CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Wilfred 'Whippy' Robert Willams
Hearing dates:	14 to 16 April 2025 Cowra Local Court
Date of findings:	14 August 2025
Place of findings:	Coroners Court of NSW, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Discretionary inquest – death of First Nations man following emergency presentation to Cowra District Hospital – deceased did not wait during triage assessment and later died at home – assessment of appropriateness of care provided by Western NSW LHD – failure of nursing staff to escalate presentation to medical officer in accordance with NSW Health policy – health outcomes for First Nations persons – Aboriginal health workers – the need for consultation with Aboriginal communities and organisations in the delivery of culturally safe health care
File Number:	2019/00288607

Representation:	**Counsel Assisting:** Chris McGorey instructed by Sarah Crellin and Imogen Pearson of the NSW Crown Solicitor's Office **Family of Whippy Williams:** Tenika Vakauta and Danielle Captain-Webb of Legal Aid NSW **Western NSW LHD:** Patrick Rooney, instructed by Matthew Renwick of McCabes **RNs Annaleigh Moore and Caroline Townsend:** Katherine Doust of Nurses and Midwives Association **Drs Peter Davidson and Tij Paguti:** Cameron Jackson, instructed by Barbara Versace of Avant Law
Findings	**Identity** The person who died was Wilfred Robert Williams (Whippy). **Date of death** He died on 13 September 2019. **Place of death** He died in Cowra, NSW. **Cause of death** He died of diabetic ketoacidosis with multi organ failure caused by pneumonia. **Manner of death** Whippy died at home, after leaving Cowra District Hospital before being seen by a medical practitioner. The triage process was flawed and the environment lacked cultural safety.

Recommendations	To the Chief Executive of the Western NSW LHD (**WNSWLHD**): Recommendation 1: The WNSWLHD examine developing and implementing an Aboriginal Health Partnership Advisory Consultative Group, whether a single group for the whole of the WNSWLHD or groups for specific communities within the WNSWLHD, considering the Terms of Reference for the Central Coast Local Health District Aboriginal Health Partnership Advisory Council/Committee and the findings in these proceedings. Recommendation 2: The WNSWLHD, in consultation with Aboriginal Health Partnership Advisory Consultative Group(s), review the efficacy of the cultural competency training it provides to its medical staff (particularly those working in EDs) particularly with respect to factors that may contribute to an Aboriginal patient feeling reticence to remain in a hospital setting or depart before undergoing a medical examination. The review should consider whether the training should mandate a component of face-to face training, which is locally created. Recommendation 3: The WNSWHLD consider enhancing its Aboriginal Health Worker program by ensuring Aboriginal Health Workers are reasonably available 24 hours a day.

Table of Contents

Introduction

1. This inquest concerns the death of Wilfred Robert Williams, known to everyone as Whippy. At the time of his death, Whippy was only 45 years of age.

2. Whippy was a Wiradjuri man who was well known in Cowra. He came from a strong and loving family and was survived by his parents, brothers and extended family. Unfortunately, Whippy's mother, Lorraine (Tammy) Bamblett died before these proceedings were held. She was his principal carer and the driving force behind requesting a full examination of the circumstances of her beloved son's death. Unfortunately, these proceedings were delayed a number of times, including during the court shutdown period caused by COVID-19. It is regrettable that this delay resulted in her not being present at the inquest she worked so hard to initiate.

3. Whippy had been unwell for a few days prior to his death. On 12 September 2019 his family were very concerned about his health and took him to the local general practitioner's surgery and then to Cowra Hospital seeking treatment. Despite the family's efforts, Whippy was never seen by a doctor. The reasons for this have been a focus of this inquest.

4. After unsuccessfully seeking treatment, Whippy and his family returned home. Tammy found her son unresponsive in the early hours of the morning of 13 September 2019. She immediately contacted Whippy's father, Cameron (Barty) Bamblett who lived nearby and together they called for an ambulance. Paramedics attended, but Whippy could not be revived.

5. Whippy's untimely death has caused his community enormous pain and anguish. I am concerned that his family were not treated with the empathy and care they deserved. In small towns deaths such as Whippy's have the capacity to significantly impact the trust community members have in important institutions such as the local hospital. There is a pressing need for community members to believe the Local Health District (LHD) can acknowledge what went wrong and work for change. A new Hospital will be opened shortly. I hope the LHD finds ways to rebuild trust with those affected by Whippy's death.

6. Family members attended this inquest each day and their grief was palpable. It was clear to me that the family had always done their best to care for Whippy and the circumstances of his death remain enormously distressing. I offer my sincere condolences to his family for their profound loss.

7. I have come to the conclusion that flaws in the triage process resulted in lost opportunities which ultimately robbed Whippy of any chance of survival. Whippy's condition was treatable and his death likely preventable with appropriate and timely medical care. The experts were clear that Diabetic Ketoacidosis will respond with swift intervention. They told this court that

had timely and adequate care been provided Whippy may well have lived. I accept their opinion.

The role of the coroner and the scope of the inquest

8. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

9. A list of issues was prepared before the proceedings commenced and provided focus for the inquest.[3]

10. In final submissions counsel assisting set out a brief chronology of events which summarized much of the evidence before this court. I have relied heavily upon this document in recording my written reasons, at times directly adopting the summary and submissions put forward by the assisting team. However, I have reviewed the evidence carefully where differences in fact or emphasis are noted by the parties and in all matters the conclusions are my own.

The context of Whippy's death

11. It is crucial to place Whippy's death in context at the outset.

12. Whippy had a history of hypertension, heavy smoking, diabetes, and schizophrenia. He had been admitted for mental health treatment as an involuntary patient on a number of occasions. Whippy's experiences in hospital had caused him to avoid medical treatment at times. Although he had not been at Bloomfield Hospital since 2016, he retained a strong fear of being placed in inpatient care.

13. Whippy's death took place against the backdrop of well-known deficiencies in the resourcing of health care in rural and regional NSW. NSW Health recognises the very real difficulties in providing care in rural areas which can be adversely impacted by distance, staffing shortages and lack of continuity of care.

---

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] Draft List of Issues as at 25 March 2025: (1) Mr Williams' capacity to properly care for himself; (2) What supports were in place to assist Mr Williams and Ms Bamblett with his care prior to 12 September 2019?; (3) Over what period of time did Mr Williams' ketoacidosis and organ failure onset? Was there appropriate and adequate treatment for Mr Williams' diabetes?; (4) Adequacy of the treatment of Mr Williams at Cowra District Hospital on 12 September 2019 and whether or not it was culturally responsive; (5) Contingency planning in respect of Mr Williams' physical and psychiatric health conditions.

14. The court heard that beyond factors that exist for all rural and regional health consumers, a broad range of structural and social factors further impact health outcomes for Aboriginal and Torres Strait Islander people.[4] There are clear links between socioeconomic disadvantage in Aboriginal communities and ongoing disadvantage in health outcomes for First Nation people.

15. Professor Yin Paradies, Chair in Race Relations, School of Humanities and Social Sciences, Faculty of Arts and Education, Deakin University provided a report to this inquest. He has conducted research on the health effects of racism and unconscious bias over many years. He advised the court that numerous Australian studies have noted disparities in hospital care experienced by indigenous patients compared to non-indigenous patients.[5] He referred the court to research which indicates that Aboriginal and Torres Strait Islander people are more likely to have "leave events" when compared to non-Indigenous Australians. These leave events can be associated with longer waiting times, which in turn can influence a decision to leave prior to being fully assessed.[6] He also referred to research which explains that waiting for care can cause trauma, anxiety and shame for Indigenous people. [7]It is useful to be aware of this research to guard against the possibility of implicit bias. Professor Paradies explained the need to examine the possibility of implicit bias in all healthcare decisions and to develop strategies to identify racial bias so that safer care can be provided. The issue of culturally safe care was relevant to these proceedings and it is an issue to which I will return.

16. Unfortunately, not all rural areas have Aboriginal Controlled Community Health Organisations (ACCHO) and many communities need to rely exclusively on general practitioners in private practice and local Emergency Departments to receive care.

17. NSW Health recognises the need for cultural safety when providing medical care and has created a number of training modules aimed at providing Local Health District staff with essential skills. The efficacy of these programs was of interest in these proceeding and is an issue to which I will return.

The evidence

18. The Court took evidence over three hearing days. The Court also received extensive documentary material in three volumes. This material included witness statements, medical records, photographs, policies and procedures.

19. The Court was also assisted by a number of experts who provided written reports including Associate Professor Randall Greenberg and Dr Simon Quilty. Both Associate Professor

[4] Inquiry into Diabetes (NACCHO submission) Volume 3, Tab 59 p.7.
[5] Paradies Report, Volume 2, Tab 55 p.4.
[6] Paradies Report, Volume 2, Tab 55 p.4
[7] Paradies Report, Volume 2, Tab 55 p.4

Greenberg and Dr Quilty also provided a joint report and gave oral evidence in conclave before me.

20. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

Background and brief chronology

21. Whippy lived with a number of known medical conditions.

22. Whippy was diagnosed with schizophrenia during his teenage years and prescribed medication for management of this condition. He was involuntarily admitted to mental health inpatient units in his early adult life including Bloomfield Hospital in Orange, NSW.[8]

23. Whippy's first admission for mental health treatment seems to have been at Bloomfield Hospital in May to June 1998 (9 May to 19 June 1998). The records of that admission noted it was in the context of schizophrenia, "*borderline intellectual capacity*" and other issues.[9]

24. There were further mental health inpatient admissions to Bloomfield Hospital in 2004, being January to February 2004 (27 January to 4 February); May 2004 (5 to 15 May).[10]

25. His last inpatient admission to Bloomfield Hospital for mental health treatment was between 5 and 15 December 2016.[11]

26. I accept that Whippy developed a fear or aversion to hospital and inpatient environments because of his experiences when admitted in the past. It follows that had this fear been properly understood at the ED in Cowra the need to triage him quickly would have been immediately revealed.

27. A Community Mental Health record made in March 2017 (discharge summary 30 March 2017: Vol 1 Tab 19 p.4) noted:

> "*Wilfred is a 42 year old Aboriginal man who is cared for by his mother Tammy. Wilfred has a long history of Schizophrenia…and he also has a mild intellectual disability. Wilfred was discharged from Bloomfield hospital in early December 2016…."*

28. As for the reference to "*mild intellectual disability"*, it does not appear Whippy underwent formal cognitive testing as regards a possible intellectual disability or whether this was based on reports from his family and the impression of the medical practitioners who had contact with him. Whatever the case, I accept that Whippy had some cognitive impairment

[8] Cameron Bamblett statement, Volume 1 Tab 7 [5].
[9] Pauline Rowston statement (Rowston statement), Volume 1 Tab 27 p.4.
[10] Rowston statement, Volume 1, Tab 27 p.3.
[11] Rowston statement, Volume 1, Tab 27 p.3.

and that this is a relevant factor in the care he received over the years. There was clearly a need to listen carefully to his mother, who was his greatest support.

