IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 3835

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Robena May Lloyd
Delivered on:	2 September 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	8, 9, 10, 11 & 12 February 2021
Counsel Assisting:	Mr Rishi Nathwani Instructed by Coroners Court Principal In-House Solicitor, Mr Lindsay Spence
Mrs Stephanie Mortimer	Self-represented
Counsel for Eastern Health:	Mr Paul Lamb Instructed by Minter Ellison

Counsel for Dr Manish Agaskar	Mr Paul Halley Instructed by Avant Law Pty Ltd

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INTRODUCTION

1. This case investigated the death of 58-year-old Robena Lloyd who died at Angliss Hospital on 7 August 2009. Robena's intellectual ability had been estimated to be that of a three-year-old child.

2. In 2003, her elder sister, Stephanie Mortimer, became her full-time carer. They travelled together, Robena was a keen knitter, had a sense of humour and enjoyed a good quality of life. Although Mrs Mortimer described her speech and actions as childlike, she was also very knowing in an intuitive way.

3. As her legal guardian, Mrs Mortimer was Robena's tireless advocate. Mrs Mortimer described Robena's death as like '*losing a child*.'

4. The love and commitment she showed to Robena during her lifetime continued following Robena's death. During the inquest Mrs Mortimer stated: '*I just want to get to the bottom of why my sister died and how it happened so that it doesn't happen again*'.[1]

5. Following the 2013 findings of a coronial investigation, Mrs Mortimer applied twice for a re-opening of the investigation. This eventually took her to the Court of Appeal, where she was successful, and the matter was remitted back to the Coroners Court for a fresh investigation.

6. This finding is the result of that fresh investigation.

BACKGROUND

7. Robena was the second daughter born to her parents. She was diagnosed with an intellectual disability at the age of three years; the family suspected it was caused by her mother being X-rayed twice in a tuberculosis screening program whilst she was pregnant. As a child Robena resided at Kew Cottages, and later transferred to Janefield in Bundoora. In her mid-20s, she developed a psychiatric illness, schizophrenia, and went to the neuropsychiatric centre at Mont Park. In 1996 Robena lived briefly with Mrs Mortimer before moving to a community residential unit in Bundoora. In 2003 Robena returned to live with Mrs Mortimer, who has a nursing background and became her full-time carer.

8. Although relatively independent with her personal needs, Robena effectively required 24-hour care and Mrs Mortimer employed some carers to assist her.

[1] Transcript (**T**) 167.1-2.

9. In 2009 Robena's health problems escalated. Her mental health deteriorated sharply[2] and her weight dropped dramatically. This was compounded by bowel problems which involved severe constipation. Between 9 and 16 July 2009 Robena was admitted to the Angliss Hospital with abdominal pain and she was treated for a urinary tract infection. During 17 July 2009 to 29 July 2009 Robena was admitted to the Alfred Hospital where she had an elective ileostomy. On 31 July 2009 Robena and Mrs Mortimer attended the Boronia Medical Centre and saw general practitioner (**GP**), Dr Gavin Lim, for follow up after the stoma formation surgery.

10. It was against this 2009 backdrop of deteriorating physical and mental health that the coronial investigation considered Robena's medical care from 31 July 2009 until her death on 7 August 2009.

11. On 31 July 2009 Mrs Mortimer took Robena to the Angliss Hospital as she had not passed urine for two days. A catheter was inserted and drained approximately 700 mls of fluid and she was placed on antibiotics for a urinary tract infection. The question arose within the inquest scope as to whether Robena should have been admitted, whether it should have been demonstrated that she could pass urine prior to leaving hospital, and whether further tests should have been conducted on the urine or an additional sample taken.

12. During this time there was also contact between Mrs Mortimer and Maroondah Hospital Area Mental Health Service concerning Robena's mental health, including telephone calls and home visits. The records show details of home visits on 3, 4 and 6 August and phone calls on 2, 3, 4, 5, 6 and 7 August 2009.

13. On 5 August 2009 Mrs Mortimer was concerned that Robena had not passed urine since Monday 1 August 2009. She sent Robena back to Angliss Hospital with two carers and asked the carers to insist a further urine sample be taken and tested. In the Emergency Department a bladder scan identified 90 mls of urine, which reassured medical staff she was not in urinary retention. Robena was given fluids and a second bladder scan some hours later identified 520 mls of urine had been produced. After seven hours of observation, Robena was discharged home with her carers. Questions at inquest were whether Robena should have been discharged, whether she should have passed urine prior to discharge, what the carers were told

[2] Mrs Mortimer described Robena's psychiatric illness at the time as '*shocking*'. Coronial brief (**CB**) 196. Exhibit 28 comprises Robena's medical records, and Appendix 2 contains Robena's mental health records for her treatment during 2009, which include descriptions of her symptoms.

regarding care for Robena and the regime to be followed at home, and whether a further urine test should have been conducted.

14. On 6 August 2009, Mrs Mortimer was still concerned about Robena and in consultation with Michael, one of the carers, decided to call a locum doctor.

15. At approximately 11.00pm on the evening of 6 August 2009, a locum doctor attended Mrs Mortimer's house. He assessed Robena and advised Mrs Mortimer to keep up fluids. The doctor's assessment and advice were considered at inquest.

16. The next morning, on 7 August 2009, Robena collapsed when her carer, Celeste, arrived. Mrs Mortimer rang for an ambulance which took Robena to Angliss Hospital.

17. On arrival at the Angliss Hospital Robena had a GCS[3] of 3 and required aggressive resuscitation measures. Mrs Mortimer did not want Robena to be intubated and she and her vicar sat with Robena until she died. Robena's presentation at hospital on the morning of 7 August 2009 was considered at the inquest.

18. The inquest also considered the care and treatment available for people with intellectual disabilities within a mainstream emergency department.

THE PURPOSE OF A CORONIAL INVESTIGATION

19. The hospital reported Robena's death to the coroner as Mrs Mortimer raised concerns about her medical care and her death was unexpected. Her death was within the definition of a reportable death in section 4 of the *Coroners Act 2008* (Vic) (**the Act**).

20. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[4] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5]

21. The '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

[3] The Glasgow Coma Scale (GCS) is a clinical scale used to measure a person's level of consciousness after a brain injury.
[4] Section 89(4) *Coroners Act 2008* (Vic).
[5] Preamble and section 67 *Coroners Act 2008* (Vic).

22. For coronial purposes, the phrase '*circumstances in which death occurred*'[6] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

23. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] This is sometimes described as 'the facts concerning the death as public interest requires.' It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[8] or to determine disciplinary matters. In this case the medical care provided to Robena was the main focus of the inquiry. This was considered in the context of what was constituted reasonable and appropriate clinical practice in an emergency department setting.

24. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, through investigation findings and comments and recommendations by coroners.

25. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[10]

BACKGROUND OF LEGAL PROCEEDINGS

26. Robena's death was originally investigated by Deputy State Coroner (**DSC**) Iain West who made a Finding without Inquest into her death dated 24 June 2013. Following correspondence from Mrs Mortimer, the finding was amended on 26 June 2013 pursuant to section 76 of the Act.

27. On 7 December 2013, Mrs Mortimer made an application to set aside the finding. DSC West made a determination dated 3 June 2014 refusing the application to re-open on the basis there were no new facts and circumstances, and it was not appropriate to re-open the investigation.

28. Mrs Mortimer appealed the determination refusing the application to re-open to the Supreme Court. This Appeal was dismissed by Associate Justice Randall in a decision dated 21 April

[6] Section 67(1)(c) *Coroners Act 2008* (Vic).
[7] *Keown v Khan* (1999) 1 VR 69.
[8] Section 69(1) *Coroners Act 2008* (Vic).
[9] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152.
[10] (1938) 60 CLR 336.

2015.[11] A subsequent Appeal against the findings and orders of Associate Justice Randall was dismissed by Justice Rush on 28 January 2015.[12]

29. On 14 March 2016 Mrs Mortimer made a second application to set aside the finding. In her application, Mrs Mortimer included a report by Dr Patrick Dewan dated 5 February 2016. Her submission was as follows:

'*Mrs Mortimer claimed in her second application that the new information demonstrated that her sister died of an untreated urinary tract infection and that there had been a failure to isolate the organism causing the infection and thus a problem with the diagnosis and selection of an appropriate antibiotic. She claimed that until the organism was isolated accurately it could not be discerned which antibiotic would be effective. She identified the deficiencies of treatment as including the failure to conduct sensitivities of the urine sample on 27 July at the Alfred Hospital, the prescription on 31 July at the emergency department of the Hospital of the antibiotic Triprim (which was said to be not a broad spectrum antibiotic but an antibiotic with limited effect); and the refusal to take a urine sample at the emergency department of the Hospital on 5 August.*'[13]

30. Dr Dewan's report noted the following concerns: Robena's urinary tract pathology was not tracked back to results from 1999, a urine infection found on 9 July 2009 should have been given more weight, the possibility of more than one pathogen from the infection showing *'mixed growth'* was not adequately considered, renal function was normal from May to 9 July 2009, July 2009 blood tests from the Alfred should had formed part of the assessment, inadequate steps were taken in response to the catheter specimen from 31 July 2009, and the 5 August 2009 blood results suggested a marked decline in renal function from results that would have been available from 11 July 2009.

31. Dr Dewan was critical of the autopsy report and concluded Robena would not have died on 7 August 2009 if she had been investigated and treated for urosepsis:

'*In conclusion, the death would reasonably be attributed to urosepsis, electrolyte imbalance and renal failure, but the death would not have occurred had Ms Lloyd not been discharged*

[11] See [2015] VSC 150.
[12] See [2016] VSC 11.
[13] [2018] VSCA 188, at pp 13-14.

on 5/8/2009. If, instead, the patient had been managed for her electrolyte imbalance, investigated for urosepsis and treated with antibiotics she would not have died on 7/8/2009.'[14]

32. DSC West made a determination dated 24 June 2016 refusing the application to re-open, following a review of the materials and advice from the Court's Health and Medical Investigation Team (**HMIT**), on the basis there were no new facts and circumstances, and it was not appropriate to re-open the investigation.

33. Mrs Mortimer appealed the determination refusing the application to re-open to the Supreme Court. The Appeal was dismissed by Justice Macaulay on 29 May 2017.[15]

34. Mrs Mortimer then appealed to the Court of Appeal against Justice Macaulay's order.

35. The Appeal was allowed on 2 August 2018. In referring to Dr Dewan's report the Court stated:

'*It clearly raised the issue of the adequacy of the assessment of the urine tests taken on 31 July 2009, the issue of whether further samples ought to have been collected, the issue of whether further testing of sensitivities ought to have been undertaken to isolate the relevant pathogen, and ultimately the question of whether Ms Lloyd ought to have been discharged from the Hospital on 5 August 2009 including whether her treatment at the time was appropriate. Dr Dewan's report was not merely a competing medical opinion that simply recorded a disagreement on medical issues. Rather, as a matter of substance, it served to shift the weight of the evidence about the medical treatment of Ms Lloyd and the basis of which the primary and secondary findings*[16] *had been made*.'[17]

36. The Court of Appeal set aside all findings of the coroner and remitted the matter to the Coroners Court for the investigation to be re-opened by a different coroner:[18]

'*For the investigation to be undertaken by someone with fresh eyes, and for justice to be seen to be done, the re-opened investigation ought be constituted by a different coroner from the coroner who undertook the original investigation*.'[19]

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[14] Dr Dewan's report dated 5 February 2016, [2018] VSCA 188 at 17.
[15] See [2017] VCS 293.
[16] [2018] VSCA 188 at 8-10: The primary finding by DSC West sought to be set aside by Mrs Mortimer was to the effect that *'Overall the medical management was reasonable in a very difficult setting of chronic behavioural disturbance and chronic mental illnesses'* and the secondary finding was*, 'it cannot be concluded that checking Ms Lloyd's urine for infection would have prevented her death; that is, that the failure to check the urine for infection on 5 August 2009 was immaterial or irrelevant to the tragic outcome.'*
[17] [2018] VSCA 188 at 40.
[18] See [2018] VSCA 188.

37. In setting aside the refusal to re-open the Court of Appeal stated:

'... it is desirable, in the interests of justice, that the investigation be re-opened, in particular to resolve the factual dispute with respect to the circumstances of Ms Lloyd's discharge from the Hospital and the regime to be followed at her home, including the clarity of the communications involved. It will also be necessary to gauge whether the 'setting of chronic behavioural disturbance' affected Ms Lloyd's treatment, and, if so, to what extent it did so.'[20]

38. In late 2019, I took carriage of this case as investigating coroner.

NEW INVESTIGATION

39. In light of the Court of Appeal's comments about a fresh investigation, the factual disputes regarding medical care and communication, as well as the potential impact of Robena's *'behavioural disturbance'* on her receiving medical care, a new coronial brief was compiled.

