JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	MICHAEL ANDREW GLIDDON JENKIN
HEARD	:	14 - 18 FEBRUARY 2022
DELIVERED	:	28 MARCH 2022
FILE NO/S	:	CORC 986 of 2018
DECEASED	:	EDWARDS, MORGAN JOHN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)

Counsel Appearing:

Mr W Stops appeared to assist the coroner.

Mr J Bennett (State Solicitor's Office) appeared for the South Metropolitan Health Service (SMHS).

Mr I Curlewis (Lavan) appeared for Identitywa.

Mr E Panetta (Panetta McGrath) appeared for Dr A Stokes.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Morgan John EDWARDS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 14 - 18 February 2022, find that the identity of the deceased person was* ***Morgan John EDWARDS*** *and that death occurred on 15 August 2018 at Fiona Stanley Hospital, from complications in association with intestinal volvulus in the following circumstances:*

Table of Contents

INTRODUCTION 4
MR EDWARDS 5
Overview 5
Medical issues 6
IDENTITYWA 7
Overview 7
Butler House 7
Staffing 7
The role of the On Call 8
Early Warning Score 9
Transfer to hospital policy 10
Change in transfer to hospital policy 13
THE EVENTS OF 14 AUGUST 2018 17
Presentation during the day 17
Concerns about breathing 17
Information provided to paramedics at Butler House 18
Contact with On Call 20
Arrival at the emergency department 21
DISCHARGE - 15 AUGUST 2018 30
Mr Edwards' presentation 30
Discharge options 30
Dr Stokes' erroneous assumption 32
Decision to discharge 34
Failure to document decision 35
Contact from FSH 36
Mr Edwards' return to Butler House 39
EVENTS AT BUTLER HOUSE - 15 AUGUST 2018 41
Morning EWS 41
Contact with GP 43
Observations during the morning 45
Afternoon EWS 45

EVENTS AT FSH - 15 AUGUST 2018 .... **48**
Appointment with gastroenterologist 48
Assessment in the ED 50
Medical Emergency Team call 51
CAUSE AND MANNER OF DEATH **52**
Post mortem examination and results 52
Cause and manner of death 52
ANALYSIS OF MR EDWARDS' MANAGEMENT **53**
SAC1 review 53
Case review by Professor Mountain 57
Case review by Professor Brown 58
Resuscitation issues 59
RECOMMENDATIONS **61**
Recommendation No.1 61
Recommendation No.2 61
Recommendation No.3 61
Recommendation No.4 62
Recommendation No.5 62
Recommendation No.6 63
Comments relating to recommendations 63
CONCLUSION **64**

INTRODUCTION

1. Morgan Edwards (Mr Edwards) was born on 24 March 1987 and he died at Fiona Stanley Hospital (FSH) on 15 August 2018 from complications associated with an intestinal volvulus.[1] At the time of his death, Mr Edwards was 31 years of age and as a result of a congenital disorder, he was non-verbal and had physical and intellectual disabilities. Mr Edwards lived at Butler House, a care home in Willagee operated by Identitywa.[2,3,4,5]

2. At about 9.00 pm on 14 August 2018, Mr Edwards was taken to FSH by ambulance after care workers became concerned about his rapid breathing. He arrived home at 4.05 am on 15 August 2018, without a definitive diagnosis. When he was eventually returned to the ED at about 3.30 pm, Mr Edwards was critically unwell, and he died at 7.05 pm.

3. The inquest focused on the appropriateness of Mr Edwards' care at Butler House and the quality of the medical treatment he received at FSH. The documentary evidence comprised one volume and during the inquest, which was held on 14 - 18 February 2022, I heard evidence from:

i. Mr Mitchell Irwin (Former care worker, Identitywa);
ii. Ms Carole Hanrahan (On-call supervisor, Identitywa);
iii. Dr Nathania Gianina (Intern, FSH);
iv. Dr Amy Stokes (Registrar, FSH);
v. Ms Ann-Marie Gladwell (Team leader, Identitywa);
vi. Ms Judith Ellis (Care worker, Identitywa);
vii. Mr Rajeshkumar Barvardia (Care worker, Identitywa);
viii. Mr David Nylund (Former care worker, Identitywa);
ix. Mr Luke Austin (Care worker, Identitywa);
x. Dr Claire Dibona (Senior registrar, FSH);
xi. Dr Vanessa Clayden (Head, Emergency Medicine, FSH);
xii. Dr Chris Cokis (Head, Cardiothoracic Anaesthesia, FSH);
xiii. Prof. Anthony Brown (Expert witness called on behalf of Dr A Stokes);
xiv. Ms Marina Re (Chief Executive Officer, Identitywa);
xv. Mr Peter Batini (Expert witness, disability services);
xvi. Mr Brett Hunt (Independent expert witness, disability services); and
xvii. Assoc. Prof. David Mountain (Independent expert - medical issues)

---

[1] Where the bowel twists on itself, causing an obstruction which can disrupt blood supply and lead to tissue death
[2] Exhibit 1, Vol. 1, Tab 1, P100 - Report of death (15.08.18)
[3] Exhibit 1, Vol. 1, Tab 2, P92 - Identification of deceased person (15.08.18)
[4] Exhibit 1, Vol. 1, Tab 3, Death in hospital form (15.08.18)
[5] Exhibit 1, Vol. 1, Tab 4, Post Mortem Report (20.08.18) and Supplementary Post Mortem Report (25.02.19)

MR EDWARDS

Overview

4. Mr Edwards had lived in care homes operated by Identitywa for about 15 years. He was described as a "*happy and mischievous person*", but there is no doubt that his behaviour could be challenging. He sometimes threw himself to the floor and he frequently engaged in "*necking*" where he would deliberately restrict the blood vessels in his neck using a bandanna or the edge of a hard object. Exactly why Mr Edwards repeatedly engaged in this behaviour is unknown, but he may have experienced a brief sense of euphoria as a result of reducing the blood flow to his brain.[6,7,8,9,10]

5. Mr Edwards could comply with very basic commands but he required assistance with toileting, grooming, dressing and household tasks. As he was non-verbal, Mr Edwards communicated by means of sounds and gestures. His methods of indicating pain included slapping his chest/head, squealing, banging his head on the floor, pinching himself, pulling his hair and/or holding on to people and refusing to let go.[11,12,13]

6. Mr Edwards used a commode for toileting and because he had no teeth, he ate a pureed diet and used modified plates and cutlery. His daily routine followed a predictable pattern. After waking, Mr Edwards was placed on his commode before being showered and dressed and given breakfast. He would then be assisted to the front lounge at Butler House where he interacted with residents and staff or watched TV.[14]

7. Mr Edwards sometimes went on community outings and he enjoyed spending time outside, especially if it was warm. He would be given lunch and would sometimes use a swing chair in the back patio area. After dinner, he would be placed on his commode and then being prepared for bed.[15]

---

[6] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 3
[7] Exhibit 1, Vol. 1, Tab 25, Attachment MR6, Behaviour of Concern - Health Care Plan
[8] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), paras 13 & 19
[9] See: https://www.nursingcenter.com/journalarticle?Article_ID=4981480
[10] ts 15.02.22 (Ellis), p119
[11] ts 15.02.22 (Ellis), pp118-119 and ts 16.02.22 (Austin), p163
[12] Exhibit 1, Vol. 1, Tab 11, Letter to Coroner's Court from Ms L-A Brensell, p1
[13] Exhibit 1, Vol. 1, Tab 25, Attachment MR7, Behaviour of Concern - Recognising pain
[14] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), paras 15-21 and ts 16.02.22 (Austin), p164
[15] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), paras 15-21 and ts 16.02.22 (Austin), p164

Medical issues

8. Mr Edwards was born with Smith-Magenis Syndrome (SMS), a complex developmental disorder typically caused by a chromosomal abnormality. Symptoms vary but commonly include distinctive facial features, skeletal malformations, varying degrees of intellectual disability, speech and motor delays and self-injurious and/or attention-seeking behaviours.[16,17]

9. As well as SMS, Mr Edwards was diagnosed with cerebral palsy and epilepsy. He was prescribed medication for these conditions and was regularly reviewed by a neurologist. He was also seen by a psychiatrist in relation to his head-banging and necking and prescribed medication to stabilise his mood. Mr Edwards also had hip dysplasia meaning his hips were prone to dislocation and as a result, his mobility was limited. Although he could walk short distances (usually by supporting himself against walls, etc.) on community outings or appointments he used a wheelchair.[18,19]

10. Mr Edwards' medical history included several admissions to hospital for bowel obstruction and pseudo-volvulus. His most recent admission was in 2016 and on that occasion (and for some of his other hospital admissions) Mr Edwards had been accompanied by a care worker.[20]

11. Mr Edwards also had Crohn's disease, a chronic, incurable, inflammatory bowel disease that can cause abdominal pain, diarrhoea, weight loss, anaemia and fatigue. Foods likely to exacerbate symptoms include alcohol, tea and coffee, corn, dairy products, fatty foods and high fibre foods.[21] Mr Edwards' Identitywa Crohn's disease health care plan noted:

> Avoid: Foods containing caffeine, **spicy foods** and fatty foods. May need to reduce dairy or source lactose free dairy products if symptoms persist.[22] [Emphasis added]

---

16 Exhibit 1, Vol. 1, Tab 7, Letter - Dr R John (17.08.18)
17 See: https://rarediseases.org/rare-diseases/smith-magenis-syndrome
18 Exhibit 1, Vol. 1, Tab 7, Report - Dr R John (17.08.18)
19 Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), para 14
20 Exhibit 1, Vol. 1, Tab 23, FSH medical records
21 See: https://www.crohnscolitisfoundation.org/what-is-crohns-disease/overview
22 Exhibit 1, Vol. 1, Tab 25, Attachment MR8, Crohn's Disease Health Care Plan

IDENTITYWA

Overview

12. Identitywa (the organisation that operates Butler House) began in 1977 as a self-help group for parents and is now an "*outreach*" of the Catholic Archdiocese of Perth. Identitywa provides services to adults and children living with disabilities, including full-time residential care, in-home support and respite care. Identitywa's activities are overseen by a board and its Chief Executive Officer, Ms Marina Re, gave evidence at the inquest. The organisation employs around 550 staff and operates 45 care homes housing about 145 residents.[23,24]

Butler House

13. Butler House is a standard residential home located in Willagee. At the relevant time, Butler house was home to five residents, including Mr Edwards.[25] Mr David Nylund, a care worker formerly employed by Identitywa, had this to say about the residents at Butler House:

> This was my first job working in a group home with people with disabilities. It was also my first job working in a house with people with quite complex and diverse needs. It was a challenging house with the different behaviours and needs, hence it was a big learning experience for me.[26]

Staffing

14. The staffing roster at Butler House is divided into three shifts. Staff on morning shift start duty at 6.15 am and finish at 2.15 pm. Afternoon shift starts at 2.15 pm and finishes at 10.15 pm, and night shift starts at 10.00 pm and finishes at 6.30 am.[27] Two staff are generally rostered on for the morning and afternoon shifts, with one staff member on duty on at night.[28] The qualifications and experience of care workers employed by Identitywa appears to vary widely.

---

[23] https://www.identitywa.com.au
[24] ts 17.02.22 (Re), pp256 & 261
[25] ts 14.02.22 (Irwin), p7
[26] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), para 8
[27] ts 14.02.22 (Irwin), pp8 & 17; ts 15.02.22 (Ellis), p106 and ts 16.02.22 (Barvardia), p123
[28] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), para 7

15. At the relevant time, Mr Nylund had a Certificate III in Individual Support and was completing a Certificate IV in Disability care. Mr Mitchell Irwin had a Bachelor of Psychology and Ms Judith Ellis had Certificate IV in Disability care and had worked as a psychiatric nurse in the United Kingdom for about 20 years. Mr Rajeshkumar Barvardia had a Master of Social Work and a Diploma of Community Services and Mr Luke Austin had a Certificate III in Community Services and a Certificate IV in Mental health.[29,30,31]

The role of the On Call

16. After hours, Identitywa care workers are supported by an experienced care worker known as the On-Call (a role performed by team leaders on a rotating basis). In 2018, guidance for the On-Call was contained in an Identitywa document entitled *On Call Procedure*.[32] The version of this document that was provided to the Court was approved in August 2019, but in any event, the document sets out the role of the On-Call in these terms:

> On Call is available outside of business hours, 4:30pm to 8am, and is contacted when an emergency situation occurs that requires immediate action or if a situation arises and an authorised worker is required.[33,34]

17. Ms Hanrahan said that in practice, the On-Call receives and responds to calls from care workers on a range of matters including staff rosters, behavioural issues relating to residents and questions about Identitywa policies and procedures. Contact with the On-Call is typically by phone and despite there being an Identitywa policy that all calls are to be documented in the On-Call Logbook/Register,[35] at the relevant time it appears that limited (if any) records were kept of such calls. Presumably this is partly because it was not uncommon for the On-Call to receive in excess of 100 calls over the course of their shift.[36,37]

---

[29] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), para 5
[30] ts 14.02.22 (Irwin), pp6-7 and ts 15.02.22 (Ellis), pp106 & 118
[31] ts 15.02.22 (Barvardia), p123 and ts 16.02.22 (Austin), p155
[32] Exhibit 1, Vol. 1, Tab 18.4, On Call Procedure (August 2019)
[33] Exhibit 1, Vol. 1, Tab 18.4, On Call Procedure (August 2019), p1
[34] See also: ts 15.02.22 (Gladwell), pp99-100
[35] Exhibit 1, Vol. 1, Tab 18.4, On Call Procedure (August 2019), p2
[36] Exhibit 1, Vol. 1, Tab 30, Statement - Ms C Hanrahan(28.01.22), paras 5-6 and ts 14.02.22 (Hanrahan), pp24-26
[37] ts 15.02.22 (Gladwell), p93

18. Despite Ms Re's evidence to the contrary, the *On Call Procedure* provides no guidance to the On-Call about decisions relating to care workers accompanying a resident being admitted to hospital. However, in 2021, Identitywa created a document entitled *On Call File: Responsibilities*, which purported to do so (the Guidance Document). In my view, as I will outline later in this finding, the Guidance Document is deficient, at least insofar as it relates to hospital admissions.[38,39]

Early Warning Score

19. Identitywa care workers monitor the vital signs of residents using a system known as Early Warning Score (EWS). The EWS was apparently developed by Leeds University in the United Kingdom and assigns scores to various observations including pulse rate, breathing rate, blood pressure, temperature, level of consciousness and perception of pain.[40]

20. The scores for each of these observations are added together and care workers refer to the EWS Response chart for guidance as to what action (if any) to take, based on the resident's total EWS score. For example, with an EWS score of "2", care workers advise the team leader and make an appointment with the resident's GP. For an EWS score of "6", care workers call an ambulance and advise the team leader.[41]

21. Whilst systems like EWS are no doubt useful in providing guidance to staff with no clinical training, rigid adherence to EWS guidance may interfere with a care worker's innate sense that "*something is not right*" and/or that action over and above that mandated by the EWS Response Chart is required.

22. As Mr Nylund said at the inquest:

> I think a lot of the EWS in my mind takes away a lot of the…intuition of the support workers to make a decision on what to do. More like, "No, we will follow this because this is the response monitoring or this is the pathway".[42]

[38] Exhibit 1, Vol. 1, Tab 18.4, On Call Procedure (August 2019), p2
[39] Exhibit 1, Vol. 1, Tab 25, Attachment MR12, On-Call File: Responsibilities (2021)
[40] Exhibit 1, Vol. 1, Tab 18.5, Early Warning System Framework
[41] Exhibit 1, Vol. 1, Tab 9.2 Response Chart, EWS Response Chart
[42] ts 15.02.22 (Nylund), p144 and see also: ts 15.02.22 (Barvardia), p134

23. As I will highlight later in this finding, the EWS system takes no account of a resident's recent hospital admission. Thus, following a resident's discharge from hospital , subsequent EWS observations start from a score of "0", as if the hospital admission had not occurred. In my view, this flaw in the guidance provided by the EWS Response chart should be addressed.

