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 2nd and 23rd days of June 2017, the 10th and 26th days of July 2017, the 2nd, 3rd, 4th, 7th, 8th, 9th, 10th, 11th, 14th, 15th and 16th days of August 2017, the 28th day of September 2017, the 4th, 5th, 6th, 9th, 10th, 11th, 12th, 13th, 16th and 17th days of October 2017, the 2nd and 20th August 2018, the 3rd, 4th, 5th, 7th and 11th days of September 2018 and the 6th day of December 2018, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Michael John Russell and Leslie Robert Graham.

The said Court finds that Michael John Russell aged 60 years, late of 44 Appelbee Crescent, Norwood, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 21st day of April 2017 as a result of intracranial haemorrhage complicating surgery for right cerebral artery occlusion complicating acute coronary syndrome due to bypass graft occlusion.

The said Court finds that Leslie Robert Graham aged 87 years, late of 4 William Road, Vale Park, South Australia died at the Royal Adelaide Hospital, North Terrace, South Australia on the 26th day of April 2017 as a result of left middle cerebral artery territory cerebral infarction. The said Court finds that the circumstances of their deaths were as follows:

1. Introduction and cause of death

1.1. Michael John Russell died on 21 April 2017 at the Royal Adelaide Hospital. He was 60 years of age. Leslie Robert Graham died on 26 April 2017 at the Royal Adelaide Hospital. He was 87 years of age. Pathology reviews were carried out in relation to

the deaths of both Mr Russell and Mr Graham. The opinion as to Mr Graham's cause of death was given as left middle cerebral artery territory cerebral infarction[1], and I so find. The opinion as to Mr Russell's cause of death was given as intracranial haemorrhage complicating surgery for right cerebral artery occlusion complicating acute coronary syndrome due to bypass graft occlusion[2], and I so find.

2. Reportable deaths

2.1. Mr Graham's death was not reported to the Coroner until 16 May 2017. In my opinion the death was clearly a reportable death due to the circumstances that preceded it. Those circumstances gave rise to the submission of a report in the Department of Health's internal Safety Learning System. The report of death was only received following the request for and the receipt of Mr Graham's Royal Adelaide Hospital notes by the Coroner's Office.

2.2. Mr Russell's death was reported to the Coroner on 22 April 2017, the day following his death. The reason for the report according to the deposition was that his death was related to the carrying out of an invasive medical procedure.

2.3. In my opinion both deaths were clearly reportable.

3. No interventional neuroradiologist available at RAH on 18 April 2017

3.1. The common feature of the deaths of Mr Graham and Mr Russell is that both men required the services of a clinician who was capable and qualified to perform a clot retrieval procedure for stroke. The two clinicians, one of whom would normally have carried out the procedure on that day on those two patients, were Dr Jamie Taylor and Dr Rebecca Scroop. For reasons that were extensively canvassed at the Inquest, neither was available to carry out that intervention on 18 April 2017. Instead, the procedures were performed by Dr Steve Chryssidis, who was appropriately qualified and fortuitously available despite the fact that he was not associated with the Royal Adelaide Hospital at the relevant time.

3.2. For that reason, the deaths of Mr Graham and Mr Russell were the subject of one Inquest.

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[1] Exhibit C9b
[2] Exhibit C9a

3.3. I am aware that Mr Russell's family may have felt that his death received less attention at the hearing of the Inquest than that of Mr Graham. There was certainly no intention on the part of the Court to accord less importance or significance to Mr Russell's circumstances than were accorded to Mr Graham's. The fact of the matter was that Mr Graham was the first of the two gentlemen to require treatment for stroke intervention at the Royal Adelaide Hospital on that day. It was his presentation which led to the realisation on the part of staff in attendance at the hospital that neither Dr Taylor nor Dr Scroop was available to attend and perform the procedure, which was urgently required to be done in each case.

3.4. In circumstances which will be more fully explained below, the staff at the Royal Adelaide Hospital were able to solve their dilemma by making contact with Dr Chryssidis who made himself available immediately. Although he was not formally credentialed at the Royal Adelaide Hospital when initially contacted, credentialing was urgently carried out in order to enable him to operate upon Mr Graham. The need for credentialing did not in any way delay the procedure.

3.5. When Mr Russell presented later in the day arrangements had already been put in place with Dr Chryssidis for him to substitute for Drs Taylor and Scroop during the period of their absence, and so the procedure for Mr Russell was not attended by the same confusion and consternation as for Mr Graham earlier in the day.

3.6. Nevertheless, Mr Russell's case has been examined by me with the same care and attention as Mr Graham's.

4. The events of April 2017

4.1. The contact made with Dr Chryssidis to request him to attend at the Royal Adelaide Hospital, the subsequent performance of the procedure on Mr Graham and the later procedure on Mr Russell are relatively uncontroversial.

4.2. On the morning of 18 April 2017 at approximately 8:45am Mr Graham was found unresponsive by his wife. He was lying on the floor. She had last seen him well the evening before at approximately 9pm. She did not hear him get up during the night. He had been well the preceding day. An ambulance was called at 9:13am and upon attending at Mr Graham's home at 9:19am South Australian Ambulance Service

(SAAS) officers notified the Royal Adelaide Hospital of a 'code stroke'. Mr Graham was conveyed to the Royal Adelaide Hospital by ambulance[3].

4.3. In assessing Mr Graham's clinical condition SAAS officers noted that Mr Graham had a Glasgow coma score of 11. He was afebrile and had a Rosier score of +4. He had a right-sided facial droop, no movement in his right arm and leg and speech disturbance. He also had left-sided weakness.

4.4. Upon arrival at the Royal Adelaide Hospital the code stroke was activated and Mr Graham was attended by Dr Jane Thompson (a stroke RMO on duty at the time) and Ms Carol Hampton (a stroke nurse on duty at the time), who took Mr Graham straight into the radiology department for imaging. Dr Jane Thompson also performed the National Institute of Health Stroke Scale (NIHSS) assessment of Mr Graham in which he scored 22, indicating a severe stroke with severe deficits[4].

4.5. Evidence was given by Dr Jane Thompson, Ms Carol Hampton, Ms Debra Matthews, Associate Professor Tim Kleinig and Dr Janakan Ravindran surrounding the attempts to ascertain who was on call for the purposes of INR/stroke retrieval and to locate a proceduralist to assist with Mr Graham's case. The Stroke Team at the Royal Adelaide Hospital were clearly confused as to whom to contact and were delayed in getting contact with an appropriate person.

4.6. Dr Jane Thompson described the situation as '*scary*', having a patient awaiting an emergency procedure and not knowing whether someone would be available to perform it[5]. Ms Hampton, an experienced nurse, described it as a '*very anxious and fluid time*'[6]. Ms Matthews, an experienced administrative support person accustomed to dealing with contacting practitioners on call, said that the situation was surreal[7]. She described Dr Jane Thompson as appearing 'quite stressed'[8]. Dr Kleinig described the events as 'quite traumatic' in an email[9] and said that it was a '*highly stressful situation*' and that Ms Hampton was '*quite distraught*' and that Dr Jane Thompson was '*emotionally affected by it*'[10].

[3] Exhibit C7, page 69
[4] Exhibit C16
[5] Transcript, page 428
[6] Transcript, page 449
[7] Transcript, page 489
[8] Exhibit C18
[9] Exhibit C25
[10] Transcript, page 357

4.7. Dr Jane Thompson was in her third year of training. After Mr Graham's scans had been done Ms Hampton informed her that Dr Kleinig[11] had been in contact regarding the scans. Dr Kleinig had access to them electronically. Dr Jane Thompson was under the supervision of Dr Ravindran that day and made contact with him. Dr Ravindran agreed with Dr Kleinig that the scans showed some core infarct, but that the remainder was largely penumbra and the penumbra was the majority of the abnormal area[12]. Dr Ravindran was of the opinion that Mr Graham was suitable for clot retrieval.

4.8. Dr Kleinig said that he was on duty at the Royal Adelaide Hospital that day in his capacity as a neurologist. He said that the scan for Mr Graham '*popped up*' on his computer[13] and he examined them. He said that as was his usual practice when a scan like that pops up on his computer he called one of the Stroke Team. He spoke to Dr Ravindran and said that Mr Graham appeared to have favourable imaging and that he should be considered for intervention[14]. He said that the final decision rested with Dr Ravindran who agreed with Dr Kleinig's opinion. Dr Kleinig's understanding of the roster that day was that Dr Taylor, though in Victor Harbor, would be able to come at short notice to perform the procedure in suitable patients[15]. Dr Kleinig said that from conversations he had had with Dr Scroop the previous Tuesday he understood that one of the neurointerventionists would get started with the procedure, namely to prep the patient, establish groin access and advance the catheters to the neck and then Dr Taylor would arrive and scrub into the procedure to remove the clot[16]. Dr Kleinig called Dr Taylor on the telephone to ask him if he had seen the images on his phone and would he get back to Dr Kleinig to discuss the case. When Dr Taylor rang him back, Dr Taylor advised that he was not available because he could not get to the Royal Adelaide Hospital in sufficient time[17].

4.9. While that was happening, it was Dr Kleinig's understanding that a discussion between Dr Jane Thompson, Ms Hampton and Dr Ravindran resulted in Dr Chryssidis being contacted[18]. Dr Jane Thompson gave evidence that after she had spoken with Dr Ravindran to confirm that Mr Graham was a suitable candidate for clot retrieval, she

[11] Dr Kleinig was a neurologist at the Royal Adelaide Hospital
[12] Transcript, page 420
[13] Transcript, page 351
[14] Transcript, page 352
[15] Transcript, page 352
[16] Transcript, page 352
[17] Transcript, page 355
[18] Transcript, page 355

walked to the angiography suite to arrange an interventional neuroradiologist to perform the procedure[19]. She said that Ms Hampton accompanied her and when they arrived at the Angio Suite they discovered that there was no interventional neuroradiologist available to perform the procedure that they required[20]. She was informed of this by Ms Hampton and Ms Matthews, the secretary in the angiography suite[21]. Dr Jane Thompson said that a number of conversations then ensued between Ms Matthews and another radiology consultant. She said that she heard mention of the name of a third doctor who she had not heard of before, Dr Wilks, who she incorrectly named as Dr Watt in the casenotes[22]. She said that there was some mention of his potential availability, but that he was not available until 5pm that day[23]. Following that she spoke again with Dr Ravindran and discussed with him the possibility of calling Dr Chryssidis who had previously been mentioned by Ms Hampton.

4.10. Dr Jane Thompson then contacted the Flinders Medical Centre where Dr Chryssidis was thought to be working. She was transferred to the Flinders Private Hospital and they provided her with Dr Chryssidis' mobile telephone number after she explained the urgency of the situation[24]. After that she called Dr Chryssidis' mobile. He did not answer and she left a voicemail message explaining the situation and the urgency. She said that a short time later Dr Chryssidis called her back and asked for details of the patient, the history of the patient and details of the reports of the scans. Dr Chryssidis said that he would come out of his private practice to assist. At that point Dr Jane Thompson approached Mr Michael Consalvo to arrange for Dr Chryssidis to be credentialed[25].

4.11. Ms Hampton gave evidence that she became aware that the roster, which can only be described as a rather confusing document, suggested that Dr Mike Wilks was on call for INR work. As a result of that Ms Hampton called Dr Wilks and gave him a very brief overview of Mr Graham and what the situation was. She asked if he was available and he said that he was not available until after 5pm[26]. It appears that at this point

[19] Transcript, page 421
[20] Transcript, page 422
[21] Transcript, page 422
[22] Transcript, page 423
[23] Transcript, page 423
[24] Transcript, page 424
[25] Transcript, page 424
[26] Transcript, page 445

Ms Hampton made a further attempt to see if Dr Taylor could assist[27] before she and Dr Ravindran arrived at the conclusion that they should call Dr Chryssidis[28].

4.12. In circumstances which I will describe in greater detail below, Dr Wilks' name did appear on the roster that day. As I say, the roster was a confusing document and contained a great deal of ambiguity. No great reliance can be placed upon it for determining the respective obligations of the various clinicians, which in itself is a matter of grave concern. Nonetheless, it was the source of the staff's thinking that Dr Wilks might be available. As it happened, Dr Wilks was at that time operating on a patient at the Memorial Hospital. He gave evidence that he had not expected that he would be required to attend the Royal Adelaide Hospital before 5pm to assist with stroke interventions if required. Accordingly, he informed Ms Hampton that he was unavailable to attend. The circumstances in which his name appeared in the roster will be described in greater detail later.

4.13. The above summary of the efforts of the staff at the Royal Adelaide Hospital to find someone to undertake the necessarily urgent intervention upon Mr Graham demonstrates what could fairly be described as a crisis. When asked about what might have happened in the event that Dr Chryssidis had not been available, Dr Ravindran described the situation very well:

> 'There would have been - I think there's better words than disastrous; it could have been completely, you know - it's as about misadventure as you can get, isn't it?' [29]

5. <u>Dr Chryssidis receives the urgent call</u>

5.1. On that morning Dr Chryssidis was working at Dr Jones and Partners at St Andrews Hospital. He was performing a therapeutic spinal pain relief treatment (involving sedation administered by an anaesthetist) when the radiographer assisting him with the procedure indicated that a landline phone call had come through on the CT Suite console from Dr Chryssidis' colleague, Dr Will Thompson, who sought to speak with him[30].

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[27] Transcript, page 446 – Dr Taylor did advise Ms Hampton that he would be able to attend, but could not get there until 2:30pm which was not regarded as sufficiently soon (Transcript, page 447)
[28] Transcript, page 446
[29] Transcript, page 546
[30] Transcript, page 970

5.2. Dr Chryssidis asked the radiographer to take a message because he was in the middle of a procedure. The radiographer informed Dr Chryssidis that Dr Will Thompson was 'insistent' and that 'it was a matter of priority' that Dr Chryssidis attend the phone call. Dr Chryssidis sensed the urgency and while he was still in 'a scrubbed, sterile state' he took the phone call with the radiographer holding the telephone to his ear. This occurred while Dr Chryssidis' patient was under anaesthesia in front of him[31].

