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 29th day of August, the 13th, 14th, 15th and 16th days of September, the 5th, 21st and 27th days of October and the 28th and 29th days of November 2022, the 3rd and 23rd day of March 2023 and the 16th day of May 2024, by the Coroner's Court of the said State, constituted of Naomi Mary Kereru, Coroner, into the death of Lynne Patricia Fisher.

The said Court finds that Lynne Patricia Fisher aged 60 years, late of 32 Wicks Road, Balhannah, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 28th day of September 2018 as a result of sepsis due to community acquired pneumonia. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Mrs Lynne Patricia Fisher died on 28 September 2018 at the Royal Adelaide Hospital (RAH), following a collapse at her home on 27 September 2018 in Balhannah. She was 60 years old. Less than 24 hours earlier, she had been discharged from the Mount Barker Soldiers Memorial Hospital (Mount Barker Hospital), following a diagnosis of bilateral pneumonia.

1.2. On 25 September 2018, Mrs Fisher attended her general practitioner (GP) and complained of a two-week illness with symptoms of a cough, shortness of breath and the production of yellow-green sputum. Mrs Fisher was diagnosed with a lower respiratory tract infection and prescribed an oral antibiotic (Augmentin Duo Forte). She was advised to return to the GP if she was not better in the next few days.

1.3. On 26 September 2018, Mrs Fisher was taken to the Mount Barker Hospital Emergency Department (ED) by her husband, Michael. The ED records reflected that at 7:20pm Mrs Fisher was experiencing shortness of breath and confusion. The notes record a 14-day history of illness for which she had been prescribed antibiotics by the GP.

1.4. Mrs Fisher's first set of recorded observations reflected a clinical picture of a high respiratory rate and a low oxygen saturation level, as well as an elevated pulse. She was also febrile and complaining of back pain.

1.5. Mrs Fisher was seen in the ED by locum, Dr Fenella Livesey, who ordered intravenous fluids and antibiotics, a nasopharyngeal swab, sputum culture and chest x-ray, but did not admit her to the hospital. Mrs Fisher was also commenced on oxygen therapy. Dr Livesey recorded that Mrs Fisher suffered from Chronic Obstructive Pulmonary Disease (COPD) based on her history of smoking.

1.6. Throughout that evening Mrs Fisher's test results became available. The chest x-ray revealed multi-lobar bilateral pneumonia, a highly elevated C-Reactive Protein level and an elevated white cell count. These results supported evidence of an infection.

1.7. Dr Livesey finished her shift at 10:30pm and conducted a handover with the night locum, Dr Meiyan Leng, when her shift commenced. Dr Leng remained at the hospital overnight and was the only doctor on site for the ED and the hospital until 8am the next morning. From approximately 9pm, Mrs Fisher was cared for by Mr Nabi Nawaz, a registered nurse, and other evening shift nurses until midnight. After midnight Mr Nawaz was the only nurse on shift.

1.8. Mrs Fisher's oxygen saturation levels improved slightly over the course of the evening and into the early hours of the morning while she was receiving two litres of oxygen via a nasal cannula (nasal specs). When tested by Mr Nawaz without oxygen therapy, Mrs Fisher's oxygen saturation levels were recorded as 86% on room air. At some point before midnight, Mrs Fisher was noted by Mr Nawaz to self-administer her Ventolin inhaler while still receiving two litres of oxygen. At 1:40am on 27 September 2018, Mrs Fisher was administered 5mg of Ventolin in accordance with a phone order from Dr Leng. Mrs Fisher was then discharged from hospital after having reached an oxygen saturation level of 92%.

1.9. Later that evening, whilst at home with her husband, Mrs Fisher complained of being short of breath and dizzy. She collapsed shortly thereafter and was conveyed to the RAH by ambulance, arriving in the ED at 9:53pm on 27 September 2018. Upon arrival at the RAH Mrs Fisher was in receipt of cardiopulmonary resuscitation (CPR) with return of spontaneous circulation (ROSC) achieved at 9:03pm.

1.10. Mrs Fisher was transferred to the Intensive Care Unit (ICU) of the RAH. Despite maximal support, Mrs Fisher continued to decline and was pronounced life extinct at 6:08am on 28 September 2018.

2. Reason for Inquest

2.1. This Inquest focused on the care provided to Mrs Fisher in the ED of the Mount Barker Hospital between 7:20pm on 26 September and 2am on 27 September 2018 and whether there were any deficits in her care that may have contributed to her death.

2.2. The Inquest explored whether the treatment Mrs Fisher received at the ED of the Mount Barker Hospital was sufficient considering her presentation. This included an exploration of why she was not admitted for further ongoing treatment.

2.3. In writing this Finding, I do not purport to summarise all of the evidence tendered or heard at the Inquest but refer to it only in such detail as appears warranted by its forensic significance. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

2.4. At the conclusion of the oral evidence there was no dispute that Mrs Fisher should have been admitted to the Mount Barker Hospital on 26 September 2018.[1] With that accepted, the pivotal issue examined during the course of the Inquest was how two senior doctors caring for Mrs Fisher at different times that evening and early morning, failed to recognise the severity of her condition. As will be expanded upon below, there were breakdowns in communication and missed opportunities in the clinical care of Mrs Fisher at the Mount Barker Hospital. For reasons detailed later in the Finding, I have found that Mrs Fisher's death was preventable at the time she was discharged from the Mount Barker Hospital on the morning of 27 September 2018.

[1] References in the closing submissions of all parties

3. Cause of death

3.1. Following Mrs Fisher's death, a pathology review was conducted by Dr Iain McIntyre and discussed with forensic pathologist, Dr Cheryl Charlwood, both of Forensic Science South Australia (FSSA). This meant that a review of Mrs Fisher's recent medical history was conducted, including her most recent attendance at the Mount Barker Hospital ED and the RAH. On 3 October 2018, Drs McIntyre and Charlwood cited Mrs Fisher's cause of death as '*sepsis due to pneumonia*'.[2]

3.2. Counsel acting on behalf of the Barossa Hills Fleurieu Health Network (BHFHN), Mr John Homburg, submitted that it was appropriate to include in the cause of death the origin of Mrs Fisher's pneumonia, namely that it was acquired in the community as opposed to an infection caught in a hospital setting, or from an episode of aspiration. As Mrs Fisher had been unwell for a period of approximately two weeks prior to attending the Mount Barker Hospital, with her stay only extending to a period of 6 hours and 40 minutes, I am satisfied that she developed pneumonia in the community, most likely as a secondary infection to a viral illness. Accordingly, I find that Mrs Fisher's cause of death was:

> 'Sepsis due to community acquired pneumonia.'

4. Evidence at Inquest

4.1. The documentary evidence at Inquest comprised 43 exhibits.

4.2. In addition to the documentary evidence, oral evidence was heard from:

- Nabi Nawaz, Registered Nurse
- Meiyan Leng, Medical Practitioner
- Merridy Chester, Registered Nurse
- Fenella Livesey, Registered Nurse
- Professor Anne-Maree Kelly, Expert Emergency Physician
- Dr Richard Watts, Expert called by Dr Leng
- Skye Haagmans, Registered Nurse

[2] Exhibit C2a

4.3. I have read and considered the written submissions of counsel assisting, the written submissions made on behalf of Dr Livesey, Dr Leng and Mr Nawaz, as well as the Barossa Hills Fleurieu Health Network.

5. Expert evidence

5.1. The Court sought an expert opinion from Professor Anne-Maree Kelly, Senior Emergency Physician, in her capacity as an expert in emergency medicine. Professor Kelly is an experienced clinician who is a fellow of the Australasian College for Emergency Medicine.[3] She currently holds the posts of Professor and Academic Head of Emergency Medicine and Senior Emergency Physician at Western Health in Footscray, Victoria and Adjunct Professor at the Australian Centre for Health Law Research, Queensland University of Technology. Professor Kelly has more than 30 years' experience in EDs as a specialist in South Australia, New Zealand and Victoria. She has worked in large, medium-sized and small EDs and in public (rural and urban) and private hospital settings treating both adults and children.

5.2. The Court also heard from Associate Professor Richard Watts, in his capacity as an expert witness.[4] Associate Professor Watts obtained his Bachelor of Medicine/Surgery from the Flinders University in 1980, a Diploma of Obstetrics in 1985, became Fellow of the Royal Australian College of General Practitioners in 1993 and was awarded a Doctorate in Medicine at the University of Adelaide in 2003. Associate Professor Watts has dedicated his professional life to rural medicine and worked in a number of rural locations including Port Lincoln, South Australia. He has co-published 54 papers in the field of medicine. I considered both Professor Kelly and Associate Professor Watts to be experts in their field.

5.3. A report was obtained by Dr Leng's solicitors from Associate Professor Watts and was premised on the assumption that Dr Leng's version of events of what transpired on the evening of Mrs Fisher's presentation were entirely accurate.[5] Dr Watts' evidence was also limited by the fact he had not been invited to consider the evidence of Dr Livesey or Mr Nawaz prior to the commission of his report or his oral evidence. To the extent there was any divergence in the opinions expressed by Dr Watts and Professor Kelly, I have preferred the opinion of Professor Kelly who was engaged for a broader purpose

[3] Elected to fellowship in 1990
[4] Exhibit C24, Curriculum Vitae of Associate Professor Richard Watts
[5] Exhibit C24a

and had the benefit of reviewing all of the relevant material. Furthermore, for reasons detailed below, I have rejected portions of Dr Leng's evidence, in particular where it conflicted with Mr Nawaz's evidence. I have accepted Professor Kelly's evidence in its entirety.

6. Mount Barker Hospital Emergency Department and Summit Health

6.1. At the commencement of the Inquest evidence was received from Ms Anne Marie Price, who was the Regional Director of Nursing for the Barossa Hills Fleurieu Region as part of the Country Health Local Health Network (CHLHN) in September 2018.[6] Ms Price was authorised to provide an affidavit on behalf of the BHFLHN which assumed control of the Mount Barker Hospital after the CHLHN was dissolved on 30 June 2019.[7]

6.2. Ms Price stated that in September 2018, under the control of the CHLHN, the Mount Barker Hospital provided 24 hours a day, 7 days a week emergency service (as it does now under the BHFLHN). The Hospital's ED comprised an administration and triage area, a resuscitation bay, a four-bed ward dedicated to ED presentations and two consultation rooms.[8] In September 2018, the Mount Barker Hospital also provided a duty doctor's overnight room where doctors could rest when not required in the ED or elsewhere in the hospital.[9] This room was located in the Administration Wing, some distance from the ED, with the allocated Room number of 201. This area has since been demolished. As will be seen below, the use of this room by doctors during shift was a matter relevant to the Inquest.

6.3. In September 2018, medical services for the Mount Barker Hospital's ED were provided by fee-for-service GPs from the Summit Health Centre. This arrangement was in place at the time of Mrs Fisher's attendance to the ED. The Summit Health Centre was situated adjacent to the Mount Barker Hospital ED and, from time to time, locum doctors organised by Summit Health were included on the ED roster.[10] This arrangement has since changed with the ED now staffed solely by doctors employed by BHFLHN. As will be detailed below, the provision of locum doctors by Summit Health to the Mount Barker Hospital ED was the subject of criticism during the Inquest, in

[6] Ms Price is now the Executive Director of Nursing and Midwifery and the Director of Clinical Governance, Quality and Safety for the BHFLHN
[7] Exhibit C8
[8] Exhibit C8, paragraph 10
[9] Exhibit C8, paragraph 15
[10] Exhibit C8, paragraph 14

particular by the nursing staff. One issue that was examined during the evidence was whether the use of locum doctors impacted either directly or indirectly on the care Mrs Fisher received during her attendance at the ED on 26 and 27 September 2018. This will be addressed below in the Finding.

6.4. Summit Health was provided with the submissions of all parties and invited to submit a response.[11] An email was received by the Court that Summit Health did not wish to be heard.

