QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Shane Paul Krog**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Caloundra
FILE NO(s):	COR 2006/61
DELIVERED ON:	13 August 2012
DELIVERED AT:	Caloundra
HEARING DATE(s):	28 February – 11 March 2011
FINDINGS OF:	Coroner Taylor
CATCHWORDS:	CORONERS: Inquest – Death in a medical setting, appropriateness of medical care, policies and procedures.

REPRESENTATION:

Counsel Assisting	Mr John Tate, Crown Law
Dr Patrick Beck	Ms RS Dune i/b Middletons
Director of Nursing Kelly	
Registered Nurses Crawford & Kruger	
Enrolled Nurses Clancy & Robarts	Ms S Robb i/b Roberts & Kane
Queensland Health	Ms SL Miller i/b Crown Solicitor
Dr Patrick Lip	Mr A Luchich i/b Flower & Hart Lawyers

I find on the evidence before me as follows:

(a) the name of the deceased person to be Shane Paul Krog

(b) the deceased person died after initially being admitted to the Murgon Hospital, a primary care facility, via ambulance suffering from a suspected narcotics overdose

During the course of the deceased's hospital admission he was the subject of regular neurological observation by nursing staff and medically ordered tests which included a chest X-ray, a cardiograph; urine drug screen; blood sugar level; full blood count; electrolyte and liver as well as medically ordered administration of intravenous fluids, Narcan, Ventolin and Atrovent and saline.

The deceased was also belatedly medically examined and assessed by the Murgon Model of Care on-call doctor, namely, Dr Lip, and further upon receipt of the deceased's blood test, Dr Lip made the overly focused clinical judgment that the deceased was suffering from rhabdomyolysis. Hence, and regrettably with hindsight, the deceased was not transferred to an intensive care unit as the deceased presented overall to Dr Lip to be clinically stable, albeit that his blood tests were abnormal and he had low blood pressure.

Subsequently, the deceased cardiac arrested. However, despite valiant resuscitative attempts being made in the main by intensive care paramedic Alexander, the deceased passed away.

(c) the deceased person died at 7.57 pm on Tuesday the 22 August 2006

(d) the deceased person died at the Murgon Hospital, Coronation Drive, Murgon in the State of Queensland

(e) the cause of death certified by Dr Milne, a specialist forensic pathologist to be:

(1) (a) morphine toxicity;
(2) ischemic heart disease, coronary arthrosclerosis and, of course, rhabdomyolsis.

It should be firstly said by way of background, the deceased was located by his wife, Lesley Anne Williams at approximately 6am on the 22 August 2006 lying in their bed in the bedroom of their residence situated at 37 Beresford Street at Proston in an unresponsive state and without breath.

In consequence, the deceased wife attended at her next door neighbour's residence and called upon Mr Brown for assistance. Mr Brown hastily attended at the residence and after making a quick examination of the deceased and noting his non-responsive condition, requested that Ms Williams contact Triple O which she did at 6.49 am.

Whilst awaiting the arrival of ambulance personnel, Mr Brown commenced operator directed CPR upon the deceased. Advanced Care Paramedic Bond from Proston Station was first to attend at the scene at 6.56 am and upon examination of the deceased, a very large man weighing approximately 100 kilograms, he found him to be unconscious, that is, he had a Glasgow coma score of three with inadequate respiration, his airway was obstructed with vomit and he had pinpoint pupils.

Further, as he was assessing the deceased for his respiratory status, Ms Williams informed him, amongst other things, that she thought some of her MS Contin, a narcotic pain management drug medication which had been prescribed to her for her chronic pain condition may be missing.

Advanced Care Paramedic Thompson arrived at approximately 7.15 am to assist and after consultation with that officer, Paramedic Bond made a decision to treat the patient as a narcotic overdose. Hence, at 7.30 am, he administered 400 micrograms of Narcan, a narcotic used to reverse the effects of a narcotic overdose by intramuscular injection to the deceased's shoulder.

Of necessity, a further 400 micrograms of Narcan were similarly injected at 7.40 am and as a result the deceased's condition improved to the extent he was able to walk with assistance from his bedroom to the ambulance stretcher. The deceased was then placed in the ambulance and at 8 am he was given another 400 micrograms of Narcan injection. At this stage Paramedic Bond noted the deceased was fully conscious, that is, he had a Glasgow coma score of 14, but was slightly confused.

Shortly thereafter, ambulance officers commenced transportation of the deceased along with his wife to the Murgon Hospital and at the 8.20 am mark, Paramedic Bond contacted registered nurse Seiler at the Murgon Hospital and advised they were en route to the hospital with a narcotic overdose patient, who was at that time, conscious with adequate vital signs.

At 8.39 am the occupants of the ambulance arrived at the hospital, which is a 15 bed rural facility with a 24 hour emergency department whereupon Paramedic Bond instituted a verbal formal handover of the deceased to the Murgon Hospital through Registered Nurse Seiler. The deceased was then taken by Paramedic Bond directly by ambulance stretcher into the high dependency ward/room, which was directly opposite the nurses' station. That particular room is normally used for patients suffering, for example, trauma; cardiac difficulties needing close monitoring and head injuries who were destined to be transported to a larger facility.

At 8.45 am triage of the defendant was commenced by the hospital Director of Nursing Ms Kelly, whereupon at approximately 9 am he was assessed as being a triage category 2 patient, that is, in accordance with the Australian Triage Scale and South Burnett Health District Policy and Procedure Manual Policy document of July/August 2006. Ms Kelly was required to notify Dr Lip of the assigned triage category to enable Dr Lip to then assess and treat the deceased within what was, in the given circumstances, perhaps, an unrealistic timeframe of 10 minutes.

Ms Kelly accepts she did not advise Dr Lip of the deceased's triage category when she telephoned him at 9.30 am on that relevant date. But in any event at approximately 8.55 am, registered nurse Alderman, an agency nurse, assumed primary care responsibility for the deceased, that is, she stayed at the deceased's beside between 7 am and 3 pm save for brief times she had to absence herself from the room, as she had been informed by Ms Kelly the deceased had taken an overdose, thus there was a need for her to ensure careful observation of him.

As a result of that directive issued by the Director of Nursing, Nurse Alderman assessed his blood pressure, which was very low, 70/40; oxygen saturations; pulse; temperature and his state of consciousness. She continued to regularly monitor the deceased throughout the day via the completion of a neurological observation sheet, which included taking the deceased's blood pressure; pulse and respiration every 15 minutes; his temperature every one to two hours.

At the outset, she placed an oxygen non re-breather mask on the deceased to assist him with his oxygen saturations and during this time, the deceased was continually trying to stand up so that he could go to the toilet as he was having difficulty in passing urine.

