QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INVESTIGATION

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| CITATION: | **Non-inquest findings into the death of Ms G** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | BRISBANE |
| DATE: | 24 October 2025 |
| FILE NO(s): | 2024/2162 |
| FINDINGS OF: | Melinda Zerner, Coroner |
| CATCHWORDS: | CORONERS: Interhospital Transfer; Delay in Transfer; Regional Hospital; Subdural Haemorrhage; Subarachnoid Haemorrhage |

# Table of Contents

## Introduction

1. Ms G was born on 17 November 1947 and died on 2 May 2024 at the Royal Brisbane and Women's Hospital. She was 76 years old.

2. Queensland Police Service (Police) reported Ms G's death to the Coroner because her death was identified as unnatural or otherwise violent within the definition of a reportable death in the *Coroners Act 2003*.

3. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

4. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

## Circumstances of death

5. On 21 April 2024 at approximately 12.10pm, Ms G was involved in a significant traffic accident. She suffered severe injuries and succumbed to those injuries on 2 May 2024.

6. The accident occurred while Ms G was travelling south-west along Main St, Park Avenue approaching an intersection. She was the sole occupant of a silver 2023 MG ZST Station Wagon (the MG) and was driving to her local IGA on Main Street and Haynes Street, Park Avenue (Rockhampton).

7. A 2011 Black Nissan Micra hatch (the Nissan) with a driver and passenger had been stopped on Haynes Street at the intersection with Main Street, the traffic light being red at the time for the black Nissan.

8. The traffic light at the intersection controlling Main Street traffic had turned red, which Ms G did not react to. She unfortunately continued through the intersection. The Nissan had driven through the green light on Haynes Street and both vehicles collied in the middle of the intersection with the front of the Nissan colliding with the rear driver's side door of Ms G's MG.

9. The Nissan sustained significant damage to the front bonnet and remained in the middle of the intersection after the crash. The MG rolled and continued to slide on its roof along Main Street, stopping approximately 20 metres from the intersection outside the Park Avenue Hotel.

10. The MG sustained extensive damage to the roof and driver's side of the vehicle. Ms G was trapped in the MG and was cut out by the Queensland Fire and Emergency Service (QFES). The Queensland Ambulance Service (QAS) attended to Ms G and transported her to the Rockhampton Hospital.

11. Ms G was hypertensive and complaining of a mild headache. A CT head scan revealed she had a left-sided subdural haematoma with underlying mass effect and effacement of the left lateral ventricle and left cerebral hemisphere denoting an element of cerebral oedema. Her other injuries included a subarachnoid haemorrhage, a thoracic vertebra endplate compression fracture (T2), a parietal haematoma and a left 5th finger fracture. She was initially for conservative management.

12. At 9.20pm, Ms G began vomiting profusely, had worsening hypertension, had a decline in her cognitive function, and was reporting a severe headache. A repeat CT scan showed worsening of her subdural haematoma. She continued to decline with unequal pupils and became unresponsive. The decision was made to intubate her, and to transfer her to the Royal Brisbane and Women's Hospital for an emergency decompressive craniectomy and subdural haemorrhage drainage.

13. Ms G was subsequently transferred to the Royal Brisbane and Women's Hospital (RBWH), being admitted to the Intensive Care Unit on 22 April 2024 at 9pm. She underwent surgery which was uncomplicated. She remained drowsy.

14. On 25 April 2025, Ms G had an increase in oxygen requirement and a loss of neurological responsiveness. A subsequent CT scan showed a small re-accumulation of the subdural haemorrhage.

15. Ms G developed nonconvulsive status epilepticus. She had ongoing neurological deterioration. On 2 May 2025, her family agreed to commence Ms G on comfort cares. She was extubated at 9.30am and was declared deceased at 9.50am.

**Forensic Pathologist examination**

16. An external examination with whole body CT scan and urine and blood samples, was undertaken by the forensic pathologist.

17. The forensic pathologist has advised Ms G had a medical history of hypertension, type-2 diabetes mellitus, and dyslipidaemia.

18. The CT scans showed evidence of recent craniotomy, focal coronary artery calcification, aorto-iliac and femoral arterial calcification, as well as patchy consolidation with effusion and/or postmortem changes in the lungs.

