CITATION: *Inquest into the death of Sandra McRae* [2008] NTMC 064

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0038/2005
DELIVERED ON:	29 October 2008
DELIVERED AT:	Darwin
HEARING DATE(s):	16 – 18 July 2008
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Unexpected Hospital Death, Pulmonary Embolism as a consequence of Fractures, Care and Treatment Thereof.

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health:	Kelvin Currie

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0038/2005

In the matter of an Inquest into the death of
SANDRA MCRAE
ON 13 MARCH 2005
AT THE INTENSIVE CARE UNIT,
ROYAL DARWIN HOSPITAL

FINDINGS

29 October 2008

Introduction

1. Sandra McRae ("the deceased") was a Caucasian female born on 5 May 1947 in Bradford upon Avon in the United Kingdom. At approximately 10pm on 25 February 2005 Mrs McRae was involved in a motor vehicle accident at the traffic light intersection of the Stuart Highway with Deviney Road. As a result of that accident she was hospitalised. Shortly following her admission, the deceased was placed under the care of the orthopaedic unit at RDH as she had suffered several fractures. Several days post her admission, on 12 March 2005, Mrs McRae collapsed and suffered a cardiac arrest and was found to have suffered a pulmonary embolism. Mrs McRae died from the pulmonary embolism at approximately 10.45am on 13 March 2005 in the Intensive Care Unit (ICU) at the Royal Darwin Hospital (RDH). A pulmonary embolism is a not unexpected consequence of the injuries suffered by the deceased, and there are 'thromboprophylactic' treatments available which are given to reduce the chances of such a death.

2. Ms Jodi Truman appeared Counsel assisting on each day of this inquest from 16 to 18 July 2008. I thank her for her valuable assistance. Mr Kelvin Currie appeared as Counsel for the Department of Health and Family Services.

Formal Findings

3. Pursuant to section 34 of the *Coroners Act* ("the Act"), I find, as a result of evidence adduced at the public inquest as follows:

   i. The identity of the deceased person was Sandra McRae, born on 5 May 1947. The deceased resided at 9 Dowdy Street, Millner in the Northern Territory of Australia.

   ii. The time and place of death was in the ICU at RDH at 10.45am on 13 March 2005.

   iii. The cause of death was acute pulmonary embolism.

   iv. Particulars required to register the death:

      a. The deceased was female.

      b. The deceased's name was Sandra McRae.

      c. The deceased was of Caucasian descent.The cause of death was reported to the Coroner.

      d. The cause of death was confirmed by post mortem examination carried out by Dr Terry Sinton.

      e. The deceased lived at 9 Dowdy Street, Millner in the Northern Territory.

      f. The deceased was retired.

      g. The deceased was married to Kevan James McRae.

4. Before setting out my findings upon this Inquest, I note that section 34(2) provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

"(1) A Coroner may report to the Attorney General on a death or disaster by the Coroner.

(2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.

(3) A Coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

This is an important section in the context of this Inquest.

The Conduct of the Inquest

5. Sergeant Anne Lade, following the outcome of a criminal trial in relation to the motor vehicle accident, investigated this death. I have before me a Coronial Brief in relation to the investigation compiled by Sergeant Lade (Exhibit 1). I also have 6 additional exhibits as follows:

   i. RDH file for Sandra McRae.

   ii. Documents provided to Sgt Lade from RDH.

   iii. Copy of passport for Sandra McRae.

   iv. Diagram of pelvis as marked by Mr Mehta.

   v. Medical certificate for Mr Cripps dated 17 July 2008.

   vi. Victorian Council Consultative Report and article of Sharrock et al.

6. I heard oral evidence from Sergeant Anne Lade and Mr Kevan McRae. I would like to thank Mr McRae for his evidence and to commend him for the respect he has shown to the process and the assistance he provided to this court.

7. I also received oral evidence from 3 consultants who were part of the orthopaedic unit at RDH at the time of Mrs McRae's death, and who remain so now; Mr Janak Mehta, Mr Matthew Sharland and Mr Robin Cripps. I also heard from Dr Dianne Stephens, called by the Department of Health and Community Services, on behalf of RDH. Dr Stephens is the Director of the Intensive Care Unit and Medical Coordinator of the Division of Surgery and Critical Care at RDH.

8. Finally I heard oral evidence from Professor John Hart who was accepted by all persons, and this court, as an expert in the field of orthopaedics. Professor Hart's qualifications are attached to his report, which forms part of exhibit 1. Professor Hart's evidence was extremely helpful to this inquest.

Circumstances surrounding the death

Events leading up to hospitalisation

9. At the time of her death Sandra McRae was 57 years of age. After working her whole adult life she retired on the same day as her husband on 17 September 2004. Their plan was to go on a "trip of a lifetime" around Australia together. The couple were in the final stages of preparations and arrangements for that trip. I heard evidence from Mr McRae that he and the deceased had changed their exercise regime to "get fit" for their trip, as it was intended that their trip would involve bush walking and the like. They had made also changes to their house for their departure. It is clear that they were both very much looking forward to their trip together.

10. On 25 February 2005 at about 10pm, the deceased was driving her motor vehicle; a red Corolla Hatchback. She was alone in that car when she was struck by another motor vehicle at the traffic light intersection of the Stuart Highway with Deviney Road. The person that caused that motor vehicle accident was Mr Darren John Partridge.

11. At about 9.30pm on the evening of 25 February 2005 Darren John Partridge was at unit 2/86 Dwyer Circuit in Driver. Police were dispatched to attend a disturbance at that address. When they attended they found Mr Partridge sitting in the driver's seat of his vehicle. The car was parked in the driveway and Mr Partridge had the keys in his possession, but the engine was not running.

12. The police spoke with Mr Partridge and noticed that his speech was slurred, he kept repeating himself, his eyes were blood shot and he smelt of alcohol. Upon the request of the police Mr Partridge gave his keys to the police officers, who then gave them to the occupant of unit 2 for safekeeping. Police told Mr Partridge not to drive his car. Mr Partridge got out of the vehicle and went into the unit, saying to police that he was going to go to sleep. Police noted at that time that Mr Partridge was unsteady on his feet.

