CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of David Scott FREEMAN
Hearing dates:	15–16 April and 26–30 August 2024
Date of findings:	21 February 2025
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – Respiratory arrest, bronchial asthma, known sensitivity to non-steroidal anti-inflammatory drugs (NSAIDs), non-allergic hypersensitivity reaction, Tenterfield Hospital, absence of medical officer, lack of nurse accreditation in first line emergency care or advanced life support
File number:	2019/337631

Representation:	Counsel Assisting the Coroner: Maria Gerace SC instructed by Leanne Kohler, NSW Crown Solicitor's Office Hunter New England Local Health District and Mr Anthony Roberts: Ben Bradley instructed by Caroline Blair, Makinson d'Apice Lawyers Dr Michael Ling: Jake Harris instructed by Judith Alderson, Avant Lawyers Registered Nurse Ernestina Amarh-Ashitei: Kim Burke, instructed by Marie Panuccio, Sparke Helmore Lawyers Enrolled Endorsed Nurse Jo-Anne Lee and Registered Nurse Stacey Butler: Pat Robertson, NSW Nurses and Midwives' Association

Findings:	**Identity** The person who died was David Scott Freeman **Date of Death** David died on 27 October 2019 **Place of Death** David died at Tenterfield Hospital, Tenterfield **Cause of death** The cause of David's death was respiratory arrest secondary to acute exacerbation of bronchial asthma caused by a non-allergic hypersensitivity reaction to aspirin administered at Tenterfield Hospital. **Manner of Death** The administration of aspirin to a person with a history of asthma and known sensitivity to non-steroidal anti-inflammatory drugs (NSAIDs), where the administration of aspirin was contraindicated, where adrenaline would have saved the person's life but was not administered and where Tenterfield Hospital was operating without a medical officer and was staffed by a registered nurse and an enrolled nurse without accreditation in emergency care or advanced life support.
Recommendations:	***Recommendation 1*** *That Ernestina Amarh-Ashitei is referred to the Health Care Complaints Commission/Nursing and Midwifery Board of Australia for investigation and review as to whether she engaged in unsatisfactory professional conduct in relation to her nursing care of David Scott Freeman on 27 October 2019, namely:* *a. her record keeping;* *b. the administration of aspirin after failing to inform Dr Ling of the disclosed allergy to ibuprofen; and* c. *the competency of her nursing skills.*

Recommendations	***Recommendations 2 and 3*** ***To the Hunter New England Local Health District:*** *That the HNELHD rewrite and simplify the pro forma Tenterfield Hospital Business Continuity Plan so that there is a singular set of instructions (if possible, on a single page) providing clear, succinct and unambiguous escalation pathways for nursing staff to follow during a period of business continuity where there is no medical officer on site at Tenterfield Hospital.* *That the HNELHD review existing referral pathways and ensure that there are clear pathways for referral to respiratory and other specialists in the treatment of asthma for patients who present repeatedly to Emergency Departments with severe asthma exacerbation and are in receipt of multiple courses of prednisolone.* ***Recommendation 4*** ***To NSW Health, in relation to the Chest Pain Pathway:*** *That a copy of the findings be sent to NSW Health and that NSW Health consider the evidence of Professor Katelaris recommending amendment of the Chest Pain Pathway to include the following cautions:* *CAUTION:* *Does the patient have severe asthma?* *Does the patient have an aspirin/NSAID sensitivity?* ***Recommendation 5*** ***In relation to systemic issues of resourcing:*** *A copy of these findings be sent to the NSW Minister for Regional Health and to NSW Health.*

Introduction

1 This inquest concerns the death of Mr David Scott Freeman. In accordance with the wishes of his family, I have referred to Mr Freeman by his first name, David, throughout these findings. David was described by his partner, Natalie Kane, as "truly one of a kind, with a humour that was as funny as it was offbeat. He was warm and friendly, with mischievous eyes and a big, cheeky grin that matched his expansive personality. [He] possessed a sharp intellect, with extensive knowledge about plants, herbal medicine, philosophy, naturopathy, and the fauna and flora of the land".

2 David was born on 5 August 1973. He died on 27 October 2019 at Tenterfield Hospital in the state of New South Wales at the age of 46 years.

3 David died from a respiratory arrest secondary to an acute exacerbation of bronchial asthma caused by a non-allergic hypersensitivity reaction to aspirin administered at Tenterfield Hospital.

4 The identity, date and place of David's death are not in dispute. This inquest has focused on the manner and cause of David's death and the relevant contributing circumstances.

5 David (who was also known as "Free") is the father of two children, Amon and AF (who is a young person) and stepfather to Adam and Ashlea. He was also a son, partner, brother and a loyal, supportive and greatly admired friend to many. Members of his family have been constant advocates for him and have been unwavering in their determination to ascertain the reasons for his untimely death. Various family members and friends have participated and contributed during these proceedings and I acknowledge the profound loss and anguish felt and experienced by them. I would like to express my sincere condolences for their loss. I hope that David's memory has been honoured by the careful examination of the circumstances surrounding his death and the lessons that have been learned from it.

The role of the Coroner and the scope of the inquest

6 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity, as well as when and how the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on evidence deduced during the inquest, which may improve public health and safety.

7 During these proceedings, a brief of evidence containing statements, interviews, photographs and other documentation, was tendered in court and admitted into evidence. In addition, oral evidence was received from

numerous witnesses. Four medical experts provided their expert opinions both in written and oral formats.

8 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by Senior Counsel Assisting, Ms Maria Gerace, Mr Ben Bradley, counsel on behalf of the Hunter New England Local Health District, Ms Kim Burke, counsel on behalf of Registered Nurse Ernestina Amarh-Ashitei (RN Amarh-Ashitei), Ms Patricia Robertson, solicitor on behalf of Endorsed Enrolled Nurse Jo-Anne Lee (EEN Lee) and Registered Nurse Stacey Butler (RN Butler) and Mr Jake Harris, counsel on behalf of Dr Michael Ling. At times, I have adopted their descriptions in these findings.

A brief overview of David's life

9 David was born on 5 August 1973 to Brian and Claire Freeman. He has an older sister, Kirsti Claymore.

10 David married Vivian Freeman in 2007 and together they have two children, a son, Amon and a daughter, AF. He was also stepfather to Ms Freeman's two children, Ashlea and Adam.

11 David attended the Conservatorium in Lismore and then Southern Cross University, where he met Ms Freeman. He studied naturopathy and complementary medicine.

12 In 2002, David was involved in a major car accident. He suffered significant injuries, including multiple broken bones, a brain injury and a clot on his lung. He experienced ongoing pain and became reliant on prescription medication. It appears that he developed asthma after the car accident and was regularly treated. He used Ventolin and carried an EpiPen.

13 The consequences of the accident had an impact on his relationship with Ms Freeman and they agreed that they should live separately. He maintained a close and ongoing relationship with Ms Freeman and their children.

14 In 2015, David became involved with Natalie Kane and they commenced living together at his property at Mole River. The property is located about 30km west of Tenterfield or about a 25-minute drive from town.

15 David was passionate about music, plants and herbs and he possessed an enduring love of the bush. He was regarded as a healer and a teacher. His knowledge of the bush was recognised by his First Nations friends who performed a smoking ceremony at his memorial service.

16 David reserved his greatest love for his children. He was proud of their achievements and the people they had become.

List of issues considered during the inquest

17 The following list of issues was prepared before the proceedings commenced and provided focus during the inquest, namely:

i. Whether Mr Freeman had:

a. an immune mediated hypersensitivity/allergy to ibuprofen; or

b. a non-immune hypersensitivity to ibuprofen; or

c. aspirin exacerbated respiratory disease.

ii. The circumstances surrounding the administration of aspirin to Mr Freeman at Tenterfield Hospital on 27 October 2019.

iii. The adequacy of the medical treatment and care that Mr Freeman received at Tenterfield Hospital on 27 October 2019.

iv. The appropriateness of the medical staffing arrangements at Tenterfield Hospital on 27 October 2019 (considering the qualifications, skills and experience of the nursing staff rostered to work on 27 October 2019).

v. The arrangements made in the weeks before 27 October 2019 to obtain medical cover at Tenterfield Hospital including whether, and to what extent, Tenterfield Hospital made attempts to obtain FLECC accredited nurses with advanced life support training to be on duty on 27 October 2019.

vi. The circumstances surrounding the decision to open Tenterfield Hospital's newly renovated emergency department ("ED") on 23 October 2019.

vii. The adequacy of the functionality of Tenterfield Hospital's ED on 27 October 2019, including:

a. whether the phone and/or video conferencing facilities in the ED were working and if not, whether Tenterfield Hospital knew;

b. nursing access to Tenterfield Hospital's electronic systems and medications; and

c. nursing orientation to the newly reopened ED.

viii. Whether it is necessary or desirable to make any recommendations in relation to any matter connected with Mr Freeman's death?

Events leading up to David's hospital admission on 27 October 2019

18 At around 4.30pm on 26 October 2019, David arrived home after being away visiting family.

19 He commenced moving heavy items on his property, including lifting a beam or log onto a trailer. Ms Kane could see that he was struggling with the weight of some of the items.

20 David finished clearing the yard at around 6.30pm and then consumed 4-5 full strength beers. He later consumed methylamphetamine and Viagra.

21 Later that night, David experienced pain to the upper left side of his chest and had difficulty raising his arm. He also experienced shortness of breath. Ms Kane activated the nebuliser. At around midnight, Ms Kane and David drove to Tenterfield Hospital rather than call an ambulance as phone reception at the property was poor.

22 David told nursing staff at 1.55am on 27 October 2019 that he was experiencing chest pain and he was admitted and taken to a treatment bed in the Emergency Department ("ED"). RN Amarh-Ashitei and EEN Lee then obtained a blood sample and arranged for an ECG. No doctor was either on duty or on-call in the local area that evening.

23 David is recorded as telling nursing staff that he had an allergy to ibuprofen. The specific details of his allergies are the subject of significant conjecture in this inquest. He also told staff that he was an asthmatic and had ingested Viagra and methylamphetamine earlier in the evening.

24 At around 2.00am, RN Amarh-Ashitei telephoned Dr Michael Ling who was the on-call doctor for the Small Town After Hours (STAH) service. He was physically located in Narrabri, some 350 kilometres away from Tenterfield. Again, there is significant controversy as to the detail and number of telephone calls between Dr Ling and RN Amarh-Ashitei that morning.

25 RN Amarh Ashitei read David's ECG results to Dr Ling. Dr Ling asserts that he was not advised that David had any allergies. He then authorised a telephone order for 300mg of aspirin.

26 At 2.05am, RN Amarh-Ashitei administered 300mg of aspirin to David.

27 At 2.15am, RN Amarh-Ashitei again contacted Dr Ling. The details of this telephone conversation are in dispute.

28 Between 2.15-2.20am the two nurses attempted to contact Ms Cathryn Jones, then Acting Operations Manager, Tablelands Sector.

29 At 2.25am, David appeared to be struggling to breathe and was placed on a Ventolin nebuliser with Atrovent added later. Dr Ling was again contacted and advised RN Amarh-Ashitei that she should contact paramedics and Armidale Hospital.

30 David's condition continued to deteriorate such that he was no longer capable of speaking in sentences given his difficulty breathing. EEN Lee called "000" and at 2.42am spoke to Ms Cathryn Jones during which Mr Freeman became unresponsive with no palpable pulse. Ms Jones advised EEN Lee to activate a Clinical Emergency Response System (CERS) assist.

31 The two nurses attempted to resuscitate David, but were unable to deploy the defibrillator as both were actively involved in administering CPR.

32 At 2.45am, an ambulance was dispatched in response to the CERS assist call.

33 Two paramedics, Mr Terence Savage and Mr Brent McGovern arrived at Tenterfield Hospital at approximately 2.52am and relieved the two nurses of David's CPR. Contact was made with Tamworth Hospital and advice was sought from Dr Steven Burrows. A third paramedic, Mr Jeremy Havlin later attended Tenterfield Hospital.

34 At 4.00am, the helicopter medical retrieval team arrived at Federation Oval in Tenterfield. They were collected by one of the paramedics and taken to the hospital.

35 At 4.35am, David was declared dead.

Tenterfield Hospital

36 Tenterfield Hospital is an 18-bed inpatient facility with a 24-hour ED. It is more than 200km from any tertiary hospital and is one of the most isolated hospitals in New South Wales, located 18 kilometres from the Queensland and New South Wales borders.

37 Tenterfield Hospital is administered by the Hunter New England Local Health District (HNELHD).

38 In April 2019, nursing allocations were changed from three to two rostered nurses on the morning and afternoon shifts. Nursing staff advised hospital administrators that, with these changes, they could not physically provide the level of care required given the inpatient numbers and ED presentations. It was reported that three registered nurses resigned in response to the nursing staff roster changes.

39 On 9 August 2019, a community rally was organised by nursing staff and the NSW Nurses and Midwives' Association. This resulted in the reinstatement of

some staff, however, another registered nurse resigned and by September 2019, there were only three permanent registered nurses. The shortfall was offset by agency nursing staff and regular staff informally agreeing to provide voluntary unpaid coverage for evening and night shifts.

40 Nursing staff raised their concerns with hospital management and particularly with Mr Anthony Roberts, the Health Services Manager at Tenterfield Hospital. In addition, nursing staff commenced recording their concerns in the hospital's daybook.

41 In 2019, no medical practitioner provided permanent coverage to Tenterfield Hospital. Accordingly, the hospital liaised with the Rural and Remote Medical Service (RaRMS) to provide locum medical practitioners on a contractual basis.

42 On 7 October 2019, Dr Dharmapala, a general practitioner who regularly provided locum medical services to the hospital on a contractual basis through RaRMS, emailed Mr Roberts, Ms Jones, RaRMS representatives and two general practitioners who were also contracted to RaRMS, Dr Singh and Dr Siribaddana. In his email, Dr Dharmapala expressed concern that the medical roster for October 2019 had not been published and that he would be finishing his period of service at Tenterfield Hospital on 14 October 2019.

43 Dr Dharmapala also indicated in his email that Dr Singh and Dr Siribaddana were not available to provide their services after 14 October 2019 as Dr Singh would be overseas and Dr Siribaddana would be in Sydney. He expressed concern that there would be no doctor available to provide medical services at the hospital at the handover on 14 October 2019. Mr Roberts responded by email dated 8 October 2019, noting that he had "previously escalated this concern" within the HNELHD and would continue to do so.

44 On 8 October 2019, RaRMS emailed Mr Roberts confirming that they had not located a doctor for the period commencing 14 October 2019. Mr Roberts responded by expressing his "extreme concern" about the situation and reminding RaRMS of their contractual obligations to supply medical officers to Tenterfield Hospital. He further noted that RaRMS had been on notice of the possibility of a medical officer shortfall since late August 2019. Mr Roberts requested that the issue be resolved that day. He received no response from RaRMS.

45 On 9 October 2019, Mr Roberts emailed RaRMS expressing his disappointment that he had yet to receive a response to his 8 October 2019 email. RaRMS responded that day indicating that they could provide a medical practitioner from 28 October 2019.

46 Also on 9 October 2019, Mr Roberts emailed members of the HNELHD executive with a preliminary roster which indicated that there would be no medical practitioner available for the periods 14–27 October 2019, 4–9 November 2019 and 18–24 November 2019 at Tenterfield Hospital.

47 HNELD's Mr Peter Finlayson responded to Mr Roberts that day indicating that "at the moment, locums are very difficult to find and significantly expensive". He suggested that Mr Roberts make enquiries about the Small Towns After Hours (STAH) service.

48 Later on 9 October 2019, Mr Roberts emailed Ms Jones with a roster confirming that a doctor would be available from 14–22 October 2019, however, no doctor would be available during the period 23–27 October 2019.

49 On 11 October 2019, RaRMS confirmed that they could provide a doctor from 14–22 October 2019. RaRMS also indicated that they had sourced a medical practitioner for the period 23–27 October 2019 (however, by 15 October 2019, that doctor was no longer available).

50 There appeared to be issues with the cost and funding of medical practitioners and RaRMS indicated to the HNELHD that they had received enquiries from "a couple of agencies" whether "we would accept a Visiting Medical Officer (VMO) that can't claim the full Medicare rebate".

51 On 16 October 2019, Ms Jones emailed the HNELHD with a request for a locum medical practitioner to provide coverage for two periods being 22–28 October 2019 and 3–11 November 2019. The request indicated that the practitioner would be required to be available 24-hours per day, 7 days per week for a non-negotiable fee of $70 an hour.

52 As no medical practitioner had been secured for the period 22–28 October 2019, Tenterfield Hospital arranged for the STAH service to provide remote medical practitioner coverage during that period. Dr Ling, a practitioner located in Narrabri, agreed to provide medical advice through the STAH service from 6pm on 25 October 2019 until 8am on Sunday 27 October 2019. The STAH cover was intended for patients presenting with symptoms falling within Australasian Triage Scale (ATS) Categories 3–5.

53 As at 12.30pm on 24 October 2019, there was no medical coverage for Tenterfield Hospital from 23–27 October 2019, 4–9 November 2019 and 18–30 November 2019. Mr Roberts was also attempting to secure additional agency nursing staff for the same periods of time.

54 On 9 October 2019, Mr Roberts advertised for an agency nurse who was a qualified RN to commence on 21 October 2019 for a period of 12 weeks.

Mr Roberts required the applicant nurse to have "ED and medical ward experience, be suitable to operate as the only RN on duty and have rural/remote experience". Mr Roberts did not specifically request that the RN be First Line Emergency Care Course (FLECC) accredited with Advance Life Support (ALS) skills. He also did not stipulate that the RN would be in charge of the ED or might be the only RN on duty without a medical officer on duty.

