QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Holly Winta Brown**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	Cairns
FILE NO(s):	2015/2427
DELIVERED ON:	12 June 2019
DELIVERED AT:	Cairns
HEARING DATE(s):	29 January 2018 – 2 February 2018
FINAL SUBMISSIONS:	26 March 2019
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	adequacy of emergency medical response and care; remote event; mass gathering event; primary health care clinic; Laura; Cook Shire Council; Torres and Cape Hospital and Health Service; Queensland Ambulance Service; nurses; fatigue leave; medical emergency; event management; risk assessment; female 17 years; myocardial scarring; past myocarditis; undiagnosed rheumatic fever; telecommunications blackspot, automated external defibrillator; event planning; risk assessment; approvals process; interagency approach; state wide mass event planning reform; Holly's Law.

REPRESENTATION:

Counsel Assisting the Coroner:	Ms J Cull and Ms M. Benn
Counsel for the Cook Shire Council	Mr C.J Ryall i/b Preston Law:
Counsel for Queensland Ambulance Service:	Ms M.G Zerner
Counsel for The Laura and District Rodeo Campdraft Association and its secretary, Ms Gostelow:	Mr Schneidewin i/b Hall & Wilcox
Counsel on behalf of Virginia Nikora and Jenae Ives and the Qld Nurses and Midwives Union:	Ms S. Robb i/b Roberts Kane Solcitors
Counsel for Torres and Cape Hospital and Health Service:	Mr A. P Suthers
Warren and Eleanor Brown:	Self Represented
Laura Amateur Turf Club:	Ms J Sorensen (self represented)

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Introduction

1. Section 45 of the *Coroners Act 2003* provides that when an inquest is held, the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest, and to officials with responsibility over any areas the subject of recommendations. These are my findings in relation to the death of Holly Winta Brown. They will be distributed in accordance with the requirements of the Act and posted on the website of the Coroners Court of Queensland.

Background

2. Holly Winta Brown was aged seventeen years when she attended the annual Laura Rodeo and Races weekend with her family including her parents and her brother, and family friends. Holly was an accomplished young horsewoman and participated in the camp drafting event that weekend. She camped at the event grounds (the Laura Races and Rodeo grounds) with her family.

3. On the evening of 26 June 2015 Holly attended a nearby campsite and socialised with her friends. Her parents, Warren and Eleanor Brown collected her at around 2:00am (27 June) and returned to the family campsite. When Holly woke that morning she told her father she was not well and that she had a sore back. Her father rubbed her back, gave her panadol and suggested she lay back down in her swag. Holly ate breakfast, vomited and went back to rest in her swag. Holly told her mother she had chest pain. When Holly's father checked on her at approximately 8.30am, or soon after, Holly could not be roused, her breathing was shallow, and she was unresponsive.

4. Warren Brown called for help and commenced cardiopulmonary resuscitation (CPR). Ms Janae Ives, a nearby off-duty nurse attending the weekend event, was alerted to the scene. By coincidence, Ms Ives was an experienced clinical nurse employed as a triage emergency department nurse at the Cairns Hospital. The Cairns Hospital is a tertiary level 5 hospital (a hospital that provides comprehensive trauma care and stabilisation of all trauma patients until transfer)[1].

5. Ms Ives played a critical and primary role in the medical response provided to Holly. She remained at Holly's side and found herself unexpectedly co-ordinating the medical response. I refer in these findings to 'Ms Ives' (although she is a nurse by profession) to distinguish that she was not on duty that day.

6. Ms Ives arrived at the Brown's campsite, (she will say by 9.00am) she saw that Holly was unresponsive, and she was present when soon after her arrival, Holly went into cardiac arrest (at around 9.10am). Ms Ives took control of the scene and the CPR. She co-ordinated the emergency response and remained with Holly as events unfolded.

[1] Department of Health (Queensland) Emergency Services Module Overview CSCF v3.2

7. Ms Ives was valiant in her efforts to revive Holly. She remained by Holly's side during an ordeal that lasted in excess of two hours.

8. Ms Ives was an impressive witness at the inquest. It was apparent that she was deeply affected by the circumstances surrounding Holly's death. During the inquest Warren and Elle Brown conveyed their gratitude to Ms Ives for her efforts to save their daughter

9. A nearby camper, Mrs Joan Berzinski arrived at the scene and placed the first Triple 0 call at around 9.40am. Mrs Berzinski was known to the Browns, her daughter and Holly were friends.

10. The Triple 0 Operations Centre activated an emergency response. The Queensland Ambulance arrived by road under a 'code 1' lights and sirens and the Queensland Emergency Careflight helicopter was deployed from Cairns.

11. Efforts to resuscitate Holly continued whilst waiting for the emergency services to arrive. Nurses from the local Laura Primary Health Clinic (LPHC), who were at that time on fatigue leave after working a double shift, arrived in the clinic troop carrier (a recovery vehicle) with a 'Thomas Pack' and a modest amount of equipment and supplies (adrenaline; a travel automatic emergency defibrillator-AED and an oxyviva).

12. Holly achieved a return of spontaneous circulation (ROSC) however it was clear that she was not responding and was in a critical condition. The resuscitation efforts and interventions provided to her at the scene were **insufficient to revive her.**

13. The Queensland Ambulance Service paramedics arrived within 1 hour and 20 minutes of being deployed via the Triple 0 operations centre, by then, almost 2 hours after Holly's cardiac arrest.

14. In evidence at the inquest the unfolding scene was described as chaotic. The Triple 0 audio recording bears out the sense of the confusion and concern at the scene. The audio recording captures the unreliable mobile phone connection, and the distress experienced by those on the ground involved in the efforts to resuscitate Holly.

15. The Queensland Ambulance Service arrived on-site at approximately 11.00am and the Careflight emergency helicopter arrived at approximately 11.15am, some two hours after Holly's cardiac arrest. By then all attempts to revive Holly were futile.

16. Holly was pronounced deceased at 11.44am by the Careflight escort doctor, Dr Dunn.

17. The whole shocking tragedy took place in front of Holly's parents Warren and Elle Brown. They did not leave Holly's side. Mr Brown played an active role in protracted resuscitation attempts to save Holly's life. He did everything within his control to save his daughter.

18. It is now known that Holly suffered an arrhythmia as a result of undiagnosed heart scarring, possibly due to (childhood) rheumatic fever. Holly's condition was rare.

19. Basic resources such as an automated external defibrillator (AED) and adrenaline were not available on site for at least 45- 50 minutes after Holly's cardiac arrest. In the circumstances, Holly's chances of survival were almost nil without immediate access to advanced emergency care and treatment and resources.

20. The purpose of this inquest was to examine the adequacy of the medical response provided to Holly and what, if anything, could be done to prevent similar deaths from occurring in the future.

Relevant Legislation

21. Pursuant to s45(5) of the *Coroners Act* 2003 a Coroner must not include in the findings any statement that a person is, or may be:

    a) guilty of an offence; or
    b) civilly liable for something.

22. The focus of an inquest is to discover what happened, not to ascribe guilt or attribute blame or apportion liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

Standard of Proof

23. Any findings of the relevant facts are made on the balance of probabilities, that is, the civil standard of proof.

Issues for inquest

24. The following issues formed the basis of the inquiry.

    ***Issue 1*:** The findings required by section 45(2) *Coroners Act* 2003, namely the identity of the deceased (Holly Winta Brown), when, where and how she died and what caused her death;

    Issue 2: The assessment of health, safety and medical risks and emergencies for the 2015 Laura Horse Sports Races and Rodeo weekend, with reference to:

    i. How, is any, such assessment was formulated and by whom;
    ii. The basis for that assessment;
    iii. What risks were identified;
    iv. How responsibility for the management of, and response to such risk was apportioned

    Issue 3: The obligations (whether contractual, regulatory, statutory or otherwise) on relevant stakeholders to ensure public safety at events such as the Laura Sports Races and Rodeo

    Issue 4: The response to the medical emergency that resulted in the death of Holly Winta Brown at the Laura Horse Sports Races and Rodeo on 27 June 2015,

with reference to medical interventions, treatment, care and equipment and response times.

Issue 5: Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act* 2003

Relevant Material and Evidence

25. In the preparation of these inquest findings I have considered and had regard to:

    i. the coronial brief of evidence;
    ii. the oral evidence of twenty three (23) witnesses during the five day inquest held in the Coroners Court of Queensland at Cairns;
    iii. comprehensive written submissions provided by all those with leave to appear;
    iv. the transcript of proceedings.

26. The Inquest traversed a number of matters that were important for context but ultimately did not bear on the issues for my consideration. Whilst I have had regard to the considerable amount of material and evidence before me, I refer only to the evidence relevant to the Issues for Inquest, and that provides the basis for my findings and recommendations.

Witnesses called to Inquest

27. Not all witnesses who provided statements were called to give evidence in person. Twenty three witnesses were called to give evidence at the five (5) day Inquest as follows:

Warren Terrence Brown	Holly's father
Dr Paull Botterill	Senior Staff Specialist Forensic Pathologist
Dr Lesley John Griffiths	Forensic Medical Officer
Jenae Marie Ives	off duty Nurse
Katherine Margaret Leighton	Nurse – Laura Primary Health Clinic
Patricia Dawn Harvey	Nurse – Laura Primary Health Clinic
Lyn Wardlaw	Executive Director (TCHHS) Nursing and Midwifery
Krystal Farrelly	Nurse
Virginia Louise Nikora	Nurse
Jennifer Sorensen	Secretary LATC
Debra Gostelow	Secretary LDRCA Inc
Pete Douglas Fenton	Director of Nursing (TCHHS)
Vikki Michelle Jackson	Director of Nursing and Midwifery
Ian Maurice Pressley	Executive General Manager – Southern Cape York
Terry Raymond Mehan	Senior Health Administrator
Leigh Andrew Broad	Nurse
Timothy Cronin	Chief executive Officer (Cook Shire Council)
Dr Mark Little	Specialist
Peter John Aitken	Qld Dept Health Senior Director

Paul Robert Chivers	Risk management Consultant
Warren Martin	Queensland Ambulance
Michael John Metcalfe	Deputy Commissioner QAS
Timothy Dunne	Qld Govt Manager Local Government and Regional Services.

Tripe 0 Audio recordings exhibited post Inquest

28. At the close of the inquest and during the preparation of these findings I issued a further Form 25 Request for Information, to the Queensland Ambulance Service for the audio recording of the two Triple 0 calls made on the day of Holly's death.

29. The audio recording and a formal transcript of those recordings (prepared by Auscript), were provided to the parties and written submissions were invited. The final submission received by the Office of Northern Coroner on 25 March 2019. Whilst this process has delayed the delivery of findings, the audio version of the calls are invaluable and provide the best available understanding of the chronology of events during the medical emergency, and resolved some of the questions unanswered at inquest (although not all).

Approach to Inquest

30. I have approached these findings with the following advice in mind "*If the aim of the coronial process is conceptualised as risk reduction and behaviour change, there is much to be said for the focus to be on issues other than individual blameworthiness. Personal deficiencies in the discharge of responsibility occur within an institutional and systemic context*".[2]

Holly Winta Brown

31. Holly Winta Brown was aged seventeen at the time of her death in 2015. She was and remains, the much loved daughter of Warren and Elle Brown and younger sister to William. The Brown family are from the Julatten District in far north Queensland. They are hardworking people and respected in the community, and by all who know them.

32. Holly attended Year 12 at Mossman State High School, it is apparent from her school records and the information available to me that she was a bright student, a happy girl, who loved school, her family, and her horses. Holly was an accomplished horsewoman. She aspired to become a vet. She was an active, sporty and vivacious girl raised within a loving family unit in a small and close knit community. At the conclusion of the inquest Mr and Mrs Brown were invited to speak about Holly and to share their memories of her. Holly's parents chose to play a slide show depicting photographs and videos of Holly, concluding with images of Holly competing in a gymkhana event.

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[2] *Minimising the Counter-Therapeutic effects of Coronial Investigations: In Search of Balance*. Ian FrecKelton QC; QUT Law Review. Volume 16 Issue 3 pp: 4-29

33. All present in court that day were left with the enduring image of Holly's delight, joy and vitality as she cleared various jumps and obstacles on horseback at full tilt. Holly's father told the inquest that the church overflowed at her funeral and that it was standing room only. Holly clearly touched the lives of many during her short life.

34. Holly's parents appeared at the inquest and represented themselves and Holly's interests over the course of the five day inquest. I was greatly assisted by Mr and Mrs Brown's participation in these proceedings. Mrs Brown was an excellent advocate, she was well prepared and often asked questions of witnesses that crystallised the relevant issues in an instant. I will later refer to Mr and Mrs Brown's submissions regarding their proposals for the implementation of 'Holly's Law'.

Autopsy results and medical evidence as to cause of death

35. The most probable cause of Holly's death was arrhythmia as a consequence of myocardial scarring, most likely from past rheumatic fever.

36. An external and full internal autopsy including a full toxicology screening was performed by senior staff specialist forensic pathologist Dr Paull Botterill on the 30th of June 2015, three days after Holly's death.

37. At the time of conducting the autopsy the cause of death was not clear. Dr Botterill considered possibilities such as respiratory infection, an irregularity of heart rhythm and drug toxicity.[3]

38. The results of the toxicology testing was negative for alcohol and drugs. Extra drug testing was ordered specifically for Gamma-Hydroxybutyric Acid, "bath salts" and synthetic cannabinoids. The toxicology certificate of analysis noted a result of 14 mg/kg of Gamma-Hydroxybutyric Acid. It was noted on this certificate that this level of Gamma-Hydroxybutyric Acid is within normal range found in post-mortem samples.[4] Dr Griffiths confirmed that the levels are affected by the amount of time between death and autopsy. [5] Both Dr Botterill and Dr Griffiths were satisfied that the level of Gamma-Hydroxybutyric Acid was within normal post-mortem range and confirmed this in oral evidence.[6]

39. Microscopic examination showed heart scarring and inflammation some of which could be contributed to protracted resuscitation, however there was localised heart muscle and scarring and inflammation.[7] Dr Botterill confirmed in his oral evidence when asked by the Coroner that the scarring was pre-existing and pre-dated the day of her death.[8] After excluding all the possibilities Dr Botterill was of the opinion that Holly died from an arrhythmia likely caused by heart muscle scarring (myocardial scarring) which was

[3] Ex A1, p. 8.
[4] Ex A.2.
[5] T1-37, 1-2.
[6] T1-26, 22- 29 & T1-37, 15-17.
[7] Ex A.1, p. 8.
[8] T1 – 31, 34-36.

possibly caused by past rheumatic fever. Dr Botterill explained in his oral evidence[9] that an arrhythmia cannot be detected at the post mortem state and that is why he recorded the cause of death as the direct cause of death 1 a) of his report was myocardial scarring and 1 b) of his report underlying condition was past myocarditis possibly rheumatic fever. [10] Dr Botterill confirmed in oral evidence that this was still his opinion as to cause of death.[11]

40. Dr Griffiths was sent the medical records of Holly from her general practitioner that dated back to 1998. After reviewing the records Dr Griffiths was of the opinion that the many entries between 2003 and 2006 where Holly presented to her GP with a sore throat and either with or without a fever could have been hidden streptococcal infections which is the body's immune response to the fever. Dr Griffiths noted that on occasions these were dealt with by prescribing antibiotics, however as Dr Griffiths explained in his oral evidence it is appropriate for general practitioners to not always reach always prescribe antibiotics.[12] In any event, Dr Griffiths stated that even if prescribed with an antibiotic such as penicillin she could still have developed the myocardial scarring which can take up to a decade to manifest.[13]

41. Neither alcohol or drugs contributed to the fatal cardiac arrhythmia that lead to Holly's death. [14]

The Township of Laura

42. Laura is a small town with a population of approximately 80 people. It is located in the Cook Shire within Cape York Peninsula. It is located approximately 300 kilometres north of Cairns and approximately 140 kilometres west of Cooktown. The Laura Rodeo and Campdraft and the Laura Races are held on the same weekend each year, falling on either the third or fourth weekend of June, at the Laura Rodeo and Racecourse Reserve grounds ("the grounds"), Peninsula Development Road Laura, approximately 3 kilometres from the township of Laura.

43. The population of the Laura township swells from a fixed population of approximately 80 people to approximately 2000 or more people for the weekend events, with many of the participants and spectators camping on site at the grounds.

44. The event is an institution and an important annual event in North Queensland, it has gained in popularity over many decades and families from around Cape York and further afield gather to enjoy the occasion each year. Many family groups have personalised, regular camping sites in and around the grounds. Until Holly's death in 2015 the event had run without a major incident.

[9] T1-27, 18-28.
[10] Ex A.1, p. 9.
[11] T1-27, 1-17.
[12] T1-35, 25-28.
[13] T1-36, 1-8
[14] T1-28, 38-47 & T1-37, 19-28.

The Laura Amateur Turf Club (LATC)

45. The LATC has operated for 120 years. It is a not-for-profit association operated by a volunteer committee, with limited funds. At the time of inquest Mrs Jennifer Sorenson was the Secretary of the Association and she appeared on behalf of the LATC at inquest without legal representation.

The Laura Rodeo and Camp Draft Association (LRCDA) Inc.

46. The Laura Rodeo and Camp Draft Association is a not-for-profit organisation operated by a volunteer committee also with limited funds. The primary person tasked with the event organisation in 2015 was Mrs Deborah Gostelow who was then the Secretary of the Association. The LRCDA engaged legal representation for the inquest. The LDRCA have organised the event for 40 years.

47. In 2015 Mrs Gostelow was responsible for event preparations including "*the medical coverage issue with the clinic*".[15] The following is extracted from Mrs Gostelow's statement:

> "*In summary, after some discussions, the clinic agreed that it would provide the medical services as it had done for previous years… 1-2 nurses at the event with the clinic ambulance. It was my expectation that this is what the clinic would provide at the site at the times agreed for the 2015 event*".

