



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 13th, 14th, 19th and 28th days of March 2008, the 18th and 19th days of June 2008 and the 26th day of June 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Harold Leslie Davies.

The said Court finds that Harold Leslie Davies aged 87 years, late of St Louis Nursing Home, 21 Foster Street, Parkside, South Australia died at Ashford Hospital, Anzac Highway, Ashford, South Australia on the 18th day of July 2005 as a result of multi organ failure due to septic shock complicating urinary tract infection and traumatic bladder catheterisation. The said Court finds that the circumstances of his death were as follows:

1. Introduction and background

- 1.1. Mr Harold Leslie Davies, who was 87 years of age, died at the Ashford Hospital on 18 July 2005.
- 1.2. Mr Davies had been a resident of the St Louis Nursing Home situated at 21 Foster Street, Parkside (the facility) since May 2005. Prior to that he had been living at his own home. Mr Davies had an extensive medical history that included heart disease, congestive cardiac failure, emphysema, recurrent urinary tract infections and atrial fibrillation for which he was prescribed Warfarin. The drug Warfarin is an anticoagulant that is prescribed in order to prevent the formation of blood clots, a dangerous complication of atrial fibrillation. Mr Davies had been involved in a motor vehicle accident in February 2005. His injuries had included fractured left fourth and fifth metacarpals and a right groin haematoma. Mr Davies had also suffered a stroke

in February 2005. He suffered from leg ulcers. Mr Davies had undergone a transurethral prostatectomy (TURP) for prostatic enlargement. He had an atonic bladder that required him to wear a chronic indwelling catheter to enable him to void urine. This catheter had been in place since mid 2004.

- 1.3. The Royal District Nursing Service of SA Inc (RDNS) had attended at Mr Davies' residence to look after his leg ulcers. From time to time Mr Davies' indwelling catheter also had to be replaced. RDNS nurses undertook responsibility for his periodic catheter changes when he was living at his own residence. The RDNS clinical records in respect of Mr Davies were tendered during the Inquest¹. They reveal that RDNS changed Mr Davies' catheter at his home on 22 October 2004 and on 11 January 2005, on both occasions without incident. The records suggest that RDNS also attended upon Mr Davies on 18 January 2005 in respect of an incident in which Mr Davies had somehow dislodged his catheter. There is no suggestion in the RDNS notes that there had been any difficulty in the re-insertion of the catheter on any occasion. Mr Davies' catheter was again changed on 9 April 2005 at the Memorial Hospital under antibiotic cover.
- 1.4. On 1 June 2005, by which time Mr Davies was resident in the facility, his general practitioner, Dr Beng Hee Ong, replaced Mr Davies' catheter, as I understand it, without antibiotic cover on that occasion. Dr Ong had been Mr Davies' general practitioner for nearly 20 years. However, 1 June 2005 was the first occasion on which Dr Ong had replaced Mr Davies' catheter.
- 1.5. On 15 July 2005, three days before Mr Davies' death, his catheter was again replaced. On that day, an attempt was made to replace the catheter by an RDNS nurse in the first instance. The attempt was unsuccessful. The nurse was able to remove the existing catheter, but had difficulty in re-inserting a new catheter to the point where he abandoned the procedure out of a concern that he might injure Mr Davies. An arrangement was then made for Dr Ong to come to the facility to replace the catheter. Mr Davies was therefore without a catheter for a number of hours. However, Mr Davies was apparently well and reported no difficulty with natural urination in the period before Dr Ong's arrival. Dr Ong performed the re-catheterisation in the late afternoon of that same day without antibiotic cover.

¹ Exhibit C12

- 1.6. At some point during the course of that day, Mr Davies suffered some significant urological trauma. The question as to whether this was sustained either in whole or in part during the failed attempts at re-catheterisation by the RDNS nurse or in the course of the re-catheterisation performed by Dr Ong, was one issue that was examined at the Inquest. Mr Davies bled quite copiously as a result of the traumatisation. The fact that Mr Davies was on a Warfarin anticoagulation regime would not have helped in this regard.
- 1.7. Some time after Dr Ong had reinserted Mr Davies' catheter, nursing staff at the facility noticed that a significant amount of frank blood had collected in the catheter bag. Attempts were made by the nursing staff to rectify the situation but they were largely unsuccessful. Mr Davies' wellbeing significantly declined thereafter and an ambulance was called by nursing staff that was, at first, cancelled but then recalled and Mr Davies was then conveyed to the Royal Adelaide Hospital.
- 1.8. In due course Mr Davies was transferred to the Ashford Hospital where he died on 18 July 2005.

2. Cause of death

- 2.1. Mr Davies' death was reported to the Coroner. On advice from Dr John Gilbert, a Forensic Pathologist employed at Forensic Science South Australia, an autopsy of Mr Davies was not considered necessary and was not undertaken. However, Dr Gilbert provided written advice in respect of the cause and circumstances of Mr Davies' death and later provided a more comprehensive analysis of those matters². In Dr Gilbert's initial advice dated 20 July 2005 he expressed the cause of death as multi organ failure due to septic shock complicating urinary tract infection and traumatic bladder catheterisation. In Dr Gilbert's more comprehensive analysis he refers in some detail to Mr Davies' clinical presentation at both the Royal Adelaide Hospital and Ashford Hospital. Mr Davies' difficulty was occasioned by the development of sepsis that, in Dr Gilbert's view, had a urinary tract infection as its origin. Urine cultures yielded a significant pure growth of the organism *Citrobacter Freundii*. Dr Gilbert expresses the view that it is more probable than any other competing explanation that Mr Davies had become septic from a pre-existing urinary tract infection.

² Exhibits C3, C3a, C3b and C3c

- 2.2. In Dr Gilbert's opinion the clinical picture, evidenced by the entirety of Mr Davies' medical notes, supported the clinical diagnosis of multi organ failure complicating sepsis due to urinary tract infection. The view of Dr Gilbert is that this was the result of a traumatic bladder catheterisation. I heard evidence during the Inquest that existing chronic urinary tract bacterial colonisations are commonplace, if not the norm, when people are required to wear chronic indwelling catheters and that the development of an acute infection can be a consequence of traumatic bladder catheterisation. Traumatic catheterisations can result in the opening of venous spaces and bacteria can gain access to the blood stream causing septicaemia³.
- 2.3. I add here that although it is clear that Mr Davies suffered from a large number of serious comorbidities, his general wellbeing prior to the attempts at catheterisation on the afternoon of 15 July 2005 had been apparently satisfactory. There was no hint that he would that evening suffer the significant decline which resulted in his eventual hospitalisation and death. In fact, the re-catheterisation that occurred on 15 July 2005 seems to have been instigated by Mr Davies himself because he was experiencing leakage caused by urinary bypass of the catheter. This would have been a matter relating more to the understandable discomfort of the patient than as the result of any clinical concern. In any event, the point is that Mr Davies' decline on the evening of 15 July 2005 was quite unexpected and the inference is overwhelming in my view that it was consequent upon the catheterisation procedure or procedures that had taken place during the day.
- 2.4. In my opinion the suggested cause of death by Dr Gilbert is correct, including his reference to the traumatic bladder catheterisation as being the underlying catalyst of Mr Davies' septic shock.
- 2.5. I therefore find the cause of Mr Davies' death to have been multi organ failure due to septic shock complicating urinary tract infection and traumatic bladder catheterisation.

³ Dr John Miller, Urological Surgeon, Transcript, page 146

3. Circumstances surrounding the death of Mr Davies

- 3.1. During the Inquest I also examined the circumstances in which Mr Davies was, in essence, electively re-catheterised and whether in any event it was appropriate for him to undergo the procedure in a nursing home and not a hospital. In this regard, there were a number of elements that might have worked to Mr Davies' disadvantage. There was a suggestion that Mr Davies' previous re-catheterisation at the hands of Dr Ong had been a difficult one. As it was, the procedure had also proven to be difficult if not impossible for the RDNS nurse to perform on 15 July 2005. In this respect, it is suggested that it could have been anticipated that the later procedure that afternoon might prove to be difficult. In addition, there were risks posed by the possibility of urinary tract infection. Bleeding as the result of anticoagulation also needed to be considered. Some might say that Mr Davies ought to have undergone re-catheterisation in a hospital in that combination of circumstances. In the event I did not understand anyone to be advocating a position whereby re-catheterisations ought routinely be carried out in a hospital, and indeed they are not. Nor is it universally agreed that re-catheterisation procedures should inevitably be preceded by prophylactic antibiotics to guard against infection or by reversal of anticoagulation which carries its own risk. It will be borne in mind that those who have to wear an indwelling catheter are frequently the elderly who for many clinical reasons are perpetually anticoagulated and that in any case chronic catheterisation will almost inevitably involve the colonisation of bacteria. However, the suggestion was made very strongly that when one combines the intrinsic risks that infection and anticoagulation might pose with the risk of trauma posed by a possible difficult catheterisation, a hospital setting would be preferable.
- 3.2. I also examined the circumstances in which an RDNS nurse had attempted the procedure in the first instance when it was clear that Dr Ong was Mr Davies' general practitioner of choice. I heard evidence that by 15 July 2005 Mr Davies had evinced a certain lack of enthusiasm for having any further catheterisation procedures performed by Dr Ong. This was said to have arisen in the light of discomfort that Mr Davies said he had experienced during the previous procedure that Dr Ong had performed on 1 June 2005. He wanted the RDNS to do this for him in the future. I turn to this particular issue now.

