CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Gia Lam
Hearing dates:	24 November 2025 to 4 December 2025[1]
Date of findings:	17 March 2026
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Deputy State Coroner, Magistrate Hosking
Catchwords:	Midwifery Support Program (**MSP**); early discharge of mothers and babies; sepsis; undiagnosed UTI; use of interpreters.
File number:	2019/0038819
Representation:	Counsel Assisting: Matthew Robinson, Counsel Assisting, instructed by L Shepherd and Z Carter of the NSW Crown Solicitor's Office Gia Lam's family: Lang Goodsell, instructed by Quy Lawyers South Western Sydney Local Health District (**SWSLHD**): Patrick Rooney, instructed by McCabes Lawyers Sieglinder Wiblen, Rita Khan and Penelope Vukovich: Neale Dawson, solicitor, NEW Law, instructed by New South Wales Nurses and Midwives' Association

[1] This inquest was heard concurrently with the Inquest into the death of Serena Lee. The common issue was that baby Serena and her mother were also discharged onto the MSP operating within the SWSLHD.

Statutory findings:

Identity of deceased: Gia Lam

Date of death: 4 February 2019

Place of death: Liverpool Hospital, Liverpool New South Wales
Cause of death: Sepsis due to pyelonephritis of the right kidney due to acute and chronic cystitis

Manner of death: Gia's death was preventable. Gia died as a consequence of multiple failures to diagnose a urinary tract infection during her antenatal and postnatal treatment and her premature and inappropriate discharge onto the Midwifery Support Program.

Recommendations:

To the SWSLHD:

1 I recommend that a sample of standard maternity observation charts or maternity observation charts relating to culturally and linguistically diverse patients be audited to determine whether observations are being documented and recorded correctly, including at the required frequency, depending upon the clinical acuity of the patient.

To the General Secretary, Nursing and Midwifery Board of Australia:

1 That consideration be given to the Nursing and Midwifery Board of Australia reviewing and/or investigating RM Khan's care of Gia during her maternity admission.

I direct that a copy of the brief of evidence be provided to the Nursing and Midwifery Board of Australia.

Publication orders:

Non-publication and pseudonym orders apply to the evidence in this inquest. A copy of the orders made by Deputy State Coroner Hosking are available upon request from the Court Registry.

Introduction

1 These are the findings of an inquest into the circumstances of the death of Gia (pronounced Yah) Lam born on 19 May 1986 in Vietnam.

2 Gia died on 4 February 2019 at Liverpool Hospital. She was only 32 years old. Gia had given birth to her son at the Fairfield hospital, 3 days prior.

3 Gia was survived by her parents and three brothers who resided in Vietnam. Tragically both of her parents passed before the inquest and without understanding the cause and manner of Gia's death.

4 Gia's Aunt and Uncle who live in Australia care for Gia's son. They attended the inquest and provided a family statement to the court. Gia was very much loved by her family and is terribly missed by them.

5 All of the medical witnesses that saw Gia with her son in the hospital after his birth expressed that Gia was a dedicated and loving mother towards her son. It is devastating that she cannot be present for her son as it is clear she would have been a loving mother to him.

The role of the coroner

6 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 (circumstances) and cause of the person's death[2]. 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[3].

7 This inquest was held because of concerns surrounding the care and treatment provided to Gia following the birth of her baby and in the lead up to her death.

[2] s 81 of the *Coroners Act 2009* (NSW) (**the Act**).
[3] s 82 of the Act.

The issues examined in the inquest

8 The issues identified for examination in this inquest were as follows.

(1) Findings required pursuant to section 81 of the Act: the identity of the deceased; the time, date and place of death; the cause and manner of death.

(2) Was the prenatal and postnatal medical care and treatment of Gia at Fairfield Hospital appropriate? In particular:

(a) the failure to use a Vietnamese interpreter during some interactions

(b) the identification and investigation of symptoms suffered by Gia after she gave birth

(c) the adequacy of note taking and information exchange between midwives at the hospital.

(3) Was the medical care and treatment of Gia during the home visit by RN[4] Wiblen appropriate? In particular:

(a) the absence of a Vietnamese interpreter during the visit

(b) the adequacy of the history taken and identification of symptoms suffered by Gia

(c) inviting Gia to refer herself to her GP rather than seeking further support or an ambulance.

[4] Registered Midwife.

(4) Whether Gia was appropriately screened and managed for symptoms for signs of a urinary tract infection in the antenatal period (especially on 15 October 2018; 21 January and 31 January 2019).

(5) Is it necessary or desirable to make any recommendations in relation to any matter connected with Gia's death?

The evidence

9 A three volume brief of evidence was tendered to the Court. In addition, I was provided with a statement of 'Agreed Facts.' I accept that this document accurately summarises much of the important evidence before me. I adopt its content and have incorporated it into my written reasons.

