CITATION: *Inquest into the death of Kristelle Ruby Mulladad aka Oliver* [2010] NTMC 64

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FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Unexpected Death, Management of Referrals, Delay in Treatment.

REPRESENTATION:

Counsel:

Assisting:	Elisabeth Armitage
Department of Health and Families Northern Territory:	Tom Anderson
Children, Youth and Women's Health Service South Australia:	Therese Karpinski

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE
NORTHERNTERRITORY OF
AUSTRALIA

No. A0057/2008

In the matter of an Inquest into the death of
KRISTELLE RUBY MULLADAD aka OLIVER

ON 16 September 2008
AT House 272 Eastside Four, Santa Teresa Community, Northern Territory

FINDINGS

(Delivered)

Mr Greg Cavanagh SM:

Introduction

1. Kristelle Ruby Mulladad ("the Deceased") was 16 years old when she died, on 16 September 2008, while sleeping next to her mother at her home in Santa Teresa Community. At the time of her death she was suffering from severe obstructive sleep apnoea ("OSA"). Her condition was first recognised in March 2004. During the next four years of her life, she was seen by numerous general medical practitioners and specialists. Her health deteriorated but her condition remained treatable. The appropriate initial treatment was surgery, an adenotonsillectomy. She was scheduled for surgery on 23 September 2008. She died one week before her surgery was due to take place. Her death was unexpected by those involved in her medical care and was appropriately reported to Sergeant Richard Mark Lyons within hours of it occurring.

2. This inquest examined the medical care provided to the Deceased following detection of symptoms of OSA in March 2004. I find that there were delays in the management of her referrals to specialists, in the scheduling of her

surgery, and in her management whilst on the waiting list for surgery at Alice Springs Hospital. I find that there was mismanagement of her referrals to the Women's and Children's Hospital Adelaide. The Deceased would not have died in the manner she did if surgery had been performed before her death. Her death was preventable.

3. The inquest was held on 9-11 July 2010at Alice Springs. Counsel assisting me was Ms Elisabeth Armitage. The Department of Health and Families was represented by Mr Tom Anderson. Dr Edward Marzac, Dr Adam Rudkin and Ms Christine Finlay were represented by Ms Therese Karpinski.

4. The Deceased's parents, Mr John Mulladad and Ms Patricia Oliver attended the inquest (together with other extended family and friends). They were not represented by counsel; however, they had discussions with Ms Armitage, who explained the inquest's purpose and procedures to them. They were assisted by an interpreter at the inquest. They did not wish to give oral evidence but their statements were received into evidence.

5. Pursuant to section 34 of the *Coroners Act*("the Act"), I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

6. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

7. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-Generalon a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

8. In order to make the findings required by s34(1) I had tendered in evidence before me a brief of evidence, prepared by Constable Sylvia Hoppe, which contained: 19 statements from witnesses; the medical records of the Deceased from Alice Springs Hospital (ASH), Danila Dilba Health Service (DDHS), Royal Darwin Hospital (RDH), Ltyentye Apurte Community Health Centre Santa Teresa (STHC), Women's and Children's Hospital Adelaide (WCHA),and health records from St. John's College Darwin. In addition I had tendered the autopsy report of Dr Terence Sinton, a report prepared at my request by Dr Rob Roseby, copies of hospital policies andproceduresrelevant to referrals and prioritisation of surgery, and a copy of the Northern Territory Hospital Network Waiting Time and Elective Patient Management Policy. I heard oral evidence from Ms Penelope Fairweather (Registered Nurse), Dr Conrad Alex Hope, Dr Peter Lynch, Dr Elizabeth Rose, Dr Edward Marzac, Ms Christine Finlay (Clinical Services Coordinator, WCHA), Dr Adam Rudkin, Dr Terence Sinton and Dr Rob Roseby.

Formal Findings

9. Pursuant to section 34 of the Act, I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the Deceased person was Kristelle Ruby Mulladad, born 4 January 1992. The Deceased resided at House 272 Eastside Four, Santa Teresa Community, in the Northern Territory of Australia.

