CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Paul Harris
Hearing dates:	18-20 and 25-27 August 2025, Griffith and Leeton Local Courts
Date of findings:	13 January 2026
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner, Magistrate Hosking
Catchwords:	Coronial inquest, death in hospital (not anticipated); risks of diagnosis on a 'most likely' basis, when to consider transfer of patients from a regional facility where diagnosis of pulmonary embolism cannot be confirmed.
File number:	2019/326190
Representation:	Counsel Assisting the Inquest: Patrick Rooney of Counsel instructed by Taylor Bird, NSW Crown Solicitor's Office. Louwesie Fitzpatrick and Leo Dedini-Fitzpatrick: Jacklyn Dougan-Jones and Kefilina Faupula, Aboriginal Legal Service. Paul's children, Alana, Cameron, Danielle and Brooke: Unrepresented. Murrumbidgee Local Health District (**MLHD**), RN Michelle Johnson and RN Jaypee Bautista, NUM Judith Charles, RN Geraldine Tuohey, CNE Rowena Jubb, EEN Lisa Everett, RN Dominique Warren and

	Sarah Sandow: Richard Sergi of Counsel instructed by Rosslyn Cooke, Hicksons Lawyers. Dr Ahmed Hosni: Zoe Alderton of Counsel instructed by Ashley McIntyre of HWL Ebsworth. Dr Muhammad Arshed: Rebekah Rodger of Counsel instructed by Emma Marel and Juliette Paterson, Avant. Stokari (VIC) Pty Ltd: Unrepresented.
Findings:	**Identity of deceased**: Paul Harris **Date of death**: 17 October 2019 **Place of death**: Hay District Hospital, 351 Murray Street Hay NSW 2711 **Manner of death**: Undiagnosed bilateral pulmonary thrombo-emboli while receiving treatment at Hay Hospital as an inpatient **Cause of death**: Bilateral pulmonary thrombo-emboli, contributory factors included obesity, coronary atherosclerosis and cardiomegaly reportedly contributed to the death.
Recommendation:	That the Murrumbidgee Local Health District give consideration to providing training to all staff (including VMOs and nursing staff) to ensure that relationships between Hay Hospital and other hospitals within the Murrumbidgee Local Health District are strengthened.

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FINDINGS

Introduction

1 Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

2 In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

3 These are the findings of an inquest into the circumstances of the death of Paul Harris born 27 October 1975. Paul died while receiving treatment at Hay Hospital on 17 October 2019.

4 Paul was the loved father of Alana, Cameron, Danielle and Brooke, partner of Louwesie, stepfather of Leo, brother and mate to many. Paul had a big personality and was described by his family as a larrikin. Paul enjoyed making people laugh. Paul was an outdoors man who enjoyed pig hunting and camping. His children cherish the time they spent with their father in the outdoors. Paul's family have suffered a great loss felt every day but particularly when he is not there to share their significant milestones. I am grateful for the memories Paul's loved ones shared in their family statements given at the conclusion of the inquest.

5 This inquest is held pursuant to the general jurisdiction afforded to me as a coroner under s 21 of the Act.

6 The participants reduced to writing an 'Agreed Summary of Evidence' which was tendered as an *aide-memoire* at the hearing. I am grateful for the work undertaken by the Assisting team to prepare this summary and for the contributions of the participants. I have drawn from this and from the submissions of Counsel assisting in relation to non-contentious issues.

The issues examined at the inquest

7 An inquest into the circumstances of Paul's death was held in Griffith and Leeton Local Courts between 18 and 27 August 2025.

8 The issues identified in the coronial investigation to be explored in the inquest were extensive and are set out in full in **Annexure A** to these findings. While I have considered all of the evidence and submissions, as the inquest progressed, some issues were more relevant than others. This is reflected in my analysis of the relevant issues below.

The evidence

9 Tendered to the court was a 6-volume brief of evidence[1] compiled by the NSW Police Officer in Charge of the coronial investigation, Senior Constable Marmo, and supplemented by the Assisting team.

10 I also received into evidence an additional volume which contains exhibits 2-7.

11 A schedule of the witnesses that gave oral evidence at the inquest is at **Annexure B**.

Findings and recommendations

12 Having considered all of the evidence and submissions in this inquest, my findings follow.

Cause of death

(1) I find that Paul died of bilateral pulmonary thrombo-emboli. Contributing factors included obesity, coronary atherosclerosis and cardiomegaly.

[1] Exhibit 1.

(2) Paul's PE may have been capable of detection if he had been transferred to Griffith Base Hospital where a CTPA[2] could have been carried out during his admission from 9 October 2019.

Q fever and Paul's employment

(3) I find that Paul had Q fever, from at or around 16 September 2019. I accept A/P Hudson's evidence that there is a connection between Q fever and the risk of thrombosis which is not widely known.

(4) The evidence does not allow a finding as to whether earlier treatment of Q fever could have reduced Paul's risk of PE.

(5) Paul's risk of Q fever was first considered by the medical team at Hay Hospital on 14 October 2019. Given his work history, his risk should have been identified earlier. That said, Paul was prescribed Doxycycline from 24 September 2019 which A/P Hudson indicated was the appropriate treatment for Q fever. If Paul had consumed what he was prescribed, it is likely his infection would have resolved by the time of his October 2019 admission. Accordingly, while it is possible that Q fever had a part to play, the evidence does not support a finding that Q fever contributed to Paul's death.

(6) I cannot find on the evidence adduced that Stokari (VIC) Pty Ltd (**Stokari**) had an appropriate system in place to manage the risk of Q fever at the time of Paul's death. However, the evidence indicates that they have had a system in place from at least February 2020 to date.

(7) I am unable to make a finding on the evidence whether Paul was vaccinated for Q fever or whether he had a previous infection at the time he commenced work at Stokari.

[2] A CT Pulmonary Angiogram – the 'gold standard' test for pulmonary embolism.

(8) I am unable to make a finding on the evidence as to whether any checks were conducted by Stokari to determine whether Paul had been vaccinated or whether he had a prior infection before commencing his employment with Stokari.

(9) While there was no legal obligation on Stokari to offer or provide Paul with a Q fever vaccination, it had a general obligation to ensure Paul's health and safety which, according to A/P Hudson could have been discharged by offering a vaccination and reducing exposure.

(10) Given the absence of further intervention from SafeWork, I conclude that Stokari's response to the Improvement Notice dated 6 February 2020 was adequate.

Pneumonia

(11) I find that Paul had pneumonia during his September 2019 admission and while he may have had a recurrent pneumonia during his October admission, it is more likely that his pneumonia had been successfully treated with antibiotics such that his October 2019 presentation was because of the PE.

(12) I am unable to make a finding on the evidence as to what contribution, if any, the September 2019 pneumonia had to his death caused by a PE.

As to the care and treatment provided to Paul from 16 September to 2 October 2019 at Hay Medical Centre and Hay Hospital

13 I find that Paul's management from 16 September 2019 to 2 October 2019 was appropriate except for the fact that the diagnosis of Q fever as the cause of Paul's febrile illness with pneumonia was not considered until his subsequent admission.

As to the care and treatment provided to Paul from 9 to 17 October 2019 at Hay Hospital

14 I am unable to make a finding on the evidence as to when Paul's PE started to develop or what its origin was. The expert evidence indicated that appropriate preventative treatment had been given, however, PE can occur despite adequate prophylaxis.

15 The evidence established that an ECG may have been beneficial, but it was unlikely to have made any difference to Paul's treatment plan or the eventual outcome.

16 The observations performed by nursing staff were adequate and in accordance with applicable policies, procedures and guidelines and Paul was appropriately seen by Dr Arshed on 9 and 10 October 2019.

17 I did not consider the decision by Dr Arshed to alter the calling criteria to be inappropriate. However, it was clear on the evidence that the procedure adopted was inaccurate and unclear in regard to how long the calling criteria was to be altered.

18 It would have been of assistance to staff at Hay Hospital if Dr Hosni had made a note of his preliminary opinion at Hay Medical Centre in the records of Hay Hospital. However, I note that the symptoms on which the concern relating to PE, being shortness of breath and coughing up blood, were identified in the Hay Hospital records. Furthermore, it would have been of assistance to staff at Hay Hospital if Dr Arshed had made a note of each of his consultations with Paul during his admissions.

19 I find that Paul ought to have been transferred to Griffith Base Hospital by virtue of the seriousness of his illness, and for a CTPA to be carried out, on 9 October 2019 or the next morning, 10 October 2019, or 15 or 16 October 2019.

However, on the evidence available I cannot make a finding as to whether earlier identification would have prevented Paul's death.

Supports available

20 I find that an Aboriginal Liaison Officer ought to have been engaged for Paul during his admissions in September and October 2019 even if this service would have been limited to tele-health virtual-type responses.

21 I find that while they should have been, Paul and his family were not informed about the REACH program.

Emergency response and resuscitation

22 The emergency response and resuscitative efforts were reasonable, appropriate and timely.

Recommendations

23 I recommend that the MLHD give consideration to providing training to all staff (including VMOs and nursing staff) to ensure that relationships between Hay Hospital and other hospitals within the MLHD are strengthened.

Background

Hay Hospital in 2019

24 Hay Hospital is a small regional hospital with about 12 beds, and there were usually 3-4 patients admitted to the hospital during any week.

25 Between 2015 and 2019, Dr Arshed and Dr Hosni both had a role as GP VMOs[3] covering Hay Hospital, generally alternating weeks.

[3] Visiting Medical Officer.

26 Dr Arshed and Dr Hosni also both worked at Hay Medical Centre, which was physically annexed to the hospital. Paul had attended Hay Medical Centre in 2014 and 2015[4].

27 The doctor rostered as the after-hours on-call GP VMO was required to be available via mobile phone[5] to provide medical advice to hospital staff and to attend Hay Hospital to provide medical care to inpatients if requested by hospital staff.

28 Hay Hospital did not have pathology or radiology services on site. An external pathology service was utilised and a local radiographer usually attended Hay Hospital once per week on either a Tuesday or a Wednesday.

29 Generally, Monday to Friday, the on-call GP VMO would attend Hay Hospital at around 8am and complete a ward round before commencing work at the Hay Medical Centre. The same doctor would return that evening and perform a second ward round prior to going home. The morning ward round could be undertaken jointly on changeover day as was the case on 26 September 2019.

Paul's work history

30 In **2016/2017**, Paul began working at 'Roo Works' in Hay employed by Stokari. He remained there until he became unwell shortly prior to his death.

31 There is no evidence that Paul ever received a Q fever[6] vaccination.

[4] There are no records of Paul attending the Medical Centre or the Hospital between 2015 and February 2019 although his partner indicated he did attend an 'Aboriginal Health Check' day and have a flu vaccination in 2019.
[5] From 6pm to 8am on weeknights and generally 24 hours per day on weekends.
[6] Q fever is a bacterial infection that can cause a severe flu-like illness. Symptoms begin about two to three weeks after coming into contact with the relevant bacteria. The bacteria is spread from animals, including kangaroos.