Also during the course of the morning, Nurse Alderman ensured the deceased was continuously administered oxygen by way of a non-breather mask. He was cardiac monitored and his legs were raised in an attempt to increase his blood pressure. Whilst Nurse Alderman was attending to her special nursing duties, her Director of Nursing at the time was continually checking on the deceased. In accord with usual hospital practice, the Director of Nursing contacted Dr Lip by telephone at approximately 9.30 am and informed him of the following:

(1) the history of events leading up to the deceased's arrival at the hospital including resuscitation and observations made by the relevant ambulance officer at the scene

(2) the content of the neurological observation sheet to date

(3) specifically the deceased's blood pressure which was 70/40

(4) that there was some thought the deceased had admitted taking MS Contin, 60 mg and two Diazepam tablets

(5) the deceased’s past medical history including a myocardial infarction at age 32 and the deceased had recently been prescribed Zyban, a drug to help people stop smoking

(6) the deceased’s prescribed cardiac medications

(7) that the deceased had been to a party in Toowoomba on the weekend prior to the 22 August 2006 and he had been binge drinking and over the weekend he had been vomiting and was quite nauseated, such that he had not quite been himself since that time.

This particular information about the binge drinking was obtained directly by Ms Kelly from the deceased's wife. By this time Dr Lip, who was relevantly the Murgon Model of Care on-call doctor whilst the Wondai Hospital was temporarily closed for redevelopment had undertaken his ward rounds at Murgon Hospital and had commenced seeing his private patients at his busy Wondai practice.

Now, as a result of his telephonic conversation with Ms Kelly, he had informed her he needed to know the deceased's blood sugar level reading and in addition, he ordered a chest X-ray be taken; an electrocardiograph be performed; a urine sample to be taken for drug screening and as the deceased was having difficulty in passing urine, that a catheter be inserted. In turn, Nurse Alderman performed an ECG and blood sugar level.

At approximately 9.45 am, Nurse Alderman noted the deceased's blood pressure had dropped to 50/35, thus she spoke to Ms Kelly, who in turn contacted Dr Lip at his private surgery at approximately 10 am and advised him of the deceased's low blood pressure and that his blood sugar level was 11.4. In consequence, Dr Lip ordered one litre of normal saline to be administered to the deceased over a 10 hour period, that is, 100 millilitres per hour.

Dr Lip also ordered that bloods be taken for a full blood count and electrolyte and liver function tests and that the ECG results be faxed to his surgery. It seems there is uncertainty as to when exactly the ECG results were faxed through to Dr Lip and by whom and there is disputation over the period in which the saline should have been administered. Dr Lip's recall was that it was two hours but, in any event, Dr Lip did in fact receive those ECG results at his surgery, which showed a non-specific intraventricular block and sinus arrhythmia, which assisted him to form a preliminary overview of the deceased's medical condition as being somewhat hypervolemic thus he wished to see the effectiveness of the intravenous saline on the deceased's blood pressure.

At approximately 10 am, the deceased's wife contacted the surgery of their own doctor, being Dr McAllister, and advised the reception of what had happened to her husband; therefore, they would have to cancel their scheduled 2.45 pm appointment for that very day. Ms Williams also observed at this stage, amongst other things, that her husband was very tired, that is, he was falling in and out of sleep continuously.

At approximately 10.10 am, Nurse Alderman inserted the indwelling catheter and although not documented by her at this stage, approximately 600 millilitres of fluid drained from the deceased. At 10.30 am, Nurse Alderman commenced to administer the saline intravenously in accordance with Dr Lip's order whilst at about that same time, the relevant urine test was undertaken by Enrolled Nurse Clancy via bottle collection where she found the deceased's urine contained a large amount of blood, such that she informed Nurse Alderman of that fact.

At 10.45 am, Nurse Alderman took the relevant bloods and then handed both the bloods and the urine specimen to Ms Kelly for pathological dispatch. In approximately mid-morning, Ms Kruger, a registered nurse from Cherbourg and the holder of a

limited licence to undertake chest X-rays and limbs, attended at the hospital to X-ray the deceased, however, she found the deceased was unable to be moved from his room, thus, she had to resort to the use of a portable X-ray machine.

The deceased at this time was pale, unable to comprehend her instructions and he appeared to have no coordination or control of his body. As he possessed a large stomach, she was unable to obtain a clinically useful X-ray imagine, because he could only be sat half upright rather than be in position lying down or sitting straight up.

Contextually Ms Kruger suggested to the director of nursing that perhaps the deceased needed to be transferred somewhere else, that being in her mind, Kingaroy, so that primarily a better image could be obtained. At approximately 12 midday, the deceased's wife made telephone arrangements with the Proston bus to collect her at the hospital at 2.40 pm that day so that she could go home to her residence to organise to have their car available to take the deceased back to the residence should that be necessary.

At 12.30 pm the deceased's state of consciousness commenced to dip slightly, however, he continued as he had done so from his admission, to remain orientated; obey commands and have normal eye reaction and limb movement, albeit that during the course of the morning he became increasingly drowsy, that is, he had his eyes closed, but was easy to rouse, but the persistent concerning feature was the deceased's low blood pressure.

At 12.52 pm, Mr Lewis, a medical scientist attached to the Kingaroy Hospital received samples of the deceased's blood and urine for analysis from the Murgon Hospital. The requested analysis was for a full blood count and liver electrolyte and mid-stream tests. After the relevant analysis had been completed, Mr Lewis noted, amongst other things, that the deceased's potassium level was excessively high which suggested to him the deceased may be suffering from some type of renal failure.

It would appear that at about 1 pm Dr Lip received during what would otherwise have been his lunch hour, a further ECG result which showed no sign of change. In addition, he received a phone call from the Wienholt Nursing Home at Wondai requesting his attendance to see a nursing home patient who was suffering a fever. In consequence, Dr Lip attended the nursing home and after conducting a short examination of the patient, he prescribed medication and then proceeded to the Murgon Hospital.

At 1.30 pm Nurse Alderman found that the deceased continued to be hypotensive around 60 to 70 over 30; he was sweaty and clammy and responded to verbal stimuli, but he only managed to keep his eyes open for a few seconds before closing them again and his urine was concentrated. Also about that time, Nurse Alderman had extreme concern about the deceased's continuing low blood pressure, which prompted her to directly contact Dr Lip by telephone at his private surgery in Wondai and during the course of that ensuing conversation she queried whether the deceased would benefit from another fluid bolus.

Accordingly, Dr Lip ordered a further one litre of normal saline, this time over two hours with return thereafter to the 10 hour rate.

It should be said at this juncture that it seems somewhat unclear that Nurse Alderman in actuality asked Dr Lip to attend the hospital because of her express concern.

At about 1.40 pm Ms Kelly had occasion to contact her line manager, Mr Potter, the District Director of Nursing for the South Burnett Health Service about the deceased's medical condition and during that conversation, amongst other things, she informed Mr Potter that she was unable to contact Dr Lip.

In turn, Mr Potter immediately contacted his line manager, Ms Hood, who was, at that time, the district manager for the relevant health service and shortly thereafter a telephone link conference was held, which involved Ms Hood, Mr Potter and Ms Kelly.

During the course of that teleconference call, Ms Kelly informed each of them of the deceased's medical condition and the number of times she had contacted Dr Lip to express her concerns about the deceased's low blood pressure. Ms Hood then advised Ms Kelly to assess the deceased after the hour bolus and if there was no improvement, then Ms Kelly should telephone Dr Lip again and advise him of the deceased's triage code two and ask Dr Lip to come and see the deceased.

