Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 49/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Donald Richard BROADRIBB*** *with an inquest held at the* ***Perth Coroner's Court, Ct 53, CLC Building, 501 Hay Street, Perth*** *on* ***2 December 2015*** *find that the identity of the deceased person was* ***Donald Richard BROADRIBB*** *and that death occurred on* ***13 October 2012*** *at* ***66 Suburban Road, York****, as a result of* ***Bronchopneumonia and Acute Bronchiolitis*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Ms R Hartley (State Solicitor's Office) appearing on behalf of the WA Country Health Service.
Ms M Nguyen (ANF) appearing on behalf of Nurse Sloss.

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INTRODUCTION

1. On the evening of Friday, 12 October 2012 Donald Broadribb (the deceased) presented at the York Hospital. He was treated by nursing staff during the evening, in consultation with a doctor based at Northam Hospital, and was discharged home at approximately 11.40 pm. After returning home the deceased remained unwell and his condition deteriorated in the early hours of the morning to the extent that his wife decided to take him back to hospital at about 6.00 am. However, before she could move him into her car the deceased collapsed into unconsciousness, so the deceased's wife called an ambulance instead. Volunteer ambulance officers arrived shortly afterwards but the deceased could not be revived. He died at home on the morning of Saturday, 13 October 2012.

2. The death was reported to the State Coroner and a coronial investigation was conducted into the death. As part of the investigation police officers from York Police Station, acting as coronial investigators, sought statements from the nursing staff and doctor involved in the deceased's care on the night before his death. After the coronial investigators experienced some difficulties obtaining all of the necessary information from relevant witnesses, the State Coroner directed that the matter should be listed for an inquest pursuant to s 22(1)(e) of the *Coroners Act 1996* (WA).

3. The inquest hearing was opened at the Perth Coroner's Court on 2 December 2015. The scope of the oral evidence on that date was limited to calling evidence from two witnesses, Registered Nurse Sarah Sloss and Dr Jean-Philippe Lalonde, who were the two health professionals primarily involved in the deceased's care on the evening prior to his death. The remainder of the evidence was tendered as documentary evidence in the form of the medical records from York Hospital and Northam Hospital,[1] a statement from Nurse Sloss,[2] as well as the full report of the police coronial investigators into the death of the deceased, with annexures.[3] The inquest hearing was then adjourned *sine die* so that the evidence could be assessed and a decision made whether the inquest hearing would need to continue, in which case it would most likely take place in Northam.

4. Some further investigations were conducted by coronial staff and, based upon all the evidence before me by late March 2016, I was satisfied that I had sufficient information to conclude the inquest

[1] Exhibit 1.
[2] Exhibit 2.
[3] Exhibit 3.

and make findings pursuant to s 25(1) of the *Coroners Act*. The relevant parties were informed of my decision.

THE DECEASED

5. The deceased was born in the United States of America on 3 August 1933. As a child he suffered from Sydenham's Chorea (a neurological disorder associated with Streptococcus infection and rheumatic fever) and spent a considerable amount of time in hospital. As a result, he developed an aversion to hospitals, which remained with him as an adult.[4]

6. At the time of his death the deceased was married to his second wife, Judith (Liz) Christmas, and they lived together in York, Western Australia.[5] He had a son, who had died, and an adult daughter from his previous marriage.

7. The deceased was a very intelligent and educated man who had studied and lectured at universities in both the United States and Australia. He was a psychologist, a Biblical scholar and a world-renowned expert and scholar in Esperanto, having translated many texts into Esperanto and edited journals in Esperanto fields of research. He was also an expert in sophisticated word-processing, in particular a program known as Mellel.[6] He was still actively involved in, and making significant contribution to, these fields at the time of his death. The deceased left behind a legacy of works as an author, editor and translator in many fields for the benefit of future generations.

MEDICAL HISTORY OF THE DECEASED

8. Throughout his second marriage the deceased experienced a number of complex health issues.

9. The deceased was an insulin-dependent diabetic, but managed his diabetes well with diet and daily insulin injections. He also had a long history of depression, which was well managed with antidepressants. The deceased experienced bouts of anxiety, for which he took diazepam (Valium) intermittently as required. He had also been diagnosed with osteoporosis, for which he was taking Fosamax and Calcium.[7]

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[4] Exhibit 3, Tab 8 [11] – [12].
[5] Exhibit 3, Tab 8 [3] and Tab 11.
[6] Exhibit 3, Tab 11.
[7] Exhibit 3, Tab 10 [4] – [8] and Tab 16.

10. In approximately 2006 the deceased was diagnosed with prostate cancer, which was treated by radiotherapy and brachytherapy.[8] The deceased was very optimistic about his long-term prognosis and had made great efforts to adopt a diet that would aid his longevity.[9]

11. In September 2012 the deceased experienced a number of additional health issues. On 15 September 2012 he had a fall at home during the night, after which he had a sore right shoulder and developed some bruising in his collarbone area and right hip over the subsequent days.[10] He was also experiencing some pain around his right-sided lower ribs.[11]

12. On 21 September 2012 the deceased experienced a whole body spasm on his right side, which lasted a few seconds and also caused a deep groan in his throat. This was on the background of post nasal dripping and less severe spasms during the previous days.[12] The deceased and his wife were sufficiently concerned by the event that they made an appointment for the deceased to see his doctor, Dr Steed, at York General Practice on 27 September 2012. The deceased had been seeing Dr Steed regularly since approximately 2004 and they had a good rapport.[13]

13. In the days leading up to the appointment the deceased continued to experience some chest spasms and pain to his right ribs when pressed. The deceased was also experiencing symptoms of depression, insomnia, urinary incontinence and constipation.[14]

14. On 27 September 2012 the deceased and his wife attended the appointment with Dr Steed. They provided detailed information to Dr Steed of the symptoms the deceased had been experiencing over the previous weeks.[15]

15. Dr Steed considered the main problem identified during the appointment was the fall, which had caused bruising to his right shoulder and ribs. The deceased reported sudden right-sided chest pain after a sneeze. He also noted symptoms of panic attack, constipation and urinary incontinence. Dr Steed thought that clinically it seemed likely that the deceased had fractured a rib during his fall. Dr Steed undertook some blood tests and

[8] Exhibit 3, Tab 16.
[9] Exhibit 3, Tab 11, p.16.
[10] Exhibit 3, Tab 10 [15] – [16].
[11] Exhibit 3, Tab 16, "Don Medical 2012".
[12] Exhibit 3, Tab 10 [17] – [19].
[13] Exhibit 3, Tab 10 [20] – [22].
[14] Exhibit 3, Tab 16, "Don Medical 2012".
[15] Exhibit 3, Tab 16, "Don Medical 2012".

treated the deceased with anti-inflammatory medication (Piroxical 20mg daily) on top of his usual medications.[16]

16. The deceased re-attended to see Dr Steed again on 8 October 2012 and was still reporting right shoulder and right anterior rib pain. The results of his blood tests were discussed and noted to be normal other than slightly low B12, for which he was given an injection of vitamin B12. The deceased's routine examination on that day was normal. Due to the deceased's continuing reports of pain Dr Steed ordered an x-ray of the deceased's chest and right shoulder to be undertaken at Northam Regional Hospital, as he still suspected the deceased had fractured a rib.[17]

17. The x-rays were performed in Northam on 10 October 2012 and both were later reported as normal.[18] The chest x-ray report indicated no definite skeletal fracture was identified, although not all portions of the ribs were clearly definable from the views taken. The findings did indicate that moderate Chronic Obstructive Pulmonary Disease was present, although there was no lung consolidation or congestive heart failure observed.[19] The right shoulder x-ray found no displaced fracture and the joints were in normal alignment.[20]

18. The deceased had made another appointment to see Dr Steed on Monday, 15 October 2012, to discuss the results of the x-rays. Sadly, the deceased died prior to that date.