Presentation to Hay Hospital on 2 February 2019

32 On **2 February 2019**, Paul presented to Hay Hospital with left ear pain. He was triaged at 8:38pm by RN Geraldine Tuohey and seen by Dr Hosni who gave him Panadeine Forte to take home.

Presentation to Hay Hospital on 16 September 2019

33 On **16 September 2019**, Paul returned to Hay Hospital and was triaged by EEN[7] McKeon and again seen by Dr Hosni. He had a cough, chills and rigors, felt unwell, had body aches and had decreased hearing in his left ear. Reportedly, those symptoms had all started two days earlier. Paul was diagnosed with an upper respiratory tract infection and left sided otitis media (a middle ear infection).

34 Paul was prescribed: Prednisolone 50 mg daily for 4 days; Amoxil 500 mg 3 x daily; Bromhexine 16 mg 6 hourly. He was to be reviewed at the Hospital 'as required' and attend his GP for follow up[8].

Admission to Hay Hospital from 23 to 27 September 2019

35 A lot will be said about Paul's observations while in Hay Hospital. As a guide, NSW Health's Standard Adult General Observation Chart[9] indicates:

	Sp02[10]	**Respiratory rate**	**Temperature°**	**Heart rate**	**Blood pressure**
Acceptable	>95%	10-25	35.5 to 38.5	50-120	100-180
Yellow	90-95%	5-10 & 25-30	34-35.5 & 38.5-41	40-50	90-100 & 180-200
Red	<90%	<5 & >30		<40 & >140	<90 & >200

[7] Endorsed enrolled nurse.
[8] The direction to see his GP for 'follow up' is somewhat artificial in that Doctors Arshed and Hosni were Paul's GPs as well as his treating doctors while he was admitted at Hay Hospital.
[9] Exhibit 6.
[10] Oxygen saturation 'on room air' – ie without oxygen being administered.

36 On **23 September 2019**, Paul returned to Hay Hospital. At 6:55pm, Paul's observations were within acceptable ranges.

37 At approximately 7:15pm, Dr Arshed arrived (having been called in) and examined Paul. Paul's family was also present.

38 Paul reported feeling unwell, having a cough, having been coughing up green phlegm, suffering from increasing SOB[11] and feeling hot and cold. He had been on oral antibiotics for a week. His temperature was 38.5 degrees.

39 Dr Arshed advised Paul he may have community-acquired pneumonia (**CAP**), however further investigations were required.

40 Paul was admitted to Hay Hospital under the care of Dr Arshed. Dr Arshed ordered intravenous antibiotics; Clexane (DVT[12] preventative); collection of bloods and a chest x-ray[13].

41 Dr Arshed stated in his supplementary statement that he 'ordered IV antibiotics ceftriaxone + oral Doxy 100mg twice a day to cover for all possible typical bacterial causes of pneumonia and atypical bacterial causes of pneumonia which included Q fever…' and did not order atypical serology testing on 23 or 24 September 2019 as it would not have changed the treatment or management plan at that time. Dr Arshed stated he did consider Q fever on 23 September 2019 'as a differential diagnosis as part of a broader diagnostic evaluation for atypical pneumonia.'

42 An ECG was performed. The results stated: Borderline ECG **Unconfirmed**.

43 At 8:03pm, RN Bautista noted that Paul presented with SOB and was 'talking in phrase'. Paul's Sp02 was 99%.

[11] Shortness (short) of breath.
[12] Deep vein thrombosis.
[13] Given this was a Monday, the x-ray was likely to be performed within 2 days.

44 At around this time, Dr Arshed also reviewed Paul noting that Paul had been unwell for three weeks, had a cough and was coughing up green phlegm, had increasing SOB, felt hot and cold, had been on oral antibiotics for a week with no benefit, and had 'nil' risk factors for PE[14] or DVT[15]. It was also noted that Paul smoked 20 cigarettes per day.

45 On **24 September 2019**, Paul's estimated weight was recorded as 88kg and his height as 172cm. He had an estimated BMI of 29.7. Based on Paul's weight at autopsy less than two months later (114kg), it appears that these estimates were not accurate.

46 At 3:04am, Paul complained of having pain in the side of his abdomen and was given Panadol.

47 At 6:23am, Paul's observations were within the acceptable range.

48 Dr Arshed briefly saw Paul prior to commencing work on the hospital ward. He did not make a record of this attendance. Paul was still awaiting the results of the blood investigations and waiting to undergo the chest x-ray.

49 At 8:44am, three of Paul's recorded observations were outside of acceptable ranges, namely: he had a temperature of 38.9 degrees, his peripheral pulse rate was 138 bpm, and his Sp02 was 93%.

50 At 9:20am, Paul's observations were within the acceptable range.

51 At 12:10pm, Paul had a chest x-ray, the report noted:

> …The lungs are mildly hyperexpanded. Mild bibasal subsegmental atelectasis. No consolidation …

52 At around 7pm:

[14] Pulminary embolism
[15] Though Dr Arshed indicated in his statement that Paul was clinically at risk of VTE given his systemic infection, reduced mobility and smoking history.

(1) Dr Arshed reviewed Paul's blood test results noting a raised white blood cell count (of 15), a raised C-Reactive Protein (of 144) and lactate result of 2.8, he noted that Paul's chest x-ray showed mild bibasal subsegmental atelectasis[16] but was otherwise unremarkable and he explained to Paul that 'this demonstrated a significant infection'.

(2) Paul reported feeling better with a settled cough and Dr Arshed observed that Paul looked better than the previous evening.

(3) Dr Arshed reviewed the previous 24 hours' observations and noted Paul was still 'spiking a fever'. Dr Arshed continued Paul on antibiotics (IV Ceftriaxone 1g daily; Doxycylone 100mg oral; and Clexane 40mg) and planned to repeat blood tests.

53 At 10:17pm, Paul had a temperature of 38.6 degrees and his Sp02 was 95%.

54 As identified in a nursing progress note entered at 11:17pm, Paul had been febrile[17] during the shift (which started at 3pm) and the doctor was aware and 'happy with same'.

55 On **25 September 2019**, Dr Arshed briefly reviewed Paul during a morning round. However, he did not document this review. He continued Paul on the same management plan (with blood testing to be repeated later that week).

56 Paul's recorded Sp02 levels were 95% at 6:11am and 8am and 96% at 12:07pm. His temperature was 39.2 degrees.

57 RN Jaypee Bautista stated:

> When a vital sign observation entered into a patient's electronic Medical Record (eMR) falls within the 'yellow zone', an alert will pop up in eMR indicating to the nurse entering the observation to initiate the Clinical Emergency Response System (CERS) protocol. The CERS protocol requires the nurse making the

[16] Small localised areas of collapse in the lower portions of both lungs.
[17] Having a high fever.

> observation to consult the nurse in charge to determine whether a clinical review by a medical officer is required.
>
> At the relevant time, I was the nurse in charge during the shift. Accordingly, escalation by me would have been to contact the medical officer for clinical review. In the circumstances of the high temperature of 39.2 degrees in the context of the other vital signs being with the calling criteria, my usual practice would have been to more closely monitor the patient's progress over the short period. If the patient's condition did not improve, I would then reconsider escalation to the medical officer.
>
> At 12:54hrs, I entered a Progress Note reporting that I took Mr Harris' observations and that his temperature was high at 39.2 degrees. I had informed the doctor in charge and gave Mr Harris ibuprofen….
>
> At 13:18hrs, I returned to take Mr Harris' temperature again which had then dropped to 37.7 degrees … Mr Harris reported that he was feeling better and was mobile.

58 At 12:54pm, a nursing progress note of RN Bautista records:

> obs attended Febrile temp of 39.2 inform MO- can give neurophen [sic] 400mg/ tab repeat temp of 37.7 feeling better walking around

59 On **26 September 2019**, Dr Arshed handed over Paul's care to Dr Hosni and accompanied Dr Hosni on the morning ward round. Following the handover, Dr Arshed did not have further involvement in Paul's care during this admission.

60 Dr Arshed stated the treatment plan was to continue Paul on IV antibiotics and order repeat blood tests for the morning of 27 September 2019. Dr Arshed aimed to discharge Paul on 27/28 September 2019 provided he continued to clinically improve.

61 Paul's Sp02 levels on 26 September 2019 were recorded as follows: 99% at 12:44am, 97% at 5:48am, 95% at 8:09am, 96% at 4pm, and 96% at 11:23pm.

62 At approximately 5:45am, Paul complained of right side flank pain. Panadol was administered with good effect.

63 At 8:38am, Dr Hosni noted that Paul was feeling and looking much better, however still had 'spiking temperatures', his blood tests indicated an

inflammatory process occurring and his chest x-ray showed some small areas of collapse.

64 On **27 September 2019**, Paul's Sp02 level was 97% at 5:43am, and 95% at 8:08am.

65 At 8:49am, Paul was discharged from Hay Hospital. The discharge note indicates Paul had 'CAP' (community acquired pneumonia) and he had improved, and that the plan was for him to be discharged on 'Augmentin DF' and Doxycycline, for review by a GP for follow-up blood testing on the Monday (30 September 2019) and for review at the Hospital ED as required.

66 Dr Hosni stated:

> [Paul] improved on 27/09/2019 and was asymptomatic. His observations were all within the normal range particularly his temperature, heart rate, blood pressures and his respiratory rate. He was discharged on oral antibiotics (Augmentin Duo Forte and Doxycycline) and was asked to present to Hay Medical Centre on 30/09/2019 for repeat blood tests and clinical review. He was also asked to present to the emergency department should his symptoms recur.

67 In his statement Leo refers to an undated hospital admission of Paul's. It appears, from the content of the statement, that he may be referring to the 23 – 27 September hospital admission.

68 Leo stated:

> My mum did say to me that Paul was not getting [sic] and was concerned that he may have Q fever and not been tested for it. She said that she had spoken with staff at the hospital but that nothing had been done about it.
>
> I think Paul was in Hospital for about 7 days and he spent all that time at Hay … When he was released from hospital, he was not given any medication or anything.
>
> When Paul was home I went and saw him and could see that he was still unwell. He looked grey and he was coughing up blood. I could see that he had lost a lot of weight … he didn't do anything around the house he pretty much stayed on the couch.

Attendance at Hay Medical Centre on 30 September 2019

69 On **30 September 2019**, Paul was seen by Dr Hosni at Hay Medical Centre. Dr Hosni stated that Paul 'was doing very well', his observations were normal, and he was asymptomatic.

70 Dr Hosni diagnosed Paul with nicotine dependence and resolving CAP. Paul's lungs were clear on examination, he had a normal respiratory rate and his Sp02 was 99%. He recommended nicotine replacement therapy. No further follow-ups were arranged.

Events in the community in October 2019

71 Leo stated that while at his house on 6 October 2019, Paul was unwell, had a coughing fit and passed out, although he regained consciousness essentially immediately.

