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, 3rd, 4th and 5th days of April 2013, the 11th and 19th days of June 2013, the 20th and 21st days of August 2013 and the 5th day of February 2014, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Eileen Hazel Cook.

The said Court finds that Eileen Hazel Cook aged 76 years, late of 14 Scott Street, Goolwa, South Australia died at Calvary Hospital, 89 Strangways Terrace, North Adelaide, South Australia on the 21st day of January 2010 as a result of hospital acquired pneumonia, multiple organ dysfunction and small bowel obstruction with contributing smoking related lung disease. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Mrs Eileen Hazel Cook died in the Calvary North Adelaide Hospital (Calvary) on 21 January 2010. She was 76 years of age. Mrs Cook had been a patient at Calvary since the evening of 14 January 2010. In the first instance, a doctor's certificate of cause of death pursuant to the Births, Deaths and Marriages Registration Act 1996 was completed by Dr Timothy Brownridge who had been involved in Mrs Cook's care at Calvary. The death certificate dated 22 January 2010 was tendered to this Inquest[1]. It recites the cause of death of Mrs Cook as:

	Disease	**Duration**
A	HOSPITAL ACQUIRED PNEUMONIA	2 days
B	MULTIPLE ORGAN DYSFUNCTION	1 WEEK

[1] Exhibit C1b

C SMALL BOWEL OBSTRUCTION 2-3 WEEKS

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Other significant conditions and duration:

SMOKING RELATED LUNG DISEASE YEARS'

It will be plainly seen that the cause or causes of death recited in the certificate are natural. Mrs Cook's death was reported to the State Coroner by way of correspondence generated by Mrs Cook's son, Mr Greg Cook, in which a number of concerns were raised in respect of the circumstances of his mother's death and, in particular, concerns about the quality of Mrs Cook's care and treatment during her two day admission to the South Coast District Hospital (SCDH) in Victor Harbor prior to her ultimate transfer by way of ambulance to Calvary on 14 January 2010. The correspondence which was produced in evidence[2] during the course of this Inquest when taken at face value suggested that there were certain unusual features and circumstances surrounding Mrs Cook's ultimate death including the manner in which she had been managed at the SCDH that involved, amongst other things, alleged lack of medical care, alleged lack of nursing care and an unduly delayed ambulance transfer, all of which allegedly contributed to Mrs Cook's death.

1.2. This Court conducted an Inquest into the cause and circumstances of Mrs Cook's death. In general terms the Court examined the issue as to whether any proven lack of medical or nursing care at the SCDH had contributed to the cause of Mrs Cook's death and whether Mrs Cook's death in any way could have been prevented by different, if not more appropriate, medical and nursing care. These are the findings and recommendations of the Court in respect of the Inquest into the cause and circumstances of the death of Eileen Hazel Cook.

2. Background

2.1. Mrs Cook resided with her husband at their home in Goolwa on the South Coast. Mrs Cook had a previous medical history that included chronic obstructive pulmonary disease said to be the product of smoking, gastro-oesophageal reflux disease, hypertension and ischaemic heart disease. Mrs Cook's general medical practitioners were the doctors who practised at the Mill House Medical Centre in nearby Middleton. The Mill House Medical Centre was one of a number of general medical practices that existed in the South Coast region in January 2010. There was also the

[2] Exhibit C10

Goolwa Medical Centre. There were a number of practices in Victor Harbor. With the exception of the doctors practising at the Mill House Medical Centre, local medical practitioners in other South Coast practices had admitting rights to the SCDH in Victor Harbor. The admitting rights possessed by these practitioners meant that they also participated in the roster for the Emergency Department of that hospital. The Mill House Medical Centre practitioners' lack of admitting rights meant that for the duration of an individual Mill House patient's admission in the SCDH, they could not administer care in respect of that patient. Another consequence was that they did not participate in the Emergency Department roster. Generally speaking, patients who were normally those of the Mill House Medical Centre and who were admitted to the SCDH, were under the care of doctors who worked within the other local practices. It is worthwhile observing that the arrangement whereby local practitioners would care for Mill House patients at the SCDH would obviously also apply in respect of hospital patients who were visitors to the district, such as holidaymakers, and who had no previous connection with any of the medical practices on the South Coast.

2.2. In 2010 the Mill House practitioners' lack of admitting rights and non-participation in the emergency roster was a bone of contention, giving rise to a situation of tension between the Mill House practitioners and other local practitioners. As I understood the evidence, the obligation on other local practitioners to care for Mill House patients admitted to the SCDH was regarded as unduly burdensome.

2.3. The Goolwa Medical Centre was unique among medical practices in the South Coast region in that it had a facility to which patients in the first instance could be brought by ambulance and where doctors possessed the means and skills to provide some emergency care. The facility was known within this practice as the 'treatment room'[3]. I was told that patients brought by way of ambulance to the Goolwa Medical Centre treatment room came from areas such as Milang, Clayton, the Strathalbyn district, Middleton and Hindmarsh Island. There were also presentations from tourists who required emergency treatment while in the region. This emergency facility, attached as it is to a private medical practice, receives Government funding that pays for additional nursing staff, additional equipment and in respect of those practitioners who perform emergency work on-call, overnight and on weekends.

[3] Transcript, page 425

2.4. When Mrs Cook fell acutely ill she was conveyed by ambulance from her home to the treatment room of the Goolwa Medical Centre. This took place on 13 January 2010, eight days prior to her ultimate death at Calvary. On the same day, namely 13 January, she was transferred by ambulance from the Goolwa treatment room to the SCDH where she would remain until her transfer the following day to Calvary, again by ambulance. Although Mrs Cook was normally a patient of the Mill House Medical Centre at Middleton, there could be nothing surprising or contentious about the fact that in the first instance she was brought by ambulance to the Goolwa Medical Centre in her acute condition. After all, she resided in Goolwa and to seek and expect to be provided with care at the closest appropriate medical facility could hardly be viewed as unreasonable. Naturally, she was seen at the Goolwa treatment room by one of that practice's medical practitioners, in this case Dr Stephen Byrne, an experienced general practitioner practising and residing in the district. Dr Byrne would administer Mrs Cook's care during the course of that day, both at Goolwa and at the SCDH, and for part of the following day as well. There would appear to be nothing objectionable about that arrangement either. Nor would there be anything unreasonable about the notion that the same practitioner should have continuity of care of the patient notwithstanding that she was normally the patient of another practice. As will be seen, however, a general practitioner practising at the Mill House Medical Centre at Middleton, Mrs Cook's usual practice, would be brought into Mrs Cook's matter at a time during Mrs Cook's admission to the SCDH. The precise reason for this is unclear, because the recruitment of the Mill House doctor into Mrs Cook's situation while at the SCDH, a hospital in which the doctor could provide no care, smacks of irrationality. The Mill House practitioner, Dr Karen Salisbury, who as I understand it generally did not reside fulltime in the district but resided for the most part in Adelaide, was also an experienced general practitioner. However, Dr Salisbury had personally administered no prior care to Mrs Cook on any occasion. Nor, of course, did she have practising rights at the SCDH. The Court has found that in all of the circumstances the involvement of Dr Salisbury in Mrs Cook's matter was wholly unnecessary and was clinically counterproductive. More of that later.

3. The course of Mrs Cook's presentation

3.1. In this section I will discuss the course of Mrs Cook's presentation during the period of 13 and 14 January 2010 up to and including her transfer from the SCDH to Calvary at North Adelaide by ambulance. In another section I will discuss the clinical management of Mrs Cook's presentation over that period.

3.2. In discussing both these matters I shall occasionally refer to the report and evidence of Dr Peter Joyner who is a general practitioner with Mannum Medical Associates and who was commissioned to review independently Mrs Cook's presentation and clinical management for the purposes of this Inquest[4]. Dr Joyner is an independent expert who had no involvement in the treatment of Mrs Cook at any stage during her life. Dr Joyner has a Bachelor of Medicine and a Bachelor of Surgery 1969 from the Adelaide University. He has a Diploma of Obstetrics and also Fellowship of the College or Rural and Remote Medicine. After a period of practice in metropolitan Adelaide, Dr Joyner moved to Mannum in 1976 where he has been in general practice ever since. Dr Joyner now works at that practice part-time and, as well, he works for Country Health SA where he is Director of Emergency Services throughout rural SA. He has been acting Chief Medical Officer for Country Health SA. His responsibilities with Country Health SA include oversight if their emergency services to ensure that Emergency Departments in country hospitals are staffed correctly, co-ordination of MEDSTAR - the retrieval group, as well as SAAS. He is Chair of the Credentialing Committee in respect of doctors' applications to practise in country hospitals. He has given expert evidence in medico-legal matters in a number of jurisdictions in this State. I regarded Dr Joyner as an expert in the practice of general medicine. I say here that I also regarded two further practitioners as experts in the field of general medicine, namely Dr Stephen Byrne and Dr Karen Salisbury who both gave oral evidence in the Inquest and, as earlier indicated, were involved in Mrs Cook's clinical management during the period of 13 and 14 January 2010.

3.3. Mrs Cook had been experiencing vomiting and diarrhoea for several days which in the first instance caused her to consult with a Dr Gilmore at the Mill House Medical Centre on Monday 11 January 2010. On this occasion she was prescribed some tablets and the plan was to see Mrs Cook in a week.

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[4] Exhibit C14

3.4. On Wednesday 13 January 2010 Mrs Cook's husband telephoned the Mill House Medical Centre to advise that Mrs Cook had deteriorated and had vomited on a number of occasions during the course of the previous night. He described loose bowel motions the day before, lower abdominal pain, weakness and failure to eat. Although an appointment was offered for Mrs Cook to see one of the doctors at that practice that afternoon, Mr Cook called back at about 11am to advise that his wife could no longer stand and that he had telephoned an ambulance. Staff at the Mill House Medical Centre then telephoned the SCDH and advised that Mrs Cook might be presenting there. As well, they faxed a health summary and copies of Mrs Cook's most recent radiology reports to the hospital.