- 3.3. Dr Ong had been Mr Davies' general practitioner for several years. There is no suggestion other than that their professional relationship had been satisfactory. However, within a matter of days following Dr Ong's re-catheterisation of Mr Davies on 1 June 2005, Mr Davies had complained to staff at the facility that he did not want Dr Ong to perform the procedure any more because he had been very uncomfortable during the recent procedure. Mr Davies had complained about this to Ms Sherrill Bickmore who was a registered nurse employed at the facility. In Mr Davies' progress notes, immediately following Dr Ong's note and the nursing note in respect of the 1 June 2005 procedure⁴, Ms Bickmore has recorded that Mr Davies had expressed to her that 'he didn't wish Dr Ong to re-catheterise him again due to trauma'. This entry is dated 3 June 2005. Ms Bickmore swore that she wrote that entry on 3 June 2005. When asked as to what was meant by trauma, Ms Bickmore said in evidence that Mr Davies had indicated to her that he had been distressed by the procedure and had experienced pain and discomfort. That said, there is no suggestion that Mr Davies had experienced any actual physical trauma that might be associated with the procedure such as the creation of a false passage by way of penetration of the urethra as can happen or haematuria which is blood in the urine. Dr Ong in his evidence before me rejected the suggestion that he knew anything about this complaint. As far as he was aware, there had been no difficulty in regards to the 1 June 2005 procedure. Dr Ong visited Mr Davies at the facility on 8 June 2005 and his note of this consultation appears immediately below Ms Bickmore's note dated 3 June 2005. Although Dr Ong's practice was to read a patient's recent progress notes, he asserts that he did not see Ms Bickmore's note when he was there on 8 June 2005. Dr Ong went so far as to say that he believed that the note of 3 June 2005 was not there at that time, the suggestion being that Ms Bickmore had written it on or after 8 June 2005. Of course, if Dr Ong had read the note it would have put him on notice that Mr Davies did not want Dr Ong to perform re-catheterisations on him. On 8 June 2005 there was no need for re-catheterisation and Dr Ong has simply recorded that there was no problem with the catheter.
- 3.4. Dr Ong saw Mr Davies again at the facility on 25 June 2005. He examined Mr Davies' leg ulcers. The catheter did not require changing on that occasion. Dr Ong made a note of his attendance on the reverse side of an already existing and completed page of the progress notes. This attendance represented another opportunity for Dr

⁴ Exhibit C6, page 3 (reverse side)

Ong to have seen Ms Bickmore's note of 3 June 2005, on the assumption that the note had been in existence and Dr Ong had gone back that far in the notes.

- 3.5. Dr Ong next saw Mr Davies at the facility on 7 July 2005. Dr Ong does not appear to have made a note of his attendance on this occasion. However, Ms Bickmore made a note and has recorded that Dr Ong visited that day, that 'no changes' were required and that Dr Ong would again visit in one or two weeks. She has then written 'staff to contact RDNS re changing catheter'. Ms Bickmore told me that she made this entry after Doctor Ong's visit and did so at his suggestion. She told me that she would not have made this note without there having been an underlying doctor's instruction. At some point Ms Bickmore completed a referral form to the RDNS. She dated it 7 July 2005 in her own handwriting. The care requested of RDNS is expressed as 'Replace IDC as required please (client aware he will need to pay)'. IDC is an abbreviation for an indwelling catheter. Ms Bickmore has written that the referral contact name is 'Sherrill Bickmore for Dr Ong'. A fax imprint on the copy of the document kept within the records of the facility bears the date '8 July 2005'. It also bears a fax imprint stating the document was faxed to the facility's fax number, not from it, on that day. Ms Bickmore told me that the blank RDNS form had to be faxed to her, as the facility did not keep any. If the completed document was ever transmitted to the RDNS there is no record of it within the RDNS file. This is surprising, as Ms Bickmore appears to have endorsed the facility's copy with a notation that it was sent. I note that although the blank document was apparently faxed to the facility on 8 July 2005, Ms Bickmore has dated it 7 July 2005, the day of Dr Ong's visit and the day she made her note to the effect that staff should make the arrangement with RDNS that this RDNS document purports to make. She agreed with Mr Stratford of counsel for Dr Ong that the date of 7 July 2005 must therefore have been an error.
- 3.6. Whether or not the RDNS referral document ever reached the RDNS, it is clear to me that it reflected Mr Davies' desire to have the RDNS perform future re-catheterisations to the exclusion of Dr Ong. Within the RDNS records⁵ is a document that in my view clearly records a personal request made by Mr Davies himself on 13 July 2005. Mr Davies had telephone access at the facility. The request was that he required a catheter change as soon as possible 'as his doctor put one in a week ago and it is very uncomfortable. Client states GP did a poor job which is why

⁵ Exhibit C12, page 2

he wants RDNS nurse.’ I note the manifest error contained within this notation that the doctor had inserted Mr Davies’ catheter as recently as a week ago. However, I see no reason not to accord full weight to the notation to the effect that Mr Davies had complained that his general practitioner had done a poor job and that he wanted future procedures to be performed by RDNS for that reason. This is an apparently genuine document and there is no reason to suppose that its maker had a motive to fabricate the information recorded within it at the time of its making.

- 3.7. The request that Mr Davies apparently made of the RDNS was that they attend on 14 July 2005, but in the event the RDNS nurse responded to the request on 15 July 2005. The complaint as expressed to the RDNS nurse on that day was that Mr Davies was experiencing leaking around the tube which is in keeping with Mr Davies’ recorded assertion on the phone that the catheter was very uncomfortable.
- 3.8. I have no doubt that Mr Davies had experienced an uncomfortable re-catheterisation on 1 June 2005, the only such procedure that Dr Ong had performed on him. I accept Ms Bickmore’s evidence that Mr Davies told her about this in early June 2005 and that he was telling her the truth. As will be seen, he was later to say the same to another nurse. I have no doubt that Mr Davies’ clear preference was that the RDNS perform the procedure and that he himself had a hand in securing their attendance on 15 July 2005. No doubt he wanted the RDNS to do this having regard to the fact that they had performed the procedure successfully and without incident on a number of occasions in the past. Dr Ong denied that he knew anything of any complaint by Mr Davies and asserts that the procedure had been satisfactory on 1 June 2005 and that no difficulty had been encountered at that time. He denies that he gave any instruction to Ms Bickmore on 7 July 2005 to the effect that they should arrange for RDNS to perform the procedure in future.
- 3.9. Dr Ong told me that if it had been indicated to him by or on behalf of Mr Davies that the latter did not want Dr Ong to perform catheterisation procedures on him, that a complaint had been made that he had traumatised Mr Davies on 1 June 2005 and that an experienced RDNS nurse had failed to achieve catheterisation earlier that day for whatever reason, he would not have performed the procedure but have referred the patient on. He believed that Mr Davies would in those circumstances have not agreed to Dr Ong doing it, but in any event agreed that he would not have felt comfortable about doing it whatever Mr Davies’ expressed attitude may have been. He said ‘*No. I*

wouldn't do a procedure that my patient expressed dissatisfaction at all'⁶, and that this was especially so if there had already been an unsuccessful attempt arising out of difficulty in insertion.

- 3.10. If during Dr Ong's attendance on 8 June 2005 he had read the note of Ms Bickmore dated 3 June 2005, as he undoubtedly would have if it was in existence at that time, he would have known that Mr Davies had a strong desire that he should not perform the procedure on him in the future. It is difficult to see why Ms Bickmore would have delayed writing her note dated 3 June 2005 until after Dr Ong's attendance of 8 June 2005. That said, I cannot explain why the RDNS referral form that she compiled bears a date that undoubtedly precedes the date of its compilation either. Ms Bickmore's own note of 8 June 2005 written following Dr Ong's next attendance is in keeping with Dr Ong having instructed her to arrange future catheterisations with the RDNS. This would naturally be consistent with knowledge on Dr Ong's part that Mr Davies did not want him to perform the procedure personally. On the other hand, Ms Bickmore's note of 8 June 2005 is not inconsistent with Mr Davies himself having asked Ms Bickmore to make that arrangement.
- 3.11. I return to the issue as to Mr Davies' attitude towards Dr Ong performing the procedure on 15 July 2005 and the appropriateness of Dr Ong performing that procedure himself below.
- 3.12. As to the events of 15 July 2005, the RDNS nurse arrived at the facility at about 2:30pm. The nurse was Mr Andrew Edwards. Mr Edwards was a registered nurse who had been employed by the RDNS for about 10 years. He had undergone training in relation to the insertion of male catheters and had performed several to this point. He did not know Mr Davies prior to this occasion. Mr Edwards made two sets of notes in relation to this attendance. One set was compiled within the facility progress notes relating to Mr Davies and the other within the RDNS notes. When Mr Edwards gave evidence the court was not in possession of the RDNS notes and so Mr Edwards did not identify or refer to them. I am nevertheless satisfied that the notes within the RDNS file are his notes, although I am not certain when they were compiled. However, I am satisfied that the notes that are contained within the facility progress notes that Mr Edwards did identify were compiled while Mr Edwards was at the facility and at a time before the tragic events concerning Mr Davies unfolded. I am

⁶ Transcript, page 341

therefore satisfied that they were made at a time when no motive on Mr Edwards' part to fabricate evidence existed.