19. The forensic pathologist concluded the cause of Ms G's death was a closed head injury comprised of subdural haematoma, subarachnoid haemorrhage with brain swelling and associated complications.

**Police Investigation**

20. The Police Forensic Accident Unit (FCU) investigated the accident. I have been provided a report.

21. The investigator obtained CCTV footage and has advised:

    a) CCTV footage from the Park Avenue Hotel was located outside of the building on the Haynes Street side of the building.

b) The CCTV footage shows the Nissan stop at the traffic lights behind an unidentified utility. As the utility and Nissan moved forward the MG is seen, from the left, along Main Street without stopping at the traffic lights. The Nissan collides with the driver's side of the MG. The traffic lights cannot be seen in the CCTV footage.

22. The FCU Investigator was able to talk to Ms G once she was extracted out of her car, she stated:

*I was driving along Main Street, the light was green then it went red and I drove through the intersection.*
*Q: Where were you travelling?*
*A: From the railway line, down towards IGA.*

*Q: What speed were you travelling?*
*A: Probably about 50km.*

*Q: What time did it happen?*
*A: About 1210ish*

*Q: Do you drive this area regularly?*
*A: Fairly regularly to go to IGA.*

*Q: When did you see the other vehicle?*
*A: When I went through the intersection, they drove through.*

*Q: Did you apply the brakes?*
*A: Yes*

*Q: Tell me about your injuries?*
*A: A little light head and my hand hurts.*

*Q: Did anything obstruct you when driving?*
*A: No*

*Q: Do you wear glasses?*
*A: Yes I was wearing them.*

*Q: Do you have any medical conditions that would impact driving?*
*A: No*

*Q: Are you on any medications?*
*A: Yes for high blood pressure.*

*Q: How did you sleep last night?*
*A: Good*

*Q: What time did you go to bed?*
*A: 1 am*

*Q: What time did you get up?*
*A: 8am*

*Q: Are you feeling ill today?*

*A: No*

*Q: Have you consumed alcohol in the past 24 hours?*
*A: No*

23. The FCU Investigator obtained a statement from the driver and passenger of the Nissan:

    a) The driver stated *"picked up my friend and we were going to go into town. I was driving on Haynes Street towards the bridges. I stopped at the intersection of Haynes and Main as there was a red light. Once the light turned green, I began to proceed through the intersection. I saw the other car, but it was too late to stop. I had a green light, so I am certain that the other car had a red light and ran through it."*

    b) The passenger stated *"My friend picked me up from my address at Whackford Street. We were driving down Haynes Street. We approached the intersection of Haynes and Main. We had a red light. We stopped at the line and waited for it to turn green. Once it was green, we proceeded through the intersection. That's when we saw the other car coming south on main street, through a red light. By the time we saw it, it was too late to stop the crash. I think we were travelling at approximately 10-20km/h as we had come to a complete stop for the red traffic light."*

24. The FCU Investigator officer obtained statements from two witnesses of the accident. They stated:

    *I was driving behind the silver car* (MG) *along Main Street, I stopped my car as the light had turned red. The silver car drove straight through the red light and hit the other small black car.*

    *I saw the black car get the green light and start driving through the intersection, the silver car has driven straight through the intersection when the light was red and hit the black car.*

25. The FCU Investigator concluded that:

    a) BWC footage of Ms G immediately after being extracted from her car captures her advising QAS Paramedics that she was not suffering any head pain. She was conscious and appeared alert.

    b) The witness version from the person travelling behind her stated that the red light was visible, and Ms G did not react to it. There was no other mention of erratic driving prior to that point.

    c) From the information available from the scene evidence and Ms G's version of events it would appear as though the cause of this crash is likely some form of distraction, not identifying the red traffic light and proceeding into the intersection.

    d) This opinion is formed in the absence of medical evidence to suggest a medical episode or condition existed at the time of the crash.

**Central QLD Hospital and Heath Service Investigation**

26. There was a delay in transferring Ms G to the RBWH.

27. An investigation was carried out by the Rockhampton Hospital in relation to the care provided to Ms G. I have received a copy of the Human Error and Patient Safety report.

