CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 24th day of September 2008, the 12th day of November 2008 and the 21st day of May 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Karl Derek Farkas.

The said Court finds that Karl Derek Farkas aged 45 years, late of 12 Pitana Avenue, Para Vista, South Australia died at Para Vista, South Australia on or about the 6th day of December 2005 as a result of intracerebral haemorrhage. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Karl Derek Farkas was 45 years of age when he died during the night of 5 and 6 December 2005. His body was discovered by his housemate at about 12:30pm on Tuesday, 6 December 2005. He was lying face down on the floor in his bedroom. His housemate had last seen Mr Farkas at approximately 11:30pm the previous night at which time Mr Farkas had gone to his bedroom, apparently to retire for the night. It would be appropriate to regard Mr Farkas as having died on or about the 6th day of December 2005 and I so find.

1.2. Mr Farkas had died of an intracerebral bleed which is a spontaneous bleed on or within the brain. The bleeding had been caused by a ruptured aneurysm. In the previous October, Mr Farkas on a number of occasions had sought medical assistance in respect of headaches both from his general practitioner and at the Emergency Department of the Modbury Hospital. As far as the evidence reveals, Mr Farkas had

last sought medical assistance on 24 October 2005. There is no evidence that between that date and 6 December 2005 when he was found deceased that he had obtained any further medical assistance. The evidence to my mind is clear that what Mr Farkas had been experiencing in October 2005 was bleeding within his skull that, in effect, heralded the eventual acute and fatal intracerebral haemorrhage that was to cause his death in December 2005. Neither the aneurysm that was responsible for this bleeding, nor the bleeding itself, were diagnosed in October despite Mr Farkas' repeated presentations to his GP and the Modbury Hospital.

1.3. This Inquest represents the third occasion in recent years in which this Court has considered the circumstances surrounding the deaths of persons caused by an intracerebral haemorrhage, in particular a subarachnoid haemorrhage. The common theme in each of the three Inquests is that opportunities to diagnose the haemorrhages or their underlying causes, at a time before they took on fatal consequences, were missed.

1.4. In 2001 an Inquest was held into the death of Margaret Joyce Taylor[1], aged 56 years, who had died of a subarachnoid haemorrhage caused by a ruptured aneurysm. The then State Coroner, Mr Wayne Chivell, made a recommendation that having regard to the fact that a subarachnoid haemorrhage can present atypically, and that the existence of the same for the most part can only be excluded by specialist investigative techniques, general practitioners who entertain a diagnosis of a subarachnoid haemorrhage, even as one of several differential diagnoses, should seek specialist advice rather than seeking to exclude the diagnosis in the surgery.

1.5. In 2007 Mr Mark Johns, the current State Coroner, heard an Inquest into the death of Peter Roy Gillam[2], aged 44 years. Mr Gillam died as the result of complications of a subarachnoid haemorrhage that had gone undiagnosed also within the Emergency Department of the Modbury Hospital (the Modbury). Mr Gillam had presented at the Modbury with a history of symptoms that were suggestive of subarachnoid haemorrhage. Mr Gillam's death had occurred in February 2005. In Mr Johns' findings he refers to a review of relevant protocols within the Modbury that had taken place in 2005 after Mr Gillam's death. A protocol for the management of headaches was implemented in July 2005 and this was then incorporated within the Emergency

[1] Inquest 28/01
[2] Inquest 13/2007

Department Clinical Guidelines of the same month. Those same clinical guidelines, containing the same protocol for the management of headaches, were tendered to me in the course of this Inquest[3]. Having heard the evidence in this Inquest, in my view the current guidelines, which are entitled 'Adult Non-Trauma Headache Treatment Guidelines'[4] do not properly address clinical expectations in respect of presentations of headaches and do not adequately deal with situations where presentations of headache caused by subarachnoid haemorrhage might be of a more subtle kind than the classic textbook presentation. More of that later.

1.6. In my opinion the evidence in this Inquest disclosed the existence of a fundamental misunderstanding among junior emergency practitioners of the symptomatology of subarachnoid haemorrhage. Much was said during the course of this Inquest about classical presentations and about the classical symptoms of subarachnoid haemorrhage. In presentations of subarachnoid haemorrhage that are to be regarded as classical, the signs and symptoms are such that a diagnosis of subarachnoid haemorrhage, or at least some form of intracranial bleed, is by and large inevitable. We are concerned here, however, not with classic presentations of subarachnoid haemorrhage in which the patient say might arrive by ambulance, but with less obvious presentations of subarachnoid haemorrhage that ought to be identified nonetheless. The previous experience of this Court and the evidence in this particular case to my mind has given rise to a concern that unless a person suffering from a subarachnoid haemorrhage presents with those classical symptoms, there is a risk that the existence of the subarachnoid haemorrhage and what is causing it will go undiagnosed. This seems, in the main, to be the result of a number of elements including a lack of relevant knowledge on the part of inexperienced practitioners, a lack of proper supervision of those same practitioners and perhaps a reluctance to subject patients to the sometimes complicated but nevertheless necessary medical examinations. In addition, there appears to have been an unwarranted level of comfort derived at least in Mr Farkas' case from the patient's positive response to analgesia, a notoriously unreliable yardstick in identifying or eliminating the aetiology of pain.

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[3] See Exhibit C8a

[4] Exhibit C8a, page 20

2. Subarachnoid Haemorrhage - Mr Farkas' post-mortem and cause of death

2.1. A post-mortem examination was conducted in respect of Mr Farkas' remains by Professor Roger Byard, a Forensic Pathologist. In his report[5] Professor Byard expresses the cause of death as 'intracerebral haemorrhage'. Professor Byard also gave evidence in the Inquest. In his evidence Professor Byard explained that Mr Farkas' intracerebral haemorrhage involved, inter alia, a subarachnoid haemorrhage that was in the layers immediately over the brain that had been caused by the rupture of an aneurysm on the internal carotid artery. An aneurysm is a small ballooning defect in a blood vessel that is prone to burst. If an aneurysm does burst, bleeding can occur around the aneurysm and into the subarachnoid space. In addition, the blood can track further by proceeding into the subdural space and can also go into the brain itself.

2.2. Professor Byard commented upon the characteristics of a subarachnoid haemorrhage in general. For Professor Byard the 'classic presentation' of a subarachnoid haemorrhage caused by an aneurysm that bursts is characterised by a sudden onset of the most severe headache that a person has experienced akin say to a severe impact to the back of the head, drowsiness, nausea, neck stiffness from the irritation of the membranes of the brain and photophobia, which is an unusual sensitivity to light. In any presentation of subarachnoid haemorrhage, be it classic or otherwise, the important feature is the sudden onset of headache in a previously well patient. In respect of such a presentation, Professor Byard said this:

> 'When people present with a severe sudden onset headache and they have been previously well the important point is to exclude the possibility of an aneurysm. A clinical examination obviously needs to be performed but if you suspect that there could be a subarachnoid haemorrhage - there is an argument whether you do CTs or lumbar punctures. When I was working in the Emergency Department we would refer the case to the neurosurgical registrar or the surgical registrar or we would organise a CT scan, we wouldn't perform the lumbar puncture ourselves. If the facilities weren't available we would refer the case to somewhere where that could be done.' [6]

Literature that was produced by Professor Byard spoke of a 'thunderclap' headache symptom and also made reference to sudden, severe headache[7]. Other expert evidence called in the Inquest also placed much emphasis upon the suddenness of the

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[5] Exhibit C7
[6] Transcript, pages 16 and 17
[7] Exhibit C7a, page 1727

onset of the headache. One can readily understand why the sudden and unexplained onset of a headache of a type and severity not experienced before should inevitably cause alarm in the mind of the patient as well as that of the treating doctor.

2.3. Professor Byard further explained that aneurysms could rupture and, at first, only give rise to a small amount of bleeding. This is sometimes called a 'sentinel' bleed. People experiencing a sentinel bleed will commonly have some signs and symptoms, even though there is not necessarily a massive haemorrhage taking place. In this case, when Mr Farkas suffered his fatal bleed, it was an extensive haemorrhage which Professor Byard regarded as virtually unsurvivable.

2.4. Upon a detailed examination of Mr Farkas' brain at autopsy, there was an older brown haemorrhage as well as the more recent haemorrhage. This suggests that there had been at least two episodes of haemorrhage. The brownish haemorrhage signified that at one point in time there had been bleeding, but that the blood had since then broken down. The old bleed was actually located within the brain itself as opposed to the subarachnoid space. However, Professor Byard made the point that an acute subarachnoid haemorrhage might disguise an old haemorrhage at the same site so that the evidence of the old haemorrhage might thereby be obscured or lost. The evidence suggested that in Mr Farkas' case, there had indeed been an earlier 'sentinel' bleed that he had survived. One such sentinel bleeding episode undoubtedly occurred in October of 2005 and it is in respect of the associated signs and symptoms of that episode that Mr Farkas presented to his GP and the Modbury and went undiagnosed.

2.5. Professor Byard said that a sentinel bleed, described alternatively on occasions during the Inquest as a 'warning leak', was not necessarily acutely fatal. It could involve only a small haemorrhage from an arterial aneurysm which might give rise to symptoms such as the sudden onset of a headache. A more extensive haemorrhage might trigger nausea, vomiting and an impairment of the affected person's consciousness. The symptoms from a sentinel bleed might dissipate. Professor Byard also referred to the possibility of symptoms of such a non-fatal haemorrhage being relieved by analgesia and he added this caveat:

> 'Pain relief is not the best guide to pathology I'm afraid.' [8]

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[8] Transcript, page 20

The point Professor Byard was making there, which was echoed by other expert evidence, was that one could not discount the possibility of serious pathology such as a subarachnoid haemorrhage simply on the basis that one of its symptoms, namely the headache, had been relieved by analgesia such as aspirin or by other common pain killers such as panadeine or codeine based preparations. Accordingly, clinicians should be aware that a positive reaction to analgesia is no reliable guide to the underlying pathology involved in a presentation of headache. After all of the evidence was heard in this case, I did not understand any entity to be disputing the suggestion that Mr Farkas' presentations in the October before his death had involved intracranial bleeding from his aneurysm, or sentinel bleeding if you like.