13. Unfortunately, shortly after the police left, Mr Partridge came into possession of his keys and he drove away from unit 2. The facts that were admitted by Mr Partridge before the Supreme Court were that Mr Partridge drove his vehicle along Roystonea Avenue towards the intersection with the Stuart Highway. As he approached the intersection he was facing a red traffic light. He failed to stop at that red traffic light. He proceeded through the intersection; turning left onto the Stuart Highway, and then drove inbound along the Stuart Highway, travelling in excess of the clearly marked 80km speed limit.

14. As he approached the intersection with Deviney Road, the traffic lights facing him were red. The orange warning lights, situated some 140m from the intersection, were also flashing. There was one vehicle located in each of the inbound lanes. Both of those vehicles were stationary at the red light. One of those vehicles was the red Corolla Hatch Back occupied by and belonging to the deceased, which was in the left lane. The other vehicle was a silver Daewoo Sedan, which was in the right lane.

15. Darren John Partridge continued to approach the intersection travelling in the left lane. He did not commence braking until he had almost reached the intersection. As Darren Partridge commenced braking, almost at the intersection, his vehicle swerved from left to right and struck both the red Corolla and the silver Daewoo. Mrs McRae's vehicle took the brunt of the impact and sustained extensive damage to the rear right hand side and the rear right passenger door.

16. The vehicle occupied by Darren Partridge drove through the intersection and stopped in the left lane. He was subsequently taken to the RDH and a sample of his blood was taken at 11.09pm, some 1 hour after the accident. That sample returned a blood alcohol reading of 0.22.

17. St John Ambulance attended the scene and transported Mrs McRae to the RDH. The Ambulance report described the deceased as a little confused, with severe pain in the region of her left hip. She had normal blood pressure and heart rate, which meant she was haemodynamically stable at that time.

Events shortly after Hospitalisation

18. Mrs McRae was admitted to the emergency department at the RDH at 11.07pm. Her blood pressure and heart rate remained normal. She remained a little confused, but this is recorded as resolving over the next 3 hours. Her only complaint remained the pain in the left pelvic region and a small bruise was noted in that area.

19. Plain x-rays were performed on her pelvis. There was a "working diagnosis" that she had a fractured pelvis. X-rays were also taken of her neck to exclude a neck injury.

20. At the emergency department, the surgical registrar, Dr Jamieson, and the orthopaedic registrar, Dr Salaria, saw Mrs McRae and examined her x-rays. The x-rays of her neck were normal, and the pelvic x-ray showed fractures

of the right superior and inferior pubic rami and the left superior pubic ramus. During this inquest I had tendered before me a diagram (exhibit 5) depicting precisely where these fractures occurred.

21. Thereafter Mrs McRae was admitted to Ward 3A, which is the orthopaedic ward. A plan was put in place for bed rest. Mrs McRae was placed upon a Jordan frame, which is a frame placed under a patient and allows only minimal patient movement; designed to keep a patient immobile.

22. Although not actually seen by him at the time of her admission, the bed card for Mrs McRae recorded Mr Cripps as her consultant. She was therefore, according to the RDH records, noted as being under his care.

23. At 2.40am on 26 February 2005 it is noted that Mrs McRae was admitted to Ward 3A under the care of Mr Cripps, who was at that time a senior orthopaedic surgeon and consultant and to whom Dr Salaria was the orthopaedic registrar. There is no evidence in the notes, or before me, to suggest however that Mrs McRae was actually seen by Dr Cripps at that time. The RDH records set out the diagnosis, management plan and complaints for each day that Mrs McRae was a patient at the RDH. It is clear from the evidence that Mr Mehta, Mr Sharland and Mr Cripps were each involved at various stages in the care of Mrs McRae.

<u>Events during the hospitalisation</u>

24. I heard evidence from Mr Mehta that as an employee and consultant at RDH, he and the other consultants were placed on rosters in terms of their duties at the hospital. Part of exhibit 3 includes rosters for the period during which the deceased was admitted to the RDH. I also heard from Mr Mehta that there could be changes to that roster, however if changes were to occur, notice was to be given to the surgical coordinator so that amendments could be made to the written roster to properly reflect those on duty at the relevant time.

25. Reflecting that evidence are the rosters in exhibit 3, which show that a number of amendments occurred to some of those rosters. Those amendments are reflected on the roster record itself, at the top right hand corner, which also records how many amendments have occurred to the roster.

26. I note that for the purpose of the inquest, Mrs McRae arrived at the emergency department at 11.04pm on the evening of 25 February 2005. The orthopaedic roster states that the specialist on duty on 25 February 2005 was Mr Cripps. Mr Cripps is recorded in the roster as being the specialist on duty up to and including 27 February 2005.

27. In evidence before me Mr Cripps initially stated that he could not recall where he was during the period in which Mrs McRae was admitted to hospital, ie. 25 February 2005 until 13 March 2005. Mr Cripps stated that he was on leave but he assumes that he was at home. Mr Cripps stated that he had a "*clear memory"* of being on 2 weeks annual leave during that time.

28. Mr Cripps then subsequently gave evidence that he "*specifically*" recalled being on annual leave as and from Monday 28 February 2005 for 2 weeks. Mr Cripps gave evidence that he returned to work on 7 March 2005. Unfortunately the hospital records do not reflect that leave having ever been approved within their own records, nor has there been a corresponding amendment to the orthopaedic roster reflecting that change for the relevant periods. I will return to this aspect of the evidence later.

29. Despite this, and for whatever reason, Mr Cripps is not recorded in the hospital records as having seen Mrs McRae until 7 March 2005. For the purpose of this inquest I have recorded Mrs McRae's late night attendance at the hospital on 25 February 2005 as day 1. I note this is also how Professor Hart has recorded the days in hospital. The first recording of Mr Cripps seeing Mrs McRae is 7 March 2005, which was day 11 of her admission to the hospital.

30. It appears from the RDH records that the first time that Mrs McRae was attended upon by a senior orthopaedic Surgeon was when she was seen by Mr Mehta on 28 February 2005, being day 4 of her admission.

31. The orthopaedic department is headed by a Director. The position was held at the time, and is still held, by Mr Matthew Sharland. There were, as at February 2005, 3 teams within the orthopaedic division, each headed by a consultant, namely Mr Sharland, Mr Cripps and Mr Mehta. Within each of those teams, under the supervision of the consultants, was a registrar and then a registered medical officer or intern.