40. Additional statements were obtained including a second statement from Mrs Mortimer dated 22 July 2019, a statement from Celeste Walker dated 7 November 2019, a second statement from Sally Gramaticu dated 20 November 2020, a second statement from Christine Goode dated 26 November 2020, a second statement from Kirralea Lancaster dated 17 November 2020, a second statement from Dr Colin Pearson dated 29 November 2020, an undated statement from carer Michael Brand, a statement by Acting Sergeant Ross Treverton dated 14 May 2020, a statement from Dr Martin Koolstra dated 11 December 2020, and a statement from Dr Andrew Chan dated 3 December 2020.

41. Expert medical reports were obtained by the court as part of the coronial investigation from Dr Jason Harney (an emergency physician at Sunshine Hospital since 2008 and experienced in Emergency Medicine since 2002) and Associate Professor Hilton Gock (consultant nephrologist at St Vincent's Hospital Melbourne, employed there since 1998, whose predominant role was acute inpatient and outpatient care with the Departments of Nephrology and General medicine in a metropolitan teaching hospital) regarding Robena's medical care. As the original forensic pathologist, Dr Baker, had passed away, an updated medical examiner's report was obtained from Forensic Pathologist Associate Professor David Ranson. Professor John Cade, (Emeritus Consultant in Intensive Care, Royal Melbourne Hospital and Professorial Fellow, University of Melbourne) provided a report on behalf of Eastern Health and Dr Patrick Dewan (paediatric surgeon, with the following qualifications, PhD MD MS

[19] [2018] VSCA 49.
[20] [2018] VSCA 48-49.

MMedSc FRCS FRACS, which included a PhD in paediatric urology, who worked at the Royal Children's Hospital until 2003, and currently is in private practice at Ringwood Private and Sunshine Private Day Surgery) provided a number of further reports on behalf of Mrs Mortimer. Associate Professor Richard King who prepared an expert report for the original investigation had since retired and was unavailable to give evidence, however his report is contained in the coronial brief.[21]

42. Further, an expert report was obtained from Professor Julian Troller regarding the medical services available for people with intellectual disabilities in the mainstream medical setting. In addition, the court sought similar information from the Department of Health and Human Services (now the Department of Heath) and the National Disability Insurance Scheme. The requests and responses are included in the coronial brief.[22]

43. The new coronial brief contained the above statements and reports, as well as those prepared during the original investigation. Mrs Mortimer had also raised concerns that Robena's death was linked to neuroleptic malignant syndrome (**NMS**) and the medications prescribed for her mental illness. As part of the fresh coronial investigation, the court obtained a medical report from Professor Richard Newton, Clinical Director at Peninsula Mental Health Service and Adjunct Professor, Monash University, dated 13 July 2020. The report stated there was no indication of this condition when Robena presented to the Emergency Department on 31 July or 5 August 2009, and it was very unlikely Robena had NMS at the time of her death. On the basis of the lack of causal connection to Robena's death and therefore relevance, although the expert report is included in the coronial brief [23] this issue did not form part of the scope of the matters to be explored at the inquest.

44. As part of the fresh investigation, I determined to hold an inquest. Forensic examination was required to determine factual discrepancies,[24] and to hear evidence regarding Robena's medical care and treatment as well as expert medical evidence about whether the care was reasonable and appropriate. I also called expert evidence regarding issues surrounding the care and treatment of people with intellectual disabilities in mainstream medical settings.

[21] CB 64.
[22] CB 252-260.
[23] CB 93-99.
[24] There were many factual discrepancies raised in the course of the evidence. I have referred to them under headings 'factual discrepancies.' Some are noted for the record, and where these discrepancies are relevant to the circumstances of Robena's death I have made findings, according to the weight of the evidence. As Mrs Mortimer was both witness and advocate, all the factual discrepancies were important to her, however not all were relevant to my statutory duty to make findings pursuant to section 67 of the Act.

45. Two directions hearings were held on 29 September and 21 December 2020. The first directions hearing, when Mrs Mortimer was represented by Counsel, detailed the progress of the fresh investigation. At the second directions hearing, Mrs Mortimer represented herself. A draft scope of the inquest and draft witness list was distributed in advance and I heard directly from Mrs Mortimer her views about the proposed scope of the inquest and witnesses list. Although the failure to conduct sensitivities on the urine sample on 27 July 2009 at the Alfred Hospital had been mentioned by Mrs Mortimer in her second application to set aside, the scope of inquest was confined to Robena's medical treatment from 31 July 2009 until her death on 7 August 2009.

46. The Inquest scope was as follows:

(a) 31 July 2009:

(i) Was the medical care reasonable and appropriate in the circumstances of Robena's presentation?

(ii) Was it reasonable not to admit Robena to hospital?

(b) 5 August 2009:

(i) Was the medical care reasonable and appropriate in the circumstances of Robena's presentation?

(ii) Was it reasonable not to admit Robena to hospital?

(iii) What were Robena's carers told regarding care for Robena and the regime to be followed at home?

(iv) What was the impact, if any, of Robena's intellectual disability upon her care and treatment?

(c) 6 August 2009:

(i) Was the medical care reasonable and appropriate in the circumstances of Robena's presentation?

(ii) What advice did Dr Agaskar provide Mrs Mortimer in respect of Robena's condition?

(d) 7 August 2009:

(i) What was Robena's presentation on the morning of 7 August 2009?

(e) Potential prevention opportunity:

(i) What are the risks and barriers for people with an intellectual disability accessing mainstream health services and receiving equitable care and treatment?

(ii) What are the current advances in this area, and what advice can be provided about ways to improve access to services and the quality of care experienced by people with an intellectual disability and their family/carers?

Inquest and evidence

47. The inquest was listed for five days commencing on 8 February 2021 and evidence was heard from 12 witnesses.

48. The examination of the facts was not assisted by the passage of time as it was more than 11 years since Robena's death. Witnesses who made statements for the original coronial investigation (and in some cases, second statements) read those statements and were examined and cross examined about that evidence and their recollection. The medical professionals involved with Robena's care had the benefit of medical records, completed contemporaneously. Mrs Mortimer was both witness and advocate. As a witness she gave evidence and had a clear and strong memory of events surrounding Robena's death. As an advocate she cross examined the witnesses at the inquest. As she put to one witness, '… *I'm not trying to blame anyone for anything. I just want to get to the bottom of why my sister died and how it happened so that it doesn't happen again.*'[25]

49. In the course of the evidence Mrs Mortimer referred the medical witnesses to Robena's medical history, which included having a torted bowel three times in 2000 and possibly having a cecal volvulus as a result of having had a left hemicolectomy, which she noted was mistakenly referenced in Robena's medical records as a right hemicolectomy. Mrs Mortimer was concerned this bowel problem may have had a causal connection to Robena's bladder issues. Whilst Mrs Mortimer asked witnesses questions about this medical condition and others, the topic did not form part of the inquest scope, which was confined to Robena's

[25] T 166-7.

medical care and treatment on the dates detailed above. During the course of the evidence and in submissions Mrs Mortimer raised many issues regarding Robena's medical care and treatment over a long period of time which were not within scope. Whilst many of these medical issues supported Mrs Mortimer's contention that historically so much of Robena's medical care in mainstream settings, both medical and psychiatric, had been fraught, they were not part of the scope of the inquest which was specifically about Robena's medical care from 31 July 2009 until her death.

50. In examination by Mrs Mortimer, her expert, Dr Patrick Dewan, introduced new evidence that the ileostomy surgery in July 2009 was the cause of Robena's ill health, borne of his interpretation of an X-ray from 5 August 2009, which he stated showed gas that was suggestive of a problem with the surgery.[26] In his view, Robena's blood tests together with the X-ray results should have informed different decision making on 5 August 2009. This emphasis on the X-ray and the sequelae of the ileostomy as a source of Robena's ill health was not revealed until near the conclusion of Dr Dewan's evidence when he was examined by Mrs Mortimer, [27] and was not referred to in Dr Dewan's reports or his commentary on the other expert reports. [28] As Robena's prior surgical history was not included in the Inquest scope, and but for Mrs Mortimer's questions about the surgery in 2000, it was not in puttage to the witnesses, and not included in the list of 22 questions prepared for consideration by the exert panel and Dr Dewan. Dr Dewan also included a 'summation' of this evidence regarding the interpretation of the x-ray in Mrs Mortimer's submission. [29]

51. Although an inquest must be conducted with as little formality and technicality as the interests of justice permit,[30] in consideration of natural justice and fairness[31] to all parties, I am of the view it would be unfair to all the interested parties, as well as being outside the scope, to consider this late evidence.

52. The inquest heard concurrent expert evidence from three experts regarding Robena's medical care who considered a set of prepared questions. This is a court room technique often used in inquests to identify and clarify points of consensus and divergence in the expert evidence. Dr Dewan gave his evidence separately and responded to the same set of questions. The inquest also heard expert evidence from Professor Julian Troller regarding the issues facing

[26] T 471.
[27] T 472.
[28] Dr Dewan's reports and responses to other reports at CB 66-68, 69-70, 79-86, & 150-156.
[29] Submission by Mrs Mortimer pp 7-8.
[30] *Coroners Act 2008* section 65(a).
[31] *Coroners Act 2008* section 9.

intellectually disabled people accessing appropriate medical care in mainstream hospital and emergency department settings.

53. At the conclusion of the inquest, Mrs Mortimer also made a personal statement to the court about Robena.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

54. On 7 August 2009, Stephanie Mortimer visually identified her sister, Robena May Lloyd, born 20 December 1950.

55. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

56. On 12 August 2009, Dr Melissa Baker, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination and provided a written report. In that report, Dr Baker concluded that a reasonable cause of death was '*Enterococcus faecalis sepsis and acute renal failure*'.

57. Dr David Ranson prepared a supplementary medical examiners report dated 4 February 2021.[32] Dr Ranson reviewed the microscopy and toxicology of tissue sections pertaining to the genitourinary tract.

58. Dr Ranson was confident there was a urinary tract infection and that there was no indication of anatomical abnormality or obstruction of the urinary tract or bowel.

59. Dr Ranson could not find any features to suggest the presence of pyelonephritis, which is a bacterial infection of the kidney and usually occurs as a result of an ascending infection that starts in the bladder and spreads up the ureters.

60. Dr Ranson could not say for certain the organism causing the infection was necessarily Enterococcus Faecalis although it may well have been. This is because Enterococcus Faecalis was identified in '*purulent material in the swab of the upper urinary tract and urine, and this organism does cause urinary tract infections, it can sometimes be recovered post-mortem as a contaminant.*'[33]

[32] Exhibit 15.
[33] CB 265.

61. In evidence the presence of Trimethoprim in the toxicology results indicated that the drug had been administered.

62. I accept Dr Baker's opinion and formulation as to cause of death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

31 July 2009 Presentation to Emergency Department, Angliss Hospital

Was the medical care reasonable and appropriate in the circumstances of Robena's presentation?

Was it reasonable not to admit Robena to hospital?

63. On 29 July 2009 Robena was discharged from the Alfred Hospital. On 31 July 2009 Mrs Mortimer took Robena to the Emergency Department of Angliss Hospital on account of her not having passed urine. Mrs Mortimer stated, *'I went to the hospital on 31 July because after Robena was discharged from the Alfred she never passed urine again.*'[34] Mrs Mortimer described Robena as '*unwell*' and '*very distressed*'[35] and agreed with the hospital records describing Robena as aggressive and hitting at staff.[36] It was not clear from the evidence why Mrs Mortimer did not take Robena back to the Alfred, where she had had surgery and been recently discharged. She had been to see her GP earlier that day for follow up after surgery and the GP noted the stoma was working. [37]

64. Dr Wilson Phiri, who treated Robena on 31 July 2009 in the Emergency Department of Angliss Hospital, made a statement to the original coronial investigation dated 10 May 2011 and a second statement dated 4 February 2021. The second statement was drawn from the medical records, his earlier statement, and his usual practice.

65. On Robena's behalf Mrs Mortimer told Dr Phiri that Robena had, *'... not having passed urine since 2300 the preceding Wednesday roughly two days prior to presentation.*'[38] The record states the presentation was for '*urinary retention*'[39] and Mrs Mortimer agreed that Robena was '*otherwise well.*'[40]

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[34] T 12.
[35] T 12.
[36] T 16 & Appendix 3 p 39.
[37] Boronia Medical Centre records 1 July – 31 August 2009, circulated to Interested Parties on 15 February 2021.
[38] CB 10.
[39] T 13 & Appendix 3 p 35.
[40] T 14 & Appendix 3 p 37.

