CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Kyle James Gallagher**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2023/3401
DELIVERED ON:	31 March 2026
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 November 2025 to 21 November 2025
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	Coroners: inquest; airway obstruction; laryngeal abscess; laryngeal chondronecrosis; airway management; and missed diagnosis.

REPRESENTATION:

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Family:	J Liddle (Counsel) instructed by Caxton Legal Centre on behalf of Ms Christina Dargush (Kyle Gallagher's mother)
	MJ Tomley (Solicitor) of Murphy's Law on behalf of Mr Matthew Gallagher (Kyle Gallagher's father)

<table>
<tr><td>Interested Parties:</td><td>BI McMillan (Counsel) instructed by Metro North Legal on behalf of Metro North Hospital and Health Services, together with Dr Low, Dr Wijesekera, Dr Yau, Dr Gillespie, Nurse Shaji, Nurse Myers, Dr Ratnavale, Nurse Festin, Dr Byrnes and Nurse Morse.

Ms S Robb (Kings Counsel) with Ms Ballas (Counsel) instructed by QNMU Law on behalf of Nurse Ekukinam and Nurse Frost.

Ms T Stevens (Counsel) instructed by Avant Law Pty Ltd on behalf of Dr Stevens.

Mr R Nattrass (Counsel) instructed by Meridian Lawyers on behalf of Dr Edey.</td></tr>
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Introduction

[1] Kyle James Gallagher ("Kyle") was born on 18 September 2000 and died on 14 July 2023 at the Surgical, Treatment and Rehabilitation Service ("STARS"). He was 22 years old.

[2] On 17 June 2023, Kyle was involved in a two-vehicle traffic accident on Boundary Road, Narangba. He was riding a Yamaha motorcycle. The second vehicle was a Mazda CX-3, driven by a male person.

[3] Police have advised Kyle had been seen riding dangerously on the Bruce Highway in a Northbound direction near Narangba. They obtained dash camera footage of Kyle riding at high speeds and on one wheel at times, overtaking other motorists just prior to the accident occurring.

[4] The investigating Police from the Forensic Crash Unit ("FCU") have described the accident as:

> *Kyle James GALLAGHER was riding a stolen grey and black 2013 Yamaha MT09 Motorcycle bearing false Victorian registration plates BILLS which had just exited the southbound lanes of the Bruce Highway onto Boundary Road and travelling in an easterly direction alongside another motorcycle rider. GALLAGHER and the other motorcycle rider were performing a 'wheelie' where they were seen by witnesses riding on the rear wheel with the front wheel lifted into the air, through the intersection of Boundary Road and Diamond Jubilee Way. Both riders continued onto Boundary Road when GALLAGHER has then lost control of the motorcycle he was riding and separated from the motorcycle with both GALLAGHER and the motorcycle sliding into the opposite lane into the path of the on-coming Mazda CX-3.*

[5] The second motorcycle rider immediately departed the accident scene. Despite attempts by Police to locate this rider, they have not been identified.

[6] Police were unable to complete a Roadside Breath Test on Kyle due to him being treated for serious injuries at the scene.

[7] Police attended the Royal Brisbane and Women's Hospital ("RBWH") where they were unable to obtain a specimen. This was due to the clinical team providing urgent medical care which could not be delayed. By the time the Police were able to speak to the treating doctor, the three-hour window for obtaining a specimen had passed.

[8] However, Police were able to secure a spare sample from Kyle's admission bloods which was obtained and sent to Forensic Scientific Services for analysis. The toxicology results are referred to below.

[9] Kyle was admitted to the RBWH with serious injuries.

[10] On 29 June 2023, twelve days after the accident, Kyle discharged himself from the RBWH against medical advice. Later in the day he returned to the RBWH with pain and discomfort. He was readmitted.

[11] On 5 July 2023, Kyle again discharged himself from the RBWH against medical advice.

[12] On 6 July 2023, Kyle re-presented to the RBWH complaining of pain and discomfort, and not coping at home. He was accepted for admission to STARS, a separate entity to the RBWH. Due to the lack of beds at STARS at the time, Kyle was sent home with his father.

[13] On 10 July 2023, Kyle was contacted to advise a bed had become available in the Brain Injury Rehabilitation Unit (BIRU) in STARS. He was admitted to the unit that day.

[14] Over the following four days Kyle continued to complain of a sore throat.

[15] On 12 July 2023, an Ear Nose and Throat ("ENT"), Principal House Officer ("PHO") reviewed Kyle and undertook a flexible nasendoscopy ("FNE") procedure which was unsuccessful.

[16] On 13 July 2023, the same ENT PHO reviewed CT images of Kyle's neck with an ENT Consultant. There were no significant issues with Kyle's airway identified.

[17] On 14 July 2023 at approximately 4am, Kyle was checked by a nurse.

[18] At approximately 5.24am, Kyle was checked again, and he was noted to be unresponsive and not breathing. A Medical Emergency Team (MET) call was made, and CPR was commenced. Despite resuscitation attempts, Kyle was not able to be revived. Tragically, he was declared deceased at 6.11am.

[19] It became evident there were potential issues with the care Kyle had received in the 24 hours leading up to his death.

The Role of a Coroner

[20] On or around 10 January 2024, the State Coroner transferred Kyle's file to me. It was necessary to await the Autopsy Report ("AR") before further considering an investigation strategy. The AR was provided on 20 December 2024.

[21] On receipt of the AR, I requested an expert opinion from an experienced Ear, Nose and Throat Surgeon (Otolaryngologist), Dr Hallam. I received Dr Hallam's report on 5 March 2025 which led me to obtain further information from the clinicians who had been caring for Kyle. I subsequently obtained an expert report from Dr Wenck, an experienced Intensivist/Anaesthetist.

[22] On or around 25 June 2025, I determined pursuant to s 28(1) of the *Coroners Act 2003* ("Coroners Act"), it was in the public interest to hold an Inquest into Kyle's death. There was a delay in convening the Inquest due to my availability and the availability of witnesses to give evidence at the Inquest.

[23] The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. The investigation is about attempting to find the root cause of the incident that precipitated Kyle's death and to consider whether appropriate remedial steps have been taken.

[24] I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to Kyle's death.

[25] I am prohibited by s45(5) and s46(3) of the Coroners Act respectively from including in the findings or comments, any statement that a person is or may be guilty of a criminal offence or civilly liable for something.

[26] As required by s45(2) of the Coroners Act, I am required, if possible, to make findings as to:

a. who the deceased person is; and
b. how the person died; and
c. when the person died; and
d. where the person died; and
e. what caused the person to die (the medical cause of death).

[27] All findings are made to the civil standard of proof. That is, the evidence presented must show that a particular version of events is more probable than not.

[28] In the circumstances of this case, the findings of who, when, where and what caused Kyle to die are not contentious. How Kyle died includes 'by what means and in what circumstances'[1] he died. It is the focus of my findings.

[29] Section 46(1) of the Coroners Act empowers coroners to comment, whenever appropriate, on anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Forensic Pathologist Opinion

[30] Dr Jennifer McCourt performed an autopsy on Kyle on 19 July 2023 to determine his cause of death. She initially determined Kyle's cause of death as 'complications of multiple injuries'.[2]

[31] The toxicology results from samples collected from the RBWH at 3.30pm on 17 June 2023 showed Kyle had been using Methylamphetamine prior to the motorcycle accident. He had a level of 0.27 mg/L in his system.

[32] Dr McCourt was asked to reconsider Kyle's cause of death following her review of the expert reports of Dr Hallam and Dr Wenck. She amended Kyle's Cause of Death to be:

1(a) Airway obstruction *due to, or as a consequence of*;

1(b) Laryngeal abscess and laryngeal chondronecrosis *due to, or as a consequence of*;

1(c) Complications of injuries *due to, or as a consequence of*;

1(d) Motorcycle collision (rider).[3]

[33] For the reasons detailed below, I accept Dr McCourt's opinion as to the cause of Kyle's death.

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[1] *Regina v Her Majesty's Coroner for the Western District of Somerset (Respondent) and another (Appellant) ex pate Middleton (FC) (Respondent* [2004] UKHO 10, [35]
[2] Ex A2
[3] Ex B22, p2

Coronial Issues and the Inquest

[34] The Inquest was held over five days from 17 to 21 November 2025.

[35] At the Pre-Inquest Conference ("PIC") held on 18 September 2025, it was agreed that in addition to the findings required by s 45(2) of the Coroners Act, the following Coronial Issues would be explored:

a. Determine the appropriateness of the Ear, Nose and Throat assessment of Mr Gallagher on 13 July 2023.

b. Determine the appropriateness of the clinical management of Mr Gallagher on 13 July 2023 and in the early morning of 14 July 2023, in the Surgical, Treatment and Rehabilitation Service (STARS) which preceded Mr Gallagher's death.

c. Determine the appropriateness of Mr Gallagher being cared for in the STARS given his presentation on 12 and 13 July 2023.

d. Determine whether there was any failure in care provided in the STARS, which caused Mr Gallagher's death, including whether the resuscitative efforts were timely and adequate.

[36] The Coronial Issues defined the scope of the Inquest, and as such I can only rely on evidence that is relevant to, and logically probative of, matters within the scope of the coronial inquiry.

[37] The Brief of Evidence ("BOE") was tendered at the commencement of the Inquest. Sixteen witnesses were called to give oral evidence. They included: Dr Benjamin Yen Siu Low, Dr Akila Wijesekera, Dr Stephanie Yau, Dr Jennifer Gillespie, Dr Maurice Stevens, Registered Nurse ("RN") Daisi Shaji, RN Lenora Myers, RN Akwaima Ekukinam RN Sapphyre Frost, Dr Achera Syara Ratnavale, RN Keanu Festin, Dr Jessica Byrnes, RN Emily Morse, and Dr Daniel Edey.

[38] The Inquest also received expert evidence, in the form of written reports and oral evidence from Dr Hallam, Otolaryngologist, and Dr Wenck, Intensivist/Anaesthetist.

[39] I thank Counsel Assisting, and the parties' legal representatives for their assistance during the Inquest and for their written submissions following the hearing, the last of which I received on 9 March 2026.

Chronology of Events

[40] Kyle was first admitted to the RBWH on 17 June 2023. He had been intubated at the accident scene by the attending paramedics.

[41] A CT neck scan performed on Kyle's admission did not report a laryngeal injury. He was extubated on 22 June 2023. Throughout his admission, Kyle experienced dysphonia (hoarseness of the voice), painful vocalisation, and was experiencing fluctuating post traumatic amnesia (PTA). Kyle was discharged from the RBWH on 5 July 2023.

[42] The relevant timeline of events related to Kyle's death, was following his admission to STARS.

[43] Kyle had been accepted for admission following his presentation to the RBWH ED on 6 July 2023 with complaints of being unable to cope with ongoing throat pain. As there were no beds available, Kyle was discharged home until a bed became available. A referral to ENT was made.

