CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATHS OF HEMANT CHADHA AND SACHINTHA NANDULA BATTAGODAGE

[2026] SACC 8

Inquest Findings of his Honour Deputy State Coroner White

30 March 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of two men who had presented to general practitioners and tertiary centres for medical attention on multiple occasions but were not admitted for inpatient care. The Inquest explored whether there was a failure to identify serious illness, whether language barriers contributed to the level of care they received and whether there was dismissiveness by paramedics that contributed to one of the deaths.

Held:

1. Hemant Chadha, aged 38 years of Parafield Gardens, died at Parafield Gardens on 23 April 2020 as a result of acute on chronic pneumonia (mycoplasma pneumoniae detected).

2. Sachintha Nandula Battagodage, aged 23 years of Mile End, died at Glenelg on 23 November 2020 as a result of acute haemothorax due to ruptured pseudoaneurysm of the right subclavian artery.

3. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MS E ROPER

Interested Party: SOUTH AUSTRALIAN AMBULANCE SERVICE, CENTRAL ADELAIDE LOCAL HEALTH NETWORK & NORTHERN ADELAIDE LOCAL HEALTH NETWORK
Counsel: MR P LEESON WITH MS S SLOAN - Solicitor: CROWN SOLICITOR

Witness: DR J THOMAS, DR T O'CONNOR, MR A KEUM, DR A TOLENTINO, DR E GOWEN, DR T ESSELBRUGGE, DR A TOLENTINO, MS M STILES & MS S BEALE
Counsel: MR P LEESON WITH MS S SLOAN - Solicitor: CROWN SOLICITOR

Witness: DR I HATHURUSINGHE & DR D DONOVAN
Counsel: MR S POTTS - Solicitor: ILES SELLEY LAWYERS

Witness: MR P VINAR
Counsel: MR J HOMBURG - Solicitor: GILCHRIST CONNELL

Witness: DR A ASLAM
Counsel: MS J CLIFF - Solicitor: DW FOX TUCKER LAWYERS

Witness: DR A AZHAR & MS V VYAS
Counsel: MR E MITCHELL - Solicitor: BARRY NILSSON

Hearing Date/s: 13/02/2024-15/02/2024, 19/02/2024-20/02/2024, 27/02/2024-29/02/2024, 01/03/2024, 04/03/2024-05/03/2024, 07/03/2024-08/03/2024, 27/03/2024, 08/04/2024, 10/04/2024, 15/04/2024, 17/04/2024, 19/06/2024, 25/06/2024-26/06/2024, 02/07/2024, 04/07/2024, 22/07/2024

Inquest No: 01/2024 **File No/s: 0826/2020, 2412/2020**

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INQUEST INTO THE DEATHS OF HEMANT CHADHA AND SACHINTHA NANDULA BATTAGODAGE [2026] SACC 8

Introduction

1 This was a jointly held Inquest into the deaths of two young men during the COVID-19 pandemic in South Australia. While the cause of their respective deaths was markedly different, their experience of the public health system during this time was not. Both men repeatedly attended Emergency Departments seeking medical treatment, and neither were admitted to an inpatient unit for investigation. Both men felt that their concerns about their health were underappreciated. Tragically, they were proven to be correct.

2 It is well-recognised that persons who re-present to an Emergency Department within a short time for the same complaint are a high-risk cohort. This Inquest has explored whether the hospitals involved had policies in place that appropriately mitigated that known risk, and if not, whether that has now been remedied.

3 Necessarily, the decisions of the practitioners involved in the medical care of these men was the subject of detailed consideration. The principles in *Briginshaw v Briginshaw*[1] apply for their evidence, namely that any adverse findings against, or comments about, individuals or entities should not be made unless the evidence provides me a comfortable level of satisfaction that the individual or entity caused or contributed to the death. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[2] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences. Such proof should be the result of clear, cogent, or strict proof in the context of a presumption of innocence.[3] I have also been very mindful to exclude hindsight bias and outcome bias from my assessment of the evidence and findings.[4]

Hemant Chadha

Background

4 Mr Hemant Chadha was born in Delhi, India on 27 August 1981. He married in 2007. His first child, a daughter, Mehar, was born in India. The Chadha family emigrated to Australia in 2013. Their son was born in 2017.

5 Before he became unwell in April 2020, Mr Chadha had not experienced any significant health problems, except for kidney stones. At the time of his death, he was on the waiting list for surgery to remove the kidney stones.[5] He was a vegetarian and did not consume alcohol. His regular general practitioner was Dr Channa Fernando.[6]

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1 (1938) 60 CLR 336 (*Briginshaw*)
2 *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw*; see also *S J Berry Pty Ltd v McEntee* (2022) 142 SASR 31
3 *Briginshaw*, pp 362-3 per Dixon J
4 Hindsight bias as defined in the Australasian Coroners Manual: *outcome bias is not allowing the fatal outcomes in this Inquest to overwhelm a rational assessment of the nature of the errors or oversights in the medical care of these men*
5 Exhibit C22, p4
6 Exhibit C21

6 On about 4 April 2020 Mr Chadha complained of stomach pain. He thought that the pain was due to his kidney stones. He then started developing flu-like symptoms. Due to the COVID-19 pandemic, and Mr Chadha's employment within the disability sector, Mr Chadha elected to stay at home from work and isolate from his children.[7]

Consultations with general practitioners

7 Mr Chadha proactively sought medical advice in relation to his illness from 4 April 2020 up until his death. This included telehealth consultations with various general practitioners,[8] in-person appointments with GPs, three ambulance attendances, and three public hospital attendances. Despite his attempts to seek effective treatment for his illness, which was diagnosed on 17 April 2020 as mycoplasma pneumonia, Mr Chadha's condition did not improve. He passed away in the company of his wife at home on 23 April 2020. He was only 38 years of age. His children were 10 and 3 years respectively.

8 In the various appointments at different medical clinics, Mrs Chadha explained that they were not very satisfied with the medical advice they had received. That was the reason for booking appointments back-to-back. She stated that they hoped that some doctor could '*suggest something better*'.[9] Their usual GP was Dr Fernando, but he had moved from the Martins Place Family Medical Practice in Parafield Gardens to the City Clinic in Adelaide. As Mrs Chadha could not drive, the appointments were booked with medical practitioners who were closer to home. As said, on some occasions the appointments were telephone consultations, and on some occasions, after a negative COVID test result on 17 April 2020, the appointments were in-person.

Cause of death

9 The cause of Mr Chadha's death was acute on chronic pneumonia (mycoplasma pneumoniae detected) as opined by forensic pathologist, Dr Cheryl Charlwood.[10] She came to this opinion based on the post mortem examination she conducted on Mr Chadha on 28 April 2020 at Forensic Science SA.[11] I accept her opinion and make a finding accordingly.

10 Pneumonia is an infection of the lung tissue. Its symptomology is usually fever and cough, but can also include other symptoms.[12] It can cause inflammation of the lining around the lung, leading to chest pain. It can decrease the amount of lung available for oxygen transfer, leading to shortness of breath.[13]

11 The autopsy findings included the observation of markedly congested and oedematous lungs. Consistent with this observation, FSSA's microscopic examination of the lung sections showed severe widespread pulmonary oedema (excess fluid in the lung).[14]

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7 T517
8 GP or GPs
9 T523
10 Exhibit C4a
11 FSSA
12 T1556
13 T1558
14 Exhibit C4, p7 - I note that Professor Kelly could not say whether the pulmonary oedema was present at the time of the chest x-ray on 20 April 2020 although this was a possible interpretation: T1585 - She explained that pulmonary oedema can developed very quickly: T1585

12 Mycoplasma pneumonia has a mortality rate of around 2%.[15] However, the atypical organisms, of which mycoplasma is one, commonly have effects outside of the lungs, including immunological problems, and effects on the cardiovascular systems, kidneys, and thrombotic tendency.[16] The detection of this bacteria by FSSA suggests that the antibiotic treatment administered had an effect on the bacterial load, as indicated by his clinical improvement, but that the infection may have reactivated.[17]

13 While cardiac pathology raised the possibility of arrhythmogenic cardiomyopathy, the changes were deemed to be insufficient for definitive histological diagnosis by specialist cardiac pathologist, Professor Anthony Thomas.[18] He did not identify any other cardiac cause for sudden unexpected death.[19]

14 No-one involved in Mr Chadha's medical care detected any signs of a cardiac condition. Further, Mr Chadha did not present with any concerns for chest pain on 21 April 2020. He had no history of a heart condition.[20] GP Dr Aslam did not detect signs of congestive cardiac failure during his examination of Mr Chadha on 17 April 2020.[21] The ECG results appeared to be normal on 20 April 2020.[22]

15 There is insufficient evidence to conclude that arrhythmogenic cardiomyopathy was a causal factor in the death of Mr Chadha. I therefore exclude it as being a relevant consideration in this Inquest.

The investigation

16 In the course of reporting her post mortem findings, Dr Charlwood recommended a clinical review regarding Mr Chadha's management due to the history of repeated medical input.[23] The State Coroner ordered this review as recommended.

17 This clinical review was conducted by Professor Anne-Maree Kelly, Senior Emergency Physician. Professor Kelly attained her MBBS from the University of Melbourne in 1983. She has been a fellow of the Australian College of Emergency Medicine since 1990. She holds a Master's degree in clinical education, and a Master's degree in health and medical law. She publishes articles extensively in the field of emergency medicine. In addition to her academic endeavours, she continues to practise as a Senior Emergency Physician for Western Health in Victoria. She has also practised in large, medium and small Emergency Departments[24] in both rural and urban environments.[25]

18 Professor Kelly furnished four reports to the Court in relation to the medical treatment provided to Mr Chadha. In her fourth report, she raised the possibility that some of the symptoms Mr Chadha was seen experiencing could be attributed to a rare disorder known as Guillain Barre Syndrome (GBS). She reported that there is an association between

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15 T1556
16 T1557
17 T1561
18 Exhibit C6a
19 Exhibit C6a, p5
20 T739
21 T1041
22 T1075 (Vinar) and T1576 (Kelly) - Noting that the absence of a troponin test to rule out a cardiac cause for Mr Chadha's failure to improve was criticised by Professor Kelly at T1577
23 Exhibit C4a, p4
24 ED
25 Exhibit C41

mycoplasma pneumoniae infections and GBS. GBS is a disorder where the body's immune system attacks the nerves and is often preceded by an infective illness.

19 Professor Kelly considered the documented symptomatology of Mr Chadha to be consistent with the known symptomatology of GBS, particularly the progressive nature of his muscle weakness.[26] She acknowledged that GBS is a very rare condition. Unfortunately, it is not possible to conclude with any certainty after his death whether Mr Chadha may have been suffering from GBS as a complication of his pneumonia.

20 Shortly before giving evidence, Professor Kelly was provided with a copy of the antinuclear antibody test results (ANA)[27] of Mr Chadha[28] from 22 April 2020. She stated that an ANA test is a screening test performed as part of a work-up for autoimmune disease but is not itself diagnostic of GBS.[29] However, the results were indicative of an overacting immune system, and were not inconsistent with a diagnosis of GBS.[30]

21 If Mr Chadha was suffering from GBS, it was Professor Kelly's evidence that this could have affected the diaphragm and the muscles around the rib cage, which would have affected Mr Chadha's ability to pull in air and cough material up from the lungs,[31] potentially exacerbating his chronic pneumonia.

22 It is not suggested that the evidence supports a finding on the balance of probabilities that Mr Chadha was suffering from GBS, or that GBS was a contributing factor in the cause of death. I therefore also exclude GBS as a relevant consideration in this Inquest.

Overview of issues

23 The evidence heard during this Inquest identified two primary causal factors in the death of Mr Chadha, namely:

a. The standard of care provided at the Lyell McEwin Hospital[32] on 21 and 22 April 2020 and, in particular, the failure to admit him to hospital for further investigation, monitoring and treatment; and

b. The behaviour of the SA Ambulance Service (SAAS) personnel who transported Mr Chadha to hospital on 20 and 21 April 2020. This behaviour, in combination with his treatment at the Lyell McEwin Hospital, resulted in Mr Chadha's refusal to allow his wife to telephone for an ambulance on his behalf on 22 April 2020 and early morning of 23 April 2020.

24 I also have to consider whether there was a third missed opportunity to prevent Mr Chadha's death on 22 April 2020, during his consultation with Dr Azhar.

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26 T1554
27 A screening test for autoimmune disorders: T1653
28 Exhibit C31
29 T1555
30 T1555
31 T1558
32 LMH

COVID-19 pandemic in 2020

25 It is important to recognise the context in which these events occurred. Mr Chadha's death occurred in April 2020, which was relatively early in the COVID-19 pandemic in South Australia. This may have impacted the standard of care provided. Mr Chadha's early medical appointments, prior to 17 April 2020, occurred via telephone, preventing physical examination. This resulted in clinicians having to make decisions on very incomplete data.[33] This limitation was highlighted by Professor Kelly in her reports.[34] I also made observations on this topic in the Inquest into the death of Ms Virginia Weekes.[35]

26 Professor Kelly also observed that hospitals were trying to free up and increase capacity at this time, resulting in processes aimed at keeping as many patients out of the hospital as possible. The net result, according to Professor Kelly, was that some patients who might otherwise have had a short hospital admission, were discharged for care in the community.[36]

27 Despite this background, it was submitted that the decision to discharge Mr Chadha on the morning of 22 April 2020 after his third presentation to an ED cannot be attributed to the COVID-19 pandemic. Rather, there was an alleged failure by the discharging clinician to recognise the gravity of his illness, and no processes were in place at the hospital to ensure that patients who re-present to the ED with the same complaints within a short time were reviewed by a senior doctor. I will deal with this issue in depth.

Circumstances leading to the death of Mr Chadha

28 Mr Chadha attended a telephone consultation[37] with Dr Kamath at the Northern Medical Centre on 4 April 2020, who provided him with a medical certificate for work. He had a further telehealth consultation with Dr Kamath on 5 April 2020 regarding the flank pain.

29 On 7 April 2020, Mr Chadha reported a sore throat and runny nose to Dr Kamath during a further telehealth consultation. Dr Kamath advised Mr Chadha to isolate for two weeks. He made a note that Mr Chadha was '*stressed about all this*'.[38]

30 Mrs Chadha recalled that it was on 11 April 2020 that Mr Chadha began coughing '*really badly*'.[39] From that date, he struggled to sleep.

31 On Sunday 12 April 2020, Mr Chadha had a telehealth consultation with Dr Ghuman at the Premium Care Medical Practice.[40]

32 Dr Ghuman's notes recorded that Mr Chadha reported a sore throat and being '*feverish and unwell*'. Further, he reported he had been having symptoms for almost a week, but the cough has become worse. Dr Ghuman prescribed the antibiotic Amoxil 500mg.[41]

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33 Exhibit C41a, p18
34 Exhibit C41a, pp4, 17
35 *Finding of Inquest into the deaths of Virginia Anne Weekes and Craig Malcolm Files* [2022] SACorC 31 delivered on 26 October 2022
36 Exhibit C41a, p18
37 Telehealth
38 Exhibit C22, p5
39 T519; Exhibit C30, p2
40 Exhibit C20, p1 - I note that Mrs Chadha initially stated that she believed this to be Dr Aslam, but conceded she could be mistaken as this was a telephone consultation
41 Exhibit C20, p1

33 On 13 April 2020, Mr Chadha had a consultation with Dr Aslam. While the note reads '*surgery consultation*', it was Mrs Chadha's evidence that all medical appointments were over the telephone until Mr Chadha had been tested for COVID-19.[42] Dr Aslam's note records that Mr Chadha had not been well for a week, that his illness had started with a sore throat and temperature, and that over the last three days his cough had increased and he could not sleep the previous night due to the cough. He also reported fever.[43]

34 On 14 April 2020, Mr Chadha reported to Dr Kamath that he had bouts of coughing and some mucous. He told Dr Kamath he had already been prescribed antibiotics from another GP. Dr Kamath's notes indicate that he told Mr Chadha to continue with the current treatment with the addition of Ventolin (via a nebuliser) and that he would have a further telephone consultation with him the following day.

35 Mrs Chadha's evidence was that the nebuliser appeared to help with her husband's cough. He was happy and thought that '*finally maybe the treatment has started now*'.[44] Mrs Chadha purchased the nebuliser despite the cost, telling her husband '*when you need it, you need it*'.[45]

36 On 15 April 2020, Mr Chadha had three medical appointments (Drs Aslam, Fernando and Kamath). Dr Aslam noted in relation to the 15 April 2020 consultation that Mr Chadha was '*better today*', had a slight temperature the night before, and that he was having '*nebs*', presumably the nebuliser. He also noted Mr Chadha was now able to sleep at night.

37 Dr Kamath also noted that Mr Chadha was feeling better but still had a mild cough and was mildly warm. He advised Mr Chadha to have a test for COVID-19.[46] Dr Fernando confirmed this advice.

38 The following day, 16 April 2020, Dr Azhar arranged for a COVID-19 test to be performed at Mr Chadha's home as he could not attend the clinic.[47] Dr Azhar's note records that Mr Chadha had a severe productive cough at this time and could not drive.[48] Dr Fernando's note from the same date however, records that Mr Chadha felt he was getting better.[49]

17 April 2020

First ambulance attendance

39 At 3:52 am on 17 April 2020, Mrs Chadha called 000 for an ambulance ('the first ambulance').[50] She advised the call taker that her husband had been coughing all night and could not breathe and that they had been trying everything. She said that he had been home sick for more than 17 days now and that they were awaiting the result of a COVID-19 test.

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42 T510
43 Exhibit C20, p2
44 T523
45 T523
46 Exhibit C22, p6 - Again, while this note reads 'surgery consultation' it was via telephone
47 Exhibit C22, p6
48 Exhibit C22, p6
49 Exhibit C21, p2
50 Exhibit C10a – audio recording

40 The ambulance arrived at 4:09 am and transported Mr Chadha to the Royal Adelaide Hospital.[51] The notes of the attending ambulance officers included '*SAAS don full PPE*'[52] and '*normal gait/balance*'. In relation to his respiratory system, the note reads '*tachypnoeic*', '*dyspnoeic*', '*mild right lower lobe consolidation*' and '*++coughing*'.

Royal Adelaide Hospital

41 Mr Chadha arrived at the Royal Adelaide Hospital[53] at 5:10 am. The medical notes indicate that he was seen by Dr Barnett at 5:56 am. By that stage, Mr Chadha's COVID-19 test results had been received. These results were negative for COVID-19, but positive for mycoplasma pneumoniae. Dr Barnett noted that Mr Chadha had difficulty completing full sentences due to shortness of breath and that he was using accessory muscles to assist with his breathing.

42 A chest x-ray was performed at 6:31 am and a blood sample was taken for analysis. The report of that x-ray[54] by the radiology registrar confirmed that Mr Chadha was suffering from pneumonia. The consultant radiologist reviewed the report of the registrar at 8:11 am.

43 The consultant added that there was peribronchial nodular infiltrate[55] in the left mid and lower zones, which was likely infective. Follow-up post therapy was recommended.

44 Mr Chadha's blood test results were essentially normal with the exception of high C-Reactive Protein (72.1), which is an inflammatory marker. His calcium level was normal.

45 Accordingly, Dr Barnett's working diagnosis was community acquired pneumonia and Mr Chadha was treated with intravenous antibiotics (amoxicillin), oral antibiotics (azithromycin), and inhaled salbutamol.

46 Mr Chadha was discharged at 8:29 am on 18 April 2020. The discharge plan was for Mr Chadha to continue with oral antibiotics with follow-up with his GP. The notes indicate that he was advised to re-attend the ED if his condition became worse or if '*red flag*' symptoms were present. The discharge letter was addressed to Dr Fernando but sent via facsimile to his old medical practice at Martins Road.[56]

47 Mrs Chadha recalled that she thought Mr Chadha was feeling a bit better when he returned from the RAH. He was particularly relieved that he did not have COVID-19.[57]

48 Later that day, Mr Chadha had medical appointments with Dr Aslam, Dr Kamath and Dr Fernando. The latter two appointments were over the telephone. Dr Aslam prescribed a cough medicine and prednisolone, an anti-inflammatory agent. A plan was made to review Mr Chadha in three days.

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51 Exhibit C17, p1; 'the RAH'
52 This is consistent with Mrs Chadha's recollection: T609
53 RAH
54 Exhibit C23
55 Nodules in the lungs
56 Exhibit C24, p23
57 T527

Opinion of Professor Anne-Marie Kelly in relation to standard of care provided at RAH on 17 April 2020

49 In her first report, Professor Kelly concluded that the overall care, treatment and discharge plan provided at the RAH on 17 April 2020 was reasonable in the circumstances based on the following factors:

a. A thorough history and examination were undertaken;

b. An appropriate range of tests were conducted;

c. A reasonable management plan, based on the findings, was made; and

d. An appropriate follow-up plan was made.

50 I accept the opinion of Professor Kelly and find that the treatment provided at the RAH on 17 April 2020 was reasonable in the circumstances.

20 April 2020

Appointment with Dr Aslam

51 Mr Chadha next saw Dr Aslam on 20 April 2020 at 12:42 pm.[58] Mrs Chadha believed that this was the first time they had seen Dr Aslam in person.[59] The consultation occurred in a mixture of English and Hindi. Mrs Chadha recalled that Dr Aslam touched her husband on the forehead and said that he had a fever. She also recalled Dr Aslam saying, '*chest is clear*',[60] and that he needed an IV as his lips were very dry and he looked very weak. Mrs Chadha recalled looking at her husband's lips and noticed that they looked dry.[61]

52 Dr Aslam gave evidence in relation to this consultation. He recalled that Mr Chadha complained of being more unwell than when he saw him previously, that he had vomited, lost his appetite and that a cough was his most prominent symptom.[62] The high temperature of 38.6°C was a concern for him as Mr Chadha was 38 years old and had only been discharged from hospital three days prior with a diagnosis of mycoplasma pneumonia. He said he would not send him home as his presentation could reflect a progression of the pneumonia, the antibiotics failing to work, or a secondary infection. In his view, there was a diagnosis that needed to be clarified and further investigations performed.[63]

53 Dr Aslam believed that Mr Chadha required hospital admission and he arranged for an ambulance to be called by his staff. Dr Aslam told the Court that he had decided to call for an ambulance rather than advise Mr Chadha to make his own way to hospital due to the totality of his symptoms, including lethargy. Understandably, he believed an ambulance was a better option because Mr Chadha could be supported while he was being transported.[64]

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58 Mrs Chadha thought that this occurred on 19 April 2020: T530
59 T530
60 T534
61 T536
62 T1016
63 T1016-7
64 T1018-9

54 Dr Aslam prepared a referral letter to the LMH.[65] He recorded that Mr Chadha had been vomiting and appeared '*significantly dehydrated*'. He stated that the difference in Mr Chadha's appearance compared to three days prior was one factor that led him to form the opinion that he was '*significantly*' dehydrated, due to slightly more sunken eyes, dry lips, shortness of breath, and fatigue. As he noted '*everything was indicating towards it*'.[66] He further believed he would have looked at Mr Chadha's pulse, which is another potential sign of dehydration.[67]

55 Dr Aslam's note of this consultation is brief, reading '*for ED review, ambulance called, drowsy and not feeling well, vomiting this am, T 38.6*'. Under the heading Reason for contact, Dr Aslam recorded '*dehydration*'.

56 A 000 call[68] was made by Nurse Ratha Yang of the practice at 1:16 pm.[69] She advised the call taker that the patient had been vomiting since this morning, that he could not keep food or water down, and that the doctor asked for the ambulance to come urgently.[70] Nurse Yang also reported that Mr Chadha was alert but lethargic, his temperature was 38.6°C and his '*sats*' were 92%. She reported no obvious increased work of breathing.

57 Nurse Yang advised that the best entrance to the surgery would be the entrance near the Coles supermarket, and that the practice was around the corner and across from Specsavers. She did not inform SAAS of the negative result of a COVID-19 test for Mr Chadha.

58 SAAS dispatched an ambulance on a priority 3 basis. Mrs Chadha waited with her husband for the ambulance in the treatment room. While they were waiting her husband was sitting on a bed and he asked her for a cup of cold water, which she brought for him.[71] She did not recall the wait being unduly long.

59 The recordings provided by SAAS include a conversation between Dr Aslam and an ambulance officer at 1:54 pm in which Dr Aslam was advised that there was a delay and that they expected to arrive in 30 minutes.

60 The ambulance arrived at the practice at 2:27 pm. A priority 3 case should be seen within 30 minutes.[72]

Second ambulance attendance

61 The two ambulance officers who attended were Melissa Stiles (nee Turner) and Paul Vinar. This was the first time they attended upon Mr Chadha.

62 The Court heard conflicting accounts regarding the events that unfolded after their arrival at the Hollywood Plaza on the afternoon of 20 April 2020.

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65 Exhibit C20, p12
66 T1046
67 T1044
68 Exhibit C17, p6; Exhibit C10a
69 Exhibit C42: Nurse Yang confirmed that she is the person who called 000 but could not recall the event - The caller is incorrectly referred to as 'Bretta' in the SAAS documents at Exhibit C17, p7
70 Exhibit C10a
71 T537
72 T1066

63 The main point of contention related to how Mr Chadha came to be in a wheelchair enroute to the ambulance.

64 Mrs Chadha told the Court that when the ambulance officers arrived at the clinic, she left the treatment room to meet them. She said that before the ambulance officers entered the room to see her husband, she asked the male ambulance officer (Paul Vinar) for a wheelchair to assist getting her husband to the ambulance.[73] She told the Court that he replied with the words '*How did he reach here in the first place? Did he crawl?*'. She was certain that these were the exact words he used because she was shocked by them.[74] She did not think that the female officer was present at that time.[75]

65 Mrs Chadha stated that a wheelchair was obtained for her husband, and he was taken to the ambulance in it. She recalled that as they were leaving, the male officer said to her '*and by the way, we're not taking you*'.[76]

66 Mrs Chadha recalled that the male officer asked whether Mr Chadha had been given any medication to which she replied '*no*'. She recalled that he rolled his eyes in response.[77] This is consistent with the note made by Mr Vinar in the PCR which reads '*FEBRILE @GP 38.8 AND LETHARGIC. NIL ACTION TAKEN*'.[78] Mr Vinar could not recall asking whether Mr Chadha had received medication at the surgery but agreed that he would ask this question on occasion.[79]

67 Mrs Chadha described Mr Vinar's tone as '*very rude*'. She spoke to Dr Ghuman about what had occurred after the ambulance had left. He advised her to complain.[80]

68 Mrs Stiles and Mr Vinar gave oral evidence to the Inquest. While they did not produce sworn affidavits, both had completed a written statement at the request of their Team Leader, David Funnell, following a complaint regarding their conduct. It appears that these statements were prepared on or prior to 7 May 2020.[81]

69 Mrs Stiles' statement was very brief in relation to the 20 April 2020 attendance. Mr Vinar's statement was more comprehensive. This is unsurprising as he was the attending officer, whereas Mrs Stiles was the driver.

70 Mr Vinar recorded in his statement:

> This was a P3 tasking and **we met the patient at the treatment room in the clinic**.[82] The nurse gave me the GP letter and indicated the pt had a type of pneumonia and needed to be reviewed at [Lyell McEwin Hospital]. **We placed the pt in a wheelchair**, escorted him out to the ambulance and stood transferred him to the barouche… (emphasis added).

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73 T537
74 T539
75 T539
76 T539 Note the parallel with consumer complaint Exhibit C33k
77 T540
78 Exhibit C17, p6
79 T1170
80 T539 There is no record of this in the medical notes
81 T2033
82 Mr Vinar later told the Court that he met Mr Chadha outside of the treatment room

71 Mr Vinar's reference in his statement to meeting Mr Chadha inside the treatment room and placing him in the wheelchair is consistent with the evidence of Mrs Chadha. This contradicted his evidence that Mr Chadha was already in the wheelchair when they arrived. Mrs Stiles supported her partner in his evidence on this topic. I note she did not make any note to this effect in her statement and no apparent reason to recall what, according to her, was an uneventful attendance.

72 Mr Vinar agreed that it was in accordance with his general practice to ask questions before acceding to a request for a stretcher or wheelchair for a patient.[83] When it was put to Mr Vinar that Mrs Chadha had said in her evidence that he had made the comment '*did he crawl here*', he responded:

> I don't recall saying 'did he crawl?' But I may have asked how he got there from the carpark to the surgery, and that would be more like a mobility question to determine what's deteriorated from him walking into the doctor's surgery and then now, in that space of time, the hour, what's changed that he can't walk. So it is not uncommon to ask mobility questions like that. I don't recall saying anything about crawling.[84]

73 He later added:

> I don't recall saying the word 'crawl'. I may have asked him. Normally we have a mobility assessment, and we just asked how they're mobile – how they're mobile. And I may have asked how did he get from the carpark to the doctor's surgery.[85]

74 Mr Vinar quite properly did not deny the alleged statement as he could not recall any interaction with Mrs Chadha on this date.

75 Mrs Stiles, on the other hand, confidently asserted to the Court that this comment was not made because Mr Chadha was already in the wheelchair and therefore crawling would not have come up.[86] It was not suggested, however, by Mr Vinar or Mrs Stiles that a comment of this nature would have been out of character for Mr Vinar. As will be referenced by other patients,[87] Mrs Chadha's impression of Mr Vinar as being very rude was consistent with the reported experiences of others.

76 It was not put to Mrs Chadha by either counsel for the paramedics that Mr Chadha was already in a wheelchair when the ambulance arrived. Therefore she was denied an opportunity to comment on that proposition. However, such a suggestion is clearly at odds with her recollection. Logic suggests if her husband was already in a wheelchair there would have been no need to request one from Mr Vinar. Unfortunately, Nurse Yang did not have any recollection of the events.[88] Dr Aslam did not see Mr Chadha leave the surgery, so was also unable to assist.[89]

77 It was submitted that there were good reasons Mrs Chadha's evidence on this topic should be preferred to the evidence of Mr Vinar and Mrs Stiles. This was an uneventful call out for the attending officers, especially Mrs Stiles who, as the driver, had no personal

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83 T1217
84 T1071
85 T1167
86 T1464, 1439
87 As detailed in [208], [209], [211], [212], and [217] below
88 Exhibit C42
89 T1023

interaction with Mr Chadha on this occasion. Mrs Stiles made the briefest of notes in relation to this attendance in her statement and made no mention of a wheelchair. It was submitted her evidence was coloured by her ongoing friendship with Mr Vinar.[90] For example, she perceived his manner as assertive but not rude or abrupt.[91] This is clearly contrary to the impressions of the many consumers who complained about his behaviour. It is also particularly pertinent that in Mr Vinar's written statement, made relatively soon after the events, he referred to placing the patient into the wheelchair.

78 Mrs Chadha was upset when Mr Vinar spoke these words. Further, she worried that the person who said this about her husband had now taken him.[92] Her evidence was that she was in disbelief. She believed when she returned to the treatment room her husband read her expression and asked her what had happened, to which she replied, '*nothing*'. The events of this day were particularly significant for Mrs Chadha. She is certain she had a clear recall of what happened, and how she felt about those events.

79 Even if I prefer the evidence of Mr Vinar and Mrs Stiles in this respect and made a finding that Mr Chadha was already in the wheelchair when the ambulance arrived, it does not necessarily follow that the impugned conversation did not occur.

80 It was Mr Vinar's evidence that seeing Mr Chadha in a wheelchair would have led him to want to know '*what's changed in the hour since they rang, and then we turned up, that's made him in a – made him wheelchair-bound*'.[93] That is, he would have asked questions about Mr Chadha's mobility and in this context may have asked whether he had crawled to the medical practice.

81 There were also several inconsistencies between Mr Vinar's oral evidence and his written statement, in addition to the issue of whether Mr Chadha was already in a wheelchair when they arrived.

82 In his oral evidence, Mr Vinar stated that after they had parked the vehicle, he met an RN and saw Mr Chadha was already in a wheelchair **outside** of the doctor's surgery, in the mall of the shopping centre. However, this evidence was contrary to both his written statement and the notes recorded in the PCR. In his statement, he referred to meeting the patient in the treatment room in the clinic. In the PCR, he recorded '*…In GP room, RN in attendance*'.[94] It is usual in this type of situation that written records or notes are usually more accurate due to their relative contemporaneity. Here the notes are consistent with the evidence of Mrs Chadha.

83 Mrs Stiles evidence was that when she arrived at Hollywood Plaza, she got out of the ambulance and went into the doctor's surgery with Mr Vinar. She was certain that she entered the surgery with Mr Vinar. She was also certain the nurse brought Mr Chadha out to them in a wheelchair,[95] contrary to the PCR, the written statement of Mr Vinar and the evidence of Mrs Chadha.

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90 T1499
91 T1499-500
92 T628
93 T1167
94 Exhibit C17, p6
95 T1349

84 Mr Vinar told the Court that Mrs Stiles came into the clinic with him, and she was '*possibly beside me, right there*' when he was speaking to the nurse. He said they '*walked into the area ourselves, as a crew*' but as to whether Mrs Stiles left his side he said, '*I'm not sure, I can't remember*'.[96]

85 Mr Vinar gave evidence that he was told (by the RN) that '*the patient has been lethargic and needs to go to the LMH, here is the doctor's letter*'.[97] He did not recall speaking with the doctor regarding any handover.

86 Mrs Chadha recalled that when they arrived the female officer was not very close to the male officer. She thought the female officer was not there when Mr Vinar made the comment '*did he crawl here*'.[98] Mrs Chadha only remembered talking to the male ambulance officer. The female ambulance officer did not speak to her.[99] This is consistent with the roles Mr Vinar and Mrs Stiles had for tasking, namely Mrs Stiles was the driver of the ambulance that day and Mr Vinar was the attendant who had the responsibility of taking observations and recording the patient's details.[100] It was the driver's responsibility to load and unload the stretcher out of the back of the vehicle, usually while the attendant was seeing the patient.[101] This tends to suggest that it was not usual for the officers to enter a premises at the same time.

87 Mr Vinar believed that he would have been wearing personal protective equipment,[102] namely a gown, mask and glasses.[103] This is inconsistent with the recollection of Mrs Chadha.[104] It is not recorded on the PCR.[105]

88 It was submitted that I should accept the '*compelling*' evidence of Mrs Chadha on this topic[106] and find that Mr Vinar said the words '*did he crawl here*' as alleged. I have been asked to consider further comments of a similar nature as being relevant to prove that Mrs Chadha's evidence should be accepted. In particular, the independent evidence of another complaint negates or lessens any likelihood of fabrication or unreliability in recollection. For reasons that will be discussed later in this finding,[107] I accept that a similar comment '*if she walked in she can walk out*' of an independent complaint of another patient is evidence supporting Mrs Chadha's recollection and I accept her evidence on this topic.

Mr Chadha's condition

89 The Court heard oral evidence from Dr Aslam in relation to his consultation with Mr Chadha on 20 April 2020.

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96 T1110
97 T1070
98 T626
99 T539
100 T1064
101 T1064
102 PPE
103 T1081
104 T630
105 Exhibit C30f
106 Submissions of Ms Roper, Special Counsel
107 See paragraph 208

90 Mr Chadha attended the practice of Dr Aslam with Mrs Chadha. The consultation occurred in a mixture of Hindi, Punjabi and English. Mrs Chadha did most of the talking, but Mr Chadha was able to speak in full sentences when asked. However, his lethargy was noted by Dr Aslam.

91 Dr Aslam found that during his physical examination, Mr Chadha had a high temperature of 38.6°C,[108] sunken eyes, dry lips, shortness of breath and fatigue, all indicating towards dehydration.[109] Taking into account the history given that morning by Mr Chadha, namely that he was vomiting and not eating well for the last two or three days, Dr Aslam formed the view that he was significantly dehydrated.[110]

92 Dr Aslam found Mr Chadha's febrile temperature worrying. Given the history of vomiting, he was concerned about the progression of Mr Chadha's pneumonia and the effectiveness of the antibiotics that he had been prescribed.[111] It was very clear to Dr Aslam in this consultation that the antibiotics were not working or were not enough.[112]

93 Dr Aslam recalled speaking to a male paramedic on their arrival to the clinic. Dr Aslam conducted a handover of basic information. He believed he would have said something along the lines of:

> I'm a GP here and this is the patient who is 38 years old presented with shortness of breath, worsening and then coughing. He's febrile now. My concerns are, is it progressing. Probably not working and he's dehydrated. So he needs to be shifted to the hospital and these are the vital signs.[113]

94 During his evidence, Dr Aslam disagreed with the assessment of Mr Vinar that Mr Chadha appeared to be well-hydrated, and that Mr Chadha had experienced no vomiting for one day.[114] This assessment and history was based on Mr Vinar's evidence of a conversation with Mr Chadha in the ambulance enroute to the hospital where he asked him about his signs and symptoms and explained his diagnosis of mycoplasma pneumonia. Mr Vinar opined that Mr Chadha '*looked hydrated*'. Mr Vinar noted that he '*looks well-hydrated*' on the PCR. Mr Vinar explained that his method to determine a patient's level of hydration was to ask questions about whether they have been able to drink, their urine colour and about other related issues.[115] He observed Mr Chadha's oral mucosa when he gave him some paracetamol and said his airway looked moist.[116] As said, Mr Chadha told him that he had not vomited for at least a day.[117] Therefore, he noted in the PCR '*nil vomiting since 1/7*'. This is contrary to the information provided to the 000 call taker by Nurse Yang.

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[108] Exhibit C20, p4
[109] T1046
[110] T1045
[111] T1045
[112] T1046
[113] T1049; see also [52]
[114] T1051
[115] T1077
[116] T1076
[117] T1075-6

95 Mr Vinar observed Mr Chadha walk two to three steps from the wheelchair to the barouche thus he determined that he was ambulant but a little bit lethargic.[118]

96 Mrs Stiles agreed with her partner's assessment that Mr Chadha did not appear significantly dehydrated, despite not having examined him herself. She believed she would have observed Mr Chadha's oral mucosa when he was talking to Mr Vinar.[119]

Acopia

97 Mr Vinar used the term '*acopia*' in the PCR. This was written to convey '*the fact that he wasn't coping at home*'.[120] He explained to the Court:

> He wasn't eating and drinking and unwell. He had had a presentation at the Royal Adelaide Hospital and gone back to his GP. Didn't seem to be coping at home with that illness. He felt as though he wasn't getting any better, that's what he said to me […].[121]

98 Mr Vinar did not otherwise note in the PCR that Mr Chadha had not been eating or drinking. This information is inconsistent with Mr Vinar's observation that he looked well-hydrated, particularly if that assessment was made taking into account his normal routine to ask about whether the patient had been able to drink.

99 When Dr Aslam's referral letter was drawn to his attention, which stated Mr Chadha was '*significantly dehydrated*', Mr Vinar responded:

> I have my own findings in that sense because once I've contacted a patient they are my responsibility and I've been trained to recognise that in the field. So he was fine in my opinion, but that he needed to go to hospital.[122]

100 Mr Vinar's conclusion on this date that Mr Chadha was fine, but needed hospitalisation, does not sit consistently easily with me as logical. I will further analyse the term acopia later in this Finding.[123]

101 In any event, Mr Vinar and Mrs Stiles transported Mr Chadha to the LMH and arrived at 2:58 pm. I am persuaded by the evidence that that was the correct decision in the circumstances.

102 Mr Vinar and Mrs Stiles both formed the firm view that Mr Chadha was not dehydrated, contrary to the assessment of Dr Aslam and Dr Barnett. I have been invited to find that Mr Chadha was dehydrated on 17 April 2020. By logic, if I do make such a finding, Mrs Stiles and Mr Vinar had formed an incorrect view that he was not. I have considered the evidence very carefully on this topic and prefer the evidence of Drs Aslam and Barnett due to their capacities as legally qualified medical practitioners and their overall care of Mr Chadha.

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118 T1075
119 T1466-7
120 T1079
121 T1079
122 T1077
123 Paragraphs [252]-[264]

The handover to the Lyell McEwin Hospital

103 Mr Vinar's evidence was that a normal handover of a patient to the hospital would be to speak to the triage nurse, who would make an initial assessment and send the paramedics to the designated area where a bed would be present for the patient.[124]

104 On 20 April 2020 it was Mr Vinar's responsibility, as the attendant, to handover Mr Chadha to the LMH staff. Unfortunately, Mr Vinar had no recollection of the handover.[125]

105 Mrs Stiles stated that in her role as the driver, she was to transfer the patient to a hospital barouche and then take the stretcher back to the ambulance to prepare for the next tasking.[126] This would occur regardless of whether or not the handover had been completed by the other crew member, and the driver would be required to remain until the handover was complete.

106 The LMH notes regarding the transfer read '*SAAS handover (tick) cubicle 28 - IDV obs & workup for MO R/V 12 lead ECG shown to Area D consultant*'.