By about 2 pm it was evident to Nurse Alderman that the deceased was becoming increasingly drowsy and difficult to rouse. His blood pressure registered 74 over 38 and he had a Glasgow coma score of 14. Also at 2 pm Ms Kelly, after herself having assessed the deceased as requested by Ms Wood, in finding that his condition had deteriorated, that he was clammy; his blood pressure had not improved and he had become more difficult to rouse, then telephoned Dr Lip and informed him of that fact. Dr Lip indicated to her that he would come to the hospital, thus she did mention to Dr Lip that she had categorised the deceased as a triage two patient.

At 2 pm Mr Lewis received a request from the director of nursing, being Ms Kelly, for a further urine drug screen analysis in accordance with laboratory practice. That was sent to Brisbane and as he does not receive the results back, they go direct to the hospital.

At 2 pm with prior agreement, the director of nursing, Nurse Alderman, erring on the side of caution, administered only a hundred micrograms of Narcan to the deceased. This in turn had a moderate result upon him. Nurse Alderman also at that time had administered Ventolin nebuliser five milligrams to the deceased upon verbal order by Dr Lip.

Between 2 and 2.30 pm, Dr Lip accompanied by his rural replacement medical student from the University of Queensland, Dr Renoud, and with Nurse Alderman and the deceased's wife present, attended upon the deceased in the high dependency unit/room to review/assess the deceased's medical condition.

By the time that Dr Lip arrived over five hours later, Ms Williams had noticed as the day progressed that her husband's breathing was not getting any better, he had become more tired and was harder to rouse. Ms Williams had to leave, as previously arranged, partway through her husband's medical examination process, however, during that time she noted her husband was so tired that he kept falling asleep and was not particularly coherent or alert and that when physically examining her husband, Dr Lip was very rough.

As she was leaving the high dependency room, Dr Lip instructed her not to give her husband any blood pressure tablets the following morning, hence, she formed the view that her husband was going to be released from the hospital at some stage. The deceased informed Dr Lip during the course of taking his medical history that he had previous ischemic heart disease and low blood pressure and that he had experienced cold/flu like symptoms for the last few days so that he had taken Panadeine Forte Ibuprofen and two only of his wife's 60 milligram MS Contin tablets.

The deceased also at that stage informed Dr Lip that his usual medications were Sertraline, the Panadeine Forte aspirin, Lipitor and Gemfibrozil and Diazepam and that he had taken the additional medications to help relieve his cold/flu symptoms and a sore neck. The deceased had taken the MS Contin for his sore back and neck the night before so that he could get some sleep.

In addition, the deceased informed Dr Lip that he suffered from sleep apnoea and was concerned about his health, but that he had no suicidal intentions. On examination, Dr Lip noted the deceased was a big man, that is, obese; that his blood pressure was 70 over 40; his pupils were pinpoint, but equally reactive both direct and indirect; his neurological signs/sensations were satisfactory; he was cooperative; talkative; lucid and able to give good details of his health and medications.

Dr Lip also noted that the deceased was weak when moving in bed. Further, Dr Lip found the deceased's cardiovascular and abdomen were normal; his reflexes were within range. He had a slight chest wheeze and his straight leg raises were up to 70/80 degrees given his previous back problems.

Upon reviewing the neurological observation sheet, Dr Lip formed the view that the deceased had low blood pressure, his pulse was fairly regular and his level of consciousness fairly normal which was consistent with his findings at examination. Dr Lip also ordered that all medications except Aspirin, Lipitor and Gemfibrozil cease and that the deceased be administered Ventolin nebuliser five milligrams four hourly and Atrovent nebuliser six hourly for his slight chest wheeze.

Dr Lip, had by this stage, formed the opinion in his own mind that there was a strong possibility the deceased was suffering from rhabdomyolsis. During the course of the deceased being assessed by Dr Lip, it was Dr Renoud's observation the deceased was rouseable, but mildly groggy and that he talked coherently and understood and responded to questions whilst the deceased appeared to Nurse Clancy to be really bright and talking to Dr Lip as she walked past the intensive care unit at those times.

After entering his basic findings in the inpatient progress notes, Dr Lip returned with his medical student to his surgery at Wondai where he continued patient consultation. It should be said that during the course of his attendance upon the deceased at the hospital, Nurse Alderman was given rather forceful instructions by Dr Lip to administer the remaining 300 micrograms of Narcan which she did.

At 2.30 pm Registered Nurse Duthie, an agency nurse, commenced what was her first day's duty at Murgon Hospital. She ultimately was handed the primary nursing care role for the deceased, somewhat unusually, by the Director of Nursing, Ms Kelly, through Nurse Alderman and then Nurse Crawford. According to Nurse Duthie she was never informed at any time that she would be required, as such, to provide one on one care for the deceased such that she would have to remain in his room 24 hours a day.

The handover process in relation to all patients, including the deceased's, lasted for 20 minutes with the involvement of her other shift colleagues being Registered Nurse Crawford also an agency nurse and Enrolled Nurse Robarts. It became obvious to Nurse Duthie during the handover process that both the Director of Nursing Ms Kelly and Nurse Alderman were somewhat frustrated/distressed that the deceased was not the subject of transfer to a larger facility primarily because of his low blood pressure, albeit that during the course of their handover, the deceased was actually being reviewed by Dr Lip.

Subsequently, Nurse Duthie conducted her own full physical examination of the deceased where she found he had low blood pressure, with a Glasgow coma score in the vicinity of 11, which suggested to her that he should be transferred to another hospital. She then reported her findings to Ms Kelly, in addition she informed Ms Kelly that she thought the deceased should be transferred to another hospital and that she was not comfortable looking after the deceased in his current condition as she had formed the view that he was going to crash.

In response, Ms Kelly emphasised a number of times that she should ensure all her documentation was up to date and in that regard it was accepted by Nurse Duthie that she did not fully comply with that instruction as she had an extremely busy shift load especially caring/managing three of her own patients that had been allocated to her out of a total of some eight to 10 patients who were otherwise not high dependency patients in the hospital at that time.

But in any event, consequentially, she and/or Enrolled Nurse Robarts, who she oversaw, continued half hourly and then hourly neurological observations of the deceased, rather than the 50 minute neurological observations of the deceased that had been conducted earlier in the day, albeit that it was Enrolled Nurse Robarts who actually took the relevant observations and entered that data into the hospital record as part of a team framework.

It may be appropriate to say at this point that Ms Duthie accepts she did not in fact at any time during the shift actually look at the neurological observation sheet entries made by Ms Robarts to ensure their accuracy.

Curiously, and as I understood it, Nurse Duthie's practice which apparently, in her view, is not an unusual nursing practice and one which she adopted on the occasion of caring for the deceased, was rather than make contemporaneous notations in the inpatient progress note section of a hospital patient's file, she would make entry notes in an unofficial notebook as to the patient's medical condition, etc, from time to time and any phone calls she made in relation to a patient, for example, to a doctor so that prior to the completion of her shift she was able to use those notes as a prompt to ensure that elaborate and flowing details are made in the inpatient progress notes.