[44] On 10 July 2023, Kyle was admitted to the STARS BIRU. The same Registrar, Dr Low, who had reviewed Kyle in the ED, reviewed him on his admission to STARS. Dr Low noted Kyle had a painful swallow and pain on vocalising but no dyspnoea (difficulty breathing).

[45] It has been submitted by Kyle's father, that it was not appropriate for Kyle to have been admitted to STARS on 10 July 2023 because he was not adequately and/or medically stable; his throat condition was acutely deteriorating; his unresolved medical issues (i.e. throat) had not been assessed; and a plan was not in place for investigation and/or management of that condition/medical issue.

[46] I do not accept this submission. As supported by the contemporaneous clinical records, Kyle was assessed as medically stable when he was reviewed on 10 July 2023. It was appropriate for Kyle to have been admitted to the BIRU at STARS. In addition to complaints of an ongoing sore throat, Kyle had reported he had not been coping at home.

[47] Kyle's pain and discomfort in his throat increased over 11 and 12 July 2023. This was actioned appropriately by the treating team at STARS with a referral on 12 July 2023 to the ENT team at the RBWH.

[48] On 11 July 2023 at around 7pm, a RN recorded that Kyle had buzzed and stated that he could not breathe. The following morning at 6.30am, another RN recorded Kyle had buzzed reporting he was having difficulty breathing.

[49] On 12 July 2023, Dr Wijesekera, an ENT PHO reviewed Kyle and performed a FNE which was poorly tolerated by Kyle and was terminated after around 10 seconds. A plan was made by Dr Wijesekera for a CT scan of the larynx and a review in one week's time. Kyle continued to complain of pain and expressed to nurses caring for him that he could not breathe. He became increasingly agitated.

[50] It became evident from the material provided prior to convening the Inquest, that the 24 hours prior to Kyle's death was the critical period in determining 'how' Kyle died. There are several factual disputes between witnesses, and at times a failure to recall events. There was also a paucity in documentation by some clinicians.

[51] At my request Counsel Assisting drafted a timeline of events for the uncontroversial aspects of Kyle's care. I asked the parties to advise if any amendments or additions were required to the timeline. I am grateful for this, and I have **annexed** the timeline to these findings.

The Coronial Issues

[52] It is necessary for me to address Coronial Issues (a) to (d) outlined in paragraph [35] above, in the first instance, as they inform the ultimate findings I am required to make pursuant to s45(2) of the Coroners Act.

Determine the appropriateness of the Ear, Nose and Throat assessment of Mr Gallagher on 13 July 2023.

[53] For the reasons detailed below, I find the Ear, Nose and Throat (ENT) assessment of Kyle on 13 July 2023 was not appropriate. The ENT clinicians did not identify the serious compromise of Kyle's subglottic airway, that is, that the CT scan results represented a potential acute airway problem. Urgent clinical assessment by an ENT surgeon of Kyle was required. This did not occur and had dire consequences in the period leading up to Kyle's death. That is, the clinicians at STARS had been falsely reassured that Kyle's airway was 'safe'. Had an appropriate ENT assessment have been undertaken, on balance, Kyle would not have died on 14 July 2023.

The CT Results

[54] On the morning of 13 July 2023, Dr Wijesekera, the ENT PHO, was contacted by Dr Gillespie, an experienced radiologist with a subspeciality interest in head and neck radiology, concerning the unexpected findings in Kyle's CT scan.[4]

[55] Dr Gillespie recorded in the formal CT report that Kyle had a 'grossly abnormal larynx'. She said by referring to this it meant it was significantly abnormal to her.[5] She had not recalled seeing a larynx that looked like Kyle's absent the setting of radiotherapy or potential trauma.[6] Her two primary concerns were the elongated (narrowed) airway and the chondronecrosis.

[56] Dr Gillespie said the purpose of her phone call would have been to flag that there was something abnormal in the CT scan and that it should be followed up.[7] Her usual practice was that she would have completed the report and then called with the report open in front of her. This is so she can write the name and time she speaks with a clinician. She would then click and send the report.[8] The CT Scan report was authorised by Dr Gillespie at 11.05am.[9]

[57] Dr Gillespie would call a clinician about imaging at least once a day, more frequently if she was rostered in the ED. She said the purpose of her call was to check what they knew about the patient and what they have seen in their examination findings, and if it was concordant with what she was seeing, or if it is '*for example, in this case, to flag something that I think is abnormal and should be followed up*'.[10]

[58] According to Dr Stevens, it was unusual for Dr Gillespie to call about imaging before a report was authorised.[11] Dr Wijesekera said Dr Gillespie would call if there were '*something that's grossly abnormal'*.[12]

[4] T2-4, 42
[5] T2-5, 7
[6] T2-5, 19
[7] T2-7, 15
[8] T2-7, 43
[9] ExC4, p4
[10] T2-6, 47; T2-6, 1-16
[11] T2-19, 26
[12] T1-32, 50

[59] In the CT reported on by Dr Gillespie, she records[13],

FINDINGS

Image quality is degraded by movement artefact.

On the original trauma CT, the cricoid and arytenoid cartilages were normally aligned. On today's study, the larynx is grossly abnormal, with diffuse oedema involving the aryepiglottic folds, more so on the left and extending into the vocal cords. The left half of the cricoid cartilage is difficult to identify and the arytenoid cartilage appears anteriorly displaced. Coarse calcification is seen just anterior to the right arytenoid cartilage which extends into the paraglottic fat. There is the impression of a peripherally enhancing collection within the left aryepiglottic fold measuring up to 11 mm in diameter. There is narrowing of the subglottic airway which measures up to 3 mm in transverse diameter.

No enhancing mucosal lesions seen elsewhere in the upper aerodigestive tract. The cervical lymph nodes demonstrate normal size and morphology. The parotid and submandibular glands have a normal CT appearance. Both internal jugular veins are patent. The carotid and vertebral arteries have a normal appearance for the phase of the study. There is a cystic lesion just posterior to the tragus of the ear measuring 13 mm in diameter. A trace of mucosal thickening is noted within the left sphenoid sinus.

Displaced healing fracture of the right mandibular condyle.

IMPRESSION

Grossly abnormal larynx. The appearance is suggestive of laryngeal chondronecrosis which may be secondary to trauma. Superimposed infection is difficult to exclude and correlation with inflammatory markers recommended.

Findings discussed with ENT reg (Dr Wijesekera) at the time of reporting.

Dr Jennifer GILLESPIE

Consultant Radiologist

[60] While Dr Gillespie does not remember her conversation with Dr Wijesekera, she said her usual practice was to just refer to the 'IMPRESSION' section of her report. Dr Wijesekera said Dr Gillespie was concerned about chondronecrosis of the laryngeal cartilages.[14] In this case she thinks she would have said something along the lines, 'the larynx looks abnormal, and I am suspicious that there is chondronecrosis or infection'.[15] I accept Dr Gillespie told Dr Wijesekera information to this effect.

[61] As to the chondronecrosis, Dr Gillespie explained both the cricoid cartilage (just above the trachea) and the arytenoid cartilage (sits at the back of the vocal cords at the cricoarytenoid joint) were abnormal.[16]

[62] The CT results that day are in the context of Kyle's larynx being reported as normal in the CT scan taken following his admission to the RBWH. This was confirmed by Dr Gillespie who had reviewed the prior CT trauma scan of 17 June 2023 prior to reporting on the CT scan on 13 July 2023. That is, the changes were new compared to the previous scan.[17]

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[13] Ex C4, p4
[14] T1-33, 25
[15] T2-8, 30-43
[16] T2-9, 16-43
[17] Ex B23, 2

The ENT Review between the PHO and the ENT Consultant

[63] On 13 July 2023, Dr Stevens was the on-call ENT Consultant and Dr Wijesekera was rostered as the on-call ENT Registrar (noting he was a PHO[18]).[19] Therefore, following the referral from the STARS team (as noted earlier, a separate entity outside of the RBWH), they were responsible for the ENT care Kyle received.

[64] There was an accepted 'chain of command' within the ENT department at the RBWH. An ENT PHO would review patients referred to the ENT department who would then discuss these patients with either a Registrar or Fellow or, if neither was available, or the Registrar or Fellow considered it necessary, the matter could be escalated to a Consultant. On 13 July 2023, Dr Wijesekera was himself filling the role of a Registrar in the ENT Clinic.

[65] Dr Hallam opined if the on-call PHO (who in this case was acting as the on-call Registrar) was contacted by the Radiologist, and if the PHO was concerned, the appropriate person to have called would have been the on-call Consultant.[20] Dr Hallam agreed it was up to Dr Stevens to identify the seniority of the Registrar, in this case a PHO with five months experience.[21]

[66] Dr Wijesekera was working in the ENT clinic at the RBWH with Dr Stevens on 13 July 2023. The clinic was busy and always ran late. Dr Stevens was required in theatre for an operating list that morning.

[67] At or around 11am, Dr Wijesekera approached Dr Stevens about Kyle's CT scan. Dr Wijesekera had not reviewed the CT report completed by Dr Gillespie when he consulted Dr Stevens. Dr Wijesekera says he conveyed Dr Gillespie's oral report to Dr Stevens along with a brief history, which included why he had seen Kyle the day prior, and why he had attempted the flexible nasal endoscopy. He states,

> *…And I essentially reiterated what Dr Gillespie had told me on the phone, because this wasn't a pathology I was familiar with, of chondronecrosis of the laryngeal cartilage, and so we then proceed to go through the CT scan and make a determination of what we thought was happening.*[22]

[68] Dr Stevens has little recall of the events of 13 July 2023. The extent of his memory seems to be that he was asked to look at some scans.[23] Dr Stevens does not recall discussing suspected chondronecrosis but thinks he knew that Dr Gillespie had called Dr Wijesekera but then later resiled from this.[24]

[69] Dr Stevens expected Dr Wijesekera would have reviewed the STARS clinical records for the last 24hour period[25] before speaking with him, and for Dr Wijesekera to have conveyed relevant information to him. Dr Stevens stated,

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[18] He had approximately 11 months experience in working under the supervision of ENT consultants (six months in a previous year in a position lower than a PHO plus approximately five months as a PHO from February to July 2023). He had not previously seen or heard of chondronecrosis.
[19] Ex C18, p3
[20] T5-5, 36; and T5-12, 21-27
[21] T5-12, 41
[22] T1-34, 15 and 40-45
[23] T2-21,12-50
[24] T2-45, 12, and 2-46, 18
[25] T2-23, 34

Well, I'd – I'd need to know a fair bit about the background. Um – how the patient managed to be in the predicament that he was in. Ah – I'd expect them to tell me what had transpired between admission and the present time. I'd expect them to tell me – ah – the status of the patient's symptoms – um – at the present time and what the indications were for doing an x-ray in the first instance – ah – or a CT scan, in this case. Um – then I would be wanting to know whether the patient was stridulous. In other words, had stridor which is a sound of breathing. Ah – which if it's inspiratory during the breathing in phase is inspiratory stridor which indicates airway obstruction sometimes. Not always. And – ah – so those are the kinds of questions I'd be asking, but I'd be mainly interested in, you know, the main reason for a sudden – for a – for a – an acute – ah – CT scan. And I'd be wanting to know exactly the status of the patient, clinically.[26]

[70] Dr Wijesekera accepts he did not review the STARS clinical records before consulting with Dr Stevens. Dr Hallam says he should have.[27] Because Dr Wijesekera did not review the records, he was not aware that Kyle had been experiencing stridor ('*noisy and wheezy breathing this morning*') and had ongoing dysphagia and dysphonia, when he spoke with Dr Stevens. Dr Low, the STARS Registrar says he spoke with Dr Wijesekera and gave a summary that he was concerned about a new stridor, he though does not remember the words he said[28], or when he had that conversation with Dr Wijesekera.[29] Dr Wijesekera does not recall having a conversation with Dr Low prior to reviewing the CT scan.[30]

[71] In evidence, Dr Stevens said he thought there was another consultant, Dr Yau involved in Kyle's care when he was approached by Dr Wijesekera. As outlined below, I find Dr Stevens is mistaken and there was no other Senior ENT doctor, be that Dr Yau or someone else involved in Kyle's care when he was approached by Dr Wijesekera to review Kyle's CT images.

