



STATE CORONER'S COURT OF NEW SOUTH WALES

Inquest: Inquest into the death of Kundayi Chiundiza

Hearing dates: 12 September – 16 September 2011

Date of findings: 16 September 2011

Place of findings: State Coroner's Court, Glebe

Findings of: Magistrate Sharon Freund, Deputy State Coroner

Recommendations:

1. To the Minister of NSW Health:
Noting that the Garling Report made a recommendation concerning the supervision of junior clinicians which appears to very useful but does not cover the situation for overseas trained doctors that have more than two years post graduate experience in countries outside of Australia, I make the following recommendation:
NSW Health should consider developing and implementing statewide policies setting out a best practice model for the supervision of overseas trained non specialist doctors working in Australian hospitals for the first time. This policy should:
 - a. define supervision;
 - b. define the objectives and content of supervision;
 - c. define the supervisory relationship including the roles and responsibilities of clinical supervisors and trainees;
 - d. set out mechanisms for resolving difficulties relating to inadequate supervision; and
 - e. recognise the importance of the supervisors role.
2. To the Executive Officer of the Australian Medical Council:
The Australian Medical Council should consider introducing specific topics in the examination required for the registration of overseas trained doctors which address the following:
 - a. communication skills;
 - b. handover; and
 - c. note taking.
3. To the Executive officer of the NSW Medical Board:
The NSW Medical Board should give consideration to the need for better pathways of supervision for overseas trained non specialist doctors working in NSW hospitals for the first time and that the NSW Medical Board should liaise with NSW Health in this regard.

File number: 1475/11

Representation: Dr. P. Dwyer, Counsel Assisting instructed by Ms. Murty and Ms. Fleeton solicitors, Crown Solicitor's Office;
Mr. McCulloch SC instructed by Pikes Lawyers for the family;
Mr. D. Villa instructed by Australian Rugby Union;
Ms. D. Ward instructed by St. Andrews Cathedral School;
Mr. Gregg for South West Sydney Health Service;
Mr. T. Kwan solicitor for St Gregorys College;
Ms. L. Alexander for Nurses Association; &
Mr. Philip Strickland SC instructed by HWL Ebsworth Lawyers for Dr. Liyanage and Dr. Kailanathan

Inquest into the death of Kundayi Chiundiza

FINDINGS

Kundayi Chiundiza was just 16 years old when he died at home on 21 June 2010, after being treated and released from Campbelltown Hospital after sustaining an injury at a Rugby game on 19 June 2010.

Kundayi was born on 8 October 1993 and was the youngest of 4 sons born to Grace and Richmond Chiundiza. He was born in Colorado Springs in the United States, whilst his parents were on sabbatical, however spent the first three years of school in Harare, Zimbabwe.

In 2002, when Kundayi was 9 years old he moved to Australia with his brother Joshua where his mother, Grace Chiundiza had been studying for several years. Kundayi originally attended Newington College in Sydney, thereafter in 2007, he was enrolled at St Andrews Cathedral School ("**St. Andrews**"). It is abundantly clear from the evidence throughout the first days of this inquest that Kundayi was a young man, who was a talented athlete, was passionate about his sport, particularly his rugby, and was much valued and loved by those who came into contact with him. In short, Kundayi was a personality to be reckoned with. He was a role model to students in the junior years, a teammate that was valued and a friend to many. His loss has had an enormous impact on the St Andrews community as well as his family.

A coroner's function is to attempt to answer five questions namely: Who died? When did he or she die? Where did he or she die? What was the cause of death? And finally, what was the manner of death? The cause of death is the immediate physical cause. The manner of death refers to a way a person dies, including the surrounding circumstances. A coroner may also make recommendations concerning public health or safety issues arising out of the death in question.

In relation to Kundayi's death, there is no issue in relation to the identity, date, place or direct cause of his death. The issues to be determined by this inquest are in relation to firstly how Kundayi came to sustain the injury that ultimately caused his tragic death and secondly, the care and treatment Kundayi received at Campbelltown Hospital and his subsequent release. Dr. Dwyer, Counsel Assisting, outlined these issues in her opening statement in greater particularly and they included following:

1. How did Kundayi sustain an injury on 19 June 2010?
2. Was the tackle Kundayi sustained a dangerous and/or illegal one?
3. Can school or youth rugby games, including interschool competitions be further regulated to make them safer for players?
4. Was the treatment received by Kundayi at the sports ground, prior to being transported to Hospital, appropriate?
5. What symptoms did Kundayi experience immediately after the injury and were these symptoms conveyed to ambulance officers and thereafter hospital staff?

6. Was Kundayi adequately examined and did he receive appropriate treatment at Campbelltown Hospital?
7. Were Kundayi and his mother appropriately advised of the strategies for monitoring and caring for Kundayi once he was discharged?

I will deal with each of these issues in turn.

How did Kundayi sustain an injury on 19 June 2010?