The Combined LATC and LRCDA Event

48. On the weekend on 26 and 27 June 2015 approximately 2000 people attended the Laura Rodeo, Races and Horse Sport events. Laura also hosted the Laura Dance Festival in 2015 the weekend prior to the combined race / rodeo event. The Dance Festival is organised and funded separately. The Dance Festival is a biennial event and many people stay on as they did in June 2015, to enjoy the rodeo and races the following weekend. Some estimates put the increase in numbers attending over the course of the dual event week every second year at 5000 or so.

49. Each of the two committees organise their separate events. The rodeo (bullriding) and camp draft events are organised by the Laura Rodeo and Campdraft Association (LRCDA). The horse racing events are organised by the Laura Amateur Turf Club (LATC).

50. The events attract many spectators and participants and events include a camp draft, horse sports (including events designed for younger people such as barrel racing and a gymkhana), a rodeo (bullriding and calf scruffing), and a bush horse race meet sanctioned by Racing Queensland.

51. At the commencement of inquest there remained uncertainty as to how many people actually attended and / or camped at the combined campdraft rodeo and races event in 2015. In a statement provided prior to the commencement of the 2018 inquest Mrs

[15] Exhibit E4 page 8 para 40

Gostelow indicated based on tickets sold that the crowd is unlikely to have exceeded 3000 people and that at any particular point in time over the weekend numbers may have been less.[16]

52. A further calculation was provided and a submission on behalf of the LRCDA was accepted at inquest, that approximately 2000 people attended over the course of the weekend for the 2015 year.

53. It is possible the number exceeded 2000, and the imprecise figures based on manual calculations of ticket sales (with each committee separately selling tickets for discrete particular events) raise a concern for regarding the accuracy of data available for future event planning and assessment of risk.

The Torres and Cape Hospital and Health Service (TCHHS) and the Laura Primary Health Clinic (the Laura Clinic or LHC)

54. The Torres and Cape Health Service is responsible for the Laura Primary Health Clinic. The LHC provides primary clinical care and primary healthcare services to the community of Laura and provides Level 2 emergency care.

55. Level 2 emergency care per the Health Queensland service description[17] is as follows:

- 24-hour access to RN/s and triage of all presentations;
- capable of providing treatment for minor injuries and illnesses;
- limited treatment of acute illnesses and injuries;
- provides basic resuscitation and limited stabilisation, including short term assisted ventilation prior to transfer to higher level service.

56. In 2015 two full time nurses were assigned to the Laura Primary Health Clinic. Their function was to provide primary clinic care and healthcare to the community of Laura, a community with a static population of 80 people. The clinic was resourced to provide an emergency first responder service to the local community (within the limitations of a level 2 primary health clinic).

57. The TCHHS engaged one additional contracted agency nurse to provide first aid at the 2015 event, and to backup the QAS.

58. At the outset, and for reasons set out below I **find** that the Torres and Cape Hospital and Health Service had a responsibility to, and did not, adequately plan for the temporary increase in population of between 2000-3000 people during the 2015 rodeo and race event (referred to as a 'mass event' as attendance exceeds 1000 people). In the absence of advance assessment and planning, the Laura clinic became the first emergency responder service to a population of 2000-3000 people.

[16] Exhibit E4 page 4 para 22 and 23
[17] Department of Health Emergency Services Module Overview CSCF v3.2

59. I **find** that in 2015 the Laura Primary Health Clinic was not sufficiently equipped, resourced or prepared to provide a first emergency responder service for unplanned medical emergencies at a mass gathering event.

60. I **find** that the emergency medical response provided to Holly Winta Brown at the 2015 Laura Rodeo and Race weekend was inadequate.

61. I **find** that the inadequate response to the medical emergency was a result of an absence of formal direction, guidance and policy establishing appropriate protocols and pathways for all stakeholders in relation to roles and responsibilities for event planning and risk assessment in the context of a mass gathering.

62. I **find** that the lack of clear policy and guidelines within the Queensland Health, the Torres and Cape Hospital and Health Service, and / or standardised procedures generally in Queensland, for mass public event planning, mitigated against co-ordinated interagency planning.

63. It is appropriate and necessary that pathways for approvals and permits that include planing for an emergency medical response, and based on contemporary risk assessment methodology, be established between the LATC and the LRCDA and local government with input from the Torres and Cape Hospital and Health Service and the Qld Ambulance Service. It is essential that event organisers play an active role in the event planning as a whole and not just for the discrete events for which they are organising. They can only do this with an informed understanding of planning for mass public events so that they can develop the risk assessment tools that will ensure safe mass gatherings into the future,

64. I intend to make a recommendation that will establish the framework for this interagency approach and trust that much needed reform will result.

Holly's medical emergency – 27 June 2015 chronology

65. Mr Warren Brown's evidence at the hearing and his statement was that Holly woke at around 6am[18]. Holly had a cup of tea and upon Mr Brown returning from the shower block he noticed that Holly was vomiting.[19] Holly said that her back was sore and she then laid down on a camp stretcher. Mr Brown rubbed Holly's back and she reported a shooting pain down her spine.

66. Around 7am Holly took the panadol provided by her father. She tried to rest but got up at one point to speak to her mother and uncle and reported a pain in the chest. At around 8.30am or soon after Mr Brown went to check on Holly and found she could not be roused. She was limp and her pulse felt weak. Mr Brown started CPR and Mrs Brown attended to the resuscitation.

67. Mr Brown called to others nearby to get an ambulance. He recalled that people were trying to call the Laura Clinic via mobile telephone but were unable to get through. The

[18] Exhibit B5 para 14
[19] Exhibit B5 para 21 / 22

Lansky family who were camped next to the Browns were also trying to obtain help. Miss Judith Guiney, camping in the group with the Brown family and others, was asked by Mr Brown to find a paramedic urgently as Holly was not breathing.

68. Members of Miss Guiney's party set off on quad bikes to the rodeo arena and race course to alert the ambulance to the emergency. As there were horse sports events in progress that morning it was anticipated that paramedics would be available. They returned with news that there were no paramedics (QAS) onsite and an announcement was made over the PA for medical assistance. It was also described that other campers took off on foot shouting for anyone at the grounds with medical training. There were reports of people also setting off on horseback to seek out medical assistance.

69. The picture is one of pandemonium and chaos. Campers commenced dismantling structures to allow access to emergency services. The closest ambulance (already en-route to the event) was 1 hour and 20 minutes away from the scene at the time the unit was first notified.

70. Miss Guiney set off to locate the first aid nurse posted at the grounds that morning. She attended the first aid hut and saw that it was open but not staffed. Miss Guiney says she called out for 5 minutes and was approached by a woman (Nurse Leighton) who said that she 'was the only first aid nurse'. Miss Guiney gave evidence that Nurse Leighton appeared to have no urgency to make her way to the scene, and no equipment or supplies with her.

71. Nurse Katherine Leighton was an agency nurse, contracted by the Torres and Cape Health Service (TCHHS) to assist the Laura Primary Health Clinic for the duration of the event. She arrived at the Laura Horse Sports and Rodeo grounds around 6.30am in her capacity as a 'first aider'. She located herself ringside. She stated, "*I was located ringside at the Rodeo and Horse Sports Area, at the site designated for me the previous day*."

72. Nurse Leighton says that she was in proximity to the first aid station (hut) where she was required to be and that she did not appreciate at the time by what was conveyed to her that the incident to which she had been called was a medical emergency.

73. Miss Guiney returned to the Brown's campsite with Nurse Leighton. Miss Guiney saw a young woman (Janae Ives) approach the scene and advise that she was an emergency nurse. Ms Ives appeared to take control.

74. Miss Guiney then went to comfort Holly's brother and friends. When she returned to the scene, she noticed a medical bag on scene and heard 'verbal frustration' that some of the equipment was not functioning properly.

75. Ms Ives, the off-duty nurse from the Cairns Hospital Emergency Department recalls being called by her father at 8.56am (she noted the time on her mobile phone) to assist Holly who was then unresponsive. During the inquest Ms Ives said she is certain about the time as she noted it on her mobile phone when her father called her to assist. She

told the inquest in oral evidence that the other times in her later statements were estimates as she didn't then have her phone to cross check when preparing her statement.

76. Ms Ives recalls examining Holly who was laying on a swag. Ms Ives observed that Holly appeared pale and sweaty, she had a patent airway, shallow breathing, a weak radial pulse, her eyes were closed but her pupils were equal and reacting to light. She was incontinent of urine. Ms Ives assessed Holly as having a Glasgow Coma Score (as assessment of consciousness) of 7 out of 15.

77. Ms Ives recalled that Holly arrested at approximately 9.10am. She says she commenced CPR at this point. She recalled that around this time there was no medical team on site and at some stage she was informed that the QAS were forty-five minutes away. She recalls being informed that a helicopter was aware of the situation and on another flight.

78. Ms Ives' evidence is that at 9.35am CPR was continuing to be performed by bystanders and she asked Queensland Police Service (QPS) officers at the scene to transport her to the Laura Clinic so that she could obtain equipment. En-route to the clinic Ms Ives saw the clinic nurses (in the LHC troop carrier) arrive at the grounds so she returned to the scene with the QPS officers without attending the clinic.

79. The chronology of events and the time of the commencement of the emergency became a significant issue for the inquest. Even with the assistance of all the evidence, it has been hard to situate an exact. accurate chronology of events.

Transcript of Triple 0 Call

80. I set out below a call log derived from cross referencing the two Triple 0 audio calls with the Auscript transcript of the calls, and the QAS operations centre incident detail report (a snapshot of the events and the actions by operations centre staff to record relevant events and to deploy resources).

JB Joan Berzinski
PM – paramedic (Taryn)
KL – Katherine Leighton (Laura clinic 'first aid' Nurse)
OP – call operator

9.38		Joan Berzinski places a Triple 0 call (summarised below).
		Queensland Ambulance. What is the town or suburb of the emergency?
	JB:	Laura it's the Laura Rodeo grounds. We're down the back in the camping area.
	OP:	Tell me exactly what happened
9.40	JB:	We've got a young girl that's laying on the ground not really conscious
	OP:	Tell me exactly what happened

JB: She's been up, had breakfast, she's spewed a few times. Now she's just gone unconscious.. she went back to sleep and she's not waking up.

OP: Is she breathing

JB: She's breathing but her eyes are slightly open…there's no – she isn't They're doing CPR on her at the moment

9.40.27 OP: They are? Okay. So she's not breathing at the moment. Okay all right.
We're organising the paramedics.

JB: Isn't somebody a nurse, we have a nurse here, but

OP: CPR In progress. That's fine. I'm getting that information out. Okay. So-okay. Is there a defibrillator available?

JB: No we need something

OP: Yeah that's fine.. we've organised paramedics to help her. Just stay on the line. I'll tell you exactly what to do next. Okay so you want to ask the nurse does she need any support with, any verbal support with CPR instructions?

JB: (speaking to nurse) , No

OP: No. That's fine. Okay I'm just going to stay on the line. We've got help on its way and just, if the nurse gets tired, if somebody else can jump I and just take over.

JB: She's a triage one.

9.41.41 OP: Yeah okay. A triage nurse. Yeah. All right. Okay and yeah. Just if she gets tired at all… is there anybody able to go to the front

JB: I think Gordon has gone out, gone out to the front to meet the ambulance? Yeah

JB: Is the ambulance on its way?

OP: Yeah we're organising that now. We do have an ambulance on it's way, but we're trying to get the Laura first responders – the clinic to come and give you some help straightaway as well. Now, I've been told that it's Craig road in Laura is the rodeo grounds.

JB: Possibly I don't know we are not from here we've just come up for the rodeo.

OP: So the patient actually got up this morning and had breakfast

9.43.06 JB: Yeah she's vomited a few times and she went back to sleep and now she's like

OP: Yeah vomited a few times Okay how long has CPR been in progress

JB: It's just started happening now.

OP: All right just when we started talking?

9.43.12 JB: Yeah they started just before I rang you. They started…

OP: Well just tell them to keep it up, keep performing the CPR. Have somebody take over as required, just to keep it effective, and just keep letting them know we're on our way. We're sending help now.

OP: and the nurse that's there, is she a local or a visitor there

JB: I'm not sure.. is this lady a local do you know, or is she a visitor, are you a local, or – yeah she's a local

OP: Sorry she's a local?

JB: She's a local

9.44.15 OP: Just, we're trying to work out all the people that are available at the moment

OP: Yeah so local nurse ok all right ok well just tell them to keep going Okay and we're coming as soon as we can

OP: Ok is the local nurse able to advise, is she the actual clinic nurse on duty at the moment?

JB: Are you the clinic nurse on duty at the moment ? Yes.

9.45.08 OP: She is. Okay. That's fine. We're trying to get the police as well.

JB: Yeah there's an ambulance on it's way Gordon but we need to know, show them where to come in.

OP: Tell them to keep going we're getting someone there as quickly as we can. So what's happening there now?

JB: Is she breathing? She's not - they're doing mouth to mouth now. They had her on her side because… but they've just rolled her back and doing mouth to mouth and CPR now
She doesn't appear to be responding at all CPR but they're all working on her
My husband was going to go to the front gate.

OP: We've got Alan from the general store as well.. he's on his way out…

9.47.47 JB: We've got a student paramedic just arrive now

OP: Is he local?

JB: I don't think so

JB: They've got her back on her side.

OP: Okay is she breathing

9.48.29 JB: Is she breathing guys? No. She's stopped again. She's stopping and starting
They're CPR-ing. They're full on pumping her chest

OP: Just tell them to keep going we're getting there as soon as we c

JB: You need to hurry. It's not good, are they actually on their way?

OP: Absolutely. Yes. From the start when we first worked out what was happening, we got resources going and what we're trying to do is get as many resources and as closer resources, the closest resources to you there in Laura. So we're doing everything we can. Are you able to find out is that paramedic Andy Stemler?

JB: I'll put her on

9.51.37 OP: Yeah, hi. The phone is going in and out there. Sorry. Who am I speaking to?

T: My name's Taryn. I'm a student paramedic. Breathing rate is two breaths per minute. No other medical conditions, so it's not to support life. They need to Code 1

OP: Yeah. We're definitely. Just please understand you're really in a remote area. We're getting as many resources and trying to get as close resources as we possibly can.
We are coming. We are looking at helicopters, everything, okay.

OP: Who am I talking to? Sorry, you're I'm very, very sorry. It dropped out as you said your name, the lines not very good. Okay all right Karen or Sharon? I'm sorry , but it's really Taryn
Excellent. Okay. I'm so sorry. The line is not very good. Well, Taryn, I'll just let you know the… has been activated.

OP: Ok this line is terrible. Just give me a second line I swap it over

T: She's not breathing properly

OP: Okay That's fine and is the clinic nurse still administering CPR .. okay all right I'm so sorry this line is just terrible. I'm getting every second word that you say

T: Yeah so the clinical – clinical nurse is doing it

OP: Yes. All right and she's doing the CPR ?
Yeah I'll just stay on the line if there's somebody there that wants to just stay in contact here. Oh great.

9.53.31 **LINE DROPPED OUT CALL DISCONNECTED**

Second Triple 0 call (Nurse Leighton)

OP: What is the town or the suburb of the emergency? Laura at the rodeo grounds Okay. And this is where the CPR is being performed on .

KL: This is correct.. we've got CPR being performed on an 18 year old girl. She was non- responsive [inaudible] causing this airways [inaudible] CPR is being [inaudible] as we speak

OP: All right I just want to reassure you we've got the helicopter has been tasked.. so we're and we're contacting all the local resources that we can possibly send to assist

KL: Well I know the … I know the ambulance is coming from the clinic we really need a helicopter…. You can't give me..

OP: I'm speaking with >

KL: You're speaking with Katherine. I am actually one of the nurses at the Laura Clinic

OP: Clinic ? okay allright

KL: I'm just down here for first aid, so I don't have anything..

OP: No. That's fine Okay thank you Katherine. OkayI can let you know yeah we've got.. no time has been given. Is there a landing zone that we can prepare

KL: There is a landing zone. The landing zone would be in the middle there – in the middle of the racetrack

OP: and do you happen to have the GPS coordinates or able to obtain them

KL: GPS coordinates, do we have GPS co-ordinates

OP: Yeah ok that's fine. Okay I just want to reassure you, we are doing everything in our power

KL: I'm speaking to the ambulance Triple 0 now. I'm Katherine. Thank you, we're getting GPS

KL: Yeah the helicopters being sent They just want GPS co-ordinates

OP: And just reading my notes, we've got the police coming out and they'll assist with the landing zone, as well there

KL: Okay so the ambulance is coming out too..

OP: The ambulances yep and we've also contacted..

KL: Where's the ambulance?
Yeah, we've contacted the firey's as well, so we're seeing if there's any extra resources there we can access

KL/OP: we can't find the local nurse

KL: I am the local nurse

OP Sorry
Yeah

KL: and I rang [inaudible] still said she was getting [inaudible] coming straight with the ambulance Nurse.. so that's why..

OP: All right. Okay so is CPR still in progress at this time?

KL: CPR is still in progress. They're waiting for the GPS co-ordinates

OP: Yes thank you very much Katherine

KL: First aid kit

OP: Okay

KL: The ambulance is coming. They will have that 20 they've got
Is there anything like that / we don't know sorry

KL: ??Over there I reckon Racecourse. Yes I'm the nurse, but other paramedic people have taken over that CPR and the breathing. She is very unresponsive and not looking good.

OP: Yeah

KL: Look we've got GPS coordinates happening.
First aid kit or anything?

KL: No the ambulance is bringing one.. Okay I've just got first aid for.. it's all I've got.

OP: Okay, Katherine I'm ready for those coordinates

KL: Yeah no I'm waiting for the co-ordinates

COORDINATES GIVEN

KL: We've got a lot of panicking people here.. I haven't got the equipment I need [inaudible] what I'm doing

9.59.22 OP: I understand So all I can do Katherine ..just be reassured we are doing everything in our power to get you the support that you need as quickly as possible. Okay?

OP: Can I just check, I've got the phone number from the original caller.. is there an alternate phone number that I can call the scene again if we need to

KL: I've got the first on call phone for the Laura Clinic, so that would be your .. First on call
Just the clinic

OP: For the Laura clinic

KL: Yep

OP: Ring that and it didn't come through earlier. Is there a sat phone on screen at all?