At 3 pm Mr Lewis contacted Nurse Alderman and advised of the results of the analyst testing and that they were printing through to her at the hospital. Once Nurse Alderman had those concerning results to hand, she showed them to the Director of Nursing and then Nurse Alderman immediately faxed the results to Dr Lip's surgery at 3.15 pm. By about 3.20 pm Dr Lip had received those relevant faxed pathological results which indicated to him that the deceased had, amongst other things, a high potassium level as well as a minor degree of dehydration.

Ms Kelly had occasion at that stage to telephone Dr Lip herself to ensure he had received the pathological results she had previously viewed, such that she felt immediate concern for the health status of the deceased, that is, the deceased was seriously ill and should be transferred.

Dr Lip informed her he had not seen the results she was talking about, but would look for them and then phone back. At approximately 3.30 pm Nurse Duthie and Enrolled Nurse Robarts commenced actual ward duty. Some time after 3 pm, it seems off-duty Nurse Duthie contacted Dr McAllister at his surgery in Murgon as the deceased was one of his regular patients to ascertain what the deceased's usual blood pressure was.

She also advised Dr McAllister that the deceased had probably taken a narcotic overdose and his conscious state had deteriorated in spite of the administration of two doses of Narcan to reverse it and his blood pressure was in the vicinity of 70 over 40 and had been extremely low since his admission and further, an IV had been inserted and Dr Lip had ordered fluid at a certain rate, which on Dr McAllister's recall was very conservative, that is, inferentially one litre of intravenous fluid over 10 hours.

Dr McAllister responded by advising Nurse Duthie that the deceased's blood pressure ranged between 110-120 systolic and 60 to 80 diastolic and that it would be his opinion that given the details provided to her the deceased probably needed more aggressive resuscitation, that is, intravenous fluid intake into the deceased's circulatory system needed to be increased to bring his blood pressure up. It should be added Dr McAllister was never requested at any stage to intervene in the deceased's treatment including that he should be transferred to another hospital.

At approximately 4 pm it would appear a decision was made by Nurse Duthie to move with at least the assistance of enrolled nurse Clancy, the deceased from his high dependency room to the children's ward of the hospital, as she had been alerted

that particular room may have to be used to house a female 14 year old drug overdose patient, but as it turned out, that particular patient did not present to the hospital, therefore, the deceased was shortly thereafter returned back to the high dependency room.

It would appear also at about 4 pm that Ms Kelly again contacted Mr Potter after she had ensured Dr Lip had received the relevant pathology results, as she was concerned about their content, such that her belief was that the deceased should be transferred. Seemingly, Mr Potter was in concurrence, but it was his view the nursing staff should await Dr Lip's decision as he was the treating doctor.

Further, at 4 pm, Dr Lip did indeed telephone the hospital and spoke with Nurse Alderman about the relevant pathology results. He stated to Nurse Alderman that they presented as a typical dehydration picture, thus he ordered that he be given more water to drink, his intravenous fluid be maintained at 10 hourly rate and to repeat his bloods in the morning. Dr Lip accepted in hindsight the first two orders did not constitute appropriate treatment for the deceased.

At approximately 4.20 to 4.30 pm Nurse Duthie telephoned Dr Lip at his surgery and explained relevantly the deceased's blood pressure was 60 over 35 and that he had not voided at all over 2.5 hours. In response Dr Lip asked if the deceased's tongue was dry and upon her informing him that it was, Dr Lip ordered increased intravenous therapy of a thousand millilitres over two hours and then another thousand millilitres over 10 hours.

It would also appear that Dr Lip at that stage ordered the withholding of the deceased's Lipitor, which is for heart/blood pressure and Gemfibrozil, which is for cholesterol medications as it was his medical understanding that those medications used in combination could cause the condition he suspected the deceased was suffering from which was rhabdomyolsis.

During the course of that conversation, Ms Duthie alleges that Dr Lip hung up on her midsentence, but accepts that she had not documented that anywhere. She also accepts that she could not now say with any certainty that she expressed her concern to Dr Lip, the deceased should not be at the hospital or that he should be transferred out.

It would also seem that late in the afternoon Dr Lip requested that the Kingaroy Pathological Laboratory perform a pharmaceutical test and it was a test on the blood of the deceased. At approximately sunset, but still being within daylight hours, the deceased's wife returned to the hospital via her own vehicle whereupon a nurse attempted to wake the deceased to let him know she had returned, but he did not respond. Ms Williams also let the deceased know that she was back.

Ms Williams, at that time, found the deceased still to be sweating profusely, thus she wiped sweat from his face with a tissue. A nurse then came into the room, so Ms Williams inquired of her the reason why there was no change in her husband's condition and the nurse replied that they were doing all they could with the information they had about the deceased and they were trying to flush his system

with saline and that the deceased was on his third bolus and they were now waiting for him to come good.

At approximately 6.15 pm Dr Lip had ceased consultations at his surgery and at approximately 6.30 pm proceeded with his medical student by motor vehicle to the Kingaroy TAFE College to attend a continuing medical education lecture. It seems somewhat unclear thereafter as to what may have transpired until the arrival of Advanced Paramedic Alexander and perhaps that is understandable given the traumatic and tragic circumstances that followed, but in any event, doing the best I can and placing more reliability relevantly on the version of events in the main as depicted by registered nurse Crawford and that of the deceased's wife.

It can be said, perhaps with some certainty, that between 7 pm to 7.10 pm Enrolled Nurse Robarts found the deceased's condition initially at least to be stable, save the deceased's pupils were 04 and reacted to light, that is up from the 2.

Now, a short time later the deceased's wife observed, amongst other things, that her husband's breathing had become shallower, hence, she asked him if anything was wrong. The deceased responded by looking up at her, fixing his eyes on her face and shaking his head from side to side as if saying no. In the result, the deceased's wife called out to a nurse the deceased's breathing had changed.

One of the nurses then stated to Ms Williams that the oxygen bottle/cylinder assigned to the deceased had run out and that nurse then called out for another nurse to immediately obtain another oxygen bottle/cylinder.

At about this time also Nurse Crawford came into the deceased's room at the request of Nurse Duthie to review/assess the deceased. Nurse Crawford found the deceased to be lying in the bed on his back and had very laboured breathing. He had decreased blood pressure, that is, approximately 30/35, very little urinary output and an irregular cardiac rhythm. Hence, Nurse Crawford called that the deceased was going into cardiac arrest.

Ms Williams noted perhaps strangely that nurses were running everywhere so at that time she stood out of the way to allow the nursing staff to do their work. Nurse Crawford, with the assistance of Nurse Duthie and the part assistance of the enrolled nurse Robarts, attempted to resuscitate the deceased.

During the course of the attempted resuscitation, Nurse Crawford instructed enrolled nurse Robarts to telephone Dr Lip, but she was unable to contact him. It seems also that enrolled nurse Robarts attempted, without success, to contact Dr Gangaram and also Dr McAllister.

Nurse Crawford then proceeded herself to the nurses station and contacted Triple O and asked the emergency operator for the attendance/assistance of the Queensland Ambulance Service at the hospital in relation to the deceased's cardiac arrest. Nurse Crawford then telephoned Ms Kelly, the Director of Nursing, and requested her immediate attendance and enrolled nurse Robarts was again requested by Nurse Crawford to contact Dr Lip.