First attendance at the Lyell McEwin Hospital

107 Mr Chadha arrived at the LMH at 2:58 pm on 20 April 2020 and was triaged at 3:06 pm.[127] The presenting complaint was listed as febrile illness and cough on the background of mild pneumonia which had been diagnosed by the GP. On examination there was mild increased work of breathing and normal oxygen saturation. Mr Chadha was assigned an Australasian Triage Category Scale of 3.

108 Mr Chadha was seen by the Resident Medical Officer[128] Dr Wang at 4 pm.[129] The notes indicate that Mr Chadha reported that in the past two to three days he had felt unwell generally, felt weak, with high temperatures every day, a poor appetite and poor oral intake. Dr Wang noted her impression that Mr Chadha's pneumonia was not responding to oral treatment. On examination, his respiratory rate was 24 (elevated), temperature 38°C (elevated) and BP 120/60 (normal).[130]

109 She ordered a further x-ray which was performed at 4:20 pm. The reporting radiologist noted an improvement in the airspace opacity in the mid left zone and no new consolidation. An ECG was performed at 3:22 pm and was normal.[131]

110 Dr Wang also ordered intravenous (IV) fluids[132] and blood tests.[133] She changed the antibiotic to IV azithromycin[134] and contacted the Acute Medical Unit (AMU) for a

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124 T1080
125 T1080
126 T1441
127 Exhibit C18, p57 (triage note)
128 A doctor usually on their first or second postgraduate year (Exhibit C41a, p12) 'RMO'
129 Exhibit C18, p63
130 Exhibit C41a, p12
131 Exhibit C18, p71; Exhibit C41a, p12
132 Exhibit C18, p68
133 Exhibit C18, p7
134 Exhibit C18, p63 (azithromycin)

treatment plan. The azithromycin[135] was administered at 4:35 pm.[136] Two litres of IV fluids (0.9% saline) were administered. The notes indicate that the first litre was administered at 3:30 pm.[137]

111 At 6:30 pm, Mr Chadha was reviewed by Dr Maganti.[138] The notes include reference to Mr Chadha feeling weak. Dr Maganti's assessment was dehydration on a background of vomiting and nausea with mycoplasma pneumonia.[139] No respiratory pathogens were detected.[140] The blood test results included some abnormalities, including a C-Reactive Protein of 17.2 (normal range 0.0-8.0), borderline low iron levels with a raised ferratin level, and mildly elevated ESR, white cell and neutrophil counts. Calcium was not measured.[141]

112 It was noted that Mr Chadha had improved following two litres of IV fluid and IV azithromycin and was able to tolerate oral intake. Mr Chadha was discharged at about 7:50 pm on 20 April 2020, with a plan for a follow-up phone call by the AMU on 22 April 2020.[142] He was provided with a prescription for oral azithromycin,[143] together with metoclopramide, an anti-nausea medication.

113 It was the evidence of Mrs Chadha that when her husband returned home, he did not complain about the treatment he received and said he felt a bit better.[144]

114 It was the evidence of Mrs Chadha that when her husband returned home from the LMH on 20 April 2020 he was weak but able to walk. He said he felt a bit better. She thought he was still '*not up to the mark*', but he said that the medication would take some time to come into effect.[145]

Opinion of Professor Kelly regarding first attendance at Lyell McEwin Hospital

115 In her first report, Professor Kelly opined that the overall care, treatment and discharge plan provided at the LMH on 20 April 2020[146] was *probably* reasonable as:

(a) An appropriate history and examination were undertaken;

(b) An appropriate range of tests were conducted;

(c) An appropriate referral to the AMU was made;

(d) A reasonable management plan, based on the findings, was made; and

(e) An appropriate follow-up plan was made; (namely the planned follow-up call from the Hospital Avoidance Clinic [HAC] on 22 April 2020).[147]

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135 Professor Kelly agreed that this was an appropriate antibiotic with which to treat mycoplasma pneumoniae: T1560
136 Exhibit C18, p65
137 Exhibit C18, p68 There is no time relating to the second litre
138 Exhibit C18, p72
139 Exhibit C18, p77
140 Exhibit C18, p7
141 Exhibit C41a, p12
142 Exhibit C18, p78 (Dr Maganti's note is recorded as 7:40 pm)
143 Exhibit C18, p70
144 T603-5
145 T542
146 Noting her report incorrectly states the date as 19 April 2020
147 T1720-1

116 She explained that while it may have been preferable to keep Mr Chadha in hospital because of the duration of his illness, his failure to improve as expected, and his recurrent hospital presentations,[148] the circumstances of the COVID-19 pandemic were highly relevant. In particular, in her experience:

> ED and hospital staff were being encouraged to keep as many people as possible out of hospital because of concerns about the possible impacts of the COVID-19 pandemic on the hospital system, based on international experience.[149]

117 I accept that as a legitimate factor to take into account for this presentation to LMH.

118 Therefore, I also accept it was appropriate for Professor Kelly to make this concession. As she explained in her written reports, she takes deliberate steps to minimise the impact of hindsight and outcome bias on her assessment of the conduct of other practitioners. In oral evidence, she explained:

> Look, I try and interpret the material based on what was known at the time. In other words to try and sort of build up a movie and interpret things in blocks as to who knew what when, rather than going to the end and coming and being critical looking back. Now you, knowing the outcome of a Coronial matter, you obviously know the outcome, but I try to be disciplined about thinking about things in each step. You know, was this okay with what was known at the time?[150]

119 She also explained that she distinguishes between perfect practice and acceptable practice, as:

> Perfect practice is not a reasonable standard to apply to anybody and obviously the circumstances in which that practice is occurring is also very important. So I try to look for what I think is reasonable in the circumstances and not specifically to be highly critical, but to be alert to significant omissions or errors.[151]

120 In considering the impact of the COVID-19 pandemic on the decisions that occurred on 20 April 2020, Professor Kelly told the Court that she was '*especially aware*' of the changes in the health system and its impacts on healthcare during that period.[152]

121 The Court did not hear evidence from Dr Maganti. Therefore, it is not known whether the pandemic played a role in the decision to discharge Mr Chadha.

122 With the evidence available to me, I find the decision to discharge Mr Chadha on 20 April 2020 was probably reasonable, particularly considering Mr Chadha's objective and subjective improvement following IV fluids and IV antibiotics and the context of the ongoing COVID-19 pandemic.

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148 T1719
149 Exhibit C41a, p21
150 T1550
151 T1550
152 T1561

21 April 2020

Mr Chadha's condition

123 The following day, 21 April 2020, Mr Chadha had a telehealth consultation with Dr Ghuman of the Premium Care Medical Centre.[153] It is unclear from the note whether this consultation occurred at 11:11 am or 2:45 pm.

124 Dr Ghuman made the following note:

> Wife syas (sic) was in the ED yesterday
>
> Was given I/V hydration and AB's feeling abit (sic) better but still very weak managing oral intake and not shortness of breath. Mainly need teh (sic) s/c for the work
>
> S/C done, adviedc (sic) red flags if any go to Ed otehrwise (sic) r/v in clini (sic) in 2-3 days

125 That evening, Mrs Chadha left the house in a taxi to get groceries. When she returned, her husband asked why she took so long and asked her to stay with him. As the evening progressed, he reported his lips were getting numb and he could not breathe, which was the first time he had mentioned anything about numbness to her.[154] She observed that his hands and feet were cold to the touch and his eyes were rolling back so she could see only the white of his eyes.

126 Mrs Chadha recalled Mr Chadha making a gesture of holding his hand to his chest, to indicate that he was not able to breathe.[155] She described him as having one leg on the floor, one leg on the bed, one hand on the bed, and one hand on his chest.[156]

127 Mrs Chadha called an ambulance at 8:21 pm[157] explaining that her husband looked like he needed immediate help.[158] The details provided to the 000 call taker included that her husband had a diagnosis of mycoplasma pneumonia, that she had given him hydrolyte, but he could not eat or drink. He had vomited, his tongue, hands and feet were getting numb such that he could not straighten his fingers, he was feeling short of breath and was '*not looking good to me*'. She said that he was not able to speak very well and she was not able to understand what he was saying.

128 Mr Chadha can be heard in the background of the recording of this call, although his words cannot be discerned. Mrs Chadha stated, '*he is saying he is not getting much oxygen to speak*'. When asked if he was having difficulty speaking between breaths, Mrs Chadha said '*yes*'. Mr Chadha can be heard coughing in the background.

129 COVID-19 screening questions were also asked. Mrs Chadha advised that her husband had received a negative COVID-19 test result but was in hospital yesterday when they tested again for COVID-19, the results were outstanding. She explained that he had been at home for weeks. When Mrs Chadha asked her husband if he had chills, he can be heard to speak. Mrs Chadha translates this as 'his face is just getting numb he said'. She said

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153 Exhibit C20, p6
154 T544
155 T546
156 T544
157 Exhibit C10a; Exhibit C17, p14
158 T547

that he had vomited 20 minutes prior, but that the cough had improved with the azithromycin. She reported that he said he needs more air to breathe.

Third ambulance attendance

130 The ambulance arrived at the Chadha residence at 8:47 pm.

131 Mrs Chadha recalled that the ambulance parked on the street rather than in the driveway. She had already opened the door for them and left the lights on so they would know which house to enter.[159]

132 When Mrs Chadha first saw the officers, she recognised them as being the same crew as the previous day (namely Mr Vinar and Mrs Stiles) and felt that this was unfortunate.[160] However, Mrs Chadha told the Court that she hoped that their behaviour would be different this time due to the increased severity of her husband's symptoms.[161] It was her evidence that when Mr Vinar stepped into the house he said loudly '*Oh it's you again. What's the matter today? What's going on here?*' in a sarcastic and rude voice.[162]

133 This was denied by Mr Vinar in his oral evidence, who said he could not recall saying these words.[163] Mr Vinar told the Court that he did not recognise Mrs Chadha from the attendance the day before.[164]

134 Mrs Stiles did not recall hearing Mr Vinar say words to this effect.[165]

135 Mr Vinar told the Court that it was when he entered the room and saw Mr Chadha that he recognised him as the same person he had taken to hospital the day before.[166]

136 Mrs Chadha also stated that Mr Vinar made the following comments to her about her husband:[167]

(a) He should man up;[168]

(b) He just came back from the hospital and the hospital just said he's fine;[169]

(c) He was causing drama;[170]

(d) He was very naughty;[171]

(e) All he needs is your pampering and you are giving him what he wants;[172]

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159 T551
160 T552
161 T658
162 T551, 657
163 T1167
164 T1084
165 T1445
166 T1085
167 It is noted that Mrs Stiles denied any of these comments were made and she could think of no reason why Mr Chadha would have felt disrespected or humiliated by his treatment: T1494
168 See also reference to 'man up' in Exhibit C22, p7; and Dr Azhar's evidence at T773, 794
169 T552, 560
170 Exhibit C30, p4; T552, 555, 616; Mrs Crews recalled the officer/s saying 'there's nothing wrong with him, he was overacting' T817
171 T553; Exhibit C30, p4 Mrs Crews also recalled Mr Vinar referring to Mr Chadha as 'naughty': T822, 824, 826
172 T552, 661

(f) We can take him to hospital so you can have a good night's sleep;[173]

(g) He's just hyperventilating;[174]

(h) He is 38 he is not going to die;[175] [176]

(i) He is having some anxiety;[177]

(j) People in this area call the ambulance all the time for no reason.[178]

137 Mrs Chadha also stated that Mr Vinar asked if they had ambulance insurance[179] which Mr Vinar denied. He stated that he would not routinely ask if patients had ambulance insurance, but that he does get asked about the bill for the ambulance '*all the time*'.[180] I do accept this would be a regular topic even in stressful situations.

138 Mrs Chadha told the Court that she was in disbelief in relation to the behaviour of Mr Vinar[181] and that no-one had ever spoken to her husband like that. She could see that he was feeling really helpless and distressed.[182] As she explained, they called the ambulance for help, not to be abused or to get humiliated.[183]

139 It was submitted the clear implication from the statements allegedly made by Mr Vinar was that Mr and Mrs Chadha were wasting their time and should not have called the ambulance service.

140 This was denied by Mr Vinar.[184]

Mr Vinar's social media comments about the northern suburbs

141 Mr Vinar had made general disparaging remarks about people in the northern suburbs, his area of work for SAAS.

142 The key issue is whether this demonstrated a poor general attitude to Mr Chadha as Mrs Chadha clearly suggested.

143 Mr Vinar also denied that he had ever used the term '*northern bludgers*' and denied that this was a term he was familiar with.[185] However, Mr Vinar was a user of the social media platform '*Facebook*'. He agreed that from time to time he would comment on news articles posted by South Australia Police on Facebook. When Mr Vinar was taken to a comment made in his name in an article dated 16 June 2020, relating to the arrest of a

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[173] T553, 664
[174] T552, 560, 661
[175] T553
[176] The Chadha's neighbour, Mrs Crews, also recalled in oral evidence that the officer said 'he's not going to die': T817
[177] T641 Mr Vinar conceded that he may have had a discussion with Mrs Stiles about Mr Chadha being anxious but he could not recall doing that: T1137
[178] T552, 658, 666
[179] T557, 666
[180] T1100, 1159 This is contrary to consumer complaints tendered as Exhibits C33j, C33k and C33n
[181] T554
[182] T553
[183] T556
[184] T1160
[185] T1160

fourth man for an alleged kidnapping in the northern suburbs, he conceded that he had a vague recollection of making the following comment: [186]

> Very filfee northern bludgers…go directly to gaol and receive a wash, 3 meals a day and further education into eluding capture…fanks.

144 When asked what he meant by the term '*northern bludgers*', he said that he was referring to the unemployed. The following exchange then occurred:

> Q. Did you have at that time a particular view about people who lived in the northern suburbs being a drain on the State's public resources?
> A. Not really. Everyone's got their individual merits.
> Q. What might the merits of a northern bludger be?
> A. I don't really know.
> Q. Well when you used that term there, you intended it to be derogatory, did you not?
> A. Well it appears to be derogatory, yes.
> Q. Is that how you intended it to be?
> A. Not as serious as I realised now, but yes that appears that way.[187]

145 As previously noted, Mr Vinar denied that he said to Mrs Chadha that people in her area called ambulances all the time for no reason. When it was suggested to him that he thought that people in her area did in fact call ambulances for no reason, he said that the Facebook remarks were made '*in a different medium*' and that he '*wouldn't be saying that to a patient or a patient's family. There's no way that I'd walk in and call someone a bludger to their face*'.[188]

146 Mr Vinar did concede that sometimes people call ambulances when they are not needed, but most of the time they are needed. He denied that people from the northern suburbs called ambulances unnecessarily more than people from other suburbs. It is not clear how Mr Vinar came to this conclusion, as it was his own evidence that he only worked in the north.[189] I do accept the common and regrettable situation of people saying words on the internet that they would never say in a face-to-face conversation.

147 Mrs Chadha stated that the female paramedic (Melissa Stiles) was not saying anything in response to Mr Vinar's comments. Mrs Chadha recalled that she was checking her husband's oxygen and doing something else as well.

148 However, Mrs Chadha did recall that the female paramedic was shouting to Mr Chadha '*like on his face*'. She told the lady that she did not have to speak that loudly. This was denied by Mrs Stiles, although she did admit to feeling frustrated during the attendance.[190]

149 Mrs Stiles explained that she had some difficulty communicating with Mr Chadha. He was lethargic, kept rolling his eyes back and becoming vague and inattentive. She mentioned that she had to continuously try to get his attention to continue questioning

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[186] Exhibit C33d
[187] T1162
[188] T1163
[189] T1157
[190] Exhibit C33b, p33

him about his symptoms.[191] She denied that he appeared to be drifting in and out of consciousness and denied that he appeared to be anxious.[192]

150 She stated that she did not raise her voice at Mr Chadha, but that she '*became assertive in getting [her] point across*'[193] that he needed to attend the hospital.

151 Mrs Stiles stated that the source of her frustration was the neighbour, Mrs Crews, being an obstacle in convincing Mr Chadha that he needed to attend the hospital.[194] This was not mentioned in her statement or the PCR she completed for the attendance.

152 Mrs Chadha's evidence was that she advised the male officer that her husband had numbness in his tongue and that he could not talk or breathe, but he did not appear to pay attention.[195]

Mrs Crews

153 Mrs Chadha recalled that Mrs Crews came running to the house when she saw the ambulance.[196] Accordingly, an affidavit was obtained from Mrs Crews in relation to her observations.[197] She gave evidence on two occasions with her service dog to reduce her stress.[198]

154 Mrs Crews recalled the attendance of the ambulance on 21 April 2020. In her affidavit, she stated that the male ambulance officer (Vinar) said something like '*he's a naughty boy, he's got a man flu or man cold*' several times. She also recalled him saying directly to Mr Chadha '*you've been very naughty and you need to behave yourself*', a phrase he also repeated several times.[199] She recalled that the conversation was fairly loud.

Decision to transport Mr Chadha to hospital

155 In her affidavit Mrs Crews stated that the male officer said, '*he has been taken to hospital already are you sure you want us to take him again*'. She and Mrs Chadha said yes, they did want Mr Chadha to be taken to the hospital.[200] This is consistent with the written statement of Mrs Stiles.[201]

156 Mrs Chadha recalled that once they agreed to take her husband to the hospital, he put on his shoes. She asked if he wanted help tying the laces, but he said no.[202] In her affidavit, she stated that she thought he was reluctant to go with the ambulance as they were making him feel like he was doing the wrong thing.[203] However, in oral evidence she explained

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191 T1446
192 T1447
193 T1449
194 T1480
195 T552, 560
196 T553
197 Exhibit C25
198 T810
199 Exhibit C25, p2
200 Exhibit C25, p3 at [10]
201 Exhibit C33b, p33
202 T556
203 Exhibit C30, p4 at [11]

that he did not say anything to express reluctance to go to the hospital,[204] rather, she could tell from his face that he did not want to go with them.[205]

157 Mrs Chadha did not recall a lengthy discussion or debate regarding whether Mr Chadha should go to hospital or stay home. This was in contrast with the evidence of Mrs Crews, Mr Vinar and Mrs Stiles.

158 I reviewed the contemporaneous records for assistance to resolve the conflict in the evidence.

159 The PCR completed by Mrs Stiles does not refer to any conversation regarding whether Mr Chadha should go to hospital. However, the PCR indicated that the crew arrived at 8:47 pm and left at 9:30 pm, therefore spending approximately 43 minutes at the Chadha home. The PCR indicated that whilst at the home, Mrs Stiles completed one set of observations.

160 There is a radio communication between Mr Vinar and SAAS at about 9:21 pm. Mr Vinar can be heard to say:

> There is a delay on scene here, the neighbour has arrived at the house and (inaudible) trying to convince him to stay here. Ah, we're still debating with (inaudible).

161 In Mr Vinar's written statement[206] he referred to the patient seeming anxious twice but added:

> We checked him out to be sure. All his obs were within normal limits and then we started discussing options of treatment. His wife was very anxious about his eyes rolling around when the attendant was asking questions so I think I said that the eyes thing is elective and not part of the condition and he had been fully checked recently and may have what is termed the man flu.[207] At this point a neighbour appeared and entered the conversation and offered to watch the patient so he didn't have to go to hospital. She was coughing quite a lot so I offered her a mask, which she declined so I continued explaining about the term man flu. This seemed to be received well by the pt's wife and the neighbour and I thought they were both reassured by this, given any obvious abnormality with the pt's obs. We spent a reasonable amount of time urging the pt to be rechecked at hospital to alleviate any of their concerns…

162 Mr Vinar also wrote:

> At one point the pt changed his mind and was going to stay home, this was at the suggestion of the neighbour and then we spent another period of time re-convincing him to be checked at hospital. He agreed and we conveyed him to the [LMH] ED again without issue.

163 Mrs Stiles wrote in her statement:

> We talked about the fact that he was a young and normally fit, healthy male who had a diagnosis and treatment plan and I stated that I was happy to take him to the Lyell McEwin again but could not promise that he would have a different outcome in order to prepare him

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[204] T558
[205] T555
[206] Exhibit C33b, p34
[207] This is consistent with the evidence of Mrs Crews as set out in [186]

> that he may get sent home again. **At that point**[208] he stated he would not go to hospital. I then spent 30 minutes convincing Mr Chadha that despite him possibly getting the same outcome, he was clearly not coping with his illness at home and therefore, I felt he should be transported to hospital for reassessment.

164 Mr Funnell's note of his conversation with Mrs Stiles and Mr Vinar on 7 May 2020 reads:

> The crew stated the PT was highly anxious and had some unusual behaviour such as rolling his eyes back and becoming verbally unresponsive for a few seconds at a time, was not very forthcoming with information and did not appear to be coping with his current Dx or management…
>
> The crew spent 42 minutes on scene with the PT as they state the neighbour started becoming involved in the conversation trying to convince him to remain at home, during this time the neighbour was coughing herself and was asked if she would wear a mask to which she refused, at no time did she remove herself.

165 Mrs Crews strongly denied being asked to wear a mask and refusing. She said:

> Absolutely that did not happen. If I had been asked to put on a mask wherever I go I put on a mask. I've got one with me. […] If I'd have been asked to put on a mask, I would have put on a mask because I obey.[209]

166 I note that Mr Vinar had previously said he *offered* Mrs Crews a mask, as he detailed in his written statement, rather than asked her to wear it and she declining.

167 Mrs Crews was adamant that she did not try to convince Mr Chadha to stay home. Her evidence was that there was a battle to get the ambulance officers to take Mr Chadha to hospital, and that they eventually won the battle because the lady said that they would take him.[210] While Mrs Crews stated in her affidavit that she was '*taken aback*' that the female officer did not interject to protect her patient,[211] it was also her impression that she was caring.[212]

168 Mrs Crews told the Court that after Mr Vinar called Mr Chadha a '*naughty boy*', he said to her in a quiet voice '*I suppose we need to also consider the cultural aspect*' or '*the culture of the man*'. She did not speculate about what Mr Vinar may have meant by that comment. However, I do note when Mr Vinar prepared his written statement, he included that '*there were no racist comments stated or implied by myself or my partner*', given his evidence that he was not informed what it was that he had allegedly done to bring about the complaint.[213]

169 Mrs Crews could not recall any discussion pertaining to who would look after Mr Chadha if he stayed at home.[214] She did not recall offering to look after him as she said she would not know how to do it.[215]

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[208] My emphasis
[209] T848
[210] T827
[211] Exhibit C25, p3 at [8]
[212] T826
[213] T1220
[214] T1711
[215] T1711

170 Mr Vinar's recollection was '*quite the opposite*' to that of Mrs Crews. It was his evidence that Mrs Crews '*wanted to keep him home and look after him*', and that she effectively got in their way.[216] When asked what exactly she said, his response was: [217]

> Something like 'if he's got the man flu I will look after him', something like that.

171 It was the effect of his evidence that there was never any question about whether Mr Chadha would be taken to hospital if he were willing to go, given his risk factors and elevated respiratory rate. Professor Kelly also opined that she would have been astounded if Mr Chadha had not been transferred to hospital given his presentation.[218] The only acceptable justification for not transporting Mr Chadha to hospital would have been his refusal.

172 Mr Vinar's impression that Mrs Crews wanted him to stay home is supported by the radio communication referred to above.

173 Mrs Stiles' evidence was that Mrs Crews was trying to encourage Mr Chadha to stay home and that she would take care of him,[219] and claiming he was better off to just stay at home.[220] She later stated that Mrs Crews was insisting that Mr Chadha stay home.[221] These observations were absent from her written statement.

174 Mrs Crews was an honest witness who was greatly affected by the loss of her neighbour. Her impression of Mr Vinar's attitude towards Mr Chadha, namely that he thought Mr Chadha was exaggerating the seriousness of his illness, was shared by Mrs Chadha and Mr Chadha himself. This is also consistent with his admitted use of the term '*man flu*' in relation to Mr Chadha, discussed further below. I need to consider her reliability as well.

175 It is also relevant that Mrs Stiles told Mr Chadha she could take him to hospital, but they might send him home again. This likely contributed to the impression that the crew did not think Mr Chadha needed to go back to hospital for medical treatment. According to Mrs Stiles' written statement, it was this remark by her that led Mr Chadha to say that he did not want to go to hospital, not any comments made by Mrs Crews. Mr Vinar, however, attributed this change of mind to Mrs Crews telling Mrs Chadha that she would look after him.[222]

176 In conclusion on this topic, I find there was some reluctance on the part of Mr Chadha to go to hospital in the ambulance on 21 April 2020. It is likely this was the result of the comments and behaviour of Mr Vinar. Mr Vinar's impression that Mrs Crews wanted Mr Chadha to stay at home, appeared to have been based on a possible offer to look after Mr Chadha if he remained at home.

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[216] T1149
[217] T1223
[218] T1626
[219] T1445
[220] T1449
[221] T1461
[222] T1092

Man flu

177 Mrs Stiles' statement included the following recollection in regard to the use of the phrase '*man flu*':

> We were wearing masks due to Mr Chadha's cough and febrile illness and therefore, our facial expressions would not have been obvious, but at no time did we laugh at him. My partner made a comment about Man Flu in jest to his wife while trying to reassure her that everything was normal with his observations and there was no explanation for why his eyes were rolling back. His wife asked what that was and I replied that men don't cope with being unwell as well as women, with a smile. Both the wife and neighbour appeared to take this lightly with no malice as intended because they both also smiled.

178 In Mr Vinar's statement he admitted to using the term '*man flu*'.

179 Mr Funnell's note reads:

> During this time on scene the partner drew attention to the '*episodes*' the PT was showing and the reason for the call and in an attempt at humour a reference was made to '*man Flu*' as to how men cope with illness. The crew advise this was done in a way to attempt to reduce the anxiety in the family and reassure the partner but they were unsure how this was perceived as the neighbour was then attempting to relay the concept.[223]

180 In his oral evidence, Mr Vinar seemed to be inconsistent with his admission that he was the person to introduce the concept of '*man flu*', as set out in his written statement. He said that he did not think Mr Chadha was acting, and that he was using the term to try and better explain symptoms of pneumonia, because Mrs Chadha did not understand him when he used the word pneumonia.[224] This was clearly an incorrect impression.

181 He said that during his simplified explanation of the symptoms of pneumonia, it was Mrs Crews that said the words '*man flu*' and he then explained to Mrs Chadha what the term meant, as she had not heard it before.[225] He acknowledged that his written statement implied he had first used the term '*man flu*', and Mrs Crews did not enter the conversation prior to him using that term.[226]

182 Mrs Chadha did not refer to the use of the term '*man flu*' in her affidavit or in her evidence in chief. However, when it was suggested to her by Mr Homburg, counsel for Mr Vinar, she agreed that the male officer said that her husband had man flu. She said '*yes, he used that word…he was just accusing him for, you know, doing drama and being naughty and then in that context he said he's got man flu, that's what he has*'.[227]

183 Mr Homburg suggested to Mrs Chadha that Mrs Crews may have joined the conversation and said something about '*man flu*'. Mrs Chadha agreed that she might have as Mrs Crews mentioned this after the ambulance had left.[228] Mrs Chadha told the Court that she did not know the meaning of the term '*man flu*'.[229]

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223 Exhibit C33b, p45
224 T1113
225 T1113
226 T1155
227 T662
228 T662
229 T662

184 It was also suggested to Mrs Chadha that Mr Vinar's reference to '*man flu*' was a joke made in an attempt to reassure her. Mrs Chadha responded, '*I don't think so; he was talking rudely, so it doesn't come up like a joke, but I remember him saying those words because they were new words to me which I didn't even know the meaning*'.[230]

185 When it was suggested to Mrs Chadha that Mrs Stiles explained what '*man flu*' was by saying words to the effect of '*men don't cope with being unwell as well as women*', she said that she could not remember that, but it may have happened. She could not recall either her or Mrs Crews smiling in response to this remark.[231]

186 Mrs Crews told the Court that the conversation regarding '*man flu*' was occurring when she walked into the room.[232] She stated that she '*felt for Hemant something awful…*'. This to me was an indication Mrs Crews was highly emotional about Mr Chadha's state of health and may have not fully absorbed or concentrated on the many words and actions happening at that time.

187 Mr Vinar agreed that his use of the term '*man flu*' was '*probably inappropriate in hindsight*',[233] but denied that he thought Mr Chadha was exaggerating his illness or malingering.[234] He used the term to try and explain to Mrs Chadha the condition of pneumonia in a really basic way.[235] He stated that he said *'…man cold is when you get a cold and you're not feeling well*'. He could not say what the gender of the person had to do with the illness. When it was suggested that the term is often levelled against men said to be exaggerating symptoms of what they are suffering, he said that he did not understand the term to mean someone was '*faking it*'.[236]

188 Mrs Stiles also refused to accept that the term '*man flu*' was derogatory. She said, '*it's a bit of a societal joke*'.

189 Professor Kelly on the other hand opined that the term man flu implied that the male patient is overreacting to his illness and '*being a bit soft*', and that the community would accept that this term certainly has very negative connotations.[237]

190 In conclusion on this topic, I am comfortably satisfied that:

(a) It was Mr Vinar who likened Mr Chadha's pneumonia to the '*man flu*' during the attendance on 21 April 2020;

(b) The use of this term undermined the gravity of Mr Chadha's illness and reflected Mr Vinar's assessment of Mr Chadha's medical condition;

(c) The use of the term '*man flu*' in these circumstances was understandably not well received by Mr Chadha, Mrs Chadha or Mrs Crews;

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230 T694
231 T684
232 T823
233 T1153
234 T1222-3
235 T1087
236 T1113-4
237 T1604

(d) The use of the term '*man flu*' was entirely inappropriate[238] and should never have been used by a representative of SAAS. It is a meaningless term at best and never used in a constructive way, in my experience.

The walk

191 When Mr Chadha got up from the bed to go to the ambulance, Mrs Chadha stated that the way he walked was '*unbelievable*'. She said that it was as if he could not see what was in front of him, could not feel the floor, and described him as '*taking big wobbly steps*' with '*legs dangling*'. He was then holding onto the wall, as if walking in the dark and taking big steps. He was lifting his legs much higher than usual.[239]

192 Mrs Chadha said her children were present, and later her daughter asked why it was her father was walking like that.[240] She also discussed the walk with Mrs Crews later.

193 Mrs Chadha was asked whether the ambulance officers said anything about the unusual walk. Mrs Chadha replied that the male said something like '*there you go drama again happening*'. She also recalled that he said, '*we're walking behind you, move fast, we've seen all that*'.[241]

194 Mrs Crews described the walk in the following way in her affidavit:

> I saw his front leg dangling and flopping around, as if the strings of a puppet had been let loose. He was holding onto the wall of the passageway with both hands to steady himself and when he finally got the leg down and lifted the next one up it was doing the same thing. His muscles weren't working; I could see this clearly as I was also in the passage. I knew something wasn't right and I told them '*no, stop, you need to get the bed*'. I was told by the ambulance officers that Hemant was faking it and they wanted him to walk out to the ambulance.[242]

195 Mrs Crews stated that the officers compromised and brought the stretcher to the door.[243] Mrs Chadha also told the Court that Mrs Crews asked for the stretcher but they did not want to bring it.[244] She conceded that her memory on this topic was vague, but thought the male officer shook his head and rolled his eyes.

196 It was the evidence of Professor Kelly that Mrs Crews' description was '*a really good description of somebody who's got a neurological problem*'. She also stated that Mrs Chadha's description was also consistent with a neurological difficulty, potentially GBS.

197 However, neither Mr Vinar nor Mrs Stiles noticed an unusual gait. There is no description of his gait in the PCR.

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238 It appears that during the complaints process, Mr Vinar was not counselled in relation to the use of this term. He ought to have been.
239 T558
240 T558
241 T563
242 Exhibit C25, p3 at [11]
243 Ibid at [12]
244 T560, 655

198 Mr Vinar stated that he has a vague recollection of seeing Mr Chadha walk '*maybe halfway down the driveway*'. He was lethargic. He did not see Mr Chadha moving from the bedroom to outside.[245]

199 Mrs Stiles confidently stated that she recalled seeing Mr Chadha walking, and that he was a bit lethargic, but there was nothing unusual about his gait.[246]

200 She stated she did not recall seeing him using walls to support himself in the hallway of the house and did not note him to be lifting his legs higher than usual.[247]

201 When asked if she heard Mr Vinar tell Mr or Mrs Chadha that he was causing drama, Mrs Stiles' answer was a definitive '*no*'.[248] This is at odds with the evidence of Mrs Chadha.

202 When considering this conflict in the evidence, it is relevant to consider the text message sent by Mr Chadha to his wife at 11:34 pm on 21 April 2020,[249] being approximately three hours following the incident. In his message Mr Chadha typed words to the effect of *'Ambos told them it's my drama*'. It was submitted that this text message supported Mrs Chadha's evidence that Mr Vinar used the word '*drama*' in reference to Mr Chadha's conduct on 21 April 2020, and that Mr Chadha was therefore concerned that the crew had told the hospital staff that he was causing drama.

203 This aligns with Mrs Chadha's evidence regarding what her husband had reported to her verbally once he returned from the hospital.[250]

Consumer complaints regarding Mr Vinar

204 It was submitted that previous complaints made by consumers in relation to Mr Vinar support the accounts of Mrs Chadha and Mrs Crews.

205 When considered as a whole, these complaints, if true and accurate, make it more likely that Mr Vinar's behaviour towards Mr Chadha occurred as alleged by Mrs Chadha and Mrs Crews. The complaints are demonstrative of a tendency to behave in a manner perceived as abrupt and rude when undertaking his work as a paramedic and conveying to patients that they should not have called an ambulance. Further, his repeated reluctance to assist patients to the ambulance and to query their need for assistance is consistent with Mr Vinar's alleged comments on 20 April 2020 (the '*did he crawl*' remark) and with his refusal to bring the stretcher into the house as alleged by Mrs Crews on 21 April 2020.

206 Exhibit C33i is a record of a complaint related to a call out on 31 October 2017 to a medical clinic in Hope Valley. The complainant was a Registered Nurse from the practice who called the ambulance for a 90-year-old woman with a blood pressure of $^{240}/_{90}$, $^{250}/_{100}$.

207 She stated that she advised the crew to take the gurney down the side of the surgery, but they instead asked the patient to walk to the front door, stating that '*if she walked into the*

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245 T1099
246 T1452
247 T1453
248 T1453
249 Exhibit C30e
250 T511, 564, 565, 610

surgery she can walk out'. They did not assess the patient before making this request or ask for a history.

208 The Consumer Feedback Management form indicates that Mr Vinar was spoken to in relation to the complaint and responded that it would have been impractical to reload the stretcher and move the ambulance around the block. In oral evidence, Mr Vinar agreed that he may have said something like '*if she walked in she can walk out*'.[251] He accepted that it was possible he may have been rude and abrupt towards the Registered Nurse, who described him as '*one of the rudest paramedics she had ever come across*'.[252] However, he complained that '*we may have said something similar, but it sounds like it was taken out of context again*'.[253] It was submitted that the admitted comment, '*if she walked in she can walk out*', is striking in its similarity to his alleged remarks on 20 April 2020, '*how did he reach here in the first place, did he crawl*',[254] making it more likely that the alleged comment was made. I refer to Mrs Chadha's evidence concerning '*did he crawl here*', as discussed in paragraph 88 of this finding. I have already found that this is probative concerning that evidence.

209 Exhibit C33f is a record related to an attendance by Mr Vinar and Mrs Stiles on 12 May 2019 upon a man complaining of chest pain. The partner of the man complained about the crew being '*very rude*'[255] and telling the patient to walk out to the ambulance while he was still in pain and could not breathe well. Mr Vinar agreed that he may have told the patient to walk to the ambulance but could not recall.[256]

210 Exhibit C33g is a record related to a complaint regarding an attendance by Mr Vinar and Mrs Stiles on 19 May 2019. The patient had fallen and a member of the public who was a doctor gave her the '*green whistle*'. Mr Vinar allegedly said loudly, '*don't treat her, she's a seeker*'.

211 The Consumer Feedback Management form recorded the complaint outcome, which indicated that Mr Vinar was spoken to by a team leader in relation to the complaint. He admitted speaking poorly to her and saying that she was a seeker. The form records '*team member well aware this behaviour is not acceptable and that all patients should be treated with respect and courtesy…team member requested I pass on his apology for being rude which I did*'. However, in oral evidence, Mr Vinar told the Court that he could not recall saying the words '*don't treat her, she's a seeker*' and was reluctant to admit that his behaviour was unacceptable.[257] He conceded that the terminology might not have been acceptable in hindsight.

212 Exhibit C33h is a record related to a complaint regarding an attendance by Mr Vinar and another officer on 17 September 2018. The complainant, who was the wife of the patient, stated that the crew were '*rude and uncaring*' and it was the first time that they had received '*such terrible treatment*'. She alleged that Mr Vinar treated her husband '*like an imposition*' and said to her '*we can take him to hospital and make him wait for ages or*

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[251] Exhibit C33i; T1201
[252] Exhibit C33i; T1201
[253] T1199
[254] T538
[255] It is noted that Mrs Chadha also described Mr Vinar as 'very rude': T539, 540, 561
[256] T1183
[257] T1192

he can get the same advice that the paramedic would give him and not go' and repeated this advice two to three times.

213 In oral evidence Mr Vinar explained that they were trying to relay that it may take some time to get him seen in the ED as it was a specialty problem. While he recalled the allegation that the patient's wife was made to feel like an imposition, he did not reflect on his conduct and stated '*I had an explanation for why we were talking in that manner, but it wasn't in my opinion, intimidating or insulting to them*'.[258] He explained that he can be assertive and if he must speak loudly that is often misconstrued. He agreed that he has been receiving feedback in relation to his manner periodically over the 33 years of his time as a paramedic. This complaint provides a further example of Mr Vinar behaving in a manner which others found rude, but which he maintained was appropriate. The complaint that Mr Vinar made the patient feel like an imposition, and that attending hospital may be pointless, is also consistent with Mrs Chadha's alleged experience with Mr Vinar on 21 April 2020.

214 Exhibit 33j is a record related to a call out on 5 December 2016 and, in particular, Mr Vinar's behaviour towards the patient's daughter, who was of Cambodian descent. It was alleged that Mr Vinar refused to help a 97-year-old patient into a wheelchair and that he told the patient's daughter she should look after her parents better because she is getting money for looking after them, and that she should put them into a nursing home. Mr Vinar noted twice on the PCR the word '*acopia*'.

215 Mr Vinar said that he would have helped to get the patient into the wheelchair because '*I would help out where I can*' but could not recall the event. He denied telling the daughter to look after her parents better, although he did file an elder abuse complaint.

216 Given that Mr Vinar was sufficiently concerned about the condition of the patient to file an elder abuse complaint, it is likely that he made his concerns known to the daughter, intentionally or unintentionally. If it is accepted that Mr Vinar refused to assist the patient into the wheelchair as alleged, this complaint supports Mrs Chadha's evidence in relation to Mr Vinar's reluctance to obtain a wheelchair for her husband. I find that Mr Vinar's action in filing an elder abuse complaint is to his credit and is inconsistent with an allegation he refused to assist the patient as alleged in this complaint. However, the filing of the elder abuse complaint is consistent with the words allegedly said to the patient's daughter. This is consistent with the submission that he reacts and speaks his state of mind quite openly and freely.

217 Exhibit C33l is a record related to a non-emergent transfer. It was alleged that Mr Vinar was extremely arrogant and rude and said to the patient '*why didn't you just take a taxi?*'. When asked if he intended to be arrogant and rude, Mr Vinar replied '*No, no. Often that's a pretty standard complaint…*'.[259] However, he agreed that he did say '*you could have taken a taxi*'.[260]

218 Exhibit C33o is a record related to an allegation he had spoken abruptly to a woman who had suffered a fall and hit her head. Mr Vinar agreed that he said, '*what do you expect me*

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[258] T1196
[259] T1207
[260] T1207

to do about it', but argued that this was taken out of context, again.[261] He said that he might have told the patient that the wait at the hospital could be 10 hours long, as patients often ask. When asked whether he acknowledged that he spoke abruptly to the patient or her daughter, his response was '*I can't recall that…but I like to think that I was treating her properly*'. When taken to the record which indicated he had in fact acknowledged he may have seemed abrupt, he conceded it was possible he said that.[262]

219 Given that the prior complaints were tendered in the form of records only, I must treat them with extreme caution. The proponents of the complaints on each occasion were not cross-examined. It was submitted that the volume of the complaints and their shared character, even treated with caution, allowed me to form a conclusion that Mr Vinar has an established pattern of behaviour while at work which is sufficient to leave patients and others with the impression that he is rude, that he is resistant to assisting patients and that he has a willingness to provide personal views about patients. When considering whether or not the assertions made by Mrs Chadha and Mrs Crews about Mr Vinar's behaviour are accurate, this demonstrated pattern becomes relevant. In other words, it is improbable that Mrs Chadha, Mrs Crews and all other prior complainants have fabricated their accounts or complained based on a misinterpretation of his words and conduct.