7. Circumstances leading up to death

7.1. Arrival at the Emergency Department

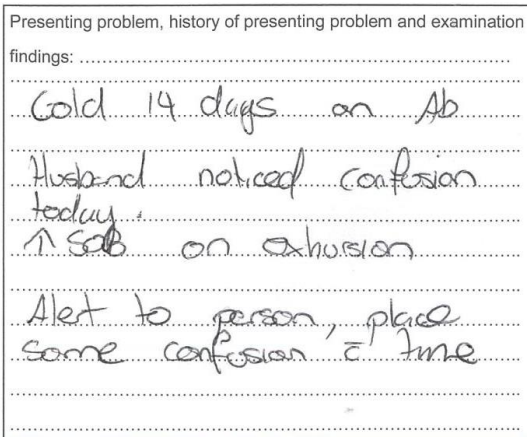
7.2. Mrs Fisher attended her local GP practice (Mount Barker and Balhannah Medical Clinic) on the morning of 25 September 2018 and saw Dr Matthew Stark. Mrs Fisher reported a two-week history of a cough with shortness of breath and production of yellow/green sputum. She also complained of pleuritic pain.[12] Dr Stark's examination revealed that Mrs Fisher was afebrile and was not short of breath. However, he could hear mid zone crackles on her lungs and diagnosed her with a lower respiratory tract infection (LRTI). Mrs Fisher was prescribed the antibiotic Augmentin Duo Forte with a tablet to be taken twice a day (bd). The entry in the case notes reflected that Dr Stark advised Mrs Fisher to rest, increase her fluid intake and to return to the GP if her symptoms were not settling, or sooner if she felt worse.[13]

7.3. Mrs Fisher's symptoms continued to worsen and her husband, Michael Fisher, took her to the ED of the Mount Barker Hospital just after 7pm on 26 September 2018. Mrs Fisher was triaged at 7:20pm by registered nurse (RN) Ms Erin Lord, with the reason for her attendance marked as shortness of breath (SOB) and confusion.[14] The MR10A document was the primary document referred to during the course of the Inquest as it was a document used in the ED where Mrs Fisher remained during her six hour attendance. The Court heard that the MR10A was a five page fold-out document designed so that one copy could be retained in the patient's case notes, one copy could be retained by the attending medical officer and one copy retained for

[11] Exhibits C17, Curriculum Vitae of Professor Anne-Maree Kelly and C17a, Report of Professor Anne-Maree Kelly
[12] Sharp chest pain that worsens during breathing
[13] Exhibit C6, page 2-3
[14] Exhibit C4, page 9; Exhibit C23, page 2

hospital administration.[15] This document included a colour coded observations chart to assist with identifying a deterioration in the patient, a medication chart and other areas to record information relevant to the patient's attendance at the ED, including their GP, Medicare details and what triage category they were provided.

7.4. Ms Lord recorded Mrs Fisher's presenting problem in the MR10A as follows:


Presenting problem, history of presenting problem and examination findings:
Cold 14 days on Ab
Husband noticed confusion today.
↑ SOB on exhusion
Alert to person, place some confusion ē time

7.5. Ms Lord also recorded the first set of observations in the coloured chart contained within the MR10A chart at 7:20pm.[16] These observations revealed an abnormal clinical picture with Mrs Fisher's respiratory rate recorded at 30 respirations per minute and in the red shaded zone. Her oxygen saturation levels were recorded at 84% and in the purple shaded zone. Her pulse rate was recorded at 115 beats per minute and in the red shaded zone.[17] While Ms Lord had no independent memory of Mrs Fisher, it was evident from the clinical notes that appropriate steps were taken by either her and/or another nurse in response to Mrs Fisher's clinical condition. Most importantly, oxygen therapy by way of a nasal specs was instituted prior to Dr Livesey's first medical consultation in the ED.[18]

7.6. I pause here to explain that the colours attributed to certain areas in the Rapid Detection and Response Adult Observation Chart (observation chart), are used to alert clinical staff to a deterioration in a patient. There is a response criterion at the back of the observation chart which guides the staff member as to what actions are required if one or more observations are recorded in a coloured area. For example, Mrs Fisher's

[15] Exhibit C8, pages 4-5
[16] Exhibit C4, page 10; Exhibit C23, page 3
[17] Exhibit C4, page 11
[18] Transcript, page 504

oxygen saturation level of 84% was so low and abnormal that it was entered into an area shaded in purple which required the clinician to:

> '… place an emergency call and specify a location, initiate basic/advanced life support, notify senior doctor responsible for patient, increase frequency observations post intervention, take advice from the MER Team.' [19]

7.7. Given that this was the first oxygen saturation level recorded at a time when Mrs Fisher was not yet in receipt of supplemental oxygen, it was reasonable to start the oxygen therapy and watch closely to see if her saturation levels improved. The evidence reflected that this was done swiftly and appropriately. Clearly, the area in which Mrs Fisher's oxygen saturation level was recorded (along with her respiratory rate and pulse rate in the red zone) was a marker of how unwell she was upon presentation to the ED.

7.8. Dr Fenella Livesey was the first medical practitioner to review Mrs Fisher in the ED. Dr Livesey obtained her medical degree from the University of Adelaide in 1985. She worked in general practice until she streamlined her practice to focus on emergency medicine in private EDs such as the Ashford and Wakefield Hospitals from the year 2000 onwards. In 2013 Dr Livesey gained employment with Summit Health in Mount Barker and worked regularly in the ED at the Mount Barker Hospital.[20] This was Dr Livesey's employment arrangement at the time of Mrs Fisher's presentation to the Mount Barker Hospital ED. On this evening, Dr Livesey commenced her shift at 6pm and was rostered to finish at 10:30pm. The records reflected that Dr Livesey first reviewed Mrs Fisher at a time between 7:20pm and 7:50pm, the latter time being when she made an entry in the MR10A record.[21]

7.9. Dr Livesey gave oral evidence that Mrs Fisher's presence in the ED was brought to her attention by the nursing staff while she was reviewing another patient. She stated:

> 'The nurses asked me to be sure that Lynne was the next patient that I saw when I finished with the one that I was seeing in the consulting room because she was so unwell with difficulty breathing and very low oxygen saturations.'[22]

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[19] Exhibit C8, page 54
[20] Transcript, page 494
[21] Transcript, page 562
[22] Transcript, page 498

7.10. Between 7:20pm and 7:50pm Dr Livesey assessed Mrs Fisher. Dr Livesey told the Court that she had a memory of her assessment, recalling the following:

> 'The initial consultation, yes, she was very unwell, unable to give a lot of history because she was so breathless. A lot of them were yes/no questions to try and make it a little easier for her. Essentially, she looked very, very unwell. She needed oxygen, her oxygen saturations improved with the oxygen, but she was very quickly written up for a Ventolin nebuliser and antibiotics to treat pneumonia and some fluids.' [23]

7.11. After assessing Mrs Fisher, Dr Livesey made a handwritten entry in the MR10A which she interpreted in her oral evidence:

> Left lower lobe pneumonia? Increasing shortness of breath on exertion with fevers, chills, confusion, anorexia, left lower chest pain radiating to back, cough was dry, now productive of yellow/greenish sputum, commenced on Augmentin Duo Forte 24 hours ago for pneumonia? On examination - looks unwell, mildly dehydrated, oxygen saturation levels 84% on room air. In mild-moderate respiratory distress with respiratory rate of 30 respirations per minute. Afebrile, tachycardic with pulse of 115 beats per minute. Blood pressure 125/65.24 Dr Livesey also ordered a Chest X-Ray, bloods to measure inflammatory markers such as C-Reactive Protein and a white cell count, a nasopharyngeal swab and a sputum culture. [25]

7.12. I pause here to highlight the relevance of Mrs Fisher's clinical condition upon presentation to the ED. Professor Kelly was asked to comment on the severity of Mrs Fisher's symptoms. She opined:

> 'The presentation in general is alarming because she's been told to come back if she's getting worse and she's come back, so that in itself is of a concern. But increasing shortness of breath suggests that whatever was happening previously is getting worse. The presence of fever is also suggestive of an infection. As we've discussed, the confusion is suggestive of a severe illness, anorexia is common with all of these things and then we have the back pain that is another feature that can be of pneumonia. Those are the features that I consider the most concerning.' [26]

7.13. Based on the evidence of Dr Livesey and the opinion of Professor Kelly about Mrs Fisher's condition upon presentation, it was open on the evidence to find that Mrs Fisher was a very unwell woman who required close medical attention and support. Professor Kelly was of the view that Dr Livesey's initial response to Mrs Fisher's condition was reasonable, taking into account the tests available to her in an out-of-hours regional hospital setting at the time.[27] That was with the exception of

[23] Transcript, page 498-499
[24] Exhibit C4, page 11; Transcript, page 500
[25] Transcript, page 500
[26] Transcript, page 647
[27] Transcript, page 653; Exhibit C17a, page 6

Dr Livesey's failure to undertake a pneumonia risk score and the inclusion of COPD in her medical history based on her history of smoking, which I will detail below.

7.14. After the initial assessment, the results from the tests ordered by Dr Livesey became available and the diagnosis of bilateral lower lobe pneumonia was confirmed, along with highly elevated inflammatory markers. The chest x-ray report, which was electronically signed by radiologist Dr Madigan at 9:14pm and '*exported*' at 10:31pm, revealed bilateral consolidation present within the upper and lower lobes, more extensive on the left, with a small peri-pneumonic effusion present on the left.[28] Dr Livesey did not have regard to the report, but gave evidence that she viewed the films that evening and made a similar diagnosis to that reported by the radiologist.[29] She recorded the results of the chest x-ray and the blood tests on the MR10A.

7.15. Dr Livesey gave evidence that her management plan was for a nebuliser, intravenous antibiotics, oral antibiotics, a litre of fluid and the continuation of oxygen therapy.[30] Dr Livesey stated that Mrs Fisher had expressed a wish not to be admitted to hospital, so it was her plan to monitor her oxygen saturation levels and attempt to wean her off oxygen. The topic of Mrs Fisher's wishes relating to not being admitted to hospital that evening will be addressed in some detail below. However, it is convenient at this point to highlight the evidence of Professor Kelly about two aspects of Dr Livesey's management of Mrs Fisher. The first being the absence of a risk stratification score for Mrs Fisher's pneumonia management, the second being the inclusion in her medical history of COPD.

7.16. <u>SMART-COP Score</u>

7.17. Professor Kelly's expert report,[31] and her oral evidence, highlighted the failure by Dr Livesey to utilise a risk score to dictate the appropriate management plan for Mrs Fisher upon the provisional diagnosis of pneumonia being made. Professor Kelly stated that the treatment of pneumonia in Australia is guided by risk-stratification scores that assist with antibiotic choice and aid disposition decisions by providing an estimated mortality and suggested disposition.[32]

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[28] Exhibit C4, page 13
[29] Transcript, pages 527, 561
[30] Transcript, page 527
[31] Exhibit C17a
[32] Exhibit C17a, page 5

7.18. The SA Health Community Acquired Pneumonia Policy,[33] which was available on the SA Health intranet at the time of Mrs Fisher's presentation,[34] suggested the use of the SMART-COP score.[35] Professor Kelly did emphasise that this score was usually undertaken when a clinician had baseline evidence and a chest x-ray result, however in Mrs Fisher's case, and based on the clinical information known to Dr Livesey at the time of her assessment (particularly the low oxygen saturation levels), Professor Kelly expressed the view that this could have been undertaken prior to the chest x-ray results and the other blood results becoming available.

7.19. As detailed in Professor Kelly's report, the score has eight components: systolic blood pressure, multi-lobar chest x-ray involvement, serum albumin, age-related respiratory rate, tachycardia, confusion, age-adjusted hypoxia (low blood oxygen level) and arterial PH. At the time the results of the chest x-ray became available[36] (revealing bilateral lower lobe pneumonia), had the SMART-COP tool been utilised by Dr Livesey, Mrs Fisher would have received a score of 5. That would have been calculated in the following way:

- bilateral lung involvement - 1 point;
- an elevated respiratory rate - 1 point;
- the presence of confusion - 1 point; and
- her low oxygen saturation levels - 2 points.[37]

7.20. Professor Kelly told the Court that this score revealed Mrs Fisher posed a one in three risk of requiring ICU intervention.[38] Before the results of the chest x-ray were known, Mrs Fisher would have scored a preliminary 4 points. Professor Kelly indicated either way, the score would have indicated an immediate hospital admission.