2.6. An intracerebral haemorrhage can be diagnosed by a CT scan. This is the usual method of investigation. It has a high degree of accuracy depending upon the length of time that has elapsed since the ictus of the haemorrhage. It has a high degree of accuracy within a day or two of that ictus. The evidence would suggest that if Mr Farkas had been subjected to a CT scan during the week in October of 2005 during which he had sought medical help, his bleeding would likely have been identified. Another method of diagnosis is by way of a lumbar puncture, but this procedure might not be the first diagnostic method of choice. An aneurysm that has given rise to the haemorrhage can be treated surgically with a reasonable degree of success.

2.7. I find the cause of Mr Farkas' death to be intracerebral haemorrhage. I also find that Mr Farkas' presentations in October of 2005 had been reflective of intracranial bleeding from an arterial aneurysm.

3. Mr Farkas' medical history and health in 2005

3.1. I received into evidence the notes of Mr Farkas' previous medical history as recorded at his general practitioner's surgery[9]. His general practitioner was Dr Ka Cho Cheung. The clinical record reveals that Mr Farkas had presented on a number of occasions in 2003, 2004 and earlier in 2005 with illnesses that involved a headache. On 25 March 2003 he had presented with what appears from the record to have been an upper respiratory tract infection that had involved, as one symptom, a headache over 3 days. On 6 June 2003 Mr Farkas had presented again with symptoms that were suggestive of some sort of viral infection with symptoms including a runny nose,

[9] Exhibit C6b

coughing and a headache. On 16 June 2004 Mr Farkas had presented again with symptoms that were suggestive of a cold, insofar as he had a runny nose, mild congestion, coughing, a sore throat and a headache. On 6 December 2004 he had presented with a headache and nausea. On this occasion there does not appear to be any record of any other symptoms such as a runny nose or coughing. On 15 March 2005 he had presented with a mild headache and mild coughing and nausea and vomiting the previous day. The diagnosis on that occasion was a viral infection. On 27 September 2005 Mr Farkas has presented as not feeling well with a mild cough, nausea, vomiting and a headache. On examination of his chest there was occasional wheezing. A diagnosis of a viral infection was made on that occasion as well. On 30 September 2005 Mr Farkas presented with a foreign body in his right eye.

3.2. The presentations referred to in the previous paragraph appear to be the only ones that involved a headache and, for the most part, appear to have been accompanied by symptoms suggestive of a cold or viral infection. I see no evidence that Mr Farkas had ever presented to a hospital with a headache, or had complained of a sudden onset headache. The next presentation involving a headache that followed upon the presentation of 30 September 2005, occurred on 17 October 2005, not to Dr Cheung, but to the Emergency Department of the Modbury.

3.3. The events that led to Mr Farkas first seeking medical attention in October 2005 were recorded by the medical practitioner who saw him at the Modbury Hospital on Monday 17 October 2005. Mr Farkas is reported as having consumed two glasses of wine on the Saturday. On the Sunday morning whilst taking a shower he had felt dizzy and nauseous. After he came out of the shower he developed a headache and he vomited on approximately 8 to 10 occasions. The headache was accompanied by pain over the neck. Mr Farkas was discharged with a recorded diagnosis of dehydration

3.4. Mr Farkas saw his general practitioner Dr Cheung about his headache the following day on 18 October 2005.

3.5. He re-presented to his general practitioner two days later on 20 October 2005, still with the headache. Dr Cheung suspected viral meningitis. On that occasion Dr Cheung sent him to the Modbury Emergency Department. Mr Farkas attended the Modbury following day, 21 October 2005. He still had the headache and was discharged from the Modbury on this occasion with a diagnosis of migraine.

3.6. Mr Farkas re-presented to his general practitioner on 24 October 2005, still with the headache. On this occasion the diagnosis was recorded as possible neck pain. He was prescribed Celebrex which is an anti-inflammatory and Panamax which is an analgesic.

3.7. There appears to have been no further medical attention given to Mr Farkas following 24 October 2005. It will be observed here that in the week between 17 October 2005 and 24 October 2005, he had been variously diagnosed as having dehydration, possible viral meningitis, migraine and possible neck pain, none of which in any way addressed the actual underlying cause of Mr Farkas' headaches.

3.8. Mr Farkas' housemate, Mr John Smith, who furnished two statements verified by affidavit to the Inquest[10], says that about 6 weeks prior to Mr Farkas' death Mr Farkas had begun complaining of an extremely sore neck and that he had felt nauseous every time he moved his head around. In the 4 or 5 days prior to his death Mr Farkas had been taking Panadeine Forte tablets. These tablets are stronger painkillers and can only be obtained on prescription. It is not known when and how Mr Farkas obtained that medicine except that it can reasonably be concluded that he did not obtain them between 24 October 2005 and his death. Mr Smith suggests also that Mr Farkas had been trying Panadol, Nurofen and Nurofen Plus. Mr Smith's impression was that Mr Farkas had been suffering bad migraine headaches that had caused him to vomit and which limited his ability to keep fluid and food down. In the 6 weeks or so prior to his death, Mr Smith states that Mr Farkas had been taking a great deal of sick leave because of the headaches. Mr Smith had been responsible for taking Mr Farkas to the Modbury Hospital on one of the two occasions I have mentioned.

3.9. It was Mr Smith who found Mr Farkas' body on 6 December 2005.

4. Mr Farkas' first presentation to the Modbury Hospital on 17 October 2005

4.1. That Mr Farkas went straight to the Modbury Emergency Department at 7:45am on this occasion says much about his presentation on that day. He was used to consulting his general practitioner when he was ill. 17 October 2005 was a Monday and there would have been no reason for Mr Farkas not to have attended his general

[10] Exhibits C1a and C1b

practitioner's office other than that there must have been something significant and unusual about his wellbeing on that day.

4.2. The clinical record at the Modbury in respect of Mr Farkas' attendances at the Emergency Department on October 2005 were tendered in evidence[11]. The nursing record[12] states that on 17 October Mr Farkas was seen by a member of the nursing staff at approximately 8:40am. The presenting complaint is described as headache plus vomiting for 1 day with no history of head injury. The headache is described as a 'frontal headache' and it goes on to state that Mr Farkas was feeling dizzy and lethargic. The nursing record also states that Mr Farkas was 'clinically not dehydrated'. The fact that Mr Farkas was observed at that point not to be clinically dehydrated is at variance with the opinion entertained by the medical practitioner who subsequently examined Mr Farkas. Indeed, when Mr Farkas was ultimately discharged, a diagnosis of 'dehydration' was recorded on no less than three individual hospital documents being the nursing record that I have referred to, the examining medical practitioner's own written record and Mr Farkas' discharge letter[13]. Whether Mr Farkas was dehydrated or not, dehydration as a definitive diagnosis was well wide of the mark.

4.3. Mr Farkas was examined by Dr Mohammad Hussain on 17 October. Dr Hussain obtained his original medical degrees from the Dhaka University in Bangladesh in 1983. He worked as a general practitioner in both Bangladesh and Iran. He also studied cardiology. In 1996 he migrated to New Zealand. In 2000 he moved to Australia. He commenced work as an intern at the Royal Adelaide Hospital in 2003 and worked as a resident medical officer there before joining the Modbury Emergency Department in February 2005. In his evidence before me Dr Hussain variously described his rank at the Modbury as Medical practitioner or resident medical officer. I was uncertain how that rank might equate within the ranking hierarchy at other hospitals, but as I understand it the rank of medical practitioner was of a relatively junior nature. Dr Hussain for instance had no authority to order certain diagnostic procedures such as a CT scan without first having spoken to and obtained the permission of a team leader, that is to say a more senior practitioner. Dr Hussain was more senior than say an intern, but junior to a registrar. Of course, Dr Hussain had

[11] Exhibit C5
[12] Exhibit C5, page 83
[13] Exhibit C5, page 80

obtained considerable experience as a practitioner before 2005. In any event, as of October 2005 he was of sufficient experience or seniority such that he was not required to obtain authorisation from a more senior practitioner to discharge a patient from the Emergency Department.

4.4. Aside from Dr Hussain, no other doctor appears to have seen Mr Farkas on 17 October 2005. Moreover, there is no evidence that Dr Hussain consulted any other practitioner about Mr Farkas' presentation. It appears, therefore, that Dr Hussain was fully reliant on his own judgment in respect of Mr Farkas' presentation and diagnosis.

4.5. Dr Hussain's examination appears to have commenced at about 9:30am. I have already referred to Mr Farkas' account of what he had experienced the day before. As far as Mr Farkas' symptoms are concerned, as recorded by Dr Hussain, there is in my view a significant omission in the record insofar as there is no detailed description of the circumstances of the onset of Mr Farkas' headache. The suddenness or otherwise of the onset of a headache is a material fact in the consideration of a diagnosis of an intracranial bleed. All that is recorded in Dr Hussain's notes is that when Mr Farkas emerged from the shower on the Sunday morning, he 'developed' a headache. In Dr Hussain's evidence before me he pointed out that Mr Farkas had not described a sudden onset of headache[14]. He told me that his impression was that the headache had gradually worsened. I would observe here that a gradual increase in the intensity of Mr Farkas' headache is not described in the notes either. Dr Hussain acknowledged in his evidence that, as of October 2005, he had understood that the suddenness of the onset of a headache was an important diagnostic consideration. In addition, the description by the patient in terms of whether it felt like the worst headache the patient had ever experienced was also a relevant matter. In a record of interview that Dr Hussain gave to the police who investigated the matter on behalf of the State Coroner,[15] he suggested that the severity of Mr Farkas' headache was 8/10, where presumably 10 would be the worst imaginable by the patient. Accordingly, one would infer that Mr Farkas had experienced and described a headache of significant severity. When it was suggested to Dr Hussain in cross examination[16] that the description that Dr Hussain had recorded was consistent with a sudden onset, he asserted that in fact he had asked Mr Farkas in terms whether the onset was sudden

[14] Transcript, page 188
[15] Exhibit C11
[16] Transcript, page 226

and Mr Farkas had said no. If Dr Hussain had asked that question of Mr Farkas because he had entertained a possible diagnosis of a subarachnoid haemorrhage or other intracerebral bleed, it is surprising that Dr Hussain would not have recorded Mr Farkas' denial of sudden onset in terms, or at least have recorded a description of a gradual onset. When one considers what Dr Hussain has in fact noted, namely that Mr Farkas had first experienced dizziness and nausea in the shower, and that when he emerged from the shower he developed a headache, it seems to me that this is consistent with Mr Farkas experiencing the sudden development of a headache upon his emergence from the shower. The sudden onset of the headache would also have been consistent with what is now understood to have been his underlying pathology at that time. If Mr Farkas had been probed about that description at all, it seems to me that it is highly likely that what in truth he had been describing was a headache with a sudden onset. In short, I was not convinced by Dr Hussain's evidence that Mr Farkas had denied a sudden onset. This evidentiary dilemma could easily have been avoided if Dr Hussain had made proper entries in the notes as to whether or not the headache had been of sudden or gradual development. Dr Hussain's discharge letter does not shed any light on the issue as to whether or not Mr Farkas' headache was sudden or gradual. I found this aspect of Dr Hussain's examination to be unsatisfactory. The suddenness of the onset of the headache was a profoundly important diagnostic consideration that should have been attended by detailed probing of Mr Farkas' symptomatology in that regard and an equally rigorous recording of the same.

