CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Shirley Elizabeth Haggett**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/2190
DELIVERED ON:	23 October 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	4 December 2023, 5 December 2023, 6 December 2023, 7 December 2023, 11 March 2024, 12 March 2024, 14 March 2024, 15 March 2024.
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, health care related death. Chronic respiratory failure, surgical removal of melanoma, high flow nasal oxygen and sedation, private hospital, post operative aspiration, delayed transfer to ICU.
REPRESENTATION:	DJ Schneidewin, Counsel Assisting G Diehm KC for Dr Jarrod Ngan

A Luchich for Dr Andrew Smith

N Mason for Metro North Hospital and Health Service (Redcliffe Hospital) and Dr Robert Nicholson

M T Hickey OAM KC for North Lakes Day Hospital

S Robb KC for CN Susan Laws, RN Amy Connelly and CN Josephine Smith

C Templeton for Dr Claire Ferreira and Dr Colin Armstrong

ORDERS:	Non-Publication order made 12 March 2024

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Introduction

[1] Shirley Elizabeth Haggett (Mrs Haggett) was born on 5 August 1940.

[2] Mrs Haggett died at the Redcliffe Hospital on 22 May 2019. She was aged 78 years.

[3] Mrs Haggett is survived by her husband Mr Peter Haggett, her children and other members of her family.

Coronial jurisdiction

[4] At the time of her passing, Mrs Haggett was a patient at the Redcliffe Hospital.

[5] I consider that Mrs Haggett's death was a health care related death as defined by the *Coroners Act 2003* (the Act). Mrs Haggett's death was thereby a reportable death under s.8(3)(d) of the Act.

[6] Pursuant to s.28(1) the Act of the, I was satisfied that it was in the public interest to hold and inquest into Mrs Haggett's death.

[7] An inquest is intended to provide the public and, the family of the deceased, with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death.

[8] The role of the Coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances surrounding the death, i.e. how the person died. Those circumstances are limited to events which are sufficiently connected to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Those are matters for other courts.

[9] The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[1] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the Coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer…In such matters 'reasonable satisfaction' should not be*

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[1] *Briginshaw v Briginshaw* (138) 60 CLR 336

produced by inexact proofs, indefinite testimony, or indirect inferences.[2]

[10] In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[3] As outlined in 'The Australasian Coroners Manual':

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation. … Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there. … Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[4]

Coronial investigation

[11] The coronial investigation revealed the following factual circumstances.

[12] Mrs Haggett had a past medical history of:

a) Bronchiectasis requiring home oxygen.

b) Chronic hypercapnia (type 2 respiratory failure).

c) Parathyroid mediated hypercalcaemia.

d) Malnutrition.

e) Osteoporosis.

f) Hypertension.

g) Previous melanoma.

h) Penicillin anaphylaxis.

[13] Mrs Haggett's usual general practitioner since 2015, was Dr Claire Ferreira (Dr Ferreira) of Narangba Doctors.

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2 *Briginshaw v Briginshaw* (138) 60 CLR 336, 362 – 363 (Dixon J)
3 Findings of the inquest into the death of Pasquale Roasario Giorgio, [140] – [142]
4 Hugh Dillon and Marie Hadley, The Australasian Coroner's Manual (The Federation Press, 2015) 10

[14] On 24 April 2019, Mrs Haggett presented for a skin cancer check to Dr Colin Armstrong (Dr Armstrong). Dr Armstrong identified a change in pigmentation of her skin on her right nose sidewall and right inner canthus.

[15] Dr Armstrong performed a biopsy on those sites on 29 April 2019.

[16] The histopathology identified a melanoma *in situ* on the right inner canthus and an invasive level 2 melanoma on the right nose sidewall.[5]

[17] On 1 May 2019, Dr Armstrong reviewed Mrs Haggett and explained the biopsy results. Various treatment options were discussed. Dr Armstrong recommended referral to Dr Andrew Smith (Dr Smith) of Northpoint Eye Care, to whom he had referred patients previously.

[18] Dr Smith is an Ophthalmologist with experience in the performance of oculoplastic surgery.

[19] In his referral letter to Dr Smith dated 1 May 2019, Dr Armstrong noted that "*Shirley's respiratory function will be a concerning factor*".[6]

[20] Mrs Haggett had history of bronchiectasis/ asthma for which she had been under the care of her respiratory team at The Prince Charles Hospital (TPCH) for many years.

[21] She had last been reviewed at the Respiratory Clinic at TPCH in February 2019 after a troublesome time the previous year in September and October when she was hospitalised for a multilobar pneumonia.

[22] Specifically, Mrs Haggett had two admissions to TPCH approximately seven months prior to her initial consultation with Dr Smith.

[23] The TPCH Discharge Referral from Mrs Haggett's admission to TPCH was sent to Dr Ferreira, as her usual GP, on or about 10 October 2018.[7]

[24] This Discharge Referral detailed her admission to TPCH from 30 September 2018 to 3 October 2018, and noted a previous admission and discharge on 17 September 2018.

[25] The Discharge Referral listed information about Mrs Haggett's chronic type II respiratory failure, bronchiectasis and that it had been identified she required home oxygen, which was arranged prior to her discharge from TPCH.

[26] In addition to the bronchiectasis/ asthma, Mrs Haggett had chronic obstructive airways disease (COAD) and a history of chronic hypercapnia.

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[5] Exhibit C5 BOE, pp. 9-10
[6] Exhibit C5 BOE, p. 11
[7] Exhibit C4 BOE, p.163

[27] Mrs Haggett's health summary from Narangba Doctors detailed several presentations to her GP for intravenous antibiotics (Ceftriaxone), for her significant lung disease.[8]

[28] Following on from the TPCH review in February 2019, Mrs Haggett was continued on home oxygen. She had limited walking tolerance and used a wheelie walker.

[29] Mrs Haggett's other co-morbidities included osteoporosis, primary hyperparathyroidism, hypertension, previous melanomas and malnutrition. Her Body Mass Index (BMI) was just less than 15.

[30] Dr Armstrong's referral letter to Dr Smith set out Mrs Haggett's history of previous melanoma, hypertension and COAD.[9]

[31] Dr Smith saw Mrs Haggett with her husband in rooms on 9 May 2019. A further history about her co-morbidities and medication was extracted from her.

[32] However, Dr Smith did not note that Mrs Haggett was then on home oxygen or that she had been on long term antibiotics for her bronchiectasis.

[33] Dr Smith had concerns about Mrs Haggett's co-morbidities and her respiratory function. He explained to Mrs Haggett that her underlying COAD and anaesthetic risk was potentially life threatening. Anaesthetic options were discussed.

[34] Dr Smith stated that he clearly recalled that Mrs Haggett was adamant that she wanted to have the melanoma removed.

[35] It was resolved that Dr Smith would discuss the treatment plan with Dr Armstrong, Dr Smith did not discuss the treatment plan with Dr Ferreria.

[36] The extent of the discussions between Dr Smith and Dr Armstrong regarding the treatment plan was explored at inquest.

[37] Dr Smith subsequently contacted Mrs Haggett to explain that surgery was required to excise the underlying lesions to reduce the risk of life-threatening metastases.

[38] A letter was then sent to Mrs Haggett confirming the right lower lid medial superficial melanoma and right nasal bridge large extensive melanoma removal and repair were scheduled to occur on Monday 20 May 2019 at Montserrat North Lakes Day Hospital (NLDH).[10]

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[8] Exhibit C4 BOE, p. 3
[9] Exhibit C5 BOE, p. 11
[10] Exhibit C3 BOE, p.16

[39] On 14 May 2019, RN Anne Nance (RN Nance) of NLDH conducted a pre-admission screening with Mrs Haggett by telephone. RN Nance noted on the Surgical Risk Assessment form an anaesthetic variance of "Bronchielitus", not "Bronchiectasis", the latter being the condition Mrs Haggett in fact suffered.[11]

[40] On the Surgical Risk Assessment form, associated with the anaesthetic variant section, there were two boxes, one with "notified doctor" and the other with "notified anaesthetist". RN Nance ticked the "notified doctor" box. The "notified anaesthetist" box was not ticked.

[41] RN Nance also noted on Health Assessment form, under the section "Any Lung/breathing condition" that Mrs Haggett had a history of "Pneumonia / Bronchielitis".[12]

[42] On the day of the surgery, 20 May 2019, Mrs Haggett presented to NLDH with a four wheeled wheelie walker.

[43] The next assessment of Mrs Haggett was by the Admitting Nurse, RN Babbage, who filled in the Surgical Pathway Admission form on the morning the surgery was scheduled, 20 May 2019 from about 9.00 am. With respect to the VTE Variance section, RN Babbage noted Mrs Haggett "cannot lie flat", and the "Notify Anaesthetist" box was ticked.[13] On the Clinical Alert Form, RN Babbage noted in the Clinical Alerts section "cannot lie flat on back, [high] BP, Brochielitus Pneumonia Oct 2018."[14]

[44] The Anaesthetist assigned to Mrs Haggett's surgery was Dr Jarrod Ngan (Dr Ngan). Dr Ngan and Dr Smith had worked together often.

[45] Dr Ngan had not consulted with Mrs Haggett prior to the morning of the surgery. The content of any pre-operative discussions between Dr Ngan and Dr Smith was explored at the Inquest.

[46] Dr Ngan consulted with both Mrs Haggett and Mr Haggett and he performed an assessment.

[47] The Surgical Pre-Anaesthetic Assessment form[15] indicates that Dr Ngan noted that Mrs Haggett had severe COAD, was unable to lie flat, had shortness of breath at rest (SOBAR), had SPO2 (oxygen saturation measured by pulse oximeter) on room air at 92-94%, and hypertension. Dr Ngan assessed Mrs Haggett as being "unsuitable for GA [General Anaesthetic]." The Anaesthetic Plan was for High Flow Nasal Oxygen (HFNO) and sedation in a sitting position.

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[11] Exhibit C1.1 BOE, p. 18
[12] Exhibit C1.1 BOE, p. 11
[13] Exhibit C1.1 BOE, p. 14
[14] Exhibit C1.1 BOE, p. 12
[15] Exhibit C1.1 BOE, p. 15

[48] There was no record that Dr Ngan performed chest auscultation upon Mrs Haggett.

[49] By the American Society of Anesthesiologists Physical Status Classification System, Dr Ngan assessed Mrs Haggett as ASA 4, as noted on the Surgical Anaesthetic Report.[16]

[50] The NLDH was not licensed to admit and treat ASA 4 patients.

[51] Despite this, the pro-forma Surgical Anaesthetic Report completed by Dr Ngan made provision for a patient to be noted as an ASA 4 patient (by the pro-forma ASA 4 box, which Dr Ngan ticked).

[52] Mrs Haggett entered the Operating Theatre at about 11:00 hours.

[53] On the Surgical Scrub/ Scout Record,[17] the anaesthetic start time was recorded as 11:18 hours and the anaesthetic finish time was recorded as 13:33 hours, about 2 ¼ hours duration.

[54] During that time, Mrs Haggett was administered Midazolam (a benzodiazepine) and Fentanyl (a narcotic), together with high flow and high concentration oxygen, at 60 – 70 L/min to maintain her saturations at 95% to 98% during the procedure.[18]

[55] At the end of the surgery, Mrs Haggett was administered 400 micrograms of Flumazenil (a benzodiazepine reversal agent) and 100 micrograms of Naloxone/ Narcan (narcotic reversal agent).

[56] No other anaesthetic agents are recorded as being used, apart from the local anaesthetic used at the site of the surgery.

[57] There are some discrepancies in the Surgical Anaesthetic Report, which were explored at the Inquest.

[58] Mrs Haggett arrived in NLDH Post Anaesthetic Recovery Unit (PACU) just prior to 13:39 hours according to the Adult Observation and Response Chart.[19]

[59] Apart from a brief period at around 16:00 hours when she was returned to the theatre following a sudden deterioration in her condition at around 15:45 hours, Mrs Haggett remained in the PACU until the Queensland Ambulance Services (QAS) transported her from NLDH to Redcliffe Hospital at or about16:26 hours.[20]

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[16] Exhibit C1.1 BOE, p.8
[17] Exhibit C1.1 BOE, p.3
[18] Exhibit C1.1 BOE, p. 8
[19] Exhibit E18 BOE (coloured copied)
[20] Exhibit C7 BOE

[60] The circumstances surrounding Mrs Haggett's time in the PACU are complex, with many competing accounts of what occurred, which were explored at the Inquest.

[61] In summary, the records indicate that:

a) When Mrs Haggett arrived in Recovery at 13.39 hours she was short of breath, with a respiratory rate of 32 and SpO2 of 89% on nasal prongs at 2 litres only;

b) There were no notes written by Dr Ngan in Mrs Haggett's chart after she left the theatre;

c) Mrs Haggett's respiratory rate was mostly above or around 30 breaths/minute for the period she was in PACU;

d) From 14.30 hours, no oxygen saturations were recorded, with a note at 15:00 hours suggesting that oxygen saturations could not be measured. There were only 3 low measurements (all at or less than 84%) taken after that.

e) Mrs Haggett's oxygen saturations were, at best, 90%, but mostly in the 80s when they were recorded, dipping down at one stage to around 73% at 15:19 hours.

f) At 15:45 hours there was a sudden deterioration in Mrs Haggett's condition when she started to cough.[21]

[62] According to QAS records, the QAS was called at 16:00 hours.[22]

[63] At around 16:00 hours (perhaps a bit later, but before QAS arrived) Mrs Haggett was returned to theatre in response to her low saturations and was put on further high flow oxygen.

[64] The QAS arrived at NLDH at 16:06 hours. [23]

[65] The QAS transported Mrs Haggett to the Redcliffe Hospital Emergency Department (ED). She arrived at 16:41 hours and was admitted to the ED at 16:46 hours. She was noted to be drowsy with a partially obstructed airway.[24]

[66] Mrs Haggett was examined in the ED at about 16:55 hours. Her examination demonstrated widespread course crackles, with reduced air entry into the left lung. At that time her oxygen saturations were 77% on

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[21] Exhibit C1.1 BOE, p. 13
[22] Exhibit C7 BOE
[23] Exhibit C7 BOE
[24] Exhibit C7 BOE

15L of oxygen via a non-re-breathe mask. Her respiratory rate was 32 and her heart rate was 95. Her BP was 150/60.[25]

[67] Venous blood gas results taken at 16:47 hours demonstrated an acute on chronic type two respiratory failure.[26]

[68] Mrs Haggett was noted to be very unwell with a guarded prognosis, so the ED contacted the ICU team for her assisted transfer to ICU.

[69] Despite the cares that were provided in the ED, Mrs Haggett's respiratory effort was decreasing, (her oxygen levels were dropping and carbon dioxide levels rising), and her consciousness level was worsening.

[70] She had a chest x-ray that was in keeping with aspiration and she had a blood gas that showed her respiratory effort was initially poor but had worsened during her initial trial of non-invasive treatment.

[71] In addition, due to her prior surgery earlier that day on her nose and the way in which the non-invasive ventilation mask fits on the face, there was difficulty in supporting her effectively with this device due to inevitable mask leak.[27]

[72] ED and ICU staff arranged a family meeting to explain the complexities of the situation to Mrs Haggett's family.[28] Following that meeting, the medical notes record that it was mutually agreed between medical staff and Mrs Haggett's family that she would be intubated. However, this was disputed by Mrs Haggett's next of kin at the inquest.[29]

[73] There were no complications with the intubation.[30] Mrs Haggett was moved to ICU where she was ventilated.

[74] The working diagnosis was of an aspiration event, with resultant aspiration pneumonia. Mrs Haggett required inotropic medication to maintain blood pressure. Antibiotics were given to cover the aspiration event. Hydrocortisone was also given.

[75] Unfortunately, Mrs Haggett's condition did not improve, and she developed multiple organ failure.

[76] At about 21:00 hours on 21 May 2019, a bronchoscopy was performed and a large amount of fluid was suctioned from Mrs Haggett's lungs.

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[25] Exhibit B17 BOE, paragraph 9
[26] Exhibit B17 BOE, paragraph 11
[27] Exhibit B16 BOE, paragraph 11(c)
[28] Exhibit B16 BOE, paragraph 13; see also Exhibit C2 BOE, p. 36
[29] T1-8, LL 38-47.
[30] Exhibit B16 BOE, paragraph 11(f)

[77] At 22:30 hours on 21 May 2019, Mrs Haggett developed hypotension and became difficult to ventilate. A chest x-ray revealed a right-sided tension pneumothorax considered to be a likely complication of the bronchoscopy.

[78] An urgent thoracotomy was performed but soon after Mrs Haggett suffered a cardiac arrest.

[79] Mrs Haggett was declared deceased at 00:38 hours on 22 May 2019.

Death Certificate

[80] At autopsy performed on 31 May 2019, the cause of death, found by Forensic Pathologist, Dr Rebecca Williams (Dr Williams), was:[31]

> "*1(a) Tension pneumothorax (surgically managed) due to, or as a consequence of*
> *1(b) Aspiration pneumonia (bronchoscopy) due to, or as a consequence of*
> *1(c) Facial melanoma (excision under general anaesthesia).*
> *2. Bronchiectasis and coronary atherosclerosis*."

Inquest

[81] A Pre-Inquest Conference was held on 13 July 2023.

Issues for Inquest

[82] The List of Issues for the Inquest were:

> "1. The findings required by s45(2) *Coroners Act 2003;* namely the identity of Mrs Haggett (deceased), when, where and how she died and what caused her death.
>
> 2. The adequacy and appropriateness of the pre-admission screening procedures and protocols at NLDH (Hospital) in the context of the following:
>
>   a) The Hospital's licence limitations for the admission of patients to day surgery;
>
>   b) The assessment of the suitability of high risk patients for admission to the Hospital for day surgery;
>
>   c) The communication of pre-admission screening information to treating medical practitioners prior to the admission of patients to the Hospital for day surgery.

[31] Exhibit A3 BOE

3. The adequacy and appropriateness of the pre-operative surgical assessment of the suitability of the deceased to undergo day surgery at the Hospital including, but not limited to, the pre-operative estimate of the length of the surgery.

4. The adequacy and appropriateness of the pre-operative anaesthetic assessment of the suitability of the deceased to undergo day surgery at the Hospital.

5. The adequacy and appropriateness of the surgical management and treatment of the deceased intra-operatively.

6. The adequacy and appropriateness of the anaesthetic management and treatment of the deceased intra-operatively including, but not limited to, the choice of technique used to anaesthetise the deceased.

7. The adequacy and appropriateness of the surgical management and treatment of the deceased post-surgery.

8. The adequacy and appropriateness of the anaesthetic management and treatment of the deceased post-surgery.

9. The adequacy and appropriateness of the Hospital's management and treatment of the deceased post-surgery.

10. The adequacy and appropriateness of the decision to transfer the deceased to the Redcliffe Hospital Emergency Department (ED) including, but not limited to, as to the timing of that decision.

11. The adequacy and appropriateness of the deceased's management and treatment in the ED.

12. The adequacy and appropriateness of the deceased's management and treatment in the Intensive Care Unit of the Redcliffe Hospital.

13. Whether any aspect of the treatment and management provided to the deceased caused or hastened her death?

14. Whether any failure to provide treatment and management to the deceased caused or hastened her death?

Witnesses called

[83] In addition to the evidence contained in the BOE, the following witnesses provided oral evidence at the Inquest:

a) Dr Claire Ferreira;[32]

b) Dr Colin Armstrong;[33]

c) Registered Nurse Anne Nance;[34]

d) Registered Nurse Juliet Babbage;[35]

e) Dr Andrew Smith;[36]

f) Registered Nurse Amy Connolly;[37]

g) Registered Nurse Lisa Tomczak;[38]

h) Clinical Nurse Susan Laws;[39]

i) Clinical Nurse Josephine Smith;[40]

j) Registered Nurse Michelle Bain;[41]

k) Director of Clinical Services Patricia Mukauskas;[42]

l) Margaret Kenny;[43]

m) Dr Jarrod Ngan;[44]

n) Dr Susan Shadforth (expert witness);

o) Dr William Glasson (expert witness);

p) Dr Drew Wenck (expert witness);

q) Dr James Bradley (expert witness).

Hearing

[84] The Inquest commenced on 4 December 2023 and continued on 5 December 2023, 6 December 2024 and 7 December 2024. The Inquest was then adjourned for further hearing commencing on 11 March 2024, continuing on 12 March 2024, 14 March 2024 and ending on 15 March

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[32] Ex B20 BOE; T1-11 – T1-19
[33] Ex B18 BOE, T1-21– T1-38.
[34] Ex B7 BOE, T1-39 – T1-57.
[35] Ex B21 BOE; T1-59-T1-73.
[36] Ex B9 BOE; T2-4- T2-70.
[37] Ex B3 BOE; T3-2 – T3-47.
[38] Ex B11 BOE; T3-48 – T3-68.
[39] Ex B5 BOE, T3-70 – T3-84.
[40] Ex B10 BOE; T3-86 – T3-112.
[41] Ex B2 BOE; T4-3 – T4-20.
[42] Ex B6 BOE; T4-21 – T4-68.
[43] Ex D5 BOE; T4-71 – T4-83
[44] Ex B8 BOE;

2024. The Brief of Evidence (BOE) was formally tendered at the start of the Inquest.

[85] In addition to Counsel Assisting's written submissions, written submissions by the following have been received and considered by me in preparing these findings:

a) Mr Diehm KC for Dr Ngan;

b) Mr Luchich for Dr Andrew Smith;

c) Ms Mason for Metro North Hospital and Health Service (Redcliffe Hospital) and Dr Robert Nicholson;

d) Mr Hickey OAM KC for North Lakes Day Hospital;

e) Ms Robb KC for CN Susan Laws, RN Amy Connelly and CN Josephine Smith.

[86] Having regard to the evidence heard at the Inquest, I did not require written submissions from Mr Templeton on behalf of Dr Ferreira and Dr Armstrong.

Evidence and findings on issues

[87] For the sake of convenience and expedience, by his written submissions Counsel Assisting combined and grouped together some of the issues that are contained within the List of Issues. I will adopt a similar approach.

[88] As Counsel Assisting also did, before turning to the List of Issues, I will deal with the fundamental, overarching factual matter.

Prior to the surgery, Mrs Haggett was identified as an ASA 4 patient[45]

[89] On the morning of the surgery, but not prior to that, Dr Ngan correctly identified Mrs Haggett as an ASA 4 patient.[46]

[90] The Clinical Services Capability Framework (CSCF) for private and licensed facilities mandated that NLDH was licenced only for the admission and surgical treatment of ASA 1, 2 and stable 3 patients.

[91] Ms Kenny, the Clinical Operational and Excellence Director of Nexus Hospitals Pty Ltd (Nexus)[47] explained:[48]

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[45] This addresses, in part, Issues 2, 3 and 4.
[46] Opinion of Dr Shadforth Exhibit G1 BOE, p.17, paragraph 5.19; Evidence of Dr Bradley at Inquest, 15 March 2024, T4-5 LL11-12
[47] Nexus acquired the Montserrat Day Hospitals, including NLDH on 1 May 2023: Exhibit B19 BOE, paragraph 2
[48] Exhibit B19 BOE, starting at Paragraph 9

"The Hospital was granted a Licence to Operate a Private Health Facility on 16 September 2016.[49]
Relevant to Mrs Haggett, the Hospital's Licence to Operate permitted it to provide services to:

(a) Anaesthetic Services Clinical Services Capability Framework (CSCF) Level 3;

(b) Perioperative Services - Day Surgery Services CSCF Level 3.