Transfer to hospital policy

24. In relation to emergency admissions to hospital for disability service organisation residents, a 2016 document issued by the Health Department (the Health Department Document) states:

> If the individual [i.e.: resident] is transported by ambulance but the DSO [i.e.: Disability Service Organisation] staff does not accompany the individual ensure:
>
> - the paramedics have the DSO provider's contact details
> - the DSO staff is advised which hospital the individual is being transported to.
>
> **It is essential that the DSO provider ensures an appropriate person attends ED to support the individual. This may be a staff and/or a family member or carer.**[43] [Emphasis added]

25. According to Ms Re, Identitywa's policy relating to the transfer of residents to hospital (the Policy) was based on the Health Department Document. However, despite that fact, and the mandatory language of the Health Department Document, in her statement, Ms Re said:

> **Identitywa policies do not specify that a support worker must accompany an individual to hospital in each instance**. The policies are drafted in discretionary language to allow for the many and varied circumstances that support workers are faced with. Such circumstances include the situation where only one support worker is present and accountable for several individuals.[44] [Emphasis added]

[43] Exhibit 1, Vol. 1, Tab 25, Attachment MR4, Hospital Stay Guideline for Hospitals and Disability Service Organisations (2016)
[44] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 9 and ts 16.02.22 (Re), p252

26. As I have noted, Ms Re's evidence was that the Policy states that it is the responsibility of the On-Call to determine how to proceed if a resident is admitted to hospital.[45] However, I was unable to find any such statement in the version of the Policy tendered into evidence during the inquest. In my view, the Policy is poorly formulated and appears to conflate booked and emergency admissions. That aside, Ms Re's assertion that the Policy does not require the attendance of a care worker (or support person) in every instance does not stand close scrutiny. On a plain reading, that is exactly what the Policy requires and a few extracts will illustrate the point:

> *Emergency admissions:*
> Emergency admissions cannot easily be planned for but it is useful to always have at hand a brief document that lists the person's medications, allergies, communication needs, swallowing and nutrition needs etc...**Also, take a copy of the person's current medication profile and medications to hospital.**[46]
>
> *Hospital staff:*
> Hospital staff have a duty to adapt their services to meet the individual needs of a person with disability. This happens better in some hospitals than others. **You may need to speak up for the person to make sure they get the support and health care they need.** Wherever possible, do this in a cooperative and non-threatening manner. **Demonstrate to staff how the person communicates.** This will help the person let staff know if they are in pain or want something.
>
> *Your role in the emergency department of a hospital:*
> **Reassure the resident who is hospitalised.** It may assist to have familiar personal items taken to the hospital…Note verbal and non-verbal communication by the resident in hospital in agreed resource, eg hospital communication book.[47] [Emphasis added]

27. It is clearly impossible for a care worker (or support person) to "*speak up for the person*", or "*reassure the resident*" unless they are physically present. The language used in the Policy is not discretionary and the obligation placed on care workers is unambiguous. That is to be expected given that the Policy was supposedly based on the Health Department Document.

---

[45] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 11
[46] Exhibit 1, Vol. 1, Tab 25, Attachment MR1, Going to Hospital Guidance (July 2018), p1
[47] Exhibit 1, Vol. 1, Tab 25, Attachment MR1, Going to Hospital Guidance (July 2018) & Attachment MR2, Hospital Admission Checklist

28. In her statement, Ms Re also made what I regard as several misconceived assertions in an apparent attempt to defend the appalling fact that when Mr Edwards attended FSH on 14 August 2018, he was unaccompanied by a care worker or support person. For example, Ms Re states "*a support worker would not automatically have aided in a better outcome for Mr Edwards during his hospital admission on 14 August 2018*".[48] In another passage, Ms Re asserts "*there is no evidence that the presence of any care worker at Fiona Stanley would have impacted on the medical treatment that Mr Morgan* [sic] *was provided*".[49]

29. In her statement, Ms Re also responded to criticism from the Court's independent medical witness, Associate Professor David Mountain (Professor Mountain) about Mr Edwards being sent to FSH unaccompanied:

> Professor Mountain makes comments and conclusions with which I cannot agree. The fundamental basis of his comments is his suggestion that an Identitywa carer/support person "was supposed to go" to the hospital "according to Identitywa notes". I do not know what "notes" Professor Mountain was referring to. The only relevant documents/policies are those set out in paragraphs 4,5 and 6.[50] None of these documents/policies support what Professor Mountain has stated. **On the contrary, there was at the relevant time on 14 August 2018, no requirement to send a carer/support person to the hospital.**[51] [Emphasis added]

30. With great respect to Ms Re, these passages from her statement demonstrate a fundamental misunderstanding of Identitywa's stated purpose, as outlined in the preamble to the Policy, namely:

> A stay in hospital can be stressful and confusing for the people we support. If you plan the visit carefully with the hospital, the stay should go smoothly. The people we support are entitled to the same quality of care in a hospital as anyone else. **Sometimes, families, advocates and support workers need to speak up to make sure this happens.**[52] [Emphasis added]

[48] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 21.3
[49] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 24
[50] A reference to the Policy, the Health Department Document and the Transfer to Hospital file (see later discussion)
[51] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 27
[52] Exhibit 1, Vol. 1, Tab 25, Attachment MR1, Going to Hospital Guidance (July 2018)

31. In my opinion, the relevant test is not that a care worker should only accompany a resident when it can be shown that their presence will have a demonstrably positive benefit for the resident. The test should be that a care worker (or support person) must accompany a resident to hospital in every situation, unless the resident has capacity and declines such support or a relative or other support person attends instead.

32. This much should have been patently obvious, especially in the case of a non-verbal resident like Mr Edwards. The care worker's presence is required to reassure the resident (who is likely to be in pain and/or in unfamiliar surroundings). The care worker can also provide clinical staff with a collateral history and/or advocate on the resident's behalf.[53,54]

Change in transfer to hospital policy

33. Given the tone of Ms Re's statement, it was somewhat surprising when, at the inquest, she said Identitywa's hospital admissions policy was amended shortly after Mr Edwards' death. Ms Re said that Identitywa's current hospital admissions policy is that, with only two exceptions, a care worker always attends hospital with a resident. The exceptions are where a resident is deemed to have capacity and declines the support of a care worker, or where another support person attends instead.[55]

34. As I have explained, contrary to Ms Re's statement, it is my view that the Policy requires the attendance of a care worker (or support person) whenever a resident is admitted to hospital. In any case, whilst the "change" in Identitywa's policy regarding hospital admissions is welcome, I am perplexed as to why Ms Re's statement was not clarified by a supplementary statement before the inquest.

35. This is especially because at the inquest, Ms Re said that although the policy change was made shortly after Mr Edwards' death, the "*paperwork*" relating to the "new" policy was not updated until 2021. Further, if the policy change really was made shortly after Mr Edwards' death, it is troubling that none of the employees of Identitywa who appeared at the inquest appear to be aware of it.

[53] ts 14.02.22 (Irwin), pp20-21; ts 14.02.22 (Hanrahan), pp32-34 and ts 15.02.22 (Gladwell), pp103-104
[54] ts 15.02.22 (Ellis), pp121-122; ts 15.02.22 (Barvardia), p135 and ts 16.02.22 (Austin), pp158, 161-165
[55] ts 17.02.22 (Re), pp277-278

36. The care workers who attended the inquest all said that their understanding of the policy was that where possible, a care worker should attend hospital with a resident. Most said that this was usually feasible during the day when two care workers were rostered on, or where the care home was co-located with another so that staff from one home could assist with residents in the other. However, all of the care workers said that at night (when typically only one care worker was rostered on) it may not always be possible for a care worker to attend hospital to support the resident.[56,57,58,59]

37. These comments by the care workers are directly contrary to Ms Re's description of Identitywa's current hospital admissions policy. It is unclear whether this misunderstanding is widespread amongst the rest of Identitywa's staff, but given that one of the staff who gave evidence at the inquest is a team leader and another is an On-Call, it would be appropriate for Identitywa to issue an urgent bulletin to ensure that all staff are familiar with the current arrangements. There is obviously no point in an organisation making fundamental changes to an important policy if some (or all) of its staff are unaware of those changes. That is a recipe for chaos.

38. At the inquest, Ms Re said that the "*paperwork*" encapsulating the new hospital admissions policy was contained in a document intended to provide guidance to the On-Call. I have already referred to this document as the Guidance Document. The Guidance Document was not attached to Ms Re's statement but, at my request, it was provided to the Court.[60]

39. Metadata associated with the version of the Guidance Document provided to the Court establishes that it was last modified on 22 September 2021, some two months before Ms Re's statement was signed.[61,62] This is curious given that "new" policy was in place before Ms Re's statement, in which she seeks to argue that the Policy does not require the attendance of care workers when a resident is admitted to hospital. In any event, it is my view that the Guidance Document is flawed, at least insofar as it purports to set out Identitywa's current policy with respect to hospital admissions.

---

[56] ts 17.02.22 (Re), pp256-257; ts 14.02.22 (Irwin), p21 and ts 14.02.22 (Hanrahan), pp26-27 & 28-31
[57] ts 15.02.22 (Gladwell), pp91-92 & 98 and ts 15.02.22 (Ellis), pp113-114 & 119-120
[58] ts 15.02.22 (Barvardia), p135 and ts 15.02.22 (Austin), pp165-166
[59] Although he is no longer an Identitywa employee, see also: ts 15.02.22 (Nylund), pp147-150
[60] Exhibit 1, Vol. 1, Tab 25, Attachment MR12, On-Call Guidance document (2021)
[61] Metadata summarises basic information about the document, for example, the date of creation/modification
[62] Email Mr T Seymour (Associate, Lavan) to Mr W Stops (17.02.22)

40. As I will now demonstrate, the Guidance Document does not encapsulate the essence of what Ms Re says is the current Identitywa policy in this area. This is obviously problematic. Guidance material should be crystal clear with respect to the duties and responsibilities of care workers. Regarding hospital admissions, the Guidance Document states:

> *Hospitalisation / Medical Treatment Required*
>
> 1. Call an ambulance [000]
> 2. Administer 1st Aid or CPR if required
>
>   NB: If the client requires hospitalisation provide;
>   - Care Plan
>   - Medication Profile
>   - Advise of any medical issues the person may have
> 3. A staff member must accompany a client to the hospital via house vehicle/ambulance **providing adequate staffing is available**. [Emphasis added]
> 4. Advise On-Call of incident, action and outcome
> 5. Complete Accident/Incident Report Form, email to Team Leader[63]

41. In my view, the words highlighted above are capable of being interpreted as meaning that a care worker will accompany a resident whenever this is logistically possible. This is inconsistent with the new hospital admissions policy Ms Re outlined at the inquest whereby a care worker (or other support person) always accompanies a resident. At the inquest, Ms Re said the highlighted words were intended to indicate that a care worker would attend hospital as additional staff could be found to backfill the care worker's position (if required) or another care worker was found to attend.[64,65]

42. In other words, if the hospital admission occurs at night when only one care worker is rostered on at the relevant care home, then that care worker would stay at the care home until they could be relieved by another worker. If this was not appropriate (e.g.: because that care worker was unfamiliar with the resident) then another care worker who was familiar with the resident would be despatched to the hospital instead.

---

63 Exhibit 1, Vol. 1, Tab 25, Attachment MR12, On-Call Guidance document (2021)
64 ts 17.02.22 (Re), pp278-281
65 ts 18.02.22 (Hunt), pp290-291

43. In my view, both the Policy and the Guidance Document should be urgently amended so as to remove any doubt about what Identitywa's current hospital admissions policy actually is, and further to clarify the respective responsibilities of care workers and the On-Call. At the inquest, Ms Re agreed that these amendments could and should be made.[66,67]

44. The amendments to the Policy and the Guidance Document should confirm that the Identitywa policy is that whenever a resident is admitted to hospital, they **must** be accompanied by a care worker (unless one of the two exceptions I outlined earlier applies). The amendments should also clarify that, where necessary, the On-Call is to arrange for additional care workers to provide support to the care home.

45. In my view, the amendments to the Policy and the Guidance Document should also include a clear requirement that whenever one or other of the exceptions I have referred to applies, the facts surrounding that exception should be clearly documented at the time by means of a comprehensive, signed and dated entry in the relevant resident's care home notes.

46. For the sake of clarity, it is my view that the following requirements should be imposed:

a. Where a resident is deemed to have capacity but declines the assistance of a care worker (or support person) an entry in that resident's notes should state who had made the determination the resident had capacity (and on what basis) and record the resident's wishes regarding support during their hospital admission; and

b. Where the NOK/guardian exception applies, the entry in the resident's notes should describe how the NOK/guardian was contacted, what the NOK/guardian was told about the resident's condition and the nature of the support that NOK/guardian agreed they would provide to the resident in relation to the hospital admission.

[66] ts 17.02.22 (Re), pp278-281
[67] See also: ts 14.02.22 (Hanrahan), pp33-34

THE EVENTS OF 14 AUGUST 2018

Presentation during the day

47. Mr Barvardia was one of the care workers on duty at Butler House during the morning of 14 August 2018. In his shift report, Mr Barvardia noted that Mr Edwards "*was happy and watching/listening* [to] *TV in the living room before* [he] *went swimming*". Mr Edwards had eaten a lunch of tuna and baked beans and appeared to be his usual self.[68]

48. Mr Austin and Mr Irwin were the care workers on afternoon shift on 14 August 2018, and both said Mr Edwards appeared to be his usual self during the afternoon. Mr Edwards was given chicken curry for dinner at about 5.00 pm, after which he was placed onto his commode before being changed and readied for bed.[69,70]

Concerns about breathing

49. As Mr Irwin was giving Mr Edwards his medication at about 5.30 pm, he noticed that Mr Edwards' breathing had "*become very rapid*" (i.e.: 35 - 40 breaths per minute), his pulse was elevated and he seemed to "*be having a little trouble breathing*". Mr Irwin mentioned this to Mr Austin, who agreed that Mr Edwards did not look well. Both care workers thought Mr Edwards may have been necking and that this may have accounted for his symptoms.[71,72,73]

50. Mr Irwin and Mr Austin monitored Mr Edwards, but by 7.00 pm, his symptoms had not resolved and he had started groaning. At that time, Mr Edwards' EWS score was "3" and the EWS Response Chart indicated that care workers should call Healthdirect, make an appointment with the resident's GP or call a locum doctor and alert the care home's team leader and the On-Call.[74,75,76,77]

---

[68] Exhibit 1, Vol. 1, Tab 8.1, Shift Report, Mr R Barvardia (2.15 pm, 14 Aug 18)
[69] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 6-7 and ts 16.02.22 (Austin), p156
[70] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), paras 5-6 & ts 14.02.22 (Irwin), p8
[71] Exhibit 1, Vol. 1, Tab 8.2, Shift Report, Mr M Irwin (10.15 pm, 14 Aug 18)
[72] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 8-9 and ts 16.02.22 (Austin), p156
[73] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 7 and ts 14.02.22 (Irwin), p8-10
[74] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 10-12 and ts 16.02.22 (Austin), pp157 & 167-168
[75] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 8 and ts 14.02.22 (Irwin), pp10-13
[76] Exhibit 1, Vol. 1, Tab 9.2 Untimed entry in EWS Observation Chart (14.08.18)
[77] Exhibit 1, Vol. 1, Tab 9.2 Response Chart, EWS Recording Chart

51. Given the time of night, Mr Irwin sensibly decided to call a locum doctor. Mr Edwards continued to groan and at times was sitting up in bed rocking. When the locum had not arrived by 9.00 pm, Mr Irwin decided to call an ambulance, and he did so at 9.05 pm.[78,79,80]

Information provided to paramedics at Butler House

52. It appears that Mr Irwin told the emergency services operator that Mr Edwards' symptoms may be due to an allergic reaction to the chicken curry he (Mr Edwards) had eaten for dinner. I say that because the section of the St John Ambulance WA (SJA) patient care record that provides paramedics with information about the job they are attending states: "*?Food Allergic reaction to spicy food*".[81] This information must have come from Mr Irwin given that Mr Edwards is non-verbal.