4.6. Dr Hussain recorded other features of his examination. He recorded that there was no blurring of vision, no slurring of speech, no weaknesses in the arms or legs and no photophobia. It is apparent from Dr Hussain's notes that he must have regarded Mr Farkas as not suffering from any neurological deficit. He has recorded him as being alert, conscious and orientated with a Glasgow Coma Score of 15 which is normal. Of course, the absence of any neurological deficit does not necessarily mean that Mr Farkas was not suffering from a subarachnoid haemorrhage or some other intracerebral bleed at that time.

4.7. The presentation of headache, nausea, vomiting and dizziness, however, is consistent with the existence of an intracerebral bleed, especially if the onset of the headache was sudden. Added to this was the fact that Dr Hussain recorded that as far as any

symptom involving neck stiffness was concerned, there was neck stiffness. I refer here to the following entry in Dr Hussain's notes of his examination:

> 'Neck stiffness - +ve' [17]

When Dr Hussain ultimately wrote his discharge letter he again referred to the issue of neck stiffness, but in these terms:

> 'Neck stiffness – initially
> resolved after treatment'

In the light of those entries it is surprising that Dr Hussain now asserts that Mr Farkas did not have neck stiffness, a well-recognised symptom of subarachnoid haemorrhage. Dr Hussain in his oral evidence now maintains that his assessment of neck stiffness was '*only subjective*'[18]. He says that Mr Farkas could actually move his neck *'quite okay but mild pain, not stiff. Stiff and pain is quite different'*[19]. He said that the patient in fact had only complained of neck pain. Dr Hussain made these assertions notwithstanding the fact that in the clinical record he had recorded Mr Farkas as being positive for neck stiffness and again referred to the existence of neck stiffness in positive terms when he compiled his discharge letter. It seems to me that if Mr Farkas had described in his own words the sensation in his neck as neck "stiffness", Dr Hussain would have needed a good reason for rejecting Mr Farkas' word about that. Similarly, if he had asked Mr Farkas directly whether Mr Farkas had suffered from neck stiffness and Mr Farkas had simply said yes, it is difficult to determine what it was that would have cast doubt in Dr Hussain's mind about that response. In Dr Hussain's evidence he told me that he believed that Mr Farkas had neck pain but that he had attributed it to pain from his headache[20]. He told me that in order to explore whether Mr Farkas had been experiencing raised intracranial pressure he had in fact asked Mr Farkas in terms whether he had neck stiffness, but that Mr Farkas had said:

> 'No, I can move it but I've got pain a little bit, I can move the neck but it's only mild pain is there, the back of my neck.' [21]

When it was pointed out to Dr Hussain that in spite of this he had written in his notes positive against the words neck stiffness, he told me that it was positive on a subjective analysis only but that it did not mean that Mr Farkas had in fact

[17] Exhibit C5, page 82
[18] Transcript, page 190
[19] Transcript, page 190
[20] Transcript, page 227

experienced neck stiffness. When asked whether therefore he thought that Mr Farkas did not have neck stiffness, Dr Hussain agreed to this proposition. This begged the question of course as to why he had written down positive against that entry and not negative. Dr Hussain's evidence on the question of neck stiffness was unsatisfactory in my view. He exhibited an impression of evasiveness in respect of the issue as to whether Mr Farkas had been experiencing neck stiffness. To my mind Dr Hussain's notation in the clinical record, as well as his description in the discharge letter, makes it plain that Mr Farkas had presented with neck stiffness. This presentation would be very much in keeping with observations of Mr Farkas made by others around the same period. Although when Mr Farkas presented to his general practitioner on 18 October 2005 Dr Cheung recorded 'no neck rigidity', when Mr Farkas re-presented to the general practitioner on 20 October Dr Cheung has recorded the existence of neck rigidity. As well as this, Mr Farkas' housemate Mr Smith says in his statement[22] that Mr Farkas had complained about his neck being extremely sore with associated nausea every time he had moved his head around. In addition, Mr Smith states that he could recall Mr Farkas suffering from restricted neck movement because he would have to turn by moving his shoulders rather than his head and that this occurred generally at the same time as a headache. I have no doubt that on 17 October 2005 Mr Farkas was suffering from neck stiffness and that Dr Hussain well knew this either from what Mr Farkas told him or from his own observation. I so find.

4.8. Immediately following Dr Hussain's notations of his examination in the clinical record, he has recorded a differential diagnosis in respect of Mr Farkas' presentation. The differential diagnoses are recorded seriatim as dehydration, SAH (subarachnoid haemorrhage), simple headache, migraine. It is significant that Dr Hussain has recorded those differential diagnoses immediately following the notations of his examination. I draw the inference that even after Dr Hussain's examination and clinical assessment, the existence of a subarachnoid haemorrhage was still entertained by him as a possibility. Put in another way, the inclusion of reference to subarachnoid haemorrhage as a differential diagnosis would be somewhat inconsistent with Dr Hussain having by then confidently dismissed the possibility of a subarachnoid haemorrhage on the basis of his clinical findings thus far. I found Dr Hussain's evidence somewhat difficult to understand in respect of what he really did entertain

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[21] Transcript, page 227
[22] Exhibit C1b

by way of the possibility of a subarachnoid haemorrhage. At one point in his evidence it appeared, perhaps, that Dr Hussain had only included a differential diagnosis of subarachnoid haemorrhage as a theoretical possibility. The difficulty with such an approach in this case was that although Mr Farkas' presentation was not the classical presentation of subarachnoid haemorrhage that involved neurological deficits, his presentation was nevertheless one where a subarachnoid haemorrhage was very much on the table and was elevated to a significant degree beyond the mere theoretical. I refer in particular to what might reasonably have been understood as a sudden onset of headache on the Sunday morning, the clear history of associated nausea and vomiting and what I find to have been neck stiffness. Indeed, expert evidence that I will refer to in due course given by a prominent neurosurgeon and emergency physician would suggest that the differential diagnosis of subarachnoid haemorrhage, although not involving a classical presentation of the same, was hardly surprising and a reasonable one[23]. In that event, it was a differential diagnosis that would have required appropriate investigation. In any event, Mr Farkas' presentation was such that a subarachnoid haemorrhage or other form of intracerebral bleed certainly had not been excluded on the basis of Dr Hussain's examination alone. It is therefore safe in my view to conclude that Dr Hussain's differential diagnosis of subarachnoid haemorrhage was more than a mere theoretical possibility and was one that did indeed require further investigation. That further investigation, comprised as it should have been by the administration of a CT scan, never eventuated.

4.9. After Dr Hussain recorded his differential diagnoses he formulated a plan that he recorded immediately below the differential diagnoses. The plan involved the administration of an analgesic, Codis, which is an aspirin based medication. This was for Mr Farkas' headache. Dr Hussain also prescribed Maxalon for the nausea and vomiting. These drugs were administered at 10:30am. Mr Farkas remained in the Emergency Department for several hours. At 2:20pm that day Dr Hussain examined him and observed and noted that Mr Farkas was 'feeling much better' with no headache or vomiting. Mr Farkas was provided with the discharge letter and a sick certificate for that day and the next. As I have already indicated, both the Emergency Department clinical record written up by Dr Hussain and the nursing record were endorsed with a diagnosis of dehydration. The discharge letter addressed to Dr Cheung, Mr Farkas' general practitioner, also bore the diagnosis of dehydration.

[23] Professor Kelly, Transcript, page 157

Other than a reference to migraine within the differential diagnoses to which I have already referred, there does not appear to be any mention of it in any of the clinical documentation as being a definitive and final diagnosis either on its own or in conjunction with dehydration. However, Dr Hussain told me that his definitive diagnosis had in fact been migraine and dehydration. That Dr Hussain would now include migraine within his definitive diagnosis is perhaps not surprising. Dehydration as a stand-alone diagnosis for Mr Farkas was not really a diagnosis at all. Dehydration was simply a symptom or manifestation of some other underlying difficulty. If there was any dehydration in Mr Farkas it conceivably could have been the result of Mr Farkas' history of his otherwise unexplained vomiting. On the other hand, he was not dehydrated when seen by the nursing staff. In whatever manner one characterises Dr Hussain's definitive diagnosis, be it migraine, dehydration or both, in reality Dr Hussain had not at any point in time properly explored let alone excluded on reasonable grounds his differential diagnosis of a subarachnoid haemorrhage. The fact that Mr Farkas responded positively to analgesia was really neither here nor there. I have already referred to Professor Byard's evidence in this regard that response to analgesia is a poor indicator of pathology. This was repeated in the evidence of Professor Kelly. Indeed, positive responses to analgesia in cases of subarachnoid haemorrhage are commonplace. I was told that reports of patients with subarachnoid haemorrhage responding to analgesics are plentiful. And to digress, Professor Kelly suggested that the giving of aspirin based analgesic would be contraindicated where a differential diagnosis of subarachnoid haemorrhage was entertained as the bleeding might be exacerbated or prolonged. Be that as it may, the fact that Mr Farkas did not deteriorate while he was at the Emergency Department of the Modbury was also a poor indicator of Mr Farkas' underlying pathology. Four to six hours of observation with no deterioration would not exclude subarachnoid haemorrhage as a diagnosis[24]. As will be seen, further investigation was required.