32. I heard evidence in relation to Mr Mehta that as at February 2005 he had not yet achieved his qualifications in terms of an Australian Fellowship. Mr Mehta was therefore at that time trained overseas as an orthopaedic specialist and was undergoing supervised practice in Australia. As a result Mr Mehta was required to be supervised by Mr Sharland. It appears however that Mr Mehta was considered by Mr Sharland and Mr Cripps to be more than capable and appears therefore that very little actual supervision occurred in relation to Mr Mehta by any other consultant.

33. Mr Mehta gave evidence that whenever a consultant was away, one of the other consultants would take over management of that consultant's patients. Mr Mehta stated that in terms of taking over the management of care of that patient there would be a "formal handover". That formal handover he described as being verbal and usually via the absent consultant's registrar. As at February 2005 the orthopaedic team headed by Mr Cripps had Dr Alex Blythe and Dr Othman Hamid as its registrars.

34. I heard evidence that in terms of decision-making, the final decision rested with the consultant on each team. Mr Mehta also gave evidence that if he had confidence in a registrar he would anticipate that the registrar might make decisions in relation to the treatment to be provided to a patient, without discussing the treatment plan with him before its commencement.

Mr Mehta did note however that he "micro managed" his teams, including when he temporarily took care of a team whilst another consultant was away, and therefore was heavily involved in the decisions to be made as to appropriate treatment for a patient.

35. In considering this evidence from Mr Mehta, I also have in evidence before me the evidence given by Dr Blythe at the criminal trial. The transcript of that evidence states at page 53, at about point 5, that it was the consultant specialists who made the final decision as to whether thromboprophylactic treatment should be commenced in relation to the treatment of Mrs McRae.

36. In relation to the decision as to whether to commence thromboprophylactic treatment or anticoagulant therapy, Dr Blythe is recorded in the transcript at page 62, at about point 1, as follows:

> "I have to restate my position that this was a clinical decision and that yes, she was at a risk of deep vein thrombosis and she was at a risk of pulmonary emboli. When she first arrived at hospital she was at risk of bleeding to death and a clinical decision was made on an ongoing basis from the day of her admission until the day she died as to whether DVT prophylaxis was appropriate or not and in such difficult circumstances a clinical decision is required, I speak to my senior doctors which I did and the consensus decision was that she did not need DVT prophylaxis".

37. Although I note that such evidence suggests that the decision surrounding the use of thromboprophylactic treatment was considered every day of the deceased's admission, that was not the evidence before me, and I do not accept that part of the evidence. However the remainder of the evidence is important in terms of who was responsible for making such a decision.

38. It is also clear from the evidence given by Mr Mehta that it was he who made a decision on 28 February 2005 (when he first attended upon Mrs McRae) in relation to the use of thromboprophylactic treatment. Mr Mehta states his decision was not to commence such treatment. I will return to this part of his evidence later. Mr Mehta openly and frankly conceded that in

terms of decision making for patients, the responsibility rested with the consultants. In my opinion that was an obvious, yet appropriate, admission to make.

39. I heard evidence that as at on 25 February 2005, and continuing thereafter, Mrs McRae was recorded as being haemodynamically stable. Mr Mehta gave evidence that as at 28 February 2005 he considered the pelvic fracture sustained by Mrs McRae to also be stable. I note that Mr Cripps gave evidence to this effect as well.

40. Mr Mehta also gave evidence however that he was concerned about the possibility of damage to the sacrum, which appears as a large triangular bone at the base of the spine and at the upper and back part of the pelvic cavity, inserted like a wedge between the two hip bones. As a result of that concern Mr Mehta gave evidence that he sought on 28 February 2005 for a CT scan that had been previously ordered to be "chased" up.

41. Mr Mehta gave evidence however that the outstanding CT scan, or the results there from, did not make a difference, or have an impact, upon his decision making process at that time in relation to the appropriate treatment to be administered to Mrs McRae.

42. Mr Mehta gave evidence that aside from the fractures to the bone structures within the pelvis, he also had concerns in relation to other possible injuries, as the motor vehicle accident was a "high energy" accident. He described this as meaning that there was an increased potential for bleeding or damage to other parts of the pelvis, outside of the damage or injury to the bone structure itself and that the areas of concern (outside of the bone structure itself) were the ligaments, urethra, bladder, bowel and potential bleeding. Mr Mehta noted that on average a person has approximately 5 litres of blood, and that in his experience (where there is damage to a pelvis) an individual can lose approximately 1.5 to 2 litres of blood. Catastrophic

bleeding from an injury to the pelvis was therefore considered by Mr Mehta to be a potential risk.

43. Mr Mehta also noted that damage to the areas outside of the bone structure itself might not be adequately depicted and/or discovered simply by the use of a CT scan. In terms of the manifestation of injuries to those various other areas however, Mr Mehta noted that in relation to any damage to the urethra and bladder, any such injuries would become manifest within a very short period of admission. Further that any injuries to the bowel would be manifest within 24 to 48 hours of admission.

44. In relation to concern as to the possibility of bleeding, Mr Mehta noted that any such bleeding would become manifest within 2 to 4 days of admission. It is noted that he first attended upon Mrs McRae on day 4 post admission (that is on 28 February 2005).

45. Mr Mehta was asked when he considered it was appropriate to administer thromboprophylactic treatment to a patient. He said that since Mrs McRae's death he now gives such treatment to all patients within 3 to 4 days of their admission, without discretion. He confirmed that this was not his practice prior to Mrs McRae's death and that at that time he considered it on a case-by-case basis, weighing up the various risk factors.

46. Mr Mehta gave evidence that on 28 February 2005 the notation of "? DVT Prop" marked in the recorded plan of treatment for Mrs McRae was a reference to the fact that he had made a determination on that day not to administer thromboprophylactic treatment, because he had decided to mobilise Mrs McRae instead. Therefore, he stated, thromboprophylactic treatment was not necessary.

47. Mr Mehta gave evidence that had Mrs McRae's mobilisation not progressed well, he would have subsequently decided to administer thromboprophylaxis. However he considered at all times that her

mobilisation was progressing well and therefore there was no necessity for a change to that decision.

