



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 13<sup>th</sup> and 15<sup>th</sup> days of June 2007, and the 2<sup>nd</sup> day of August 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Peter Roy Gillam.*

*The said Court finds that Peter Roy Gillam aged 44 years, late of 4 Charles Street, Tea Tree Gully died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 24<sup>th</sup> day of February 2005 as a result of sepsis and pulmonary thromboemboli complicating a ruptured cerebral artery aneurysm, with subarachnoid haemorrhage. The said Court finds that the circumstances of his death were as follows:*

### 1. **Cause of death**

Peter Roy Gillam was born on 1 November 1960. He was 44 years of age when he died on 24 February 2005 at the Royal Adelaide Hospital. He had been transferred from the Modbury Public Hospital on 21 December 2004 following a collapse at home. Professor Roger Byard, Forensic Pathologist gave the cause of death as sepsis and pulmonary thromboemboli complicating a ruptured cerebral artery aneurysm, with subarachnoid haemorrhage and I so find.

### 2. **Mr Thomas Gillam**

2.1. Mr Gillam's father, Thomas Gillam gave evidence at the Inquest. He stated that Peter Gillam was living with him and his wife at their home as at December 2004. He was working at Chubb Security at that time. He had been in a relationship that ended

shortly before December 2004. The relationship had been an “off and on” relationship for some time.

- 2.2. Thomas Gillam stated that Peter did not have a psychiatric history to his knowledge. He had no particular medical problems apart from asthma for which he took Ventolin. However, on 16 December 2004 Thomas Gillam persuaded Peter to visit Thomas Gillam’s general practitioner, Dr Milton Hart. This was because Peter had been suffering from a headache which had escalated to vomiting. Thomas Gillam stated that generally Peter was reluctant to visit the doctor, but on this occasion was reasonably willing because of the severity of his headache. According to Thomas Gillam, Peter had been suffering headaches for three to four weeks prior to this event. As will be seen shortly, this is at odds with a history that was taken by Dr Hart from Peter on 16 December 2004. However, I do not think much turns on this.
- 2.3. Mr Thomas Gillam stated that he took Peter to Dr Hart’s rooms late in the afternoon of 16 December 2004. Thomas Gillam went into the surgery but not into the doctor’s room, with Peter. When Peter returned to the waiting room after having seen Dr Hart, he showed Thomas Gillam an envelope and informed him that Dr Hart had said that Peter had to have a “scan”. Peter did not tell Thomas Gillam what the scan was for.
- 2.4. Thomas Gillam stated that Peter said he had to have the scan at Modbury Hospital as soon as possible. Accordingly, Thomas Gillam suggested that they go straight to the Modbury Hospital as it was already after 5:00pm. They attended at the Emergency Department and Thomas Gillam saw a male he presumed to be a nurse who was walking out of a doorway. Thomas Gillam stopped the nurse and explained the situation, informing the nurse that they had a form from their general practitioner and that Peter was to have a scan. The nurse informed Mr Gillam that the facility was closed. Thomas Gillam said that the nurse suggested that because the relevant facility was not then open, it would be necessary for the Gillams to pay for the service prior to receiving the scan if they wished to have it that night. Thomas Gillam said that he asked what they should do, and the nurse suggested that they return in the morning. The male nurse did not take the envelope containing the request for a scan from the Gillams. According to Thomas Gillam the nurse did not seem to be very interested in them. Thomas Gillam stated that he did not inform the nurse what sort of scan Peter Gillam required as they did not know. The Gillams then left the hospital, following

the nurse part of the way. According to Thomas Gillam, the nurse went into the hospital canteen.

