Submission No 575

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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My name is Hayley Olivares and on 15 September 2020 my mother, Dawn Trevitt died in the Gulgong Multipurpose Service (MPS) without a doctor physically present. She was 66 years old.

THE DAY

On the afternoon of 15 September 2020, my mother was transported by ambulance from her home in Young Street, Gulgong to the Gulgong Multipurpose Service (MPS) a trip of approximately 1.7km. Within 90 minutes she was pronounced dead.

The Gulgong MPS had no doctor or Visiting Medical Officer (VMO) contracted since June 2020. This was something the Gulgong community had been campaigning to resolve for quite some time to no avail. Not only was there no contracted doctor, but there was no bypass guideline in place to allow a paramedic to use clinical judgement on whether a patient should be transported to a more suitable facility depending on their condition.

On the afternoon of 15 September 2020, I received a phone call from my Aunt who was visiting my parents in Gulgong at the time. She advised me that my mum was not well and had been transported by ambulance to the local MPS. I allowed 20 minutes or so to pass, before I rang the MPS to confirm mum's presentation expecting them to tell me she was being transported to a larger facility. During this phone call, I spoke to one of the paramedics who confirmed that Mum was still at the MPS and was currently being worked on by all staff that were currently on shift at the MPS. He confirmed that Mum was conscious, talking to them, but gravely unwell with her blood pressure being concerningly low. He advised I should give them 20-30 minutes, call back and hopefully they would have something further to discuss. Before that period of time had lapsed and I had a chance to call back, a nurse at the MPS had called me. She confirmed I was listed as my Mum's emergency contact and asked me to come down to the MPS. Noting I live in Canberra, attending the MPS in person was not an option for me, so I asked for her to let me know over the phone what had happened. She said she couldn't do that and instead I needed to find a family member or close personal friend to attend in person. The only other family we have in Gulgong is my father, who is disabled after having a serious stroke in 2012. My Mum was his primary carer. He is unable to drive, or live independently, so it was not an option to send him down to the MPS to receive the news. Instead, we had to make the decision to leave him at home unattended and send my Aunt to the MPS to be briefed by the staff.

When she arrived, she was met at the door and advised that Mum had passed away.

AFTER DEATH

I arrived in Gulgong on the afternoon of 16 September 2020. Mid to late that afternoon a local police Constable attended my parent's house to return my Mum's personal belongings. During that visit, my brother asked the Constable whether a member of our family was required to attend the MPS to identify Mum's body. We were informed there was no requirement for us to do that as she had already been identified by a lady who works at the MPS, who allegedly knew

my Mum and happened to be a neighbour. I was mortified that as a grieving family, we were not afforded the opportunity to do this ourselves. I found this incredibly disrespectful, noting that my Mum had no family with her when she died, and we as a family had no chance to say goodbye to her.

As the Constable continued his conversation with us, he confirmed that Mum had gone into cardiac arrest not long after presentation and was subsequently not able to be revived. He suggested that the cause of death for Mum was more likely than not Sepsis but that there were issues with the formal cause of death process due to a lack of Doctor physically present. I remember vividly looking at my brother with confusion. Until this time, we had no idea there was no doctor at the MPS to support my Mum's treatment. The Constable explained that there had not been a Doctor in Gulgong for quite some time and that there was Doctor from Dubbo engaged via TeleHealth during Mum's treatment. How could it possibly be acceptable for an MPS to be left to function without a Doctor. This was not a case of a Doctor not being on shift, or needing to be on call after hours. This was as simple as there was no Doctor or VMO contracted to this facility for over three months. How could it be acceptable that an ambulance can deliver a critically ill patient to a facility with no Doctor. So many questions needed to be answered.

Mum's case was subsequently referred to the NSW Coroner. Initially our engagement started with the Forensic Medical Unit in Newcastle. We were provided with a single point of contact / liaison officer who facilitated all of our engagement which took place over a 48-72 hour period. We were advised that an on-call pathologist had reviewed Mum's clinical treatment notes from the MPS together with her medical history and was of the opinion she had died of gastrointestinal hemorrhage. This caused alarm bells for our family, as until this point, we were of the understanding that Sepsis was the likely cause of death. We immediately expressed our strong desire for a post-mortem examination. As a family we felt that there were numerous unconfirmed circumstances/possibilities around my Mum's passing and that we wanted all avenues explored to provide assurance to our family that the most probable cause of death was identified. I also had concerns that should there have been any inherited medical conditions that contributed to her passing, I wanted to be aware of those.