29. The Community Mental Health records for March 2017 referred to scheduled appointments Whippy had not attended with the Community Mental Health Team for review of his medication. It was noted that *"Wilfred did not attend as he was frightened that he would be sent back to Bloomfield hospital"* although his mother (Ms Bamblett) attended to discuss Whippy's condition.

30. A progress note made by a psychiatric registrar on 9 February 2017, at a scheduled outpatient review that Whippy did not attend, noted:[12]

> *"[Whippy's mother] reported that Wil has shown intention to avoid the interview today, and the thought of any potential admission to Bloomfield Hospital is frightening him…he gets anxious and scared with any treatment associated with hospital…she brought up the suggestion to attend consults at the medical centre in Cowra instead to receive proper treatment….patient has been going to the medical centre regularly for injections, and thus Tammy feels that he'll be more compliant in attending consultations there…"*

31. In a subsequent note made on 15 March 2017, the attending psychiatric registrar noted:[13]

> "*On mental state examination Wil is an overweight, indigenous man, casually, neatly dressed in yellow T-shirt and shorts. Difficult to establish rapport with Wil. He appeared euthymic with blunt affect and staring gaze.* ***There is poverty of thought and his speech mumbled, monosyllabic and difficult to understand at times****. There is no suicidal /homicidal thoughts.* ***There is evidence of slow information processing****. Perception normal. He was attentive at the beginning of interview however stood up abruptly in the middle of interview and stated that he needed to go to the toilet.* ***Limited insight and with regards to judgement he has presented today for mental health review, which he usually/historically avoids***." (emphasis added)

32. Whippy also suffered Diabetes Mellitus (Type 2). It appears from Whippy's GP records that he was diagnosed with that condition by 2010. His GP records indicate that he was non-compliant with general lifestyle advice. He was *"addicted"* to coca cola, continued to smoke and seemed unable to alter his lifestyle.[14]

[12] MH progress note 9.2.2017 Volume 1 Tab 24 p.14-15.
[13] MH progress note 15.3.2017 Volume 1 Tab 24 p.21-22.
[14] Cowra Medical Service records, Volume 1 Tab 15, p.2.

Whippy's circumstances as of September 2019

33. Counsel assisting set out a summary of Whippy's circumstances at September 2019.

34. Whippy had lived long term with his mother and depended on her for assistance with his day to day living and attending medical appointments. He was not employed, was not in a relationship and had no dependents.

35. Whippy's mother, was (and had been over the long term) his "*primary carer and knew everything about his medical history"* although this wasn't a formal arrangement. There was no guardianship order in place.

36. Whippy's physical health and diet was not ideal. He smoked, liked sugary soft drinks and didn't always eat healthily. That lifestyle was not ideal for the management of his diabetes. At the time of his death, he weighed 105kg and had a body mass index of 32.8 kg/m^2 (1.79m tall).

37. Whippy was not having regular contact or engagement with the Community Mental Health Service as of September 2019 (note: the Community Mental Health Team wrote to him on 30 August 2019 to arrangement a psychiatric review at the Cowra Health Service on 24 September 2019).[15]

38. Whippy was not in receipt of NDIS funded supports.

39. Whippy's main medical contact was through his local general practitioner Dr Peter Davidson. Dr Davidson gave oral evidence at these proceedings and impressed the court as a caring doctor who had committed his working life to rural practice. He clearly cared for Whippy, respected Ms Bamblett and had an overall understanding of the medical issues Whippy faced.

40. Whippy attended the surgery once a month for his depot injection (Abilify or Aripiprazole injection 400 mg). This was usually administered by a nurse. He also occasionally saw Dr Davidson for check-ups and issuance of prescriptions for his diabetes medication (Metformin 1000 mg).[16]

41. Many clinicians were of the view that Whippy presented with a cognitive impairment although this was never formally assessed. In the view of Dr Davidson, as detailed in his contemporaneous medical records and oral evidence, Whippy's cognitive impairment

[15] Community Mental Health Team letter 30.9.2019, Volume 1 Tab 22.

[16] PBS records record Whippy being issued on 17 May 2019 Quetiapine (60 tablets) (5 repeats) by Cowra Medical Service(no further prescriptions more proximate to September 2019): Volume 1, Tab 25. Last metformin prescription issued 20 January 2017: Cowra Medical Service Records, Volume 1 Tab 15 p.4.

declined over time (e.g. "*gradual deterioration in [his] cognition"* relative to how Whippy presented in preceding years).[17]

42. I accept counsel assisting's summary of Whippy's health as of September 2019. Whippy was vulnerable in several respects namely:

    (1) He was in his mid-forties, obese, with confirmed diagnoses of diabetes type 2 and a history of obstructive pulmonary disease.

    (2) His diabetes was poorly managed and compounded by his lifestyle particularly his diet, fondness for sugary drinks (coke) and cigarettes.

    (3) He was potentially susceptible to serious respiratory infections.

    (4) He had a long term diagnosis of schizophrenia for which he received monthly depot injections.

    (5) Impaired cognitive function and reliance on his mother regarding his accommodation and general day to day living.

43. Counsel for Whippy's family were critical of Whippy's general practitioner in a number of respects. It was noted that Dr Davidson did not consider a referral to a diabetes educator or dietician. He appeared to base this decision on his belief that behavioural change was unlikely to materialise. Ms Vakauta for the family was critical of Dr Davidson for not taking a more proactive approach to Whippy's care.

44. I accept that Whippy may have benefitted from more proactive care and agree that the lack of *"wraparound holistic care"* is regrettable. His chronic diabetes required greater attention, but I accept it would have been very challenging to manage. I have some considerable sympathy for Dr Davidson who was in a difficult position, without the benefit of having a local Aboriginal Community Controlled Health Service to which to refer Whippy.

45. Mr James Newman, Chief Executive Officer and Managing Director of Orange Aboriginal Medical Centre gave evidence before me. He has held that position for twenty years and had considerable knowledge about the provision of Aboriginal health services in Cowra, having been involved in an unfunded outreach program in partnership with the Local Health District for some five or six years until it was eventually discontinued. In his view there is a critical need to have Aboriginal Medical Services providing comprehensive health care in

[17] Cowra Medical Service Records Volume 1, Tab 15 p.2.

places like Cowra. However, in the absence of that service I note that he spoke very highly of Dr Davidson's practice and their attempts to help fill a significant gap.

46. Dr Davidson had treated Whippy for a number of years. He told the court that his nurses had developed quite a good rapport with Whippy and were usually able to encourage him to have his depot psychiatric medication. He advised there were times when they went to the car to persuade him to come in for his injection.[18]

47. In my view the criticism lies not with Dr Davidson who was running a private GP clinic, but with the lack of funding to extend ACCHO services to Cowra. Mr Newman stated that while people living in Cowra *could* travel 100 kilometres to get care in Orange, this was usually too expensive and too inconvenient to make it a realistic possibility for many.

48. The current funding levels for Aboriginal Medical Services need to be increased so that towns like Cowra, with large indigenous populations, can be adequately serviced.

Days preceding 12 September 2019

49. In the day or days preceding 12 September 2019, Whippy had a noticeable cough and had presented to his mother as lethargic or *"not his normal self"*. The latter was articulated by Ms Bamblett on 13 September 2019 to the effect of: "[*Whippy had been] coughing of late and…lately has been just laying around the house, which is a little unlike him*".[19]

Attendance at the GP surgery on the afternoon of 12 September 2019

50. Ms Bamblett and Whippy's father, Mr Bamblett, took Whippy to the Cowra Medical Service (also known as Cowra Medical Associates) on the afternoon of 12 September 2019.

51. According to Ms Bamblett's 2020 Statement:[20]

    (1) She made an appointment that day to take Whippy's to the surgery because Whippy had been "*laying around and looking sick*". He had not gotten up and gone out. This had been going on for about two days and was "*unusual".*

    (2) Mr Bamblett drove them to the Cowra Medical Centre.

    (3) On arrival there Whippy refused to exit the car.

[18] T14/4/25 19.40 onwards.
[19] See the report of Ms Bamblett in the P79A – Report of Death to the Coroner, Volume 1 Tab 1, p.3.
[20] Statement of Lorraine Bamblett, Volume 1 Tab 6 [3]-[8].

(4) Ms Bamblett said she spoke to someone at the surgery (a doctor) who said to her, when she told them Whippy would not enter, "*well take him to hospital and they'll do his bloods".*

(5) They then drove to the Cowra District Hospital which was about 10 minutes' drive from the surgery.

52. An electronic progress note made at the Cowra Medical Service that same date, at 5:03pm, by the Receptionist recorded:[21]

"*Patient DNA appointment with Dr Phuong*

Patient was in parking lot and Mum informed would not get out of the car".

53. In my view it is most unfortunate that staff at the Centre do not appear to have gone to the car to get Whippy to come inside, something it is clear they had done in the past. More critically, the failure of someone at the medical practice to contact the ED, is a significant issue and one to which I will return.

Attendance at the Cowra District Hospital Emergency Department

54. Mr and Mrs Bamblett drove Whippy to Cowra District Hospital's Emergency Department (the **ED**), which is part of the Western NSW Local Health District (**WNSWLHD**).

55. As at the current date, the Cowra District Hospital building is that which existed as at September 2019. I was informed that construction of a new hospital building is near completion and expected to open in late 2025. I had the benefit of viewing the Cowra District Hospital, including the ED, on the morning of 14 April 2025, the first day of the inquest. It is relevant to note that the carpark that was referred to in evidence is just metres from the ED entrance.

56. Upon arrival, Mr and Mrs Bamblett drove the car up a ramp at the rear of the hospital that led to the doorway providing afterhours access to the ED. This door is locked outside business hours. A person attending after business hours uses an intercom to speak to nursing staff within the ED.

57. Nearby to the afterhours access door are double doors used by paramedics to bring patients into the ED. The usual practice is for the ambulance to pull up near to that double doorway.

