CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 2nd and 3rd and 17th of July 2001 and the 24th of August 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Saverio Gadaleta.

I, the said Coroner, find that Saverio Gadaleta, aged 28 years, late of Martin House, Minda Homes, King George Road, Brighton, South Australia, died at Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 30th of July 1999 as a result of peritonitis and septic shock complicating perforation of the terminal small bowel. I find that the circumstances of the death were as follows:

1. Introduction

1.1. On 29 July 1999 Saverio Gadaleta was a resident at Minda Incorporated, a residential institution for disabled people. Mr Gadaleta suffered from cerebral palsy, microcephaly with resultant spastic quadriplegia, and epilepsy.

1.2. Mr Gadaleta was incapable of verbal communication. He was described by Mr Marco Iammarino, the Unit Manager at Martin House where he resided, as a very happy and pleasant man who communicated with smiles and gestures (T190-191).

1.3. During the evening of 29 July 1999, Mr Gadaleta gave staff at Minda the impression that he was suffering from abdominal pain. Ms Annette Vidic, who came on duty at 8:10pm that night, said that he was sitting on the floor in

the laundry, he was sweating and was not his usual smiling self. She said he didn’t look ‘normal’ (T11).

1.4. Mr Gadaleta’s condition was monitored throughout the evening by Registered Nurse (RN) Richard Hill, and he was transferred to the Clinical Health Care Unit (CHCU) at around midnight.

1.5. As his condition did not improve, an ambulance was called and Mr Gadaleta was transferred to the Flinders Medical Centre (FMC) where he arrived at 2:48am. He was categorised by the Triage Nurse as a Priority 3 patient which meant that he should have been seen by a doctor within half an hour.

1.6. Mr Gadaleta was seen by RN Jennifer Stanger at about 3am and was taken to a cubicle for observations. No further treatment was administered.

1.7. Mr Gadaleta was not seen again until 5:30am when RN Heather Reid recorded observations, and while RN Reid was still dealing with him, Mr Gadaleta suffered a cardiac arrest at about 5:45am.

1.8. Despite extensive efforts to resuscitate him, Mr Gadaleta could not be resuscitated and death was certified at 6:10am.

2. Cause of death

2.1. A post mortem examination of the body of the deceased was performed by Dr R A James, Chief Forensic Pathologist, on 1 August 1999 at the Forensic Science Centre at Adelaide.

2.2. Upon examination of the small intestine, Dr James found a foreign object approximately 7cm before the ileo-caecal valve in the terminal ilium. He noticed that the bowel at that point was stretched and showed an obvious perforation measuring 0.5cm in length. Upon opening the bowel, Dr James found an impacted red 3cm screw-top plastic lid from a Coca-Cola bottle. He noted that the small bowel proximal (up stream) to the swallowed lid contained liquid contents and was distended.

2.3. Dr James also noted acute peritonitis in the peritoneal cavity. This was confirmed upon microscopic examination which suggested a duration of at least several hours, and probably less than 24 hours. (Exhibit C1a, p3).

2.4. In the opinion of Dr James, the cause of death was:

> 'Peritonitis and septic shock complicating perforation of the terminal small bowel by a swallowed screw top lid of a Coca-Cola bottle.'
>
> (Exhibit C1a, p1)

3. **Background**

3.1. Mr Gadaleta first became a resident at Minda on 10 June 1999. Prior to that, he had lived with his mother and father and family at Port Pirie. According to a letter from Dr Geoffrey Stewart of Port Pirie to Minda dated 29 June 1999 (in the Minda notes, exhibit C15), his diagnoses were described as follows:

- cerebral palsy
- microcephalic spastic quadriplegia with mental retardation
- epilepsy

Dr Stewart added:

> 'PS, long term placement would be beneficial for both Savvy and parents.'

3.2. According to Mr Iammarino, Mr Gadaleta was a very happy and pleasant person who easily made friends with other people in his unit. Both Mr Iammarino and Ms Annette Vidic, a Developmental Care Worker, said that he often sat on the floor, often in a kneeling position in front of a mirror or at the workstation in the unit. Importantly, both Ms Vidic and Mr Iammarino stated categorically that he had never been in the habit of picking up objects from the floor and swallowing them. Mr Iammarino told me that he had seen him on most days when he was at work, and that, since Mr Gadaleta's death, he had checked every one of the night and day books kept during the time of his residence at the unit and had never found any suggestion to that effect (T192-193).