KL: A sat phone. We've got the police on scene.
OP: Okay. Police are now on scene
KL: No we haven't got a sat phone
OP: No. That's fine. I just thought I would ask the question. Okay all right Thank you Katherine
OP: So police are on the scene. No not
KL: No other – just – this is our ambulance.
OP: Ok so the clinic ambulance is now there?
KL: Clinic ambulances out here have got everything they need in the back
OP: Excellent
KL: Well we've got a few more things than we had before.
OP: All right now Katherine do they have a defibrillator on board that ambulance?
KL: No we don't have a defibrillator
OP: No?
KL: Do we?
KL: We've got , yes
OP: That's fine. Okay
KL: This is the only [Inaudible] now, just calm down girls.
OP: Yeah we are doing everything in our power
10.02.24 KL: I know. I know. I know. There's [inaudible] AED has come in. Let's just [inaudible] okay. We've got AED on site now
OP: You do? There is an AED on site? All right that's great.
KL: We've got the drugs. Have you got the drugs still [inaudible] have you got the adrenaline
This doesn't have adrenaline in it
KL: Operator
OP: I'm right here
KL: [inaudible]
OP: Do you need to be released to go an help
KL: go with them, what key?
? we need keys to get in to the
KL: Ok we've got oxygen happening now, we've got the AED
OP: okay. And so is the – are they returning to the clinic to pick up the adrenaline?
KL: we've got quite a bit of stuff here. Okay, all right, I'm staying on the phone.
OP: Okay
OP: So Katherine are they returning to the clinic to pick up the adrenaline?
KL: somebody yes
? I will get this adrenaline up
So do we have adrenaline? Yes we do have adrenaline
OP: Ok all right and CPR is still in progress?
KL: we've got CPR being maintained. We've got the defibrillator on. We've got someone doing [inaudible] we'll be able to put the adrenaline in that
We've got [inaudible] being oxygen

OP: yeah all right has she got a good airway now?
KL: Her airway's not too great.
OP: No okay does she have a medical history that you're aware of?
KL: Nothing aware of.
OP: Yeah is she there with her family, the patient or is she there on her own?
KL: Who's doing a needle
KL: No she's [inaudible] rodeo.
OP: Okay she's with the rodeo?
KL: She's with a group at the rodeo
OP: Okay. Sorry. Yeah Okay.
KL: So that's one milligram. We're giving her one milligram of adrenaline.
OP: Okay what's happening there now?
10.06.27 KL: Shocking the patient
OP: Okay. What's happening there now? Are we back to administering the pump?
KL: nine- 10.05 Adrenaline is…
Got an airway
airway 10.07 – 10.07 let's put 10.07
Adrenaline
Airways
Defib. Shock. No shock advised [inaudible] yeah yeah.
All right I'm
OP: All right Katherine
KL: 10.08
KL: all right
OP: Okay Katherine
KL: Katherine if the clinic ambulance has arrived and you've got all hands on deck working on her, what I will do is let you go.
KL: No we haven't got the QAS ambulance, we've only got the clinic
OP: The clinic ambulance? Yes, that's fine. Is there any further support that I can give you over the phone at this time
KL: No there isn't, you can…
Thank you
Bye
Call back on triple 0

Mobile telephone coverage and communications

81. There was sufficient evidence in the inquest to satisfy me that mobile phone coverage was of the poorest quality. Evidence of this need only be found in the Triple 0 calls firstly made by Mrs Berzinski with that call dropping out. The quality of the second call was equally poor. Despite having the audio formally transcribed by the official court transcription service, there is literally much lost in the translation (as the reader will note from the gaps in the above) because the quality of the phone connection was so poor. Critical information was lost or misunderstood. The operator required skill and patience to glean the relevant information from the callers (she herself says "*this line*

is terrible"). The phone reception impeded both Mrs Berzinski and Nurse Leighton from the benefit of clear communication with the operator.

Findings in Relation to the Chronology of Events

82. On balance I **find** that the most accurate chronology available to me on the evidence is as follows:

    a) Holly was noted to be non-responsive by her parents sometime between 8.30am and 9.00am;

    b) Holly's father and nearby family friends commenced CPR and called for assistance;

    c) Janae Ives was alerted to the emergency at around 9.00am; she attended and saw Mr Brown, and others, performing CPR; she completed her own assessment and took a brief history from Holly's parents;

    d) At around 9.10am Holly, in Ms Ives presence, went into cardiac arrest. Ms Ives commenced CPR and called for assistance.

    e) At 9.38am (first logged keystroke) the first Triple 0 call was made by Joan Berzinski;

    f) At 9.40am. Mrs Berzinski told the call centre operator that CPR had been in progress since just prior to her call;

    g) Nurse Leighton (the first aid nurse) arrived on scene at or around 9.54am;

    h) The Laura clinic nurses (Harvey and Farrelly) arrived on site in the clinic troop carrier at 10.00am (with an AED; adrenaline and oxygen);

    i) Between 10.02am and 10.06am a travel AED was applied and registered a non shockable rhythm; oxygen was administered; adrenaline was administered;

    j) The QAS crew arrived at the grounds at around 11.00am;

    k) The Careflight helicopter and doctor arrived on scene at 11.15am.

83. I was required to reconcile Ms Ives recollection as to the time Holly went into cardiac arrest (around 9.10am), and the time provided by Mrs Berzinksi to the Triple 0 operator (at 9.38am).

84. I also took into account the QAS electronic ambulance report form (EARF) which noted:

> *"cardiac arrest – witnessed by other 27 June 2015 9.30 & outcome no spontaneous circulation"*

85. I do not know if the reference to 9.30 on the EARF is a carry over from the information provided by Mrs Berzinski to the operator (that CPR commenced just prior to the commencement of Mrs Berzinski's triple 0 call or by way on an independent handover (by a nurse) when the QAS arrived.

86. Two possibilities arise, the cardiac arrest:

    i. the cardiac arrest occurred at 9.10am as stated by Ms Ives and therefore the first Triple 0 call was placed almost 30 minutes after cardiac arrest (Mrs Berzinski had only just arrived on the scene herself and in the confusion she may not have realised that CPR had been in place for a longer period or had conveyed incorrect information provided by someone at the scene); or:
    ii. the cardiac arrest occurred just prior Mrs Berzinski's first Triple 0 call (between 9.35am and 9.40am), as she reported to the operator, and therefore Ms Ives recollection of the time is inaccurate.

87. Ms Ives further evidence is that she had been working on Holly for about 'one hour prior to the first shot adrenaline being administered'. Ms Ives observed Holly go into cardiac arrest at or around 9.10am. The Triple 0 call corroborates the first shot of adrenaline was administered sometime around 10.06am, therefore Ms Ives recollection of Holly arresting at around 9.10am can be accepted as accurate.

88. On the balance of probabilities, I find in favour of scenario 73 i. above, and I accept the evidence of Ms Ives, that Holly went into cardiac arrest at approximately 9.10am, (and therefore 30 minutes prior to the first Triple 0 call).

89. I attribute the delay in (any person) making a Triple 0 call to the confusion at the scene and an apprehension by those present, including Mr Brown, Holly's father, that an ambulance was already on site (thereby delaying the need to call Triple 0 immediately).

90. I make no criticism whatsoever of Mrs Berzinski's recollection of events, she conveyed the most accurate picture based on her observations and knowledge to the Triple 0 operator at the time.

91. I am also satisfied when the Triple 0 operator asked "*is the local nurse able to advise, is she the actual clinic nurse on duty at the moment*"? Mrs Berzinski asked Janae Ives "*Are you the clinic nurse on duty at the moment*". Mrs Berzinski then replied to the operator, "*Yes*".

92. The (Laura) clinic nurses (Farrelly and Harvey) were not on the scene at the time. Ms Ives was in fact a 'clinical' nurse in her professional life and I find that when asked by Mrs Berzinski, she may have misunderstood the question and responded accordingly. A student paramedic 'Taryn' (also off duty and attending the event as a spectator) confirmed with the operator (when referring to Ms Ives performing CPR), "*the clinical nurse is doing it*".

93. Having reconciled the issues of (a) the probable time of Holly's cardiac arrest and (b) the issue of a 'clinic nurse' (not) being on site, I **find**:

    (i) The Laura Clinic nurses and troop carrier arrived within 20 minutes of the first Triple 0 call, although the trigger for their deployment to the grounds was due to direct communication from Ms Gostelow to Nurse Farelly's private mobile phone (not via Triple 0 call centre);
    (ii) Holly arrest occurred fifty minutes prior to the arrival of the clinic nurses;
    (iii) A Queensland Ambulance was assigned to the job at 9.41am and proceeded code one under lights and sirens, arriving on site at 11.02am. QAS were further delayed upon arrival because entry into the grounds was made difficult (there was only one access) and no one was present to meet or escort the QAS to Holly.

Nurse Kathrine Leighton

94. At around 9.54am Nurse Katherine Leighton, attended the grounds in the capacity of a 'first-aid nurse' and to back up the Queensland Ambulance if required. Nurse Leighton made the second call Triple 0 call at 9.54am. She remained on the line until the triple 0 operator terminated the call (upon the arrival of the Laura Primary Health Clinic troop carrier) at around 10.06am.

95. During her 12 minute Triple 0 call Nurse Leighton impressed on the operator that a serious emergency was underway. She advised the operator that she had contacted the Laura clinic nurses and knew the clinic ambulance was on its way, but that a helicopter was needed on site. Nurse Leighton also conveyed that there was a landing zone in the middle of the racetrack and she obtained GPS co-ordinates during the call to provide to the operator.

96. Nurse Leighton also conveyed that "*other paramedic people*" (a reference to off duty student paramedics attending the event in a private capacity) 'have taken over CPR and the breathing' and that "*she is very unresponsive and not looking good*".

97. I formed the impression from the audio of the Triple 0 call that Nurse Leighton was professional in her demeanour, she was concerned, and seized of an understanding of the seriousness of the matter. She was frustrated at the lack of resources available to her, she was willing and able to facilitate all that was asked of her by the operator including obtaining GPS co-ordinates for the helicopter.

98. She told the operator, "*we've got a lot of panicking people here……..I haven't got the equipment I need.*"

99. Nurse Leighton also confirmed that she had the first on-call phone for the Laura Clinic and that she was the point of contact at the scene. Nurse Leighton conveyed that there was no satellite phone at the scene. At 10.02am Nurse Leighton told the operator that the clinic ambulance was on site and that they would have everything they needed in the back. There then appeared to be some confusion at the scene about whether or not a defibrillator and adrenaline was available when the clinic nurses arrived in the ambulance.

100. At 10.02am Nurse Leighton can be heard saying (who I accept were Nurses Farrelly and Harvey from the Laura Clinic), "*Just calm down girls.*"

101. Nurse Leighton can then be heard having a discussion about a key to get 'back in' (to the Laura Clinic to get more supplies). Nurse Leighton conveyed to the operator that there was 'oxygen and an AED'.

102. Nurse Leighton also conveyed to the operator that there was a person returning to the clinic to pick up adrenaline. She then quickly indicated that the adrenaline had been located. "*We've got CPR being maintained. We've got the defibrillator on. We've got someone doing (inaudible) we'll be able to put the adrenaline in that. We've got (inaudible) being oxygen, her airway is not too great, we're giving her 1mg of adrenaline.*" At 10.06am Nurse Leighton advised that Holly was being shocked, "*Adrenaline, airways, defib, shock, no shock advised*."

103. Soon thereafter the Triple 0 operator suggested terminating the call because the ambulance was on site. Nurse Leighton indicated "*we haven't got the QAS we've only got the clinic*" The QAS incident detail report notes 1st Unit (I now understand this to be a reference to the Laura Clinic vehicle) arrived 10.06.38 (hrs). The operator replied "*the clinic ambulance, yes that's fine*" and after confirming no more support could be delivered over the telephone the operator terminated the call.

104. Nurse Leighton has been a registered nurse since 1977, and worked as a remote area nurse for ten years. She was on assignment to the TCHHS via a nursing agency (a service that provides nurses to rural and remote communities) for a one week period to cover the Laura Rodeo and Race weekend.

105. Nurse Leighton at inquest gave evidence that she had been assigned to the event as a first aid nurse only, and then, only as back up to the Queensland Ambulance Service. The only equipment to which she had access on site at the grounds was a basic first aid kit. Her role, essentially as she understood it, was to attend to minor injuries and to assist the Queensland Ambulance Service if called upon to do so. She could also call the Laura clinic for assistance if required.

106. It is apparent from the Triple 0 call during the 12 minutes that she was assisting the operator that Nurse Leighton was aware and concerned at the lack of equipment available to her, noting that she was first on-site. She also expressed an appropriate professional appreciation of the medical emergency unfolding. During that call it was apparent that Nurse Leighton was competent and clearly conveyed the required information. She also attempted to calm the nurses from the clinic when they arrived on-site and saw the extent of the emergency underway.

107. I refer to the statement of Katherine Leighton[20] wherein she states,

[20] Exhibit G 7.1

"*I was instructed to provide first aid only from Vikki Jackson as the Director of Nursing and Patricia Harvey as the Health Centre Manager. The conversations were between Vikki Jackson and Patricia Harvey. Further support in the event of a medical emergency was available through phone contact with nurses at the LPHCC"*.

108. Nurse Leighton sought further advice from the Director of Nursing as to the expectations of the team and stated that she received no further direction.

"*It was ongoing from when I arrived and I wanted further clarification through conversations with the Health Centre Manager. I also had a conversation with the nursing agency I was employed through*."

"*My understanding was the reason I was employed was to support the QAS and offer first aid support when the QAS was not in attendance*."

"*I can't recall exactly who or when I requested information that LPHCC nurses were not to provide services unless requested*."

"*I can't recall exactly when I was informed we were not to provide services at the grounds unless requested or when that changed to then providing first aid services at the venue*."

109. Nurse Leighton stated[21] when she attended the grounds on Friday afternoon she then realised the QAS were not present for the afternoon horse events and was informed by an organiser that events were organised by different groups with QAS attending the higher risk events.

"*I was not aware until my arrival on Saturday morning (*27 June*) that QAS would not be at this event*."

"*I was not aware, nor did I realise that I was the only medical person on site until I got there*."

"*I thought my role was to provide initial first aid. I formed this opinion through my belief in what I was employed for and reaffirmed through the nurses discussion at the LPHCC*."

"*I did not know that my role was to cover all public needs*."

"*I was prepared for basic first aid care only*."

"*The plan was to phone for back up which was nearby at the Health Clinic*."

"*There were no instructions relating to the communication method with either the public or the organisers. No communication devices were provided*."

[21] Paragraph 18

110. Nurse Katherine Leighton was not properly briefed or prepared as to the nature and extent of the role and expectations required of her on 27 June 2015 or for the event as a whole.

111. Nurse Katherine Leighton completely exposed as the employed 'medical person' at the grounds on 27 June and it is troubling in the extreme that Nurse Leighton was not aware until she attended the grounds on that Saturday morning that she was the only medical person on site and that QAS were not scheduled to attend the morning event.

112. Further compounding Nurse Leighton's vulnerability, despite the fact that the nurses then on fatigue leave were 'second on call', Nurse Leighton had no adequate onsite backup available to her whatsoever. Nurses Farelly and Harvey had by that time been on duty for almost 24 hours and were entitled to fatigue leave – and yet were placed in the position of having to be on call at all on the morning of 27 June (as backup). Nurse Leighton was unable to meaningfully assist a medical emergency given her designated role and lack of resources.

113. Upon her arrival at the scene of Holly's emergency Nurse Leighton immediately knew that the situation was critical and she knew she had absolutely no equipment or resources to advance the care already being administered by Janae Ives and student paramedics with the assistance of bystanders.

114. For these reasons I find any characterisation of Nurse Leighton as being professionally inadequate to be without merit. She was not provided with any professional scaffolding whatsoever by the TCHHS such that she could adequately respond to a medical emergency, the magnitude of Holly's.

Laura Health Clinic Nurses

Nurse Krystal Farrelly

115. At the relevant time Krystal Farrelly was employed at the Laura Primary Health Care Clinic as a registered nurse. It is apparent from Nurse Farrelly's statement and her evidence at inquest that she was aware of conflicting emails and communication between Vikki Jackson and Trish Harvey (wherein it was discussed that nurses were not to attend the rodeo event and were to work normal shifts), and the emails and communication between Mr Fenton and Mr Shattock (where nurses were to attend the events).

116. Nurse Farrelly was aware that Nurse Leighton was expected to attend the grounds on Friday and Saturday as a first aider and to provide relief for the clinic nurses. Nurse Farrelly became aware on the morning of 27 June 2015 that Nurse Leighton was expected to be the only medically trained person attending the grounds. Nurse Farrelly also gave evidence as to the protocols, that the first on-call was not to attend a serious medical event on her own, instead she was to contact the second on-call nurse so they could attend the emergency together.

117. Nurse Farrelly and Nurse Harvey were both on fatigue leave at the time of Holly's emergency. They had, after their day shift, both (as a pair), completed two return trips from the Laura Primary Health Clinic to Cooktown to convey unwell and injured patients to the Cooktown Hospital:

> **Trip One** Nurses Farrelly and Harvey conveyed an unwell patient from the Laura Health Care Clinic to Cooktown at approximately 6.30pm the evening before and returned home at about 11.00pm on 26 June 2015.
>
> **Trip two** Nurse Farrelly and Harvey were called to a further incident at 1.30am (27 June) which required both nurses to convey a patient with a possible spinal injury from Laura Primary Health Clinic to Cooktown and they returned to Laura at approximately 6.30am.

118. At the conclusion of their day shift on 26 June, Nurse Harvey and Farrelly were then required to undertake two return conveyances (Laura – Cooktown) by road during the night, a total of 600 kilometres within 12 hours. As they had attended two call-outs in the one night and worked the day shift prior, they determined it was not in the best interests for them to attend the grounds for the events scheduled on 27 June and assigned Nurse Leighton as the first aider at the site.

119. Nurse Farrelly stated that during the five weeks she worked at the Laura Primary Health Clinic she had just three days off (when her mother admitted to a Brisbane hospital).