(ii) The time and place of death were between midnight and 6am on 16 September 2008 at House 272 Eastside Four, Santa Teresa Community, Northern Territory.

(iii) The cause of death was obstructed breathing and heart arrhythmia secondary to severe obstructive sleep apnoea and morbid obesity.

(iv) Particulars required to register the death:

1. The Deceased was Kristelle Ruby Mulladad aka Kristell Ruby Oliver.

2. The Deceased was of Aboriginal decent.

3. The death was reported to the Coroner.

4. A post-mortem examination was carried out by Dr Terrence Sinton.

5. The Deceased's mother is Patricia Oliver and her father is John Mulladad.

6. The Deceased was a school student aged 16 years.

Relevant circumstances surrounding the death

10. The Deceased was an Aboriginal girl born at Alice Springs Hospital on 4 January 1992. She lived with her parents, brothers and sisters in Santa Teresa Community. After her birth she failed to gain weight at an appropriate rate and this necessitated several admissions to hospital. Her parents were greatly relieved when her health finally appeared to settle and she started to gain weight.

11. The Deceased attended primary school at Santa Teresa. On 28 January 2005 she commenced boarding at St. John's College in Darwin. She received promising reports from her teachers, but they also reported concerns about her health. In particular, they were increasingly concerned about her weight, her snoring, and her inability to stay awake during the day. In spite of her poor health, the Deceased remained a student at St. John's until shortly before her death. The school sent her home in June 2008 for reasons including her poor health, and suggested that she not return to school until after her surgery and recovery.

12. The Deceased maintained her weight within a normal range until about the age of 12 years of age. From around that time, she became overweight and thereafter her rate of weight gain remained higher than appropriate for a girl her age. By the time she was 16, she weighed over 100 kilograms and was in the morbidly obese range.

13. From the age of 13, concomitant with her weight gain, the Deceased displayed symptoms of obstructive sleep apnoea ("OSA").Over the next 3 years, as her obesity worsened, so did her OSA. By late 2007 she was "falling asleep all the time" and was "difficult to wake".

14. In his report dated 15 October 2009, Dr Roseby, a specialist in adolescent and respiratory medicine, described OSA in the following terms:

> "OSA is common in children and adults. It is a condition consisting of frequent pauses in breathing while asleep due to obstruction or blockage of the airways. In young children, especially those under 6, the obstruction is almost always a result of enlargement of the tonsils and adenoids. These are glands that tend to swell up during a viral infection especially, but also on exposure to irritants such as cigarette smoke. In later childhood the tonsils tend to shrink a little, and the airways grow larger. However obesity is characterised by infiltration of fat into all the body's tissues, resulting in decrease of the size of the airways. During sleep, with relaxation of the muscles, OSA can occur. OSA in children generally causes interruption to sleep, or disturbance of sleep quality, with more frequent arousals from deeper to lighter sleep states. This leaves one feeling tired during the day, with decreased concentration, poorer life functioning and ultimately a poorer quality of life."

15. Dr Roseby informed me that the treatment recommended for children with OSA is an adenotonsillectomy. Sleep studies are not required to diagnose OSA or before surgery is recommended.

16. Dr Alex Hope, the Deceased's general practitioner at Santa Teresa Health Clinic, first identified her symptoms of OSA in March 2004. On 23 March 2004, Dr Hope sent his first letter of referral to the Ear, Nose and Throat("ENT") specialist at Alice Springs Hospital requesting assessment and advice as to the Deceased's future management. Dr Hope did not receive a response to his first letter and faxed it a second time on 5 May 2004.