The CSCF provides a standard set of minimum capability criteria for services planning and delivery, The private hospital sector in Queensland is obligated to use the CSCF for licensing purpose. The CSCF consists of modules, Relevantly the modules include one for 'Anaesthetic' and one for 'Perioperative'.
Clinical services in the CSCF are categorised into six service levels with Level 1 managing the least complex patients and Level 6 managing the highest level of patient complexity. Complexity of care may vary between modules. The Hospital's service level is Level 3, Day Hospital.
Anaesthetic Services CSCF Level 3 permits the carrying out of local anaesthetic for:

(a) surgical complexity I procedures with low to high anaesthetic risk;

(b) surgical complexity II procedures with low to high anaesthetic risk;

(c) surgical complexity III procedures with low to medium anaesthetic risk;

(d) surgical complexity IV procedures with low to medium anaesthetic risk.

Surgical complexities are defined in Appendix 1 to the Anaesthetic Services CSCF. The Hospital was permitted to perform procedures on patients with low to high anaesthetic risk, which equates to American Society of Anesthesiologists scalea (ASA scale) 1 to 5.
The ASA scale though is used in conjunction with surgical complexity measures. In the case of day surgery for surgical complexity II, it is necessary to refer to Section 2, Day Surgery Services of the Perioperative Services - Day Surgery Services CSCF,s Perioperative Services - Day Surgery Services CSCF Level 3 permits the carrying out of surgical procedures on low to

[49] Exhibit C1.2 BOE

medium risk patients with day surgical complexity I, II or III, and who are ASA scale 1 to 3 (ASA scale 3 only if medically stable). As I understand it all standalone Day Hospital's in Queensland are classified and licensed the same way. That is, they are limited to only providing services to patients who are ASA scale 1 to 3 (and ASA scale 3 only if medically stable)."

[92] Therefore, upon Mrs Haggett being correctly identified as an ASA 4 patient by Dr Ngan, the surgery to be performed on her by Dr Smith at NLDH on 20 May 2019 was not surgery that could be performed at NLDH under its licence.

[93] Counsel Assisting submitted that if this had been recognised and understood:

(a) the surgery should not/ would not have proceeded at NLDH on 20 May 2019; and, in turn

(b) Mrs Haggett would not have been anaesthetised at NLDH on 20 May 2019;

(c) Mrs Haggett would not have suffered the post-surgical anaesthetic complications she suffered on 20 May 2019; and

(d) Mrs Haggett would not have died as a consequence of the post-surgical anaesthetic complications she suffered on 20 May 2019.

[94] Counsel Assisting further submitted that it follows the performance of the surgery at NLDH on 20 May 2019, in non-compliance with the facility's licence limitations, was a fundamental causative factor in Mrs Haggett's death.

[95] Mr Luchich for Dr Smith submitted, in effect, that such a finding is not open because:

(a) it would ignore the direct cause of Mrs Haggett's death as submitted by Counsel Assisting at paragraph [196] of his submissions; and

(b) Even if Mrs Haggett had been admitted to a hospital which was licenced to provide medical services to patients who were assessed as an ASA4 or higher, in the event the same anaesthetic technique had been chosen by Dr Ngan, it is difficult to see how the outcome would have been any different, save perhaps for potentially some different decision making in the post-operative care period; and

(c) Counsel Assisting's submission that the performance of the surgery at NLDH on 20 May 2019 in non-compliance with the facility's licence limitations, is a foundational causative factor in Mrs Haggett's death overstates the position.

[96] No other party has taken issue with Counsel Assisting's submission in this regard.

[97] I am concerned only with what was the cause/s of Mrs Haggett's death on 20 May 2019. It is a simple matter of fact that Mrs Haggett died because she underwent the surgery at NLDH on 20 May 2019. It is also a simple matter of fact that she ought not have undergone the surgery at NLDH on 20 May 2019 on account of the licensing restrictions of the NLDH. On the other hand, that the same anaesthetic technique might have been utilised by Dr Ngan at another facility in a different context is a matter of speculation. Indeed, that Dr Ngan might have been the anaesthetist involved at another facility in a different context is also matter of speculation. Speculating about what might have happened at another facility in a different context does not detract from finding these simple matters of fact.

[98] I reject Mr Luchich's submission and find that the performance of the surgery at NLDH on 20 May 2019, which was in non-compliance with the facility's licencing limitations, was a foundational causative factor in Mrs Haggett's death.

[99] To be clear, this should be of no moment or concern to Dr Smith because, as canvassed by Counsel Assisting at length and for the reasons outlined below, I have found that Dr Smith was not aware of the ASA 4 licensing limitations prior to the time the surgery was performed on 20 May 2019.

[100] On the other hand, the NLDH, through its relevant employees, was aware of the ASA 4 licensing limitations.

[101] In that regard, Ms Kenny provided the following evidence about the systems that were in place at the relevant time to manage the admission of patients to NLDH in the context of its licence limitations:[50]

> "*A patient's clinical record was (and still is) kept in DOX, a rudimentary electronic medical record. Essentially, the clinical record was (and still is) in hardcopy, and on a patient's discharge, the hardcopy is scanned into DOX. Each episode of care is filed by date of admission. Another, primarily financial platform, SIMDAY, feeds into DOX. A patient's admission booking is logged through SIMDAY, and theatre lists are generated through SIMDAY.*
> *As far as I am aware from my review of the Hospital's records, at the time of Mrs Haggett's death there were several policies and procedures to collectively manage the admission of patients in accordance with its Licence to Operate.*
> *The Hospital's By-Laws in force in May 2019 (exhibit E45) provide that:*

[50] Exhibit B19 BOE, starting at paragraph [18]

(a) It is expected that all accredited VMOs will adhere to the CSCF (clause 21.D.(iv));

(b) VMOs may only treat patients if the Hospital is licenced to carry out the procedure (clause 22);

(c) VMOs must comply with the By-Laws, all applicable laws concerning the provision of health care services to patients at private hospitals and the policies, rules, and procedures of the Hospital (clause 97).

The Hospital's Admission of a Patient Policy, version 5.1 dated May 2018 (exhibit E30), states that it applied to all VMOs and Hospital clerical and nursing staff, and aimed to ensure the Hospital operated in accordance with the CSCF.
The policy identifies that the Hospital was licenced in accordance with the CSCF and referred the reader to the Hospital's specific licence. It provided guidelines for patient selection and anaesthetic risk, permitting the admission of patients assessed ASA scale 1 to 3, but with medically stable ASA scale 3 patients requiring assessment by the Hospital's nursing staff in consultation with the attending anaesthetist. The policy specifically states:

> *"Admission of patients with an American Society Anaesthetist score…..physical status of 1, 2, or 3, can be treated, but only ASA 3 if they are medically stable and are assessed pre-operatively by the nursing preadmission service in consultation with the attending Anaesthetist'.*

This policy outlined the broad criteria that a patient must have met in order to be admitted to the Hospital. <u>As it applied to VMOs, it is my understanding the Hospital's expectation (as prescribed in its By-Laws) was that VMOs would only seek to admit patients if they met those requirements</u>…."

[my emphasis]

[102] As to the system that was in place at the time of Mrs Haggett's death for the communication of the licence limitations to staff and VMOs wanting to admit patients to NLDH, Ms Kenny explained:[51]

"*My review of the Hospital's records indicates that when the Hospital provided accreditation to VMOs, both on acceptance and at renewal, it provided them with a copy of the current By-Laws.*
I understand the Hospital's licence was displayed prominently in the front reception of the building.

[51] Exhibit B19 BOE, starting at paragraph [48]

The Hospital's licensing limitations were otherwise communicated through the Hospital's Admission of a Patient Policy (and associated policies and procedures)."

[103] Apart from implementing the Admission of a Patient Policy (and associated policies and procedures) and communicating the relevant content to VMOs by the means referred to above, the NLDH essentially relied upon VMOs to assess whether a particular patient met the admission requirements under the licence and to regulate the admission of patients accordingly. Notwithstanding that the NLDH held the licence[52] on the mandated conditions set out in s.48(1) of the *Private Health Facilities Act* 1999[53], the NLDH had no system of its own in place that would detect and prevent the admission of a patient who did not meet the admission requirements under the licence in circumstances where a VMO might seek to admit such a patient in contravention of the Admission of a Patient Policy (and associated policies and procedures).

[104] Indeed, as observed above, the pro-forma Surgical Anaesthetic Report completed by Dr Ngan on the day of Mrs Haggett's surgery made provision for a patient to be noted as an ASA 4 patient (by the pro-forma ASA 4 box, which Dr Ngan ticked)[54] which clearly suggests, at least on the face of that document, that an ASA 4 surgical patient could be treated at the facility.

[105] Otherwise, I observe that Clauses 21.D.(iv) and 22 of the Montserrat Day Hospital By-Laws[55] do not specifically refer to the NLDH's licence limitations under the CSCF, including that the NLDH was not licensed to admit and surgically treat ASA 4 patients.

[106] On 2 October 2013, Dr Ngan was notified in writing that Montserrat Day Hospitals had granted to him *Full Clinical Privileges* to practice within the Scope of Clinical Practice of Anaesthesia at various facilities, including NLDH. The correspondence enclosed a copy of the Montserrat Day Hospital By-Laws.[56] On 11 December 2013, Dr Ngan signed the correspondence accepting his full credentials with Montserrat Day Hospitals and agreeing to comply with, *inter alia*, the Montserrat Day Hospital By-Laws.[57]

[107] After reapplying for his credentials on 2 July 2016, Dr Ngan was again notified in writing by letter dated 3 August 2016 that Montserrat Day Hospitals had granted to him *Full Clinical Privileges* to practice within the Scope of Clinical Practice of Anaesthesia at various facilities, including NLDH. This letter also enclosed a copy of the Montserrat Day Hospital By-Laws. On 19 September 2016, Dr Ngan signed the correspondence accepting his full credentials with Montserrat Day Hospitals and agreeing

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[52] Exhibit C12 BOE
[53] Specifically, s.48(1)(d)
[54] Exhibit C1.1 BOE, page 8
[55] Exhibit E45.1 BOE
[56] Being those referred to by Ms Kenny in her evidence above
[57] Exhibit C1.33 BOE

to comply with, *inter alia*, the Montserrat Day Hospital By-Laws.[58] The full credentials provided at this time were current as at the date of Mrs Haggett's surgery at NLDH.

[108] Neither of the credentialling letters of 2 October 2013 and 3 August 2016 enclosed a copy of the CSCF, a copy of the NLDH's licence, or a copy of the policies, rules, and procedures of the NLDH, including the Admission of a Patient Policy (and associated policies and procedures), with which VMOs were expected to comply pursuant to Clause 97 of the Montserrat Day Hospital By-Laws.

[109] At the Inquest, Dr Ngan was examined and gave evidence as follows:[59]

> "*Sorry, I misled you. I said before that the recredentialling most proximate was in September of 2016 but, by reference to this document, it was in August of 2016?---August. Okay.*
> *And if you can just scroll down and pause – keep going. Just check the bottom, please. That's where you've accepted the terms of the full credentials on the 19th of September 2016?---Yes.*
>
> *What I want to talk to you – or explore with you is the acknowledgment that you would agree to comply with the scope of – your scope of your clinical practice, but also the Day Hospital bylaws and Queensland credential and legislation. And, in particular focusing on the bylaws for the moment, what did you understand – and you'll see just above that acknowledgment, sorry, Doctor – you'll see that the – there's a notification that the bylaws have been enclosed with that correspondence?---Yes.*
>
> *Is that what you recall in terms of the recredentialling process, that you make the application, you'd get this notification and you'd get a copy of the bylaws?---Yes.*
>
> *And do you recall whether you reviewed the bylaws on that particular occasion?---I'm fairly certain I wouldn't have specifically gone through and read the bylaws.*
> *You would have or would not have?---Would not have.*
> *Okay?---Not specifically.*
> *Would you have done that at any time in your time at the North Lakes Hospital?---Potentially on first accreditation back in 2012, but highly unlikely to have on subsequent renewals…*
> *..*
> *- - - what Ms Kenny's evidence at paragraph 48 to 49 is directed to is evidence that, at the time of credentialling or recredentialling, it was the hospital's process and system to provide the VMO, such as yourself, with a copy of the current bylaws; I think you*

[58] Exhibit C1.36 BOE
[59] T5-8 L34 – T5-9 L17; T5-9 LL25 – 38; T5-10 LL5 - 17

acknowledged that that's likely what happened. And also at paragraph 49, in the context of what the hospital's licencing requirements were – or limitations, rather, were, there was a display in relation to those licensing limitations at the front reception of the building. Do you have any recollection about the second aspect?---No. I don't.
Okay. We'll come back to this in some detail later on, but as I understand your evidence, at the time that you proceeded with the anaesthesia of Mrs Haggett, you were not aware at that stage that a ASA4 patient ought not be – ought not undergo surgery at the hospital? Was not permitted to undergo surgery at the hospital?---That's correct…..
….
Doctor, just in relation to the licensing limitation of the hospital in relation to patients who are ASA 4, your evidence is that at the time your – the surgery was performed on Mrs Haggett, you were unaware of that requirement?---Yes.

Were you aware of what the hospital's expectation was in terms of VMOs reviewing by-laws?---No. I wasn't.
Okay. Were you provided with any information by the hospital as to the licensing limitation other than what is referred to in the by-laws?---No. I wasn't.

Were you provided with any information by the hospital about the licensing limitations other than what was contained in the – some of the policies and procedures of the hospital?---No"

[110] During the course of his evidence, Dr Ngan was shown the Admission of a Patient Policy[60] and was examined as follows:

"*Okay. I'll just take you, then, too – just to be certain about this – exhibit E30. Is this a document that is familiar to you, Doctor?---No, it's not.*
Okay. I'll just take you through it, just for completeness. If you go to the second page, page 2, and under the heading Referrals Accepted for Day Surgery, you'll see there that there are a number of criteria imposed by the hospital for patients who are acceptable to undergo day surgery. Were you familiar that that was the policy requirement of the hospital at the time that you assessed Mrs Haggett?---I'm unfamiliar with this document. I've not seen this document before, so - - -
You've not seen the document before? Okay?---No. So - - -
I'll just go through it just to be – for completeness. Go down to section 3. And there it states the limitation or the guidelines for patient selection by reference to the ASA score, and, again, I take it that you haven't seen – previously seen - - -?---No.

[60] Exhibit E30 BOE

- - - that that was the hospital's policy in relation to patient selection by reference to an ASA score at the relevant time?--- That's correct."

[111] As a further indication that he was not aware of ASA 4 licensing limitation, Dr Ngan stated that he could recall other ASA 4 patients being surgically treated at the NLDH prior to Mrs Haggett: "*at the most, a dozen patients*."[61]

[112] Mr Hickey KC for the NLDH briefly cross-examined Dr Ngan as follows:

> "*Do you accept that, in agreeing to comply with the bylaws, it behove you as a responsible practitioner to read the bylaws?--- Yes, but there's a context that I'd like to explain, which is that we – we reaccredit in multiple hospitals; I think I'm accredited at 12 to 13 hospitals on a three-yearly basis, and, whilst I accept I should've read those bylaws, they are lengthy documents which are quite repetitive. It would've been helpful to have in this particular case, I guess, something as important as the admission criteria highlighted in some way, but I accept that I should've read those.*"

[113] Mr Hickey KC also cross-examined Dr Bradley as follows:[62]

> "*And you're aware that no doubt as part of that process you're required to apply for reaccreditation from time to time?---Yes.*
> *And as part of that process you're familiar with the fact that hospitals will routinely provide you with documentations which provide the legal framework within which you are entitled to operate within their particular hospitals, and in operate I mean perform your services not surgically operate?---<u>I'm not aware of that. I'm certainly aware of the hospital bylaws which are invariably reattached to reapplications but no, I don't recall in my particular case specific information about the clinical services capability framework requirements</u>.*
> *All right. Can I ask you then to assume that if the bylaws included information of that kind and that you were invited to agree to abide by them in order to perform work at a particular hospital, you would expect a prudent anaesthetist would read that documentation?---Well, I personally believe that every prudent anaesthetist should read the bylaws, I agree.*"
> [my emphasis]

[114] Again, consistent with Dr Bradley's experience, apart from the provision of the By-laws, a copy of the CSCF, the NLDH's licence, and the policies, rules, and procedures of the NLDH, including the Admission of a Patient

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[61] T5-10, L47
[62] T8-20, LL5- 20

Policy (and associated policies and procedures) were not provided to Dr Ngan (or routinely to any VMO, including Dr Smith) at the time of credentialling.

[115] Mr Hickey KC also took up the issue with Dr Glasson:[63]

> *"You'd agree with me, wouldn't you, that the very nature of studying to become a medical practitioner of any kind requires a student to become capable in assimilating significant amounts of very complex information in writing?---Yes.*
> *And so it's not the fact, is it, that a doctor is incapable of understanding or assimilating difficult information that's communicated to them in writing?---Not at all.*
> *And, indeed, that's part of any kind of doctor's fundamental skill?---Absolutely.*
> *You'd agree with that?---I do.*
> *It's an important responsibility of any referring doctor to a day hospital to understand for themselves the scope of that hospital's patient accreditation?---Yes.*
> *Any responsible doctor would inform themselves independently of any other information they had been given, whether or not the patient they were purporting to refer should or should not be treated at that particular facility?---Yes.*
> *That's best practice for a doctor, isn't it?---Best practice, yes.*
> *And, indeed, that same responsibility is one which you knew is not only to a surgeon but also to an anaesthetist, in your experience?---Yes.*
> *Or, indeed, any other kind of practitioner?---Yes.*
> *And if a medical practitioner had any doubt at all about whether or not a patient was appropriate to be referred to a particular facility,*
>
> *he or she or they would inform themselves about whether or not the hospital was fit to perform the procedure?---Yes.*
> *And, indeed, having regard to the evidence that that you've been asked about today, in particular that information about the clinical presentation of this particular patient, her respiratory background, if a surgeon or an anaesthetist had any doubt at all about whether post-operative care would be appropriate in a particular facility, they would go and inquire and inform themselves about whether or not that facility could properly treat that patient?---Absolutely.*
> *And you'd agree with me that in making application for accreditation to perform procedures at a particular hospital, it's the usual practice, isn't it, that doctors will be sent some paperwork which they're required to sign and complete?---Yes.*
> *That's your experience?---Yes.*
> *And, indeed, in completing that paperwork doctors are required to sign up to having understood certain sorts of things?---Yes.*

[63] T5-22, L16 – T5-22, L22

And you'd agree with me as a practitioner of long experience that it's entirely appropriate that a doctor who signs that documentation should inform themselves about what's in the documents before they would sign off on them?---Yes.
And that if they signed off on it, not having read the information, they expose themselves to the risk that they may well fall foul of the rules?---Yeah, I – yes, I understand that, yes.

And they ought not do that?---They ought not do that, correct."

[116] I acknowledge the point of Mr Hickey KC's line of questioning of the witnesses but, insofar as being informed of the ASA 4 licensing limitation of the NLDH was concerned, I observe that at the time VMOs "*signed off*" on the credentialling documentation:

(a) VMOs were accepting the "*full credentials*" with Montserrat Day Hospitals;

(b) VMOs were agreeing to comply with the Scope of Clinical Practice for which they had been credentialled;

(c) VMOs were agreeing to comply with the By-laws (including Clause 97);

(d) VMOs were agreeing to comply with Queensland credentialling legislation;[64]

(e) VMOs were provided with a copy of the By-laws which, it can be accepted, they should have read, although reading the By-laws alone would not have informed the VMOs of the NLDH's ASA 4 licensing limitation;

(f) VMOs were not provided with a copy of the CSCF, a copy of the NLDH's licence, or a copy of the policies, rules, and procedures of the NLDH, including the Admission of a Patient Policy (and associated policies and procedures), with which VMOs were expected to comply pursuant to Clause 97 of the By-laws;

(g) to inform themselves of the NLDH's ASA 4 licensing limitations (if they apprehended there were such limitations), VMOs would have to locate for themselves:

    (i) a copy of the CSCF and review it; and/or

    (ii) a copy of the NLDH's licence and review it (although the licence was said to have been "*displayed prominently"* in the reception of the facility, it was apparently not displayed in a way so as to cause it to come to, for example, Dr Ngan's attention at any

[64] See, for example, Exhibit C1.11 BOE

time over the many years he had provided anaesthetic services at the facility prior to Mrs Haggett's surgery); and/or

(iii) a copy of the policies, rules, and procedures of the NLDH, including the Admission of a Patient Policy (if they were aware of the existence of such documents and where to find them) and review them.

[117] In line with Dr Ngan's suggestion that "*it would've been helpful to have in this particular case, I guess, something as important as the admission criteria highlighted in some way",* Mr Diehm KC took up the following with Dr Glasson:[65]

> "*Yes, thank you. A separate topic. Again, you were asked questions about limitations on a scope of practice for a day hospital. Some of those matters raised with you might concern licensing limitations, such as whether a patient who is an ASA 4 might be operated upon. Others might come out of hospital policies, per se, rather than a licensing limitation. Is that a fair description – – –?---Yeah. Yes.*
> *– – – of the source of these things?---Absolutely. Yep.*
> *And you spoke of an example from your own experience of where you became aware of a limitation at a particular day hospital you were practising at, when indeed you tried to admit a patient who wasn't under one of those criteria able to be admitted at that hospital. In terms of the provision of information to VMOs working in these day hospitals in the form of lengthy policy documents and bylaws, would you accept that that's somewhat problematic where it comes to critical important information about limitations on the scope of the type of patients who might be admitted because it's hard in those circumstances for the doctors to get to the information – – –?---Correct.*
> *– – – that they really need?---Yes, and there's so much of it.*
> *I'm sorry?---There's so much of it.*
> *Yes, indeed. And so does it reduce to this, that to the extent that there is some critical pieces of information that may well be contained in detailed policy documents or bylaws, the best practice to ensure that VMOs are aware of the limits of the scope of patients who might be admitted to the day surgery is to give it to them in a summary form?---Absolutely.*
> *All right?---Absolutely.*"[66]

[118] Otherwise, I find that Dr Ngan's acknowledgement that he had failed to read the By-laws when he should have (at least at the time of the most recent accreditation) was an appropriate concession on his part.

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[65] T5-21, LL9 - 37

[66] See also, Counsel Assisting's line of questioning of Dr Glasson on this point: T5-16, L1 – T5-17, L5

[119] At times, when examined about this issue, Dr Smith was a combative and unhelpful witness who required direction from me at least a couple of occasions to answer the questions being asked of him.[67] Consequently, it is difficult to distil from his examination precisely what he understood about the NLDH's ASA 4 licencing limitation prior to Mrs Haggett's surgery and what was expected of him when seeking to admit a patient in the context of that licensing limitation.