3.5. An ambulance with paramedics attended at Mrs Cook's home address at about 10:30am. The SAAS report of this attendance[5] reveals that the ambulance crew were at Mrs Cook's home address in Goolwa between approximately 10:30am and 11am during which time it was recorded that on two occasions Mrs Cook was significantly tachycardic, that is to say she had a significantly elevated heart rate. Figures of 160 and 175 beats per minute were recorded at 10:45am and 10:55am. It does not reveal whether these rates were recorded within the ambulance or inside her home. However, Mrs Cook's pulse rate had descended to 90 beats per minute at 11am. The earlier high figures are perhaps explicable on the basis of elevated potassium numbers that would later that day be revealed by blood testing, but there is uncertainty about that and nothing turns on it in any case. I therefore make no finding as to the aetiology of the tachycardia.

3.6. Mrs Cook was taken by ambulance to the Goolwa Medical Centre treatment room. She arrived there at about 11:04am. There she was seen by Dr Stephen Byrne. Dr Byrne assessed Mrs Cook as possibly having resolving gastroenteritis but in view of her abdominal distension and dehydration he arranged for her to be admitted to the SCDH at Victor Harbor. Following her admission to the SCDH, intravenous therapy was commenced. An abdominal X-ray was performed and blood biochemistry was ordered.

3.7. The abdominal X-ray report which became available that day expressed findings consistent with a clinical diagnosis of a small bowel obstruction. This was an

[5] Exhibit C9

accurate diagnosis. In the event, this obstruction would require surgical rectification at Calvary following Mrs Cook's ultimate transfer there.

3.8. In fact there were two blood biochemistry analyses taken on 13 January 2010 at the SCDH. The first blood sample taken for these purposes was collected from Mrs Cook at 3:45pm and the results were in due course made available that day. The second blood sample was collected at 8pm and the results were made available later than evening.

3.9. There is no dispute that Dr Byrne from the Goolwa Medical Centre was the medical practitioner responsible for Mrs Cook's care during 13 January 2010. Dr Byrne's input into Mrs Cook's care extended well into the night of 13 January 2010. For example, it is clear that at as late as 11:30pm Dr Byrne was enquiring as to Mrs Cook's status. Overnight there was a medical practitioner situated at the hospital as well as nursing staff, but there does not appear to have been any input into Mrs Cook's care by that medical practitioner. It is also clear that Dr Byrne was responsible for Mrs Cook's care during the early to mid morning of the following day, 14 January 2010. He attended the hospital that morning, ordered further blood testing and was involved in discussions in respect of Mrs Cook's intended transfer to Calvary.

3.10. It is as well to record here that although during 13 January 2010 and for the early part of 14 January 2010 Mrs Cook's clinical presentation was for the most part unremarkable, it was clear that she was unwell and that she was experiencing a small bowel obstruction. Certain aspects of the blood examinations that were ordered by Dr Byrne were of particular concern, as was the fact that during the day and overnight she was passing only small quantities of dark and very concentrated urine through an indwelling catheter (an IDC) in spite of the fact that she was being administered intravenous fluid therapy.

3.11. Both sets of biochemistry results indicated significant renal failure. This state of affairs is revealed by a number of the relevant parameters described within the biochemistry results. That Mrs Cook was experiencing significant acute renal failure was confirmed clinically by her minimal output of urine while within the SCDH. In addition, both blood results demonstrated potassium levels well above the normal range; in fact dangerous levels that can precipitate a lethal cardiac arrhythmia such as ventricular fibrillation, a condition that is fatal unless corrected. In the event such an

arrhythmia did not occur, but the potential for it occurring was one that could not be safely ignored. Potassium levels of the magnitudes here, namely 8.1mmol/L and 7.6mmol/L respectively, in the normal course should require the administration of a 12 lead ECG in order to monitor the heart's rhythm and to detect abnormalities as and when they might arise. For periods, Mrs Cook was placed on a 4 lead heart monitor that would have been inadequate to detect subtle cardiac arrhythmias that might have been of significant concern having regard to the high potassium levels. Her high potassium levels in themselves would require, in the normal course, corrective measures as well. Such corrective measures would have included consideration of immediate transfer to a tertiary hospital, the administration of ventolin or salbutamol and the administration of dextrose and insulin. If there was concern generated by the ECG, a medical practitioner would administer calcium gluconate intravenously as an emergency measure to protect the heart from further electrical damage. None of these measures are time consuming. None of them were administered in Mrs Cook's case. Significantly, no 12 lead ECG was put in place and so but important heart changes, short of the self evident such as ventricular fibrillation or cardiac arrest, would not have been detectable.

3.12. There were also low glucose levels exhibited by both biochemistry results, namely 1.6mmol/L and 2.5mmol/L respectively, which would require attention.

3.13. The first potassium result as revealed by the sample collected at 3:45pm, namely 8.1mmol/L, was so alarmingly high that Dr Byrne was advised by the IMVS technician at Victor Harbor that the blood testing should be repeated in case the result was an error. Naturally, the second result of 7.6mmol/L confirmed a very high potassium level in respect of Mrs Cook. Thus the first reading was not likely to have been an error.

3.14. Mrs Cook was observed overnight and was administered intravenous fluid therapy for the most part to address a condition that was also undoubtedly reflected in the biochemistry results, namely dehydration. Overlaying all this was the question of the unresolved small bowel obstruction. As I understood Dr Byrne's evidence, which I will cover in more detail later, Dr Byrne was hopeful that the obstruction might resolve overnight thereby obviating any need for surgical intervention or transfer to a tertiary hospital in Adelaide for that purpose. The question of Mrs Cook's undoubted acute renal failure and how and whether that was addressed overnight I will deal with in another section.

3.15. The nursing observations of Mrs Cook overnight were that she had experienced a peaceful night and had been quite comfortable but had vomited at 6:30am. She was afebrile and all her observations were satisfactory. It was felt that she looked better. However, the IDC was noted to have drained only a very small amount of urine, although it looked less concentrated than before. Dr Byrne communicated by telephone with nursing staff at 6:45am and he ordered an increase in the rate of intravenous therapy. He indicated that he would be in to review Mrs Cook before 9am.

3.16. Dr Byrne attended at the SCDH that morning. Also in attendance that morning was Mrs Cook's son, Mr Greg Cook. Mr Cook is a police officer. In addition, he is a registered nurse having completed his training in 2009. He had been employed as a nurse for a little over a year at the Calvary North Adelaide hospital, but on completion of that year he had returned to police duties. When Dr Byrne examined Mrs Cook he noted in the clinical record that Mrs Cook's abdomen had become more distended. It was apparent to him that the small bowel obstruction would not respond to conservative management and would require intervention that was not available at the SCDH. Mr Greg Cook formed the impression that his mother was in pain and looked very weak, although she was able to converse. Mr Greg Cook would remain with his mother during the entirety of that day until she left the SCDH by ambulance destined for Calvary. He would ultimately follow the ambulance to Calvary in his private vehicle.

3.17. During the course of the night and early morning Mrs Cook's vital signs were relatively unremarkable. However, at 10am it was seen that her oxygen saturations had descended from normal levels to 85% on air which is significantly low and was consistent with Mrs Cook's general debilitation. As a result Mrs Cook was administered oxygen via nasal specs. The oxygen saturation did improve throughout the course of the day, but at 6pm her oxygen saturation was 89% on 4 litres of oxygen. This is also a concerning figure. The figure of 89% is intrinsically low and is of even greater concern having regard to the fact that it is being supported by oxygen therapy.

3.18. From a discussion that he had with Dr Byrne at the hospital, Mrs Cook's son understood that his mother's blood results from the day before were highly deranged, although Dr Byrne did not go into any great detail about the nature of the

derangement. Mr Cook did understand from the discussion that the blood results were not good and was given the impression by Dr Byrne that his mother would be transferred out of the SCDH sooner rather than later, and that in any case an ambulance would arrive at about 11am. In circumstances that I will discuss later, the ambulance would not depart the SCDH for Calvary until approximately 6:35pm that day. Mr Greg Cook, who as I have said is a registered nurse himself, told the Court in his oral evidence that throughout the day it became obvious that there had been a steady decline in his mother's condition[6]. She became more drowsy, less talkative and she was in pain. He could see that she had low blood pressure and a high heart rate and she '*just looked worse and worse throughout the day*'[7]. He also noted his mother's poor urine output which raised a fear in his mind of renal dysfunction. I am not certain whether possible renal dysfunction was specifically discussed with Mr Cook, but it will be remembered that Mrs Cook had an IDC that enabled her urinary output to be monitored and it is reasonable to conclude that Mr Cook would have had a professional understanding of the kind of urinary output that would be less than optimal. In any event Mr Cook's impression of possible renal dysfunction was correct. Mr Cook did not give any evidence as to whether or not he specifically understood that his mother's potassium levels were extraordinarily high and what impression of his mother's presentation and wellbeing he would have gained from that knowledge. However, it is clear from Mr Cook's evidence, which I accept, that as the day wore on he became increasingly concerned about his mother's condition, and with good reason.

3.19. In the section of this finding that follows I will discuss the arrangements that were made in respect of Mrs Cook's transfer from the SCDH to Calvary, a transfer that was in the first instance expected to have occurred during the morning of 14 January 2010 but which did not occur until the evening of that day. In that period Mrs Cook remained in the SCDH. I have referred to descending oxygen saturations during that period and the apparent deterioration in her condition. A further blood examination was ordered by Dr Byrne and the sampling for that purpose occurred at 10am. The results of that examination were made available and were printed at 12:35pm. I have found that during the course of that day, neither Dr Byrne nor Dr Salisbury would see the results of that examination nor were otherwise made aware of those results.

[6] Transcript, page 28
[7] Transcript, page 28

Clearly, Dr Byrne having ordered the blood examination himself was at least aware that the results of that examination would be available at some point in time during the course of that day. On the other hand I have found that Dr Salisbury was not made aware at any time of the fact that a blood examination had taken place, nor that its results were imminent. As it transpired, the results of the blood examination of that day were also of some concern. They included another concerning potassium level of 6.5mmol/L. They demonstrated that Mrs Cook was still experiencing acute renal failure, and there were certain abnormalities in hepatic enzymes indicating possible incipient liver failure. In his report the independent expert practitioner Dr Joyner states, and I accept this evidence, that even though her clinical status was reasonable, the blood results of that day should certainly have placed Mrs Cook into the category of severely ill patients going into severe renal failure with incipient multiple organ failure requiring urgent intervention. As well, the potassium level of 6.5mmol/L was still a worrying figure, and a figure that needed to be addressed. I have already referred to the fact that during the morning Mrs Cook's oxygen saturation had descended to concerning levels which had required the administration of oxygen. Meanwhile, prior to Mrs Cook's ultimate transfer, she was continued on intravenous therapy and given ice chips to consume. She would not be transferred until after 6pm.

