CORONERS ACT, 2003

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 4th and 5th days of June 2013, the 3rd, 4th, 5th and 24th days of July 2013 and the 21st day of March 2014, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Beryl Jean Morgan.

The said Court finds that Beryl Jean Morgan aged 73 years, late of Peninsula Residential Care, 8 Mine Street, Kadina, South Australia died at Wallaroo Hospital, Ernest Terrace, Wallaroo, South Australia on the 26th day of June 2010 as a result of pneumonia and renal failure with hyperthermia. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Mrs Beryl Jean Morgan, aged 73 years, died on 26 June 2010 at the Wallaroo Hospital having been admitted the previous afternoon. Mrs Morgan had been a resident of the Peninsula Residential Care Centre (PRCC) in Kadina on the Yorke Peninsula.

1.2. Mrs Morgan had a number of comorbidities that included a history of bipolar affective disorder and type 2 diabetes. Mrs Morgan's longstanding mental illness had caused her to be admitted to the PRCC several years before. It was also thought in the last stages of her life that aside from her mental illness, Mrs Morgan was developing dementia. Mrs Morgan's mental illness had been managed for a considerable period of time by a number of different medications that had been prescribed by a general practitioner. Shortly before her death she had been prescribed the antipsychotic

(neuroleptic) drug, Haloperidol. The administration of this drug is said to have been one of the contributing factors involved in Mrs Morgan's decline and death. Indeed, on the day before her death a local medical practitioner had formed the view that Mrs Morgan was suffering from a condition known as neuroleptic malignant syndrome (NMS), caused in her case by Haloperidol. In reality this impression progressed no further than a differential diagnosis that, in the event, was not established with clinical certainty prior to Mrs Morgan's death.

1.3. A post-mortem examination of Mrs Morgan was conducted by Dr Cheryl Charlwood, a forensic pathologist at Forensic Science South Australia. The salient features of the pathological findings included pneumonic consolidation bilaterally, dark urine and the presence of Haloperidol and Venlafaxine, an antidepressant, in Mrs Morgan's post-mortem blood. Dr Charlwood naturally had access to the clinical information in respect of Mrs Morgan's recent admission at the Wallaroo Hospital which had included marked dehydration and a differential diagnosis of possible NMS.

1.4. In her post-mortem report[1] Dr Charlwood expresses the cause of death as follows:

> '1 a) PNEUMONIA AND RENAL FAILURE WITH HYPERTHERMIA
> b) NEUROLEPTIC MALIGNANT SYNDROME (HALOPERIDOL THERAPY)'

Dr Charlwood gave oral evidence in the Inquest and there provided a more fluent expression of the cause of death, namely:

> 'Pneumonia, renal failure with hyperthermia, probably due to neuroleptic malignant syndrome or complicating haloperidol therapy with neuroleptic malignant syndrome.' [2]

I did not understand Dr Charlwood to have made any post mortem finding that was solely attributable to NMS. Rather, Dr Charlwood's opinion as to the contribution of NMS was based upon an assessment of Mrs Morgan's clinical picture before her death.

1.5. During the course of the Inquest differing hypotheses arose as to the contributing factors involved in Mrs Morgan's death. Expert views differed, not unreasonably, as to whether Mrs Morgan had experienced NMS complicating Haloperidol therapy, or whether in fact Mrs Morgan had been experiencing serotonin syndrome, a condition engendered by SSRI medication, and possibly complicated in her case by the addition

[1] Exhibit C9
[2] Transcript, page 21

of Haloperidol therapy. This latter opinion was proffered by Associate Professor Craig Whitehead, an independent geriatrician and Regional Clinical Director for Rehabilitation and Aged Care for the Southern Local Health Network, who was engaged by counsel assisting the coroner to provide an expert overview of Mrs Morgan's care in the period before her death. A third issue, namely whether either syndrome had been in existence at all in Mrs Morgan's case, was also debated at the Inquest. Additionally, the contribution, if any, of Haloperidol to Mrs Morgan's decline and death was questioned. However, there can be little doubt that the immediate cause of Mrs Morgan's death was pneumonia. I have also accepted Dr Charlwood's opinion that renal failure with hyperthermia was also part of the cause of Mrs Morgan's death.

1.6. After careful consideration of the evidence in its entirety, and having regard to counsel's submissions, I have concluded that it is not appropriate for the Court to refer to NMS and its possible association with Haloperidol therapy in the finding as to the cause of death. To summarise, although Mrs Morgan's clinical picture was not inconsistent with either NMS or serotonin syndrome, the question as to whether she had been experiencing one syndrome or the other, or at all, has not been answered with sufficient certainty. Moreover, while a strong element of suspicion exists that Haloperidol therapy played a role in Mrs Morgan's decline, the suspicion in large part arises from the temporal connection between its administration and that decline and upon a clinical impression only. Its role to my mind has not been established with sufficient clarity. There was a competing possible explanation for Mrs Morgan's presentation and decline, namely pneumonia caused by aspiration unconnected with NMS, SSRI medication or Haloperidol consumption. As well, her clinical picture and symptomatology in the period just prior to her death was not wholly out of keeping with certain features of Mrs Morgan's longitudinal medical history that had included well documented episodes of diaphoresis, agitation and swallowing difficulties. I am also mindful of the fact that there is an issue in this case in respect of the appropriateness of this therapy, particularly in relation to the prescribed dosages. In the circumstances an underlying finding that the prescription of Haloperidol contributed to Mrs Morgan's death would in my view require the Court to reach such a conclusion on evidence that is clear and it would require a very high degree of satisfaction for such a conclusion to be drawn. To my mind the evidence, on careful analysis, cannot be so characterised and I am not so satisfied. For all of those reasons

I do not recite any contribution of Haloperidol therapy in Mrs Morgan's cause of death. However, I am satisfied that the immediate cause of Mrs Morgan's death was pneumonia of an uncertain aetiology together with renal failure and hyperthermia.

1.7. Having not been satisfied that Haloperidol therapy was instrumental in Mrs Morgan's decline and death, it would not be appropriate to make any finding as to the appropriateness of this therapy.

1.8. Of greater relevance to the Inquest was an examination of the adequacy of the level of care that was given to Mrs Morgan in the final stage of her life.

1.9. I find that the cause of Mrs Morgan's death was pneumonia and renal failure with hyperthermia.

2. Background

2.1. Mrs Morgan's behaviour in recent times had deteriorated. In the clinical notes for Mrs Morgan kept at the PRCC it is evident that in the several weeks prior to her fatal episode there had been occasions involving aggressive behaviour towards staff and other residents. There are a number of references also to agitation and verbal aggression. By the beginning of June 2010 it was noted that Mrs Morgan's behaviour had not altered for the better, with a notation that there was an impression of dementia.

