

New South Wales

CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Garry Small
Hearing dates:	31 March 2025, 1 & 2 April 2025, 4 April 2025, 5 May 2025
Date of Findings:	28 May 2025
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, Emergency Department management, sepsis, antibiotic therapy, Sepsis Pathway, lactate level, delirium, falls risk, supervision by senior clinician, availability of antibiotics
File number:	2020/00249596
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Findings made pursuant to Garry Small died on 26 August 2020 at Nepean Hospital, Kingswood section 81(1) *Coroners Act* NSW 2747. *2009*.

The cause of Mr Small's death was subdural haemorrhage on a background of an unwitnessed fall and anticoagulation therapy. Insulin dependent type 2 diabetes mellitus, hypertension, ischaemic heart disease and osteomyelitis were significant conditions contributing to Mr Small's death.

Mr Small died as a result of misadventure with the cause of the fall being multifactorial. Although Mr Small was not administered antibiotic therapy in a timely manner and was not managed entirely in accordance with the Sepsis Pathway, it is not possible to conclude whether any difference in Mr Small's management, including his antibiotic therapy, would have prevented the fall or materially altered the eventual outcome.

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1. Introduction

- 1.1 On the morning of 17 August 2020, Garry Small, a 71 year old man, was taken by ambulance to Nepean Hospital with a fever and hypoglycaemia. Following triage in the Emergency Department (ED) where it was noted that Mr Small had an infection from an unknown source, Mr Small was admitted under the geriatrics team. A number of investigations were performed over the next two days. During his admission, Mr Small showed signs of delirium.
- 1.2 In the early hours of the morning on 19 August 2020, Mr Small was found next to his bed after suffering an unwitnessed fall and hitting his head. A computed tomography (CT) scan revealed a subdural haematoma and Mr Small underwent surgery later that morning. Following this, he was admitted to the Intensive Care Unit (ICU) but made no meaningful neurological improvement. Following discussions between Mr Small's family members and his treating team, a decision was made to withdraw active care. Mr Small later died at 9:34pm on 26 August 2020.

2. Why was an inquest held?

- 2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.
- 2.2 Mr Small's death was considered reportable because he died as a consequence of the fall at hospital meaning that the manner of his death was not due to natural causes. In addition, the coronial investigation identified aspects of Mr Small's care and treatment at hospital which required clarification in order to more precisely understand the circumstances leading up to his death. Accordingly, the coronial investigation gathered evidence from a number of health care practitioners, independent experts, and the Nepean Blue Mountains Local Health District (NBMLHD), within which Nepean Hospital is located.
- 2.3 It should also be recognised that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Small's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the

preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

- 3.2 Mr Small was born in Queensland in 1949 but later moved to Sydney with his parents when he was 19 or 20 years old. He spent most of his life in the western suburbs of Sydney.
- 3.3 Mr Small later married Christine Murphy. They had two children together, Judy and Jeffrey.
- 3.4 Mr Small worked in the printing department for a national magazine publication before ceasing employment and receiving a disability pension. After his relationship with Ms Murphy later ended, Mr Small raised his children as single parent.
- 3.5 Mr Small was a wrestling and NRL fan. His favourite wrestler was "Stone Cold" Steve Austin and he was devoted to the mighty Western Suburbs Magpies (now the West Tigers). Mr Small also enjoyed a bet, and loved a good movie and his loud music.
- 3.6 Mr Small's family describe him as humorous, witty and clever. He brought much laughter and smiles to those around him and lived a life that was full of happiness.
- 3.7 Mr Small was a much beloved father, grandfather, great grandfather, son and brother. His loss has caused enormous pain and sadness for his family and loved ones, but the fond memories of his life will always be in their hearts.

4. Mr Small's medical history

- 4.1 Mr Small had a history of ischaemic heart disease with three previous myocardial infarctions, coronary artery bypass graft, pacemaker insertion and type 2 diabetes. He had limited mobility and used a walking frame.
- 4.2 Mr Small had previously been admitted to hospital in May 2016 following several falls. He was found to have a large acute left-sided subdural haematoma but no acute intracranial haemorrhage. Following discharge, Mr Small was referred to a cognitive clinic for further assessment for dementia.
- 4.3 On 20 July 2020, Mr Small was admitted to Westmead Hospital suffering from a lower leg infection which required surgery. Following his discharge, Mr Small was prescribed blood thinning medication. He continued to experience issues with his leg which required antibiotic therapy.

5. The events of 17 to 26 August 2020

- 5.1 On the morning of 17 August 2020, Mr Small woke up and had difficulty getting out of bed. His son later attended his home and called an ambulance. When paramedics arrived they found Mr Small lying in bed, orientated but agitated. Mr Small was noted to have a fever and to be hyperglycaemic.
- 5.2 Mr Small was taken by ambulance to Nepean Hospital where he was triaged at around 11:04am. It was noted that he had a temperature of 40.1 and that he had been given paracetamol by the paramedics with good effect.

- 5.3 Dr Alana Muller, an intern undertaking a first-year rotation in the ED, assessed Mr Small. He was found to be drowsy and irritable at times. Mr Small reported six falls in the last six months. Dr Muller discussed Mr Small's case with Dr Alexei Narushevich, an ED Staff Specialist, and a plan was formulated for blood tests, chest x-ray, urinalysis and urine microscopy culture sensitivities (**MCS**), bolus normal saline, stat ceftriaxone and consideration for admission under the geriatrics team.
- 5.4 At around 3:02pm, Dr Sina Fathieh, a Senior Registrar with the Aged Care Rapid Assessment Unit (ACRAU) reviewed Mr Small. It was noted that Mr Small had a C-reactive protein of 111, lactate of 4.5 and blood sugar level of 20.3. A plan was formulated for review by the Aged Care Services Emergency Team, right ankle x-ray, wound review, urinalysis and MCS, blood cultures, allied health review, dietician review and transthoracic echocardiogram, and changing Mr Small's antibiotic therapy to flucloxacillin and gentamicin.
- 5.5 At 3:38pm a wound culture was collected which ultimately showed heavy growth of proteas mirabilis. Blood culture results from blood taken at 11:35am also showed that *proteus mirabilis* was isolated. This was noted to be sensitive to ampicillin, gentamicin and ceftriaxone.
- 5.6 At 5:31pm, Dr Muller recorded that Mr Small was not for admission under geriatrics and that if the source of infection was the ulcer this would require vascular input.
- 5.7 At 7:29pm, a decision was made to admit Mr Small under the geriatrics team with vascular surgical input. It was also noted that there was a need to switch to ampicillin and gentamicin for sepsis of unknown source.

