CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF WARREN RICHARD TAYLOR

[2026] SACC 3

Inquest Findings of her Honour Deputy State Coroner Kereru

26 February 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a 79-year-old man who attended at the Whyalla Hospital Emergency Department following a fall about 15 hours prior to his death. The Inquest explored the circumstances leading to his discharge from the Emergency Department an hour after being seen by a doctor without sepsis being detected, notwithstanding clear signs and symptoms of that condition being recorded.

Held:

1. Warren Richard Taylor, aged 79 years of Whyalla Norrie, died at Whyalla Norrie on 5 December 2022 as a result of urinary tract infection with E coli bacteraemia on a background of ischaemic hypertensive heart disease and morbid obesity.

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

Recommendation made.

Counsel Assisting: MR D EVANS

Interested Party: FLINDERS AND UPPER NORTH LOCAL HEALTH NETWORK
Counsel: MR T DAYMAN - Solicitor: GILCHRIST CONNELL

Witness: DR J SNYDER
Counsel: MS H VEALE - Solicitor: MDA NATIONAL

Witness: DR C PATEL
Counsel: MR A KALALI - Solicitor: WALLMANS LAWYERS

Hearing Date/s: 18/06/2025-19/06/2025 & 14/08/2025

Inquest No: 17/2025 **File No/s: 2980/2022**

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INQUEST INTO THE DEATH OF WARREN RICHARD TAYLOR [2026] SACC 3

Introduction

1 Warren Richard Taylor was 79 years old when he died at home on 5 December 2022. He had been discharged from Whyalla Hospital the day before, after being assessed as safe to return home. The Inquest explored the circumstances that led to that determination and whether there was any opportunity to identify the seriousness of Mr Taylor's situation.

Background

2 Mr Taylor lived at his Whyalla Norrie home with his wife of about 61 years.

3 Mr Taylor's past medical history included hypertension, Type 2 diabetes, undefined heart conditions, sleep apnoea, hypercholesterolemia, arthritis and a stroke. He mobilised with the assistance of a walking stick or a four-wheeled walker.

Events of 4 December 2022

4 On 4 December 2022, Mr Taylor fell while attempting to take a step up to the toilet. He did not hit his head or lose consciousness, but he was unable to get up from the floor. The South Australian Ambulance Service (SAAS) was called at 10:30 am.

5 Upon their arrival, paramedics took a detailed history. This included a six-day history of symptoms consistent with a urinary tract infection (UTI), and a recent onset of rigors and fever. Additionally, it was recorded that Mr Taylor was suffering from global weakness. Mrs Taylor reported that her husband had been vague and confused that morning.

6 The paramedics recorded observations of Mr Taylor including tachypnoea, distress and sweatiness. He was noted to have shortness of breath, low oxygen saturation levels, an increased respiratory effort and it was noted that he was febrile with a temperature of 39.1°C.

7 Mr Taylor was conveyed to the Whyalla Hospital Emergency Department (ED), arriving at 12:04 pm. He was triaged at 12:08 pm. The reason for attendance was recorded as '*post fall febrile confusion,* [query] *UTI*', and he was assigned triage category 3.[1]

8 At 12:30 pm, ED consultant Dr O'Neil, was notified of Mr Taylor's presence and an assessment of Mr Taylor by a nurse was conducted around this time.

9 A medical note timed at 2:30 pm suggested that Mr Taylor was seen by ED Resident Medical Officer (RMO) Dr Joseph Snyder at approximately 2 pm. Dr Snyder recorded that Mr Taylor had suffered a fall at home. He reported six days of pain on urination and increased urinary frequency, but denied sweats and fevers, which was inconsistent with what had been recorded by paramedics. Some, but not all, of the observations taken by the paramedics were recorded in Dr Snyder's entry.

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[1] Exhibit C6, page 4

10 Following an examination and bedside urinalysis, Dr Snyder assessed Mr Taylor as having a UTI. He considered the fall to be mechanical. Blood and urine samples had already been taken and had been sent for culture testing, a process that takes at least a day. Regular blood tests were also underway. A later entry recorded signs of infective markers in Mr Taylor's blood test results.

11 Following the results of an ECG and postural blood pressure, which were unremarkable, Dr Snyder spoke with a more senior doctor on shift in the hospital, Dr Chirag Patel, about his differential diagnosis and plan to discharge.

12 At 3:15 pm, Mr Taylor was discharged from hospital.

13 Discharge paperwork was given to Mr Taylor which recorded 'urine infection likely, febrile but no features of sepsis.'[2] He was given a prescription for the oral antibiotic trimethoprim.

14 In the early hours of the following morning, Mr Taylor called out to his wife. She found him on the floor, sweating, hyperventilating and complaining of feeling unwell. He said that his body felt cold, but that he did not want an ambulance to be called as he was worried about the cost.

15 Mrs Taylor tried to help him off the floor about four times, however, he kept falling back down. Consequently, Mrs Taylor left the bedroom and called triple zero.

16 On her return to the bedroom, Mrs Taylor struggled to open the bedroom door as Mr Taylor had fallen and was positioned against it. Through the gap in the doorway she was able to see that her husband was now unresponsive.

17 Mrs Taylor made another call to triple zero which resulted in fire services, in addition to the ambulance, being dispatched.

18 At 3:45 am an ambulance crew of four attended and moved Mr Taylor away from the wall and immediately commenced cardiopulmonary resuscitation.

19 Unfortunately, Mr Taylor was unable to be resuscitated and at 4:04 am, he was declared life extinct.

20 Distressingly for Mrs Taylor, Dr Patel contacted her a few hours later to advise that Mr Taylor's blood culture test revealed a bacterial infection and asked that he return to hospital for treatment. Mrs Taylor's daughter, Jodie Taylor, had to take the phone as her mother had become too upset to speak. Jodie Taylor then informed the doctor that her father had died that morning.

Cause of death

21 A limited post-mortem examination was conducted by a consultant forensic pathologist of Forensic Science SA, Dr Stephen Wills, on 14 December 2022 with a report subsequently prepared for the Court.[3]

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[2] Emphasis added
[3] Exhibit C2a

22 Dr Wills found evidence of Mr Taylor's chronic conditions. Toxicological analysis revealed that Mr Taylor had taken the trimethoprim prescribed by Dr Snyder. Dr Wills concluded that Mr Taylor's death was multifactorial. His opinion is that it was most likely due to a urinary tract infection with E coli bacteraemia arising against the background of his significant comorbidities.

23 Dr Wills' opinion was not challenged during the Inquest and in my view, it properly reflects the evidence. I therefore enter a finding that Mr Taylor's cause of death was:

> *Urinary tract infection with E coli bacteraemia on a background of ischaemic hypertensive heart disease and morbid obesity*

Reason for Inquest

24 Mr Taylor's death was reported to the State Coroner as it met the criteria for a reportable death under section 3(e)(i) of the *Coroners Act 2003*, namely that Mr Taylor had died within 24 hours after having sought emergency treatment at a hospital.

25 In addition to the mandatory notification, Mr Taylor's family also contacted the State Coroner's office with concerns about his discharge from hospital the day before.[4]

26 A coronial investigation was commenced, and an independent expert report was obtained from emergency physician Professor Anne-Maree Kelly, who raised criticism of the care provided to Mr Taylor at the Whyalla Hospital ED.

27 Professor Kelly's opinion must be viewed in the context that the provoking cause of Mr Taylor's death was a bacterial infection (E coli bacteraemia) from a UTI. Professor Kelly opined that Mr Taylor presented to the ED with symptoms suggestive of sepsis from this infection. She was of the view that it was not reasonable for Dr Snyder to reach the conclusion that there were no features of sepsis based on the information he had available to him.

28 As outlined by Professor Kelly, sepsis is a medical emergency. It is the body's systemic immunological response to an infectious agent that can lead to end stage organ dysfunction and death. In her oral evidence Professor Kelly explained:

> Sepsis is the body's response to an infection. So the body has an immune system, that is designed to respond to threats, and most of the time it responds in a controlled way. In other words, it responds – it fights the threat, in this case an infection, but it does not damage itself. Sepsis is the situation where there is now an uncontrolled response to infection. So, in fact the body – the body's own infection-fighting processes turn on the body and start damaging the organs of the body. ...So basically, the body, as well as fighting the infection, starts damaging itself.[5]

29 Alarmingly, sepsis has significant mortality. It has a mortality rate for patients aged 65-79 of about 25%,[6] but if detected once it has progressed to severe, it has a mortality of 40-50%.[7] Sepsis is the most common final pathway to death for any person dealing with

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[4] Email to Coroners Court from Jodie Taylor, dated 7 December 2022
[5] Transcript, page 85
[6] Exhibit C15 at 11
[7] Transcript, page 86

a serious infection.[8] Sepsis is not always easy to detect, often with subtle signs in the initial stages. Once vital signs significantly deteriorate (such as low blood pressure) the infection enters the high mortality area. As a consequence, recognising sepsis in its early stages gives a much better chance of a good outcome.

30 Professor Kelly outlined that there have been concerted efforts both in Australia and internationally to develop and implement evidence-based approaches to improve the recognition and treatment of sepsis.[9] This has seen the development of sepsis pathways which set out steps to be taken when dealing with potential sepsis. These incorporate screening for sepsis (based on risk factors and vital signs) and a structured approach to treatment involving the timely administration of antibiotics and escalation of care.

31 The issues explored in this Inquest were narrow in their focus, specifically limited to the condition and diagnosis of sepsis. The evidence focused on the clinical information that should be considered and should activate the sepsis pathway, in the context of the cause and circumstances of Mr Taylor's death.

Evidence at Inquest

32 The documentary evidence at Inquest comprised 17 exhibits.

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

- Dr Joseph Snyder, medical practitioner, Whyalla Hospital
- Dr Chirag Patel, medical practitioner, formerly of the Whyalla Hospital
- Professor Anne-Maree Kelly, emergency physician

Hindsight bias

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

35 A description of 'hindsight bias' is given in the Australasian Coroners Manual, namely:

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

36 As stated, I am very mindful of this warning when considering the evidence in this Inquest.

37 In writing this Finding, I do not purport to summarise all of the evidence tendered or heard at the Inquest, but refer to it only in such detail as appears warranted by its forensic

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[8] Transcript, page 86

[9] Exhibit C15, page 8 19 – citing ACQSHC, Sepsis Clinical Care Standard – https://www.safetyandquality.gov.au/standards/clinical-care-standards/sepsis-clinical-care-standard

significance. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

The Whyalla Hospital in December 2022

38 After Dr Patel became aware of Mr Taylor's death when he spoke to Mrs Taylor and her daughter, he quite properly lodged a Safety Learning System (SLS) incident.[10] This commenced a procedure of the incident being raised with management for assessment of performance and system improvement. The SLS identified the Incident Severity Rating as Level 1, the most serious level, meaning that the incident had resulted in the death of a patient.

39 A Critical Incident Brief was then provided to the Chief Executive of the Department of Health and Wellbeing, Dr Robyn Lawrence. In that document, it was said that the incident related to the discharge of a consumer (Mr Taylor) with urosepsis resulting in his death.[11] The brief then recorded that the following actions had been taken to manage the incident:

- an SLS Report,
- a Pitstop Huddle, and
- initial contact with patient's family.[12]

40 Further, there was planned management and investigation involving a multidisciplinary clinical case review and open disclosure with the Taylor family.

41 Following the review processes, a number of changes were implemented at the Whyalla Hospital. An affidavit of Dr Lindy Washington, sworn on 6 August 2025, was tendered to the Court.[13] Dr Washington is the Executive Director of Medical Services for the Flinders and Upper North Local Health Network (FUNLHN). Her affidavit provided a context to the backdrop in which Mr Taylor received treatment on 4 December 2022.

42 Dr Washington outlined the staffing levels, induction program and levels of supervision for junior doctors at the Whyalla Emergency Department in December 2022. She also provided a copy of the Adult Sepsis Pathway protocol (Sepsis Pathway) that was in place at that time. This document was received into evidence.[14]

43 Junior staff orientation between 2020 and 2022 in Whyalla Hospital was specifically addressed in Dr Washington's affidavit. She explained that while there was a face-to-face induction week and a handbook provided to new salaried staff, the medical education sessions (covering sepsis and deteriorating patient scenarios) were not compulsory. Due to the COVID-19 pandemic in this period, orientation for salaried and locum staff was, at times, complicated and interrupted.[15]

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[10] Exhibit C9

[11] I observe that a causative link between the discharge and death was apparently made by the author of the brief, however I will proceed to make my own determination of whether that link is in fact proved on the evidence

[12] Exhibit C9, page 2

[13] Exhibit C17

[14] Exhibit C10

[15] Exhibit C?17, paragraphs 11-14

44 As will be seen later in the Finding, Dr Snyder did not have a memory of consulting the Sepsis Pathway at the time he assessed Mr Taylor. He told the Court that he was not aware that it was held on the internal hospital system.

45 The other issue Dr Washington addressed was medical staffing levels in the ED. In December 2022, there were 38.5 medical staffing hours delivered in the Whyalla Hospital ED in a 24-hour period (excluding breaks). This equated to one doctor on at all times and a second doctor for only 14.5 hours a day.

46 Dr Washington explained that Mr Taylor's death led FUNLHN and Whyalla Hospital to reflect on the systems in place for the management of potentially septic patients as well as the support and supervision of staff in the ED.[16]

47 Since 2024, there have been a number of changes as detailed in Dr Washington's affidavit. The changes include:

a. an endorsement for the use of an updated Sepsis Pathway (Updated Sepsis Pathway)[17] from March 2024. This was adapted from a version proposed by the NSW Clinical Excellence Commission as it was identified as better able to support clinicians to identify sepsis risk factors and commence treatment rapidly,

b. an increase in medical staffing levels in the Whyalla Hospital ED to 60 hours in a 24-hour period (excluding breaks), comprising of six 10-hour shifts (ie three senior doctors and three junior doctors at all times),

c. improvements to junior medical officer orientation and supervision,

d. the introduction of a rural Emergency Nurse Practitioner model of care,

e. the implementation of the Sunrise Electronic Medical Record (Sunrise EMR) in February 2024 with training,

f. the establishment of a Sepsis Work Group, and

g. the standardisation of Point of Care lactate testing to enable compliance with the Updated Sepsis Pathway.

48 The work conducted by FUNLHN was comprehensive. I am satisfied that a timely and thorough review was conducted by FUNLHN following Mr Taylor's death and that appropriate changes have now been implemented. In particular, I draw attention to the introduction of Point of Care testing for lactate, which enables a swift and reliable confirmation where sepsis is suspected. Together with the improved pathway, this is a particularly meaningful change. I have taken the changes already implemented into account when considering potential recommendations in this matter.

Circumstances leading up to death

Involvement of the South Australian Ambulance Service

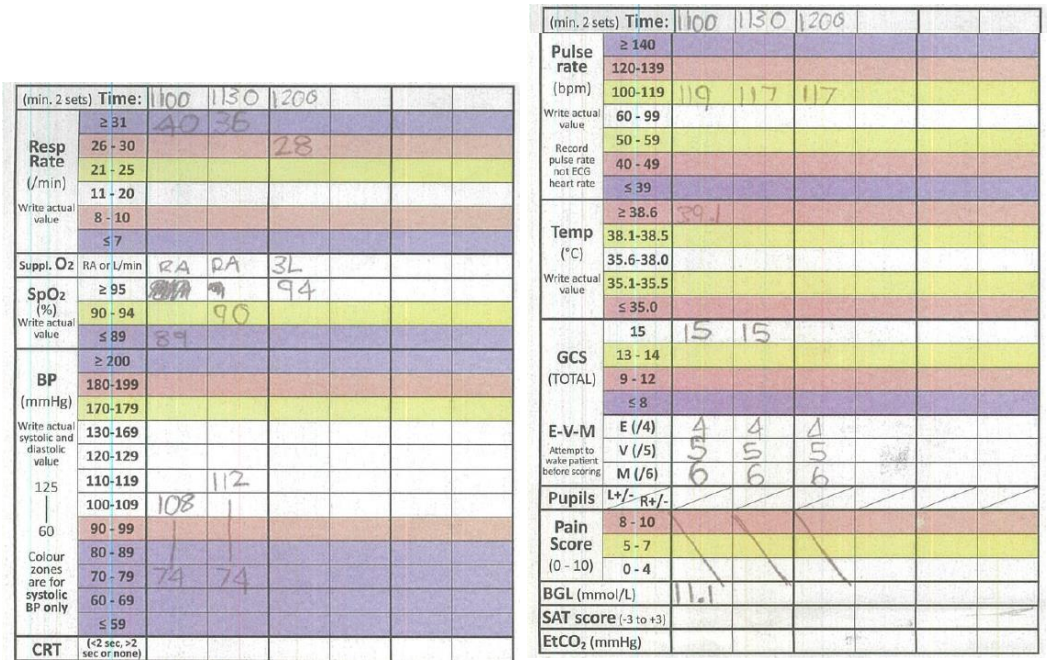
49 The involvement of the South Australian Ambulance Service was pivotal to the issues arising at Inquest. The Patient Clinical Record (PCR) produced by the paramedics

[16] Exhibit C17, paragraph 48
[17] Exhibit C17, Annexure LW1

involved was particularly important to understanding Mr Taylor's presentation. This was because it set out in detail the symptoms as reported, not just by Mr Taylor but also by his wife, as collateral information. It was also significant because there were three vital signs as measured by the paramedics (respiratory rate, oxygen saturation, and pulse) which were recorded in coloured areas of the vital signs chart. Had those observations recorded by paramedics been applied strictly to the Sepsis Pathway, Mr Taylor's journey in the ED would have been different.

50 I heard evidence that the colours attributed to the vital sign chart in the PCR are the same used in hospital settings (including the ED) for patient observations taken at various intervals. Observations placed within a coloured area notify clinicians of vital signs outside normal ranges and specifically raise the alarm for critically unwell or deteriorating patients. The use of coloured charts is standard among modern healthcare systems and medical practitioners are well familiar with their manner of operation.

51 The observations of Mr Taylor recorded by one of the attending paramedics were as follows:[18]



52 Importantly, Mr Taylor was tachypnoeic (ie had an elevated respiratory rate) with a respiratory rate of 40 and 36 breaths per minute at 11 am and 11:30 am, respectively. Both readings were recorded in the purple zone meaning that they were of the highest level of concern. At 12 pm, Mr Taylor's respiratory rate decreased but was still 28 breaths per minute and recorded in the red zone, putting it at the second highest level of concern.

53 Mr Taylor's oxygen saturation levels (SpO_2) were low at 89% at 11:00 am (in the purple zone), coming up slightly to 90% SpO_2 at 11:30 am, bringing them into the yellow zone. Once in receipt of three litres of supplied oxygen, Mr Taylor's saturations improved to 94%, which was a non-coloured area of the chart, reflecting a normal saturation level.

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[18] Exhibit C6, page 6

54 Finally, Mr Taylor's heart rate was elevated (ie tachycardic) with his recorded pulse rate remaining in the yellow zone for the three observations recorded. His heart rate was 119 beats per minute, 117 beats per minute and then 117 beats per minute again.

55 In addition to the concerning vital signs, the information recorded within the '*presenting complaint'* area of the PCR was equally important for the consideration of sepsis. Mr Taylor was noted to be distressed and sweaty. Mrs Taylor informed the paramedics that her husband had been experiencing UTI symptoms for six days and had a recent onset (the previous night) of rigors and a temperature. Mrs Taylor told the paramedics that she had observed him to be vague and confused that morning.

56 There was no dispute raised during the Inquest as to the observations made by paramedics. They appear to be cogent on their face and I am prepared to accept that they accurately reflected Mr Taylor's presentation at the time he was with paramedics and the background facts that the paramedics were advised.

57 Fundamental aspects of the PCR were not considered by Dr Snyder, leading him to be falsely reassured with Mr Taylor's vital signs stabilising while in the ED. I will discuss that in detail later.

The Whyalla Hospital Emergency Department

58 The clinical records reflected that Mr Taylor arrived in the ED at 12:08 pm with the reason for his attendance recorded as '*post fall febrile confusion ?UTI'*. He was assigned a triage category 3 which means an urgent case with a serious but stable condition that requires medical assessment within 30 minutes of presentation.

59 Dr O'Neil was notified at 12:30 pm and Mr Taylor was seen by Registered Nurse (RN) Dakota Toth at 12:30 pm. RN Toth was not called as a witness but provided an affidavit which was received into evidence.[19] She also made three contemporaneous entries in the clinical records in respect of her involvement with Mr Taylor.

60 At the time of her involvement in Mr Taylor's care, RN Toth was approximately 10 months post-graduation from her Bachelor of Nursing. She was completing her SA Health Transition to Professional Practice Program as a junior RN, based in the Whyalla ED.

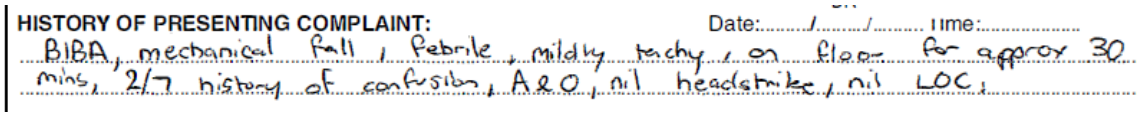
61 When she met him, RN Toth remembered Mr Taylor from previous attendances at the Whyalla Hospital and understood he had a number of chronic health conditions. RN Toth was not asked to provide her affidavit until 2025. Notwithstanding the time between Mr Taylor's attendance at the ED and providing her statement, RN Toth had an independent memory of her involvement with him due to learning of his death shortly after it occurred. She explained:

> I have an independent recall of aspects of Mr Taylor's attendance on 4 December 2022, as there are elements that have stayed in my mind given his unfortunate death.[20]

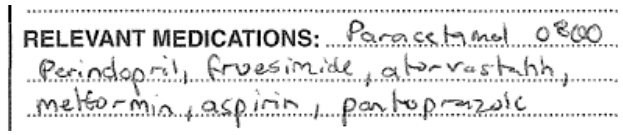
[19] Exhibit C16
[20] Exhibit C16, paragraph 2

62 RN Toth was not involved in the triage process but did receive a handover from the triage nurse. In addition to this, it was her general practice to review the SAAS observation chart.

63 Following the handover, RN Toth introduced herself to Mr Taylor and took a history. She recorded this on a form titled 'Adult RDR Chart (MR 59A –ED)'. It read:


HISTORY OF PRESENTING COMPLAINT: Date: / / Time:
BIBA, mechanical fall, Febrile, mildly tachy, on floor for approx 30 mins, 2/7 history of confusion, A&O, nil headstrike, nil LOC,

and


RELEVANT MEDICATIONS: Paracetamol 0800
Perindopril, frusemide, atorvastatin, metformin, aspirin, pantoprazole

64 RN Toth took her first set of observations from Mr Taylor at 12:30 pm and recorded them in the hospital's Observation Chart which was also colour coded. She noted retrospectively in her affidavit that she entered Mr Taylor's temperature of 38.0°C in the yellow shaded area when it should be entered into the red zone above. Notwithstanding this error, RN Toth was mindful of Mr Taylor's two-day history of confusion and that he was tachycardic and febrile. She was also aware that Mr Taylor's observations taken by paramedics were abnormal, in particular his heart rate and elevated temperature.

65 While she did not specifically locate and view the Sepsis Pathway, RN Toth was aware both of its existence (through her recent orientation) and was conscious of the steps to follow. Suspecting sepsis, RN Toth anticipated that blood cultures[21] would be required and intravenous (IV) antibiotics would potentially be needed. She therefore inserted a cannula to prepare for the IV medicine and took a set of bloods at approximately 12:45 pm.[22]

66 The actions taken by RN Toth at this point in Mr Taylor's care wholly supported the notion that she considered the possibility of sepsis. Further, I consider that the actions taken were both appropriate and in accordance with the Sepsis Pathway.

67 RN Toth recalled assisting Mr Taylor to the bathroom after taking a history and observations. He required a wheelchair to mobilise and assistance getting in and out of the chair. She noted that he became quite fatigued on exertion during this process but once settled back into bed, his respiratory rate reduced to a more stable level.

68 RN Toth obtained a urine sample from Mr Taylor to assess for infection. It returned a result consistent with a UTI as follows:[23]

> Leukocytes/white blood cell count +3
> Nitrituria +

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[21] A blood culture is a test to check the blood for bacteria, fungi or other microorganisms to diagnose a serious bloodstream infection by growing germs found in special machines. The growth typically takes 24-48 hours, although some organisms can take longer

[22] Exhibit C16, DT1, the SA Pathology Request form for blood cultures

[23] Exhibit C16, paragraph 30

pH 5
Proteinuria +2
Haemoglobinuria +4

69 After completing her assessment and making her notes in the clinical records, RN Toth provided a handover to Dr Snyder. The information she recalled handing over was as follows:

> This included informing Dr Snyder of Mr Taylor's temperature, and that I had subsequently taken bloods and collected a urine sample. I also believe I informed him that a cannula had been placed in-situ in case of the need for IV antibiotics to be administered.[24]

Dr Joseph Snyder

70 Dr Snyder completed his Bachelor of Medicine and Surgery in 2019 at the University of Adelaide. When he treated Mr Taylor, he was three years post-graduation and in his second year as an RMO. Having rotated through a number of departments at FUNHN, he worked in the Whyalla Hospital ED and in-patient wards from August 2022 to March 2024. During this time, Dr Snyder worked a week on, week off roster from 8 am to 6 pm each Wednesday through to Tuesday. At the time he gave oral evidence at the Inquest, he was working in the Northern Adelaide Local Health Network as a palliative care RMO.

71 Dr Snyder had some recollection of Mr Taylor which was supplemented by reviewing the clinical records. He provided a detailed affidavit[25] and gave oral evidence at the Inquest.

72 It is important to observe that Dr Snyder was a candid and thoughtful witness who said he had reflected on the care he provided to Mr Taylor. It was evident that he had. In both his affidavit and his oral evidence, he expressed his sincere condolences to the Taylor family, acknowledging the pain, distress and suffering his death had caused them. He volunteered during his evidence that he had thought of Mr Taylor almost every day since treating him in the ED.[26] This evidence was heartfelt and genuine. Dr Snyder deserves recognition for the straight-forward manner in which he approached his evidence.

73 Dr Snyder was a valued member of staff at the Whyalla Hospital. Dr Patel gave evidence that he considered Dr Snyder to be a capable and conscientious doctor and RN Toth described having a good working relationship with him.

74 In considering Dr Snyder's treatment of Mr Taylor, it is important to consider the context of Dr Snyder being a junior doctor at the time in a largely unsupervised but high-pressure working environment. I also take into account the staffing issues, both generally and as a result of COVID-19 at the time. On the day of Mr Taylor's presentation, in addition to his rostered duties, Dr Snyder was asked to assist by covering both the ward round and the afternoon ED shift due to the hospital being short staffed.[27] I also observe that these events occurred in a rural setting which is more isolated but no less difficult than metropolitan medicine.

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[24] Exhibit C16, paragraph 34
[25] Exhibit C13
[26] Transcript, page 41
[27] Exhibit C13, paragraph 12

75 I have taken these factors into account when considering my findings in this matter.

Dr Snyder sees Mr Taylor

76 Dr Snyder saw Mr Taylor between 2 pm and 2:30 pm, with his handwritten notes in the clinical records marking 2:30 pm.[28]

77 While Dr Snyder had only a vague recollection of the handover from nursing staff, his memory that it included a reference that Mr Taylor '*had a fall'* at home and a suspected UTI was not inconsistent with the evidence of RN Toth or the entries in the clinical records. He could not remember being told by the nurse that there was a report of confusion.

78 There was however a reference to a two-day history of confusion in the nursing entry which Dr Snyder had regard to when assessing Mr Taylor's case. He noted there was also a record that Mr Taylor was observed to be alert and oriented at triage.

79 During his evidence, Dr Snyder reviewed the observation chart in the paramedic's PCR (noting heart rate, respiratory rate and temperature) which he compared to observations taken in the ED. He could not recall if he had seen much of the detail recorded in the '*presenting complaint*' of the PCR.[29]

80 It was apparent from Dr Snyder's oral evidence that a significant focus of the history he took from Mr Taylor related to the fall that occurred in the home. Dr Snyder noted down that Mr Taylor had suffered a fall at home that morning, after stepping out the back door, where he found he could not negotiate the stairs. When attempting to rest back on his four wheeled walker, he missed and fell backwards.

81 Mr Taylor told Dr Snyder that he remembered the fall, he did not hit his head, he had no loss of consciousness or dizziness at the time of the fall and denied chest pain or shortness of breath.

82 Importantly to Dr Snyder, Mr Taylor presented as a good historian, appeared of sound mind with no signs of confusion. Added to this was a more reassuring vital sign picture since presenting to the ED.

83 Dr Snyder made notes of a history of painful urination for six days with an increase in frequency, but a denial of sweats, fevers or being unwell.

84 Dr Snyder then conducted a physical examination of Mr Taylor which was unremarkable. This was recorded in his entry.

85 The impression formed by Dr Snyder at this point was that Mr Taylor had suffered a mechanical fall (meaning that it was of an external environment cause, unrelated to an illness or infection) and that he was suffering a UTI which was the source of his fever.

86 Dr Snyder's plan was to send the urine and blood samples off for a culture, to obtain a postural blood pressure and conduct an ECG. With the exception of the urine and blood

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[28] Exhibit C6, page 8
[29] Exhibit C13, page 18 and Transcript, pages 19 and 21

cultures to look for the presence of bacteria, the other tests ordered were to rule out a heart or blood pressure related cause for Mr Taylor's fall.

87 It was apparent from his assessment of Mr Taylor, that while Dr Snyder had turned his mind to the possibility of sepsis, he did not seriously consider it as a differential diagnosis. Dr Snyder testified that the key signs of sepsis that he would look for in the ED were tachycardia, hypotension, elevated temperature, decreased oxygen saturations, reduced consciousness or reduced motor skills or eye movement.[30] Viewed in isolation, the only sign observed by Dr Snyder in the ED was an elevated temperature and that had improved with the administration of paracetamol. Accordingly, Dr Snyder did not activate the Sepsis Pathway, and importantly, did not commence IV antibiotics.

88 The difficulty with his assessment, as properly conceded by Dr Snyder in oral evidence,[31] was that Mr Taylor was exhibiting each and every one of those signs of sepsis he had identified in his oral evidence at the time paramedics attended his home. Further, they were all documented in the PCR which was a document Dr Snyder had access to and had in fact looked at, although it would appear, fleetingly.

Blood results

89 Following Dr Snyder's assessment of Mr Taylor, the blood test results, although not the blood culture results, became available. Relevantly, there were signs of an infection as follows:

- The C-Reactive Protein (CRP)[32] was elevated at 112.8 mg/L (against a normal range of 0.0-8.0);[33] and
- The white cell count (WCC)[34] was elevated at 16.26 $x10^9$/L (against a normal range of 4.00-11.00).[35]

90 Dr Snyder reviewed these results and recorded them in Mr Taylor's clinical record. He formed the view that while Mr Taylor was showing some signs of infection, the raised inflammatory markers were consistent with the presence of a simple UTI, with potential for more.[36]

91 An ECG had already been performed by RN Toth at 1:46 pm.[37] The trace reported that it was an 'abnormal ECG'. Mr Taylor suffered from pre-existing heart disease and Dr Snyder compared the ECG to a previous ECG in the clinical records. He came to the conclusion that there had been no change in Mr Taylor's baseline. There was no criticism of this assessment and it appears to reflect the situation.

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[30] Transcript, page 36
[31] Transcript, page 29
[32] A non-specific inflammatory marker
[33] Exhibit C7, page 4
[34] A non-specific inflammatory marker
[35] Exhibit C7, page 6
[36] Transcript, page 20
[37] Exhibit C6, page 15

Plan to discharge and discussion with Dr Patel

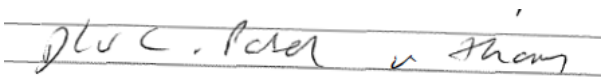
92 As he explained in his oral evidence, Dr Snyder formed a plan to discharge Mr Taylor with oral antibiotics to treat his UTI and to recommend a general practitioner follow up in three days.

93 Before he put the plan into action, Dr Snyder discussed Mr Taylor's case with a more senior doctor, Dr Chirag Patel. Dr Patel was not rostered to work in the ED, however the senior doctor on duty at the time, Dr O'Neill, was busy with another case and not available. An entry that there had been a discussion was recorded in Mr Taylor's notes, but no detail as to the content of it.

94 Dr Snyder's decision to discuss Mr Taylor's case with a more senior doctor was entirely appropriate. The issue that arose was not with the decision to obtain advice, but what information was discussed during this conversation.

95 As I have discussed and will be detailed further below, the vital signs and history contained within the paramedic's PCR held the key to a proper understanding of Mr Taylor's underlying condition. Because Dr Snyder had not fully considered this information himself, he did not discuss it with Dr Patel. Had he done so, I consider that it is probable the advice would have been to admit Mr Taylor to hospital and commence IV antibiotics.

96 In his statement, Dr Snyder explained that he did not recall the specifics of the conversation with Dr Patel but did remember presenting Mr Taylor's case, the observations, the blood results and the suggested plan.[38] He also recalled a discussion around the improvement of Mr Taylor's observations with the administration of paracetamol. This was consistent with Dr Patel's evidence about the discussion. Dr Snyder recorded in his notes:[39]



97 Dr Patel gave oral evidence at the Inquest. He was trained in medicine at Cardiff University and became a Fellow of the Royal Australian College of General Practitioners in 2018, having already obtained a Certificate in Emergency Medicine.[40] Dr Patel also studied in Clinical Education and holds a Rural Generalist Fellowship.

98 At the time of Mr Taylor's presentation to the ED, Dr Patel was a visiting locum rural generalist at FUNLHN, working at the Whyalla Hospital approximately one to two weeks per month, usually starting on a Monday and working through to Sunday, with shifts approximately 12 hours in length. Depending on where Dr Patel was working in the hospital, his start time would vary.

99 He explained that at the Whyalla Hospital, there were two separate departments: the ED and the inpatient area or wards. In December 2022, there were two doctors rostered for

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[38] Exhibit C13, paragraph 31
[39] Exhibit C6, page 7
[40] Exhibit C14

the ED at any one time; one senior and one junior doctor. The inpatient area would be covered by one doctor.[41]

100 Dr Patel explained that on 4 December 2022, there were two doctors rostered in the ED, Dr Snyder who was the junior doctor and Dr O'Neill as the senior doctor. Dr Patel was working in the in-patient area as the sole doctor on duty for inpatients.[42]

101 Dr Patel had some independent memory of Dr Snyder approaching him to ask about Mr Taylor. He understood that Dr Snyder was seeking reassurance in relation to his planned decision to discharge Mr Taylor. He didn't know the patient to be Mr Taylor at the time, just an older patient with a fever that Dr Snyder was treating in the ED.[43] Given his role as merely providing advice, I am not critical of Dr Patel not having a greater familiarity with Mr Taylor specifically.

102 Dr Patel was not Dr Synder's supervising doctor but did not consider it strange that Dr Snyder had sought advice from him. He explained that the supervising ED doctor could have been busy with another patient. He subsequently learnt that in fact Dr O'Neill was dealing with a very serious case at the time Dr Synder approached him.[44]

103 In relation to his discussion with Dr Synder, Dr Patel gave the following evidence:

> So I remember he came to me to ask me about Mr Taylor. He said he had a plan regarding his discharge but wanted to run it past somebody to make sure that it was appropriate. I can't remember like specifics of the conversation but my usual practice when I give advice to somebody else would be to ask about the history, any specific problems with any abnormalities of the observations, any particular symptoms that were concerning and blood work investigations, what they were like, how they presented in the emergency department and go through all the red flags I guess when we see patients that come into the emergency department…[45]

> So, I know there was a fall. From recollection I kind of got the impression that it was a low mechanism fall, there was a finding of a fever, I can't remember the exact number but it was above 38. There was some suggestion there were some urinary symptoms but I can't recall him mentioning that there were any rigors or a delirium. I can't recall any abnormal observations other than the temperature. From my recollection the observations were normal. He couldn't find anything on examination that was concerning. I did remember going through the bloods because that was electronic at that time and the bloods and the urine pointed towards a urine infection and then my usual practice would be to ask, you know, how are they feeling, are they mobilising etc., and so I think from what I remember he was mobilising independently and in the emergency department he was keen on going home. And so based on that information I agreed with Dr Snyder's plan to start oral antibiotics.[46]

104 Dr Patel explained that the absence of rigors or delirium was reassuring to him as either or both symptoms would raise concerns for the presence of sepsis.

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[41] Transcript, page 55
[42] Transcript, page 56
[43] Transcript, page 60
[44] Transcript, page 61
[45] Transcript, page 57
[46] Transcript, page 58

105 Dr Patel and Dr Snyder reviewed Mr Taylor's blood results (in particular his raised CRP and WCC) on a nearby computer together, but Dr Patel did not review the medical file. Knowing Dr Snyder as a capable doctor, and having worked with him numerous times, he stated that there was no reason to doubt what he was being told.[47] Of course, the issue that arose was not with misinformation, it was instead missing critical information that was readily available in the PCR.

106 During cross-examination, Dr Patel was shown the paramedic's PCR. He did not think he had been shown this document at the time he spoke with Dr Snyder. This was supported by his evidence that his advice to Dr Synder would have been different if he had seen the PCR on 4 December 2022. He said:

> Based on that information, I would have recommended an admission, based on this… I'd be concerned about sepsis.[48]

107 Dr Patel went onto explain what it was within the document that would bring him to this position. He said:

A. So, I'd be - the first thing I'd be looking at is the history, particularly. And just looking at the history about the Rigors and the confusion, delirium, that initially would be a concern. And then when I look at the observations, some of the observations are out of normal range and so that would be something that I would be concerned about as well.

Q. Which in particular.

A. So, I use - generally, I would use things like respiratory rate and the heart rate and the use of oxygen.

Q. So, the fact that Mr Taylor's respiratory rate was 40 at 11 o'clock, 36 at 11.30 and then had come down to 28 at midday.

A. Yes.

Q. And the fact that his oxygen saturations were 89, then 90 on ... and 94 on 3 litres of oxygen.

A. Yes.

Q. Are those the features that you would -

A. And the heart rate.

Q. And the heart rate.

A. Yes.

Q. And that was at 11 o'clock 119 beats per minute, and then at 11.30 and at midday both 117 beats per minute.

A. Yes.

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[47] Transcript, page 60
[48] Transcript, page 66

Q. Is there anything else.

A. No. So those are the main things I would be concerned about.[49]

108 Dr Patel further explained that the positive urine result by itself would not automatically equate to a suspicion of sepsis but when taken with the history, observations and then the blood work (CRP and WCC) together, it was a convincing picture of something more serious at play.

109 Dr Patel's evidence was that while the physiological metrics recorded by the paramedic were important, it was the history (a summary in the presenting complaint area) of the PCR that he would place the greatest weight on. He was of the view that the history gives you 80% of the diagnosis making it '*very important*'.[50]

110 Under cross-examination, Dr Patel accepted that as he had not assessed Mr Taylor himself, Dr Snyder (who had done so) was in the best position to assess his presentation. Namely, that his story was consistent, he appeared of sound mind and that he denied having any fevers or sweats.[51] Dr Patel agreed that Dr Snyder's assessment, different as it was to the paramedic's PCR, was likely to be a correct assessment *at that time*.[52] Dr Patel also agreed that the signs of sepsis can be subtle and difficult to diagnose. He maintained however that importance needed to be placed on the history of delirium (from Mr Taylor's wife, recorded in the PCR) as patients with delirium can sometimes present as clear and lucid.[53]

111 Dr Patel had worked with Dr Snyder since 2020 and described him as '*a very capable conscientious doctor'*.[54] While expressing a level of understanding for Dr Snyder's decision making on the day, he remained firm in his position that the history contained within the PCR was suggestive of a septic process underway.

112 I considered Dr Patel to be an impressive witness and I accept his evidence in its entirety. In particular, I accept that had he been shown the PCR (or provided with the information contained within it), he would have recommended that Mr Taylor be admitted to the hospital. This would have seen IV antibiotics commenced quickly, as a route of administration had already been placed by RN Toth.

113 I accept that, notwithstanding the raised CRP and WCC, the picture provided to Dr Patel by Dr Snyder was consistent with a simple UTI, which would have been appropriate to treat with oral antibiotics in the home environment.

114 I pause to acknowledge that the events leading up to Mr Taylor's death had an obvious effect on Dr Patel. Despite being quite emotional, he took the opportunity at the conclusion of his evidence to convey his sympathy to the Taylor family. Once again, this appeared to be genuine and reflected another commendable approach to this matter.

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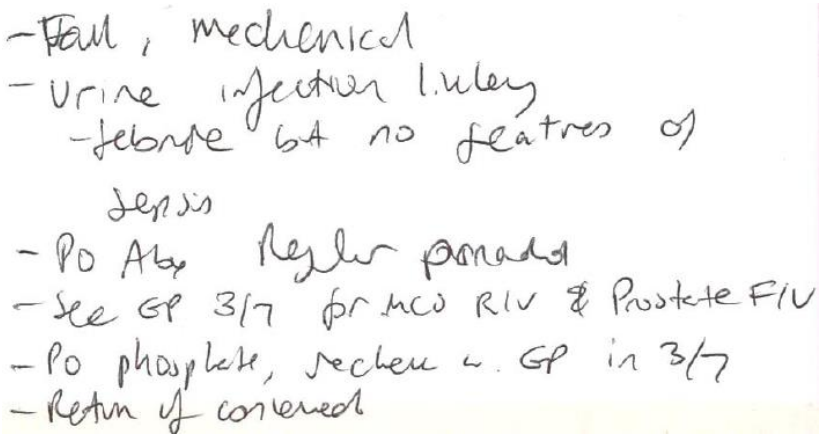
[49] Transcript, pages 66-68
[50] Transcript, page 68
[51] Transcript, page 77
[52] Transcript, page 78
[53] Transcript, page 78
[54] Transcript, page 57

Mr Taylor's discharge home

115 RN Toth completed a set of observations at 3 pm, including the postural blood pressure test ordered by Dr Snyder. Dr Snyder examined Mr Taylor's blood pressure as recorded in the observation chart. He noted that he had mobilised to the toilet and back with no concerning postural drop. Together with his review of the ECG (which was unremarkable in light of Mr Taylor's known conditions), RN Toth was advised that Mr Taylor was suitable for discharge.

116 Dr Synder provided Mr Taylor with a script for the oral antibiotic trimethoprim. Mr Taylor was also given a discharge note which contained the following information:



117 RN Toth made an entry in the clinical records at 3:30 pm which recorded this information as well as documenting the removal of the IV cannula. She then wheeled him out to the car park and assisted him in getting into a car.[55]

5 December 2022

118 The day after Mr Taylor's discharge, Dr Patel was working in the ED. He received a phone call from the laboratory to notify of an urgent result. He made a note that the result related to a blood culture test for Mr Taylor. Dr Patel said that prior to then, he was unaware that a blood culture had been requested. The blood culture revealed the presence of E coli. The significance of this test result was that a bacteria had grown in the sample overnight, indicating that there was bacteria in Mr Taylor's blood which signifies a life-threatening condition. This caused Dr Patel to contact the Taylor residence as I have described.

119 As touched on earlier in the finding, when he made contact with Mrs Taylor, he was informed that Mr Taylor had died that morning.

Professor Anne-Maree Kelly

120 I heard oral evidence from Professor Kelly. She has been a medical practitioner since 1983 and a Fellow of the College for Emergency Medicine since 1990. During her career, Professor Kelly has published an impressive number of research articles, chapters of text books and has contributed to the medical profession in countless ways. She regularly appears as an expert witness in coronial jurisdictions in the different States and Territories

[55] Exhibit C6, page 10

of Australia, as well as in civil jurisdictions. Professor Kelly is a senior emergency physician as well as an academic head at Western Health, Footscray in Victoria. She is the Director at the Joseph Epstein Centre for Emergency Medicine Research and a Professorial Fellow at the Department of Medicine – Department of Critical Care, Melbourne Medical School at the University of Melbourne. It is difficult to reduce into brief words how extensive Professor Kelly's experience is and how much assistance her evidence brings to the task at hand. Her full Curriculum Vitae was received into evidence.[56]

121 Professor Kelly's opinion focussed on two main issues; the importance of considering all evidence available to an emergency doctor including the value of collateral information, and the subtle, yet clear, signs of sepsis that need to be considered. She said that it was more often junior medical practitioners who miss the subtle signs of sepsis, as more experienced practitioners generally act more cautiously when there is some indication albeit accompanied by reassuring signs.[57]

122 Professor Kelly said that Mr Taylor's presentation indicated sepsis. She explained:

> My rationale is that he had a report to SAAS of altered conscious state. He was definitely febrile. He had a report from his wife of rigors. He had urinary symptoms. He was also a high risk person because of his age and his diabetes and he had purple zone and red zone vital sign characteristics.[58]

PCR

123 Professor Kelly said that if she was assessing Mr Taylor's case in the absence of the PCR, she would be less concerned about sepsis, but that she would think about a UTI that had not yet become sepsis that needed to be watched closely for some hours.[59]

124 However, Professor Kelly said that experience has shown that it is '*a dangerous thing*' to disregard information on paramedics' documents.[60]

> Q. And if they are discounted, what are the risks involved in doing that.
>
> A. The risks are that you miss serious illness, that you - for example, again, you might miss that there was a period of severe hypoxia, which could indicate things like pulmonary embolism, etc., which are notoriously transient in some of their features. So it's about missing clues to a serious diagnosis, is the big risk.[61]

125 Professor Kelly said that in her experience, patients are not always the best source of information. She said that often they do not always recognise their own symptoms, particularly confusion where the existence of the confusion confounds their ability to appreciate the confusion.[62]

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[56] Exhibit C15a
[57] Transcript, page 93
[58] Transcript, page 94
[59] Transcript, page 98
[60] Transcript, page 104
[61] Transcript, page 85
[62] Transcript, page 84

126 I accept Professor Kelly's evidence and I find that Dr Snyder ought to have considered the detail of the paramedic's PCR which particularly highlighted several features of sepsis.

Subtlety of sepsis

127 Professor Kelly gave evidence that while sepsis has a high mortality rate, its signs are not always as obvious as doctors would like.[63] She said that once the condition develops to a clear state, it is usually too late to treat with ease. She explained that for that reason, protocols that draw out subtle and early signs are particularly important.

128 Professor Kelly also explained that the signs of sepsis are not always all present and are not always constant:

> So temperature can wax and wane even in a person with sepsis. And the pulse rate can change a bit. Blood pressure not quite so much. Rigors come and go. And confusion can be really subtle and hard to pick up. So when we assess conscious state at the screening level, we only use what's called the Glasgow coma score which basically says if they've got their eyes open do they know where they are and can they move their arms and legs. So it's not a particularly high bar to pass that test. Whereas a family member often will pick up when somebody's not quite right cognitively and be confused about little things, like you know where the Cornflakes are in the cupboard. Those sort of things are not going to be picked up by that Glasgow coma score test.[64]

129 Professor Kelly gave evidence of a particularly important tool to assist with the early detection of sepsis – lactate testing. Professor Kelly explained:

> …lactate is a byproduct of the body's metabolism of oxygen, and how that's transmitted into energy. The body usually clears lactate quite well if there's good blood flow, if there's good perfusion of tissues. Where perfusion of tissues is not good, for example in sepsis, but also in conditions like significant bleeding from another cause, the lactate level will rise. So it's an indication that there is not good tissue perfusion.[65]

130 She said that this is why the Australian Commission on Safety and Quality in Health Care had incorporated lactate as a key step in sepsis detection. She said that lactate levels can be tested in Point of Care venous blood gas testing machines that are available, more often than not, in EDs.[66]

131 Given the subtlety of sepsis and its high mortality rate, Professor Kelly said that it is important to commence IV antibiotics as soon as possible. She said that most pathways in Australia have a one-hour timeframe for the commencement of antibiotics and that it is important not to wait for regular blood test results before commencing. She explained that where the source of infection is unclear, broad-spectrum antibiotics can be commenced, but where the source is obvious, a more targeted antibiotic can be given.[67]

132 Professor Kelly gave evidence that there are some cases where the sepsis pathway is commenced and then the patient's condition turns out not to be sepsis. She described this

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[63] Transcript, page 86
[64] Transcript, pages 91-92
[65] Transcript, page 87
[66] Transcript, page 88
[67] Transcript, page 90

as 'a wonderful thing for all the parties concerned'.[68] That is, it would be a relief for the patient and the doctor. She said that the pathways across the country had been deliberately designed to over-include patients to ensure that no sepsis patient is ever missed. Professor Kelly was very clear that commencing early treatment for sepsis in this situation usually results in better patient outcomes and the approach of the doctors can simply alter course to address the condition that revealed itself. In short, where sepsis is a potential, doctors are encouraged to approach with caution and commence treatment before the full diagnosis is reached. Professor Kelly gave the following explanation:

> Q. If you had a patient and you recognised potential sepsis and commenced with a broad antibiotic, and later you discovered the patient was not in sepsis, is that a problem medically.
>
> A. We're discussing a risk balance issue here. So when you give any medication there is always a small risk of adverse events, for example, an allergic reaction, but also failure to treat sepsis has really bad outcomes. So in general, the risk of not treatment vastly outweighs the risk of treatment.[69]

133 Upon reviewing the Sepsis Pathway, Professor Kelly explained that any observation in the purple zone would combine with any single symptom of sepsis to lead to an approach of sepsis until proven otherwise. She said that the Pathway also provided that two or more red zone observations would have the same result.

134 I accept Professor Kelly's evidence and I find that Dr Snyder ought to have followed the Sepsis Pathway after considering the paramedic's PCR in detail and that if he had, it would have led to the administration of IV antibiotics.

Preventability

135 Professor Kelly was asked for her opinion about Mr Taylor's prognosis if he had been administered IV antibiotics while in hospital. She said:

> Remembering that he's a man of older age with significant - quite significant comorbidities, including of his heart and diabetes, it is likely he would've had a better outcome and it's likely that he would've survived, but you know, there is still a risk that he might - about a 20% risk that he might pass away from this illness.[70]

136 Professor Kelly explained that, as Mr Taylor's blood sugar levels were not low while he was in hospital, he would not be considered to be in the next category of seriousness, which would be patients with severe sepsis or septic shock.[71] His case was therefore in a stage where it was treatable. Professor Kelly said that IV antibiotics would take about 15 to 20 minutes to be drawn up once ordered and then would be administered over a period of time up to about an hour.[72] This was well before Mr Taylor's final deterioration and so was certainly achievable before his condition progressed.

137 In light of my analysis above, I am of the view that, on the balance of probabilities, Mr Taylor's death was preventable. Given that the signs and symptoms of sepsis were

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[68] Transcript, page 93
[69] Transcript, page 90
[70] Transcript, page 101
[71] Transcript, page 101
[72] Transcript, page 108

readily apparent when the PCR was properly and fully comprehended, and that treatment for sepsis was readily available, had Mr Taylor's condition been identified, there was ample opportunity to intervene.

Recommendations

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

139 I have observed above that comprehensive and meaningful changes have been made by FUNLHN in response to Mr Taylor's death. I am satisfied that those changes will have the effect of preventing or at least significantly reducing the likelihood of a recurrence of the same circumstances. That largely addresses the need for recommendations. However, there is one matter where I consider a change should be made.

140 I therefore make the following recommendation to the Minister for Health and Wellbeing:

One That the Updated Sepsis Pathway be amended to explicitly state that the purple and red observations referred to within the pathway include those recorded by hospital staff as well as paramedic staff (if the patient is brought in by ambulance).

141 In my view, if that change were made, it would remove the ambiguity that Dr Snyder felt had led him astray in assessing Mr Taylor's presentation. If that notation had been there, it would likely have directed Dr Snyder's attention to a more careful consideration of the paramedic's observations which would have mandated the pathway and the true nature of Mr Taylor's condition would have been identified in time for treatment.

Acknowledgments

142 I acknowledge the valuable assistance of all counsel in this matter.

143 I would like to convey my sincere condolences to the family and loved ones of Mr Taylor. While he faced significant health challenges, his death would have been no less a shock and the circumstances that Mrs Taylor faced were traumatic and regrettable.

Keywords: *Emergency Departments; Sepsis; Rural Medicine*