- 2.5. Thomas Gillam stated that they left the hospital without seeing a doctor and without signing any documents or leaving any other record of their attendance on that day. Thomas Gillam drove Peter home and that evening Peter seemed to be reasonably normal. Thomas Gillam informed him that he would take Peter the following morning to the hospital for the scan to be done. Mr Gillam stated that he and Peter attended at the Modbury Hospital the following morning, 17 December 2004, at approximately 11:00am. That morning Peter was not complaining of a headache, but Thomas Gillam drove him to the hospital because he wanted to make sure that Peter actually did attend. They took the letter from Dr Hart to the Emergency Department and it was still in its envelope, which had not been opened. They went to the Emergency Department counter and handed the envelope to a person at the counter, informing them that the contents of the envelope would explain their reason for attending. They were sent to another counter to give their Medicare details and other particulars. After approximately ten minutes Peter Gillam was taken to an examination cubicle. Thomas Gillam remained outside at first, but after approximately an hour he made some enquiries and was taken in to where he found Peter lying on a bed in an examination cubicle. Peter informed Thomas that he had been talking to a doctor but had not had a scan. Shortly after this the doctor returned in the presence of Thomas Gillam and gave Peter a letter and told him that he could now go.
- 2.6. Thomas Gillam stated that Peter informed him that the letter was a referral back to the general practitioner. Peter informed him that the doctor at Modbury Hospital had said he wanted Peter to see a psychiatrist. Peter stated that he had not been given the scan as requested by the general practitioner originally.
- 2.7. Thomas Gillam stated that an appointment was made at Dr Hart's practice for the following Monday, 20 December 2004 for Peter. According to Thomas Gillam, Peter duly attended that appointment and advised Thomas subsequently that a doctor at the practice – Dr Robertson, not Dr Hart, had consulted him and had made an appointment for him to see a psychiatrist the following Friday.

- 2.8. Thomas Gillam stated that the Sunday, 19 December 2004, was a good day for Peter. Peter was feeling bright and went to see a friend. He tried out a motorbike at the friend's house. Peter then came home and ate a good meal and when Thomas Gillam saw him the following day, he also appeared to be quite well.
- 2.9. Thomas Gillam stated that on 21 December 2004 he found Peter at approximately 7:30am on the floor of his bedroom, having collapsed. He called an ambulance and Peter was conveyed to the Modbury Hospital. Thomas Gillam and his wife were subsequently told that Peter was to be retrieved from Modbury Hospital by a trauma team, and taken to the Royal Adelaide Hospital.

### **3. Modbury Hospital medical records**

- 3.1. The medical records from Modbury Hospital were admitted as Exhibit C5 in these proceedings. They contain a copy of a letter from Dr Hart dated 16 December 2004 which states:

‘Thank you for seeing Peter acute onset of severe headache neck pain and stiffness associated with ejaculation yesterday – he is still vomiting and has neck stiffness but some headache improvement – can you assess to exclude subarachnoid bleed or similar?’

The notes also contain a Benson Radiology referral form which was completed by Dr Hart. Under the heading “Examination Requested” the form states “CT- Head. Sudden onset of severe headache and neck stiffness yesterday – persists – exclude subarachnoid bleed”.

- 3.2. An entry on an Emergency Department form within the notes dated 17 December 2004 shows that Peter was seen by a doctor by the name of Al-Khalifa at 11.50am that day. The note apparently by Dr Al-Khalifa states as follows:

‘Referred by GP headache. See enclosed letter.

PC Not eating solid food. R depression since last Sunday.

HPC A 44 year old male living with his mum, security officer, complaint of reactive depression to his serious partnership problems. He has been reluctant to eat since then but he continued taking fluids. They broke up on Tues. this week and he suffered (Tues, Wednesday and Thursday) increased depression, headache and feeling sick. In addition every time he put down solid food he vomited. Today he complained only of his inability to take solid food but no headache no nausea or vomiting, but still feeling depressed.

OE 1. Alert, orientated, GCS 15

2. Obs stable, BP <sup>145</sup>/<sub>102</sub> (11.30) (<sup>184</sup>/<sub>103</sub> 13.30)

3. Neurological ex NAD
4. Chest: clear, VBS, no creps or rhonchi
5. CVS: HS audible and nil added
6. Other: unremarkable

A 1. Reactive depression

2. HT

P 1. Observe vital signs

2. Consult med and psychiatry registrars.

\* ***The Med Reg has been seen and the case discussed with him and concluded that in the absence of headache today (SAH) can be excluded and there is no need to do CT head scan.<sup>1</sup>***

\* The case has also been discussed with the psychiatry nurse who gave me options, one of them, which is taken by the patient is to discharge the patient and to be followed by his GP and the GP would make him an appointment to see psychiatry people.

3. The patient is happy to be discharged and followed by his GP.

4. A letter to GP to make a psychiatry appointment for and to follow the increased blood pressure of the patient.

5. Patient discharged.'

The form contains a notation of a diagnosis of reactive depression and hypertension and a further note that Peter was discharged at 2:30pm.