It is undisputed that Kundayi attended and played in the first 15's Rugby team for his school, St Andrews Cathedral School ("**St Andrews**") on 19 June 2010 against St Gregory's College ("**St Gregs**"), at their campus in Campbelltown. It was approximately 8 minutes into the second half of the game when a student of St. Gregs, Max Keene tackled Kundayi. It was this tackle that caused Kundayi to suffer an injury, and as he did not return to the field, was attended to by ambulance officers and was subsequently transferred to Campbelltown Hospital where he was later discharged.

Was the tackle Kundayi sustained a dangerous and/or illegal one?

At the time of Kundayi's death, much was made of the tackle he sustained. Amateur DVD footage of the match forms part of the coronial brief. The tackle that caused Kundayi's injury can be seen at Scene 3 from approximately 7.59 to 8.22 on the counter. An expert's opinion was obtained for the purpose of the inquest from Mr. Terrance Willis who advised in his report dated 2 September 2011 inter alia that:

1. The tackle executed was a dangerous shoulder charge, in that the player “charged or knocked down an opponent carrying the ball without trying to grasp Kundayi”¹;
2. That in his experience many similar tackles would not have been sanctioned on the field and at most a penalty kick should have been awarded to St. Andrews²;

It was conceded by all the teachers who gave evidence on the first day of the hearing that it was ultimately the referee’s role to decide and rule on whether a tackle was illegal or dangerous. The referee of the match had decided the tackle that injured Kundayi was not. If he had on the day decided it was in fact illegal, he may have awarded a penalty to St Andrews. However, this would not have had any effect on whether or not Kundayi sustained the injury that unfortunately claimed his life due to circumstances beyond the control of either Max Keene who tackled Kundayi or the referee.

Furthermore, I think it is important to note that there was clearly no intention or malice on the part of Max Keene who tackled Kundayi. Injury is an unfortunate consequence of contact sports such as Rugby Union and Kundayi’s death is in no way the fault or responsibility of Max Keene.

¹ Exhibit 2 Volume 2 tab 47 page 21;
² Ibid;

Can school or youth rugby games, including interschool competitions be further regulated to make them safer for players?

On the first day of the inquest evidence was heard with respect to the way in which school boys Rugby is divided into teams based on the age and skill levels of the players. In the more junior divisions adjustments can be made to ensure there is no great disparity in the weight of the children participating. In the open level, a player who was 16 years old and turning 17 years old was permitted to play in the 16 years division if he weighed less than 65 kgs

It is now clear that the issue of the weight to age ratio of players is not one that should trouble me in this inquest for the following reasons:

Firstly, Kundayi was approximately 66kg at the time he was tackled and while there is evidence that Max Keene was a teenager with a bigger frame, their size difference was not so great that any of Kundayi's teachers or his coach were concerned.

Secondly, Kundayi was a player of exceptional skill. His coach Mr. Michnewicz indicated that he had excellent defensive skills and he had no concerns that Kundayi was not a match for other players on the field. The skill set taught by his coach, and demonstrated by Kundayi, is aimed in part at limiting the risk of serious injury.

Finally, a number of reports were tendered that demonstrated that Australian Rugby Union and other bodies involved in the regulation of this sport have gone to significant effort to make school boys rugby union as injury free as it can be. The issue of weight

disparity has been carefully considered and there are already policies which allow for adjustment where it is most needed, namely, at the more junior levels.

All contact sports involve the risk of some injury but I am satisfied that those with the necessary expertise have gone to great lengths to introduce what seem to be appropriate safety guidelines and accordingly I don't intend to make any recommendations in that regard.

Was the treatment received by Kundayi at the sports ground, prior to being transported to hospital, appropriate?

It was clear immediately after the tackle that Kundayi had been hurt. Mr. Tim Gardiner, who was the 1st XV trainer, attended Kundayi on the field to assess his injuries and then assisted him from the field, as it was obvious that he was unable to continue playing.

Both Mr. Gardiner and Mr. Michael Turton, the head of sport at St Andrews, then treated Kundayi on the sideline. An ambulance was called at approximately 4.13pm and responded with lights and sirens arriving at the St Gregs sports field at 4.24pm.

I note that both Mr. Gardiner and Mr. Turton both held first aid certificates and attended to Kundayi's injury without delay. In my view the treatment received at the sports ground prior to his transport to hospital was appropriate and caring.

What symptoms did Kundayi experience immediately after the injury and were these symptoms conveyed to ambulance officers and thereafter hospital staff?

There is a wealth of evidence regarding the symptoms experienced by Kundayi after the tackle, all of which is essentially consistent. The evidence is gleaned from the various teachers including, Mr. Turton and Mr. Gardiner who treated Kundayi on the sideline prior to the arrival of the ambulance. The symptoms experienced by Kundayi after the tackle can be summarised as follows:

1. He was in a lot of pain;
2. He had vomited twice; and
3. He was having difficulty remaining conscious.

The symptoms were corroborated by the ambulance notes, which recorded the following:

Patient Incident History: PMHx Nil

C/T Traumatic injuries. O/A found 16 yo lying on ground.

PT states was shoulder charged at the chest. Pt fell to the ground. O/E Pt alert, oriented and well perfused. Pt had 2 x vomits post tackle, nil LOC, neck or back pain. PEARL BS R=L, clear slight tenderness on palp of chest. L L region, nil deformity noted. Abdo soft and non (?) tender. Pt ↓ temp post lying on wet grass. Pt denies dizziness or headache. Pt Tx for further management. Stable en route. Mother escort.