2.2. Members of Mrs Morgan's family lived locally. There are notations in the clinical notes for the facility that illustrate occasions on which nursing staff contacted members of Mrs Morgan's family to explain their concerns about Mrs Morgan. Ms Katrina Ann Penney is the daughter of Mrs Morgan. She gave oral evidence in the Inquest. Ms Penney also provided a statement to police dated 28 June 2013[3]. Ms Penney herself is an enrolled nurse and at the time of this Inquest was working at the Star of the Sea Nursing Home at Wallaroo. Ms Penney explained her mother's history, and in particular her mother's engagement with the PRCC that commenced when Mrs Morgan was about 49 or 50 years of age. Mrs Morgan could not cope with living at home and her quality of life seemed to improve with proper medication and the proper routine provided by the PRCC. Ms Penney suggested that she was the

[3] Exhibit C1b

primary next of kin for the purposes of liaison between Mrs Morgan's family and the PRCC. Ms Penney saw her mother on a weekly basis at the PRCC.

2.3. I have already referred to the medication that Mrs Morgan was being administered. It is necessary to mention some detail of this in order to place Mrs Morgan's decline in proper context. As well, regardless of whether or not the addition of Haloperidol to Mrs Morgan's medication contributed to her presentation, there is force in the contention that it ought to have dictated a greater degree of monitoring of Mrs Morgan's wellbeing on the part of nursing staff at the PRCC. In the event, a suspicion that Haloperidol was contributing to Mrs Morgan's presentation, as entertained by nursing staff, caused them to stop that medication. More of that in a moment.

2.4. On 4 June 2010 Mrs Morgan was seen at the PRCC by Dr Michael Gregg who was one of the medical practitioners attached to Kadina Medical Associates, a private medical practice in Kadina. It was on this occasion that Dr Gregg added Haloperidol to Mrs Morgan's medication regime at the dosage of 1.5mg twice per day. The notation of that day in the clinical notes for Mrs Morgan suggested that this was added to the regime in the first instance to assess her response in terms of her behaviour with the possibility that Risperidone, another anti-psychotic drug, in due course would be ceased with an increase of Haloperidol. As I understood the evidence this medication regime continued until 17 June 2010 when Dr Gregg increased the dosage of Haloperidol to 5mg twice per day due to the fact that Mrs Morgan's behaviour had not improved. There are entries in the clinical notes in the days preceding 17 June 2010 that suggest that Mrs Morgan had been quite disruptive, had been yelling and swearing at staff and others and that several one-on-one interventions had been required. After settling it was noted that Mrs Morgan would soon display the same behaviour. There were a number of recorded instances of agitation and yelling and the delivery of abuse to other residents with little effect from one-on-one intervention. Refusal to eat and verbal agitation directed at staff when attending to Mrs Morgan's ADLs is also noted. The evidence is not entirely clear as to when exactly the first increased dosage of Haloperidol was administered, but for the purposes of this finding it seems to have been on or about 18 June 2010. I note that the evidence made it reasonably clear that the administration of Risperidone was discontinued at the same time in accordance with Dr Gregg's initial plan of 4 June 2010.

2.5. By 23 June 2010 staff observed that Mrs Morgan's physical condition had deteriorated. One notation of 23 June 2010 suggested that Mrs Morgan was suffering badly from tremors, was unable to give herself a drink without spilling it everywhere and was noted to have sweats and a flushed appearance. Attempts were made on that day and the next to secure Dr Gregg's attendance at the facility. Dr Gregg did attend on the evening of 24 June 2010 and he reviewed Mrs Morgan on this occasion. A notation of 24 June 2010 suggests that staff contacted Ms Penney on this day about her mother.

2.6. Nursing staff stopped Mrs Morgan's Haloperidol medication as they suspected that it might be contributing to her presentation. Dr Gregg would confirm that discontinuance when he reviewed Mrs Morgan on the evening of 24 June 2010.

2.7. On the following day, 25 June 2010, Dr Daniel Lu, also of the Kadina Medical Associates' practice, attended at the PRCC and saw Mrs Morgan there. Mrs Morgan at that point was profoundly unwell and so Dr Lu arranged for her to be transferred to the Wallaroo Hospital in the first instance with a view to having Mrs Morgan ultimately transferred to the Royal Adelaide Hospital (RAH). From Dr Lu's assessment of Mrs Morgan he suspected NMS due to recent Haloperidol administration, which in fact had already been ceased. One significant feature of Mrs Morgan's presentation when seen by Dr Lu was his clinical assessment of severe dehydration. This assessment was made in the nursing home. At the Inquest, nursing staff who were called to give evidence eschewed the suggestion that Mrs Morgan had not been hydrated adequately in the days before her terminal collapse. Assertions that Mrs Morgan had in fact been appropriately hydrated could not be substantiated by written records. I accepted Dr Lu's evidence that Mrs Morgan was very dehydrated when he examined her at the nursing home.

2.8. On admission to the Wallaroo Hospital on 25 June 2010 severe dehydration would be confirmed in Mrs Morgan's biochemistry results. NMS is recorded as a differential diagnosis, no doubt on Dr Lu's assessment. The first notation timed at 2:35pm indicates that Ms Katrina Penney had discussed her mother's situation with her sister. It was decided that Mrs Morgan should be kept at the Wallaroo Hospital and that comfort care should be provided only. In the event, Mrs Morgan was not sent to the RAH. She was provided with comfort care and she died the following day. The notation states that Mrs Morgan's respirations ceased at 6:40am.

3. Mrs Morgan's decline and management

3.1. I have already referred in brief terms to Mrs Morgan's deterioration in the days prior to her admission to the Wallaroo Hospital and death. On 22 June 2010 a clinical note describes Mrs Morgan as having been very shaky and '*sweating* + + +' during the afternoon. The following day, as already alluded to, Mrs Morgan was suffering from tremors to the point where she was unable to give herself a drink without spilling it. She has had intermittent sweats and a flushed appearance. At that time her blood glucose level (BGL) was 16.1 which is elevated. As a result of these observations, nursing staff intramailed Dr Gregg at the Kadina practice in the hope and expectation that Dr Gregg would attend to assess Mrs Morgan. Intramail was an email type of device that enabled nursing staff of the facility to communicate with doctors and staff of the Kadina practice. It is obvious, and I so find, that Mrs Morgan's presentation on 23 June 2010 was something out of the ordinary notwithstanding her chronic conditions, prompting as it did the need for Dr Gregg to come and see her. The intramail message which was compiled by a registered nurse, Julie Bailey, said that Mrs Morgan '*really isn't herself'* and that something was '*going on*'[4]. Dr Gregg did not attend that day, nor did any other practitioner from his practice attend at the nursing home that day. In fact, no response from the practice was received. A nursing note timed at 9:57pm that evening, which was nearly 9 hours since Dr Gregg had been intramailed, described Mrs Morgan as having offensive urine but that a urine analysis was not able to have been obtained on the ward. She is noted to have remained in bed unwell and was profusely sweating.