72 Louwesie told Paul to return to hospital to be checked, however Paul did not want to do that and said he would attend the doctor's surgery when it reopened[18].

Presentation to Hay Medical Centre on 9 October 2019

73 On **9 October 2019** at approximately 5:12pm, Paul attended Hay Medical Centre and was seen by Dr Hosni.

74 The progress note provides Paul had shortness of breath on exertion and was reporting 'he had haemoptesis[19] [sic]'. The treatment plan was for:

> Referred for Hay hospital to r/o PE.
>
> Can be recurrent pneumonia.
>
> Will need a CTPA.

[18] As this was a long weekend, he did not attend Hay Medical Centre until Wednesday 9 October 2019.
[19] Coughing up blood from your lungs or airways.

75 Dr Hosni stated his differential diagnosis was 'pulmonary embolism [(**PE**)] and a recurring pneumonia'. He was reportedly concerned that Paul's symptoms had recurred, with coughing of blood this time, which is a 'red flag for pulmonary embolism.'

76 Dr Hosni referred Paul to Hay Hospital for 'urgent investigations to rule out a pulmonary embolus as a differential diagnosis'.

77 Significantly, a PE could not be ruled out at Hay Hospital as it was not possible for a CTPA to be performed. Further, Dr Hosni's notes taken at the Hay Medical Centre were not available to those subsequently caring for Paul at Hay Hospital.

Admission to Hay Hospital from 9 to 17 October 2019

78 On **9 October 2019**, Dr Hosni admitted Paul to the Hospital.

79 Dr Hosni was not aware of the existence of Aboriginal Liaison Officers (**ALO**) during Paul's admission, and (to his knowledge) hospital staff did not notify an ALO of Paul's admission.

80 Paul's observations were taken at 6:10pm: temperature 38.1°, heart rate 102, respiratory rate 32 and Sp02 95%.

81 RN Warren noted that Paul was increasingly unwell and using accessory muscles to breathe.

82 Dr Hosni reviewed Paul. He considered that Paul was suffering from CAP. Paul was admitted and prescribed Caftriaxone[20] [sic] 1 gram daily, Doxycycline 100 mg BD, nicotine patch, Venous Thromboembolism prophylaxis, chest physiotherapy, a chest x-ray on the Tuesday (15 October 2019), and blood tests including blood cultures.

83 In his supplementary statement, Dr Hosni said:

[20] Likely Ceftriaxone, an antibiotic.

Upon my review of the medical records, it appears that my concern about ruling out a pulmonary embolism, which had been documented in the Medical Centre records, is not reflected in the Hospital records.

Given the passage of time, I cannot now recall precisely why I did not document in AH-7 my concern about ordering a CTPA to rule out a pulmonary embolism.

One possibility is that between 5.12pm (when I saw Mr Harris at the Medical Centre) and 6.28pm (when he was admitted to the Hospital). I did not recollect my earlier concern about pulmonary embolism. I cannot now recall definitively but it is likely that I did attend on other patients either at the Medical Centre or the Hospital after seeing Mr Harris at 5.12pm and before re-examining him at 6.28pm. The medical records of the Medical Centre are not available at or accessible from the Hospital.

It is also possible that upon re-examining Mr Harris at the Hospital at about 6.28pm, his presentation and blood test results were more consistent with an infective process such as pneumonia, tuberculosis or an atypical pneumonia.

On reflection, I think it is more likely that upon re-examining Mr Harris at the Hospital at 6.28pm, I considered that his presentation was more consistent with an infective process, because:

(i) He was not experiencing any symptoms which would suggest he was suffering from lower limb thrombosis, such as swollen legs or leg pain; and

(ii) He was febrile at 38.1°C and experiencing chills and rigors.

From reviewing Mr Harris' medical records, there were other features of his presentation throughout his admission between 9 and 14 October that in my mind were more consistent with an infective process than a pulmonary embolism, including:

(i) A previous admission for community acquired pneumonia;

(ii) Mr Harris was spiking temperatures up to 38.9°C;

(iii) Mr Harris had shortness of breath and haemoptysis, both of which can be associated with a chest infection;

(iv) Mr Harris' white cell count was elevated, at 14.1 (3.7 - 9.5) with a predominant neutrophilia on 9/10/2019 which is consistent with an infective process;

(v) Mr Harris had elevated CRP levels, which is consistent with an infective process.

(vi) Mr Harris was spiking temperatures, as referred to in my answer to Question 7 below.

84 Dr Hosni's evidence during the hearing was that after assessing Paul at the Hospital, he changed his mind, and at that stage he did not think that Paul had a PE. Dr Hosni said that he thought it was more likely Paul had pneumonia

because of his other symptoms such as chills and rigors. Dr Hosni noted that hemoptysis occurs in many conditions other than PE, such as pneumonia.

85 At 6:31pm, Dr Hosni conducted a VTE[21] risk assessment and Paul was deemed to be at 'moderate' risk.

86 Dr Hosni's statement refers variously to the differential diagnosis being 'pulmonary embolism and a recurring pneumonia' or to it being 'unresolving pneumonia'.

87 Paul's observations were taken by nursing staff and his temperature was 38.5°. Dr Hosni felt the diagnosis was more likely to be a recurrence of pneumonia, and as a result, an ECG was not indicated.

88 Dr Hosni commenced DVT prophylaxis therapy with subcutaneous Clexane (an anticoagulant medication).

89 At 7:44pm, Paul's Sp02 was 95%.

90 At 8:15pm, RN Warren completed an admission risk assessment. Paul was estimated to weigh 112 kg and be 170cm tall, with an estimated BMI of 38.8.

91 RN Warrren noted Paul had been increasingly unwell: he had SOB on exertion, CAP two weeks prior, and was coughing up blood that morning.

92 On **10 October 2019**, at 8am and 5:40pm, Paul's Sp02 was 95%.

93 There are no records indicating that Paul was seen by a doctor between 10 and 13 October 2019. However, Dr Arshed said he was the on-call doctor for most of that period and having reviewed his pay slips he believes he did attend upon Paul, he just did not record his observations as he ought to have done.

[21] Venous Thromboembolism.

94 On **11 October 2019** at 12:03am, Paul's Sp02 was 97%.

95 At 6:25am on 11 October 2019, EEN Everett recorded that Paul was febrile at the commencement of the shift but declined paracetamol when offered, his temperature had 'dropped to 37.8°', he felt fine and he felt that his current treatment was working.

96 At 7:59am, Paul's Sp02 was 95% and at 7:14pm it was 96%.

97 On **12 October 2019** at 3:15am, Paul's Sp02 was 95%.

98 At 3:56am, RN Bautista entered a progress note indicating that Paul was afebrile, he complained of mild SOB, he felt better when placed in an upright position, and he had been informed to use the call bell if his SOB increased.

99 At 8:34am, Paul's Sp02 was 96%.

100 At 3:48pm, Paul's Sp02 was 95%. At 3:57pm, RN Tuohey noted that Paul's observations were 'between the flags', he had SOB on exertion, and he had a low grade fever (37.8°).

101 On **13 October 2019** at both 5am and 8:16am, Paul's Sp02 was 95%. At 2:44pm, Paul was complaining of SOB and felt that he was not ready for discharge.

102 At 3:56pm, RN Tuohey noted that Paul had a 'pasty pale skin colour'. She otherwise had no concerns during that shift.

103 During this admission Paul was self-caring and was walking around the hospital in day clothes. RN Tuohey recorded that Paul stated he did have a cough and he reported he was 'very short of breath when ambulant'.

104 At 11:50pm, Paul's temperature was slightly elevated (38.9°). His Sp02 was 95%.

105 On **14 October 2019**, at a time between 3:55am and 6:10am, Paul reportedly stated that he was feeling better that day.

106 At 8:08am, Paul's Sp02 remained at 95%.

107 Dr Hosni saw Paul just prior to handing over his care to Dr Arshed. Dr Hosni recorded at 11:17am:

> Marginal improvement if any.
>
> Pt still indicating he has significant exrtional [sic] SOB. Noticed spike of temp despite the abx.
>
> Chest is not wheezy.
>
> Plan:
>
> > CXR tomorrow please.
> >
> > Bloods tomorrow …
> >
> > Sputum microscopy and acid fast bacilli please, also respiratory viruses screen please.
> >
> > Urine pneumococcal and legionella PCR please.
> >
> > If the CXR is normal or non-specific or equivocal finding, we might consider sending the patient for a lung CT scan.

108 Dr Hosni considered that Paul had not improved to the extent that was hoped. Although his observations were normal, he was reportedly still suffering SOB, and he had spiked a temperature the previous night at around 11pm. Dr Hosni arranged further tests and a chest x-ray. Dr Hosni's diagnostic impression was of ongoing pneumonia, atypical pneumonia, tuberculosis or lung abscess.

109 Dr Hosni stated that:

> With the ongoing fevers and the inflammatory changes in the CXR and the blood results, alternative diagnoses other than pulmonary embolism were more prominent. Moreover, the patient was on [VTE] prophylaxis throughout his admission. However, I thought about there might be something unusual happening hence I made the recommendation for further investigation by my more experienced colleague, Dr Arshed.

110 Dr Hosni was ‘not on’ that day but attended the handover and helped Dr Arshed arrange blood tests and Chest x-rays and made notes. The blood tests included an ‘Atypical pneumonia screen’ including ‘Q fever serology’.

111 Dr Hosni noted that Paul was on empirical antibiotics throughout his illness – the same treatment he would have received if there had been a confirmed diagnosis of Q fever.

112 When he handed over Paul’s care to Dr Arshed, Dr Hosni noted if the CXR was normal, or non-specific, or equivocal finding, ‘we might consider sending the patient for a lung CT scan’. This would require transfer to Griffith Base Hospital. Dr Arshed also referred Paul for physiotherapy.

113 Dr Arshed stated:

> During both admissions Mr Harris was administered prophylactic Clexane daily (enoxaparin 40mg daily) to mitigate the risk of venous thromboembolism in accordance with standard hospital protocol for all medically unwell inpatients with reduced mobility, to mitigate the risk of hospital-acquired venous thromboembolism (VTE). Mr Harris was clinically at risk due to systemic infection, reduced mobility, and smoking history. I did not believe there were clear or escalating features consistent with thromboembolism. I therefore did not believe there were clinical indications for Mr Harris to undergo a CT pulmonary angiogram. Had I been aware of Dr Hosni's outpatient concern for PE or had there been clear or escalating features consistent with thromboembolism, I would have actively considered transfer to Griffith Hospital to undergo a CT pulmonary angiogram to exclude a thromboembolism.
>
> …when I took over Mr Harris' care from Dr Hosni, there was no documented inpatient suspicion of PE, nor did Mr Harris' clinical presentation support this differential.
>
> At the time of my review on 14 October 2019, and when I reviewed Mr Harris during his admission in September 2019, I believed Mr Harris exhibited signs and symptoms consistent with community-acquired pneumonia (CAP) - this included a high-grade fever, productive cough, raised inflammatory markers (notably neutrophilia and CRP elevation).