220 The prior complaints also have a second use which is related. That is, in assessing the overall credibility of Mr Vinar as a witness, and specifically the veracity of his denial of the alleged behaviour, his prior pattern of behaviour and repeated denials of multiple separate complaints may be used.

221 Further, it is relevant that Mr Chadha himself reported being very upset by the attitude and behaviour of the SAAS crew.[263] He was also concerned that the ambulance officers had probably told the hospital staff that it was his '*drama*'.[264] It is highly unlikely that Mr Chadha, Mrs Chadha and Mrs Crews all reported Mr Vinar making these remarks if he did not make them. It was not suggested to Mrs Chadha or Mrs Crews that they fabricated their evidence on this topic, or that the similarities in their accounts were the product of collusion. Indeed, the evidence of Dr Azhar makes it plain that both Mr and Mrs Chadha were greatly distressed by the conduct of the crew on 21 April 2020.

222 Dr Azhar stated that throughout his consultation with Mr and Mrs Chadha, Mr Chadha would state repeatedly that there was '*no point*', '*they will disrespect me again*', and '*they will not believe me*'.[265] In his additional consultation note the following day, Dr Azhar wrote '*he told to the patient that why he is making this all up and that he should man up and why he is bothering his family*'. In his oral evidence he clarified that these were the exact words used by Mr Chadha the day before, and he was quoting him.[266]

223 Accordingly, it cannot be suggested that outcome bias has coloured Mrs Chadha's recollection of the behaviour of Mr Vinar.

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[261] T1214
[262] T1216
[263] Exhibit C22, p7; See also evidence of Dr Azhar, T733
[264] T511; Exhibit C30e (text message to Mrs Chadha from hospital)
[265] T788
[266] T794

Anxiety

224 The Consumer Feedback Management form documents relating to the Chadha complaint refer to the crew reporting to Mr Funnell that Mr Chadha was '*highly anxious*'. Mrs Stiles referred to Mr Chadha's inability to cope with his illness at home as the reason why she felt he should be transferred to hospital for reassessment. Mr Vinar stated that they urged Mr Chadha to be rechecked at hospital to alleviate any of their concerns. The PCR again included reference to the term '*acopia*'. Neither statement referred to Mr Chadha's increased respiratory rate, increased blood pressure, or any other concerns in relation to his medical condition. They both attributed the symptom of tingling lips to hyperventilation.[267]

225 During oral evidence, Mr Vinar stated that paramedics are not to determine anxiety in the field, and that there are many reasons why someone would have an elevated breathing rate.[268] He stated that concerns for Mr Chadha's known lung condition and possibility of deterioration were the reason they urged Mr Chadha to attend hospital.[269] He could not recall telling Mrs Chadha that her husband had anxiety.[270]

226 Mrs Stiles also could not recall telling Mrs Chadha that her husband had anxiety.[271] She denied that he appeared anxious,[272] and was unsure why she would have omitted a diagnosis of anxiety from her PCR, given her confident assertion that she had seen diazepam on the nightstand, which she said would confirm an underlying condition of anxiety.[273]

227 As to Mrs Chadha's concern about her husband's eyes rolling in his head, Mr Vinar noted in his statement that he told Mrs Chadha that '*the eyes thing is elective and not part of the condition and he had been fully checked recently and may have what is termed the man flu*'. Mrs Stiles wrote in her statement that she became frustrated as frequently when she asked Mr Chadha questions he would '*just roll his eyes back and not answer*'. She also recalled Mr Vinar telling Mrs Chadha that there was no explanation for his eyes rolling back.

228 The written statements of Mr Vinar and Mrs Stiles that were made in response to the complaint following Mr Chadha's death make it plain that they formed the view that Mr Chadha only needed to attend the hospital due to his inability to cope with his illness at home and his anxiety, and not for hospital attention and treatment. This attitude must have been apparent to Mr Chadha, Mrs Chadha, and Mrs Crews.

The handover to the Lyell McEwin Hospital

229 Mr Vinar's evidence was that it was Mrs Stiles' role as the attendant to conduct the handover of Mr Chadha. He had escorted her as far as the second triage point. Once Mr Chadha was onto the hospital bed, he took the barouche back and then cleaned down the ambulance and the bed outside to prepare for the next job.[274]

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[267] T1090, 1094, 1096, 1112, 1137, 1140, 1145, 1448, 1498
[268] T1221
[269] T1225
[270] T1137
[271] T1447
[272] T1497
[273] T1513, 1494
[274] T1103

230 As Mrs Stiles was the attendant, she handed over Mr Chadha to the staff at the LMH while Mr Vinar returned the barouche. When asked during examination in chief whether she told the person doing the handover that Mr Chadha had anxiety as part of his condition, she replied that she did, because he was diagnosed and on diazepam.

231 However, during cross-examination, she repeatedly claimed not to recall whether she told the nurse at handover that he had anxiety.[275] She declined to comment on what she said during handover as it was not included in her note and explained that she could not comment on what she said four years ago. This was in stark contrast to the remainder of her evidence, which I found showed her willingness to comment upon what was, and was not said, four years ago on other topics, particularly in defence of Mr Vinar, in the absence of a record to assist her.

232 When asked if Mr Chadha had seemed anxious to her, she said that he did not, he seemed more lethargic than anxious.[276] When it was again suggested that she thought he seemed anxious, she replied '*... I previously answered I didn't actually feel that he appeared anxious...*'.[277] She later accepted '*he potentially was anxious*'.[278] As is made clear in these paragraphs, the evidence of Mrs Stiles on this topic was unclear and not compelling.

233 When taken to the triage assessment document, which included the words '*some anxiety*', Mrs Stiles said that she could not recall whether that information came from her during the handover, but that it was possible.[279]

234 The PCR was provided to the hospital. It included the words '*acopic with illness at home*'.

235 Mr Vinar also denied that he attributed Mr Chadha's presentation to anxiety.[280]

236 In relation to the stark contrast between the oral evidence and the written accounts of the crew members, it was submitted that the more contemporaneous written accounts should be preferred, due to conventional reasons that they are likely to be based on a better memory of the events.

237 Despite the denials by both attending crews members, I do find that the statements made by Mr Vinar and Mrs Stiles following the complaint are clear that both crew members had formed the view that Mr Chadha was highly anxious during their attendance on 21 April 2020.

Diazepam

238 Mrs Stiles told the Court that she observed diazepam on the bedside table on 21 April 2020. She said that she read the label. When asked if she could be mistaken, she retorted '*Well, I know what diazepam looks like on a label on a medication box*',[281] and later, '*Well, given that it was with his current medications on his bedside table and it was prescribed to him, I guess maybe I made the assumption that he was currently taking it*

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[275] T1498
[276] T1447, 1513
[277] T1497
[278] Ibid
[279] T1498; Exhibit C18, p18
[280] T1221
[281] T1496

because it was with all his other medication'. She said that she did not make a note of it because she probably forgot that she saw it.

239 It was submitted that Mrs Stiles must be mistaken, and that she did not see diazepam on Mr Chadha's bedside table because it was not there. Therefore, great caution should be exercised prior to accepting her evidence.

240 The Court received a Pharmaceutical Benefits Scheme (PBS) Patient Summary[282] which listed Mr Chadha's prescribed medications between 1 January 2013 and 23 April 2020.

241 The PBS Patient Summary shows that Mr Chadha had been prescribed diazepam on only one occasion, being the prescription from Dr Azhar following the 22 April 2020 consult.

242 There were no other listed prescriptions for this medication.

243 Mrs Chadha later supplied a supplementary affidavit to the Court stating that she could not recall any time her husband was prescribed diazepam prior to 22 April 2020, and that she has no memory of seeing this medication in the house prior to 22 April 2020.[283]

244 The first reference to this medication is found in the medical records of Dr Azhar.[284]

245 This Court has received medical records from the following medical practices:

(a) Premium Care Medical Centre[285]

(b) Northern Medical Centre[286]

(c) City Clinic 7 Day & Night[287]

246 Until 22 April 2020, there was no reference to anxiety or mental health concerns at any time in any of the medical records. This is consistent with the affidavit of Mrs Chadha and with her oral evidence in relation to Mr Chadha's health.

247 Further, when police attended Mr Chadha's residence at about 7:40 am on 23 April 2020, all of Mr Chadha's medications were seized, as was a folder containing medical documents.[288] The medications are itemised in Annexure A of exhibit C9.

248 Apo-diazepam 2mg, is listed as prescribed by Dr Azhar on 22 April 2020. The box contained 12 of the 15 tablets prescribed.

249 There is no other reference to diazepam in the list of medications seized by police on 23 April 2020.

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[282] Exhibit C45
[283] Exhibit C50
[284] Exhibit C22, p7
[285] Exhibit C20
[286] Exhibit C22
[287] Exhibit C21
[288] Exhibit C9, p6

250 Police also observed a pink coffee table next to the bed where Mr Chadha had been sleeping. On this table were tissues, Panadol, water and a mug containing what appeared to by Hydrolyte.[289]

251 Mrs Chadha administered devoted care to her husband while he was convalescing. It is highly improbable that there was diazepam on his bedside table on 21 April 2020 which had not been prescribed to her husband, and that she was unaware of it. I find that Mrs Stiles' evidence that she saw diazepam on the bedside table was incorrect. Her memory of reading the label, too, must have been incorrect. Mrs Stiles' evidence on this topic is demonstrative of an element of reconstruction or a clear mistake perhaps based on another attendance upon a patient at home.

Acopia

252 The words '*acopic*' and '*acopia*' were used by Mrs Stiles and Mr Vinar in their PCRs. Both Mr Vinar and Mrs Stiles maintained that their use of this word to describe Mr Chadha was appropriate to convey that he was not able to cope at home.

253 Mr Vinar's evidence was that this word was being used to convey that he was not eating and drinking, and felt he was not improving and continued to be unwell.[290]

254 Mrs Stiles described the word as '*the absence of coping*'. She stated that she would not consider it to be a derogatory term and considered it to be on the same level as a word like '*asymptomatic*', '*afebrile*', or '*asystole*'.[291]

255 However, it was the evidence of Professor Kelly and Drs Tolentino and Esselbrugge that the term can have negative connotations. Drs Tolentino and Esselbrugge treated Mr Chadha on his presentation to the LMH on this occasion.

256 Professor Kelly stated that it has the implication that a person is not coping with their illness because of a psychological deficiency. It is a term that is strongly discouraged in medical practice because of the negative connotation. She clarified that not providing a description of '*not coping with what and why*' implies a global assessment that a person is unable to cope in circumstances where they should be able to do so.[292] She was surprised and disappointed to read this term in the PCR.[293] She explained that this term, if communicated to the staff in the ED, sets up a line of thinking that the patient's presentation has a psychological overlay.[294] It is significant that this was Mr Chadha's impression of how his case was presented to the hospital staff by SAAS, as conveyed to his wife via text message.[295] Professor Kelly also warned that the danger associated with the use of this word is not mitigated by the user's intention as those reading or receiving the information may interpret the word as conveying a negative connotation.[296]

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289 Exhibit C9, p3
290 T1079
291 T1440
292 T1606
293 T1628
294 T1629
295 Exhibit C30e
296 T1631

257 Dr Tolentino's evidence was that the interpretation of the word depends on the intention of the person who wrote it, but there are cases where it can be perceived as a negative comment.[297]

258 Dr Esselbrugge's evidence was that '*acopic*' is a term that is preferred not to be used in the medical profession, as it implies somebody is just not managing well in a negative way. It is a term that medical students are taught not to use.[298] He considered it to be a '*loaded phrase*'.[299] This analysis seems to be apt for '*man flu*' as well.

259 Given the evidence from each of the medical practitioners that the term '*acopia*' has negative connotations, the use of this term by SAAS in written or oral communication with hospital staff has the potential to negatively influence the care provided to the patient by swaying clinicians to attribute the presentation to a psychological cause rather than fully exploring a physical cause.

260 While the staff involved in Mr Chadha's care may not have knowingly been influenced by the use of this word in the SAAS documentation,[300] the effect of language such as this can be insidious. As Professor Kelly observed, it is hard to be certain that this did not influence the thinking of clinicians in a subconscious way.[301]

261 Anxiety was one of two diagnoses listed in the patient assessment despite Mr Chadha having no recorded history of anxiety. It is not known whether Dr Esselbrugge's RMO, Dr Lopa, was influenced by the word '*acopia*' in her assessment, or by the nursing notes which made several references to anxiety. The nursing staff may also have viewed Mr Chadha's presentation as being driven by anxiety due to the SAAS documentation and/or handover from Mrs Stiles. This is discussed later in this Finding when I focus on the treatment he received at the LMH on his second attendance.

262 Ms Sarah Beale, State Duty Manager, formerly Acting Clinical Effectiveness Development Officer for Metro North, of SAAS, told the Court that paramedics would be encouraged not to use the word '*acopia*' as it carries an implication that a patient simply not coping is not a significant medical issue.[302] However, she was not aware of any documentation suggesting that the crew were counselled or chastised in relation to the use of the word '*acopia*',[303] which was confirmed by Mrs Stiles.[304]

263 Despite the evidence of Mr Vinar and Mrs Stiles that they did not use the word acopia in a derogatory sense, the inclusion of this word allowed the inference that they perceived Mr Chadha's primary issue to be behavioural rather than medical. This also allowed consideration that it influenced the manner in which Mr Vinar behaved towards Mr Chadha, including Mr Vinar's use of words suggesting malingering, such as '*man flu*', '*drama*' and '*naughty*'.

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297 T720
298 T938
299 T993
300 It is noted that Professor Kelly was concerned that staff were uncertain as to whether they read the case card: T1632
301 T1365
302 T2061
303 T2061
304 T1490

264 In these circumstances it could be understandable Mr Chadha felt anxious due to a concern that the ambulance officers did not appreciate the gravity of his illness and may have conveyed to the hospital staff that he was malingering, as suggested by the text message he sent his wife.[305]

Personal Protective Equipment

265 Significant time was spent questioning witnesses as to whether Mrs Stiles and Mr Vinar were wearing PPE on both occasions. The significance of this line of questioning was related to Mrs Chadha's evidence in relation to the facial expressions of the crew,[306] namely the crew smiled at the way Mr Chadha walked out to the ambulance, implying that they noticed the unusual walk, and that they found it amusing as they did not believe there was a medical cause.

266 In her statement, Mrs Stiles referred to wearing a face mask.[307] Her PCR did not include any reference to PPE.[308] However, in oral evidence she said that she was wearing a mask, gown, and a face shield.[309]

267 It appears that the crew told Mr Funnell that they attended in '*full PPE due to symptoms and as such most of their face was covered*'.[310]

268 Mr Vinar did not refer to PPE in his written statement. In oral evidence he stated that where there is no aerosol generating, there is flexibility to not wear full PPE, and just wear goggles and an N95 mask.[311]

269 He later stated that in April 2020, there would be an expectation to wear full PPE to any respiratory case in a closed location, such as a house, where air is not freely moving around.[312]

270 Mrs Chadha was asked whether the crew of Mr Vinar and Mrs Stiles were wearing masks in relation to the verbal complaint she had made to the ambulance officers who attended on 23 April 2020. Her response was that she could no longer remember if they were wearing masks.[313] However, she explained '*we all have gone through that phase when people are wearing a mask and we could see if they are smiling or not*'.[314] She did recall that the first crew were '*wearing all that*', which is consistent with the PCR.

271 Mrs Crews was also asked whether the crew were wearing PPE. She stated, '*they were just wearing their ordinary ambulance gear*'. She said she could not remember seeing any masks,[315] but conceded that they could have been wearing them. She could, however,

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305 Exhibit C30e
306 'Their facial expressions were not great': T667; Exhibit C33b, p32 (Winnie Peck: rolling their eyes and laughing under their masks)
307 Exhibit C33b, p33
308 Note: Exhibit C17, p1 regarding attendance on 17 April 2020 includes 'SAAS don full PPE'. There is no reference in the PCRs of 20 or 21 April 2020 to PPE.
309 T1470
310 Exhibit C33b, p35
311 T1081
312 T1061
313 T667
314 T694
315 T850

recall seeing the ambulance uniforms,[316] and recalled seeing the woman's face.[317] Under cross-examination by Mr Homburg for Mr Vinar, Mrs Crews stated that she would not argue with his suggestion that they were wearing masks as she was not too sure about it. She explained '*I was just more shocked about what was happening*'.[318]

272 Mr Vinar also produced a SAAS policy and a photograph of himself.[319] This evidence was tendered in support of a submission that the crew did not make any of the alleged facial expressions, or if they did, that these would have been obscured by the PPE.

273 Mr Vinar explained that the context of the call out was relevant when considering which items of PPE to wear.[320]

274 He stated that in April 2020 he would have been wearing full PPE wherever possible, as he was more susceptible to the effects of COVID-19 due to his age.[321] He stated that in non-respiratory cases he would wear an N95 respirator and goggles, but if there were aerosol fluids such as coughing or spitting, he would wear a face shield as well.[322]

275 Mrs Stiles' evidence was that she was wearing a disposable gown, a mask '*which was a bit more than a normal mask*', and a face shield and gloves.[323] She stated that Mr Vinar was wearing the same.

276 I accept that regardless of the extent of the PPE the crew were wearing on this occasion, their facial expressions were apparent to Mrs Chadha and a positive finding need not be made as to what they were wearing.

The complaint regarding Mr Vinar and Mrs Stiles

277 The first complaint in relation to the crew's attitude and conduct towards Mr Chadha was raised by the attending crew of 23 April 2020,[324] following Mr Chadha having been found deceased by his wife.

278 This incident was considered by the SAAS Safety Learning System Quality and Assurance Group (QAG) on 5 May 2020. It was determined that Mr Funnell would conduct a face-to-face discussion about the complaint with Mr Vinar and Mrs Stiles. The evidence of Mrs Stiles is that this discussion occurred prior to completing the written statement, placing it at a date on or about 6 May 2020.[325]

279 The evidence of Mr Vinar was that he was notified that Mr Chadha had passed away and a complaint was raised in relation to it in the same conversation.[326] He and Mrs Stiles were

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316 T820
317 T847
318 T847
319 Exhibits C33 and C33a
320 T1061-2
321 T1061
322 T1062
323 T1470
324 Exhibit C33b
325 T1458
326 T1103

approached after the end of their shift and stayed behind to complete a written statement in relation to their understanding of the events.[327]

280 The interview portion of the review was finalised by Mr Funnell on 7 May 2020. The complaint was closed on 19 May 2020. It did cover the additional complaint email sent by Mr Nitin Chadha on 18 May 2020. The complaint email was considered by the QAG on 21 May 2020, and the complaint was reopened for further investigation.

281 Mrs Chadha cooperated fully with SAAS in the complaint. She permitted two SAAS staff members[328] into her family home to discuss her complaint, in the presence of Mrs Crews. She was assured, both orally and in writing, that remedial action had been taken to prevent a recurrence of the events she experienced. She was told in the letter dated 23 July 2020 that the staff involved '*will be undertaking Cultural Awareness and Code of Ethics training, as well as Aboriginal Cultural Learning training. They will also take part in the SA Health program TeamSTEPPS, which aims to improve communication skills within the healthcare setting*'. Mrs Chadha also received the following written apology:[329]

> We are sorry that the behaviours displayed during these attendances did not meet our high standards, and also for the ongoing impact which this has had on you and your loved ones at this very difficult time.

282 She was told by Ms Beale that the staff involved had been interviewed and had a '*robust discussion*' about their perceived behaviour and attitude on scene, and their inappropriate language and the communication used. She indicated that both staff members had been required to undertake training packages and were subject to ongoing mentoring and review. Ms Beale also indicated that the crew had expressed regret regarding the experience of Mr Chadha, Mrs Chadha, their children, and bystanders.

283 This appears to be at odds with the evidence contained in Ms Beale's affidavit, which indicated the decision for Mrs Stiles and Mr Vinar to undertake Cultural Awareness training, Aboriginal Cultural Learning Package, Code of Ethics Awareness Package, and the TeamSTEPPS Package was not finalised until 5 August 2020, after the meeting with Mrs Chadha and Mrs Crews took place.

284 Ms Beale clarified that she was aware Mrs Stiles and Mr Vinar had not yet been directed to complete the required packages at the time of the open disclosure meeting, and interpreted her wording to refer to the packages as being still in discussion.[330] Ms Beale's intention was to inform Mrs Chadha of what her recommendations were going to be.[331] She could not recall if she clarified that orally to Mrs Chadha.

285 The recommendations were put forward by Ms Beale in discussion with her operations manager prior to 15 July 2020.[332] They were put forward in consideration of the email sent by Mr Chadha's brother in relation to interacting with people from diverse cultural backgrounds.[333]

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327 T1130
328 Ms Perry and Ms Beale
329 Exhibit C30d
330 T2025
331 T2056
332 T2043
333 T2054

286 The purpose of recommending Mr Vinar and Mrs Stiles complete the packages, despite them having completed the packages prior, was presumably to encourage them to be more aware about the way that their behaviour might be perceived by others.[334]

287 Ms Beale felt like the tone of the meeting was that her recommendations for Mr Vinar to complete the packages were being treated as recommendations only, and that they were not going to be enforced.[335]

288 This decision was conveyed to the acting Team Leader responsible for Mr Vinar,[336] Mr Kosmala, and then apparently relayed to Mr Vinar with a piece of paper. Mr Vinar stated that he was told words to the effect of '*this is the result of an investigation, and you have to do these packages*'.[337]

289 Mr Vinar stated that he asked Mr Kosmala for more information, as he had already completed all of the training packages on the note, and was told that information about the complaint or the issue surrounding it could not be found.[338] Mr Kosmala conveyed this information to Ms Beale, and a meeting was organised between Ms Beale, Mr Vinar and Mr Lemmer on a date that could not be determined.[339]

290 In her affidavit, Ms Beale indicated that the purpose of the meeting was to convey the outcome of the investigation and provide Mr Vinar with the information about his required training programs.

291 The phrases '*required* training' and '*recommended* training' were used interchangeably throughout Ms Beale's affidavit. It was not made clear to Mr Vinar during this meeting that he was being directed to complete the training packages. Mr Vinar's evidence was that he was told at that meeting that '*it's been sorted*', and that there was '*no result from that meeting*'.[340]

292 Ms Beale stated in her oral evidence that she did recall apologising to Mr Vinar, but that it was because she felt the communication between herself and Mr Vinar was not particularly forthcoming in relation to the complaint. It had been Mr Kosmala in his acting role to deliver the message to him.[341] She stated at no point did she apologise to Mr Vinar for the outcome of the investigation.[342] It was not up to her to decide that Mr Vinar was no longer required to complete the packages.[343]

293 The result was that at no point was Mr Vinar *required* to re-complete the training packages. It was his evidence during the Inquest that he had still not completed the packages a second time.[344]

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334 T2057
335 T2047-8
336 Mrs Stiles having not been working at the time
337 T1102
338 T1106
339 In Mr Vinar's evidence, he indicated this was 'maybe November': T1106; Ms Beale thought this would have occurred around a month after Mr Kosmala spoke to Mr Vinar: T2019
340 T1127
341 T2019-2020
342 T2021
343 T2021-2022
344 T1128

294 It was Mr Vinar's evidence that when a complaint is made, normally this would be dealt with on a team leader basis, a '*one-on-one*'. He told the Court that '*normally you get interviewed and often you don't get feedback*'.[345]

295 It was his impression that he only had two or three complaints made about his behaviour,[346] which was clearly a significant understatement. During his evidence, it was apparent that he did not understand from Mrs Chadha's complaint that there had been any finding of inappropriate conduct made against him.[347]

296 Mrs Stiles was not made aware of the outcome of the complaint, as she had been declared medically unfit to drive during May 2020 due to an injury. She never returned to the workplace.[348] She was never required to undertake any of the programs Mrs Chadha was informed she would undertake.

297 Neither Mrs Stiles nor Mr Vinar were advised that their behaviour did not meet the high standards of the SAAS.

298 Regrettably, Mrs Chadha learned through her participation in this Inquest that there was no evidence that remedial action had been taken in response to her complaint, despite the multitude of behavioural complaints made about Mr Vinar in the past.

299 Mr Vinar also told the Court about the problematic behaviour of another colleague referred to as '*HS*' for the purposes of anonymity. Mr Vinar had complained about the conduct of '*HS*' to his team leader by calling him and saying, '*he's done it again*'. Mr Vinar said that he tried to move shifts to avoid this colleague. In a period of a week, as a crew with HS, they had half a dozen complaints. He described working with this colleague as being '*like walking, following someone with a fire extinguisher, putting out fires*'.[349] In relation to a complaint outlined in exhibit C33m, the Consumer Feedback Management form indicated that a nurse who worked in coronary care was at the scene of a car accident and recognised the patient, telling the ambulance officers that he had angina but was experiencing chest pain and pain down his arm. Mr Vinar recalled HS telling her that he was not interested in the patient's life history and she could just leave now.[350]

300 This evidence suggested that the failure by SAAS to appropriately manage the conduct of its employees was not isolated. Mr Vinar was justified raising the complaint about '*HS*' based on this evidence.

SAAS complaints policy 2020

301 In 2018, SAAS commenced a review of the internal reporting culture within its organisation. It was found that SAAS generally treated errors made by its employees in a punitive manner, rather than an opportunity for those staff to learn and improve their practices following a reported incident.[351]

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345 T1197
346 T1157
347 T1135
348 T1506
349 T1211
350 T1211
351 C43

302 At the time of the complaint submitted on behalf of Mrs Chadha by the attending paramedics of 23 April 2020, an incident report was generated on the Safety Learning System for review by the QAG. It was the evidence of Ms Beale that these review meetings occurred fortnightly at the time of Mr Chadha's death.[352]

303 The role of the QAG was to ensure the quality of investigation, and not to impose disciplinary steps.[353]

304 The management structure, including team leader and operations manager, would be expected to enforce the recommendations, including leadership through the Executive Director, Clinical Effectiveness Development Officer, or Clinical Support Officer where required to address specific issues.[354]

305 The Safety Learning System procedure guided how investigations were conducted in April 2020 and required that the team leader identify disputed facts during an investigation, and to clarify disputed facts.[355] Incidents and complaints are usually handled separately.[356]

306 There were no factual findings made by SAAS about whether the allegations made by Mrs Chadha were an accurate reflection of what happened.[357]

307 Ms Beale did not have the power to enforce the recommendations at the time, but felt satisfied that they would be enforced, as she conveyed the information in the presence of Ms Perry, who did have the power to enforce them at the time.[358]

308 It is difficult to conceive of a more serious complaint about the behaviour of a crew than the complaint made by Mrs Chadha. The effect of this behaviour upon Mr Chadha was clear from the evidence of his wife, Mrs Crews and Dr Azhar. Their behaviour caused Mr Chadha to refuse an ambulance when he was dying. This consequence was known to SAAS on the day of Mr Chadha's death, when Mrs Chadha told Winnie Peck that her husband declined an ambulance and said '*no I don't want the ambos to come again and "abuse me" again and treat me badly. I'll wait tonight out and go and see my GP in the morning because they will treat me badly again*'.[359]

New SAAS complaint policies

309 The manner in which SAAS handled this complaint did not reflect its severity. There were no consequences for the crew involved, despite what Mrs Chadha had been told both in person at her home and in writing.[360] It was unconscionable to provide false reassurance to Mrs Chadha in these circumstances.

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352 T2012
353 T2035
354 T2056
355 T2051-2
356 T2053
357 T2055
358 T2058 - This role was also shared by Mr Lemmer at certain points
359 Exhibit C33b, p32
360 Exhibit C30d

310 The updated policies in relation to consumer complaints were tendered via the affidavit of Catherine Wright.

311 Following the review in 2018, SAAS created the Patient Incident Analysis Framework[361] published in 2023. In the course of the review, SAAS also looked at the Complaint Management Framework,[362] with a new framework being drafted and designed on 12 July 2022.

312 It was designed '*to provide management with guidance on how to manage complaints and provide the appropriate feedback to clinicians with a focus on the clinicians being able to learn from the complaint*'.[363]

313 Not only was Mr Vinar not given the opportunity to learn and improve his practice following the incident, but he was also not subject to any corrective measures by SAAS. This was unacceptable. The impact of the new policies remains to be seen.

314 I have gone into close detail on these ambulance encounters. It has focussed significantly on Mr Vinar and to a lesser extent Mrs Stiles.

315 I acknowledge that the result of this last encounter is that Mr Chadha did get taken to the LMH where he was transferred into their care. Therefore, logically, the focus shifts to the treatment and care at the LMH. However, to leave it as that is too simplistic or one-dimensional and not consistent with the purpose of the Inquest and the Act.

316 I have already mentioned the reported symptoms relayed to SAAS via telephone including numbness, a diagnosis of mycoplasma pneumonia and shortness of breath. The last thing needed was a poor relationship with the attending SAAS officers.

317 It was obvious that Mr Chadha and his family were not South Australians who engaged in casual use of language or robust banter that is often used by many Australians. The term '*man flu*' was lost on Mrs Chadha, a gentle, quiet and dignified woman.

318 This encounter should have been conducted differently by SAAS officers. This encounter had a profound effect on the late Mr Chadha as he refused to use SAAS again, when he needed them most desperately.

Mr Vinar's written submissions

319 I have closely considered Mr Vinar's written submissions in response to intense criticism by Special Counsel, much of which I have already outlined.

320 Mr Vinar has properly raised, that even accepting for the purpose of argument, that the criticisms are valid, this does not equate to being a cause of Mr Chadha's death as defined by the Act.

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[361] PIA Framework
[362] CM Framework
[363] Exhibit C43

321 He submitted the correct question in considering this evidence is '*was Vinar's behaviour on either 20 April and/or 21 April 2020 a reason why Mr Chadha did not seek hospital treatment on 22 April 2020 or in the early hours of 23 April 2020?*'.[364]

322 I have thought deeply about this issue as raised and the authorities. I have found his clinical cause of death was as expressed by Dr Charlwood.[365]

323 I refer to Lander J in *WRB Transport and Others v Chivell*[366] where his Honour said:

> I agree that the circumstances to be inquired into cover a much wider area of inquiry than the cause. In my opinion, the jurisdiction given by the Act to the coroner is quite extensive. It is not limited, as suggested to a particular inquiry into the direct cause of the deceased. The coroner has a jurisdiction and, indeed, an obligation to inquire into all facts which may have operated to cause the death of the deceased and as well to inquire into the wider circumstances surrounding the death of the deceased.

324 Based on this guidance, I find it appropriate to assess Mr Vinar's evidence, and evidence about him by other witnesses, as relevant to the circumstances of Mr Chadha's death.

325 The distinction between '*cause*' and '*circumstances*' is often very difficult as noted in 1988 by Dr Ian Freckleton AO KC.[367] I have chosen to consider Mr Vinar as relevant to the circumstances of Mr Chadha's death.

326 I have considered Mr Vinar's submissions on key issues he identified. I accept the broad submission that SAAS officers work in the presence of distressed family and friends of the patient. These people inevitably will be anxious, or distressed, or bewildered, or scared, or a combination of the above.

327 Therefore, as I understand, it can be difficult for these people to be reliable in recollection of events. Mrs Crews was understandably concerned about the Chadha family as they are very important to her. Mrs Crews' evidence displayed her strong sense of love and care for them on the night of 21 April 2020 and in giving evidence.

328 I do allow consideration for her to be mistaken due to the stressful and highly dynamic situation she became involved in. I find her reliability to be less than optimal. There is no question that she was an honest witness.

329 Mr Vinar further submitted that:

(i) His mention of not making racist comments in his statement to SAAS was a legitimate response to the terms of the complaint made by Mrs Chadha that the family '*felt they were victims of racism*'.[368]

(ii) The Consumer Complaint should not be used as propensity evidence to prove that he behaved in a similar way to Mr and Mrs Chadha.

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364 Written submissions on behalf of Paul Francis Vinar at [16]
365 See finding made at [9]
366 [1998] SASC 7002 as quoted in Mr Vinar's written submissions at [8]
367 The Inquest Handbook (1988) edited by Hugh Selby
368 T1220

330 In assessing this Consumer Complaint evidence, I have already been careful to use it as if it was subject to the rules of evidence. I accept I am not bound under the Act to apply the rules of evidence. At the same time, Mr Vinar must be given procedural fairness and therefore I will consider this evidence much like a situation of discreditable conduct evidence in a criminal trial. I accept it must be used for permissible purposes only consistent with the test of admissibility in s 34P(2)(b) of the *Evidence Act 1929,* as amended. I must find that the Consumer Complaint evidence has '*strong probative value*' as circumstantial evidence of a fact in issue, namely that he was rude and treated Mr Chadha and his family below the required level of care and professionalism as a SAAS officer attending a call out for a patient.

331 I must not use it as evidence simply demonstrating Mr Vinar is a bad person in general. I also must not be distracted from the proper task of assessing the evidence of the witnesses, including Mr Vinar, about the interactions he had with Mr and Mrs Chadha and those present on those occasions.

332 I further agree with a submission of Mr Vinar that this Inquest is not an inquiry into Mr Vinar's behaviour in the course of his employment.[369]

333 Mr Vinar's and Mrs Stiles' involvement with Mr Chadha was a substantial circumstance in the detailed circumstances of Mr Chadha's death. That is the relevance of the evidence and in particular Mr Chadha's refusal to seek SAAS's help on the night/early morning he died. Mr Vinar submitted that a finding should not be made that he was a cause of Mr Chadha's refusal to call SAAS that night, as it does not take into account Mr Chadha's expressed dislike of hospitals and sought the alternative option of a GP consultation.

334 I have taken all matters raised by him into account. In assessing his evidence, I also note that SAAS did not signify to him in its investigation that he needed to be subject to disciplinary action by SAAS.

335 Mr Vinar, I find, failed to understand or totally ignored the nature of who he was dealing with concerning the Chadha family. On either proposition, he failed to meet the necessary standards of SAAS.

336 It was unsurprising that the Chadha family was upset and felt like they were subject to racism. In the end, irrespective of his true state of mind, I find the effect of what he said and did was a major influence on Mr Chadha's decision not to seek SAAS's help in the final hours of his life. The small hope that he had of survival at that point was lost.

337 This finding does not lessen the error identified in Mr Chadha's hospital care.

338 I find that consumer complaints were relevant on the basis that it demonstrated a pattern of behaviour that excludes the evidence of Mrs Chadha in particular as being unreliable or dishonest on this topic. I prefer her evidence to his when a dispute exists between them.

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[369] Written submissions on behalf of Paul Francis Vinar at [66]

Second attendance at the Lyell McEwin Hospital

Dr Tolentino

339 Mr Chadha arrived at the LMH at 9:53 pm on 21 April 2020 and was assigned a triage category of 3 (target maximum wait time 30 minutes).

340 He was seen by RMO Dr Aldric Tolentino. Dr Tolentino obtained his medical degree from the University of the East, Philippines, in 2013. He then worked as a general practitioner and emergency physician from 2014-2017 in Manila. He obtained his accreditation to practise in Australia and worked in various hospitals in Queensland from 2018-2020. He then practised as an emergency medical doctor at the LMH as an RMO from 2020.

341 Dr Tolentino did not have any contact with Mrs Stiles or Mr Vinar[370] and did not recall receiving a handover from anyone else about Mr Chadha.[371]

342 Dr Tolentino had limited recollection of Mr Chadha's presentation given the passage of time. However, when he met with Mr Chadha, he was aware of his previous presentations at the LMH on 20 April 2020 and the RAH on 17 April 2020. He recalled reading the notes made by his colleague from the previous day.[372]

343 Dr Tolentino told the Court it was his practice to read the observations recorded on the Adult RDR chart[373] and the observations chart[374] completed by the triage nurse. These documents included reference to the following key symptoms:

(a) Shortness of breath

(b) Tingling around lips, hands and feet

(c) 2 x prior presentations for shortness of breath

(d) Diagnosis of mycoplasma pneumonia

(e) Tachypnoea 30-35 (elevated respiratory rate) at 9:59 pm

344 Dr Tolentino interpreted the SAAS notes[375] to indicate that they perceived his elevated respiratory rate as being related to Mr Chadha being anxious.[376] He interpreted the word '*acopia*' as being a signal of a patient whose medical concerns have not been attended to or may be worsening, or that there is a social situation at home that is making it difficult for the patient to cope at home.[377] Dr Tolentino did not form the view that Mr Chadha was acopic or otherwise exaggerating his condition. He explained that, in his view, there was a rational medical explanation for Mr Chadha to feel as he presented.[378]

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370 T744
371 T745
372 T724
373 Exhibit C18, p25
374 Exhibit C18, p26
375 Dr Tolentino told the Court he did read the PCR: T718
376 T722
377 T748
378 T749

345 Dr Tolentino was taken to the nursing notes from this presentation, which he had not seen prior to the death of Mr Chadha. The note apparently made at 11 pm referred to Mr Chadha still being anxious, and hyperventilating. He was noted to be less anxious with a decreased respiratory rate by 2 am,[379] but more anxious at 4:28 am when he was administered 2.5mg of diazepam. A note at 4 am reads '*Pt walked to toilet*'. The 6:10 am note indicates that the patient was for discharge, had clinically improved from yesterday, and was taken to triage in a wheelchair.

346 Dr Tolentino told the Court that he likely assessed Mr Chadha between the hours of midnight and 1 am, given that he had spoken with his team leader, Dr Mohammad, by 1 am.[380] Mr Chadha relayed his history to Dr Tolentino, including his previous presentations, diagnosis of mycoplasma pneumonia, that his previous chest x-ray showed no consolidation and effusion, and that he had completed two courses of oral antibiotics and had been on four days of oral azithromycin.[381]

347 Dr Tolentino performed a physical examination of Mr Chadha at about 12:40 am, including a brief neurological examination.[382] He found Mr Chadha's respiratory rate to be elevated at 24 breaths per minute and noticed that his lips were dry and his eyeballs appeared sunken. He concluded Mr Chadha was moderately dehydrated. He listened to Mr Chadha's chest and heard bilateral crackles, which did not necessarily accord with the x-ray from 20 April 2020.

348 The neurological examination involved conducting a brief primary survey of Mr Chadha, testing certain cranial nerves as well as his strength and sensation of his extremities to gross touch.[383] Dr Tolentino recorded '*$^4/_5$ motor strength of all extremities*', indicating that he had developed weakness. Dr Tolentino attributed this to Mr Chadha's current medical condition and did not believe it to be a direct reflection of a neurological problem.[384] He noted that the sensation of the face was normal.[385] Dr Tolentino recalled seeing Mr Chadha walking and did not make a note that there was anything unusual in his gait.

349 Dr Tolentino's neurological examination did not include examination of Mr Chadha's reflexes or the sensation in his limbs.[386] He considered the blood test results to indicate a certain degree of inflammation and, more importantly, an infection.[387] He recalled comparing the blood test results with the previous presentation and considered that the changes indicated a degree of mild improvement.[388]

350 Professor Kelly regarded Dr Tolentino's examination as reasonably thorough, although she noted that it did not include reflexes or gait examination.[389] Further, at a minimum, she opined that there should have been an examination of how Mr Chadha walked, and

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379 Exhibit C18, p27
380 Exhibit C18, pp31-33
381 T725
382 T727
383 T727; Exhibit C18, p32
384 T728
385 Exhibit C18, p32; T1594
386 T729
387 T730: White cell count 1171 and neutrophil count 97
388 T732
389 T1590

she would have preferred that a reflexes exam was done.[390] This examination could have enabled the clinicians to distinguish between weakness caused by lethargy resulting from pneumonia, and a neurological complication.[391]

351 Dr Tolentino also interpreted the x-ray from 20 April 2020 to show signs of improvement when compared to the x-ray taken at the RAH on 17 April 2020.[392]

352 Dr Tolentino did not order an x-ray on 21 April 2020. He explained that he likely considered this and discussed it with Dr Mohammad. He told the Court that certain investigations such as a chest x-ray proved difficult at this time, and that these may have been relevant considerations.[393] He formed the view that further imaging was not necessary in the ED.[394]

353 Dr Tolentino told the Court that Mr Chadha's symptoms were consistent with his diagnosis and that his dehydration could have resulted from poor oral intake over previous days.

354 There was no note by Dr Tolentino of Mr Chadha reporting tingling in his face or lips.

355 Dr Tolentino discussed his findings with Dr Mohammad. They agreed that Mr Chadha needed medical review and admission under the medical team.[395] Dr Tolentino explained that Dr Mohammad was an emergency consultant who, at that time, was finalising his accreditation to practise as an emergency consultant in Australia. He obtained his emergency specialist qualification with Australia later in 2020.