The liaison officer advised that Mum's medical history formed a strong basis for consideration and that she had acquired Mum's medical records from the local Medical Centre. The liaison officer mentioned that Mum's stroke in 2012 had been included in those medical notes and when I immediately rebutted the fact my Mum had never had a stroke she said 'Perhaps you just didn't know or she didn't tell you'. I was well versed in my Mum's medical history having attended medical appointments with her numerous times over the years and having both her and my Dad staying with my family regularly over the last 8 years since my father had a stroke in 2012. I explained to the liaison officer that my father had in fact had a stroke in the same month in 2012 that she was reporting my Mum had had one and that I believed there had been a mix up with the medical records that had been provided to the Forensic Medical Unit. I was

ensured that this was not a significant issue and that they would simply put a footnote on the file for the Coroner to say that there were inconsistencies in Mum's recollected medical history. Both my brother and I objected to progressing any further until we could ensure that the medical records attached to Mum's file were in fact her own and provided an appropriate factual base for the Coroner to make an informed decision. That same afternoon, I attended the Gulgong Medical Centre, sat with the Practice Manager and reviewed the medical notes attached to my Mum's file. The Practice Manager acknowledged that the note relating to the stroke had been added to my Mum's file in error and that the Doctor would be required to send a letter of correction through to the Forensic Medical Unit in Newcastle. Had our family not persisted or expressed our concerns with the inaccuracies, I have no doubt the Coroner's office would have made a finding prematurely.

Despite our family's strong request / plea for a post mortem examination, one was not granted. The Coroner signed a certificate with Gastrointestinal hemorrhage as the cause of death and that was that.

The situation that unfolded on that afternoon in the Gulgong MPS, and of course, Mum's subsequent passing, brought a large amount of media interest to the issue of regional and rural health care. As previously mentioned, the Gulgong community had been campaigning their state government representatives for months without making any traction. It took a death for anyone to stop and listen.

REVIEW

The NSW Health Minister, Brad Hazzard called for a review into the situation that unfolded for my Mum. Unfortunately that actually just resulted in a Root Cause Analysis Review of which my family were interviewed in November 2020 and we have the Open Disclosure Meeting on Friday, 22 January 2021 to discuss the findings and recommendations. I have read the report, and as expected there is very little accountability on the Local Health Service or Ministry of Health.

TELEHEALTH

I have always been very firm when discussing the situation that unfolded for my Mum. I will never know whether having a doctor physically present could have made a difference for her. What concerns me, is that this is something we as a family have to live with now. Unanswered questions because TeleHealth is taking the place of doctors on the ground and this is just one example of how traumatic the consequences can be.

I am confident there is a place for TeleHealth in the medical system, but it can't be for critical or emergency care. There were no doctors present to assist in the attempt to resuscitate my Mum, or to try and help the nurse put in IV lines which continued to be unsuccessful. There is no truth in the NSW Government's position that TeleHealth is a supplementary approach. There

are more and more rural and regional communities that are being forced to live with TeleHealth as their principal health care service.

ADDITIONAL

Week's after my Mum's passing, I received a copy of a statement being provided to your Inquiry from a lady who was in the room next to my Mother at the Gulgong MPS the afternoon/evening she passed. The statement outlines the trauma and stress the nurses were under when trying to treat my mum. How they were pleading for someone to help them including the paramedics who were still on site. The statement confirmed the kitchen cook was left to care for the rest of the patients at the MPS as Mum deteriorated. There were no other medical practitioners available to care for other patients as the two nurses on shift were both trying to save my Mum. My family asked the Root Cause Analysis team to meet with this lady as part of their investigation and to the best of my knowledge, they chose not to.

I hope this inquiry focuses on current system failures and improvements, what role TeleHealth is actually playing in rural and regional areas and how best to integrate TeleHealth into a functional and accessible health system. There should not be stark differences in the quality of health care an Australian citizen can expect to receive dependent on the postcode in which they reside. Appropriate health care is a basic human right and at the present time, there are significant risks to millions of Australians in rural and regional areas.

I welcome the opportunity to discuss this issue further with the Committee should it be required.