58. Cameras are positioned near to the afterhours access door. This captured the area immediately outside that door and the ambulance double doors. The CCTV footage

[21] Cowra Medical Service Records 12.9.2019, Volume 1 Tab 15 p.4.

captured is displayed on a monitor inside the ED. The CCTV footage from the night of 12 September 2019 was kept for about 28 days after which it was overwritten and was not available at these proceedings

59. The ED is small with a three-bed capacity with a fixed nursing station and a mobile doctor's station (computer that was moveable). A small room was set aside with AVL facilities for link up and remote consults with specialists at Dubbo Base Hospital. This was sometimes used to place patients experiencing mental health difficulties as it reduced their exposure to other patients and movements and activities within the ED.

60. A small space is assigned as a triage station with a desk, a computer and instruments for taking vital signs typically taken during triage. It is located inside between the afterhours ED entrance and the ED itself.

61. Two nurses were on shift in the ED, being Caroline Townsend (nee Stalmachowski) RN and Annaleigh Moore RN. Dr Tij Paguti, Medical Officer, was a locum on shift in the ED.

62. A security officer, Ian Burns,[22] was also on shift for the whole of the hospital.

63. There was no Aboriginal Health Worker on shift or available to be called on that afternoon.

64. Whippy was reticent about exiting the car and entering the hospital. This no doubt related to his fear and aversion to hospitals. The fact that he clearly felt unwell and was probably very uncomfortable was also likely to be a factor.

65. At some point RN Townsend commenced the triage process for Whippy. RN Townsend had been a registered nurse for approximately three years at this time. Although the records disclose that she had cared for Whippy in 2017, she had no memory of this. Due to the passage of time she also informed the court that she only had a limited recollection of her interaction with Whippy in 2019.

66. Ms Bamblett was present when RN Townsend commenced triage. This process began with Ms Townsend creating a new electronic record, within Whippy's electronic records, for that presentation. Ms Townsend took a brief report of the reason for the presentation and began taking vital signs using instrumentation in the triage area. That information was entered into the triage electronic form.

[22] Rowston statement, Volume 1, Tab 27 [28].

67. Ms Townsend was part way through taking Whippy's vital signs when he left the triage area and went outside. She had apparently taken his respiratory rate, oxygen saturations, heart rate and blood pressure but had not yet measured his blood glucose levels.

68. Whippy exited the ED waiting area and was outside near the afterhours entrance for a time. RN Townsend states he went in and out a number of times.

69. At some point Whippy told to his parents that he would not go back inside and that he wanted to return home notwithstanding their attempts to persuade him otherwise.

Initial triage record entered by Ms Townsend at 6:10pm

70. The ED activity log records Whippy being *"checked in"* at 6pm.

71. A triage form entered at 6:10pm, recorded to have been performed at 6:01pm, noted:

> *"Triage COW*
>
> *Triage Presenting Information: lethargic*
>
> *Additional Presenting Information:* ***mother brought patient up to hospital due to being [lethargic]] today****. went to the GP today but refused to get out of the car mother reports to brought him here. needed a lot of convincing to get out of the car and unable to triage due to keep leaving department. mother reports he was in bed all day today and yesterday and dozing off a lot today. has a moist cough for a few weeks. vocal chest. Mother states he is drink a lot of fluids recently.*
>
> *Denies pain, denies SO*
>
> *Lives at home with mother.*
>
> *History:*
>
> - *MH problems*
> - *Smoker*
> - *Past drug use.*
>
> *….*
> ***Triage Category: 2***
> *Triage Group: Emergency COW*
> *…*
> ***Indigenous Status: Neither, Aboriginal nor Torres Strait Islander***

…

Respiratory rate: 23 brpm.

Oxygen saturation: 100%.

...

Systolic blood pressure: 132mmHg

Diastolic Blood pressure: 87mmHg

Peripheral Pulse Range: 157 bpm

Peripheral Pulse Rate Regularity: Regular

Temperature, Axilla: 36.8 DegreC.

…

Triage Alerts ST:

*****NO GENERAL ALERTS AVAILABLE FOR THIS PATIENT"*

(Emphasis added)

72. Whippy's electronic record did not have alerts about (i) his mental health, (ii) possible cognitive impairment or (ii) his fear and/or aversion to hospital settings.[23]

73. There are five triage categories used by NSW Health which descend from *Triage category 1 (Immediate treatment needed)*, being people considered to have a serious and life-threatening condition and require immediate treatment, down to *Triage category 5 (Non-urgent condition*), being people considered presenting with minor illnesses or symptoms recommended to have treatment within 2 hours.

74. Whippy was assigned a *"triage category 2"* by Ms Townsend when she electronically entered the triage record. The applicable NSW Health procedure for Triage categorisation was *Triage of Patients in NSW Emergency Departments* (Issued 6 Dec 2013).[24] This specifies that a "*Triage category 2: Urgent treatment needed"* is assigned to patients that potentially have an "*imminently life-threatening condition"* and recommends treatment by a medical officer within 10 minutes.

75. Ms Townsend's assignment of a *"triage category 2"* reflected her view as to the potential severity of Whippy's condition based on the information known to her. That information included the vital signs she had obtained which included Whippy's heart rate of 157 bpm.

[23] In a statement concerning the electronic alert arrangements, Ms Pauline Rowston (Tab 27 Vol 1 [19]) outlines the procedures for alerts in electronic medical records (*this includes that there are options for a "Fear associated with health care" and "Fear of hospitals"* alert).

[24] See NSW Health Triage policy at Volume 1, Tab 40.

Ms Bamblett, in her written statement, recalled Ms Townsend stating to the effect that Whippy's "*heart is racing"*.[25]

76. Whippy's measured heart rate fell within the NSW Health Standard Adult Observations Chart's "*red zone"* category. This was a high pulse rate for someone who had attended in a vehicle and had not engaged in activities involving physical exertion before triage. This was a clear indicator of the severity of his condition at that time.

77. While Whippy's heart rate placed him in the red zone and of itself warranted a triage category of 2, I retain significant concerns about the recorded oxygen saturation results. While it cannot now be reliably established, with the benefit of hindsight, it appears that the result may have been a mistake and should certainly have been retested had Whippy remained at Cowra Hospital. We now know Whippy had pneumonia. He also had a history of smoking, respiratory infections and obstructive pulmonary disease. He had been unwell for some days and was coughing. The medical records disclose that on a prior occasion in 2017 when he had similar symptoms of coughing and lethargy, he had saturation levels of 91-93.[26]

78. Dr Quilty expressed some doubt about the accuracy of recorded oxygen result. In his view, given the known history, it would be unlikely that Whippy's baseline saturations would have been above 95% and likely that they would be less than 90% at the time of triage.[27] Whatever the case, in my view a recorded result of 100% should have spurred some curiosity and likely retesting, had Whippy ever seen a doctor.

79. It is noted that the triage form incorrectly recorded that Whippy was "*neither Aboriginal nor Torres Strait Islander*". This is an important issue to which I will return.

Subsequent progress note completed by Ms Townsend about 6:47pm

80. The ED Log recorded Whippy's *"check out"* time as 6:48pm.[28]

81. Ms Townsend entered an electronic progress note at about 6:47pm. The note recorded the "*service*" time as 6:37pm and recorded as follows:[29]

> *"**ED bed blocked at the time of arrival with NSW police in attendance for another patient***

[25] Statement of Lorraine Bamblett, Volume 1, Tab 6 [11].
[26] See discussion of this at T16/4/25 222.4.
[27] See T16/4/25 209.14.
[28] ED Activity Log, Volume 1 Tab 20A.
[29] Health Summary Sheet and Progress Notes, Volume 1 Tab 20 p.15.

mother rang ED bell stating her son needs help getting out of the car as he refused to get out at the medical centre so brought him here instead.

***security and nursing staff went out to seen the patient**, patient continues to refuse to get out of the car.*

explained to parents we could not get him out against his will.

mother and father able to get him out and rang ED bell again. given green form and said we will be with them shortly on multiple attempts to triage patient

patient had left waiting room back to the car and family unable to get him to come back Inside the department.

***[eventually] able to be triaged, stood up and walked out of triage room while being assessed and getting BGL test completed**.*

Mother stated she thinks he wanted a smoke and followed him out offered him to go out and have a cigarette and return mother said she will try and get him to come back in

***later received phone call from mother stating he would not come back into the building**, advised that he can't be assessed <u>If he won't stay In the department for the dr and nurses to see him</u>,*

mother agreed. stated if she was concerned to try and bring him up to the hospital again or call ambulance service". (emphasis added)

82. Much of the information recorded concerned Ms Townsend's earlier interactions with Whippy and his parents after he arrived outside the ED until he left the triage area.

83. The "green form" is a document given to new arrivals to the ED to fill out. It has basic information (name, address, etc) which is later used by the triage nurse to create an electronic triage record for that presentation.

84. The reference to "*ED bed blocked*" meant all available ED beds were in use or not available. The ED log for the period 4:30 to 7pm records five people as admitted or presenting to the ED in the period Whippy attended and/or was triaged.[30] One patient checked in at 5:27pm, who remained overnight, was listed as presenting with "*Self-harm"* and involving "*Mental Hlth".* This patient was brought by way of ambulance (with accompanying police officers)

[30] ED Activity Log Volume 1, Tab 20A.

and was the one referred to in Ms Townsend's note (e.g. "*NSW police in attendance for another patient"*).[31]

85. The recorded "*service*" time of 6:37pm constituted the time Ms Townsend had her last verbal interaction with Ms Bamblett. This time was based on a note made by Ms Townsend at the time of the conversation or was a subsequent approximation of that time.

86. On the available evidence, it is likely Whippy had left the ED by then.

87. Ms Townsend did not expressly notify or discuss with Dr Tij Paguti the fact of:

(1) Whippy's presentation;

(2) Her assignment to him of a '*triage category 2*' or his recorded vital signs (particularly his heart rate);

(3) Whippy had left without his blood sugar level and other vital signs being taken; and

(4) Whippy had not been assessed by a medical officer when he left.

Events overnight at home on the evening of 12 September/early hours 13 September 2019

88. Whippy returned home with Ms Bamblett.

89. Ms Bamblett likely went to bed about 9pm that night.[32]

90. Ms Bamblett heard Whippy coughing while sleeping on the lounge. When she checked on him in the morning, she found him on the floor unresponsive. She sought help from Mr Bamblett who lived across the road. Mr Bamblett made a call to triple zero.