48. Mr Mehta gave evidence that following a person suffering a pelvic fracture their risk of developing a thrombus, ie. blood clot, is increased. Mr Mehta also agreed that other risk factors that constitute an increased risk of developing a thrombus were as follows:

    i. Past history of DVT.

    ii. A family history of DVT.

    iii. Age.

    iv. A number of pre-existing diseases or medical conditions.

    i. Smoking.

    ii. The contraceptive pill.

    iii. Obesity.

    iv. Immobilisation.

49. Mr Kevan McRae, gave evidence that in their relationship of over 24 years, he was not aware of any past history of the deceased having suffered DVT, nor of any family history of DVT. He was not aware of any pre-existing diseases or medical conditions suffered by the deceased, and she was not a smoker.

50. I also have in evidence before me a statutory declaration from Dr Anthony Brownjohn of the Carpentaria Medical Centre who had previously treated the deceased. From his records the doctor confirmed that the deceased had no relevant history of sore legs, no symptom consistent with thrombus of her calf or pelvis, no swelling of the legs complained of or noted, and no known factors predisposing her to thrombus formation.

51. Mr McRae also gave evidence that at the time of her admission his wife would have weighed no more than 75kgs. He agreed her height was, as recorded in the autopsy report, 165cms. I also note that Mr Mehta gave evidence that he did not believe Mrs McRae to be "any more than" between 70 and 75kgs and he certainly did not, in all those circumstances, consider her a person who could be described as obese.

52. Mr Mehta stated that on 28 February 2005 he carried out an assessment of the above risk factors. I note however that there is no record of any such assessment being carried out in the notes of the RDH on that occasion, nor on any other occasion, by Mr Mehta, or any other person.

53. Although it was acknowledged by Mr Mehta that Mrs McRae met some of the risk factors, he still did not consider that the administration of thromboprophylactic treatment was appropriate at that time, because of his plan to mobilise Mrs McRae.

54. Mr Mehta gave evidence that there are in fact a number of different types of thromboprophylactic treatments that can be administered to a patient. Mr Mehta noted specifically the use of compression stockings and calf pumps, and also "chemical" prophylactic medication. Mr Mehta also gave evidence in relation to chemical prophylactic medication regularly used. He said there are Heparin and Warfarin, which both have an "antidote" should there be subsequent bleeding in a patient. Mr Mehta also gave evidence that there is low molecular weight Heparin, also known as Clexane. In this case there would have been a significant disadvantage to using this at the time of the deceased's admission, as there was then no antidote to its effects, should there be a subsequent bleed.

55. Mr Mehta also acknowledged that there were other thromboprophylactic treatments including calf compression devices, such as foot pumps, and also Inferior Vena Carva (IVC) filters. Mr Mehta gave evidence that calf compression devices, including calf pumps, were used in the operating

theatre at the RDH, rather than generally. He also stated that IVC filters were used, but he did not consider them in relation to Mrs McRae, given that he had made the decision that she be mobilised.

56. Mr Mehta also stated that he was aware of guidelines at the RDH in relation to the use of thromboprophylactics. I have before me in evidence a document headed "Venous Thromboembolism Prophylaxis Royal Darwin Hospital Guidelines 2005" (part of exhibit 3). Mr Mehta gave evidence that he was aware of those guidelines, and also of covering correspondence from Mr John Tracey dated 15 May 2003 stating that such guidelines were to be utilised at the hospital.

57. In considering those guidelines, Mr Mehta gave evidence that in his opinion Mrs McRae fell within the low to moderate risk category contained at table 1 of the guidelines. Mr Mehta stated that he considered he had complied with those guidelines when undertaking the treatment of Mrs McRae. It is noted that in table 1 of those guidelines the recommended prophylaxis for low risk patients is to consider "GCS", ie. graduated compression stockings. It is further noted that in the moderate risk category the recommended prophylaxis is the use of "Enoxaparin", which Mr Mehta stated was another word for Clexane or low molecular weight Heparin, "or the use of GCS and/or IPC if Enoxaparin contraindicated". IPC means Intermittent Pneumatic Compression, ie. calf pumps.

58. Mr McRae gave evidence that he could not recall seeing compression stockings on his wife during her time in hospital. He specifically recalled an occasion where she was rolled in bed and he noticed extensive bruising on her legs, at which point he did not see any compression stockings. The hospital records themselves make no mention of compression stockings being placed upon Mrs McRae at any time. The autopsy report of Dr Sinton describes clothing on the deceased's body and does not mention compression stockings.

59. Mr Mehta stated that the use of compression stockings were "routine" and although he could not specifically recall them being placed upon Mrs McRae, he would "expect" in all circumstances that they would be placed upon a patient. Mr Mehta gave evidence that a possible explanation for their absence at autopsy was that they had been removed at the time of her admission to the ICU, following her collapse and cardiac arrest.

60. In this regard I note that the records from the ICU are also included in the hospital records of exhibit 2. There is, once again, no mention whatsoever of any compression stockings being on the body of the deceased in those records, nor of them being removed. I find it more likely than not that there were none.

61. In relation to the use of calf pump exercises, or compression devices, Mr McRae also gave evidence that he did not recall ever seeing any exercises or physio of the lower limbs occurring during his extensive daily visits with the deceased. Mr Mehta gave evidence that he believed such exercises were occurring, however he accepted that it was clear on the notes that the only exercises that were recorded as occurring were of the upper limbs, and not the lower limbs.

62. In relation to the various thromboprophylactic medications that could be administered, Mr Mehta was also asked as to the possibility of Aspirin being used as an anticoagulant. At this point in time, Mr Mehta indicated that it was not a "consensus opinion" that Aspirin was an effective anticoagulant medication. Therefore when he considered thromboprophylaxis, he was not considering the use of Aspirin.

63. In addition to the administration of thromboprophylaxis medication, Mr Mehta also gave evidence that there were physical examinations that could be conducted to assess the possible development of a thrombus in a patient. Those physical examinations were via the use of direct physical examination of the limb itself and also assessment of any complaints of pain by a patient

within the limb. Mr Mehta gave evidence that if a limb was tense or swollen, then that was often a reliable indicator of the possible development of a thrombus.

64. Mr Mehta gave evidence that such examinations "would have" occurred upon Mrs McRae during her admission, however he acknowledged that there was no recording of such assessments in the hospital records themselves, nor of there being any direct inquiries as to pain in the relevant "at risk" limbs. The only inquiry as to pain is noted generally in the records.