[72] Dr Stevens accepted on the basis Dr Yau was not involved, his questioning of Dr Wijesekera at the time of reviewing the CT images was insufficient given his relatively junior position.[31]

[73] Dr Wijesekera and Dr Stevens reviewed the CT images together. Dr Wijesekera said they discussed the scan "*as a whole*" and "*we went through all the images*".[32] Dr Wijesekera said with his level of knowledge at the time, he was reliant on Dr Stevens' opinion of the scan.[33] Dr Stevens was asked what his usual practice is with a junior doctor in reviewing films, he responded,

Ah – in light of the fact there are other things going on around me, I – I'd scan the films and – ah – have a – have a – a brief look at them and – ah – and try to extract some – ah – clinical information because it's, you know, ah – an x-rays not the first way that you examine a patient. Um – it's about the third or fourth way that you examine them so it's – it's – ah – it's not by any means the appropriate way to assess a patient but – um – so I had a general look at it, and he said, "Look at this. Look at this. What do you think of this? What do you think of that?" And I said, "Well, you know, one of the things was probably that – ah – disruption in the supraglottis, the

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[26] T2-23, 7
[27] T5-4, 39
[28] T1-12, 1
[29] T1-13, 31
[30] T1-32, 29
[31] T2-57, 33
[32] T1-40, 40
[33] T1-41, 46

> *area above the vocal cords, and I could see that. Um – I don't recall seeing the narrowed airway in the – in the upper trachea, I must say. But that – he did tell me that – a few basic pieces of information about the patient clinical in – and that – and he demonstrated to me that he wasn't concerned about the patient's airway and the patient was not distressed. And so that – that meant that I didn't need to be overly concerned for the moment.*[34]

[74] Dr Hallam said if he had been told the radiologist had mentioned concerns for chondronecrosis, he would have wanted to scroll through the CT images himself from top to bottom.[35]

[75] Dr Stevens confirmed that when reviewing the images, if the imaging is minimised, they could click on the report which had been completed by Dr Gillespie. He did not believe they did that when reviewing the images.[36] This was because he did not expect the report would be available.[37] It had been authorised at 11.05am. It is not clear if the report was available, but if not, it would likely have become available while he and Dr Wijesekera were reviewing the images, or shortly thereafter.

[76] Dr Stevens agreed it was his expectation that ENT clinicians, including Registrars, not only view the CT scans when they have been ordered but also to read the report of the Radiologist. This is because a Radiologist has much more knowledge of radiology than they do. He stated,

> *…when it comes to complicated cases like this one – this was a very complicated case, then, you know, it's imperative that you listen to what the radiologist has to say.*[38]

[77] Dr Wijesekera had a different view when it came to reading the radiologist report, and stated,

> *Not always, and the reason I say that is when it comes to surgical specialties, we tend to read the scans ourselves and make a determination of what we think is happening, and Dr Stevens is a very senior and tenured ENT head and neck surgeon, um, so, yeah, it's not uncommon for us not to read a CT report.*[39]

[78] Dr Stevens said if an ENT Registrar was working under him with a practice of not reading CT reports, that they need to change their ways.[40]

[79] Dr Wijesekera did recall reading the report in the afternoon when he brought Kyle back to the ENT clinic for the further FNE.[41] Despite this, he did not bring the report to the attention of a more senior doctor, including Dr Stevens or Dr Yau.

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[34] T2-22, 11
[35] T5-54, 32
[36] T2-22, 37
[37] T2-22, 45
[38] T2-57, 38
[39] T1-36, 13
[40] T2-57, 42
[41] T1-36, 7

[80] Dr Hallam would have expected when Dr Wijesekera read the CT report, he would have brought that to the attention of Dr Stevens so he would know how serious the problem was.[42] He expected a PHO to have been aware of the significance of the 3mm airway reported in the CT scan.[43]

[81] Dr Stevens reviewed the images and explained some of the features in his oral evidence. He was taken to slide 148 of the CT images. He accepted it showed a transverse airway of three millimetres. He did not consider it was a medical emergency if the patient was not distressed. If the patient had stridor, it was a matter of urgency rather than emergency, requiring close hourly observations looking for signs of the accumulation of carbon dioxide.[44] The evidence supports Kyle had experienced intermittent stridor in the period prior to the discussion which had taken place between Dr Wijesekera and Dr Stevens. It was therefore a matter of urgency that Kyle be reviewed.

[82] At or around 11.32am, Dr Low made an entry in the clinical record[45],

CT reported:
Grossly abnormal larynx. The appearance is suggestive of laryngeal chondronecrosis which may be secondary to trauma.
Superimposed infection is difficult to exclude and correlation with inflammatory markers recommended.

3 weeks post extubation

Discussed with Dr Wijesekera (ENT reg),
- has reviewed CT and discussed with Dr Stevens
- they feel it is more consistent with intubation/extubation injury
- less likely to be chondronecrosis, no clear ring enhancement to suggest infection/abscess

Noted the nasendoscopy examination was poorly tolerated in setting of ABI
Discussion about facilitating any examination that's required with support person and diazepam etc.
ENT advised for watching and waiting approach
No role for dexamethasone at this stage

Plan
For ENT review in 1/52 and repeat endoscopic examination - plan for some diazepam/support person to be present
Await CRP today - regular bloods incl. CRP
Close NS monitoring of airway/respiratory status

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[83] Dr Low confirmed the reference to 'less likely to be chondronecrosis, no clear ring of enhancement to suggest infection/abscess' was reference to what Dr Wijesekera would have told him during their phone conversation.[46]

[84] On 18 July 2023, Dr Wijesekera entered further information into the clinical record after Kyle's death. This was prompted following a discussion with the coronial registrar. As to the consultation with Dr Stevens on 13 July 2023, he recorded,

[42] T5-18, 16
[43] T5-26, 4
[44] T2-27,46-50; T2-28, 0-40
[45] Ex C6, p23
[46] T1-14, 23

CT-Larynx occurred on the 13/7 ~1130, got a call from Dr Jen Gillespie that CT looked abnormal, concerning for left cricoid chondronecrosis, no evidence of crico-arytenoid subluxation.
Discussed with Dr Stevens (Consultant on-call) in clinic, went through story, Dr Stevens felt in keeping with traumatic intubation/extubation causing cricoid injury, felt unlikely to be infection and potentially just that half the cricoid hadn't ossified yet (as seen on previous CT) and this was the discrepancy between left and right side. Given that the patient was otherwise saturating well with no increased respiratory effort or rate, the dysphonia thought to be paradoxical, or muscle tension related. Dr Steven's plan was for follow up in 3-4 weeks, speech pathology input and clinical monitoring. Asked Dr Stevens, if there was any utility for a microlaryngoscopy and palpation of the joint/closer inspection – Dr Stevens said given it'd been 3 weeks post-extubation, any injury that's occurred would be too late to rectify and need to see what happens and monitor clinically.

Informed Ben Rehab reg above, and that the patient had been discussed with Dr Stevens and this was the plan.

[85] In the contemporaneous clinical note of Dr Low, he refers to chondronecrosis and infection/abscess. In his note, Dr Wijesekera refers to infection, and that Dr Stevens felt it was unlikely to be infection but that it was in keeping with a traumatic intubation/extubation. While written on 18 July 2023, the retrospective entry of Dr Wijesekera is consistent with Dr Low's entry on 13 July 2023. I accept Dr Wijesekera who had just gotten off the phone from Dr Gillespie, conveyed the oral report of Dr Gillespie to Dr Stevens. That is, that she suspected Kyle had chondronecrosis or an infection.

[86] I asked Dr Stevens at the time he saw the CT scan, why the 'chain of command' was not followed. That is, why action was not taken by him as the on-call Consultant. This resulted in an exchange between Dr Stevens and me,

---Um – I don't know the answer to that but my impression at the time that I was asked to see the scans was that it was an informal "have a look at these, what do you think" sort of thing.

So was it that Dr – sorry, I'm trying to understand this informal approach when you're approached by the on-call PHO for referral from STARS, chain of command is to the on-call consultant. How can it be an informal review if they're asking you as the consultant that they're going to, for advice about this patient?---Well, it's because we share the work around, you know, and – and we don't – you don't – as a consultant you don't necessarily have to take work from another person because you're the person on-call. If I wasn't there on that Thursday morning I wouldn't have ever seen this – seen the X-rays, nor the patient. And Dr Yau would have done that because she was there.

But - - -?---And so sometimes the more senior of the junior staff will say oh, we can handle this, we'll call Dr Stevens if we need him. And so that's how – the – we share the work around according to who's available.

Sure. Going back to that particular consultation with the PHO and that particular scan, and given the chain of command, if it's the case that you didn't clinically review the patient and you didn't arrange to clinically review the patient, isn't it your responsibility as the on-call consultant to arrange for another consultant to actually review that patient to ensure the patient is being reviewed by an ENT consultant?---I – is it my responsibility. I also had a responsibility to an unconscious patient in the operating theatre.

I understand that?---I can't be responsible for everything that's happening at every moment in time. And on that particular occasion, the patient in question was being looked after by a competent person, being Dr Yau, because she was more available than I was, and that's the best explanation I can offer.

