QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**INQUEST INTO THE DEATHS OF:** **Yvette Michelle Wilma BOOTH** **Adele Estelle SANDY** **Shakaya GEORGE** **("RHD Doomadgee Cluster")**	
TITLE OF COURT:	Coroners Court of Queensland	
JURISDICTION:	Northern	
FILE NO's:	2019/4445; 2020/2244; 2020/3951	
DELIVERED ON:	30 June 2023	
DELIVERED AT:	Cairns	
HEARING DATES:	Day 1 Doomadgee Part 2 Cairns Part 3 Cairns Final day Brisbane	18 July 2022 15-19 August 2022 12-15 September 2022 13 October 2022
DATE OF FINAL SUBMISSION:	6 February 2023	
FINDINGS OF:	Nerida Wilson, Northern Coroner	

CATCHWORDS:	Coroners: inquest, Rheumatic Heart Disease; Doomadgee, female; Care and treatment; North West Health Service; Doomadgee Hospital; Gidgee Healing Primary Health Service; Mount Isa Base Hospital; bicillin injections; prevention; primordial factors; primary health care; inability to share medical records; Aboriginal Controlled Health Care; siloed and fragmented health services; cultural safety; Qld Ending RHD Strategy.

LEGAL REPRESENTATION:

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Publication

1. Section 45 of the *Coroners Act 2003* ('the Act') 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 130-page findings in relation to Yvette Michelle Wilma BOOTH and Adele Estelle SANDY and Shakaya GEORGE. They will be distributed in accordance with the requirements of the Act and published on the website of the Coroners Court of Queensland.

PART ONE

History[1] Culture and Acknowledgement

2. Approximately ninety percent or more of the community of Doomadgee identify as Aboriginal. The Waanyi and Gangalidda people are recognised as the traditional custodians.

3. The original Aboriginal Mission of Doomadgee (referred to as 'old Doomadgee') was originally established on the coast near Burketown by the Christian Brethren with the support of the 'Chief Protector of Aboriginals'. The settlement was moved to the present location in 1937 on the banks of the Nicholson River.

4. The old Burketown Mission and the Protector reportedly sent children to 'old Doomadgee'. The Queensland Government reports these removals as 'unofficial' and not recorded in Qld government removal registers.

5. Around 50 children and 20 adults were living at old Doomadgee just prior to relocation (to the current site). The Chief Protector of Aboriginals vigorously supported the relocation despite local opposition, arguing it would facilitate 'better control of the natives, and improve facilities for the employment of Aboriginal labour by landholders of the district. 'Official' removals to (current day) Doomadgee totalled more than 80 between 1935 and 1957

6. Prior to the establishment of Doomadgee, many Aboriginal children in the Gulf region were removed to the mission at Mornington Island and to other missions and reserves further south. Queensland Government records indicate that over 160 people were removed from Burketown between 1900 and 1974.

7. Archival records and personal accounts by residents describe the restrictive and difficult conditions at Doomadgee. In 1950, a government report severely criticised practices in use in the dormitory. At the time, mission policy required that all children over 6 years old live in dormitories. Boys left the dormitory around the age of 14 to take up station work. Girls were trained in domestic duties and often remained in the dormitories until they married.

[1] https://www.qld.gov.au/firstnations/cultural-awareness-heritage-arts/community-histories/community-histories-c-d/community-histories-doomadgee

8. By the late 1950s, many residents left Doomadgee and went to the Mornington Island mission, where the practice of separating children from parents in dormitories had been abandoned. During the 1960s, older, unmarried girls began returning to their parents. The dormitories closed at some point in the late 1960s.

9. In 1969, the Queensland Government was appointed trustee of the reserve on which Doomadgee was located. Continuing criticism of conditions at Doomadgee led the Queensland Government to assume administrative control from the brethren in August 1983.

10. On 30 March 1985, the Doomadgee community elected 5 councillors to constitute an autonomous Doomadgee Aboriginal Council. On 21 May 1987, the Aboriginal reserve was transferred from the Queensland Government to the trusteeship of the Doomadgee Aboriginal Council, under a Deed of Grant in Trust (DOGIT).

11. It is reported that the last of the 'mission people' did not move out of Doomadgee until 1988. The town is now controlled by the Doomadgee Aboriginal (Shire) Council (since 2005).

Doomadgee 1959-60

ACKNOWLEDGEMENT OF COUNTRY

12. On behalf of the Coroners Court of Queensland I acknowledge the contemporary Aboriginal community of Doomadgee, who have survived removal and dispossession and yet who continue to maintain their identity, culture and Indigenous rights.

13. I acknowledge the senior lore man (culture precludes me from addressing him by name) who remained present in court with the families of the deceased women for the duration of the Inquest and I ask that he convey the gratitude of the Court to all affected family and the many persons who supported the families and others who so generously and willingly participated in these inquest proceedings reliving the grief and trauma of the loss of loved ones upon them, and I thank the community of Doomadgee community and express my deep gratitude for receiving me in community on Day 1 of inquest.

14. I also acknowledge and thank Mr Alex Doomadgee who attended all days of Inquest. He is related to two of the deceased women (Ms Sandy and Kaya) and

assisted the court to navigate matters of language and culture throughout proceedings.

Findings required s.45 *Coroners Act* 2003

15. Pursuant to s.45 of the *Coroners Act* 2003 I must, if possible, make findings as to:

    a. Who the deceased person is;

    b. How the person died;

    c. When the person died;

    d. Where the person died; and

    e. What caused the person to die

16. I must not include within those findings any statement that a person is, or may be:

    a. Guilty of an offence; or

    b. Civilly liable for something.

Standard of Proof

17. The particulars a Coroner must, if possible, find under section 45, need only be made to the civil standard but on the sliding *Briginshaw* scale. That may well result in different standards being necessary for the various matters a coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made.

18. The paragraph above was specifically contemplated by the Court of Appeal with apparent approval. The Court went on to state:

> *Two things must be kept in mind here. First, as Lord Lane CJ said in R v South London Coroner; ex parte Thompson, in a passage referred to with evident approval by Toohey J in Annetts v McCann: …an inquest is a fact finding exercise and not a method of apportioning guilt … In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use. Secondly, the application of the sliding scale of satisfaction test explained in Briginshaw v*

Briginshaw does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not."

Background

19. At the request of family, in these written findings, Yvette Michelle Wilma Booth is referred to as "Betty", Adele Estelle Sandy (nee Diamond) is referred to as "Ms Sandy", and Shakaya George is referred to as "Kaya".

20. Betty was born on 9 January 2001 and died at the Doomadgee Base Hospital on 23 September 2019, aged 18 years.

21. Ms Sandy was born on 27 March 1983 and died on 30 May 2020 at the Doomadgee Base Hospital aged 37 years.

22. Kaya was born on 20 December 2002 and died on 12 September 2020 at the Queensland Children's Hospital Brisbane, aged 17 years.

23. All are Aboriginal women who lived within the remote community of Doomadgee, in the lower Gulf of Carpentaria. To appreciate how remote, Doomadgee is it is just 140 kilometres east of the Northern Territory border, 630 kilometres northwest of Mount Isa, and 2,200 kilometres northwest of Brisbane.

24. Betty died from Rheumatic Heart Disease.

25. Ms Sandy died from Rheumatic Heart Disease.

26. Kaya died from an intra-cerebral haemorrhage, multi organ failure, and anticoagulation therapy after the repair of her aortic right ventricle as a consequence of chronic rheumatic heart disease.

27. The deaths of three young women from the same remote Aboriginal community, within 12 months of each other, prompted a coronial investigation into what would otherwise be considered 'natural cause' deaths.

28. Their deaths shook the small community, population approximately 1400. Their families sat through an exhaustive inquest, travelling the 1000 kilometres from Doomadgee to Cairns to attend the majority (9 of 11 days) of the inquest was held. [The first day of the inquest was held in Doomadgee to take in evidence from key members of the community, and the final day of the inquest was held in Brisbane with the Coroner attending remotely from Cairns].

Issues for Inquest

29. The following six (6) issues were examined at Inquest:

    - The findings required by s45(2) of the *Coroners Act* 2003; namely the identity of the deceased, when, where and how they died and what caused their deaths.
    - The adequacy of the primary health services provided by Gidgee Healing at Doomadgee in providing treatment, education and

follow up to the deceased persons regarding their diagnosis of RHD.

- The adequacy of the care provided by Doomadgee Hospital to the deceased persons, with particular emphasis on the six (6) months prior to their deaths.
- Whether there was delay in transferring Kaya to the Queensland Children's Hospital for surgical intervention, and if so, why?
- The adequacy of the care provided to Kaya by the Queensland Children's Hospital in the period 28 July 2020 to 12 September 2020.
- The adequacy of screening RHD and the public health, education/prevention and follow up provided in the Doomadgee community regarding ARF and RHD.

Conduct of Proceedings and Witnesses

30. The inquest took place over the course of 11 days. The community of Doomadgee hosted Day 1 of proceedings on country at Doomadgee where family members of the deceased women gave their evidence in person.

31. In all a total of 29 witnesses appeared at inquest and gave oral evidence they are:

    a. Edgar Sandy (Husband of Ms Sandy);

    b. Paula Booth (Older sibling of Betty);

    c. Martin Evans (Uncle of Betty);

    d. Kylie McKenna (A/Manager of the Queensland RHD Register and Control Program);

    e. Weenie George (Mother of Kaya);

    f. Alec Doomadgee (Family of Kaya and Ms Sandy);

    g. Dr Robert Justo (Director of Paediatric Cardiology, Queensland Paediatric Cardiac Service);

    h. Dr Benjamin Craig Hamilton (former Medical Superintendent Doomadgee Hospital, NWHHS);

    i. Dr Mary Anderson (Locum practitioner, Doomadgee Hospital, NWHHS);

    j. Brytt Grogan (Registered Nurse, Doomadgee Hospital, NWHHS);

    k. Lesley Salem (Registered Nurse, Gidgee Healing);

    l. Dr Benjamin Reeves (Paediatric Cardiologist, Cairns Hospital);

    m. Nazihah Asgar (Director of Nursing, Doomadgee Hospital, NWHHS);

n. Dr Benjamin Anderson (Paediatric Cardiologist, Queensland Children's Hospital);

o. Dr Andrew Kelly (Expert paediatric interventional cardiologist);

p. Dr Rosalie Schultz (Senior Medical Officer, Ngaanyatjarra Health Service);

q. Barry Walden (Chairman of the Board 'Ganawana Jungai');

r. Jacynta Savo (Lower Gulf Primary Health Care Manager, Gidgee Healing);

s. Dr Samuel Stevens (GP Expert, engaged by OHO);

t. Dr Mark Wenitong (Expert medical administrator);

u. Kelly Barclay (Secretary & Director Yellagundgimarra Health Council);

v. Dr David Rosengren (A/Chief Operating Officer, Queensland Health);

w. Vicki Wade (Director, RHD Australia);

x. Professor Anna Ralph (Senior Clinical Advisor, RHD Australia);

y. Joy Savage (Executive Director, Aboriginal and Torres Strait Islander Health, Cairns and Hinterland Hospital and Health Service);

z. Renee Blackman (CEO, Gidgee Healing);

aa. Shaun Solomon (Chairperson of the Board, Gidgee Healing);

bb. Troy Fraser (CEO, Doomadgee Aboriginal Shire Council); and

cc. Craig Fraser (Chairperson of the Board, Gidgee Healing).

Witnesses not required to give oral evidence

32. The following 13 persons provided statements and were not required to attend and give evidence in person:

a. Dr Mitchell Shaw (CFMU);

b. Dr Elizabeth Walsh;

c. Dr Paolo Amodeo (dec.);

d. Alisha Peter (QAS);

e. Dr Natalie MacCormick;

f. Dr Christian Alexander Adrian Mattke;

g. Dr Christopher Stephen James;

h. Dr Andrew Kelly;

i. Dr Anna Howell;

j. Dr Ram Nair;

k. Dr Gary Hall (CFMU);

l. Dr Manickman Muthu; and

m. Trent Daniel Alkemade (QAS).

General Introduction

33. RHD is one hundred percent preventable. It is almost exclusively a disease of poverty and social disadvantage. There are currently 3600 active clients on the Queensland RHD Register and Control Program, of those, 68% of clients identify as Aboriginal or Torres Strait Islander.

34. Indigenous Queenslanders have a prevalence of acquiring RHD at a rate of 582 times higher than non-Indigenous people living in Queensland.

35. Rheumatic Heart Fever is a precursor to Rheumatic Heart Disease and can often go undetected. [2]Rheumatic heart disease starts as a sore throat from a bacterium called *Streptococcus pyogenes* (group A streptococcus) which can pass easily from person to person in the same way as other upper respiratory tract infections. Strep infections are most common in childhood.

36. In some people, repeated strep infections cause the immune system to react against the tissues of the body including inflaming and scarring the heart valves. This is what is referred to as rheumatic fever. Rheumatic heart disease results then from the inflammation and scarring of heart valves caused by rheumatic fever. Rheumatic fever mostly affects children and adolescents in low- and middle-income countries, especially where poverty is widespread and access to health services is limited. People who live in overcrowded and poor conditions are at greatest risk of developing the disease.

37. The disease results from damage to heart valves caused by one or several episodes of rheumatic fever, an autoimmune inflammatory reaction to throat infection with group A streptococci (streptococcal pharyngitis or strep throat). It most commonly occurs in childhood and can lead to death or life-long disability.

38. Rheumatic Heart Disease was eradicated in white Australia many decades ago. A leading cardiac specialist during evidence at inquest, referred to the unnecessary deaths and cardiac surgeries still occurring in Aboriginal communities across Australia as a "*national disgrace*".

39. On 26 May 2018 the seventy first World Health Assembly (WHA 71.14) urged member states:

    a. to accelerate multisectoral efforts towards reducing poverty and improving socioeconomic standards by all means, tackling the known root determinants of rheumatic heart disease, including poor housing, overcrowding and reduced access to care;

[2] World Health Organisation www.who.int/news-room/fact-sheets/detail/rheumatic-heart-disease

b. to improve access to primary health care including through investing in a community and primary health care workforce trained in prevention, diagnosis and evidence-based management of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever, and rheumatic heart disease with its potential complications, alongside improving understanding of prevention and control of rheumatic heart disease among at-risk populations, further stating as follows:

> *Noting with concern that rheumatic heart disease is a significant, preventable cause of morbidity and mortality for people in all WHO regions which, even with incomplete data, is known to affect at least 33 million individuals and cause over 300 000 deaths annually, especially among vulnerable and marginalized groups including children, adolescents, pregnant women and poor and* ***indigenous populations****.*
>
> *Recognizing that rheumatic heart disease is a preventable condition arising from acute rheumatic fever, a secondary sequela of group A beta haemolytic streptococcal pharyngitis, and that early detection and diagnosis of this form of pharyngitis, acute rheumatic fever and rheumatic heart disease, with judicious antibiotic treatment of group A beta haemolytic streptococcal pharyngitis and appropriate antibiotic prophylaxis for those who have experienced acute rheumatic fever, can substantially reduce morbidity and mortality in a cost-effective way.*

Barriers to Care

40. These findings examine the medical journey for each of the deceased women and focus on the adequacy of their care and treatment. Ultimately it is obvious that the eradication of this devastating disease can only occur with prevention.

41. RHD is prevented by the most simple and basic measures of health and hygiene including washing of hands, washing of clothes, regular showering / bathing, and early treatment of sores and fever.

42. In general terms, social determinants, a lack of basic health education, and awareness, overcrowding, and a lack of ‘health hardware’ impacts the outcomes for those with rheumatic heart fever and rheumatic heart disease.

43. Rheumatic Heart Disease / fever is just one of many chronic medical conditions and diseases symptomatic of broader underlying issues with the community of Doomadgee.

44. Professor Anna Ralph (the Director of RHD Australia and co-author of the national RHD guidelines and a leader in Aboriginal Health Care) informed the court that RHD could be used to illustrate and provide a platform for other important environmental health messages.

> *“We have other childhood infectious diseases like ear disease, trachoma, bronchiectasis and other things that all share exactly the same risk factors,*

those risk factors being household over-crowding, lack of access to shower facilities and knowledge about the importance of washing every day".

Doomadgee Hospital

Acute Rheumatic Fever and Rheumatic Heart Disease

45. A Health Service Investigation was established under the *Hospital and Health Boards Act 2011* into the death of Yvette Booth (referred to as 'Betty's Story'). The investigation was undertaken over eight weeks by three highly qualified independent investigators. A useful synopsis and information about RHD (compatible with the World Health Organisation information referred to earlier) is captured within that report (*italicised*) as follows:

> *"RHD is damage to one or more heart valves that remains after an initial or recurrent episode of ARF. It is caused by an episode or recurrent episodes of ARF, where the heart has become inflamed. The heart valves can remain stretched and/or scarred, and normal blood flow through damaged valves is interrupted. Blood may flow backward through stretched valves that do not close properly or may be blocked due to scarred valves not opening properly. When the heart is damaged in this way, the heart valves are unable to function adequately, and heart surgery may be required.*
>
> *Untreated, RHD causes heart failure and those affected are at risk of arrhythmias, stroke, endocarditis and complications of pregnancy. These conditions cause progressive disability, reduce quality of life and can cause premature death in young adults. Heart surgery can manage some of these problems and prolong life but does not cure RHD.*
>
> *ARF and RHD occur at very high rates among Aboriginal and Torres Strait Islander people. These diseases predominantly affect children, adolescents, and young adults, and are important causes of premature mortality.*
>
> *ARF is an illness caused by an immunological reaction to infection with the bacterium group A streptococcus (GAS). It causes an acute, generalised inflammatory response, and is an illness that affects only certain parts of the body, mainly the heart, joints, brain, and skin. Individuals with ARF are often severely unwell, in great pain and require hospitalisation. Despite the dramatic nature of the acute episode, ARF leaves no lasting damage to the brain, joints or skin.*
>
> *However, damage to the heart, or more specifically, the mitral and/or aortic valves, may remain once the acute episode has resolved.*

People who have had ARF previously are much more likely than the wider community to have subsequent episodes. These recurrences of ARF may cause further cardiac valve damage. Hence, RHD steadily worsens in people who have multiple episodes of ARF."

46. Prognosis of RHD is relatively poor. According to the Northern Territory RHD Register, young people with severe RHD at the time of diagnosis have a rapid disease progression. 50% require surgery within two years with 10% being deceased within six years. Mortality at 10 years is 22%, which is a composite of patients who did and did not undertake surgery.

47. Preventative measures for ARF (and in turn RHD) include washing of the body; washing of clothes and bedding; safe removal of wastewater; adequate nutrition; avoidance of overcrowding; reducing impact of animals, insects, and vermin (in the spread or continuation of infection); controlling environmental temperature; and reducing trauma.

48. Primary prevention includes the treatment of Group A Streptococcus ('GAS') infections with antibiotics to prevent acute episodes of ARF. The difficulty is that there are no single accepted clinical criteria for the diagnosis of strep throat or skin infections. Treatment within nine days of diagnosis is potentially able to reduce ARF incidence. The antibiotic of choice is typically a narrow spectrum penicillin.

49. Secondary prevention refers to the consistent and regular administration of antibiotics to people who have had ARF or RHD. This is to prevent further GAS infections and recurrent ARF. Penicillin is again the recommended antibiotic with painful Bicillin injections administered every 21-28 days depending on treatment outcomes and individual variability. These injections may be required from 5 years following diagnosis, and in cases of severe RHD the monthly injections may be required until 40 years of age.

50. Tertiary prevention is described as intervention in individuals with RHD to reduce symptoms and disability and prevent premature death.

51. Delivery of secondary prevention is challenging for health services, patients, and their families. It requires intensive resources to ensure clients receive optimal management and follow-up. According to Ms McKenna, former Acting Manager of the Queensland RHD Register and Control Program ('the RHD Program'), the factors contributing to low levels of prophylaxis delivery included:

    a. Availability and acceptability of health services.

    b. The difficulty in attracting and retaining skilled clinical staff with cultural awareness. This hampers successful community engagement and trust between clinician and client.

    c. The pain caused by injections (intramuscular Bicillin is very painful, and, in Ms McKenna's words, the pressure and consistency of the injection make it *"like getting toothpaste administered in a very large needle"*).

    d. A lack of knowledge and the understanding of the serious health

consequences of ARF and RHD.

52. Patients who develop severe mitral valve disease (resulting in heart failure) require valve replacement surgery. This can be with a bioprosthetic or a mechanical valve. A bioprosthetic valve has a life of around 10 years. While a mechanical valve will last a lot longer, it requires the patient to take life-long anticoagulation therapy to prevent significant complications including stroke and death.

53. A patient requiring Warfarin (an anticoagulant) needs to monitor their therapeutic level of Warfarin through regular blood tests (an International Normalised Ratio or 'INR'). Adherence is an issue. An audit of INR testing in the Northern Territory found 40% of persons with a mechanical valve replacement were not adherent with INR testing, and 75% had identifiable non-therapeutic periods of warfarin therapy.

54. Australia has evidence-based guidelines for the management of ARF and RHD which are produced by the Menzies School of Health Research. The current version is '***2020 Australian Guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (3rd edition)***'

55. Ms Vicki Wade (Director of RHD Australia) and Professor Ralph (Clinical Advisor for RHD Australia) each contributed to the development of the Guideline. Both gave evidence at inquest.

Queensland RHD Register and Control Program ('RHD Program') and Screening

56. The RHD Program is a State-wide Commonwealth initiative which was commenced in 2009. It aims to improve detection, monitoring, and management of clients with ARF and RHD in Queensland. As of 9 September 2022, the RHD Program was monitoring 3,861 active ARF/RHD clients.

57. The RHD Program has a team of four clinical nurse consultants ('CNC') who are based in Cairns and Townsville, one program manager, and three data staff. A monthly reminder service is offered to all providers of clients on Bicillin in Queensland.

58. Since 2017, the RHD Program has delivered education to 123 clients and their families and 384 clinicians (Doctors, Nurses, Health Workers and Health Practitioners) within the NWHHS. However, the high turnover of staff exceeds the capacity of the RHD Program to provide education for each new staff member working in high-risk areas. The RHD Program is funded to travel to two communities in each high-risk HHS per year

59. There are other educational materials and guidelines available for Queensland clinicians.

60. As noted above, the RHD Program not only registers ARF/RHD clients but records information such as dates of Bicillin injections. Accurate data input relies upon staff at local health clinics manually faxing or emailing records of

injections to the RHD Program to be uploaded to the register within 24 hours. This data is then able to be immediately accessed by Queensland Health clinicians in real time.

61. Information can also be accessed by any clinician with an Australian Health Practitioner Regulation Agency ('AHPRA') registration in Queensland upon request through a program known as "The Viewer". "The Viewer" allows an extract of patient information to be viewed, as opposed to edited or updated, by clinicians.

62. The visible information on The Viewer does not include a full health care plan, but includes vital information about dates of Bicillin injections and echocardiograms (i.e. last known and next due). INR or Warfarin doses are not recorded as the RHD Program does not have easy access to those records.

63. The RHD Program has also had some involvement in ad hoc screening initiatives, whereby specialists are deployed to remote Aboriginal and Torres Strait Islander communities to diagnose cases of RHD by echocardiogram. Following a successful targeted Rheumatic Carditis Early Case Identification Program ('RCECI') in the Torres Strait in 2018, the RHD Program facilitated the conduct of a similar screening program on Mornington Island, and in Doomadgee and Dajarra in July 2019.

64. The screening program targeted school aged children under the age of 18 years and the Screening Team comprised:

    a. Three paediatric cardiologists (Dr Bo Remenyi from the Northern Territory, Dr Ben Reeves from Cairns, and Dr Justo, Director of Paediatric Cardiology at QCH, who also conducts outreach paediatric cardiology clinics for the NWHHS);

    b. A Registered Nurse from Gidgee Healing; and

    c. A representative from the RHD Program.

    d. Further, the NWHHS employs a RHD nurse who would usually have been included in the team. The nurse was on leave at the time of the screening.

65. On 9 March 2020, Dr Justo wrote to Mr Garry Jeffries of the Doomadgee Aboriginal Shire Council ('the Shire Council') to provide an update on the RHD screening data. Dr Justo advised a total of 681 children had been screened in five communities in NWHHS and 130 children were confirmed to have rheumatic carditis. This represented a prevalence of 44 per 1000 (4.4%). Dr Justo states:

> "*On the information available to me, 746 children of screening age were registered at Doomadgee hospital in 2018, suggesting that we have screened about 38% of the eligible population. If one includes the patients diagnosed with RHD prior to the screening program, 29 children have rheumatic heart disease in the Doomadgee community. This would give an overall prevalence in the community of 38.9 per 1000 (3.9%), with the knowledge that about 60% of the children have not been screened.*

Unfortunately, this suggests a high incidence of rheumatic heart disease in your community, accepting that a significant number of children were not screened".

"***In my opinion, if there was increased state-wide recognition by both the Indigenous community and health services in Queensland that early RCECI programs*** **[screening]** ***are an appropriate intervention in the current environment, where Rheumatic Fever is endemic in at-risk populations, this would make service provision and access to communities much more effective and time efficient. For example, this could streamline consenting and reporting pathways****".*

66. Dr Justo maintained at inquest that whilst there was no consensus regarding screening (as in no formalised strategy), screening remained important in diagnosing RHD as an "*essential part of the approach of managing disease in the current area*".

67. Chief Operating Office Qld Health Dr Rosengren gave evidence that Queensland Government has invested in the delivery of consistent primary healthcare services on the ground, as opposed to intermittent echocardiogram screening programs that visit communities' months or years apart.

    [*I acknowledge at this juncture the extraordinary work in the area of RHD screening in remote indigenous communities undertaken by committed specialists utilising their personal discretionary leave, including Dr's Justo, Reeve and Remenyi.]*

68. Prior to this inquest commencing, there had been no further screening within the NWHHS catchment since March 2020. Dr Justo says he has been advised there was no financial support currently available via Queensland Health or the RHD Program to conduct further screening in Queensland during the 2022/2023 financial year.

69. Dr Justo and Dr Reeves themselves obtained some limited external funding to undertake a RHD project to conduct further screening and education, as well as raising awareness of ARF/RHD in remote North Queensland communities. The project was largely dependent upon the goodwill of those health professionals involved, some of whom accessed annual or professional development leave to participate or did so on a voluntary basis or funded their own travel and accommodation.

70. Due to COVID-19 restrictions, this further screening had not occurred by the commencement of this inquest, but ultimately went ahead in September 2022. Of 111 children screened in Doomadgee in September 2022, three were newly identified as borderline RHD cases.

71. Dr Rosengren indicated that the 'Ending RHD Strategy 2021 – 2024', would strengthen the capability of the RHD Register by permanently appointing staff and improving technology to manage and share data.

72. Once diagnosed, the treatment for RHD is seemingly brutal and requires the monthly administration of a bicillin injection (described as "toothpaste" like consistency).

Core Issues and Concerns

73. The people of Doomadgee do not have ready access to adequate washing machines, beds, and quality produce. Local Elder Mr Barry Walden told the inquest that many people are limited only to what is available in the community because they do not own a vehicle or cannot afford the petrol to drive five hours to the nearest 'major' centre Mount Isa for these significant purchases. There is no public laundromat in Doomadgee and purchasing a washing machine locally would cost at least $900. In Mr Walden's words, *"We don't get that kind of money*"

74. The current CEO of the Shire Council Mr Troy Fraser shared his professional and personal observations as follows:

> *"Now, you have good housing, you have good education, you have pathways, then you have jobs. And once you have jobs, you're able to afford what they call health hardware … So let's not focus on the problem here. Let's not focus on the symptoms here. Let's focus on what the core problem is, because the issues is, is that we all want to – we have that little bit of a shovel and scrape the dirt. Let's dig deep. What is the actual problem … How many times have I seen that people have gone throughout and done these studies from a government perspective and yet they focus on a symptom. Let's not focus on the symptom here".*

75. Mr Fraser spoke of the housing built in the community consisting of generic white rectangle boxes with a few walls inside that make up a bedroom, a lounge room, and a kitchen. He said that this type of housing did not contemplate the needs or lifestyle of Doomadgee locals, who spend a lot of time outside and live within larger family structures. He also noted there are 340 days of sunshine in Doomadgee, which had not been capitalized upon to reduce the cost of electricity. Mr Fraser is hopeful of influencing change during the next funding round of housing, so that building works are better tailored for Doomadgee life.

76. Schools can play an important role in raising awareness among students and staff about 'keeping skin clean' and management of children with sores. The enrolment at Doomadgee School is 367 children, there is a 34.8% attendance.

77. Specialists in the field of delivery of medical services to indigenous people were critical of the lack of cultural capability and therefore culture safety. Aboriginal specific access to healthcare requires a deep willingness and understanding by practitioners to deliver safe medical care.

78. This inquest also revealed that as between health care providers there was confusion as to which service was responsible for the care and management of persons with RHD and RHF including the administration of bicillin injections and a lack of sharing relevant medical records providing yet another barrier to appropriate care and treatment.

79. The Commonwealth Government Doomadgee Local Implementation Plan 2010 – 2014 identified a number of Closing the Gap Building Blocks[3] including Health and Healthy Homes. Notwithstanding the lapse of 10 years since

[3]www.dss.gov.au/sites/default/files/documents/05-2012/doomadgee.pdf

implementation of that Plan, the issues identified in those building blocks were highly relevant during this Inquest as essential to both the prevention and treatment of RHF and RHD.

80. On the available evidence before this inquest I conclude these 'Gaps' have not been closed.

81. The Health statement from that Implementation Plan is as follows:

> *Indigenous Australians' access to effective, comprehensive primary and preventative health care is essential to improving their health expectancy, and reducing excess mortality caused by chronic disease.*
>
> *All health services play an important role in providing Indigenous people with access to effective health care and being responsive to and accountable for achieving government and community health priorities. Closing the Indigenous health gap requires a concerted effort in the prevention, management, and treatment of chronic disease. Indigenous children and their parents need to access programs and services that promote healthy lifestyles.*

82. The Healthy Home statement from the Implementation Plan is as follows:

> *A healthy home is a fundamental precondition of a healthy population. Important contributors to the current unsatisfactory living conditions include inadequate water and sewerage systems, waste collection, electricity, and housing infrastructure (design, stock and maintenance). Children need to live in accommodation with adequate infrastructure conducive to good hygiene and study, and free of overcrowding.*

83. Senior community member Mr Walden quite simply said the 'system' was broken. His solution was stated as follows:

> *Community will lead that conversation, not Gidgee, not Queensland Health, it must be done by the community themselves because they are the ones – we need to be the ones that create our own destiny. We don't need anyone telling us that or we don't need to make decisions based on something that's broken and has been fractured. We – we unfractured that, we fix it because it's been fractured, you know? The more that they put – resolve it around putting money into it, it's just getting broken and broken and broken because there is no – there isn't no responsibility for that because I think what – a solution is putting a Band-Aid solution to an issue that is affecting a clan group of people, a race of people. That's got to stop".*

Safety and trust issues between Service Providers and the Community

84. At the time of these deaths a Tripartite Agreement was in place. The three stakeholders included the Western Queensland Primary Health Network; Gidgee Healing (Mount Isa Aboriginal Controlled Health Service) and North West Hospital and Health Service. The intention of this agreement was to improve the health of the Aboriginal people of North West Queensland.

85. The evidence bore out that despite the best of intentions the agreement was poorly executed, leaving workforce deficiencies in both number and skill mix; confusion about roles and uncertainty around identity for Gidgee Healing. This

in turn created confusion amongst staff and consumers being the people of Doomadgee.

86. The longstanding Medical Superintendent of the Doomadgee Hospital Dr Craig Hamilton, a self-described MacGyver[4] type guy, (a unique problem solver aiding vulnerable populations) foresaw problems with the implementation of the Tripartite agreement and the handover over primary health care to Gidgee Health. He vocalised those concerns and a clash between Gidgee Health and Dr Hamilton and Qld Health ensued. Dr Hamilton's approach was described by Gidgee as confronting and disrespectful.

87. The CEO of Gidgee Healing Ms Blackman, spoke with candour about the difficulties with the transition under the agreement and accepted in her evidence that it "*could have been done better*" and "*I don't know that is was navigated well*" and that "*there was no clear role delineation*".

88. An example of the difficulties included the handover of all local RHD patients in Doomadgee to Gidgee. Only three patients remained with the Doomadgee Hospital for management and bicillin injections and the balance of 47 people were for transfer to Gidgee for ongoing care. It is now apparent that Gidgee did not have the resources for that undertaking. Mr Craig Carey, the then CEO of NWHS who has since resigned, gave evidence that regular RHD meetings between stakeholders are now in place to provide a safety net and a resolve to act more collaboratively between health services.

89. Many of the concerns raised by Dr Hamilton were ultimately borne out at Inquest. At inquest I understood Dr Hamilton to say that the handover of care of community members to Gidgee Health, an organisation that he considered was not mature enough or equipped either by skill or workforce or systems to take on the immediate primary care of the local community, set up delivery of health service in Doomadgee. I accept those concerns were legitimate.

90. Gidgee nurses had described feelings of overwhelm when dealing with Dr Hamilton during this period. There was not then a doctor on staff at Gidgee and new staff in a new organisation were left to deal with a fraught situation and a perceived power imbalance. The fledgling organisation was struggling to establish its identity and perhaps understandably Gidgee was at first unwilling to concede the need for help or to yield its position because so much was at stake.

91. The heightened manner in which the dialogue unfolded caused an intractable rift with his employer, and Dr Hamilton was removed from his long-term post as Medical Superintendent at the Doomadgee Hospital and redeployed to a different rural hospital.

92. Dr Hamilton's departure represents a significant loss of local and organisational knowledge. The position of a permanent medical superintendent at Doomadgee Hospital remained unfilled at the conclusion of the inquest.

[4] www.wikipedia.org

93. If the transition of primary care to Gidgee and the implementation of the tripartite agreement had been better managed by the major stakeholders, the stress experienced by all at the time could have been avoided.

94. Dr Hamilton is one of a number of key staff and employees who no longer provide health care at Doomadgee. Others include Dr Mary Anderson, and the former Director of Nursing Asgar at Doomadgee Hospital has since resigned. Further, key staff at Gidgee and the CEO of NWHS Craig Carey have departed their roles. I can infer the scrutiny of this Inquest and national media attention has had an impact.

95. Recruitment and retention of staff remains the highest priority for Doomadgee. The fallout from the deaths of Betty and Kaya and Ms Sandy is immeasurable.

96. The fragmentation of health systems and the transition of responsibility for oversight of all chronic illness required much a more considered implementation.

Information Sharing, Data Sovereignty and Continuity of Care

97. Establishing separate and distinct health services which did not have the ability then or now to share all relevant information and medical records is high risk. The lack of any ability for both Gidgee and the Doomadgee Hospital (QHEALTH) to see all the relevant records of the patients they share inevitably led to an inability to have the full RHD picture of any one person at any given time.

98. At no time during this inquest was the court provided with any example of successful record sharing across multi health organisations or where fragmentation of health services exists. I remain unsure whether such is aspirational or can be properly implemented by collaboration between services. It may be that legislative changes are required.

99. On any given day in Doomadgee up to multiple data sets for one patient may be in use. The Hospital uses three (3) or more sources to document patient care including a hard copy paper chart, EDIS system for presentations to ED, and Communicare for outpatient clinics and Community Health. The Flying Doctors and Mental Health services also have separate record keeping systems. Gidgee uses a platform called Best Practice. None of the electronic platforms are integrated or interface with the other. There are also a number of fly in fly out medical outreach programs with medical records.

100. At Doomadgee Hospital administration staff download the EDIS notes into the Communicare system.

101. The integrated electronic medical record (ieMR) is a Qld Health electronic medical record designed to provide real time patient information and improve efficiency available across multiple health services in Queensland. 'The Viewer' is an application that collates data from multiple Qld Health systems to access information without needing to log into multiple systems or systems not available at any given facility (for example discharge summaries, medication

profiles and emergency department presentations and hospital admissions. The Viewer is available on computers and mobile devices and is for use by healthcare professionals. I do not know to what degree these Qld Health systems are implemented or utilised at Doomadgee Hospital or who has what level of access.

102. The complexity of medical record keeping, also includes a consideration of data sovereignty. It is a fundamental human right for all people to control and protect personal data and to expect organisations to control and protect that data, which in turn increases First Nations access to control decisions and the narratives that affect them and their communities. This need for 'data to reflect reality' is what Walter and Andersen (2013) refer to as 'the cultural framework of Indigenous statistics'[5] and to "capture meaningful data about important constructs that give Aboriginal, and Torres Strait Islander lives meaning and value".