91. At about 4:30am Ambulance NSW paramedics arrived at the home. Police arrived about 5am.

92. Paramedics declared Whippy to be deceased at the scene soon after their arrival.

Autopsy

93. An autopsy was completed by Dr Dianne Little on 23 September 2019 in Sydney. Dr Little states that the direct cause of Whippy's death was Diabetic Ketoacidosis with multi-organ

[31] Health Summary Sheet and Progress Notes, Volume 1 Tab 20 p.15.
[32] According to the P79A – Report of Death to the Coroner, Ms Bamblett last saw Whippy about "2100" hours, Volume 1 Tab 1 p.2.

failure with pneumonia as an underlying condition. I accept her opinion which is in line with other expert evidence I received.

94. Signs of pneumonia were seen in both his lungs (*bilateral bronchopneumonia*). Microbiological cultures isolated *Pseudomonas species*, said to be a recognised cause of pneumonia in diabetic patients. Dr Little stated:

> "*Infection can precipitate serious metabolic complications in diabetics, particularly if their medications are not taken regularly. One complication is diabetic ketoacidosis where there is a raised blood sugar level and markedly elevated ketone level…Typically the blood sodium level is low. All of these biochemical abnormalities were present in Wilfred Williams.*
>
> *Examination of the kidneys under the microscope showed changes associated with diabetes and there was also evidence of acute kidney injury on biochemical testing. Additionally there was necrosis (tissue death) in the liver likely secondary to poor perfusion/shock. These features are consistent with multi-organ failure.*
>
> *In my opinion, the direct cause of his death was diabetic ketoacidosis with multi-organ failure that developed secondary to pneumonia*."

95. Counsel assisting accurately summarised other findings Dr Little noted during autopsy:[33]

(1) Acute congestion and oedema in the lungs, with bronchopneumonia present in the right lung and left lower lobe.

(2) An enlarged dilated heart with a moderate degree of single vessel coronary atherosclerosis (about 60% narrowing).

(3) Mild steatosis (building up of fat) of the liver with centrilobular necrosis (death of liver cells near the central vein).

(4) Diabetic nephrosclerosis (also known as diabetic kidney disease, is the chronic loss of kidney function in those with diabetes mellitus. It is a leading cause of chronic kidney disease and end-stage renal disease).

(5) Postmortem blood analysis showed Aripiprazole (0.07mg/L) and Quetiapine (0.47mg/L) (*within therapeutic range of concentration*).

[33] Autopsy Report, Volume 1 Tab 5.

The expert evidence

96. The Court had the benefit of the expert opinion of two medical clinicians, Associate Professor Randall Greenberg (**A/Prof Greenberg**) and Dr Simon Quilty (**Dr Quilty**), both of whom have extensive experience in the provision of medical care in Emergency Department settings in regional areas.

97. The experts' joint opinion was summarised accurately by counsel assisting, as follows:

    (1) Whippy was "*likely suffering from diabetic ketoacidosis and pneumonia at the time of his presentation [e.g. 5 to 6pm], with evidence suggesting early multi-organ dysfunction*".[34]

    (2) Whippy's condition was critically life-threatening at the time of his presentation, given the findings of significant tachycardia and the rapid deterioration leading to death within 12 hours that followed. [35]

    (3) Whippy's condition was treatable and his death likely preventable with medical intervention, particularly for Diabetic Ketoacidosis, which is highly treatable with timely care. Appropriate treatment would have included intravenous fluid resuscitation, insulin infusion, antibiotics, and transfer to a regional intensive care unit (e.g. Dubbo Base Hospital) for ongoing management.[36]

    (4) The incomplete triage information, particularly the absence of Whippy's blood glucose level, limited the assessment of severity but "*the documented tachycardia was a clear indicator of hemodynamic instability and severe illness"*.

    (5) The assignment of Triage Category 2 was reasonable given the clinical presentation specifically the tachycardia and the overall condition.

98. As to the importance of a rapid examination by a medical officer, A/Prof Greenberg explained that when a patient is in a *"red zone"* in hospital it prompts a rapid response. Within the ED environment it is understood there is an emergency team present to provide treatment. Dr Quilty agreed with this opinion. Even if the *"red zone"* protocol did not apply in the ED the fact that Whippy's heart rate was in the red zone underscored the need to expedite his examination.

99. Counsel assisting submitted:

---

[34] Joint expert report, Volume 2 Tab 58.
[35] Ibid.
[36] Ibid.

(1) Treating clinicians had to assume, on the information gained in triage, Whippy had an imminently life-threatening condition until that possibility had been excluded.

(2) The responsible medical officer should have been told that Whippy was assigned a triage 2 categorisation as soon as possible after the classification was assigned (e.g. shortly after 6:10pm when the triage record was electronically entered) *and*, additionally, notified when Ms Townsend learnt that Whippy had departed the hospital without examination.

(3) At the time *"NSW Health – Emergency Department Patients Awaiting Care"* protocol (issued March 2018) provided that "a *senior clinician must be notified of any concerns about patient's safety. Documentation of conversation with the patient, family/carers and senior clinician is to be recorded in the patient's health care record".*[37]

(4) The senior clinician (in this case Dr Paguti) bore responsibility for the response thereafter. That may have included attempting to contact a patient or requesting other supports to make contact (e.g. Aboriginal Health Worker). It might also involve requesting Ambulance NSW paramedics to attend the patient's home to assess the patient.

100. I accept counsel assisting's submission that Whippy should have been treated as having a life-threatening condition until that possibility had been excluded. Further I accept that the failure to notify the responsible doctor about Whippy's presentation, his triage classification and his departure was a very significant omission. I note that WNSWLHD accept and agree that Dr Paguti should have been notified and that in oral evidence RN Townsend accepted, with hindsight, that she should have notified the doctor. It is appropriate and heartening that all parties recognised this significant missed opportunity.

101. Dr Paguti gave evidence before me. Dr Paguti was a career medical officer who was working his first week at Cowra District Hospital at the time of Whippy's presentation. He had limited recollection of the evening, stating that until he was contacted to give evidence, he was not aware that Whippy had come to the ED, that a triage assessment had taken place recording a level 2 priority, or that Whippy left prior to being seen.

102. I accept Dr Paguti's evidence that had he been informed of Whippy's departure, he would have personally attempted or got another staff member to attempt to get Whippy to come back so that he could be treated.

[37] *NSW Health ED Patients Awaiting Care*, Volume 2 Tab 42 pp.12-13.

103. Counsel assisting submitted that notification would have increased the likelihood of:

(1) Further contact being made to Whippy and his parents to discuss his condition and to persuade him to return.

(2) Whippy undergoing a further medical assessment either by returning to hospital or at his home by paramedics attending there, and/or

(3) His returning to hospital for the treatment.

104. Counsel assisting submitted that it cannot be assumed that Whippy would necessarily have refused to return to hospital. Whippy's history records him being brought to hospital in the past by ambulance without resistance and accepting overnight admission for treatment: e.g. admission to the Cowra District Hospital ED between 1 to 3 January 2019 (during which he was reviewed by Dr Davidson)[38] and 15 to 16 January 2019 (discharged into his mother's care after review by Dr Davidson).[39]

105. On this issue counsel for the WNSWLHD submitted that while Whippy *may* have re-entered hospital if a doctor or Aboriginal Health Worker had spoken to him, given his known aversion to hospitals, the issue is far from clear and no positive finding should be made. I accept it is impossible to know, but after hearing from Dr Davidson and the experts on this issue I have great confidence that a skilled doctor with some cultural awareness or an Aboriginal health worker would have had a good chance of bringing Whippy back to the ED.

106. A somewhat related issue examined at inquest is that RN Townsend recorded that Whippy was neither Aboriginal, nor Torres Strait Islander. Her supplementary statement in relation to this issue states that it was her belief that she made a typographical error with this question, likely choosing the wrong option from the drop-down menu.[40] However in her oral evidence a very different explanation was given about what had occurred. She told the court that she did not know Whippy or his family and as there were other ethnic groups living in Cowra, she could not assume Whippy was an Indigenous person. The conflicting explanations do not inspire confidence.

107. RN Townsend's counsel submitted that not wanting to make an assumption was not an *"unreasonable approach"* to take in the circumstances. I do not agree. Firstly, the importance of asking the question, if one is not sure is paramount and a matter of training for all health staff. Secondly, while it is undoubtedly true that some people may appear of ambiguous background (and thus the need for asking the question), I just do not accept that

[38] Documents from admission on 1 January 2017, Volume 1 Tab 21.
[39] Documents from admission on 15 January 2017, Volume 1 Tab 22.
[40] RN Townsend supplementary statement, Volume 1 Tab 12A [17].

it would have been possible for an appropriately trained staff member, having met Whippy and his family and having had access to his medical records, to not be able to accurately identify his First Nations heritage. The capacity to identify First Nations patients is important for a number of reasons. In this context, it would allow a health practitioner to be especially mindful of those health issues that are known to disproportionately impact First Nations patients, for example diabetes. It would also alert a well-trained and empathetic health practitioner to considerations of cultural safety.

108. Counsel assisting briefly canvassed the issue of whether the threshold for involuntary treatment had been crossed, specifically whether there were sufficient grounds to enliven statutory powers to detain Whippy to convey him to hospital for assessment and potential admission under the *Mental Health Act 2007* and if that threshold was reached whether it was in Whippy's best interests to exercise those powers.

109. Given the state of the evidence, the question was largely hypothetical. Whippy never saw a doctor and in my view, I do not need to decide that question. However, I accept counsel for WNSWLHD's submission that the use of physical restraint or coercion would most likely have been undesirable.

Issues for consideration

(1) *Whippy's capacity to understand severity of his condition and to make informed decisions about his medical treatment*

110. I accept that Whippy's capacity to understand his medical needs and advice on treatment was substantially impaired. He is *likely* to have lacked capacity to make informed decisions about medical treatment. This vulnerability was compounded by his fear or aversion to hospital and/or clinical settings.

111. In my view, these circumstances only increased the need for careful and culturally appropriate care. There was also a need to listen and take seriously his mother's genuine and pressing concerns.

(2) *Availability of community based supports/Aboriginal Medical Service*

112. Whippy's primary support was that given by his mother, his father and his extended family. Whippy was not regularly attending a diabetes clinic for management of his diabetes.

113. Whippy's mental health treatment was limited to that provided by his GP and GP's surgery. He had a strong aversion to inpatient mental health care. I accept that Dr Davidson presented as having been genuinely concerned for Whippy. It appears Dr Davidson and

the surgery's staff did what they could to assist him (before 12 September 2019). Specifically, I heard that nurses at the practice had previously spoken to Whippy at the car and persuaded him to enter for his psychiatric medication injection.