3.3. It is noted in the day book for 29 July 1999, that Mr Gadaleta had been incontinent of faeces at about 1:30pm, and that he had become verbally aggressive at tea time, lying flat on the floor and refusing to stand. It was noted that after tea he appeared to be having stomach cramps. Ms Vidic, who started work at 8:10pm, found him lying on the floor of the laundry. She said he appeared to be in pain, was sweating profusely, and did not look his usual smiling self (T10-11). A laxative was given at 8pm and Panadol were given at

8:30pm. His temperature at 8:15pm was 39.6ºC, which is substantially elevated. Ms Vidic called the Night Supervisor, Mr Richard Hill, who is a Registered Nurse. He attended at about 9:15pm and stayed with Mr Gadaleta for quite a while to monitor his condition.

3.4. By 10pm Mr Gadaleta's temperature had dropped back to 37.6 degrees. Mr Hill described his examination as follows:

> 'A. Well his general - his general physical stature was - he had the cerebral palsy so he had the general increased muscle tone of his limbs and his abdomen. But I palpated his abdomen and - there was no guarding, like he just wanted to push me away - he didn't - didn't make any sounds of disapproval. I was able to palpate and he didn't seem to adversely respond to that.
> Q. And his stomach was not distended at that stage.
> A. No there was no distension, there was no visible signs, other signs of unusual noises and he hadn't been reported to have vomited at all … and his chest sounded ok, his breathing was clear.'
> (Exhibit C3a, p6)

3.5. Mr Hill concluded that Mr Gadaleta may have been suffering some 'abdominal or gatro-intestinal condition' and decided to monitor the situation. He did not consider that it was necessary to call for a doctor at that stage. (Exhibit C3a, p7).

3.6. At 11pm Mr Hill decided to transfer him to the CHCU because his condition had not improved. He was transferred between 11:15pm and 11:30pm.

3.7. At the CHCU, Mr Gadaleta was cared for by RN Janet Johns. At about midnight, his vital signs remained within normal limits (exhibit C4a, p3). She noticed some tenderness over his abdominal area although he was unable to describe it to her (exhibit C4a, p3). She gave him some Panadol which he spat out, and then Mylanta, most of which he also spat out.

3.8. At 1:45am Mr Gadaleta's pulse rate had increased to 120, his respirations had increased to 24 and his temperature had gone back up to 39.6ºC. RN Johns commented:

> 'There was a change in his state. It appeared as if the pain level had increased visually; he had more rigidity in his abdominal area … no distension'
>
> (Exhibit C4a, p6)

She decided to call an ambulance immediately. She wrote a letter to the 'Doctor Concerned' at FMC, saying:

> '(Savvi) Saverio has been experiencing abdominal discomfort since 2100 today 29/7/99. Temp 39.6. Pulse 120. Resps 24. Neither Panadol nor Mylanta given @ 0100 relieved discomfort. Savvi is non-communicative and has plastic (spastic) quadriplegia – bowels last open 28/7/99.'

The letter went on to describe his medication. The letter appears in the FMC casenotes (exhibit C10).

3.9. The ambulance attended at 2:19am and conveyed Mr Gadaleta to FMC arriving at 2:40am. Ms Vidic accompanied Mr Gadaleta in the ambulance.

3.10. In the ambulance report, which forms part of FMC casenotes (exhibit C10) the following note appears:

> 'past history of crawling on ground eating anything.'

I have not been able to determine where the ambulance officer obtained this information, as I will discuss later. According to his carers at Minda, it was completely wrong.

4. Arrival at Flinders Medical Centre

4.1. The ambulance arrived at FMC at 2:40am and Mr Gadaleta was seen by RN Julie Roylance, the Triage Nurse in the Emergency Department ('ED'). It was RN Roylance's role to conduct a quick assessment of Mr Gadaleta's condition, and then assign a priority from 1 to 5, according to the general classification for triage set out in the National Triage Code established by the Australian College for Emergency Medicine in 1993. (Exhibit C11).

4.2. According to the Code, a patient with 'acute abdo pain' should be assigned a Priority 4, classified as 'semi-urgent', and should be seen by a doctor within 1 hour.

4.3. RN Roylance said that she noted that Mr Gadaleta's abdomen was not distended, and there was no reaction on palpation and no increase in pain (exhibit C9, p1). She said that his temperature was 34.8 degrees, although she thought that the thermometer was reading low. He was lying on his side with his knees up, he was alert and breathing spontaneously, and he was holding his

abdomen and groaning (T40-41). RN Roylance said she was told by the ambulance crew that he had a history of abdominal pain, groaning and fever, and that he had a history of putting things in his mouth. She did not see the ambulance report or the letter from Minda.