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[33] Exhibit C8, AMP 12
[34] Exhibit C8, paragraph 28
[35] The SMART-COP score was derived in Australia and has been shown to predict the need for intensive respiratory or vasopressor support, with high sensitivity and negative predictive value
[36] Exhibit C12a, paragraphs 5.9, 5.10
[37] Transcript, page 655; Exhibit C17b
[38] Exhibit C17a, page 5; Transcript, page 660

7.21. Dr Livesey told the Court that at the time of treating Mrs Fisher she was not familiar or aware of the SMART-COP tool or any other risk stratification tools for patients with pneumonia.[39] Dr Livesey gave the following evidence:

> 'We don't use those parameters in private EDs, we basically just ring a consultant and speak to them and determine treatment from there, but even single lobe pneumonias are generally admitted.' [40]

7.22. Irrespective of such a tool, Dr Livesey gave evidence that she did want to admit Mrs Fisher and spoke to her about this. Based on Mrs Fisher's wishes to go home, a compromise of sorts was reached, that if she was able to maintain oxygen saturation levels of 90% and above without the need for oxygen therapy she could be discharged.[41] Dr Livesey explained that she was guided in the figure of 90% oxygen saturations with reference to her belief that Mrs Fisher had COPD.

7.23. While I accept Dr Livesey wished for Mrs Fisher to remain in hospital, had she been aware of the SMART-COP tool and applied it, it is likely that she would have had a greater appreciation of the level at which Mrs Fisher's condition needed to be managed, including the possibility of having her transferred to a larger tertiary hospital with intensive care facilities available. The risk stratification tool would have brought into sharp focus the high risk of mortality that Mrs Fisher's infection posed. This was a missed opportunity for Mrs Fisher to be admitted soon after Dr Livesey's first review of her.

7.24. <u>Chronic Obstructive Pulmonary Disease (COPD)</u>

7.25. As I touched on at the beginning of the Finding, Dr Livesey formed the impression based on Mrs Fisher's smoking history, that she most likely had a degree of COPD. COPD is a common lung disease causing restricted airflow and breathing problems. It is diagnosed with the use of spirometry, to detect lung capacity. For those suffering severe COPD, carbon dioxide (CO_2) can be difficult to expel from the lungs and can build up over time. This is called CO_2 retention. For this category of patient, the administration of supplemental oxygen must be managed cautiously as it can cause

[39] Transcript, pages 521-522
[40] Transcript, page 521
[41] Transcript, page 572

hypercapnia[42] respiratory failure. Accordingly, a target range for a COPD patient who retains CO_2 is an oxygen saturation level of between 88-92%.[43]

7.26. Dr Livesey gave evidence that in Mrs Fisher's case she was not making a diagnosis of COPD, but considered the presence of some level of lung disease highly likely given Mrs Fisher's smoking habit.[44] Dr Livesey was not told by Mrs Fisher that she had been diagnosed with COPD, nor did she ask her.[45] Dr Livesey made the entry of COPD on Mrs Fisher's MR10A in the box marked '*Relevant past medical history*'. She told the Court that she did this to differentiate between Mrs Fisher and another patient with pneumonia who was also in the ED that night.[46]

7.27. Going back a step, Mrs Fisher was a regular patient at the Mount Barker/Balhannah Medical Clinic and had been since 2010. The Clinic's case notes reflected that her past medical history included a total left knee replacement, back pain, osteoarthritis in her right knee, a hysterectomy and depression. It also recorded that Mrs Fisher was a smoker of 10 cigarettes per day.[47] Nowhere contained within these notes was there a diagnosis, or even a suggestion, that Mrs Fisher suffered from COPD or that she was a CO_2 retainer. It is open on the evidence to find that Mrs Fisher's medical history did not include a diagnosis of COPD, and similarly made no mention of her being a CO_2 retainer.

7.28. The relevance of COPD being included in Mrs Fisher's past medical history by Dr Livesey was that it dictated the parameters of her oxygen therapy, and in turn, the saturation levels she was required to reach to be discharged. These parameters were quite properly followed by the nursing staff after Dr Livesey left the hospital at the conclusion of her shift. While Dr Livesey could not recall if she had conveyed to Mr Nawaz that Mrs Fisher's oxygen saturation levels should remain between 88-92% due to COPD, Mr Nawaz had a memory of Dr Livesey handing over this information when he arrived for his shift at 9pm that evening.[48] As will be detailed below, it was inappropriate for Dr Livesey to have assumed that Mrs Fisher suffered from COPD for the purposes of setting a lower oxygen saturation level for discharge.

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[42] High levels of carbon dioxide in the blood
[43] Transcript, page 672
[44] Transcript, page 501
[45] Transcript, page 573
[46] Transcript, page 501
[47] Exhibit C6, page 1
[48] Transcript, page 207

7.29. Offer of admission to the Mount Barker Hospital

7.30. Dr Livesey gave evidence about her second entry on the MR10A. This was after her final review with Mrs Fisher and before her shift ended. Dr Livesey could not be precise about the time of her review but thought it likely to be around 10pm. Dr Livesey explained that during the review she noted Mrs Fisher's condition to have improved. The intravenous (IV) antibiotic infusion had commenced at 9:30pm and was completed at approximately 10pm. Mrs Fisher's oxygen saturation level had risen with the observation chart reflecting her saturation level as 92% at 10:05pm. Her respiratory rate had almost normalised to 21 breaths per minute, and her pulse had lowered. It was during this review that Dr Livesey recalled a discussion with Mrs Fisher about admission to the hospital.

7.31. In Dr Livesey's affidavit, signed on 30 July 2019, she stated:

> '[Mrs Fisher] was offered admission to the hospital which she declined and she stated that she felt so much better with the treatment we had given her ... When Lynne advised me that she did not want to be admitted, I did reinforce that she must visit her GP the following day or return to the emergency centre the following day.' [49]

7.32. In her oral evidence, Dr Livesey stated that the term '*offered admission*' in her affidavit was a poor choice of words and that the more accurate description was that she had advised Mrs Fisher, '*she really should stay in hospital*'[50] and further that '*it was risky for her to go home … that ultimately pneumonia could still cause death*'.[51] There was a level of inconsistency between Dr Livesey's affidavit, her oral evidence and the contemporaneous handwritten entry made on the MR10A shortly before she finished her shift, in that it did not record her advice for Mrs Fisher to be admitted to hospital and her subsequent refusal. Furthermore, it did not detail the requirement for a certain oxygen saturation level to be achieved before discharge. The handwritten note reads:

> 'Discharge home with Ventolin, Azithromycin complete, Aug Duo BD52, bed rest and to be reviewed if no better within 24 or 48 hours.' [53]

7.33. Dr Livesey explained that this entry was made at a time when Mrs Fisher was still receiving supplemental oxygen therapy and the understanding between herself, Mrs Fisher and the nursing staff was for her to remain in the ED until such time as she

[49] Exhibit C17a, paragraphs 14 and 16
[50] Transcript, page 599
[51] Transcript, page 520
[52] Augmentin Duo (antibiotic) BD (twice daily)
[53] Exhibit C4, page 11

could be weaned from supplemental oxygen, whilst still maintaining an oxygen saturation level of 92%. Dr Livesey indicated that her entry was therefore NOT a discharge note, rather a provisional plan for discharge.[54] Mrs Fisher remained in the ED for almost another four hours after this entry was made and Mr Nawaz (whose evidence I will come to) gave evidence of an understanding that aligned with the plan by Dr Livesey after his arrival on shift. I therefore accept that Dr Livesey intended for this entry to be a provisional discharge plan, and I so find. I also accept the submission put to me by Ms Sally Giles of counsel assisting, that those left caring for Mrs Fisher (particularly Mr Nawaz) did not rely on the literal meaning of this entry to inform her subsequent care. This was evidenced by Mr Nawaz continuing to monitor and assess Mrs Fisher's oxygen saturation levels for in excess of three hours after the entry was made. Finally, Dr Leng, the night locum, gave evidence that at no time during Mrs Fisher's presentation did she review Mrs Fisher's notes, therefore the entry had no bearing on what she did or did not do for Mrs Fisher that evening/morning.

7.34. To her credit, Dr Livesey conceded that this entry relating to discharge was totally inadequate.[55] She also stated that, irrespective of her knowledge or otherwise of risk stratification tools for patients with pneumonia, she had enough information available to insist on Mrs Fisher being admitted to the Mount Barker Hospital, which she did not do. In respect of the consideration of COPD and the subsequent plan for Mrs Fisher to achieve a lower oxygen saturation for contemplation of discharge (90-92%), Dr Livesey accepted that this was not a reasonable or appropriate level given the information she had available to her at the time.

> 'Yes, that was unfortunately the minimum that I was happy to accept, I just wanted to see that she was consistently over 90% if she wanted to go home, which is probably not reasonable.' [56]

7.35. Professor Kelly opined that Dr Livesey did not have a proper basis to make the assumption of COPD. Further, it was unsafe to diagnose COPD during an acute respiratory illness and that smoking history alone was not enough to justify the diagnosis.[57] Professor Kelly gave this evidence:

> '… some of the logic is not unreasonable in that it is possible that Mrs Fisher had an underlying level of some airways disease, but as I said, … smoking alone is not enough and further inquiry, for example, about what Mrs Fisher's background – how far she could

[54] Transcript, pages 513, 527
[55] Transcript, page 510
[56] Transcript, page 588-589
[57] Transcript, page 645

> walk when she was well would have given her more evidence for her to make … that conclusion. And of course, it ran the risk of not accurately … what a normal oxygen saturation would have been for her in the circumstances. That was a really big risk in this case … it was inappropriate to proceed on the assumption that [Mrs Fisher] had significant enough COPD that oxygen saturation at baseline would be reduced.' [58]

Professor Kelly opined that with Mrs Fisher's smoking history, an acceptable oxygen saturation level would have been greater than 94%.[59] This evidence was not seriously challenged. It is not necessary to enter into a debate about whether or not Dr Livesey made a diagnosis of COPD on 26 September 2018, or whether she considered it to be part of Mrs Fisher's past medical history. The relevance of COPD was that it guided certain parameters for oxygen saturation levels. Dr Livesey accepted that she fell into error by setting these particular parameters. Accordingly, it is open on the evidence to find that the inclusion of COPD in the consideration of Mrs Fisher's treatment on the evening of 26 September 2018 was an erroneous distraction for Dr Livesey which contributed to the tragic outcome. Mrs Fisher was allowed to leave the ED with oxygen saturation levels below a satisfactory range. While Dr Livesey accepted the responsibility for putting this plan into place, there were other missed opportunities to have prevented Mrs Fisher's discharge from the Mount Barker Hospital, and ultimately her death. I will detail them now.

7.36. <u>The handover and Dr Leng's shift</u>

7.37. The inadequacy of Dr Livesey's provisional plan for discharge entry became a focus for the Inquest in relation to the appropriateness or otherwise of the care provided by Dr Leng to Mrs Fisher. Dr Leng gave evidence that from the commencement of her shift until Mrs Fisher's discharge she did not see Mrs Fisher to review her, made no decisions as to discharge, and had no involvement with Mrs Fisher's care at all that evening/morning with the exception of a telephone order for Ventolin at 1:30am. It was submitted on Dr Leng's behalf that given the existence of a discharge plan (and the content of the handover which will be detailed below) it was appropriate for Dr Leng to proceed on the assumption that '*all things being equal*' Mrs Fisher would be discharged in accordance with the plan put in place by Dr Livesey.[60] For the following reasons, I have rejected that submission.

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[58] Transcript, pages 642-643
[59] Exhibit C17a, page 7
[60] Written submissions on behalf of Dr Meiyan Leng, Mr Ralph Bonig of Counsel, 25 January 2023, paragraph 14

7.38. Dr Leng graduated from a Bachelor of Medicine and Bachelor of Surgery in 2002 and held a Master of Nutrition and Dietetics which she received in 2006. Dr Leng commenced as an intern at the Flinders Medical Centre (FMC) in 2008 until 2012 when she commenced employment with the Queen Elizabeth Hospital. A year later Dr Leng left South Australia to work as a Resident Medical Officer (RMO) in emergency medicine and then moved back to South Australia to take up locum work in tertiary hospital EDs for approximately a year before commencing General Practice Training with the Australian General Practice Training Program in February 2015.[61] She provided an affidavit[62] to the Court and gave oral evidence.

7.39. In both her affidavit and her oral evidence, Dr Leng placed emphasis on Dr Livesey's level of experience as a GP and the trust she placed in Dr Livesey's decision making. I understood this point was made to highlight the level of deference afforded to Dr Livesey by Dr Leng as the more senior doctor on 26 of September 2018, and therefore her corresponding confidence in the plan for Mrs Fisher. While I accept that the field of medicine (like many other professions) can be hierarchical, with junior doctors looking up to and deferring to senior doctors, Dr Leng was by no means a junior doctor. I formed the view that Dr Leng was also an experienced doctor based on her years of training and employment, and her work in a number of EDs including at tertiary, regional and remote hospitals, both in South Australia and interstate.