At 7.25 pm Ms Williams was asked by one of the nurses if she wouldn't mind stepping outside while they treated the deceased. Accordingly, Ms Williams removed herself to the hospital veranda.

At 7.28 pm Intensive Care Paramedic Alexander and student Paramedic Cantell, attended upon the deceased in his high dependency room and found him to be extremely comatosed and pale and that he had an intravenous cannula attached to his right arm as well as an intravenous normal saline fluid drip running. Paramedic Alexander also observed that the deceased was connected to a life pack 12 defibrillator and that the electrical cardiogram rhythm was asystole, that is, flat lined as there was no heart activity as the relevant nurses at the hospital were unfamiliar with the machine's use.

The deceased was then intubated by Paramedic Alexander and under his direction the student paramedic administered to the deceased intravenously one milligram of adrenalin, however, he did not respond. Paramedic Alexander administered a further one milligram of adrenalin. Once again, the deceased did not respond, thus, he administered one milligram of Atropine, which proved not effective, so a further 2 milligrams of adrenalin followed by one milligram of Atropine was given, but the deceased continued not to respond.

At approximately 7.40 pm, Ms Kelly, the director of nursing attended as requested at the hospital and immediately called Dr Lip. Dr Lip's phone was answered by Mr Renoud, who informed her that they were en route from Kingaroy to Murgon Hospital. At 7.42 pm Paramedic Alexander, although believing it futile by this stage, administered 400 micrograms of Narcan, and as expected the drug had no effect on the deceased.

At 7.45 pm, after the administration of another two milligrams of adrenalin, Paramedic Alexander detected on the ECG a very fine fibrillation, therefore, the deceased was defibrillated at 200 joules and then the deceased went into asystole.

At 7.46 pm as Paramedic Alexander considered the ventricular fibrillation genuine, he administered 50 millilitres of sodium bicarbonate to the deceased.

At 7.51 pm, another two milligrams of adrenalin was administered, however, there was still no change to the deceased's condition. Paramedic Alexander continued to reassess the deceased and waited to see if the adrenalin would have any effect and during that period he performed CPR, which prior to that time had been continuously being performed by the relevant hospital nursing staff.

At approximately 7.55 pm Ms Kelly contacted Dr Prasad, the medical superintendent/on-call doctor at the Cherbourg Hospital who resided at that time only a short distance from the Murgon Hospital and after having received Ms Kelly's brief about the deceased's situation, Dr Prasad attended upon the deceased within minutes.

Paramedic Alexander then briefed Dr Prasad on the deceased's medical condition

and information about the medications administered and overall treatment and the fact that he was about to cease resuscitation. Dr Prasad examined the deceased, but could not detect any cardiac output and after considering the treatment that had already been administered the time on which the paramedic and nursing staff had been working on the deceased, his intubation and ventilation and medication given and the overall demonstrated good efforts that had been made, Dr Prasad concurred with Paramedic Alexander that all resuscitation efforts should cease.

In the result, Dr Prasad again examined the deceased and found the deceased to have fixed and dilated pupils, thus, he pronounced the deceased to be life extinct at 7.57 pm.

At 8 pm Dr Lip walked in to the room, once again accompanied by his medical student, both having just arrived back in Dr Lip's motor vehicle from Kingaroy somewhat distressed as the passing of the deceased was unexpected, such that it will remain one of those black days in his life.

Dr Prasad, in essence, handed over the situation to Dr Lip, the treating doctor, informing him that he had just arrived himself at the hospital and that resuscitation of the deceased had ceased.

Paramedic Alexander also briefed Dr Lip on what had occurred. Dr Lip then spoke very briefly to relevant nursing staff and made relevant entry notes both in the hospital administration front sheet and the inpatient progress notes. In consequence, Dr Lip indicated to the on-duty nursing staff that the deceased's death was one that should be referred to the Coroner and in that case the police should be advised, albeit that it was seen that action of that type had already been formulated by Paramedic Alexander.

Accordingly, also at 8 pm, Nurse Duthie reported the deceased's death to the Murgon Police. In turn, Constable Milburn attended at the hospital and initially spoke to nursing staff. Thereafter, relevant nursing staff and Paramedic Alexander at varying times spoke in a consoling way to the deceased's wife and Ms Williams spent some time alone with her dearly departed husband while she waited at the hospital for the arrival of her brother from Gayndah.

Subsequently, Constable Milburn returned to the Murgon Hospital and spoke to Ms Williams, who was also able to identify the body of the deceased as that of her husband to the officer and after obtaining the necessary information from Ms Williams, Officer Milburn again returned to Murgon Police Station and subsequently completed the requisite form 1B and the police report of the death to the Coroner.

At approximately 10 pm the body of the deceased was conveyed by undertakers under police escort to the Kingaroy Hospital Mortuary for lodgement.

In the morning of the 23rd of August 2006 the requisite blood tests requested by Dr Lip that previous afternoon became available indicating that the deceased's Paracetamol was within the therapeutic range whilst his creatine kinase was grossly deranged.

On the 24th of August 2006, as a result in part of the deceased's demise, Ms Wood, the district manager of the South Burnett Health Service issued a risk management strategy for clinical safety of patient memorandum to the Murgon Director of Nursing and her staff for implementation where it was considered that inappropriate medical care was being provided by a medical officer.

On the 26th of August 2006, the deceased's body was then conveyed from the Kingaroy Hospital Mortuary to John Tonge Centre in Brisbane by Government undertakers under escort by Constable Milburn for the purpose of a Coronial autopsy.

On the 28th of August 2006, Dr Milne, a specialist forensic pathologist, conducted an autopsy on the body of the deceased and at that time he possessed all the relevant form 1 and the Murgon Hospital medical notes/charts, minus the neurological observation sheet, which he took into consideration when formulating his autopsy findings.

Dr Milne concluded that the death of the deceased presented as a very complex one both from pathological and a clinical point of view, albeit that Dr Milne had not clinically treated a patient for some considerable period of time. He found the condition directly leading to the death of the deceased, that is the most likely cause of death, was morphine toxicity, but that there were other significant conditions acute and chronic in the background which would have led to the deceased's condition deteriorating more quickly such as to provide some contribution to death, that is, ischemic heart disease which basically damaged the heart from the previous heart attack, coronary atherosclerosis which narrowed the arteries and rhabdomyolysis, which in basic terms is damaged muscle tissue and that tissue then circulates through the body causing some damage to the kidneys. In the deceased's case, the broken down muscle was blocking the tubular of his kidneys.

That rhabdomyolsis could have been occurring over a period of days and probably was a reaction of the cholesterol lowering drugs. The difficulty that the deceased had in voiding in the earlier part of the day could be attributed to the morphine as it is well known to cause urine retention, whilst his low blood pressure could have been caused by either morphine or cardiac illness.

The standout feature for Dr Milne from the relevant biochemistry results was a dangerously high potassium level which indicated acute renal failure.

It would seem that on the 1st of September 2006, Dr Lip was suspended with pay from his position as medical superintendent with the right of private practice Wondai Hospital until further notice.