114 At approximately 4:50pm, RN Tuohey observed Paul. RN Tuohey stated all of Paul’s observations were ‘between the flags’. Paul’s Sp02 was 95%.

115 At approximately 5pm during an evening ward round, Dr Arshed reviewed Paul. Paul reported feeling better and that his SOB had improved. Dr Arshed

continued Paul's management plan, being to continue on IV antibiotics and undergo a chest x-ray the following day.

116 At approximately 10:30pm, RN Tuohey observed Paul with a low grade temperature, an increased pulse rate and an increasing respiratory rate. His Sp02s were slightly higher than previously.

117 RN Tuohey stated Paul's observations were still 'between the flags.' She recorded that Paul remained SOB on exertion, was tachycardic, and he said he was not getting any better. RN Tuohey believes, based on her usual practice, that she would have relayed her concerns and observations to the night staff during the handover at approximately 11pm.

118 On **15 October 2019**, at around 8:54am, Dr Arshed reviewed Paul during a morning round. Paul was feeling much better although still spiking in temperature, he was afebrile with bibasal crepitations[22] in his chest, a chest x-ray was to occur that day, and blood sampling was to be taken for testing the following day.

119 Dr Arshed noted from Paul's observations that he had spiked a low grade fever the previous night (37.5°). In light of that, Dr Arshed changed Paul's antibiotics from Ceftriaxone to Piptaz (a broad-spectrum antibiotic).

120 Dr Arshed had access to Hay Hospital records from Hay Medical Centre and said that he would have reviewed Paul's progress throughout the day.

121 At around 11:44am, Paul had a chest x-ray.

122 At 1:46pm Paul's Sp02 was 90%. At around that time, NUM Charles called Dr Arshed and advised of the reduced oxygen saturation but also that Paul reported feeling well and not experiencing any SOB on rest. Dr Arshed advised NUM Charles to change Paul's PACE[23] criteria to 90% for 8 hours, and to check

[22] Abnormal breathing sounds.
[23] Patient and carer escalation.

Paul's observations again in 2 hours and update him[24]. In his oral evidence Dr Arshed explained that he did not want to give Paul oxygen as this would prevent him from monitoring to determine whether his saturation levels were improving or deteriorating.

123 At 2:01pm, a 'BTF Altered Calling Criteria/Frequency' note recorded by NUM Judith Charles provides that as authorised by Dr Arshed, altered calling criteria for Paul was in place from 15 October 2019 at 2:01pm, to be next reviewed on 16 October 2019 at 2:01pm. The 'Rationale for Altered Calling Criteria' was recorded as: 'Known lung disease'. The 'Prescribed Frequency of Obs' was recorded as '4 hourly'. The 'Rationale for Frequency of Observations' was recorded as: 'Monitor temp & O2 ats'. This note records the altered SpO2 ranges as being: 0-85 (red zone bottom range); 86-87 (yellow zone bottom range); and 88-100 (normal range).

124 Dr Arshed stated in relation to the altered calling criteria:

> Between 9 to 17 October, I was only informed once on 15 October 2019 of the patient being in the yellow zone.
>
> On 15 October at 13:46, Paul's oxygen saturation dropped transiently to 90%. I temporarily adjusted the calling criteria threshold to 90%, based on:
>
> i. His baseline saturation of ~94-95% as a chronic smoker; and
>
> ii. His clinical stability and reported lack of increased dyspnoea at rest.
>
> The clinical intent of the altered calling criteria was to observe the trajectory of his oxygenation over the ensuing hours **without the administration of supplemental oxygen,** in order to ascertain his true physiological status. This approach was taken to determine whether his condition was spontaneously improving or deteriorating. By contrast, had the calling criteria remained unchanged and supplemental oxygen been commenced immediately, it would have obscured this assessment by potentially masking early signs of deterioration.
>
> …
>
> This adjustment was temporary and was carefully monitored.

[24] When a patient is in the yellow (or red) zone, nursing staff need to inform the doctor of the abnormal vital sign and request clinical review of the patient. If the physician determines the observations are normal or expected in the clinical scenario, they may consider altering the calling or review criteria.

125 At 3:09pm, NUM Charles recorded ‘O2 sats 88-90% RA. Dr Arshed aware for ACC for 24 hours.’ Paul’s observations were at times in the red zone, and his ‘calling criteria’ had been altered.

126 At 4:07pm Paul’s Sp02 was 92%. Dr Arshed was telephoned by nursing staff regarding this.

127 During the evening ward round, Dr Arshed reviewed Paul. He did not record any notes. He made no change to Paul’s management plan and noted that Paul’s condition had not changed.

128 Dr Arshed noted that the chest x-ray had not been performed and the radiographer was scheduled to attend Hay Hospital the following day (Wednesday, 16 October 2019).

129 On **16 October 2019** at 2:27am, Paul’s Sp02 was 90%. While this was outside the acceptable range it was within the ‘white’ based on the altered calling criteria.

130 RN Tuohey assumed care of Paul at 7am. During the morning ward round, she recalled hearing deep respirations as she entered Paul’s room, and he continued to display SOB on exertion.

131 At around 7am, Dr Arshed briefly reviewed Paul. Dr Arshed’s progress note records ‘Doing well / Nil fever overnight / Feeling much better / SOB has settled’ and that the plan was for blood to be taken for testing that day.

132 Paul expressed a desire to go home and said he was feeling much better. Dr Arshed considered that Paul would benefit from 2 to 3 additional days of IV antibiotics and close observation.

133 At around 8:23am, Paul’s Sp02 was 92%. RN Tuohey recorded at 8:30am that his Sp02 was fluctuating between 90-94%.

134 Paul said that his breathing was ‘not right yet’ and that he had a productive cough. RN Tuohey recorded: ‘audible deep respirations, from doorway, SOBOE’.

135 RN Tuohey discussed Paul with Dr Arshed stating:

> To the best of my recollection, I said to him that the patient was still not progressing and I was not happy with the level of his oxygen saturations. We discussed the possibility of Q fever as a diagnosis. We queried whether the patient could have picked it up because of his work as a kangaroo skinner. I asked Dr Arshed if we could add the Q fever test to his bloods and he agreed. I recall during that discussion Dr Arshed said he was planning to discharge Paul, not that day, but after bloods and other tests had been performed.
>
> During my conversation with the doctor, I suggested Paul could be transferred to Griffith Base Hospital if he was not getting any better.

136 Dr Arshed stated:

> I do not recall any nursing staff recommending or initiating Q fever testing. As noted in the medical records, I took the blood and ordered the atypical serology on 15 October 2019 at approximately 5.30pm (prior to the discussion RN Tuohey has referred to in her statement). The bloods could not go to the lab until the morning of 16 October 2019.

137 At approximately 10:45am, a sample was collected from Paul for virology testing. The results of that testing indicated ‘current or recent Q fever infection’.

138 At 11:02am, Paul was seen by physiotherapist, Russell Alexander who documented a plan for referral for spirometry (a breathing test) and to continue using the ‘Active Cycle of Breathing Technique’ as well as another physiotherapy tool.

139 At 11:29am, Paul’s Sp02 was 94%.

140 After 11:29am Dr Arshed noted Paul’s Sp02 taken at 7am that day by nursing staff had returned to baseline at 94%, and that per the observations, Paul had not spiked any temperature after changing IV antibiotics.

141 At approximately 12:34pm, RN Tuohey noted that blood had been collected and Q fever testing had been added as a test to be performed.

142 RN Tuohey also noted Paul's Sp02 had increased to 96% when walking with the physiotherapist.

143 At 4:08pm, Paul's peripheral pulse rate was 122 bpm and his Sp02 was 92%.

144 While Paul underwent a chest x-ray on 15 October 2019, the report was prepared at 4:46pm on 16 October 2019 as follows:

> Clinical indication:
>
> LRTI [Lower respiratory tract infection]
>
> Findings:
>
> Lungs are hyperinflated with coarsening of bronchovascular markings favouring COAD changes. Superadded infective/inflammatory changes cannot be entirely ruled out. Bilateral basal atelectatic changes seen with the suspicion of an effusion on the right side. Patchy consolidation seen involving the right lower zone favouring infective/inflammatory aetiology which is a new finding since the previous radiograph from 24/09/2019. Stable bony thoracic radiographic appearances and cardiomediastinal contour.

145 That afternoon, Dr Arshed reviewed the x-ray and reviewed Paul briefly. Dr Arshed verbally advised Paul of the chest x-ray results[25].

146 Dr Arshed stated Paul's x-ray showed a hyperinflated lung consistent with COPD[26] and 'patchy consolidation in the right lower zone, favouring infective/inflammatory changes.'

147 Dr Hosni stated that the x-ray results 'showed patchy consolidation seen involving the right lower zone favouring inflammatory/infective changes which were new since the CXR from 24 September'.

[25] Dr Arshed recorded notes of this review later in time, the following day (being the day of Paul's death).
[26] Chronic Obstructive Pulmonary Disease.

148 Expert vascular surgeon, Associate Professor Anthony Grabs stated in his expert report:

> [Paul's] second chest x-ray was on 16 October 2019 [*or perhaps more accurately the 15 October 2019 x-ray] and in retrospect, the findings in the right lower lobe on chest x-ray represented pulmonary infarction secondary to pulmonary embolism. The treating physicians may have interpreted this x-ray as evidence of a right lower lobe pneumonia, which they were treating appropriately. It would be important to seek an expert opinion from a respiratory physician as to the interpretation of the chest x-ray in the context of his admissions.
>
> The lack of availability of a chest x-ray, as a simple investigation to manage chest infections may have hindered treating physicians in confirming suspected diagnoses.

149 That evening, Paul's blood test results were available. Dr Arshed's impression at that time was that the blood test and chest x-ray results 'confirmed the suspected diagnosis of CAP' and he explained that to Paul.

150 Dr Arshed planned for Paul to continue physiotherapy and IV antibiotics and await the atypical serology results, which usually take five to seven days to be returned.

151 At 11:49pm, Paul's Sp02 was 94% and his respiratory rate was 25 bpm.

Paul's death

152 On **17 October 2019** RN Warren had taken over Paul's care at 11pm the previous night. At 5:54am she noted that Paul was awake for most of the night, with a persistent cough.

153 Between 7am and 7:15am, Paul's care was taken over by RN Sandow and CNE[27] Jubb. CNE Jubb's progress note, completed later in time, records that Paul had been admitted with '? pneumonia, currently on IVABs though clinically not improving throughout admission'.

[27] Clinical Nurse Educator.

154 Paul was seen by RN Sarah Sandow and CNE Jubb during a morning ward round. AIN Murphy accompanied those nurses on a walk around the ward to greet each patient. Paul spoke to those three nurses.

155 AIN Murphy stated:

> I believe that I said good morning and asked if he was feeling any better. He said not really. I remember I told him he should give up smoking and I said we would catch up later.