55 On 10 October 2019, the HNELHD Staffing Service issued a request for agency nurses to fill various vacancies at hospitals within the HNELHD.

56 On 11 October 2019, Mr Roberts received a copy of RN Amarh-Ashitei's CV which indicated that she was "enrolled and currently in process -certificate not yet obtained" in the ALS course. In addition to not having FLECC or ALS accreditation, RN Amarh-Ashitei did not have any experience as a nurse in charge of an ED where no medical officer was on duty.

57 On 17 October 2019, Mr Roberts confirmed RN Amarh-Ashitei's placement at Tenterfield Hospital, commencing 22 October 2019.

58 On 21 October 2019, Mr Roberts declared a Business Continuity Plan (BCP), sometimes referred to as a Critical Operations Standard Operating Procedure (COSOP). A BCP is "used as a strategic response to mitigate the risk of not having a medical officer on site". Mr Roberts indicated that he then notified the "Tenterfield Hospital executive and senior executive managers". The BCP was due to commence at 8pm on 22 October 2019 until 8pm on 28 October 2019.

59 Mr Roberts noted that the "BCP details the actions to be taken in the event that a medical officer is not available for inpatient and Emergency Department (ED) presentations. Amongst other information, the BCP contains contact details for nursing staff to use in the event of a critical incident. A copy of the BCP and the contact sheet was available at the main desk telephone".

60 At the time the BCP was declared, Tenterfield Hospital had no medical officer available for the relevant period. Additionally, there was no RN with FLECC accreditation or ALS training. Mr Roberts, who was also the Nursing Unit Manager (NUM), was scheduled to take leave commencing 25 October 2019.

61 After the BCP had been declared, the old ED was decommissioned and the new ED was commissioned on 23 October 2019. A general orientation to the new area was conducted on 16 and 17 September 2019, however at that time, equipment and supplies had not been transferred to the new ED.

62 The new ED was expected to be operational by August 2019, however the opening date was delayed. Mr Roberts indicated that the new opening date was expected to occur after the BCP but was brought forward to 23 October

2019. It appears that the new opening date was wholly dependent on the availability of contractors who had been retained by the HNELHD to move the critical care camera and "they arrived, so the decision was made to relocate it from where it was in the general ward out into the new refurbished ED".

Registered Nurse Ernestina Amarh-Ashitei's statement

63 RN Amarh-Ashitei provided a statement dated 4 March 2020. Annexed to her statement was her CV and several reference checks. RN Amarh-Ashitei gave oral evidence during the inquest on 29 August 2024.

64 In her statement, RN Amarh-Ashitei confirmed that she had first spoken to David and Ms Kane at 1.50am on 27 October 2019. David had complained that he was experiencing "left sided chest pain, which was radiating to his left shoulder" and that it started at 12.30am. He was taken to the new ED and placed on a bed in Bay 1.

65 RN Amarh-Ashitei said that David told her that he had a history of asthma but no history of cardiac issues or symptoms. He said that he had not experienced chest pain previously, that the pain was sharp and radiating to his left shoulder and that when he moved his left shoulder the pain worsened. David also told her that he had an allergy to ibuprofen and that he had earlier ingested methylamphetamine and Viagra. RN Amarh-Ashitei gave Ms Kane a questionnaire to complete. Ms Kane recorded David's allergy to ibuprofen.

66 RN Amarh-Ashitei said that she obtained a blood sample and asked EEN Lee to perform troponin testing and other relevant blood tests. RN Amarh-Ashitei attempted to connect the ECG machine without success. After replacing the pads, the machine began working.

67 Approximately five minutes after David's presentation to the ED, RN Amarh-Ashitei telephoned Dr Ling, the STAH on-call locum medical officer. She recalled that her conversation with Dr Ling was around 2 to 3 minutes in duration and that she advised him of David's blood test results, except for the troponin results. At around 2.03am, EEN Lee told RN Amarh-Ashitei that the ECG and troponin results were ready and these were read to Dr Ling.

68 RN Amarh-Ashitei said that Dr Ling then prescribed 300mg of aspirin and she "wrote the drug and the time on the drug chart". She indicated that she then returned to David and asked him if he was allergic to aspirin, to which he replied, "no". She said that Ms Kane did not say anything in response to her question.

69 RN Amarh-Ashitei confirmed that David was administered aspirin at 2.05am, rather than at 2.15am as set out in the clinical notes. She said that she

believed "this error occurred as the notes were recorded retrospectively, given the fact that we were understaffed and were both attending to the Deceased. I am not sure if the time at the front of the Nurse's station did not correspond with the time in the triage room and ED, or when Jo re-wrote the medication chart if she mistakenly mis-recorded the time".

70 After taking the aspirin, David appeared stable and did not display any allergic reaction symptoms.

71 RN Amarh-Ashitei said that if the aspirin "did not work" the next treatment, being glyceryl trinitrate (GTN), was contraindicated in patients who had taken Viagra. She was also concerned that David had declined her offer of "analgesia for his discomfort (he told me he was trying to 'get clean') which prompted me to call Dr Ling to come and review him". RN Amarh-Ashitei spoke to Dr Ling by telephone and asked what she should do next and whether she should arrange to have David transported to Armidale Hospital. She indicated that Dr Ling agreed with that course.

72 RN Amarh-Ashitei returned to the ED and noted that David seemed to be functioning within normal limits. She asked EEN Lee to contact the "Senior Nurse" to attend the hospital and assist with the transport arrangements, as the NUM, Mr Roberts was on leave. She also noted that Mr Roberts had left the printed phone numbers for the STAH doctor and the doctor at Armidale Hospital at the Nurses' station.

73 RN Amarh-Ashitei then called an ambulance, as well as the doctor at Armidale Hospital. Following those two calls, she returned to assess David and noted that his pain score had reduced to 5 from a high of 7. She then went to fill out paperwork at the Nurses' station. Whilst at the Nurses' station, she heard EEN Lee call out from the ED at 2.25am that David was experiencing shortness of breath.

74 RN Amarh-Ashitei returned to the ED and noted that David appeared to be experiencing shortness of breath, however his colour was normal. She said that she asked EEN Lee to bring the Ventolin nebuliser while she readied the nebuliser mask and placed it on David. She then called Dr Ling again and advised him of the developments. Dr Ling prescribed Ventolin at 2.25am. She also said that she rang for an ambulance a second time and enquired when the senior nurse would be attending.

75 RN Amarh-Ashitei returned to the ED and said that Ms Kane told her that David had an allergy to aspirin. RN Amarh-Ashitei said that she immediately reviewed David's respiratory and heart rates and noted that there were no signs of any allergic reaction at that time.

76 RN Amarh-Ashitei then returned to the Nurse's station and called the doctor at Armidale Hospital a second time to report David's allergy to aspirin and his presentation, including his shortness of breath. She said that the doctor advised her to administer Ventolin and Atrovent. She also said that she recorded the medication order at that time, which was at 2.27am, rather than 2.25am as it appears in the clinical notes.

77 RN Amarh-Ashitei said that she then realised that she had not obtained the troponin results and spoke with EEN Lee who said that there had been insufficient blood to produce a test result. RN Amarh-Ashitei then attempted to take a further blood sample. She said that the original cannula had 'tissued' from David moving around and she attempted to place another cannula in his arm. RN Amarh-Ashitei also said that "as I was doing this, I said to Jo that I had noticed earlier there was no EpiPen in the emergency box but there was adrenaline. I said that if we needed it, adrenaline was there".

78 When RN Amarh-Ashitei turned back to David, he had become unresponsive. She commenced chest compressions while EEN Lee administered oxygen. They continued with CPR for around 8-10 minutes until two paramedics attended and relieved them both. She provided details of the arrival of the retrieval team and their unsuccessful efforts to revive David.

79 In her statement, RN Amarh-Ashitei indicated that she was hampered in her ability to perform her duties that night owing to the following:

a. a number of the amenities were still located in the old ED;
b. the Nurses' station was 25 metres from the ED and required a member of staff to pass through two security swipe access doors;
c. the phone in the ED was not working which required her to travel between the ED and the Nurses' station to make any of the telephone calls that night;
d. she was unable to locate the switch to activate the video conferencing camera in the ED; and
e. she was unable to activate the electronic triage system as her security access was limited and she had to rely on EEN Lee to access the triage form. She had been given a new password a few days before, however it had not become active.

Oral evidence given by RN Amarh-Ashitei

80 RN Amarh-Ashitei gave oral evidence on 29 August 2024. She confirmed that she had been trained and worked in Ghana until 2004. She became a registered nurse in Australia in 2004 and worked at various hospitals. She

completed a pharmacotherapeutic course for remote area nurses through Charles Darwin University in 2018.

81 Prior to commencing work at Tenterfield Hospital, RN Amarh-Ashitei had not worked as a charge nurse in any hospital where there was not a doctor on duty or on-call.

82 RN Amarh-Ashitei was not FLECC accredited in 2019 and had not completed the ALS training program. She said that the agency was aware of her situation. She denied that she had told the agency that she had completed ALS training but did not have the certification. The agency records do not accord with her assertion and form part of the tendered evidence.

83 RN Amarh-Ashitei commenced her agency placement at Tenterfield Hospital on 22 October 2019 and was introduced to Mr Roberts. She said that Mr Roberts introduced her to an IT person to facilitate her access into the Integrated Patient Management System (iPMs). She said that she was told that her access to iPMs would be available the following week.

84 iPMs is an electronic database for entering patient information and requires authorised access. It allows users to store and maintain data for patient alerts (including allergies), inpatient episodes, medical record tracking and ED activity. iPMs also supports the Clinical Application Portal (CAP) which enables a patient's investigation and pathology results to be accessed remotely by treatment providers, as well as Med Chart, an electronic medication management system.

85 RN Amarh-Ashitei said that she had previously had access to iPMs at Moree Hospital, where she was working in the ED and acute medical ward, although she could not recall if she had accessed iPMs herself at Moree, as there was always another RN in charge to access it. RN Amarh-Ashitei also gave evidence that she had been accredited to use the i-STAT card system at other hospitals, where an educator would assess her capacity to use it prior to her authorisation. She did not say whether this had occurred at Tenterfield Hospital.

86 RN Amarh-Ashitei said that she understood that she would be acting as a supernumerary for two weeks whilst she was trained and oriented to Tenterfield Hospital's medical environment. She noted that she received two days of orientation from Mr Roberts in the old ED area prior to commencing shift work.

87 RN Amarh-Ashitei said that she received no orientation to the newly refurbished ED and only became aware of the move there when she started her

shift on the evening of 23 October 2019. She said that the Nurses' station remained unchanged following the move from the old to the new ED.

88 RN Amarh-Ashitei said that she was not aware, as of 22 October 2019, that the hospital would be operating without a doctor on site or on-call from that time until 28 October 2019. She said that she had seen doctors on site during the three shifts she completed between 22–24 October 2019. She also said that she had seen doctors on site during the afternoon but not the evening shifts on those days. RN Amarh-Ashitei said that she was not aware that a BCP had been declared at the hospital from 22–28 October 2019. She denied that she had seen a copy of the BCP on the table at the Nurses' station. She also said that she had not heard of a COSOP and was unaware that it was in place on 27 October 2019.

89 RN Amarh-Ashitei said that Mr Roberts had pasted the contact numbers of the doctor and on-call nurse (Ms Cathryn Jones) on the table at the Nurses' station and told her, "this is the doctor's number you have to call, and this is the nurse on call, the senior nurse. When you need help, immediately call her".

90 RN Amarh-Ashitei said that she first became aware that there would be no doctor either on site or locally on-call when she called Dr Ling about David. She also said that "normally when the doctors order a drug for the patient, immediately they follow to come up to ask the patient questions like they review the patient. But Dr Ling didn't turn up, so I went back to call him and said, "are you coming to review the patient?" And he said, "where?" And I said, "Tenterfield Hospital. I just spoke to you about Mr [Freeman] and you ordered aspirin. Are you coming to review the patient with their chest pain?" And he said ,"no, I'm living far away". That is when I knew that there was no doctor on the hospital, yeah".

91 RN Amarh-Ashitei originally said in oral evidence that she became aware that there was no doctor on site the first night that she worked night shift, being the night before David's admission. She subsequently said that she had treated a patient on the first night shift for low blood pressure and had contacted a doctor by telephone. She could not recall the name of the doctor. She said that the doctor gave her a fluid order and the patient responded positively. She also said that the doctor told her that "he will come and review the patient in the morning if the patient is fine. But if anything, and I'm concerned, I should call him, but the patient responded immediately so I didn't call him again, and I handed over to the morning nurses that day. They should call the doctor to come and review the patient".

92 RN Amarh-Ashitei confirmed that she had worked on two morning shifts and one afternoon shift before working the evening shift when David presented as a

patient. It was suggested to her that the hospital daybook had recorded her working on the 22 and 23 October and then again on 25 October 2019. In response, she said that she had attended for "two mornings and then one afternoon, and then night". She also said that she had worked two evening shifts with EEN Lee and did not accept that EEN Lee was on leave until the evening shift commencing on 26 October 2019.

93 RN Amarh-Ashitei said that the nurse that was involved in the handover at the commencement of her shift on 26 October 2019 did not tell her that there was no doctor available on duty or on-call. She said that the handover nurse directed her attention to the telephone numbers on the table in the Nurses' station.

94 RN Amarh-Ashitei denied that she had been provided with a portable phone and did not see EEN Lee use one. She said that when she started at Tenterfield Hospital she used one portable phone and it was not working. A manager apparently told her, "don't use it. All my portable phones are not working". She said that the lack of portable phones made it difficult to communicate as she and EEN Lee had to move through two security access doors to access the Nurses' station. She said that at other hospitals she had been provided with a headset to facilitate communication.

95 RN Amarh-Ashitei also said that the telephone in Bay 1 of the new ED was not working that night. She recalled that the phone had no dial tone. She conceded that after the paramedics arrived later that morning the phone appeared to be working.

96 RN Amarh-Ashitei denied that EEN Lee had asked her if she had "worked in ED much?"

97 RN Amarh-Ashitei confirmed that she spoke to David and Ms Kane when he first presented to the ED. She said that she took David into Bay 1 and EEN Lee commenced the observations, while she attempted to connect the ECG machine. She said that the "power points were interfering with the ECG". After unplugging other items, the ECG machine began working. RN Amarh-Ashitei also drew blood from David and gave the sample to EEN Lee to process through the i-STAT machine.

98 RN Amarh-Ashitei was questioned about David's ED triage notes which indicated the triage date as 27 October 2019 and a commencement time of 1.55am. Those notes are reproduced as follows:

NSW GOVERNMENT Health
Hunter New England Local Health District

MRN: N1965261:
SURNAME Freeman OTHER NAMES David Scott
ADDRESS 73 Riches Road Ettrick 2474
DATE OF BIRTH 05/08/1973 SEX: Male
PHONE 0476401025
Mother's Phone number 0412577712

HSMR 7C Emergency XXXXXX EMERGENCY DEPARTMENT TRIAGE NOTES Emergency XXXXXX

EMERGENCY DEPARTMENT TRIAGE NOTES

J214 - Tenterfield Community Hospital

TRIAGE: Date: 27/10/2019 Time: 01:55 | Time of Arrival: 01:45

Presenting Problem: Male aged 46 years, 2 months presents with Pain - Chest (Cardiac Origin), .Walked in to ED with partner c/o pain in L side of chest and into L shoulder. No cardiac history . Chronic asthmatic with past history of smoking , patient stated he had smoked methamphetamine that night and also taken viagra. Also stated stated that he had been doing hard physical labour today.Nil WOB noted,, patient just guarding L side.