3.3. The Modbury Hospital notes also contain a referral letter from Dr Al-Khalifa to Dr Hart which states:

'Thank you for referring this patient who presented to ED with reactive depression and inability to eat solid food but no headache or other symptoms. Examination was unremarkable apart from HT (BP <sup>145</sup>/<sub>102</sub> 11.30am, <sup>84</sup>/<sub>103</sub> 13.30). The patient is quite happy to see you to arrange him an appointment with the psychiatry people and to follow his BP and put him on antihypertensive medications if you find that necessary.'

The letter is apparently signed by Dr Al-Khalifa.

3.4. According to Exhibit C1a which is a statement made by investigating officer Senior Constable First Class Gross, his enquiries revealed that Dr Al-Khalifa is no longer employed at the Modbury Hospital and no forwarding contact details were available from that institution. Furthermore, Dr Al-Khalifa is no longer registered as a medical practitioner in this State. Senior Constable Gross stated that the whereabouts of Dr Al-Khalifa remain unknown. Unfortunately this is not the first time that a medical

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<sup>1</sup> My emphasis

practitioner employed within the public health system who has knowledge of the treatment of a patient that is highly relevant to the cause of the patient's death has not been available to give evidence at an Inquest in this Court. By way of example, I refer to Dr Hassan Hasan<sup>2</sup>. In my view, public hospitals should take steps to ensure that they keep track of the whereabouts of medical practitioners who leave their employ, at least for a reasonable period thereafter.

- 3.5. I requested that counsel for Modbury Hospital obtain information about the qualifications and experience of Dr Al-Kalfa. By letter dated 20 July 2007 from Finlaysons, solicitors for Modbury Hospital, I was provided with the following information. Dr Al-Kalfa studied for a Bachelor of Medicine and Surgery at the College of Medicine, Baghdad University, Baghdad, Iraq, between 1972 and 1978. He obtained a Diploma in Forensic Medicine, from the Department of Forensic Medicine and Science, University of Glasgow, Scotland in 1987, and did a doctoral thesis in Forensic Medicine at the same University in the years 1986 to 1989. His employment history included a medical internship at the Alyamook Teaching Hospital, Baghdad, Iraq between 1978 and 1984, a Specialist Trainee in Forensic Medicine, Institute of Forensic Medicine, Ministry of Justice, Baghdad and Forensic Medical Department, London Hospital, Medical College, London UK between 1984 and 1986. He was a researcher in Forensic Medicine at the University of Glasgow Scotland between 1986 and 1989, and Assistant Professor in Forensic Medicine, Pathology and Forensic Medicine, College of Medicine, Almustansiriya University, Baghdad, Iraq from 1989 to 1992. He was a Forensic Pathologist with the Attorney General's Office, Sana'a Yemen between 1992 and 1995, and Assistant Professor in Forensic Medicine, Faculty of Medicine, Sana'a Yemen from 1995 to 2001. There is no record of his activities from 2001 until he was awarded a provisional certificate for limited registration by the Medical Board of South Australia on 10 December 2004. On 13 December 2004 he commenced employment at Modbury Hospital as a Career Medical Officer, in the Emergency Department. He resigned from Modbury Hospital in September 2005 and his whereabouts after that time is unknown.
- 3.6. From the above outline of his qualifications and experience, it can be seen that for most of his career, Dr Al-Kalfa was a forensic pathologist. His last period of known clinical experience in a hospital environment was in 1984, the final year of his

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<sup>2</sup> Inquest 21/2005 – John Matthew Murray

internship at the Alyamook Teaching Hospital in Baghdad. Forensic Medicine is of course a most highly skilled discipline. However, it involves a quite different set of medical skills from those required in dealing with patients in an ordinary clinical setting.

- 3.7. Doctor Al-Kalfa started work at Modbury Hospital on 13 December 2004, and saw Mr Gillam four days later, on 17 December 2004. The information provided by the solicitors for Modbury Hospital about his experience does not reveal anything about his activities between 2001 when he was working in Forensic Medicine in Sana'a Yemen and December 2004 when he started working in the Modbury Hospital. However, it is reasonable to assume that if he had been working in any relevant field of practice, he would have provided information about that to the Modbury Hospital when seeking employment there. It is therefore open to find that Dr Al-Kalfa had not practised medicine in a clinical sense between 1984 when he worked in a Baghdad teaching hospital and 2004 when he commenced working in Modbury Hospital in South Australia. If that is correct, it is difficult to escape the conclusion that he was a relatively inexperienced clinician when he saw Mr Gillam.