53. When paramedics arrived at Butler House at 9.11 pm, Mr Irwin relayed his observations of Mr Edwards' symptoms. He also told paramedics he wasn't sure if there was anything wrong with Mr Edwards but that he wanted him "*checked over*". Paramedics recorded Mr Edwards' vital signs as: respiration rate: 32 breaths per minute, pulse rate: 88 beats per minute and oxygen saturation on room air: 90%.[82,83]

54. Mr Edwards left Butler House in the ambulance at about 9.31 pm and the SJA patient care record completed by paramedics relevantly states:

> Staff stated patient has multiple food allergies and was found on his bed with tachypnoea [abnormally rapid breathing] with unknown cause. ?Food allergy. Staff stated patient normally has tachypnoea with blotchy skin that self [resolves], nil blotchy patterns or rashes noted on patient tonight, denied any recent illness or fevers, nil Hx [history] of anxiety. Patient found sitting on bed with tachypnoea, large tongue protruding from mouth, flushed in colour. Carer stated togue normal for patient and is of normal colour, only concern is the tachypnoea.[84]

---

[78] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 9 and ts 14.02.22 (Irwin), p13
[79] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), para 14 and ts 16.02.22 (Austin), p157
[80] Exhibit 1, Vol. 1, Tab 20.1, SJA Patient Care Record (14.08.18), p1
[81] Exhibit 1, Vol. 1, Tab 20.1, SJA Patient Care Record (14.08.18), p2
[82] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 10 and ts 14.02.22 (Irwin), p14
[83] Exhibit 1, Vol. 1, Tab 20.1, St John Ambulance Patient Care Record (14.08.18), p2
[84] Exhibit 1, Vol. 1, Tab 20.1, St John Ambulance Patient Care Record (14.08.18), p2

55. Although the SJA patient care record states: "*Staff stated will be in contact with on-call staff member to present to FSH ED to care for patient*",[85,86] the appalling truth is that Mr Edwards was never supported by a care worker (or support person) at any stage during this presentation to FSH. At the inquest Mr Irwin agreed that, with the benefit of hindsight, a care worker should have accompanied Mr Edwards to FSH and that this "*would have improved the situation*".[87]

56. Before paramedics left Butler House, Mr Irwin gave them Mr Edwards' "*Transfer to Hospital file*" (Mr Edwards' Transfer file) which contained information about Mr Edwards' conditions, medications, behavioural issues and dietary requirements.[88] A *Transfer to Hospital file* is maintained for each Identitywa resident and accompanies that resident to hospital admissions and medical appointments.[89]

57. Mr Edwards arrived at FSH at about 9.41 pm, and in her statement, Dr Stokes says the information FSH received from paramedics during their handover was that Mr Edwards' shortness of breath had started "*a little while after*" he had eaten chicken curry for dinner, and that this was a food Mr Edwards didn't usually eat.[90]

58. The FSH discharge summary for 14 August 2018 relevantly states:

> 31 M with a background of Smith-Magenis syndrome with intellectual disability, ?food intolerance, Crohn's disease, bowel obstruction BIBA [brought in by ambulance] from a disability home with tachypnoea, non-verbal, baseline GCS [Glasgow Coma Score] of 11.[91].
>
> Disability home worker reported that had dinner around 5pm (chicken curry, worker **unsure whether pt** [patient] **had this before but unusual to have in disability home**), associated with tachypnoea at 8 pm associated with hypertension (140/110).[92] [Emphasis added]

---

[85] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 10 and ts 14.02.22 (Irwin), pp13-14 & 19
[86] Exhibit 1, Vol. 1, Tab 20.1, St John Ambulance Patient Care Record (14.08.18), p2
[87] ts 14.02.22 (Irwin), p22
[88] Exhibit 1, Vol. 1, Tab 25, Attachments MR5-MR10, Transfer to Hospital File documents
[89] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 10 and ts 14.02.22 (Irwin), pp14-16
[90] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 20
[91] The Glasgow Coma Score ranges from a score of "3" (completely unresponsive) to a score of "15" (responsive)
[92] Exhibit 1, Vol. 1, Tab 31.4, FSH Discharge summary (3.44 am, 15.08.18)

59. On this issue, Ms Re said "*whilst curry was not a specified food in the Plan, Mr Edwards had eaten curry on previous occasions and enjoyed it*" and I note that in their respective statements, Mr Austin and Mr Irwin agreed with this assertion.[93,94,95,96] On the face of it, chicken curry would seem to be a curious meal choice for someone with Crohn's disease and I note that Mr Edwards' health care plan does say he should avoid "*spicy food*".[97] Nevertheless, as this issue does not appear to be directly related to Mr Edwards' death I do not propose to take the matter any further.

Contact with On Call

60. After Mr Edwards had left Butler House in the ambulance, Mr Irwin contacted the On-Call (Ms Carole Hanrahan) and told her "*everything that had happened*". Mr Irwin says he asked Ms Hanrahan if anyone needed to follow Mr Edwards to hospital and she responded with words to the effect of "*it was not necessary, but it was up to me*". At the inquest, Mr Irwin said Ms Hanrahan told him: "*Look it's your call. It's your judgement call. Just do what you think is the necessary thing*.[98] Mr Irwin says Ms Hanrahan told him she would advise the team leader for Butler House (Ms Anne-Marie Gladwell) that Mr Edwards had gone to FSH.

61. Mr Irwin also said: "*My judgment was that Mr Edwards would be okay by himself, as he was just being checked over and the hospital would have the Transfer to Hospital file*".[99] However, at the inquest, Mr Irwin was asked how he had decided no one needed to accompany Mr Edwards, and he said:

> I wasn't like thinking that someone definitely didn't need to go with him at some point. I…just couldn't go with him at that time. So, I would have maybe thought that…when…Judith [i.e.: care worker Judith Ellis] started that maybe she would have gotten someone to relieve her and then she would have like gone to the hospital. So…from my point of view, I had finished my shift. I had done a handover. I… just wasn't sure how serious Morgan's condition was, so I thought that possibly he might have needed some sort of care sooner rather than later.[100]

---

[93] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 20
[94] Exhibit 1, Vol. 1, Tab 25, Statement - Ms M Re (30.11.21), para 23
[95] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), para 7
[96] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 6
[97] Exhibit 1, Vol. 1, Tab 25, Attachment MR8, Crohn's Disease Health Care Plan
[98] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 11 and ts 14.02.22 (Irwin), pp13-14
[99] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 11
[100] ts 14.02.22 (Irwin), p17

62. Mr Irwin's shift concluded at 10.15 pm and he was relieved by Ms Ellis, who arrived at Butler House at 10.00 pm. After briefing Ms Ellis about the events of the evening, Mr Irwin left to go home. Despite what paramedics recorded they were told about a staff member attending FSH to "*care*" for Mr Edwards, neither Ms Ellis, nor Mr Irwin did so.[101]

63. Ms Hanrahan could not remember details of the calls she received whilst she was the On-Call on 14 August 2018. However, after examining the communication book from Butler House, she accepted that Mr Irwin had called her to advise that Mr Edwards had been taken to FSH.[102] At 9.44 pm, after speaking with Mr Irwin, Ms Hanrahan sent a text message to Ms Gladwell advising her of Mr Edwards' admission. Ms Hanrahan sent a further text message to Ms Gladwell at 6.11 am on 15 August 2018 in these terms:

> Good morning, Morgan Edwards returned from Hospital @ 4:05 am. NA reports he is still unwell and will be seeking further medical advice this morning. Kind regards Carole.[103,104]

64. At the inquest, Ms Re said the guidance Ms Hanrahan gave Mr Irwin was contrary to Identitywa's policy, which supposedly was that the On-Call was responsible for making decisions about the attendance of care workers when residents were admitted to hospital. Notwithstanding the views she had earlier expressed in her statement, at the inquest Ms Re also said that the decision to send Mr Edwards to hospital without a care worker had not been adequate.[105]

Arrival at the emergency department

65. After Mr Edwards arrived at the emergency department at FSH (ED) he was assessed by the triage nurse before being moved into the resuscitation area. This is an area where very unwell patients or those who need monitoring and/or close supervision are taken. I note that there are 15 beds in the ED and generally 24 nurses on duty during a night shift.[106]

---

[101] Exhibit 1, Vol. 1, Tab 12, Statement - Mr M Irwin (27.06.21), paras 11-13 and ts 14.02.22 (Irwin), pp17-18
[102] Exhibit 1, Vol. 1, Tab 30, Statement - Ms C Hanrahan(28.01.22), paras 8-10 and ts 14.02.22 (Hanrahan), pp25-26
[103] Exhibit 1, Vol. 1, Tab 30, Statement - Ms C Hanrahan(28.01.22), para 11
[104] Exhibit 1, Vol. 1, Tab 29, Statement - Ms A-M Gladwell (28.01.22), para 5
[105] ts 17.02.22 (Re), p253-254 & 258 and ts 18.02.22 (Hunt), pp286-287
[106] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 16-19

66. Nurse Lisa Scully said that when she first saw Mr Edwards in the ED, he was being assessed by Dr Nathania Gianina, who was then a resident medical officer (RMO) and had been working in the ED for about two months. As noted, Mr Edwards was unaccompanied by a support person and SJA paramedics provided a handover to Dr Gianina. During the handover, paramedics mentioned that Mr Edwards had Smith-Magenis Syndrome and Crohn's disease and he was non-verbal. Paramedics also told Dr Gianina that care workers were concerned about Mr Edwards' rapid breathing which could possibly be due to a food allergy.[107,108]

67. As an RMO, Dr Gianina was subject to supervision by more senior doctors. On 14 August 2018, Dr Gianina's supervisor was Dr Amy Stokes, who at that time, was a registrar in the ED. Dr Gianina's responsibilities included taking patient histories, conducting examinations and ordering basic investigations such as blood tests and x-rays.[109]

68. Although she had a limited memory of Mr Edwards' management, Dr Gianina recalled he was difficult to assess and, because he was non-verbal, he was unable to "*give feedback during the examination*". Dr Gianina recalled being given Mr Edwards' Transfer file and accepted she had called Butler House at least twice and had tried to contact Mr Edwards' next-of-kin. Although she could not recall why she had made these calls, Dr Gianina said it was likely she had been seeking "*a collateral history*".[110,111]

69. Dr Gianina noted that abnormal breathing (such as Mr Edwards had presented with) can have various causes including pneumonia, pneumothorax, pulmonary oedema, allergic reactions, sepsis and metabolic acidosis. Although blood tests and a chest x-ray were ordered, Dr Stokes recalled that Dr Gianina had not ordered these investigations on her own initiative and that she (Dr Stokes) had to direct Dr Gianina to do so. The significance of this piece of evidence will become clear shortly.[112]

---

[107] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 20-23
[108] Exhibit 1, Vol. 1, Tab 35, Att. LS2, Adult Triage Nursing Assessment (10.20 pm, 14.08.18)
[109] Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), paras 4-10 and ts 14.02.22 (Gianina), p36
[110] Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), paras 4-17
[111] ts 14.02.22 (Gianina), pp36-40
[112] ts 14.02.22 (Stokes), pp57 & 59-60

70. Nurse Scully said that Mr Edwards did not appear distressed or in pain and showed no obvious signs of breathing difficulties. However, he did become agitated by the equipment monitoring his vital signs and so the observation leads were removed. Nurse Scully (who is trained in "neuro-observation") said she did not detect any signs indicating that Mr Edwards' condition was deteriorating.[113]

71. Nurse Scully recalled that Mr Edwards had attempted to stand up in bed and that she had moved him to Bay 3 in the resuscitation area of the ED (the observation pod). Dr Stokes also recalled Mr Edwards being moved to the observation pod which she said had a higher nurse to patient ratio and from where, Mr Edwards could be more closely observed from the "*fishbowl*" (i.e.: the central staff area in the ED).[114,115,116]

72. Nurse Scully said FSH staff were unaware of what Mr Edwards' normal vital signs were and after taking readings she recorded the following results:

Breathing: 36 breaths per minute;
Oxygen saturation on room air): 100%;
Pulse: 88 beats per minute;
Blood pressure (systolic): 127 mmHg; and
GCS: 11/15 (reported as normal by paramedics).[117,118]

73. Nurse Scully said with the exception of his respiration rate, Mr Edwards' observations were unremarkable.[119] The uncontested evidence of Professor Mountain was that a respiration rate of over 24 breaths per minute in a hospitalised patient was "*a marker of critical illness*". Professor Anthony Brown (the medical expert called on behalf of Dr Stokes) agreed with Professor Mountain's observation but noted that such results had to be considered in the context of the patient's overall presentation.[120,121]

[113] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 26-30, 34-36 & 39-40
[114] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 31-32
[115] Exhibit 1, Vol. 1, Tab 23, FSH Adult Triage Nursing Assessment 10.20 pm, 14.08.18)
[116] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 25-26 and ts 14.02.22 (Stokes), p65
[117] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 27 & 37
[118] Exhibit 1, Vol. 1, Tab 23, FSH Adult Triage Nursing Assessment 10.20 pm, 14.08.18)
[119] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 38-40 & 43
[120] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p5 and ts 18.02.22 (Mountain), p297
[121] ts 17.02.22 (Brown), pp223-224

74. Dr Stokes recalled that Mr Edwards had severe physical and intellectual disabilities and was unable to speak. She said he "*almost certainly had a very limited understanding about what was told to him and the events happening around him*".[122] Although it is clear that Mr Edwards' Transfer file went with him to the ED, Dr Stokes noted:

> We did not receive any documentation from the care home specifically containing the events of the evening or their concerns (which is common in patients coming from care homes and nursing homes), so we initially had to rely on the history given to us by St John Ambulance (SJA) paramedics. The care home was later contacted by the junior doctor and during this conversation, this account of events was confirmed.[123]

75. I accept that the *Transfer to Hospital files* maintained by Identitywa for its residents contain useful information. However, in the context of a busy ED, the information in those files may not always be easy to access and/or digest. Further, Mr Edwards' Transfer file did not contain a brief statement about his presentation over the past few hours, nor was there any indication of why Mr Edwards had been referred to the ED. To address these difficulties, I have recommended that Identitywa consider amending the *Transfer to Hospital file* documentation to include (on the front of the file) a single A4 sheet containing critical information about the resident and, importantly, a brief explanation of the reason for sending the resident to hospital.

76. In the event of an emergency admission, clinical staff would then have access to a single document detailing key information about the resident and the reason for the admission. Both Dr Clayden and Ms Re agreed that this would be a useful amendment to the *Transfer to Hospital file* documentation.[124]

77. In her statement (signed on 2 November 2021), Dr Stokes said she had observed Mr Edwards from the end of the bed "*multiple times*".[125] However, in an undated statement made eight or nine days after Mr Edwards' death,[126] I note that Dr Stokes said: "*As the patient was in bay 3, I was able to look at him from the end of the bed on at least **2 occasions***"[127] [Emphasis added].