Temperature: 34.7°

<i>Time</i>	<i>Resp rate</i>	<i>Breath sounds</i> <i>L R</i>	<i>SpO %</i>	<i>Pulse</i>	<i>Systolic</i>	<i>Diastolic</i>	<i>GCS</i>	<i>Pain Score</i>
1628	26	N N	100	84	120	60	4+5+6=15	10
1650	24	N N	100	84	120	60	4+5+6=15	8

<i>Time</i>	<i>Rhythm</i>	<i>Observations, Drugs and Fluid Treatments</i>	<i>Dose mcg/mg/G/m L</i>	<i>Route</i>	<i>Shock</i>	<i>Response</i>
1630	SR	Methoxyflurane	3 ML	Inhal	-	↓ pain

Accordingly, I am satisfied that the ambulance staff were adequately advised of the circumstances of Kundayi's injuries and the symptoms he had and was currently suffering from.

It is also important to note that Mrs Chiundiza accompanied Kundayi in the ambulance to the hospital. Although Mrs Chiundiza had not witnessed the actual tackle, she had seen and was aware of his symptoms suffered on the sideline post tackle.

In relation to the handover between the ambulance officers and the medical staff at Campbelltown Hospital, I note that ambulance notes form part of the hospital file.

It was the evidence of Dr. Radeeka Liyanage that at the time she attended to Kundayi she had access to the ambulance records. Accordingly, I am satisfied that there was an adequate handover between the ambulance officers who had brought Kundayi to the Emergency Department and the staff at the hospital.

Was Kundayi adequately examined and did he receive appropriate treatment at Campbelltown Hospital?

The major issue for this inquest was in relation to the care and treatment received at Campbelltown Hospital. Kundayi arrived at Campbelltown Hospital (accompanied by his mother Grace Chiundiza) by ambulance at about 4.50pm on 19 June 2010. He was subsequently seen and attended to by the following members of staff:

1. Nurse Helen Malcolm, the triage nurse;
2. Dr Radeeka Liyanage, a Career Medical Officer in Emergency Medicine;
3. Clinical Initiative Nurse, Bronwyn James; and finally
4. Dr Kailanathan Ayngkaran, Career Medical Officer.

I will deal with the care and treatment by each of the abovementioned health professionals in turn.

NURSE HELEN MALCOLM

Nurse Helen Malcolm gave evidence on the first day of the hearing. It was her evidence that:

1. She triaged Kundayi on 19 June 2010 at 4.59pm with a presenting problem of *“chest pain on inspiration”*³;
2. The ambulance personnel had stated that Kundayi had been *“shoulder charged to the chest and fell to the ground, had vomited twice since the incident and had equal breath sounds. That he had no loss of consciousness, no neck pain and had chest pain on inspiration”*⁴;
3. He had a Methoxy whistle and was not using it;
4. Kundayi had stated that he had felt better since vomiting; and
5. That she triaged Kundayi as category 4 as per the Australian Triage Scale.

At the time of giving her oral evidence Nurse Malcolm indicated that she had no independent recollection of Kundayi or what occurred on 19 June 2010. That is not surprising given that in her position as a Triage nurse, she sees a large number of patients coming into the casualty department a day and it has been over a year since she attended to Kundayi.

As triage category 4, Kundayi was required to be seen by a medical officer within one hour. This clearly occurred.

³ exhibit 2, volume 1 tab 20 page 122;

⁴ Ibid

It was the evidence of Dr. Sammut that:

“... I note that the triage was conducted in a thorough manner with a good documentation of the presenting problem. The time of triage was 1659. A pain score is not recorded. It is noted that the triage nurse records “has methoxy – not using it . Feels better since vomiting...” A BP measurement is not recorded. A triage category is 4”⁵

He goes on to state that:

“A triage category of 4 for a patient who presents by ambulance with a history of chest pain, (worse on inspiration) and a history of vomiting after the recorded mechanism of injury(abdominal trauma) was in my opinion, a missed opportunity. A higher triage score would have almost certainly resulted in admission to a bed in the ED with its associated period of more prolonged and closer hemodynamic and other observations, together with almost continual observations of Master Chiundiza’s general demeanour and a review in a bed prior to discharge. Such a period of observations may also have revealed any level of ongoing pain or anxiety by Master Chiundiza”⁶.

Following Kundayi’s death, the Western Area Health Service engaged the services of Dr. Sammut to conduct an analysis/ audit of what occurred in the Emergency Department. That audit, and the hospital responses to it, are contained within the coronial brief. I note that as at 1 November 2010, steps have been taken by Campbelltown Hospital to ensure that all pediatric trauma patients, like Kundayi, need to be seen in either the Emergency Department Paediatric section or in the Resuscitation Area. I commend Campbelltown Hospital for their prompt re-evaluation of their procedures following Kundayi’s death.