In September 2007 the medical board of Queensland, as it then was, commenced disciplinary proceedings against Dr Lip in the Health Practitioner Tribunal in relation to the treatment of amongst others, the deceased at the Murgon Hospital. In the course of those proceedings, Dr Lip accepted that he had behaved in a way that constituted unsatisfactory professional conduct with respect to his treatment of the

deceased.

On the 22nd of December 2007, then Detective Senior Constable, now Detective Sergeant Barron, was tasked in accordance with the Queensland Police Service Manual to fully investigate the circumstances surrounding the sudden death of the deceased at the Murgon Hospital.

A lengthy investigation was undertaken as Operation Foxtrot Manaku and seemed to focus on any criminality that could attach to Dr Lip, such that he could be prosecuted for manslaughter due to criminal negligence under the provisions of section 282/303 of the Criminal Code. However, there has not been any prosecutory action taken to date.

On the 21st of October 2008, the Health Practitioners Tribunal made a number of orders which included, amongst other things, the suspension of Dr Lip for six months, that during the period of his suspension or within such further time as the Medical Board of Queensland allows and at his own expense, he was to undergo training and education approved by the said Board relevantly in the areas of (a) communication skills; (b) emergency presentations and management thereof and that following the said period of suspension, at his own cost, he is to practice in accordance with a supervised practice plan approved by the board.

Be that as it may, on the 19th of April 2010, the then Coroner and now the late Coroner G J Buckley, determined that an inquest into Mr Krog's death should be held.

On the 25th of June 2010, a pre-inquest hearing was held before the late Coroner at Kingaroy and the issues that were identified to be investigated at inquest are:

(1) the facts and circumstances surrounding the death of the deceased at Murgon Hospital on the 22nd of August 2006;

(2) the adequacy of care provided to the deceased during his admission to Murgon Hospital;

(3) clinical governance and administrative arrangements during the admission and care of patients at Murgon Hospital.

On the 23rd of December 2010, a further pre-inquest conference was held before me at Caloundra. Subsequently, on the 31st of January 2011, Detective Barron compiled a more detailed police Coronial report, which was forwarded for practical purposes to the Coroner's office at Caloundra.

On the 28th of February 2011, the inquest proper was commenced at Kingaroy and proceeded over the course of 10 days where a total of 30 witnesses were called and 71 exhibits were tendered.

On the last day of the taking of evidence, being the 11th of March 2011, the absence of time precluded hearing oral submissions from the relevant parties, thus I invited

written submissions to be made. Such written submissions were subsequently received at my office between the 19th of September 2011 and the 11th of January 2012 and have been read by me.

Now, it should be said that during the course of the inquest a number of expert medical witnesses were called, namely:

(1) Dr Evans, who was a private general practitioner, but with considerable experience and knowledge in rural and remote medicine, initially provided a medical report/review to the Queensland Health Quality and Complaints Commission concerning Mr Krog's death. She was ultimately of the opinion, given her now understanding of the totality of the deceased's clinical picture, which at review she did not possess, that it fell to a clinical judgment call to be made by Dr Lip as to how to treat the deceased on the day in question, notwithstanding that hospital documentation was extremely brief and often lacked clinical detail, example, fluid charts. Albeit, as the deceased had persistent low blood pressure and presented as an opiate/drug overdose MS Contin, but Narcan responding, clinically in her view, the Murgon Hospital was not the place for the deceased to have been received and then monitored in the very event that there was an adverse outcome;

(2) Dr Elcock, who is a very experienced emergency medical specialist practising the aerial retrieval of critical care patients and pre-hospital care attached to Queensland Health, was, in essence, of the opinion when faced once again with the deceased's overall clinical condition and the fact that at the time of giving his statement he was not aware of the content of the autopsy and forensic toxicology reports, that there was a failure on the part of Dr Lip to recognise and respond to the deteriorating medical condition of the deceased, especially his persistent hypotension such that at the very least upon Dr Lip's receipt of the relevant blood tests in the latter part of the afternoon, it should have become glaringly obvious to him that the deceased needed to be transferred out. That is notwithstanding, amongst other things, acceptance that an inaccurate fluid chart would create a difficulty for Dr Lip as the reviewing clinician. That Dr Lip's telephone ordered investigations, where appropriate, provided Dr Lip had the intent to see the deceased at a very much earlier time, that is, some 20 to 30 minutes after being advised of the deceased's hospital presentation and the deceased's associated history by the director of nursing and the fact that the director of nursing did not inform Dr Lip that she had triaged the deceased as a category 2 patient;

(3) Dr Rowan has had some six years' experience as a rural and remote general practitioner exercising the right of private practice and has considerable experience in the specialities of addiction medicine and medical administration. Because of his standing at the relevant time as president of the Rural Doctors' Association of Queensland, Dr Rowan was also tasked by the Queensland Health and Quality Complaint Commission in approximately February 2007 to review in a medico/legal sense, the death of the deceased relying as he did upon limited information that was provided to him, which consisted of a photocopy of the deceased's medical, hospital, medical record,

including the relevant pathology results.

Further, it would seem to me, that ultimately Dr Rowan's clinical opinion based upon his experience of having previously practised in rural and remote settings and his acceptance that the deceased now did not initially present as a critical ill patient, that is, he was conscious; breathing, but drowsy, was that the deceased, in any event, was clearly an unhealthy/clinically unwell man who should not have remained at Murgon Hospital for as long as he did and, in that regard, should have been transferred to a much more appropriate hospital facility probably not later than that morning.

(4) Dr Ringrose, who is a very experienced specialist/consultant physician, having practised as a visiting physician in such locales as Longreach and Mount Isa and who, I might add, was the only expert opportunely that had provision of extensive relevant material to assist in the compilation of his written report.

Dr Ringrose was of the clinical opinion, when reduced to its bare essentials, that the deceased did not receive appropriate medical care, that is, the deceased should have been seen by Dr Lip in a timely manner, albeit, that Dr Ringrose noted, amongst other things, at paragraph 4 of page 4 of his report which states, "However, it is well documented that he had severe coronary heart disease, he had a history of myocardial infarction with balloon angioplasty in the past and the description of his coronary arteries in the autopsy is indicative of severe disease. When one combines with this respiratory failure and hypercalcaemia and renal failure his prognosis, in my opinion, was very poor from the outset."

Dr Ringrose went on to say, "If the optimum treatment had been undertaken and he had been airlifted to another centre, I would suggest that he still had only a 20 per cent chance of survival. If he had survived, he may well have had serious morbidity for the rest of his life."

Dr Ringrose based that opinion on numerous contributing factors and they are as follows:

(a) The deceased had ingested a very serious level of morphine the amount of which is set out in the analyst certificate being total morphine three milligrams per kilogram which in turn is approximately six times the average total dosage;

(b) The deceased was apparently opiate naive, that is, he had less effective tolerance to morphine;

(c) The deceased was suffering from exceptionally severe heart disease for a person of his age;

(d) That at approximately 10.40 am on the day in question the deceased was already suffering from substantial organ failure, that is hypercalcaemia and renal;

(e) The deceased was a smoker of long standing with high cholesterol and high blood pressure and he had an enormous fatty liver most likely caused by being 110 kilograms in weight;

(5) Dr Mahoney, who is an experienced forensic pathologist, gave evidence, amongst other things, that MS Contin was a slow release morphine drug, that is, the drug is gradually released over three to four hours and then it maintains that level for approximately 12 hours and that morphine acts as a central nervous system depressant.