3.2. On 24 June 2010 a note timed at 6:25am describes Mrs Morgan as having sweated intermittently with tremors overnight. At 9am Nurse Julie Williams entered a note into the clinical record which acknowledged the earlier nursing note adding that Mrs Morgan had a red rash to her upper body and had tremors. Ms Williams contacted Dr Gregg's medical practice at 8:50am. In her witness statement[5] Ms Williams explained that on that morning she was concerned that something was not right with Mrs Morgan. She thought there may have been a drug interaction involving Haloperidol. As a result she stopped the administration of that medication.

3.3. In her oral evidence before the Court Ms Williams was not certain as to whether she had spoken to Dr Gregg himself or to one of the practice's nurses, but she had an

[4] Exhibit C8a
[5] Exhibit C11

expectation that Dr Gregg would return her call. It does not appear that Dr Gregg returned the call.

3.4. A further intramail addressed to Dr Gregg was sent by Ms Williams timed at 12:13pm. The intramail requested Dr Gregg to review Mrs Morgan '*ASAP*'. The message went on to describe profuse sweating, tremors, the blotchy red rash to her upper body and difficulty swallowing. In the intramail Ms Williams raised a question as to whether or not Mrs Morgan's presentation was a reaction to Haloperidol in conjunction with another drug. The intramail described some of Mrs Morgan's vital signs including an elevated BGL of 16.1.

3.5. In her oral evidence Ms Williams suggested that Mrs Morgan's presentation on 24 June 2010 was in keeping with her general presentation over the previous few months, except for her rash. Ms Williams told the Court that she did not observe any sign of dehydration on 24 June 2010.

3.6. Ms Williams did not purport to have attempted to contact Dr Gregg again that day by telephone. Ms Williams worked until 3:30pm that day. She did not work at the facility again until 26 June 2010, the day of Mrs Morgan's death at the Wallaroo Hospital. Ms Williams told the Court that it was her belief that a sample for urinalysis had been taken from Mrs Morgan on the morning of 24 June 2010. On 26 June 2010 at 2:11pm, which was at a time after Mrs Morgan's death earlier that day, Ms Williams would enter what appears to have been the final clinical note relating to Mrs Morgan and it stated as follows:

> 'Late entry for 24/6/10 : Urinalysis obtained, PH 5, SG, 1.025, NAD'

If correct, this urinalysis demonstrated no abnormality and would not have signified to nursing staff any dehydration in Mrs Morgan at the time the urinalysis was undertaken. However, other evidence that I will discuss would suggest that the significance of such a result would be limited if not misleading. There was no record kept within Mrs Morgan's file of the urinalysis results as originally written down. Ms Williams told the Court that the original record would have been made on the handover sheet that was no longer available at the time of inquest. Ms Williams suggested that in order to record the urinalysis result in the clinical record on 26 June 2010, she would have access to the original handover note. I will return to this unsatisfactory aspect of the matter in due course.

3.7. Enrolled Nurse Julie Bailey entered a note in the clinical record timed at 2:25pm on 24 June 2010 recording that Dr Gregg had been intramailed again. Dr Gregg had been intramailed at 12:13pm. Ms Bailey's note recorded Mrs Morgan as having trouble swallowing and that she still had tremors, a flushed appearance and was profusely sweating, although she stated that she felt good. There is a note included in this entry to the effect that Ms Williams had contacted Mrs Morgan's daughter, Katrina, to inform her that they were waiting for Dr Gregg to review her mother. Ms Penney had indicated that she would probably visit her mother the following day. This entry also recorded certain vital signs including a persisting elevated BGL of 15.1.

4. Dr Gregg's involvement and his review of Mrs Morgan

4.1. Dr Gregg attended at the nursing home to see Mrs Morgan during the evening of 24 June 2010. This occurred sometime prior to 10:19pm at which time an enrolled nurse, Ms Julie Chivell, made a note of Dr Gregg's attendance in the clinical record. Dr Gregg himself did not make any note in respect of his attendance. It will be remembered that Dr Gregg by way of intramail had initially been asked to attend to review Mrs Morgan on the afternoon of the day before.

4.2. I will discuss Dr Gregg's own recollections of this review in a moment, but it is as well first to refer to the statements of Ms Julie Chivell in relation to this attendance. Ms Chivell provided two statements to the Inquest[6]. The statements were taken on 3 July and 11 July 2013 respectively. The only other written material upon which Ms Chivell could rely are a number of entries within the clinical record including one that relates to Dr Gregg's attendance on the evening of 24 June 2010.

4.3. Ms Chivell was an enrolled nurse at the PRCC. Ms Chivell statements explain that she had been on duty during both evenings of 23 and 24 June 2010. It was Ms Chivell who had unsuccessfully attempted to conduct a urinalysis on the evening of 23 June 2010 at which time she noted that Mrs Morgan had remained in bed unwell and was profusely sweating. In her statements Ms Chivell added that she had recorded a high blood sugar level that evening and thought that this might be reflective of a urinary tract infection. Ms Chivell indicates in her statement[7] that she

[6] Exhibits C16 and C16a
[7] Exhibit C16, paragraph 18

had an expectation that a urinalysis would be obtained during the following shifts. She does not recall whether she herself performed it during her next shift.

4.4. As to Dr Gregg's attendance, Ms Chivell's statements record that she recalls Dr Gregg attending at around 6pm to 7pm for the specific purpose of seeing Mrs Morgan. She remained with Dr Gregg during the review. She asserts that she did not see Dr Gregg '*take observations*'[8]. Ms Chivell noted in her entry in the clinical record that Dr Gregg requested Haloperidol to be ceased and that he would review Mrs Morgan in one week. Ms Chivell's second statement[9] was taken in order to clarify matters from her first statement. In the second statement she indicates that at the start of her shift that day Mrs Morgan was stable and that she ate and drank but had been generally unwell[10]. She does not recall anything specific about sweating, tremors, speech or vagueness at the time of Dr Gregg's examination, although it is to be observed that in her entry in the clinical record made later that evening she indicated that the patient continued to sweat and still has tremors. In any event Ms Chivell asserts in this subsequent statement that Mrs Morgan had a rash on her upper body for a day or so and that she did in fact have tremors and sweating on both days, 23 and 24 June 2010 and that they were worse than her normal condition. It is highly unlikely that Mrs Morgan's sweating and tremors, the salient features of her presentation, abated at any time. I find that she exhibited these signs during Dr Gregg's attendance.