10 Oral evidence was adduced at the inquest from:

(1) Dr Vanessa Thomas, Obstetrics and Gynaecology Registrar, Fairfield Hospital

(2) Dr Yvette Lukac, Obstetrics and Gynaecology Registrar, Fairfield Hospital

(3) RM Blanca Tanira Barrios Marquez, Fairfield Hospital

(4) RM Roya Hussein Omar, Fairfield Hospital

(5) RM Ingrid Pastor, Fairfield Hospital

(6) RMN Sieglinder Wiblen, Midwifery Support Program (**MSP**)

(7) Sharon May, Director of Nursing and Midwifery Services, Fairfield Hospital.

Experts

(8) RN Kate Pigott, Clinical Midwifery Consultant, Royal North Shore/Ryde Hospitals

(9) Associate Professor Bradley de Vries, Obstetrician and Gynaecologist, Head of Department of Obstetrics, Royal Prince Alfred Hospital.

Findings and recommendations

11 Having received all of the evidence and submissions in this inquest, my findings and recommendations are summarised below.

(1) There was a missed opportunity on 21 January 2019 to diagnose Gia with a urinary tract infection (**UTI**) which, if appropriately treated, would have prevented her death.

(2) There was a further missed opportunity on 31 January 2019 to diagnose a UTI and avoid the course of events which led to Gia's death.

(3) On 3 February 2019, when she was discharged, Gia was suffering a UTI.

(4) RM Khan unreasonably failed to attach significance to the odour referred to in her clinical notes.

(5) Appropriate management of Gia at this stage, including escalation for medical review, would have resulted in her receiving antibiotics which more likely than not would have avoided her death.

(6) I find that the failure to use interpreter services to communicate with Gia so as to enable her to describe her pain and other senses as well as to educate her on post-natal care was inappropriate.

(7) The absence of documented observations obscured a potential early indicator that Gia's pain trajectory was not normal.

(8) Gia's discharge was premature and inappropriate.

(9) Gia died on 4 February 2019 at Liverpool Hospital from sepsis due to pyelonephritis of the right kidney due to acute and chronic cystitis.

(10) RM Wiblen ought to have recognised the significance of Gia's deterioration, she should not have recommended that Gia self-refer to her GP. Rather, an ambulance ought to have been called. However, even if these steps had been taken, the evidence does not establish that Gia's death could have been avoided.

(11) Gia should have been offered an accredited interpretation service to enable her to freely communicate with RM Wiblen during this MSP visit.

12 I recommend to the SWSLHD:

(1) That a sample of standard maternity observation charts or maternity observation charts relating to culturally and linguistically diverse patients be audited to determine whether observations are being documented and recorded correctly, including at the required frequency, depending upon the clinical acuity of the patient.

Background

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

14 I have drawn from submissions by Counsel assisting in relation to non-contentious factual matters and issues. I am grateful for this assistance.

15 Gia immigrated to Australia on a partner visa in or before 2010. At the time she was married to Tu Minh Lam. Gia and Tu Minh separated in around 2016/2017 and subsequently divorced.

16 In around mid-2017, Gia met Tu Minh Lu and they married on 2 June 2018.

17 Gia and Mr Lu lived in a house at Cabramatta with Thi Thuy Trang Tran from whom they rented.

18 On 9 June 2018, Gia reported to her general practitioner Dr Nguyen that a positive result had been received from a pregnancy test. An ultrasound was performed and 27 January 2019 was recorded as Gia's estimated date of delivery.

19 On 27 June 2018, Gia attended an appointment with Dr Nguyen and complained of mild, intermittent abdominal pain. Dr Nguyen's plan was to closely observe Gia.

20 On 7 July 2018, Dr Nguyen arranged for Gia to undergo pathology testing. The urine test indicated a possible Escherichia coli (E. coli) urinary tract infection and the full blood count showed a mild monocytosis. Dr Nguyen prescribed antibiotics.

21 On 25 July 2018, an ultrasound was performed which revealed that Gia had a subchorionic haematoma which is a collection of blood between the uterine wall and the outer fetal membrane (chorion) that occurs during pregnancy. Gia was referred to Fairfield Hospital by Dr Nguyen for shared antenatal care.

22 On 15 August 2018, Gia attended her first antenatal appointment at Fairfield Hospital for blood and urine testing. The pathology results record that Gia had low creatinine levels (at 37µmol/L), and slightly elevated mean corpuscular haemoglobin (MCH) levels (at 32.1 pg). In relation to the urine culture, it was recorded that there was no significant growth of any microorganisms. Upon reviewing these results, Dr Ahmed Maruid, of the Antenatal Clinic at Fairfield Hospital, faxed a form to the Liverpool Liver Clinic requesting Gia be followed up and reviewed in relation to her Hepatitis B.

23 On 8 October 2018, Gia presented at the Birth Unit at Fairfield Hospital. Gia spoke to the nurse (a Vietnamese speaker) in Vietnamese and complained that she had been having 'pain on/off from 5:00am this AM.' Gia did not report any

vaginal bleeding or dysuria. Cardiotocography (**CTG**) results were recorded as 'reassuring.' Dr Afifa Ata, Obstetrics and Gynaecology Registrar, reviewed Gia and observed that Gia's pain had settled and her observations were within normal limits. Gia was discharged home.