Triage Intervention: Chest Pain Pathway Observation, ECG, bloods for Trop and chem8, CGH

Pathway/Clinical Practice Guideline: Not Specified | Indigenous Status: Neither

Last ED Attendance at Tenterfield Community Hospital: 02/08/2019
Previous ED Attendances at Tenterfield Community Hospital in last 12mths: 3

Interpreter Required: ☐ YES ☑ NO
Visit Type: Emergency Presentation

Priority: 2 - Emergency

Area: 1) ER Bed

Triager Print Name: Roberts Mr Tony ERNESTINA AMARH-ASHIE Triager Signature:

GP:Dr Nilukshi Siribaddana; 0267360919; Tenterfield Medical Practice 123 Rouse Street Tenterfield NSW 2372 Ph 67360919 Fax 67360929

Person to Contact: Viv Freeman Address: 18 Keats Street Byron Bay Ph: 0413898999 Mobile: Relationship: Wife (ex) Father Brian Freeman 0412577712

i.PM Alerts:

Adverse Drug Reaction/Including Drug Allergies	Ibuprofen

Allergies: ~~Brufen~~ Ibuprofen

Investigation: (circle) FBC UEC GLU LFT Amy CE CXR C-SPINE OTHER:

Blood Alcohol: YES ☐ NO ☐ Number: | Weight: 74

Procedures ECG ☑ Cannulation Size _____ Inserted by RN ☐ MO ☐

PRINT NAME, SIGNATURE, TIME AND RECORD DESIGNATION FOR ALL ENTRIES

Doctor Notified: Date: 27.10.19 Time: 0205 phone call (STAH Only) (Rural Sites only)

Attending Medical Officer: — Time Attended: _____

TIME	
0155 27.10.19	46yr old male walked to ED with partner with c/o chest pain(Lt) sided which radiates to Lt shoulder. Pt has history of asthma. NO cardiac history. History of smoking and substance use. Pt stated he used viagra and methamphetamine that night before coming to ED. Observation done Resp 22 HR 112 BP 144/80

Health
Hunter New England
Local Health District

MRN: N1965261

SURNAME **Freeman** OTHER NAMES: David Scott
ADDRESS: 73 Riches Road Ettrick: 2474
DATE OF BIRTH: 05/08/1973 MO
PHONE: 0476401025

EMERGENCY DEPARTMENT TRIAGE NOTES J214 - Tenterfield Community Hospital

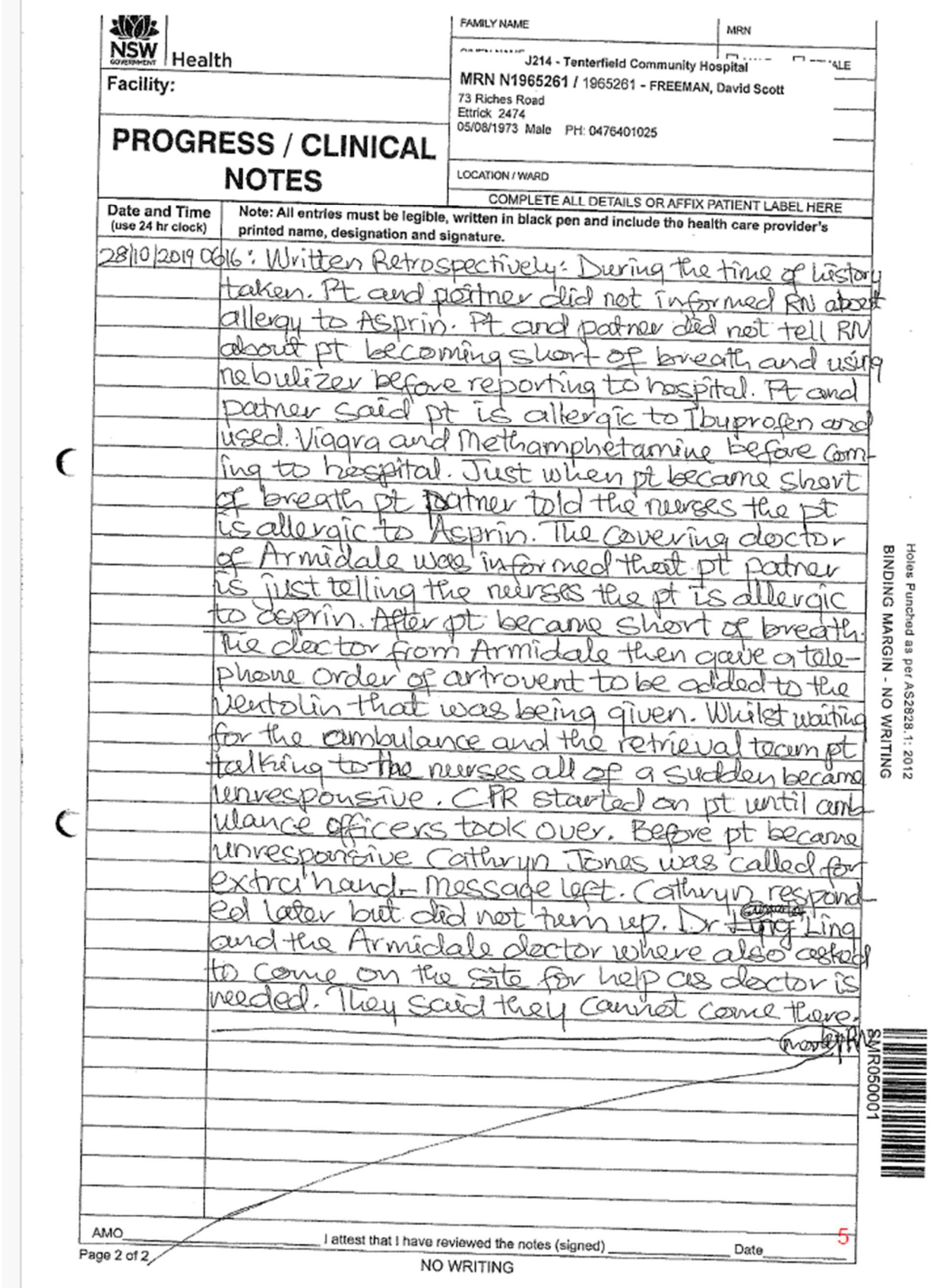
PRINT NAME, SIGNATURE, TIME AND RECORD DESIGNATION FOR ALL ENTRIES

27/10/19
Time 0155 Notes cont'd: Sats: 98% Temp 37.0. ECG done Sinus Rhythm. Difficult to put ~~blood~~ error in IVC. Managed to get blood to do chems and CG4. Unable to obtain troponin due to blood not enough. Hospital is on CESOP. Therefore STAH doctor Michael Ling rang and informed about pt observations and history. Dr Ling gave a telephone order for Asprin 300mg. Pt asked of any allergy before ~~it~~ given. Pt said would read Aspirin Ibuprofen – Allergy. Asprin given at 0215. Dr Ling informed about transfering pt to Armidale. Armidale rang and covering doctor asked retrieval team to be rang by doctor. RN told her there is no doctor and RN took number from Armidale – the doctor. In retrospective called Armidale when pt became short of breath. The covering RMO ordered. Ventolin and Atrovent at 0225 by the covering RMO at Armidale. Retrieval team called. Ambulance Called 0215 and Retrieval team called after the ambulance called. After ventolin and Atrovent whilst waiting for ambulance and retrieval team pt was asked about pain and short of breath, pt said it is getting better. Pt suddenly became unresponsive and immediately CPR Started. Airway put in (Oropharyngeal) CPR continued until arrival of ambulance officers. Resciation assumed by station officer Terence Savage – Intensive Care paramedic at 0252hrs. RN maintained communication and instructions with doctor. ——— (initial) RN
Pt was pronounced dead at 0435hrs by retrival doctor. – (initial) RN

Medical Officer's Signature: STAH (Dr Ling)

Date Discharged: **Time Discharged:**

Referred to on Departure:



NSW Health

Facility:

PROGRESS / CLINICAL NOTES

FAMILY NAME | MRN

J214 - Tenterfield Community Hospital

MRN N1965261 / 1965261 - FREEMAN, David Scott
73 Riches Road
Ettrick 2474
05/08/1973 Male PH: 0476401025

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
28/10/2019 0616	Written Retrospectively: During the time of history taken. Pt and partner did not informed RN about allergy to Asprin. Pt and patner did not tell RN about pt becoming short of breath and using nebulizer before reporting to hospital. Pt and patner said pt is allergic to Ibuprofen and used. Viagra and Methamphetamine before coming to hospital. Just when pt became short of breath pt partner told the nurses the pt is allergic to Asprin. The Covering doctor of Armidale was informed that pt patner is just telling the nurses the pt is allergic to Asprin. After pt became short of breath. The doctor from Armidale then gave a telephone order of artrovent to be added to the ventolin that was being given. Whilst waiting for the ambulance and the retrieval team pt talking to the nurses all of a sudden became unresponsive. CPR started on pt until ambulance officers took over. Before pt became unresponsive Cathryn Jones was called for extra hand- Message left. Cathryn responded later but did not turn up. Dr Ling Ling and the Armidale doctor where also asked to come on the site for help as doctor is needed. They said they cannot come there.

AMO _____ I attest that I have reviewed the notes (signed) _____ Date _____

Page 2 of 2

NO WRITING

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR050001

99 RN Amarh-Ashitei agreed that the triage notes are in her handwriting. She maintained that the entries on pages 1 and 2 were written while David was alive and that the only entries which were written retrospectively appear on

page 3 beside "28/10/2019 0606". She insisted that the retrospective notes were made on the Sunday morning after David's death and not on Monday, 28 October 2019 as she did not return to the hospital after Sunday morning. She later gave evidence that she returned to the hospital on Tuesday, 29 October 2019 to meet with a social worker. She said that four people attended that meeting.

100 Page 2 of the triage notes do not appear to be wholly contemporaneous given the notation, "in retrospective (sic) called Armidale when the patient became short of breath…".

101 As noted above, RN Amarh-Ashitei gave evidence that she was unaware that a COSOP had been declared, however at 1.55am (page 2 of the triage notes) she wrote, "Hospital is on COSOP. Therefore STAH doctor Michael Ling rang and informed about pt observations and history".

102 At no time in her purported contemporaneous notes on pages 1 and 2 of the triage record does RN Amarh-Ashitei indicate that Ms Kane had said that she believed that David was allergic to aspirin. In her retrospective notes on page 3, she said, "just when pt became short of breath partner told the nurses the pt is allergic to Aspirin".

103 RN Amarh-Ashitei gave evidence that she contacted Dr Ling on three separate occasions. On the first occasion, she told Dr Ling that David presented with chest pain which radiated to his left arm and neck. She read David's blood and ECG results to Dr Ling noting that she was still waiting on the troponin results.

104 RN Amarh-Ashitei said that she told Dr Ling that David had disclosed that he was allergic to ibuprofen and that Dr Ling had then prescribed aspirin. Page 2 of the triage notes does not reflect her assertion and is completely silent on her purported discussion with Dr Ling relating to the ibuprofen allergy. RN Amarh-Ashitei denied that she told EEN Lee about the conversation and insisted that she called EEN Lee during the first phone call so that EEN Lee could witness Dr Ling's phone order for 300 milligrams of aspirin.

105 She further insisted that she completed the medication chart at 2.05am and that both she and EEN Lee signed it at that time. She denied that the medication chart was rewritten as the entry had been incorrectly written under the heading "Nurse initiated" rather than under the heading "Doctor ordered".

106 In the triage notes, RN Amarh-Ashitei wrote "Pt asked of any allergy before brufen given. Pt said Ibuprofen – Allergy. Aspirin given at 0215". "Brufen" was crossed out and in the margin RN Amarh-Ashitei had written, "should read aspirin". RN Amarh-Ashitei was taken to her statement where she had said, "the deceased took the aspirin at 0205 hours. I noted this incorrectly recorded

as being taken at 0215 in the clinical records". Her statement continued, "I believe this error occurred as the notes were recorded retrospectively". In her oral evidence she said, "I wrote some of the notes before I wrote some, and the one I wrote later I wrote 'retrospective' there".

107 Despite initially disagreeing that the medication chart had to be rewritten due to the entry being written in the "Nurse initiated" rather than the "Doctor ordered" column, RN Amarh-Ashitei later agreed that the medication order was rewritten. The rewritten medication chart, countersigned by both nurses, indicates that David was given aspirin at 2.15am.

108 RN Amarh-Ashitei later gave evidence that the medication chart was rewritten after David's death. She said, "I'm not denying it. I can't remember". She eventually conceded that she could not remember when the aspirin was administered.

109 Prior to giving David aspirin, RN Amarh-Ashitei said that she had again asked him if he was allergic to aspirin. She says that David, "said no, and Natalie (Ms Kane) was there, she didn't say anything". She denied that when she returned from her first phone call with Dr Ling that Ms Kane and David were discussing whether he could be allergic to aspirin and that she then said, "the doctor thinks it's going to be okay if you have it".

110 RN Amarh-Ashitei says that her second phone call with Dr Ling was initiated by her as she was surprised that Dr Ling had not attended the hospital to assess David. She said that when he told her that he was "far away" this was the first time she realised that there was no medical officer available to the hospital that night. She said that she then asked Dr Ling to arrange for a referral for David to Armidale Hospital and said that she would approach Armidale Hospital to arrange his transportation.

111 RN Amarh-Ashitei said that she asked EEN Lee to contact Ms Cathryn Jones to assist with arrangements for the transportation. RN Amarh-Ashitei then contacted NSW Ambulance to arrange the transfer. She indicated that during this process, EEN Lee told her that David was becoming short of breath.

112 RN Amarh-Ashitei reassessed David and noted a deterioration in his presentation. She asked EEN Lee to prepare a Ventolin nebuliser while she readied the mask. She said that she then returned to the Nurses' station and called Dr Ling for a third time. Dr Ling prescribed Ventolin and directed RN Amarh-Ashitei to contact Armidale Hospital and to not call him again as he had referred the case.

113 RN Amarh-Ashitei called the doctor at Armidale Hospital and was directed to add Atrovent to David's nebuliser. She then returned to the ED and noted that

David's respiratory rate was not settling with the nebuliser. She said that it was at this time that Ms Kane advised her that David "is allergic to aspirin".

114 RN Amarh-Ashitei's evidence is confusing as to how many times she contacted the on-call doctor at Armidale Hospital. However, she said that after being told about David's allergy to aspirin, she called an unnamed doctor at Armidale Hospital and told him about the allergy and was advised to add Atrovent to the nebuliser.

115 RN Amarh-Ashitei said that Ms Kane also told her that David usually carries an EpiPen but that he did not have it with him at the hospital. She said that she had noticed earlier that there was no EpiPen in the emergency box, but that there was adrenaline.

116 RN Amarh-Ashitei was asked whether she should have "immediately…gone and told Armidale, 'look, he's allergic to aspirin. He normally carries an EpiPen. I don't have one. Can I give him some adrenaline?'' She answered, "yes, I before told her, and she said give Atrovent. So I told even – I told Mr Freeman, 'look, I've told the doctor that Natalie said you are allergic to aspirin, but let me put it in, and I will get this cannula quickly, and if it's not – you are not improving for like a minute or some seconds, I will go back to her'".

117 RN Amarh-Ashitei was asked, "you know that patients that carry EpiPens, that means they have the type of reaction that requires an injection of adrenaline to correct. You understood that then, didn't you?", to which she answered, "yes, please". She eventually agreed that she should have told the doctor in Armidale about David's allergy to aspirin and the EpiPen but did not and could not explain why she failed to pass on that information.

118 RN Amarh-Ashitei said that she commenced CPR with EEN Lee after David became unresponsive. She agreed that she was distressed, however denied that she was panicking and was told by EEN Lee to calm down.

119 RN Amarh-Ashitei said that when she finished her pharmacotherapeutic course, she was aware that ibuprofen was an anti-inflammatory drug which was part of a group of drugs called NSAIDs. She also said that she recognised that aspirin was also part of the NSAID group. She was not aware that a person with an allergic reaction to ibuprofen could also have an allergic reaction to aspirin.

120 The evidence suggests that RN Amarh-Ashitei was not aware that she would be on duty without a doctor from 26 –27 October 2019. It was clear that she was not FLECC accredited, nor had she completed ALS training. She became overwhelmed when David's condition deteriorated and was not able to lead the CPR.

121 RN Amarh-Ashitei's evidence was confusing, inconsistent and contradicted by other evidence. She was not a reliable witness.

Endorsed Enrolled Nurse Jo-Anne Lee's statement

122 EEN Lee provided one statement dated 13 January 2020 and gave oral evidence on 29 August 2024 . She completed her training in 2009 and had been employed by HNELHD since 2011. She had worked at Tenterfield Hospital since 2016.

123 EEN Lee confirmed that the new ED opened on 23 October 2019 with two ED beds. There was also an Acute Ward with eleven beds, although there were no patients in that ward from 26 –27 October 2019.

124 EEN Lee returned from three weeks leave and her first shift was the night shift which commenced at 10.45pm on 26 October until 7.15am on 27 October 2019. EEN Lee recalled attending a handover with RN Mathews and RN Amarh-Ashitei at around 10.45pm. She said that "RN Mathews said we should call the Small Town After Hours Program (STAH) on-call Doctor, Dr Ling from Narrabri, if we required a Doctor during the night". RN Mathews also showed RN Amarh-Ashitei the STAH service on-call list and the form which needed to be completed following contact with the STAH doctor.

125 After the handover, EEN Lee began orienting herself to the new ED as she was unfamiliar with the location of equipment and had not received any orientation since returning from leave.

126 EEN Lee recalled speaking with RN Amarh-Ashitei and enquiring about her experience in emergency departments. She said that RN Amarh-Ashitei told her that she had had little previous ED experience. EEN Lee suggested that they check the emergency equipment and i-Stat machine together. At this point, they became aware that RN Amarh-Ashitei did not have authorised access to either the i-STAT machine or iPMs.

127 EEN Lee recalled seeing David and Ms Kane at 1.55am. He complained of left sided chest pain radiating into his left shoulder and was immediately escorted to Bed 1 in the new ED. She said that David confirmed a history of asthma with numerous previous presentations to hospital. He also said that he had no prior cardiac history, had previously been a cigarette smoker and had consumed Viagra and Methylamphetamine earlier that night. She recalled him saying that he had a known allergic reaction to "Brufen". His observations were then recorded on the Standard Adult General Observation (SAGO) chart.

128 EEN Lee said she saw RN Amarh-Ashitei attempt to connect the ECG to David without success due to poor contact with the electrodes. EEN Lee was able to

successfully troubleshoot the problem and an ECG printout was obtained. EEN Lee also recalled seeing RN Amarh-Ashitei attempt to cannulate David to collect blood for the i-STAT machine. A small blood sample was eventually obtained; however it was insufficient for a troponin test.

129 EEN Lee said that she attempted to log into the computer beside David's bed to enter the information into iPMs but realised that the computer was not linked to the system. She then returned to the Nurses' station to log into another computer.

130 EEN Lee said that RN Amarh-Ashitei contacted Dr Ling at "about 2.10am". After that telephone call, she recalled being told by RN Amarh-Ashitei that Dr Ling had instructed her to give David 300mg of aspirin. She also recalled RN Amarh-Ashitei telling her that she had told Dr Ling that David had an allergy to 'Brufen' and that he said that it was safe to give him aspirin.

131 EEN Lee said she saw RN Amarh-Ashitei administer aspirin to David at 2.15am. She said that she was told by RN Amarh-Ashitei that Dr Ling had advised that David would need to be transferred to Armidale Hospital. At that time, David and Ms Kane were discussing whether he was also allergic to aspirin, with David reportedly saying, "I don't think so, maybe I could be a bit allergic to it".