EVENTS ON 12 OCTOBER 2012

19. The deceased had been unwell on 11 October 2012. His wife reports he was experiencing difficulties swallowing, which was not unusual for him and she reported that he often took Valium (diazepam) prior to a meal to help with this issue. On the morning of 12 October 2012 he experienced a blood nose and was unable to eat his full breakfast. He was so unwell during the day that he was unable to eat or take any of his normal medicines, other than his morning anti-depressant tablets. He vomited up any food he attempted to eat.[21]

20. At about 8.15 pm the deceased asked his wife if she thought they should go to the York Hospital. Given his dislike of hospital, she was surprised that he had made the suggestion but pleased he

[16] Exhibit 3, Tab 16, Letter of Dr Steed dated 27.11.12.
[17] Exhibit 3, Tab 16, Letter of Dr Steed dated 27.11.12.
[18] Exhibit 3, Tab 16, Letter of Dr Steed dated 27.11.12.
[19] Exhibit 3, Tab 16 and Tab 20.
[20] Exhibit 3, Tab 16.
[21] Exhibit 3, Tab 10 [39] – [46].

had taken the initiative to suggest it. She readily agreed and drove him to the hospital shortly afterwards.[22]

21. I accept that the fact that the deceased volunteered to go to hospital is significant as an indicator at how seriously unwell he was feeling at that time, given his known strong preference not to attend hospital.

22. York Hospital has no resident doctors and is staffed only by nursing staff. By October 2012 no local doctors were on call.[23] Instead, there was an arrangement in place for the nurses at the hospital to contact Northam Hospital if they needed to speak to a doctor.[24]

Initial Triage

23. The deceased's wife reports that when they first arrived at the hospital they were met by two nurses who asked the deceased to explain why he had come. He was told by one of the nurses, later identified as Nurse Bloxsome, not to tell the whole story, but just the main thing that had brought him there. The deceased then mentioned the pain he was in and they were allowed entry to the hospital. Ms Christmas has indicated that she felt the way the deceased was told to indicate the main reason he had attended hospital may have put the deceased under pressure to specify only one symptom, rather than a combination of factors, which may have contributed to later events.[25]

24. Nurse Bloxsome also apparently asked them why they had waited until so late at night to come and the deceased's wife explained that the deceased had been reluctant to come as he hated hospitals.[26]

25. I note that the only information I have as to what occurred at this stage of the evening comes from Ms Christmas and the medical records as the nursing staff declined to speak to the investigating police or provide statements. Only Nurse Sloss, who saw the deceased later in the evening, provided a statement some years after the events and she was also called to give oral evidence.[27]

26. The hospital triage form records the deceased presenting at the York Hospital at 8.45 pm. He was initially assessed by registered nurse Ann Bloxsome.[28] Nurse Bloxsome recorded on the triage

[22] Exhibit 3, Tab 10 [48] – [50].
[23] T 23.
[24] T 23.
[25] Exhibit 3, Tab 10 [51] – [54].
[26] Exhibit 3, Tab 10 [57].
[27] Exhibit 3, Tab 6, p.8.
[28] Exhibit 3, Triage form 12.10.12.

form that the deceased presented complaining of vomiting undigested food, coughing which was causing vomiting and difficulty swallowing. He also complained of pain in his right knee and neck. His pain score was noted as 6 out of 10 in intensity and in the right upper quadrant of his abdomen. The deceased was given an initial triage score of 4 out of 5 (with 5 the lowest) by Nurse Bloxsome, indicating a moderate level of acuity.[29]

27. Nurse Bloxsome recorded in the medical notes that the deceased was anxious and complained of abdominal pain predominantly in the right upper outer quadrant and "feeling raw." He also reported that he was constipated, with his bowels not opening for the last three or four days.[30] The deceased's observations were recorded and showed an elevated temperature of 38°C, an elevated blood pressure of approximately 150/100, a respiratory rate of 24bpm, oxygen saturation of 95% and a pulse of 90–100bpm. Apart from his temperature and blood pressure, the other observations were within a normal range for a person with the deceased's history, although I note the deceased's wife believes the heart rate was high for the deceased as she thought his normal rate was 80 or lower.[31] It is likely his blood pressure was elevated due to the deceased not having been able to swallow his usual blood pressure medications and his anxiety at being in hospital and in pain.

28. During this initial period Ms Christmas indicates that she felt that the deceased was not made to feel welcome by the nurses, which would not have assisted with his anxiety levels and, correspondingly, his blood pressure and comfort levels.[32]

29. Although observations were taken and the deceased's responses were recorded, there are no examination notes made of the chest and abdomen.

30. Ms Christmas recalls that they told the nurses they were waiting for the chest x-ray results and possibly also mentioned that they had an appointment with Dr Steed on 15 October 2012.[33]

31. The nurses explained to the deceased and his wife that they would have to phone the doctor in Northam and that it could take some time because he had to prioritise patients according to urgency.[34]

[29] T 5; Exhibit 3, Triage form 12.10.12.
[30] Exhibit 3, Tab 21, Medical Notes, Entry 12.10.12, 20.50.
[31] Exhibit 3, Tab 21, Medical Notes, Observations Chart and Exhibit 3, Tab 10 [61] – [62].
[32] Exhibit 3, Tab 10 [59].
[33] Exhibit 3, Tab 10 [68].
[34] Exhibit 3, Tab 10 [71].