24 On 15 October 2018, Gia attended Fairfield Hospital and another urine test was performed. There was no significant growth identified on culture; however, increased leucocytes (white blood cells) and epithelial cells were identified on microscopy. It was also recorded that Gia complained of right lower quadrant pain, but no urinary symptoms were documented.

25 On 11 December 2018, at around 1:00pm, Gia presented to the Birth Unit at Fairfield Hospital alone. Gia complained of a small amount of vaginal bleeding but reported she was not experiencing any pain. It is recorded that her pad was clean and dry, and CTG results were reassuring. The results were relayed to a doctor who was not happy with the fetal movements on the CTG and directed that the CTG be reapplied. At around 1:30pm, the CTG results were considered to be reassuring and Gia was discharged home.

26 At her antenatal appointment at Fairfield Hospital on 21 January 2019, RN Vukovich documented that Gia 'has had difficulty passing urine' and 'nil dysuria'. Gia was encouraged to increase her fluid intake.

27 On 31 January 2019, at her antenatal appointment at Fairfield Hospital, Gia's urinalysis results documented on the 'antenatal short stay observation chart' at 12:30[5] showed:

> protein – trace
> ketones +++
> erythrocytes +++

28 The author of these notes remains unclear.

[5] After Gia left the antenatal clinic and was transferred to the Birthing Unit.

29 At around 3:30pm, Gia was admitted to Ward 2D for induction of labour. Induction was considered necessary as she was past her due date (40 weeks and three days) with a slightly elevated blood pressure (130/90).

30 At around 6:40pm, a registered interpreter was used (via the telephone) to explain to Gia the process regarding the induction of labour. Gia provided her verbal consent to proceed.

31 At 11:36pm, Gia's membranes ruptured spontaneously. Gia's vital signs were recorded as being 'within the flags' and the CTG was recorded as 'reassuring' until around 3.00pm the following day.

32 At 4:19pm Gia's baby was delivered using a Kiwi cup for a vacuum assisted delivery. She suffered a tear which was sutured using sterile technique, and there was an estimated blood loss of 300mL. Gia was counselled on how to care for her perineal wound after repair.

33 On 2 February 2019, at 7:10am, Gia complained of a sore perineum; her perineum was checked and was found to not be swollen, an offer of an icepack was declined and paracetamol was given. At 8:35am, Gia was seen by Dr Afifa Ata and a plan was made for pain relief.

34 Gia had 'a lot of pain' during the evening shift (not specified to be perineal) and was given paracetamol and diclofenac[6] at 6:00pm. Panadeine Forte was given at 10:05pm.

35 On the evening of 2 February 2019, shortly after 10:00pm, a midwife contacted the on-call obstetrics and gynaecology registrar, Dr Yvette Lukac, to obtain a verbal order for Panadeine Forte for Gia, who was experiencing significant pain. Dr Lukac had not reviewed Gia, was not asked to do so, and gave a telephone order for PRN Panadeine Forte. A/P de Vries observed that the need for opioid-based analgesia for undiagnosed pain in the post-partum period is, in his opinion, an indication for medical review, either at the time or later in the shift,

[6] An anti-inflammatory drug to treat pain and reduce inflammation.

even if the registrar was busy. He acknowledged that this may not reflect common practice within NSW Health, where phone orders for perineal pain are routinely made – as the evidence adduced at the inquest suggested.

36 On 3 February 2019, at 2:15am, Gia was given analgesia for pain as requested. At 6:35am, Gia complained of further pain which was understood to be emanating from her perineum. RM Panuve documented that she examined Gia's perineum and no swelling could be seen. Gia was given pain relief. RM Panuve reported that she was unable to educate Gia on perineal care and afterbirth pain due to there being a language barrier and that she would handover this information to the next shift so that an interpreter could be organised and Gia provided with postnatal care education.

37 Significantly, no registered interpreter was organised prior to Gia's discharge.

38 Prior to Gia's discharge, RM Khan recorded that she encouraged Gia to shower as 'very offensive smell peri[neum].' It is further documented that Gia 'washed [her]self with a lot of encouragement.'

39 At 2:10pm, Gia was discharged from Fairfield Hospital with her baby. The discharge care plan was discussed with Gia and Ms Tran, and Gia was accepted into the Midwifery Support Program (**MSP**).

40 At around 10:00pm, Gia was complaining of pain in her vaginal area and, and according to Gia's husband, Gia appeared to be in 'agony.' Gia was frequently urinating, and she complained that it was painful to do so.

41 On 4 February 2019, at around midday, Gia phoned Ms Tran and complained that she was not feeling well, had pain in her stomach, and wanted to see a doctor.

42 At around 12:30pm, RM Wiblen arrived at Gia's home and entered the property via the rear entry.

43 On her arrival, RM Wiblen observed Gia to be 'in a lot of pain,' 'breathing quickly,' and noted that she 'appeared distressed.' Gia gestured, by way of pointing, that the pain was located in her neck and legs. Gia then phoned Ms Tran so that she could translate.