Examination of Robena

66. Dr Wilson stated:

> '*On examination she did not appear distressed. She was afebrile at 37 degrees Celsius and her oxygen saturation was 99%. Her abdomen was soft and displayed multiple surgical scars. The bladder was not palpable. A bladder scan indicated 700 mls of urine.*'[41]

Treatment & diagnosis

67. A catheter was inserted and 790 mls of urine was drained. Dr Phiri stated, '*Urinalysis indicated nitrates, large blood and leucocytes+.* '[42]

68. The urinalysis was a dip stick test on the urine:

> '*On the basis of these results, I was and am confident that Ms Lloyd had a urinary tract infection. This was uncomplicated at that time, as demonstrated by the absence of fever, her being otherwise well (supported by her sister's report of her being well) and the normal abdominal examination.*'[43]

69. Dr Phiri stated it was routine to manage uncomplicated urinary tract infections on an outpatient basis. Based on the urinalysis, Dr Phiri prescribed trimethoprim 300mg orally for seven days, '*for a presumed urinary tract infection based on the urinalysis. I felt a urinary tract infection in the context of recent surgery was probably the cause of urinary retention.*'[44]

Discharge plan

70. The catheter was removed, and '*It was not confirmed that Ms Lloyd was able to pass urine prior to discharge.*' Dr Phiri's plan for discharge was for her to pass urine at home. He stated:

> '*There was no need for Ms Lloyd to be retained for a trial of void. This would involve her being kept in hospital in an unfamiliar environment. Given that she had an intellectual disability, it is likely that she would have been more comfortable in her home, with her family.*'[45]

[41] CB 10.
[42] CB 10.
[43] Exhibit 5, Statement by Dr Wilson Phiri dated 4 February 2021, paragraph 11.
[44] CB 10.
[45] Exhibit 5 paragraph 13.

Dr Phiri explained the notes in the medical record[46] as '*shorthand for what I explained earlier: ... a review by the GP, return if no urine is passed or the patient is worse, developed fevers, nausea, vomiting or anything that concerns their carer or guardian*.'[47]

71. Mrs Mortimer stated she was unaware of the discharge plan for Robena to pass urine at home: '*Well, nobody ever discussed that. I just took her home hoping the antibiotics would have some effect, having expressed my concern that they weren't adequate, and being told I had to go.*'[48] It may be that the formal description 'discharge plan' was not used. Mrs Mortimer confirmed she was aware the plan was for Robena to urinate at home, and that if there were concerns about urination she was to return to hospital or call an ambulance.[49] Mrs Mortimer was also aware she could take Robena to her regular GP although stated, '*I rarely went to the regular GP, it was too much of a nightmare waiting to see them with other patients waiting.*'[50]

72. Mrs Mortimer was concerned about the antibiotic prescribed. She spoke to the nurses that she wanted '*her to have Erythromycin, she's not allergic to it and it's a much stronger antibiotic*.'[51] She stated she was told by the nurses to give Robena two tablets of trimethoprim, on account of the infection. Dr Phiri stated he had no knowledge of the nurses' instructions to take two tablets or of Mrs Mortimer's antibiotic preference and this is not noted in the hospital records.

73. Mrs Mortimer's contention that the medical care Robena received was not reasonable was because she was in urinary retention and was sent home before she could prove she could pass urine. When Mrs Mortimer queried the logic of Robena being sent home to pass urine in a familiar environment, given she had been in urinary retention when at home,[52] Dr Phiri advised the difference was that Robena had been started on antibiotics.

74. Mrs Mortimer confirmed Robena did pass urine on Monday 3 August 2009, *'... one o'clock on Monday she passed urine with great relief, and she's promptly said to me, 'I want sausages for tea.*'[53] Mrs Mortimer's evidence was that was the last time Robena passed urine until her death on 7 August 2009.[54]

[46] Appendix 3, p 38.
[47] T 156.
[48] T 64.
[49] T 64.
[50] T 64.
[51] T 17.
[52] T 18.
[53] T 56.
[54] T 58.

Factual discrepancies at the hospital

75. Mrs Mortimer did not recall *'... see[ing] the doctor much in casualty because she was so busy.*'[55] Mrs Mortimer stated she mostly spoke to the nurses about Robena and '*I don't recall Dr Phiri at all, and I don't recall speaking to her.*'[56] When Dr Phiri was described to Mrs Mortimer she advised '*I definitely didn't speak to him on the 31st. I never saw him*'[57] and denied a number of times seeing an African doctor on 31 July 2009.[58]

76. I am satisfied by the evidence namely, Dr Phiri's statements, his evidence, and the medical records confirm that he examined Robena on 31 July 2009.

77. In evidence, Mrs Mortimer described Robena's urine as '*like jelly*' and that the nurses had to '*milk it down the tube.*'[59] Mrs Mortimer was adamant with this description, *'I recall it because I couldn't believe how thick the urine was*.' She described the nurses as taking ages to milk it down the catheter into the specimen jar, and the nurses telling her to give Robena two tablets of the antibiotics immediately.[60]

78. This particular description of Robena's urine is not noted in the nursing records. In response, Dr Colin Pearson, Staff Specialist, Emergency Department of the Angliss Hospital referred to the pathology results[61] particularly the 'specific gravity' of 1.015. He described as '*sort of mid range. And so there's no way it would have been jelly like*'[62] and explained that '*specific gravity is a measure of the amount of water in the urine and the density ... it's relatively low. So it's not concentrated at all.*'[63]

79. I note the discrepancy between Mrs Mortimer's recollection of the urine consistency. This was not noted by Dr Phiri or in the medical record. Dr Pearson interpreted the pathology results which detailed the properties of the specimen.[64]

Urine sample and analysis

80. A significant amount of evidence at inquest considered the 31 July 2009 urine sample. The Court of Appeal decision accepted Dr Dewan's report which:

[55] T 18.
[56] T 53.
[57] T 56.
[58] T 63.
[59] T 15.
[60] T 60-1.
[61] Appendix 3, p 44.
[62] T 203.
[63] T 204.
[64] Appendix 3.1 Pathology results pp26-7.

'*… raised the issue of the adequacy of the assessment of the urine tests taken on 31 July 2009, the issue of whether further samples ought to have been collected, the issue of whether further testing of sensitivities ought to have been undertaken to isolate the relevant pathogen*.'

81. 'Sensitivities testing' refers to determining the sensitivity of bacteria to an antibiotic. The results of a sensitivities test can help a doctor determine which drugs are likely to be most effective in treating the infection.

82. A number of witnesses gave evidence about the 31 July specimen including Dr Phiri and Dr Pearson, who treated Robena on 5 August 2009. Dr Dewan gave evidence about the specimen, as did Ass/Prof Gock on behalf of the expert panel.

83. The evidence explored the following questions: the likelihood of a catheter sample being contaminated, how mixed growth results should be interpreted from a catheter sample, and when should sensitivities testing be investigated to isolate relevant pathogens, when are laboratory results received and when should a second sample be required, and who follows up whether an antibiotic is working.

*Dipstick test in the emergency department (**ED**)*

84. Dr Phiri stated the dipstick urinalysis was consistent with infection: '*It showed some leucocytes (white cells, an indicator of infection or inflammation) and nitrates (released by bacteria breaking down chemicals within the urine) and blood (also consistent with infection).*'[65] As noted, he stated the urinary tract infection was uncomplicated at that time demonstrated by absence of fever, Robena being otherwise well as reported by her sister, and having a normal abdominal examination.

85. After taking an analysis via a dipstick test on the urine, Dr Phiri stated:

'*I arranged cultures of the urine. I would not have seen the culture results, which would have been reported after I went off shift. They would have been routinely available on the medical records once they were reported and to a patient's GP on request.*'[66]

86. When asked about chasing up sensitivities, in cross examination Dr Phiri stated, '*Yes, correct. But when I sent Robena home, the idea was for her GP to review her and check the sensitivities and the culture results.*'[67] He agreed it was highly unlikely for the urine sample

[65] Exhibit 5, paragraph 10.
[66] Exhibit 5, paragraph 14.
[67] T 151.

collected by catheter to be contaminated, '*In general yes. Catheter specimens are better than mainstream specimens or clean catch specimens*.'[68]

87. With respect to whether there was follow up to ensure the antibiotic was working, Dr Phiri stated:

'*Again, that was the domain of the reviewing general practitioner to chase up the urine cultures, sensitivities, as they became available and also monitor the patients' progress as to whether they were getting better or not*.'[69]

88. Subsequent to the inquest, Robena's GP records were obtained from Boronia Medical Centre.[70] The records included the laboratory results from the 31 July 2009 urine analysis, received 4 August 2009. The GP records indicate Robena's last appointment was on 31 July 2009 prior to her presentation to the Emergency Department.

89. As an ED physician Dr Phiri did a dipstick test and sent the sample off for analysis, the results of which were in his view the responsibility of Robena's treating GP, as was any follow up regarding effectiveness of the antibiotic.

90. Ass/Prof Gock provided an expert report to the court. He stated:

'*The discharge and advice for return for review if required and note of local doctor follow up was a reasonable safeguard. Pathology results such as urine cultures returning to ED department after patient is discharged from ED are generally communicated to local doctor accordingly to assist ongoing management in the community. For example, a culture and sensitivity panel may result in a change to a more optimal antibiotic*.'[71]

Pathology analysis and 'mixed growth organisms'

91. The general meaning of a 'mixed growth organisms' result is that the sample is contaminated by the patient's bacterial flora during collection.

92. Dr Pearson was asked about the pathology results of the 31 July specimen. He stated:

'*Mixed growth would indicate a contaminated sample and therefore it's of little value … There's multiple bacteria which are generally either skin flora or bowel flora of general sort*

[68] T 151.
[69] T 152.
[70] Boronia Medical Centre records 1 July – 31 August 2009, circulated to Interested Parties on 15 February 2021.
[71] CB 159.

of perineal flora, so there's a multitude of different bacteria. What we're looking for is a specific single isolated growth, not multiple mixed growth.'[72]

Whilst, he stated, ideally a catheter specimen would be sterile, it was not always the case. He stated because there were so many different bacteria involved *'you don't know which the actual source would be if one of those was causing a urine infection*.'[73] Dr Pearson stated it will not be all the bacteria causing the infection, it might just be one, and bowel and skin organisms have different sensitivities, '*So it's generally a broad spectrum antibiotic that would have been used, in this case Trimethoprim*.'[74]

93. Mrs Mortimer put to Dr Pearson it was *'highly unlikely'* a specimen taken by catheter would be contaminated. Dr Pearson agreed it was *less likely* but that there was potential for contamination, '*Bacteria can be from the bowel or skin flora or perineum that can get into the urine sample and produce growth, but that's not a urinary infection*.'[75]

94. Mrs Mortimer put to Dr Pearson it was a systemic failure by the hospital not to do a sensitivities test on Robena's urine '*when a person's [p]resented in retention on an antibiotic that is clearly not working.*'[76] Dr Pearson responded, '*We would have to dispute that the antibiotic was clearly not working*.'[77]

95. Mrs Mortimer maintained in her submissions [78] that it was virtually impossible that a catheter specimen was contaminated and thus pathology should isolate organisms on mixed growth urine specimens.

Expert evidence

96. In accordance with usual practice, a list of questions was prepared for the experts' consideration. The expert panel comprised Dr Harney, Ass/Prof Gock and Professor Cade. The experts were provided with the questions when they met to confer and then gave affirmed evidence to the inquest. The experts nominated between themselves, dependent on their expertise, who would answer the questions. They were also advised that they should indicate to the court if they did not agree with evidence given or if a question was outside their expertise.

[72] T 164.
[73] T 169.
[74] T 169.
[75] T 185.
[76] T 190.
[77] T 190.
[78] Submission by Stephanie Mortimer p 1.

97. Ass/Prof Gock gave evidence as part of an expert panel in response to the specific questions about the urine samples.

98. Ass/Prof Gock explained the dipstick test does not reveal the micro-organism but can indicate whether there are white cells, and other components of infections such as nitrates that help add to the clinical assessment. '*So if you think there is infection, … you'd empirically treat … that's not guessing, that's just standard practice*.'[79] He explained that as a culture result can take 24 to 48 hours, there is no other way to understand what the infection is, or identify the organism and the sensitivity.

99. Ass/Prof Gock also disagreed that it was unlikely a catheter urine sample would be contaminated. He stated he often sees contaminated samples from patients with bowel problems.