4.5. Ms Chivell asserts that Dr Gregg's clinical examination of Mrs Morgan consisted of sitting down on the bed next to her and talking to her. It will be recalled that Mrs Morgan had recorded significantly higher BGLs in the recent few days. These included a BGL of 17.9 that Ms Chivell had noted herself. Ms Chivell asserts in her second statement that she does not specifically recall whether she told Dr Gregg of the BGL, or anything about a urinalysis or dehydration, but that it would be her usual practice to do so, including reference to her observations of Mrs Morgan's offensive urine and her concern that she might have a urinary tract infection. Regarding dehydration, Ms Chivell asserts that she did not believe Mrs Morgan to have been dehydrated. She had based that assessment on an absence of signs of dehydration, Mrs Morgan's copious sweating and the absence of any report from other staff that Mrs Morgan was not taking fluid. Ms Chivell does not recall Dr Gregg saying

[8] Exhibit C16, paragraph 20
[9] Exhibit C16a
[10] Exhibit C16a, paragraph 2

anything about Mrs Morgan's presentation or what it might be consistent with. Ms Chivell asserts that she does not recall whether or not Dr Gregg asked to inspect Mrs Morgan's clinical record or whether in fact he did so.

4.6. Ms Chivell's second statement asserts that when Dr Gregg came into the facility he was rushed. This would be in keeping with what on Ms Chivell's description appears to have been of a somewhat cursory examination by him and by the fact that Dr Gregg did not himself make any note either in the clinical record nor on the drug chart, the latter omission being contrary to his usual practice.

4.7. Dr Gregg is an experienced general practitioner who commenced practice in Kadina in 1997. In 2010 there were approximately eight partners in the Kadina medical practice. Dr Gregg told the Court that aside from his work in Kadina, he practised at the Wallaroo Hospital servicing both the clinic and an inpatient practice in that institution. He also provided a service for the two aged care facilities in the region, one of which was the PRCC at Kadina. He also conducted a part time practice in Snowtown which he visited two half days per week on Tuesday afternoons and Friday mornings. Dr Gregg told the Court this:

> 'So in June 2010 I considered myself to be under extreme I guess time pressure, and in May 2010 I began negotiations with the Burra, Clare, Snowtown Hospital Board about stopping going to Snowtown and that eventually - that eventuated at the end of 2010, so New Year's Eve I think was my last working day - 2010 in Snowtown.' [11]

4.8. Dr Gregg provided two signed statements to the Inquest. The first statement was given to investigating police on 4 July 2012[12], two years after the events with which this Inquest is concerned. A further signed statement dated 3 July 2013[13] was provided by Dr Gregg's legal representatives. Dr Gregg gave oral evidence at the Inquest. For reasons that will become apparent, I found the analysis of what Dr Gregg could recall of the events with which this inquest was concerned to be difficult. His recollections of what occurred and of what he thought appear to have come back to him in a piecemeal fashion. I was not convinced that Dr Gregg was completely reliable as to his recollections.

4.9. In Dr Gregg's first statement he pointed out that at the time of Mrs Morgan's death it was the busiest time in his professional life. In 2010, due to the pressure of work at

[11] Transcript, pages 513-514
[12] Exhibit C17a
[13] Exhibit C17b

that time, he was in the process of negotiating with a view to cease visiting Snowtown. Dr Gregg points out that by June 2010 he had given 13 years of dedicated, passionate service to the town of Snowtown which would otherwise not have had a doctor. Dr Gregg describes the cessation of the Snowtown practice as a highly emotional and difficult decision that was forced on him by extreme physically debilitating work circumstances that were exacerbated by doctor shortages at the Kadina clinic. He also pointed out that at that point in time, the number of phone calls that he would receive on any given working day could be extraordinarily high. Those calls could come from health professionals including those in nursing homes, nurses from two hospitals, district nurses, pharmacists, other doctors and from Adelaide hospitals. He also described the impact of internal calls, both clinical and administrative, that he had to deal with in his own practice. Many of these calls involved the supervision of interns within the clinic. In his statement of July 2013 Dr Gregg provided more detail about his practising regimen as it had existed in 2010. The detail does not need to be repeated here except to say that it was clearly an arduous regimen. As well, in his capacity as the practice principal at Kadina, Dr Gregg bore a significant administrative workload, and even then his allocated time for the pursuit of his administrative duties and responsibilities was frequently consumed by the need to see numerous patients.

4.10. As to the intramail system, Dr Gregg suggested in his first statement that his usual practice was to check incoming intramails when he had free time, usually at the end of the working day. He stated that there were a number of reasons to explain why an intramail may not be checked or acted upon immediately, or even on the day it was received. He was unaware of any formal guidelines on intramail management, but acknowledged an obligation to check intramail and email. He regarded intramail as a second grade means of communication, most useful for non urgent and non clinical communications, whereas for urgent communication the telephone was a much more efficient and safe means. I observe here that at the time at which this Inquest was concerned, the PRCC possessed a written procedure[14] in respect of intramail communication between the facility and the Kadina medical practice that confined its use to non urgent matters and which stipulated that in respect of matters that required medical attention within 24 hours, intramail was not appropriate. The policy

[14] Exhibit C11c

mandated that in such circumstances, telephone contact must be made with the appropriate doctor.

4.11. Dr Gregg's original statement to police asserts that he had no recollection that nursing staff had become concerned about Mrs Morgan's condition in the period leading up to her hospitalisation and death. He stated that he could not recall receiving any notification about her condition, and in particular could not recall receiving telephone calls or intramails about Mrs Morgan. The impression that this statement creates is that he knew nothing of Mrs Morgan's decline until 25 June 2010 when he discovered that Mrs Morgan was in the Wallaroo Hospital. Dr Gregg's second statement and his oral evidence at the Inquest would differ from that position.

4.12. In Dr Gregg's more recent statement, his stated recollections of events spanning the period from 23 to 25 June 2010 concerning Mrs Morgan are more acute than those that he had expressed in his original police statement. The intramail sent by Ms Bailey at approximately 1pm on 23 June 2010 was not something that Dr Gregg specifically remembered seeing, but he states that he recalled a phone request to attend at the nursing home[15]. In another paragraph of the same statement[16] Dr Gregg appears to assert that he did see the intramail on the day in question but did not regard it as requiring a particularly urgent response. He believed that he had planned to see Mrs Morgan the following day.