44 Ms Tran asserts that she advised RM Wiblen that Gia was experiencing pain in her lower back that went to her stomach and had recently started feeling pain in her neck. RM Wiblen advised Gia to see her family doctor, and that Gia took some paracetamol for the pain. RM Wiblen performed a postnatal review of Gia, which included checking her breasts, uterus and perineum; it did not include any further observations such as temperature, blood pressure or heart rate. RM Wiblen recorded that Gia's perineum was clean and dry, and that she 'encouraged [Gia] to shower.'

45 At around 1:08pm, RN Wiblen left Gia's home with a plan to review her again the following day.

46 At around 5:15pm, Ms Tran arrived home and found Gia lying in bed with a cloudy, offensive smelling fluid on the floor. Ms Tran took the baby from the room, and Mr Luong took Gia's blood pressure, recording a reading of 180mmHg. Gia was observed to be pale and sweaty, and NSW Ambulance (**NSWA**) was called at 5:29pm.

47 At around 5:40pm, an ambulance arrived at Gia's home. Two paramedics, Stephanie Denton and Sahar Afiouny, entered the home and were directed to Gia by Ms Tran. Denton observed Gia to be in a critical condition. Afiouny directed Denton to return to the ambulance to retrieve further equipment and contact Intensive Care paramedics.

48 Afiouny performed observations of Gia which were recorded on the NSWA Service Patient Care Record. Gia's respiratory rate was recorded at 48 breaths per minute, her heart rate was 164 beats per minute, and blood pressure was '55/palp'.

49 Gia was conveyed to Liverpool Hospital arriving around 6:40pm. On arrival, Gia was observed to be moribund[7] and peri-arrest with a GCS[8] of 3 out of 15.

50 Shortly after her arrival, Gia's heart rate began to drop, and her pulse couldn't be felt. At 6:30pm, Gia went into pulseless electrical activity cardiac arrest. Resuscitation efforts continued until 8:10 pm when she was sadly declared deceased.

51 Gia's placenta was sent to The Children's Hospital at Westmead for examination. On 14 February 2019, a biopsy report was prepared by Dr Michael Krivanek that noted, inter alia, the placenta showed subtle inflammation characteristics of amniotic fluid infection/intrauterine neutrophil chemotaxis as well as a foetal inflammatory response.

Post-Mortem

52 Dr Istvan Szentmariay performed a post-mortem examination on Gia on 7 February 2019. He opined that Gia's cause of death was sepsis due to pyelonephritis of the right kidney due to acute and chronic cystitis.

53 Consistently, A/P de Vries opined that it is likely that Gia had a urinary tract infection in the post-partum period before she was discharged from hospital.

Issues

Findings required pursuant to section 81 of the Act

54 It is not controversial that it was Gia that died on 4 February 2019 at Liverpool Hospital. I accept Dr Szentmariay's opinion and find that Gia died from sepsis due to pyelonephritis of the right kidney due to acute and chronic cystitis. This is consistent with A/P de Vries opinion that Gia was discharged with an undiagnosed urinary tract infection.

[7] At the point of death.
[8] Glasgow coma scale.

55 The circumstances surrounding Gia's death (ie manner of death) is the subject of further discussion below.

Was the medical care and treatment of Gia at Fairfield Hospital appropriate?

Prenatal period

56 A/P de Vries opined that Gia most likely had a UTI while at her antenatal appointment on 21 January 2019 noting RM Vukovich recorded 'difficulty passing urine' in her notes of Gia's visit.

57 At that visit, Gia was encouraged to increase her fluid intake. RM Pigott considered that difficulty passing urine was not a normal or routine presentation. It was a presentation requiring further investigation including urinalysis and escalation to a medical officer. A/P de Vries opined that, more probably than not, investigation on this date by a medical officer would have led to diagnosis of UTI and treatment thereafter which would have led to resolution of the UTI and the avoidance of Gia's death two weeks later.

58 RM Vukovich has reflected on her engagement with Gia. She did not readily identify difficulty voiding as a presentation warranting urinalysis. In her view, difficulty passing urine can be a physiological problem which develops in late pregnancy due to the positioning of the fetal head. While that opinion appeared to be reasonably held by her, her management on 21 January 2019 did not reflect appropriate or reasonable management when considered against the expert evidence.

59 I find that there was a missed opportunity on 21 January 2019 to diagnose Gia with a UTI which, if appropriately treated, would have prevented her death.

60 RM Vukovich also saw Gia on 31 January 2019. RM Vukovich recorded that Gia denied dysuria, identified that the fetal head was engaged, and obtained a blood pressure of 130/90, representing a mild tachycardia. Given the tachycardia, RM Vukovich performed urinalysis to exclude pre-eclampsia and

therefore was keen to ensure protein was not high. The tests revealed a trace of protein and ketones +++.