4.10. I should mention here that before Dr Hussain came to court he had made certain out of court statements. In Dr Hussain's initial interview with the investigating police[25], which took place on 9 February 2007, he said that at the end of his initial examination he had come to the conclusion that the headache could have been a migraine, could have been bleeding in the head, or it could have been a simple headache with

[24] Professor Kelly, Transcript, page 177
[25] Exhibit C11, page 2-3

dehydration as well. It was then that he had implemented his plan involving observation and the giving of analgesia. As to the possible diagnosis of subarachnoid haemorrhage and why he had considered that, Dr Hussain in the interview made reference to the patient not improving and to the seriousness of such a diagnosis. In this context Dr Hussain referred to symptoms of subarachnoid haemorrhage such as continuous vomiting and photophobia as well as neck stiffness and neurological deficits. He said that out of that array of symptoms the only one he had ticked was neck stiffness, which again seems to contradict what he was to say in his evidence about that being only a subjective assessment. Overall, these passages in Dr Hussain's police interview tend to reinforce the notion that Dr Hussain had in fact seriously considered subarachnoid haemorrhage as a possible diagnosis. Dr Hussain was subsequently asked to examine a transcript of his police interview and he provided the Coroner with another document in which he purported to correct and amend the transcript of his police interview[26]. In this subsequent document he purported to amend what he had said about the possibility of subarachnoid haemorrhage having occurred to him by saying that after his examination he had come to the conclusion that it was 'unlikely' to have been a bleeding in the head[27]. Dr Hussain also indicated at this time that his eventual diagnosis of migraine plus dehydration had been reached because of the quick improvement in Mr Farkas' condition and a consideration on his part that subarachnoid haemorrhage was very unlikely, with signs not consistent with subarachnoid haemorrhage and with rapid response to migraine management. It was on this occasion that he mentioned for the first time that the neck stiffness was only a subjective consideration. Dr Hussain's overall inconsistency led me to doubt the accuracy of much of his evidence, particularly that in which he downplayed any of Mr Farkas' symptoms that had been relevant to or indicative of a diagnosis of subarachnoid haemorrhage such as onset of headache and neck stiffness.

4.11. Mr Farkas was discharged the Modbury at 2:45pm that day. He was provided with the discharge letter directed to the attention of his general practitioner.

4.12. The following day, 18 October 2005, he presented with this letter to his general practitioner.

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[26] Exhibit C11

[27] Exhibit C11, page 1

5. Mr Farkas' presentation to his general practitioner on 18 October 2005

5.1. As seen earlier, the discharge letter written by Dr Hussain expressed the previous day's diagnosis as dehydration. The word migraine does not appear anywhere in the letter. Dr Cheung observed and noted that although Mr Farkas had experienced no more vomiting, he still had a headache. There was no neck rigidity on this occasion. It will also be observed from the discharge letter from the Modbury that no reference is made to any differential diagnosis such as subarachnoid haemorrhage. Dr Cheung recorded that the headache was mild.

5.2. Dr Cheung considered that Mr Farkas was suffering from a viral infection.

6. Mr Farkas' presentation to his general practitioner on 20 October 2005

6.1. Mr Farkas presented again to Dr Cheung on 20 October 2005, two days after his first presentation there. This was the Thursday of that week. Mr Farkas was still complaining of headache and said that the headache had radiated to his neck which he noted as 'neck rigidity'. He said that he was experiencing nausea but had not vomited nor experienced diarrhoea. The headache was described as one that was diffuse all over the head. He said he felt giddy. To Dr Cheung Mr Farkas did not look well. Dr Cheung performed a neurological examination but found no signs of a neurological deficit. However, there was some photophobia on this occasion.

6.2. Given the worsening of the headache, some neck rigidity, photophobia and giddiness, Dr Cheung formed the not unreasonable view that something serious was taking place inside Mr Farkas' head, but he was not entirely sure what the problem was. Subarachnoid haemorrhage as a diagnosis did not come to mind, but Dr Cheung likened Mr Farkas' presentation to one in the past in which he had correctly diagnosed someone with viral meningitis. Dr Cheung decided to seek an investigation in respect of that possibility. Accordingly, he referred Mr Farkas to the Modbury Hospital.

6.3. Dr Cheung had a referral letter typed that day[28]. In his letter Dr Cheung has referred to the previous attendance at the Modbury on 17 October 2005 and to the continuation since then of Mr Farkas' complaint of 'severe headache all over the head, more so in the frontal region'. The letter also confirmed the existence of neck rigidity and

[28] Exhibit C6, page 8

photophobia and giddiness. In the letter Dr Cheung has stated this as a possible diagnosis:

> '? viral meningitis'

6.4. Viral meningitis is a condition that can be diagnosed by way of a lumbar puncture. As it happens, a lumbar puncture might also lead to a diagnosis of subarachnoid haemorrhage. This is the kind of examination that Dr Cheung had in mind when he referred Mr Farkas to the Modbury. Dr Cheung also told me that another possible investigation might have involved the administration of a CT scan. However, in his referral letter Dr Cheung did not suggest either investigation as being appropriate. He considered that his having raised a possible diagnosis of viral meningitis would, of necessity, have involved the administration of the examinations that he had in mind. In my opinion it was not unreasonable for Dr Cheung to have taken that view. He was entitled to assume that having referred a patient with a possible diagnosis of viral meningitis, the necessary tests would be undertaken either to confirm or exclude that diagnosis. In the event, no such examinations were conducted at Modbury as we will see.

6.5. As seen, at no stage was the possibility of a subarachnoid haemorrhage raised with Dr Cheung either with the patient himself or within the discharge letter from the Modbury dated 17 October 2005. Dr Cheung told me that he had not formed any impression as to the nature of the onset of the headache in the first instance. While he had a definite impression as to the severity of the headache, he did not ask anything of Mr Farkas about its onset, and I take it that he did not, for instance, ask him whether it had been sudden or gradual. When Mr Farkas had presented to Dr Cheung for the first time on 18 October 2005, Mr Farkas' headache had been established for some two days and in those circumstances it is perhaps unsurprising that Dr Cheung would have regarded the headache as not acute. It appears that the manner of its onset was something that Dr Cheung never gave any consideration to for that reason. Nevertheless, the observation can be made that it would have been appropriate for Dr Cheung to have asked Mr Farkas whether the headache had originally arisen through a sudden or gradual onset. Dr Cheung may well have asked that question, say, if Dr Hussain's discharge letter of 17 October 2005 had mentioned his differential diagnosis of subarachnoid haemorrhage. Indeed, Dr Cheung told me that if he had seen any notation of a differential diagnosis of subarachnoid haemorrhage, he would

have regarded that as a 'red flag'[29]. In that event he would have asked more questions about the nature of the headache. As it was, Dr Cheung was accurate when he formed the tentative belief that something adverse was taking place within Mr Farkas' head. However, a clearer communication from Dr Hussain as to what he had entertained by way of a provisional diagnosis may well have prompted Dr Cheung, a man not totally inexperienced in presentations of subarachnoid haemorrhage himself, to consider that in addition to meningitis.

6.6. In my view Dr Cheung cannot be criticised for his management so far. His referral to the Modbury on 20 October 2005 was clearly the correct management strategy and he was entitled to expect that his tentative thoughts that Mr Farkas was suffering from meningitis would be properly considered and excluded after appropriate clinical assessment and investigation. Indeed, he was entitled to think that the necessary investigations would be conducted to definitively diagnose Mr Farkas even if meningitis turned out not to be that diagnosis.

7. <u>Mr Farkas' presentation to the Modbury Hospital on 21 October 2005</u>

7.1. Mr Farkas attended with his letter at the Modbury Emergency Department on 21 October 2005. This was the Friday of that week.

7.2. Mr Farkas was not seen by Dr Hussain on this occasion. Moreover, it does not seem at all likely that Dr Hussain's notes from the previous attendance on the Monday morning were made available to Emergency Department staff on this subsequent occasion. It is unclear as to how such a set of circumstances came about. Nevertheless, it is clear that it was well understood within the Emergency Department on 21 October 2005 that Mr Farkas had been seen at the Emergency Department on 17 October 2005. Dr Cheung's letter told them that. A copy of the letter is within the Modbury clinical record for Mr Farkas. Suffice it to say if ever there was an occasion when it was important for notes from a previous presentation to have been fetched, this was that occasion. The notes from 17 October 2005 should have been made available to Emergency Department staff on 21 October 2005. Dr Anna Tan, an intern, saw Mr Farkas on 21 October.

[29] Transcript, page 62

7.3. Dr Tan was not called to give evidence in this Inquest as she now resides overseas. However, an interview had been conducted with Dr Tan on 9 February 2007 by Senior Constable First Class Muir of the Police Coronial Investigation Section. Senior Constable Muir's statement and the record of his interview with Dr Tan were tendered in the Inquest and were covered by Senior Constable Muir's affidavit[30]. In addition to that, during the course of the Inquest a number of written questions were posed to Dr Tan and she responded to those questions from abroad. The questions and answers were reduced into a further document that was signed by Dr Tan and dated 27 October 2008[31].

7.4. Dr Tan has a Bachelor of Medicine and a Bachelor of Surgery from the University of Adelaide that was conferred in December 2004. As at 21 October 2005 she was an intern at the Modbury in her first year of practice.