356 Dr Tolentino explained that he and Dr Mohammad advocated for Mr Chadha to be admitted, primarily due to his multiple presentations to different EDs within a short time for the same complaint.[396] He explained that he thought Mr Chadha required an admission for longer than 24 hours, otherwise he would have referred him to the short stay unit.[397]

357 Dr Tolentino then had a telephone conversation with the medical team leader,[398] who on that evening was Dr Esselbrugge. Dr Tolentino did not make a note of this conversation. However, it was his expectation that Mr Chadha would be admitted.[399] He told the Court that he would have given Dr Esselbrugge a brief summary of the patient and why they recommended him for a review with the medical team.[400] He considered the repeated presentation to the ED to be a factor weighing heavily in favour of admission.[401] He explained why:

> …it is very unusual for a patient to re-present in this case three times to a hospital…for the same issue. And what more is a bigger red flag is when you consider that it is within roughly within the 24 hours that the patient has presented for the same issue, that only leads me to

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390 T1591
391 T1593
392 T733
393 T733
394 T1263
395 T734
396 T762
397 T1250
398 T735
399 T739-740
400 T1251
401 T1253

> conclude, even on my independent assessment of the patient that there is a need that is not being addressed during that time…And also if you take into consideration that this is the height of COVID, I wouldn't think that any regular person who is constantly being reminded of the height of COVID would dare present to an emergency department three times for that matter.[402]

358 Dr Tolentino told the Court that in his experience, the patients who presented during the height of COVID-19 significantly needed help.

359 Dr Tolentino also opined that it was relevant to consider the fact that Mr Chadha had been taking azithromycin for four days, which is an antibiotic not commonly dispensed in the ED.[403] He agreed that this was a case of a '*clinical mismatch*' in that the clinical results (x-ray and blood test results) suggested Mr Chadha should have looked better, and yet he was re-presenting at the ED.[404]

360 The fact that Mr Chadha appeared dehydrated was also regarded by Dr Tolentino as a factor in favour of admission.[405] Dr Tolentino prescribed two litres of IV saline, which was administered at 1 am and 2:50 am.[406] He did not recall being aware that fluids had also been administered at the RAH.[407]

361 Dr Tolentino regarded Mr Chadha as presenting a higher risk of clinical deterioration and believed further investigations were required to get to the bottom of the clinical mismatch.[408] These investigations may have included a follow-up x-ray and consideration of a chest CT.

362 Dr Tolentino told the Court that he would have communicated his views regarding admission to Dr Esselbrugge during their telephone conversation. His notes would have also been available to Dr Esselbrugge. He expected that Dr Esselbrugge would have understood that Dr Mohammad shared his view that Mr Chadha should be admitted.[409]

363 The LMH medical records contain a form which is to be completed when a patient is referred for medical assessment. This form included a section entitled '*handover summary*', which includes a space for the practitioner to fill in the '*ISBAR*[410] *protocol*'. That section of the form is blank.[411] Dr Esselbrugge told the Court that these forms are not always completed, and that this would depend on the workload at the time and the individual doctor.[412]

364 Dr Esselbrugge did make a note, albeit a very brief one.[413] He had a recollection of discussing Mr Chadha with Dr Tolentino. He said Dr Tolentino gave him a rundown of the history and how he was presenting now and asked for him to be reviewed.[414]

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402 T1254
403 T1257
404 T1258
405 T1263
406 Exhibit C18, p48
407 T1263
408 T1266
409 T1256
410 Identity, Situation, Background, Assessment and Recommendation: T943
411 Exhibit C18, p35
412 T942
413 T752; Exhibit C18, p45
414 T942

365 When Dr Tolentino later learned that Mr Chadha had not been admitted under the medical team, and was being discharged, he prepared the discharge letter '*out of courtesy and of concern*', as he felt obliged to inform the GP of what had transpired at the hospital.[415] He explained that he utilised the documentation completed by the medical team to draft the letter.

366 Dr Tolentino did not recall any further discussion with the medical team regarding Mr Chadha after the handover.[416]

Dr Esselbrugge

367 After the telephone conversation, Mr Chadha was reviewed by Dr Esselbrugge. Dr Esselbrugge made the decision to discharge Mr Chadha. That decision was not reviewed by a consultant.

368 At the time of giving evidence, Dr Esselbrugge was a basic physician trainee and had obtained his medical degree in 2017.

369 Dr Esselbrugge told the Court that the discharge summary from the RAH would have been available to him, but he could not recall whether he read it. He did however recall reading the report of the x-ray from the RAH,[417] and reviewing the blood test results.[418] When taken to the notes of Dr Wang,[419] the ED RMO who examined Mr Chadha on 20 April 2020 at the LMH, he stated that he could not recall whether he read those notes, but it was his practice to examine the medical review notes rather than the ED notes.[420] When taken to the medical review notes made by Dr Maganti, he was not sure whether he had read those either.[421] He could not recall whether he read the PCR,[422] but told the Court that he would not have taken the term '*acopic*' into account in his own assessment if he had.[423]

370 Dr Esselbrugge's resident[424] assessed Mr Chadha and presented her history and findings to him.[425] Dr Esselbrugge did not perform a neurological examination and did not see Mr Chadha walk.[426] Professor Kelly was critical of this omission, noting that the results of Dr Tolentino's testing were not normal, and that $^{4}/_{5}$ muscle strength is reduced strength and she would have expected the medical unit to perform an independent assessment of neurological function.[427]

371 The resident's note indicated that Mr Chadha said that at home he was worried that he would deteriorate more as there was no oxygen available.[428]

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[415] T736
[416] T750
[417] T926
[418] T932
[419] Exhibit C18, p63
[420] Presumably the notes of Dr Maganti: Exhibit C19, p72
[421] T930
[422] T936, 993
[423] T938
[424] It is noted that this practitioner was junior to Dr Esselbrugge: T981
[425] T941
[426] T946
[427] T1594
[428] Exhibit C18, p36 - Dr Esselbrugge could not recall Mr Chadha telling him this, but assumed this was a part of their conversation: T982. He agreed that this is relevant to the question of admission to hospital: T983.

372 Dr Esselbrugge told the Court that he remembered going to see Mr Chadha briefly and having a chat to him. He recalled sitting down next to Mr Chadha and talking to him about how he was feeling and how he thought Mr Chadha was improving. He said that he would have discussed the objective findings of improvement on the x-ray and blood test results, and that it would probably be reasonable that they could get him home.

373 Dr Esselbrugge's note included:

> Long discussion regarding clinical improvement however patient remains anxious ++ Unable to elicit exact cause for why, though periodically more settled. Suggest small dose of diazepam (2.5mg) to see if patient can rest, to facilitate discharge in the morning.[429]

374 Dr Esselbrugge interpreted his note to mean that the patient was very anxious and that he could not nail down the cause. He said '*…but, I mean, presumably now it's because he was feeling unwell*'.[430] He was not sure if he discussed with Mr Chadha under what circumstances he should re-present to hospital. A discussion of this nature is not documented in his notes.[431]

375 He could not remember how Mr Chadha described his presenting complaint and could not recall any issues communicating with him. He could not recall whether the requirement to wear PPE hampered his assessment of Mr Chadha but recalled that it did make communication harder and may have led to less patient contact due to the need to re-PPE.[432]

376 Based on his notes and his memory, Dr Esselbrugge formed the impression that Mr Chadha looked quite anxious and tired.[433] When it was suggested to him that Mr Chadha may have been hyperventilating, he said '*he was a little bit, yeah*'. He recalled the issue of facial numbness coming up at some point.[434] In terms of tingling of the face, Dr Esselbrugge told the Court that he believed that this had resolved by the time he read about it in the review.[435] However, he made no note to this effect. It is unlikely he was actually aware of this symptom as it was only referred to in the note of the triage nurse.[436] Dr Esselbrugge would only occasionally read nursing notes.[437]

377 If Dr Esselbrugge had enquired about the lip tingling and satisfied himself that it had resolved when Mr Chadha's respiratory rate reduced, this could suggest that the lip tingling was caused by hyperventilation rather than a neurological cause.[438] However, other than Dr Esselbrugge's vague suggestion that be believed the lip tingling had resolved by the time he read about it in the review of his resident, there is no evidence that this was the case.

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429 Exhibit C18, p41
430 T957
431 T958
432 T984
433 T944
434 T946
435 T1002
436 Exhibit C18, p25; T1745 (Professor Kelly) - I note that Mrs Chadha stated that she reported this symptom to SAAS at: T661, however, the PCR does not refer to tingling, only numbness
437 T991
438 T1746

378 Dr Esselbrugge did not think that he read the nursing notes which referred to Mr Chadha being anxious as it was not his standard practice to read nursing notes.[439] He did not believe he spoke with anyone in relation to Mr Chadha's oral intake.[440] He could not definitively say whether he was aware that Mr Chadha had required IV fluids during his previous presentations, although that information would have been easy to find.[441] He did not know whether he turned his mind to the question of why Mr Chadha was dehydrated again so quickly.[442]

379 When considering the blood test results, Dr Esselbrugge said they were '*all pretty normal, he's got just a very mild white cell count raise but it's only a little bit above normal*'. He said that is usually a mark of an infection.[443] He opined that the down trending from the previous blood test was '*good*', and that the x-ray from 20 April 2020 was also better than the x-ray from 17 April 2020.[444] He noted that the quality of the x-ray from 20 April 2020 was not quite as good as the previous x-ray,[445] but it still appeared improved from previous. He explained that this used to be an issue with the portable x-rays and that while the software enables the image to be manipulated to an extent, '*you can't quite correct enough*' for an image like the image from 20 April 2020.[446] He described the quality of the images as '*not great*' but believed that you could still make a reasonable assessment from it.[447] It is noted that Professor Kelly viewed the haziness of the film as a potential difficulty, as the haziness could be consistent with pulmonary oedema. She opined that this interpretation may have prompted a troponin test or a natriuretic peptide test for cardiac failure.[448]

380 Dr Esselbrugge's registrar diagnosed mycoplasma pneumonia and anxiety and recommended that Mr Chadha was not for medical admission. Dr Esselbrugge agreed with that view. He explained why:

> I think a combination of things. I think, sort of, based on my notes there, his chest x-ray looked improved; his bloods looked like they were improving; his vital signs were essentially normal; and he was a 38-year-old man with good support at home and he had, like, a telehealth with our clinic the next day as well. So, it seemed like he was fairly well safety-netted.[449]

381 He later added that Mr Chadha did not look '*too unwell*' when he went to talk to him and that was another factor in favour of discharge.[450]

382 When asked if he discussed the decision with the on-call consultant, he responded '*No, nope*'.[451] When asked if he discussed the decision with anyone in the ED, his response was '*I mean, I assume I would've spoken to somebody in ED - either the ED RMO or the*

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439 T991-2; Exhibit C18, p27
440 T560
441 T1003
442 T1004
443 T948
444 T949-50
445 T953
446 T953-4
447 T990; Professor Kelly noted that the portable x-rays are usually taken from the front instead of the back and the quality tends to be inferior: T1582
448 T1583
449 T955
450 T989
451 T956

ED in-charge - to say, like, we've just said they're not for admission, they're just sitting in ED with no plan'. However, he did not actually recall any discussion taking place,[452] nor is there any note of such a conversation.[453] Dr Tolentino did not recall being involved in a discussion of this nature.

383 In the end, there is no satisfactory evidence that there was any consultation with the ED clinicians following the decision to discharge. I believe had there been such a conversation, it is likely to have been noted. The notes indicated that the decision to discharge was communicated to the nursing staff, who then prepared Mr Chadha for discharge. It is likely that if there had been a conversation with a clinician from the ED, it would not have fallen upon Dr Tolentino to prepare the discharge letter as a courtesy and of his own volition.

384 In terms of the diagnosis, Dr Esselbrugge was initially unsure whether he reached a diagnosis of anxiety out of proportion to his illness. He explained that he attributed Mr Chadha's representation to both his anxiety and his medical condition.[454] He conceded that his documentation was not very good.[455] He agreed that he was aware Mr Chadha did not have any documented mental health history or any previous presentations where anxiety was listed as the cause.[456] He remembered having the impression that Mr Chadha looked quite anxious and tired. Further, he observed that the nurses and his resident also documented that Mr Chadha looked quite anxious, '*so I don't know whether that's where I've got that from, but certainly my impression on seeing him was that he was quite anxious*'.[457] Dr Esselbrugge prescribed the anti-anxiety medication diazepam. His note reflects that the purpose of this was to allow Mr Chadha to rest to facilitate discharge in the morning.[458]

385 Considering the matter with the benefit of hindsight, and with knowledge of the criticisms made by Professor Kelly in her reports, Dr Esselbrugge still did not know whether it would have been preferable to admit Mr Chadha on 21 April 2020 for further investigation.[459] When it was put to him that he should have admitted Mr Chadha, he replied:

> It's very hard for me to say I would disagree given hindsight and I can't remove myself from that bias.[460]

386 He said that he was not sure if Mr Chadha would have had any further investigations had he been admitted but said that him being observed might have been helpful, given his re-presentations. He settled on a concession that, with hindsight, admission would possibly have been preferable, but at the time it seemed very clinically reasonable for a young man to be discharged.[461] He speculated that a consultant would likely have discharged him the next day anyway.[462] I note that Professor Kelly did not believe that

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452 T956
453 Professor Kelly would expect such a note to be found in the medical record: T1770
454 T1005
455 T986
456 T992
457 T993
458 Exhibit C18, p41
459 T959
460 T1003
461 T959
462 T962

this could be concluded with surety and stated that she very much doubted a consultant would have sent him straight home if they reviewed him at 8 am.[463] She correctly identified that she has more experience of what physicians do and do not do than Dr Esselbrugge.[464]

387 It was suggested to Dr Esselbrugge that further investigations could have included a high contrast CT scan of Mr Chadha's chest. Dr Esselbrugge agreed that this would have been a reasonable and helpful test,[465] although at the time he did not think it was clinically warranted.[466] However, he did agree that an arterial blood gas possibly should have been performed to rule out respiratory failure.[467] He did not believe that performance of that test would have changed the outcome.

388 He also agreed that, with hindsight, ideally a further x-ray would have been taken during this admission,[468] although in his view it was questionable as to whether it would have shown any significant changes.[469] He did not agree that a CTPA was warranted.[470] In conclusion, he accepted that it was hard to disagree with the criticism of Professor Kelly that the treatment, investigation and monitoring of Mr Chadha at the LMH on 21/22 April 2020 was suboptimal.[471]

Opinion of Professor Kelly regarding standard of care provided on 21 April 2020

389 Professor Kelly believed firmly that Mr Chadha should have been admitted for further assessment, observation, monitoring and treatment under a medicine team on 21 April 2020.[472] She regarded the overall care, treatment and discharge plan provided at the LMH on 21 April 2020 as suboptimal.

390 Professor Kelly provided the following reasons in support of her opinion that Mr Chadha should have been admitted for further investigation, observation and treatment, namely:

(a) The three ED presentations over a short time period;

(b) He required intravenous therapy for rehydration, having been administered this therapy approximately 24 hours prior, suggesting doubt regarding his ability to manage his oral hydration;[473]

(c) He reported new symptoms – numbness and tingling of the face, lips, hands and feet, all of which required explanation and may have made eating and drinking difficult;[474]

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463 T1623
464 T1754
465 T980
466 T978; see also Exhibit C32a: one panel member suggested that a CTPA was warranted as this was the third presentation
467 I note that the failure to perform an arterial blood gas was noted in the Group Clinical Review, Exhibit C32a, p3
468 T990
469 T1000
470 T999
471 T1005
472 Exhibit C41d, p2; T1737
473 T1608-10 - Mr Chadha was administered two litres of fluid on 20 April 2020 and a further two litres of fluid on 21 April 2020. Professor Kelly was not satisfied that the reference to 'gave one cup of water' in the nursing notes was evidence that Mr Chadha was able to tolerate oral fluids: T1727, 1744.
474 T1609, 1744

(d) The duration of his illness;

(e) The failure by Dr Esselbrugge to investigate or appreciate the significance of the report of weakness;[475] and

(f) The failure to improve as expected.

391 The further investigations may have included:

(g) CT scan of the chest;[476]

(h) Arterial blood gas analysis;[477]

(i) Ionised calcium measurement;

(d) Measurement of troponin; and

(e) Assessment of oxygen saturation on exertion.[478]

392 His monitoring would have included the monitoring of food and fluids and his vital signs over time.

CT scan of chest

393 Professor Kelly[479] and Dr Azhar[480] both expressed the view that a high contrast CT scan of the chest should have been performed on 21 April 2020.[481] Professor Kelly believed that if this scan had been done, it may have made a difference to Mr Chadha's prognosis. She explained that if the CT showed pneumonia that was not obvious on the second x-ray (noting that the x-ray, being two dimensional, is not particularly sensitive or specific in terms of identifying the degree of pneumonia),[482] this may have confirmed the diagnosis. However, if significant pneumonia was not detected on CT, this should have led to consideration of why Mr Chadha was short of breath and weak, leading to further investigations into the possibility of pulmonary oedema or a cardiac problem.[483] She explained that the CT was clinically indicated due to the continued reports of shortness of breath.[484]

394 I believe a high contrast chest CT should have been performed prior to discharging Mr Chadha for the following reasons:

- The quality of the x-ray from 20 April 2020 was substandard;
- A high contrast chest CT is more sensitive in identifying lung pathology than a chest x-ray;[485]

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475 T1586, 1590, 1722
476 T1568
477 Professor Kelly explained that this may have provided additional information that might have been particularly helpful to a less experienced person interpreting blood gases as it may have drawn attention to a bigger than expected gap between the arterial and the venous oxygen levels: T1571 - Dr Azhar was of the view that this test should have been performed: T787-8
478 Exhibit C41b, p7
479 T1580
480 T787
481 Dr Dobler was also in agreement: Exhibit C49, p11
482 T1585
483 T1580
484 T1750
485 T1568

- There was a disparity between the results of the x-ray and blood tests, which appeared to show improvement of Mr Chadha's pneumonia, and Mr Chadha's clinical presentation, particularly his shortness of breath, his concerns about his shortness of breath, his report of weakness, and his new symptoms of tingling and numbness; and
- The fact that this was Mr Chadha's third presentation to an ED in four days.

Arterial blood gas test

395 Professor Kelly explained that she did not believe on balance that performance of an arterial blood gas analysis would have altered the outcome for Mr Chadha.[486] However, it may have confirmed whether Mr Chadha was hyperventilating.[487] If, for example, this test was performed and refuted hyperventilation, a further cause for the symptom of tingling lips may have been sought. It is noted that Dr Esselbrugge conceded this test was indicated, and the internal review identified this as an omission.[488]

Ionised calcium measurement

396 Professor Kelly regarded the ionised calcium measurement as an investigation which ought to have been performed to explore whether the cause of the symptom of tingling around the mouth was hypocalcaemia. She explained that hypocalcaemia can cause arrhythmias of the heart which can be fatal.[489]

397 While Mr Chadha did have a history of hypocalcaemia, this did not appear to have been disclosed to the clinicians at the LMH. Professor Kelly opined that My Health Record could be of assistance in providing clinicians with important information such as this, provided that the ED systems could link to it.[490] She opined that there appeared to be a jumping to the conclusion that the tingling to the lips was due to the high respiratory rate, which she stated was ill-advised in the circumstances.[491]

398 It was not clear to Professor Kelly whether the tingling was a symptom that resolved when Mr Chadha's respiratory rate returned to a more normal level, which would be expected if the cause was hyperventilation. While Dr Esselbrugge told the Court that he thought that this symptom had resolved by the time he saw Mr Chadha, there was no note to this effect. Dr Esselbrugge did not know whether he asked Mr Chadha any questions about the symptom of tingling of the face. The effect of his evidence was that he did not strongly consider this symptom as indicative of a low calcium level.[492] The uncertainty of Dr Esselbrugge's evidence on this topic does not allow for a positive finding to be made that the symptom of tingling had resolved as a result of his reduced respiratory rate. Rather, it suggested that this symptom was not given adequate consideration by Dr Esselbrugge and that it ought to have prompted further investigations, including an iodised calcium measurement.

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[486] T1571
[487] T1752
[488] Exhibit C32a, p3
[489] T1574 - It is noted that azithromycin may not have been prescribed in the history of hypocalcaemia was known, see Exhibit C41a, p19
[490] T1773
[491] T1573
[492] T1002

399 Further, it was significant that the PCR referred to numbness to the face and lips preventing drinking.[493] In addition to providing a reason for his dehydration and requirement for IV rehydration, this note, if read, would have put the clinicians on notice that Mr Chadha may have been suffering from a neurological complication of his pneumonia, or at least that there was another possible cause for the unusual facial sensation.

Measurement of troponin

400 Professor Kelly explained a measurement of troponin is a test that looks for damage or strain of the heart muscle.[494] She opined that this would be a reasonable screening test to investigate why Mr Chadha was short of breath out of proportion to what would be expected for improving pneumonia.[495] She told the Court that in these circumstances, she would be asking the question '*what are we missing?*', and to find out, she explained that what was clinically indicated was either further investigation for pulmonary embolism or troponin, or both.[496] She expressed the following view:

> Again as I say I think that the clinicians closed too quickly on its just pneumonia and he's not coping when the evidence was suggesting that, you know the CRP had improved, the chest x-ray looked better, so the chances that there was something else going on were significant and the two obvious targets are pulmonary embolism and a cardiac problem.[497]

Oxygen saturation on exertion – three-minute walk test

401 Professor Kelly explained that the three minute walk test is a '*really easy bedside test*' to determine oxygen saturation on exertion. It has been proven to predict people who need hospital admission as it can identify whether a person has an evolving problem with their oxygen carriage in their blood.[498] She explained that this test is conducted with a clinician beside the patient for a minimum of three minutes utilising an oxygen saturation metre to enable changes in oxygen saturation and heart rate to be measured.[499] This test could also have identified any neurological problems, as if he could not walk for the three minutes required that would be a sign that something significant was occurring.[500] She was not satisfied that the nursing note that Mr Chadha walked to the toilet was a substitute for this test[501] as it did not say how well he walked, or whether he walked without incoordination or with difficulty.[502] She was also not satisfied that the assessment for baseline limb strength conducted during the nursing assessment comprised an adequate neurological assessment.[503] She explained that while a person with pneumonia might feel weak, when you examine their neurological system, they usually have normal muscle strength.[504]

402 Professor Kelly was taken to various notes made during this admission where there was no reference to a complaint of weakness. For example, Professor Kelly was taken to the

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493 Exhibit C18, p24
494 T1576
495 T1577
496 See also T1752
497 T1578
498 T1579
499 T1742
500 T1539
501 T1589
502 T1589
503 T1725
504 T1733

notes of RMO Dr Lopa, who did not include weakness in the history section. However, Professor Kelly noted that the phrase '*very tired*' was used. While clinicians distinguish between muscle weakness and lethargy, Professor Kelly pointed out that patients often do not distinguish between the two concepts.[505] Further, she was concerned that there were some omissions in the history, particularly in relation to exercise tolerance.[506] In any event, Professor Kelly emphasised that there was a finding of $^{4}/_{5}$ muscle strength by Dr Tolentino, which is not normal power.[507] Accordingly, she opined that a neurological examination should have been repeated by the acute admitting unit.[508] Further, Professor Kelly regarded Mr Chadha's statement that he was worried he would deteriorate at home without oxygen as a '*really powerful statement*'.[509] She noted that he was a disability support worker and not naïve to healthcare. Regrettably, it does not appear that his concern in relation to his oxygen saturation was taken into consideration.

The crux of the issue

403 Professor Kelly explained that the '*big problem*' with this case is not that there may have been a rare condition such as an arrhythmia or GBS. Rather, the issue is that the clinicians failed to recognise the risk of there being an additional issue that was causing muscle weakness and repeat presentations to the ED. The failure to appropriately investigate the new symptoms of numbness and tingling[510] was also problematic, as was the failure to ensure that he was adequately eating and drinking prior to discharge.[511] She explained that the course proposed by Dr Tolentino was appropriate. That is, Mr Chadha needed further investigations by the acute medical unit, largely on the basis that this was the third presentation within a few days, suggesting a high likelihood of a missed diagnosis or unexpected disease progression.[512]

404 She was also concerned that the assessment by the acute medical unit was performed by a junior doctor. Further, the registrar, Dr Esselbrugge, did not conduct his own examination.[513] Whilst he spoke with Mr Chadha, Professor Kelly distinguished between a conversation about an illness versus a history and examination.[514] She opined that if Mr Chadha had been admitted, he would more than likely have been reviewed by a very senior clinician who may well have performed a more thorough assessment.[515] Further, this would have provided an extended period of observation, which she described as a particularly powerful tool[516] as it enables a pattern of food and fluid intake and vital sign progression over time.[517]

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505 T1730
506 T1731
507 T1730
508 T1735
509 T1768
510 I note that this criticism is made in the supplementary report dated 22 September 2021, and prior to the issue of GBS being raised
511 T1610
512 T1736
513 T1737
514 T1737
515 T1754
516 T1754
517 T1756

405 After an assessment of the evidence, I accept Professor Kelly's opinion[518] that Mr Chadha should have been admitted on 22 April 2020 for further investigation at a minimum.[519] Secondly, the planned follow-up phone call from the HAC would have been an inadequate means by which to monitor his progression.[520] Depending on the investigations that ensued, this may well have resulted in his deterioration being detected and his death thereby avoided.

406 I accept that Mr Chadha's x-ray results and blood test results suggested that his pneumonia was improving. However, his physical condition was deteriorating. This means either his pneumonia was not improving which could have been confirmed or refuted by a high contrast chest CT, or Mr Chadha was suffering from an additional illness, likely neurological, which required investigation and treatment.

407 A medical cause for Mr Chadha's re-presentation was not adequately investigated as his return to hospital was attributed to anxiety and he was discharged. It is unclear whether the treating clinicians were aware of Mr Chadha's multiple consultations with multiple GPs prior to this presentation to the LMH,[521] and whether that would have altered the decision to discharge. It was submitted by Special Counsel that this is very unlikely, given Dr Esselbrugge's impression that Mr Chadha was highly anxious and, accordingly, it is likely that this behaviour would also have been attributed to anxiety.

Diagnosis of anxiety

408 Professor Kelly inferred from the note of Dr Esselbrugge (++plus anxiety) that he made a diagnosis of anxiety. She explained that the assessment part of the notes is usually where the diagnosis is recorded,[522] and referred to the note of RMO Dr Lopa listed under the heading, Assessment (primary diagnoses):

- Mycoplasma pneumonia
- Anxiety[523]

409 Dr Esselbrugge was unsure whether he had made a diagnosis of anxiety-out-of-proportion-to-illness.[524]

410 In Professor Kelly's supplementary report, she stated that a diagnosis of anxiety-out-of-proportion-to-illness should be a diagnosis of last resort after appropriate investigation and observation have been completed.[525]

411 Professor Kelly expressed the view that Mr Chadha's concerns about increasing shortness of breath were under-appreciated. In oral evidence, she elaborated:

> Being anxious is actually a normal response to when you think that there is a threat to your life, future health, or other things, and in fact if a patient with shortness of breath tells me

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[518] Professor Kelly referred to her 'strong opinion' that discharge was inappropriate on several occasions, see for example T1756
[519] T1755
[520] T1756
[521] T1662
[522] T1747
[523] Exhibit C18, p40
[524] T958
[525] Exhibit C41b, p7

> they are anxious, I really worry and I'm…more vigilant to watch them closely because they are usually right. They are usually sicker than they look. So, yes, anxiety is a very important feature, a very important clue to severity of illness.[526]

412 She expressed disappointment that this diagnosis was made and stated that she did not think it was justified, in part due to his lack of any history of anxiety.[527] She explained that making the diagnosis of anxiety without having explored other alternative diagnoses runs a very significant risk of missing something important, which in her view is what occurred in relation to Mr Chadha.

413 She believed that the prescription of diazepam could make things worse in a patient with shortness of breath who has not been conclusively diagnosed.[528] It could also have masked other symptoms and reduced his anxiety such that Mr Chadha believed he was safe to remain at home after his final discharge and await his appointment the following day with Dr Azhar.[529]

414 In conclusion on this topic, the prescription of diazepam was only reasonable if Dr Esselbrugge diagnosed anxiety, as his notes suggest, and viewed the cause of the presentation as largely behavioural.

Guillain-Barre Syndrome (GBS)

415 Professor Kelly explained that when she reconsidered the material in preparation for giving evidence, she was concerned that some of Mr Chadha's symptoms were unexplained, namely muscle weakness, numbness to the lips, face, hands and feet, and unusual gait while walking to the ambulance on 21 April 2020.[530]

416 She conducted research of medical journals to see if she could identify other potential causes for Mr Chadha's progressive muscle weakness. She identified that mycoplasma pneumonia can cause neurological complications, one of which is GBS.[531] Tingling in hands, lips and feet may precede or accompany muscle weakness in GBS. Professor Kelly opined that the observation by Mrs Chadha and Mrs Crews of Mr Chadha appearing uncoordinated and walking with a high stepping gait was potentially consistent with GBS. Further, Dr Tolentino's observation of $^{4}/_{5}$ muscle strength in limbs indicated reduced strength, which Professor Kelly told the Court was not explained by the duration of Mr Chadha's illness.[532]

417 Professor Kelly told the Court that she could not determine with any certainty whether Mr Chadha was suffering with GBS at the time of his second presentation to the LMH.[533] As she explained further in oral evidence:

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526 T1560
527 T1578
528 T1763
529 T1605
530 T1605
531 A rare disorder in which the body's immune system attacks nerves; T1553
532 T1730
533 T1554, 1761

> It does not matter what the final diagnosis was, it was the process to monitor somebody with a potential misdiagnosis, therefore to identify his deterioration and have the opportunity to diagnose and treat it that was missed.[534]

418 Dr Tolentino opined that there may have been a remote possibility that the symptom of tingling in the lips was a presentation of GBS.[535] He believed that the tingling of the lips may have been a presentation of hyperventilation.[536] Professor Kelly agreed that hyperventilation may cause tingling to the face, but noted that this would depend on whereabouts on the face the tingling was. If it was restricted to one side of the face, for example, that would not be consistent with hyperventilation.[537] Tingling to the feet is a less common symptom of hyperventilation.[538] Further, Professor Kelly interpreted the venous blood gas analysis as being inconsistent with significant hyperventilation,[539] making a neurological cause for the tingling more likely.

419 Professor Kelly also noted that it is important to distinguish between the symptoms of numbness and tingling.[540] Dr Lopa noted '*numbness on face*' in her medical assessment,[541] but there was no reference to the location on the face of the numbness, and no reference to tingling. Dr Esselbrugge's note does not refer to either numbness or tingling. Dr Esselbrugge said that tingling of the lips is not classical for GBS, and that this would not be his first thought.[542] The triage nurse noted tingling around the lips, hands and feet.[543] There was no evidence any doctor read this note.[544]

420 When considering the differing opinions on the question of whether Mr Chadha had symptoms consistent with GBS, I prefer Professor Kelly's opinion due to her extensive qualifications and experience, together with the research she conducted in preparation for this Inquest. In any event, the criticism made by Professor Kelly did not depend on Mr Chadha having GBS. Rather, she was critical of the failure to adequately explore his unusual symptomology in the case of a pneumonia that was objectively improving.

421 Professor Kelly was asked to provide her opinion in relation to the effect of the prescription of diazepam. She explained that it may have contributed to the effects of GBS, if he was in fact suffering from that condition, but only in a very small way due to its muscle relaxant properties.[545] Professor Kelly opined that the major problem with the prescription of diazepam was the fact that it implied a completely incorrect diagnosis and may have decreased his anxiety and falsely reassured him that he was alright.[546] It is possible to probable that Mr Chadha being prescribed and administered an anti-anxiety medication contributed to his decision to refuse an ambulance on the night of 22 April 2020, and thereby contributed to his death.

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534 T1761
535 T738
536 T739
537 T1598
538 T1599
539 T1769-70
540 T1599
541 Exhibit C18, p36
542 T963
543 Exhibit C18, p25
544 Dr Tolentino said that he may have read these notes as it was his general practice: T722 - Dr Esselbrugge told the Court it was not his practice to read nursing notes: T991
545 T1605
546 T1605

Repeat presentations

422 Professor Kelly explained that return visits to ED are recognised indicators of potential problems with care.[547] These can include a missed diagnosis, unexpected progression of illness, under-estimation of disease severity, inadequate advice to patients and complications of treatment. In her experience, many ED clinicians have processes in place to identify this at-risk group, which often includes review of the patient by a senior doctor and a lower threshold for hospital admission.[548] She explained that a large number of hospitals have processes in place requiring a senior decision-maker to be involved in the care of a patient in this cohort.[549] For a third presentation, some hospitals have a procedure requiring admission unless the presumption in favour of admission has been rebutted.[550] She rejected the suggestion that a policy requiring admission for repeat presentation would place an enormous strain on bed availability.[551] Rather, she described this cohort as a '*very, very, very small group*' and explained that '*there is justification for keeping those in whom you cannot identify the cause of their deterioration or their symptomology in hospital to try and work it out. We do it all the time*'.[552]

423 The significance of repeat presentations was also acknowledged by Dr Thomas[553] and Dr O'Connor in relation to Mr Battagodage, which is detailed below. It was accepted as well by Dr Tolentino in relation to Mr Chadha.

424 Dr O'Connor stated that a repeat presentation should alter the practice in treating the patient. He stated it is generally accepted that a patient who re-presents should be seen by either a registrar or a consultant.[554]

425 Dr Tolentino stated that the repeated presentations were an important factor considered in his decision for Mr Chadha to be referred to Dr Esselbrugge for admission.[555] He stated that it is very unusual for a patient to re-present three times to a hospital. That these presentations occurred within 24 hours with the same issue could only lead him to the conclusion that Mr Chadha had a need that had not yet been addressed.[556]

426 Dr Tolentino stated that multiple repeat presentations '*is actually the biggest red flag*' regardless of the age of the person reattending.[557]

427 Dr Esselbrugge was also of the opinion that patients with repeated presentations to hospital are a high-risk group and should have a lower threshold for admission.[558] This indicated that the key issue regarding the premature discharge was not a lack of awareness of the fact that repeated presentations should lead to a high index of suspicion. Rather, two other factors were instrumental. First, Dr Esselbrugge's clinical assessment, which led to his acceptance of the RMO's recommendation to discharge. Secondly, the lack of

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547 See also T1722
548 Exhibit C41b, p6
549 T1610
550 T1611
551 T1754
552 T1754
553 T1754
554 T1284-5
555 T1253
556 T1254
557 T1257-8
558 T1004

an appropriate safety net in place via hospital policy requiring review by a senior doctor in the case of a re-presentation.

Preventability

428 Professor Kelly believed if Mr Chadha had been admitted, as requested by Dr Tolentino, it is more likely than not that his deterioration on 22 April 2020 would have been detected and intervention undertaken that would have prevented his death.[559]

429 She further explained that if a more thorough medical assessment had been made by Dr Esselbrugge or his team, they may well have made the diagnosis of neurological problems and there would have been an opportunity to intervene, such as by supporting breathing by intensive care interventions. Further, had he been admitted and subject to reasonable monitoring by nursing staff, they would have detected a change in his respiratory rate, a change in his ability to lie down, and a change in his oxygen saturation, which would have set off alert calls in the hospital and resulted in an escalation of his care and recognition of the gravity of his illness.[560] Even if the cause was not identified, the LMH would have been able to provide support for his breathing and monitoring of his heart. This may well have prevented his death.[561]

Impact of COVID-19 pandemic on discharge decision

430 Professor Kelly considered the circumstances of the COVID-19 pandemic resulted in changes to the healthcare system that may have contributed to Mr Chadha's death. These included:

- The use of telehealth consultations which limited the ability of GPs to examine Mr Chadha in-person;
- Reduced access to healthcare;[562]
- The inability of Mrs Chadha to attend hospital with her husband, resulting in important information regarding the progression of Mr Chadha's illness being unknown to treating hospital clinicians; and
- A potentially higher threshold for hospital admission during this period as hospitals strived to have beds available for an expected wave of patients with COVID-19.[563]

431 However, it was the evidence of those involved in the care of Mr Chadha at the LMH that COVID-19 was not a factor in the decision to discharge him home.

432 Dr Tolentino stated that he did not feel any pressure not to admit patients simply because the presentation had occurred during the height of the COVID-19 pandemic. He was firm that any patient who needed to be admitted will be advocated for admission, regardless of any policy, official or otherwise.[564] This is what he did regarding Mr Chadha.

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559 Exhibit C41a, p21
560 T1603
561 T1604
562 T1611
563 Exhibit C41d
564 T1268

433 Dr Esselbrugge stated that though there were some concerns about avoiding admission to ensure availability of beds when the number of COVID-19 infected patients was increasing,[565] he was satisfied with Mr Chadha's clinical improvement based on the results of his x-ray the day prior, and his vital signs being within normal limits. It was not the effect of his evidence that he would have admitted Mr Chadha if not for the circumstances of the COVID-19 pandemic, although it is not possible to exclude an unconscious propensity to discharge given his evidence that there was an impetus to keep patients out of hospital where possible.[566] His decision to discharge can be attributed to his relative inexperience.

434 The effect of the pandemic on health care was multifaceted. Professor Kelly explained that in her experience through conducting internal case reviews, she identified that there were missed opportunities for better healthcare in this period due to the absence of family members to provide collateral information.[567] I find Mrs Chadha, who was devoted to caring for her husband during his illness, in all probability would have attended hospital if permitted to do so and provided collateral information. This may have included her observation of his unusual gait on the way to the ambulance, together with her observations of his increasing weakness. Further, as suggested by Professor Kelly, it is likely that Mrs Chadha would have questioned the decision to discharge had she been present.[568] As an overall assessment, I find that the care provided at the LMH on 21 April 2020 was below the expected standard.

22 April 2020

Consultation with Dr Azhar

435 Mrs Chadha told the Court that when her husband returned from the LMH he was in tears and reported that he had been treated badly. They attended Mr Chadha's scheduled consult with Dr Azhar at the Northern Medical Centre together.[569] Dr Azhar noted that Mr Chadha was unwell looking and dry, unable to walk and unable to stand. Dr Azhar had a clear recollection of the consultation of 22 April 2020. It was an in-person consultation at the very end of the day.[570] Mr Chadha was brought into the clinic using a wheelchair with the assistance of Dr Azhar and Nurse Vyas.

436 Mr Chadha's presenting complaints were that he had no energy, felt weak, and was not improving. He spoke at length about his treatment by the hospital, and that he had lost faith in the system. He stated that Mr Chadha said he was told by the ambulance officers to '*man up*' and that he was '*bothering his family*'.[571] His family was very upset about the behaviour and the attitude of the crew. These words also appear in the retrospective note completed by Dr Azhar dated 23 April 2020.

437 In his contemporaneous consultation record, Dr Azhar noted Mr Chadha to be unwell looking. Dr Azhar was concerned for Mr Chadha's ongoing tiredness, weakness and lack or energy, suspecting that '*something else was going on*'.[572] In his retrospective note and

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565 T924
566 T924
567 T1588
568 T1601
569 Exhibit C22, p7
570 T772
571 T773
572 T774

his oral evidence, Dr Azhar stressed that he had told Mr Chadha that he needed to be admitted to the hospital, but that it was Mr Chadha who refused to go. This advice is absent from the contemporaneous consultation note,[573] which simply reads '*detailed counselling done*'. Dr Azhar explained that this note reflected his attempt to reinvigorate Mr Chadha's faith in the healthcare system.[574]

438 The contemporaneous consultation note records that the ED doctors and Mrs Chadha thought that Mr Chadha had developed severe anxiety *which had caused him*[575] to be unable to walk or stand. Dr Azhar raised some concerns about Mr Chadha's high neutrophil results, indicating ongoing infection.[576]

439 In his retrospective note, Dr Azhar set out in some detail his recollection of this consultation. This note stated that Mr Chadha had been advised that hospital admission was required. However, due to his past three bad experiences, Mr Chadha did not want to attend hospital as he thought they would just discharge him again. Dr Azhar noted that he could see Mr Chadha required hospital admission, but that he was unable to achieve this. He was concerned that the LMH was missing a diagnosis, and further investigation was required which should have been done in hospital. This note records that Dr Azhar asked Mr Chadha if he had private health insurance, with a view to arranging private hospital admission. However, he did not have it. Dr Azhar arranged to call Mr Chadha the following day instead.

440 During his oral evidence, Dr Azhar stated that he was not reassured by the improvements shown on Mr Chadha's x-ray results, as it was a '*clinical mismatch*' with what Mr Chadha was telling him. He was concerned that there was a diagnosis being missed.[577] Mr Chadha looked dehydrated.

