



Western

Australia

RECORD OF INVESTIGATION OF DEATH

Ref No: 12/12

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of **Andrew Ian ALLAN** with an inquest, held at the **Northam Coroner's Court, 118 Wellington Street, Northam** on **9-11 May 2012** find the identity of the deceased child was **Andrew Ian ALLAN** and that death occurred on **17 September 2010** at **638 Bogling Road, CALJIE** as a result of **Pneumonia Complicating Influenza A (H1N1) Infection** in the following circumstances:

Counsel Appearing :

Ms Melanie Smith assisted the Deputy State Coroner
Ms R Hartley (State Solicitors Office) appeared on behalf of the Health Department and WA Country Hospital Services (WACHS)
Mr T Dobson (Terry Dobson Legal) appeared for the family
Ms B Bourke (ANF) appeared for Sebastian Swoboda

Table of Contents

Introduction	2
Background.....	2
Medical History.....	3
September 2010.....	5
Presentation at Northam Regional Hospital	8
Post Mortem Examination.....	13
Events following Andrew's Death.....	19
Northam Regional Hospital	21
Conclusion as to the death of the deceased	31
Comments on the Administration of Public Health	33
Recommendations	35

INTRODUCTION

Andrew Ian ALLAN (Andrew) indicated to his mother he was feeling unwell on Saturday 11 September 2010. He did not improve, and on Thursday 16 September 2010 his mother took him to Northam Regional Hospital (NRH) where he was seen briefly by a Registered Nurse. He was told he had gastroenteritis and sent home with his mother. He was found deceased, in his bed, on the morning of 17 September 2010.

Andrew was 16 years of age.

BACKGROUND

Andrew was born on 4 February 1994 in Fremantle and was the eldest of three siblings.

The family all lived on a farm at Caljie, approximately 22 kilometres out of York, where his parents kept horses. Andrew was a student at Northam Senior High School in Year 11. He was a good student and hoped to work in computing eventually. He worked part-time as a kitchen hand at Chicken Treat in Northam, where both his mother and sister also worked part-time.

Andrew's father was working away from home at the time Andrew died.

MEDICAL HISTORY

Andrew had a reasonably normal childhood health wise, but was diagnosed with Attention Deficit Hyperactive Disorder (ADHD) by a Consultant Paediatrician, Dr Savery, in August 2006. He was prescribed Dexamphetamine but suffered weight loss and was instead prescribed Concerta (extended release methylphenidate) which suited him better. In March 2009 Dr Savery added Ritalin to his prescription.

On 9 June 2010 Andrew attended the Wheatbelt General Practice located within Northam Regional Hospital (NRH) and saw Dr Olateju Jinadu with a swelling on his right upper lip to the extent it was deforming the right side of his cheek. In evidence Dr Jinadu explained he diagnosed cellulitis as the result of infection and due to his concern with the location of the swelling prescribed three days of IV antibiotics (Ceftriaxone) to be followed by oral antibiotics (Flagyl) and Panadeine for pain. Andrew was to be reviewed on the third day for the effectiveness of the treatment and the follow-up script.

The arrangement with NRH is they provide the nursing side of Dr Jinadu's practice and the NRH file shows Andrew attend NRH Emergency Department (NRHED) on 9 & 10 June 2010 for his antibiotic injections, but not 11 June 2010. Nor did he attend on Dr Jinadu for a follow-up on that date to enable Dr Jinadu to evaluate the effectiveness of the injections or a script for oral antibiotics.

Dr Jinadu noted from the NRH file Andrew's two injections were for IM Rocephin, not IV Ceftriaxone, and had required lignocaine for pain due to the IM procedure being painful. The IV procedure would have required a cannula be put in place which may not have been convenient if not admitted to hospital.

Andrew re-attended Dr Jinadu on 5 July 2010 with an infection on his calf. Dr Jinadu prescribed oral flucloxacillin, an antibiotic directed towards usual skin infections on this occasion, which would be easier for compliance. On 26 July 2010 Andrew again presented with an infection, this time on his forehead, and Dr Jinadu again prescribed flucloxacillin but at a higher dosage. Dr Jinadu said the location was not part of the "*danger zone*" so he was happy the oral antibiotic remain the antibiotic of choice at that stage.

He also wrote a referral to Dr Savery, at Mrs Allan's request, for Andrew's ADHD and outlined Andrew's current presentation. Dr Savery responded to Dr Jinadu by letter on 24 August 2010 confirming his review of Andrew's progress on Concerta and Ritalin and also suggesting the addition of Chlorhexidine washes and Bactroban Nasal ointment to reduce *Staphylococcal* carriage (load). Dr Savery referred to impetigo, as opposed to cellulitis, which may have seemed significant but in context both are references to infections by common skin pathogens targeted by Flucloxacillin.

In evidence Dr Speers, Head of Microbiology at PathWest, Sate Reference Laboratory, stated he did not think Andrew's non-compliance with the third day of antibiotics in June 2010 had any bearing on the events of September 2010, other than to indicate Andrew had a predisposition, along with many others in the general population, to colonise *Staphylococcal* sp. bacteria.

Dr Speers indicated oral flucloxacillin was an appropriate antibiotic for the treatment of common skin bacteria and used to bring infections, such as Andrew's, under control. Later, with concern colonisation had occurred, it was appropriate to add Chlorhexidine washes and Bactroban Nasal ointment to reduce the carriage of bacteria in an attempt to prevent further outbreaks of infection. In serious cases, recurring over a long period, a different antibiotic is pursued to ensure colonisation is prevented.¹

Andrew does not appear to have presented to Dr Jinadu following his 26 July 2010 attendance again.

SEPTEMBER 2010

Andrew's mother, Kylie Allan, worked at Chicken Treat in Northam as a part-time Assistant Manager. On Saturday 11 September 2010 Mrs Allan started work at 7:30am with Andrew. He appeared to be well at that stage. Mrs Allan finished work at 1:00pm and left Chicken Treat.

¹ Transcript 10.5.11, pg 89.

At 5:00pm Mrs Allan returned to Chicken Treat to collect Andrew. At that time Andrew said he was not feeling well and “*thought he was getting a cold*”. He ate dinner and went to bed.

The following morning Mrs Allan woke early because she was intending to go to a horse show. She and her daughter left the house by 4:30am leaving Andrew and his younger brother at home.

At about 11:30am, as Mrs Allan was heading home, she received a text message from Andrew asking she collect him “*some strong medicine*” as he was feeling really unwell. Mrs Allan stopped at a chemist on Albany Highway and bought some cough medicine (Robitussin) and Strepsils.

Mrs Allan arrived home at approx 1:30pm to find Andrew playing on his play station in his room and cooking himself some lunch.

By that evening Andrew seemed to have a bit of a cough and a cold, but nothing which gave Mrs Allan undue concern. Her son took some of the medication and the whole family went to bed at about 7:00pm. Mrs Allan was required to get up and go to the vet in association with her horses around midnight. At that time her children were asleep at home and all appeared well.

Mrs Allan returned home by 5:00am on Monday 13th and commenced to get the children up for school at around 6:00am.

Andrew said he was still feeling sick and tired so Mrs Allen kept him home from school. Emily, his sister, also felt unwell and she also stayed at home.

Mrs Allan noted Andrew was coughing and drinking a lot of water, and had lost his appetite. He spent most of his day at home, on the lounge, or using the internet.

On Tuesday 14th Andrew did not appear to be any better and he was still taking Robitussin, with Panadol for a headache.

The following day, Wednesday 15th September, Andrew went to see his mother at approximately 6:00am. He was still unwell. He slept all day and was not eating and only drinking small amounts of water. Mrs Allan was quite concerned and gave him some gastrolite in the late afternoon but he was unable to keep it down and vomited it back up.

On the morning of Thursday 16th September Andrew became extremely unwell. He could not eat or drink anything, he was vomiting, had diarrhoea and was sweating profusely. He was extremely weak, could not stand and was pale/white. He had a fever.

Mrs Allan rang Dr Jinadu in Northam, but, was unable to get an appointment. She tried the York doctors' surgery, but was again unable to obtain an appointment. She telephoned NRH at approximately 2:00pm. She was advised to bring her son to hospital. Mrs Allan collected her other children returning from school at 3:15pm, and, after taking her daughter to work, went onto the NRH with Andrew at approximately 4:45pm.

PRESENTATION AT NORTHAM REGIONAL HOSPITAL (NRH)

There is CCTV footage of parts of NRH which was made available to police for the purposes of the investigation into Andrew's death. It contains a time line which has been used to verify Andrew's times of attendance and leaving NRH. The CCTV coverage does not extend to the triage area itself, but is a useful tool in verifying the reliability of witnesses' recall of events.

Mrs Allan walked into NRH with Andrew at 4:50pm on 16 September 2010. At reception she was directed to NRH Emergency Department (NRHED). Andrew had settled on a couch in reception and Mrs Allan indicated he should follow her down to the ED.

Mrs Allan described Andrew as "*wobbly on his feet as he was walking in*" and in the police analysis of the CCTV they described Andrew as "*appears to be unsteady on his feet, a female comes out of the entrance as he approaches and he*

steps back awkwardly and appears to stagger sideways. He is steadied by Kylie putting her hand forward at the hospital entrance sliding doors”..... “Andrew walks straight towards a couch and appears to fall onto the couch. Kylie talks to somebody in reception area. She then walks towards NRHED and it appears she needs to encourage her son to follow”²

In evidence, Leanne Walsh, an independent clinical ED nurse co-ordinator, who had been asked to review the file stated her view of the CCTV was that Andrew walked *“in a lethargic, lumbering fashion with unsteadiness”* which she clarified as *“I considered that he walked in a way a 16 year old wouldn’t have walked. He was stooped.”³*

Mrs Allan can then be seen walking in front of Andrew down to the ED. The triage area for the ED is to the right of the corridor from reception and has its own waiting room, all of which can be observed from the triage desk behind the glass triage window, but not from the ED proper.

Mrs Allan said she waited a few minutes and then a male nurse came to the window and she explained to that nurse her son was sick. The male nurse concerned was RN Swoboda. In evidence Mrs Allan described Andrew as wheezing and having noisy breathing while in the hospital.

² Exhibit 1/2, pg7

³ Transcript 10.05.12, pg 137

At that time the CCTV footage of the ED shows Dr Jinadu and a female nurse standing at the nurses station completing paper work, however, they cannot see Mrs Allan or Andrew enter the triage area.

RN Swoboda came out of the ED and into the triage waiting area where Mrs Allan described Andrew's symptoms to him. Mrs Allan advised RN Swoboda Andrew was vomiting, had diarrhoea and had a fever. She described a headache. Mrs Allan was concerned Andrew had pneumonia as her sister had died from pneumonia recently.

RN Swoboda asked Andrew if he had a sore neck to which Andrew replied "Yes". According to Mrs Allan the RN did not appear to take this further by asking Andrew whether or not he was photophobic, or had a rash, nor according to Mrs Allan, did he check Andrew's blood pressure, pulse or respirations.

RN Swoboda, in evidence, effectively indicated Andrew's symptoms did not appear to indicate he was particularly unwell and, having satisfied himself Andrew's symptoms were inconsistent with meningococcal, he believed Andrew was suffering gastroenteritis, an illness he had experienced recently.

RN Swoboda obtained a pamphlet on gastroenteritis, some junior Panadol and two hydrolyte poles, one of which he gave to Andrew and suggested he consume it then, which he did.

RN Swoboda advised Mrs Allan Andrew should be better in approximately 10 days.

Mrs Allan was certain there was more wrong with Andrew and told the nurse she believed he was severely unwell. She agreed RN Swoboda checked Andrew's temperature and said it was over 40°C, however, RN Swoboda recorded it the following day as 39.4°C and said in evidence it was not 40°C.⁴

The RN gave Andrew some children's Panadol but took no further action. Mrs Allan did not see the RN record any observations or notes with respect to Andrew's condition nor did he ask for his name. She did not observe the RN to have anything with which to write, or to write on, in the whole time he was with them in the triage area. She thought he appeared reluctant to touch Andrew in case he caught whatever it was Andrew had. She accepted what the RN said because he was supposed to know what he was doing.

Mrs Allan left NRHED with Andrew and indicated he was still unwell and unsteady on his feet. On the CCTV footage of the Allans leaving NRH Andrew can be seen initially going to the wrong car, before his mother corrects him. Mrs Allan went to the chemist and obtained more hydrolyte sticks for Andrew and also collected something for dinner, whilst waiting to collect her daughter from work.

Andrew remained very unwell in the car and slept until they arrived home at 9:30pm.

⁴ Transcript 11.05.12, pg 200

Andrew went straight to bed after showering and his younger brother, Sean, with whom he shared a room, was aware of Andrew moaning and moving in his sleep with a distinctive cough. This was so bad Sean moved to another room to enable him to sleep in preparation for school the next day.

Mrs Allan heard her son move from one area of the veranda to another, but assumed it was Andrew, rather than Sean, as Andrew frequently used to come out during the night.

At 5:30am on Friday 17 September 2010 Mrs Allan was up when her son, Sean, came in and told her Andrew must be feeling better because *“he wasn’t being noisy anymore”*. Mrs Allan was very concerned and believed something was wrong. She ran straight to the boys’ room and discovered Andrew lying on his stomach with his arms on the pillow. He was wearing long pants and a T-shirt with his head turned away from the door but she could see his fingers and forearms were blue.

Mrs Allan touched her son and felt he was cold.

Mrs Allan called an ambulance and telephoned her husband. She did not attempt resuscitation because to her it was obvious her son was dead.

POST MORTEM REPORT

Andrew's post mortem examination was conducted by Dr Clive Cooke, Chief Forensic Pathologist at the Path West State Mortuary on 21 September 2010.

Dr Cooke noted an apparent infection in Andrew's main airways with laryngo-tracheo-bronchitis. The lungs were congested, raising the possibility of pneumonia. The body organs appeared to be otherwise normally developed with no obvious pathology.

Further testing in the form of microbiology and microscopic examination confirmed pneumonia in the lungs. Both a bacterial and viral infection was identified in Andrew. The viral infection was identified as influenza A virus RNA (H1N1), while the bacterial organism (*Staphylococcus aureus*) was in the larynx, trachea, lungs, blood, spleen and a lymph node in the chest.⁵

In evidence Dr Cooke confirmed his opinion on his investigations Andrew died as the result of a bacterial infection (*Staphylococcus aureus*) complicating a viral infection (influenza A H1N1/Swine 'flu).⁶

Dr David Speers, Infectious Diseases Head and Clinical Microbiologist, Department of Microbiology, Sir Charles

⁵ Exhibit 1, Att 19

⁶ Transcript 9.05.11, pg 57

Gairdner Hospital, was asked to provide an overview of the circumstances surrounding Andrew's presentation to NRHED.

Dr Speers indicated H1N1 is a strain of influenza A which was first detected in 2009 and was responsible for the 2009 influenza pandemic. It also contributed to the 2010 influenza season, and 2011. September is the usual influenza season seen in Perth and the south of Western Australia. Usually H1N1 causes mild to moderate respiratory disease with fever and muscle soreness, but can cause a severe viral pneumonia. Andrew's presentation with diarrhoea and vomiting was typical of approximately 30% of cases in young people. Unwellness with a viral infection often leads to complication with a bacterial infection causing sinusitis, middle ear infection, bronchitis or pneumonia. *Staphylococcus aureus* is one of the most common bacteria involved in this complicating pneumonia. The young and middle aged are more vulnerable to this type of influenza than other more elderly patients, due to a belief older people have a certain resilience derived from earlier exposure to a similar virus.

From the post mortem results Dr Speers had no doubt Andrew was suffering from H1N1 09 influenza A infection, shortly before death, despite the viral culture being negative.

Dr Speers believed this was most likely due to the fact Andrew had been suffering from the infection for approximately six days and his immune system had responded to the virus and produced antibodies to combat the influenza. He thought it

likely the immune response had neutralised the virus by the time of Andrew's death. However, there was abundant infection by *Staphylococcus aureus*, cultured from Andrew's nose, larynx, trachea, left and right lung, spleen and blood.

Dr Speers confirmed Dr Cooke's cause of death indicating Andrew had *Staphylococcus* infection of the upper and lower respiratory tract and had developed septicaemia. His view was Andrew died from severe *Staphylococcus* sepsis as a complication of H1N1 09 influenza A infection.⁷

It is likely Andrew's preceding skin infection was also *Staphylococcus aureus* for which Andrew had been prescribed an appropriate antibiotic, Flucloxacillin. Flucloxacillin will settle an acute *Staphylococcal* infection, but will not clear *S.aureus* colonisation, which would have been present in Andrew's nose and throat.

In Dr Speers view the likely series of events was:

“Andrew was first colonised in the nose and throat by a strain of S aureus that had caused him problems over the preceding months. When he became infected with the influenza, the virus disrupted his respiratory tract lining breaking down its defences and allowing the S.aureus to invade causing the laryngo-tracheo-bronchitis and pneumonia. Membranous laryngitis and tracheitis due to S.aureus as a complication of influenza is uncommon but is seen more often in the young, especially males. It can be a severe infection leading to airway obstruction manifesting as wheeze or croup and can be fatal. Staphylococcus aureus

⁷ Exhibit 3

pneumonia following influenza infection is also recognised, including with the H1N1 09 influenza A strain”.

Andrew’s wheezing and noisy breathing had been noted by both his mother and his younger brother, especially on the night he died, to the extent Sean was unable to remain in the same room to sleep.

Dr Speers continued,

“once this infection was established it then spread to his blood to cause septicaemia”.

Overall, Dr Speers suspected Andrew had been recovering from the influenza virus but his recovery was complicated by the *Staphylococcus aureus* already present in his system. He developed pneumonia and septicaemia and died.

It is possible to treat influenza A with anti-viral agents, but Dr Speers was not prepared to conclude Andrew would have survived, given an anti-viral agent because he did not believe the influenza A was Andrew’s direct cause of death. Nor did he believe anti-viral agents would have prevented the secondary *Staphylococcus* sepsis, although they may assist.

Flucloxacillin is an appropriate antibiotic for the treatment of *Staphylococcus aureus* and would have been the antibiotic of choice in Andrew’s situation.

However, Dr Speers was doubtful oral Flucloxacillin would have been effective with Andrew by Thursday 16 September 2010, when he presented to NRHED, due to his significant unwellness and vomiting. By that time Dr Speers was of the view only IV antibiotics would have been effective and this should have been the treatment given to Andrew on that presentation, if it had been appreciated how unwell he was.

Dr Speers would not commit as to whether or not IV antibiotics at approximately 5:00pm on 16 September 2010 would necessarily have saved Andrew's life. However, there is no doubt appropriate antibiotics for the bacterial infection, and appropriate life support for his well being, would have improved his chances of surviving the septicaemia, which by that time Dr Speers considered was well developed.

Dr Speers felt Andrew had developed the influenza A on the Saturday when he first reported feeling unwell. He should have been improving by the Wednesday, but instead worsened, making it likely that was the time the *Staphylococcal* infection became aggressive. The fact he was vomiting with headache, diarrhoea, sweats and unsteady by Thursday 16 September 2010, and had a febrile temperature of 39.4°C, indicated it was well developed. Dr Speers commented:-

“fever due to influenza is usually only prominent in the first few days of infection and a temperature to this degree 6 days into illness would not be expected. At this point the

bacterial infection would have been well established causing the fever and Andrew's other symptoms”⁸

It was Dr Speers' view Andrew was already septicaemic when he attended NRHED as the symptoms he was exhibiting are consistent with those described by his mother and reflected in the CCTV footage available for NRH.

Dr Speers suspected Andrew would have been tachycardic (fast pulse rate) and hypotensive if those observations had been recorded. The high fever and sweats, with cold hands and blotchy skin reported by his mother at that time are consistent with septic shock. The fact Andrew died some few hours later led Dr Speers to believe Andrew may have subsequently died, even if admitted and given appropriate antibiotics, as by that time the *Staphylococcal* septicaemia may have been irreversible.

Dr Speers believed this was a tragic case -

“where an uncommon yet fatal bacterial infection complicating influenza was mistaken for a gastrointestinal illness due to the presenting complaints of vomiting and diarrhoea on presentation to the ED. However, from other testimony there were additional signs and symptoms present to indicate a more serious illness”.

Dr Speers believed the later recorded temperature of 39.4°C should have been enough to prompt better assessment which he believed would have revealed abnormal observations.

⁸ Exhibit 3.

In evidence Dr Speers described the mechanism of the interaction between the viral and bacterial infections as follows:

“I believe Andrew is what we call “immunocompetent” where his make up of his immune system is robust. The influenza doesn’t damage the immune system per se, what it does is it disrupts the lining of the respiratory tract. There’s normally good barriers on the lining of the respiratory tract to keep bacteria out, but when you get a virus infection it infects all the cells lining the respiratory tract and they die, and that allows breaches in the lining of the respiratory tract which then allow the bacteria access deeper inside. So the immune system is working but the physical barrier to keep the bacteria out is what actually is compromised with influenza. How quickly you then go on and get septicaemia is variable, as I said, but it can happen quickly, within several days.”⁹

EVENTS FOLLOWING ANDREW’S DEATH

On the morning of Andrew’s death, Dr Steed, in York, became involved with the Allan family and his initial concern was whether or not Andrew’s death suggested his family were at risk from whatever had affected Andrew. Mrs Allan had notified NRH of Andrew’s death and the Acting Manager Clinical Services, RN Pitter, was anxious to discover the involvement of the hospital. No paper work had been completed for Andrew’s presentation to the ED but a file in his name had been placed in the ED sometime during the evening of 16 September 2010.

⁹ (Transcript 10.05.12, pg 90

RN Tracey van den Ende had seen the file but not the patient. There was no MR1 on the file. RN Swoboda had been on duty and when he arrived at work he explained to RN Pitter he had seen Andrew but had not completed the MR1 due to other more urgent presentations. He agreed to complete a retrospective MR1 to assist Dr Steed in his review of the family. Later results showed Emily tested positive to the H1N1 virus, consistent with her un-wellness on the Monday morning.

The only observation recorded retrospectively on the NRHED MR1 for Andrew is a temperature of 39.4⁰C with a Triage Score of 4. The narrative section covers an assessment to exclude meningococcal as a diagnosis. It covers observations Mrs Allan says were not assessed, and one which is in contradiction to Mrs Allan's description of Andrew at the time of triage.

In addition, RN Swoboda's given reasons for not documenting Andrew's presentation at the time by way of a completed, or even semi completed MR1, are not supported on the CCTV footage of the ED and the NRH reception.

RN Swoboda recalled Andrew as presenting at a time when there may not have been a doctor in NRH and denied registering Dr Jinadu in ED. In the CCTV footage RN Swoboda can be seen walking around Dr Jinadu and a senior nurse in ED when he went to the drug room to obtain children's Panadol for Andrew.

The hospital records also indicate the emergency presentation to which RN Swoboda referred, as occurring almost four hours after Andrew's presentation.

In every aspect in which RN Swoboda's version of events can be tested by other evidence he proved to be unreliable. In any dispute between his evidence, and that of Mrs Allan as to what occurred at triage, one has to accept Mrs Allan's version as being reliable and, in fact, consistent with the lack of documentation and proper assessment at the time.

NORTHAM REGIONAL HOSPITAL (NRH)

NRH, despite being a Regional Hospital, does not have any resident doctors and until 2006 was exclusively operated from the medical perspective by the attendance of medical General Practitioners (GPs) from the area, on roster. NRH services eight other country hospitals in its region, none of whom have resident doctors.

In 2006 WA Country Hospital Services (WACHS) instituted a service whereby they assisted a GP with their practice in return for GP assistance, in the hospital, during normal working hours. Apparently this was triggered by one of Northam's GPs being unable to continue on the roster system.

Dr Jinadu was employed by WACHS to assist NRH by having a general practice within the hospital facility, in return for attending emergencies within the ED during normal working

hours. He also attended in the ED between the hours of 11:00am to noon, and from 4:00pm to 5:00pm, to attend non-urgent presentations. He was also part of the town GP roster system for out-of-hours attendances to NRHED. This effectively tied in with the Australasian Triage Scores which are utilised Australia wide for the treatment of patients presenting at the ED of Public Hospitals.

Essentially, a triage score of 1 or 2 would entail Dr Jinadu presenting immediately to the ED to assist, a score of 3 at the time he had completed his current patient appointment, and a score of 4 or 5 would be attended in his regular twice daily hours in the ED. In return NRH provided Dr Jinadu's practice with nursing care so that when he wrote a prescription for a particular treatment it was taken to the ED, and would be attended to by the nurses. This was the first time NRH had its own doctor available, on site, during working hours.

The practice in NRH was for a patient to attend at the ED waiting room, where there was a triage desk facing the waiting room, with a glass window. A nurse sitting at the triage desk had a pile of blank MR1 forms to the right of their seat, and the expectation was that when a patient presented to the window the MR1 would be completed as part of the assessment as to whether or not a patient needed to be admitted to the ED for further assessment and review by a doctor.

In the event a file had not yet presented to the ED, the MR1 was to be placed on the file when it became available. The MR1 therefore necessitated the patient's name being written in the appropriate blank space at the top of the MR1. That would indentify the patient and file to whom the assessment belonged.

The expectation was the MR1 would be filled by whichever RN triaged that particular patient to determine the reason for their presentation.

In September 2010 there was no Triage Competency Assessment; however, the Australasian Triage Guidelines did specify nurses performing triage should have some training in triage. The observations needed to establish a triage score are basic nursing training. The score itself may entail some interpretation, which may be a more subjective exercise and improve with experience. One would expect a nurse with less experience to err on the side of caution if no more senior input was available.

There are in operation numerous Health Department Operation Circulars and Operational Directives referring to guidelines for triage for patients in non-teaching hospitals. These are protocols and directives of the Health Department and are available on line for the use of all staff and are maintained in EDs in hard copy by way of policy and procedure manuals.

The intention is a patient presenting to an ED will be attended by a medical practitioner, but the urgency with which that occurs depends on a nurse assessing the patient to determine the urgency or priority of the presentation. Triage scores of 4 or 5 are usually not considered to be urgent, and patients will frequently leave and attend a GP by appointment, rather than wait for appropriate review by a doctor, particularly if an ED is busy.

The presentation must, however, be recorded accurately by the triage nurse, to ensure those requiring urgent attention are seen in as timely fashion as possible.

I accept triage times are not always met Australian wide, but I am satisfied that in the month prior to Andrew's presentation, NRH had met the majority of its triage scores in reasonable times. The records for NRH generally indicate urgent patients scored as between 1 and 3 are seen by a doctor within triage times. This is often not the case in large tertiary teaching hospitals where there is considerable pressure on EDs. Most EDs manage scores of 1 or 2 effectively.

RN Swoboda was a ,junior nurse, employed at NRH as a casual level 1.2 RN. He had approached NRH for employment and, not unusually, NRH was interested in the availability of an RN to assist in the hospital. He gave his experience since graduation as primarily in the areas of mental health, coronary care, and ED at Fremantle Hospital. In his CV he describes himself in very positive terms.

RN Pitter, along with the Acting Operations Manager, Jenny Lee, interviewed RN Swoboda in June 2010 and believed he appeared to be a confident and competent nurse who would, with experience, become a valuable part of NRH. He had some experience with remote nursing, having obtained his qualification at the Broome Notre Dame Campus, and had some experience with nursing in the Broome Regional Hospital. Broome has had resident doctors for sometime.

RN Pitter decided RN Swoboda would be useful for their ED in view of his prior experience, but noted she believed he would need support at Triage. This was due to his junior experience.

In evidence RN Swoboda advised the court he had never triaged alone before. In the Fremantle ED he had acted as a waiting room nurse where he assessed patients to ensure nothing urgent occurred prior to primary triage assessment, or patients waiting admission to ED.

RN Pitter agreed in evidence she had not advised RN Swoboda he would need support at triage because she believed it obvious a junior nurse would refer to a more senior nurse in any areas in which he was uncertain. The MR1 form indicates the observations required for the purposes of assessing a triage score, and while the score may be subjective and based on experience, the observations themselves are objective. As an RN, RN Swoboda knew how to take all the necessary observations.

RN Pitter said she had rostered herself on with RN Swoboda when he first commenced work and her overview of his competence was he was managing well, and would be able to operate in the ED with senior nurses for reference and a doctor on site for emergencies. RN Pitter said she provided RN Swoboda with a preceptor for his initial acclimatisation to the NRHED and, there was a senior nurse rostered on duty with him on each occasion.

RN Pitter rostered RN Swoboda's preceptor as Tracy van den Ende, however, RN van den Ende did not recall ever being told RN Swoboda needed support at triage.

RN Pitter agreed she had not emphasised to RN Swoboda the difference between a tertiary hospital and NRH, however, believed that was obvious from his experience in Broome, and the fact all nurses understand the difference between a tertiary teaching hospital and more remote locations.

RN Kim Clothier, Acting Workforce Development Coordinator for WACHS in 2010, gave evidence she was responsible for organising all training for all staff across the eight sites of the Wheat Belt Western District including essential skills and induction. She was located at NRH and there provided the initial orientation to the hospital, and specific orientation based on wherever staff were to be working.

RN Clothier cannot specifically recall RN Swoboda's initial day orientation, but does recall she had been asked to provide it. RN Clothier provided to the court a copy of all her orientation documentation which fell into two parts. One part involved personnel information with respect to the hospital, and the other part was a Competency Training Package, which nurses were supposed to work through and be assessed on at periodic reviews. The first review is usually six weeks after a new nurse's start date.

It became obvious from the evidence RN Swoboda worked at NRH as a casual nurse for six weeks before he went away on leave. On his return from leave he was absent for a period due to un-wellness and had only been back at NRH for a period of weeks before Andrew's presentation. He was therefore both a junior nurse and relatively inexperienced at NRH.

RN Swoboda denied having received an orientation package of Competency Training he was supposed to study, but agreed he was shown where the operational directives and protocols were located in the ED and received the human resources part of the package. He stated he had never triaged alone but agreed the observations required for triage were basics that, as a RN, he would be able to complete.

It is common ground he did not receive his six week review because of his absence from NRH at the time it fell due.

It is also clear he was not followed up on his return to NRH.

It is also evident RN Swoboda did not frequently ask for assistance, although it would have been obvious there were always senior nurses present; and from his evidence in court it appeared he considered his general nursing practice to be superior to that of other nurses, and his clinical skill superior to that of Dr Jinadu. I find this surprising as the expert overview of Dr Jinadu's treatment of Andrew with respect to his earlier skin infections, was considered to be appropriate; while I have to accept the assessment RN Swoboda made of Andrew at approximately 5:00pm on 16 September 2010 was lacking.

In evidence RN Swoboda said he did conduct an assessment of Andrew and jotted notes on a piece of card. He denied he had told Mrs Allan's Andrew's temperature was over 40°C. In a statement provided before the inquest to the court the RN stated he had discounted the temperature because he believed tympanic thermometers to be inaccurate. He could not explain why he had not filled out the MR1 from the piece of card, other than to say he was distracted by a more urgent presentation which he remembered as immediately following Andrew's presentation, rather than four hours later.

He stated there was no doctor on call at the time which he thought was about 6:0pm, although Dr Jinadu was a significant presence within the ED at the time of Andrew's presentation.

On RN Swoboda's assessment of Andrew's presentation there was no need to call Dr Jinadu to review Andrew because he was showing no signs of being seriously unwell. Had it not been for all the other objective evidence negating RN Swoboda's version of events it may have been a clear dispute between RN Swoboda's alleged assessment, and Mrs Allan's assertion he did not assess Andrew at all.

I have already said I found RN Swoboda's recollection unreliable and would accept Mrs Allan's evidence as to Andrew's presentation. In addition the evidence of Dr Speers indicated the evidence of Mrs Allan was more likely to be accurate in view of the imminent fact of Andrew's death, hours later.

I accept young healthy people often maintain an ability to compensate for a compromised metabolic system; and when no longer able to compensate crash very quickly, but Andrew was clearly showing signs of septic shock and observations would have indicated abnormalities in his functions.

While I accept NRH should have made it clear to both RN Swoboda, and all senior nurses with whom he worked, he was to be supervised for triage activities, I do not accept a RN, no matter how junior, is incapable of the objective observations required to substantiate an appropriate triage score. Andrew's recorded temperature of 39.4⁰C along with serious parental concern should have been enough, for even a

junior nurse, to seek the assistance of a more senior nurse, and indeed the doctor who was metres away in the ED.

I am sure RN Swoboda was correct in saying not all patients are referred to a doctor, but assume he is referring to those not attending for assessment and triage, or attending for assessment and receiving a triage score of more than three after objective observations have been taken. It was accepted patients presenting are not always seen by a doctor but steps were taken, where relevant, to obtain GP appointment elsewhere.

RN Swoboda was not a newly graduated RN. He had worked in Fremantle hospital which is a busy ED. While I accept the situation in NRHED may not reflect that of a tertiary institution the procedures and protocols for triage, referral to doctors, and admission needs are not so very different, just more awkward to instigate. There is often an advantage with remote EDs having fewer emergencies, but a disadvantage in there being less capacity to deal with multiple emergencies.

I am unable to accept RN Swoboda as being unaware Dr Jinadu was still available in the event he had actually put his mind to proper assessment and referral to a medical practitioner, if necessary.

Dr Jinadu and RN van den Ende are clearly visible approximately a metre and a half from RN Swoboda just before he goes to the triage window. He must have been distracted

not to have taken the opportunity offered by the doctor, still present in ED, and presentation of a 16 year old with a very concerned mother.

I accept the procedures and protocols available to triaging nurses were extensive and acknowledge it is very difficult to remain abreast of all information without specific training and education alerting triage nurses to special concerns.

This is now mandatory and triage nurses are accredited for competency.

Andrew's presentation none-the-less warranted, at least, a proper assessment by proper observation. Had Andrew been referred for medical review he could have been admitted, provided with IV antibiotics, adequate fluid support and transferred to a tertiary Perth Hospital.

At least in that situation Andrew's family would feel all that could have been done, was done, and that he had an opportunity for survival.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied Andrew was a 16 year old student who, in the months preceding his death, had suffered from skin infections. He had been provided with, firstly IM, and then oral antibiotics which had settled the eruptions.

On or about 11 September 2010 he contracted influenza A which exhibited itself with him feeling unwell. He did not seek medical attention at that stage because he believed he was getting a cold. Andrew stayed home and was probably recovering from the influenza infection when a pre-existing *Staphylococcus* colonisation invaded his disrupted airways and caused bronchitis. Instead of recovering from the influenza A H1N1, Andrew began to suffer from *Staphylococcal* pneumonia.

On 16 September 2010 Andrew felt extremely unwell, to the extent he was accepting of the fact he needed medical intervention. Unable to obtain him a GP's appointment Mrs Allan took Andrew to NRHED. This was in fact the most appropriate place for his presentation in view of the fact he now needed IV antibiotics at the very least.

Unfortunately, the extent of Andrew's illness was not recognised and his superficial symptoms dismissed as gastroenteritis. The fact of the abnormally high temperature, sweats, blotched skin and clammy cold hands was not adequately assessed as indicating septic shock and as a consequence he was not referred for medical assessment, despite the fact a doctor was present in ED meters away. Andrew was septicaemic.

Andrew was discharged home where he went to bed and died in the early hours of the 17 September 2010.

It is impossible on the evidence of Dr Speers to say Andrew would have survived despite full and appropriate medical intervention at 5:00pm on 16 September 2010, however, I find he was deprived of the opportunity for proper medical care and succumbed to a naturally occurring medical condition.

Accordingly, I find death arose by way of Natural Causes.

COMMENTS ON THE ADMINISTRATION OF PUBLIC HEALTH IN NRH

I accept NRH responded very promptly to the situation in the ED once the realisation of Andrew's inadequate triage assessment was clarified. I also accept WACHS acted very promptly to ensure all nurses triaging patients at country hospitals were competence assessed for the purpose.

I acknowledge Health Department Directives now require nurses performing triage have appropriate training and experience before triaging alone, by way of Competency Compliance assessment.

There are now very clear guidelines in WACHS EDs for the purposes of triage and there are protocols and policies for both primary and secondary triage.

In addition, the CCTV coverage in NRH now ensures coverage of the triage area from within the ED and so enables senior

nurses to view the triage process even though they may not be present. This would ensure knowledge of what was happening, but would not necessarily promote intervention if it looked as though appropriate assessment was occurring. It would be a support tool for later audit, however.

I acknowledge NRH has difficulty filling senior positions which puts quite unreasonable pressure on those prepared to act in senior roles. It is to their credit they do so, and to her credit RN Pitter accepted some responsibility for a lack of on-going supervision of RN Swoboda, in that she had not advised him or others he needed support at triage.

While I have some sympathy for the situation in which RN Swoboda felt he found himself, and accept it was partly due to inexperience, I note he did not consider himself junior or inexperienced prior to 16 September 2010. While confidence is a good attribute for effective decision making, over-confidence can be dangerous. In the event of uncertainty one would expect over-referral, rather than under-referral, for experienced input.

I am concerned regional hospitals need to spend more time ensuring relatively inexperienced nurses have a good understanding of the realities of the differences between a teaching hospital and a remote hospital.

In view of the fact the practices, procedures, protocols, operative circulars and operational directives concerning all

aspects of hospital care, and particularly protocols within the ED are so extensive; it must be impressed upon inexperienced nurses they must always work in conjunction with a more senior nurse until all orientation competency packages have been appropriately completed and reviews undertaken.

The evidence from RN Daly and RN van den Ende was, the ongoing competency packages take months to work through appropriately, and in the case of triage competency, need to be refreshed annually. This is required to be completed out of work hours if necessary, and the reality in the country is many nurses have little time in which to keep abreast of information without specific educational sessions. I have referred to the difficulties with resources to back fill nursing positions to allow at work education workshops previously.¹⁰

I recommend:

1. WACHS develop a standardised on-line e-learning package for preceptors.
2. Nursing rosters make it plain who is a preceptor on any given shift.
3. Introduction of a requirement all new nursing staff sign to acknowledge receipt of orientation documentation and

¹⁰ West 1/10

that the document they sign contains an index of the documents they receive.

4. Mandatory provision of verbal and written advice to all new nursing staff detailing the differences between working in a tertiary hospital in the metropolitan area and a regional hospital such as NRH.
5. Mandatory provision of verbal and written advice to all new nursing staff detailing the role of preceptors and the area/s in which it is believed the new nurse requires support over and above that of adapting to a new regime/facility.
6. Mandatory completion of the MR1 (or equivalent) patient name and basic observations at/for every presentation to triage unless impossible due to the patient's state of consciousness and/or required immediacy of treatment.
7. The Department of Health continue the roll-out of the new patient administration system to ensure improved access to clinical information to country hospitals and real time access to patient information.
8. Provision of on-site educational workshops to assist in competency compliance in key areas which must include triage. This will require roster support.

Finally, Counsel for RN Swoboda indicated he has already been referred to the Nursing and Midwifery Board of the Australian Health Practitioner Authority (AHPA) with respect to this incident. In those circumstances I will not separately refer this matter to AHPA for their determination as to the appropriateness of his triage assessment and conduct in view of his registration.

EF VICKER
Deputy State Coroner
18 May 2012