⁵ exhibit 2, volume 1 tab 20 at page 1 of the report;

⁶ Ibid at page 1 of 5;

DR RADEEKA LIYANAGE

At the time Kundayi presented at Campbelltown Hospital Emergency Department, Dr. Liyanage had been employed by Campbelltown Hospital as a Career Medical Officer for a period of approximately 3 months.

The inquest had the benefit of the following evidence in relation to Dr. Liyanage's care and treatment of Kundayi:

Firstly, her contemporaneous notes of her attendance on Kundayi on 19 June 2010 at about 5.50pm which were recorded by her approximately 15-20 minutes after her attendance on Kundayi. Those notes recorded the following:

"Been tackled by another player while playing rugby.

Been hit in between chest & abdomen.

Vomitting twice after that.

No SOB. Pain incr with breathing,

Now no vomiting / nausea.

Pain 8/10

Otherwise well.

....

SHx Goes to school

Not smoking / drinking

O/A Distressed with pain

No SOB RR – 18/min Sats- 100%

Afebrile

HR – 84/min

BP – 120/80 mmtg

Lungs Clear, Equal air entry

[diagram indicating "Tenderness"]

?Muscle injury

CXR no obvious #

Nurofen 400mg

Panadeine fort 2poi”⁷

Secondly, her undated statement, prepared at the request of Dr. Prahalath, approximately a week after Kundayi had died⁸, and finally her oral evidence which was given on the second day of the hearing.

Dr. Liyanage’s undated statement, recorded most notably the following:

“Complaints

- *Abdominal pain in the epigastric area*
- *Pain increased with breathing*
- *No chest pain or shortness of breath*
- *No nausea or vomiting*

History of Presenting Complaints:

Patient was tackled by another player while playing rugby at about 1600hrs today.

He was shoulder charged by an opponent with a blow on to epigastric area.

Patient fallen to the ground after that.

Pain was 8/10 at the time.

He did not hit his head or did no loose [sic] consciousness.

Patient managed to get up and walk.

He vomited twice after the blow and felt relieved of pain.

There were no other complaints or injuries.

...

Examination

Patient was able to get up from wheel chair and get on to examination bed himself without assistance.

He was still having abdominal pain.

Afebrile.

Not pale.

...

Epigastric tenderness was present where he was hit.

Mild tenderness over right side of abdomen and deep palpation.

No rebound tenderness

⁷ exhibit 2, volume 1 tab 20 at pages 122 and 123;

⁸ exhibit 2, volume 1 tab 16;

No guarding

No neurological deficits noticed'

There were a number of inconsistencies in relation to Dr. Liyanage's versions of evidence in particular:

1. In relation to how Kundayi described his pain. It is of interest that her handwritten hospital notes indicated that Kundayi's "pain was 8/10", her statement stated "pain 8/10 at the time" and her oral evidence was "he indicated his pain was 8/10 when he was hit and then he threw up twice and he felt better now".
2. Dr. Liyanage also indicated in her hospital notes that Kundayi was "distressed with pain" whilst in her statement she makes no mention of this. Her oral evidence was that she noticed that Kundayi did "not look happy". His face looked like he was in pain and that "he didn't look like he wanted to be answering questions".
3. There is no mention in Dr. Liyanage's hospital notes about his movement or how he got to the examination table/bed. However, her statement prepared approximately one week later indicated that Kundayi got on the bed unassisted from the wheelchair. She went further in her oral evidence indicating that Kundayi got up comfortably. "His face still looked unhappy and showed pain but he managed by himself. His body did not show any indication of pain. He did not groan".
4. In relation to her examination of Kundayi's abdomen her contemporaneous notes refer to "tenderness" and a shaded diagram of the abdomen. Her statement states "Epigastric tenderness was present where he was hit. Mild

tenderness over right side of abdomen on deep palpitation”⁹. Her oral evidence was different again where she stated that she did not ask the scale of tenderness. She said, "Is it very tender or mildly tender?" Kundayi said it was mild. She did not write this down. She had to press more firmly on the abdomen to get the tenderness. Later in cross-examination Dr. Liyanage indicated that Kundayi did not say anything about how tender these 2 areas were. She concluded the level of tenderness because the epigastric area was tender on deep palpation, and therefore she thought it was mild tenderness. Regarding the right lower abdomen, she said she asked, "if it was very sore". He said "no". She said, "Were you hit there?" He said, "its not that bad" so she concluded that it was very mild.

Mrs. Chiundiza remained with Kundayi throughout his examination by Dr. Liyanage. She has provided two statements for this inquest. The first was given to the Officer in Charge in the days following Kundayi's death (it having been commenced on 7 July and signed on 21 July 2010). Thereafter, the second statement was prepared in more detail with the help of her legal representatives within the same month. I note that in the preparation of her statements at a time so soon after Kundayi's death that she would not have had the benefit of seeing Dr. Liyanage's statement or even the hospital records.