3.20. It is against that background that the alleged failure of Mrs Cook to be transferred to Calvary in a timely manner comes to be examined.

4. <u>The interaction between Mr Cook, Dr Byrne and Dr Salisbury and the arrangements for Mrs Cook's transfer to Calvary</u>

4.1. Mr Greg Cook told the Court of another aspect of the conversation that he had with Dr Byrne shortly after 8am. Dr Byrne explained to him that his mother would need to be transferred to a hospital in Adelaide in respect of the bowel obstruction. He further explained that although he was the admitting doctor, her usual general practitioner did not have admission rights at the hospital and so his clinical intervention with Mrs Cook had to cease at that point. Dr Byrne was apologetic and said that his '*hands were tied*'[8]. Dr Byrne then explained that her general practitioner, Dr Salisbury, would be looking after his mother but went on to explain that Dr Salisbury did not have admission rights to the hospital. Nevertheless, Mr Cook understood from his

[8] Transcript, page 24

conversation with Dr Byrne that because his mother was Dr Salisbury's patient, Dr Byrne could not continue with her care[9]. Mr Cook did not have any conversation with Dr Salisbury at any time. It will be remembered that although the Mill House Medical Centre at Middleton was the general practice that habitually cared for Mrs Cook, Dr Salisbury had not personally seen Mrs Cook at any time. As it happened, Dr Salisbury was on this particular day working as the sole practitioner at her practice and was only scheduled to work until the early afternoon. She had personal commitments in the metropolitan area that afternoon. Dr Byrne also told the Court that this was his day off as well, although it was his habit to attend to administrative matters at his practice notwithstanding.

4.2. It was originally contemplated, by Dr Byrne at any rate, that Mrs Cook would be transferred to Flinders Medical Centre (FMC). I think it is fair to say Dr Byrne's preference would have been a transfer to FMC because of his greater familiarity with that hospital's admission practices. However, Mr Greg Cook who at one point had enjoyed a professional connection with the Calvary Hospital at North Adelaide, personally arranged for a surgeon at Calvary to assume his mother's care. Mr Cook recalled in evidence that to begin with he may have attempted to secure the services of a Dr Luck at Calvary. Mr Cook's recollection of the possible proposed involvement of Dr Luck in the first instance was less than clear but I am satisfied from notations made in the Mill House Medical Centre casenotes[10] regarding Mrs Cook that Mr Greg Cook telephoned staff at the Mill House Medical Centre and advised them that he was a nurse at Calvary Hospital and had organised for his mother to go there and that he had secured a bed and the services of Dr A Luck who could operate that day if required. This communication must have occurred after Dr Byrne had advised Mr Cook of Dr Salisbury's imminent involvement in Mrs Cook's matter. The staff member at the Mill House Medical Centre noted that there would be a need for a referral letter to Dr Luck to be compiled. This note was intended to inform Dr Salisbury as to what was taking place in respect of Mrs Cook. In the event it was not Dr Luck who would agree to take over Mrs Cook's surgical care at Calvary. Rather, that responsibility fell to Mr Darren Tonkin, another surgeon at Calvary.

4.3. The alleged assertion by Dr Byrne that his hands were tied in respect of his continuing care of Mrs Cook due to his not being Mrs Cook's regular general practitioner must

[9] Transcript, page 24
[10] Exhibit C5

be examined in conjunction with the terms of a phone conversation that Dr Byrne had with Dr Salisbury that morning. In addition, it also has to be examined against the background of the ongoing situation concerning the Mill House Medical Centre practitioners' lack of admitting rights to the local hospital and the general attitude of local practitioners in respect of that issue.

4.4. When Dr Byrne phoned Dr Salisbury that morning the latter was in the process of consulting with a patient at the Middleton practice. Dr Salisbury's note of the conversation is as follows:

> 'Dr Burn (sic) phoned after that said asking for direction apparently requires hospitalised remains distended had IVI overnight said needed admission to tertiary facility and surgical review now handing back to me to organise that'[11]

Dr Byrne's handwritten note in the SCDH[12] progress notes that encompasses this telephone conversation with Dr Salisbury is as follows:

> 'MED no vomiting
> Abdo more distended
> D/W children T/F to Adelaide
> D/W Dr K Salisbury
> She will arrange T/F
> SB' [13]

In her oral evidence before the Court Dr Salisbury said that Dr Byrne phoned and told her that Mrs Cook had been in the SCDH overnight with what he thought was probably a subacute bowel obstruction. He said that despite her having taken nil by mouth and having been administered intravenous fluid, she continued to have a distended abdomen and that she now required transfer to a tertiary hospital. Dr Salisbury told the Court that there was some discussion regarding that tertiary centre being the FMC. Dr Salisbury told the Court that she had suggested the FMC and that when she suggested that, Dr Byrne responded by saying that he had 'babysat' Mrs Cook enough and that Dr Salisbury should organise the referral. Dr Salisbury told the Court that she took this to mean that Dr Byrne did not want to continue managing Mrs Cook but that he wanted Dr Salisbury to continue management. Dr Salisbury further testified that it was not clear to her whether, as well as arranging transfer to another hospital, it was expected that she should continue to treat Mrs Cook whilst in the

[11] Exhibit C5, page 8-9
[12] Exhibit C7
[13] Exhibit C7, page 10

SCDH. Dr Salisbury said that the conversation ended before this was made clear. However, Dr Salisbury said that she understood Dr Byrne's comment about having babysat Mrs Cook to be a reference to the Mill House Medical Centre's lack of admitting rights[14]. Dr Salisbury also told the Court that from this conversation she had felt that Dr Byrne had finished managing Mrs Cook's care and that it was now in her hands to organise the transfer and to attend to any other matters that may '*have come into play*'[15].

4.5. Dr Salisbury's assertions that she had been told by Dr Byrne that he had babysat Mrs Cook, or a Mill House Medical Centre's patient, long enough was not challenged during her cross-examination by Mr Stratford, counsel for Dr Byrne.

4.6. In his oral evidence before the Court, Dr Byrne's own counsel questioned him firstly, as to whether he had told Mr Greg Cook that his hands were tied in respect of his continuing care of Mrs Cook and, secondly, whether he had told Dr Salisbury that he had babysat Mrs Cook long enough. However, both of these issues were not tackled in such direct terms. Both of these issues were addressed in Dr Byrne's examination in chief by questions by counsel that were couched in terms of whether he had any recollection of saying those two things respectively as distinct from whether he had in fact said them[16]. Dr Byrne equivocated. He said that he did not have any recollection of saying to Dr Salisbury that he had babysat her patient. In respect of the matter as to whether he recalled telling Mr Greg Cook that his hands were tied, he said:

> 'It's not a normal expression I'd use. I might have discussed some professional etiquette but that's an unusual phrase for me.' [17]

Dr Byrne did not express unequivocal denials that he had said either thing. The assertion of an objective unlikelihood to my mind is a poor substitute for a denial, even allowing for the passage of time. The questions as posed to Dr Byrne in respect of both issues, couched as they were in terms of Dr Byrne's recollection or otherwise, enabled Dr Byrne to avoid the issue while still appearing to answer the questions literally. In what turned out to be lengthy cross-examinations by other counsel, Dr Byrne did not expressly deny saying either thing in either conversation. But he did not admit them either. I deal with these two issues together because it seems to me

[14] Transcript, page 84
[15] Transcript, page 303
[16] Transcript, pages 486, 493
[17] Transcript, page 493

that there is a link between Dr Byrne's allegedly telling Mr Cook that his hands were tied and allegedly telling Dr Salisbury that he had 'babysat' Mrs Cook for long enough. Both statements relate to the issue of Dr Byrne's preparedness to continue with Mrs Cook's management until her transfer by way of ambulance out of the SCDH. Both can be interpreted as attempts by Dr Byrne to divest himself of responsibility in respect of Mrs Cook's ongoing care.

4.7. I accept the evidence of Mr Cook and Dr Salisbury respectively in respect of these alleged utterances by Dr Byrne. I prefer Mr Cook's direct assertions on that topic to Dr Byrne's equivocality. I have no reason to suppose that he would not use an expression such as *'hands were tied'* if he thought it necessary to convey a point even if the expression was not one that he commonly used. After all, it is not an uncommon expression. I am mindful of the fact that Dr Salisbury did not include reference to the expression *'babysat'* in her clinical note, but notwithstanding this I am satisfied that she told me the truth in relation to that issue. It is unsurprising that Dr Salisbury would not include such a colloquialism in her clinical note, even if it had struck her as disrespectful. When the terms of the conversation as recorded in the note are examined as a whole, there is nothing inconsistent about the expression having been used. Indeed, it is quite in keeping with the recorded assertion attributed to Dr Byrne that he was *'handing back'* the patient to Dr Salisbury. It would have been natural for Dr Byrne to have provided some explanation for doing that, impertinent or otherwise. There is no reason to suppose that Dr Salisbury's recollection is faulty. Dr Byrne's assertion is the kind of thing that a person in Dr Salisbury's position that morning would well remember.

4.8. In my view both of Dr Byrne's alleged utterances did in fact relate to a lack of preparedness on Dr Byrne's part to continue with Mrs Cook's care. The explanation for that lack of preparedness given to Mrs Cook's son on the one hand was an assertion that for reasons of formality or protocol connected with the fact that he was not his mother's usual general practitioner, he could no longer continue with her care. On the other hand, his explanation to Dr Salisbury for insisting that she arrange Mrs Cook's hospital transfer was that he had been responsible for Mrs Cook's care for long enough when he was not her usual general practitioner. Having regard to the fact that the alleged utterances were made within a short time of each other and at a time when Dr Byrne's enthusiasm for Mrs Cook's ongoing care was objectively

decreasing, as exemplified by the fact that he would not even write the referral letter to Calvary, it is too much of a coincidence for them not to have both been said. There is absolutely no evidence of collusion between Mr Cook and Dr Salisbury. In any event, I prefer the unequivocal and direct assertions by Mr Cook and Dr Salisbury respectively to the equivocality displayed by Dr Byrne in respect of both issues. I find that both things were said by Dr Byrne. I find that Dr Byrne said these things in order to excuse himself from further responsibility in respect of Mrs Cook's care. I further find that his assertion to Mr Greg Cook that his hands were tied in respect of Mrs Cook's continued care was an assertion that had no basis in fact. In reality there was no professional impediment to Dr Byrne's continued care of Mrs Cook. Dr Byrne did not lay claim to any such professional impediment when he gave evidence.