18 August 2020

- 5.8 On the morning of 18 August 2020, Mr Small was reviewed by both the ACRAU team and vascular team. It was noted that he was suffering from gram-negative septicaemia of an unknown source, potential infective endocarditis, the range liver function tests, acute renal impairment and hypoglycaemia.
- 5.9 Mr Small's management plan included a transthoracic echocardiogram, ultrasound study and endocrine review. A falls risk assessment was later performed and that evening Mr Small was administered 10mg of oxycodone (Endone).
- 5.10 At 7:54pm on 18 August 2020, Dr Fathieh recorded that the wound culture and blood culture revealed the presence of *proteus mirabilis* but with no sensitivity back yet. These results were discussed with an infectious diseases physician and it was decided that intravenous augmentin as a single agent was suitable with formal infectious diseases consult to take place the next day.

19 August 2020

5.11 At around 2:30am on 19 August 2020, Mr Small was reviewed by Dr Petrina Cheng, intern, following an unwitnessed fall. Mr Small had reportedly been walking around the ward when he slipped and fell to the ground, striking his head. He appeared anxious, said that he felt scared, and expressed concerns that there was someone in the corridor who wanted to shoot him. On assessment, Mr Small reported no headache or visual changes, and he was found to have no scalp haematoma or laceration.

- 5.12 Dr Cheng formulated a plan for a CT brain scan, 1:1 nursing and moving Mr Small closer to the nurses' station, and for oxycodone to be ceased with paracetamol given as needed.
- 5.13 At 3:56am, Mr Small was noted to be complaining of headache, constantly attempting to get up and to be very unbalanced on his feet, but refused to have his observations taken.
- 5.14 At 4:46am, Mr Small was noted to be very restless for about 30 minutes, continually attempting to get up from a chair and demanding to go to the kitchen. Mr Small was observed to suddenly become quiet and sit back on his chair, with drooling observed from the left side of his mouth. He was also noted to be verbally unresponsive, with a slight left-sided facial droop. The medical emergency team was called and Mr Small was given oxygen therapy.
- 5.15 Subsequent imaging investigations identified a large left cerebral convexity acute subdural haematoma with significant mass effect causing midline shift, with some falcine and uncal herniation, with suspected early hydrocephalus.
- 5.16 On 19 August 2020, a craniectomy was performed. A large haematoma was evacuated and a posterior arterial bleeding point was found and cauterised.
- 5.17 Mr Small was subsequently admitted to the intensive care unit where neuroprotective measures were adopted and antibiotic therapy for the *proteus mirabilis* was given. However, Mr Small made no meaningful neurological improvement. Following discussions between the treating team and Mr Small's family a decision was made to cease advanced life support and institute comfort care. Mr Small was pronounced life extinct at 9:34pm on 26 August 2020.

6. The post-mortem examination

- 6.1 Mr Small was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Kendall Bailey forensic pathologist, on 31 August 2020. The subdural haemorrhage with subfalcine and uncal herniation seen at hospital was noted. The examination identified features of vascular insufficiency of the lower legs including a deep ulcerating lesion on the lateral surface of the right ankle.
- 6.2 Ultimately, Dr Bailey opined that the cause of Mr Small's death was subdural haemorrhage on a background of an unwitnessed fall and anticoagulation therapy. Insulin dependent type 2 diabetes mellitus, hypertension and ischaemic heart disease were noted to be significant conditions contributing to Mr Small's death.

7. What issues did the inquest examine?

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

- (1) What was the cause and manner of Mr Small's death?
- (2) Was Mr Small's medical condition adequately and appropriately managed between presentation at Nepean Hospital on 17 August 2020 and the time of the fall on 19 August 2020?
- (3) The adequacy and appropriateness of processes NBMLHD have in place to ensure that patients with suspected sepsis are assessed and managed in a timely fashion and in accordance with the Clinical Excellence Commission's Sepsis Pathway.
- (4) The adequacy and appropriateness of processes NBMLHD have in place to ensure that routine antibiotic medications are available for use within all areas of the hospital.
- (5) Whether it is necessary or desirable to make any recommendations in relation to any matter connected to Mr Small's death pursuant to section 81 of the Act.
- (6) Whether the available evidence indicates that consideration ought to be given to the application of section 151A(2) of the *Health Practitioner Regulation National Law* (NSW) No 86a of 2009.
- 7.2 For clarity, some of the issues have been divided into a number of sub-issues. Also, given the conclusions reached regarding issues (1) to (4) it is unnecessary to consider issues (5) and (6) in these Findings.
- 7.3 As part of the coronial investigation, the following independent experts were instructed to provide reports addressing a number of questions regarding the circumstances of Mr Small's death:
 - (a) Associate Professor David Andresen, Senior Staff Specialist clinical microbiologist and infectious diseases physician (instructed by the legal representatives for NBMLHD);
 - (b) Associate Professor Bernard Hudson, Senior Staff Specialist clinical microbiologist and infectious diseases physician and Head of Departments of Clinical Microbiology and Infectious Disease, Royal North Shore Hospital (instructed by the Assisting Team);
 - (c) Dr Sanj Fernando, senior emergency physician (instructed by the legal representatives for Dr Narushevich);
 - (d) Dr John Obeid, consultant geriatrician (instructed by the Assisting Team).
- 7.4 Each expert also gave evidence during the inquest.

8. What was the cause and manner of Mr Small's death?

8.1 The primary question relevant to this issue is what caused Mr Small's unwitnessed fall on 19 August 2020. In his report, Dr Obeid expressed the view that the cause of Mr Small's fall was multifactorial and that "*[i]t would be simplistic to say that an act or omission caused the fall*". When asked to identify the factors that contributed to Mr Small's fall, Dr Obeid gave this evidence:

His overall clinical state. So - and that consisted of the - the pre-existing frailty, the sepsis, the delirium, the medications being used in his case, particularly the - the diazepam, and maybe to some extent the oxycodone, and his - and the multiple problems that occurred as a result of the delirium - as a result of the sepsis.