5.3. Dr Will Thompson informed Dr Chryssidis that there was a patient at the Royal Adelaide Hospital who required urgent treatment for a stroke intervention. Dr Chryssidis asked why '*the usual treatment pathways weren't being utilised*' (that is Drs Taylor and Scroop) to which Dr Will Thompson replied that those usual pathways were '*not available*'[32].

5.4. Dr Will Thompson told Dr Chryssidis that he had been asked by the Stroke Team at the Royal Adelaide Hospital to see whether Dr Chryssidis could do the stroke intervention. Dr Will Thompson handed the phone over to a member of the Stroke Team. Dr Chryssidis' memory was hazy, but he recalled speaking to Dr Jane Thompson. He also referred to Ms Hampton with whom he had worked before[33]. The effect of the information that Dr Jane Thompson and Ms Hampton conveyed to Dr Chryssidis was that there was a patient (Mr Graham) in his mid-80s, previously independent, with a wake up stroke who had been found unresponsive at 9am. Dr Chryssidis was told that Mr Graham had been subjected to the routine diagnostic imaging[34] and on the basis of that imaging it was believed that he had a small to moderate infarct core, but also a sizeable penumbra, making him a suitable candidate for treatment for large vessel occlusion. It was also understood that Mr Graham was not a suitable candidate for intravenous thrombolysis due to the uncertain timeframe as to when the clot occurred[35].

5.5. Dr Chryssidis said that he felt '*compelled*' to attend. Later in his evidence he explained that he felt uncomfortable going to the Royal Adelaide Hospital because of his history of interpersonal dispute with Drs Scroop and Taylor, but said that he also felt that it was important that he conduct himself professionally and respond to the clinical team's very serious request and the clinical need of the patients they had under their care[36].

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[31] Transcript, page 971
[32] Transcript, pages 971 and 973
[33] Transcript, page 972
[34] CT angiography, CT brain and CT perfusion – Transcript, page 973
[35] Transcript, page 973
[36] Transcript, page 1475

Dr Chryssidis told Ms Hampton and Dr Jane Thompson that he would make arrangements to make his way to the Royal Adelaide Hospital as quickly as possible.

5.6. After the phone call Dr Chryssidis informed his team at St Andrews Hospital of what was going on. He spoke with his anaesthetist who understood the severity and importance of the situation and with the nursing and radiography staff. He liaised with his onsite radiology team to seek cover and support so that the elective patients who were expecting treatment appointments during that day could still be appropriately managed and treated. He then left for the Royal Adelaide Hospital, arriving shortly before midday[37].

5.7. In the meantime Dr Jane Thompson, having learned that Dr Chryssidis would be attending at the Royal Adelaide Hospital, returned to the Emergency Department with an anaesthetist in order to obtain Mr Graham's family's consent to the clot retrieval process[38]. Also at this time administrative steps were being taken at the Royal Adelaide Hospital to attend to Dr Chryssidis' credentialing at short notice. Ms Hampton said that she went to see Mr Consalvo straight away to arrange credentialing[39]. Dr Ravindran had also asked Dr Jane Thompson to attend to that issue.

5.8. Dr Buckley was the Clinical Campus Head for Radiology at the Royal Adelaide Hospital at that time. He gave evidence that on 18 April 2017 he was away from work. He received a telephone call from Mr Consalvo advising him that there was a problem getting an appropriate radiologist to do a procedure. Dr Buckley recalled that he felt the need to get to the Royal Adelaide Hospital as quickly as possible[40]. On that day Professor Slavotnik, the Clinical Director of South Australian Medical Imaging, said that he was contacted by Mr Consalvo by text message so that he could attend to Dr Chryssidis' credentialing on an urgent basis, which he did[41]. Professor Slavotnik described his awareness of the fact that Dr Chryssidis had performed such procedures at Flinders Medical Centre in the past and said that he also checked the CCINR register[42] to confirm that Dr Chryssidis was listed (which he was). Professor Slavotnik confirmed that he signed and returned the credentialing paperwork '*within minutes*' of it being sent to him[43].

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[37] Transcript, page 974
[38] Exhibit C16
[39] Transcript, page 449
[40] Transcript, page 93
[41] Transcript, page 283
[42] The CCINR register will be described later in this finding
[43] Exhibit C12 and Transcript, page 283

5.9. Mr Consalvo subsequently informed Ms Matthews that Dr Chryssidis was appropriately credentialed and that all that was needed to complete the process was Dr Chryssidis' signature on the forms, which was just a formality[44]. The requirement of credentialing did not cause any relevant delay in the carrying out of the procedure.

5.10. Dr Chryssidis gave evidence that when he arrived at the Royal Adelaide Hospital he parked in the multi-storey carpark at the back of the hospital[45]. Dr Chryssidis said that it took some time to park due to the time of the day. He then made his way to the angiography suite in the radiology department. He knew where to go having previously worked at the Royal Adelaide Hospital. Dr Will Thompson was there waiting for him along with Dr Fox who was the anaesthetist for the procedure[46]. Dr Chryssidis was told that his credentialing was taken care of and that he was to go straight to the operating suite. He understood at all times that he was appropriately credentialed[47].

5.11. Dr Chryssidis met with members of the Stroke Team. He said that he was '*surprised and slightly overwhelmed by how the team had organised and actioned the system to bring Mr Graham to the angiography suite*' noting that the team had already attended to the consenting process, arranged for Mr Graham to be brought to the angiography suite, coordinated the anaesthetist support and the nursing and radiography staff had already started preparing themselves for the procedure[48]. I took Dr Chryssidis to be commending the Stroke Team on the efficiency with which they put in place the necessary clinical steps and arrangements, despite the trying circumstances they were operating under[49].

6. <u>Dr Chryssidis reviews the imaging</u>

6.1. Dr Chryssidis said that in order to prepare himself he needed to review the imaging and confirm in his own mind that it was appropriate to proceed to clot retrieval. He did this from the viewing station in the angiography control room[50]. He said that in addition to the information that had been conveyed to him by the Stroke Team, he assessed the CT brain and the CT angiography. He looked at the anatomy from the neck to the intracranial space and conducted a close assessment of the CT perfusion. He said that

[44] Exhibit C18
[45] At this time the hospital was in its former site at the eastern end of North Terrace
[46] Transcript, page 976
[47] Transcript, page 977
[48] Transcript, page 977
[49] Transcript, page 977
[50] Transcript, pages 977-978

despite being given detailed clinical information he felt it important to verify it for himself before making a decision to proceed with the clot retrieval[51].

6.2. Dr Chryssidis said that he reviewed the CT angiography to assess the arteries within the head, neck and brain, thus giving an indication of the access to the brain (for example if there is a narrowing along the course of the internal carotid artery or the vertebral artery). Such a review also gave him an indication of the tortuosity of the access vessels. He said that working through that imaging assists him with getting a feel for the collateral supply to the brain substance, the brain parenchyma, and around that the affected, non-perfused core area[52].

6.3. Dr Chryssidis said that he then reviewed the CT perfusion for cerebral blood flow, blood volume, transit times, time to peak and other parameters to establish the extent of viable and non-viable tissue. He then correlated the CT angiography and the CT brain to confirm his findings and opinions[53].

6.4. Dr Chryssidis said that the CT brain imaging demonstrated that although there was an area of non-viable tissue, there was a large territory of viable tissue (also known as penumbra) and that somehow Mr Graham's blood supply was managing to maintain the integrity of that tissue – this area of the brain was still receiving blood flow despite the clot[54]. He said the CT brain demonstrated there was no big blood clot in the substance of the brain, no blood on the surface of the brain, no tumour, a relatively small area of non-viable tissue and a large area of viable tissue[55]. Dr Chryssidis said that from the CT angiography that the clot was in the middle cerebral artery predominantly within the MCA M1 division with perhaps some extension into the Sylvian branch[56]. He was asked whether he thought there was any extension of the clot into the M3. He said that he did not believe that there was such an extension, and that it would not be entirely logical either. He explained that the M3 is a sub-1mm vessel and that it is in the nature of a clot that it has already obtained a 'rubber-like' characteristic and it is displaced from a source, such as the heart, and travels via high

[51] Transcript, page 975
[52] Transcript, page 983
[53] Transcript, page 983
[54] Transcript, page 986
[55] Transcript, pages 987-989
[56] Transcript, pages 990-991

flow areas but corks at a larger diameter vessel than the M3, typically the M1[57]. In short, it was his view that the clot was in the M1 proximal M2[58].

6.5. Upon reviewing the images Dr Chryssidis formed the view that because there was a relatively small core infarct and large penumbral salvageable tissue, it was appropriate to proceed with endovascular clot retrieval. He recognised there might be some challenges in selecting vessels and some vessel tortuosity, but it was a large vessel occlusion, there was a large volume of penumbra and Mr Graham had previously been functionally independent. Dr Chryssidis also thought that it was significant that Mr Graham was previously caring for a family member[59].

6.6. Dr Chryssidis made it clear that if he had formed the view that it was inappropriate to proceed with treatment it would have been necessary to have a discussion with the Stroke Team and then to convey that advice to the family[60].

7. Preparation for the procedure

7.1. Dr Chryssidis noted that in addition to reviewing the imaging he also needed to identify, locate and prepare the appropriate tools and this took some time because he was not aware of their location and of all the devices held at the Royal Adelaide Hospital. He needed assistance and direction as to where they were stored. This was not a significant delay but it was evidently a source of some frustration for Dr Chryssidis[61]. Notwithstanding this, it was Dr Ravindran's opinion that the 70 minutes it took for Dr Chryssidis to be in a position to commence the procedure was '*well within the acceptable time period*'[62]. Dr Kleinig commented that the time from arrival at the hospital to groin puncture was 108 minutes which he said was 'longer than our recent average but not exceptionally so' and that he did not feel that 'any potential delay adversely affected the procedural success or patient outcome'[63]. Dr Chryssidis was also of the view that there was no significant delay. It was fortuitous that he was nearby in a metropolitan hospital. He might have gained some minutes if he had been onsite and had been familiar with the team members and the location of some of the tools[64].

[57] Transcript, page 992
[58] Transcript, page 992
[59] Transcript, pages 994, 997 and 1036
[60] Transcript, page 997
[61] Transcript, page 977
[62] Exhibit C17
[63] Exhibit C13
[64] Transcript, page 1000

8. Performance of the procedure on Mr Graham

8.1. Dr Chryssidis helpfully gave a demonstration to the Court by reference to equipment he provided, how the procedure is undertaken. He explained that he made four attempts or '*passes*' to position the stent retrieval device into the clot and retrieve it. He described that after each attempt it was necessary to retract the device, confirm whether there was persistent or ongoing occlusion and then, if so, to reinsert the microcatheter and reposition it over the clot and try again[65]. He explained how a larger catheter (a long sheath) remains insitu while the smaller access catheter passes through it[66]. Having undertaken four passes with a 4mm stent, Dr Chryssidis decided to attempt the retrieval with a 6mm stent[67]. He said that he undertook a pass with the 6mm stent which slightly improved filling across the area, but unfortunately while trying to reposition for a second pass with the 6mm stent, the entire system backed out[68]. Dr Chryssidis explained that only small fragments of the clot were able to be retrieved and that he was not able to achieve an adequate revascularisation[69]. He said that at the point when the 6mm stent had backed out the procedure had been underway for at least two hours and Mr Graham was cerebrally agitated[70]. He said that it became clear to him that he had made :

> '… little impact, little improvement to the blood flow despite multiple devices and didn't feel that it was the appropriate thing .. to try and put Mr Graham through anything further.' [71]

8.2. Dr Chryssidis removed his access devices and closed the groin access site. He discussed the status of the procedure with the Stroke Team members and informed the Neurology Team that he had been unsuccessful in achieving reperfusion and revascularisation of the target vessel. He then asked where the family was and the Neurology Team volunteered to communicate that information to them[72]. He said that because he had not achieved revascularisation or reperfusion there was a high probability of the stroke progressing and evolving and he expected there would either be significant morbidity or death[73].

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[65] Transcript, page 1007
[66] Transcript, page 1007
[67] Transcript, page 1007
[68] Transcript, page 1007
[69] Transcript, page 1007
[70] Transcript, page 1011
[71] Transcript, page 1008
[72] Transcript, pages 1008-1009
[73] Transcript, page 1477

8.3. On the whole of the evidence I have no hesitation in finding that it was appropriate for Dr Chryssidis to attempt the procedure in Mr Graham's case.

9. Mr Graham's outcome

9.1. While the procedure was not successful, it did not cause any harm to Mr Graham. This was the opinion of Dr Chryssidis[74] and Dr Ravindran[75]. Dr Kleinig expressed the view that 'Mr Graham was not harmed by the procedure'[76] and said that it did not make his condition any worse[77]. One of the external reviewers who reviewed the case as part of the Royal Adelaide Hospital internal review, Professor Parker, expressed the opinion that the attempted thrombectomy 'did not help or harm the patient'[78].

10. Dr Chryssidis' agreement to provide cover for INR following Mr Graham's procedure

10.1. Shortly after Dr Chryssidis had completed the procedure on Mr Graham he had a telephone conversation with Dr Buckley about providing cover for INR for the Royal Adelaide Hospital for a few days while Drs Scroop and Taylor were not available[79]. Dr Buckley asked Dr Chryssidis if he could provide service support and Dr Chryssidis agreed to do so. Dr Chryssidis asked Dr Buckley to confirm the request in writing which Dr Buckley did by way of email sent at 3:58pm that day[80]. Dr Chryssidis advised that the agreement to provide cover was subject to an anaesthetic procedure that Dr Chryssidis had the following Friday afternoon within which period he would be unable to provide assistance[81]. Dr Buckley recalled making this request to Dr Chryssidis and said that he understood his request to be in respect of joining the INR on call roster for the short term during which both Drs Scroop and Taylor were on leave[82].