103. The complexities are further compounded by the multiple funding models across state and commonwealth governments. An immediate mapping exercise is essential to understand where the deficiencies gaps and learnings are

Failure to facilitate flow of medical records and information

104. The ability to provide continuity of care cannot be achieved without first addressing the necessity for an unimpeded flow of information.

105. **I find that the barriers to an unimpeded flow of medical records and health information across all relevant health services and facilities in Doomadgee, represented a serious systemic failure**.

106. Those services and facilities included but may not be limited to, Queensland Health, the North West Hospital and Health Service, the Doomadgee Hospital, the Mount Isa Base Hospital and Gidgee Health.

107. The siloing of critical health records and the inability to share the information across all platforms was known by all entities and yet continued and continues without complete rectification. The inability of health providers and professionals to gain a full clinical picture at crucial times impacted the care and treatment of Betty, Kaya and Ms Sandy.

108. This inquest represents just one of the many investigations into the deaths of Betty Kaya and Ms Sandy. All reviews and investigations undertaken to date reveal issues of record keeping and information sharing as deficient.

109. The tendency in high profile and highly charged enquiries is to look for individuals to 'blame'. When one stands back in all three of these deaths there is no one individual. Simply put: Systems failed. The systems failed Betty, Kaya and Ms Sandy. The systems also failed the health professionals and the

[5] Centre for Aboriginal Economic Policy Research. College of Arts and Social Sciences. The Australian National University. Canberra Research Monograph No. 38 2016 [https://press-files.anu.edu/downloads/press/n2140/html/ch12.xhtml/refer=&page=22]

practitioners on the ground in Doomadgee. **A lack of ability to share information and records denuded health professionals and clinicians of critical professional scaffolding essential for the conduct of professional State sanctioned health services.**

110. In this case all three women were living in a remote community suffering a chronic and ultimately fatal medical condition. From a global perspective by almost all criteria indigenous Australians are one of the most vulnerable populations on earth. If however you are an indigenous Australian living in Doomadgee that vulnerability is heightened. The people of Doomadgee were placed in that location by a State government only relatively recently. There is no economy there is no industry. The old people speak historically of there being no illness. Betty's parents in their oral family statement said that as a result of illness, you can now hear the young people breathless walking home from school in Doomadgee.

111. The health systems and processes that might work elsewhere do not work in Doomadgee, they have "*not been contextualised for indigenous communities nor with provision for indigenous cultural approaches to maintain health and wellness*".[6] The complexity is almost beyond the limitations of non-indigenous understanding.

Failure to properly execute the Tri-Partite agreement

112. **I find that the start-up of the tri-partite agreement between the North West Hosptial and Health Service, Gidgee Healing and the Western Qld Primary Health Network was not adequately executed.** Without properly educating and preparing the local hospital and Gidgee and the local QHEALTH community health service and most importantly the intended consumers – the people of Doomadgee, all people and all organisations were exposed to risk. The was a lack of understanding as to roles, there was a lack of skilled workforce in place at Gidgee, there was a lack of shared relevant clinical information about current consumers and the physical co-location of Gidgee with Qld Community Health, both of which are physically located behind and within walking distance of the Doomadgee Hospital exacerbated the confusion for local people.

113. Such an environment exposes all to risk, the clinicians, the health care workers and the consumers. The result is that there is now a complete and fundamental breakdown of trust between as between health services, and as between health services and consumers and the community of Doomadgee at large.

114. Trust and confidence has also been eroded by the use of fly in fly out models of care and service delivery. (it is not just doctors and health staff that fly in most of the government departments servicing Doomadgee operate in that way). I accept that in the current circumstances there is little choice but to fly

[6] Barnabe C. Towards attainment of Indigenous health through empowerment: resetting health systems, services and provider approaches. BMJ Glob Health. 2021 Feb;6(2):e004052. doi: 10.1136/bmjgh-2020-004052. PMID: 33547176; PMCID: PMC7871239

members of the health workforce into Doomadgee. There are current limitations to acquiring full time live-in doctors and doctors.

115. Ms Vicki Wade (co-author of the RHD Australia guidelines and expert in Aboriginal controlled health care) referred to fly in / fly out models as a 'band aid service'. Noting the difficulty of recruiting qualified persons to Doomadgee Ms Wade promoted the benefits of community members as 'care navigators' or advocates for local patients to break down the barriers when dealing with western trained doctors and nurses.

116. Mr Alec Doomadgee, an Elder within the Doomadgee community and assisting two of the families at inquest (Ms Sandy and Kaya) also promoted the benefits of a guardian angel model as a conduit between indigenous families and health professionals. This role would be independent of QHealth and local primary health services.

117. It was also obvious the community of Doomadgee distrust both Doomadgee Hospital the government sanctioned health service, and Gidgee Healing the Indigenous Primary Healthcare Service. They are confused as to where they should attend. This lack of trust leads to a lack of confidence in the health care provided on the ground.

118. When asked to suggest solutions for this fundamental breakdown between the community and the various health systems and providers) Ms Wade suggested an external facilitator be engaged to act as a cultural broker between the community and the health services and said:

> *"So it's sitting down with the Aboriginal leaders, the traditional owners, people like Barry Walden, others, Alec Doomadgee and other leaders in the community, sitting together, coming together, talking about what healing they want. So you're sitting down and you're having the yarning between the two in there, but you need to do it – there is specific trauma informed frameworks to use. Judy Atkinson is an Aboriginal academic but also has done a lot of work on trauma trails and trauma. Mick Gooda, our ex-social justice commissioner, has done a lot of work on healing and communities. Tom Calma, ex-social justice commissioner. Seek advice from them, how it would work. I – I think you'll find from this inquest when things have settled a bit that people will want to change, and I'm hopeful that they will come together. So although I say it's community led and owned, you will have to get the health services to want to come to the party also."*

119. Dr Rosengren in his evidence said there was:

> *"a mutual responsibility around coexisting and partnering around improving health outcomes rather than belonging to one side or another … It goes back to my previous point, that no amount of money is going to fix this challenge. It's a much more complex issue than that. And yes, being accepted and being part of and being understood by community is going to be a core fundamental requirement for us to be able to support community to have a better health outcome. How we do that and how we engage is something we clearly have not got right, and so focus on improving that and being – and working in partnership with our community families and our community leaders to understand how we can close that gap has to be the core component, because that will help and inform primordial prevention, primary care, etcetera, etcetera,*

because that's where we need to get to, to support their better health outcomes".

120. I accept the evidence of Ms Wade that the engagement of a culturally appropriate external facilitator working within a trauma informed framework may be the only solution to effect a repair between the community, government, and health services in Doomadgee.

121. I also acknowledge Dr Rosengren's observation that no amount of money is going to get this right.

122. Without getting the fundamentals right and the acknowledging the primacy of the community nothing will change. Taking white structures borne out of colonisation and placing them within a communal society and excluding community voices, whether consciously or unconsciously, and creating an environment where people do not feel safe and they do not feel heard and are reliant on that dominant system for their healthcare, does not work and has not ever worked.

Barriers to care and treatment in Doomadgee

123. The inquest provided the opportunity to examine an extraordinary repository of information and material. The inquest was provided a forum for experts, front line workers, clinicians, and community members to identify each offer their views and opinions. The solutions to RHD prevention and treatment are well known.

124. In the context of these deaths in Doomadgee the following is a broad snapshot of factors that coalesced and contributed to the outcomes for Ms Sandy, Betty and Kaya.

    a. Lack of basic health education and awareness within the community (including for example that there is a connection between Strep. A infection and RHD / RHF, identification of skin sores, sore throat etc);

    b. Lack of access to health hardware (washing machines; bed**s)**

    a. Lack of access to nutritional food sources;

    b. Overcrowding and a lack of adequate housing;

    c. No formalised RHD screening program;

    d. Treatment is painful and requires monthly bicillin injections often for years or decades;

    e. Tension between health services;

    c. Transient / Lack of a stable and qualified health workforce;

    a. Loss of key staff (including before, during, and after this inquest);

    b. Fly in fly out models of service delivery seen as a 'band aid';

    c. Lack of ability to provide suitable and safe accommodation for Gidgee staff;

d. Disparity in pay and entitlements between employees of Gidgee and QHealth (Hospital)

e. Unsafe working conditions (24/7 continuous cover by hospital doctor on the ground during their locum)

f. Outside workers not engaging with community while on the ground;

g. Mistrust between health services and consumers and community;

h. Lack of record sharing

i. Lack of access to RHD register by Gidgee;

j. Low administration rates / follow up for bicillin;

k. Confusion about which service delivers what care and treatment;

l. Mistrust of government;

m. Lack of cultural competency and safety;

n. Uncertainty as to how to best apply the 'Ending RHD' State government funding by 30 June 2023.

Human Rights Commission

125. On 4 July 2022 I granted leave for the Qld Human Rights Commission to appear at Inquest pursuant to s.51 *Human Rights Act* 2019 (Qld) I found that the holding of an inquest pursuant to the *Coroners Act* 2003 and making findings and recommendations to prevent deaths is an administrative function of the court and therefore subject to the obligations imposed by the *Human Rights* Act.

126. I accept that the Queensland Department of Health (Queensland Health), the North West Hospital and Health Service (NWHHS) and the Doomadgee Shire Council, as well as their staff and executive officers, are all public entities within the meaning of the Human Rights Act.

127. Gidgee Healing accepts that it is likely to be a public entity under the Human Rights Act (and acknowledges that in the course of providing health care services it receives funding from the Queensland Government as well as a number of public entities. The evidence in the inquest was that Gidgee Healing expanded into Doomadgee to provide health services previously provided by NWHHS).

128. I accept that even if Gidgee Healing is not a public entity, that does not affect the function of the coroner to make comments or recommendations.

129. A public entity does not include a court or tribunal except when acting in an administrative capacity

130. Public entities have obligations to act and make decisions compatibly with human rights, and to give proper consideration to human rights when making decisions.

131. Section 58(5) provides that “proper consideration” includes, but is not limited to:

    a. identifying the human rights that may be affected by the decision; and

    b. considering whether the decision would be compatible with human rights.

132. In accord with the submissions of the Human rights Commission I accept as Coroner I am therefore obliged pursuant to section 58(1) of the Human rights Act to:

    a. conduct the inquest in a manner that is compatible with human rights (including the right to life, the right to a fair hearing, equality before the law, and the cultural rights of Aboriginal peoples and Torres Strait Islander peoples);

    b. undertake a thorough and effective investigation that takes into account all surrounding circumstances, in accordance with the right to life. This may include making findings on failures by public entities to comply with the Human Rights Act that may have caused or contributed to the deaths. If the relevant acts or decisions occurred before the Human Rights Act commenced, human rights are relevant to the coroner’s power to comment on matters to prevent deaths from happening in the future, given that these public entities have human rights obligations going into the future;

    c. give proper consideration to human rights, and to make decisions, findings, and comments that are compatible with human rights;

    d. in making recommendations, take into account the protection of human rights, including a consideration that recommendations should be designed to protect human rights (such as the right to life, the right to health services and cultural rights) and should not disproportionately limit human rights (such as the right to privacy).

133. The Human Rights Commission supported both the recommendations proposed by Counsel Assisting and the factual basis for those recommendations contained with the comprehensive written submissions prepared by Counsel Assisting and the HRC sought only to amplify the inquest issues and the recommendations to the extent of addressing matters relevant to human rights. I am assisted by those submissions.

PART TWO
Care and Treatment of Betty, Kaya and Ms Sandy

Post Mortem Examination and Autopsy Results

134. Although Ms Sandy, Betty and Kaya died from complications associated with RHD, the cause of their deaths were notably different.

    a. Dr Botterill concluded the most probable cause of Betty's death (on 23 September 2019) was a cardiac arrhythmia complicating heart failure due to the consequences of past rheumatic fever. Betty had only been diagnosed with RHD two months prior on 26 July 2019 and had not yet had any surgical intervention (she was awaiting further investigation and treatment at the time of her death).

    b. Dr Botterill concluded the likely cause of Ms Sandy's death was the malfunction of her artificial heart valve due to clotting on the valve surface, and the consequences of elevated lung blood pressure. Ms Sandy had undergone a mechanical valve replacement in 2009.

    c. Dr Ong concluded Kaya's cause of death was intracerebral haemorrhage. The underlying cause was due to coagulopathy, likely combination from diffuse intravascular coagulopathy, multi-organ failure and iatrogenic (therapy with heparin). She had developed complications following two procedures to attempt to repair an aortic-right ventricular outlet fistula she had developed due to the failure of a Konno patch. The Konno procedure with aortic valve and mitral valve replacement surgery had been undertaken in 2017.

Circumstances of Betty's death and Expert Opinions

135. Dr Justo, a paediatric cardiologist, has provided cardiology outreach services to NWHHS from around 2000. Since about April 2017, NWHHS have funded flights to outlying clinics including Doomadgee. He can visit most communities one to two times per year. There is support provided to the local clinicians in between clinic visits, either by way of contacting the paediatrician in Mount Isa in the first instance, Dr Justo as the treating cardiologist, or the on-call cardiology service in Brisbane.

136. Betty was first seen at Gidgee on 26 July 2019 with RHD. Her disease had only been picked up coincidentally through the RHD School Screening program conducted by Dr Justo and Dr Bo Remenyi. Betty was not a student at the time, but her family were familiar with Dr Remenyi from her previous work in the community and took the opportunity for Betty and her sister to be screened.

137. Dr Justo and Dr Remenyi assessed 164 children in Doomadgee, with Betty and

her sister amongst those children. If a child was diagnosed with significant pathology, their family would be contacted, and the diagnosis and its management discussed. Then, if agreed, the child would be referred to Gidgee with a diagnosis and treatment plan.

138. Dr Remenyi reviewed Betty and her Echo result was discussed with Dr Justo who confirmed the diagnosis. Dr Remenyi counselled the family regarding the severe RHD, the need for a Bicillin injection, and the need for cardiac surgery.

139. Dr Justo was the cardiologist responsible for arranging follow up. He completed the screening sheet which included the treatment plan. In accordance with his usual practice, he understood and believed the original of the sheet was given to the local team for their records. However, there is no screening sheet on Betty's Gidgee or Doomadgee Hospital records.

140. Dr Justo says there was a meeting with members of the local healthcare services at the conclusion of the screening. He believes he would have discussed Betty's case. Ms Wheeler one of the Doomadgee Hospital Community Health workers was present for the debrief. The debrief did not extend to clinicians at the Doomadgee Hospital, and there is no record of the meeting in Betty's clinical record.

141. In evidence, Dr Justo stated that the screening team had relied upon the local community to ensure all necessary people were there for the briefing and, in future, the team would exercise their own due diligence to make sure all health members were present. Dr Hamilton was the Medical Superintendent of the Doomadgee Hospital at the relevant time and had been in that role since 11 June 2015. Prior to that he had been working consistently in Doomadgee since 2011 as a Senior Medical Officer. His role as Medical Superintendent required fly in fly out and working solo providing 24 hour per day medical coverage for the community.

142. Dr Hamilton explained that hospital clinicians had less involvement with this delivery of information (that is, the screening results) as many outreach portfolios were being transitioned to Gidgee (although he was unable to pinpoint a specific date when this occurred).

143. After Betty's initial diagnosis, Dr Justo made some enquiries about referral pathways for her and was advised the Indigenous Cardiac Outreach Program ('ICOP') may be suitable. He intended on making contact on his return to Brisbane but, in the meantime, believed his description of the echocardiogram results would be enough evidence of the need for surgery for ICOP to contact Betty's family. After completing further screening in Cairns, he returned to work on 5 August 2019.

144. Betty was referred to Gidgee and registered as their new client. Treatment with Bicillin was commenced and she was for follow up injections every 21 to 28 days. Betty and her family were provided education and Betty was advised she would require surgery to replace a valve. Betty was for an ECG and dental check on 28 July 2019 and an Adult Health Check on 29 July 2019. These did not occur.

145. On 30 July 2019 at 2240hrs, Betty presented to the Doomadgee Hospital with

'fever/ hyperthermia +cough'. She had a temperature of 38.1 degrees, a pulse rate of 123 beats per minute, and a respiratory rate of 20. Betty was assessed by a nurse who recorded that at 2300hrs Betty's fever had decreased and her heart rate returned to normal following the administration of hydrolyte and paracetamol (there were no other observations recorded following those taken at 2240hrs). Betty was instructed to return during clinic hours for review by a medical officer.

146. On 31 July 2019 at 2230hrs, Betty returned to the Doomadgee Hospital with 'fever/hyperthermia/cough'. She was reviewed by the same nurse. Betty had not attended the clinic for review by a medical officer as had been requested. She was examined by a nurse and her observations recorded. Her temperature was 39.3 degrees and her pulse rate 129. She was administered paracetamol and ibuprofen and given hydrolyte for mild dehydration. At 2359hrs, her temperature was around 38.1 degrees and her pulse around 105. Betty was again asked to come back and see the doctor during clinic hours.

147. On 1 August 2019, there was an entry in the Gidgee clinical record labelled as a "non- visit". The entry recorded a review of the notes and reminders by clinic staff that Betty required follow up, ECG and health assessment. However, Nurse Practitioner Salem told the inquest that she saw Betty that day, but that Betty had declined an assessment and been booked in for the following week.

148. On 1 August 2019 at 1600hrs, Betty presented to the Doomadgee Hospital. It was noted it was her third presentation in three days and that she reported her cough was worse at night. She was afebrile but had developed a wheeze on the right side of her chest. Dr Hamilton examined Betty. He diagnosed Betty with an Upper Respiratory Tract Infection ('URTI') and prescribed her Amoxycillin and Panadol.

149. On Saturday 3 August 2019 at 1415hrs, Betty presented to the Doomadgee Hospital with an ongoing cough and cold symptoms. Betty's mother reported that she was coughing up blood. She coughed up some bright red blood while in the Emergency Department ('ED'). She was afebrile, with a respiratory rate of 25 and a pulse rate of 129 beats per minute. A nurse recorded Betty had crackles in her chest and a slight wheeze. Dr Hamilton was contacted by phone. He ordered a stat dose of intravenous Ceftriaxone and then for Betty to commence oral Augmentin. Betty was discharged and advised to return on the Monday to be reviewed by the doctor in clinic hours.

150. Dr Hamilton says that while he does not recall the telephone conversation with the nurse, if he had been informed Betty was coughing up blood and had crackles on auscultation, he would have asked further questions or attended the hospital to initiate an afterhours medical review himself. The nurse who contacted Dr Hamilton was not called to give evidence at the inquest.

151. On 4 August 2019 at 0258hrs, Betty presented again to the Doomadgee Hospital because she was unable to sleep due to a dry cough. There is no triage form or observations recorded in the medical record. However, Betty was noted to be afebrile, to have no respiratory distress but to have oxygen saturations of 97%. She was administered a thymol gargle and a normal saline

nebulizer. After twenty minutes, Betty was reported to be feeling much better with no more throat itchiness and a decrease in her coughing. She was advised to come back the following morning for review by the medical officer.

152. On 4 August 2019 at 1135hrs, Betty returned to the Doomadgee Hospital with 'cough/rhinorrhoea'. At 1300hrs Betty was assessed by a nurse. She was afebrile, with a heart rate of 110, a slightly elevated respiratory rate, and an oxygen saturation of 100%. Her lungs were clear, but she was noted by the nurse to have a productive barking cough with some traces of blood in her sputum.

153. Dr Hamilton says he was asked by the nurse to review Betty and that Betty's mother requested he undertake a review. He assessed Betty and diagnosed her as suffering an URTI and further prescribed three days of intravenous ('IV') / intramuscular ('IMI') Ceftriaxone with daily review. This antibiotic was in addition to the oral Augmentin which had been ordered on 3 August 2019. He says he was not particularly concerned about Betty's symptoms and did not consider she required admission to the hospital. He did not see any blood and noted only 'yellow phlegm'.

154. Betty's mother mentioned to Dr Hamilton that Betty was scheduled for cardiac valve replacement surgery. This was the first Dr Hamilton had heard this, which surprised Betty's mother. She was uncertain of the details and consequently Dr Hamilton did not know the type of surgery which was proposed. However, he noted Betty's heart rate and rhythm were regular upon auscultation and all her other vitals were normal, which was reassuring to him.

155. Dr Hamilton could not locate any record of the scheduled surgery or any record of the diagnosis of a non-compliant valve or RHD. He contacted The Prince Charles Hospital ('TPCH'), the Townsville Hospital and the Cairns Hospital to try and obtain further information. This was to no avail. He was advised by Ms Wheeler, Nursing Unit Manager ('NUM') of Community Health, that Betty's valve issue had been picked up at a school examination and that the hospital had no record of it as it was being coordinated by Gidgee.

156. On 4 August 2019 at 1855hrs, Ms Wheeler wrote to Dr Justo and others seeking confirmation as to whether letters will be provided detailing the echocardiogram results and ongoing required treatment. She referred to a debrief at the end of the screening which she said was very useful and provided some directions in moving forward. She states:

> "*The reason we ask is the patient who you advised will require Cardiac valve surgery presented to the hospital over the weekend and her mother shared the need for surgery and the RHD diagnosis but our hospital doctor was not aware and could not find any notes anywhere detailing the diagnosis. He was concerned that her echo results could impact or alter treatment in some diagnosis. Her presenting this time was probable tonsillitis, while coughing up some blood stained frothy phlegm*".

157. Ms Wheeler's email had been copied to Dr Hamilton. At 1904hrs he emailed Ms Wheeler, Dr Justo and others to advise his concern was that he did not have any documentation concerning the screening by Dr Justo and his

colleagues. He said he was not able to confidently diagnose Betty without having all the information. He had already contacted Townsville, Cairns, and TPCH but nobody had any record of a scheduled surgery or notes of the review. He asked if her care was being coordinated by Gidgee.

158. Dr Hamilton completed an Incident Report about the lack of documentation in the clinical record regarding Betty's recent diagnosis.

159. On 5 August at 1030hrs, Dr Hamilton left Doomadgee in accordance with his rostered day off. However, shortly before leaving he contacted his medical defence organisation to protect his interests in relation to a dispute with NWHHS (they were redeploying him to Normanton against his wishes). Various communications occurred between Dr Hamilton's lawyers and NWHHS over the ensuing days which ultimately culminated in the termination of Dr Hamilton's employment with NWHSS on 13 August 2019. He did not return.

160. On 5 August 2019, Dr Justo recalls that he called the ICOP and told them of Betty's history, her diagnosis of severe RHD and that she would require fairly urgent surgery. He was advised the most effective way of referral would be to send correspondence to the ICOP team, addressed to Dr Javorsky.

161. Dr Justo wrote to Dr George Javorsky, Director of Cardiology at TPCH. He noted Betty was 18 years of age and while she presented as asymptomatic, on questioning she had a nocturnal cough and a mildly reduced exercise endurance. Dr Justo wrote:

> "*A screening echocardiogram detected significant rheumatic heart disease. A subsequent detailed cardiac ultrasound showed that she had thickened dysplastic mitral valve leaflets with severe mitral valve regurgitation. She also had moderate aortic valve regurgitation. Her left ventricle was dilated with an LVED of 5.4cm and her fractional shortening was reduced by 27%. There was mild TR which demonstrated elevation of her right ventricular systolic pressure to 60mmHg*.
>
> *Yvette had been commenced on Bicillin prophylaxis. I would appreciate it if you could arrange for your ICOP service to arrange clinical review in a timely manner. I expect that she will require surgical intervention to her mitral valve*".

162. In evidence, Dr Justo accepted that his letter and the use of the word "timely" probably did not give a sufficient sense of urgency in relation to the review of Betty. However, he believed that his detailed description of the echocardiographic findings would have raised a concern, particularly the elevation of the right heart pressure. In hindsight, Dr Justo regretted not contacting the cardiologist at TPCH directly and wishes he had.

163. At 1523hrs (that same day on 5 August 2019), Dr Justo responded to Dr Hamilton. He advised Betty had been discussed at the ICOP that morning and attached the clinical information concerning Betty. He said details of all other patients with a positive diagnosis would follow. **Dr Hamilton did not receive the email as he had left Doomadgee on days off and did not again return to the hospital**.

164. I infer therefore that this critical information including Betty's clinical information did not immediately make its way to Betty's file within the hospital. If that is the

case it is a fundamental failing by the North West Health Service to ensure that relevant patient information received to Dr Hamilton's email address was not triaged and actioned after his departure. As events transpired that information provided to be critical.

165. Dr Hamilton (having since read Dr Justo's reply email) says despite Dr Justo being advised of Betty's presentation to the hospital, including that she had coughed up some bloodstained frothy phlegm, did not suggest there was a need to change the management of Betty moving forward.

166. At 1637hrs, Betty returned to the Doomadgee Hospital to have another dose of IV Ceftriaxone. It was noted Betty was going for valve replacement surgery but that the medical officer had no records of this and that it was being managed by Gidgee (this is the first mention of Betty requiring valve replacement surgery in the Doomadgee clinical record). Betty's name was put in the recall book for further IV antibiotics and review by the medical officer the following day. Her observations were recorded and were relatively normal.

167. On 6 August 2019 at 1253hrs, Betty was reviewed by a nurse. The entry states:

> "*asked don nida does patient needs any mo review said no as no paperwork available from specialist when the patient came to the ed and there is no previous notes saying needs mo review and also patient has no issues and feeling well does not feel sick and she does not want to see mo for anything today so not referred to mo but later on when checked with don at 17.00 received email paperwork so she said she will forward the paperwork to mo put the patients name in recall for iv antibiotics and mo review for next day*".

168. Director of Nursing ('DON') Asgar explained that a nurse would not ordinarily add a patient to a recall list in these circumstances unless there was some reason to believe they had not understood the advice given to them. However, she had no specific memory of this conversation with staff.

169. Betty did not return the following day. Gidgee was not aware of her multiple presentations to the hospital ED over late-July and early-August 2019.

170. Dr Justo opines Betty's symptoms could have been an exacerbation of her mitral valve disease. He had believed that Doomadgee Hospital would recognise the bloodstained phlegm as a potential sign of congestive cardiac failure and discuss this further with the cardiac team either at TPCH or Townsville Hospital. However, Dr Justo accepted that he could have contacted TPCH himself to escalate Betty's review and regrets that he did not. Dr Hamilton gave evidence that the symptom of coughing up blood (which he had not personally seen) could have also been consistent with pneumonia or bronchitis, not simply congestive cardiac failure.

171. Dr Justo acknowledged in his written statement that having the information contained in his letter to the ICOP available to the medical team in Doomadgee may have been important in guiding Betty's care during the relevant period but, in his opinion, it would not have avoided Betty's death.

172. Dr Hamilton explained, not knowing of Betty's recent RHD diagnosis inhibited his own process of diagnosing a "seemingly well" young woman, in a remote

environment where there are logistical hurdles to running timely pathology and other diagnostics.

173. On 12 August 2019, Dr Justo had an email exchange with Ms Wheeler from Doomadgee Community Health. She enquired whether Betty's appointment with ICOP could wait until the next visit on 6 and 7 November 2019. In response, he wrote:

> *"I would check with ICOP. I would see value in transferring patient to TPCH prior to that for assessment for possible surgery. Have now received copy of ECHO from Bo and will forward to TPCH hopefully this week when I can get it copied*".

174. Dr Justo explained that there had been some delay in him receiving the echocardiogram images, as Dr Remenyi sent these on a disc in the mail from the Northern Territory. It could not be forwarded electronically given incompatible technologies between hospitals and jurisdictions. Dr Justo forwarded the echocardiogram images to Dr Javorsky, by letter dated 12 August 2019, for his consideration.

175. There is no record of Betty returning to the Doomadgee Hospital until 23 September 2019 (the day of her death). There is however a prescription for a Bicillin injection in the Doomadgee Hospital medical record on 19 August 2019, and a signature indicating it was administered on that day. Also on that day, a Cardiac Clinical Nurse referred Betty for an outreach review in Doomadgee in January 2020, despite email advice from Dr Justo to contact the ICOP to discuss earlier review of Betty. There is no progress note or reference to why Betty attended the hospital on 19 August 2019 or how the nurse came to complete the referral form.

176. On 19 August 2019, Nurse Salem reviewed Betty at Gidgee. Her progress notes record, "*Patient needs referral to nurse navigator – Same Completed. Patient is for operation in Brisbane for RHD. Discussed having 715* [adult health assessment] – *appointment made for Wednesday*". On the same day Registered Nurse Vogelpoel notes Betty had been due for Bicillin on 16 August, but notes she confirmed with Queensland Health that it had been given that day. Betty did not return to the clinic for her health assessment.

177. Nurse Salem completed the referral in writing to a Nurse Navigator and gave it to Ms Wheeler, Nurse Unit Manager ('NUM') of Community Health, who forwarded the referral to the Nurse Navigator. DON Asgar assumed Community Health became involved due to staff shortages at Gidgee. The referral was not completed properly. Nurse Salem's evidence was that she was not made aware of why the Nurse Navigator did not accept the referral. She stated that a copy of the referral should have been retained in the Gidgee record and could not explain why it was not.

178. Nurse Salem said she persuaded Betty to come back for a 715-health check and ECG on 21 August 2019. Betty did not attend.

179. Betty, therefore, had attended both health services, Gidgee and the Doomadgee Hospital, on 19 August 2019 for follow up and referral. In her evidence, Nurse Salem accepted that this was a duplication in services, but it was ultimately a

choice for the patient where they attended and both services practiced opportunistic medicine in treating those patients who did attend.

180. On 23 August 2019, Cardiac Clinical Nurse Rendell advised Ms Wheeler she had spoken to the ICOP. They had consulted with Dr Javorsky and advised it might be worthwhile having Betty seen in Mount Isa by the Townville cardiologist, as ICOP would not be returning to Doomadgee until November. Ms Rendell said she could organise this as soon as possible, subject to travel logistics. Dr Justo had no problem with the proposed plan.

181. On 28 August 2019, the cardiologist from TPCH assessed and categorized Betty's referral as Category 1. In his evidence, Dr Justo stated that, when he first wrote of the need for a "timely review", he would have hoped that this would happen "a bit more quickly" than over a month after Betty's diagnosis. There was the delay in receiving the echocardiogram images, but Dr Justo accepted that he might have been able to expedite the process by directly speaking to the Cardiologist at TPCH about the results.

182. On 28 August 2019, there is an email from a Clinical Nurse from the Heart and Lung Clinics at TPCH to the ICOP. The nurse recorded:

> "*the cardiology team feel that Yvette needs to be reviewed prior to the outreach clinic on 5th November. The dates I have available are 17/9 23/9 and 30/9. Yvette will need an echo prior to her appointment with her cardiologist. Please can you speak with the team in Doomadgee and let me know which appointment would be suitable for Yvette to travel to Brisbane. Once I have a date I will book an echo and appointment and forward the letter to you.*"

183. On 2 September 2019, the Clinical Nurse in the Heart and Lung Clinics again followed up with the ICOP as to whether they had heard from Betty as to a suitable date. The nurse stated, "*Dr Wee would like to see Yvette within the next month*".

184. At the beginning of September through to approximately 17 September 2019, Betty travelled to Townsville to visit her mother and father. Betty's sister confirmed that their parents had been in Townsville for three years because they required long term dialysis. They had wanted Betty to stay in Townsville to see doctors there, but she wanted to return to country in Doomadgee.

185. On 16 September 2019, the Clinical Nurse in the Heart and Lung Clinics followed up with ICOP again. She says she was told maybe 23 or 30 September for the clinic with Dr Wee. The ICOP emailed back advising Betty was due in Doomadgee the following day and that they will follow up with her then and hopefully book in a date.

186. Dr Justo opines as Betty was in Townsville, she could have had a more formal cardiac assessment with the Townsville cardiology team. He sees this, (and not seeking further advice after Betty's multiple presentations to the ED in Doomadgee), as missed opportunities. In evidence, he accepted that **intervention or review between these various presentations and her death would likely have made a difference.** Ms McKenna also observed that the RHD Program could have assisted in facilitating an opportunistic cardiologist review or dental clearance while she was in Townsville, had they known she

was there.

187. The Investigators who completed 'Betty's Story' received information that the type of valve surgery available in Townsville was different to that available at TPCH and relates to the replacement of valves as opposed to repair.

188. On 18 September 2019, the Clinical Nurse in the Heart and Lung Clinics sent a further follow up email to the ICOP.

189. On 18 September 2019, a staff member from Gidgee recorded, "*Yvette is identified as overdue for bicillin injection and there are no available contacts for the client attempts to be made to Doomadgee staff to follow up with client*". They relied upon Ms Wheeler, NUM at Community Health, who shares a physical office site with Gidgee, to make contact with Betty's parents on their behalf.

190. Nurse Salem says Gidgee were not made aware of details of any cardiac consultations, pre-tests, assessments, or surgical preparation that she undertook at the Doomadgee Hospital. She says that ordinarily notes of this kind would be prepared by the Nurse Navigator and recorded in the Queensland Health system at Doomadgee. However, **Gidgee did not have access to the Doomadgee Hospital notes or the separate system that the Nurse Navigator used at that time.**

191. Nurse Salem says Ms Wheeler from Community Health would assist Gidgee in bringing patients into the clinic if transport and follow up were needed, as well as assisting patients with the process of attending telehealth appointments with specialists. She was the one who contacted Betty's parents to establish her whereabouts.

192. As part of 'Betty's Story', a comprehensive investigation and review into the referral process for Betty, and the interactions between various entities, was undertaken. It is clear the Investigators had access to persons and records not included in the coronial brief of evidence. I accept the facts as outlined by the Investigators.

193. On 22 September 2019, Betty's sister says she took her to the hospital as she was unwell. They gave her Panadol without examining her and they were told to take her to Gidgee the next day. There is some confusion as to Betty's presentations at the Hospital prior to her death. The Investigators in 'Betty's Story' spoke with Betty's mother who advised that, on the night of 22 September 2019, Betty was feeling unwell, and a friend walked her to the hospital.

194. There is no record of this presentation to the Hospital. DON Asgar explained the triage process at the Hospital and said that any patient presenting would usually be seen by a clinician and that would be documented in the record; the same would apply if Panadol was administered. DON Asgar commented that if Betty presented and there was no clinical record of the presentation, then it would be concerning practice.

195. There is no mention of the previous presentation to the Hospital in the Gidgee or Hospital clinical notes during Betty's attendance the following day (although

the circumstances as outlined below might explain why). Although the hospital does not record Betty's as attending, I have regard to the fact that Betty was by then in significant decline as she died the very next day. I have no reason to disbelieve that she sought some type of treatment or relief and I have no reason to disbelieve Betty's mother's version as told to the Betty's Story reviewers (I accept that version was not provided under oath), or to disbelieve Betty's sister.

196. **I find** it more probable than not that Betty attended the Doomadgee Hospital sometime on 22 September 2019, was provided a Panadol, and that no clinical record was made. There is support that the hospital was not keeping adequate records (as recently for example on 19 September when Betty attended hospital for a bicillin injection – the only indication is that the prescription on file was signed indicating the bicillin had been dispensed. There is no other note on file as might be expected confirming Betty's attendance).

197. On 23 September 2019 at 1450hrs, Betty presented to Gidgee with shortness of breath, a weeping left eye, a productive cough, and a painful left calf. It was noted she had a long drive from Townsville two days previously. Her respiratory rate was 42 with an irregular pulse of 91. She was thought to be in Atrial Fibrillation ('AF') and was escorted to the Doomadgee Hospital for further review. She was administered her Bicillin injection prior to transfer to the hospital.

198. In the ED, Betty advised she felt unwell and had a cough for a couple of days, which had worsened that morning. An ECG revealed a high and irregular heartbeat.

199. Dr Mary Anderson arrived into Doomadgee as the incoming locum at 1500hrs to commence her shift. She had earlier that day flown into Doomadgee to start her one-week placement. She met the outgoing doctor, Dr Muthu, in the hospital carpark as he was leaving for his flight out of town at the conclusion of his locum. While putting his bags in the car he briefly mentioned two patients in the ED; one was a male who was stable awaiting retrieval but needed a potassium check and the other was Betty who he said had a fever and fast heart rate. Dr Muthu advised he would check his bags in at the airport and return for a formal handover. This did not occur for unknown reasons. Dr Anderson received several text messages from Dr Muthu before he departed relating to the male patient.