4.9. I find that Dr Byrne's assertion to Dr Salisbury that he had 'babysat' Mrs Cook long enough was a reference to the fact that to that point Dr Byrne had been required to provide care for Mrs Cook in the place of a practitioner from her usual practice due to the inability of Dr Salisbury or other members of her practice to have cared for Mrs Cook at the SCDH.

4.10. However, as will be seen, both Dr Byrne and Dr Salisbury would at different times during the course of that day order certain treatment measures in respect of Mrs Cook which were ordered remotely and not actually from the hospital premises.

4.11. Notwithstanding the fact that Mrs Cook's transfer to Calvary was a matter that was decided relatively early on the morning of 14 January 2010, the SAAS was not contacted by the SCDH nursing staff until 11am. I could divine no sensible reason for this from the evidence. Dr Byrne told the Court that he would have asked nursing staff to arrange transfer of Mrs Cook *'as soon as possible'*, in the expectation that she would leave the hospital '*within often 30 minutes, but perhaps an hour*'[18]. Naturally such an instruction would best be made as soon as the matter of transfer was decided. The task of contacting SAAS fell to Registered Nurse Debra Smith (nee Brearley). Ms Smith gave oral evidence in the Inquest. The transcript of her telephone communication with SAAS was produced in evidence, as were the transcripts of other relevant SAAS communications that occurred during the course of that day[19]. Ms Smith had commenced her shift at 7am that day. The transcript of the SAAS

[18] Transcript, pages 482-483
[19] Exhibit C2d

telephone communication reveals that at that time Ms Smith had an appreciation of a number of relevant matters in relation to Mrs Cook including the provisional diagnosis of a small bowel obstruction, that she was dehydrated and that she would be undergoing surgery at Calvary. Although it was mentioned in the communication that Mrs Cook was receiving oxygen via nasal specs, no mention was made to the SAAS operator that Mrs Cook's oxygen saturations had descended to as low as 85%. Nor was there any mention of the fact that she was experiencing acute renal failure with very high potassium levels, information that should have been available to nursing staff at that point in time. Ms Smith indicated to SAAS that there were two doctors '*involved*', namely Dr Byrne and Dr Salisbury. When asked as to which of those practitioners was authorising the transfer, Ms Smith replied '*probably Dr Salisbury I would think*'. When asked specifically as to the time she would like Mrs Cook to be picked up from the SCDH, Ms Smith replied '*as soon as you could*'. At the very end of the communication the SAAS operator asked Ms Smith whether the '*next available ambulance*' was '*fine*', Ms Smith said '*yep*'. In her evidence before the Court Ms Smith explained this as follows:

> 'I just meant as soon as they can get here; it wasn't a priority booking, it was just as soon as they can get here.' [20]

Ms Smith's request that Mrs Cook be picked up by SAAS as soon as they could was very much in keeping with Dr Byrne's instruction that Mrs Cook be transferred as soon as possible.

4.12. Ms Smith's description of Mrs Cook's condition and her assertion about the lack of any need for priority significantly understated the position. It took no account of the blood results, Mrs Cook's acute renal failure, the dangers posed by high potassium levels that were known to be high from the night before and her deteriorating oxygen saturation. With some hesitation I am not critical of Ms Smith because it may well be that she had an imperfect understanding as to the need for urgency and for priority. In the final analysis matters such as degree of urgency and priority were matters that required specific clinical consideration by the medical practitioner who was responsible for Mrs Cook's care. Ms Smith did say in her evidence that if she had seen blood results in respect of Mrs Cook and specifically had seen the abnormal

[20] Transcript, page 191

results that they revealed, she would have contacted the doctor about them[21]. As it would transpire, there was some communication between Ms Smith and Dr Byrne at around midday, but it is by no means clear to me whether Mrs Cook's actual condition in any detail was discussed at that time. Ms Smith told the Court that no person had asked her to make any priority booking with SAAS. She said that if a doctor wanted a patient to be transferred as a priority she would have conveyed that to SAAS, '*otherwise the patient would just transfer in the normal course of events*', meaning that the arrival of the ambulance service would depend on how busy SAAS was.

4.13. In the 11am telephone communication with SAAS no indication was given as to when SAAS would arrive at the SCDH to collect Mrs Cook. A nursing note made by Ms Smith timed at 12:15pm indicated that the ambulance was booked for 1:30pm. It was not clear to the Court where precisely this time came from. Ms Smith could not explain where she obtained that time[22]. In any event the ambulance did not arrive at 1:30pm. An internal SAAS communication timed at 1:40pm[23] tends to suggest that any arrangement that had been made for the ambulance to attend at the SCDH in respect of Mrs Cook had been overtaken by the need to convey a Category C psychiatric patient to FMC. In that same communication there was a suggestion that SAAS would not be able to effect Mrs Cook's transfer to North Adelaide until approximately 4:30pm. SAAS Communications telephoned the SCDH at approximately 1:48pm. It was indicated that after various breaks to which the crew were entitled, an ambulance crew would be coming from FMC and that they would be at the SCDH just after 3:30pm[24], a time that came and went without the arrival of the ambulance.

4.14. At 3:23pm SAAS had communicated with SCDH. A SAAS operator spoke to Ms Smith regarding Mrs Cook's current condition. Ms Smith described Mrs Cook as having been *'a bit dehydrated*', but that this had settled down a little. She mentioned that the distended abdomen had become worse since the day before. Ms Smith made reference to existing uncertainty about the plan for Mrs Cook once at Calvary, indicating that the difficulty was that they did not have much information due to the fact that Mrs Cook was a patient of the Mill House Medical Centre whose

[21] Transcript, page 204
[22] Transcript, page 192
[23] Exhibit C2d(f)
[24] Exhibit C2d (h)

practitioners did not have visiting rights at the hospital. Ms Smith indicated that she was under the impression that Mrs Cook would be having surgery at some stage. There was mention of dehydration, the small bowel obstruction, the fact that Mrs Cook was receiving intravenous therapy and that the doctor had said that if Mrs Cook's blood sugar levels were satisfactory they should not continue with further fluids at that stage. In fact at that time the fluid had been discontinued, but it would be reinstituted at 4pm. Another operator then explained to Ms Smith that there was a delay due to the number of transfers that were required from Victor Harbor to Adelaide. The operator specifically indicated that SAAS were endeavouring to ascertain whether Mrs Cook's case was *'time critical'*, the difficulty being that SAAS needed to retain emergency coverage for Victor Harbor. The operator indicated that they would try to attend to Mrs Cook's case as quickly as they possibly could. Ms Smith indicated that this arrangement was *'fine'*. Ms Smith indicated in this communication that she was about to conclude her shift and that she would pass on the arrangements to the team leader of the afternoon shift, a Ms Jill Western. Again there was no mention of any difficulty with Mrs Cook in terms of her renal function or her oxygen saturations, nor indeed any mention of high potassium levels.

4.15. At 4:07pm SAAS communicated with the SCDH and on this occasion spoke to an enrolled nurse by the name of Chris Gilbert. SAAS indicated at that point that their estimated time of arrival to collect Mrs Cook would be approximately 2 hours from then. Ms Gilbert acknowledged this timeframe and added *'okay'*. Ms Gilbert asked SAAS whether this estimate was a promise and discussion then ensued about that question, but it appears that in the event this estimate proved to be reasonably accurate because the ambulance did arrive between 6pm and 7pm. There was some further discussion in this communication regarding the urgency of Mrs Cook's case, but only in terms of when it was that Mrs Cook would be undergoing surgery. The SAAS operator indicated that if she had been booked in for actual surgery, as opposed to surgical assessment, they would hurry things up. No actual surgery had been scheduled.

4.16. I have alluded to one of the SAAS communications making reference to the involvement of a Ms Jill Western. Ms Western is a registered nurse whose shift on that afternoon had commenced at 1:15pm. Ms Western was called to give oral evidence in the Inquest. She was the senior nurse working in the private ward in

which Mrs Cook was accommodated on the afternoon of 14 January 2010. Ms Western asserted that she had no recollection of Mrs Cook. Ms Western expressed a measure of indignation about what transpired in respect of Mrs Cook that day. For instance, Ms Western offered this:

> 'She was going for surgery and obviously she needed to be transferred and I mean looking at her results from the day before, I don't understand why she ever came to South Coast. I don't understand why she didn't go straight to a tertiary hospital where she needed treatment for her high potassium. I'm an intensive care nurse. You don't treat someone in a country hospital with a potassium over 7. I mean it's just outrageous. She should have gone straight to town.' [25]

Ms Western considered that Mrs Cook should have been assigned SAAS priority 2, if not priority 1.