132 At 2.20am, while RN Amarh-Ashitei was on the phone to the Armidale Hospital on-call doctor, EEN Lee observed that David appeared to be slightly breathless and had said that he felt a bit "asthma-y". She then approached RN Amarh-Ashitei in the Nurses' station and asked if it was alright to give David Ventolin via a nebuliser. EEN Lee returned to the ED and administered Ventolin. RN Amarh-Ashitei then told her that the Armidale Hospital doctor had advised that they also add Atrovent, which was then administered.

133 At 2.25am, David became increasingly uncomfortable and EEN Lee went to tell RN Amarh-Ashitei who was on the phone to the Armidale Hospital doctor. She recalled RN Amarh-Ashitei dropping the phone and running towards the ED. EEN Lee asked her to stop and instead tell the Armidale Hospital doctor what was happening.

134 EEN Lee returned to the ED and Ms Kane told her that David usually carried an EpiPen. She recalled Ms Kane yelling and screaming at her and RN Amarh-Ashitei calling out loudly. EEN Lee told RN Amarh-Ashitei to call an ambulance, but instead she called out for help generally.

135 EEN Lee called Ms Cathryn Jones and left a message on her message bank. She then called 000 at 2.35am and requested assistance. Cathryn Jones called back shortly afterwards and EEN Lee told her, "we have a man arresting, there are two of us here and we have no Doctor" and then ended the call.

136 EEN Lee and RN Amarh-Ashitei commenced CPR. By this time, Ms Kane was very emotional and EEN Lee had to remind RN Amarh-Ashitei to focus on the CPR and continue until paramedics arrived. Two paramedics arrived at around 2.52am and continued CPR. They assumed complete care and instructed EEN Lee to draw up adrenaline which was cross-checked and administered by Intensive Care Paramedic, Mr Terence Savage.

137 EEN Lee said that she continued to work with the paramedics "while the Retrieval Doctor in Tamworth was on speaker phone in the ED providing clinical support. I was asked to switch on the Telehealth camera but was unable to locate the switch due to being unfamiliar with the ED set up and lack of signage".

138 The Retrieval Team arrived at 4.00am. EEN Lee said that RN Amarh-Ashitei "returned to the ED to ask for advice on filling out the STAH Doctor Form". EEN Lee was actively assisting with the resuscitative efforts and told RN Amarh-Ashitei that she was unable to assist her at that time. RN Amarh-Ashitei then left the ED.

139 At 4.35am, David's venous blood gas result was received and resuscitation was ceased.

Oral evidence given by EEN Lee

140 As noted above, EEN Lee gave oral evidence on 27 August 2024. RN Amarh-Ashitei was present in Court during EEN Lee's evidence.

141 EEN Lee attended an orientation of the new ED on either 16 or 17 September 2019. She recalled that there was no equipment in place at that time and that the "take home message from that orientation was that if you do not keep those doors locked at all times, you will be disciplined or you will be fined", in reference to the swing doors between the ED and the triage room which had previously been chocked open.

142 EEN Lee accepted that the distance between the ED and the Nurse's station was approximately 9 – 11 metres, rather than the 25 – 30 metres described in her statement.

143 EEN Lee recalled being informed, either during the orientation or by email, that nursing staff would be issued with Spectralite phones to assist with communication between staff. She did not recall seeing the phones during the orientation.

144 EEN Lee was aware from a colleague that the hospital would be subject to a BCP and would be operating without the support of a medical practitioner when she returned to work from leave. She said that she was not informed

about this situation by management and had not previously worked under a BCP/COSOP.

145 EEN Lee said that at the handover at the start of her 26 October 2019 shift, RN Mathews told her that they could contact the STAH doctor if required and discussed how to complete the STAH forms. She noted, from her experience, that they could also contact the doctor in Tamworth, if required.

146 EEN Lee said that she had not previously worked with RN Amarh-Ashitei and asked her whether she "had much ED experience?" She was told ,"no, not very much at all" and responded, "you'll get plenty here". She said that she and RN Amarh-Ashitei then checked the emergency equipment and the i-STAT machine together, as well as the emergency trolley.

147 EEN Lee said that she and RN Amarh-Ashitei had discussed the fact that RN Amarh-Ashitei did not have access to the i-STAT machine or iPIMs. She also attempted to log into the computer in Bay 1 and recalled, "I logged in and it brought my page up. Then I [went] into Citrix, logged into that, did all the welcoming and the loading, whatever. But then it, it came to a point where it said, 'this computer is not configured to the system'. That was at that point. Now, I don't know why. I thought, I just thought maybe I'm just, because I'm back off days off, I was, you know, being away, but I just went into the nurses' station and logged in there and logged straight in".

148 EEN Lee recalled experiencing a similar problem when she tried to access iPMs after David presented to the ED. She again utilised the system at the Nurses' station.

The triage record and medication chart

149 After David presented to the ED, EEN Lee felt that she was, at times, having to prompt RN Amarh-Ashitei which she described as "tricky" given that she was an EEN and not a RN. She did not perceive RN Amarh-Ashitei had "taken the lead" but she resorted to "talking out loud" to encourage her to perform tasks.

150 EEN Lee said that she did not make any contemporaneous notes during her shift and that she did not see RN Amarh-Ashitei make any either.

151 EEN Lee said that she could identify her handwriting on the triage notes, including the reference to "brufen", "probably the tick" and "Freeman". She was also able to identify where Ms Kane had made some notations. EEN Lee confirmed that the information relating to the "Brufen" allergy was documented prior to the first telephone call to Dr Ling.

152 EEN Lee said that the entries on pages 1 and 2 of the triage notes were made after David's death on at least two separate occasions. She recalled helping

RN Amarh-Ashitei enter the typed information on page 1. She said she told RN RN Amarh-Ashitei "we need to go to this bit now, then we press that button and that brings this up and this is where you type in your triage note, and then you go there". EEN Lee said that she "had to lead that and I believe I did help her with the wording. Whether she typed it or I typed it, I couldn't tell you".

153 EEN Lee said that the first two lines of the handwritten entries were made by her, however the last line, referring to observations made at 2.25am was not in her handwriting, despite her initialling the record. She said, "I may have because it perhaps hadn't been signed and I was there when she was doing the obs so I just signed it".

154 EEN Lee admitted that she had rewritten the medication chart and had not retained the original. She said that she had done so as RN Amarh-Ashitei had written the order for the aspirin in the "Nurse-initiated" rather than the "Doctor ordered" column. EEN Lee acknowledged that she should not have altered the records and said that she "wish(ed) I kept the original".

155 EEN Lee was shown the RN patient communication form and confirmed that this was the form she was referring to as the "ISBAR style form". She said that she had not authored that form, did not know when it was completed and played no role in forwarding it elsewhere.

Sequence of events

156 EEN Lee said that she did not ever speak with Dr Ling and RN Amarh-Ashitei had not asked her to listen to any telephone conversation between her and Dr Ling.

157 EEN Lee saw RN Amarh-Ashitei administer aspirin to David and then leave the room to call a doctor. After RN Amarh-Ashitei had left, she heard Ms Kane say to David, "are you sure you're not allergic to aspirin?"

158 EEN Lee recalls that about 5-10 minutes after the administration of aspirin, David started to become breathless and there was a discussion about his use of a "puffer" just prior to her commencing the nebuliser. As David became more breathless, he told her that he usually carries an EpiPen but did not have it on him at that time. EEN Lee still believed that David was experiencing an asthma attack and went to the pharmacy to see if there were any EpiPens so that he could self-administer adrenaline, although she didn't believe that there would be any there. She said that the pharmacy had not been unpacked. She also said that there was adrenaline available on the emergency trolley.

159 EEN Lee confirmed the other details referred to in her statement regarding CERS assist and the attendance of the paramedics and the retrieval team.

160 EEN Lee was questioned about her knowledge of ibuprofen and aspirin. She said ,"I'm aware that they are in the same family. They are a non-steroidal anti-inflammatory drug. I know they are in that group. I, I guess my, my pharmacology training is at TAFE level, so I'm aware they're in the same group. For me they are separate drugs because you don't give ibuprofen for chest pain, so therefore to me they would do – have different purposes. I also have asthma and I take aspirin, so for me, no. I felt if the doctor had said it's okay, yeah, I didn't, I didn't question it any further, no".

161 EEN Lee felt that after David died "everything was left to me to sort out" and said she had never been in that situation before. Ms Cathryn Jones called her at 5.30am and asked her if she was okay, to which EEN Lee responded, "no, I'm not, but Mr Freeman is deceased. The RN is in a terrible state, and I'm not sure what to do". Ms Jones then told her what forms would need to be completed and EEN Lee went to try and locate them.

162 EEN Lee recalled receiving a phone call from David's parents, seeking information and asking for assistance. A few minutes later, EEN Lee received a phone call from Ms Jones who started to explain what information should be relayed to Mr and Mrs Freeman. EEN Lee asked Ms Jones to contact David's parents and provide that information.

163 At 6.45am, David's parents rang again and asked EEN Lee if she had heard anything. She apologised and told them she was going to ring her manager immediately. EEN Lee then rang Ms Jones and eventually spoke with her. Ms Jones confirmed that she had not yet contacted David's parents but would do so straight away.

164 EEN Lee said she received no communication from management until Mr Roberts contacted her on the Wednesday, via text message. She said that she was not contacted by a social worker.

165 EEN Lee indicated that she had been gently agitating for enrolled nurses to be able to attend ALS training. In January 2020, the Nurse Educator announced that enrolled nurses would be permitted to attend ALS training. EEN Lee explained that she attended the course in February 2020 and was given a certificate of attendance. This meant that "every year I could go and be tested, or be involved in the, like, the scenarios that they would do on the day…and then I could go and get tested to sort of just keep it up to date every year, and then I went and did the whole day again a few months ago just for my own benefit".

166 EEN Lee was a credible witness. She accepted that she should not have rewritten the medication chart and should have retained the original. Her evidence was clear, concise and consistent.

The evidence of Intensive Care Paramedic, Mr Terence Savage

167 Mr Terence Savage provided a statement dated 13 January 2020 and gave evidence at the inquest on 16 April 2024. Mr Savage is an Intensive Care Paramedic and the Station Officer at Tenterfield, with 38 years' experience.

168 He said that he received a CERS assist dispatch from Tenterfield Hospital at 2.44am on 27 October 2019 indicating that a patient at the hospital was an asthmatic with ineffective breathing. He attended the hospital at 2.52am in the company of Mr Brent McGovern, paramedic.

169 As they entered the hospital, Mr Savage and Mr McGovern were approached by Ms Kane who was yelling, "he needs adrenaline". They then entered the resuscitation room and Mr Savage recalled that RN Amarh-Ashitei and EEN Lee were conducting CPR on a patient. He also recalled that no-one appeared to be in charge and that they then took over CPR.

170 Mr Savage said that EEN Lee assisted with equipment and drawing medication as directed whilst he intubated David. He said that David was difficult to ventilate which was consistent with his history of asthma. He inserted two cannulas and commenced administering adrenaline.

171 Mr Savage said that he had brought with him eight ampules of adrenaline and a total of eleven ampules were used during the resuscitation attempt. He confirmed that the other three ampules must have been sourced from the hospital's supplies, however, was unable to say where EEN Lee found them.

172 Mr Savage said that nursing staff had been unable to access the critical care camera in the ED and that he and Mr McGovern relied on telephone communication with Tamworth Hospital. He recalled that the landline in the ED bay was functional.

173 At 3.03am, Mr Savage contacted Western Operations requesting further paramedic assistance as "the treatment from the registered nurse was ineffective. The enrolled nurse, known to me as 'Jo', was performing her duties without hesitation".

174 After consulting Dr Burrows at Tamworth Hospital, Mr Savage administered Tenecteplase and Enoxaparin and continued CPR and other treatments. At 4.03am, the retrieval team arrived. Mr Savage said that resuscitation ceased at 4.35am and that he remained at the hospital until 6.18am, completing paperwork and consoling the nursing staff.

175 Mr Savage said that he and Mr McGovern responded immediately to the CERS assist call. He agreed that local ambulances may be required to attend to call-outs or to transfer patients to other facilities and may not have been readily available.

The evidence of Paramedic Mr Jeremy Havlin

176 Mr Jeremy Havlin is a paramedic with nine years' experience. He was off duty when he received a phone call at 3.03am on 27 October 2019. He attended Tenterfield Hospital about ten minutes later.

177 He recalled being told that David had had a cardiac arrest witnessed by hospital staff and that paramedics Savage and McGovern were already present and administering treatment.

178 He became aware that paramedics had already administered adrenaline as approved by an on-call doctor. He said that assisted respiration for David was difficult, which suggested that he was suffering from an airway issue.

179 He recalled that the scene was very chaotic. He saw Ms Kane yelling and screaming, "I need to find adrenaline". He said that "the Registered Nurse on scene was profoundly flustered. She was crying and screaming. At times she was squatting in the corner of the Resus room and crying. The other nurse, Jo Lee, was facilitating drug preparation, pathology and advanced life support under guidance of Station Officer Savage".

180 He confirmed that there were issues with nursing staff being able to locate some supplies but could not recall if that related to equipment or medication.

181 He also recalled that there was an issue with the critical care camera. He said that there had been a discussion about it at the time but was now unsure whether staff said that they were unable to turn the camera on or that they were unable to locate the switch that turns it on.

182 He confirmed that the retrieval team arrived and that thereafter resuscitation was ceased. He said that he remained at the hospital until 7.00am to provide emotional support to staff.

The evidence of Ms Natalie Kane

183 Ms Kane had been in an intimate relationship with David for four years and resided with him at the Woodside Road, Mole River property.

184 Ms Kane was interviewed by Constable Lara Goodyear and Senior Constable Colin Bird at 7.30pm on 27 October 2019. A notebook statement was prepared by Constable Goodyear and the conversation was recorded on body worn video by Senior Constable Bird. Ms Kane also provided two statements dated

27 October 2019 (which reflects the contents of the notebook statement) and 4 September 2023.

185 In her first statement, Ms Kane said that "David is allergic to Aspirin. He has a severe reaction when given Aspirin. At the hospital David was given an Aspirin tablet for his pain even after I advised he was allergic to it. Approximately 20 minutes after taking the Aspirin, David started struggling to breathe saying to me 'Nat I can't fucking breathe'. He was clutching at his throat and his lips started turning blue".

186 In her second statement, Ms Kane recalled that there were two nurses at the hospital; an agency nurse and an enrolled nurse. She said the agency nurse left the room saying that she was going to speak to the doctor. She said that the enrolled nurse was looking through various items and then started to set up the ECG machine.

187 Ms Kane recalled the agency nurse returning and saying, "we are going to send you down to Armidale, the Ambulance is on the way". She said that there was no discussion about allergies, that there were problems with the ECG machine getting a connection and that the agency nurse attempted to take a blood sample but "kept missing".

188 Ms Kane recalled the agency nurse again leaving the room and presumed that she was going to speak with the doctor. She said that the agency nurse returned about 5 minutes later and said, "the doctor wants you to have some Aspirin." Ms Kane said that David immediately said, "I can't have Aspirin, it will cause asthma, I'm allergic to it". Ms Kane then said, "he can't have it." Ms Kane was clear that this was the first time that she and David had informed the two nurses about his allergy. She recalled the agency nurse leaving the room and saying, "I'll go and speak to the doctor again". Ms Kane said that the enrolled nurse remained and would have heard her and David discussing his aspirin allergy.

189 Ms Kane said, "I didn't know the aspirin was for pain management, I believed it was possibly used for people who were going to have a stroke or a heart attack, that's why I thought they were looking at administering it to him, I believe after our conversation, David was thinking the same thing".

190 Ms Kane recalled that the agency nurse returned and said, "the doctor thinks it's going to be okay if you have it". Ms Kane said she did not remember "if there was any discussion at that point about the fact he couldn't have aspirin, I believe we were relying on the doctor's judgment, but we had both made it clear just prior that he could not have it. At that time, I believe that the doctor was possibly on his way or close by the hospital". David then took the aspirin.

191 Ms Kane said that David started to struggle with his breathing and the agency nurse left. David then started to really struggle with his breathing. Both nurses put an oxygen mask on David and he had a "massive asthma attack and became unconscious, and CPR started".

192 Ms Kane was not required to give oral evidence in these proceedings.

The evidence of Dr Michael Ling

193 Dr Michael Kwong Sing Ling prepared two statements in these proceedings dated 9 September 2021 and 24 July 2023 and gave oral evidence on 30 August 2024.

194 Dr Ling was the STAH doctor on-call on the night of 26 –27 October 2019. He had been involved with the STAH service since its inception ten years earlier.

195 He confirmed that the STAH service "provides a telephone link between a registered nurse in a rural and remote hospital and a GP VMO from a district sized town for cases falling within triage category 3-5, when the GP rostered to be on-call at the hospital is unavailable".

196 He recalled receiving a telephone call from RN Amarh-Ashitei at around 2.00am on 27 October 2019. He was told that David presented with left sided chest pain which radiated to his left shoulder and that he had a history of asthma. He could not recall being told that David had an ibuprofen allergy.

197 Dr Ling said he advised the nurse to follow the Chest Pain Pathway and administer 300mg of aspirin. The Chest Pain Pathway involved taking observations and conducting ECG and blood tests. Dr Ling assessed that David fell into ATS Category 2 and as such should be transferred to the nearest referral hospital for advice and treatment. He said that he told RN Amarh-Ashitei that she should arrange David 's transfer to Armidale Hospital.

198 Dr Ling recalled receiving another call from RN Amarh-Ashitei approximately 15 minutes later. She told him that David was now experiencing shortness of breath. He instructed her to contact Armidale Hospital and to arrange for paramedics to attend immediately. He then telephoned Armidale Hospital and spoke with an on-call doctor who advised that she was already aware of the patient and was providing treatment advice to the registered nurse. He denied that he instructed RN Amarh-Ashitei to administer Ventolin.