In contrast to the evidence of Dr. Liyanage, Mrs. Chiundiza's evidence has remained consistent and steadfast with regard to the examination, care and treatment by Dr. Liyanage. Her evidence can be summarised as follows:

⁹ exhibit 2, volume 1, tab 16 page 103

1. That Kundayi was in significant pain at the time he was transferred to the examination room;
2. That Kundayi was assisted from the wheelchair to the examination bed/table by Dr. Liyanage and herself as he was “struggling”¹⁰;
3. Kundayi indicated that his pain at the time of examination was 8/10¹¹;

During Cross-examination by Mr. Strickland SC, counsel for Dr. Liyanage, Mrs. Chiundiza denied:

1. That Kundayi stated that his pain was 8/10 at the time of the tackle;
2. That Kundayi moved from the wheelchair to the examination bed unaided;

Mr. Strickland SC. submitted that Dr. Liyanage’s evidence should be preferred over that of Mrs Chiundiza for the following reasons:

1. Although there is no doubt Mrs Chiundiza was a witness of truth in that she genuinely believed what she stated, she admitted that she was in “such a state” because of having to take her son to hospital and the distressed condition he was in;
2. It could not be expected that Mrs Chiundiza could recall with 100% accuracy the exact conversations that took place between Dr. Liyanage and Kundayi.
3. Furthermore, it is more probable than not that she has simply forgotten or did not register a number of things which actually took place whilst her son was in hospital

I simply do not agree. In my view, Dr. Liyanage’s version of events has evolved over time and she in fact herself conceded in cross-examination by Mr. McCulloch, counsel

¹⁰ exhibit 2, volume 1 tab 8, first statement dated 21 July 2010 at paragraph 17 and second statement dated July 2010 at paragraph 21;

¹¹ exhibit 2, volume 1 tab 8, second statement dated July 2010 at paragraph 21;

for the family, that “she framed her statement to put herself in the best possible light”. Her oral evidence that Kundayi had indicated his pain was “8/10 at time of impact” does not sit comfortably with firstly, her contemporaneous notes that record “*distressed with pain*” and “*No SOB. Pain incr with breathing, Now no vomiting / nausea. Pain 8/10. Otherwise well.*”

Accordingly, I prefer the evidence of Mrs Chiundiza and find that Kundayi at the time of his examination by Dr. Liyanage needed assistance from the wheelchair to the examination bed and had reported his pain to be 8/10.

Dr. Liyanage conceded the following matters in relation to her care and treatment of Kundayi:

1. That at the time she had treated Kundayi she had no experience in relation to rugby or injuries in relation to contact sports generally;
2. She did not even consider that Kundayi may have suffered an internal injury to the abdomen;
3. She had no differential diagnosis for Kundayi only her diagnosis of “*? muscle injury*”;
4. That she didn’t ask Kundayi’s mother if she had any concerns about Kundayi and she should have;
5. That the notes at the time were inadequate in that they were not fulsome and that they did not have a plan of management. Since Kundayi’s death she has come to learn the importance of accurate note taking and handover.

I had the benefit of reports and oral evidence from four eminent specialists in emergency medicine during the course of this inquest, namely Professor Fulde,

Dr. Robert Day, Dr. John Raftos and finally Dr. Sammut. All the experts agreed that they would not have expected junior doctors (or a doctor with Dr. Liyanage's experience) or even more senior experienced emergency medicine doctors to initially diagnose the posterior rupture of the duodenum suffered by Kundayi.

However, they also agreed that Kundayi's presentation namely pain and presence of abdominal tenderness,

“demanded that the doctor should undertake further assessment in order to determine the cause of the pain. It was not reasonable or appropriate for the doctor to dismiss the pain and tenderness as a possible muscle injury without considering and confirming or excluding the possibility of injury to internal abdominal organs”¹².

They also agreed that:

“It would be reasonable to expect that an ordinary skilled hospital doctor would have appreciated the need to exclude the possibility of injury to internal abdominal organs when Kundayi presented with severe abdominal pain and upper abdominal tenderness following an upper abdominal injury.

Given Kundayi's persistent severe pain and abdominal tenderness, Dr Radeeka's failure to consider the possibility of injury to his internal organs and to confirm or exclude that possibility by.....consulting with a specialist surgeon or emergency physician represents a major departure from what would have been widely accepted by peer professional opinion in Australia in 2010 to be competent professional practice”¹³.

I note that all the experts in their oral evidence, were of the view that they did not expect Dr. Liyanage to order a CT scan of the abdomen but that she should have consulted a more senior medical officer or staff specialist in relation to Kundayi's persistent abdominal pain and tenderness and ensured that he was observed until a proper

¹² exhibit 2, volume 1, report of Dr Raftos dated 4 August 2010 page 8;

¹³ *ibid*;

diagnosis explaining the pain had been made or the pain had completely resolved. I note that all the experts agreed that it is rare to have “abdominal muscle bruising”.

Unfortunately Dr. Liyanage, at the time of treating Kundayi, had gaps in her knowledge. Quite simply “she did not know what she did not know”. She had made her diagnosis namely a “muscle injury”. She was under no direct supervision at the time, despite the fact she had only worked at Campbelltown Hospital for 3 months, and was only to seek out guidance or supervision from a more senior practitioner if she thought she required it. Accordingly, Kundayi’s true diagnosis went unnoticed.