If it's the case that I accept that Dr Yau wasn't available, wasn't aware of this when you reviewed - - -?---It would have been me.[47]

[87] Dr Hallam agreed ENT Consultants rely heavily on the junior doctors to convey a clinical impression of how important escalation of a case is. He says if there were significant clinical concerns, he would have looked at the scan in detail. If there was not, a cursory review may occur.[48] Dr Hallam confirmed in his opinion he thought Dr Wijesekera was too junior to recognise the seriousness of the concerns on the images without having read the CT radiologist's report.[49]

[88] Dr Hallam confirmed if he only had Kyle's CT images, when he looked at the CT images himself, he would have wanted to personally review Kyle clinically.[50] As to the CT images, he states,

When I looked through that scan, the supra – you – you – the supraventricular area was, really, fairly min – if that's all he looked at, he would not have created great concern.
Okay?---However, ***when you went down lower in the airway into the subglottis and – um – area that was greatly diseased, he would have been greatly concerned, as myself and a few other doctors all went through it and we all knew straight away there were major problems*** *and* – (emphasis added)

[89] Dr Yau who I refer to below, has since reviewed the CT images and confirmed the narrow airway at the subglottis could be seen on the CT images. She said if she had seen those images, she would have wanted to clinically assess Kyle.[51]

[90] Dr Hallam confirmed the chondronecrosis and/or infection referred to by Dr Gillespie in her report was well below the vocal cords.[52] Dr Hallam opined if a junior doctor had said words to the effect 'The radiologist has rung me and said there may be chondronecrosis. There may be an infection', when reviewing the images, you would look below the vocal cords.[53]

[91] Dr Hallam explained the role of an ENT Consultant is to review a patient, consider their history and to 'bring all the pieces of information together' to work out a plan for the patient.[54] This did not happen in Kyle's case. Dr Hallam stated,

I think the clinical scenario, when I read through the progress notes, in combination with that CT scan, was sufficient to say we have a real problem.[55]

[92] Dr Low made a contemporaneous note at 11.32am which reported what Dr Wijesekera had said. There is reference to 'less likely to be chondronecrosis' in his note. I accept Dr Wijesekera provided a brief history and conveyed Dr Gillespie's oral report to Dr Stevens and that Dr Wijesekera had conveyed there was a suspicion of chondronecrosis or infection. Dr Stevens acknowledged Dr Gillespie would make a call if she was concerned about a patient. I find that he was aware she had made the call.

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[47] T2-66, 14-50
[48] T5-8, 23-33
[49] T5-41, 28
[50] T5-6, 41
[51] T1-85, 1
[52] T5-9, 3
[53] T5-9, 25
[54] T5-6, 32-37
[55] T5-14, 18

[93] Even though Dr Stevens did not gain the impression from Dr Wijesekera that he was concerned about Kyle's condition, I find the reference to the suspicion of possible chondronecrosis (a relatively rare condition) or infection, in the context Dr Gillespie having made the call and personally conveyed the information to Dr Wijesekera, it should have been sufficient to put Dr Stevens on heightened alert. This in turn should have led Dr Stevens to seek further information from Dr Wijesekera, the junior doctor with only five months experience as an ENT PHO, and to have reviewed the CT images in detail, as Dr Hallam put it, from 'top to bottom,' rather that what seems on the evidence to have been a cursory review of the images. Further, in the circumstances, Dr Stevens should have asked more questions of Dr Wijesekera.

[94] Appreciating Dr Wijesekera was not familiar with the condition of chondronecrosis, following his phone call with Dr Gillespie, I find it was incumbent upon Dr Wijesekera to have reviewed the STARS clinical records, and to have possibly conferenced with Dr Low about Kyle's condition (noting Dr Low says he had spoken with Dr Wijesekera at some stage). This, before Dr Wijesekera consulted with Dr Stevens. He should have equipped himself with all the relevant information available and conveyed that information to Dr Stevens. He did not.

[95] Further, I find as was agreed by Dr Hallam, it was incumbent upon Dr Wijesekera to have brought the CT report to the attention of Dr Stevens when it became available, and to have read it. This particularly in circumstances when he had been contacted by Dr Low at or around 1.14pm to inform him that Kyle had worsened from the review the day prior, to which I refer below.

[96] Dr Wijesekera may not have consulted Dr Stevens again because of his mistaken belief that it is not uncommon for ENT Consultants not to read a CT report, and that he was comforted that Dr Stevens had reviewed the raw CT images. In any event, I find following the telephone call from Dr Low at or around 1.14pm, Dr Wijesekera should have sought input from either Dr Stevens or a more senior ENT doctor. I hope Dr Wijesekera's position has since changed and that he now appreciates the value of the reporting by a radiologist, in this case, a leading head and neck radiologist.

[97] I do not accept that Dr Wijesekera was required to have consulted with a Registrar or a Fellow prior to consulting with Dr Stevens. The referral for Kyle came from STARS. For all intent and purposes, Dr Wijesekera was the on-call Registrar, and his direct report was Dr Stevens, the on-call ENT Consultant.

[98] Dr Stevens said he was frequently asked informally to review scans all the time. He thought this was such an occasion and did not think that he was formally engaged regarding Kyle's management. It is evident there was miscommunication between Dr Wijesekera and Dr Stevens, when Dr Wijesekera approached Dr Stevens with the CT images. This led Dr Stevens not to appreciate he was being asked to consult regarding Kyle. As such, he failed in his obligation to appropriately review the CT images, to seek further information from Dr Wijesekera, and to arrange to have Kyle clinically reviewed either by himself, by the ENT Fellow, or by another ENT Consultant.

[99] I accept however that had Dr Wijesekera provided Dr Stevens with all the information he had available to him at the time, it may have led Dr Stevens to thoroughly review the CT images. However, Dr Wijesekera was a PHO with five months experience, he clearly did not appreciate the seriousness of the situation. In my view, as referred to above, it fell back to Dr Stevens to ask more questions.

[100] Putting the miscommunication issue aside, as I have found Dr Wijesekera did inform Dr Stevens that Dr Gillespie had phoned him and that she had suspected chondronecrosis or infection, this should have resulted in a thorough review of the images by Dr Stevens from 'top to bottom' which would have identified the serious issue with Kyle's abnormal larynx. This did not occur.

The Nasal Endoscopy performed by Dr Wijesekera and Dr Yau

[101] Dr Wijesekera wanted to undertake a further re-examination of Kyle's neck and glottis via a flexible nasendoscopy procedure ("FNE") as he wanted to establish a baseline for further examinations to compare against.[56]

[102] Dr Wijesekera was not asked in evidence if the trigger for the further examination was as a result of the phone call he had received from Dr Low at or around 1.14pm, or whether he had pre-determined that a further review was required. The phone call by Dr Low was made after Kyle had been reviewed by the rehabilitation team, including the rehabilitation consultant. In the contemporaneous clinical record at or around 1.14pm, Dr Low records,

> *Contacted ENT reg* ***regarding stridor and secretion/diet management that is persistent and worsened today from yesterday's review***
> *ENT OPD review today*
> *Pre-medication diazepam*
>
> *Plan*
> *ENT nasendoscopy this afternoon – valium prior, NS escort, mum support*
> *Monitor airway/secretion management or fever/chills*
> *-low threshold for emergency ENT/ED if any of the above.*[57]
> (emphasis added)

[103] Dr Yau recalled Dr Wijesekera approached her as she was walking through the outpatient's department requesting assistance and supervision with a flexible nasendoscopy procedure ("FNE"). She had had no previous involvement with Kyle prior to being approached by Dr Wijesekera.

[104] It was Dr Yau's understanding that the FNE was because there had not been a good study performed the day earlier. She was not of the understanding that there had been any deterioration in Kyle. She said, Dr Wijesekera explained that he had discussed Kyle's case with Dr Stevens and a preliminary plan had been developed. This was consistent with Dr Wijesekera's evidence and the contemporaneous clinical records. He also recalled telling Dr Yau that Dr Stevens considered the scans were more consistent with an intubation/extubation injury rather than chondronecrosis. She was aware there were ongoing concerns about stridor. She did not review the clinical records or the CT Scan as a plan had already been made by Dr Stevens. From her perspective she was simply supervising a procedure.

[105] As to what she would have done, should she have had all the information, the following exchange in oral evidence occurred,

[56] Ex B4, 2
[57] EX C8, 38

Doctor, in the sense that if you had the CT scan available to you, and the report, and/or watched and looked at the images, you had the clinical assessment of the things that, for example, Dr Low has said previously in his notes, I think it was relayed to you by counsel assisting, and you had the panendoscopy results, what, if any action would be, from your perspective, required?---So – I mean, I would – if I had all of that information at the time, um, I mean, I probably would be concerned that this patient may have needed some further assessment. Um, as I've mentioned earlier, this is such a rare complication, and I've never seen chondronecrosis or anything like that, of the larynx, so – and the consultant who was on call is vastly more experienced than I am, and so it is really difficult to say whether or not, um, I would have actually made a different decision if I had all of those things together.[58]

[106] Dr Yau says she would have been very trusting of Dr Stevens' assessment as he is a very experienced ENT surgeon.[59]

[107] Dr Hallam confirmed it was appropriate for Dr Yau to have supervised Dr Wijesekera with the FNE and that it was not necessary to consult Dr Stevens.[60] Further, that it was appropriate for Dr Yau to rely on the information provided by Dr Wijesekera that Dr Stevens had previously reviewed Kyle's imaging, and not to have reviewed the CT imaging, report, or progress notes herself.[61]

[108] On 18 July 2023, Dr Wijesekera made a retrospective entry in the clinical record regarding his review of Kyle with Dr Yau. He records[62],

I later requested pt to be transferred again to clinic to re-review and try and get a better scope of glottis to have as a baseline. Pt brought over again at 1500 that day. This time, pt had exaggerated respiratory effort – gasping for air for seeing patient, but with curtains closed no stridor or wheeze heard ?potential behavioral component. Alerted Dr Yau (Fellow) that I had brought patient back for re-review after speaking to Dr Stevens as I wanted to try get a better view of glottis and case explained.
Dr Yau saw patient with me. Patient refused co-phenylcaine and the FNE was done through the left nostril (recorded on the stacks) – again technically difficult scope as patient kept trying to pull away and contorted neck throughout scope
-Right hemilarynx appeared grossly normal – mildly edematous but true cord ok with full movement.
-Left hemilarynx – cricoarytenoid hypomobile, but actual true left vocal cord mobile.
-sensation appeared intact, there was post-cricoid salivary pooling seen.
- visible subglottis appeared ok, and there was full glottic closure and adequate abduction was a safe upper airway.
- Importantly, when scoping patient, patient was not stridulous and didn't have exaggerated work of breathing, was calm.
- there was intermittent paradoxical vocal fold movements.
- Impression was PVFM with structural abnormality of left cricoarytenoid, but with a safe upper airway.

Plan from Dr Yau was the same as initial plan from Dr Stevens to monitor clinically, No role for surgery at this stage as supraglottic airway still safe, notify of any changes or deterioration, and re-review in clinic in 2 - 3/52. Speech therapy for PVFM techniques.

Ben Rehab reg informed of above, and to notify if any concerns of changes, previously I had booked appointment for 1/52 (after initial review, which hadn't been cancelled) and instead of rebooking for 2-3/52 elected to keep the 1/52 (20/7/23) as a precaution in case of any acute deterioration.