[120] There was some evidence from DCS Mukaukas to the effect that Dr Smith was aware of the ASA 4 licensing limitations, as follows:

> "*All I can - I can say is that Dr Smith had - had - had previous patients cancelled because there (sic) were an ASA 4 or 5, and he was quite clearly told that the patients weren't a patient that should be in our hospital because of their scoring. It wasn't the first time Dr Smith had tried to admit a patient that wasn't appropriate for the - for the hospital*."[68]

[121] However, this evidence first emerged in DCS Mukaukas' oral evidence after Dr Smith had provided his evidence, was not contained in her written statement, and the assertion had not been put to Dr Smith by the then Counsel for the NLDH. In effect, Counsel Assisting submited that in these circumstances, as a matter of procedural fairness, that I ought not find that Dr Smith had prior knowledge of the ASA4 licensing limitations as asserted by DCS Mukaukas.

[122] In addition, Mr Luchich for Dr Smith submitted, *inter alia*, to the following effect:

(a) The oral evidence of DCS Mukaukas at its highest would not be sufficient to support a finding that Dr Smith was aware of the ASA4 licensing limitations.

(b) The evidence of DCS Mukaukas was never to the extent that she told Dr Smith that he could not admit patients who were assessed as ASA4 or higher.

(c) The only example DCS Mukaukas could give of the cancellation of a patient in which she was personally involved, was one who had been identified on a pre-admission assessment conducted by the NLDH as having a cardiac issue. The patient was cancelled, and Dr Smith apparently had no difficulty with that decision. However, the evidence of DCS Mukaukas was not that she told Dr Smith, or even his rooms, that the patient had been assessed as an ASA4 because of the cardiac issue and that, due to the licence limitations, the admission could not proceed.

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[67] T2-30, L37; T2-37, L6

[68] T4-26, LL22-25

(d) That ought not be considered surprising, because it cannot have been the case that, at the pre-admission assessment, this patient with the cardiac issue was identified as an ASA4 (or higher) because the NLDH pre-admission screening process did not actually provide for ASA scores to be measured.

(e) Furthermore, on this point, the NLDH has not produced any document to suggest that Dr Smith had ever been told that a patient had been cancelled because they were assessed as an ASA4 (or higher) and the facility was not licenced to admit such patients.

[123] For the reasons submitted by both Counsel Assisting and Mr Luchich, I am not prepared to find that Dr Smith had the prior knowledge DCS Mukaukas asserted he had.

[124] Otherwise, Dr Smith's evidence is to the following effect:

(a) Prior to Mrs Haggett's surgery, he was not familiar with the policy or requirement that an ASA 4 patients should not be treated at the NLDH;[69]

(b) Prior to Mrs Haggett's surgery, he either did not know what the CSCF was, or was not familiar with its content:

> "….*I'm in particular going to take you to some provisions which refer to what is called the Clinical Services Capability Framework, do you understand what that is?---No, I don't.*
>
> *DEPUTY STATE CORONER: Sorry, what was the answer?---No, he doesn't understand what it is, your Honour.*
>
> *MR SCHNEIDEWIN: Can I indicate to you that it is the framework that is in place throughout the state, which provides the standard of the minimum capability criteria of services and planned delivery for hospitals such as these day hospitals, do you understand anything that I'm talking about?---I can understand where you're going with this, yes.*
> *Right, so you didn't have any direct familiarity with the framework, if I can put it that way?---I could not recall.*"[70]

(c) Prior to Mrs Haggett's surgery, he likely had read, at some stage, the By-laws provided as part of the credentialling process but not in great detail and in a very brief manner:

> "*Okay, now if you have a look at by-law 21(D)(iv), which you'll find on page 11 of exhibit 45. Now, just to put it into context for you, doctor, just so I don't want to mislead you in any way. It is the hospital's position that this by-law - these are by-laws that*

[69] T2-29, LL37-41
[70] T2-30, LL1- 14

governed how proceeding with surgery was to be performed at the hospital, and including what the hospital's expectation was insofar as visiting medical officers were concerned, in relation to their referral of patients, and in relation to their management of patients at the hospital, okay. So, that's the context in which I'm asking these questions. Now, first of all, have you, or can you say that you've ever seen these by-laws?---I cannot say that I have read the by-laws in the detail that you're about to go into.
Well, just bear with me, I'll put it to you, and you can respond. At clause 21(D)(iv), you scroll down, the by-laws require that a medical practitioner in your position, that is a visiting medical practitioner at the hospital, would adhere to the relevant guidelines for the Clinical Services Capability Framework that we've been talking about?---Am I provided with those guidelines?
I'm asking you whether you were familiar with that provision?---Am I familiar to what extent? Would be my answer. So, are you - I know where you're going with this, so - - -
DEPUTY STATE CORONER: Doctor, don't worry about where he's going, just answer the questions he asks you. So, have you ever seen this document before today?---I can't remember reading this document, but that was a requirement of us getting the - - -

DEPUTY STATE CORONER: I see, thank you, that's helpful.

MR SCHNEIDEWIN: I know this is a difficult process because it's uncomfortable, I'm sure, but I've got to ask you the questions because the hospital has a position which it maintains, in relation to what its expectation was of you as a visiting medical officer, okay. So, I'll put the questions and if you can just answer the questions. To repeat her Honour's question, have you reviewed the by-laws prior to today?---Not recently.
Okay. You would have, at some time in the past, reviewed the by-laws?---The detail that I would read this, I think you have to understand that as well.
Okay, well you can put it into context. Would you have?---This would have been a - 5 the reading of this document would have been a very brief manner. I would not have gone into it and said, "Point D/4, I'm adhering to the Australian Standards, I wonder what they are, then I need to research where that is and look into that".
Okay?---So it would have been a very brief review of this document."[71]

(d) He did not consider it was his role to determine whether the NLDH was licenced to treat a particular patient; rather he believed that was the role of the NLDH:

[71] T2-30, L16 - T2-31, L10

"*Okay. Did you understand, whether by reference to the by-laws or otherwise, that it was expected of you, that you would only treat patients at the hospital, for which the hospital was licensed to treat then?---I would say yes, but as a caveat to that, as we've gone through before, the determination of whether the patient's suitable as far as the licensing of the hospital is concerned, is the hospital's role, not my role….*

…

All right. But your view, if I understand it, is that your assessment as to suitability is whether the surgery could be performed at the hospital, regardless of what the ASA score might have been, is that right?---The - I mean the ASA score comes much later. After the hospital's made their assessment as well. So, the hospital wouldn't make a determination about the ASA status either. And the hospital, to be fair, would have much more idea of what their guidelines for the surgery are, than me. And that's part of the hospital's questionnaire, I imagine.

Okay. But if the by-laws, as they seem to indicate, required you, as a medical practitioner, to only arrange surgery at the hospital for which it was licensed to undertake, you are saying, and I'm putting this to you, what you are saying is that that was news to you?---No, that's putting words into my mouth. So, what I am saying is that the assessment was that Mrs Haggett was a suitable patient to be operated on those - at the hospital, like all of the patients that I have operated on there before, and by their guidelines, and adhering to their guidelines, and that she would be subsequently - the suitability via the hospital's guidelines would also be determined by the hospital and as well, determined by Dr Ngan."[72]

(e) He understood that in accordance with the By-laws he was otherwise required to comply with the policies and procedures of the NLDH;[73]

(f) Although he was particularly combative on this point, I find that it is probably the case that he had not seen the Admission of a Patient Policy[74] prior:

"*Now, I asked you to have a look at exhibit 30, a copy of which you've got in front of you. And first, I ask whether that is a policy document that was familiar to you at the time of Mrs Haggett's surgery?---Can I ask in response, where this document's from?*

No. I'm asking you, is that a policy document that was familiar to you at the time of Mrs Haggett's surgery?---And can I ask, what do you mean by "familiar"? Is it something that I reference regularly? Or was it - - -

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[72] T2-31, LL22- 27; T2-31, L48 – T2-32, L15

[73] T2-32, L21

[74] Exhibit E30 BOE

Had you seen the document prior to the surgery you performed on Mrs Haggett in 25 May of 2019?---I can't recall whether I've seen this document.
Can you recall whether you've ever seen the document?---No."[75]

(g) On review of the Admission of a Patient Policy, he agreed it applied to him;[76]

(h) He agreed that he was the admitting practitioner in the case of Mrs Haggett;[77]

(i) He did not agree with the proposition that the Admission of a Patient Policy, in prohibiting the admission of ASA 4 patients, in effect required him as the admitting practitioner to have an understanding of what the ASA score of the patient was prior to seeking to admit them to the NLDH.[78]

[125] Throughout his evidence, Dr Smith maintained that he had not been aware of the hospital's policy or requirement that an ASA 4 patients should not be treated at the NLDH prior to proceeding with the surgery. Towards the end of his examination on this issue, Dr Smith's evidence was:

"*All right, and if you had been aware in the case of Mrs Haggett, that her ASA score was 4, would you have proceeded with the surgery?---The ASA status of 4 is an anaesthetic risk, and that is determined by the anaesthetist.*
DEPUTY STATE CORONER: Not the question. Answer the question you were asked please, doctor?---Sorry, can you repeat the question, please?
MR SCHNEIDEWIN: If you had been made aware that Mrs Haggett had been assessed as an ASA 4 prior to the surgery, would you have proceeded with the surgery?---No, I wouldn't."[79]

[126] This response is at odds with his earlier evidence that prior to Mrs Haggett's surgery he was not familiar with the policy or requirement that an ASA 4 patients should not be treated at the NLDH. The point was taken up by Mr Diehm KC in his cross-examination:[80]

"*Now on that question about ASA, the question was asked of you by counsel assisting after the lunch break today, to this effect, that if you had been made aware at the time of Mrs Haggett's procedure or shortly before it, that her ASA score was 4, would you have proceeded with the surgery? And your answer was no, you would not have*

[75] T2-34, LL16 - 27
[76] T2-35, LL1-2
[77] T2-35, LL13-14
[78] T2-36, LL31-36
[79] T2-37, LL1-11
[80] T2-56, LL13- 29

?---And I would have asked what an ASA 4 meant.
Well, doctor, you see, this is why I wanted to ask you this question, because your evidence today has been that, firstly, you did not know that there was a policy at the hospital that if the patient had an ASA score of 4, that they should not be admitted, let alone operated on at the hospital, that's so, isn't it?---Sure.
So, it can hardly be the case that if you'd been told that the patient had an ASA 4 score, that you would have refused to proceed with the surgery?---I would have clarified what the ASA 4 meant. And then if - I dispute the patient from our perspective knowledge, not from
our retrospective bias that's inherent in this case, that she was an ASA 4. If I read those documents, she had stable respiratory disease, it was not an imminent threat of death every day."

[127] Dr Smith's ultimate response to Mr Diehm KC's question was somewhat unclear, but the better view of the overall evidence is that it would not have mattered whether or not Dr Smith had been aware of Mrs Haggett's ASA 4 status; the surgery would have proceeded when it did regardless because both he and Dr Ngan were not aware of the NLDH's licensing limitations and I find accordingly.

[128] I also find that the NLDH had the primary responsibility for regulating its licensing limitations and that the system the NLDH had in place for that purpose was not adequate. To be clear, I find as follows:

(a) According to Ms Kenny[81], the NLDH's expectation was that VMOs would only seek to admit patients who met the requirements outlined in the Admission of a Patient Policy[82] namely:

"*Admission of patients with an American Society Anaesthetist score….physical status of 1, 2, or 3, can be treated, but only ASA 3 if they are medically stable and are assessed pre-operatively by the nursing preadmission service in consultation with the attending Anaesthetist."*

(b) In other words, apart from implementing the Admission of a Patient Policy (and associated policies and procedures) and communicating the relevant content to VMOs by the means referred to in paragraphs [48] - [50] of Ms Kenny's statement[83], the NLDH essentially relied upon VMOs to assess whether a particular patient met the admission requirements under the licence so as to regulate the admission of patients accordingly.

(c) Notwithstanding that the NLDH held the licence[84] on the mandated conditions set out in s.48(1) of the *Private Health Facilities Act*

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[81] Exhibit B19 BOE, paragraphs [21], [22], [23]
[82] Exhibit E30 BOE
[83] Exhibit B19 BOE
[84] Exhibit C12 BOE

1999[85], the NLDH had no system of its own in place that would detect and prevent the admission of a patient who did not meet the admission requirements under the licence in circumstances where a VMO might seek to admit such a patient in contravention of the Admission of a Patient Policy (and associated policies and procedures).

(d) The pro-forma Surgical Anaesthetic Report completed by Dr Ngan on the day of Mrs Haggett's surgery made provision for a patient to be noted as an ASA 4 patient (by the pro-forma ASA 4 box, which Dr Ngan ticked)[86] rather suggesting, at least on the face of that document, that an ASA 4 surgical patient could be treated at the facility. To this extent, the NLDH's own pro-forma documentation was inconsistent the Admission of a Patient Policy and potentially misleading to VMOs seeking to admit patients to the NLDH

(e) I find that neither Dr Smith, nor Dr Ngan knew of the NLDH's ASA 4 licensing limitations prior to Mrs Haggett's surgery. On that basis alone I find that the system for regulating the licensing limitations, or for ensuring ASA 4 patients were not admitted to NLDH (i.e. "*that VMOs would only seek to admit patients if they met [the Admission of a Patient Policy] requirements*") was inadequate. More particularly I find that:

(i) Whilst VMOs were provided with a copy of the By-laws at the time of their accreditation (and any subsequent renewal), which they were required to comply with[87] (implying that the By-laws should be read), Clauses 21.D.(iv) and 22[88] do not specifically refer to the NLDH's licensing limitations under the CSCF, including that the NLDH was not licensed to admit and surgically treat ASA 4 patients.

(ii) Reading the By-laws alone would not have informed the VMOs of the NLDH's ASA 4 licensing limitation.

(iii) The credentialling correspondence sent to VMOs did not enclose a copy of the CSCF, a copy of the NLDH's licence, or a copy of the policies, rules, and procedures of the NLDH, including the Admission of a Patient Policy (and associated policies and procedures), with which VMOs were expected to comply pursuant to Clause 97 of the By-laws.

(iv) Prior to Mrs Haggett's surgery, Dr Ngan had not seen the Admission of a Patient Policy.

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85 Specifically, s.48(1)(d)
86 Exhibit C1.1 BOE, page 8
87 Acknowledged by both Dr Ngan and Dr Smith; see Exhibits C1.33, C1.36, C1.9, C1.11
88 The Clauses the NLDH point to as requiring VMOs to adhere to the CSCF and to only treat patients if the NLDH is licensed for the procedure in question.

(v) On balance I find that Dr Smith had not seen the Admission of a Patient Policy prior to Mrs Haggett's surgery.[89]

(vi) Neither Dr Smith, nor Dr Ngan had been provided with a copy of the Admission of a Patient Policy by the NLDH at any time;

(vii) Neither Dr Smith, nor Dr Ngan had been informed by the NLDH where they could locate the Admission of a Patient Policy to review it (had they been aware it existed, which I find they were not).

(viii) Displaying the NLDH's licence "*prominently in the front reception of the building*"[90] as the only other means of communicating the licensing limitations to VMOs was clearly inadequate for the purpose of informing VMOs of the licensing limitations in circumstances where, over many years, the licence, displayed as it might have been, had not come to the attention of either of Dr Ngan or Dr Smith.

(f) The system that was in place at the time of Mrs Haggett's surgery had patients admitted to the NLDH prior to undergoing a pre-operative anaesthetic assessment, including an assessment of their ASA score. Whilst this did not prevent the cancellation of the scheduled surgery if it was determined the patient did not satisfy the requirements of Admission of a Patient Policy, the performance of a critical qualifying assessment post admission was not adequate patient care and management.

(g) Of particular concern is Dr Ngan's evidence that he can recall other ASA 4 patients being surgically treated at the NLDH prior to Mrs Haggett: "*at the most, a dozen patients*."[91] I have no reason not to accept Dr Ngan's evidence in this regard and I find accordingly;

(h) It follows that Mrs Haggett's admission and treatment at the NLDH in breach of the licensing limitations was not a "*one-off occasion*" and I find accordingly;

(i) It further follows that the NLDH's system for detecting and preventing the admission of ASA 4 patients had failed previously and I find accordingly. This would have placed other patients at risk prior to Mrs Haggett. I consider this to be highly unsatisfactory and a matter of grave concern.

(j) It also follows that NLDH's failed system had gone unnoticed until Mrs Haggett's death. I find that there were no audits performed prior to Mrs Haggett's death to ensure that the system the NLDH relied

[89] During examination on this point Dr Smith was combative and evasive but ultimately stated to the effect that he could not recall if he had ever seen the Admission of a Patient Policy.
[90] Exhibit B19 BOE, paragraph [49]
[91] T5-10, L47

upon (i.e. "*that VMOs would only seek to admit patients if they met [the Admission of a Patient Policy] requirements*") had been complied with and was achieving its purpose.

[129] I find that the NLDH's failed system for detecting and preventing Mrs Haggett's admission as an ASA 4 patient materially caused or contributed to her death.

[130] Ms Kenny has provided a comprehensive summary of the changes that have been made to the system for detecting and preventing the admission of ASA 4 patients in response to Mrs Haggett's death, exhibiting the relevant policies and documentation giving effect those changes.[92]

[131] I have considered those changes carefully and find that they are an adequate and appropriate response to the system failure that led to Mrs Haggett's death, directed to avoiding similar tragedies in the future.

[132] I also find that Dr Smith's increased vigilance in checking that a particular patient's ASA score is appropriate for the facility before proceeding with surgery[93] is an adequate and appropriate response to the circumstances that led to Mrs Haggett's admission and surgery being performed at NLDH on 20 May 2019.

[133] Similarly, having regard to the whole of his evidence on this issue, I find that Dr Ngan's subsequent understanding that patients assessed as ASA 4 are not permitted to undergo surgery at day hospital facilities such as the NLDH is an adequate and appropriate response to the circumstances that led to Mrs Haggett's admission and surgery being performed at NLDH on 20 May 2019.

Issue 2: The adequacy and appropriateness of the pre-admission screening procedures and protocols at the NLDH

[134] In addition to the issues related to the ASA 4 licensing limitation referred to above, there were, on the occasion of Mrs Haggett's pre-admission screening, some deficits in the performance of the screening procedures, and the screening procedures themselves could have been more comprehensive and instructive to those performing the pre-admission screening:

(a) RN Nance gave evidence to the following effect:

(i) She conducted the pre-admission screening of Mrs Haggett by telephone on 14 May 2019.[94]

(ii) Prior to the time of Mrs Haggett's death she had been working at the Monsterrat Day Hospital at Gaythorne and had been

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[92] Exhibit B19 BOE
[93] Exhibit B9 BOE, page 13, paragraph [106]
[94] Ex B7 BOE [2].

working with Monsterrat since July 2010. She was familiar with the Admission of a Patient Policy[95] at the time.[96]

(iii) She considered Mrs Haggett was probably an ASA 3 for anaesthetic risk but that this was not for her to decide.[97] She stated that she understood that in accordance with the Admission of a Patient Policy only ASA 1, ASA 2 and a stable ASA 3 patient could be admitted to the NLDH[98] with all stable ASA 3 patients requiring anaesthetist consultation.[99]

(iv) She conceded Mrs Haggett's low BMI should have caused her to escalate her case to management as it indicates some degree of surgical or anaesthetic risk[100] but there was no written policy in place at the time prescribing a lower limit BMI.[101]

(v) Mrs Haggett told her that she suffered from bronchiolitis, which she understood to be an inflammation of the airways. She asked if she was breathless or had a cough to which she replied "*No, I'm fine now*".[102]

(vi) She was not aware at the time of the pre-admission that bronchiolitis might manifest in adults but was aware it manifested in children.[103] Ms Nance said that she understood that bronchiectasis is a more serious condition and that it "*would have rung alarm bells for her*".[104]

(vii) She recorded on the preadmission forms that Mrs Haggett was fully mobile as she was not informed that she used a wheelie walker.[105] Ms Nance stated that the use of a wheelie walker would have indicated to her that Mrs Haggett was quite frail with risk associated with the surgery and anaesthesia.[106] Ms Nance gave evidence that the recording of information regarding wheelie walker use would have been on the falls risk variance of the surgical risk assessment form.[107]

(viii) Mrs Haggett indicated she had high blood pressure but that it was controlled by her medications.[108]

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[95] Ex E30 BOE.
[96] T1-40 LL 16-26.
[97] T1-41 LL 2-25.
[98] T1-42 LL 27-31.
[99] T1-43 LL 15-16.
[100] T1-46 L 40- T1-46 L 6.
[101] T1-46 LL 38-41.
[102] T1-50 LL 40-48.
[103] T1-51 LL 10-13.
[104] T1-51 LL 28-33.
[105] T1-52 LL 38, 42-43.
[106] T1-52 L 23.
[107] T1-57 LL 10-14.
[108] T1-50 L 22-23.

(ix) Mrs Haggett had provided information about having had pneumonia 12 months previously and that "*on reflection I should have asked more questions*" but that the way the form was written did not encourage this.[109]

(x) The surgical risk assessment form at the time did not encourage the asking of more questions and that it was up to her to make those inquiries using her clinical judgment.[110]

(xi) There was no clear mechanism for escalation if a pre-admission screening raised concerns other than just calling the anaesthetist on the phone. Ms Nance gave evidence that she would "*probably not*" have even known at this time who the anaesthetist was for Mrs Haggett's surgery,[111] but that she could have instead rung the surgeon.[112]

(xii) Mrs Haggett assured her that the surgeon knew about her respiratory condition so she ticked the box indicating that the doctor knew of the history.[113] However on reflection she stated that she "*should have notified myself*".[114]

(b) RN Babbage gave evidence to the following effect:

(i) She had been employed at NLDH as a contract casual registered nurse for "*about three weeks*" at the time of Mrs Haggett's death and performed the surgical pre-anaesthetic assessment.[115]

(ii) She could not recall whether she was required to review any of the Hospital's policies and procedures regarding pre-admission before she commenced work at the Hospital and did not recall having seen the Admission of a Patient Policy or having been trained in relation to that issue.[116] She said that the Admission of a Patient for Surgery- Work Instruction was not familiar to her and that she did not remember having received training in relation to what was required to complete the form.[117]

(iii) She did not know what the ASA measurement was or how it related to patients.[118]

(iv) Her process for identifying anaesthetic variance was to ask questions and go through the blood pressure and past history

[109] T1-53 LL 33-49.
[110] T1-53 LL 45-49, T1-54 LL 4-8.
[111] T1-54 LL 24-40.
[112] T1-55 LL 4-6.
[113] T1-55 LL 11-12.
[114] T1-56 LL 22-23.
[115] T1-61 LL 36-48.
[116] T1-62 LL 21-22, 28.
[117] T1-64 LL 1-12.
[118] T1-62 LL 32-36.

looking for indications whether or not they were able to have surgery on that day.[119]

(v) She noted on the Surgical Pre-anaesthetic Assessment form that Mrs Haggett could not lie flat on her back, that she had increased BP or hypertension, and had bronchiolitis and pneumonia in October 2018.[120] She did not know anything about bronchiolitis at the time she completed the form.[121]

(vi) She "*probably would have*" had access to the pre-admission telephone checklist at the time of completing the form but that she did not take the information regarding bronchiolitis from the form and "*would have asked her*" herself.[122]

(vii) She was familiar with bronchiectasis, could not remember what it was, but thought that bronchiectasis was more severe.[123] If Mrs Haggett had told her that was the condition she had, she would have flagged it.[124]

(viii) She ticked the box "*notify anaesthetist*" regarding her notation that Mrs Haggett could not lie flat, and this was confirmation that she did in fact pass that on to the anaesthetist.[125]

(ix) She took observations of Mrs Haggett's blood pressure, respiratory rate, temperature and oxygen saturations. Of these observations she considered they were within normal limits except for the oxygen saturations which were "*just borderline*" at 94, with 95-100 being the target range. She said she would have flagged this.[126]

[135] Whilst theses assessments failed to elicit from Mrs Haggett a number of "red flags" that might have led to a better understanding of the extent of her respiratory condition, and whilst each of the nurses performing the assessments might have done something differently with the benefit of hindsight, the deficits in the assessments were primarily systematic in nature.