7.40. There was no dispute that Dr Leng commenced her shift at 10:30pm on the evening of 26 September 2018 and received a handover from Dr Livesey around this time. Both Dr Leng and Dr Livesey gave evidence about the handover, where it was conducted and what information was exchanged. Both doctors had a memory of the handover, however there was little common ground between the two accounts.

7.41. In her affidavit, affirmed on 19 December 2019, Dr Leng detailed the content of the handover from Dr Livesey. She recalled:

> 'Dr Livesey explained during the handover that she had already planned to discharge Mrs Fisher after the administration of IV antibiotics. For this reason, it was accepted that Mrs Fisher did not require any further review prior to discharge. We did not have access to Mrs Fisher's notes at the time of the handover, however Dr Livesey said that Mrs Fisher was in her 50s, was a heavy smoker, had COPD, had infective exacerbation of the COPD/pneumonia, and that she was having IV antibiotics but she would be able to go

[61] Exhibit C13
[62] Exhibit C13a

> home after the antibiotics. There was no mention of the patient's oxygen saturations in the handover, but they are a key factor and I assumed Dr Livesey had taken them into account. I was not asked to review the patient prior to discharge.' [63]

7.42. This account was given at a time when her memory of events would have been clearer. Based on this account, Dr Leng gave evidence that she had no concerns for Mrs Fisher and considered her to be a low priority.[64] Dr Leng indicated in her affidavit:

> '[i]f I had any reason to be concerned about Mrs Fisher, then I would have reviewed her myself. There were many other patients in the ED requiring attention and I had no reason to be concerned about Mrs Fisher given Dr Livesey's discharge plan.' [65]

Accordingly, she did not speak to or review Mrs Fisher and did not review her clinical notes.[66]

7.43. Dr Livesey's affidavit, affirmed at around the same time as Dr Leng's affidavit was prepared, stated that she '*handed over Lynne's care*' to Dr Leng, but did not address the details of the handover.[67] During her oral evidence, Dr Livesey recalled telling Dr Leng that Mrs Fisher had pneumonia and COPD and that she had been provided with antibiotics, but she was receiving oxygen and needed to be weaned off onto room air. Dr Livesey was clear in her evidence that she had asked Dr Leng to review Mrs Fisher later in the evening.[68]

7.44. Under cross-examination, Dr Livesey agreed that the thrust of her handover to Dr Leng conveyed that everything was in place for Mrs Fisher's discharge ***except for a medical review***.[69] When it was suggested to her that she did not mention a medical review to Dr Leng, Dr Livesey insisted that she had done so, and explained that if she had not wanted Dr Leng to review her, there was no need to have mentioned Mrs Fisher at all during the handover.[70] There was a plausibility to this explanation from Dr Livesey. Further adding to this plausibility, it was clear from the case notes and from Mr Nawaz's evidence that while the intravenous antibiotics and saline infusion had finished, and medication written up for Mrs Fisher to return home with (oral antibiotics and a Ventolin inhaler), supplemental oxygen continued for a period of hours after Dr Livesey had left. With that therapy continuing, there was a strong inference that a

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[63] Exhibit C13a, paragraph 6
[64] Transcript, page 261
[65] Exhibit C13a, paragraph 9
[66] Transcript, page 233
[67] Exhibit C15, paragraph 15
[68] Transcript, pages 570-572, 626
[69] Emphasis added
[70] Transcript, page 571

review would have been necessary to assess if Mrs Fisher was able to maintain satisfactory room air saturation levels or, more importantly, if she was unable to.

7.45. In her affidavit, Dr Leng stated that during the handover there was no mention of the patient's oxygen saturation levels, but she had assumed Dr Livesey had taken this into account as oxygen saturation levels are a key factor in pneumonia treatment.[71] Dr Leng indicated that she was told there was a plan to discharge Mrs Fisher after the administration of the antibiotics.[72] With the medication chart on the MR10A reflecting that the administration of medication commenced at 9:30pm,[73] and Dr Livesey estimating that the medication would have taken approximately ten minutes to administer,[74] that would place the completion of the dose at 9:40pm or thereabouts. Certainly, by the time Dr Livesey handed over to Dr Leng, the administration of IV antibiotics would have been complete. While other witnesses expressed the view that the administration of this particular antibiotic would take about thirty minutes,[75] there was still no reason for Mrs Fisher to remain in the ED beyond the handover taking place, if the antibiotic was the only reasons for her to remain. This was put to Dr Leng in cross-examination who responded by stating she did not know that the IV antibiotics were complete during the handover and assumed they were either yet to commence or were underway and that discharge would follow thereafter.[76] Once again, this evidence had the ring of plausibility to it.

7.46. I note that the '*discharge entry*' written by Dr Livesey prior to the handover taking place reflected: '*Azithromycin complete*'.[77] I understood from the evidence of both Dr Livesey and Dr Leng that this was an oral medication. The ceftriaxone antibiotic was the medication being administered intravenously. Dr Livesey's entry unfortunately made no mention of whether the IV therapy had been completed and as such did not advance the issue.

7.47. With the two doctors having an independent memory of the handover, it is difficult to reconcile how they could have walked away with two very different understandings. Ultimately, I have been unable to find on the balance of probabilities whether or not Dr Livesey asked Dr Leng to review Mrs Fisher before she was discharged from the

[71] Exhibit C13a, paragraph 6
[72] Exhibit C13a, paragraph 6
[73] Exhibit C4, page 10
[74] Dr Livesey - Transcript, page 503
[75] Dr Leng - Transcript pages 237, 340; Mr Nawaz - Transcript, page 165
[76] Transcript, page 240
[77] Exhibit C4, page 11

ED. As was put to me by Mr John Homburg of counsel, the evidence is simply irreconcilable. What is clear from Dr Leng's evidence is that she was aware Mrs Fisher was in the ED when she arrived, and formed the view that Mrs Fisher's discharge was imminent, thus requiring no clinical review. While she may have been entitled to form that view initially based on her understanding from the handover, the contemporaneous notes reflected she was involved in the care of Mrs Fisher prior to discharge at Mr Nawaz's request. In her evidence, Dr Leng agreed that she had provided authorisation for additional medicine to be administered to Mrs Fisher. This was not medication prescribed by Dr Livesey prior to her departure. Whatever the plan Dr Leng understood Dr Livesey had put into place, it was changed when Mr Nawaz contacted Dr Leng requesting medication that had not been authorised by Dr Livesey. Therefore, '*all things*' were no longer equal.

7.48. It is for the foregoing reasons that I am unable to make a positive finding about the details of the handover. I have however found that Dr Livesey's discharge entry was inadequate but did not reflect her intentions for Mrs Fisher's care, nor did it reflect what was communicated to Mr Nawaz. I have also found that it was not appropriate for Dr Leng to proceed on the assumption that Mrs Fisher would be discharged in accordance with the plan as set out on the MR10A. Whatever the discharge note said or did not say, I make the rather obvious point that Dr Leng did not review the clinical notes of Mrs Fisher during her presentation and was therefore unable to rely on it. In any event, as will be detailed below, events later in the evening and morning overtook any understanding that could reasonably have been relied upon by Dr Leng; namely that Mrs Fisher did not require a medical review before being discharged.

7.49. <u>Blood results</u>

7.50. Dr Livesey remained in the ED after the handover with Dr Leng to complete paperwork. It was during this time that Mr Nawaz notified Dr Livesey what the results of the blood tests taken earlier were.[78] The C-Reactive Protein (CRP) was 404mg/L and the White Cell Count (WCC) was 20.3. Both results were markedly elevated and revealed a picture of severe bacterial infection. Dr Livesey told the Court that she was '*very alarmed*' with these results, and as a general rule would not allow anyone with a CRP above 100mg/L to go home.[79] Dr Livesey described looking for Dr Leng to report the results to her. However, Dr Leng was with a patient by that stage, and she did not

[78] Transcript, page 511
[79] Transcript, page 597

wish to disturb her, so instead recorded them on the MR10A in a blue pen so they stood out from the rest of the notes that were recorded in a different colour.[80] Dr Livesey stated:

> '… I wrote them down, I would've expected that [Dr Leng] would see them … if anybody had pointed [the results] out to me, yes I would have said this needs admission, she can't go home.' [81]

7.51. Dr Livesey was within the ED at the time she received these results. The printed results have a time stamp of 10:23pm[82] and 10:25pm[83] respectively. With the handover having already taken place, it is likely that Dr Livesey became aware of the results closer to 11pm. While there is an inference that by virtue of recording the concerning results in the clinical notes, Dr Livesey had an expectation that Dr Leng would review Mrs Fisher and her notes, it did not absolve Dr Livesey from communicating this additional information to the incoming doctor who would be responsible for Mrs Fisher. Particularly as the results were interpreted as '*fairly dreadful*'[84] and further supported the case for hospital admission, which was being resisted by the patient. Dr Livesey conceded that she did not communicate these results to Mrs Fisher either.[85] I agree with the submission of Ms Giles that in respect of the inflammatory marker results (CRP and WCC) it was unsatisfactory for Dr Livesey not to communicate the results to Dr Leng and to Mrs Fisher directly to emphasise the importance of her being admitted to hospital. I so find.

7.52. <u>Registered Nurse Nabi Nawaz</u>

7.53. Mr Nawaz commenced his nursing shift at the Mount Barker Hospital ED at 9pm on 26 September 2018. Mr Nawaz obtained his Bachelor of Nursing from FMC in 2011, but additionally held degrees in Dentistry (Bangladesh) and Information Technology (UK). He worked at the Mount Barker Hospital for a total of five years, leaving in 2019 when he left to take up employment as a Registered Nurse at the Prince Alfred Hospital. This was his place of employment when he gave oral evidence at the Inquest.

7.54. Mr Nawaz's first entry in Mrs Fisher's clinical records was at 9pm when he recorded certain observations in her observation chart. While Mr Nawaz placed the time of his

[80] Transcript, page 512
[81] Transcript, page 597
[82] Exhibit C4, page 10
[83] Exhibit C4, page 12
[84] Transcript page 597
[85] Transcript, page 520

nursing handover at about 9:45pm, it is evident from the clinical records that he saw Mrs Fisher immediately upon starting his shift as he made entries in the observation chart at 9pm. I agree with the submission that, given his immediate attention to Mrs Fisher upon the commencement of his shift, it is reasonable to infer he was made aware of her and her condition soon after arriving.

7.55. There was no controversy in relation to the care Mr Nawaz provided to Mrs Fisher while she was in the ED. Mr Nawaz detailed in his affidavit that he was aware of Dr Livesey's plan to discharge Mrs Fisher home if she was able to maintain an oxygen saturation levels of 92% or above on room air, after receiving the IV antibiotics and the IV saline infusion.[86] Mr Nawaz recalled placing the pulse oximeter on one of Mrs Fisher's fingers to regularly monitor her oxygen saturation levels. It was clear with reference to the observation chart that he attended on Mrs Fisher to observe her saturation levels on at least four occasions after his initial review at 9pm. These times were recorded as 10:05pm, 11pm, 12:30am and 1:55am.[87] Mrs Fisher was in receipt of two litres of supplemental oxygen on all but the last occasion.