17. On 5 August 2004, the Deceased was seen by the ENT specialist, Professor Rupa Verdantam, who observed symptoms consistent with OSA. At that stage Professor Vedantam did not recommend surgery, but instead recommended further investigations including blood tests, x-ray and a sleep study. On review of the file, Dr Rob Roseby informed me that, in his opinion, there was sufficient information available at that time to recommend surgery. Had surgery been recommended, it would have been prioritised as a category 2, with surgery deemed desirable within 90 days (see [23] below). In requesting further investigations, Professor Verdantum

adopted a very conservative approach which, as it turned out, was the first of a number of factors that lead to delay in the Deceased's treatment.

18. Other factors also contributed to the delay. These included difficulty in obtaining parental consent to surgery; the mobility of the Deceased and her unavailability for surgery; communication difficulties between Alice Springs Hospital and Santa Therese Health Clinic; and the mismanagement of referrals by the Women's and Children's Hospital Adelaide.

19. The Deceased's father, who was present during the first consultation with Professor Verdantam, did not consent to further investigations or surgery. Consent was required from the parents as the Deceased was a child. Obtaining written parental consent continued to be an obstacle during the Deceased's interaction with Alice Springs Hospital. The Deceased and her family spoke English as a second language. About a year after the appointment with Professor Verdantam, the Deceased's parents approached Dr Hope because the Deceased's condition had deteriorated. At that time, it became clear to Dr Hope that the Deceased's father did not understand the procedure to be performed and that his exaggerated fears had made him unwilling to give consent. Dr Hope explained to Mr Mulladad that the doctors "don't need to cut her nose off" and consent to further investigations was verbally obtained. Dr Hope then sent his third and fourth letters to Professor Verdantam informing her of the parents' consent to investigations and requesting that they be conducted.

20. In September 2005 Professor Verdantam resigned and was immediately replaced. However, her replacement was not communicated to Dr Hope. Given the delays in obtaining an appointment in Alice Springs, in November 2005 and again in February 2006, Dr Hope attempted, via his fifth and sixth letters to nursing staff at St. John's College, to have the Deceased reviewed by the ENT clinic at Royal Darwin Hospital. Dr Hope noted that the Deceased's parents were prepared to travel to Darwin should an operation be

required. At that stage it was clear to Dr Hope that the Deceased's parents were consenting to surgery.

21. In April 2006, the Deceased attended Alice Springs Hospital for the blood tests and x-ray recommended by Professor Verdantam almost 2 years earlier, and was seen by Dr Mary Kurien. Dr Kurien detected significant tonsil and adenoid enlargement and recommended surgery. However, records note that the Deceased's parents again indicated they were not ready to consent to surgery.

22. I did not have an opportunity to hear from Professor Verdantam or Dr Kurien. However, having reviewed the material it is clear that there was a failure to adequately communicate between Alice Springs Hospital and the Deceased's parents. I have already referred to the exaggerated fears of Mr Mulladad identified by Dr Hope. Hospital records also provide evidence of miscommunication. On 3 August 2008 Dr Hope phoned the Hospital on behalf of the Deceased's parents, inquiring why surgery had not taken place. The parents had kept the Deceased home from school in the expectation surgery would occur. It seems clear that the Deceased's parents wanted and were consenting to surgery.

23. Given that the Deceased was first identified with symptoms in August 2004; that Dr Hope was pressing for appointments; that in April 2006 the obstructions were described as "significant"; and that there was clearly an identified misunderstanding by the parents – which misunderstanding was communicated to the hospital - more could and should have been done by Alice Springs Hospital to ensure the Deceased received the treatment she required. However, there was no evidence presented to me that an interpreter or cross-cultural liaison person was ever offered to the family by Alice Springs Hospital to assist with communication. If the cross-cultural communication problems had been identified and addressed, it is possible

that parental consent might have been obtained in a form satisfactory to the Hospital at a much earlier point in time.

24. On 3 August 2006, as a result of Dr Hope's phone call, the Deceased was placed on a waiting list at Alice Springs Hospital as a category 2 admission. The Northern Territory Hospital Network Waiting Time and Elective Patient Management Policy (the "Waiting Time Policy"), effective from 9 August 2003, stipulated that "categorisation of elective patients by clinical priority is required to ensure they receive care in a timely and clinically appropriate manner". A category 2 priority indicated that "admission within 90 days is desirable".