[136] Ms Kenny has provided a comprehensive summary of the changes that have been made to the pre-admission screening procedures at the NLDH in response to Mrs Haggett's death, exhibiting the relevant policies and documentation giving effect those changes.[127] I have considered those changed procedures closely and find that the changes are an adequate

[119] T1-62 LL 32-36.
[120] T1-66 LL 34-38.
[121] T1-67 L 2.
[122] T1-67 LL 22, 33.
[123] T1-67 LL 37, 44.
[124] T1-68 L 2.
[125] T1-68 LL 23.
[126] T1-69 LL 46, 48.
[127] Exhibit B19 BOE

and appropriate response to deficits in the screening procedures that manifested and became apparent in the case of Mrs Haggett.

[137] Otherwise, I find that the deficits in the pre-admission assessments of Mrs Haggett did not contribute to her death in a material way.

Issue 3: The adequacy and appropriateness of the pre-operative surgical assessment of the suitability of the deceased to undergo day surgery at the NLDH[128]

[138] Insofar as this issue is directed to Mrs Haggett's ASA status, I refer to the above findings.

[139] Dr Armstrong and Dr Smith had a difference in recollection of the matters discussed between them after Dr Armstrong's referral of Mrs Haggett to Dr Smith. That difference in recollection is unable to be reconciled following their evidence at the Inquest.

[140] Despite that, I am not critical of Dr Armstrong for the following reasons:

(a) His treatment and management of Mrs Haggett for the condition with which she presented was appropriate;

(b) His referral of Mrs Haggett to Dr Smith was appropriate;

(c) He correctly identified in his letter of referral to Dr Smith that "*Shirley's respiratory function will be a concerning factor*"[129] based on the history that was provided to him;

(d) He was not Mrs Haggett's usual GP and did not have access to her full medical history as regards her respiratory function;

(e) There was no role for him to play in formulating an anaesthetic plan for the surgery Dr Smith planned to perform;

(f) It was appropriate for him to expect that Dr Smith would inform himself about the nature of Mrs Haggett's respiratory function and that Dr Smith would make the enquires he considered were necessary and appropriate in that regard;

(g) As to whether Dr Armstrong should have brought Mrs Haggett's usual GP "*into the loop*", Mr Diehm KC for Dr Ngan made the observation that "*one might expect that when there is a referral from a specialist, not a GP, to a specialist, the usual treating general practitioner is copied in on the referral. They are brought into the loop. No criticism has been directed to Dr Armstrong for not doing such a thing, and as a general practitioner providing a referral, it*

[128] Including, but not limited to, the pre-operative estimate of the length of the surgery.
[129] Exhibit C5 BPOE, p. 11

should be accepted, in the absence of evidence to the contrary, it is not a usual thing for a general practitioner in his position to do."[130] Although, in hindsight, it is unfortunate that Mrs Haggett's usual GP was not brought into the loop for what that would likely have revealed about the nature of her respiratory condition, I agree it would not usually be expected that a referring GP in the position of Dr Armstrong should do so.

[141] As to the adequacy and appropriateness of Dr Smith's pre-operative surgical assessment of the suitability of Mrs Haggett to undergo day surgery at the NLDH, Dr Glasson provided the following evidence at the Inquest:[131]

> *"Right. Can I then take you to paragraph 15 of Dr Smith's statement. It's a very brief paragraph. And I just want you to note for the moment that it appears that although he doesn't say precisely what his concerns were in that paragraph, that he did have some concerns – – –?---Yeah*
>
> *– – – about her comorbidities as they had been relayed to him, and also her respiratory function. Can I then ask you to go over to paragraph 21, and you'll see there that he acknowledges that he – well, it must be that he identified the respiratory function issue because he provided some explanation to Mrs Haggett about her underlying COD, and he identifies that there was anaesthetic risk associated with that. So, again, some level of concern about that presentation, including that it was potentially life-threatening. He – and if I can take you to paragraph 22, he talks about explaining the various anaesthetic options?---Yep.*
>
> *But that in the – given the nature of her condition, really she wasn't for – she wouldn't be able to have a general anaesthetic?---Absolutely not.*
>
> *So, again, some level of concern presented – – –?---Yep.*
>
> *– – – to him by reason of her respiratory condition. And then he decided – he says he decided to have a discussion with Mrs – sorry*
>
> *Dr Armstrong. Now, having regard to what Dr Smith acknowledges there in his statement about his concerns, particularly in relation to the respiratory function, the risks that he identified and spoke to Mrs Haggett about, are they the sorts of – earlier in your evidence you indicated that it might have been reasonable to reach out to others to find out more information if he was concerned. Are they the sorts of concerns that you would*

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130 Paragraph [36] Submissions on behalf of Dr Ngan

131 T7-11, L33 – T7-13, L20

– if you had those sorts of concerns would you expect him to reach out to other practitioners for more information?---Yeah, I mean, if – in a patient like this, if I've – I've got the information of the patient, and I'm – and some from the GP, and I'm satisfied that I can proceed with the planned procedure without any undue consequences and – and obviously he's planned to sit her up, he's planned to do it under light sedation, then he's sort of accounted for the co – for the respiratory comorbidity at least anyway, in terms of doing the procedure. So, yes, I think it is appropriate. The other person that I would've reached out to is probably the anaesthetic as well, to be honest with you. And maybe I'm just OCD but I do talk to my anaesthetist a lot beforehand, if I've got anybody I'm worried about. So I probably would've reached out to my anaesthetist.

Yes, I was going to ask you that question. Because you see in paragraph 24, I mean, he's very frank, I suggest, in saying – you know, stating what the predicament was that he had. He was weighing up, you know, the potential life-threatening risk posed by the anaesthetic and the potential life-threatening risk posed by the melanoma?---Highly appropriate.

In the weighing up of that, I suggest, it would have been appropriate for him to really reach out to the anaesthetist at that time for input. Would you agree with that proposition?---Yeah, look, it – ju – for no other reason than you don't want surprises on the day of surgery, either from the anaesthetist's point of view or the surgery point of view or the theatre point of view. So you try and inform people as much as possible, that there's a patient coming up, she's high risk, there's a potential for her to die from the procedure – under the procedure. And I agree with Dr Smith saying, you know, "We've got a melanoma on one side here that will eventually kill you, but you've got a respiratory function in this side that's going to kill you as well." So which is going to win, I'm not quite sure. But – but obviously once the patient hears the word "melanoma", as you – if I tell you you've got a melanoma, your heart sort of sta – starts to reach extra beats. So the patient naturally wants to get this thing done, despite the fact she knows there's risks to her life. And through this whole reading all the literature on this, obviously she was very keen to have this done and get rid of this – for good reason, by the way, as I would be. But – and I think Dr Smith was – you know, did try to balance that and discuss with her other options about the use of other non-surgical options, but that was never going to cure the condition. Never.

Just if I could take you then to paragraph 30 of his statement. There he – and I should preface this by noting that there is a factual dispute as to the extent to which there was an agreement between Dr Armstrong and Dr Smith about this, but setting that

aside, it seems that Dr Armstrong had in – sorry, I withdraw that. It seems that Dr

Smith had in mind a provisional anaesthetic plan, but it was subject to his discussion with the anaesthetist. Would it have not been appropriate to have that discussion with the anaesthetist – the provisional plan that he had, would it not have been appropriate to have that discussion with the anaesthetist well in advance of the surgery?---Yes. Look, at least, ha – I would have reached out to the anaesthetist before, yes, but not on – I'm talking what would the average ophthalmologist do. Certainly on the day of the theatre, I would have called Dr Ngan and said, "Listen, we've got case 5 or case 6" – whatever she was – "that is a concern to us in terms of respiratory function." And inform him, well, at the – and so he can think about – and think what need – needs to be done. And Dr Smith – it is on the anaesthetic plan – I noticed he corrected himself in another statement in terms of his surgical plan, but it is an anaesthetic plan. You, in your own mind as a surgeon, even though you're not an anaesthetist, still have to have a plan about what – what you need to give in terms of anaesthetic to keep this person, (a), alive, and, (b), you know, relaxed and no pain. So I think he's perfectly correct in what he's done here, and he's got in his own mind, "I've taken all of – all this respiratory issue into account. If I prop her up, if I give her minimum anaesthetic, sedation, then we should be quite okay." So I think his plan was perfectly correct and appropriate, and he's thought – thought it through well."

[142] Later in his evidence, Dr Glasson responded to the following line of questioning:[132]

"MR SCHNEIDEWIN: He had an – he says he took about five minutes to consult with the patient prior to the procedure. And it's also the case that he gave evidence to the effect that he thought, having undertaken that assessment, it was safe to proceed with the plan that he – he's formulated on that morning. My question is directed to the appropriateness of a patient such as Mrs Haggett being left, whether at the systemic level, whether it was at the surgeon level, or whether it be the anaesthetist's level, to have such an assessment undertaken in that period of time immediately prior to a surgery of this nature; or whether there was a better way in which that could be done, and safer way in which that could be done?---Yeah. I mean, to answer your question, ideally it's to inform the anaesthetist well ahead of time, but obviously not on the day of surgery; well ahead of that. To ring them and say, "We've got this patient," so the anaesthetist can reach out to the patient if need be, even see the patient if need

[132] T7-13, L33 – T7-14, L30

be, to discuss what is the most appropriate anaesthetic to move forward. You might argue, "Well, listen, it's just going to be local. It's going to topic – a local anaesthetic," etcetera, etcetera. But still these people with this, they are so fragile, they'll fall below the line so easily with any sort of sedation intra – intravenously particularly. And so, in a way, probably Dr Ngan was sort of suddenly subjected – not subjected, but suddenly presented with this patient and he has to make decisions. Now, they do this all the time. Where do – doctors make – make instant decisions all the time, but we didn't have to necessarily here. We – we had time to actually sort of talk to – so the doctor had time to talk to the patient before, and maybe talk to the relatives, and maybe talk to the GP or respiratory physician to get a better idea of what – you know, what was – what was appropriate anaesthetic at the time.

Yes. Those opportunities were available. What I'm exploring with you is, is there a system that might have provided a greater period of time, and by that I mean not hours but perhaps days, by which this additional information might have been obtained to assist not only the anaesthetist but also the surgeon about the suitability of a patient like this proceeding with in a day surgery facility. And if I can put this to you: if there was a pre-anaesthetic assessment on – in the day before, that that might have allowed more time to gather the information. Is that a practical solution in a day surgery context like this?---Yes, it – it really is. I mean, I – I – not commonly but I'll often refer the patient to see the anaesthetist well ahead of the procedure, to – so that it better informs the – both the patient as to what's going to happen, but inform the anaesthetist what he ne – he or she needs to do to minimise any possible adverse events. So, no, that's – that's still avail – that's available. I would – I use that facility not on – often, but I will do it. In fact, a patient I did last week, I did just that. She had a special condition that we weren't quite sure how the anaesthetic would – she'd go with the anaesthetic. She was the wife of a doctor, so it made me even more worried. So I said to her – rang the anaesthetist, and I said, "Ring this patient now. Talk with her. If you want to see her face to face, then please organise a consultation, but I want to make sure the patient feels comfortable and you feel comfortable when we do the procedure next week." So there – that – that is already in the system."

[143] Dr Bradley provided the following evidence from the point of view of an anaesthetist:[133]

"*So what I'd like to explore with you is, is there a better system than that or should there be a better system than that for pre-anaesthetic assessments at day surgery facilities?---If I go back to the situation that occurred about 15 or 20 years ago, before*

[133] Starting at T4-7 L5 (15 March 2024)

day-surgery admission became routine, the patients would be admitted to hospital the night before surgery and the anaesthetist would see the patient at that time in the ward. That provided for time to order some additional tests if possible, to have discussion with other specialists or GPs that might be relevant, but to more effectively enable the anaesthetist to assess the patient with enough time to change the course of management. Now, forces came into play 15 or 20 years ago to promote day-surgery admission and basically these were economic. There were enormous savings in bed to be made if patients arrived in the hospital and then proceeded directly to the operating room. What was lost here was the ability of the anaesthetist to, in person, assess the patient the day before. The proxies that were developed to enable assessment were the ones that we've seen in action here. They've been underpinned by the content of the national standards which are written by the Australian Council for Quality and Safety in Healthcare. They've been embraced more or less by all hospitals in fairly similar forms and they're assessed by the routine inspections of the hospitals by the hospital accreditor. So we've seen it in action here, where there are various questionnaires and phone calls undertaken by a registered nurse usually I believe of the patients and these normally do a pretty good job. There are flags for calling the anaesthetist or calling the surgeon. There seems to have been a flag here but we don't know whether or not the anaesthetist was contacted. But normally it works pretty well and when the anaesthetist arrives and he hasn't heard anything about the patient before the operation he will have this long list of questions already answered by the patient to assess during the relatively brief period of time he's got to look at the patient. If it's an ASA 4 patient it's obviously a lot – it's a much deeper exchange.

All right. So the process that has emerged or evolved over the years since – how it used to be done would be a satisfactory process or system for the majority of patients having day surgery?---Yes."

[144] Counsel Assisting submitted that there is scope for a finding that Dr Smith could have considered conferring with Dr Ngan about the anaesthetic plan for Mrs Haggett well in advance of the surgery given the concerns he held about her respiratory function but there is no evidence to support a finding that in doing so that would have revealed more about the nature of her respiratory function to either of Dr Smith or Dr Ngan.

[145] Mr Luchich for Dr Smith submitted to the following effect:

(a) It is right to submit, as Counsel Assisting did, that there is no evidence to support a finding that, if Dr Smith had conferred with Dr Ngan about the anaesthetic plan in advance of the surgery, it would

have revealed more about the nature of Mrs Haggett's respiratory function to either Dr Smith or Dr Ngan;

(b) It is probably correct to submit that Dr Smith could have conferred with Dr Ngan before the day of Mrs Haggett's surgery, but the real issue is whether it was inappropriate or inadequate of Dr Smith not to do so;

(c) The expert evidence of Dr Glasson was that it would have been reasonable for Dr Smith to have conferred with Dr Ngan before the day of Mrs Haggett's surgery, as Dr Glasson says he would have done, but his evidence was also that it was reasonable not to do so in the circumstances of this case where Dr Smith had thought through the issues and come up with a preliminary plan as to how he would deal with Mrs Haggett's respiratory issues subject to what Dr Ngan thought necessary;[134]

(d) In circumstances where it was reasonable to both confer with Dr Ngan prior to the day of Mrs Haggett's surgery, but also reasonable not to do so, no adverse finding should be made against Dr Smith that he did not do so.

[146] As Dr Glasson's evidence demonstrates, different surgeons may take different approaches to planning for and dealing with an identified anaesthetic risk in a patient. Undoubtedly, with the development of day surgery becoming routine, surgical and anaesthetic planning for an identified anaesthetic risk in a patient prior to the day of the planned surgery has become less common place and is no longer the norm, with both surgeons and anaesthetists relying on the proxy systems described by Dr Bradley. It can be accepted that such proxy systems are generally adequate in managing the risk.

[147] Consequently, in the modern context of day surgery with the expectation that the systems in place are generally adequate for managing identified anaesthetic risk in a patient, whilst I agree with Counsel Assisting that Dr Smith could have conferred with Dr Ngan about the anaesthetic plan for Mrs Haggett in advance of the surgery, I find that it was not inappropriate or inadequate of Dr Smith not to have done so in the case of planning for Mrs Haggett's identified anaesthetic risk.

[148] Otherwise, I find that, having regard to Dr Glasson's opinion, the plan Dr Smith put in place (subject to review by Dr Ngan) was appropriate and adequate based on the information Dr Smith had been provided. Dr Glasson did not suggest any alternative plan would have been more appropriate.

[149] I will address below Counsel Assisting's submission that there is no evidence an opportunity to undertake an anaesthetic assessment of Mrs

[134] T1-25 L20 to T1-26 L5 (14 March 2024)

Haggett prior to the day of the surgery would have revealed more about the nature of her respiratory function.

[150] As to the pre-operative estimate of the length of the surgery, this issue arose because in his original statement to the Court[135], Dr Ngan stated that the surgery had taken longer than he had anticipated. He recalled that he had asked Dr Smith how long the surgery would take and Dr Smith had told him about an hour. Based on this, Dr Shadforth opined:

> "*Dr Ngan asked Dr Smith how long the surgery would take, he replied about an hour. Anticipated length of surgery is important information for the anaesthetist. Patients like Mrs Haggett will often tolerate a short duration of surgery. About an hour is usually the time limit after which they become restless, which is what happened with Mrs Haggett. She required further infiltration with local anaesthetic and a top of her sedation. This was noted on the anaesthetic chart and also by the Surgical Scrub Nurse. I appreciate Dr Smith modified his surgery, but she was in theatre from 11:00 am until 13:33, more than double the time estimate given to Dr Ngan. Dr Smith, in his report to the coroner, talks about "the prolonged nature of the surgical procedure". The surgical scrub nurse Amanda Wiley also writes in her report "the long duration of the case was anticipated due to the nature of the pathology of the patient", so presumably this had been communicated to her.*
> *If indeed Dr Smith anticipated that the surgery was going to be prolonged, as he himself writes in his coronial report, it appears he did not communicate this to Dr Ngan, and he should not have chosen a freestanding day unit for Mrs Haggett's operation*" [136]

[151] Evidently, Dr Shadforth was concerned about the length of the surgery because "*receiving high flow oxygen of high concentration for two hours is likely to have resulted in very high blood carbon dioxide levels in Mrs Haggett's blood, leading to carbon dioxide narcosis (extreme sleepiness) that was exhibited post operatively*."[137]

[152] Dr Smith maintained that he did not tell Dr Ngan that the wurgery would take one hour.

[153] By his further statement dated 10 March 2024[138] Dr Ngan stated that:

> *"At paragraph 31 of my statement (B8) I state that I had a conversation with Dr Smith about Mrs Haggett before surgery and*

[135] Exhibit B8 BOE, paragraph [39]
[136] Exhibit G1 BOE, paragraphs [5.16] and [5.17]
[137] Exhibit G1 BOE, paragraph [1.4]
[138] Exhibit B8.4 BOE, starting at paragraph [4]

I recalled Dr Smith saying words to the effect "The operation won't take too long, probably about an hour.
It remains my recollection that Dr Smith said words to that effect although I do not recall the exact words he used in that conversation.

I acknowledge the statements made by Dr Smith at paragraphs 19-22 of exhibit B9.13 and the annexures "JN1" to my statement of 5 December 2023 in this matter (exhibit B8.3) contain an indication that Dr Smith expected Mrs Haggett's procedure to take two hours.

The surgery and anaesthetic did in fact take did (sic) take approximately two hours. Beyond possibly contributing to a marginally longer duration of recovery, I did not have a concern about the duration of the surgery."

[154] Consequently, even if Dr Ngan had understood preoperatively that the estimated length of Mrs Haggett's surgery was two hours, it seems that would not have changed his management as regards the anaesthetic technique he adopted.

[155] On that basis, the issue ultimately became redundant and, as such, I do not need to consider it further.

Issue 5: The adequacy and appropriateness of the surgical management and treatment of the deceased intra-operatively.

[156] It is convenient to deal with this issue before turning to Issue 4 below.

[157] The relevant evidence touching on this issue is to the following effect:

(a) Dr Glasson opined that Mrs Haggett was a suitable patient to undergo the procedure at NLDH. He said: "*It was not the surgical procedure that led to the patient's demise; it was most likely the use of too much sedation, which then led to the subsequent respiratory complication*."[139]

(b) At the Inquest, when cross examined by Mr Luchich, Dr Glasson stated:

"In circumstances where Dr Smith had identified that Mrs Haggett's respiratory function did pose a risk to her such that she was not suitable for a general anaesthetic, and you agree that that was correct?---Absolutely.

[139] Exhibit G3 BOE, response to Q.9

And that he planned, therefore, to do the procedure, the superficial skin excision by way of only local anaesthetic, minimal sedation, sitting up at 45, without any contemplation of high-flow oxygen, in those circumstances can I suggest to you that that surgery for Mrs Haggett on that day was not actually high risk?---No, the actual surgery wasn't high risk. It's probably the anaesthetic – look, you know, the fact she – she was – had a compromised respiratory system was the issue, not the – not the surgery. The surgery's a superficial – when I say "superficial" it's done – it's a skin operation. So it's not as though you're going inside the head or the – or the abdomen or something. And it's routine in terms of – of how it's excised and how it's repaired. So, yes, so the procedure itself was technically – yeah, you needed to be a plastic surgeon but it was technically straightforward.
Right. So the surgery, itself, was not high risk?---No."

(c) Dr Diane Conrad, by her report provided to AHPRA,[140] stated that she could not identify any part of Dr Smith's management that was not of a high standard, including his surgical management and treatment of Mrs Haggett.

[158] On the basis of this evidence, I find that Dr Smith's intra-operative surgical management and treatment of Mrs Haggett was adequate and appropriate.

Issue 4: The adequacy and appropriateness of the pre-operative anaesthetic assessment of the suitability of the deceased to undergo day surgery at the NLDH.

Issue 6: The adequacy and appropriateness of the anaesthetic management and treatment of the deceased intra-operatively including, but not limited to, the choice of technique used to anaesthetise the deceased.

[159] It is convenient to deal with these two issues together.

[160] Insofar as Issue 4 is directed to Mrs Haggett's ASA status, this has been addressed above.

[161] As to the choice of the technique used to anaesthetise Mrs Haggett, Dr Shadforth opined:[141]

"On 20th May 2019 Dr Jarrod Ngan (anaesthetist) was presented at North Lakes Hospital, with an ASA 4 patient (A patient with severe systemic disease that is a constant threat to life) with type 2 respiratory failure (type 2 respiratory failure occurs when lung ventilation is insufficient to excrete/exhale the carbon dioxide

[140] Exhibit E5
[141] Exhibit G1 BOE, paragraphs [1.2] to [1.4]

produced by the body, resulting in high blood carbon dioxide (CO2) levels). Mrs Haggett's type 2 respiratory failure went undetected. Prior notification regarding the severity of her respiratory disease would have assisted in formulating a management plan, including questioning the suitability of a day surgery facility.

Dr Ngan's anaesthetic plan of local anaesthetic with small amounts of sedation in a semi-recumbant position was considered and appropriate. The oxygen delivery system (Opiflow) that administering (sic) close to 100% oxygen to Mrs Haggett was not appropriate because of Mrs Haggett's Type 2 respiratory failure.