#### **4. Dr Nicholas Kasmeridis**

- 4.1. The medical records revealed that the medical registrar who was on-duty at Modbury Hospital that day was Dr Nicholas Kasmeridis. Dr Kasmeridis was interviewed by Senior Constable Gross and a transcription of the record of interview was admitted as Exhibit C4 in these proceedings. Furthermore, Dr Kasmeridis gave evidence at the Inquest.
- 4.2. Dr Kasmeridis stated that he was the medical registrar at Modbury Hospital in December 2004 and was doing basic physician training at that time. He became aware of Peter Gillam's death after the event. He stated that the role of the medical registrar was to coordinate medical cases. However, it was not part of his role to supervise emergency department doctors, although he would attend at the emergency department to admit new medical cases.
- 4.3. Dr Kasmeridis stated that it was he to whom Dr Al-Khalfa spoke in relation to Peter Gillam. Dr Kasmeridis stated that he never examined Mr Gillam. He stated that he had a very brief conversation with Dr Al-Khalfa lasting a matter of seconds. He was in the Emergency Department doctor's office and was writing some notes about

another patient when Dr Al-Khalifa approached him about a patient who Dr Al-Khalifa stated had psychological problems because he had been separated or divorced. Dr Kasmeridis stated that Dr Al-Khalifa did not mention any “sinister signs” and that he was a bit surprised that Dr Al-Khalifa even spoke to him about it. Dr Kasmeridis felt that he was not being asked to give a medical opinion and thought that Dr Al-Khalifa was seeking direction about a psychiatric patient. Dr Kasmeridis told him to speak to a psychiatrist. Dr Kasmeridis was very upset with Dr Al-Khalifa and very surprised when Senior Constable Gross showed him the medical records. He was also very surprised to see the letter from Dr Hart referring to the subarachnoid haemorrhage. He stated that this was not given to him at the relevant time.

4.4. Dr Kasmeridis said that he had been introduced to Dr Al-Khalifa before this event, but that he had not had any professional interaction with Dr Al-Khalifa previously. Dr Kasmeridis stated that he was aware that Dr Al-Khalifa was an overseas trained doctor and was employed at Modbury Hospital, according to Dr Kasmeridis, as a career medical officer. Dr Kasmeridis stated that career medical officer is a reasonably senior role at Modbury Hospital and so Dr Kasmeridis was surprised that he was being consulted by someone who he perceived as being in a senior role about a non-medical<sup>3</sup> issue. In the light of the information that has been provided to me about Dr Al-Khalifa’s experience, I am not surprised that he was making such an inquiry. He had only worked at Modbury for four days at that time, and so would not have known the organisation very well at all. Furthermore, while Dr Kasmeridis regarded the position of career medical officer as one of some seniority, it seems reasonable to assume that Doctor Al-Khalifa’s clinical experience was not commensurate with Dr Kasmeridis’ reasonable expectations of such a medical officer.

4.5. Dr Kasmeridis stated that if he had been aware of the actual circumstances of the case he would not have hesitated to assist. Dr Kasmeridis stated that nothing was said to him in relation to a request for a CT scan of the head nor of headaches. Dr Kasmeridis stated that had he seen Dr Hart’s letter, he would have taken the view that even in the absence of a headache on 17 December 2004, it still would have been necessary to exclude subarachnoid haemorrhage by a CT scan and, if necessary, a lumbar puncture. Dr Kasmeridis stated that the only reason that he could see for not

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<sup>3</sup> i.e. a psychiatric issue

doing a CT scan in the circumstances would have been if the patient refused to have one.

- 4.6. It is clear that Dr Kasmeridis' account of the interaction is entirely different from the impression one gains when reading Dr Al-Khalifa's note in the medical record quoted above. It is possible to read that record differently. While it would plainly convey that the Medical Registrar has agreed with the proposed course of action, it is still possible that it is merely recording that Dr Al-Kalfa has spoken to the Medical Registrar, however briefly, and that he has then drawn his own conclusions about the exclusion of sub-arachnoid haemorrhage and the need for a CT scan. In the light of Dr Kasmeridis' evidence, which I accept without reservation, that is the only interpretation of the note that is open to me.