61 We also have Gia's 'antenatal short stay observation chart.' The author of that document was not identified in the inquest. It appears to be the chart used in the antenatal clinic and for short stays in the birthing unit and post-natal ward. At 12.30pm, someone has recorded:

> protein – trace
> ketones +++
> erythrocytes[9] +++

62 It also remains unclear how a result for erythrocytes was obtained. RM Vukovich denied that she obtained a result for erythrocytes and asserted that the dipstick urine tests used at Fairfield Hospital did not measure erythrocytes. Further inquiries supported this. It is therefore unknown whether someone identified blood in the urine, either form a visual inspection or a positive result for blood on the dipstick urine test, and recorded erythrocytes instead of simply blood. That would be unusual, but it is possible. Alternatively, it is possible that a positive result for something like leucocytes was obtained, and in error erythrocytes was recorded. I am unable to make a finding on the evidence in this regard.

63 The evidence was clear that the dipstick urine test performed at approximately 12:30 pm on 31 January 2019 was not normal. A/P de Vries opined that Gia probably had a UTI on 31 January 2019, having regard to her previously reported difficulty passing urine and the chronicity of her cystitis observed at post-mortem, which indicated an infection of more than four days' duration.

64 RM Pigott and A/P de Vries were clear that a midwife or doctor who believed erythrocytes to be present in Gia's urine should have escalated Gia's treatment to a medical officer and/or obtain a mid-stream urine sample for MCS[10]. A/P de

[9] Red blood cells.
[10] Microscopy, Culture and Sensitivity test.

Vries opined that had these steps been taken, a UTI would have been diagnosed and antibiotic treatment commenced and Gia would not have died.

65 I find that there was a further missed opportunity on 31 January 2019 to diagnose UTI and avoid the course of events which led to Gia's death.

66 A/P de Vries opined, and I accept, that Gia's labour was appropriately managed by Dr Thomas.

Post-natal period

67 At 7.10pm on 1 February 2019 Gia complained of a sore perineum. Her perineum was examined and noted not to be swollen; she declined an offered icepack, and paracetamol was administered. During the evening shift Gia's chart reflects that she was experiencing 'a lot of pain.' Shortly after 10:00 pm, Dr Lukac was asked for a verbal authorisation for Panadeine Forte which she gave[11]. A/P de Vries expressed the view in his report that the need for opioid-based analgesia for undiagnosed post-partum pain is, in principle, an indication for medical review. His concern, however, was directed to what he believed to be a broader practice within NSW Health of issuing telephone orders for analgesia for perineal pain, rather than at Dr Lukac in this case.

68 Dr Lukac explained that her usual practice was to obtain a standard ISBAR[12] handover, being a structured method of ensuring safe and accurate communication of clinical information. Through that process she would ascertain the nature of the birth – here, an instrumental vacuum-assisted delivery – and confirm that the post-natal course was consisted with a mode of delivery that might reasonably be expected to require Panadeine Forte. On her evidence, that is what occurred. Notwithstanding A/P de Vries' concern about the practice of issuing telephone orders for analgesia for perineal pain in the absence of review, no criticism can properly be made of Dr Lukac.

[11] Panadeine forte had already been prescribed – Dr Thomas indicated that pain was anticipated given the nature of Gia's perineal tear.
[12] Identity, Situation, Background, Assessment and Recommendation.

69 First, Panadeine Forte had in fact already been prescribed at the time of birth. Dr Thomas' evidence was that, given the nature of Gia's labour and instrumental vacuum-assisted delivery, analgesia in the form of Panadeine Forte was likely to be required. The telephone call to Dr Lukac was therefore unnecessary.

70 Secondly, having regard to Dr Lukac's evidence as to the information she would ordinarily obtain before authorising Panadeine Forte – albeit noting again that the call to her was not required – there is nothing to suggest that a telephone order, in those circumstances, was inherently inappropriate in the absence of a further medical review. Thirdly, there is no basis on which to find that medical review by Dr Lukac (or any other person) would have revealed a medical problem. As referred to immediately below, Gia was reviewed by an obstetric register at 8:35 am and no problems were identified.

71 At 8:35 am on 2 February 2019, Dr Afifa Ata saw Gia and a plan was made for pain relief. Dr Ata cleared Gia from an obstetrics and gynaecology perspective, discharging her to a midwifery led model of care. Dr Ata was the last doctor to review Gia. He did not have the benefit of an accredited interpreter. His examination of the perineum recorded it as healthy in appearance, and there is no evidence that, at that point, Gia's presentation warranted further investigation or escalation. Critically, A/P de Vries does not regard this review as representing a departure from a reasonable standard of care. Gia was, during the day, under the care of RM Khan. RM Khan was required by policy to conduct one set of observations during her shift. While RM Khan maintained in her evidence that observations would have been undertaken, she conceded on review of Gia's records that they were not recorded during her shift.