28. I have been advised there were multiple requests to transfer Ms G to the RBWH under the care of the neurosurgery department, but those requests were denied. Ms G subsequently deteriorated within the Rockhampton Hospital Emergency Department. She was intubated and following a further delay was transferred to the RBWH on 22 April 2024.

29. The experts who reviewed the case have advised,

    a) The trauma call attendance and management plan devised at the Rockhampton Hospital was appropriate. The team concur that the advice received initially from the RBWH Neurosurgical Department (NROS), for local management and monitoring, was appropriate for the patient's clinical and radiological picture. ED staff contacted the surgical team at the Rockhampton Hospital for admission.

    b) The beginning of the deterioration in Ms G's condition commenced from approximately 9pm when her pain score was 10 out of 10 (worst imaginable pain). Then at 9.29pm there were definitive signs of physiological deterioration, with signs of intracranial pressure present – increased vomiting, 10/10 headache, a blood pressure with a systolic reading of 200. A Queensland Adult Deterioration Detections System (QADDS) score of six was appropriately escalated by a Registered Nurse to both senior medical and nursing staff and Ms G was moved to Resuscitation Bay 1.

    c) There was a missed opportunity for recognition of the deterioration in Ms G's condition by the Rockhampton Hospital Principal House Officer at initial assessment at 10pm with no escalation to either the RBWH NROS team or the Surgical Consultant at the Rockhampton Hospital to assist with transfer to a tertiary hospital. It is not evident in the documentation that Ms G had a further medical review approximately one hour later by the ED Senior Medical Officer at 10.50pm at which time escalation occurred to the RBWH NROS team. Ms G should have been accepted for transfer at this time.

    d) There was an underappreciation of the severity of the evolving situation by the RBWH NROS PHO, leading to further deterioration and a missed opportunity to recognise and respond to the deteriorating patient by the RBWH. The RBWH NROS Registrar at 12.40am should have escalated the case to the RBWH NROS Consultant for further discussion and decision making regarding the proposed inter-hospital transfer. It was thought this was likely due to an underappreciation of the case rather than a reticence to contact a consultant after hours.

    e) There were also no further internal escalations within the Rockhampton Hospital, following the denied transfer request, by the Surgical team within existing frameworks – that is, escalation to RH Surgical Consultant, Director of Medical Services, Executive on-call. This was a missed opportunity for local consultants (ED/Surgical/ICU) to discuss the clinical picture and deterioration directly with the neurosurgical consultant at the RBWH.

f) The review team are of the opinion it appears there was a false reassurance felt by a junior surgical registrar, given the advice provided by the Tertiary Hospital Neurosurgical Registrar. There was also a reticence to further escalate and challenge the advice provided from the tertiary hospital.

g) The experts agreed that from a referring centre point of view, Clinical Directors need to educate and reiterate to junior staff that some registrars at accepting facilities are at an early stage of their training and the advice provided needs to be discussed with/escalated to local team consultants as a matter of urgency if this advice relates to unwell/deteriorating patients.

h) The review team noted a potential barrier regarding difficulties with the RBWH switchboard. They noted instances where Rockhampton Hospital medical officers have tried to escalate to consultants at the RBWH, and whilst there are no restrictions or policies to prevent this contact, RBWH switchboard operators are not putting through calls to the consultant on call. Rockhampton Hospital team members noted that this had occurred multiple times across various specialities. The RBWH neurosurgical expert noted that the reluctance of switchboards to put calls through to consultants on call is a recurring problem and needs to be addressed. They state, '*if a consultant is on call, they should be available*'.

30. Recommendations were made by the review team, they include,

**Recommendation One**

*a) Joint Grand Rounds presentation by Royal Brisbane & Women's Hospital and Rockhampton Hospital highlighting the difficulties faced and potential solutions from all perspectives (Regional & Tertiary) utilising the findings from this HEAPS analysis and the RBWH M&M Analysis, including but not limited to:*

i. Challenges faced by regional facilities (clinical service capabilities/tyranny of distance/time delays experienced in relation to logistics for transfer.

ii. Importance of Escalation, particularly in an after-hours situation;

iii. Empowerment of Junior Doctors in speaking up for safety;

iv. Reiteration of the importance of doctor-doctor discussion for time critical patients.