[74] Transcript, page 1036
[75] Exhibit C17
[76] Exhibit C13
[77] Transcript, page 350
[78] Exhibit C30
[79] Transcript, page 1019
[80] Exhibit C25, page 285
[81] Transcript, pages 1019-1020
[82] Transcript, page 83

11. Mr Russell

11.1. Presentation of Mr Russell to Royal Adelaide Hospital

Mr Russell presented to the Emergency Department at the Royal Adelaide Hospital at 5pm on 18 April 2017 with chest pain. He was found to have an acute inferior ST-Elevation Myocardial Infarction. He was transferred to the cardiology unit for an angiogram[83]. The record of the angiogram appears in Mr Russell's clinical records[84]. It shows that Ticagrelor, an antiplatelet or anticoagulant was loaded on table. This is a normal part of a coronary procedure to assist with ensuring that any stent inserted remains patent. It appears from the record that a 'very large thrombus' was identified and that the proceduralist found an occluded bypass graft (from previous surgery). It appears that attempts were made to reperfuse the blocked coronary artery, through aspiration of the clot material. ReoPro was then administered to try to break up the clot. ReoPro is an anticoagulant agent. Mr Russell became restless, dysphasic and dysarthric about 45 minutes into the procedure and the treating practitioners observed persistent neurology with subtle facial droop. This led to the calling of a code blue at 6:30pm and code stroke at 6:35pm. Professor Anderson expressed the opinion that:

> 'An embolus was triggered by the angiogram wire traversing the aorta for the coronary angiogram, exacerbated by hypercoagulopathy associated with the coronary syndrome.' [85]

It was this which caused Mr Russell's stroke.

11.2. Dr Cheong who was the Stroke Fellow and Ms Dodd, stroke nurse, attended the code stroke immediately[86]. When Dr Cheong and Ms Dodd arrived at the cardiac suite they received a handover from the cardiology consultant. Ms Dodd recalled being told that Mr Russell had suffered a heart attack earlier that day and had self-presented to the hospital. She was also told that while removing a clot from his coronary artery he had developed left-sided arm, face and leg weakness which prompted the code stroke. She was told a bit about what had been done in the cardiac procedure, such as what drugs Mr Russell had been given and his clinical condition[87].

11.3. Dr Cheong also recalled being provided with information from the cardiac team. He obtained information about the medications Mr Russell had received and when he had

[83] Exhibit C6
[84] Exhibit C6
[85] Exhibit C30
[86] Transcript, page 1522
[87] Transcript, page 1503

received them. He was conscious of the fact that Mr Russell had been administered blood thinners for the purposes of the procedure[88]. Dr Cheong examined Mr Russell and noted that he had evidence of severe right hemispheric stroke presenting with left-sided weakness. He noted that Mr Russell had left-sided weakness, visual loss to the left side and gaze deviation[89].

11.4. Dr Cheong formed the view that Mr Russell was not an appropriate candidate for thrombolysis because of the fact that he had already been administered blood thinners, thus increasing the risk of bleeding inside his head and he already had an open groin wound from the angiogram. Dr Cheong took the view that it was too dangerous to proceed with thrombolysis. Dr Cheong then proceeded to arrange the usual imaging to consider whether endovascular therapy (clot retrieval) would be appropriate. Dr Cheong and Ms Dodd took Mr Russell to the CT scanner for this purpose[90]. The notes suggest that they arrived at the radiology suite at 7:20pm[91]. A CT brain, CT angiogram and CT perfusion were undertaken at approximately 7:25pm. They revealed a right MCA territory ischaemia with a significant penumbra (that is, salvageable brain) with occlusion of the M2 branch of the right MCA[92]. Dr Cheong was of the opinion there was still a significant amount of salvageable brain and his written notes confirmed those observations[93].

11.5. Dr Cheong telephoned Dr Ravindran who was the stroke consultant on call and informed him of the history, the examination and the findings of the imaging to make a decision about the most appropriate therapy[94].

11.6. Following a review of Mr Russell's history and his CT perfusion imaging, Dr Ravindran recommended intra-arterial clot retrieval and to contact Dr Chryssidis[95]. It was confirmed that it was unsafe to thrombolyse and that they should proceed with endovascular clot retrieval[96].

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[88] Transcript, page 1523
[89] Transcript, page 1523
[90] Transcript, page 1526
[91] Exhibit C6 and Transcript, page 1503
[92] Exhibit C46
[93] Exhibit C6, Transcript, page 1527
[94] Transcript, page 1528
[95] Exhibit C17
[96] Transcript, page 1528

11.7. Stroke Team contact Dr Chryssidis

Ms Dodd gave evidence that she had been informed earlier that day by Ms Hampton that both Drs Scroop and Taylor were away. She was also informed about the morning's events involving Mr Graham and that Dr Chryssidis had stepped in. She also received an email that afternoon to the same effect from Dr Kleinig[97]. She therefore knew that Dr Chryssidis was the person to contact in the event of an emergency requiring clot retrieval. She knew and had worked with Dr Chryssidis before at the Queen Elizabeth Hospital in her capacity as a stroke nurse, but had never worked with him at the Royal Adelaide Hospital[98].

11.8. Dr Chryssidis said that he was made aware by this telephone call that a gentleman of about 60 years of age had, while receiving treatment for a coronary artery condition, become unresponsive on the table. He was told that the usual imaging had been obtained which showed a large vessel occlusion and a large penumbral area with little or no core infarct. He said that he also understood from the phone call that Mr Russell was not a candidate for IV Clot Buster due to having been administered ReoPro[99]. Dr Chryssidis told Dr Cheong that he would attend immediately[100].

11.9. Dr Chryssidis returned to the Royal Adelaide Hospital. It took him approximately 10 to 15 minutes to get there. He parked in the same carpark as he had used earlier in the day and proceeded to the radiology department. He met Ms Dodd at the department[101].

11.10. Dr Chryssidis then reviewed Mr Russell's imaging. Dr Chryssidis gave evidence that Mr Russell's clot was located at the junction of the MCA and M1 and M2. He explained that the clot was in a similar location to Mr Graham's, but on the opposite side, and appeared to be smaller fragment of clot than Mr Graham's[102]. He said that Mr Russell's imaging showed a large area of viable tissue and essentially little or no core[103]. He formed the view on the basis of the imaging that Mr Russell was a suitable candidate for clot retrieval[104] and confirmed it with the Stroke Team. Dr Chryssidis said that Mr Russell had much to gain from undergoing clot retrieval. The favourable considerations included the timing, the presence of a large volume of penumbra, little

[97] Transcript, page 1499 and Exhibit C50
[98] Transcript, page 1498
[99] Transcript, pages 1020-1021
[100] Transcript, page 1529
[101] Transcript, page 1022
[102] Transcript, page 1026
[103] Transcript, page 1026
[104] Transcript, page 1026

or no core infarct, the fact that he had previously been functionally independent and there were no contraindications for treatment[105]. In short, he considered that it was appropriate to proceed to clot retrieval in Mr Russell's case and I agree.

11.11. Consent

Dr Chryssidis obtained appropriate consent with Mr and Mrs Russell in the presence of Dr Cheong and Ms Dodd. He explained the risks of the proposed clot retrieval stating that there was a 70% chance of reperfusion, a 10% chance of death and a 1% to 2% chance of vessel perforation, ie a tear in the wall of the artery resulting in extravasation (ie blood leaking out into the brain)[106]. He explained to Mr Russell that the procedure is undertaken with sedation and not under general anaesthesia. He explained that the approach was trans femoral and could not recall whether he discussed the specific medication by name (ReoPro) that had already been administered to Mr Russell as part of the coronary procedure[107]. Ms Dodd said that Mr Russell was '*quite aware of what was happening and able to give his consent*' so Dr Chryssidis was explaining the situation to both Mr and Mrs Russell together[108]. She also recalled Dr Chryssidis discussing the risk of bleeding, vessel damage and complication[109].

11.12. Risk of vessel perforation

The risk of vessel perforation was estimated by Dr Chryssidis at 1% to 2%[110]. He explained that the risk is small, but that as a result of either the positioning of the stent retrieval device or catheter manipulation or wire manipulation there is a risk of injury to the vessel wall which can lead to the leaking of blood into the areas around the brain[111]. This is known as extravasation. Dr Buckley in his evidence assessed the risk at 1% to 2% of cases[112]. Dr Ravindran confirmed that the complication rate is an '*unfortunate known complication of this procedure but rare*'[113]. Professor Anderson who performed an external review for the Royal Adelaide Hospital noted that vessel perforation is an 'uncommon but accepted complication of mechanical thrombectomy'[114]. Likewise, Professor Parker described the complication of vessel

[105] Transcript, pages 1035-1036
[106] Transcript, page 1027
[107] Transcript, page 1484
[108] Transcript, page 1514
[109] Transcript, page 1514
[110] Transcript, page 1027
[111] Transcript, page 1027
[112] Exhibit C10
[113] Transcript, page 535
[114] Exhibit C30

perforation as 'unfortunate, but … a recognised and very serious, but uncommon (about 1% of cases) complication of thrombectomy'[115].

11.13. Timing

The time between the completion of the CT perfusion imaging and commencement of the procedure in this case was 60 minutes. Thus there was no relevant delay in commencing the procedure. Dr Chryssidis acted in an appropriate and timely manner.

11.14. Performance of procedure on Mr Russell

Dr Chryssidis commenced the procedure at approximately 8:30pm. The procedure took approximately 1½ to 2 hours[116]. Dr Chryssidis used the retrievable stent system and within two attempts was able to secure most of the clot[117]. Dr Chryssidis made a first attempt to retrieve the clot and then retracted the device. There was incomplete revascularisation which meant that there was some clot left over after the first attempt. This led to Dr Chryssidis attempting to reposition the micro catheter over the remaining clot fragment. Unfortunately while the micro catheter wire and stent was in place, a vessel injury had been sustained. Dr Chryssidis said that he became aware of contrast leaking from around the vessel as a result of an apparent vessel injury[118]. He noticed the leaking contrast immediately and recognised that he needed to act quickly. He removed the devices and told the anaesthetist that a vessel injury had been sustained and that they needed to immediately reduce blood pressure to reduce pressure on the injured part of the vessel[119]. Dr Chryssidis then requested an emergency CT scan in order to establish how much impact the blood extravasation had had on the surrounding tissues[120]. The imaging showed that the contrast had leaked into the brain. Following a review of the repeat CT brain, Mr Russell was moved out of the CT scanning room and Dr Chryssidis spoke with the Stroke Team and Dr Ravindran while completing his progress notes[121]. Ms Dodd was with Mr Russell after his repeat CT scan. She noticed that he was becoming '*very drowsy and not responding in the way that he was*' and that there was some right-sided symptoms which were new. She alerted Dr Chryssidis[122]. As a result of this Dr Chryssidis asked Ms Dodd to take Mr Russell back into the CT

[115] Exhibit C30
[116] Exhibit C20
[117] Exhibit C20
[118] Transcript, page 1029
[119] Transcript, page 1030
[120] Transcript, page 1031
[121] Transcript, page 1032
[122] Transcript, page 1509

scanning suite to initiate another CT brain scan. This occurred[123]. Dr Chryssidis' plan at this stage was to maintain systolic blood pressure in a range of 120 to 140, to discuss Mr Russell's status with the Stroke Team and to communicate the situation to the Neurosurgery Team. Dr Chryssidis said that he thought it was prudent that the Neurosurgery Team be notified, particularly given the presence of ReoPro. He also coordinated for Mr Russell to be managed in ICU with one-to-one monitoring and asked that the Neurosurgery Team be notified if there was a drop in the Glasgow coma score of one to two points in that period[124].

11.15. Dr Chryssidis then spoke with the neurosurgeon and he then informed Mrs Russell and explained the intraprocedural complication that had happened. He explained to her the subsequent imaging that had been performed and told her that the imaging indicated that there had been a perforation and that Mr Russell was going to be closely observed and monitored while in ICU. Mr Russell was transferred to ICU and the Neurosurgery Team was consulted. Dr Chryssidis was not further involved in Mr Russell's care[125].

11.16. Unfortunately Mr Russell continued to haemorrhage. Given his poor prognosis he was extubated and subsequently died.

11.17. Dr Chryssidis said:

> 'Irrespective of ReoPro it's still a gut wrenching appearance to have on the screen. The probability of recovery is improved however if there is no ReoPro or ReoPro-like agent on board. The ReoPro, although very effective, unfortunately also meant the injury to the wall, it would be very difficult for the injury to the wall to be sealed by the body or near impossible.' [126]

11.18. Dr Chryssidis said that had the vessel not been perforated and if the cardiac issues had been addressed there was a high probability that Mr Russell would have made a very good recovery, and I so find. The external review reports demonstrate that this tragic complication was within the bounds of possible outcomes and there is no occasion to be critical of Dr Chryssidis in any way[127]. However, Dr Chryssidis did acknowledge that the events of the day of 18 April 2017 were not typical. Indeed, they were stressful.

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[123] Transcript, page 1032
[124] Transcript, pages 1032-1033
[125] Transcript, page 1035
[126] Transcript, page 1486
[127] Exhibit C30

He was asked if he could say whether the extra stress and pressure of the day contributed to the complication in Mr Russell's case and he frankly responded:

> 'It certainly may have. It was not - not at all a typical day. There were a lot of new matters to be dealt with.' [128]

He also referred to a level of anxiety in having to return to the Royal Adelaide Hospital[129].

12. Why was there confusion about who would do the procedures on 18 April 2017?

12.1. The unavailability of Drs Scroop and Taylor on 18 April 2017 was not unplanned. It should have been anticipated as early as December 2016.

12.2. On 15 November 2016 Dr Taylor applied for leave from 13 April to 23 April 2017[130]. This application was approved by Dr Buckley on 6 December 2016 in his capacity as Campus Clinical Head. The leave was entered on the master roster. As at 10 February 2017 the master roster showed Dr Taylor on leave for these days and Dr Scroop on call[131].