4.13. The more recent statement asserts that in respect of the phone call made from the PRCC to the practice at 8:50am on the following morning, Thursday 24 June 2010, he has a moderate to reasonably strong recollection of receiving that call. He believes that he was at that time enroute from the Wallaroo Hospital where he had seen patients. This was a Thursday morning which was his allocated administrative function period, but his records indicated that he in fact saw twelve patients that morning. Duties later that day enabled him to perform some administrative tasks but the afternoon was taken up by the supervision of junior practitioners' consulting sessions. As to the lunchtime intramail message of that day, he asserted that he had no recollection of receiving via intramail any message to review the patient.

4.14. Dr Gregg's second statement also deals with the question of his attendance at the nursing home on the evening of 24 June 2010 at which Ms Chivell was present. He

[15] Exhibit C17b, paragraphs 81-82
[16] Exhibit C17b, paragraph 83

stated that he had no recollection of personally reviewing the patient at the nursing home on that day.

4.15. At the Inquest Dr Gregg gave oral evidence at some length. Dr Gregg testified that he still had no recollection of receiving any of the intramails that were sent from the PRCC and which were addressed to him[17]. However, he told the Court that he could '*reconstruct*' that he had in fact opened the intramail on 23 June 2010. He accepted that at some point he must have opened the intramails of 24 and 25 June 2010, although he did not know when it was that he had opened those messages. I will deal with the events of 25 June 2010 in the next section. Dr Gregg's acknowledgement that must have opened the intramail of 23 June 2010 on that day appears to be at odds with his written statements, but it seems that nothing turns on this because of his general acknowledgement that on 23 June 2010 he had an appreciation by one means of communication or another that the PRCC staff wanted him to attend to see Mrs Morgan.

4.16. Dr Gregg did not purport to explain in his evidence why it was that he did not attend on 23 June 2010 as requested. However, in his statement of July 2013 he stated that on that evening he had been working until reasonably late and that he had gone home and gone straight to bed. In this context he alluded to the burden of work that he was experiencing at that time. The other point that Dr Gregg makes is that he did not regard the need to see Mrs Morgan as being particularly urgent. In assessing the validity of this assertion, it will be observed that the originating intramail sent by the nursing home referred to Mrs Morgan's tremors being so severe that she could not even hold a drink without spilling it everywhere. That said, the general tenor of the intramail of that day does not of itself suggest that Mrs Morgan was in any imminent danger of collapse. It refers to all of her vital signs as being satisfactory. It is difficult to conclude, therefore, that there was anything wholly unreasonable about a decision by Dr Gregg to defer any review of Mrs Morgan until the following day. If there had in fact been any sense of urgency in the need to review Mrs Morgan, Dr Gregg might have been entitled to expect serial attempts to contact him by phone as opposed to intramail which was, strictly speaking, supposed to be confined to non urgent matters.

4.17. As to the events of 24 June 2010, in his oral evidence Dr Gregg stated that he recalled receiving a phone call on 24 June 2010, remembering of course that Ms Williams

[17] Transcript, page 557

asserted that she attempted to phone him at 8:50am that morning. However, he could not recall to whom he spoke or whether that person was even a nurse or perhaps a person at the clinic[18]. Somewhat unexpectedly having regard to the contents of his previous statements and in particular to the fact that the second of those statements was compiled shortly before he gave oral evidence, Dr Gregg told the Court that in fact he did have a recollection of the attendance at the PRCC on the evening of 24 June 2010 after all. Dr Gregg's recollection of this attendance on Mrs Morgan appears to have been revived by his having read Ms Chivell's witness statement shortly before he gave evidence. Dr Gregg did not dispute anything contained within Ms Chivell's statement as to her account of these events[19]. Although he could not identify the precise occasion, he told the Court that he was at home when Ms Chivell telephoned him sometime between 7pm and 8pm. He recalled in general terms that Ms Chivell was seeking his opinion as to whether Mrs Morgan should go to hospital. As a result of that call he attended the nursing home to make an assessment of Mrs Morgan. Clearly DR Gregg here was recalling and describing the events of the evening of 24 June 2010. I so find. Dr Gregg did not have any specific recollection of the features of Mrs Morgan's then presentation, in particular of tremors and sweating as would be noted by Ms Chivell, nor of ordering the cessation of Mrs Morgan's Haloperidol medication, nor of his intention to review Mrs Morgan in one week's time. The impression that Dr Gregg obtained upon reviewing Mrs Morgan was that she was not sick enough to be in hospital, being '*not too dissimilar to the state she'd been in recent weeks*'[20]. Dr Gregg believed that he looked through the clinical notes for Mrs Morgan and had a recollection, which he described as '*not a firm memory*', that he assessed Mrs Morgan's vital signs as written in the notes[21], including those recorded at about 2pm on 23 June 2010 that included a BGL of 16.1. He acknowledged that a blood sugar level of 16.1 would be described as a high blood sugar level. It will be observed that on the afternoon of 24 June 2010 the BGL was recorded at 15.1, also an elevated level.

4.18. In cross-examination by Ms Cacas, counsel assisting, Dr Gregg sought to cast some doubt upon whether he would have viewed the clinical notes, but acknowledged that he would usually speak to the nursing staff to find out what had been going on in

[18] Transcript, page 560
[19] Transcript, page 568
[20] Transcript, page 564
[21] Transcript, page 568

respect of a patient[22]. When asked as to what the nursing staff had told him on this occasion, he believed that he had received a briefing from the nurse and that he had attempted to establish through the nurse Mrs Morgan's measurable vital signs[23]. I think it is plain, and I so find, that by one means or another Dr Gregg came to understand during the course of his review of Mrs Morgan what her most recent measurable parameters had been, including high BGLs, the most recent of which had been recorded that day as being 15.1. To my mind it would be unthinkable for Dr Gregg to have been asked to review a patient in a nursing home, particularly in respect of an issue as to whether or not she should be hospitalised, without examining the most recent evidence of her objective wellbeing. As well, from the fact that he was phoned after hours, I find that Dr Gregg must have deduced a significant level of a concern on the part of nursing staff that Mrs Morgan's wellbeing had appreciably deteriorated. When asked by counsel assisting what he thought was wrong with Mrs Morgan that night, he stated as follows:

> 'Okay, look, as I said before, I felt this was falling into a pattern of progressive dementia that had been on a progressive course for a long period of time. I didn't think she was showing any features that she hadn't shown before. So the sweating was not new, agitation, I think - I vaguely remember that she was a bit agitated, that was nothing new. So for having followed her through for so many years, it just fell into a pattern of progression of her underlying clinical condition which considered to be, with multiple investigations in the past, had never shown any sign of any infection under these circumstances. There's pages and pages of investigations that have been done in the past when she presented in a similar fashion, and never showed any sign of any infection.' [24]

Dr Gregg did agree '*in retrospect*'[25] that the level of sweating that Mrs Morgan would have been exhibiting evinced a different pattern from her usual condition. He conceded that his prior knowledge of Mrs Morgan's chronic conditions might have clouded his judgment with regard to a potential acute condition on this occasion.