156 At approximately 7:52am, during the ward round, CNE Jubb recorded observations of Paul in the electronical medical record ('eMR'), which she generally does contemporaneously on a computer wheeled between patients.

157 There were two vital signs within the yellow zone, namely a high respiratory rate and low Sp02 (at 93%). As such, there were two alerts in the eMR which required CNE Jubb to take action before the alert would close.

158 Not long afterwards, (at around 7:45am) Dr Arshed attended Paul's room during his morning ward round, whilst RN Sandow and CNE Jubb were still present and CNE Jubb was assessing Paul.

159 RN Sandow stated:

> I recall Paul was sitting upright in the chair and speaking in full sentences. Dr Arshed mentioned discharge in a few days and I recall Paul seemed to be unsure about it.

160 CNE Jubb stated:

> Dr Arshed asked Paul how he was feeling about going home. Dr Arshed said that Paul might get a CT scan after discharge as an outpatient. CNE Jubb discussed with Dr Arshed that Paul was in the yellow zone.

161 Dr Arshed's note (recorded retrospectively at 9:18am) records:

> 'S/
>
> State feeling much better

> Nil fever for last 3/7
>
> State still little bit of SOB but has this for last 06 months but it is improving Nil chest pain
>
> OE:
>
> Afebrile, Sats 93% on RA
>
> Chest: Bilateral equal entry, Bibassal [sic] crepitations CVS: Dual HS…
>
> Plan:
>
> Continue with IV Abs
>
> Spirometry today
>
> Likely discharge on Sat
>
> Will do CT Chest on discharge to rule out any occult Abscess. Bloods today'.

162 Dr Arshed stated:

> At or around 8am on 17 October 2019, I reviewed [Paul]. …
>
> On examination, [Paul] was afebrile, and his chest showed Bi-basal crepitation. His oxygen saturation was noted to be 94% (at 11.49am on 16 October) and 93% (at 7.52am on 17 October).
>
> I again discussed [Paul's] CXR with him and explained to him the patchy consolidation, which demonstrated to me a likely diagnosis of community acquired pneumonia and COPD. I also explained to [Paul] that, as he did not have a recurrent fever, we had ordered atypical serology and I explained that I would like him to have a chest CT performed to rule out any occult abscess.
>
> As the hospital does not have a CT machine, we planned to transfer [Paul] to Griffith Base Hospital to undergo the CT scan at the time of his discharge.
>
> We tentatively planned for discharge in 3 days' time, subject to improvement of [Paul's] clinical condition'.

163 Once the nurses and Dr Arshed left Paul's room, CNE Jubb told Dr Arshed that she 'did not think [Paul] was appropriate for discharge home on Saturday as he was not improving' and she suggested since Paul was not improving, he be transferred for the CT scan as an in-patient.

164 CNE Jubb said that Dr Arshed was happy to continue with the current management plan which was to continue with intravenous antibiotics and the

plan for spirometry testing the same day to determine the cause of his shortness of breath.

165 Approximately 30 minutes after seeing Paul, RN Sandow was with CNE Jubb at a desk when she heard the 'normal patient call bell'. RN Sandow and CNE Jubb both responded to the call as soon as they heard it (at 8:38am, within 1-2 minutes). RN Sandow was the first to walk into Paul's room.

166 CNE Jubb said Paul 'was walking out of the shower cubicle and he was grey, sweaty, confused and agitated'. They provided reassurance and helped him get onto the bed. CNE Jubb's retrospective progress note also says Paul was feeling very short of breath and he stated, 'I'm dying'.

167 RN Sandow stated: 'Paul was sitting on the bed. He had just come out of the shower and was having difficulty breathing'. Her retrospective progress note also indicates Paul was pale, diaphoretic (sweating excessively), '[u]sing accessory muscles' (to breathe) and '[t]alking in short sentences'.

168 RN Sandow stated she told CNE Jubb that they should give Paul oxygen. CNE Jubb collected a defibrillator and oxygen mask from the ED as they were not in the room, and NUM Jubb followed her back with a trolley[28].

169 RN Sandow stated: 'Paul was agitated and when CNE Jubb returned with the oxygen mask he kept pushing it away'. CNE Jubb states that on her return, Paul was 'agitated and combative' which she notes is a sign of hypoxia (insufficient oxygen).

170 CNE Jubb pressed the staff assist/emergency call button to get more help.

171 Further nursing staff attended Paul's room, including:

[28] The trolley is the hospital's 'crash cart' which was able to be retrieved from Paul's room in moments.

(1) EEN Gardiner who ran approximately 75 metres to Paul's room (room 5) and acted as a scribe.

(2) AIN Murphy who noted Paul was sitting on the bed and wearing an oxygen mask. She tried to reassure him and observed that he was grey.

(3) RN Tuohey who noted Paul was sitting up in bed and still conscious however was starting to become cyanosed.

172 Dr Arshed stated that shortly prior to 8:40am, he received a call while he was at Hay Medical Centre. He was advised that Paul had suddenly become very short of breath walking back from the bathroom and was sitting on the side of the bed. Dr Arshed immediately went to review Paul, who was sitting on the side of the bed. Paul went into cardiac arrest within approximately 45 seconds of his arrival and whilst he was placing an oxygen mask on Paul. Dr Arshed commenced CPR and requested nursing staff urgently request assistance from Dr Hosni. At approximately 9:00am, Dr Hosni was requested to urgently attend the hospital to assist with resuscitation.

173 When Dr Arshed arrived, he assumed clinical leadership of the emergent resuscitative efforts. Once Dr Hosni arrived, Dr Arshed assigned roles, with Dr Hosni assisting to manage Paul's airways. [29] Paul was unconscious when Dr Hosni arrived.[30]

174 RN Sandow stated that soon after CPR started, Dr Hosni and Dr Arshed arrived. Others also attended, including RN Bautista (whose role related to medication), RN Tuohey (responsible for airway assistance, along with AIN Murphy), and NSW Ambulance Service paramedics Dean Smith and Glen Everett. Those paramedics were in their office, which is located within Hay Hospital, when they received a call from the hospital requesting assistance.

[29] Tab 13A, Supplementary statement of Dr Muhammad Arshed, [12.d]-[12.e].
[30] Tab 12A, Supplementary statement of Dr Ahmed Hosni, [82]-[83].

175 RN Bautista administered adrenaline.

176 Dr Hosni checked the airway tube was in the correct position as Paul aspirated.

177 At or around 8:42am, Dr Arshed commenced ‘advanced cardiac life support’.

178 Dr Hosni intubated Paul.

179 Dr Arshed stated:

> Point-of-care biochemical analysis demonstrated no acutely correctable abnormalities, with potassium measured at 4.6 mmol/L, bicarbonate at 19 mmol/L, and an anion gap of 21. Unfortunately, no return of spontaneous circulation (ROSC) was achieved, and Mr Harris' terminal rhythm remained asystolic throughout.

180 Dr Arshed stated:

> After 24 minutes of sustained resuscitative intervention, and following collective deliberation among the medical and nursing team, the decision was made to discontinue efforts at 09:04 hrs. All reversible causes-outlined within the established "4 Hs and 4 Ts" algorithm-were systematically evaluated and excluded.

181 At about 9:04am, a decision was made to cease CPR.

182 At an unrecorded time, CNE Jubb completed a Verification of Death form.

183 At approximately 9:05am, once resuscitation attempts were ceased, Dr Arshed requested that NUM Tracey Jubb contact Paul’s family.[31] NUM Tracey Jubb also, as suggested by the Cluster Manager, called the Aboriginal Manager for the MLHD who arranged for two support workers to travel to Hay to support Mr Harris’ family.

[31] Tab 25, Hay Hospital records, p. 220; see also, Tab 12, Statement of Dr Ahmed Hosni, p. 9.

184 At 9:24am or 11:06am, Dr Arshed completed a note, providing that Paul had a sudden onset of SOB after coming out of a shower, was very pale, stated he could not breathe, and suddenly stopped breathing.

185 A number of nursing notes were entered retrospectively after Paul's death.

Events following Paul's death

186 Paul's partner stated that after they left Hay Hospital, Dr Arshed called (on Paul's phone) and said that he would be willing to sign a death certificate for Paul saying he had died of a heart attack and that it would save the family a lot of 'drama', however she refused. Dr Arshed denies that conversation occurred. He says they had a discussion regarding an autopsy.

Autopsy report and toxicology results

187 Dr Harding performed an autopsy on 7 November 2019. He opined that the cause of Paul's death was bilateral pulmonary thrombo-emboli. The conditions of obesity, coronary atherosclerosis and cardiomegaly reportedly contributed to the death.

188 At autopsy, Paul's weight was 114 kg and his height was 177cm.

189 The autopsy report also noted the following:

(1) Macroscopic and microscopic examination showed bilateral fixed pulmonary thromboemboli in the left and right main pulmonary trunk, and multiple small thrombo-emboli in the distal pulmonary vasculature of the right and left lung. The deceased had a number of risk factors for pulmonary thrombo-embolus including obesity, prolonged bed rest, smoking and heart disease.

(2) Examination at autopsy also showed 'a right lower lobe pulmonary infarct with an associated pleural effusion', which is 'an uncommon finding as each lung has a dual blood supply'.

(3) The heart was enlarged (cardiomegaly). The report provides: '[c]ardiomegaly is independently associated with an increased risk of sudden death due to sudden rhythm disturbance (arrythmia)'. The heart showed 'concentric left ventricular hypertrophy and a thickened intraventricular septum'.

(4) Paul was obese (class III), with a BMI of 36.4 kg/m^2. The report states '[o]besity infers a high relative disease risk, particularly cardiovascular diseases with an increased risk for coronary artery atherosclerosis'.

(5) Post-mortem radiology results were in keeping with sustained CPR, with anterior rib fractures.

Toxicology

190 The post-mortem toxicology testing did not detect any alcohol or other drugs.

191 The autopsy report does not refer to Q fever. It also does not refer to the virology testing results arranged by Hay Hospital which detected a recent or current Q fever infection as of 16 October 2019 In his letter dated 26 March 2025, Dr Harding explained that the virology results were not included in the medical records provided to him prior to completion of the post-mortem report. He also confirmed that post-mortem virology testing was not undertaken.

Analysis of the relevant issues

Issue 1: What factors caused and/or contributed to Paul's death?

192 I accept the opinion of Dr Harding and find that Paul died of bilateral pulmonary thrombo-emboli. The conditions of obesity, coronary atherosclerosis and cardiomegaly reportedly contributed to the death.

193 I also find that Paul's PE *may* have been capable of detection if he had been transferred to Griffith Base Hospital where a CTPA could have been carried out during his admission from 9 October 2019.

Issue 2: If and when did Paul have Q fever and did that cause or contribute to his death?

194 I accept the opinion of A/P Hudson to the effect that Paul had Q fever, from at or around 16 September 2019. This is consistent with his virology serology report of 16 October 2019 reflecting a current or recent Q fever infection.