120. Nurse Farrelly was employed at the Laura Clinic from 1 June 2015 to 13 July 2015 and during that period she indicated that there were numerous emails and phone calls between Vikki Jackson, Julie Ross (the acting Director of Nursing), James Shattock (Agency recruitment for Queensland Health), herself, and Nurse Harvey, and the nursing agency to address the issues of fatigue.

121. Nurse Farrelly made a decision to cease her three month contract at Laura after only 5 weeks due to the issues that had arisen at the clinic.

122. She deposed:

> *"a minimal fatigue structure, minimal breaks whilst on fatigue as calls to the Queensland Ambulance Service communications department would still be diverted to the (her) on call phone resulting in broken fatigue*.
>
> *Two nurses were required to attend call outs and as there were only ever two nurses posted at the clinic there was never a chance to have fatigue or a day off.*
>
> *A lack of support by Queensland Health in regards to equipment access and safety including multiple issues with the stretcher and equipment and no lights or sirens to attend emergencies and no life packs in the vehicles*.

In her first week at the clinic nurses were expected to attend call outs on their own, including a suicide by hanging where the clinical nurse was going to attend the incident on her own. Nurse Farrelly suggested she attend with her."

123. After Holly's death, Nurse Farrelly (when she realised Nurse Harvey would be leaving) expected that the clinic would then revert to one nurse when Nurse Harvey between the changeover of clinical nurses.

124. Nurse Farrelly stated that, "*The role and expectations of the registered nurse/clinical nurse role is far beyond reasonable in regards to workload. As this was my first remote placement, I felt very overwhelmed as an RN. I was not comfortable to attend call outs on my own and had addressed this with my clinical nurse in the first week, however it was not until the change of clinical nurses that it was addressed. It was never outlined in my contract that I would be working/on call 24/7 including weekends"*.

125. In preparation for the 2015 event Mrs Gostelow of the LRCDA contacted a private service (Townsville First Aid) for first aid / paramedic attendance at various events throughout the weekend. Mrs Gostelow also posted a request for assistance on Facebook and Nurse Farrelly responded. The exchange follows:[22]

LRCDA communication with Nurse Farrelly

On 5/6/2015: (KF: Krystal Farelly. DG: Debra Gostelow)

KF- This is in relation to the post for a medic for the camp draft, I work at Laura Clinic, as an RN. I may be help you out on the Saturday morning depending if I'm on call or not. I will let you know.
DG- Thank you Krystal please let me know as soon as you can
KF- Will do

On 17/6/2015:
DG- Hi Krystal, did you find out if you can help us out Saturday
KF- Sure have n yes I can, won't be a problem
Have you got a first aid kit etc
What time to you need me??
DG- we start at 6.30am and finish about 12 or 12.30. We only have a store bought first aid kit? We can pay the clinic for anything we need if that works. You can't do Friday can you? We'll pay for your time of course.
KF- That should be fine. Sorry I'm rostered on at the clinic on Friday otherwise I would. Hope that helps though.
DG- Thank you so much you're gold.
KF- Not a problem, I'll be around Saturday where will I go when I am there
DG- Come to the tea stall (canteen). Maybe send me your mobile so we can stay in touch. Mine is…….. if you have any questions. You don't know anyone who can do Friday morning?
KF- No, sorry. We're all rostered at the clinic on Friday but they are meant to be getting extra QAS to attend for the rodeo so I'm told. My contact is…..

[22] Appendix 5 statement of Krystal Farrelly 4 December 2017

Sorry but who am I talking with?

KF- But if there are any problems on Friday you can call the clinic on Friday we can attend if we need to and your concerned, or send them in.

DG- Sorry, Krystal its Debbie Gostelow, I'm the secretary and yes I have QAS for Saturday night and Sunday but it's very expensive for the club. Is there a manager for the clinic.

KF- Yes you could speak to Peter Fenton he works mainly from Wujul Wujul clinic so you could contact him from there. I'm happy to go Friday if I get the okay from him. But I am unsure if he will.

DG- Maybe it's best to sort out price now, what would you like for that period of time? I have no clue what you guy's are paid and we'll pay extra for your early start.

KF- I will give you a call.

DG- Ok I'll ring Peter tomorrow thanks.

126. It is apparent from this exchange that arrangements for an on site medical presence at the grounds for Saturday 27 June was not in place as recently as 10 days prior to the event. It is also apparent that the LRCDA considered the cost of engaging QAS 'was very expensive for the club' and were trying to find alternate means to cover some LRCDA events.

127. The lack of an inter agency preparedness plan in 2015 resulted in last minute arrangements by the organisers.

Nurse Patricia Harvey

128. Nurse Harvey was the in charge clinical nurse consultant (CNC) at the Laura Clinic at the relevant time. Nurse Harvey is a registered nurse and had experience as a full-time acute, emergency nurse for a health service.

129. Nurse Harvey's evidence was that she and Nurse Farrelly were involved in two conveyances of patients from Laura to Cooktown return on 26 and 27 June 2015 after which they both returned to the Laura Clinic at 6.30am on Saturday morning, 27 June. They were both tired and felt it was best not to attend the event at the grounds due to fatigue so they assigned Nurse Katherine Leighton to attend the event as a first aider that morning on the understanding that Nurse Leighton would call the clinic nurses if backup was required. Nurse Harvey understood from discussions with the Director of Nursing Julie Ross that one nurse was to attend the rodeo as a first aider.

130. Nurse Harvey stated that their first advice regarding Holly's emergency was when Nurse Farrelly received a phone call on her private mobile number from the LDRCDA organiser Deb Gostelow at 0949 hours asking if they had been contacted about a cardiac arrest at the rodeo grounds. Nurse Harvey heard Nurse Farrelly knocking at her door and then saw her reversing the clinic ambulance and then jumped into the ambulance with her and they left for the rodeo grounds immediately.

131. Nurse Farrelly told Nurse Harvey that she had tried to call her private number but Nurse Harvey had her private mobile phone off to rest as she does not use it for the clinic. Nurse Harvey checked her phone and did not see that there was a call made to her work mobile from Nurse Leighton at the rodeo grounds.

132. Upon arriving at the rodeo grounds the nurses in the clinic ambulance encountered large volumes of traffic and people walking up the road, most appeared unwilling to move in a hurry at the entry gates and that caused a delay in reaching Holly despite the fact that they were sounding the vehicle horn and people could see it was an ambulance troop vehicle. There was a further delay because the nurses could not locate the exact area that Holly was in as they had not been given exact directions over the phone.

133. Nurse Harvey stated she raised issues of fatigue and the requirements of staff at the Laura Primary Health Clinic on several occasions with Queensland Health including numerous emails and phone calls between Vikki Jackson, Julie Ross, James Shattock (the agency recruitment point of contact for Queensland Health) and the nurses.

134. Nurse Harvey ceased her one month contract at the Laura Primary Health Clinic after Holly's death and stated that the problems and reasons which contributed to to Holly's medical emergency were as follows:

a) "*With only two nurses at the clinic at all times there is nil fatigue management structure in place at the Laura Primary Health Clinic. There is no way that you are able to have proper time off and not be on-call. At the beginning of my placement nurses that were first on-call were to attend on their own whether it was in clinic or out in the community. As I had already been to a couple of call-outs on my own in the community at night I knew the circumstances of a call-out felt unsafe for staff and clients. I proceeded to change the call-out procedure for the safety of staff and clients that if call-out was not in clinic then two people had to attend the call-out*".

b) "*It was within my discretion as CNC to have the second on-call nurse go with the first on-call nurse for safety reasons. This system also worked well in providing support to the first on-call nurse if during a call-out a patient was needed to be transferred by ambulance as you needed one person to monitor the patient and another person to drive. If the first on-call nurse was called in the early hours there was to be a minimum of an 8 hour break between call out time and start of work at the clinic. If there was less than 8 hours break the first on-call nurse would not attend the clinic until the 8 hour break was had. If however, both nurses were called out to the clinic, the clinic would then need to be closed until the 8 hour break was taken to comply with fatigue rules. This would leave the town without a clinic. This did not occur as we still received calls interrupting our break in service which therefore resulted in broken fatigue relief*".

c) *I felt there was a lack of support by Queensland Health in regards to equipment and access and safety. Multiple times there were issue with the patient vehicle stretcher, equipment. Along with the fact the vehicle contained no flashing lights or sirens to attend an emergency quickly. There were also no life packs in the vehicle*.

d) *I felt that the role and expectation of the CNC/RN far beyond reasonable in regards to workload. It was never outlined in my contract that I would be working on-call 24/7 including weekends. It did state that I would be doing on-call duties but not that I would not have days off and be able to leave the community, to be able to go shopping or to have lunch in Cooktown or stay away for the night. In the one month (four weeks) that I was in the position of CNC I only had one day off, otherwise I was either at work or on-call.*

e) *If our other callouts had taken longer we would not have been able to attend the incident at all and there would have been no-one to attend except Katherine Leighton who was rostered as the first aider for the rodeo. Therefore the CNC/RN were well above the fatigue level to perform duties within a safe level for themselves and the community but responded regardless to the best of our ability under the circumstances*.

135. Nurse Harvey deposed to receiving confusing instructions from management personnel and explained in her Form 25 response to the Coroner as follows:

> "*The instructions from several management personnel was confusing, that we had a third nurse hired for the rodeo which was Katherine Leighton. This was informed by email on 16 May 2015. Then on the 23rd of May 2015 an email from Pete Fenton informing myself that the third nurse would be present at the rodeo on the Friday and Saturday mornings till midday, to assist first aid when the Queensland Ambulance Service was not in attendance. We were to maintain our current roster and normal clinic hours. Then on 24/5/2015 an email was sent from Vikki Jackson stating that she was still waiting on contact from QAS and states that at this stage she has the support of the Executive Director of Nursing and Midwifery (EDONM), not to have staff at the grounds and to do our normal shifts. Then on 25/5/15 an email Vikki Jackson stating that Katherine was specially contracted to support the QAS at the grounds, to offer first aid when QAS was not in attendance, and that we were to maintain our normal current roster and clinical hours. We also had a meeting with Vikki Jackson and Julie Ross at the Laura Clinic in attendance with myself and Nurse Krystal Farrelly trying to make sure what was put in place for the rodeo.*
>
> *I was aware on 27/5/2015 Nurse Leighton would be the only medical person employed to be at the Laura Horse Festival and Rodeo event scheduled for that morning. We also put in place if Nurse Leighton required any further assistance that she had an on-call telephone and to ring the second on-call telephone which I had and did not receive any calls or texts that morning. I am also aware that she had Nurse Farrelly's personal mobile number to call if assistance was needed.*
>
> *I was of the understanding that Nurse Leighton was there for first aid assistance and if needed to call for emergency assistance if required. I am almost certain we organised a backpack of first aid equipment as that is all Nurse Leighton was contracted for.*

Several times it was brought up by myself with management at Queensland Health the issues of staff fatigue and the requirement of more staff at Laura PHC. The issues were raised between and including Vikki Jackson DON, Julie Ross Acting DON and Pete Fenton who was in the process of going on leave."

136. I note that negotiations within the TCHHS and the Laura Clinic regarding resourcing the event were occurring up to 4 weeks prior to the commencement of the event, indicative of the lack of a considered planning well in advance.

137. Nurse Harvey was entitled to fatigue leave without interruption. She and Nurse Harvey should have been properly covered by qualified nursing personnel on the ground in Laura that day in these circumstances. There was no adequate contingency plan for nurses on fatigue leave that weekend. There was certainly no contingency plan in place for two nurses being on fatigue leave at the same time. The nurses on the ground in Laura were trying to manage as best they could without any support from the TCHHS.

138. As a result of fatigue and a lack of staffing the many hundreds of people at the grounds that weekend and the resident population of Laura had limitations on their access to care.

Oversight of the Laura Primary Health Care Centre

Vikki Jackson

139. Vikki Jackson was in the temporary role of Director of Nursing (DON), Laura Primary Health Care Centre to cover the 6 day period from 22 June 2015 to 28 June 2015 between the substantive Director of Nursing commencing annual leave, and the Director of Nursing who was appointed to relieve the substantive position commencing on 29 June 2015. (In essence Nurse Jackson was to fill a short term gap as DON at a critical juncture, covering only the week leading up to, and including, the weekend event).

140. Ms Jackson deposed to several emails and verbal conversations between relevant persons that contradicted the agreement arrived at between the Executive Director of Nursing and Midwifery and herself. She became aware via email correspondence with James Shattock (nursing workforce) that Nurse Leighton had been specifically contracted to assist the Queensland Ambulance Service. She received an email from Nurse Harvey regarding the equipment needed to support Nurse Leighton and seeking clarification as QAS were requesting the nursing presence between 0600 and 1200 hours Friday and Saturday. Vikki Jackson received a further email from Nurse Harvey about first aid equipment that was needed and not available to Nurse Leighton via QAS. Vikki Jackson informed Nurse Harvey by email of her attempts to contact QAS for clarification of roles and logistics (to which she says QAS by then had not replied).

141. Nurse Jackson also contacted the Executive General Manager over the phone requesting information about the QAS role and the Queensland Health role, the EGM was going to follow up in person with QAS but Ms Jackson says she did not receive a response from the EGM.

142. Ms Jackson deposed to having concerns about the planning for the event as she could get no clear direction from the Executives regarding staff placement over the period leading up to the event.

> *"Staff seemed not to have a clear pathway or expectation for their roles and appeared to have limited knowledge around orientation or indeed what my role would be or for how long I would be assisting them. As the Director of Nursing and Midwifery covering for that week I felt that I had been provided with misleading information and an inaccurate handover regarding the upcoming organisation of the event. It appeared to me that decisions were made without full disclosure and stakeholder consultation.*
>
> *Prior to the event I was not aware of any issues regarding staffing levels however I became aware of fatigue issues and problems with equipment after the event."*

143. DON Jackson was in a very difficult position. She was given a temporary (if not fleeting) management role and was caught without clear direction about resourcing the mass public event. She should not have been placed in this position. The lack of leadership and considered planning by the TCHHS well in advance of the event resulted in poor or no communication about critical matters such as resourcing and confusion and resulted in uncertainty between the DON and the nurses on the ground at the Laura Clinic.

Nurse Virginia Nikora

144. At the relevant time Nurse Nikora was employed as the Clinical Nurse Consultant (CNC) at the Laura Primary Health Care Centre employed on a four week on, four week off rotational roster. Nurse Nikora had completed her first four week 'on' roster (part of a temporary trial employment system started by the Torres and Cape Health Service using casual relieving nursing staff). She was sharing the role with a nurse that she said she had not met before from the Northern Territory. At the time of Holly's emergency Nurse Nikora was on four weeks off (her first rostered leave). She attended the weekend event as a spectator with friends.

145. On the morning of Saturday 27 June 2015 while at the grounds Nurse Nikora became aware of a situation unfolding nearby. She approached and was told the situation was under control and that there were plenty of nurses already assisting. Not knowing the seriousness of the matter Nurse Nikora left and returned to her campsite.

146. Nurse Nikora then saw the Laura Clinic troop carrier arrive at the scene and she returned again to offer assistance. Nurse Nikora recalled as follows:

"Holly was supine on the ground surrounded by many people. A man was performing cardiac compressions, a female was on Holly's left side inserting an intravenous cannula, two females were at Holly's head managing airway with a bag/mask and another female unknown to me was on Holly's right side with an AED and appeared to be coordinating the resuscitation. The Laura Clinic retrieval pack was open on the ground to Holly's right side with items spread out on top of and around the pack. Two nurses I know to be employed at the Laura Clinic were observing the event from nearby.

I observed that Holly was unresponsive/floppy/pale face with blue lips. I could hear that whilst CPR was being performed there was fluid in the airway and suction was required. The portable oxygen/suction was not visible. I asked the Laura nurses where it was and they replied it was at the clinic. I asked the CNC if she had contacted the Cooktown doctors and she replied no 'There is a lady talking to the QAS and there is a helicopter on the way'.

I advised the CNC to immediately phone the doctor on-call, she did but was struggling to give a handover so I took the phone call with Dr Min Min Mo and gave a history of Holly's presentation and interventions in process and requested further instructions. Dr Mo advised to continue with CPR until QAS arrived.

I asked the CNC for the Clinic keys and police officer offered to drive me to the clinic to get the oxyviva (portable oxygen suction). This took approximately 15 minutes. Upon my return suction was used via the oxyviva and later by a manual hand pump.

