training, or reported having such training years before.

216. The evidence from the experts related to the fact that cultural training relates to making a First Nations person feel safe in the hospital environment. Dr McBride spoke of the need to recognise the different needs of this specific group that has, historically, had worse outcomes from presentation. This is a group that historically will be presenting later than others in the community, and connection and understanding is needed to improved medical outcomes.

217. Dougie's parents also suggested that there be a number of changes to create a culturally safe 'checklist' for the hospital, but the breadth of the recommendations so far will allow the process to commence and the relevant consultation process to make the determination of how best to proceed.

218. Ms Murray suggested areas of improvement to mandatory training. This proposal echoed the expert evidence and that of Dr McBride as previously discussed, and I accept the adjustments made by Senior Counsel Assisting in proposed recommendation 3(c) to fully encapsulate the evidence of Dr McBride.

That the LHD expand the Aboriginal Liaison Officer staffing in the Emergency Department of Dubbo Base Hospital to ensure 24 hours coverage.

219. I accept that this is another very important recommendation and submissions of family and Counsel Assisting supported the making of this recommendation. The LHD does not, given the difficulties arising in emergency particularly in the evening shifts. I accept the hospital submissions that attraction of suitable candidates for these important roles can be very difficult, and to add the extra burden of nightshift work to this small group of identified workers could serve to detract from the roles. It is for that reason that I do not intend to make this recommendation. In this case if a daytime First Nations staff member had been available, Dougie should have been able to be seen in either of the day shifts, and importantly he could be seen prior to discharge.

(4) That consideration be given to including the following information as mandatory when documenting a plan of management as referred to in Appendices A and C to Local Operating Protocol D23/11137:

a. what outstanding investigations are to occur;

b. whether there is a need for medical review;

c. who is required to undertake the medical review; and

d. when the medical review should be conducted during the patient's stay.

220. This recommendation was proposed by Ms Murray, and is accepted as a practical suggestion in relation to management plans. The need for a clear plan to be articulated was highlighted in the present case, where there seemed to be some confusion over the proposal to discharge, the reason he was staying overnight, the failure to medically review Dougie and how often that review should have occurred. This recommendation reflects matters raised by Associate Professor Holdgate in respect of recording of information for patients in the SSU. Dr Stewart agreed that it may be helpful to incorporate the matters raised by Associate Professor Holdgate.

221. The submissions for Dougie's parents supports this position, with additional detail added to include the involvement of the advisory group. This proposal however relates to a medical decision and determination, and reflects future treatment of the patient in the hospital and is therefore best responded to by the treating medical team alone.

(5) That consideration be given to amending Appendix B of Local Operating Protocol D23/11137 to say: "A discharge from the EDSSU must be approved by a senior medical officer."

222. It appears this recommendation has been adopted by the hospital.

223. This is a reflection of the evidence of Associate Professor Holdgate. The submissions of Dougie's parents and Ms Murray were to the effect that it is preferable that a senior medical officer review each discharge summary or conduct a face to face review of every patient for discharge. Dr Hardacre indicated that a junior medical officer can complete a discharge summary where the content has been agreed by a senior medical officer. I accept this submission.

In relation to Dr Sokol Nushaj

(6) That Dr Sokol Nushaj is referred to the Health Care Complaints Commission for investigation and review as to whether he engaged in unsatisfactory professional conduct under the *Health Practitioner Regulation National Law (NSW) No 86a* in

relation to his treatment of Ricky Douglas Hampson including the diagnosis of cannabinoid hyperemesis syndrome on 14 August 2021.

224. There were extensive submissions as to why it is not appropriate that a referral be made to HCCC. I have reviewed carefully those submissions. Dr Nushaj has indicated that he understands his errors, and that he did not have a proper basis for the diagnosis. He apologised to the family, and the hospital determined to take no further action in relation to the matter. On that basis it is submitted that there are insufficient grounds for a referral to be made.

225. It is not the role of the Coroner to make any such findings, attribute blame nor impose penalty. However the Coronial process is one that is done on behalf of the community. Evidence is gathered including expert evidence and this is done at a cost to the community.

226. The evidence of Dr Nushaj continued to show that he did not have a proper or full understanding of the criteria for diagnosis of CHS. It was a catastrophic diagnosis that informed the remainder of the treatment of Dougie, to his detriment. I am of the view that the test has been satisfied for referral.

227. There were no findings from the evidence that there was any conscious or unconscious racial bias in relation to the treatment of Dougie by Dr Nushaj. The issues raised by the medical experts related to the clinical diagnosis and treatment of Dougie.