- 3.13. Mr Edwards confirmed that the reason for the catheter change was that it was leaking. Mr Edwards told me that before he undertook the procedure he contacted Dr Ong by phone to obtain his permission to go ahead with the procedure. He sought that permission in the light of the fact that it was a self-referral and not a referral by a medical practitioner. Mr Edwards told me that most of the catheter changes that RDNS perform in the community on a regular basis originate from a medical officer or a hospital, although a request from a medical practitioner for an ongoing service would not require permission on each and every occasion. I note in this regard that it had been Dr Ong who had performed the previous catheter change and that Mr Davies himself had made a personal request on this later occasion. It is therefore not surprising that Mr Edwards would have wanted confirmation from Mr Davies' general practitioner that it was appropriate for the RDNS to perform the procedure on this occasion. When Mr Edwards made his entry into the facility progress notes he noted that he had gained Dr Ong's consent to perform the procedure. Dr Ong denied that Mr Edwards had telephoned him in advance of the procedure to obtain his consent. He admitted that Mr Edwards had phoned him after the attempted procedure to tell him that he had been unsuccessful. Mr Edwards told me that he had phoned Dr Ong after the failed attempt and had arranged for Dr Ong to attend later that day to insert the catheter. In other words, he had two separate phone conversations with Dr Ong; the first to secure permission and the second to tell Dr Ong that he had been unsuccessful and to ask Dr Ong to come to the facility to complete the procedure. I prefer and accept the evidence of Mr Edwards in this regard. Mr Edwards made a note of the fact that he spoke to Dr Ong on the two separate occasions. There is no question but that Mr Edwards made his note before he left the facility and therefore at a time before anyone questioned the appropriateness of the procedure being performed in these circumstances. For instance, in the phone conversation that Dr Ong admits did occur, he does not claim that he rebuked Mr Edwards for having proceeded with an unsuccessful procedure without his prior consent. Any suggestion that Mr Edwards had a motive to conceal the fact that he had not obtained Dr Ong's permission and then fabricated a note to the effect that he had obtained it out of a concern that he had not obtained that permission, is an intrinsically fanciful one in my view and I would reject it. Furthermore, if Mr Edwards made a bogus note, he ran the

risk of Dr Ong seeing it later that day and taking issue with it, either with himself or worse, his employer. To my mind it is highly unlikely that he would take that risk. In fact Dr Ong told me in evidence that he did read Mr Edwards' notes as one would have expected. I had the impression that Dr Ong was reluctant to admit that he had read anything suggesting that he had given his permission for the procedure to go ahead. He said that he could not change what other people had chosen to write in their notes⁷. Having seen Mr Edwards give evidence, I found Mr Edwards to be an honest and straightforward witness whose evidence on important matters is supported by contemporaneous notations. On the other hand, Dr Ong found himself to be at loggerheads on a number of occasions with the evidence of other witnesses, and in one instance that I shall mention later and which concerned the circumstances in which the ambulance came to be cancelled, was demonstrably shown to be wholly incorrect on a significant matter. I find that Mr Edwards phoned Dr Ong twice and that in the first conversation Dr Ong gave his consent to perform the re-catheterisation in advance of Mr Edwards' attempts.

- 3.14. Mr Edwards attempted to insert a size 20 catheter at first and then a size 16. He was unable to reach the bladder and obtain a urinary output. He told me that he did not apply undue force. He said that there was obviously an obstruction of some description, in his view most likely the result of an enlarged prostate, being generally the most common cause of obstruction. He described his attempts to go beyond the obstruction as '*sustained gentle pressure*'⁸. He desisted from the attempts because he did not want to subject Mr Edwards to the risk of trauma. He told me that Mr Davies did not experience any overt acute pain and he did not notice any blood on the tip of the catheter after his attempts at insertion. Mr Edwards did not believe that he had created a 'false passage' into the tissues surrounding the urethra. If he had penetrated the urethral wall, he would have expected acute pain and signs of trauma such as blood loss. In addition, such traumatising in his view would have required more pressure than what he had applied. He denied any suggestion that he had caused, or had told anyone that he had caused, light traumatising. Mr Edwards' attempts had not involved him applying a catheter bag at any point. Mr Davies told him that he had then passed what Mr Davies himself described as dark coloured urine. He agreed in evidence that this was possibly, but not necessarily, indicative of blood in the urine.

⁷ Transcript, page 337

⁸ Transcript, page 76

Mr Edwards did not personally see the urine. He included a reference in the progress notes to what Mr Davies had said about passing dark coloured urine.

- 3.15. Mr Edwards told Mr Davies that he had contacted Dr Ong and that Dr Ong would come to the facility and attempt reinsertion. He did not recall Mr Davies expressing any concern about that prospect. Mr Edwards left the facility and later wrote up notes of his attendance in Mr Davies' RDNS file. The RDNS note is not inconsistent in any material aspect either with the entry that Mr Edwards made within the facility progress notes or with what he told me in evidence.
- 3.16. Mr Edwards believed that he visited the facility at about 2.30pm and stayed there for approximately 45 minutes. At one point he spoke to a member of the nursing staff who herself was an agency nurse and whose shift had commenced at about 2.30pm. That nurse was Ms Julie Anne Beard who was employed by Health Management and Nursing Services (HMNS). This was the first occasion on which Ms Beard had worked at the facility. She did not know Mr Davies. A nursing handover had taken place between her and Ms Bickmore. She was aware at the beginning of her shift of the attendance of an RDNS nurse upon Mr Davies within the facility. She was also aware that the nurse had been unsuccessful in his attempts at re-catheterisation and that Dr Ong would attend during her shift to complete the task. When Ms Beard was originally spoken to by the police who investigated this matter, she told them that the RDNS nurse, who was clearly Edwards although she did not refer to him by name, had told her that after his attempts Mr Davies had experienced 'some light traumatisation' and that there was 'some light haematuria in the bag'⁹. In her evidence before me she retracted this comment and in fact ascribed the statement about light traumatisation to Dr Ong after his later intervention. I find that Ms Beard was in error when she originally ascribed this statement to Mr Edwards. Mr Edwards had applied no urine bag to Mr Davies because he had been unable to catheterise him. Thus Mr Edwards was in no position to have made any observation about whether there had been any haematuria in the bag after his failed attempts. None of this, of course, confirms the accuracy of Ms Beard's more recent assertions that it was Dr Ong who had said those things.

⁹ Exhibit C9, pages 3 and 4

- 3.17. I accept Mr Edwards' evidence that he there was nothing overt about Mr Davies to indicate that he had necessarily traumatised Mr Davies. He readily noted that Mr Davies had told him that he had passed dark coloured urine. If Mr Edwards had been endeavouring to conceal something more sinister it seems unlikely to me that he would have recorded this much. This to my mind is inconsistent with a desire on his part to conceal anything that he had personally observed to be suggestive of trauma.
- 3.18. Dr Ong attended the facility at about 5.30pm that afternoon. If Mr Edwards failed attempts at re-catheterisation had occurred between about 2:30pm and 3:15pm, this left Mr Davies without a catheter for between 2 and 3 hours. There is no evidence of any overt deterioration in Mr Davies well being in that hiatus. Ms Beard told me that he was not distressed at all in the intervening period and was seen walking around his room in a normal manner. She said:

'He appeared quite well and he didn't require any assistance. He wasn't complaining of any bladder problems or urgencies or wanting to go to the toilet. He was doing his normal activities in his room'.¹⁰

He did not complain of any bleeding from his penis. Ms Beard on occasions exhibited some confusion especially about times and the sequence of events during her shift. For the most part this had manifested itself during her police interview. I exercised caution when assessing the accuracy of her evidence. That said, having observed Ms Beard in the witness box over several hours of detailed and searching examination by all counsel, I concluded that she was an honest witness who had done her best to tell the truth as she believed it to be. In fact in respect of a material matter surrounding the circumstances in which the ambulance was cancelled, and in respect of which there was a dispute as between her and Dr Ong, Ms Beard's evidence was supported by other evidence and was demonstrably correct. I accept Ms Beard's evidence about the state of Mr Davies' apparent well being in the period before Dr Ong's arrival. Dr Ong did not suggest that when he arrived at the facility Mr Davies was anything other than well.

- 3.19. Ms Beard also told me that before Dr Ong's arrival, Mr Davies had spoken to her about the prospect of Dr Ong performing the re-catheterisation. She testified that she was made aware of the fact that Mr Davies had a preference for the RDNS to re-catheterise him rather than Dr Ong. Mr Davies told her that his previous experience

¹⁰ Transcript, page 129

with Dr Ong inserting the catheter had been a difficult one and she inferred from this that it had involved discomfort at the time. She said that she also inferred from this conversation that Mr Davies was not 'overly thrilled' at the prospect of Dr Ong inserting the catheter but that he was fully aware that Dr Ong was coming to do it¹¹. I accept that evidence. Mr Davies' statements in this regard would be in keeping with what he had told Ms Bickmore and with the fact that he had personally approached RDNS to perform the procedure and not Dr Ong. I note, however, Ms Beard had put the matter rather more robustly during her police interview. She told the interviewing officer that Mr Davies had an 'aversion' to Dr Ong performing the procedure. In her police interview, Ms Beard had said that she suspected that Mr Davies had only allowed Dr Ong to perform the procedure on the afternoon of 15 July 2005 'under some duress' and that any consent that Mr Davies may have given to Dr Ong was not 'fully consent'. It goes without saying that these are serious allegations¹².

