CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Helen Frances Honey
Hearing dates:	11-13 & 16-17 June 2025 Newcastle Local Court 21-22 October 2025 Lidcombe Coroner's Court
Date of findings:	21 August 2026
Place of findings:	Lidcombe Coroner's Court
Findings of:	Deputy State Coroner, Judge Devine
Catchwords:	CORONIAL LAW - involuntary patient - Mental Health Older Persons Unit - abdominal aortic aneurysm - adequacy of Rapid Response Team and Emergency Department responses - Calvary Mater & John Hunter Hospitals - applicable policy in the Emergency Department - manner and cause of death
File number:	2021/50339
Representation:	Dr G O'Mahoney, Counsel Assisting, instructed by Mr T Dinjar (Department of Communities and Justice) Mr J Downing SC for Hunter New England Local Health District and Calvary Mater Hospital, instructed by Ms Z Samadie (Crown Solicitor's Office). Ms R Rodger for Dr Nathan Gore-Lenskyj and Dr Mohamed Elsamani, instructed by Ms E Marel and Ms J Paterson (Avant Law) Dr P Dwyer SC for Dr Ibrahim Elmezayen, Dr Alycia Senthinathan, and Dr Micah Kokada, instructed by Mr A Davey (Unsworth Legal)

Ms G Lewer for Dr Johann Gildenhuys, instructed by Ms C Darroch and Ms N Speight (Meridian Lawyers)

Ms B Epstein for Dr Nipun Athukorala, instructed by Ms L Biviano, Ms S Hawkins-Adams & Ms J Hayes (Meridian Lawyers)

Mr R Sergi for Dr Samantha Khoo, instructed by Ms A Burke and Ms L Cantrill (Mills Oakley)

Ms J Sandford for Dr Geraud Freer, instructed by Mr G Tripodi and Ms N Aprea (Barry Nilsson)

Ms K Burke for Dr Bassem Ibrahim, instructed by Wallace, Ms K Poh & Mr S Canton (Moray & Agnew)

Mr P Madden for RN Jason Robards (NSW Nurses & Midwives Association)

Ms K Doust for RN Sarah Lazarou (NSW Nurses & Midwives Association)

Section 81(1) Findings

Identity of deceased: Helen Frances Honey

Date of death: 21 February 2021

Place of death: John Hunter Hospital, Newcastle

Cause of death: Ruptured abdominal aortic aneurysm

Manner of death: Ms Honey died of natural causes associated with a rupture of an abdominal aortic aneurysm, in circumstances where there had been clinical deterioration the evening before her death, but where there was a delay in diagnosis of the rupture and consequent delay in consideration of treatment options

FINDINGS

Introduction

1. This inquest concerns the death of Ms Helen Frances Honey (**Ms Honey**), who was born on 29 January 1951 and who died at about 6.36am on Sunday, 21 February 2021. Ms Honey was 70 years of age at the time, and was the wife of Ross Honey and mother of Rebecca Walker.

2. At the time of her death, Ms Honey was detained as an involuntary patient under the *Mental Health Act* 2007 (Mental Health Act) and was being treated for a decline in her mental state. Ms Honey had been admitted under Section 19 of the *Mental Health Act* on 3 December 2020.

3. Some six days before her death, on Monday 15 February 2021, Ms Honey was diagnosed with an 8cm abdominal aortic aneurysm (**AAA**). The AAA had been incidentally identified in an X-ray the week before. The AAA was apparently asymptomatic at this time, and a review by the Vascular team at John Hunter Hospital (**JHH**) had been arranged for the following Monday, being 22 February 2021.

4. Ms Honey did not survive to attend that review, as the AAA ruptured over the course of the weekend before.

Jurisdiction

5. A Coroner has the responsibility to investigate all reportable deaths under the Coroners Act 2009 (**the Act**). Reportable deaths are defined in s.6 of the Act.

6. The Court had jurisdiction to hear this inquest under a number of jurisdictional bases under the Act including:

    a. the person died under … unusual circumstances (as per s.6(1)(c) and s.21(a) of the Act); and

b. the person died while in … a declared mental health facility within the meaning of the *Mental Health Act* 2007 and while the person was a patient at the facility for the purpose of receiving care, treatment or assistance under the *Mental Health Act* 2007 … (per s.21(a) and s.6(1)(f) of the Act).

7. In holding this inquest, s.81 of the Act requires the Court to make findings with respect to the identity, date and place, and manner and cause of death. In this inquest the findings as to identity, date, place, and direct cause of death are not contentious.

Why was an inquest held?

8. Ross Honey and Rebecca Walker provided statements that were tendered. Those statements set out their support for an inquest to be held into the circumstances (or manner) of Ms Honey's death, and more generally they raise serious concerns as to Ms Honey's care and treatment in the lead up to Ms Honey's death.

9. Although those concerns were at the centre of the inquest it is important to understand that an inquest is not a forum where a Coroner sets out to prove any allegation or proposition or attribute blame or responsibility. Rather, inquests have a preventative focus, and Coroners often exercise the power provided for by s.82 of the Act, to make recommendations.

10. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified and examined during an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

11. Where an inquest can identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of similar deaths in the future.

12. It was obvious to me in this inquest that Ms Honey's family wanted not just to understand the full circumstances of Ms Honey's death, but to be part of any positive change that could arise from her passing.

Recognition of the impact on family

13. The coronial process in general represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature compel a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

14. It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a very lengthy one. This is such a matter. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated. Again, this was painfully obvious in this inquest and on behalf of the Court I express my sincerest condolences to Ms Honey's family and friends.

Recognition of Ms Honey's life

15. The coronial process exists because of the value we, as a community, place on human life. Understanding the impact that the death of a person has had on those closest to the person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully, meaningful way.

16. With that in mind, I note that during the inquest (and in addition to receiving their statements) I heard from Ms Honey's husband, Mr Ross Honey and her daughter, Ms Rebecca Walker.

17. Mr Honey spoke of being married to Ms Honey for 38 years and that together, they had a daughter, Ms Walker, in 1986. That Ms Honey was a woman with a strong faith and that she always prayed and encouraged the family to go to Church. He said that the family look forward to the day when they can see her again in God's kingdom but until then, she is sadly missed by them all.

18. Ms Walker spoke of Ms Honey having a difficult life. That, unfortunately, she suffered at the hands of institutions and the medical system, as well as in life, through various health challenges, but that Ms Honey was nonetheless a strong, resilient and faithful person.

19. She said Ms Honey had the ability to see the good in others, sometimes caring too much but that she was always helping people. She said Ms Honey was warm and had a childlike optimism and sense of humour. She said that in her youth Ms Honey was the life of the party and that she travelled and worked hard until her mental health impacted her ability to live life to the fullest.

20. Ms Walker continued that Ms Honey had a strong moral compass and a sense of social justice and that Ms Honey inspired her to pursue a career in social work and to work specifically in mental health. She said Ms Honey loved children and wanted many but, as that was not possible, they were best friends.

21. Ms Walker said further that Ms Honey was always a loving and dedicated mother. That Ms Honey was loved by many people, and, in this context, she spoke of how much Ms Honey looked forward to becoming Nanna to her two granddaughters, Evie and Audrey and how much Ms Honey loved them and would have enjoyed watching them grow up. Ms Walker also spoke of the difficult time when Ms Honey and the family were separated by the pandemic and closed borders of 2020.

22. Once again, it was evident that the sudden and tragic way in which Ms Honey was separated from her family continues to be deeply felt by those that loved her most.

The Evidence

23. A coronial investigation precedes an inquest. During the investigation considerable evidence, in form of witness statements, expert reports, medical records, hospital policies and more are obtained by, and provided to, the Coroner. A report as to the cause of death (a post-mortem report) is provided by a forensic pathologist.

24. In the case of the investigation into Ms Honey's death, a multi-volume brief of evidence complied by the Officer in Charge (**OIC**) of the coronial investigation, Senior Constable Naomi Hatton, and extensively supplemented by the Inquests, Inquiries and Representation legal team of the Department of Communities and Justice (**Assisting team**), was tendered to the Court. Additional material was tendered during the course of the inquest.

25. The material tendered included statements from a number of health professionals from the Calvery Mater Hospital (**CMH**) and Hunter New England Local Health District (**HNELHD**) and numerous guideline and policy and procedure documents (**Guideline Documents**), from CMH, HNELHD and from NSW Health considered relevant to the issues in this inquest, including documents in force at the relevant time in February 2021, as well as the versions of those currently in force.

26. For all of those policy materials, it is noted that the principal issue regarding policy which was considered during the hearing of this Inquest, turned on a concern on the part of certain personnel within the Emergency Department that there was a policy which, in effect, precluded Ms Honey, following her arrival in the Emergency Department, from being cared for by Emergency Department staff. In light of the evidence that has fallen, there is no need for the Court to consider in any great detail all of the Guideline Documents before it.

27. I thank the Officer in Charge of the Investigation and the Assisting team for the thoroughness of their investigations and the work done by them because, to a very considerable extent, it brings to light the full facts surrounding Ms Honey's death.

28. The inquest also heard oral evidence over 7 days at Newcastle Local and Lidcombe Coroners Courts. During that evidence the Court heard not only from those involved in Ms Honey's care. It also had the considerable benefit of hearing from expert witnesses and senior hospital staff appointed since Ms Honey's death. This evidence shone further light on the issues.

29. In receiving the entirety of the evidence referred to above, making issues known as they developed and giving interested parties an opportunity to be heard and make submissions thereafter, the Court has sought to balance the obligation to afford procedural fairness to those whose reputation and interests are in question in a public forum with the need to confine, in an appropriate manner, the scope of the inquest in order to meet the "primary duty" in s.81 of the Act.

30. Given the volume of material before the Court, it is not possible (nor desirable) to refer specifically to all the available evidence but I want to assure Ms Honey's family that I have had the opportunity to thoroughly review and consider the entirety of the material and I have done so with the benefit of written submissions from all interested persons and I will touch on those aspects of the evidence that I consider most significant.

31. In deciding what matters to touch on I have also been guided by an Issues List that was circulated amongst the legal representatives appearing in the matter.

Factual Background

32. The following outline of background facts is drawn from the submissions of Counsel Assisting which, in turn, is principally drawn from the documents contained in the Brief of Evidence, with primacy given to the contemporaneous documents, where available. I am enormously grateful to Counsel Assisting in this regard. Indeed, Counsel Assisting's assistance has been exemplary in the conduct of this challenging inquest.

33. As Counsel Assisting did in his submissions, where there is an inconsistency between accounts based on recall, to the extent it is necessary or appropriate to resolve that inconsistency, I give primacy to the account that is consistent

with the contemporaneous documents. As is noted below, there are a number of conflicts concerning retrospective accounts of events, which do not need to be (and ultimately cannot reliably be) resolved.

Admission to Mater Mental Health Service: 3 December 2020

34. On **3 December 2020**, Ms Honey was admitted to the Lake Macquarie Mental Health Unit of the Mater Mental Health Service, where a *Mental Health Assessment* was undertaken. At that time the *Reason for Referral* was listed as "Voluntary presentation, brought in by husband", and with a *History of Presenting Problem* commencing with, "69 year old woman presents brought in by her husband with [about] 1 month decline in mental state; psychotic relapse of Schizoaffective disorder evidenced by persecutory delusions and auditory hallucinations".

35. At this time, Ms Honey's *Medical History* was noted to include diabetes, hypertension, asthma, and hypercholesterolaemia, and *Development and Personal History* to include:

> Lives with husband in Blackalls Park
> Generally independent with ADLs, husband doing majority now mobility poor
> Prev NDIS support
> Worked as secretary

36. The *Formulation/Overall Clinical Impression* concluded that Ms Honey "Required admission for stabilisation and medication review".

37. The Initial Management Plan included:

> 1. Admit as Mentally Ill
> 2. Open ward. Most appropriate for MHUOP however no beds.

38. Also on the day of Ms Honey's admission (3 December 2020), Ms Honey's husband, Mr Honey and her daughter, Ms Walker, signed the relevant forms to

formalise their nominations as Designated Carers, pursuant to Section 72 of the *Mental Health Act*. Both Mr Honey and Ms Walker were listed in the medical records, more generally, as Ms Honey's "Person[s] for Notification".

39. On **17 December 2020**, Ms Honey was the subject of a Mental Health Review Tribunal (**MHRT**) review. A Medical Report dated 16 December 2020, prepared for the review, noted Ms Honey had been admitted involuntarily as mentally ill under the *Mental Health Act* to Lake Macquarie Mental Health Unit, set out her progress since the admission, which included non-compliance with medication, and requested an "Involuntary Inpatient Order – 8 weeks". An order was made on that day that Ms Honey be detained until no later than 11 February 2021.

Transfer to the Mental Health Older Persons Unit: 18 December 2020

40. On **18 December 2020**, Ms Honey was transferred to the Mental Health Older Persons Unit (**MHOPU**), and was admitted under the care of staff specialist psychiatrist, Dr Mohamad Elsamani, also known as Ms Honey's "AMO" (Attending Medical Officer). The MHOPU is a mental health unit geographically attached to the CMH, Newcastle, however administratively, is a part of the HNELHD, rather than the CMH.

41. Ongoing psychosis and medication compliance issues were noted following the transfer, as were issues in relation to constipation and Ms Honey's bowels, as well as a recurrent expression by Ms Honey of a belief she was pregnant.

42. The Progress Notes for **29 December 2020** record a psychiatric review, where in addition to psychiatric issues, it was noted: "Bowels last opened recorded 23/12 [complained of] abdo pain", with a part of the *Plan* to include the laxatives "Movicol … Coloxyl [with] senna".

43. Issues related to Ms Honey's bowels were regularly documented from this time, including on 30 December 2020 (re laxatives), 4 January 2021 (refused laxatives as stated "bowels open well"), 5 January 2021 ("Bowels opened yesterday"), 6 January 2021 ("Pt bowels opened"), 8 January 2021 ("refused to finish her movicol stating her bowels are moving already"), 9 January 2021

("Reported bowels opened"), 10 January 2021 ("stated bowels open (Large)"), 11 January 2021 (cease laxatives), 14 January 2021 (re belief of clip on bowel).

44. On **18 January 2021**, Ms Honey reported to the doctors and nurses that someone had put glass in her bowels, and a *Plan* was recorded to continue a Bowel Chart.

45. On **19 January 2021**, following a review by Dr Elsamani at the Multidisciplinary Team Review, the *Plan* included an order for a Bowel Chart, AXR and CXR [abdominal and chest x-ray], and laxatives (Movicol and Coloxyl with senna).

46. The Abdominal X-ray conducted on that day reported:

> There is faecal loading throughout the colon. … Curvilinear calcification is seen in the left paravertebral region from L1-L4 vertebra. Etiology and significance of this calcification are uncertain. Comparison with previous imaging is suggested. Alternatively it could be further assessed on lateral x-ray or CT scan if clinically warranted.

47. Ms Honey continued to raise issues in relation to her bowels, and bowel and constipation related issues continued to be documented, including on 20 January 2021, 21 January 2021, 22 January 2021, 24 January 2021, 27 January 2021, 30 January 2021, 1 February 2021, 2 February 2021, 3 February 2021, 4 February 2021, 5 February 2021, 6 February 2021, and 8 February 2021.

48. There were times when Ms Honey's beliefs in relation to her bowels, and in relation to being pregnant, intersected, such as on 21 January 2021, where a nurse recorded in the Progress Notes, "Refused to have enema, pt stating 'you are trying to kill my baby and there is glass in my back and I can feel it'", or on 1 February 2021, where a nurse reported Ms Honey stating, "I'm pregnant", and "my bowels are stuck to my baby".

49. On **9 February 2021**, Ms Honey was the subject of a MHRT review. A Medical Report dated 8 February 2021, prepared for the review, noted that despite some

improvement Ms Honey continued to have psychotic symptoms, and that she continued to meet criteria for being mentally ill under the [*Mental Health Act*], with an element of risk which justified continued detention, with a request for a further 12 weeks of detention. Following the hearing, the MHRT made an order for Ms Honey's further detention until 8 May 2021.

50. On Wednesday **10 February 2021**, Dr Elsamani and his team carried out a review of Ms Honey, where the consequent *Plan* included an abdominal x-ray, due to "? Constipation, impacting delirium".

51. The abdominal x-ray was carried out on that day (10 February 2021). The *Clinical History* on the report was recorded as being, "Past AXR indicated ++ faecal loading. Pt has ongoing dellusional [sic] content. ?Delirium secondary to constipation". The x-ray was conducted at 2.42pm, and the report stated:

> A large curvilinear calcific density at the left para vertebral region which may mimic a large abdominal aneurysm measuring at least 7.6cm. … Suggest further evaluation with CT with contrast. There is also faecal loading seen at the ascending and descending colon. …

52. On Thursday **11 February 2021**, Ms Honey underwent a lateral abdominal x-ray which reported:

> Lateral abdomen image obtained as requested and demonstrated an oval shaped calcified mass. This is more likely to be related to calcified large aortic aneurysm and extends about 10cm in length and about average 5cm in AP and transverse diameter.

53. On Friday **12 February 2021,** the medical records note the results of a physical examination of Ms Honey's abdomen, which included the words '*pulsatile*', '*firmed edged*' and '*tender*'. The *Plan* following this included '*Aim CT abdo*'. A CT scan was booked for later that day, however, was cancelled due to an '*issue [with] canula*', and was booked for the following Monday.

54. On Monday **15 February 2021** at 1.11pm, Ms Honey underwent a CT Abdomen and Pelvis scan, with IV Contrast, which revealed a "8cm infrarenal abdominal aortic aneurysm as described with calcified rim, correlating with curvilinear calcification seen on abdominal x-ray. … Vascular referral is recommended".

55. On that same day (15 February 2021), the Progress Notes record a review by Dr Elsamani and Dr Georgette Goode (Registrar) at 4.00pm. The notes, made by Dr Goode, record the findings from the abdominal CT earlier in the day, along with the note, "I [Dr Goode] have [discussed with] [Vascular team from JHH] who will update re plan / 1x1 (Alison – Reg)".

56. Dr Alison McGill was a registrar with the JHH Vascular team at the time, who provided a statement for use in these proceedings. In that statement Dr McGill sets out her recall of receiving a call on that day from the psychiatry registrar from CMH, and also her recall that she discussed what she had been told with the on-call consultant, Dr Mathew Sebastian. Of this Dr McGill stated:

> *I discussed the plan with Dr Sebastian and we understood that the plan was for the Mater to arrange a workup in the form of spirometry and a MIBI [MIBI is short for Sestamibi Scan, scheduled for 18 February 2021]. I scheduled Ms Honey to attend our clinic the following Monday, 22 February 2022 [sic, 2021], with her husband and the workup results so that we could assess her. I confirmed these arrangements with the psychiatry registrar and arranged the clinical appointment.*

57. Dr Mathew Sebastian was and is a vascular surgeon, and senior staff specialist and Director of Vascular Ultrasound at JHH and he confirms that he was the vascular consultant on-call and operating at JHH on 15 February 2021. For his part, in his statement Dr Sebastian sets out his recall of his involvement with Ms Honey's care on that day:

> *7. On 15 February 2021, I was the vascular consultant on-call and operating at **JHH.** While I was scrubbed in the vascular angiography suite performing a vascular procedure, I was approached by my*

*registrar, Dr Alison McGill. Dr McGill noted that she had been called by a doctor at Calvary Mater Newcastle hospital **(the Mater)** in relation to the referral of a patient on their psychiatric unit.*

8. *Dr McGill noted Ms Honey was a psychiatric patient that had undergone a CT angiogram on 15 February 2021, which showed an abdominal aortic aneurysm **(AAA)** with a maximum diameter of 8cm, but no evidence of leak or rupture. I specifically recall Dr McGill stated, upon her specific questioning, the referring team had said Ms Honey was "asymptomatic".*

9. *During that initial conversation, I requested Dr McGill pull up the CT scan. I do not recall the specific time when we looked at the scan, whether it was during a break in the procedure I was performing, or straight after the procedure. I do recall, however, that I was still in scrubs when I reviewed the CT scan with Dr McGill, and that we reviewed the scan on the monitor in the control room of the Angiography lab. I recall Dr McGill and I reviewed Ms Honey's CT scan in detail. I was satisfied that the aneurysm was as large as was stated, and that there were no signs of a leak. I remarked at the size of the AAA, and that she was reportedly asymptomatic. While it is my usual process to transfer patient with a AAA to JHH, as Ms Honey was a psychiatric patient and her AAA was reported to be asymptomatic, I asked Dr McGill to contact the referring team to confirm whether Ms Honey was still suffering active psychosis.*

10. *If the referring team noted Ms Honey was still suffering active psychosis, I asked Dr McGill to advise the referring team that, so long as Ms Honey's AAA remained asymptomatic, it would be reasonable for her to continue to receive treatment for her active psychosis under the psychiatric service at the Mater until I could see her for an assessment in my outpatient clinic, together with family members, the following week. As Ms Honey's AAA was asymptomatic, I felt that our acute surgical ward*

was not the appropriate place for management of her active psychosis while she awaited assessment by our team.