114. As foreshadowed, Jamie Newman, Chief Executive Officer of the Orange Aboriginal Corporation Health Service (**OAMS**) gave evidence in these proceedings. OAMS services include annual Aboriginal health assessments, Diabetes Educator Services, Dieticians, Diabetes Multidisciplinary Group Sessions and monthly Diabetic Clinic reviews. It also offers mental health supports.

115. Although OAMS is funded to provide primary health services at Orange, and outreach services to Cowra and Bathurst for Drug and Alcohol support, it is not funded to provide outreach primary health services in Cowra.

116. This is notwithstanding:

(1) The sizeable portion of the Cowra area that is Aboriginal as compared Statewide (Ms Rowston in evidence said 9.4% of Cowra's population are Aboriginal).

(2) The prevalence of conditions for which there is an increased incidence in Aboriginal communities as compared to the wider community. The WNSWLHD's evidence is that 6.1% of the WNSWLHD and Far West LHD's population suffers from diabetes, which is higher than the national average of 5.5%, with people in these regions 40% more likely to die because of diabetes as compared to the rest of NSW.[41]

(3) The evidence as to the positive outcomes for Aboriginal people that can regularly access Aboriginal Health Services.

117. Whippy would have needed to travel to Orange to access an Aboriginal Health Service. Given the distance this would have been a lengthy and expensive trip to make regularly. The distance constitutes a real barrier for someone like Whippy.

118. There is a pressing need for the greater availability of Aboriginal Community Controlled Health Services in Cowra and better funding for Aboriginal medical services generally.

(3) ***GP surgery not notifying the ED that Whippy was expected to present there***

119. The staff at the surgery did not contact the ED by phone to provide the ED staff information about Whippy's medical history (including his known reticence to engage with medical staff, particularly ones he did not know) and what had been reported when he attended with his

[41] Stimpson and Beahan statement 16.9.2024, Volume 1 Tab 28 p.2.

parents. This kind of referral or warm introduction to a potentially busy ED can be very useful for any patient; for a vulnerable patient is it crucial. With the benefit of hindsight, a call by the surgery to the ED may have increased the latter's understanding of Whippy before he arrived, so that appropriate planning could have occurred.

120. This issue was addressed by Dr Davidson, who agreed that there should have been communication with the hospital as soon as Whippy left the vicinity of the surgery. I accept that Dr Davidson was not involved with Whippy's care on the day. I also accept that it was his usual practice, when sending a patient to the ED directly from the surgery to provide them with documentation or call ahead to alert the Hospital and provide background information. He said "*I would never send them to hospital without documentation or a phone call*."[42] Unfortunately, it appears from the records that the doctor notified of Whippy's attendance outside the surgery was a registrar who was completing a six-monthly rotation at the practice. There is no evidence that he knew Whippy or that he or a nurse went outside to speak with Whippy. In any event, no information was provided to the hospital.

121. The failure to call ahead was a significant missed opportunity in improving the care Whippy received.

(4) *What time did Whippy arrive at the hospital*

122. In my view it is difficult to be precise about exactly when staff at Cowra District Hospital became aware that Whippy was on the premises. The passage of time since the events took place make an assessment of this question extremely difficult. I accept counsel for WNSWLHD's submission that although Whippy may have arrived in the carpark shortly after 5pm, there is likely to have been a period of time before staff became aware of his attendance.

123. I accept the family's submission that the wait appeared lengthy to them in circumstances where Whippy was unwell and at times agitated. I think it most likely that there was some coming and going from the car to the ED before the triage began.

124. Counsel assisting made the following submissions on the issue.

125. The Cowra Medical Service record was entered at 5:03pm and given the short distance between the surgery and the hospital, they likely arrived there soon after 5pm.

126. The ED activity log records Whippy being *"checked"* into the ED at 6pm. That is the time the triage assessment began. It is not the time Whippy first arrived.

[42] T14/4/25 23.7.

127. Some time passed between Whippy's arrival in the car and the triage's commencement. That included:

(1) Ms Bamblett speaking to ED staff through the intercom at the entrance.

(2) Whippy exiting the car and entering the ED waiting area after coaxing from his parents.

(3) Whippy exiting the ED waiting area more than once likely because he was anxious being inside.

128. Counsel assisting submitted that it is likely that somewhere between 30 to 45 minutes (at least) passed between Whippy's arrival and the triage taking place. Amongst other matters this considers:

(1) The timing of the record made at the GP surgery (shortly after 5pm).

(2) The short distance between the GP surgery to the hospital (it would not have taken long to drive between the two). Mr Bamblett, in his recent statement, stated that the sun was still up when they arrived at the ED.

(3) The description of Whippy's movements and actions when he first arrived (e.g. there was an amount of time involved in persuading Whippy to get out of the car into the hospital and then to remain inside to undergo the triage process).

129. However, a difference arises in the accounts of RN Townsend and Ms Bamblett as to whether RN Townsend came outside when they *first* arrived, namely:

(1) In her oral evidence Ms Townsend said she recalled exiting out the afterhours door, with a security guard (Ian Burns), after Whippy's family first arrived. At that point she spoke to Ms Bamblett and not Whippy sitting in the car. Ms Townsend recalled explaining to Ms Bamblett she could not forcibly drag someone out of the vehicle against their will.

(2) In her statement Ms Bamblett said she rang the afterhours entrance *"bell"* then "*[the] three of us went in and we must have waited getting on two hours and Whippy was getting agitated"*.[43] Her statement does not mention being approached by a nurse before the triage assessment (this is a matter Ms Bamblett could not be examined about at hearing).

[43] Bamblett statement, Volume 1 Tab 6 [9].

130. I accept that the evidence does not permit a positive finding in relation to the exact time between the family's attendance and RN Townsend having some knowledge that Whippy needed to be seen quickly. However, by the time the formal triage commenced at 6:01pm, swift action should have been taken to immediately escalate the matter by informing the doctor on duty. I accept RN Townsend's evidence that Whippy came in and out of the triage area on multiple occasions and that she found it difficult to conduct a smooth triage process. However, in my view she certainly had enough information soon after 6pm to escalate the issue to Dr Paguti. Further, I think it likely that Whippy's mother had been trying to get attention well before that time.

131. RN Townsend's failure to recognise the seriousness of the situation, even after correctly identifying the fact that Whippy was a triage level 2 patient is extremely difficult to understand. Had Whippy been treated shortly after the triage commenced, he had a real chance of survival.

(5) *What time did Whippy leave the hospital*

132. Ms Townsend *"checked out"* Whippy (at 6:48pm[44]) soon after completing and entering that progress note (at 6:47pm). The progress note refers to 6:37pm as the "service" time which likely relates to the time of Ms Bamblett's call to Ms Townsend.

133. Whippy likely left the hospital about or shortly before 6:37pm.

134. I accept, given her contemporaneous note, that Ms Townsend spoke with Ms Bamblett by phone, likely around 6:37pm, shortly before Ms Townend entered her progress note and checked Whippy out.

135. After Whippy was *"checked in"* at about 6pm, he appeared on an electronic list of presenting/admitted patients to the ED. That list was displayed on the computer at the nurses' station and was also accessible to the medical officer on shift in the ED. When Ms Townsend "checked out" Whippy at 6:48pm, he no longer appeared on this list.

136. RN Townsend accepted in oral evidence that she could have left Whippy on the dashboard and that it would still have been appropriate to speak to the doctor at this stage.

(6) *What the triage nurse knew about Whippy's history*

137. Ms Townsend did not recall any prior interaction with Whippy and had no prior awareness of his history before his presentation on 12 September 2019.

[44] ED log, Volume 1 Tab 20A.

138. Ms Townsend did not realise Whippy had a diagnosis of diabetes and schizophrenia before his departure although she noted he had a history of "*MH problems*".[45]

139. Whippy's diagnoses of diabetes and schizophrenia were mentioned within WNSWLHD's electronic medical records. Ms Townsend did not peruse those records after triage. In her experience it was not normal practice for the triage nurse to review those records. That was something done by the medical officer carrying out the subsequent medical examination. This underscores the importance of the medical officer being made aware that a triage 2 patient has arrived, even before examination. It is also possible a medical officer, informed of Whippy's departure, would have perused those records when considering how to respond.

140. Accepting Ms Townsend did not know that Whippy had a diagnosis of schizophrenia and diabetes or a reticence about hospital settings or medical clinicians (at least ones he did not know):

(1) Ms Townsend understood Ms Bamblett was concerned about Whippy's condition, which is why they had brought him to the ED and remained there even though Whippy was hesitant to get out of the car to begin with and exited the ED waiting area multiples times before the triage assessment began.

(2) Ms Townsend understood Whippy had not wanted to enter the hospital and had left the ED waiting area on more than one occasion before his triage. It does not appear Ms Townsend questioned Ms Bamblett as to what the reason/s for this behaviour was.

(3) Ms Townsend noted in triage Ms Bamblett's report that Whippy had a history of "*MH problems"*. There were other flags pointing to possible cognitive issues including how Whippy presented, his reticence to remain in triage (without any known reason for that behaviour) and Ms Bamblett answering most of the questions.

(4) The information recorded by Ms Townsend in the triage record and her progress note, with nothing more, meant Whippy had to be assumed as potentially having an imminent life-threatening condition until determined otherwise.

141. In my view it is also important to draw attention to the fact that RN Townsend did not record Whippy's Aboriginality. It demonstrates her lack of understanding about how important

[45] ED Admission documentation, Volume 1 Tab 23, p.1.

asking that question is. I accept Dr Quilty's opinion that in a culturally safe environment the question would have been asked.[46]

142. Whippy's mother, Tammy was not available to give evidence before me, but I had the benefit of the statement she made in 2020[47]. It is perfectly clear that she wanted Whippy admitted that evening. She had spent her life caring for Whippy and knew something was seriously wrong. She was desperately worried about her son and she wanted action. In my view, her concerns were serious enough to have triggered escalation to a medical practitioner. In a culturally safe environment, she would have been given the respect she deserved.

(7) ***Whether Whippy might have been engaged by staff outside after he left the triage assessment***

143. Ms Townsend gave evidence about the local practices in this respect. She told the court that it is not general practice for ED nursing staff at Cowra District Hospital to attend on patients outside on the ramp afterhours particularly in fading light/after dark. Her counsel drew the court's attention to the fact that this occurred after hours when fewer staff were present and that the duress system only operates within the building. Counsel assisting was not critical of her actions in this context.