200. Dr Muthu has limited recollection of events. He confirmed his flight was at 1600hrs and that he would have left the hospital at or around 1500hrs. He does not recall reviewing Betty or being aware of her arrival to the ED. He states that he did not provide any care or treatment to Betty but says that, if a critical patient had attended the hospital, he would not have left without treating them or providing handover to the incoming doctor.

201. Dr Muthu says he was aware of Betty's presence in the ED but that he had not been asked or had the opportunity to review her prior to his departure. This is due to the following reasons:

    a. Dr Anderson's recollection of events was that Dr Muthu told her there was a patient sent from Gidgee with fever and fast heart

rate, (which was recorded only weeks after Betty's passing);

b. Betty was first seen by a nurse in the ED at 1450hrs who took Betty's observations and an ECG and identified that Betty was "an emergency";

c. Dr Anderson commenced her formal duties in the ED at 1505hrs;

d. After taking the ECG, the nurse immediately notified the "Medical Officer" that Betty's heart rate was very high and irregular; and

e. The "Medical Officer" (Dr Anderson) attended on the patient straight away.

202. This lack of a formal handover was unusual in Dr Anderson's experience of Doomadgee Hospital and other remote placements. She said that these would ordinarily take place over a number of hours, during which both doctors would review the patients together and get the incoming doctor settled. This occasion felt rushed she said in her oral evidence.

203. Dr Muthu had mentioned to Dr Anderson (via text) a patient with fever and fast heart rate and was clearly aware of Betty's presence in ED. I have formed a view that he was rushing out the door and reliant on Dr Anderson to take up with the patient from the time she arrived 10 minutes later.

204. While no one in that specific moment at 3.00PM could have foreseen the medical emergency unfolding then and there resulting in Betty's death approximately 4 ½ hours later she was declared formally deceased at 7.45PM

205. This is a clear example of the risks of no formal handover; fly in fly out roles where small aircraft are waiting on the tarmac to return to home base.

206. It is unknown what Dr Muthu could have offered in terms of handing over care of Betty or appreciated how unwell Betty was given that Dr Justo's email and clinical information had been sent directly to Dr Hamilton in August and Dr Hamilton had not returned to the hospital and presumably those records had not made their way to the file. Whilst speculative it may be that had Dr Muthu been in possession of the information intended for Dr Hamilton he would have arranged a recall

207. Upon her arrival at the hospital Dr Anderson found she could not access her electronic medical records because her account was locked out and she did not have the opportunity to contact IT support because she was responding to Betty's acute condition. She explained that she often encountered issues with computer access when working in Doomadgee. Further, there was no access to the Gidgee records, and no referral document was provided. Dr Anderson was able to retrieve some information about Betty from her hard copy chart. From this, and her discussions with a local nurse, she was aware of Betty's RHD diagnosis.

208. Dr Anderson assessed Betty. She was febrile at 39.5, had a respiratory rate of 34 and a heart rate of 188. Her oxygen saturations were 97% on room air. She had been expectorating bloodstained yellow sputum and had bronchial breath sounds in her left mid chest on auscultation. Betty's sister was able to provide

collateral information. Dr Anderson's initial impression was Betty had a left upper lobular pneumonia with likely septicaemia in rapid new onset atrial fibrillation, on the background of underlying severe valvular heart disease with some degree of heart failure.

209. Dr Anderson commenced treatment and spoke with Dr Justo who agreed Betty was in symptomatic heart failure. He agreed with her management and proposed transfer but recommended she seek advice from an adult cardiologist. Dr Anderson spoke with Dr Win, a cardiology registrar from the Townsville Hospital, and sent him a copy of Betty's ECG. He agreed with Dr Anderson's management and was of the opinion Betty required transfer to Mount Isa Hospital to initially treat her chest infection before consideration for transfer to Brisbane for surgical intervention.

210. At 1613hrs, Dr Anderson called the Mount Isa ED and spoke with the Senior Medical Officer. She provided an overview of the situation. The doctor agreed to accept Betty and did not provide any further suggestions to Dr Anderson's management plan.

211. At 1700hrs, Dr Anderson called the Royal Flying Doctors Service ('RFDS') retrieval team. She consulted Dr Brown, Specialist Emergency Physician. He agreed urgent retrieval to Mount Isa was required and would be organised as soon as possible; minimum arrival would be 1 hour 20 minutes.

212. At 1715hrs, Betty deteriorated further, and Dr Anderson contacted Dr Brown, who recommended Betty be commenced on a continuous positive airway pressure ('CPAP') machine. A Townsville-based plane was tasked for transfer and the destination changed from Mount Isa to Townsville. The plane departed Townsville at 1824hrs, with a flight time of approximately two hours to Doomadgee. Retrieval Services Queensland ('RSQ') notified the Townsville Hospital ED Consultant and the Cardiology Consultant of Betty's transfer.

213. At 1830hrs, Betty deteriorated. Dr Brown was dialled into the Telehealth screen in the emergency room at the Hospital. He had direct visual coverage of the state of the patient. At 1850hrs Betty went into asystole. Dr Brown coordinated the resuscitation. Eight cycles of adrenalin were used, and Betty was in asystole for 55 minutes. At 1945hrs, Dr Brown advised to stop Cardio Pulmonary Resuscitation ('CPR').

214. As part of the 'Betty's Story' report, a review into the retrieval process for Betty was undertaken. I am assisted by reference to pages 33 to 35 of 'Betty's Story'. It is clear the Review Team had access to persons and records which are not included in the coronial BOE. I accept the facts concerning this issue as outlined by the Investigators.

215. In a retrospective entry after Betty's arrest, Dr Anderson recorded Betty was asleep on CPAP but at around 1840hrs woke up and tried to pull her mask off. She was administered a bolus dose of 1mg of IV morphine which was repeated after five minutes as she continued to struggle. At around 1850hrs Betty developed generalized spasm, assuming a de-corticoid posture. Her heart rate declined rapidly, and she lost consciousness. Resuscitation attempts were commenced, and CPR was stopped at 1945hrs.

216. Dr Anderson spoke with Dr Hall from the Clinical Forensic Medical Unit. Dr Anderson advised the likely cause of death was *"cardiac arrest likely secondary sepsis and rapid AF from L Lobe Pneumonia on the background of symptomatic heart failure 2ndry to severe RHD"*. Dr Hall requested a death certificate and advised if the family wished for closure with autopsy, they could request this through the coroner's office.

217. Dr Justo explained why a patient such as Betty became at risk of a fatal arrythmia when sick, stating:

> "*With the damage – with the leaking mitral valve that puts increased stress on the atrium which is the chamber behind the mitral valve, and that chamber would be under stress, and that puts her at risk of an atrial arrhythmia which is a type of arrhythmia she had [indistinct]. If she developed that arrhythmia then the heart function becomes less effective, and if you already have heart failure it's a bad combination.*"

218. He noted that Betty was always at long-term risk of cardiac arrythmia, therefore it was important to treat the heart failure.

219. Dr Anderson says the situation rapidly deteriorated in the community following Betty's death. A nurse well-known to the community broke the news to Betty's family and friends. The situation became hostile with threats of violence. The police were called, and the hospital staff isolated in the pharmacy for safety.

220. The nurse who delivered the news to family was not a First Nations person. Dr Anderson advised the Hospital did not have Aboriginal Health Workers rostered on nights shifts. Dr Anderson was not present when the nurse told the family of Betty's passing but says from the way the family reacted, they thought her death was due to medicating with Morphine.

221. In evidence, Dr Anderson explained her basis for administering Morphine. She explained that Betty was very agitated (apparent from her trying to take her CPAP mask off and rip her cannula out) and that she had given her half the usual dose of Morphine and a small dose of Midazolam to try and calm Betty down. She says what was prescribed was very standard practice. In addition to calming Betty so that the CPAP could be maintained, and the cannula secured, the medication had the effect of alleviating Betty's distress.

222. The RFDS team arrived at about 2045hrs and supported the staff and Dr Anderson at the hospital with a debriefing.

223. In the week after Betty's death, Dr Anderson arranged two consecutive meetings with the staff, Betty's family, and community Elders (of which she participated in one). She felt the meetings went as well as could be expected in the difficult circumstances. Dr Anderson recalled that the family was understandably very upset, and she was not sure if they quite understood the cause of Betty's death arising from her heart condition.

224. At Inquest Dr Anderson extended her apologies to Betty's family for their loss. The experience had clearly deeply affected Dr Anderson who remains committed to servicing remote Aboriginal and Torres Strait Islander communities. She has struggled to return to Doomadgee after these events

because she felt the relationship of trust between her, and the community had been “broken”.

225. Dr Anderson was a locum doctor on a contract through an agency. She said she would have benefitted from debriefing and, as Betty’s death happened at the start of her shift for the week, she would have appreciated another doctor being sent to relieve her. Dr Anderson acknowledged though that she did not seek relief or report how she was feeling about the traumatic events surrounding the death to the agency or NWHHS.

226. **I find** that Dr Anderson did all that she could in the circumstances and the evidence does not bear out any concerns regarding Dr Anderson’s emergency care and treatment of Betty in the hours during which Dr Anderson had carriage of her care. Dr Anderson inherited a shocking medical situation. She has been deeply affected by the circumstances of Betty’s death. Notwithstanding that Dr Anderson did not specifically ask for employee assistance or to leave her post I was left with the distinct impression that NWHS did not fully appreciate her situation nor offer support. She has not returned to Doomadgee to practice.

RHD Program

227. Ms McKenna whilst the co-ordinator of the RHD Program was asked to review Betty’s case and she provided some further history prior to Betty’s diagnosis of RHD.

    a. At 9 years of age, Betty was seen by a paediatric cardiologist for follow up of a small persistent arterial duct in early infancy. The cardiologist stated, “*Yvette had a structurally and functionally normal heart and a soft innocent heart murmur. She should be treated entirely as normal*”.

    b. There is no documented diagnosis of ARF. The only evidence of a Streptococcal infection was from a skin lesion swab take on 24 August 2001. There is no evidence Betty had ever been investigated for ARF.

    c. Betty’s RHD developed during the nine-year period between 2010 and 2019. The damage to Betty’s valves would have been due to multiple undetected episodes of ARF.

Expert Opinions

Opinion of Dr Hall, Clinical Forensic Medicine Unit

228. Dr Gary Hall, of the Clinical Forensic Medicine Unit, provided a preliminary opinion. Dr Hall did not have the benefit of any information from treating physician Dr Anderson or the audio recordings from RSQ.

229. I rely on the other independent expert opinions obtained in relation to reviews of Betty’s care and treatment.

Opinion of Dr Schultz, General Practitioner and Public Health Physician (retained by the Court)

230. Dr Schultz was critical of the screening team who diagnosed Betty with RHD for not recommending treatment for heart failure, as recommended by the 2012 RHD Guideline ('the Guideline'). She noted that Betty reported symptoms to the screening team that she did not disclose to Gidgee, such as her night-time cough and shortness of breath (she clarified that the latter was her interpretation of Dr Justo's note stating 'mildly reduced exercise endurance'). Dr Justo did not directly examine Betty or take her history but conceded her nocturnal coughing was probably a symptom of heart failure and that in future screening he would refer a patient with such symptoms to a hospital for assessment.

231. Dr Schultz noted Betty was not able to be contacted by Gidgee on 18 September 2019. She was critical of Gidgee's recall system and recording of contact details. Nurse Salem was not able to advise why Gidgee did not have Betty's contact number but advised the Community Health NUM Wheeler had Betty's parents' number and was able to contact them.

232. Dr Schultz was critical of Gidgee not providing a written handover letter or extract from the clinical patient information system to the Hospital on 23 September 2019. There was no evidence of such handovers in the clinical records before the court.

233. Dr Schultz is critical of the way in which Bicillin injections are recorded by Gidgee. She states, "*Gidgee Healing could make their role easier if penicillin doses were recorded in a format that would enable doses and recall efforts to be readily identified, monitored and audited*". Nurse Salem said that the Best Practice software used at Gidgee did not have the ability to do so. She advised staff try to code attendances with references to Bicillin injections or as being RHD-related under the 'reason for encounter'. She was not able to advise of the ability to run a report showing a patient's status with respect to Bicillin adherence.

234. Dr Schultz was of the view that the capacity of Doomadgee Hospital to provide adequate care from 26 July to 5 August 2019 was undermined by lack of information about Betty's diagnosis (noting Gidgee had this information). She says that, even without this information, there were some failings by the Doomadgee Hospital.

235. The discharge of Betty on 30 July 2019 did not include confirmation she could attend the following day and, when she did not attend, the recording of "failing to attend" was problematic. In her opinion, the use of such words is stigmatizing language that can transmit bias and affect quality of care. There was debate throughout the inquest regarding this use of such language. This issue is addressed further below.

236. Dr Schultz also suggested that on 30 July 2019 there should have been handover of Betty's case to the medical officer when they came on duty or to contact emergency on-call medical officers by telehealth to ensure the care was

adequate. However, Dr Schultz accepted in evidence that if Betty had indicated to the nurse that she would return, and in the absence of a suspicion otherwise, it would have been reasonable to accept that on face value. It was noted in the course of Dr Schultz's evidence that Betty did ordinarily return to the hospital when advised to do so.

237. Dr Schultz was critical of the prescription of Amoxycillin on 1 August 2019 by Dr Hamilton. She opined that throat infections in Aboriginal people of Betty's age should be treated with Penicillin, consistent with the Guideline.

238. Dr Hamilton maintained that Amoxycillin was an appropriate choice based upon the information that he had to hand at the time. He understood Betty to be suffering from tonsillitis and knew Amoxycillin, as a broad-spectrum antibiotic, would treat this as well as protecting against the potential for pneumonia. He noted that Amoxycillin would also be capable of killing a streptococcus infection, although he would not have realised the significance of this at Betty's presentation.

239. In evidence, Dr Schultz agreed there was scope for a medical practitioner to depart from guidelines and exercise their clinical judgement, but best practice would dictate that they document their reasons for doing so. When cross-examined by Dr Hamilton's legal representative, Dr Schultz asserted that Betty was at a "high risk" of ARF as an 18-year-old Aboriginal girl in a remote community, which in her view made it all the more important for the Guideline to be followed.

240. The issue of the prescription by Dr Hamilton of Amoxycillin was explored with Dr Stevens. He was not critical of a prescription of Amoxycillin in the circumstances, but on the basis that it was for a 10-day course. This is because he says Amoxycillin is a broader spectrum antibiotic than phenoxymethylpenicillin.

241. The order for Amoxycillin was made by Dr Hamilton on 1 August 2019. There is no reference to the dose, frequency, or duration in the clinical record. On 3 August 2019, Dr Hamilton ordered Betty commence on Augmentin 875/125 (Amoxycillin/Clavulanic Acid). On 4 August 2018, there is an entry that Dr Hamilton prescribed Augmentin Duo Forte, and that Betty was to finish the course which was for 10 days. This was in addition to the order for IV / IM Ceftriaxone.

242. I accept that ideally the Guideline should be followed, however I am not critical of Dr Hamilton for the antibiotics he prescribed Betty.

243. Dr Schultz said that, considering Betty's haemoptysis on 3 August 2019, an ECG should have been performed, noting it may have demonstrated characteristics of severe RHD or atrial fibrillation and led to an escalation of care. Again, in her view, this was a deviation from the Guideline that ought to have been justified within the clinical record.

244. Dr Schultz is critical of communication between Dr Hamilton and nursing staff about a phone order on 3 August 2019. As noted above, Dr Hamilton did not recall the phone call or giving the order, or what the nurse told him. He accepted

that the conversation occurred by virtue of the contemporaneous note but was sceptical that all of the observations of Betty documented in the record had been relayed to him.

245. Dr Schultz was critical that no ECG was performed on 4 August 2019 despite the evidence of haemoptysis. Dr Hamilton says he did not observe blood in Betty's sputum he recorded yellow phlegm in the clinical record. Dr Hamilton was asked whether, given Betty's symptoms and upon becoming aware she was for cardiac valve replacement surgery, whether there was a consideration of doing an ECG. He acknowledged that he could have done so but says on auscultation of Betty's chest that she had a regular heart rate and rhythm which was reassuring to him.

246. The need for an ECG was explored with Dr Stevens. He says while Dr Schultz is technically correct, a doctor retains some discretion as to whether an ECG is required when a patient presents with blood in their sputum. However, there is no such discretion when it comes to a nurse or indigenous health worker because this is stipulated in the PCCM as part of the required patient assessment.

247. **I find** that an ECG should have been performed by the nursing staff although at Dr Hamilton's discretion as to whether an ECG was required based on his overall assessment of Betty. He did not consider it was warranted in these circumstances.

248. Dr Schultz was critical of Dr Hamilton's abbreviated clinical notes. Dr Hamilton disagreed saying that his notes reflect standard international abbreviations. Dr Stevens opined that more fulsome notes were required and commented that, "*I don't understand what those abbreviations are for*".

249. **I find** that Dr Hamilton's clinical record keeping was deficient, although had no impact on Betty's condition or her ultimate outcome.

250. In evidence, Dr Schultz explained that, if she had a patient suffering severe RHD who had presented with Betty's symptoms, she would have arranged a specialist consultation at that point. She acknowledged Dr Hamilton's frustration in the lack of information and his attempts to try and obtain information by contacting three hospitals. When questioned on that point by Dr Hamilton's counsel, Dr Schultz accepted that the email sent to Dr Justo on 4 August 2019 (by NUM Wheeler in collaboration with Dr Hamilton) was effectively an escalation to cardiology.

251. Dr Schultz was critical of Dr Justo and says he did not attend to the symptoms of Betty, which were apparently more severe than when she attended the screening. She stated, *"Dr Justo did not change his management plan, which was for non-urgent referral to adult cardiologist, and the other email recipients did not respond. Therefore, care was not escalated"*. Dr Justo said from the information he had, he had presumed that due to Betty's presentations to the Hospital they would have reassessed her and discussed her condition directly with TPCH. He regrets he did not take any action himself and acknowledged it was something he could have done.

252. Given Betty's symptoms, Dr Schultz believed her care should have been escalated by the Doomadgee Hospital once the information had been provided by Dr Justo on 5 August 2019. As referred to above, **Dr Hamilton left the Hospital that morning** and was redeployed. Despite DON Asgar advising that Betty was to be put in the recall book for review the following day, there was no follow up by the Hospital of Betty. **I find** this was clearly a missed opportunity.

253. Overall, Dr Schultz is of the opinion the communication systems between the three health services of the screening service, Gidgee and Doomadgee Hospital were inadequate.

Opinion of Dr Stevens, Rural Generalist (retained by the OHO in relation to Ms Sandy)

254. Dr Stevens provided a fulsome review of Ms Sandy's case, canvassed in more detail below. He was not provided with Betty's full clinical records but was able to comment on some aspects of her case in a general sense, based upon his experience as a Rural Generalist at an Aboriginal Medical Service in Kingaroy and acute care settings such as Kingaroy, Cherbourg and Murgon Hospitals. His comments concerning Betty's care have been incorporated into the summary of Dr Schultz's evidence above.

Review by NWHHS

255. The focus of 'Betty's Story' was on quality improvement, identifying the lessons that could be learnt from 'Betty's Story' and recommending actions to improve the care and treatment provided to those patients with ARF and/or RHD.

256. The Investigators noted:

    a. Betty had been referred to the Indigenous Respiratory Outreach Clinic ('IROC') for a chronic cough in June 2015 which reconfirmed an earlier diagnosis of Asthma. Despite the intention for follow up this did not occur.

    b. During 2016, Betty presented to the hospital on multiple occasions for febrile illness, cough, shortness of breath and skin infections. She was treated for asthma and/or an upper respiratory tract infection. The Investigators stated, "*Not suspecting an alternative cause and further investigating for Strep A infection may have been missed opportunities to diagnose and treat Betty for ARF. This possibly increased the risk of recurrent ARF and cumulative heart damage*".

    c. On diagnosis of RHD, the screening cardiologist accompanied Betty and her mother to Gidgee for the purpose of handing over the plan for Betty's primary care. They were advised Betty required:

        - Immediate administration of Bicillin;

- Full assessment including serology and dental check as soon as possible [a comprehensive health assessment was not completed];
- Weekly review until surgery [weekly medical reviews did not occur];
- Administration of Bicillin every 28 days; and
- To call Dr Justo if there were any concerns.

d. Betty's diagnosis was not shared with other medical staff at Gidgee and no reminder letters were entered into 'Best Practice'.

e. There was no clinical debrief to inform clinicians in Doomadgee of the results of the screening and to advise of the follow-up needed, and no copies of the screening results were left with Gidgee, Doomadgee Community Health or the Doomadgee Hospital.

f. There was a delay in the referral process for Betty.

g. Despite being diagnosed and needing relatively urgent review, the full referral for a Nurse Navigator was received and accepted at an Intake Meeting on 29 August 2019. The Investigators noted the complex process for the appointment of a Nurse Navigator.

h. There was a suggestion that Betty could have been seen in Townsville but the RHD Nurse for NWHHS was advised on around 27 or 28 August that an appointment with the Townsville team would not be needed as the preference was for Betty to be seen by the team at TPCH.

i. Betty presented to the Doomadgee Hospital on multiple occasions between when she was diagnosed with RHD on 26 July 2019 and her death on 23 September 2019 (the Investigators helpfully provide a summary of each presentation). The Investigators stated:

> "…*is not able to provide medical comment on these presentations. However, a retrospective clinical review involving a Cardiologist may find that generally patients do not present in the middle of the night for no reason and it is rare for them to present frequently at that time. This, together with a good understanding of ARF and RHD may have led clinical staff to consider coughing and/or dyspnoea at rest and/or when lying down may be an indication that heart function is compromised prompting additional lines of inquiry when determining a diagnosis*".

j. Betty's mother understood Betty went to the Doomadgee Hospital on the night of 22 September 2019 as she was feeling unwell. A friend walked with her to the hospital but there is no record of this presentation in the clinical record. I refer to my earlier finding that

it is more probable than not that Betty did attend and there is simply no record. As Betty's Story investigators identify, Betty was attending regularly in the months leading up to her death and I have no reason to doubt her mother's recollection.

k. On the day of Betty's death, the treating team made several contacts with RSQ and the Telehealth Emergency Management Support Unit ('TEMSU'):

- At 1645hrs, RSQ provided some advice on medications and rated the transfer at P3 (3 to 6 hours and a flight nurse as a clinical escort that evening);
- At 1715hrs, as Betty's condition was deteriorating, the priority rating was escalated to P2 (response time between 1 to 3 hours with medical officer and flight nurse for clinical escort);
- At 1745hrs as Betty's condition continued to deteriorate, a plane was tasked for the transfer and the destination changed from Mount Isa to Townsville – the plane departed Townsville at 1824hrs with a flight time of two hours.
- RSQ notified the Townsville Hospital ED Consultant and the Cardiology Consultant of Betty's impending transfer;
- At 1800hrs, TEMSU provided Telehealth support and recommended CPAP;
- At 1900hrs, TEMSU support was requested when Betty went into cardiac arrest.

257. In or around **20 March 2020**, the Investigators made several recommendations. They included:

a. *Increase awareness and knowledge of ARF and RHD among all clinical staff who currently, or will, work in locations with a high prevalence of ARF and/or RHD through, for example:*

- *Including an introductory session in the orientation program alerting medical staff, nursing staff and Indigenous health workers to the prevalence of ARF / RHD and what to look for*
- *Having clinical staff complete the on-line healthcare professional modules available through RHD Australia as part of their clinical orientation*
- *Arranging a schedule of staff and patient education through the Queensland RHD Registry Office*
- *Providing clinical pathways for ARF / RHD in clinical areas*
- *Putting mechanisms in place to ensure short-term staff understand and use this information.*

b. *Provide clinical staff with access to tools that assist them to appropriately detect ARF / RHD by:*
    - *Making available on NWHHS devices, and informing clinical staff of, the RHD Australia 'Guidelines and Diagnosis Calculator' which is in the form of an App available for iOS and Android devices. This App provides a text and visual reference for each technical stage of a diagnosis. It is designed to minimise diagnosis error and inconsistency; it also filters out cases that aren't rheumatic fever so that a clinician is not over-diagnosing*
    - *Requesting the new Office of Rural and Remote Health to amend the information on ARF / RHD contained in the PCCM to improve the ability of clinical staff to appropriately suspect and investigate ARF / RHD, such as adding ARF / RHD to the paediatric differential diagnosis flowcharts.*

c. *Implement protocols for the conduct of early detection or screening programs in the NWHHS that include:*
    - *A member of screening team visiting the community prior to and after the screening to work with Gidgee Healing, Community Health and the hospital to educate staff and set up systems for follow up.*
    - *Appointing a local coordinator who will have responsibility for ensuring:*
        - *there is a clinical debrief held with the screening team to share diagnosis and prioritise actions with:*
            - *hospital doctor(s) and nursing staff*
            - *community Health NUM and Health Workers*
            - *Gidgee Healing, or other service as appropriate, doctor(s), nursing staff and Health Workers*

          If for any reason, any of these groups are not represented at the debrief, ensure the information is shared with those individuals within 1 working day of the debrief.

        - *a copy of the screening results is provided to Gidgee Healing, the hospital and community health screening results are entered into / loaded onto Communicare notes within 1 working day of the debrief*
        - *ongoing education is provided to those children and families with a confirmed diagnosis*
        - *education on RHD is provided to clinical staff (regardless of screening results)*
        - *each person identified with RHD has someone nominated to coordinate their care and a personal management plan with a copy of the management plan located in records held at the hospital, community health and Gidgee Healing*

- *an action plan (detailing what needs to happen, when and by whom) is compiled in accordance with the National RHD Guidelines and monitored through the morning meetings. Ensure responsibilities are clear:*
    - *local medical assessments and reviews are scheduled and completed as required*
    - *referrals to specialist services are completed and appointments confirmed within the required timeframe, and attendance is facilitated*
    - *medication is ordered, commenced and monitored*
    - *notification to the RHD registry is completed.*

d. *Consider how case reviews of patients who frequently present with similar symptoms and/or with complex needs could assist to improve health outcomes.*

e. *Review the Joint Guideline – communication pathway June 2018 between Gidgee Healing and the NWHHS, particularly the structure and format of the morning inter-service meetings to allow:*

- *Representatives of all clinical groups from each local service, the Nurse Navigator Service and any other service regularly involved in the care of patients to be part of any discussion around the care that is needed and/or provided to patients*
- *All services in (a) above to have full knowledge of the agreed priorities and which service is coordinating the associated plans of care, or specific actions within those plans*
- *All local services to have current patient information including new diagnosis, investigations and/or health assessment findings, care plans, medications and referrals made.*

f. *Improve the use of electronic patient information systems by reviewing:*

- *How staff know to access and use The Viewer*
- *Review the effectiveness of the use of triggers / alerts in the various patient information systems used.*

g. *Improve the cultural capability of clinical staff by:*

- *Supporting the Doomadgee Health Council to work with designated leaders in Doomadgee to develop and implement:*
    - *a program that introduces locums, agency staff, staff of visiting services and NWHHS staff to local cultural values, beliefs and practices*
    - *a set of cultural considerations to be observed in the delivery of healthcare.*
- *Include a respected local community member on all staff selection panels.*

h. *Jointly engage with clinical staff and community leaders to explore what would make local health services more welcoming for patients and Doomadgee a place staff enjoy working in and want to stay.*
i. *Establish a consistent approach to applying the national ARF / RHD guidelines, including clarifying and articulating:*
    - *Where and how monitoring of patients diagnosed with ARF / RHD will occur*
    - *How notification of newly diagnosed patients to the RHD registry will occur*
    - *Who will coordinate care which includes:*
        - *completing and monitoring (including reviews) a personal management plan with the patient and placing a copy of the management plan in records held at the hospital, community health and Gidgee Healing*
        - *scheduling local medical or health assessments and reviews and making sure they occur*
        - *completing referrals to specialist services for review*
        - *monitoring and enacting changes in care made by specialist services*
        - *coordinating arrangements for appointments to external services*
        - *monitoring the ordering and administration of medication.*
j. *Establish open communication channels when a seriously ill patient presents for care by:*
    - *Considering an expanded role for Health Workers where they provide a link between clinical staff and family members when a seriously ill patient is being treated at the hospital*
    - *Requesting the new Office of Rural Health to work with rural and remote HHSs and communities to develop Sudden Death response guidelines to provide guidance on how HHSs respond and support a community when there is a sudden or unexpected death in a community; these guidelines could be attributed to Betty similar to how the process available for families to escalate concerns over a patient's health condition has been attributed to Ryan Saunders.*

258. One of the Investigators, Ms Joy Savage, was called as a witness at the inquest. During the course of the inquest the Investigators were provided with the statements of Dr Anderson, Dr Muthu and Dr Hamilton and asked to comment, which they did after further meeting and responding to the court.

259. The Investigators reiterated they had not been asked to undertake a review of the medical or cardiology clinical care and/or treatment provided to Betty. The Investigators confirmed the statements they were provided did not change their

findings, conclusions, or recommendations in 'Betty's Story'. However, they provided some additional comments based upon on additional statements as follows:

a. Some consideration could be given, for very remote communities with level 2 hospitals, to be provided with more time to allow orientation and introductions to other health service providers and key community leaders before assuming care responsibility.
b. 'Betty's Story' does make comment with respect to deficits found with communication between health services and individual clinicians, and the risk this creates to the continuity of care for patients who are continually moving between and across services and how failure to address them poses a risk to health outcomes.
c. The statement of Dr Anderson aligns with the findings of 'Betty's Story' which provides some detail on the fragmentation of patient information and the difficulties the various systems in use created for accessing clinical notes.

Circumstances of Ms Sandy's death and Expert opinions.

260. Ms Sandy had been diagnosed with ARF sometime prior to the age of five years when living at Tennant Creek. She subsequently developed RHD and required mitral valve surgery in 2009. The inquest focused upon the six months prior to each of the deceased women's deaths.

261. I accept the submission that the starting point for Ms Sandy should be the months leading up to when she became unwell with an intra-abdominal haemorrhage due to a haemorrhagic cyst in November 2019, which resulted in her transfer to the Mount Isa Hospital.

262. Ms Sandy's history is outlined below:

a. Ms Sandy had been prescribed monthly prophylactic Bicillin since around the time of her diagnosis but there is evidence of numerous instances Ms Sandy not availing herself of those injections;

b. There are several instances of Ms Sandy suffering illnesses that may have been associated with Streptococcus infection, but were not treated with antibiotics;

c. By 2009, Ms Sandy had chronic severe mitral regurgitation with a low normal ejection fraction at 52% (normal is 65-75%);

d. On 9 October 2009, Ms Sandy underwent a mechanical valve replacement which resulted in Ms Sandy having to take Warfarin for the rest of her life;

e. There were numerous instances of Ms Sandy not availing herself of Warfarin and sporadic INR testing that resulted in non-therapeutic dosing over many periods and over many years;

f. On 23 May 2017, Ms Sandy suffered a transient ischaemic attack ('TIA') or brief stroke requiring retrieval to Mount Isa Hospital for management. Ms Sandy was advised it was necessary to keep taking Warfarin, or she would have a further TIA/stroke; and

g. On 11 October 2017, Ms Sandy suffered a further TIA (she had again not been taking Warfarin over several months).

263. On 15 May 2019, Ms Sandy presented to Gidgee for the first time. She was seeking an influenza vaccination and an INR. Her INR was 1 and she advised Nurse Salem that she had not taken medications for many months. She was taken to the Hospital who supplied her medication. The following day Nurse Salem records Ms Sandy was happy to transfer her care to Gidgee.

264. Ms Sandy returned to Gidgee for INR monitoring on several occasions. Overall, Nurse Salem testified that Ms Sandy "engaged well" with their service and was attending the clinic regularly, averaging three visits per fortnight.

265. On 24 May 2019, there was some confusion over dispensing Warfarin. Gidgee had ordered Coumadin and not Marevan, the medication Ms Sandy required. Ultimately, following discussion with Nurse Grogan, Dr Hamilton prescribed the required medication and requested Ms Sandy return on the Monday for an INR check.

266. Nurse Salem gave evidence that Ms Sandy should not have been on different types of Warfarin. She stated it was dangerous for patients to receive different brands because the dosing is different with each sort but could not say who had changed her over. Dr Kelly (albeit a paediatric cardiologist) also discussed this topic and observed that changing between brands would see INR levels fluctuate more widely than desired and would require more frequent testing to monitor levels.

267. On 11 June 2019, Ms Sandy was seen at the Doomadgee RHD Outreach clinic by Dr Goundar. Nurse Rendell recorded:

> *"PLAN:*
>
> *Penicillin V tablets dispensed to Adele by Doomadgee staff with thanks*
>
> *RHD RN at Doomadgee (Brytt) to follow up on ongoing compliance to oral prophylaxis an ensure Adele continues to have tablets dispensed*
>
> *For ongoing ICOP and echo review*
>
> *INR and warfarin dosage managed by Gidgee Healing Doomadgee Compliant with oral medication: No (No penicillin dispensed since 2018) Compliant: Yes (Last echo 5/2/19)*
>
> *Cardiology review: Yes (Seen by ICOP 5/02/2019)".*

268. The Gidgee records confirm Ms Sandy was prescribed 25 days' worth of Penicillin on 11 June 2019 (a total of 50 tablets to be taken twice per day). This was the only occasion that she appears to have been prescribed Penicillin during her months as a patient at Gidgee. Given that Ms Sandy had chosen not to receive Bicillin injections, it was especially important that her intake of oral Penicillin was carefully monitored. When asked about this shortfall, the

explanation offered by Nurse Salem was that Ms Sandy had not wanted to take the medication home, but this was not indicated within Nurse Salem's contemporaneous notes. I consider this to be a significant omission. Attempts should have been made to reengage Ms Sandy in taking this medication, and such attempts should have been documented.

269. On 23 July 2019, Nurse Salem noted Ms Sandy had not been taking her medications. She had an INR test and was advised to recommence Warfarin. Ms Sandy also attended the ICOP outreach cardiology clinic. She was noted to be more compliant with her Warfarin therapy. No adjustments were made to her treatment. She was for review in twelve months' time.

270. On 2 September 2019, it was noted Ms Sandy had not taken Warfarin over the last four days. She was to recommence same.

271. On 7 November 2019, Ms Sandy went to Gidgee to have her INR checked, it was 8 (significantly high). She also complained of some mild back pain. Nurse Salem discussed her proposed management plan with Dr Manny, who was based at the Hospital. She consulted him because he was onsite in Doomadgee and there was no doctor at Gidgee at that time. Nurse Salem sought his opinion on whether to administer Vitamin K to bring down Ms Sandy's INR, but it was decided she was to stop Marevan for that night and the next. She was told she could bleed or bruise easily and to take caution for several days.

272. On 15 November 2019, Ms Sandy presented to the Doomadgee Hospital with lower abdominal pain and nausea. Dr Kindt recorded that Ms Sandy had been seen on 12 November 2019 with abdominal distention and poorly localized pain. It was thought she had probable constipation. He records her INR was greater than 8 and her Warfarin was ceased. She was asked to return for daily INR but failed to present despite several reminders.

273. It is noted there is no clinical record for 12 November 2019. There is a clinical note of 14 November 2019 wherein Dr Kindt recorded:

> "*asked to attend for review INR and abdo pain yesterday*
>
> *has not presented to here or Gidgee despite repeated attempts to ask her to come up*
>
> *CRP 76, INR unregistrable on POC test (ie>6).*"

274. Ms Sandy was very unwell, and it was thought she may have had a urosepsis, chronic congestive cardiac failure or an occult gastrointestinal bleed. A retrieval to Mount Isa was organised.

275. At Mount Isa, Ms Sandy was diagnosed with an intrabdominal bleed secondary to supratherapeutic warfarin. She required admission to the Intensive Care Unit ('ICU') and a blood transfusion. She improved. A CT scan revealed a multilocular ovarian cyst.

276. Ms Sandy was discharged from Mount Isa on 23 November 2019. She was for a repeat pelvic ultrasound on 12 December 2019 and review in the Gynaecology outpatient department. It was noted she may need surgery at that time. The

author of the discharge plan stated, "*Decided to discharge patient with clexane instead of warfarin as she would need bridging if she would proceed with surgery in Dec. Discharged with S/C clexane with education to her and her partner*".

277. The prescription for Clexane was one prefilled syringe twice a day by subcutaneous injection. Her husband, Mr Edgar Sandy recalled he and his wife were taught how to give the injections and that he sometimes would administer it, but that Ms Sandy would also administer the medication. From his recollection, she was only having one injection at night.