*b) Review of the HENRI system to add an additional field to be utilised as a prompt for regional doctors, to advise of any logistical issues which may arise with the inter-hospital transfer of the patient, so this can be considered in the decision-making by the Royal Brisbane & Women's Neurosurgical Department.*

**Recommendation Two**

It is proposed to the Executive:

*a) The team has recognised that there are a number of existing recommendations/lessons learnt from recent SAC 1 investigations endorsed by the CQHHS Executive currently in progress which seek to strengthen escalation processes in the situation of deteriorating patients.*

*b) Rather than formulations of additional recommendations from the findings the team believe the existing review into any barriers/culture issues pertaining to escalation are sufficient to meet the similar findings within this review.*

*c) The existing recommendations/lessons learnt relate to RM #4932450, RM# 4888005; and RM # 5729051.*

**Recommendation Three**

*A Morbidity & Mortality analysis to be undertaken by the RBWH on events prior to the patient's arrival at the RBWH, focussing on the Rockhampton Hospital Emergency Department episode of care and all communications pertaining to the inter-hospital transfer.*

**Lesson Learnt 1**

*Difficulties experienced by Rockhampton Hospital in which the RBWH switchboard decline phone transfer to a Consultant across various specialities.*

31. All the recommendations and the lessons learnt were accepted by the health service executive.

32. I sought an update from the Rockhampton Hospital concerning 'Recommendation Two' and have been advised,

> *Rockhampton Hospital has progressed a range of actions aligned with prior serious clinical incident recommendations, a number of which have been formally implemented and closed. Despite this, the recurrence of escalation-related concerns highlights the ongoing need for deeper cultural reinforcement, practical application at the clinical frontline, and sustained oversight.*
>
> *These initiatives form part of a broader program of continuous improvement across the Central Queensland Hospital and Health Service, informed by learnings from clinical incidents involving similar themes of missed escalation and delayed response.*
>
> *Multiple strategies have been undertaken to reinforce escalation expectations — including targeted clinical education, case-based learning, and messaging from senior medical leaders. However, it is recognised that these efforts must now move beyond awareness into consistent embedded behaviour across all disciplines and clinical levels. Particular emphasis is being placed on strengthening consultant involvement in complex or deteriorating cases and on supporting junior staff to escalate concerns promptly and appropriately.*
>
> *Case-based learning has been incorporated into local teaching sessions and Grand Rounds programs, with a focus on speaking up for safety and normalising escalation. In parallel, strategies are being progressed to address behavioural and systemic barriers — including audit activity, consultant-led discussions, and reinforcement of psychological safety for staff who raise concerns.*
>
> *A joint Grand Rounds with the Royal Brisbane and Women's Hospital is scheduled for 2025, focusing on the challenges regional hospitals face in coordinating time-critical transfers to tertiary centres. This session will highlight the importance direct clinician-to-clinician communication, timely decision-making, and shared accountability.*

*Work is also underway to revise the HENRI referral platform used for inter-hospital transfers. Proposed enhancements include a prompt to flag clinical urgency and logistical considerations when referring patients from regional facilities, aiming to support more informed and timely triage by receiving hospitals.*

*In parallel, a thematic review of clinical incidents involving deterioration is in progress across the health service. Findings from this case are contributing to that work and will help shape future escalation processes, education, and service planning. Additionally, safety huddle practices have been reviewed to support earlier identification and escalation of patients of concern, particularly during times of operational pressure.*

*Targeted education has been delivered to reinforce escalation expectations during after-hours periods, and there is renewed focus on enabling direct senior-to-senior conversations in urgent or complex transfer scenarios, where traditional hierarchies may contribute to delay.*

*Rockhampton Hospital acknowledges that escalation in complex inter-hospital transfers is a shared responsibility. However, local accountability has been taken to ensure that all available pathways for recognition, escalation, and advocacy are understood, accessible, and used. While not all improvement actions have reached formal closure, the concerns raised in this case continue to inform ongoing improvement efforts.*