Change of Nurses

32. Nurse Sloss began her shift at 9.00 pm and at that time the deceased was the only patient at York Hospital.[35] Ms Christmas and the deceased overheard the nurses during the handover and noted they were laughing, which gave Ms Christmas the impression they were unconcerned about the deceased's condition.[36]

33. Following the verbal handover Nurse Sloss believes she would have gone to do a full assessment of the deceased sometime about 9.30 pm.[37] She noted in her statement that she had a long discussion with the deceased about his health and why he had come to hospital.[38]

34. Nurse Sloss' evidence was that the deceased was 'a very difficult person to assess"[39] because his history kept changing. She found it difficult to ascertain what his concerns were and what had brought him to the hospital that particular night.[40] At the time Nurse Sloss saw him the deceased stated he had a pain score of 8 out of 10, which had increased from when he first arrived. However, Nurse Sloss observed he was not exhibiting any physical signs to indicate pain, such as clutching or writhing.[41]

35. Nurse Sloss recalls that the deceased was very concerned about his stomach and constipation, so she gave him some nurse-initiated medication (Biscodyl and a glycerine suppository) to help him open his bowels. She noted that this had a good result and relieved a lot of his pain, and she made an entry to that effect in the medical notes.[42] She also gave him two Panadol suppositories for his pain at 10.30 pm[43] and encouraged him to take one of his own Valium (diazepam) for his anxiety.[44] The deceased's wife does not recall the deceased actually taking one of his Valium that evening, although I note that diazepam is detected in the toxicology findings, which would support the possibility that he did, although I take it no further than that given the doubt raised by Ms Christmas on the matter and the possibility that he took it earlier in the day.[45]

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[35] T 4.
[36] Exhibit 3, Tab 10 [73], [154].
[37] T 4, 6.
[38] Exhibit 2 [9].
[39] T 5.
[40] T 5.
[41] Exhibit 2 [10].
[42] T 6 – 7; Exhibit 3, Tab 21, Medical notes, Entry 12.10.12, 22.10..
[43] T 12; Exhibit 2 [24].
[44] T 12.
[45] Exhibit 3, Tab 5; Tab 12, p.4.

36. During her initial examination Nurse Sloss had listened to the deceased's chest and noted that she thought it was "wet",[46] which she explained meant she could hear some kind of fluid or movement on his lungs, which she was concerned about. She recalls being told by the deceased and his wife that it was not a sudden onset symptom and, given the deceased had seen his doctor a day or two earlier, Nurse Sloss made the assumption that this was normal for the deceased.[47] Nurse Sloss observed in that context that "[l]ots of people do live with chronic chests,"[48] in the sense of an ongoing mild unresolved chest infection. She also noted that his recorded respiratory rate of 24 was a little high but wasn't out of the normal parameters for a person of his age and with his health conditions.[49] His oxygen saturation rate was also fine.[50]

37. The deceased and his wife had told Nurse Sloss that when they saw Dr Steed a day or two earlier he had not listened to the deceased's chest, but she considered they were probably mistaken as she thought he would have listened to the deceased's chest given the history of a fall and suspected fractured ribs.[51]

38. Nurse Sloss' evidence was that after all of her discussions with the deceased and general examination she was "led to believe that his main issue was his bowels, and that was making him feel so uncomfortable and so yucky."[52] Although she had contemplated the possibility of an infection, given some of his symptoms,[53] she thought it was most likely an ongoing chest issue and not an acute respiratory problem.[54] The absence of a continued high temperature, in the range of 39°C, suggested to her that he did not have an aspiration pneumonia. If she had thought that was a likely possibility, she would have wanted a chest x-ray and some blood cultures to be performed, neither of which were available at York Hospital.[55]

39. At 11.00 pm Nurse Sloss recorded in her notes that the deceased still rated his pain as an 8 out of 10 and "unbearable" and he reported he had experienced nil improvement except that he was less constipated.[56]

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[46] Exhibit 2 [16].
[47] T 8.
[48] T 8.
[49] T 8.
[50] T 8.
[51] T 18 – 19.
[52] T 10.
[53] T 11.
[54] T 12.
[55] T 12.
[56] Exhibit 3, Tab 21, Medical Notes, 12.10.12, 23.00.

40. Around this time Nurse Sloss made a telephone call to Dr Lalonde who was working at Northam Hospital. Nurse Sloss had faxed an Inter-Hospital Telephone Communication Record (the LIME form) to the hospital at 10.00 pm[57] and it seems from Dr Lalonde's evidence that Nurse Sloss then followed it up with a telephone call (although she wasn't sure if she had made the call or received one from the doctor).[58]

41. In the form Nurse Bloxsome had indicated the problem was "vomiting undigested food since this afternoon" and Nurse Sloss had added that the deceased was constipated, possibly showing anxiety, had abdominal pain, had experienced a fall two days prior and been seen by his GP and possibly had a rib fracture for which he had been given Panadol.[59]

42. Dr Lalonde was based in Northam from July 2012 to early 2013 and worked out of a general practice that also provided obstetric and anaesthetic services in Northam Hospital.[60]

43. Dr Lalonde was at home when he received the call from Nurse Sloss.[61] He had only returned home from Northam Hospital shortly before receiving the call so he was awake when she rang.[62] Dr Lalonde did not have a copy of Nurse Sloss' fax before him when he took her call and had not seen the document.

44. Dr Lalonde and Nurse Sloss had approximately a ten minute conversation about the deceased.[63] There are no clear records of what was discussed either in the York Hospital notes or written contemporaneously by Dr Lalonde. Other than a diary note of the call made for billing purposes,[64] Dr Lalonde indicated that he did not make any notes during the phone call.[65]

45. During his evidence Dr Lalonde did mention that he had made some notes a few weeks after the event.[66] Dr Lalonde uses the notes to help refresh his memory during his evidence. Efforts were made some time after the inquest to obtain a copy of those notes from Dr Lalonde, as he had indicated he would be willing to provide them to the court,[67] but regrettably Dr Lalonde has been extremely difficult to contact and to date coroner's court staff and

[57] T 15.
[58] T 27.
[59] T 16 – 17; Exhibit 3, Tab 21, Medical Records, Inter-Hospital Telephone Communication Record – LIME form, 12.10.12.
[60] T 26.
[61] T 27.
[62] T 27.
[63] T 15, 17.
[64] T 27.
[65] T 28.
[66] T 28.
[67] T 28.

police officers have been unable to reach him. I am told he is no longer practising medicine in Narrogin and his whereabouts in Perth are unknown. In those circumstances, I have proceeded to complete the finding without the benefit of his notes.

46. Nurse Sloss recalls she explained during the phone call the deceased was still in pain, although she did not think his subjective assessment of pain as being 8 out of 10 matched her objective assessment.[68] It was still thought by Nurse Sloss that the pain was abdominal pain related to his bowels and she conveyed this impression to Dr Lalonde.[69] Dr Lalonde was concerned to control the deceased's pain and ordered medications for that purpose.[70]

47. Dr Lalonde recalls that Nurse Sloss told him that the deceased had marked abdominal pain, on the background of a history of not having opened his bowels for three or four days, and he had experienced marked relief after she had given him a suppository.[71] She mentioned there had been episodes of vomiting, but not since he had been in the Emergency Department.[72] She explained that the deceased had then described increases in his pain score and so they discussed options for managing his pain better.[73] She also informed him that the deceased's observations were within normal limits.[74]

48. Dr Lalonde explained in his evidence that it is not uncommon for a patient with a history of constipation to initially experience relief following a suppository and then have ongoing abdominal pain as often the suppository will empty the rectum but not the entire bowel, so there is still a large faecal loading for a period of time. He also noted that constipation is very common in a person of the deceased's age.[75] In that context, the history provided to Dr Lalonde appeared to describe a common problem for an elderly patient. He was aware that the deceased had multiple co-morbidities, including diabetes, a past history of stroke and anxiety, which he also took into account.[76]

49. Dr Lalonde prescribed:

    - Buscopan, an antispasmodic/muscle-relaxant;

[68] T 19.
[69] T 19.
[70] T 14, 19, 21.
[71] T 28.
[72] T 31.
[73] T 29.
[74] T 32.
[75] T 30.
[76] T 31.