That in his report dated the 23rd of March 2007, it was Dr Mahoney's opinion, in part, that the three milligrams per kilogram of total morphine detected in the deceased's antemortem blood specimen collected at 10.45 am on the day in question and thereafter the post-mortem blood level of one kilogram per kilogram reflected the falling total blood morphine levels in the hours prior to the deceased's death, and further that both those blood levels were high and likely to be fatal in an individual with tolerance to morphine which I think on balance can be said to be the case in relation to the deceased.

Dr Mahoney also opined in his report the very high level of morphine detected in the deceased's antemortem blood could not be accounted for by ingestion of 120 milligrams of MS Contin. If MS Contin was the source of the blood morphine it must have been a much larger dose.

Further, Dr Mahoney was of the view that the death of the deceased in the circumstances as he understood them was a complex one.

Now, I have previously referred to the Murgon Model of Care/Murgon Model of Medical Management, which historically was in existence at the time of the deceased's death, having commenced on the 29th of July, it seems, 2005.

That model of care, which was principally devised and finalised by Miss Hood, the then district manager of the South Burnett Health Service District, came into effect after extensive consultation with relevant stakeholders including, amongst others, Dr Lip, Dr McAllister and Dr Gangaram, and was as a result of the ministerially approved redevelopment of the Wondai Hospital.

That is the Wondai Hospital was to be demolished and a nursing home facility was to be erected with five hospital beds. From a medical perspective the relevant model of care was based on Local Government boundaries in that Dr Lip was relatively responsible for the care of all public patients from Wondai and the southern shires, which included, amongst others, residents from Proston, whilst Dr McAllister and Dr Gangaram were to be relevantly responsible in a shared way for all public patients from Murgon, Kilkivan and the northern shires.

In January 2007 Queensland Health had occasion to amalgamate, as part of a broader amalgamation program throughout the State, the district health service of West Moreton and South Burnett. As part of that particular amalgamation a number

of changes/improvements occurred including:

(1) The Patient Safety and Quality Improvement Service became available which enables, for example, a district nurse to call the on call medical superintendent at Ipswich for support if a doctor is not attending a rural hospital. In turn that medical superintendent could ring the doctor concerned to ask him/her to attend or the medical superintendent could give permission for a patient if it was in the patient's best interest to do so.

(2) Murgon Hospital has been supplied with an i-STAT machine which is an advanced hand held blood analyser that provides real time lab quality results within minutes to accelerate the onsite patient care decision making process thus reducing some of the issues associated with off site blood analysis.

(3) The establishment of the centrally managed clinical coordination unit/centre which enables district doctors to ring or in the case of Murgon Hospital do video conference with that unit/centre and request that a patient be moved to a hospital with increased capacity to treat the patient. The unit is tasked with the transport of a patient and the finding of a bed and can also provide advice to the doctor in the management of a patient while awaiting transport or advice on the need for transport.

(4) Ongoing graded assertiveness training, which is probably helpful to nurses. That training provides nurses with guidance with respect to being assertive with doctors, that is, for nurses to use appropriate clinical communication language to insist that a doctor attend to a patient and also, if necessary, to escalate in matters to management.

(5) Working hand in hand with the graded assertiveness training system is a likely introduction across greater Queensland, which I assume will include small rural towns such as Murgon, of an early warning identification system. Such a system will provide early warning of a deteriorating patient. For example, in a small rural hospital like Murgon, observations will be scored in areas such as blood pressure and respiratory rate and once a patient has reached a certain score of deterioration the nurse then contacts the treating doctor and if that doctor is unavailable for whatever reason and notwithstanding there may have been some treatment verbally ordered there is an automatic trigger that after 30 minutes for the nurse to take the matter to the director of nursing who will in turn contact the treating doctor and if that doctor still is unable to attend then the director of nursing will contact the medical superintendent at Kingaroy, Ipswich or Toowoomba.

(6) For agency nurses, despite orientation, there is a system in place to ensure that no agency nurse in a rural hospital is left by themselves. On the very rare occasion that would occur there will always be a more experienced on call nurse made available either by telephone or to actually attend the hospital at short notice.

Subsequently, it seems, in October 2008 the positions of medical superintendents

with private practice for both Wondai and Murgon were phased out and the medical model changed by increasing the compliment at Cherbourg Hospital with three full time senior medical officers solely dedicated to Queensland Health patients for Wondai, Murgon and Cherbourg.

Those medical officers now work on a one to three on call roster, that is, they are on call one night in every three with another senior doctor from outside the local area providing weekend relief. Those on call arrangements have been put in place to manage not only fatigue but to maintain stability of staffing with the view to improvement in the quality of patient care.

At this stage it is perhaps opportune to say that it should be understood contextually that an inquest is not a trial between opposing parties but an inquiry into the death of a deceased.

In a leading English case, R v. South London Coroner; ex parte Thompson [1982] 126 S J 625, is described this way: "It is an inquisitional process, a process of investigation, unlike a criminal trial where the Prosecutor accuses and the accused defends. The function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires. The focus is on discovering what happened not on ascribing guilt, attributing blame or apportioning liability.

One of the purposes is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result the Coroners Act 2003 authorised the Coroner to make comment, if appropriate, concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. However, a Coroner must not include in his findings any statement that a person is or may be guilty of an offence or civilly liable for something. It is, I think, well established that a Coroner should apply the civil standard of proof in relation to coronial investigations with the approach referred to in Briginshaw v. Briginshaw [1938] 60 CLR 336 to 361 per Sir Owen Dixon J has applicability. This means that the more significant issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer or more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard. Also it can be said that a Coroner is obliged to comply with the rules of natural justice and to act judicially. This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As Annetts v. McCann [1990] 65 ALJR 167 at 168 makes clear that includes being given an opportunity to make submissions against findings that may be damaging to the reputation of any individual or organisation."

Bearing in mind what I have just said, I think, however, it can be said from the evidence that it is clear that the hospital record keeping that pertained to the deceased's death was, to put it bluntly, poor such that it can be said, amongst other things, that the relevant fluid chart was unreliable in certain respects and the accuracy of the relevant neurological observation sheet questionable.

I also found, regrettably, that I had a general unease in the main about the evidence

given by Nurse Duthie because of her many inconsistencies such that it was difficult to place significant weight on it. However, in saying that, I do not wish to imply that she was being deliberately untruthful.

It was also obvious from the evidence that universally the medical experts were of the opinion that Dr Lip should have attended at the Murgon Hospital in a much more timely way than he did, and further the deceased should have been transferred out to a more appropriate facility being an intensive care unit at a tertiary hospital and that criticism, subject to hindsight in certain respects, was essentially accepted by Dr Lip.

Perhaps not unsurprisingly I found that all the medical witnesses presented as impressive. However, I was particularly impressed with the evidence given by Dr Ringrose and in saying that it is not my intention to be seen as disrespectful to the other clinical medical experts who demonstrably gave of their valuable time to review available relevant material and provide statements and managed to come along to the inquest to give their insightful evidence.