The on-site Medical Response provided to Holly

147. The sequence of events on the evidence is as follows:

1. After Holly's cardiac arrest and with no help in sight at around 9.35am in the absence of equipment or assistance, Ms Ives requested QPS escort her to the Laura Clinic. En-route she passed the Laura Clinic nurses in the troop carrier and returned to Holly without attending the clinic;
2. Nurse Farrelly received a call alerting her to the scene at 9.49am from Ms Gostelow;
3. Nurse Leighton arrived on scene just prior to 9.55am and contacted Triple 0 during which she observed 3-4 persons (now known to be off duty nurses and paramedics) attending to Holly;
4. Ms Ives and Nurse Leighton have no recollection of each other on site;
5. The clinic nurses gathered the travel defibrillator, a Thomas Pack and airway equipment from the troop carrier and were provided a handover by Ms Ives who then advised Holly had been unresponsive for at least 30 minutes;
6. Ms Ives advised that she was advanced life support trained and needed to gain IV access;
7. Nurse Farrelly cannot recall Ms Ives providing a handover;
8. It was obvious from the interaction between Nurse Leighton and Nurses Harvey and Farrelly during the Triple 0 call that Nurse Harvey and Farrelly were

distressed when they arrived (with Nurse Leighton urging them to 'remain calm');

9. Ms Ives says Nurse Harvey threw the (medical) bag on the ground and was told to look in the bag for the equipment requested (this is denied by Nurse Harvey and Farrelly);
10. Ms Harvey unsuccessfully attempted intraosseous access (confirmed in the autopsy report)
11. Ms Ives successfully gained IV access;
12. Nurse Farrelly and Harvey then stood back from the interventions and started to scribe (contemporaneous notes were provided to the inquest);
13. At around 10.06 the travel defibrillator was attached and shock was not advised and Ms Ives administered 1 mg adrenaline;
14. Ms Ives says that a shockable rhythm was subsequently detected and a shock administered. Ms Ives says that she was limited by the absence of an advanced defibrillator to monitor cardiac rhythm (the inquest heard that an advanced defibrillator was available at the clinic but was not portable), and also by not having access to amiodarone;
15. The notes provided by the Laura nurses record adrenaline being administered at 10.05; 10.10 and 10.12.
16. Holly's airway was poor. No LMA mask was available on site with the equipment. The suction was not effectual because the portable oxygen supply ran low very quickly (Nurse Harvey had checked the supply and noted the portable cylinder to be full on the Friday morning);
17. Blood was noted to be coming from Holly's mouth, the portable suction device was not adequate to suction Holly's airway of viscous fluids;
18. Ms Nikora (off duty Laura CNC from the Laura clinic) approached the scene and asked the Laura nurses where the oxyviva was and was told it was at the clinic. Nurse Nikora was driven to the clinc by the QPS to retrieve the oxyviva (a specialised medical oxygen resuscitator). Ms Nikora in evidence stated that the oxyviva should have been at the scene as part of the emergency callout.
19. Before leaving the scene Nurse Nikora asked Nurse Harvey to call on call Dr Moe in Cooktwon and note Nurse Harvey was struggling with a handover so Nurse Nikora took up the call with Dr Moe;
20. At 10.17 a return of spontaneous circulation was recorded (ROSC);
21. Attempts to secure Holly's airway at 10.28 were unsuccessful;
22. At 10.30 am Holly achieved ROSC and subsequently arrested;
23. Ms Ives in her evidence recalls Holly achieved ROSC on up to three occasions;
24. The Laura clinic notes record one ROSC;
25. Ms Nikora says says she drew up glucose (after consulting a bystander doctor) at 10.40 (per the notes) but did not administer it;
26. No equipment to support Holly's airway was available on site until after 10.00am and then the initial and subsequent equipment provided was not fit for the purpose. A patent airway was not ever established.

The QNMU and Fatigue Leave

148. At the time of Holly's emergency on Saturday morning Nurses Farrelly and Harvey were resting for the first time in almost 24 hours. They had not slept since Thursday evening.

149. They were entitled to an 8 hour break after completion of their day shift, and then arguably after each of the two trips to Cooktown. It may be that their 2015 employment agreements / contracts contained different provisions (they were not in evidence at

Inquest) in the context of a rural primary health clinic setting however the 10 hour break between shifts is understood to be an industry standard, unless altered by written agreement to an 8 hour break.[23]

150. On the evidence it seems that the LPHCC BPF Service Profile for the 2014/15 financial year was in draft as at June 2015 and was never finalised. The evidence of the QNMU via Ms Veach's was that it remained in draft as at 29 October 2014[24] and that this was a breach of the BPF process.[25] Ms Wardlaw's evidence is that TCHHS have been unable to locate an evidence that the LPHCC BPF Service Profile for 2014/15 was ever endorsed.[26] Ms Wardlaw suggested that the BPF had some limitations for primary health care centres and lacked an "appropriate 'in depth' view" in this context.[27] Dr Newland accepted that the BPF is an important tool for assessing workload requirements of a service but noted other steps were taken in 2015 to monitor fatigue and workload at the LPHCC.[28] In hindsight these steps were not adequate, particularly during times of high demand.

151. The evidence of Ms Wardlaw and Dr Newland does not alter the fact that on the evidence of QNMU the BPF has been industrially mandated since 2003 and that it is required to be applied yearly. It is also submitted that the evidence of Ms Veach that the BPF ensures that individual circumstances of clinical and geographical environments are taken into consideration ought to be accepted and that the BPF should have been finalised and may have provided greater stability at the LPHCC and prevented changes to the nursing model (from a CNC and CN to a CNC and RN) occurring in the way they did.

152. It is not clear on the evidence that finalisation of the LPHCC 2014/15 BPF Service Profile would in itself have resulted in better planning for the 2015 Laura

Joint responsibility of event organisers

153. It was inferred at inquest that as Holly's emergency (Saturday morning) coincided with the campdraft event at the grounds meant that the LRCDA organisers should somehow assume either more, or all, of the responsibility for the lack of an adequate medical presence.

154. I do not accept that inference.

155. There are two distinct issues at play, in my view they are:

    a. The access to medical coverage for <u>participants</u> during horse related events; and

[23] Nurses and Midwives Certified Agreement (EB 10) 2018 to be read in conjunction with Best Practice Rostering Guidelines
[24] Ex M3, para 33.
[25] Ex M3, para 34.
[26] Ex G3.4, para 17.
[27] Ex G3.4, para 7.
[28] Ex G15, para 12.

b. The access to medical coverage for all persons attending the rodeo and race weekend for the duration of the weekend (participants, spectators and campers).

Access to medical coverage for participants during horse related events

156. The horse related events included horse sports; campdrafting; rodeo; bullriding and horseracing.

157. The LATC is an affiliate of Racing Queensland. The LATC fulfilled obligations and requirements of the racing industry for a QAS presence at the horse racing events.

158. The LRCDA is not affiliated with a professional body. The LRCDA decides what type of medical coverage should be assigned to a particular event.

159. In 2015 the LRCDA approached a private medical provider and at the same time via Facebook called for interested 'medicos' to cover the weekend campdraft events. The LDRCA engaged the QAS to cover the bullriding events (deemed to be higher risk) whereas a first aid nurse was deemed sufficient to cover other events including the campdrafting scheduled and in progress at the time of Holly's emergency.

160. Any medical coverage arranged by the LATC and the LRCDA is to cover the 'events' organised by the respective associations. There is no specific additional planning for medical coverage across the entire weekend for non event related emergencies.

Access to medical coverage for all persons attending the rodeo and race weekend.

161. Separate from, and in addition to, the actual horse related events over 2000 people attend the weekend event with many attending as spectators during the days and or camping at the grounds for the duration of the weekend. Holly's medical condition was rare. An otherwise healthy 17 year old girl was not expected to suffer a fatal arrhythmia as a result of an undiagnosed condition. However, the demographic of other attendees would include a significant numbers of persons with underlying illnesses / morbidities, known and unknown, treated and untreated. It is likely that some attendees could be caught unawares by a potentially fatal condition.

Risk Assessment

162. The event planning for the Laura Rodeo and Race weekend must include a risk assessment of the event as a whole and not just the discrete events run by separate organisations. It should not matter in what capacity people attend the event, all should have access to medical coverage that complies with best practice including access to the Chain of Survival.

163. I can discern no reason why the responsibility for attendees to access 24 hour medical assistance should not be apportioned equally between the organising committees and in accord with event planning best practice, with reference to the TCHHS and QAS for input. Both committees must play an active role in the formulation of a preparedness plan that demonstrates access to medical coverage in accord with the 'chain of survival'.

164. I set out the steps in the Chain of Survival below. Accepted international standards for out of hospital cardiac arrests require access to an AED and CPR within 3-4 minutes, and access to advanced care within 8 minutes of the arrest.

165. Compliance with those standards cannot be met by using the Laura clinic as a base during the event. It is inescapable that the starting point must be consideration of 24 hour on site medical presence by a fully stocked resourced and staffed medical provider or service.

Chain of survival

166. The International Liaison Committee on Resuscitation (ILCOR)[29] advocate as follows:

- that health professionals who have a duty to respond to a person in cardiac arrest should have a defibrillator available either immediately or within 1 to 2 minutes;
- for the patient to have the best chance of surviving an out-of-hospital cardiac arrest, CPR and early defibrillation must be provided within the first 4 minutes of the cardiac arrest (the European Resuscitation Council and American Heart Association recommend 3 minutes):
- followed by Advanced Life Support within the first 8 minutes of the arrest.

167. Dr Mark Little an emergency medicine expert currently based at the Cairns Hospital gave the following evidence at inquest:

> "*Holly's chances of survival were severely compromised without immediate and available defibrillation within 3 to 4 minutes of her cardiac event, and then if defibrillation was provided immediately, she required advanced pre hospital care including administration of drugs and other measures*".

168. Dr Little's evidence reflects best practice in accord with international guidelines.

169. Holly did not receive defibrillation and adrenaline until approximately 10.04am, almost one hour post cardiac arrest.

The Links in the Chain of Survival

170. The Chain of Survival depicts the critical actions required to treat life-threatening emergencies, including heart attack, cardiac arrest, stroke, and foreign body airway obstruction.

171. The links within this Chain of Survival include:

I. **Early Access** to the emergency response system;
II. **Early CPR** to support circulation to the heart and brain until normal heart activity is restored;
III. **Early Defibrillation** to treat cardiac arrest (caused by Ventricular Fibrillation); and
IV. **Early Advanced Care** by EMS (emergency service) and hospital personnel.

[29] See ILCOR resuscitation guidelines

Early Access

172. Early Access to the emergency response system, includes early recognition of the cardiac emergency and early notification of rescue personnel via a universal telephone system (such as Triple 0) as well as an internal alert system within specific facilities to trigger a response by designated trained and equipped personnel.

173. In regards to a universal telephone system I find that at the time of Holly's medical emergency:

i. There was no access to a landline telephone at the Laura Rodeo and Race grounds;
ii. that mobile telephone coverage from the grounds was compromised and inadequate;
iii. that the first Triple 0 call failed and was disconnected due to limited poor mobile reception.

174. In regards to early notification of rescue personnel I **find** that the QAS operations call centre was unable to contact:

a) The clinic nurses via the 'second' on call mobile phone;
b) QAS community first responders in and around the Laura district (trained to provide first aid and dispatched to provide initial care while the ambulance is en-route) ;
c) The QAS unit (already en-route to the event for the afternoon events) due to poor satellite phone coverage.

175. In regards to a response by designated trained and equipped personnel I **find**:

i. The TCHHS made no provision to back up fatigued nurses that weekend. Whilst it might be argued Nurse Harvey and Farrelly were on 'fatigue leave' in fact they remained on call after already completing a double shift.
ii. Nurses Harvey and Farrelly should not have been required to attend on site at the ground at all on Saturday 27 June. They were entitled to a minimum 8 hour break. They were unable to provide optimal care.

176. It is recognised that safe patient care can be compromised by the presence of fatigued nurses.[30]

177. Professor Little in his evidence at Inquest said:

"Ms Cull : But the day of the event – the two nurses – two of the nurses involved of the three had been on all-night callouts, and then – so on the Saturday morning they hadn't slept since the Thursday night. They went on fatigue leave then, but the other nurse who was at the

[30] Australian Nursing and Midwifery Federation press communique (via the QNU secretary) October 2012

rodeo had their contact details and they were in fact contacted. Do you think that could have contributed to the - - -?---

Professor Little: Look, I do. Nurses – nursing unions and nursing organisations within, say, the hospital are very, very good at looking at fatigue and fatigue issues, and again, far better than I am. But certainly I think it's reasonable to say that those nurses were well and truly fatigued if they had been up for 36 hours which is what it sounds like, and I think that, again, that reflects that process of planning where people haven't said, "What if?" And again, it revolves around were there different ways to move the people overnight? Should the ambulance have been contacted and maybe met them halfway – there's a whole range of other things that could have happened, but certainly they were fatigued and I think that has contributed to the events."

178. TCHHS management did not either forsee or make provision for adequate nursing cover for Laura nurses requiring fatigue leave. Given that the Laura Clinic was responsible for the out of hospital care for in excess of 2000 people that weekend it would not be unreasonable to have a backup nursing crew ready for deployment to the clinic that weekend.

179. Key TCHHS management and senior nursing staff were on leave that weekend.

180. Nurses Harvey, Farrelly and Leighton were on their first secondments to the Laura Health Clinic and had no prior familiarity with the area.

181. The only nurse from the local health clinic on site and on duty at the grounds was equipped only for 'first aid' and was not designated to attend an emergency response (and not without a second nurse accompanying her per local guidelines).

182. There was no means of conveying Holly to the Laura clinic. The local clinic troop carrier, which contained limited equipment, was purposed to 'scoop and return' to the clinic and convey of patients to hospital. At inquest it was obvious that there was a tension between placing the troop carrier at the grounds which would take away a resource from the Laura community, or to leave at the clinic and not have the resource available at the event. Local nurses should not have been required to resolve this issue amongst themselves. This was a matter that needed to be properly planned for by the TCHHS. Event organisers were under the impression that the troop carrier would be at the grounds as it was in previous years.

183. Although the troop carrier was described by Nurse Nikora as 'nothing like an ambulance' and is used to 'scoop and return', if on site and used that day would have provided Holly with access an advanced defibrillator and emergency drugs (assuming all was adequately stocked and in order), possibly including second tier drugs such as amiodarone. Nurse Nikora's evidence of a 15 minute round trip (presumably under lights and sirens) between the grounds and the clinic would suggest that a one way conveyance to the clinic could occur within 10 minutes (under optimal conditions, immediate accessibility to the troop carrier, availability of lights / sirens or a QPS escort, and clear access out of the grounds). Even if my estimate is inaccurate the point I make is that with an emergency vehicle positioned at the grounds access to potentially life saving measures at the clinic could have been in place well under 50 minutes.

Early CPR

184. The second link in the Chain of Survival is Early CPR, a set of actions that the rescuer performs in sequence to assess and support airway, breathing and circulation.

185. Early CPR was initially administered by various non medically trained bystanders (including Holly's father) sometime between 8.30am and 9.00am and before the arrival of Ms Ives.

186. Ms Ives witnessed Holly's cardiac arrest and immediately assumed primary responsibility for CPR at around 9.10-915am. She was assisted by student paramedics. Holly's airway was poor.

187. Without the availability of advanced life support measures within minutes, including suction, oxygen an AED and front line drugs, CPR was rendered ineffectual, that is CPR of itself was not enough.

Early Defibrillation

188. The third link, **Early Defibrillation**, is the delivery of a shock to the heart to convert the heart's rhythm back to a normal heart rhythm (if the rhythm is shockable).

189. Early defibrillation was not delivered to Holly.

190. The first AED on site arrived with the clinic nurses in the troop carrier around10.02am. There was initially some confusion as to whether the AED was present in the troop carrier – although it was eventually located. The first AED reading (administered between 10.02am and 10.06am, approximately one hour after cardiac arrest) indicated a non shockable heart rhythm.

Early Advanced Care

191. The fourth link, **Early Advanced Care**, relates to the response of highly trained and equipped pre-hospital emergency service personnel (paramedics) who can respond to the patient and provide for the administration of drugs, advanced airway procedures, and other interventions and protocols, prior to the arrival of the patient at an advanced care facility.

192. Early Advanced Care was not available to Holly.

193. I **find** that the first fully trained, equipped and resourced emergency responders on site were the QAS paramedics at 11.00am, by then almost two hours after Holly's cardiac arrest (and 1 hour 20 minutes after deployment).

194. Mr Martin in oral evidence provided the court with a helpful explanation of the differences between the types of paramedics and their respective scopes of practice. A field officer is a paramedic officer who has a P1 skill set. Mr Martin used Mr Ron Beckett as an example who is also a liaison officer to the local disaster management group. He is heavily involved in community engagement and training. The next level is an advanced care paramedic ('ACP'). An ACP can manage an arrested patient to

a certain point, their airway management is limited to a Laryngeal mask.[31] They are also limited in terms of the pharmacology access, they have access to adrenaline but not amiodarone[32] and are limited in their interpretation of the results generated by a defibrillator.[33] Lastly, a critical care paramedic ('CCP') is the highest level clinician the QAS have. They have access to and can administer advanced airway management including intubating a patient with an endotracheal tube.[34] Additionally, they have access to all pharmacology, including amiodarone.[35] They also in Mr Martin's words *'make the best use of our defibrillators'*[36] as they can identify complex rhythms. There are no CCPs in Mr Martin's LASN.[37]

195. The first paramedics to arrive on the day was an ACP, Jay Orbin-Greenwood and a clinical support officer ('CSO'), Grantly Culic.[38] They were at Holly at 11:00 am. As Jay Orbin-Greenwood is an ACP he was limited to the use of a Laryngeal mask and adrenaline. Mr Orbin-Greenwood between 11:00 am and 11:10 am cleared Holly's airway, shocked Holly with the automatic defibrillator and administered 1 mg of adrenaline. Soon after, the helicopter arrived which had a CCP and a flight doctor on board, known as the 'care flight team'. They arrived and were at the scene at 11:12 am and at the patient, Holly, at 11:16 am.[39] The care flight team at 11:20 am administered Sodium Bicarbonate and Rocuronlum and successfully intubated Holly. After consoling with the family Holly was declared life extinct at 11:44 am

Preparations for the event within Torres and Cape Hospital and Health Service

Initial refusal to provide a nursing presence during the 2015 Laura Horse Sports Races and Rodeo Weekend

196. A request by the LDCRA for a nursing presence at the camp-draft event on the morning of 27 June 2015 was sent by letter dated 9 April 2015, from Mary Shepard, former secretary of the LDCRA to the "Officer in Charge, the Laura Medical Centre".[40]

197. This letter was forwarded on to the "TCHHS –Nursing-Midwifery" and "TCHHS Nursing-Workforce" email addresses by Mr Peter Fenton, DON, Remote, Hopevale, Laura and Wujal Wujal, on 20 April 2015.[41]

198. Evidence of Mr Fenton was that he experienced difficulties from the TCHHS executive leading up to the Laura Horse Sports Weekend. His statement indicated that generally

[31] T4-39, lines 46-47.
[32] T4-40, lines 10-13.
[33] T4-40, lines 24-27.
[34] T4-39, lines 42-45.
[35] T4-40, lines 15-18.
[36] T4 -39, lines 25-33.
[37] T4- 41, lines 5-6.
[38] Ex F1.9, p.12.
[39] Ibid.
[40] Ex E1.1.
[41] Ex G8.3, p 3.

the executive staff at TCHHS were seeking to cut staff during the six month period leading up to the Laura Horse Sports Weekend and he stated specifically 'my requests for additional Nursing staff for events were denied'.[42] This issue is dealt with in further detail below in relation to the organisational issues facing TCHHS in June 2015 and evidence from the Queensland Nurses and Midwives Union.