11. I asked Dr McGill to arrange an appointment for Ms Honey and her husband with me in the JHH outpatient clinic the following week (which was arranged for the Monday, 22 February 2021), to discuss the benefits and risks of repairing the aneurysm, either by an endoluminal or surgical technique. I also asked Dr McGill to specifically advise the referring team that, should Ms Honey's AAA become symptomatic in the interim, to inform our team immediately and transfer Ms Honey to JHH.

58. In the 15 February 2021 Progress Notes, Dr Goode also recorded that Mr Honey had been contacted and updated in relation to the CT findings and plan.

59. The Progress Notes of Tuesday, **16 February 2021** record a Multidisciplinary Team Review with Dr Elsamani and his team, with the notes made by Dr Juliette Archibald, who was then a Junior Medical Officer (**JMO**) and a part of that team. The first issue raised in the notes was in relation to the AAA, stating:

> [Discussed with] vascular surg yesterday + again this morning (Alison reg for Dr M Sebastian)
> --> only had a chance to discuss case [with] consultant this AM.
> For outpatient clinic [with] vasc surgery to discuss surgical intervention on MONDAY (22/02)
> -->for spirometry + MIBI prior
> [Discussed with] family (husband Ross and daughter Rebecca)
> --> [no history of] AAA
> --> to provide info sheets.
> * please monitor for any signs of deterioration + notify team for urgent clinical review *
> --> ↓ [decrease in] BP [blood pressure], tachycardia, bradycardia, chest pain, abdo pain.

60. In keeping with the above notation, in her statement Dr Goode annexed a copy of an email, and its attachment, that she sent to Mr Honey and Ms Walker at 2.16pm on Wednesday, **17 February 2021**. The email provided Ms Honey's family with detailed information about the upcoming tests on 18 February 2021, and about the meeting with Dr Sebastian and his team on Monday 22 February 2021. The attachment to the email comprised a four page "Patient information from BMJ [British Medical Journal]" in relation to AAAs, which provided detailed information to the family as to what an AAA was, what the symptoms were ("… some people get pain in their abdomen, groin, or back, which can be a sign that an aneurysm may soon rupture"), as well as treatment options, surveillance, and aneurysm repair.

61. On Thursday, **18 February 2021**, a nursing entry in the Progress Notes records that Ms Honey's physical observations were Between the Flags, however a 10-point postural drop in blood pressure was recorded.

62. Later that day (18 February 2021), Ms Honey was escorted to JHH and underwent the pre-surgical tests as ordered earlier in the week by the Vascular team, being a NM Sestamibi (**MIBI**) Stress – Scan and Spirometry test.

63. In relation to the MIBI Stress – Scan, the report recorded that there was no evidence of reduced coronary perfusion reserve; there was no evidence of prior transmural myocardial infarct; and there was normal left ventricular systolic function at rest. The report concluded that the study, in isolation, stratified the patient to be in the low-risk category for peri-operative coronary events during high-risk surgical procedures.

64. In relation to the Spirometry test, the Respiratory Function Report recorded that the Spirometry had been poorly performed and that the results were uninterpretable.

65. On Friday **19 February 2021** at 1.10pm, a notation was recorded in the Progress Notes in relation to Ms Honey's blood pressure:

ATSP [asked to see patient]: re Postural BP drop; SBO -> 100 to 84; Rechecked BP 100/70 sitting; Pt has only had small oral intake this AM; Pt feels well [with no] pain abdo or other; […] other obs BTF [between the flags] (HR 111)

66. Low blood pressure, in the absence of any abdominal (or chest) pain, was also recorded in the Progress Notes later that day at 4.50pm and 8.20pm, which was associated with attendances by medical staff.

Saturday-Sunday, 20-21 February 2021

Saturday, 20 February 2001 at around 11.00am

67. On Saturday, **20 February 2021** at around 11.00am, Ms Honey was reviewed by Dr Nipun Athukorala, who was the JMO covering the day shift for the MHPOU on that day.

Dr Athukorala was new to this role and had not encountered Ms Honey before this. He was however aware, from a handover on 19 February 2021 to prepare for the weekend shift, and from hearing about it generally on the ward that:

(a) Ms Honey had the AAA and that she was booked for vascular surgery at JHH on Monday, 22 February 2021;

(b) given the presence of the AAA, any review performed by him of Ms Honey would need to be discussed with one of the psychiatry registrars covering the shift, and likely also the JHH vascular surgery team; and

(c) any urgent transfer for a vascular surgery procedure at JHH would need to be organised directly with the JHH vascular surgery team.

The Progress Notes for Dr Athukorala's review of Ms Honey run to one and a half pages of notations. They included:

-Known [background] of AAA (8cm diameter), to see Vascular on Monday.
-Pt reports R abdominal pain since last night.
-Reports vomiting this AM.
-Reports currently no pain “comes and goes”.
-Denies back pain.
-Difficult to elicit [history] as pt seemed to not understand or hear sometimes.

68. At this time, Ms Honey’s abdomen was noted not to be obviously distended, however it was recorded she reported generalised tenderness and pointed to the right side when asked where the pain was.

69. Following the making of this notation at around 11.00am, at 11.45am Dr Athukorala recorded:

Spoke to JHH Vasc Reg:
-Not concerned
-Recommended do bloods & look for Hb drop
-Monitor & call back if changes or Hb drop for likely CT
PLAN: 1) Bloods now
2) [Nursing staff] to please monitor & notify if any changes

70. Dr Athukorala ordered blood testing & reviewed the results. He made another entry (time not stated) in Ms Honey’s clinical notes. Dr Athukorala recorded:

-N/S report given aperients
<u>Review of bloods</u>
-Hb 143 (N) -Trop <3
-WCC 11.9 [increased]
Impression: not concerning for AAA rupture
<u>PLAN</u>: 1) Notify MO if ongoing pain or vomiting.

71. In addition to the contemporaneous entries into the Progress Notes at the time, Dr Athukorala has also provided a statement where he sets out, in the context of his contemporaneous records, his recall of events at that time, including his contact with the Vascular Surgery Registrar, noting however that he "did not catch her name". Dr Athukorala sets out his account of what he informed the Vascular Surgery Registrar, and of what she advised him.

72. Whilst not documented in any MHOPU or JHH records at the time, the Vascular Surgery Registrar that Dr Athukorala spoke to was Dr Samantha Khoo. Dr Khoo has provided a statement setting out her account of the conversation she had with Dr Athukorala, who she referred to as a "ward male medical practitioner", and of the advice she says she gave.

73. The extent to which the retrospective accounts of Dr Athukorala and Dr Khoo differ, and the significance of the differences, was explored in the course of the hearing (see **Issue 1**, below) – as was expert evidence in this respect.

74. At 2.30pm that same day, the nursing staff recorded that Ms Honey had complained of abdominal pain and that she was reviewed by a medical officer, and that she was also later reviewed by a 'ward doctor' at 5.30pm, however that there were nil complaints of pain at that point.

<u>Saturday, 20 February 2021 late evening: MHPOU</u>

75. The following health professionals were involved in the care of Ms Honey in the evening of Saturday 20 February 2021 through to the early hours of Sunday 21 February 2021:

Location or Role	**Health professional** (shaded if off-site)
Attending Medical Officer (AMO)	Dr Mohamed Elsamani (Note: called by Dr Ibrahim)
Night duty nursing staff in the MHPOU	RN Shaun Spowart (In charge), RN Yulie de Groot, RN Karen Dorsett

Location or Role	Health professional (shaded if off-site)
Nurse Manager, afternoon shift (aka PEC or PECC Manager)	RN Kenneth Graham
Nurse Manager 3, After Hours Nurse Manager (aka Night Supervisor); Manager on Duty for the Mental Health Centre	RN Vicki Clarke
Nurse Manager (night shift)	RN Jason Robards
Director of General Medicine (available to Nurse Managers and others)	Dr Suzanne Wass (Note: called by RN Robards)
Executive on Call (available to Nurse Managers and others)	RN Tracy Muscat (Note: called by RN Robards at ~00.20am)
Psychiatric registrar, Psychiatric Emergency Care Centre (PECC) (aka PEC)	Dr Nathan Gore-Lenskyj
Rapid Response Team	Dr Geraud Freer (ICU Registrar), Dr Bassem Ibrahim (Medical Registrar); Dr Alycia Senthinathan (Resident/Intern/Junior Medical Officer); Dr Micah Kokada (Resident/Junior Medical Officer); RN Elizabeth Curry (ICU RN)
Staff Specialist in General Medicine; Medical consultant on call (available to Medical Registrar)	Dr Paul Wilson (Note: called by Dr Ibrahim and RN Robards)
ICU Consultant on call (available to ICU Registrar)	Dr Menaka Perumbuli-Achchige (Note: called by Dr Freer at 1.03am)
Emergency Department nursing staff	RN Sarah Lazarou (In charge), RN Reshma Kuriakose (Triage), RN Mollie Tollis (RN scribe, Short Stay Unit), RN Pradeep George Babu (Resuscitation)
Emergency Department medical staff	Dr Johann Gildenhuys (Director Emergency Department and staff specialist on call), Dr Ibrahim Elmezayen (Senior Emergency

Location or Role	Health professional (shaded if off-site)
	Department Registrar), Dr Annaliese Leerdam (Emergency Department Registrar)
JHH Vascular team	Dr Kirrily-Rae Warren (Vascular surgeon (On call), Dr Samantha Khoo (Vascular Fellow/ Registrar)

76. On Saturday **20 February 2021,** in the late evening Ms Honey was found by a nurse to be 'very sweat, cold skin' and to have a blood pressure of 86/21. The nurse who found Ms Honey, RN de Groot, retrospectively recorded in the Progress Notes (at 2.30am on 21 February 2021), that she had found Ms Honey in this condition at 10.15pm. The events that followed were summarised by RN de Groot as:

> Called PEC manager ask [for] doctor [review]. [Reviewed] by doctor, called Rapid Response. Pt brought to ED.

77. Unfortunately, recorded entries in the Progress Notes setting out the events that took place over the following hours are scant, with most accounts available in the Progress Notes and associated documents written retrospectively in the morning of Sunday 21 February 2021, and around the time, or after, Ms Honey had been transferred to JHH.

78. Further accounts of events have been provided by health professionals who have provided statements of their later retrospective recollections from that night, some supported by contemporaneous documents, and some not.

79. Based on the accounts of events provided by the various health professionals, either in the contemporaneous medical records or in the retrospective accounts provided in statements, the chronology of events immediately leading up to Ms Honey's arrival at the Emergency Department, appears to be broadly as follows:

Event
RN de Groot found Ms Honey sitting on the bed, “very sweat, cold skin”, and “blood pressure, temperature, respirations rate and oxygen saturation were outside the flags”
RN de Groot informed the in-charge nurse, RN Spowart, of this observation, and called the Psychiatric Emergency Care Centre (**PECC**) Manager, “Kenny” [RN Kenneth Graham]
Nurse Manager Graham (PECC) received call (from RN de Groot), and he and Dr Gore-Lenskyj (Psychiatric Registrar) went to MHOPU Nurse Manger Graham called Rapid Response Team
Following being informed of Ms Honey’s condition by RN de Groot, the in-charge nurse, RN Spowart, contacted RN Clarke, Night Supervisor, and a Rapid Response was called
Dr Gore-Lenskyj was informed Ms Honey had an AAA. He undertook an initial assessment of Ms Honey, who was deteriorating. He observed oxygen saturations were at 93%, that she had an unobstructed airway, respiratory rate 36 breaths per minute (**BPM**), and saw automatic blood pressure as reading 93/20, and noted cold peripheries. After attending to Ms Honey for 2 to 3 minutes, Dr Gore-Lenskyj requested that the Nurse Manager call the Rapid Response Team
The Rapid Response Team arrived 3 to 5 minutes after the call, and comprised a Medical Registrar (Dr Ibrahim), ICU Registrar (Dr Freer), and nurses (including ICU nurse RN Curry)
RN Robards received notification of the Rapid Response call and attended the MHPOU
A handover was undertaken between Dr Gore-Lenskyj and the Rapid Response Team (Dr Ibrahim and Dr Freer)
A “consensus” decision was made to transfer Ms Honey to the Emergency Department (Dr Ibrahim, Dr Freer, RN Robards)
Ms Honey was transferred from the MHPOU to the Emergency Department accompanied by Dr Freer, Dr Ibrahim, RN Curry, RN de Groot, and RN Robards
Mr Honey arrived at the Emergency Department

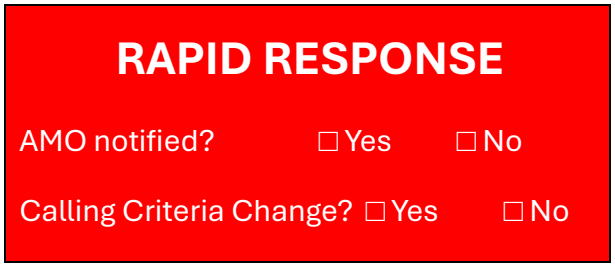
80. The Nurse Manager RN Graham stated in his statement that when a Rapid Response is called, a scribe is designated to take all notes with respect to the Rapid Response, however he could not recall who the scribe was on that occasion.

81. In the Progress Notes, at pages 183-184, there is an entry that runs for one and a half pages, that comprises the notations of a scribe (**the Scribe notations**). Times are listed at 11.20pm, 11.25pm, 11.35pm, 11.45pm, 00.00am, 00.08am, and next to those times various events and notations as to Ms Honey's condition are set out. The entries are not signed, however the Scribe has been identified as Dr Micah Kokada.

82. The first entry of the Scribe notations is at 11.20pm (page 183) and notes:

> Rapid Response for [decreased] GCS – E2V2MI= 5
> RR36
> BP110 SP96%

83. In the upper left part of page 183 there appears (on the colour copy provided) to be a red sticker, with white printed text, measuring approximately 6.8cm wide by 3.4cm high, on which the following is printed:



84. None of the boxes on the red sticker have been ticked, therefore providing no indication as to whether the Rapid Response Team turned its mind to whether (or not) to notify Ms Honey's AMO of the Rapid Response and its circumstances.

85. To the right of the red sticker, and continuing under it, the following was written:

> B/G [Background]
> Admitted for ~~schizophrenia~~ schizoaffective disorder (involuntary adm)
> AAA (8cm)
> -> Incidental finding on AXR
> Diabetes, HTN, Asthma, [increased] chol

Noted r/v earlier today for [increased] BP, nausea + vomiting

86. In the context of the handover from Dr Gore-Lenskyj to the Rapid Response doctors, Dr Gore-Lenskyj states he handed over to the medical registrar from the Rapid Response Team (Dr Ibrahim) and told him that Ms Honey had an AAA, also noting Ms Honey's respiratory rate and her low blood pressure.

87. Dr Freer recalls being told of the AAA.

88. For Dr Ibrahim's part, while he states he does not deny the information may have been provided by the psychiatric registrar, he says he does not recall hearing it from the registrar. However, whilst not recalling being told of the AAA by Dr Gore-Lenskyj, Dr Ibrahim does state that whilst still in the MHOPU, that on "another review of Ms Honey's medical file" a "past medical history was noted by a member of the [Rapid Response Team]" which included an AAA. Of this Dr Ibrahim states, "I do not recall any mention of a recent diagnosis of an AAA, or recent abdominal pain and discussions with vascular surgery".

89. In relation to the issue of the content of the handover between the medical staff, in particular, communication of the existing diagnosis of an AAA, there are differing accounts provided by Dr Gore-Lenskyj, Dr Ibrahim, and Dr Freer. The extent to which the retrospective accounts of the doctors differ, and the significance of the differences, was explored in the course of the hearing. The significance of an existing AAA diagnosis to potential and/or differential diagnosis considered by each of the doctors was similarly explored (see **Issue 2**, below) – as was expert opinion in relation to these issues.

90. None of these doctors gave evidence that at this point they either reviewed Ms Honey's medical records themselves or called Ms Honey's AMO to consult or otherwise obtain more information.

91. The Scribe notations indicate that at 11.35pm, Ms Honey was transferred to the Emergency Department. The Scribe notations do not indicate however, who

made this decision (**the Emergency Department transfer decision**), or the basis on which it was made.

92. Dr Freer has stated that he and Dr Ibrahim worked collaboratively and that he believed them to be "joint leaders" of the Rapid Response Team. Dr Ibrahim stated that he and Dr Freer worked together and that no Team Leader had been designated.

93. The issue of team leadership of the Rapid Response Team between Dr Ibrahim and Dr Freer, and decision making, including the Emergency Department transfer decision, was explored during the hearing (see **Issue 2**, below). Expert opinion in relation to these issues was also explored.

Saturday, 20 February 2021 late evening: Transfer to Emergency Department

94. Based on the accounts of events provided by the various health professionals, either in the contemporaneous medical records or in the retrospective accounts provided in statements, the chronology of events following Ms Honey's arrival at the Emergency Department, appears to be broadly as follows:

Event (shaded where off-site contact)
Ms Honey arrived at the Emergency Department, accompanied by Dr Freer, Dr Ibrahim, RN Curry, RN de Groot, and RN Robards
Dr Freer spoke with Dr Gildenhuys re Ms Honey
Dr Gildenhuys left the Emergency Department to go home
Dr Ibrahim called Dr Wilson re Ms Honey and noted not receiving assistance from Emergency Department staff
Dr Freer returned to Resuscitation Bay after speaking to Dr Gildenhuys
RN Robards called Dr Wass, who suggested he contact Dr Wilson
RN Robards called Dr Wilson and asked him to call Dr Gildenhuys
Dr Wilson called Dr Gildenhuys
Dr Wilson called Dr Ibrahim and told him he had spoken to Dr Gildenhuys, and relayed that the ICU was the most appropriate destination for Ms Honey's care
GCS 13

Event (shaded where off-site contact)
Dr Elmezayen assisted with the care of Ms Honey
Dr Freer called Dr Perumbuli-Achchige
RN Lazarou contacted Dr Gildenhuys at his home and asked him to return to the Emergency Department as Ms Honey was unstable and needed to be intubated
Dr Freer recalled: Dr Ibrahim reviewed Ms Honey's medical records and said words to the effect: *Ms Honey has been complaining of abdominal pain in the preceding days. The vascular team at JHH has been consulted because she has an 8cm AAA, and there is a review planned for next Monday.*
Dr Elmezayen asked Dr Ibrahim to contact Ms Honey's admitting Psychiatrist
Dr Elsamani received a call from the CMH, which he missed, but called back straight away, and spoke to Dr Ibrahim
Dr Elsamani called CMH to check on Ms Honey's progress and again spoke to Dr Ibrahim
Dr Gildenhuys returned to the Emergency Department
Dr Gildenhuys and Dr Elmezayen in attendance
Dr Ibrahim reported to Dr Gildenhuys, Dr Elmezayen, Dr Leerdam, and RN Lazarou, that Ms Honey had a known AAA
Dr Gildenhuys performed bedside abdominal ultrasound and identified free fluid in abdomen
Ms Honey attended imaging
Ruptured 8.7 cm infrarenal abdominal aortic aneurysm was confirmed
GCS 3
Dr Warren, as on-call Vascular surgeon for JHH, notified of Ms Honey's case
Hunter Retrieval Service tasked with Ms Honey's transfer to JHH
Dr Ibrahim called Dr Elsamani and informed him they had confirmed a bleed of the AAA and that Ms Honey was awaiting retrieval to JHH
Later in the morning of 21 February 2021, RN Clarke went to the Emergency Department and retrieved Ms Honey's medical file, and faxed Ms Honey's Progress Notes and legal status document to JHH
Ms Honey arrived at JHH and was directly transmitted to theatre, followed by surgical intervention and resuscitation attempts
Ms Honey pronounced dead at 6:36am, 21 February 2021

95. The Scribe notations indicate that at 11.45pm, Ms Honey arrived at the Emergency Department. At this time, those notes recorded "Improving

consciousness", "E3V5M", and "HR94". Low and further declining blood pressure was recorded at this point as "BP 70/50".

96. The last two Scribe notations were at 0.00am, which included "US-guided cannula insertion", and at 0.08am, which included "Pt responsive" and "nauseous".

97. The Emergency Department Triage Notes (per RN Lazarou) record the date and time of Emergency Department triage as 21 February 2021 at 0.50am, with Priority 1 listed as being Resuscitation. The presenting problems were stated as:

> Female aged 70 years presents with Hypotension, Pt Brought around from mental health older persons with decreased LOC. unable to obtain BP. Taken to procedure bay with rapid response team in attendance.
>
> hx schizophrenia under mental health act.