441 Dr Azhar measured Mr Chadha's oxygen saturation, which was 98% on room air. While this may appear to be unusual given Mr Chadha's death less than 12 hours later, Professor Kelly explained that oxygen saturation can hold up quite well until quite late, particularly in the case of a young, otherwise well person.[578]

442 During the consultation, Dr Azhar listened to Mr Chadha's chest using a stethoscope, and thought it accorded with the results of the x-ray. There was good air entry, and some very mild crackles on the left rib zone, which also matched with the results from the pulse oximeter.[579]

443 Mr Chadha's temperature was also checked, showing no fever, indicating that he was clinically improving.

444 Blood pressure was checked, with results slightly on the higher side. Dr Azhar stated that these results did not surprise him, as Mr Chadha was quite emotional when explaining

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[573] Professor Kelly explained that it would be important to make a contemporaneous note of a patient's refusal to attend hospital against medical advice for medico-legal reasons, and also to document that patient's decision making, especially if you consider that the decision might impact on their outcome in terms of morbidity or mortality: T1566
[574] T773-4
[575] My emphasis
[576] T777-8
[577] T779
[578] T1569-70
[579] T781

what had happened to him. It would be sensible to attribute the reading to a physiological cause rather than to Mr Chadha having hypertension.[580]

445 Dr Azhar clarified during his evidence that he stressed to Mr Chadha that only a short hospital admission was required in order to try and convince him to go to hospital, but Mr Chadha refused to go back to the hospital.[581]

446 He told Mr Chadha that he must call an ambulance if he felt as though his health was worsening.[582]

447 Dr Azhar called the laboratory at the LMH to add an ANA test, as he was concerned Mr Chadha's infection may have triggered an autoimmune disorder.[583] He also requested further radiological imaging[584] to be conducted, and prescribed diazepam for his anxiety as per the discharge summary from the LMH.

448 Nurse Vyas was also present for this consultation. In evidence, she described Mrs Chadha as arriving at the clinic when it was about to close, knocking at the door, and requesting a doctor see her husband with a desperation that concerned Nurse Vyas.[585] She did not make any contemporaneous note of what occurred that day. Her only statement in relation to this event was given four years later, for the purpose of this Inquest.

449 In evidence she recalled Mr and Mrs Chadha being '*very stressed out*' or '*frustrated*' when speaking about what had occurred when the paramedics attended. She recalled Mr Chadha repeating the same things over and over.[586]

450 Dr Azhar '*mentioned*' to Mr Chadha that he should not have been discharged and he should return to hospital.[587] Although this was consistent with Dr Azhar's retrospective note,[588] Dr Azhar denied saying this to the couple.[589]

451 Nurse Vyas stated that Dr Azhar repeatedly told Mr Chadha to attend hospital, and that Mr Chadha refused. Her evidence was Dr Azhar responded with words to the effect of '*That's fine if you don't want to go now, but at least if when you feel like you are really unwell, please call triple zero and call the ambulance*'.[590]

452 Based on these words of Dr Azhar, it may have conveyed the message to Mrs Chadha that it was fine if Mr Chadha did not wish to go directly to hospital, but that he should go if he became worse.

453 Mrs Chadha recalled that, when discussing Mr Chadha's symptoms, Dr Azhar continuously used phrases to downplay the severity of his illness, including '*he's fine now. Look, he's breathing fine*', '*Both of you need to go home and relax, he's fine*', '*You*

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580 T781-2
581 T782
582 T789-90
583 T784
584 High resolution chest CT: Exhibit C22, p8
585 T1785
586 T1789
587 T1793
588 Which reads as follows: 'he needs further work up, which ideally should be done in hospital, but now I have to do it on my own'
589 T900
590 T1794

need to keep eating, drinking, and you'll be fine'[591] and '*See, you're fine, your brain is working better than us*'.[592]

454 She had no recollection of being told to return to hospital, only that Dr Azhar had simply told them to '*come and see me every day*', that there was no risk to Mr Chadha's life, and that he did not have COVID-19.[593]

The factual dispute about Dr Azhar's consultation

455 As set out above, there is clearly a difference between the recollections of the persons present. This difference was not necessarily the product of deliberate fabrication or knowing reconstruction. Rather, this divergence may have been the product of differing perspectives on what occurred and what was said and the passage of time, together with hindsight and outcome bias.

456 Mrs Chadha was adamant that Dr Azhar did not advise hospital attendance. Dr Azhar was adamant that he did provide that advice, as was Nurse Vyas. Nurse Vyas was open in her respect for Dr Azhar, with whom she has maintained contact since leaving her employment at his practice. This, coupled with hindsight and outcome bias, may have coloured her memory, which was also compromised by the fact that she was not required to turn her mind to the events of 22 April 2020 for some four years.

457 Mrs Chadha, on the other hand, was a compelling witness. She had a detailed recollection of the consultation, but where she could not remember the details, she said so.[594] Mrs Chadha was clearly deeply concerned about her husband's illness and health. This is best illustrated by Nurse Vyas' description of Mrs Chadha as being '*desperate*' for an appointment with a GP for her husband.

458 She described a very real sense of relief upon hearing Dr Azhar say that he had physically checked her husband and he was fine. She was reassured by the consultation.

459 It is difficult to conceive of circumstances in which Mrs Chadha would silently accept her husband's refusal to accept clearly given medical advice to go directly to hospital.

460 Mrs Chadha's evidence was consistent with Dr Azhar's evidence in several respects. Dr Azhar said that he did need to calm the couple down and reassure them and tell them he would look after Mr Chadha. He said this was because they were very upset about the previous treatment from the paramedics and hospital staff. Dr Azhar also prescribed a small dose of diazepam. This action is consistent with Mrs Chadha's version of the advice given that '*you need to go home and relax*'.

461 Further, although Dr Azhar stated that the need to go to hospital was '*voiced to the maximum, advised to the maximum*' this clearly was not Mrs Chadha's interpretation. Dr Azhar was asked whether he might have been more gentle than forceful in providing that advice. He replied that he did not know how the advice was received and agreed that

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591 T568
592 T569
593 T569
594 T611, 679-684

he was being '*extremely gentle, more than gentle*' with Mr Chadha and trying to restore his faith in the medical system.

462 I find that Dr Azhar's evidence on this topic has been affected by hindsight and outcome bias. He may now genuinely believe that he provided this advice, but he must not have, at least not in a sufficiently clear manner.

463 I find it is significant that Dr Azhar did not make a contemporaneous note of the advice he says he provided. This omission is significant as, if the advice had been refused, the fact it was provided was important in terms of Mr Chadha's ongoing medical care and for medicolegal reasons. Dr Azhar put the notetaking omission down to the time of day and the length and complexity of the consultation. However, this would not have been a lengthy note to make. Nurse Vyas gave evidence that Dr Azhar usually made comprehensive notes. The absence of a note that medical advice was refused is consistent with the evidence of Mrs Chadha that this advice was not given. I prefer Mrs Chadha's evidence to Dr Azhar on this topic.

464 It is also observed that Dr Azhar's oral evidence was significantly firmer on this topic than his retrospective note. In oral evidence, he stated that he gave strong and firm advice on this topic, but the advice was refused. This can be distinguished from his note that hospital admission was advised/discussed in detail, and they were '*not keen*' to return to hospital for fear of being discharged again. This is demonstrative of the effect of outcome and hindsight bias.

465 Even if Dr Azhar did advise Mr Chadha to return to hospital, the advice was not provided in terms strong enough to convey the urgency to Mr or Mrs Chadha. Rather, it was more likely as expressed by Nurse Vyas in her evidence, rather than '*voiced to the maximum*' as Dr Azhar asserted.

466 I find that Dr Azhar did believe that Mr Chadha should have been treated in hospital, and told the Chadha's this, without actually advising they attend directly that day.

Expert opinions regarding standard of care provided by Dr Azhar

467 In her written reports, Professor Kelly was not critical of the care provided by Dr Azhar,[595] or any of the GPs involved in Mr Chadha's care. She opined that COVID-19 testing was clinically indicated on 7 April 2020 but did not think the delay had any bearing on the outcome.[596]

468 However, in relation to the consultation on 22 April 2020, Professor Kelly re-read Dr Azhar's consultation note[597] in Court. She expressed concern in relation to the comment '*he's developed marked weakness, unable to walk or even stand*'. She explained that this was unusual, did not quite fit with someone with an uncomplicated pneumonia,[598] and was suggestive of a neurological condition. Accordingly, she was critical of Dr Azhar's failure to perform a neurological examination. She told the Court that when she first read this note she was under the impression that this was probably a telehealth

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595 Exhibit C41a, p20
596 T1562, 1564
597 Exhibit C22, p7
598 T1565

consultation and hence she was not critical of the failure to perform a neurological examination.[599] However, having been provided with the transcript of Dr Azhar's evidence, which showed this was an in-person consultation, she changed her view,[600] as a neurological examination would have been possible.[601] As an aside, she observed that there was a lack of clarity in all of the GP notes regarding which consultations were in-person and which were not.[602] It was her experience that early in the COVID-19 pandemic some of the GP systems did not allow them to differentiate clearly between in-person and telehealth consultations. Therefore, she allowed some leeway for the documentation.[603] In her initial reports, she gave the benefit of the doubt to the GPs that the consultations may not have been in-person. This resulted in her being less critical of the failure to perform physical examinations and to identify visual clues.[604]

469 It was suggested to Professor Kelly that the note of Dr Azhar makes it clear that this consultation was in-person as it referred to physical observations such as a blood pressure reading.[605] However she explained that, in her experience, many people had medical observation equipment at home early in the pandemic.[606] It is noted that a blood pressure cuff is visible in the last photograph taken of him by his wife.[607]

470 Professor Kelly did not accept that she knew at the time of preparing her first report that this consultation with Dr Azhar was in-person[608] or that her change of opinion was the product of hindsight bias.[609] However, upon reviewing the note, and having read the transcript, she conceded that the consultation was in-person. She told the Court:

> […] I agree with you, looking at it now, especially having had the opportunity to look at the transcript and to reconsider the notes, I absolutely agree that he was seen in-person but my opinion that a neurological examination was needed is not changed.[610]

471 She explained that proofing prior to Court provided her with the opportunity to explore further the cause for the reported unusual gait, which led her to revisit the documentation and to conduct research. She then revisited her opinion in accordance with her duty as an expert witness to the Court.[611] In the end, it only matters to me that Professor Kelly's opinion on this topic was based on accurate facts.

472 Professor Kelly opined that in the circumstances a neurological examination was essential. Had that been performed, she would have been '*very happy with his management*'.[612]

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599 Professor Kelly expressed uncertainty in her initial report at p6 in relation to an appointment with Dr Aslam
600 T1564
601 T1634
602 T1635-6
603 T1771
604 T1771
605 T1636
606 T1636
607 Exhibit C30a
608 T1636
609 T1461
610 T1637
611 T1641
612 T1657

473 Professor Kelly's evidence was she would be less critical of the failure to perform a neurological examination if Dr Azhar had advised Mr Chadha to attend the hospital,[613] a matter upon which she understood there to be a factual dispute. However, she explained that the failure to perform a neurological examination impacted upon Mr Chadha's ability to make an informed decision about whether to attend hospital. She stated that one of the things that a clinician can do to encourage a reluctant patient to attend hospital is to make sure that they have all relevant clinical information.[614] Without all relevant information, Mr Chadha was not able to make an informed decision on the matter. Professor Kelly hypothesised that if Dr Azhar had performed a neurological examination, and Mr Chadha was told that he was nearly paralysed and further tests were required or the possible consequences were dire, that might have persuaded Mr Chadha to attend hospital. In Professor Kelly's opinion, this information would potentially have been more persuasive than simply telling Mr Chadha that his chest seemed to be getting better, but that something else might be going on.[615]

474 Professor Kelly explained that if there had been a neurological examination, the progression from mild muscle weakness, as observed by Dr Tolentino on 21 April 2020, to the stage where Mr Chadha could not walk or even stand would have alerted a clinician to the fact that something progressive was occurring requiring further urgent assessment and investigation.[616] If this information was obtained via neurological examination and conveyed to Mr Chadha, it would have increased the chances he would have attended hospital if that advice were given.

475 Professor Kelly did not accept that Dr Azhar was entitled to assume that Mr Chadha's condition had been thoroughly investigated at the LMH, or that they had performed a neurological examination. She opined that it is not uncommon for hospitals to get things wrong,[617] that GPs should consider this possibility, and that illness can progress markedly over time and it is important for GPs to consider the possibility that something else has developed in the interim.[618] Further, she would expect an experienced GP such as Dr Azhar to appreciate that severe anxiety is an important symptom that should not be ignored.[619]

476 If Mrs Chadha's recollection is correct, however, and Dr Azhar did not advise Mr Chadha to attend the hospital, Professor Kelly opined that Dr Azhar's treatment was unacceptable and fell below the level of reasonable practice[620] due to the absence of a neurological examination and the failure to assess that he could adequately eat and drink. Dr Azhar noted that Mr Chadha appeared dry looking, which should not have been the case given the administration of IV fluids at the LMH.[621]

477 Professor Kelly and Dr Azhar agreed that there was a clinical mismatch and that based on the investigations, Mr Chadha ought to have been up and about and healthy looking,

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613 T1565
614 T1650
615 T1651
616 T1566
617 Professor Kelly noted that the possibility of error is increased overnight as night duty staff tend to be relatively junior doctors: T1639
618 T1638
619 T1638
620 T1567
621 T1568

not sitting in a wheelchair. They both expressed the view that you treat the patient, not the numbers, and that his appearance of being '*very unwell looking*' suggested a missed diagnosis.[622]

478 Professor Kelly's expertise in the area of general medicine was questioned by counsel for Dr Azhar, Mr Mitchell. She explained that while she is not a GP, her opinion is based on her broad experience in the health system and in adverse event management.[623] As set out above, Professor Kelly is an internationally recognised researcher, teacher and practitioner in the field of Emergency Medicine. Her experience includes providing medicolegal opinions in various jurisdictions, and she is the author of over 200 publications in peer reviewed journals.

Dr Ken Dobler

479 As a result of the unexpected criticism of Dr Azhar, he sought and provided two expert reports from Dr Ken Dobler. This was totally understandable and justifiable due to procedural fairness.

480 Dr Dobler is a retired regional GP and has been practising in the field of general medicine since 1991. He has co-authored one publication in 1986. He holds the position of Deputy Chairman on the Hunter Valley Grammar School Board. He has also been the visiting medical officer at several regional hospitals and is an accredited registrar supervisor.

481 In his initial report, Dr Dobler states '*the evidence in this matter is that Dr Azhar did entreat Mr Chadha to return to hospital*'. He does not mention Mrs Chadha's conflicting evidence, as he was not provided with her transcript and hence would have been unaware of the factual dispute. In any event, this conclusion is not the subject of proper opinion evidence.

482 In relation to the failure to perform a neurological examination, Dr Dobler opined that Professor Kelly's criticism is infected by her suspicion of GBS as a possible diagnosis. His view was that in the absence of a history of other symptoms apart from loss of energy and general weakness, and in the knowledge that the patient is continuing to suffer with marked shortness of breath from a diagnosed pneumonia, and in whom a physical examination has shown evidence of dehydration, performing a neurological examination would not be common or expected practice.[624]

483 Dr Dobler stated that in any event, performance of a neurological examination would not have changed the outcome unless Mr Chadha actually had GBS, which cannot be proven. Further, if absent reflexes were detected upon neurological examination, it would not be within the scope of knowledge or practice for a reasonable GP to suspect GBS, and it was not unreasonable for Dr Azhar not to suspect a possible neurological condition.[625] Dr Dobler also doubted that information gleaned from a neurological examination, such as muscular weakness and loss of reflexes, would have swayed Mr Chadha to attend hospital. He noted that it would be highly unlikely that Dr Azhar could interpret the significance of the likely results of the neurological examination, again, making it less

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622 T1648
623 T1642, 1758
624 Exhibit C49, p14
625 Exhibit C49, p14

likely that this information could have persuaded Mr Chadha to attend hospital. He opined that Dr Azhar's management of Mr Chadha would be widely viewed as competent professional practice by his professional peers.

484 Professor Kelly was clear however that her criticism regarding the failure to perform a neurological examination did not depend upon Mr Chadha actually having a diagnosis of GBS, or on the clinicians suspecting GBS.

485 The note that she returned to several times during her evidence was this:

> Emergency Department Drs, and wife says that he has developed severe Anxiety and **hence** developed marked weakness - unable to walk and even stand. (emphasis added)

486 The significance of this note was not apparent until Professor Kelly devoted particular attention to this consultation during her evidence and her review of the materials in preparing for the Inquest.

487 Dr Dobler in his report stated that one should be judged by the standards of one's peers, such that GPs should not be judged in their actions by another doctor who has special qualifications in a specific area, but rather by the standards of other GPs. He refers to the Bolam principle in support of this assertion.[626]

488 Professor Kelly explained that when assessing the conduct of other practitioners, she places herself in their position insofar as that is possible, bearing in mind their qualifications and experience. It is accepted that given her extensive experience and expertise, she is at a disadvantage when assessing the state of knowledge that a GP would be expected by his or her peers to have regarding neurological conditions. I do note that Dr Azhar set out in some detail during his evidence his own significant experience as a clinician, including working within EDs in South Australia.

489 Further, it is plain that Dr Azhar appreciated Mr Chadha's extreme weakness and lethargy and he was concerned about his condition. The question to be resolved is therefore whether it was unreasonable for Dr Azhar not to suspect a neurological cause of Mr Chadha's extreme weakness.

490 Dr Azhar was concerned about a missed diagnosis, but his attention was focussed on the possibility of an autoimmune cause and on restoring confidence in the medical system. The evidence establishes that he did not know about the unusual gait, which was the symptom most indicative of a neurological problem. He described that the consultation was complex and prolonged, with long discussion regarding the way in which Mr and Mrs Chadha were treated by Mr Vinar and Mrs Stiles.[627]

491 I do not overlook or underestimate the significance that Dr Azhar had a lot of history to consider, together with Mr Chadha's previous adverse experiences of being accepted when trying to convey how sick he had become.

492 It is open for me to simply accept the view of Professor Kelly that Dr Azhar should have recognised the gravity of the symptom of weakness and performed a neurological

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[626] It is not suggested that this principle has application to the coronial jurisdiction in South Australia
[627] T902

examination, particularly if he had provided advice to attend hospital and that advice was refused.

493 However, as I have tried to articulate, it was not an easy situation for him. Further, it is not suggested that this was an egregious omission, bearing in mind the facts known to Dr Azhar at the time and the complexity of the consultation. Dr Azhar was clearly compassionate, and devoted significant time to Mr Chadha on the evening prior to his death. It would be understandable to conclude that the significance of his report of weakness was overshadowed by the heightened emotional circumstances. Further, I accept that a GP may be less likely to attribute a neurological cause to the symptom of weakness than an emergency physician of Professor Kelly's calibre.

494 It would be harsh in the circumstances to find that Dr Azhar missed an opportunity to prevent the death of Mr Chadha by failing to perform a neurological examination. I would need to be comfortably satisfied about it and have regard to the principles of *Briginshaw*. If Dr Azhar recommended hospital attendance, an adverse finding should not be made against him due to his failure to perform a neurological examination alone, as it is unlikely that this omission would have affected the outcome for Mr Chadha if he had attended hospital and received reasonable monitoring and treatment.

495 If Dr Azhar did not provide clear advice to attend hospital, the evidence is capable of establishing that Dr Azhar's treatment fell below the expected standard, as opined by Professor Kelly.

496 I note Dr Dobler's opinion that Dr Azhar's treatment would not have been unreasonable even if he did not refer Mr Chadha to hospital, as the advice provided would be in accordance with peer professional practice.[628] If I were to accept that opinion, then it may be unnecessary to resolve the factual dispute.

497 However, in the end, this opinion does not withstand scrutiny. In support, Dr Dobler cited the SA Health Guidelines for the management of Community Acquired Pneumonia, which recommends outpatient care for pneumonia unless any of the specified criteria are met, such as inability to tolerate oral antibiotics, need for supportive oxygen and functional status.[629] Dr Dobler stated that these conditions were not met for Mr Chadha. However, Mr Chadha could barely walk or even stand. This status alone would have justified admission pursuant to the guidelines. Accordingly, I reject Dr Dobler's opinion on this topic.

Conclusion regarding Dr Azhar

498 This was a complicated situation. I accept that Dr Azhar was left in a difficult position by previous events. He should not have had to do any more than examine and assess Mr Chadha. He should not have had to defend the medical system of South Australia. That would have been distracting from his core task to say the very least.

499 Both Mr and Mrs Chadha were desperate and disappointed by this stage. A lot was said in this consultation. It was also difficult because of previous findings by the LMH. The effect of anxiety being diagnosed previously would have been hard to ignore, especially

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[628] Exhibit C49a, p8
[629] Exhibit C49a, p6

as Mr Chadha's pneumonia markers were not presenting at a critical level, despite his condition.

500 The neurological markers of being unable to walk or stand were previously classified as relevant to anxiety, as Dr Azhar had contemporaneously noted.[630]

501 I have accepted that Mrs Chadha is to be preferred over Dr Azhar in these unusual circumstances.[631]

502 Even so, I find it hard to be critical of Dr Azhar. He agreed to see Mr Chadha after a long day of working in the clinic. He was a caring doctor to him. If he was in error about the lack of a neurological examination, it was not because of a lazy or poor attitude. He had arranged to see Mr Chadha the next day.

503 I find that I need not make any further finding on this consultation other than to say he only became involved because Mr Chadha was not admitted to the LMH when the evidence of that presentation, together with expert opinion of Professor Kelly, leads me to conclude he should have been.

Preventability on 22 April 2020

504 Professor Kelly opined that if Mr Chadha had attended hospital following his appointment with Dr Azhar, it is probable that his death would have been prevented,[632] assuming reasonable behaviour by the ambulance service and hospital. I accept that and find accordingly.

The events following Dr Azhar's consultation

505 When they returned from their appointment with Dr Azhar, Mrs Chadha told her husband words to the effect of '*if you still want a doctor or an ambulance today, I will call it and tell them not to send the same crew*'. Mr Chadha said not to; he said he would wait for Dr Azhar's appointment the following day.[633] He said that he had been treated badly by them and did not want to go through that again.

506 Dr Fernando also had contact via the telephone with Mr Chadha on 22 April 2020 at 6:56 pm. Dr Fernando advised to call an ambulance if he got worse.[634]

507 On the evening of 22 April 2020, Mrs Chadha thought her husband appeared feverish. He said that he had body aches. She stated that usually he would return to his room, but that that day he stated he wanted to stay with her in the living room. He apologised for calling the ambulance crew who treated him and his family poorly.[635]

508 He wanted to wait for his appointment with Dr Azhar the following morning. He asked his wife to stay with him, not to leave him, and to talk with him. Mrs Chadha tried to arrange for a locum doctor to attend but was unable to secure their attendance.[636] She

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630 See [413]
631 See [430]-[441]
632 T1602
633 T512
634 Exhibit C21, p2
635 T513
636 T569-70

recalled that her husband told her to stop wasting her time on the phone. They fell asleep together on the couch at around 3 am.

509 When Mrs Chadha awoke at about 4:45 am, she could not rouse her husband. He felt cold to the touch. She called an ambulance and attempted to resuscitate him. However, it was clear he had passed away. He was declared life extinct at 5:30 am on 23 April 2020.

510 Mrs Chadha complained to the attending ambulance officers about the behaviour of the previous crew. She reiterated to the Court that this behaviour had affected her husband to the point where he prevented her from calling an ambulance out of concern that they would treat him the same way again.[637]

511 Mrs Chadha believed her husband may have been hiding his symptoms from her the night before his death so that she would not call an ambulance for him.[638] She was under the impression that his health was improving, and recalled him using his mobile telephone, which he had not done recently. She took his photograph.[639]

512 It was the opinion of Professor Kelly that Mr Chadha's death was preventable up until the final critical event, which was probably either cardiac or respiratory arrest.

513 I find Mr Chadha's death could have been prevented had an ambulance been called for Mr Chadha either on the evening of 22 April 2020, or in the early hours of the morning, prior to cardiac or respiratory arrest.[640] Mr Chadha's refusal of an ambulance can be attributed to the way he was treated by Mr Vinar and Mrs Stiles, and his experiences at the LMH on 21 and 22 April 2020.

514 It is noted that three of the diazepam tablets prescribed by Dr Azhar were missing from the pack when police attended the home. While this may suggest Mr Chadha had taken more than the amount prescribed, this does not appear to be significant, as diazepam was not detected in his post mortem blood sample, and the drug is within the scope of analysis.[641]

Internal review conducted by the Lyell McEwin Hospital

515 Dr Tolentino was informed of Mr Chadha's death by the Head of Emergency, Dr Augustus Kigotho. He told Dr Kigotho what he recalled of Mr Chadha's presentation, what he did, the fact that he discussed the patient with the team leader, and then referred Mr Chadha to the medical team with the expectation that he would have been admitted.[642] He did not believe there was any specific education conducted as a result of this case.

516 Dr Esselbrugge was informed of Mr Chadha's death by a senior registrar. He told the Court that he was not involved in any internal review of Mr Chadha's death and was only

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637 T571; Exhibit C33b
638 T516
639 Exhibit C30a
640 T1602
641 Exhibit C5
642 T739

recently made aware that there was a review.[643] He stated that he would have liked to have read the review documents a few years ago.[644]

517 However, since the death of Mr Chadha, Dr Esselbrugge said that he has admitted more patients based off their own concerns. He stated that maybe he placed less weight on Mr Chadha's concerns at the time due to his level of experience.[645] He said that he now has a lower threshold to admit with re-presentations.[646]

518 Professor Kelly regarded it as '*unfortunate*' that those involved in the case were excluded from the review as they have knowledge of the nuances of the situation. She explained that including those involved in the review also has an educational benefit.[647]

519 Five documents were tendered in relation to the Northern Adelaide Local Health Network (NALHN) clinical review of the death of Mr Chadha:

- Case Review Recommendations/Shared Learnings[648]
- Group Clinical Review Report[649]
- Hospital Admissions through NALHN Emergency Departments dated February 2024[650]
- NALHN Insights and Learnings from Experience Newsletter[651]
- Affidavit from Dr John Brian Maddison[652]

520 A joint Group Clinical Review (GCR) report was finalised by NALHN and the Central Adelaide Local Health Network[653] on 10 August 2020. The panel found that in relation to Mr Chadha's third presentation to hospital, the clinical review could have been different. The panel identified four primary issues:

- Failure to discuss repeat presentations with the on-call consultant
- Triage to the respiratory zone limiting patient contact
- No formulation of differential diagnosis and early closure of the case (premature closure bias or anchoring bias played a significant role in this case, leading to other diagnoses not being formally considered, and assessment being limited to the known illness)
- The lack of any pathway or procedure for review of these repeated presentations resulted in discharge prior to a consultant input

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643 T964
644 T997
645 T983
646 T984
647 T1616
648 Exhibit C32
649 Exhibit C32a
650 Exhibit C32b
651 Exhibit C32c
652 Exhibit C38
653 Within which the Royal Adelaide Hospital falls

521 The GCR made three primary recommendations, which are also set out in the table marked exhibit C32a. The table does not include all relevant material.[654]

- If an otherwise healthy patient is a second time presenter with similar/same medical symptoms, the patient is not to be discharged from the hospital, without consultant (ED or Inpatient) consultation or review.[655] A differential diagnosis is to be considered during that review and documented.

- There is formal education added to the junior medical officer program, and a Grand Round Presentation regarding the regular incursion into diagnostic thinking of the concept of cognitive bias. This is defined as systematic errors in thinking that influence decision making and judgment. The education is to include ways NALHN can place systemic barriers to address this widespread issue.

- NAHLN formally write to the SA Ambulance Service to note the use of the word '*acopia*' in Mr Chadha's handover documentation, where that reference was erroneous, and as such, may have contributed to the weight placed on the patient's anxiety.[656]

522 Dr John Maddison, Executive Director Medical Services NALHN, provided an affidavit concerning NALHN's response to the GCR.

523 He stated that the GCR recommendations were discussed and amended by the NALHN Clinical Governance Committee. In relation to recommendation 1, the procedure was updated to state:

> For patients who re-present to the Emergency Department with the same symptoms within a short time frame (e.g. 72 hours) medical staff should have a high index of suspicion for a more serious underlying cause. The decision to discharge these patients should not be made without discussion with a senior decision maker (refer to divisional guidance as to the level of seniority).

524 This procedure was effective from 15 February 2024.[657] The documentation provided did not appear to specify who this senior decision maker would be, namely if it would be a consultant, or a basic physician trainee such as Dr Esselbrugge. Professor Kelly's opinion is that the level should be at a minimum a senior registrar, and preferably a consultant.[658]

525 The new procedure does not adopt the recommendation that differential diagnoses are to be documented.[659] This is regrettable as the requirement to document this may prompt more detailed discussion of the differential diagnoses. Further, there is nothing contained within the policy requiring the clinician to document the name of the senior decision maker, what information they were provided with, and what advice they gave.[660]

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654 See also Exhibit C38, p3

655 It is noted that at the time of Mr Chadha's death there was no policy to Dr Esselbrugge's knowledge that required consultant input for repeat presentations: T994

656 It is noted that this was not implemented as it was not thought to be within NALHN's jurisdiction: Exhibit C38, p6

657 Exhibit C38, p4 at [14]

658 T1619

659 I note that Professor Kelly stated that all clinicians should write appropriate medical records, implying that this ought not need to be enshrined in policy: T1617

660 T1618 Professor Kelly told the Court that this should be a requirement in any clinical encounter

526 In relation to the recommendations,[661] Dr Esselbrugge told the Court that he was only recently made aware of the changes to the admissions policy for repeat presentations.[662] It was his evidence on 4 March 2024 that the new policy was only drawn to his attention by counsel in relation to this Inquest.[663] When asked whether he agreed that the new policy was an appropriate way to manage re-presentations, he responded that he was not sure. He explained that calling a consultant at two or three in the morning is not an easy thing to do.[664]

527 The new procedure had been effective for over two weeks at the time Dr Esselbrugge attended Court to give evidence. According to Dr Maddison, this updated procedure would have been disseminated via the ED Weekly Memo and via the NALHN weekly wrap.[665]

528 Given Dr Esselbrugge's role at the LMH, whereby he determines whether patients are to be admitted, his naivety to this policy suggests problems with implementation. It is imperative that all medical practitioners within the inpatient units of the LMH and Modbury Hospital are specifically made aware of this amended procedure, or it is of no value in minimising poor patient outcomes.

529 Professor Kelly expressed concern in relation to the implementation plan. She explained that you need a process that ensures communication, and monitors compliance. This should be developed before the policy is enacted.[666] She was distinctly unimpressed by the suggestion that leaving printed copies of a new policy in a staffroom and uploading a copy of the policy onto the intranet comprised a satisfactory implementation plan.[667] She explained that an implementation plan is usually multimodal and includes direct communications from senior executives, direct communications from the head of the department, discussion at team meetings, perhaps email communication, and perhaps providing a written copy to each member of the relevant team.[668] In her experience, the most powerful tool of implementation is for the head of each unit to talk to their staff and make it clear that it is their expectation that they follow this new policy and indicate that compliance will be monitored.[669]

530 Further, Dr Esselbrugge's concerns regarding calling a consultant in the early hours of the morning are suggestive of a cultural issue, which this procedural change does not address. Professor Kelly told the Court that it is well-known that in some hospitals there is a culture where junior staff are quietly discouraged from bothering their bosses overnight.[670]

531 Further, the new procedure is not expressed in compulsory terms – rather, it indicates what should be done. If Dr Esselbrugge's concerns regarding contacting the on-call

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661 Exhibit C32
662 T967
663 T995
664 T1004
665 Exhibit C38, p4 at [16]
666 T1764
667 T1765
668 T1765
669 T1766
670 T1613

consultant are indicative of a wider issue, a policy expressed in terms of '*should*' rather than '*must*' is unlikely to bring about a change in practice.

532 Dr Esselbrugge was also unaware of any medical education being implemented to address cognitive bias.[671] Dr Maddison stated that cognitive bias training is now included within education for trainee medical officers, namely interns and RMOs. This may explain why Dr Esselbrugge was unaware of this training being implemented. However, it is not known upon what basis this training has been restricted to trainee medical officers, when it was apparently introduced to remedy issues with Dr Esselbrugge's diagnosis of anxiety,[672] as a basic physician trainee.

533 Dr Esselbrugge was taken to the NALHN clinical insights learning and experience newsletter from October 2021. When asked if he had received the newsletter he said that he was not sure, it may be somewhere in his email.[673] He told the Court that he only became aware of the newsletter very recently in preparation for Court.[674] He would not normally look at these newsletters.[675] He was not aware of there being any expectation that he read these newsletters.[676] Professor Kelly regarded this as a serious issue, and told the Court that the number of people who will actually read a weekly memo is probably less than 5%.[677]

534 The utility of the GCR report was severely limited by the failure to interview the staff involved to identify what actions they took, and why. However, the Review did identify the need for a pathway to ensure consultant review for repeat presentations. This Inquest has highlighted a clear need for a consultant review in these situations, particularly given the evidence of Dr Esselbrugge that his relative inexperience at that time played a part in his decision to discharge.

535 It is regrettable that no steps were taken to identify the factors which prevented Dr Esselbrugge from seeking the input of the on-call consultant.

536 Further, the policy regarding repeated presentations does not require consultation with the referring team in circumstances where a referral for admission is rejected. According to Professor Kelly, this is more than a matter of professional courtesy. It is a quality and safety issue that should be enshrined in policy to ensure that less people '*fall through the cracks*'.[678] She explained that there is a culture within some individuals that does not respect the views of the ED staff, even specialists.[679] At her hospital, emergency physicians have admitting rights and can admit a patient to hospital irrespective of the views of the registrar.[680] There has been an audit of this procedure. It found that their error rate is very low in terms of people discharged within 24 hours by an inpatient specialist.

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671 T967
672 Dr Esselbrugge was not sure whether this was the diagnosis he made: T959
673 T969
674 T970, 995
675 T995
676 T997
677 T1620
678 T1614
679 T1615
680 Ibid

537 In general, Professor Kelly was supportive of the change in policy but had concerns regarding the dissemination of the information.[681] She accepted that this is a very difficult problem. She explained that some units use an induction handbook that new staff have to read and sign that they have read to convey information regarding policies. She agreed that the relevant practitioners who make the decision to admit or discharge after referral ought to acknowledge that they had received and read a copy of the updated admission information.[682]

Admitting rights

538 Dr Esselbrugge told the Court that emergency staff cannot generally make a decision to admit a patient without referring first to the medical team, although the situation was '*a bit murky sometimes*'.[683]

539 Professor Kelly said that many hospitals require the medical unit, who intends to discharge a patient referred to them for admission, to discuss the case first with the referring clinician.[684] She observed that in Mr Chadha's case, there was a senior registrar, Dr Mohammad, present who, if consulted, may have challenged Dr Esselbrugge's discharge decision.[685] Further, if a conversation was mandated in these circumstances, it may have brought to light relevant information not considered by Dr Esselbrugge and provided an opportunity for Dr Mohammad and/or Dr Tolentino to advocate their concerns.

Consultation with referring ED clinician

540 Professor Kelly also told the Court that some hospitals also have mechanisms that allow the ED clinicians to formally challenge a discharge decision as a safeguard.[686] In her experience, almost always the outcome of such a challenge is for the patient to be kept in overnight and seen by the consultant in the morning.[687]

Recommendations concerning the death of the late Mr Chadha

541 I now consider my duty under the Act to make recommendations that '*might prevent, or reduce, the likelihood of a recurrence of*'[688] a death occurring in a similar way as Mr Chadha.

542 This caused a number of recommendations to be proposed. I have considered these all, including any opposition to them being made.[689]

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681 T1620
682 T1622
683 T935
684 T1595
685 T1596
686 T1596
687 T1596
688 Section 25 of the Act
689 Including any objection to them in full or part

543 Accordingly, I make the following recommendation directed to the Northern Adelaide Local Heath Network:

One That the 'Hospital Admission through NALHN Emergency Departments Procedure' be reviewed and amended to include the following requirements:

1. That ED Consultants have the authority to admit a patient who has re-presented to the ED with the same symptoms within a short timeframe of about 72 hours to an inpatient unit.
2. That patients who re-present to the ED with the same symptoms within a short timeframe of about 72 hours must not be discharged without review of that patient by a senior decision maker within the ED.
3. That the definition of '*senior decision maker*' be reviewed to ensure that it includes only consultants and, if deemed appropriate, senior registrars.
4. That patients who have:
    a. Re-presented to the ED with the same symptoms within a short timeframe of about 72 hours; and
    b. Been referred by an ED clinician to an inpatient unit for admission

    must not be discharged until documented consultation has occurred with the referring clinician and/or the senior decision maker within the ED.
5. That a procedure be introduced allowing the referring clinician or senior decision maker within the ED to formally challenge a decision to discharge a patient who has re-presented.
6. That the amended procedure be audited on a 12-monthly basis to monitor compliance.
7. That appropriate steps be taken to implement the new procedure, including that all clinicians with the authority to admit or discharge a patient be advised of the new procedure in writing and be required to sign a document confirming that they have read and understood the new procedure.

544 I make the following recommendation directed to the Minister for Health and Wellbeing:

Two That consideration be given to the implementation of a uniform procedure across all Local Health Networks regarding patients who re-present to the ED with the same symptoms within a short timeframe of about 72 hours, and that the amended uniform procedure include the following safety measures:

1. That ED Consultants have the authority to admit a patient who has re-presented to the ED with the same symptoms within a short time frame of about 72 hours to an inpatient unit.
2. That patients who re-present to the ED with the same symptoms within a short time frame of about 72 hours **must not** be discharged without **review** of that patient by a senior decision maker within the ED.
3. That the definition of '*senior decision maker*' be reviewed to ensure that it includes only consultants and, if deemed appropriate, senior registrars.

4. That patients who have:

    a. Re-presented to the ED with the same symptoms within a short time frame of about 72 hours; and

    b. Been referred by an ED clinician for admission

    must not be discharged until documented consultation has occurred with the referring clinician and/or the senior decision maker within the ED.

5. That a procedure be introduced allowing the referring clinician or senior decision maker within the ED to formally challenge a decision to discharge a patient who has re-presented.

545 I make the following recommendations directed to the Chief Executive Officer of the SA Ambulance Service:

Three That the SA Ambulance Service discontinue use of the term 'acopia' in all written and oral communications with hospital staff. SAAS should implement alternative descriptive terminology that accurately reflects the patient's clinical presentation without risk of influencing or narrowing subsequent diagnostic reasoning.

Four That consideration be given to the implementation of an inclusive language program.

Five That an audit of compliance with the current consumer complaints policy be undertaken to monitor compliance with recommended actions.

Condolences

546 In conclusion, I express my condolences to the Chadha family and acknowledge the attendance of Mrs Prabhleen Chadha throughout the Inquest. I also acknowledge the courage of young Mehar Chadha in attending Court to read the moving poem she had prepared about her father. This illustrated for the Court the impact of Mr Chadha's death on his family.

Sachintha Nandula Battagodage

Background

547 Sachintha Nandula Battagodage was born in Sri Lanka on 15 January 1997. He married Yeleni Perera on 25 January 2019. They emigrated to Australia in 2019, with Ms Perera arriving first, and Mr Battagodage arriving a few months after.

548 They first settled in Melbourne, before moving to Adelaide in the latter half of 2019.

549 Mr Battagodage joined a local rugby team shortly after his arrival. He had never been seriously injured while playing rugby. Further, he had no serious medical issues prior to becoming unwell in November 2020.

550 He did not have a regular treating GP since his arrival in Australia and relied on private insurance to pay for his medical expenses as he did not have access to Medicare.

551 Mr Battagodage had limited English skills causing him to rely on Ms Perera for assistance communicating outside of basic conversational English. Ms Perera herself required the assistance of an interpreter when she gave evidence.

552 Mr Battagodage became unwell on 19 November 2020. Due to the COVID-19 pandemic, Ms Perera was not permitted to attend the hospital with her husband and act as his advocate and translator. Ms Perera explained that her husband had never attended a hospital in Australia prior to November 2020.[690] He was a physically strong man, but they both lacked confidence in advocating for his care when presenting to the unfamiliar hospital environment.[691] Unfortunately, Mr Battagodage passed away four days after first becoming unwell, shortly after an outpatient chest scan at Benson Radiology. He was just 23 years of age.

553 The Inquest focussed on why Mr Battagodage was not admitted to the Royal Adelaide Hospital for investigation and treatment, despite the evidence of his wife that they attended seeking medical assistance on three occasions.