7.56. Where the controversy arose was in relation to Dr Leng's contact with Mrs Fisher. As touched on above, Dr Leng was adamant that she had no contact with Mrs Fisher at all that night or early morning. She stated:

> 'I have never reviewed her … I was never requested to review her, I have never even seen her face.' [88]

7.57. Mr Nawaz gave evidence that Dr Leng saw Mrs Fisher on at least two occasions (the first shortly after the handover with Dr Livesey,[89] and the second just after 11:15pm). He was also critical of the care that Dr Leng provided to Mrs Fisher on 26/27 September 2018. Mr Nawaz's evidence about the interactions he had with Dr Leng about Mrs Fisher can be summarised as follows:

- Dr Leng saw Mrs Fisher at the request of Mr Nawaz after approximately 11:15pm when Mrs Fisher was de-saturating after being weaned from supplemental oxygen, but she did not make an entry in the MR10A;[90]

[86] Exhibit C10, page 4
[87] Exhibit C4, page 11
[88] Transcript, page 379
[89] Transcript, page 61
[90] Exhibit C10, paragraphs 12, 13

- Dr Leng provided a phone order of Ventolin nebuliser from another area of the hospital after Mrs Fisher had self-medicated a Ventolin inhaler whilst still in receipt of supplemental oxygen, but did not come to her room to assess her;[91]

- After the Ventolin nebuliser was complete, Mr Nawaz contacted Dr Leng again enquiring whether she wanted to review Mrs Fisher, to which she declined. Dr Leng told Mr Nawaz to discharge Mrs Fisher in accordance with Dr Livesey's discharge plan;[92]

- Dr Leng was not responding to communications from Mr Nawaz that night, which he believed he had reported to the nurse in charge.[93]

7.58. At 11pm the observation chart reflected that Mrs Fisher was saturating at 94% with two litres of supplemental oxygen. Mr Nawaz thought that shortly after this observation was recorded, he checked Mrs Fisher's oxygen level on room air. This meant that the supplemental oxygen was stopped momentarily to observe Mrs Fisher's oxygen saturation levels, measured by the pulse oximeter. On this occasion he observed Mrs Fisher to desaturate, meaning that her oxygen saturation levels dropped well below the benchmark of 92% set by Dr Livesey.[94] In his affidavit, Mr Nawaz stated that he contacted Dr Leng and requested her to review Mrs Fisher.[95] In his oral evidence, Mr Nawaz recalled making this request for review by phone, believing that Dr Leng was in a different part of the hospital, Room 201, a room where doctors went to rest.[96]

7.59. What is clear from the contemporaneous records is that Mr Nawaz did see Mrs Fisher at approximately 11pm when he entered her saturation levels at 94% in the observation chart. This evidence was supported by the entries in the clinical record. Mr Nawaz understood that his task was to observe Mrs Fisher without supplemental oxygen which I accept he did. When Mrs Fisher desaturated, Mr Nawaz recommenced the oxygen therapy. He then stated that he called Dr Leng. Given that Mrs Fisher was being trialled on room air for the purposes of discharge, it was an entirely logical and clinically appropriate step for the only RN on shift to communicate to the only doctor on shift that Mrs Fisher could not maintain a certain oxygen level, as it meant a number

[91] Exhibit C10, paragraphs 15, 17
[92] Exhibit C10, paragraph 19
[93] Exhibit C10, paragraph 24
[94] Exhibit C10, paragraph 12
[95] Exhibit C10, paragraph 12
[96] Transcript, page 63

of clinical decisions may follow. This included consideration of more medication, admission and/or transfer to a tertiary hospital, none of which could be actioned without the approval of a doctor.

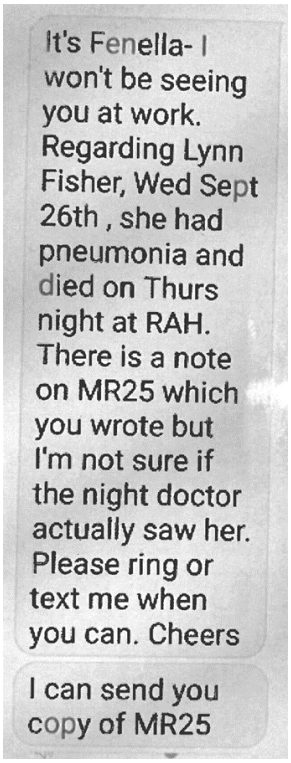
7.60. In respect of Mr Nawaz's evidence generally, the submission advanced by Mr Ralph Bonig of counsel (for Dr Leng) was that he was not a good historian and on crucial topics his evidence was unreliable because of his limited recollection of events. In his written submissions, Mr Bonig highlighted in excess of twenty occasions when, in response to questions from his own counsel (Mr Homburg), Mr Nawaz either stated outright, or prefaced his answer with, the words '*I can't recall*', or '*I can't remember*'.[97] Mr Bonig went so far as to submit that Mr Nawaz had significantly reconstructed aspects of the events of the night in question.[98] The submission advanced on behalf of Dr Leng was that where an inconsistency arose between Dr Leng and Mr Nawaz's evidence, Dr Leng's evidence should be preferred.[99]

7.61. Mr Nawaz's affidavit was provided on 26 June 2019,[100] nine months after Mrs Fisher's death. This was at a time when events would have been relatively fresh in his mind. The issues raised in his affidavit relating to Dr Leng were set out clearly and raised concern about Dr Leng's care of Mrs Fisher. However, when it came to Mr Nawaz's oral evidence, there was some force to Mr Bonig's submission. Mr Nawaz's oral evidence lacked the clarity of his affidavit and at times he was difficult to follow. Mr Nawaz also struggled to follow some of the questioning. There may have been a number of explanations for this. However, it was not necessary to delve into these reasons as before the Court were other more contemporaneous forms of evidence. The screenshots of text messages between Dr Livesey and Mr Nawaz were of particular forensic significance. These text messages were exchanged in the month following Mrs Fisher's death, about the events of 26/27 September 2018. They were provided to the Court by Dr Livesey.

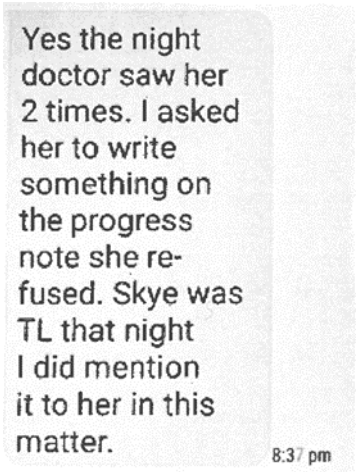
7.62. Dealing firstly with Mr Nawaz's evidence that he contacted Dr Leng after 11:15pm to inform her that Mrs Fisher had desaturated on room air, the following exchange is relevant. To provide context to the messages sent by Mr Nawaz, it is necessary to see

[97] Written Submissions on Behalf of Dr Meiyan Leng, dated 25 January 2023, paragraph 15
[98] Written Submissions on Behalf of Dr Meiyan Leng, dated 25 January 2023, paragraph 16
[99] Written Submissions on Behalf of Dr Meiyan Leng, dated 25 January 2023, paragraph 17
[100] Exhibit C10

the message from Dr Livesey to which he responded. Dr Livesey sent this text message on 17 October 2018: [101]

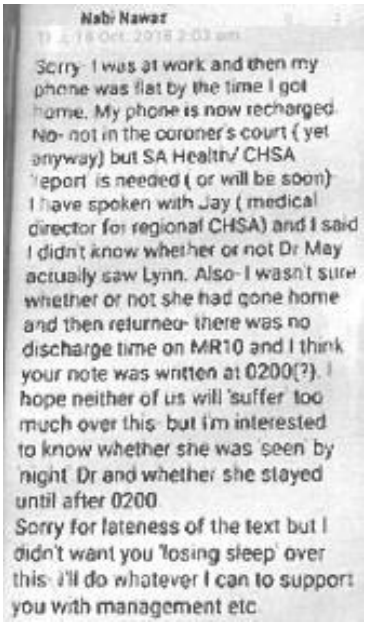


7.63. Mr Nawaz responded:[102]



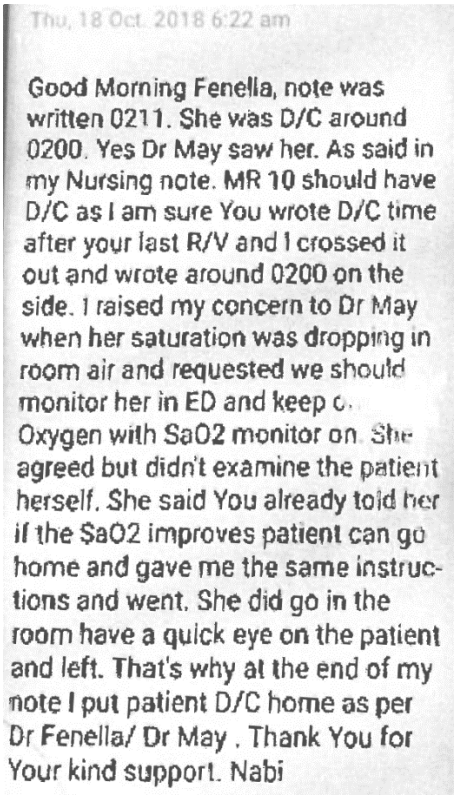
[101] Exhibit C11, page 1 of 5
[102] Exhibit C11, page 3 of 5

7.64. Dr Livesey sent the below text message to Mr Nawaz:[103]


Nabi Nawaz

Sorry- I was at work and then my phone was flat by the time I got home. My phone is now recharged. No- not in the coroner's court (yet anyway) but SA Health/ CHSA report is needed (or will be soon) I have spoken with Jay (medical director for regional CHSA) and I said I didn't know whether or not Dr May actually saw Lynn. Also- I wasn't sure whether or not she had gone home and then returned- there was no discharge time on MR10 and I think your note was written at 0200(?). I hope neither of us will 'suffer' too much over this- but I'm interested to know whether she was 'seen' by night Dr and whether she stayed until after 0200.
Sorry for lateness of the text but I didn't want you 'losing sleep' over this- I'll do whatever I can to support you with management etc.

7.65. Mr Nawaz repeated his assertion that Dr Leng had seen Mrs Fisher in his response to Dr Livesey:[104]


Thu, 18 Oct. 2018 6:22 am

Good Morning Fenella, note was written 0211. She was D/C around 0200. Yes Dr May saw her. As said in my Nursing note. MR 10 should have D/C as I am sure You wrote D/C time after your last R/V and I crossed it out and wrote around 0200 on the side. I raised my concern to Dr May when her saturation was dropping in room air and requested we should monitor her in ED and keep o. Oxygen with SaO2 monitor on. She agreed but didn't examine the patient herself. She said You already told her if the SaO2 improves patient can go home and gave me the same instructions and went. She did go in the room have a quick eye on the patient and left. That's why at the end of my note I put patient D/C home as per Dr Fenella/ Dr May . Thank You for Your kind support. Nabi

[103] Exhibit C11, page 7 of 15
[104] Exhibit C11, page 8 of 15

7.66. There were two issues arising from Mr Nawaz's evidence about contacting Dr Leng shortly after 11:15pm. The first was whether he did contact her at this time, something Dr Leng denied.[105] The second was whether Dr Leng saw and/or reviewed Mrs Fisher after speaking with Mr Nawaz. In his affidavit, Mr Nawaz stated that after Mrs Fisher desaturated on a trial of room air, he called Dr Leng to ask her to review Mrs Fisher, which she did but she made no entry in the MR10A. In his text message to Dr Livesey, he responded that Dr Leng had seen Mrs Fisher twice, he asked her to write in the progress notes, but she refused. The two accounts had a similarity in that a review was requested but no entry was made by Dr Leng in Mrs Fisher's clinical record.

7.67. As touched on earlier, it was an entirely logical step to have contacted Dr Leng after Mrs Fisher desaturated. Mr Nawaz's affidavit and his text messages supported the contact having taken place and that no entry was made by Dr Leng. I am satisfied on balance that Mr Nawaz did contact Dr Leng and asked her to review Mrs Fisher. Accordingly, I reject Dr Leng's account that this contact did not occur.

7.68. It was then necessary to consider whether Dr Leng reviewed Mrs Fisher after 11:15pm. I pause here noting that there was a propensity during the Inquest and in the documents before the Court, to conflate the words '*see/saw'* with '*review*'. I am of the view that they were two different propositions. Dr Leng may have '*seen*' Mrs Fisher momentarily during her time passing by her room, and at the hand over with Dr Livesey (as noted by Mr Nawaz), however the real issue was whether Dr Leng '*reviewed*' Mrs Fisher.