12.3. Dr Scroop signed an application for leave for April 2017 on 29 December 2016[132] which was approved by Dr Buckley on 10 February 2017.

12.4. In February 2017 Dr Taylor became aware that Dr Scroop had planned to travel to the United States of America in the April school holidays[133]. Dr Buckley said that when he approved Dr Scroop's leave request he did not realise that both she and Dr Taylor would be absent simultaneously during the period in question. He was first made aware of this by Ms Lazarro, his executive assistant[134]. Dr Buckley said that after he became aware that Dr Scroop and Dr Taylor would not be available during this period he contacted Dr Scroop to discuss what could be arranged and this occurred in March 2017[135]. On 30 March 2017 Dr Taylor sent an email to Dr Buckley advising him that he wished to discuss the matter[136]. That email records the fact that both Drs Scroop and Taylor are to be away during the relevant period. It states that there may be an impact

[128] Transcript, page 1489
[129] Transcript, page 1489
[130] Exhibit C14, JT02
[131] Exhibit C14, JT03
[132] Exhibit C15, RSO7
[133] Transcript, page 2365
[134] Exhibit C10, paragraph 17
[135] Exhibit C10
[136] Exhibit C14, JT04

on the general interventional and neurointerventional service. Dr Taylor recorded that he was unaware of what contingency arrangements may have been made, but said that 'I may be able to assist during some of the overlapping period'. The email continues:

> 'During the period April 18-22 I will be at Victor Harbor with my family. It may be that I could return for individual emergency cases depending on their timing.' [137]

12.5. Dr Taylor said that on 27 March 2017 there was a meeting involving he, Dr Scroop and Dr Buckley[138]. Dr Buckley referred to the meeting[139]. He said that during that meeting Dr Scroop said that she would speak with Dr Mike Wilks, an interventional radiologist at the Royal Adelaide Hospital to ascertain whether he was available to cover the INR service and be placed on the on call roster for the relevant period. Dr Buckley stated that Dr Scroop contacted Dr Wilks and later informed him that Dr Wilks was able to provide cover for the INR service throughout this period. He said that:

> 'I was not completely satisfied with this outcome as Dr Wilks is an IR and not an INR. However Dr Scroop assured me that Dr Wilks was appropriately skilled and competent to perform INR procedures. Given her experience and competence I trusted her recommendation of Dr Wilks and approved the roster accordingly.

12.6. Dr Buckley also said that Dr Taylor was available by telephone for conversation and less acute cases, notably aneurysm, coiling and treatment of cerebral vasospasm which are less urgent and which could await his return[140]. Dr Buckley elaborated in his oral evidence. Dr Buckley made the obvious comment that a 24 hour a day, 7 day a week INR service provided by only two people, namely Drs Scroop and Taylor, is '*a very fragile roster indeed, in my opinion*'[141]. Dr Buckley said that he was very concerned to learn about the possible absence of both doctors at the same time[142]. He said that most of his discussion about what to do about the matter was '*really with Dr Scroop because my understanding was certainly that Dr Taylor had booked his leave first, he would be able to cover the less acute INR procedures*'[143].

12.7. Dr Buckley said that it was Dr Scroop who raised the possibility that Dr Wilks would be able to fill in. She reassured Dr Buckley that he would be able to do the acute INR

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[137] Exhibit C14, JT04
[138] Exhibit C14, paragraph 6.6
[139] Exhibit C10, paragraph 19 and continuing
[140] Exhibit C10, paragraph 23
[141] Transcript, page 77
[142] Transcript, page 78
[143] Transcript, page 78

work[144]. He said that the acute work he was referring to was stroke treatment or, to use a synonymous expression, thrombectomy treatment[145].

12.8. Dr Buckley admitted that he did not himself speak to Dr Wilks about the matter[146], but would have expected Dr Wilks to be available for an emergency at any time during that period from 18 to 22 April 2017.

12.9. Dr Buckley said that it was his understanding that Dr Scroop would be overseas and that Dr Taylor would be available to respond to non-urgent cases which did not include stroke cases[147]. He said that he did have some hesitation about the situation because it was a new situation from his point of view. He said that he was reassured by Dr Scroop that Dr Wilks would be capable of doing what was required and that he had a lot of trust in her judgment[148].

12.10. Dr Buckley said that he understood that Dr Taylor would not be the first attender at a stroke case[149]. He said that he understood Dr Wilks would be designated to be on call for the entire period between 18 and 22 April 2017[150]. He said he had not given a '*great deal of thought*' to whether Dr Wilks would have to give up his private work during business hours in that four day period in order to meet that expectation[151].

12.11. Dr Buckley said that he double checked with Dr Scroop that she had indeed fixed up cover with Dr Wilks because he wanted to be '*absolutely sure she had done it and that she was truly confident in him*'[152].

12.12. Dr Buckley conceded that he should have contacted Dr Wilks himself to confirm the arrangement[153], but he thought that he had been '*reasonably diligent*' in confirming with Dr Scroop a second time that she had indeed done what had been agreed upon[154]. Dr Buckley said that if the availability of Dr Wilks had not been as he expected it to be, namely 24 hours a day, he would have asked Dr Taylor to stay in Adelaide '*because it would have been so unacceptable to not actually have cover*'[155].

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[144] Transcript, page 79
[145] Transcript, page 80
[146] Transcript, page 80
[147] Transcript, page 99
[148] Transcript, page 100
[149] Transcript, page 105
[150] Transcript, page 107
[151] Transcript, page 108
[152] Transcript, page 118
[153] Transcript, page 211
[154] Transcript, page 212
[155] Transcript, page 213

12.13. Dr Buckley said that he understood that because Dr Taylor was in Victor Harbor he would not be available for emergency procedures, but that to the extent that he was available for consultation, it would be by telephone because the journey time for acute stroke treatment '*would be just too long*'[156].

12.14. In summary, Dr Buckley's understanding of the situation was that Dr Wilks would be available to do stroke cases day and night including business hours during the relevant period and, furthermore, that Dr Taylor would not be able to physically respond to such cases because of the amount of time it would take for him to get to the Royal Adelaide Hospital from Victor Harbor. Any uncertainties he had about the arrangement were put to rest by the assurances Dr Scroop provided him.

13. Dr Kleinig's understanding of the arrangements

13.1. Dr Kleinig is a consultant neurologist with a particular interest in strokes at the Royal Adelaide Hospital. Dr Kleinig became aware of the difficulty posed by the absence of both Drs Scroop and Taylor on 11 April 2017. On that day he was informed of the situation by his colleague, Dr Jannes, and as a result Dr Kleinig make contact with Dr Scroop in a telephone conversation that lasted seven minutes[157]. Dr Kleinig said that his understanding of the roster was that Dr Taylor, though in Victor Harbor, would be able to come at short notice to perform stroke thrombectomies. He said he understood that one of the other interventionists could get started with the procedure by prepping the patient, establishing groin access and advancing the catheters to the neck which would take between half an hour and an hour by which time Dr Taylor would arrive, scrub into the procedure and remove the clot[158]. He said that Dr Scroop did not mention Dr Wilks in the conversation[159].

13.2. Dr Kleinig said that he thought the arrangement was '*not an ideal situation but I thought the timeframes of him*[160] *being able to return if he was in Victor Harbor straight in his car* ..' would be feasible[161].

[156] Transcript, page 215
[157] Transcript, pages 371-372
[158] Transcript, page 352
[159] Transcript, page 353, 373
[160] This is a reference to Dr Taylor
[161] Transcript, page 354

13.3. Dr Kleinig made it plain that Dr Scroop specifically mentioned that Dr Taylor would be available to be called back within an hour or so for stroke cases[162].

13.4. Dr Kleinig acknowledged that he may have raised with Dr Scroop the possibility of Dr Chryssidis being available during the period that Drs Scroop and Taylor were both away. He was aware that that was Dr Scroop's recollection and he said that it may well have happened[163].

13.5. Counsel for Dr Scroop put to Dr Kleinig that Dr Scroop had specifically mentioned Dr Wilks and Dr Kleinig did not accept that[164]. It was also put by counsel for Dr Scroop that she told Dr Kleinig that Dr Taylor would be available to discuss stroke cases with Dr Wilks and to assist him depending on Dr Taylor's availability. Dr Kleinig said that he did not remember those caveats being expressed and added that if they had been expressed:

> 'I then very much would have forcefully expressed the opinion that Steve[165] should be considered to be on the roster.' [166]

13.6. It was also plain from Dr Kleinig's evidence that had he been informed that Dr Wilks would be potentially required to conduct a stroke thrombectomy alone and unassisted he might have accepted Dr Scroop's assurance that Dr Wilks was competent to do the procedure '*depending on the nature of that reassurance, on the substance of that reassurance*'[167].

13.7. It is very clear from Dr Kleinig's evidence that Dr Scroop said nothing to him about the possibility that Dr Wilks might have to conduct the potential stroke thrombectomy alone and unassisted. It is also clear that his evidence was that no mention was made of Dr Wilks in the conversation and that it was his understanding that Dr Taylor would be available to be back within an hour or so if he got straight into his car and that, although not ideal, Dr Kleinig was prepared to accept the situation. Had he been aware that Dr Taylor may not be able to attend for stroke cases he would have '*forcefully expressed*' the opinion that Dr Chryssidis should be considered to be on the roster unless Dr Scroop had been able to assure him that Dr Wilks was competent to do the

[162] Transcript, page 373
[163] Transcript, page 377
[164] Transcript, page 377
[165] This is a reference to Dr Chryssidis
[166] Transcript, page 378
[167] Transcript, page 380

procedure and that this would have depended on the nature of the reassurance and the substance of the reassurance.

14. Dr Wilks' understanding of the arrangement

14.1. Dr Wilks is a general interventional radiologist at the Royal Adelaide Hospital[168]. His evidence was that he was approached by Dr Scroop to see if he could contribute to on call services for the week in question and he agreed[169]. He said that his understanding of the arrangement was that he would not be required to attend at the Royal Adelaide Hospital for neurointerventional services during ordinary working hours, but only after 5pm[170]. He said that his understanding was that Dr Taylor was also on leave, but that if he, Dr Wilks, felt that there was a procedure that needed to be done earlier he should organise for that to be done by liaising with Dr Taylor[171].

14.2. Dr Wilks said that Dr Scroop told him that Dr Taylor would be available on the phone to discuss stroke cases and that he may be able to return to Adelaide to assist with stroke cases[172]. Dr Wilks was firm in his evidence that he did not understand from Dr Scroop that he would be required to attend during ordinary business hours because if that had been raised it would have been necessary for him to take annual leave from his private practice and that was a matter that was simply not raised or addressed with him[173]. He did concede that he might be asked to take phone calls at any point during the 24 hour period and would have done so if he was available[174]. His position was that Dr Scroop did not ask him to attend to stroke cases during office hours and that if she had intended to convey that she ought to have made it plain to him that he would need to do so because that would have necessitated him taking annual leave from his private practice. Dr Wilks' understanding of Dr Taylor's availability seems to accord with Dr Taylor's version as also understood by Dr Buckley, namely that Dr Taylor might be available, but only for liaison[175].

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[168] Transcript, page 639
[169] Transcript, page 640
[170] Transcript, pages 642-643
[171] Transcript, page 644
[172] Transcript, page 684
[173] Transcript, page 692
[174] Transcript, pages 685-686
[175] Transcript, page 643

15. Dr Taylor's understanding

15.1. On 6 February 2017 Dr Taylor sent an email[176] to Dr Scroop advising that he was to be away for certain periods including the period in question. His email stated:

> 'Given sufficient notice, I may be able to attend for a cerebral aneurysm case during this period, if I am in town I could assist in other cases. General intervention will also need to be covered.'

Although that email requires no interpretation, it is plain that Dr Taylor cannot be taken as suggesting that he would be available at short notice to assist a stroke case. At its highest, it raises the possibility that he could assist in a stroke case 'if I am in town'. The email to Dr Scroop is also consistent with Dr Taylor's email to Dr Buckley dated 30 March 2017[177] in which he stated that during the period between 18 and 22 April 2017 he would be at Victor Harbor with his family and that 'it may be that I could return for individual emergency cases depending on their timing'. Once again, that email is far from an undertaking to be generally available, rather it is in the nature of a willingness to assist if he happened to be in town and near at hand.

15.2. Dr Taylor's evidence was that he became aware that Dr Wilks would be rostered to cover neurointervention during the period and Dr Taylor was satisfied that Dr Wilks could safely perform thrombectomies[178]. He added that for an aneurysm case he would make arrangements to return to attend if required, but that there would be a period of up to 24 hours in which that could happen, describing aneurysms as non-emergency cases[179].

15.3. Dr Taylor was asked by counsel for Dr Scroop whether in the meeting with Dr Buckley he said that he would be available to assist Dr Wilks. He said that his position, as indicated by the email shortly after the meeting, and possibly at the meeting itself, was that he would be '*unavailable to be on call*' but that he would be available for non-urgent aneurysms the following day[180]. He said that he had made it very clear that it would be impossible for him to provide cover for stroke cases whilst at Victor Harbor[181]. He was asked by counsel for Dr Scroop if he agreed that he would be available to discuss stroke cases with Dr Wilks and he responded that he would answer his phone if

[176] Exhibit C53
[177] Exhibit C14, JT04
[178] Transcript, page 2158
[179] Transcript, page 2158
[180] Transcript, page 2204
[181] Transcript, page 2205

possible and be as helpful as possible, but that '*I was not on call and I provided no guarantee as to my availability*'[182].