195 A/P Hudson gave persuasive evidence to the effect that there is a connection between Q fever and the risk of thrombosis which is not widely known.

196 The evidence does not allow a finding as to whether earlier treatment of Q fever could have reduced Paul's risk of PE.

197 The evidence indicated that the earliest consideration of Paul's risk of Q fever was identified at Hay Hospital on 14 October 2019 when the special pathology tubes were ordered. Given Paul's work history, his risk should have been identified earlier.

198 Paul was prescribed Doxycycline from 24 September 2019 which A/P Hudson indicated was the appropriate treatment for Q Fever. If Paul had consumed what he was prescribed, it is likely his infection would have resolved by the time of his October 2019 admission. Accordingly, while it is possible that Q fever had a part to play, the evidence does not support a finding that Q fever contributed to Paul's death.

Issues 3 and 4: Did Paul have pneumonia? What connection (if any) was there between the pulmonary thrombo-emboli, Q fever and pneumonia?

199 The expert evidence in relation to this issue is not consistent.

(1) A/P Flecknoe-Brown initially considered that Paul had an infective exacerbation of chronic COPD (**IE-COPD**) which he considered had a strong connection with Paul's subsequent death from PE[32]. In his oral

[32] Tab 56 Report of A/Prof Flecknoe- Brown 8 July 2025, p. 7 [5].

evidence, A/P Flecknoe-Brown indicated he would defer to Professor Yee, as a specialist in the field.

(2) Professor Yee considered that it was 'highly likely' that Paul had pneumonia[33] during his September 2019 admission though he would have liked to have seen changes on the chest x-ray consistent with a pneumonia and clinical findings on examination to form a concluded view.[34]

(3) Professor Yee also considered that, during the admission from 9 to 17 October 2019, there may have been a pneumonia, based on his history and assessment, however, his post-mortem did not confirm obvious consolidation (pneumonia) and bilateral PE was seen.[35]

(4) Professor Yee indicated that, for the October 2019 admission, the assessment performed by the medical practitioners suggested that there may have been a recurrent pneumonia, but that this would have been a little unusual in the context that Paul had been on a pretty broad-spectrum antibiotic in the first admission in September 2019.

(5) Professor Yee considered that, based on Paul's pathology results, it was difficult to untangle the connection between Q Fever, pneumonia and the risk of PE.[36]

200 I find that Paul had pneumonia during his September 2019 admission and while he may have had a recurrent pneumonia during his October admission, it is more likely that his pneumonia had been successfully treated with antibiotics such that his October 2019 presentation was because of the PE.

[33] Transcript 25 August 2025, p. 254, lines 2 to 3.
[34] Transcript 25 August 2025, p. 254, lines 3 to 6.
[35] Tab 60 Report of Professor Brendan Yee 20 July 2025, p.3 [3].
[36] Transcript 25 August 2025, p. 255, lines 16 to 22.

201 I am unable to make a finding on the evidence as to what contribution, if any, the September 2019 pneumonia had to his death caused by a PE.

Issue 5: Did Paul's place of work have an adequate system in place as at 2019 to ensure workers were vaccinated for, or otherwise immune to, Q fever?

202 Lachlan Rivett provided a written statement and gave oral evidence on behalf of Paul's employer, Stokari. However, his evidence was limited in that the primary person who was addressing matters relevant to Q fever exposure, employees and dealings with SafeWork NSW was Ashley Neill who passed away in 2022.

203 Rivett asserted that Neill was responsible for the management of the knackery where Paul was employed. Further, Neill was responsible for maintaining employees' records, including all Health and Safety records.

204 On 24 January 2020 Barber of SafeWork spoke to Neill. Neill is reported to have said that he would look back through his diary, however he believed that Paul may have been immunised a couple of years back. He alleged that all workers at the Abattoir have either been immunised or have previously been Q fever positive. He added that the company did not keep a register to that effect, however he would 'get something underway.'

205 Susan Howie (a SafeWork NSW inspector) visited the Hay workplace on 5 February 2020. She met with Neill to assess compliance with Work Health & Safety laws. Howie enquired if the company had a system in place for the control of Q fever exposure in the workplace. Neill presented Howie with a Q fever register that had the names of the nine employees on it.

206 Rivett said that Howie issued an Improvement Notice (S191) numbered 7-369869 which, Rivett maintained, Neill dealt with[37] and SafeWork considered the Improvement Notice to have been complied with. Rivett's best

[37] Documents produced by Stokari (VIC) Pty Ltd[37] identified that David Preece (on behalf of Stokari) had forwarded to Howie a file with Q fever procedures in response to the Improvement Notice on 20 February 2020.

understanding in oral evidence was that Neill had a Q fever register on-site at all times.

207 Rivett indicated that Stokari currently requires new employees to provide evidence that they have been vaccinated against Q fever, or that they have previously tested positive for Q fever. He says that if the status is unknown, the employee is requested to present to the local hospital for a Q fever test.

208 The evidence therefore suggests that those Q fever procedures were in place, at least as at 20 February 2020.

209 The evidence could not readily satisfy or establish that those Q fever procedures were also in place as at September and/or October 2019 or at any time since receipt of an earlier Improvement Notice in 2014.

210 SafeWork NSW also articulated that it did not conduct any investigation into Paul's death specifically. It acknowledged, however, that it did make inquiries with the kangaroo processing plant at the premises into the policies and procedures used by those conducting the business to ensure the control of Q fever amongst its workers.

211 It is submitted that whilst there is evidence from Rivett that a Q fever register would have been in place at the time of Paul's employment, no such register was produced which included Paul's name on it. The Q fever register produced appeared to have been dated '2020'. No such register was produced which reflected the names of employees working at the premises in 2019.

212 There is no evidence that confidently establishes that Q fever procedures provided on behalf of Stokari to SafeWork NSW on 20 February 2020 were actually in place and followed in September or October 2019.

213 A/P Hudson considered Stokari's current policy acceptable depending on what the local Work Health & Safety guidelines state.

214 I cannot find on the evidence adduced that Stokari had an appropriate system in place to manage the risk of Q fever at the time of Paul's death. However, the evidence indicates that they have had a system in place from at least February 2020 to date.

Issue 6: Was Paul vaccinated for Q fever and/or had he previously had Q fever as at the time he commenced working for his place of work? Were any checks conducted by his place of work to ascertain that, or should they have been?

215 I am unable to make a finding on the evidence whether Paul was vaccinated for Q fever or whether he had a previous infection at the time he commenced work at Stokari.

216 I am unable to make a finding on the evidence as to whether any checks were conducted by Stokari to determine whether Paul had been vaccinated or whether he had a prior infection before commencing his employment with Stokari.

217 While there was no legal obligation on Stokari to offer or provide Paul with a Q fever vaccination, it had a general obligation to ensure Paul's health and safety which, according to A/P Hudson could have been discharged by offering a vaccination and reducing exposure.

Issue 7: Was any response by Paul's place of work to the improvement notice issued as a result of the SafeWork investigation adequate?

218 Given the absence of further intervention from SafeWork, I conclude that Stokari's response to the Improvement Notice dated 6 February 2020 was adequate.

Issue 8: With respect to Paul's admission and various presentations at Hay Hospital and Hay Medical Centre from 16 September 2019 to 2 October 2019, was the care and treatment provided to Paul reasonable, appropriate and in accordance with any applicable policies, procedures and guidelines?

Was Q fever considered as a diagnosis by hospital staff? Should it have been (and if so, when)?

219 I am unable to make a finding on the evidence that Q fever was considered as

a diagnosis by staff of Hay Hospital during the period from 16 September 2019 to 2 October 2019.

Should Paul have been admitted to Hay Hospital when he presented on 16 September 2019?

220 I find that the evidence did not suggest that Paul ought to have been admitted to Hay Hospital on 16 September 2019.

Was Paul's reported abdominal pain on 24 September 2019 and flank pain on 26 September 2019 appropriately investigated by the relevant doctor/s? Was that pain caused by a pulmonary embolus?

221 A/P Grabs considered that the working diagnosis from 23 to 27 September 2019 was that of Paul likely having CAP which was treated appropriately.

222 A/P Hudson considered that Paul's management was in accordance with accepted practice of infectious diseases, except for the fact that the diagnosis of Q fever as the cause of his febrile illness with pneumonia was not considered until his last admission, with the blood for Q fever serology only being collected on 15 October 2019.

223 A/P Flecknoe-Brown considered the September admission was managed entirely appropriately and in accordance with applicable policies, procedures and guidelines.

224 A/P Grabs referred to the events of 26 September 2019 when there was a nursing note that Paul had developed right flank pain which settled with paracetamol. He considered there is a remote possibility that this pain may have been pleural, either due to infection or a PE with earlier ischemia of the lung.

225 I find that Paul's management from 16 September 2019 to 2 October 2019 was in accordance with accepted practice of infectious diseases, except for the fact that the diagnosis of Q fever as the cause of Paul's febrile illness with pneumonia was not considered until his last admission.

Issue 9: With respect to Paul's final admission to Hay Hospital from 9 to 17 October 2019, was the care and treatment provided to Paul reasonable, appropriate and in accordance with any applicable policies, procedures and guidelines?

Should a CTPA have been performed for Paul, in circumstances where he was admitted to hospital for urgent investigations to rule out a pulmonary embolus and for a CTPA? Why was he not transferred to another hospital for that to occur?

226 Dr Hosni's evidence in relation to 9 October 2019 was that at Hay Medical Centre, a brief history was taken from Paul. His actual assessment of Paul didn't take place until Paul attended Hay Hospital. After assessing Paul at Hay Hospital, he did not think that Paul had a PE. Dr Hosni thought it was more likely that Paul had pneumonia because of his other symptoms such as chills and rigors.

227 Both Dr Hosni and Dr Arshed were of the view that Paul could be adequately treated at Hay Hospital.

228 Dr Hosni reflected that he should have thought more every day about PE. When he considers PE to be part of a differential diagnosis now, he prioritises ruling it out by objective testing.

229 A/P Grabs maintained that a diagnosis of PE required a CTPA. Whilst a chest x-ray was prepared and obtained, it was not diagnostic of PE specifically. A/P Grabs maintained that unless a pulmonary CTPA is performed when there is a suspicion, appropriate therapy would not be commenced.

230 Professor Yee confirmed that PE cannot be diagnosed from a chest x-ray.

231 Professor Yee considered, however, that there should have been red flags that Paul had PE on 16 October 2019. He considered that Paul ought to have been transferred that morning for a CTPA given he was not improving, he was having episodes of low oxygen saturation, he was complaining of persisting breathlessness and, in his view, there should have been a higher suspicion, noting that he had been on appropriate broad-spectrum antibiotics.

232 Professor Yee considered a CT scan should have been performed. He also said that discussions with physicians or respiratory colleagues would have been indicated.