65. Throughout his evidence Mr Mehta maintained that he considered there was regular and significant improvement in the mobilisation of Mrs McRae. It is noted that as from 28 February 2005 the hospital records themselves depict that whilst there was a noted plan for Mrs McRae to sit up in bed, "30 to 40 degrees as pain allowed". There was no recording of her ever actually achieving that planned goal.

66. Mr Mehta acknowledged that the first recording of any actual physical mobilisation of Mrs McRae's lower limbs is on 7 March 2005, where a physiotherapist notes that Mrs McRae is going "from sitting to standing" and standing for 5 minutes "which she managed well, and then returned to bed". It is noted that 7 March 2005 was in fact day 11 of the admission of Mrs McRae.

67. Mr Mehta did however maintain that despite there being no record of it within the notes, it "would have" been the case that Mrs McRae sat up in bed, as it would "not be possible" for her to go from laying supine to suddenly sitting and then standing. Again, this is not reflected in the RDH notes.

68. In addition to the physical examinations that can be conducted to try to detect a DVT, Mr Mehta acknowledged that there can also be the development of "silent" DVT's, which do not present with any symptoms.

In relation to those sorts of circumstances Mr Mehta said that one of the ways of detecting the development of such a thrombus was with the use of a "Doppler scan" or "Venogram".

69. Mr Mehta gave evidence that a Doppler scan was an ultrasound scan using a probe along the calves to detect any changes. Mr Mehta gave evidence that a Venogram was the cannulation of a vein in the foot, which was an invasive process and one that often caused significant pain to patients and was therefore not often used by him. Mr Mehta gave evidence that he would use the Doppler scan where a patient complained of pain or pressure within a limb.

70. In terms of mobilisation, Mr Mehta maintained in his evidence that he considered that there was significant progress in the mobilisation of Mrs McRae. He states that it was unusual, in his experience, for a patient to be able to even roll in bed without significant pain, and although Mrs McRae was not sitting up and getting out of bed immediately, her progress in being able to roll in bed was therefore significant.

71. Mr Mehta gave evidence that as a result of the death of Mrs McRae, he is now administering anticoagulation prophylaxis without discretion in all his patients. Mr Mehta gave evidence that he does this despite the increased risk that a patient could suffer a catastrophic bleed, which would be difficult to stop if anticoagulant prophylaxis had been administered. He also indicated that patients were now being provided with pamphlets and information in relation to the administering of thromboprophylactic treatment, and this had happened since Mrs McRae's death. There is no record a discussion of such treatment being held with Mrs McRae.

72. Mr Mehta stated that the fracture and injuries that Mrs McRae suffered in the motor vehicle accident on 25 February 2005 were "imminently survivable", and her death was not expected. Mr Mehta however was at pains to remind the court that even if Mrs McRae had been administered

thromboprophylactic treatment, there was no guarantee that the development of a thrombus, or a pulmonary embolism from the thrombus, would have been prevented. Mr Mehta gave evidence that there was always the risk of complications and he did not know if the administration of such treatment would have avoided her death, however he acknowledged that it was likely to reduce the risk.

73. Dr Dianne Stephens next gave evidence, Dr Stephens is an intensive care specialist and is the Director of the Intensive Care Unit and Medical Co-Director of the Division of Surgery and Critical Care at the RDH. Her role at the RDH encompasses providing leadership to medical staff within the Division to deal with aspects of clinical leadership, policies, protocols, teamwork etc. Dr Stephens provided a statement to this inquest dated 9 July 2008. That statement commences as follows:

> "The hospital regrets the death of Mrs Sandra McRae and extends to all members of the family its deepest sympathy"

74. Dr Stephens goes on at page 8:

> "We regret that in the case of Mrs Sandra McRae there was a failure to follow hospital thromboprophylaxis guidelines and the decision to withhold thromboprophylaxis remains unexplained in the medical record and that decision/omission may well have contributed to her death"

75. Dr Stephens ends her statement at page 10 as follows:

> "The hospital sincerely regrets the death of Mrs Sandra McRae and has taken significant steps in order to ensure that the issues raised by her death do not recur. We look forward to any additional recommendations that the Coroner may have for the Hospital and the Department that would further improve our systems"

76. During the inquest I did, as I do now, commend the proactive approach taken by the hospital through Dr Stephens in relation to addressing the issues that have arisen since Mrs McRae's death. Although it appears there has been some delay in addressing some of the issues following her death, it

is apparent that a great deal has however been done under the direction of Dr Stephens to try and address the failures and omissions made in relation to the treatment provided to Mrs McRae.

77. One of the most important parts of a inquest can be the introduction of changes to systems to try and prevent a similar death occurring. It appears that the hospital is now well aware of the need for changes following the death of Mrs McRae and is undertaking changes to prevent a similar event occurring in the future.

78. Attached to the statement of Dr Stephens is a letter from John Tracey setting out what were considered, as at 15 May 2003, to be "*appropriate guidelines for prophylaxis against venous thrombo embolism in the hospital*". Those guidelines remained in place in February 2005. Those guidelines set out risk categories and the recommended prophylaxis for each risk category being low, moderate and high. At page 6, point 6.3, it states as follows:

> "Up to 75% of fatal PE ("Pulmonary Embolism") in general hospitals occur in non-surgical patients immobilised by medical illness, yet there are fewer trials on DVT Prophylaxis for hospitalised medical patients compared to surgical patients. Available data suggests that prophylaxis can prevent 2/3's of DVT cases in medical patients, a reduction rate similar to prophylaxis in surgical patients"

79. Dr Stephens gave evidence that in her opinion Mrs McRae "*definitely*" fell within the moderate to low risk group, and that in fact had Mrs McRae been her patient she would have in fact assessed Mrs McRae as being in the high risk group.

80. Dr Stephens acknowledged that this therefore meant that at the very least graduated compressive stockings and/or intermittent pneumatic compression should have been used in relation to Mrs McRae. In terms of her own assessment, Dr Stephens states that she would have ensured that stockings were used and then conducted an assessment for the use of Heparin. Dr Stephens stated that this treatment would still be considered by her to be

appropriate even though it was possible that Mrs McRae still could have developed a pulmonary embolism despite the use of such medication.