15.4. He was asked by counsel for Dr Scroop whether he had said that he would '*assist Dr Wilks depending on the severity of the case and your availability*' or words to that effect[183] and he responded that so far as stroke cases were concerned:

> 'Most definitely not. In fact, I specifically indicated that I would be some hours away from the hospital and would most definitely not be able to assist in stroke cases. That was reiterated in a number of subsequent discussions and also in my email.' [184]

15.5. Dr Taylor said that Dr Scroop was well aware of the fact that when he was at Victor Harbor he would go fishing and that in those circumstances it would be impossible for him to attend a stroke case. He said he did not think anyone could have thought it was feasible for him to attend for a stroke case and that he would not have said he was available for that purpose because it would be '*plainly impossible for me to do so and that would be well-known to the other parties*'[185]. He denied in answer to a question from counsel for Dr Scroop that he indicated to her that he would be available if Dr Wilks needed to discuss a case and to assist him depending on the severity of the case and his availability.

15.6. In relation to this subject I regard Dr Taylor as being a truthful witness. I also accept the evidence of Drs Buckley, Kleinig and Wilks, all of whom gave what I regarded as truthful evidence on this topic.

16. Dr Scroop's evidence

16.1. Dr Scroop made a statement in these proceedings[186]. The statement was made before the commencement of oral evidence. In her statement she introduced the subject of Dr Wilks in the context of certification with the Conjoint Committee for the Recognition of Training in Interventional Radiology (CCINR). She noted that there are consultant radiologists '*such as Dr Michael Wilks*'[187] who perform INR procedures, although not certified on the CCINR register. She said that Dr Wilks had often

[182] Transcript, page 2205
[183] Transcript, page 2205
[184] Transcript, page 2205
[185] Transcript, page 2206
[186] Exhibit C15
[187] Exhibit C15, paragraph 16

scrubbed into stroke cases with her and on occasions he had acted as the primary operator[188].

16.2. Dr Scroop referred to the meeting between herself, Dr Buckley and Dr Taylor and said that it was agreed that she would approach Dr Wilks to enquire if he would provide INR cover[189]. She said that her understanding of Dr Taylor's availability was as follows:

> 'It is my recollection that the effect of what Dr Taylor said was that he would be available to assist Dr Wilks with aneurysm cases because they were not necessarily time critical and that he would be available to discuss stroke cases with Dr Wilks if Dr Wilks needed to discuss a case and to assist Dr Wilks depending on the severity of the case and Dr Taylor's availability.' [190]

She said that Dr Wilks agreed to provide the on call cover for the INR service[191].

16.3. She said that her expectation was that Dr Wilks would be available to respond to stroke cases 'preferably within 30 minutes of being informed'[192].

16.4. It is notable therefore that in her statement Dr Scroop made no assertion that Dr Taylor would definitely be available to perform a stroke case as she had told Dr Kleinig. The highest her assertion about Dr Taylor's availability reached was that Dr Taylor would be available to discuss and assist depending on Dr Taylor's availability.

17. Dr Scroop's oral evidence

17.1. I did not find Dr Scroop to be a convincing witness. There were inconsistencies in her evidence and her position changed as the examination proceeded. At times she was evasive. I do not accept her evidence where it differs from that of the other witnesses in a number of areas.

17.2. Dr Scroop was not taken by her counsel through a detailed account of the arrangements she made with Dr Wilks. She and her counsel left her statement as adequately explaining to her satisfaction the events leading to the 'cover for the period of leave in April 2017'[193]. It was notable that such an important topic was not dealt with in detail in her evidence-in-chief. Indeed, her subsequent answers to questions from other

[188] Exhibit C15, paragraph 16
[189] Exhibit C15, paragraph 40
[190] Exhibit C15, paragraph 41
[191] Exhibit C15, paragraph 42
[192] Exhibit C15, paragraph 47
[193] Transcript, pages 2417-2419

counsel revealed that she certainly had knowledge above and beyond the contents of the statement. Important aspects of this question were left to be fleshed out in questioning by counsel for other parties. The analysis of her evidence which follows is taken from her examination by counsel for other parties and counsel assisting.

17.3. Dr Scroop said that she was asked by Dr Buckley to come up with a proposal to cover her absence and that of Dr Taylor[194]. She said that no-one else volunteered to do it so she took it upon herself to come up with a proposal[195].

17.4. She was asked about her options for a potential solution and she referred to Dr Wilks and mentioned that he was happy to be '*the first point of contact and utilising people within our department*'[196]. This is in contrast with the language used in her statement[197] where she referred to Dr Wilks being available to respond to stroke cases.

17.5. Dr Scroop was asked by counsel for Dr Wilks about her conversation with Dr Wilks. She said that she did not remember the specifics of what was said[198] but repeated that she asked him if he would provide '*a first point of contact*' for INR cases, particularly stroke, and he agreed[199].

17.6. She said that her expectation was that Dr Wilks would be available to be contacted if required at any point during that period of cover[200] and clarified that she understood the arrangement to be that this would include '*any time of the day*'[201].

17.7. It was put to Dr Scroop that the only arrangement she made with Dr Wilks was that he would provide on call cover '*for afterhours purposes*' and she disagreed[202].

17.8. Dr Scroop said that she personally informed Dr Kleinig and Dr Buckley of the arrangements she had made[203].

17.9. Dr Scroop said that she expected Dr Wilks to perform stroke thrombectomies '*after he had the opportunity to discuss cases with Dr Taylor*'[204].

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[194] Transcript, page 2534
[195] Transcript, pages 2534-2535
[196] Transcript, page 2535
[197] Exhibit C15
[198] Transcript, page 2551
[199] Transcript, page 2551
[200] Transcript, page 2552
[201] Transcript, page 2553
[202] Transcript, page 2559
[203] Transcript, page 2563
[204] Transcript, page 2565

17.10. Importantly, and significantly, Dr Scroop agreed that she contemplated the possibility that Dr Wilks would be the only person who was available and present and ready to do a stroke intervention regardless of his comfort or otherwise in performing that particular intervention[205].

17.11. Very shortly after that concession, she was asked about what she told Dr Kleinig about Dr Wilks. She then reverted to saying that she informed Dr Kleinig that Dr Wilks would do the procedure '*and he would be in contact and make arrangement with Dr Taylor*'[206], but '*how that eventuated was not my responsibility to determine*'[207].

17.12. She agreed that she told Dr Kleinig that Dr Taylor would be available to assist Dr Wilks, but did not accept that she told Dr Kleinig that Dr Taylor would drive to Adelaide and perform the procedure[208]. In that respect her evidence differed from that of Dr Kleinig and I prefer Dr Kleinig's evidence.

17.13. Dr Scroop had moved in the space of two pages of transcript from agreeing with the proposition that she must have contemplated the possibility that Dr Wilks might be the only person available to do a stroke intervention alone and unaided to the proposition that he would do it after making arrangements with Dr Taylor, which arrangements she did not define. She was asked about that inconsistency and acknowledged it[209].

17.14. She attempted to explain the inconsistency by saying that although she believed Dr Wilks had the clinical competence to perform the procedure alone and unaided, '*I think there was some concern from the neurologist they wanted him to have back up*'[210]. She was asked what neurologist and responded that she was referring at least to Dr Kleinig[211]. That passage of evidence was significant because shortly before in her evidence she cavilled with the suggestion that Dr Kleinig had some concern about her proposed arrangement[212], but was now asserting that Dr Kleinig was concerned[213]. She had no satisfactory explanation for that inconsistency in her evidence other than a reference to wanting '*to protect Dr Wilks' position in the scenario*'[214]. I do not accept

[205] Transcript, page 2568
[206] Transcript, page 2569
[207] Transcript, page 2569
[208] Transcript, page 2569
[209] Transcript, page 2569
[210] Transcript, page 2569
[211] Transcript, page 2570
[212] Transcript, page 2564
[213] Transcript, page 2570
[214] Transcript, page 2570

that explanation. She was reluctant to admit that Dr Kleinig expressed concern about the situation to her, but then when faced with another inconsistency in her evidence, namely the question whether Dr Wilks would be required to perform the procedure alone and unaided, she introduced the notion that the neurologist was concerned.

17.15. In this passage of evidence I believe that Dr Scroop had realised the difficulty presented by the need to reconcile Dr Kleinig's version of events with what she said occurred. She somehow needed to reconcile Dr Kleinig's version, namely that she told Dr Kleinig that Dr Taylor would come up from Victor Harbor and complete a procedure started by someone else with her concession that she had known that it was possible that Dr Wilks would be alone and unaided for a stroke intervention. In attempting to reconcile those two positions she suggested that Dr Kleinig had some concern about Dr Wilks' clinical competence and wanted him to have backup. In fact, Dr Kleinig could have had no concern about Dr Wilks' clinical competence in this scenario because it was never his expectation that Dr Wilks was involved. Dr Kleinig's evidence was that Dr Wilks was never mentioned. Indeed, Dr Kleinig made it clear that he would have argued the position if he had been informed that there was any doubt about Dr Taylor being available to return for stroke cases. It will be recalled that Dr Kleinig had said that in that scenario he would have forcibly suggested that Dr Chryssidis be included in the roster. It follows that when Dr Scroop said that Dr Kleinig did not have a concern about the arrangement she was being truthful at that point[215], but not when she gave the opposite version shortly thereafter[216].

17.16. Dr Scroop's attempt to explain the situation was in some disarray at this point as illustrated in the following passage of evidence:

> 'Q. In your discussion with Dr Wilks about whether or not he would assist with the roster, did you tell him that if there was a procedure that needed to be done urgently he was to organise for that to be done by liaising with Dr Taylor.
>
> A. No, not specifically, that he would be the point of contact and arrange for the procedure to commence, and then he would contact Dr Taylor.
>
> Q. Why would you start a procedure and then try and contact the consultant, because you may not reach the consultant.
>
> A. Well, my understanding was Dr Taylor was aware that he would be providing back up to Dr Wilks, and by start the procedure there are a lot of infrastructure, having

[215] Transcript, page 2564
[216] Transcript, page 2570

> anaesthetics involved, having the staff in the room, etc., so commence the proceedings for the procedure. ' [217]

That passage of evidence cannot be accepted. It is not tenable to suggest that Dr Wilks would start a procedure that he could not complete by himself without assistance from Dr Taylor, with the intention of contacting Dr Taylor after the procedure had commenced when he would well know that that may not be possible.

17.17. Dr Scroop was asked by counsel for Dr Taylor about her knowledge of his Victor Harbor property and difficulties in making contact by telephone with Dr Taylor when he was at his Victor Harbor property. She avoided answering the question at first and then suggested that it was irrelevant before being reminded by the Court that she was required to answer the question. She reluctantly admitted that the phone connection was probably '*patchy*'[218].

17.18. Under cross-examination by counsel for Dr Taylor, Dr Scroop departed from her earlier evidence that Dr Wilks might find himself conducting a stroke alone and unassisted:

> 'I think I clarified with his Honour that Dr Wilks would be the first point of contact and then he would call Dr Taylor who would be able to assist if the case was thought appropriate to proceed.' [219]

This passage of evidence plainly contradicted her evidence at transcript, page 2568.

17.19. At this point in her evidence Dr Scroop adopted the approach of denying responsibility:

> 'I might - Dr Wilks and Dr Taylor and Dr Buckley were all aware of the arrangements that I had voluntarily sort of put together. If they were unhappy with those arrangements or the manager was unhappy with those arrangements it was not my responsibility to make alternative arrangements. I had approved leave for that period, I was just trying to assist them to come up with a plan. If any of the participants in that plan or the manager who instigated that plan were unhappy, that is not my responsibility. Dr Taylor is an equal member of this service and he has an equal responsibility for ensuring that period of time was covered.' [220]

17.20. Later she was asked what she meant by the expression 'assist'. She answered that it meant to provide '*hands on*' assistance[221]. She was asked how Dr Taylor could provide such assistance if he was unable to answer the phone at Victor Harbor and she reverted

[217] Transcript, page 2571
[218] Transcript, page 2579
[219] Transcript, page 2583
[220] Transcript, pages 2584-2585
[221] Transcript, page 2588

to the response that she was not responsible for the arrangements and they were a matter for the manager of the department[222].

17.21. Dr Scroop was asked why it was that if Dr Wilks was a competent person to nominate for cover in the period it was necessary for Dr Taylor to be ready to provide assistance and she was unable to provide a satisfactory answer[223].

17.22. Dr Scroop's final position in respect of Dr Taylor's role was that Dr Taylor should have realised he was on call on Tuesday 18 April 2017 and that meant he should have understood he had to be close to a phone that would receive a phone call, be close to a car and be able to get into that car forthwith upon receipt of a phone call and drive to Adelaide as quickly as he could[224]. She said that the responsibility of ensuring that '*those arrangements were understood*' should have been '*translated through the manager to Dr Taylor*'[225].

17.23. Dr Scroop made a point about 'management' being responsible for implementing her proposed arrangement and said that the problem was that 'management' failed to do that and the arrangement '*didn't translate into fact*'[226]. She said there were two respects in which her arrangement did not translate into fact. The first was what she described as the '*misunderstanding*' of Dr Wilks about what was required of him and, secondly, the lack of understanding on the part of Dr Taylor as to what was required of him in coordinating with Dr Wilks[227].