554 To assist the Court, two independent expert witnesses were engaged: senior emergency consultant, Associate Professor Holdgate and cardiothoracic surgeon, Professor Julian Smith. The Court also heard evidence from several medical practitioners involved in the care of Mr Battagodage, including Dr David Donovan, the radiologist who attempted to resuscitate Mr Battagodage at Benson Radiology, Dr Indika Hathurusinghe, general practitioner, together with the practitioners involved in the care provided at the RAH, Dr Elizabeth Gowen, Dr Jessica Thomas, Registered Nurse Andrew Oh Keum and Dr Thomas O'Connor.

Cause of death

555 A post mortem examination was performed by Dr Stephen Wills of Forensic Science SA on 1 December 2020. Dr Wills concluded that Mr Battagodage died as a result of an acute

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690 T42
691 T56

haemothorax which resulted from a rupture of a pseudoaneurysm of the right subclavian artery.

556 Dr Donovan told the Court that there was no evidence of haemothorax in the scans taken at Benson Radiology on 23 November 2020. However, he surmised that after the pseudoaneurysm had ruptured, blood rapidly entered the pleural cavity resulting in the haemothorax.[692] The results of the post contrast neck and chest CT performed revealed a large right pseudoaneurysm associated with the subclavian artery measuring 52 mm x 45 mm x 89 mm, and regional haemorrhage in the adjacent lung. The central enhancing component of the pseudoaneurysm measured 65 mm x 28 mm x 37 mm. The sac of the pseudoaneurysm was identified at autopsy which communicated with a perforating defect in the inferior aspect of the right subclavian artery.[693] The radiological imaging taken just prior to death along with the autopsy findings establish with a high degree of certainty that the cause of Mr Battagodage's death was as given by Dr Wills: acute haemothorax resulting from rupture of a pseudoaneurysm of the right subclavian artery. The cause of the pseudoaneurysm is, however, less certain.

557 Based on Dr Wills' examination and conclusion, as supported by Dr Donovan's evidence, I find that Mr Battagodage's cause of death was acute haemothorax due to a ruptured pseudoaneurysm of the right subclavian artery.[694]

558 Dr Wills, Dr Moffatt, Dr Donovan and Professor Smith[695] agreed that it was more likely that Mr Battagodage's pseudoaneurysm was caused by an inflammatory or infective origin, rather than trauma.

559 It was suggested to Ms Perera during oral evidence that Mr Battagodage told Dr Donovan that he had been injured while playing rugby a week prior to him beginning to cough up blood. She stated that it was normal for her husband to be tackled during rugby, and that he was not bruised or in any pain following the tackle.[696] He did not report any injury to the practitioners involved in his care.

560 Ms Perera recalled that during the consultation with Dr Donovan on 23 November 2020, they were both wondering why he was coughing up blood. She said it was likely Mr Battagodage raised it with Dr Donovan in case it might have been relevant to what he had seen on the images.[697]

561 In his radiology report, Dr Donovan opined that trauma would seem the most likely cause of the pseudoaneurysm.[698] He clarified in oral evidence that he was influenced by the information provided to him that Mr Battagodage had suffered a minor injury to the right shoulder. However, upon reflection, he observed that there was no identifiable injury to the rib or clavicle, indicating insufficient severity to cause a pseudoaneurysm.[699] Dr Donovan stated that there was no evidence of bone destruction, erosion, or any

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692 Exhibit C26, p15
693 Exhibit C2a, p3
694 See Exhibit C2a – Report of Dr Willis dated 10 February 2022
695 T1952
696 T195-6
697 T195
698 Exhibit C12, p1
699 Exhibit C26, p15

evidence of trauma on any of the scans taken of Mr Battagodage.[700] Dr Donovan believed that the pseudoaneurysm was of an inflammatory or infective origin. This view was based in part on the post mortem histology samples taken from Mr Battagodage, and the presence of granulomas.[701] He did not have this information at the time of drafting his radiology report.

562 Dr Wills also noted that post mortem imaging did not reveal any indication of an associated rib or clavicular fracture and the overlying soft tissue appeared unremarkable.[702]

563 Associate Professor Holdgate also explained that very significant trauma would be necessary to cause an injury resulting in a pseudoaneurysm of the right subclavian artery. This is because the vessel is so well protected by the surrounding structures.[703] She postulated that if there had been an inflammatory process occurring at that time causing weakness in the blood vessel wall, that may have made it easier to injure with relatively minor trauma. However, she warned that this was postulation as the condition was very rare.[704]

564 Dr Wills noted the presence of multiple noncaseating granuloma within the lungs and the liver but did not identify any organisms using histochemical stains.[705] Accordingly, he sought a second opinion from Dr David Moffatt, consultant anatomical pathologist. Dr Moffatt reported that he also favoured an infective cause of the pseudoaneurysm despite the absence of an identifiable infecting organism.[706]

565 Associate Professor Holdgate identified the most likely infective cause for the pseudoaneurysm as tuberculosis,[707] followed by a fungal infection as the second most likely.[708] Other possible causes were rare diseases such as leprosy.[709] She postulated that TB could have weakened the wall of the blood vessel making it more prone to injury via relatively minor trauma. Unfortunately, the result of the TB PCR performed at autopsy was invalid.[710] No testing for TB was performed at the RAH. Professor Smith did not believe that TB played a part in the cause of the pseudoaneurysm.[711]

566 In conclusion, the evidence overwhelmingly favoured an infective cause of the pseudoaneurysm. Further, given Mr Battagodage's place of birth, TB was a possible infective cause.[712] However, the evidence was insufficient to support a finding that Mr Battagodage had TB.

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[700] T280
[701] Exhibit C26, p15
[702] Exhibit C2a, p8
[703] T1357
[704] T1368
[705] Exhibit C2a, p3
[706] Exhibit C2a, p10: Second opinion of Dr David Moffatt
[707] TB
[708] T1358-9
[709] T1358
[710] Exhibit C2a, p3
[711] T1951-2
[712] It is noted that Mr Battagodage reported to Nurse Keum that he was uncertain as to whether he had been screened for TB upon entry to Australia when he arrived two years prior: Exhibit C14, p28

Circumstances leading to the death of Mr Battagodage

19 November 2020

567 Ms Perera saw Mr Battagodage begin to cough up blood at about 8 pm on Friday 19 November 2020. She was in the kitchen pantry while he was taking a phone call on the veranda when he began to cough.[713] It was not the sound of a normal cough but sounded like a cough that would precede vomiting.[714]

568 Mr Battagodage retrieved Ms Perera to observe what he had coughed up. She saw phlegm with blood intermixed. She described it as like a vomit, but with a little bit of phlegm with black blood. She had never seen anything like it and was scared.[715]

569 Being limited in his ability to speak English, Mr Battagodage used his mobile telephone to photograph the blood as he thought that this would be the best way to describe what had occurred to a doctor.[716] Six photographs were located on Mr Battagodage's mobile telephone which were taken on 19 November 2020.[717]

570 Mr Battagodage called the Blair Athol Clinic, having been informed by a friend that there was a doctor at that clinic who would be on duty. That doctor was Dr Kandasamy. The consultation took place on speakerphone, with Ms Perera present. It was conducted with all participants speaking in Sinhalese.[718]

571 Mr Battagodage explained his symptoms to Dr Kandasamy who directed him to attend the RAH ED immediately. Mr Battagodage followed this advice. He did not send the photos he had taken to Dr Kandasamy.

The first visit to the RAH

572 The medical records from the RAH indicate that Mr Battagodage arrived at the ED waiting room and was seen by the triage nurse at around 10:09 pm.[719] Ms Perera lined up inside with her husband but was not permitted to go further due to restrictions in place at that time due to the evolving COVID-19 pandemic. She had concerns regarding her husband's ability to explain his symptoms to the doctors and to relay the information back to her afterwards.[720] She felt she would have been able to provide the doctor with a better explanation about what had occurred and better placed to understand the feedback from the doctor.[721]

573 Before her husband left, she told him to show the photographs to the doctor.[722] When he returned, he said that he had done so.[723] However, as Ms Perera acknowledged in her affidavit, while she believed the photographs were shown by her husband to hospital staff

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713 Her initial evidence was that he was in the corridor, and she was in the kitchen - this was later clarified at T43
714 T44
715 Ibid
716 T44
717 Exhibit C27d
718 T43
719 Dr Gowen told the Court that this time would reflect the first time he presented to clerical staff: T100
720 T47
721 T47
722 T51
723 T48

on 19 November 2020, she was not there when it happened.[724] Ms Perera recalled that when her husband returned he said to her that while they were scared by looking at the photographs:

> They (the hospital staff) didn't take it as something serious, they did not think much about it, except that they said for the pain to take Panadol. That's what we understood…He didn't think they took it seriously.[725]

574 Ms Perera told the Court that because there was blood, they were under the impression that the hospital should have taken an x-ray or a scan.[726] She considered it doubtful that her husband would have asked for the x-ray to be performed as it was his first time in a hospital in Australia. They did not know the rules and procedures, and they were scared. She thought that he would not have asked for anything and would have gone with whatever they were saying.[727]

575 The RAH records indicated that Mr Battagodage was assessed by the triage nurse at 10:09 pm who listed the chief complaint was '*Resp Haemoptysis*'. He was assigned an Australasian Triage Scale category of 3.[728] The notes recorded at 10:16 pm included the following information:

> Onset 2100 sudden onset cough, with haemoptysis, 5-6 times. Onset R sided non radiating CP at this time. Nil change in dee expiration, CP moderate. Nil Hx of similar. Hx/meds nil. States breathing normal. Social smoker. Not distressed at triage. RR 18.[729]

576 At 10:31 pm, a registered nurse made the following addition to the notes:

> Onset of dry cough today. Haemoptysis this evening. (R) sided non radiated chest pain only when coughing. Mild. Nil significant PMHX.

577 The problem list section of the notes included a question regarding overseas travel in the last 12 months. This was answered in the negative.[730]

578 Mr Battagodage was seen by Dr Elizabeth Gowen between 10:31 pm and 10:48 pm.

579 Dr Gowen was the emergency registrar. At the time he had been a qualified medical practitioner for six years.[731] She was subject to supervision by an emergency consultant between 8 am and midnight each day. If she required assistance between midnight and 8 am, she could telephone the emergency consultant on-call. She would have been the most senior doctor within the ED between the hours of midnight and 8 am. The consultant would have been expected to supervise the more junior doctors.[732] She was awarded her fellowship of Emergency Medicine in June 2022.

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724 Exhibit C27a, p2
725 T52-3
726 T53
727 T55-6
728 This indicates that the maximum wait time should be within 30 minutes. I note that Dr Gowen's evidence that this was a 60 or 90 minute target time was incorrect: T102. Associate Professor Holdgate agreed that this was the appropriate triage category: T1384.
729 Exhibit C18, p60
730 Exhibit C14, p61 - Mr Battagodage arrived in Australia in June/July 2019
731 T96
732 T97

580 Dr Gowen stated that Mr Battagodage's case had stuck with her for some time. She still had some memories of him which were consistent with the medical records.[733] Dr Gowen's recollection was that there was nothing untoward in what Mr Battagodage told her, that there were no '*red flags*', and nothing that jumped out to her as atypical or unusual.[734]

The assessment

581 Dr Gowen could not recall what she would have asked Mr Battagodage in relation to his medical history but was certain that basic topics were part of her assessment.[735]

582 Dr Gowen's note of the consultation included reference to the onset of dry cough that morning, and development of small volume haemoptysis in the evening. She recorded '*describes bright red blood scantly mixed in with sputum*'. Her note also referred to central chest pain developing after several hours of coughing. He reported a feeling of tightness or pain in his chest when he coughed.[736]

583 Dr Gowen noted the absence of sick contacts, chills or rigors, and no epidemiological risk factors for COVID-19.

584 Dr Gowen could not recall the exact words Mr Battagodage had used to describe his haemoptysis, but her impression was that there was not a lot of blood, just little bits mixed in with sputum.[737]

585 In terms of the volume of the haemoptysis, Dr Gowen's note referred to '*small volume*'. However, in evidence she referred to the volume as being '*very small*'. She could not say which was correct.[738]

586 Dr Gowen was certain that she did not see Mr Battagodage cough up blood during her consultation.[739]

587 At the time of her consultation, Dr Gowen was not informed that Mr Battagodage had sustained a knock or a hit while playing rugby. She could not recall if it was because she did not ask a specific question about it, or if it was because Mr Battagodage did not volunteer the information.[740]

588 When asked if haemoptysis was clinically concerning in a 23-year-old man, Dr Gowen stated that very small volume haemoptysis in a man with no previous medical history would not be particularly concerning. There were a huge number of factors to take into consideration before making the decision whether or not to be concerned about it, such as whether there was the absence of sputum, or if the volume had been increasing.[741] She was reassured by the description of blood being mixed in with sputum.[742]

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[733] T99
[734] T104
[735] T106
[736] T107
[737] T107
[738] T142
[739] T110
[740] T110
[741] T110-11
[742] T111

589 Dr Gowen's goal was to ensure it was safe for Mr Battagodage to leave the hospital, not necessarily to provide him with a diagnosis. She explained:

> We don't always have to find a diagnosis, but we have to make sure that we have considered whether or not we have excluded things that may kill them in the near future essentially.[743]

590 She explained further that:

> ...everyone in medicine has a slightly different personal risk approach, everyone has a slightly different personal risk acceptance level, kind of everyone's happy to accept different levels of risk. Some people would – the, the impression that I got from the debrief was that the consultant I spoke to might have done a chest x-ray but equally he wasn't saying I was wrong for having not done a chest x-ray. It's just a different personal approach. He accepted my reasons why I hadn't performed it as appropriate, and he was happy with that.[744]

591 It is not apparent that this fatal case caused Dr Gowen to adjust her personal risk level.

592 Dr Gowen was unsure if she knew that Mr Battagodage was born in Sri Lanka and said that this information would not necessarily be provided to her.[745] She determined that he was experiencing a 1 out of 10 for chest pain, that he had not been in contact with anybody openly infectious and ruled out a pulmonary embolus having been caused by prolonged immobilisation through the history given and examining his calves.[746] She could not hear any abnormal sounds by listening to Mr Battagodage's lungs using a stethoscope.

593 Dr Gowen was unable to rule out the possibility of pulmonary embolis given Mr Battagodage's presenting complaint.[747] However, she determined that he had no other features, signs, or risks for having a pulmonary embolism.[748] She did not order a chest x-ray as it her feeling was that the patient had very benign symptoms of very short duration. This impression was clearly conveyed to Mr Battagodage, who relayed to his wife, namely that the staff did not share their concern about the symptoms.

594 Dr Gowen viewed the presence of blood in his sputum as a '*very common thing*'.[749] When asked if it was difficult to arrange for a chest x-ray at that time she agreed, although it was significant that she did not volunteer this difficulty as a factor she considered when deciding not to order an x-ray.[750] She told the Court that it took longer to arrange for an x-ray at this time due to the need to sterilise the room and use PPE.[751]

595 Dr Gowen's impression was that the source of the blood was likely a microscopic tear in the mucosa caused by coughing,[752] therefore further investigation would not add anything to the clinical picture that she had not already covered with her examination. She agreed

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[743] T112
[744] T166
[745] T113
[746] T116
[747] T117
[748] Associate Professor Holdgate was not critical of this decision
[749] T118
[750] T120
[751] T120
[752] T137

that it was not common for a person who had developed a cough in the morning to be experiencing haemoptysis by the evening but said that '*it does happen*'.[753]

596 She did not conduct an oropharyngeal examination as she had the impression that the blood was not coming from inside his mouth and was likely to be further down and therefore not visible on oropharyngeal examination.[754]

597 In her note, she recorded '*likely viral cough resulting in haemoptysis*'. She reached that view because she thought that there was an acute inflammatory cause of his haemoptysis, that the inflammatory cause was likely an infection, and that the infection was likely a virus. She thought that this was a '*non-sinister*' cause of the symptoms.[755]

598 Dr Gowen did not believe that a COVID-19 test was performed.[756] However, she recommended that given the presence of COVID-19, Mr Battagodage attend a COVID-19 clinic to exclude the possibility of it, and that he follow-up with his local treating GP in two days if he found his symptoms persisting.

599 She stated that it was likely she discussed '*safety netting*' with him and gave him the advice to see his GP if his symptoms were not getting worse but also not getting better. In her note, under the heading '*plan*', she recorded '*advised that if bleeding worsening – coughing up blood without any sputum involvement – patient should return to emergency for further review*'.[757]

600 Dr Gowen's usual practice would be to conduct her assessment, write her notes, and then print a copy of the notes to be given to the patient. While she could not definitively recall whether she had done this for Mr Battagodage,[758] the notes indicate that she did.[759] Ms Perera believed she had been provided with a discharge letter.[760]

601 Dr Gowen recalled that she had a '*kind of corridor discussion*' with her consultant about Mr Battagodage, reporting '*I've seen this guy who's got very mild haemoptysis, I'm not too concerned about him, I'm going to get him home again*'.[761] There was no note of this conversation.

The photographs marked exhibit C27d

602 Dr Gowen stated that Mr Battagodage did not show her any photos.[762] She was shown the photographs marked exhibit C27d and told the Court that the first time she had seen them was the previous evening in preparation for court.[763]

603 She described the photographs as depicting small scale haemoptysis. She told the Court that she would probably not say the haemoptysis was '*scant*'.

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[753] T136
[754] T121
[755] T122
[756] T121
[757] Exhibit C14, p63
[758] T125
[759] Exhibit C14, p63
[760] T202
[761] T122
[762] T108
[763] T108

604 Dr Gowen was asked whether seeing the photographs would have led her to conduct further investigations on 19 November 2020. Her response was '*Yeah, I think I probably would have, to be honest*',[764] but added the caveat that hindsight bias made it difficult to say. She stated that if she had seen the photos, she likely would have ordered a chest x-ray to look for a cause of the bleeding (either in the ED or privately).[765] The blood depicted in the photos was a bit brighter than she had imagined, and that it was moving towards what she would describe as '*frank blood*'.[766] She would expect haemoptysis caused by tiny mucosal tears to be a little bit darker than what she could see in the photographs.[767] She agreed that the photographs probably tended against her diagnosis of haemoptysis caused by a viral cough.[768]

605 She told the Court that she would have recalled seeing the photographs because they would have helped and a '*picture paints a thousand words*'.[769] It was her experience that nursing staff would usually record if a patient has presented photographs in their triage note.[770] She would not expect the nurse to tell her personally.[771]

606 I accept that Dr Gowen probably did not see the photographs. However, it does not necessarily follow that Mr Battagodage did not show them to other staff at the hospital. Ms Perera's evidence was that Mr Battagodage reported to her that he had shown the photographs while at the hospital on 19 November 2020. It is feasible that Mr Battagodage may have shown the photographs to a staff member at the hospital other than Dr Gowen, but this person did not record the information. This would not be surprising as the photographs may not have been considered alarming, particularly when viewed on a mobile telephone.

English as a second language

607 Dr Gowen agreed it was clear to her English was not Mr Battagodage's first language. There were times where she needed to either speak slowly or choose a different word.[772] Despite this, she felt like they were able to have a conversation and he could provide information to an appropriate level.[773] Interpreter services were available at the RAH, but Dr Gowen could not recall whether she considered using one.[774] He was able to give information beyond simply saying '*yes*' or '*no*' and was able to speak in complete sentences at an appropriate level that she felt she was able to obtain relevant information from him.[775] However, she did note that he did not volunteer a lot of information other than what she asked.[776] It was not common for her to take a clinical history from a patient who is not fluent in English.[777]

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[764] T146
[765] T147, 150 - Later in her evidence she acknowledged hindsight bias, and stated that she could not definitively guarantee whether the photos would have caused her to direct an x-ray be performed, given the difficulties with access due to COVID-19 restrictions: T172-3
[766] T156
[767] T157
[768] T158
[769] T142
[770] T142
[771] T151
[772] T132
[773] T132
[774] T132
[775] T132
[776] T105
[777] T131

608 She read the notes of the triage nurse before seeing Mr Battagodage. However, the triage nurse had noted '*onset 2100 sudden onset cough, with haemoptysis, 5-6 times*',[778] which conflicted with her note '*onset of dry cough this morning*'.[779] It appeared that she was unaware of this inconsistency. She was also taken to a further inconsistency between her note and the note of the triage nurse relating to the location and severity of the chest pain.[780]

609 However, she believed that this did not necessarily indicate that Mr Battagodage was struggling to communicate accurate information to the hospital staff but accepted that this was a possibility.[781]

610 In her note, Dr Gowen described the haemoptysis as '*bright red blood scantly mixed in with sputum*'. Upon viewing the photographs of the haemoptysis in Court, she accepted that her mental image of what Mr Battagodage was trying to describe was different to that depicted in the photographs.[782]

611 It is significant that Dr Kandasamy recorded in his notes of his consultation with Mr Battagodage on 19 November 2020 (which occurred in Sinhalese) that the patient described his haemoptysis as a '*fairly significant amount of fresh blood*'.[783]

612 This indicates to me that Mr Battagodage was a vulnerable patient given his limited ability to speak English. This was made worse due to the lack of an interpreter being made available to assist him, his naivety to the hospital system in Australia, and cultural factors which likely deterred him from questioning medical practitioners.[784] A near enough description of the blood Mr Battagodage was expectorating was not satisfactory, given the significance of the colour, volume and consistency of the blood in terms of categorising the symptom as benign or potentially life-threatening.

613 I find Dr Gowen was falsely comforted by an inaccurate description of the haemoptysis which led to an erroneous assessment of the gravity of this symptom, and consequently, a failure to investigate the cause. Had Mr Battagodage had the benefit of an interpreter, he may have mentioned the photographs he had on his phone, assuming he had not done so, as they were the best evidence of his haemoptysis. Alternatively, he may have provided a more detailed and accurate description of his haemoptysis, including that it was a fairly significant amount of fresh blood. Further, if Ms Perera had been contacted to provide information, she may have referred to the photographs, given their significance was clearly apparent to her.

614 Ultimately, Mr Battagodage was discharged from the hospital at 10:56 pm. Dr Gowen could not recall whether she provided Mr Battagodage with a copy of her notes or a

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778 Exhibit C14, p60
779 Exhibit C14, p63
780 Dr Gowen recorded that the chest pain was central chest pain, whereas the nurse recorded right-sided chest pain: T137. The nurse recorded more moderate chest pain, in contrast with Dr Gowen's score of 1/10: T140.
781 T139
782 T174
783 Exhibit C15, p1
784 T244, see also T1422 (Holdgate)

discharge summary.[785] She denied that there was impetus to raise her usual threshold for admission due to the COVID-19 pandemic.[786]

Independent expert opinions regarding the treatment of Mr Battagodage at the RAH on 19 November 2020

615 The Court heard evidence from Associate Professor Anna Holdgate and Professor Julian Smith in relation to the standard of care provided during this presentation.[787]

616 Associate Professor Holdgate is currently a senior staff specialist in the Department of Emergency Medicine at the Liverpool Hospital in Sydney.

617 She has been a Fellow of the Australasian College of Emergency Medicine for over 20 years. She commenced practising as a medical practitioner in 1985 and attained a Master's degree in health law and medicine, focussing on clinical epidemiology. In addition to her ongoing clinical practice, Associate Professor Holdgate is a conjoint Associate Professor at the University of New South Wales, a Hearing member of the Health Professional Councils Authority, and practitioner member of the NSW Medical Council Orange Committee. She publishes extensively in peer reviewed journals and has been a senior examiner for the Australasian College of Emergency Medicine Court of Examiners since 2011.[788]

618 Professor Smith obtained a Bachelor of Medicine in 1981, Master of Surgery in 1986 and Master of Surgical Education in 2015. As a junior doctor he worked in the field of emergency medicine.[789] He obtained his fellowship in General Surgery in 1989, and his fellowship in Cardiothoracic Surgery in 1992. He currently works at Monash Health in the Victorian Heart Hospital, having previously been the Head of Department of Cardiothoracic Surgery at Monash Health up until 2023. He also practised at Stanford University in California and Papworth Hospital in the United Kingdom specialising in heart and lung transplantation.

619 In addition to this, Professor Smith is also the editor-in-chief of the Australian and New Zealand Journal of Surgery. This requires him to stay abreast of developments in the field of cardiothoracic surgery, as well as developments in other surgical specialties including vascular surgery.[790] He is the author of a book chapter on the topic of haemoptysis in the '*Textbook of Surgery*',[791] a publication of which he is an editor. His experience is extensive as evidenced by his curriculum vitae.[792]

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785 T125
786 T135
787 It is noted that the Court also received into evidence the report of the late Dr Jacob Goldstein AM, cardiothoracic surgeon (Exhibit C7). However, as the report was not based upon all relevant evidence before this Court, reliance is not placed upon the conclusions reached therein insofar as they relate to the conduct of the practitioners involved. Dr Goldstein's opinion regarding the gravity of the symptom of haemoptysis, particularly in a healthy young man, is relied upon. Further, his views in relation to preventability are also relied upon. It is noted that his views on this topic are in accord with the views of Professor Smith in any event.
788 Exhibit C37
789 T1922
790 T1907-8
791 T1943
792 Exhibit C46

620 In her report, Associate Professor Holdgate opined that the care provided to Mr Battagodage on 19 November 2020 was below the expected standard. She made the following criticisms:

a. The examination was incomplete in that an oropharyngeal examination was not performed;

b. There was a failure to consider differential diagnoses such as tuberculosis in a patient who was at higher risk of this illness;

c. The diagnosis of viral illness was not supported by the documented findings on history or examination; and

d. A chest x-ray should have been performed and Mr Battagodage should not have been discharged until this had been done.[793]

Oropharyngeal examination

621 Dr Gowen did not accept that she ought to have conducted an oropharyngeal examination as the chance of it adding anything was of very little value.[794] She did not expect that this would have assisted in identifying the source of the bleeding[795] and, in her view, examination of the oropharynx in a person with haemoptysis would not be a standard procedure.[796]

622 Associate Professor Holdgate disagreed. She believed that the standard approach starts with examining as much of the airway as you can see, which includes an examination of the mouth. To her, if the cause of the haemoptysis was a minor mucosal tear in the back of the throat, it may be obvious on examination.[797]

623 However, Associate Professor Holdgate told the Court that the failure to conduct this examination did not impact upon her assessment of Mr Battagodage[798] or the ultimate outcome. She was also perplexed as to why a COVID-19 test was not performed on this occasion but did not suggest that this was a causative factor in the death of Mr Battagodage.[799]

Tuberculosis

624 Dr Gowen did not entirely accept that she ought to have asked Mr Battagodage how long he had been in Australia and whether he had a family history of TB, despite this having been raised with her by the Director of Emergency Medicine after the death of Mr Battagodage.

625 However, it was her evidence that she would like to think that if she had known Mr Battagodage was from Sri Lanka, this may have made it more likely that she would

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[793] Exhibit C37a, p6
[794] T162
[795] T163
[796] T162
[797] T1370
[798] T1370
[799] T1371

have considered this diagnosis.[800] She said that this information was not readily available to her on Sunrise EMR, the electronic medical records system utilised by the RAH.

626 Associate Professor Holdgate regarded Dr Gowen's failure to enquire about the possibility of TB as a '*fairly significant oversight*' as the presence of active haemoptysis could have suggested Mr Battagodage was highly infectious.[801] I find that this omission was significant from a public safety perspective, particularly in the context of Mr Battagodage's employment as a courier and Uber Eats driver.

627 In addition to the opinion of Associate Professor Holdgate, I considered the opinion of general practitioner, Dr Hathurusinghe on this topic. Dr Hathurusinghe, upon hearing from Ms Perera that Mr Battagodage was experiencing haemoptysis, immediately turned his mind to pulmonary TB,[802] no doubt due to his increased awareness of this condition.

628 In terms of the impact of this oversight on the outcome, it cannot be determined with absolute certainty that Mr Battagodage had TB, and if he did, whether this was the cause of his pseudoaneurysm.

629 However, the failure to consider TB may have impacted upon the outcome for Mr Battagodage. Associate Professor Holdgate opined if Dr Gowen considered TB, she may have been better prompted to perform a chest x-ray[803] on the basis that if a patient did have TB and active haemoptysis, that would often suggest they were highly infectious. This was disputed by Dr Gowen, who stated that even in hindsight, consideration of TB would not have changed her management of Mr Battagodage in any way or made it more likely she would have ordered a chest x-ray to occur in the ED. However, she did say that she may have performed a blood test and sent him home for follow-up with his GP for an x-ray.[804]

630 It was submitted that it was highly unlikely that in the circumstances of the COVID-19 pandemic that Dr Gowen would have taken such an approach if she considered TB as a differential diagnosis. I find that the failure to consider TB by Dr Gowen, and the subsequent omission to order an x-ray, was a missed opportunity to prevent the death of Mr Battagodage.

631 However, even accepting Dr Gowen's evidence on this topic, this omission in the history taking may not have influenced the outcome for Mr Battagodage as it is unlikely that an x-ray arranged by a GP would have been performed prior to 21 November 2020, particularly in the absence of a negative COVID-19 test.

632 In the end, the most significant factor was the misdiagnosis of viral cough causing haemoptysis and the subsequent failure to adequately investigate the cause of the haemoptysis.

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[800] T169
[801] T1368
[802] T239
[803] See: T1368-9 for explanation of diagnosis of TB
[804] T160-1

The diagnosis of 'viral cough'

633 Dr Gowen maintained that her diagnosis of '*likely viral cough resulting in haemoptysis*' was reasonable. She explained this was the most likely cause of the haemoptysis given the absence of other symptoms.[805] She remarked that she would '*really love to know*' what Associate Professor Holdgate would say about what the alternative diagnoses were for Mr Battagodage's presentation.[806] She did not accept that she ought to have conducted further investigations to determine the cause of the haemoptysis, despite the outcome and having prepared a presentation of the causes of haemoptysis with Dr Thomas as part of the review.[807]

634 Associate Professor Holdgate responded to this challenge as follows:

> I think this is really a key question, that there weren't really any alternatives. There was no explanation for his symptoms and I think for that reason, that's the argument why more investigation should have been done because there was not really any explanation for why he had haemoptysis. He's a healthy young man with no infective symptoms, who's come in coughing up, albeit a small amount, of bright red blood, with no reason to explain it and in a patient who's at increased risk for tuberculosis. So my argument would be, well there was no explanation why he had haemoptysis. It's a significant symptom and it shouldn't be ignored and therefore there were reasons for at least some basic investigations such as a chest x-ray.[808]

635 Associate Professor Holdgate disagreed with Dr Gowen's assertion that haemoptysis present in the context of a cough was a common occurrence with mild chest infections. She believed it is more commonly associated with serious chest infections like pneumonia.[809] She explained that for an acute chest infection to cause haemoptysis, it has to have acute symptoms associated with it, and it is quite an unusual presenting symptom particularly in an otherwise healthy young man.[810]

636 I find the logic of Associate Professor Holdgate's evidence on this topic compelling. There were no upper respiratory tract symptoms such as runny nose or fever, or any other symptoms in support of a viral cause. He reported no sick contacts. Dr Gowen's explanation that '*common things occur commonly*'[811] suggested that she looked for a common cause for Mr Battagodage's symptoms and attributed one to his presentation even though it was unsupported by the evidence. Associate Professor Holdgate did not agree that this phrase was a guidance in the field of emergency medicine.[812] She explained that it is the duty of the doctor to take an adequate history and perform an adequate examination, rather than to simply attribute a common cause to a symptom.[813] Further, Associate Professor Holdgate disagreed with the suggestion that viral coughs very often cause haemoptysis, or that they are the most common cause of haemoptysis.[814] She was

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[805] T164
[806] T165
[807] T165
[808] T1372
[809] T1355
[810] T1677-8
[811] T165
[812] T1679
[813] T1679
[814] T1679

adamant that it was not reasonable to attribute Mr Battagodage's haemoptysis to a viral cough.[815]

The failure to order an x-ray

637 I am driven to find that Dr Gowen's failure to direct any investigations into the cause of Mr Battagodage's haemoptysis was a serious error caused by her underappreciation of the significance of the symptom. The failure to perform an x-ray was identified as an error by the authors of the local team-based review conducted by the Central Adelaide Local Health Network,[816] Associate Professor Holdgate, Professor Smith and Dr Hathurusinghe. The local team-based review report concluded that a chest x-ray would have shown abnormalities which would have prompted further investigation on 19 November 2020. This was also the opinion of Professor Smith, discussed further below.

638 When taken to Associate Professor Holdgate's observation that it is very unusual for a mild viral illness to cause haemoptysis in an otherwise well young man, Dr Gowen responded:

> It's not necessarily common but it's not rare. So we do see it happening, it doesn't, you know, it's not the standard for most people to develop haemoptysis when they have a mild viral infection, but we see the spectrum in ED, we see the spectrum of people who have turned up because it has developed and it's not entirely infrequent for it to occur, in my experience at least.[817]

639 Associate Professor Holdgate's experience differed from Dr Gowen's. She expressed that haemoptysis is '*actually a very rare, uncommon presenting problem and always raises concerns for a serious diagnosis*'. Associate Professor Holdgate was adamant that a chest x-ray was indicated based on the information available to Dr Gowen on the day as it is a standard part of a workup of a patient with haemoptysis, and there are a wide range of differential diagnoses, many of which will be apparent on x-ray. She rejected the assertion that a viral illness could be attributed as the cause in these circumstances.[818]

640 Professor Julian Smith, cardiothoracic surgeon, also believed he would not consider the symptoms reported to Dr Gowen to be benign. He would be concerned by a young, previously healthy young man coughing up blood mixed with his sputum.[819] He explained that as the patient described bright red blood, and 5-6 episodes of haemoptysis,[820] this would be a real concern as it would suggest that there is some significant active bleeding occurring. He believed that a chest x-ray should have been performed at a minimum as the very significant symptom of haemoptysis was not explained.[821] He maintained that despite the difficulties caused by the pandemic at this time:

> There is a young patient who is coughing up blood and there is no apparent cause for it and I think the time should have been expended to at least perform a chest x-ray. A chest x-ray

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815 T1679-80
816 Exhibit C18, p2 'CALHN'
817 T159
818 T1683
819 T1921
820 T1957-8
821 Exhibit C46a; T1920

> is a simple non-invasive relatively cheap investigation and a very useful screen tool for someone with haemoptysis.[822]

641 Dr David Donovan stated that when he reviewed the image request form, the information that immediately caught his attention was the combination of a mass on radiological imaging with acute haemoptysis and shortness of breath, as this was a very unusual presentation in a young and previously healthy patient.[823]

642 Dr Hathurusinghe also believed that at the very least a chest x-ray should have been completed on 19 November 2020, if not a CTPA contrast scan of the pulmonary artery and a CT of the chest.[824] He noted that this should have been done in the ED as this was a weekend and most outpatient radiology services were closed.[825] While Dr Hathurusinghe was not working within the ED environment during November 2020, he does have significant experience working within an ED setting[826] prior to commencing his practice as a GP. Accordingly, I believe his medical opinion as to the appropriate management of Mr Battagodage remains relevant.

643 Dr Gowen's evidence in relation to her experience of the frequency of haemoptysis within the ED was clearly at odds with the more extensive experience of Associate Professor Holdgate. However, it is submitted that the crux of the issue in relation to this presentation was Dr Gowen's failure to appreciate the *significance* of this symptom, contributed to in part by her misunderstanding in relation to the volume and colour of the haemoptysis.

644 I accept the combined weight of the evidence of Associate Professor Holdgate, Professor Julian Smith, Dr Goldstein and Dr Hathurusinghe in relation to the significance of the symptom of haemoptysis as compelling. I prefer it to the evidence of Dr Gowen. Dr Gowen clearly underestimated the significance of this symptom at the time of the consultation, and her evidence demonstrated she continued to underestimate its significance, despite the grave outcome and the review that followed.

645 Her failure to accept that she ought to have ordered an x-ray given the circumstances known to her at the time suggests that there is a need for further education amongst staff at the RAH in relation to management of haemoptysis.

646 I find Dr Gowen failed to appreciate the clinical significance of Mr Battagodage's haemoptysis and attributed his presentation to a benign cause without adequate investigation. I have made the finding considering the principles of *Briginshaw*.

647 I note Dr Gowen did not proffer the COVID-19 pandemic as a factor in her decisions.[827] Further, I note when Dr Thomas ordered an x-ray two days later at 4:23 pm, the results were received at 6:03 pm,[828] despite the need for COVID-19 precautions. As an aside,

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[822] T1921-2
[823] Exhibit C26, p6
[824] T245
[825] T245
[826] Exhibit C29, p1
[827] T160-1
[828] Exhibit C13

Associate Professor Holdgate told the Court that she would consider this to be a miracle in her ED.[829]

648 I find that an x-ray should have been performed based on the information available to Dr Gowen on 19 November 2020.[830] Therefore, Mr Battagodage ought not to have been discharged until it had been done.

Likelihood of detection of the mass via x-ray on 19 November 2020

649 In her report, Associate Professor Holdgate stated that if an x-ray had been performed on 19 November 2020, it would '*almost certainly*' have demonstrated the right upper lobe abnormality.[831] However, in oral evidence, she reflected on the increase in the size of the pseudoaneurysm between 21 and 23 November 2020 and revised her opinion on the likelihood of the pseudoaneurysm being detected by x-ray on 19 November 2020 to '*more likely than not*'.[832]

650 Given the potential significance of this issue, an expert report was sought from Professor Julian Smith. Even accepting he is a cardiothoracic surgeon, not a radiologist, Professor Smith reviews radiological images on a daily basis. It is part of the training of a cardiothoracic surgeon to interpret radiological images. He acknowledged his speciality does not require a higher qualification in radiology, they have '*deep experience in looking particularly at chest x-rays, CT scans, echocardiograms and coronary angiograms either done via CT or formal coronary angiography*'.[833] Professor Smith said he would be referred a patient with a diagnosis of an aneurysm every week or two. This was usually of the aorta. His expertise would usually be sought regarding optimal management of the aneurysm or pseudoaneurysm, particularly surrounding surgical management.[834]

651 Professor Smith explained that management interventions were usually either surgery or endovascular stenting, depending on the location of the pseudoaneurysm, the cause, the condition of the patient, and the experience and facilities available in a given institution. The appropriate course of action will be guided by the radiological imagery. If endovascular stenting is the better course of treatment, this would usually be done by an interventional radiologist or a vascular surgeon, or both.[835]

652 Professor Smith's ability to comment upon the availability and practicality of ordering an x-ray in the ED during this time was questioned. He appropriately conceded that in matters of emergency medicine, he would defer to the opinion of Associate Professor Holdgate given her deep experience in this area.[836] As stated, Associate Professor Holdgate's firmly held view was that an x-ray should have been ordered by Dr Gowen, even accepting that was more complex with respect to time and resources due to the COVID-19 pandemic.

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829 T1399
830 T1683
831 T1683
832 T1682
833 T1909
834 T1916
835 T1916
836 T1922

653 Following provision of his independent expert report,[837] Professor Smith was asked to consider additional materials including key video footage, the photographs marked exhibit C27d, the evidence of Drs Donovan, Gowen and O'Connor, and the affidavit of Ms Perera. These materials did not cause him to alter the opinions expressed in his report, namely:

(i) On 19 November 2020 (first presentation), Mr Battagodage should have at least had a chest x-ray **which would have**[838] revealed the right upper thorax/lower neck mass;

(ii) This should then have resulted in an immediate chest CT scan with arterial contrast which would have revealed the pseudoaneurysm of the right subclavian artery; and

(iii) Prompt admission to hospital and referral to the vascular and cardiothoracic departments at the RAH would have resulted in treatment by an endovascular approach (stenting) or by open surgical repair prior to rupture.[839]

654 In oral evidence, Professor Smith explained that the mass must have been present on 19 November 2020 as Mr Battagodage was coughing up blood because of bleeding into his airway from the lung, caused by blood leaking from the subclavian artery. This blood in the lung tissue would present as opacity on an x-ray. He opined that some abnormality would be visible.[840] Under cross-examination, he elaborated on this answer to explain that there must have been sufficient changes in the lung tissue to result in blood in the airway, which was then expectorated.[841] When it was suggested to him that his opinion as to detectability was mere speculation, his response was '*definitely not, knowing the situation where the patient is bleeding and coughing up blood, that does not occur without changes on the x-ray*'.[842]

655 In his experience, a mass of the size of 1-2 cm would be detectable on x-ray, or even smaller depending on the location of the mass.[843] While the size of the mass on 19 November 2020 cannot be known, Professor Smith explained that the fact that Mr Battagodage was bleeding suggested that there was blood in the lung tissue, which is visible radiologically. He had a high degree of certainty that an x-ray performed on 19 November 2020 would have detected the pseudoaneurysm.[844]

656 The radiological imaging established that on 21 November 2020, the pseudoaneurysm measured 39 mm x 46 mm x 54 mm.[845] By 23 November 2020, the pseudoaneurysm had increased in size to 52 mm x 45 mm x 89 mm and changed in shape.[846] However, Professor Smith stated that he could not deduce from this information the size of the pseudoaneurysm on 19 November 2020 as the rate of expansion cannot be predicted.[847]

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[837] Exhibit C46a
[838] My emphasis
[839] Exhibit C46a, p2
[840] T1919
[841] T1962
[842] Ibid
[843] T1923
[844] T1924
[845] Exhibit C12, p1
[846] Exhibit C12; Exhibit C26, p8
[847] T1925

He could only conclude that the pseudoaneurysm appeared to be consistently expanding over time.[848]

657 Professor Smith explained that if the x-ray revealed the pseudoaneurysm, which he believed with a high degree of certainty it would have, the next step would have been to perform a CT scan with arterial contrast. Following that scan, treatment options would be urgently discussed. He opined that he would have strongly advocated for an endovascular approach as it would be the quickest and easiest means of getting control. He was certain that service was available at the RAH.[849] However, he believed that surgery would also have been a possibility. He would expect that a patient could proceed to endovascular care or surgery within an hour or two, allowing for the COVID-19 related delays.