- 8.2 This raises a number of further questions, namely whether Mr Small presented with sepsis, whether sepsis caused his subsequent delirium, and whether Mr Small's delirium was a primary contributing factor to his fall. The questions regarding sepsis are dealt with in further detail below.
- 8.3 Associate Professor Hudson gave evidence that infection, especially in older patients, can cause delirium. Associate Professor Andresen gave evidence that patients with infection commonly exhibit confusion, agitation and sometimes obtundation. Associate Professor Hudson also gave evidence that it is not uncommon, especially for older patients, to have low blood pressure when standing up. Therefore, Associate Professor Hudson postulated that Mr Small may have become very dizzy when he stood up and this precipitated his fall.
- 8.4 Associate Professor Andresen expressed the view at the time of Mr Small's fall he "*either had a new delirium or a worsening delirium*". Both Associate Professor Andresen and Associate Professor Hudson agreed that the cause of Mr Small's delirium was multifactorial. Associate Professor Hudson explained that "*it's only with treatment of the infection that you can come to an understanding of how much was due to the acute illness and how much was pre-existing*". Associate Professor Andresen also noted other reasons for why Mr Small may have experienced new or increasing delirium, referring to the possibility of benzodiazepine withdrawal and ketonemia (elevated ketone levels due to inadequate diabetic control).
- 8.5 Notwithstanding, Dr Obeid was asked about the possibility that Mr Small may have had ongoing delirium even if any sepsis had been controlled with appropriate treatment. He gave this evidence:

Yes, it is - it is possible that that's the case. I think in an earlier question when you asked me, I said that the - the - the quicker you get on to the treatment, the - the quicker the delirium will - would resolve, and that - that remains true, but it's - it's certainly well-reported in the literature that it can take quite some time for the delirium to settle and, you know, the - it also can take quite some time for the physical effects on the patient to also improve.

- 8.6 Dr Obeid gave evidence that the sooner that a patient is treated for delirium and sepsis, the likelihood of a better outcome for the patient. If Mr Small's sepsis had been recognised immediately upon presentation and he had received appropriate antibiotic therapy immediately this would have provided the best chance to shorten any period of delirium. However, Dr Obeid also referred to the need to reverse Mr Small's renal dysfunction, acidosis and very high blood sugar readings. In this context, Dr Obeid explained that it is difficult to be certain as to the most likely outcome for Mr Small even if these steps in his management had occurred.
- 8.7 In a letter dated 21 March 2025 responding to some opinions expressed in the various expert reports, Dr Bailey stated the following:

There is no way to establish If Mr Small fell because of underlying illness, or the effects of medications. The fall was unwitnessed, and it is unclear if he fell from a seated height, standing

height, or rolled from bed. It is unclear if any other mechanical factors were involved, such as tripping on clothing or bedsheets, which may occur in the absence of intrinsic risk factors for falls. Conversely, any or all of these risk factors may not be excluded as contributing factors.

- 8.8 Dr Bailey also noted that Mr Small's osteomyelitis undoubtedly had a detrimental effect on Mr Small and his pre-existing medical conditions. Further, Dr Bailey explained that Mr Small's diabetes mellitus and ischaemic cardiovascular disease were most certainly the underlying cause of his osteomyelitis.
- 8.9 **Conclusions:** The available evidence does not allow for any reliable conclusion to be reached as to the cause of Mr Small's unwitnessed fall on 19 August 2020. The possibility of a mechanical factor contributing to the fall cannot be entirely excluded. Even if such mechanical factors could be excluded, the expert evidence establishes that the cause of Mr Small's fall was multifactorial, with delirium being one such intrinsic risk factor.
- 8.10 The expert evidence establishes that the cause of Mr Small's delirium was also multifactorial. Therefore, although early treatment of infection provides the best prospects for reducing any period of delirium, it cannot be concluded that alternative antibiotic therapy for Mr Small would have treated his delirium in a way that would have made a material difference to the eventual outcome.
- 8.11 In these circumstances, the cause of Mr Small's death was subdural haemorrhage on a background of an unwitnessed fall and anticoagulation therapy. Insulin dependent type 2 diabetes mellitus, hypertension, ischaemic heart disease and osteomyelitis were significant conditions contributing to Mr Small's death. Mr Small died as a result of misadventure with the cause of the fall being multifactorial. Therefore, it is not possible to conclude whether any difference in Mr Small's management, including his antibiotic therapy, would have materially altered the outcome.

8. Was Mr Small's medical condition appropriately managed between 17 and 19 August 2020?

- 9.1 Central to this issue is management of Mr Small's antibiotic therapy during the course of his hospital admission and consideration of a number of sub-issues which are dealt with separately below. It is therefore useful to summarise the following relevant aspects of Mr Small's antibiotic therapy:
 - (a) At 1:00pm on 17 August 2020, stat ceftriaxone 1mg was ordered but not given;
 - (b) At 3:33pm on 17 August 2020, Dr Muller charted flucloxacillin 1gm to Mr Small;
 - (c) The flucloxacillin was not given to Mr Small until 6:04pm on 17 August 2020;
 - (d) At 7:29pm on 17 August 2020, gentamicin 320g was charted;
 - (e) The gentamicin was administered to Mr Small at 8:09pm om 17 August 2020;
 - (f) Also at 7:29pm on 17 August 2020, an unspecified dose of ampicillin was ordered;

- (g) At 10:24pm on 17 August 2020, the ampicillin was recorded as not given to Mr Small as there was no stock;
- (h) At 11:40am on 18 August 2020, a further dose of ampicillin was charted but also not given;
- (i) No further antibiotics were given to Mr Small until 1:28pm on 18 August 2020;
- (j) At 6:00pm on 18 August 2020, amoxicillin 1mg was given to Mr Small; and
- (k) At 7:55pm on 18 August 2020, amoxicillin-clavulanate was ordered and later given to Mr Small at 10:14pm.
- 9.2 It can be seen from the above that Mr Small only received two doses of antibiotics within the first 24 hours of his presentation to the Nepean Hospital ED. Associate Professor Hudson explained that of these:
 - (a) flucloxacillin has no useful activity against the *proteus mirabilis* that was identified from blood cultures; and
 - (b) whilst gentamicin has excellent activity against *proteus mirabilis* in bloodstream infection, it is inappropriate therapy for skin and soft tissue infection and bone infection.

Was Mr Small suffering from sepsis when he presented to the emergency department?

- 9.3 The clinicians involved in Mr Small's care and the various experts expressed differing views regarding whether Mr Small was suffering from sepsis at the time of his presentation to the Nepean Hospital ED. These views are summarised below:
 - (a) Dr Muller stated the following:

Based on Mr Small's clinical observations at the time of my initial review, it does not appear that he would have met the criteria for either severe sepsis or septic shock.