4.17. Although Ms Western claimed to have no recollection of any of these events, she must have had some detailed knowledge of Mrs Cook's situation at the time having regard to the fact that she was the senior nurse on duty and that she would have had personal access to Mrs Cook's clinical notes including the concerning oxygen saturation figures. Ms Western herself had personally recorded in the notes that Mrs Cook's oxygen saturation was 89% on 4 litres of oxygen at 6pm, a concerning figure in and of itself. Perhaps more significantly, she therefore must have seen the earlier oxygen saturation figures that were of even greater concern. That afternoon she also spoke on the telephone to Dr Salisbury in respect of pain relief. The clinical record reveals that she contacted Dr Salisbury and, as a result, gave Mrs Cook pain relief at 4:25pm and then again at about 6:35pm[26]. Mrs Cook's blood chemistry would have been available to all nursing staff that afternoon. The passage quoted above from Ms Western's evidence suggested that had she known of Mrs Cook's potassium levels, she would have had as good an idea as anyone about their significance. Ms Western also must have realised that Mrs Cook was at the SCDH all throughout the course of that afternoon. Ms Western offered this in respect of the delay, which must, of course, amount to a reconstruction when her lack of recollection is taken into consideration:

> 'When I found out it was delayed, obviously, by my actions, you know, Dr Salisbury was contacted, so my only conclusion is that Chris got the call and sort of really sort of thought 'Well, they'll be here soon' because she sort of didn't question it, and then said to

[25] Transcript, page 265
[26] Transcript, page 255

> me perhaps later on, you know, 'They'd been delayed again', but I can't believe that if I knew earlier that I wouldn't have done something about it. I just - I would not have let that go.' [27]

The 'Chris' to whom Ms Western refers is undoubtedly Ms Chris Gilbert who had communicated with SAAS at 4:07pm in which Ms Gilbert had acquiesced in the indication that SAAS would be there for Mrs Cook in about 2 hours.

4.18. Ms Western told the Court that she believed that she would have conveyed Mrs Cook's '*whole picture undoubtedly*' to Dr Salisbury [28]. In assessing the legitimacy of that claim, it naturally has to be borne in mind that she has no recollection of having done so. I find that I am unable to rely on this assertion in the absence of confirmation by Dr Salisbury that this was the case. There is no evidence that the request of Dr Salisbury for pain relief would necessarily have involved the giving of a complete clinical picture to Dr Salisbury.

4.19. SAAS arrived to collect Mrs Cook from the SCDH at 6:35pm and departed the hospital at 6:51pm. The ambulance arrived at Calvary at 8:41pm.

4.20. As explained in the statement of Dr Timothy Brownridge to whom I have already referred, upon admission to the Calvary Critical Care Unit on the evening of 14 January 2010 Mrs Cook was obtunded, hypoxic and shocked and was in acute renal failure with profound acidosis and biochemical derangement. The surgery that she would ultimately undergo for a confirmed small bowel obstruction was delayed due to the fact that in the two days between 14 and 16 January 2010, the day of the surgery, Mrs Cook required resuscitation and stabilisation before proceeding to laparotomy[29]. The description of Mrs Cook's condition appears not to be different from Mrs Cook's general condition during the course of the morning and afternoon of 14 January 2010 while in the SCDH.

4.21. I accept Ms Western's evidence as quoted above that there had been a need all along for Mrs Cook to be transferred from the SCDH at the earliest opportunity, and that was on the night of 13 January 2010.

4.22. In my view no criticism in respect of delay attaches to SAAS, having regard to the exigencies of their workload during the course of that day and taking into account,

[27] Transcript, page 273
[28] Transcript, page 275
[29] Exhibit C1a, page 3

more importantly, the fact that no-one at the SCDH explained to an SAAS operator the true nature of Mrs Cook's condition, involving as it did acute renal failure and the other matters I have discussed. The issue of priority had been left on the basis that Mrs Cook would be transferred as soon as possible. This did not properly convey the urgency with which Mrs Cook needed to be transferred. Even if it had been intended that Mrs Cook's case required expedient transfer, the notion that she would be transferred as soon as possible was incapable of conveying the appropriate degree of expedition. The effectiveness of expressions such as 'as soon as possible' or 'as soon as you could' depended upon the exigencies of the SAAS workload that day. Such vague expressions could not sufficiently have conveyed to SAAS the need for Mrs Cook to be transferred by way of priority greater than that attaching to other cases that SAAS had on its books that day. It was an arrangement that was destined to put Mrs Cook's case on the back burner and that is what it did. In the event, the category assigned to Mrs Cook's case by SAAS was Category 5, whereas clearly it should have been Category 1 or 2.

5. The quality of Mrs Cook's care at the SCDH

5.1. Dr Byrne acknowledged that he had been aware of the results of the blood examinations that he had ordered in respect of Mrs Cook that day. It will be remembered that there were two such examinations conducted on 13 January 2010. Dr Byrne acknowledged that he knew of both potassium results. He was advised of the blood chemistry results by telephone. He told the Court of some initial uncertainty about the accuracy of the very high initial potassium reading of 8.1 and the need to repeat that test. The second reading of 7.6 could only have confirmed the accuracy of the original test and have established beyond doubt that Mrs Cook's potassium readings had been alarming all the way through her admission at the SCDH thus far. According to the evidence of the independent expert, Dr Joyner, there were other worrying aspects of the blood chemistry results of 13 January 2010 quite apart from the potassium results that included a picture of acute renal failure as well as a very low glucose level of 1.6. The glucose levels would increase but not to levels that were reassuring[30]. The second potassium level of 7.6 in Dr Joyner's view was still in a very dangerous range warranting immediate assessment and treatment[31]. I have already referred to the fact that there was no ECG monitoring on 13 January 2010. I

[30] Transcript, pages 684-685
[31] Transcript, page 685

have accepted all of Dr Joyner's evidence in this regard. In the light of that acceptance I have found that certain aspects of Dr Byrne's management of Mrs Cook were questionable. On the evidence that I have heard, particularly in relation to the concerning potassium levels and the evidence of acute renal failure as evidenced by the biochemistry results as well as poor urinary output, all of which evidence the Court found compelling, Dr Byrne could not reasonably have failed to come to the understanding that Mrs Cook was seriously ill. Nevertheless Dr Byrne decided to manage Mrs Cook conservatively by way of rehydration measures and observation. Even allowing for the fact that the concerning initial blood biochemistry results would not be confirmed until the evening of that day, the picture illustrated by the first set of results was worrying in and of itself. Dr Byrne acknowledged that the first set of results suggested significant dehydration and that Mrs Cook's kidneys were not coping with that dehydration[32]. As a result Dr Byrne felt that Mrs Cook needed to continue with intravenous therapy that had already been conducted and that it needed to be accelerated. Dr Byrne suggested that the vomiting and diarrhoea that had taken place earlier had stopped and her improvement in other ways made him feel that the process would start to reverse itself[33]. He thought, therefore, that the bowel obstruction might be improving and that transfer at that time of night might be difficult and might not improve her condition. In hindsight Dr Byrne acknowledged that this was probably not the right approach[34]. His thought processes can be summarised in the following answer given by him in evidence:

> 'Yes. My impression at that stage was that there was no benefit overall in transferring her at that stage but because this illness had been going for some weeks and that she had a bowel obstruction now, further investigation of why she was having the bowel obstruction would be required at some stage, probably the next day and that with some extra information obtained clinically overnight it would be easier to talk to the most appropriate person in the most appropriate institution to make that transfer work well for Mrs Cook.' [35]

Dr Byrne suggested that at that point in history on the South Coast night time transfer of a patient by ambulance to a tertiary hospital in Adelaide was not always as easily achieved as it was during the day.

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[32] Transcript, page 467
[33] Transcript, page 471
[34] Transcript, page 472
[35] Transcript, page 473

5.2. It must be acknowledged that Dr Byrne's exhibited a large measure of professional concern for Mrs Cook on the 13 January. He was involved in discussions concerning Mrs Cook's blood picture during the course of the night of 13 January 2010 and as late as 11:30 that evening he was telephoning the hospital about Mrs Cook's condition and current status. Early on the morning of 14 January 2010 he was making enquiries about Mrs Cook's status. However, Dr Byrne's decision not to transfer Mrs Cook to Adelaide on the night of 13 January has to be examined against other evidence that suggested that in reality there would not have been any significant difficulty about transferring her to a tertiary institution by way of ambulance. Secondly, the evidence as a whole tends to suggest that Dr Byrne misjudged the seriousness of Mrs Cook's condition, including acute renal failure. For instance, there is no record made by Dr Byrne in the clinical casenotes relating to Mrs Cook at the SCDH of any reference to acute renal failure, nor to the possible significance and risk posed to Mrs Cook by the high potassium readings. Dr Byrne's strategy appears to have been one whereby the treatment of Mrs Cook's undoubted dehydration was the cure for all of her worrying symptomatology.

5.3. Yet Dr Byrne told the Court that he did in fact consider that Mrs Cook was suffering from acute renal failure on the night of 13 January 2010[36]. Indeed, he acknowledged in his evidence that the blood results could be suggestive of nothing other than acute kidney failure[37]. Dr Byrne also said that he was aware of the importance of the potassium results. It would be surprising for an experienced medical practitioner not to be so aware and that is why Dr Byrne's management of Mrs Cook is so perplexing. Mr Cox, for and on behalf of Dr Salisbury, when cross-examining Dr Byrne took him through the blood results for 13 January 2010 in minute detail. Dr Byrne acknowledged, as he had to, that several aspects of those results were consistent with acute renal failure. Nevertheless Dr Byrne stated in his evidence that he expected Mrs Cook's acute kidney failure to improve through the giving of fluids. When asked how he expected that would occur physiologically, he said:

> 'That she was dehydrated initially, and that by giving her fluids that would repair the dehydration and that renal function would improve.' [38]

[36] Transcript, page 564
[37] Transcript, page 565
[38] Transcript, page 580

5.4. He also suggested that Mrs Cook's electrolyte imbalance could be improved by the same process. He said he expected her abnormally low sodium to increase and her abnormally high potassium to decrease and that other parameters would alter for the better as well[39]. Of course the difficulty with this approach was that there had been no significant improvement between 3:45pm and 8pm, the two times at which the two separate blood examinations were sampled, over which period intravenous fluid therapy had been administered with limited effect. When Mr Cox suggested in cross-examination to Dr Byrne that in fact Dr Byrne had not realised that Mrs Cook was suffering from acute renal failure on the night of 13 January 2010; Dr Byrne responded that he had so realised.

5.5. Having considered the matter carefully, and having regard to Dr Joyner's evidence, Dr Salisbury's evidence, and the fact that it appears to be common ground throughout that Mrs Cook's biochemistry results of 13 January 2010 could have been consistent with nothing other than acute renal failure, to my mind it is highly unlikely that Dr Byrne did not consider that Mrs Cook was experiencing acute renal failure to some degree or another. However, to my mind Dr Byrne had underestimated the significance of that condition in terms of its overall effect on Mrs Cook's presentation and its potential to adversely affect her wellbeing. Also in my view Dr Byrne did not place sufficient weight upon the concerning potassium levels. I accept Dr Joyner's evidence that it would have been far better, and feasible, for Mrs Cook to have been transferred by ambulance to a tertiary institution in Adelaide on the night of 13 January 2010. To my mind indecision by Dr Byrne not to effect that transfer was flawed by a failure to appreciate the true seriousness of Mrs Cook's condition and by misplaced reliance on the potential benefit of intravenous fluid therapy.