- Maxolon, an antiemetic that is also a pro-kinetic medication that helps speed up the bowel process;
- an injection of Ketoralac, which is a pain relief medication; and
- 2.4mg of morphine, if required, for further pain relief.[77]

50. The deceased was told of the doctor's recommendations and apparently accepted them and the medications were given by injection. Information provided by Ms Christmas after the event indicates the deceased and his wife did not perhaps have a full understanding of what medications were being offered but they accepted the treatment as perhaps the best option that they had at that time.

51. Shortly after the injection of Ketoralac had been administered the deceased opened his bowels and after that he reported to Nurse Sloss that he felt much better and she believes he said he was happy to go home. At that time his assessment of his pain had dropped from a score of 8 out of 10 to a score of 1 out of 10.[78] On that basis, he was not offered the morphine and I note from Ms Christmas' statements that they were not keen for him to take any opiate based medication in any event given the risk of further constipation.[79]

52. Nurse Sloss' evidence was that she offered for the deceased and his wife to go to Northam, and indicated that the doctor would be happy to review them there, but the deceased and his wife were understandably not keen to take the 30 – 40 kilometre drive that late at night.[80] Ms Christmas recalls that Nurse Sloss told them that if the painkillers did not work the deceased would have to go to Northam Hospital.[81]

53. Dr Lalonde also indicated that there was the possibility that if the deceased's abdominal pain continued he would need a CT abdomen with contrast, which couldn't be performed in Northam at that time due to equipment failure, so he would more likely have been required to go to Swan District Hospital or Royal Perth Hospital.[82]

54. Nurse Sloss recalls that after speaking to the deceased and his wife it was agreed that she would arrange for the deceased to see his usual doctor first thing the next morning, which she believed at the time would be an adequate timeframe for a doctor's

[77] T 30.
[78] Exhibit 3, Tab 21, Medical Records, 12.10.12, 23.40; Exhibit 2 [31].
[79] Exhibit 3, Tab 10 [83].
[80] T 11, 17, 20.
[81] Exhibit 3, Tab 10 [86].
[82] T 41.

review.[83] Nurse Sloss also made a note that the deceased's wife would return to the hospital if she became concerned in the meantime.[84]

55. Ms Christmas recalls that they were told that they couldn't admit the deceased without a doctor signing off on the admission, which she took to imply that they should go home. She does recall that they were told that they could come back to the hospital at any time if they needed to.[85]

56. Nurse Sloss took some final observations prior to the deceased leaving hospital and the observations were all within the normal range for a patient with the deceased's history.[86] The deceased appeared to Nurse Sloss to be keen to go home at that time and she noted he was able to walk to his car without assistance.[87] Nurse Sloss gave the deceased some ice to suck on during the journey home.

Evidence about the deceased's chest being "wet"

57. Nurse Sloss can recall mentioning to Dr Lalonde during their telephone conversation that she had listened to the deceased's chest and 'it wasn't good,"[88] but couldn't recall if she told Dr Lalonde it was "wet". She also couldn't recall what Dr Lalonde said in response.[89]

58. Dr Lalonde cannot recall if Nurse Sloss told him that she listened to the deceased's chest. He accepts that he could have asked her if she did, but can't recall if he did or not or if she told him that she had. He made no note to that effect when he documented the matter a short period after the deceased's death and he can only now recall being aware that the deceased had a history of asthma. Dr Lalonde recalls the focus being on the deceased's abdominal pain rather than any issue relating to his chest.[90] This was consistent with Nurse Sloss' evidence.

59. Dr Lalonde was in court during Nurse Sloss' evidence of listening to the deceased's chest and reaching conclusions in the context of the history provided, and Dr Lalonde agreed in his evidence with Nurse Sloss' explanation for not having focused on the deceased's chest in those circumstances.[91] Dr Lalonde agreed

[83] T 11.
[84] Exhibit 3, Tab 21, Medical Records, 12.10.12, 23.40.
[85] Exhibit 3, Tab 10 [96].
[86] T 22, 32 – 33
[87] T 21 – 22.
[88] T 18.
[89] T 19.
[90] T 32.
[91] T 32.

with Nurse Sloss that the deceased presented as having a chronic respiratory issue as an opposed to experiencing an acute event that had caused his presentation.[92]

60. Infection was not raised as a possible differential diagnosis during Nurse Sloss and Dr Lalonde's telephone conversation. Based upon what was known at the time, Dr Lalonde's evidence was that chest infection would not even have been in his top ten possible diagnoses. If a chest infection had been considered even a remote possibility Dr Lalonde indicated it would have been a relatively simply option to give the deceased a single dose of intravenous antibiotics prior to the deceased seeing Dr Steed in the morning. However, the deceased exhibited no prominent symptoms for an acute chest infection so that option was not considered.[93]

EVENTS AFTER DECEASED RETURNED HOME

61. The deceased's wife recalls they left the hospital at about 11.55 pm and arrived home at about midnight. After arriving home the deceased went to the lounge room to try and sleep or rest. The deceased's wife finished a task she had to complete and then got ready to go to bed at about 1.00 am. She spoke to the deceased, who said he felt hot but when Ms Christmas touched him he didn't feel like he had a particularly high temperature. She went to bed just after 1.00 am, leaving the deceased on the couch.[94]

62. Before she fell asleep Ms Christmas could hear the deceased coughing sporadically. She describes it not as a heavy cough, but "just a light irritant cough."[95] She does not mention him vomiting after coughing at this time, as he had been prior to the hospital visit. Ms Christmas woke up sometime during the night and could no longer hear the deceased coughing, so she went to check on him. She found the deceased sitting in a chair in the computer room. He was wearing only his underwear and his face was expressionless. She noticed that he was holding a container and there were tissues in it marked with fresh blood, which she assumed was due to a nose bleed.[96]

63. Ms Christmas tried to persuade the deceased to come to bed but noted he appeared anxious, so she suggested that they watch a DVD together to try to calm him down. The deceased set up the

[92] T 34 – 35.
[93] T 36 – 37.
[94] Exhibit 3, Tab 10 [99] – [102].
[95] Exhibit 3, Tab 10 [103].
[96] Exhibit 3, Tab 10 [104] – [106].