278. There was no discharge summary provided by Mount Isa Hospital to either Doomadgee Hospital or Gidgee. DON Asgar commented that usually it would be emailed or faxed to both providers and was surprised this had not occurred. However, she noted that the document would be accessible to them through "The Viewer".

279. On 11 December 2019, Nurse Salem from Gidgee recorded, "*Patient was in hospital at Mt Isa. Now on Clexane*". There was no follow up or review by Gidgee of Ms Sandy prior to her death.

280. Nurse Salem stated, "*As we did not receive a discharge summary with details for Gidgee Healing to follow up her care arrangements, it was assumed by the clinic that she was still undergoing tests and being managed by the hospital*". In evidence, Nurse Salem maintained that because Ms Sandy kept presenting to the hospital for acute care and they kept treating her from that date, and no correspondence or instruction was sent to Gidgee to hand back her care, it was "out of scope" for what Gidgee could provide in a primary health care setting.

281. On this point, DON Asgar's evidence was that every ED presentation was discussed and handed over to Gidgee at the morning meetings between the staff of each service, so Gidgee should have been aware that Ms Sandy was back in the community and needed follow up. She asserted that Gidgee should not have had to wait for instructions to continue her care.

282. In evidence, Ms Savo, the current Clinical Manager for Gidgee in the Lower Gulf and a qualified Aboriginal healthcare practitioner, agreed that it was incumbent upon Gidgee as the primary healthcare provider to follow up with patients in Ms Sandy's position. There was a clear failure by Gidgee to follow Ms Sandy up in circumstances Gidgee was supposed to be managing Ms Sandy's primary healthcare.

283. On 18 December 2019, an Aboriginal and Torres Strait Islander Health Worker recorded, "*Handed recall letter for MO review to Adele*". A copy of the letter itself did not appear on the file.

284. On 18 December 2019, Ms Sandy attended the Doomadgee Hospital for review. She had been recalled due to a positive urine culture on 12 November 2019. The doctor noted Ms Sandy had just returned from Mount Isa after a follow up appointment (the record of this follow-up appointment has not been located in either the Mount Isa or Doomadgee Hospital records - it is assumed it was the appointment of 12 December 2019, which had been planned on her

discharge from Mount Isa). The doctor recorded:

> "*Some knowledge of her current medications and plan for treatment but doesn't appear to be certain.*
>
> *I am concerned about medication compliance. Poor communication for Mount Isa re plan.*
>
> *Obtain a discharge summary from The Viewer*
>
> *Noted is to be on Clexane BD for now and not on any warfarin until surgery Plan: Medications reviewed and updated on her chart*
>
> *Clexane 80mg BD Phenoxymethylpenicillin 500mg bd Frusemide 40mg 0d*
>
> *Explained to her that she doesn't need doxcylcine and flagly any more Await letter from Dr Uma*".

285. I do not know why the doctor at Doomadgee did not immediately check The QHealth Viewer at that time to find out the information he had outlined in his notes.

286. On 7 January 2020, there is a progress note completed by Nurse Wheeler which stated:

> "*Travel itinerary given to Adele's partner, and he advised not sure if they would be able to go. Adele contacted travel admin and request change of appointment, same re-booked for 22.01.20, explained same to Adele and advised she really needs to attend this*".

287. It is not clear what this appointment was for; it seems it was either a medical or gynaecology outpatient review. No clinical record of an outpatient appointment for 22 January 2020 has been located.

288. On 8 January 2020, there is a specialist referral form from Dr Liem from obstetrics and gynaecology to medical. Dr Liem wrote, "*Well known RHD patient that was lost to follow up with medical and cardiac team. Dr Kalum had discussed this patient with Dr Uma. For review in outreach clinic"*.

289. It is unclear on the material whether Ms Sandy was seen by a doctor from gynaecology on 8 January 2020 or at all following her discharge. No outpatient note has been located.

290. On 11 February 2020, Ms Sandy attended the Doomadgee Community Health Centre for a Medical Outreach appointment. She was noted to have dyspnoea and swelling of her feet. It was noted she had not been taking any medication. There is a further clinical note by the Medical Intern who notes the provisional diagnosis of infective exacerbation of Chronic Heart Failure. The intern recorded the plan as:

> *"CXR tomorrow am in clinic*
>
> *PO augmentin duo forte now*
>
> *Clexane 80mg now*
>
> *Review tomorrow*
>
> *Awaiting lap cystectomy".*

291. On 13 February 2020, a Registered Nurse noted Ms Sandy had a chest x-ray completed. There is no record of Ms Sandy having a medical review. It appears Ms Sandy was to remain on Clexane but there is no reference to when or if the laparoscopic cystectomy was to occur.

292. The NWHHS pharmacy records indicate Ms Sandy was dispensed with 10 pre-filled syringes of 80mg Clexane on 22 November 2019 to be injected twice daily; 12 syringes of 40mg on 28 November 2018 to be injected twice daily; 10 syringes of 80mg Clexane on 2 December 2019 with instruction to have medical officer review before the next script was to be filled; 20 syringes of 80mg of Clexane twice daily on 6 December 2019; 30 syringes of 80mg of Clexane twice daily on 18 December 2019; and 10 syringes of 80mg of Clexane twice daily on 11 February 2020.

293. There were a series of attempts to follow up Ms Sandy, as follows:

    a. On 25 March 2020, an Assistant in Nursing, Ms Ketchup recorded, "*Attended clients home attending telehealth tomorrow.*"

    b. On 26 March 2020, Ms Ketchup recorded, "*Attended clients address and no one was there.*"

    c. On 21 April 2020, Ms Ketchup recorded, "*Attended clients address with IHW*

       [Indigenous Health Worker] *unable to locate her.*"

    d. Later on 21 April 2020, Ms Ketchup recorded, "*Went to clients address with IHW and handed appointment letter to clients partner.*"

    e. On 22 April 2020, Ms Ketchup recorded, "*Located partner at Roadhouse with IHW and reminded him of telehealth appointment for tomorrow.*"

    f. On 23 April 2020, a Registered Nurse recorded, "*Was given appointment reminder to partner on 22.4.20 but she failed to attend her appointment. Unable to contact via telephone.*"

294. The documentation was lacking any detail about the purpose of this appointment. There was no entry of attempts to contact Ms Sandy again for follow up after this time.

295. DON Asgar was unable to explain why those attempts had stopped and stated that they should never have stopped, especially in circumstances where Ms Sandy had been discharged from an acute hospital admission months earlier and required monitoring of her INR levels and Warfarin adherence.

296. Nurse Salem did not recall any approach by Community Health to Gidgee to assist with re-engaging with Ms Sandy during this period. She said that the follow up that they were attempting would have been on instruction from the hospital. For reasons identified above, I reject this assertion.

297. Nurse Salem recalled that, prior to Ms Sandy's death, Mr Sandy told her that he and Ms Sandy had lost faith in modern medical treatments and were turning

to traditional healing practices and bush medicine as a result. In examination, Mr Sandy denied saying this. The contemporaneous documentation supports Ms Sandy stopped engaging with the health services. It is not possible to establish what caused Ms Sandy to do this. It may well be that she lost faith in the system that was in place in Doomadgee.

298. In his statement, Mr Sandy said the last time Ms Sandy went to the hospital was on 25 May 2020. However, in the recorded interview with the Office of the Health Ombudsman ('OHO') Mr Sandy and Ms Sandy's sister seemed confused about the date and he suggested it was 26 May 2020. Ms Sandy's sister recalled Ms Sandy was taken by ambulance from her mother's place. There are no ambulance records for the period prior to 27 May 2020 and no clinical records of any presentation prior to 27 May 2020 in the hospital record.

299. I am unable to reconcile the presentation of Ms Sandy to the hospital in the days leading up to 27 May 2020.

300. On 27 May 2020, Ms Sandy was admitted to Ward 1B of the Doomadgee Hospital with Atrial Flutter. She was administered Clexane 80mg subcutaneously and 10mg of Warfarin. Dr Amodeo discussed her condition with Mount Isa Hospital, and she was for admission overnight on cardiac monitoring and for repeat Troponin and ECG.

301. Dr Amodeo provided written statements exhibited in evidence at inquest. He was not required for oral evidence. He is since deceased. Dr Amodeo counselled Ms Sandy regarding the importance of long-term anticoagulant and acknowledged her previous haemorrhagic episode. He advised her they would keep a close eye on her INR and be careful with her dosage. He said he did this in layman's terms and that she was familiar with Warfarin therapy given her history.

302. Ms Sandy's family say they pleaded to have Ms Sandy transferred to another hospital. Dr Amodeo does not recall any family being present or speaking with any family. He says it did not occur and that he consulted with the doctor in Mount Isa who agreed with his proposed treatment and there had been no indication to transfer Ms Sandy on 27 May 2020.

303. Provided the contemporaneous notes, and Dr Amodeo's follow up of the patient on the night of 27 May 2020, I cannot establish on the evidence that the family requested transfer to Mount Isa on the evening of 27 May 2020.

304. On 28 May 2020, Ms Sandy's INR was 2.2 and she was administered 5mg of Warfarin and a dose of subcutaneous Clexane. Ms Sandy was also administered Camphor Linctus for a chesty cough (Ms Sandy had asked for some Camphor Linctus to take with her on discharge).

305. On 29 May 2020, at 0715hrs, Ms Sandy's respiratory rate was 28 (the highest it had been since admission). Her oxygen saturation rate was 98% on room air. Her blood pressure was in line with previous readings at 108/75. She was tachycardic with a pulse of 108 (the highest since the observations were recorded in the ward). Her Queensland Adult Deterioration Detection System ('QADDS') Score was 2.

306. On 29 May 2020, at or around 0845hrs, Ms Sandy was reviewed by Dr Amodeo.

She complained of some epigastric discomfort and nausea, and it was noted her bowels had not opened for a few days. She was prescribed Panadol and Coloxyl and Senna. She was for an INR later in the day.

307. Ms Sandy was administered the Panadol and Coloxyl and Senna at 0930hrs. There are no subsequent entries in the clinical record. Ms Sandy was discharged at 1100hrs.

308. Dr Amodeo says as Ms Sandy was stable, and there were no further episodes of AF, she was for discharge but that he instructed her to attend the ED the following morning for an INR and review. He says she was in good condition with normal vital signs and a QADDS score of 0 (he is mistaken on that point). He stated, "*She was medically fit for discharge, and she was happy to go home*". For the reasons identified above, and based on the expert evidence outlined below, I reject Dr Amodeo's evidence on this point. Ms Sandy was not medically fit to go home.

309. There were no follow up arrangements or care plan entered into the discharge summary in the clinical record, nor were any recipients listed. DON Asgar observed that this presentation fell on a weekend when there would not have been a GP working at Gidgee and so, in those circumstances, Dr Amodeo was effectively referring Ms Sandy back to himself.

310. On 30 May 2020, at 1615hrs, Ms Sandy presented to the ED with altered breathing, abdominal pain, shortness of breath and rapid AF. The QAS were not able to get a radial pulse or Ms Sandy's blood pressure.

311. Nurse Grogan was on shift with two other nurses, one being her Team Leader. She received handover from the QAS and assisted her Team Leader and the other Registered Nurse care for Ms Sandy.

312. Ms Sandy was immediately seen by Dr Amodeo. It was noted her INR on discharge the previous day had been 3.9 and she had not taken any further medication since. Ms Sandy was clearly very unwell and was hypotensive and acidotic. The provisional diagnoses included a possible intra-abdominal bleed (based on her abdominal pain, past medical history, and a query high INR); possible cold sepsis; or possible embolic episode with bowel ischaemia. Dr Amodeo discussed Ms Sandy's condition with Mount Isa Hospital who agreed with transfer and Ms Sandy was accepted for retrieval. She seemed to improve slightly but then became suddenly unresponsive and went into cardiac arrest. The QAS paramedics were called back to assist with CPR.

313. Nurse Grogan made the 000 call and agreed for the dispatcher to also send the QPS. This was because QPS officers had previously assisted with CPR and she thought the more people available to assist the better. DON Asgar elaborated that resuscitations can be lengthy and tiring so, in many locations including Doomadgee, police are often called to help.

314. Nurse Grogan also contacted TEMSU for assistance as is the usual practice in an emergency. She explained the situation to the doctor and TEMSU provided support and advice during the resuscitation. TEMSU advised the staff in Doomadgee to speak with the family before ceasing CPR. Mr Sandy was called

into the room and the situation was explained to him and he was encouraged to ask questions. Mr Sandy relayed the information to his family.

315. Mr Sandy says he and his family were not told any information about Ms Sandy, and any information came from Ms Sandy herself. There is a recording with RSQ wherein Dr Amodeo says he told Mr Sandy the blood tests showed Ms Sandy was pretty sick, and she would need to go to Mount Isa and Townsville. Mr Sandy remained in the room and could see staff actively treating Ms Sandy. Dr Amodeo recalled telling Mr Sandy what was happening with Ms Sandy and the treatment he was providing. This is corroborated by the contemporaneous notes of Nurse Grogan within the medical record, which document events almost by the minute and refer to Mr Sandy being in the ED room.

316. I find that Mr Sandy was advised of Ms Sandy's condition while she was in the ED. It is possible due to his grief and the passage of time that his recollection of the events immediately prior to his wife's passing may differ.

317. In examination, Mr Sandy said that family members were waiting outside the hospital and that the waiting room doors were locked. He recalled leaving the hospital to collect some belongings from home ahead of Ms Sandy's transfer to Mount Isa and, upon his return to hospital, accessed the waiting room and was taken into the ED.

318. Nurse Grogan recalled being the one to advise Mr Sandy to pack some clothes for his wife. She said that despite COVID-19 restrictions in place at the time, there were no restrictions on family visiting. The visitors room at the Hospital was always open for family to use. She recalled Mr Sandy freely coming and going from the resuscitation room. DON Asgar said that, if it was afterhours, the front door of the hospital would be closed and people would have to ring the intercom system to get inside as there would only be two staff on duty but, once inside, the waiting room was open to the public.

319. Nurse Grogan had also called DON Asgar, who was off duty, to attend the hospital and assist with resuscitation. DON Asgar coincidentally happened to be on a walk with four other nurses at the time and they all agreed to attend too. She recalled that, when she arrived at the Hospital, QAS and QPS were already in attendance and family members were sitting outside. QPS left upon seeing there were enough staff present.

320. DON Asgar said that when there is a resuscitation, she tries to have one of her indigenous workers or ambulance staff liaise between the hospital and patients because it is difficult for the nurses to leave the resuscitation. In Ms Sandy's case, Ms Alisha Peter, an indigenous officer of the Queensland Ambulance Service ('QAS'), was helping them and was keeping the family informed as to what was happening.

321. Ms Sandy's family had concerns about the police being called to the hospital. I accept the family concerns as genuine. While in this case I accept the police were assisting resuscitation efforts at the request of nursing staff the attendance of police at the hospital caused distress to the family.

322. Ms Peter provided support to the family on her arrival to the hospital. She says

after she arrived with her colleague, she went outside and was liaising with family members. Mr Sandy also recalled this. Ms Peter says she asked Ms Sandy's mother, sister, and husband if one or two family members wanted to be present inside the hospital with Ms Sandy. She told them CPR was in progress as Ms Sandy's heart was not working. Ms Peter recalls Ms Sandy's mother and sister decided to stay outside and comfort each other. She says everyone appeared emotionally upset and that it was a difficult time.

323. When staff realized that Ms Sandy could not be resuscitated, Mr Sandy was brought in, and the situation was explained to him. Ms Peter recalled Mr Sandy being in the emergency room and that she was trying to comfort him and explain what was happening to Ms Sandy. He would come in and out of the room because it would get too emotional for him.

324. Ms Peter told Mr Sandy there was not much improvement and that Ms Sandy had passed. He broke down, calling her name. She recalled that the doctor explained to Mr Sandy what happened and then went outside and explained what happened to the other family outside the hospital.

325. The DON was present and spoke with Mr Sandy and other elders present at the hospital after Ms Sandy died. After Ms Sandy passed, the family were able to come in to see her. Ms Peter was there when the family came inside and said their last goodbyes. She gave her condolences to some of the family. She recalls it was very emotional for everyone. Ms Peter stated:

> "*I thought that it was a good thing that I was there because I was able to talk to Ms Sandy's Husband and explain what was happening. That is not something that the hospital asked me to do, but it is something that I often take on myself in this role, living and working in community, to make sure families can understand what is happening. This hospital is aware that I do this.*
>
> *I often take on this liaison role if there is no Aboriginal Health Worker around at the time. They do have Aboriginal Health Workers at the hospital, but I'm not exactly sure what their roles and responsibilities include. I don't think they work after hours, after 5pm".*

326. I cannot establish if there was a deliberate attempt by staff to 'lock family out of the waiting room'. Mr Sandy had been advised his family of Ms Sandy's condition prior to her death and the clinical staff, including Ms Peter, explained to Mr Sandy and his family what had occurred after Ms Sandy had passed. The situation may have been better managed if the Hospital had an IHW or clinician available (rather than Ms Peter) to keep them informed as to what was occurring.

327. There was a further meeting that took place between hospital staff and Ms Sandy's family on 1 June 2020. It was during this meeting that Ms Sandy's brother Alec Doomadgee, who was linked via telephone, raised the issue of systemic racism.

Evidence of Dr Amodeo

328. Dr Amodeo provided a statement dated 15 August 2020 and a further supplementary statement on 19 January 2022. He was excused from giving oral evidence at the inquest due to his health issues. The parties were provided the opportunity to pose questions in writing to Dr Amodeo and he was also provided with expert reports from Drs Schultz, Stevens and Wenitong for comment. He responded on 2 August 2022. Dr Amodeo's evidence is incorporated in the summary of care above.

RHD Program

329. With respect to Ms Sandy not taking her prescribed medication, Ms McKenna noted Ms Sandy was afraid of needles (perhaps having been traumatized by a badly given one, or too many, or medical overwhelm) and that there was no documentation in the clinical records indicating attempts to encourage the numerous strategies available to try and manage her reluctance of needles.

330. In evidence, Ms Sandy's husband denied that she had a fear of needles and confirmed she would inject herself with Clexane. It seems likely it was the pain associated with the Bicillin injection that was the issue but, as Mr Sandy explained to the Court, *"Over the years she got used to it, you know.* The contemporaneous documentary evidence supports that Ms Sandy declined Bicillin injections and instead sought oral Penicillin. This though was prescribed sporadically.

331. Ms McKenna also provided a breakdown of Ms Sandy's secondary prophylaxis:

    a. Between 1988 and 2012, Ms Sandy:

        - received 123 of the 301 Bicillin injections she required (41% adherence);
        - was only protected against recurring streptococcal infections and recurrence of AF for 38% of the time;
        - had 14 possible streptococcal infections during days at risk;
        - had many missed opportunities for the administration of Bicillin (this includes 7 of the 14 possible streptococcal infections).

    b. Between 2013 and 2018, Ms Sandy:

        - was only dispensed with oral penicillin to cover 310 of the 2072 days she was prescribed the medication (10%).

    c. From 23 October 2018 to May 2020, Ms Sandy:

        - had been documented as requiring Bicillin but there is no evidence it was recommenced.

332. Ms McKenna notes there was no documentation of any education provided to Ms Sandy about the importance of Bicillin injections or what causes ARF, RHD

or potential complications or outcomes if treatment is not adhered to.

333. Ms McKenna noted there was incorrect or non-existent investigations of possible recurrent ARF episodes and no follow-up/recall after possible ARF presentations.

Expert Opinions

Clinical Review by Dr Walsh (retained by NWHHS)

334. NWHHS asked Dr Walsh, an Emergency Physician, to clinically review the case. She found:

    a. On 27 May 2020, there had been no consideration of an infective precipitant of the arrythmia, that is, no chest xray or urinalysis was noted.

    b. On 28 May 2020, there had been no documentation of Ms Sandy's physical examination findings and despite the variable QADDS score and the patient requiring cough medicine, there had been no further review of Ms Sandy's respiratory system.

    c. On 29 May 2020, the QADDS score had been 2 consistently since 0330hrs and there had been no physical examination. Ms Sandy was discharged when her observations were not within normal limits.

    d. On 30 May 2020, after Ms Sandy went into cardiac arrest:

        - it took approximately 15 minutes for assistance to arrive, first in the form of police and paramedics, followed by the Director of Nursing and the on-call Clinical Nurse and Registered Nurse; and
        - The first rhythm check occurred 11 minutes post arrest.

335. Dr Walsh identified four contributing factors:

    a. *Possible premature closure with respect to the initial diagnosis in the ED – cardiac cause considered, but infective cause does not appear to have been considered, Nil CXR or urinalysis.*

    b. *Patient's observations continued to fluctuate during admission and were not normal at discharge, "chesty cough" reported to nursing staff was not escalated to the doctor on duty.*

    c. *Epigastric pain and hypercoagulable state may have been an indication of risk of deterioration.*

    d. *ALS protocol cannot be properly followed without adequate staff.*

336. Three recommendations came out of the review:

    a. All staff to attend education on writing contemporaneous notes; to be included in orientation on commencing employment at any

NWHHS facility.

b. Appropriate time stamps on ECGs in the ED including patient label, date, and time.

c. All nurses to complete PaRROT (Pathways to Rural and Remote Orientation and Training) Series Essentials for Rural and Remote Health Practice within three months of commencing employment at a remote facility.

Opinion of Dr Shaw, Clinical Forensic Medicine Unit

337. Dr Shaw was of the view that Ms Sandy 's presentation for shortness of breath on 27 to 29 May 2020 was not adequately explained by her AF alone and was unresolved at the time of discharge with no clear plan of management. He stated:

> "*There is a lack of examination or investigation undertaken to identify or address the issue of shortness of breath. It is possible had this occurred, it may have led to identification of heart failure and thrombotic complication of her mechanical valve*".

338. Dr Shaw was not critical of the treatment of Ms Sandy when she re-presented to the Hospital on 30 May 2020.

Opinion of Dr Schultz, General Practitioner and Public Health Physician (retained by the Court)

339. Dr Schultz was critical of Gidgee with respect to its follow up of Ms Sandy. Dr Schultz was of the view the documentation of INR and Warfarin doses was lacking, with no longitudinal consideration. She noted the issue of prescription of different brands of anticoagulant between Gidgee and the Doomadgee Hospital contrary to recommendations. She was critical of Ms Sandy's management when she had an elevated INR of 8 in November 2019. However she accepted in evidence that the use of vitamin K as an antidote had been considered and reasonably decided against.

340. Dr Schultz was critical of Ms Sandy's prophylactic treatment with Penicillin noting it was not followed up closely, particularly in circumstances where Ms Sandy had been prescribed oral Penicillin. She stated:

> "*I am also concerned that the local Aboriginal community-controlled health service was not leading the provision of comprehensive, accessible, and culturally safe care that could enable Ms Sandy to effectively engage with life- saving preventive care and treatment of her complex and difficult to manage rheumatic heart disease and valve replacement. She was not taking regular penicillin to prevent worsening rheumatic heart disease, there was no mention of contraception to prevent pregnancy while on warfarin that should not be taken in pregnancy, and her INR ranged between 1 and 8. There was no*

evidence of efforts to understand and manage her INR, for example through review of diet, or consistent use of the same brand of medication, undertaken by Indigenous Health Practitioners".

341. Dr Schultz was critical of the care provided by the Doomadgee Hospital in November 2019, which ultimately led to Ms Sandy's acute transfer to Mount Isa with intrabdominal haemorrhage and admission to the Intensive Care Unit. While this seems likely on the clinical records, I exercise caution as the relevant clinicians were not afforded the opportunity to give evidence to the inquest.

342. Dr Schultz was critical of the decision by Mount Isa to discharge Ms Sandy in November 2019 on Clexane. This is because Warfarin is the mainstay for treatment and is usually ceased about five days before surgery. She noted there is no information in the clinical records about Ms Sandy's appointments with the gynaecology department in Mount Isa. In evidence, she summarized:

> *"She was meant to be on Clexane for two weeks because they thought she was quickly going to go in for an operation which, in fact, never happened, and it's just such a tragedy that she was – there was a lack of communication and*
>
> *… follow up. She didn't have that operation. She continued on without having Warfarin and, ultimately, that contributed to her death."*

343. In evidence, Dr Schultz rejected the assertion that Gidgee would have needed to await a referral or instructions following Ms Sandy's discharge from Mount Isa to resume her care in the community. She said that, as a primary health care provider herself, she would have assumed responsibility to seek out a discharge summary on "The Viewer" or, failing that, make some telephone calls.

344. Regarding the Guideline, she noted there was no mention in the records of either Gidgee or the Hospital concerning the importance of avoiding unexpected pregnancy and the need for contraception. Nurse Salem did not have any recollection of advising Ms Sandy about this.

345. Dr Schultz noted the lack of follow up for Ms Sandy, and the medical outreach appointment on 11 February 2020, which made no mention of her gynaecological issues or which anticoagulant was recommended. There is no recommendation for treatment, despite symptoms of dyspnoea on exertion and swollen feet, with documented raised heart and respiratory rate which suggests Ms Sandy was in heart failure. There was no correspondence to Gidgee.

346. Dr Schultz is critical of the care provided to Ms Sandy over the period 27 to 29 May 2020. She says if Ms Sandy's symptoms of epigastric discomfort and nausea were considered in a patient with mitral valve replacement, limited time when INR was in therapeutic range, her recent onset of atrial fibrillation, her abnormal vital signs and her grossly abnormal blood tests, they should not have been ignored, but discussed with the physician in Mount Isa and the patient. At the very least, Dr Schultz stated further blood tests and ECG should have occurred to ensure those results were closer to normal before discharge. She noted there was no discussion concerning the administration of prophylactic Penicillin to prevent worsening rheumatic heart disease.

347. Dr Schultz is of the opinion that the care provided to Ms Sandy at the Doomadgee Hospital on 30 May 2020 was adequate. Whilst recognizing there are tensions between community and police, she did not take issue with relying on police to assist with a resuscitation in a remote community such as Doomadgee given they are trained and available to do so.

348. Dr Schultz repeated her observations about stigmatizing language, citing several examples within Ms Sandy's records such as "failure" to attend.

Opinion of Dr Stevens, Rural Generalist (retained by the OHO)

349. Dr Stevens makes several assumptions in providing his initial opinion to the OHO. He accepts some propositions of the family which I was unable to reconcile, I have therefore set aside those aspects of Dr Stevens evidence.

350. Dr Stevens did not have the full clinical records for Ms Sandy nor statements from Dr Amodeo in preparing his first report. On receipt of that material, Dr Stevens was asked to provide an addendum report. He formed the opinion that Dr Amodeo's assessment and treatment of Ms Sandy on the night of 27 May 2020 was to a standard expected of a Senior Medical Officer in a rural hospital.

351. In evidence, Dr Stevens was asked to comment on Ms Sandy's discharge from Mount Isa Hospital in November 2019. He opined that it was poor practice for Mount Isa Hospital to have not provided clinical handover to Doomadgee Hospital by, at the very least, contacting them and verbally directing them to the discharge summary available via The Viewer. Noting that Gidgee purportedly could not access The Viewer at that time although had become aware Ms Sandy was back in the community, Dr Stevens agreed that it was incumbent upon Gidgee to make enquiries about her discharge plan including the management of Clexane and pre-surgery appointments. He remarked that Clexane was not an appropriate long-term treatment option.

352. Dr Stevens noted there was no reference to Ms Sandy being reviewed by a medical officer on 28 May 2020. He says the clinical documentation does not outline why Ms Sandy was discharged on Friday 29 May 2020. He is of the opinion it was premature and clinically inappropriate given Ms Sandy was not entirely stable at the time of discharge; she had persistent tachypnoea with no previous documented respiratory disease. This is especially with the knowledge that Ms Sandy had such a complex cardiac history with known non-adherence to medical advice. He says it was disappointing Ms Sandy's family were not involved in the discharge process.

353. Dr Stevens noted there was no evidence of the involvement of an indigenous health worker in Ms Sandy's discharge. He says it is vital to involve such a person in the discharge process as they are often used to locate patients for follow up care. Conversely, he observed that the efforts at following up Ms Sandy in the community from 26 March to 23 April 2020 had involved an IHW. He observed that the multiple attempts at follow up over that period were very reasonable, but he was concerned that, given Ms Sandy's chronic condition,

the attempts seemed to stop for no particular reason. Dr Stevens was highly critical of the documentation in the medical records. He made similar observations to Dr Schultz in terms of the language used in the records, which he described as "paternalistic" in nature.

354. Dr Stevens was asked to comment on Ms Sandy's cause of death, which was recorded in the autopsy report as resulting from clotting on her valve. Dr Stevens concluded that there was a direct correlation between the cause of death and Ms Sandy not being on anticoagulant therapy from 16 February to 27 May 2020. He explained that:

> *"In the absence of any form of anticoagulant or thinning of the blood, the mechanical valves often attract red blood cells that then congregate on the valve, and then grow bigger and bigger until they form such a clot. If Ms Sandy was on Clexane or had a therapeutic level of Warfarin, that would not have occurred on the mitral valve."*

355. He agreed that this possibly could have been avoided if Ms Sandy had the benefit of an active **case manager** looking after her in the community in relation to her RHD, including monitoring her Penicillin and anticoagulation.

356. Like Dr Schultz, Dr Stevens had no criticism of the resuscitation efforts on 30 May 2020.

Opinion of Dr Wenitong, Indigenous Doctor (retained by the OHO)

357. Dr Wenitong is critical that there was no discharge plan for Ms Sandy upon her discharge from Doomadgee Hospital on 29 May 2020.

358. Dr Wenitong says it is difficult to demonstrate from the progress notes any specific cultural issues in Ms Sandy's final presentation. The family were surprised that she was discharged on 29 May 2020 when she was looking unwell. Dr Wenitong suggested a family conference with the doctor prior to discharge would have been helpful.

359. Dr Wenitong says Queensland Health guidelines '**Sad News Sorry Business**' were not documented to have been followed (most clinicians who gave evidence at inquest were **not** aware of these guidelines). Of note, an Aboriginal Liaison or Indigenous Health Worker was not contacted. Dr Wenitong was not aware of the evidence of Ms Peter and her involvement in acting as a liaison person for the Sandy family. He was informed of this during the inquest through questions posed by the lawyer acting for the Booth family and indicated that Ms Peter communicating Sorry Business to the family was "totally appropriate" where an IHW was not available.

360. Dr Wenitong was critical of Ms Sandy's medication management and follow up by both Gidgee and the Hospital and referred to the **Queensland Aboriginal and Torres Strait Islander Patient Care Guidelines**. He says Ms Sandy would have benefited from a much more proactive approach, as some of her medication issues were likely because of her sensitivity to Warfarin and this may have impacted on her adherence; that is to say that a patient with her

range of INR results needs more support and education. The same applied regarding the prophylactic treatment of Penicillin.

Circumstances of Kaya's death and Expert opinions

361. By age 17, as she was at the time of her death, Kaya had a significant cardiac history, including multiple cardiac surgeries. Prior to identifying a leak occurring through the Konno patch aortic sinus to her right ventricle in or around March 2019, it is noted that she:

    a. developed RHD after ARF in 2009;

    b. underwent aortic and mitral valve repair on 21 June 2010;

    c. had a redo of a mitral valve repair on 24 June 2010;

    d. had a 29mm onyx valve in mitral position on 29 June 2010;

    e. had a mitral valve replacement (27mm St Jude) and aortic valve replacement for progressive AS (24mm Medtronic) in April 2017 plus a Konno incision.

362. On 11 March 2019, Kaya was reviewed by Dr Reeves, a paediatric cardiologist in Cairns. On echocardiogram, a tiny defect was seen with continuous flow from the region of the aortic sinus into the right ventricle outflow tract (RVOT). In layman's terms, Dr Reeves explained that Kaya's artificial valve had developed a leak from part of the aortic root into the right side of the heart, leading out in the lung arteries. This meant that, with every heartbeat, blood was leaking into the lungs and causing pressure on the arteries and lungs to increase, as well as requiring the heart to pump harder and possibly faster to compensate for the lost blood.

363. Dr Reeves had the images reviewed by Dr Gooi at the QCH Cardiology Unit. He subsequently wrote a letter to (D Health) Djarragun College in Cairns, where Kaya was attending as a student. In the letter, he recorded:

> "*He* (Dr Gooi) *didn't think the defect needed any obvious intervention at this stage. I'll review them relatively soon in 2 weeks, just to keep an eye on things. She should probably avoid strenuous exertion in the interim and present to Emergency if she develops any chest pain*".

364. On 25 March 2019, Kaya was again reviewed by Dr Reeves. In his letter to D Health, he wrote:

> "*Shakaya has stable echo findings. Again, I've discussed with the team in Brisbane the significance of the continuous flow. Their initial impression was that it was likely to be a post-operative phenomenon but we haven't seen this before on previous scans aside from the last few weeks. They'll review the images at their weekly cardiac surgical meeting this Friday. I can't see any reason for any obvious intervention required at the moment but will see her again in 2 months' time for a review*".

365. On 29 March 2019, Kaya's condition was discussed at the Cardio-Surgical Conference (Dr Reeves and Dr Justo). The reason for discussion was Kaya's *'aorta to RVOT fistula (observe versus further investigations)'*. The report stated:

> *NEW FINDING*
>
> *NO H/S/O INFECTIVE ENDOCARDITIS MOST LIKELY A NEW KONNO PATCH LEAK*
>
> *NO CLINICAL CONSEQUENCES AT THE PRESENT TIME WATCH CLOSELY*
>
> *IF INDICATED – CARDIAC CATHETER IN THE FIRST INSTANCE*

366. On 10 June 2019, Kaya was reviewed by Dr Reeves. She had an echocardiogram which showed it was stable from previously. In a letter to D Health, Dr Reeves recorded:

> "*Shakaya seems to be doing well. We'll keep a close eye on her and see her in 6 months for repeat echo. She will need antibiotic prophylaxis for dental and other at-risk procedures. I suggested she remain physically active but avoid contact sports given that she's anticoagulated. There are no other precautions required in the meantime*".

367. Dr Reeves copied this letter to Dr Justo, Doomadgee Hospital, the RHD Register, and the medical records. There was no record of this letter in Kaya's Doomadgee Hospital record. He says it is useful to copy several different people into correspondence especially with very mobile patients and families. He routinely copies the RHD Register into his letters as a good central store of information, so other clinicians involved in a patient's care can access the correspondence. Ms McKenna explained that such correspondence would be uploaded to the RHD Register within 24 to 48 hours, but would not be readily accessible to any clinician via "The Viewer". Dr Reeves stated that he would not ordinarily copy a child or their parents into correspondence but would do so if they requested it.

368. Kaya was regularly seen at the Doomadgee Hospital for INR monitoring and prescription of Warfarin. There were several times when Kaya had missed taking her Warfarin medication. On 6 December 2019, Kaya's mother was told about Kaya not taking her medication and the importance of being on Warfarin.

369. It is not clear why Kaya was attending the Hospital as a preference to attending Gidgee. Kaya's mother said Doomadgee Hospital had always treated Kaya and there was no discussion about moving her treatment to the newer Gidgee service. She was unsure if Gidgee could provide Kaya with INR testing.

370. In January 2020, Kaya travelled to the Northern Territory to meet her boyfriend's family in Mount Allan (she had met her boyfriend at boarding school). Kaya's mother said Kaya was feeling good when she left, and they made sure she had enough medication for the trip.

371. In March or April 2020, Kaya's mother and father went to the Northern Territory to pick Kaya up. However, they had car troubles in Tennant Creek and then had to stay there while COVID-19 travel restrictions were in place.

372. On 1 April 2020, Kaya was referred from Yuelamu clinic at Mt Allan to the Alice Springs Hospital ('ASH') Cardiology Clinic. It was noted Kaya had moved from Queensland and had severe RHD. The doctor recorded, "*Last echo appears to have been done 6/2019 and there was a plan for review and repeat echocardiogram around the end of 2019*".

373. On 14 April 2020, Kaya was noted for a telehealth appointment as a Category 1 patient.

374. On 20 April 2020, there was correspondence drafted to Kaya but, as there was no address on the letter, it is uncertain how it was provided or if it was provided to Kaya at all. The letter set out the details for a telehealth appointment with consultant cardiologist Dr Nair on 6 May 2020. The letter recorded, *"Please contact your local hospital or clinic staff to arrange."* Kaya's mother was not with Kaya at that time. She did not recall Kaya having an appointment arranged with a cardiologist.