25. On 16 August 2006 a verbal offer of surgery was made by the ENT Clinic Alice Springs Hospital to the Santa Teresa Health Clinic. The hospital was informed that the Deceased was in school in Darwin. This communication was apparently interpreted by the hospital as an indication that the Deceased was either "not ready for care" or alternatively that her parents were not consenting to surgery. However, there is no evidence that the offer was ever passed onto the Deceased's parents, Dr Hope or St. John's College, nor is there evidence of any efforts being made to make arrangements for the Deceased to travel.

26. In spite of the 90 day admission target under the Waiting Time Policy, no further offer of surgery was made by the ENT clinic to either the Deceased's parents or the Santa Teresa Health Clinic until 20 July 2007.

27. Dr Hope saw the Deceased on 27 June 2007. She was exhibiting extreme tiredness which was symptomatic of her OSA. The Deceased told Dr Hope that she wanted the operation. On 2 July 2007, Dr Hope discussed surgery with the Deceased's parents who agreed to proceed but also requested more information.

28. On 20 July 2007 an offer of surgery was made after the Alice Springs Hospital received a Waiting List Audit Form from the Santa Teresa Clinic which indicated that the patient was ready for care. However, when the offer of surgery was made apparently the hospital was again told the Deceased was in school in Darwin, and again apparently interpreted this as the patient not being ready for care. Given that the offer of surgery was made during school holidays, the Deceased's most recent expressed wish for surgery, her parent's recent verbal consent, the School's concerns for her health and Dr Hope's efforts to secure a date for surgery, it seems most likely that had the offer been clearly communicated to the Deceased's parents or Dr Hope, the Deceased's attendance for surgery could and would have been arranged.

29. I note in passing that neither the Santa Teresa Health Clinic nor Alice Springs Hospital have any record of who might have received these calls. I am informed that there is a large turnover of clinic staff in all remote communities, Santa Teresa being no exception, save for Dr Hope who has been serving the community for the past 11 years. It is possible that the calls were taken by someone who had little or no knowledge of the Deceased.

30. After 20 July 2007, no further offer of surgery was made.

31. In October 2007 and again in February 2008 St. John's College referred the Deceased to Danila Dilba because she was "falling asleep", "unable to stay awake" and was "difficult to wake". In Dr Roseby's opinion this was a "crescendo" of symptoms which should have "set off alarm bells".

32. During January 2008, the Deceased returned to Santa Teresa and was seen by Dr Hope who noted her very enlarged tonsils and audible breathing. Following further concerns expressed by the Deceased's father, Dr Hope again wrote to the school (his seventh letter) requesting they arrange an ENT assessment in Darwin as there was "no ENT surgeon" in Alice Springs and her "obstructive breathing is really appalling now". Dr Hope further confirmed that the Deceased's parents would travel to Darwin for surgery. I

note that the ENT surgeon Dr Kurien had resigned in Alice Springs in December 2007 and been replaced in February 2008, but Dr Hope had not been told that a replacement ENT surgeon had commenced.

33. On 3 April 2008 the Deceased returned to Santa Teresa for holidays. By coincidence she happened to be in Santa Teresa when an ENT outreach service was provided to the community as part of the National Emergency Intervention in the Northern Territory ("the Federal Intervention"). On 15 April 2008, the Deceased was assessed by a very experienced ENT specialist, Dr Libby Rose. Dr Rose diagnosed the Deceased as being obese and suffering from severe OSA. She discussed her findings with the local ENT surgeon, Dr Achama Balraj. Both considered that the Deceased was now a high-risk adolescent case with increased risk of complications following surgery. That risk necessitated referral to a tertiary hospital. Dr Rose personally phoned the Registrar of the Women's and Children's Hospital Adelaide. She discussed the Deceased's case and a referral was written (16 April 2008) and faxed (18 April 2008) as requested by Dr Adam Rudkin who was then acting as the Registrar of ENT at the Women's and Children's Hospital. Although acting in the position of Registrar, Dr Rudkin was in fact a first year resident doctor and he described himself to me as the most junior member of the ENT team.