7.5. Dr Tan managed Mr Farkas' presentation on 21 October 2005 from start to finish and indeed was responsible for compiling the eventual discharge letter, again addressed to Mr Farkas' general practitioner, Dr Cheung. The precise nature and extent of the involvement of any other medical practitioner, in particular a senior medical practitioner, in Mr Farkas' presentation that day is not entirely clear. Dr Tan's notes record that when Mr Farkas was ultimately reviewed at 4:30pm, which was very shortly before his discharge, she discussed Mr Farkas with a Dr Detlev Seifert. Dr Seifert was the team leader on duty at that time and he was a CMO (Chief Medical Officer) in the Emergency Department. As such he was Dr Tan's supervisor at the time. Dr Seifert received his medical qualifications in Germany in 1994. What Dr Tan may have discussed with Dr Seifert is not recorded in the notes. Dr Seifert has not made any record himself. Dr Seifert was unable to give evidence in the Inquest on the grounds of ill health. No statement had been taken from Dr Seifert in the first instance. However, Dr Seifert provided an affidavit during the course of the Inquest[32]. The affidavit of Dr Seifert attaches a record of interview that was conducted between himself and Senior Constable Muir. In that interview Dr Seifert confirmed that he had been the rostered senior doctor on the occasion in question and that his duties entailed the supervision of junior doctors and seeing 'your own patients as well'[33]. He described the supervisory role as involving junior doctors presenting cases to him, the

[30] Exhibits C4, C4a and C4b
[31] Exhibit C13
[32] Exhibit C12

discussion of those cases and the further management and the diagnosis of the patient. Junior doctors such as Dr Tan were obliged to seek his opinion in respect of the diagnosis of a patient.

7.6. Dr Seifert said that he had no recollection of Mr Farkas' presentation on 21 October 2005. Specifically, Dr Seifert had no recollection of whether he had personally conducted any examination of Mr Farkas. The notes do not reveal any such examination. According to Dr Seifert his usual practice would be to make his own note of having reviewed a patient, but on this occasion there is no such note. All Dr Tan's notes record is the fact that there was a discussion between Dr Tan and Dr Seifert at 4:30pm prior to Mr Farkas' discharge.

7.7. I will come to the details of Dr Tan's examination of Mr Farkas in a moment, but it is clear that a diagnosis of subarachnoid haemorrhage was not entertained. In any event, whatever Dr Seifert's actual involvement was with Mr Farkas' presentation that day, there is no evidence that the possibility of subarachnoid haemorrhage was drawn to his attention or was even discussed between Dr Tan and Dr Seifert. The notations suggest that Dr Seifert's involvement in the matter occurred at a very late stage during Mr Farkas' time in the Emergency Department. I record here that Mr Farkas appears to have been at the Emergency Department from 11:55am until shortly after 4:30pm. If Dr Seifert did not have any involvement in the matter until shortly before Mr Farkas' discharge, I would consider that to be a very unsatisfactory state of affairs given Dr Tan's inexperience.

7.8. There were a number of factors operating to Mr Farkas' disadvantage when he was examined and assessed by the inexperienced Dr Tan. Firstly, Dr Tan had no experience with subarachnoid haemorrhage. Secondly, Dr Tan only had a classical textbook notion of how a subarachnoid haemorrhage might present. She said this:

> 'The way they, I'd never had any experience with a subarachnoid haemorrhage and the only way they taught us was a very specific set of signs and symptoms such as A, he wouldn't have been a GCS of 15 which was in the triage notes, he would have had a very high blood pressure, something in the order of 210 over 100 or something which he didn't have, he would have talked about having had the worst headache ever that felled him or felt like a thunderclap and he wouldn't have been able to talk to me, he wouldn't have been neurologically intact, his pupils wouldn't have been equal and he would have

[33] Exhibit C12, page 2

> had neck stiffness and that's what was taught to us as when you consider a subarachnoid haemorrhage, these are the things that you look for and he just didn't have any of that.' [34]

Thirdly, although Dr Tan seemed to evince some basic knowledge of what was described in the Inquest as a warning leak from a brain aneurysm, she did not know how one might determine if a presenting patient was, or had been, experiencing one. Fourthly, she did not have the benefit of the notes from Mr Farkas' previous presentation on 17 October 2005. It is conceivable that if Dr Hussain's reference to the possibility of a subarachnoid haemorrhage in those notes had been seen, the discussion between Dr Tan and Dr Seifert could have resulted in a CT scan being performed. Additionally, the notes and the discharge letter from that occasion mentioned neck stiffness, and although Dr Hussain now choses to divest himself of these descriptions, the fact remains that neck stiffness was described in the notes in positive terms and they would have alerted Dr Tan to the existence of one of the relevant symptoms that she herself would consider as consistent with subarachnoid haemorrhage.

7.9. During Dr Tan's examination she recorded Mr Farkas' history since the previous weekend and she referred to the various symptoms that Mr Farkas had experienced. She specifically recorded that there was no neck stiffness on the occasion of her examination. Although she did not have Dr Hussain's notes, Dr Tan certainly had the referral letter of Dr Cheung that stated that Mr Farkas had some neck rigidity as of 20 October 2005, the day before Dr Tan's examination.

7.10. In the event, Dr Tan arrived at a diagnosis of 'likely migraine'. Her plan was to treat Mr Farkas as per the migraine protocol and to that end he was prescribed paracetamol and metoclopramide. I note that these were administered at 3:10pm which is over an hour prior to her discussion with Dr Seifert. When Mr Farkas was reviewed at 4:30pm, at which time the discussion with Dr Seifert apparently took place, Mr Farkas is recorded as 'now pain free'. This appears to be another instance of where Mr Farkas' positive response to analgesia has wrongly influenced both the ultimate conclusion as to his presentation and his assessment as being fit for discharge. The treatment plan said to have been in accordance with the migraine protocol was embarked upon seemingly at a time before Dr Seifert had any involvement in the matter. An inference is available that the treatment plan was embarked upon by Dr

[34] Exhibit C4b, page 5

Tan, based as it was on her assessment that Mr Farkas was suffering a migraine, at a time before any proper consultation had taken place with a senior medical practitioner. If this in fact was the case, it was inappropriate in my view.

7.11. As to Dr Cheung's suggestion of possible viral meningitis, in Dr Tan's first interview she said that when she examined Mr Farkas she could not reproduce any neck stiffness, that his pupils were equal and reactive and the rest of his nervous system was grossly intact. She said that the absence of neck stiffness 'ruled out any meningeal irritation or meningitis and the like'[35]. The diagnosis of migraine was then entertained.

7.12. Dr Tan suggested in her first interview that there would have been some meaningful discussion with Dr Seifert. She referred to the diagnosis of migraine as the one that they had come up with, as if to say it was a joint diagnosis, or at least one with which Dr Seifert conclusively agreed. She also said that they had considered the possibility of viral meningitis in the light of the general practitioner having raised it and that they had considered it and ruled it out. Again, suggestive of a joint approach to Mr Farkas' presentation. When asked as to whether consideration had been given to referring Mr Farkas to any specialist medical practitioner, she said 'no, because it was a migraine'[36]. It would appear from Dr Tan's first interview that having ruled out viral meningitis clinically, there was no case for the performance of a lumbar puncture or any other test. If the more serious possible diagnosis of viral meningitis was eliminated at all by Dr Tan, or by Dr Tan and Dr Seifert in consultation with each other, it could only have been on the basis of a lack of neck stiffness and the absence of other central nervous system abnormalities. The discharge letter that is set out below tends to confirm that this was at least Dr Tan's line of reasoning.

7.13. In her second document[37] Dr Tan suggested it was her normal practice to request the senior medical officer, in this case Dr Seifert, to examine the patient and for her to ask whether any further investigations were required. This was because hospital policy dictated that only senior medical officers could order investigations such as CT scans and, by extension, lumbar punctures. She said in this document that she could not recall what she had told Dr Seifert but it was her normal practice to show the senior medical officer the letter of referral together with any of her notes and clinical

[35] Exhibit C4b, page 4
[36] Exhibit C4b, page 7

findings, diagnosis and management plan. She said that it would have been on the basis of her discussion with Dr Seifert and upon agreement by him with her diagnosis that Mr Farkas' discharge was effected.

7.14. Although, as it transpired, Mr Farkas did not die from viral meningitis, if he had been subjected to a lumbar puncture in order to exclude it, the evidence would suggest that the detection of a subarachnoid haemorrhage might have been more likely. I expand on this below.

7.15. In the event, it is difficult to be critical of Dr Tan owing to her inexperience, particularly given that she did not have the notes of the previous presentation and the fact that she had an imperfect knowledge of the symptomatology of subarachnoid haemorrhage. It is not being unkind to suggest that Dr Tan was out of her depth with this presentation. This was a re-presentation in which serious symptomatology had been identified over the previous few days and which at various stages had been suggestive of the existence of an intracerebral bleed. In addition, there was the general practitioner's pointed concern about the existence of some intracranial pathology. It was simply not good enough for a re-presentation such as Mr Farkas' to be managed by someone so inexperienced as Dr Tan and have been the subject of what appears to have been limited scrutiny by a more senior medical practitioner.

7.16. Dr Tan's discharge letter to Dr Cheung, which Mr Farkas took with him, stated the diagnosis as migraine. I set out the letter in full:

> 'Thank you for your referral of Mr Farkas. Based on his Hx + the absence of any neck stiffness or neurological Sx we have treated his headache as a migraine. His headache resolved after 1500mg paracetamol + 10mg metoclopramide + 1000 ml N/S.
>
> We have advised him to see you should further problems arise. Thank you for your continued care of this patient.' [38]

As I say, the letter confirms that the diagnosis of viral meningitis had been eliminated on the basis of the absence of neck stiffness and neurological symptoms and that on that same basis Mr Farkas had been denied the opportunity of having a lumbar puncture that just might, fortuitously it is granted, have revealed his subarachnoid haemorrhage. Given that Mr Farkas had, I find, presented with and described neck stiffness on no less than two occasions during the week, namely to Dr Hussain on the

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[37] Exhibit C13

[38] Exhibit C5, page 74

Monday and to Dr Cheung on the Thursday, it is difficult to reach any conclusion other than that, notwithstanding the irony provided by the fact that Mr Farkas did not have viral meningitis, the exclusion of that diagnosis and a decision not to administer a lumbar puncture was flawed.

8. Mr Farkas' presentation to his general practitioner on 24 October 2005

8.1. Mr Farkas obviously continued to experience symptoms after 21 October 2005 and he presented yet again to Dr Cheung on 24 October 2005. Dr Tan's discharge letter was furnished to Dr Cheung. Dr Cheung has recorded that Mr Farkas was suffering from a recurrence of the headache with hot and cold flushes and neck stiffness.