72 On 3 February 2019, at 2:15am, Gia was given analgesia for pain as requested. At 6:35am, Gia complained of further pain which was understood to be emanating from her perineum. RM Panuve documented that she examined Gia's perineum, and no swelling could be seen. Gia was given pain relief. RM Panuve reported that she was unable to educate Gia on perineal care and afterbirth pain due to there being a language barrier and that she would

handover this information to the next shift so that an interpreter could be organised and Gia provided with postnatal care education. A common problem affecting the Standard Maternity Observation Chart completed in Gia's case is that only once was Gia's pain documented on the Chart. That cannot be because she was not experiencing pain. In the post-partum period was given Panadeine Forte on three occasions, Paracetamol on five occasions, and Diclofenac on two occasions.

73 The failure to document Gia's pain each time observations were recorded on the Standard Maternity Observation Chart had important clinical consequences. RM Pigott explained that the purpose of repeated pain scoring in the post-partum period is not merely administrative; it is to allow clinicians to detect whether pain is escalating, changing in character, or failing to respond to treatment. Without consistent documentation, it was not possible to identify a trend in Gia's pain, including whether it was worsening or evolving in a way that might have signalled an underlying complication rather than routine perineal discomfort.

74 I find that the absence of documented observations obscured a potential early indicator that Gia's pain trajectory was not normal.

75 No registered interpreter was organised in the post-natal period. Being able to communicate freely and unimpeded is essential to accessing appropriate medical care. Reliance on friends and family, as did happen with Gia on an ad hoc basis, is inappropriate unless the patient has been given the opportunity to consent to the disclosure of their otherwise private medical information to their friend or family member. For such consent to be freely given, it would have to be obtained absent the friend or family member and with the use of an interpreter.

76 I find that the failure to use interpreter services to communicate with Gia so as to enable her to describe her pain and other senses as well as to educate her on post-natal care was inappropriate.

77 From 7:00 am on 3 February 2019, Gia was under the care of RM Khan. RM Khan documented that she encouraged Gia to shower because there was a 'very offensive smell peri[neum],' and that Gia 'washed [her]self with a lot of encouragement.'

78 RM Khan was an unimpressive witness. She was reluctant to concede that a 'very offensive smell' was out of the ordinary, or that it suggested something exceeding the usual physiological odours of the post-partum period. She was similarly reluctant to accept, even with knowledge of the circumstances of Gia's death and the expert opinions of A/P de Vries and the forensic pathologist, that the odour was, with hindsight, likely secondary to infection. She maintained that it may have been due to poor hygiene or an old pad.

79 Ms Lu's evidence was that when she collected Gia at discharge, she was told that Gia's groin 'smelled bad.' That indicates that the smell persisted after showering. RM Khan did not dispute that she likely gave information at discharge that the groin smelled, or words to that effect. There is no coherent explanation for why such an odour would persist after a shower and a presumed change of pad. The evidence of both Ms Pigott and A/P de Vries is that any belief that the smell was merely due to poor hygiene ought to have been dispelled after a shower.

80 Significance should have been attached to the odour and it should have prompted both a mid-stream urine test and escalation to a medical officer.

81 A/P de Vries' evidence was unequivocal: Gia was suffering from a urinary tract infection on 3 February 2019, more probably than not right-sided pyelonephritis, which may have been detectable on abdominal or flank examination. Whether or not it was detectable on physical examination, appropriate management on that date would have led to diagnosis of UTI and would have involved commencing treatment. A/P de Vries considered that intravenous administration would have been preferable, though acknowledged that some clinicians at that time may have commenced oral antibiotics. His evidence was that, had appropriate treatment been instituted on 3 February 2019, Gia would

more likely than not have avoided the development of overwhelming sepsis and her subsequent death. Both he and RM Pigott considered Gia's discharge in the face of the documented odour to have been premature and inappropriate.

82 Gia and her son were discharged at about 2:10 pm on 3 February 2019. There was no contemporaneously documented vital observations. In the view of RM Pigott, given Gia's presentation was not a normal one having regard to the presence of odour, vital observations ought to have been taken prior to discharge.

83 I find that:

(1) on 3 February 2019, when she was discharged, Gia was suffering a UTI

(2) RM Khan unreasonably failed to attach significance to the odour referred to in her clinical notes

(3) appropriate management of Gia at this stage, including escalation for medical review, would have resulted in her receiving antibiotics which more likely than not would have avoided her death

(4) Gia's discharge was premature and inappropriate.

84 On 3 February 2019, at around 2:30pm, Gia and Ms Tran arrived home from Fairfield Hospital with Gia's son.

Was the medical care and treatment of Gia by RN Wiblen appropriate?

85 At around 12:30 pm on 4 February 2019 RM Sieglinder Wiblen, attended Gia's home. No interpreter service was engaged, rather Gia called Ms Tran so that she could interpret over the phone. It is unknown whether Gia had any objection to the necessity that her personal medical information be disclosed to Ms Tran in circumstances where there appears to have been no offer of an accredited interpretation service.