18. Conclusion with respect to Dr Scroop's arrangement for 18 April 2017

18.1. I have said that I accept the evidence of Dr Kleinig, Dr Buckley, Dr Wilks and Dr Taylor. Where there is conflict between their accounts and Dr Scroop's account, as to the arrangements for 18 April 2017, I reject the evidence of Dr Scroop. It follows that her attempt to deflect responsibility onto 'management' by which she means Dr Buckley, for failing to implement the arrangement is not entirely fair. Dr Buckley clearly deferred to Dr Scroop in many, if not all, aspects of the INR service at the Royal Adelaide Hospital. He said in his evidence that he double-checked with Dr Scroop

[222] Transcript, page 2588
[223] Transcript, page 2589
[224] Transcript, page 2599
[225] Transcript, page 2599
[226] Transcript, page 2594
[227] Transcript, page 2594

about the adequacy of the arrangement. Dr Buckley knew that Dr Taylor was not going to be available at all unless by happenstance he was temporarily in Adelaide at the precise moment he was needed. Dr Buckley had obtained a reassurance from Dr Scroop that Dr Wilks was ready, willing and able to assist. For his part, Dr Wilks was approached by Dr Scroop in what was, it would appear, a conversation in the workplace. The details of the conversation were not confirmed by Dr Scroop in writing. Dr Wilks' account was that if Dr Scroop had truly conveyed to him that he would be required 24 hours per day for the period between 18 and 22 April 2017 he would have had to have taken annual leave from his private practice, thus freeing him from his pre-existing obligations during working hours. He made the assumption that she was only referring to what he was asked to do out of hours. Perhaps some criticism could be levelled at him for that, however he was not primarily responsible for the INR service. Historically that service had been managed autonomously, as will be seen hereunder, by Drs Scroop and Taylor. On any view Dr Scroop's approach to Dr Wilks did not flesh out the implications of her request sufficiently to Dr Wilks to enable him to appreciate that he was to be required at short notice for stroke cases, even during ordinary business hours when he knew that Dr Scroop knew that he had other obligations. It was incumbent upon Dr Scroop to make the full implications of her proposal known to Dr Wilks and she did not do so. That is not to say that Dr Wilks should not have made further inquiries. Had he done so, the problems of 18 April 2017 may have been avoided.

18.2. It was quite apparent from Dr Kleinig's account that he was very interested to know what arrangements would be in place for the stroke service during the absence of both Drs Scroop and Taylor. He said that he was informed by Dr Scroop that Dr Taylor would be at Victor Harbor but would be available to attend within the hour. I accept his evidence. It was powerful and convincing.

18.3. The overall effect of the arrangement was that Dr Buckley knew that Dr Taylor would not be available, but accepted Dr Scroop's assurances that Dr Wilks could fill the role during the relevant period. He did not turn his mind to whether Dr Wilks needed to take annual leave from his private practice or matters of that kind. He did not speak to Dr Wilks directly. Undoubtedly he should have done so and he conceded as much in his evidence[228].

[228] Transcript, page 211

18.4. Dr Wilks rather casually accepted the proposed arrangement proffered by Dr Scroop. He thought that he would fill in to do urgent stroke cases, but only after hours. Dr Kleinig thought that Dr Taylor would be available despite being at Victor Harbor and would actually perform the stroke cases during the relevant period. Dr Taylor thought that he could go on holidays at Victor Harbor and be free of any obligations regarding urgent attendance for stroke thrombectomies. Thus Drs Buckley, Taylor and Wilks had a similar understanding of the proposal. Dr Kleinig's understanding was entirely different. The common link in all of the discussions was Dr Scroop.

18.5. It would at all times have been possible for Dr Scroop to have nominated Dr Chryssidis to be on call during the relevant period. He was at the relevant time listed on the CCINR register. He was also providing an INR service under the auspices of the Flinders Medical Centre, another major public hospital in South Australia run by the Department of Health, the same employer of the radiologists at the Royal Adelaide Hospital. It seems to the objective observer an obvious solution and it is legitimate to ask why it was not enacted.

19. <u>The Royal Adelaide Hospital INR service – an autonomous service</u>

19.1. The evidence throughout the Inquest makes it absolutely clear that the INR service at the Royal Adelaide Hospital was autonomously managed by Drs Scroop and Taylor and latterly, more so by Dr Scroop. Dr Buckley was the Campus Clinical Head and was ostensibly responsible for the service. For example, he was obliged to sign the leave forms and he did participate in an attempt to resolve the conundrum of what would be done during the proposed absence of both Drs Scroop and Taylor.

19.2. Dr Buckley was evidently not a strong leader. His evidence reflected that he deferred in practically every sense to the judgment of Drs Scroop and Taylor.

19.3. It was clear from the evidence that Dr Scroop was a more assertive personality than Dr Taylor. It is clear on the evidence that Dr Scroop took a more assertive role in relation to the service in the years leading up to 2017 than Dr Taylor.

19.4. The following are examples of the autonomous nature of the service:

1. Dr Buckley said that normally it was his expectation that the INR roster would be '*planned by the two interventional radiologists and then it would come to me for signing off*'[229].

2. Dr Buckley said that the INR component of the general roster for the radiology department changes frequently and '*obviously Dr Taylor and Dr Scroop would be better equipped to discuss this*'[230].

3. Dr Buckley sought assurances from Dr Scroop about Dr Wilks' abilities saying '*she's the expert in INR and I am not*'[231].

4. Dr Buckley was asked about Dr Chryssidis' participation in the INR service, noting that Dr Scroop did not believe that Dr Chryssidis was 'of a level that she was happy with'. Dr Buckley was asked about his own view and said that he did not have concerns about Dr Chryssidis' capabilities, but '*I'm not an expert in this area. So I've never worked with him in this area, not being an interventional neuroradiologist. My opinion is of very little value, really I would have to say*'[232].

5. Dr Buckley was aware that Dr Scroop and Dr Taylor had been providing a service 24 hours a day, 7 days per week between the two of them for a long time and that it was '*just too much work*' and '*a lot of stress*'. He referred to fatigue, weariness and low morale[233], but it appears that he did nothing effectively about that[234].

6. Dr Buckley acknowledged that there was a leave protocol which was designed to avoid both Dr Taylor and Dr Scroop being on leave at the same time and that it was not followed in this case and that he generally left the rostering issues to Drs Scroop and Taylor in any event:

> 'So I was, because Dr Taylor and Dr Scroop work closely together and have worked very successfully, I was trusting them to work out a system whereby there would not be an overlap, which has always happened in the past.' [235]

[229] Transcript, page 74
[230] Transcript, page 76
[231] Transcript, page 79
[232] Transcript, page 85
[233] Transcript, page 86
[234] Transcript, page 87
[235] Transcript, page 101

7. Dr Buckley said that the decision as to who would be rostered on a particular day prior to April 2017 in the INR service was determined by Drs Scroop and Taylor[236].

8. Even in his evidence at the Inquest when asked about Dr Wilks' understanding that he was only to be available after hours, Dr Buckley deferred to Dr Scroop:

> 'You would have to ask Dr Scroop what she agreed with him, because I wasn't present.' [237]

9. Dr Buckley appeared to turn a blind eye to the fragility of a 24 hour, 7 day per week service run by two people and adopted a hands-off approach[238].

10. Dr Buckley was asked why, given the sharp increase in thrombectomy work of recent years was Dr Wilks not put on the roster for the purposes of performing thrombectomies regularly prior to April 2017 and he responded:

> 'That was not the sort of decision I would make and that was not really my task.' [239]

He was then asked whether as Campus Clinical Head he could give directions to Drs Scroop and Taylor about administrative matters such as who would be on the roster. He said he preferred to use the expression that he could give them advice rather than direction. It was pointed out to him that he had it in his power to introduce an available third potential neurointerventionist, namely Dr Wilks, if he chose to and he responded:

> 'I think in practice it would have been very difficult for me to tell them that he would from now on be doing more INR.' [240]

11. Dr Buckley was asked why it would be difficult in practice to do that and he responded '*there is a lot of autonomy within the interventional area*' and he added '*with regard to the INR in a sense the person who's really - the people who run it really are Dr Scroop and Dr Taylor*'[241]. Following that passage of evidence Dr Buckley was challenged and asked if the real reason he did not wish to influence the introduction of a third interventionist was because he was aware that it would create problems with Dr Scroop and/or Dr Taylor and he was not

[236] Transcript, page 106
[237] Transcript, page 113
[238] Transcript, pages 114-115
[239] Transcript, page 119
[240] Transcript, page 121
[241] Transcript, page 121

prepared to put himself through that unpleasantness. His answer was an exercise in obfuscation. He attempted to suggest that prior to April 2017 there was not '*as much awareness*' about the growing workload[242]. That was plainly just not true on a reading of the whole of the evidence in this case and indeed, Dr Buckley retreated from that position in his very next answer. In short, Dr Buckley then agreed that a golden opportunity had existed in Dr Wilks. That whole passage of evidence and Dr Buckley's general demeanour and approach demonstrated a deferential and timorous approach on his part to the conduct of the INR service.

12. Dr Buckley was asked who was responsible for filling the gap in the roster in the relevant period and he replied that he thought '*we all had responsibility for the gap*', namely Dr Scroop, Dr Taylor and himself[243]. That is not an assertive approach.

13. Dr Buckley was asked whether if the problems with the arrangement proposed by Dr Scroop had been recognised he would have contacted Dr Chryssidis to ask him to assist. His first option was that he would ask Dr Taylor to cancel his leave. He was reluctant to accept Dr Chryssidis as an alternative because of the difficult relationship that existed between Dr Chryssidis on the one hand and Dr Scroop, and to a lesser extent, Dr Taylor on the other. He said:

> '.. but knowing the background would have, would've made me reluctant to opt for Steve Chryssidis as a first choice over, say, Mike Wilks, necessarily. But if I became aware that cover was absent, I think there is - in fact I know I would've had no problem with contacting Steve Chryssidis and asking if he could help; and in fact of course that's what I did later on that day.' [244]

In that passage of evidence when he used the words '*knowing the background*' he was referring to the background of the fractious relationship I have referred to above[245]. Again this passage of evidence indicates that Dr Buckley was clearly affected by what he knew would be the reaction to the suggestion of Dr Chryssidis being included in the roster. This is a clear sign that he was leaving the management of the INR service to be heavily influenced by the attitudes of Drs Scroop and Taylor. This timorousness on his part would clearly have been

[242] Transcript, page 122
[243] Transcript, page 211
[244] Transcript, page 214
[245] Transcript, page 214

known to Drs Scroop and Taylor. They were well aware that they had a very high degree of autonomy in the conduct of the INR service.

14. Dr Buckley left the matter of conveying the arrangement for the relevant period in April 2017 to the neurologists to Dr Scroop. He was reluctant to acknowledge that that was a matter he should have assumed control of[246]. Again this is suggestive of a hands-off approach and the existence of an autonomous service in the INR area.

15. Dr Scroop was asked about an occasion when she made an approach to a company that supplied devices to INR service providers in an effort to ascertain whether Dr Chryssidis was providing an INR service elsewhere in Adelaide. She was asked in what capacity she considered herself to be making the approach to the device supplier and responded:

> 'It was made aware to me by that service provider and I was under the impression that that was being provided at the Queen Elizabeth Hospital. It wasn't in respect to what was occurring in the private practice, that is nothing that I have any jurisdictional governance over. I was under the impression that they were looking at setting up an aneurism and INR service at the Queen Elizabeth Hospital.' [247]

In that passage Dr Scroop is effectively asserting that she had '*jurisdictional governance*' over INR services in the State's public hospitals. That is very much suggestive of an autonomous approach on her part. Certainly her approach to the device supplier was not authorised by any other person within the Department of Health – it was her decision alone and her own initiative. It was indicative of a desire to control and manage the provision of the INR service throughout the public hospital system.

16. Dr Scroop accepted the proposition that almost everybody defers to the views of herself and Dr Taylor in relation to INR work[248]. Just after that passage of evidence she deflected responsibility for the implementation of the arrangement with respect to the relevant period onto Dr Buckley. I do not accept that deflection of responsibility. In fact, Dr Scroop particularly was at pains over many years to establish an autonomous INR service and was reluctant to brook any interference in that autonomy. Indeed she resisted it.

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[246] Transcript, pages 215-216
[247] Transcript, pages 2490-2491
[248] Transcript, pages 2593-2594

20. Dr Scroop's attitude to the establishment of an INR service at Flinders Medical Centre in 2015

20.1. Following his resignation from the Royal Adelaide Hospital in early 2014 Dr Chryssidis commenced working at Flinders Medical Centre from April 2014 and established an INR service at that hospital. Dr Chryssidis described the nature of that service, the support that it had from the Southern Adelaide Local Health Network (SALHN) and the various medical disciplines at Flinders Medical Centre[249]. He said that the service was developed with the support from the then Chief Executive Officer of SALHN, Dr Belinda Moyse, together with the Head of Surgery, Professor Padbury and the Head of Neurosurgery, Dr Vrodos. A business case was developed for the service and put forward to the New Procedures Committee at Flinders Medical Centre as part of the process of seeking formal approval[250]. The INR service was formally approved by the New Procedures Committee in mid-2015[251]. Before the INR service was formally approved, several INR procedures were carried out, but each was the subject of specific approval from all appropriate authorities, including the Chief Executive Officer of SALHN. These procedures were requested by the neurosurgical team at Flinders Medical Centre[252].

20.2. It was quite clear that the INR services at Flinders Medical Centre were properly authorised. Dr Agzarian made it completely clear in his then capacity as Clinical Campus Head at Flinders Medical Centre that the service was appropriately planned and approved at all times and he personally had no doubts about its utility[253].

20.3. Dr Agzarian ceased to be the Clinical Campus Head in May 2015 when Professor Slavotnik took over that role[254]. Professor Slavotnik became aware of the Flinders Medical Centre INR service shortly after commencing in the role as Clinical Campus Head. He was aware that it was supported by the Chief Executive Officer of SAHLN and the Heads of Medicine and Surgery and Dr Chryssidis[255].