(b) Dr Narushevich stated the following:

[I]n view of Mr Small's new confusion, fever, increasing oxygen requirement, high BSL, decreased blood pressure (albeit not really significantly in absolute value but significant in the context of the presentation) and comorbidities that could lead to infection, as well as the clinical picture of a delirium secondary to an infective process and early evidence of sepsis would seem to be quite obvious on clinical grounds alone, even if not explicitly stated.

- (c) Dr Narushevich also gave evidence that in discussion with Dr Muller he would have likely stated that Mr Small was at risk of sepsis;
- (d) Dr Fathieh gave the following evidence in response to this question from Counsel Assisting:

Q. Is there any doubt in your mind that Mr Small had sepsis as at 17 August 2020 when he presented to hospital?

A. No. And that's why actions were taken to try to at least start the treatment for that;

- (e) Dr Obeid gave evidence that Mr Small's acute renal failure with elevated lactate levels, excessive acid buildup associated with markedly elevated blood sugar readings and delirium were all diagnostic of the presence of sepsis. In addition, Dr Obeid considered that Mr Small had "*delirium and a temperature of 40 degrees and evidence of multi-system dysfunction*" which demanded immediate or urgent attention;
- (f) Dr Cindy Hastings, Director of the Nepean Hospital ED, noted that Mr Small's observations were always between the flags, and that the other abnormalities such as renal dysfunction and mild deliver abnormality were present prior to this most recent presentation. On this basis, Dr Hastings gave evidence that she did not think there were clear indicators that Mr Small had sepsis at the time of his presentation;
- (g) Associate Professor Stuart Lane, Senior Staff Specialist in intensive care at Nepean Hospital, considered the question of whether Mr Small had sepsis on presentation to be "*an arguable fact*" but that he had at least a fever and some symptoms that would suggest a potential infection somewhere;
- (h) Associate Professor Andresen gave evidence that Mr Small had probable infection upon presentation to hospital, which was later confirmed, but that he never had sepsis. Associate Professor Andresen gave evidence that part of the definition of sepsis is life-threatening endorgan dysfunction which, in his view, was not present in Mr Small's case. Instead, Associate Professor Andresen considered that there was "*probably a linguistic issue*" with the terms infection and sepsis being used interchangeably, in the context of Dr Narushevich's evidence that he considered Mr Small had early sepsis. In addition, Associate Professor Andresen opined that Mr Small's lactate level was "*probably artefactual*" as it was not in keeping with his other clinical features on presentation;
- (i) Associate Professor Hudson expressed the view that on presentation, Mr Small was showing signs of early sepsis due to elevated lactate level which is an indication of tissue hypoperfusion due to infection until proven otherwise. Associate Professor Hudson considered that Mr Small's lactate level placed him at risk of organ dysfunction, if not already present. In addition, Associate Professor Hudson gave this evidence:

I did provide in my report a small advisory from the Clinical Excellence Commission that noted that the most common mistake made in the interpretation of - in managing - one of the more common mistakes made in managing sepsis was to ignore the - not to ignore, but to assume that the elevated lactate was due to another cause and not sepsis, specifically stated in the document that's put out by the CEC; and

(j) In his report Dr Fernando referred to Mr Small having sepsis when he presented to hospital. However, in oral evidence Dr Fernando corrected this by referring to Mr Small having "*potential sepsis*".

- 9.4 It is evident from the above that differing opinions were expressed by those witnesses, including expert witnesses, who were not involved in Mr Small's care and management. However, the views expressed by Dr Narushevich and Dr Fathieh, the two senior clinicians who were involved in Mr Small's care and management is consistent. Further, Associate Professor Lane, Associate Professor Andresen and Associate Professor Hudson all accepted that Mr Small's elevated lactate level represented evidence of end-organ dysfunction until proven otherwise.
- 9.5 **Conclusions:** The evidence from Dr Narushevich and Dr Fathieh, two senior clinicians involved in Mr Small's care, is persuasive and leads to a conclusion that Mr Small was most likely suffering from sepsis at the time of his presentation to hospital on 17 August 2020. The views of these two clinicians are supported by the expert evidence of Dr Obeid and Associate Professor Hudson.

Was Mr Small managed in accordance with the Sepsis Pathway?

- 9.6 The Clinical Excellence Commission (**CEC**) produces adult, maternal, neonatal and paediatric sepsis pathway documents to support clinicians to identify sepsis risk factors, signs and symptoms, commence treatment rapidly and to escalate a patient's care to a senior clinician. The Adult Sepsis Pathway (**Sepsis Pathway**) provides that if a patient meets the Red Zone criteria then a Rapid Response is required, unless already made, or targeted history and clinical examination is to be conducted. In addition, the following management steps are to be conducted in the first 24 hours:
 - (a) Frequent observations at a minimum of every 30 minutes for two hours, then hourly for four hours so that the patient can be monitored and reassessed for signs of deterioration;
 - (b) repeat lactate four and eight hours post recognition;
 - (c) fluid resuscitation based on the patient's condition via the prescription of intravenous fluids;
 - (d) reassess the patient via confirmation of diagnosis and/or place consideration toward other causes of deterioration; and
 - (e) review the treatment/management plan via discussion with the Admitting Medical Officer, document plan to continue, change or cease antibiotics, continue monitoring for deterioration including urine output and discuss the plan of care with the patient's family.
- 9.7 During the next 24 to 48 hours, the patient is to be reassessed in view of the diagnosis and source of sepsis, with a plan documented as to whether there is a need to continue, change or cease antibiotics. The Sepsis Pathway also notes that two sets of blood cultures from two separate sites should be obtained but that antibiotics are not to be delayed.
- 9.8 For patients displaying signs of severe sepsis or septic shock, antibiotics are to be prescribed and administered within 60 minutes of sepsis recognition. For patients displaying signs of sepsis, the prescription and administration of antibiotics must be provided in a prompt timeframe as directed by a senior clinician and within two hours.