**Clinical Excellence Queensland**

33. I sought information from Clinical Excellence Queensland regarding inter-hospital transfers in another recent case I have, which had also resulted in a delayed transfer in a critically ill patient between hospitals, within the same Hospital and Health Service. I have been advised,

    a) Queensland Health has a Protocol for management of inter-hospital transfers. The protocol outlines the minimum requirement for process of interhospital transfers. Key elements of the protocol pertaining to this case include the following:

    ***3. Management of inter-hospital transfers***
    *A senior clinician is available for each facility 24/7 as a single point of contact to address access issues related to critically ill patient transfers.*

    ***3.1 Pre-transfer requirements:***
    - *Before transferring a patient, it is essential that adequate communication occurs between the referring and accepting facilities, and Queensland Ambulance Service.*
    - *The accepting HHS will prioritise in-patient bed availability for patients received via planned inter-hospital transfer. The accepting hospital is to advise of the entry point to the hospital for the patient, e.g. the in-patient bed location for a direct ward admission, the Emergency Department, or entry via the Transit Lounge.*
    - *The transfers of critically ill patients will not be delayed due to bed availability.*

***3.4 Transferring patients will be transported directly to an available inpatient bed unless:***

*They have an agreed clinical requirement for Emergency Department treatment as decided by the receiving hospital ED Consultant (or delegate) prior to the patient's departure from the referring hospital. OR*

*They have an undifferentiated condition requiring further specific investigations prior to placement in an inpatient bed.*

*OR*

*They have deteriorated in transit, necessitating Emergency Department treatment.*

*OR*

*A system is in place for the rapid transfer of a critically ill or multisystem trauma patient.*

***3.5 Communication and handover***

*iv. In the event of any disagreement surrounding the transfer, consultation must occur between the referring and accepting Consultants or most senior Medical Officers available and the accepting Bed Manager. If the disagreement remains unresolved, this shall be escalated to the Director of Medical Services (DMS) or equivalent at both facilities.*

## Conclusion

34. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings in relation to Ms G's death.

35. Ms G was involved in a significant car accident wherein she sustained a head injury. From the information available it would appear the cause of this crash was Ms G accidentally driving through a red light, likely due to some form of distraction.

36. Ms G was initially treated at the Rockhampton Hospital. Her condition deteriorated and for the reasons identified herein, there was a delay in escalating and transferring her care to a tertiary hospital for acute neurosurgical intervention. I accept the forensic pathologist's opinion as to the cause of death.

37. The Rockhampton Hospital and the RBWH have reviewed the care provided to Ms G, it has been acknowledged there were several missed opportunities in her care. I note there have been recommendations and learnings by both hospitals. I am satisfied there has been an appropriate investigation and the hospitals are taking steps to try and avoid a similar event from occurring again in the future.

38. Balancing the resources required to hold an inquest (formal court hearing) and based on the extensive investigation which has already been undertaken by the hospitals, and the recommendations and learning each has taken from the case, I have decided not to hold an inquest. I do though, with Ms G's family's permission, intend to publish these findings. This is so other clinicians and health services can learn from the case. I also intend to provide a copy of my findings to Clinical Excellence Queensland and the Office of the Health Ombudsman (OHO).

39. From the other recent case I have investigated which also involved a delay in transfer, and which is published on the CCQ website[1], I am concerned there may be a wider systemic issue concerning timely inter hospital transfers. I consider this may be an

[1] Non-inquest findings into the death of Mr S 01/10/2205

issue for the Office of the Health Ombudsman and Clinical Excellence Queensland to consider and closely monitor.

40. I extend my condolences to Ms G's family and friends for their loss. This is an unimaginable tragedy for you all. I recognise there are no words which can adequately express the depth of your sorrow, or the profound impact Ms G's loss has had on you all.

**Findings required by s.45**

**Identity of the deceased** – Ms G

**How she died** – CAUSE OF DEATH
1(a) Head Injury

ANTECEDENT
1(b) Motor vehicle collision (driver)

**Place of death** – Royal Brisbane Women's Hospital, Butterfield Street HERSTON QLD 4006 AUSTRALIA

**Date of death**– 02/05/2024

I close the investigations.

Melinda Zerner
Coroner
CORONERS COURT OF QUEENSLAND - BRISBANE OFFICE
24 October 2025