98. RN Tollis was working a night shift in the Emergency Department that night and was designated as the "scribe nurse" once the Emergency Department became involved in the care of Ms Honey. Those Progress Notes (the Emergency Department scribe notations) commence at 0.50am with the following recording:

> Nursing: Pt received to resus from MH unit post MET call for [decreased] LOC & [decreased] BP. Pt GCS 13 ATOR.
> A. Patient, talking in sentences.
> B. Irregular RR 20-28. Nil sign of [increased] WCB
> C. Hypotensive SBP 60-80 on arrival to Resus, dry mucous membranes. IVF commenced
> Stat 2.5L given ATOR.
> D. GCS 13, pt confused + drowsy
> E. Temp 36.8 pt in gown + blanket

99. There were further entries in relation to various resuscitation interventions and associated issues at: 1.10am, 1.35am, 1.45am, 2.10am, 2.20am, 2.30am, 2.35am, 2.35am, 2.39am, 2.45am, 2.55am, 3.00am, 3.10am, 3.28am, 3.29am, 3.31am, 3.34am, 3.40am, 3.45am, 3.40am, 3.45am, 3.55am ["Pt attending CXR, CTB & Abdo CT"], 4.46am ["… GCS – 3 ?AAA …"].

100. The Adult Emergency Department Observation Chart for the early hours of 21 February 2021 disclosed the following blood pressure readings:

00.50am 78/55
01.00am 79/68
01.25am 85/66
01.40am 44/32
01.45am 53/41

101. Blood pressure readings following those times were recorded on an Observations Sheet.

102. By all measures, Ms Honey was critically unwell and her condition continued to deteriorate over the course of the early hours of 21 February 2021, including further decline in blood pressure, with no certain diagnosis of the cause of the deterioration identified. That is, until the Emergency Department doctors became aware of the existing diagnosis of an AAA, after which the diagnosis of an AAA rupture was immediately considered and investigated.

103. For its part, the RRT [Rapid Response Team] Collection Form had identified "Septic Shock" as the "RRT Diagnosis". It is unclear at what stage of Ms Honey's deterioration this diagnosis was recorded on that form, and also unclear who made this diagnosis, as Dr Freer denied making it.

104. Retrospective accounts of the events over the course of time that Ms Honey was in the Emergency Department were located in the medical records:

a. Dr Leerdam (ED Registrar), written at 6.00am;

b. Dr Freer (RRT and ICU Registrar), written at 6.00am and 7.00am;
c. Dr Ibrahim (RRT and Medical Registrar), written at 7.00am;
d. Dr Ibrahim Elmezayen (ED Registrar), two versions of typed notes, typed at time unknown;
e. Nursing (per ED RN Lazarou), written at 6.30am;
f. Nursing (per ED RN Babu), written at 7.25am.

105. In relation to the transfer of care of Ms Honey from the Rapid Response Team to the Emergency Department medical staff following arrival, details of any handover are unclear.

106. In particular, all Emergency Department staff have reported in their statements that Ms Honey's known AAA was not communicated to them until after Dr Gildenhuys had returned to the Hospital, which is likely to be sometime between 3.00am and 3.20am. Following this, an ultrasound, and then CT scan, was undertaken, which confirmed a rupture of the AAA, after which transfer to JHH was arranged.

107. In contrast to the statements of each of the Emergency Department doctors, Dr Ibrahim reported that he informed Dr Elmezayen about the AAA at an earlier stage.

108. Dr Freer said in his statement that he heard Dr Ibrahim stating, inter alia, that Ms Honey had an AAA diagnosis, when he and Dr Elmezayen were both present, however did not state whether he was able to observe whether Dr Elmezayen heard the statement or otherwise responded to it.

109. In relation to the issue of medical staff handover from Rapid Response Team to Emergency Department, communication of existing diagnosis of AAA was explored during the hearing, as was investigation and diagnosis of AAA rupture, and the response to ruptured AAA (see **Issue 3**, below). Expert opinion in relation to these issues was also explored.

110. Relevantly, various Guideline documents were also examined during the hearing, both in relation to compliance of medical health professionals with those Guideline documents, but also in relation to adequacy and appropriateness (see **Issue 4**, below). Key Guideline documents included:

Clinical Emergency Response Guideline Documents

(CMH): Clinical Emergency Response System – Emergency Department (v4.0): applicable as at February 2021 and currently

(CMH): Clinical Emergency Response System: applicable as at February 2021 (v9.0) and current version (v12.0)

(HNELHD): JHH_JHCH_0019 – Urgent Clinical Review and Escalation: applicable as at February 2021 and current version

(NSW Health): PD2020_018 - Recognition and management of patients who are deteriorating: applicable as at February 2021 and current version PD2025_14

Transfer and Handover Guideline Documents

(CMH): Transfer of Care between Calvary Mater Newcastle and Mater Mental Health Services: current version (v1.0) - not applicable as at February 2021

(HNELHD): PD2019_020: PCP 2 – Clinical Handover – Communication and Handover of Clinical Care: applicable as at February 2021 and current version

(NSW Health): PD2019_020 – Clinical Handover: applicable as at February 2021 and currently

Health Care Records Guideline Documents

(NSW Health): PD2012_069 – Health Care Records - Documentation and Management: applicable as at February 2021 and currently

Sunday, 21 February 2021: Transfer to JHH

111. At around 4.50am on 21 February 2021, contact was made with Dr Kirrily-Rae Warren in her rostered role as on-call Vascular Surgeon. Dr Warren was off-site at the time.

112. Given the time-critical nature of the situation, Dr Warren requested urgent transfer of Ms Honey to the JHH for further resuscitation and repair. She also requested that the referring hospital continue to attempt to notify Ms Honey's family of her situation, poor prognosis and impending transfer.

113. In order to expedite Ms Honey's care, Dr Warren accessed some of Ms Honey's CT images from home to ascertain if the aneurysm would be amenable to endovascular repair or would require open repair, which would enable mobilisation of the appropriate operating environment and staff.

114. On viewing the images, Dr Warren identified a large AAA, being 8.6 cm in AP diameter, with characteristics which led Dr Warren to decide on an open repair.

115. Dr Warren then drove to JHH, which took around 15 minutes. During this transit she contacted the on-call Vascular Fellow, to attend and act as surgical assistant. The Vascular Fellow was Dr Samantha Khoo.

116. At around this time, Dr Warren also contacted both the Nursing Manager in charge of operating theatre overnight and the Duty Anaesthetist to notify them of the imminent transfer of Ms Honey, and request that they prepare an operating theatre for her transition on arrival.

117. Upon arrival at JHH, Dr Warren reviewed the CT images and ensured that the Emergency Department and Blood bank had been notified.

118. Ms Honey arrived at JHH at approximately 6.10am, and handover was undertaken between the Retrieval Service Physician and Dr Warren.

119. Given Ms Honey was in extremis at that point, and despite knowing the slim chance of a good outcome in that setting, Dr Warren made the decision to transit directly to theatre without further resuscitation in the Emergency Department to attempt aortic cross clamping in an effort to prevent further loss of cardiac output.

120. Dr Warren then undertook the procedure, as planned, however Ms Honey lost cardiac output and CPR was commenced. Further procedural interventions were undertaken, however Ms Honey remained in non-shockable cardiac rhythm. A medical consensus was reached that further efforts would be futile and would not result in Ms Honey's survival, particularly given the protracted period of poor neurological response and hypotension overnight. No further intervention was attempted, and Ms Honey was pronounced dead at 6.36am.

Post mortem External Examination

121. Three days following Ms Honey's death, on 24 February 2021, an external examination and medical review was undertaken by Dr Allan Cala, a Senior Staff Specialist in Forensic Pathology. In the *External Examination Report* dated 12 April 2021, Dr Cala recorded "Ruptured Abdominal Aortic Aneurysm" as being the "Direct Cause" of death.

Issues

122. As already noted, the Court is required to make findings as to identity, date, place, and direct cause of death and these are not contentious. More complex issues arise in a consideration of the *manner* of Ms Honey's death, which has been the focus of inquiry in this inquest.

123. There were five issues that were the primary focus of the inquest and I will deal with them in turn.

Issue 1 – Saturday, 20 February 2021: 10.00am to 5.30pm

Having regard to the period of 20 February 2021 from 10.00am to around 5.30pm, was the investigation, diagnosis, monitoring, management and treatment of Ms Honey in relation to her abdominal aortic aneurysm (AAA) adequate, appropriate and timely, specifically in relation to the care provided by:

a. Hunter New England Local Health District (HNELHD) medical health professionals:

i. Mental Health Older Persons Unit staff
ii. John Hunter Hospital (JHH) Vascular Surgery Team

When examining the care and management of Ms Honey during this time period, the following issues will be included in that examination: documentation; communication; diagnostic formulation, including differential diagnosis; team leadership; and handover of care.

124. Ms Honey was first diagnosed with an AAA following an incidental finding on an x-ray conducted on 11 February 2021. That finding was confirmed by a CT scan taken of her abdomen on 15 February 2021.

125. Both Dr Robinson and Dr Middleton, experts in vascular medicine who gave evidence during the inquest, opined that Ms Honey's AAA was sufficiently serious to call for a degree of caution to be exercised in her treatment. Dr Middleton described the risk of rupture as "reasonable", whereas Dr Robinson described it as "significant", noting in his statement that there was a risk of rupturing at around 30 – 50% each year.

126. The team at the MHOPU was aware of the potential for the AAA to rupture and cause a medical emergency, and to that end was alerted to the particular symptoms which might indicate a rupture, including abdominal pain, a sudden drop in blood pressure, and an elevated or decreased heartrate. So much was communicated to the multidisciplinary team on 16 February 2021.

127. Dr Athukorala was asked to review Ms Honey for symptoms including elevated blood pressure, nausea and vomiting. When he attended upon Ms Honey, he found her able to sit up in bed, not appearing pale, sweaty or drowsy, but that she would at times seem not to comprehend his questions. He recalled that she complained of abdominal pain the previous night, but denied having any abdominal pain or back pain at the time.

128. He decided to contact the vascular surgery team at John Hunter Hospital (JHH), and after one unsuccessful call spoke to a registrar, who was Dr Khoo.

129. Broadly, the focal points for the purposes of this issue, turn on:

(a) The nature and extent of clinical information provided by Dr Athukorala to Dr Khoo to enable her to provide advice;

(b) The advice provided by Dr Khoo to Dr Athukorala.

Information provided by Dr Athukorala to Dr Khoo

130. Dr Athukorala said he informed Dr Khoo of the situation and the observations he had made.

131. Prior to making the call, Dr Athukorala had observed that an X-ray of Ms Honey conducted on that day (ie 20 February 2021) revealed loading, that the results of an echo-cardiogram were not concerning, that Ms Honey's blood pressure had been taken as 130/100 and her heart rate was around 100 beats per minute, and that she had complained to nursing staff of nausea and vomiting in the morning, as well as right abdominal pain since the previous night.

132. In his oral evidence, Dr Athukorala was unsure about what aspects of those observations he conveyed to Dr Khoo. He noted that when making the call, certain symptoms were on his mind:

> *Q. In terms of some evidence you gave moments ago as well, I think you said and I'm more or less quoting you, that in the context of some*

questioning from Mr Sergi that the concern you had on your mind as at the time of calling Dr Khoo was quote, unquote, "new symptoms" in the context of an aneurism.

A. Yes.

Q. What were those symptoms you had on your mind?

A. Abdominal pain and vomiting and one of the signs would have – that I was also concerned about was her elevated blood pressure.

Q. Did you raise those concerns with Dr Khoo?

A. Yes.

133. Dr Khoo said that Dr Athukorala had relayed the change in Ms Honey's blood pressure, but that the only abdominal pain which had been reported, was that which had been ongoing throughout her admission, and which was being treated as constipation. She recalled being told that Ms Honey had not complained of that pain during Dr Athukorala's attendance in the morning, and that it was not ongoing at the time of the call.

134. The key difference in their evidence is, therefore, the extent to which the pain described by Dr Athukorala was indicated to be new or changed. That is important because, as was emphasised by both Dr Middleton and Dr Robinson, reports of pain or tenderness are an important starting point for investigating change or instability in an AAA prior to rupture.

135. Dr Khoo also referred to Dr Athukorala indicating that he was not concerned. During cross-examination, she explained her impression at the time was there were no particular parameters or aspects of the patient's wellbeing that he was concerned about at the time of the call, although she acknowledged that there must have been a general concern about the patient to justify the call.

136. Dr Athukorala, during oral evidence, recalled that he did feel concerned when he made the call to Dr Khoo, and on that basis thought he would not have indicated anything to the contrary to Dr Khoo. He said it was unlikely he would have told Dr Khoo he was not concerned. His explanation for the call was that, although he did not form the view that Ms Honey had a ruptured AAA, he was

concerned that the symptoms may have indicated an impending rupture, and wished to confirm that assessment with a specialist. Dr Khoo described the conversation as being with someone who was casual, relaxed, and not distressed about a patient.

Advice provided by Dr Khoo to Dr Athukorala

137. Dr Athukorala said that Dr Khoo suggested that the patient may have been constipated, then recommended that he conduct blood tests and look for a drop in her haemoglobin levels. Finally, he stated that Dr Khoo suggested he continue to monitor Ms Honey, and that if there were any changes in her blood tests he should call the vascular surgery team again.

138. Dr Khoo confirmed that her impression was that the symptoms reported of did not indicate a deterioration of Ms Honey's condition relating to the AAA. This much is clear from the following answer in evidence:

> *A. To clarify again, Dr Athukorala told me that the patient was not in pain and did not have tenderness on palpation. So they have an aneurism, they have ongoing discomfort that is not present at the time of the phone call but has existed throughout the admission. So my thought process would have been they appeared to be about the same as they were when they had the CT and the discovery of the aneurism, but the new thing that this doctor is calling me about is hypertension.*

139. In this respect, the lack of a consistent understanding regarding the degree or nature of Ms Honey's reported pain played an important role in determining the advice of Dr Khoo and, as a result, the course taken by Dr Athukorala.

140. Dr Khoo confirmed that a report of a tender aneurysm would have invited greater enquiry into whether that symptom was caused by some change in the AAA. That would, she said, have prompted her to advise Dr Athukorala that the surgical registrar at the CMH should further examine Ms Honey.

141. Dr Middleton described the approach taken by Dr Khoo as an observational approach, which he agreed was appropriate given the information to hand which did not tell of an acute rupture. He indicated that the approach would be reasonable even if the call made to Dr Khoo had been one borne out of what was thought to be potentially new symptoms of generalised tenderness in a context where the patient had experienced tenderness before and denied back pain.

142. Dr Robinson agreed that the general treatment of Ms Honey's AAA was appropriate.

Dr Khoo's submissions

143. Dr Khoo in submissions dated 13 March 2026, makes a number of submissions on Issue 1.

144. Firstly, the treating team at MHOPU had a detailed longitudinal clinical picture of Ms Honey. Dr Khoo was at significant practical clinical disadvantage when Dr Athukorala called her as the on-call vascular registrar at JHH because (i) she did not have that knowledge, (ii) Ms Honey was a patient she did not know, (iii) she was unable to personally observe Ms Honey and (iv) she did not have access to any clinical records relating to Ms Honey.

145. Dr Khoo makes the related submission that, consistent with Prof. Holdgate's evidence, the absence of an accessible electronic medical record compromised Dr Khoo's capacity to be fully informed of Ms Honey's clinical picture. As a result, the telephone consult between Dr Athukorala and Dr Khoo was subject to Dr Athukorala's expression of his subjective observations and findings, and to Dr Khoo's understanding of what Dr Athukorala had communicated. An electronic record may also have allowed Dr Khoo to record the substance of the consultation.

146. Secondly, Dr Athukorala had no difficulty conveying his concerns to Dr Khoo and did not feel that Dr Khoo was in any way obstructive. He did not experience any difficulty in his communication with Dr Khoo. To the contrary, Dr Athukorala

found Dr Khoo to be both responsive and approachable and felt that his concern had been appropriately addressed.

147. Thirdly, Dr Khoo gave forthright but respectful evidence. She was a credible and reliable witness who provided honest testimony to the best of her knowledge, information and belief.

148. Fourthly, it is most unlikely that the conversation between Dr Khoo and Dr Athukorala included discussion of relevant and important clinical symptoms such as abdominal or low back pain or tenderness in the context of Ms Honey's diagnosed AAA that warranted the provision of advice other than that which was provided by Dr Khoo.

149. It is most unlikely because:

(a) The expert opinion of the vascular surgeons Dr Middleton and Dr Robinson is to the effect that a symptom of abdominal or low back pain or tenderness in a patient with a diagnosed AAA is a material clinical matter of significance and must be acted upon.

(b) Dr Khoo was informed by Dr Athukorala that Ms Honey had a diagnosed AAA. As an experienced practitioner and member of a specialist vascular team, Dr Khoo well understood the gravity of the risk of rupture in such a condition.

(c) As a potential symptom of significance, the existence or otherwise of abdominal pain would very likely have formed part of Dr Khoo's interrogation of Dr Athukorala. Similarly, given Dr Khoo's training and experience, Dr Khoo would not have ignored or not acted upon important clinical symptoms of potential or actual rupture of a diagnosed AAA in any patient, including Ms Honey.

(d) Dr Khoo's approach when "dealing with many requests for vascular input and advice over the phone" included seeking information as to whether

the patient had on examination a tender abdomen or an acute abdomen, and the extent of any ongoing pain.

(e) Having regard to both Dr Athukorala's handwritten notes, his statements and his oral evidence, it is clear that nursing staff asked Dr Athukorala to review Ms Honey for increased blood pressure, and nausea and vomiting. Dr Athukorala was not asked to review Ms Honey on account of any reported pain.

(f) The same evidence demonstrates that whilst Ms Honey reported experiencing right-sided pain the previous evening, she was not experiencing abdominal pain at the time of Dr Athukorala's examination of her.

(g) Dr Athukorala was uncertain about what aspects of his observations were conveyed to Dr Khoo whereas Dr Khoo was resolute in her evidence that Dr Athukorala did not convey the existence of any symptom of abdominal pain. That evidence was consistent with her first statement where Dr Khoo summarised the information provided to her as follows:

> *Relevantly to this matter, my understanding of the discussion with the doctor on the phone was that no tenderness on examination was reported, and the patient's pain had resolved at the time of the discussion. These findings supported that an alternate diagnosis / explanation for the pain was more likely. This impression was reinforced by the patient being haemodynamically stable, and not appearing unwell from the end of the bed assessment.*

(h) There is no contemporaneous clinical note to support what Dr Athukorala said in his initial statement to the effect that there was a "palpable, pulsatile mass in the left of the umbilical region" when he examined Ms Honey. In circumstances where Dr Athukorala agreed that this may be

an important finding and he largely relied on contemporaneous records rather than his memory when preparing his statements, the evidence does not establish this was likely conveyed to Dr Khoo.

(i) It follows that at the time Dr Athukorala spoke to Dr Khoo, whilst there *was* a discussion of Ms Honey having suffered from intermittent abdominal pain that was diagnosed and treated as constipation, there were no material clinical symptoms of a rupture of an AAA and it is inherently unlikely that Dr Athukorala would have informed Dr Khoo of the presence of such symptoms.

150. Fifthly, concerning the question of whether or not Dr Athukorala was 'concerned' at the time of the telephone consult, Dr Khoo accepts Dr Athukorala was sufficiently concerned to seek input from her but says that having spoken to Dr Athukorala, it was her impression of Dr Athukorala that he wasn't concerned; in the sense that there was a specific actual or impending significant clinical deterioration.

151. Sixthly, it is to mischaracterize Dr Khoo's understanding of the information conveyed to her to say, as Counsel Assisting submits, that there was "a lack of understanding regarding the degree or nature of Ms Honey's reported pain". Dr Khoo's contention is grounded on the basis that it is more probable than not that Dr Athukorala conveyed Ms Honey's report of prior intermittent right-sided abdominal pain that was no longer present, and his own findings on examination of generalised abdominal tenderness.

Dr Athukorala's submissions

152. In his submissions dated 12 March 2026, Dr Athukorala also makes a number of submissions concerning Issue 1.

153. Firstly, it is uncontroversial that Dr Athukorala called the JHH vascular registrar for guidance following the 11am review; and that the second time he tried, he spoke with vascular registrar, Dr Khoo.

154. Secondly, Dr Athukorala maintains that Dr Khoo was told that Ms Honey had complained of pain that had been “coming and going” since the previous evening (not merely of abdominal discomfort throughout Ms Honey’s admission).

155. Thirdly, Dr Athukorala was indeed concerned about Ms Honey, specifically because of the AAA and her new symptoms. His concern was not that the AAA had ruptured, but about symptoms that might indicate an impending rupture.

156. Fourthly, Dr Athukorala’s concern is objectively demonstrated in the fact he made two calls to the vascular registrar.

157. Fifthly, in general terms a clinical note outlines the doctor’s assessment of symptoms, the doctor's diagnosis and the treatment plan. It is not a transcript of everything that occurs but rather a summary of what transpired. A doctor is required to strike a balance between having enough time to perform clinical tasks and making notes that will be useful for others to review.