658 I accept the evidence of Professor Smith and Associate Professor Holdgate that the mass would most likely have been detected if an x-ray had been performed on 19 November 2020. Further, it is noted that the authors of the local team-based review,[850] which included SA medical imaging staff, also believed that the mass would have been visible on x-ray on 19 November 2020.

Preventability on 19 November 2020

659 Associate Professor Holdgate opined in her report that if a chest x-ray had been performed on 19 November 2020, Mr Battagodage would have had a much greater likelihood of survival. In terms of the likelihood of successful treatment, she properly deferred to the opinion of a cardiothoracic surgeon.[851]

660 Professor Smith opined that if Mr Battagodage's pseudoaneurysm had been detected and treated within the day,[852] it was highly likely he would have survived with successful radiological management. He estimated the chances of survival if an endovascular approach were undertaken as better than 95% based on his age, health and clinical stability at that time, and the documented success of endovascular stenting under fairly controlled conditions.[853] He opined that the percentage would be very similar if a surgical approach were undertaken.[854]

661 Further, it was Dr Gowen's own evidence that if she had further investigated the cause of the haemoptysis via x-ray, and the x-ray had detected the mass, further investigations would have occurred in the ED to try and clarify that mass further.[855] When shown the radiology report from 21 November 2020, she understood the radiologist to be recommending a contrast CT rather than a CTPA.[856] She opined that she would have performed the contrast CT in the ED as it was an unexpected finding. The x-ray does not provide sufficient information to determine what was the abnormal density.[857]

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848 T1925
849 T1926-7
850 Exhibit C28, p2 (A CXR would have shown abnormalities which would have prompted further investigations on 19 November 2020)
851 Exhibit C39a, p11
852 T1927 (he would expect a patient to be able to proceed from diagnosis to surgery within the day)
853 T1929
854 T1971
855 T152
856 T153
857 T154

662 Based on the experts' evidence, I find Dr Gowen ought to have ordered an x-ray to investigate the cause of the haemoptysis. Further, if she had done so, it was highly likely that the mass would have been detected, a contrast CT chest ordered, and successful intervention would have followed, preventing the death of Mr Battagodage.

Events following discharge on 19 November 2020

663 After leaving the ED, Mr Battagodage returned to Ms Perera. He told her that he had shown the photos on his phone to the doctor in the ED.

664 In her letter to the State Coroner received on 27 November 2020,[858] Ms Perera stated that after her husband returned from the ED on 19 November 2020,[859] he stated to her words to the effect of '*…[he was told to] take two Panadol and take a COVID test*'.[860] Ms Perera understood that he was to present to ED again if his symptoms worsened.

665 Ms Perera recalled asking her husband what the hospital staff thought of the photos of what he had coughed up. She recalled him saying something along the lines of '*…they didn't take it as something serious, they did not think much about it*'.[861]

666 She was under the impression that an x-ray should have been taken if there was coughing with blood, and not having any investigation done gave both her and her husband an impression that they had not taken his symptoms seriously.[862]

667 The two of them returned home between 10:30 or 11 pm.[863]

20 November 2020

668 The following day, being Friday 20 November 2020, Mr Battagodage attended work as usual. Ms Perera told the Court that he did not complain of any pain or discomfort to her on this day.[864]

669 During the day, Ms Perera telephoned Dr Hathurusinghe. The phone call took place on speakerphone with all parties conversing in Sinhalese. Dr Hathurusinghe provided an affidavit as to his recollection of this conversation.[865] He stated that he was informed by Ms Perera that Mr Battagodage had been coughing up blood for one or two days. He could not recall doing so, but Dr Hathurusinghe's usual practice would have been to query how much blood, and what it looked like. He formed an opinion based on the description by Ms Perera that the haemoptysis was primarily phlegm with some blood.

670 Ms Perera discussed with him the previous presentation to hospital and the subsequent discharge. Dr Hathurusinghe recalled that she was unhappy with the way Mr Battagodage was treated.

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858 This had been written in Sinhalese and translated into English by a friend
859 In her evidence, Ms Perera clarified that the dates in her letter should read November, not October: T51
860 T52
861 T52
862 T53
863 T54
864 T55
865 Exhibit C29

671 Dr Hathurusinghe advised that if Mr Battagodage continued to cough up blood, or if the amount of blood he was coughing up began to increase, that he needed to return to ED urgently.[866]

672 It is important to note that Dr Hathurusinghe was not a treating practitioner of Mr Battagodage, and in fact by November 2020, had not yet met Mr Battagodage. He did not consider himself in a position to make a clinical judgment about the cause of the haemoptysis, but was satisfied it was not serious, on the basis Mr Battagodage had been seen at the RAH ED the evening prior.[867] That was a fair assumption to make in the circumstances. Dr Hathurusinghe had provided his telephone number to Ms Perera at the request of a mutual Sri Lankan friend when they moved to Adelaide in case they needed his assistance.

21 November 2020

673 On Saturday 21 November 2020, Mr Battagodage was laying down on his bed after lunch when he suddenly started to cough again. He stood up and went to the toilet where he began to cough up a large amount of blood, as well as bleeding from his nose. Ms Perera described the volume as '*much more*' than what was seen on the previous occasion. She described it as without phlegm, and only being '*thick pure blood*'.[868]

674 Again, Mr Battagodage took photos of what he had coughed up.[869] Ms Perera explained that this was so that the doctor could be shown and understand his symptoms.[870] She explained that neither of them would be able to explain what they were seeing, and she thought if the photo was shown and the colour and consistency of the blood could be seen, it might help the doctor with a diagnosis.[871]

675 These photographs were taken at 3:02 pm on 21 November 2020.[872]

676 When questioned further, Ms Perera explained she thought it would be useful for a doctor to be able to compare the photos from 19 November 2020 to the photos of 21 November 2020 and see the progression of her husband's symptoms.[873] This was astute and effective.

677 Mr Battagodage also recorded a video at 3:04 pm, described during the Inquest as Video 8,[874] which depicted him coughing up blood into his bathroom sink.[875]

678 Mr Battagodage presented again to the RAH ED in accordance with the advice of Dr Gowen. Ms Perera was again unable to enter the ED with him and returned home alone.

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866 Exhibit C29, p3
867 Exhibit C29
868 T56
869 Exhibit C27c
870 T61
871 T61
872 Exhibit C34
873 T62
874 Exhibit C27f
875 Exhibit C34

The attendance at the RAH

679 Mr Battagodage first spoke with a triage nurse or administration officer at 3:32 pm on 21 November 2020. The time of triage was at 3:34 pm and the category assigned was 3. At 4:07 pm, Mr Battagodage was moved from the waiting room section into the west side of the ED into bed 2.[876] The initial nursing assessment was conducted at 4:18 pm by registered nurse Andrew Oh Keum.

680 Nurse Keum attained a Bachelor of Nursing in 2011. He had been employed by the RAH since 2012. He had been working in the ED of the RAH since 2013 and was the Clinical Nurse at the time of Mr Battagodage's presentation.

681 On 21 November 2020 his shift commenced at 1 pm and concluded at 9:30 pm. Mr Battagodage was triaged at 3:34 pm by registered nurse Debbie Bartley and seen by Nurse Keum at 4:18 pm.[877] The chief complaint was listed as '*Resp. distress/Shortness of breath*' and the initial information read:

> PATIENT PRESENTED WITH INCREASE SOB AND HAEMOPTYSIS PATIENT STATES THE SYMPTOMS STARTED THURSDAY. PATIENT CAME FROM SRI LANKA 2 YEARS AGO UNSURE IF THEY HAD A TB TESTING ADVISED ON THE LETTER TO GET A COVID TEST HAS NOT GOT ONE DONE YET.

682 After his initial assessment Nurse Keum added under the heading '*situation*' at 4:18 pm:

> Haemoptysis. Frank since yesterday. Multiple episodes. Nil meds. Nil recent surgery. Nil Lung Hx. Presented to RAH yesterday. Nil fever chills. Nil epidemiological criteria.[878]

683 Nurse Keum interpreted his note, stating that his reference to frank haemoptysis was in reference to the blood appearing to be oxygenated and fresh, rather than old blood.[879]

684 At 4:39 pm Nurse Keum entered a contemporaneous note into the hospital record[880] which he clarified still formed part of his initial assessment and was for the purpose of documenting what he had done for Mr Battagodage up to that point.[881]

685 The note stated that Mr Battagodage had shown Nurse Keum a video of '*small to moderate frank blood with sputum*'. Nurse Keum was played Video 8 in Court, identifying it as the video he likely saw which he had referenced in his contemporaneous assessment note.[882] Nurse Keum could not recall seeing the video and stated that he would not describe it was showing a small amount of blood with sputum. Rather, he would describe the video as showing moderate frank blood with sputum.[883]

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876 T422
877 Exhibit C14, p27
878 Exhibit C14, p28
879 T1857
880 Exhibit C14, p28
881 T1858
882 T1862
883 Exhibit C44, p3 at [16]-[17]

686 The letters '*SB ED MO*' appear within the note, and Nurse Keum clarified that this was shorthand for '*seen by ED medical officer*'. This was a standard note when a patient had either been seen by a doctor or was in the process of being seen by a doctor.[884]

687 Nurse Keum had no independent recollection of when he wrote the note but stated that it was likely at the time Mr Battagodage was being assessed.[885]

688 Dr Thomas was the junior emergency registrar present in the ED that evening,[886] working a 2 pm until midnight shift. She completed her medical degree at the end of 2015 and at the time of giving evidence was a trainee in the Australasian College of Emergency Medicine specialty program.

689 Dr Thomas had some recollections of Mr Battagodage's attendance.[887] She was notified of his death shortly after his presentation and she has recollected on her experience treating him. She believed that she first saw him at between 4 pm and 4:30 pm.[888]

690 She was aware Mr Battagodage had previously attended the RAH on 19 November 2020 and said she would have read the notes of Dr Gowen.[889] She had read the note of Nurse Keum which recorded '*haemoptysis frank since yesterday*', and this would have made her cautious that something significant was going on. She said she also would have looked at the vital signs' observations.[890]

691 As a doctor at registrar-level, Dr Thomas had a degree of autonomy but was supervised by consultant Dr Thomas O'Connor.[891]

692 Dr O'Connor began practising medicine in 2008 and became a fellow of the Australasian College of Emergency Medicine in 2018. In 2020 he was employed as an emergency consultant at the RAH. Part of his role was to supervise junior medical officers in their management and assessment of patients who present to the ED, including providing advice, or seeing a patient alongside the medical officer.[892] He stated that it was his role to supervise, predominantly, the doctors allocated to the area of the ED assigned to him, but that he would also be responsible for any doctors coming from another part of the ED to work in his designated area.[893]

693 Dr O'Connor stated that as his role is supervisory, he needs to be available to anyone within the area, including being contactable by phone. Therefore, he does not spend a large amount of time seeing patients himself, to keep himself available for performing other required tasks.[894] It was also one of his responsibilities to make decisions regarding

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884 T1863
885 T1864
886 T438
887 T369
888 T382
889 T370
890 T378
891 T1288
892 T1277
893 T1278
894 T1278

patient treatment and discharge in the case of junior medical officers, but not necessarily with registrars.[895]

Video 8

694 Dr Thomas said that she had not read the note of Nurse Keum, entered at 4:39 pm which read '*shown video by PT with small to moderate frank blood with sputum*'. She agreed that she possibly had access to the note. She would have liked to think its significance would have been apparent to her if she had read it and she would have viewed the video.[896] However, it was not her standard practice to read nursing notes.[897]

695 She had no recollection of being told by Nurse Keum about the video,[898] but stated that if she had read his note, it would be her practice to ask for a copy of the video. She had no recollection of seeing a video from Mr Battagodage at any point.[899]

696 Nurse Keum stated that it would not be his usual practice to inform a doctor about the kind of video that he had been shown by Mr Battagodage. He would trust the doctors to ask the questions required to prompt the patient to show the video.[900] It would be his usual practice to tell the patient to show the video to the doctor, but he had no recollection of instructing Mr Battagodage to do this.[901] He stated he may have mentioned the video to the doctor he asked to review Mr Battagodage's ECG, which he undertook given the complaint about chest pain, but he could not recall doing so.[902] Dr Thomas confirmed that her signature is not the one that appears on the ECG.[903] Dr O'Connor stated that he would have been the one to sign the ECG, which was conducted to investigate the source of Mr Battagodage's chest pain.[904] Dr O'Connor's evidence was he was aware of the existence of the video.

697 When played Video 8, Dr Thomas repeated that she had no recollection of seeing it. Further, she stated the haemoptysis in the video did not accord with the description of Nurse Keum as she could not see any sputum. Dr Thomas said that she would describe it as a video of a patient coughing frank blood with no presence of sputum.[905] To her, the presence of frank blood was significant as it suggested active bleeding. She would not describe what can be seen in the video as a small amount of blood.[906] She classified it as at least a moderate amount of blood.[907]

698 The accuracy of the description of Video 8 did not impact on the assessment by Dr Thomas as she did not read it. Therefore it could not have led her to underestimate the volume of the haemoptysis. Further, she had read Nurse Keum's earlier note which referred to the haemoptysis as '*frank*' in any event.

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[895] T1278-9
[896] T462
[897] T465
[898] T380
[899] T381
[900] T1864-5
[901] T1866
[902] T1879
[903] T472
[904] T1301
[905] T382
[906] T429
[907] T430

699 Dr Thomas said that if any member of staff saw this video and were concerned by it, she would expect them to bring it to her attention.[908] When she was shown this video in the Crown Solicitor's Office she was shocked by it. Her first thought was that if she had seen the video, she would have shown her consultant[909] and relied upon him to then redirect that patient's care. She agreed that the impact this video had upon her suggested that she had not seen it on 21 November 2020.[910] She believed that if she had seen the video, it definitely would have influenced her opinion on the care and management plan for Mr Battagodage.[911] She would have urged that he be admitted.[912] While she said that she could not be one hundred per cent certain given the passage of time, if she had viewed the video, she would have shown it to her consultant as she was a junior registrar and this was the most objective evidence of the volume and type of haemoptysis.[913]

700 Dr O'Connor recalled reading the note of Nurse Keum referring to Video 8, but did not see this video himself.[914] Dr O'Connor recalled speaking to Dr Thomas and suggesting to her that it would be useful to see the video or photos mentioned in the note as they would be informative.[915] He recalled that this advice was provided during the first conversation he had with Dr Thomas about Mr Battagodage. It was clear from his evidence that Dr Thomas should have been aware of the video's existence because they discussed it.[916]

701 In oral evidence, and having reviewed the video, Dr O'Connor stated that he would describe the volume of haemoptysis as at least moderate. He agreed with the suggestion that it was more accurately described as moderate to excessive.[917] He believed that if he, and possibly Dr Thomas, were made aware that the volume of the haemoptysis was moderate, Mr Battagodage would have remained in hospital for further investigations.[918]

702 His evidence was that he was led to believe that the volume of haemoptysis experienced by Mr Battagodage was small.[919] While the note of Nurse Keum described the volume of the haemoptysis as small to moderate, he stated that he would have placed more weight on the description provided by Dr Thomas than the note of Nurse Keum, as her training and terminology use would be different than Nurse Keum's.[920]

703 Dr O'Connor believed that if there had been a method enabling him to view the video via Mr Battagodage's electronic record, he would have viewed the video himself.[921] If he had seen the video, he would have considered it necessary for Mr Battagodage to have further imaging done while still in the hospital.[922]

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908 T427
909 T427
910 T428
911 T429
912 T465
913 T467-8
914 T1291
915 T1293
916 T1315
917 T1292, 1310 - It is noted that Professor Smith described the haemoptysis as 'massive' based on the definition in the medical literature: T1933
918 T1337
919 T1316-18
920 T1318
921 T1329
922 T1330

704 Dr Thomas was recalled in response to this unexpected evidence from Dr O'Connor. Dr Thomas could not recall Dr O'Connor telling her that it would be useful to see the video mentioned in the notes.[923] She could not say whether it was possible this conversation happened.[924] She agreed that she would have spoken with Mr Battagodage after her first conversation with Dr O'Connor, which is the time at which Dr O'Connor told the Court he mentioned the video, and therefore had the opportunity to ask Mr Battagodage to see the video. However, she did not ask about the video.[925]

705 Dr Thomas accepted that if she knew of the existence of the video, she ought to have watched it.[926] When asked to consider any impediments to following the advice of Dr O'Connor to watch the video, she said:

> It was a busy shift…there's entirely the possibility I thought he was referring to another patient…I may not have recalled the conversation with Tom, and then I saw that patient later in the shift. And, I suspect, reading through this, most of my assessment of the patient had been done prior to that conversation with Tom.[927]

706 I find that Mr Battagodage showed at least Nurse Keum a video of his haemoptysis on 21 November 2020, most likely Video 8, recorded at 3:04 pm on the day of his attendance at the RAH. At the very least, Video 8 showed moderate haemoptysis. While Nurse Keum told the Court that he would not describe the video as small to moderate, this may be the product of further experience and hindsight. Commonsense dictated that Mr Battagodage would have provided the video that he had just recorded of his haemoptysis in order to describe it to Nurse Keum, rather than a video taken at an earlier time.

707 I find that had Dr O'Connor seen the video or been provided with an accurate description of its content, Mr Battagodage would not have been discharged without further investigation.

708 It could be argued that as the note of Nurse Keum referred to '*small to moderate frank blood with sputum*' Dr O'Connor had sufficient information available to him to warrant personally reviewing the patient before discharge regardless of the information from Dr Thomas. If Dr O'Connor directed Dr Thomas' attention to the video and suggested that she watch it, I believe he was entitled to rely upon her to do so, and that she would have returned to him for further advice if the volume of the haemoptysis was not small.

709 It was not suggested to Dr O'Connor that he was untruthful or mistaken in his evidence regarding his conversation with Dr Thomas about the video.

710 I found Dr O'Connor a considered and thoughtful witness. The tragedy of the events that followed had clearly impacted upon him. I found Dr Thomas and Dr Gowen in contrast were defensive in response to questions. By way of example, when informed that the updated discharge letter had been sent to the wrong GP, Dr O'Connor was visibly saddened. There was no obligation upon him, as the consultant with oversight of an entire area within ED, to read the nursing notes, and yet he did so. If he had not volunteered that information to the Court, and simply stated that he relied upon what his registrar had told

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923 T1842
924 Ibid
925 Ibid
926 T1843
927 T1843

him, he could not have been criticised for doing so. He readily accepted that with hindsight, Mr Battagodage was a patient he should have personally reviewed.[928]

711 I have considered Dr O'Connor's, Dr Gowen's and Dr Thomas' evidence very closely. I prefer the evidence of Dr O'Connor on this topic about Video 8 and find that Dr Thomas was made aware of the existence of the video by him, who suggested she ought to watch it, and that she did not do so. This omission constituted a missed opportunity to avoid the death of Mr Battagodage. In making this finding on the evidence, I referred myself to the principles in *Briginshaw*.

712 It is not suggested, nor do I make, an adverse finding in relation to Nurse Keum. He made a note of the existence of the video. Only Dr Thomas appeared to suggest that he should have done more than this.[929] Dr Gowen, for example, did not have an expectation that nursing staff would locate her if a patient showed her a photograph, believing a note in the medical record to be adequate.[930]

713 Nonetheless, given the potential significance and increasing prevalence of video and photographic evidence of symptoms, consideration should be given to developing a function within the medical records system that allows media to be uploaded, or a '*red ink*' system be introduced allowing staff to highlight notes they believe to be clinically significant.[931]

714 That is not to say that it should be necessary for patients to present physical objective evidence of their symptoms. If Dr Thomas had obtained an accurate description of Mr Battagodage's haemoptysis, namely that it was at least moderate, he would not have been discharged without further investigation. It is possible that Dr Thomas' task of obtaining a history may have been hindered by underappreciated communication difficulties exacerbated by the need to wear PPE, in addition to her failure to appreciate the significance of the symptom of haemoptysis. It is likely that a greater awareness of the potential significance of this symptom may have led to a more thorough description being obtained and conveyed to Dr O'Connor. As discussed further below, this is likely to have changed the outcome for Mr Battagodage.

English as a second language

715 While assessing Mr Battagodage, Nurse Keum did not have any concerns about his ability to speak or understand English. He did not initiate an interpreter to attend as he was satisfied with Mr Battagodage's understanding.[932]

716 Dr Thomas thought Mr Battagodage appeared well, and she did not recall having any difficulty communicating with him. She did not consider whether a translator was necessary.[933] However, much like Dr Gowen, she did not recall Mr Battagodage being particularly forthcoming with information and he was simply answering direct questions. When asked whether, on reflection, a translator was necessary, she said that she was

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928 T1333
929 T465
930 T176-7
931 T468
932 T1880
933 T383

unsure.[934] Dr Thomas was taken to her note in which she mentioned Mr Battagodage living with nine family members, which was inconsistent with the evidence of Ms Perera that she and her husband lived in a shared house, but had no family of friends living in Adelaide.[935] When asked if this indicated that she overestimated Mr Battagodage's command of the English language, she said she was unable to comment.[936]

717 In general, if Dr Thomas was having difficulty communicating with a patient the first step would be to get a family member in the room to translate and also to provide collateral information.[937] She said that in the ED, they attempt to organise interpreters only when they think they are '*absolutely necessary*'[938] as their presence often causes delays. Dr Thomas agreed that she could have telephoned Ms Perera.[939]

718 In terms of the haemoptysis, Dr Thomas recalled that Mr Battagodage reported coughing up small amounts of blood intermittently. However, this description of the amount of haemoptysis is absent from her note. Dr Thomas only made one note of what she said were at least three to four attendances upon Mr Battagodage.[940] This note was entered into the electronic medical record at 10:51 pm.[941] Dr Thomas conceded that her note ought to have included details regarding the colour, consistency, and frequency of the haemoptysis.[942]

719 It seems that Dr Thomas' failure to make a note of the volume of the haemoptysis was more likely the result of her failing to ask targeted questions about it rather than an omission in her documentation. Questions of this nature may well have prompted Mr Battagodage to present his video evidence of the haemoptysis. That was his and Ms Perera's purpose of taking the photographs and videos.

720 Further, her failure to make a note of this important clinical information suggests a lack of appreciation of its significance. This was the presenting symptom.

721 Dr Thomas believed the volume of haemoptysis was '*a little bit*', consistent with her recorded remarks to Mr Battagodage on discharge. It is unlikely that Mr Battagodage would have used these words to describe his haemoptysis given his level of concern about his condition,[943] and the fact that he must have known that he was not coughing up a '*little bit*' of blood.

722 If Mr Battagodage did in fact use these words, or words to this effect, that can only be attributed to his limited English.

723 Dr Thomas accepted with hindsight that she underestimated the volume of Mr Battagodage's haemoptysis.[944]

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934 T383
935 T197; Exhibit C27, p82
936 T474
937 T383
938 T421
939 T476
940 T383
941 Exhibit C14, p46
942 T476
943 T52, 56, 82
944 T479

724 In oral evidence, Dr Thomas said Mr Battagodage reported that he had a cough which had developed multiple days ago, and that the cough had occurred for multiple days before he developed haemoptysis. This is not an accurate history of Mr Battagodage's developing illness as the cough and the haemoptysis commenced on the same day. It is possible that Mr Battagodage provided an inaccurate history due to his limited English, or that Dr Thomas' recollection is incorrect. Dr Thomas' note did not include a reference to a cough commencing multiple days before the haemoptysis. Rather, she noted '*2 days of dry cough. Developed associated shortness of breath. Has been intermittently coughing up blood*'. Dr Thomas also told the Court that she was under the impression that the haemoptysis started the day of his first presentation to the ED,[945] which is correct.

725 In conclusion on this topic, I find that Dr Thomas must have overestimated Mr Battagodage's ability to communicate with her in his second language. He was a vulnerable patient who was naïve to the healthcare system in Australia, presenting to hospital during the pandemic without his wife to translate and advocate for him. In circumstances where decisions about his medical care depended so heavily upon the precise words used by Mr Battagodage to describe his haemoptysis, further steps should have been taken to ensure an accurate description was obtained from him. This could have been through contacting his wife via telephone or arranging for an interpreter, or asking him further questions to obtain a description of colour, consistency and frequency. This Inquest highlighted the need for increased awareness by ED staff that patients presenting with English as a second language represent a high-risk cohort.

Investigations

726 In terms of the investigation, Dr Thomas ordered blood tests and a chest x-ray at 4:23 pm.[946] The blood test revealed an elevated D-Dimer of 1.38 mg/L (reference range 0.00-0.49 mg/L),[947] causing Dr Thomas to be concerned for pulmonary embolism. The chest x-ray, which had been ordered to investigative an infective cause, was also abnormal, with the consultant radiologist reporting an abnormal density to the right of the upper mediastinum of uncertain aetiology. The radiologist advised '*CT of chest is recommended to further assess*'.

727 Dr Thomas understood the radiologist to be recommending a CT scan of the chest area, but believed that the request was not specific in terms of what type of CT should be performed.[948] Associate Professor Holdgate was not critical of this interpretation,[949] although Dr Donovan opined that the radiologist was clearly referring to a contrast CT,[950] and this was also the interpretation of Dr Gowen[951] and Dr O'Connor.[952]

728 Dr Thomas stated that she discussed the elevated D-Dimer and the x-ray results with Dr O'Connor.[953] It was decided that a CT Pulmonary Angiogram (CTPA) would be performed to rule out pulmonary embolism. Dr Thomas explained that her concern from

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945 T386
946 Dr Thomas stated that it was more difficult and time consuming to perform a chest x-ray during the pandemic: T392
947 T389; Exhibit C14, p47
948 T395
949 T1400
950 T304
951 T153-4
952 T1302
953 T391

pulmonary embolism increased after viewing the chest x-ray as the mass could indicate a possible malignancy.[954] Dr O'Connor indicated that it would have been his practice to review the imaging himself if an abnormality was reported,[955] and that it would have been his decision to request a CTPA be performed.[956] He acknowledged that it was not the specific scan that was recommended by radiology,[957] clarifying that he chose to give the advice to order a CTPA specifically to rule out a pulmonary embolism.[958] Associate Professor Holdgate was not critical of this decision,[959] having read his explanation of his rationale.[960]

729 Dr Thomas also believed that the CTPA would allow them to exclude sinister causes of the mass detected on x-ray, such as cancer.[961] Dr Thomas did not know whether it was possible for her to order a CTPA and a CT Chest simultaneously, as suggested by Dr Donovan and Associate Professor Holdgate, but said it was not routinely done in the ED.[962] She said that they try to limit radiation exposure caused by performing multiple CT scans on the same part of the body.[963]

730 The CTPA was performed at 7:53 pm on 21 November 2020. Initially, radiology registrar Dr Annie Chen reported the results of the scan at 8:52 pm.[964] She noted that there was a well-circumscribed mass within the right upper thorax/lower neck that extended superiorly to the level of the first posterior rib. She added that this resulted in a mass effect with compression of distal small airways in the right upper lobe of the lung. Dr Chen noted adjacent ground glass changes around this mass within the right upper lobe likely due to atelectasis.

731 Dr Chen also observed that enhancement characteristics are not adequately assessed on CTPA study. In conclusion, she stated that the mass:

> Can be further characterised on postcontrast CT neck/upper thorax or MRI. Benign aetiology such as ganglioneuroma or solitary fibrous tumour of the pleura favoured. Malignancy thought less likely.

732 Dr Chen's report was reviewed by a consultant radiologist at 6 am on 22 November 2020, Dr Perera. Dr Perera added the following:

> Agree. The peripheral ground-glass change of the mass likely due to associated mild pulmonary haemorrhage. [965]

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954 T452
955 T1300
956 T1302
957 T1302
958 T1304
959 T1396
960 Associate Professor Holdgate modified the view expressed in her report that it was more appropriate to order a CT chest rather than a CTPA: Exhibit C37a, p7
961 T396
962 Ibid
963 T397
964 Exhibit C13, p2
965 Exhibit C14, p48

733 Dr Thomas did not see this addendum report until after Mr Battagodage had left the hospital. She said that she would expect to be called about an addendum report but was not.[966]

734 Dr Thomas understood Dr Chen's original report to mean that there was no clot in the lung, that there was a mass within the right upper side of the lung that extends into the lower part of the neck, and that there was an associated sign of lung collapse and inflammation around that mass.[967] She understood from the CTPA results that the mass was unlikely to be cancerous. Dr Thomas considered the CTPA report to be inconclusive but did not believe it demonstrated anything that was concerning at the time. She was satisfied that the mass could be followed up by his GP, and that the mass may explain his symptoms.[968]

735 When asked if the mass could have caused haemoptysis by pressing on a blood vessel, she responded that the mass could cause inflammation or irritation of surrounding blood vessels or surrounding lung tissue, or there could be infective change around that in keeping with the atelectasis-type of change referred to in the report. She believed that the ground glass changes were likely representative of inflammatory change.[969] Due to her level of experience at the time, she did not consider the ground glass changes to indicate pulmonary haemorrhage.[970]

736 Dr O'Connor stated that ordering an MRI within the ED was not considered, as it would have taken a significant amount of time as no MRI technicians were present in the hospital at the time the report was returned, requiring them to be recalled.[971] He believed there would be significant resistance from radiology if this approach were taken.

The call to the radiology department

737 Having read the CTPA report, Dr Thomas said that she telephoned radiology to ascertain the urgency of the follow-up imaging requested.[972] She did not make a note that she consulted radiology or what transpired during that conversation. However, it was her recollection that a radiology registrar, who may or may not have been Dr Chen, informed her that the scan could be performed as an outpatient.[973] She said that the conversation was '*fairly brief*' and related to whether they felt that the imaging needed to be done urgently that evening or whether it was appropriate to be done in an outpatient setting.[974] She was unsure what information she provided to the radiology registrar about Mr Battagodage's clinical presentation and whether it was any information not included in her referral[975] for the CTPA.[976] She could not recall whether she relayed any information regarding his haemoptysis.[977]

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966 T400
967 T397-8
968 T402
969 T442
970 T443
971 T1327
972 T398
973 T399
974 T440
975 Exhibit C13, p2
976 T440
977 T441

738 In any event, Dr Thomas told the Court that the registrar said that the scan would be appropriate to do in an outpatient setting, and there was no discussion about when that should occur.[978] She did not ask questions of the registrar in relation to the report, such as the size of the mass. She did not think that this would assist her to determine the urgency of the investigation.[979]

Discharge decision

739 Dr Thomas eschewed responsibility for the discharge decision. She was adamant that the decision to discharge was made solely by Dr O'Connor.[980] In contrast, Dr O'Connor recalled discussing the results of the CTPA with Dr Thomas after she had spoken to radiology to determine the urgency of these scans.[981] He stated that he and Dr Thomas would have jointly made the decision to discharge Mr Battagodage.[982]

740 Irrespective of who was involved in this decision, Dr Thomas set out the following reasons in support of discharge:

(a) Mr Battagodage had been stable in the ED for seven hours and she was not notified by nursing staff that his observations changed significantly over that period;[983]

(b) His GP was the appropriate person to ensure that Mr Battagodage received adequate follow-up in the community;

(c) The recommended post-contrast chest CT was not urgent and could be performed in an outpatient setting, as advised by the radiology registrar; and

(d) His GP could organise the post-contrast CT to further assess the lesion and on-refer him for biopsy if required.[984]

741 It was suggested to Dr Thomas that until the aetiology of the mass was known, she could not rule out a life-threatening cause. Her response was that the absence of reported signs of active bleeding and his clinical stability satisfied her that he was safe for discharge.[985] She accepted that diagnostic certainty had not been reached at the time of discharge.[986] She also accepted that with hindsight, and based on the information she had at the time of Inquest which included Video 8 and the addendum CTPA report, that the scan should have been performed in the hospital.[987]

742 Dr O'Connor stated that the prevailing COVID-19 pandemic was a factor in favour of discharge and explained that getting apparently non-urgent investigations done within the ED would take significant amounts of time.[988] He took into consideration the advice Dr Thomas said she had been given by radiology that the scan could be done as an

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978 Ibid
979 T443
980 T480
981 T1307
982 T1307
983 T410 - It is noted that Mr Battagodage's blood pressure appeared to drop significantly, unbeknownst to Dr Thomas
984 T403
985 T451
986 T464
987 T481
988 T1307

outpatient, and therefore believed it would have been considered by radiology to be a low priority and taken in excess of four hours.[989]

743 Dr O'Connor told the Court that the decision to discharge was made on the basis that there was a small amount of haemoptysis and relatively reassuring investigations. It is inevitable, to conclude, that an accurate appreciation of the volume and colour of the haemoptysis would have made the urgency of the contrast CT apparent to all involved in Mr Battagodage's care and he would not have been left to arrange for the scan to be done privately.

The addendum CTPA

744 Dr O'Connor was not made aware of the addendum report until the week after learning about Mr Battagodage's death.[990] He stated that if he had received the addendum report identifying pulmonary haemorrhage, it would have changed the investigation pathway. He would have reviewed Mr Battagodage himself.[991] I find this would have likely resulted in review of the video, and admission for further investigation.

745 Dr O'Connor stated that it is not uncommon to see addendum radiology reports, as the images are first reviewed by a radiology registrar who will write the initial report. Then the images will be reviewed by a radiology consultant to ensure that nothing of significance has been missed.[992]

746 Dr Thomas opined that if she had been made aware of the addendum CTPA report, she would have approached Mr Battagodage's case differently as she would have been concerned that there were signs of active bleeding.[993] She would have considered the follow-up imaging more urgent.[994] She explained that she did not have the clinical experience at that time to assess the CTPA report for herself and would have relied on the opinion of the radiologist.[995] She would have expected the consultant radiologist to have appreciated the significance of the addendum report and called the results through to the duty emergency physician phone, which is manned 24 hours a day.[996]

747 However, the documentary evidence indicated that the reviewing consultant did not notify the ED duty doctor at 6 am on 22 November 2020 as they did not determine that it would make an immediate management change, and the reported mode of follow-up was identified.[997]

748 Associate Professor Holdgate regarded the significance of the addendum as uncertain,[998] as in her view there was sufficient reason to admit for investigation without it. However, she explained that this was based on an appreciation of the volume of the haemoptysis

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[989] T1307
[990] T1309
[991] T1309
[992] T1308
[993] T400
[994] T400
[995] T405
[996] T481
[997] Exhibit C35, p4
[998] Exhibit C37a, p8

which Dr Thomas and Dr O'Connor did not have. She accepted that the further information may have swayed Dr Thomas to conduct further investigations.[999]

749 It was submitted that the major omission in the medical care provided to Mr Battagodage on 21 November 2020 was Dr Thomas' failure to obtain an accurate description of his haemoptysis, make a note of that description, and provide it to Dr O'Connor. The submission continued that had she done so, further investigations would have ensued, and it was likely Mr Battagodage would still have been in hospital when the addendum CTPA report was received the following morning. In all probability, this would have resulted in life-saving intervention. Alternatively, if the volume of haemoptysis had been accurately recorded, the significance of the addendum report may have been apparent to the consultant radiologist, who may then have notified the ED or Mr Battagodage in accordance with their policy.

Discussion with Mr Battagodage regarding discharge

750 Mr Battagodage was discharged at 10:59 pm on 21 November 2020.

751 Prior to discharge, Dr Thomas had a discussion with Mr Battagodage whilst wearing PPE.[1000] As a result, she was under the impression that he understood the importance of following up with his GP.[1001] Mr Battagodage recorded this conversation on his mobile telephone. That recording was tendered as exhibit C27b.

752 During the discharge conversation, Dr Thomas explained that it was arranged for a CT scan of his chest because there was '*a little bit that looked a little bit abnormal*' at the top of his chest. She said that the CT scan showed a '*sort of mass*' in his chest, which was possibly a tumour but did not look like cancer. She said it was important it gets followed up to make sure that it is not cancer. She then explained that the tumour was putting pressure on the lung which might be causing the coughing and possibly even the coughing up '*a little bit of blood*'. She recommended he isolated for the next couple of days and '*see if the cough gets better*', because it was possible he might also have a viral infection and they just happened to find the mass. She said that if the cough does not get better, that means it is probably from the mass. She said it was important he take his letter to the GP, but that she was happy he could go home and that there was '*nothing nasty*' on the scans to worry about. She instructed him to wear a mask on his way out.

753 During the recorded conversation, Mr Battagodage can be heard to say, after the first reference to him coughing up blood, '*also just now also coming when I'm coughing*' before Dr Thomas said, '*When x-ray came back…*'. Dr Thomas told the Court that she did not hear this, possibly due to the PPE. On the recording, her response to Mr Battagodage's remark was to say '*okay*', indicating she heard him say something, but then moved directly on to discuss the x-ray results. Dr Thomas stated that if she heard him properly, she would have asked to see the tissue or whatever he had coughed blood into.[1002]

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[999] T1413
[1000] T484
[1001] T407
[1002] T484

754 It is clear from the recorded conversation that Dr Thomas was aware of the possibility that the cough was related to the mass, and that it was also possible that the haemoptysis was caused by the mass. In oral evidence, Dr Thomas explained that she was focused on reassuring Mr Battagodage that he did not have cancer.[1003]

755 Dr Thomas believed that the discharge letter would have automatically been faxed to Mr Battagodage's GP. She also gave him a copy to take with him. She explained that Dr Brooks amended the discharge letter as she must have been working as the results checking doctor on the morning of Monday 23 November 2020 and located Dr Perera's addendum CTPA report.

756 Based on the documents provided to the Inquest, no staff were rostered to check results on a Sunday at that time and no telephone call was made by radiology to the ED as the consultant did not believe that the change to the report would have changed management, as the report already suggested the appropriate follow-up scan.[1004]

757 On Monday morning, being 23 November 2020, Dr Brooks updated the discharge letter. It was sent electronically, in error, to a GP[1005] with the same surname as Mr Battagodage's GP. That GP was in fact an obstetrician. Dr Thomas stated that given the significance of the addendum, she personally would have called the result through to the patient directly or to their GP and asked them to re-present to the hospital for further examination.[1006] The documents indicate that a GP was called on Monday 23 November 2020, although by this time, the scan had already been arranged.[1007] The document does not specify the name of the GP contacted.

758 I believe a recall of Mr Battagodage to hospital on Sunday 22 November 2020 was likely to have resulted in life-saving intervention, as there would have been sufficient time to conduct the contrast CT and arrange for an endovascular or surgical procedure. Given the documentation of Dr Thomas in relation to the haemoptysis, I do not make an adverse finding in relation to the consultant radiologist or Dr Brooks.

Events following discharge on 21 November 2020

759 Mr Battagodage was discharged at 10:59 pm on 21 November 2020.

760 Mr Battagodage was collected by Ms Perera. He explained to her what he understood to have been said to him at the hospital and then played her the recording he had taken. Ms Perera's evidence was that the advice given on the recording was comforting.[1008]

761 She explained that her husband still appeared to be stressed after his discharge, but that he did not say anything about being so to her. She reasoned this was likely because he was trying to be considerate of her and not cause her more stress or worry.[1009]

[1003] T409
[1004] Exhibit C28, p1
[1005] T408
[1006] T483
[1007] Exhibit C28, p1
[1008] T76
[1009] T76

Opinion of Associate Professor Holdgate regarding treatment on 21 November 2020

762 In her written report, Associate Professor Holdgate queried whether Dr Thomas was appropriately supervised, given her lack of any documentation regarding advice from a senior colleague.[1010] Associate Professor Holdgate expressed the view that if she did seek senior advice, this should have been documented in the notes.[1011] The evidence of Dr Thomas that she did seek advice in relation to these matters came as a surprise to the Court and created an unfortunate but necessary delay in proceedings. Associate Professor Holdgate was then provided with the transcript of the evidence of Dr Thomas and Dr O'Connor prior to giving her evidence.