Receiving high flow oxygen of high concentration for two hours is likely to have resulted in very high blood carbon dioxide levels in Mrs Haggett's blood, leading to carbon dioxide narcosis (extreme sleepiness) that was exhibited post operatively."

[162] Later in her report, Dr Shadforth opined:[142]

"In my opinion that the administration for over two hours of high flow, high concentration oxygen would have led to a substantial rise in Mrs Haggett's carbon dioxide levels and contributed to her depressed conscious state at the end of the case and subsequent aspiration."

[163] At the Inquest, Dr Shadforth explained:[143]

"*Let's talk about the high flow oxygen. I understand from your evidence that it is a technique that is nowadays becoming quite a commonly used technique in these sorts of facilities and endoscopy facilities, et cetera?---Yes.*

In 2019, can you give us some indication of how and where this technique was being used?---Yes. It was first introduced into hospitals early in 2017 so it had been around a couple of years. Certainly it's become a lot more prevalent, they are using a lot more of them than they used to. There's risks associated with it. Given to the wrong patients it can be dangerous and this is certainly the wrong patient to use it in. Patients <u>- about 30 per cent to 50 per cent of patients who have severe COPD will be CO2 retainers</u> and there's evidence that Mrs Haggett was a CO2 retainer because we had the summary from Prince Charles Hospital and it was saying she had type 2 respiratory failure, which means that the CO2 levels were high. We also have the information from Redcliffe Hospital saying that she had chronic hypercarbia, so we know that she did have - I didn't see a blood gas on her prior to her admission to Redcliffe Hospital. But it

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[142] Exhibit G1 BOE, page 26
[143] T8-32, L30 – T8-32, L5

would appear that she certainly ran with a high CO2, and patients who run with a high CO2, we need to be extremely careful with the amount of oxygen. So it's not so much the flow, it's the percentage of oxygen, so there's two different devices. There's an Optiflow, which is high-flow, nearly 100 per cent oxygen, and then there's Airflow, which is the sort of device that's used in these kind of patients very commonly. Which allows you to give the flow, so you have the advantage of flow without the percentage of oxygen, because they're explicitly sensitive to increasing their oxygen – in increasing their oxygen administration. So if you increase their oxygen administration through a number of mechanisms, what usually happens is, it pushes the CO2 and they become narcotised from CO2."

[emphasis added]

[164] On the day following her evidence, Dr Shadforth cited a publication addressing hypercarbia in patients with COPD as support for her evidence that "*about 30 per cent to 50 per cent of patients who have severe COPD will be CO2 retainers"*, which became Exhibit G1.10 BOE. It is noted that the authors of that publication state:

"*The prevalence of hypercapnia is around 30–50% in patients with very severe COPD (predicted forced expiratory volume in the first second (FEV_1) <30%)"*

[emphasis added]

[165] Subsequently, the legal representatives for Dr Ngan took challenge to Dr Shadforth's point as follows:

(a) The letter sent by Prince Charles Hospital to Dr Ferreira typed 4 March 2019 reported an FEV1 of 41%;[144]

(b) Dr Bradley subsequently wrote:

"*I confirm that the GOLD Classification of COPD severity is as follows:*

- *Stage I (Early): Mild COPD with FEV-1 ≥ 80% predicted.*
- *Stage II (Moderate): Moderate COPD with FEV-1 between 50% and 79% predicted.*
- *Stage III (Severe): Severe COPD with FEV-1 between 30% and 49% predicted.*
- *Stage IV (Very severe): Very severe COPD with FEV-1 < 30% predicted.*

[144] Exhibit C6 BOE, page 76

You have asked me to comment on content of the paper "Hypercapnia in COPD: Causes, Consequences, and Therapy" authored by Csoma et al (Exhibit G1.10). I confirm that where Csoma et al is referencing "very severe COPD," it is referencing the GOLD classification descriptors and criteria.

I note that the letter from the Prince Charles Hospital about Mrs xxxxxto her General Practitioner Dr xxxxx of 4 March 2019 reports an FEV1 of 41%. Using the GOLD classification to assign severity, Mrs xxxxxt would be classified as Stage III ("severe")."

(c) That is, Dr Shadforth was incorrect in stating that "*30 per cent to 50 per cent of patients who have <u>severe</u> COPD will be CO2 retainers"* because that statistic expressly related to patients who had <u>very severe COPD</u>, which Mrs Haggett was not documented as having.

[166] To the extent it is relevant, this is a matter to be taken into account below.

[167] Dr Wenck explained:[145]

"I wish to emphasise two important points that Dr Shadforth makes regarding the CO2 retention this patient suffered.

The issue of Oxygen induced hypercarbia in patients with chronic lung disease is very poorly understood by most medical practitioners.

There are patients who have permanently raised CO2. Typically, they are obese with obstructive sleep apnoea and may also have chronic lung disease. These patients may well have hypoxic respiratory drive and typically become somnolent on oxygen without respiratory distress.

There are other patients who don't retain CO2 normally but have very severe lung disease. If these patients are given high concentrations of oxygen their CO2 rises due to a different mechanism. The oxygen inhibits their hypoxic pulmonary vasoconstriction reflex. This impairs their ability to maintain their ventilation perfusion match. Both shunt and dead space rises leading to both hypoxia and raised CO2. The patient tries to compensate by increasing respiratory rate and tidal volume but is severely limited by diseased lungs.

This is the situation that Mrs Haggett faced. Her respiratory rate was 32 but despite this she had a very high CO2 and severe hypoxia.

[145] Exhibit G2 BOE

The use of a high flow oxygen device in the operating theatre was highlighted by Dr Shadforth in her report. I agree this was the pivotal issue. These devices provide 100% oxygen fully humidified at high flow. They are used widely in endoscopy suites and operating theatres.

The concentration of oxygen cannot be varied unlike those in the wards and ICU environments. They can lead to CO2 retention in those patients with severe lung disease and cause near apnoea in those with chronic CO2 retention."

[168] Having regard to the opinion evidence, I find that the more than two hours of high flow, high concentration oxygen delivered to Mrs Haggett led to a substantial rise in Mrs Haggett's carbon dioxide levels and contributed to her depressed conscious state at the end of the case and subsequent aspiration.

[169] Further, having regard to the opinion evidence extracted below in dealing with Issues 11 and 12, I find that once Mrs Haggett aspirated, it is very unlikely she could have been salvaged. In that sense, I find that the anaesthetic technique Dr Ngan chose to administer to Mrs Haggett caused or materially contributed to her death.

[170] In that regard, Dr Ngan accepted:[146]

> "….do you accept that the opinions that have been expressed as to what was the likely cause of her post-surgical obtunded state, and that is that high-flow oxygen caused her to become hypercarbic?--- I accept that that's one of the causes.
>
> Yes. You accept that that's likely to have eventuated by reason of the high-flow oxygen that had occurred in her case?---Yes.

[171] I infer from Dr Ngan's evidence that he would not have made the decision to use high flow, high concentration oxygen in sedating Mrs Haggett if he had known she was on home oxygen and that she had been diagnosed with Type II respiratory failure.[147]

[172] It can be accepted that neither of Dr Smith's pre-operative assessments of Mrs Haggett, nor the pre-admission process at NLDH revealed that information about Mrs Haggett's respiratory function.

[173] It can also be accepted that Dr Ngan had limited opportunity to consult with Mrs Haggett on the morning of her surgery (a duration of about 5 minutes).

[174] Further, Dr Ngan's own enquiries of Mrs Haggett during the limited opportunity he had to consult with her did not reveal this information about her condition.

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[146] T5-43, LL 29-34

[147] See, for example, paragraph 21 Exhibit B8

[175] Dr Ngan's limited opportunity to consult with Mrs Haggett on the morning of the surgery, and without any opportunity to do so prior to the day of the surgery, ought to be considered in the context of the following evidence.

[176] In Dr Shadforth's written report she said, at paragraph 5.2:

> "*Being presented with such an unwell and difficult patient on the day of surgery with no opportunity for forward planning is less than optimal*".

[177] At paragraph 5.24 Dr Shadforth said:

> "*It is often difficult to pick up which patients are the chronic carbon dioxide retainers and stresses the importance of the involvement of our respiratory physician colleagues in cases like these*".

[178] At paragraph 5.25 Dr Shadforth said:

> "*Most patients, like Mrs Haggett, would come with a warning from their respiratory consultant of the fact the patient is a CO2 retainer . . .* ".

[179] At paragraph 5.15 of her report Dr Shadforth elaborated that normally the relevant collateral information about the patient would come from the general practitioner referring to the surgeon, which was missed here because it was not the usual general practitioner who made the referral. I note there is no evidence to suggest that Dr Ngan knew or ought to have known of this circumstance.

[180] In her oral evidence,[148] Dr Shadforth said that it was "*very suboptimal*" that no prior warning was given to the anaesthetist of a patient of Mrs Haggett's type, with the first knowledge of her and her difficulties becoming known on the morning of the list.

[181] Dr Shadforth also stated:

(a) "*but once a patient gets to that point it is very difficult to stop the whole process*"[149]

(b) *"And whilst an anaesthetist might, in those circumstances, think that they are making, objectively, the right judgment about what to do or what not to do, particularly when it comes to considering the option of cancelling the surgery, despite that being their thinking about what they 're doing, they may well be influenced by those circumstantial pressures?---Yes, you are.*

[148] at T4-23 L35 (15 March 2024)
[149] at T4-24 L5 (15 March 2024)

This is one of the very reasons, is it not, why, in cases where there is cause for concern about a patient's anaesthetic risk, that there ought to be a consultation with the anaesthetist prior to the day of surgery?---That's exactly right."[150]

[182] In answer to questions from Counsel Assisting, Dr Shadforth explained:[151]

> "*So it would have been a simple, practical measure to guard against the risk of managing this patient for Dr Smith to have run it by Dr Ngan that this was a patient that he intended to perform surgery on at the hospital and that could have provided Dr Ngan with an opportunity to undertake an earlier assessment if he desired to do so?---Yes. Yes. It also gives the anaesthetist time to think about what they are going to do rather than, wham, ham, five minutes before you've got to suddenly - you 're presented with someone who is very ill and you've got to make a decision of what you 're going to do and how you 're going to do it. You can talk to your colleagues, you know, get help. It's so important to have pre-warning for these sort of cases.*
>
> *Or you might inform yourself sufficiently that this is not a patient that should proceed -?---Exactly.*
>
> *- - - to surgery at this facility?---Correct. Yes.*
>
> *Just in terms of the observation you make about the - I think you described it as a wham bam situation, Dr Ngan's evidence was that, yes, he first had the opportunity well the first time he saw the patient was immediately prior to the surgery. He said he spent about five minutes with her in undertaking the assessment. He agrees he could have taken longer if he thought it was necessary to do so. Notwithstanding that point, that he could have taken longer if he wished to, the environment that he was in in undertaking that assessment is different, is it not, to an environment that he might have been in if a pre-anaesthetic assessment had occurred the day prior?---Absolutely. By the time you get to this point there is pressure of time, theatre is waiting for you, you can look things up, the patients are expecting - they have fasted, they 're not expecting to be turn away and surgeons do not like having their cases cancelled. I don't- you know, that's just the way it is, they don't like it*."

[183] Dr Shadforth identified that there ought to have been a system that identified relevant patients days before for a prior assessment- a screening mechanism.[152]

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[150] at T4-52 L30-40 (15 March 2024)
[151] T4-26 L30 to T4-27 L5 (15 March 2024)
[152] T4-24 L30 (15 March 2024)

[184] Returning to paragraph [126] of Counsel Assisting's submissions, I note Mr Diehm KC submitted that "*in the above there is evidence that shows, at the least, that had such an opportunity arisen, Dr Ngan may well have become aware of the relevant information, or at least that there was a reasonable chance that he could do so*."

[185] I accept Mr Diehm's point that there may have been a "*reasonable chance*" Dr Ngan may have become aware of the relevant information if he had been afforded the opportunity to consult with or consider the anaesthetic plan for Mrs Haggett well in advance of the surgery, but I do not think the finding can be put any higher than that. I also accept that, in part, the problem was systemic in that at day surgery facilities such as the NLDH, patients like Mrs Haggett are being seen by anaesthetists for the first time immediately before surgery.

[186] That said, I do not accept that Dr Ngan not being aware of the relevant information in the case of Mrs Haggett can be attributed entirely to the systemic issues connected with day surgery generally, or those that specifically existed at NLDH, for the following reasons:

(a) Dr Ngan had long experience practicing as an Anaesthetist at day surgery facilities such that I infer he was aware of the systemic issues associated with the consultation process immediately before surgery, the risk that presented in some patients, and the need to proceed with caution in assessing such patients;

(b) Although I acknowledge Mr Diehm's point at paragraph 30 of his written submissions that there is a distinction between what Dr Ngan "*could have done*" and what he "*should have done*", I reject his submission that Dr Ngan made no concessions in respect of the latter because, in respect of the critical aspect of Mrs Haggett's medical history, namely that she was on home oxygen, Dr Ngan quite clearly volunteered that he should have asked her about that:[153]

> "*So it's not the case that you just rely on the patient-provided history when you're making your assessment?---Yes.*
>
> *You are, of course, free to ask all the questions that you think are necessary?---Yes. There's endless questions that you could ask in that regard, but most patients volunteer when they're on home oxygen that they're on – it's – she's on 15 litres a day – 15 hours a day, so that's a lot of oxygen.*
>
> *Yes?---Yeah.*

[153] T5-37, L34 – T5-40, L20

That's right. I mean, most patients might volunteer that, but what I'm putting to you is you had sufficient information to inquire further - - -?---Yes.

- - - about her medical history. You would agree with that?---That's correct.

And that might or might not lead you to that finding, but it likely would have provided you with more information - - -?---That's correct.

- - - in terms of the nature of her disease - - -?---Yes.

- - - who had been treating her, for example - - -?---Yes.

- - - what physicians at what facility, etcetera?---Yes. At this stage, you know, she had been through a few different physicians, all of which were unaware, so I should've asked her about the oxygen, but there were – yeah.

Yes. I appreciate that other physicians also didn't' ask the question - - -?---Yes.

- - - but to be fair, I put to you that really, that's your main game, is to ask those sorts of questions - - -?---Yes.

- - - when you're undertaking the anaesthetic assessment?---Yes.

All right. And if it is the case from your perspective that knowing that she was on home oxygen was the decisive issue - - -?---Yes.

- - - what would you have done if that were the case, if you'd been given that information?---I believe I would – I believe that we would not have proceeded with the surgery because it's such an end-stage therapy and for such a long duration."

[emphasis added]

(c) Where Dr Ngan's direct evidence, by volunteered concession on his part, was that he "*should've asked her about the oxygen",* Dr Shadforth's evidence to the effect that she did not think most anaesthetists would have asked such a question is of no assistance;

[187] Consequently, I find that:

(a) As he appropriately conceded, Dr Ngan had sufficient information to enquire further of Mrs Haggett about her medical history, which he

accepted would likely have provided him with more information about the nature of her disease and who her treating doctors were;

(b) As he also appropriately conceded, Dr Ngan should have asked her about oxygen;

(c) If Dr Ngan had asked her directly, it is likely Mrs Haggett would have told him she was on home oxygen and he would have made the decision not to proceed with the surgery on 20 May 2019 at NLDH;

(d) Dr Ngan's failure to enquire further of Mrs Haggett having regard to the information he had, specifically in respect of his failure to ask about oxygen, was not adequate or appropriate management of her anaesthetic risk;

(e) This failure led to Dr Ngan's administration of an anaesthetic technique which was the direct cause of her death.

[188] A secondary issue that arose related to Dr Ngan's intraoperative record keeping on the Surgical Anaesthetic Report,[154] which contained various alterations and internal inconsistencies as between the volumes of drugs recorded as having been administered comparted to the volumes of drugs that were recorded as having been discarded.

[189] This record was also inconsistent with what was recorded in the NLDH's Dangerous Drug (**DD**) book[155] and the logbook Dr Ngan was then required to maintain.[156]

[190] In respect of this secondary issue, Counsel Assisting made submissions to the following effect:

(a) Dr Ngan acknowledged the error in his record keeping;

(b) Dr Ngan's explanation for how the inconsistencies arose, albeit not optimal in terms of good practice, was plausible.[157] At or near the start of the surgery he recorded the discard amount as 40 micrograms of Fentanyl because that is what he assumed he would be discarding (not expecting he would later administer a further 20 micrograms during the course of the surgery). He later forgot to adjust the discard amount. In light of the evidence of RN Bain[158] it cannot be said that there was any sinister motive behind the inconsistencies;

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154 Exhibit CI.1 BOE, page 8
155 Exhibit B2.2 BOE, paragraph [14]
156 Extract provided at paragraph [11], Exhibit B8.2 BOE
157 Exhibit B8.3 BOE, paragraphs [3] – [8];
158 Exhibit B2.2 BOE

(c) RN Bain's evidence about her usual practice, her role in witnessing Dr Ngan's logbook, and her evidence about how the anomaly in the DD book likely arose were consistent with Dr Ngan's explanations;

(d) Otherwise, there is nothing to indicate that the inconsistencies in Dr Ngan's recording keeping, or the circumstances surrounding that, caused or materially contributed to Mrs Haggett's death.

[191] I accept Counsel Assisting's submission and find that in the above circumstances, there is nothing to indicate that the inconsistencies in Dr Ngan's recording keeping, or the circumstances surrounding that, caused or materially contributed to Mrs Haggett's death.

Issue 7: The adequacy and appropriateness of the surgical management and treatment of the deceased post-surgery.

[192] Dr Smith's evidence was to the following effect:

(a) He did not at any time assess Mrs Haggett in PACU as he was not required to do so unless there is a surgical problem raised with him.[159]

(b) No issue was raised with him that required him to attend on Mrs Haggett in PACU, that he completed his paperwork, clarified with Dr Ngan that Mrs Haggett was his responsibility, and returned home.[160]

(c) Subsequently, he received two voicemail messages from CM Smith and received a phone call from Dr Ngan at 14.58 hours.[161] During this phone call, Dr Ngan said it was his understanding that Mrs Haggett was to be transferred to Peninsula Private Hospital.[162] This was subsequently confirmed in his conversation with CM Smith.[163] The impression Dr Smith obtained from these phone calls was that both Dr Ngan and CM Smith were not worried about Mrs Haggett's situation.

(d) He then received a voicemail message from CM Smith at 16.26 hours informing him that Mrs Haggett was then being transferred to Redcliffe Hospital.[164]

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[159] T2-41 LL 10-16.
[160] T2-41 LL 25-35.
[161] T2-42 LL 6-21.
[162] T2-42 LL 35-41.
[163] T2-42 L 46.
[164] T2-44 LL 22-23.

(e) He did not consider Mrs Haggett's slow recovery from sedation to be within the remit of a respiratory physician as Dr Ngan reassured him that he had seen this before.[165]

[193] Dr Shadforth opined that:[166]

> "*In my experience, most surgeons and proceduralists will drop in on their patient in the recovery prior to leaving the hospital, particularly, if they have the degree of concern that Dr Smith notes that he had pre-operatively. I acknowledge he states he left the care with Dr Ngan, and anaesthetists do take the primary care role in recovery, however nevertheless I would consider it unusual Dr Smith did not review Mrs Haggett prior to leaving North Lakes*."

[194] At the Inquest, Mr Luchich, counsel for Dr Smith, took up this issue with Dr Shadforth, referring specifically to Dr Smith's evidence, as follows:[167]

> "*So I'm just going to ask you some questions about the matters that are above that, just to give you some framework to what we're dealing with. And so the first matter I'd just like to ask you some questions about is the sentence immediately above where you say:*
> *Dr Smith left the facility without checking Mrs Haggett's condition.*
> *Do you see that sentence?---I do see it.*
> *Do you accept that that is not an accurate characterisation of the evidence that you had before you when you prepared this report?---No, I don't think Dr Smith checked on Mrs Haggett before he left.*
> *All right. Can we go please then to Dr Smith's statement, which is B9, and it is paragraph 66. I'll just ask you to reread paragraph 66 and 67 to yourself please?---Yes, I'm familiar with that, but that is not – – –*
> *I'm just going to ask the question if I could first, Dr Shadforth. So Dr Smith is saying there - so he had a conversation with Dr Ngan where he asked about Mrs Haggett's condition. See that?---I do.*
> *He responded - Dr Ngan to Dr Smith, said, "She's a bit slow to wake up, common in patients like her. I am not worried." He asked, "Should I stay here?" and Dr Ngan responds, "No, you're fine to go home. She'll be fine. I will stay here for a bit."*
> *And Dr Smith goes on to say, in the next paragraph, that Dr Ngan did not seem more worried about Mrs Haggett's condition. So if we can go back now to your report, G1, I ask you again, do you accept the statement that you made that Dr Smith left the facility without checking Mrs Haggett's condition is not an accurate characterisation of the evidence you had when you prepared this report?---No, I am saying that Dr Smith did not go to recovery and see Mrs Haggett before he left the facility. Given the amount of*

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[165] T2-44 LL 5-20.
[166] Exhibit G1 BOE, paragraph [5.37]
[167] T8-48, L26 – T8-49, L29

concern he expressed in his first report, although that was quite different to his second report, he felt was not much problem at all in his second report, the first report he thought she had a life-threatening condition. I would have thought that he would have dropped into recovery physically and seen the patient for himself before he left the facility, which he did not do, and thereby I stand by that statement.

You see the difficulty, Dr Shadforth, isn't it, that reading that sentence in the summary section of your report, anyone would think that Dr Smith left without asking anyone anything about Mrs Haggett's case, including the anaesthetist?---Well, perhaps I should have put Dr Smith left the facility without physically checking on Mrs Haggett's condition.

And with respect to the concept of Dr Smith going and seeing Mrs Haggett before he left the hospital, in circumstances where at that point in time, 2.30, about 2.30 pm, I ask you assume this to be true, no nurse has come to him and said there's an issue with Mrs Haggett of any kind, he speaks with Dr Ngan in the terms of what we've just seen in his statement, and he's reassured that she is essentially fine, a bit slow to wake up, but Dr Ngan's not worried at all. In those circumstances, it is perfectly reasonable, I suggest, for him to leave the hospital at that point without physically checking on Mrs Haggett himself. Do you agree with that?---Many surgeons would check, perhaps he didn't - well, he didn't. But I think someone as ill as that, doing a prolonged procedure, you would check in before you left."

[195] In his cross examination of Dr Ngan, Mr Luchich did not specifically raise with him the terms of the conversation Dr Smith described he had with Dr Ngan at paragraph [66] of Exhibit B9 (referred to in the extract of Mr Luchich's cross examination of Dr Shadforth above). Nevertheless, Dr Ngan has not contended that the conversation in the terms maintained by Dr Smith did not take place. On that basis, I am prepared to find that the conversation took place as described by Dr Smith.

[196] As an aside, I reject Mr Luchich's written submissions at paragraphs [34] and [35]. On an issue that was apparently considered critical enough for Mr Luchich to challenge the factual foundation of the opinion expressed by Dr Shadforth, I would not have considered it inefficient or a waste of the Court's time for counsel representing Dr Smith to put the detail of the conversation to Dr Ngan. Nor do I consider it Counsel Assisting's role to do so where it was in Dr Smith's interests to establish the fact of the conversation in the terms he asserts took place. It was for his counsel to do so if his counsel considered it necessary to protect his interests. That is why parties are granted leave to appear with legal representation.