5.6. I have already referred to some aspects of the events of 14 January 2010 prior to Mrs Cook's transfer. Dr Byrne was the practitioner who ordered the further blood sampling at 10am. In the event I have concluded that at no stage during that day prior to Mrs Cook's transfer was Dr Byrne made aware of the result of that blood test, a result that was, in reality, no less concerning than the blood results from the previous day. The potassium was still elevated at 6.5 and, in addition, Mrs Cook was still in acute renal failure. There is no evidence that Dr Byrne advised nursing staff at the hospital that morning that he should be told of the blood chemistry results as soon as

[39] Transcript, pages 580-581

they were in. Equally there is no evidence that he indicated to nursing staff with sufficient emphasis that in his opinion the blood chemistry from the day before indicated that Mrs Cook was in acute renal failure with concerning potassium levels. As a reflection of this, there is no reference to either matter in any of the recorded discussions between SAAS staff and nursing staff at the SCDH that day.

5.7. Dr Byrne told the Court that his intention in bringing Dr Salisbury into Mrs Cook's matter was to facilitate the transfer of information about Mrs Cook's previous medical history, and of other relevant information that the Mill House Medical Centre possessed, to the hospital to which Mrs Cook would be transferred. While this may well have been within Dr Byrne's contemplation, I do not accept that that was the entirety of Dr Byrne's intention. To my mind Dr Byrne's desire was to have Mrs Cook's further management placed in the hands of one of the doctors from her usual general practice and to all intents and purposes relinquish his own responsibility in that regard. For instance, Dr Byrne did not write any referral letter to the surgeon, Mr Tonkin at Calvary; nor did he personally communicate with Mr Tonkin. Any communication with the receiving doctor was all left to Dr Salisbury, a practitioner who had no personal knowledge of Mrs Cook's presentation other than what I have found to be the scant information that Dr Byrne imparted to her during their phone conversation. It was she who compiled the referral letter of two pages. Yet it is to be acknowledged that Dr Byrne would further be involved in Mrs Cook's management when he ordered, shortly before midday, continued intravenous therapy and ice chips as well as intravenous tropisetron for nausea. It is difficult to determine the circumstances in which Dr Byrne was chosen to be consulted about this. The tropisetron was administered at 11:50am and I would infer that this occurred shortly after Dr Byrne ordered it on the telephone. The blood chemistry results by that time were probably not yet available. There is no evidence that Dr Byrne made any enquiry as to whether and when they would be made available, yet Dr Byrne rejected the suggestion that he wanted Dr Salisbury to take over the care of Mrs Cook[40].

5.8. As to Dr Byrne's knowledge or otherwise of the blood results of 14 January, again the issue was addressed in his evidence-in-chief by way of questions that were posed in terms of his recollection as distinct from fact. Dr Byrne said he had no recollection of receiving a report of the results nor of being spoken to about the results[41]. There is no

[40] Transcript, page 630
[41] Transcript, pages 495-496

positive evidence that he did know of the results. With hesitation, I have found that Dr Byrne did not know of the results. Dr Byrne stated in evidence that if he had known about the blood results of 14 January 2010 he would have arranged for Mrs Cook to be transferred out of the SCDH by ambulance with lights and sirens, in other words with the utmost priority. The question still remains, therefore, why if he had not in his own mind relinquished care of Mrs Cook, did he not follow up the blood results. I can find no sensible answer to this question other than that Dr Byrne, as far as he was concerned, had divested himself of responsibility for Mrs Cook.

5.9. There is no written evidence as to whether or not Dr Byrne advised Dr Salisbury in his telephone conversation with her on the morning of 14 January 2010 of Mrs Cook's acute renal failure and/or high potassium levels from the night before, or that he had ordered a further blood examination. There is no note of any of that in either Dr Byrne's note of the conversation in the SCDH clinical record nor in Dr Salisbury's note of the conversation in her record. In his evidence before the Court, Dr Byrne said that he felt that he had spoken to Dr Salisbury about that; a matter that was never put to Dr Salisbury in cross-examination by Dr Byrne's own counsel. I prefer and accept Dr Salisbury's evidence that in her conversation with Dr Byrne she was told nothing of acute renal failure, of high potassium results nor of the existence of further blood sampling having taken place on 14 January 2010.

5.10. However, what is clear is that certain documentation was faxed to the Mill House Medical Centre on 14 January 2010 that included the biochemistry results from the night before, but made no reference to the fact that further blood sampling had been taken that morning. This material was faxed by Registered Nurse Smith. It consists of 16 pages of clinical notes relating to Mrs Cook. The precise time at which this material was faxed is unclear. The fax header itself states a time of 02:43, which suggests a sending time of 2:43am on 14 January 2010. However, this is impossible because there are entries within the faxed documentation that relate to events that occurred after 2:43am. I also do not believe that the time stated could be a reference to 2:43 on the afternoon of 14 January 2010. Ms Smith told the Court, and I accept her evidence, that she would have faxed the material using the original documentation as opposed to a photocopy of the documentation. In any case she stated that she would have faxed the material as it existed at the time of faxing, as distinct from the way it existed possibly several hours before. Of significance is the fact that Ms

Smith's own notation made at 12:15pm on 14 January 2010 was not within the faxed material. The clear inference which I therefore draw is that the material was faxed to the Mill House Medical Centre before Ms Smith made her entry at 12:15pm. Due to the fact that the faxed material bears the entry relating to the 10am oxygen saturation measurement of 85% on air, a further conclusion is available, which I draw, that it must have been faxed after 10am. I therefore find that the material was faxed to the Mill House Medical Centre at a time between 10am and 12:15pm on 14 January 2010.

5.11. The time at which the material was faxed to Mill House is of significance because Dr Salisbury told the Court that she left the clinic some time after 12:30pm. At one point in her evidence she stated that she left 'roughly' at 12:45pm and later[42] she noted that she normally finished about '1-ish'. The material therefore was transmitted at a time before Dr Salisbury left her practice for the afternoon. I am uncertain whether Dr Salisbury ever came back to the clinic later that day because she returned to the metropolitan area where she was residing for the most part and where she had certain personal commitments to attend to during the course of the afternoon. As alluded to above, the material that was faxed to the Mill House Medical Centre at a time prior to 12:15pm included the biochemistry results from the night before, that is to say the results of the sampling ordered by Dr Byrne at 8pm. This had demonstrated the high potassium result of 7.6 as well as a picture of acute renal failure. However, there is no convincing evidence that Dr Salisbury that day was ever placed in possession of, or saw, or was otherwise informed of, the fact that blood sampling had been taken on the morning 14 January 2010 or of the results of the blood tests.

5.12. The question therefore is whether Dr Salisbury had access to the faxed material before she left for the day or whether it escaped her attention. There is no direct evidence either way aside from Dr Salisbury's denials that she saw the material. I also have to take into account the theoretical possibility that even if the material was transmitted by fax from the hospital to Mill House before Dr Salisbury left for the afternoon it was not effectively received in good order by Mill House at the same time.

5.13. It is clear that Dr Salisbury saw the faxed material at some point because she wrote on it. Dr Salisbury told the Court that she did not see any of Mrs Cook's various results, including biochemistry, until the following day, namely 15 January 2010 when she asserts that she made a hand written entry on one page of the faxed material. Of

[42] Transcript, page 309

course by then Mrs Cook was no longer in either her care or that of Dr Byrne, but was at Calvary. I was somewhat concerned about Dr Salisbury's assertions having regard to the terms of what she wrote on the faxed copy of the SCDH progress notes for Mrs Cook. Her own handwritten entry appears as follows:

'Referred to Dr Luck at Calvary Hospital who will kindly continue management.' [43]

Dr Salisbury told me on her oath that she did not write this notation until the 15 January. However, the note suggests that Dr Salisbury wrote that entry at a time when it was her understanding, as undoubtedly it had been at one point, that Dr Luck would be responsible for Mrs Cook's surgical review at Calvary. As already observed, that expectation had been short lived because Mr Tonkin was engaged and Dr Salisbury well knew that at a time before she left for the day on 14 January, as demonstrated by the fact that she wrote the referral letter to him before leaving. The notation of Dr Salisbury further suggested, therefore, that she had written it on the morning of 14 January 2010, not on 15 January 2010 as she asserts. That conclusion was available because Dr Salisbury could only have been of the understanding that Dr Luck was the surgeon on 14 January 2010. Having considered the matter carefully I am not prepared to reject Dr Salisbury's explanation that the reference to Dr Luck was simply a slip and that she had mistakenly written Dr Luck instead of Mr Tonkin when she came to write her entry when she returned to the practice on 15 January 2010. I observe that her notation utilises the word *'referred'*, that is to say she used the past tense, raising the possibility that she made the entry at a time after she had written the referral letter to Mr Tonkin. If so, the reference to Dr Luck in the notation would indeed be an error as Dr Salisbury asserts. It would be an error that is equally consistent as having been made the day after the event as opposed to the day of the event. I therefore infer nothing from that entry in terms of when it was that Dr Salisbury saw the faxed material from the hospital for the first time, including the blood chemistry results from the night of 13 January 2010.

5.14. It is clear that Dr Salisbury did have something to do with Mrs Cook's clinical management on 14 January 2010 because Mrs Cook was administered morphine on two occasions that day, both on the instructions of Dr Salisbury, the first time at 4:25pm and the second at a recorded time of 6:40pm around the time Mrs Cook left the SCDH by ambulance. As far as the earlier order of morphine is concerned, clearly

[43] Exhibit C5, page 40

Dr Salisbury had an appreciation of the fact that Mrs Cook was still at the hospital. I am not critical of Dr Salisbury for not ordering Mrs Cook's transfer to be expedited at that stage because I am not satisfied that Dr Salisbury had a complete understanding of the seriousness of Mrs Cook's condition during the course of the afternoon of that day.