DVD without assistance and Ms Christmas noted he didn't cough during this process. He tried to sip some flat soft drink while watching but vomited it back up. After watching the DVD for only about ten minutes the deceased said that he was having difficulty staying awake and Ms Christmas suggested he should lie down with her. She went to bed and the deceased eventually joined her.[97]

64. The deceased had not been in bed long when he said to his wife "This isn't working," and then followed with "I'm confused." Ms Christmas agreed and raised the question of whether they should go back to the hospital or wait for the doctor's appointment.

65. The deceased then asked Ms Christmas, "Is this thing going to kill me?"[98] This response immediately prompted Ms Christmas to decide that they should return to the hospital. The deceased went to the toilet while Ms Christmas got him some clothes. He dressed unassisted and Ms Christmas then went to the garage and moved the car as close to the house as possible to make it easier for the deceased to get to the car. She then walked back to the house and stood at the door. She asked the deceased if he was coming and he responded "If I can." He was sitting in a chair approximately two metres from the door at this time.[99]

66. The deceased told Ms Christmas "I'm having extreme difficulty breathing,"[100] although she noted that to an outside observer it was not apparent that he was struggling to breathe as he was not coughing or wheezing or showing any other detectable sign of difficulty. She went over the deceased and took his hand to help him up. As she held his hand the deceased suddenly collapsed. His hand lost all strength and his body slumped over. Ms Christmas then ran to the phone and called for an ambulance.[101]

67. After making the call to emergency services Ms Christmas returned to the deceased and tried unsuccessfully to lift him off the chair. She then tried to straighten him up in the chair to open his airway and performed heart compressions as best she could in the circumstances. She was still doing compressions when the ambulance arrived.

68. Three volunteer ambulance officers attended the deceased's home. They had received a call to attend as a priority 1 at

[97] Exhibit 3, Tab 10 [109] – [115].
[98] Exhibit 3, Tab 10 [119].
[99] Exhibit 3, Tab 10 [120] – [125].
[100] Exhibit 3, Tab 10 [125].
[101] Exhibit 3, Tab 10 [126] – [130].

approximately 6.00 am and they arrived at the scene at 6.18 am. They took over care from the deceased's wife and placed the deceased on the floor. No pulse could be detected and they began to perform cardiopulmonary resuscitation on the deceased.[102] After continuing CPR for approximately 20 minutes they noted the deceased still had no pulse, was not breathing, his heart showed no electrical output and his pupils were fixed and dilated. In those circumstances, a decision was made to cease resuscitation efforts and he was certified life extinct. Dr Steed attended the home and spoke briefly to Ms Christmas. Police officers were informed of the unexpected death of the deceased and a coronial investigation commenced.[103]

CAUSE OF DEATH

69. A post mortem examination was conducted by a Forensic Pathologist, Dr D.M. Moss, on 17 October 2012. The initial examination revealed heavy congested lungs with some pulmonary oedema and purulent appearing mucus in one of the lobes. Microscopic examination of tissues showed patchy, although widespread, evidence of acute infection within the lungs (bronchopneumonia and bronchiolitis).[104] Virology testing was conducted of the right and left lung and ruled out most common viruses. [105]Microbiology testing did not show a specific pathogenic organism. However, Dr Moss explained that bacteria may be difficult to identify post mortem and it was most likely that the infection in the lungs was an acute bacterial infection.[106]

70. Mild scarring of the heart and some hardening and narrowing of the blood vessels over the surface of the heart was identified. Mild chronic scarring of the kidneys was identified and the liver showed mild congestion and fatty change. There was evidence of old strokes.[107]

71. Biochemistry testing showed evidence of good diabetic control.[108]

72. Toxicology analysis showed a therapeutic level of diazepam (Valium) and a low therapeutic level of paracetamol. The antiemetic metacolpramide (Maxolon) and the antidepressant paroxetine were also detected. There was no evidence of alcohol or common drugs of abuse.[109]

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[102] Exhibit 3, Tab 10 [134].
[103] Exhibit 3, Tabs 13, 14, 15; and Tab 21, St John Patient Care Record.
[104] Exhibit 3, Tab 4.
[105] Exhibit 3, Tab 3.
[106] Record of telephone conversation with Dr D.M. Moss 15.8.2016.
[107] Exhibit 3, Tab 4.
[108] Exhibit 3, Tab 4.
[109] Exhibit 3, Tabs 4 and 5.

73. Ms Christmas raised some concerns in material provided to this court about the role that the medications provided to the deceased in hospital the night before his death might have played in his death. None of the toxicology results suggested that there were any concerning levels of medications in the deceased's system. I will deal more specifically with her concerns about the medications administered later in this finding, but note that there is no evidence before me that those medications contributed to the deceased's death.

74. After considering the results of all the investigations Dr Moss formed the opinion that the cause of death was bronchopneumonia and acute bronchiolitis.[110] I accept and adopt the conclusion of Dr Moss as to the cause of death.

75. Dr Moss indicated that the bronchopneumonia and bronchiolitis may have been present at the time the deceased underwent the earlier chest x-ray, even though it was not noted on the results, if the infection was in the early stages and also because the bronchiolitis is located in the alveoli rather than in the air spaces, which is more difficult to see on a chest x-ray.[111]

76. It is relevant to note in that regard that, as part of the coronial investigation, the chest x-ray images were reviewed by Dr Richard Price, Head of Radiology at Fiona Stanley Hospital, who also found that the chest x-ray showed that the lungs were clear, with volume and architectural changes consistent with COPD but no signs of consolidation.[112]

COMMENTS ON SUPERVISION, TREATMENT AND CARE

77. Under s 25(2) of the *Coroners Act 1996*, a coroner may comment on any matter connected with the death, including public health.

78. Ms Christmas provided detailed information to the coronial investigators and expressed her concerns in relation to some aspects of the health care provided to her husband prior to his death. In particular, she expressed the opinion in her statement that the hospital staff could have kept the deceased alive "if they had taken his situation more seriously"[113] and avoided jumping to conclusions at the triage stage.[114] Ms Christmas also

[110] Exhibit 3, Tab 4.
[111] Exhibit 3, Tab 4.
[112] Exhibit 3, Tab 19.
[113] Exhibit 3, Tab 10 [161].
[114] Exhibit , Tab 12, p. 7.

suggested that the treatment of the deceased should be viewed in the broader context of considering the potential weaknesses of a health system linking doctorless smaller hospitals with larger rural hospitals such as Northam.

79. In investigating the death of the deceased, I have kept in mind these concerns raised by Ms Christmas.

WACHS Response

80. At the request of the Coroner's Office Ms Caroline Langston, the Wheatbelt Regional Director for the WA Country Health Service (WACHS) provided a report about the investigation into the deceased's death conducted by the WACHS. Ms Langston advised that following a clinical incident review the issues identified were:

- A failure to complete a secondary assessment prior to discharge in the physical absence of a doctor;
- Adequacy of the record of phone consultation.