199 Dr Ling said that he received a third phone call from RN Amarh-Ashitei a few minutes later and that during this call she asked him to attend the hospital. He advised her that he was in Narrabri and not in Tenterfield and would be unable to physically attend.

200 Dr Ling prepared the HealthWISE medical officer communication form ("the form") dated 27 October 2019. He indicated that his usual practice was to make notes on a piece of paper at the time of a call, noting the patient's name, age and date of birth. He was unable to produce any contemporaneous notes regarding David.

201 Dr Ling said that he may have completed "the form" either the "next morning or [it] could be one or two days later". He agreed that the purpose of "the form" is to record contemporaneous notes of the consultation between a doctor and a registered nurse. He recalled that he had access to David's observation chart at the time he completed "the form" which included information which was not discussed with RN Amarh-Ashitei during the first, or subsequent, phone calls.

202 Dr Ling could not remember when he was advised of David's death, however, it was likely that it was "during that week". Dr Ling eventually agreed in his oral evidence that he had no independent memory of the first conversation he had with RN Amarh-Ashitei. He agreed that he could not recall whether RN Amarh-Ashitei had informed him that David had disclosed an ibuprofen allergy.

203 Dr Ling was aware that a patient who has asthma may have hypersensitivity to NSAIDS, although he had treated many asthma patients who tolerated NSAIDs. He agreed that when treating a patient with a history of asthma that it is important to enquire whether the patient can tolerate NSAID medications. He also agreed that where he had not been given a history of allergies he should ask, "Does this patient have any allergies?"

204 Dr Ling accepted that it was an error not to have turned his mind to the possibility of NSAID sensitivity in the context of David's history of asthma. He further agreed that if he had been told that David had an allergic reaction to ibuprofen, he would have needed to consider the possibility of an aspirin hypersensitivity prior to prescribing it.

David's known history of asthma

205 David had a long-standing history of poorly controlled asthma.

206 A few days prior to his presentation at Tenterfield Hospital on 27 October 2019, David had attended his GP for asthma exacerbation. His GP prescribed David Prednisone, in addition to his usual Ventolin medication.

207 David had numerous ED presentations over the years where he had required increasing doses of Ventolin, in addition to oral corticosteroids. In the preceding year, David had at least three hospital presentations related to asthma exacerbation. An asthma history that included three hospital

presentations within a year, placed David in a category of patients at risk of a life-threatening attack and death.

208 Hospital records frequently noted David's allergy to ibuprofen. On 29 March 2017, he presented to Tenterfield Hospital with asthma and both ibuprofen *and aspirin* were noted in the triage notes as allergies. Subsequent hospital presentations appear to record only an allergy to ibuprofen.

The evidence of Professor Constance Katelaris

209 Professor Constance Katelaris is a professor of immunology and allergy at Western Sydney University and the Senior Staff Specialist in immunology and allergy at Campbelltown Hospital. She also has private rooms at Westmead.

210 Professor Katelaris provided two expert reports for these proceedings dated May 2021 and 4 February 2024 and gave oral evidence on 15 April 2024.

211 Professor Katelaris noted that asthma is a very common respiratory disease, with one feature being reversible airway obstruction. Asthma causes undue reactivity or twitchiness of the bronchial tubes. When an asthmatic encounters items that produce inflammation, their airways close off. This can cause shortness of breath, wheeze, coughing and mucus production.

212 Asthma varies in the severity of symptoms. Professor Katelaris reviewed David's medical history and concluded that he had long-standing, poorly controlled asthma. He had numerous presentations to EDs and GPs presenting with shortness of breath, and at times, more severe accompanying symptoms which required the use of increasing doses of Ventolin and oral corticosteroids.

213 Professor Katelaris commented that more than one exacerbation per year characterised severe poorly controlled asthma. She noted that David had had at least three hospital presentations in the year prior to his death which placed him in a category of patients at risk of a life-threatening attack and death.

214 Professor Katelaris noted that severe asthma symptoms can appear similar in presentation to cardiac symptoms. Patients have described chest discomfort as chest pain and the work of breathing caused by the exacerbation of their asthma can cause respiratory muscle discomfort. She did not perceive David's complaint of left arm pain was consistent with an asthma attack.

215 Professor Katelaris considered that David' asthma was likely to have been unstable when he presented to Tenterfield Hospital on 27 October 2019, particularly noting that he had consulted his GP a few days earlier and been prescribed prednisone.

216 Professor Katelaris noted that both aspirin and ibuprofen are NSAIDs which can cause reactions in patients with underlying asthma. She explained that

NSAIDs can cause hypersensitivity reactions, being either allergic hypersensitivity or non-allergic hypersensitivity reactions. She said that most patients with hypersensitivity reactions have non-allergic hypersensitivity reactions, however, a small group will have allergic hypersensitivity reactions.

217 An allergic hypersensitivity reaction is where the NSAID stimulates the allergic antibody and the patient may be allergic to one type of NSAID. A patient with a non-allergic hypersensitivity to NSAIDs will have the same reaction to *all* NSAIDs.

218 Professor Katelaris considered that David likely had a non-allergic hypersensitivity to NSAIDs and therefore was likely to react to both ibuprofen and aspirin unless a drug allergy investigation had been conducted and excluded hypersensitivity to different NSAIDS. She opined that "it is not appropriate to provide someone with aspirin who declares an 'allergy' or hypersensitivity to ibuprofen".

219 Professor Katelaris commented that the "description of the events following the administration of aspirin to an individual declaring an allergy to ibuprofen is very consistent with a severe bronchial obstruction leading to respiratory arrest due to a hypersensitivity reaction". She said that patients with non-allergic hypersensitivity to NSAIDs will exhibit a symptomatic reaction to the ingestion of aspirin anywhere from 10-15 minutes and up to 3 hours afterwards. The onset of David's increased work of breathing 15-30 minutes after taking aspirin is consistent with him having a non-allergic hypersensitivity response to it.

220 Professor Katelaris opined that "from the material provided, I certainly believe aspirin was a major contributor to Mr Freeman's demise. However, it is quite possible that his asthma was initially unstable as evidenced by the fact that his partner stated that he required Ventolin that evening. Moreover, Mr Freeman admitted to using methamphetamine that night and this can produce chest pain and can have a cardiotoxic effect, particularly when combined with alcohol which he also admitted to imbibing earlier that night. All these factors may have predisposed him to having a more severe reaction, but it was the administration of aspirin to an individual with known NSAID hypersensitivity that ultimately caused his death. Unfortunately, from the descriptions given, the initial resuscitation efforts were probably suboptimal; there is no mention of early use of adrenaline; these factors may have contributed to the tragic outcome".

221 Professor Katelaris considered that trained medical staff should have an understanding that ibuprofen is a nonsteroidal anti-inflammatory agent and that aspirin falls within the same category of nonsteroidal anti-inflammatory

agents. She was of the view that medical staff should question a patient who declares sensitivity to one agent about the possibility of an allergy to others.

222 Professor Katelaris said "we do have other options to aspirin in that event, if somebody couldn't take aspirin and if you had a strong suspicion that they were having an impending heart attack. So, what I suggested, I mean something good has to come out of this, in my view, is that asthma and aspirin sensitivity, in fact, or NSAID sensitivity, is common enough that there should be a warning to ask patients, do you have an allergy to NSAIDs, including aspirin, and two, do you have severe asthma, because it's the group with severe asthma, as I said, up to 25% we know would be sensitive to aspirin if they were given it, even if they don't know about it".

223 Professor Katelaris said that David required adrenaline when he started exhibiting respiratory symptoms after being given aspirin. Whilst it was appropriate to have administered Ventolin and Atrovent, her view was that David should have been given adrenaline when he was unresponsive. Professor Katelaris said that adrenaline is the "only drug on earth" that acts promptly enough to reverse airway obstruction and that it should have been administered within the first few minutes of the onset of respiratory symptoms. In her opinion, the early administration of adrenaline would have been lifesaving and was available to nursing staff. By the time adrenaline was administered by paramedics, it was too late to be effective. Professor Katelaris conceded that hospital policy may have prevented a nurse without FLECC or ALS training from administering adrenaline, but commented that "policies go so far, but common sense and clinical acumen have to override any written document". She said, "we allow parents, carers and patients to themselves to initiate adrenaline".

224 Professor Katelaris offered two recommendations for consideration. The first was a proposed modification to the Chest Pain Pathway to include, "CAUTION: Does the patient have severe asthma? Does the patient have an aspirin/NSAID sensitivity?"

225 The second recommendation related to nursing staff training. Specifically, she said nursing staff "must have specific and specialised skills to allow them to be competent in emergencies; this includes specific training in recognition of anaphylaxis, impending respiratory or cardiac arrest and to have competence in basic resuscitation procedures such as prompt administration of adrenaline. For staff to face a crisis for which they are not trained causes huge distress and as can be seen in this case, can result in a terrible tragedy".

The evidence of Professor Alison Jones

226 Professor Alison Jones is the Executive Director of the Sunshine Coast Health Institute and a specialist general physician at the Sunshine Coast Hospital and Health Service. She has been a specialist general physician and clinical toxicologist since 1998.

227 Professor Jones prepared an expert report dated 23 March 2024 and gave oral evidence on 16 April 2024.

228 In her expert report, Professor Jones indicated that she agreed with Professor Katelaris' report and the opinions expressed in it.

229 Professor Jones was asked whether she would expect a doctor to be aware of the potential for a patient allergic to one type of NSAID to have a hypersensitivity reaction to other NSAIDs. She responded, "I absolutely would, because the mechanism of action of these drugs all goes through cyclooxygenase and again, it's something that's drilled into us very early in our medical schools so that would be an expected standard for anyone graduating from a medical school; and I'm saying that with experience because I have, in the past, been Dean of Medical schools and so I would have expected – and we deliberately taught our medical students to recognise that, that if somebody says they're allergic to aspirin, that you would either assume that they're allergic to the whole non-steroidal bundle or that you take a more detailed history. But even having taken a detailed history, you wouldn't be game to give somebody aspirin if they had an allergy to any other non-steroidal".

230 Professor Jones considered the effects and implications of the other known substances David had ingested earlier on 26 October 2019.

231 In relation to methylamphetamine, Professor Jones said that it can cause cardiotoxicity and cardiac arrhythmias. The EGC performed in the ED indicated that David had a normal sinus rhythm with no abnormal features. However, his heart rate on his initial presentation was observed to be between 110-120 beats per minute, which she said would be tachycardic. Professor Jones said that this was not normal and may be "either the effects of drugs or some other cause". She noted that if a patient had a fast heart rate, it was more likely that they may experience arrhythmias. Although it was noted on the ECG that there was no evidence of any arrhythmia, Professor Jones noted that "sometimes people can have short runs of arrhythmia such as self-limiting ventricular tachycardia…but as a broad generalisation, a normal ECG with the addition of the sinus tachycardia would not alert me clinically to the fact that this individual may then have cardiac arrhythmias".

232 In relation to David's Viagra ingestion, Professor Jones said that she found "no indicator that Viagra (Sildenafil) contributed to Mr Freeman's death".

233 In relation to his consumption of alcohol, Professor Jones said that "whilst I cannot exclude that alcohol was present at some stage, the absence at or around the post-mortem time indicates to me that that's unlikely to be a contributor to his death".

234 Professor Jones was asked to provide her opinion on the effect of salicylic acid, a constituent of aspirin, on David. Professor Jones noted that it was detected at a therapeutic concentration in David's post-mortem blood sample. Professor Jones said, "I consider aspirin/salicylic acid a major contributor to his death. And we know that even one or two tablets, from the medical literature, has been known to produce sudden death in hypersensitive, asthmatic people".

235 Professor Jones said that the administration of the aspirin was the catalyst for David's respiratory arrest, due to severe bronchial obstruction. She opined that the "early administration of adrenaline would have potentially been lifesaving".

236 Overall, Professor Jones reached the conclusion that "aspirin [was] the drug of concern here and the methylamphetamine could have contributed because once somebody has low oxygen levels in their blood and a toxic level of methylamphetamine, you can get cardiac arrhythmias that could have occurred after the respiratory arrest. But on the balance of probabilities, it was an aspirin-induced reaction that is the primary cause, in my opinion, of death in this case".

237 Professor Jones identified at least three factors which she said also significantly contributed to David's death; physical barriers to effective care (that is, Tenterfield's rural and remote location), chaotic in-hospital arrangements (namely, the absence of an on-site doctor) and the failure to administer appropriate emergency drugs (eg adrenaline) post-arrest.

The evidence of Mr Anthony Roberts

238 Mr Anthony Roberts was the Health Services Manager at Tenterfield Hospital in 2019. He is also a registered nurse. Mr Roberts prepared five statements dated 8 July 2021, 13 February 2024, 12 April 2024, 31 July 2024 and 5 August 2024 and gave oral evidence on 26 August 2024.

239 A precis of some of Mr Roberts' evidence is referred to above.

240 In relation to the staffing levels required under a BCP, Mr Roberts said that "it is not mandatory" that a FLECC accredited RN should be rostered for the BCP period. This assertion appears to contradict the BCP proforma at the time

which states, “a FLECC accredited RN should be rostered for the period medical service is not available and it is expected the facility must have an RN with ALS skills on duty”. Mr Roberts perceived that this direction was a “guide” and only needed to be complied with “if possible”.

241 Mr Roberts’ evidence in relation to current staffing at the hospital was confusing. He said that “we probably have more staff on now per shift than we had in 2019…We will go to 3,3,2 regularly as opposed to the 3,2,2. It does depend on, again, on staff availability…I think it’s essentially a 3,2,2 or 2,2,2 with that overlap shift, yes. That’s our minimal requirement”. This appears to reflect the issues that were being agitated by staff in 2019 in terms of inadequate general staffing numbers.

242 Mr Roberts confirmed that Tenterfield Hospital continues to rely on agency nursing staff.

243 Mr Roberts was asked whether he recalled turning his mind to whether RN Amarh-Ashitei had completed her ALS training and he responded, “I can’t recall particularly looking at her CV but it would have been a reasonable assumption that you would look to see if someone had ALS…I can’t recall whether in this particular instance I did or I did not…I cannot recall actually saying, ‘Have you completed your ALS now?’”

244 Mr Roberts said that he believed that he had escalated his concerns about there potentially being no doctor available to the hospital from 14 October 2019 to Ms Jones.

245 Mr Roberts confirmed that the BCP was the first BCP he had been involved with. He believed that a copy of the BCP was placed on the desk in the Nurses’ station and a second copy was placed in the ED in Bay 1 when it opened on 23 October 2019.

246 He said that he had spoken with staff and had advised them that they would be subject to a BCP and that no doctor would be available during that time. He said, “I was working on the floor. I was handing over to staff on the oncoming shift. When I wasn’t on the floor, I was taking [sic] in the handover to bring this point to people’s attention. I wanted people to be fully aware of what was going on, and what the process was going to be”.

247 Mr Roberts said that “when the BCP was put out, STAH had not been put in place”. He said that the STAH service was added to the BCP by upper management sometime between 18 October 2019 and 22 October 2019. He also said that “when STAH became available, whenever that was, that would have been added as a supplemental bit into the BCP folder”.

248 In evidence, Mr Roberts was referred to Annexure D to his statement dated 1 February 2024. Annexure D is titled "Tenterfield Hospital Back Up during COSOPS" and bears the dates 22 October 2019 to 29 October 2019. On 26 October 2019, the name "Julie" had been added to the column 'first backup'. Mr Roberts said that "this was a document that I produced to allow staff to put themselves as available should they be available to back up the staff on duty. This was in the COSOP's folder, BCP folder".

249 Mr Roberts was unable to indicate what shifts "Julie" had offered to "backup" on 26 October 2019, saying, "I don't know what she was making herself available for" yet he was satisfied that this unknown offer from "Julie" could be relied upon and was then placed in the COSOP/BCP folder.

250 Mr Roberts confirmed that he had forwarded a copy of the BCP to Ms Jones on 22 October 2019. That is, after its commencement.

251 Mr Roberts said that he "had a vague recollection of having a conversation, about delaying the opening of it (the new ED). It was a telephone conversation, I believe, and it was shut down. It was, 'No, we're going to go ahead'. I don't have any evidence to back that up but that is the recollection I have". He then said that "it was a senior manager, but I can't remember who".

252 Mr Roberts agreed that he was present in the ED during the transition from the old to the new ED.

253 Mr Roberts said that both the iPIMs system and the critical care camera were operational after the move to the new ED. He said that RN Amarh-Ashitei had previously accessed the iPMs through the "Hunter New England broader system". He also said in evidence that he called "the IT people" when she was in his office and that "they threw the switch". He eventually agreed that he had not included this information in his statements.

254 Mr Roberts was not particularly candid or cooperative when giving his evidence. He was at times, unresponsive, combative and difficult. He would frequently preface his response to questions with the words, "I believe".

The evidence of Mr Stewart Symons

255 Mr Stewart Symons is the Technical Services Manager for the HNELHD and has occupied that position since 2013. Mr Symons provided a statement in these proceedings dated 11 April 2024 and gave oral evidence on 27 August 2024.

256 Mr Symons confirmed that "the telephones, computers and [the critical care camera] in the refurbished ED share the same data points. The installation and commission of those data points was undertaken by Kelso Services on 12 July 2019…The data outlets relevant to equipment required in the new ED were then

patched to the network switch to make them active on the network". He confirmed that he had tested all electrical sockets in the clinical areas of the ED on 12 August 2019 and that the "ED refurbishment, including installation and testing of the data points and electrical sockets was completed in early September 2019". Mr Symons did not have any documentation to confirm the installation and testing in early September 2019.