**5. Identification of male nurse at Modbury Hospital on 16 December 2004**

- 5.1. Senior Constable Gross located, by elimination, the male nurse who was apparently seen by Peter and Thomas Gillam on the evening of 16 December 2004. A record of their conversation was admitted as Exhibit C1m in these proceedings. That interview records that the nurse in question, Allan Laube, had no recollection of any interaction between himself and the Gillams on 16 December 2004. He stated that although he could not recall anything about the situation, he would have adopted the approach of informing the Gillams that Peter should be seen by a doctor and if the doctor deemed it appropriate for him to have a CT scan then the necessary arrangements would be made for that to happen.
- 5.2. In the face of this evidence, I am unable to be certain that the person to whom the Gillams spoke was indeed Mr Laube. However, I have no reason not to accept Mr Thomas Gillam's recollection of the interaction with a person he thought was a male nurse on that night. Mr Thomas Gillam's account has the "ring of truth" to it. Needless to say, the actions of the nurse to whom the Gillams spoke, if indeed the person was a nurse, were completely inappropriate. I note that Modbury Hospital has taken steps to advise its staff of the appropriate protocols and processes to be followed in such an event.

## 6. **Dr Matthew Ryan**

- 6.1. An overview of Peter's treatment was obtained from Dr Matthew Ryan, Emergency Physician. Dr Ryan is a Fellow of the Australasian College for Emergency Medicine and a Fellow of the Australian College of Legal Medicine. He practises as an Emergency Physician at the Geelong Hospital in Victoria and is Director of Training of Emergency Medicine at the same hospital. He prepared a report in relation to this matter which is dated 1 December 2005. It was admitted as Exhibit C8 in these proceedings. Dr Ryan also gave evidence at the Inquest.
- 6.2. Dr Ryan defined subarachnoid haemorrhage as meaning bleeding into the space around the brain and spinal cord. He stated that it normally occurs either after a trauma, for instance a head injury, or spontaneously. He stated that the most common cause of a spontaneous subarachnoid haemorrhage is rupture or leaking of an arterial aneurysm. He explained that an aneurysm is an abnormal ballooning of a blood vessel which causes a weakening of the blood vessel that is prone either to a rupture or leak. He noted that Peter had suffered from a spontaneous subarachnoid haemorrhage which was indeed caused by a leak or rupture of a sub-arterial aneurysm. When Peter was operated on at the Royal Adelaide Hospital the aneurysm was noted at the site of the bleeding and the artery was clipped at that point, namely the base of the brain.
- 6.3. Dr Ryan explained that the most important feature in clinical diagnosis of subarachnoid haemorrhage is the history of the patient. The most important historical feature is that the patient has suffered a headache, and the history of an onset of the headache is particularly significant. He stated that classically the headache from subarachnoid haemorrhage is extremely sudden in onset, often described as instantaneous, coming on in less than one second. The headache is also severe, and will often be described by the patient as the worst headache of his or her life<sup>4</sup>.
- 6.4. Dr Ryan explained that there is a spectrum of clinical features ranging from the patient who becomes comatose early on in the bleeding and thus is unable to provide any history, through to the conscious patient who is able to relate a history of a sudden onset of a very severe headache. He stated that patients in the former category who are comatose from the outset are likely to have a poor outcome because most of

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<sup>4</sup> Transcript, page 67

the brain damage has occurred and there is very little to be gained from treatment<sup>5</sup>. Those patients with a minor subarachnoid haemorrhage and who are alert initially benefit from an early diagnosis because they can be treated before the situation becomes worse. Paradoxically the patients with the most serious haemorrhage will be easier to diagnose than the patient at the minor end of the spectrum. The paradox lies in the fact that it is these patients at the minor end of the spectrum for whom early diagnosis is most useful as they have a lot to lose if the bleeding recurs<sup>6</sup>. Dr Ryan pointed out that patients presenting with a headache to a general practitioner or an emergency department are extremely common and that the most common cause of headaches presenting in such settings is certainly not subarachnoid haemorrhage. However, those who do have a subarachnoid haemorrhage and who are not diagnosed correctly may re-bleed and suffer an adverse outcome<sup>7</sup>. Dr Ryan said that Mr Gillam was one of those patients in that his initial haemorrhage was at the more minor end of the scale because he was alert and his headache seemed to have resolved quite a bit by the time he was seen on 17 December 2004<sup>8</sup>.