100. The panel was asked whether the catheter urine specimen from 31 July 2009 indicating contamination for mixed growths organisms should have been tested for sensitivities. Ass/Prof Gock advised when the sample is taken the dipstick result does not reveal the '*mixed growth organisms'* result. Standard practice is to treat the infection empirically, which is a 'best guess,' with antibiotics '*without knowing the result with the hope that you cover the likely organisms that cause urinary tract infection*.'[80] If the 'mixed growth organisms' result had been immediately available then the urine test would be repeated to try and get a clean sample. He stated, '*that is not practical in reality, so that's why you give empirical treatment*.'[81]

101. Ass/Prof Gock advised the prescribing of Trimethoprim was '*entirely appropriate and consistent with the antibiotic guidelines that help guide our practice*.'[82] He stated that further testing of the sensitivities was '*irrelevant once you start antibiotic treatment.*'

102. The usual practice once antibiotic treatment is started, is to be guided by the clinical picture of the patient. Ass/Prof Gock explained when there is mixed growth by nature of it being contaminated, there is no point testing for sensitivities because it is a contaminated sample, and it is not known which organism is causing the urinary tract infection:

'*… to go through the extent in cost testing sensitivities would essentially overwhelm every pathology lab in the country….so that's just not done. It's not precise, a midstream urine*

[79] T 396-7.
[80] T 367.
[81] T 368.
[82] T 368.

culture sensitivity collection, culture insensitivity is not a precise science; it's a guide to the clinical picture.'[83]

103. Ass/Prof Gock was asked why sensitivities would have been tested on the 11 July 2009 urine sample, but not on the 31 July 2009 sample. Ass/Prof Gock explained the microbiology lab tries to assist the clinician wherever possible in guiding treatment. The sample from 11 July 2009 showed a white blood cell count 1000+ which is a strong indicator of urinary tract infection so the microbiology lab would be trying to guide the clinician's treatment. He explained by looking at the organisms with predominant growth, they might test sensitivities to guide the clinician. Compare this result to 31 July 2009 where the white blood cell count was 150 which is an indicator of infection, but not as strong as 1000, '… *the picture is not so clear'*. A microbiology lab might not do sensitivities, '*if they did, they'll end up with clinicians overprescribing antibiotics*.'[84]

104. Ass/Prof Gock explained there is no 'hard and fast' rule that applies in testing for sensitivities. There is no 'cut off' number for white blood cells to test for sensitivities. Rather than meaning the infective organism has been overlooked, he stated it means the infective organism was not identified, '*The clinical picture suggested an infection; an empirical treatment was given. So in that sense, … it's not overlooked, it just wasn't identified.*'[85]

105. In Ass/Prof Gock's opinion there was no reason for a further sample to be taken in ED as the dipstick suggested infection which prompted the empirical treatment. The subsequent lab results indicating contamination was not known at the time.

106. The expert panel was of the view there was no indication Robena should have been admitted, nor that she should have remained in the emergency department until she passed urine. The reasons for this included her recent discharge from hospital, she presented in retention with a large volume of urine and an infection had been identified and treated:

'*So the best way to avoid retention is to have the patient in the least stress environment as possible, if otherwise well, with the underlying cause of the problem treated and restoring her to her home situation.*'[86]

[83] T 369.
[84] T 372.
[85] T 373.
[86] T 374.

107. The panel's view was the discharge plan was appropriate and '*it was appropriate that a general practitioner can follow things such as the microbiology results, a clinical review of the patient*.'[87]

108. Professor Cade prepared a report dated 27 May 2020 on behalf of Eastern Health. He was not of the view the urine sample from 31 July 2009 should have been subject to further investigation '*as the correct diagnosis of urinary tract infection was in fact reached at this time, based on the information available, and an appropriate antibiotic was then prescribed*.' In his opinion there was no dominant pathogen, therefore it was not overlooked.

109. In his 2016 report, Dr Dewan stated that as the urine specimen was from a catheter, contamination was less likely. In his view the mixed growth result was indicative of a pathogen and that sensitivities should have been directed. Dr Dewan noted his concerns regarding the urinary tract pathology:

'*Inadequate steps were taken in response to a CATHETER specimen of 31/7/2009 – White Cell count 150, with bacteria seen on microscopy and with mixed growth of organisms, indicating sepsis, given the presence of bacteria from a catheter specimen. At least there should have been a further specimen collected. It was reasonably likely that the fatal infection was present in the urine at that stage*.'[88]

110. In Dr Dewan's opinion, as outlined in the excerpt from his 2016 report above, the 31 July 2009 urine specimen should have been subject to further testing for sensitivities and further evaluation of the urine results:

'*… that's a system failure that has let Robena down … there should have been a follow up of a sub-culture, and if that was not sufficiently informative, there should have been an arrangement for a further specimen …*'[89]

111. My understanding of his evidence is that as the catheter sample would usually be uncontaminated, the mixed growth organism result is surprising. Whilst the expert panel was of the view the mixed growth result indicated a contaminated sample, Dr Dewan took it to mean the bacteria present will likely be the bacteria causing the urinary tract infection. The testing of further sensitivities enables the most effective antibiotic to be prescribed.

[87] T 375.
[88] CB 18.
[89] T 419.

112. Dr Dewan was of the opinion a follow up urine sample should have been taken, and it could have been delegated to a GP. Further, in his view Robena should have been admitted to hospital on 31 July 2009, because she had been in retention and had recently been very sick. Dr Dewan noted it was '*in retrospect very obvious she would have been admitted*.'[90] In his view it was *medical nonsense* and *fanciful* to expect Robena to pass urine at home and it was unreasonable for her to be sent home prior to having passed urine at the hospital.[91]

113. Whilst Dr Dewan agreed that Trimethoprim was a good option for the management of urosepsis, in his opinion Robena's medical record should have been available to review her history of urosepsis.

114. He produced a document, in which he plotted Robena's urine results during 2009.[92] He identified various bacterial organisms, namely Klebsiella in March 2009 and Pseudomonas on 14 May 2009 which were *worrying*. There was a mixed growth result a day or two before Pseudomonas, an evolving infection in a situation where there was some degree of contamination. At the end of the chart in July 2009 was more mixed growth results and Dr Dewan stated:

'*… you could well be heading to the situation of 14 May. That's what you should, as a clinician, actually expect. That if you get that mixed growth with the minimally raised white cell count, are we sure we haven't got a bacteria hiding there that is now going to make this patient sick? Particularly when we have these six episodes of definite infection from 26 March 2009.*'[93]

115. He concluded this point that Trimethoprim was a very reasonable first line antibiotic, which should have been followed up. He described the discharge plan as '*concept*' only, querying how was it communicated to Robena's GP, and that it was not adequate.[94]

116. I note Dr Dewan was of the view a further urine sample should have been taken and this could have been taken by Robena's GP. Ass/Prof Gock explained that lab results are not available in ED and queried the utility of further testing for sensitivities on a contaminated sample. Ass/Prof Gock also queried the utility of a further urine sample once Robena had commenced on antibiotics.

[90] T 420.
[91] T 421-2, 424.
[92] Exhibit 29.
[93] T 423.
[94] T 424.

117. Dr Dewan confirmed his view the catheter sample was unlikely to be contaminated and with the mixed growth result, '*are we sure we haven't got a bacteria hiding there?*' In his report he stated:

'*… mixed growth organisms, indicating sepsis, given the presence of bacteria from a catheter specimen. At least, there should have been a further specimen collected. It was reasonably likely that the fatal infection was present in the urine at that stage.*'

Conclusions

118. I accept Dr Phiri's treatment on 31 July 2009 was reasonable and discharge was appropriate for follow up by GP. I accept his evidence, and that of the expert panel it was not necessary for Robena to be admitted or to stay in hospital to pass urine.

119. Whilst a catheter sample is less likely to be contaminated, this is not always the case. The lab results indicating contamination were not immediately available to Dr Phiri in the ED, therefore there was no indication to him to take a further sample. Once Robena started on antibiotics, the utility of a second sample (to reveal pathogens) was questionable. In any event, Robena did not attend her GP for follow up so there was no opportunity for a second sample to be taken. The prescription of Trimethoprim was agreed by the expert panel and Dr Dewan to be reasonable.

120. With respect to whether the 31 July catheter sample should have been tested for sensitivities, the expert panel was of the view the contamination meant there was general bacteria from either the skin, bowel or perineum, a multiple mixed growth which is not worth testing. Dr Dewan was of the view as the catheter specimen was unlikely to be contaminated, the contaminating bacteria should have been tested further to identify the pathogen. The lab results refer to '*squamous epithelia + and bacteria ++*'. The microscopy comment states: '*Note the presence of squamous epithelia cells indicates perineal or urethral contamination*.' The culture is noted as '*Mixed Enteric and skin flora*.'[95] Dr Dewan's report stated, '*It was reasonably likely that the fatal infection was present in the urine at that stage*.'[96]

121. I prefer the expert panel's evidence that given the white blood cell count of 150 and the mixed growth result indicating contamination, usual practice and in combination with the clinical presentation mitigated against further testing suggested by Dr Dewan.

[95] Appendix 3.1 p 27.
[96] CB 67.

122. In any event, it is not clear who had responsibility for considering whether further testing should be conducted. It is unclear on the evidence presented by Dr Dewan when the further tests on the 31 July sample should have been done and ordered by whom. In her submissions Mrs Mortimer stated the casualty doctor should have contacted pathology requesting the predominant organism be isolated and tested for sensitivities. An infection was identified via the dipstick and a reasonable antibiotic was prescribed. Robena's clinical signs did not suggest further tests were required. The contamination of the sample was revealed by the laboratory testing. It is likely the contamination was from Robena's skin flora. A further urine sample is of limited utility once antibiotics are commenced.

123. I accept Dr Phiri's evidence he did not have the lab results in ED, and further follow up, if there were concerns, was the domain of Robena's GP. Whilst Robena's GP records indicate the lab results were received on 4 August 2009, Robena did not have a further appointment with her GP. I understand it is standard practice for GPs to review all pathology tests that are received by them and follow up important results. As I did not hear evidence from Dr Lim, I am not able to draw a conclusion as to what happened in this case.

124. In considering the expert evidence I prefer the expert panel's evidence to that of Dr Dewan. There are a number of reasons. Firstly, with respect to expertise, Ass/Prof Gock is a nephrologist, an expert in renal medicine, and Dr Harney is an experienced emergency physician. The expertise of the panel members was not impugned. Their expertise covered emergency medicine, nephrology and Dr Cade was an expert in intensive care.

125. Dr Dewan is an experienced paediatrician and urologist, who, although he has not treated adult patients since 2003, does have relevant expertise in treating diseases of the urinary tract. Although his 2016 report was pivotal to the Court of Appeal decision, I am of the view the expert panel had more relevant expertise, not just in subject matter, but relevant experience treating adults in hospital emergency departments. Dr Dewan did not have the same level of relevant clinical experience and the chart he produced in evidence [97] was not the type of collated information readily available to emergency clinicians. His evidence was often absent of clinical context and the further investigations that he proposed were not in accordance with the evidence regarding reasonable peer accepted practice in an ED setting.

126. Dr Dewan was of the view there should have been extensive review of Robena's medical records. The expert panel was asked how far back medical records should be examined when a patient presents to a hospital emergency department. The panel agreed there is no rule about

[97] Exhibit 29.

this, it depends on the case and the clinician's judgement. For example, the panel was of the view Robena's 1999 cystoscopy was irrelevant to her presenting problems on 31 July and 5 August 2009 and that it was unreasonable to expect that an emergency clinician would read four volumes of medical records on an emergency presentation. In contrast, it was assumed that medical staff were aware of Robena's recent ileostomy surgery, as was noted by Dr Phiri[98] (and Dr Pearson in relation to 5 August 2009[99]) in the medical records.

127. Secondly, Dr Dewan struggled with his role as an expert: he could not differentiate between the duty as an expert to provide an impartial professional opinion to the court and being a self-described *advocate* for Robena. His understanding of the obligations of an expert and the expert code of conduct was unclear. [100] Dr Dewan described his role as *'... to assist the court to improve the care in Emergency Departments and in the management of those with an intellectual disability and those with urosepsis*.'[101] He also described himself as '… *an advocate for Robena Lloyd*.'[102] A criticism of Dr Dewan's evidence was that he overstepped the usual bounds of an expert by becoming both an *advocate* for Robena and *assisting* Mrs Mortimer during the inquest. When this was put to him, he responded, '*It was certainly not my intent. My intent was to inform the court about the medical facts*.'[103] Although Dr Dewan did assist Mrs Mortimer in court during the inquest, I acknowledge his understandable desire to do so given the challenges Mrs Mortimer faced as both witness and advocate in this case.

128. Dr Dewan made direct contact with the court by sending emails addressed to myself and or the State Coroner on numerous occasions prior to and including during evidence at inquest. This required me, in open court, to request that he desist from this conduct and the relevant email was distributed to the interested parties.[104] It is not unusual for the court in its investigative role to receive correspondence directed to the investigating coroner from family; it is unusual to receive repeated emails from a professional expert witness. In evidence he explained his position as '*assisting the court ... I was acting as somebody who was in the interest of the court reading, reaching a safe decision.*'[105] When asked whether he was

[98] Medical records vol 3 p 35.
[99] Medical records vol 3 p 28.
[100] T 450.
[101] T 444.
[102] T 448.
[103] T 450.
[104] T 158.
[105] T 449.

'*overstepping the bounds of the usual independent expert,'* Dr Dewan denied this, '*That was not my intent. My intent was the [sic] inform the court about medical facts*.'[106]

129. This behaviour, whilst potentially well-meaning, impacted on my assessment of his objectivity, and diminished the weight I can give, and subsequently gave, to his expert opinion.