144. It cannot be known with certainty what difference the involvement of an Aboriginal Health Worker might have made, had one been available. Certainly, it was Tammy Bamblett's view that it could have made a huge difference.[48] This worker might have had better success engaging Whippy, possibly in the outside area, and persuading him to return.

145. There is also a good chance that a medical officer, who became aware of Whippy's vital signs and presentation and that he was declining to return inside, would have gone outside to encourage him to return. Certainly, it was something Dr Paguti would have considered had he been informed in a timely manner. Whether that could have occurred depends on the medical officer being notified about Whippy before he left and returned home. In Whippy's case, Dr Paguti was not notified of Whippy's presentation.

146. I found the evidence given by the experts on this issue compelling. Associate Professor Greenberg stated *"I think without a doubt I would have gone out there in- to – the car. I would have gone to see him and I would have done everything in my power to …get him into a hospital…I'd like to think that I could have somehow coaxed him back into the hospital*

[46] T 16/4/25 238.50.
[47] Statement of Lorraine Bamblett, Volume 1, Tab 6
[48] Statement of Lorraine Bamblett, Volume 1, Tab 6 [17]

with anything, anything in my power to get him back in…"[49] Dr Quilty was equally passionate on this subject. He told the court "*I would have tried as hard as I could as well. I would have used all the resources available to me*."[50] Both doctors saw the carpark, which was just adjacent to the ED as part of their domain and saw a clear responsibility to do all they could to get a patient like Whippy back inside. Both experts also spoke of the need to have engaged Whippy's mother immediately in relation to his reluctance.

147. Ms Townsend's evidence is that she only learnt of Whippy's departure when Ms Bamblett called. She did not realise he had left beforehand. It is unclear how long Whippy was outside before his departure and whether it was of such a duration that it should have prompted Ms Townsend to check on Whippy and his mother or at least notify the doctor of Whippy's status. Even if Whippy was already gone there remained a need for the medical officer to be notified of the attendance so that consideration could be given to renewing contact with the family.

(8) *Why wasn't the medical officer notified of Whippy's of his departure*

148. Given the lack of any record and the evidence of RN Townsend, I accept that it is perfectly clear that Dr Paguti was not informed of Whippy's presence or departure.

149. Ms Townsend gave evidence to the effect that:

(1) As of 12 September 2019, she had no experience with a patient leaving before the completion of their triage (at least one to whom she had assigned a triage 2 category). She described the situation as difficult stating "*when a person has left…that's their decision to leave"*.

(2) Ms Townsend said she had not seen the *NSW Health – Emergency Department Patients Awaiting Care* protocol (issued March 2018[51]), either before 12 September 2019 or before giving her evidence in the inquest.

(3) Ms Townsend accepted that the *NSW Health – Emergency Department Patients Awaiting Care* required notification to be given in such circumstances.

(4) Ms Townsend did not believe she had ever undergone formal training specific to responding to a situation such as this.

[49] T16/4/25 215.39 onwards.
[50] T16/4/25 215 49 onwards.
[51] *NSW Health ED Patients Awaiting Care,* Volume 2 Tab 42 pp.12-13.

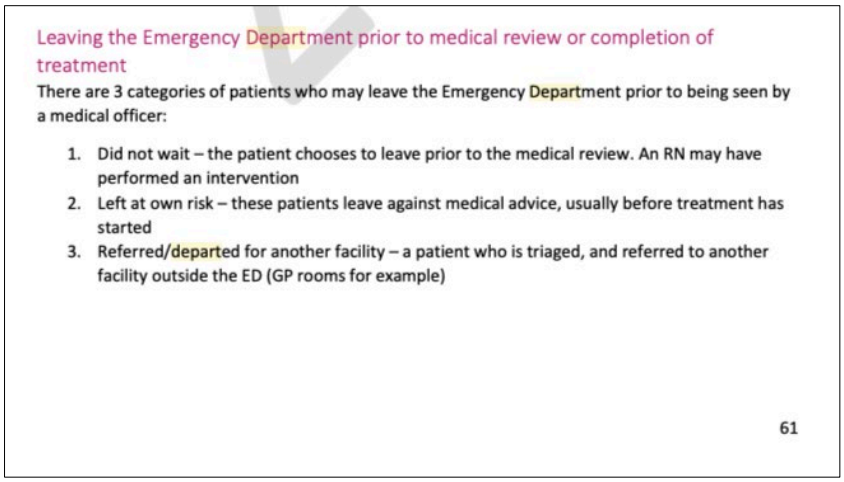
(5) She said with the benefit of hindsight she should have told Dr Paguti of Whippy's departure. If those circumstances were ever to repeat themselves, she would do so now.

150. It is understood, from evidence provided through the WNSWLHD after Ms Townsend's evidence, that:

(1) Ms Townsend was certified competent for triage following an assessment under the WNSWLHD Triage Education Framework on 16 November 2016 (see Tab 14 Vol 1 p.14). It is not known from the face of the records whether that assessment covered the *NSW Health – Emergency Department Patients Awaiting Care* protocol, as existed in 2016, and whether it instructed the kind found in the March 2018 version.

(2) In September 2019 to current day, WNSWLHD delivers triage education to nurses via a two-hour Triage Education Session (delivered virtually) known as the *WNSWLHD Triage Workshop.* This includes a PowerPoint presentation however it appears that presentation does not deal with the issue of departing patients.

(3) Since 2021 the triage workshop has also included the completion of the WNSWLHD Triage Workbook. The 2023 version of that Workbook provides the following regarding patients who leave before medical review of completion of treatment:


Leaving the Emergency Department prior to medical review or completion of treatment

There are 3 categories of patients who may leave the Emergency Department prior to being seen by a medical officer:

1. Did not wait – the patient chooses to leave prior to the medical review. An RN may have performed an intervention
2. Left at own risk – these patients leave against medical advice, usually before treatment has started
3. Referred/departed for another facility – a patient who is triaged, and referred to another facility outside the ED (GP rooms for example)

61

(4) Ms Townsend completed the WNSWLHD Triage Workshop on 2 July 2024. It is not known what instruction Ms Townsend received in that workshop (if any) about the *NSW Health – Emergency Department Patients Awaiting* (March 2018) or how she should respond if a patient leaves before examination. This considers Ms Townsend's evidence that she had no recollection of ever seeing this policy when she gave evidence in the inquest (April 2025).

(5) Neither the WNSWLHD nor NSW Health provide specific training to triage staff about responding when a patient leaves before examination.

(6) The *Emergency Triage Education Kit* (**ETEK**) released in 2009 provided limited guidance in this area. A more recent version, released in 2024, provides more guidance regarding departing patients. The WNSWLHD intends to refer to that in a forthcoming revised WNSWLHD Triage Workshop. It is also expected this will be included in forthcoming online module training provided to all NSW Health through *My Health Learning* (modules produced the *Health Education and Training Institute* or **HETI**).

151. It does not appear that Workbook provides much if any guidance in how to respond to a departing patient.

152. It cannot be ascertained what training or instruction Ms Townsend received about the *NSW Health – Emergency Department Patients Awaiting* (March 2018), or about how she should respond to departing patients, before 12 September 2019.

153. It is positive the WNSWLHD is examining how it can improve its practices in this respect although it is regrettable this opportunity for improvement was not identified closer in time to Whippy's death.

154. In line with evidence referred to by Professor Paradies, Dr Simon Quilty told the court that Aboriginal patients often have higher *"did not wait"* rates compared to non-Aboriginal patients presenting to Emergency Departments. For this reason, it is important that any training in relation to the *"did not wait issue"* provides some cultural contexts.

155. It is an issue to which I will return.

Serious Adverse Event Review (SAER)

156. Whippy's death did not trigger an incident review (Serious Adverse Event Review or **SAER**) by the WNSWLHD.

157. The WNSWLHD considers directions issued since Whippy's death means that a SAER would be triggered if it occurred today.

158. That is significant as it appears the WNSWLHD did not identify the failure to notify the senior clinician of Whippy's departure until the inquest proceedings got underway. It is hoped a SAER would have identified this omission. The commencement of a SAER also results in

a WNSWLHD contact being assigned to the family and an invitation extended to them to take part in the process.

159. The WNSWLHD has confirmed its intention to meet with Whippy's family to discuss Whippy and any concerns the family has if the family wish. That intention was spoken about by Ms Towers in her evidence.

160. I accept the WNSWLHD's evidence that a SAER *will* be triggered in future in such circumstances, have decided that a recommendation is not necessary in these circumstances.

Cultural safety

161. The court heard evidence about the WNSWLHD's more recent efforts to improve service to the local Aboriginal community in Cowra. This is of paramount importance since 14.5% of the population within the WNSWLHD are Aboriginal compared with 3.4% for NSW.

162. Without being exhaustive, counsel assisting drew my attention to the following evidence, which I have considered carefully:

(1) The statement of Tony Martin (then Executive Director, Aboriginal Health and Wellbeing) (Vol 1 Tab 26) about the *Respecting the Difference* policy and training which includes four hours of online mandatory training for WNSWLHD staff, the creation of the position of Manager for Aboriginal Cultural Capability (that position was filled in June 2024 by Ms Lesa Towers), engagement with Aboriginal Community Controlled Organisations and a "*deep dive*" review into whether its EDs are "*culturally safe and accessible for Aboriginal people, and to design and implement culturally safe and Aboriginal-led service models*".

(2) The evidence of Ms Pauline Rowston, Manager of Cowra Health Service (statement Vol 1 Tab 28 and oral evidence), which included the building of the new hospital building and how cultural considerations has informed its design.

(3) The evidence of Leanne Stimpson (District Manager Care in the Community, WNSWLHD) and Debbie Beahan (Aboriginal Wellbeing Coordinator, WNSWLHD) regarding WNSWLHD's efforts to enhance its services and education for diabetes *and* the Statewide commencement of the *Planned Care for Better Health* (**PCBH**) in April 2021. Amongst other things the PCBH tries to identify patients at risk of hospitalisation within the WNSWLHD with use of an algorithm to predict a patient's risk of unplanned hospitalisation. Patients identified at risk may be assigned a designated Care Coordinator to assess and coordinate health and social care

services. Initial enrolment in the program typically lists 12 weeks after which enrolment is reviewed. The Care Coordinator is expected to:[52]

> *"…[drive] complex case reviews with members of the patient's treating team. The role of the Care Coordinator is to 'pull together' the broader treating teams and services. The aim of the PCBH program is to empower patients and/or their families/carers to manage their health care. The Care Coordinator works with the treating teams and the patient and/or their families/carers to set goals and form care plans, with the aim of long term care being managed in the community by the patient and/or their family/carer and their primary health network (i.e. GP or community-based services)."*

(4) The evidence of Ms Lesa Towers (WNSWLHD Manager of Aboriginal Workforce Capability Development and Culture) (statement Vol 1 Tab 28A and oral evidence) which extended to Aboriginal community consultation and enhancing trauma-informed care for Aboriginal people and medical staff and addressing unconscious bias.