To NSW Health

(7) That NSW Health consider whether it should amend NSW Health Policy *Aboriginal and Torres Strait Islander – Recording of Information of Patients and Clients* PD2012_042 to ensure that all medical and nursing clinicians are advised of the Aboriginal or Torres Strait Islander status of a patient to ensure that it is considered in the treatment of such patients.

228. The evidence was that no real attention was given to Dougie's Aboriginality. I agree that the concept of colour-blind treatment does not work in a section of our community that is prone to far worse outcomes than the remainder of the population. Recognition should be given to that fact and in line with the hospital's own evidence, culturally appropriate treatment should be provided. That is a goal that they are trying to achieve, and this inquest supports their goal, and the goals of impressive staff such as Dr McBride in their endeavours, and as such I am persuaded that the recommendations are both necessary and required.

229. Submissions support this recommendation. First Nations status can effect the health outcome of a patient. In that regard I make this recommendation in support of improving health outcomes for our First Nations people.

Other proposed recommendations

230. Proposed recommendations were put forward regarding the development of tools to analyse institutional racism within the LHD and measure the existence of implicit bias in the provision of healthcare.

231. Dr Stewart reinforced the fact that DBH is in a unique position to conduct research and trial programs specific for First Nations people. Ms Bickerton seeks to create a plan where DBH becomes a centre for research for First Nations health care. These are excellent suggestions proposed by family, however, these are matters in early stages of consideration and implementation. These matters are of great interest, however in my view I do not have sufficient evidentiary basis to make this recommendation with enough specificity to be useful.

232. Ms Murray also proposed that Dougie's name is used in case studies for training in the future. The LHD has indicated that this is occurring. In any event, this is a voluntary decision to be made by both the hospital and the family, and as such I would decline to make a recommendation enforcing this position on either the family or the hospital, particularly when this is already occurring.

233. Finally the recommendation on behalf of Dougie's parents addressing the mentorship program is also an excellent proposal. The mentoring program has been adopted and embraced by the LHD. I agree however that this is a program that involves questions of staff capacity and a desire to be involved, and as such although recognising the power of it, I will not make a formal recommendation.

234. The LHD raises a barrier created due to policy in relation to recommendation proposed by Dougie's parents regarding memorials, and I accept that, and will not make that recommendation.

Conclusion

235. Dougie's death was preventable. When revisiting the beautiful reflections by his mother, father, aunt and sisters and brother, and those of the children it is a reminder that preventable death extends well beyond the person, to the family and loved ones who are left, as in this case, with a huge loss, and what is even more difficult for them to bear is the fact that the loss occurred after he presented to hospital, a place that he did not like to go, and he was ultimately discharged without adequate treatment, in pain from a place that should have identified the life threatening condition from which he suffered.

236. Although in this case I have not found that there was any specific racial bias influencing the treatment of Dougie, either conscious or unconscious, Dougie's story has nonetheless presented as the opportunity to consider the question of the importance of identification of indigeneity as an important factor in informing medical treatment. That is, a relevant piece of evidence to improve outcomes for First Nations people begins with clear identification that they are in fact First Nations.

Issues Answered

237. The following were explored at inquest, and were able to be answered:

1. The name, date and location of the death of the deceased was Ricky Douglas Hampson;

2. Mr Hampson was suffering from a perforated duodenal ulcer or ulcers when he presented to Dubbo Base Hospital Emergency Department on 14 August 2021;

3. Mr Hampson's perforated duodenal ulcer or ulcers was not diagnosed at Dubbo ED, including in the short stay unit, on 14-15 August 2021 because of an inappropriate initial diagnosis of CHS, that was not revised or revisited, tested or further explored. He was not seen by a doctor prior to discharge, his notes disclosing a popping or tearing in his abdomen were not appropriately reviewed, there was a failure to undertake further scanning or testing to eliminate serious causes, and reports of both his tachycardia and pain levels were not adequately communicated to treating doctors when necessary to do so. These matters led to his premature discharge and inadequate treatment.