375. On 7 May 2020, there was further correspondence drafted to Kaya. Again, there was no address on the letter and so it is uncertain how it was provided, if it was provided, to Kaya. The letter noted that Kaya did not attend the scheduled telehealth appointment and the author writes, "*If we do not hear from you within 30 days from the date of this letter, your name will be removed from the waiting list and you will be discharged from the Telehealth Clinics.*"

376. On 16 June 2020, Kaya was taken to the ASH ED by her mother. She had experienced chest pain the previous day, which had been triggered by vomiting. She had been feeling unwell with vomiting and abdominal pain for a week. Kaya was assessed, as it was thought she had gastroenteritis and query heart failure on the background of RHD. She was for admission and further investigation.

377. Kaya's mother said Kaya looked sick, was weak, was losing a lot of weight and her body and legs were swollen.

378. On 18 June 2020, Kaya had an abdominal ultrasound which was suggestive of venous congestion or back flow/tricuspid regurgitation. She was for a transthoracic echocardiogram ('TTE').

379. Dr Anna Holwell was the Staff Specialist in General Medicine who initially reviewed Kaya. She says given the complex nature of Kaya's presentation, that is, the new symptoms of likely heart failure on the background of her very complex cardiac issues, she requested review by the cardiology team.

380. Kaya was reviewed by a doctor from cardiology (the doctor's name is illegible). Her abnormal TTE results were noted. The doctor noted her previous cardiac surgery in Brisbane, that she was having follow up in Cairns, and that her last TTE was in 2019 in Cairns Hospital which was apparently normal. Kaya was reported to look well and had no dependent oedema.

381. The doctors thought given Kaya's acute heart failure and tachycardia, it was concerning for acute valve dysfunction. The differential diagnoses were valve thrombosis, or acute infection and deterioration, or ruptured sinus of Valsalva. The doctor records the TTE from Cairns 2019 would be helpful if available and

notes: "*we will chase*".

382. Kaya was reviewed later in the day by the same cardiologist. The cardiologist recorded, "*I note the letter from cardiologist in June 2019 that mentions known breakdown of Konno graft/patch with pressure of 60 mmhg. Now pressures appear 80-90 mmHg*". The cardiologist commented that these findings suggested the hole/dehiscence was smaller. On this basis, it was decided Kaya did not need a transesophageal echocardiogram.

383. On 19 June 2020, Kaya was seen by the same cardiologist who noted, with regard to the Konno patch breakdown, that Kaya was stable/improved from the imaging six months ago but there was progression of her mitral valve stenosis. Kaya was seen to be feeling well, was not experiencing shortness of breath, no orthopnoea and no dependent swelling. It was decided Kaya could be discharged from a cardiac perspective.

384. On discharge, the plan was for Kaya to commence Spironolactone (diuretic); undertake a review of fluid status and bloods the following week; hold off adding a beta blocker at present; and/or outpatient cardiology review in 3-6 months with repeat TTE. The cardiologist stated, "*I will call cardiologist Dr Reeves to update.*"

385. Dr Holwell says Kaya was keen to return to Doomadgee. She found Kaya no longer had symptoms of right heart failure. Her observations were in normal range. Her oxygen saturations were 100% on room air and her weight was down 3kg from admission. The weight loss suggested an improvement in her vital signs and that there had been an adequate diuresis in response to the prescribed therapy.

386. Dr Holwell contacted cardiology to clarify Kaya's follow up arrangements and was advised that her care would be handed over to Dr Reeves as documented. Dr Holwell stated:

> "*Ms George's presenting symptoms had resolved, her condition was stable and she had initiated appropriate treatment (frusemide and spironolactone). Given she had been cleared for discharge from a cardiac perspective with appropriate follow up arrangements in place, I felt it was reasonable to discharge Ms George so that she could travel home to Doomadgee where she would return to the care of her treating doctors and review by her usual cardiologist. My team prepared a discharge summary which was sent to Yuelamu Clinic and the Doomadgee Hospital*".

387. Dr Reeves had no independent recollection of a specific conversation with the cardiologist at ASH regarding Kaya, or any independent recollection of any advice or information from that time. Dr Reeves reviewed the Cairns Hospital ieMR and his email records, and could not find any correspondence from Alice Springs. In evidence, he explained that he would not necessarily write an entry into the medical record if he received a quick update or enquiry from another centre but may do so if he gave some detailed or specific advice. He accepts that it is possible that he took the call. However, he said he would have expected to receive written correspondence from Alice Springs Hospital regarding Kaya's admission.

388. Dr Nair, the consultant cardiologist at ASH, says his registrar Dr Meere telephoned Dr Reeves' team in Cairns and finally spoke to the team after multiple attempts. Dr Meere was not sure whether he spoke to Dr Reeves or to one of his team members. Dr Nair states:

> "*Dr Meere has advised me that he apprised Cairns Hospital of Miss George's admission to Alice Springs Hospital, discharge, and clinical status. Our recommendation was for review and TTE by Dr Reeves/Cardiology Clinic at outreach Doomadgee hospital in 3-6 months. As noted above, this was based on her asymptomatic and NYHA Class 1 status at discharge from Alice Springs Hospital*".

389. Dr Nair recommended a review and TTE in 3-6 months based on Kaya's clinical status at the time. He acknowledged that in complex cases, such as Kaya's, situations can quickly change and can be hard to predict.

390. Kaya was then managed through the Hospital In The Home ('HITH') program, receiving daily visits to the hotel that she and her mother were staying in at Alice Springs. She was seen daily.

391. On 23 June 2020, a facsimile was sent from the Medical Records Department NWHHS at Mount Isa to Alice Springs in response to an urgent request for a copy of her recent echocardiograms (since 2017), as well as any cardiology correspondence. The request had been made on 18 June 2020. The information did not include any of the correspondence from Dr Reeves or Kaya's recent echocardiogram results from 2019.

392. A similar request for information had been made to QCH on 16 June 2020, seeking medical records from her two previous surgeries. It seems the operative reports from 2010 and 2017 were provided. It is not clear when they were forwarded to Alice Springs. The correspondence from Dr Reeves of 10 June 2019 was not included in the material.

393. On 24 June 2020, Kaya's mother advised the nurse from HITH that they needed to head back to Doomadgee for a funeral.

394. On 26 June 2020, Kaya was discharged from HITH. She was advised to take 6mg of Warfarin daily until she could see a doctor and get her INR check, preferably within 5- 7 days. Kaya was given sufficient supply of Warfarin.

395. A comprehensive 12-page discharge summary was completed by HITH. Under the heading 'Follow up', the author recorded:

> "*HITH visited Shakaya for 1 week to bridge her from clexane to warfarin.*
>
> *She has since travelled with family to Tennant Creek to ultimately return to Qld. She will need to be followed up with Cardiologist in Doomadgee Hospital as outlined by the ASH Cardiology Team in 3-6 months with a repeat TTD.*
>
> *DC on low dose Spironolactone 25mg daily in an effort to prevent right heart remodeling.*
>
> *If any questions/concerns regarding Shakaya's admission to ASH please contact the Medical Team 2 Junior Doctors via ASH Switchboard*…".

396. The discharging doctor had deferred to the recommendation of the consultant

cardiologist with respect to the period for specialist review. Dr Nair, the consultant cardiologist, explained that he had recommended the review and TTE within that period based on Kaya's history and clinical status at that time. Kaya had been asymptomatic upon discharge and in the 7 days she was under observation by HITH.

397. Kaya's mother says she had been told she had to get back to Doomadgee so that Doomadgee could do some follow up and Kaya could be flown to Brisbane. The hospital gave her a letter with the results from Kaya's admission. In evidence, Kaya's mother identified the document given to her as the 12-page discharge summary from ASH. Her understanding was that Kaya needed to get back home straightaway *"to find a referral at the hospital at Doomadgee"*.

398. A copy of the discharge summary from the Alice Springs HITH also appears on the Doomadgee Hospital record. It is not clear how and when it was received. Dr Reeves did not receive this document.

399. In his written statement, Dr Reeves expressed the opinion that, based on the handwritten notes in the Alice Springs record reflecting that Kaya had stable echocardiogram findings, a six month review was appropriate (on the proviso that she seek medical advice sooner if she developed symptoms such as breathlessness with exertion and fatigue). **However, by the time Dr Reeves gave oral evidence at inquest his opinion had changed entirely, having subsequently seen the typewritten echocardiogram report (from 18 June in ASH) referring to a mean gradient of 16mm across Kaya's mitral valve.**

400. Dr Reeves explained that this **indicated severe mitral stenosis** likely causing an element of heart failure, which would have required much earlier review and intervention than recommended at ASH. Dr Reeves opined that, had he been managing Kaya, he would have **referred her immediately to Brisbane** and not let her return to Doomadgee where there are no routine cardiac services.

401. Dr Benjamin Anderson, the paediatric interventional cardiologist who ultimately treated Kaya in the QCH says, based on his review of the records, Kaya had an acute febrile illness with symptoms that resolved during her admission, leading to her discharge. She was noted to have ongoing presence of an aortic to RVOT fistula, mitral valve dysfunction and heart failure symptoms. He stated:

> "*In retrospect, in my opinion and with the benefit of hindsight, this may have been an acute illness exacerbating progressive underlying cardiac failure, although given the documented resolution of the presenting symptoms based on my review of the ASH medical records, this may not have been obvious at the time. It is likely the diuretics used during her admission improved the symptoms of heart failure, although these did not resolve the underlying causative process*".

402. Dr Holwell was not familiar with the specifics of cardiology outreach services in remote Queensland, and therefore felt that Dr Reeve's input for ongoing planning was vital. She was reassured that cardiology at Alice Springs Hospital would contact him.

403. Within 10 days of departing the NT, on 6 July 2020, Kaya went to the Doomadgee Hospital with her mother for an INR test. It was noted she had

been in the Northern Territory for six months and had returned for a funeral. The nurse recorded, "*Apparently Shakaya is requiring further surgery in Brisbane and the mother said they will re-present tomorrow for further follow up"*.

404. On 8 July 2020, Kaya returned to the ED to have her observations checked and was seeking assistance for transfer to Brisbane. She refused to have her INR checked and her mother refused the Warfarin tablets as the hospital did not have any Coumadin. It was noted Kaya's observations were within normal limits, and that she had no chest pain or shortness of breath. Kaya's mother refused for Kaya to be reviewed by a medical officer and just wanted to finalise the travel to Brisbane and as noted further below she was recorded to be 'demanding for valve replacement surgery in Brisbane at each visit'.

405. I am in no doubt that at all times Kaya's mother appreciated the urgency of Kaya's situation and consistently and persistently raised with the Doomadgee hospital the need to attend Brisbane for surgery. The evidence infers a lack of any urgency between 8 and 17 July by the Doomadgee Hospital to follow up the Kaya's NT admission and commence processes for transfer despite Kaya's mother advising from first attendance on 6 July at hospital upon their return of the need for surgery in Brisbane, information she repeated on each visit.

406. On 9 July 2020, Kaya presented to the Doomadgee Hospital for an INR check. She was assessed and noted to be asymptomatic. The Medical Officer suggested it was okay to provide Kaya with Marevan brand while she was in Doomadgee. The nurse noted, "*Spoke with admin re the update on patients travel to Brisbane. Fredericka will follow up with Alice Springs and Brisbane and will ring the pt's mom*".

407. On 12 July 2020, Kaya returned to the Doomadgee Hospital for an INR check and Warfarin supply. She was assessed and her observations were normal. She had no shortness of breath, and no chest pain. No concerns were raised by Kaya, or her mother and they did not want medical review. Kaya was advised of her Warfarin dose for the next three days.

408. On 13 July 2020, Kaya returned to the Doomadgee Hospital for an INR check and a medical officer review. Kaya was reviewed by Dr Ajulo who noted Kaya's history, including her TTE in June 2019 and the repeat TTE in Alice Springs in June 2020 which showed the leak around the aortic graft repair had improved. The doctor recorded, "*Her cardiologist (Dr Reeves) in Brisbane is aware and she will be followed up here at Doomadgee Cardiology outreach clinic within the next 3/12*". (On the evidence, this entry was erroneous.)

409. Dr Ajulo noted Kaya had complained of a cough over the last two days with greenish sputum but no fevers. She had mild shortness of breath on exertion and still had some leg swelling. Her observations were recorded and were relatively normal, however her pulse was 101 beats per minute. An ECG showed no acute changes. She was observed to have mild pitting oedema, mostly in the pretibial region bilaterally. Her oxygen saturations were 99%. She had good and equal air entry in her lungs bilaterally. Her blood was tested, and the abnormalities noted. The impression was that Kaya had Congestive Cardiac

Failure, possible Lower Respiratory Tract Infection and that her INR was over therapeutic range. The plan was recorded as:

> "*omit warfarin tonight: recheck INR mane and review PO Augmentin due Forte – 1 bd x 7/7*
>
> *Restart frusemide – 40mg po stat: should continue with same dose daily for at least 1/52 (patient has a supply at home)*
>
> *I will review her on her return tomorrow and establish the situation regarding her follow up with her cardiologist*".

410. On 14 July 2020, Kaya returned for review by Dr Ajulo. Kaya's mother was in attendance. It was noted she has been taking Frusemide and had not had her Warfarin the previous night. Her INR was 3.4 and she was advised to recommence Warfarin and to return on 17 July 2020 for a check INR.

411. On 17 July 2020, (some three weeks after Kaya's discharge from the NT) Kaya again returned to the Doomadgee Hospital ED. She complained of swelling to her lower limbs since the previous night and said it was worse than usual. A nurse noted the swelling and that there was no pitting oedema of the limbs or feet.

412. Kaya was reviewed by Dr Ajulo. Her observations were recorded, her respiratory rate was 19 and her oxygen saturations 98% on room air. She was noted to have good and equal air entry in her lungs bilaterally. She still had mild pitting oedema up to her shins and it was noted it was unchanged from previously. She was administered a COVID- 19 test and advised to self-isolate for the next 2-3 days until the results were known. She was for Panadol/Nurofen as required, Warfarin and to continue with the Frusemide. Dr Ajulo recorded:

> "*mum is very keen to get patient valve replacement surgery (revision) done and had been demanding for this at each visit. I have explained that the discharge letter from alice springs hospital has indicated that a referral has been made to a cardiologist, dr reeves who is planning to do a trans-thoracic ECHO & review in 3/12*
>
> *Mum was not happy with this, so I have contacted alice springs hospital to ascertain where dr reeves is based – he was not found on the list of cardiologist when I contacted the prince charles hospital switchboard*
>
> *alice spings hospital (dr anna holwell's team) promised to get back to me with that information*".

413. In an entry later that day, Dr Ajulo recorded:

> "*WITH THE HELP OF NURSING STAFF, WE HAVE SUCCEEDED IN LOCATING DR BEN REEVES – PAED CARDIOLOGIST AT CAIRNS HOSPITAL*
>
> *CONTACTED CAIRNS HOSPITAL SWITCHBOARD… IT IS A PUBLIC HOLIDAY IN CAIRNS TODAY, SO NO ADMIN STAFF AVAILABLE TO ANSWER THE ENQUIRIES AROUND PATIENT'S APPT*
>
> *PLAN:*
>
> *PATIENT'S REFERRAL & FOLLOW UP WITH DR REEVES WILL BE FOLLOWED UP ON MONDAY 20 JULY 2020*

THIS WILL BE HANDED OVER TO THE INCOMING DOCTOR IF NO SUCCESS WITH ABOVE

PATIENT WILL ALSO BE RETURNING TO DOOMADGEE HOSPITAL THAT DAY FOR A CHECK OF HER INR".

414. Kaya's mother did not understand why they tested Kaya for COVID-19 when they had already undertaken tests before coming back to Doomadgee for Ms Sandy's funeral. She says she **argued with the hospital and told them it was urgent, and that her daughter had heart problems**, but that they were not looking at her heart. Kaya's mother said, "*We went to Doomadgee Hospital and Kaya was getting worse, she was short of breath and her body and legs were swollen. The Hospital gave her Panadol and sent her home.*"

415. I accept Ms Weenie George's version of events.

416. Kaya's mother says they decided to go to Burketown to try and get Kaya seen there. They took her to the clinic on 18 July 2020. Kaya was assessed and they were advised to stay nearby and monitor her and if she got any worse to come back and they would get the flying doctors in. Kaya got worse, so they returned to Burketown Clinic and Kaya was transferred to Mount Isa.

417. The author of the Mount Isa triage record of 19 July 2020 at 1757hrs stated:

> "*TRANSFER FROM BURKETOWN CLINIC – 2/7 ANKLE SWELLING – THIS MORNING PRESENTED TO BURKETOWN CLINIC SOB. DENIES CHEST PAIN. INR 2.3 . ECG NAD*
>
> *PMHX – VALVULAR DISEASE + RHD*".

418. Kaya was assessed by Dr De Boos. Her history was noted. On examination, Kaya's respiratory rate had been 40 but decreased to 30. Her oxygen saturations were 98%, and her heart rate in the 90s. She had an elevated Jugular Venous Pressure (JVP), pitting oedema up her legs, hepatomegaly, poor air entry bilaterally and creps. She was tender everywhere in her abdomen. Her ECG showed prolonged QTc. The doctor recorded:

> "*This girl is very unwell*
>
> *Clear CCF which I presume is worsening however also viral sounding symptoms*
>
> *Her heart has been unwell for some time*".

419. One of the treating doctors talked about transfer of Kaya. Her mother enquired about Brisbane but, as Townsville was the referral centre, it was decided she would be transferred there. Townsville Hospital was happy to accept Kaya. In the transfer letter, Dr Somartna, Staff Specialist Internal Medicine, recorded:

> "*On examination her respiratory rate is 35-40 with stable haemodynamics and a HR of 97 and spO2 of 96 mmHG on RA. A grade 5 continuous murmur is heard over the anterior precordium with additional pansystolic mumur near the right sternal edge. Lungs are clear with elevated JVP and hepatomegaly and bilateral pitting ankle oedema*".

420. Dr Reeves was not contacted by Mount Isa Hospital. He says that while it is possible to transfer a patient from Mount Isa to Cairns, it would be very unusual;

he only recalls one case in the last 10 years. He says in most cases where a child needs urgent cardiac assessment, they would be transferred to Brisbane. In the case of an adult, the more likely site would be transfer to Townsville, as they have cardiac surgical services (unlike Cairns) and provide outreach to Western Queensland. Given her age, Kaya fell on the cusp of adolescence and adulthood, and it was thought she would need adult cardiology support in future. Dr Reeves' evidence was that either destination would be clinically appropriate, and he expected by that stage there was little he could have added based on his dated past encounters with Kaya.

421. On 20 July 2020 at around 0150hrs, Kaya arrived on the ward at the Townsville Hospital via the ED. She was assessed by the cardiac team, including the consultant at about 1030hrs. She was for further investigations and review.

422. On 20 July 2020, Kaya was seen by the Indigenous Health Liaison Officer ('IHLO'). The IHLO records, "*IHLO to maintain contact with family during this admission*". Kaya's mother remembers having regular contact with the IHLO but that she had limited information to provide, as they were all awaiting further information from the doctors.

423. On 21 July 2020, Kaya underwent an Echocardiogram. The plan was to discuss with the Brisbane surgical team once Kaya had further investigations including a Cardiac MRI and a transesophageal echo ('TOE'). The author recorded, "*Mother and patient aware that current problem likely to require surgical intervention. Aware that there is a leak in the heart, failure of previous patch*". Dr Reeves does not recall being contacted by Townsville Hospital to discuss Kaya's history.

424. On 22 July 2020, Kaya was reviewed, and it was determined she would need an iron infusion, a cardiac MRI, a TOE and optimization of her Potassium and Magnesium. She was for review by the Haematology team about her haemolytic anaemia.

425. On 23 July 2020, the IHLO met with Kaya to discuss her resistance to a suggested blood transfusion. It was agreed she would wait until her mother attended before going ahead. Kaya was reviewed by the cardiothoracic surgery team and advised that it was very likely she would need another open-heart surgery and it may happen in Townsville. Her case was discussed at the Multi-Disciplinary Team ('MDT'), in particular as to whether her surgery would be performed in Brisbane or Townsville. In the meantime, the surgeon who performed her original surgery from QCH was contacted via his Fellow. The case would be considered, and they would respond.

426. On 24 July 2020, Kaya was reviewed by the Cardiac team, including the consultant. It was noted she had decompensating cardiomyopathy from Aorto-RVOT fistula from failing Konno patch and that she would need eventual surgical intervention. She was clinically well and not in fluid overload. Her haemolytic anaemia was improving with the blood transfusion. She was for discussion with the *"Brisbane children's hospital regarding transfer to Brisbane"*.

427. On 26 July 2020, Kaya's mother was present when she was being reviewed by

the Cardiac registrar and intern. She was advised that Kaya was to travel to Brisbane the day prior, but there was patient who had since deteriorated and required more urgent transfer. They were advised they would follow up transport timings. Kaya was otherwise noted to be stable. The triage process for transfers was purely a matter for Retrieval Services Qld, outside of the hospital's control, and depended upon the urgency of patients and the availability of aircraft and crew.

428. On 27 July 2020, it was again noted that Kaya was to transfer to Brisbane the day prior but was unable to do so, due to more unwell patients. Kaya underwent a cardiac MRI scan. She was noted to be clinically well, awaiting transfer to Brisbane. She was commenced on oral antibiotics for a boil on her right upper leg. The boil was noted on 25 July 2020 and the cardiac team made aware. It was not red and did not require intervention at that time. She was for Blood Cultures and consultation with Infectious Diseases if she became febrile or unwell.

429. I infer that by no one involved had either received; reviewed or was aware of the typewritten echocardiogram report from ASH undertaken 18 June referring to a mean gradient of 16mm across Kaya's mitral valve which according to Dr Reeves evidence at inquest indicated severe mitral stenosis likely causing an element of heart failure, requiring immediate transfer to Brisbane.

430. Transfer of this information to the appropriate health service in Queensland was critical to Kaya's outcome.

431. On 28 July 2020, the Indigenous Liaison Team Leader met with Kaya and her boyfriend to explain the process of the RFDS flight. Kaya was discharged and transferred via the RFDS to QCH.

432. Dr Anderson reviewed Kaya's clinical records while she was in Townsville. He stated:

> "*Whilst Kaya's underlying cardiac state was concerning, in my opinion, the time spent in TUH* [Townsville University Hospital] *and management instituted by the treating team was important in improving her overall state and clinical condition prior to transfer. Further investigation and optimisation of her clinical state was continued after transfer to QCH and prior to undertaking intervention*".

433. On her arrival from Townsville, Kaya was noted to be tired. She had been unwell since April and breathless all the time. She was swollen everywhere with a lot 'of fluid onboard'. Her observations were relatively stable.

434. On 29 July 2020, Kaya was reviewed by the paediatric cardiology team. She was to undergo cardiac fluoroscopy, a dental review, and for treatment of her boil.

435. On 1 August 2020, Kaya was reviewed by the paediatric registrar. It was decided Kaya would need to complete antibiotics for her boil and to undergo a dental review and treatment before undergoing any cardiac procedure. Dr Reeves explained in evidence that it is routine to eliminate infection anywhere in the body prior to embarking on surgery involving a fragile organ such as the heart.

Dr Anderson also confirmed the importance of optimizing Kaya's physical condition ahead of surgery of this magnitude.

436. That same day, on 1 August 2020, Kaya was taken off cardiac monitoring and was able to go outside into the garden. She was told she would be in hospital for a few weeks.

437. On 3 August 2020, Kaya was referred by the Doomadgee Hospital to the Townsville Hospital (by then she was already in Brisbane), Cardiology Department for ongoing care. The triage urgency was noted to be 'Routine'. **The Hospital was not aware Kaya had been transferred to the Townsville Hospital as an acute patient on 19 July 2020 and then transferred to QCH.**

438. On 7 August 2020, Kaya was advised she would be for a fistula repair in the cardiac catheter lab in one and a half to two weeks after her infection resolved.

439. On 12 August 2020, Kaya was reviewed. An alternative date for the procedure was scheduled for the following week, noting it was to be a week after she stopped antibiotic treatment for her boil.

440. On 17 August 2020, it was noted Kaya would be for her procedure on Thursday 20 August 2020.

441. On 18 August 2020, Dr Anderson, the paediatric interventional cardiologist, first met with Kaya and her family to discuss the scheduled procedure. Given the severity of Kaya's underlying condition, he highlighted the potential complications, and discussed the risk of potential emergency surgery or a need for unplanned surgery. Kaya's parents signed the consent form. Later that day he further discussed the procedure with Mr Alec Doomadgee, a trusted family member and father figure. Mr Doomadgee had been reassured that the surgery was the best way forward for Kaya's health.

442. Dr Anderson had previously been involved in discussions concerning Kaya and the management of her condition at the Queensland Paediatric Cardiac Service team meetings on 24 and 31 July 2020. At the latter meeting on 31 July 2020, it was collectively agreed Kaya required catheter-based intervention involving the insertion of a device to plug the leak, as opposed to open heart surgery. Both surgeries were technically difficult and carried significant risks but given the catheter-based closure was less invasive, it was deemed the lower risk. It had also been agreed that treatment of Kaya's leg infection was to occur prior to the procedure.

443. On 20 August 2020, Kaya underwent an attempted closure of the aortic RV fistula under TOE and fluoroscopy guidance. The record states:

> "*initial deployment of 10mm Amplatzer ASD device was in good position, although with residual shunt noted on TOE and angiogram;*
>
> *Subsequent deployment of a 13mm Amplatzer ASD device was difficult; although the device was well seated there was impingement on the aortic valve with one of the leaflets non-mobile in the closed position; therefore the device was removed*".

444. Dr Anderson said given the two attempts had not been successful, the decision was made to abandon the procedure, allow Kaya to wake and settle, and to

discuss further management options for her.

445. Kaya developed elevated Troponin levels and ST changes in her electrocardiograph during the procedure. Dr Anderson says the elevated Troponin appeared to be consistent with the post-procedure state with difficult haemodynamics. He opines the ST changes were reflective of Kaya's haemodynamic state and coronary artery perfusion and are often found during complex interventional procedures which can affect cardiac output.

446. Post-operative TOE revealed important tricuspid regurgitation, although without obvious prolapse/chordal rupture.

447. On 21 August 2020, a request for Kaya to commence on Extracorporeal Membrane Oxygenation ('ECMO') was made. The notes record that she had deteriorated overnight since her catheter procedure the day prior. The etiology was unclear, but she had a lactate of 17. The catheter was inserted at around 1252hrs. Due to the potential circular flow via the aorto-RV fistula, the decision was made to attempt further occlusion of the communication. The record states:

> "*Initially a 9mm Amplatzer ASD device was delivered under fluoroscopy and TOE guidance; the device was seated well clear of the aortic valve although had significant residual shunt noted on TOE; therefore the device was removed and replaced with a 12mm Amplatzer ASD device; this device was ultimately well seated and clear of the aortic valve with both mechanical leaflets noted to be mobile; there was a smaller residual shunt noted on TOE*".

448. On 22 August 2020, Kaya developed compartment syndrome to her right leg because of the ECMO cannula. She underwent another procedure to reinstate ECMO and to repair her right femoral vein.

449. On 24 August 2020, Kaya had improved and the ECMO was removed.

450. Kaya then deteriorated following a haemorrhagic infarct of her left occipital region.

451. On 12 September 2020, indicated a meeting with Kaya's family. They were concerned there was a cover up as to why Kaya had deteriorated and ultimately was going to die. It was noted Kaya had been without sedation in the last days and despite this had not shown any signs of life, or rousing, or gag/cough. The family agreed upon the difficult decision to extubate Kaya. She was taken out to the balcony to spend time with her family. She was extubated there with her family around her and passed away at 1630hrs.

452. The progress notes demonstrate significant social work support for Kaya's family and her boyfriend. Further, there were numerous meetings held with clinical staff.

453. A summary of her progression was made following her death. Dr Mattke records:

> *# Fistulous connection Aorta to RV: At first catheter intervention a Qp:Qs of 2.1 was found. Attempt to place occlusion device in fistula. Adequate occlusion of the fistula was not possible given the device needed to occlude the fistula would have been so big that the adjacent aortic valve could not have functioned in an unimpaired fashion. In addition, there was concerns that the coronary arteries*

would be obstructed by the device. Further concerns were that a smaller device would embolise into the pulmonary arteries, which could lead to a sudden cardiac arrest.

After placement on ECMO for severe lactic acidosis and a high central venous pressure (after the first post OP night) a second catheter intervention was undertaken, given an assessment was made that Shakaya would not be able to recover without closure of the fistula. At the second catheter intervention an occlusion device that was small for the fistula, but was able to occlude the fistula at least partially, was placed. This resulted in an immediate increase in the diastolic blood pressure (patient still on ECMO).

 # Right ventricular failure and tricuspid regurgitation: Shakaya presented with poor right ventricular function which was one of the indications to attempt to close the Aorta to RVOT fistula. After her initial catheter intervention, but also after the second one, she had episodes where - with slightly elevated blood pressure - the central venous pressure would rise acutely up to around 3040 mmHg. This was most likely related to an increase of shunting through the fistula, and a worsening of her tricuspid regurgitation due to dilation of her RV.

 # Encephalopathy and multiorgan injury: After her initial catheter intervention Shakaya did not wake up as expected. Directly after the catheter intervention a CT head was normal. After admission to PICU she developed (first post OP night) a severe lactic acidosis (max 21), a brief event of hypoglycaemia (lowest1.7) as well as biochemical evidence of a hepatorenal insult (creat134, ALT max1280, AST 4380, LD 7300). In addition, she had evidence (CK 813 and elevated myoglobin) of muscle breakdown. The encephalopathy resolved over the next days, and she was extubated on the 2nd of September, responding - albeit still sedated -reasonably. She had a new deterioration after

24 hours with poorer consciousness level, deteriorating lung disease, increased work of breathing and was re-intubated on the 3rd for further mechanical ventilation.

At this point a propofol infusion syndrome was considered but was not felt to be the cause given the very short duration and low level of propofol administration. In addition, she has had previous episodes of propofol infusion that were unremarkable. A metabolic consult did not reveal the cause of the high lactate levels. Riboflavin deficiency was a remote possibility and Shakaya was treated with Riboflavin.

 # VA ECMO: instituted on 21/8 after the first night post cardiac catheter. Weaned off and separation from VA ECMO on 24/08/2020.

 # Compartment syndrome: evidence in R) leg secondary to venous congestion from ECMO cannulation. Swapped to L common femoral vein in first 24 hours. R femoral vein was repaired and compartment syndrome resolved.

 # Haemodialysis: commenced 2018 due to severe renal insult. Unclear why renal injury as severe as it was. Supported with renal replacement therapy until her death. Some urinary output later in illness but remained dependent on renal replacement therapy until her death.

 # Anticoagulation: Ongoing need for anticoagulation due to two artificial valves. Initially severe coagulopathy that was treated aggressively with FFP and cryoprecipitate. Gradual improvement of underlying coagulopathy over 4 days post initial procedure. Anticoagulation with heparin throughout her stay. Very

sensitive to heparin. Low heparin administration rates around 10 units/kg/hr. Despite this occasionally elevated APTT to 150. Mostly in 70-90 range however.

 # Haemorrhagic infarct L occipital region: On 4/9/20, Shakaya acutely developed unequal pupils and progressive non responsiveness. CT brain revealed a large haemorrhage involving both intra-and extra-axial compartments of the left cerebral hemisphere, centred on the occipital region. Significant associated mass-effect causing acute left obstructive hydrocephalus, subfalcine and likely uncal herniation. Urgent referral to Neurosurgical team - devastating unsurvivable neurological event and decompression was not appropriate. All clinicians in agreement to redirect Shakaya's care.

 # Infection: Shakaya was treated with antimicrobials for suspected sepsis. She was colonised with ESBL E.coli. No cultures were found positive except for candida in the respiratory system and urinary tract.

 # Social: Shakaya's parents and her extended family were distraught by the sudden news of the new deterioration that was witness (sic) *after the 3rd of September, particularly as they had witnessed some progress in her condition after the surgery.*

 # Neurological decline: Her neurological condition further deteriorated after the 3rd of September and she showed severe brain stem dysfunction. Over multiple meetings, further discussions were had, and the family agreed to limit life sustaining therapy and she was extubated. She passed away on 12/9/2020 at 4.30 pm. Parents and extended family expressed perceived concerns regarding the management of Shakaya's illness. This persisted despite multiple explanations and clarifications from the various members of the treating team, and hence the case was referred to the coroner.

454. Kaya had an unexplained intraoperative or postoperative event whereby she did not wake up from her anaesthetic and became critically unwell. Subsequent CT including angiogram imaging showed no obvious stroke event. However, she developed unexplained lactic acidosis. She had increased creatinine with declining urine output with grossly abnormal liver function tests. Multiple investigations and consultations occurred but the cause of the event was not identified. She went into multiorgan failure and eventually had a haemorrhagic stroke.

455. In evidence, Dr Anderson was asked whether he was able to add any insight as to why Kaya did not wake. In layman's terms, he proffered:

> *"Why she did not wake up from anaesthetic wasn't immediately clear to us. In hindsight, it was probably a combination of things. It was probably the combination of the stress of going through the surgery, particularly the first surgery, and then the second … In combination with her underlying problem, the fact that she had this defect there that was requiring treatment and was channelling her blood in such an unusual way that was putting such a strain on her heart that meant she had very little reserve to cope with anything … That would also mean that any medications that were used during the procedure, and any anaesthetics that were used during the procedure, would be cleared much more slowly than usual. So that the way that the body would normally remove those from its system might be much slowed down by the way her*

haemodynamics were at that time. So I think in my understanding, and my interpretation, it was a combination of all of those factors together."

456. Dr Anderson was asked if earlier surgery would have made a difference. He says this is a difficult question to answer. He stated:

> "*Kaya had a difficult problem presented by the impact of her aortic root to right ventricular fistula and the haemodynamic effects of this over time. The decision making is a balance between ongoing observation and undertaking a high-risk intervention. In addition, the procedural management options available for the treatment of the underlying condition remained the same – either a higher-risk redo surgical procedure or a high-risk catheter-based device closure.*
>
> *…*
>
> *Performing the procedure sooner (although exactly when is a difficult question to answer) as her clinical course may have found her in a more robust state with some more reserve to cope with the required procedure. The procedural options would have been the same at an earlier timepoint, however the defect may have been smaller and thus amenable to closure with a smaller device, potentially making the procedure technically easier. Adequate closure of the defect may have been more likely to have been achieved in this circumstance."*

457. Conversely, Dr Anderson explained in evidence that specialists may have been reluctant to carry out a high-risk procedure sooner if the patient had appeared to be very well and not suffering significant impacts of the illness, as Kaya appeared when examined by Dr Reeves. That is to say, Kaya may have been "too well" for surgery at that point. When examined by counsel representing the Sandy and George families, Dr Anderson stated, *"I don't know how she would have coped with that* [intervention] *six weeks earlier."*

458. Dr Anderson told the Court that dealing with the aftermath of RHD is incredibly difficult and, despite specialists like him doing their best, sometimes they were not able to achieve the positive outcomes they would have liked for patients like Kaya. He concluded his statement by observing that: *"**Ideally, the need for this type of intervention would be avoided by aiming to prevent the disease and the progression long before the need for invasive procedures**.*"

459. **I find** that as at 18 June there was a lost opportunity to triage Kaya directly to Brisbane. The chain of events subsequent to her discharge from the ASH caused delay.

460. Kaya became progressively unwell due to progressive underlying cardiac failure. Stabilisation her before surgery was essential, and treatment of her infective processes could have been addressed potentially weeks earlier, (including her boil and dental treatment) which time was lost as such preparations did not commence until 1 August. Her surgical interventions commenced on 20 August.

461. I cannot conclude with any certainty that Kaya would have survived her operation had it been undertaken earlier, however there is no doubt that time was of the essence and successful heart surgery depended on a patient robust enough and optimised for surgery.

462. Kaya's operation was undertaken by the most skilled specialised surgeons available and the impact of her death on them was obvious at inquest. Her care and treatment by the specialised paediatric cardiology team at the Royal Childrens Hospital Qld was of the highest standard.