7.69. Dr Leng maintained that she did not review Mrs Fisher at any time. While Mr Nawaz made reference to a '*review*' by Dr Leng in his affidavit, issue was taken with whether or not Mr Nawaz actually observed Dr Leng review Mrs Fisher. He accepted in his oral evidence that he was with another patient at the time he *thought* Dr Leng saw Mrs Fisher.[106] Mr Nawaz conceded in cross-examination that he saw Dr Leng enter Mrs Fisher's room (Room 54) from his position in the resuscitation room (Room 56), but he did not see what she did in the room and could not remember how long she stayed in there.[107]

[105] Transcript, page 277; Exhibit C13a, paragraph 16
[106] Transcript, page 64
[107] Transcript, page 101

7.70. Based on Dr Leng's evidence about her level of perceived responsibility for Mrs Fisher's care generally, I am satisfied that Dr Leng had formed a view early on in her shift that Mrs Fisher was going to be discharged, and quietly disregarded Mr Nawaz's request. In support of this conclusion, the Court heard unchallenged evidence provided by another Registered Nurse (detailed below) that portrayed Dr Leng as dismissive of concerns raised by nurses, in a manner seemingly similar to that encountered by Mr Nawaz. While I accept that Mr Nawaz saw Dr Leng around the area of Mrs Fisher's room, and she may have stood in the doorway of Mrs Fisher's room, it was more likely that Mr Nawaz was mistaken about Dr Leng entering the room. This was for two reasons; it was a busy night and the area around Mrs Fisher's room was a high flow area. Dr Leng's evidence was that the majority of her assessments for patients in the ED were undertaken in either Room 61 or Room 52, which were the two rooms on either side of Mrs Fisher's room.[108] From the resuscitation room where Mr Nawaz was positioned, it is entirely plausible that he thought Dr Leng entered Mrs Fisher's room, when in fact she was moving between Rooms 52 and 61. In turn, this provided a likely explanation for the absence of an entry by Dr Leng in the MR10A and supported the evidence given by Dr Leng that she did not review Mrs Fisher at any time.

7.71. In assessing the reliability of Mr Nawaz's evidence, it was necessary to consider a factual inaccuracy that appeared in both his affidavit and the text messages he sent to Dr Livesey. This related to the report of concern about Dr Leng to the Team Leader (TL) '*Skye*'. Skye Haagmans was a Registered Nurse at the Mount Barker Hospital at the relevant time and provided an affidavit to the Court as well as giving oral evidence.[109] Ms Haagmans was not on duty as the Team Leader on the evening of 26 September 2018, starting her shift at 7am on 27 September 2018. Mr Nawaz finished his shift at 7:30am on that morning. Ms Haagmans could not recall Mr Nawaz raising a concern about Dr Leng to her but accepted it could possibly have happened.[110] In her oral evidence Ms Haagmans, who had worked with Dr Leng at the Mount Barker Hospital, was asked to elaborate on certain comments she had made about Dr Leng in her affidavits. She told the Court that while she had not perceived Dr Leng as rude, she

[108] Transcript, page 338
[109] Exhibit C25
[110] Exhibit C3, paragraph 5

found her to be abrupt. Further, Ms Haagmans felt concerns that she raised with Dr Leng were brushed off.[111]

7.72. In his oral evidence, Mr Nawaz clarified that he had confused Ms Haagmans with Ms Pamela Baldock, who was the Nurse Team Leader that evening. Ms Baldock provided an affidavit to the Court, confirming that she was indeed the Team Leader that evening. She stated that she had no memory of Mr Nawaz speaking to her about Dr Leng, but he may have done so.[112] I am satisfied that Mr Nawaz simply confused Ms Baldock for Ms Haagmans, and that the reference in the text messages to '*TL Skye*' was in fact Ms Baldock who was the Team Leader that night. In addition to this conversation, I accept that Mr Nawaz also discussed Dr Leng with Ms Haagmans when she arrived for her shift the next morning.

7.73. I acknowledge that there were deficiencies in Mr Nawaz's evidence, including some inconsistencies and matters about which he said he could not recall. Despite this, at no time did I form the view that he was being evasive, coy or disingenuous. After considering the evidence as a whole, I was satisfied that Mr Nawaz was a truthful witness who did his best to assist the Inquest. I also formed the view that Mr Nawaz was a competent nurse who held concerns for Mrs Fisher's welfare while she was in the ED.

7.74. On balance, I am satisfied that Dr Leng did not assess Mrs Fisher when asked to by Mr Nawaz shortly after 11:15pm. I further find that Dr Leng should have assessed Mrs Fisher at the request of Mr Nawaz. Dr Leng gave evidence that had she assessed Mrs Fisher and it is likely that she would have applied the pneumonia risk stratification score, as was her usual practice for patients suffering pneumonia.[113] During her evidence Dr Leng was able to rather deftly calculate Mrs Fisher's SMART-COP score with reference to the diagnosis of multi-lobar pneumonia, CRP of 404, the confusion she presented with and the oxygen saturation level of 84%, which Dr Leng stated would have amounted to a high mortality risk for Mrs Fisher, possibly requiring ICU admission.[114] This demonstrated Dr Leng's clear understanding of the tool and its application to patients suffering pneumonia. Accordingly, it is likely that had Dr Leng reviewed Mrs Fisher, she would have turned her mind to assessing Mrs Fisher in the

[111] Transcript, page 811
[112] Exhibit C19, paragraph 12
[113] Transcript, page 260
[114] Transcript, page 265

context of the pneumonia risk stratification. I find that this was a missed opportunity for Dr Leng to have realised how unwell Mrs Fisher was and involved herself actively in her care.

7.75. Another significant aspect of Mr Nawaz's request to Dr Leng for review shortly after 11:15pm was that if she was not aware earlier, she must have become aware that Mrs Fisher had not been discharged home as expected. As Professor Kelly observed:

> 'Mrs Fisher's care had been handed to Dr Leng, so Dr Leng is responsible for her care, and is in the hospital, employed to look after patients in the Emergency Department. Secondly Dr Leng has been – is being made aware that Mrs Fisher has not gone home as anticipated, and needed to ascertain why that was not the case.' [115]

7.76. While I am critical of Dr Leng not reviewing Mrs Fisher just after 11:15pm, the more egregious failing came just before Mrs Fisher was discharged home. I will detail that below.

7.77. <u>The Ventolin inhaler and the Ventolin nebuliser</u>

7.78. Mr Nawaz gave evidence that he observed Mrs Fisher self-administering a Ventolin inhaler whilst in receipt of supplemental oxygen through the nasal specs. Mr Nawaz's entry in the progress notes reflected that this occurred at 11:40pm. This observation alarmed Mr Nawaz for two reasons; firstly because the medication could have an impact on the vital signs which were being recorded[116] and secondly because her respiratory symptoms may not have been under control even with oxygen therapy in place.[117] Mr Nawaz gave evidence that he thought he conveyed this information to Dr Leng at some point, as that would be his usual practice. However, he couldn't recall exactly what he said. As Mr Nawaz made a contemporaneous record of this in the progress note, detailed below, there can be little doubt that Mrs Fisher did self-medicate with a Ventolin inhaler while in receipt of supplemental oxygen. I am unable to make a finding as to whether this information was passed onto Dr Leng specifically.

7.79. Mr Nawaz took Mrs Fisher's observations again at 00:50am. He then attempted to contact Dr Leng who he believed was in Room 201. Mr Nawaz could not remember whether he spoke to her at that time or not, or whether there was more than one attempt to contact Dr Leng, but what was clear from the clinical records was that Mrs Fisher

[115] Transcript, page 694
[116] Transcript, page 195
[117] Transcript, page 195 and page

received 5mg of Ventolin administered through a nebuliser 50 minutes after this observation was recorded. As this did not form part of Dr Livesey's original treatment plan, Dr Leng was required to provide authority for it to be administered. Mr Nawaz recalled obtaining an order via phone from Dr Leng.

7.80. The Ventolin was commenced at 01:40am and lasted for approximately six to seven minutes. Mr Nawaz then tested Mrs Fisher's oxygen saturation levels and at 1:55am made an entry in the observation chart that she was able to maintain 92% on room air. Mrs Fisher was recorded to have been discharged at 2am, five minutes after her oxygen saturation level was recorded in the observation chart, and 11 minutes before Mr Nawaz made his entry in the progress notes. That left time between 1:55am and 2am for Mr Nawaz to have contacted Dr Leng again to inform her that Mrs Fisher had reached the target set by Dr Livesey. Mr Nawaz gave this evidence:

> 'Q. Why did you contact Dr Leng.
>
> A. I contacted Dr Leng because the patient kept the saturation 92% after she had the nebs but previously she was not having the nebs and then with oxygen lowering it down or at least putting the oxygen level down to see she was desaturating. So I from the clinical point of view I requested the patient needs review before discharge.
>
> Q. What did you want Dr Leng to do.
>
> A. To assess the patient, if she is fit to be discharged home because that what she was referring and my point was if this patient is going back to home, she may not keep the saturation level to 92% because this is the effect of Ventolin, she needs to be assessed and then a decision to be made.
>
> Q. So you wanted Dr Leng to assess her.
>
> A. Yes.
>
> Q. Before the decision was made to discharge Mrs Fisher.
>
> A. Discharge, yes.[118]

7.81. Dr Leng's memory of these phone calls with Mr Nawaz was limited. She did however accept that she must have ordered the Ventolin, as it was recorded in the MR10A, and a doctor must authorise the medication. Dr Leng also accepted that she was likely to have taken the call in Room 201 and that this was a room where doctors would rest or sleep in quieter moments. Her practice when providing phone orders for patients from the Room 201 was to jot it down on a piece of paper and update the record of the patient later. Dr Leng also accepted that while she had no memory of it, it was possible she had a further conversation with Mr Nawaz after the nebuliser had finished.

[118] Transcript, page 86

7.82. Dr Leng was asked why she provided an order for Ventolin nebuliser. She explained:

> 'Q. At some point in the early hours of the morning you prescribed a nebuliser of Ventolin didn't you.
>
> A. Yeah.
>
> Q. Why did you prescribe that Mrs Fisher.
>
> A. Because, like I said, if COPD patient at the home they need Ventolin puffers, they been there for a couple of hours so for them to have Ventolin is normal.
>
> Q. You prescribed a Ventolin nebuliser rather than a Ventolin puffer, didn't you.
>
> A. Yes, yeah.
>
> Q. Why did you prescribe the nebuliser.
>
> A. Because it's more reliable. So, different people techniques use Ventolin is different, even some medical staff you can't guarantee the way they use it is correct. So, nebuliser is more reliable, so you will make sure the bronchodilator is, or has been delivered to the patient in an effective way. So that's why till COVID time I always use nebulisers.'[119]

7.83. Dr Leng explained that the call at approximately 1:30am requesting Ventolin for Mrs Fisher did not cause her to consider that Mrs Fisher's condition might be deteriorating. Dr Leng relied heavily on the inclusion of COPD in the notes by Dr Livesey. While this dye had been cast by Dr Livesey, the diagnosis of pneumonia was still very much an acute risk and one that Dr Leng was aware of. Despite this understanding, when asked for her verbal authorisation for Ventolin, Dr Leng conceded that she did not have regard to Mrs Fisher's clinical notes, or the observation chart, or look at the chest x-ray or the results of her blood tests, all of which were available to her in the ED at 1:30am. It logically followed that Dr Leng could not have been satisfied that Mrs Fisher's clinical condition was stable. Dr Leng was challenged about this but remained steadfast in her oral evidence that a clinical review of Mrs Fisher at that time was not warranted and that Mrs Fisher could be discharged in accordance with Dr Livesey's earlier plan.

7.84. There were a number of aspects to Dr Leng's evidence that required analysis. Firstly, Dr Leng accepted she was in Room 201 when she received a phone call from Mr Nawaz. She was therefore available to physically assess Mrs Fisher as she was not otherwise occupied. Secondly, when the request for Ventolin was made, Dr Leng explained that while she could not exactly recall the content of the conversation with Mr Nawaz, she did not need to enquire as to the reasons for the medicine as Mrs Fisher

[119] Transcript, page 351

was a COPD patient with pneumonia and the prescription of Ventolin was part of the expected treatment. Finally, during her oral evidence, Dr Leng maintained the firm view that Mrs Fisher did not require a review either before or after the administration of the Ventolin. Astonishingly, while Dr Leng had not enquired as to Mrs Fisher's current clinical status, she accepted that she was aware of certain worrying features of her presentation at that time. This included:

- Mrs Fisher was suffering from pneumonia (in addition to the belief that she had COPD); and
- Mrs Fisher was still in the ED, over three hours after Dr Livesey had handed over her care; and
- She was requiring a medication for her breathing (Ventolin) which had not been part of Dr Livesey's treatment plan.[120]

7.85. In support of Dr Leng, Associate Professor Watts endorsed Dr Leng's decision not to review Mrs Fisher either before or after providing phone authorisation for Ventolin. In forming this opinion Dr Watts relied on the assumption that Mr Nawaz had not asked Dr Leng to review Mrs Fisher.[121] While Mr Nawaz's evidence was not entirely clear on this topic in terms of exactly what he said to Dr Leng, the thrust of Mr Nawaz's evidence as a whole was that he wanted Dr Leng to review Mrs Fisher. Mr Nawaz was concerned about Mrs Fisher being discharged.[122] He told the Court he rang Dr Leng (at least) twice, once for the phone order and a second time to enquire about discharge. Dr Leng agreed that it was possible Mr Nawaz called her twice in this timeframe. It was difficult to resist the conclusion that Mr Nawaz would not have contacted Dr Leng in the Room 201 on two occasions unless he wanted her direct input in the clinical decisions of Mrs Fisher.