- 6.5. Dr Ryan explained that where, as in Peter's case, the initial headache appears to abate or disappear, there is a logical explanation. He said that if the degree of haemorrhage initially is quite small, this will still cause severe pain and headache. However, if there is no further bleeding initially, the blood that has leaked will be reabsorbed by the body and the headache will gradually decrease over a day or two, just as happened in Peter's case.
- 6.6. Dr Ryan considered that the letter from Dr Hart to which I have already referred, described symptoms which were not inconsistent with a diagnosis of subarachnoid haemorrhage. Thus, going by the letter alone, and without examining Peter, Dr Ryan would have been concerned about the possibility of subarachnoid haemorrhage in the patient<sup>9</sup>. He acknowledged that it was possible that the patient when assessed might give a different story such that subarachnoid haemorrhage was not likely. However, Dr Ryan stated that once a general practitioner has raised the possibility of a subarachnoid haemorrhage it is very difficult on clinical grounds to say that a

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<sup>5</sup> Transcript, page 70

<sup>6</sup> Transcript, page 71

<sup>7</sup> Transcript, page 71

<sup>8</sup> Transcript, page 71

<sup>9</sup> Transcript, page 69

subarachnoid haemorrhage had not occurred because a patient looks well<sup>10</sup>. Dr Ryan acknowledged that if the history of the headache was that it had come on very gradually then it would be unlikely that it was due to a subarachnoid haemorrhage. For this reason he explained that it is very important for the clinician to prepare a carefully documented clinical history because a doctor in an emergency department having been alerted to the possibility of subarachnoid haemorrhage by a general practitioner would need very good reasons for not investigating. The only reason that Dr Ryan could think of would be that on proper clinical examination the patient provided a history that was clearly inconsistent with subarachnoid haemorrhage<sup>11</sup>.

6.7. Dr Ryan was of the opinion that the note taken by Dr Al-Khalifa did not record a sufficient justification for dismissing the need for a CT scan or otherwise justified the removal of a need to investigate for subarachnoid haemorrhage. Dr Ryan agreed that the note of Dr Al-Khalifa suggested that he placed heavy reliance upon the absence of a headache on 17 December 2004 when he examined Peter. Dr Ryan said that this was a totally insufficient basis on which to exclude subarachnoid haemorrhage at that point, bearing in mind the fact as he had explained earlier in his evidence that a headache with subarachnoid haemorrhage can diminish or go away completely. Therefore the absence of headache on presentation did not obviate the need for further investigation<sup>12</sup>.

6.8. In his report dated 1 December 2005<sup>13</sup>, Dr Ryan stated:

‘It is highly likely that the headache developed by Mr. Gillam on 16<sup>th</sup> December represented a SAH<sup>14</sup>. It is highly likely that correct diagnosis on 16<sup>th</sup> December and subsequent referral for neurosurgical treatment would have greatly reduced the probability of death in this case.’

6.9. Dr Ryan elaborated upon this in his evidence. He stated that most CT scans would pick up most subarachnoid haemorrhages. He said that 95% of haemorrhages are diagnosed on CT and most of the remaining 5% are normally picked up with a lumbar puncture examination. He said that a subarachnoid haemorrhage would be diagnosed in up to 99% of cases by CT scan followed by lumbar puncture. Dr Ryan further

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<sup>10</sup> Transcript, page 72

<sup>11</sup> Transcript, page 72

<sup>12</sup> Transcript, pages 75-76

<sup>13</sup> Exhibit C8

<sup>14</sup> SAH is an abbreviation for subarachnoid haemorrhage

stated that it was highly likely that Peter Gillam, if diagnosed early and treated early, would have done as well as any patient with a subarachnoid haemorrhage:

‘...that is, would have had in excess of 80% chance of survival, and survival with good outcome.’<sup>15</sup>