After Kundayi was seen and examined by Dr. Liyanage, he was given the prescribed Nurofen and Panadeine Forte and asked to wait in the wheelchair in the waiting room, despite Mrs. Chiundiza’s protests that her son was sleepy and wanted to lie down.

It was Dr. Liyanage’s evidence that after she examined Kundayi she did the following:

1. She was finishing her shift and gave an oral handover to Dr Kailanathan Ayngkaran to the effect that Kundayi had been injured in a rugby game, that it appears to be a muscular injury and the plan was to discharge patient if pain settles with medication.
2. She asked the Clinical Initiative Nurse (“**CIN**”) to “observe the patient and to inform doctors of improvement or deterioration of the patient”
3. She gave no instructions either in her notes or otherwise for how long Kundayi was to be observed prior to discharge, but simply that he could be discharged once the pain has settled;

I am not overly critical of Dr. Liyanage’s examination and assessment of Kundayi. I am however critical of her failure to ensure he remained for a proper period of observations

(namely at least four hours) and that those observations were to be conducted in a proper and reasonable manner namely in a bed (as soon as one became available), with regular observation and recording of vital signs and pain levels.

CLINICAL INITIATIVE NURSE, BRONWYN JAMES

Nurse James was the Clinical Initiative Nurse on shift on 19 June from 7am to 7.30pm. As she explained, her role as CIN is to take care of patients in the waiting room after they have been triaged but before they are seen by a Medical Officer. The CIN can re-triage if necessary and may also give pain relief, but their main duty is to review and communicate with the patient, and the patient's family members, prior to them being seen by the Medical Officer.

There is some controversy over what instructions were given by Dr. Liyanage to nurse James regarding the care and treatment of Kundayi.

Firstly, in the statement that she prepared one week after Kundayi's death, Dr. Liyanage states:

"Clinical Initiative Nurse advised to observe patient and to inform doctors or (sic) improvement or deterioration of patient".

However in her oral evidence this week, Dr. Liyanage said that she asked the CIN to observe Kundayi, and later in her evidence, that she asked her to do a "set of obs".

Nurse James records in her statement dated 28 June 2010 the following, that to the best of her recollection:

*“Dr Radeeka came and told me that Mr Chiundiza was in the waiting room. Dr. Radeeka showed Mr. Chiundiza’s notes in the waiting room box and told me that she had handed over his care Dr Karan”.*¹⁴

Furthermore, in her oral evidence Nurse James agreed that she was asked to observe Kundayi while he was waiting for that medical review.

Mr Strickland SC suggested to Nurse James in cross examination that she was asked to do a “set of obs” however, in re- examination by Dr. Dwyer it was clear that if she had been asked to “do a set of obs” she would have done just that, namely, followed the doctor’s direction, taken a set of observations, namely blood pressure, temperature, heart rate etc and then recorded those observations on the appropriate chart that would have been included in the patients notes. As the chart does not appear in Kundayi’s hospital notes, I am satisfied on balance that all that Dr. Liyanage asked Nurse James to do was to observe Kundayi while he remained in the waiting room.

Nurse James did take notes of what she physically observed of Kundayi and her discussion with his mother and she recorded them carefully on 19 June. She gave evidence that she had been concerned by what Kundayi’s mother told her about his level of drowsiness. When first told that he was drowsy, she offered an explanation that this might have been caused by the Panedeine Forte he had been given. However, when told by Mrs Chiundiza that Kundayi had been drowsy since the incident, and that he had not hit his head, or suffered any loss of consciousness, then she considered that the drowsiness was a troubling symptom. Nurse James could not recall whether she had spoken to Dr Angykararan about Kundayi’s drowsiness, but she assumed that the

¹⁴ exhibit 2, volume 2 tab 18 paragraph 7;

doctor would read her notes about it prior to his review of the patient. As she said in evidence “why else would she make them”.

Nurse James was a forthright and honest witness. She attended to Kundayi in a timely manner (particularly bearing in mind the pressures she was under on 19 June 2010) and most notably she was the only medical practitioner who listened to Mrs Chiundiza’s concerns and recorded them and she should be commended for doing so.

DR KAILANATHAN AYNGKARAN

As at 19 June 2010, Dr. Ayngkaran had just over 6 months experience, as a Career Medical officer at the Campbelltown Hospital Emergency Department. He was at that time considered senior enough to supervise other more junior doctors within the Emergency Department.