- 9.9 There was no dispute amongst the various witnesses, including the expert witnesses, that Mr Small's lactate of 4.5mmol/L placed him within the Red Zone criteria for the Sepsis Pathway. The evidence regarding Mr Small's management on the Sepsis Pathway may be summarised as follows:
 - (a) Dr Narushevich gave evidence that as soon as Mr Small's blood test results were verified (between around 12:12pm and 12:18pm) and his lactate level was made known to medical staff and discussed with a senior clinician, Mr Small ought to have received antibiotics "*immediately thereafter*". Dr Narushevich gave evidence that the reference to "*stat ceftriaxone*" in Mr Small's medical records conveyed "*the urgency of antibiotics*";
 - (b) Dr Fathieh gave evidence that it was necessary to provide a timely and appropriate antibiotic therapy to Mr Small, and it is a "*huge concern*" when medication is charted but not given as was the case with the delay in gentamicin administration. Dr Fathieh also gave evidence that antibiotic therapy should have ideally commenced within half an hour of the blood culture results being available;
 - (c) Associate Professor Lane gave evidence that antibiotic therapy for Mr Small ought to have been instituted "reasonably early" but emphasised that the context of Mr Small's presentation needed to be taken into account:

I guess what I'm coming to is, I know there's boxes to put certain things in around requirements, around a guideline, which is not mandatory, but I think there's also some clinical rationale that could say, yeah, this is not clear. There was - or evidence that it's not as severe as what people might suggest by the actual reading. I do think it's difficult if people rely on one reading to treat without taking the other context into consideration. But I do recognise it's a requirement to focus peoples' minds on certain forms of treatment using these parameters.

- (d) However, Associate Professor Lane also gave evidence that antibiotics ought to have been administered to Mr Small "as soon as possible" and that it would be reasonable to expect that they would be prescribed within two hours of the lactate result becoming available. Associate Professor Lane gave evidence that that the ministration of flucloxacillin to Mr Small was outside the timeframe of what should have occurred.
- (e) Dr Hastings gave evidence that once infection was recognised and a decision was made to treat it, antibiotics should be given within 60 minutes;
- (f) Dr Obeid gave evidence that in an ideal situation where sepsis is recognised early, following discussion between a junior and senior clinician, antibiotic therapy should be commenced within an hour. However, in Mr Small's case, it is likely that the discussion between Dr Muller and Dr Narushevich occurred closer to 2:47pm than 1:00pm, meaning that Mr Small had been suffering from sepsis for at least three hours. In this situation, it would not have been acceptable for antibiotic therapy to be commenced within an hour and that instead the urgency of the matter should have been impressed upon clinical staff;
- (g) Dr Fernando gave evidence that there was a delay in providing Mr Small with antibiotics;

- (h) Both Associate Professor Hudson and Associate Professor Andresen agreed that with the lactate result being available at 12:18pm, and with Mr Small in the Red Zone, antibiotics ought to have been administered within the hour. Both experts also agreed that the medical records did not indicate that Mr Small was observed in accordance with the Sepsis Pathway.
- (i) Associate Professor Andresen also gave evidence that Mr Small's lactate level required management on the sepsis pathway but sought to explain that this also required escalation to a senior clinician who "*pulls together all that diagnostic information and confirms or refutes the diagnosis of sepsis*". When it was explained to Associate Professor Andresen that Dr Narushevich gave evidence that, as a senior clinician, he considered that Mr Small had early signs of sepsis, Associate Professor Andresen accepted that Mr Small should have been continued to be managed in accordance with the Sepsis Pathway. However, Associate Professor Andresen sought to qualify this by saying that the Sepsis Pathway was "*deliberately designed to be overinclusive*" and captures "*patients who don't have true sepsis*". Associate Professor Andresen expressed the belief that this is what happened in Mr Small's case.
- (j) Associate Professor Andresen also gave evidence that once escalation occurs and a senior clinician orders immediate antibiotics then it should be administered immediately. However, Associate Professor Andresen did not consider that "*there were any harms by that omission*".
- (k) Associate Professor Andresen gave evidence that because Mr Small's lactate levels normalised approximately 36 hours after it was first taken this meant that the initial reading was likely artifactual. However, Associate Professor Andresen acknowledge that he could not be "dogmatic about that". Both Associate Professor Andresen and Associate Professor Hudson agreed that the only way to determine the accuracy of the lactate level was to perform a repeat test.
- 9.10 **Conclusions:** Due to his initial lactate level, Mr Small met the criteria for Red Zone management on the Sepsis Pathway. This required timely administration of antibiotics, ideally almost immediately and certainly within 60 minutes of the lactate level being known. However, as the timeframes for prescription and administration of antibiotics described above demonstrates, Mr Small was not given antibiotics in accordance with the Sepsis Pathway. Further, periodic observations and a repeat lactate were also not performed in accordance with the Sepsis Pathway. Notwithstanding, it is not possible to conclude that compliance with the Sepsis Pathway would have materially altered the eventual outcome.

Was the choice of antibiotics for Mr Small appropriate?

- 9.11 As noted above, stat ceftriaxone was ordered for Mr Small following triage and discussion between Dr Muller and Dr Narushevich on 17 August 2020. However, the final blood culture results did not become available until 2:54pm on 20 August 2020. These results show that the *proteus mirabilis* which was isolated was sensitive to ampicillin, gentamicin and ceftriaxone.
- 9.12 Associate Professor Andresen expressed the view that at the time of charting on 17 August 2020 ceftriaxone was "*not the best choice in a patient with sepsis without a clear focus*" because it does not have good anti-staphylococcal activity and insufficiently broad coverage against more resistant

pathogens. Associate Professor Andresen instead considered the correct antibiotic therapy would have been flucloxacillin and gentamicin.

- 9.13 Associate Professor Hudson gave evidence that the two most common causes of communityacquired bacteraemia are *staphylococcus aureus* and *E. coli*. He agreed that for a patient with sepsis without an unidentifiable source, it is important that antibiotic therapy include good antistaphylococcal activity and broad coverage.
- 9.14 Both Associate Professor Andresen and Associate Professor Hudson also agreed that the decision of the ACRAU team to chart gentamicin and flucloxacillin was an acceptable regime for an undifferentiated source.
- 9.15 Associate Professor Andresen described the decision to accept Mr Small under the geriatrics team but to change the antibiotic from gentamicin to ampicillin to be "*slightly odd*". This is because it appeared that such a therapy was moving away from a "no clear focus regimen to a urinary tract focus regimen". Both Associate Professor Andresen and Associate Professor Hudson gave evidence that the medical record did not provide a justification for this change in antibiotic therapy. Associate Professor Andresen considered that this may be due to "*potential mistranscribing or confusion regarding the cognitive rationale for the change*" and noted that with hindsight, the more appropriate regime would have been continuation on gentamicin and flucloxacillin.
- 9.16 **Conclusions:** Given that Mr Small presented with an infection of unclear source, the most appropriate antibiotic therapy instituted on 17 August 2020 would have been flucloxacillin and gentamicin, and not ceftriaxone, due to their anti-staphylococcal activity and broad coverage. However, the final blood culture results were not known until 20 August 2020. These results demonstrated that the *proteus mirabilis* that was isolated was sensitive to ceftriaxone and therefore that the initial order for it was appropriate.
- 9.17 Similarly, at the time that Mr Small's antibiotic therapy indicated that he was not for ceftriaxone, with flucloxacillin and then ampicillin charted, the final blood culture results and relevant sensitivities were not known. In these circumstances, it cannot be said that the choice of antibiotic therapy for Mr Small was inappropriate.