7.86. Professor Kelly held a different view to Associate Professor Watts. She gave the following evidence:

> 'Mrs Fisher was due to go home, and there were no further orders for drugs made by Dr Livesey. So this was a new request for an order, suggesting this lady who had been there considerably longer than was expected, after the handover, required further

[120] Transcript, page 358
[121] Transcript, page 763
[122] Transcript, page 190

> treatment. And request for a further drug treatment, in my opinion suggests that something is not going according to the discharge plan and that review of the patient should occur.'[123]

7.87. Dr Leng stated that she would not necessarily be alarmed if a patient who was organised for discharge at 10:30pm had not left the ED by 1:30am, as this was not an uncommon occurrence.[124] Ms Merridy Chester, the Acting Director of Nursing and Midwifery with a nursing background of 30 years in 2018, gave evidence that this was a highly unusual timeframe with the longest delay being more in the order of an hour, in her experience.[125] Professor Kelly was also dismissive of this time frame.[126] I reject Dr Leng's evidence on this topic. Further, her explanation that the order of further medication designed to relieve symptoms of shortness of breath in a patient who has been diagnosed with pneumonia and potentially COPD was not a cause for concern, was simply implausible. It was also at odds with Dr Leng's own evidence that she would consider herself responsible for Mrs Fisher's care if anything in her condition was to change.[127] When Mr Nawaz contacted her requesting further medication, there was every risk that her condition had changed. I therefore reject Dr Leng's evidence on that topic also. I find that the request by Mr Nawaz for Ventolin at approximately 1:30am was a potential sign of a deteriorating patient requiring a review from Dr Leng.

7.88. After the evidence had been heard, parties were requested to submit written submissions. Dr Leng indicated in the submissions that she, on reflection, changed the position expressed in her evidence. I acknowledge the following submissions filed on behalf of Dr Leng on the topic of reviewing Mrs Fisher before discharge:

> 'Dr Leng has instructed us that upon reflection and after further consideration of her actions and the evidence in this Inquest, she acknowledges that it would have been prudent medical practice to have reviewed Mrs Fisher at least at around the time she prescribed the Ventolin nebuliser, given the length of time that had passed since the handover and the request for the prescription of Ventolin.' [128]

7.89. 'The Locum Lounge' (Room 201)

7.90. One important question that required exploration was why Dr Leng did not leave Room 201 to assess Mrs Fisher before her discharge, particularly when it was accepted that by virtue of her being in this room, she would not have been busy with other patients.

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[123] Transcript, page 722
[124] Transcript, page 328-329
[125] Transcript, page 458
[126] Transcript, page 723
[127] Transcript, page 353
[128] Written Submissions on behalf of Dr Meiyan Leng, paragraphs. 24-25

There was a suggestion during the Inquest that Dr Leng was sleeping in Room 201 when contacted by Mr Nawaz. This suggestion did not come directly from Mr Nawaz, rather a statement contained in the affidavit of Ms Skye Haagmans. As touched on earlier in the Finding, Ms Haagmans was an RN who had worked at the Mount Barker Hospital prior to the Summit Health arrangement, during that arrangement and after the BHFHN took control of the staffing arrangements for the ED. Dr Leng did not dispute that Room 201 was where the overnight doctor would go to rest. She agreed with the proposition that this would not be a work area.[129]

7.91. In her affidavit, Ms Haagmans stated that Dr Leng '*preferred sleeping rather than checking on the patients*'.[130] A further affidavit was obtained from Ms Haagmans, which detailed that when Summit Health commenced providing locums to remain overnight in the ED, she observed a poor culture develop that saw some GPs sleeping overnight in Room 201.[131] The inference being that those GPs who were present for the overnight shift, were prioritising sleep over their clinical duties. This topic was relevant to the reason why Dr Leng did not review Mrs Fisher before her discharge. Ms Haagmans was invited to elaborate on these claims in her oral evidence. Ms Haagmans' evidence was not challenged by counsel for Drs Leng and Livesey.

7.92. Ms Haagmans told the Court that prior to Summit Health providing doctors for the overnight shift, local GPs were called in as required but were not stationed overnight at the hospital. When Summit Health commenced managing the overnight ED doctors, the arrangement was for a GP to remain physically at the hospital for the entire overnight shift. However, upon this change, Ms Haagmans observed a pattern whereby the locum GPs would retreat to Room 201 and be less than accommodating with requests by the nursing staff for patient care. Ms Haagmans recalled that the nursing staff referred to the room as the '*Locum Lounge*'. Ms Haagmans described the following:

> 'A. Some doctors when you would ring them to review a patient, they would ask you to tell them about the patient on the phone and make orders over the phone and refuse to come and review the patients, but I can't pinpoint a direct case though.
>
> Q. You say in para.13 that some doctors were abrupt to nurses who contacted them when they were in the overnight room.
>
> A. Yes, that's right.

[129] Transcript, page 337
[130] Exhibit C3, paragraph 7
[131] Exhibit C3a

Q. Can you give an example of that.

A. I can't give an exact example; I can give a generalised example but not a -

Q. You have indicated in para.16 of your second affidavit, you are not singling out any particular doctor here, this was your impression of the GP service generally. Is that right.

A. Yes that's right.

Q. In para.13 you talk about - you have mentioned it already - some doctors prescribing medication over the phone rather than coming down to the wards to review patients.

A. Correct, yes.

Q. Was that a practice that from your experience was evident after the Summit Health arrangement came into place.

A. Yes, correct.' [132]

7.93. Ms Haagmans recounted an experience with Dr Leng in the context of her being contacted in Room 201 that had similarities with the evidence given by Mr Nawaz:

'A. Yes, I think that was from my one or two shifts from working with her, I remember trying to call her to review a patient, but I can't recall what patient or what it was about, and there was a lot of pushback to actually come up and review the patient.

Q. So, you said this was in relation to one or multiple occasions, can you recall now whether it was one occasion that occurred, or multiple occasions.

A. I can't, it was at least one, I can't recall more, how many more.' [133]

7.94. Ms Haagmans held the view that the practice of reviewing a patient before authorising medication was the appropriate one, based on her past experience and good clinical practice.[134] Ms Haagmans' expectation aligned with the expectation that Mr Nawaz held for Mrs Fisher's care on the night before her death. Specifically, that when a night nurse required authorisation to give a patient in the ED medication, the night doctor would review the patient before prescribing the medication.

7.95. Ms Chester who initiated a review of Mrs Fisher's care after her death, gave oral evidence that irrespective of whether a patient required more medication after a period of time in the ED, a new discharge plan should be generated if the patient had remained in the ED for a lengthy period of time.[135] In respect of Mrs Fisher's care at the Mount Barker Hospital, Ms Chester stated that by virtue of the time lapse of three and a half hours since handover by Dr Livesey, Dr Leng should have turned her mind to reviewing

[132] Transcript, pages 813-814
[133] Transcript, page 825
[134] Transcript, page 814
[135] Transcript, page 456

Mrs Fisher and, if appropriate, to formulate a new discharge plan when contacted by Mr Nawaz at 1:30am.[136]

7.96. Ms Chester also gave evidence about concerns that had been raised with her about Dr Leng. These concerns were about Dr Leng not being present in the ED. Her evidence was as follows:

> Q. And when you say, 'Not being present in the emergency department', were there complaints that she was somewhere other than the hospital or somewhere else in the hospital.
>
> A. Somewhere else within the hospital.
>
> Q. So in terms of the timing of these complaints, were these complaints made to you prior to September 2018 or after September 2018, or both.
>
> A. My recollection is probably about after.
>
> Q. So are we talking about one concern that was raised, or multiple concerns.
>
> A. I think, from memory, there was probably three.
>
> Q. Three concerns from three separate people.
>
> A. Yes.
>
> Q. And were all of the people that raised concerns about this, nursing staff.
>
> A. Yes.
>
> Q. And I think you mentioned all three of those were after Mrs Fisher's death, is that the case.
>
> A. Yes.
>
> Q. The nurses that raised concerns with you, were they nurses that were working in the emergency department or elsewhere in the hospital.
>
> A. Emergency department.
>
> Q. Can you just elaborate on the concerns that were raised with you about Dr Leng not being present.
>
> A. If they had a concern and had rung Dr Leng, they found it a challenging conversation for her to come and review the patient, or their concern. That was the general gist of all three of those.
>
> Q. Can you elaborate on what your understanding of a challenging conversation was. Did they give you more details about what was challenging.
>
> A. That there was some resistance.
>
> Q. When you say 'resistance', resistance from whom.
>
> A. Dr Leng.
>
> Q. And resistance in regard to what.
>
> A. To responding to their request. And it might have been a requirement to come and see a patient and to have a review.

[136] Transcript, page 457

7.97. It was not necessary to explore these complaints in any detail. The relevance of this evidence was that it lent support to Mr Nawaz's dealings with Dr Leng in respect of Mrs Fisher and had similarities to the experience of Ms Haagmans. Namely, that there was resistance from Dr Leng to review patients in the ED when she was in Room 201 as the overnight doctor. This was relevant to the circumstances leading up to the death of Mrs Fisher, for reasons I have detailed above.

7.98. If there was any doubt remaining about the contact Mr Nawaz had with Dr Leng just prior to Mrs Fisher's discharge, the most compelling evidence was found in Mr Nawaz's entry in the clinical records, made at 2:11am on 27 September 2018.[137]

DATE & TIME	PROGRESS NOTES—PRINT NAME, DESIGNATION AND SIGN FOR ALL ENTRIES, USE BLUE OR BLACK BALLPOINT PEN
27/9/18 0211	Nursing Note – Patient stayed back after Dr Fenela Leveseys R/V due to ↓ SaO_2 in R/A. 85–86%. Had x2 puff self medicated around 2340 hrs, 5mg Ventolin given as per Dr May's order. 2L O_2 via NC/S continues after Dr. Fenela R/V her. SaO_2 in R/A after 2nd Neb in A&E increased to 92%. D/C home as per Dr. Fenelas / May's instruction — [signature]

7.99. This entry summarised the care provided to Mrs Fisher in the ED after Dr Livesey had completed her shift. Importantly it made reference to:

- Mrs Fisher remaining in the ED due to the desaturation at approximately 11pm;
- Mrs Fisher self-medicating with a Ventolin inhaler;
- The administration of 5mg of Ventolin nebuliser as ordered by Dr Leng (which was the second administration of Ventolin by nebuliser);
- The trial of room air after the second Ventolin nebuliser where Mrs Fisher was able to maintain 92% oxygen saturation levels; and
- The discharge of Mrs Fisher in accordance with Dr Livesey's and Dr Leng's instructions.

[137] Exhibit C4, page 12

7.100. This entry was consistent with Mr Nawaz's evidence at Inquest and was made at a time before there had been an adverse outcome for Mrs Fisher. Beyond his expressed level of frustration in relation to Dr Leng, there could be no alternative explanation for this entry other than Dr Leng had instructed Mr Nawaz to discharge Mrs Fisher.

7.101. It is for the above reasons that I find Mr Nawaz rang Dr Leng while she was in Room 201 to request authority for Ventolin. Upon this request being made, Dr Leng should have enquired why it was required. Those enquiries should have prompted an assessment of Mrs Fisher by Dr Leng.

7.102. I further find that Mr Nawaz rang Dr Leng a second time to report on Mrs Fisher's ability to maintain 92% oxygen saturation after the administration of the Ventolin nebuliser. Upon this contact being made, Mr Nawaz requested guidance from Dr Leng, including whether or not she wished to conduct a review of Mrs Fisher. Dr Leng resisted this request from Mr Nawaz and authorised Mrs Fisher to be discharged. For reasons that I have detailed above relating to Dr Leng's understanding of pneumonia risk stratification scores, it is likely that Mrs Fisher would not have been discharged if Dr Leng had assessed her.

7.103. I also note Professor Kelly's concern that based on the timeframe between the conclusion of the Ventolin nebuliser and Mrs Fisher's discharge, being approximately 15 minutes, there had not been sufficient time to observe whether Mrs Fisher could maintain the oxygen saturation level set by Dr Livesey. Professor Kelly opined that it would have been more appropriate to have waited for a period of 30 minutes post nebuliser.[138] While Professor Kelly expected a nurse would be aware of such a period, she would equally have expected a doctor to instruct the nurse on this timeframe. Once again, this evidence highlighted the importance of Dr Leng assessing Mrs Fisher when contacted on these two occasions by Mr Nawaz, which she did not do.