199. Ms Wardlaw's evidence was that her initial recommendation to Ian Pressley was that a nursing presence at the Laura Horse Sports Weekend should not be provided. Her evidence was that this recommendation was made on the basis that the TCHHS budget did not have the capacity to accommodate this.[43] The relevant emails from Ms Wardlaw were sent on 1 and 5 May 2015.[44]

200. The specific details of the email correspondence leading to the decisions are as follows. Ms Wardlaw responded to the request from Mary Shepphard by email to Ian Pressley on Friday 1 May 2015, stating, "FY Action – from a nursing perspective we can help by being available at the clinic if required but cannot be available on site? Will let you follow up with them – thanks – Lyn."[45]

201. Mr Pressley forwarded this email to Helen Reed and Ann Richards (Public Health Manager Southern Section) on 1 May 2015 stating "Helen and Ann I seem to remember the EPC were involved with this last year. Please advise".[46]

202. Ms Ann Richards responded on 4 May 2015 stating "Hi Ian, This had been our previous response maybe we should do something similar this year. Pete [Fenton] any additions to the draft 2015 plan?". Mr Fenton responded to this email on 5 May 2015 stating "Ann, My understanding of the TCHHS's current position is that we have not yet agreed on the provision of a third nurse for the Laura Dance Festival or Rodeo as per previous years. Currently we have agreed to two Nurses at Laura PHCC for the DRY or 'bust season'. If this remains our position we can only be providing a minimal support system to QAS during these events. I am unaware whether this situation has been communicated to QAS as yet." [47]

203. Following this, Ms Richards forwarded the email to a number of recipients, including Ms Wardlaw and Mr Pressley, by email of 5 May 2015 stating "Hello Ian and Lyn, Re: Pete's comments below will someone be responding to the requests of assistance (camp draft committee) and alerting QAS?"[48]

204. Ms Wardlaw responded to a number of recipients, Anne Richards, Pete Fenton, Ian Pressley and Helen Reed by email dated 5 May 2015 stating "Hey Ann, I've left this for Ian to respond as EGM – I note some previous letters that could be redrafted for

[42] Ex G10, para 11.
[43] Ex G3, p 1-2, paras 7-.
[44] Ex G8.2, paras 2-3
[45] Ex G8.4, p 3.
[46] Ex G8.4, p 3.
[47] Ex G8.4, p 2-3.
[48] Ex G8.4, p 2

this year. I don't believe we have capacity or budget for an additional 3rd nurse but will have 2 nurses out there over this period."[49] Mr Pressley suggested in oral evidence that this email constituted advice from Ms Wardlaw that the presence of two nurses would be sufficient.[50]

205. Mr Pressley responded on 5 May 2015 stating "Lyn Thanks for the advice. Ian".[51]

206. Ms Warlaw has stated that upon advising the budget did not have the capacity "I received no further email that a budget for the event would be forthcoming."[52] During oral evidence Ms Wardlaw accepted there was no evidence that she had made any active representations that a budget for the event was required or should be provided, although indicated if she was to make such representations she would do so verbally.[53]

207. On 8 May 2015 Ms Richards sent an email to Mr Pressley, Ms Wardlaw and Ms Helen Reed ccd to Mr Fenton stating "Good morning All, Yesterday Pete and I were going to finalise this year's Laura preparedness and response plan in preparation for the upcoming Dance Festival and Horse events however, as the clinic will be running as per usual business with no additional RANs over this time period we consider there is no reason to have an additional stand-alone plan (copy of 2013 document attached). TCHHS and Laura Emergency Response and Preparedness Plans are in place..."[54]

208. Mr Pressley responded to this email on 8 May 2015 stating "Ann I will be sending letter to Mary Shephard today." Ms Wardlaw responded the same day stating "Thanks, well done Lyn."[55]

209. There is no evidence that Ms Wardlaw turned her mind to the nature of events to be held over the weekend or the population increase and the associated risks involved. In her oral evidence Ms Wardlaw acknowledged that she was not aware of the likely population increase associated with the event and her evidence suggests she did not have an understanding of what was involved in the activities being run, admitting she did not know at the time what a camp draft was.[56]

210. On 8 May 2015 Mr Pressley wrote to Mary Shephard, advising that "I recognise that this is an event that we have previously supported and appreciate the importance of medical assistance. Unfortunately we cannot guarantee the availability of full-time onsite medical services by our clinical staff from LPHCC for the Rodeo/Races. Torres and Cape Hospital and Health Service will have nursing staff available at the clinic during this time as it is expected with the increased visitor numbers that there may be an increase in the demand for medical services…".[57]

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[49] Ex G8.4, p 1-2.
[50] T3-42, lines 12-13.
[51] Ex G8.4, p. 1.
[52] Ex G3, p.1, para 8.
[53] T1-31, lines 32-35.
[54] ExG8.7, p.1.
[55] ExG8.7, p.1.
[56] T1-137, lines 36, 39 and 44.
[57] Ex G8.5.

211. The oral evidence of Mr Pressley was that this refusal was sent by him prior to going on leave, but his intent was to leave things open and that it was his understanding that Ms Wardlaw would be making additional attempts to secure further nursing resources and also that she would be meeting with QAS.[58] However it is submitted that there is no evidence to support this assertion. In fact when Mr Pressley advised that he had sent the letter to Mary Shephard, Ms Wardlaw replied "Thanks, well done. Lyn."

212. Further there is no evidence that there was any meeting with QAS following this email exchange. Mr Pressley accepted in oral evidence that whilst it may have been his expectation that such a meeting would occur, in fact it did not.[59]

213. Mr Pressley was asked during oral evidence whether he put in place any other steps to make sure the LPHCC was adequately equipped to respond to the weekend, given the influx of people and the high risk nature of the events. He stated, 'No, not that I can recall.'[60]

Evidence regarding the subsequent decision to engage a third nurse for the weekend

214. Ms Wardlaw, subsequently agreed that the Torres and Cape HHS would provide additional nursing resources over the period of the Laura Dance Festival and the Laura Horse Sports Weekend. She did not make the exact nature of the support to be provided over the Laura Horse Sports Races and Rodeo weekend clear to her staff however.

215. This decision to provide additional nursing resources followed correspondence from Mr Culic of QAS, forwarding an email from Mr Fenton to Ron Beckett of the QAS, ccd to Ms Virginia Nikora, Ann Richards and Vicki Jackson on 27 May 2015 at 8:07am[61] which indicated a third nurse was not being provided by the TCHHS for the Laura Dance Festival period.

216. This email was forwarded on 28 May 2015 at 9.40am by Ron Beckett to Mr Culic and Mr Martin with a request that the position of Mr Fenton "be clarified downstairs with QH management.".[62] Mr Culic forwarded the email on to Ms Wardlaw with the request "Hi Lyn, Could I get some clarification on the email below from Peter Fenton. Many thanks. Grantly."[63]

217. Ms Wardlaw responded by email on 29 May 2015 stating that "we intend to offer either one (CNC or RN) to assist at the Laura Dance Festival. Could you confirm dates for this and the races/rodeo or are they all the same?"[64]

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[58] T3-43, lines 18-22.
[59] T3-52, line 30
[60] T3-45, line 36.
[61] Ex G8.14, p.6.
[62] Ex G8.14, p.6.
[63] Ex G8.14, p.6.
[64] Ex G8.14, p.5.

218. Mr Culic responded providing details of the dates for the Laura Dance Festival (Friday 19 to Sunday 21 June) and the Laura Horse Sports Races and Rodeo weekend (26-18 June 2015). In relation to the Laura Horse Sports Races and Rodeo weekend Mr Culic stated "Laura Races and Rodeo are the following weekend, starting with camp drafts on the Friday the 26th, races on the Saturday the 27th and rodeo on Sunday 28th June. Historically speaking, QH has looked after the camp drafts as this is a low risk event and QAS has looked after the horse races and rodeo/bull rides as these are high risk events."[65] As noted above, this email did not provide specific times of events and did not mention that there was also a camp draft scheduled for the morning of 27 June 2015, during which period the medical emergency involving Holly occurred.

219. Ms Wardlaw subsequently indicated in her email response of 30 May 2015 at 12.05pm that she would secure an additional nurse for the period of the Laura Dance Festival and Laura Horse Sports Races and Rodeo weekend stating "Hey Grantly, no probs, I will have the workforce team sort the RN out to ensure she is aware of the dates evets ect– regards Lyn."[66] 131. Jane Davies emailed Ms Wardlaw in response to this email, on 1 June 2015 at 8.21am stating "So do you want to over-establish, or we could ask them to have TF off and work the weekend?? Just one nurse? Thanks." Ms Wardlaw replied, giving unclear direction stating "Perfect and yes – Lyn".[67]

220. Ms Davies subsequently emailed Mr Fenton on 1 June 2015 at 3pm, forwarding the email from Mr Culic detailing the QAS presence at Laura Horse Sports Races and Rodeo weekend events and Ms Wardlaw's email response agreeing have having nursing workforce sort out an RN, stating "Hi Pete, Think we are got you sorted for Laura? With the Rodeo and dance festival what is your usual process? As below QAS are requesting support for it, is that doable for you? Do you run them as overtime on the Sat-Sunday and give days off during the week?? Let me know if you need anything further…"[68]

221. Mr Fenton replied to this on 1 June 2015 at 3:15pm as follows:

> *"In previous years, Laura PHCC has been extremely busy over those few weeks due to both the Dance Festival and the Rodeo so we need the two Nurses at the PHCC to cope with the presentations.*
>
> *Also, the Cape (now TCHHS) has always provided an additional Nurse (making 3 Nurses during this period). This Nurse would be stationed at the QAS stand at the Festival and provide the additional support, but*
>
> *This year, when we asked for an additional Nurse, we where [sic] knocked back…I have informed QAS that without the extra Nurse we're out of the Festival, but 'business as usual at the PHCC.*

[65] Ex G8.14, p.4.
[66] Ex G8.14, p.4.
[67] Ex G8.12, p.1.
[68] Ex G8.14, p.4.

So, the short answer is – it isn't doable with two Nurses (could be 4 to 5 thousand people on set days, and we've ever [sic] withdrawn from the Laura Emergency Planning preparation as we don't have anything extra to contribute."[69]

222. Ms Davies replied indicating the possibility of an additional nurse being available for the Laura Horse Sports Races and Rodeo period (as well as the Laura Dance Festival period) by email of 1 June 3.31pm stating "Thanks for that Pete Will keep you posted, so if we had someone from the 18th-29th would that cover it?".[70]

223. Mr Fenton replied "Jane Then we would make a Nurse available to attend the Festive each day at the QAS post – BUT THIS WAS REFUSED OUTRIGHT BY EXEC – what's changed?"[71]

224. Mr Fenton said in oral evidence that from this point (1 June 2015) that he had an 'indication from the nursing workforce unit that there may be a possibility 'of a third nurse being engaged but it was not subsequently confirmed to him and there was no further communication with him about a third nurse.[72]

225. A contract was subsequently arranged between TCHHS and the Central Queensland Nursing Agency to supply a nurse on-site at events during the Laura Dance Festival and the Laura Camp-draft, Races and Rodeo weekend. Ms Katherine Leighton was the agency nurse engaged through CQ nursing.

226. The only subsequent written evidence of any arrangements being made by Ms Wardlaw or Mr Fenton (who was the Director of Nursing up until 19 June 2011) able to be located by Counsel Assisting are two emails sent by Mr Fenton to Ms Patricia Harvey, CNC during the Laura Horse Sports Races and Rodeo Weekend (her contract commended on 22 June 2015).

227. The first email was sent to Ms Harvey, on 16 June 2015 at 3.18pm, prior to her commencing her contract. In his email Peter Fenton forwarded an email from Mr James Shattock, Nurse Manager Workforce, Direct Nursing Services Torres, regarding the contract for an agency nurse over the period of the Laura Dance Festival and Laura Horse Sports Races and Rodeo weekend, and stated "Trish This Nurse is coming up to assist for 10 days (18.06 to 29.06.2015) over the Dance Festival and Rodeo weeks. I'll talk to you about organisation tomorrow. Ta".[73] It is submitted that it is clear from this email Mr Fenton was aware before he went on leave and definitely by 16 June 2015 that there would be a third nurse engaged.

[69] Ex G8.14, p.3-4.
[70] Ex G8.14, p.3.
[71] Ex G8.4, p3
[72] T2-122, line 46 to T2-123 line 5.
[73] Ex G8.13, p.1; G1.16, p.
1. .

228. The second email was sent on 18 June 2015, and stated "Trish With the 3rd Nurse present could you ensure that there is a Nurse at the Rodeo on Friday and Saturday morning. In additional please provide any support required for QAS on these days. Ta".[74] No information was provided in this email about what equipment should be taken to the event, the specific event times, nor specifically whether or not QAS would be present during the times when the nurses were required to be present at the events.

229. There is no documentary evidence of any further communication between QAS and TCHHS. There is no documentary evidence of any further advice from Mr Fenton, Ms Wardlaw or Mr Pressley to the nurses on duty for the Laura Horse Sports Weekend in 2015 or to Vikki Jackson, who was the DON covering the LPHCC for the one week during which the event took place as to the expectations with respect to the services the LPHCC nurses would be providing, whether or not QAS would be present and whether the LPHCC retrieval vehicle was required to be taken to the event.

Evidence of Mr Pressley, Ms Wardlaw and Mr Fenton as to their understanding of the nature of the weekend

230. Mr Pressley, Ms Warlaw and Mr Fenton were all asked during the inquest if they appreciated the implications for the TCHHS of the weekend, in particular whether they were aware of what the population increase would be, what the events held over the weekend would entail and whether they turned their minds to the increased public health risks associated with the weekend and the likely need for increased capacity to respond. The evidence of Ms Wardlaw to the effect she did not know what a camp draft was and did not know what the population increase would be is referred to above. Mr Pressley's evidence was also that he couldn't recall what the population increase would have been.[75] Mr Fenton's evidence was that when he gave a briefing to Ms Nikora about the upcoming dance festival and Laura Hose Sports weekend he told her there could be anywhere between 1000 and 5000 people attending. He acknowledged during his evidence he was aware that over the Laura Horse Sports weekend there would be alcohol and camping on site, horses, livestock and people with morbidities and co-morbidities and he accepted that the weekend was a fairly high risk event.[76]

231. The three witnesses were also asked whether they felt that the LPHCC was adequately equipped to provide an emergency medical response over the course of the weekend.

232. Mr Fenton gave evidence that he was aware of the limited experience of nurses engaged over the Laura Horse Sports Weekend.[77] In relation to whether the LPHCC was adequately equipped in terms of equipment and staff to respond to medical emergencies at the event over the weekend Mr Fenton stated 'we can do the best we can do…I think if I could do what I needed to do, it'd be a whole different story, but I answer to Lyn Wardlaw. She makes those decisions.'[78]

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[74] Ex G8.16, p.1-2
[75] T3-44, lines 38-39.
[76] T2-124, line 35- T2-125 line 3.
[77] T2-127, lines 29-30.
[78] T2-128, line 27; lines 29-31.

233. Ms Wardlaw's evidence was that she did not have any concerns about the skill mix at the clinic at the time of the Laura Horse Sports Weekend.[79] Her evidence was also that if the retrieval van had all of the equipment that was required from the clinic then the LPHCC was equipped and the staff adequately trained to provide an emergency response at an out of hospital context at a major public event[80] although she subsequently modified her response stating that 'I think to respond externally, it's always difficult to respond externally. We do the best that we can with what we have and what we're funded for and that's what we were trying to do.'[81]

234. Mr Pressley's evidence was that prior to going on leave he was aware the TCHHS needed to look seriously at how they staffed the clinic given the likely population increase over the weekend.[82]

Failure to prepare a 2015 Laura Horse Sports and Rodeo Weekend Preparedness and Response Plan

235. Despite preparation of Preparedness and Response Management Plans in 2013 and 2014, no similar plan was prepared in 2015.

236. Ann Richards emailed Peter Fenton on 6 May 2015 stating "Hey we should talk over the phone and finish off this plan so it can be flicked to the GM. Any time this week good for you?". Mr Fenton replied on 6 May at 2015 stating "How about Thursday when I'm back in WW PHCC".[83]

237. On 8 May 2015 Ms Richards sent an email to Mr Pressley, Ms Wardlaw and Ms Helen Reed ccd to Mr Fenton stating "Good morning All, Yesterday Pete and I were going to finalise this year's Laura preparedness and response plan in preparation for the upcoming Dance Festival and Horse events however, as the clinic will be running as per usual business with no additional RANs over this time period we consider there is no reason to have an additional stand-alone plan (copy of 2013 document attached). TCHHS and Laura Emergency Response and Preparedness Plans are in place..."[84]

238. Mr Pressley responded to this email at 7.33am on 8 May 2015 stating "Ann I will be sending letter to Mary Shephard today." Ms Wardlaw responded to this at 8.12am on 8 May stating "Thanks, well done Lyn."[85]

239. There was no further response from Ms Wardlaw or Mr Pressley regarding the decision not to prepare a Preparedness and Response Management Plan for the relevant events.