Was Dr Muller's care of Mr Small appropriate?

- 9.18 Having regard to what is set out above regarding the appropriate antibiotic therapy for Mr Small, this issue concerns Dr Muller's involvement in the ordering, but not charting, of ceftriaxone on 17 August 2020.
- 9.19 At that time, Dr Muller was an intern who was at most a couple of weeks into her ED rotation. Apart from vaguely recognising Mr Small from photos, she had no independent recollection of interacting with Mr Small. She gave evidence that the time she "*would not have been particularly independent or confident*" in making decisions regarding treating a patient with suspected sepsis.
- 9.20 Dr Muller accepted that when given a direction by a senior clinician, for example stat ceftriaxone, it was her responsibility to write the prescription up. She also acknowledged that the lactate test

ought to have been repeated to identify any trend. Dr Muller gave evidence that as at August 2020 her usual process for medication prescription would be to document the plan, chart the medication and then verbally instruct a nurse to administer the medication.

9.21 When asked to provide any explanation as to why she did not write up a stat dose of ceftriaxone, Dr Muller gave this evidence:

Yeah, I'm not sure. Ordinarily, I would. And it's like when the geriatrics registrar came later, and they said, you know, give flucloxacillin, I charted that quite quickly. So I don't know why I wouldn't have charted the ceftriaxone. The only, like, speculating possibilities is I either wasn't, I either wasn't sure of the dose, or we were going to see whether the geriatricians agreed with the plan. That's the only - but I'm speculating. That's just possible, I suppose, as to why it wasn't done immediately.

- 9.22 Dr Muller later promptly wrote up the flucloxacillin recommended by the geriatrics team following their assessment at 3:33pm, although it was not given until 6:08pm. Gentamicin was later charted by Dr Fathieh at 7:29pm and given at 8:09pm.
- 9.23 When asked why the flucloxacillin, but not the gentamicin, was charted Dr Muller gave this evidence:

I'm just kind of speculating, but the gentamicin dosing is much more nuanced, so it's possible that - it's even possible Dr Fathieh had to discuss or decide on the dose because it's - it's a range of milligrams per kilo depending on renal function and things, so it's a little more complex prescribing. So it - it - it might be that they hadn't decided the dose yet and - or that - yes, I - I wasn't confident in deciding the dose, but - whereas the flucloxacillin is much more straightforward. It's sort of one gram rather than calculating based on the renal function. So, I suspect that's why.

- 9.24 This was consistent with Dr Fathieh's evidence that gentamicin required more careful consideration.
- 9.25 **Conclusions:** Although Dr Narushevich recognised the need for timely antibiotic therapy to be instituted by ordering stat ceftriaxone, this was not charted by Dr Muller. The reason for this is not clear particularly in circumstances where Dr Muller's evidence established that she understood, and usually followed, the correct process when given instructions by a senior clinician regarding medication administration. This is evident when Dr Muller properly charted flucloxacillin later on the same day.

9.26 Although Dr Muller proposed a number of possibilities why the ceftriaxone was not charted, this only amounts to speculation. It is therefore not possible to identify why Dr Muller departed from her usual practice. In these circumstances, and taking into account Dr Muller's relative inexperience at the time, a conclusion cannot be reached that Dr Muller's care of Mr Small was inappropriate.

Was Dr Narushevich's supervision of Dr Muller appropriate?

9.27 At the commencement of his evidence, Dr Narushevich described the operation of the Nepean Hospital ED on 17 August 2020:

I do recall that that morning was particularly busy in resus from the - a - a cluster of septic patients that morning, including a - a renal transplant patient that needed to be transferred out that I was

involved with - and then another cluster of sick patients between roughly 11 and 2 o'clock, including a paediatric seizure, a paediatric cardiac arrhythmia, a paediatric head trauma, a massive overdose that needed an intubation and transfer to ICU - he was..(not transcribable)..and a - undifferentiated initially but identified complex abdominal sepsis from a bowel perforation that went into septic shock. I do recall, that day, from looking at the record, that we had two vacancies in our middle grade - so that would be registrar equivalent, you could consider it - and one of our consultants was sick. So we were already looking very busy.

9.28 When asked whether he considered that Mr Small's condition warranted personal review by him and whether he was able to adequately manage the situation by supervising Dr Muller, Dr Narushevich gave this evidence:

My position is that at the time of discussion with me with the facts in front of me, he would not have been as much of a priority as other patients within the department that were sicker. I suspect if that wasn't the case I may have reviewed him personally, but I can't say not having exact recollection of everything that happened that day.

9.29 In evidence, Dr Narushevich was taken to the Australasian College for Emergency Medicine policy, *Supervision of junior medical staff in the Emergency Department* (**Supervision Policy**) which provides:

The complex nature of emergency medical care means that junior doctors need extensive support and oversight to function safely and efficiently in the ED.

[...]

In the case of interns, the roster profile should ensure that a senior decision maker with experience in EM is available to provide direct supervision, on a case-by-case basis, at all hours of the day. There should be capacity for oversight of procedures, interpretation of tests (including x-rays) and clinical decision-making (in relation to both treatment and disposition). Interns should be considered supernumerary for staffing purposes.

9.30 Dr Narushevich was asked, in essence, how closely he needed to supervise Dr Muller's care of Mr Small. IN referring to the Supervision Policy, Dr Narushevich gave this evidence:

It is a judgment based on the individual's level of experience, that your assessment of their degree of skill in any particular task and what availability you have at the time. It does note that ultimately supervision is important, but the provision of clinical care is more of a priority when it can conflict with that. That does not mean we need to watch over their shoulder, otherwise we wouldn't be doing our own tasks and that would unfortunately mean that other patients wouldn't get seen in a timely fashion.