- 3.20. This brings me to the question of whether it was at all appropriate for Dr Ong to have gone ahead with the catheterisation. If one were to accept that Dr Ong knew that Mr Davies had a desire that Dr Ong should not perform this procedure and knew that Mr Davies had made a complaint of traumatisation against him, and having regard to Dr Ong's undoubted knowledge that there had already been an unsuccessful attempt at catheterisation that day, then the circumstances that, on his own evidence, would have precluded Dr Ong from performing the procedure were enlivened. This is a very difficult matter in respect of which I have experienced some little hesitation. I would in any case reject the characterisation of Dr Ong's actions as duress. There is insufficient evidence to support a finding of this degree of gravity.
- 3.21. Having considered the matter carefully, I am not prepared to find that Dr Ong knew of any intractable desires or aversions on Mr Davies' part that would necessarily have precluded him from performing the procedure. While acknowledging the force of Ms Bickmore's evidence about her documentation, I am uncertain whether Dr Ong saw and absorbed her note dated 3 June 2005 even if it had been existence when Dr Ong next visited the facility on 8 June 2005. In addition, although Dr Ong may have been put on notice on 7 July 2005 that Mr Davies had a preference that the RDNS perform the procedure from then on, there is no evidence that any person ever told Dr Ong that under no circumstances could he perform the procedure ever again. In this regard,

¹¹ Transcript, page 128

there can be no suggestion that Dr Ong ever had a positive understanding that he had traumatised Mr Davies on the previous occasion, because notwithstanding Ms Bickmore's characterisation of the matter in those terms in her note dated 3 June 2005, there is no evidence of traumatisation as such. I also add this. Even if by 15 July 2005 Mr Davies had an actual aversion to Dr Ong performing this procedure, there is no suggestion that Mr Davies had suggested an alternative solution once the RDNS attempt had failed. There is no evidence that anyone in authority at the facility that afternoon postulated an alternative either. Mr Edwards, whose evidence I accept, drew no reaction from Mr Davies when he told him that he had called Dr Ong to complete the procedure. I think all of this reflects a willing resignation on Mr Davies' part that Dr Ong would perform the procedure that day. I heard evidence that despite all of his physical infirmities, there was nothing wrong with Mr Davies' mental faculties and that he was his own man, as it were. It will be remembered that he arranged the attendance of RDNS that day on his own initiative. There is no evidence that Mr Davies or anyone else for that matter voiced any objection to Dr Ong himself. Whatever the position may have been and whatever Mr Davies' true attitude was, the evidence does not permit me to find that any knowledge that Dr Ong may have had as to Mr Davies' lack of enthusiasm in relation to him should have meant that Dr Ong ought to have desisted from performing the procedure altogether. Even if Dr Ong had full knowledge of Mr Davies' wish that he not perform the procedure from now on, the fact was that RDNS had contacted him and had specifically requested him to perform the procedure. Dr Ong would have been entitled to conclude that this approach was made with Mr Davies' full knowledge and consent in this particular instance and, absent some later objection that might have been voiced of which there is no evidence, that he could go ahead with the procedure. Dr Ong's position would have been reinforced by the fact that even if his previous catheterisation of Mr Davies on 1 June 2005 had caused discomfort at the time, it had been an otherwise successful one in the sense that it had been effective and I repeat that there is no evidence that there had been any trauma as such. In essence, there is no evidence that before mid July when Mr Davies apparently experienced leakage, and by which time many would say that the catheter may have required routine replacement in any event, the 1 June 2005 procedure had involved anything other than a satisfactory catheterisation. I also

take into account the many years of satisfactory professional relationship between the two gentlemen.

- 3.22. Dr Ong told me that he had a number of nursing home patients who from time to time required re-catheterisation and he performed them. He became aware that he was required to change Mr Davies' catheter on 15 July 2005 when the RDNS nurse contacted him and told him he had been unsuccessful at changing Mr Davies' catheter. Dr Ong claimed that if the nurse had contacted him in advance of the attempt he would have advised him that he would have needed to see the patient's condition for himself before agreeing to a change of the catheter. As discussed earlier, Dr Ong told me that he did not give the nurse permission to proceed. He also told me that he would not have given permission over the phone. I have found that Dr Ong did give that permission in advance over the phone. In the light of Dr Ong's assertion that he would have wanted to see the patient before he gave such permission, the fact that he did not do so on this particular occasion is unexplained.
- 3.23. Dr Ong told me that he believed that a male staff member of the facility had been present during the re-catheterisation procedure. That person has not been identified. There is no evidence that there was any male employee on the premises that day. Ms Beard expressed a belief that an employee had been present during the procedure. She believed that it might have been a student nurse by the name of Dina Cowley (nee Vogt). Ms Cowley told me in evidence that she had no recollection of having been present during the procedure. Ms Cowley was later to be involved in the attempts to rectify Mr Davies' difficulties with the new catheter and gave me a detailed account of what had happened at that time. She had formed an impression at the time that Mr Davies had suffered a traumatic catheterisation. In those circumstances, I think it highly unlikely that she would have forgotten the fact that she had been present during a catheterisation procedure for Mr Davies that had only happened that same day if in fact she had been present. I found Ms Cowley to be a witness of truth. I accepted her evidence that she had no recollection of having been present. In my view she had not been present. Interviews of other staff members by the police failed to elucidate whether any other person had been present and who that person may have been.
- 3.24. Dr Ong told me that he managed to successfully introduce a 16-gauge catheter at the first attempt. Mr Davies normally wore a 20-gauge catheter, but Dr Ong chose the smaller gauge catheter in the light of the fact that the RDNS nurse had failed with

both gauges of catheter and that insertion of the smaller catheter bore a greater chance of success. He swore that he did not utilise any unusual degree of force. He obtained a flow of urine within a few seconds which meant that he had successfully reached the bladder. There was no blood in Mr Davies' urine which was clear yellow. Dr Ong believed that he left to the nursing staff the task of connecting the catheter bag.

3.25. Ms Beard, who incidentally did not know Dr Ong before this, claims that Dr Ong approached her and told her that he had performed the procedure and that Mr Davies had experienced light traumatisation but that she need not be concerned. He suggested analgesia. He said that there was some light haematuria in the bag. It will be remembered that when the police interviewed Ms Beard, she had originally ascribed the statements about light traumatisation and haematuria to Mr Edwards. I have already indicated that in my view she is mistaken about this. Dr Ong could also not have said this if he is correct that he had seen no blood in the bag after the procedure. I do not know what, if anything, Dr Ong said about this because Ms Beard's confusion as to the identity of the person who said this to her makes me hesitant about relying on her evidence about this particular issue. However, I accept her evidence that after Dr Ong left, at some point she gave Mr Davies some paracetamol and noticed for herself light haematuria in the bag. She also saw that there was urine in the bag which of course meant that Dr Ong had successfully introduced the catheter into Mr Davies' bladder.

3.26. Dr Ong's successful introduction of the catheter into the bladder does not in itself negate the possibility that trauma may have been inflicted in the attempts leading thereto. Dr Ong says that the catheter was introduced at the first attempt with no pain. Ms Beard told me that when she gave Mr Davies his analgesia, Mr Davies told her that he had experienced some discomfort with the catheterisation. In her police statement she had said that Mr Davies had described 'extreme pain'¹³. If anybody was present during Dr Ong's procedure, he or she has not been identified notwithstanding thorough police investigation. As seen earlier, Ms Beard had an impression that Dina Cowley had been present. In fact, Ms Beard originally told the police that she believed that the female staff member had told her that she had been present during the procedure and had said that Mr Davies had experienced quite a lot of pain, that it had appeared that Dr Ong had forcibly pushed the catheter past whatever stricture had

¹³ Exhibit C9, page 8

been in the way and that this had caused Mr Davies to go white. In evidence, Ms Beard told me that she believed this person to have been Dina. Dina Cowley does not substantiate this. In any event, I give no weight to Ms Beard's assertions in this regard, which are clearly hearsay, and I ignore them for all purposes. I make the observation here that evidentiary difficulties of this nature could be avoided if there was a requirement in place that rendered it mandatory for procedures such as these when conducted in nursing homes to take place in the presence of an identified individual. As it is, Dr Ong's assertions that he had no difficulty in catheterising Mr Davies and that Mr Davies experienced no pain are uncorroborated. On the whole I found it difficult to rely on Dr Ong's evidence on material matters unless other evidence supported it. This owes itself to the fact that in my view Dr Ong was shown to be wholly incorrect on other issues including as to whether he had given Mr Edwards permission to go ahead with the procedure. He was also demonstrably wrong on another matter connected with the circumstances in which the ambulance was cancelled. I was not convinced that Dr Ong was completely candid in relation to these issues. His intransigence in relation to those issues, especially in the light of compelling evidence to the contrary, only served to heighten my reluctance to accept his evidence unless corroborated by a reliable source. In short, I was unable to rely on Dr Ong's evidence that he had encountered no difficulty in catheterising Mr Davies and that Mr Davies had experienced no pain. That said, this does not in itself mean that the opposite had been the case.