257 In his statement, Mr Symons said that "staff orientation to the refurbished ED took place on 16 and 17 September 2019. The training included training in relation to two SpectraLite telephones, both of which had been installed around that date. The SpectraLite phones have a duress alarm function and can be used to make calls. The telephones are intended to be worn by the nurses on duty in the ED". In his oral evidence, Mr Symons conceded that he was not present during the staff orientation on either 16 or 17 September 2019.

258 Mr Symons said that on 23 October 2019 he logged onto the network with his own laptop using one of the data points in Bay 2 of the ED. He also said that he used one of the landline 'Cisco' phones in Bay 2. In oral evidence, he said, "I logged into [the network in] Bay 2, but I also did witness the telephones were working in Bay 1 and the computers were connected to the network". He conceded that he had not referred to the Bay 1 telephone in his statement.

259 He noted that the i-STAT machine and the critical care camera (CCC) were moved from the old ED to the new ED on 23 October 2019. In his statement he said, "after the CCC was installed, Armidale Hospital ED was contacted and the CCC function was tested. I witnessed the camera being on and functional, and I can say that the CCC was tested and found to be working on 23 October 2019". In his oral evidence, Mr Symons conceded that he had not contacted Armidale Hospital. He said, "I witnessed the camera being on, I was actually in the ED at the time, the light on the switch was – the switch was turned on, the light on the switch was turned on, the camera was powered up, and the power indicator was on, and also the on-air indicator was on, which indicates that the camera was connected, and someone could see in". He agreed that he did not know what was happening from the Armidale Hospital end at that time, "but as I said, the camera was – the on-air indicator was on, which indicates that it was connected to the network and operating".

260 Mr Symons gave oral evidence that the CCC was checked on 28 October 2019 in anticipation of patients arriving following a bus accident. He said that the "CCC function was checked and it was operating."

The evidence of RN Ms Stacey Butler

261 Ms Butler provided two statements dated 20 March 2024 and 14 May 2024 and gave oral evidence on 27 August 2024.

262 Ms Butler commenced work at Tenterfield Hospital in April 1995 and resigned in September 2020. She was a Senior RN and a Clinical Nurse Specialist with both FLECC and ALS training.

263 Ms Butler said that nursing staff cuts began in April 2019 at Tenterfield without any consultation with staff. She said that when "nursing staff were reduced to two nurses per shift, the pressure on the staff became overwhelming as the inpatient numbers and ED presentations increased significantly as did the acuity of the patients. It was evident that two nurses could not physically provide the care required to the ED patients and inpatients simultaneously".

264 Ms Butler also said that staff were "constantly working through meal breaks, working overtime and extra shifts to cover the heavy workload with no clinical backup…For many years staff informally agreed to provide unpaid on-call coverage for the evening and night shifts, when able to do so. This is how the hospital operated safely for many years".

265 Ms Butler said that a separate issue arose when a request was made for three nurses to be rostered on every shift "to mitigate the safety concerns identified by the nursing staff prior to the opening of the new refurbished Emergency Department (ED). The staff raised concerns that the new security swipe access doors posed a risk to patient care by isolating the ED from the inpatient ward, impacting the ability of the two nurses to simultaneously maintain observation and oversight of the patients in the ward and the ED".

266 Ms Butler also said that before October 2019, there was usually a doctor available on-site or on-call and that she could only recall about three or four occasions when there was no doctor available. Ms Butler recalled two prior occasions where the hospital had operated under a BCP. She also recalled times when locum doctors were so "exhausted from doing 24 hours a day, seven days a week on call. So, we sort of had to sort of do an informal kind of BCP there where we just rang Armidale for backup".

267 Ms Butler confirmed that the staff were seeking to have three nurses on shift for the morning and afternoon shifts and two nurses on the evening shift with a permanent on-call RN for evening and night shifts to assist in emergency situations. These staffing levels were in the context of a doctor being either available on site or on-call. Ms Butler said that "it was just near impossible to manage patient safety, provide the care the community deserved and needed" and staff were resigning.

268 On or around 16 October 2019, Ms Butler raised her concerns with Mr Roberts that there was not going to be a doctor available over the weekend of the 26 – 27 October 2019 and an agency nurse who had little or no experience working without a medical emergency team for backup. She was aware that Mr Roberts was going on leave and offered to return from leave without pay and be on-call over the weekend. Her offer was declined by Mr Roberts, with him indicating that they would "sort it out".

269 Ms Butler said that staff would be placed in a dangerous position "where there was only an RN in there, and especially an agency, an agency staff who, they don't know the protocols in the, how the hospital runs and, you know, it's a unique little hospital and its – its, you know, you can't just walk in and expect to know it like that. Especially when you're going in there with no doctor and no back up".

270 Ms Butler said that the situation was exacerbated by the move to the new ED, as you would need to "get down there and familiarise yourself".

271 Ms Butler explained that a nurse with ALS training "can initiate defibrillation with shockable, shockable rhythms. We can, do-administer adrenaline when it's, needed. Look at reversible causes". She confirmed that with FLECC training, a RN will follow guidelines to administer medications for "asthma, anaphylaxis, snake bites, burns, you know, cardiac, acute coronary syndrome" with no doctor present. Ms Butler also confirmed that in her experience it is "almost impossible" for two nurses to conduct a resuscitation themselves.

272 Ms Butler said that she "felt so helpless when EEN Lee called me on Sunday, 27 October 2019, after Mr Freeman's passing. She was so overwhelmed and devastatingly upset and we both cried as we fought so hard to get adequate and safe staffing to prevent something like this from happening, it was only a matter of time. I have witnessed how this incident has destroyed Jo-Anne Lee and taken over her life for the last four and a half years".

273 Ms Butler was clear, concise and credible when giving her evidence. Her evidence should be accepted where it is at odds with the evidence of Mr Roberts or Ms Jones.

The evidence of Ms Cathryn Jones

274 Ms Cathryn Jones was formerly the Operations Manager, Tablelands Sector. She received a Diploma in Management and had previously acted as a Nurse Manager and a Health Services Manager.

275 Ms Jones prepared five statements dated 5 July 2021, 8 April 2022, 13 December 2023, 11 April 2024 and 30 July 2024 and gave oral evidence on 27 August 2024.

276 Ms Jones confirmed that Mr Roberts reported to her and that she reported to Ms Catherine D'eath, Mr Peter Williams and Ms Lisa Ramsland.

277 Ms Jones said that the new Tenterfield Hospital ED was not expected to open on 23 October 2019, however, "we had to work with the contractors who were going to move the critical care camera, in that they arrived so the decision was made to relocate it from where it was in the general ward, out into the new refurbished ED". She agreed that she had prepared a briefing note to senior management about the proposed move on 21 October 2019, "because we knew that they [the contractors] were scheduled to come on the 23 [October 2019]".

278 Ms Jones agreed that the opening of the new ED coincided with the BCP. She said that she could not recall speaking with Mr Roberts about delaying the move. She also said that as of 21 October 2019, they were still hopeful that they would be able to secure the services of a locum doctor, even though the BCP was due to commence the next day on 22 October 2019. Ms Jones denied that anyone raised with her that the move to the new ED should not occur on 23 October 2019.

279 Ms Jones confirmed that she was not aware that the STAH service had been added to the BCP after its commencement.

280 Ms Jones was asked about the doors between the ED and the Nurses' station. She said that the doors have required swipe access since 2014. She said that keeping the doors open was "a breach of protecting people and property, and the *Work Health and Safety Act*".

281 Ms Jones was asked whether she agreed that a nurse on duty in the ED when a doctor was not available should be FLECC trained. She responded, "it would be preferable, yes". She conceded that not having a FLECC trained nurse on duty in these circumstances "is also a nurse safety issue".

282 Ms Jones recalled attending Tenterfield Hospital on the morning of Monday, 28 October 2019. She also said she tested the critical care camera in the ED and that it was operational. She recalled talking with RN Amarh-Ashitei in person but did not recall seeing EEN Lee (although she said that she had previously spoken to her over the phone).

283 Ms Jones' evidence came across as being partisan and inflexible.

The evidence of Dr Porges

284 Dr Kate Porges is a Senior Staff Specialist in Emergency Medicine and is the clinical director of Western Virtual, formerly vCare Critical Care Advisory Service, which provides virtual critical care services and support to lower triage categories in emergency departments across Western NSW.

285 Dr Porges prepared an expert report for these proceedings dated 19 March 2024 and gave oral evidence on 29 August 2024.

286 Dr Porges confirmed that in her current role there are about 20-25 small hospitals (or multipurpose services) that have small inpatient units and EDs and see similar presentations per day as Tenterfield Hospital. She said that those hospitals face the same types of staff shortages as Tenterfield.

287 In situations where there is either a COSOP or a BCP, Dr Porges oversees both a Virtual Rural Generalist Service (VRGS) to look after lower acuity patients and vCare, which is an emergency physician led service for higher acuity patients. The services are available to nurses or medical officers requiring a high level of care and are staffed by medical practitioners who are either emergency physicians or have significant training in emergency medicine and are on-call 24-hours per day.

288 The VRGS is designed to provide respite for locum doctors who work 7-day shifts, often for 24 hours per day.

289 In relation to RN Amarh-Ashitei's CV, Dr Porges noted that there is "no evidence of any staff clarifying her capacity to work in charge of ED, with her or the agency, despite references not indicating her capacity to do so, and her referees coming from ward-based positions. She was offered a 12-week contract with Tenterfield Hospital. In her CV there is no evidence of triage training, ALS, or having any advanced ED skills that would prepare her for being the in-charge RN of an ED or a hospital overnight, and indeed, on the date of engagement the belief was that she would be supported by a doctor being available to the ED".

290 Dr Porges noted that on 16 October 2019, Mr Roberts was informed by RaRMS that they could not provide a doctor from 22 –28 October 2019. After receiving that advice, Mr Roberts signed a temporary placement agreement to employ RN Amarh-Ashitei for 12 weeks. Dr Porges said, "I find it surprising that someone is accepted completely on face value without some form of check or balance to, to support the, the superficial words on paper of a CV or a recommendation". Dr Porges agreed that when it became clear that no doctor was available, it would have been prudent for management to critically assess

whether the agency nurse had an adequate skill set for a role which would now require them to run the ED without a doctor in a newly refurbished ED.

291 Dr Porges noted that it was not uncommon in remote and rural NSW to struggle to find medical and nursing staff to work in hospital EDs. She considered that Mr Roberts made a significant effort to secure medical coverage in the days leading up to 27 October 2019.

292 Dr Porges said that once the BCP/COSOP had been declared, management needed to ensure that the plan included "bolstering the skill mix, ensuring clear guidance on activation of the plan, and escalation pathways when patients present to ED. This escalation may have included calling in extra nursing staff or medical staff, and utilisation of remote medical support, or telehealth services. The support of telehealth critical care services can also assist with nurses and employed doctors when they are on site and improve recruitment to these facilities".

293 Dr Porges noted that after the formulation of the BCP, the STAH service was added as another option. She believed that this caused confusion as the treatment and advice pathways became unclear. She opined, "in my mind there needed to be one number, and I think there appeared to be multiple different options for these people. Could they ring the, the STAH service? Could they ring the person on call to come and help? Could they call Armidale, or is it Tamworth, or is it the medical retrieval unit, or is it a CERS response, or is it NSW Ambulance? And, and I think complexity confuses people, and we needed, they needed a very simple, simple approach that said this is what you do if there's any, if there's an issue".

294 Dr Porges continued, "the BCP has multiple action sheets for whom nursing staff in ED should have escalated to over the period whilst there was no doctor, however the contact details are the same for "ED Presentations ATS 1 and 2", "Emergency Presentations ATS 3" and "Emergency Department Presentations ATS 4 and 5." These contact lists are ambiguous, giving multiple options including Armidale ED, Tamworth ED, Retrieval Services in all documents, with "consider Telehealth" (with no contact details), only for patients presenting as Triage 4 or 5. Despite this, all staff felt that the first point of escalation was the STAH doctor, and those other pathways were not followed". Dr Porges commented, "I don't think RN Amarh-Ashitei really even understood, comprehended that there was no doctor. When she spoke to the STAH doctor, she thought that that doctor could come in, so I don't think the, the sort of momentousness of, you know, there is no doctor here tonight, hadn't really been portrayed".

295 Dr Porges was concerned that there was limited or no orientation of the staff to the available pathways in the BCP. She said that she would be "making sure it was plastered on every single wall in that ED, and I'd be making sure that everyone was completely aware and oriented to it within an inch of its life and making it as simple as possible".

296 Dr Porges continued, "I do not believe that appropriate diligence was followed in ensuring the competence mix of nursing staff covering the hospital on the night of October 26th. An assumption was made as to the skill mix of agency nurse RN Amarh-Ashitei, without clarifying these skills with her, or with her referees. There was no clarification of triage skills, ALS, or significant work as a nurse in charge. She was not aware that she was going to be working in an ED without a doctor to support her, and there is no evidence that she had previously worked as an isolated RN with no doctor available to respond to the hospital. There is no evidence of attempts to bolster the nursing skill mix during the week of Oct 22 –28 when no doctor was available. Whilst the HSM Mr Roberts believes he performed orientation to her in the "old" ED, there is no evidence of orientation to the new refurbished ED, with her having no IT access or i-STAT access".

297 Dr Porges formed the view that it was "clear that RN Amarh-Ashitei was not familiar with the escalation processes at Tenterfield. She was unclear as to whom to initially ring when a patient attended, or what their role was, nor whom to ring for immediate assistance on site. She had limited triage skills, needing the advice of EEN Lee for the triaging of a patient with chest pain. She was unclear how to activate a CERS ASSIST response, or how to arrange a transfer out of Tenterfield. She was out of her depth in leading the resuscitation".

298 Dr Porges also noted that "moving into a new ED is always challenging, and there should be clear testing of all workflows, including patient access, IT, cameras, telephony PRIOR to starting. It would be common practice to ensure adequate staffing, or enhance staffing, during the early weeks of a new ED to take into account any unforeseen challenges that may arise". Dr Porges gave evidence that her practice has been "that we have upstaffed for a period of time over that opening time. So, yes, that, and then add no doctor, just creates multiple avenues for errors to occur". Dr Porges indicated the upstaffing would depend on the size of the ED and the "problems that you find" but it would usually be one week of additional staffing.

299 Dr Porges was asked to comment on the offer that Ms Butler had made to be on-call on the weekend of 26 –27 October 2019. Dr Porges said, "I think it would have been an opportunity to jump at, yes". Dr Porges was also asked to

comment on the ad hoc voluntary informal unpaid system of staff which had historically supported short-staffed rosters. She said, "I think that, yes, that the, the roster needs reconsideration, and it needs to be considered whether that, that ad hoc arrangements need to be more formalised".

300 Dr Porges was also critical of the "failure to have a visible electronic medical record [as this] also hinders staff to see a patient's past medical history, including allergies. If Dr Ling had been able to see this clearly, he may have delved deeper into the form that allergy took, and considered not giving aspirin to this patient, with a severe allergy to Ibuprofen, with an EpiPen at home".

301 Dr Porges noted that "the STAH telehealth service was a telephone support service, with no use of videoconferencing, reliant upon a general practitioner who was woken from sleep, working "on-call" after a full day's work, rather than being awake and alert, being paid to work a full shift. This will inevitably be a less reliable service, as that doctor will not be as diligent or thorough as one who is actively working".

302 Dr Porges agreed that both ibuprofen and aspirin are NSAIDs and "an allergy to Nurofen, Ibuprofen, has significant cross-reactivity with allergies for aspirin". Dr Porges said that a doctor should be aware of this cross-reactivity. In relation to whether a registered nurse should also be aware of this cross-reactivity, Dr Porges commented, "probably not. Depending upon the level of nursing staff, not really. The aspirin is a slightly different, non-steroidal…however, with a significant allergy requiring previous adrenaline and having an EpiPen, I think, I'd hope that they would escalate that to the general practitioner".

303 Dr Porges considered that a FLECC accredited or Emergency Care Assessment and Treatment (ECAT) trained RN should be rostered on every shift. She noted that, "FLECC training has been…notoriously difficult to obtain which is why we've changed it to the ECAT system which they're rolling out now, but that's post, since 2019".

304 Dr Porges said that there were "multiple contributing causes to this tragic event, which will be devastating not only to Mr Freeman's family, but also to the staff involved". In her opinion, those multiple contributing causes included:

a. Poor screening of the skills for agency nursing staff;

b. Failure to ensure full functionality of the newly refurbished ED;

c. Poor orientation to the new ED and IT failure adding complexity to care (including the inability for remote medical staff to have direct face to face contact with patients);

d. Unclear escalation pathways for nursing staff to access medical care whilst there was no doctor available to attend onsite to the ED;

e. The Business Continuity Plan was ambiguous as to which remote support service to use for which patients presenting to the ED;

f. The Business Continuity Plan was poorly implemented, with failure to appropriately bolster staffing, nor ensure staff present were clearly informed of escalation pathways;

g. an electronic medical record, to ensure timely access to past medical history and remote access, was lacking;

h. the on-call doctor failed to check for allergies, or the severity of allergies; and

i. there was no fully functional remote telehealth service for all triage category patients, with a single phone number point of access and videoconferencing capability.

305 Dr Porges made the following recommendations:

i. More rigorous screening of agency nursing staff to ensure an appropriate skill set for the role required;
ii. Standardised orientation of new staff, with supernumerary shifts to ensure capacity to work independently, especially if the role is to be the in charge RN;
iii. A revised Business Continuity Plan which includes enhanced nursing staff, an appropriate nursing skill mix, back up on call capacity and clear lines of escalation;
iv. Widespread visibility of the BCP and education and communication to all staff;
v. Implementation and utilisation of a standardised telehealth service, utilising real time bedside videoconferencing, electronic ordering and allergy flagging, staffed by senior critical care trained doctors; and
vi. Utilisation of a fully functional electronic Medical Record, accessible both locally and remotely.