4.19. Aside from ceasing Mrs Morgan's Haloperidol administration, which already had been stopped by nursing staff, and his indication that he would review Mrs Morgan in one week, it is difficult to discern what if anything Dr Gregg did for Mrs Morgan when regard is had to what nursing staff had identified as an apparent acute exacerbation of Mrs Morgan's difficulties. Dr Gregg did not make any note of his

[22] Transcript, page 587
[23] Transcript, page 610
[24] Transcript, page 612
[25] Transcript, page 612

own in relation to Mrs Morgan. When asked as to why he did not make any note of his own, he said:

> 'I would say it's because of the - my level of stress, tiredness at that period of time, that I'm sure this call was after hours, maybe 7 or 8 o'clock at night and it would have taken time to switch on the computer records and put an entry in the computer records. I believe that would be my guess as to why that would have happened that way.' [26]

5. The events of 25 June 2010

5.1. Enrolled Nurse Rebecca Daly was on duty at the nursing home during the early hours of the morning of 25 June 2010. Ms Daly made three entries in the clinical notes in respect of Mrs Morgan's condition during the course of that night. A note made by her at 2am referred to Mrs Morgan's continued profuse sweating and tremors, together with a mottled rash on her inner thigh. Her observations at that stage included a temperature of 38.2° which is elevated and a BGL of 18.1 which is significantly high. She recorded that Mrs Morgan was extremely vague when spoken to and that her speech was incoherent. Ms Daly administered Panamax for Mrs Morgan's temperature.

5.2. Ms Daly made another entry onto the clinical record at 6:47am that referred to patient observations taken at 3:30am including a temperature of 38.1°. During the course of that night she had telephoned the Wallaroo Hospital to ascertain the identity of the on-call medical officer, but proceeded no further than the registered nurse who was on duty. This nurse is recorded as having given advice to continue monitoring Mrs Morgan's temperature and to persist with Panamax. Ms Daly attempted to cool Mrs Morgan with a flannel. Observations at 5:30am included the still elevated temperature and a BGL of 19.3. A further attempt to administer more Panamax was unsuccessful because Mrs Morgan could not ingest it.

5.3. Ms Daly gave oral evidence in the Inquest. As well, a statement given by her to police in April 2012 was tendered[27]. In her oral evidence Ms Daly explained that she had been asked to review Mrs Morgan by a carer who had clearly been concerned about Mrs Morgan's condition. Ms Daly had been sufficiently concerned about Mrs Morgan, and in particular by her failure to respond to Panamax as a means of lowering her temperature, to have telephoned the hospital. She explained in her

[26] Transcript, page 613
[27] Exhibit C15

evidence that she had endeavoured to contact the on-call medical officer but had been told by the registered nurse that the doctor was unavailable[28]. However, Ms Daly explained that she was not sufficiently concerned about Mrs Morgan to have considered transfer to hospital. She did not regard Mrs Morgan's observations as being extremely abnormal. She at least regarded Mrs Morgan as stable[29]. When asked as to whether she had considered Mrs Morgan to have been dehydrated, she told the Court that it was not something she had considered.

5.4. Ms Daly handed Mrs Morgan over to the registered nurse who came on duty that morning. As it happened, that person was Ms Daly's sister, registered nurse Jacqualyn Lawrence. Ms Lawrence was called to give evidence. She had provided a statement to police in April 2012[30]. Ms Lawrence came on duty at 7am and was still on duty at the time that Mrs Morgan was seen by Dr Lu and was transferred to hospital. Ms Lawrence did not purport to have a particularly good recollection of the events of that day, but by reference to a note in the clinical record that she made at 9:18am, it had been clear to her that Mrs Morgan's condition had deteriorated overnight. She endeavoured to contact an 'MO' by phone and in addition sent an intramail addressed to Dr Gregg timed at 9:15am asking him to review Mrs Morgan again, pointing out her deterioration and the fact that she had been running a temperature and was now '*chesty*'. It is clear that Dr Gregg did not respond either to a telephone attempt nor to the intramail attempt to communicate with him. In the event, Dr Lu, a Registrar at the Kadina practice, was made aware of the situation regarding Mrs Morgan and he attended at the facility. His attendance occurred at a time I find to have been between 11:30am and midday. In her oral evidence before the Court, Ms Lawrence curiously suggested that from the terms of her intramail and of her note in the clinical record made shortly thereafter, she did not regard the need for a doctor to attend as being urgent. Yet by the time of Dr Lu's arrival Mrs Morgan had clearly become acutely and profoundly unwell because she was seen by him upon his arrival to be unresponsive and that she required immediate hospitalisation. In particular, Dr Lu observed the high fever in Mrs Morgan, the fact that she was very sweaty and had a constant tremor. Her arms were very rigid. She was very dehydrated. I accept the evidence of Dr Lu as to his observations of Mrs Morgan. The impression that Dr Lu formed from her clinical condition and from recent entries in the clinical record about Mrs Morgan was that she had been in her present status for

[28] Transcript, page 435
[29] Transcript, page 445
[30] Exhibit C14

some hours. Dr Lu's impression of significant dehydration would be confirmed at the hospital once Mrs Morgan was admitted.

5.5. It is not clear to me what the condition of Mrs Morgan had been in the intervening period of about 2.5 hours between Ms Lawrence making her own note of her observations at 9:18am and the arrival of Dr Lu. In particular, I do not know at what point Mrs Morgan had become unresponsive. There is no record of unresponsiveness prior to Dr Lu's observation to that effect. Ms Lawrence was unable to help the Court as to the point in time at which Mrs Morgan had become so profoundly unwell as to have been regarded as unresponsive and in need of immediate hospitalisation. While Ms Lawrence did not claim to have sat with Mrs Morgan throughout the entire morning, she did assert in her evidence that if a carer or enrolled nurse had detected that Mrs Morgan was unresponsive, that person would have been under an obligation to inform Ms Lawrence. She could not recall receiving any such information. If she had received that information she would have telephoned the Kadina medical practice again and it also may have prompted ambulance involvement at that point in time. Ms Lawrence agreed that the detection of unresponsiveness in a patient, involving as it would by definition a lack of consciousness and a lack of any ability to verbalise or move, would be a medical emergency[31]. In her evidence Ms Lawrence was asked this series of questions:

> 'Q. Now if a close eye had been kept on her that morning then her state of unresponsiveness when it occurred would have been identified.
>
> A. Yes.
>
> Q. Do you agree with that.
>
> A. Yes.
>
> Q. And was it.
>
> A. I don't know.' [32]

5.6. Ms Lawrence did not recall Mrs Morgan appearing to have been dehydrated that morning.

5.7. I found the lack of detail about Mrs Morgan's condition throughout the period before the arrival of Dr Lu to be unsatisfactory.