As a result of the clinical review the Regional Nurse Director met with staff at the hospital to discuss communication style and the importance of thorough secondary assessment.[115]

81. I am also aware from correspondence that senior medical staff from the WA Country Health Service have also met with Ms Christmas personally to discuss the deceased's death, explain the post mortem findings and provide some open disclosure about events and hear her concerns.[116]

82. The absence of contemporaneous documentation of the phone conversation between Dr Lalonde and Nurse Sloss in the form of detailed notes that could be included in the deceased's medical record, certainly presented difficulties for the coronial investigation. As noted at the start of this finding, there was little information available to coronial investigators as to what had occurred prior to convening the inquest and hearing the evidence of Nurse Sloss and Dr Lalonde. Dr Fatovich was also hampered in providing an assessment of the care by the gap in the record keeping.

83. I note that following the WACHS review that problem has been raised with the staff involved, so I do not take it further.

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[115] Letter to Principal Registrar, Coroners Court of WA from Ms Langston, Regional Director Wheatbelt, WACHS, 14 November 2013.
[116] Exhibit 3, Tab 12; Letter to Principal Registrar, Coroners Court of WA from Ms Langston, Regional Director Wheatbelt, WACHS, 14 November 2013.

GP Review

84. Dr Barry Fatovich, a very experienced general practitioner who has been working general practice since 1978 and is also involved in teaching general practice to medical students and Registrars,[117] was asked as part of the coronial investigation to review the medical care given to the deceased on the evening prior to his death. Dr Fatovich provided two reports, the first after he had reviewed the initial material available[118] and the second after he was provided with the evidence given by Nurse Sloss and Dr Lalonde.[119]

85. Dr Fatovich was aware that the deceased had seen Dr Steed on 27 September 2012 and 10 October 2012) and was provided with the deceased's wife's account of events on the night of 12 October 2012 as well as the relevant medical records.

86. Dr Fatovich notes that the deceased's observations at discharge were stable, with no change in his respiration rate, an improvement in his oxygen saturation to 98%, an improvement in his blood pressure (125/100) and a general decrease in his temperature, although it had gone up again to 37.5°C from a low of 37°C over that time. The deceased's neurological observations throughout were normal and stable, which is consistent with his wife's account.[120]

87. Dr Fatovich considers that the treatment of the deceased's gastrointestinal symptoms was appropriate. However, he observes that the focus on the deceased's gastrointestinal symptoms seems to have caused the nurses to overlook the significance of the deceased's slightly elevated temperature.

88. Dr Fatovich explains in his first report that the most common cause of an elevated temperature is an infection, which in the elderly is most commonly found in the bladder or chest. Although the deceased's temperature dropped somewhat while he was at York Hospital, Dr Fatovich believes this was most likely due to the air-conditioning and then perhaps assisted later by the administration of Panadol. The environment and treatment therefore helped to obscure the underlying disease as the nurses were falsely reassured by the temperature settling. Dr Fatovich also suggests that the nursing shift change may have contributed to the nursing staff not fully recognising the subtle changes in

[117] Exhibit 3, Tab 17 and Exhibit 4.
[118] Exhibit 3, Tab 17.
[119] Exhibit 4.
[120] Exhibit 3, Tab 17.

his clinical state.[121] Further, Dr Fatovich notes that, according to the deceased's wife the communication style of the nurses was abrupt, which perhaps caused the history given by the deceased to be less comprehensive than it might have been.[122]

89. Nurse Sloss accepted in her evidence that it occurred to her there was a possibility that the deceased had an infection. She mentioned the deceased's initial high temperature (although it came down when she was observing him), his reported difficulty in swallowing (although it was thought this was possibly due to his previous stroke) and his 'wet' chest as symptoms that might point to this conclusion. However, given the overall picture seemed to her to be an abdominal complaint and his temperature dropped after the initial reading, she dismissed infection as a likely possibility.[123]

90. Dr Fatovich notes in his first report that Murtagh's textbook of General Practice identifies that the "elderly have a problem with impaired thermoregulation so they may not develop a fever in response to suppurative infection compared with younger people. This can be misleading in the diagnostic process."[124] He states that it is difficult to comment on whether the nurses in the emergency department should be expected to know that an older patient may have an impaired temperature response, as opposed to nurses who work in geriatric care.[125]

91. Dr Fatovich also notes that pneumonia can present with abdominal pain but clarifies that it is not a classical or typical presentation (more the exception than the rule), so it is perhaps not surprising that Nurse Sloss did not see this as an obvious marker of pneumonia.

92. In conclusion, based on Dr Fatovich's reports it appears that while there were some signs that the deceased had developed a chest infection when he was at York Hospital, they were not necessarily symptoms that would be obvious to a nurse such as Nurse Sloss. This was consistent with her evidence that there were some signs that made her think of the possibility of infection, but ultimately dismiss it as a likely cause of his symptoms.

93. Dr Lalonde was asked whether Nurse Sloss raised the possibility of infection with him during their telephone call. Dr Lalonde

[121] Exhibit 3, Tab 17.
[122] Exhibit 3, Tab 17.
[123] T 10 – 11.
[124] Murtagh's General Practice, 5th edition, John Murtagh, McGraw Hill Australia Pty Ltd, 2011, p.569.
[125] Exhibit 3, Tab 17.

indicated that the focus of their conversation was on the deceased's abdominal pain and infection as a differential diagnosis was not raised.[126] He also indicated that based on what was known about the deceased on the night, it would not have placed high on the list of differential diagnoses based on his experience.[127]

94. During his evidence Dr Lalonde indicated that looking back now in hindsight, with the benefit of the information that the deceased had a high level of predisposition to a chest infection due to his history of stroke (so potential for aspiration) and his history of a recent fall that might have affected his mobility, a suspicion might be raised of infection playing a role in the deceased's reported pain and other symptoms.[128] However, he only became aware that there was concern the deceased had potentially fractured his rib sometime after the deceased's death.[129] Also, Dr Lalonde emphasised the lack of other symptoms you would generally expect to see in someone with that level of lung infection, namely: an acute pleuritic cough, difficulty breathing reflected in a higher respiratory rate (for example 35 or 40 rather than the deceased's recorded 24), evidence of fever, marked tachycardia and a notable decrease in oxygenation.[130]

95. Dr Fatovich suggested that if Dr Lalonde had seen the fax from York Hospital identifying the deceased's initial temperature of 38°C this might also have prompted him to consider a chest infection as a cause of his fever. In that regard, Dr Fatovich described the fact that Dr Lalonde did not receive the fax before he left the hospital and received Nurse Sloss' call as a system problem.[131] No evidence was given about why this occurred, and I note that Dr Lalonde did not give evidence that he thought this would have altered his view as the temperature was not in the range he would expect with pneumonia and it had settled to a normal range at the time he spoke with Nurse Sloss.[132] Therefore, I do not make any comment about the system in place at the time that allowed this to occur.