The evidence of Dr Anna Holdgate

306 Dr Anna Holdgate is a senior staff specialist in emergency medicine in Sydney with 25 years' experience. She prepared an expert report for these proceedings, dated 11 January 2024 and gave oral evidence on 30 August 2024.

307 Dr Holdgate noted that David presented to the ED on 27 October 2019 complaining of chest pain but did not initially complain of shortness of breath.

As such, "there was no reason why the nursing staff on their initial assessment would have sought to clarify his history of asthma". Dr Holdgate noted that although David had used Ventolin earlier that night, this was not initially disclosed to nursing staff.

308 Dr Holdgate said that Dr Ling was contacted "at 2am by a nurse he did not know, working at a hospital that he was not familiar with. He relied on the history provided to him by RN Amarh-Ashitei and determined that the primary acute problem was chest pain". Dr Holdgate said that she was "mildly critical of Dr Ling for not seeking to clarify whether or not Mr Freeman had any known allergies given the history of asthma and plan to prescribe aspirin. However, I am very mindful that Dr Ling was contacted in the middle of the night by unfamiliar staff at an unfamiliar hospital and did not have access to the previous medical records". Dr Ling's evidence has clarified that he gained access to the hospital notes to prepare the HealthWISE medical practitioner form. It is unclear when he became aware of David's asthma history.

309 Dr Holdgate said that "as a matter of routine, the medical records should have been available for review by both the nursing staff and Dr Ling. If Dr Ling had been able to access the medical records, he more likely would have identified the ibuprofen allergy and its potential significance". Dr Holdgate noted that the only reference to an allergy to aspirin in David's notes was recorded on 29 March 2017, with no other detail. She also noted that "had the medical records been available in an electronic format it is possible that the aspirin allergy may have been more clearly and more easily identified".

310 Dr Holdgate said that "nursing staff would almost certainly not have been aware of the potential to exacerbate Mr Freeman's asthma. Dr Ling may have been aware of this potential, but in the circumstances had no specific reason to consider this risk. Dr Ling was providing advice regarding the management of chest pain and states that he was unaware of the ibuprofen allergy".

311 Dr Holdgate said that her considerable experience in emergency medicine has been in an urban, rather than in rural and remote areas, however, she was nonetheless of the view that the "medical staffing arrangements on 27 November 2019 were far from ideal and fraught with risk".

312 Dr Holdgate said that the key factors that contributed to David's death were:

a. Nursing staff were unfamiliar with the layout of the ED and the referral pathways. As David had been classified as triage category 2, RN Amarh-Ashitei should have contacted Armidale Hospital to arrange transfer, rather than speak with Dr Ling who was on-call for ATS Category 3-5 patients;

b. Dr Ling being on-call in the middle of the night for a location he was not familiar with, staff he was not familiar with and no access to medical records or other relevant clinical information;

c. Dr Ling being unable to assess David via a video link to clarify the clinical history; and

d. A lack of easily accessible electronic medical records which may have more easily identified the aspirin allergy recorded in 2017.

313 Dr Holdgate made the following recommendations:

i. An electronic medical record system which can be accessed both locally and remotely;
ii. A centralized method of documenting allergies via an electronic medical record;
iii. A coordinated virtual medical health service that has senior doctors rostered on shift, rather than on-call in addition to their usual work commitments. The virtual medical health service should include (a) the capacity to communicate with the patient and staff directly through a video link (b) the capacity for the virtual provider to have real time access to medical records, imaging, blood results and ECGs, and (c) the capacity for the virtual provider to remotely prescribe electronically; and
iv. The virtual medical service would need to work with local agencies to develop clear pathways for transport and referral.

The evidence of Ms Lisa Ramsland

314 Ms Lisa Ramsland is the General Manager, HNELHD and has held that position since 2021. She also has experience as a Registered Nurse, Clinical Nurse Specialist and Clinical Nurse Educator. Ms Ramsland prepared a statement dated 12 April 2024 and gave oral evidence on 30 August 2024.

315 Ms Ramsland recognised that Tenterfield Hospital was operating on a BCP at the time of David's presentation on 27 October 2019 and acknowledged that this contributed to the treatment he received.

316 Ms Ramsland said it was an expectation that there would be an appropriate skill mix rostered on to work during the hospital's BCP which she said would include a FLECC accredited and ALS trained nurse and an enrolled nurse. She said that when she prepared her statement, she was unaware that RN Amarh-Ashitei did not have ALS training. In addition, she did not appreciate that neither RN Amarh-Ashitei nor EEN Lee were aware that there was a nurse on-call that night.

317 Ms Ramsland agreed that anyone with responsibility for the delivery of services in a health facility should identify the needs and the risks, including the likelihood and potential consequences of those risks. She said forward planning must consider all those features.

318 Both Ms Ramsland and Ms Jones have provided details of the changes and improvements made by HNELHD since October 2019.

319 At the time of David's admission, Tenterfield Hospital had no access to electronic medical records ("eMR") and relied on paper records. As noted above, iPMs had the capacity to record patient allergies, however it remains unclear what, if anything, had been recorded on iPMs relating to David's past and current admissions.

320 Dr Katelaris emphasised the need for a hospital to maintain a record system which allows for the recording and disclosure of patient allergies to prevent further adverse drug reactions. The medical records for David's 29 March 2017 admission to Tenterfield Hospital disclosed an allergy to both ibuprofen and aspirin. This was not replicated on subsequent medical records.

321 HNELHD has now implemented the Digital Medical Record (DMR) system. This enables a patient's paper record to be scanned and stored for immediate or remote access. In 2025, it is anticipated that the DMR system will be superseded by the Single Digital Patient Record (SDPR). The SDPR will have the capacity to store a patient's medical information, including allergies, for clinicians to access in real time.

322 Armidale Hospital no longer provides support to the Tablelands Sector Hospitals and the STAH service is no longer used.

323 Between September 2020 and April 2021, HNELHD moved all clinical telehealth services to MyVirtual Care. Two telehealth carts with dedicated computers, known as Computers on Wheels or COWs, are now available in addition to the critical care camera (CCC).

324 Since July 2022, Tenterfield Hospital has utilised "My Emergency Doctor", an external contract care service which provides a 24-hour service staffed by doctors with specialist accreditation for ED medical consultations for ATS Category 3 and 4 patients.

325 ATS Category 1 and 2 patients are now managed according to the HNELHD's Guideline and Procedure Critical Care Telemedicine Advice for Adults dated 14 October 2021, the Critical Care Tertiary Referral Networks (Paediatrics), "Recognition and management of patients who are deteriorating" dated June 2020 and the Tenterfield Community Hospital Clinical Emergency Response

System (CERS) utilising the critical care camera. If there are any delays with retrieval, My Emergency Doctor can provide consultancy and support for ATS Categories 1 and 2 as an interim measure.

326 According to Ms Ramsland, the hospital's "CCC is generally used for ATS Category 1 and 2 patients. There is a new CCC at the Hospital which does not require regular testing and there is a state portal where eHealth identifies when any of the cameras are offline".

327 Dr Katelaris recognised that nursing staff in remote and rural EDs must have specific and specialised skills to allow them to be competent and confident in emergency situations. She recommended that nursing staff be given specific training in the recognition of anaphylaxis, impending respiratory or cardiac arrest and competence in basic resuscitation procedures such as the prompt administration of adrenaline.

328 Tenterfield Hospital implemented a new orientation process in January 2024, with the earlier commencement of a part-time Clinical Nurse Educator (CNE). Nursing staff with limited experience in acute or critical care are rostered as "supernumeraries" to help support their transition into their new role. The hospital's orientation program for nursing staff is supported by Armidale Hospital, with one week of orientation and supernumerary clinical shifts in the ED. Staff skills are assessed for competency by the CNE and a determination is then made as to whether an individual nurse requires further support. For more experienced staff with acute and ED experience, including agency staff, 3 to 4 supernumerary orientation days are now available. A 'buddy system' has been implemented and an Orientation Manual and self-assessment checklist are available.

329 The HNELHD has strengthened the requirement for nursing agencies to screen agency nurses to ensure that their skills, qualifications and competencies are appropriate for the position. The Nursing Locums, Workforce Portfolio (formerly the Staffing Services) is "responsible for the onboarding and allocation of nurses and midwives who specifically provide short-term support to facilities right across the LHD".

330 In 2022, the HNELHD initiated the Rural Reliever casual pool consisting of current employees willing to work across a range of rural and regional facilities.

331 Ms Ramsland gave evidence that in circumstances similar to those on 27 October 2019, the HNELHD has sent after hours nurse managers from Armidale to Tenterfield Hospital to cover gaps. In addition, Health Service Managers have travelled from Glenn Innes and other facilities to work clinical shifts when required. The HNELHD also now issues district wide alerts to place

nurses where there is a shortage of staff with ED nursing training, triage and ALS skills.

332 Ms Ramsland confirmed that as at August 2024, all but one Tenterfield Hospital nurse held current ALS qualifications. NSW Health now offers ECAT training to all registered and enrolled nurses. ECAT commenced on 27 May 2024 and it is anticipated that all ED nursing staff will complete this training. Since June 2024, 90% of enrolled nursing staff at Tenterfield Hospital have completed the first module of the ECAT course and 75% have completed the second module. A nurse who has completed both modules can administer adrenaline.

333 Ms Ramsland accepted that the new BCP document was outdated and a more simplified version should be prepared as recommended by Dr Porges.

Cause of David's death

334 On 4 November 2019, Dr Alison Ward, forensic pathologist, conducted David's autopsy. Dr Ward prepared a post-mortem report dated 6 April 2020.

335 Dr Ward noted that her "post mortem investigation revealed macroscopic and microscopic evidence of bronchial asthma which was the cause of death, including airway remodelling, acute inflammation within the airways, and mucus plugging. In addition, there were abundant acute inflammatory cells seen in numerous vessels within the lungs and heart, indicating an acute inflammatory process was occurring at the time of death".

336 Dr Ward also noted that "during his hospital presentation it was reported (in the P79A) that the deceased became breathless and went into respiratory arrest shortly after being given aspirin. The deceased was known to have an allergy to Ibuprofen. When medications such as non-steroidal anti-inflammatory drugs (NSAIDs) eg Ibuprofen and/or aspirin are administered to some asthmatics, an overproduction of pro-inflammatory leukotrienes (acute inflammatory cells and inflammatory mediators) can occur, causing severe asthma exacerbations".

337 Dr Ward commented that "immunology revealed a minimally elevated tryptase (a marker of anaphylaxis), with the level too low to be considered anaphylaxis. The total IgE level was also tested and was elevated. Total IgE is the hallmark of type 1 hypersensitivity and can be used to screen for and detect allergic diseases such as asthma. The deceased's elevated total IgE level is therefore in keeping with his history of asthma".

338 Dr Ward noted that the "toxicological analysis of the femoral blood revealed the presence of methylamphetamine (and metabolite amphetamine). This is in

keeping with the deceased reporting having taken the drug earlier in the evening prior to his death. Non-toxic levels of salicylic acid (constituent of aspirin) was detected. Sildenafil (Viagra) was also detected at a low, non-toxic level. Salbutamol (a bronchodilator used in asthma) was also detected".

339 Dr Ward concluded that David's cause of death was "Bronchial Asthma".

340 Dr Katelaris and Professor Jones opined that David died because the administration of aspirin provoked a severe asthma attack leading to respiratory arrest. Dr Katelaris noted that even though David's asthma was unstable, aspirin was the major contributor to his death. His unstable asthma and use of methylamphetamine and alcohol may have predisposed him to a more severe reaction, but it was the administration of aspirin to an individual with a known NSAID hypersensitivity that ultimately caused his death.

341 Taking into consideration the expert evidence available, David's cause of death will be recorded as "respiratory arrest secondary to acute exacerbation of bronchial asthma caused by a non-allergic hypersensitivity reaction to aspirin administered at Tenterfield Hospital".

Determination of factual disputes

a. Did David or Ms Kane advise the nursing staff of his allergy to aspirin prior to being given the aspirin?

342 The strongest evidence for the assertion that David and/or Ms Kane advised the two nurses of David's allergy aspiring prior to its administration is the body worn video interview police conducted with Ms Kane at around 7.30pm on 27 October 2019.

343 In her second statement dated 4 September 2023, Ms Kane recalled RN Amarh-Ashitei coming back into the room a second time and saying that "the doctor wants you to have some aspirin" and David responding, "I can't have aspirin, it will cause asthma, I'm allergic to it." Ms Kane said that RN Amarh-Ashitei left again and when she returned, she said "the doctor thinks it's going to be okay if you have it". Ms Kane perceived that staff were considering giving David aspirin to stave off a stroke or a heart attack. Ms Kane said that EEN Lee was in the room for some time and would have heard her discussing David's allergy to aspirin with him.

344 RN Amarh-Ashitei and EEN Lee do not agree with Ms Kane's assertion and maintain that they were not told about David's aspirin allergy until after he ingested it and began to experience an adverse reaction. Neither nurse is assisted by the lack of contemporaneous patient observations or progress notes.

345 EEN Lee's evidence was clear that she had been told by David that he had an allergy to 'Brufen' when he first came into the ED. This appears to be consistent with the Client Registration Form which was made contemporaneously and does not appear to have been altered or authored retrospectively.

346 The evidence is silent as to whether either nurse was able to access David's historical patient records. Whilst Ms Butler recalls treating David on a prior occasion, there is no evidence that EEN Lee had provided him with earlier treatment for asthma.

347 Whilst Ms Kane's assertion appears to have merit, the Court would need to carefully assess the evidence and be satisfied to a high standard that two qualified nurses had administered medication to a patient, knowing that the patient had a serious allergy to it, with knowledge (or wilful blindness) of the likely consequences of their actions.

348 Ms Kane was not called as a witness and her account remains untested in Court. I make no adverse finding against Ms Kane at all.

349 Relying on the available evidence, I am satisfied on the balance of probabilities that David told the nurses that he had an allergy to 'Brufen', meaning ibuprofen, shortly after his arrival at the ED and before the first telephone call was made by RN Amarh-Ashitei to Dr Ling.

350 I am satisfied that David's potential allergy to aspirin was raised by him and Ms Kane after he had ingested it.

b. Did RN Amarh-Ashitei inform Dr Ling about David's allergy to ibuprofen?

351 RN Amarh-Ashitei says that she told Dr Ling about David's allergy to ibuprofen during their first phone call. Dr Ling does not recall being told about any allergies during any of his telephone calls with RN Amarh-Ashitei.

352 Page 2 of the triage notes reproduced above shows the following notation:

> *ECG done sinus rhythm. Difficult to put in IVC Managed to get blood to do chems and CG4. Unable to obtain troponin due to blood not enough. Hospital is on COSOP. Therefore STAH doctor Michael Ling rang and informed about pt observations and history. Dr Ling gave a telephone order for Aspirin 300mg. Pt asked of any allergy before [aspirin] given. Pt said Ibuprofen – Allergy. Aspirin given at 0215. Dr Ling inform need about transferring pt to Armidale. Armidale rang and covering doctor asked retrieval team to be rang by doctor.*

This note suggests that the first time David was asked about allergies was after the first phone call with Dr Ling which is inconsistent with the evidence given by both nurses.

353 Page 3 of the triage notes reproduced above states:

> *During time of history taken, Pt and partner did not inform RN about allergy to Aspirin… Pt and partner said pt is allergic to Ibuprofen…. Just when pt became short of breath pt partner told the nurses the pt is allergic to aspirin. The covering doctor of Armidale was informed that pt partner is allergic to aspirin*.

Nowhere on page 3 of the triage notes does it appear that RN Amarh-Ashitei told Dr Ling that David had an allergy to ibuprofen.

354 Dr Ling's notes do not indicate that he was told that David had an allergy to ibuprofen. His notes are also problematic in that it is unclear when and what he recorded the following day and what he recorded later after gaining access to David's medical records. Dr Ling accepts that he was told that David had a history of asthma, however, he cannot recall being provided with any other patient history. In his first statement, Dr Ling records that David presented with left sided chest pain, which was radiating to his left shoulder, and was told about his history of asthma. In his second statement, the attached notes suggest that Dr Ling was also told about David's recent use of methylamphetamine.

355 Relying on the available evidence, I am satisfied on the balance of probabilities that:

b. RN Amarh-Ashitei did not tell Dr Ling that David was allergic to ibuprofen;
c. Dr Ling did not ask RN Amarh-Ashitei about David's allergies and it was incumbent on him to have done so; and
d. Dr Ling was advised that David had a history of asthma and should have enquired whether he had any allergies, particularly prior to prescribing aspirin. Dr Ling also should have considered whether an alternative medication was available to address David's perceived cardiac issues.

c. Was the equipment working in the ED and were RN Amarh-Ashitei and EEN Lee sufficiently oriented to the ED equipment?

356 RN Amarh-Ashitei and EEN Lee both said that they did not have access to a Spectralite phone in the ED between 26 –27 October 2019.

357 EEN Lee recalled being told that staff would receive Spectralite phones when she attended orientation training on either 16 or 17 September 2019. However, she does not recall seeing Spectralite phones at that training.

358 Mr Symons gave evidence that Spectralite phones were made available to staff at the September 2019 orientation sessions. He later conceded that he was not present during the orientation training.

359 RN Amarh-Ashitei said that the landline telephone in Bay 1 of the ED had no dial tone which required her to make numerous trips back to the Nurses' station to make phone calls to Dr Ling, NSW Ambulance and Armidale Hospital. RN Amarh-Ashitei conceded that the phone appeared to be working when paramedics attended at around 2.52am.