233 A/P Flecknoe-Brown considered that Paul should have been transferred to a different hospital on the night of 9 October 2019 or given a therapeutic dose of anticoagulation medicine (that is, a full dose of Clexane) and then transferred the next morning for a CTPA. He considered the coughing up of blood was a red flag for PE. He also considered a call should have been made from Hay Hospital to Griffith Base Hospital.

234 A/P Flecknoe-Brown was concerned about the potentiality of PE by virtue of the fact that one of Paul's symptoms was coughing up blood (even if the phrase PE was not expressly said). He also indicated that the timing was relevant to the extent that Paul had been in hospital in September 2019 with certain symptoms and certain diagnoses and that on 9 October 2019, there was a history of coughing up blood. He maintained that, even if the expression PE was not discussed or used, he would have considered it appropriate to have Paul transferred to Griffith Base Hospital to undergo a CTPA.

235 Professor Kelly was advised of the evidence given by Dr Hosni at the time of Paul's admission to Hay Hospital on 9 October 2019. Professor Kelly remained concerned about the diagnostic approach of choosing a diagnosis that is thought to be 'more likely,' rather than ensuring the ruling out of things that are possible and potentially life-threatening. She maintained that Dr Hosni had correctly identified the risk of a PE and yet failed to rule it out.

236 Based on Wells' criteria[38], Professor Kelly maintained that Paul had fallen into a group that had seven points on that scale, which put him in a group that has about a 4 out of 10 risk of having a PE. She described it as quite a high risk. Professor Kelly acknowledged under cross examination by Alderton, that her selection of 'immobilisation' as an identified risk was in error. She also acknowledged that any application of the Wells' criteria requires a subjective

[38] A clinical decision tool used to assess PE.

assessment of either information being applied or interpretation of results. However, she went on to say that hospitals generally have protocols for interpretation and that rural hospitals in particular regularly take a conservative approach to risk.

237 Professor Kelly later explained that without reference to Wells' criteria she would have been concerned that PE was a significant risk and needed to be excluded (based on his presentation of shortness of breath, reporting of coughing up blood and having a tachycardia).

238 Professor Kelly had earlier maintained that Paul had abnormal vital signs so that he was at risk for serious illness and needed tests to sort out what was wrong with him. She considered therefore that, even if the PE had not been thought about at all, his condition was such that he would have been better off escalated to appropriate investigations at a 'bigger hospital'. She indicated that if they turned out to be all right and he turned out to be suitable for care at Hay Hospital, they could have always transferred him back.

239 By 15 October 2019, Professor Kelly considered that Paul had a sudden obvious deterioration in his condition. She indicated the most obvious time point is somewhere around the middle of the day. She made reference to vital signs at 6 o'clock in the morning showing an oxygen saturation of 95% and the vital signs at half past 1, or thereabouts, are now showing oxygen saturations of 90%. Professor Kelly said this is a major deterioration. She also indicated that his oxygen saturation stayed poor for all of that day (15 October 2019) and the next day (16 October 2019).

240 Professor Kelly maintained that at or about 15 October 2019 there should have been a discussion with a specialist, for example, at Griffith Base Hospital. Professor Kelly considered that it was likely that a specialist in Griffith would have suggested, given Paul's level of illness, that he should be transferred to Griffith.

241 Professor Kelly also maintained that, if a nurse or a doctor is experienced enough to consider that a patient looks unwell and therefore they have a concern, it almost does not matter if they have one or more yellow zone observations.

242 Counsel for Dr Arshed highlighted that Professor Kelly's assessment failed to account for the improvements in observations following the change in antibiotic to Piptaz at 9am on 15 October 2019 and the impact of Paul's weight and smoking on his oxygen saturation.

243 Considering the entirety of the evidence and the limitations faced in Hay Hospital, I find that Paul ought to have been transferred to Griffith Base Hospital by virtue of the seriousness of his illness, and for a CTPA to be carried out, on 9 October 2019 or the next morning, 10 October 2019, or 15 or 16 October 2019.

When did Paul's PE start developing, and what was the origin?

244 The expert analysis does not allow a finding as to when the PE started to develop or what its origin was.

If Paul's PE had been identified at an earlier stage, could that have made a difference to the eventual outcome?

245 Professor Yee considered that a CTPA, carried out in the evening of 16 October 2019, would have shown bilateral pulmonary embolic disease. He also considered that, if there was suspicion for PE, the clot could have been controlled with treatment. Professor Yee indicated that if Paul had therapeutic doses of anticoagulation and the diagnosis of PE was made earlier, the clot could have been controlled.

246 A/P Grabs considered the same question and indicated that it was more than likely that the CTPA would have been positive for a clot. He also said, however, it is a grey area and that the CTPA could have shown nothing.

247 A/P Grabs was asked if it was possible to say if the clot on 16 October 2019 could be managed, controlled or anything else. He indicated it was too difficult to say, but that, sometimes full anticoagulation can do remarkable things and improve the whole situation, but again you really start to need to get into advanced medicine that may even be beyond the capability of Griffith Base Hospital.

248 On the evidence available I cannot make a finding as to whether earlier identification would have prevented Paul's death.

Were adequate preventative measures taken for any risk of PE?

249 Consistent with the expert evidence, I find that appropriate preventative treatment had been given, however, PE can occur despite adequate prophylaxis.

From 10-13 October 2019, when was Paul seen by a doctor? If he was not seen by a doctor for an extended period during that time, why not?

If Paul was not seen by a doctor for an extended period of time from 10-13 October 2019, was that an irregular occurrence for patients at Hay Hospital as at 2019 (and is it currently)? What processes are in place to ensure patients admitted to Hay Hospital are seen by doctors at appropriate intervals?

If Paul had been examined more frequently by a doctor between 10 and 13 October 2019, could that have made any difference to the treatment plan or the eventual outcome?

250 Paul was seen by Dr Arshed on 10 and 11 October 2019. If a nurse considered that Paul required attendance on 12 or 13 October 2019, they could have contacted the on-call doctor and Paul would have been seen.

Should the testing for Q fever performed on 16 October 2019 have occurred at an earlier stage (and if so, when)? Could any such earlier testing have made any difference to Paul's treatment plan or the eventual outcome?

251 I find that Q fever testing ought to have been undertaken earlier (at each presentation) noting Paul's risk given his employment. However, given he was prescribed Doxycycline, earlier testing for Q fever would not have prevented Paul's death.

Should an ECG have occurred (and if so, when)? Could that have made any difference to Paul's treatment plan or the eventual outcome?

252 Professor Yee considered that an ECG would have been beneficial, based on Paul's presentation of breathlessness and a smoking history. However, this would not be diagnostic of a PE. It would have been useful to exclude acute cardiac syndrome.

253 A/P Hudson considered an ECG may have provided clues to PE and earlier confirmation of that diagnosis although he deferred to other experts.

254 A/P Flecknoe-Brown noted that Paul's ECG on admission in September was abnormal which should have raised concerns. A lack of attention was paid to the first ECG such that it may not have made a difference if another ECG had been performed during Paul's admission in October.

255 The solicitor for Paul's family submitted that Dr Hosni's evidence supported that an ECG would have been beneficial based on Paul's status as a First Nations man given the prevalence of rhematic heart disease in the Aboriginal population.

256 The evidence establishes that an ECG may have been beneficial, but it was unlikely to have made any difference to Paul's treatment plan or the eventual outcome.

Were the observations performed by nursing staff adequate and in accordance with applicable policies, procedures and guidelines?

257 The observations performed by nursing staff were adequate and in accordance with applicable policies, procedures and guidelines.

Were observations outside of acceptable or normal ranges appropriately responded to?

258 There was a disconnect in the evidence about what actions were to be taken when a patient demonstrated a 'yellow zone' observation as distinct from two

yellow zone observations. NUM Charles' evidence was that if a patient is in a yellow zone, the nurse must notify the medical officer so that they are aware[39].

259 As outlined at paragraphs 122 to 129 above, the 'calling criteria' was adjusted by Dr Arshed. It cannot be established on the evidence as to what the calling criteria was after 2pm on 16 October 2019. On that basis, the evidence does not support a finding that observations outside of acceptable or normal ranges were not responded to appropriately.

Were any decisions to alter the calling criteria during Paul's admission appropriate?

260 Professor Kelly considered it was not appropriate for Dr Arshed to change the calling criteria of the vital sign observations when faced with Mr Harris' new and unexplained hypoxia on 15 October 2019. However, as is highlighted at paragraph 242, Professor Kelly's opinion appears not to have taken into account the change in treatment from 9am on 15 October 2019 and perceived improvements.

261 Professor Yee also felt that altering the calling criteria was probably not the best option until a medical review. He said this should have been undertaken before changing the calling criteria. However, in his oral evidence he acknowledged that Paul's vital signs could be monitored by Dr Arshed from the medical centre and that Dr Arshed did review Paul once he finished work at the medical centre.

262 A/P Flecknoe-Brown considered a more energetic response to Paul's abnormalities would have been appropriate, rather than simply altering the calling criteria.

263 Dr Arshed's evidence was that NUM Charles was seeking a decision as to whether or not Paul ought to be given oxygen. Dr Arshed determined that oxygen should not be given as it could mask Paul's true symptoms. Dr Arshed altered the calling criteria so as to observe Paul's true oxygenation over the 8-

[39] Transcript 20 August 2025, p. 191, lines 10 to 21.

12 hours following. Dr Arshed still received an update at 4pm as to how Paul was performing.

264 On balance, I do not find that the decision by Dr Arshed to alter the calling criteria was inappropriate.

265 On the evidence, the length of time that the calling criteria was altered for could not be established. Once Dr Arshed determined that the calling criteria required alteration, there is no evidence indicating that the altered calling criteria had been extended further.

266 The effect of this, on 16 October 2019, was that nurses appear to have been acting on the basis that the calling criteria continued to be altered when this may not have been the case. The evidence simply does not establish with certainty what occurred with respect to the alteration of the calling criteria on 16 October 2019. This signals a systemic issue in relation to the method by which it was altered.

Was Paul's care adequately escalated during the admission?

267 I find that Paul's care was not adequately escalated during October 2019. Paul should have been transferred to Griffith Base Hospital for a CTPA, on 9,10, 15 or 16 October 2019.

Was medical record-keeping adequate and in accordance with applicable policies, procedures and guidelines?

268 I find that the medical record-keeping by nursing staff was sufficiently adequate during the September 2019 and October 2019 admissions and in accordance with applicable policies, procedures and guidelines.

269 It would have been of assistance to staff at Hay Hospital if Dr Hosni had made a note of his preliminary opinion at Hay Medical Centre in the records of Hay Hospital. However, I note that the symptoms which would raise a red flag for PRE (ie SOB and coughing up blood), were identified in the Hay Hospital records. Furthermore, it would have been of assistance to staff at Hay Hospital

if Dr Arshed had made a note of each of his consultations with Paul during his admissions.

Was the engagement with Aboriginal Liaison Officers appropriate and in accordance with applicable policies, procedures and guidelines? Should Aboriginal Liaison Officers have been contacted by Hay Hospital staff at an earlier stage?