158. In this context, given it was already well known that Ms Honey had a very large AAA and Dr Athukorala was more concerned about things like the tenderness of the AAA, he should not be criticised for not recording a palpable, pulsatile mass when he palpated Ms Honey’s abdomen.

159. Sixthly, where there is any dispute about the details of the conversation between Dr Athukorala and Dr Khoo, Dr Athukorala’s evidence should be preferred for reasons including the following:

    (a) He was very new to his JMO role (he commenced his first shift as such just under 3 weeks earlier, on 1 February 2021) and had been briefed by Dr Goode about the AAA and the importance of both thorough assessment if called to review Ms Honey, and escalation of care to JHH vascular surgery.

(b) He made a detailed note of his review, including the call to Dr Khoo. He wrote:

> "I informed her of the situation and asked whether the blood pressure was concerning for rupture, to which she said that it was unlikely. She said it was possible the patient was constipated. She advised that I take a set of bloods and look for a drop in her haemoglobin levels ("Hb") from previous results. She also advised to monitor and call back if there were any changes in her bloods from previous results, at which point Ms Honey would likely need a CT Scan."

(c) In his oral evidence, Dr Athukorala explained that the term "the situation" was used, not because he could not recall what he had conveyed to Dr Khoo, but to "generally summarise my history and examination and reason for concern enough to call the vascular team."

(d) Without criticism of Dr Khoo (who could not be expected to recall in detail a one-off conversation over the phone with a doctor from a different facility, about a patient about whom she had no pre-existing knowledge) Dr Khoo had no contemporaneous note to assist her and was incorrect about basic factual matters, for example that she had made clinical notes and that Dr Athukorala was a senior resident medical officer on call at the CMH.

160. Seventhly, there was no expert evidence critical of Dr Athukorala. The Court would find that Dr Athukorala had appropriate concern regarding Ms Honey given his knowledge of the AAA and attended promptly when asked to review her. He performed a thorough review and examination and arranged appropriate further testing and treatment for her presentation at that time. He appropriately escalated Ms Honey's care to both the psychiatry registrar and to the vascular registrar at JHH, seeking guidance and assistance from these more senior doctors.

161. Eighthly, an electronic record system may have assisted both him and Dr Khoo.

Findings in relation to Issue 1

162. Having had regard to the evidence and submissions outlined above in relation to this issue, I accept Counsel Assisting's submissions and find it is unnecessary (and ultimately not possible) to determine:

(a) what precisely was communicated by Dr Athukorala to Dr Khoo regarding Ms Honey's condition; and

(b) the extent to which it was apparent to Dr Khoo that Dr Athukorala was 'concerned'.

As Prof. Holdgate said: "I don't think we'll ever know exactly what that conversation entailed."

163. In reaching that conclusion, I note the following:

(a) Each of Dr Athukorala and Dr Khoo gave evidence to the best of their recollections. Those recollections differed. Each was questioned in detail on the consultation. The impression I obtained from their evidence is that they were both providing honest evidence to the best of their recollection.

(b) The only contemporaneous note of the conversation – that recorded by Dr Athukorala – is such that it does not provide any real assistance on the matters of contention.

(c) The issue of Dr Athukorala's 'concern' must be viewed in the context of Dr Athukorala's concession that he is unsure of the conversation, the limits of his contemporaneous note, the absence of any contemporaneous note produced by Dr Khoo and the fact that their accounts turn on matters of impression.

164. Having said that, I find that Dr Athukorala must have had some concern about Ms Honey's condition, he acted appropriately in contacting Dr Khoo and in relaying the information he did, and that, in turn, Dr Khoo acted appropriately in providing the views and advice that she communicated.

165. Given that both Dr Khoo and Dr Athukorala agreed that a palpable, pulsatile mass would be a significant observation, the fact that it does not feature in Dr Athukorala's notes tends to support the conclusion that Dr Khoo was not informed of that finding.

166. While Prof. Holdgate expressed "mild criticism" of Dr Khoo on the basis that "she probably should have established exactly who she was speaking with and their level of experience and seniority", that largely obscures the real problem at this point of Ms Honey's care.

167. Any criticism in respect of this stage of Ms Honey's care, should be levelled at a record keeping system which let Dr Khoo, and more importantly, Ms Honey down. The absence of electronic records plainly compromised the provision of care to Ms Honey. Two things are clear in this respect.

168. *Firstly,* an electronic record system had the potential to provide real assistance to Dr Khoo and Dr Athukorala in caring for Ms Honey, including by ensuring that her treatment was not dependant on the expression (and interpretation) of Dr Athukorala's subjective observations. Such a record keeping system would have allowed Dr Khoo to review and interrogate the clinical notes as to Ms Honey. As Prof. Holdgate stated:

> *Had [Dr Khoo] been able to see the electronic medical record which would have included all the clinical notes including the recent sequence of events and…her recent observation chart, it might have given her a greater opportunity to understand the context of what Dr Athukorala was saying … on the background of what had happened over the previous few days. Otherwise [Dr Khoo] was entirely dependent [on] what he told her over the phone…*

But I do think…it's a big problem if you're trying to review patients at a distant site for a complex specialist problem that can't be managed at a distant site, yet you can't see…any information about the patient other than what you've been told over the phone…So, I do think the lack of electronic medical records did hamper her ability to make a, a real time assessment of this patient.

169. *Secondly*, such a record keeping system should have been in place at the relevant time. As Prof. Seppelt said: "New South Wales has been moving very slowly towards a single digital patient record that is now promised to be rolled out over the next three years and three tranches." Prof. Holdgate's evidence in this respect is telling:

At the time of this event there were many, many, many other LHDs in NSW, in fact, most that did have electronic medical records, so that fact that John Hunter didn't was something of an outlier.

170. Although noting that electronic medical records have a lot of problems, Prof. Holdgate said: "in terms of…allowing shared communication across sites, they certainly offer that and that's been available for many years…amongst different LHDs in NSW."

Consideration of a Recommendation

171. Both the HNELHD and CMH acknowledge the benefits that will likely flow from having a single digital patient record (**SDPR**) which is accessible in real time by clinicians at different locations – particularly given the inter-relationship between the hospitals making up the HNELHD and CMH.

172. Both the HNELHD and CMH support the introduction of a SDPR. They note that:

(a) The first phase of the SDPR rollout, which includes the LHD and CMH, was due to occur in March 2026. That date was recently put back to May 2026. Importantly, introducing the SDPR is a very large undertaking, and

it is important to have in place prior to the system going live the necessary infrastructure, technical support and crucially, have delivered training to the staff members who will use the SDPR.

(b) The likelihood is that by the time these findings are delivered, the SDPR will have been rolled out in the LHD and CMH.

(c) NSW Health was not an interested party to this inquest and accordingly, has neither put on its own evidence nor sought to cross-examine witnesses. In the circumstances, there is not a proper basis on the evidence to suggest that the SDPR introduction be expedited across the State, as opposed to it being rolled out by the Single Digital Patient Implementation Authority in a phased manner across NSW Health Agencies, as has been planned for a considerable time.

173. Although more than five years have passed since Ms Honey's death, given the matters identified by the HNELHD and CMH, I accept it is both unnecessary and inappropriate to recommend an expedition of the system's rollout across the entire NSW Health system beyond what is already proposed.

Ms Honey's condition at the time

174. For completeness, in relation to issue 1, Dr Middleton opined that no rupture of Ms Honey's AAA occurred while she was still in the MHOPU. That view was based on the fact that Ms Honey was, at the time, hemodynamically stable, her blood pressure was within normal limits, and there were no abdominal signs or back pain that might be indicative of a rupture.

175. Dr Middleton's opinion was the same in relation to Ms Honey's condition at around 11:00am on 20 February 2021 – as, although Ms Honey had reported some stomach pain like she had throughout her admission, it was variable and it later dissipated. Dr Middleton also noted that the X-ray showed no evidence of a rupture, and the blood test showed no evidence of a drop in her haemoglobin.

176. Dr Middleton opined that even after that time, up until around 10:00pm, it is unlikely that any rupture occurred. Dr Robinson agreed, stating that the aneurysm had not ruptured before around 10:00pm.

Issue 2 – Saturday, 20 February 2021: 5.30pm up to and including the Emergency Department transfer

Having regard to the period of 20 February 2021 from 5.30pm up until and including the transfer to the Emergency Department, was the investigation, diagnosis, monitoring, management and treatment of Ms Honey in relation to her AAA adequate, appropriate and timely, specifically in relation to the care provided by:

a. Calvary Mater Hospital (CMH) medical health professionals:

i. PECC staff
ii. Rapid Response Team

When examining the care and management of Ms Honey during this time period, the following issues will be included in that examination: documentation; communication; diagnostic formulation, including differential diagnosis; team leadership; and handover of care.

177. The starting point for considering this phase of Ms Honey's care is the problem which consistently emerged during the Inquest, regarding maintaining contemporaneous clinical notes. In relation to a medical review of Ms Honey conducted on the relevant afternoon, in respect of which there was no record, Prof. Holdgate said: "…when patients are reviewed by a doctor, that doctor should write notes about that review…a lack of documentation isn't really what you would expect".

Handover between Dr Gore-Lenskyj and the RRT

178. Dr Gore-Lenskyj was the psychiatric registrar who, on the night of 20 February, was on shift at the Psychiatric Emergency Care Centre (PECC aka PEC). He

was the first to assess Ms Honey when her condition began deteriorating and conducted an initial assessment just before 11:00pm. Ms Honey was not previously known to Dr Gore-Lenskyj.

179. During his initial assessment, Dr Gore-Lenskyj formed the view that Ms Honey may in fact have been deteriorating rapidly. In his oral evidence, he made particular reference to the fact Ms Honey had an elevated respiratory rate, a concerningly low blood pressure, and cold peripheries indicative of inadequate blood circulation.

180. His evidence is that, upon entering the room, he was told of the existence of the AAA, but not any further details about it. He said:

> *I was only told…by nursing staff, as I was…entering the room that she had a diagnosis of schizophrenia and that she had a triple A. And those are the only things I knew.*

181. The evidence does not expose the circumstances whereby the handover given to Dr Gore-Lenskyj did not include relevant diagnostic and clinical information concerning the AAA.

182. Having said that, I accept it was appropriate for Dr Gore-Lenskyj to rely on that verbal handover in circumstances where he was not working on the MHOPU, Ms Honey was not known to him, and given the emergent situation he was called upon to urgently deal with upon his arrival to the MHOPU.

183. Dr Gore-Lenskyj requested a nurse to retrieve the notes for Ms Honey. He explained it was the practice of the MHOPU for the patient's paper medical records to go with the patient once handover to an RRT occurred. He did not read Ms Honey's clinical notes because, again, quite understandably, he was concerned with commencing an ABCDE approach in circumstances where Ms Honey was deteriorating.

184. Dr Gore-Lenskyj made the decision to call the RRT after forming the view that Ms Honey required emergency treatment. His evidence is that the RRT arrived within three to five minutes of being called.

185. Dr Gore-Lenskyj regarded himself as "responsible for [the] handover" and said it was brief. His recollection was that his involvement in the process was confined to a matter of minutes. There is no evidence that any person other than Dr Gore-Lenskyj verbally handed over information to the RRT on the MHOPU about Ms Honey's medical history as it related to the AAA, or otherwise.

186. There was conflicting evidence from Dr Gore-Lenskyj, as the doctor responsible for handing over to the RRT, and those members of the RRT who interacted with him (particularly Dr Ibrahim), as to what was communicated in the course of the handover. This turned largely on what was said regarding the existence and nature of Ms Honey's AAA diagnosis.

187. Dr Gore-Lenskyj said he told members of the RRT, primarily Dr Ibrahim, about Ms Honey's elevated respiratory rate, low blood pressure, history of schizophrenia and the presence of the AAA. He stated that he had "at least a partial memory of it", referring to the conversation he had with the RRT.

188. He gave evidence that he knew very little about Ms Honey, and that his greatest concern at the time was that the other symptoms were related to a potential rupture of the AAA. He accepted, however, that he did not raise with the RRT his concern that the AAA may have ruptured.

189. Dr Gore-Lenskyj said he remembered seeing the medical registrar, Dr Ibrahim, palpating Ms Honey's abdomen.

190. He also said that he requested Ms Honey's notes to be provided to the RRT.

191. The evidence of Dr Freer accords with some of the account given by Dr Gore-Lenskyj. He recalled the handover being brief and being informed about Ms

Honey's background, including the existence of the AAA. Dr Freer did not recall, however, being told anything specific about the AAA, including regarding its size and the recency of its identification. He said this in his second statement:

> *The fact that Ms Honey had an abdominal aortic aneurysm (AAA) was verbally handed over to the RRT by the psychiatry registrar as part of Ms Honey's history… The handover was brief. No question or concern was raised with the RRT that the AAA could be accounting for Ms Honey's presentation. The RRT was not told that the AAA was a newly diagnosed issue of clinical significance that was actively being investigated with surgical review planned for the following Monday. Specifically, neither the size of the AAA nor the recent history of abdominal pain was handed over to the RRT. Nor was the RRT told that diagnostic imaging had recently been performed, and that the vascular surgery team at JHH was involved in Ms Honey's care.*

191. Dr Kokada, a JMO in the RRT, recalled being told that Ms Honey had a reduced Glasgow Coma Scale (GCS) and an increased respiratory rate, but does not recall receiving any other information on arrival. She accepted, however, that the contemporaneous documentation, being the progress note that she wrote up, indicates an awareness of the AAA.

192. Dr Kokada indicated her recollection of that night is limited. It was put to Dr Kokada that the relevant notation in the progress notes may have been the result of her review of Ms Honey's treatment notes and she had no recollection one way or the other.

193. That the notes made by Dr Kokoda were derived from a review is suggested by the content of the 'background' she recorded (that included documentation of adverse drug reactions (abbreviated as "ADR"), comorbidities (diabetes, hypertension, asthma and elevated cholesterol), a measurement of left ventricular ejection fraction (LVEF) reported on a sestamibi scan undertaken on 18 February 2021 and results of lung function testing) in circumstances

where there is no evidence that these matters were canvassed in discussion with the RRT.

194. Additionally, Dr Kokada recalled that upon her arrival to the MHOPU and taking the handover she was initially engaged in making attempts to cannulate Ms Honey and was occupied with that task for some time before she had the opportunity to step back and make notes.

195. Another intern who was in the RRT that night, and had only a partial recollection of the handover, Dr Senthinathan, could not recall being informed about the AAA.

196. Dr Ibrahim, for his part, gave evidence to the effect that upon arrival to Ms Honey's room, he was informed that the patient had a high respiratory rate, a reduced consciousness level, and that there had been difficulties taking a blood pressure reading. However, he did not recall any discussion while within the MHOPU, or in transit to the Emergency Department, about the AAA.

197. In this context, the later telephone conversation between Dr Ibrahim and Dr Elsamani at around 2:40am warrants noting. Dr Ibrahim's evidence of the call is that it involved discussing general bleeding as a potential cause of Ms Honey's deterioration, although he was of the opinion that it was unlikely to be a cause of the shock, given the haemoglobin readings they had taken. He recalled discussing Ms Honey's history, including the existence of the AAA, but did not recall whether the specific possibility of a rupture was discussed, or the recent abdominal pain.

198. Dr Elsamani recalled first confirming with Dr Ibrahim that Ms Honey did have a diagnosed AAA, then asking whether or not Dr Ibrahim believed it had ruptured. He said that Dr Ibrahim indicated haemoglobin tests pointed against a bleed being the cause of Ms Honey's shock, although Dr Elsamani recalled the conversation occurring in the context of considering the possibility of a rupture, not of a bleed in general.

199. Overall, Dr Elsamani's impression was that Dr Ibrahim was already aware of the AAA during the course of their phone call, but his recollection in this respect was far from unequivocal:

> *Q: Your best recollection sitting here now I appreciate some time later is that you said to him something along the lines of "Do you know about the triple A?" and he said something to you like "Yes"?*
>
> *A: Possibly.*
>
> *Q: The impression you had though was that he was aware of the triple A before you brought the topic up. Is that fair?*
>
> *A: That's fair, yes.*

200. Dr Ibrahim was otherwise unable to recall precisely when he was first informed about the AAA, although he said it was possible he first learnt of it during the call with Dr Elsamani. Dr Ibrahim's evidence was as follows:

> *A past medical history was noted by a member of the rapid response team that included schizoaffective disorder, asthma, type-2 diabetes, hypertension and an abdominal aortic aneurism. I do not recall any mention of a recent diagnosis of an AAA or recent abdominal pain and discussions of vascular surgery.*

201. That history was "noted" by a member of the RRT while they were still at the MHOPU. However, Dr Ibrahim did not read Ms Honey's file until later. While he could not recall precisely when that occurred, he gave evidence that it was around 15 minutes before or after his call with Dr Elsamani, which occurred at around 2:40am.

202. Dr Freer said that Dr Ibrahim only reviewed Ms Honey's notes and notified the rest of the team of the size and symptomatic nature of the AAA later in the evening, after the blood gases result had returned. He indicated that this was

conveyed to him during the process of inserting a femoral, central and arterial line.

203. RN Robards recalled only finding out about Ms Honey's AAA at around 3:00am. He recalled being told by Dr Ibrahim, although he had no indication of how Dr Ibrahim came into that knowledge. During his oral evidence, he said Dr Ibrahim may have discovered the AAA through Ms Honey's notes or using the electronic clinical access portal.

204. As indicated by Dr Kokada of the RRT, the clinical notes she prepared record, in an entry listed as being from 11:20pm on 20 February 2021, that Ms Honey had a known AAA, being 8cm in length and being an incidental finding from an X-ray.

205. Dr Elsamani's notes from his call with Dr Ibrahim, from around 2:40am, also record the AAA being mentioned, and note discussion of the fact that Ms Honey was pending surgery.

206. Against this backdrop, in submissions dated 23 February 2026, Dr Ibrahim seeks to explain the inconsistency between his evidence and that of Dr Freer on whether the fact of the AAA was communicated to the RRT, by contending that Dr Ibrahim was likely examining Ms Honey at the time of the handover, that this included having a stethoscope in his ears listening to Ms Honey's chest and heart sounds and thus he may not have heard the AAA being mentioned in the handover or may not have processed the information if he did hear it.

207. There is some contextual support for that submission.

208. Firstly, it is undoubtedly clear that Dr Ibrahim was dealing with a patient in urgent need of emergency medical attention and that he was involved in examining Ms Honey at various points after he started providing care to her. This included using a stethoscope.

209. Secondly, it is equally clear that this must have been a source of real stress for him (especially given his relative inexperience compared to other medical professionals who treated Ms Honey on the night in question). It cannot be known how he dealt with that stress and what impact it had on how he received or processed information.

210. Thirdly, both Dr Ibrahim and Dr Freer were credible and honest witnesses and Dr Ibrahim's evidence on this issue was consistent.

211. Ultimately, it cannot be known why or how Dr Ibrahim did not hear what Dr Freer says was relayed about the existence of the AAA, but I accept Dr Ibrahim's submission is a plausible explanation for what is otherwise inconsistent evidence regarding whether the fact of the AAA was communicated to the RRT.

212. Dr Ibrahim's submissions continue that given the relevant evidence, it is more likely than not that he reviewed Ms Honey's clinical notes (and, therefore, learned about the recency of Ms Honey's AAA) after Dr Elmezayen became involved in Ms Honey's care (at which time Dr Ibrahim assumed the Emergency Department had taken over care and he charted the intravenous fluids, antibiotics and antiemetics) and before his conversation with Dr Elsamani.

213. The medication chart, the intravenous fluid chart and the scribe notes demonstrate that those medications and fluids were prescribed and started between 0100hrs and 0145hrs.

214. Regardless of when Dr Ibrahim reviewed Ms Honey's file, given the evidence canvassed to this point, I find it is most likely that the AAA was mentioned during the handover to the RRT but it is entirely unlikely the RRT were made aware of how recently it was discovered, or of other facts which may have indicated the potential danger it posed to Ms Honey. This is unsurprising given, as Prof. Holdgate observed:

> *The psychiatry registrar who did the handover…didn't know Mrs Honey, and I'm not sure if he understood how recent the diagnosis was either.*

So, I'm not sure he could have given any clearer information because he wasn't aware of it.

Leadership within the RRT

215. The issue of leadership within the RRT figured significantly in the expert evidence.

216. Dr Kokada, a member of the RRT, said there was no particular leader designated on this particular night. Dr Senthinathan gave evidence to similar effect.

217. Dr Ibrahim said there was not always a defined or designated RRT leader, and that he understood that he and Dr Freer were working collaboratively on the care of Ms Honey.

218. Dr Freer's account was to similar effect, although he noted that at no point was there a disagreement within the RRT about how Ms Honey should be managed.