34. On receipt of the phone call from Dr Rose, Dr Rudkin started to fill out a Surgery Booking Form, which is part of the surgical waiting list documentation maintained by the ENT clinic at the Women's and Children's Hospital. The form documents a variety of information including the patient's Waiting List Admission Category. This categorisation determines the priority that will be given to the patient's surgery. An ENT specialist determines the priority to be given according to the information contained in the patient's referral letter. Although Dr Rudkin commenced this documentation, he did not complete it. It is obvious, even to a non-expert, that a number of different hands have added to the Surgery Booking Form. It

is almost impossible to identify when entries were made or by whom. Dr Rudkin has given evidence in these proceedings that he did not complete the Booking Form, that he provided a partially completed form to an administrative officer in the ENT clinic, and that he never personally received or saw Dr Rose's subsequent faxed referral. I have no reason to doubt his evidence.

35. I am satisfied that Dr Rose's referral dated 16 April 2008 and faxed to the ENT clinic fax number on18 April 2008 was received by the ENT clinic at the Women's and Children's Hospital. Sufficient documentation was completed by the hospital at or about the time the referral was faxed for me to be so satisfied, and the matter was not contested by Ms Christine Finlay who gave evidence about records systems and maintenance in the hospital's Outpatient's Department. It is not disputed that the initial referral was lost before it was properly considered and entered onto the hospital's records system. As a result the Deceased's surgery was not given the priority that it ought to have been given.

36. Dr Edward Marzac, visiting medical specialist and Chairman of ENT Department at the Women's and Children's Hospital Adelaide, was responsible for determining the criteria for categorisation of ENT referrals. He was asked in these proceedings to apply the Department's categorisation criteria to Dr Rose's referral dated 16 April 2008. He gave evidence that the referral should have been prioritised as a category 1, in which case surgery should have occurred within 30 days. It is sadly obvious that, had the referral been correctly handled and prioritised, surgery may well have been provided within (or close to) the 30 days recommended by the guidelines, and this child's death could have been avoided.

37. However, for reasons unexplained by the evidence, and probably due to human error, the Deceased's ENT Surgery Booking Form was prioritised as a "Staged admission", which meant her admission was deferred until it was

"medically appropriate". This error was transposed from the hand-written Booking Form to the hospital's computerised records system known as Homer.

38. As a result of these errors, no surgical date was allocated and no notice was provided to either Alice Springs Hospital or the Santa Teresa Health Clinic that the referral had been received or that it had been given a low priority.

39. There was confusion as to who had responsibility for following up the referral. The Federal Intervention had no plans in place. Dr Rose returned to Victoria very shortly after the referral was faxed. The referral was faxed from Alice Springs Hospital following consultation with Dr Balraj, but no-one at the hospital considered they had any responsibility to follow it up, nor would Dr Lynch, Director of Medical and Clinical Services and Acting General Manager, concede in evidence that it amounted to a hospital- to-hospital referral. Dr Hope did not consider he had responsibility to chase a referral from a visiting specialist that was sent from Alice Springs Hospital, but he continued to advocate for the Deceased in any event, and he and staff at Santa Teresa Health Clinic continued to make phone calls to find out what was happening. They were repeatedly told they had to wait for a surgery date to be allocated.

40. On 23 July 2008, a very frustrated RN Penny Fairweather of the Santa Teresa Health Clinic, demanded to speak to the ENT Registrar at the Women's and Children's Hospital Adelaide. It was only then discovered that the original referral was lost. Dr Rose was contacted and a second referral marked urgent was faxed to the Women's and Children's Hospital Adelaide on 30 July 2008.