130. I am also of the view Dr Dewan's opinion was inclined towards hindsight bias whereby the known result or outcome influences the interpretation of preceding conduct. Rather than conducting a real time assessment of the sequence of her medical treatment and clinical presentation in the context of what was within peer acceptable practice, he focused on pathology results often without the context of Robena's clinical presentation.

131. I accept the expert panel's evidence that Robena's medical treatment and tests conducted on 31 July 2009 was reasonable and appropriate in the circumstances of Robena's presentation and that it was reasonable to discharge her home and not admit her to hospital

5 August 2009

Was the medical care reasonable and appropriate in the circumstances of Robena's presentation?

Was it reasonable not to admit Robena to hospital?

What were Ms Lloyd's carers told regarding care for Robena and the regime to be followed at home?

What was the impact, if any, of Robena's intellectual disability upon her care and treatment?

132. The main issues considered for this part of the scope centred around whether Robena should have had a further urine test, whether she should have passed urine before being discharged or been admitted to hospital when she attended the Emergency Department on 5 August 2009.

133. On 5 August 2009, Mrs Mortimer described Robena as being '*cold, clammy and sweaty*.' Robena had not passed urine for two days, '*that's why I sent her to the hospital*.'[107] That day Mrs Mortimer had to drive to Notting Hill to buy more stoma bags so she asked carers Sue Young and Gary Leeworthy to take Robena back to the Emergency Department of Angliss

[106] T 451.
[107] T 26.

Hospital. Mrs Mortimer gave them a note to take to hospital explaining Robena had not passed urine since 1 pm on Monday, namely 48 hours. Mrs Mortimer stated:

'... it was Wednesday morning and I was beside myself about it and I gave Garry and Sue strict instructions they were not to bring her home until her urine was properly tested and sensitivities done.'[108]

Nursing assessment and treatment in ED

134. Robena arrived in the Emergency Department and at 9.29am was given a triage rating of 3. Her presenting problem in the triage note was described as *'?urinary retention'* and she *has not passed urine for 24/24*.[109] A nursing entry states, '*Relative noticed pt has not passed urine for 24/24.*'[110]

135. Sakravadee Gramaticu was the registered nurse who looked after Robena from 10.00am to 11.15am. In her first statement she could not recall Robena, prepared her statement from case notes and was not called as a witness at the inquest.

136. Ms Gramaticu noted Robena's surgical history of the ileostomy bag, and her recent attendance at Angliss Hospital a week prior, when she was diagnosed with a urinary tract infection as shown on a catheter specimen urine result. She noted Robena had been taking trimethoprim for four days.[111] On presentation Ms Gramaticu was told Robena had not passed urine for the past 24 hours. Just after 10.00am she performed a bladder scan, which revealed 90 mls of urine. At 10.10am she noted Robena as alert with the following vital signs: Blood pressure 122/73, heart rate 104 per minute and temperature 36.6ºC.[112]

137. Ms Gramiticu made a second statement, in which she stated she had '*some memory'* of Robena stating, '*As I recall, Ms Lloyd was calm and quiet.*'[113]

138. Christine Goode, a registered nurse, took over Robena's care from Ms Gramaticu on 5 August 2009. She also had minimal recollection of Robena, had prepared her statement from the medical records, and was not called to give evidence at the inquest.

[108] T 27.
[109] Medical records, Appendix 3 p 24.
[110] Medical records, Appendix 3 p 28.
[111] CB 11.
[112] CB 11.
[113] CB 176.

139. A blood test was sent to pathology, and at 11.15am and 12.15pm observations of Robena were taken of alertness, heart rate, blood pressure, respiratory rate and blood sugar level. Robena was reviewed by the doctor on duty, her carers were given a 700 ml jug of water to encourage fluid intake and Ms Goode observed her to consume 100 mls. A further bladder scan was requested and during Ms Goode's care, nil urine output was recorded.

140. Ms Goode made a second statement and '*could recall a few things about Ms Lloyd'* and that she did not recall having any concerns about the way she presented.[114]

141. Kirralea Lancaster, a registered nurse, took over from Ms Goode when she started the afternoon shift at about 1.00pm. She was unable to accurately recall Robena, had prepared her statement from the patient history and was not called as a witness.

142. Ms Lancaster noted in her statement she observed Robena '*to be restless and wandering around the department in agitated manner. I can recall it being difficult to assess Ms Lloyd due to her disability and the fact she was in an agitated state.*'[115] She noted at one-point Robena threw a cup containing soluble Panadol at her carer, however also noted that later at 1430hrs '*she appeared more settled*' and that when performing a bladder scan, '*At 1515hrs I documented Ms Lloyd was cooperative …*'.[116] In her second statement, Ms Lancaster confirmed her recollection, that she could, '*visualise her in her agitated state as she walked around the department*.'[117]

143. Robena was in Ms Lancaster's care from about 1.00pm until her discharge at 4.30pm. At 1.40pm she was unsuccessful in getting Robena to have some analgesia. At 1.45pm she documented Robena was unable to pass urine, and she gave her some crushed up Panadeine. At 3.15pm she conducted a bladder scan and recorded 540 mls. She noted Robena was unsuccessful in passing urine and '*during her stay did not void at all*.'[118] At 4.30pm the doctor was happy for her to leave, noting she was producing urine despite not having voided.

Dr Pearson's examination, assessment and treatment

144. Dr Colin Pearson was the staff specialist in the Emergency Department of the Angliss Hospital. Dr Pearson noted, '*Carers state has not passed urine for 24 hours*.'[119]

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[114] CB 178.
[115] CB 13.
[116] CB 13.
[117] CB 180.
[118] CB 13.
[119] Exhibit 28, Medical records Appendix 3 p 25.

145. On examination Dr Pearson noted Robena's temperature was 36.6ºC, heart rate, oxygen saturation, blood sugar and blood pressure were all normal. Her abdomen was lax and non-tender, with active bowel sounds, with fluid in the ileostomy bag, and no bladder was palpated. A bladder scan revealed 90 mls of urine.[120]

146. In Dr Pearson's opinion, Robena was not dehydrated or in urinary retention but her '*ability to produce urine that was in issue, assuming Ms Lloyd had in fact not passed urine in the previous 24 hours*.'[121] Robena's urea and creatine levels were checked to see if her renal function was normal. To assess her ability to make urine, fluids were administered.

147. Blood investigations revealed a lowered sodium level 129 mmol/L, elevated potassium of 5.3 mmol/L, elevated(?) bicarbonate level of 20 mmol/L and normal urea and creatine levels. The full blood examination showed elevated platelets at 440 x 10(9)/L and normal white cell counts. An abdominal ray showed distention of the bowel, but this was noted as unchanged from previous X-rays.

148. Dr Pearson was of the view the lowered sodium levels were not due to fluid depletion given Robena's vital signs, fluid in the bag, and normal urea and creatinine levels and that lower sodium levels are a common side effect of Robena's other medications.

149. A repeat bladder scan indicated Robena was producing adequate amounts of urine and she was discharged at 4.40pm.

Factual discrepancies

150. There were a number of discrepancies in the evidence about Robena's symptoms and demeanour, as well the information the carers gave ED staff, what they asked for and what they were told on discharge.

151. Firstly, Mrs Mortimer described Robena as being cold, clammy and sweaty when she went to ED, however Dr Pearson stated he was surprised to hear that description and there was no reference to those symptoms in the medical records.[122] He confirmed that if he had noted it on examination, he would have recorded it.

[120] Exhibit 28, Medical records Appendix 3 pp 25-27.
[121] CB 17-18.
[122] T 160.

152. Secondly, Dr Pearson was also surprised that Robena's carer, Sue Young, described Robena in her statement as '*very agitated*.'[123] Dr Pearson noted in the record, *'calm for Robena'*[124] and there was no description of agitation in the nursing or medical notes.[125] Ms Young's description accords with Nurse Lancaster's statement who also described Robena as *'agitated.'*

153. Thirdly although Mrs Mortimer stated to the carers that Robena had not passed urine for 48 hours, the weight of evidence, namely three references in the medical records[126] and evidence from Mr Leeworthy[127] suggests carers told ED staff Robena had not passed urine for *24 hours*.

154. Fourthly, in his evidence Mr Leeworthy confirmed that Mrs Mortimer had given him a note, but he could not recall whom he gave it to. He recalled Mrs Mortimer was insistent that Robena have a urine sample taken.[128] Dr Pearson could not recall the note and could not say what had happened to it, but he did state, '*Under no circumstances would I believe a staff member would have just discarded it and not taking any concerns legitimately*.'[129] It is unknown what became of the note Mrs Mortimer wrote and gave to the carers to present to ED staff.

155. Fifthly, Ms Young described Robena as:

> '*… very ill, both Gary & I had to walk her round for at least 5 hours as she was very agitated, the reason for that was she was in agony & it was her way to show us how sick she was*.'[130]

Ms Young stated Robena should never have been sent home on 5 August 2009 '*and if they had kept her in and did more tests, I believe she would have been here today*.'[131] Ms Young believed as a carer her concerns were ignored and that '*Because Robena was intellectually challenged and showing aggression she was ignored*.'[132]

[123] As Ms Young had passed away she was not able to be called as a witness.
[124] Exhibit 28, Medical records Appendix 3 p 26.
[125] T 197.
[126] Exhibit 28, Medical records Appendix 3 pp 24, 25 & 26.
[127] T 234.
[128] T 230.
[129] T 183.
[130] CB 21 Statement Sue Young 11 July 2013.
[131] CB 21.
[132] CB 21.

156. Dr Pearson did not recall Robena presenting in the way described by Ms Young. There were no notes in the medical or nursing record to reflect this.[133] Dr Pearson expressed '*extreme surprise*' the carers stated Robena was distressed: '*That certainly wasn't the impression of myself or the nursing staff.*'[134]

Request to take a urine sample

157. One of the significant factual disputes was whether the carers asked for a urine sample to be taken.

158. Dr Pearson stated that on Robena's presentation the primary focus was whether she was in urinary retention and once it was proven she was not in retention the question became whether she was producing urine:

> '*… we demonstrated well within the emergency department that she was producing urine. Obviously there were examination findings, there's the temperatures, there's the full blood examination which were all performed, and nothing on those and in the knowledge that she was already on antibiotics would we go looking additionally for a urinary tract infection*.'[135]

159. Dr Pearson was of the opinion there was no indication of infection or urosepsis as Robena's temperature was normal, there was no raised white cell count with neutrophilia. He did not take a urine sample because:

> '*…we were not looking for a urinary tract infection because she was already on antibiotics for a urinary tract infection, and if you're on antibiotics the urine generally doesn't actually grow any organisms and is hard to interpret anyway*.'[136]

160. Dr Pearson could not recall the carers asking for a urine test and he considered a urine test was not required on that day.[137] He stated that guidelines had been developed in 2018 as to when a urine test should be taken:

> '*… on the basis of those tests we would not have done the urine or culture on Robena. We were very much looking for signs of infection, we're looking for signs of dysuria, we're looking for fevers … abnormalities in the blood tests*.'[138]

[133] T 197.
[134] T 212.
[135] T 164.
[136] T 165.
[137] T 175.

161. Mr Leeworthy stated that Mrs Mortimer asked that a sample of urine be tested, however the doctor refused saying he had just taken bloods. Mr Leeworthy texted this to Mrs Mortimer and she reiterated that the urine needed to be tested. Dr Pearson stated if someone was insisting, for example on a urine test, he stated he would probably write down that they were insisting, likewise if carers really felt Robena was distressed.[139]

162. Dr Pearson was asked about the relevance of the 31 July urine specimen to Robena's treatment on 5 August 2009. He explained Robena's urinary retention had been diagnosed as a urinary tract infection on 31 July 2009. That infection was treated with Trimethoprim which had been an effective antibiotic for Robena's previous infections. Her presentation on 5 August 2009 was for urinary retention so investigations were taken to establish whether or not she was in urinary retention. As well as establishing Robena was producing urine, she had a normal temperature, which '*was very much against there being an infection or urosepsis*.'[140] A full blood examination was performed and Robena was already on antibiotics.

Carers instructions on Robena's discharge

163. The other significant factual dispute was what the carers were told when Robena was discharged home.

164. Dr Pearson stated it was not his practice to write detailed care plan at discharge and that, *'... it would have been a verbal care plan*'[141] '*… about making sure the lady passes urine and their concerns and indications for re-attendance at the Angliss emergency department*.'[142]

165. Dr Pearson's first statement refers to Robena's discharge and to conducting the '*trial of voiding*' as an outpatient and that '*the carers demonstrated they knew what to watch for and were in agreement with this plan*.'[143] Dr Pearson made a second statement in which he explained he may not have used the phrase '*trial of void*' with Robena's carers:

'*My usual practice would be to say that the carers should: (a) Make sure she passes urine, (b) Watch out for signs of bladder distension, which might be distress or pain caused by*

[138] T 176.
[139] T 199.
[140] T 165.
[141] T 173.
[142] T 173.
[143] CB 19.

pressure from the bladder. (c) Bring her back to hospital if she did not pass urine or became distressed.'[144]

166. In his statement made in 2013, Mr Leeworthy stated there were no instructions given to supervise '*trial voiding*' and they were not told to tell Mrs Mortimer about this.