360 I am satisfied that the landline telephone in Bay 1 of the ED was functional on the morning of 27 October 2019.

361 Mr Roberts asserted that his usual practice would be to orient a new member of staff to the critical care camera in the ED. He did not positively assert that he had done so with RN Amarh-Ashitei. RN Amarh-Ashitei's evidence suggests that she had no idea where the camera was located, given she believed that it was mounted on the wall rather than the ceiling. EEN Lee was familiar with the camera in the old ED, however, as she had just returned from leave, she had not been oriented to the placement and controls for the camera in the new ED.

362 Paramedic Savage recalled that there was some discussion about switching on the critical care camera, however, said "it wasn't able to be established, so we established a phone line to the consultant in Tamworth Base Hospital". Both Mr Symons and Ms Jones gave evidence that that the critical care camera was functioning the following day when a number of bus passengers were admitted after an accident.

363 The evidence is equivocal as to whether the critical care camera was functioning on 27 October 2019. The evidence in relation to the poor or non-existent orientation of both nurses to the critical care camera is clear and compelling. In an ED where there was no doctor on duty or on-call, it was imperative that staff were familiar with vital equipment to liaise with doctors at other hospitals, particularly for patients which were ATS Category 1 or 2.

d. Was the nursing staff skill mix unsafe for patients and for the nursing staff?

364 On 27 October 2019, the hospital was operating under a BCP, with no doctor on site, or on-call locally. The ED was staffed by an agency registered nurse and an endorsed enrolled nurse.

365 Agency nurse, RN Amarh-Ashitei, did not appear to understand that there was no doctor on duty or locally available to review David. She had no triage training, was not FLECC accredited and had not completed ALS training. She was not familiar with the hospital setting and was not registered to use the

i-STAT machine. She relied on EEN Lee's registration card for access. The evidence is unclear as to whether RN Amarh-Ashitei had been granted access to iPMs or whether she had been granted access and was not aware she had it.

366 EEN Lee had just returned from leave and had not been oriented to the new ED with equipment and supplies in place. In addition, EEN Lee had no orientation to the BCP and had never worked with RN Amarh-Ashitei.

367 Prior to 27 October 2019, Mr Roberts and the HNELHD had made significant attempts to secure the services of a doctor for the ED. The evidence confirms that neither Mr Roberts, nor the HNELHD, specifically sought to recruit a FLECC accredited nurse with ALS training for the BCP period. Mr Roberts said that he was hopeful that he would still be able to recruit a doctor for that period, however, he did not tell the nursing agency that there would be no doctor available at the hospital during the engagement period (and that in those circumstances, the applicant would need FLECC accreditation and ALS skills). Mr Roberts was aware that no local registered nurse with FLECC accreditation was available after 25 October 2019.

368 RN Amarh-Ashitei did not have the skill set required in the circumstances. As noted above, she was not FLECC accredited, had not completed her ALS training, was unfamiliar with Tenterfield Hospital, was not initially aware of the BCP and was not sufficiently oriented to the new ED.

369 The evidence confirms that Mr Roberts and the HNELHD were aware, prior to 27 October 2019, that the proposed nursing staff mix for the BCP period was unsafe for both patients and staff.

e. Was the transition to a new ED during the BCP poorly timed and potentially a risk for both patients and staff?

370 On 23 October 2019, the hospital moved into the newly refurbished ED. The evidence suggests that the relocation date had been altered and the reason the move proceeded that day was to accommodate technicians, who no doubt are scarce in regional areas. It is confounding why the move was ratified during a BCP, where there would be no doctor and nursing staff who had either had no or very limited orientation to the new ED. The experts agreed that a significant move, such as this, requires at least one week of additional staff to familiarise and orient to the new environment.

371 The evidence confirms that the transition to the new ED was both poorly timed and risky for both patients and staff.

f. Was the inadequate orientation to the new ED and to the BCP and did this directly impact on David?

372 At the handover on the evening of 26 October 2019, both RN Amarh-Ashitei and EEN Lee were advised that if they needed to contact a doctor during their shift that they should contact Dr Ling at the STAH service for all types of triage cases. The BCP had been amended after it had been declared to include the STAH service. Dr Porges considered this addition to the BCP caused confusion as to the treatment and the advice pathways that the nurses were required to follow.

373 The evidence indicates that there was inadequate orientation to the new ED and to the BCP and that this had a direct impact on David's care and treatment, particularly as he should have been triaged as ATS Category 2 and transferred immediately to Armidale Hospital.

g. Were the resuscitation measures implemented when David became short of breath suboptimal?

374 RN Amarh-Ashitei had not completed ALS training and EEN Lee was unable to undertake it as an EEN. The evidence indicates that with their skill sets, it was almost impossible for the two nurses to have successfully undertaken an appropriate resuscitation. That is, for the nurses to access the defibrillator, one of them would have had to stop administering CPR to obtain, set up and start defibrillation.

Parliamentary Inquiry

375 In May 2022, the Report of the Legislative Council on Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW made various findings and 44 recommendations.

376 Recommendation 16 proposed that NSW Health expedite its review of the nursing and midwifery workforce with a view to urgently increasing nurse and midwifery staffing numbers based on local need across rural, regional and remote NSW. The Legislative Council recommended that any outcome ensure that there are staffing levels that enable optimal patient care and for that care to be delivered in a professionally, physically and psychologically safe environment.

377 The Legislative Council also recommended that NSW Health publicly report on an annual basis its performance in meeting this outcome. The recommendation was made after evidence that nurses in a rural context were bearing the brunt of the doctor shortages in rural locations, as well as themselves being overworked, underpaid and experiencing unsatisfactory

working conditions, particularly with respect to hours of work because of resourcing, staffing shortages and demands on health services.

Considerations

378 Tenterfield Hospital is a small rural hospital. It is unique in its geographical location and its distance to any base hospital is two hours in every direction.

379 Like many rural and regional hospitals, Tenterfield Hospital is plagued by staff shortages and demands on health services.

380 In 2019, the staffing situation at Tenterfield Hospital had become untenable. Staff were overwhelmed and overworked and were resigning because of the stress of the work environment and the perceived lack of support from management. It had become a usual occurrence for staff to agree to be available on-call, and without pay, simply to support their nursing colleagues.

381 In early October 2019, three locum doctors gave notice that they would not be available to provide medical coverage to the hospital after 14 October 2019. In an email, one of the doctors raised his concern that despite it being early October, no staff roster had yet been published.

382 Enquiries were then made with RaRMS for medical staff to cover the remainder of October and November 2019. At the same time, management were making enquiries with nursing agencies to fill vacancies left by the resignation of nursing staff.

383 Ultimately, a BCP was declared and scheduled to commence on 22 October 2019. Despite this, hospital management decided to proceed with the relocation of the old ED into the newly refurbished ED.

384 The agency nurse that was hired, RN Amarh-Ashitei, did not have the skills required to manage an ED while a doctor was available. It became very clear that she especially did not possess the skills to manage an ED when there was no doctor available and limited nursing support. As Dr Holgate opined, this was a "far from ideal and fraught with risk".

385 The risks to patients on the morning of 27 October 2019 were legion. The nursing staff had not been sufficiently oriented to their new environment and, in the case of RN Amarh-Ashitei, did not have FLECC accreditation or ALS training. Equipment shortcomings, the lack of access to electronic medical records and potential allergies, miscommunications, questionable contemporaneous record keeping and misunderstandings as to triaging of patients, placed David in a grave situation.

386 The BCP should have been simple, clear and obvious. It was not. It resulted in David being referred to Dr Ling rather than to Armidale Hospital. Dr Ling had no access to David's medical records.

387 The situation was exacerbated by nurses who did not have any or adequate training in leading resuscitation and the administration of adrenaline.

388 HNELHD have made some positive changes and improvements since David's death. These include transitioning to an electronic medical records system. This is a particularly important improvement to a medical environment which unfortunately relies on temporary and locum medical staff. It will hopefully permit 'real time' assessment of a patient's medical history and allergies.

389 HNELHD have now also moved to 'My Virtual Care' to provide clinical telehealth services and no longer source support from either the STAH service or Armidale Hospital. In addition, the hospital has commenced using the "My Emergency Doctor" service, a 24-hour service staffed by doctors with specialist accreditation.

390 ECAT training has been offered to nursing staff and the completion rates are most impressive. The inference is that the local nursing community recognised and wanted the opportunity to advance their professional skills. Importantly, the completion of the ECAT training program will permit nursing staff to administer adrenaline in emergency situations.

Recommendations

391 At the conclusion of the evidence, Senior Counsel Assisting proposed six recommendations, as follows:

1. *That Ernestina Amarh-Ashitei is referred to the Health Care Complaints Commission/Nursing and Midwifery Board of Australia (NMBA) for investigation and review as to whether she engaged in unsatisfactory professional conduct in relation to her nursing care of David Scott Freeman on 27 October 2019, namely:*
    a. *Her record keeping.*
    b. *The administration of aspirin after failing to inform Dr Ling of the disclosed allergy to ibuprofen.*
    c. *The competency of her nursing skills.*
2. *That Dr Ling 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 David Scott Freeman on 27 October 2019 when prescribing Mr Freeman aspirin, namely:*

a. *He failed to ask the nurse whether Mr Freeman had any allergies; and*

b. *He failed to recognise the possibility that an asthmatic like Mr Freeman may have a sensitivity to NSAIDs.*

3. *That HNELHD rewrite and simplify the pro forma Tenterfield Hospital Business Continuity Plan (Annexure M to the statement of Lisa Ramsland) so that there is a singular set of instructions (if possible, on a single page) providing clear, succinct and unambiguous escalation pathways for nursing staff to follow during a period of business continuity where there is no medical officer on site at Tenterfield Hospital.*

4. *That HNELHD review existing referral pathways and ensure that there are clear pathways for referral to respiratory and other specialists in the treatment of asthma for patients who present repeatedly to Emergency Departments with severe asthma exacerbation and are in receipt of multiple courses of prednisolone.*

5. *A copy of the findings be sent to NSW Health recommending that NSW Health consider the evidence of Professor Katelaris recommending amendment of the Chest Pain Pathway to include the following cautions:*

   CAUTION:
   Does the patient have severe asthma?
   Does the patient have an aspirin/NSAID sensitivity?

6. *A copy of the findings be sent to the NSW Minister for Regional Health and NSW Health.*

392 I have considered the evidence in relation to Dr Ling and his suggested referral to Health Care Complaints Commission. I am of the view that his actions on 27 October 2019 were lacking in terms of his contemporaneous note taking and his use of additional medical records to complete a form that was expected to reflect the contemporaneity of the situation. Dr Ling accepted that his behaviour fell short of professional expectations.

393 Dr Ling should also have turned his mind to enquiring whether David had any allergies, particularly to aspirin, when RN Amarh-Ashitei told him that David was an asthmatic. The expert evidence of Professor Katelaris, Professor Jones, Dr Porges and Dr Holdgate made it very clear that this was a significant professional oversight.

394 I accept, on the balance of probabilities, that Dr Ling was not told of David's allergy to ibuprofen prior to him prescribing aspirin. He was also unable to access David's medical records as they existed in paper form only.

395 Dr Holdgate was "mildly critical" of Dr Ling's conduct noting that he had been woken from sleep, rather than being rostered on-call, was not familiar with RN Amarh-Ashitei, was not able to review David on video camera and should not have been referred an ATS Category 2 patient.

396 A number of other matters were raised on Dr Ling's behalf, which are more of a subjective nature to be considered by the Health Care Complaints Commission. Dr Ling was fully accepting of his professional shortcomings on that evening and did not attempt to minimise his behaviour. I have therefore concluded that a referral in these circumstances is not necessary. This does not diminish my view that his conduct was inappropriate and that his care and treatment of David was lacking.

Conclusions

397 David's death was wholly preventable.

398 Dr Ling and RN Amarh-Ashitei should not have been placed in the situation that they faced on the morning of 27 October 2019. Although it is acknowledged that Mr Roberts made efforts to engage medical staff prior to the BCP, the reality was that staffing levels and skill sets had been mismanaged by more senior management for some time and the BCP was poorly handled.

399 David and his family should not have been placed in the situation that they faced on the morning of 27 October 2019.

400 David's death did not result from one simple mistake or miscalculation. His death resulted from multiple system failures at Tenterfield Hospital, all of which could have been avoided with better planning, staff support and training.

Family reflections

401 David's parents, Brian and Claire, his sister Kirsti, Vivian and Natalie all speak of a man who was unique, loving and loved. Each of them continues to reflect on the enormous loss and grief that persists each day.

402 David was described as a "raconteur and a capable man indeed". His parents said that he "carried individuality and was his own man. He loved the bush especially where he lived in Tenterfield, and he developed many practical skills to give him self-sufficiency and to look after country. He loved taking his children into the world of nature to teach them about life in a different world from that of their hometown Byron Bay. He was well read and devoured books of all types and built a wide store of knowledge. He loved music and amassed

an extensive music collection shared with all. He was a philosopher of sorts and quite the poet".

403 His sister said "David was unlike anyone else. He was my brother, he was easy to love, hard to live with and his death has left a hole in my world and in so many other people's worlds…One of the names David went by was 'Free'. And that is how I will remember him. He lived by his own rules, he walked on the earth, but he also walked the sky and the stars, and he will forever be flying free".

404 Vivian recalled him as an "intelligent, brilliant man. His understanding of the world was like no other. David fathered my two children like his own. He tutored them for school and taught them to be good, heartfelt, respectful humans. He inspired wild, adventurous behaviour. We married and brought two more beautiful children into the world. David adored the kids and was a very hands-on father…David was the anchor of our family. He loved me and spoilt me every day. He always cooked meals and read stories to the children".

405 Natalie said, "Free was well-versed in the lore of the land and held a profound connection and respect for the Nundjalung people. The local elder, Lewis Walker, captured the essence of Free at his wake by saying, "This is a man among men, who lived to his fullest in his own way". This is why the Frank Sinatra song "My Way" often comes to mind when I think of Free. He was compassionate and kind, not only to family and friends but also to strangers, always ready to lend support to those in need".

Closing Observations

406 Before turning to the findings that I am required to make, I would like to acknowledge my gratitude to Ms Maria Gerace of Senior Counsel and Ms Leanne Kohler, solicitor, for their significant assistance, commitment, support and preparation of this case.

407 I would also like to acknowledge and thank the Officer in Charge of this investigation, Senior Constable Marie Cross for her assistance and commitment.

408 I have had the opportunity to see David's parents and sister every day in Court during the inquest. I was struck by their decency and good grace in the face of unrelenting loss and anguish. At no time have they sought to blame RN Amarh-Ashitei, EEN Lee or Dr Ling.

409 Ms Claymore said, "I also want to say I feel for the nurses and the other health staff who tried to save David. I know they too carry a wound and that this process must be stressful for them too. For me this inquest is not about laying

blame but about finding the cracks in the systems that have led us here. Jo and Tina, I know you did everything you could at the time. My hope for you and for the other staff is the same as it is for my family and me, that we can move through this grief and pain to a place where healing can happen".

410 His parents said, "we wish it to be recorded that we hold no anger or enmity towards the nurses at this hospital and we trust thar this inquest will provide insight and guidance with a finding that prevents an event recurring and that other families do not suffer as this family has and continues to do so".

411 Finally, I would like to again record my most sincere condolences to David's family.

Findings

I make the following findings pursuant to section 81 (1) of the *Coroners Act 2009 (NSW)*:

The identity of the deceased

The person who died was David Scott Freeman

Date of Death

David died on 27 October 2019

Place of Death

David died at Tenterfield Hospital, Tenterfield

Cause of death

The cause of David's death was respiratory arrest secondary to acute exacerbation of bronchial asthma caused by a non-allergic hypersensitivity reaction to aspirin administered at Tenterfield Hospital.

Manner of Death

The administration of aspirin to a person with a history of asthma and known sensitivity to non-steroidal anti-inflammatory drugs, where the administration of aspirin was contraindicated, where adrenaline would have saved the person's life but was not administered and where Tenterfield Hospital was operating without a medical officer and was staffed by a registered nurse and an enrolled nurse without accreditation in emergency care or advanced life support.

Recommendations

I make the following recommendations pursuant to section 82 of the Coroners Act 2009 (NSW):

In relation to Ernestina Amarh-Ashitei

1. That Ernestina Amarh-Ashitei is referred to the Health Care Complaints Commission/Nursing and Midwifery Board of Australia for investigation and review as to whether she engaged in unsatisfactory professional conduct in relation to her nursing care of David Scott Freeman on 27 October 2019, namely:
    a. her record keeping;
    b. the administration of aspirin after failing to inform Dr Ling of the disclosed allergy to ibuprofen; and
    c. the competency of her nursing skills.

To the Hunter New England Local Health District

2. That the HNELHD rewrite and simplify the pro forma Tenterfield Hospital Business Continuity Plan (Annexure M to the statement of Lisa Ramsland) so that there is a singular set of instructions (if possible, on a single page) providing clear, succinct and unambiguous escalation pathways for nursing staff to follow during a period of business continuity where there is no medical officer on site at Tenterfield Hospital.
3. That the HNELHD review existing referral pathways and ensure that there are clear pathways for referral to respiratory and other specialists in the treatment of asthma for patients who present repeatedly to Emergency Departments with severe asthma exacerbation and in receipt of multiple courses of prednisolone.

To NSW Health, in relation to the Chest Pain Pathway

4. That a copy of the findings be sent to NSW Health recommending that NSW Health consider the evidence of Professor Katelaris recommending amendment of the Chest Pain Pathway to include the following cautions:

    CAUTION:
    Does the patient have severe asthma?
    Does the patient have an aspirin/NSAID sensitivity?

In relation to systemic issues of resourcing

5. A copy of the findings be sent to the NSW Minister for Regional Health and NSW Health.

I now close this inquest

Magistrate Joan Baptie
Deputy State Coroner

21 February 2025