81. Dr Stephens stated that despite the guidelines being in place since 2003, the hospital acknowledged that they did not appear to be followed in relation to Mrs McRae. Dr Stephens gave evidence that one of the changes introduced as a result of the death of Mrs McRae was the development of further guidelines specifically directed to the orthopaedic division in relation to the use of thromboprophylaxis treatment (part of exhibit 3). One of the changes in that guideline, which remains in draft form as at the date of the inquest, is as follows:

> "Pelvic fractures should undergo Prophylaxis following a 24 hour period of monitoring for possible bleeding"

82. Dr Stephens was asked during this inquest that given guidelines were not compulsory, and given that one of the problems that appears to have existed in relation to guidelines in the treatment of Mrs McRae is that they were not being followed, how was it anticipated by the hospital that the failure to follow guidelines would be remedied? In answer to that question Dr Stephens acknowledged that "written policy" was not enough and that it was intended that there be ongoing education and information provided to the specialists, and their teams. Further, that there was an expectation that the guidelines would be followed, and if they were not, there was an expectation that there would be detailed notation in the patient's record as to why they were not being followed. This is clearly an essential improvement on the previous scheme.

83. In relation to the issue of note taking, Dr Stephens also stated that the note taking in relation to the treatment proposals and decisions made for Mrs McRae was inadequate. In terms of her own interpretation of what was meant by the notation made on 28 February 2005 of "? DVT Prop", Dr Stephens stated that she considered it "impossible to interpret that notation".

84. Dr Stephens gave evidence that part of the changes to be implemented would be better note taking to enable persons who subsequently took carriage of the care of a patient to be able to quickly analyse and assess the decisions made, the basis for such decisions and to conduct an assessment of their appropriateness in light of any changes since the decision was made. Again this appears to be an important change.

85. Dr Stephens also gave evidence that the death of Mrs McRae was a potentially preventable death in all of the circumstances and that this was accepted by the hospital. That is an important admission and one that gives confidence that it is the hospitals intention to make changes with a view to endeavouring to avoid a similar death in future.

86. Dr Stephens also noted that there had been an inadequate response to this sentinel event, ie. the potentially preventable death of Mrs McRae. That is most unfortunate indeed. However it is clear on the evidence that under the direction of Dr Stephens a great number of steps have been taken, such as peer performance review, access to clinically useful data, and ensuring knowledge of guidelines, which would have been part of the usual steps taken following a sentinel event occurring. It is also clear that as a result of Mrs McRae's death the RDH policy surrounding sentinel events now appears more widely known and I share the hopes of Dr Stephens that such a failure to comply with the sentinel event policy of the hospital is one unlikely to occur again in the future.

87. In her evidence Dr Stephens indicated that the following statement by Professor Hart at page 12.9 of his report was entirely reasonable:

> "In retrospect it would have been appropriate to have administered prophylactic anticoagulants between 28 February 2005 and 6 March 2005 while the patient was immobilised"

88. Dr Stephens in fact went further and stated that she herself may have indeed administered such prophylactic anticoagulants earlier than 28 February

2005. It is my finding that this proactive attitude taken by the hospital under the direction of Dr Stephens bodes well for the future in determining whether the hospital is appropriately addressing the issues that have arisen since Mrs McRae's death.

89. Dr Stephens also noted that one of the failings in relation to the adequacy of the treatment of Mrs McRae was that there did not appear to have been a "solid handover" between the orthopaedic teams in relation to her care. Dr Stephens noted that there was nothing in the notes to reflect that any kind of handover had ever been conducted and that when there was not a clear handover, the "care of the patient can slip through the cracks".

90. Dr Stephens stated that one of the changes to be introduced and implemented following Mrs McRae's death was that there was to be a noted and clear handover between the teams, including a face to face meeting between the consultants, and that such a handover was to be documented in the patient's notes for all to see.

91. Dr Stephens also indicated that there is now a greater promotion of teamwork between the teams, so that there was no longer an attitude of autonomy. One of the hopes identified by Dr Stephens of such change in better note taking was that it would avoid the situation that had clearly arisen in terms of the notes taken in relation to Mrs McRae that it was not "possible to say what anyone was thinking at the relevant time because of the notes".

92. Dr Stephens also noted that one of the changes was that registrars were also always to note what the consultant said in relation to treatment, and if questions were asked of the consultants then those questions, and the response, were also to be noted.

93. As stated previously, I commend Dr Stephens on her work and endeavours to introduce changes, and implement them, as a result of the death of Mrs McRae, particularly in relation to:

i. The changes proposed for better note taking;

ii. Better identification of decisions made in relation to patients and the reasons for the decisions made in order to assist with the sharing of the care and treatment of a patient;

iii. Identification of consideration of applicable RDH guidelines; and

iv. Solid hand overs between consultants of a patient's care.

94. These appear to be most important changes. Not only do such changes mean that decisions made can be examined and reviewed by any doctors who subsequently take carriage of the care of the patient, however the changes also assist in conducting assessments of those decisions when an unexpected death subsequently occurs, and to consider what changes are appropriate following the death of a patient.

95. Mr Sharland gave evidence confirming that he first met Mrs McRae on 3 March 2005, during what is known as the "grand round". Mr Sharland gave evidence however that at that time he considered the responsibility for the care and treatment decisions related to Mrs McRae to have rested solely with Mr Mehta, who he considered had taken responsibility. Mr Sharland was also unable to explain where Mr Cripps was during the relevant period of Mrs McRae's admission to hospital. He stated he did not know why Mr Cripps was absent, particularly as there were no records for leave for Mr Cripps during that period. Mr Sharland also noted that there was no formal handover, as far as he was aware, between Mr Cripps and Mr Mehta when Mr Mehta took over the care of Mrs McRae.

96. Professor John Hart was called and gave evidence as an expert in this matter. His qualifications as an expert were not in dispute. I note that Professor Hart has been a practising Consultant Orthopaedic Surgeon for the last 32 years, and is also a Medico Legal Consultant, and is presently employed as a Clinical Associate Professor of Surgery with the Department of Surgery at Monash University.

97. Professor Hart gave oral evidence in addition to his extremely detailed and helpful report dated 21 January 2008. I thank Professor Hart for his evidence, and report, which have been extremely useful to this inquest, and also for the dedication he has provided in analysing a great deal of medical evidence, but also considering a large amount of the transcript of evidence given at the Supreme Court Trial of Darren Partridge.