4.4. RN Roylance's conclusion was as follows:

> 'I categorised him as priority 3 to be seen in the next 30 minutes. He did not appear to be in pain. Because of the communication difficulties and history of groaning I thought it was appropriate that he be a priority 3.'
> (Exhibit C9, p2)

Both Dr Philip Aplin, who was the consultant emergency physician on duty that night and Dr Christopher Baggoley, who was then the Director of the Emergency Department at FMC, said that the assessment of Mr Gadaleta as a priority 3 patient was entirely appropriate (T99, T139).

4.5. Triage of Mr Gadaleta at priority 3 set a standard that he should have been seen by a doctor within half an hour. This did not occur.

4.6. The next person to see Mr Gadaleta was RN Jennifer Stanger, who saw Mr Gadaleta at about 3am. She said that she was not aware that he had been brought in by ambulance and did not see the ambulance report. (Exhibit C5a, p4).

4.7. RN Stanger was directed by the Shift Coordinator, Ms Tania Palmer, to take Mr Gadaleta to a cubicle to do a 'workup' (ie. take his observations, perform an examination and form an assessment of his condition).

4.8. RN Stanger found that his temperature was 36.4ºC, his pulse was 100 and his respirations were 16 which were all within the bounds of normality. She was unable to obtain a blood pressure as she was unable to straighten his arm due to his muscular contractions. She said she was unable to obtain a pulse from one arm, but the carer, Ms Vidic, explained that this often occurred. (Exhibit C5a, p5).

4.9. RN Stanger said that she discussed Mr Gadaleta with Ms Vidic. She said:

> 'So I do remember that and I remember the carer telling me that she felt that he had abdominal pain and so I'd say to her 'Well what makes you think that?' and she would say to me 'He keeps pulling his knees up to his chest' and she said

> 'Also he keeps putting his fingers in his mouth and he's moaning all the time'. And I said to her 'Well what is he normally like?' and she said to me 'He likes to lay on the floor curled up in a ball', which I presume is with - she said with his knees up to his chest, 'And he puts everything into his mouth - fingers, rocks, everything in his mouth all the time'. So she was telling me 'This is why I think he's got pain' and then in the same sentence she would say 'but that's how he always is'. So I found it quite - I found it difficult, to be honest, to know whether he had pain or not. Certainly from what I can recall he didn't look to be in pain and with the moaning she also said that that was the only way he could communicate, so it didn't sound as if that were any different. What else. That's the other thing - I did note when I was working him up that his hands were almost a purpley colour and I said to the carer, I said 'His hands are a very odd colour' and she said to me 'They're always that colour', so there were things about him that normally would trigger things for me but she - everything I asked her about she would say was normal. That's all I can remember I'm afraid.'
> (Exhibit C5a, p6)

It is significant to me that RN Stanger did not record any of these issues in the casenotes at the time. I would have thought that such florid symptoms would have been noted, along with Mrs Vidic's purported explanations, if this in fact occurred.

4.10. There is a clear dispute on the evidence between Ms Vidic and RN Stanger about this conversation. Ms Vidic denied that she told RN Stanger that Mr Gadaleta always had his knees up to his chest, or that she said he had a history of putting things in his mouth, or that she said he often moaned or that his hands were normally discoloured (T17, 25, 34).

4.11. I am inclined to accept Ms Vidic on this issue. Her evidence and that of Mr Iammorino clearly establishes that Mr Gadaleta did not have a habit of putting things in his mouth. As I have already mentioned, this had never been recorded in the day or night books.

4.12. It seems to me that a significant communication breakdown occurred between RN Stanger and Ms Vidic on the night. The information about Mr Gadaleta putting things in his mouth appears to have come from the ambulance officers although RN Stanger said she did not read their report. I accept that the information did not come from Ms Vidic.

4.13. This breakdown in communication was a potentially serious one which could have had quite serious consequences, particularly in a case where, as here, Mr Gadaleta could not communicate for himself.

4.14. The effect of the misinformation went both ways. The misinformation about putting objects in his mouth should have put the staff at FMC on notice that a bowel obstruction due to swallowing a foreign object could have been the cause of his abdominal pain. On the other hand, the unusual colour of his hands might have indicated to RN Stanger that Mr Gadaleta was 'shutting down' (losing his peripheral circulation due to shock) which indicated an emergency situation (see RN Stanger's evidence at T179).