[109] Dr Wijesekera did not consult Dr Stevens before or after the FNE. When asked why, he said,

[58] T1-77, 25
[59] T1-83, 43
[60] T5-17, 24
[61] T5-17, 27
[62] Ex C6, 23

---Because the plan from Dr Stevens was already set in motion and he'd already given his opinion of the scan, and the plan from that point of view was if the patient were to clinically deteriorate, then it would be worthwhile trying to re-examine him.[63]

[110] Dr Wijesekera said one of the reasons for doing the FNE was because it would give them a view of the infraglottis, and it would tell them how patent that was, and it would tell them the state and patency of the airway.[64] He also said it would give them an idea of the aetiology of the subglottic pathology.[65]

[111] Dr Hallam was shown the FNE video in evidence. He confirmed it was not possible to visualise the infraglottis or subglottis and that the video did not show anything below the vocal cords.[66] Noting, the concerning features on the CT scan were ***below*** the vocal cords.

[112] Dr Hallam opined a diagnosis of Paradoxical Vocal Fold Movement ("PVFM") in light of the CT images, the CT report and the progress notes was not appropriate.[67] He accepted that if Dr Yau was only supervising the procedure, had not seen the CT images or the CT report and was reassured they had been reviewed by Dr Stevens, and was aware Kyle had an intermittent stridor that she may have come to the conclusion of PVFM. Further, that only based on the FNE Dr Yau could have assumed Kyle's airway was safe; but given Dr Wijesekera was so junior it would have been prudent for Dr Yau to have seen the CT scan and the history for herself. He though acknowledged Dr Yau was in a 'very casual position'.[68]

[113] I find Dr Wijesekera is mistaken about his ability to have seen Kyle's infraglottis or to be informed of the aetiology of the subglottic pathology on the FNE.

[114] I find Dr Yau was asked, as what commonly occurs in a teaching hospital environment, to supervise the FNE procedure being performed by a junior doctor, Dr Wijesekera (PHO). I accept Dr Yau took comfort in the information which had been relayed to her by Dr Wijesekera, particularly that Dr Stevens (the most experienced ENT surgeon at the RBWH) had reviewed the CT scan and that a management plan was in place. The FNE by its nature did not show any structures below the vocal cords. It was not possible to see the chondronecrosis on the FNE. Kyle did not have stridor during the FNE, but Dr Yau was aware of reports of stridor. I find given the prior events and the information Dr Yau was aware of, she acted appropriately in the circumstances.

<u>If an appropriate ENT assessment had been undertaken</u>

[115] Dr Hallam felt as a result of the narrowed 3mm airway with intermittent stridor with no respiratory distress, there was a need to pursue the issue further. He did not consider immediate intubation was required but that Kyle required examination in the operating theatre so the area could be visualised, and that the ENT surgeon could then decide to intubate or insert a tracheostomy.[69]

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[63] T1-44, 24
[64] T1-45, 46
[65] T1-46, 16
[66] T5-19, 47; and T5-20, 6
[67] T5-20, 10
[68] T5-23, 41
[69] T5-28, 24-34

[116] Dr Hallam agreed he would have wanted Kyle transferred to the ENT ward with oxygen monitoring, hourly observations, watching for increased anxiety and consideration of Carbon Dioxide ("CO2") checks. He said with the benefit of hindsight now knowing what happened, he would have wanted to have secured Kyle's airway before he went to bed.[70]

[117] Later in evidence, Dr Hallam agreed that if an ENT surgeon had all the available information concerning Kyle on 13 July 2023, he states, '*If a senior ENT surgeon knew all those facts, he would recommend that the patient go to an operating theatre and have an airway established*".[71]

[118] Dr Hallam said there was a possibility if Kyle had had a tracheostomy, he may never have had an opportunity to remove it, and if the damage was further down the airway, the trachea, he may not have survived it.[72] That is, while a tracheostomy would have established an airway and Kyle would have survived, with a terrible infection of the upper airway, sometimes even a tracheostomy cannot save the patient's life.[73] He also thought in Kyle's case that had he survived, he may have had to have a tracheostomy for the rest of his life.[74]

[119] In essence, Dr Hallam confirmed had Kyle's airway have been secured on 13 July 2023, he would have survived, with the long term outcome more difficult to determine.[75]

[120] Dr Wenck is an intensive care and anaesthetic specialist. He acknowledged there are a number of risks in deciding to intubate a patient or to insert a tracheostomy, and that those risks need to be taken into account when deciding how to manage a patient's airway. As to Kyle's case, he stated,

> *The benefits would have definitely outweighed the risk. When you see the subglottic stenosed airway on the CT scan and the fact – and the clinical facts that the patient had stridor and was agitated and had difficult – and was complaining of difficulty breathing, there is only one course of action there – is to secure the airway. What we're talking about in terms of later problems with tracheostomy are well-known and well-described, but these aren't common problems in modern airway management. They still occur, of course, but these are things that occur weeks to months down the track. The most important thing in front of us right now is the acquisition of a safe airway for the patient, and – um – the risks – uhm – the benefit outweighs the risks dramatically in this circumstance.*[76]
>
> **…** *I mean, you have to acquire the airway, and then the infection has to be then dealt with as a separate issue. If there is an abscess, you acquire the airway, then you drain the abscess and we'll – um – you might do both con – you know, at the same time contempora – I can't really say the word – uh – at the – at the same time. But, nevertheless, the airway is the primal problem here, that is – the issue is the airway, and the airway has to be acquired, and then drainage of – ah – of sepsis, et cetera, comes as a – as the next consideration, the next thing to do in the operating theatre once the – ah – the – ah – airway is acquired and the patient's safe.*[77]

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[70] T5-29, 4
[71] T5-33, 5
[72] T5-29, 20
[73] T5-30, 1
[74] T5-48, 19
[75] T5-48, 31
[76] T5-62, 43
[77] T5-63, 10

[121] Dr Wenck is of the opinion that a patient with stridor should be transferred to an acute hospital rather than being in a rehabilitation ward. Putting that aside, once the CT scan was available showing Kyle's subglottic stenosis on the background of Kyle's reported stridor, he should have been immediately transferred to an acute facility.[78] As to monitoring the patient he stated,

> *I mean, there's no – there's no point monitoring a patient with an obstructed airway. You need to fix the airway first, and then you can monitor them afterwards. If, for some reason, there is some tremendous reason why you can't acquire the airway, like maybe a big abscess in front of the – the neck or – uh – an aneurysm of a – of a great vessel in the way of all this or some obstruction to his upper airway, you might want to observe the patient, but you would never do that in anything other than an intensive care unit. But that's not the right treatment. The right treatment is definitive management of that airway.*[79]

[122] Dr Stevens held the view that it would have been appropriate to have transferred Kyle to the ENT ward at the RBWH as in his opinion the nurses had the appropriate experience and were familiar with monitoring patients with airway compromise. To this Dr Wenck stated,

> *I think that's – um – unit-specific. If the ear nose and throat surgeon – uh – has confidence in his – in his – uh – ward that that's the case, then – then that would be – that's his opinion, and that's more than reasonable. It would depend on – on the – on the ward. It would depend on the skill mix at the time. I mean, there's a lot of unknowns there. I mean, I still would prefer a patient with stridor would be in an intensive care unit or in the operating theatre because there's people with definitive airway management skills walking past the bed, so in a – in a – in an ICU, firstly, there's very senior doctors there, and, secondly, there are consultants that are very senior doctors – um – there – um – for the vast majority of the – of the 24-hour cycle. So – um – those patients are much safer in an intensive care unit, but I accept in a very good Ear, Nose and Throat ward, that the nursing staff would have that expertise, but that would be specific to that particular unit, and if the Ear, Nose and Throat surgeon who runs that unit feels that's the case, then that's his opinion, and it's probably more – I mean, I'm sure that's more than reasonable. However, they have – there's no one there 24 hours a day in a ward, a doctor that can immediately move to the bedside and do something about that airway. In an Ear, Nose and Throat ward they have to call for help. They have to have a MET team. They have to have an – uh – a – a doctor – airway doctor coming, whereas in an ICU, they're there already on the floor in front of them. That would be my only caveat to that – uh – opinion.*[80]
>
> And
>
> *…If something does go wrong, as to the speed of the intervention; that the – my only -uh point about that, in the Ear, Nose and Throat Ward, you have to then call the ear, nose and throat specialist, but you really need an anaesthetist or an intensive care specialist to acquire the airway by intubation, and if that can occur quickly form the Ear, Nose and Throat Ward, then that's fine.*[81]

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[78] T5-70, 10
[79] T5-70, 24
[80] T4-70, 10
[81] T5-78, 17

[123] I accept had Dr Stevens have appreciated the significance of the CT images and an appropriate ENT assessment have been undertaken, it would have been established on the morning of 13 July 2023 that Kyle had an acute airway obstruction with intermittent stridor. Kyle would then have received definitive treatment following an emergent transfer to the RBWH.

[124] On Dr Stevens' evidence, Kyle would have required close monitoring in the ENT ward which would have resulted in escalation in his care as necessary. Others would have adopted a more aggressive approach which, given the concerning features as expressed by Dr Hallan and Dr Wenck would in my view have been the prudent course. In any event, I find on balance, Kyle would not have died on 14 July 2023 had an appropriate ENT assessment have been undertaken on the morning of 13 July 2023. It is not for me to determine the likelihood of longer term complications and/or Kyle's possible mortality into the future.

Determine the appropriateness of the clinical management of Mr Gallagher on 13 July 2023 and in the early morning of 14 July 2023, in the Surgical, Treatment and Rehabilitation Service (STARS) which preceded Mr Gallagher's death.

[125] For the reasons detailed below, I find the clinicians working in STARS, without the benefit of hindsight, acted reasonably in monitoring Kyle and managing his symptoms during 13 and 14 July 2023.

[126] On 13 July 2023, after Dr Wijesekera and Dr Stevens had reviewed the CT scan images, at 1.14pm, Kyle was reviewed by Dr Low and the treating rehabilitation consultant. Dr Low contacted Dr Wijesekera to discuss the current plan regarding Kyle's stridor and secretion/diet management that was persistent, and which had worsened from that day compared to the day prior.[82] As outlined above, Dr Stevens was not advised of this. This prompted the repeat FNE. Dr Low recorded a clinical note following the FNE at or around 3.302pm:

=====
Discussion with ENT registrar following nasendoscopy
Reviewed case with CT and nasendoscopy
Good quality study today
Impression of paroxysmal vocal cord movements superimposed onto his post traumatic changes
Mildly hypofunction of left cricoarytenoid joint
Airway not threatened or unstable

[127] Based on the information provided by Dr Wijesekera, Dr Low's plan was for Kyle to undergo speech therapy, respiratory retraining, biofeedback, psychology review – psychotherapy, and for Diazepam as required in the short term. Kyle was for reassurance and for staff to continue observations and to monitor Kyle's airway. The planned outpatient follow up appointment was not required for the following week. They were to continue to monitor progress and to liaise with ENT if there were any concerns.[83]

[82] Ex C8, p38
[83] Ex C8, p39

[128] Dr Low said he was reassured by Dr Wijesekera's plan and that if there were any concerns with Kyle from an airway management perspective or any pathology with respect to Kyle's airway, including whether Kyle could continue to be managed at STARS, he would have expected the ENT clinicians to have raised that with him.[84] He finished his shift at or around 4.30pm.