---

[122] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 16 and ts 14.02.22 (Stokes), p53
[123] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 19 and ts 14.02.22 (Stokes), pp54 & 81
[124] ts 17.02.22 (Clayden), pp207-209; ts 16.02.22 (Re), pp260-262 and see also: ts 18.02.22 (Hunt), pp291-292
[125] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 27-28 and ts 14.02.22 (Stokes), p72
[126] ts 17.02.22 (Clayden), pp180-181
[127] Exhibit 1, Vol. 1, Tab 24.1, Attachment to Statement - Dr A Stokes (02.11.21)

78. Either way, Dr Stokes said that on the occasions she observed him, Mr Edwards did not appear to be in respiratory distress. He had looked "*comfortable*" and was moving about in bed. He had his shirt off and Dr Stokes says she noted no signs of "*increased work of breathing*" or abdominal distension. Although Dr Stokes noticed Mr Edwards' tongue was sticking out of his mouth (which was normal for him), she said his breathing was not laboured.[128,129]

79. In her statement, Dr Stokes also said that in accordance with her usual practice, she believed she had physically examined Mr Edwards in the ED, but that her memory was "*not completely clear about this*".[130] It was therefore surprising when, at the inquest, Dr Stokes said she now had a clear memory of having examined Mr Edwards, partly because his bed height had to be adjusted so that the examination could take place. Quite why Dr Stokes did not recall this on 2 November 2021, when she signed her statement, is unclear.[131]

80. In any event, Dr Stokes says that after Dr Gianina had examined Mr Edwards, she "*presented*" his case, meaning that Dr Gianina explained the circumstances of Mr Edwards' presentation for the purposes of receiving direction from Dr Stokes about Mr Edwards' future management. Dr Stokes said she discussed the difficulties and vulnerabilities of disabled patients with Dr Gianina and noted Mr Edwards' was non-verbal.[132,133]

81. Dr Stokes says that despite Mr Edwards' "*largely normal observations*", she decided "*we would do some blood tests and a chest x-ray*" and that these tests may assist her in determining whether an infection or aspiration was likely. Although Dr Stokes felt Mr Edwards "*looked well clinically*", his respiration rate at this point was still quite elevated.[134] In accordance with Dr Stokes' direction, an imaging request for a chest x-ray was completed (apparently by Dr Gianina) at 10.32 pm (the First x-ray).[135]

---

[128] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 42-44 and ts 14.02.22 (Stokes), p58
[129] Exhibit 1, Vol. 1, Tab 24.1, Attachment to Statement - Dr A Stokes (02.11.21)
[130] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 27-28
[131] ts 14.02.22 (Stokes), pp82-83
[132] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 29-30 and ts 14.02.22 (Stokes), p58
[133] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 29-30 and ts 14.02.22 (Stokes), p58
[134] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 31-32 and ts 14.02.22 (Stokes), p57
[135] Exhibit 1, Vol. 1, Tab 31.2, FSH Imaging Request (10.32 pm, 14 August 2018)

82. The First x-ray request form noted Mr Edwards' clinical details including his age, medical conditions and presenting symptoms and under the heading "*Clinical question to be answered*", the words "*cause of tachypnoea*" appear.[136] Although Mr Edwards was taken to the Radiology Department, the First x-ray could not be performed. After Mr Edwards had been returned to the ED, Dr Stokes was told that the attempt to perform the First x-ray had been unsuccessful.[137]

83. Nurse Scully said that although she was not the nurse who accompanied Mr Edwards to the Radiology Department, she spoke to the nurse who did. That nurse said that the First x-ray could not be completed because Mr Edwards became agitated, and staff could not get him to lie still. It had also been impossible to position Mr Edwards as they needed to, in order to perform the requested imagining.[138]

84. Dr Gianina said when she examined Mr Edwards, she found he had a tense abdomen but there was "*no suggestion of pain from Mr Edwards' appearance*". At the inquest, Dr Gianina agreed that assessing a non-verbal patient was challenging and conceded that, with the benefit of hindsight, if Mr Edwards had been in pain, this may have been missed because he was non-verbal.[139,140]

85. In terms of differential diagnoses (i.e.: explanations for Mr Edwards' presentation) Dr Stokes says she was considering pneumonia/respiratory tract infection and also whether his symptoms could be related to a food allergy, although he showed no signs of a rash or wheeze. Dr Stokes says she was also mindful of the possibility Mr Edwards had choked on his dinner and aspirated (inhaled) some food particles. Dr Stokes said that in some cases of aspiration, a patient will develop pneumonia. She noted that the Australian Therapeutic Guidelines recommend that antibiotics only be administered where a patient with aspiration becomes unwell.[141]

---

136 Exhibit 1, Vol. 1, Tab 31.2, FSH Imaging Request (10.32 pm, 14 August 2018)
137 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 38 and ts 14.02.22 (Stokes), pp61-62
138 Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 44-50
139 Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), paras 24-28 and ts 14.02.22 (Gianina), pp45 & 47
140 ts 16.02.22 (Brown), pp221-222 and ts 18.02.22 (Mountain), p295
141 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 34-36 and ts 14.02.22 (Stokes), pp54 & 60

86. Dr Stokes said in many cases of aspiration, the patient can simply be observed (often at home) after initial blood tests and a chest x-ray were normal. It was only in a case where the patient subsequently became unwell that they would be returned to hospital and, at that time, the patient would be then treated with oxygen and antibiotics.[142]

87. In Mr Edwards' case, blood tests results showed he had a normal white blood cell count but a slightly raised CRP (C-reactive protein), a marker that can be elevated in infection and other inflammatory processes.[143] Mr Edwards was also found to have an elevated lactate level of 2.3. Elevated lactate levels can be due to a number of causes including increased work of breathing, impaired tissue oxygenation, various types of shock, and sepsis.[144,145,146,147]

88. After being advised that the First x-ray had not been performed, Dr Stokes says she told her colleagues it was important that a further attempt be made to get the chest x-ray because Mr Edwards "*had presented with a respiratory complaint*". Dr Stokes said she was aware that a nurse accompanied Mr Edwards during the second attempt in the hope this would reassure him and enable the images to be obtained. Dr Stokes also said the Radiology Department had questioned whether Mr Edwards should be sedated, but she did not consider this was appropriate.[148]

89. At 11.09 pm on 14 August 2018, a second imaging request was completed (apparently by Dr Gianina) for a chest x-ray **and** an abdominal x-ray (the Second x-ray). In addition to clinical details copied from the First x-ray request form, the words "*abdo distended*" were added meaning that when Mr Edwards' abdomen was examined, it was found to be distended. The clinical question to be answered by the Second x-ray was expressed as: "*perforation of bowel ?bowel obstruction? cause of tachypnoea*".[149]

---

[142] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 36 and ts 14.02.22 (Stokes), p60
[143] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.10.18), p5
[144] See: Exhibit 1, Vol. 1, Tab 31.4, FSH Discharge summary (3.44 am, 15.08.18)
[145] See for example: https://www.webmd.com/a-to-z-guides/what-is-a-lactic-acid-blood-test
[146] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 37 and ts 14.02.22 (Stokes), p61
[147] ts 16.02.22 (Brown), p226-227 and ts 18.02.22 (Mountain), pp300-301
[148] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 37 and ts 14.02.22 (Stokes), pp61-62 & 66
[149] Exhibit 1, Vol. 1, Tab 31.3, FSH Imaging Request (11.09 pm, 14 August 2018)

90. As it happens, the Second x-ray was also unsuccessful because Mr Edwards would not lay still. At the inquest, a great deal of time was spent exploring the issue of whether Mr Edwards should have been physically restrained or sedated for the purposes of obtaining the Second x-ray. I accept that it would have been highly inappropriate to have physically restrained Mr Edwards. It would probably have been ineffective in any case, because Mr Edwards would almost certainly have struggled during the attempted procedure. There is also an obvious danger to staff attempting to restrain Mr Edwards in the vicinity of an operative x-ray machine.[150,151,152,153]

91. As to whether Mr Edwards should have been chemically sedated for the purposes of the Second x-ray, I accept that whilst this may have been technically possible, there were risks in doing so. At the time, Dr Stokes assessed those risks as being outweighed by the benefits to be gained from obtaining the requested images. Although we now know that Mr Edwards died from complications associated with an abdominal volvulus, there is no way of knowing whether this was present during the time he was in the ED on 14 August 2018, and/or whether a volvulus (had it been present) would have shown up on the Second x-ray.[154,155]

92. A separate but related issue is whether it was appropriate to discharge Mr Edwards in the absence of any imaging, and I will have more to say about this issue later in this finding. For now, I will merely observe that on the evidence before me, the decision not to sedate Mr Edwards for the purposes of the Second x-ray appears to have been justifiable.[156]

93. In her statement, Dr Stokes says she does not recall ever requesting an abdominal x-ray and that Mr Edwards' history and examination did not suggest abdominal pathology, such as bowel obstruction or perforation.[157] However, despite her inability to recall ordering an abdominal x-ray, for reasons I will now explain, I find that Dr Stokes did exactly that.

---

150 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 45-50 and ts 14.02.22 (Stokes), pp61-66
151 Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p5 and ts 18.02.22 (Mountain), pp304-307
152 Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), pp11 & 14-15
153 ts 16.02.22 (Brown), pp229-231
154 Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p5
155 Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), pp11 & 14-15
156 Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), pp11 & 14-15
157 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 29-30 and ts 14.02.22 (Stokes), pp72-73 & 82

94. In her statement, Dr Gianina made the following comments about the Second x-ray (and I note her evidence was not contradicted at the inquest):

> Although I cannot be certain, I think I may have felt that a chest x-ray was necessary and ordered this before the subsequent request for abdominal x-ray **following the recommendation of the Registrar** (i.e.: Dr Stokes). Although I am not certain, I suspect that an abdominal x-ray was requested due to Mr Edwards' past medical history including Crohn's disease and bowel obstruction. It may also be due to the slightly raised lactate of 2.3 on the blood gas or finding of a distended abdomen on examination, as documented on the abdominal x-ray request.[158] [Emphasis added]

95. At the inquest, Dr Stokes claimed it was "*very common*" for RMO's to order x-rays without guidance from registrars and that perhaps this is what Dr Gianina had done with respect to the Second x-ray. However, when I challenged her about this evidence, Dr Stokes conceded she was not in a position to dispute Dr Gianina's recollection that she (Dr Stokes) had recommended the Second x-ray be performed.[159]

96. I have already noted that Dr Gianina's relative inexperience meant she had not ordered basic blood tests and the First x-ray without first being directed to do so by Dr Stokes. In those circumstances I find it inconceivable that Dr Gianina would have ordered the Second x-ray (which included an abdominal x-ray) without Dr Stokes' express approval.

97. Therefore, on the basis of the uncontradicted evidence before me, I find that Dr Stokes directed Dr Gianina to order the Second x-ray. Further, given the clinical question to be answered by the Second x-ray, it seems logical to conclude (as Professor Brown agreed at the inquest) that abdominal issues, in this case perforated bowel and/or bowl obstruction, must have been part of Dr Stokes' differential diagnosis, despite her evidence to the contrary.[160,161,162]

---

158 Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), para 23 and ts 14.02.22 (Gianina), pp41-42
159 ts 14.02.22 (Stokes), pp59-60 & 83-85
160 Exhibit 1, Vol. 1, Tab 31.3, FSH Imaging Request (11.09 pm, 14 August 2018)
161 Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p2
162 ts 16.02.22 (Brown), p249 and see also: ts 18.02.22 (Mountain), p303

DISCHARGE - 15 AUGUST 2018

Mr Edwards' presentation

98. Whilst he was in the ED, repeat observations showed that Mr Edwards' oxygen saturation was 98% on room air and his respiration rate had improved marginally, but was still elevated at 26 breaths per minute. Despite the fact that a previous blood test had shown an elevated lactate level, this test was not repeated and so there is no way of knowing for certain whether Mr Edwards' elevated lactate level had improved or not.[163] At the inquest, Dr Stokes said that with the benefit of hindsight, she wished she had checked Mr Edwards' lactate before discharging him so as to be certain it had not risen and Professor Brown agreed with this rationale.[164,165]

99. According to Dr Stokes, Mr Edwards looked "*calm and undistressed*" and his chest was "*clear*" when she listened to it with her stethoscope. He had been in the ED for six hours and had been observed by her "*on multiple occasions*". Contrary to Dr Gianina's earlier observations that Mr Edwards' abdomen had been "*distended*" and "*tense*", Dr Stokes found Mr Edwards' abdomen was "*soft and non-tender*" and there was no sign of abdominal distension. Mr Edwards was not short of breath and was not displaying signs of "*increased work of breathing*". Further, an intravenous catheter been inserted earlier by Dr Gianina, and this would have been difficult had Mr Edwards been distressed.[166]

Discharge options

100. I now turn to the discharge options available to Dr Stokes on the night of 14 August 2018 in relation to Mr Edwards. In her statement, Dr Stokes said that her clinical impression of Mr Edwards was that he had presented with a breathing complaint and that a chest x-ray had been indicated. Although this imaging had not been completed, Dr Stokes said she had decided to keep Mr Edwards in the ED for a longer period for observation and that he appeared well and was not in respiratory distress.[167]

---

[163] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 41
[164] ts 14.02.22 (Stokes), p77
[165] ts 16.02.22 (Brown), p227
[166] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 42-44 and ts 14.02.22 (Stokes), p73
[167] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 49 & 52

101. Dr Stokes said she "*took some time to think about an ongoing plan*" and although she had considered admitting Mr Edwards to FSH:

> He had no significant findings that would allow for an admission under the medical team, particularly as we were not treating him in any way (he did not need oxygen or antibiotics).[168]

102. Dr Stokes says she also considered admitting Mr Edwards to the ED short stay unit, but because he had been "*well in the department*", she considered he would benefit from being at home with his carers. Dr Stokes noted that the ED was a busy, bright, loud and stimulating environment and that Mr Edwards did not have a carer or other familiar face with him.[169]

103. Dr Stokes said it is not uncommon for patients who present to ED with symptoms that then resolve, to not have a clear diagnosis when discharged. Dr Stokes said the aim of an assessment in the ED was to "*rule out bad things*" such as medical issues that needed immediate treatment or observation and that patients who do not need specific treatment are commonly discharged, "*even without a clear diagnosis*".[170]

104. Whilst I accept this may be so, in the case of an unaccompanied, non-verbal patient with significant disabilities, I would have thought that a prudent clinician would err on the side of caution and, in those circumstances, would admit the patient for extended observation especially in the absence of imaging (in this case chest and abdominal x-rays) and a repeat blood test.

105. In Mr Edwards' case, two attempts at imaging had been unsuccessful and as I have demonstrated, abdominal issues were clearly being considered at the time the Second x-ray was requested. Whilst it might be correct to say that Mr Edwards' respiration rate had improved (i.e.: from 36 to 26 breaths per minute), it would not be correct to say Mr Edwards had returned to his baseline. In fact, there is no evidence that he did so at any stage he was in the ED.

---

[168] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 49 & 52-54
[169] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 55
[170] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 56

Dr Stokes' erroneous assumption

106. In her statement, Dr Stokes says she discussed Mr Edwards' discharge with Dr Gianina and that she (Dr Stokes) had wanted to ensure that if Mr Edwards was returned to Butler House, he would:

> [B]e going somewhere safe, with people to watch him and send him back to ED should he become unwell, or his symptoms recur. I discussed these requirements with the junior doctor [Dr Gianina] and asked her to call the care home to ensure this was the case.[171]

107. Dr Stokes said it was common for these sorts of calls to be made by RMOs and that this task is normally delegated to them to free up senior doctors to "*undertake tasks that the junior doctors are not qualified to do, such as make decisions about patient care and disposition* [i.e.: discharge].[172]

108. Dr Stokes says that Dr Gianina called Butler House and advised her that staff at the care home were happy to have Mr Edwards returned.[173] Dr Stokes' evidence at the inquest on this point was as follows:

> So Dr Gianina spoke to the care home and she actually said to me, "No, they're very happy to do that. They have advised that they have a good number of carers, that he will be watched carefully, and that they would be happy to send him back".[174]

109. At the inquest, Ms Ellis denied she would have said that she was "*very happy*" to have Mr Edwards retuned to Butler house. Instead, her evidence on this point was:

> Well, I wouldn't say that I was very happy to have him back. I would accept him back based on the fact that they're saying that he's fit to come home.[175]

[171] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 57
[172] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 58
[173] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 59
[174] ts 14.02.22 (Stokes), p68
[175] ts 15.02.22 (Ellis), p117

110. At the inquest, Dr Stokes elaborated on her decision to discharge Mr Edwards to Butler House, and it became clear that her decision to do so was motivated by an erroneous assumption on her part. Dr Stokes says she thought there was a registered nurse at Butler House who could assist in monitoring Mr Edwards and she explained the basis for her assumption in these terms:

> Well, given…the disability that he [Mr Edwards] has and the medications he's on, etcetera, that they would have to have at least one RN [Registered Nurse] at the care home, and that it would be a higher level care than, say, other care homes because he was significantly disabled.[176]

111. The significance of this assumption cannot be understated. At the inquest, I asked Dr Stokes whether her decision to discharge Mr Edwards would have been different if she had known there were no registered nurses at Butler House. Dr Stokes' reply was: "*It may well have been, yes*".[177]

112. The following exchange between Dr Stokes and I further highlights the importance of this issue in her mind:

> *Coroner Jenkin:*
> Well, from what you're saying, if you had known those things at the time, it sounds to me…that it's…more likely than not that you would have admitted him?
>
> *Dr Stokes:*
> It's more likely than not. You are right, yes...It certainly would have tipped that decision to yes, tip the scale.[178]

113. Although Dr Stokes' evidence on this issue was not part of her earlier statement, neither was her evidence at the inquest about recalling that she physically examined Mr Edwards in the ED because his bed level had to be adjusted. After carefully listening to Dr Stokes' evidence (which she gave on oath) I find **all** of her evidence at the inquest was truthful, including her remarks about assuming there was a registered nurse at Butler House.[179,180]

---

[176] ts 14.02.22 (Stokes), p74
[177] ts 14.02.22 (Stokes), p78
[178] ts 14.02.22 (Stokes), p78
[179] ts 14.02.22 (Stokes), p82
[180] See also: ts 18.02.22 (Panetta), pp347-348

Decision to discharge

114. In the end, Dr Stokes decided to discharge Mr Edwards back to Butler House where she assumed his symptoms would be monitored by a registered nurse. As noted, Dr Stokes considered the ED was a noisy and unfamiliar environment and that Mr Edwards would be more comfortable in his own bed.[181] On the face of it, this appears to be a reasonable plan.