4.15. RN Stanger decided that Mr Gadaleta's condition was stable, and was happy that his triage priority should remain at 3. She accepted Ms Vidic's report that he had suffered a high temperature earlier, but thought that this had been relieved with Panadol. She did not believe that he was suffering from abdominal pain at the time she examined him, although she acknowledged that he could have been in pain earlier. It did not occur to her that he may have swallowed a foreign object. She took no further steps in relation to treatment.

4.16. <u>Emergency called</u>

Ms Vidic remained with Mr Gadaleta in the cubicle for another 90 minutes or so. In her statement, she said:

> 'At 5:40am Friday morning while still in the cubicle Saverio started to go blue around the lips, I asked the nursing staff who was a female who had walked into the cubicle if he could have some oxygen, the nurse said he was looking and feeling cold and clammy the nurse also said she though he was shutting down but she then left and a short time later about 2 minutes later she returned and said she was going to put some oxygen on Saverio but just as she was placing the oxygen mask over his face I said I think he has stopped breathing, the nurse immediately left and went to get help from other staff members and a doctor. A few seconds later help came and they tried to revive Saverio by using paddles and giving medication but nothing seemed to work. At about 6:10am he was declared deceased.'
>
> (Exhibit C8, p2)

4.17. Dr Philip Aplin, the consultant emergency physician present that night (he should have finished his shift at 11pm but could not leave because of the extraordinary workload), was called to Mr Gadaleta at about 5:45am. He

confirmed that Mr Gadaleta was in cardiac arrest when he arrived. A registrar (senior specialist trainee) was also present. Cardio-pulmonary resuscitation (CPR) was performed, he was defibrillated several times, he was intubated, ventilated, and adrenaline, atropine, calcium and other medications were administered, all to no effect. Resuscitation was discontinued at 6:10am (exhibit C13, p8).

5. Issues arising at the inquest

5.1. Overcrowding/under-resourcing

I am unable to reach a firm conclusion as to how the breakdown in communication between Ms Vidic and RN Stanger occurred, but the circumstances which prevailed at FMC that night and early morning offer a potential explanation. The circumstances also explain why Mr Gadaleta was not seen by a doctor within half an hour, as dictated by the National Triage Code.

5.2. There is little doubt on the evidence before me that FMC Emergency Department that night was grossly overcrowded, to the extent that it was impossible for the staff to comply with the stipulations of the code.

5.3. Several witnesses described the conditions that night as being like a ‘war zone’ (see for example the evidence of the Area Coordinator, RN Tania Palmer at T67). RN Stanger described it as ‘very, very busy’, and cited the example of an elderly lady waiting more than 8 hours to see a doctor (exhibit C5a, p3). RN Roylance described it as ‘unbelievable’, and cited examples of patients with chest pain who could not be monitored on an ECG machine as all monitors were in use. (T43). She also used words such as ‘dangerous’, ‘out of control’, and ‘war zone’. (T43-44).

5.4. Dr Philip Aplin, the Senior Consultant in the Emergency Department, described the situation as follows:

> ‘Very busy night, you know, it had been a very busy day. I think, … there had been problems with getting patients admitted to the ward throughout the day and when I came on at three, there were already quite a few patients waiting in the Emergency Department who weren't going to be getting beds in Flinders that night. So already there was a, … this access block had, had become a significant issue and (it) was a continuous busy night and it never really settled down. Even

> around, … you expect things to settle down around three in the morning, that sort of time, (there) was, … just another influx of - some people came in at that point in time and that was what we were dealing with all night. So there were patients in the corridors, monitored patients, sick patients, occupying beds in cubicles in the Emergency Department who couldn't get to the ward and so it was very difficult to move patients in to be seen in the first place. And then if they, once they were seen and needed to be admitted then they were, had nowhere to go. So, yeah, that was a combination of those factors, the business of the night, the … acuity of the patients and the lack of beds, and then the build up of admitted patients in the Emergency Department all contributed to being a particularly difficult night.'
>
> (Exhibit C13, p3)

5.5. Dr Aplin's shift was normally between 3pm and 11pm, but he was forced to work all night. He said that he thought they were making progress at between 2am and 3am, to the extent that he might be able to go home, but after 3am there was another influx of patients (one Priority 1, five Priority 2 and others) which maintained the pressure right through the night.

5.6. Dr Aplin told me that he did not see Mr Gadaleta, nor was he told of any concerns about his condition that evening until he was called after Mr Gadaleta arrested (T97).