20.4. Dr Agzarian gave evidence about an incident that took place on 21 March 2015 which illustrates Dr Scroop's attitude to the Flinders Medical Centre INR services. He

[249] Transcript, pages 1101-1102
[250] Exhibit C20 – SC2
[251] Transcript, page 2666
[252] Transcript, page 2667
[253] Transcript, page 2668
[254] Transcript, page 1743
[255] Transcript, page 285 and 1744

explained that on 21 March 2015 he was in Melbourne giving a lecture at the Australian and New Zealand Society of Neuroradiology annual scientific meeting[256]. In his absence Dr Peter Downey was filling in for Dr Agzarian as acting Clinical Campus Head[257]. Dr Agzarian said he spoke to Dr Downey on that day. Dr Downey had received a telephone call from Dr Scroop in the morning. Dr Agzarian said that Dr Scroop was:

> '.. really quite forcibly asking for details about why this procedure had occurred. Peter also was quite distressed and I think words were used like "this is clear breach of protocol and guideline". So I think he actually felt – I didn't – the impression I got from Peter was Peter was a bit scared, you know. I think he actually felt like he'd – it was a pretty forceful conversation that, for him, came fairly much out of the blue.' [258]

20.5. Dr Agzarian said that he suggested to Dr Downey that Dr Scroop should contact Dr Agzarian directly.

20.6. Dr Agzarian said that during that day he was also approached by Dr Meredith Thomas and Dr Mary Moss at the conference who told him that Dr Scroop really needed to talk to him. Dr Agzarian made an attempt to call her back and he finally spoke to her in the afternoon[259]. Dr Agzarian, in a very compelling passage of evidence, said that it was quite a '*distressing phone call for me*'. He said:

> 'I had someone who was very, very angry, who was saying that there had been aneurysm coiled at Flinders the night before which would have been the Friday night and that that was you know, words along the line of breach of SA Health practice and she said that was very disappointed in me for allowing this to occur.' [260]

Dr Agzarian said that he honestly felt quite shaken up after the phone call which he described as a very direct phone call.

20.7. He said that when he had arrived in Melbourne the previous day he had received a telephone call on the Friday night from Dr Vrodos, the Head of Neurosurgery at Flinders Medical Centre[261] to tell him that there was an aneurysm that he thought warranted coiling. Dr Vrodos had contacted Dr Belinda Moyse, the Chief Executive Officer of SAHLN, who had agreed that the procedure could go ahead. Dr Vrodos was the referring neurosurgeon and wanted Dr Chryssidis to carry out the procedure and

[256] Transcript, page 2669
[257] Transcript, page 2670a
[258] Transcript, page 2670b
[259] Transcript, page 2669
[260] Transcript, pages 2669-2670
[261] Transcript, pages 2668-2670

Dr Chryssidis was happy to do so, but wanted to ensure that Dr Agzarian was comfortable and to let him know out of courtesy[262]. As a result Dr Agzarian was aware that the procedure was to be carried out.

20.8. Dr Agzarian said that the phone call he received from Dr Scroop the following afternoon was unexpected and a '*forceful conversation*'[263].

20.9. Dr Agzarian said he did not believe that what had occurred had been a breach of any relevant practice or protocol as asserted by Dr Scroop in the telephone conversation that Saturday afternoon. He said that the Chief Executive Officer of the LHN, in this case Dr Moyse, is empowered to make decisions on the advice of senior clinicians. He said that this was not something that was being done '*under the radar*'[264]. He said it was being done with the approval of the head of the health service and did not involve any breach of SA Health policy or practice.

20.10. Dr Agzarian, in a powerful passage of evidence, summed the conversation up in the following words:

> '… getting up in front of your peers at a sort of trans- Tasman conference is not easy, and you know I'd given my lecture and I was sort of trying to sit back and perhaps relax a little bit more and enjoy the rest of the conference and I remember the call went for some time, I would say at least somewhere between half an hour and 45 minutes, I ended up being outside in a sort of a corridor, not in the conference because of the call, and I really was, you know when I finished, I was sort of, you know, the shirt is sweaty, the heart rate is up, you're actually feeling a little bit sort of tremulous, I remember thinking I felt really sort of shaken up, and it took of that - you know, then I sat and listened to the rest of the conference in the afternoon, but I didn't feel the calm and relaxed that I did feel when I'd actually, I'd say, finished my talk, I was left feeling anxious and it wasn't a pleasant conversation and it wasn't a pleasant feeling afterwards.' [265]

20.11. Dr Scroop was asked about her conversation with Dr Agzarian by her own counsel[266]. She acknowledged that there was '*certainly a heated conversation*' and the conversation was '*about wanting to progress the INR service and frustrations from both ends*'. Dr Scroop said that she was making the point to Dr Agzarian:

> 'That establishing an ad hoc, unprepared service was not the best way to approach things and that I had been previously approached by the head of neurosurgery at Flinders to have

[262] Transcript, page 2670
[263] Transcript, page 2670
[264] Transcript, page 2672
[265] Transcript, page 2674
[266] Transcript, pages 2431-2432

> input into setting up this service. I felt that developing it and establishing it without considering all the factors that needed to be present was a little premature.' [267]

20.12. I pause to note that Dr Scroop in that passage of evidence betrays her attitude to the provision of INR services in the public hospital system. It must be remembered that the procedure that occurred at the Flinders Medical Centre was with the approval of the Head of Neurosurgery, the Chief Executive Officer of SALHN and the Clinical Campus Head, Dr Agzarian. To suggest that this was '*an ad hoc, unprepared service*' could only be a reflection of Dr Scroop's personal opinion. It clearly was not shared by those other senior people. The fact of the matter was that Dr Scroop did not have the authority to make decisions with respect to the provision of INR services beyond her own service at the Royal Adelaide Hospital. Although Dr Scroop denied that she had adopted a 'bullying attitude' to Dr Agzarian, I found Dr Agzarian's account of the conversation to be convincing and sincere. As I have already said, I found Dr Scroop to be an evasive witness who in some respects gave evidence that I could not accept. I find that Dr Agzarian's account of the conversation was accurate. It had the ring of truth about it, including his references to feeling shaken and discomforted by the conversation even to the detail of having a sweaty shirt at the end of it. It certainly would be a very stressful thing to receive a telephone call from a forceful personality such as Dr Scroop asserting that a procedure had been carried out contrary to SA Health policy and procedure. It would not be the sort of telephone call a professional clinician would typically expect to be engaged in. Dr Agzarian had good reason to recall it in detail and with accuracy.

20.13. Dr Scroop said that prior to the conversation on 15 March 2015 she had had a previous discussion with Dr Agzarian about the proposed establishment of an INR service at Flinders Medical Centre. She had told him that it should involve all stakeholders and discuss the infrastructure required to replace the existing service which was to transfer patients to the Royal Adelaide Hospital. She said there needed to be infrastructure '*in terms of equipment, training of ancillary staff, before that was established*'[268]. She said that she had also had discussion to the same effect with the Head of Neurosurgery by which I assume she was referring to Dr Vrodos[269].

20.14. Dr Agzarian had no recollection of any specific discussion in those terms prior to 21 March 2015 but he agreed that it was always the intention to engage in training and

[267] Transcript, page 2432
[268] Transcript, page 2429
[269] Transcript, page 2429

support of ancillary staff at Flinders Medical Centre[270]. He denied having reached any agreement about those matters with Dr Scroop '*largely because the service hadn't received approval from the SAHLN New Procedure Committee nor the Chief Executive, so it was a little bit premature to be ..*'[271].

20.15. However, Dr Agzarian said that during his conversation with Dr Scroop on that Saturday afternoon he tried to reach some resolution[272]. He said that Dr Scroop had said that if there was going to be a service at Flinders Medical Centre she wanted to be part of the on call arrangement for it. He said that she followed that up with an email in late March or early April. He said that this proposed participation by Dr Scroop in an on call arrangement never amounted to anything because no afterhours service was ever developed for INR at Flinders Medical Centre and therefore there was no roster for anyone to be involved in[273].

20.16. He said that he then ceased to be the Clinical Campus Head and Professor Slavotnik took over that task. He said that Dr Scroop had then contacted Professor Slavotnik by email following the matter up. I will come to that email correspondence shortly.

20.17. For completeness I should mention that Dr Agzarian said that he spoke with Professor Padbury when he got back from the Melbourne conference and Professor Padbury described a similar conversation with Dr Scroop to that which Dr Agzarian had experienced. Dr Agzarian said that from his discussion with Professor Padbury it was a very similar conversation to the one Dr Scroop had had with him[274]. Again, Dr Scroop in her evidence denied having a bullying attitude with Professor Padbury saying that:

> 'I don't think anyone could bully Dr Padbury.' [275]

It is unnecessary for me to reach any conclusion about the nature of her conversation with Professor Padbury, particularly given my findings in relation to her conversation with Dr Agzarian which are sufficient for my purposes.

20.18. On any view Dr Scroop was taking it upon herself to interfere in the provision of medical services being provided by another local health network, a subject in respect of which she had no business interfering.

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[270] Transcript, page 2669
[271] Transcript, page 2669
[272] Transcript, page 2670
[273] Transcript, page 2670
[274] Transcript, page 2671
[275] Transcript, page 2432

20.19. Dr Scroop persisted in her endeavours to insert herself into the question of the appropriateness or otherwise of an INR service at the Flinders Medical Centre following the events of 21 March 2015. On the following Monday, 23 March 2015 she sent an email to Dr Agzarian with copies to Trevor Saunders and Professor Padbury as follows:

> 'Just wanted to follow-up on our discussion from the weekend. I am still a little unclear as to the line management for radiological services at FMC?
>
> What is your responsibility to Trevor Saunders/Gloria Wallace? Given that SAMI[276] have previously not endorsed an INR service at FMC, pre Transforming Health, maybe a discussion needs to be had regarding provision of this service at FMC. There are many issues that need to be addressed in regards to imaging equipment, stock and emergency/elective service provision.
>
> In any event until these issues are resolved it would be appropriate to maintain the current INR service via RAH. Keen to discuss further. Rebecca' [277]

That email represents a further attempt, as I have said, to insert herself into the question of the appropriateness of an INR service at Flinders Medical Centre. Dr Agzarian gave evidence that he understood Dr Scroop's email to him to be questioning his line management and his authority to approve the procedure that Dr Chryssidis had performed[278] and to be suggesting that INR services at Flinders Medical Centre should be ceased[279]. Dr Agzarian did not agree with this view[280] and it was certainly within his authority to make that decision, it was not a decision for Dr Scroop.

20.20. Dr Agzarian politely replied to Dr Scroop's email on 24 March 2015. He took the trouble to explain the governance structure of South Australian Medical Imaging and his reporting lines. The tone of the email is notably more courteous than the one he received. Even more graciously, he finished by responding that he welcomed Dr Scroop's request to participate in an out of hours roster, which as I said was never established[281].

20.21. Professor Padbury replied to Dr Scroop's email also, it having been copied to him. His reply was also most courteous and civil, embracing her offer.

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[276] South Australian Medical Imaging
[277] Exhibit C20cc, page 3
[278] Transcript, page 2675
[279] Transcript, page 2676
[280] Transcript, page 2676
[281] Exhibit C20cc, page 2

20.22. The next email in the chain was one from Dr Scroop to Professor Padbury, Dr Agzarian and various others including Dr Moyse and Dr Vrodos, but notably not Dr Chryssidis. The email is as follows:

> 'Dear Rob
>
> Thanks for your time yesterday. As discussed further discussion needs to occur regarding INR services for SA and how that looks at FMC. Perhaps you could suggest an appropriate venue and time to discuss this? In addition to those in the email train I think Neurosurgical representation from the RAH and perhaps SAMI either Gloria Wallace or her delegate.
>
> Rebecca'[282]

20.23. Professor Padbury replied to the group on 30 March 2015 in a manner which appears to be intended to politely discourage Dr Scroop:

> 'Dear All,
>
> I'm very pleased to assist where possible in the development of the INR service. However I will leave it to Marc and Nick to drive the process of organising meetings etc.
>
> Rob' [283]

That email referencing Marc and Nick is a reference to Drs Agzarian and Vrodos who were stationed at the Flinders Medical Centre. I take the email to be indicative of a resolve on Professor Padbury's part to resist Dr Scroop's overtures.

20.24. On the following day, 31 March 2015, Dr Scroop again persisted with an email to Professor Padbury, Dr Agzarian, Dr Wallace, Dr Moyse and Dr Vrodos. The email had a pre-emptory tone:

> 'Mark
>
> Are you able to arrange this?
>
> Rebecca' [284]

20.25. I merely note that the email is not expressed as considerately as the correspondence from Dr Agzarian to Dr Scroop had been and goes to support my conclusion that Dr Agzarian's version of the conversation of 21 March 2015 was to be preferred over hers.

20.26. The next development was Dr Scroop sending an email to Trevor Saunders with copies to Dr Buckley and Professor Slavotnik. By that stage Professor Slavotnik was the

[282] Exhibit C20cc, page 1
[283] Exhibit C20cc, page 1
[284] Exhibit C20cc, page 1

Clinical Campus Head at Flinders Medical Centre, having taken over that role from Dr Agzarian. The email is as follows:

> 'Dear Trevor
>
> Since I last touched base in regards to INR services in SA there has obviously been a change in governance at FMC. Marc[285] and I had reached a point where we felt the requirement for a review of the activity that is occurring at FMC and to confirm process regarding INR service delivery in SAMI. This has seemingly fallen in an administrative heap but it is imperative that action is taken in the near future. As we had discussed previously I have particular concerns regarding the motivation for an INR service at FMC and its need in SAMI, especially in light of the work that was done to review this exact area.
>
> Kind regards
>
> Rebecca Scroop'[286]

20.27. That email was not copied to Dr Agzarian. When it was shown to him in the course of his evidence he said he had not reached any such agreement with Dr Scroop. He said that the email was incorrect in its import, inferring as it did that the INR service at Flinders Medical Centre should be ceased.

20.28. It need hardly be said that it is a serious matter for Dr Scroop to be communicating even indirectly with Dr Agzarian's successor suggesting that an agreement had been reached when it had not. This was a service at another local health network which was not the direct concern of Dr Scroop at all. It was not for her to concern herself in the matter and certainly not for her to assert that an agreement had been reached when it had not. This is a clear example of her desire to exert a generalised control over the delivery of INR services in the public hospital system across the State, a function which was not properly hers to perform.

20.29. Professor Slavotnik was also asked about that email. He said that he took the email to be questioning why there was a service at Flinders Medical Centre[287]. Professor Slavotnik said he could recall asking in some of his email responses '*in what capacity are you approaching me? Because as a member of staff at the Royal Adelaide Hospital, as I pointed out, normally that would be through Head of Department up to SA*'[288].