115. However, at the time Mr Edwards was discharged, his respiration rate was still well above normal, although admittedly it had improved marginally. Further, x-rays which Dr Stokes had requested had not be performed because of Mr Edwards' agitation, and there was no repeat blood test to check on Mr Edwards' previously elevated lactate level.

116. Given how finely balanced Dr Stokes' decision to discharge Mr Edwards appears to have been, it is very unfortunate that a lower threshold for admission was not applied in this case. With the benefit of hindsight, it would clearly have been appropriate to admit Mr Edwards to the ED short stay unit on 14 August 2018, for further observation. This is especially because Mr Edwards was non-verbal and was unaccompanied by a care worker. Further his respiration remained above normal limits, imaging to exclude chest and/or abdominal issues had not been performed and a definitive cause for his observations had not been identified.[182,183]

117. Although it would have been appropriate for Mr Edwards to have been admitted for further observation, given the imponderables in this case, I accept that it is not possible to say that had this occurred, Mr Edwards' clinical journey would necessarily have been any different.

118. All that can be said is that if Mr Edwards had been admitted to FSH (e.g.: to the ED short stay unit) there is at least a possibility that his subsequent clinical deterioration might have been identified at an earlier stage. Again, on the basis of the available evidence, it is not possible to say whether Mr Edwards' clinical journey would have been different had this occurred.

---

181 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 55 and ts 14.02.22 (Stokes), pp67-68
182 See also: ts 14.02.22 (Gianina), pp49-50
183 See also: ts 16.02.22 (Brown), pp246-247 and ts 18.02.22 (Mountain), pp307-309

Failure to document decision

119. Dr Stokes did not document (in the FSH notes at the time, or at all) her reasoning for discharging Mr Edwards on 14 August 2018. Although she later prepared a summary of her clinical interaction with Mr Edwards (the Notes), this occurred after Mr Edwards' death and following a meeting Dr Stokes had with Dr Vanessa Clayden (Head of Emergency Medicine at FSH). That meeting related to the clinical incident investigation of Mr Edwards' death, that was then underway.[184,185,186]

120. In her statement Dr Stokes said that her failure to make her own notes about Mr Edwards' case was a matter she regretted "*immensely*". In her defence, she said it had been a busy night with a heavy patient load and that she had prepared the Notes "*a few days later*".[187] However, according to Dr Clayden, it appears that the Notes were actually created eight or nine days after Mr Edwards' death.[188]

121. For reasons which were not explained, the Notes were undated and unsigned. Further, the Notes were not incorporated into Mr Edwards' FSH records as a retrospective entry, despite the fact that they contain important information about Mr Edwards' clinical management.[189]

122. I accept that at all relevant times, the ED was very busy and that Dr Stokes had numerous pressing calls on her time.[190] Nevertheless, her decision to discharge Mr Edwards was momentous and her reasoning for doing so should have been recorded in Mr Edwards' FSH record, as should the difficulties encountered in attempting to obtain imaging. Dr Stokes' failure to make even the most cursory of entries in the FSH record was clearly inappropriate and well below the standards expected from a doctor of her seniority.[191,192] However, it is pleasing that since Mr Edwards' death, Dr Stokes says that she has altered her practice in relation to making entries in the medical notes of the patients under her care.

---

[184] ts 14.02.22 (Stokes), pp70-71
[185] ts 17.02.22 (Clayden), p180-181
[186] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.10.18)
[187] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 60 and ts 14.02.22 (Stokes), p70
[188] ts 17.02.22 (Clayden), pp180-181
[189] Exhibit 1, Vol. 1, Tab 24.1, Att. Statement - Dr A Stokes (02.11.21), para 60 and ts 17.02.22 (Clayden), pp181-182
[190] Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), paras 8-15 and ts 14.02.22 (Stokes), p70
[191] Exhibit 1, Vol. 1, Tab 33, Statement - Dr V Clayden (13.01.22), para 14
[192] Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), p12

123. In her statement, Dr Stokes had this to say about her current practice in relation to note-taking:

> Though it is not uncommon for junior doctors to be the only note writers for some cases in ED, I wholeheartedly feel that I should have written notes in this case. This is something I have learned from and have definitively changed in my practice since Mr Edwards' presentation. Now whenever I make a significant decision about a patient's care, I write notes about it. I take care to explain my thoughts and my reasoning.[193]

Contact from FSH

124. Ms Ellis was on duty at Butler House between 10.00 pm on 14 August 2018 and 6.30 am on 15 August 2018. She says that during her shift, she received three calls from FSH. The first was at about 10.45 pm when a "*female doctor*" (presumably Dr Gianina) called and asked "*general questions*" about Mr Edwards, including whether he was usually healthy and what medications he was currently taking.[194,195]

125. I note that this call was made notwithstanding the fact that Mr Edwards' Transfer file went with him to FSH and starkly demonstrates the importance of a care worker or support person accompanying an intellectually handicapped, non-verbal resident (like Mr Edwards) in order to provide a collateral history and information about the resident's usual presentation and responses to pain, etc.

126. Ms Ellis says she received a second call from FSH at 1.55 am on 15 August 2018, when "*a second doctor*" told her Mr Edwards had not been cooperative when staff were "*conducting imaging*" and was "*quite agitated*". The doctor said they could find no cause for Mr Edwards' symptoms and he should be returned home. Ms Ellis said she was unable to collect Mr Edwards as she was the only staff member at Butler House until 6.15 am.[196,197]

---

193 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 61 and ts 14.02.22 (Stokes), pp70-71
194 Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 4-7 and ts 15.02.22 (Ellis), pp108-109
195 Exhibit 1, Vol. 1, Tab 8.3, Shift Report, Ms J Ellis (6.30 am, 15 Aug 18)
196 Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 8-9 and ts 15.02.22 (Ellis), p108
197 Exhibit 1, Vol. 1, Tab 8.3, Shift Report, Ms J Ellis (6.30 am, 15 Aug 18)

127. Dr Gianina said she contacted Butler House and spoke to a care worker (who must have been Ms Ellis). Dr Gianina said it was her practice, when discharging patients from the ED, to explain to the patient (and/or the patient's support person) the symptoms they should monitor to determine whether they needed to come back to the ED or seek medical attention.[198] Dr Gianina also said she would seek guidance from her supervisor before making such calls.[199,200]

128. Given Dr Gianina's relative inexperience and Dr Stokes' evidence about being responsible for discharging Mr Edwards, it makes sense that Dr Gianina would have consulted Dr Stokes before contacting Butler House. Dr Gianina did not make notes of the advice she gave Ms Ellis and whilst this is regrettable, at the inquest, Dr Gianina said it was now her practice to make detailed notes about these types of matters.[201]

129. Dr Gianina also said that when discharging patients with respiratory issues, it was her practice to tell the patient (and/or the patient's support person) to look out for the following symptoms: persistent or worsening breathing difficulties, increasing distress, chest pain and/or palpitations, dizziness and/or "*if there are ongoing concerns*". Dr Gianina said that she would have explained that if any of these conditions developed the patient should be returned to the ED immediately.[202]

130. At about 3.00 am on 15 August 2018, Ms Ellis said a nurse from FSH (who must have been Nurse Scully) called and told her that that Mr Edwards was "*fine*", his beathing was "*okay*", and that he was being "*sent home in an ambulance*".[203,204]

131. Nurse Scully could not recall what she had told Ms Ellis when she called to provide a handover but said that given her usual practice, she (Nurse Scully) would have provided a summary of Mr Edwards' care.[205]

---

198 Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), para 29 and ts 14.02.22 (Gianina), pp 43 & 45
199 Exhibit 1, Vol. 1, Tab 24.1, Statement - Dr A Stokes (02.11.21), para 58
200 Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), para 29 and ts 14.02.22 (Gianina), pp 43 & 45
201 ts 14.02.22 (Gianina), pp43-44
202 Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), paras 31-33 and ts 14.02.22 (Gianina), p44
203 Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), para 10 and ts 15.02.22 (Ellis), p108
204 Exhibit 1, Vol. 1, Tab 8.3, Shift Report, Ms J Ellis (6.30 am, 15 Aug 18)
205 Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 57-63

132. Nurse Scully says she also told Ms Ellis that Mr Edwards "*needed to be monitored as we did not have a diagnosis at the time*" and recalled checking that there "*was staff at the home who were able to monitor Mr Edwards*". Nurse Scully recalled telling Ms Ellis to "*be sure to send him back to the ED if his condition deteriorated or they were concerned*". Nurse Scully said that during a phone handover, she always asked the person she is speaking with if they have any questions and checks to ensure the person understands the discharge plan.[206]

133. I note that Ms Ellis made no attempt to contact the On-Call to arrange for a care worker to attend FSH to assist Mr Edwards, even though at 1.55 am on 15 August 2018, FSH had advised that Mr Edwards was "*quite agitated*" after the attempt to obtain the First x-ray. Similarly, no attempt was made send a care worker to FSH before Mr Edwards was discharged in order to speak with clinical staff and/or accompany Mr Edwards home.[207]

134. Nurse Scully said during the time he was in the ED, Mr Edwards seemed to improve and "*was settled*" by the time he left. However, before he left the ED, Mr Edwards' vital signs were not recorded, as they should have been. Despite saying Mr Edwards was settled, Nurse Scully noted:

> It is possible that we took a set of observations together with SJA before transferring him onto SJA's trolley. **He had been agitated and we may have been trying to move him with minimal interference.**[208] [Emphasis added]

135. The FSH discharge summary for Mr Edwards was signed by Dr Gianina at about 2.54 am on 15 August 2018 and relevantly states:

> Discussed with disability home: as patient has settled, stable and no imaging can be performed. If disability home is happy to observe him at home, he can go back. There is a carer there who is able to monitor patient and refer patient back if there [are] ongoing concerns or [becomes] unstable. *Discharge plan:* 1) Please monitor patient overnight and to refer back if symptoms re-developed or if ongoing concerns.[209]

[206] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 64-67
[207] ts 15.02.22 (Ellis), pp114-115
[208] Exhibit 1, Vol. 1, Tab 35, Statement - Nurse L Scully (02.02.22), paras 70-73
[209] Exhibit 1, Vol. 1, Tab 31.4, FSH Discharge summary (3.44 am, 15.08.18), p2

136. It is deeply regrettable that Mr Edwards' discharge plan provided no guidance about the symptoms which should be monitored and what signs would (or should) indicate "*ongoing concerns*". In my view, additional information about these matters should have been provided in the discharge plan, especially given that Mr Edwards was non-verbal and was being returned to a care home. That additional information should have included detail about the symptoms Dr Gianina says she would have referred to in cases of abnormally fast breathing and some guidance about the "normal" range for each of those symptoms.

137. In my view, a direction in a discharge plan to "*monitor symptoms*" with no indication of the symptoms to be monitored is unhelpful and should be avoided. Similarly, a direction to "*bring the patient back to hospital if there are any concerns*" without additional guidance as to the parameters which should indicate concern is simply unhelpful.

138. I have recommended that SMHS amend its discharge plan policy to provide more detailed instructions in relation to care home residents.

Mr Edwards' return to Butler House

139. Mr Edwards arrived back at Butler House by ambulance at about 4.05 am on 15 August 2018. Despite the fact that the SJA patient care record states that all of Mr Edwards' observations were "*unremarkable*", his respiration rate was recorded as 36 breaths per minute at 3.51 am, and 30 breaths per minute at 3.58 am.[210] Both readings are in fact well above normal.[211]

140. As Mr Edwards was being wheeled inside, Ms Ellis says one of the paramedics said: "*there was nothing wrong with Mr Edwards*" and "*the whole exercise of taking Mr Edwards to hospital had wasted everyone's time*". After giving Ms Ellis the FSH discharge summary, the paramedics left. Ms Ellis says Mr Edwards "*was very sleepy*" and after settling him in bed at about 4.15 am, she read the discharge summary.[212,213]

---

[210] Exhibit 1, Vol. 1, Tab 20.2, SJA Patient Care Record (15.08.18), p2
[211] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p5
[212] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 11-14 and ts 15.02.22 (Ellis), pp109-110
[213] Exhibit 1, Vol. 1, Tab 8.3, Shift Report, Ms J Ellis (6.30 am, 15 Aug 18)

141. When Ms Ellis checked Mr Edwards about 10 minutes later, he was sitting up in bed and his breathing was "*laboured at times*" before returning to normal. Ms Ellis also noted that every time Mr Edwards moved he seemed short of breath. Although Mr Edwards had just been discharged from FSH and was clearly not well, Ms Ellis did not consider "*that anything urgent needed to be done*". Instead, she tried to make Mr Edwards comfortable by moving him to his chair although he did not fall asleep and she moved him back to bed.[214,215]

142. Ms Ellis says that because Mr Edwards' breathing was laboured, she re-read the FSH discharge summary to make sure she hadn't "*missed anything*". She said that although Mr Edwards' breathing did not seem normal, the FSH discharge summary "*only said*": *to monitor Mr Edwards and return him to hospital if symptoms redeveloped or there were ongoing concerns*.[216] Despite the fact that Mr Edwards did not look well and his breathing was laboured, in her shift report Ms Ellis merely noted: "*To seek further medical attention once day staff arrive*".[217]

143. As I have noted, it is clearly regrettable that the FSH discharge summary did not provide detail about the symptoms to be monitored and some guidance about when to return Mr Edwards to FSH. However, given that Ms Ellis thought Mr Edwards' breathing was not normal, it is most unfortunate she did not immediately return Mr Edwards to FSH, especially when, as a result of her experience as a psychiatric nurse, she ought to have been familiar with signs of clinical deterioration.

144. It seems obvious that Mr Edwards should have been returned to the ED shortly after his arrival back at Butler House, if not immediately. Mr Edwards was clearly not well and he had been discharged from FSH without a definitive diagnosis. Nevertheless, on the basis of the evidence before me (and given the imponderables that must apply in a case like this) I am not able to say that had Mr Edwards been returned to the ED shortly after his return to Butler House, his clinical journey would necessarily have been any different.