5.7. A system of 'ambulance diversion', whereby if an Emergency Department is under pressure, ambulances can be diverted to another (hopefully less-pressured) hospital, was not in operation at that time, and was not an option open to Dr Aplin to deal with the influx of high priority patients. (T95).

5.8. The then Director of the Emergency Department, Dr C J Baggoley (who has since resigned and is now Consultant Medical Director for the Adelaide Community Healthcare Alliance, Chairman of the Committee of Presidents of Medical Colleges and Councillor for the College of Emergency Medicine for South Australia and the Northern Territory) arrived at FMC at 8am on Friday, 30 July 1999 for a teaching session. He expected that Dr Aplin would be arriving at work at the same time, but quickly learned that he had been there all night and that Mr Gadaleta had died. (Exhibit C14, p10).

5.9. Dr Baggoley made inquiries and established that it had been an extraordinarily busy night. A census of patient activity was obtained and demonstrated that the number of patients in the department rarely fell below 40 for the entire night. The department is designed for a total of 21 patients. Dr Baggoley

explained that the use of Emergency Departments had vastly increased in recent years. He said that at 6am, one could expect to find 5 patients in the department in 1993/1994, and this had increased to 10 in 1996/1997, rising to an average of 17 in July 1999. Even having regard to that enormous increase in the average in the space of 5 years from 5 to 17, the presence of 40 patients was extraordinary (T117-118).

5.10. Dr Baggoley explained that the problem is not that the usage of Emergency Departments has increased. The problem is that, due to closures, there are fewer beds available in substantive wards. As a result of that, patients remain in the Emergency Department until there is space in the wards to place them. The total number of beds in FMC had fallen from 500 in 1995 to 400 in 1999. This is the phenomenon described by Dr Aplin as 'access block'. Indeed, Dr Baggoley prepared a compendium of correspondence and articles dealing with that issue from 1992 to 1999, for the use of the incoming Chief Executive Officer of FMC in 1999 (exhibit C14c). The documents demonstrate that concern was being expressed at this phenomenon as far back as 14 September 1992 where, in a memorandum to the Director of Nursing, the following statement appears (I have emphasised certain passages by use of bold typeface):

> 'The re-organisation of services have had the predicted effect of worsening the backlog of inpatients in the Accident & Emergency Department. Not only does this cause prolonged delays for treatment of other patients attending A&E, but more disturbingly **patients safety and comfort and staff's ability to cope is significantly compromised**.'
>
> (Exhibit C14c, Section A1)

5.11. Further documents in exhibit C14c demonstrate that, since 1992, numerous representations have been made both by Dr Baggoley and by successive Chief Executive Officers at FMC to have this situation addressed. Unfortunately, this has not worked, and the situation has become progressively worse. For example, in 1995 the proportion of patients spending longer than 12 hours in the Emergency Department was 0.5%. In 1997, this had grown to 5%, in 1999 to 10% and in 2000 to 20%. On 27 October 1997, Dr Baggoley wrote to the Chief Executive Officer:

> '**In writing to advise you that the situation has deteriorated to an extent that we cannot guarantee the safety of our patients**, I realise our priorities and performance will be scrutinised. This is consistent with our wish that other area's priorities and performance are similarly scrutinised.

You have always taken a direct interest in the work of the Emergency Department and you know the issues well. They relate to patient load, access block and the lack of senior staff – nursing and medical.

The problems we have flagged for some years continue to worsen. Our workload, as measured by patient attendances, acuity and the time we have to care for them, has hit record levels in the last two months. As you remember we briefed Ray Blight of all the problems of access block earlier this year. Then, 6% of adult patients were waiting more than 12 hours for a bed. Now it is over 10%. We cannot continue to be as busy as we are and also provide ward care – **the potential for a major incident/disaster is high**.

…

I need your help to:

- Ensure the rest of the Hospital understands what we do and the extreme pressures we have to cope with;
- Ensure that the rest of the Hospital improves its ward work practices, so that we can reverse the trend of an increasing access block;
- Ensure that every Division that undertakes expenditure restrictions does so without their impacting on the Hospital's emergency service, and consults with other Divisions to ascertain their impact;
- Ensure that the budget for the Emergency Department is such that staffing levels are in line with the other Emergency Departments in this city, as a minimum.

Unfortunately your own keen interest in, and understanding of, our problems has not yet translated into relief for our patients or our staff.'