- 3.27. Mr Davies was later that evening found to be bleeding into the bag. I find that this was discovered at about 7.30pm. This state of affairs was drawn to Ms Beard's and Ms Cowley's attention. Expert evidence from an experienced urologist, Dr John Bolt, suggested that nurses have a tendency to wrongly describe what might be blood within urine as frank blood. Whether that is right or not, in my view what Ms Beard and Cowley witnessed was a collection of frank blood in Mr Davies' catheter bag that signified some serious traumatisation. Ms Beard thought that about 250 to 300mls had collected in the bag. It was clear to me that both women had an acute appreciation of the distinction between blood that might collect and mix with urine in the bag and a collection of actual frank blood. Ms Beard described it as like what one would see in a unit of blood required for a transfusion. She said it was very bright and very red and the bag had very little urine in it. When later describing Mr Davies' loss of blood to a South Australian Ambulance Service (SAAS) operator, she

described it as ‘frank blood, not rosé ... real dark blood’¹⁴. Ms Cowley also said that Mr Davies was bleeding quite profusely and was losing a lot of bright red blood with frank blood clots that were blocking the catheter. She said that it was not blood mixed with urine as this has a rose colour. I reject the suggestion that what the two nurses saw was simply blood mixed with urine in the catheter bag.

- 3.28. Ms Beard endeavoured to milk and flush the catheter. She applied about 50mls of solution but was only able to receive back about 30mls which suggested a blockage. There were blood clots and the blood appeared for the most part to be coming down the catheter. The milking was designed to remove the clots. Her efforts at flushing were designed to restore Mr Davies to some level of comfort. At one point she managed to achieve some urinary output. Mr Davies was becoming distressed and became unwell. Ms Beard endeavoured to phone Dr Ong but at first could not reach him. It appears that she left a message. She rang another facility nurse who was off duty and then rang SAAS. A transcript of her conversation with the SAAS operator is in evidence¹⁵. SAAS records reveal that the call was made at 8.20pm. I do not doubt that in this conversation Ms Beard accurately described Mr Davies’ presentation at that time. Ms Beard told the operator that at that point the catheter was completely blocked off by frank blood, that Mr Davies had lost about 250mls of frank blood and that he was bleeding from the urethra or the bladder itself. She said that she had been unsuccessful in flushing the catheter. She said that Mr Davies was pale and in distress with pain. Ms Beard’s level of concern was reflected in the fact that she agreed with the SAAS operator that lights and sirens would be appropriate. It would therefore be surprising if when Dr Ong returned her call that she would downplay the seriousness of the situation with Dr Ong or fail to mention to him that an ambulance had been called. Yet Dr Ong told me that when he spoke to Ms Beard on the phone he was not told anything about an ambulance having been called. Ms Beard says that she was sure she told Dr Ong that the catheter had blocked off by blood, that he had lost a large amount of blood and that she was sending him off in an ambulance¹⁶. In those circumstances why a medical practitioner would second-guess the nurse’s decision to organise an ambulance is difficult to comprehend, but that is what Ms Beard told me Dr Ong did. She told me that Dr Ong said that he wanted to review the patient before he went and ordered her to cancel the ambulance. Ms Beard told me that as a result,

¹⁴ Exhibit C1b, page 2

¹⁵ Exhibit C1b

she rang SAAS and cancelled the ambulance. Dr Ong denied that he told Ms Beard to cancel the ambulance.

- 3.29. When asked to comment on the suggestion that she had not told Dr Ong that she had rung for an ambulance, Ms Beard responded as follows:

'I am flabbergasted; I definitely told Dr Ong I had rung an ambulance because I had started to fill in the paperwork, and I definitely told Dr Ong I had rung an ambulance, and he was the one who said 'I wanted to review the patient before he went' and he ordered me to cancel that ambulance.'¹⁷

When asked whether it was remotely possible that she would have cancelled the ambulance without having been told to do so by Dr Ong she said:

'Absolutely not; I had a reason to send Mr Davies off to hospital. He had blood in his bag that I considered to be a pint of blood; if anybody loses a pint of blood, there is active, fresh bleeding taking place. You want to get further medical treatment to prevent any further loss, and I attempted to do that. On Dr Ong's instructions I cancelled that ambulance.'¹⁸

I carefully examined Ms Beard's demeanour when she gave the above answers. I saw nothing about it that gave me any reason to think that she was not telling me the complete truth.

- 3.30. According to SAAS records Ms Beard rang them to cancel the ambulance at 8.31pm. The transcript reveals that Ms Beard said to the operator:

'I just rang for an ambulance for an elderly gentleman, the GP I've con, I managed to contact and he does not want him to go to hospital.'¹⁹

If, having contacted Dr Ong, Ms Beard cancelled the ambulance on her own initiative, there is no evidence as to why she would have done that. Nothing Dr Ong had told her had allayed any of her concerns about Mr Davies. None of the reasons that had prompted Ms Beard to order an ambulance in the first place had disappeared. If she had a motive to ascribe the decision to cancel the ambulance to Dr Ong as and when she spoke to the SAAS operator, it is difficult to conceive of one other than the most fanciful. I have no doubt that Ms Beard cancelled the ambulance on Dr Ong's instructions. Dr Ong's denial that he cancelled the ambulance means that the Court

¹⁶ Transcript, page 109

¹⁷ Transcript, page 251

¹⁸ Transcript, pages 251 and 252

¹⁹ Exhibit C1c

has no explanation from him as to why he would have wanted to cancel the ambulance other than what he told Ms Beard that he wanted to review the patient first. If the urgency of Ms Beard's tone when she ordered the ambulance in the first place had been replicated in her phone conversation with Dr Ong, there would have been no reason for Dr Ong not to have acquiesced in her decision. In Dr Ong's witness statement²⁰ he states that if the nurse had advised that she had called an ambulance, he would expect his response to have been, in circumstances where the patient was stable, that he would see the patient first and then make a decision. He does not describe what he would do if the ambulance had already been called in terms of cancellation. There was nothing in Ms Beard's conversation with Dr Ong to suggest that she had given him any impression that Mr Davies was stable. The notion that Ms Beard would have indicated stability in terms, or have given information to Dr Ong from which he could have concluded that he was stable, is highly unlikely in my opinion. Dr Ong's assertions that nothing in Ms Beard's phone conversation implied a degree of urgency requiring hospital intervention have to be examined in the light of the fact that I reject his evidence that he ordered the ambulance to be cancelled. In short, I am unable to rely on Dr Ong's evidence about the content of his phone conversation with Ms Beard.

- 3.31. Dr Ong arrived at the facility some time between 8:31pm when the ambulance was cancelled and 9:01pm when, after Dr Ong's arrival and on his instructions, Ms Beard called SAAS again and re-booked the ambulance. By then Mr Beard had bled even more and his condition had further deteriorated. The original catheter bag had been replaced with another bag and a further collection of frank blood had been deposited into this. There was no question but that Mr Davies required hospitalisation at that time. When Ms Beard rang SAAS at 9:01pm to re-book the ambulance she explained to the operator that Dr Ong had originally asked not to send the patient, but that he was now asking for him to be sent. She told the operator that he had lost approximately 500mls of blood and that he was by then quite cold, shocked, pale, clammy, shut down and that he was using his Ventolin puffer quite excessively. Ms Beard again requested lights and siren. The ambulance arrived at the facility at 9:09pm and was mobile with Mr Davies at 9:25pm.

²⁰ Exhibit C11

3.32. When Mr Davies was examined at the Royal Adelaide Hospital, it was suspected that the catheter was not in the bladder at that time and a ‘false passage’ into the tissue surrounding the urethra was also suspected. Leaving aside the suspicions of a false passage having been created at some point in the attempts at catheterisation, the finding that the catheter was not in the bladder seems at odds with the fact that Dr Ong had reached the bladder and had induced a flow of urine. The fact that there had been a urinary flow was supported by Ms Beard who had originally seen urine in the catheter bag after Dr Ong had performed the procedure. Dr John Miller, a urologist, postulated that the interpretation that the catheter was not in the bladder may simply have been more of a reflection of the fact that by the time Mr Davies arrived at the Royal Adelaide, the catheter was just blocked²¹.

3.33. Two urologists have examined the circumstances of Mr Davies’ catheterisation. The two specialists both examined a number of issues that had been identified during the course of the Inquest. They addressed the following broad issues:

- a) The manner in which Mr Davies suffered the neurological trauma, when and at whose hands;
- b) The appropriateness of the procedure having been performed not in a hospital setting;
- c) The appropriateness of the procedure being performed without antibiotic cover and reversal and/or monitoring of anticoagulation.