---

[214] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 11-14 and ts 15.02.22 (Ellis), pp109-111
[215] Exhibit 1, Vol. 1, Tab 8.3, Shift Report, Ms J Ellis (6.30 am, 15 Aug 18)
[216] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), para 15 and ts 15.02.22 (Ellis), p111
[217] Exhibit 1, Vol. 1, Tab 8.3, Shift Report, Ms J Ellis (6.30 am, 15 Aug 18)

EVENTS AT BUTLER HOUSE - 15 AUGUST 2018

Morning EWS

145. Mr Barvardia arrived at Butler House at about 6.15 am on 15 August 2018, and Ms Ellis told him about Mr Edwards' return from hospital earlier that morning and showed him the FSH discharge summary. Ms Ellis also mentioned the paramedic's comment about it being a "*waste of time*" to take Mr Edwards to FSH.[218,219]

146. In an email dated 27 August 2021, SJA stated:

> St John WA is unable to verify the alleged comment made by an employee who transported…Mr Edwards from the hospital to the disability care home where he resided, as the individual no longer works for St John Ambulance WA. We can confirm that such a comment, if made, in no way reflects St John WA's values, policies or training given to staff and would be considered a highly inappropriate comment for a St John WA employee to make.[220]

147. On the basis of Ms Ellis' evidence, I find that the remarks she attributes to the paramedic were made. Clearly, those remarks were highly inappropriate and unprofessional. However, as this matter is peripheral to Mr Edwards' death and the paramedic who made the remarks is no longer employed by SJA I do not intend to take the matter any further. However, I note at the inquest, Ms Ellis denied the paramedic's remarks had influenced her assessment of Mr Edwards in any way.[221]

148. When Ms Ellis and Mr Barvardia went to check on Mr Edwards, Ms Ellis told Mr Barvardia that Mr Edwards "*had not looked good*" since his return from FSH and was "*not sleeping comfortably*". She also told Mr Barvardia that "*the hospital could not find anything wrong*" with Mr Edwards. After Ms Ellis left Butler House, Mr Barvardia helped Mr Edwards to shower and dress and gave him his medications. Mr Barvardia noticed that at times Mr Edwards' breathing "*was very fast before returning to normal*".[222,223]

---

[218] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 16-18 and ts 15.02.22 (Ellis), p111
[219] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), paras 4, 6 & 7-8 and ts 15.02.22 (Barvardia), p124
[220] Exhibit 1, Vol. 1, Tab 28, Email - SJA to Coroner's Court (27.08.21)
[221] ts 15.02.22 (Ellis), pp111-112
[222] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 16-18 and ts 15.02.22 (Ellis), p111
[223] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 9 and ts 15.02.22 (Barvardia), p124

149. Mr Barvardia says he took Mr Edwards' blood pressure, pulse, and temperature at 6.40 am and a score of "3" was recorded in the EWS Observation chart by Mr Nylund, the other care worker on duty at Butler House that morning. An EWS score of "3" was also recorded at 7.15 am, and I note that this is the last notation in the EWS Observation chart until 12.00 pm.[224,225,226]

150. At 7.29 am, Mr Barvardia sent an email to Ms Gladwell noting that although Mr Edwards had initially been "*OK*" after returning home from hospital, "*in the morning* [he] *was not looking OK*". Mr Barvardia said Mr Edwards' respiratory rate was high and that EWS observations would be performed every two hours. Mr Barvardia noted there had been some improvement after Mr Edwards was given his medication and a drink, but that if there were any concerns, Mr Edwards would be taken back to hospital. Mr Barvardia also said that in any event, an appointment would be sought with Mr Edwards' GP (Dr Richard John).[227,228]

151. Notwithstanding the lack of documented entries in the EWS Observation chart between 7.00 am and 12.00 pm, Mr Barvardia says he made regular attempts to monitor Mr Edwards' vital signs during the morning, but that Mr Edwards declined to cooperate. In my view, unsuccessful attempts to take a resident's observations should be noted in the EWS Observation chart under the section entitled *EWS Recording Chart - Continuation Sheet*. Observations which can be taken without the resident's cooperation (e.g.: respiration rate) should obviously be recorded.[229,230]

152. Although an EWS score of "3" had prompted Mr Irwin to arrange for Mr Edwards to be taken to FSH by ambulance on the night of 14 August 2018, Mr Barvardia followed the EWS Response chart which takes no account of a resident's recent hospital admissions. I will have more to say about this issue later in this finding.

---

224 Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 11 and ts 15.02.22 (Barvardia), pp125-126
225 Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), paras 27-32 and ts 15.02.22 (Nylund), p141
226 Exhibit 1, Vol. 1, Tab 9.2 Entries in EWS Observation Chart (6.40 am & 7.15 am, 15.08.18)
227 Exhibit 2, Email - Mr R Barvardia to Ms A-M Gladwell (07.29 am, 15 Aug 18)
228 ts 15.02.22 (Gladwell), pp95-97 and see also: ts 15.02.22 (Ellis), p112
229 Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 11 and ts 15.02.22 (Barvardia), pp128 & 132
230 Exhibit 1, Vol. 1, Tab 9.2 EWS Recording Chart - Continuation Sheet

153. In his shift report, Mr Nylund made the following observations about Mr Edwards:

> Seemed unwell, EWS monitoring, **vomited his breakfast**, did not eat his lunch, **high heart and r/r (respiration rate), was groaning nearly all of the shift, looked quite tired and fatigued**. Played on the swing sat in the family room and in bed. **Refused lunch and did not take fluids in the PM.**[231] [Emphasis added]

Contact with GP

154. At about 7.30 am on 15 August 2018, Ms Gladwell says she called Mr Barvardia to check on Mr Edwards. Mr Barvardia told Ms Gladwell that Mr Edwards was still unwell, and they resolved that he (Mr Barvardia) would call Dr John for advice. At the inquest, there was some confusion about how many times Mr Barvardia called Dr John and when. However, it appears that Mr Barvardia called Dr John once in the morning and once in the early afternoon.[232,233,234]

155. Mr Barvardia says that when he called Dr John for the first time (in the morning) there was no answer, and he left a message "*detailing Mr Edwards' current symptoms and his trip to hospital the previous night*". According to Mr Barvardia, Dr John returned his call shortly afterwards and advised him to continue monitoring Mr Edwards and give him plenty of fluids and "*be prepared to take him back to hospital*".[235,236,237]

156. At the inquest, Mr Barvardia said that the instruction to closely monitor Mr Edwards and return him to hospital if his symptoms became worse had occurred during the second conversation with Dr John at around lunchtime. Mr Barvardia also says he told Dr John that Mr Edwards had an appointment with a gastroenterologist at 2.00 pm, although it is not clear whether this occurred during the first or second call.[238]

---

[231] Exhibit 1, Vol. 1, Tab 8.4, Shift Report, Mr D Nylund (2.15 pm, 15 Aug 18) and ts 15.02.22 (Nylund), p139
[232] Exhibit 1, Vol. 1, Tab 29, Statement - Ms A-M Gladwell (28.01.22), para 6 and ts 15.02.22 (Gladwell), p94
[233] Exhibit 2, Email - Mr R Barvardia to Ms A-M Gladwell (07.29 am, 15 Aug 18)
[234] ts 15.02.22 (Barvardia), pp126-127; 130-131 & 136
[235] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 11 -14
[236] ts 15.02.22 (Barvardia), pp126-127; 130-131 & 136
[237] Exhibit 1, Vol. 1, Tab 9.2 EWS Response Chart
[238] ts 15.02.22 (Barvardia), pp 126-127 & 131

157. Mr Edwards' gastroenterology appointment was for an annual review of his Crohn's disease and it does seem clear that Dr John suggested that the gastroenterologist be told about Mr Edwards' ongoing symptoms. However, it is unclear whether Dr John was ever informed that Mr Edwards had been continually groaning and had vomited that morning, observations made earlier by Mr Nylund.[239,240,241]

158. In a letter to the Court, Dr John said, "*a staff member from Identitywa*" called his medical centre at about 12.30 pm on 15 August 2018 and advised that Mr Edwards was "*suffering from episodes of rapid breathing*" and although he had attended FSH the night before, clinical staff had "*found no serious cause*" for Mr Edwards' symptoms. After speaking with the staff member (who must have been Mr Barvardia) Dr John says it was decided that as Mr Edwards was due to see the gastroenterologist in about one hour, it would be best for him to be assessed there, as Dr John had no available appointments.[242]

159. Mr Barvardia did not make a record of either of the calls he says he made to Dr John and it is possible that Mr Barvardia's recollection of the contents of one or both of these calls is faulty. However, in her statement, Ms Gladwell says that after Mr Barvardia had spoken to Dr John, he called her back to update her on the situation. Ms Gladwell relevantly states:

> I subsequently received a call back from Raj Barvardia to report his discussion with Dr John. He told me that Dr John had advised him to keep closely monitoring Mr Edwards, give him plenty of fluids and be prepared to take him back to hospital should he deteriorate.
>
> Raj Barvardia also told me that Dr John said that the condition of Mr Edwards should be reported to the gastroenterologist with whom Mr Edwards had a scheduled appointment later on that day. My recollection is that this discussion with Raj Barvardia took place early during work hours on 15 August at about 9.00 am to 9.30 am.[243]

---

239 Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 14 and ts 15.02.22 (Barvardia), p126-127
240 Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), paras 24-25 and ts 15.02.22 (Nylund), pp139 & 143
241 Exhibit 1, Vol. 1, Tab 8.4, Shift Report, Mr D Nylund (2.15 pm, 15 Aug 18)
242 Exhibit 1, Vol. 1, Tab 26, Report - Dr R John (23.12.21)
243 Exhibit 1, Vol. 1, Tab 29, Statement - Ms A-M Gladwell (28.01.22), para 6 and ts 15.02.22 (Gladwell), p96

160. Ms Gladwell's evidence appears to establish that Dr John's instructions to monitor Mr Edwards and to return him to hospital if his condition deteriorated were conveyed when Dr John called Mr Barvardia back following Mr Barvardia's morning call. Although, it is unclear why Dr John's letter only refers to Mr Barvardia's phone call at about 12.30 pm, either way there seems to be no dispute about what Mr Barvardia was told.[244]

Observations during the morning

161. In his statement, Mr Barvardia says he "*continued to run hourly tests*" to check Mr Edwards' blood pressure, heart and breathing rates and, although this was in accordance with the advice given by Dr John, there is no record of any of these hourly checks in the EWS Observation chart.[245] At the inquest, Mr Barvardia clarified that he had attempted to use the blood pressure machine to conduct these checks but that Mr Edwards had refused to cooperate.[246]

162. Mr Barvardia recalled that at some stage during the morning, Mr Edwards had walked unaided to a swing in the patio area. Mr Barvardia considered this would have been difficult for Mr Edwards to manage on his own and might have been a sign that he (Mr Edwards) "*was starting to get better*". Mr Barvardia says that later that morning, he gave Mr Edwards lunch and readied him for his appointment with the gastroenterologist, although this is inconsistent with Mr Nylund's shift report which states that Mr Edwards refused lunch.[247,248]

Afternoon EWS

163. Despite his earlier uncooperativeness, Mr Edwards permitted Mr Nylund to take EWS observations at 12.00 pm and again at 1.00 pm. On both occasions, Mr Edwards' pulse rate and blood pressure were elevated and his breathing rate was significantly raised at above 30 breaths per minute.[249,250]

---

[244] Exhibit 1, Vol. 1, Tab 26, Report - Dr R John (23.12.21)
[245] Exhibit 1, Vol. 1, Tab 9.2 EWS Observation Chart (15.08.18)
[246] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 15 and ts 15.02.22 (Barvardia), pp128 & 132
[247] Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), paras 16-17 & ts 15.02.22 (Barvardia), pp128 & 135
[248] Exhibit 1, Vol. 1, Tab 8.1, Shift Report, Mr R Barvardia (2.15 pm, 14 Aug 18)
[249] Exhibit 1, Vol. 1, Tab 9.2 Entries in EWS Observation Chart (12.00 pm & 1.00 pm, 15.08.18)
[250] Exhibit 1, Vol. 1, Tab 16, Statement - Mr D Nylund (25.05.21), paras 27-32 and ts 15.02.22 (Nylund), pp141-142

164. A score of "5" was recorded for both the 12.00 pm and 1.00 pm EWS observations, but surprisingly the "*pain score*" section of the EWS Observation chart was blank for both readings. This is despite the fact that Mr Edwards had been observed groaning since his return from FSH that morning.[251,252,253,254]

165. If Mr Edwards' EWS score had been "6", he would have been immediately returned to FSH by ambulance. As it was, the EWS scores were being considered in isolation from each other. Further, no account was taken of factors such as Mr Edwards' recent discharge from FSH or that he simply didn't look well. Thus, although Mr Edwards' breathing rate had been significantly elevated at various times since his return from FSH (and was over 30 breaths per minute as early as 6.45 am) no immediate action was taken to send him back the ED.[255,256]

166. Had the EWS Response Chart factored in Mr Edwards' recent discharge from FSH, particularly given there was no definitive diagnosis, then the EWS observations taken after Mr Edwards' return to Butler House would not have started from a score of "0". Further, had a pain score been recorded in the EWS observations taken at 6.45 am (on the basis of Mr Edwards' groaning) and had some account been taken of the fact that he had vomited, it seems certain that his EWS score would have reached the "magic" figure of "6" and he would have been returned to FSH by ambulance.

167. Had Mr Edwards been returned to FSH soon after 6.45 am, it is likely he would have been accompanied by a care worker. In those circumstances, it is possible that Mr Edwards might have cooperated with imaging attempts, although given the imponderables in this case (not the least of which is that it seems likely Mr Edwards' volvulus was intermittent),[257] there is no way of knowing whether anything would have been seen on those images and/or whether the outcome in this case would have been any different.

[251] Exhibit 1, Vol. 1, Tab 9.2 Entries in EWS Observation Chart (12.00 pm & 1.00 pm, 15.08.18)
[252] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p5
[253] Exhibit 1, Vol. 1, Tab 9.2 Entries in EWS Observation Chart (12.00 pm & 1.00 pm, 15.08.18)
[254] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Ellis (27.06.21), paras 16-18
[255] Exhibit 1, Vol. 1, Tab 9.2 EWS Response Chart
[256] Exhibit 1, Vol. 1, Tab 9.2 Entries in EWS Observation Chart (6.45 am, 15.08.18)
[257] Exhibit 1, Vol. 1, Tab 22.1, Supp. Report - Assoc. Prof. D Mountain (16.02.22), p2 and ts 18.02.22 (Mountain), pp327-329

168. It is regrettable that neither Ms Ellis, Mr Barvardia nor Mr Nylund adopted a lower threshold of concern in terms of returning Mr Edwards to FSH and I agree with Professor Mountain's observation on this point. He said:

> I am perplexed by the willingness of the IdWA staff to continue to just monitor a patient who was clearly distressed, had significant physiological derangements and who clearly met the criteria to be returned to the ED for repeat review…Once the (EWS) score reached "5" a series of actions are indicated including calling the GP for an urgent appointment and ringing Health Direct. However, this was a patient where there had been ongoing concerns for over 12 hours, where ED care had been sought and where [his] condition clearly met the criteria for re-review in ED.[258]

169. Professor Mountain also said that the only basis for not escalating the situation and returning Mr Edwards to the ED would be if care workers had been given medical advice not to do so, and there was no documentation to this effect.[259]

170. However, in fairness to the care workers, I would observe that the most likely reason Mr Edwards was not immediately returned to the ED was more likely to have been that care workers were following the EWS system (as they had been directed to do) and, as I have explained, that system is flawed. Although the EWS system may be useful in guiding the responses of care workers, in practice it may have the effect of promoting an inflexible or non-intuitive approach, especially when EWS observations are considered in isolation.