Dr. Ayngkaran’s evidence before this inquest consists of the following:

1. His contemporaneous handwritten note that he had advised Kundayi of the sedative effect of Panadeine Forte¹⁵;
2. His typed notes on the discharge summary which consisted of:
“pain settled with Neurofen 400 and Panadein Forte 2 tabs.
Observed in ED.
CSR – No obvious abnormalities
Plan on Dx
Panadine forte 2 tab PRN

¹⁵ exhibit 2 volume 1 tab 20 page 121;

GP R/V in 2 days

Come to ED in any concern"

3. His statement prepared approximately 1 week after Kundayi's death; and
4. His oral evidence.

As Dr. Ayngkaran's contemporaneous notes are almost non-existent I am left to consider his evidence on the basis of his written statement prepared some time after the event and his oral evidence which can be summarised as follows:

1. He received an oral handover in relation to Kundayi and his symptoms from his colleague Dr. Liyanage;
2. He did not read Dr. Liyanage's notes regarding her examination and findings in relation to Kundayi;
3. He had been approached by Nurse James to review Kundayi and that he had been told by Nurse James that "his pain was better". He does not recall if she mentioned the issue about Kundayi being drowsy or his mother's concern about his drowsiness. He did not read the notes on the file by Nurse James.
4. He had looked for but was unable to find any beds available in the emergency department on which to examine Kundayi;
5. He therefore approached Kundayi in the waiting room. Kundayi was sitting in the wheelchair and was "tossing the methoxy whistle up and down" and did not appear to be in pain. He had a brief conversation with Kundayi and was advised that "the pain was better after the medication". Kundayi did not appear to be drowsy. He asked Kundayi if he could "palpate his tummy", which he did whilst Kundayi remained in the wheelchair and he asked Kundayi to tell him if it was sore. Kundayi did not respond. Kundayi then asked him if he could go and he responded with "not yet" as he needed to get him a discharge letter and prescription.

6. Dr. Ayngkaran then arranged the prescription for Panadiene Forte and completed the discharge letter which was sealed in an envelope. He returned to the waiting room and handed the documents to Kundayi. He then says he said to Kundayi and his mother “that they were to go to the GP the next day and to return to an Emergency Department if there is a reappearance of chest or abdominal pain, dizziness, vomiting, headache or any new symptoms”¹⁶

Mrs. Chiundiza’s evidence in relation to Dr. Ayngkaran is markedly different. Her evidence (which again I note was consistent throughout her various statements and oral evidence) was:

1. Dr. Ayngkaran attended to Kundayi in the waiting room and said “The doctor who first saw you has finished her shift. The x-ray is clear. I am going to give you a prescription for Panadeine Forte and a letter to take to your GP on Monday.”¹⁷
2. That she:
 - a. Was never advised to return to the Emergency Department if the pain reoccurred;
 - b. That she was not told to see the GP the next day but to take Kundayi to the GP on Monday;
 - c. Was given no information for symptoms to look out for like nausea, vomiting or reoccurrence of pain;
3. Furthermore Mrs. Chiundiza categorically denied that she observed Dr. Ayngkaran examine Kundayi in the wheelchair or that Kundayi was sitting in the wheelchair prior to seeing Dr. Ayngkaran tossing or playing with the methoxy whistle.

¹⁶ exhibit 2, volume 1 tab 13;

¹⁷ exhibit 2, volume 1 tab 8, second statement paragraph 32;

Mr. Strickland SC, Counsel for Dr. Ayngkaran, submitted that I should prefer the evidence of Dr. Ayngkaran over that of Mrs Chiundiza in that the examination of Kundayi's abdomen did take place in the wheelchair and that Mrs Chiundiza may have missed it or simply did not recall it. She was on her own admission in a stressed state and that could explain this.

Once again I do not agree. Mrs Chiundiza's evidence was clear, concise and at no time did she attempt to embellish with respect to the events surrounding Kundayi's death.

Dr. Ayngkaran thought it important to record the side effects in relation to the Panadeine Forte but not that the tenderness had subsided on palpitation. It beggars belief that if Dr. Ayngkaran had in fact examined Kundayi in the wheelchair and found no tenderness that he would not have recorded that fact either in the handwritten notes or within the discharge letter. Accordingly, on the balance of probabilities I am not satisfied that Dr. Ayngkaran examined Kundayi in the wheelchair by palpating his abdomen.

Furthermore, despite the notation in the discharge letter of "*come to ED in (sic) any concerns*" I do not accept that Dr. Ayngkaran advised Mrs. Chiundiza or Kundayi to return to an emergency department if the pain reoccurred or he experienced any other symptoms.

I was left with no doubt that Mrs Chiundiza was an attentive, caring and devoted mother. If she had been advised to take Kundayi back to an emergency department if the pain reoccurred or even increased she would have done so. Accordingly, on balance, I am satisfied she was not given that advice.

Dr. Ayngkaran conceded during the inquest that:

1. His notes were inadequate;

2. He should not have simply accepted Dr. Liyanage's diagnosis of a muscle injury without carrying out his own assessment and examination;
3. Even accepting that he had carried out an examination of Kundayi's abdomen in the wheelchair (which I do not) that it is not appropriate to conduct such an examination as any result in such circumstances is of no clinical value;

Mr. Strickland SC submitted the following:

1. That even if Dr. Ayngkaran had taken the most comprehensive clinical notes of his examination and treatment it would not have altered his misdiagnosis;
2. That all the experts who provided evidence to the inquest agreed that Dr. Ayngkaran's poor clinical notes were not crucial to his diagnosis;
3. Dr. Ayngkaran had simply assumed that any injury suffered by Kundayi was muscular and not an internal abdominal injury, having accepted Dr. Liyanage's diagnosis without making his own assessment and examination;
4. That the specialist experts were unanimous that Dr. Ayngkaran's failure to diagnose the perforation of the duodenum did not constitute conduct significantly below the standard of care reasonably expected of a doctor of equivalent level of training and experience;
5. Taking into account the suboptimal environment in which Dr. Ayngkaran was working in on 19 June 2010 the experts agreed that if Dr. Ayngkaran had examined Kundayi's abdomen in the waiting room doing so did not fall significantly below the standard of care reasonably expected of a doctor of equivalent level of training and experience.