167. When he was asked about discharging Robena, (he could not recall her discharge) Mr Leeworthy stated: '*I think they were wanting us to do like trial walking her around and do trial voiding or something like that … And I really don't know what that meant at that time*.'[145]

168. Mr Leeworthy struggled to have an independent recollection of what he was told on 5 August 2009 in the Emergency Department. In his statement he states there was no mention in the Emergency Department of '*trial voiding*,' in evidence he stated he was told this, but did not know what it meant. In cross examination he agreed that trial voiding meant passing urine.[146]

169. In her statement Ms Young stated the carers were *not* told about '*trial voiding*', '*Myself, being one of the carers don't even know that term & I can definitely say no-one asked us to do that because I would have queried what it was*.'[147] As Ms Young had passed away, her evidence could not be tested at Inquest.

Blood results

170. Dr Pearson was taken through Robena's blood measurements. He stated, '*The blood pressure was generally in the normal range. 104 is probably towards the lower end of the normal range but it's still within the normal range. It's not overly concerning in this setting*.'[148] When cross examined by Mrs Mortimer about blood pressure in the context of Robena's usual results of 135 or 140 over 80 or 90 meaning her blood pressure was low, Dr Pearson stated:

'*The previous presentations obviously relate to the context of those and the blood pressure, if she's distressed with her twisted bowel then that's going to push her blood pressure up. But if she's up, she's walking around, she seems to be behaving normal for Ms Lloyd*.'[149]

[144] CB 185.
[145] T 231.
[146] T 243-244.
[147] CB 21.
[148] T 161.
[149] T 184.

171. Dr Pearson described Robena's creatinine of 84 as '… *well within the normal range for creatinine levels.*'[150] Her eGFR rate was 61 and he stated, '*Over 60 is considered normal renal function.*'[151]

172. Dr Pearson's opinion was Robena was not dehydrated, given her creatinine, urea and eGFR levels and although her sodium level was '*a touch below normal range*'[152] which can be consistent with dehydration, he did not detect any signs.[153] Although Robena's potassium level was '*mildly high … we felt it didn't need any intervention or treatment within the emergency department.*'[154] In cross examination by Mrs Mortimer regarding Robena's sodium level Dr Pearson stated:

'… *there was no major reason that Ms Lloyd needed to be kept in hospital for a low sodium of 129, nor was it predictive of the subsequent outcome … It's just into the moderate side of things. Again though it would not be an indication for admission per se. It would depend on other factors as to whether it needed to be treated or followed*.'[155]

He agreed low sodium represented hyponatremia.

173. Dr Pearson was of the view with Robena's blood results '*in no way could it be said that they were predictive of the subsequent outcome*' and that '… *neither then nor now would she be admitted through a Melbourne public hospital emergency department with those numbers*.'[156]

174. In her submissions Mrs Mortimer's confirmed her view Robena's eGFR, sodium and electrolyte results were not normal. She also notes the case '*demonstrates the danger of looking at one isolated day of pathology results*.'[157]

175. When asked about the bowel X-ray, Dr Pearson stated, '*I know I wrote in the notes that the X-ray was similar to previous X-rays so that was not a concern … certainly the interpretation on the day is that it's not something that would have been affecting her.*'[158] Dr Pearson was asked further about the interpretation of the X-ray as the accompanying report would have been delayed. He stated, '*we would compare that to the previous X-rays because the system*

[150] T 161.
[151] T 161.
[152] T 162.
[153] T 163.
[154] T 163.
[155] T 181-2.
[156] T 163.
[157] Submissions from Mrs Mortimer, p 5.
[158] T 174.

allowed … ready access to previous X-rays. So you're basically comparing it to what she had before.'[159]

Dr Pearson's diagnosis and treatment plan

176. Dr Pearson believed a urinary infection was highly unlikely because Robena was already on an antibiotic which had been effective for previous urinary tract infections. The urine culture from 31 July 2009 had not grown any bacteria, Robena did not have a fever and her white blood cell count was normal.

177. Dr Pearson's view was that the decision for Robena to pass urine as an outpatient was reasonable because this had been done after 31 July attendance and carers knew what to watch for. Robena's urea and creatinine and renal functioning was normal and she was drinking fluids.

178. Dr Pearson was consistent in his position that, despite knowing now that Robena died on 7 August 2009, on 5 August, '… *on the basis of what we saw and what we treated on that day, on the basis of her past history, her previous events. I think that was in no way predictable.*'[160] He stated, '*we're obviously not denying that she became very unwell and, unfortunately passed, but I do not believe in any way that … those tests predicted of such a rapid deterioration.*'[161]

Expert evidence – 5 August – urine sample and ability to pass urine

179. Dr Jason Harney an experienced emergency physician, prepared a report for the court and gave evidence with the expert panel. He stated that on both 31 July and 5 August, ideally the patient would have been observed to pass urine[162] but that this needs to be considered in '*the context of the entire patient history and complexities with management of behavioural problems in the past and trying to do the least harm.*'

180. Dr Harney was of the opinion that obtaining a urine sample on 5 August 2009 would not have changed the decision to discharge and there was '*no indication that to obtain a urine specimen on 5 August was required.*'[163]

[159] T 212.
[160] T 184.
[161] T 200.
[162] CB 87 & 88.
[163] CB 91.

181. In Dr Cade's opinion, a further urine sample was contraindicated as catheterisation is invasive, there was no clinical suggestion of a new urinary infection and Robena was part way through an antibiotic course for a recently diagnosed infection.[164]

182. Dr Dewan's view was that Robena was not in urinary retention but in fact was failing to produce urine.[165] He was of the opinion Robena should not have been discharged without passing urine, and indeed, should not have been discharged on 5 August 2009.[166] To suggest a urine sample should not be taken from a woman who had had six episodes of urinary tract infection since March was '*ludicrous*' and '*negligent*'[167] and the production of 90 mls of urine in 24 hours was indicative of Robena being dehydrated or in renal failure. Her urine production was *well short* and in his view it was dangerous to assume she must have passed urine.[168] The production of 90 mls of urine in 24 hours indicated to Ass/Prof Gock that 'urine output was missed.' however Mrs Mortimer strongly refuted this as a possibility.

183. Dr Dewan noted if clinicians had been able to chart Robena's levels of potassium, sodium, EGFR and creatinine and urea, '*that would have shown them that she was in an unwell zone and needed to have better, different care*.'[169] Dr Dewan referred to his chart[170] which included Robena's pulse and blood pressure, noting 5 August indicated her blood pressure was going down and her pulse rate was going up. Whilst acknowledging his chart was a record '*that's probably not readily available in the hospital notes but that's the type of interrogation of the record that I would have embarked upon in a patient like this*.'[171] Dr Dewan was critical of the hospital ED not responding to these indicators which, when read in combination over the year, demonstrated Robena was unwell.

184. The expert panel was of the view Robena was in neither urinary retention nor failing to produce urine. In the panel's opinion Robena was not in urinary retention as she had only 90 mls of urine in her bladder. When she was given fluid, she was able to produce urine as demonstrated on the ultrasound.

185. The working diagnosis was a urinary tract infection which was being treated with antibiotics. The panel's opinion was the question asking whether a 'new' urinary tract infection should have been investigated was illogical, as the test is whether there is adequacy of treatment with

[164] CB 74.
[165] T 425.
[166] T 427.
[167] T 427-8.
[168] T 427.
[169] T 428.
[170] Exhibit 29.
[171] T 429.

the existing antibiotics. The basis for accepting Robena was responding to antibiotics was that she was clinically well, walking around, the ultrasound showed she was making urine, and the presenting problem was excluded. The panel was not of the opinion a further urine sample should have been taken.

186. The panel was of the opinion there was no need for Robena to wait in the emergency department until she had passed urine.

Conclusion

187. The reasons I gave at paragraphs 124-130 above for preferring the expert panel's evidence to that of Dr Dewan also apply to my assessment of Robena's medical care on 5 August 2009.

188. I accept Dr Harney's evidence it would have been preferable for Robena to have passed urine prior to leaving hospital but it was not essential. I note she had been in the ED for over seven hours, arriving at 9.29am and discharged with carers at 4.40pm.

189. I accept the expert panel advice that given her clinical presentation and being on antibiotics there was no utility in a further urine test.

Expert evidence 5 August 2009 – should Robena had been admitted to hospital

190. Associate Professor Richard King prepared a report for the original coronial investigation. As he had retired he was not available.

191. In his report he stated:

'*On 5 August 2009 Ms Lloyd was sent home with abnormal biochemical tests and decreased renal function associated with not having passed urine. I think at this time she probably should have been admitted and her biochemical and fluid status normalised. However I do understand the problems of hospitalising such a patient. Checking her urine for infection may have prevented her re-presenting in septic shock …*'[172]

192. Dr Pearson disagreed with Associate Professor King. In Professor King's opinion, given her abnormal biochemical test and decreased renal function, Robena '*probably should have been admitted until her biochemical and fluid status normalised.*'[173] Dr Pearson also disagreed that

[172] CB 65.
[173] CB 65.

Robena's presentation and '*the problems of hospitalising such a patient'* were factors which worked against her admission.[174]

193. Dr Dewan agreed with Associate Professor King's report that Robena should have been admitted to hospital and her biochemical and fluid status normalised. His report stated:

'*In conclusion, the death would reasonably be attributed to urosepsis, electrolyte imbalance and renal failure, but the death would not have occurred had Ms Lloyd not been discharged on 5/8/2009. If, instead, the patient had been managed for her electrolyte imbalance, investigated for urosepsis and treated with antibiotics she would not have died on 7/8/2009*.'

194. Professor Cade stated that if Robena had been admitted on 5 August '*it seems obvious in hindsight that she would probably have survived if she had been in hospital at the time*' however, he was of not of the view her admission to hospital was indicated:

'*Her observations were normal, and her laboratory results were unremarkable (apart from a possible small decrease in renal function, decrease in sodium and increase in platelets – all minor and non-specific findings). A good urine production was achieved … After 7 hours of assessment her carers were comfortable for her to return home, with the recommendation that she return to hospital if there were any concerns. This seems to me to have been a reasonable course of action under the circumstances.'*[175]

195. Dr Harney stated that on 5 August 2009, Dr Pearson noted the abnormal sodium and potassium and that the urea and creatine were normal. It was not clear from Dr Pearson's notes if he noticed the eGFR result but, '*It would not be unusual working in the Emergency Department to not notice this eGFR result when the urea and creatinine are normal*.'[176] In Dr Harney's opinion:

'*The sodium and potassium result would not immediately alone with a normal creatinine and urine require referral to inpatient medical or nephrology team for admission in my opinion and it would be reasonable to check that these return to normal in a few days time*.'[177]

196. Ass/Prof Gock's report was that the treatment on 5 August 2009 was reasonable and appropriate. It was sound clinical reasoning to pursue a full blood examination and as Robena

[174] T 201, CB 65.
[175] CB 73.
[176] CB 89.
[177] CB 89.

was being treated for a UTI, an elevated white cell count could show that current treatment may be insufficient. He stated:

'*The most salient point with the biochemistry result on 5 August 2009 is that taken together with Dr Pearson's assessment that day was a patient seemingly at baseline. The biochemistry abnormalities were not sufficiently abnormal to require any immediate intervention in that context.*'[178]

There was no indication that the course of antibiotics was not adequately treating her urinary tract infection.[179]

197. Ass/Prof Gock surmised possible interpretations of the biochemistry results from 5 August 2009. He concluded '*biochemical abnormalities caused by medications seem the best fit*.'

198. In Ass/Prof Gock's view the treatment and discharge was reasonable. There were no particular indications for further investigations or admission to hospital. Robena was not in urinary retention.

199. In response to Associate Professor King's report the panel's view was that Robena's biochemical tests '*at best were mildly abnormal* …', the clinical assessment showed there was no evidence of dehydration, and was at odds with the biochemistry which is often recognised by '*pattern recognition by clinicians as common of what you might see in somebody that's dehydrated … because it's so common its often recognised as such …*'.[180] Associate Professor King's finding Robena had '*decreased renal function associated with not having passed urine*' was not accepted by the panel who did not find that Robena had decreased renal function or not passing any urine.[181] The panel did not accept that the blood results of 5 August 2009 suggested a marked decline in renal function. The clinicians view, taking into account her presentation, was that Robena '*essentially had normal kidney function*.'[182]

200. The panel disagreed with Associate Professor King and was of the consensus there was '*no particular reason to warrant admission,*' there should have been follow up and the discharge from hospital was appropriate.