86 RM Wiblen observed Gia to be ‘in a lot of pain,’ ‘breathing quickly,’ and noted that she ‘appeared distressed.’

87 On reflection RM Wiblen agreed that she failed to appreciate the severity of Gia’s condition. Critically, she did not attach significance to Gia’s breathlessness, nor did she recognise that Gia’s pain was abnormal, both in its severity and in its spread to her legs and neck. She properly conceded that she ought to have measured Gia’s respiratory rate and pulse, that she should have regarded Gia’s pain as concerning, and that breathlessness was a potential indicator of infection. She also accepted that recommending review by a general practitioner, rather than advising immediate re-presentation to Fairfield Hospital, was an error.

88 Both Ms Pigott and A/P de Vries were critical of the failure to identify that Gia was significantly unwell. A/P de Vries’ evidence was that Gia was, by that time, critically unwell and probably septic. The difficulty, however, lies in the extent of Gia’s deterioration by the time of the MSP review. Because she was already septic, A/P de Vries was unable to express an opinion that different management on 4 February 2019, such as calling Triple Zero and arranging emergency transfer to hospital, would more likely than not have saved her life. His evidence was that, as at that date, Gia may have been too unwell for even appropriate treatment to alter the outcome, and he could not provide a prognosis had appropriate care been initiated at that point.

89 There was also no interpreter engaged at this visit leaving Gia unable to communicate freely and meaningfully.

90 I find that RM Wiblen ought to have recognised the significance of Gia’s deterioration, she should not have recommended that Gia self-refer to her GP. Rather, an ambulance ought to have been called. However, even if these steps had been taken, the evidence does not establish that Gia’s death could have been avoided.

91 I also find that Gia should have been offered an accredited interpretation service to enable her to freely communicate with RM Wiblen during this visit.

92 Appropriately, when she arrived home at around 5:15pm, Ms Tran called an ambulance. Paramedics Denton and Afiouny arrived around 5.40pm, CPR was commenced and Gia was conveyed to Hospital, arriving at 6:40 pm. She was observed to be moribund and peri-arrest with a GCS of 3 out of 15. Thereafter her heart rate began to drop, and her pulse became unpalpable. At 6:30pm, Gia went into pulseless electrical activity (PEA) cardiac arrest. Resuscitation efforts continued until 8:10 pm when she was declared deceased.

Is it necessary or desirable to make any recommendations?

Developments since Gia's death

93 Sharon May gave evidence as to reforms and policy development occurring since Gia's death. Key changes are described below.

(1) In 2025, NSW Health introduced a new policy for the 'Recognition and management of clinical deterioration', together with the transition to a standardised, electronic, state-wide Maternity Observation Chart (**MOC**) replacing the paper-based Standard Maternity Observation Chart (**SMOC**) in use at the time of Gia's care. May indicated that the MOC is designed to reduce variation and improve the early detection of abnormal maternal observations.

(2) There has been a revision and expansion of patient-facing educational materials, now provided in multiple languages and accessible through QR-coded digital resources.

(3) Practices regarding interpreters has been strengthened since Gia's death. Interpreter use is now mandatory for women from culturally and linguistically diverse backgrounds when obtaining consent, during midwifery assessments, during discharge planning, and during all MSP visits. This is reflected in revised LHD-wide and Fairfield Hospital specific

guidelines, as well as in the implementation of the Maternity Interpreter Checklist, which is now required to be completed for all women in this cohort.

(4) The equipment available to MSP midwives was standardised and expanded in mid-2019. MSP staff are now required to carry thermometers, blue pressure cuffs and machines and pulse oximeters at all times, enabling them to undertake standard observations during home visits, observations that could not reliably be performed at the time of Gia's MSP review.

(5) Escalation pathways were revised in late 2019 and again in 2020 to make clear that any concerns identified during an MSP visit must result in referral back to hospital for urgent medical assessment, not referral to a general practitioner. These changes are now reflected in both local and LHD-wide policies.

Recommendations requested by Gia's family

94 Counsel for Gia's Aunt requested I consider the following recommendations.

(1) Each patient is to be offered the services of an accredited interpreter for significant medical assessments such as release from the care of obstetrics and gynaecology to the care of midwives and or assessments for the purposes of discharge from hospital.

(2) Each patient that is admitted to the labour ward is to be asked if they have had a UTI during the course of their pregnancy and if so a sample of urine is to be obtained and sent to pathology upon admission.

(3) If medical staff propose to use a person visiting the patient as an interpreter; the best practice is to ask the visitor to step outside for a moment and to attempt to check with the patient as to whether they agree to the person interpreting for them.

(4) The Sepsis Pathway is to be updated to include consideration of an alternative source of infection (such as UTI) if a wound is not showing signs of infection.

(5) The MSP is to consider further training and policy changes in respect of the use of accredited interpreters in all non-English speaking patient consultations.

95 In relation to proposed recommendations (1) and (5) above, extensive work has been undertaken by the SWSLHD to incorporate and normalise the use of interpreters. The evidence adduced from practitioners during the inquest support that practices have improved. On that basis, it does not appear to be necessary to make recommendations relating to the use of interpreters in this setting.