41. On 5 August 2008, RN Fairweather rang the ENT clinic at the Women's and Children's Hospital to find out the proposed date for surgery. She was told that the surgery was "still several months away". It took a further phone call from Dr Rose to the ENT clinic Adelaide in order for a date for surgery to

be allocated. It appears that after that phone call the Deceased was categorised as a category 2 admission, a priority which indicated that admission between 31 – 90 days was acceptable. She was given a date for surgery of 23 September 2008, which fell within this time frame.

42. In his evidence Dr Marzac said that based on of the content of the second referral, the Deceased should have been categorised as a category 1 patient. Accordingly her surgery should have been allocated within 30 days. It is very sad, that even at this latest of dates, if surgery had occurred within a category 1 time-frame, this child's death would still have been avoided. Tragically, the Deceased died on 16 September 2008, 7 days before her listed date for surgery. She had waited for 4 years suffering from a "crescendo" of symptoms, for surgery that could have prevented her death and could arguably have been offered as early as August 2004.

Multifactorial causes of delay

43. As early as 5 August 2004, the history of the Deceased and the findings of multiple obstructive abnormalities were sufficient to justify recommending surgical intervention. The further investigations recommended by Dr Verdantam were not strictly necessary and may have contributed to the delay in her treatment. It is recognised that there are long waiting lists for sleep studies and indeed no sleep study was ever carried out. None of the doctors who gave evidence in these proceedings considered that a sleep study was necessary prior to surgery.

44. The Deceased's parents are Arrente speakers. The Deceased's father speaks English as a second language. Although Mr Mulladad possesses workable conversational English, it is clear that he did not fully understand the medical concepts, procedures and risks associated with the Deceased's recommended treatments. Indeed, it is clear that he suffered from exaggerated concerns about the risks associated with the surgery because at one stage he believed his daughter's nose might be cut off. At no stage

during the specialist consultations or during management on the Alice Springs Hospital waiting list was an interpreter, cross-cultural liaison officer or case manager provided to assist with the process of communication. Such a person may well have identified and addressed communication issues, cultural concerns, or misunderstandings that in this case delayed the provision of parental consent to surgery, and resulted in confusion as to their consent.

45. The Deceased's mobility between Santa Teresa and Darwin made her appointments and referrals more difficult to manage. She missed some appointments in Darwin but this does not seem to have been critical to her care. Her mobility was, however, critically important when two dates for surgery offered by Alice Springs Hospital were treated as declined because the hospital was told she was in Darwin. Given the number of referrals to Alice Springs Hospital initiated by Dr Hope and her deteriorating condition, 2 offers of surgery over a period of 18 months does not appear to be an adequate response to the Deceased's circumstances.

46. I am concerned that there is no evidence that either offer of surgery was conveyed to the Deceased's parents, or to Dr Hope; nor were any practical solutions offered concerning arrangements for the Deceased to travel for surgery. Certainly by the time of the second offer, on 20 July 2007, both the Deceased and her parents had clearly communicated their consent for surgery to Dr Hope. The school wanted her to undergo surgery, and would no doubt have arranged her travel if requested. I am not satisfied that in the circumstances of this case, it was appropriate for Alice Springs Hospital to treat the response, "she is in Darwin" as meaning the offer of surgery was declined, without further inquiry or effort to facilitate the Deceased's attendance. Although clearly proactive in seeking surgery, Dr Hope was not directly advised of either offer of surgery. I have no doubt that he would have done more to facilitate arrangements for the Deceased to attend for surgery had he been given the opportunity. As it was, other than two phone

calls, nothing was done by Alice Springs Hospital to assist or encourage the Deceased to attend for her recommended surgery. More could and should have been done.