5.15. Dr Salisbury told the Court that if she had seen blood results such as those pertaining to Mrs Cook, then she would have done something in order to effect Mrs Cook's transfer at a time earlier than it ultimately occurred[44]. I accept that evidence. This evidence mirrors that of Dr Byrne who said he would have ordered lights and sirens if he had seen the biochemistry results of that day.

5.16. It must be said that the fact that neither of Dr Byrne nor Dr Salisbury were aware of the biochemistry results of that day was highly unsatisfactory. Fundamentally, it meant that the entity that ultimately had responsibility for her hospital transfer, namely SAAS, were kept in the dark about the correct prioritisation for her case. Had either doctor known and fully understood the significance of those results it would have meant that Mrs Cook would have been transferred with some priority rather than having to wait until after 6:30pm to be transferred by way of ambulance. This is especially so in the case of Dr Byrne who knew of the blood results of the previous day. I am not critical of Dr Salisbury because, I find, that she had an imperfect understanding of Mrs Cook's clinical predicament.

5.17. On the other hand, Dr Byrne must have known that Mrs Cook was still at the SCDH at around midday because he ordered tropisetron at that time. Given Dr Byrne's acknowledgement that it had been his assumption that Mrs Cook would have been transferred '*quite rapidly*' that morning[45] and his assertion that her transfer was time critical[46], it is surprising that even if, as he asserts, he was not told that Mrs Cook would not be transferred for another 90 minutes at 1:30pm, he did not make any enquiry about a timeframe for transfer[47]. Why the revelation that Mrs Cook was still at the hospital would not have prompted him to enquire about or to arrange more expeditious transfer can only be answered by reference to the notion that Dr Byrne did not consider himself under any responsibility to do so.

[44] Transcript, pages 119-120
[45] Transcript, page 605
[46] Transcript, page 606
[47] Transcript, page 605

5.18. As indicated earlier Dr Joyner provided a written report[48] and as well gave evidence. In his report Dr Joyner indicated that in his view the assessment made at the Goolwa Medical Centre by Dr Byrne on 13 January 2010 was correct and his decision to hospitalise Mrs Cook was also correct, as was the original management at the SCDH. He expressed concern about subsequent management in respect of two aspects, namely a failure to recognise and treat the increasing electrolyte imbalance, renal failure, acidosis, high potassium and low sodium levels which he regarded as presenting *'quite grossly*' from 13 to 14 January 2010. In his view the raised potassium levels on 13 January 2010 were dangerous levels and the lower sodium levels were concerning levels. The confirmation potassium level of 7.6 was very dangerous and should also have raised severe concerns. The results of 14 January 2010 should have placed Mrs Cook into the category of severely ill patients going into severe renal failure with incipient multiple organ failure requiring urgent intervention. Dr Joyner opined that there appeared to be a lack of awareness of Mrs Cook's physiological state. He opined that Dr Byrne should have been aware of those matters and questioned why he did not arrange for rapid intervention to occur, at least on the morning of 14 January 2010.

5.19. Dr Joyner suggested that in respect of Dr Byrne's alleged statement to Mr Cook that he was unable to continue with his mother's care, there was no specific medical obligation to replace her into the care of a doctor who had not seen her, who was not totally aware of her clinical situation and was only acting on phone advice and information limited to that provided by Dr Byrne himself. The information that should have been imparted to Dr Salisbury should have included severe dehydration and incipient multiple organ failure with already declared renal failure being present with the marked electrolyte abnormalities.

5.20. In his report Dr Joyner expressed the view that retrospectively at least it could be said that Mrs Cook being transferred to a tertiary level hospital or a significantly equipped private hospital such as Calvary on 13 January 2010 would have been the 'ideal management'. Dr Joyner suggested that Mrs Cook at the latest should have been transferred out of the SCDH on the morning of 14 January 2010 when her treatment provided by way of IV fluid had not in any way improved her biochemical status which had continued to deteriorate.

[48] Exhibit C14

5.21. Dr Joyner observed that there was a demonstrable lack of awareness by the nursing staff on duty at the SCDH of the severity of Mrs Cook's illness. This lack of awareness meant that her priority for transfer, in terms of SAAS priority assignment, should have been much higher than priority 5, probably priority 2. Dr Joyner made the point in this regard that it is not normally the province of the nursing staff to review blood results in totality, and in particular to assess the concerns that are raised from them, but experienced nursing staff should understand severe abnormalities such as severe renal impairment and electrolyte imbalances. I observe here that Ms Western told the Court that she would have appreciated the significance of such levels had she known about them, although it will be remembered that she claims to have no recollection of these events. Thus her level of awareness of these concerning parameters in respect of Mrs Cook is something of a moot point.

5.22. In summary, Dr Joyner felt that there had been inadequate awareness of the rapid decline in the health status of Mrs Cook.

5.23. In his oral evidence Dr Joyner emphasised all of those matters and added, as already alluded to, the need for consideration to have been given to the rectification of Mrs Cook's high and dangerous potassium levels including monitoring by way of 12 lead ECG. He regarded the 4 lead mechanism that was instituted as being inadequate as a diagnostic component[49]. He also opined that any therapy that was provided to Mrs Cook, in particular IV therapy with dextrose, could not have addressed the high potassium levels[50]. Dr Joyner emphasised that of all the conditions that Mrs Cook was exhibiting, the high potassium level was the one that she could die from in the next few hours if not treated[51].

5.24. Dr Joyner said in his evidence that most doctors would seriously think of transferring a patient such as Mrs Cook for care to a place where one could treat the three different aspects of her presentation, namely the small bowel obstruction, dehydration and renal failure with secondary electrolyte imbalance. The fact that she was producing small amounts of concentrated urine heightened the need for transfer on 13 January 2010[52].

[49] Transcript, pages 688-690
[50] Transcript, page 698
[51] To 699
[52] Transcript, page 701

5.25. Dr Joyner held a different view from that expressed by Dr Byrne in relation to the feasibility of ambulance transfer at night. Dr Joyner was of the view that there was practicality in transferral at night, even at midnight. He did not regard there as having been any impediment to her transfer to a tertiary hospital in those circumstances. He said it happens all the time, although he acknowledged that it is slightly easier to achieve this in daylight hours53. In any event a receiving doctor at any major public hospital, having been given Mrs Cook's potassium figures, would inevitably have indicated that she needed to be transferred immediately as it would have been looked upon as a medical emergency54.

5.26. Dr Joyner found that the process of involving Dr Salisbury was '*very unusual*'. The Court shares the same view. The primary obligation for Mrs Cook's care was that of Dr Byrne, the doctor who was looking after the patient[55]. Only that person understands what has gone on to date. If the patient needed to be transferred for further tertiary care, Dr Joyner regarded it as the responsibility of the treating doctor to undertake and organise it[56]. If for some reason care needed to be assigned to another doctor, there would have been a need to very accurately outline to the second doctor all that had taken place so as to give that doctor a total understanding of the concerns relating to the patient and of the physiological parameters that had changed. This would be necessary in order to achieve on the part of the second doctor the same level of care and concern that Dr Byrne would have had himself. He said as follows:

> 'If Dr Salisbury was aware of all of those aspects and agreed to undertake that responsibility, that would be reasonable, but if either of those two factors were failing, she either didn't know the total complexity, urgency or otherwise, and she didn't agree to undertake total management, then it would be unreasonable. It is complicated by the fact that really Dr Salisbury can have no say in what occurs in the South Coast Hospital because she doesn't have visiting rights, isn't credentialed to work there. So, that really means that a nurse on duty would not really be able to contact or get from her any orders, intervention or otherwise. So, it struck me as illogical to have the care of a patient who is in the hospital, taken over by a doctor that can't control, intervene, assess or support that patient's treatment, because Dr Salisbury doesn't have that ability.' [57]

As to Dr Byrne's explanation for bring Dr Salisbury into the matter, namely as a conduit for information concerning Mrs Cook's history, Dr Joyner acknowledged that it would be ideal for that kind of information to be made available[58], but that this was

[53] Transcript, page 703
[54] Transcript, pages 703, 704
[55] Transcript, page 709
[56] Transcript, page 709
[57] Transcript, page 709
[58] Transcript, page 710

a task that could have simply been achieved by the press of a button or a phone call to the patient's normal surgery. Regardless, Dr Byrne should have been the practitioner who wrote the letter of referral as he was '*the only doctor who has been treating Mrs Cook with this episode over the last 24 hours or so*'[59].

5.27. Dr Joyner told Mr Stratford, counsel for Dr Byrne, that he did not agree that it was sufficient for Dr Byrne to have attempted to *cc* Dr Salisbury in on the results of the blood tests taken on the morning of 14 January 2010. Although it was common to copy test results to another doctor for the sake of convenience, in Dr Joyner's view the doctor who orders the test is primarily responsible for following up those tests unless he or she has specifically discharged that responsibility to another doctor[60]. For reasons that I have already explained, namely that in my view Dr Byrne did not provide Dr Salisbury with sufficient information about Mrs Cook's presentation during their telephone conversation, the need for the blood tests on 14 January 2010 to be followed up was clearly that belonging to Dr Byrne.

5.28. As to the appropriate instruction to nursing staff regarding transfer, Dr Joyner expressed the view that Mrs Cook required a higher category of priority and that he believed that Dr Byrne would have wanted Mrs Cook to be leaving the SCDH within an hour, and that would be only having regard to her poor urinary output and the fact that surgery was going to be required in any event[61]. Dr Joyner did not regard directions for transfer to be made 'as soon as possible' to be helpful. In his experience the ambulance service does not simply accept such an instruction without it being defined further because in any event it did not fit in with the accurate triage system that they operate. In this context Dr Joyner regarded a direction for transfer 'as soon as possible' to be likened to the old adage based on the length of a piece of string.

5.29. To conclude, Dr Joyner rejected the notion that it was reasonable for a decision to be made not to transfer Mrs Cook until she was assessed the following morning simply on her clinical picture. Dr Joyner was of the view that one could not put Mrs Cook's biochemistry results to one side as they were '*a very overwhelmingly significant fact*'[62].