163. The court also heard from both the experts that localised in-person training appears to be the most effective. A/Prof Greenberg said that his insight into the potential impacts of cultural experiences, on how safe or secure an Aboriginal person feels in a hospital or clinical setting, has been most aided by hearing directly from Aboriginal community members about their experiences and perceptions. Dr Quilty gave a similar opinion.

164. Both experts identified the usefulness of Aboriginal Health Workers when delivering medical care. Unfortunately, Aboriginal Health Workers are not available at the Cowra District Hospital afterhours. There currently no capacity for these positions to be on call to attend after business hours.

165. In the context of this investigation, one cannot help but think that it is possible an Aboriginal Health Worker may have been able to assist in engaging Whippy on the night, to persuade him to complete the triage assessment, or being involved in subsequent contact after he departed. This is one of the matters the experts, in their joint report, proposed in terms of recommendations *("Ensuring availability of ALOs after-hours could bridge cultural gaps and enhance engagement").* It is an issue to which I will return.

[52] Stimpson and Deahan statement, Volume 1 Tab 28.

166. Representatives for Whippy's family stressed the need for consultation and involvement with the local Aboriginal community. They provided the Court the terms of reference enacted by the Central Coast LHD (**CCLHD**) for an *Aboriginal Health Partnership Advisory Council*. This provides (amongst other matters) that:

> *"The Aboriginal Health Partnership Advisory Council (the Committee) is responsible for providing oversight, guidance, cultural integrity, and cultural advice to the Central Coast Local Health District (CCLHD) and CCLHD Executive Directors and their direct reports that are responsible for implementing the Key Priority Areas outlined within the Central Coast Local Health District Aboriginal Health Plans and guidelines."*

167. Its membership consists of:

(1) CCLHD Chief Executive

(2) District Director Aboriginal Health

(3) Manager Aboriginal Health

(4) Nunyara Aboriginal Health management team

(5) Representative from Bungree Aboriginal Corporation

(6) Representative from Darkinjung Local Aboriginal Land Council

(7) Representation from The Glen Aboriginal Drug and Alcohol Rehabilitation services

(8) Representative from Regional Central Coast Aboriginal Education Consultative Group

(9) Two Aboriginal community (consumer) representatives.

168. The Consultative Group's responsibilities include:

(1) Monitoring and tracking the progress of CCLHD Aboriginal Health and Workforce Strategic Plan 2024 to 2026.

(2) Monitoring and tracking the progress of the CCLHD response to key priority areas identified within the implementations to the Central Coast Aboriginal Health and Workforce Strategic Plans and guidelines.

(3) Ensuring the community has a voice to drive improvements on services delivered to the local Aboriginal community by the CCLHD Clinical and Service Directorates.

(4) Driving improvements, greater awareness, understanding and education about Aboriginal health issues that affects our community.

(5) Acting as a forum for sharing of best practice and Aboriginal expertise to ensure consistent implementation of best practice by CCLHD Directorates.

(6) Ensuring the CCLHD has a single Aboriginal forum to present and receive consultation on specific strategic plan, service level operational plans and guidelines developed within the CCLHD arena.

(7) Acting as a conduit for the CCLHD Executive to receive cultural advice, consult and receive guidance to any issues that affect the local Aboriginal community or service delivery to our local Aboriginal community.

(8) Improving the integration of services through effective partnerships, communication, and cooperation.

169. There presently is not a formal entity or framework of this kind operating in the WNSWLHD.

170. With respect to the possibility of a similar arrangement being developed for the WNSWLHD, the WNSWLHD submitted

> *"There are no permanent Aboriginal consultative committees or working groups established within WNSWLHD. The examples provided in oral evidence of working parties/committees in Brewarrina, Bourke and the Northern Rivers are within other Local Health Districts.*
>
> *We note that Mr Williams' family (via their legal representatives) have provided a copy of the Terms of Reference for the Central Coast Local Health District (CCLHD) Aboriginal Health Partnership Advisory Council. We imagine the councils/committees/working groups in Brewarrina, Bourke and the Northern Rivers operate under similar terms, although we do not know the specific details.*
>
> *Following this inquest, Ms Towers (who is now in the role of Executive Director Aboriginal Health and Wellbeing for WNSWLHD) has commenced discussions with a view to establishing an Aboriginal consultative council/committee/working group in Cowra. These discussions are in the very early stages and no firm view has been formed yet as to the membership of such a council/committee/working group, however it is likely to include representatives of the Cowra Health Service,*

representatives of local Aboriginal services, local community practitioners/services, as well as representatives of the local Aboriginal community.

Whilst WNSWLHD acknowledges that having a Local Health District-wide Aboriginal Health Advisory Council (or similar committee/working group) may be beneficial, caution ought to be exercised in drawing a direct comparison to the council established within CCLHD. WNSWLHD encompasses a far larger geographical area, with significantly more communities and health services (and Aboriginal Medical Services) within that region (e.g. 4 hospitals within CCLHD versus 39 hospitals/health services within WNSWLHD). The Aboriginal population of WNSWLHD is nearly double that of CCLHD and the community is significantly more dispersed across the region. Whilst there may be common issues arising across Aboriginal communities within WNSWLHD, there are also many differences within each of the communities which may render a Local Health District-wide Aboriginal Health Advisory Council not feasible, at least as a first step.

With the above mind, it is the view of WNSWLHD that establishing a community-specific Aboriginal consultative council/committee/working group within Cowra is a more appropriate first step, with a view to expanding to Aboriginal consultative councils/committees/working groups within other regions and/or across the Local Health District as appropriate."

171. It is positive that the WNSWLHD is open to the establishment of community Aboriginal consultative groups. As to whether it would be more effective to have several community level frameworks as opposed to a single framework for the whole of the WNSWLHD, is a matter appropriately left to the WNSWLHD to examine in consultation with relevant Aboriginal community members. However, the model put forward by Whippy's family is clearly one to *consider*. It is an issue to which I will return.

172. One matter this consultative group may wish to consider is whether the new Cowra District Hospital can have a safe outdoor area for patients awaiting assessment/treatment through the ED; and whether that can be an environment nursing staff feel able to safely access afterhours to engage patients.

Draft Recommendations for consideration

173. The following draft recommendations were proposed by counsel assisting for consideration

To the Chief Executive of the WNSWLHD:

(1) The WNSWLHD continue to examine the efficacy of its instruction, and training, as to (i) the requirements for nursing staff to notify as soon as possible the responsible medical officer that a patient has been assigned a triage 2 classification (or higher), (ii) that the patient has departed before being examined and / or (iii) the guidance provided to medical staff about how to respond to a patient departing in those circumstances (including consideration as to whether Whippy's case can be used as a scenario in training or instruction given) having regard to the findings in these proceedings.

174. This recommendation arose directly out of the circumstances of Whippy's death. The failure by nursing staff to inform the responsible medical officer of a patient with a triage 2 classification in the ED had serious consequences. Once Whippy left, before a full examination had taken place, the need to inform the medical officer did not abate. In my view the need for further training around this issue was established by the evidence before me.

175. I note that Whippy's family supported this recommendation and agreed that it would be appropriate to use the story of Whippy's death to make sure the issue was well understood.

176. I note that RN Townsend conceded that she should have informed the medical officer of Whippy's attendance at triage.

177. I have carefully considered the submissions made by counsel for WNSWLHD on this issue. I note that the LHD appears to accept further training is necessary. The court was informed that WNSWLHD is currently developing a new triage education program to align with the second edition of the Emergency Triage Education Kit (ETEK). The court was informed the new training will include guidance on patients who do not wait and there is an openness to including reference to the circumstances of Whippy's death to explain how quickly things can go wrong and result in disastrous consequences. The experts made clear that there is research that indicates the number of Aboriginal patients who *"do not wait"* is higher than the figure for the general population. This statistic must be better acknowledged if change is to occur.

178. I accept that the issue is understood by the WNSWLHD and that work is already underway on this issue, and for that reason I decline to make the recommendation as drafted.

(2) The WNSWLHD examine developing and implementing an Aboriginal Health Partnership Advisory Consultative Group, whether a single group for the whole of

the WNSWLHD or groups for specific communities within the WNSWLHD, considering the Terms of Reference for the Central Coast Local Health District Aboriginal Health Partnership Advisory Council/Committee and the findings in these proceedings.[53]

(3) The WNSWLHD, in consultation with Aboriginal Health Partnership Advisory Consultative Group(s), review the efficacy of the cultural competency training it provides to its medical staff (particularly those working in EDs) particularly with respect to factors that may contribute to an Aboriginal patient feeling reticence to remain in a hospital setting or depart before undergoing a medical examination.[54]

179. These recommendations arose directly out of the circumstances of Whippy's death and relate to concerns raised by experts about whether the care provided at Cowra District Hospital at the time of Whippy's death was culturally safe. I accept the expert evidence that when patients do not perceive safety, there is a direct impact on health outcomes, including an increase in the rate of departure before treatment. I also accept the evidence that cultural safety for Aboriginal people can only be assured by direct input from Aboriginal organisations and health consumers. Appropriate partnerships need to be developed and ongoing consultation must take place.

180. The recommendations echoed those already made by Magistrate Kennedy to WNSWLHD in the *Inquest into the death of Ricky Hampson* (20 August 2024) and drew attention to a model developed by the Central Coast Local Health District.

181. Counsel for the WNSWLHD submitted that the recommendation was neither necessary nor desirable. It was submitted that to the extent that the recommendations are identical or substantially similar to the recommendations already made to WNSWLHD, they are *"duplicative and therefore neither necessary or desirable".* The court was referred to the response already provided in relation to the Hampson Inquest which notes that the intent of the recommendation is supported and that certain actions have been taken.

182. At the same time, WNSWLHD have confirmed that there are currently no permanent Aboriginal consultative committees or working groups established within WNSWLHD. The court was directed to the fact that WNSWLHD has partnership agreements with a number of Aboriginal Community Controlled Health Services (ACCHS) and separately to the fact that Western NSW Primary Health Network (**WNSWPHN**) has an established Aboriginal Health Advisory Council. Further, it was submitted that caution must be exercised in drawing

[53] A similar recommendation was made by DSC Kennedy in the *Inquest into the death of Ricky Hampson* (20 August 2024) (see recommendation 1).
[54] Also see recommendations 2 and 3 in the *Inquest into the death of Ricky Hampson*

a direct comparison to structures established within the Central Coast Local Health District, given the very different geographical and population parameters.