4. Mr Hampson was not suffering from CHS and he should therefore not have been treated with droperidol at Dubbo Base Hospital;

5. Further investigations of Mr Hampson's medical condition should have been undertaken by medical staff at the hospital including conducting a CT scan, medical review or other diagnostic steps;

6. Mr Hampson should not have been discharged on 15 August 2021;

7. If Mr Hampson had been properly diagnosed, his duodenal ulcers could have been successfully treated;

8. The failure to treat Mr Hampson's duodenal ulcers led to or contributed to his death;

9. The health care that Mr Hampson received at Dubbo Base Hospital on 14-15 August 2021 (including treatment and discharge) was not of an appropriate standard;

10. Mr Hampson being an Aboriginal man required clear identification of his First Nations status, and indeed that fact should have influenced his treatment at Dubbo Base Hospital;

11. Dr Sokol Nushaj will be referred to the Health Care Complaints Commission with respect to his treatment of Mr Hampson; and

12. The following recommendations are made including with respect to the operation of the Dubbo Base Hospital and the treatment of Aboriginal patients:

Recommendations

To the Western NSW Local Health District:

1. That the Western NSW Local Health District (**LHD**) consider establishing a standing First Nations consultation and advisory group in liaison with the local Aboriginal community controlled health organisations, such as Dubbo Regional Aboriginal Health Service, to be consulted from time to time.

2. That the LHD refer its training programs to that consultation group for review and recommendation for revision or additional modules if required.

3. That the LHD ensure that cultural induction and recurrent training to medical and nursing staff at Dubbo Base Hospital involve face to face engagement with First Nations people from the community of Dubbo and the wider catchment area for the LHD.

3(a): The LHD ensure that cultural induction training, including information specific to the local Aboriginal and Torres Strait Islander community, is provided to all medical and nursing staff who will be employed at the hospital for 6 weeks or more, including staff on a locum basis, as close to the start of their commencement as possible. This training should preferably include face to face engagement with Aboriginal and Torres Strait Islander people from the catchment area of the LHD.

3(b): That the LHD consider whether recurring face to face training in the areas of cultural competence, responsiveness, awareness, humility and safety, can be provided to LHD staff regularly, preferably annually.

3(c): That consideration be given to improving and enhancing mandatory training for staff in respect of:

i. why First Nations patients are a high-risk, vulnerable community;

ii. the scope of practice of Aboriginal Health Workers and Aboriginal Health Practitioners, including the ability of staff to make referrals to Aboriginal Health Workers and Practitioners; and

iii. how Aboriginal Health Workers and Practitioners can be integrated into the clinical practice of doctors and nurses to improve patient experiences.

4. That consideration be given to including the following information as mandatory when documenting a plan of management as referred to in Appendices A and C to Local Operating Protocol D23/11137:

a. what outstanding investigations are to occur;
b. whether there is a need for medical review;
c. who is required to undertake the medical review; and
d. when the medical review should be conducted during the patient's stay.

5. That consideration be given to amending Appendix B of Local Operating Protocol D23/11137 to say: "A discharge from the EDSSU must be approved by a senior medical officer".

In relation to Dr Nushaj:

6. That Dr Sokol Nushaj is referred to the Health Care Complaints Commission for investigation and review as to whether he engaged in unsatisfactory professional conduct under the *Health Practitioner Regulation National Law (NSW) No 86a* in relation to his treatment of Ricky Douglas Hampson including the diagnosis of cannabinoid hyperemesis syndrome on 14 August 2021.

To NSW Health:

7. That NSW Health consider whether it should amend NSW Health Policy *Aboriginal and Torres Strait Islander – Recording of Information of Patients and Clients* PD2012_042 to ensure that all medical and nursing clinicians are advised of the Aboriginal or Torres Strait Islander status of a patient to ensure that it is considered in the treatment of such patients.

Findings pursuant to section 81

Identity

The person who died was Ricky Douglas Hampson

Date of death

His date of death was on 16 August 2021

Place of death

His place of death was 6 Collins Avenue Dubbo, New South Wales

Cause of death

The cause of his death was a perforated duodenal ulcer

Manner of death

He died of natural causes in circumstances following presentation to hospital and the failure of hospital staff to diagnose and treat duodenal ulcer, discharging him home.

Acknowledgements

To all who participated in this inquest, for assisting in the process by giving evidence, family statements and expert reports. To the officer in charge and the representatives of the sufficient interest parties.

To the team Assisting me, Mr Beckett SC for extraordinary presentation, thorough examination and thoughtful submissions, with Ms Dunn who took a great deal of care and time to facilitate a succinct yet very productive presentation of the evidence. To Ms Lowe (ACISP) who supported the entire process, and all of those who participated in it.

To Dougie's family, who were all so very important to him and equally he to his entire family, I extend by most sincere condolences for their very sad loss. I thank them for their joint contribution, participation and active interest. The inquest included beautiful cultural reflections from the initial smoking ceremony at Dubbo, the Aboriginal dance by his children as part of their family statement and the final reflection on the day of findings by way of a smoking ceremony.

I now close this inquest.

Deputy State Coroner Kennedy