[197] Otherwise, Dr Glasson opined that:[168]

[168] Exhibit G3 BOE

"It was quite appropriate for Dr Smith to have left the hospital without reviewing the patient, as he had discussions with his anaesthetist before leaving and was just reassured that the patient was stable but still somewhat sedated. I firmly believe that any post-operative anaesthetic issues lie with the anaesthetist, not the surgeon."

[198] Mr Luchich submits that there should be a finding that Dr Smith's post-operative management and treatment was appropriate and adequate in all respects.

[199] The only aspect of Dr Smith's post-operative management and treatment of Mrs Haggett that I am concerned with is his leaving the hospital without first reviewing Mrs Haggett in the PACU.

[200] In that regard, whilst it may be the case that some surgeons would check on a patient such as Mrs Haggett before leaving the facility in line with Dr Shadforth's expectation and experience, I find that it was not inappropriate for Dr Smith not to have done so in the context of the conversation he had with Dr Ngan.

Issue 8: The adequacy and appropriateness of the anaesthetic management and treatment of the deceased post-surgery.

Issue 9: The adequacy and appropriateness of the Hospital's management and treatment of the deceased post-surgery.

Issue 10: The adequacy and appropriateness of the decision to transfer the deceased to the Redcliffe Hospital Emergency Department (ED) including, but not limited to, as to the timing of that decision.

[201] It is convenient to consider these issues together.

[202] To put these Issues into context, it is noted that at the close of the surgery, at or about 13.30 hours, Dr Ngan administered the following reversal agents before Mrs Haggett was moved to PACU:[169]

(a) 100 micrograms of Naxalone (a narcotic (Fentanyl) reversal agent);

(b) 400 micrograms of Flumazenil (a Midazolam reversal agent).

[203] According to Dr Wenck:[170]

"Despite pharmacologic reversal of the sedative and opiate drugs she was drowsy in the Post Anaesthetic Care Unit (PACU). She had low oxygen saturations and had a high respiratory rate."

[169] Exhibit B8 BOE, paragraph [44]
[170] Exhibit G2 BOE

[204] At the Inquest, Dr Wenck explained:[171]

"*Yes. So I won't take you to the entries, but – it is the case that Dr Ngan administered the reversal agents, both the opioid reversal agent - - -?---Correct.*
- - - and the – benzodiazepine reversal agent?---All right.
The – what his expectation was in administering those reversal agents, I think, were effectively twofold, that is: that Ms Haggett would at some stage after the administration return to a baseline respiratory rate, that – that which was normal for her within a reasonable period of time and that she would improve her level of consciousness or – or come out of the state of unconsciousness that she was in or the reduced state of consciousness that she was in within a reasonable period of time and I appreciate, Dr, that every patient is probably different. But is there a period of time which might be regarded as reasonably – a reasonable expectation of how long those – those things might take to occur after the – after the administration of those drugs?---Okay, so with regard to the opiate – opiate reversal with a drug called naloxone, it is pretty well immediate. A couple of minutes is generally speaking, these drugs cross the blood-brain very, very quickly; they work very, very quickly. And the same with the reversal agent for – for the – for the benzodiazepine – I'm sorry, I got a mind blank there – benzodiazepine, they work pretty quickly as well. Within about five minutes both drugs should have been adequately assess what has – what has happened.
And in terms of – which one – which one improves the respiratory rate or which one returns the – the patient to - - -?--- [indistinct]
Sorry, I didn't hear your answer?---So both, really. I mean, it depends on the – on the amount of drug that was given, etcetera. But both – all opiate will – can cause drowsiness and decrease respiratory rate as can midazolam, benzodiazepine drugs. So both of them will return the patient to consciousness and to increase their respiratory rate if that is the cause of their unconsciousness to being with….
…
And can I just ask you, this is the PACU obs chart or resp chart that was maintained after the patient was taken to recovery. And I just want you to assume just a couple of things for the purposes of these questions. First of all, that the reversal agents were administered at about 13.30 hours. And the second thing that I want you to assume is that the observations, in particular the respiratory rate, for the purposes of these questions are accurate. So just focusing on the respiratory rate of – that's indicated on that observation chart, is that what you would have expected to – the patient's respiratory rate to be maintained at after the giving of the reversal agents?---No, the respiratory rate should be low with those agents onboard if that's the cause: the both the

[171] T6-12, L45 – T6-14, L5

midazolam and the opiate that was used decrease respiratory rate and, yes, reversal should increase respiratory rate but not to an abnormal level. It should increase it to between, you know, around the 15 to 20 mark. It's certainly not 34, 30 to 34 I think it's written there, so that's a very high respiratory rate indicating the patient's in respiratory failure.

And in relation to the level of – of consciousness level is it recorded, sorry. I'll withdraw that question. The respiratory rate of being maintained over 30 at least up until around 2 pm or 13.59 hours. Quite apart from what the cause of that might be including that Ms Haggett was a CO2 retainer, is that a level of respiratory rate that is of concern in the post-operative period?---Yes, yes, it is."

[emphasis added]

[205] At the Inquest Dr Shadforth explained:[172]

"I understand Dr Ngan's purpose in administering those agents were, was to improve Mrs Haggett's consciousness – state of consciousness?---Yes.

And also to return her to a normal respiratory rate?---Yes

Is that consistent with the purpose of giving those?---Correct. Flumazenil will reverse Diazepam. Narcan will reverse Fentanyl, and the effects are usually very quick. Almost immediately, certainly within a couple of minutes.

All right, I was going to ask you about that. Just understanding the timing of – how times are recorded on this document. Again, the effect of Dr Ngan's evidence is that – see where there is an 11, there's a 12 and there's a 12, each box represents a 10-5 minute point in time. So that arrow which appears under the notation for the reversal agents, suggests that they were given at 13.30 hours, do you see what I'm saying?---Yes. The anaesthetic nurse makes a comment at the end of the – at the end of the anaesthetic, that she was difficult to rouse, and I suspect that that's when he gave those reversal agents, because they weren't given in recovery, they were given in the operating room. So I suspect the took the drapes off, realised that she was not responsive and decided that they would administer those.

And that's what you would ordinarily expect an anaesthetist to do if that – if the patient was not rousable at that time?---If they were concerned, yes. Depending on the circumstances, you might, in any case he was concerned about her, otherwise you'd just leave them and let them wake up naturally.

Right. Now, you mentioned – I think you already gave some evidence about this moments ago, in terms of the expectation of response to the reversal drugs – reversal agents, what sort of timeframe would you expect to see some effect? And what would

[172] T8-38, L32 – T8-40, L6

the effect be?---You – the timeframe is very quick. Within a couple of minutes of administration. And you'd expect them, if – if the cause of the diminished conscious stage was drug-related, then you would expect her to wake up pretty quickly after that.
Okay, within minutes?---Yes. Five maximum.
And would that be the case for all patients of does it vary depending on?---No, everyone.
All right. And in terms of whether or not the administration of these agents would have any effect on respiratory rate, would you expect the respiratory rate to increase with the administration of these drugs?---If the - if the respiratory rate was lower because of the drug effects, yes. But if the respiratory rate was not affected, it was related to some other problem, then you're not going to get any effect from it.
Okay. Would you expect the respiratory rate to be elevated to over 30 in response to the administration of these drugs?---No.
Okay. And that it would persist at a level at or around 30 in response to this drugs?---Oh no, not at all, no. The idea of naloxone is, if the patient has a slow - and it's a slow - with narcotic overdose, you get - actually get a slow respiratory rate. So, you know, you give naloxone, the respiratory rate shoots up. If there is - but it just goes up to normal. It doesn't go way up. It just goes to a normal rate. No, you don't expect it to go to 32, no.
So to use a simplistic description then, if, after the administration of these reversal agents and the patient hasn't woken up or become more alert in a period of about five minutes or so, the reason - the reasonable deduction is that her state of consciousness is not related to the sedation - the drugs that have been used for the purpose of the sedation?---That's correct. There was no other sedative or an anaesthetic agent used in this case, and so, yes, you would have expected the patient to be quite rousable after that if the reason for diminished conscious state was the drug - was drug- related."

[emphasis added]

[206] Without going to it in detail, the evidence of the witnesses (referred to below) and the record makes it clear that Mrs Haggett never recovered from her obtunded state to the extent expected, or at all, following the administration of the reversal agents. The opinions of both Dr Wenck and Dr Shadforth are to the effect that from very soon after the reversal agents were administered (within 5 or 10 minutes) it ought to have been deduced that Mrs Haggett's state of consciousness (or lack thereof) was not related to the sedation that she had been administered during the surgery.

[207] By his initial statement to the Court,[173] Dr Ngan provided the following evidence about Mrs Haggett's post procedure recovery:[174]

[173] Exhibit B8 BOE
[174] Starting at paragraph [45], page 9

"At about 1400 hrs I delivered Mrs. Haggett to the 'PACU' following her procedure. Her observations were stable on continuing nasal prong oxygen therapy (2L per minute). I handed-over the specifics of her case and her medical history to the nurse in the PACU.

I was in the Hospital for some time after Mrs. Haggett went to the PACU, during which time I had lunch. Prior to leaving, roughly 30 minutes after her procedure finished, I brought Mr Haggett in to see Mrs. Haggett. She was still slightly drowsy but responded appropriately to questions with stable observations. When I asked her if she had any pain she shook her head. I believed that her state of health and the longer than expected duration of her procedure meant she would take some time to recover fully, but she was on the 'right track'.

I was not made aware of Mrs. Haggett's respiratory rate of 30 at any stage and I did not notice that she was obviously more dyspnoeic than usual, however I did not specifically count her respiratory rate myself. She did not appear any more dyspneic compared to her preoperative state."

[208] At the Inquest, Dr Ngan's evidence as to the expected effect of the reversal agents was as follows:[175]

"When you administered the reversal drugs - - -?---Yes.
- - - what was your expectation in the case of Mrs Haggett in terms of her response from both drugs?---Just the reversal of the sedation; that she would become more alert.

Okay. Within a 20 minute period, half an hour, an hour, two hours?---If you're going to see a response, it would normally be within minutes.

In minutes. Okay. And that's in relation to both the drugs, so - - - ?---Yes.
- - - the other drug – you would expect a response in the respiratory rate within minutes?---Yes.

So you wouldn't expect there to be a long period of no improvement in terms of consciousness or respiratory rate?---Yes, that would be accurate, yeah.

And also in terms of reduced oxygen saturations?---The oxygen – the oxygen saturations would have improved just as a result of potentially breathing a little more, but not necessarily the primary aim or the primary focus. It really is respiratory rate and level of consciousness."

[175] T5-59, LL11- 31

[209] At Inquest[176], Dr Ngan:

(a) Agreed he transferred Mrs Haggett to PACU earlier than 14.00 hours noting the first entry in the PACU record was at 13.39 hours;[177]

(b) Agreed he remained at the NLDH until at least 14.30 hours because he reviewed Mrs Haggett in PACU at or about that time;[178]

(c) Agreed that despite the giving of the reversal agents (which might have the effect of increasing a patient's respiratory rate), Mrs Haggett's elevated respiratory rates as charted at 13.39 hours to 13.59 hours were concerning;

(d) Agreed that the combination of low oxygen saturations of say 88% and a respiratory rate greater than 30 at 13.59 hours was "*certainly concerning*";[179]

(e) Could not recall whether he observed Mrs Haggett's respiratory rate when he reviewed her in PACU at 14.30 hours;[180]

(f) Thought that he was more focussed on Mrs Haggett's level of consciousness at that time (14.30 hours);[181]

(g) Initially said that Mrs Haggett's then level of consciousness was "*potentially concerning given that it hadn't returned to normal by that stage. Potentially concerning*."[182]

(h) Agreed that Mrs Haggett was quite impaired from a consciousness point of view at that time (14.30 hours);[183]

(i) Agreed that Mrs Haggett's state of consciousness had not returned to anything much beyond (i.e. improved) what it was when she came out of the surgery;[184]

(j) Agreed that Mrs Haggett had been in her obtunded state for close to an hour by that stage (14.30 hours);[185]

(k) Agreed that Mrs Haggett's prolonged period of being in that obtunded state for close to an hour was, in fact, concerning by that time;[186]

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176 Dr Ngan accepted the times in the record to be accurate: T5-60, L19
177 T5-60, LL22-33
178 T5-61, LL5-7
179 T5-63, LL 40-44
180 T5-66, L19
181 T5-66, L21
182 T5-66, LL22-24
183 T5-66, L27
184 T5-66, LL29-31
185 T5-66, LL33-34
186 T5-66, LL36-37

(l) Agreed that the ongoing respiratory rate of above 30 was also concerning at that time (14.30 hours);[187]

(m) Agreed that although the nurses did not inform him of Mrs Haggett's respiratory rate at that time, he could have observed that for himself;[188]

(n) Agreed he could have reviewed the ADDS chart and the Obs chart at that time (14.30 hours) and that information would have been available to him;[189]

(o) Agreed that the plan he made was that reflected in the note in the record[190] - "….*To continue to monitor in PACU for an hour. Will review and reassess @ 1530 hours*."[191]

(p) Agreed that he left the premises of the NLDH shortly after his review of Mrs Haggett at 14.30 hours.[192]

[210] When asked to reflect on the above circumstances and to consider whether his management of Mrs Haggett would have been any different, Dr Ngan stated:[193]

> "*Okay. Reflecting on the position at 2.30 pm now - - -?---Yes.*
> *- - - and noting those concerning issues that we've been talking about - - -?---Yes.*
> *- - - do you think your management would have been any different than what it*
> *was?---<u>I should've acted then</u>.*
>
> *Okay. And in what way?---I think I was fixated on the fact that she'd had sedation and she was an elderly, frail woman who was very slight and was just going to take longer, <u>but I should've thought that there was something else concerning leading to those observations</u>.*
>
> *And what could they – could that have included the possibility that she was retaining CO2 or becoming hypercarbic?---Yes.*
> *Anything else that might've - - -?---She could have aspirated by that stage. She could've had a stroke. She could have had a surgical complication from the – a complication from the local anaesthetic. Just from – you know, off the top of my head, those would be some things.*

[187] T5-66, LL39-40
[188] T5-66, LL45-46
[189] T5-67, LL4- 5
[190] Exhibit C1.1, page 11
[191] T5-68, L25
[192] T5-68, L20
[193] T5-67, L9 – T5-68, L

Okay. So there was at least a number of potential explanations for why she remained in that state - - -?---Yes.
- - - at that time which ought to have warranted some intervention - - -?---Yes.
- - - at that time?---Yes.
You would agree with that?---I would agree.
Okay. And that intervention would have included – should have been what?---Are you – are we making the assumption now that we knew that she was retaining carbon dioxide or just - - -
No. Just if you'd made the observation of a high respiratory rate - - -?---Yes.
- - - and the long period of loss of – sorry, the long period whereby she's not recovered any real degree of consciousness. So don't worry about whether you should've deduced or could've reduced (sic) the CO2 retainer?---Yes.
What do you think – or what should you have done at that stage?---Well, the ultimate management probably would've been I should've transferred her then, and prior to that I should've considered those potential causes more carefully."

[emphasis added]

[211] Later in his evidence at Inquest, when examined by his counsel, Mr Diehm KC, Dr Ngan explained his decision in the following way:[194]

"All right. You've said in your evidence here today that you accept that by about 2.30, the time of your review, that you ought to have had an appreciation that things weren't going as they ought to have been and that, ultimately, you should have been putting in place the plan for the transfer of the patient – I think your evidence was - - -?---That's correct.
- - - to the Redcliffe Hospital - - -?---Yes.
- - - ultimately, because of the various reasons as to why she may be as she was?---Yes.

Are you able to offer any insight, looking back at your own conduct now, as to why it was that that didn't occur to you at that time?---I think it was a fixation error.

And what were you fixated upon?---I was fixated on my experience that – and my clinical judgment that – well, I didn't know about her medical history in as much detail as I should have, but just fixated on the fact that in the past, I've had patients who take a lot more time to recover, particularly with frail, elderly patients.

All right. Now, had you have known that this patient, in fact, had a previous diagnosis of type respiratory failure and was on – had

[194] T5-87, L24 – T5-88, L24

been prescribed home oxygen for her lung condition, leaving aside your evidence that - - -?---Mmm.
- - - you wouldn't have gone ahead with the procedure from an anaesthetic point of view in the first place, if you had known that information, would that have made a difference to your thinking in the circumstance that presented itself when the patient was in the PACU?---So if, at that moment, I knew that she was a carbon dioxide retainer on home oxygen, yes, the decision to transfer somewhere where non-invasive ventilator assistance or invasive ventilator assistance could be employed to help her reduce her CO2 would have been in place.

All right. Now, going back to the reality of the situation, that you didn't know – didn't have that information - - -?---Yes.
- - - available to you and looking in particular at the time of your review at 2.30, are you able to, looking again at your own conduct, offer any insight into why it was that you weren't looking at the observation chart for the patient?---I think that you become – the end of the bed assessment is something that particularly experienced practitioners will do. I – I accept, though, that I should have looked more closely at the observation chart. I think that, in my mind, the numbers on the chart, in hindsight, kind of don't quite correlate in terms of urgency with the clinical picture itself. She appeared not as unwell as her numbers suggested.

And what role, if any, did your expectation about what the clinical course for this lady was going to be play in the degree to which you did look at numbers of that kind?---It was probably a little detrimental, because I was fixated on her improving and I wasn't necessarily focused on other causes.

[212] Dr Ngan's concession that Mrs Haggett should have been transferred from the NLDH at 14.30 hours when he reviewed her is broadly consistent with the expert evidence:

(a) Dr Wenck opined to the following effect:[195]

(i) Tolerating Mrs Haggett's state in the PACU for half an hour would have been long enough before transferring her;

(ii) He would have been concerned to transfer Mrs Haggett from about 14.00 hours;

(iii) Mrs Haggett's very high respiratory rate and low saturations warranted investigation for a myriad of causes;

(iv) A plan to transfer Mrs Haggett to the care of a respiratory physician was not appropriate;

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[195] T6- 14, L1 – T6

(v) Mrs Haggett needed to be transferred to a facility that had an ICU.

(b) Dr Bradley opined as follows:

(i) At 14.30 hours, "*the possibility of transfer to a higher-level facility must – must – must arise*."[196]

(c) Dr Shadforth opined as follows:

(i) "*So if we can proceed on this basis, even if it was reasonable to wait a short period of time, certainly by 2 pm, so 20 minutes after the - that was long enough before there should have been, what, a transfer at that stage?---Yes, I would be - knowing that this patient is a respiratory cripple, knowing that she's an ASA 4, knowing that she hasn't recovered from her anaesthetic, knowing that her observations – that her respiratory rate's double what it was when she was admitted, I would want her out of there 45 pronto*."[197]

(ii) At the time of Dr Ngan's review of Mrs Haggett at 14.30 hours, she should have been transferred to a hospital with an ICU;[198]

(iii) "*DEPUTY STATE CORONER: Firstly, I want to ask – Doctor, you've said 2.30 would have been the time for transfer. Is there - is that the earliest time at which you would have transferred this patient?---She came to recovery at about 13:33. It's hard to say, your Honour, in light of – certainly this was the latest time I would have wanted to transfer her, whether to transfer her earlier, you know, there's indications that she was not doing well from the moment she arrived in PACU, so I think it would be reasonable to start to organise a plan to get her out of there really earlier than that, but certainly, by 14:30, well and truly she should be getting out of there.*

When you said there would - should have been a plan earlier than that, when? On those observations, when?---Oh, well, really from when she first arrived."[199]

[213] In respect of Counsel Assisting's submission at paragraph 170(e) of his submissions, Mr Diehm KC submits:

> "*It is said in that submission that regardless of Dr Ngan's explanation of having experienced a "fixation error", the plan was inappropriate. Dr Ngan's evidence about the fixation error, which is cogent and plausible, stands only as an explanation for how the events that he was responsible for came to happen. It may be*

[196] T8-14, LL28-30
[197] T8-41, LL40 - 46
[198] T8- 43, LL10 - 27
[199] T8-43, LL31- 41

added that the fixation error was likely influenced by a state of mind, which Dr Ngan plainly had, that this was surgery within the hospital's capability and so it should be uneventful. It is the nature of fixation errors that their foundation is a genuine belief that the situation presenting is within the bounds of normal, even though it plainly was not."

[214] I accept that Dr Ngan's evidence about fixation error stands only as an explanation for how the events that he was responsible for came to happen.

[215] Having regard to the concessions Dr Ngan made at Inquest and the opinion of the experts, I find as follows:

(a) Very soon after the reversal agents were administered to Mrs Haggett (within 5 or 10 minutes), it ought to have been apparent to Dr Ngan that Mrs Haggett's state of consciousness (or lack thereof) was not related to the sedation that she had been administered during the surgery and was due to some other cause;

(b) Dr Ngan should have transferred Mrs Haggett to a facility with an ICU at or about the time she was admitted to PACU, or shortly thereafter at or about 14.00 hours;

(c) Failing that, Mrs Haggett should have been transferred to a facility with an ICU at the time of Dr Ngan's review at or about 14.30 hours;

(d) The failure to transfer Mrs Haggett to a facility with an ICU at or about 14.30 hours was inappropriate;

(e) I accept that Dr Ngan's evidence about fixation error stands only as an explanation for how the events that he was responsible for came to happen. I also accept that explanation as cogent and plausible, and that Dr Ngan genuinely believed that the situation presenting was within the bounds of normal. However, regardless of that explanation, I find that Dr Ngan's plan "….*To continue to monitor in PACU for an hour. Will review and reassess @ 1530 hours*" was inappropriate;

(f) Having regard to Mrs Haggett's ongoing obtunded state at 14.30 hours, Dr Ngan's decision to leave the NLDH was also not appropriate;

(g) Dr Ngan's inappropriate plan caused or contributed to the delay that followed in transferring Mrs Haggett to a facility with an ICU, at least for a further hour, until 15.30 hours.