8. Entries in the clinical record

8.1. It was acknowledged by the witnesses who gave evidence in this Inquest that there was a paucity of notes in Mrs Fisher's clinical record. Mr Nawaz accepted that he did not record conversations that he had with Dr Leng, nor did he record the occasions where Mrs Fisher was weaned from supplemental oxygen onto room air and desaturated. He acknowledged that he should have made more comprehensive notes.[139] As touched on

[138] Transcript, page 685
[139] Transcript, page 213

earlier in the finding, Dr Livesey acknowledged that her '*discharge note*' was completely inadequate.[140] Ms Chester gave detailed evidence on the results of her review relating to the inadequacy of the entries in Mrs Fisher's Clinical record.[141]

8.2. Evidence was heard that the evening of Mrs Fisher's presentation was an extremely busy one.[142] Further, there was only one doctor on duty for the overnight shift for the entire hospital (Dr Leng),[143] and only one nurse in the ED for the overnight shift from midnight onwards (Mr Nawaz).[144] While this goes some way to explaining the reason why the MR10A was incomplete in some areas and there was just one entry in the progress notes, it also explains why the forensic task of the evaluating the care of Mrs Fisher received was so complex. The importance of entries in a patient's clinical record cannot be overstated.

8.3. It is a timely reminder to staff working in busy EDs, with patients who are at risk of deterioration, to make entries in the clinical record. This is primarily for the communication between clinicians caring for the patient at the time, but also to establish an adequate record of what care has been provided after the fact, should it become necessary.

9. Hindsight bias

9.1. I warn myself concerning a vital consideration in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias.

9.2. A description of '*hindsight bias*' is given in the Australasian Coroners Manual, namely as:

> 'The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation…
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.' [145]

[140] Transcript, page 510
[141] Transcript, pages 397-398, 401
[142] Transcript, pages 39, 226, 248, 426, 497
[143] Transcript, page 201
[144] Transcript, page 63
[145] The Australasian Coroners Manual, page 10

9.3. As stated, I am very mindful of this warning when considering evidence of the events of the night and early hours of 26 and 27 September 2018 at the Mount Barker Hospital.

10. Preventability

10.1. Professor Kelly opined that Mrs Fisher's death was preventable at the time of her discharge from the Mount Barker Hospital ED. This evidence was not the subject of challenge. She gave the following evidence:

> 'In my opinion, [Mrs Fisher's] death was preventable. She was seriously ill at the time of her presentation to Mount Barker Hospital, with the estimated mortality of her condition approximately 10%. With appropriate respiratory and cardiovascular support and antibiotics, it is my opinion which is supported by the literature, more probable than not that she would have survived.' [146]

10.2. Professor Kelly placed emphasis on the importance of the risk stratification tools, such as SMART-COP in coming to her conclusion on preventability. She stated:

> 'The risk scores that we talked about earlier do give an estimate of mortality based on a patient's clinical condition. They're derived from very large population samples, mostly in Western countries, so in high health care countries, and the estimated mortality in those scores was between about 8 and 10%, which means about a 90% chance of survival with proper treatment. So that's how I reached the conclusion that her death may well have been preventable.'[147]

10.3. I find that had Mrs Fisher not been discharged from the Mount Barker Hospital ED at approximately 2am on 27 September 2018, and thereafter received appropriate treatment for bilateral pneumonia, her death would have been prevented.

11. Conclusions

11.1. The findings I have made are set out in accordance with the issues above. I have come to these conclusions on the basis that I am comfortably satisfied each of them were established on the evidence.

11.2. Several of the findings that I have made are adverse to Dr Leng and, to a lesser extent, to Dr Livesey in that they identify errors and missed opportunities in Mrs Fisher's clinical care. In coming to these conclusions, I have been mindful of the need to satisfy myself that such findings should only be made based on the relevant evidence presented as being reliable and compelling. In doing so, I have applied the principles expressed

[146] Exhibit C17a, Professor Kelly's Report, page 7
[147] Transcript, pages 694-695

by the High Court of Australia in '*Briginshaw v Briginshaw*'.[148] I also refer to the recent Supreme Court of South Australia analysis of the Briginshaw case in an appeal case of '*SJ Berry Pty Ltd v McEntee*'.[149]

11.3. The Court reached the following conclusions:

1. On 25 September 2018, Mrs Fisher attended a general practitioner complaining of a two-week respiratory illness. She was diagnosed with a lower respiratory tract infection and prescribed oral antibiotics.
2. On 26 September 2018, Mrs Fisher was conveyed to the Mount Barker Hospital ED by her husband with symptoms of shortness of breath and cough at approximately 7:20pm.
3. Mrs Fisher was seen quickly by the triage nurse and appropriately triaged.
4. The set of observations taken at triage revealed Mrs Fisher was very unwell with particularly low oxygen saturation levels.
5. Mrs Fisher was quickly commenced on supplemental oxygen which was appropriate.
6. Dr Livesey was notified by nursing staff of Mrs Fisher's presence in the ED and assessed her within an appropriate timeframe.
7. Dr Livesey ordered an appropriate suite of tests for Mrs Fisher and provisionally diagnosed her with pneumonia.
8. Dr Livesey also recorded that Mrs Fisher suffered from Chronic Obstructive Pulmonary Disease (COPD), based on an assumption due to Mrs Fisher's history of smoking alone. Dr Livesey did not have a proper basis upon which to make this assumption.
9. Dr Livesey set a satisfactory oxygen saturation limit for Mrs Fisher between 88% and 92% based on her assumption that she suffered COPD. This upper limit for Mrs Fisher was too low and placed her at risk.
10. Mrs Fisher had never been diagnosed with COPD.

[148] (1938) 60 CLR 336 in particular Dixon J at 362, 'Briginshaw'
[149] (2022) 142 SASR 31

11. Mrs Fisher's pneumonia was not risk stratified by Dr Livesey. This should have occurred in accordance with the tools available through the SA Health intranet at the Mount Barker Hospital ED.

12. Had the risk stratification tool been applied by Dr Livesey, she would have gained a greater appreciation for the high risk of mortality Mrs Fisher's illness posed.

13. While Dr Livesey wanted Mrs Fisher to remain in hospital, she did not insist which she should have done.

14. A handover took place at the conclusion of Dr Livesey's shift and the start of Dr Leng's shift. This was at approximately 10:30pm.

15. It is not possible to determine what was said at the handover, but Dr Leng understood Mrs Fisher was to be discharged after a course of intravenous antibiotics without a review. Conversely, Dr Livesey understood that Dr Leng would review Mrs Fisher before discharge.

16. Dr Livesey made an entry in the MR10A which detailed discharge instructions for Mrs Fisher. It made no mention of the oxygen saturation levels that were required before discharge could be considered. This entry did not reflect the true intention of Dr Livesey's treatment plan for Mrs Fisher. This entry was inadequate.

17. Dr Livesey conveyed her treatment plan relating to oxygen to Mr Nawaz who then followed her instructions. While the oxygen saturation limit of 92% was too low, it was appropriate for Mr Nawaz to follow Dr Livesey's instructions.

18. Just before leaving the hospital, Dr Livesey reviewed Mrs Fisher's blood results which revealed a picture of serious infection. Dr Livesey entered the results into the MR10A but did not convey these results to either Dr Leng or Mrs Fisher in an attempt to convince her to be admitted to hospital. This was a missed opportunity.

19. Just after 11pm, Mr Nawaz trialled Mrs Fisher without supplemental oxygen, but she desaturated below 88%. Mr Nawaz recommenced oxygen and contacted Dr Leng to request that she review Mrs Fisher. This was appropriate.

20. Dr Leng did not review Mrs Fisher at that time, believing that Mrs Fisher was to be discharged. Dr Leng should have reviewed Mrs Fisher.

21. At some point prior to midnight, Mrs Fisher self-administered a Ventolin inhaler whist in receipt of two litres of supplemental oxygen.

22. At approximately 1:30am, Mr Nawaz contacted Dr Leng in Room 201 requesting authorisation to administer a Ventolin nebuliser.

23. Dr Leng was in Room 201. Dr Leng verbally authorised the medication. It was at this time that Dr Leng should have reviewed Mrs Fisher given that she had been in the ED for over three hours after the handover and was now requiring respiratory medication that had not been authorised by Dr Livesey.

24. After the administration of Ventolin, Mr Nawaz contacted Dr Leng again in Room 201 informing her that she had maintained an oxygen saturation level of 92%, as set by Dr Livesey, and requested guidance on discharge or otherwise. Dr Leng authorised Mrs Fisher's discharge however should have reviewed Mrs Fisher at this time.

25. Had Dr Leng reviewed Mrs Fisher on one of the three occasions as set out above, she would have applied the risk stratification tool for pneumonia and realised how unwell Mrs Fisher was. Following that, it is probable that Dr Leng would have admitted Mrs Fisher to Hospital.

26. Had Mrs Fisher been admitted to the Mount Barker Hospital at the time of her discharge (or before) and received appropriate treatment for bilateral multi-lobar pneumonia, her death would have been prevented.

12. Changes to the Mount Barker Hospital ED

12.1. I acknowledge the Clinical Case Review that was conducted by Country Health Local Network (specifically Ms Chester) and Summit Health.[150] I also acknowledge the significant changes that have been implemented at the Mount Barker Hospital ED since Mrs Fisher's death.

12.2. The affidavit of Ms Price, referred to in paragraph 6.1 detailed several changes including:

a) The ED is now staffed by doctors employed by BHFLHN;

b) The nursing compliment on night shift has been increased to a minimum of three staff, plus one additional on-call nurse;

[150] Exhibit C12, Annexure A

c) An After-Hours Coordinator/Team Leader is now rostered to support escalation of issues and patient flow, and to respond to any emergencies across the hospital;

d) The introduction of a dedicated Nursing Unit Manager for the ED has been introduced;

e) The position of a Nurse Educator Emergency Department was introduced in April 2022;

f) Nursing staff performing key roles such as the team leader, the triage nurse, the airway nurse and the nurse assigned to MET call roles are now identified each shift and wear labels so that staff can identify their roles;

g) Communication within the nursing team has been improved by the introduction of a Connecting and Purpose Framework and a Connecting with Purpose Huddle Guide.[151]

12.3. There is now a blood gas machine within the Mount Barker Hospital ED which was not in place at the time of Mrs Fisher's presentation.[152]

12.4. Relevantly, Ms Haagmans who was well placed to give evidence about the workings of the ED under the different administrations (before, during and after the Summit Health arrangement), told the Court that the Mount Barker Hospital ED is a very different place. She stated:

> 'I think the whole running of the ED has changed. We now have a nurse unit manager to manage, particularly the ED. The doctors are very approachable, very experienced doctors, they are available 24 hours a day to see their patients, which they do. The nursing care is a lot better as well, well-staffed now and educated as well.' [153]

13. Recommendations

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

13.2. One area for further improvement relates to the education of practitioners about the risk scores for community acquired pneumonia. Curiously, Dr Livesey was not aware of

[151] Exhibit C8, paragraph 40
[152] Transcript, page 477
[153] Transcript, page 822

any of the risk scores detailed by Professor Kelly in her report before she viewed her report as part of this Inquest. She also gave evidence that none of her colleagues working in the private system whom she had asked about these risk scores were aware of them either.[154]

13.3. Professor Kelly was of the opinion that:

> 'reinforcing the importance of an appropriate risk stratification would be a very welcome finding, but the way that it is done might have to vary by locality, based on resources etc.' [155]

13.4. Accordingly, I make the following recommendations directed to the Minister for Health and Wellbeing and the Royal Australian College of General Practitioners.

1) That the Royal Australian College of General Practitioners release an alert to its members educating them on, and explaining the importance of, the risk scores and '*red flags*' relating to community acquired pneumonia; and

2) That SA Health release an alert to all South Australian Licensed Private Hospitals that treat patients in an emergency setting educating them on, and explaining the importance of, the risk score and '*red flags*' relating to community acquired pneumonia.

Key Words: Hospital Treatment; Country Hospital; Pneumonia; Emergency Departments

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

Seal the 16th day of May, 2024.

Coroner

[154] Transcript, page 522
[155] Transcript, page 709