96 Proposed recommendation (3), also dealing with interpreters, would have been appropriate if practices remain as they were when Gia died. In Gia's case, Ms Tran, Gia's landlady/friend was used in the absence of an accredited interpreter. Gia's consent to this course could only freely be obtained in the absence of Ms Tran and, given Gia's ability to communicate in English, the conversation surrounding consent would require an interpreter. However, this issue was prominent in a situation where friends and family were readily and frequently used absent an appropriate practice or expectation that an accredited interpreter would be used. On the basis that now an accredited interpreter is relied on for significant communications, it appears the pendulum has swung from the presumption that family and friends would be relied upon to the presumption that an accredited interpreter be used. On that basis I do not consider the recommendation is necessary in light of current practices.

97 In relation to proposed recommendation (2), a blanket approach does not seem to be warranted in this case. Gia was not asymptomatic when she was admitted to the birthing unit or when she was considered for early discharge onto the MSP. The issue in this case is that there were errors in clinical judgment. Further urinalysis and medical review ought to have occurred:

(1) on 21 January 2019 when Gia reported difficulty passing urine

(2) on 31 January 2019 when erythrocytes +++ were recorded by an unknown person who ought to have referred Gia for medical review and taken further urinalysis

(3) on 3 February 2019 when RM Khan unreasonably failed to attach significance to the odour referred to in her clinical notes.

98 Blanket and potentially unnecessary testing is not a substitute for appropriate clinical review and practices.

99 In relation to proposed recommendation (4), on an appropriate operation of the Maternal Sepsis Pathway, the presence of a 'wound' does not assume primacy in the assessment of whether there is an infection, or whether a patient is septic. The Maternal Sepsis Pathway identifies numerous 'signs or symptoms of infection,' occupying eight different categories of which 'breast, wound or line redness, swelling, pain …' is but one. If an appropriate clinical assessment of Gia had been performed on 3 February 2019 consistent with the Maternal Sepsis Pathway, Gia's sepsis would have been identified. Absent evidence of a systemic or recurrent issue, it is not appropriate or necessary for the recommendation to be made.

Recommendations

100 An issue which has not been addressed in the policy developments implemented by the SWSLHD is the infrequency with which Gia's pain score was documented on the SMOC.

101 To address this:

(1) I recommend to the SWSLHD that a sample of SMOC or MOC Charts relating to CALD[13] patients be audited to determine whether

[13] Culturally and linguistically diverse.

observations are being documented and recorded correctly, including at the required frequency, depending upon the clinical acuity of the patient.

102 Counsel assisting submitted that I may consider a recommendation pursuant to s 82(2)(b) of the Act, that the Nursing and Midwifery Board of Australia investigate RM Khan's care of Gia.

103 Section 82(2)(b) provides that:

> (1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.
>
> (2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation—
>
> (a) public health and safety,
>
> (b) that a matter be investigated or reviewed by a specified person or body.

104 At the time of Gia's death, RM Khan had been working for some 12 years as a registered midwife.

105 RM Khan's care of Gia was lacking in the ways described below.

(1) RM Khan failed to document any observations she did take on 2 February 2019.

(2) RM Khan inappropriately failed to recognise what she described as an offensive smell as a clinical symptom of sepsis in favour of dismissing it as a hygiene issue.

(3) RM Khan was an unimpressive witness who showed little insight into the inadequacies in the care she provided to Gia. To that end, even with the benefit of hindsight, inclusive of knowledge of the cause of death and having had access to the expert opinions, RM Kham was not prepared to accept that the offensive odour was a possible sign of infection.

106 I have considered the submissions filed on behalf of RM Khan. They do not deal with the central criticism of RM Khan, being her failure to recognise that the offensive odour was a clinical symptom of sepsis.

107 The standard of care provided to Gia during her maternity admission by RM Khan fell well short of the standard expected of an experienced registered midwife. In all the circumstances, it is appropriate and necessary to make the following recommendation to the Chief Executive, Nursing and Midwifery Board of Australia:

(1) That consideration be given to the Nursing and Midwifery Board of Australia reviewing and/or investigating RM Khan's care of Gia during her maternity admission.

I direct that a copy of the brief of evidence be provided to the Nursing and Midwifery Board of Australia.

Closing remarks

108 I will close by conveying to the Lam family and in particular, Gia's son, her Aunt and Uncle, my sympathy for the loss of their beautiful mother and niece.

109 I thank the Assisting team for their outstanding support in the conduct of this inquest.

110 I thank the officer in charge, Detective Senior Constable Mitchell Doubleday, for his work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

Statutory findings required by s 81(1)

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

Identity

The person who has died is Gia Lam.

Place of death

Gia Lam died at Liverpool Hospital, Liverpool New South Wales.

Date of death

Gia Lam died on 4 February 2019.

Cause of death

Sepsis due to pyelonephritis of the right kidney due to acute and chronic cystitis

Manner of death

Gia's death was preventable. Gia died as a consequence of multiple failures to diagnose a urinary tract infection during her antenatal and postnatal treatment and her premature and inappropriate discharge onto the Midwifery Support Program.

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe

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