However I have found that Dr. Ayngkaran did not perform even a cursory examination in the waiting room and in such circumstances it was the view of Dr Sammut and Professor Fulde that Dr. Ayngkaran's standard of care did fall significantly below the standard of care of a doctor of equivalent training and experience.

Were Kundayi and his mother appropriately advised of the strategies for monitoring and caring for Kundayi once he was discharged?

I have previously found that despite the notation in the discharge letter made by Dr. Ayngkaran of “come to ED in (sic) any concerns” I do not accept that Dr. Ayngkaran advised Mrs. Chiundiza or Kundayi to return to an emergency department if the pain reoccurred or he experienced any other symptoms.

I was left with no doubt that Mrs Chiundiza was an attentive, caring and devoted mother. If she had been advised to take Kundayi back to an emergency department if the pain reoccurred or even increased she would have done so. Accordingly on balance I am satisfied she was not given that advice.

Kundayi Chiundiza was an active, healthy, strong and fit young man prior to the injury he sustained on 19 June 2010. He presented to Campbelltown Hospital Emergency Department with abdominal pain and was discharged with a prescription for Panadeine Forte as needed into care of his mother only one hour after he was triaged, and whilst he was still in pain. His discharge instructions were limited at best he as was not advised to return to an Emergency Department if the pain got worse or reoccurred. In fact whilst at home and prior to his death Kundayi asked his mum when they could go to the doctor, and she told him that she intended to take him first thing the following morning as instructed to by Dr. Ayngkaran but by which time it was too late.

I have heard a lot of evidence from highly regarded emergency specialists during the course of this inquest. The system as it was in June 2010 at Campbelltown Hospital, was strained. There was clearly a shortage of beds and medical staff. Kundayi's death was not a result of one simple mistake but a system breakdown that led to the tragic death of this young man cut short in his prime. The two junior doctors that attended to Kundayi had clear gaps in their respective medical knowledge that had to this point not been recognised by their superiors. Unfortunately it has taken this tragedy for this lack of knowledge to be recognised.

The inadequacy of contemporaneous notes (or virtually non-existent ones) may not have directly led to Kundayi's misdiagnosis but in my view is an indicator that there is something amiss in someone's training and communication skills. Working in a hospital environment involves teamwork between staff on all levels, effective communication between the staff and the various specialities is essential. None of the notes taken by the treating doctors referred to Kundayi's pain in a meaningful way and at no point could anyone later assess the pain and by how much had it improved or in fact objectively whether it had in fact improved at all while he was in the hospital.

Accordingly some initial supervision of junior doctors newly employed into an Emergency Department needs to be considered.

I note that after the tragic death of Kundayi, the Western Area Health Service conducted an audit of its procedures and commissioned a detailed report into the circumstances of Kundayi's death from Dr. Sammut. That report and the actions taken in relation to it

form part of the Coronial brief. I do not intend to recite those changes in these findings but note that they have been made and commend the Western Area Health Service for having made them.

CONCLUSION

Accordingly I now turn to the findings I am required to make pursuant to section 81 of the *Coroners Act 2009*.

I find that Kundayi Chiundiza died on 21 June 2010 at unit 3/512 New Canterbury Road, Dulwich Hill from peritonitis as a result of a ruptured duodenum following blunt trauma of the torso.

Pursuant to section 82 of the *Coroners Act 2009* I make the following recommendations arising out of the death and subsequent inquest into the death of Kundayi Chiundiza:

1. To the Minister of NSW Health:

Noting that the Garling Report made a recommendation concerning the supervision of junior clinicians which appears to very useful but does not cover the situation for overseas trained doctors that have more than two years post graduate experience in countries outside of Australia, I make the following recommendation:

NSW Health should consider developing and implementing statewide policies setting out a best practice model for the supervision of overseas trained non specialist doctors working in Australian hospitals for the first time. This policy should:

- a. define supervision;
- b. define the objectives and content of supervision;
- c. define the supervisory relationship including the roles and responsibilities of clinical supervisors and trainees;
- d. set out mechanisms for resolving difficulties relating to inadequate supervision; and
- e. recognise the importance of the supervisors role.

2. To the Executive Officer of the Australian Medical Council:

The Australian Medical Council should consider introducing specific topics in the examination required for the registration of overseas trained doctors which address the following:

- a. communication skills;
- b. handover; and
- c. note taking.

3. To the Executive officer of the NSW Medical Board:

The NSW Medical Board should give consideration to the need for better pathways of supervision for overseas trained non specialist doctors working in

NSW hospitals for the first time and that the NSW Medical Board should liaise with NSW Health in this regard.

16 September 2011

Magistrate Sharon Freund

Deputy State Coroner