98. In addition to Professor Hart's Report (part of exhibit 1) I also had in evidence before me two further documents that Professor Hart referred to in his evidence. These formed exhibit 7 and were as follows:

> "i. *Victorian Surgical Consultative Council Triennial Report 2005 to 2007*" attaching a letter from Jonathon Rush FRACS, Chairman of the Victorian Surgical Consultative Council to all Chief Executive Officers of Victorian hospitals in November 2005 entitled "*DVT Prophylaxis – Use of Appropriate Form in the Patient Record for the Prophylaxis of Venous Thromboembolism – Letter to CEO's*".
>
> ii. Article from Sharrock et al entitled "*Potent Anticoagulants are associated with a Higher All-Cause Mortality Rate after Hip and Knee Arthroplasty*."

99. Professor Hart gave evidence that he considered the importance of the correspondence from Jonathon Rush to be the last paragraph of that report which states as follows:

> "For each patient admitted a decision about the type of prophylaxis should be made and noted in the medical record; with consideration of the patients age, the nature of the operative procedure and the presence of identified risk factors (this includes "nil required" where this is applicable)"

100. In addition, in relation to the Sharrock article, Professor Hart stated that he considered the importance of the article to be to highlight that there has always been controversy associated with the use of thromboprophylactics and that in a certain group of thromboprophylactics (identified in the article as low molecular weight heparin, ximelagatran, fondaparinux or rivaroxaban), there may be more risks of those prophylactics than there are gains.

101. Despite this recent report, it remained the opinion of Professor Hart that some form of thromboprophylactic treatment should have been given to Mrs McRae. In evidence, Professor Hart stated that although there was no real hard data that the development of a thrombus or pulmonary embolism would have been prevented, he considered that thromboprophylactic treatment should have been given.

102. Professor Hart stated that the fact that Mrs McRae was haemodynamically stable and there was no evidence of bleeding after a reasonable period, it would have been reasonable to have used thromboprophylactic treatment either the administration of low molecular weight heparin or at the very least the use of mechanical devices such as calf compressions/foot pumps, compression stockings and Aspirin.

103. Professor Hart gave evidence that although it was apparent from the RDH records that there was "consideration" of the use of thromboprophylactic treatment, the records did not reflect any <u>actual</u> decision being made, and also reflected that there were a number of different people involved in the decision making for Mrs McRae which resulted in a lack of continuity of care.

104. Professor Hart noted that the RDH records appeared to indicate that "nothing really" was done in respect of the question of the use of thromboprophylactic treatment, and although he was aware it was the evidence of Mr Mehta that an actual decision had been made not to use

thromboprophylactic treatment, that "decision" was not reflected in the notes, nor was the conditional nature of that decision, ie. that it was dependent upon Mrs McRae becoming mobilised.

105. In relation to the evidence given by Mr Mehta (that he considered there had been an improvement in the mobilisation of Mrs McRae, such that there was no longer a need for thromboprophylactic treatment), Professor Hart stated that in his opinion whilst rolling in bed, and moving her feet and legs in bed was "arguably" mobilisation and could perhaps "help a little", in his opinion sufficient mobilisation was actually getting out of bed, and this did not occur until day 11, ie. on 7 March 2005.

106. As stated earlier in this decision, in his report Professor Hart considered that "*in retrospect it would have been appropriate to have administered prophylactic anticoagulants between 28 February and 6 March 2005*", while Mrs McRae was immobilised. It is also the finding of this inquest that such prophylactic treatment should have been administered during that period.

107. Professor Hart indicated that he was aware of the changes that have been initiated, and are being implemented, at the RDH as set out in the statement of Dr Dianne Stephens. Professor Hart indicated that in his opinion such proposed changes were important in terms of an increase in awareness in relation to the issue of the administration of thromboprophylactic treatment, and also to improve note taking and documentation in relation to decision making and the recording of decision making made in the care and treatment of a patient.

108. The final witness to be called in this matter, after a number of weeks, was Mr Robyn Cripps. As stated previously in this decision, Mr Cripps gave evidence before me that the first time he saw Sandra McRae was on Monday

7 March 2005. I note that initially there was some confusion as to the precise date, given the records, however I find it more likely than not that the actual records themselves incorrectly record Mr Cripps attending upon Mrs McRae on 6 March 2005, and it was in fact not until 7 March 2005 that Mr Cripps first saw Mrs McRae. I pause to note that this was day 11 of Mrs McRae's admission.

109. As stated previously, Mr Cripps gave evidence that he was away as and from 28 February until and including 6 March 2005. Mr Cripps stated he had a "*clear memory*" of being on 2 weeks annual leave. The leave records of the hospital themselves do not reflect this. The roster record of the hospital does not reflect this. As stated during these proceedings, either Mr Cripps has reconstructed the events as to his whereabouts in order to explain his failure to attend upon Mrs McRae who was his bed carded patient, or the roster and leave records at the Royal Darwin Hospital were in a shambles.

110. I find that it is more likely that not that it is the case that Mr Cripps is mistaken in his evidence. I do not accept that Mr Cripps was on scheduled and authorised leave during this period. I do accept that probably, he was at his home as he stated in evidence instead of attending the hospital as he should have. I find that Mr Cripps was not involved, nor ever came into the physical presence of Mrs McRae before 7 March 2005. As a result of Mr Cripps absenting himself from the hospital, he was not available to give advice and to lead his team in accordance with his rostered requirements.

111. Mr Cripps gave evidence before me that on 7 March 2005, when he first saw Mrs McRae, he made a decision to have her mobilised and therefore he did not administer thromboprophylaxis (or anticoagulant) treatment. I note that at this stage Mrs McRae had been in hospital for 11 days by the time this decision was made.

112. During the course of his evidence Mr Cripps was taken through day by day of the hospital records of any mobilisation or "ambulation" undertaken of

Mrs McRae. I note that contrary to what was stated by Mr Mehta, it was the opinion of Mr Cripps that simply rolling in bed with assistance, and being able to sit up, was not sufficient mobilisation or ambulation such as to excuse the administration of thromboprophylactic treatment. I note that this is a similar opinion to that given by Professor Hart, and I find that there was insufficient mobilisation prior to 7 March 2005 to have excused the administration of thromboprophylactic treatment to that point in time.