RHD Program

463. In considering Kaya's history and adherence with prophylaxis:

a. Ms McKenna suspects Kaya had a missed episode of ARF in 2006. This at a time when she was diagnosed with Sydenham Chorea. This is because Sydenham Chorea is strongly associated with carditis and the development of RHD. She notes these patients should receive secondary prophylaxis and be carefully followed up with echocardiography for the subsequent development of RHD.

b. While Kaya had elevated Anti-DNase B (ANDB) antibodies without an echocardiogram or cardiologist review she is not able to confirm if it was a missed ARF episode.

c. Kaya was diagnosed with ARF in March 2009. She had a recurrence in March 2010 and there is evidence of significant non-adherence to secondary prophylaxis and evidence of strep infections and scabies prior to ARF recurrence in March 2010.

464. Ms McKenna acknowledged there is limited access to clinical notes due to Kaya's movement between the Northern Territory, NSW and Doomadgee. In her oral evidence, she reflected that unfortunately issues with continuity of care are quite common with clients of the RHD Program, as once they move outside of Queensland (or the Northern Territory), the Register will not be automatically notified of Bicillin injections and there is no way of capturing that data.

465. On the information to hand, the records demonstrate poor adherence with secondary prophylaxis. There are only four Bicillin injections recorded on the RHD Register between 2010 and 2014. She was only dispensed with oral Penicillin three times between 2018-2020.

Expert Opinions

Opinion of Dr MacCormick, Clinical Forensic Medicine Unit

466. Dr MacCormick noted the first procedure to repair the fistula, which was a technically very difficult procedure was unsuccessful. This was because of the two sinuses around the Konno. One device could not occlude both sinuses as it would interfere with the aortic valve and obstruct the coronary arteries. A smaller device could embolise into the pulmonary arteries and cause sudden cardiac arrest.

467. Dr MacCormick says during the procedure Kaya deteriorated with low blood pressure and dynamic ST changes on ECG and that she failed to wake up and became critically unwell requiring admission to the ICU.

468. As it was concluded Kaya would not recover without closure of the fistula, a second catheter intervention was attempted on 21 August 2020. This succeeded to partially occlude the fistula, immediately improving her diastolic blood pressure.

469. Dr MacCormick says Kaya's CT head scan post procedure was normal and her encephalopathy improved over the following days. She was extubated on 2 September and her progress appeared promising, but she deteriorated within 24 hours requiring reintubation due to a reduced level of consciousness and worsening respiratory function.

470. Dr MacCormick stated:

> "*The cause of this new deterioration was not entirely clear. There were concerns that she had an undefined disease process causing an overwhelming inflammatory storm causing multiorgan shutdown. An underlying rheumatological disease was also considered and screening tests were requested. Propofol infusion syndrome (a condition caused by long-term high dose propofol infusion leading to cardiac failure, metabolic acidosis, rhabdomyolysis and acute kidney injury) was considered but discounted due to the short duration and low-dose infusion. A metabolic consult did not reveal the cause of the lactic acidosis. Riboflavin deficiency was considered and supplementation provided.*
>
> *Ms GEORGE had suffered a severe renal insult and continued to require renal replacement until her death. The treating team were perplexed by the severity of her renal injury"*.

471. In considering the care provided to Kaya, Dr MacCormick opined:

> "*This case is a healthcare related death from the perspective that the repair of the RVOT fistula on the 20th of August triggered a series of clinical events that ultimately hastened Miss GEORGE's death. However, her deterioration was a diagnostic dilemma, and probably could not have been anticipated or prevented. An opinion from a Paediatric Intensivist would be helpful here. From what I can see she was provided with appropriate supportive care and all appropriate treatment options were explored and exhausted. Overall, I do not have any concerns with the treatment decisions or healthcare provided to Miss GEORGE.*
>
> *I note the complex family dynamic and their concerns regarding the management of Miss GEORGE's illness, particularly surrounding her deterioration on the 3rd of September. The treating team seem to have shown candour and actively attempted to explain the clinical issues to the family. However, I noted that there was a degree of clinical uncertainty about the cause of each of Miss GEORGE's deteriorations, and this may have been perceived as the treating team omitting information. However, I have not identified anything to suggest that there was an attempt to 'cover up' by medical and nursing staff*".

Opinion of Dr James, Paediatric Intensivist (retained by the Court)

472. Dr James undertook an exhaustive review of Kaya's QCH medical record. He is satisfied Kaya received excellent quality of care and was appropriately managed throughout her stay on the Paediatric Intensive Care Unit ('PICU'). He considered the treatment and timeliness of the interventions to be appropriate.

473. Dr James opined that Kaya's intracranial haemorrhage was the cause of her final demise. He does not think that could have been anticipated or prevented. He says the decision to withdraw intensive care support was the correct course of action, and the timing appropriate.

Opinion of Dr Andrew Kelly, Paediatric Cardiologist (retained by the Court)

474. Dr Kelly confirmed the first time the Aortic-RVOT fistula had been identified was by Dr Reeves on 11 March 2019. He says it is unclear whether this had been acquired or was post-operative, but it had not been previously seen.

475. Dr Kelly notes the several mitigating factors in Kaya's case which included:

    a. *Kaya had severe Rheumatic Heart Disease (RHD), which is frequently difficult and problematic to manage.*

    b. *Her case exemplifies some of the difficulties commonly encountered in RHD patients with mechanical valves living in remote communities in Australia, for example management of anti-coagulation with Warfarin, which can be difficult even in the most optimal of circumstances.*

    c. *Her further complication (of an aortopulmonary shunt because of the Konno patch leak) presents an added complexity in terms of assessing her physiology/haemodynamic state.*

    d. *Much of the healthcare received in June/July 2020 occurred within regional and remote locations, none of which are major cardiac care centres. Some of the locations (Doomadgee and Mount Isa) likely have no local/resident cardiac specialist service.*

476. Regarding the care provided to Kaya, he stated:

> "*In my opinion the quality of the care in each of the health settings in this time (ASH, Doomadgee, Mount Isa, and Townsville) was of an adequate standard, and frequently of a high standard. Clinical assessments were in general thorough and timely, documentation was adequate, appropriate differential diagnoses were made, and there was considered planning of management. Frequently there was documentation that culturally appropriate care was given."*

477. Dr Kelly was not critical of the care provided at Doomadgee Hospital. He commented that the observations at that time had not changed significantly from what had been recorded at ASH, indicating a reassuring degree of stability. He characterized Kaya as being in "controlled heart failure" at that time.

478. He noted there were some areas which could have been improved:

    a. *Ms George was diagnosed with heart failure for the first time in ASH. At that time, it was unclear what the trajectory of that had been, ie how acute. And given her overall complexity I think that a plan for specialist follow up in 3-6 months was too long, and I think a review in something like 1 month would have been more appropriate. As it turned out (and of course this is only known in hindsight), her clinical situation had in fact deteriorated significantly within 6 weeks.*

    b. *It is unclear whether a formal discussion and referral to another Cardiologist had been made by the time of discharge from ASH, there was no record of a discussion with any of the health services that had previously been involved in her care. This could have facilitated a more appropriately timed follow up and may have avoided the need for review at so many different sites before her eventual transfer to QCH.*

    c. *It is unclear to me who made the decision for Ms George to go to Mount Isa Hospital, but I think this was probably the family's decision. This may have been avoided if the medical staff at Doomadgee Hospital were able to discuss her case with either Dr Reeves or staff at QCH. There were many attendances at the Doomadgee health service, which should have led to the opportunity for such a discussion to occur.*

    d. *Care in Mount Isa seems to have been rapid, thorough, and appropriate. It was identified that she was very unwell, with worsening heart failure. Notes suggest that it was considered whether she should be transferred to Townsville or QCH. A discussion with QCH, or indeed a conference call between the three services could have occurred, and perhaps could have resulted in direct and earlier transfer to QCH.*

479. Dr Kelly said it is difficult to know if Kaya's complicated course and poor outcome would have been significantly different were she to have had definitive treatment several weeks earlier. In evidence, he explained that *"if she had presented earlier she may have presented with less severity and there may have been a watch and wait period of time"*, as the risks of surgery may have been greater than the risk of not intervening at that point.

480. Dr Kelly was not critical of the care by the QCH or the planned procedure for Kaya. He was not critical of the time from admission through to the procedure, noting it was important Kaya had the necessary treatment for her boil and dental work to ensure she was stable and there was no chance of bacterial infection at the time of the surgery. He supported the choice of the catheterization procedure over open-heart surgery.

481. With respect to the procedure itself, he noted it was a long procedure and if the records are correct commenced at 0930hrs and ended at 1617hrs. In his evidence, Dr Anderson confirmed that Kaya was certainly in the operating room

for that period, although he believes he finished the procedure itself a little bit earlier than that.

482. Dr Kelly says this was consistent with a technically challenging and very long procedure. He elaborated upon the reasons for this in his oral evidence:

> *"The catheter procedure was being done as an attempt to close or block off this fistula or connection between the aorta and the right ventricle … That kind of connection is not standard anatomy … And so, you know, a sort of bespoke procedure had to be undertaken where a device needed to be found that was suitable to occlude the defect.*
>
> *And you don't always have as clear an idea of the anatomy of the defect as you would like until the time of the procedure. And the fistula is in a position where it's very close to very important structures in the heart, particularly her coronary artery orifices and aortic valve leaflets. And so you're trying to position a device close to these structures without harming their function and close the hole ... It's not the same as a surgeon who is inside the heart and can directly visualize them and place an object in the hole to block it off. You're doing this, sort of, indirectly with a radiology showing you where you're positioning catheters. And it's technically very challenging."*

483. There was evidence of reduced cardiac output affecting perfusion and oxygenation during the catheter procedure. This included ST segment changes on the ECG, low diastolic pressure, and an increased Lactate and reduced pH at the conclusion of the procedure. Dr Kelly opined that Kaya's pathology results post-procedure strongly suggest she suffered a hypoxic insult during the catheterization procedure. He stated:

> "*In summary, I think that the likely cause of her deterioration after the catheter procedure on 20/8/2020, causing her to not wake up properly, was related to a hypoxic insult during the catheterisation procedure. This occurred in someone who was already haemodynamically compromised, with likely little cardiac reserve, and is a not surprising, and a known potential, complication of a technically very challenging procedure.*

484. Dr Kelly confirmed in evidence that he had no criticism of either of the procedures and the fact that Kaya did not wake up was not a consequence of any inadequacy in the performance of the procedures themselves.

485. He concluded his evidence by remarking that Kaya was clearly very well looked after by her family.

486. After statements from Dr Holwell and Dr Nair were obtained (these having been requested after the evidence of Dr Reeves was heard during the inquest), Dr Kelly was asked to provide a supplementary report.

487. Dr Kelly maintained his view that there were elements of the discharge planning that could have been better, including a plan for Kaya to have been reviewed sooner, which could have potentially resulted in a better outcome. By way of explanation, he made the following points:

- *At the point of discharge from hospital there needs to be a clear plan as to what follow up is necessary, when that should be, where that should occur, and with whom.*

- *A 3–6-month timeframe for follow up is vague. Three months may have been reasonable but needs to be supported by an actual appointment.*
- *In addition, a safety plan needs to be made, such that if in the meantime there was a deterioration (worsening symptoms), then an earlier review could be made. This should include a consideration regarding the capacity for Ms George or the relevant health services to enact that plan, eg to have an appointment with the cardiologist brought forward.*
- *An adequate handover of care should occur. A verbal discussion was not documented in the case record but has been confirmed to have occurred by recollection of Registrar, Dr Meere. Dr Meere gave a recommendation that Ms George should be reviewed in an outreach clinic by Dr Reeves in 3-6 months. It is not documented if Dr Reeves agreed with that or if he agreed that he would make an appointment and send that to Ms George. This documented verbal discussion should also be followed by a written handover, which could be in the form of a discharge summary that should be sent directly to the receiving clinician (in this case Dr Reeves), and this is not documented to have occurred.*
- *The fact that Ms George had deteriorated into heart failure with an otherwise relatively minor viral infection suggests that she may have been likely to further deteriorate unexpectedly at any time. After such a long period of having not had heart failure concerns (ie before 2019, and then between Dr Reeve's last review in June 2019 until June 2020) her presentation in heart failure suggests I think a worsening in her underlying cardiac condition in that time. Given the complexity of her case and the unusual physiology that has been noted I think this mandates an adequate discussion with clinicians that had previously been involved in her care, and who had experience with the kind of anatomical and physiological situation as present in her case.*

<u>Opinion of Dr Schultz, General Practitioner and Public Health Physician (retained by the Court)</u>

488. Dr Schultz was critical of the staff at Doomadgee Hospital not making enquiries as to the status of Kaya's cardiac follow up after her discharge from ASH. This was on the basis that the medical records reflect that the need for a cardiology review is mentioned six times. She noted that at the last presentation on 17 July 2020 attempts were made to contact Dr Reeves but, as it was a public holiday, he could not be reached. Kaya did not return to Doomadgee after this consultation. She says appropriate care would have involved contacting cardiology services to confirm Kaya had been referred with the appropriate degree of urgency.

489. Dr Schultz is critical of Doomadgee Hospital's management of Kaya's INR and Warfarin management. Dr Schultz stated:

> "*Doomadgee Hospital managed Ms George's warfarin treatment but did not provide comprehensive care required of a primary health care service, including care coordination and early identification and management of new issues. The records from Doomadgee Hospital did not mention a primary health care service and without coordination between hospital and primary care, the responsibility for primary health care appears to fall on the hospital. For a female patient with severe rheumatic heart disease, dental care, monthly penicillin prophylaxis and contraception should have been addressed (RHD Australia (ARF/RHD writing group), 2012)*".

490. Dr Schultz says when Kaya went to Burketown, she was immediately transferred to Mount Isa. For the reasons outlined above this is incorrect. She is critical of a clinician referring to Kaya as a 'very poor historian'. She commented, "*This statement about a seriously unwell teenager seems inappropriate and places blame on the patient for the inability of the clinician to elicit a useful history*".

491. Dr Schultz opined there was a need for more urgent referral from Townsville to Brisbane and then an inappropriate delay of Kaya's operation for dental procedures and other treatment. This view is contradicted by cardiologists. In evidence, Dr Schultz appropriately deferred to the opinions of the paediatric cardiologists who gave evidence at the inquest.

492. Further, Dr Schultz states that the logistics associated with accommodating her five escorts may have delayed her transfer. I accept there is no evidence of this in the record. There was evidence that a patient with a greater clinical need delayed Kaya's transfer. RSQ was solely responsible for triaging patients for transfer.

493. Dr Schultz was critical of the Doomadgee Hospital's attempts to prevent Kaya getting recurrent rheumatic fever, noting there was no reference to Penicillin injections. Further, that there was no discussion or note about contraception.

PART THREE

Themes identified during evidence

494. Throughout the inquest there were several themes which arose which were relevant to all of the deaths investigated.

495. Some of the themes are reflective of systemic issues regarding the provision of healthcare in the Doomadgee community and go beyond the narrow issue of RHD.

496. I note at this juncture that the written submissions on behalf of all represented parties at the conclusion of inquest by and large adopted the factual narrative as outlined by the Counsel Assisting in her comprehensive submissions, and

all submissions identified common themes, and with some minor adaption reflected and amplified the ultimate recommendations. This approach was reflective of the level of professionalism cooperation and respect with which all legal Counsel, their instructors and their clients approached the Inquest.

Tripartite Agreement and the Relationship between the Doomadgee Hospital (NWHHS) and Gidgee

497. Mr Solomon, the Chairperson of Gidgee said the impetus for establishing Gidgee primary health services in Doomadgee and other communities in the Lower Gulf was in part due to **the 2016 paper** 'The Health of the Lower Gulf: Case for Change' ('case for change paper'). In preparing his statement for inquest he had only been able to locate a draft version of this paper. He did not think there was any significant change between the draft and the final version.

498. The author of the case for change paper was Dr Barbara Schmidt. Dr Schmidt says the review was largely a desktop activity but that it had been informed by earlier and recent consultations to inform the WQPHN health needs assessment, the NWHHS strategic and clinical planning process, and Gidgee planning. In the '**Analysis of Key Issues'**, the author stated:

> *"The health service system analysis clearly demonstrates a fractured service delivery environment that potentially results in gaps and duplication in care, poor communication of care, and leads to an adverse impact on patient experiences and care outcomes."*

499. In the 2016 case for change paper, Dr Schmidt referred to the lack of integration which could be seen at three levels:

Organisational

- *No common frame of reference (ie shared mission, vision, values) between key health organisations servicing the Lower Gulf.*
- *Limited inter-organisational relationships in place (eg strategic alliance, joint commissioning, select contracting) between key health organisations servicing the Lower Gulf, including common governance mechanisms to deliver comprehensive services to Lower Gulf population.*
- *Previous planning exercises (of which there are many) and funding initiatives have promoted siloed services.*
- *Perceived trust and turf war issues amongst some service providers.*

Service

- *Services structured and organised around the needs of the services, not the parties.*
- *Limited coordinated care across local primary health care, visiting specialist, hospital and tertiary services (vertical integration).*

- *Limited coordinated care between health services, social care services and other care providers (horizontal integration)*
- *Perceived professional tribalism and turf wars.*

Clinical

- *Lack of coherent processes within and/or across professions to support coordinated care (e.g. shared treatment guidelines, clinical pathways, disease registers, recall systems)*
- *Limited joint multi-professional care planning and case management*
- *No shared clinical records across the multi-professional team.*
- *Limited clinical leadership*
- *Unclear clinical governance arrangements*

500. A Tripartite Agreement ('the Agreement') was signed by WQPHN, Gidgee and NWHHS in 2017. The agreement is not legally binding. It is said to provide 'authentic commitment' between the three parties to work together to improve the health of the Aboriginal and Torres Strait Island people in northwest Queensland.

501. The document is described as a high-level memorandum of understanding. It is a statement of commitment and describes the intention of the three stakeholders to work collectively to delivery health services across the northwest. Dr Rosengren stated:

> "*…it would be very difficult to performance manage a memorandum of understanding that does not have any explicit expectations around outcomes or deliverables next to it.*"

502. There are four key "agreement domains" canvassed in the Agreement, including Leadership, Quality, Workforce, and Model of Care.

503. Relevantly, under the heading '**Workforce**', the Agreement states the parties will:

> "*Jointly invest in a workforce development, education and employment pipeline that will support collaborative organisational structures and processes to harness human and community capability through both individuals and the community*".

504. Under the heading 'Model of Care', it states the parties will:

> "*Co-design and jointly implement a new primary health care model of care that is place based; clinically integrated; culturally informed; supported by evidence; and targeted towards key health improvement priorities. New models of care will promote effective coordination and integration across provider networks and focus on the patient journey. The adopted model will identify the clinical, cultural and social supports necessary to optimize health outcomes.*"

505. Mr Carey, the then Chief Executive of NWHHS, described the Agreement in the following terms:

> "*The Tripartite Agreement was established to facilitate collaboration, reduce duplication, and to focus on the delivery of integrated, culturally appropriate healthcare with a specific focus on Aboriginal and Torres Strait Island peoples and their communities within North West Queensland*."

506. As is clearly borne out by the evidence in this inquest, several, if not all of the issues identified by Dr Schmidt in the case for change paper in 2016 remain an issue in the provision of healthcare in Doomadgee today.

507. Dr Hamilton referred to the difficulties in the 'roll out' of Gidgee in the Doomadgee community in 2017 and throughout 2018. In an email of 29 November 2018, he wrote:

> "*Without being harsh we are attempting to merge two organisations with entirely different organisational philosophies, principle focus, and as it pertains to our industry shared medical knowledge. The issues currently reported at Doomadgee Hospital are largely the same issues as experienced in the first few weeks of the Gidgee Healing's 'soft roll out' as it was referred to 18 months prior. This is a very involved multi-layers series of failures that have resulted in Gidgee Healing admittedly not being able to accomplish what was promoted in the Doomadgee community 18 months ago. A miscalculation of implementing a complex task.*"

508. Mr Solomon thinks that, once the Tripartite Agreement was developed, Gidgee executives had met with the local Yellagundgimarra Aboriginal Health Council ('the Health Council'), a group of community members and Hospital and Gidgee staff on the ground to discuss what their intention was and to listen to the community's response.

509. Ms Blackman commenced as the CEO of Gidgee on 30 July 2018. She acknowledged the transition of moving towards the system of Gidgee providing primary health care and the Hospital providing acute care was not navigated well.

510. Ms Blackman confirmed in evidence that Gidgee did not have a clinical governance committee until the beginning of 2020. She placed it during this time because it coincided with the first outbreak of COVID-19. The purpose of the committee was to look at clinical governance for the organization as a whole, across all service areas from primary healthcare teams to human services.

511. Ms Blackman agreed clinical governance included the oversight of policies and procedures; complaint management; incident reporting; incident review; and an audit process. She conceded in evidence that, based on her experience, she would expect an organization to have had a clinical governance committee in place when setting up a health service such as Gidgee. She saw it as quite a large gap.

512. Ms Blackman accepted there was no clear role delineation between the services. With regard to the relationship between Gidgee and the Hospital, she stated:

> "*My experience was the communication and the style of communication between Gidgee and hospital staff was difficult, which then led absolutely to probably a relationship that broke down … I think where it broke down, though, was the relationship between Gidgee staff and hospital staff around exactly what this transition was.*"

513. Ms Blackman put a lot of the issues between Gidgee and the Hospital down to not being able to take over the lease for the Community Health building, which had been occupied by NWHHS. However, she referred to the need for collaboration between the two health service providers. She was challenged on the importance of obtaining the lease, and stated:

> "…*For me as a CEO, very important for our staff to feel like they belonged in a particular area, and without that particular, I guess, lease, let's say or that particular piece of paper that actually gives us licence to be in the building, we were actually made not welcome … The lease in some respects would have given the staff who were on the ground who were local people, a little bit more peace of mind that Gidgee actually does have a place here.* "

514. Mr Blackman explained there was capital works funding that was available to Gidgee once they obtained the lease. The plan was to make alterations with community input to give the community a sense of ownership of the building, in keeping with the ideologies at the foundation of Aboriginal community-controlled services.

515. The Model of Care in Doomadgee was discussed with Ms Blackman. She accepted that, in other areas, health services are delivered by way of an acute hospital with an attached community outpatient department, which are complemented by GP clinics out in the community, who may or may not also provide primary healthcare services.

516. It was accepted, because of the Tripartite Agreement, the longer-term plan was that Doomadgee Hospital would no longer provide a community health layer in Doomadgee. However, during the transition period, Community Health staff from the Hospital were working alongside Gidgee staff. Ms Blackman acknowledged there was crossover that needed navigating in terms of who did what or what could be undertaken collaboratively. She stated:

> "*I know that we both could have done probably better on both parts there because there was definitely some cross-over in terms of what the hospital existing model was and what Gidgee was actually bringing to the community*".

517. Ms Blackman accepted that the confusion with the change of model of care in Doomadgee was the source of major communication issues between the services and that there was no clear role delineation between the two services. Ms Blackman agreed the present model of care in Doomadgee is a "*very unique model of care*". She acknowledged there needs to be additional processes not in practice in other models of care, or consideration of a hybrid model of care shared between Gidgee and the Doomadgee Hospital.

518. With respect to alternative models of care, the following proposition was put to Ms Blackman, and she responded accordingly (in bold):

> "*Would it make sense also that, for example, there was an opportunity for the community to know that it was one service, a health service that is a combined health service, providing services to Doomadgee, that the patient presents to the service, the combined service, and they are guided to whatever is the appropriate service within that facility, be it a combined facility physically or not, but they are then directed as to where is best met for their services and that there is that collaboration that occurs in their – in their care?---**Yes, absolutely. I'd absolutely agree with you on that one".***

519. Regarding the viability of a hybrid model, Ms Blackman noted that relationships between Gidgee, the Doomadgee Hospital and the NWHHS needs to be repaired and there needs to be delineation of roles. She stated, "*There's a lot more things that need to be realised before a hybrid model can become a reality, I think.*"

520. Similarly, Mr Solomon is of the view there needs to be some restorative work undertaken between the clinicians from Gidgee and the Doomadgee Hospital before considering and implementing new systems and processes. He suggested the involvement of a community leader to help facilitate such a process *"around play*[ing] *nicely in the sand together*".

521. Ms Blackman confirmed Gidgee had not been resourced to provide the level of service it was attempting to provide to the community. A population the size of Doomadgee required two GPs working in a clinic such as Gidgee. She stated:

> "…*if I go by a workforce model that we apply across an Aboriginal community controlled model, I would absolutely say no. A population like Doomadgee requires permanent full-time GPs, we are unable to, one, give Doomadgee specific funding to be able to do that; two, we're unable to accommodate that, and then alongside the two GPs comes the complementary team in terms of your nursing breakdown as well as Aboriginal health workers.*"

522. With respect to the roll-out of Gidgee in accordance with the Tripartite Agreement, Ms Blackman is of the view that there was a lack of strong and robust corporate services at Gidgee behind the scenes.

523. Ms Savo, the Lower Gulf Primary Health Manager of Gidgee, said that the Tripartite Agreement predated her employment but observed that there were inconsistencies in how it had been rolled out across different locations in the Lower Gulf. She confirmed that the agreement still is yet to be fully operationalized across the whole region. She spoke of the Agreement in the following terms:

> *"I guess a really sort of great plan up at the executive level to sort of improve consistent health service deliveries around the footprint, it was never really greatly operationalised throughout the region and it's – it's diverse in different regions… I feel the resources weren't there to support this great plan above us."*

524. Ms Savo said that the community's understanding of Gidgee and NWHHS is largely impacted by the communication and collaboration between the two practices. She stated, "*The communication between NWHHS and Gidgee Healing regarding services planning and development, and day to day interactions had been challenging at times.*"

525. Ms Savo acknowledged there can sometimes be a lack of agreement between Gidgee and NWHHS as to who is responsible for the provision of certain services, which has led to tensions between the staff of Gidgee and NWHHS on occasion. She stated:

> "*I think more effort is needed to define the acute and primary care local pathways and protocols between the practices and communicate this to patients. The communications also need to be more flexible and responsive during periods when there are doctor shortages, and during after-hours.*"

526. Nurse Salem said there were no documented arrangements for Gidgee to, as a strict rule, to take over a patient's primary healthcare. Gidgee is a primary health provider and provides primary health care treatments to patients on a case-by-case basis in accordance with their needs and Gidgee's resources.

527. In November 2020, the WQPHN contracted the Global Substance Use and Mental Health Unit within the Centre for Health Services Research at The University of Queensland to conduct an independent evaluation of the Tripartite Agreement's progress, specifically in terms of its system leadership, engagement and co-design, culture and attitude, integration, and cultural appropriateness. The evaluation was completed on or about 4 March 2021 ('the evaluation').

528. The findings of the evaluation were informed by findings from semi-structured interviews with 21 key informants. The researcher found that, while the majority of key informants praised the Agreement, there were areas for potential improvement identified, as follows:

    i. *Increased visibility of the Agreement document to the wider community;*

    ii. *Proactive response to the impact of staff turnover at senior organisational levels;*

    iii. *Improved engagement and devolution of responsibility to all levels of relevant staff members to ensure meaningful support and buy in;*

    iv. *Enhanced consultation and engagement with community-based stakeholders and consumers in ensuring that the Agreement responds appropriately to local context and need and is culturally appropriate;*

    v. *Improved key performance indicators to measure the Agreement's progress;*

    vi. *Greater integration and interoperability across IT systems to enable effective sharing of data and patient records;*

    vii. *Actively addressing of institutional racism to improve cultural safety of the health system.*

529. The researcher made 15 recommendations. They are not set out in full herein. **Five** recommendations relevant to the inquest include:

    a. *Consider the implementation of measurable indicators through*

which to monitor the performance of system and health outcomes and allow for accountability and continuous quality improvement;

b. *Consider a review of current data management systems, data sharing and reporting arrangements to support shared population level health improvement targets, clinical integration, and reduce fragmentation of patient information and care pathways;*

c. *Promote joint commissioning and shared investment to leverage from existing arrangements and explore further shared integrated models (e.g. infrastructure and workforce) at a regional and community level to assist the outcome measure of the Agreement;*

d. *Continue to enable self-determination and community leadership through shared decision making and supporting a coherent touchpoint for primary care engagement (i.e. consistent messaging from partner organisations);*

e. *Consider opportunities to build shared business models including refining roles and responsibilities of organisations.*

530. Mr Carey advised that no action is currently being taken internally in relation to the evaluation or its outcomes. He said the evaluation was brought about by the WQPHN COVID-19 response and strategies. He noted the qualitative nature of the review but did not disagree with any of the recommendations that had been made. He advised that, although they have not been taken up by any of the organisations, there was continued engagement between the parties. He acknowledged there was a recognition of the need for a *"significant refresh"* of the Tripartite Agreement.

531. Again, the issues identified in the evaluation remain a problem regarding the provision of health service in Doomadgee.

532. Overall, Mr Carey conceded the inquest had revealed the following systemic issues between NWHHS and other services, extending beyond the discrete issue of RHD:

a. Significant concerns around role confusion;

b. Issues with information-sharing;

c. Patients falling between the gaps of Gidgee and NWHHS services;

d. Gidgee not being able to undertake the intended scope of work due to resourcing issues; and

e. Communication issues between the clinicians at NWHHS and Gidgee.

533. He stated that, *"These proceedings have shone the light on areas that clearly need to be addressed, and so going back to the point of whether or not it's useful to do another plan, we are currently deliberating … in terms of whether or not the focus is on further evaluation and review, or whether or not the focus of our energy is on other areas for collaboration similar to the collaboration that's been*

demonstrated over the last few months, specifically in relation to rheumatic heart disease."

534. Dr Rosengren, the Chief Operating Officer of Queensland Health, described the difficulty in providing healthcare in Doomadgee. He stated:

> *"I think it is very challenging in a community like Doomadgee, and Doomadgee's just one example, to understand how to properly navigate the health system, and we all have an absolute commitment to self-determination and community controlled health environments, particularly in the primary care setting, but in doing so I think we've created a further level of complexity for community. I think when you attend Doomadgee, do I turn right or do I turn left. Do I go here, do I go there. Do I have confidence here, do I have confidence there. Are they open? Is there a doctor here? Is there a doctor there? Who does what?* ***I think in the best interests of delivering on our obligations around closing the gap and health equity, I think we've created an additional complexity that we haven't found a solution to, and we have – we've added a layer of difficulty, and I'm not saying it's right or wrong****."*

535. Dr Mary Anderson did not believe Doomadgee was functional when she was working there. She explained this was because the two health providers did not communicate and were operating separately. As a result, she did not understand her patients as well as she should have. Mr Solomon, the Chairman of Gidgee agreed the current arrangement for the provision of healthcare in Doomadgee is dysfunctional.

536. DON Asgar was of the view that the most important issue for Gidgee is to be appropriately and adequately resourced to provide a service to the Doomadgee community. In her view, this is currently not happening.

537. Nurse Salem confirmed that there were miscommunications between services in relation to clinicians knowing who is doing what for patients. She stated:

> "*It is confusing. If you're in Mount Isa, there's total separation from the two institutions. But because Doomadgee is so small, there's this crossover. And it's never been able to be clearly defined. So we rely on those morning meetings which have become a bit diluted on the content that we've been given. So we try and communicate things, who's serious and who needs to be followed up, what are the issues. But yes, I can't tell you whether things are still happening like that.*"

538. Mr Solomon made his own observations on the issue:

> *"…I think a key factor is just people, whether that's clinicians, community, executives, government, and everybody just I think needs to really commit to listening and a big part of that, I think …* ***if I'm honest, the Doomadgee community's voice is somehow has been lost in this, and all the stakeholder true commitment to hearing that and listening to that, and allowing that to inform behaviour and policy and resourcing.*** *That to me is where a refocused effort by everybody should be, might actually address some of these ongoing issues. But also recognizing that it's not a quick fix. It's a long term commitment and it's going to take time."* (emphasis added)

539. Dr Wenitong stated, "*In my opinion there is a need for an up-to-date service level agreement between GH* [Gidgee Healing] *and QH* [Queensland Health]

as to the coordination of their various services including medication supply and who is funded to manage the RHD programs".

540. Mr Troy Fraser, the CEO of the Shire Council, described the situation between Gidgee and the Hospital as *"them two flexing who have the biggest biceps"*. Using this analogy, he went on to explain the importance of self-determination by the community in moving forward:

> "*The way that we change that is that community flex it. We've got the biggest biceps. So you've got to come with ours, with what we see … We've just got to change that strategic approach around*".

541. Mr Sandy expressed his hope for Doomadgee healthcare in the following terms: *"We just need better - better health care up here. Hopefully one day we'll all work together and not against each other*".

Bicillin Injections

542. Bicillin injections are 84-96% effective in treating RHD and oral penicillin is 56 to 64% effective. The 2020 RHD Guideline states:

> "*Oral penicillin should be reserved for patients who experience bleeding problems following injection, and for those who consistently decline intramuscular BPG despite attempts to identify and address the barriers to injections*.
>
> …
>
> *If a patient is provided with oral penicillin, the consequences of missed doses must be clearly emphasised, and the patient carefully monitored for Strep A infections and recurring symptoms of ARF*."

543. There are inherent limitations within the current RHD database in attempting to extract data reflecting population level monitoring at a prior given point in time. The data can be skewed by movement, death, or inactivity of an individual client, or the addition of newly diagnosed patients in the intervening period between points of extraction. That said, the data provided at the outset of the inquest suggests there had been a decrease in adherence to Bicillin injections in Doomadgee:

Adherence (%)	**1 May 2019 – 1 May 2020**	**11 August 2021 – 11 August 2022**
Nil recorded	8%	2%
1-49%	32%	49%
50-79%	39%	38%
80-99%	4%	6%
100%	17%	4%
Clients on Bicillin	48	47

544. Prior to Gidgee commencing operation in Doomadgee, the management of RHD patients (including the administration of Bicillin injections) was conducted by the Doomadgee Hospital. The inquest did not consider the level or appropriateness of that care, including historical adherence to Bicillin injections.

545. There was however evidence received at the inquest about training and resources specific to RHD that were provided at the Hospital. Nurse Grogan, who commenced working in Doomadgee in 2018 as a Graduate Nurse, recalled that DON Asgar had encouraged all staff to undertake the six online education models on ARF and RHD Australia.

546. Nurse Grogan also referred to the Hospital having an 'RHD book', which listed RHD patients, the date of their last Bicillin injection and when it was next due. It also included some resources and information that could be provided to patients.

547. Similarly, both the Hospital and Gidgee would receive a monthly email from the RHD Register with an identical list of patients' names, the date of their last Bicillin injection and when it is next due.

548. DON Asgar advised that since December 2018, patients with chronic conditions such as RHD were managed by Gidgee as the primary healthcare provider. The Hospital continued to care for RHD patients who presented to the ED but referred them to Gidgee where appropriate.

549. In late 2019, Gidgee informed DON Asgar that they would be following up on all RHD patients to avoid duplication of service. She understood there would be increased effort and resources on Gidgee's part to ensure follow up of all clients for Bicillin injections, especially those under 21 years of age.

550. DON Asgar was aware of only three patients (out of the total of approximately 47 patients) requiring Bicillin injections in Doomadgee who chose to continue going to the Hospital for their follow up. Her understanding is that Gidgee is responsible for the remainder of the patients.

551. Nurse Salem said there was a slow merging of various responsibilities being handed over from the Hospital to Gidgee. From her perspective there was no official handing over of Bicillin patients. She stated:

> *"We've always worked collaboratively. The hospital – the patients have always had a right to choose where they go to. So we've all worked at – and it's something still discussed at the morning meeting every morning. We all get that monthly report at the beginning of the month, and we look through, we discuss if we know people are in town, not in town. We ask our local workers, our people in town. So it's still very much collaborative."*

552. I am of the view there is sufficient evidence to support that Gidgee was responsible for the monitoring of all patients in Doomadgee who required Bicillin injections unless the patient specifically requested to have their injections at the Hospital.

553. Prior to Gidgee taking over the RHD patients, the Hospital had a Registered Nurse (referred to as the 'RHD Nurse') who was responsible for:

a. Orientating new staff about the resources available at the hospital about RHD;

b. Faxing or emailing RHD patient list at the end of each month to the RHD register; and

c. Receiving and reviewing emails from the RHD Clinical Nurse Consultant (based in Mount Isa) regarding ongoing patient care or queries which were then referred to the Medical Officer or Community Health Nurse Practitioner for follow up.

554. Nurse Grogan said that once Gidgee took over the management of RHD patients, if a patient presented to the Hospital, staff would email the RHD Register and copy the correspondence to Gidgee, along with the Mount Isa RHD outreach nurse to notify them that the patient had received their Bicillin injection.