171. At the inquest, Ms Ellis agreed that with the benefit of hindsight, there should have been a lower threshold of concern in returning Mr Edwards to FSH, especially when he continued to display the very symptoms that led to him being taken there in the first place. Mr Nylund also said he now works for a care organisation where the threshold for sending a resident to hospital is lower. I have recommended that the EWS Response Chart be amended to factor in a resident's recent hospital admission.[260,261]

---

[258] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, para 26, p10
[259] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, para 26, p10
[260] ts 15.02.22 (Ellis), pp115-117 and ts 15.02.22 (Barvardia), p132 and ts 15.02.22 (Nylund), pp144-147
[261] ts 15.02.22 (Austin), p167; ts 16.02.22 (Re), pp263-265 and ts 18.02.22 (Mountain), p315

EVENTS AT FSH - 15 AUGUST 2018

Appointment with gastroenterologist

172. Mr Austin arrived at Butler House at about 1.30 pm on 15 August 2018, to take Mr Edwards to his gastroenterology appointment. While Mr Edwards was being helped into the car, Mr Austin noticed brown liquid dripping from Mr Edwards' mouth.[262]

173. In his statement, Mr Barvardia said Mr Edwards had "*just eaten chocolate pudding*".[263] However, this evidence is inconsistent with Mr Nylund's shift report which states that Mr Edwards refused lunch. At the inquest, Mr Barvardia said that Mr Edwards had eaten chocolate pudding for breakfast. In any event, care workers apparently assumed the brown liquid coming from Mr Edwards' mouth was chocolate pudding residue.[264,265]

174. Gastroenterologist, Dr Jesica Makanyanga, saw Mr Edwards at 2.00 pm. Dr Makanyanga (who had not previously met Mr Edwards or been involved in his care) says he did not look well, was short of breath and seemed fatigued.[266] Dr Makanyanga said Mr Austin told her Mr Edwards had not been well the previous day and had been admitted to the ED overnight with shortness of breath. Mr Austin also said Mr Edwards "*seemed to improve a bit*" but was now "*not himself*". At the inquest, Mr Austin said that during the appointment, Mr Edwards had been unable to settle and seemed distressed.[267,268,]

175. Mr Austin also said he continued to wipe up the brown liquid "*dribbling*" from Mr Edwards' mouth, and this was seen by Dr Makanyanga (although I note that there is no mention of it in her statement).[269,270] In any event, on the basis of the assessment conducted in the ED a short time later, it seems clear that the brown liquid was faecal matter and was an indication that Mr Edwards was very seriously unwell.[271]

---

262 Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 15-17 and ts 16.02.22 (Austin), pp157-158
263 Exhibit 1, Vol. 1, Tab 13, Statement - Mr R Barvardia (30.06.21), para 19
264 Exhibit 1, Vol. 1, Tab 8.1, Shift Report, Mr R Barvardia (2.15 pm, 14 Aug 18) ts 15.02.22 (Barvardia), p128
265 Exhibit 1, Vol. 1, Tab 8.1, Shift Report, Mr R Barvardia (2.15 pm, 14 Aug 18)
266 Note: this contrasts with the EWS entry for 1.00 pm on 15.08.18, which assessed Mr Edwards as "*alert*"
267 Exhibit 1, Vol. 1, Tab 36, Statement - Dr J Makanyanga (04.02.22), paras 9-12
268 ts 16.02.22 (Austin), pp159-160
269 Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 18-20 and ts 16.02.22 (Austin), p160
270 Exhibit 1, Vol. 1, Tab 36, Statement - Dr J Makanyanga (04.02.22)
271 Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 15-17 and ts 16.02.22 (Dibona), p170

176. Dr Makanyanga tried to get Mr Edwards out of his wheelchair so she could examine him, but he was uncooperative. His pulse rate was 80 beats per minute and there were "*fine crackles*" in both of his lungs. Dr Makanyanga did not record Mr Edwards' breathing rate but said it would have been raised because "*he was audibly short of breath*". Although her examination was limited, Dr Makanyanga said Mr Edwards' abdomen "*felt normal*". There was no abdominal distension, nor did Mr Edwards appear to react when Dr Makanyanga touched his abdomen.[272]

177. Dr Makanyanga says Mr Austin told her that Mr Edwards' bowels had been the same as usual and that while he had not been experiencing diarrhoea or vomiting, Mr Edwards had some loss of appetite. It appears Mr Austin was unaware that Mr Edwards had vomited after breakfast, may have refused lunch and had been groaning for most of the day.[273,274]

178. Dr Makanyanga's impression was that although Mr Edwards' Crohn's disease was stable, he may have a lower respiratory tract infection (LRTI). However, given that Mr Edwards appeared "*quite unwell*", and Mr Austin was clearly concerned, Dr Makanyanga said she did not feel Mr Edwards was well enough to return to Butler House. As a consequence, she contacted the ED consultant and referred Mr Edwards to the ED for further assessment and possible admission.[275,276]

179. Despite her limited examination of Mr Edwards, Dr Makanyanga said she was "*not suspicious of an intestinal volvulus*" and her handwritten referral to clinicians in the ED states:

> Today he is increasingly short of breath, unable to eat and looking more unwell according to the support worker. He has no symptoms of Crohn's flare. On examination he has increased work of breathing and bilateral chest crackles. I think he has LRTI and don't think he is manageable in the group home with oral antibiotics. Thank you for seeing him.[277,278]

[272] Exhibit 1, Vol. 1, Tab 36, Statement - Dr J Makanyanga (04.02.22), paras 18-23
[273] Exhibit 1, Vol. 1, Tab 8.4, Shift Report, Mr D Nylund (2.15 pm, 15 Aug 18)
[274] Exhibit 1, Vol. 1, Tab 36, Statement - Dr J Makanyanga (04.02.22), paras 24
[275] Exhibit 1, Vol. 1, Tab 9.3, Identitywa Medical Treatment Form completed by Dr J Makanyanga (15.08.18)
[276] Exhibit 1, Vol. 1, Tab 36, Statement - Dr J Makanyanga (04.02.22), paras 25-34
[277] Exhibit 1, Vol. 1, Tab 36, Statement - Dr J Makanyanga (04.02.22), paras 22-23 & 36
[278] Exhibit 1, Vol. 1, Tab 36, Attachment JMAAT2 to Statement - Dr J Makanyanga (04.02.22)

Assessment in the ED

180. In accordance with Dr Makanyanga's referral, Mr Austin wheeled Mr Edwards straight to the ED, and arrived there at about 3.30 pm. Mr Austin handed over Mr Edwards' Transfer File and during an initial review by an RMO, he answered questions about Mr Edwards' presentation. The RMO clearly appreciated that Mr Edwards was seriously unwell and asked Dr Clare Dibona, then a senior registrar in the ED, to urgently review him.[279,280]

181. Dr Dibona said that as soon as she saw Mr Edwards, it was apparent he was very unwell. He was gasping for breath and she immediately appreciated that the brown liquid dripping from his mouth was faeculent material. A cannula was inserted and Mr Edwards was started on intravenous antibiotics (for a possible LRTI). A chest x-ray was also performed using a portable machine and although Mr Edwards had been uncooperative with imaging attempts the previous day, he offered no resistance presumably because he was so unwell.[281,282]

182. Mr Edwards' vital signs were recorded as: respiration rate: 32 breaths per minute, pulse: 130 beats per minute, systolic blood pressure: 140 mmHg, temperature: 38.2°C, and oxygen saturation on room air: 88%. At the inquest, Dr Dibona confirmed that all of these results were abnormal and indicated Mr Edwards was seriously unwell.[283]

183. Dr Dibona said she was "*trying to figure out*" why Mr Edwards might have a possible bowel obstruction when he had been referred for a respiratory illness, possibly as a result of aspiration. She reviewed the chest x-ray performed in the ED and noted it showed a right lower pneumonia and an obvious volvulus. A volvulus is a serious condition requiring immediate surgery to repair the twisted bowel and remove dead tissue.[284,285]

---

[279] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 22-23 and ts 16.02.22 (Austin), pp160-161
[280] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 14-16 and ts 16.02.22 (Dibona), p169-170
[281] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 17-20 & 27-28
[282] ts 16.02.22 (Dibona), pp170-172
[283] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), para 21 and ts 16.02.22 (Dibona), p173
[284] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 23 & 29-30 and ts 16.02.22 (Dibona), pp174-175
[285] ts 16.02.22 (Brown), pp228-229

184. In his statement, Mr Austin says he was asked to hold Mr Edwards' head whilst clinical staff attempted to insert a nasogastric tube. Mr Austin complied with this request, but was very concerned about doing so because this was "*not a way I was used to dealing with him* [Mr Edwards]".[286] I accept that at times, circumstances may require support persons to assist with these sorts of procedures. However, it is obviously preferable that they be performed by clinicians whenever possible.[287]

185. Having determined that Mr Edwards was critically unwell, Dr Dibona arranged for urgent reviews by the acute surgical unit, the intensive care unit and the Anaesthetic Registrar. These specialists arrived in the ED and determined that intubation was required for respiratory support and to enable a CT scan to be performed to confirm the volvulus. The duty anaesthetist intubated Mr Edwards and he was taken to the Radiology Department for the CT scan.[288]

186. While Mr Edwards was in the Radiology Department being prepared for a CT scan, Dr Dibona inserted an intravenous catheter so that contrast dye could be administered. As she was doing so, Mr Edwards' heart trace went into an abnormal beating rhythm (arrhythmia) that looked like ventricular tachycardia or ventricular fibrillation. These are both critical arrhythmias that require shocking.[289]

Medical Emergency Team call

187. Dr Dibona made a Medical Emergency Team call and the ED consultant arrived promptly and, at Dr Dibona's request, they took over Mr Edwards' resuscitation. A defibrillator was used to shock Mr Edwards' heart, but only pulseless electrical activity was detected. Despite the concerted efforts of clinical staff, including the administration of bolus doses of adrenaline, Mr Edwards could not be revived, and he was declared deceased at 7.05 pm.[290,291]

[286] Exhibit 1, Vol. 1, Tab 14, Statement - Mr L Austin (30.06.21), paras 21-25 and ts 16.02.22 (Austin), p162
[287] ts 16.02.22 (Dibona), pp176-178 and see also: ts 16.02.22 (Re), p259
[288] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 31-40 and ts 16.02.22 (Clayden), p198
[289] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 41-44
[290] Exhibit 1, Vol. 1, Tab 3, Death in hospital form (15.08.18)
[291] Exhibit 1, Vol. 1, Tab 37.1, Statement - Dr C Dibona (09.02.22), paras 41-44

CAUSE AND MANNER OF DEATH

Post mortem examination and results[292]

188. A forensic pathologist (Dr Jodi White) conducted an internal post mortem examination of Mr Edwards' body on 20 August 2018. Dr White found dilation and obstruction of the large intestine due to a volvulus at the sigmoid colon. There were evident changes within the bowel caused by a restriction of blood supply to the tissues (ischaemic changes).

189. Mr Edwards' lungs were heavy and there was some scarring in his kidneys, but minimal coronary artery disease was seen. Histological studies confirmed the above findings and toxicological analysis detected a range of medications in Mr Edwards' system, that were consistent with his medical conditions and hospital care.

Cause and manner of death[293]

190. At the conclusion of the post mortem examination, Dr White expressed the opinion that the cause of Mr Edwards' death was complications in association with intestinal volvulus.

191. I accept and adopt the conclusion of Dr White as my finding in relation to the cause of Mr Edwards' death. Further, on the basis of the available evidence, I find that Mr Edwards' death occurred by way of natural causes.

[292] Exhibit 1, Vol. 1, Tab 4, Post Mortem Report (20.08.18) and Supplementary Post Mortem Report (25.02.19)
[293] Exhibit 1, Vol. 1, Tab 4, Post Mortem Report (20.08.18) and Supplementary Post Mortem Report (25.02.19)

ANALYSIS OF MR EDWARDS' MANAGEMENT

SAC1 review

192. A confidential clinical investigation report was completed after Mr Edwards' death (SAC1 review). At the inquest, Dr Clayden explained the rationale for the SAC1 review in these terms:

> It's for root cause analysis to try and look at the whole clinical encounter and determine if they're root causes [or] system issues that…a change in system process might improve…it's to attempt to identify system issues that could be improved to reduce the risk of a similar incident occurring again.[294]

193. The SAC1 review identified several factors which contributed to Mr Edwards' death, namely:

> *Communication factors:*
> Limited information from the residential care facility with the lack of a patient carer/escort who was familiar with the patient, limited the ability of clinical staff to assess the patient's presenting clinical state with his usual behaviour and utilise mechanisms which may have calmed the patient to enable imaging. This may have altered the patient's course of care during his first presentation.
>
> *Patient factors:*
> The patient's co-morbidities including non-verbal communication status, combined with lack of presence of a carer/advocate who knew the patient well, increased the difficulty for clinical staff to assess the patient and obtain imaging during the first presentation. It is unable to be determined if this may have altered the course of the patient's care.[295]

194. The SAC1 review considered that Dr Stokes' decision not to sedate Mr Edwards for the purposes of imaging was appropriate, given the inherent risks of sedation balanced against the fact that during his six hours in the ED, Mr Edwards' oxygen saturation on room air was 100% and his respiration rate had improved.[296]

---

[294] ts 17.02.22 (Clayden), pp182-183
[295] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), pp12 & 13
[296] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p9

195. The SAC1 review also determined that Dr Stokes' decision to discharge Mr Edwards back to Butler House was "*appropriate*", essentially because of Mr Edwards' "*clinical improvement*" during the six hours he was under observation in the ED. This finding was made despite the fact that imaging had not been possible (and was not reattempted), Mr Edwards' respiration rate remained elevated and no repeat blood test had been performed to check on his lactate levels.[297]

196. The SAC1 review did not appear to have access to Dr Stokes' evidence about her assumption that there was a registered nurse at Butler House who would undertake regular observations after Mr Edwards was discharged. The SAC1 review was also apparently unaware of the significance of this assumed fact for Dr Stokes or that had she been aware this was not the case, it would have likely "*tipped the scales*" in favour of admitting Mr Edwards for extended observation.[298]

197. Had the SAC1 review had access to this information, it would clearly have informed the panel's assessment of the appropriateness of Dr Stokes' decision to discharge Mr Edwards, and may have led to a recommendation about the importance of ensuring that information crucial to discharge decisions is accurate, and has been clearly documented.

198. The SAC1 review made two recommendations. The first was that FSH develop a resource package to improve care provision in the ED to persons with disabilities. It was suggested that the focus of the package be on specific strategies and information to be gathered from the patient's care home to "*aid in the completion of assessments and delivery of treatment*".[299]

199. The second recommendation was that the Department of Communities be asked to consider establishing a "*process of handover documentation*" for group home facilities to use when transferring patients to the ED. The SAC1 review said that this handover documentation and patient information "*will assist with clinical assessment, treatment, communication with the patient and continuous care delivery*".[300]

---

[297] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p10
[298] ts 14.02.22 (Stokes), p78
[299] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p15
[300] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p16

200. In her statement, Dr Clayden said as far as she was aware, all of the SAC1 review's recommendations had been completed.[301] Whilst this is pleasing, in my view the SAC1 review is seriously flawed. First, after noting the difficulties of assessing non-verbal patients like Mr Edwards who are unaccompanied by a support person, the SAC1 review falsely states: "*there was no documentation accompanying the patient from the facility to support such assessments*".[302]

201. The evidence before me clearly establishes that Mr Edwards' Transfer file went with him to FSH. Had the SAC1 review panel identified this fact, there could have been a useful discussion about the adequacy of the information contained in Mr Edwards' Transfer file and what improvements, if any, were necessary with respect to that information.[303,304,305]

202. I accept that the members of the SAC1 review panel (the Panel) were not involved in providing clinical care to Mr Edwards. However, had the Panel spoken to Dr Gianina, it would have become obvious that documentation was provided by Butler House. Whilst the contents of Mr Edwards' Transfer file were not scanned into the FSH record (for obvious logistical reasons), the Panel could easily have obtained the document, and this would have informed the second of the Panel's recommendations.