8.2. Dr Cheung diagnosed a neck pain that he expressed in this fashion in his notes:

'Dx ? neck pain' [39]

8.3. Dr Cheung concluded from the hospital discharge letter that the treatment that Mr Farkas had undergone at the hospital had been effective in terms of a diagnosis of migraine. As far as his own diagnosis of neck pain was concerned, Dr Cheung concluded that Mr Farkas was probably experiencing spasm in the muscles in the neck, that this was causing his pain and that the pain was radiating to the head causing the headaches. He prescribed Panamax and Celebrex which is an anti-inflammatory.

8.4. He did not see Mr Farkas again after that consultation.

8.5. Dr Cheung told me that on 24 October 2005 he had not been unduly concerned about the absence of any reference in the Modbury letter to there having been a lumbar puncture or a CT scan conducted at the Modbury, notwithstanding the fact that he had earlier entertained a concern that Mr Farkas was suffering from viral meningitis. He told me that as far as he was concerned the patient had been assessed at the hospital and presumably had been examined by a medical registrar or the equivalent. In the event, we know that an intern had seen him. Dr Cheung believed that the hospital had eliminated the suspicion of viral meningitis simply on a clinical basis and in particular the absence of neck stiffness or neurological symptoms. That said, Dr Cheung told me that he was not entirely happy about the fact that the hospital had not performed a lumbar puncture or CT scan. When asked as to why Dr Cheung did not then himself send Mr Farkas privately for further examinations such as a CT scan, he said that the

patient had improved, had been assessed by the hospital and the diagnosis had been migraine. He had no obvious reason to order a CT scan himself[40]. It will be observed that a CT scan would not have been the first examination of choice in any event as far as viral meningitis was concerned. As to the absence of any lumbar puncture having occurred at the hospital, Dr Cheung reiterated that he was entitled to believe that the doctor at the hospital had been comfortable and confident in excluding viral meningitis on a clinical basis and that a more senior medical officer had probably been consulted. He also had regard to the fact that a lumbar puncture is not undertaken lightly and that it also has its own risks.

8.6. Dr Cheung may well have been reinforced in his lack of concern about Mr Farkas owing to the fact that Mr Farkas did not come back after 24 October 2005. On that basis it would have been reasonable for Dr Cheung to suppose that his diagnosis of pain originating in the neck had been the correct diagnosis.

9. The evidence of Associate Professor Brian Brophy

9.1. Dr Brophy is a neurosurgeon. He is an Associate Professor and Director of Neurosurgery at the Royal Adelaide Hospital. Dr Brophy provided a written professional overview in respect of Mr Farkas' management. His report was tendered to the Inquest[41]. Dr Brophy also gave oral evidence.

9.2. Dr Brophy told me that misdiagnosis or failure to diagnose subarachnoid haemorrhage is not uncommon. This was because in a percentage of cases the patient's presentation is less dramatic and the diagnosis is more difficult. The classic symptoms will not all necessarily be present in a patient. Given that headache is a very common presenting symptom, it would require an astute general practitioner to pick up that somebody with an atypical or more persistent headache may have a subarachnoid haemorrhage.

9.3. The atypical presentation, or less dramatic presentation, might be associated with cases in which there has not been an acute rupture of an aneurysm but a smaller bleed. Dr Brophy suggested that the problem of failure to diagnose subarachnoid haemorrhage has been in existence for a long time and that continuing medical

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[39] Exhibit C6, page 5
[40] Transcript, page 93
[41] Exhibit C9

education for emergency room physicians should include the repetitive warning that clinicians should be aware of the atypical or persisting headache which could be subarachnoid haemorrhage.

9.4. In Mr Farkas' case, his presentations between 17 October 2005 and 24 October 2005 during which time he was seen variously by his general practitioner and at the Modbury, was consistent with a rupture of the aneurysm on 15 October 2005 and the initiation of a bleeding process that was not in and of itself going to be fatal. However, given that in the ensuing months there is a very high rate of re-rupture of an aneurysm, there is a significant risk of mortality. I have no doubt that this occurred in Mr Farkas' case. It is evident to me that on 15 October 2005 he experienced a leak from the aneurysm that was present within his head and that his symptoms over the ensuing 9 days were the result of that.

9.5. Dr Brophy referred to the symptoms that Mr Farkas had presented with to the Modbury on 17 October 2005, namely headache, nausea, vomiting and dizziness which Dr Brophy regarded as probably having a spontaneous onset. He also referred to the positive test for neck stiffness[42]. The Emergency Department physician had entertained a possible diagnosis of subarachnoid haemorrhage. Given all of that, he believed that a CT scan at that time would have been the appropriate investigation. Once a diagnosis of subarachnoid haemorrhage is entertained, Dr Brophy told me that the only way to rule it out in an atypical presentation is by way of the CT scan. The improvement in Mr Farkas' condition and the disappearance of symptoms would not help differentiate between an origin that was migraine as opposed to a subarachnoid haemorrhage. The other feature of Mr Farkas' presentation that was important was that he arrived at a public hospital Emergency Department at 7:45am and that this was in keeping with a very acute and unusual occurrence in the person's health.

9.6. As to the presentation to Dr Tan on 21 October 2005, Dr Brophy was of the view that Dr Tan's description of the typical set of signs and symptoms for subarachnoid haemorrhage, and her expectation that if Mr Farkas had been suffering from such a bleed that he would have presented in accordance with that description, demonstrated a poor understanding of subarachnoid haemorrhage on her part. It will also be remembered that on 21 October 2005 the Modbury should have had access to the

[42] Transcript, page 118

notes of 17 October 2005 and they would have been assisted no doubt by the fact that a subarachnoid haemorrhage had been part of the differential diagnoses on that occasion.

9.7. As to the possible effectiveness of further examinations in Mr Farkas' case, Dr Brophy told me that a CT scan would be positive in approximately 98% of cases soon after the ictus of a subarachnoid haemorrhage. In Mr Farkas' case, he suggested that on 17 October 2005, the day of his first presentation at the Modbury, there was an approximately 95% chance that the internal bleed would have been detected by CT, but that this would fall to an approximate likelihood of 60% in the next 5 or 6 days. It would therefore appear that if Mr Farkas had been subjected to a CT scan on 17 October 2005 the risk of the subarachnoid haemorrhage not being detected would have been very small. As far as the chances and risks on 21 October 2005 were concerned, although the chances of detection were smaller, they were still of a level where detection was more probable than not.

9.8. Dr Brophy suggested in evidence that Mr Farkas had a relatively good chance of survival if the subarachnoid haemorrhage had been detected in October 2005. He said the following:

> 'A good grade case and he was good grade, the location was not particularly demanding, I would hope sort of - should have a high chance of an uneventful course, perhaps better than 90% uneventful outcome.' [43]

9.9. Finally, Dr Brophy commented upon the type of examination that may have been indicated in terms of suspected viral meningitis. It will be remembered in this regard that on 20 October 2005 Dr Cheung in his referral letter to the Modbury had queried meningitis as a possible diagnosis, but that the staff at the Modbury did not perform any specific examination relating to such a possible diagnosis because it was believed that viral meningitis had been eliminated clinically. Dr Brophy told me that a CT scan would not detect viral meningitis, but that the appropriate examination in respect of that suspected pathology would be a lumbar puncture. Although as it transpired in Mr Farkas' case he did not have viral meningitis, the administration of a lumbar puncture might have revealed the presence of Mr Farkas' haemorrhage. A lumbar puncture may have revealed blood stained cerebral spinal fluid. In that event one would then have performed the CT scan which would in turn have likely revealed the

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[43] Transcript, page 131

presence of the haemorrhage. Dr Brophy also suggested that even in a case of suspected viral meningitis, a presentation of headache might lead one to perform a CT first in any event. Either way, Dr Cheung's suggested possible diagnosis of viral meningitis, if properly evaluated, may have serendipitously led to the detection of the haemorrhage[44].

10. The evidence of Professor Anne-Maree Kelly

10.1. Professor Kelly is Professor of Emergency Medicine at Western Hospital in Footscray, Victoria. She has in excess of 20 years experience in hospital Emergency Departments and has had more than 15 years as a specialist in South Australia, New Zealand and Victoria.

10.2. Professor Kelly provided the Court with a written overview of Mr Farkas' management from an emergency medicine perspective[45]. Professor Kelly also gave oral evidence.

10.3. Professor Kelly was firstly critical of the note taking that had taken place in respect of Mr Farkas' presentations at the Modbury on 17 and 21 October 2005. I have already commented upon that note taking for my own part. Professor Kelly remarked upon the lack of any description of the onset of the headache within the notes made by Dr Tan on 21 October 2005. The same comment in my view can be made in respect of Dr Hussain's notes on 17 October 2005. In respect of Dr Hussain's notes, Professor Kelly observes in her report that they 'seem to indicate that the headache came on quickly'[46]. This was suggestive of course of a sudden onset but it will be remembered that Dr Hussain eschewed that suggestion. I agree with Professor Kelly's characterisation of suddenness. I repeat that Dr Hussain's notes should have left no-one in any doubt as to whether the onset of the headache was sudden or gradual, given that it is a very important characteristic of a subarachnoid haemorrhage.

10.4. Professor Kelly spoke of the incidence of misdiagnosis. She said in her report that it has been estimated that about 19% of subarachnoid haemorrhages are initially misdiagnosed in patients with normal mental state at presentation, in other words patients with no neurological deficit. Professor Kelly also referred to small volume

[44] Transcript, pages 124-127
[45] Exhibit C10
[46] Exhibit C10, page 1

haemorrhage as being a factor associated with misdiagnosis. Professor Kelly referred to a study that had found that migraine was the most common incorrect diagnosis (36%) and that the failure to perform a CT scan was the most common diagnostic error (73%). Both of those erroneous elements were present in Mr Farkas' case.