3.34. The circumstances in which Mr Davies suffered the urological trauma

In his report²², Dr Miller, an experienced urologist, suggested that on the basis that the RDNS nurse did not use undue force in an effort to replace the catheter, it was nevertheless likely that some trauma occurred with his catheterisation attempts and that this perhaps contributed to some blood stained urine being passed following his failed catheterisation attempt. It will be remembered that Mr Edwards reported that Mr Davies had told him that he had passed some ‘dark coloured urine’. In his report Dr Miller also states that he doubted that any further urethral or prostatic damage was encountered because of the change of catheter by Dr Ong. It became evident during the course of Dr Miller’s testimony at the Inquest that his assumptions in relation to trauma having been likely caused by the RDNS nurse and not by Dr Ong was

²¹ Transcript, page 161

²² Exhibit C10

predicated on the acceptance of Dr Ong's assertions that, later in the afternoon, he had no difficulty in performing the procedure and that he was able to gain access to Mr Davies' bladder at the first attempt, assertions on which, as I have stated, I cannot rely. However, he said that where the anticoagulant Warfarin was involved in the patient's management thereby making the patient more susceptible to bleeding, even minor trauma occasioned during insertion of a catheter could result in quite dramatic bleeding and in sufficient quantity to block the catheter.

- 3.35. On a review of the medical notes relating to Mr Davies, Dr Miller believed that the creation of a false passage into the tissue surrounding the urethra was fairly likely. According to Dr Miller, if one acts on the basis that Dr Ong had easily achieved free urine draining from the bladder, one would infer that the catheter had successfully been placed within the bladder. This in turn would imply that the RDNS nurse had earlier created a false passage in his attempts at reinsertion²³. While the dark coloured urine that had reportedly been passed was not necessarily indicative of trauma²⁴, Dr Miller very much doubted that the dark coloured urine did not contain blood.
- 3.36. As an alternative, Dr Miller postulated that if the catheter had been successfully placed within the bladder, as Dr Ong reports and which is supported by the evidence of Ms Beard, the source of the frank bleeding could have been the bladder mucosa, the bladder wall or have come from the prostatic remnant²⁵.
- 3.37. If the RDNS nurse had created the false passage during his attempts at catheterisation, Dr Miller suggested that Mr Davies would at that time obviously have been experiencing some pain and also some bleeding per the urethra. He suggested that he probably would have continued bleeding and have experienced difficulty urinating. It will be noted here that there was no evidence of either pain or bleeding in the two to three hour gap between the nurse's attempts and Dr Ong's attempts. Indeed, Dr Miller agreed that if Mr Davies were able to urinate unaided, it would suggest that any false passage was not of a significant size²⁶.
- 3.38. Regarding Dr Miller's assertion in his report that he doubted that any further urethral or prostatic damage had been encountered due to the change of catheter by Dr Ong, he agreed that this view was based on an impression that Mr Edwards had 'extreme

²³ Transcript, page 162

²⁴ Transcript, page 193

²⁵ Transcript, page 203

difficulty' during the course of his efforts to introduce the catheter and that Dr Ong had inserted the catheter more readily and had obtained clear urine. There is no evidence that Mr Edwards himself characterised his attempts as involving 'extreme difficulty' insofar as that expression might carry an implication that he used extreme measures to overcome that difficulty. It will be remembered that Mr Edwards desisted from his attempts on the basis that he did not want to inflict any trauma upon Mr Davies. I accepted his evidence in that regard. I also repeat here that it was difficult for me to place any significant weight on Dr Ong's assertions as to the ease by which he introduced the catheter.

- 3.39. In the event, while Dr Miller acknowledged that the cause of the frank blood that Mr Davies lost was likely to be due to urinary tract trauma, he said that it was difficult to assess whether it occurred at the previous catheterisation attempts or at Dr Ong's catheterisation, or whether earlier trauma had been aggravated by Dr Ong's catheterisation²⁷. He suggested that the significant loss of frank blood after Dr Ong's catheterisation suggested that the loss of blood was more likely to have been contributed to by Dr Ong as opposed to having been wholly caused by him. When asked specifically whether the efforts of the RDNS nurse alone were unlikely to have caused the significant loss of frank blood that Mr Davies had experienced following Dr Ong's attendance, Dr Miller again suggested that it was difficult to say. However, based on Mr Davies' relative stability following the RDNS nurse's attendance, he opined that the trauma caused by the RDNS nurse was probably less than that caused by the reinsertion by Dr Ong²⁸.
- 3.40. Dr Miller suggested that Ms Beard's efforts as trying to flush and aspirate the catheter would not have made much difference to the outcome. He suggested that by then Mr Davies had experienced ongoing bleeding that the nurses were simply unable to stop, even with flushing. Of course it will be remembered that Ms Beard's attempts at milking and flushing the catheter only occurred after and as the result of the accumulation of a significant amount of frank blood within the bag. In those circumstances, having accepted that evidence from Ms Beard, it is difficult to see how it can be said that Ms Beard's efforts were the catalyst for Mr Davies' bleeding and rapid decline thereafter.

²⁶ Transcript, page 164

²⁷ Transcript, page 199

²⁸ Transcript, pages 200 and 201

3.41. Dr John Bolt is another experienced urologist. In Dr Bolt's affidavit²⁹ he expressed the opinion that it was likely that the attempt at catheter change by the RDNS nurse caused trauma that may have created a false passage, although he acknowledges that this has not been confirmed by other evidence³⁰. Dr Bolt gave evidence before me. In his evidence he stated that a false passage in the urethra could happen with relatively gentle force³¹ and that the patient may only experience minor discomfort at the time of the creation of the false passage³². Bleeding might be experienced around the catheter if a false passage had been created. If the patient has not been re-catheterised after the creation of the false passage, one might experience a discharge of blood. If the patient were anticoagulated, bleeding might persist for the order of 15 to 30 minutes³³. In Dr Bolt's view, Mr Davies' normal observations and stability following the RDNS nurse's attendance were still consistent with trauma having occurred during the RDNS nurse's attempts at catheterisation. He said that the bleeding might have stopped relatively easily because the degree of bleeding is not usually torrential unless the trauma was severe. Dr Bolt suggested that the lack of distress in Mr Davies in the period between the two attempts at catheterisation was not necessarily conclusive, as a degree of trauma that is ill defined can occur with relatively little disturbance to the patient. On Dr Bolt's view of the matter, therefore, even if one were to accept Mr Edwards' expressed beliefs that he had not applied sufficient force to traumatise Mr Davies, or had witnessed no evidence of the same, Mr Davies may nevertheless have been so traumatised. This view differs from that of Dr Miller because Dr Miller would have expected pain, bleeding and difficulty in urination if Mr Edwards had significantly traumatised the patient.

3.42. Dr Bolt suggested that while it was possible that the trauma may have been occasioned from an aggravation of previous catheter cystitis in the bladder, in his view it was more probably associated with trauma of the urethra that had occurred in association with the catheter change. In any event, Dr Bolt agreed that the degree of blood loss experienced after Dr Ong's successful catheterisation was most likely related to the catheterisation and the trauma, compounded by the fact that Mr Davies was on Warfarin. Having said that, Dr Bolt doubted the accuracy of the nursing observations that Mr Davies had experienced a loss of frank blood into the catheter

²⁹ Exhibit C10

³⁰ Exhibit C10, paragraph 6

³¹ Transcript, page 373

³² Transcript, page 374

bag. Dr Bolt suggested that this was more likely to have been heavily blood stained urine. I have already made the observation that the evidence of both Ms Beard and Ms Cowley to the effect that it was frank blood was very compelling, especially that of Ms Beard who was very aware of the distinction to the point of making that distinction during her first conversation with the SAAS operator.

- 3.43. Like Dr Miller, Dr Bolt suggested that it was difficult to be precise as to when and by what mechanism the urological trauma was sustained and suggested that there was an element of speculation about Dr Miller's suggestion that the trauma caused by the nurse was probably less than that caused by Dr Ong. This was due to the fact that there was inevitably a lack of precision about how much difficulty each person had experienced beyond the fact that the nurse admitted to having some difficulty but had then desisted and that the doctor stated that there had been no difficulty at all³⁴. He said:

'But it is very difficult to estimate the degree of who caused the most trauma.'³⁵

- 3.44. Dr Bolt suggested that there were a number of possibilities in relation to the infliction of the trauma. He suggested that even if Dr Ong had obtained clear urine at the first attempt he may well have compounded or aggravated some pre-existing trauma that was in the urethra or the bladder. This would be so if one worked on an assumption that the initial attempt by the RDNS nurse created some trauma that might have left an abrasion in the mucosa of indeterminate depth. The bleeding may have stopped just with time as it does, despite the Warfarin, and the passing of the catheter over that clot, even if it was relatively atraumatic, could easily have re-established bleeding from the existing urethral trauma. Dr Bolt acknowledged that it was possible that the RDNS nurse had not caused any trauma, but pointed out that one would need to understand why a competent nurse had difficulty in reinserting the catheter because difficulty implies a problem in an otherwise straightforward process.
- 3.45. Dr Bolt agreed that the 'dark coloured fluid' reportedly passed by Mr Davies was consistent with trauma³⁶. He suggested a number of different possibilities including the infliction of damage to the area originally the subject of Mr Davies' TURP

³³ Transcript, page 376

³⁴ Transcript, page 382

³⁵ Transcript, page 383

³⁶ Transcript, page 401

procedure³⁷. He suggested that although the false passage was not confirmed, it was his opinion that there was some degree of trauma either by way of creation of a false passage, abrasion at the level of the urethra, the sphincter, the bladder neck or the prostate fossa.