219. RN Robards' evidence was that a leadership role within the team was played by Dr Freer and Dr Ibrahim jointly.

220. Broadly speaking, three points emerge from the evidence in this respect.

221. Firstly, the question of team leadership did not, on the evidence of any of those involved in the RRT, cause tension or disagreement regarding the care of Ms Honey.

222. Secondly, the importance of clearly identifying a team leader (and delineating his or her role) within an RRT cannot be overstated. This is one of the themes and priorities that emerges most emphatically from the expert evidence. As Prof. Holdgate made clear:

[Members of an RRT] need to have some training to understand, if they're going to be part of an RRT, what their roles are going to be

and…who's going to be the designated team leader because there needs to be someone who's overall in charge…

223. Dr Day's analysis is also instructive:

I think the leadership by consensus that apparently occurred really meant that there was no leadership so that the important roles of the leader such as task allocation, actually going through a diagnostic process to work out what had happened, didn't actually *occur…as it should have done…it meant that there was, sort of, more confusion than leadership.*

As Prof Holdgate said…these are things that can be addressed by training and I think that a particular issue in this situation was that…the person nominated as the team leader in the policy was actually much relatively more junior than the medical registrar, Dr Ibrahim, who'd had more experience, so that led to…nobody taking…leadership and the idea of having a nominated leader and having training around the roles of that leader would have meant that if that had occurred adequately, prior…that junior person can lead a team, effectively, or that there's a process for that junior person to hand over leadership to a more senior colleague, and then in the course of time that also allows the leader to make decisions about the best disposition of a patient and to allow handovers to occur from the leader…of the RRT, to the…leader of the team that's taking over that didn't really occur as well, which was a large deficiency in what occurred.

224. Thirdly, the training received by the RRT was not adequate. As Prof. Holdgate said:

So I think Dr [Gourlay], from memory, outlined a whole lot of training components to the RRT, but it wasn't clear to me whether any of those…had actually happened and, certainly, Dr Freer, in his report, indicated his lack of awareness and, certainly, lack of having gone

through any of those training processes. I mean…there are many ways to do this sort of training.

225. Prof. Seppelt gave similar evidence about the lack of training provided to the RRT.

Dr Ibrahim and Dr Freer

226. The HNELHD and CMH accept that there were multiple factors, including systemic factors, which led to the failure of the RRT members, particularly, Dr Ibrahim and Dr Freer, to focus on the AAA as the most likely explanation for Ms Honey's deterioration. It is accepted by the HNELHD and CMH, consistent with the evidence of the experts, particularly Prof. Holdgate, that the training of the RRT was "probably the key thing that was missing".

227. Nevertheless, the HNELHD and CMH submit that, after making allowance for Dr Ibrahim's and Dr Freer's relative levels of experience and the rapid response context, both doctors nonetheless demonstrated a lack of clinical acumen in not piecing together what was before them and known by them so as to settle on changes in the AAA as the most likely explanation for Ms Honey's deterioration.

228. In support of that submission the HNELHD and CMH point to the criticism, albeit mild, of Dr Ibrahim and Dr Freer by Prof. Holdgate that they did not 'join the dots' on the clinical picture in front of them. That is, where Ms Honey was shocked and she had a known, large AAA, it should have been pretty straightforward to pose the question of whether that was the cause of the shock and undertake investigations to either support or refute that presumptive diagnosis.

229. Dr Ibrahim submits that during the course of his initial assessment of Ms Honey he worked through his usual structured approach to elicit the cause of the shock observed and thus it would be wrong to conclude that he did not apply any clinical reasoning *at all*. Rather, having considered bleeding as a cause and being initially comforted by the first haemoglobin result, that led to Dr Ibrahim discounting bleeding as a likely cause of Ms Honey's shock. Additionally, the

RRT's primary task was resuscitation, and this was still being provided by the RRT in the Emergency Department, at least until Dr Elmazayen offered to assist them.

230. Dr Ibrahim makes the further submission that the decision to have Ms Honey moved to the Emergency Department was not only appropriate but that it was the *only* option available to evaluate, make a diagnosis and make decisions about Ms Honey's care.

231. Dr Ibraham makes that submission on the basis that he was the only medical registrar on duty for the whole hospital, the two junior medical residents were part of the RRT and already present and assisting and Dr Freer was the only ICU Registrar on duty. So, had Ms Honey been transferred to another ward or ICU or if the RRT had treated Ms Honey in the procedure bay, both Dr Ibrahim and Dr Freer would still have been the only two registrars available to provide ongoing assessment, treatment and management. The Emergency Department, meanwhile, had additional staff and was the only place with a senior staff member on site.

232. Dr Freer contends, in his submissions, that in considering the adequacy and appropriateness of the care he and Dr Ibrahim provided to Ms Honey, and more particularly, whether they gave the AAA the attention they should have, regard must be had to what the RRT reasonably expected would occur once Ms Honey's care was escalated to the Emergency Department.

233. He draws attention to the following evidence in support of that submission:

(a) The evidence of Dr Freer was:

> *Our impression, largely based on Ms Honey's appearance and apparent deterioration while we remained on the MHOPU was that cardiac arrest may be imminent. The developing situation on the ward was emergent and the imperative was to transfer Ms Honey to a better resourced environment where appropriate*

equipment (including vascular ultrasound) would be available to facilitate vascular access, and where we expected skilled critical care staff would be available to assist in resuscitating and stabilising Ms Honey, while simultaneously conducting investigations.

(b) Dr Freer described the decision to transfer Ms Honey to the ED as one that was informed by what he and other members of the RRT perceived to be the "clinical imperative…to resuscitate and stabilise Ms Honey" in relation to which he added:

…we expected the resources of that department (in terms of equipment and skill-set) to be applied collaboratively to assist with efforts to resuscitate and stabilise Ms Honey.

(c) Dr Ibrahim explained:

…myself and Dr Freer…shared quite significant concerns about the state of the patient to the effect that we asked for defibrillator pads to be prepared and put on…indicating our concerns that an arrest could occur at any time…Ms Honey was shut down peripherally…all canulating attempts by…all medical members of the [RRT] had failed, therefore more equipment was required to help with that. The discussion resolved that the best place for Ms Honey was the [ED]…because we felt that this was a significant resuscitation that was going to be required.

(d) The perception that the clinical imperative was to resuscitate and stabilise Ms Honey was correct. As Prof. Seppelt observed:

At the time Ms Honey arrived in the ED she was clearly critically unwell, and a differential diagnosis had not yet been formulated. The first priority was immediate resuscitation and stabilisation, then consideration of a likely diagnosis.

(e) Dr Ibrahim agreed that the circumstance of having to apply defibrillator pads during a rapid response was an "outlier" and constituted "amongst the most serious emergency situations [he had] encountered." He explained further:

> *What we recognised pretty quickly was…a deteriorating patient with limited time and we needed significant resources as a far as more staff, nursing medical, as well as more senior staff to oversee the overall care…*

(f) In his oral evidence, Dr Freer emphasised the importance, over and above "objective things like the numbers for vital signs", of what he described as "the subjective". He described having attended a rapid response "where patients have looked as unwell as Ms Honey a handful of times". In this context he observed:

> *…I think the most important or a really important thing in this case is that Ms Honey, her clinical condition looked terrible from even in the mental health - even when like you know there was a blood pressure recording of 100, that subjective component I think was probably the most important. So, she clinically appeared very unwell and continued to look that way and continued to look even worse and this was the case when the ED in charge nurse Sarah Lazarou was - came to the resuscitation bay and had the conversation I outlined earlier.*

234. In answer to Counsel Assisting's submissions, Dr Freer contends that the Court should *not* make a finding consistent with the evidence of Prof. Holdgate that, having heard that Ms Honey had an AAA on handover in the MHOPU, Dr Freer did not use that information in "an appropriate way" nor did he interpret those words with any sense of importance – "he just didn't appreciate the significance of that bit of history" - because of his junior level.

235. In support of that contention Dr Freer notes (a) it is common ground that a history of known AAA was handed over but no other detail, diagnostic or clinical information was provided, (b) initial testing conducted by the RRT did not point to internal bleeding as a likely cause for Ms Honey's condition, (c) the fact that Dr Freer had never before "seen or managed a patient with an acutely rupturing AAA", (d) that in speaking to Dr Gildenhuys he sought to make the conversation about Ms Honey's clinical status but Dr Freer felt he was not given an adequate opportunity to present Ms Honey's case and discuss the clinical information then known to him (see further below, Issue 3), (e) had such a discussion taken place or the ED assessed Ms Honey upon arrival, the probabilities are that the AAA would likely have been canvassed, (f) the expert evidence is that even if that information had been acted on at some earlier point following the handover in the MHOPU it is highly unlikely to have changed the outcome for Ms Honey, and (g) his concession that the AAA should have taken on significance earlier than it did was in the nature of a retrospective reflection.

236. The adequacy and appropriateness of the care provided by Dr Ibrahim and Dr Freer may, in the context of the evidence and submissions summarised above, be dealt with briefly. At a general level, I make the following findings in respect of their role and conduct:

(a) The decision to have Ms Honey moved to the Emergency Department was, as the experts observed, appropriate. That was the *best* place in the hospital to evaluate her, make a diagnosis and make decisions about her treatment.

To find it was the *only* option available to evaluate, make a diagnosis and make decisions about Ms Honey's care overstates the inability of the RRT to provide the necessary care, as Counsel Assisting submits.

(b) Each of Dr Ibrahim and Dr Freer, made every attempt to provide – based on their training and skillsets – urgent medical care to Ms Honey. Having exhausted their own ideas and abilities in this regard, they formed the

view that Ms Honey's medical needs would be best met by personnel within the Emergency Department.

(c) In the course of caring for Ms Honey, the RRT focused on the technical task of attempting to gain intravenous access, rather than applying a process of clinical reasoning to work out what the potential causes of Ms Honey's condition were. This technical task was part of the RRT's efforts to resuscitate Ms Honey and initiate treatment.

(d) While Dr Freer did hear the reference to Ms Honey's AAA on the RRT taking over her care, that information was not used in an "appropriate way" where Dr Freer did not interpret "those words" with any sense of importance "because of his junior level" – "he just didn't appreciate the significance of that bit of history".

(e) Had the RRT received further training, and therefore been alive to the "significance" of the AAA history, then further efforts to diagnose and investigate the AAA as a cause of Ms Honey's deterioration (including by seeking out diagnostic information that was not in fact communicated to the RRT), are more likely to have taken place. While it cannot be known with certainty what difference (if any) such efforts may have made to Ms Honey's trajectory on the relevant night, such training may have enabled those efforts to be undertaken before Ms Honey's arrival at the Emergency Department.

(f) It is difficult to level criticism at Dr Freer (or Dr Ibrahim) in this regard, where ultimately there was a failure of training (including for the purpose of assisting RRT members identify a clear team leader and the particular role/s of that person). Moreover, the limited experience of Dr Freer only underscores why the decision was made to take Ms Honey to the Emergency Department.

(g) It is made more difficult again because (whilst the RRT did not 'join the dots' between the known AAA and Ms Honey's condition), it is most

unlikely they were aware of important diagnostic information concerning the AAA, there was the immediate importance of seeking to resuscitate Ms Honey and the disconnect between what they expected would occur once Ms Honey was escalated to the Emergency Department and what in fact occurred. These contextual matters weigh against the suggestion that it would be "pretty straightforward" to fully investigate the potential AAA diagnosis.

(h) No criticism is made of Dr Freer for leaving Ms Honey in the circumstances he did (noting this is relevant to Issue 3). To the contrary, Dr Freer may have been exposed to criticism had he not returned to evaluate a deteriorating patient in the ICU (where he was the one doctor responsible for the ICU after hours, and there were four critically ill patients in the ICU). It must be noted, in this regard, that as soon as he could, Dr Freer returned to the Emergency Department and again took part in the care of Ms Honey.

(i) Dr Ibrahim is to be commended for staying with Ms Honey (again noting this is relevant to Issue 3). As Dr Day stated, it is understandable that his efforts to resuscitate Ms Honey took precedence over diagnostic efforts. That he "never reached the point in his involvement to actually stop and think about what might actually be going on" was no doubt driven by multiple factors, including that he was "probably overwhelmed by the severity of her illness, the lack of support he was getting, the struggle of the technical aspects of her care such as getting intravenous access".

237. Having said all that, and again without criticism of Dr Freer and Dr Ibrahim, the fact remains that the RRT did not give the AAA the attention they should have in attempting to diagnose and treat Ms Honey. As Prof. Holdgate said:

I think, unfortunately, that the…members of the RRT who were aware of the diagnosis…didn't use that information in an appropriate way for whatever reason, and I think that falls back to the training issue about

the team leader or somebody stopping…and using some clinical reasoning to work through the potential causes of shock in a patient like Mrs Honey…

Consideration of Recommendations

239. I accept that live-time clinical notetaking in the context of a medical emergency is often not practical. I further accept that clinical notes are made first and foremost for the purpose of enabling a doctor to manage a patient rather than the provision of a transcript of every incident and exchange that occurs.

240. It follows that doctors must strike a balance between performing clinical tasks and making notes that will be useful for others to review. In this context, the Court notes Dr Elsamani's evidence that a clinical note will basically outline a doctor's assessment in terms of symptoms, the doctor's diagnosis and the treatment plan.

241. I further acknowledge that:

(a) Considerable time has elapsed since Ms Honey's treatment and that by the time these findings are handed down the training standards in relation to the maintenance of clinical documents may have improved at the HNELHD, JHH and CMH. If that be the case, further action by the relevant bodies may be unnecessary.

(b) In their submissions, the HNELHD and CMH included a specific Policy Directive in respect of health care records, created as an interim measure and in anticipation of the implementation of theSDPR across NSW Health agencies (including HNELHD, JHH and CMH). This Policy Directive specifies what records created by medical practitioners and nurses and midwives must include and further, sets out documentation standards, including as to their completeness, accuracy, reliability and timely creation.

(c) It is a mandatory requirement of the Policy Directive that NSW Health agencies develop a training and education strategy based on the requirements of the Policy Directive, with such training and education being provided as part of orientation and then delivered regularly.

(d) The HNELHD and CMH support ongoing training in respect of creating and maintaining clinical records being provided to HNELHD and CMH staff. They also support a recommendation that those responsible for developing the training associated with the commencement of the SDPR, review its contents to ensure it provides adequate guidance as to the importance and purpose of medical records.

(e) The HNELHD and CMH included in their submissions a policy which deals explicitly with matters such as minimum RRT membership, the role of the Team Leader and the education and training required under RRT procedures.

(f) Dr Gourlay said in his statement that an HNELHD Rapid Responder Development Pathway was soon to be implemented and it would provide a defined pathway for Rapid Responders to ensure that they had the experience and skills to respond to deteriorating patients. The HNELHD and CMH included in their submissions the implemented policy.

(g) As part of the training and education of its staff, the HNELHD has an established Simulation Centre. It delivers simulation-based team training with such training mapped out in the Rapid Responder Development Pathway. The training includes simulation training in respect of deteriorating patients and Advanced Life Support (ALS) training. Role clarity, communication and leadership are components of ALS training via the HNELHD Simulation Centre.

(h) In circumstances where NSW Health is not an interested party, was not represented and did not call or examine witnesses, there is not a proper basis on the evidence for recommendations that cover every hospital in

NSW. I note the HNELHD and CMH will, however, provide a copy of the findings in this inquest, along with any recommendations, to NSW Health.

242. These things being said, this inquest heard repeated concerns expressed in the expert evidence about the lack of clinical notes and meaningful records in the context of Ms Honey's treatment. As Prof. Holdgate stated: "So, I thought the quality of the medical notes was either non-existent by the Emergency Department staff or of a poor quality by the medical staff".

The expert evidence makes clear that the repeated failure to make appropriate clinical notes (and in some cases any notes at all) at different stages of Ms Honey's care is problematic and without reasonable excuse. This mandates a recommendation that the training standards in relation to the maintenance of clinical documents, such as they existed at the time of Ms Honey's treatment, be improved. The impending rollout of the SDPR must not result in any delay in improvements to training on this issue because it is just too important – as the regrettable events the subject of this inquest bear out.

243. As for RRT training, given the lack of clarity as to leadership within the RRT that cared for Ms Honey, whilst it may be that no change needs be made at the policy level, there must be a recommendation concerning implementation of that policy. For the same reason, a recommendation concerning the emphasis that is given to simulated emergency scenarios in training RRT members is required.

This would align with the opinion of Prof. Holdgate:

> *Probably, the most effective way [to train RRT members] is simulation training where you get various people who will be involved in RRTs, running through scenarios such as this for the acutely collapsed patient and how you would manage that and what the roles of the various team members are, and that's something that has to be done repeatedly, so it*

would be done at regular intervals and would have to involve all the members of the RRT.

244. While there are challenges to finding the time "off the floor" to do this sort of training, the circumstances the subject of this inquest highlight the "significant consequences" of not undertaking such training, where – as Prof. Holdgate stated – "you just don't know how to do this stuff off the top of your head".

Recommendations

245. I make the following recommendations directed to CMH and the HNELHD based on the evidence and submissions concerning this stage of Ms Honey's care:

(1) To provide more intensive training on the need for (and importance of) maintaining comprehensive, and up to date clinical documentation by staff working in the PECC/PEC, as well as hospital staff working in RRTs and the Emergency Departments in the HNELHD.

(2) A leader be appointed to every RRT that convenes within any hospital in the HNELHD, with a clearly identified role (and clearly delineated tasks), and that focused training be provided to such team leaders in respect of the same.

(3) The appointment of an RRT leader for the purposes of (2) above be based upon an assessment of the person within a given RRT who, based on his or her experience and skillset, is best placed to play a leadership role within that team.

(4) The training provided to RRT members in the HNELHD be enhanced to ensure a greater emphasis on simulated emergency scenarios.

Issue 3 – Saturday, 20 February 2021: Arrival at Emergency Department up to transfer to John Hunter Hospital on Sunday, 21 February 2021

Having regard to the period from the time of Ms Honey's arrival at the Emergency Department late on 20 February 2021 up to her transfer to John Hunter Hospital on 21 February 2021, was the investigation, diagnosis, monitoring, management and treatment of Ms Honey in relation to her AAA, including its rupture, adequate, appropriate and timely, specifically in relation to the care provided by:

a. CMH medical health professionals:

i. Rapid Response Team
ii. Emergency Department staff

When examining the care and management of Ms Honey during this time period, the following issues will be included in that examination: documentation; communication; diagnostic formulation, including differential diagnosis; team leadership; and handover of care.

246. Given the adequacy and appropriateness of care provided by the RRT members has to a very significant extent been addressed above (and will be considered again in the context of Ms Honey's arrival in the Emergency Department), in addressing this issue, focus will be on the adequacy and appropriateness of the care provided to Ms Honey by the Emergency Department.

247. The most regrettable and problematic aspect of the evidence before the Court concerns what happened to Ms Honey upon and following her arrival in the Emergency Department. This was examined in detail in both the lay and expert evidence.

Contextual matters

248. The context in which Ms Honey was brought to the Emergency Department is important.

249. The decision to transfer Ms Honey to the Emergency Department was made by Dr Ibrahim and Dr Freer, at the suggestion of RN Robards.

250. Dr Ibrahim said there was a need for further equipment and believed that Ms Honey would likely require a significant resuscitation. Those needs, in his view, would be better met in the Emergency Department. He also believed the Emergency Department would have a better chance than the RRT of establishing the necessary IV connection.

251. Dr Freer said that, as he perceived it, there was nothing more that could be done within the MHOPU for the treatment of Ms Honey and shared the view that the Emergency Department would be more likely to have the necessary equipment.

252. RN Robards said the RRT had effectively exhausted what they would be able to achieve in the Mental Health Unit, and that Ms Honey needed access to the resuscitation resources available at the Emergency Department.

253. Dr Ibrahim gave evidence that the decision to attend the Emergency Department, as opposed to a different part of the hospital, was informed by the fact that it was the only place in the hospital that still had additional staff available to help with the resuscitation of Ms Honey.

254. No party takes issue with the RRT's conclusion, at the time, that Ms Honey should be taken to the Emergency Department.

Relative experience of relevant medical personnel

255. Dr Gildenhuys was the specialist in charge and the specialist on-call for the Emergency Department on the relevant night. He accepted, in his oral

evidence, that the members of the RRT were relatively junior members of the medical staff. In particular, he acknowledged that Dr Freer, being only on his sixth shift of his first rotation as an ICU registrar, was very junior.

256. Dr Gourlay said that the members of the RRT were “relatively junior, though not junior”.

257. Dr Gildenhuys did not recall knowing at the time that Dr Freer was only on his sixth shift, although he accepted knowing that he was junior in the general sense. However, he qualified that view given his observation that Dr Freer was an ICU registrar and a part of the RRT, and the individual he assumed to be leader of that team. Those observations, he explained, indicated at least a certain level of experience or training.

258. His expectation at the time regarding members of the RRT generally, is that they must have had some experience and been competent, and have been trained in managing the care of critically ill patients. He explained that in some other instances, he would be told in advance that there would be a particularly inexperienced registrar or resident involved in the RRT. That did not occur in relation to Ms Honey.