[216] As to the consequences of the failure to transfer Mrs Haggett by no later than 14.30 hours:

(a) Dr Shadforth opined:

(i) "*All right, moving then back to the post-operative period, as you indicated in your evidence earlier today, we know that at some point Mrs Haggett had an aspiration, or suffered an aspiration event. And going to whatever is available to you, including the ADDS chart if it's useful, and any other evidence that's been before you, are you able to estimate at what point in time that likely occurred?---Well, she aspirated in the time between she - when she was admitted to hospital and when she arrived at Redcliffe. And I think that almost certainly occurred at 15:45 because the patient, first of all, she hadn't been coughing and she starts coughing and everybody knows when something goes down the wrong way you start coughing and it's one of the first signs of aspiration. Jo Smith said at that point then she could hear rattles from the end of the bed. The young nurse student, who was looking after her, said that she had listened to her chest and said she had crackles all the way from the top to the bottom of her chest. Her observations then took - became even worse with saturations down to the 60s…*"[200]

(ii) "*All right, so it's the - if I understand what you're saying is, doing the best you can on the information that is available, you think on a more likely than not basis she aspirated at about 15:45?---I would say that absolutely without a doubt it happened at quarter to 4.*"[201]

(iii) *"And, again, are you able to say, either by reference to what's recorded in terms of your observations on the ADDS chart or else by reference to any of the other evidence that is before you, at what - what would have been the latest point at which Mrs Haggett might have been salvaged or saved if a different course of management had been undertaken?---I think certainly, if she'd been sent at 2.30 when she was reviewed, maybe, I don't know. I don't know whether an earlier transfer would - like I said in my report - would have changed her outcome. But certainly by the time she's had a large volume aspiration, which she'd had, as evidenced when she arrived at Redcliffe Hospital, and her premorbid condition, I don't think there's any way she could have been salvaged.*
After the assumed aspiration?---After the aspiration, yes, the aspiration was the final nail in the coffin, so to speak."[202]

(b) Dr Wenck opined:[203]

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[200] T8-45, LL10 - 23
[201] T8-46, LL1-5
[202] T8-46, LL21 - 34
[203] T6-18, L44 – T6-18, L33

"*DEPUTY STATE CORONER: Dr Wenck, if you'd been transferred out to the ED and seen an ICU consultant at or about 2 o'clock, which I think is when you said she should've been transferred, what would her outcome have been then?---That's very hard to say, because it depends if she had aspirated then or after, or whenever she aspirated. Once Mrs Haggett had aspirated her – her stomach contents, and – within respiratory failure from that, then her – her prognosis was sealed, really.*

I'm looking at - - -?---It's very hard for me to say – to answer that properly.

Certainly. Looking at exhibit E18, page 2, which is the ADDS chart, are you able to give your estimate of when you think she aspirated?---Basically, it does look like at around 3.15 or something like 15.09, because you see the – the SATS dropped quite dramatically at that point. But there's no saturations from 14.30 onwards, and that's because her peripheral circulation would've been impaired, and there was – unable to – that – the machine was unable to pick it up. So that means that her peripheral circulation was already failing at that point, because the saturation meter couldn't pick up what was going on. So it could've been around that time. But certainly, there was a precipitous drop after that. But before that, her circulation was impaired because the machine wasn't picking up the saturation, so her peripheral perfusion was impaired. It may have been at that stage, as well. It could've been at 14.20, 14.30. It's very hard to say, I'm sorry.

All right. It seems the evidence we've heard was that when it's written "unable" in pink for the oxygen saturation and the respiration – and obviously, the saturation's missing – we're told the nurse believed it was between 70 to 89. Does that make any different to your opinion?---No, it still could've been – she still could've aspirated at that time. It's basically – you know, the – if – if she's – if she aspirated, her SATS would've dropped precipitously, and it's hard to say because they weren't able to measure it, but it looks like afterwards, they were precipitously dropped. So it could've occurred at that time, 14.20, 14.30.

So given that assumption – if you – she'd been transferred, as you said, at about 2 o'clock, does that give you any better prospect of survival?---Well, it depends. She might've aspirated on the – on – you know, in the ambulance on the way over as well. She might've already aspirated. If she'd already aspirated - - -

Okay?---There's – the – her – her – her fate was sealed, really."

(c) Dr Bradley's evidence was:[204]

> "*Okay. All right. Now, I think in your report you've spoken about the issue around whether Mrs Haggett had aspirated at any point in time. And I took from what you had to say that there was some doubt in your mind about that, is that correct?---Well, I see nothing in the chart that says she aspirated apart from post [indistinct] observations from the Redcliffe Hospital.*
>
> *All right. Would a clinical decline – a significant decline in her clinical state at around 1545 hours associated with her commencing to cough be consistent with aspiration at that point?---Patients can cough when their aspirates hidden, for instance, and that is not uncommonly seen in drowsy patients in the recovery room. Now, as for – as for – I'm aware of Dr Shadforth's comment that the stomach may have become dilated because of the high-flow oxygen but, on the other hand, the patient had also been fasting before the operation.*
> *All right. So your position is there's simply not enough information available to you to conclude if or when she aspirated from your perspective?---I don't know if she – exactly."*

[217] Given the degree of uncertainty around when Mrs Haggett aspirated, together with the difficulty the experts exhibited in predicting Mrs Haggett's likely course/ prognosis for survival generally, it is not open for me to find, having regard to the requisite standard of proof,[205] that the failure to transfer Mrs Haggett to a facility with an ICU by no later than 14.30 hours and/or Dr Ngan's fixation error and/or Dr Ngan's inappropriate plan caused or materially contributed to her death.

[218] Otherwise, the evidence about the events and circumstances that arose in the PACU on 20 May 2019 is as follows.

[219] RN Connolly's evidence at Inquest was to the following effect:

(a) She was working on the NLDH recovery unit on the day of Mrs Haggett's surgery and recalled that Mrs Haggett arrived to the unit at 1.39pm.[206]

(b) She received a handover from Dr Ngan who explained Mrs Haggett had COPD.[207] She said that Mrs Haggett's oxygen saturation levels at that time were 92, which is below the normal of 95, and that she asked Dr Ngan if he wanted her oxygen kept to two litres or increased, to which he replied it was fine.[208]

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[204] T8-15, LL21 - 39
[205] That is to the civil standard, on the balance of probabilities, but on the *Briginshaw* scale: *Anderson v Blashki* [1993] 2 VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73
[206] T3-5 L 42.
[207] T3-6 LL 26, 29.
[208] T3-5 LL 40-45.

(c) Dr Ngan did not provide a care plan[209] but said that he would be back to check on the patient which she recorded in the notes.[210]

(d) She recorded Mrs Haggett's saturation levels early in her time in the recovery unit as between 80 and 88-90.

(e) She had an understanding of COPD and how this presents risks to patients receiving oxygen therapy but did not receive this information from Dr Ngan.[211] She was concerned that the instruction given to her regarding oxygen saturation levels was not adequate but she did not raise this with Dr Ngan as he had left the PACU.[212] At or about 14.02 hours she noted in the record "*? CO2 retainer*."

(f) She considered Mrs Haggett's blood pressure was probably quite high for her weight range and that she moved Mrs Haggett's probe from her finger to her ear to get a better reading. She tried to rouse Mrs Haggett.

(g) Mrs Haggett was only ever rousable by voice and then would very quickly doze back off basically to sleep.[213]

(h) There was an absence of preoperative observations recorded on Mrs Haggett's chart but they were elsewhere in the documentation.[214]

(i) At the time of Mrs Haggett's death the procedure for a MET call was printed on the wall of the PACU but that it was not very clear. Her understanding was that if available theatre staff could assist, even if that meant they had to pause surgery, but if not available nursing staff would assist.[215]

(j) Between 15:15 and 15:30 Mrs Haggett satisfied the criteria for a MET call.[216] She also agreed that at 13:39 and 13:59 Mrs Haggett qualified for a mandated MET call and that at 13:49 she was borderline but that she did not make a MET call then "*because Jarrod was happy with what Shirley's observations were, I think I stupidly took on the advice to just continue monitoring until she woke up*".[217]

(k) She thought Mrs Haggett "*was a MET call the entire time she was in PACU*".[218]

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[209] T3-7 L 21.
[210] T3-7 L 39.
[211] T3-8 LL 30-37 T3-9 LL 2-4.
[212] T3-8 LL 14-20.
[213] T3-11 LL 1-5.
[214] T3-11 LL 38-49.
[215] T3-14 LL14-38, T3-14 LL 26-27.
[216] T3-16 LL 1-6.
[217] T3-116 LL 11-26.
[218] T3-21 L 18.

(l) She had a discussion with CN Laws around 1515 hours that she gave evidence as follows:

> "*I recall being very panicked and swearing at Sue to escalate Shirley to transfer out. Because I recall Lisa handing over that Jarrod wanted to transfer her and I recall at 3.30 to update him and then potentially escalate for transfer. So I recall being very upset that she was still obviously there post-review*".[219]

(m) She had understood the plan had been to transfer Mrs Haggett to another facility at 3.30pm if she had not improved. [220]

(n) She called Dr Ngan, but there was conflict between them.

(o) She formed the plan to transfer Mrs Haggett without Dr Ngan's consent.[221]

(p) Following her phone call with Dr Ngan she returned to Mrs Haggett's bedside where RN Smith and CN Laws were, swore and said "*We need to call an ambulance*". She said that "*it just slowly escalated to an ambulance being called*" and that she did not leave Mrs Haggett's bedside at that time. [222]

(q) At around 15:45 hours, Mrs Haggett had the urge to cough and it was very moist and crackly.[223] She said that at around 15:49 hours one of the nursing students listened to Mrs Haggett's breathing and observed bilateral crackles, suggesting she may have aspirated and that she had pneumonia.[224]

(r) At around 16:00 hours CN Laws and she moved Mrs Haggett into theatre to apply high-flow oxygen with the hope of improving her oxygen levels.[225]

(s) At about this time there was a handover to QAS officers who said "she can't go to Peninsula, she has to go to Redcliffe. Peninsula is not a suitable hospital for Shirley".[226]

(t) She prepared a RiskClear report but that she was asked to change it. She said the statement "*Whilst the anaesthetist offered to return to assess the patient, he was informed that the expectation was that the patient would be transferred before he could return to the*

[219] T3-21 LL 37-41.
[220] T3-21 L 47.
[221] T3-23 LL 44-47.
[222] T3-23 LL 47-48.
[223] T3-24 LL 44-47.
[224] T3-25 LL 39-43.
[225] T3-26 LL 6-9.
[226] T3-26 LL 26-29.

hospital" was inserted by someone else.[227] She was asked to change the report as her detailing of the phone conversation was "*passing blame to Dr Ngan*".[228] RN Connolly did not recall that she was asked to change the report because it contained information that was not related to the patient's care. [229]

[220] RN Tomczak's evidence at Inquest was to the following effect:

(a) She provided care to Mrs Haggett in relief of RN Connolly. She was provided with a handover which included that Mrs Haggett had a history of COPD and RN Connolly's concerns around transfer.

(b) She was concerned that she was unable to effectively monitor Mrs Haggett's stats and performed a Glasgow Coma Scale assessment which Mrs Haggett scored 12.[230]

(c) It was not documented anywhere in the medical records that Mrs Haggett was a CO2 retainer.[231]

(d) She instigated the plan to use a "Hudson mask" on Mrs Haggett to minimise the risk of her breathing in extra carbon dioxide.[232] She found it difficult to locate equipment that she needed for Mrs Haggett as they did not have equipment on hand for such complicated patients.[233]

(e) She had a conversation with the clinical manager, Trish, in which she discussed that it was inappropriate for Mrs Haggett to have had day surgery as they did not have the necessary equipment.[234]

(f) The variances in Mrs Haggett's oxygen saturation levels, the changing respiratory rate, the presence of COPD and shortness of breath preoperatively were all reasons for consideration of transfer. She said it was within her scope to escalate to the anaesthetist and clinical manager which she did, but that she regretted not calling an ambulance herself.[235]

(g) In her experience a MET call could mean she would call on the treating doctors for the patient or she could press a button on the wall which would result in other medical professionals attending. It would be her expectation on any site, in any hospital, that the team

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[227] T3-28 LL 26-30.
[228] T3-29 LL 33-34.
[229] T3-31 L 49.
[230] T3-52 L 33.
[231] T3-56 L 34.
[232] T3-58 LL 6-7.
[233] T3-58 L 29.
[234] T3-59 LL 13-24.
[235] T3-60 LL 39-48.

wouldn't leave until they were past a certain point. She did not know that Dr Ngan had left the premises.[236]

[221] CN Laws' evidence at Inquest was to the following effect:

(a) She went to the PACU area to assess Mrs Haggett on request of Ms Smith at approximately 3:15pm. She considered it "absolutely" appropriate for RN Connolly to call Dr Ngan at that time and that it was her view that Mrs Haggett needed to be transferred to another hospital.[237]

(b) She said that they were not any clearer on what the plan was for Mrs Haggett after this call.[238]

(c) She contributed to the RiskClear report with RN Connolly. She recalled that they were told to "tone it down" and "make it more diplomatic".[239]

(d) Her understanding of MET call procedure was that a MET call in a day surgery is a Queensland Ambulance Service call and that escalation to the manager is required including, she assumed, through the visiting medical officer.[240] She said the wall buttons don't necessarily have the "back up" behind them to assist. That is if there are no doctors on site a "red button won't really do anything".[241]

(e) At around 1550hours she very clearly recalled that she said "I am going to call for an ambulance. I don't care what anyone says, I'm going to do it now".[242] She and CN Connolly then moved Mrs Haggett into a theatre so that she could be placed on high flow oxygen.

[222] CN Smith's evidence at Inquest was to the following effect:

(a) Dr Ngan came into her office and told her and DCS Mukauskas that he thought Mrs Haggett was stable but that she would take some time to wake up.[243]

(b) She spoke with RN Tomczak around 1500 hours and RN Tomczak told her that Dr Ngan had said if Mrs Haggett did not improve she would have to be transferred and that this was the way they were going.[244] She accepted there was a disconnect in terms of the information given from Dr Ngan and RN Tomczak.

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236 T3-61 LL 33-39.
237 T3-73 LL 3, 6.
238 T3-73 L 17.
239 T3-81 LL 12-15.
240 T3-81 LL 30-42.
241 T3-81 LL 46-49.
242 T3-77 LL 9-10.
243 T3-89 LL 29-31.
244 T3-92 LL 9-11.

(c) At 15:20 RN Connolly said that she wanted to contact the anaesthetist and she told her to do so. She agreed this plan was different to the plan Dr Ngan had conveyed to her earlier.[245] Following this call RN Connolly was "*quite distressed and angry because he was not helpful, he didn't want to speak to her and he said that he had- she has verbalised to me that he said he'd given the plan to Trish and she should go and speak to Trish*".[246]

(d) Following RN Connolly's telephone conversation with Dr Ngan she spoke with Trish immediately who said she had just been on the phone with Dr Ngan and he thought Mrs Haggett needed further monitoring and that they needed to consider transfer.[247] It was her understanding that at this point Dr Ngan was making arrangements to transfer Mrs Haggett out of the hospital.[248] It was her belief at that time that Mrs Haggett needed to be transferred.[249]

(e) She had a discussion with DCS Mukauskas to the effect that she would contact the surgeon because she was concerned that the patient was not improving, that people needed to know and needed to understand and they needed to take further action.[250]

(f) She called Dr Smith and left a message and he returned her call within 5-7 minutes. She explained that Mrs Haggett was not improving, not regaining consciousness, respiratory rate was high and they were having trouble getting her oxygen saturations. Dr Smith asked if she had spoken to Dr Ngan and conveyed that there was something of a plan or arrangements in motion to transfer.[251] She considered the plan was that they continue to monitor Mrs Haggett and wait for confirmation to call the ambulance for transfer.[252] She told Dr Smith that Mrs Haggett was stable and he agreed with her that should she deteriorate they should call an ambulance.[253] CN Smith accepted that she did not in this conversation tell Dr Smith that Mrs Haggett's oxygen saturations were down to 70 per cent or that her blood pressure had decreased.[254]

(g) When she returned to PACU Mrs Haggett had been moved to theatre for additional oxygen. She then immediately called QAS herself.

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[245] T3-95 LL 27-34.
[246] T3-96 LL 5-7.
[247] T3-96 LL 20-22.
[248] T3-96 LL 45-47.
[249] T3-102 LL 5-6.
[250] T3-97 LL 15, 21 30.
[251] T3-98 LL 4-20.
[252] T3-102 LL 13-21.
[253] T3-111 LL 6-20.
[254] T3-111 LL 25, 39.

(h) There was a procedure in regards to calling ambulances but that it is "*quite weak and not helpful*". She was at the time looking for the correct documentation which was not readily available.[255]

(i) RN Connolly and CN Laws were upset that they were waiting for transfer to be arranged and not calling an ambulance themselves and she agreed with them but that she "*felt like I was getting pressure from the other side not to do that*".[256]

(j) It was not appropriate for Mrs Haggett to have remained in PACU with the recorded observations after 14:30 hours.

[223] Director of Clinical Services (DCS) Mukauskas' evidence at Inquest was to the following effect:

(a) She recalled it being brought to her attention that there was a woman coming into recovery who was not well.[257] She understood that she was an ASA 4 which immediately highlighted to her that she should not have been at their hospital as they were not licensed and this was alarming to her.

(b) Following the incident investigations had occurred as to how Mrs Haggett had been accepted into the hospital. She said she spoked with the anaesthetist regarding why she had been taken through who said he had had a lengthy conversation with Mrs Haggett and her husband who had both agreed she wanted to go ahead with the surgery.[258]

(c) Given Mrs Haggett's observations at the time she arrived in the PACU it would not have been her call to make to have her transferred at that stage. The anaesthetists were quite confident that she would be able to recover efficiently to be sent home.[259]

(d) She did not make an assessment herself regarding the need for Mrs Haggett to be transferred because Dr Ngan was handing the patient over to recovery and it was not normal procedure for her to step in.[260]

(e) Dr Ngan came past her office as he was leaving. Said he was going home and would be contactable. He said he was happy with Mrs Haggett's condition. She said she was happy with that plan.[261]

(f) She had been into recovery a couple of times and not noticed much change in Mrs Haggett's condition. She said that "*the only thing the*

[255] T3-101 LL 34-38.
[256] T3-102 LL 44-48.
[257] T4-24, LL 28-29.
[258] T4-25 LL 9-12.
[259] T4-27 LL 38-40.
[260] T4-28 LL 12-17.
[261] T4-33 L 11.

nurses were mentioning to me was the fact that the stats monitor wasn't working properly and that's when it was suggested that she get the little probe".[262]

(g) To transfer a patient they needed a doctor to do this so they could pass her care onto another hospital and that at this stage Dr Ngan was still very much involved in the care and it wasn't indicated to her that Mrs Haggett was in any danger.[263]

(h) She agreed that from 1430 there was difficulty monitoring Mrs Haggett but there were no observations brought to her at any stage. She was not getting that information.[264] She said that it became obvious to her between 1500 and 1530 that Mrs Haggett would need to be transferred.[265]

(i) Regardless of whether the oxygen saturation reading at 15.19 hours was reliable or not, the fact that it was obtained in the context of Mrs Haggett's ASA 4 score, and not having shown any improvement, it was not her call to make to call the ambulance or remove Mrs Haggett from the facility. They had informed Dr Ngan who said he would organise a private transfer.[266]

(j) She did not recall the nurses in PACU pressing her to call an ambulance nor did she recall Ms Smith telling her that the nurses were pressing for an ambulance to be called. DSC Mukauskas gave evidence that she recalled CN Laws saying to her that Mrs Haggett needed to be transferred to Redcliffe Hospital and not Penninsula Private as she would not get the appropriate the care.[267]

(k) She did not directly tell Dr Ngan that Mrs Haggett would be transferred to Pennisula Private as this was where they always transfer patients.[268] She did not recall any of the PACU nurses asking her to arrange for an ambulance transfer at all at that time.

(l) She did not remember saying to Dr Ngan's question as to whether he should return to the hospital in their telephone conversation "*No I'm not worried about her at the moment*" but does recall Dr Ngan offering to return to the hospital.[269] She said that on the contrary they were all worried.[270]

[224] As to the RiskClear report, DCS Mukauskas gave evidence that she had difficulties with the earlier version, she wanted some timelines put in, and

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262 T4-31 LL 33-35.
263 T4-35 LL 18-26.
264 T4-36 LL 26-30.
265 T4-37 LL 23-25.
266 T4-38 LL 9-17.
267 T4-47 LL 12-15.
268 T4-39 LL 13-25.
269 T4-40 L 43.
270 T4-41 L 4.

there were details of a personal interaction between RN Connolly and Dr Ngan which she did not think should be included in a clinical incident.[271] She could not recall exactly what had been removed.

[225] I have no criticism of the conduct of RN Connolly, RN Tomczak and CN Laws. On the contrary, it is evident that they were doing the best they could to care for Mrs Haggett in extremely challenging circumstances, and to facilitate her transfer from the NLDH to appropriate facility. It is also clear that they were under considerable stress and in distress, and that they have been adversely affected by the experience.

[226] CN Smith, the clinical manager who was responsible for managing the nursing staff, also came to accept that Mrs Haggett needed to be transferred but it seems she felt constrained in arranging that directly with QAS because of what she perceived to be administrative (bureaucratic) protocols and procedures, which she was having difficulty locating or negotiating.

[227] In brief, I find that:

(a) There was confusion or uncertainty around whether Mrs Haggett was a MET call and the process around making a MET call;

(b) Nursing staff had difficulty monitoring Mrs Haggett's stats effectively;

(c) There was inadequate equipment in the PACU and/or nursing staff had difficulty locating appropriate equipment to provide proper care to Mrs Haggett;

(d) Nursing staff were required to "fashion" equipment with what they had, e.g. the "Hudson mask" applied in an attempt to manage Mrs Haggett's CO2;

(e) There was confusion about the management plan and who had been informed of the plan (there was no written management plan provided by Dr Ngan);

(f) There were complex or unclear hierarchical lines of management and communication, which hampered and delayed the escalation of Mrs Haggett's care and her transfer from the NLDH;

(g) There was uncertainty about what alternative care Mrs Haggett required and where she was to be transferred;

(h) The protocols and procedures for the transfer of a patient were unclear, or difficult to locate and negotiate;

(i) There was conflict and miscommunication between nursing staff and Dr Ngan.

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271 T4-45 LL 4-31-41.

[228] Having regard to these circumstances (being largely systemic in nature), I find that Mrs Haggett's care and management in the PACU of the NLDH on 20 May 2019 was not adequate and not appropriate.

[229] Otherwise, Counsel Assisting submits that there is one aspect of DCS Mukauskas' evidence that is a matter of concern. He referred to her evidence as follows:

(a) At about the time Mrs Haggett was brought into the PACU, DCS Mukauskas became aware that she was an ASA 4 patient:

> *"Okay. And how was it that you came to be in contact with her at that - is that a normal thing to occur?---No. It's not, but it had been brought to my attention that she'd been in recov - she had been in theatre longer than intended, and the doctor had - had suggested that she was an ASA score of four, so I went in to make sure that the patient was arriving safely.*
>
> *Okay. So I'll just ask you a couple of things about that. Who had informed you that Mrs Haggett had been - - -?---I've actually been trying to recall that. I don't know whether it was the anaesthetic nurse at the time, but I know it was brought to my attention that there was a woman coming into recovery that was not well.*
>
> *Okay. So before she even came into recovery, you had some information from someone that she was - - -?---As she was being brought into recovery.*
>
> *Yeah. That she was not well at that stage?---Well, not that she wasn't well. No. But that she was an ASA score of four, which immediately highlighted to me that she shouldn't have been in our - in our day surgery hospital.*
> *Okay. That's right, isn't it, because the day surgery was not licensed for ASA 4 patients?---No. Definitely not.*
>
> *And no doubt that came - that was alarming to you?---Most definitely."*
>
> [emphasis added]

(b) DCS Mukauskas agreed that apart from the licensing limitation, there were practical reasons for why an ASA 4 patient should not be operated on at the NLDH:[272]

> "*And can I suggest this to you; that one of the - although there may be licensing - strict licensing issues in relation to why an ASA 4 patient should not be operated on in this particular facility, one of the practical reasons why it should not occur is because it may*

[272] T4-26, LL41-45

be that a such a patient could not be properly managed at such a facility; is that right?---That's correct."