10.5. In her evidence Professor Kelly stated that she would have regarded Dr Hussain's differential diagnosis of subarachnoid haemorrhage as a reasonable one having regard to the particular features of Mr Farkas' presentation. Although Mr Farkas' presentation was not a classical presentation of subarachnoid haemorrhage when seen by Dr Hussain, and that while there are unusual presentations where the diagnosis may reasonably not be considered in the overall context, the concern in this case was that the diagnosis had in fact been considered by Dr Hussain and reasonably so, but that the next logical step in the process of diagnosis was not taken - namely the CT scan. When asked by counsel to comment upon the appropriateness of Dr Hussain noting the possibility of subarachnoid haemorrhage but then proceeding to exclude that by way of clinical examination, Professor Kelly suggested that in such a circumstance the only way of assuring oneself that the diagnosis of subarachnoid haemorrhage was no longer viable was by performing the necessary investigations[47]. The fact that the patient did not deteriorate and had some positive response in his headache after several hours of observation was no basis upon which a diagnosis of subarachnoid haemorrhage could properly be excluded[48].

10.6. Professor Kelly did not think that dehydration or migraine had been a viable diagnosis for Mr Farkas. His would be an unusual and atypical presentation for migraine. The neck stiffness did not quite fit with such a diagnosis and, as well, it would be unusual for a man in his 40s to present with migraine in the absence of an established history of the same. This of course echoes much of what Dr Brophy said about the need to take into account the circumstances in which a person might present to an Emergency Department with a severe headache.

10.7. Professor Kelly told me that the collective international experience is that 1 in 10 patients who present with the sudden onset headache but who are neurologically normal, as Mr Farkas was, will have a subarachnoid haemorrhage. To my mind, that

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[47] Transcript, pages 175-176
[48] Transcript, page 177

seems to be a relatively high incidence and one that would need to be seriously taken into consideration in any diagnostic exercise.

10.8. The point to be highlighted from Professor Kelly's evidence about Mr Farkas' presentation in my view is that it was not as if the differential diagnosis of subarachnoid haemorrhage was a theoretical one only. There were features of his presentation that supported such a diagnosis clinically, namely the sudden onset of headache, if Mr Farkas' description to Dr Hussain is to be given any weight, as well as neck stiffness. Those two features of Mr Farkas' presentation to my mind remain as significant factors from which a conclusion could reasonably have been entertained that Mr Farkas was in fact suffering from an intracranial bleed that required further investigation in the form of a CT scan. In this regard Professor Kelly agreed that on 17 October 2005 a bleeding event in Mr Farkas' brain was likely taking place.

10.9. As far as Mr Farkas' re-presentation on 21 October 2005 is concerned, Professor Kelly was of the view that Dr Cheung's suggested diagnosis of viral meningitis did not necessarily mean that the practitioners at the Modbury would only need to rule that out. The clear inference from Dr Cheung's referring letter was that he was not happy with the condition of the patient and that while he thought that Mr Farkas might be suffering from viral meningitis, the real impact of Dr Cheung's message was that something serious was taking place in his view. Given the amount of time that had elapsed since the onset of Mr Farkas' symptoms, personnel from the Emergency Department may not inevitably have considered subarachnoid haemorrhage because such a presentation tends to occur at an early stage. However, Professor Kelly said:

> 'The nature of the ongoing severe headache and symptoms are what concerns me here rather than the differential diagnosis of subarachnoid haemorrhage per se.' [49]

Professor Kelly believed that in this presentation a CT scan was justified on the evidence provided but that it was a less clear cut case for it than on Mr Farkas' first attendance. As far as a possible diagnosis of viral meningitis was concerned, and whether on 21 October it was a possible explanation for Mr Farkas' ongoing presentation, Professor Kelly said that if there had been no viral features and she was happy that the patient did not have a fever or convincing evidence of neck stiffness on that occasion, she might have discounted that diagnosis without performing the lumbar puncture. However, his presentation had to be seen in the context of Mr

Farkas' clinical picture over the previous 4 to 5 days, and so viewed, there was clearly something taking place with Mr Farkas and a CT scan would have been the preferable first investigation. I agree with that assessment of the situation.

10.10. Professor Kelly discussed the desirability of having Mr Farkas' notes from his previous presentation made available. She referred to the fact that it is not an uncommon occurrence for notes not to be available in these circumstances. However, if they had been available and read, then the question of subarachnoid haemorrhage or a similar diagnosis may have been more prominent in the thinking of the medical practitioners on 21 October 2005. However, she was of the view that she still believed a CT scan was indicated notwithstanding. Professor Kelly also referred to the fact that re-presentations statistically imply a greater risk of serious pathology at work.[50] Depending on the staffing of the particular hospital there was in her view a desirability, if not a requirement, that a registrar or preferably a consultant should see the patient. It will be remembered in this regard that Dr Tan was an intern. As far as discharge was concerned, Professor Kelly suggested the following:

> 'Many hospitals already have a policy in place that all patients seen by interns, irrespective of whether it is their first presentation or a repeat presentation as in this case, that interns have to discuss every case, at least discuss every case, with a senior staff member before discharge. Certainly in a re-presentation there should have been some consultation with a more senior colleague before the patient was discharged, in particular because the GP has even flagged they are worried about the patient, so it is almost a double push.' [51]

While it was not always practicable in a busy Emergency Department for the more senior practitioner to examine the patient for themselves, it was a desirable feature. In this regard, I shall later refer to recommendations that were made in an Inquest some years ago in respect of the desirability of re-presenting patients being seen by senior medical practitioners.

10.11. Professor Kelly was not critical of the general practitioner, Dr Cheung. I was not surprised at this for reasons I have already identified. At one point it exercised my mind as to whether Dr Cheung may have left himself open to criticism in respect of his management on 24 October 2005 which was the fifth consultation that Mr Farkas had been involved in over the past week. Professor Kelly suggested that by the third

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[49] Transcript, page 165
[50] Transcript, page 166
[51] Transcript, page 168

attendance upon Dr Cheung, Mr Farkas appeared perhaps to be clinically better and that Dr Cheung's conclusions at that time were reasonable. She thought it was regrettable that no CT scan was still undertaken at that time, but did not think that this meant that the general practitioner had behaved unreasonably. I have already referred to the fact that, in my view, there was a certain entitlement on Dr Cheung's part to assume that the Modbury had competently clinically evaluated Mr Farkas on 21 October 2005.

11. Conclusions

11.1. On Sunday, 16 October 2005 the deceased, Mr Farkas, experienced symptoms of a leak or small bleed emanating from an aneurysm in his head. The symptoms consisted of nausea, vomiting, dizziness, and severe headache.

11.2. On Monday, 17 October 2005 he presented at the Emergency Department of the Modbury Hospital and explained to a medical practitioner, Dr Hussain, that he had on the previous day experienced dizziness and nausea whilst taking a shower and that when he emerged from the shower he developed a headache that was at the front of his head and also over his neck. I infer from this description as recorded by Dr Hussain that the onset of the headache was sudden and not gradual. I also infer that Mr Farkas had presented at the Modbury because he was rightly anxious about the symptoms that he had been experiencing and because the symptoms were for him uncharacteristic and unexplained. I also find that upon his presentation at the Modbury Mr Farkas was experiencing neck stiffness and that Dr Hussain well knew that.

11.3. On 17 October 2005 Dr Hussain recorded amongst differential diagnoses for Mr Farkas' headache - dehydration, subarachnoid haemorrhage, simple headache and migraine. The differential diagnosis of subarachnoid haemorrhage, based as it could have been on the sudden onset of Mr Farkas' headache the day before and his neck stiffness, was a reasonable diagnosis and one which required further examination and investigation before it could be excluded. The necessary investigation would have, in the first instance, involved the administration of a CT scan of his head. This could and should have been administered. I find that the overwhelming likelihood is that had such a CT scan been administered on that occasion, Mr Farkas' intracerebral

bleed would have been detected. If so, then his chances of survival after the appropriate surgery would have been very favourable.

11.4. As it was, Dr Hussain recorded a diagnosis of dehydration within Mr Farkas' clinical record and he was discharged. I accept Dr Hussain's evidence that the diagnosis also involved, as a component, a migraine headache. However, for reasons that I have already mentioned, this diagnosis or diagnoses were erroneous and made after inadequate investigation.

11.5. On Friday, 21 October 2005 Mr Farkas re-presented at the Emergency Department of the Modbury Hospital. In the meantime he had seen his general practitioner, Dr Cheung. When he presented to the Modbury on 21 October 2005 he had in his possession a referral letter from Dr Cheung that referred to the fact that Mr Farkas continued to complain of severe headache, nausea, photophobia, giddiness and some neck rigidity. Dr Cheung in his letter queried whether Mr Farkas might have been suffering from viral meningitis.

11.6. On 21 October 2005 an intern, Dr Tan, saw Mr Farkas. Dr Tan did not have access to the notes of Mr Farkas' previous presentation on 17 October 2005. Dr Tan had an imperfect understanding of the symptomatology of a subarachnoid haemorrhage. She believed that a classical presentation of the same involved symptoms that would virtually make such a diagnosis inevitable. Mr Farkas did not present with those classic symptoms. In the event Dr Tan also came to a diagnosis of migraine that was also erroneous. I am not certain as to whether on this occasion a more senior medical practitioner actually examined Mr Farkas. In the event, Mr Farkas was not subjected to any investigations either for viral meningitis or any other intracranial pathology when he should have been subjected to a lumbar puncture and possibly a CT scan. The suggested possible diagnosis of viral meningitis was eliminated, in my view, inappropriately on clinical grounds alone. While viral meningitis would not have been the correct diagnosis, a correct evaluation of the possible diagnosis of viral meningitis may well have led medical staff at the Modbury to have arrived at a diagnosis of an intracerebral haemorrhage that Mr Farkas had been experiencing.

11.7. To my mind on both 17 October 2005 and 21 October 2005 undue weight was placed upon Mr Farkas' positive response to analgesia as a basis for eliminating serious underlying pathology as the origin of his headache.

11.8. On 21 October 2005 medical staff at the Emergency Department of the Modbury did not have access to the notes of Mr Farkas' previous presentation. These notes should have been made available and may well have resulted in Dr Tan or another more senior medical officer considering the possibility of subarachnoid haemorrhage which had been a differential diagnosis as of 17 October 2005.

11.9. If Mr Farkas had been subjected to a CT scan on 21 October 2005, it is more probable than not that it would have revealed the bleeding that had taken place within his head. If he had been subjected to a lumbar puncture, there is a strong possibility that this would also have revealed bleeding having taken place within his head. Had either test revealed such a result, it is in my opinion likely that a diagnosis of an intracranial bleed would have been made. Again, the chances of Mr Farkas being successfully operated upon to correct the underlying aneurysm would have been favourable.