9.31 Dr Hastings was asked about her expectations regarding whether senior staff are required to personally review patients. She explained that in August 2020, the supervisory expectations of senior ED staff at Nepean Hospital was "*at least twice that of other facilities*". Dr Hastings went on to explain:

So I think it's always a judgment. I think that the interns do need support, and most of the time people will go and see their patients, but there may be times when it's a very simple presentation in subacute with a minor thing that you've heard about, you might not go and see those patients.

So everything is on a spectrum and it's impossible to give hard and fast guidelines about what you will and won't see, and it will also depend on your competing priorities at that particular moment in time.

- 9.32 Dr Hastings also gave evidence that it would be impossible and not practical for a senior clinician to check that every order for antibiotics for a patient had been charted and administered. Dr Hastings described the workload as being constant with constant interruptions and the ability to check on other people's work to be something that is "*outside your normal capabilities*".
- 9.33 Dr Fernando gave evidence that in most cases it would be his expectation that after discussing a plan with a junior clinician, that clinician would report back with an update. However, Dr Fernando acknowledged that on 17 August 2020 there may have been "*multiple other things going on*" and that this may not have been possible. Dr Fernando also gave evidence that he did not consider it to be Dr Narushevich's role to seek confirmation from a junior clinician that antibiotics had been charted and given because "*there's just no time to do that*". Rather, Dr Fernando gave evidence that his expectation is that "*if a senior tells you to do something, then you do it*".
- 9.34 **Conclusions:** The demands of working in the Nepean Hospital ED generally, and particularly on 17 August 2020, meant that it was not possible for Dr Narushevich to supervise every aspect of Dr Muller's role and responsibilities. There is no evidence to suggest that Mr Small's initial presentation on 17 August 2020 warranted personal review by Dr Narushevich. Further, Dr Narushevich was required to balance the need to manage higher acuity patients with ensuring that patients of lower acuity were appropriately managed by junior clinicians. Having issued an order for ceftriaxone to be charted and administered, it was reasonable for Dr Narushevich to expect that his order would be carried out.

Was the prescription of diazepam and oxycodone to Mr Small appropriate?

- 9.35 Mr Small was administered oxycodone 10mg shortly before 6:00pm on 18 August 2020. No indication for opioid algesia was recorded in the medical record. Dr Obeid considered the prescription of oxycodone to Mr Small to be inappropriate because, as an opioid, it had the potential to make Mr Small's delirium worse. Instead, Dr Obeid expressed the view that it would have been appropriate to start with the least toxic and centrally-acting drug on the analgesic ladder, namely paracetamol. Further, if opioid medication was required, Dr Obeid opined that the more appropriate starting point would be 2.5mg, and not 10 mg, for a patient like Mr Small who was frail with delirium.
- 9.36 Mr Small was administered diazepam 5mg shortly after midnight on 18 August 2020, with no clear entry in his medical record why it was prescribed. However, it is possible that it may have been prescribed due to concerns for benzodiazepine withdrawal given that Mr Small had been on nitrazepam at home. Dr Obeid gave evidence that administration of a benzodiazepine (diazepam) for a patient who has delirium is "*relatively contraindicated*" as it would worsen Mr Small's delirium and was a poor choice because of how long-acting it is. Dr Obeid also expressed the view that if there was concern for benzodiazepine withdrawal for Mr Small then "*a very tiny dose*" of diazepam, possibly 1mg, could have been considered.

9.37 **Conclusions:** The expert evidence established that the administration of both diazepam and oxycodone to Mr Small was not appropriate as both medications had the potential to worsen his delirium. In addition, the indication for each prescription was not clearly documented in the medical record. However, given the conclusions reached above regarding the multifactorial cause for Mr Small's delirium, it is not possible to conclude whether the prescription of either medication had any actual bearing on Mr Small's delirium and, consequently, his unwitnessed fall on 20 August 2020.

Could Mr Small's fall on 20 August 2020 have been prevented?

- 9.38 It has already been noted above that the cause of Mr Small's fall was multifactorial and may have resulted from mechanical factors or intrinsic risk factors, or a combination of both.
- 9.39 One matter raised by Dr Obeid was that staff could have appropriately taken steps to implement 1:1 nursing, or if there were other patients with behavioural disturbances, to co-locate these patients and assign one dedicated to nurse to look after them. Dr Obeid gave evidence this can be an effective way to at least reduce the risk of falls but recognised that can be difficult to obtain adequate staffing at short notice. Further, Dr Obeid gave evidence that that even if staff resourcing is available this does not mean that every fall can be prevented.
- 9.40 However, the inquest did not receive any evidence regarding staff resourcing levels at Nepean Hospital on 19 and 20 August 2020 and whether 1:1 nursing for Mr Small, or assignment of a dedicated nurse to manage a small cohort of patients, was feasible. Even if such measures could have been implemented they would not have entirely eliminated the risk of a fall.
- 9.41 **Conclusions:** There is insufficient evidence as to whether additional staff resources were available on 19 and 20 August 2020 to allow for 1:1, or dedicated, nursing for Mr Small so as to mitigate the risk of a fall. The expert evidence establishes that even if such staff resources were available, such a risk could not be eliminated entirely.

10. Do the processes within NBMLHD allow for the adequate and appropriate management of patients with suspected sepsis?

- 10.1 Dr Hastings stated that upon presentation to the Nepean Hospital ED. Patients with suspected sepsis are triaged as persons with an imminently life-threatening condition. Management steps for such patients include:
 - (a) an alert being available in FirstNet, the Electronic Medical Record (**eMR**) application which supports the operation of EDs across NSW, which may be activated to alert medical staff to consider sepsis;
 - (b) the patient being placed under the care of a senior medical practitioner;
 - (c) where the patient has an elevated lactate, this is escalated to the senior doctor on shift to ensure treatment is provided in accordance with the Sepsis Pathway; and