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[285] This is a reference to Dr Agzarian
[286] Exhibit C12a
[287] Transcript, page 1745
[288] Transcript, page 1746

Professor Slavotnik said that he did not think it was appropriate to Dr Scroop's role to be taking it upon herself to forward such correspondence[289].

20.30. On 4 August 2015 Dr Scroop sent a further email to Professor Slavotnik rather briskly asking to meet with him or speak with him about INR at Flinders Medical Centre[290]. When she received no reply from Professor Slavotnik immediately, she followed that email up with a further email on 7 August 2015, again with an economy of language 'Can we meet next week?'[291]. This precipitated a reply from Professor Slavotnik by email as follows:

> 'Hi Rebecca,
>
> Firstly, apologies for not responding sooner.
>
> If you are seeking information regarding the CRC process and outcome at FMC that information is under privilege and I am not able to discuss this.
>
> Were there other matters you wish to discuss and in what capacity?
>
> Best Regards,
>
> John' [292]

20.31. Dr Scroop replied on 9 August 2015 as follows:

> 'Hi John
>
> My email was precipitated by a phone call from Nick Vrodos regarding an INR service at FMC. I stated I was not aware of the plans and that my opinion is that there needs to be a business case presented that supports this. I personally think it is unsafe to do INR cases, especially elective, on a single plane angio unit and if our biplane is out of action I cancel cases rather than use the single plane GE machine. How this effects (sic) an INR stroke service also needs to be looked at and will be to some extent in the current work state storke (sic) group being run by Jim Jannes. I also asked if the soon to be released INR credentialing criteria would affect scope of practice?
>
> In any event Nick is keen to meet.
>
> Rebecca '[293]

20.32. On 11 September 2015 Dr Scroop sent a further email to Professor Slavotnik stating amongst other things:

> 'Again I ask why a time tested and safe service at the RAH is not being used purely it would seem to serve FMC stakeholders own desires not the safety of the patient.' [294]

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[289] Transcript, page 1747
[290] Exhibit C12a
[291] Exhibit C12a
[292] Exhibit C12a
[293] Exhibit C12a
[294] Exhibit C12a

20.33. Professor Slavotnik was asked about these emails. He said that he was not aware of why Dr Vrodos would have called Dr Scroop and he had no awareness of how that engagement occurred. It appears clearly that he did not follow it up. He said that throughout the process of receiving these emails he was concerned about the capacity in which Dr Scroop was communicating with him. He said he thought there were a range of motivations and when asked if he was concerned that this was an attempt by Dr Scroop to stop Dr Chryssidis' provision of an INR service at Flinders Medical Centre, he responded:

> 'I think certainly that that possibility crossed my mind at another (sic)[295] of times; did I form a certain opinion? No. The pattern was concerning.' [296]

20.34. In my opinion Professor Slavotnik has understated the nature of the communications that were coming from Dr Scroop. She was overreaching her limited role in the public hospital system. There is little doubt that she was attempting to stop the provision of an INR service at Flinders Medical Centre, something which it was no part of her official role to concern herself in.

20.35. All of this material supports the conclusion that Dr Scroop certainly ran an autonomous INR service at the Royal Adelaide Hospital and her influence in that service was dominant. Certainly Dr Taylor could exercise some influence in the management of the service, but the evidence as a whole showed that he did not adopt a particularly assertive role.

20.36. Furthermore, in addition to her predominant role in the INR service at the Royal Adelaide Hospital, Dr Scroop sought to exert further influence, including efforts to thwart the continuation of the limited INR service that had been established at the Flinders Medical Centre in 2015.

20.37. The point of all of this is that Dr Scroop cannot avoid all responsibility for the state of the INR service at the Royal Adelaide Hospital between 18 and 22 April 2017 as she attempted to do in her evidence. Having adopted an assertive and pivotal role in the provision of the INR service at the Royal Adelaide Hospital itself, and having attempted to exert her influence beyond that service into other parts of the public health system, including at the Flinders Medical Centre and at the Queen Elizabeth Hospital (I refer to

[295] As it appears in the transcript - I take it to mean 'a number of times'
[296] Transcript, pages 1749- 1750

her reference to 'jurisdictional governance'), it is simply not tenable for Dr Scroop to suggest that the arrangement regarding Dr Wilks was not an arrangement for which she bore almost entire responsibility.

20.38. Indeed, even her willingness and desire to assume control of the arrangements to be made in the period of her absence and that of Dr Taylor is revealing. I have already set out the way in which her discussions with Drs Wilks, Buckley, Taylor and Kleinig unfolded. It was her desire to have as strong an influence as possible on the arrangements that would apply during her absence and that of Dr Taylor. In particular, it is reasonable to conclude that a significant part of her motivation was to avoid the very scenario that eventuated, namely the participation of Dr Chryssidis in any aspect of the INR service at the Royal Adelaide Hospital.

21. Causation

21.1. The evidence concerning Dr Chryssidis' conduct of the procedures on both Mr Graham and Mr Russell demonstrate that the procedures took place within acceptable time limits and the unfortunate outcomes were not the result of the absence of either Dr Taylor or Dr Scroop on 18 April 2017.

21.2. On the other hand, the Court's jurisdiction is to investigate the cause and circumstances of a reportable death. The word 'circumstances' has a very wide embrace. It would be quite artificial to embark on an exploration of the deaths of both Mr Graham and Mr Russell that ignored and disregarded the absence of both Drs Scroop and Taylor on that day. The evidence I have referred to previously in this finding demonstrates that there was at the very least consternation and confusion amongst the Royal Adelaide Hospital staff on that morning, and in some cases it verged on near panic. From the point of view of Dr Chryssidis it is no minor thing that he was interrupted in the course of treating another patient to respond urgently to the need for him to attend at the Royal Adelaide Hospital that morning to attend to Mr Graham. I therefore have no hesitation in concluding that the circumstances that led to the absence of both Dr Taylor and Dr Scroop from the service on that day required consideration in this finding. The evidence at the Inquest encompassed events going back as early as 2007 and even earlier. There was considerable evidence about Dr Chryssidis' early attempts to participate in the INR service and the interpersonal antipathy that arose between Dr Chryssidis and Dr Scroop. It is as well to be aware of those matters, but the fact is

that events that took place nearly 10 years prior to 2017 cannot be regarded as sufficiently proximate to warrant detailed analysis and conclusions. I have referred to particular events in 2015 for the purpose of demonstrating the extent to which Dr Scroop particularly exercised influence in relation to the provision of INR service within the State's public hospital system and attempted to effectively dominate all decision making in that sphere. She was ultimately unable to influence the establishment of an INR service at Flinders Medical Centre which was undoubtedly a recognised and properly accredited service run within the auspices of South Australia's public hospital system as at April 2017.

21.3. Dr Scroop undoubtedly held a negative view of Dr Chryssidis' technical competence. I have not attempted to determine the merits of her opinions on that subject because in my view it is unnecessary to do so. The short answer is that Dr Chryssidis was trusted by the public hospital system, in particular the SALHN and Flinders Medical Centre, to provide a service at that facility. As Dr Buckley noted '*the fact that he performs them at Flinders, that he is on the CCINR and our register says that he has an accepted satisfactory level of technical competence*'[297].

21.4. Dr Buckley agreed that in circumstances where the public hospital system, South Australian Medical Imaging, SALHN and Flinders Medical Centre are all comfortable with him performing procedures at Flinders Medical Centre and permitting him to do so it is simply untenable for Dr Scroop to erect an objection based on his technical competence when the very organisation within which they and he work was welcoming his contribution in another workplace[298].

21.5. One of the circumstances that created the unsatisfactory situation that existed on 18 April 2017 was that Dr Scroop, having volunteered to make an arrangement to meet the exigency presented by her absence and that of Dr Taylor in the relevant period failed to consider what objectively must be regarded as an obvious solution to the problem, namely the recruitment of Dr Chryssidis to fill in. The only conclusion that can be reached is that she would not do so because of the personal antipathy that existed between them.

[297] Transcript, page 205
[298] Transcript, pages 205-206

22. The CCINR

22.1. I have already said something about the Conjoint Committee for the Recognition of Training in Interventional Radiology. It was formed in 2014. It is a Committee external to the Royal Australian and New Zealand College of Radiologists. It consists of representatives of international neuroradiologists, neurosurgeons and neurologists[299].

22.2. I do not propose to canvas the extensive evidence surrounding the CCINR and listing within that service. It is sufficient to say that in order to be listed on the CCINR register it is necessary for interventional neuroradiologists to demonstrate a minimum amount of experience consisting of a minimal number of completed cases together with a minimal number of cases being performed going forward. No doubt it was part of Dr Chryssidis' motivation to participate in the INR service at the Royal Adelaide Hospital and the intensification of that desire in 2010 to 2012 was motivated by his knowledge of the proposed introduction of minimum requirements as contemplated by the CCINR. The obvious way to gain such experience locally in South Australia was to be permitted to have access to the Royal Adelaide Hospital INR service.

22.3. In any event Dr Chryssidis was listed on the CCINR register in 2017 and in the years immediately preceding, including 2015. He was the only radiologist in South Australia apart from Drs Scroop and Taylor that had that advantage. Attempts were made in the course of the Inquest, particularly by Dr Scroop, to suggest that Dr Chryssidis' period of registration, for want of a better word, on the CCINR was limited to one year compared to the three years which she enjoyed. I find it unnecessary to speculate upon the significance of that distinction. I did not hear evidence from the administrators of the CCINR and the relevant decision makers in that body to establish the true significance. To have done so would have been well beyond the scope of the Inquest. For my purposes it is sufficient to note that Dr Chryssidis was in fact listed at all relevant times.

22.4. At least until April 2017 within the South Australian health system, the evidence in this case showed that registration on the CCINR was not mandatory for the purposes of undertaking stroke thrombectomies and other procedures which are regarded as INR procedures. Indeed, the Royal Adelaide Hospital scope of clinical practice[300] does not

[299] Exhibit C54, paragraph 25
[300] For example Exhibit C15 RS3

mandate listing on the CCINR register to undertake INR procedures. After April 2017 a centralised credentialing system was introduced with the SA Health INR Scope for Clinical Practice Policy Directive[301]. The minimum training requirements to perform an INR procedure in a South Australian health facility now require the INR consultant to be listed on the CCINR register[302].

22.5. However, I am concerned with events prior to April 2017. As I say, prior to that time listing on the register was not mandatory. The attitude in relation to CCINR throughout the evidence appeared to me to be quite inconsistent. It appeared to me that sometimes not being listed on the INR was deployed as a reason for a person to be excluded from performing thrombectomies, but at other times it was not so employed and Dr Buckley emphatically agreed with that observation:

> 'I think that's an absolutely correct observation if I may say so.' [303]

22.6. Indeed, the best illustration of that proposition was Dr Scroop's decision to nominate Dr Wilks as the person who would be filling in to perform stroke thrombectomies during the relevant period. Dr Wilks was not listed on the CCINR at that time, nor had he ever been.

23. The 2016 recruitment process

23.1. In July 2016 a panel chaired by Professor Slavotnik undertook the task of recruiting radiologists across the three South Australian Medical Imaging sites[304]. The panel report ranked the candidates for appointment[305]. Despite the panel's recommendations no action was commenced by SAMI to engage the recommended appointees. This was due to a decision by SAMI to test the market to see if there was an interest in outsourcing the radiology services at the Lyell McEwin Hospital due to minimal interest in the advertised position at that hospital as part of the recruitment process[306].

23.2. In December 2016 the Health Department decided to outsource radiology services at the Lyell McEwin Hospital. This led to the need to redeploy existing permanent staff radiologists from that hospital to other employment[307]. This was why SA Health put

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[301] Exhibit C15b
[302] Exhibit C15b, paragraph 3.2
[303] Transcript, page 124
[304] Exhibit C12, paragraph 36
[305] Exhibit C10, paragraph 39 and Transcript, page 89
[306] Transcript, pages 561-562
[307] Exhibit C12, paragraph 41

the July 2016 recruitment process on hold because the number of potential redeployees from the Lyell McEwin Hospital radiologists exceeded existing vacancies[308].

23.3. Most of the displaced radiologists from the Lyell McEwin Hospital were redeployed to the Royal Adelaide Hospital and as a consequence the recommended candidates from the July 2016 recruitment process were not engaged[309]. The panel had recommended that 0.6 of an FTE[310] would be allocated to Dr Lan-Anh Do who had almost completed her training as an INR, but that did not occur because of the need to redeploy the Lyell McEwin Hospital radiologists. Those radiologists did not have INR skills[311].

23.4. There was some controversy in the Inquest concerning a meeting that took place in early February 2017. I have been unable to reach any conclusion as to what transpired at that meeting. There was a suggestion by Mr Kolovos that he made it plain to the other attendees that he had reserved 0.6 of an FTE from the 2016 recruitment process. That was not the understanding of other attendees at the meeting including Dr Scroop. I make no finding as to that matter. However, I have no doubt that had the 2016 recruitment process been allowed to proceed unaffected by the need to redeploy surplus radiologists from the Lyell McEwin Hospital, the Royal Adelaide Hospital INR service would have had a third INR by April 2017.

23.5. The conclusion is inescapable that the decision to halt the recruitment process was motivated by budgetary considerations and the knowledge that there would be excess radiologists from another campus for whom a budget allocation had to be made, thus precipitating the cancellation of the 2016 recruitment process. In my view it is extraordinary that a clear need for a third INR at the Royal Adelaide Hospital was overlooked and set aside by what can only be described as a bureaucratic response to a highly regulated and industrialised set of employment practices which did not have the flexibility to permit decisions to be made for the benefit of the health system as a whole, instead of for the benefit of persons with industrial rights who were subject to redeployment because their roles had become otiose.

[308] Exhibit C12, paragraph 42
[309] Transcript, page 89
[310] Full-Time Equivalent
[311] Transcript, page 2104

24. Recommendations

24.1. I have no recommendations to make in this matter

Key Words: Stroke; INR Services

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 6th day of December, 2018.

State Coroner