96. As noted above, Dr Moss provided some explanation for why the chest x-ray might not have shown the developing chest infection, even if it were present, but it does not explain why the deceased was relatively asymptomatic when he presented at York Hospital. It is also not clear why the chest infection progressed so rapidly, from a relatively clear chest x-ray the day before and few obvious

[126] T 36.
[127] T 36 – 37.
[128] T 37 – 38.
[129] T 29.
[130] T 33 – 34, 38.
[131] Exhibit 3, Tab 17.
[132] T 33 – 34.

symptoms that evening, to an acute infection by the next morning. Dr Fatovich could not provide an explanation for why this occurred[133] and Dr Moss and Dr Lalonde also did not suggest any explanation.

97. Dr Price, who reviewed the chest x-ray images, noted that the chest x-ray showed the presence of a hiatus hernia, which might have had some relevance to his reported symptoms on the night he attended York Hospital. In that regard it would have assisted the York Hospital staff if they had known of this result. However, this is more relevant to diagnosing the cause of his symptoms and does not explain why he was largely asymptomatic for infection, nor why the deceased succumbed to such a rapidly progressive illness.[134]

98. If Nurse Sloss or Dr Lalonde had included the possibility of infection in their differential diagnosis that night, there were some options available to them. The most obvious would have been to administer intravenous antibiotics. Dr Lalonde accepted that it would have been simple to give the deceased a dose of intravenous antibiotics prior to his seeing Dr Steed in the morning, if it had been thought that there was a remote chance he had a chest infection. However, at the time it was not considered necessary as infection was not at the forefront of their minds and Dr Fatovich agreed from his review that the evidence for a chest infection at that time was not strong.[135]

99. It is also relevant to note that if antibiotics were administered they may have assisted the deceased to recover from the infection, but it cannot definitely be said that they would have changed the outcome.[136]

100. Other options included transfer to Northam Hospital for a repeat chest x-ray and a full blood picture, but Dr Fatovich notes that given the improvement in the deceased's symptoms, it would not have been a reasonable course to adopt that night.

101. The other option was to admit him at York Hospital for further observation. The benefit would have been that routine observations would have revealed the seriousness of the deceased's underlying condition as his condition deteriorated. However, according to Dr Fatovich, based on the clinical picture on the night even admitting the deceased to York Hospital would have been overtreatment. It would also have been dependent on the deceased agreeing to that course even though he was feeling

[133] Exhibit 4, p. 1.
[134] Exhibit 3, Tab 19.
[135] T 36 – 37; Exhibit 4, p. 2.
[136] Record of telephone conversation with Dr D.M. Moss 15.8.2016.

better.[137] Nurse Sloss' evidence in her statement was also that Dr Lalonde had instructed her to send the deceased home after treatment,[138] although she said in her oral evidence that she recalled that Dr Lalonde had also said that if the deceased and his wife were worried they could go over to Northam Hospital, but they preferred not to do that, which was understandable given the time of night, the distance to travel and the reassurance they were receiving from the clinical staff about the urgency of his medical condition.[139]

Medications Administered

102. As mentioned above, Ms Christmas appears to have done some independent research and expressed concern about the possible adverse effects of the medications administered to the deceased at York Hospital under the direction of Dr Lalonde. Expert advice was sought from a general practitioner to clarify whether there was evidence to suggest the medications may have played a role in the deceased's death.

103. In relation to the Buscopan, Ms Christmas queried whether it may have led to the death by causing respiratory issues. I am advised that Buscopan can cause anticholinergic side effects, which are usually mild and include symptoms such as dry mouth. However, it does not commonly cause respiratory issues other than, in a very rare case, anaphylaxis. There was no suggestion from the symptoms the deceased experienced that he suffered from anaphylaxis in the hours prior to his death.

104. In relation to the Maxolon, Ms Christmas raised concerns about possible adverse effects of this medication taken in conjunction with the deceased's paroxetine medication, such as serotonin syndrome. Serotonin syndrome is a very rare complication of metoclopramide administration. Symptoms include confusion, hallucination, seizure, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness and tremor. The deceased is not reported to have had these symptoms, which does not support the conclusion that he developed the syndrome.

105. Ms Christmas appears to believe that the deceased was given an injection of desmethyldiazepam, which she suggests may have suppressed his respiration. Desmethyldiazepam is a metabolite of diazepam (Valium), which was one of the deceased's regular medications. Nurse Sloss's evidence is that she encouraged the deceased to take one of his own diazepam tablets that night to alleviate his anxiety, although Ms Christmas disputes this.

[137] Exhibit 3, Tab 17.
[138] Exhibit 3, Tab 22 [30].
[139] T 17.

Nevertheless, the deceased was known to take diazepam regularly, so it is not surprising that the metabolite was found post mortem and there is no evidence it played a role in his death.

106. Ms Christmas specifically told the nursing staff that the deceased should not be given opioid medication. He was given Ketoralac, which is an anti-inflammatory and is not related to opioid medications. It is also not associated with respiratory depression. The deceased had received other anti-inflammatory medications in the past without any report of side effects, so it is unlikely that this medication caused any major adverse effects to the deceased that evening and into the morning.

107. Ms Christmas also raised a concern about the fact that the deceased was not monitored for long after the administration of the medications. As noted above, the WACHS indicated that a secondary assessment would ordinarily be expected before a patient is discharged when they have not been physically seen by a doctor and this issue has been addressed with the staff. A secondary assessment would also have gone some way to alleviating Ms Christmas' concerns about possible adverse effects of the medications that were administered, and is another indicator of why that practice should be routinely followed.

Telehealth

108. At the time of the deceased's death a new system known as the Emergency Telehealth Service (ETS) had recently begun to be used in the WACHS. The ETS uses high definition videoconferencing equipment to provide specialist emergency medicine support to clinical staff in rural and remote hospital emergency departments. They assist with the diagnosis, treatment and transfer of critically ill and injured emergency patients.[140]

109. The Director of Medical Services of the WACHS Wheatbelt, Dr Peter Barratt, has advised that York Hospital was one of the first sites to come online with ETS. The hospital commenced use of the service on 31 August 2010, some six weeks prior to the deceased's death. However, in October 2010 the ETS was still in a trial period and its hours of operation were limited to Fridays, Saturdays and Sundays from 10.00 am to 10.00 pm each day. If staff at York Hospital considered that they needed expert emergency medical advice or assistance during those operating hours they were able to call the ETS for any type of case.[141]

[140] http://www.wacountry.health.wa.gov.au/index.php?id=telehealth.
[141] Letter from Dr Peter Barratt (WACHS) to Counsel Assisting 29.4.2016.

110. Nurse Sloss's recollection was that the ETS was not available on the night of the deceased's death. She believes if it was, she would have used it.[142] She was, however, vague about the exact date when the ETS commenced use at York Hospital.[143]

111. The difference in Nurse Sloss' recollection and the information provided by Dr Barratt about the availability of the ETS can be reconciled when attention is paid to the timing of events. Although the deceased attended York Hospital at a time of night when the ETS was available, by the time Nurse Sloss took steps to contact a doctor it was after 10.00 pm. At that time ETS was no longer available as it was outside the trialled operating hours. The available option for medical advice was to contact a doctor at Northam Hospital (as had been the general practice in the past) and Nurse Sloss appropriately set about initiating that contact.