203. Another flaw relates to the Panel's analysis of the request for the Second x-ray, and in my view is more serious. In relation to the Second x-ray, the SAC1 review states:

> After discussion, the panel concluded that if an x-ray had been able to have been taken on the patient's first presentation, it may have indicated further review or assessment and/or treatment for either chest consolidation, bowel distension or both. It was confirmed that a senior review was carried out by a Registrar. The panel was unable to exclude that the patient may have been admitted. In the absence of the post-mortem report for the patient, the investigation panel concluded that postulation regarding the course of care was not possible.[306]

---

[301] Exhibit 1, Vol. 1, Tab 33, Statement - Dr V Clayden (13.01.22), para 16
[302] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p9
[303] Exhibit 1, Vol. 1, Tab 15, Statement - Mr M Irwin (27.06.21), para 10
[304] Exhibit 1, Vol. 1, Tab 31.1, Statement - Dr N Gianina (05.01.22), para 15
[305] ts 16.02.22 (Clayden), pp193-197
[306] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p10

204. In my view, the Panel should have asked detailed questions about why the Second x-ray request was made and on whose instructions. These matters should have been regarded as crucial to any proper analysis of the circumstances which led to Mr Edwards' death. That is because the clinical question to be addressed by the Second x-ray was whether or not Mr Edwards had a perforated bowel or a bowel obstruction.[307]

205. The Panel's failure to properly address the relevance of abdominal issues during Mr Edwards' first presentation to the ED at a point close in time to his death, meant that crucial clinical insights evaporated. Further, although the SAC1 review was completed before the supplementary post mortem report was finalised, the Panel would have been aware that Dr Dibona's analysis of the x-ray taken during Mr Edwards' second presentation was that it clearly demonstrated a volvulus.

206. The SAC1 review states that all available imaging for Mr Edwards was reviewed, including images taken during his previous presentations at FSH for pseudo-obstruction of the bowel. The Panel noted Mr Edwards demonstrated "*consistent distention of the bowel*" (reported to be common with pseudo-obstruction) and had his bowels open during his first ED presentation. The Panel also noted that the Head of Gastroenterology had:

> [P]rovided the opinion that in the context of the patient's co-morbidities, there is a reduced likelihood that the abdominal issues were the primary cause of the deterioration.[308]

207. Nevertheless, had issues relating to the Second x-ray request been properly analysed at the time, the matters I referred to above, namely why the request was made and by whom, could have been properly explored. These issues had relevance to the appropriateness of the decision to discharge Mr Edwards, because that decision was taken in the absence of any of the requested imaging and suggested that the differential diagnoses included respiratory and abdominal issues, neither of which had been excluded by the time Mr Edwards was discharged.

[307] ts 17.02.22 (Clayden), pp183-186 & 198-199
[308] Exhibit 1, Vol. 1, Tab 21, Clinical Incident Investigation Report (03.10.18), p10

208. As I have noted, by the time Dr Stokes signed her first statement to the Court on 2 November 2021, her recollection of key clinical issues relating to Mr Edwards' presentation was understandably faulty. It is my view that issues related to the Second x-ray request should have been comprehensively explored during the SAC1 review, a point which Dr Clayden conceded at the inquest.[309]

Case review by Professor Mountain

209. Professor Mountain identified Mr Edwards as a patient who was difficult to assess and manage because he was non-verbal, was not known to clinical staff and was unaccompanied by a support person who could provide information about his usual presentation. Further, despite the fact that on other occasions when he presented to FSH, Mr Edwards had been accompanied by care workers and/or had cooperated with imaging attempts, that was not the case during his presentation to the ED on 14 August 2018.[310]

210. In relation to the imaging attempts, Professor Mountain considered that sedation by means of intravenous ketamine or midazolam would have been reasonable, but that if sedation was "*felt to be untenable*", then:

> [O]vernight admission to the ED Observation ward or to an inpatient unit were also reasonable options to allow ongoing observations and to allow carers who knew the patient to be available when he was reassessed. A high-risk decision to discharge a patient with ongoing physiological derangements with an inadequate diagnostic workup mandates a significant senior input, with clear documentation and properly set out reasoning, and should not rely on intern assessments or documentation.[311]

211. At the end of his report, Professor Mountain set out his conclusions in relation to Mr Edwards' care over the last 24 hours of his life. The first conclusion Professor Mountain makes is that the decision not to sedate and x-ray Mr Edwards during his first attendance at the ED was "*probably the incorrect decision*".[312]

[309] ts 17.02.22 (Clayden), pp183-186
[310] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p4
[311] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, pp5-6 and ts 18.03.22 (Mountain), pp307-308
[312] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p11

212. As I have already stated, on the basis of the evidence before me, I am prepared to accept that sedating Mr Edwards for the purposes of obtaining images was potentially risky and that the decision not to do so was arguably reasonable on the basis of the information available at the relevant time.[313]

213. In her statement, Dr Clayden referred to a meeting on 19 July 2021, to discuss the contents of Professor Mountain's report and in relation to the threshold for admission in cases like Mr Edwards, she relevantly states:

> It was agreed that this case and similar cases should be used to provide education to the registrar teaching group highlighting the diagnostic challenges of patients who are difficult to assess and that this should prompt earlier senior involvement and/or lower the threshold for investigations or observation.[314]

214. Professor Mountain also concluded the lack of an early diagnosis allowed the "*disease to progress to an unsalvageable degree*". In my view it is difficult to say with certainty that Mr Edwards' clinical journey would necessarily have been different if imaging had been possible during his first presentation to the ED, especially if, as appears to be the case, his volvulus was intermittent.[315] Professor Mountain also referred to Dr Stokes' failure to document her reasoning in discharging Mr Edwards and the failure of care workers to return Mr Edwards to the ED at an earlier stage. I have already addressed both issues in this finding.[316]

Case review by Professor Brown

215. In Professor Brown's view, the standard of care and treatment provided to Mr Edwards at FSH "*was of a high standard and fulfilled the duty of care for Mr Edwards presenting with tachypnoea alone*".[317] However, the request form for the Second x-ray included a request for an abdominal x-ray and the clinical question to be addressed was whether Mr Edwards had a perforated bowel or a twisted bowel. In other words, the imaging that Dr Stokes had requested went beyond respiratory issues.[318]

[313] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, para 27(a), p11
[314] Exhibit 1, Vol. 1, Tab 33, Statement - Dr V Clayden (13.01.22), para 15
[315] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, para 18, p8 & paras 27(b), p11
[316] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, paras 27(c) & 27(d), p11
[317] Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), pp11-12
[318] Exhibit 1, Vol. 1, Tab 31.3, FSH Imaging Request (11.09 pm, 14 August 2018)

216. Professor Brown also expressed the view that Dr Stokes' decision to discharge Mr Edwards in the absence of imaging, and when his respiration rate was "*still marginally raised*" at 26 breaths per minute, was "*entirely correct and appropriate*".[319] However, as I noted, at the inquest Professor Brown agreed that a respiration rate of over 24 breaths per minute in a hospitalised patient was "*a marker of critical illness*".[320,321]

217. It also appears that at the time he wrote his report, Professor Brown was unaware that Dr Stokes' evidence at the inquest would be that she assumed there was a registered nurse at Butler House who could observe Mr Edwards once he was discharged and that had she known this was not the case, it would have "*tipped the balance*" in favour of admitting Mr Edwards overnight.[322]

218. Nevertheless, on the basis of the available evidence, I agree with Professor Brown's opinion that even if imaging had been possible on the night of 14 August 2018, there is no guarantee that it would have shown a volvulus. The severity of Mr Edwards' symptoms seems to have fluctuated and it may be that his volvulus was intermittent. I also agree with Professor Brown's view that it is not possible to definitively state that Mr Edwards' death was preventable.[323]

Resuscitation issues

219. Whilst the assessment, diagnosis, and decision to intubate Mr Edwards during his second presentation to ED was viewed positively by all of the experts who gave evidence at the inquest, there was a difference of view about the adequacy of the fluid support given to Mr Edwards during his resuscitation, and potentially the choice of drugs used to sedate him. Professor Mountain expressed concern about the lack of fluid resuscitation Mr Edwards received and the fact that he was given bolus doses of the sedative, propofol.[324,325]

---

[319] Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), pp11-13
[320] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, p5
[321] ts 17.02.22 (Brown), p223
[322] ts 14.02.22 (Stokes), p78 and ts 17.02.22 (Brown), p247
[323] Exhibit 1, Vol. 1, Tab 27.1, Statement - Prof. A Brown (26.11.21), pp13-15
[324] Exhibit 1, Vol. 1, Tab 22.1, Report - Assoc. Prof. D Mountain, paras 27(e) & 27(f), p11
[325] ts 18.02.22 (Mountain), pp309-311 & 317-320

220. Dr Chris Cokis is the Head of Cardiothoracic Anaesthesia at FSH and although he agreed that the doses of propofol and fentanyl given to Mr Edwards were "*at the upper limit of the range for anaesthetising an unwell patient*", he expressed the opinion that the doses were "*not unreasonable*".[326]

221. Dr Cokis also noted there had been "*some fluid administration*" after the induction of anaesthesia but he disagreed that fluid management should have been the mainstay of Mr Edwards' treatment. Dr Cokis said:

> Mr Edwards was already demonstrating signs from his illness of 'capillary leakage' into his lungs, with low oxygen levels. Early on in the course of this illness fluid resuscitation can be useful but there is a point in septic shock when fluid administration may not be helpful and may even worsen the situation. Ultimately, unless the volvulus was actively managed, it is unlikely that fluid resuscitation itself would have changed the outcome.[327]

222. As to Mr Edwards' cardiac arrest, Dr Cokis noted that because this event occurred about 40 minutes after the induction of anaesthesia, it was unlikely that the sedating medication administered to Mr Edwards had contributed to the arrest. Dr Cokis said in his experience, ventricular fibrillation was unusual in patients who did not have pre-existing cardiac disease. Dr Cokis noted that Mr Edwards had abnormal electrocardiograms in 2016 and on 15 August 2018, which raised the possibility of a pre-existing cardiac condition. Dr Cokis also noted that a severe electrolyte imbalance related to Mr Edwards' volvulus and sepsis may have been contributory.[328,329]

223. Given the conflicting evidence before me and the clinical imponderables in this case, I have been unable to conclude, to the relevant standard, that a different approach with respect to either sedation or fluid resuscitation during Mr Edwards' second presentation to the ED would necessarily have altered his clinical journey.

---

[326] Exhibit 1, Vol. 1, Tab 32, Statement - Dr C Cokis (25.01.22), para 6
[327] Exhibit 1, Vol. 1, Tab 32, Statement - Dr C Cokis (25.01.22), paras 12-13
[328] Exhibit 1, Vol. 1, Tab 32, Statement - Dr C Cokis (25.01.22), paras 14-17 and ts 16.02.22 (Cokis), pp211-215
[329] See also: Exhibit 1, Vol. 1, Tab 27.2, Statement - Prof. A Brown (02.02.22), p14

RECOMMENDATIONS

224. In light of the observations I have made in this finding, I make the following recommendations:

Recommendation No.1

The Identitywa policy relating to residents being admitted to hospital (the Policy) is that the resident will always be accompanied by a care worker except where the resident has capacity and declines support, or where the resident's guardian/next-of-kin attends instead.

As a matter of urgency, Identitywa should amend the document entitled: *Going to Hospital Guidance*, as well as the "*Hospitalisation/Medical treatment required*" section of the document entitled *On Call File: Responsibilities* to ensure that both documents accurately reflect the Policy.

Recommendation No.2

Identitywa should issue an urgent bulletin to its staff reminding them of the requirements of Identitywa's current policy with respect to residents being admitted to hospital, so as to ensure there is no confusion as to the respective responsibilities of care workers, team leaders and the On-Call.

Recommendation No.3

Identitywa should engage a suitably qualified health professional to review its Early Warning Score system (EWS) and associated documentation. The purpose of the review would be to amend the EWS Response Chart to take account of the situation where a resident has recently been discharged from hospital, is still exhibiting symptoms and/or appears "unwell". The review should consider the appropriateness of observations made after the resident's discharge from hospital at an EWS score other than "0".

Recommendation No.4

Identitywa should consider amending its *Transfer to Hospital file* documentation to include (on the front of that file) a single A4 summary sheet setting out critical information about the resident (e.g.: NOK details, medical conditions, current medications, allergies, etc) along with a brief statement of the reason for the referral to hospital. Although much of the information in the "summary sheet" could be pre-populated, the reason for referral to hospital would probably need to be handwritten in a legible manner. In the event of an emergency hospital admission, the summary sheet would provide clinical staff with a single point of reference detailing key information about the resident and the reason why the resident has been sent to hospital.

Recommendation No.5

South Metropolitan Health Service should consider amending its policy relating to discharge summaries to provide greater clarity and more detailed instructions in relation to the symptoms which should be monitored after a patient's discharge and the circumstances in which the patient should be returned to hospital.

To be clear, directions in a discharge plan to "*monitor symptoms*" with no indication of the symptoms to be monitored should be avoided. Similarly, a direction to "*bring the patient back to hospital if there are any concerns*", in the absence of guidance as the parameters which should indicate concern, ought to be avoided.

Clinical staff should be reminded that the requirement to provide additional clarity in a discharge plan is particularly important when the patient is a resident in supported accommodation and/or is non-verbal. Clinical staff should also take account of the fact that staff in supported care facilities will usually not have clinical skills.

Recommendation No.6

South Metropolitan Health Service should consider advising emergency department clinicians to adopt a lower threshold for admission with respect to patients who are non-verbal and for whom no definitive diagnosis has been arrived at, following the patient's initial assessment and examination.

Comments relating to recommendations

225. After reviewing the available evidence, I determined it would be appropriate to make six recommendations. It is my practice to forward a draft of any recommendations I intend to make, to all parties appearing at an inquest and invite comments. In accordance with that practice, Mr Will Stops (Counsel Assisting the coroner) forwarded a draft of the above recommendations to the counsel for each of SMHS, Identitywa, and Dr Stokes on 11 March 2022.[330]

226. In a letter dated 15 March 2022, Mr Ian Curlewis (counsel for Identitywa) advised that Identitywa had no objection or comment to make about the wording of the draft recommendations.[331]

227. By email dated 16 March 2022, Mr James Bennett (counsel for SMHS) advised that SMHS is exploring a "*medical handover form*" for patients being returned to residential care facilities which could assist in addressing Recommendation No. 5. Mr Bennett also made a useful suggestion about the scope of Recommendation No. 6.[332]

228. No feedback was received from Dr Stokes and after carefully considering the submissions received, I made what I considered were appropriate amendments.

[330] Email - Mr W Stops to Mr J Bennett, Mr I Curlewis & Mr E Pannetta (11.03.22)
[331] Letter - Mr I Curlewis to Counsel Assisting (15.03.22)
[332] Email - Mr J Bennett to Counsel Assisting (16.03.22)

CONCLUSION

229. Mr Edwards was a 31-year-old man with severe physical and intellectual disabilities who was a resident at Butler House, a care home operated by Identitywa. Mr Edwards became unwell on 14 August 2018, and he was sent to FSH by ambulance, unaccompanied by a support person. This was an appalling position for Mr Edwards to have been placed in, especially because he was non-verbal.

230. Since Mr Edwards' death, Identitywa has amended its policy on hospital admissions so that now, except in two specific circumstances, a care worker always accompanies a resident being admitted to hospital. Whilst this change is welcome, I remain concerned that Identitywa's documentation does not accurately reflect this major policy shift. I have made several recommendations aimed at ensuring Identitywa's documentation relating to its hospital admission policy is crystal clear and that the EWS system it uses is fit for purpose.

231. After being investigated at FSH, Mr Edwards was returned to Butler House with no definitive diagnosis in the early hours of 15 August 2018. Care workers said that Mr Edwards did not look well, but by the time he was returned to the ED later that afternoon he was gravely ill, and he died despite the efforts of clinical staff.

232. I have recommended that the SMHS provide additional information in discharge summaries for patients like Mr Edwards, in order to give care workers greater guidance as to the symptoms they should monitor and the circumstances in which a resident should be returned to hospital. I have also recommended that SMHS consider adopting a lower threshold for admission for patients like Mr Edwards.

233. It is my hope that the changes I have recommended will, if implemented, enhance the management of patients with complex needs, like Mr Edwards.

MAG Jenkin
Coroner
28 March 2022