5.8. Dr Gregg, I find, was not in Kadina on the morning of 25 June 2010. He attended the practice at Snowtown. Prior to that he had seen five patients at the Wallaroo Hospital

[31] Transcript, pages 406-408
[32] Transcript, page 409

and had performed one home visit. He did not normally attend at the Kadina practice before attending Snowtown on a Friday morning. He had no recollection of receiving any intramail that morning. I accept that evidence. Dr Gregg came to know about Mrs Morgan's predicament only later that day after she had been transferred to hospital.

6. The evidence of Professor Craig Whitehead

6.1. Professor Whitehead prepared a written report in relation to Mrs Morgan[33]. He also gave oral evidence in the Inquest. I have already referred to the divergence of opinion regarding the effect of Haloperidol administration. Much of Professor Whitehead's evidence concerned the possible relevance of Haloperidol administration as it may have complicated an already existing serotonin syndrome in his opinion. I do not need to say more about that issue as I was not satisfied that it played a role in Mrs Morgan's presentation.

6.2. Professor Whitehead gave evidence about Mrs Morgan's management as it had existed in the few days prior to her death. Nevertheless, and regardless of whether Haloperidol did play a role in fact, I accept the evidence of Professor Whitehead that the fact of Haloperidol administration required a level of monitoring closer than the norm, particularly having regard to Mrs Morgan's elderly status. In any event, Professor Whitehead was of the view that there were a number of issues surrounding a failure of care in respect of Mrs Morgan. In particular, he opined that there had been an inadequate assessment of Mrs Morgan's fluid intake. He expressed the view in his report that the issue:

> 'The issue of her progressive, quite severe dehydration occurring in the week prior to death appears not to have been noticed by the aged care facility at all.'

In Professor Whitehead's experience the inability to monitor fluid intake is quite common in aged care facilities. The evidence given in this Inquest from the PRCC nursing staff was to the effect that Mrs Morgan had been drinking a sufficient volume of fluid, or at least a sufficient volume had been made available to her for consumption. The fact remains, however, that by the time Dr Lu came to examine Mrs Morgan on 25 June 2010 she was significantly dehydrated and that this clinical impression was confirmed biochemically once she was hospitalised that day.

[33] Exhibit C10

Therefore, I find that there is validity in Professor Whitehead's observation that Mrs Morgan's progressive dehydration was something that went unnoticed despite any impression of fluid consumption to the contrary. In this regard I found the evidence of Ms Williams about her ex post facto recording of the urinalysis result of 24 June 2010, a result that was normal and showed no sign of dehydration, to be unconvincing. It was not supported by any other written material and any impression of normality as far as hydration is concerned is contradicted by Mrs Morgan's severe dehydration on 25 June 2010. Professor Whitehead stated in his report that most of the physical findings of dehydration are non-specific and do not necessarily reflect well in laboratory results. Therefore, while I am prepared with some hesitation to accept Ms Williams' evidence about the results of a urinalysis, it really means nothing in terms of Mrs Morgan's presentation on 25 June 2010 and the manner in which she should have been managed that day and the day before when her condition was acutely deteriorating. Another important point made by Professor Whitehead in his report was that the inability or failure to monitor fluid intake is not an uncommon circumstance in an aged care facility. Professor Whitehead stated that he personally had a number of clinical experiences of patients under his care who have presented as being profoundly dehydrated, often in the context of advancing dementia and the use of psychotropic drugs. Commonly there has been no attempt to measure fluid intake in the facility and frequently long periods of poor intake have occurred before eventual transfer to hospital. He regarded a minimum fluid intake prescription to be an important concept in frail, older people.

6.3. As to Mrs Morgan's quality of care between 23 and 25 June 2010, Professor Whitehead accepted that an aged care facility is not ordinarily constructed to deliver hospital level care. However, he suggested that in any aged care environment there needs to be a clear policy as to the circumstances in which it is considered no longer safe to keep someone in the facility. In his report Professor Whitehead posited what would have happened if Mrs Morgan had been living at home and her condition had been detected by a family carer. He suggested that with her symptoms, Mrs Morgan undoubtedly would have been taken straight to hospital by a family carer and that this would have occurred at a time well before the aged care staff at the PRCC in the event transferred her. The fact that Mrs Morgan resided in the country and not in an urban setting where there are large Emergency Departments, should in his view not have many any difference to the manner in which Mrs Morgan was managed. Professor

Whitehead believed that the staff of the nursing home did not adequately appreciate the severity of Mrs Morgan's illness. In his report Professor Whitehead expressed the firm belief that Mrs Morgan should have been transferred to hospital at a time earlier than she was. In his view there was a need for a clear escalation policy identifying the circumstances that would trigger transfer to hospital where attempts to secure a proper medical review have failed to produce results as had been the case with Mrs Morgan.

6.4. In Professor Whitehead's oral evidence he expressed surprise at the fact that Dr Gregg had not believed Mrs Morgan to have required hospitalisation at the time he reviewed her on the night of 24 June 2010. He stated that physical observations such as pulse, blood pressure, temperature and respiration are frequently not very reliable signs of illness. There had clearly been a change in Mrs Morgan's mental state. Professor Whitehead expressed concern that there had been no attempt by Dr Gregg on that occasion to assess Mrs Morgan's hydration status by way of blood testing[34]. Clinical bedside assessment of hydration status is difficult in older persons and is unreliable. As to the urinalysis, Professor Whitehead did not regard the results as being '*all that helpful*'[35]. The most reliable way of assessing a person's hydration status is to measure their serum osmolality with a blood test[36]. There was therefore a need for reliance on blood tests; and this was certainly the recommendation in most geriatric medical text books, although in fairness Professor Whitehead acknowledged that this fact is not widely known in the medical or nursing community[37]. Professor Whitehead expressed the view that Mrs Morgan's pathological results on 25 June 2010 as detected at the Wallaroo Hospital were incompatible with her having been hydrating adequately. He said it was not in any way consistent with the suggestion of good or even reasonable oral intake over the preceding days[38]. I accept that evidence.