112. There remains the question why Nurse Sloss didn't initiate an ETS consultation prior to 10.00 pm? I note that the deceased had been allocated a non-urgent triage rating of 4 by Nurse Bloxsome and Nurse Sloss was required to complete her own assessment of the deceased after the nursing handover, which on her account would have taken her very close to the 10.00 pm cut off time before she could have formed any view about whether a doctor required consultation.[144] The ETS was also still in its infancy, so the nurses at York Hospital would not have been in the habit of using it. Taking into account those factors, it is explicable why Nurse Sloss did not use the ETS that night.

113. If the deceased had been seen by a doctor via the ETS, it is possible that an experienced doctor might have asked questions about the deceased's medical history that may have generated a suspicion of chest infection. However, it can't be put any higher than that. The chances of that diagnosis being made must also be viewed within the context of Dr Fatovich's observation that the evidence for a chest infection was not strong and the clinical signs were fairly subtle.[145]

114. The ETS is now available at York Hospital daily from 8.00 am to 11.00 pm. Outside of those hours Northam Hospital continues to provide medical support via telephone and video conference, as occurred on the evening in question. However, Northam Hospital now has a doctor on site at all times, which would presumably reduce the likelihood of the doctor not having the faxed LIME

[142] Email from ANFLegal to Counsel Assisting 17.5.2016.
[143] T 24.
[144] T 6 – 8.
[145] Exhibit 4.

form before them during the conference, as occurred in this case.[146]

115. Due to the implementation of ETS the WACHS believes the Wheatbelt is now much better connected to metropolitan services.[147] Both Nurse Sloss and Dr Lalonde, who are both still regionally based, gave evidence of their use of telehealth since the deceased's death. They both spoke very positively about their experience of the system.

116. Nurse Sloss described the ETS as "working really well"[148] and still continually improving. She explained how the patient speaks on a live link-up to a consultant, which she believes is beneficial to both the patient and doctor, as the patient feels like they have been seen by a doctor and the doctor is able to see the patient for themselves in detail. It is also easier to access doctors quickly as they are purely allocated to the ETS and are not also seeing patients on the wards.[149] Nurse Sloss' evidence was that she currently uses ETS several times a night if she is on a night shift and has never had a single problem with it.[150]

117. Nurse Sloss also mentioned in her evidence that they now use a new improved form that is faxed to the ETS staff instead of the old LIME form and the nurses have had a lot more training in assessment skills on what the doctors need to know as well as advanced life support skills and paediatric life support skills. Nurse Sloss described the system currently in place as a "wonderful system" and a significant improvement on the system that was in place at the time of the deceased's death.[151]

118. Dr Lalonde also currently works with the ETS and he indicated that it had made a huge difference to him from a personal point of view as a doctor based at a regional hospital, as it has significantly reduced the number of telephone calls he receives during operating hours and allows him and the other doctors at the hospital to focus on the presentations in their own emergency department. It also enables the doctors to contact an experienced emergency specialist themselves for ideas and suggestions, when required as well as enabling them to quickly find available ICU beds for very sick patients that need to be transferred.[152]

119. Ms Christmas has suggested that a lesson can be learnt from her husband's death is that triage of patients in emergency

[146] Letter from Dr Peter Barratt (WACHS) to Counsel Assisting 29.4.2016.
[147] Letter from Dr Peter Barratt (WACHS) to Counsel Assisting 29.4.2016.
[148] T 25.
[149] T 24 – 25.
[150] T 25
[151] T 24.
[152] T 39 – 40.

departments should be more careful and accurate and health professionals should avoid jumping to conclusions.[153] The changes brought about by the implementation of the ETS would appear, on the evidence, to have gone some way to achieving that goal.

CONCLUSION

120. After becoming increasingly unwell, on Friday, 12 October 2012 the deceased went with his wife to York Hospital for help. This was despite the deceased generally being reluctant to go to hospital unless absolutely necessary. On arrival they did not feel they were made welcome, which made the deceased even more anxious than he was already, and perhaps contributed to the events that followed.

121. After an initial triage by one shift of nursing staff, the deceased's care was handed over to Nurse Sloss. From the time she took over the deceased's case I accept that Nurse Sloss was attentive and endeavoured to identify the deceased's most concerning medical symptoms and treat them as best she could while also seeking medical advice on a diagnosis. Unfortunately, due to some difficulty obtaining a clear history from the deceased and his wife and the deceased's recorded observations being falsely reassuring, Nurse Sloss did not identify that the deceased had a rapidly progressive illness and the information she provided to Dr Lalonde also did not enable him to make that diagnosis. Instead, after discussion with Dr Lalonde, Nurse Sloss treated the deceased for his most obvious problem of constipation and then arranged for him to be discharged home in the care of his wife.

122. Even after returning home the seriousness of the deceased's illness was not readily apparent. However, after the deceased continued to decline and became increasingly distressed, his wife became so concerned that she decided to take him immediately back to York Hospital rather than wait for him to see his general practitioner later that morning, as arranged by Nurse Sloss. Sadly, it was too late and the deceased succumbed to bronchopneumonia and acute bronchiolitis in the arms of his wife at their home.

123. The deceased's sudden death, after being discharged from York hospital only hours earlier, has understandably caused the deceased's widow enormous grief and left her with many unanswered questions as to how it could occur. Regrettably, I am only able to answer some of those questions in this inquiry, as

[153] Exhibit 3, Tab 12, p. 7.

many of her concerns are outside the scope of this investigation, which requires me to focus upon the findings I must make under s 25(1) of the *Coroners Act*. However, I have endeavoured to address her concerns wherever possible.

124. In the end, what is definitely known is that the deceased died as a result of bronchopneumonia and bronchiolitis, that was potentially treatable if it had been identified in time. A chest x-ray taken a couple of days before his death did not identify any signs of the infection, which suggests that it may have been a rapidly progressive form of illness. In addition, despite the seriousness of the infection, the deceased was largely asymptomatic until his death. This made the diagnosis and treatment even more difficult.

125. A medical review of the care given to the deceased has concluded that, while regrettably, the failure to diagnose the deceased's chest infection was understandable given the lack of severity of his infective symptoms. The system in place at that time to some extent contributed to that occurring, with the doctor reliant solely on the information conveyed to him by the nurse. Since that time there has been a significant improvement in procedures, with the implementation of the ETS on a much broader basis. There is also additional hope that it will eventually become available 24 hours a day/7 days a week.[154] Such a system still cannot not entirely replicate having the doctor and patient together in the hospital face to face, but in a state as large and sparsely populated as Western Australia that system is not always possible. I am satisfied that the implementation of the ETS is at least a significant step towards a viable, safe alternative to the ideal.

126. In conclusion, taking into account the cause of death and the general circumstances of the death, as outlined above, I find that the manner of death was natural causes.

S H Linton
Coroner
28 September 2016

[154] T 39 – 40.