[emphasis added]

(c) Referring the point in time when Mrs Haggett was admitted to PACU, DCS Mukauskas was asked:[273]

"*Would it not have been better, at that point in time, having regard to her observations and the fact that she was an ASA 4 patient, for her to be transferred out of the facility at that time?---That actually wouldn't have been my call. The anaesthetists were quite concerned - it was quite - quite confident that she would be able to be recovered efficiently to be sent home.*

Why wouldn't it be your call?---Well, the patient was already - had - had already had the theatre. She was already there. The husband was with her, and it was never suggested to me that she be transferred at that stage.

I know, but I'm asking you why you couldn't have arranged the transfer at that stage given there's - - -?---I didn't think that it was appropriate to do so.
At that stage?---At that stage
Because she - notwithstanding that she was ASA 4, and that her respiratory rate was high and that her oxygen saturations were low, and that someone had expressed concern to you that there was a patient coming out of theatre that you needed to go and have a look at?---Yep.

So you made an assessment yourself at that stage that she wasn't to be transferred; is that right?---No. I didn't make an assessment at all that she wasn't to be transferred. It wasn't suggested to me at all that she was being transferred, and there was no indicat - indication that she wouldn't be recovered efficiently enough to go home.

Okay. Is it the case, then, that you didn't think that you should make an assessment at that stage because no-one had asked you to?---That - that's correct. Dr - Dr Ngan was - was handing the patient over to the recovery staff for recovery, and it wasn't normal procedure for me - for me to step in. It wasn't indicated by any of the nurses that they weren't, at that stage, confident to look after her. So no. It didn't - it didn't come into the equation at all that I would transfer that lady."

[273] T4-27, L36 – T4-28, L

(d) It became known to DCS Mukauskas that the nursing staff were having difficulty obtaining reliable readings for Mrs Haggett. When taken to that issue, her evidence was:[274]

> "*The only thing that the nurses were mentioning to me was the fact that the sats monitor - sats wasn't working properly, and that's when it was suggested that she get the little probe, and then they picked up the - the sats a little bit clearer.*
>
> *And was that concerning that they were worried about not getting reliable readings, from your perspective?---Yeah. That - that was voiced to me. Yes. I knew that there was a concern.*
>
> *Was it concerning to you that she might not be able to be properly monitored at your facility because of that?---It - it's not - <u>that wasn't an issue for our facility. It was actually Mrs Haggett herself being very small, and, you know, we were just having trouble picking it up</u>, which does happen with patients when they're very - I think her BMI was something like about twel - 15 or something, so it can happen on very - very little people like that. That's why we got the paediatric one on her ear.*
>
> *<u>Right. So if it's patient-indicated - the difficulty is related to the patient - does that not come to the same thing that the patient was not suitable to be monitored in that facility at that time</u>?---Well, it could happen with a patient with - that's a - say, of - of one. It doesn't necessarily mean, you know - you - you never know that the patient's going to have difficulty with their sats monitor until they get into recovery, depending on how they're recovering and - - -*
>
> *<u>Yes. But we're talking about - we're not talking about a hypothetical patient with an ASA of one. We're talking about a patient who's got a known ASA score of four. She's frail and tiny, by your own observation. You're being told by the nursing staff that they're concerned about reliability of the reading that they can get with the equipment that's available to them in the hospital. Isn't that concern concerning enough for you to consider that Mrs Haggett could not be properly monitored at that facility for those reasons alone?---No</u>. When the monitor was placed on her ear, the girls started getting - the girls informed me that they were getting a better reading."*
>
> [emphasis added]

(e) When taken to Mrs Haggett's status at or about 15.00 hours (according to the ADDS chart), DCS Mukauskas:[275]

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[274] T4-31, LL33 – T4-32, L13
[275] T4-35, L6 – T4-36, L45; T4-37, L15 – T4-38,

"All right. Now, if can get you to go back to the ADDs chart. And you see there, at 1500 hours, in relation to the respiratory rate and the oxygen saturation levels, there's a note:

Unable/P.

And the evidence of the nurses involved is to the effect that they couldn't get readings at that stage. Was that conveyed to you that they were unable to get readings at all at that stage?---No.

If that had been conveyed to you, would that have been a matter of concern in terms of whether the facility had the capability of managing this patient?---Look, all - all I can probably say is that to transfer the patient, we needed a doctor to do that for us, so that they - so that they could pass that care onto another hospital. So that couldn't have been done by me; it had to be done by one of the doctors.

Would it not be the case that if there was sufficient concern about the facility's capacity to manage this particular patient - and I am including patient-specific issues, as well as hospital limits on its equipment that was available. Would it not have been possible for you to make a decision to transport her to a public hospital by ambulance, without the doctor's approval?---At that stage, Dr Ngan was still very much involved in the care, and it wasn't indicated to me, then, that she was in any danger; however, it did become evident that she wouldn't be able to go home; that she wasn't going to be recovered efficiently enough to be- to go home.

All right. I'm not - I'm not putting this to you as any indication of criticism of Dr Ngan, in particular, but at 3 o'clock, by 3 o'clock, he had - he'd left the premises at around 2.30 pm. So it's difficult to see how he was still involved in her care at that point; he wasn't at her - at the premises. And I understood you to say that you hadn't - sorry.

Had you kept him updated between 2.30 and 3 o'clock about the progress of the patient?---No. That's not what I'm saying, but what I'm saying is when he left at 2.30, he left those instructions. And I wasn't going in and out of the recovery, when I knew that the clinical nurses were in there looking after - and - and - and the clinical manager was in there as well. So it wasn't indicated to me that she was in any danger that we needed to transfer urgently at that stage.

All right. Well, one of the instructions that he gave you, I understood from your evidence, was that the nurses in PACU should continue to monitor the patient
?---Mmm.

Okay. And I would imagine that what he meant by that would be to effectively monitor the patient so that if there was any deterioration in the patient, it would be detected, and that he could, then, be notified according to his plan; would you accept all of those issues?---I would accept that. Yes.

Okay. So that if the patient is in a situation at this facility where she cannot be monitored, they are unable to monitor her in relation to these vital signs, isn't there, then, a problem in terms of keeping Dr Ngan informed? How do you know if there's not a deterioration?---Because the lady - at 3 o'clock, the lady was pink, and that's when Josephine Smith saying to use clinical - clinically assess the patient because we couldn't get the effect - I wasn't aware that there was all that - that area there where there was no - nothing taken because as - as you're all, I'm sure, aware by this stage, when Mrs Haggett decided to - did, in fact, deteriorate, it was quite rapid.

Well, you were aware - - -?---It'd been a - it's been a period of a time where she had just been stable, and we were following - of the - the nurses were following Dr Ngan's instructions just to wake her slowly, but then that became evident towards the end of the care that it wasn't acceptable for her to be there. No.

Okay. Well, I'm talking about the inability to monitor her effectively at 1500 hours. If it was Dr Ngan's expectation that the PACU nurses should continue to monitor her, and you understood that to be effectively monitoring her, would it not have been prudent to notify him at that time that the hospital was unable to effectively monitor her?---It wouldn't have been very long after that that we - that I did contact Dr Ngan and ask him to start organising a transfer of Mrs Haggett.

Well, according to your statement, you didn't contact him until about 3.30, but we'll come to that, so about half an hour after this. And if you have a look at the ADDS chart again, given the gap in the monitoring, it rather suggests that there was difficulty effectively monitoring Mrs Haggett from about 1430, shortly after Dr Ngan left; would you agree with that?---I do agree with it, but as - as - I do agree with what you're saying. Yes. But looking up the observations chart, there was no observations there that the girls brought to me at any stage. So I wasn't getting that information.

But you were getting information that they were having difficulty monitoring her ?---Yes. But, 3 o'clock, they were having concerns, but she was pink and rousable, and then, obviously, the deterioration started, but as I - I wasn't made aware of any of that during that period of time. I'm sorry. I wasn't made aware. The nurses hadn't communicated that to me at all.

All right. Had Josephine Smith communicated that you in that period of time?---I'm sorry. I can't - I can't recall when I was talking to people. I'm - I just can't recall. I know - I couldn't even recall who - who the nurses were on duty until I actually saw the paperwork because it's a long time ago, and I wasn't involved in the clinical care.

Okay. Do you think you would have - I think you said before that you did pop in to PACU in that period from 1430 hours. Am I right in recounting that?---<u>I went in a couple of times. Yes. And I know that RN Connolly came to see me once, and I know that Jo Smith was keeping - came to see me again</u> - - -

I'm - I'll have to ask you some more questions about timing - - -?---Yes. Okay.
- - - and do the best that we can, because it's not clear from your statement. Now, at paragraph 7, you say:

> *It became apparent to me and the PACU nurses that the patient would need to be admitted overnight to a nearby facility as she was not recovering.*

Now, I'm - I'll have to try and ask you, by reference to other records, when that became apparent to you?---<u>It would - it would've been around - between the 3 o'clock and the 3.30 mark</u>.

Okay. Again, doing the - if we can use the ADDS chart as a bit of a guide?---Yeah.

Would that, perhaps, help? You'll see that at 1519, there is a - what appears to be a significant reduction in oxygen saturation levels to 73 per cent?---Yep.

Now, you would agree, I suggest, that that is concerning at that point in time?---<u>It is concerning. It is concerning. Yes. I - I - I think they were questioning whether or not it was - it was a true reading</u>.

All right?---Hindsight is a wonderful thing. I've obviously - it was a true reading, but because they were having trouble previously with the readings, it was questioned or not whether it was.
Well - - -?---But it was certainly the trigger to start - to ena - you know, for us to start the transfer process.

<u>Well, I'll suggest this to you again; whether it - there be some concern about that being a reliable reading or not, the fact that it was a reading that was achieved at that point in time, that was concerning, would that not have been enough, having regard to all of those issues we've spoken about - an ASA 4 patient who</u>

was barely rousable by that time, who had not recovered, in fact, was appearing to deteriorate by that time - to call the ambulance and remove her from the facility?---I - I am not aware of - I've only just been told previously, so I shouldn't probably say, but apparently, like, the husband was told that she would need to be transferred, and the decision was made that she would go to the Peninsula Private Hospital.

DEPUTY STATE CORONER: Didn't answer the question. Repeat the question, please.

MR SCHNEIDEWIN: I'll repeat the question, again?---Okay. Regardless of whether or not the reading that was attained at 1519 hours, the oxygen saturation reading, was a reliable reading or not, the fact that that was the reading that was obtained, in the context of all of the other things we've been discussing, including that Mrs Haggett was an ASA 4 patient, who had not shown any signs of improvement up to that point in time and, in fact, it would seem, this was a sign of deterioration, would that or not - would that alone not be enough to call the ambulance and remove her from the facility?---That was not a call that I - I made. We informed Dr Ngan, and he said that he would organise a - a transfer to the private hospital which is, you know, 10 minutes away.

All right?---It wasn't - it - it. No. I - I didn't think - - -

I understand it wasn't the call that you made, but it is a call that you could have made; is that correct?---I have never been put in a position where I would need to make that call. No. That would be totally - as far I'm concerned - the doctor's concern. I've never made - and I - I - I've never made a call like that before. I don't know whether - I know you're saying that I was the - the manager on site, but I don't know whether that would've been my call to make. I was relying on the expertise of the doctors and trying to follow their orders."

[emphasis added]

[230] Counsel Assisting went on to submit that, in the context of DCS Mukauskas knowing that Mrs Haggett was an ASA 4 patient from the time she was first admitted to PACU (and that "*she shouldn't have been … in our day surgery hospital"),* and given the difficulties the nursing staff were having in monitoring Mrs Haggett (whether they were patient specific or not), I might find her explanations as unconvincing for why she didn't keep herself better informed of Mrs Haggett's progress and arrange (or otherwise cause to be arranged) a transfer to an appropriate facility earlier than was the case. Counsel Assisting submitted that, at the very least, her explanations serve to demonstrate the flaws in the system that was in place at NLDH for escalating the management, care and transfer of a

patient in Mrs Haggett situation, and emphasises why Mrs Haggett should never have been admitted to the NLDH in the first instance.

[231] Counsel Assisting also submitted:

(a) It is open to me to find that, as the Director of Clinical Services of the NLDH, Ms Mukauskas' management of the circumstances that arose in the PACU on 20 May 2019 was inadequate.

(b) It is open to me to find that the inadequate and inappropriate care of Mrs Haggett in the PACU on 20 May 2019 and Ms Mukauskas' inadequate management of the situation caused or contributed to the delay in transferring Mrs Haggett to an ICU.

(c) It is further open to me to find that this delay resulted in Mrs Haggett aspirating in the PACU where she could not be adequately managed, and after which time it is very unlikely she could have been salvaged. However, Counsel Assisting also submitted that this needs to be considered in the context of the state of the expert opinion referred to at paragraph [172] of his submissions, and which he says should be treated similarly in respect of this delay.

[232] I do not take Counsel Assisting's submission that I might find Ms Mukauskas' explanations as unconvincing to suggest she was being disingenuous or deliberately untruthful. However, to be clear, although she did exhibit a tendency not to answer the question asked of her by Counsel Assisting on at least one occasion (which did leave me with the impression that she was inclined to avoid answering questions that she perceived were critical of her), I am satisfied that overall she was genuine and truthful in the evidence she provided.

[233] Notwithstanding, accepting Ms Mukauskas' evidence and that of the others in the PACU on 20 May 2019 as being genuine and truthful, I find that Ms Mukauskas' management of the circumstances that arose in the PACU on 20 May 2019 was inadequate and that this contributed to the delay in transferring Mrs Haggett to an ICU.

[234] Specifically I find that, by no later than 1519 hours when Mrs Haggett returned an oxygen saturation level of 73% (regardless of whether of not that result was considered reliable) and in the context of DCS Mukauskas knowing that Mrs Haggett was an ASA 4 patient from the time she was first admitted to PACU, Ms Mukauskas, as Director of Clinical Services, should have taken measures to remove Mrs Haggett to an ICU (and regardless of what she understood the protocol and procedure was for transfer to be arranged/ authorised by the treating medical practitioner).

[235] However, given the degree of uncertainty around when Mrs Haggett aspirated, together with the difficulty the experts exhibited in predicting Mrs Haggett's likely course/ prognosis for survival generally, it is not open

for me to find, having regard to the requisite standard of proof,[276] that the failure to transfer Mrs Haggett to a facility with an ICU by no later than 1519 hours caused or materially contributed to her death.

[236] Ms Kenny has otherwise provided evidence of the changes that have been made since Mrs Haggett's death.[277] I have considered those changes, and I am satisfied they are adequate and appropriate for preventing similar circumstances arising at NLDH in the future.

[237] It is not necessary for me to make any recommendations for change.

Issue 11: The adequacy and appropriateness of the deceased's management and treatment in the ED.

Issue 12: The adequacy and appropriateness of the deceased's management and treatment in the Intensive Care Unit of the Redcliffe Hospital.

[238] It is convenient to address these issues together.

[239] I find that Mrs Haggett's treatment and management at the ED and in the ICU of the Redcliffe Hospital was adequate and appropriate.[278]

[240] I also find that it is likely that Mrs Haggett was not salvageable by the time she was transferred to the Redcliffe Hospital. In this regard, I refer to and rely on the following evidence:

(a) Dr Shadforth opined that:

> "*Mrs Haggett's clinical course after arrival at Redcliffe Hospital was entirely predictable. I believe her biochemical and radiological findings indicated that she was an in an unrecoverable condition for an extremely frail 78-year-old with pre-existing hypercapnic respiratory failure. With the extreme acidosis she was suffering, multi-organ failure would have already been setting in. The occurrence of a pneumothorax is not uncommon in patients like Mrs Haggett when ventilated, that is requiring a breathing machine. Although, not known at the time, her severe triple vessel coronary artery disease found on post-mortem would have added to her bad prognosis*."[279]

(b) At Inquest, Dr Shadforth's evidence was:

> "*And, again, are you able to say, either by reference to what's recorded in terms of your observations on the ADDS chart or else*

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[276] That is to the civil standard on the balance of probabilities but on the sliding *Briginshaw* scale: *Anderson v Blashki* [1993] 2 VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73

[277] Exhibit B19 BOE

[278] Opinion of Dr Drew Wenck, Exhibit G2 BOE;

[279] Opinion of Dr Shadforth, Exhibit G1 BOE, paragraph 5.47

by reference to any of the other evidence that is before you, at what - what would have been the latest point at which Mrs Haggett might have been salvaged or saved if a different course of management had been undertaken?---I think certainly, if she'd been sent at 2.30 when she was reviewed, maybe, I don't know. I don't know whether an earlier transfer would - like I said in my report - would have changed her outcome. But certainly by the time she's had a large volume aspiration, which she'd had, as evidenced when she arrived at Redcliffe Hospital, and her premorbid condition, I don't think there's any way she could have been salvaged."[280]

(c) Dr Drew Wenck opined that:

"*This patient was very unlikely to survive given the multiple problems. She was in respiratory failure, cardiovascular failure and renal failure. Her ventilation was problematic from the outset with critically high airway pressures. A pneumothorax is common in these circumstances. The cardiac arrest was almost inevitable at that point.*"[281]

(d) At Inquest, Dr Wenck's evidence was:[282]

"Okay. Having regard, then, to what's referred to – or, what's described by Dr Hames and Dr Nicholson in their statements, and having regard to what you've reviewed previously in the medical records themselves, what was Mrs Haggett's prognosis in terms of survival at the time she arrived at the ED?---Given what I've said about her chronic disease, the fact that the – that she had a – a low BMI and was very frail, and her – her age, the prognosis was very poor, indeed. It's – she would be extremely unlikely to survive given all those problems.

All right. And as you will be aware, there was some time taken for reasons explained by Dr Nicholson in his document, to intubate the patient – Mrs Haggett, rather. Do you have any concerns about the period of time taken to intubate her in the circumstances?---Unfortunately, we're often faced with this situation where someone who has got, unfortunately, very, very severe disease and then has a – a – an event on top of it which is non-survivable. But it's such an acute event. It's very hard for the patient, and for the family to – to take all of this on board in the acute setting. And so it's often – it's important to try and discuss this with the family prior to embarking on – on advanced life support in the situation, because it's likely to be futile. However, you know, we take into account the family's wishes, patient's wishes, etcetera, and I think it was agreed that they

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280 T8-46, LL21-30
281 Exhibit G2 BOE
282 T6-17, L11 – T6-18, L40

would proceed with advanced life support, but if her heart would stop, then that would – would not be any further treatment would be presented. It's just a very difficult situation for all the doctors in the acute setting, because they haven't got a relationship with the family. Family don't know them. They don't know what's the situation at all, and it's very hard to, sort of, give all that information in the acute setting when their – their loved one is deteriorating and suffering in front of them. So it's a very difficult situation, and it's important to try and establish goals of care, though, so everyone's on the page as to what exactly is going to – is likely to happen here. It is unfortunate, but a 78 year old lady with – with that frailty, that BMI, that severe lung disease having suffered a major aspiration event, it's extremely unlikely that she would survive.

And because of that extreme unlikelihood, is it reasonable to say that any delayed intubation probably was not material in terms of the outcome?---I don't think it was material at all. She – the – the non-invasive ventilation had held her. She'd already aspirated at this stage, so you're not trying to prevent aspiration. She was held in a – in a reasonable physiological state for those discussions to occur. It was just very important to have those discussions, I think, to – just to be sure that the family realised what a terrible situation that their loved one was in.

All right. After Mrs Haggett was intubated, she went on to develop a tension pneumothorax. And was that a consequence of the intubation itself, or if not, what was the mechanism which gave rise to the tension pneumothorax?---Okay. So when Mrs Haggett was intubated, you – you'll see on the notes that she had very, very high airway pressure. So – if I recall, it was about 36 centimetres, border. Now, anything above 30 is – is dangerous, and above 36, you're getting into quite dangerous territory, but there's nothing you can do about it if that's the pressure required to give her an adequate tidal volume to keep the patient alive. Now, with these patients with chronic obstructive airways disease, or COPD, as we call it, the – if you look at the lung, it's really quite confronting. The lung has these little out-pocketings all over it called blebs, and they're very, very thin-walled sacs of air which are not present in healthy lungs. And those sacs of air are very prone to be ruptured, so when you positively pressure ventilate the patients – so not when the patient is breathing spontaneously, that's negative pressure. But this is positive pressure pushing open the lungs. Those alveoli, those blebs on the alveoli – those emphysematous bullae is the proper term for them – they will rupture. And when they rupture, they will cause the lung to collapse. Now, that can have occurred. She had very high airway pressures when she was intubated and ventilated. Very high airway pressures indeed. The intensive care doctors tried to suck out some stuff that was – had aspirated in the lung to try and

cause more air in the lungs to be opened up, so therefore trying to lessen the airway pressure for a given tidal volume, but that wasn't successful, and it often isn't in these terrible circumstances, but they were trying everything they could to try and keep the patient alive and to try and lessen those airway pressures. And so a tension pneumothorax is tension because when it ruptures, the airway pressure that's using to drive open that long goes into the wrong area between the pleura and – and the lung and collapses the lung down, and that is a further life-threatening event. But remember, this patient was already in cardiovascular failure with two inotropes, or two drugs to keep her heart beating and her circulation going. The patient was then – respiratory failure, because they were on a ventilator – and very advanced respiratory failure, I might add – and in addition to that, they had renal failure requiring acute dialysis, which had already been commenced to try and improve the patient's metabolic status. So the patient had three major organ system failures with very high airway pressures. A tension pneumothorax, in these circumstances, is not unusual and commonplace, I'm afraid.

And ultimately, Mrs Haggett suffered cardiac arrest, and that was due to the cardio-respiratory issues that she was dealing with; is that correct?---Well, yes. The stress of a – of a – of a – of a tension pneumothorax would've impaired her circulation even more, and may have initiated further cardiac ischemic events, etcetera. It would've caused a cascade of disaster which resulted in – in the – in the – her death."

Issue 13: Whether any aspect of the treatment and management provided to the deceased caused or hastened her death?

Issue 14: Whether any failure to provide treatment and management to the deceased caused or hastened her death?

[241] I have made findings in relation to these issues above.

Findings pursuant to s.45 *Coroners Act 2003*

[242] I make the following findings pursuant to s.45 *Coroners Act 2003*:

(a) The deceased person is Shirley Elizabeth Haggett, born on 5 August 1940;

(b) The deceased died from tension pneumothorax (surgically managed) due to, or as a consequence of aspiration pneumonia (bronchoscopy), due to or as a consequence of facial melanoma (excised under High Flow Nasal Oxygen and sedation in a sitting position).

(c) The deceased died on 22 May 2019;

(d) The deceased died at the Redcliffe Hospital in Redcliffe, Queensland;

(e) As to what caused the deceased to die, the direct cause was the anaesthetic technique Dr Ngan chose to administer to Mrs Haggett, his ‘fixation error’ in his consideration of her post operative state, but there were various other contributing causes as outlined above, including the foundational causative factor of NLDH’s failed system for detecting and preventing Mrs Haggett’s admission as an ASA 4 patient in the first instance.

I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE