STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Naomi Williams
Hearing dates:	17-21 September 2018 (Gundagai); 13-15 March 2019 (Lidcombe)
Date of findings:	29 July 2019
Place of findings:	Tumut Local Court
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – septicaemia, secondary to *Neisseria meningitides* infection, nurse directed discharge, implicit racial bias in health care systems, Aboriginal Health Workers
File numbers:	2016/2569
Representation:	Ms L Whalan SC, Counsel Assisting, instructed by Mr J Herrington, Crown Solicitor's Office Ms M Gerace and Mr C Longman instructed by Ms N Jandura, National Justice Project, for Ms Williams' family Mr M Fordham SC, instructed by Mr L Sara, Hicksons Lawyers, for the Murrumbidgee Local Health District Ms T Berberian, instructed by Ms A Cran, MDA National, for Dr Elizabeth Golez Ms P Kava, New Law, for Registered Nurses Shirley Adams, Julie-Ann Brewis and Lorraine O'Sullivan

Non-publication orders: Pursuant to s. 74 of the *Coroner's Act 2009*, a non-publication order is made with respect to the contents of Exhibits 4 and 5.

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Introduction

1. Naomi Jane Williams ('Naomi') was a Wiradjuri woman, born in Tumut on 14 April 1988. She was 27 years of age at the time of her death. Naomi was pregnant, the pregnancy at that time being at least 22 weeks of gestation. Naomi and her partner, Michael Lampe were looking forward to the birth of their son with immense anticipation and happiness.

2. Naomi was well loved and well respected in her community. Her mother, Sharon shared the following description of her only daughter,

> *Nay was an outgoing child. She enjoyed the local Aboriginal community where she lived and she was involved in community activities from an early age. Nay loved movies, music, writing poetry and painting Aboriginal art. After finishing school, Nay completed a business administration traineeship. She worked for the Yurauna Centre. She worked for Barnardos and she did relief work at Toora Women's Refuge. When she went home to Tumut she became qualified as a disability support worker and she worked at Valmar with disabled adults and her clients loved her.*
> *At the time of her death my daughter was a beautiful 27 year old woman, passionate about social justice, excited about being pregnant with her first child and she was highly respected for the strong, hard-working Wiradjuri woman she was.*[1]

3. Naomi's partner, Michael Lampe described their joy in anticipating the birth of their son. He spoke of Naomi's love of nature and family. He described her loving care of his daughter and how content they were creating a life together. His significant loss encompasses both Naomi and his unborn son. He told the court,

> *We had the birth of our beautiful baby boy to look forward to…We talked about getting married and eventually moving closer to my daughter down the coast. The dream Naomi and I wanted was starting to come together, where in life we wanted to be. It really was a dream come true.*[2]

4. Many other family members also shared their love and respect for Naomi and their profound feelings of loss when she died.[3]

5. At the outset, I acknowledge the enormous pain Naomi's family and friends feel and I thank them for their courageous attendance and dedicated participation in these difficult proceedings. It is clear to this court that their motivation has been twofold. They have been dedicated to trying to find out exactly why Naomi died, but they have also been looking for ways to improve health outcomes for other Indigenous patients in their local community. In this way they are honouring Naomi's life and acknowledging her status as an emerging leader of her community.

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[1] Transcript 15/3/19, page 73, lines 20 onwards
[2] Transcript 15/3/19, page 75, line 17 onwards
[3] See statements of Aunty Sonia Piper, Cheryl Penrith, Talea Bulger, Robert Bulger

Background

6. Naomi's death was reported to the coroner on 1 January 2016. Her death was sudden and the exact cause was unconfirmed at that time. After initial investigations, including the provision of an autopsy report and a police brief of evidence, Magistrate Dare SC dispensed with holding an inquest on 23 May 2016. The cause of death was recorded as *Neisseria meningitides* (serotype W135) Septicaemia.

7. Representations to hold an inquest were made by the National Justice Project, on behalf of Naomi's family to the then State Coroner, Magistrate Barnes in December 2016. Magistrate Barnes determined that an inquest should be held. Magistrate Barnes requested the Chief Magistrate's consent to holding an inquest pursuant to s. 29 *Coroners Act* 2009 NSW, given that Magistrate Dare SC was about to retire and would not be available to hold such an inquest.

8. Judge Henson, Chief Magistrate of the Local Court, gave consent to hold an inquest on 15 January 2017 and I was subsequently directed to hold an inquest.

9. Further expert and other evidence was gathered and the inquest commenced in September 2018, with further evidence taken in March 2019.

The evidence

10. The court took evidence over eight days. The court also received extensive documentary material in five volumes. This material included witness statements, medical records, photographs and expert reports.

11. The court heard directly from family members, and from nurses and a doctor involved directly in Naomi's care. A number of expert witnesses gave oral evidence, including Ms Eunice Gribbin, Registered Nurse, Ms Jasmin Douglas, Registered Nurse, Associate Professor Randall Greenberg, Emergency Physician, Dr Hilary Tyler, Emergency Physician, Associate Professor David Andresen, Infectious Diseases Physician and Professor Yin Paradies, Professor of Race Relations.

12. The court also received evidence from Ms Maria Roche. Ms Roche is the Tumut Cluster Manager for Murrumbidgee Local Health District. As at 1 January 2016, Ms Roche was the Acting Rural Group Manager for the Riverina Group, which included Tumut Health Service. She had been in that role since 2013. Ms Roche gave oral evidence but also provided four statements.

13. A list of issues was prepared before the proceedings commenced. It included:

1) The adequacy of the care Naomi received on her first presentation to Tumut Hospital ("the Hospital") on 1 January 2016 at approximately 0015 hrs.
2) The adequacy and management of Naomi's longstanding and retractable condition (which included vomiting, abdominal pain and dehydration) and whether her repeat presentations to the Hospital in the course of 2015 for such symptoms affected:
    a. Naomi's perception or expectation of receiving proper care at the Hospital, including on 1 January 2016;
    b. The assessment of Naomi's condition by Hospital staff on 1 January 2016;
    c. Any delay in her re-presentation to the Hospital on 1 January 2016.
3) The adequacy of Naomi's antenatal management by Dr Golez, including during Naomi's consultation with her on 30 December 2015.
4) The adequacy of the Naomi's antenatal management by the Hospital, including at the time of her first presentation on 1 January 2016.
5) The adequacy of the management of Naomi as an Indigenous patient, including cultural awareness and training of staff at the Hospital and compliance with mandatory education.
6) The policies and policies in force as at 1 January 2016 (and in the months leading to that date): whether they applied, or were applied, to Ms Williams; staff awareness and training with respect to those policies, including: Recognition and Management of a Clinically Deteriorating Patient ('Between the Flags'); Maternity – Clinical Risk Management Program; Maternity National Midwifery Guidelines for Consultation and Referral; Sepsis Kills policy; and Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health.

14. At the commencement of the inquest it could already be established to the requisite standard that Naomi had died on 1 January 2016 at Tumut Hospital, NSW. The medical cause of her death was septicaemia, secondary to *Neisseria meningitides* infection. It follows that much of the contentious evidence in these proceedings centred around the broader circumstances or "manner" of her death.

Scope of the inquest

15. Submissions received from Murrumbidgee Local Health District (MLHD) state that in line with an earlier objection "MLHD objects to the findings addressing issues prior to 31 December

2015 as part of the "manner of death". It follows that recommendations directed to those matters also lack jurisdiction and are beyond power."[4]

16. The MLHD acknowledge that Naomi had multiple presentations at Tumut Hospital in the period before her death. However, it submits that no known relationship has been established between the *Neisseria meningitides* infection which killed her and the chronic gastrointestinal disorders and other health issues which came before. The MLHD further submits that it follows that jurisdiction does not extend to the making of any findings or recommendations in relation to events prior to 31 December 2015. In my view, the matter is not that simple.

17. In support of its argument the MLHD referred the court to well known passages of *Conway* v *Jerram* (2010) 78 NSWLR 371. In that case Barr AJ explained at [52] (in a passage supported by Campbell JA's remarks denying leave to appeal [2011] NSWCA 319 at [39]) that the phrase "*manner of death*" should be given "broad construction to enable the coroner to consider by what means and in what circumstances the death occurred." On the application for leave to appeal in *Conway*, Young JA explained that the scope of an inquest is a matter for the coroner to determine and the appropriate scope depends on all the circumstances of the case (at [47]), while acknowledging that "a line must be drawn at some point which, even if relevant, factors which come to light will be considered too remote [49].

18. It is clear from the authorities that "manner of death" is a phrase that is not readily susceptible to a tight definition. The issue of 'remoteness" will be dependent on the facts of each case. A common sense approach has sometimes been urged. Clearly it would be inappropriate to review Naomi's medical records since birth, but her recent contact with health providers, especially in relation to the very type of symptoms with which she complained (at least to her partner and friend)[5] on 1 January 2016 may well shed light on her expectations for care.

19. I have already stated that I am satisfied that it is appropriate, in the circumstances of this case to examine the nature of the medical history which existed at the time of Naomi's presentation to Tumut Hospital on 1 January 2016. To do that, it is necessary to have some background. It may be that Naomi's decisions or the decisions made by health professionals at a critical time were influenced by what had gone before. It is necessary to have a full picture of the therapeutic relationship between Naomi and her health care providers in an attempt to understand the decisions made by her and by those caring for her in the period just prior to her death. To view the final presentations in isolation is to potentially miss the complex interplay of factors leading up to her final presentations. I have carefully read the submissions provided by

[4] Submissions on behalf of Murrumbidgee Local Health District. Attached to Court file.

[5] Naomi in a text message to Ms McGrath at 11.40pm on 31 December 2015 stated: "…No bleeding, six months today Going to be sick all the way"

those representing MLHD and my earlier view as to whether it is appropriate to look at the final event in isolation has not changed.

20. I am therefore satisfied that in the circumstances of this case, a proper investigation of the manner of Naomi's death involves some review of her recent medical history, that is over the period from May 2015 to 1 January 2016 when there was increased contact with health professionals and the Hospital.

21. Further, I note Barr AJ's observation in *Conway* at [63] that once the evidence justifies the calling of an inquest and an inquest is duly held "the power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death." The power of course does not arise until there is an inquest. Nevertheless, I do not feel constrained to strictly limit any recommendations to events occurring on 31 December 2015 or 1 January 2016.

Brief chronology

22. Naomi had an exceedingly high number of presentations to the Hospital in the period between 10 May 2015 and 1 January 2016. Those presentations were investigated in an attempt to understand whether that history influenced her manner of death in any way. One of the questions which needed addressing was whether the prior management of her medical issues may have produced in Naomi low expectations of care and in turn whether that may have influenced her presentation on the early hours of 1 January 2016 or prevented her early return in the daylight hours. Another issue which arose out of the evidence related to the way in which her prior medical consultations had been recorded. The court was interested in learning whether an appropriate alert on her patient record might have escalated the care she received at the crucial time.

23. It was also necessary to provide the experts with a full picture of her health in the preceding period. This included her attendance at private clinics as well as at Tumut and Calvary Hospitals. In particular, it was essential that a full history could be set out for Associate Professor Andresen, in case it shed any light on the infection which killed Naomi.

24. I have had the benefit of an extremely comprehensive chronology of the medical care Naomi received, which was set out in the detailed submissions of Counsel Assisting.[6] I have considered that chronology in light of the evidence given at the hearings and the submissions I

[6] I have relied heavily on the submissions of Counsel Assisting in the preparation of these Findings, both with respect to the chronology and the analysis of the evidence.

have now received from the parties in this matter. The chronology was not the subject of challenge. I adopt that chronology as part of these findings as follows:

25. On 21 April 2011, Naomi underwent a laparoscopic cholecystectomy.[7] Dr James Fergusson at the Canberra Hospital performed the operation.[8] For an extended period, prior to that surgery, Naomi had suffered nausea, vomiting and pain associated with cholecystitis and later, gallstones.

26. Naomi continued to suffer variously from epigastric pain, abdominal pain, nausea, vomiting and diarrhoea following the removal of her gall bladder. In the period up to May 2015 the presentations and admissions to the Hospital increased, and are summarised in the paragraphs below:

27. On 7 June 2012, Naomi presented to the Hospital complaining of nausea and vomiting extending for several days prior.[9] She was admitted until 9 June and received IV fluids and medication.[10]

28. On 22 October 2012, Naomi saw Dr Sanaur Khan at the Connection Medical Centre.[11] She presented with a history of loose watery stools. She had mild dehydration and the diagnosis was listed as gastroenteritis. Dr Khan advised rest and medication. Review was advised after three days.

29. On 8 May 2013, Naomi saw Dr Winston Wy at the Connection Medical Centre.[12] She presented after having had 5 episodes of diarrhoea. Dr Wy wrote her a medical certificate.

30. On 11 May 2013, Naomi presented to the Hospital with vomiting.[13] She had also had diarrhoea prior to her presentation. She was admitted, received IV fluids and was medication. She was discharged the same day.

31. On 6 November 2013, Naomi saw Dr Eftekharuddin at the Connection Medical Centre.[14] She presented with a cough, vomiting, diarrhoea and abdominal pain. Her observations were stable and Dr Eftekharuddin advised rest, medication and fluids.

32. On 28 February 2014, Naomi saw Dr Regy Joseph at Connection Medical Centre.[15] She presented with vomiting and runny stools, and abdominal pain when vomiting. After discussion

[7] Exhibit 1, Vol 3, Tab C – Canberra Hospital Records, pages 118-120
[8] Exhibit 1, Vol 3, Tab C
[9] Exhibit 1, Vol 3, Tab 14
[10] Exhibit 1, Vol 3, Tab 14
[11] Exhibit 1, Vol 1, Tab 16, pages 7-8
[12] Exhibit 1, Vol 1, Tab 16, page 9
[13] Exhibit 1, Vol 3, Tab 16
[14] Exhibit 1, Vol 1, Tab 16, pages 10-11
[15] Exhibit 1, Vol 1, Tab 16, pages 11-12

with Dr Thi Tran, a general practitioner who also practised at that Centre, Dr Joseph advised medication, blood tests and a pregnancy test. The pregnancy test was negative.

33. On 1 March 2014, Naomi presented to the Hospital with vomiting.[16] She was admitted and received IV fluids and medication. The Progress Notes state she "*admits smoking marijuana on and off*". She was discharged the same day.

34. On 2 March 2014, Naomi presented to the Hospital with nausea, vomiting and diarrhoea.[17] She received medication. She was to be reviewed by Dr Shaheenul Islam, a general practitioner who also practices at Connection Medical Centre.

35. On 3 March 2014, Naomi saw Dr Islam at Connection Medical Centre. [18] She presented for follow-up. She was feeling better, with symptoms almost settled.

36. On 24 September 2014, Naomi presented to the Hospital with vomiting.[19] The nursing notes indicate she had diarrhoea as well as shivers and shakes. She medication. She was not admitted.

37. Presentations to both the Hospital and to the rooms of general practitioners became more frequent still in the period between 10 May 2015 and 1 January 2016. It was this period, which received closer examination at the Inquest and is set out below.

38. On 10 May 2015, Naomi presented to the Hospital with hot and cold flushes and vomiting.[20] She was seen by Dr Golez, a general practitioner practising at that time at Tumut Family Medical Centre. This was Naomi's first consultation with Dr Golez, who she subsequently saw on many occasions both in rooms and at the Hospital. At this first consultation, Dr Golez recorded no history of abdominal surgery, though Naomi was in fact a post-cholecystectomy patient (April 2011). Dr Golez noted a possible diagnosis of food poisoning or viral gastro. Naomi was given maxalon and Dr Golez recorded a plan for Naomi to be reviewed by her GP after 48 hours if she was still unwell.

39. On 12 May 2015, Naomi presented to the Hospital with persistent vomiting.[21] She was examined by Dr Regy Joseph, a general practitioner who also practiced at Connection Medical Centre. Naomi's blood test indicated a raised white cell count and low potassium. She was admitted to the Hospital and received fluids, maxalon, somac, paracetamol, zofran and valium. On the Adult Risk Screen Form completed for Naomi, cannabis use is ticked, "*no*". Naomi was recorded to be, "*very insistent on wanting to go home*". She was discharged on 13 May 2015.

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[16] Exhibit 1, Vol 3, Tab 17
[17] Exhibit 1, Vol 3, Tab 18
[18] Exhibit 1, Vol 1, Tab 16, page 12
[19] Exhibit 1, Vol 3, Tab 19
[20] Exhibit 1, Vol 3, Tab 15
[21] Exhibit 1, Vol 3, Tab 16

40. On 14 May 2015, Naomi saw Dr Joseph at Connection Medical Centre.[22] She presented as having felt unwell for several days, though she was feeling better at the time of presentation. Dr Joseph discussed Naomi's low potassium and recorded that Naomi was experiencing some epigastric tenderness. He noted that Naomi was already on amoxicillin from the Hospital and prescribed pariet and maxalon. He advised Naomi to eat fruit and ordered blood tests. Dr Joseph recorded a plan for review following receipt of the test results.

41. On 5 June 2015, Naomi presented to the Hospital with nausea and vomiting.[23] An entry in the Progress Notes records that Naomi, "*admitted she is depressed*". She was admitted and received zofran, maxalon and IV fluids. The Progress Notes also indicate she was referred to the Local Mental Health Team.

42. On 14 June 2015, Naomi presented to the Hospital with ongoing nausea and vomiting.[24] She was seen by Dr Tran. Nursing assessment notes record Naomi was, "*having counselling for stress-related problems*". She was given maxalon and an abdominal ultrasound.

43. On 15 June 2015, Naomi presented to the Hospital with vomiting.[25] She was seen by Dr Tran. The notes state Naomi's Implanon, a contraceptive device, had been removed because of an ongoing problem with nausea and vomiting. The notes also state Naomi, "*admitted that she uses marijuana*" and had, "*been using it for years*". Dr Tran noted that drug and alcohol counselling was offered and that a form was given to Naomi to have an ultrasound.

44. On 15 June 2015, Naomi saw Dr Joseph at Connection Medical Centre.[26] She presented with vomiting for three days prior. Dr Joseph noted Naomi had recently tested positive for Helicobacter Pylori. He prescribed nexium, esomepraxole, amoxicillin, clarithromycin, maxalon and hydralyte. He recorded a plan for review after two days. On 17 June 2015, Naomi had the abdominal ultrasound ordered by Dr Tran.[27] The report of Dr Yadav on the ultrasound recorded no significant abnormality.

45. On 18 June 2015, Naomi presented to the Hospital with abdominal pain.[28] She was admitted and examined by Dr John Curnow, a general practitioner who also practiced at Tumut Family Medical Centre. Dr Curnow's entry in the Progress Notes indicates that Naomi had returned a positive test for Helicobacter Pylori that week. The plan was for Naomi to remain in the Hospital overnight, to receive morphine or zofran and to be kept nil by mouth until review in the morning. She was to continue medication to treat Helicobacter Pylori. She received morphine and maxalon and was discharged on 19 June 2015.

[22] Exhibit 1, Vol 1, Tab 16, pages 14-15
[23] Exhibit 1, Vol 3, Tab 22
[24] Exhibit 1, Vol 3, Tab 23
[25] Exhibit 1, Vol 3, Tab 24
[26] Exhibit 1, Vol 1, Tab 16, pages 15-16
[27] Exhibit 1, Vol 3, Tab 25
[28] Exhibit 1, Vol 3, Tab 25

46. On 28 June 2015, Naomi presented to the Hospital with vomiting.[29] She was seen by RN Julie-Anne Brewis. RN Karen Hart was also involved in Naomi's management. The provisional diagnosis is recorded as, "*digestive system diseases – emesis* (vomiting)". RN Brewis recorded that Naomi had been presenting to the Hospital, "*with similar symptoms over past couple of months…".* Naomi was noted to be distressed and crying due to sickness affecting her ability to work. Despite an entry in the notes by RN Megan Crain stating that, "*Pt denies drug use*", a later entry in the notes by a doctor (identity unknown) stated that his impression was of possible gastritis, a bile duct stone, or that Naomi' symptoms were a, "*reaction to marijuana*". Naomi was admitted and medications and fluids were planned. She was discharged the same day.

47. On 29 June 2015, Naomi presented to the Hospital at 00:40 with nausea, vomiting and diarrhoea.[30] She was seen by RN Brewis and RN Hart. RN Hart recorded that Naomi, "*denies use of marijuana*". Naomi was given maxalon and left the Hospital around 01:00, with a plan to continue fluids and follow up with her Local Medical Officer.

48. On 29 June 2015, Naomi saw Dr Golez at Tumut Family Medical Centre.[31] In the medical centre notes, Dr Golez states Naomi had a soft abdomen and was "*tender on the epigastrum*".[32] Dr Golez noted that Naomi was undergoing treatment for Helicobacter Pylori but was unable to tolerate the recommended treatment in tablet form.[33] Dr Golez therefore changed Naomi's Helicobacter Pylori treatment from tablets to a syrup. Dr Golez advised Naomi to present to the Hospital for IV fluid replacement and assessment.[34]

49. On 29 June 2015 at 16:40, Naomi presented to the Hospital with vomiting.[35] She was seen by RN Crain who recorded that Naomi was complaining of epigastric pain and "*denies marijuana use*". Later, RN Crain recorded in the notes that Naomi "*admitted to being a heavy marijuana user for the past ten years…Will have daily, if available, but at least weekly…Patient doesn't believe her vomiting related to this, but has agreed to being referred to Drug and Alcohol worker and has been faxed*". RN Crain also recorded that, "*Pt says gave up ETOH two years ago and cigarettes eight weeks ago cold turkey*".

50. At that presentation, Naomi was admitted and examined by Dr Jaison Mangahis, a general practitioner who also practised at Connection Medical Centre. Dr Mangahis noted Naomi did not tolerate oral antibiotics as treatment for Helicobacter Pylori. He also noted Naomi admitted to smoking cannabis daily and that his impression was that her vomiting/epigastric pain was a

[29] Exhibit 1, Vol 3, Tab 26
[30] Exhibit 1, Vol 3, Tab 27
[31] Exhibit 1, Vol 1, Tab 15, page 6
[32] Exhibit 1, Vol 1, Tab 15, page 6
[33] Exhibit 1, Vol 1, Tab 11, para 9, Statement of Dr Golez
[34] Exhibit 1, Vol 1, Tab 11, para 9, Statement of Dr Golez
[35] Exhibit 1, Vol 3, Tab 28

"*secondary complaint of H Pylori infection and marijuana*". The plan was for fluids and Dr Mangahis recorded that Naomi was "*advised to cease marijuana as it* [illegible] *contributes to her symptoms*". Naomi was discharged the same day.

51. On 30 June 2015 at 01:00, Naomi presented to the Hospital with nausea and vomiting.[36] RN Leonie Power noted this was the "*3rd presentation today*". Dr Mangahis was contacted. The notes record Naomi was given maxalon and advised to continue to hydrate and see a medical officer in the morning.

52. On 1 July 2015, Naomi presented to the Hospital with vomiting.[37] She was admitted for review by Dr Golez in the morning. An entry in the notes by RN Leonie Power states Naomi had "*ongoing vomiting for past few weeks…*[secondary to] *marijuana use*" and that she had previously been given a referral to see a drug and alcohol worker. An entry in the Progress Notes by Dr Golez states Naomi had "*SUD* [substance use disorder] *for years – marijuana mild-moderate use*", with the last use being three days ago. Dr Golez's assessment is recorded as, "*substance use dependence…symptoms secondary to withdrawal?*" Dr Golez recorded a plan for drug and alcohol review, continued treatment for Helicobacter Pylori clearance, and for Naomi to be given buscopan.

53. Naomi received Drug and Alcohol and Mental Health Review during this admission. An entry by Viviana Pinelli and Zoe Ezekiel after review of Naomi stated that although Naomi advised she had occasionally used marijuana, "*as self-medication for pain experienced in last two months*", there were no indications of substance dependence or signs or symptoms of mental health issues. Naomi went home around 23:45 on 1 July, against advice that she remain for review by a medical officer in the morning.

54. On 3 July 2015, Naomi saw Dr Curnow at Tumut Family Medical Centre.[38] She presented with nausea and vomiting. The notes state Naomi had been receiving treatment for Helicobacter Pylori and that this had caused the significant nausea and vomiting. Naomi had been maintaining hydration but finding work difficult. She was advised to finish her Helicobacter Pylori treatment and told she may need to seek specialist review after ceasing treatment if her symptoms did not settle. A breath test was organised for Helicobacter Pylori.

55. On 8 July 2015, Naomi saw Dr Golez at Tumut Family Medical Centre.[39] She presented for follow up after completing her Helicobacter Pylori treatment. Dr Golez said she advised Naomi in a long discussion to cease using marijuana, to prevent her having cycles of withdrawal

[36] Exhibit 1, Vol 3, Tab 29
[37] Exhibit 1, Vol 3, Tab 30
[38] Exhibit 1, Vol 1, Tab 15, page 6
[39] Exhibit 1, Vol 1, Tab 15, pages 6-7

symptoms of nausea and vomiting.[40] In her statement, Dr Golez also notes she discussed the need for specialist review if Naomi's symptoms persisted following the Helicobacter Pylori treatment.[41] Dr Golez recorded a plan for Naomi to continue omeprazol and then have a urea breath test.

56. On 13 July 2015, Naomi saw RN Wendy Hargreaves at Dr Golez's rooms.[42] Naomi presented with vomiting and, in consultation with Dr Golez, RN Hargreaves advised Naomi to go to the Hospital for hydration.

57. When Naomi presented to Hospital, her complaints of nausea, vomiting and abdominal pain were noted.[43] An entry in the Progress Notes states Naomi's situation was chronic, that there was no abnormality detected in her vital signs, that she was moist and not dehydrated, and that she had H. pylori causing symptoms of vomiting. She was admitted and given antiemetics. Naomi received a visit from 'Drug & Alcohol' worker, Ms Ezekiel. The entry in the Progress Notes that Ms Ezekiel made is the most detailed recitation in all of the records about how Naomi's condition and the symptoms she was experiencing at this time. The entry is therefore set out in full below:

> *"Drug and alcohol review. Upon entering the room, Naomi was on all fours, hunched over holding a sick bag. Once she began talking to me, she cried and sat up. She then started talking and appeared to be feeling better. She then stated she felt a lot better just talking to someone. She talked for about 45 minutes, all about the stresses in her life. We discussed how stress can often make people feel physically ill. She spoke about missing her mother in Canberra and plans on visiting her this week. She feels that her stomach pains are still a result of her gall bladder being removed and wants further testing. Currently states she is having treatment for helicobacter. Naomi states she ceased ETOH two years ago and ceased tobacco 2 months ago. States she uses cannabis occasionally when she has woken up feeling sick and can't get back to sleep. She feels this helps and finds it difficult with pain medication to get back to sleep. Naomi states that she is not dependent on cannabis and does not use it when she doesn't have funds and doesn't feel she suffers from withdrawals. Naomi has agreed to follow up from MH to talk about her issues and stresses. Naomi does not feel she is at a point where she can give up the occasional cannabis use as it is currently serving a purpose of self-medication for the pain and vomiting. I will arrange follow up by MH worker Rebecca Slater, as agreed to by Naomi".* [44]

[40] Exhibit 1, Vol 1, Tab 11, para 12
[41] Exhibit 1, Vol 1, Tab 11, para 12
[42] Exhibit 1, Vol 1, Tab 15, page 7
[43] Exhibit 1, Vol 3, Tab 31
[44] Exhibit 1, Vol 3, Tab 31, page 3

58. Naomi received a visit from mental health worker, Ms Rebecca Slater, mentioned in the above note. Ms Slater's entry in the Progress Notes records that Naomi was distressed with being sick and feeling depressed. She was noted to be physically sick, from vomiting, as well as distressed and depressed. The initial management plan included psychiatrist review and referral to a support group, but there is no evidence within any of the medical records available suggesting this referral was made or that assessment by a psychiatrist occurred at any stage of Naomi's care.

59. Later, on 13 July 2015, Dr Golez made an entry in the Progress Notes which states, *inter alia*:

> "*Hx of drug use – marijuana (claims off it when sick) …*
>
> *On examination now well. Wants to go home as mum is coming for her tomorrow …*
>
> *Advised symptomatic relief*
>
> *Observe – refer for gastroscopy if still symptomatic 2-3/7 …*
>
> *Decided to go home since mum is coming. Risks explained. Will see her in the rooms for gastroscopy referral instead* [45]

60. Referral for a gastroscopy, or for specialist review, did not occur at this or at any other time. Naomi was discharged the same day.

61. On 16 July 2015, Sharon Williams, Naomi Williams' mother, wrote to Ms Lorraine O'Sullivan, the Acting Multi Service Manager of Tumut/Batlow.[46] In her complaint, Sharon Williams expressed concern that Naomi's illness was being overlooked. She stated that her Naomi did use cannabis, but that when presenting to the Hospital she was being "*stereotyped as some sort of drug addict*" and continually referred to drug and alcohol services, which was "*adding extra stress to her*". Ms Sharon Williams stated she was, "*very concerned*" about her Naomi's condition and specifically raised the need for specialist referral to determine the nature of Naomi's stomach problem.

62. In response to the complaint, Ms O'Sullivan, reviewed the records. She determined that Dr Golez had a plan for gastroscopy (recorded on 8 July 2015) and therefore Ms O'Sullivan, "*did not pursue it any more*". [47]

63. On 13 August 2015, Naomi was seen by Dr Curnow at Tumut Family Medical Centre.[48] By the time of this consultation, Naomi was pregnant, but that was not known at the time. The notes

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[45] Exhibit 1, Vol 3, Tab 31, page 7; Exhibit 2 Supplementary Statement of Dr Golez dated 19 September 2018
[46] Exhibit 1, Vol 1, Tab 10A; Exhibit 1, Vol 1, Tab 11C
[47] Transcript 16/10/18, page 68, lines 5-11
[48] Exhibit 1, Vol 1, Tab 15, page 7

state Naomi, "*has deduced that menstrual cycle +/- gynae pathology may be implicated in episodic hyperemesis*". Dr Curnow made an imaging request and a request for a blood test. The blood test ordered at this consultation later showed Naomi was pregnant.[49]

64. On 1 September 2015, Naomi presented to the Hospital with vomiting.[50] She was seen by Dr Golez who noted Naomi was pregnant. Naomi was admitted and given zofran, somac, metoclopramide, vitamin B6, promethazine, dozylamine and ranitidine. Naomi was discharged on 4 September 2015.

65. During this admission, Dr Golez referred Naomi again to 'Drug & Alcohol'. Dr Golez questioned whether Naomi's symptoms were withdrawal from marijuana, but referred her again because Naomi was pregnant and, "*in pregnancy we have zero tolerance for alcohol, zero tolerance for smoking and zero tolerance for illicit drugs".*[51] Dr Golez said that she also did consider that Naomi's symptoms might be physical and did think about specialist referral, but could not work out to which specialist Naomi should be referred.

66. The level of distress that Naomi was suffering from is clear from the evidence of Ms O'Sullivan. She describes Naomi as highly emotional, very anxious and worried about her newly diagnosed pregnancy. She said that Naomi was crying, clinging to her hand and asking her for help and advice.[52] Ms O'Sullivan thought that the right thing to do was for Naomi to be referred to 'Drug & Alcohol and the Mental Health team'. She was asked whether Naomi physical's symptoms needed to be investigated. She said she was satisfied that the doctors were following up that avenue.[53]

67. The discharge summary for this admission completed by Dr Golez noted a plan to review Naomi in one week. [54]

68. On 4 September 2015, Naomi was seen by Dr Golez at Tumut Family Medical Centre.[55] The reason for the visit is recorded as antenatal care. Dr Golez noted that an ultrasound showed Naomi was 7 weeks pregnant and had sub-chorionic haematoma. Naomi was given a medical certificate.

69. On 12 September 2015, Naomi presented to the Hospital with nausea and vomiting.[56] She was seen by RN Jeanette Meredith. Zofran was ordered by Dr Joseph over telephone. Naomi was told to see own GP if the problem persists.

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[49] Exhibit 1, Vol 1, Tab 11, para 14, Statement of Dr Golez
[50] Exhibit 1, Vol 3, Tab 32
[51] Transcript 15/10/18, page 27, lines 10-12
[52] Transcript 16/10/18, page 73, lines 30-43
[53] Transcript 16/10/18, page 74, lines 23-25
[54] Exhibit 1, Vol 3, Tab 32, page 2
[55] Exhibit 1, Vol 1, Tab 15, page 7; Statement of Dr Golez, Vol 1, Tab 11, para 15
[56] Exhibit 1, Vol 3, Tab 33

70. On 21 September 2015, Naomi was seen by Dr Golez at Tumut Family Medical Centre.[57] The reason for the visit was recorded as antenatal care. Dr Golez recorded that somac was to be continued, ordered an ultrasound and blood tests and noted that Naomi was to be reviewed in one month.

71. On 2 October 2015, Naomi saw Dr Osman Darwiche at Tumut Family Medical Centre.[58] She presented with Hyperemesis Gravidarum and was prescribed maxalon.

72. On 19 October 2015, Naomi was seen by Dr Golez at the Tumut Family Medical Centre.[59] The reason for the visit was recorded as antenatal care. Dr Golez gave Naomi a medical certificate and ordered an oral glucose tolerance test.

73. On 17 November 2015, Naomi telephoned the Tumut Family Medical Centre.[60] She was distressed and complained of vomiting. She spoke to RN Hargreaves who told her to go to Hospital.

74. Naomi presented to the Hospital, as directed, with vomiting.[61] She was noted to be 17 weeks pregnant and "*very nauseated and upset*". Hospital records indicate that apart from multiple presentations for morning sickness in the last few weeks, she was, "*otherwise healthy*". Her 12-week ultrasound was recorded as normal. An entry in the progress notes states that Naomi was vomiting small amounts of blood. She was admitted and given antiemetics. The notes state she was to stay overnight if her symptoms did not improve. She was discharged the same day with a plan for follow up with her GP.

75. On 18 November 2015, Naomi was seen by Dr Darwiche at Tumut Family Medical Centre.[62] The reason for her visit was recorded as Hyperemesis Gravidarum. Dr Darwiche noted Naomi was not dehydrated and prescribed zofran.

76. On 19 November 2015, Naomi was seen by Dr Golez at Tumut Family Medical Centre.[63] The reason for her visit was recorded as Hyperemesis Gravidarum. Dr Golez noted Naomi was distressed and crying and wanted to go to Hospital for IVF hydration. She was given IM ondansetron and referred to the Hospital by Dr Golez for hydration.

77. On 19 November 2015 at 14:15, Naomi presented to the Hospital with nausea, vomiting and dehydration.[64] She was admitted and given IV fluids and ondansetron per phone order by Dr

[57] Exhibit 1, Vol 1, Tab 15, pages 7-8; Statement of Dr Golez, Vol 1, Tab 11, para 16
[58] Exhibit 1, Vol 1, Tab 15, page 8
[59] Exhibit 1, Vol 1, Tab 15, page 8; Statement of Dr Golez, Exhibit 1, Vol 1, Tab 11, paras 17-20
[60] Exhibit 1, Vol 1, Tab 15, pages 8-9
[61] Exhibit 1, Vol 3, Tab 35
[62] Exhibit 1, Vol 1, Tab 15, page 9
[63] Exhibit 1, Vol 1, Tab 15, page 9; Statement of Dr Golez, Vol 1, Tab 11, para 21
[64] Exhibit 1, Vol 3, Tab 36

Golez. Dr Golez was also contacted regarding plan of care prior to discharge. Naomi was discharged the same day with a plan to follow up with her GP in two weeks.

78. On 2 December 2015, Naomi was seen by Dr Golez at Tumut Family Medical Centre.[65] The reason for her visit was recorded as antenatal care. Dr Golez's statement records that she requested a routine morphology ultrasound and spoke to Naomi about referral to the high-risk pregnancy clinic once the findings of the ultrasound were available. No referral occurred at that stage.

79. On 15 December 2015, Naomi presented to the Hospital with vomiting.[66] She was initially seen by RN Kerrie Ellison. The notes state Naomi had Hyperemesis Gravidarum. She received IV fluids and zofran. She was advised to speak to a community midwife regarding her anxiety during pregnancy and to see her local medical officer the next day.

80. On 16 December 2015, Naomi saw Dr Golez at the Tumut Family Medical Centre.[67] Dr Golez noted Naomi was "*vomiting again*". Dr Golez gave Naomi stemetil and advised her to go to Hospital for IVF therapy.

81. Naomi presented to the Hospital, as directed. She presented with nausea and dehydration from vomiting.[68] She was initially seen by RN Kellie Oddy and then by RN Amanda McLennan. The Progress Notes state that Naomi was sent to Hospital by Dr Golez for intravenous therapy. The notes also state Naomi was 22 weeks pregnant and had severe morning sickness. She was admitted, given IV therapy and discharged the same day.

82. On 17 December 2015, Naomi was seen by Dr Golez at Tumut Family Medical Centre.[69] Dr Golez recorded that Naomi had, "*come back again for vomiting*" and was, "*unable to tolerate fluids*". Dr Golez noted her to be afebrile. She recommended that Naomi present to Tumut Hospital. In her statement, Dr Golez notes Naomi had lost weight and that she therefore urged Naomi to be seen in the high risk obstetric clinic. Dr Golez also noted that Naomi indicated she was moving to Canberra. Dr Golez recorded a plan to transfer Naomi to Canberra Hospital Maternity for further management.[70]

83. On 17 December 2015, Naomi presented to the Hospital with nausea, vomiting, dehydration and weight loss.[71] She was triaged by RN McLennan who recorded the reason for the visit as dehydration and stated in the progress notes that Naomi had a history of cannabis use but that she, "*states nil currently*". Naomi was admitted, blood tests were ordered and she was given

[65] Exhibit 1, Vol 1, Tab 15, pages 9-10; Exhibit 1, Statement of Dr Golez, Vol 1, Tab 11, paras 22-23
[66] Exhibit 1, Vol 3, Tab 37
[67] Exhibit 1, Vol 1, Tab 15, page 10; Statement of Dr Golez, Vol 1, Tab 11, para 24
[68] Exhibit 1, Vol 3, Tab 38
[69] Exhibit 1, Vol 1, Tab 15, page 10; Statement of Dr Golez, Vol 1, Tab 11, paras 25-27
[70] Exhibit 1, Statement of Dr Golez, Tab 11, page 5 para 27
[71] Exhibit 1, Vol 3, Tab 39

IVF therapy and antiemetics. Dr Golez also wrote a referral letter to Canberra Maternity[72] noting Naomi, "*has a long-standing history of retractable vomiting*", has "*now developed severe hyperemesis gravidarum*" and "*has lost weight significantly*". Naomi was discharged the same day on the basis that she was going to Canberra.

84. Dr Golez recorded in the Discharge Summary that Naomi had a high-risk pregnancy.[73] That information was not recorded as an alert in Naomi's hospital records.

85. On 18 December 2015, Naomi presented to Calvary Public Hospital in Canberra with left shoulder pain, abdominal pain, nausea and decreased oral intake.[74] The Emergency Department records state Naomi had presented to Tumut Hospital with the same symptoms which were "*treated as morning sickness*". Naomi was examined by Dr Elliott, which included taking a fetal history. Dr Elliott noted the presenting symptoms and recorded "*self-discharge from Tumut Hospital yesterday*" as "*felt she wasn't receiving adequate treatment there*". Dr Elliott noted Naomi had "*had similar issues prior to pregnancy too*", was diagnosed with Helicobacter Pylori and received treatment, and "*admits to recreational marijuana use – had use today to relief the muscle spasms*".[75]

86. Naomi remained stable, with normal observations. A full blood count was done and hypokalaemia (low potassium) was suspected. Naomi received anti-emetics, xylocaine/gastrogel and chlorvescent for low potassium. She was advised to take antiemetics as needed and to avoid marijuana. The notes state Naomi tolerated oral intake and felt improved. She was given a prescription for chlorvescent and advised to see her GP in the next few days to check her potassium levels. She was discharged on 19 December 2015.

87. On 21 December 2015, Naomi was seen by Dr Oria Teahan at Winnunga Nimmityjah Aboriginal Health Service.[76] The Health Service notes state Naomi was six months pregnant and had Hyperemesis Gravidarum. The notes also state that Naomi said she sometimes needs IV drips and gets muscle spasms. A note was also made regarding Drug and Alcohol Services and Naomi's anxiety and depression. RN Kay Steed conducted a nursing assessment and an Aboriginal and Torres Strait Islander Health check. Naomi was noted as suffering from ongoing nausea, vomiting, low potassium and muscle spasms in her back.

88. Naomi returned to Tumut. On 30 December 2015, Naomi saw Dr Golez at the Tumut Family Medical Centre.[77] The reason for the visit was recorded as antenatal care. In her statement, Dr Golez says that Naomi, "*looked well*" and reported that Naomi told her that she was the best

[72] Exhibit 1, Vol3, Tab 39, page 22
[73] exhibit 1, Vol 3, Tab 39, page 2
[74] Exhibit 1, Vol 3, Tab B
[75] Exhibit 1, Vol 3, Tab B
[76] Exhibit 1, Vol 1, Tab 19, page 12
[77] Exhibit 1, Vol 1, Tab 15, page 10; Statement of Dr Golez, Exhibit 1, Vol 1, Tab 11, para 28

she had ever been.[78] Dr Golez ordered blood tests[79]. There is no evidence that the blood tests were ever performed. Dr Golez thought Naomi was cured.[80]

89. On 31 December 2015 at 09:30, Naomi telephoned the Tumut Family Medical Centre.[81] The Centre's records indicate she spoke with Miss Karen Baker who left a message requesting that Wendy Hargreaves return Naomi's call. The notes from the Centre state Naomi was, "*contacted in joint consultation with Wendy Hargreaves RN*". Oral evidence from Ms Baker and Ms Hargreaves did not illuminate any aspect of the conversations.

90. Mr Lampe's initial evidence was that Naomi was not "overly ill" during the day of 31 December 2015.[82] He stated that it was a "normal day". In his later statement, he said she was "sick as usual", but by about 20:30, she was "really bad". It appears that her condition deteriorated from there.

The lack of escalation of care in the period preceding Naomi's final presentations

91. On the face of the evidence, the sheer number of presentations prior to 31 December 2015, without specialist review, is deeply troubling. In relation specifically to Dr Golez, counsel for Dr Golez submitted that "there is no evidence that Dr Golez developed anything but a caring and functional therapeutic relationship with Naomi which was based on trust and mutual respect."[83] While it is clear that Naomi returned to Dr Golez on a number of occasions seeking help, in my view there is little evidence that a strong rapport developed. Dr Golez's treatment is largely reactive and despite regular contact there appears to have been a reluctance to take a proactive, leading role in Naomi's health care.

92. Dr Golez's evidence about the reasons why Naomi did not receive a referral for specialist consultation or gastroscopy or transfer to another hospital (such as Wagga Wagga) are: that Naomi either left the hospital before treatment was completed; treatment of acute symptoms was successful so she did not qualify for an urgent transfer from hospital to hospital and therefore there would be difficulties in effecting such a transfer; and Naomi became pregnant and therefore investigations under anaesthetic, such as gastroscopy, carried risks. She did not regard an obstetrics referral as indicated, on around 4 September 2015, because she said it was not known if the pregnancy would be viable.

93. Both the expert emergency physicians who reviewed this history agreed that Naomi should have had her care escalated to a specialist, given the recurrent symptoms and

[78] Transcript 15/10/18, page 44, lines 8-10
[79] Transcript 15/10/18, page 44, lines 24-32
[80] Transcript 15/10/18, age 44, line 13
[81] Exhibit 1, Vol 1, Tab 15, page 11
[82] Exhibit 1, Vol !, Tab 8 Statement of Michael Lampe dated 10 March 2016, at [17]
[83] Submission on behalf of Dr Golez page 2

presentations/admissions for nausea, vomiting and pain. Associate Professor Greenberg noted in his report that, "*multiple presentations within a 24-hour period is generally considered a 'red flag', meaning that this is an event that needs to be escalated*".[84] The experts were taken in oral evidence to that opinion and three periods in 2015 when Naomi presented and represented with the same or similar symptoms: June/July 2015; 1-4 September 2015; and 15-17 December 2015. The experts' evidence in respect to each is considered below.

94. Naomi had three presentations, all within 24 hours, over the period 29 & 30 June 2015 for nausea, vomiting. (She had also presented to the Hospital with similar symptoms on 5 June, 14, 15, 18 and 28). With respect to this period, Associate Professor Greenberg said that a referral to a gastroenterologist "*might have been the best thing*" and given that Wagga Wagga was about an hour and a quarter drive from Tumut, he thought that speaking to a gastroenterologist or a gastroenterology registrar and making an appointment was necessary given that "*it had been going on for so long*". [85]

95. Associate Professor Greenberg indicated that there were different ways of achieving referral, one would be to have had Naomi admitted to Wagga Wagga Hospital or she could have been seen in the specialist's rooms in Wagga Wagga. Dr Tyler agreed that specialist's referral would have been a good thing to happen at that time, and should have happened. [86]

96. The experts were asked to consider the explanation given by Dr Golez that it was necessary to treat the acute symptoms. Dr Tyler said it was obviously important to treat the symptoms that were present at the time, but rather than just treating symptoms as occurred in this case, what was needed was a referral on. Associate Professor Greenberg agreed with that opinion.[87] He said that Naomi needed to be treated for acute illness but should have at some stage been referred to a specialist. Associate Professor Greenberg said that one of the problems here was that Naomi seemed to get well each time. She came to hospital; she was treated with IV fluids. In his view that did not stop the plan which should have been for referral. Dr Tyler agreed.[88]

97. The experts were asked about the meeting, which took place at the Hospital on 1 July 2015 at which Ms O'Sullivan provided a 28-day admissions report, upon which Naomi's name appeared. The conclusion from that meeting was that one of the doctors talked about Dr Golez managing Naomi from the surgery and that her marijuana use was being looked at as maybe the cause of her symptoms. The experts were asked whether that reflected a reasonable position to take with respect to Naomi's care. Dr Tyler thought that there needed to be a direct discussion with Dr Golez at what was going on and what escalation of care was

[84] Exhibit 1, Volume 4, Tab 13, page 3
[85] Transcript 13/3/19, page 67, lines 32-37
[86] Transcript 13/3/19, page 68, lines 5-12
[87] Transcript 13/3/19, page 69, lines 20-33
[88] Transcript 13/3/19, page 69, lines 35-48

happening. She questioned whether it was sufficient for the doctors at the meeting to say that Dr Golez was looking after the patient. Dr Tyler added that there should be a management plan.[89]

98. With respect to the marijuana use being considered a cause, Dr Tyler did not think that putting Naomi's symptoms down to marijuana use, without any evidence that that was the case, was a sufficient end of diagnostic enquiry. Dr Tyler added there should have been communication following that clinical meeting with Dr Golez. Associate Professor Greenberg agreed with Dr Tyler's answer but added that he expected the health service manager to have had a conversation with Dr Golez or there should have been a plan at that meeting for someone to communicate with Dr Golez. [90]

99. The experts were asked to consider the findings of the referral for drug and alcohol assessment on 1 July 2015 (and again on 13 July 2015). The 1 July assessment found no indications of substance dependence and the file was closed. On 13 July 2015, it was recorded that Naomi's use of cannabis was occasional and served the purpose of self-medication. The only follow up identified at the conclusion of the assessment was that there be a follow up with a mental health worker, being the only step identified at the end of the review on 13 July.

100. The experts were asked whether, given the outcome of assessments by the 'Drug & Alcohol' team, Naomi's medical management should have been for the symptoms she complained of being vomiting, nausea and pain. Dr Tyler said there should have been other diagnoses (apart from substance dependence), actively investigated and considered at that point by the clinic, by the Hospital and by a referral.[91] Associate Professor Greenberg agreed with that opinion. [92]

101. On 13 July 2015, Dr Golez's plan was to refer Naomi for gastroscopy if she was still symptomatic in 2-3 days. Dr Golez said that the plan was obtained from, "*somebody at Wagga Wagga Hospital*". She did not record the conversation in the notes, or the fact that the conversation had occurred. No gastroscopy referral ultimately occurred, although it is clear that Naomi's symptoms returned. Dr Tyler said a referral should have been made. Associate Professor Greenberg said that whether it was made at that time or in the next few days did not really matter, but it should have been made. [93]

102. The experts were taken to the period of 1-4 September 2015, when Naomi was admitted to the Hospital with similar symptoms to those she was having at the time of the July plan for

[89] Transcript 13/3/19, page 70, lines 26-31
[90] Transcript 13/3/19, page 70, lines 35 to page 71, line 7
[91] Transcript 13/3/19, page 71, lines 27-29
[92] Transcript 13/3/19, page 71, lines 31-33
[93] Transcript 13/3/19, page 71, line 50 onwards

gastroscopy, and at other times. Naomi was confirmed to be pregnant. The experts were asked whether Naomi still should have had a specialist's review or gastroscopy. Associate Professor Greenberg considered that once Naomi was pregnant, the whole clinical picture became "*clouded*", which made it a bit difficult from a diagnostic point of view. Associate Professor Greenberg's view was that, "*the pregnancy clouds everything*" and made for a difficult decision to make that referral. He also said the picture became more clouded once Naomi was pregnant because it was unclear whether the ongoing vomiting was associated with the pregnancy or something else. He accepted Dr Golez's concern that subjecting a pregnant patient to an anaesthetic for the gastroscopy, but nonetheless agreed that specialist referral was not precluded by Naomi's pregnancy.[94]

103. Dr Tyler expressed a stronger view. There were clearly ongoing problems, which needed escalation of care. In her opinion, it could be argued that Naomi needed both a gastroenterologist and an obstetrician. The diagnostic uncertainty meant that referral was required to both an obstetrician and gastroenterologist. She said that was "*probably what I would consider*". Dr Tyler, on the other hand, said that the ongoing symptoms of nausea and vomiting before pregnancy made Naomi, "*an excellent candidate to be referred early to an obstetrics service, even if the pregnancy may not progress*". [95] I accept Dr Tyler's views on these issues.

104. The experts were taken to the period of 15 -17 December 2015, when Naomi was admitted to the Hospital with vomiting. It was in that admission that Dr Gomez determined that Naomi had a high-risk pregnancy and recorded that in the Discharge Referral. She also wrote a referral to Canberra Maternity, which she says she gave to Naomi. Dr Tyler considered it was good practice to actually make a call to Canberra Hospital, not just provide a referral. Dr Tyler considered that the referral letter should have more detail, but Associate Professor Greenberg regarded it as adequate. He agreed with Dr Tyler that there should have been a telephone call and it would have been better practice to actually organise an appointment for Naomi.[96]

105. Associate Professor Greenberg said that there are often barriers, of the kind Dr Golez thought were present, *"I guess that is what we're trained to, deal with as part of our job, to deal with those barriers*". He added that the Hospital should have ensured that Naomi reached Wagga Wagga and agreed, "*that is really just what should have happened*". I accept his evidence in this regard.

106. Associate Professor Greenberg considered that Dr Golez's antenatal care of Naomi was appropriate. Dr Golez had attended to all of the necessary antenatal checks and investigations.

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[94] Transcript 13/3/19, page 72, lines 40-42
[95] Transcript 13/3/19, page 74, line 30-33
[96] Transcript 13/3/19, page 77, line 13 onwards

Dr Tyler had a different view. She did not consider that Dr Golez could manage Naomi to the standard of a Fellow of the O&G College. In her view Naomi should have been referred to an Obstetrician when the pregnancy was confirmed. It can be inferred from Dr Tyler's answer that referral should have been given whether or not the pregnancy would continue, and that Dr Tyler does not accept Dr Golez's reason (not knowing if the pregnancy was viable at that time) as a reason not to refer to an obstetrician. I prefer Dr Tyer's opinion on this issue.

107. I have carefully considered the experts' opinion of the care Naomi received during this period. In my view, there are clear and ongoing inadequacies in the care she received. In particular, greater efforts should have been made to secure a specialist's review of her troubling condition, both before and after confirmation of her pregnancy.

108. It is perfectly clear that for an extended period Naomi felt she was not being taken seriously. Sharon Williams made a formal complaint on behalf of her daughter in July 2015. Naomi had contacted her mother and asked for her help.[97] Naomi felt she was being stereotyped as a drug user and she wanted to see a specialist. Sharon Williams was concerned enough to email the Hospital.

109. Sharon Williams told the court that around September 2015, Naomi contacted her again about "not being heard."[98] She was reluctant to go back to Tumut Hospital as "*she didn't feel comfortable going back there. She just said it was the same thing was happening over and over and they weren't looking at what was really wrong with her.*"[99]

110. The situation did not improve once Naomi was pregnant. Sharon Williams told the court that Naomi wanted to have her baby in Canberra because she felt she would receive a better service. She would have access to a local Aboriginal Medical Service, where she felt more comfortable and where they would "hear what she was saying." On 18 December 2015, Naomi told the doctor she saw at Calvary Public Hospital that that she had self discharged from Tumut Hospital as "*felt she wasn't receiving adequate treatment there*".

111. On the basis of the evidence before me, I have no difficulty finding that Naomi's expectations of Tumut Hospital affected her decisions in relation to medical care by the end of December 2015. She felt unheard and was already planning to have her baby elsewhere. On the basis of the expert evidence I accept that her concerns were legitimate. The treatment she had received informed the low expectations of care she had by then developed.

[97] Transcript 21/9/18, page 40, line 35 onwards
[98] Transcript 21/9/18, page 43, line 5
[99] Transcript 21/9/18, page 43, line 5-9

The final presentations

112. Sharon Williams said that Naomi looked better after she was discharged from Calvary and attended Winnunga. She returned to Tumut. Ms Bulger thinks she picked Naomi up from the bus stop in Tumut. Ms Bulger said that Naomi still looked a bit sunken in the face with weight loss and Naomi said she was a bit sore "*but kept referring back that she felt better with the potassium tablets*".[100] Ms Bulger said towards the end of the night she did get sick again.[101]

113. Ms Bulger next saw Naomi about two days before she died. Ms Bulger said that she looked sick and pale, like a bad flu. She could not recall any contact with Naomi after that, by telephone or text message.

114. On 1 January 2016, at about 00:15 hours, Naomi presented to Tumut Hospital. She had by that time presented to the Hospital eighteen times or more since May 2015.

115. She was seen by Triage Nurse Shirley Adams ('RN Adams') and Midwife Julie-Ann Brewis ('MW Brewis')[102.] Naomi was assessed by them jointly at 00:19 hours.[103]

116. Observations were recorded at 12:20 hours.[104] Naomi was given Panadol at 12:25 hours.[105] Observations were repeated at 12:35 hours.[106] After 34 minutes from the time of triage, that is at 00:53 hours, Naomi was discharged[107] and she returned home.

117. At about 14:30 hours, Naomi returned to the Hospital by ambulance.[108] She had collapsed at home and become unresponsive. She arrived at the Hospital in cardiac arrest.[109] Resuscitation delivered at the Hospital was unsuccessful.[110] At 15:08 hours, Naomi was pronounced deceased.[111]

118. An autopsy was performed on 6 January 2016 by Dr Rexson Tse at the Department of Forensic Medicine, Newcastle[112]. The examination showed generalised micro-thrombi in the small arteries throughout Naomi's body and sub-endocardial haemorrhage in the left ventricle

[100] Transcript 16/10/18, page 5, lines 10-11
[101] Transcript 21/9/18, page 5, line 15
[102] Exhibit 1, Vol 3, Tab 40, page 1
[103] Transcript 17/09/18, page 55, lines 45-47; Transcript 18/09/18, page 72, lines 35-40
[104] Exhibit 1, Vol 3, Tab 40, page 1
[105] Exhibit 1, Vol 3, Tab 40, page 5
[106] Exhibit 1, Vol 3, Tab 40, page 7
[107] Exhibit 1, Vol 3, Tab 40, page 4
[108] Exhibit 1, Vol 3, Tab 41, page 11
[109] Exhibit 1, Vol 3, Tab 41, page 4
[110] Exhibit 1, Vol 3, Tab 41, page 4
[111] Exhibit 1, Vol 3, Tab 41, page 17
[112] Exhibit 1, Vol 1, Tab 5

of the heart, both consistent with septic shock[113]. Dr Tse identified the cause of death as septicaemia, as a result of an infection involving the bacteria *Neisseria meningitides*.[114]

Why did Naomi attend Tumut Hospital in the early hours of 1 December 2016?

119. Naomi's partner Michael Lampe said that around 20:30 on the evening of 31 December 2015, Naomi was ill and vomiting. He said that she was suffering headaches as well as back pains and spasms. According to Mr Lampe, Naomi "struggled to get up and out of bed" and "began to burn up". Around midnight, Mr Lampe described Naomi as feeling "quite unwell". He said she was breaking out in sweats.[115] It appears that Naomi tried to call her cousin Talea Bulger for assistance, but could not reach her.

120. It is certainly clear that Naomi wanted help. Naomi contacted her friend Nicole McGrath by text message at 23:40 on 31 December 2015. She texted:

> "Hey babe, you wouldn't be able to get me to the hospital, would you? I can barely move"

121. Ms McGrath indicated that she was in Tumbarumba. She suggested Naomi call an ambulance. Naomi said she couldn't afford an ambulance and that her partner was unable to take her. She told Ms McGrath her body was aching all over. She indicated that she would get there.

122. Mr Lampe told the court that Naomi described feeling "the worst I've ever felt."[116] She told him not to worry if she didn't come back that night as she anticipated being put on a drip, before driving herself the short distance to Tumut Hospital.

123. Naomi drove herself to Tumut Hospital and pressed the call bell at the entrance. It was RN Adams' evidence that Naomi "looked quite well."[117]

124. RN Adams, recorded the "Emergency Documentation" for triage at 00:19 on 1 January 2016. The reason for the visit was recorded as "Pain, generalised". Her respiratory rate was 18 brpm, Oxygen saturation 96%, Peripheral Pulse rate 120 bpm, and her temperature was recorded as 36 degrees.[118]

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[113] Exhibit 1, Vol 1, Tab 5, page 3
[114] Exhibit 1, Vol 1, Tab 5, page 3
[115] Exhibit 1, Vol 1, Tab 8, page 4 at [18], Transcript 21/9/18, page 23,
[116] Exhibit 1, Vol 1, Tab 8A, page 5, paragraph 38
[117] Statement of RN Adams at [6]
[118] Exhibit 1,Vol 3, Tab 40, page 1

125. At 00:20 hours, MW Brewis recorded the following observations on the Standard Maternity Observation Chart ('SMOC') 120 bpm for heart rate, 90/50 for blood pressure, 96% oxygen saturations, 18 respiratory rate and 36 for temperature. [119]

126. RN Adams recorded an entry in the Progress Notes[120] timed at 00:29 hours and states:

> "Presented to ED with generalised aches & pains. States she is 6 months pregnant & has been having these pains but has run out of Panadol. Stated she had not been sick (vomiting) since yesterday. Looks well.
>
> Eating an ice-block".

127. At 00:35 hours, MW Brewis recorded observations on the SMOC. The blood pressure reading was 95/52 and her heart rate was 105bpm.[121]

128. At 00:53 hours, RN Adams made one further entry. It states:

> "Progress Note
>
> Conversing well with staff. Advised to see GP next week & book into hospital. Happy to go home and sleep".

129. These are the only notations made prior to Naomi's death. In my view, it is significant that there is no reference to hip pain. The clear contemporaneous ED record refers to generalised aches and pains.

130. After Naomi's death, and on 2 January 2016, RM Brewis recorded an entry in the notes retrospectively about the presentation the day before. That note states:

> "***2/1/16 WRITTEN IN RETROSPECT***
>
> *0200 hours*
>
> *Pt presented to A+E complaining of generalised aches and painful hips that she stated was due to the pressure of the baby. Pt stated she was 6 months pregnant with her first baby and had been unwell throughout her pregnancy with nausea and vomiting but for past two days had been well besides sore hips. Observations attended BP 90/50 P 120 afebrile, RR 18 SpO2 96% RA. Pt denied any dizziness.*
>
> *Pt states she has been tolerating oral fluids and often has hydrolyte ice blocks or eats ice chips if nauseated. Pt stated she has been in Canberra Hospital recently and is now on chlorvescent tablets which she had taken today. Pt stated she had not vomited or been nauseated for past couple of days. Mucous membranes noted to be moist. Pt stated baby very active and normal fetal movements today. When questioned pt stated*

[119] Exhibit 1, Vol 3, Tab 40, page 7
[120] Exhibit 1, Vol 3, Tab 40, page 3
[121] Exhibit Exhibit 1, Vol 3, Tab 40, page 8

no concerns with baby during pregnancy and Drs are happy with growth. Pt denied abdo pain or PV loss. Pt stated the only relief she got from her hip pain was walking around and she was unable to get to sleep tonight and didn't have any Panadol. Pt stated she tried to ring her cousin to go to her house for a bath to relieve pain, but was unable to contact her so she came to hospital for Panadol. Pt administered 1gm of paracetamol as charted. Pt sat and talked for approx. 30 mins and during that time, drank two cups of water.

BP rechecked manually 95/52, P 105. Naomi had not booked into Tumut Hospital and stated she was not sure whether she would birth here or if she would be in Canberra with her mother. Naomi had been seeing Dr Golez and had recently referred to Canberra. Discussed with Naomi that she needed to book into Tumut Hospital in case she presents here with a maternity issue so we have her details. Naomi stated that she had an appointment with Dr Golez in approx. 3 weeks and would ring hospital on Monday to book in. Naomi was happy to go home and she stated she was tired and she wanted to go to bed. Pt was advised to return if any further concerns or follow-up with GP @ surgery.

Signature (Brewis) RM"

131. I accept that it was quite proper for RN Brewis to make a retrospective note after Naomi's death. However, I treat it with some caution where it adds significant material absent from her earlier contemporaneous recording. The recorded symptom and emphasis on "hip pain" rather than generalised pain is puzzling.

132. While Naomi may have requested Panadol, in my view the evidence reliably indicates that Naomi did not set out for Tumut Hospital, merely to obtain that drug. She was likely to have had distressing symptoms and to have been feeling generally unwell. Her dissatisfaction with Tumut Hospital is well documented. I find that Naomi would only have attempted to find someone to drive her to the Hospital, and ultimately driven herself when that attempt failed, in the very early hours of New Year's Day, if she had felt very unwell indeed.

133. I note that Naomi's partner Mr Lampe told the court they had both Panadol and Nurofen at home that evening. [122]This is corroborated by photographs taken by investigating officers[123]. In my view it is likely that Naomi experienced and complained of generalised pain, in line with her text message to Ms McGrath and her conversation with her partner. I accept that she thought that she may end up on a drip. I note that while "hip pain" is referred to in the retrospective note, it is not recorded in any of the contemporaneous records and was not a symptom reported to Mr Lampe or Ms McGrath.

[122] Transcript 21/9/18, page 37, line 29 onwards
[123] "Report to the Coroner" Detective Sergeant Mark Lake

What was the nature of the care Naomi received in the early hours of 1 December 2016?

134. RN Adams was an experienced RN, who had been employed at Tumut and Batlow Hospitals for about 40 years. MW Brewis had worked at the Hospital since 2006. She commenced as an enrolled nurse, but later qualified as a registered nurse. She worked as a registered nurse between 2011 and 2013. From 2013, she commenced working at the Hospital as a registered midwife as well as a registered nurse.

135. At the time of Naomi's presentation at about 00:15 hours on 1 January 2016, RN Adams and MW Brewis were working in the Hospital's Emergency Department ('ED'). Naomi rang the doorbell at the entrance to ED. RN Adams and MW Brewis were at that time in the nurses' station. It was New Year's Eve/Day, but they told the court that they were not observing that occasion in any fashion. They went together to answer the door, in accordance with a safety protocol for that time of night.

136. Initially in her oral evidence, RN Adams stated that she was not aware at that time of any of Naomi's previous presentations for history of vomiting. Later in oral evidence she said that she recognised Naomi because she had seen her in ED before. She had also seen Naomi in room 10 at the Hospital on occasion, receiving fluids.

137. MW Brewis remembered seeing Naomi a couple of times at the Hospital. Initially she said she did not recall anything about Naomi's presentations, but later she thought she recalled seeing Naomi in a room at the Hospital receiving fluids. The records show that both nurses previously had some involvement in Naomi's care at the Hospital - RN Adams on 2 September 2015, during Naomi's four-day admission and MW Brewis on 28 June 2015. I accept they had an incomplete memory of this prior care, given the number of patients they see.

138. There was a conversation with Naomi at the front door. MW Brewis said that Naomi asked if she could get some Panadol. She complained of sore hips and "*she was a bit aching*". MW Brewis said that Naomi reported having tried to get some Panadol from her cousin, but she was not home so Naomi had come to the Hospital for Panadol. [124]

139. According to RN Adams, Naomi said that she was looking for some Panadol and that all her friends were out for New Year's Eve. RN Adams said she asked Naomi what the problem was and Naomi told her that she had pain in her hips from the baby moving.[125]

[124] Transcript 18/9/18, page 72, lines 9-12
[125] Transcript 17/9/18, page 51, lines 10-16

140. RN Adams and MW Brewis walked with Naomi into ED. She walked with them, without any observed difficulty. They walked into the waiting room and up a ramp, into ED. RM Brewis said that Naomi told them she was 6 months pregnant, as they were walking in to the ED.[126]

141. Once in the Triage area of ED, RN Adams entered Naomi on the computer. Although Naomi was eating an ice-block, she was not vomiting. According to RN Adams, Naomi said she had not been sick for the last couple of days.[127] She said that the pain was only in Naomi's hips, but she chose 'generalised' from a 'drop-down box' selection on the computer.

142. RN Adams says she asked Naomi to rate her pain score but Naomi did not give a score. RN Adams did not press her for one. Naomi's pulse she considered was a little higher than normal at 120 beats per minute. She did not consider it concerning.[128]

143. RN Adams said they took Naomi's blood pressure, but did not record it because they realised the SMOC should be used for recording Naomi's observations. She said that, "*blood pressure was 90/50-something*". [129]

144. RN Brewis said that the blood pressure at the time of Triage assessment was 90/50 and to her that reading was 'Between the Flags' and not in the yellow zone. She gave Naomi a drink of water because her blood pressure was on the lower side of normal. She asked Naomi about headaches and dizziness and the response was negative.

145. At 00:25 hours, RM Brewis gave Naomi some Panadol, which Naomi took and RM Brewis recorded on the medication chart. RN Brewis said that Naomi remained seated in a chair. RM Brewis talked to Naomi about her presentation. During that conversation RN Brewis told the court that she advised Naomi that it would be a good idea to book into the Hospital, so that they had her details "in case she presented for any antenatal issue."[130]

146. RM Brewis said that during that conversation, Naomi said that had come up to the Hospital for Panadol because her hips were aching, relieved by walking around. RM Brewis said that Naomi told her that she was tired and wanted to go to bed, but did not have any Panadol. It was Naomi who said that both hips were sore, from the pressure of the baby.[131]

147. RN Brewis did not ask Naomi for a pain score at any time and said, "*I probably didn't do a very good assessment of her pain*".[132] RN Brewis assessed Naomi's pain based on how Naomi appeared, which was that she did not appear to be in extreme pain but rather she had minimal

[126] Transcript 18/9/18, page 75, lines 15-25
[127] Transcript 17/9/18, page 51, lines 1-3
[128] Transcript 17/9/18, page 57, lines 46-49
[129] Transcript 17/9/18, page 58, lines 11-12
[130] Transcript 18/9/18, page 86, lines 37-39
[131] Transcript 18/9/18, page 81, lines 1-4
[132] Transcript 18/9/18 page 81, line 9

pain. RM Brewis did not undertake any physical assessment of Naomi and did not undertake a fetal assessment.

148. RN Brewis repeated observations 15 minutes after the first observations were measured and recorded, that is at 00:35 hours. Naomi's blood pressure was 95/52 and her heart rate was 105. MW Brewis thought that repeating these observations, 15 minutes after the first observations to be sufficient, although she accepted that she did not repeat the temperature sign and should have. RN Brewis was satisfied that Naomi's observations at 00:35 hours were normal and there was no need to repeat them.

149. Neither RN Adams nor MW Brewis was aware that Naomi's pregnancy had been assessed as high risk by her general practitioner, Dr Elizabeth Golez, who was managing Naomi's care at her private rooms and during admissions, or presentations, to the Hospital.

150. Naomi did not give MW Brewis the impression that Naomi was uncomfortable about booking in her antenatal care at the Hospital. MW Brewis said "*some people get a bit anxious about booking in*". She wanted Naomi to feel welcome to come back to book in. She said that she made Naomi feel welcome because she "*Just sat and chatted and I asked her about her pregnancy and we talked ..."* She felt that she did develop a rapport with Naomi, because when Naomi left that night she said, "*I thank you for being so nice*".

151. RM Brewis at the time had no understanding of what the state of Naomi's antenatal care was at the time of this presentation. She could not recall whether she asked Naomi about her antenatal card, but agreed that at six months pregnancy there may be important information recorded on the card. MW Brewis was aware that Naomi had recently presented to a hospital in Canberra but did not enquire about which hospital Naomi had been admitted to in Canberra or learn that Naomi had in fact been admitted to Calvary Hospital. MW Brewis agreed that she probably should have enquired about that, given that Naomi was six months pregnant and hospital admission was recent.

152. RM Brewis was aware that Naomi was taking chlorvescent tablets for low potassium and that low potassium can be a serious condition in pregnancy, depending on how low the potassium level involved. She did not ask Naomi about how low her potassium was, but assumed that it was not critically low if Naomi had been discharged on tablets.

153. At the end of the assessment, MW Brewis agreed that she had no idea whether the pain that Naomi was describing was in fact due to the baby. She knew that the pain was disturbing Naomi's ability to sleep, which is why Naomi had come to the Hospital for Panadol.

154. Although RN Adams completed Naomi's discharge electronically, after Naomi had left the Hospital, RM Brewis said that it was she rather than RN Adams who made the decision that Naomi was safe for discharge. RN Brewis advised Naomi to return to the Hospital if she had

any concerns. Both RN Adams and MW Brewis told the court that they walked Naomi out to the front door.

155. Neither RN Adams nor MW Brewis considered it necessary to arrange for a medical review of Naomi at any stage during her 34-minute presentation.

156. The evidence of RN Adams and MW Brewis, in what each documented about Naomi and said in their oral evidence suggests that Naomi's presentation was to obtain Panadol, with the only physical complaint being sore hips. Their assessment was that the first observations needed to be repeated. When that occurred, the observations were normal. Although MW Brewis accepted that additional assessments and enquiries should have been undertaken, both witnesses regarded Naomi's discharge at 00:53 hours as appropriate.

157. As I have already stated I find it most unlikely that Naomi arrived at the Hospital merely to obtain Panadol. It is entirely inconsistent with the contemporaneous message she sent to her friend Ms McGrath, stating that she could "barely move" and was "aching all over"[133] Whilst it was not literally true that Naomi could barely move, as she drove herself to the Hospital, the text messages suggest that Naomi was not going to the Hospital simply to get Panadol. Additionally, the reference to "*aching all over*", suggests that the pain was generalised, as RN Adams recorded at the time, rather than confined to her hips.

158. Naomi's partner, Michael Lampe provided two statements in connection with Naomi's death. In the first, he states that at around 20:30 on the evening of 31 December 2015, Naomi became ill and began vomiting. Mr Lampe stated Naomi was suffering from headaches as well as back pains and spasms. According to him, Naomi, "*struggled to get up and get out of bed*" and "*began to burn up*". He also noted she would, "*just start to break out in sweats*".[134] Around midnight, Mr Lampe stated Naomi was feeling "*quite unwell*".[135]

159. The account from Mr Lampe and from Naomi herself, is difficult to reconcile with the picture portrayed by the accounts of RN Adams and MW Brewis.

The evidence of the nursing experts

160. The court was assisted in evaluating the nursing care given to Naomi by the expert evidence of two nursing experts, Ms Gribbin and Ms Douglas. In line with an earlier objection, the MLHD urged that "little, if any weight" should be given to the evidence of Ms Gribbin and Ms Douglas.[136] It was submitted that neither was a midwife and that their nursing experience

[133] Mobile Phone Correspondence, Vol 1, Tab 10B.
[134] Statement of Michael Lampe, Vol 1, Tab 8, [18].
[135] Statement of Michael Lampe, Vol 1, Tab 8, [18].
[136] MLHD submissions, page 19

was at larger institutions, not recent enough or of the wrong sort. This concern was also raised by legal representatives for RN Brewis, RN Adams and RN O'Sullivan.[137]

161. I have had the opportunity to review both practitioners curriculum vitae. I note that Ms Gribbin has had training and supervisory involvement with respect to midwives. I note that Ms Douglas has experience in clinical governance and in clinical practise. I am comfortable that their training and experience is useful to the court. I note that their evidence is, in important respects, consistent with the evidence of the Emergency Physicians retained.

162. With respect to the vital signs recorded at 00:20 hours, for respiratory rate, oxygen saturations, pulse, blood pressure and temperature, as well as the history recorded by RN Adams at that time, Ms Douglas said she would be concerned about the blood pressure reading of 90/50 and also the heart rate reading of 120bpm. She was also concerned about the presentation itself, with respect to generalised aches and pains in a pregnant woman. Ms Douglas said there are so many possibilities about what could be causing those symptoms and some could be quite serious. She said that she would want to know a little more about the generalised aches and pains, as that description is very non-specific. [138]

163. Ms Gribbin agreed with Ms Douglas' opinions, stating that the observations taken were not reassuring. Ms Gribbin also agreed that given that Naomi was six months pregnant, and had presented with aches and pains, that needed to be investigated. [139]

164. Both Ms Douglas and Ms Gribbin remained concerned about the heart rate, low blood pressure and the pain that was recorded, notwithstanding RN Adams' evidence that Naomi at that time, *"looked well",* in her face and her body overall. She looked *"blossoming from pregnancy".* Both experts said their answer with respect to concerns about the elevated heart rate, the low blood pressure and the pain, remained the same, even with RN Adams' account of what she observed clinically. [140]

165. Both experts were asked about the action taken of repeating the observations fifteen minutes after the first set. Ms Douglas said that was one appropriate action, but was not sufficient. There should have been a longer period of observations and a medical officer should have been notified. Ms Gribbin agreed. [141]

166. The observations taken by RM Brewis at 00:35 hours were commented on by Ms Douglas and Ms Gribbin. They did not consider the vital signs at that time to be reassuring. Ms Gribbin said that the pulse rate had come down slightly, but the blood pressure had not changed. She

[137] Submissions on behalf of RNs, page 4
[138] Transcript 13/3/19, page 8, lines 18 onwards
[139] Transcript 13/3/19, page 9, line 1 onwards
[140] Transcript 13/3/19, page 10, line 10 onwards
[141] Transcript 13/3/19, page 10, line 35-48

later said there had been a minor variation in blood pressure. Both accepted that pregnancy could change the blood pressure and also the pulse.

167. An adequate period of observation of a patient in ED is important to determine whether vital signs are trending upward or downward over time. A single set of repeat observations in a short time frame is not sufficient to determine whether the condition of the patient was stable, or whether it was trending to a safe position or alternatively trending downwards.[142] Both Ms Gribbin and Ms Douglas agreed that the second set of observations were in the white zone. They agreed on the numbers alone, there was a slight improvement from the first set. Ms Gribbin said, "*not enough to make me discharge someone*". [143]

168. Ms Gribbin said she would expect someone to be kept for a minimum of four hours, but that would depend upon how the observations were after that time, if that pain settled and after being seen by a doctor. She said it was, *"A bit difficult to say exactly how long she should have been kept".* Ms Douglas did not identify a period of observation for which Naomi should have been kept, but said that in her view, it was inappropriate to discharge Naomi at 00:53 hours. Ms Douglas said that further assessments were necessary at that time, given the symptoms and vital signs with which Naomi presented. [144]

169. Both Ms Gribbin and Ms Douglas were asked whether their view remained the same, given the evidence from RN Adams at 00:53 hours, that Naomi was conversing well with staff and was happy to go home and sleep. Both indicated their view that discharge was inappropriate at that time, remained the same. [145]

170. With respect to a pain score, both witnesses agreed that a pain score was required as a part of a more comprehensive pain assessment. That should have been done because pain was one of her presenting symptoms. It is appropriate to assess pain as a score out of ten.[146]

171. Ms Douglas and Ms Gribbin said that Naomi ought to have been seen by a doctor, regardless of the assessment made by Dr Golez on 17 December 2019, that Naomi had a high-risk pregnancy. They both said that *if* there had been an alert in place (to the effect *"patient with complex medical needs, please call for MO review if she represents*"), it was an instruction that should be followed even if the nurses did not consider that there was a more serious illness present.

172. Ms Gribbin said given that Naomi was six months pregnant and had aches and pains, that it was mandatory that she be seen by a medical officer, before being discharged. Ms Gribbin

[142] Transcript 13/3/19, page 26, lines 18-28
[143] Transcript 13/3/19, page 51, line 4-5
[144] Transcript 13/3/19 ,page 13, lines 15-29
[145] Transcript 13/3/19, page, lines 31-43
[146] Transcript 13/3/19, page 14, lines 35 onwards

said that the period for which Naomi was in the ED needed to be longer, *"34 minutes is… just not adequate".* Ms Douglas said that in Naomi's case, there was, "*no real diagnostic information other than two sets of vital signs*". She said that longer period of observations should have occurred without specifying the number of hours required, "*but certainly longer than the time that she was there".* [147]

173. Both Ms Douglas and Ms Gribbin were of the view that there was in fact no investigation of the presenting complaints of generalised aches and pain, by the nursing staff. When Naomi left the Hospital, both agreed there was no understanding of what had caused Naomi's pain and what likely symptoms or progress she might have experienced when Naomi left. Accordingly, both Ms Douglas and Ms Gribbin agreed that no assessment that Naomi was safe for discharge had been made.[148]

174. Both Ms Gribbin and Ms Douglas agreed that history-taking was one of the core competencies in nursing. Similarly, contemporaneously recording the history provided is a core competency. The same is true of the assessment of pain in a patient in ED.

175. Ms Gribbin and Ms Douglas agreed that as part of the provision of emergency care to a pregnant patient, consideration needs to be given to whether fetal observations are needed. Those observations should be taken either by a midwife or by a doctor in a six-month pregnancy patient. Both Ms Gribbin and Ms Douglas in this situation, working in an emergency department, would call a midwife or a doctor to perform fetal observations. [149]

176. In terms of the pain assessment, one should include a history of onset, the locations of the pain and any change in frequency, severity and duration of pain. It ought to include questions about the analgesia being taken, how frequently and what had been taken in the past, prior to the presentation. It would be important to identify whether this presentation was different from earlier presentations. Ms Douglas agreed that pain is a subjective measure, which is why a pain score is taken. It gives a quantifiable baseline for a particular patient so that the nurse can measure if the pain gets worse, or if treatment is administered, then the effectiveness of that treatment. Both agreed that it is one thing to talk about pain but also to look at a patient to see if they're showing evidence of suffering pain.[150]

177. Both agreed that they would expect a registered nurse to drill down into where pains were being felt, where a patient complained of generalised aches and pains.

178. With respect to discharge from ED, Ms Douglas has had experience in hospitals that have local policies setting out "*very specific circumstances*" in which nurses can discharge patients

[147] Transcript 13/3/19, page 30, lines 20-22
[148] Transcript 13/3/19, page 32, lines 39-46
[149] Transcript 13/3/19, page 23, lines 17-38
[150] Transcript 13/3/19, page 48, lines 36-46

without having patients being seen by a medical officer. Such protocols and policies are in writing and identify those matters that can be attended to by a nurse, such as a simple dressing change. Ms Gribbin has had the same experience as Ms Douglas, in that regard. Both agreed that different hospitals around the state have different local protocols as to when doctors need to come in to examine a patient before discharge.[151]

179. Both Ms Douglas and Ms Gribbin agreed that Naomi's repeat presentations to the Hospital should have put the nurses on notice that this may be a high-risk presentation. Both gave evidence of experience where a patient's records might be marked as having a particular risk. In either situation, where the nurse recognises the patient has had repeat presentations, or a doctor has recorded that a particular condition is a high-risk one, both nurses agreed that this mandates medical officer review prior to discharge. It is noted that both considered review by a medical officer was necessary for Naomi regardless of those matters.

180. Ms Gribbin said that it was not sufficient for Panadol to be given at 00:25 hours and a further set of observations to be done at 00:35 hours, to assess the adequacy of the analgesia and any change in presenting complaints. Ms Douglas agreed that it was necessary to undertake further assessment of pain in terms of asking questions, making an assessment of pain scale. Ms Douglas said it was the only way to monitor the effectiveness of the medication. Ms Gribbin agreed.

181. A discharge letter is ordinarily addressed to a patient's GP, when a patient is discharged, according to Ms Douglas. Ms Gribbin said that was also her experience.

182. Ms Douglas was asked about what additional risk factors would be elevated for a patient like Naomi, who was Aboriginal and pregnant, with prior drug history and repeat presentations. Ms Douglas said that these risks associated with pregnancy, could include loss of pregnancy. Additional complications that might be seen are increased risk of bleeding, early labour or a rupture of membrane. She said it is known that Aboriginal people carry "*a higher disease burden*" than non-Aboriginal people. She said she would be cognisant of that fact and that a young woman felt unwell enough to take herself alone to an emergency department after midnight on New Year's Eve. [152]

183. Whilst RN Adams said it did not cross her mind that someone must be feeling pretty bad to come to an emergency department on New Year's Eve, Ms Douglas described that fact, "*in itself was a red flag for me*". She would have turned her mind to a pregnancy related complication, but infection would have crossed her mind also. A vital observation on the border

[151] Transcript 13/3/19 page 40, lines 8-16
[152] Transcript 13/3/19, page 35, line 37-39

of the yellow zone would have caused her to have a higher index of suspicion. She would have called for medical review.

184. Ms Gribbin agreed that whilst a nurse would want to tell a patient to come back if there is any further concern, she said that the patient also needs specific advice as to pain, temperature, feeling or whatever. Ms Douglas also said she would give advice of specific issues to look out for and accepted she would say to a patient to come back if they had any other concerns.

185. It is known that Naomi did not like going to the Hospital. There is a substantial amount of evidence recorded and reported to that effect. There is evidence that Naomi did not consider that she was receiving adequate care at Tumut Hospital, most notably in the contemporaneous entry in the Progress Notes recorded by Dr Elliott at Calvary Hospital on 18 December 2015. It would not be surprising if she had low expectations of the care she would receive, given her prior experience. On the other hand, Naomi does not appear to have been vomiting at that time and she may have attempted to "put a brave face" on her condition.

186. Having reviewed all the evidence I am satisfied that had there been more curiosity and inquiry involved by those caring for Naomi at the time of her presentation, a fuller picture of her condition may have emerged. A pain scale, a fuller history, and further investigation about the reason for her generalised pain and attendance at Hospital would have assisted in patient care and patient safety. In my view, advising and encouraging Naomi to stay for a longer observation period and consideration of medical review would also have assisted. The court was told that the Hospital was not particularly busy or stretched that evening. Curiosity in a safe environment may have kept Naomi long enough for swift and appropriate intervention when her condition did not improve.

The evidence of the expert emergency physicians

187. As has been stated, Naomi was not reviewed by an emergency doctor during her presentation to Tumut Hospital in the early hours of 1 January 2016. Tumut Hospital is a small facility. As at 1 January 2016, a number of general practitioners (approximately 9-10) worked in the capacity of visiting medical officers at the Hospital,[153] and there were therefore times when only nurses, and no doctor, would be staffing the Hospital. At those times, nurses in the Emergency Department could call an on-call doctor, or speak to one in Wagga Wagga, to request a medical officer review of a patient.[154] This was the case on 1 January 2016, when Naomi presented after midnight. RN Adams stated that Dr Curnow was the on-call doctor

[153] Transcript, 15/3/19, page 48, line 33
[154] Transcript, 15/3/19, page 43, line 20

overnight on 31 December 2015, and that he was two minutes away.[155] RN Adams stated that at no time on 1 January 2016 did she consider it necessary to call the doctor, as Naomi was "clinically well." She stated that the fact that this was New Year's Eve made no difference to whether she would call the doctor at home.[156] MW Brewis said that she also did not think she needed to call the doctor when attending to Naomi on 1 January 2016.[157] She denied that it would have been a matter of any inconvenience to call a doctor in the middle of the night.[158]

188. The court was assisted by the expert evidence of two emergency doctors, Dr Tyler and Associate Professor Greenberg. They gave useful concurrent evidence, having had the opportunity to review all the medical records.

189. The expert Emergency Physicians were taken to the vital signs recorded on the SMOC at 00:20 hours.[159] They were asked what features of those vital signs would each consider to be concerning or reassuring for the presence or absence of a more serious illness. Dr Tyler said that, "*Naomi was afebrile and her respiratory rate of 18 was in the normal range and was reassuring*". The heart rate of 120, she considered abnormal, "*too fast*".[160] The blood pressure she considered too low. In those circumstances, Dr Tyler would expect an extended observation after those vital signs have been obtained and she would expect a medical officer review. Associate Professor Greenberg agreed that the pulse was high at 120 and the blood pressure was "*on the low side*". [161]

190. In light of the history that RN Adams recorded, containing the note, *inter alia*, of "*generalised aches and pain"*, Dr Tyler did not consider that to change her opinion. She said the pulse rate was very high and "*stands on its own*".[162] Whilst she accepted that RN Adams' clinical observation, "*looks well*" is a very important part of the assessment, she added that people could look well and be very sick. Associate Professor Greenberg did not agree with the opinion about the vital signs standing alone, but rather said that, "*the worry is persistent tachycardia"*, if it stays persistently high. He agreed that, "*120 bpm was of concern but what is important is it comes down or not*". [163]

191. The experts were taken to the next set of observations, taken at 00:35 hours. Associate Professor Greenberg said that the blood pressure was still a little low but that could be explained by the pregnancy. Dr Tyler agreed that the heart rate going from 120 to 105 was reassuring, but not sufficient. She thought the blood pressure remained low. She added that it

[155] Transcript, 17/9/18, page 48, line 18
[156] Transcript 18/9/18, page 24, lines 20-40
[157] Transcript 18/9/18, page 117, line 38
[158] Transcript, 18/9/18, page 117, lines 40-45
[159] Transcript 13/3/19, page 78, line 46 onwards
[160] Transcript 13/3/19, page 79,line 14
[161] Transcript 13/3/19, page 79, line 30
[162] Transcript 13/3/19, page 80,line 1-2
[163] Transcript 13/3/19, page 80,line 26

is useful to obtain the patient's old notes and compare blood pressure readings from previous observations. That would give a broader understanding of Naomi's presentation, while waiting for the Panadol to take effect.[164] Associate Professor Greenberg did not disagree with Dr Tyler about seeking out the records.

192. Dr Tyler and Associate Professor Greenberg were asked about the note that RN Adams recorded prior to discharge, in light of the vital signs and whether discharge at 00:53 hours was appropriate. Dr Tyler said, "*I think probably not*".[165] She considered a longer period of observations was required at that time. In his evidence, Associate Professor Greenberg initially said it would not seem unreasonable to send her home if the patient was happy to go home but revised this opinion as set out further below.

193. Associate Professor Greenberg thought that fetal heart should have been checked, as well as palpation of the abdomen. Dr Tyler agreed with those opinions. [166]

194. Dr Tyler said when there has been a heart rate of 120 and a blood pressure that's "*saggy*", an hour would be very reasonable as a period of observation. Associate Professor Greenberg said (specifically in relation to the heart rate and blood pressure) that it was hard to make a rule like that, because "*it just depends*".[167] Dr Tyler added that she thought a longer period of observation necessary when there have been abnormal vital signs and whilst the context is important, a six months' pregnant woman with a heart rate of 120, a blood pressure lower than normal, would not have only mandated a longer period of observation but would also have mandated a medical officer review.

195. Associate Professor Greenberg agreed that there was no investigation or diagnosis undertaken of the source of the generalised pain that was recorded by RN Adams. Dr Tyler agreed. Dr Tyler added that more should have been done to determine the source of the generalised aches and pain. Associate Professor Greenberg also accepted that more should have been done. Both agreed with the proposition that it was important to record history taken contemporaneously and then repeat the observations, with further history. They agreed that doing so was necessary to obtain a picture in a linear fashion, in order to understand whether there had been improvement or deterioration or any change in the character of the symptoms.[168]

196. Both experts agreed that there ought to have been a pain assessment, involving a pain scale as part of the overall pain assessment. Both agreed that within the administration of analgesia at 00:25 hours, fifteen minutes would not be sufficient time to comprehend whether

[164] Transcript 13/3/19, page 82, lines 47-50
[165] Transcript 13/3/19, page 83, line 34
[166] Transcript 13/3/19, page 87, line 19
[167] Transcript 13/3/19, page 88, line 9-40
[168] Transcript 13/3/19, page 97, line 1-11

the analgesia had been effective to deal with the complaints of pain. Both agreed that it was necessary to repeat the process of questioning to try and elicit what the pain and presentation was at the time. Associate Professor Greenberg, in light of that, said that doing so made "*perfect sense*" and "*she should have been kept for longer*". [169] Dr Tyler agreed.

197. With respect to how long Naomi should have been kept in ED, Associate Professor Greenberg indicated that it would be half an hour to one hour to assess the effect of 1mg of Panadol, given at 00:25 hours. Dr Tyler said that, "*it takes half an hour before Panadol starts working.* At that point, it would be necessary to reassess her pain, according to Associate Professor Greenberg. [170]

198. Both doctors accepted that a patient with generalised aches could have the flu or could be the beginning of sepsis. [171]

199. Associate Professor Greenberg said that, "*looks well*" is part of the decision process, but agreed that the decision could not be made purely by reference to her looking well. Dr Tyler did not think that Naomi looking well was a sufficient basis for discharge.

200. At one point in his evidence, Associate Professor Greenberg indicated that his contention was that the combination of white zone readings and the perception of the nurses at the time, looking prospectively, it was appropriate to discharge. Associate Professor Greenberg clarified his opinion in that regard and stated that if analgesia was given, then it was necessary to wait to see if it worked and from that point of view Naomi should have stayed in ED longer.[172]

201. Dr Tyler said that had Naomi been observed for longer, it would have maximised the ability to pick up deterioration. [173]

202. I am satisfied that Naomi did not have a sufficient assessment of her pain, that Naomi should have remained in the ED longer to permit a proper assessment of her pain after she had been given Panadol and that her records ought to have been checked in the ED to learn more about her presentation and history.

203. With respect to the issue of calling for medical review, Dr Tyler and both the nursing experts said that Naomi should have been seen by a doctor before discharge. Associate Professor Greenberg in his oral evidence did not express clear agreement or clear disagreement with that proposition. Nevertheless, I am satisfied that best practice would have involved a medical review. At the very least, a doctor should have been contacted by telephone for advice and management.

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[169] Transcript 13/3/19, page 98, lines 8-22
[170] Transcript 13/3/19, page 98, line 38-40
[171] Transcript 13/3/19, page 99, lines 23-31
[172] Transcript 13/3/19, page 110, lines 38-43
[173] Transcript 13/3/19, page 120, lines 35-36

What happened after Naomi left Tumut Hospital?

204. It appears that Naomi drove herself home from Tumut Hospital. It is clear that her symptoms persisted and became worse. Mr Lampe was surprised to see her home. According to Mr Lampe, Naomi told him they would only give her Panadol at the Hospital so she came home.[174] Naomi returned to bed. According to Mr Lampe, Naomi was still unwell, vomiting and unable to keep anything down. Later that morning, Mr Lampe found Naomi had fallen to the floor and lost control of her bowels.[175] He stated that upon helping Naomi to the shower he noticed she was "*quite warm*".[176] He stated that "*she couldn't get into the shower and* sat on the floor at the door".[177] After around 15 or 20 minutes, Mr Lampe helped Naomi move to a lounge and around this time Naomi stated she could not feel her legs.[178]

205. Also that morning, Naomi's cousin Talea Bulger visited Naomi to drop off some teabags, having received a telephone call from Naomi at about 11 or 11:30am. Ms Bulger described Naomi when Ms Bulger arrived that morning as "*hunched over and could not straighten up*".[179] Ms Bulger also stated that Naomi told her she had been vomiting and that her "*head and hips were still in pain*".[180] Ms Bulger said Naomi was "*sweaty and pale*". Ms Bulger left and later returned.

206. At about 13:30, Naomi called Ms Bulger and asked her to come over to the house.[181] When Ms Bulger arrived, Naomi was on the lounge. Shortly after Ms Bulger arrived, Naomi began having what appeared to be a seizure. Mr Lampe and Ms Bulger commenced CPR and an ambulance was called at 14:25.[182]

207. Upon reaching hospital, Naomi was triaged at 14:57 and RN Kellie O'Connell recorded the triage presenting information as "*unresponsive, seizure, not breathing*". Attending doctors included Dr Curnow and Dr Golez. The Progress Notes record that CPR was ceased at 1508 and Naomi was pronounced deceased.[183]

208. It appears that by the time Naomi returned to Hospital, she was already *in extremis*. There is nothing to suggest the quality of her care at this point affected her chances of survival, it was by then too late. I am satisfied on the evidence before me that, by that time, Naomi had already lost confidence in Tumut Hospital. Exactly how that factored into her decision not to

[174] Statement of Michael Lampe, Vol 1, Tab 8, [19]
[175] Statement of Michael Lampe, Vol 1, Tab 8, [20]
[176] Statement of Michael Lampe, Vol 1, Tab 8, [20]
[177] Statement of Michael Lampe, Vol 1, Tab 8, [20]
[178] Statement of Michael Lampe, Vol 1, Tab 8, [21]
[179] Statement of Talea Bulger, Vol 1, Tab 9,[18]
[180] Statement of Talea Bulger, Vol 1, Tab 9,[18]
[181] Statement of Talea Bulger, Vol 1, Tab 9,[19]
[182] Ambulance Electronic Medical Record, Vol 1, Tab 13
[183] Vol 3, Tab 41.

return to the Hospital as her conditioned worsened on 1 January 2016 is difficult to determine with any precision. However in my view it is most likely that her experience of care in the early hours of that morning was a factor in her delayed representation later that day.

209. Once Naomi had died, the care that the Hospital provided to her family was not compassionate or appropriate.[184]

The evidence of Associate Professor David Andresen

210. Naomi had experienced complex symptoms over a long period of time. She had been diagnosed with both infection, marijuana related vomiting and more recently *Hyperemesis Gravidarum.* It was necessary to examine whether any of her prior conditions were in any way related to her final illness. In particular it was necessary to rule out any possible connection between Naomi's *Helicobacter pylori* and the *Neisseria meningitides* which ultimately caused her death. For this reason, the court sought the assistance of an infectious diseases expert.

211. Associate Professor Andresen said there is no evidence of any relationship between *H. pylori* infection or Naomi's chronic gastrointestinal symptoms or disorders and *Neisseria meningitides*.[185]

212. The causal relationship between Naomi's *Helicobacter pylori* ('*H. Pylori*') and the symptoms of nausea, vomiting and pain cannot be known on the balance of probabilities. Nor can it be said that *H. pylori* was the cause of her ongoing pain. Naomi did not have a documented completion of a test of cure examination. It cannot therefore be determined whether her symptoms continued once that was eradicated (if it was), and therefore whether *H. pylori* was the cause. [186] Meningococcal sepsis is an extremely serious illness but is treatable. Associate Professor Andresen said many antibiotics that are widely available will be effective if given sufficiently early.[187] Effective antibiotics include benzyl penicillin and cefotaxime and ceftriaxone. Associate Professor Andresen agreed that Neisseria meningitides would have been present when Naomi first presented on 1 January 2016.

213. Where a patient develops symptoms of meningococcemia and presents to hospital, they are assessed, the diagnosis is either made or suspected and antibiotics are commenced in that clinical environment. Other measures would also occur in that setting. Resuscitation and physiological support are an important part of sepsis care. Associate Professor Andresen said these can even be perhaps more important than correct antibiotic therapy. If a patient is in a

[184] Transcript, 15/3/19, page 64, lines 20-25; Exhibit 1, Vol 1, Tab 10, Annexure A, pages 2-3
[185] Transcript 13/3/19, page 4,37-47
[186] Transcript 13/3/19, page 2, lines 41-47
[187] Transcript 13/3/19, page 8, line 45-49

clinical environment, all those things can start to happen. I accept his opinions as to the above matters.

214. A sudden change in blood pressure can be a sign of sepsis but can also be a sign of other clinical concerns. In retrospect, Associate Professor said he was certain that Naomi's relative hypotension was due to early sepsis at the time of her presentation. Total body pain or aches and pains all over can be part of a subacute meningococcemia. There is no typical pain of meningococcemia.

215. It is important to note that both MW Brewis and RN Adams told the court they were familiar with the SEPSIS KILLS Policy and had received training in sepsis at Tumut Hospital.[188] However, the signs they saw did not trigger a specific concern in this regard.

216. Associate Professor Andresen said it is not clear whether Naomi had a subacute septic process or a fulminant septic process. He said it is an open question, whether Naomi had a first phase of meningococcemia or whether it was an unrelated illness at the time Naomi reported a fever illness just before Christmas. Meningococcemia does not tend to be a disease that spontaneously remits, but he could not exclude that as a possibility. He considered, however, the fever before Christmas was probably an unrelated illness.

217. To exclude the presence of sepsis, the sepsis workup involves physical examination, physiological parameters, blood examination, parameters like lactate and inflammatory indices' like c-reactive protein. It involves specific microbiological testing such as blood cultures. There is a need to make a judgment call while waiting for blood results, whether the patient is sufficiently concerning for sepsis to commence antibiotic therapy, which is not itself without risk. There is no doubt that antibiotics were available that would have been effective against the micro-organism.

218. Associate Professor Andresen said that he regards the risk trajectory for an individual to be "*unknowable"*[189]*.* However, you can look at an individual patient and identify some aspects of what goes in their favour and some that do not. Being young is a good prognostic factor for recovery for most infections and meningococcal sepsis in particular. Meningococcal is not one of the classic infections of pregnant women but it is plausible that Naomi's risk for *Neisseria meningitides* was slightly increased by pregnancy, an increase of, "*something like 20-30% above the population baseline risk*". [190]

219. In terms of Naomi's chance in surviving, Associate Professor Andresen did not know how to tease that out in terms of her ability to respond to antibiotics. Associate Professor Andresen

[188] Transcript 18/9/18, page 108, line 32 onwards and elsewhere
[189] Transcript 13/3/19, page 9, line 36
[190] Transcript 13/3/19, page 5, lines 20-35

said that he is not aware of any data in relation to pregnancy increasing or reducing response to antibiotics.[191]

220. In Naomi's case, she had an absence of rash at the point of presentation. She did not look particularly sick and her physiological parameters were not extremely deranged.

221. Associate Professor Andresen advanced a figure of 5% as a risk of death even with antibiotic treatment, but with "*a large uncertainty around that figure*". In his report,[192] he indicates that a possible explanation for Naomi's death fourteen or so hours after her first presentation to Tumut on 1 January 2016, is that she was one of the 5% of the population who would have died even if antibiotics had been commenced at the earlier presentation.

222. Associate Professor Andresen was asked whether 5% statistic could be inverted to say that Naomi had a 95% chance of survival. In his answer to that question he referred to the problems and difficulties with the framework he has used in an attempt to answer this specific question, about the effect of delayed antibiotics. He agreed that the hours of delay required before the patient's population mortality risk was greater than 50%, is nine hours.

223. After careful examination of his and other evidence, I am unable to make a clear finding about whether Naomi would have survived if she had remained in the ED. However, her chances of having the presence of bacterial infection suspected or diagnosed and treated would have been greatly increased.

The evidence of Professor Yin Paradies

224. The evidence before this court made it necessary to examine whether Naomi's care was affected or compromised by unconscious, implicit bias or racism. It was necessary to place Naomi's care within the context of the well-known disparity between the health outcomes of Aboriginal people and those from the non-Aboriginal population[193], but also to place it in the context of the specific community and family dissatisfaction which was reported. A number of witnesses provided statements to the court of their perceptions of local racism and second rate care at Tumut Hospital. Robert Bulger stated that a lot of Aboriginal people "feel they cannot go up to the Hospital as they won't get the treatment they need"[194] He spoke of a relationship which was troubled historically. Talea Bulger, Coral Bulger and others spoke of bad experiences or of feeling family members were stereotyped because of their Aboriginality.[195] These accounts, together with an established disparity between health outcomes for Aboriginal

[191] Transcript 13/3/19, page 6,lines 10-12
[192] Report of Associate Professor Andresen, dated 30 July 2018, page 6
[193] Respecting the Difference – An Aboriginal Cultural Training Framework for NSW Health.
[194] Exhibit 1, Vol 4, Tab 3 [22]
[195] See for example Exhibit 1, Vol 1,Tab (A

and Non-Aboriginal populations make it essential not to shy away from the issue or sweep it under the carpet for fear of causing offence.

225. Professor Yin Paradies said that often the hardest step is acknowledging that there is both individual and institutional racism in an organisation but from that acknowledgment, a better understanding flows, leading to a motivation to address the issues. He had direct experience of how this can work in a local health district setting. With respect to that kind of 'motivation', he referred to the Hunter New England initiative, which he said arose from the presence of "champions in the system". Here he was referring to individuals who felt that this was something that should be the core business of that service. He added that these initiatives start from individual champions. With initiatives taken by the 'champions', culturally safe healthcare can become embedded.[196]

226. The court was also referred to the NSW Health Policy "*Respecting the Difference*" as a starting point. One of the goals of that policy is to understand "the impact that racism and discrimination has upon Aboriginal people's experience of health care."[197]The policy talks of providing "more respectful, responsive and culturally sensitive services."

227. The *Respecting the Difference* policy was introduced statewide by NSW Department of Health. The policy was introduced in recognition of "*the disparity between health outcomes of Aboriginal people and those of the non-Aboriginal population*". This issue was identified as "*a priority*" and "*an urgent need to address these health inequities*". One of the stated goals of the policy framework is to ensure "*that all staff are empowered to deliver more respectful, responsive, and culturally sensitive services to Aboriginal people, their families and communities*".

228. Professor Paradies agreed that it is important to maintain, as is mandatory, participation by all staff in programs like *Respecting the Difference*. This is, "*a key aspect that you would require*", but it is possible to go further. As at 1 January 2016, not all staff at the Hospital had completed all components of the Respecting the Difference training. RM Brewis had completed both the online and face to face components. RN Adams had completed the online but not the face to face training. Ms Roche identified a shortfall in the mandatory staff training, with 93% of staff having completed the mandatory training.

229. Professor Paradies agreed that the Indigenous community is not a homogeneous group of people with the same ideas, beliefs and expectations. That is why, he said, it is not a simple matter of participating in one-off training. Professor Paradies said that there has to be ongoing dialogue and interactions and relationships where different sectors or elements of the Aboriginal community are identified, and their differing concerns acknowledged. Recognising

[196] Transcript 14/3/19, page 31 lines 13-15
[197] Respecting the Difference – An Aboriginal Cultural Training Framework for NSW Health.

diversity allows an understanding of individual needs of Aboriginal people as well as needs that stem from the fact that they are part of an Aboriginal community.

230. Professor Paradies explained that cultural competency of health care services can directly increase Aboriginal people's access to health care and improve the disparities in health outcomes. He agreed that aspects of cultural competency that would be important include respect and trust, transport, flexibility, time, support, outreach and working together. He added that it's about looking at many aspects of an organisation, "*through a lens of cultural competency*".

231. The court was also greatly assisted by the evidence of Professor Paradies with respect to understanding how implicit bias or unconscious bias operates in healthcare settings. Professor Paradies explained that this problem can lead people to act in particular ways or to form judgments or make decisions influenced by bias or preconceived ideas about a particular group.[198] Stereotyping in terms of a connection between Indigenous patients and drug use is one of the examples he raised.[199] In this regard, he said that there is evidence of the stereotyping of Indigenous people as more likely to use drugs and alcohol[200]. Studies show a link between implicit bias and clinical decision-making. It reduces adherence to best practice. It impairs best decision-making. [201]

232. Professor Paradies said there are studies that show experiences of racism within hospital settings for patients, including implicit racism reduce the patient's satisfaction with their care.[202] The potential for Naomi's reduced satisfaction with her care was also identified by Dr Tyler. In her report, Dr Tyler said "*both the lack of the escalation of care, and the perception/actuality of racism at the hospital likely impacted on Naomi's reticence to attend the hospital as well as her having minimal expectations of care*".[203] There is no direct evidence that Naomi's view that she was receiving inadequate care was one she attributed solely to racism on the part of Tumut Hospital. However, there is other evidence that may support this possibility. Sharon Williams' complaint to Ms O'Sullivan that Naomi was not receiving proper care mentioned that Naomi was being 'stereotyped as a drug user' implying that it was racial stereotyping involved. Naomi attended the Winunga Nimityjah Aboriginal Health Service in December 2015 and it was said that she felt listened to at that service.

233. Professor Paradies indicated that there is data in Australia that Aboriginal patients in hospitals across the country compared to non-Indigenous patients, received 30% fewer procedures. According to Professor Paradies, there is a correlation between less treatment and

[198] Transcript 14/3/19, page 35, lines 27-33
[199] Transcript 14/3/19, page 36, lines 5-7
[200] Transcript 14/3/19, page 36, line 9 onwards
[201] Transcript 14/3/19, page 38, line 41-47
[202] Transcript 14/3/19, page 39, lines 11-18
[203] Exhibit 1, Vol 4, Tab 16, page 2

Aboriginality at an epidemiological level. However, Professor Paradies said that in an individual case "*it can be difficult*" to say whether a lack of treatment is directly referable to a patient's Aboriginality. After carefully reviewing the material before me, I consider that it is not established on the evidence available to find that any individual decision with regard to treatment offered to Naomi or denied was directly referable to her Aboriginality. What can be said, as Professor Paradies has observed, is that it is "consistent with a pattern".[204] I accept that there is difficulty in extrapolating from the general to the individual situation as confirmed by the careful evidence of Professor Paradies.

234. The evidence of Professor Paradies makes it clear that acknowledging local community concerns about unequal treatment, and placing those in a known context of state wide health outcome inequality, is a useful step forward.

Opportunities for change

235. The purpose of the inquest was not to lay blame on individuals. However a careful review of individual conduct, which is how healthcare is in fact delivered, can sometimes assist in shining a light on improvements applicable to a whole system. The evidence raised a number of areas where there appear opportunities for improvement or change.

Alerts and Flagging High-Risk Patients

236. Both Emergency experts were asked about the best manner for alerting triage staff that Naomi was a patient with complex medical needs and that a medical officer review should take place if she re-presents. Dr Tyler said alerts have to be systemic, something used for all patients, not just for Naomi. Dr Tyler said it should have been usual practice in ED for the notes to be read. Associate Professor Greenberg agreed. Dr Tyler added that if it was possible to have an alert system, it was essential that it be used. Dr Tyler and Associate Professor Greenberg also agreed with the proposition that it is essential that there be an alert system.

237. Dr Tyler said that when things cannot be flagged, then it is imperative that the notes are read so that one can determine whether a patient is a high-risk situation or not. Associate Professor Greenberg agreed. [205]

238. Dr Tyler said that at Alice Springs Hospital the Triage nurse and the doctors in the ED have access to an electronic freeform written note, of chronic disease or re-presentations or difficulties or management plans. These notes she said were very useful. As at 1 January

[204] Transcript 14/3/19, page 34, lines 22-23
[205] Transcript 13/3/19, page 85, lines 1-8

2016, the system in place at Alice Springs for flagging a high-risk patient was that "a little 'C'" comes up on an electronic screen beside the patient's name to let staff know there is an alert for that patient. [206]

239. Associate Professor Greenberg agreed that there ought to be some sort of indicator, or alert, of a high-risk pregnancy. He was not sure of how that would be done, because he was not familiar with what was at Tumut Hospital as at 1 January 2016. Dr Tyler also agreed that there should have been some high-risk pregnancy flag, as at 1 January 2016.

240. Naomi's high-risk pregnancy ought to have been flagged on her patient records once Dr Golez made that assessment on 17 December 2015. The Hospital had the capacity at that time to signal a high-risk patient. I note that it was RN Brewis's evidence that had she known the pregnancy was high risk, that she "*probably would have done something differently, maybe looked at her records a bit better,…at her past history*."[207]

241. Ms Roche was asked whether there was any system in place for alerting triage staff to patients having complex medical needs or having a high-risk of some kind, as at 1 January 2016. Ms Roche said, "*on our system, yes*".[208] The system, she explained, was a sheet at the front of the paper form records where alerts could be written. As at 1 January 2016, the Hospital was in a changeover period between paper form and the electronic medical records system. Ms Roche confirmed as at 1 January 2016, the combination of a paper and electronic system was used for alerts. [209]

242. If staff required the paper form patient records, they had the ability to access those medical records. Ms Roche agreed that if they did not recognise a high-risk in a patient, or that the patient had complex medical needs, staff may not in that instance access the paper records. [210]

243. Since Naomi's death, the FirstNet system has the capacity to enter information such as high-risk pregnancy or "*complex medical needs, please call medical officer if [the patient] re-presents*".

244. Ms Roche confirmed that up until May 2016, the ED used the Edison system. MW Brewis also referred to this system. Presently at the Hospital, the ED is working with PowerChart and FirstNet. The "*IMP Admission Document – Clinical Records*" is a document that the administrative staff in each facility enter the information about the patient so that the patient can be identified, by name, date of birth, gender and next of kin. It also has an alert system

[206] Transcript 13/3/19, page 85, lines 26-35
[207] Transcript 18/9/18, page 86, lines 16-19
[208] Transcript 15/3/19, page 34, lines 27-31
[209] Transcript 15/3/19, page 67, lines 3-9
[210] Transcript 15/3/19, page 35, lines 20-23

where alerts can be entered. In relation to those alerts, there are drop-down menus, free text or a combination of both.[211]

245. There is a clinical record, which is a document that comes up in the emergency department or in the ward when staff enters a patient's electronic record. There is a space for alerts set out in the clinical record document. If for example, the risk entered into the alert is a high-risk of falls, when a staff member enters the patient in the IPM system, that alert will come up and alert staff to progress the next stage. It will engage staff to do a risk assessment. In that sense, staff are informed of the risk and of the assessment that needs to be made because of that risk. [212]

246. An alert has now been put on the IPM system, which tells staff if a patient leaves the Hospital against advice.[213] This is part of the project being undertaken within the three facilities, which Ms Roche manages, for what is termed 'discharge planning'. Ms Roche clarified that although she says, "*discharge planning*", it's about the care of patients in the facility. She is leading this project, as it is a part of her role. [214]

247. It appears that during this period of record management changeover, it may be appropriate to provide brief training to all staff in relation to the current alert system and its capacity to save lives.

Nurse directed discharge

248. Associate Professor Greenberg said that the situation of nurse directed discharge should be improved with protocols, clear guidelines for when to call the doctor and when to be able to send a patient home[215]. Earlier in his evidence, Associate Professor Greenberg referred to the 'NDEC protocol', meaning Nurse-Directed Emergency Care. [216] He indicated there are strict criteria for nurses (who have to do certain training) and there are inclusion and exclusion criteria for what the nurse can manage. NDEC has not been rolled out everywhere, and he assumed (correctly) that it was not in existence at Tumut Hospital in 2015.[217]

249. It is clear from Ms Roche's evidence that, as at the date of Naomi's presentation on 1 January, if a nurse felt a patient was suitable to be treated by a nurse only in the emergency department and discharged by a nurse only, that was accepted, "*Nurses can discharge a patient without consulting with a doctor if they feel the patient is fit*". There was a similar process to NDEC called, "ESOP Extended Scope of Practice for our Nurses". Registered

[211] Transcript 15/3/19, page 66, lines 40, 49-67
[212] Transcript 15/3/19, page 68, line 15 onwards
[213] Transcript 15/3/19, page 33, lines 16-17
[214] Transcript 15/3/19, page 34, lines 40, 49-67
[215] Transcript 13/3/19, page 117, lines 28-30
[216] Transcript 13/3/19, page 81, line 6-8
[217] Transcript 13/3/19, page 81,lines 8-12

nurses could train to be an ESOP nurse. There is no evidence that RN Adams or RM Brewis was an ESOP nurse. Ms Roche told the inquest that the Hospital is moving to the NDEC guidelines as a model of care so that credentialed registered nurses can undertake assessment, investigation, intervention and discharge by following detailed protocol and guidelines. This is to be commended.

Complaints within the Hospital system

250. If Ms Roche had been aware of the complaint made by Ms Sharon Williams to Lorraine O'Sullivan, she would have "*managed it differently*".[218] Ms Roche said she would have had rung Ms Sharon Williams to inform her she had received her concerns. That would give her the opportunity to find out if there were any more issues. She would set a time to come back to Ms Williams (in this case). She would also ask if Naomi was aware of the concerns raised. She would ask Ms Williams how she would like to deal with this in the first instance, either meeting as a group or whether she would "*just gently*" talk to Naomi. She would look at the notes, look at her presentation and gather information. She said she would certainly be meeting with the doctor and indicate that the family had raised this concern, "*even trying to organise a meeting between the family and the doctor*". [219]

251. Ms Roche said she would also look at the referrals, whether or not they were warranted. She said, "*It's about listening to the consumer*". She agreed that she would have discovered the number of presentations or admissions that Naomi had had by 16 July 2015, for recurrent symptoms of vomiting, nausea and pain.

252. Associate Professor Greenberg said that "*the Hospital did drop the ball on a number of occasions with a lack of escalation of care*".[220] He referred in particular to when Sharon Williams wrote to the hospital manager and Naomi's care was still not escalated. He said, "*That I don't understand*".[221] The importance of this opinion is not that gastrological investigation was likely to reveal a cause for Naomi's physical complaints but it justifiably, in these circumstances, would have reassured Naomi that her complaints were being taking seriously and everything was being done to find out the cause of her recurrent syptoms.[222] Instead, this lack of escalation caused her to have low expectations of receiving proper care in Tumut.

[218] Transcript 15/3/19, page 65, line 15
[219] Transcript 15/3/19, page 70 lines 1-3
[220] Transcript 13/3/19, page 117, lines 29-32
[221] Transcript 13/3/19, page 117, line 32
[222] As Associate Professor Greenberg specifically states in his report dated 13 August 2018.

253. Ms Roche indicated that there has been a change to the way facility managers deal with the complaints since that time. Ms Roche has a meeting with each of her managers and part of that process "*actually identifies all complaints*", so that Ms Roche is told of all complaints. It is part of the introduced Monthly Accountability Meeting system ("MAM"), implemented in December 2016.[223]

254. Ms Roche said that, "*Absolutely the hospital is looking at multiple presentations and not just looking at a minimum 28-day period. They are looking at anyone who is admitted to hospital a number of times a year and the opportunities to look at their care and make sure we get it right".* [224]

255. If a patient presented fifteen times in a five-month period (as Naomi in fact did), that is something Ms Roche would want to know about. In response to this, she said she would be asking the manager what actions they are undertaking and where they are up to. She would want to know how the patient is being managed and why they are being admitted. If the reason was not for palliative care (by way of example) but rather for nausea, vomiting, abdominal pain and sometimes diarrhoea, Ms Roche agreed that she would want to be reviewing that.

256. She is now aware that Naomi presented many times between 10 May 2015 and 1 January 2016. One of the things that she has learned from Naomi's case is that she would have treatment and in a very short space of time, feel better and choose to leave. Ms Roche said that what is looked at, is what is being done when people do leave before the completion of care. This is now a subject of an IPM system alert, as described.

257. The Hospital also updated its escalation plan in September 2018. [225] If a patient or a patient's family appears to be distressed, they are to notify the facility manager. Ms Roche described this as, "*It's not a maybe. It's a definite*", because of the importance of the facility manager and Ms Roche herself being aware of any concerns in the facility in that regard.

258. Ms Roche also gave evidence of a range of other procedures and programs which were now in place to provide greater consumer care. Since September 2016 the REACH program has provided a way for patients' families and supporters to request an immediate review.[226]

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[223] Transcript 15/3/19, page 24, lines 19-20
[224] Transcript 15/3/19, page 32, lines 24-27, lines 29-32
[225] Transcript 15/3/19, page 24, line 37 onwards
[226] Exhibit 11, supplementary statement of Maria Roche, dated 18 September 2018 [20], and Transcript 15/3/19, page 26, line 1 onwards

Measures to embed values to promote culturally safe healthcare for Aboriginal people

259. Professor Paradies and others spoke of a number of practical ways that health services, such as MLHD, can improve their ability to provide culturally safe health care. These included increasing the numbers of Indigenous employees and strengthening liaison services. He explained, in terms of representation of the workforce at Tumut Hospital, if the population of catchment is 5.1%, then, *"that should be the target"*[227] to achieve proportional representation of the Aboriginal employees within the Hospital. It is also important that the Hospital's work force is representative, that it entails people at all levels with different types of seniority. That would include nurses and doctors. [228]

260. There needs to be a focus on retention and satisfaction of Aboriginal workers. Those two concepts are related and they result in a culture of safety, for both Aboriginal patients and for Aboriginal staff. It is important that there is understanding of family commitments, an understanding of racism that Aboriginal people have experienced, in order to produce a culture where there is trust, communication and respect for the Aboriginal workforce. [229]

261. Professor Paradies said that the representation on the local health advisory committee by Aboriginal people should be the same proportion of Aboriginal people in the catchment area of the Hospital.[230] He said that it could be difficult being a sole representative on committees. What can be achieved by that representation is the involvement of the community in the operation of the institution. Asked how he sees that it improves care for an individual patient, he said that, "*it helps the hospital staff to have a better understanding of the community and builds trust between the community and the hospital, which is very important for good communication between patients and providers*".[231]

262. The concept of exchange and role reversal was important. Professor Paradies explained that this involved Aboriginal people in the community getting a better sense of the work of the Hospital, so that they are able to understand not just the kind of patient experience, but to have sense of how hospitals work. That included an understanding of the roles of various staffs in the Hospital, whether that is doctors, nurses or administrative staff. It is also having opportunities for the Hospital's staff to visit Aboriginal organisations in the community. That would allow an understanding of, "*where Aboriginal people are coming from as well*". [232]

[227] Transcript 14/3/19, page 29, nline 2
[228] Transcript 14/3/19, page 27, line 47 onwards
[229] Transcript 14/3/19, page 28, line 7 onwards
[230] Transcript 14/3/19, page 26, lines 18-31
[231] Transcript 14/3/19, page 27, lines 10-12
[232] Transcript 14/3/19, page 29, line 13

263. The role and availability of Aboriginal Liaison Officers (ALO's) at the Hospital was also investigated and examined at the inquest, as a strategy for improving care. At the Hospital, in the latter part of 2015, there were two ALO's, one engaged in women's business, Ms Sharon Connolly, and one engaged in men's business.[233] Although it was clear that Ms Connolly was engaged in 'outreach' work outside of Tumut. Neither worked out of usual business hours.

264. There is a record indicating that Naomi saw Mr Connolly and Ms Connolly on 1 July 2015.[234] Mr Connolly says that Naomi declined their assistance. There is no other evidence of any further or other involvement of ALO's in Naomi's care, despite numerous presentations and admissions up to and including 1 January 2016. Staff members were unclear about when the ALO should be contacted for a patient, RM Brewis for example believed that it was to be done only when a patient was admitted.

265. Associate Professor Greenberg, Dr Tyler and Professor Paradies all agreed on the importance of the role of ALOs. Professor Paradies said that it is important for them to come into contact with Aboriginal patients in a timely fashion.[235] It is important that they are able to advocate for those patients and to identify issues that they may be experiencing and have processes through which they can address those concerns.

266. Professor Paradies said that their effectiveness depends on "*... really a matter of how well are they embedded within the rest of the hospital system*"[236], and so they can do their job to help patients successfully navigate hospital systems.

267. In the latter part of 2015 and including 1 January 2016, it appears that many opportunities were missed to involve an ALO. There is an opportunity to ensure the ALO system is more firmly embedded in hospital care at Tumut.

268. Professor Paradies said that more robust collection and analysis of data with respect to the experience of Aboriginal people coming into the hospital system was also needed. It is important to think about organisational culture and identify what are the incentives and disincentives to provide culturally safe care to Aboriginal people. He posed the question that should be asked in this context, "*Is there support at all levels of the organisation in terms of leadership?"*

269. Ms Roche accepted that there is a perception among many in the Aboriginal community in the Tumut District that the Hospital is not a safe place for them and they do not feel heard.[237] She agreed that she would like more assistance from the community about how to engage with

[233] Exhibit 17, page 1 [14]
[234] Exhibit 1, Vol 4, Tab 20, page 5
[235] Transcript 14/3/19, page 28, lines 40-43
[236] Transcript 14/3/19, page 28, lines 49 onwards
[237] Transcript 15/3/19, page 57, lines 25-28

that community. She also agreed with each of the following, "*If NSW offered to provide her and her nurses with some training about how to build effective consultation with the community, that would be a very useful first step – to try and improve outcomes in the area; if Aboriginal elders were willing to give some advice about how to go and talk to the community elders, that advice would be accepted; once a way of talking to the elders is established, the conversation then needs to turn to what the Aboriginal elders' views are about health care; it would be very useful to know what local Aboriginal people want out of their health care system in the local context; she would like access to 24-hour care from Aboriginal health workers at the hospital for Indigenous patients*". [238]

270. Ms Roche agreed that, "*Aboriginal knowledge, Aboriginal identity, Aboriginal views as to help, should be questions to be discussed on a daily basis in a hospital between staff; those questions should come up every time a patient who is Indigenous is handed over between two staff members*". [239]

271. Ms Roche agreed she would like Aboriginal representation on all of the communities that contribute to the kind of healthcare that is provided in the area. She agreed that it is possible to measure systemic bias in an organisation, in the way Professor Paradies described, and that would be a useful thing to do in the hospitals under her control.[240]

272. Additionally, Ms Roche agreed that it would be useful for the following to occur:-

- Support for Ms Roche from experts in cultural safety;
- Develop protocols and methodology around appropriate forms of community consultation;
- Develop a local Aboriginal interagency community comprised of Brungle, Tumut LALC, Brungle Aboriginal Medical Service, Coo-ee Cottage and other Aboriginal organisations; and
- Conduct structured and minuted meetings between Ms Roche, Tumut Facility Manager and Brungle Tumut Elder Groups.

273. Ms Roche agreed it would be useful to visit the Brungle Community and Brungle Aboriginal Medical Service to learn about the local community and what culturally safe health care looks

[238] Transcript 15/3/19, page 58, line 40 onwards
[239] Transcript 15/3/19, page 60, line 41-48
[240] Transcript 15/3/19, page 61, lines13-17

like, as well as to engage *Reconciliation Australia* to help develop and implement culturally safe health care for Aboriginal people in that community. [241]

274. She also outlined some initiatives which she said would improve care for Indigenous patients, including the 48 hour after-discharge follow-up program in the MLHD, [242] efforts to increase the Aboriginal workforce at the Hospital[243], and further community engagement with programs such as Aunty Jeans.[244]

275. It was clearly stated by Ms Roche in oral evidence that she recognised opportunities for change. She said that she wanted change to occur in the way Hospital services were delivered to the Aboriginal community and that she wanted increased community involvement in the Hospital. She stated that these improvements were for her a personal and a professional commitment. [245] I commend Ms Roche for the commitment expressed and for the thoughtful and straightforward manner in which she gave this evidence at the inquest.

Scope for recommendations arising from the evidence

276. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

277. I am satisfied that the following recommendations arise from the evidence before me.

Findings

278. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Naomi Jane Williams.

Date of death

Naomi died on 1 January 2016.

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[241] Transcript 15/3/19, page 64,lines 5-7
[242] Transcript 15/3/19 page 10, line 30 onwards
[243] Exhibit 1, Vol 2, tab 31 [13]
[244] Statement of Maria Roche, 1/3/19
[245] Transcript 15/3/19, page 41, line 45-47

Place of death

Naomi died at Tumut Hospital, New South Wales.

Cause of death

Naomi died from septicaemia, secondary to *Neisseria meningitides* infection

Manner of death

At about 14:30 hours on 1 January 2016, Naomi arrived at Tumut Hospital by ambulance *in extremis*. She had been briefly treated in the Emergency Department of Tumut Hospital in the early hours of 1 January 2016 ('the presentation'). Naomi's history of numerous and frequent presentations to the Emergency Department in the months immediately preceding that presentation, where she received brief symptomatic treatment rather than necessary investigation or specialist intervention of underlying causes, likely led to her having reduced expectations of care at this time. It could not have been known by the nurse and the midwife at the presentation that Naomi was suffering from a bacterial infection, which was life threatening. It was not known that she had high complex needs because her hospital notes were not read at the presentation. It was not known that she had been assessed with a high risk pregnancy, about two weeks earlier, because that information had not been flagged.

On the basis of some of the clinical information known and recorded at the presentation Naomi should have been further investigated. She was discharged earlier than was clinically indicated, after which she deteriorated from septicaemia associated with Neisseria meningitides infection.

Recommendations pursuant to section 82 *Coroners Act 2009*

279. For reasons stated above, I make the following recommendations,

To Murrumbidgee Local Health District (MLHD)

1. That consideration is given to providing a training session to all staff about the importance of safety alerts (such as "re-presentation calls for medical review", or "high risk pregnancy") and a consistent method for implementing such alerts is communicated to all staff.

2. That consideration is given to implementing a Nurse Directed Emergency Care (NDEC)policy as a matter of urgency.

3. That consideration is given to strengthening the Aboriginal Health Liaison Worker program by
    - ensuring Aboriginal Health Liaison Workers are available 24 hours a day;
    - ensuring that all staff are aware that the NSW Health Policy "Notification/referral of Aboriginal Inpatients (MLHD PROC208) applies to patients who present at the Emergency Department as well as those who are admitted.

4. That consideration is given to adopting targets within the MLHD for the employment and retention of Indigenous health care professionals in numbers at least equivalent to the number of Indigenous residents in the local area.

5. That consideration is given to auditing the possibility of implicit bias by recording statistics for Indigenous and non-Indigenous patient triage categories, discharge against medical advice, triage times and referrals for drug and alcohol reviews for patients presenting to the Emergency Department at Tumut Hospital.

6. That consideration is given to identifying other assessment tools to measure the existence of implicit bias in the provision of health care and commit to making such tools available to Tumut Hospital.

7. That consideration is given to establishing targets for the proportionate representation of Indigenous people (by population and no less than two) on the Local Health Advisory Committee and Murrumbidgee Local Health District Board.

8. That consideration is given to establishing an ongoing consultation process with the HEAL (Healthy Enriched Aboriginal Living) Mawang (Together) Group with a view to developing a strong local model for providing culturally safe health care, in line with initiatives implemented by Hunter New England Health.

9. That consideration is given to seeking immediate consultation with Hunter New England Health in relation to strategies for developing culturally appropriate care, in line with the detailed model they have developed.

Conclusion

280. Once again, I acknowledge the significant pain suffered by Naomi's family, partner and community. I have no doubt that Naomi was an emerging leader and the profound loss suffered by her community is ongoing. I sincerely thank Naomi's family for their courage and integrity in engaging with the inquest process. I understand their motivation for change and I commend it.

281. The evidence in this inquest necessarily touched upon the subject matter of poor health outcomes for Aboriginal people in the health sector. The fact that Aboriginal people suffer poorer health outcomes across NSW is well established in the policies and literature provided to this court by NSW Health and elucidated by Professor Paradies. Examining how these issues may have played a role for an individual patient, as Naomi was, in a small community is both fraught and painful for all concerned. The transcript of these proceedings would not indicate the many tears shed during this inquest, not only by the family but by employees of the Local Health District. Ms Maria Roche, the Tumut Cluster Manager of MLHD stated that she wanted change and improvement. She acknowledged that there is a perception in the local community that the Hospital is not a safe place for Aboriginal people and that some drive to other hospitals to avoid it. Ms Roche accepted that many among the Aboriginal community have not previously felt heard about these concerns[246]. She recognised that there is now an opportunity for change. This recognition needs to be forged into further and immediate action.

282. I hope this inquest is a step in that process.

283. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
29 July 2019

NSW State Coroner's Court, Lidcombe

[246] See passage Transcript 15/3/19, page 58 onwards