[79] T1-127, line 37.
[80] T1-137, lines 16-18.
[81] T1-141, lines 43-45.
[82] T3-44, lines 20-24.
[83] Ex G8.4, p 1.
[84] Ex G8.7, p 1
[85] Ex G8.7, p 1

240. Mr Fenton's evidence was that the plan was not prepared because the decision of executives not to engage a third nurse meant that it was "business as usual". Specifically he stated

> *"During this period [the six months leading up to the 2015 Laura Dance Festival and the Laura Camp-draft, Races and Rodeo] I had many discussions with the EMG [Ian Pressley] and the EDON [Lynne Wardlaw] … and my requests for additional Nursing staff were denied. Due to this refusal to support additional Nursing staff, there was limited value in re-developing an extended Preparedness Plan which would have needed nursing staff to attend the events. For this reason while the Public Health Nurse [Ann Richards] and myself reviewed & undated [sic] the preparedness plan for most eventualities, I had to take the position it was business as usual, ie we would maintain the PHCCs ability to respond to emergencies from the Clinic as best we could under the circumstances without attending the events."*[86]

241. However, as noted above emails between Mr Fenton and Ms Davies indicate Peter Fenton was aware by 1 June 2015 well prior to him going on leave that it was a possibility that a third nurse would be engaged.[87]Specifically in an email from Ms Davies to Mr Fenton on 1 June 2015, 3.31pm she "Thanks for that Pete Will keep you posted, so if we had someone from the 18th -29th would cover it???" and email in response from Peter Fenton to Jane Davies 1 June 2015 3.51pm "Jane Then we would make a Nurse available to attend the Festive each day at the QAS post – BUT THIS WAS REFUSED OUTRIGHT BY THE EXEC – what's changed?". Mr Fenton was certainly aware by 16 June 2015, that a third nurse had been engaged, given the email he sent to Ms Harvey regarding this.[88]

242. Mr Fenton was asked during the inquest why he did not consider preparing a plan after he became aware a third nurse was to be engaged. His oral evidence was unclear. He stated he was 'unaware of a third nurse being granted permission to come in until much later, right towards the period of time that I actually went on leave.'[89]

243. Mr Fenton was asked whether, in terms of planning for the 2015 Laura Horse Sports Weekend, irrespective of preparation of a formal document, he turned his mind to the possibility that the clinic might require additional equipment given the population influx. His evidence was that the only possible additional equipment that might be required was extra medication for people who had forgotten theirs.[90] He stated 'Never in our preparedness plans prior was there any additional equipment.'[91]

[86] Ex G10, paras 11-12.
[87] Ex G8.14, p.3
[88] G8.16, paras 1-2.
[89] T2-122, lines 44-45
[90] T2-122, lines 19-22.
[91] T2-122, lines 23-24.

Confusion on the part of TCHHS staff as to the presence of QAS at the campdraft events

244. During the inquest hearing, it became apparent that TCHHS staff, in particular Ms Wardlaw and Mr Fenton, were unclear about the periods during which QAS would be present at the events.

245. Mr Fenton accepted during questioning by Counsel for QAS that he had been involved in preparation of the 2014 Laura Events Preparedness and Response Management Plan[92] and that he was aware of this plan[93] Mr Fenton also accepted that it was clear from this 2014 Preparedness and Response Management Plan that there was no involvement in 2014 by QAS or any request by TCHHS for QAS to be involved in the horse sports or camp-drafting events.[94]

246. During questioning from Counsel for QAS Mr Fenton was asked if he had seen the email from Mr Culic of 29 May 2015, which advised Ms Wardlaw of the fact that Queensland Health looked after the camp draft historically, and Ms Wardlaw's response including 'no probs, I will have the workforce team sort the RN out to ensure she is aware of the dates events ect [sic]…'[95]. Initially Mr Fenton indicated he had not seen this email[96] but later accepted he had[97], given that Jane Davies had forwarded it to him stating 'Hi Pete, Think we got you sorted for Laura? With the Rodeo and dance festival what is your usual process? As below QAS are requesting support for it, is that doable for you?'[98]

247. It was submitted that given the above, Mr Fenton ought to have been aware QAS would not be in attendance at the camp draft events as he had been provided with that information. However, he clearly did not turn his mind to it and left open with the nurses for whom he had responsibility the possible understanding that QAS would not be present, in his email to Ms Harvey of 18 June 2015 detailed above, asking her to ensure the nurse present at the camp drafts provided 'any support required for QAS on these days'.[99]

248. In her oral evidence Ms Wardlaw referred to QAS being present at the camp draft event, and indicated she was working on the assumption that QAS would be present for the entire weekend. [100] Counsel Assisting drew Ms Wardlaw's attention[101] to the email from Mr Culic of 29 May 2015 at 2.07pm which included a reference to the following "Historically speaking, QH has looked after the camp draft as this is a low risk event and QAS has looked after the horse races and rodeo/bull rides as these are high

[92] Ex G1.3
[93] T2-138, lines 16, 19.
[94] T2-138, line 34.
[95] Ex G1.17, p.4.
[96] T2-135, lines 28-29.
[97] T2-136, line 7.
[98] Ex G1.17, p. 4.
[99] Ex G8.16, para 1-2.
[100] T1-133, lines 23-26.
[101] T1-134, lines 14-45 to T1-135.

risk events"[102] and to her response "Hey, Grantly, no probs, I will have the workforce team sort out the RN to ensure she is aware of the dates, events…"[103]. Ms Wardlaw's response was that she could not recall this email.[104] However, it is clear on the evidence that she did receive it.

249. It is relevant that whilst the information provided by QAS clearly indicated they would not be present at the camp draft, the information as to the dates of the events during the Laura Horse Sports Races and Rodeo weekend was slightly inaccurate in that the email did not refer to the fact that camp draft events were to be held on 27 June 2015 in addition to 26 June.

250. Whilst the email information provided by QAS was not wholly accurate, it made clear that QAS would not be at the camp draft and there is no evidence that Ms Wardlaw or Mr Fenton took specific steps to ascertain the details of the times and dates of various events and the presence or absence of QAS at these events. It was submitted there was a lack of attention to detail on the part of both Ms Wardlaw and Mr Fenton, which contributed to subsequent confusion on the ground as to expectation of nurses over the Laura Horse Sports Weekend and in particular whether they were to be providing a support role to QAS or to be the first responders themselves. However it is noted there is also no evidence as to further correspondence from QAS to TCHHS to clarify the exact times and dates they would be present. It was submitted that the limited information provided by QAS as to their presence during that weekend (for example provision of incorrect dates for specific events) may have contributed to this confusion.

251. It noted that the email from Mr Fenton to Ms Davies sent on 1 June 2015 (after she forwarded the email from Mr Culic with details of the Laura Horse Sports Races and Rodeo events and the QAS presence, and Ms Wardlaw's response agreeing to an additional nurse), still fails to differentiate between the Laura Dance Festival and Laura Horse Sports Races and Rodeo weekend or to indicate an appreciation for the different level of QAS support at the two events. It states simply "Jane then we would make a Nurse available to attend the Festive [sic] each day at the QAS post…".

252. There was ongoing confusion up until 25 June, the day before the commencement of the Laura Horse Sports Races and Rodeo weekend, as to the expectations of the three LPHCC nurses over the period including with respect to whether any of them were expected to actually attend the horse sports and camp draft events over the weekend at all, up until 25 June 2015, one day before the weekend events began.

253. It was submitted that this confusion occurred in part due to neither Mr Fenton nor Ms Wardlaw obtaining details of the timing and nature of the events over the Laura Horse Sports Races and Rodeo weekend, or the presence or otherwise of QAS during those events and failing to ensure this was communicated to the nurses. It was submitted that this confusion was exacerbated by a change in the Director of Nursing just prior to the Horse Sports Races and Rodeo weekend and inadequate handover.

[102] Ex G8.14, p.4.
[103] Ibid.
[104] T1-135, line 15.

Specifically, Mr Fenton went on long service leave from his position on 19 June 2015[105] and Vicky Jackson was responsible for covering the role of DON for the week of 22 to 28 June 2015, prior to the commencement of Julie Ross as Acting DON.[106]

254. In terms of Mr Fenton's actual instructions to the nurses, the only firm evidence is the email to Ms Harvey of 18 June 2015. There is no evidence that he gave clear instructions to the nurses as to the expectations he had and whether they should attend with or without the vehicle.

255. Ms Jackson came into the role on 22 June 2015 for an interim period of one week between 22 June 2015 and 28 June 2015. Her evidence was that she received an inadequate briefing with regards to the weekend. She stated "I had concerns about planning for the event as I could get no clear direction from the Executives regarding staff placement over the period leading up to the event. Staff seemed to have not been given a clear pathway or expectation for their roles and appeared to have limited knowledge around orientation or indeed what my role would be or for how long I would be assisting them. As the DONM covering for that week I felt that I had been provided with misleading information and an inaccurate handover regarding the upcoming organisation of the event. It appeared to me that decisions were made without full disclosure and stakeholder consultation."[107]

256. When asked during the inquest who had provided her with a handover she stated initially that she believed it was Mr Fenton but then could not recall if it was Mr Fenton or Rebecca Buldo, who was in the role prior to her.[108] This is consistent with Mr Fenton's evidence that he handed the 'information and keys'[109] over to the then acting DON of the Cooktown multipurpose facility, Rebecca.[110]

257. Ms Jackson's oral evidence was that the information given to her was that everything had been sorted out and a third nurse was engaged.[111] However she stated that the nurses on the ground didn't have all the information they should have. [112]In relation to whether the nurses were required to work from the clinic or at the grounds of the Laura Horse Sports Weekend Ms Jackson said that her interpretation was that that the nurses were employed to be at the clinic but should couldn't find the answers to 'actually give concrete advice to the girls.'[113]

258. It seems Ms Jackson only gained an understanding on 23 June 2015, from advice from local QAS officers, that the QAS would not be present at the grounds during the events

[105] T2-117, line 43.
[106] T3-5, lines 30-43.
[107] Ex G11, para 16.
[108] T3-6, lines 1-4.
[109] T2-118, line 5.
[110] T2-118, line 15.
[111] T3-6, line 4.
[112] T3-6, line 23.
[113] T3-6, lines 25-39.

the nurses had been asked to cover, and that she confirmed this with Ms Harvey on that day.[114]

259. On 23 June 2015 at 10.27pm Ms Harvey sent Ms Jackson an email forwarding the email from Peter Fenton on 18 June 2015 (extracted above) advising that a nurse should be at the rodeo on Friday and Saturday morning. Ms Harvey's email to Ms Jackson stated "Hi Vicky Here is the email that Pete sent about the rodeo can you please let me know how you wish this to pan out…"[115]

260. Ms Jackson sent an email on 24 June 2015 to Ms Harvey stating "Hi Trish, Have being trying to ring you this afternoon but the phone goes to message bank…Still waiting for QAS to get back to me have contacted local branch again today and the QAS manager is well aware I want to talk to him. At this this stage I have support from the EDONM NOT to have you guys in attendance the grounds [sic] so just work your normal shifts from the clinic. I will just tell Warren that when he gets around to returning my call requests."[116]

261. Following this however, on 25 June 2015, the day prior to the Horse Sports Races and Rodeo weekend starting, Ms Jackson emailed Patricia Harvey stating "Hi Trish I have just had a long chat with James Shattock (nursing workforce) Katherine was specifically contracted to support the QAS so she will be expected to be at the grounds to offer first aid support when QAS not in attendance. You and Virginia will maintain the current roster and work from the clinic in normal hours."[117]

262. Ms Jackson was asked during the inquest specifically what discussions she had with Ms Wardlaw regarding expectations that the nurses would not attend the grounds of the Horse Sports Races and Rodeo weekend. Ms Jackson stated that she was aware from previous discussions with Ms Wardlaw that her expectation was that the nurses were to work from the clinic[118] (it is not clear whether these discussions were specifically with respect to the Laura Horse Sports and Races Weekend and seems there may have been more general discussions).[119] However her understanding is consistent with Ms Wardlaw's evidence that her position was that the nurses should work from the clinic.[120]

263. Ms Jackson gave evidence that she couldn't get in touch with anyone during the week[121] that she was working as the DON, to get clear direction.[122] She stated she tried to get in contact with Ms Wardlaw and QAS on different occasions.[123]

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[114] Ex G11, p 8 (Att 4).
[115] Ex G11, p 6 (Att 2).
[116] Ex G11, p 5 (Att 5).
[117] Ex G11 (Att 1).
[118] T3-6, lines 38-40.
[119] T3-6, lines 44-45.
[120] T1-132, lines 30-31.
[121] T3-7, line 16.
[122] T3-7, lines 8-9.
[123] T3-7, lines 23-24.

264. On 25 June 2015 at 9am Patricia Harvey sent an email to Vicki Jackson, stating "Hi Vikki, Have just spoken to the rodeo people and they have nil equipment for the first aid and have said that we bring the car and a fist response bag with us if that is done then we have no emergency gear here at the clinic for call outs please inform me in what you would like me to put in place."[124]

265. Ms Jackson gave evidence that her position was that the LPHCC "Ambulance" should not be taken to the events and that she gave verbal instructions to Patricia Harvey to this effect.[125] She stated in oral evidence that this position was taken on the basis that the vehicle ought to be at the centre and available for use from there.[126] Mr Fenton gave evidence that he was surprised to hear that Ms Leighton was present at the event with a first aid kit and stethoscope only.[127] However, it later appeared this was because he was operating on the assumption QAS would be there[128], even though it is clear from the above evidence he did not have any basis for forming that assumption. His evidence seems to be more that he was surprised Ms Leighton was only at the event with first aid supplies as he believed (mistakenly) that QAS would be there. He stated in evidence following questions from Counsel for QAS that he was not aware that in previous years to 2015 the LPHCC troopy was actually in attendance at the event grounds during events when QAS was not available.[129]

266. Ms Jackson was asked whether she attended a meeting at the LPHCC prior to the events. Counsel Assisting put to Ms Jackson the assertion of Patricia Harvey in her statement that "We also had a meeting with Vikki Jackson and Julie Ross at the Laura clinic in attendance was myself and nurse Krystal Farrelly trying to make sure what was to be put in place for the rodeo."[130] Ms Jackson denied this meeting occurring noting that she did not attend the LPHCC prior to the Horse Sports Races and Rodeo weekend. She did note that there was a meeting at the LPHCC following Holly's death.[131]

267. In relation to her communications and attempts to contact QAS prior to the event, the evidence of Ms Jackson at the inquest was that she tried to get in contact with QAS on numerous occasions[132] and was waiting for 'Warren' [Martin] to get back to her[133] and had left messages for him.[134] Counsel for QAS suggested to her that Warren Martin's equivalent was Ms Wardlaw,[135] usual communication would be between Ms Wardlaw or Mr Pressley and Mr Martin and Mr Martin had had the same mobile for 14

[124] Ex G11 (Att 1).
[125] T3-9, lines 38-40.
[126] T3-9, lines 39-41.
[127] T2-129, line 46.
[128] T2-131, lines 35-36 and lines 43-44.
[129] T2-139, lines 41-47.
[130] Ex G6.1, para 7.1.
[131] T3-10, lines 25 and 34-35.
[132] T3-7, lines 23-25.
[133] T3-18, line 7.
[134] T3-19, lines 34-36.
[135] T3-19, line 45-46.

years and received no message or phone call from Ms Jackson.[136] Whilst this may be the case it is submitted that the Coroner should accept on the evidence that Ms Jackson did make some attempts to contact Mr Martin, albeit possibly though the wrong channels.

268. Irrespective of whether the clinic vehicle was expected to be at the clinic or otherwise, there is no evidence that any consideration given, at least by Ms Wardlaw, to the lack of a back-up plan, for circumstances where the LPHCC clinic retrieval vehicle was in use on another call out and no plans were put in place for this quite likely eventuality.[137]

269. The evidence is that just during the night prior to the medical emergency involving Holly, the retrieval vehicle had been used for two separate retrievals and transfers to Cooktown, by Ms Farrelly and Ms Harvey.[138]

270. A key failure on the part of Ms Wardlaw and Mr Fenton in particular was to turn their minds to the possibility that there was only one vehicle, meaning that given the population increase, there was a high risk that this could have been in use either at the Laura Horse Sports weekend when required for an urgent call out, or vice versa. Ms Nikora discussed this difficulty in her oral evidence stating 'regularly, we're getting visitors or - in the community that have [indistinct] that are very, very sick that need us just as much as the Laura Rodeo.'[139] She considered that big event such as the Laura Hose Sports Weekend 'needs a second vehicle.'[140] Ms Nikora also indicated there would be difficulties associated with taking the retrieval vehicle to the Laura Horse Sports Weekend because this would take it away from the community.[141]

Fatigue Management

271. There were a number of organisational issues that contributed to inadequate planning for the weekend on the part of TCHHS:

272. There was no TCHHS fatigue leave policy in place at the time of the 2015 Laura Horse Sports Races and Rodeo weekend. There was a Queensland Health policy in place only, which TCHHS had administratively adopted.[142] This document is included in the inquest brief of evidence.[143] Ms Wardlaw indicated in her oral evidence that this is what would have been relied on.[144] She acknowledged nurses have entitlements to fatigue leave under their award.[145] The Queensland Nurses Union also provided evidence about the risks associated with fatigued workers and potential implications for

[136] T3-20, lines 1-7.
[137] T1-141, lines 34-39.
[138] Ex G6, paras 15-21; Ex G4, para 9.
[139] T2-67, lines 41-43.
[140] T2-69, line 5.
[141] T2-67 lines 40-45.
[142] Ex G3.4, paras 4-5.
[143] Ex G13, p. 1.
[144] T1-128, line 2.
[145] T1-128, lines 11-12.

compliance with workplace health and safety legislation.[146] However, there were limited arrangements in place to ensure adequate cover during periods when fatigue leave needed to be taken.

273. The TCHHS has since the incident involving Holly developed and implemented a Fatigue Risk Management Policy.[147] Whilst this contains some controls for managing fatigue and provides that exceptionally fatigued staff should not work[148] this document in itself does not specifically provide for back up arrangements for staffing primary health care centres where staff need to have a period of rest due to high fatigue scores under the policy.

Nurse skill mix

274. The submissions of the QNMU was that the draft LPHCC BPF Service Profile 2014/15 indicated that core nursing staff at the LPHCC should have emergency skills including some experience in accident and emergency as well as current pre-hospital trauma life support and advanced life support endorsement and an ability to function in remote areas under difficult circumstances and that these requirements were reasonable.