[129] Following discussion with Dr Wijesekera, Dr Low had directed there be 'close monitoring' of Kyle. There was no direction or medical order for continuous oxygen saturations or the frequency in which observations were to be recorded. The order at 11.24am was for 'close NS monitoring of airway/respiratory status'.[85]

[130] The usual frequency of observations on the rehabilitation ward was eight-hourly.[86] The nursing staff elected to increase the frequency of observations to four hourly in combination with the hourly visual observations Kyle had already been on due to his risk of absconding. The recorded vital signs were documented at 7.38pm, 2.59am, and 3.25am. They were all within normal limits.

[131] In the evening of 13 July 2023 and into the morning of 14 July 2023, Kyle was agitated, distressed, and expressing a view that he was concerned he was going to die.[87] He was gasping for air and hyperventilating. He was pressing the call bell with increasing frequency from the previous shifts and requesting a constant nurse presence.[88] The key events are recorded in the annexed chronology.

[132] The evidence of the three nursing staff caring for Kyle on the night shift, was that information had either been handed over or they had formed a view that Kyle's complaints about his breathing and sense of impending death were a symptom of anxiety and his brain injury. That is, that his complaints were 'behavioural' in nature.

[133] There was an experienced after hours nurse manager ("AHNM") at STARS, AHNM Morse. The majority of her 30 year career was in critical care, and among other qualifications, she held a Master of Nursing (Critical Care) and a Graduate Certificate in Emergency Nursing.[89] AHNM Morse recalled her shift started at 9pm and that Kyle had been flagged as a 'patient of concern' (a patient that could potentially deteriorate or cause problems overnight).[90] She had not been made aware of any reports of stridor. The main concern was Kyle's history of discharging himself against medical advice.[91]

[134] AHNM Morse had become aware from reviewing the iEMR (electronic clinical record), or from the nurse on the floor that Kyle had been 'signed off' by the ENT team, which meant to her that Kyle was not required to go back to the hospital and that they (ENT) were happy with how he looked, and because they had a direct view laryngoscopy, they were happy with those results.[92] When she was rounding at 9.45pm she looked in on Kyle and did not observe him with any respiratory distress. The nursing staff reported Kyle was anxious and wanting to go home.[93]

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[84] T1-26, 33
[85] Ex C8, p43
[86] T3-74
[87] Ex C8, pp26-27
[88] Ex C14 and Ex C8, 29
[89] B14, p1
[90] T4-11, 47
[91] T4-12, 15-27
[92] T4-13, 1-7
[93] T4-13, 20

[135] At or around 9.45pm, AHNM was aware Kyle had made comments that he was not able to breathe and that he felt he was going to die. The following exchange in evidence occurred,

> *When – um – patients make those kind of comments – uh – it does sort of make me feel a little bit anxious. Um – it's sore of like that feeling – I mean, I've been nursing 35 years. It's like that feeling of, you know, impending doom, and it does worry me, which is why I made so many rounds on him during the night – um – and why I actually go in and talk to him, have a look to see if there's any noisy breathing, you know, the intercostal recession, the increased work of breathing.*
>
> *So did you make any assessment at that time, on your first round, about what was potentially causing him to feel that way? ---Uh- the staff had said that he was very anxious. Um – he – he was sort of moving around in bed, anxious, not wanting to sit still. Um – you know, I've seen patients that are – that are anxious like that. But everything that I'd seen – and when I looked on ieMR and his observations, nothing sort of stood out at me for – for me to actually escalate anything any further.*
>
> *Okay. So you didn't request – you didn't consider a medical review was necessary at the time?---Uh -no, not at that time.*[94]

[136] AHNM Morse next reviewed Kyle at 1am. She did not observe any change in Kyle's respiration effort or rate. She went into his room, checked his pulse and made sure he was not sweaty or diaphoretic. Kyle remained anxious and restless, but everything looked okay. It was not her practice to record her observations when checking in on a patient during her rounds.[95] She knew the team leader on the ward was seeking to speak with the Resident Medical Officer (RMO).[96]

[137] The team leader, Clinical Nurse ("CN") Festin stayed in Kyle's room even though he was not caring for Kyle. AHNM Morse said the male nurse had a calming effect on Kyle and he enjoyed him being there.[97]

[138] At 6.57am, CN Festin made an entry of the events which occurred during the shift in the clinical record.[98]

[139] For 1.40am, CN Festin wrote,

> 0140hrs- PT constantly pressing the buzzer every 5mins . PT stable. wanted to talk to NS for re assurance. TL re assured pt he
> will be okay ++. PT wanted TL to talk to him helps him relax. PT does not want NS and AIN. TL told PT that he will be monitored
> frequently thru the night tht hes got nothing to worry about.
> PRN diaz given with some effect.
> PT expressing that he is scared what happens if he cant breath.
> TL re assured ++ he is in a good place and he needs to work on his breathing as per Speech training. PT is complying with
> suggestion breathing techniques

[94] T4-13, 50
[95] T4-14, 18
[96] T4-16
[97] T4-16, 40
[98] Ex C8, 26-27

[140] For 2-2.30am, CN Festin wrote,

> 0200hrs ?behavioral wanted NS to be present all time. TL spoke to pt that he needs to relax and focus on deep breathing.
> 0230- PT pressed buzzer. c/o cannot breath encourage breathing exercise. PT was not complying . expressing wanted to leave
> or find somewhere to jump off . PT states he is scared (cannot clarify what he is scared). TL continued advice deep
> breathing .PT was calm and thankful being there.scared)
> Temperature 36.5 (02:59)
> Systolic Blood Pressure 123 (02:59)
> Diastolic Blood Pressure 78 (02:59)
> Pulse 84 (02:59)
> SpO2 98 (02:59)
> Respiratory Rate 16 (02:59)
> EW Score: 0 (14/07/23 02:59:00)

[141] At 3am, CN Festin wrote,

> 0300hrs- PRN endone given (refer MAR) throat pain. PT consistent pressing buzzer. wanted to talk and reassurance TL spoke
> to pt that he need to tr and sleep. no point trying to express of leaving. PT states that he only trust the ND TL not any other
> nurses as he feels safe.

[142] The RMO was contacted at around 3.10am by CN Festin. She was not told of Kyle's history of dysphonia, dyspnoea, or stridor. She though had reviewed the ieMR and was aware of recent events. The nursing staff did not record or report any respiratory related compromise. The theme of the discussion by CN Festin was Kyle's anxiety and the request for medication. There was no urgency, and they did not convey that Kyle's condition was deteriorating.[99] CN Festin wrote,

> 0310. AH RMO notified for some advice. PT still asking for medication to help with anxiety and sleep. TL notified the AH RMO
> that non pharmacological intervention was not working. Its only working when pt is being 1on1 special by TL.
> Pt does not want NS and AIN. PT requested TL to talk to and calm him down.
> AH charted stat dose of diazepam to help pt sleep. (refer MAR). hourly visuals
> Temperature 36.6 (03:25)
> Systolic Blood Pressure 117 (03:25)
> Diastolic Blood Pressure 74 (03:25)
> Pulse 89 (03:25)
> SpO2 98 (03:25)
> Respiratory Rate 17 (03:25)
> EW Score: 0 (14/07/23 03:25:00)

[143] At 3.15am, the AHNM returned to the ward to check on Kyle. Kyle was still saying the same things about how he was feeling. Kyle was not stridulous, he had no difficulty breathing, he was not sweaty, and his pulse was within normal limits.[100]

[144] Kyle's last set of observations at 3.25am, are consistent with AHNM Morse's evidence. Kyle had a respiratory rate of 17, a pulse rate of 89 and oxygen saturation of 98%. So, while Kyle's observations were stable, and he was anxious and expressing thoughts of impending doom, without the benefit of hindsight, there was no objective clinical information that led the nursing staff to question that Kyle was experiencing airway difficulties.

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[99] T3-62 – T3-64
[100] T4-16, 11

[145] At 4am, CN Festin wrote,

> 0400hrs visual obs. PT sound asleep breathing well. no respiratory distress.
> Resp 16. SP02 99% RA.

[146] Kyle had been administered opioid and sedative medications to attempt to relieve his symptoms. At 5.22pm, he had 5mg of Diazepam (Valium), at 1.43am he was administered 5mg of Valium and 5mg of Oxycodone, at 3.10am he was administered 5mg of Endone, and at 3.10am, 5mg of Valium as prescribed by the RMO.

[147] At around 4.15am, CN Festin who had been providing frequent one on one support to Kyle went on his meal break. Another nurse was assigned to the nurse station to monitor patients and to answer any buzzer calls. She recalls she had been informed Kyle was sleeping. She herself observed Kyle to be sleeping and could see the rise and fall of his chest.[101] When CN Festin came back from his break at around 5.15am, he was told that Kyle had remained 'settled'. He commenced his hourly visual observation round and found Kyle was unresponsive, and not breathing.[102]

[148] Dr Wenck explained how the administration of opioid and sedative drugs affected Kyle due to his narrowed airway. CO2 would have accumulated in Kyle's blood because it could not be expelled due to the obstructed airway causing increasing agitation and anxiety. This would have led to shortness of breath which can be suppressed by the administration of sedative drugs. The Endone and Valium would have acted in conjunction to reduce both Kyle's anxiety and his breathing by blunting his response to CO2. His respiratory rate would have decreased as well as his anxiety, but because of the obstruction the CO2 would have continued to rise.[103]

[149] Dr Wenck advised the drop in oxygen saturations in this type of scenario would have occurred very late, and stated, "*so he could have very significant carbon dioxide retention leading to unconsciousness, but his saturations could still be within the normal range*".[104] When Kyle's oxygen saturations did eventually drop, he would have become hypoxic which would have led to his cardiac arrest.[105] He estimated the drop in saturations would have occurred in the 10 to 15 minutes prior to the cardiac arrest.[106]

[150] Dr Hallam accepted given Kyle's background in terms of his significant injuries from the motorcycle accident, his brain injury, his history of absconding from hospital in the past, the team had good reason to be reassured that Kyle was not medically deteriorating.[107]

[151] Dr Hallam says it was reasonable that the clinicians in STARS were reassured by the ENT advice they had received.[108] He says they thought based on the information they had been provided, that Kyle had a functional problem and therefore continued with medical treatment, which is Valium and Endone. He states, "*they would not have done that if they thought there was an airway problem, so they – they were reassured that wasn't the case*".[109]

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[101] Ex B9, 4
[102] T3-95
[103] T5-60, 7
[104] T5-60, 3
[105] T5-61, 10
[106] T6-61, 9-21
[107] T5-46, 30
[108] T5-24, 45
[109] T5-42, 43

[152] While there could have been more frequent vital signs recorded, I accept Kyle was appropriately monitored in the context of the information the staff had been provided, and the reassurance about Kyle's airway by the ENT Team ('Airway not threatened or unstable'). The nursing staff, including a very experienced AHNM did not identify any issues with Kyle's airway or respiratory status.