47. In his report dated 15 October 2009, Dr Roseby made the following observations:

"There was no defined case manager. This is not to underplay the advocacy role played by several individuals as evidenced by their clinical correspondence, notably Dr Alex Hope from Santa Teresa. However the clinical case manager and co-ordination role played, by, for example, the Paediatric Liaison nurse unit at Alice Springs Hospital is useful to consider. This girl was not within their remit, however I have no doubt that if hypothetically they were involved in this case, surgery would have occurred much closer to the time the family first agreed to it being August 2006. Such a unit would be staffed by nurses who understand the health system and therefore have ability to advocate for patients by helping them to co-ordinate the myriad things required sometimes to obtain appropriate health care. They can attend to practicalities such as…ensuring a consent form is signed, [and] to ringing surgeons to arrange or rearrange operation dates if necessary…The consequences for those poor at navigating the [health system] can be disastrous. Clinical case managers can mitigate this disadvantage somewhat."

48. I am satisfied that, had the Deceased been provided with a case manager the cross-cultural communication and consent difficulties discussed in these findings would have been identified and addressed at a much earlier stage. I am also satisfied that difficulties with obtaining appointments, obtaining dates for surgery and the Deceased's availability for surgery would have been better managed. It is likely that timely surgery would have occurred and this death would have been avoided, if Alice Springs Hospital had appointed a case manager.

49. I have been provided with submissions from the Department of Health and Families ("DHF"). They refer to a recommendation I made on 4 June 2009 in the *Inquest into the death of Kunmanara Forbes*[2009] NTMC 024. That matter involved the death of a teenage girl in Alice Springs. I recommended that the Director General for DHF introduce an Adolescent Health Service within NT Department of Health. I am informed by DHF that in response to that recommendation it is planned to establish a Youth Hub at Anzac Hill in Alice Springs for vulnerable youth. I am told work on the centre will commence in December 2010 and it is intended to co-locate educational, recreational and support services for Alice Springs youth at the centre. I am told that it will provide a shared-services approach to case co-ordination and management. DHF are currently considering how to best integrate youth health services with other Youth Hub activities. I am informed that it is DHF's intention to incorporate remote health and hospital services into the Youth Hub in an effort to provide a more streamlined process for assessment and management of high-risk clients.

50. When it is operational, this initiative should assist vulnerable youth in Alice Springs. However, I have not been provided with any specific information about how a person such as the Deceased, from a remote community, might be referred to the Youth Hub, or how the Youth Hub might in practice have assisted her in negotiating a path to timely surgery.

51. As identified by Dr Roseby, there are nurses already operating in Alice Springs Hospital providing the sort of advocacy and co-ordination of care that is likely to have assisted the Deceased. In the future it may be that this role could be devolved to a centre such as the Youth Hub. In the meantime, however, I RECOMMEND extending the services of the existing Paediatric Liaison nurses to Aboriginal adolescents from remote communities when it is identified that their access to care is being complicated or compromised by cross-cultural issues, remoteness, or other identified complexities.

52. I am further informed that DHF have a plan in place to produce educational DVDs to assist in explaining elective processes and procedures to Aboriginal clients. These will no doubt go some way to assisting in cross-cultural communication about the hospital system and processes. The DVDs will not, however, replace direct communication between staff and patients about their condition and proposed treatment. Dr Lynch gave evidence that there have been a number of innovations in recent years to address the challenges of communication with Aboriginal patients. Specially devised DVDs, interpreters and Aboriginal Liaison Officers area available at the hospital. It is perhaps simply unfortunate that these resources were not better utilised in the circumstances of this case. Staff should be encouraged to use these resources, and discouraged from making assumptions that effective communication has been achieved. No formal recommendation is required, however, as I am satisfied Alice Springs Hospital is well aware of the existence of cross-cultural difficulties and is taking progressive steps to redress those difficulties as best it can.

53. Dr Hope found communication with Alice Springs Hospital difficult, time-consuming and frustrating. The Santa Teresa Health Clinic did not receive timely responses to referrals. Referrals had to be followed up by numerous phone calls and further letters before appointments were offered. Dr Hope learned of specialist departures in an *ad-hoc* way but was not informed of replacements, and so was left expending time exploring alternative avenues of treatment.