270 No Aboriginal Liaison Officer was engaged for Paul's benefit during his admissions to Hay Hospital.

271 A/P Flecknoe Brown considered that Aboriginal Liaison Workers can be very helpful in coordinating what is happening in the Hospital with what is available in the community.

272 There was no ALO located in Hay in October 2019. Reid indicated that ALOs work across the whole of the District. They can be dispersed and are able to be contacted depending on whether they are in the town where that service is required, but they can provide a tele-health virtual-type response as well.

273 An ALO ought to have been engaged for Paul during his admissions in September and October 2019 even if this service would have been limited to tele-health virtual-type responses.

Were Paul and his family adequately informed of the 'REACH' program (which enables patients or family members to escalate their concerns regarding deteriorating patients)? Should they have been provided information in relation to that by Hay Hospital staff at an earlier stage?

274 I find that while they should have been, Paul and his family were not informed about the REACH program.

Issue 10: Matters with respect to the emergency response and resuscitative efforts on 17 October 2019.

Was that reasonable, appropriate, timely and in accordance with applicable policies, procedures and guidelines?

Was there adequate medical equipment in Paul's hospital room?

275 The emergency response and resuscitative efforts were reasonable, appropriate and timely.

276 The evidence did not indicate that there was an issue with access to medical equipment.

Issue 11: Should Paul have been transferred from Hay Hospital to another hospital such as Griffith Hospital? If so, when?

277 Paul should have been transferred to Griffith Base Hospital for a CTPA, on 9,10, 15 or 16 October 2019.

Issue 12: Were the staffing arrangements at Hay Hospital and Hay Medical Centre appropriate as at 16 September 2019 to 17 October 2019, and are those currently appropriate?

278 Staffing arrangements were affected by resources and funding issues.

Issue 13: Are any recommendations necessary or desirable?

279 Each of the experts were invited to consider the need for system improvements.

280 Professor Yee considered that there should be medical imaging available more frequently than once per week. He also considered there should be better links between Griffith Base Hospital and smaller hospitals (and the ability for doctors to seek advice via phone).

281 A/P Hudson considered there should be stricter oversight of Q fever screening prior to working in certain occupations. He also considered there should be access to radiology services/pathology services/diagnostic services in smaller hospitals that should be reviewed.

282 A/P Grabs considered that doctors should be able to phone external specialists (for example, at St Vincent's Hospital) and discuss cases with them. He considered this would also be helpful as doctors may focus on one diagnosis and not look 'outside of the box'. He noted there are already some connections between St Vincent's Hospital and the Murrumbidgee Local Health District[40].

283 Morley also considered there could be improvement in relationship building between staff at larger and smaller hospitals.

284 Professor Kelly considered it is really important that hospitals be very clear about the limitations as to what care can be provided at that particular hospital.

285 Reid indicated that currently there is a central point of contact for Hay Hospital staff, being a 1800 number, for the Patient Flow and Transport Unit. She indicated that there is support for appropriate patient escalation. She indicated that, through that 1800 number, staff can access:

(1) the Critical Care Advisory Service

(2) the Remote medical consultation service

(3) a Virtual Nurse Assist which provides advice to nurses in relation to a patient from a senior nurse.

286 Reid gave evidence that, as at 2019, there was also a centralised number that Hay Hospital staff could call for the Patient Flow Transport Unit. Since 2019, however, she said there had been some changes, including that the service has increased its operations and expanded its hours of operation (it is now 24/7). With respect to x-rays, she indicated that x-rays are still currently only available one day per week due to funding and also demand. She said,

[40] Griffith and Wagga Wagga doctors frequently contact St Vincent's Hospital specialists about concerns on an ad hoc basis.

however, that x-rays can now be reported on daily. She indicated there is also still no on-site pathology services due to funding[41].

287 Ms Reid indicated that some of the relevant policies are NSW Health policies and that the Murrumbidgee Local Health District works under those policies.

288 She also indicated that Hay Hospital always had suction equipment and oxygen available in hospital rooms like Paul's, but that now nurses check during their handover every morning that there is an oxygen mask and tubing in every acute room (and that there is a comprehensive check every week or after it is accessed).

289 The Murrumbidgee Local Health District has made numerous system improvements to work practices.

290 Counsel assisting submitted that the following recommendation may be made:

(1) That the Murrumbidgee Local Health District give consideration to providing training to all staff (including VMOs and nursing staff) to ensure that relationships between Hay Hospital and other hospitals within the Murrumbidgee Local Health District are strengthened.

291 Counsel for MLHD indicated that this recommendation is not reasonably required. I disagree. Rural hospitals are limited in terms of technology, equipment and staffing. The more common it becomes for staff to communicate openly and frequently between the smaller satellite hospitals and the larger hospitals, the more supported the practitioners in the smaller hospitals will be and patients will benefit from more senior doctors in larger hospitals being more accessible to more junior doctors.

292 I make the recommendation as submitted by Counsel assisting.

[41] Pathology is NSW Health-based, rather than MLHD.

Concluding remarks

293 I will close by conveying to Paul's family members my sympathy for the tragic loss of Paul.

294 I thank the Assisting team, Patrick Rooney and Taylor Bird, for their outstanding work in the course of the inquest.

295 I thank Senior Constable Marmo for her work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting Team.

Statutory findings required by s 81(1)

296 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is Paul Harris

Place of death

Paul died at Hay District Hospital, 351 Murray Street Hay NSW 2711

Date of death

Paul died on 17 October 2019

Cause of death

Paul died from bilateral pulmonary thrombo-emboli, contributory factors included obesity, coronary atherosclerosis and cardiomegaly reportedly contributed to the death.

Manner of death

Undiagnosed bilateral pulmonary thrombo-emboli while receiving treatment at Hay Hospital as an inpatient.

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe

ANNEXURE A

1 What factors caused and/or contributed to Paul's death?

2 Did Paul have Q fever? If, so, when, and did that cause or contribute to his death?

3 Did Paul have pneumonia? If, so, when, and did that cause or contribute to his death?

4 What connection (if any) was there between the pulmonary thrombo-emboli, Q fever, pneumonia and any other relevant condition?

5 Did Paul's place of work have an adequate system in place as at 2019 to ensure workers were vaccinated for, or otherwise immune to, Q fever?

6 Was Paul vaccinated for Q fever and/or had he previously had Q fever as at the time he commenced working for his place of work? Were any checks conducted by his place of work to ascertain that, or should they have been?

7 Was any response by Paul's place of work to the improvement notice issued as a result of the SafeWork investigation adequate?

8 With respect to Paul's admission and various presentations at Hay Hospital and Hay Medical Centre from **16 September 2019 to 2 October 2019**, was the care and treatment provided to Paul reasonable, appropriate and in accordance with any applicable policies, procedures and guidelines, including with respect to the following:

(1) Was Q fever considered as a diagnosis by hospital staff? Should it have been (and if so, when)?

(2) Should Paul have been admitted to Hay Hospital when he presented on 16 September 2019?

(3) Was Paul's reported abdominal pain on 24 September 2019 and flank pain on 26 September 2019 appropriately investigated by the relevant doctor/s? Was that pain caused by a pulmonary embolus?

9 With respect to Paul's final admission to Hay Hospital from **9 to 17 October 2019,** was the care and treatment provided to Paul reasonable, appropriate and in accordance with any applicable policies, procedures and guidelines, including with respect to the following:

(1) Should a CT pulmonary angiogram have been performed for Paul, in circumstances where he was admitted to hospital for urgent investigations to rule out a pulmonary embolus and for a CT pulmonary angiogram? Why was he not transferred to another hospital for that to occur?

(2) When did Paul's pulmonary embolism start developing, and what was the origin?

(3) If Paul's pulmonary embolus had been identified at an earlier stage, could that have made a difference to the eventual outcome?

(4) Were adequate preventative measures taken for any risk of pulmonary embolism?

(5) From 10-13 October 2019, when was Paul seen by a doctor? If he was not seen by a doctor for an extended period during that time, why not?

(6) If Paul was not seen by a doctor for an extended period of time from 10-13 October 2019, was that an irregular occurrence for patients at Hay Hospital as at 2019 (and is it currently)? What processes are in place to ensure patients admitted to Hay Hospital are seen by doctors at appropriate intervals?

(7) If Paul had been examined more frequently by a doctor between 10 and 13 October 2019, could that have made any difference to the treatment plan or the eventual outcome?

(8) Should the testing for Q fever performed on 16 October 2019 have occurred at an earlier stage (and if so, when)? Could any such earlier testing have made any difference to Paul's treatment plan or the eventual outcome?

(9) Should an ECG have occurred (and if so, when)? Could that have made any difference to Paul's treatment plan or the eventual outcome?

(10) Were the observations performed by nursing staff adequate and in accordance with applicable policies, procedures and guidelines?

(11) Were observations outside of acceptable or normal ranges appropriately responded to?

(12) Were any decisions to alter the calling criteria during Paul's admission appropriate?

(13) Was Paul's care adequately escalated during the admission?

(14) Was medical record-keeping adequate and in accordance with applicable policies, procedures and guidelines?

(15) Was the engagement with Aboriginal Liaison Officers appropriate and in accordance with applicable policies, procedures and guidelines? Should Aboriginal Liaison Officers have been contacted by Hay Hospital staff at an earlier stage?

(16) Were Paul and his family adequately informed of the 'REACH' program (which enables patients or family members to escalate their concerns regarding deteriorating patients)? Should they have been provided information in relation to that by Hay Hospital staff at an earlier stage?

10 With respect to the emergency response and resuscitative efforts on 17 October 2019:

(1) Was that reasonable, appropriate, timely and in accordance with applicable policies, procedures and guidelines?

(2) Was there adequate medical equipment in Paul's hospital room?

11 Should Paul have been transferred from Hay Hospital to another hospital such as Griffith Hospital (and if so, when should that have occurred)?

12 Were the staffing arrangements at Hay Hospital and Hay Medical Centre appropriate as at 16 September 2019 to 17 October 2019 (during Paul's presentations and admissions), and are those currently appropriate?

13 Are any recommendations necessary or desirable pursuant to s. 82 of the *Coroners Act 2009*?

ANNEXURE B

1 RN Geraldine Tuohey

2 RN Dominique Warren

3 RN Sarah Sandow

4 CNE Rowena Jubb

5 Dr Ahmed Hosni

6 RN Jaypee Bautista

7 RN Michelle Johnson

8 NUM Judith Charles

9 Dr Muhammad Arshed Shahzad (**Dr Arshed**)

Experts

10 Professor Brendon Yee, Respiratory Physician

11 A/Professor Bernard Hudson, Infectious Diseases

12 A/Professor Anthony Grabs, Vascular Surgeon

13 Catherine Morley, Nurse

14 A/Professor Stephen Flecknoe-Brown, Haematologist

15 Professor Anne-Maree Kelly, Emergency Medicine

Institutional witnesses

16 Tegan Reid, MLHD