(Exhibit C14c, Section A11)

5.12. In contrast to Dr Baggoley's advice, the General Manager of the Health Commission advised the Minister for Human Services, in a briefing note dated 31 October 1997, only four days later, as follows:

'SAHC is advised that despite documented delays in admission from the Emergency Department **there is no suggestion that quality of care has been compromised and indeed waiting times in the Department have been improved over the last few months**.'

(Exhibit C14c, Section A13)

5.13. Even after that briefing was given to the Minister, the Chief Executive Officer, Ms Judith Dwyer, wrote to Dr Baggoley saying, inter-alia, as follows:

'Finally, I would like to assure you that the Operations Committee and the Board are well aware of the problems associated with our high level of emergency patients. The skill and commitment of your staff is widely recognised, and I hope that they will not again have to cope with the level of additional workload arising from access block experienced this winter.'

(Exhibit C14c, Section A14)

5.14. As time progressed, the problem received increasing recognition within the SA Health Commission ('SAHC'). In a letter dated 21 May 1998, the Executive Director of the Purchasing Office of SAHC, Ms Jean O'Callaghan, expressed concern that they may suffer financial penalties in the Medicare Agreement because:

> 'The 1997/98 data received to date indicates that thresholds are not being achieved for priority code 1 patients. In the period from July to December 1997, approximately 2000 more Emergency Department visits were recorded than for the preceding six months. It is of note that this 8% increase in activity is associated with a 12% decrease in the wait time standard achieved.'
>
> (Exhibit C14c, Section A)

It should be noted that the above figures were inaccurate and, in a letter dated 3 June 1998, Ms O'Callaghan was notified that 100% of priority 1 patients were treated immediately but it was the patients in categories 2 and 3 that were of most concern. They were:

> 'exposed to increased risk due to longer waits, that is, they are likely to continue experiencing worsening of their conditions, their symptoms and/or their pain during their wait. However we are not able to identify any cases of serious clinical deterioration occurring during waiting times in the last twelve months. **It is to the best of our knowledge a situation of increased risk rather than actual adverse outcomes**.'
>
> (Exhibit C14c, Section A17)

5.15. The level of frustration evident in FMC management is clearly illustrated in the letter from the CEO, Ms Judith Dwyer, to the Executive Director of the Purchasing Office of SA Health Commission dated 3 June 1998, just over a year before Mr Gadaleta's death, as follows:

> 'While I am aware that there is a general perception in the Health Commission that FMC's long-standing problems with emergency workload are somehow of our own making (or at least would not be a problem if we were better managers), I can only advise you that this hospital is under more pressure from emergency admissions than any other hospital in this country. When this fact is considered in conjunction with the fact that our performance on all relevant benchmarks (ALOS, rate of admission of patients in all NTS categories, rate of transfer on to other hospitals, turnover interval of beds etc) is at or above average, and with the fact that we are recognised nationally as effective and innovative bed managers, **it seems to me that it would be logical to conclude that we are dealing with a very difficult situation as well as is humanly possible**.'
>
> (Exhibit C14c, Section A17)

5.16. Despite continuing strenuous efforts to address these problems, including the report of a taskforce entitled the 'Bed Management Project' in February 1999, they failed to abate. Included in exhibit C14c is a petition to the CEO dated 19 July 1999, only 11 days before Mr Gadaleta died. The petition was prompted by reported comments, attributed to the Executive Director of Statewide Services in SAHC, Professor Brendon Kearney, in the media denying that there was a crisis at FMC. The petition, signed by approximately 40 members of staff, includes the following comment:

> 'Brendon Kearney could explain what is meant by '**managing reasonably well**' as we are aware of the imbalance of workload and resources across the system. As of early this morning, after18 days of July, 142 patients waiting an in-patient bed spent 12 hours or more in the Emergency Department. Overnight waits are far more common than Brendan's interview implied.'
>
> (Exhibit C14c)

5.17. It is in this context that Dr Baggoley told Senior Constable Gross, investigating this matter on my behalf, the following:

> 'I believe that the issue of over-crowding, and excessive workload (were) certainly significant factors on that night, and that as a result the staffing levels were insufficient to cope with the workload that was there.'
>
> (Exhibit C14, p13)

5.18. In oral evidence, Dr Baggoley explained the effect of chronic and constant overcrowding on Emergency Department staff as follows:

> 'I see the issue - I've obviously had several years to reflect on this … the key issue in relation to that night is one of overcrowding, and not just overcrowding that night, but constant overcrowding which, of course, can have an impact on patients and an impact on staff; and the impact of chronic overcrowding on staff is that they can become overwhelmed, they are required to rush to get their work done, which, of course, increases the risk of mistakes, and puts communication under stress; and, in fact, I think it was Paul Gross that showed me a cutting from the Advertiser in which the Minister was quoted where he is saying - at that time he was saying that he was concerned, or maybe it was soon after, about the pressure on the public hospital system and the fact that the pressure of increased work, the impact of that could be on patients' safety and staff workload, and the potential for mistakes. So I found myself agreeing with the Minister on that occasion as to his assessment of the problem. But when the situation is overcrowded and chronically so, it just has an ongoing effect on the ability to perform. Now I must admit that I found that when it became overwhelmingly busy, my ability to function efficiently, just as a clinician, would drop off. Now

> I think there's a level of busy at which you can be most efficient and beyond which you almost start to move in circles, so I think this issue of overcrowding is one that just can't be overestimated. Now on that time we've spoken about staffing as well and there's the other staff there ready to be seen. I mean, if I had come in that night, if Dr Aplin had called me in to get to work to see some of the patients, I think I too would have been overwhelmed by the number of patients. There would have been people everywhere, and I would have also not found myself looking to see a 28 year old man with abdominal pain as the one most likely needing my urgent attention.'
>
> (T129-130)

5.19. Indeed, the petition dated 19 July 1999, to which I have already referred, comments:

> 'Staff are most anxious at the unrelenting demands over these few weeks (and continuing). **Some of us are fearful for patients, some of us are constantly tired, and all of us are apprehensive about the weeks and months ahead**.'
>
> (Exhibit C14c, Section A26)

5.20. Conclusion

The evidence before me in this case justifies, in my opinion, a finding that the failure of communication between Ms Vidic and RN Stanger in the early morning of 30 July 1999 occurred in the context of an Emergency Department that was grossly overcrowded, when its staff were working at absolute maximum capacity, and in a situation where it was just physically impossible for Dr Aplin, or the other doctors on duty, to see Mr Gadaleta, having regard to the number of priority 1, priority 2 and earlier priority 3 patients they still had to see. It is not surprising, in those circumstances, that such errors of communication will occur when staff are stressed to that extent.

5.21. Even if Dr Aplin had seen Mr Gadaleta within 30 minutes of admission and had diagnosed an emergency situation, it is by no means certain that the outcome would have been any different. Dr Baggoley outlined the steps that could have been taken as follows:

- careful questioning of the carer, Ms Vidic, to try and clarify his symptoms;
- careful assessment of his apparent symptoms although the examination would have been difficult in view of his disability;
- depending on the outcome of those measures, arranging further tests, probably a blood test and an x-ray;

- depending on the outcome of those tests, if a decision was made that surgery was needed, calling in the surgeon from home since there are no on-call surgeons any longer;
- having arrived, the surgeon would then have needed to carry out a further assessment of the patient, and then arranged for the setting up of an operating theatre, and the transport of the patient to the theatre (T103-104).

5.22. It can be seen that each of these steps would have taken some time, to the extent that even if the need for surgery had been ascertained, an hour or more may well have elapsed. Dr Baggoley commented:

> 'Even if each step of the way had gone as it should, it may well be that if he had made the operating theatre, then the – the likelihood would have been he would have died on the table … most likely he would have died still in the Emergency Department waiting to get to the operating theatre.'
>
> (Exhibit C14, p60)

5.23. I accept Dr Baggoley's evidence about this. Dr Aplin gave evidence to a similar effect:

> 'I think what we were seeing was a process which had been going on for some hours, if not 12 hours or more, and (had Mr Gadaleta) been seen in half an hour or hour of his arrival might not have changed his prognosis very much.' (T99).

5.24. Accordingly, I am unable to find, on the evidence that, even had Mr Gadaleta been seen within 30 minutes of admission at 2:45am at FMC, the outcome would have been any different.

5.25. However, it is completely undesirable that FMC were failing to meet the standards laid down in the National Triage Code by such a wide margin. There was always a chance that Mr Gadaleta could have been saved had he received correct and timely treatment even if the probabilities were against it. Peritonitis does not always progress so quickly, and, in patients whose illness may have taken longer to develop, the chances of survival would have been greater.

6. <u>Recommendations</u>

6.1. In these findings I have attempted, in a very superficial way, to describe the systemic difficulties being faced by the staff at FMC Emergency Department

during the early morning of 30 July 1999. It is an extremely complex issue involving issues of Commonwealth and State funding, the Medicare Agreement, and internal management issues within the SAHC and FMC. The evidence before me is not sufficiently broad to deal with these highly complex topics in detail. Ambulance diversion, for example, has been adopted since this incident, but with limited success.