763 Having considered that evidence, Associate Professor Holdgate modified her position and accepted their rationale for ordering the CTPA as '*probably reasonable*'.[1012] This was an appropriate concession and indicative of the balanced approach taken by Associate Professor Holdgate in relation to her expert review of this situation as a whole.[1013] She indicated that while this would not necessarily have been her approach, she accepted that it was reasonable.

764 However, she did not accept that it was appropriate for the investigations to end with the CTPA. In her view, it was not reasonable to conclude that the mass was unrelated to the haemoptysis based on the investigations performed on 21 November 2020.[1014] Having excluded pulmonary embolus, she viewed the chances of the mass and the haemoptysis as being unrelated as '*close to zero*' as there was no other explanation for why Mr Battagodage had haemoptysis.[1015] She could not think of any pathology that could explain his presentation in which the mass and the haemoptysis were unrelated.[1016] In her view, it was only reasonable to assume that the bleeding was coming from the mass or was related to the mass.[1017] Further, it was unreasonable to discharge him without having identified what the mass was and what caused it.[1018] Whether malignant or not, the mass was causing acute serious symptoms which required admission to hospital for further delineation.[1019] She opined that Mr Battagodage should have stayed in hospital until he had a more definitive test that showed how the mass and the haemoptysis were related to each other, and that would have been a contrast CT of the chest.[1020]

765 Associate Professor Holdgate was asked whether it was reasonable to discharge Mr Battagodage based on the investigations conducted, bearing in mind their naivety to the degree of the haemoptysis. She said that this may not have been totally unreasonable, but '*they would have wanted to actively know that the volume haemoptysis was small*'.[1021] Also, an expedited outpatient investigation was necessary and indicated the urgency of it,[1022] which was not done.

[1010] T76
[1011] Exhibit C38a, p7
[1012] T1401
[1013] See for example: T1348 regarding perfect practice vs reasonable practice
[1014] T1406
[1015] T1406
[1016] T140
[1017] T1408
[1018] T1405
[1019] Exhibit C37a, p8
[1020] T1684
[1021] T1414
[1022] Ibid, see also T1421

766 However, this does not provide mitigation for Dr Thomas as she did not actively know that the volume of haemoptysis was small. She did not make a note of the description, a matter on which Associate Professor Holdgate was critical. There was no description of colour, volume and the absence or presence of blood clots.[1023] Associate Professor Holdgate viewed this as a crucial piece of information that should have been both asked and documented in the history.[1024]

767 Associate Professor Holdgate queried whether Mr Battagodage was actually asked to provide a description of his haemoptysis as, if he had been asked, she expected that he would have produced his video or photographs.[1025] She said that the standard question would be '*can you tell me how much blood you have been coughing up and what it looks like*'. She understandably imagined that this would prompt '*pretty much every patient to volunteer that information if they've got it available on video*'.[1026] She considered the failure to make a note of Mr Battagodage's answer to this question, if it were asked, as very significant. She stated, '*I can only assume that a lack of questioning is why he didn't reveal that video footage to them*' and observed that the easiest way for him to describe his haemoptysis, given his limited English, was to show the footage.[1027] As stated, this is a very logical and persuasive assumption.

768 I do note that there is no indication that Mr Battagodage showed Dr Gowen the photographs he had taken on 19 November 2020. Her notes indicated that she asked the core questions regarding consistency and volume.[1028] The other alternative is that Mr Battagodage assumed that Dr Thomas was already aware of the video and what it depicted, although he would have known that she had not seen it as it was on his mobile telephone, and he would have had to have shown it to her.

769 Associate Professor Holdgate was not critical of Dr O'Connor's assumption that Dr Thomas would have followed his advice and watched the video.[1029] In her view, he was entitled to expect Dr Thomas to draw to his attention any concerns she had regarding the video.[1030] She also regarded the initial assessment by Dr Thomas to be adequate, except for her failure to perform an oropharyngeal examination[1031] and to enquire about tuberculosis.[1032] She regarded Dr O'Connor's supervision as reasonable.[1033]

770 Associate Professor Holdgate was, however, critical of the discharge advice provided by Dr Thomas, describing it as '*falsely reassuring*'. In support, she referred to the recorded conversation in which Dr Thomas stated that '*this is all very reassuring*'.[1034] She did not regard the advice provided as appropriately conveying the urgency of further investigation, perhaps because Dr Thomas herself did not recognise it.[1035] She was also

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[1023] T1392
[1024] T1687
[1025] T1389
[1026] T1391
[1027] T1394
[1028] T1692
[1029] T1395
[1030] T1395
[1031] Associate Professor Holdgate accepted in oral evidence that COVID-19 may have mitigated this omission, although Dr Thomas did not offer it as an explanation: T1396
[1032] Exhibit C37a, p7; see also T1396
[1033] T1416
[1034] T1406
[1035] T1412

critical of the failure to provide Mr Battagodage with a referral for the scan, citing this as an unnecessary delay.[1036]

771 Associate Professor Holdgate agreed that the main contributing factor to the erroneous discharge was the underestimation of the haemoptysis.[1037] She described the degree of haemoptysis as the key indicator that Mr Battagodage needed a contrast CT of the chest before he left hospital.[1038] Her opinion was that the care provided on 21 November 2020 was not of an acceptable standard and was not consistent with peer professional practice, largely hinged on an understanding of the degree of haemoptysis.[1039] In her view, clinicians have a responsibility to actively seek out information relevant to the patient's problem and are trained to do so.[1040] It would not have been appropriate, in her view, to rely upon a nursing note describing the haemoptysis.

772 It was submitted that the failure to appreciate the degree of Mr Battagodage's haemoptysis was indefensible. He presented video evidence of his haemoptysis, and this fact was recorded in his medical notes. There was no better way in which he could have conveyed the gravity of his symptoms to the hospital staff. If systems and procedures at the RAH were inadequate to ensure that information of this level of importance is conveyed to the relevant practitioners, those systems and processes require close review.

773 Associate Professor Holdgate believed that there should be a mechanism in place whereby patients who re-present to the ED within a short timeframe are automatically reviewed by a senior doctor. This view accorded with the views expressed by Professor Kelly regarding Mr Chadha. Associate Professor Holdgate's opinion was that if Mr Battagodage had been reviewed by a senior doctor, including a review of the video footage and the CTPA result, he would not have been discharged on 21 November 2020.[1041]

774 This hypothesis was proven correct by the evidence of Dr O'Connor. He would have viewed the video if the pandemic did not prevent him from attending personally upon Mr Battagodage, or if he correctly understood the volume of the haemoptysis. If he had viewed the video, he would not have discharged Mr Battagodage for an outpatient scan.

Opinion of Professor Smith regarding treatment on 21 November 2020

775 In his report, Professor Smith opined that Mr Battagodage should have had a chest CT scan with arterial contrast on 21 November 2020, and that this would have revealed the pseudoaneurysm of the right subclavian artery. He believed that prompt admission to hospital and referral to the vascular and cardiothoracic departments at the RAH would have resulted in treatment by an endovascular approach (stenting) or by open surgical repair prior to rupture.[1042]

776 He also expressed the view in his report that on each attendance to the RAH, the significance of clearly documented frank haemoptysis in a previously well young man

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[1036] T1411
[1037] T1410
[1038] T1412
[1039] T1415
[1040] T1415
[1041] Exhibit C37a, p10
[1042] Exhibit C46a, p2

was largely ignored. Notably, this opinion was based on a review of materials which did not include the photographs or the videos. Rather, his opinion was based on the description in the notes of bright red blood, or frank blood. Professor Smith explained that bright red blood is arterial bleeding into the airway. By 21 November 2020, the doctors knew it had been occurring for two days, and they still did not know the cause. He described this symptom as very significant.[1043] He believed it was inappropriate to refer Mr Battagodage for an outpatient CT scan because they knew he had ongoing arterial bleeding, they knew he had a mass, and they had not identified the cause or the source of the bleeding.[1044]

777 Professor Smith reflected on the fear that must have been experienced by Mr Battagodage and his wife at the time he was experiencing this symptom, which he described as '*massive haemoptysis*'. He said, '*do not quibble over what this man has experienced*' and stated that this was a medical emergency.[1045]

778 Professor Smith believed that it still would have been possible to adopt an endovascular approach on 21 November 2020, depending on the radiological imaging.[1046] He said at that time, either an endovascular or surgical approach could have been done on that day. He was confident that Mr Battagodage's death could have been prevented by either method of intervention on this day.[1047] The chance of prevention was still highly likely on 22 November 2020,[1048] and indeed, at any time prior to rupture and while Mr Battagodage's condition was still stable.

779 In conclusion, after careful consideration of the evidence and submissions of the State of South Australia, who acted for Dr Thomas and Dr O'Connor, I find that the care provided to Mr Battagodage on 21 November 2020 was not of an acceptable standard and was not consistent with peer professional practice. Care should have been taken to ensure that his most concerning symptom was properly assessed and the cause delineated. That was not done, resulting in his discharge when he should have been admitted and his serious condition further investigated.

22 November 2020

780 On the morning of 22 November 2020, Ms Perera sent a text to Dr Hathurusinghe at 9:58 am with the discharge letter provided to Mr Battagodage the night before. She also sent the recording of Dr Thomas providing Mr Battagodage with advice, and a request that he please explain the content, and if he could recommend them a good GP to follow-up with.[1049]

781 Dr Hathurusinghe told the Court that he was reassured after listening to the recording of Dr Thomas, however continued to be concerned about the possibility of pulmonary tuberculosis.[1050]

[1043] T1933
[1044] T1976
[1045] T1934
[1046] T1934
[1047] T1935
[1048] T1937
[1049] Exhibit C29
[1050] T248

782 During oral evidence, Ms Perera stated that on the afternoon of 22 November 2020, her husband was complaining of experiencing chest pain, that he had a slight fever, and he was finding it difficult to breathe.[1051]

783 They did not consider returning to the hospital and instead booked an appointment with Dr Hathurusinghe for the following day. That appointment was made for 9:24 am on 23 November 2020.

784 Ms Perera stated that she did not believe Mr Battagodage was coughing on this day, because she did not remember cleaning up any blood on 22 November 2020. She could not recall him being able to cough without the presence of blood since he first became unwell.[1052]

23 November 2020

785 On the morning of 23 November 2020, Mr Battagodage's condition had deteriorated to the point where he needed to use his wife's shoulders to keep himself upright. This was the first day that he had told her that he was feeling very unwell.[1053] She recalled observing that he looked worse than the days prior.

786 Ms Perera had returned home from an overnight shift at approximately 7:30 am. She woke Mr Battagodage. He began to brush his teeth prior to coughing up blood. On this occasion, a video was taken by Ms Perera.

787 Ms Perera explained that her only thought was that she needed to show somebody what was happening. That is why she took the video.[1054] This was sound behaviour under stress.

788 Ms Perera called Dr Hathurusinghe to advise him of her husband's worsening symptoms of shortness of breath and fatigue. She was given the advice to take him straight to the ED.[1055] Mr Battagodage did not attend the 9:24 am appointment that had been made with Dr Hathurusinghe. Ms Perera took her husband directly to the RAH ED as advised.

789 Dr Hathurusinghe told the Court that he recalled taking the call from Ms Perera while driving to work in his car. Accordingly, he believed that this phone call occurred at or shortly after 8:30 am.[1056] Once she reported her concerns to him, he told her to go to the ED. She said that she was going to take him to the RAH.[1057] Dr Hathurusinghe thought that Ms Perera sounded worried and wanted the investigations to be done more quickly.

The attendance at the RAH

790 Ms Perera explained that her husband was too weak on this date to walk to the triage counter himself and sat in a chair in the waiting room while Ms Perera spoke to a woman at the counter.[1058] She did not know if this person was a nurse. She described in her

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[1051] T179 - In her statement, she mistakenly thought this was on 21 November 2020
[1052] T180-1
[1053] T77
[1054] T78
[1055] T251
[1056] T250-1
[1057] T251
[1058] T79 - She was not sure if this person was a nurse, only recalling that this person was female

statement[1059] that they walked in through the front entrance door of the RAH ED and that she stood in the queue behind two or three others. She stated that her husband was seated on the second or third chair from the right, against the wall perpendicular to the nurses' station.

791 She recalled that she told the woman that they had been there twice before, that her husband was coughing up a lot of blood, and that last night it was very difficult to breathe. She said that he needed to be admitted. Ms Perera told the Court that she pointed to her husband and told the woman '*that's the patient*'. She presented the two discharge letters to the woman, who took them inside to show someone else. Within two minutes or so they came out and advised that the doctor said to do the CT scan remotely and come back.

792 Ms Perera told the Court that she was almost begging at that point, telling the lady that he was extremely weak and had passed a lot of blood. She asked them to give him some vitamins or do something because they were all alone and had no one else.[1060] However, she was told they would have to go and get the CT scan done from outside the hospital.

793 She stated that she was repeatedly told to take her husband to the GP, even when she pleaded for him to be admitted for immediate treatment as she had become fearful for his life.[1061] She said that she was extremely upset as she felt like her husband needed immediate treatment. She had '*absolutely no idea*' what else she should do.[1062]

794 Ms Perera's evidence was that nobody from the hospital approached her husband on this occasion. She was told that her husband needed to have his CT scan done before he could be admitted to the hospital. She returned to her husband to convey this information. She recalled her husband telling her words along the lines of '*maybe I need to go back to Sri Lanka, can you look at some flights*'.[1063] He thought that he could get better medical care in Sri Lanka.[1064]

795 When it was put to Ms Perera during cross-examination that there was no record of Mr Battagodage's attendance to the RAH on 23 November 2020, Ms Perera stated that she could imagine that being the case, since it was only her who spoke.[1065] She maintained they went there as advised by Dr Hathurusinghe that morning.

796 Ms Perera told the Court that she and her husband returned to their car by leaving through the entry door, walking past a line of patients waiting to be seen at the triage desk as they left. Ms Perera was unsure if the same person she had spoken to was still at the triage desk, or if that person saw Mr Battagodage's condition as he walked past.[1066]

797 Ms Perera sent a text message to Dr Hathurusinghe at 9:32 am which read '*If you free please call me*'. Shortly afterwards, and while between patients, he called Ms Perera. He believed that this would have been at about 9:42 am.[1067] Dr Hathurusinghe recalled being

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[1059] Exhibit C27e
[1060] T82
[1061] T185
[1062] T185
[1063] T82
[1064] T188
[1065] T214
[1066] T186
[1067] T253

told by Ms Perera that they had gone to the RAH and that the hospital had refused to admit Mr Battagodage. He thought that Ms Perera sounded concerned and upset.[1068] This evidence clearly supported that she and her husband did go to the RAH as he directed.

798 Ms Perera advised Dr Hathurusinghe that they were told to have the recommended investigations done by their GP.[1069]

799 Dr Hathurusinghe was confused that Mr Battagodage was not admitted given his continuing haemoptysis, shortness of breath and fatigue, but that he was comforted, wrongly, by the assumption that Mr Battagodage had been seen by the team in the ED and had been cleared of any threat to his life.[1070]

800 Ms Perera drove straight to the Darlington Medical Centre after this conversation.[1071] In her evidence she stated that Mr Battagodage spent the drive looking up flights to Sri Lanka.[1072] It is shocking that he felt that way so soon before his death.

The consultation at Darlington Medical Centre

801 The consultation at Darlington Medical Centre occurred at around 10:46 am. This was the time recorded on Medical Director, the program used by the practice to manage patient information.[1073]

802 Dr Hathurusinghe's evidence was that Mr Battagodage did not appear acutely unwell, that he was able to engage normally, and did not appear to have any signs of respiratory distress.[1074] Mr Battagodage did not cough during the conversation and did not produce any haemoptysis.

803 During the consultation, Dr Hathurusinghe was shown the video[1075] taken of Mr Battagodage's haemoptysis, in addition to some photos.[1076] He distinctly recalled seeing the photo including the cigarette[1077] and the photo of the sink.[1078] He did not know when these photos were taken.[1079] He described the volume of the first photos as '*small volume haemoptysis*', and the sink photos as '*frank haemoptysis*', '*but not massive haemoptysis, it's somewhere in between*'.[1080]

804 Dr Hathurusinghe decided to call respiratory specialist Dr Karunarathne to discuss Mr Battagodage's symptoms. Dr Karunarathne recommended an urgent CT scan. Dr Hathurusinghe completed a referral letter to Dr Karunarathne,[1081] in addition to a request to complete a CT scan at Benson Radiology.

[1068] T253
[1069] Exhibit C29, p6
[1070] T254
[1071] This conversation occurred just after 9:32 am, estimated by Dr Hathurusinghe: T234
[1072] T188
[1073] Exhibit C16; T230
[1074] T235
[1075] Exhibit C27f
[1076] T235
[1077] T263; Exhibit C27d
[1078] T264; Exhibit C27c
[1079] T264
[1080] T265
[1081] Dr Karunarathne had availability to see Mr Battagodage on 25 or 27 November 2020

805 Dr Hathurusinghe was not concerned with a threat to Mr Battagodage's life during this consultation but requested that he have the CT scan completed as soon as possible[1082] as the ongoing, frequent haemoptysis concerned him.[1083] He was however comforted knowing that Mr Battagodage had been seen twice at the RAH and had been sent home.[1084]

806 During the consultation, Dr Hathurusinghe took a blood pressure reading, which was notably lower than the one taken at the RAH the day prior. This could have indicated a decrease in blood volume, however in the absence of an increasing heart rate, it was not an immediate cause of concern for Dr Hathurusinghe.[1085] There was also no pallor to Mr Battagodage's conjunctiva, which supported this conclusion.[1086]

807 Using a stethoscope, Dr Hathurusinghe examined Mr Battagodage's heart and lungs, noting no respiratory distress, but a presence of rhonchi from the lungs.[1087] Rhonchi is the noise produced from airway obstruction often caused by bacterial infection.

808 Dr Hathurusinghe formed the impression that Mr Battagodage might have been suffering a respiratory tract infection or asthma. He stated during oral evidence that rhonchi are common to hear in smokers, however with the benefit of hindsight, thought it was likely the rhonchi was caused by bleeding.[1088]

809 Based on the impression that the photos and video had been seen by the doctors in the ED, Dr Hathurusinghe was satisfied there was no threat to Mr Battagodage's life. However, he did believe that there was some urgency to organising the outpatient CT and being seen by a respiratory specialist.[1089] He felt the priority was for Mr Battagodage to have the CT done as soon as possible, rather than call an ambulance to take him back to the hospital, due to Mr Battagodage's vital signs largely appearing within normal limits.[1090] He was concerned that there would be a long wait.

The attendance to Benson Radiology

810 Mr Battagodage was taken to Benson Radiology Glenelg, as it was the quickest appointment that could be secured for him by Ms Perera. The Glenelg branch provided, at that time, only basic radiological procedures. It was staffed by one radiologist, approximately three clerical staff, and six radiographers.[1091] On arrival to Benson Radiology, Ms Perera filled in the paperwork for her husband. This included an intravenous contrast questionnaire.[1092] Mr Battagodage was then taken for his scans to be undertaken by one of the radiographers while Ms Perera waited for him in the waiting room.

[1082] T237
[1083] T239
[1084] T249-50
[1085] T257
[1086] Exhibit C29
[1087] Exhibit C29; T258
[1088] T258
[1089] T270
[1090] T272
[1091] Exhibit C26, p2
[1092] Mr Battagodage's signature appears on the bottom of this form

811 Mr Battagodage's scans were performed by radiographer Giulia Puccini. Ms Puccini took a number of initial images to plan the scan and ensure that Mr Battagodage was positioned correctly, followed by 264 images taken in slices of 1.25 mm.

812 In his affidavit, the present radiologist, being Dr David Donovan, stated that it takes approximately 20 minutes from the time the radiographer collects the patient to the time the complete CT scan is finished. However, Dr Donovan stated that prior to the scan being completed he had looked at the request form completed by Dr Hathurusinghe. He was immediately concerned about the combination of a mass being noted on radiological imaging in conjunction with acute haemoptysis and shortness of breath.[1093] His immediate concern was unfortunately justified.

813 Dr Donovan recalled looking through the images prior to them being '*signed off*' by Ms Puccini. This took no more than a few minutes to do so. It was immediately clear to him that the mass was a very large pseudoaneurysm of Mr Battagodage's right subclavian artery. It was the biggest he had ever seen.[1094]

814 Dr Donovan then searched for Mr Battagodage's earlier CTPA of 21 November 2020 and compared it with the images that had just been taken. He observed that the pseudoaneurysm had significantly increased in size between the two scans by approximately one third.[1095] The amount of haemorrhage in the lung had also increased. He commented that due to the shape, the pseudoaneurysm was becoming more susceptible to potential rupture.[1096] This brief review would have only taken him a few minutes.[1097]

815 Following the scans, Dr Donovan entered the CT room and advised Ms Puccini that Mr Battagodage needed to attend the hospital immediately, as he had a large pseudoaneurysm in his subclavian artery. Dr Donovan was directed to Mr Battagodage, who was just leaving the changing room and began to explain his findings to him. However Mr Battagodage requested that he speak to Ms Perera instead. Dr Donovan left to retrieve her from the waiting room.

816 Dr Donovan recalled the discussion occurred in the hallway outside the CT room. Ms Puccini was also present.[1098] He recalled telling Mr Battagodage and Ms Perera that they needed to return to the RAH as soon as possible, but did not recall mentioning the possibility of surgery.[1099] He explained that there are a number of treatment options for a pseudoaneurysm, and that decision would be best made by an interventional radiologist and vascular surgeon.[1100]

817 Dr Donovan recalled asking Mr Battagodage whether he had suffered any recent trauma, to the area, and recalled someone telling him about a '*knock*' to the right shoulder in rugby

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[1093] Exhibit C26, p6
[1094] Exhibit C26, p6
[1095] T280
[1096] Exhibit C26, p8
[1097] T296
[1098] Exhibit C26, p10
[1099] Exhibit C26, p10
[1100] T297

a few weeks prior but did not recall whether it was Ms Perera or Mr Battagodage who told him this.

818 Ms Perera stated that she was told that her husband had a serious condition and needed to attend the hospital for '*immediate surgery*'. She recalled being asked if she was able to take him, or if she needed an ambulance to be called for him.[1101]

819 While Ms Perera was speaking to Dr Donovan, it was the evidence of Ms Perera that Mr Battagodage began to cough and asked the location of the nearest toilet. Dr Donovan could not recall hearing him cough, and did not recall him saying anything, but conceded that a comment may have been in a language he could not identify or understand.[1102]

820 Mr Battagodage walked to the disabled toilet directly adjacent to where this discussion took place. He only partly closed the door.

821 Ms Perera and Dr Donovan then heard a loud noise. They both entered the bathroom immediately to find Mr Battagodage on the floor. Dr Donovan suspected that the pseudoaneurysm had ruptured and Mr Battagodage was rapidly losing blood and entering hypovolaemic shock.[1103] Ms Perera stated that she saw a lot of blood in the sink, and Dr Donovan directed that staff members bring oxygen for Mr Battagodage.[1104]

822 Dr Donovan saw blood in the basin and on the wall behind it. He recalled Mr Battagodage was agitated and incoherent. An intravenous line was inserted by Dr Donovan, and fluids were run to maintain his blood volume. Oxygen was commenced at a rate of 10-15 L/min. Dr Donovan requested that staff call for an ambulance.

823 Within the following few minutes Dr Donovan stated that Mr Battagodage's agitation, which he had attributed to hypovolaemic shock, had waned, followed by him stopping breathing and entering cardiac arrest.

824 Following the arrest, Dr Donovan inserted an airway device to maintain Mr Battagodage's airway and commenced CPR to maintain oxygen supply to Mr Battagodage's essential organs. Dr Donovan continued to administer CPR until paramedics arrived and were prepared to take over.

825 Once paramedics took over, Dr Donovan explained what had occurred to Ms Perera.

826 Dr Donovan was confident that there was nothing else that could have been done to assist the resuscitation of Mr Battagodage.[1105] Naturally, no adverse finding is made in relation to Dr Donovan's treatment of Mr Battagodage. On the contrary, I praise him for his efforts.

Expert opinions regarding the attendance on 23 November 2020

827 Looking backwards from the known time of rupture on 23 November 2020, Professor Smith opined that even on the morning of 23 November 2020 (assuming an arrival time

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[1101] T191-2
[1102] Exhibit C26, p10
[1103] Exhibit C26, p11
[1104] T193
[1105] T318

of approximately 9:30 am), there was still sufficient time to admit Mr Battagodage and administer life-saving treatment as there appeared to have been sufficient time to perform the contrast CT scan. Had the rupture occurred in hospital, Professor Smith could not say with certainty that Mr Battagodage would have survived, although he believed his chances would have been significantly better.[1106]

828 The timing of the necessary investigations prior to surgery was a matter that was explored extensively with Professor Smith in cross-examination. He accepted that, given the time taken to perform the imaging on 21 November 2020, he could not say with a high degree of certainty that Mr Battagodage's death would have been prevented if he had been admitted to the hospital on the morning of 23 November 2020.[1107]

829 Professor Smith opined that after the investigations were complete, the procedure could occur within an hour.[1108] The procedure itself could take an hour, if an endovascular approach was taken, or two to three hours if a surgical approach were taken.[1109]

830 He was taken to the results of the CTPA, reported by Dr Chen at 8:52 pm on 21 November 2020,[1110] having been requested at approximately 5:53 pm. This therefore suggested a wait time of three hours, bearing in mind that there was no perceived urgency about the performance of this scan by the requesting doctor.

831 However, it was suggested to Professor Smith that the CTPA imaging took between four to six hours to complete on this evening,[1111] rather than three. A contrast CT undertaken at Benson Radiology takes 20 minutes to complete from the time the radiographer collects the patient from the reception area to completion of the scan.[1112] While the RAH may have had competing demands for their radiology suite on the morning of 23 November 2020, if the gravity of the situation had been identified, this scan could have, and surely would have, been prioritised. Even if it had taken three hours to arrange for the scan, it could have been completed by 12:30 pm, allowing three hours for intervention to take place, which, according to Professor Smith, would have been sufficient.

832 Dr Hathurusinghe also believed that if Mr Battagodage had been in hospital when the rupture of the pseudoaneurysm occurred, he may have been saved with the prompt intervention of a vascular surgeon.[1113] He further stated that even if there was only a 10% chance, it would have been the only chance that Mr Battagodage had once the aneurysm ruptured.

833 Professor Smith estimated the chances of survival as somewhere between 10% and 50%, with the caveat that it is very difficult to predict what will occur after a catastrophic rupture.[1114]

[1106] T1937
[1107] T1985
[1108] T1966
[1109] T1370
[1110] I note that it was suggested to Professor Smith that the results were reported at 10:14 pm
[1111] T1969
[1112] Exhibit C26, p5
[1113] T260
[1114] T1985-7

The undocumented attendance to the RAH on 23 November 2020

834 It was not suggested to Ms Perera that she fabricated her evidence in relation to this attendance. However, it was implied during her cross-examination that she may have been mistaken about this attendance. Ms Perera thought her husband had started coughing prior to 9 am, because they had the appointment with Dr Hathurusinghe at 9:24 am. She estimated this to have been around 8:45 am.[1115] It was put to her that this did not align with the content of her statement, which said '*we went to the RAH at about 8:30 am*'.[1116] It was put to Ms Perera that she could not have taken Mr Battagodage to the RAH at 8:30 am, if he did not start coughing until 8:45 am. She responded that the timing was an approximation that was given to the police to set out a rough timing and that it was not exact.[1117]

835 It was also suggested to Ms Perera that she could have been mistaken in her evidence that they attended the RAH on 23 November 2020 and that she spoke to staff at the front desk and asked for her husband to be admitted to the hospital.[1118] She was adamant that these events occurred as described. Ms Perera had a clear recall of her attendance on the morning of 23 November 2020, and of her distress in relation to the interactions that took place. I find it totally implausible she was mistaken. The calls surrounding this timeframe all provide narrative about an attendance at the RAH.

836 The affidavit of Mr Philip Coward, ED Advanced Nurse Unit Manager at the RAH, indicated that if hospital policies and procedures were adhered to, Mr Battagodage would have been triaged by a nurse qualified to do so and a note would have been made in his electronic medical record.

837 According to Ms Perera, her husband was turned away without being seen, which would have been a breach of procedure. If staff were aware of Mr Battagodage's presence, they ought to have assessed him. If Ms Perera's evidence that she pointed to her husband and said '*that's the patient*' is accepted, the staff member concerned would have known Mr Battagodage was seated in the waiting room and that they were obliged to triage him. If that staff member decided not to comply with this obligation, it is highly improbable that they would have made a note of this omission.

838 Further, there was no dispute that Ms Perera was advised by Dr Hathurusinghe to attend the ED that morning at about 8:30 am, and that she said she would attend the RAH. She then reported to Dr Hathurusinghe that she *had* attended the RAH, but they had not admitted him. It is highly improbable that she could have been mistaken about where she had just been when she spoke with Dr Hathurusinghe.

839 Various other staff members were asked questions in relation to COVID-19 screening procedures in place at this time and their understanding of the triage process. It is submitted that Nurse Keum was best placed to comment upon these matters given his direct involvement in triage.

[1115] T210
[1116] Exhibit C27a
[1117] T211
[1118] T332

840 Nurse Keum stated that people often present to the ED looking for outpatient services. When that occurs, they would be directed to the correct area. It would not be his expectation that this would be entered into the medical records system.[1119]

841 Nurse Keum stated that it would be an incredibly rare situation for a person to present to the ED with the intention to be triaged and to be turned away instead.[1120]

842 Associate Professor Holdgate suggested that if Ms Perera spoke to a reception clerk or an administrative clerk, they may have just read the discharge letter and said '*well, you've been told what to do, go away and do it*'.[1121] That is a feasible proposition.

843 As already stated, I find that Mr Battagodage attended the RAH on 23 November 2020 as described by Ms Perera, and that the failure to review him was an egregious error. I find that, had he been triaged, his death may still have been prevented. Her evidence is consistent with Mr Battagodage being treated as a malingerer or exaggerator of his feelings of sickness. Even allowing for the unusual COVID-19 times and the stress and apprehension that the RAH staff may have had because of it, he was not treated appropriately based on her description of events in evidence.

The RAH review

844 Following Mr Battagodage's death at Benson Radiology, Dr Donovan made the decision to call the ED consultant at the RAH out of courtesy to inform them of what had occurred. This was with the intention to provide information to assist with a review.[1122] Dr Donovan recalled being told by the consultant, though he could not remember who it was, that they would take the matter to a review meeting.[1123]

845 Dr Gowen was informed of Mr Battagodage's death within a few days of the hospital being notified of his passing.[1124] She was aware of, but not involved in, the review that the RAH conducted into the care that Mr Battagodage had received at the hospital. She described being informed in a '*debrief*' session with one of the emergency consultants, talking through what she had done, why she had done it and what other options there would have been. She stated that she was involved in using the case for peer review and teaching purposes.[1125] She considered the conversation with the Director to be '*just an advice kind of thing*'.[1126] She stated that one of the topics raised was Mr Battagodage's Sri Lankan heritage and her failure to consider tuberculosis as a cause of his haemoptysis. She considered this to be '*more of a teaching session*' than a criticism, and a reminder to think about it in her upcoming exams. She said:

> …it was just kind of more of an awareness more than anything, I should have acknowledged that he was from a Sri Lankan background, had not been in Australia very

[1119] T1893
[1120] T1896
[1121] T1423
[1122] T318
[1123] T318-9
[1124] T100
[1125] T127
[1126] T127

> long and from an epidemiological perspective that tuberculosis probably should have been considered or at least documented that I'd considered it.[1127]

846 I found Dr Gowen's responses were oddly self-absorbed given the loss of life.

847 Dr Gowen stated that she and Dr Thomas presented the case to the registrars in December 2020 to provide information and education to training doctors.[1128]

848 Dr Gowen did not understand from any of the events that followed that anyone was critical of her failure to perform an x-ray. She said her consultant accepted her rationale for not performing this test.[1129] She did not think that the information she had available to her at the time was sufficient to enable her to detect the gravity of Mr Battagodage's condition.[1130] This was inconsistent with the conclusion recorded in the local team-based review that a chest x-ray should have been ordered. It appears, regrettably, that Dr Gowen did not learn from this error, perhaps because it was not made clear to her that this was an error.

849 Dr Thomas told the Court that she was working a day shift on 24 November 2020 and was taken into the ED Director's office at 4 pm and informed that Mr Battagodage had died.[1131] Her director of training was also present. They informed her that they were very surprised by the diagnosis, which was very rare. They then debriefed with her and reassured her. What Dr Thomas recalled was her director saying that:

> As ED physicians we are taught to hear hoof beats and think horses. We are taught to make sure that we don't miss the zebras, but that every now and then there is a snake in the grass that bites the zebra and we aren't super-human and able to find all of those.[1132]

She said that they did not discuss whether she should have admitted Mr Battagodage or whether they should have ordered the CT chest to be done in the hospital.[1133] It is clear that Dr Thomas was clearly not left with the impression that she had made an erroneous decision to discharge before performing the CT chest and considering the results.

850 Dr Thomas was aware that Dr Huynh conducted an internal investigation into the death of Mr Battagodage. She was interviewed in relation to the case. She also debriefed with Dr O'Connor and spoke with her director of training, Dr Alistair Fergusson. She understood that the only criticism made by Dr Huynh was that her documentation could have been more detailed. However, she did not accept that it was her responsibility to document the conversations with Dr O'Connor, stating that:

> The responsibility of documentation falls to both of us. I think it's my responsibility to document, from my perspective, the interaction, but I think, overarchingly, the consultant is responsible for the plans that they make decisions, not myself.[1134]

[1127] T128
[1128] Exhibit C28
[1129] T166
[1130] T171
[1131] T412
[1132] T412-13
[1133] T413
[1134] T419

851 In relation to Dr O'Connor, she told the Court that he reminded her that she had been under supervision, and at the end of the day she was the junior doctor.[1135] In relation to Dr Fergusson, he described his role as pastoral care.

852 Dr Thomas also told the Court of the education session she conducted with Dr Gowen to the ED trainees during a Thursday teaching session. She said that they presented this case and spoke about haemoptysis, its most common causes and how to investigate it.[1136] One of the '*learnings*' from her perspective was a broader understanding of some of the far rarer causes of haemoptysis, and the fact that in some cases, a CT angiogram, not a pulmonary angiogram, can more definitively show the source of bleeding in some patients.[1137]

853 She was aware of the recommendations that were made to SA Medical Imaging reiterating that all consultant addendums are to be rung through to the duty emergency physician.[1138]

854 Dr O'Connor was not involved in the review or the subsequent education relating to the case, but he did recall discussing the case with Dr Quinn to obtain some personal feedback.[1139]

CALHN clinical review

855 Three documents were presented to the Court in relation to the CALHN clinical review of the death of Mr Battagodage:

a. Local Team-Based Review marked exhibit C28
b. Notification of Significant and/or Unexpected Findings marked exhibit C36
c. SA Health Incident Event Investigation Review marked exhibit C35

856 The only recommendation arising from the local team-based review was to provide education to the ED registrar group on assessment and management of haemoptysis.[1140] Further, the reviewing consultant noted that they had provided '*feedback and education*' to Dr Gowen regarding her failure to perform a chest x-ray for work up of Mr Battagodage's haemoptysis. This feedback did not have the effect of conveying to Dr Gowen that she ought to have ordered a chest x-ray on 19 November 2020.

857 A memorandum was circulated to medical imaging staff reminding them of the existing policy regarding calling through addendum reports where they are viewed as urgent and/or significant findings. As acknowledged by Meegan Gunn of SA Medical Imaging, there is a certain element of individual decision-making as to whether the findings will alter immediate management.[1141]

858 I find that the internal investigation was inadequate. Associate Professor Holdgate noted that it was surprising that the review did not identify the poor history taken from Mr Battagodage on 21 November 2020 regarding the haemoptysis, and that no review of

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[1135] T414
[1136] T415
[1137] T419
[1138] T415
[1139] T1313
[1140] Exhibit C28, p1
[1141] Exhibit C35, p4

the video took place.[1142] Further, the review did not identify that Dr O'Connor suggested that Dr Thomas watch the video, and that she failed to do so. The rationale for the decision not to admit Mr Battagodage on 21 November 2020 required exploration. As identified by Associate Professor Holdgate, the fundamental questions to ask were firstly, how was the conclusion reached that Mr Battagodage was coughing up a small amount of blood? Secondly, what steps could have been taken to get a more accurate assessment of the degree of haemoptysis?[1143]

859 Unlike the review into the death of Mr Chadha, this review did not identify the need for a mechanism whereby patients who re-present to the ED in a short timeframe with the same symptoms are reviewed by a senior doctor. As identified above, if Dr O'Connor had personally reviewed Mr Battagodage, he would have viewed the video and life-saving intervention would have likely followed.

860 Further, the review did not address the apparent refusal to assess Mr Battagodage when he re-presented on 23 November 2020. This was clearly a significant issue. If considered and investigated during the review, it is possible that further information would have been gleaned regarding the events of that day.

Topics of proposed recommendation

Repeat presentations

861 It was submitted that Mr Battagodage's case demonstrated the necessity of a consultant review in the case of re-presentations within a short timeframe for the same complaint.

Clinical reviews of treatment and care provided by medical staff[1144]

862 It was suggested I consider the following recommendation to the Central Adelaide Local Health Network concerning clinical reviews:

a. That a copy of the local team-based review report is provided to all staff involved in the incident under review;

b. That staff to whom recommendations are directed are appropriately advised of the findings made by the review team and provided with an opportunity to respond; and

c. That monitoring of recommendations takes place to ensure that appropriate action is taken to prevent the recurrence of similar incidents.

Sunrise EMR / EPAS

863 Dr Thomas expressed the view that EPAS should have a function that allows photographs and videos from patients to be uploaded.[1145] She explained that this would make the video easily viewable for anyone who became involved in the patient's care.[1146]

[1142] T1426
[1143] T1692
[1144] Clinical reviews
[1145] T427
[1146] T428

864 Nurse Keum stated that in his view there should be a way of notifying on the emergency board that there is additional media evidence.[1147]

865 Associate Professor Holdgate advised that in her hospital there is a system present for uploading photos, although she was unsure if it could be used for videos.[1148] She clarified that many patients bring images that might not be clinically relevant, and that the photos are only uploaded by practitioners if they are significant.[1149]

866 Professor Smith said a system called Cerner is used by Monash Health. This has the capacity to enter clinical images or videos into a patient's medical record.[1150]

867 It was suggested that I consider making the following recommendation to the Central Adelaide Local Health Network:

> That consideration be given to developing a means by which photographs and videos provided by patients can be incorporated into a patient's electronic medical record.

English as a second language

868 It is a striking feature from the evidence heard in both Inquests that there is a tendency amongst staff working within fast-paced ED environments to overestimate the ability of patients to communicate important clinical information in their second language. It was submitted that all Local Health Networks should consider additional education to alert clinicians to this risk and to encourage the use of interpreters where the precise words used by the patient may have a significant outcome for the patient's medical care.

869 I was asked to make the following recommendation to the Minister for Health and the Minister for Multicultural Affairs:

> That consideration be given to the development of an education program for public hospital staff members aimed at increasing awareness in relation to the heightened risk of adverse outcomes for patients attempting to communicate important clinical information in their second language.

870 After careful consideration about this issue, I have decided not to make a recommendation based on this issue. The facts of these deaths should be clear enough that great caution should be exercised in assessing a history from a patient given in English by a person who has it as his or her second language.

Recommendations concerning the death of the late Mr Battagodage

871 I have considered the submissions on proposed recommendations and the attitude of the State of South Australia about those submissions made through the Crown Solicitor's Office.

872 These recommendations are discrete, based on the issues already discussed in detail that were major factors in the decision of the RAH not to admit Mr Battagodage. The issue of

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[1147] T1889
[1148] T1378
[1149] T1378-9
[1150] T1940

a recommendation regarding repeat presentation of a person with the same health complaint has been made already in the finding for the late Mr Chadha.

873 Therefore, I make the following recommendations to the Minister of Health and all Local Health Networks in South Australia:

Six That consideration be given to developing a means by which photographs and videos provided by patients can be incorporated into a patient's electronic medical record.

Seven That a copy of the Local Team-Based Review Report is provided to all staff involved in the incident under review.

Eight That staff to whom recommendations are directed are appropriately advised of the findings made by the review team and provided with an opportunity to respond.

Nine That monitoring of recommendations takes place to ensure that appropriate action is taken to prevent the recurrence of similar incidents.

Condolences

874 I express my condolences to Ms Perera and the family of Mr Battagodage.

875 I thank Special Counsel assisting me, Ms Emma Roper, for her dedicated and thorough presentation of the evidence. I also thank Counsel for the interested parties for their thoughtful presentation of their clients' respective positions on the many issues that were subject of evidence.

Keywords: *Emergency Departments; Multiple Presentations; Pneumonia; Pseudoaneurysm*