6.5. In his oral evidence Professor Whitehead considered the issue of Mrs Morgan's high blood sugar readings. He regarded them as a potential cause for dehydration. He opined that to become dehydrated from diabetes one would need to consistently have blood sugars between 15 to 20. However, in Mrs Morgan's case, while the blood sugar levels may have contributed, he did not believe it would have been the sole

[34] Transcript, page 629
[35] Transcript, page 659
[36] Transcript, page 660
[37] Transcript, page 633
[38] Transcript, page 640

cause of her dehydration[39]. Rather, the real materiality of Mrs Morgan's blood sugar levels was as an indicator that she was unwell. He regarded them as a mark of her ill health[40]. Mrs Morgan's high blood sugar levels needed to be taken into consideration in conjunction with other aspects of her presentation on the night of 24 June 2010[41]. Professor Whitehead agreed with counsel, Dr Gray, that the underlying cause of that marker of illness would require investigation[42]. In particular the high blood sugar levels could have been a marker of a broad range of infections and other potential diagnoses including pneumonia[43]. Professor Whitehead said this:

> 'I guess they are a symptom or a sign that something is going on. In fairness they had plenty of symptoms and signs that something was going on. If you read the emails that have been sent, the nursing entries they know that the patient is sick. It is simply a manifestation that the patient is sick and it's going to the next step from identifying the patient is sick to identifying the cause of it is really the critical question and it is fair to say that those sugars are again a marker of general illness severity rather than a marker of something specific that you would have needed to be managed aggressively.' [44]

6.6. In his evidence before the Court Dr Gregg acknowledged that a blood sugar reading of 16.1 was a high level[45]. He agreed that the level of 15 experienced by Mrs Morgan was also a high level. As to whether these levels called for investigation, Dr Gregg asserted that would depend on all of the circumstances. He believed that the high blood sugars were not unusual for Mrs Morgan and were not catastrophically high. However, Dr Gregg was forced to acknowledge that those readings had been significantly higher than the pattern evinced by earlier readings which appeared to reflect Mrs Morgan's usual levels. So while Dr Gregg maintained that the high levels did not necessarily call for investigation, they called for assessment. He agreed that they could have been consistent with an infection. In any event Dr Gregg told the Court that he believed that he had a reasonable explanation as to why Mrs Morgan's blood sugar levels had been elevated and that was her agitation and emotional distress[46].

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[39] Transcript, pages 675-676
[40] Transcript, page 678
[41] Transcript, pages 679-680
[42] Transcript, page 681
[43] Transcript, page 681
[44] Transcript, page 682
[45] Transcript, page 569
[46] Transcript, pages 575 and 617

7. Conclusions

7.1. The Court reached the following conclusions:

1) That the cause of Mrs Morgan's death was pneumonia and renal failure with hyperthermia;

2) It is not possible to conclude that Haloperidol administration contributed to Mrs Morgan's decline and death;

3) Irrespective of the cause of Mrs Morgan's decline, I find that between 23 and 25 June 2010 there was an obvious and sharp decline in her wellbeing that consisted for the most part of an acute exacerbation of chronic symptomatology including excessive sweating, tremors and a rash. I would reject any suggestion that Mrs Morgan's presentation between 23 and 25 June 2010 was consistent with, and no worse than, her usual chronic state. It was an obvious exacerbation of her condition and was viewed by nursing staff as such;

4) Mrs Morgan's acute decline in her wellbeing rightly generated concern on the part of nursing staff at the PRCC;

5) Nursing staff at the PRCC made a number of attempts to contact Mrs Morgan's general practitioner, Dr Michael Gregg, on 23 and 24 June 2010, all of which were unsuccessful in securing his attendance until the evening of 24 June 2010. These attempts were made for the most part by way of intramail, in the opinion of the Court an inappropriate method of communication in relation to an urgent matter as this was. It would have been far better if more persistent attempts had been made to contact Dr Gregg, or an alternate medical practitioner, by way of telephone;

6) The Court has found it difficult to give credence to the suggestion that at all material times between 23 and 25 June 2010 Mrs Morgan was being adequately hydrated. I find that she was significantly dehydrated at the time she was clinically assessed by Dr Lu around midday on 25 June 2010. This level of dehydration is not consistent with Mrs Morgan having been adequately hydrated whilst at the PRCC. If any reliance had been placed on a urinalysis, the results of which only for the first time were recorded after her death, then any such reliance was misplaced;

7) Mrs Morgan I find should have been transferred to hospital earlier than 25 June 2010. However, I am not critical of nursing staff insofar as they were largely reliant upon a medical assessment being made by a medical practitioner. The medical assessment that did take place was belated and cursory save and except for Dr Lu's thorough assessment on 25 June 2010. It would have been better, however, if there had been systems in place at the PRCC that would have automatically triggered transfer to hospital in circumstances where a patient such as Mrs Morgan deteriorated in the manner that she obviously did;

8) Dr Gregg attended upon Mrs Morgan on the evening of 24 June 2010 in person. I have accepted Professor Whitehead's evidence that in essence Dr Gregg's assessment was not adequate. I so find. A blood test should have been ordered by Dr Gregg. As well, the question of her transfer to hospital should have been considered. To my mind Dr Gregg's review of Mrs Morgan that evening was adversely affected by his very heavy workload and the level of stress that he was experiencing at the time due to the exigencies of his medical practices;

9) It is not possible for the Court to determine whether or not Mrs Morgan's death could have been prevented by more timely medical intervention and more timely identification of the severe dehydration that she was experiencing. While it can be said that Mrs Morgan should have been transferred earlier to hospital, and should have been more adequately hydrated in the period before her eventual transfer to hospital, it is not possible to say whether earlier transfer or more adequate hydration would have altered the outcome.

8. Recommendations

8.1. 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.

8.2. The issue of importance that has been identified in this Inquest is the recognition of the deteriorating resident by nursing home staff, and in particular the recognition and diagnosis of dehydration in that resident.

8.3. I make the following recommendations directed to the Minister for Health and Ageing, the Australian Medical Association and Aged and Community Services Australia:

1) That strategies be developed, reduced into writing and utilised in aged care facilities to ensure the recognition of the deteriorating resident by aged care facility staff that includes reference to the circumstances in which medical assistance should be sought in relation to the resident, to the circumstances in which transfer to a hospital should be considered, the need to ensure adequate hydration in the deteriorating resident and the need to ensure that proper records are made in respect of the hydration of the deteriorating resident;

2) That strategies be developed, reduced into writing and utilised in aged care facilities to ensure that undue reliance is not placed on urinalysis in order to determine hydration status, and addressing the need for aged care facility staff to communicate by phone or word of mouth when urgent communication with a medical practitioner about a deteriorating resident is required;

3) That the Australian Medical Association bring these findings to the attention of its members, and in particular to the attention of medical practitioners who practice in rural areas and in aged care facilities within those areas. The Association should remind its members that they should carefully consider the question of dehydration in a deteriorating elderly patient, not to rely only on clinical impressions regarding the same and to have regard to the importance of blood testing in the identification of dehydration.

Key Words: Medical Treatment - Medical Practitioner; Haloperidol

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 21st day of March, 2014.

Deputy State Coroner