[178] CB 161.
[179] CB 163.
[180] T 385.
[181] T 385.
[182] T 380.

Conclusion

201. The panel was of the view the medical treatment on 5 August was reasonable.

202. In her submission Mrs Mortimer summarised her concerns that on 5 August a simple urine test would have saved Robena's life, as would have an understanding of the significance of a mixed growth urine result, looking at multiple tests and results rather than one day's tests and an isolated temperature, and knowing the significance of the bowel X-ray.

203. The expert panel was of the view a further urine test was not indicated, and that the mixed growth results from the urine test on 31 July indicated a contaminated sample. Dr Dewan conceded the ED would not have a chart of Robena's 2009 results (along the lines of the one he produced) and the nursing and medical records indicate awareness of Robena's recent surgery and recent presentation on 31 July as well as diagnosis and treatment. Dr Pearson's evidence was the x-ray results were not changed.

204. I agree with the expert panel that the clinical indicators were not sufficient that Robena's admission to hospital was warranted on 5 August 2009. The assessment whether Robena should have been admitted to hospital can only be made with reference to her presentation during the seven hours she was in ED being observed and having tests. It is a logical fallacy to form the view that because her death was unexpected on 7 August 2009 Robena *should* have been admitted to hospital on 5 August 2009 as this conclusion does not follow logically from what preceded it.

205. With respect to what Robena's carers were told regarding her care and the regime to be followed at home, I find it most unlikely Dr Pearson used the phrase 'trial voiding' as indicated in Sue Young's statement, she had never heard of the phrase and Mr Leeworthy stated the same in his 2013 statement. In evidence, Mr Leworthy, was quite vague, which was not surprising given the passage of time. I accept Dr Pearson's evidence he gave the carers some oral instructions regarding Robena's care. However, whilst there is a note to '*encourage oral*,' a plan is not recorded in the medical records and communication was not sufficient to constitute a verbal care plan.

On 6 August 2009 was the medical care reasonable and appropriate in the circumstances of Robena's presentation?

What advice did Dr Agaskar provide Mrs Mortimer in respect of Robena's condition?

206. Mrs Mortimer was concerned about Robena on 6 August 2009. In the morning she stated she and Robena's carer Gary took her shopping and for a drive to Millgrove.[183]

207. That evening, Mrs Mortimer, in consultation with Robena's carer Michael, decided to call a locum doctor. At approximately 11 pm on the evening of 6 August 2009 locum doctor Dr Manish Agaskar attended Mrs Mortimer's house.

208. Dr Agaskar examined Robena. He noted her temperature was 36.5ºC, her chest was normal and *'her abdomen was soft on palpitation with no pain or resistance to examination*.'[184] He listened to her abdomen with a stethoscope '*and found her bowel sounds were normal in intensity and frequency*.'[185]

209. On the basis of the history and examination Dr Agaskar believed Robena was recovering from recent surgery and suffering from a urinary tract infection. *'I had not found anything in my examination to indicate that there was any serious or urgent condition present*.'[186]

210. He stated he explained two options to Mrs Mortimer; he could arrange an ambulance to take Robena to the nearest hospital ED for overnight observations, or the night duty carers could observe her fluid intake and if she did not manage to take fluids in the next two hours, to call an ambulance. He stated he discussed the options with Mrs Mortimer and the second option was chosen.[187]

Factual discrepancies

211. Mrs Mortimer recalled Dr Agaskar stating to keep the fluids up and to report to hospital ED if she deteriorates, but stated Dr Agaskar never mentioned calling an ambulance.[188] Dr Agaskar described that he took handwritten notes of each consultation and would enter these onto a computer when he got home, but prior to 9.00am the following morning. A screen shot of the

[183] CB 197.
[184] CB 24, Exhibit 10, which was amended to delete the third last sentence which referenced discussing Robena's management plan with Mrs Mortimer and two night carers.
[185] CB 24.
[186] CB 24.
[187] CB 24.
[188] T 274.

notes he entered was tendered.[189] The notes do not record the option to call an ambulance, but Dr Agaskar stated that was his usual practice.[190] Under treatment, the entry states: '*Observe, keep up fluids, if can't, report to hospital ED*.'

212. Mrs Mortimer stated Dr Agaskar listened to Robena's chest, took her pulse for a minute and her temperature '*and said it was 37.3 it's nothing to worry about and then he proceeded to close his bag and walk out and I said, 'You're not going,' and he said 'Yes I am*.'[191] With respect to discussing options for Robena's care, Mrs Mortimer stated:

'No, he [never][192] mentioned an ambulance. The only thing he [said] was keep the fluids up to her and I remember giving Michael a jug of water and a glass so that if she was disturbed during the night he could give her something to drink.'[193]

213. Dr Agaskar did not recall Mrs Mortimer telling him Robena was short of breath. He did not recall Robena as presenting as 'cold and clammy,' although he has noted her symptoms as 'Sweating, feels cold'[194] and that 36.5ºC was a normal temperature. He could not recall anything about the case to suggest he should have arranged an ambulance for Robena to attend hospital.

214. Michael Brand was Robena's overnight carer on 6 August 2009 commencing at 7.00pm. Although present when Dr Agaskar arrived, he was not party to any of the conversations between Mrs Mortimer and Dr Agaskar.

215. Mr Brand had some recollections of the evening, of Robena pulling her stoma out and, as '*Stephanie was asleep at the time, and Robena needed to be cleaned up. I assisted Robena into the shower and washed her, including cleaning out the stoma*.'[195]. When questioned by Mrs Mortimer he recalled Robena having reflux from the stoma bag, '*coming through her mouth and her eyes and it was stinking so I cleaned her up myself*.'[196]

216. There were discrepancies between Mr Brand and Mrs Mortimer's evidence, although both agreed Mr Brand waited with Mrs Mortimer for the locum doctor to arrive. Mr Brand recalled when he arrived the heater was on and it was stifling hot and when he arrived at 7.00pm and

[189] Exhibit 11 & the clinical details, diagnosis and treatment are replicated at CB 25.
[190] T 276.
[191] T 40.
[192] It appears the this may be a transcript error as this word is omitted.
[193] T 40.
[194] Exhibit 11.
[195] CB 28.
[196] T 219.

that Robena was awake, yelling and screaming rather than being in bed. He insisted he cleaned out the stoma bag and showered Robena.[197] Mr Brand believed he handed over the next day to Gary Leeworthy and denied ever having met Celeste who was in fact Robena's carer who arrived at 9.00am the next morning.

217. Mrs Mortimer denied Robena was screaming and stated Robena had been a lot quieter since Dr Serban had changed her medication. Mrs Mortimer denied Mr Brand ever showered Robena or cleaned out her stoma bag.[198]

218. I note these discrepancies only to illustrate how time and perspective can affect memory and recollection of the same events without any intention to misrepresent the truth. The discrepancies in evidence between Mrs Mortimer's and Mr Brand's recollection are not relevant to my assessment of events on the evening of 6 August 2009, but the discrepancies between Mrs Mortimer's recollection and Dr Agaskar's are. I accept Dr Agaskar's contemporaneous record entered on the evening of his consultation with Robena. Dr Agaskar made a note of Robena's temperature as 36.5ºC however Mrs Mortimer recalls he stated it was 37.3ºC. The difference between these temperatures is marginal, and both are within normal range. Although Dr Agaskar did not recall Robena being *cold and clammy* he noted her symptoms as *'sweating, feels cold*'. He did not recall nor note her being *'short of breath'* although Mrs Mortimer states she told him this. There is a discrepancy as to whether he offered the option to immediately call an ambulance: he states he did, (but it is not in his notes) and Mrs Mortimer states he did not. Even if he did not give this advice, I note it was always open for Mrs Mortimer to call an ambulance herself at that time for Robena if she felt it was warranted and did not require Dr Agaskar's imprimatur to do so.

219. I prefer the contemporaneous written record made by Dr Agaskar as to the clinical details entered and diagnosis and treatment. I accept his medical opinion that nothing recorded in his examination indicated or warranted urgent or different treatment.

7 August 2009

What was Robena presentation on the morning of 7 August 2009?

220. The next morning when Mrs Mortimer checked on Robena she was asleep. After Mr Brand left she checked Robena again and '*I thought, 'She's freezing cold. I'll put her in the bath*

[197] T 220.
[198] T 36.

when she wakes up.'[199] When Mrs Mortimer and Celeste walked into the bedroom, she described Robena as '*on the floor, and her limbs were all awry*.' Mrs Mortimer described herself as horrified, and originally thought to give her a bath to warm her up and then decided to ring an ambulance, pleading '*with the ambulance drivers to take her to the Alfred as they refused to treat her at the Angliss.*'[200]

221. Ms Celeste Walker worked as a support companion and carer for Robena two or three years prior to her death. Ms Walker clarified she had nothing to do with Robena's medical care.

222. In her statement Ms Walker described seeing Robena on the morning of 6 August 2009 and described her as 'conscious but catatonic.'[201]

223. On 7 August 2009 she arrived at 9am and described Robena as '*blue*' and that she collapsed in the hall, and '*Robena's breathing became shallow and progressively more blue around her face. I suggested Stephanie call an ambulance and Stephanie was suggesting Robena would be OK*.' Ms Walker recalled Robena as either in bed or sitting on the edge of the bed when she arrived.

224. Mrs Mortimer explained the ambulance staff arrived and she asked if they could take Robena to the Alfred hospital and they said:

'*You need to come with us,' and I said, 'No, I can't. I have to attend to Celeste's time sheet … I signed it for three hours. And then I got into the car and drove to the Angliss, and when I got there Robena was on a trolley on her own … in casualty … no one near her*'.[202]

225. An ambulance was called and when it arrived, Ms Walker described Robena as '*more blue and in my opinion appeared to be fading*.' Ms Walker stated she left Robena with the paramedics and declined to accompany her to hospital. She stated: '*While the paramedics were tending to Robena I recall Stephanie was on the telephone, I presume she was talking to the hospital as she was saying they had killed her sister.*'[203]

226. Mrs Mortimer queried Ms Walker's recollection she worked on 6 August 2009, stating on that day she and Gary took Robena on a drive to Millgrove.

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[199] T 42.
[200] T 42.
[201] CB 34.
[202] T 43-44.
[203] CB 34.

227. Ms Walker was unable to comment about whether the Ambulance driver used Mrs Mortimer's telephone to get permission for Robena be taken to the Alfred or whether Mrs Mortimer started to film Robena, stating '*I'll show them how sick she is*,' however she agreed on the day that Mrs Mortimer was very distressed and agitated.[204]

228. Dr Martin Koolstra is an emergency medicine physician and in 2009 was the Clinical Director of the Angliss Hospital Emergency Department. On 7 August 2009 Robena arrived via ambulance as a signal 1 case '*meaning the patient needed immediate attention.'* He stated Robena was:

'*… in a poor state. She was GCS 3 and so was unresponsive. Her blood pressure was low, at around 80 systolic, and the administration of metaraminol, an inotrope, had only a moderate effect. The nursing notes show her skin was cyanotic (blue), cold and clammy, indicating hypoxia. She continued to be hypoxic even with 15L of oxygen via a mask. Her oxygen saturations, a measure of the oxygen content of her blood, initially rose into the low 90s, and then dropped off again*.'[205]

229. Dr Koolstra stated:

'*… it was my view unless she was intubated and placed on a ventilator. She was likely to pass away … Ms Mortimer was clear that she did not want Ms Lloyd to suffer any further, and did not want her to be intubated or to go to intensive care. I have noted she said that Ms Lloyd's quality of life was very poor.*'[206]

230. Dr Kooltra gave evidence when Robena reached hospital she was placed in a resuscitation bay. He disagreed with a number of scenarios, namely that Robena was left on a trolley by herself, and that when he told Mrs Mortimer that Robena needed to be intubated he stated, *'You can't be with her.'* He stated that although he did not recall the specific conversation, it was '*highly unlikely to be true … In fact I'm a proponent of having family involved in the care of patients up to and including intensive resuscitation, CPR intubation and in general…*'.[207]

231. Mrs Mortimer stated when she reached the hospital and saw Robena on the trolley on her own, she described Dr Koolstra as running up to her and Dr Koolstra said to her, '*I'm going to intubate her,' and I said, 'I'll need to be with her.' He said, 'You can't be with her.*'[208]

[204] T 293-4.
[205] CB 186.
[206] CB 186-7.
[207] T 300-1.
[208] T 46.