275. RN Leighton's Curriculum Vitae ('CV'), indicated she undertook ALS training in 2003 to 2004 and was reaccredited in 2006 to 2007. There is no reference to further reaccreditation of her ALS certification following this period.[149]

276. There is reference in CNC Harvey's CV to being able to apply 'advance resuscitation techniques' however it is not clear when she was last accredited for ALS.[150]

277. The issue of ALS accreditation was not put to RN Leighton or CNC Harvey in evidence. According to RN Farrelly's CV, she was current in her ALS accreditation, having completed an update in 2015.[151]

278. QAS joined with Counsel Assisting in submitting that if the Laura Clinic staff had the appropriate equipment with them and had the necessary up to date ALS accreditation, there should have been no difference in the level of response provided by the LHC and the QAS ACP paramedics.[152]

279. I accept that submission however I add that even if all nurses were equipped and ALS accredited:

i. they were entitled to be on fatigue leave at the time of Holly's emergency and TCHHS had no backup or contingency plan for fatigue leave;
ii. there was no emergency vehicle on site to transport Holly to the clinic;

[146] Ex M3, paras 2-7.
[147] Ex G13, p. 89.
[148] Ex G13, p. 97.
[149] QAS submissions
[150] QAS submissions
[151] QAS submissions
[152] QAS submissions

Nurse Ives and Nikora

280. I accept the submissions made by Ms Robb of Counsel on behalf of Nurse Ives and Nurse Nikora and I make no criticism of RN Ives' or RN Nikora's clinical practice, or their interventions, treatment, care or response times. The interests of RN Ives and RN Nikora were not impugned in any way in the course of the inquest. RN Ives and RN Nikora were both placed in inadequate and unenviable positions – as nurses who were off duty and trying to help Holly without adequate support.

Nurse, Harvey, Farrelly and Leighton

281. I accept that the Laura Clinic nurses, Nurse Harvey, Farrelly and Leighton were also placed in unenviable, if not unacceptable positions as set out in these findings.

282. On 27 June all three clinic nurses were inadequately equipped to attend to an out of clinic medical emergency at the weekend event.

283. The TCHHS became responsible for the out of hospital first responder emergency response to the Laura community in the absence of a formal preparedness plan and / or other arrangements to cover the event. .

284. The TCHHS had prior experience and knowledge of the event and in previous years (as the Cape York Health Service) had a preparedness plan in place.

285. In 2015 the Laura Primary Health Clinic was not equipped or resourced or staffed sufficiently to effect an emergency response to a mass public event in a way that would comply with recognised best practice for chain of survival and advanced life support.

286. The TCHHS did not undertake an independent review or assessment for the 2015 event as a whole resulting in confusion, a lack of clear communication and nurses new to the Laura clinic and the community without an adequate understanding of their role over the weekend.

287. The TCHHS did not engage with the QAS with a view to bolstering a medical presence in Laura that weekend.

288. The TCHHS did not plan for an out of hospital medical emergency at the grounds outside of times when the QAS were not present. Nurses Harvey, Farrelly and Leighton were left exposed and vulnerable in the circumstances that unfolded.

The QAS

289. The QAS were engaged by event organisers for discrete events which the QAS planned for and attended. The QAS applied appropriate risk assessment tools including the QAS risk assessment calculator. The QAS have demonstrated sufficient skill and interest in refining their risk assessment tools and in my view given that no criticism is directed to the QAS it is outside the ambit of this inquest to suggest any change or modification to those tools.

290. I make no finding in respect of the QAS risk assessment calculator. In my view to do so is beyond the remit of the Inquest. In the absence of a 2015 preparedness plan the QAS were not engaged in risk assessment and planning for the 2015 event. QAS were not asked for input into the risk assessment for the weekend and therefore nor required to apply the calculator to the event as a whole.

291. The absence of a 2015 preparedness plan, and not the incorrect application of the QAS calculator, or the correct application of a deficient calculator, contributed to the inadequate emergency medical response to Holly.

292. I note that the QAS have prior to 2015 and subsequent to Holly's death provided subsidised services to the Laura rodeo and race weekend.

293. The QAS will bring much to the table when considering my recommendation to establish protocols around planning for a medical emergency at mass public events.

294. Holly's only chance of survival was immediate access to the Chain of Survival protocols. Saying that, whilst immediate access to emergency medical response would have optimised her care and treatment, it would not have guaranteed her survival.

295. It seems inescapable that provision for an onsite QAS ambulance and trained personnel and / or an equivalent of a health clinic fully stocked ambulance and personnel to be on site within minutes of any call for emergency assistance.

COMMONWEALTH GOVERNMENT BLACKSPOT PROGRAM

296. There must be fully functioning communications with a default or back up system - to this end I intend to refer a copy of these findings to the Australian Government Blackspot program and noting the evidence of Mr Cronin (the then CEO of the Cook Shire Council) is that only 1 % of the Shire is covered by an adequate mobile service.

297. Satellite communication also failed at critical times on that day. I accept the evidence that variables such as blackspots; dips in roads and cloud cover can affect even satellite communication.

298. As Mrs Brown indicated during the Inquest there is no landline to the Laura Rodeo and Race grounds. In the absence of all other reliable forms of communication provision for a landline to ensure a reliable carriage to Triple 0 operations centre may be a consideration.

299. There is / was no two way radio between the grounds and the Laura Clinic.

INTERAGENCY CONSULTATION

300. The relevant event organisers should be responsible for assessing and planning the events in consultation with the local government and state agencies.

301. A preparedness plan for out of hospital emergencies during the event weekend specific to the township of Laura was, and is, the responsibility of the TCHHS who are tasked with responding.

302. Provision for an out of hospital emergency medical response in the context of a mass event in a remote location, such as the Laura Races and Rodeo weekend must be regulated by appropriate guidelines. Contemporary risk assessment and planning practices necessarily ensures that each stakeholder in the chain understands their role and responsibility.

303. Events such as the Laura rodeo and races no doubt started as small localised bush race meet and now gained enormous popularity and is a major event by any measure. Recognised (and standardised) planning and assessment tools must be invoked (and can be tailored to the event) to ensure that all stakeholders can plan for an optimal emergency response. Most importantly all who attend the weekend whether participants, spectators, campers, bystanders are entitled to know that within the context of the location and circumstances they will have access to all steps within the chain of survival and life support protocols if emergency medical care is required. In other words that all that can be done will be done. Holly was not afforded that care.

MY RESPONSE TO HOLLY's PARENTS

304. Holly's parents in their written submissions ask:

> "*Why were the clinic nurses so ill equipped and so ill prepared. We witnessed mistake after mistake.*

305. I have earlier noted that the clinic nurses should not ever have been put in the position they were. They were entitled, and needed to, take a full rest break before coming back on duty. A process should have been in place for a backup nursing team to cover Nurses Harvey and Farrelly that day. They were not fit for duty. They should not ever have been expected to make critical, potentially life saving decisions, and administer life saving treatments in their fatigued state.

306. They were not prepared for the medical emergency when they arrived and it was necessary for return trips to the clinic to obtain equipment**. Otherwise hard working, caring, rural nurses were made to look and feel incompetent. Their usual competency and professional capacities should not be measured against the events of that day.**

307. Nurses Harvey, Farrelly and Leighton are not personally accountable for all that went wrong on that day. Nurses Harvey and Farrelly did not arrive until almost fifty minutes after Holly's cardiac arrest. Notwithstanding their lack of preparedness and lack of equipment fit for the purpose – any response fifty minutes after a cardiac arrest was inevitably ineffectual.

308. In final oral submissions at Inquest Mr Brown acknowledges:

"… I don't blame the nurses. They were thrown into a situation there, where I don't think they could handle, especially in that short a period of time"

309. I agree with Mr Brown on that point.

310. Nurse Harvey sent an email to Vikki Jackson on 25 June (the day before the weekend event commenced) as follows:

> "*Have just spoken to the rodeo people and they have nil equipment for the first aid and have said we bring car and first response bag with us. If that is done we have no emergency gear here at the clinic for call outs. Please inform me what you would like put in place*"[153]

311. It is unacceptable that only 24 hours prior to the event, a clinic nurse was still grappling with the logistics of covering the event, and the needs of the community of Laura. Nurse Harvey should have been supported by good executive decision making within the TCHHS and supplied with additional resources as required. She essentially had to make a call between either servicing the community, or assigning meagre resources available to her (including the clinic troop carrier) to the event grounds.

312. Mr and Mrs Brown concluded in their written submissions:

> *"We watched our beautiful Holly die in the dirt. The terror Holly felt we witnessed, waiting for advanced life support to come. Waiting for the forgotten equipment and watching Holly with her airway compromised, negates the cost of an ambulance*."

313. I agree and would add that the indignity of being attended to in full public view for two hours with no immediate access to anything resembling advanced life support was inhumane.

314. Holly may not have survived even with advanced life support in, or out, of hospital. However, in this case, no one, not the event organisers, the TCHHS, nor anyone who assisted, or witnessed the tragedy, and especially Holly's parents can look back on Holly's death, and know that all that could and should have been done, was.

Root Cause Analysis - Torres and Cape Hospital Health Service

315. A Root Cause Analysis was commissioned by the TCHHS on 15 September 2015. The purpose of such a report is to identify the root cause of a situation in order to assist to solve the problem.

316. The RCA identified four contributing factors (which I accept all contributed to the inadequate response to Holly's medical emergency) as follows:

[153] Exhibit G11

Contributing Factor Statement 1.

317. There is no consistent local Council requirement in Queensland for event organisers to obtain a Council permit system to hold public or special events where that event will impact on local health services. This enabled an event in the Cook Shire being held without coordinated inter-agency notification or emergency planning for the event. Consequently there was no emergency preparedness plan established. This may have contributed to an uncoordinated response to a health emergency at a public cent within the Hospital and Health Service's geographical area of responsibility.

Contributing Factor Statement 2.

318. There is an absence of Department of Health policy and direction establishing Health Services responsibilities related to public or special events. This led at an absence of Torres and Cape Hospital and Health Service adopting a responsibility for establishing interagency planning toward public event being held within its geographical responsibility and absent recognition that an emergency preparedness plan was required. Consequently, there was no emergency preparedness plan established for the event. This may contributed to an uncoordinated response to a health emergency at a public event within the Hospital and Health Service's geographical area of responsibility

Contributing Factor Statement 3.

319. There is an absence of TCHHS policy and procedure related planning and preparing for public or special events within its geographical responsibility. This meant there was an absence of coordinated interagency planning and;

- an absence of a risk assessment,
- an absence of a plan,
- limited resource planning for the local primary health centre,
- unclear role expectations for the nurse/s on-site,
- an absence of a health care professional in charge at site,
- sub-optimal equipment and communications for the emergency response.

320. Consequently there was sub-optimal onsite management of the emergency which may have contributed to an uncoordinated response to the health emergency at the public event.

Contributing Factor Statement 4.

321. There is only one Thomas (retrieval) pack at the Laura PHCC. As both nurses had just completed a transfer using the pack it was not fully restored ready for the next emergency response. This led to the Thomas pack being inadequately stocked with equipment and may have contributed to an uncoordinated response to a health emergency at a public event within the Hospital and Health Service's geographical area of responsibility.

My further comments relating to the lack of preparedness by the TCHHS

322. By 2015 the TCCHS (or CYHHS as it was previously referred to) was familiar with the annual event and had actively engaged with preparations for the event by preparing management plans and obtaining and allocating resources – including in 2013, subsidising the presence of QAS to auspice the Laura Clinic during the event.

323. The newly formed TCHHS and Executive Managers, including those in key decision making roles one of whom (Ms Wardlaw) had assumed her role a little over six months prior to the 2015 event, and who properly conceded at inquest, a lack of proper understanding of the event demonstrated by the following exchange:[154] :

Coroner: *…Ms Wardlaw, are you able to tell me how many people attended the Laura Campdraft Horsesports weekend that weekend?---As in outside of nursing?*

Ms Wardlaw*:* *Outside of nursing. So, sorry, general public, spectators, campers, participants?---No, I don't recall how many people attended.*

Coroner: *How could you make a decision about anything if you didn't not have enough raw data to act on?---*

Ms Wardlaw*:* *We did the best with what we had.*

Coroner: *But you didn't know what you had?---*

Ms Wardlaw: *Correct.*

Coroner: *This is a fairly direct question: do you know what a campdraft is?---*

Ms Wardlaw: *I do now, but I didn't then.*

Coroner: *And is it the case that you personally didn't have a good enough understanding of the differentiation between all of the horse sports that were being conducted over the course of those two to three days?---*

Ms Wardlaw: *Correct. I was heavily reliant on others' information and assumptions.*

324. Regardless, the TCHHS service made decisions regarding the resourcing and staffing of the Laura for that weekend (and for the Laura Dance festival the weekend prior). The TCHHS was responsible for all out of hospital care for the Laura township with a static population of 80 people. The TCHHS did not properly inform themselves as to the increase in population, to 2000, for a mass gathering event that involved, horse sports of varying descriptions and where alcohol was available over the course of two-three days. The probability of a significant number of attendees having an underlying morbity or co-morbities were high. The fact that 17 year old Holly Brown suffered a complication from an undiagnosed heart condition was statistically low compared to the age and probable state of health of others in attendance.

Holly's Law - submissions on behalf of Warren and Eleanor Brown prepared by the Townsville Community Legal Service

325. Holly's parents, Warren and Eleanor Brown advocate for an enforceable regulatory framework (to be referred to as "Holly's Law) applicable to mass gathering events in Queensland to ensure safeguards and an appropriate medical response and provision of health services.

[154] Page 137 (day 1) line 32

326. All stakeholders involved in the Laura Rodeo and race weekend should have a clearly defined pathway (planning and risk assessment tools) to ensure an optimal response to a medical emergency. **The current literature in this area is commonly referred to as 'event medicine', indicative that an emergency medical response is a discrete and specialised component of event planning.**

327. There are a number of valuable tools available to stakeholders including a manual commissioned by the Commonwealth Government "Safe and Healthy Mass Gatherings: A Health, Medical and Safety Planning Manual for Public Events".

328. **Without a mandated event planning framework in place, mistakes will be made. While there was no guarantee that Holly would have survived her out of hospital cardiac emergency she was not afforded an adequate medical response. She did not have access to the Chain of Survival protocols in the timeframes required to give her any chance of surviving. Every link in that chain was broken.**

Findings required by s. 45

329. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how she came by her death. After considering all the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased - Holly Winta Brown

How she died – Holly died from a fatal arrhythmia caused by heart muscle scarring as a result of a previously undiagnosed rheumatic fever whilst camping at the Laura Rodeo and Race grounds for an annual horse event. Holly woke that morning complaining of a sore back and vomited. She became unresponsive and her father Warren and other bystanders commenced CPR. Holly went into cardiac arrest at approximately 9.10am in the presence of an off duty nurse who commenced cardio-pulmonary resuscitation. No emergency medical service was available at the grounds and an AED and adrenaline was not available on site for approximately 50 minutes when local Laura Primary Health Clinic Nurses arrived in the clinic troop carrier. The QAS arrived within 1 hour and 20 minutes after deployment by the QAS operations centre. The equipment and care provided was inadequate to effect chain of survival protocols. The emergency medical response provided to Holly was inadequate. The Laura clinic was not adequately resourced, staffed or equipped to provide an emergency medical response at a mass event. The lack of formal guidance and protocols for all stakeholders in relation to event planning and risk assessment contributed to the inadequate medical

response. I recommend that an interagency executive group be convened to consider reform for mass gathering events in Queensland and specifically to formulate protocols for an out of hospital emergency medical response at the annual Laura Rodeo and Race event.

Place of death – Laura Rodeo and Racecourse Reserve Grounds, Peninsula Development Road, Laura

Date of death– 27 June 2015

Cause of death – 1(a) Myocardial scarring
Condition giving rise to the underlying condition
1(b) Past Myocarditis (? rheumatic fever)

Comments and recommendations

330. Pursuant to the *Coroners Act 2003:* A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to*:*

> *46 (1) (a)* "public health or safety" and
> 46(1)(c) "ways to prevent deaths from happening in similar circumstances in the future."

331. I intend to frame recommendations reflecting the essence of the Browns submissions, however I have confined my recommendations specifically to the emergency medical response at the Laura Rodeo and Races event. I am optimistic that such a recommendation will trigger state wide reform for mass gathering public events

RECOMMENDATION ONE

332. That within six (6) months of these findings an interagency executive group be convened to consider reform for mass gathering events in Queensland and specifically to establish a standardised protocol to provide for an out of hospital emergency medical response at the annual Laura Rodeo and Race event.

333. The protocol must be sufficient to effect the Chain of Survival in compliance with International best practice standards addressing:

- Access to and Early and reliable emergency response communications system;
- Access to early CPR;
- Access to defibrillation within the first 3 – 4 minutes of a cardiac arrest;
- Access to advanced care by emergency services personnel within 8 minutes of cardiac arrest

334. The roundtable is to include executive representation from (not limited to):

Laura Amateur Turf Club

Laura Rodeo and Campdraft Association Inc.
Torres and Cape Hospital and Health Service
Cook Shire Council,
Queensland Ambulance Service
Queensland Police Service
Queensland Fire and Emergency Service
Representatives of relevant state agencies (including departments with responsibility for health, event planning, emergency services, and local government)

335. The protocol should have regard to (although not limited to):
- The provision of effective communication systems;
- Marked and known access for emergency services to enter and exit the Laura Rodeo and race grounds;
- The resourcing, staffing and skill mix of emergency responders.
- The incorporation of an approvals / permit process for the event organisers that complies with contemporary risk managements and planning for mass events.
- The context of the Laura Rodeo and Race weekend, including the significance to the local community, the unique location, the development of the event by community not for profit organisations over many decades; assistance to encourage and support the continuation of this important and unique community event.

I request that when the interagency group is formed that an authorised representative contact the Office of Northern Coroner to confirm its formation and so that I can consider the release of other relevant material that I have relied on and considered in the preparation of these findings. I am prepared to release that material so that the group can have regard to a significant body of work prepared for this inquest to enable an expedited response.

RECOMMENDATION TWO

336. That Holly's name be attributed to the standardised process referred to in Recommendation One.

CONDOLENCES

337. I close by offering my sincerest condolences to Holly's parents Warren and Eleanor and to Holly's brother William and her wider family and friends for their tragic loss.

I close the inquest.

Nerida Wilson
Northern Coroner
CAIRNS
12 June 2019