- 3.46. Dr Bolt suggested that the flushing of the catheter by the nursing staff at the facility may have aggravated some initial trauma, but again I make the point that significant frank bleeding had been well identified even before any attempt at flushing the catheter had taken place. In any event, Dr Bolt agreed that milking and flushing of the catheter was a reasonable measure for the nursing staff to have attempted. However, he made the observation that the attempt at flushing it, particularly bearing in mind that it was a smaller gauge catheter, was a ‘big ask’ and likely to be unsuccessful and might have simply aggravated the bleeding³⁸.
- 3.47. The above analysis in my view leads inevitably to the unfortunate conclusion that it is impossible to determine at what point in time, and at whose hands, the trauma occurred. It is impossible to ascribe the totality of the trauma to either the RDNS nurse or Dr Ong, or any part of the trauma for that matter. This is in spite of the fact that in the period between the two attempts no particular distress was observed in respect of Mr Davies, and also in spite of the fact that Mr Davies only went into his decline and suffered the copious bleeding in the period after Dr Ong had re-catheterised him. Insofar as it might be suggested that a conclusion could be based upon Dr Ong’s asserted lack of difficulty in reinserting the catheter, I would not entertain that suggestion because I have difficulty in placing reliance on Dr Ong’s evidence in that regard.
- 3.48. The appropriateness of the procedure not being performed in a hospital setting
It is fair to say that the views of Drs Miller and Bolt differed in this regard as well. In his report Dr Miller suggested that there are a number of factors that made Mr Davies’ catheterisation unsuitable for a registered nurse to perform, and indeed perhaps for a general practitioner. Those complicating factors were the reported difficulty in previous urethral catheterisations, particularly in the setting of a TURP procedure, secondly the inevitable urinary tract infection and thirdly, the Warfarinisation. It is fair to say that in any case Dr Miller was of the view that the changing of Mr Davies’

³⁷ Transcript, pages 402 and 403

³⁸ Transcript, page 411

catheter at his election was not indicated and ought to have been discouraged. The point being made here was that there was no clinical basis for it to be changed at all. There were no objective signs of a blocked catheter, for example, that may have explained the leaking around the catheter. In that event, Dr Miller would in effect advocate leaving well enough alone. Also, as I understood his position on this, an elective catheter change could not be justified especially given Mr Davies' level of risk having regard to all of the adverse circumstances that prevailed in his case.

3.49. In his report, Dr Miller makes reference to the recent confirmation of the presence of a urinary tract infection from a urine sample taken in May which would have rendered it prudent to first treat the infection and await a clear specimen before changing the catheter in elective circumstances. He also refers to the fact that it was reported that when Mr Davies was examined at the Royal Adelaide Hospital on 15 July 2005 his INR Warfarinisation level was in excess of 3.0 and that his anticoagulation should have been stabilised at between 1.5 and 2.0 for a catheter change to be attempted in a nursing home setting.

3.50. In his evidence Dr Miller made reference to the fact that in his view, based on experience and documented research, it was inevitable that Mr Davies would have had a urinary tract infection. Dr Miller told me that although Mr Davies was on a Hiprex regime, this is not an antimicrobial or an antibiotic. It is basically an agent that is given in an attempt to reduce the incidence of infection, but it does not treat infection itself. It would not provide sufficient protection to a patient in the context of a catheter change³⁹. As regards the desirability of antibiotic cover in catheter changes generally, Dr Miller had this to say:

'Q. So are you saying that there should be antibiotic cover in all cases of the change of catheter, or not.

A. In changes of chronic catheters, yes. Certainly that is my practice, and it doesn't need to be a prolonged course, and certainly putting indwelling catheter patients on a prolonged course of antibiotics; all you are going to do is create resistant bacteria. A short course around the time of catheter change is actually what is recommended by the Urological Society and also by microbiologists that I have talked to.'⁴⁰

3.51. As far as Mr Davies' anticoagulation is concerned, in his evidence Dr Miller expressed the belief that in Mr Davies' circumstances no-one could be confident that

³⁹ Transcript, page 157

⁴⁰ Transcript, page 168

his INR level was such that it would make it safe to perform a procedure such as a re-catheterisation⁴¹ and he points out that in the hospital later that day his INR was 3.3. He suggested that his practice is to stop Warfarin therapy three days before a change of catheter to allow time for the INR to reach a more normal level. In difficult cases he would check the INR level before going ahead to change the catheter.

- 3.52. In short, Dr Miller expressed the opinion that Mr Davies had a number of complicating factors which made it difficult to change his catheter in a nursing home⁴², but modified this opinion to the extent that if Mr Davies' anticoagulation had been corrected, any infection was treated and controlled and that there was no anticipated difficulty in the catheterisation, it was fine to undertake the procedure in a nursing home⁴³. Dr Miller argued that at least two of those three issues were not addressed within the nursing home. He opined that in Mr Davies' case his change of catheter needed to be done under controlled conditions and the best place to achieve that was in a hospital.
- 3.53. Dr Bolt's views differed somewhat from those of Dr Miller on this particular aspect of the matter. Dr Bolt suggested in his affidavit that unless the patient was unwell, was suffering an obvious infection or was bleeding at the time, it would be reasonable for a catheter change to be attempted in Mr Davies' case, and by implication of course to be undertaken in a nursing home. In saying this, Dr Bolt acknowledged that a urine specimen could often be contaminated in patients with catheters. In any event, in many nursing homes catheters are changed in the exact same circumstances as applied in the case of Mr Davies, and that included the fact that the patient might be on Warfarin. In the same affidavit, Dr Bolt suggested that it is not standard medical practice to transfer a nursing home patient to hospital for a change of catheter under antibiotics. Dr Bolt pointed out that there is a distinction between chronic bacterial colonisation and actual active infection that results in symptoms⁴⁴. There does not appear to have been any evidence of active symptoms in Mr Davies, notwithstanding that in May there had been a detection of a urinary tract infection. If the procedure is not a traumatic one, which means that one knows one is not causing any difficulty, antibiotics are not routinely utilised. He suggested that loading a patient up for two

⁴¹ Transcript, page 155

⁴² Transcript, page 172

⁴³ Transcript, page 189

⁴⁴ Transcript, page 385

days with antibiotics before a catheter change is not standard, not necessary and not routine practice.

- 3.54. The same considerations in his view apply to the question of Warfarinisation. If one is not expecting any difficulty with the procedure, then the presence of Warfarinisation was not a bar to the change of a catheter in a nursing home environment. Dr Bolt suggested that most people on Warfarin have their catheters changed notwithstanding, unless there is an anticipated degree of difficulty such as a stricture or a dilatation or the need for an introducer. He suggests that it was not necessary for patients to have a recent INR reading established before undergoing a catheter change. He said that that is not his practice and one is entitled to assume that the patient's Warfarinisation is stable, although in a difficult or complicated procedure there might be a need to check it⁴⁵.
- 3.55. Mr Edwards of the RDNS told me that he was aware of issues regarding the possible need for antibiotic therapy and appreciated the relevance of anticoagulant therapy. He did not believe that antibiotic therapy was necessary in catheter changes, unless there was a urinary tract infection, in which case patients probably should have a number of days course of antibiotics⁴⁶. Mr Edwards had no recollection of any documentation suggesting that Mr Davies had a current urinary tract infection and he did not recall there being any evidence or any signs of the same.
- 3.56. As far as Mr Davies' Warfarinisation was concerned, Mr Edwards did not have any recollection of this, but suggested that he could have proceeded in any event depending upon the coagulation level. It will be remembered that Mr Edwards said that he had obtained Dr Ong's permission to perform this procedure and I do not believe it could ever be suggested that any shortcoming that was based upon the need for antibiotics or reversal of anticoagulation ought necessarily have impacted upon what Mr Edwards did or refrained from doing. I find that he had a medical practitioner's consent to go ahead with the procedure and in those circumstances it is not surprising that he would proceed with the re-catheterisation attempt. It also has to be acknowledged that Mr Edwards desisted from the procedure when he discovered that he could not reach the bladder, and the reason he desisted was to prevent trauma to Mr Davies.

⁴⁵ Transcript, pages 391 and 392

⁴⁶ Transcript, page 31

3.57. The appropriateness of the procedure being performed without antibiotic cover and reversal and/or monitoring of anticoagulation

As to the issue of possible infection, Dr Ong had visited Mr Davies at the facility on 22 May 2005 and at that time Mr Davies had complained that his catheter was not feeling right and that he had an amount of discomfort. The samples taken from Mr Davies on this occasion revealed a possible urinary tract infection that Dr Ong suspected was simply a contamination of the catheter. However, he acknowledged in evidence that Mr Davies was possibly suffering from a urinary tract infection at that time. Dr Ong told me that he had attended on 1 June 2005 to change the catheter because that was his treatment of choice for addressing the possible urinary tract infection. Dr Ong did not believe that any antibiotic cover was warranted and pointed out that Mr Davies was already on Hiprex long-term. Dr Ong acknowledged that Hiprex was an antiseptic and not an antibiotic and acknowledged that an antiseptic would not eliminate a urinary tract infection⁴⁷.