Mrs Mortimer said to the nurse, Robena was not for resuscitation, just antibiotics, and denied having a conversation with Dr Koolstra about intubation, quality of life or Robena's end of life treatment.[209] *'He said I couldn't be with her when she was intubated, and I said she's three to five intellectually, and he refused twice. And so I said she's not for resuscitation.*'[210]

232. Mrs Mortimer disputed saying anything about Robena's quality of life to Dr Koolstra, which she stated was excellent. Dr Koolstra disagreed.[211]

Conclusion

233. Ass/Prof Gock was '*unable to completely reconcile the stable clinical picture of 5 August 2009 [with] the severity of presentation on 7 August 2009*.'[212]

234. With respect to her sudden deterioration, the panel was of the view sometime after 5 August 2009 Robena developed a blood borne infection, septicaemia, as there was no doubt her presentation on 7 August was for severe septicaemia, '*What we can't reconcile is what the precise source of that is*.'[213]

235. 'Sepsis' is a broad term that describes a clinical syndrome occurring as a result of a patient's dysregulated or exaggerated response to infection. Sepsis exists on a continuum of severity ranging from localised infection, such as in the urinary tract, to bacteraemia, where bacteria enter the blood stream, to sepsis and septic shock, which can lead to multiple organ failure and death. This process, depending on the virulence of the bacteria involved and the host's existing health, can result in rapid deterioration over a short period of time and carries a mortality of over 40 percent.

236. Robena's rapid deterioration between Dr Agaskar's assessment on the night of 6 August and her collapse on the morning of 7 August 2009, reflects the potentially rapid and irreversible nature of E.coli septicaemia.

Impact of Robena's intellectual disability and her medical care

237. Mrs Mortimer expressed her concern during the evidence that some of the medical records, (encompassing Robena's medical treatment at the Alfred, Maroondah and Angliss Hospitals

[209] T 47-8.
[210] T 48.
[211] T 307.
[212] CB 168.
[213] T 387.

during 2009)[214] referred to Robena having '*social admissions*' to hospital. Mrs Mortimer was of the view these references suggested Robena was not admitted to hospital for a medical purpose and carried an imputation that both she, as carer, and Robena were a '*nuisance*' to the hospital staff. Mrs Mortimer referred to work Dr Dewan had complied confirming that all Robena's admissions to hospital had a valid medical basis. [215]

238. Mrs Mortimer's other concerns related to Robena not being given pain medication, but rather sedatives instead of pain relief,[216] and the imputation in some of the medical records that Mrs Mortimer did not always adhere to Robena's medical management plan. As far as the evidence traversed some of these topics, I took it into consideration with regards to the inquest scope as it related to a consideration of the treatment of people with intellectual disabilities within mainstream medical practice.

239. In his evidence Dr Pearson apologised for any perception Mrs Mortimer had that she was seen as a 'pest' or that her concerns were dismissed, '… *it's not the values of Eastern Health. And we do put the patient first and obviously try and provide great care everywhere all the time*.'[217] Further, when Mrs Mortimer described Robena as in pain from a torted bowel, Dr Pearson expressed his disappointment she was not given adequate pain relief.[218] Mrs Mortimer stated Robena was given so many sedatives she ended up with pneumonia.[219]

240. In another example, Mrs Mortimer believed she had been accused of telling lies because a nurse (Gwen) rang the Crisis Assessment and Treatment Team that was visiting Robena every day and stated to them that Robena was *not* in urinary retention.[220] Further, Mrs Mortimer stated Dr Koolstra (on an earlier presentation) referred to Robena's bowel problems as '*all in her mind'* and that she was '*perserverating*'[221] about her bowels. Mrs Mortimer also stated Dr Koolstra said he would contact the Guardianship Board to have her removed as Robena's guardian and wrote that he had to '*reinstate*' Robena's medication.[222]

241. None of the evidence from Dr Phiri, Dr Pearson or Dr Agaskar indicated their treatment of Robena was sub optimal or influenced negatively by the fact she had a dual disability namely a mental illness and an intellectual disability.

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[214] Exhibit 28.
[215] T 465 and Mrs Mortimer's submissions, p 6.
[216] T 316.
[217] T 203.
[218] T 180.
[219] T 181.
[220] T 183. Exhibit 28 Medical records Appendix 2, p 148.
[221] T 49 'Perseveration' is repetitive and continuous behaviour, speech or thought that occurs due to changes in cognition skills such as memory, attention and mental flexibility. From www.synapse.org,au 26/7/2021.
[222] T 50.

Potential Prevention Opportunity

What are the risks and barriers for people with an intellectual disability accessing mainstream health services and receiving equitable care and treatment?

242. Professor Julian Troller prepared an expert opinion at the request of the court. Dr Troller is a neuropsychiatrist, with 25 years of clinical experience treating people with intellectual or developmental disabilities and complex health needs, and over 30 years' experience as a medical practitioner. Professor Troller's evidence set out the areas where services provided to those with intellectual disabilities and their families can be vastly improved.

243. Professor Troller's report noted Australians with intellectual disability have a reduced life expectancy and elevated comparative mortality rates that exceeds other groups in society with health disadvantage. Most of the health disadvantage is unrelated to aetiology of the intellectual disability and in NSW the average life expectancy is 54 years, versus 81 years for the general population, representing a 27-year life expectancy gap. Professor Troller also noted younger onset frailty, in that those over 50 with intellectual disability have similar rates of frailty as the general population over the age of 75.

244. Relevant to this case, Professor Troller noted Australians with intellectual disability are overrepresented in the health service system, with:

'*1.6 times the rate of emergency department use compared to people without ID and were more likely to present into the health system via emergency department presentation suggesting poorly managed primary care needs*.'[223]

He also raised relevant issues including the absence in mainstream health and mental health services of clearly defined clinical care pathways, a lack of skills or resources to make 'reasonable adjustments' to support inclusion of the persons with a disability in their health care journey, inadequate training for student nurses and doctors in understanding the specific health care needs of people with intellectual disability and little formal training for ED registrars and physicians. Professor Troller also referenced poor access by people with intellectual disability to preventative health care, hampered by models of practice in primary care, such as inadequate Medicare Benefits remuneration for GP's when they see people with intellectual disability and complex conditions in prolonged consultations.

[223] CB 247.

245. Professor Troller noted people with an intellectual disability experience one of the greatest health disadvantages of any population group in Australia. He quoted the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a disability which has made the substantive finding:

'*the evidence justifies the Royal Commission finding that people with a cognitive disability have been and continue to be subject to systemic neglect in the Australian health system. We make that finding*.'[224]

246. In his evidence Professor Troller noted:

'*that overall a very high proportion of deaths for people with intellectual disability were potentially avoidable and that the proportion of deaths that were potentially avoidable was about double that of the general population*.'[225]

A 'potentially avoidable death' is one occurring for people under the age of 75 when medical intervention or access to healthcare could have prevented the death occurring.

247. Professor Troller also gave evidence about *'overshadowing,'* which means when a person's disability is seen first, and health needs remain unrecognised. This may be because the health care professional has had little or no training in the area and may not know how to adjust their clinical approach to communicate effectively. Pain might be expressed as heightened distress, or self injury or irritability and someone who is inexperienced 'may conclude that this change in behaviour relates to the disability, and not to her health condition.[226]

248. This issue was reflected in evidence from Mrs Mortimer that she often felt Robena was sedated rather than receiving appropriate pain relief.

249. With respect to training Professor Troller stated there was very little specific content around the health needs of people with intellectual disability in nursing and medical courses nationally, and a recent audit revealed over 20 years there had been no improvement in content and in some instances gone backwards. Further, despite a higher proportionate representation in emergency departments, staff would have received little or no content in their professional training directly relevant to people with intellectual disability. His data shows people with intellectual disability have to wait longer to be seen for similar acuity conditions and are more likely to leave before being seen.

[224] CB 249.
[225] T 482.
[226] T 488.

250. Professor Troller estimated 40% and up to 60% of people with intellectual disability also have a mental illness, so it is two to three times as common compared to the general population including core mental health conditions such as schizophrenia with a slightly earlier onset in people with intellectual disability.[227] He also noted overall there seemed to be a greater vulnerability to infection, however this might be related to context factors such as general frailty or living conditions.

251. Mrs Mortimer gave evidence that she was treated as a nuisance, '*They treated me as if I'd tell a lie about her health, that I wasn't credible. They referred to the admissions as social admissions*.'[228]

252. The other effect of feeling like a *nuisance* was that Mrs Mortimer stated it made it difficult to return to the hospital and Professor Troller agreed this happens often reflecting lack of skills and training of health staff.[229]

253. Mrs Mortimer reiterated her desire for a designated 15 bed facility at the Dual Disability unit at St Vincent's hospital 'so *no other person with a dual disability or their family is ever treated like this again*.' [230]

254. Professor Troller advised that physical signs can be absent or different and gave an example of a patient with a gall bladder infection and sepsis who presented with a low temperature*, 'So she was hypothermic instead of hyperthermic.'*[231] He went on to explain that:

> *'…sometimes there's impaired regulation at a central level of temperature and response to things like infection, which means that not necessarily all the signs are present when someone's evaluating the severity of things like infection or the risk of sepsis.'*[232]
>
> He added that is about being able to put the bits of the puzzle together, 'because medical practitioners rely on key science, key symptoms.'[233] This means, sensitive to these factors, he stated, '*I might make a slightly different clinical decision than I otherwise would have for a person without intellectual disability and complex health needs*.'[234]

[227] T 495.
[228] T 49, 52.
[229] T 503.
[230] Submission in reply from Mrs Mortimer p 2.
[231] T 504.
[232] T 504.
[233] T 504.
[234] T 505.

255. In response to Professor Troller's evidence, Eastern Health detailed the implementation of a Disability Action Plan and training for staff when dealing with patients with a disability. [235] Eastern Health also positively referenced Professor Troller's evidence about the '*reasonable adjustments*' provision in the UK Equality Act. This relates to the legal and practical obligation to make reasonable adjustments in service provision when medical staff encounter a person with disabilities. Eastern Health outlined a few examples they could be adopt for people with intellectual disabilities, such as priority appointments, longer appointments and relevant staff training. I note the *Equal Opportunity Act* 2010 (Vic) has a 'reasonable adjustment' requirement regarding the provision of services. I presume this includes health services, to ensure health professionals and services meet the needs of people with disabilities to the greatest extent possible in their health care journey.

256. In light of Professor Troller's evidence, the Royal Commission's finding and the experience detailed by Mrs Mortimer as feeling 'like a nuisance' when seeking medical assistance for Robena, I intend to make recommendations regarding training for health professionals. Professor Troller reported to the Royal Commission that '*Three audits highlight that at present, the majority of future nurses and doctors will graduate with inadequate or no understanding of the specific health care needs of people with intellectual disability. Without the development of targeted strategies to address this issue, the health inequalities experienced by this population are likely to continue.*' [236]

257. I also take into account Mrs Mortimer's evidence and written statement referring, at the time of de-institutionalisation some thirty years ago, to the promise of a 15-bed in-patient facility for intellectually disabled people with dual disabilities to receive appropriate medical care. Whilst I have not been able to locate the relevant announcement from the time, I note when Mrs Mortimer raised it, Professor Troller was approving, and I intend to make a recommendation to the Health Minister to re-visit this proposal.[237]

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

258. I recommend the **Secretary of the Victorian Department of Health** gives consideration to formulate an action plan to mandate skills training for health professionals in the private and

[235] Received 3 March 2021 and distributed to the interested parties.
[236] Professor Troller's submission dated 11 February 2020 to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability p 37.
[237] In his submission dated 11 February 2020 to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Professor Troller noted '*Access to specialised intellectual disability health services in Australia is currently very limited … Where they do exist, specialist services form a very valuable component of comprehensive health services for people with intellectual disability*', p 36.

public health care sectors about the health needs of people with intellectual and other cognitive disabilities to address the lack of specific content around the health needs of people with intellectual disability in nursing and medical courses in this State, given Professor Troller's evidence at paragraph 256 that a recent audit revealed over 20 years there had been no improvement in content, and in some instances it had gone backwards.

259. I recommend the **Victorian Health Minister** give consideration to the establishment of a 15-bed facility (possibly as part of the Victorian Dual Disability Service), for in-patient services for people with dual disabilities, including intellectually disabled adults like Robena, along the lines originally announced so that their medical needs can be addressed when they are ill.

FINDINGS AND CONCLUSION

260. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Robena May Lloyd, born 20 December 1950, died on 7 August 2009 at Angliss Hospital, 39 Albert Street, Upper Ferntree Gully, Victoria, from enterococcus faecalis sepsis and acute renal failure in the circumstances described above.

261. Pursuant to section 73(1) of the *Coroners Act 2008* I direct this finding be published on the Internet.

262. I convey my sincere condolences to Robena's family for their loss.

263. I direct that a copy of this finding be provided to the following:

Mrs Stephanie Mortimer, Senior Next of Kin

Eastern Health (care of Minter Ellison)

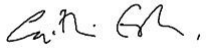
Dr Manish Agaskar (care of Avant Law Pty Ltd)

The Hon. Martin Foley, Minister for Health

Professor Euan Wallace, Secretary, Department of Health

Acting Sergeant Tracey Ramsey, Victoria Police, Coroner's Investigator.

Signature:



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CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 2 September 2021