## **7. Modbury Hospital’s response**

- 7.1. I now turn to consider Modbury Hospital’s response to Peter Gillam’s tragic death. According to an affidavit of Ms Michelle McLay, the Unit Manager of the Emergency Department at Modbury Hospital in 2004, which was admitted as Exhibit C2 in these proceedings, the following steps were taken in relation to the information provided to the Gillams by the male nurse on 16 December 2004. Each staff member on shift on 16 December 2004 was spoken to individually. Each staff member was counselled to the effect that it was inappropriate and wrong to inform a patient or relative of a patient that a patient was to be charged for procedures as if the patient were a private patient. Each staff member was informed that every patient coming into the Emergency Department is a public patient and should be seen by a doctor and that the cost of any procedure recommended by the doctor, including imaging whether conducted during hours or after hours, was a cost to be borne by the Department. Furthermore, a staff meeting was convened at which this message was repeated. Minutes of the meeting were taken and placed in the Nursing Staff Communications Book. A memorandum was circulated to all staff reiterating the same message. Finally, the message is regularly reinforced by Nurse Educators at the Modbury Hospital when they undertake sessions on responsibility and accountability and managing triage.
- 7.2. It has been assumed by Modbury Hospital that Dr Al-Khalifa is no longer in Australia. I believe that is a reasonable assumption. The hospital conducted a review of protocols for medical staff in the emergency department in 2005. As a consequence of that review, tutorials about non-traumatic headache and subarachnoid haemorrhage which had been scheduled for July 2005 were brought forward and conducted in February 2005. A draft protocol for management of headache was implemented and finalised in July 2005. That draft protocol was incorporated in the Emergency Department Guidelines which are situated in the Emergency Department and accessible to all departmental staff. Additional details of the after hours services of

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<sup>15</sup> Transcript, page 77

Bensons Radiology were incorporated within the Orientation Guide. These matters are elaborated in an affidavit of Dr Anthony Wong, Deputy Director of the Emergency Department at Modbury Hospital. That affidavit was admitted as Exhibit C3. Dr Wong pointed out that the Emergency Department policy on supervision was brought to the attention of all medical staff. It appears in the Emergency Department Orientation Guide and states that all newly appointed career medical officers, junior medical staff and casual medical officers are required to seek authorisation of the senior medical officer to discharge, amongst others, patients referred into the hospital by a general practitioner for review.

## **8. Conclusions**

- 8.1. It is most unfortunate that Dr Al-Khalifa was no longer in Australia and could not be called upon to explain why he acted as he did on 17 December 2004. It appears that he was distracted by what he regarded as reactive depression in Peter Gillam. However, that should never have diverted him from fully investigating the suggestion of subarachnoid haemorrhage which had been raised by Dr Hart. There is a possible dispute between the evidence given orally by Dr Kasmeridis that the matter of subarachnoid haemorrhage and CT scan and headache was never raised with him by Dr Al-Khalifa and the medical record note made by Dr Al-Khalifa which implies the opposite. I have not heard from Dr Al-Khalifa for the reasons already explained. Therefore I have heard no explanation from him as to the implicit difference in the account recorded by him in the medical notes and the oral evidence of Dr Kasmeridis. I am left with the explanation that the note is misleading, and was not intended to convey that those matters were actually raised with Dr Kasmeridis, but that there had been some other interaction between them.
- 8.2. Whatever the explanation for the note of Dr Al-Kalfa, I see no reason not to accept the evidence of Dr Kasmeridis on this point. I find that in fact Dr Al-Khalifa did not address this issue with him. A possible explanation is that Dr Al-Khalifa's communication skills were not good enough for him to be able to convey to Dr Kasmeridis the situation with which he was confronted. In any event, Dr Al-Kalfa failed to properly convey the true situation to Dr Kasmeridis. Furthermore, Dr Kasmeridis was not an appropriate person with whom to raise these issues in any event, belonging as he did, to the Department of Medicine.

- 8.3. I have considerable reservations about the adequacy of Dr Al-Kalfa's experience as a clinician to perform the role assigned to him at Modbury Hospital on 17 December 2004. I have not had sufficient information to explore that issue thoroughly. I recommend that it be further investigated by the Department of Health.
- 8.4. As to the events of 16 December 2004, it does appear that a person wrongly advised the Gillams in relation to the availability and cost of after-hours medical imaging. On the evidence it appears that that person was Mr Laube. The evidence clearly shows that the information conveyed to the Gillams on that topic was not consistent with Modbury Hospital's policy in relation to after hours medical imaging at that time.
- 8.5. I recommend that public hospitals maintain a system by which the whereabouts of doctors who they think are likely to leave Australia for a protracted time or permanently can be ascertained, if necessary, for coronial investigations.
- 8.6. In view of the steps already taken by Modbury Hospital in relation to these matters I do not consider it necessary to make any other recommendations in this matter.

*Key Words: Emergency Departments; Hospital treatment; Incorrect diagnosis; Subarachnoid Haemorrhage*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 2<sup>nd</sup> day of August, 2007.*

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*State Coroner*