[153] All of Kyle's vital sign recordings up to 3.25am on 14 July 2023 were stable. He was observed to be 'settled' at 4am. The explanation by Dr Wenck outlined above is consistent with what seems to have occurred in this case, and which led to the staff not being concerned about Kyle's airway. Provided Kyle's history of a traumatic brain injury and his previous discharge against medical advice, together with the advice from ENT that his airway was safe, I consider putting Kyle's symptoms down to anxiety was not unreasonable. I find without the benefit of hindsight, given the circumstances as discussed herein, the clinicians at STARS acted appropriately in their monitoring and management of Kyle.

Determine the appropriateness of Mr Gallagher being cared for in the STARS given his presentation on 12 and 13 July 2023.

[154] For the reasons outlined above, I find it was inappropriate for Kyle to remain a patient at STARS after Dr Gillespie had contacted Dr Wijesekera to orally report on the CT scan, and then when she provided her report to the ENT team, on 13 July 2023.

[155] The CT scan result should have triggered a clinical review by an ENT Consultant, or in the alternative, an ENT Fellow. There was documented evidence of Kyle experiencing intermittent stridor, and his condition had worsened from 12 to 13 July 2023. Urgent care was required.

[156] I find on balance, an ENT clinical review in the context of the very concerning CT scan result, the presence of intermittent stridor, a report by a nurse at 11.42am on 13 July 2023 that Kyle was 'breathing hard and using accessory muscles'[110], and his worsened condition from the previous day, Kyle would have been transferred acutely to the RBWH.

[157] While Dr Stevens says in his view Kyle would have been closely monitored in the ENT ward, which was a conservative view in comparison to the opinions expressed by Dr Hallam and Dr Wenck, I consider it is likely an appropriate clinical assessment would have resulted in a more acute management plan which would have resulted in Kyle's airway having been secured in a timely manner.

Determine whether there was any failure in care provided in the STARS, which caused Mr Gallagher's death, including whether the resuscitative efforts were timely and adequate.

[158] For the reasons detailed below, I find there was a short delay in the commencement of resuscitation efforts after Kyle was found unresponsive. I though accept the delay did not impact on Kyle's outcome.

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[110] ExC8, p41

[159] The Medical Emergency button was activated at 5.24am.[111] Dr Edey and the AHNM arrived as part of the medical emergency response team ("MET") at 5.30am.[112] The clinical records support CPR was not commenced until the arrival of the MET at 5.30am.[113]

[160] The delay seems to be due to the CN Festin wanting to check the status of Kyle's acute resuscitation plan which was his usual practice at the time.[114] Dr Wenck opined CPR should always be commenced immediately and said 'and that's all there is to it'.[115] I hope CN Festin has since reflected on this, and that in future, if he does not know the resuscitation plan for a patient, he will commence CPR and then seek confirmation as to the resuscitation plan.

[161] As to Kyle being found cold with fixed and dilated pupils by the AHNM, Dr Wenck stated,

> *So the – the thing about the patient being cold – um – CO2 when it's very high can have a – uh – a vasoconstrictive effect because the patient's – uh – adrenaline levels are through the roof because the patient's being – is dying basically from carbon dioxide and hypoxia. The patient's – um – uh – sympathetic nervous system will be active – extremely active, and he would've had an enormous amount of adrenaline and noradrenaline being secreted by his – um – adrenal glands, hence he would've had some vasoconstriction, hence the cool skin. There was no core temperature taken, so we're only talking about skin here. So it's most likely just due to his – um – his – uh – activation of his – um – his – uh – sympathoadrenal access – uh – pri – just prior to the body dying. The fixed and dilated pupils are a typical feature of a severely hypoxic patient, as is asystolic cardiac arrest. That's the typical way a patient arrests, particularly a young patient arrests – uh – from hypoxia is [indistinct] asystole. Um – that's not true for patients with – that are elderly with heart disease. People who are my age, for instance, can [indistinct] asystole just from heart disease, but if you're young with no heart disease, which is presumably the case here, otherwise it would've been found at autopsy, then the – um – the – asystole is a common presentation of hypoxic – uh – or hypoxia causing cardiac arrest. And the fixed and dilated pupils are just a feature of the brain not having oxygen, and [indistinct] the brain doesn't have oxygen, the brain doesn't work, pupils become fixed and dilated.*[116]

[162] Dr Wenck was asked if earlier intubation following Kyle being found in cardiac arrest would have made a difference. He advised severe hypoxia is very difficult to come back from, and even if they had achieved return of spontaneous circulation, a patient would often have quite severe brain damage. He doubted it would have made any difference one way or the other for Kyle.[117] I accept on balance, the short delay in resuscitation would not have altered the outcome for Kyle.

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[111] Ex C8, pp20 and 114
[112] Ex C14, p3
[113] Ex C8, pp20 and 114
[114] T2-97, 34-50
[115] T5-73, 45
[116] T5-66, 10
[117] T5-69, 25

The findings required by s. 45 2) of the Coroners Act 2003, namely the identity of the deceased, when, where and how he died and what caused his death.

Identity of the deceased –	Kyle James Gallagher
How he died –	Kyle died from an airway obstruction due to an abscess and laryngeal chondronecrosis which had not been appropriately identified by the ENT team at the RBWH despite a CT scan of 13 July 2023 showing a narrowed airway and suspected chondronecrosis/infection.
Place of death –	Surgical Treatment and Rehabilitation Service ("STARS") Herston Road HERSTON QLD 4006 AUSTRALIA
Date of death–	14 July 2023
Cause of death –	1(a) Airway obstruction *due to, or as a consequence of*; 1(b) Laryngeal abscess and laryngeal chondronecrosis *due to, or as a consequence of*; 1(c) Complications of injuries *due to, or as a consequence of*; 1(d) Motorcycle collision (rider).

Comments and Recommendations

[163] Dr Wijesekera who was the on-call ENT Registrar appropriately sought the input of his direct supervisor, the on-call ENT Consultant, Dr Stevens.

[164] I acknowledge there was a practice in the ENT Department for junior doctors to seek out more senior doctors before speaking with an ENT Consultant and in some circumstances to consult a Fellow. A position at this time held by Dr Yau who had already completed her ENT training but was on the roster as a Registrar with a different ENT Consultant as her supervisor.

[165] Dr Stevens assumed he was being consulted just to look at the images and was not 'engaged' as the treating ENT Consultant and that Dr Wijesekera would escalate any clinical concerns to the Fellow.

[166] Dr Wijesekera was too junior a doctor to appreciate and understand the significance of the CT images. Following his conversation with Dr Gillespie, Dr Wijesekera appropriately informed Dr Stevens, and he reviewed the CT images with Dr Stevens.

[167] Dr Stevens formed the view Dr Wijesekera had not demonstrated to him that he was concerned about Kyle's airway or that Kyle was distressed. This may have been because Dr Wijesekera had not reviewed Kyle's records or sought further information from STARS before speaking with Dr Stevens. He should have.

[168] Regardless of whether Dr Wijesekera had demonstrated concern for Kyle's condition, Dr Stevens had been asked by a junior doctor to review CT images following a telephone call from an experienced head and neck radiologist during which the junior doctor was informed, and told Dr Stevens, that she had suspected Kyle had chondronecrosis or infection. Even if Dr Stevens did not think that he was the treating ENT Consultant, he was required to appropriately review the CT images and provide advice to the junior doctor.

[169] There was much made of the 'chain of command', and it was suggested Dr Wijesekera had not followed that. I do not accept that. Dr Wijesekera was working in the clinic with Dr Stevens, had taken a call as the on-call Registrar from STARS, a separate entity to the RBWH, and conferred with his on-call Consultant. There was some emphasis that Dr Wijesekera as the junior doctor should have somehow expressed his concern or put Dr Stevens on notice that there was a problem. I do not accept that. Dr Stevens was aware of the call from Dr Gillespie, and he was asked to review the scans. The evidence supports the images required him to take urgent action by either clinically reviewing Kyle himself or to have another ENT Consultant, or the ENT Fellow review Kyle.

[170] There was miscommunication between Dr Stevens and Dr Wijesekera when the images were presented to Dr Stevens. Additionally, Dr Stevens was to be in surgery for an ENT list which had already commenced that morning, and the ENT clinic which was due to finish at 10am but was still going at 11am. I suspect Dr Stevens was under significant time pressure. This in addition to the miscommunication may have contributed to why he missed what was an obvious compromised (narrowed) subglottis airway with suspected chondronecrosis on the CT images, and why Dr Wijesekera was not informed that there was a concern for Kyle's airway. Whatever the reason was for Dr Stevens not having appropriately reviewed the CT images, it set off a series of cascading events which I have determined, on balance, led to Kyle's death on 14 July 2023.

[171] There was a further missed opportunity after Dr Wijesekera had read the CT report of Dr Gillespie and he had received the phone call from Dr Low at or around 1.14pm. Dr Hallam is of the opinion the reference to the 3mm airway in the report was enough to have alerted Dr Wijesekera there was a problem. Dr Wijesekera then received the phone call where it was reported that Kyle had a stridor and that his condition had worsened from the day prior. He did not escalate the concerns imparted to him from the rehabilitation team to either Dr Stevens or Dr Yau. He should have. This would likely have led to a clinical assessment of Kyle by Dr Stevens or Dr Yau, which on balance would have altered the course of the cascading events. That is, Kyle would not have died on 14 July 2023.

[172] I appreciate this has been a difficult case for all the clinicians involved in Kyle's care and that they have all likely reflected on the care they provided. The case has demonstrated the need for:

a. clear communication between junior and senior medical staff;

b. senior medical staff to establish the basis on which they are being consulted by junior doctors;

c. junior doctors to escalate concerns when contacted by the treating team about a deterioration in a patient;

d. immediate commencement of CPR when the resuscitation plan for a patient is unknown.

[173] As is standard practice for all health care related deaths, a copy of these findings will be provided to the Office of the Health Ombudsman. In this case, I also intend to provide a copy of these findings to Clinical Excellence Queensland.

I close the inquest.