It is obvious from the evidence that universally the clinical medical experts were of the opinion that Dr Lip should have attended at the Murgon Hospital in a much more timely way than he did and further that the deceased should have been transferred out to a more appropriate facility being an intensive care unit at a tertiary hospital either in the morning or at the very latest in the afternoon of the day in question after receipt by Dr Lip of the relevant blood test and that criticism, subject to hindsight in certain respects, was essentially also accepted by Dr Lip.

Dr Lip also accepted in hindsight that he ought not to have gone to Kingaroy in the late afternoon/early evening on the day in question to attend the relevant continuing medical training session.

Be that as it may, Dr Ringrose was quite frank in stating in his clinical opinion, which was an opinion, that he was not prepared to resile from at inquest was that even if the deceased had been retrieved and everything was done by the book the deceased from the outset had only a 20 per cent chance of survival for the reasons that I have alluded to previously and that even if he had lived/survived then he would have been significantly damaged.

Regard, of course, must be had to the fact that the deceased presented at the Murgon Hospital having, at first instance, inappropriately taken medication that was prescribed for his wife's use only, that is, at least two by 60 milligrams of MS Contin tablets or possibly more according to Dr Mahoney, such that he was found on death to have a serious level of morphine in his system, that is, approximately six times the average fatal dose.

Now I glean from Dr Ringrose's oral evidence that firstly he thought that the relevant nursing staff had acted appropriately in the circumstances in which they found themselves on the day in question and secondly that in principle he did not think that the relevant model of care would have effectively compromised patient safety.

Section 46 of the said Coroners Act provides that a Coroner may comment on

anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent death from happening in similar circumstances in the future. That requires the Coroner to consider with the death under investigation was preventable or whether other deaths could be avoided in the future if changes are made to the relevant policies or procedures.

On the whole of the evidence before me I have come to conclusion that I accept the evidence of Dr Ringrose which I appreciatively set out above over the evidence of the other clinical experts where they may be conflicted.

I accept that the deceased's prognosis was very poor from the outset and that even if optimum treatment had been undertaken and he had been air lifted or otherwise transported to another centre that his chances of survival could only be rated at 20 per cent and if, indeed, he had've survived he would have unfortunately experienced serious morbidity for the rest of his life.

I think it is also significant on the deceased's death presented from a pathological and toxicologically perspective to be a very complex one.

As stated previously Dr Lip acknowledged that he should have attended at the Murgon Hospital to see the deceased earlier on the 22nd of August 2006 and that with the benefit of hindsight that he should have sought to transfer the deceased to an intensive care unit at a tertiary hospital. Notwithstanding the certain steps taken by him in the clinical management of the deceased during the course of that fateful day it could be seen contextually to be appropriate and as it turned out the deceased was in part suffering from rhabdomyolysis which was the medical condition that he suspected being one of the significant conditions that contributed to the deceased's death but was not related to the primary cause of death.

Further, on the evidence, I am not persuaded that the hospital administrative arrangements that were in place at the relevant time played a material part in the death of the deceased.

It is unclear from the evidence which of the agency nurses received induction for 20 minutes by the director of nursing on the day in question. Certainly, Nurse Duthie gave evidence that she was not on inducted at all and if that was the case it would be matter of some concern especially as part of the induction process is to understand how to use all the relevant hospital equipment.

But in any event relevantly Dr Lip was the designated on call doctor and at no time did he indicate to any of the relevant nursing staff that he would not or cease to be available to medically treat the deceased.

Miss Lane, the district chief executive officer of the now Darling Downs West Moreton Health Service District gave evidence, I thought impressively, of the numerous changes and improvements that will have a significant impact on the operation administratively and clinically of small rural hospitals like Murgon such that so far as reasonably and humanly practicable a death in similar circumstances as that of the deceased is avoided in the future, and that if it is necessary to say so I would

endorse those requisite changes or improvements for the benefit of patient safety and outcome.

Before concluding I will just say this. I have noted that the next of kin, Miss Williams, in her written submissions, raises amongst other things the issue of criminal negligence on the part of Dr Lip and by extension section 48 of the Coroners Act 2003 which relevantly provides that: "If from information obtained while investigating a death a Coroner reasonably suspects a person has committed an offence the Coroner must give the information to, for an indictable offence, the Director of Public Prosecutions."

In that regard it is my view that a next of kin does not have legal interest in whether a public prosecution by the Director of Public Prosecutions occurs. However, should I not be correct on that point it should be understood it is not my intent to make findings as are adverse to Dr Lip because firstly during the course of the inquest I indicated it is not an avenue that was to be explored having regard to the parameters set at the prehearing conference held on the 25th of June 2010. That position may have changed, of course, if any new or fresh evidence had been led but in my view that has not occurred here.

Secondly, section 303 of the Criminal Code provides that:
"Any person who unlawfully kills another in circumstances which do not constitute murder is guilty of manslaughter."

Section 288 of the Criminal Code provides so far as is relevant that it is the duty of every person who undertakes to administer surgical or medical treatment to any person to have reasonable skill and use reasonable care in doing such act and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty. It has been held that the negligence necessary to establish a criminal charge is greater than that required in a civil case.

The test as to criminal liability is set out in R v. Bateman [1925] 94 LJKB 791 (1925) All England Reports 45; (1925) 19 CrApp R 8 where Hewitt LCJ said: "In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime Judge's have used many epitaphs such as culpable, criminal, gross, wicked, clear, complete but whatever the epitaph be used and whether an epitaph be used or not in order to establish criminal liability the facts must be such that in the opinion of the jury the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for life and safety of others as to amount to a crime against the State and conduct deserving punishment. It is desirable that as far as possible the explanation of criminal negligence to the jury should not be a mere question of epitaphs. It is in a sense a question of degree and it is for the jury to draw the line but there is a difference in kind between the negligence which gives right to compensation and the negligence which is a crime."

It is my view, on the evidence, that it could not be proved to the criminal standard that the departure from the appropriate standards by the doctor in this case was of this

magnitude.

I do not believe it to be shown that the doctor, that is Dr Lip, disregarded the deceased's welfare in the circumstances in which he knew that by doing so he was placing the deceased's life at risk. Dr Lip accepted, as has been said on many occasions and I have so found, amongst other things, that he belatedly medically examined the deceased and ably focused his clinical judgment on the deceased suffering from rhabdomyolysis and that in hindsight the deceased should have been transferred out. But having regard to all the circumstances I do not consider that a charge of manslaughter would have reasonable prospects resulting in a conviction.

It must also be remembered, as Dr Lip's counsel has pointed out, that his conduct has already been heavily sanctioned by the Health Practitioners Tribunal and whilst I appreciate that may be of little comfort to the deceased's wife she does have some solace that since the death of her late husband, close to six years ago, significant changes and/or improvements have been brought to the public health system that will especially be beneficial to small rural communities such as Proston where she lives so that so far as reasonably and humanly possible the tragic loss of her life partner that she did experience on the 22nd of August 2006 will not be revisited upon others.

The inquest will now be closed.

Coroner Taylor
Caloundra
13 August 2012