3.58. Dr Ong agreed that in hindsight he should have repeated another culture after the 1 June catheterisation procedure but pointed out that on a clinical examination of Mr Davies there was no suggestion of infection. Of course, I heard evidence that there would be an inevitable colonisation of bacteria but it will also be remembered that there was a distinction to be drawn between colonisation and active infection of which there was no evidence in respect of Mr Davies in July. The eventual sepsis that took hold in respect of Mr Davies may have been caused through the introduction of bacteria into the bloodstream, not from any active infection necessarily, but simply from the colonisation of bacteria normally associated with catheterisation. Dr Ong summed up his attitude in this way:

'I was not convinced about him having clear urinary tract infection otherwise I would have put him on antibiotics or considered putting him onto the hospital or catheterisation.'⁴⁸

In short, there is no sufficient evidence to suggest that on 15 July 2005, when Mr Davies' catheter was changed by Dr Ong, that he was suffering from an active urinary tract infection as opposed to the usual colonisation.

⁴⁷ Transcript, page 320

⁴⁸ Transcript, page 327

- 3.59. As to Warfarinisation, Dr Ong pointed out that his last INR result had been satisfactory at 2.4 and that, in any event, a level of between 2.0 and 3.0 was therapeutic as far as Mr Davies' atrial fibrillation was concerned. He would have regarded a discontinuation of Warfarin for days leading to a catheter change as being a poor medical practice in Mr Davies' case. This is because his atrial fibrillation, a serious heart condition that was the reason for the anticoagulation regime in Mr Davies, was more life-threatening for him than sustaining some haematuria. He had not seen any need to reverse Mr Davies' anticoagulation, nor had seen any reason to have Mr Davies re-catheterisation take place in a hospital. He believed it could be done safely in a nursing home setting⁴⁹.
- 3.60. As we know, in any case, the difficulty with Mr Davies was not so much loss of blood. The difficulty was with the traumatising in conjunction with the introduction of bacteria from a urinary tract bacterial colonisation.
- 3.61. It is difficult to form any firm conclusion from the evidence concerning the desirability of having Mr Davies' re-catheterisation take place in a hospital setting with antibiotic therapy and reversal of anticoagulation. Dr Bolt tells me and I accept his evidence that these procedures are routinely carried out in nursing homes, notwithstanding the ever-present risk of urinary tract infection and notwithstanding anticoagulation, features that appear to be not uncommon in the elderly. The difficulty of course in this case was that there was material to suggest that Mr Davies' re-catheterisation might not be a straightforward one. The catheterisation on 1 June 2005 had reportedly been a difficult one, and if Dr Ong did not have an appreciation of that fact then it was perhaps a matter he ought to have had an appreciation of. By 15 July, at least, Mr Davies' reported difficulties with the 1 June procedure were understood. As well, the attempts by the RDNS nurse had also been attended with difficulty. However, in the event, both Dr Miller and Dr Bolt thought it reasonable for Dr Ong to have attempted to re-catheterise Mr Davies then and there⁵⁰. When all things are considered, it does not appear that Dr Ong's proceeding with the re-catheterisation within the nursing home was necessarily an unreasonable one in the circumstances. This is particularly so given that Mr Davies had been without a catheter for some hours and required re-catheterisation.

⁴⁹ Transcript, page 329

⁵⁰ Dr Miller at Transcript, pages 187 and 188 and Dr Bolt at Transcript, page 405

3.62. In the light of the differences in opinion and approach by Drs Miller and Bolt, it is difficult to reach any conclusion about the appropriateness of the procedure having been attempted in the first instance and then completed later in the day in the circumstances that existed. In my view, however, it should not have been attempted or completed if there was a perceived risk of trauma or if there was an expectation of a degree of difficulty. Although it is to be accepted that there were no clinical signs of an active urinary tract infection, Mr Davies had a history of the same, and there was the inevitable colonisation in any event. There was always an undoubted level of anticoagulation irrespective of whether it was within or in excess of the therapeutic range. I accepted Mr Edwards' evidence that once he encountered difficulty he did not unduly persist in his attempt to catheterise. Dr Ong's assertions that he had no difficulty in completing the procedure are uncorroborated and I do not know where the truth lies in that regard.

4. The adequacy and timing of the provision of medical treatment for Mr Davies

4.1. To my mind the efforts of the nursing staff at the facility cannot be criticised. I do not think that there was any undue delay in Ms Beard calling the ambulance on the first occasion. Her efforts at milking and flushing the catheter, it appears, consumed approximately 45 minutes. They were designed to restore Mr Davies to a level of comfort by restoring his urinary outflow. Neither of the expert witnesses levelled any criticism of the nurse's efforts. I accept Dr Miller's evidence that it was reasonable for Ms Beard, in response to the first sign of difficulty with Mr Davies, to have flushed out the catheter. Dr Miller said that flushing was the first step that would be attempted in those circumstances and the one measure that would be attempted before resort was had to calling an ambulance, or calling Dr Ong⁵¹.

4.2. Naturally, it was also appropriate for Ms Beard to have called the ambulance at 8:20pm given the level of concern that had developed in her mind in the meantime. On the description of Mr Davies' condition, as related by Ms Beard to the SAAS operator, which included the reference to frank blood, Mr Davies' distress, the fact that he was on Warfarin, that he had lost approximately 200mls of blood already and that she had been unable to flush the catheter, Dr Miller agreed that the same would have given rise to an indication for Mr Davies to be taken to hospital. Equally, Dr Miller suggested that if the same symptoms had been imparted to Dr Ong and,

⁵¹ Transcript, page 194

notwithstanding an ability on the part of Dr Ong to attend the facility within 20 or 30 minutes, Dr Miller would still have expected Dr Ong to view the calling of an ambulance as a good idea⁵². Dr Bolt on the other hand suggested that although the transfer to a hospital would have been appropriate having regard to Mr Davies' blood loss, he agreed with Mr Stratford of counsel that if Dr Ong himself was able to attend to the patient within 30 minutes it was reasonable for him to do so before arranging a transfer to hospital. As I have mentioned, we do not know the reason why Dr Ong gave instructions for the ambulance to be cancelled. Suffice it to say, Ms Beard's decision to book an ambulance was a reasonable one that was based upon a sound assessment of Mr Davies' difficulties. In those circumstances, to my mind a very compelling reason would have needed to exist for that decision to have been second-guessed by a person who had not actually seen Mr Davies'. I have been unable to discern what that reason was.

- 4.3. To my mind, Ms Beard cannot be criticised for cancelling the ambulance on Dr Ong's instructions, given the fact that he was Mr Davies' general practitioner. We know that the first ambulance call happened at 8:20pm and the second ambulance call was made at 9:01pm. On the assumption that if the ambulance had arrived at the facility in response to the first call with the same alacrity that the ambulance responded in respect of the second, Mr Davies' transfer to hospital could have been fast-tracked by approximately 40 minutes. However, there is no evidence from which it can be concluded that the elimination of this delay would necessarily have made any difference to Mr Davies' chances of survival.
- 4.4. There is no basis upon which the management of the St Louis Nursing Home, nor any of its fulltime or temporary staff, can be criticised in respect of this matter.

5. **Recommendations**

- 5.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.
- 5.2. I agree with counsel assisting, Dr Rachael Gray, that this case highlights the potential dangers associated with the insertion of catheters in uncontrolled environments such

⁵² Transcript, page 198

as nursing homes in circumstances where patients have potential complications. Dr Gray suggested that the evidence demonstrated that when a patient is subject to anticoagulation therapy and difficulty is encountered inserting a catheter occasioning significant blood loss, then immediate transferral to a hospital would be indicated. The further suggestion, based upon that observation, is that the nursing alerts of the various agencies that might undertake responsibility for catheterisation procedures in nursing homes be amended to include reference to the desirability of hospitalisation in those circumstances. I agree that these suggestions would be the appropriate subject of recommendation. To my mind, the same recommendation could be directed towards general practitioners who undertake responsibilities in relation to catheterisations in nursing homes.

5.3. The second area that has been suggested as worthy of recommendation concerns the possible need to issue a warning to nursing staff and medical practitioners who perform catheterisations concerning the dangers posed by performing the procedure on a patient on anticoagulation therapy other than in a hospital environment, and that where a patient is on such anticoagulation therapy, and difficulties are encountered in catheterisation, that transfer to hospital should be undertaken. I agree with that suggestion as well. Both Dr Miller and Dr Bolt agreed that a reference to the fact that a patient is under a Warfarin regime should be included in nursing alerts in respect of this procedure.

5.4. I make the following recommendations:

- 1) That the Department of Health, the Medical Board of South Australia and the Nurses Board of South Australia draw the circumstances of this case to the attention of members of the medical and nursing professions.
- 2) That the Department of Health undertake a review of the circumstances in which it would be appropriate or inappropriate for catheterisation procedures to be undertaken in nursing homes and to design protocols accordingly.
- 3) That the Department of Health and the Nursing Board of South Australia encourage nursing agencies who provide catheterisation services in nursing homes to amend their protocols and nursing alerts to include reference to the need to be aware of a patient's anticoagulation status.

- 4) That the Department of Health and the Medical Board of South Australia cause medical practitioners to be reminded to consider (a) the desirability of antibiotic therapy and (b) the patient's anticoagulation status when performing catheterisation procedures.
- 5) That the Department of Health, the Medical Board of South Australia and the Nursing Board of South Australia remind their respective constituents to consider the need or desirability to transfer a patient to hospital in difficult cases of catheterisation and in particular, in instances where bleeding occurs.

Key Words: Traumatic Bladder Catheterisation; Medical treatment - medical practitioner

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 26th day of June, 2009.

Deputy State Coroner