Melinda Zerner
Coroner
BRISBANE

Annexure

IN THE CORONERS COURT OF QUEENSLAND

INQUEST INTO THE DEATH OF KYLE JAMES GALLAGHER

Time	Event
13.07.2023	
07:45 **08:20**[1]	Nursing staff requested an urgent review[2] in relation to concerns of new stridor.[3] Kyle reviewed by Dr Ben Low, Rehab registrar, who noted '*noisy and wheezy breathing this morning*'.[4] Kyle was noted to be feeling anxious. The ENT review from the previous day was noted and the impression was of '*stable respiratory status with upper airway stridor thought secondary to traumatic ventricular fold oedema'*. A plan was made for 'close monitoring' and a CT neck with nurse escort. A message was left with ENT.[5]
09:55	Kyle reviewed by a Rehab Junior House Officer (JHO) who noted that he had stridor but was not distressed. An irritable throat was noted but pain was 'otherwise controlled'. Ongoing dysphagia and dysphonia was noted. A plan was made for continuous Sp02 monitoring and to await ENT advice.[6]
11:05[7]	The CT Neck report was authorised by Dr Jennifer Gillespie. The 'impression' of the imaging was reported as: *'Grossly abnormal larynx. The appearance is suggestive of laryngeal chondronecrosis which may be secondary to trauma. Superimposed infection is difficult to exclude and correlation with inflammatory markers recommended.* *Findings discussed with ENT reg (Dr Wijesekera) at the time of reporting.'*[8]
11:24[9]	CT Report impression noted by Dr Low, and discussed with Dr Wijesekera. Dr Low noted that the nasendoscopy examination was poorly tolerated and discussed facilitating any examination required with a support person and diazepam. A plan was made by Dr Low for close nursing monitoring of '*airway/respiratory status*.'[10]

[1] Ex C8, p 49; T1-9, LL 32 – 33.
[2] Ex C8, p 51.
[3] T1-9, L 35.
[4] Ex C8, p 50.
[5] Ex C8, p 50 – 51; T2-7, LL 25 – 37.
[6] CCMS #11474336 p47
[7] Ex B23, [12].
[8] Ex C4, pp 4-5.
[9] Ex C8, p 42.
[10] Ex C8, p 43.

12:00	Kyle reviewed again by JHO Dr Wong, with Dr Low. Ongoing stridor was noted however the Kyle was mobilising with normal Sp02. Subcostal recession was noted.[11]
13:14[12]	Kyle reviewed by Dr Ben Low, with the treating consultant, Dr Cassandra McLennan.[13] The ENT reg was contacted by Dr Low regarding stridor and secretion/diet management that was '*persistent and worsened today from yesterday's review*'.[14] A plan was made for ENT endoscopy that afternoon, monitoring of airway/secretion management and for fever/chills. It was noted there would be a low threshold for emergency ENT/ ED.[15]
13:23	Kyle was given 5mg Valium prior to transfer to nasendoscopy.[16]
14:23	Kyle made ongoing complaints of shortness of breath and sore throat/ rib pain to the nurse caring for him on the morning shift, RN Daisy Shaji,[17] who noted that the Kyle appeared to be '*breathing hard, using accessory muscles*.'[18] The team leader was informed. Saturations were continuously monitored throughout the shift at 98-99% on room air. The day shift nurse raised concerns with the treating team registrar regarding the Kyle's fluid intake, noting he could not tolerate much due to difficulty swallowing/ difficulty breathing.[19]
14:39[20]	Dr Wijesekera performed a flexible nasendoscopy (FNE) on Kyle, which was overseen by Dr Stephanie Yau. Prior to overseeing the FNE, Dr Yau had observed Kyle to have mild stridor.[21]
14:43	Dr Wijesekera views the CT report.[22]
15:02[23]	Dr Low discussed Kyle with the ENT registrar following nasendoscopy. The impression relayed by Dr Wijesekera[24] was of paroxysmal vocal cord movements superimposed onto his post traumatic changes. Mildly hypofunction of left cricoartenoid joint was noted. Kyle's airway was conveyed to be *'not threatened or unstable'*.[25]

[11] Ex C8, pp 46- 47.
[12] Ex C8, p 37.
[13] Ex C8, p 38.
[14] Ex C8, p 38.
[15] Ex C8, p 38.
[16] Ex C8, p 143.
[17] Ex C8, p 40- 41.
[18] Ex C8, p 41.
[19] Ex C8, p 42; T2-78, LL 30 – 50.
[20] Ex C12.
[21] Ex B19, [19].
[22] Ex C18.1, L 558.
[23] Ex C8, p 38.
[24] T1-20, LL 26 – 33.
[25] Ex C8, p 38; T1-20, LL 26 – 33.

15:06	Dr Wijesekera makes a progress note recording that Kyle was seen again after the CT neck which was '*concerning for potential chondronecrosis of the cricoid left > right*'. An area of enhancement over the left was also queried.[26] 'On review today',[27] he noted that the Kyle was '*stridulous at rest, but not desaturating*'. Henoted that the FNE showed element of PVFM, and that both cords were mobile, left crico-arytenoid joint hypomobile and inflamed, but '*able to protect the airway and is sensate*'. He noted that Kyle was also seen by Dr Yau [fellow]. The plan was for speech pathologist input for PVFM, to monitor clinically, to notify of any changes or deterioration, and for review in the outpatient department in 2-3 weeks.[28] The progress note was revised at 08:42 on the 14th of July 2023 to indicate that this was discussed with Dr Stevens and images reviewed.[29]
15:42	Kyle was given 5mg Endone.[30]
16:05[31]	Kyle was reviewed by a speech pathologist after being asked by the treating medical team to review regarding PVFM. Kyle was seen for 30 minutes of treatment for PVFM management. Kyle complained of headaches, feeling cold, ongoing difficulty breathing and odynophagia. PVFM strategies were explained. Kyle required a lot of reassurance and support from the Speech Pathologist and mother throughout. [32]
16:30[33]	Dr Low reviewed Kyle and discussed the findings of the CT with Kyle and his mother, who were advised of the management strategy for paroxysmal vocal cord dysfunction.[34] It was noted that observations should continue with airway monitoring and to liaise with ENT if there were concerns. ENT follow up was planned in the outpatients department and it was noted that the Kyle didn't need a review next week.[35] This would be the final in person medical review Kyle received prior to his death.

[26] Ex C6, p 24 – 25.
[27] Ex C6, p 25.
[28] Ex C6, p 25.
[29] Ex C6, p 24 – 25.
[30] Ex C8, p 143.
[31] Ex C8, p 31.
[32] Ex C8, p 32.
[33] B13, [85] – [95]; T1-24, LL 17 – 24. NB this review was entered into the progress notes (Ex C8, p 38) at 17:29, however Dr Low's evidence was that it occurred at 16:30, which is supported by the diazepam prescription occurring at 16:49 (Ex C8, p 260), and the evidence of RN Myers (T2-98, LL 17 – 31).
[34] Ex C8, p 39.
[35] Ex C8, p 39.

16:49	Dr Low charted a prescription for diazepam 5mg - PRN ('as required') for anxiety. The dosing interval is 8 hourly.[36]
17:33	Kyle was given 5mg Diazepam.[37]
19:47	PRN 5mg Endone administered together with regular Targin (5/2.5mg).[38]
21:00	Kyle was complaining of pain/discomfort in throat multiple times throughout [afternoon] shift. '*Reassurance and ++++ TLC given from multiple nursing staff*', advised to take slow and deep breaths to sit up.[39] Kyle was still complaining of pain and not being able to breathe despite having all required pain relief. Kyle stating '*I want to go to ER they'll give me something*'.[40] Kyle was often 'expressing [he would] discharge against medical advice (DAMA) if he didn't get pain relief'.[41] The Nurse call bell records show that Kyle activated the call bell fifteen (15) times over the course of the afternoon shift, which was significant compared to the previous evenings.[42]
14.07.2023	
01:40	Clinical Nurse (CN) Festin, who was the nursing team leader that night, provided care to Kyle for the first time in response to him frequently pressing the call bell.[43] Kyle complained of not being able to breathe, and expressed that he was "*scared what happens if he can't breathe"*.[44] CN Festin reported contemporaneously that Kyle was '*constantly pressing the buzzer every 5 mins'*.[45] The Nurse call bell records show that at this time and after the commencement of the evening shift, Kyle had activated the call bell twice at 01:21am and 01:33am.[46]
01:43	Kyle was administered PRN diazepam 5mg and PRN Oxycodone 5mg.[47]
02:00	Kyle wanting [nursing staff] to be 'present all the time'. Kyle was told to relax and focus on deep breathing.[48]

[36] Ex C8, p 260.
[37] Ex C8, p 142.
[38] Ex C8, pp 141 - 142.
[39] Ex C8, p 29.
[40] Ex C8, p 29.
[41] Ex C8, p 29.
[42] Ex C14.
[43] B10 [12]; T3-78, LL 27 – 36.
[44] Ex C8, p 26. T3-78, L 40 to T3-79 L 4.
[45] Ex C8, p 26.
[46] Ex C14, p 2.
[47] Ex C8, p 139.
[48] Ex C8, p 2

02:26[49]	Kyle activated the nurse call buzzer and complained of not being able to breathe.[50] Kyle was encouraged by CN Festin to do breathing exercises. Kyle was not complying, expressing he '*wanted to leave or find somewhere to jump off*'. Kyle stating that he was scared. Advised to continue deep breathing.[51]
02:56	Kyle activated the nurse call buzzer for the final time.[52]
02:58	STARS RMO was paged by CN Festin.[53]
02:59	The first set of vital sign observations were completed since the previous vital sign observations done at 19:38:[54] Temperature 36.5 (02:59) Blood Pressure 123/ 78 (02:59) Pulse 84 (02:59) SpO2 98 (03:06) Respiratory Rate 16 (03:06)
03:10	A further 5 mg of PRN Endone was administered.[55]
03:12	A 'once-only' dose of 5mg of diazepam was prescribed by Dr Ratnavale.[56]
03:19	The 'once-only' dose of 5mg of diazepam prescribed by Dr Ratnavale was administered.[57]
03:25	A final full set of vital signs were taken by CN Festin:[58] Temperature 36.6 (03:25) Blood Pressure 117/74 (03:25) Pulse 89 (03:25) SpO2 98 (03:25) Respiratory Rate 17 (03:25)
05:24	Medical Emergency buzzer activated.[59]

[49] C14, p 2. Recorded as 02:30 in C8, p 27.
[50] Ex C8, p 27.
[51] Ex C8, p 27.
[52] Ex C14.
[53] Ex C22.
[54] Ex C8, p 165;
[55] Ex C8, p 140.
[56] Ex C8, p 259.
[57] Ex C8, p 140.
[58] Ex C8, p 164.
[59] Ex C14, p 3.

05:30	Doctor Edey and RN Morse (After-Hours Nurse Manager) arrived.[60]
05:47	Cardiac Arrest Call (333) is made via switchboard.[61]
05:56	Intubation with size 8 endotracheal tube by Dr Jessica Byrnes.[62] Assessment of differentials, discussion with Dr Cohen ICU consultant, Dr Friend General Physician, agreement with futility of ongoing efforts for CPR/ALS.[63]
06:11	Efforts at resuscitation ceased.[64]

[60] Ex C8, pp 20 and 114; Ex B14, [12](h).
[61] Ex C7, p 10.
[62] Ex C8, pp 20 and 114.
[63] Ex C8, p 21; B6 [16]; B8 [44].
[64] Ex C8, p 20.