259. Dr Gourlay said that, in fact, despite having less experience than someone like Dr Gildenhuys, each of the members of the RRT were “adequately experienced”.

260. The fact that Dr Gildenhuys was not aware of the background of the RRT members, likely contributed to the delay in Ms Honey’s treatment. This is an example of information not being fully or adequately conveyed, and assumptions being made that were not accurate.

Attempted Handover Between the Rapid Response Team and Emergency Department

261. A factual controversy which figured prominently in the inquest involved the circumstances surrounding the attempt by the RRT to have the Emergency

Department staff provide assistance, whether in the form of help, or as part a formal handover.

262. Dr Gildenhuys explained the general process for receiving a patient from the RRT. If the RRT called ahead, he explained, the nurse in charge would instruct the RRT where to take the patient. When the RRT arrived, the triage nurse would usually join them and the nurse in charge, and a decision would be made about next steps in relation to the patient's care. If a bed was available, a handover would occur. The Emergency Department doctors might otherwise become involved in the care of the patient if they were particularly unwell.

263. Dr Ibrahim's evidence was to similar effect. In his experience, when a patient was taken from the MHOPU, the Emergency Department was warned in advance so that a triage nurse would be present and prepared to conduct a handover of the patient. He said that in this case, while the bed manager [RN Robards] indicated that he would advise the Emergency Department of the RRT's arrival with Ms Honey, no staff were present and available to assist upon their arrival.

264. Dr Freer said that upon the RRT's arrival in the Emergency Department he expected that a member of the medical or nursing staff, or both, would come and meet them. He noted that RN Robards had said he would forewarn the Emergency Department.

265. RN Lazarou recalled having received instructions from nursing management in the Emergency Department that admitted patients should only be transferred from inpatient wards to other inpatient wards, not to the Emergency Department, even if they needed access to it.

266. There was also conflicting evidence given regarding whether the Emergency Department was in fact notified of Ms Honey's impending arrival.

267. Dr Freer gave evidence that RN Robards said "I've arranged for Ms Honey to be received in the Emergency Department".

268. RN Robards' evidence was that he tried, unsuccessfully, to call the nurse in charge, but was subsequently able to speak to the triage nurse, whom he notified of Ms Honey's impending transfer. He estimated that the phone call was made approximately ten minutes before the RRT arrived in the Emergency Department.

269. Dr Gildenhuys, who was in the Emergency Department at the time, gave similar evidence that a call was made to the triage nurse, as opposed to the nurse in charge who would usually be notified. However, his recollection was that the notification was never relayed back to himself or RN Lazarou, who was the nurse in charge on that night. He said he was not present for any conversation between RN Lazarou and RN Robards about the arrival of Ms Honey.

270. RN Lazarou said she was notified by the triage nurse of Ms Honey's imminent arrival. She explained that her view at the time, that a patient should not be brought to the Emergency Department following a rapid response to the MHOPU, was the reason she repeatedly attempted to call RN Robards prior to his arrival.

271. She also recalled RN Robards arriving prior to the rest of the RRT and coming to Dr Gildenhuys and the nursing staff to notify them of Ms Honey's condition and pending arrival.

272. Despite otherwise accepting the account of Dr Gildenhuys to be correct, RN Lazarou maintained that she was involved in a conversation with RN Robards and Dr Gildenhuys prior to the RRT's arrival.

273. Dr Elmezayen gave evidence that, following his handover with Dr Gildenhuys that took place at about 10:00pm (when Dr Elmezayen commenced his shift), he became aware of the pending arrival of a patient from the mental health ward to the Emergency Department. His recollection was that he overheard a conversation between Dr Gildenhuys and RN Lazarou to that effect, but that there was no discussion at that point of Ms Honey's situation. He also recalled

one of the nurses – although he could not identify who – stating that the patient who had been expected with an RRT had arrived.

274. That recollection is also reflected in his notes from the evening, which record him being told by Dr Gildenhuys that a patient from the MHOPU may be brought to the Emergency Department by an RRT.

275. The RRT arrived in the Emergency Department at approximately 11:45pm. At that time, neither the resuscitation bay, nor the procedure bay were being used. RN Lazarou recalled directing the RRT to use the procedure bay, for the purpose of ensuring that the resuscitation bed remained available. That is what the RRT did.

276. The lack of assistance provided to Ms Honey by staff within the Emergency Department for some time after her arrival within that department, is a striking feature of the relevant factual matrix. That occurred where the evidence reveals that members of the Emergency Department were better placed and equipped to provide the care Ms Honey needed, and that the RRT, without direction/assistance from Emergency Department staff, had difficulty in navigating the Emergency Department environment.

277. Both Dr Freer and Dr Ibrahim recall having the impression that the Emergency Department staff "appeared to be avoiding us" at that time. That impression included the fact that no staff were sitting at the triage desk when the RRT arrived. Dr Freer referred to what he perceived as "hostile glances".

278. RN Robards also confirmed that, while in his experience Emergency Department staff would normally conduct an assessment of the patient upon arrival, no one from the Emergency Department approached Ms Honey.

279. Dr Gildenhuys did not recall doing anything that may have been perceived as hostile. Dr Elmezayen did not recall any avoidance of the RRT, and said that each of the staff in the Emergency Department would have seen the number of

staff already with Ms Honey and concluded that, in the interests of resource use, they should attend to other patients.

280. There were conflicting accounts as to whether members of the RRT sought assistance from the Emergency Department staff. The evidence of Dr Ibrahim and Dr Freer is that such help was sought. Dr Gildenhuys gave evidence that no assistance was sought from him by the RRT.

Communications between RRT and Emergency Department staff following Ms Honey's arrival in the Emergency Department

281. The Court heard extensive and inconsistent evidence about the content of conversations between members of the RRT and Emergency Department staff following Ms Honey's arrival in the Emergency Department. While it is appropriate to summarise the differing recollections, the evidence that arises and the submissions made in this regard, for reasons that will become clear, little (if anything) ultimately turns on resolving these tensions in the evidence.

RN Lazarou's evidence

282. As is noted above, RN Lazarou says that she, Dr Gildenhuys and RN Robards had a conversation in advance of the RRT's arrival. On her account, Dr Gildenhuys explained their understanding that patients would normally only travel between inpatient units, and that they both told RN Robards that the Emergency Department lacked the capacity to take on an additional patient. She recalled that it was she who first raised concern regarding whether Ms Honey should have been brought to the Emergency Department, and that she sought clarification from Dr Gildenhuys.

283. Her evidence was that, based on her understanding of the relevant policy at the time, the Emergency Department was not required to take charge of Ms Honey's care, and that she should have instead been taken to another ward.

284. She also recalled explaining, as an alternative option, that the Emergency Department had been used as a location for treatment by the RRT if there were

no beds available. On her account, Dr Gildenhuys then offered the RRT use of the Emergency Department's procedure bay.

285. She explained that the offer to use the procedure bay was made because RN Robards had explained that Ms Honey was too unwell for the ward, but also not unwell enough to attend the ICU.

286. On the question of whether anyone from the RRT had asked for help, her evidence was that the discussion did not involve a request for someone from the Emergency Department to assess Ms Honey. She explained that, at the time, she did not think there was a need to enquire into or otherwise investigate Ms Honey's condition, given what she thought was an understanding that the RRT would care for Ms Honey.

287. She recalled that the conversation came to an end at around the time the RRT arrived in the Emergency Department with Ms Honey. During her oral evidence, she said that she observed Ms Honey sitting up and conversing with the RRT, informing her view that Ms Honey must have been stable. She accepted that this could also be explained as a response to Ms Honey suffering nausea and wishing to sit up in case she vomited.

288. She recalled a subsequent conversation about policy when RN Robards approached her and asked what the Emergency Department staff were going to do with Ms Honey. She said to RN Robards that only the Emergency Department location could be used, and that the RRT could continue to care for Ms Honey until such a time as they decided to move her to another location, with any discussion about whether Emergency Department staff would provide help requiring a conversation to be had with Dr Gildenhuys, who was already at home.

289. In her written evidence, RN Lazarou said that she understood from the RRT that Ms Honey was not unwell enough to be taken to the ICU. She said it was Dr Freer who made those representations. RN Lazarou also said that

information to this effect was first conveyed by RN Robards, then Dr Freer at a later point in the evening.

290. In her submissions, RN Lazarou contends that:

(a) As Shift Coordinator, in what was undoubtedly a busy night in the Emergency Department, RN Lazarou had responsibility for managing the Emergency Department flow, offloading of ambulances and moving patients around the Emergency Department and short stay unit, as well as ensuring patients were provided with adequate care and assessment while they were in the Emergency Department.

(b) At around the time Ms Honey was transferred to the Emergency Department she was informed that Ms Honey had "? Decreased level of consciousness" and required intravenous fluids. It was not conveyed to her that she was hypotensive, her vital sign observations were abnormal and she was deteriorating.

(c) At the time Ms Honey was transferred to the Emergency Department she was under the care of the RRT. It was her understanding that the RRT had the skill set to manage her care and that at no time prior to 00:25 hours did the RRT raise concerns or call out for assistance to RN Lazarou about the management of Ms Honey.

(d) It was her understanding that patients could not be transferred to the Emergency Department staff until a proper handover had taken place and the Emergency Department had capacity to accept and safely manage a patient. She had not received any training on inter/intra facility transfer.

(e) It was in the context of these matters that RN Robards was informed the RRT could use the Emergency Department procedure bay to care for Ms Honey while alternative arrangements were being made.

(f) CMH conducted a formal investigation into RN Lazarou's conduct. The investigators took into consideration information given by other practitioners and RN Lazarou's response and found the allegations of unsatisfactory professional conduct with respect to her care were not substantiated.

(g) In the absence of evidence from a nursing expert (that included a review of her conduct) it would be unfair for RN Lazarou to be formally and directly criticised with respect to her conduct on the night of 20-21 February 2021 in these findings.

Dr Freer's evidence

291. Dr Freer's evidence was that at around 11:50pm, he went to seek out a member of the Emergency Department staff to speak to, given the RRT had not yet been spoken to by any staff members there. He recalled eventually beginning a conversation with Dr Gildenhuys:

> *I approached Dr Gildenhuys, who was sitting at the desk. He had, kind of, a, a set and stern expression. I, I was conscious of the time. Like I said, I wasn't expecting him to be present, so I said words to the effect of, "Hi Johann. Are you still here?", to which he responded, "No," and "Are you the person that's trying to sneak patients into the ED?" And I, I was taken aback by that question, and I said, "Yes," even though I wasn't trying to sneak anybody anywhere, and I said, "Can I please discuss a patient with you?"*

292. Dr Freer recalled Dr Gildenhuys then stating that, as a matter of policy, patients from the Mental Health Unit were not to be taken to the Emergency Department.

293. Dr Freer said he then explained to Dr Gildenhuys Ms Honey's condition, including that they were uncertain of the cause of her deterioration, that she had a low blood pressure of 100 systolic, high oxygen saturation, and that there

was yet to be any resuscitation. He confirmed upon further examination that he did not, in his recollection, mention Ms Honey's GCS.

294. He explained that he communicated this information in an attempt to justify why, in his view at the time, neither the medical ward nor the ICU would be appropriate. He recalled stating that the ward was inappropriate because the RRT was not sure what was causing Ms Honey's condition.

295. Dr Freer said no question was asked about Ms Honey's condition or medical history during this discussion.

296. It is uncontroversial that this conversation yielded no offer of assistance and, on the back of it, Dr Freer returned to Ms Honey and the RRT.

297. In Dr Freer's submissions he contends that:

(a) The RRT having identified an urgent need for the application of critical care expertise and resources, it is reasonable to expect that the RRT would act in a manner consistent with that imperative and attempt to secure that level of care, especially when it was not forthcoming via the orthodox process of triage and assessment at first instance. It follows that it is inherently improbable that Drs Freer and Ibraham (and RN Robards) would not have requested assistance from Emergency Department staff.

(b) The evidence of individual members of the RRT that touched on this issue was compelling and what emerged from it was, firstly, a shared sense of disbelief and dismay arising from the unexpected and unprecedented approach of certain senior members of staff in the Emergency Department and, secondly, the experience has had a significant impact upon them.

(c) For a variety of reasons, including (a) and (b), the evidence of Dr Freer about the content of conversations between members of the RRT and

Emergency Department staff following Ms Honey's arrival in the Emergency Department should be accepted in these findings.

(d) In assessing the quality of care provided to Ms Honey by the RRT upon her arrival to the Emergency Department, the RRT was left in an invidious position when it did not, despite the attempts of its members, receive assistance from Emergency Department staff as they expected and were entitled to receive. Despite these challenging circumstances, Drs Freer and Ibrahim conscientiously continued to provide care for Ms Honey within the limitations of their expertise and respective skill-sets.

(e) Accepting that Drs Freer and Ibrahim did not stand back and engage in a process of diagnostic reasoning over the period for which they were primarily responsible for Ms Honey's care, it was not practicable or safe for them to assume that role and it would be unfair to say, in the context of their first priority being an intensive and difficult resuscitation (where they were not supported by the Emergency Department) that they were focused on attempting to gain vascular access *rather* than applying a process of clinical reasoning to identify the potential causes for Ms Honey's condition.

298. Dr Freer calls upon the following evidence in support of these contentions:

(a) RN Robards had significant experience as a registered nurse and was working as Nurse Manager of Clinical Resources, a position he had occupied on a full-time basis since 2009. He made a relatively contemporaneous record of the fact that directly following Ms Honey's arrival to the procedure bay the Emergency Department was "at that stage allowing real estate use only".

In his written and oral testimony RN Robards recounted having initially asked for "some help over here please" some five minutes after Ms Honey's arrival to the procedure bay in the Emergency Department

whereupon he was told (by RN Lazarou) that Ms Honey (being an admitted mental health patient) was “your responsibility”.

RN Robards confirmed that he was “taken aback” and “quite surprised” as he had “never” before encountered this when he had brought patients to the Emergency Department from Mental Health. RN Robards went on to describe the multiple additional (unsuccessful) efforts made by and on behalf of the RRT to obtain assistance from Emergency Department staff, and to engage with the issue of policy that had been raised. His evidence was that he had he not ever encountered such a situation “in the context of a critically ill patient”.

He described the sentiment he felt as a medical professional in these circumstances as “[q]uite powerless”. When invited to identify whether this incident had had an impact on him RN Robards stated that the incident “was confronting” and has had a “profound” effect on him. RN Robards became visibly upset when he gave this evidence.

(b) Dr Kokoda described her reaction to learning that the Emergency Department “was not going to accept Ms Honey” as “frustration and helplessness”. She explained “we did recognise that [Ms Honey] was unwell and that we didn’t have the right equipment at the mental health unit and that we needed senior help and that prompted the decision to move her…to the [Emergency Department]”. She added that there was a “shared frustration and puzzlement that there was a dispute over policy that took precedence over patient care before us” and identified that what gave rise to that concern was:

> *That we had a patient before us who was deteriorating. That there were three to four of us trying to stabilise the patient and we were at the – we wheeled her to emergency to seek help from others who are more senior but that was not met.*

(c) On learning from Dr Freer that the Emergency Department was not going to assist the RRT to care for Ms Honey, Dr Ibrahim described his reaction as “shocked”. He elaborated:

> *The shock was for, I guess, a number of - two main reasons. One, was that we had essentially junior staff requesting assistance, not only from senior staff but staff who are specifically trained to deal with resuscitation and being told no, which had never been experience I have noted before. Essentially asking for help and not receiving it. And the other one was because in no prior experience I have had as a rapid response member have I taken a patient to the emergency department and been told that that was - that we were not going to receive help from the emergency department. That had never occurred before.*

In these circumstances, Dr Ibrahim “wanted to try anything, essentially, to change the circumstances we were in”. Accordingly, he telephoned Dr Wilson with a view to enlisting Dr Wilson’s assistance to persuade the Emergency Department to assist with Ms Honey’s care. The call was made at 12:13am.

(d) The evidence of Dr Wilson is of being told by Dr Ibrahim that Ms Honey had been retrieved to the Emergency Department having been found to be “critically unwell with undetectable or barely recordable blood pressure”, and of being informed that the RRT was “struggling to get [IV] access and organise appropriate tests” and was not receiving assistance from Emergency Department staff “who were of the view that they were just providing the physical space for the patient to be assessed”. In this way, it is said the conversation was *not* focused on matters of policy.

(e) Dr Wilson ultimately spoke with Dr Gildenhuys (who had left the Emergency Department and gone home). Dr Ibrahim gave evidence that Dr Wilson telephoned him a little later to confirm that despite having spoken to Dr Gildenhuys “ED was still not prepared to get involved” and

"that if Ms Honey required an admission under medicine in ICU she should be moved [there] to continue resuscitation".

(f) Dr Ibrahim went on to describe how "a lot of [his] efforts were going into making phone calls…to try to escalate but it felt like too many conversations were occurring and not resulting in action". He added that RN Robards had "spoken to heads of departments and the executive of the hospital…which is a fairly rare occurrence in my experience and none of those conversations yielded a definitive outcome of having staff assist with the resuscitation".

(g) The evidence of Dr Freer is that he went in search of a senior member of staff in the Emergency Department to discuss Ms Honey's clinical status and seek assistance. The discussion he ultimately had with Dr Gildenhuys "immediately became about… policy".

(h) Whilst Gildenhuys denied that Dr Freer said to him "Can I please discuss this patient with you?" he made concessions to the effect that Dr Freer told him "I don't think this patient is suitable to go to the ward because we don't really know what's going on", that Dr Gildenhuys "turned the conversation into one about policy", that the "gravamen of what [Dr Gildenhuys] told [Dr Freer] was that he shouldn't have been bringing a patient from the mental health unit to the ED" and that policy dictated his approach to the course of events that night.

(i) Dr Freer went on to describe feeling "powerless to challenge Dr Gildenhuys" given he was a junior registrar new to the hospital and Dr Gildenhuys was a senior emergency physician and the Clinical Director. He also observed that "…not to diminish the importance of policy in running a hospital and conducting these things, but that - yeah, that was the last thing that we were expecting to speak about when we brought Ms Honey to the emergency department."

(j) Later, and in the context of the exchange between RN Lazarou and Dr Ibrahim where RN Lazarou said “you can use our space, but you can’t use our staff”, Dr Freer spoke of a sense of desperation when resuscitation efforts began to fail. That feeling, he said, was lifted when Dr Elmezayen first came to the resuscitation bay, but he also felt a sense of frustration at the time that had passed whilst the RRT had been asking for help.

(k) On the lasting impact of what happened, Dr Freer said:

> *…I found the events that occurred on this, this evening with Ms Honey highly disturbing and traumatic and certainly they - I haven't experienced anything remotely similar to them in my practice. I've only been working for eight years but nothing even comes close. I debriefed with a lot of - with other members of the intensive care profession and even people who were staff specialists and have been working a lot longer than I have said, told me when I was debriefing the events with them that they hadn't ever heard of anything like this occurring. So, it was, yeah, it was difficult to deal with and it's something that I've kept coming back to again and again in my mind and it's - these events played a large role in my decision to leave intensive care training which I did at the end of last year. So, yeah, it was a challenging experience...*

(l) Prof. Seppelt described this situation, whereby “a junior intensive care registrar and a junior medial registrar” were left “to do their best”, as “completely inappropriate”. One consequence was that Drs Freer and Ibrahim were left to attempt to resuscitate and stabilise Ms Honey in an unfamiliar environment without what Dr Day described as the “really vital” help from nurses who “actually know where equipment is”.

(m) Similarly, Prof. Holdgate remarked: “one of the biggest challenges they were facing was gaining [IV] access, so knowing where that particular

equipment and particularly the extra equipment you might need is kept would be really critical to obtaining [IV] access". In the same context, Prof. Holdgate observed: "working in the resuscitation bay, there's a particular layout of equipment that really only the emergency nurses and doctors would be particularly familiar with. It's always very challenging to go into a new environment and start trying to find bits and pieces of equipment and work out how to do things".

(n) Prof. Seppelt said that when the RRT arrived with Ms Honey to the Emergency Department: "the first priority was immediate resuscitation and stabilisation, then consideration of a likely diagnosis". He went on to say (consistent with the evidence of Drs Freer & Kokoda) that "Ideally a team leader is able to stand back and think, and not get completely focused on the procedural aspect of what needs to be done." Rather than expressing criticism of Dr Freer in this regard, Prof. Seppelt was critical of the CMH 'system' that allowed this to happen.

(o) Dr Freer explained in his evidence "we never got to that coalescence phase of a rapid response where everything comes together". He explained this was because he was "focused solely on the technical aspects" of the resuscitation of Ms Honey and this required all his concentration. About that situation, Dr Day considered it was "quite understandable" that Dr Ibrahim didn't have time to "sort of coalesce" when "the…efforts to actually try and resuscitate [Ms Honey] took precedence on that". Dr Freer says that given he was simultaneously engaged with Dr Ibrahim in undertaking resuscitative efforts, that Dr Day's observation applies equally to him.