54. In its submission to me the DHF referred me to the current Northern Territory Hospital Network Waiting Time and Elective Treatment Services Policy and Guidelines, approved October 2009. In many material ways this current policy is the same as the Waiting Time Policy current at the time of the Deceased's treatment. The notification requirements to patients and medical practitioners are unchanged (as per paragraphs 4.2.and 4.3). There was no evidence provided to me that Alice Springs Hospital complied with

the policy in respect of the requirement to send notification letters to Dr Hope. Furthermore, although surgery was not provided within 90 days, there was no evidence before me of any clinical reviews being conducted in accordance with paragraph 5.3, or any evidence of postponement or removal from waiting list letters being sent (see Appendices 4 – 5(c)), as apparently required by the policy.

55. The policy has no effect if it is not adhered to. According to Dr Hope, he is still not receiving letters in compliance with this policy. It is therefore necessary for me to RECOMMEND that adherence to the policy be reinforced at Alice Springs Hospital.

56. In his evidence, Dr Lynch told me that communication with general practitioners had improved, particularly with the increased use of electronic forms of communication. Dr Hope, however, said that he had not experienced any improvements. Indeed, Dr Hope said that he had attempted to open a dialogue with Dr Lynch about communication problems but felt that he had met with little success.

57. Dr Hope suggested that a way forward might be to establish a GP Hospital Liaison position, the equivalent to a similar position apparently working well at Royal Darwin Hospital. In their submissions, DHF did not concede the need for such a position. DHF noted that a Primary Care Liaison Committee had recently been established. I am told that its membership includes representatives from the Alice Springs Hospital, Aboriginal Primary Health Care Services, the Central Australian Aboriginal Congress, general practitioners and St Johns Ambulance.

The stated role of that committee is:

"To identify, review and improve continuity of care and communication between the hospital and primary care sectors in Central Australia."

Stated responsibilities include:

"Enhance communication and consistency regarding the clinical management of patients in central Australia."

"Provide a forum to identify systems issues that prevent communication between sectors and compromise patient care."

58. On reflection, it appears that such a committee is aptly placed to identify and address the sorts of communication difficulties identified by Dr Hope. It is to be hoped that the specific matters raised by Dr Hope with Dr Lynch have been referred to the committee for consideration. Given the steps taken by DHF and Alice Springs Hospital to provide a vehicle to redress communication difficulties, no further recommendation in that regard is required.

59. It is evident that referrals to the Women's and Children's Hospital Adelaide were mishandled and incorrectly prioritised.

60. The evidence before me suggests that the mishandling and loss of the first referral was due to human error rather than systems failure. Ms Finlay gave evidence that the procedures for managing referrals have been reinforced with hospital staff. I received into evidence a new Booking Form template (Form No.320532). I am told that initial referrals can no longer be entered as "Staged" which will ensure dates for surgery are allocated. Further, the Booking Form must now be completed by a medical officer and not an administrative officer. This should ensure correct prioritisation is given to referrals.

61. Having said that, it is apparent from Dr Marzac's evidence that in his opinion, inappropriate categorisations were given to both of the Deceased's referrals. In the circumstances, given the tragic consequences that flowed there from, it is appropriate that I make a recommendation that the criteria for categorisation of referrals to the ENT Clinic at the Women's and Children's Hospital Adelaide be reinforced and strictly adhered to.

Recommendations

62. That Alice Springs Hospital adhere to the Northern Territory Hospital Network Waiting Time and Elective Treatment Services Policy and Guidelines particularly in respect of GP notification requirements.

63. That Alice Springs Hospital extends the services of the Paediatric Liaison nurses to complex adolescent cases.

64. That the Women's and Children's Hospital Adelaide ensure the criteria for categorisation of referrals to the ENT Clinic are strictly applied.

Dated this 29th day of October 2010.

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GREG CAVANAGH
TERRITORY CORONER