113. I also note that when giving his evidence Mr Cripps stated that he was not aware in February of 2005, ie at the time of the admission of Mrs McRae to the hospital, that there were any guidelines in place at the hospital concerning the administration of venous thrombo embolism prophylaxis. Mr Cripps in fact gave evidence that he had not even seen the guidelines that form part of exhibit 3 which were in place in 2005 until the actual day of giving his evidence, namely 2 September 2008.

114. The death of Mrs McRae was a double tragedy for her husband and family in the sense that they would have had to endure the shock, fear and heart break of her motor vehicle accident, to then discover she had sustained injuries described by the relevant medical practitioner as "imminently survivable" and to improve, and yet then to have her collapse and then die on day 17 of her admission.

115. Furthermore they have endured the undoubtedly extremely difficult circumstances of a Supreme Court criminal trial in relation to the prosecution of the driver that caused the said motor vehicle accident, only to hear that the driver's actions were not what caused the death of their loved one. They heard evidence that it was the decisions, or lack thereof, made during her admission to hospital that were likely to have contributed to her death.

116. The question of the administration of thromboprophylactic treatment is still one very much being discussed amongst the experts, and that even if Mrs

McRae had been anticoagulated, there is no guarantee that the development of a thrombus or a pulmonary embolism, would have been prevented.

117. I find on all of the evidence that, after having determined that the deceased was haemodynamically stable, and that there was no evidence of bleeding, she should have been administered anticoagulant thromboprophylaxis of some form. This was in fact in accordance with the very guidelines of the hospital.

118. I note that during submissions from Counsel for the hospital, Mr Currie submitted that the guidelines placed before the inquest did not contain a category for trauma patients and therefore some kind of differentiation could be made. I do not accept such a submission. I note that Dr Stephens, who was called by Mr Currie, gave evidence that the guidelines were applicable to a patient such as Mrs McRae and that it was the hospital's position that there should have been the administration of such treatment in accordance with those guidelines.

119. The failure of Mr Cripps to attend the hospital and be available in relation to the treatment of the deceased (who had been placed in his care) resulted in a lack of continuity of care. This meant that when the treatment was taken over by other consultants and their teams, there was no one person who was aware of all relevant circumstances who could pass information on so as to ensure that adequate information was being provided for any future decision making process. This became even more so important due to the fact that there was clearly inadequate note taking of the decisions being made, and the processes undertaken, by the relevant practitioners in relation to the appropriate care and/or treatment to be given to Mrs McRae.

120. Better note taking and more formal handovers of a patient's care means the decisions made, and the reasons why, can be examined by the next person who takes over the care and/or treatment of a patient. That next practitioner is then able to become involved and quickly assess the circumstances of the

patient and assure themselves that those things that should have been considered in relation to the potential treatment to be provided in relation to the patient, have in fact been considered. The next practitioner is then able to have those notes of the decisions made previously to compare against their own examinations and/or assessments of the patient.

121. Better note taking also assists when an unexpected death occurs of someone who has suffered what is described as "*imminently survivable*" injuries. Better note taking assists in an inquiry as to the decisions made and the adequacy of such decisions. It also assists the family in coming to terms with the death of a loved one and accepting evidence that is given, sometimes many years later, in relation to the decisions made in the treatment of their loved one and whether those decisions were appropriate and sufficient in all of the circumstances. A failure to take adequate and appropriate notes leads families very often, and sometimes the courts, to be extremely suspicious about the quality of care that has been given to a patient.

122. As Dr Stephens said in her evidence, the notes kept in relation to Mrs McRae are "impossible to interpret".

123. Further, I find that the recorded mobilisation of Mrs McRae of rolling in bed, was such that it was insufficient to obviate the need for the administration of some form of thromboprophylactic treatment. I also find that a more formal handover should have taken place in relation to the care and treatment of Mrs McRae between each of the teams. It appears that the failure of a more formal handover was significantly contributed to by the unexplained absence of Mr Cripps.

124. It is also the finding of this inquest that the failure to record proper notes of the decision making process undergone by the relevant medical practitioner, ie. both Mr Mehta and Mr Cripps, in relation to the decision not to

administer thromboprophylactic treatment contributed to a failure to properly assess the risk factors particular to Mrs McRae.

125. I am unable to find that Mrs McRae's death would have been prevented by the administration of thromboprophylactic treatment, or prevented by a continuity of care for her in terms of her consultant. Deaths do happen, even when the best possible treatment, and continuity of care, has been provided to a patient. I am however left in no doubt that, just as the hospital itself has accepted, this death was potentially preventable. As was stated by Mr Mehta in his evidence the administration of thromboprophylactic treatment *may* have reduced the risk of the development of a fatal pulmonary embolism.

126. I have heard evidence from Dr Stephens in relation to the changes that have been commenced, and are to be commenced, at the RDH as a result of the death of Mrs McRae. I find that the changes appear, in accordance with the state of medical knowledge at the present time, to be appropriately targeted at fixing the system issues that appear to have contributed to the death of Mrs McRae. I commend Dr Stephens and her team for their clear efforts in this regard.

127. I recommend that her system changes be implemented as quickly as possible and supported, particularly by the Orthopaedic Division and in particular the head of that Department, Mr Sharland, who did not appear to be aware of such changes when he gave his evidence before me. It is important that any heads of Departments keep abreast of such important changes as and when they occur.

128. I am also of the opinion however that a recommendation should be made to all Northern Territory hospitals similar in terms to that made by Mr Jonathon Rush in his letter to all Chief Executive Officers of all Victorian hospitals. That recommendation is that for each patient admitted a decision about the type of prophylaxis should be made and noted in the medical

record with consideration of the patient's age, the nature of the operative procedure and/or treatment, and the presence of identified risk factors (including "nil required" where this is applicable). I note that counsel for the Department stated in his submissions that such a recommendation should be made and "that the plan in relation to the prophylaxis be set out so that people reading the notes know what's happening". I agree.

129. I had planned to order that a copy of the transcript of the evidence given by Mr Cripps be provided to the Medical Superintendent of RDH for his consideration and assessment. In the event, I understand that Mr Cripps has resigned his position and retired from practice and, accordingly, I decline to forward the transcript.

Mr Greg Cavanagh :

Dated this 29th day of October

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GREG CAVANAGH
TERRITORY CORONER