[59] Transcript, page 711
[60] Transcript, page 715
[61] Transcript, page 718
[62] Transcript, page 751

5.30. I accept Dr Joyner's opinions in their entirety with one exception. Dr Joyner expressed a view that it was difficult to see that Dr Byrne had recognised and had understood the significance of the kidney failure, particularly when it was quite significant[63]. If Dr Joyner was there suggesting that Dr Byrne did not turn his mind to the question of renal failure at all, I am not convinced that this was the case. No reasonable medical practitioner in Dr Byrne's position could have failed to understand that Mrs Cook's biochemistry results and poor urinary output indicated acute renal failure to a significant degree. No reasonable medical practitioner could have failed to have understood the significance of her potassium levels. This is why I find Dr Byrne's management of Mrs Cook so perplexing. It is especially perplexing that there was no sense of urgency ever demonstrated by Dr Byrne in respect of his management of Mrs Cook. Equally puzzling is his failure to impart significant information to Dr Salisbury when he had a perfectly good opportunity to do so. Dr Salisbury needed to be told in plain terms as to what was going on with Mrs Cook. It was not sufficient for material to be faxed to her in the hope and expectation that she would read the relevant material, or for her to be copied in to the pending blood results of the 14 January. There was no reason why Dr Byrne could not have imparted that information on the phone.

6. Was Mrs Cook's death preventable?

6.1. The evidence demonstrates that Mrs Cook had been a lifelong smoker since the age of 14 and was actively smoking up until her hospital admissions on and following 13 January 2010. She had chronic airways disease and asthma for which she intermittently received steroids. She also had mild pulmonary hypertension. She had recently been under investigation for weight loss to under 50kg and malabsorption for which no cause had yet been established. This is all explained in the statement of Dr Timothy Brownridge to whom I have already referred[64]. Dr Brownridge was a medical practitioner at Calvary who was one of a team of intensive care specialists. Although, as I have recorded earlier, Dr Brownridge stated that on admission to the Calvary Critical Care Unit Mrs Cook was obtunded, hypoxic, in shock and in acute renal failure with profound acidosis and biochemical derangement, it is clear that she had been unwell for two to four weeks before this occasion with diahorrea, vomiting and increasing lethargy. In addition he speaks of Mrs Cook's family having

[63] Transcript, page 717
[64] Exhibit C1a

expressed concern to him about Mrs Cook's deteriorating state of health over a period of about 18 months. Dr Brownridge describes Mrs Cook's presentation at Calvary, her operation and then her decline until her passing on 21 January 2010. As indicated earlier, Dr Brownridge was the medical practitioner who completed the doctor's certificate of cause of death. I find Dr Brownridge's stated cause or causes of death as set out earlier in these findings to have been Mrs Cook's cause of death. Dr Brownridge does not offer any opinion as to the contribution, if any, to Mrs Cook's ultimate cause of death from the course of events that spanned 13 and 14 January 2010, in particular her deterioration over that period and the delay in her transfer to Calvary.

6.2. I have already referred to the involvement of Mr Darren Tonkin, the general surgeon whose care Mrs Cook was under. Tendered in evidence is a letter written by Mr Tonkin to Dr Salisbury dated 21 January 2010[65], the day of Mrs Cook's death. The letter advised Dr Salisbury of Mrs Cook's death. In that letter Mr Tonkin explains the nature of Mrs Cook's surgery that had taken place on Saturday 16 January 2010 following 48 hours of resuscitation in the Calvary Critical Care Unit during which her electrolyte parameters were normalised. In the letter Mr Tonkin makes the point that the surgery was successful and had been conducted without complication. Mr Tonkin explains Mrs Cook's post operative care and makes it plain that she had ongoing respiratory problems on the background of her already existing chronic obstructive airways disease. Mrs Cook's decline and death is also described in the letter. In the letter Mr Tonkin suggests that Mrs Cook probably would have been better off having come to Adelaide a day or two earlier. He makes the point that Mrs Cook was 'a lot sicker' when she arrived in Adelaide than Mr Tonkin had expected. Mr Tonkin did not express any opinion in the letter as to whether or not Mrs Cook would have survived, or possibly would have survived, if she had been transferred with the urgency that Mr Tonkin was suggesting could appropriately have occurred in her case.

6.3. Dr Joyner in his evidence before the Court was asked to consider Mrs Cook's prognosis and in particular the effect of delayed transfer to Adelaide. I set out in full Dr Joyner's evidence in this regard:

> 'It's difficult to be sure because it's only a guess, or an educated guess. There's several things I took into account when coming up with my answer which I'll give you in a

[65] Exhibit C11h

> moment. If we look at her stay during the time at Calvary, she was essentially - went to ICU on admission because her state had deteriorated markedly from when she left South Coast. She then was treated and resuscitated, for want of a better word, and her condition stabilised. She undertook an operation which was relatively simple and straightforward, one band only to be severed, and as I said, in the spectrum of surgery, a small operation. She was then - had been on the respirator and they tried, over the next week, to be able to have her off the respirator and off ... pack etc., which is external breathing help, and she was unable to breath satisfactorily by herself and then in that setting developed pneumonia and then died. In the background are factors to do with organ problems, kidney and liver, which gives rise to the multiple organ dysfunction. I can't accurately remember the biochemistry of her renal/kidney function immediately prior to her dying a few days after the operation, but as her main cause of death was her respiratory problem, that may well have been the problem which would have caused her to die irrespective of when she went to Calvary - or to Adelaide. It would be fair to say that, in my opinion, she should have been transferred earlier and that would have reduced the severity of her kidney dysfunction, electrolyte imbalance, etc., but I'd have to say that on balance, because of her respiratory failure being the cause of death probably it would not have changed her outcome unfortunately.' [66]

Dr Joyner also stated that delay puts a patient at greater risk of sudden events occurring, such as cardiac complications from high potassium levels. In addition, the kidneys and possibly other organs such as the liver may become damaged to a point where they cannot recover completely and that aspect of poor function would affect a person's general health[67]. Thus every little bit of dysfunction in her body adds to the inability of her body to deal with infections such as pneumonia in this case. Having regard to Mrs Cook's deterioration on the morning of 14 January 2010 as evidenced by the decline in oxygen saturation, Dr Joyner suggested that if Mrs Cook had been transferred the day before and her various biochemical problems been corrected, the flow on effect of the lowering of oxygen saturations may not have happened. So in that sense she would have been in better condition without going to some degree of respiratory failure if she had been transferred to Calvary the night before. Dr Joyner said that taking into account the facts known on the evening of 13 January 2010, in his view it was clear that the sensible course would have been to transfer her at that stage and that this would have given her the best chance of survival. However, Dr Joyner added the rider that she may not have survived in any event[68].

6.4. Dr Joyner's opinions during the course of the Inquest were made known to Mr Tonkin, Mrs Cook's surgeon. Mr Tonkin in a statement dated 6 December 2013[69]

[66] Transcript, pages 725-726
[67] Transcript, page 727
[68] Transcript, pages 729-730
[69] Exhibit C17a

indicated that he does not have a view that differs from that of Dr Joyner. Mr Tonkin observes that Mrs Cook was a very frail woman, and although it would have been optimal for her to have come earlier to the Calvary, Mr Tonkin was unable to say whether it would have changed the outcome.

6.5. In the light of the evidence, the Court is unable to make positive finding that Mrs Cook would have survived if she had been transferred to an Adelaide hospital on the night of 13 January 2010. Put in another way, it is not possible for the Court to say that the failure to transfer, or any other shortcoming in Mrs Cook's management, contributed to the cause of her death.

7. Recommendations

7.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

7.2. I have found the issues in this Inquest to have been difficult in their resolution. This is because it seems that there was an element of irrationality about Mrs Cook's clinical management that is difficult properly to explain. Even if it could be regarded as reasonable for Mrs Cook not to have been transferred to the city on the afternoon or evening of 13 January 2010, but to have observed her overnight instead, it is unfathomable that Mrs Cook was permitted to linger at the SCDH for what effectively was all of the following day when clearly what was required on any analysis of her presentation on the morning of 14 January 2010 was immediate transfer out of the SCDH to a facility that could provide appropriate care. There were systems in place for Mrs Cook to have been so transferred. Dr Byrne ought to have known that Mrs Cook was seriously ill and that the correct priority for transfer was immediate transfer. Mrs Cook had not improved overnight with conservative management. There can be little doubt that if Mrs Cook's case had been accorded the correct priority, and that this had been conveyed to SAAS as distinct from the vague arrangement that they would arrive 'as soon as possible', Mrs Cook would have been transferred with the necessary urgency. It was not as if Mrs Cook's clinical presentation was ambiguous. If plain terms had been used by Dr Byrne both in discussion with nursing staff or with Dr Salisbury, one can be reasonably confident that Mrs Cook's transfer would have been timely. For all of those reasons the Court

has found it somewhat difficult to formulate recommendations that might prevent such a death of Mrs Cook's in the future.

7.3. Ms Kereru, counsel assisting the Court, submitted that this Court could make two recommendations based upon the need for education of rural medical practitioners in relation to the significance of electrolyte imbalances and the deteriorating patient and, secondly, the need for proper communication between nursing staff and ambulance officers in respect of priority for transfer. Having considered the matter carefully it seems to me that both of these matters would not need to be the subject of recommendation. Firstly, as far as education of rural practitioners is concerned, the matters that related to Mrs Cook's clinical status which were discussed during the course of this Inquest are so fundamental that no reasonable rural practitioner could have failed to have understood them. There was nothing arcane about any of the medical concepts involved. To my mind there is no need for general education to be directed towards rural practitioners other than having these findings drawn to their attention. As far as communication between nursing staff and SAAS operators is concerned, I was told in evidence that SAAS have a triage priority system that works perfectly well and is clear in its interpretation and application. I do not see any need for it to be modified in any way, except to the extent that vague arrangements that are not within the triage priority system, such as those based upon notions such as 'as soon as possible', clearly need to be eliminated from any conversation that is conducted between nursing staff of a hospital and SAAS. I so recommend.

7.4. The Court understands that practitioners of the Mill House Medical Centre now have practising rights at the SCDH.

Key Words: Hospital Treatment; Country Areas – Medical Service

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 5th day of February, 2014.

Deputy State Coroner