555. Nurse Salem's evidence suggests there was no policy or procedure guide in place for the management of RHD patients by Gidgee when they commenced operations in Doomadgee.

556. When referred to the 'Gidgee Healing Chronic Disease Care Protocol', Nurse Salem stated that it had been developed by Dr Marjad Page, the Chief Medical Officer at Gidgee, when the numbers of RHD patients in the community were fully appreciated. She elaborated:

> *"I would believe that Gidgee didn't know what type of problems would be faced. They would assume that it would be the normal cardiac issues and diabetes and that. But this became very predominant as we went along and engaged more people. So we grew and understood the scope was taking other things."*

557. In its early days, Gidgee had a transport driver and a community liaison officer ('CLO').

558. The CLO's role was to ensure staff were being culturally appropriate and adhered to the local traditions and cultural beliefs. Nurse Salem said they did not have sufficient staff to leave the clinic and conduct home visits, so relied on the CLO and driver to try and engage patients in community. These positions became vacant in or around 2020 and were not filled.

559. Nurse Salem noted there were hurdles to following up and maintaining contact with patients by usual means. Many patients do not have a phone or share one with relatives; transience and illiteracy are obstacles to delivering letters; and appointment times are ineffective. The use of IHWs and providing transport were helpful when available.

560. DON Asgar reported that Gidgee was not completing care plans for patients suffering from RHD and other chronic conditions, contrary to what is required of primary healthcare providers. Nurse Salem said that nurse practitioners are denied the ability to do a management plan through Medicare funding. She accepted that, as the primary health care provider, there should have been a detailed health care plan in place for such patients, but she had not seen that occur during her time at Gidgee.

561. Since the media interest garnered by these deaths (the Four Corners story 'Heart Failure' was televised by ABC in March 2022), Nurse Salem said there had been huge local interest in RHD and there are now weekly meetings. She said that lots of people are telling Gidgee that they were behind in giving Bicillin injections, but resourcing was a hurdle: "*We still only have one nurse on the ground*".

562. Nurse Salem went on to state:

> *"We get told we're behind in injections by committees. State committees, area committees. Everyone's online telling us that we're behind and how can this happen when you've got one RN and one NP looking after 1,400 people. And there's over 100 depot injections, 47 Bicillins, mental health depots as well as all the chronic diseases. It's a little stretching to try and do it all."*

563. DON Asgar said that, since it had become known that Bicillin injections were overdue and there was a need for a RHD nurse on the ground, the NWHHS had added more positions in Mount Isa dedicated to RHD and were assisting Gidgee to bring patients into the clinic. There are also daily meetings to try and facilitate patients receiving timely injections.

564. Ms Savo said that Gidgee was finalising recruitment of a Care Coordinator, with a large part of the role envisaged to include managing the RHD portfolio in collaboration with the Family Health Team at Gidgee and external stakeholders.

565. By the time of the inquest hearings, Ms Savo confirmed that a person had recently commenced in the Care Coordinator role, and that he would be responsible for supporting specialist telehealth and outreach services, follow up, transport and other issues for RHD patients. The role is based in Mount Isa with fortnightly visits to Doomadgee, with support provided by a health worker at the local Gidgee clinic in for follow ups in the meantime. This role is in addition to the number of roles created by NWHHS to specifically address RHD within their catchment area.

566. Nurse Salem acknowledged the workload at Gidgee did not allow them to go into the community to follow up patients who required Bicillin injections. Nurse Salem thought the drop in Bicillin adherence statistics reflected the loss of stable staff, especially the driver and health worker, who were able to proactively bring patients into the clinic. She stated:

> "*I think that data reflects when we had stable staff at the time, bringing them in. COVID has mucked up everything. A lot of people couldn't come from their usual places to go to work up there. And I think that data, although it's still poor, it shows a higher success rate when we had systems in place and good people who were willing to go and chase these people and ask them, 'Would you like to come in.'*"

567. Nurse Salem agreed that usual methods of follow up and patient engagement is not working in Doomadgee, and that change was required to go out into the community to deliver this type of service.

568. Ms McKenna thought the decrease in rates of Bicillin injections were not unique

to Doomadgee and said COVID-19 has played a large role. People have been unwilling or unable to go to their primary healthcare providers. There has also been the loss of stable staff and issues with the transience of staff, which has made it difficult for patients to get an appointment.

569. In a paper submitted to the inquest by the National Aboriginal Community Controlled Health Organisation ('NACCHO'), it read:

> "*One of the major factors contributing to low prophylaxis delivery in Doomadgee is a decrease in clinician long term retention, and an increase in fly-in-fly-out or locum clinicians. This erosion of the local workforce decreases trust between clinicians and patients/carers and makes the current workforce model unsustainable for both health care workers and the community.*"

570. The relationship of trust between health services, clinicians, patients, and the community are explored further below.

Screening for RHD

571. Screening programs for RHD involving visiting paediatric cardiologists occur in Doomadgee (and other remote Aboriginal communities in Queensland) approximately every two to three years. These initiatives are ad hoc in nature and have grown organically as the result of the interests of individual clinicians such as Drs Justo, Reeves, Remenyi, and others.

572. Dr Rosengren aptly remarked in his evidence that *"a screening program in a remote community is only as good as the people it captures on any given day."* The ability of these screening programs to capture the largest possible portion of the Doomadgee population has depended largely upon community engagement by local school and health services to identify eligible children and obtain the family's consent to assess them before the screening team arrives in community, as well as the level of school attendance on the day.

573. Both Dr Justo and Dr Reeves spoke of a renewed focus on community engagement for their most recent screening trip in 2022, in the hopes of increasing local participation and understanding of their program. Ms Barclay, a Director and Secretary of the local Health Council, also spoke of the Health Council's role in promoting the dates for the screening program over the radio.

574. Ms Savo said that Gidgee has incorporated a RHD screening process as part of Gidgee's everyday practice. The purpose is to upskill frontline staff in RHD assessments and allow clinicians to take appropriate action should a community member present to the clinic with ARF/RHD symptoms. This is in line with the Queensland Government's investment in primary healthcare services, which Dr Rosengren was for the purpose of performing "screening" by way of detecting sore throats, skin infections and abnormal cardiovascular status.

575. The viability of training nurse practitioners or other healthcare workers in using echocardiograms for screening was explored throughout the course of evidence; the idea being that patients could be remotely screened for RHD by

a clinician onsite in Doomadgee capturing the images and having those interpreted by cardiologists in metropolitan centres.

576. Dr Rosengren explained that Queensland Health is presently reviewing whether expert or non-expert models of screening best aligned with the targets and objectives of the 'RHD Strategy 2021 – 2024' and hoped to resolve this by January 2024.

577. Dr Kelly cautioned against a non-expert model. He explained that there was a high level of skill involved in taking and interpreting echocardiogram images for the purposes of screening such a complicated heart problem. Dr Kelly added that there was potential harm in families being falsely reassured by inaccurate Echo results and that abnormalities could be missed. Dr Reeves also expressed concerns surrounding quality control and supervision, as well as the huge additional workload it would place on the cardiologists who would be interpreting the images.

Training and information available to Health Professionals

578. Dr Anderson advised she had no certified training in ARF or RHD specifically, although it had formed one aspect of her training in chronic diseases and Indigenous medicine throughout her career. The Locum Orientation Handbook she was provided had no information concerning ARF and RHD. However, she was familiar with the RHD Guidelines. She was also aware of resources such as access to outreach services, community nurses and RFDS retrieval services. She received no formal cultural training through NWHHS but had undertaken online training of this nature through other hospitals.

579. Dr Hamilton commenced in Doomadgee in 2011. He did not recall receiving any direct education concerning ARF or RHD nor any resources specific to these conditions at Doomadgee Hospital. He said that there may not have been sufficient resources for clinicians at Doomadgee on this topic, but it was his responsibility as a medical practitioner to inform himself. He referred to the RHD Guidelines and phone application and had access to information available on the Queensland Health intranet. He had received cultural training in 2011 and has since obtained an Advanced Skills Training in Aboriginal and Torres Strait Islander Health from his medical college.

580. Nurse Grogan did not recall receiving any face-to-face education on ARF or RHD. During 2019, she completed six online clinical education modules in relation to ARF and RHD on the RHD Australia website. The modules are updated so it is necessary to redo the education modules once this occurred. The training was not mandatory but was undertaken at the encouragement of the DON. There was also an RHD folder at the hospital with resources and educational material on ARF and RHD for patients. She said that, on occasion, she had contacted RHD Queensland for advice. During her orientation week as a Graduate Nurse at NWHHS, she had undertaken face-to-face cultural training from a local Indigenous person in Mount Isa. She completed a mandatory online training program about Aboriginal and Torres

Strait Island Cultural Practice in 2018.

581. DON Asgar said that she had undertaken the cultural training provided by the NWHHS including online training and a face-to-face component running 4 hours, which was required to be completed every 5 years. There was no cultural training specific to Doomadgee. DON Asgar told the Court that her cultural education was "*ongoing every day*" and that she had learnt the most from local elders, a local indigenous healthcare worker and the Health Council.

582. A number of these clinicians working at Doomadgee Hospital were aware of local customs but were not specifically familiar with the Queensland Health document 'Sad News, Sorry Business' nor the convention of having another Indigenous person inform a family of a loved one's passing.

583. Nurse Practitioner Salem said it is common for staff at Gidgee to use the resources available on the RHD Australia website. She said that each Aboriginal Medical Service generally has their own training encompassing local traditions and lore that are connected to healthcare. She said that her practice manager at Gidgee, an Indigenous man local to Doomadgee, had set aside a whole day for cultural training specific to that area. As a First Nations woman, she acknowledged that it was a privilege to come into community and learn the traditions unique to every mob.

Communication between Gidgee and the Doomadgee Hospital

584. There was a lot of evidence about communication issues between Gidgee and the Hospital staff. This ranged from interpersonal conflict and the different views on conducting clinical handover meetings each morning, through to electronic patient records not being accessible by the reciprocal health service.

585. Since the arrival of Gidgee to the Doomadgee community, there appears to have been issues with communication and in particular the daily handover meetings between the Hospital and Gidgee.

586. In addition, there were issues identified with documentation and the ability to share clinical records between services. The Hospital uses (at least) three sources to document patient care including a hard copy paper chart, EDIS system for presentations to ED, and Communicare for outpatient clinics and Community Health. Furthermore, the Flying Doctors and Mental Health services also have different record keeping systems. Gidgee used another platform, Best Practice. None of the electronic platforms are integrated.

587. Ms Blackman was of the view, from her time and experience as CEO at Gidgee, that the style of communication between Gidgee and the Doomadgee Hospital staff was difficult, which led to a breakdown in the relationship. Ms Blackman stated:

> "…*Without the morning meetings understanding what was coming out of the hospital to provide care in community, there was absolutely a break down there*".

588. Ms Savo advised that the meetings are working well presently and have

improved since the time of these deaths. They are run professionally with an agenda and minutes recorded and she is confident that they are productive. The meetings canvass every ED presentation overnight and every Bicillin injection that has been administered and provides handover for Gidgee to follow up. According to Nurse Salem, this did not occur for every patient previously. Ms Savo believes that there is now less potential for patients such as Betty and Ms Sandy being lost to follow up in community after hospital presentations.

589. Nurse Grogan also believed that communication has improved between Gidgee and the Doomadgee Hospital in recent times, after the hospital was provided a laptop with access to Gidgee records. She was unable to recall the date when this occurred but estimated that occurred in 2021 (within the last 12 months). In practice, she said hospital staff were now looking across multiple record systems to get a full picture of a patient's history. Nurse Grogan added that it would be useful to have some integration of the systems but understood the need for separation between the two.

590. Ms Blackman acknowledged there was an issue with information sharing through the services. She stated:

> "*I think the missing link there was commonality in terms of that transition around the training, in terms of accessibility to that record, and making sure that each and every person that accessed Best Practice or even a hospital record understood the protocols or the way to be able to interact in those systems*".

591. Ms Savo referred to a written document being developed with the input from Gidgee and NWHHS. It is aimed for the document to formally outline the required daily communications, weekly meetings, regional monthly meetings, ongoing communications, and review process between the practices, when dealing with patients diagnosed with ARF/RHD. The document also provides the relevant RHD service contacts at both Gidgee and NWHHS.

592. Up until recently, outpatient clinics were still being managed by the Doomadgee Hospital Community Health staff because Gidgee was still in 'transition'. Ms Savo advised that, Gidgee took over coordinating the outreach services at the end of 2021. She was unsure what the Doomadgee Hospital Community Health staff are doing now that Gidgee has taken that on.

593. The outreach services are provided from other Queensland Health sites, for example Dr Justo from QCH or clinicians from Mount Isa. They are documenting their clinical findings in Communicare. However, Gidgee staff running the clinic do not have access to Communicare and will document their notes in Best Practice. The doctors provide a written script, and it has to be scanned and then uploaded to Best Practice by Gidgee. This issue was explored with Nurse Salem, and she responded accordingly (in bold):

> "*So can you see that that's problematic, in the sense that you've got clinicians providing services to your [indistinct]. They're not your patients, but shared patients, but they're in Gidgee Healing and they're Gidgee Healing patients, and they're being seen. And you as a clinician is there with them, but you can't document in their notes, and they can't document in your notes?---**I have a lot of issue with it. They're Queensland Health staff, and yet Gidgee have to attend to them instead of the Queensland Health Community staff***

attending to the Queensland Health staff, who are visiting, and then providing a summary at the end, a written summary so you're not doing it on hearsay or somebody telling you to update something. And so now the one RN and one nurse practitioner has taken on yet another role."

594. Further, Nurse Salem said:

> "*So normally any AMS* [Aboriginal Medical Service] *doesn't play host to Queensland Health staff in a Queensland building to have to do things and not be able to access their notes. If a visiting specialist comes to any other AMS they have to use the notes that are there. So there's blurred – there's still blurring between roles*".

595. Nurse Salem went on to accept that this "blurring" was, in fact, better characterized as a "complete and utter disjunct" between the two services.

596. Both Dr Schultz (NT) and Dr Kelly (SA) referred to 'My Health Record' as a central repository for sharing of information such as referrals and discharge summaries. Dr Stevens observed that the current practice within Queensland Health was that only a formal discharge summary following a hospital admission would be uploaded to 'My Health Record', whereas there would be no documentation for an emergency presentation without a formal discharge plan.

597. Dr Reeves suggested that a national-based RHD Register covering all jurisdictions that is freely available to all clinicians practicing in this area would assist in improving access to information across services, noting that this already occurs for the National Immunisation Register.

Cultural Safety

598. Ms Barclay, as a Waanyi woman, expressed what cultural safety meant to her, saying:

> *"I can go to a service and I can be respected for being an Aboriginal woman and I can get the best service possible without fear of either being discriminated or being victimized by an employee of that service."*

599. In her opinion, Gidgee was not fulfilling its ideal of being a community-controlled health organization, as it was based in Mount Isa and is perceived by the community as a Mount Isa Aboriginal Medical Service.

Language

600. There were references by Dr Schultz and the RHD Australia witnesses (Ms Wade and Professor Ralph) regarding the use of prejudicial language used by clinicians. It was agreed that language matters and, in that respect, Professor Ralph stated:

> "*I think language – the most important thing, I think, is that it's – it's the individual sometimes interprets it. There is some unconscious bias, sometimes but most importantly is that people, the nurses, the Allied Health, there's so many people that access medical records that can then form a judgment of*

somebody without even knowing. That's – that's the main thing. A lot of medical records and the language we use has the potential to perpetrate stereotyping."

601. Professor Ralph gave the specific example of the terminology "non-compliance". She explained that the term was not widely used in contemporary practice and practitioners should be discouraged from using it as a descriptor, as it tends to impliedly blame a patient for their own health outcomes. She said "non-adherence" is preferred.

602. Dr Stevens noted some of the language used in Ms Sandy's clinical record demonstrated medical paternalism. He agreed that "non-compliance" was an example of troubling language and has the potential to unconsciously lead to bias in the decision-making process. He also took issue with the use of "failure to attend", considering it a negative term to be avoided. He stated:

> "*I think it would be reasonable for Queensland Health to bring to the attention how some language is used in a negative light*".

603. Dr Rosengren was adamant that he had no issue with the use of the acronym "DNA" (did not attend) or "failure to attend" as a descriptor in medical records. He characterized these as factual statements that do not carry negative connotation. In his view, the use of such language is not a value judgement but acts as a trigger point for Queensland Health staff to escalate attempts to try and engage with the person and their care in a more meaningful way.

604. Professor Ralph accepted that if there was a process of follow up around "failure to attend" then that is appropriate. However, in a small community such as Doomadgee she questioned why there was not a transport system that can go out into the community and provide outreach or bring patients back into the clinic.

605. Similarly, Dr Rosengren did not see any issue with the use of "non-compliance" as a descriptor in medical records. Again, he considers it is a factual statement describing what has occurred. It is important information to help understand the clinical reason why a patient is accessing or receiving care, as opposed to a judgment by a clinician.

Sad News, Sorry Business

606. Dr Wenitong referred to the Queensland Health Guideline, '**Sad News, Sorry Business**' and that there was no indication the document had been followed regarding Ms Sandy's death (specifically in relation to the use of IHWs). He subsequently accepted that the role played by Ms Peter of the QAS on that day was entirely appropriate.

607. Several clinicians were taken to the 'Sad News, Sorry Business' during evidence with many not having seen or heard of the document before. Dr Rosengren said the document is widely referenced through Queensland Health's' very accessible digital platforms. There is a direct links from the Queensland Health cultural capability page and multiple other platforms. He stated:

> "*There's no restriction to access to it, and so any reflection that you're seeing will be simply challenges around awareness to prompt people around it. We do have mandatory expectations around cultural capability training where we profiles and – and make those sorts of documents readily accessible and available*".

608. As observed by Dr Rosengren, all health services have cultural capability programs internally as part of their own obligations and commitments.

Cultural Training

609. Many witnesses were asked about cultural training during the inquest. The overwhelming response was that they had completed some form of either face to face or online training. This was canvassed above under the heading 'Training and information available to Health Professionals'.

610. Professor Ralph was of the view that online mandatory type training is not very effective at impacting a clinician's actual day to day practice. She expressed that *"so- called mandatory cultural safety training doesn't always quite hit the mark in terms of actually truly changing the behaviour that matters at the coalface.*"

611. She suggested that a better approach was through an apprenticeship model where people can demonstrate and observe cultural safety in practice. She believed that cultural training needs to be ongoing, and on the job led by senior clinicians who provide the modelling of how to provide safe medical care. She stated:

> "…*if you've got Aboriginal health practitioners and other Aboriginal experts in the room during handover to help modify the language that's being used about patients, for instance, I think people are going to be less likely to speak pejoratively of the patients, for instance, during handover, which is something I've seen an awful lot of over the many years of working in Aboriginal health.*"

612. In addition to these suggestions for modelling and having Aboriginal health professionals employed to advocate for patients, Professor Ralph referred to the need for an ongoing reflective process. She referred to a tool developed by Menzies **'Ask the Specialist'**, a podcast over a seven-week timeframe with a one-hour reflective exercises based on the context of the podcast. The Specialists are Aboriginal people who are leaders in their community and have experience in the health system. They answer doctors' questions about how to treat Aboriginal patients in hospitals. Regarding this suggested strategy, Dr Ralph stated:

> "*So that's a sort of model that can – is likely to work best. It's obviously fairly labour-intensive, and it's not as easy as just doing online mandatory tickbox training or just providing a one-off thing during orientation. But if we want to get this right, we have to do it properly."*

613. Mr Solomon is contracted to NWHHS, acting as their clinical capability officer for several years. In this role, he delivers the cultural capability training mandated by Queensland Health. He explained that the training is provided for

four hours, within the broader three-day orientation program. The program was developed in Brisbane under the '**Making Tracks'** framework and focuses upon principles of cultural capability that is localized for the North West but does not focus upon any individual groups across the region. Mr Solomon said there was scope to develop community-specific cultural capability training onsite, which would require additional investment and essential feedback from the community.

614. Mr Solomon explained there is a difference between cultural capability and cultural safety. He sees cultural safety as a person's ability to hear and listen to whether an Indigenous person is feeling culturally safe. It is centred on an individual practitioner and their culture and attitudes, and, in his view, it cannot be taught in a four-hour session on the ground but should happen in situ on a ward or in a direct community, primary health care setting. He said these skills are best built *"when you're actually on the ground engaging with a Gangalidda person if they're identifying as that"*.

Community Involvement

615. Ms Wade acknowledged the difficulty of recruiting to Doomadgee and suggested the need to use members of the community who can act as 'care navigators' or advocates for a patient. She believed that would make a big difference to building trust and rapport and breaking down the barriers. She stated:

> "*You have the Aboriginal views of health, their culture and you have western views of health and the predominant cultures that the doctors and nurses bring with them. So you could combat that by having an advocate or a care navigator coming from the community that comes into the hospital in critical time and just to – even just talk to the doctors, talk to the nurses around culture, around the law and the policies that the community has. So the cultural policies are really important and that then can help the – this building up the trust and rapport of the communities, particularly with the fly in and fly outs where there's really no time other than band aid – I think to me sometimes it's band aid service*".

616. Mr Doomadgee, a close relative of Ms Sandy and Kaya, proposed a "guardian angel" service akin to the role Murri Watch plays in watchhouses. This person would act as a conduit between Indigenous families and health professionals, as well as advocating for the best interests of the patient. He said that this role would be best placed independently to Queensland Health or Gidgee, so there is no conflict of duties. It could be a member of the community or an outsider who receives appropriate training in the community.

617. Mr Barry Walden, an Elder in the Doomadgee community, agreed that there would be benefit in a role like this, particularly if it was filled by a local Indigenous person who understood the traditional family groups and recognized the people with the appropriate cultural authority to speak on behalf of their family (i.e. "Jungai"). He agreed that this service was valuable and worthy of payment and should be independent from Queensland Health.

Metal Cage at the Hospital

618. Until recently the hospital had an old waiting area for patients after they had seen the doctor. The waiting area ante-room had a Crim Safe mesh window with an open slot at the bottom to allow paperwork and medications to be passed through it. The "metal cage" at the hospital was described as prison-like in appearance by family members of the deceased women and there was a perception that it was designed to "*block us out*".

619. Dr Hamilton recalled the Crim Safe mesh from his time at Doomadgee Hospital and, although he was not involved in the decision to install it, he understood that its purpose was to protect the facility and keep it operational 24 hours a day. He acknowledged that it was probably culturally insensitive and remarked, *"It looks horrible for 99 per cent of people that are doing the right thing. But it actually keeps the windows from being destroyed on occasion"*, and therefore kept the hospital open and running.

620. The people of Doomadgee understandably found the structure confronting and I accept it would have sent a clear message to the community of being 'other'.

621. The mesh has since been removed.

PART 4
Coronial Issues

Coronial Issue 1

The findings required by s45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused their deaths.

Betty

622. I find that:

a. The identity of the deceased person is **Yvette Michelle Wilma Booth ("Betty")**.

b. On 23 September 2019, Betty presented to the Doomadgee Hospital Emergency Department with shortness of breath and rapid atrial fibrillation. She was diagnosed with pneumonia following a chest x-ray. This was on the background of symptomatic heart failure secondary to having been diagnosed with severe Rheumatic Heart Disease on 26 July 2019. Betty deteriorated and went into cardiac arrest while in the Emergency Department awaiting retrieval to the Townsville Hospital.

c. Betty's date of the death is 23 September 2019.

d. Betty was formally declared deceased at the Doomadgee Hospital, Queensland.

e. Betty's cause of death of the deceased person was cardiac arrythmia complicating heart failure due to the consequences of past rheumatic fever.

Ms Sandy

623. I find that:

a. The identity of the deceased person is **Adele Estelle Sandy (nee) Diamond ("Ms Sandy")**.

b. On 30 May 2020, Ms Sandy presented to the Doomadgee Hospital Emergency Department with altered breathing, shortness of breath and rapid atrial fibrillation. This presentation was on the background of symptomatic heart failure secondary to serve Rheumatic Heart Disease which resulted in Ms Sandy having undergone a mechanical mitral valve replacement on 9 October 2009, and no anticoagulant therapy since in or around March 2020. Ms Sandy deteriorated and went into cardiac arrest while in the Emergency Department awaiting retrieval to the Mount Isa Hospital.

c. Ms Sandy died on 30 May 2020.

d. Ms Sandy died at the Doomadgee Hospital, Queensland.

e. Ms Sandy died as a result of the malfunction of her artificial heart valve due to clotting on the valve surface, and the consequence of elevated blood pressure.

Kaya

624. I find that:

a. The identity of the deceased person is **Shakaya George ("Kaya")**.

b. On 20 August 2020, Kaya underwent an attempted closure of her aortic Right Ventricular fistula in circumstances where Kaya had been diagnosed with RHD in 2009, requiring multiple cardiac surgeries. In April 2017, Kaya had a mitral valve replacement and aortic valve replacement plus a Konno incision. On 11 March 2019, Kaya was diagnosed with a leak from her aortic valve which required monitoring. In June 2020, Kaya developed heart failure which led to the need for the attempted closure of her aortic Right Ventricular fistula. Kaya did not recover from the procedure. It is likely this was due to a hypoxic insult, a known complication of a very technically challenging procedure.

c. Kaya died on 12 September 2020.

d. Kaya died at the Queensland Children's Hospital at Brisbane, Queensland.

e. Kaya's cause of death was intracerebral haemorrhage with the underlying cause due to coagulopathy, likely combination from diffuse intravascular coagulopathy, multi-organ failure and iatrogenic (therapy with heparin).

Coronial Issue 2:

The adequacy of the primary health services provided by Gidgee Healing at Doomadgee in providing treatment, education and follow up to the deceased persons regarding their diagnosis of RHD.

625. This inquest revealed serious issues that directly impact patient care in Doomadgee.

626. The evidence supports that while there were good intentions by the parties to the Tripartite Agreement in establishing an Aboriginal Community-Controlled primary healthcare clinic in Doomadgee, the execution of the plan at the coalface was flawed. This has led to a breakdown in the relationship between Gidgee and the local Hospital, and a breakdown in trust with the community. It remains to be seen if the relationships can be repaired and the potential for a solution may be found in the evidence of Ms Wade, Mr Fraser and Mr Walden.

627. In addition to the poor execution of the plan, there was a lack of sufficient resourcing and an underappreciation of what level of care was required in Doomadgee. Gidgee did not have a clinical governance committee in place until 2020 and, lacked appropriate policies and procedures to ensure the delivery of quality patient care. The lack of collaboration between the services to try and address the resourcing issues has led to clear gaps in the service.

628. Despite these three deaths, the findings from the 'Betty's Story' report in March 2020, and the evaluation of the Tripartite Agreement by a researcher from the University of Queensland in November 2020, it is apparent from the evidence given throughout the inquest that many of the issues identified in 2016 and throughout the intervening 7-year period remain unresolved.

629. **I find** on the evidence demonstrate identified failures by Gidgee concerning Betty and Ms Sandy.

630. Despite Gidgee having taken over the management of patients with RHD in the community, Kaya was not a patient. It seems that this is most likely due to Kaya primarily living at a boarding school in Cairns during the relevant period.

Betty

631. The starting point in relation to Betty's care was the RHD screening undertaken

by Dr Justo and his team. Dr Justo appropriately made several concessions about the care provided by him and his team in evidence. These have been addressed above.

632. Issues of screening aside, there was a lack of any adequate communication between Gidgee and the Hospital on several occasions regarding Betty's care. Despite Betty's new diagnosis of RHD, there was no care plan or management plan developed in consultation with Betty. Despite having no formal plan Gidgee did not discuss Betty's new diagnosis and her proposed treatment plan with clinicians from the Doomadgee Hospital. Gidgee did not follow up Dr Justo about where Betty had been referred for Cardiology review and when this was to occur.

633. Although there was reference to 'morning meetings' between Gidgee and the Hospital throughout the inquest, there is no evidence that Gidgee was aware of Betty's numerous presentations to the Hospital from 30 July 2019 to 6 August 2019. Had Gidgee been made aware of the presentations, one would assume Betty's recent diagnosis of RHD would have been discussed, and the significance of this appreciated in the context of her presenting symptoms.

634. The day longstanding Doomadgee Hospital Medical Superintendent Dr Hamilton departed Doomadgee, was coincidentally the day the Hospital became aware of the extent of Betty's diagnosis. Follow up and escalation of her care did not occur by either Gidgee or the Hospital after 6 August 2019. This was a missed opportunity to attempt to obtain an earlier cardiology review. Dr Justo is of the view that may have made a difference to Betty's outcome.

635. Despite Gidgee taking on the primary health care for Betty, a referral to a Nurse Navigator was not completed until 16 August 2019. This same day, a referral was made by the Hospital for outreach review in Doomadgee in January 2020.

636. While an appointment for a health assessment was made by Nurse Salem, Betty did not attend. There was no follow up to establish why Betty did not attend the appointment or any attempts made to re-engage Betty to attend for assessment.

637. There was a duplication of service and then some confusion as to which service was managing Betty in organising her cardiology review. As the Investigators found in the 'Betty's Story' report, there were multiple touchpoints during the referral process by several different services.

638. Despite correspondence being exchanged between the various services, there was no evidence Betty was kept appraised of the proposed appointments or the alternative of her undergoing a review in Townsville while she was visiting her parents. Despite being Betty's primary healthcare provider, Gidgee did not have her contact phone number and did not actively manage her follow up and care.

639. With reference to the evidence before the inquest and the findings from 'Betty's Story' and the expert opinion of Dr Schultz, **I find that** Gidgee did not provide appropriate primary health care to Betty, a young woman newly diagnosed with severe RHD.

640. **I find that had Betty undergone** an earlier cardiology review, her heart failure would most likely have been treated, and although a different outcome was not guaranteed, she would potentially have been at less risk of developing the fatal arrythmia which led to her death.

Ms Sandy

641. Gidgee Healing took over Ms Sandy's primary healthcare in May 2019. Ms Sandy engaged well with the service. The evidence supports a view that there was no care plan or management plan regarding Ms Sandy's longstanding health issues associated with RHD. There was no active engagement with Ms Sandy regarding her need to take Penicillin (orally - which seems to have been her choice) on a regular basis and discussing the importance of this medication.

642. While taking over the primary healthcare of Ms Sandy, Gidgee relied on Doomadgee Community Health staff on 11 June 2019 to follow up on Ms Sandy's adherence to oral prophylaxis. This was despite Ms Sandy presenting to Gidgee before and after this consult, with no prescription or mention of non-adherence to penicillin. Nurse Rendell of Doomadgee Community Health provided Ms Sandy with education on the importance of taking oral penicillin and noted Ms Sandy had not had any penicillin dispensed since 2018. It was noted 'INR and warfarin Dosage was managed by Gidgee Healing'.

643. Ms Sandy's INR was unstable (the time it takes for blood to clot). There was no exploration as to what was causing the fluctuation in her INRs, noting Ms Sandy was non-adherent at times. As referred to in the clinical records, Gidgee prescribed Ms Sandy a brand of Warfarin that was incompatible with what she had been prescribed in the Hospital. This suggests a lack of collaboration between services in the treatment of patients such as Ms Sandy.

644. With respect, based on the contemporaneous documentary evidence and the expert opinion of Dr Schultz, **I find that** the prophylactic primary healthcare provided by Gidgee to Ms Sandy was inadequate.

645. Due to a high INR on 15 November 2019, Ms Sandy experienced an intrabdominal haemorrhage and required urgent transfer to Mount Isa. Following an ICU admission, Ms Sandy was discharged on 23 November 2019. She was prescribed Clexane.

646. Nurse Salem made an entry on 11 December 2019, noting Ms Sandy had been in Mount Isa and was now on Clexane. I reject the view that Gidgee required 'instruction' to recommence Ms Sandy's primary care in Doomadgee. Gidgee **was the primary care provider** to Ms Sandy and had an obligation to actively follow her up on discharge, including obtaining a copy of her discharge plan and reengaging Ms Sandy with its service for the active management of her anticoagulation therapy, her prophylactic treatment and in assisting her to understand the need for follow up.

647. **I find that** there were significant issues with Ms Sandy's follow up by Gidgee

following her discharge from the Mount Isa Hospital in November 2019. This was particularly the case in relation to the ongoing prescription of Clexane in circumstances where Ms Sandy had a serious chronic illness, no surgery booked, a history of unstable INRs, and her history of nonadherence and disengagement from care.

648. Noting the many issues raised in this inquest particularly those around cultural safety I am concerned that Ms Sandy's nonadherence and disengagement may have been a direct result of the medical overwhelm experienced by her over many years of prior treatment for her condition.

649. I **find** there is a direct link between Ms Sandy's lack of anticoagulation therapy and the clot which formed on her aortic valve ultimately causing her death.

Coronial Issue 3:

The adequacy of the care provided by Doomadgee Hospital to each of the deceased persons, with particular emphasis on the six (6) months prior to their deaths.

650. Gidgee and the Doomadgee Hospital and the North West Hospital and Health Service each had a responsibility to work through the start-up issues relevant to the Tripartite Agreement to ensure a streamlined collaborative service was provided to the Doomadgee community. This did not occur. The evidence supports that services were siloed, with an 'us and them' mentality.

651. I accept the Human Rights Commission submission that The Doomadgee Hospital appears on relevant occasions to have failed to provide patients and their families with sufficient information about their health care and treatment, to enable them to fully understand their health conditions and the benefits of treatment, and to appropriately involve families in the provision of health care. In addition, the failure to adequately communicate with Gidgee Healing about shared patients appears to have led to a breakdown in providing adequate follow-up. These factors have impacted on the protection of patients' health by limiting the right to life and the right to health services.

652. At times the Hospital did not deliver culturally safe services, and there appears to have been at least a perception among some patients of racism and, more generally, in their interactions with health workers affecting the right to equality, the right to health services, and cultural rights.

Betty

653. Due to a lack of communication between the services, the Hospital was not aware of Betty's diagnosis and the extent of that diagnosis until 6 August 2019. As Betty had been presenting to the Hospital frequently over 30 July 2019 to 6 August 2019, her presentations should have been handed over to Gidgee during

the ‘morning meetings’. There is no evidence that Gidgee was advised of these presentations.

654. There was a missed opportunity for an ECG when Betty presented to the ED on 3 August 2019. However, Dr Hamilton provided evidence that on auscultation, Betty’s heart rate and rhythm were reassuring to him. The issue of antibiotics has been dealt with earlier.

655. The primary concern is the lack of follow up of Betty following receipt of the Echo results from Dr Justo on 6 August 2019. Despite a nurse recording the paperwork was to be sent to the Medical Officer (it is assumed this was the medical officer who would have arrived that afternoon to replace Dr Hamilton) and that Betty was to be followed up the following day, this did not occur. Dr Justo assumed the Hospital staff would identify her symptoms as a potential sign of congestive cardiac failure and discuss this further with the cardiac team or the Townsville Hospital. Dr Justo accepted he could have contacted TPCH himself to escalate Betty’s care.

656. **I find** that Betty should have been followed up by the Doomadgee Hospital and her need for a cardiology appointment escalated.

657. There was a duplication in services on 19 August 2019. There is no clinical record within the Doomadgee Hospital record as to why Betty had attended the Hospital, only a signature on a medication chart confirming she had received a Bicillin injection and the referral to outreach review. It is not clear why Betty also attended Gidgee on that same day and a nurse completed another referral to the Nurse Navigator. There was no evidence of a clinical assessment by either practitioner.

658. There was an overlap in roles and confusion as to who was responsible for managing Betty’s care and follow up.

659. There was no evidence that Betty was kept advised of the proposed appointments or the alternative of her undergoing a review in Townsville while she was visiting her parents. Despite being Betty’s primary healthcare provider Gidgee did not have Betty’s contact phone number and did not actively manage her follow up and care, the Doomadgee Community Health staff were able to contact Betty’s mother but did not follow up on the possibility of organising an earlier cardiac review in Townsville.

660. **I find** that the Doomadgee Hospital did not provide appropriate follow up care to Betty, a young woman newly diagnosed with severe RHD.

661. **I find** that had Betty undergone an earlier cardiology review it is probable her heart failure would most likely have been treated, and she would therefore have been at less risk of developing the fatal arrythmia which led to her death.