(p) It was the opinion of Prof. Holdgate (with which Dr Day and Prof. Seppelt agreed) that the biggest "missed opportunity" in Ms Honey's care was the arrival in the Emergency Department and the lack of engagement by Emergency Department staff to be involved in the assessment and management of Ms Honey.

299. Dr Freer (and to a much lesser extent Dr Ibrahim) goes on to make further submissions concerning the role of senior consultant staff that were contacted whilst Ms Honey was in the ED with specific reference to the expert evidence. They contend that the available expert evidence concerning those senior doctors should be taken into account in assessing the quality of care provided by RRT generally.

300. Dr Freer acknowledges that certain of those staff were not interested parties and that the need to afford them procedural fairness assumes significance. For those reasons I have determined there is, ultimately, not a proper basis for consideration of those submissions in these findings.

RN Robards' evidence

301. RN Robards gave evidence that, after his conversation with the triage nurse and RN Lazarou, he and Dr Freer went to seek help from a medical staff member.

302. He said that, when they approached Dr Gildenhuys, it appeared that he was in the process of finishing his shift. He recalled Dr Freer raising Ms Honey and seeking advice, and that Dr Gildenhuys responded by stating that mental health patients should be taken either to the ward or the ICU.

303. RN Robards said that Dr Freer began to communicate some of Ms Honey's parameters, but that Dr Gildenhuys again insisted that she be taken either to the ward or ICU.

304. In his submissions, RN Robards contends that:

(a) He was the 'circuit breaker' which led to the decision to move Ms Honey from the MHOPU and appropriately escalate her care to the ED: where it was anticipated Ms Honey would receive the best available medical care and resources. RN Robards notes in support of that contention the evidence of Dr Freer:

… It was actually the after-hours manager, Registered Nurse Jason Robards, who made the comment, "You guys aren't winning here" or words to that effect, "And I've arranged for Ms Honey to be received in the Emergency Department." And that, kind of, was a bit of a trigger for us to stop and step back, and we immediately realised that he was right, that Ms Honey looked unwell. Our initial attempts to provide any sort of resuscitation to her were failing."

(b) He was concerned with the medical needs of Ms Honey. By making the phone calls he did and obtaining the CERS policy, he was seeking to resolve the impasse between the RRT and the Emergency Department and get Ms Honey medical treatment in the Emergency Department as soon as possible. The phone calls he made and obtaining the CERS policy were reasonable and appropriate in the circumstances of the impasse.

(c) After the Emergency Department had taken over Ms Honey's care, RN Robards returned to check on Ms Honey later in his shift despite not being directly involved in her care. He also sent an email to hospital executives outlining what had taken place, raising his concerns and suggested improvements to the CERS policy. RN Robards was forthright, insightful and reflective in this email.

(d) Having regard to these matters and the evidence he gave, the Court would find RN Robards to be an empathetic, professional and knowledgeable clinician still deeply affected by Ms Honey's death and that, not only should he not be criticised, his involvement with Ms Honey was commendable.

<u>Dr Gildenhuys' Evidence</u>

305. Dr Gildenhuys said he first became aware of Ms Honey at 12:30am. However, he accepted that it was possible that the interaction occurred earlier, at around

11:50pm or 11:55pm, which would align with Dr Freer's recollection. That timing also aligns with the communication records which showed that Dr Gildenhuys had left the Emergency Department by around 12:13am.

306. Dr Gildenhuys explained that, before he was approached by any members of the RRT, he was aware of a conversation between RN Lazarou and the RRT regarding a question of policy.

307. He recalled that RN Lazarou then approached him, accompanied by Dr Freer and RN Robards. According to him, RN Lazarou brought the two members of the RRT to his desk and raised with him her interpretation of a particular policy.

308. The policy in question was, he explained, that the RRT was to take responsibility for the patient until the handover to the Emergency Department could occur. The policy was relevant, he said, because RN Lazarou had already told the RRT that the Emergency Department did not have the resources to conduct such a handover, such that the RRT would need to remain with the patient until the necessary resources were freed up.

309. Dr Gildenhuys relied on RN Lazarou's interpretation of the policy - he did not, on the night, read the policy himself (although he had read the policy in the past).

310. It was at this point that Dr Gildenhuys says Dr Freer remained at his desk, and continued to ask to hand over Ms Honey. He recalled the discussion as follows:

> *… Dr Freer was pretty much standing in front of me and then he wanted to hand over the patient as well and I've explained him we don't have the resources, we're about to go down to one of the night shift doctors, there was pretty much only two doctors on the main floor and one junior doctor for the, for the short say doctor – short stay ward. And, and I affirmed that policy again and said, "Yes, no, you guys take care of the patient until handover can concur (as said)"…*

311. While Dr Freer says he wanted to explain Ms Honey's condition, Dr Gildenhuys said, in his oral evidence, that he asked about the patient's condition. His evidence is that Dr Freer described Ms Honey as having been brought from the Mental Health Unit on the basis of a drop in blood pressure, and upon further questioning about her, added that she had a blood pressure of 100 systolic, and a GCS of 13. He added that the blood pressure reading was reported as an improvement, in that Dr Freer had told him that Ms Honey had a systolic blood pressure of 60 when in the ward.

312. Dr Gildenhuys explained that RRTs would, at times, bring patients to the Emergency Department without there being an emergency situation on foot, and that some patients would at the time of arrival be recovered and stable.

313. That experience, he explained, made him prepared to accept that Ms Honey was stable and that there was no emergency afoot when she arrived. He added that, when he considered the information he received, he formed the view that Ms Honey was stable, and "just a little bit confused", independent of those earlier experiences.

314. He denied that he was being dismissive of Dr Freer or that he reprimanded him.

315. He also denied the account of the conversation given by Dr Freer, to the extent it was inconsistent with his own account, except for a number of matters. For example, he accepted that he made reference to the notion that sending patients to the Emergency Department from other parts of the hospital was "reversing the flow". He also recalled Dr Freer explaining that he did not believe Ms Honey was suitable to be sent to the ward because they were unsure about what was causing her condition.

316. RN Lazarou said there was no conversation after Ms Honey's arrival between herself, Dr Freer and Dr Gildenhuys. She also expressly denied that she was responsible for bringing Dr Freer and RN Robards to Dr Gildenhuys.

317. In his submissions dated 11 March 2026, Dr Gildenhuys makes the following general observations:

(a) It is important to guard against a risk of hindsight bias that can develop when the Court has the benefit of careful examination of decisions and events that occurred relatively quickly in a finitely resourced Emergency Department. For this reason, the important public benefit of the inquest (to prevent similar incidences occurring in the future) should be paramount, rather than necessarily determining all disputed factual matters and attributing blame to individuals.

(b) The facts of this inquest do not present a diametrically opposed set of considerations: patient care vs hospital policy. To paint the events that occurred in such a simplistic way avoids the reality of the public hospital environment in which the staff were working on the night of Ms Honey's death. Public resources for patient care were limited. Patient care decisions needed to be made in light of those resourcing considerations. This was specifically why the CERS Policy required the involvement of a bed manager, whose task it was to consider where resources were available in an individual case.

(c) The Emergency Department at the time of Ms Honey's presentation was faced with a large number of patients requiring urgent care. The inquest heard significant evidence about the number (and experience) of the staff rostered onto the Emergency Department that night and how busy it was during the public health emergency of the COVID-19 pandemic. There was a clear breakdown in communications and understanding of the Hospital's policies about patients who were cared for by an RRT under the CERS policy, but the issues in Ms Honey's case cannot be solved by the simple recantation that patient care should come first.

(d) To see Ms Honey as soon as she presented to the Emergency Department would have taken staff (and a funded bed) away from other patients presenting in the Emergency Department. For that reason, it

was important that the Hospital's policies make clear if patients from the RRT had any particular priority (and how this was to be assessed) and for information about the clinical condition of the patient to be clearly conveyed through an appropriate channel. That did not occur in this case. The policy has since been amended to address these issues. That reflects a recognition that the Hospital's policies at the time lacked clarity and were confusing.

(e) Dr Gildenhuys has also changed his approach since the tragic events of this night. Since these events he no longer "rel[ies] on, on other people to give me a, a short history at the triage" and inevitably goes and sees the patient himself. The fact that he now does so should not be understood as a concession that he was not entitled to rely on other clinicians at the time.

(f) At the time Ms Honey presented to the Emergency Department, Dr Gildenhuys was many hours over having completed his ten-hour shift. Resourcing considerations meant that he was not even supposed to be on site at that time. Dr Gildenhuys' commitment to his patients and work meant that he was still there. This also reflects the evidence given at the inquest about Dr Gildenhuys' longstanding commitment to the public by working in public hospital Emergency Departments and his focus on patient care.

318. In his submissions, Dr Gildenhuys goes on to contend that:

(a) The clear factual disputes in the evidence about what exactly occurred on the way to and when Ms Honey presented at the Emergency Department, is unsurprising given the effluxion of time and the nature of the events that transpired and the setting in which they occurred (a busy Emergency Department and hospital).

(b) Dr Freer makes a number of very serious allegations against Dr Gildenhuys. To find that a conversation took place in the terms

recounted by Dr Freer, the Court would be required to be satisfied about that to the standard established in *Briginshaw v Briginshaw* (1938) 60 CLR 336.

(c) A finding that Dr Gildenhuys refused to assist a more junior doctor would be contrary to the evidence given at inquest about the type of clinician and person Dr Gildenhuys was. It would also require rejection of Dr Gildenhuy's own evidence (in which he denied important aspects of Dr Freer's account), evidence that Counsel Assisting described as "candid" (and in circumstances where Dr Gildenhuys said he was "very" certain about the terms of the conversation whilst Dr Freer's recollection of that conversation is not corroborated by anyone else).

(d) What is more likely to have occurred is some form of misunderstanding or miscommunication in which Dr Freer believed he asked for help but that was not conveyed in the conversation. His recollection of the discussion of the CERS policy may well also have been discussion that was led by Nurse Lazarou and not Dr Gildenhuys as Dr Freer reported. In any event, it appears that whether it was Dr Freer who was unable to explain it, or Dr Gildenhuys who was unable to comprehend it, Dr Gildenhuys was clearly not aware of how sick Dr Freer now reports Ms Honey was at that time (the presence of the AAA not being discussed with Dr Gildenhuys at any point before he returned to the Hospital).

(e) Ultimately, the Court could not make any specific finding about the exact terms of the conversation that took place between Drs Gildenhuys and Freer because there is simply an absence of reliable evidence to support any such finding. He cites the fact that the participants to the conversation cannot even agree as to who was present during the conversation and the absence of any contemporaneous note, in support of this submission. He further contends that, given the traumatic nature of the events, particularly for Dr Freer, there is a real risk that his and others' memories of events may not be accurate.

(f) While it was clear that there was some conversation that took place that included discussion of Ms Honey's arrival at the Emergency Department, some aspects of her clinical presentation, as well as the CERS policy, the Court should make no finding beyond those matters and not attribute to Dr Gildenhuys the words ascribed to him by Dr Freer.

319. In response to Counsel Assisting's submissions, Dr Gildenhuys says:

(a) At a systems level, he can accept the contention that an assessment of Ms Honey should have been conducted. Whether it should have been upon arrival in the Emergency Department is more difficult to sustain. Such assessment should have been conducted before she was brought to the Emergency Department by the RRT. If it had not been conducted before she arrived at the Emergency Department, then clearly it should have occurred at the Emergency Department. However, the RRT was required to explain what assessment, if any, had been conducted and Dr Gildenhuys was entitled to rely on a policy that provided for such assessment to be conducted by the RRT (unless he were told otherwise).

(b) If the Hospital considered that a person brought to the Emergency Department ought to be assessed by the Emergency Department (and not by, or in addition to, the RRT) it was incumbent upon them to create a policy that clearly set that out. It did not do so. In the absence of clear policy requiring the Emergency Department to conduct the assessment (rather than the RRT) the Court should not find that Dr Gildenhuys (who had finished his shift) was bound to conduct such assessment or find someone else to do it when there were other patients waiting to be seen.

(c) The Court would not find that Dr Gildenhuys was bound personally to assess Ms Honey (or find someone to do so) *regardless of the precise content of the discussions that accompanied Ms Honey's arrival in the Emergency Department* because it is a key tenet of patient care that a doctor can only act on the information that is provided to him or her. Dr

Gildenhuys and the other Emergency Department staff were required to deal with patients in terms of their clinical presentation and severity.

(d) He accepts that if an assessment had occurred upon Ms Honey's arrival in the Emergency Department, the overwhelming likelihood is that the cause of her deterioration would have been identified much sooner than it was (and the trajectory of her treatment would have significantly altered) although it may well have been the case that by this time, in any event, it was too late to avoid a catastrophic outcome. In those circumstances and given the scope of ss81 and 82 of the Act, the contentions advanced by Counsel Assisting may fall outside the scope of appropriate findings.

(e) In relation to Counsel Assisting's contention that certain staff in the Emergency Department were inappropriately focused on policy over the immediate needs of the patient, whilst it is appropriate that this inquest has considered matters of policy and their application, it is imperative that such policies exist to give clear guidance to clinicians facing the exceedingly difficult job of balancing competing calls for attention by many patients. Focus on policies by clinicians in a hospital setting is not necessarily "inappropriate". What the policies should not have done however, is trump discussion of patient presentation, but again, Dr Gildenhuys could only act on the information provided to him and it was the RRT's responsibility to convey information about the patient to permit care to be given.

(f) He accepts there was no policy which prevented the Emergency Department from caring for Ms Honey upon her being brought by the RRT to that department (and, even if there was, it should not have been allowed to take precedence over her urgent medical needs) but again notes that Ms Honey's urgent needs were not known to him at that time.

(g) Counsel Assisting has focused on the conduct of Emergency Department staff and Dr Gildenhuys at the expense of adequately

addressing issues raised about the RRT and, in particular, the criticisms made by Dr Holdgate about the RRT members and the care they provided Ms Honey.

Dr Gildenhuys does not submit that there should be any adverse finding made about the RRT members, but suggests there might be a perception of imbalance in how the issues were considered at inquest and addressed by Counsel Assisting given other failures in Ms Honey's care were revealed, such as the failure by the RRT to contact the ICU consultant about Ms Honey (or indeed to raise any concerns about Ms Honey's case when Dr Freer called Dr Menaka Perumbuli-Achchige at 1:00am).

This failing was conceded by Dr Freer and had there been consultation with the ICU consultant, this may have also led to assessment of Ms Honey well before 3:00am, either by the on-call consultant herself, or by discussion between the on-call consultant and Dr Gildenhuys in which the true state of Ms Honey's health might have been conveyed.

Similarly, Dr Holdgate makes criticism about failures of the RRT to provide a proper clinical handover and ensure appropriate diagnostic steps were underway. There were also the obvious failures in noting or conveying to others the presence of the AAA.

Again, Dr Gildenhuys does not suggest that the Court ought to find blameworthiness against the members of the RRT, but says if the Court were to only make findings in the terms advanced by Counsel Assisting and not consider other equally open contentions, then such findings would not be accurate and that it may be that no such conclusions ought be reached in the terms advanced by Counsel Assisting, particularly in light of the fact that Ms Honey's condition was such that whatever care she might have received was likely to be immaterial to the outcome.

320. Dr Guildenhuys makes two further submissions. Firstly, at a time much more proximate to the events, the Hospital conducted an inquiry into what occurred and the allegations made about Dr Gildenhuys by Dr Freer. After considering the evidence, it determined that no adverse action ought be taken against Dr Gildenhuys. Secondly, whilst Counsel Assisting does not argue that any referral ought be made about Dr Gildenhuys' conduct, the fact of the contemporaneous investigation by health care professionals militates against any referrals.

Two immediate conclusions arising from the competing evidence

321. Regardless of what precisely transpired, in terms of the content of the above conversations, immediately after the RRT's arrival, I find that two things are abundantly clear. The *first* is that the RRT was left without assistance in the Emergency Department for some time. The *second* is that the Emergency Department staff did not become aware of Ms Honey's condition when they should have.

322. Dr Gildenhuys' and RN Lazarou's evidence is to the effect that, on the basis of the observations either relayed to them or otherwise apparent, there was no reason to believe that Ms Honey was in a deteriorating state and in urgent need of medical care.

323. This is exceedingly difficult to reconcile with the circumstances that led to Ms Honey being brought to the Emergency Department, and the clear view formed by senior members of the RRT that Ms Honey was in a rapidly deteriorating condition and needed urgent assistance from the Emergency Department. It is also difficult to reconcile with the defibrillator pads that arrived with Ms Honey into the Emergency Department.

324. Having said that, little (if anything) turns for present purposes on resolving these tensions in the evidence. That is because of:

(a) The oral evidence of Dr Gildenhuys and the concessions he made regarding what the Emergency Department did (and what it should have done) in relation to Ms Honey on the relevant night. He expressed regret

that he did not make visual contact with Ms Honey at the time. He acknowledged that he would have been a valuable resource in assisting the RRT care for Ms Honey. It is likely the case that, if he had visually assessed Ms Honey, urgent steps would have been taken by the Emergency Department – under his direction – to respond to Ms Honey's medical needs. He made clear in his oral evidence that, regardless of what was precisely said or understood in the communications between the RRT and Emergency Department staff before and upon Ms Honey's arrival in the Emergency Department, every effort should have been made by the Emergency Department to ensure Ms Honey was assessed. He expressed remorse about the fact that this did not occur.

(b) The unequivocal evidence of the experts to the effect that Ms Honey should have been assessed upon her arrival in the Emergency Department. Prof. Seppelt observed: "As Prof. Holdgate said, whether the emergency physicians like it or not, sometimes people do come in from unusual directions, but once they're there, they have to be assessed like anybody else". Prof. Holdgate summarised the position at follows:

> *And I know there's been a lot of conflicting evidence about what was said by various people within the Emergency Department, but…I think it's still very hard to digest the fact that this critically ill patient lay in the Emergency Department and there was no Emergency Department staff actively involved in her care, or doctors actively involved in her care for some time.*

Prof. Seppelt said "the one thing…that I find very hard to understand is how a senior emergency physician who was actually on call, could leave without at least standing in the doorway and going 'What's going on? Is everything okay?'". He continued by explaining the "pretty powerful test" that is the "end of the bed test", before reiterating that he could not understand why a senior emergency physician did not do that before leaving.

(c) RN Lazarou's acceptance that it would have been appropriate for her to conduct a visual assessment of Ms Honey. She also accepted that positive steps to identify the needs of the patient could have been taken but expressed concern about the way information was communicated to her. The real concern, as the evidence of the experts referred to at (b) above makes clear, is not the manner in which information was communicated, but the failure on the part of the Emergency Department to undertake any assessment of Ms Honey. That assessment would have put the Emergency Department staff on notice of a chain of enquiry directly relevant to the cause of Ms Honey's condition – as Prof. Seppelt said, "This is exactly what Dr Gildenhuys did when he came back in at 3am, but…why not do that at midnight?".

(d) The unanimous view of the experts that any discussion or concern about policy should have made way to responding to the immediate needs of the patient. One especially inexcusable feature of the evidence – regardless of which (if any) particular account is accepted – is the extent to which discussions between staff within the hospital (and so far as is known outside the hospital) centred on a debate about policy rather than identifying and appropriately responding to the cause of Ms Honey's deteriorating condition. Plainly, that would not have occurred had Dr Gildenhuys and RN Lazarou not taken the approach they did in relation to Ms Honey's arrival at the Emergency Department. As Prof. Holdgate put it, "…the focus of the conversation around policy was totally inappropriate". Based on the manner in which Dr Gildenhuys gave evidence (including the regret and contrition he expressed), it seems clear that such prioritising of policy over the immediate needs of a patient is unlikely to occur again in any Emergency Department he oversees.

Interdepartmental friction – a cultural issue?

325. Dr Gildenhuys explained that the working culture of the Emergency Department was one in which each member of staff there would look after each other, but that the values and visions of the Emergency Department would necessarily

differ from other parts of the hospital. He said that caused some degree of conflict, particularly where staff from the Mental Health Unit would increase the patient load of the Emergency Department by leaving patients with them, often for significant periods of time. He observed that situations where patients from the mental health ward would "backflow" to the Emergency Department would also cause "friction" between departments.

326. He explained that the friction would occasionally result in debates about who would have responsibility for the patient, and while it would rarely escalate to obvious confrontation, it would at times lead to delay in patient care.

327. Dr Elmezayen described what he observed as a "tension" between departments, arising particularly from issues regarding which department would have responsibility for a patient. Dr Gourlay agreed with this description, stating that while the cultural problems have since that time decreased, there was and still is some degree of friction.

328. That tension may have, to some degree, informed the approach taken by Dr Gildenhuys and RN Lazarou to receiving Ms Honey in the Emergency Department. It may provide some explanation for why no one from the Emergency Department conducted even a cursory assessment of Ms Honey upon her arrival there.