11.10. As to why Mr Farkas did not seek further medical treatment after 24 October, one can only speculate. It would have been reasonable for Mr Farkas to think that having seen his GP three times and having been assessed in a hospital emergency room twice, that there was nothing seriously wrong with him. Perhaps he thought that his symptoms would resolve over time. He was also taking a very strong analgesic in the form of panadeine forte. On one interpretation of Mr Farkas' behaviour before his death, he may have come to terms with his pain, as the night before his death Mr Smith observed him to be in a buoyant frame of mind.

11.11. In my view, Mr Farkas' death was preventable. It is no exaggeration to say that he was badly let down at the Modbury. He clearly should have been given the necessary diagnostic examinations at the Modbury. If he had been so given them, it is likely that he would still be alive today.

11.12. In my opinion, no criticism attaches to the management of Mr Farkas by his general practitioner, Dr Cheung.

12. Recommendations

12.1. 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.

12.2. I have already referred in these findings to the recommendation that was made by the former State Coroner, Mr Chivell, in the Taylor Inquest[52]. It will be observed that the recommendation related to a scenario in which general practitioners might consider a differential diagnosis of subarachnoid haemorrhage in the setting of their surgeries. The underlying difficulty identified within the terms of the recommendation was that the condition may present atypically. This was a very powerful consideration in the present case as well. It seems to me that there is still a need, as evidenced by the circumstances of this case, that in any diagnostic setting, be it within the GP's rooms or the emergency department of a hospital, for further emphasis to be placed upon the fact that atypical presentations of subarachnoid haemorrhage, or non-classical presentations, should be considered as a possibility.

12.3. I have also already referred to the Modbury Hospital guidelines that were referred to in the Gillam Inquest[53] in 2005. To my mind an important inadequacy in these guidelines has been identified in this current Inquest. To the extent that there appears to be an implication within the four walls of the guideline that subarachnoid haemorrhage will necessarily present in its classic form, this impression needs to be rectified. As a measure of this, the current guidelines clearly did nothing to dispel Dr Tan's notion of how a subarachnoid haemorrhage would necessarily present. A subarachnoid haemorrhage or intracerebral bleed appears to be described in the guidelines in terms of the worst ever headache with a 'thunderclap' onset together with focal neurological symptoms and signs, onset with syncope (unconsciousness), features atypical of previous migraine, meningism, etc. The guideline asks the clinician to ask him or herself whether those features are in existence. They are described as the 'key' questions. Incidentally, it will be observed here that the relevance of neck stiffness is not spelt out in the protocol. It seems to me that another key question, or at least key issue, is whether the clinician needs to be alive to the fact that atypical presentations do not necessarily feature all of the classical parameters. The suddenness of the onset of the headache, as demonstrated by the evidence in this case, is if anything the key parameter and might well in and of itself prompt the investigations necessary to exclude an intracerebral bleed. It is not given due prominence in the protocol. In addition, the guideline does not refer to the possibility of sentinel bleeds from an aneurysm. In the light of the experience in this case, it

[52] Inquest 28/01
[53] Inquest 13/2007

seems to me that practitioners in an Emergency Department need to be guided towards thinking about a diagnosis of subarachnoid haemorrhage or other intracerebral bleed even where the symptoms are not necessarily classically indicative of the same.

12.4. There also appears to be a need in any event for further education to be directed towards junior medical practitioners concerning atypical presentations of subarachnoid haemorrhage.

12.5. The other area of concern identified by the circumstances of Mr Farkas' death relates to what should take place within an Emergency Department when a patient re-presents. There are two aspects to this. Firstly, it seems to me that where a person re-presents within a very short space of time to the same Emergency Department, the notes from the previous presentation ought to be made available to clinical staff especially if the patient presents with the same complaint, recognising of course that this might not always be possible and also bearing in mind that the patient may not necessarily present to the same hospital. In this regard, in the Inquest into the death of Christopher Lazopolous[54], a recommendation was made that the Royal Adelaide Hospital implement measures to ensure that X-ray films and reports were always made available to Emergency Department practitioners whenever a patient re-presents to the Emergency Department. A similar recommendation can be made in my view in respect of ensuring that clinical notes are also similarly made available in re-presentations.

12.6. Secondly, there is a question as to the level of expertise that should be brought to bear upon the diagnostic exercise involved in a re-presentation. In the same Inquest of Lazopolous I made a further recommendation that the Royal Adelaide Hospital should consider implementing measures whereby patients re-presenting to the Emergency Department of that hospital are personally examined or reviewed by practitioners of the rank of registrar or above before they are discharged. In the present case the evidence is not entirely clear to me as to the exact involvement of the registrar, Dr Detlev Seifert, during the re-presentation by Mr Farkas on 21 October 2005. It will also be remembered that Mr Farkas was examined, treated and discharged by Dr Tan, an intern. It occurs to me that an inappropriate level of emphasis is placed upon the involvement of the more senior medical practitioner at the time of discharge as

opposed to the time of examination. One would have thought that in cases of re-presentation, especially where the possibility of a diagnosis of a serious illness might be at stake, the involvement of the senior practitioner ought to occur sooner than later in the presentation. For instance, it does not seem right that an intern should be embarking upon a plan of treatment without first having consulted a more senior practitioner about that plan. The Orientation Guide to the Emergency Department at the Modbury Hospital[55] contains within it a section concerning supervision of junior practitioners. It sets out a protocol in respect of discharge. Newly appointed CMOs, junior medical staff and casual medical officers are required, pursuant to the protocol, to seek the authorisation of a senior medical officer to discharge patients who have been referred to the department by a general practitioner for review. That was the scenario with Mr Farkas on 21 October 2005. Junior medical staff are also required to discuss with a senior medical officer any patient who has 'returned for an unplanned review'. I take it that this requirement refers to patients who unexpectedly re-present with the same complaint, like Mr Farkas. It is difficult to know what value can be placed upon mere discussion as opposed to the senior practitioner examining the patient for him or herself. One suspects that it all depends upon the circumstances. On would have thought, however, that the more serious the complaint, the greater the level of expertise and scrutiny required before the patient could be discharged. It is not difficult to reach a conclusion that the best practice would be that in any re-presentation scenario, a more senior medical officer of the rank of registrar ought to examine the patient. It will be appreciated that this may not, in practice, be achievable in every Emergency Department, but at least it can be identified as an appropriate benchmark.

12.7. I recommend the following:

(1) That the Minister for Health and the South Australian Medical Board cause this matter and the Taylor and Gillam matters to be drawn to the attention of the medical profession, with particular emphasis towards the education of general practitioners and Emergency Department practitioners in all hospitals in respect of the matters identified in these Inquests;

(2) That the Minister for Health and the South Australian Medical Board recommend to tertiary institutions, in particular medical and nursing schools,

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[54] Inquest 20/2005

and the Royal Australasian College of General Practitioners, that reference be made in their respective curricula to atypical presentations of subarachnoid and intracerebral haemorrhage and to the symptomatology in respect of the same, with particular reference to the suddenness of the onset of headache;

(3) That the Minister for Health and the South Australian Medical Board cause educational programs to be directed to medical practitioners, in particular general practitioners and emergency department practitioners, especially junior practitioners, to the effect that when considering a possible diagnosis of subarachnoid or other intracerebral haemorrhage they should have regard to the following matters:

(a) the need to properly investigate by the appropriate means, eg CT scans, the possibility of the existence of subarachnoid or other intracerebral haemorrhage in a presenting patient where the same forms part of a differential diagnosis;

(b) the need to exercise care in eliminating possible diagnoses of subarachnoid or other intracerebral haemorrhage in a patient on the basis of a clinical examination alone;

(c) the need to exercise care in eliminating possible diagnoses of subarachnoid or other intracerebral haemorrhage in a patient on the basis of the patient's response to analgesia alone;

(d) the need always to address the issue of and to specifically think about the possibility that the patient is presenting with an atypical presentation of subarachnoid or other intracerebral haemorrhage;

(e) the need to consider that the patient's presentation may be consistent with a 'sentinel bleed' from an aneurysm;

(f) the need to exercise care to ensure that the patient is asked about the nature of the onset of any symptom of headache and to thoroughly note the patient's response;

(g) the need to have regard to the circumstances in which the patient presents to an Emergency Department and the need to ask appropriate questions of

[55] Exhibit C8

the patient designed to elicit whether their presentation is uncharacteristic in terms of their general and usual state of health;

(4) That the management of the Modbury Hospital amend the 'Adult Non Trauma Headache Treatment Guidelines' (a) to include reference to the need for Emergency Department medical practitioners to consider the possibility of an atypical presentation of subarachnoid or other intracerebral haemorrhage and to include reference to the characteristics of the same such as the significance of the nature of the onset of the symptom of headache, and (b) to consider including specific reference to the symptom of neck stiffness.

(5) That the management of the Modbury Hospital create and install prompts in the Emergency Department that remind the practitioner to consider and be aware of the possibility of the atypical presentation of subarachnoid or other intracerebral haemorrhage.

(6) That the Minister for Health draw recommendation (5) herein to the attention of the management of all other hospitals and recommend that they should consider implementing the same requirement.

(7) That the management of the Modbury Hospital ensure, as far as is possible, that the clinical record of a patient be made available upon a re-presentation by that patient to that hospital.

(8) That the Minister for Health draw recommendation (7) herein to the attention of the management of all other hospitals and recommend that they should consider implementing the same requirement.

(9) That the management of the Modbury Hospital ensure as far as is possible that patients who re-present to the Emergency Department with the same complaint are examined by a senior medical practitioner, and that in any event that a treatment plan not be implemented until the senior medical practitioner has at least been consulted.

(10) That the Minister for Health draw recommendation (9) herein to the attention of the management of all other hospitals and recommend that they should consider implementing the same requirement.

Key Words: Misdiagnosis; Inexperience; Subarachnoid Haemorrhage

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

Seal the 21st day of May, 2009.

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Deputy State Coroner

Inquest Number 31/2008 (3005/2005)