Ms Sandy

662. Following Ms Sandy’s discharge from Mount Isa, Gidgee did not re-engage with her.

663. Ms Sandy was discharged on 23 November 2019. The Mount Isa Hospital did not provide a discharge summary to the Doomadgee Hospital or to Gidgee. There was no follow up appointment confirmed for Ms Sandy regarding further review in relation to a prescription for Clexane. Despite this Ms Sandy had prescriptions for Clexane renewed at the Doomadgee Hospital on 28 November, 2 December, and 6 December 2019 without medical review. There are no clinical notes nor evidence of any review of Ms Sandy during this time.

664. On 18 December 2019, Ms Sandy was reviewed by a medical officer. Although he was concerned about her adherence to medication, and about the plan from Mount Isa for surgery and (why) the need for Clexane, the medication was again prescribed for Ms Sandy. This was a missed opportunity by the Hospital to liaise with Mount Isa and establish the plan for Ms Sandy moving forward.

665. On 11 February 2020, Ms Sandy was seen at the Medical Outreach clinic. Ms Sandy was diagnosed with a provisional diagnosis of infective exacerbation of Chronic Heart Failure. She was commenced on oral antibiotics and had an x-ray the following day. There was no further medical review or follow up despite the provisional diagnosis, on the background of a patient with RHD with artificial aortic and mitral valves. There was no letter regarding the consult provided to Gidgee. Despite no surgical plan being confirmed, Ms Sandy was again prescribed Clexane. This was the last prescription of an anticoagulant provided to Ms Sandy before she presented to the Hospital on 27 May 2020.

666. The documentation in the clinical notes at Mount Isa and Doomadgee are very poor. It is difficult to establish if Ms Sandy was followed up by Mount Isa regarding potential surgery and the original prescription for Clexane. Similarly, while attempts were made to follow up Ms Sandy regarding a telehealth appointment after 11 February 2020, it is not clear what the appointment was for. Importantly it is noted Ms Sandy was not followed up regarding her need for anticoagulant therapy or her potential infective exacerbation of Chronic Heart Failure.

667. When Ms Sandy did not attend the appointment on 23 April 2020, no further attempts were made to follow Ms Sandy from then until she presented to the Hospital on 27 May 2020. There is no evidence of communication to Gidgee regarding the appointments of 18 December 2019 and 11 February 2020 respectively, nor a request that Gidgee follow up Ms Sandy.

668. **I find** there were significant issues with Ms Sandy's follow up by the Doomadgee Hospital following her discharge from the Mount Isa Hospital. This is particularly in relation to the ongoing prescription of Clexane in circumstances where she had no surgery booked, her history of unstable INR, and her disengagement from care.

669. **I further find** that the prescription of Clexane by the Mount Isa Hospital, for Ms Sandy who was to return to Doomadgee with no definite plans for surgery, was inappropriate.

670. **I find** there is a direct link in Ms Sandy's lack of anticoagulation therapy and the clot that formed on her aortic valve, which ultimately caused her death.

671. Ms Sandy was prematurely discharged by Dr Amodeo on 29 May 2020. I am also critical of Dr Amodeo's follow up and assessment of Ms Sandy after her admission on 27 May 2020 and in that respect Dr Amodeo's care of Ms Sandy was not adequate.

672. The criticism does not extend to Dr Amodeo or the clinical staff treatment of Ms Sandy on 30 May 2020.

Kaya

673. Following Kaya's discharge from the Alice Springs Hospital, she presented to the Doomadgee Hospital for INR monitoring and to facilitate referral and transfer to Brisbane for further treatment. Despite her mother's (Ms Weenie George) genuine attempts to have the Hospital staff make enquiries, it seems the discharge summary from Alice Springs Hospital may have hindered that process, as staff placed reliance on its reference to Kaya not requiring cardiac review for 3-6 months.

674. Ms George mentioned on five occasions the need for Kaya to go to Brisbane before a clinician investigated what the plan for Kaya was and agreed to contact her cardiologist Dr Reeves. It is apparent that the doctor at Doomadgee had no idea who Dr Reeves was or where he practiced, likely because none of Dr Reeves' correspondence was on the Doomadgee Hospital file.

675. Unfortunately, by this time, Ms George had become despondent and was concerned about the care being provided to Kaya and left Doomadgee to seek medical assistance for her daughter elsewhere.

676. The clinical records, together with and the expert opinion of Dr Kelly, support that Kaya was initially well when presenting to Doomadgee but had started to develop symptoms of congestive cardiac failure by 13 July 2020. She was appropriately treated by being commenced on Frusemide and antibiotics. Her condition deteriorated on leaving Doomadgee on 17 July 2020, requiring retrieval from Burketown to Mount Isa on 19 July 2020. Her clinical condition upon her arrival to Mount Isa, including her observations, were markedly different from her last presentation in Doomadgee.

677. I find that staff failed to act on Weenie Georges' reasonable concerns for her daughter, having conveyed the import of the information provided to her daughter at discharge in the Northern Territory that she required further surgery. Ms George's concerns about the need for cardiology review were not acted on for a period of almost three weeks when meaningful enquiries commenced to locate Dr Reeves.

Coronial Issue 4:

Whether there was delay in transferring Kaya to the Queensland Children's Hospital for surgical intervention, and if so, why?

678. When Kaya was discharged from the Alice Springs Hospital, she was for follow up in three to six months. There was **no firm appointment** made and **no discharge letter** provided to Dr Reeves.

679. If the Registrar from Alice Springs spoke with someone in Dr Reeves' team at some stage during Kaya's admission, the conversation is not contained within any written documentation and there was no firm discharge plan nor appointment for Kaya to see Dr Reeves.

680. Dr Reeves was of the opinion Kaya should not have been discharged back to Doomadgee where there were no routine cardiac services. His view was that she should have been flown to Brisbane. Dr Kelly opined that the discharge plan established by the Alice Springs cardiology services was vague and that an actual appointment was required. Further, he said that a safety plan should have been put in place in case of deterioration before the appointment.

681. I find that the discharge plan made by the cardiology services in Alice Springs was inadequate in the circumstances.

682. Would earlier intervention have changed the outcome. Dr Kelly opined that it was difficult to know for certain whether Kaya's outcome would have been significantly different had this transfer occurred weeks earlier. Earlier transfer would not have guaranteed earlier surgery.

683. Dr Benjamin Anderson remarked that the time taken to transfer Kaya from Townsville Hospital to QCH would not have changed her trajectory one way or the other, especially considering that many of the treatments commenced in Townsville (i.e. for her leg infection and dental caries) were continued in Brisbane for a period of time to ensure she was in an optimal position for surgery. In his view, the steps taken and the timeframe were appropriate.

684. In evidence, Dr Reeves commented that the eight-day delay in transferring Kaya *"does seem like a long time to wait"* but, when considering the time was used to assess Kaya and begin planning intervention with the specialists in Brisbane before her arrival, Dr Reeves agreed that in all the circumstances this was a reasonable timeframe for that to occur.

685. There was some delay in Kaya being transferred from the Townsville Hospital due to the prioritisation of patient transportation by RSQ.

686. **I find** that Kaya's condition may have been compromised by the delay, and that the reason for delay stems from the lack of access or knowledge of the echocardiogram report (from 18 June in ASH) referring to a mean gradient of 16mm across Kaya's mitral valve and the failure by Doomadgee Hospital to properly follow up the information provided to them by Kaya's mother that she was for valve surgery and required timely transfer to Brisbane.

687. I make no criticism of the staged care then provided by the Townsville University Hospital.

Coronial Issue 5:

The adequacy of the care provided to Kaya by the Queensland Children's Hospital in the period 28 July 2020 to 12 September 2020.

688. Dr Kelly noted that there were 23 days between Kaya's presentation to QCH and her first catheter procedure. In his view, this timeframe was not unreasonable for a complete workup prior to surgery to reduce the risk of infection and is deemed to be standard.

689. With respect to the procedures on 20 and 21 August 2020, Dr Kelly supported the chosen type of surgery and the decision to proceed with a second catheter procedure as being appropriate. He was not critical of either procedure. In fact, Dr Kelly thought Dr Anderson's work during the second surgery, by managing to successfully place a device partially blocking the fistula, was "impressive".

690. Paediatric intensivist Dr James stated that Kaya's care and management throughout her entire stay on the PICU was of "excellent quality". The cause of her death could not have been anticipated or prevented by the staff there.

691. It was patently clear from the evidence that Kaya's treating specialists provided the highest standard of care and were deeply affected by Kaya's death after her surgical intervention. Kaya's surgery was highly specialised, complex and medically technical and was performed against a background of Kaya's multiple surgeries and her chronic disease. Tragically Kaya succumbed to the complications of surgery which was always a known risk.

692. I find that the care and treatment delivered to Kaya at the Queensland Children's Hospital from 28 July to 12 September 2020 was of the highest standard.

693. The best prognosis to prevent Kaya's death (indeed all three women) was primordial prevention.

Coronial Issue 6:

The adequacy of screening RHD and the public health, education/prevention and follow up provided in the Doomadgee community regarding ARF and RHD.

694. Based on the whole of the evidence before me I find that:

    a. The 2018-2021 Action Plan has had little impact at a local level in Doomadgee.

    b. There was and remains poor knowledge in Doomadgee regarding the cause and prevention of ARF and RHD in the community;

    c. The levels of adherence to Bicllin injections in Doomadgee was and remains poor and is likely linked to the lack of awareness in the community regarding the importance of this medication in the management of ARF and RHD;

    d. There is no environmental plan or environmental health officer in Doomadgee addressing the issues concerning the prevention of ARF and RHD in the Doomadgee community;

    e. There is an inability to provide effective culturally safe care due to

the hurdles in recruiting and retaining Indigenous Health Workers and Indigenous Liaison Officers in Doomadgee; and

f. There has been a general breakdown in the trust in the community regarding the provision of the health care services provided in Doomadgee.

695. In line with the submissions of the Human Rights Commission I find that adequate screening for RHD is yet to be achieved in Doomadgee. I acknowledge the extraordinary work undertaken by Dr Justo and Dr Reeves who have selflessly dedicated personal leave and professional study leave to attend Doomadgee and undertake screening programs – and that as a result children and community members with RHD have been identified.

696. The Human Rights Commission submits that rheumatic fever which leads to RHD, is most commonly seen in children aged 5 to 14 years, and that any limitation to strategies for prevention limits the rights of children. I accept that submission. It is clear that sufficient resourcing and a formalised screening program will benefit Doomadgee and the NWHS catchment.

Gidgee Healing submissions

697. The written submissions by Counsel on behalf of Gidgee Healing are considered, and provide essential clarification, context and updating information which I extract below (paragraph 698-720):

698. Gidgee Healing remains dedicated to improving health and social wellbeing outcomes for Aboriginal and Torres Strait Islander people in Doomadgee, the greater Mount Isa region and the Lower Gulf region.

699. Gidgee Healing is committed to working collaboratively and inclusively with the Doomadgee community and the North West Hospital and Health Service (**NWHHS**) to continue to improve cultural safety and uplift the health services provided by the various health care providers and to improve health outcomes within the Doomadgee community.

700. As a preliminary issue, Gidgee Healing wishes to clarify that it is not the case that all primary health care services in Doomadgee have been, or will be, transitioned to Gidgee Healing in Doomadgee. Rather, it is the case that some primary health services remain within the remit of Queensland Health, the NWHHS and the Doomadgee Hospital. For example, the NWHHS continues to receive funding to provide an RHD Chronic Disease outreach team within the community and, as was acknowledged by Dr Rosengren in his evidence, the Queensland Government has invested in the delivery of consistent primary healthcare services “on the ground”.

701. By way of contrast, Gidgee Healing receives no dedicated funding to provide services in relation to RHD in Doomadgee, yet it is assumed that Gidgee Healing now undertakes those services[2] (largely through self-funding). For example, for the 2021-2022 financial year, Gidgee Healing received funding from Queensland Health in the sum of $223,440 under the Making Tracks First

Nations Health program to assist with meeting the cost of providing primary health care, being a fraction of what is required to provide comprehensive primary health care services to the community. While additional Commonwealth fundings exists, largely through accessing the Medicare Benefits Schedule (**MBS**) fees for service payments rebates, optimising these payments is contingent on an adequate and sustained workforce. During the COVID-19 lockdowns and under the present circumstances, it is not achievable for Gidgee Healing, as an Aboriginal Community Controlled Health Organisation (**ACCHO**), to provide all of the primary health care services required in Doomadgee and the other areas serviced by Gidgee Healing, and this is particularly the case where the NWHHS is enabled to supplement these services as a mainstream health care service provider.

702. Gidgee Healing's ability to conduct 715 health checks during certain periods the subject of the Inquest was severely impacted by COVID-19, modified workflow and clinical protocols and a lack of sufficient workforce due to disruption to the workforce supply. Additionally, throughout the period, while cognisant of the identified health needs of the community, Gidgee Healing had limited capacity to fully utilise local data and health intelligence to take a more proactive role in recalling patients for screening and follow-ups. Gidgee Healing also did not have access to a sophisticated system that could analyse how many patients' 715 health checks were outstanding. Gidgee Healing has recently employed an individual in a designated role within the organisation who has as a component of their role, the responsibility to promote the meaningful use and access to data to assist systemisation and follow-up within its clinics.

703. It is accepted that the inability to properly access and share data by each of Gidgee Healing, the Doomadgee Hospital and the NWHHS negatively impacted the Doomadgee community, in that there was not effective collaborative care for Betty and Ms Sandy.

704. Gidgee Healing has not been able to obtain full accreditations for all clinics to date, due to insufficient capacity and capability to do so. Some of the challenges facing Gidgee Healing in obtaining accreditation were explored during the evidence of Ms Blackman and Mr Solomon.

705. Subsequent to the cessation of the Inquest hearings, Gidgee Healing has appointed a Chief Medical Officer (**CMO**), who plays a key leadership role in the organisation's clinical governance, including clinical supervision and clinical audits. Further, a dedicated senior position has been established to oversee the review and enhancement of all clinical systems and processes, including accreditation. In 2023, Gidgee Healing also intends to expand its capacity with the additional appointments of experts to the practice support and capability development frameworks within the organisation.

706. Over recent months, Gidgee Healing has acquired experienced personnel to assist the process of local accreditation under General Practice Accreditation (**GPA**). Preparing for this external certification against the Royal Australian College of General Practitioners (**RACGP**) 5th Edition Standards will require significant review and upgrade of local policies and procedures. It is anticipated

this will also provide significant opportunities to enhance communication and engagement between the primary health care clinic and stakeholders.

707. Gidgee Healing has commenced significant practice improvement activities and registered for Australian General Practice Accreditation Limited (**AGPAL**) accreditation against the RACGP 5th Edition Standards. These Standards are fully inclusive of patient-centred approaches and meaningful use of data tools and recall mechanisms to provide proactive care for patients. With these additional resources, Gidgee Healing is confident it can commit to having completed accreditation by the end of 2023 for the remaining two primary health care clinics at Doomadgee and Mornington Island.

708. Gidgee submit the evidence borne out in the Inquest demonstrates that Gidgee Healing has less ability to attract the funding and resources necessary to support the provision of health care in Doomadgee when compared to other health care providers such as the NWHHS and the Doomadgee Hospital, as well as community health and outreach services.

709. In addition, Gidgee Healing's status as an ACCHO has seen it wield less or immaterial influence, both politically and within the health services community, in determining how Queensland Government funding and resources are allocated within the Doomadgee community in support of improving health outcomes. As was heard during the Inquest, Gidgee Healing often does not have a voice when important decisions regarding health care in Doomadgee are made.

710. With respect to the availability of funding for primary health care, the Doomadgee Hospital continues to be able to utilise an exemption to claim Medicare rebates for providing primary health care services under the Rural & Remote Medical Benefits Scheme (**RRMBS**). Gidgee Healing holds a 19(2)-b exemption under the MBS. The dichotomy between the Doomadgee Hospital and Gidgee Healing with respect to the ability to access Medicare funding for primary health care plays out further in circumstances where the Doomadgee Hospital is open at all hours across a week, with a full-time doctor onsite able to access a range of RRMBS items. By contrast, Gidgee Healing is open only five days a week for limited hours and where a General Practitioner is unavailable, the Nurse Practitioner onsite can access only six MBS items. This greatly impacts Gidgee Healing's access to the MBS and related funding. Gidgee Healing submits that by receiving the rebates under the RRMBS, the NWHHS continues to play a role in providing primary health care support to Doomadgee (and other communities). This is evidenced by the ability for the NWHHS to generate funding by accessing the MBS schedule, which provides the NWHHS an additional revenue stream in Doomadgee.

711. By way of further background, the 'Making Tracks Investments Strategy 2018-2021' was published by Queensland Health in September 2018, with a view to closing the gap in health outcomes for Aboriginal and Torres Strait Islander Queenslanders. This document makes references to the Lower Gulf Strategy to transition all Queensland Health primary health care services provided in the Lower Gulf region to community control under Gidgee Healing. While the document sets out a proposed strategy that aligns with the policy framework to

transition Queensland Government funded services to community-controlled health care service providers, there is no evidence of formal implementation nor any meaningful examples of transition on the ground in the Doomadgee community.

712. By way of further example, on 23 January 2023, the Queensland Minister for Health and Ambulance Services announced that $1.038 billion was to be invested in rural and remote health infrastructure in Doomadgee and (not relevant to the Inquest) Millmerran. The announcement indicated that the Doomadgee Hospital and Community Health Centre will be tendered in early 2023, with completion scheduled for 2025, and that the existing facilities within Doomadgee will be replaced. It is unclear from the press release, but it appears that the replacement of facilities within Doomadgee is to include the building in which Gidgee Healing is operating.

713. Notwithstanding this important development that will directly impact Gidgee Healing's provision of health services within Doomadgee, Gidgee Healing was not consulted about this decision, and the first it became aware of it, was as a result of the Minister's press release.

714. With respect to information sharing, the Court heard evidence about there being multiple platforms of clinical records within the Doomadgee Hospital, including hard copy paper charts. Additionally, the evidence illustrated that Gidgee Healing used another platform that the Doomadgee Hospital did not have access to, prior to laptops being made available by Gidgee Healing at their own expense.

715. Gidgee Healing was proactive in trying to establish continuity of care by making available a laptop, so that staff of the Doomadgee Hospital could access information about Gidgee Healing patients. This was not reciprocated by the Doomadgee Hospital, and Gidgee Healing is of the view that the lack of reciprocity contributed to the lack of collaborative care between the Doomadgee Hospital and Gidgee Healing.

716. The evidence heard at the Inquest indicated that Gidgee Healing had limited access to Queensland Health's data sharing platform ("**The Viewer**"). It is submitted that the lack of information sharing does not provide Gidgee Healing with the comprehensive level of information it requires in order to provide continuity of care. It is further submitted that in order to provide continuity of care and collaborative care, it is necessary for there to be improved and embedded information sharing between the Doomadgee Hospital and Gidgee Healing, at a minimum.

717. It is submitted that the parties to the Tripartite Agreement failed to implement a documented process to properly map the purported transition of primary health care services to Gidgee Healing in accordance with the Queensland Health policies and procedures. If such a process had been implemented, all relevant stakeholders could have been made aware of what services had been fully transitioned from Queensland Health to Gidgee Healing (including related funding), as well as those services that had been partially transitioned or not transitioned at all. Not unreasonably, it follows that those services yet to be fully

transitioned to Gidgee Healing must necessarily remain the responsibility of Queensland Health until such time as circumstances change.

718. The absence of such a documented process, which could have been communicated to all relevant stakeholders and the Doomadgee community, has led to misalignment between health care service providers, as well as confusion within the local community regarding expectations of services to be provided by Gidgee Healing and the NWHHS. This is particularly the case with misunderstandings as to what services Gidgee Healing is and isn't funded to provide. The mixed-messaging and confusion remain in place today. This was demonstrated during the evidence of Mr Carey, amongst others[7]. It is submitted that such misunderstandings contributed to the breakdown of relationships between the Doomadgee Hospital and Gidgee Healing.

719. During the period that Gidgee Healing has operated in Doomadgee, there have been a number of executive level staff changes within the NWHHS, in addition to the Board of the NWHHS being sacked by the Minister for Health in June 2021. It is submitted that the instability of executive leadership within the NWHHS contributed to the failure to implement the Tripartite Agreement. Further that this lack of continuity of leadership contributed to the breakdown in relationships between the Doomadgee Hospital and Gidgee Healing. No evidence was heard from any previous Chief Executives of the NWHHS as to how conflict was being resolved between the Doomadgee Hospital and Gidgee Healing. As such, it is submitted that the evidence of Ms Blackman should be preferred to demonstrate the attempts to resolve the issues that were raised. The latest staffing figures show that 77.56% of Gidgee Healing's staff identified as First Nations people in 2022.

720. Of the total staff, 95% of Gidgee Healing's staff have completed the online cultural training on its human resources platform (ELMO) since 2021. Gidgee Healing is committed to the ongoing and deepening of its cultural training program and welcomes the opportunity to undertake further cultural training from the Doomadgee community.

721. I accept that establishment of ACCHO's in Doomadgee is demonstrative of the empowerment of, and self-determination by, the community to take control of their health care journeys.

722. I find that that cultural rights are preserved by the existence of Gidgee Healing in Doomadgee in that it:

    a. Supports community identity, such as employing local community members and/or Aboriginal or Torres Strait Islander people more broadly;

    b. Ensures that there is observance of language and cultural expression;

    c. Recognises kinship ties and how those relationships might be impacted, such as local staffing, patient interactions and genuine immersion of staff in the community;

    d. Ensures that Aboriginal and Torres Strait Islander people are

not forced to assimilate, for example by allowing autonomy of choice to use a mainstream service such as the Doomadgee Hospital; and

e. Is governed by a predominately First Nations Board of Directors and CEO, including a number of Directors with close cultural connections to Doomadgee.

723. All of these features promote cultural safety and self-determination.

724. I accept that Gidgee Healing is committed to working with the Doomadgee community in collaboration with the hospital and the health service.

RECOMMENDATIONS in accordance with Section 46

725. In accord with Section 46 of the Coroners Act a coroner may comment on anything connected with a death that relates to:
    a. Public health and safety,
    b. The administration of justice, or
    c. Ways to prevent deaths from happening in similar circumstances in the future.

726. There have been many reviews, strategies and opinions provided on how to improve the provision of healthcare in Doomadgee. The 2021-2024 Strategy (for which Dr Rosengren is taking personal responsibility) and the announcement of the recent comprehensive NW Equity Strategy provides some hope for the future however, for each to be successful, the various interventions must reach the grassroots level in not only the Doomadgee community but all communities within the NWHHS catchment.

727. The starting point for Doomadgee is healing. Significant time and care is needed for repair of relationships at all levels.

728. I embrace completely the language of Kaya and Ms Sandy's family in their submissions assisted by Mr Sandy and Mr Doomadgee that the adoption of any recommendation must be implemented **with** the community of Doomadgee and not just for the benefit of the Doomadgee community.

729. At an institutional level it is essential that racism in all its forms (written, oral and by action) can be identified, measured and monitored. Self-reporting "I am not racist" is subjective and not sufficient or appropriate in a mature society. I accept the submission on behalf of Kaya and Ms Sandy's family that there are tools such 'The Matrix' (not tendered at inquest) available to measure public health sector engagement with First Nations People. Tools are available that assist the objective assessment of racism. Language matters and is at the forefront of societal change.

730. A significant issue arising from the inquest was appropriate housing for health and medical personnel. I note specifically the submission of Betty's family that housing options should be explored as part of the wider review.

731. I accept the submission by Counsel on behalf of Gidgee Healing that Gidgee Healing in regard to housing and accommodation:

    a. Is not generally included in the infrastructure planning of the Doomadgee community and is not permitted to access or occupy the secure Queensland Government-owned properties within Doomadgee for the purpose of accommodating its staff. Given the NWHHS can provide secure accommodation to all its staff encompassing all positions from administrative to clinical personnel to Director of Nurses, Gidgee Healing is at a distinct disadvantage when seeking to recruit and retain staff. Gidgee Healing has a limited capacity of only three accommodation spaces in Doomadgee, which is hugely inadequate given the nearly 1,000 active patients it has within Doomadgee. In the circumstances, Gidgee Healing has no other option other than to pay market rates to rent less-secure accommodation for its staff. Of note, Gidgee Healing is unable to build further facilities in Doomadgee given the Deed of Grant in Trust (DOGIT) status that applies to the community land.

    b. As a result of the limited capability to provide safe accommodation to the employees, there have been issues relating to the safety and security of Gidgee Healing's accommodation. There were incidents where locums recruited to a temporary position had their rooms broken into and personal belongings scattered in front of the rooms. Safety incidents such as this were reported back to the recruitment agencies who struggle to promote, or no longer wish to promote, Gidgee Healing and/or Doomadgee as a suitable workplace option.

    c. The lack of permanent and consistent accommodation for its staff makes Gidgee Healing struggle to attract and retain long term staff. As such, Gidgee Healing cannot compete with the NWHHS on recruitment on a salary basis or an incentive basis.

732. I take into account those submissions and strongly endorse considerations of housing and accommodation for health staff within the overall review that will be undertaken after release of these inquest findings.

733. It goes without saying that considerations of funding for all stakeholders to properly implement the recommendations is an essential component of the implementation. How that occurs is beyond the ambit of this forum.

734. I recommend as follows:

    [1] The North West Hospital and Health Service and Gidgee Healing, together with Queensland Health, consider engaging an expert to work **with the community** and each relevant service to assess and map the healthcare services currently provided in Doomadgee to:

        i. Identify duplication and fragmentation of care;

        ii. Identify what services and consumers have been

transitioned and ensure provision of those individual medical records (with consents);

iii. Identify gaps in service provision;

iv. Clearly define the roles of each service and develop (or refine) guidelines for information sharing between Gidgee and NWHHS;

v. Identify appropriate and achievable processes for follow up and the engagement of patients in the community;

vi. Identify issues and propose solutions regarding the safe and appropriate accommodation of clinical staff from Gidgee and NWHHS in Doomadgee;

vii. Propose a model of care which will effectively meet the community's needs; and

viii. Consider streamlining the management of RHD patients by the introduction of a Nurse Navigator role based in Doomadgee (due to the issues recently identified in the media and through this inquest, there are now multiple clinicians who have 'an interest' in a patient with RHD, which holds the potential for duplication, confusion, and lack of continuity of care).

[2] That a restorative expert be engaged to assist in repairing the relationship between clinicians and between all stakeholder health services in the provision of care in the Doomadgee community.

[3] That a cultural leader/restorative expert be engaged to facilitate a process to attempt to restore the trust and relationship between the community and healthcare providers in Doomadgee (and only upon recommendation or endorsement of the community).

[4] The community to consider appointing an independent community member as a Community Liaison Officer (or similar such title) who is employed to act as an independent conduit between the local Health Council and the Health Service Providers, and who can promote and assist in the recruitment of local people to work with the Health Service Providers.

[It is noted that the NW Equity Strategy has identified funding for such a position.]

[5] The community, through the Community Liaison Officer, to consider developing a model for the provision of community support to the local health services, including cultural training and immersion, and the

development of a group of community members who can attend Gidgee or the Hospital to assist with patient management in times of acute illness or a patient dying.

[such as the the development of a 'guardian angel service'].

[6] That consideration be given to identifying willing community members and training them in CPR to develop greater capacity within the community to support the medical workforce when responding to life-threatening emergencies, but not aimed at replacing trained medical personnel.

[Queensland Health submitted that the availability of an appropriate training course is a matter that requires consideration, and it would be beneficial for the Yellagundimarra Aboriginal Health Council to be consulted in the first instance, to determine how this could be implemented, rather than Queensland Health imposing it upon the community].

[7] Queensland Health to consult with the Doomadgee Shire Council and provide funding and support for training and employing a further environmental health officer to address the primordial risks associated with RHD and other communicable diseases (there is an opportunity to learn from other communities, the NACCHO paper refers to the Maningrida community in the Northern Territory as a case study).

[8] The community to consider developing a local RHD action plan in consultation with the local school, Gidgee and the Doomadgee Hospital which has actionable targets and dovetails into the 'Ending Rheumatic Heart Disease: Queensland First Nations Strategy 2021-2024'.

[9] Queensland Health to consider, in consultation with the community, a project with other government stakeholders to build a laundromat and showering facilities or, in the short-term, approach an organisation such as Orange Sky to provide a laundry/shower truck for Doomadgee.

[10] The North West Hospital and Health Service to:

i. Review its discharge plan processes to ensure a discharge plan is sent to the relevant receiving primary care provider and local hospital;
ii. Consider how to address the issue of the inappropriate prescribing of Clexane in circumstances where a patient's surgery has not been scheduled within days of discharge;
iii. Review its doctor coverage and rostering practices at the Doomadgee Hospital to ensure there is appropriate medical coverage for the Hospital, and that those

doctors have timely access to the electronic medical record/s;

iv. Consider 'any lessons' learned in Doomadgee as highlighted through this inquest, and how they may apply to other communities in the NWHS district including ongoing training in areas of cultural safety and competency and training in 'Sad News Sorry Business'.

[11] Queensland Health with the First Nations community to consider whether Ryan's Rule needs to be adapted to ensure it is culturally appropriate for First Nations people and then promoted and / or adapted accordingly.

[12] That Queensland Health take steps to determine the most effective approach to identify ARF and RHD in Doomadgee and other First Nation communities where there is a high incidence of those conditions and a vulnerability of members of the community to contracting those conditions.

[13] That Queensland Health request that the RHD Register and Control Program (the Program), (as part of the review of its services), clarify the purpose and function of the Program, and propose ways of: (a) ensuring that clinicians understand the purpose and value of the Program in providing centralised information to support the coordination and provision of care; (b) ensure that the purpose and function of the Program is explained to patients and their families, and they are aware of how the Program can support them.

[14] Queensland Health through the RHD Register and the relevant Hospital and Health Services identify strategies to encourage clinicians working in prevalent communities to adopt a **high-risk index of suspicion** for ARF/RHD when treating patients in these communities.

[15] Queensland Health consider project guidelines for the agreed future roll out of an ACCHO in a community which is currently only serviced by a Hospital and Health Service. This includes ensuring the services are mapped and there is an appropriate model of care identified prior to the ACCHO commencing in the community.

[16] That Queensland Health, the Northwest Hospital and Health Service and Gidgee Healing consider adopting or adapting a risk matrix such as *Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* (Marrie, A. and Marrie, H. 2014);

[In December 2018, the Anti-Discrimination Commission Queensland (ADCQ) released a report Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services (Marrie A, 2017) which used as its auditing tool the Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services

developed in 2014 by Adrian Marrie and Henrietta Marrie AM. The report and it's response by Queensland Health (QH), has introduced a new strategy for dealing with institutional racism. The Matrix is designed as an external, evidenced-based practical desk-top tool for measuring Closing the Gap health policy transparency, implementation, and accountability. Based on the response by QH, the Matrix has clear potential to expose and address institutional racism in the public health system. As a research tool it has the potential to monitor public policy implementation and accountability over time and to be used to undertake health- and cost-benefit analyses of the impacts of eliminating institutional racism from the delivery of public health care to Aboriginal and Torres Strait Islander people][7].

[17] That Queensland Health, the Northwest Hospital and Health Service and Gidgee Healing consider whether any improvements could be made with respect to the recording of clinical notes so as to avoid implicit negative cultural and racial connotations.

[18] That relevant stakeholders co-design with the Doomadgee community a program for ensuring that all clinicians and staff have appropriate training in understanding cultural safety and communicating in a culturally safe way with patients with an understanding of cultural matters specifically relevant to the Doomadgee community.

[19] That the Coroners Court Queensland apply allocated funding to the recruitment of a cultural capability officer and the requirements of the role include provision of service to First Nations families at Inquest, and provision of assistance and advice to coroners conducting inquests and investigations touching on First Nations people and issues, so as to ensure the cultural capability of the Coroners Court Queensland.

Acknowledgments

I acknowledge the efforts of Ms Melinda Zerner Counsel Assisting this inquest for her skill, professionalism, and efforts on behalf of the court and the families of each woman. To each member of the bar table, Ms Mahlouzarides (assisting Ms Zerner), Mr Jackson, Ms Taylor, Ms Callaghan, Ms Robb, Mr Hamlyn-Harris, Mr Hickey, Ms Tarrago and Mr Schneidewin I express my deepest appreciation for the application of your finest skills to traverse deeply complex issues and to meaningful assist me and this court and most importantly Betty's Kaya's and Ms Sandy's family and loved ones.

Reflections

This inquest has perhaps identified the worst although brought out the best in all involved. Without exception all individuals and organisations have acknowledged the circumstances of each death has identified gaps that were both known and unknown

[7] The Australian Institute of Torres Strait and Islander Studies https://aiatsis.gov.au/publication/116522

in health care at Doomadgee. All say they want to understand and do better. The time has come for action.

I draw an appropriate reflection from an article I referred to earlier[8] "*What is empowering of others is supporting but not leading, verifying the potential impact of actions before taking them, demonstrating humility and reflexives and promoting decolonising process internally and externally in longitudinal fashion. Aligned with antiracism activities, colonial health system leadership and providers have a clear role resetting health services and healthcare delivery while ceasing to be complicit in the injustices and inequities in health care systems and perpetuating inequities"*.

Condolences

I extend my deepest condolences to the community of Doomadgee and to each family.

The prolonged trauma on family and community has taken a various serious toll on the emotional and psychological health of all involved. Our court was privileged to take in oral statements from the family at the conclusion of the evidence. To hear directly from those affected in such a powerful and deeply personal way left no one present in doubt of the work ahead to make meaning of the deaths of these precious young women who are deeply loved by their family and community.

May Betty, Kaya and Ms Sandy rest in deep peace.

Findings required by s. 45

Identity of the deceased –	**Yvette Michelle Wilma Booth ("Betty")**
How she died –	On 23 September 2019, Betty presented to the Doomadgee Hospital Emergency Department with shortness of breath and rapid atrial fibrillation. She was diagnosed with pneumonia following a chest x-ray. This was on the background of symptomatic heart failure secondary to Betty having been diagnosed with severe Rheumatic Heart Disease on 26 July 2019. Betty deteriorated and went into cardiac arrest while in the Emergency Department awaiting retrieval to the Townsville Hospital.
Place of death –	Doomadgee Base Hospital DOOMADGEE QLD 4830 AUSTRALIA
Date of death–	23 September 2019

[8] Barnabe C. Towards attainment of Indigenous health through empowerment: resetting health systems, services and provider approaches. BMJ Glob Health. 2021 Feb;6(2):e004052. doi: 10.1136/bmjgh-2020-004052. PMID: 33547176; PMCID: PMC7871239

Cause of death – Cardiac arrythmia complicating heart failure due to the consequences of past rheumatic fever.

Identity of the deceased – **Adele Estelle Sandy (nee) Diamond ("Ms Sandy")**

How she died – On 30 May 2020, Ms Sandy presented to the Doomadgee Hospital Emergency Department with altered breathing, shortness of breath and rapid atrial fibrillation. This presentation was on the background of symptomatic heart failure secondary to serve Rheumatic Heart Disease which resulted in Ms Sandy having undergone a mechanical mitral valve replacement on 9 October 2009, and no anticoagulant therapy since in or around March 2020. Ms Sandy deteriorated and went into cardiac arrest while in the Emergency Department awaiting retrieval to the Mount Isa Hospital.

Place of death – Doomadgee Base Hospital DOOMADGEE QLD 4830 AUSTRALIA

Date of death– 30 May 2020

Cause of death – As a result of the malfunction of her artificial heart valve due to clotting on the valve surface, and the consequence of elevated blood pressure.

Identity of the deceased – **Shakaya George ("Kaya")**

How she died – On 20 August 2020, Kaya underwent an attempted closure of her aortic Right Ventricular fistula in circumstances where Kaya had been diagnosed with RHD in 2009, requiring multiple cardiac surgeries. In April 2017, Kaya had a mitral valve replacement and aortic valve replacement plus a Konno incision. On 11 March 2019, Kaya was diagnosed with a leak from her aortic valve which required monitoring. In June 2020, Kaya developed heart failure which led to the need for the attempted closure of her aortic Right Ventricular fistula. Kaya did not recover from the procedure. It is likely this was due to a hypoxic insult, a known complication of a very technically challenging procedure.

Place of death –	Queensland Childrens Hospital at BRISBANE QLD 4101
Date of death–	12 September 2020
Cause of death –	Intracerebral haemorrhage with the underlying cause due to coagulopathy, likely combination from diffuse intravascular coagulopathy, multi-organ failure and iatrogenic (therapy with heparin).

I close the inquest.

Nerida Wilson
Northern Coroner
CAIRNS