183. I accept that each area will have very particular needs and constraints. Nevertheless, the recommendation only calls for consideration of a structure that is operating elsewhere in the context of issues which have been raised in this inquest.

184. In my view, there remains work to be done within the WNSWLHD to strengthen cultural safety by implementing some kind of Aboriginal Health Partnership Advisory Consultative Group.

185. WNSWLHD did not support the recommendation aimed at reviewing the efficacy of cultural competence training. Counsel for WNSWLHD submitted that there was no evidence before the court suggesting that the cultural competency training currently provided by WNSWLHD is inadequate or requires review. On the contrary, counsel for WNSWLHD drew the court's attention to the training currently provided and asserted that it is both up-to-date and tailored to the requirements of the local area.

186. WNSWLHD re-launched its cultural training in 2024. It consists of an online Health Education and Training Institute (HETI) module which is available statewide. WNSWLHD also delivers four one-hour training sessions which are described as "*face to face*", *"* but delivered virtually. These sessions include reference to *"lived experience and truth telling stories."* Further, counsel for WNSWLHD advised that the facilitators use several videos that reiterate the key messaging and address racism and unconscious bias.

187. I accept that on what has been provided to this court, the re-launched training may be an improvement on what was available at the time of Whippy's attendance at Cowra Hospital in 2019. However, given the WNSWLHD do not have a consultative committee, it is difficult to know how the training's localised content was developed. The draft recommendation calls for a review. In my view this is appropriate.

188. One of the issues raised by Whippy's family is the importance of face-to-face training devised locally. It was an issue addressed by Dr Quilty. He expressed concern about some generic online courses. I accept his opinion that locally devised training delivered face-to-face is more effective. In my view, this should be considered when cultural competence training is reviewed

189. I intend to make both these recommendations.

(4) The WNSWHLD consider enhancing its Aboriginal Health Worker program by ensuring Aboriginal Health Workers are reasonably available 24 hours a day.[55]

190. This draft recommendation arises directly from the circumstances surrounding Whippy's death. His decision to leave the ED, prior to treatment, had catastrophic results. The real possibility that an Aboriginal Health Worker may have had capacity to develop some rapport with Whippy and change the trajectory of his visit to the ED cannot be ignored.

191. As counsel for WNSWLHD emphasises there was "furious agreement" amongst the witnesses that having Aboriginal Health Workers available after hours (ie 24/7) would be of *"*huge benefit*".*

192. However, WNSWLHD did not support the recommendation pointing out the practical difficulties presented by the limited number of trained workers able to take that role. According to a letter from Mr Renwick dated 7 July 2025:

> *"There are currently 57 FTE Aboriginal staff working in the classification of either Aboriginal Health Worker (AHW) or Aboriginal Health Practitioner (AHP) across WNSWLHD. To put this in context, this is across 22 of the 38 facilities across WNSWLHD. The current FTE profile for AHW/AHP roles across WNSWLHD is 67 FTE and there is a current 10 FTE vacancy that have not been able to be filled.*
>
> *In order to have AHW/AHPs working across every WNSWLHD facility and to have a balance of male and female AWH/AHPs at every site and every shift (i.e. 24/7), there would need to be approximately 228 FTE AHW/AHPs across WNSWLHD. This is an additional 161 FTE to the current profile (of which there are currently 10 vacant FTE roles that have not been able to be filled).*
>
> *For further context, there are currently only approximately 230 AHPRA registered AHPs across the whole state of NSW, and it takes two years to complete the qualification."*

193. I accept that Aboriginal Health Workers are currently in high demand, and that there are practical difficulties in meeting this need across the LHD including funding, recruitment, onboarding and qualification, amongst other things. However, as stated above, Cowra has a particularly high Aboriginal and Torres Strait Islander population. The Court heard evidence that the Cowra community is very under resourced in terms of health care and related outcomes.[56] As such, we must continue to push for more Aboriginal Health

[55] A similar recommendation was made by your Honour in the *Inquest into the death of Naomi Williams* (29 July 2019) (see recommendation 3).
[56] See for e.g., Jamie Newman Statement, Volume 3 Tab 61 p.2.

Workers to be trained.

194. I intend to make the recommendation.

To the Chief Executive for NSW Health:

(5) **NSW Health examine its policy directives and training it provides or has involvement in, as regard triage in Emergency Departments, as to (i) the requirements for nursing staff to notify as soon as possible the responsible medical officer that a patient has been assigned a triage 2 classification (or higher), (ii) that the patient has departed before being examined and / or (iii) the guidance provided to medical staff about how to respond to a patient departing in those circumstances (including consideration as to whether Whippy's case can be used as a scenario in training or instruction given) having regard to the findings in these proceedings.**

195. While NSW Health was not a party to this inquest, the court was greatly assisted by representatives of the WNSWLHD who advised the Ministry of the issue and sought further information regarding this draft recommendation.

196. It was confirmed that at the time of Whippy's presentation at Cowra Hospital there were no online modules covering triage and patients who do not wait produced by HETI available to NSW Health staff via My Health Learning. Instead triage education was delivered exclusively on a local basis.

197. However, the court was advised that HETI is currently developing an online module on triage and it is expected that this module will include *"did not wait"* and *"left at own risk"* content. Once developed this module will be available to all health staff and will be in addition to training developed locally. The court was advised that the work is already underway and should be completed by September 2025.

198. I urge those devising this new content to examine how research reflects that certain vulnerable groups have much higher *"*did not wait rates*"* than the general population. However, for reasons set out above, I have decided not to make the recommendation.

Referral of RN Townsend to the HCCC

199. Ms Vakauta for the family submitted that RN Townsend could be referred to the Health Care Complaints Commission (**HCCC**) for investigation and review as to whether she engaged in unsatisfactory professional conduct under the *Health Practitioner Regulation National Law (*NSW) No 86a in relation to her treatment of Whippy on 12 September 2019.

200. Counsel for WNSWLHD advised the court about the processes which have already taken place in relation to RN Townsend. The court was advised that following the conclusion of evidence in this inquest representatives of Cowra Health Service engaged in a practice improvement process with RN Townsend regarding events on 12 September 2019. This included her undertaking a reflective practice exercise where she was asked to review what had occurred and to identify knowledge gaps that contributed to the incident. RN Townsend was asked to reflect on what she had learnt and any resultant changes to her practice. Following completion of the exercise there was a discussion and later the preparation of a powerpoint presentation that could be used to assist others to learn from her actions. Further, a number of additional opportunities for RN Townsend to improve her care have been developed.

201. These include:

a) a review of 10 triages conducted by RN Townsend over the next three months to ensure clinical accuracy and due process;

b) The development of an audit tool to help RN Townsend to develop a quality project looking at patients who *"did not wait"* at Cowra Health Service;

c) Ensuring that RN Townend completes the online learning module *"Asking the question: Improving the identification of Aboriginal People"*; and

d) Ensuring that RN Townsend has completed the online learning module called *"Impact of Trauma on Patient Engagement".*

202. I accept that there has been real engagement by the WNSWLHD since these proceedings to consider what remedial action is necessary.

203. Ms Doust for RN Townsend provided a number of reasons which would militate against a referral. In submissions, Ms Doust noted that although it is six years since Whippy's death, only recently was RN Townsend asked to engage in a Reflective Practice Process. She has embraced this process and undertaken further learning, including further training such as a *"Respecting the Difference*" course which has given her further cultural awareness. She has also completed a Graduate Diploma in Emergency Nursing, which has strengthened her skills in triage and patient prioritisation.

204. Ms Doust drew the court's attention to her evidence which included some aspects of her hindsight learning.

205. I have carefully considered whether I should refer RN Townsend to the HCCC. I accept that the length of time since the single instance of sub-standard care, together with the further learning and training she has undertaken make it unlikely that a referral will result in further

action. I decline to make a referral. Whippy's family or legal representatives remain able to make a referral should they wish.

Findings and Recommendations

206. For reasons stated above I make the following formal findings pursuant to section 81 of the Coroners Act:

Identity

The person who died was Wilfred Robert Williams (Whippy).

Date of death

Whippy died on 13 September 2019.

Place of death

Whippy died in Cowra, NSW.

Cause of death

He died of Diabetic Ketoacidosis with multi-organ failure caused by pneumonia.

Manner of death

Whippy died at home after leaving Cowra District Hospital before being seen by a medical practitioner. The triage process was flawed and the environment lacked cultural safety.

Recommendations pursuant to section 82 *Coroners Act 2009*

207. For reasons stated above, I make the following recommendations pursuant to section 82 of the Coroners Act:

To the Chief Executive Officer of WNSWLHD:

Recommendation 1: The WNSWLHD examine developing and implementing an Aboriginal Health Partnership Advisory Consultative Group, whether a single group for the whole of the WNSWLHD or groups for specific communities within the WNSWLHD, considering the Terms of Reference for the Central Coast Local Health District Aboriginal Health Partnership Advisory Council/Committee and the findings in these proceedings.

Recommendation 2: The WNSWLHD, in consultation with Aboriginal Health Partnership Advisory Consultative Group(s), review the efficacy of the cultural competency training it provides to its medical staff (particularly those working in Emergency Departments) with respect to factors that

may contribute to an Aboriginal patient feeling reticence to remain in a hospital setting or depart before undergoing a medical examination. The review should consider whether the training should mandate a component of face-to-face training, which is locally created.

Recommendation 3: The WNSWHLD consider enhancing its Aboriginal Health Worker program by ensuring Aboriginal Health Workers are reasonably available 24 hours a day.

Conclusion

208. I offer my sincere thanks to counsel assisting Christopher McGorey and his instructing solicitors Ms Sarah Crellin and Ms Imogen Pearson of the NSW Crown Solicitor's Office.

209. I thank the OIC, Senior Constable Rebecca Hughes of the Chifley Police District for her assistance in these proceedings.

210. I thank Ms Nicolle Lowe, Aboriginal Coronial Information and Support Worker of the NSW Coroners Court for her very great assistance in the preparation of this inquest.

211. I recognise the trauma that Whippy's death has caused in his community. His death was ultimately preventable and the pain of knowing that remains with his family.

212. Finally, once again I offer my sincere condolences to Whippy's family, and I thank them for their attendance at court.

213. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner's Court, Lidcombe
14 August 2025