6.2. An Emergency (incorporating trauma) Clinical Services Review was commissioned by the SA Government and reported in January 2000. I have not been provided with a copy of that report. An implementation plan was developed by DHS in response to its findings (exhibit C16). Included in the implementation plan are the following strategies:

- There are ‘opportunities for enhancement’, and the Statewide Division, in conjunction with major health units, will implement an agreed clinical service model by March 2001 (p16);
- There will be ‘Heads of Agreement’, ‘planning and policy directions using collaborative advisory structures’ and the development of a ‘statewide model of service collaboration that will be provided by a Clinical Network’ (p16);
- Emergency Extended Care Units within the major metropolitan health units ‘to support management of patients requiring short-stay admissions’ (in the case of FMC, a temporary EECU to be developed by May 2001, and a permanent one by the end of 2001) (p18);
- The exploration of opportunities to enhance Noarlunga Health Service through collaboration with FMC;
- Co-location of General Practitioner Services within Emergency Departments (this approach was questioned by Dr Baggoley (T153);
- Development of further policies for ambulance diversion including management strategies which give priority to Emergency Department admissions, and which enable reassessment of elective surgery schedules and early discharge options;
- Recruitment of specialist staff to provide services to patients in Emergency Departments with mental health or drug related illnesses;
- Development of ‘Nurse Practitioner’ proposals;
- Development of enhanced information systems;
- Improvement in service delivery of emergency and trauma medicine to patients in rural and remote areas.

6.3. I heard some evidence that changes have been made to hopefully address some of these problems. For example, triage assistants have been employed to assist with workload, and nurses have been allocated particular cubicles to provide

some accountability for particular patients. Procedures have been put in place to allow access to the recovery and paediatric wards in times of severe stress.

6.4. Ms Cliff, Counsel for FMC, made certain submissions concerning, for example, increases in funding to FMC Emergency Department, administrative issues which have been addressed within FMC as a whole, FMC-Minda liaison to improve communication, mental health issues and other matters. I heard no evidence on any of these topics, and Dr Baggoley and Dr Aplin were not cross-examined on them. Ms Cliff sought to demonstrate that the problems identified by Dr Baggoley are not being ignored, that they are being addressed on a broader level (T230).

6.5. Since I heard Ms Cliff's submissions, Dr Baggoley has provided further information in the form of a copy of the submission to the SA Parliament Select Committee on Funding of the Public Hospital System by the SA Faculty of the Australian College for Emergency Medicine in April 2001. Dr Baggoley said:

> 'The data in the submission was provided with the approval of all relevant hospital Chief Executives.' (p1)

6.6. This data indicates that, far from improving, the situation has continued to deteriorate. The rate of patients waiting 12 hours or more has now increased to 20%, for 2000/2001, double that of 1999/2000, and triple that of 1998/1999. Indeed, the number of patients waiting more than 12 hours exceeded 200 in September, October, November and December 2000, and reached a record 260 in March 2001. The inescapable inference is that the standards set down in the National Triage Code are being breached by wider and wider margins each year.

6.7. There are other complex issues to be taken into account. The number of nursing home patients occupying ward beds has increased, and the number of patients presenting with mental illness has also increased presenting not only resources but security issues as well.

6.8. There is no doubt, on the evidence before me, that Mr Gadaleta stood a better chance of survival if he had been seen by a doctor within 30 minutes of admission. The unusually rapid development of his illness made his survival

less likely, but his loss of a chance is what grieves his relatives. The fact that he did not see a doctor earlier was due to the gross overloading, and under-resourcing, of the FMC Emergency Department that night. This was a fact which has been evident since 1992, and has been brought to the attention of health administrators and governments repeatedly since then. Some changes have been made, but the situation continues to deteriorate, leaving a substantial risk that further tragedies will occur. Further improvements are hoped for, but are yet to be demonstrated.

6.9. Recommendation

Pursuant to Section 25(2) of the Coroner's Act 1975, I recommend that, now that EECU's and other strategies are now in place, the Minister for Human Services should urgently review the situation in all Emergency Departments in South Australian hospitals with a view to ensuring that there is compliance with the National Triage Code in all hospitals.

Key Words: Hospital Treatment; Intellectual Disability; Emergency Departments.

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 24th day of August, 2001.

……………………………..………

Coroner

Inq.No. 15/01