329. The fact that a full handover of care may not have been immediately possible, should not have affected what would otherwise have been clear upon any assessment of Ms Honey – that she was in an extremely serious condition and needed urgent assistance from the Emergency Department staff.

330. The fact that the Emergency Department staff did not understand (and did not take steps to understand) the nature of Ms Honey's condition, meant that an opportunity for doctors and nurses with greater emergency medicine experience to intervene, was missed. The capacity of the Emergency Department staff to make an immediate difference in caring for Ms Honey was

underscored when certain of those staff members ultimately became involved in her care.

Subsequent Treatment of Ms Honey in the Emergency Department

331. The rest of the RRT was informed that the Emergency Department would not accept Ms Honey, and not assist in her treatment, when Dr Freer returned from speaking to Dr Gildenhuys. The most likely timeline of Ms Honey's treatment then proceeded as follows.

332. When the discussion with Dr Gildenhuys concluded, RN Robards escalated the policy issue to the executive person on call.

333. That person was, as he recalls, Nurse Tracey Muscat. He asked whether she knew of any changes to the CERS policy which would prevent the RRT from bringing patients to the Emergency Department. He recalled her stating that she was not aware of such a change, but that any issue of handover should be an arrangement between the medical teams, so it was for the RRT and Emergency Department to decide what to do with the patient.

334. Dr Gildenhuys also recalled that call being made, although his evidence was that RN Robards rang Nurse Muscat while in his presence, or that he was at least aware of the call. He could not, however, recall overhearing anything said by Nurse Muscat.

335. After the call to Nurse Muscat concluded, RN Robards felt he had been unsuccessful in securing help for the RRT. It was at this point that he recalled obtaining the CERS policy and returning with it to the Emergency Department. Dr Ibrahim recalled the search for that policy taking some time, and RN Robards estimated it took about 5 minutes.

336. RN Robards attempted to show the document to Dr Ibrahim and Dr Freer, in a conversation that he estimated lasted less than 5 minutes. He then asked them to call Dr Wilson, the on-call physician for medicine. Dr Ibrahim's evidence differed slightly from RN Robard's account – he recalled that he first instructed

RN Robards to show the document to the members of the Emergency Department, as he was preoccupied with Ms Honey's care, but agreed that he subsequently made a call to Dr Wilson.

337. The communication records from the hospital show that the first call to Dr Wilson was made at 12:13am. That call focused on matters of policy, not Ms Honey's immediate medical needs.

338. The context here is worth noting. The RRT were responsible for the care of Ms Honey while she was in a critical condition. Yet they found themselves having to navigate policy materials and involve themselves in discussions about policy, in an attempt to secure the assistance of the Emergency Department. Plainly, that is a situation which should not have occurred. The urgent medical needs of Ms Honey needed to take precedence over any such policy concern.

339. Dr Ibrahim said that Dr Wilson asked to speak to Dr Gildenhuys, who had already left for the evening, so Dr Wilson was instead put on the phone with Dr Leerdam, the Emergency Department registrar. That conversation did not result in any further Emergency Department staff or resources being made available for the treatment of Ms Honey.

340. Dr Freer, with Dr Ibrahim's assistance, was able to establish IV access for the first time shortly after the discussion regarding the CERS was had. That IV access remained only for around 20 minutes, but allowed 500mL of fluid to be provided to Ms Honey, noticeably improving her condition.

341. The failure to maintain IV access for more than 20 minutes highlights an RRT that was in need of urgent assistance, a fact that was obvious to each of the members of the team (and which would have been obvious had any bedside assessment of Ms Honey been conducted by staff within the Emergency Department).

342. At around this time, RN Robards recalled making a call to Dr Suzanne Wass, the director of General Medicine, to make similar enquiries about whether there

had been any change to the CERS policy. He explained that she reported not knowing of such a change, and that she suggested that he speak to Dr Wilson.

343. That led to a second call to Dr Wilson, although this time it was RN Robards who made the call. The communication records show that this call was made at 12:34am. RN Robards recalled first asking Dr Wilson about whether the CERS policy had changed, and then asking Dr Wilson to call Dr Gildenhuys for the purpose of getting assistance from the Emergency Department staff.

344. Dr Wilson called Dr Gildenhuys, who by that point had arrived home, at 12:41am. Dr Gildenhuys denied that this conversation involved any mention of Ms Honey's condition. He accepted that Dr Wilson mentioned he had originally been called by Dr Ibrahim. He said the conversation was limited to a discussion about the policy.

345. Around the time when the cannula tissued, Dr Freer and Dr Ibrahim both recalled that RN Lazarou approached the RRT and Ms Honey and that RN Lazarou was asked for help with the treatment of Ms Honey.

346. They said that RN Lazarou replied with "you can use our space, but you can't use our staff", before leaving the procedure bay. Neither recalled RN Lazarou asking any questions about Ms Honey's condition or history.

347. RN Robards said he returned to the part of the Emergency Department where Ms Honey was located having finished his phone call to Dr Wilson, but made no mention of RN Lazarou's presence at that time. He recalled members of the Emergency Department coming to assist shortly after he returned.

<u>Involvement of Dr Elmezayen</u>

348. The first member of the Emergency Department to provide assistance was the Emergency Department registrar, Dr Elmezayen, who offered to assist with establishing an IV connection. Dr Freer estimated the time of his arrival at between 12:30am and 1:00am. Dr Ibrahim placed the time at around 12:50am.

349. That timing is supported by contemporaneous documents, including the intravenous fluid order form.

350. Dr Elmezayen recalled Ms Honey being taken into the procedure bay at around 12:00am, and noticing that there was already a number of doctors and nurses attending to her. He said that, around 10 or 15 minutes later, he asked RN Lazarou what was happening in relation to Ms Honey, and she told him that she thought the patient's blood pressure was low. He subsequently approached the RRT.

351. He was told by the RRT that Ms Honey's blood pressure was low, and that her cannula had failed. He then offered to assist with the reinsertion of the cannula.

352. It was around this time, when Dr Elmezayen began to assist with Ms Honey's care, that Dr Freer departed for the ICU to attend to another patient there.

353. Dr Elmezayen was able to establish an IV connection. While Dr Ibrahim could not recall precisely how long that process took, it was a shorter time than had been spent by the RRT attempting to achieve the same result.

354. Dr Elmezayen provided significant help in the ensuing treatment of Ms Honey, including guiding some of the drugs administered to alleviate her low blood pressure, which in turn allowed Dr Ibrahim to deal with other tasks such as the charting of antibiotics and ordering of X-rays.

355. Dr Freer recalled that, upon his return to the Emergency Department, more Emergency Department staff began to provide assistance, including both medical and nursing staff. That included Dr Leerdam.

Return of Dr Gildenhuys

356. Dr Gildenhuys had, as previously indicated, left the Emergency Department following the discussion he had with Dr Freer. It seems he had left the Emergency Department at least by some time shortly before 12:13am. He

accepted in oral evidence that his written evidence that he left the hospital at around 1:00am, was incorrect.

357. Dr Gildenhuys received a call from RN Lazarou at 2:24am. Dr Freer recalled that call as follows:

> *… the ED in charge nurse Sarah Lazarou in my presence called Dr Gildenhuys and said, I can recall this like direct quote, "Do you remember that patient from the Mental Health Unit? Well she's become our problem and you need to come in now and intubate her."*

358. Dr Gildenhuys said RN Lazarou told him that she was worried about the patient and mentioned that Ms Honey's blood pressure had dropped.

359. When he returned, after 3am, Dr Gildenhuys became immediately involved in Ms Honey's care. He intubated her and arranged for her to be taken to the CT scanner.

360. While Dr Gildenhuys gave evidence that he did not need to contribute to any particular procedure carried out, or the diagnosis, he accepted that he assumed leadership of Ms Honey's care which was "instrumental" in organising the medical assistance she received. This only underscores the role that he would have been able to play had he become involved in Ms Honey's care earlier in the evening, following her arrival in the Emergency Department.

361. It is important to note the context in which those events occurred, that may explain or at least inform how the events played out in the manner they did. As Dr Gourlay explained, the staffing limitations within the Emergency Department at the time meant that Dr Gildenhuys was coming off a ten-hour shift in which he was the sole emergency specialist in the department, even before Ms Honey arrived. Those environmental pressures created by such staffing/resourcing issues almost certainly contributed to what occurred following Ms Honey's arrival in the Emergency Department.

362. The events of the evening in question cannot be reconciled with the significant contribution Dr Gildenhuys has made to emergency care across his career. Dr Elmezayen said that Dr Gildenhuys was an “amazing doctor”, and that he had never before seen him refuse to assist junior staff who were seeking his help. To his credit, Dr Gildenhuys candidly accepted that he should have at the very least ensured Ms Honey was assessed on arrival in the Emergency Department, and not allowed any concern about policy to prevail over the needs of any patient.

Conclusions On Issue 3

363. I make the following findings, noting they arise after careful consideration of the conflicting evidence concerning what took place immediately after the RRTs arrival in the Emergency Department and the submissions made about that evidence (see above):

(a) The circumstances that existed in the Emergency Department at the time of Ms Honey’s arrival must be acknowledged. Those circumstances included the pressures of working in that department, the large number of patients already present and the finite resources (both in terms of staff and facilities available) to facilitate their treatment. Plainly, policy has a part to play in achieving effective allocation of those resources and prioritization of tasks.

(b) Having said that, Ms Honey was in urgent need of critical care and it is generally accepted that an assessment of Ms Honey should have been conducted when Ms Honey arrived in the Emergency Department. As such, I make that finding.

(c) Dr Gildenhuys should have attended to this (or ensured it occurred) before he left the Emergency Department on the relevant night. No doubt the circumstances referred to in (a) together with inadequate structures, systems and training being in place concerning handovers between the MHOPU and the Emergency Department contributed to the emphasis

certain Emergency Department staff gave to policy in the face of Ms Honey's arrival in the Department. Interdepartmental friction may have also informed the approach taken by Dr Gildenhuys and RN Lazarou to receiving Ms Honey.

(d) There was no reasonable basis for Emergency Department staff, including Dr Gildenhuys, to have concluded that the RRT did not require assistance, or that Ms Honey's medical needs were being adequately met. In this regard I find that (i) at least some request for assistance or support was made by the RRT through Dr Freer, and (ii) absent a visual inspection, Emergency Department staff did not (and could not) know what Ms Honey's medical needs were.

(e) The most likely situation concerning communication between RRT staff and Emergency Department staff upon arrival is that there was some miscommunication which resulted in Dr Freer thinking that he communicated a request for help but that was not interpreted as such by Dr Gildenhuys. That miscommunication likely contributed further to the position taken by some in the Emergency Department.

(f) Had an assessment of Ms Honey occurred upon her arrival, the overwhelming likelihood is that (i) the cause of Ms Honey's deterioration would have been identified much sooner than it was, (ii) the trajectory of her treatment would have significantly altered, and (iii) patient care would have been prioritised ahead of (and brought an end to) any discussion as to handover policy.

(g) Having said that, it is appropriate to acknowledge the expert evidence that, whilst the cause of Ms Honey's deterioration would have been identified much sooner than it was and the trajectory of her treatment would have significantly altered, it may well have been the case that by this time, in any event, it was too late to avoid a catastrophic outcome for Ms Honey.

(h) By reason of the approach that certain staff within the Emergency Department took to the arrival of Ms Honey there, an inappropriate focus was given to matters of policy (and an ensuing debate about policy) over the immediate needs of the patient. That should have never been allowed to occur.

(i) It is no answer to the lack of engagement by certain Emergency Department staff upon Ms Honey's arrival in the Emergency Department that space within the Emergency Department could be utilised by the RRT independently of that Department's staff and their resources.

(j) There was no policy which prevented the Emergency Department from caring for Ms Honey upon her being brought by the RRT to that department (and, even if there was, it should not have been allowed to take precedence over her urgent medical needs).

(k) The result of (a) and (h) above was that the members of the RRT "felt deserted for most of the night", and for an extended period of time Ms Honey lay in the Emergency Department with no Emergency Department staff actively involved in her care.

(l) The events surrounding Ms Honey's passing still deeply affect most of those involved in her care.

(m) Dr Elmezeyan is to be commended for the initiative he displayed in involving himself in the care of Ms Honey. The steps that Dr Elmezeyan took, in effect, cut through an inappropriate focus on policy which (to the understandable frustration of the RRT members) had occurred within the Emergency Department up to that point. It also set in train a course of events which culminated in the intervention of Dr Gildenhuys and the identification of the cause of Ms Honey's condition.

(n) The difference Dr Gildenhuys was able to make – in terms of identifying the cause of Ms Honey's condition and making decisions about the

urgent treatment steps she needed – upon his arrival back to the Emergency Department at around 3am, only highlights the difference his experience was likely to have made some hours earlier (noting what is set out at (g) above about the reality that it may well have been too late to avoid a catastrophic outcome by the time Ms Honey arrived at the Emergency Department.

(o) From that point onwards, the decisions that were made and the steps that were taken by Dr Gildenhuys and those assisting him in caring for Ms Honey, were adequate and appropriate.

Consideration of Recommendations

364. The Court heard evidence from Dr Gourlay, as to the significant changes that have been made since, and arising out of, Ms Honey's death, including to prevent a similar problem occurring whereby debate about policy application trumped the immediate needs of a particular patient.

365. The court also heard the evidence of experts who endorsed the changes that had been made.

366. Not only have changes been made to policy and procedure, they have been reinforced by repeat communications to staff in order to emphasise that where a patient like Ms Honey is present in the MHOPU and deteriorates, the appropriate place for her to be assessed and managed is the Emergency Department.

367. In such circumstances, the CMH supports a recommendation that CMH review its existing training of Emergency Department staff as proposed by Counsel Assisting. This includes review with a view to providing training as to the importance of not letting the application of policy distract from the clinical needs of individual patients. CMH further proposes that as part of that review, it consider including a case study based on the facts of this matter.

Recommendations

368. I make the following recommendations directed to CMH:

(1) All staff in the Emergency Department be provided training that specifically focuses on the interplay between policies and the immediate needs of a particular patient (and the ultimate responsibility to ensure the primacy of the latter in emergency contexts);

(2) All staff in the Emergency Department be provided training that specifically focuses on the need to conduct an assessment of any patient that is brought by any RRT to that department, regardless of where that patient has been brought from;

(3) All staff in the Emergency Department be provided training that highlights the differing experience levels of RRT members, and which highlights the need to assume that if an RRT brings a patient to the Emergency Department, that the patient requires emergency care (at least until any assessment conducted by the Emergency Department determines otherwise);

(4) In relation to the tension between staff in the Emergency Department and staff/patients in the Mental Health Unit addressed above, every effort should be made to put in place training and education programs (including by reference to the specific circumstances the subject of this inquest) aimed at promoting awareness of the significant consequences that may flow from a clinical environment where staff from different departments are not working together collaboratively and respectfully.

Issue 4 – Policy and procedure documents

Are there any policy and procedure or other guideline documents (Guideline documents) of either the CMH, HNELHD, JHH or NSW Health of particular relevance to the care and management provided to Ms Honey over the time periods referred to in Issues 1 to 3?

a. If yes, what are those Guideline documents?

b. If yes, were those Guideline documents complied with by those providing Ms Honey with care?

369. While extensive policy, procedure and guideline documents were before the Court, and the subject of evidence, the principal issues related to policy and procedure have been addressed in respect of issues 1-3. Most notably, they are: *(a)* the need to ensure, in any context like that involving Ms Honey, the immediate needs of the patient are prioritised over concern or discussion about policy; *(b)* the absence of any policy which precluded the Emergency Department providing care to Ms Honey (and the reality that, in light of *(a),* even if there had been such a policy it should never have been allowed to take priority over responding to the immediate needs of a patient in Ms Honey's condition).

Issue 5 – Whether it is necessary or desirable for the coroner to make recommendations pursuant to section 82 of the *Coroners Act* 2009 in relation to any matter connected with the death of Ms Honey

370. Proposed recommendations, referable to each issue, are set out above. Having said that, and whilst the evidence in this case does not suggest that there was a lack of day to day involvement with mental health patients that led to Ms Honey's condition going undiagnosed, the expert evidence underscores the value in all RRT and Emergency Department staff being provided with some training and education about the particular challenges involved in reviewing and diagnosing acute mental health patients.

371. As Dr Middleton noted, in the case of an AAA, psychiatric patients may under-report pain or tenderness, which is an indicator that the AAA may be unstable. Such challenges arise in the treatment of such patients generally, where they may not be able to reliably or accurately communicate their symptomology. Consistent with the evidence of Dr Robinson, this training should focus on the need to approach cautiously the symptoms and history such patients self-report.

372. I therefore recommend that training be provided to all RRT and Emergency Department personnel at CMH who are not involved in the day-to-day care of acute mental health patients, about the diagnostic challenges that such patients can present.

373. Counsel Assisting makes the further submission that given the issues with contemporaneous clinical notes and records which repeatedly arose at different stages of Ms Honey's care, (a) it should additionally be recommended that more intensive training be provided to *all* hospital staff and (b) there is likely to be a need to consider ensuring and implementing a more effective regime for disciplining staff in respect of such non-compliance.

374. In response to submissions made by CMH and the HNELHD, Counsel Assisting says that such recommendations:

(a) Align with the recommendations made in relation to Issue 2 but extend beyond the RRT the subject of Issue 2;

(b) Do not go unnecessarily beyond what was canvassed by the evidence before the Court; and

(c) Are necessary to ensure the failings of staff to keep meaningful and contemporaneous notes, as happened in Ms Honey's case, do not compromise future patient care and outcomes.

375. With regard to these submissions, I recommend that more intensive training be provided to *all* hospital staff at CMH and the HNELHD on the need for (and importance of) maintaining contemporaneous and comprehensive clinical documentation. This recommendation expands upon that at paragraph 245(1) above, that is, it extends beyond the entities which are the subject of Issue 2.

376. I decline to make a recommendation for ensuring and implementing a more effective regime for disciplining staff in respect of non-compliance with record keeping. In doing so I note the HNELHD and CMH support the current practice

of (a) assessing staff who complete the relevant training and education, (b) providing repeat training and education over time and (c) conducting audits of those who completed the training and education from time to time. Given this support and the limited available evidence no further recommendation is appropriate.

Concluding remarks

377. I will close by again conveying to Ms Honey's family my sympathy for her tragic loss. I acknowledge that she is forever lost to them.

378. I thank the Assisting team, particularly Mr Greg O'Mahoney and Mr Timothy Dinjar of DCJ Legal for their outstanding support in the conduct of this inquest.

Statutory findings required by s 81(1)

379. I make the following findings:

Identity of deceased:	Helen Frances Honey
Date of death:	21 February 2021
Place of death:	John Hunter Hospital, Newcastle
Cause of death:	Ruptured abdominal aortic aneurysm
Manner of death:	Ms Honey died of natural causes associated with a rupture of an abdominal aortic aneurysm, in circumstances where there had been clinical deterioration the evening before her death, but where there was a delay in diagnosis of the rupture and consequent delay in consideration of treatment options

Recommendations

380. I make the following recommendations directed to CMH and the HNELHD:

(1) More intensive training be provided to all hospital staff at CMH and the HNELHD on the need for (and importance of) maintaining contemporaneous and comprehensive clinical documentation.

(2) A leader be appointed to every RRT that convenes within any hospital in the HNELHD, with a clearly identified role (and clearly delineated tasks), and that focused training be provided to such team leaders in respect of the same.

(3) The appointment of an RRT leader for the purposes of (2) above be based upon an assessment of the person within a given RRT who, based on his or her experience and skillset, is best placed to play a leadership role within that team.

(4) The training provided to RRT members in the HNELHD be enhanced to ensure a greater emphasis on simulated emergency scenarios.

381. I make the following recommendations directed to CMH:

(1) All staff in the Emergency Department be provided training that specifically focuses on the interplay between policies and the immediate needs of a particular patient (and the ultimate responsibility to ensure the primacy of the latter in emergency contexts);

(2) All staff in the Emergency Department be provided training that specifically focuses on the need to conduct an assessment of any patient that is brought by any RRT to that department, regardless of where that patient has been brought from;

(3) All staff in the Emergency Department be provided training that highlights the differing experience levels of RRT members, and which highlights the need to assume that if an RRT brings a patient to the Emergency Department, that the patient requires emergency care (at

least until any assessment conducted by the Emergency Department determines otherwise);

(4) In relation to the tension between staff in the Emergency Department and staff/patients in the Mental Health Unit addressed above, every effort should be made to put in place training and education programs (including by reference to the specific circumstances the subject of this inquest) aimed at promoting awareness of the significant consequences that may flow from a clinical environment where staff from different departments are not working together collaboratively and respectfully.

I close this inquest.

Judge Stuart Devine
Deputy State Coroner
Lidcombe Coroners Court

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