- (d) the ED Clinical Emergency Response (**CER**) system allowing nursing staff to raise alerts regarding abnormal vital signs so that care may be escalated and a timely response activated for patients who are clinically deteriorating.
- 10.2 The Sepsis Pathway is a paper document which is generally printed by nursing staff and added to a patient's file. Although the Sepsis Pathway is not available in electronic format at Nepean Hospital, the eMR system provides alerts in the event of abnormal blood results, and the Pathology Department also notifies the ED medical officer in charge of any critical results. In 2023, the CEC undertook a review of the Sepsis Pathway, with feedback provided that it needed to be converted to work within the eMR to allow increased use of this resource. Dr Hastings stated that during the currency of the review, Nepean Hospital had recirculated information to staff about the Sepsis Pathway and made copies readily available in the ED to increase use.
- 10.3 As to the conversion of the Sepsis Pathway into electronic form, Dr Hastings gave evidence of her awareness that due to planned changes from the current eMR to a new version, there is a lack of investment in the current eMR. Dr Hastings described this as "*disappointing*" but that the issue "*has been raised multiple times*" in other forums. Dr Hastings went on to describe the effect of shifting to an eMR system:

[I]n the past, when our records were paper-based, you would turn up to the patient's bedside and the pathway would be there, be it a chest pain pathway, or a sepsis pathway, and that would serve as a reminder to check those things off, both from a nursing and a medical sense, and the integration into the eMR, I think, has lost certain aspects that were good prompts, and they haven't been replicated in the electronic medical record sufficiently to prompt people in the right direction when they're busy and distracted.

- 10.4 NBMLHD has indicated that all clinical nursing and medical staff are assigned mandatory training regarding recognising and responding to deterioration in a patient which includes two nonmandatory sepsis modules which staff complete relevant to their clinical area. These modules are created and maintained by the CEC. In addition, interns receive weekly education sessions as part of their training programs including a session on sepsis during the first quarter of the year.
- 10.5 Information was received from the NBMLHD regarding a number of education programs:
 - (a) current education sessions provided in April 2025 to interns and in May 2025 to residents include the new Sepsis Pathway;
 - (b) orientation for all medical staff annually in February and August includes sepsis as a topic; and
 - (c) in early 2025, the CEC released its new program regarding recognising and responding to deterioration within which a sepsis scenario is taught.

10.6 **Conclusions:** There were appropriate processes in place at Nepean Hospital in August 2020, and currently, to allow for the appropriate management of patients with suspected sepsis. Proposed integration of the Sepsis Pathway into the eMR appears to remain uncertain due to planned changes to the current version of the eMR. However, physical copies of the Sepsis Pathway have been made readily available to staff and regular training is provided to junior and senior medical staff regarding the Sepsis Pathway. Whilst Mr Small was not managed in accordance the Sepsis Pathway in August 2020, there is no evidence which demonstrates that this was a result of any shortcoming in the relevant processes and systems in place at Nepean Hospital at the time.

11. Do the processes within NBMLHD ensure that routine antibiotics are available in emergency departments?

- 11.1 Dr Hastings stated that as at August 2020, ampicillin "*was not widely available in the ED at Nepean Hospital*" as a result of a decision made in 2016 to substitute amoxycillin for ampicillin due to a national shortage of the latter. Ampicillin was therefore not routinely available in the ED since 2016 until a decision was made in May 2023 to re-stock ampicillin for regular use.
- 11.2 Dr Hastings also stated:

In the event that a particular routine antibiotic becomes unavailable for use in the ED, standard practice is for the pharmacy department to notify staff and seek advice from the infectious diseases team to source an alternative.

- 11.3 Dr Hastings went on to explain that as at August 2020 and currently, the pharmacy department conducts two-weekly checks of medications stores to ensure medications are re-stocked when needed. Minimum and maximum stock levels are calculated based on usage and which ensures that ED stock levels are adequate.
- 11.4 As to the attempts by nursing staff to source ampicillin for Mr Small, Dr Hastings gave this evidence:

I think if you're still struggling, my experience would be that the staff would - if they hadn't been able to get something, then they may well have come to someone in emergency and said, look, I've asked and they haven't done it, can you just change it to amoxicillin, cause it was known at that time that if you didn't - you didn't give them ampicillin, you gave amoxicillin. So it's a simple switch. It's not really a change in care.

I think that's another option available to the staff. I can't say why they didn't persist with asking the doctor to do that, or why they didn't ask someone in emergency. It's - the - the standard - the standard plan is for patients that are admitted that have an issue is to go to the inpatient team, but if that didn't work, I can't say why there wasn't a second step taken.

- 11.5 **Conclusions:** Ampicillin was not widely available in the Nepean Hospital ED in August 2020. Whilst attempts were made to source this for Mr Small, one solution would have been to switch the prescription from ampicillin to amoxicillin which was readily available. It is unclear on the evidence why this step was not taken.
- 11.6 Since 2023, ampicillin has been re-stocked in the Nepean Hospital ED for regular use. Further, the pharmacy department at Nepean Hospital has appropriate processes in place to ensure maintenance of adequate medication stock levels and for appropriate advice to be sought from the infectious diseases team if an alternative medication is required.

12. Findings

- 12.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Karen Kumar, Counsel Assisting, and her instructing solicitor, Ms Ashliegh Heritage from the Crown Solicitor's Office. I am grateful for the comprehensive assistance that they have provided throughout all stages of the coronial process, for their attention to detail and fairness, and for the compassion that they have shown to Mr Small's family.
- 12.2 I also thank Constable Skye Cameron for her role in the investigation and compiling the initial brief of evidence.
- 12.3 The findings I make under section 81(1) of the Act are:

Identity The person who died was Garry Small.

Date of death

Mr Small died on 26 August 2020.

Place of death

Mr Small died at Nepean Hospital, Kingswood NSW 2747.

Cause of death

The cause of Mr Small's death was subdural haemorrhage on a background of an unwitnessed fall and anticoagulation therapy. Insulin dependent type 2 diabetes mellitus, hypertension, ischaemic heart disease and osteomyelitis were significant conditions contributing to Mr Small's death.

Manner of death

Mr Small died as a result of misadventure with the cause of the fall being multifactorial. Although Mr Small was not administered antibiotic therapy in a timely manner and was not managed entirely in accordance with the Sepsis Pathway, it is not possible to conclude whether any difference in Mr Small's management, including his antibiotic therapy, would have prevented the fall or materially altered the eventual outcome.

- 12.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Mr Small's daughter, Judy; his son, Jeffrey; his grandchildren, Cara and Nathan; and his great grandchildren, other family members and loved ones, for their loss.
- 12.5 I close this inquest.

Magistrate Derek Lee Deputy State Coroner 28 May 2025 Coroners Court of New South Wales