Young v Central Australian Aboriginal Congress Inc & Ors [2008] NTSC 47

PARTIES:	YOUNG, Rosario (as representative of the family of CLIVE HENRY IMPU) v CENTRAL AUSTRALIAN ABORIGINAL CONGRESS INCORPORATED BOFFA, John Dominic CGU INSURANCE LIMITED (ABN 27 004 478 371)
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY exercising Territory jurisdiction
FILE NO:	61/03 (20303381)
DELIVERED:	19 November 2008
HEARING DATES:	11-21 February; 25 & 26 August 2008
JUDGMENT OF:	THOMAS J

CATCHWORDS:

TORTS -- NEGLIGENCE -- DUTY OF CARE
Clinic's duty of care to patient – medical practitioners duty of care to patient – opportunistic follow-up system – serious administrative errors – failure of clinic to follow-up deceased's diagnosis – failure of clinic to follow-up deceased's treatment

TORTS -- NEGLIGENCE
Vicarious liability of clinic against doctor – direct liability of clinic against doctor – whether insurance company liable to indemnify clinic for administrative error of medical practitioner – whether medical practitioner failed to properly diagnose – whether medical practitioner failed to properly treat – whether medical practitioner failed to follow-up – systems in place at clinic at relevant time

TORTS -- NEGLIGENCE -- CONTRIBUTORY NEGLIGENCE
Failure of patient to keep appointment – failure of patient to follow up recommended tests – failure of patient to mention at subsequent attendances his failure to attend recommended tests and appointments – failure of patient to mention at subsequent attendances the concerns of the initial medical practitioner

TORTS -- NEGLIGENCE -- SOLATIUM FOR DEATH OF PARENT -- SOLATIUM FOR DEATH OF SPOUSE

DAMAGES -- MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT -- CAUSATION

Whether breach of duty caused or contributed to harm – whether administrative error caused or contributed to the harm – clinic's failure to follow-up – systems in place at clinic

Compensation (Fatal Injuries Act), ss 7, 11(1), 13

Law Reform (Miscellaneous Provisions) Act, pt V

Albrighton v Royal Prince Alfred Hospital (1980) 2 NSWLR 542; *Elilade v Nonpareil Ltd* (2002) 124 FCR 1; *Ellis v Wallsend District Hospital* (1989) 17 NSWR 553; *Kondis v State Transport Authority* (1984) 154 CLR 672; *Rogers v Whitaker* (1992) 175 CLR 479; *Wayne Tank and Pump Co Ltd v Employers Liability Assurance Corporation Ltd* [1974] QB 57; *Wyong Shire Council v Shirt* (1980) 146 CLR 40, applied.

X (minors) v Bedfordshire County Council [1995] 2 AC 633, considered.

Kite v Malycha (1998) 71 SASR 321; *Tai v Hatzistavrou* [1999] NSWCA 306, distinguished.

REPRESENTATION:

Counsel:

Plaintiff:	P Barr QC & A Lindsay
First Defendant:	S Gearin
Second Defendant:	H Abbott
Third Party	J Kelly

Solicitors:

Plaintiff:	Povey Stirk
First Defendant:	Collier & Deane
Second Defendant:	Morgan Buckley
Third Party	Minter Ellison

Judgment category classification:	C
Judgment ID Number:	tho200805
Number of pages:	125

IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Young v Central Australian Aboriginal Congress Inc & Ors [2008] NTSC 47
No. 61/03 (20303381)

BETWEEN:

YOUNG, Rosario
Plaintiff

AND:

CENTRAL AUSTRALIAN ABORIGINAL CONGRESS INC
First Defendant

BOFFA, John Dominic
Second Defendant

CGU INSURANCE LIMITED (ABN 27 004 478 371)
Third Party

CORAM: THOMAS J

REASONS FOR JUDGMENT

(Delivered 19 November 2008)

[1] The plaintiff claims the defendants are liable to an action for damages in negligence pursuant to s 7 of the Compensation (Fatal Injuries) Act.

[2] The claim arises from the death of the plaintiff's spouse, Clive Henry Impu, on 26 January 2001.

[3] The plaintiff sues pursuant to s 13 of the Compensation (Fatal Injuries) Act for her own benefit and for the benefit of the children:

- Bruce Impu born 19 September 1994
- Norman Impu born 17 July 1996
- Raelene Impu born 5 October 1999.

Introduction

[4] The plaintiff was born on 6 October 1971. The deceased was born at Alice Springs on 8 February 1975. The plaintiff and the deceased formed a relationship in 1992. They subsequently had three children, Bruce Impu born 19 September 1994, Norman Impu born 17 July 1996 and Raelene Impu born 5 October 1999.

[5] The deceased died at the Alice Springs Hospital on 26 January 2001. The deceased was 26 years of age at the time of his death. The cause of death was coronary thrombosis. The comments of the pathologist on the autopsy report (Exhibit P8) were as follows:

> "1. The cause of death was coronary atherosclerosis (ie. fatty narrowing of the coronary arteries which supply blood to the heart), which resulted in coronary thrombosis (ie. the formation of a blood clot in a coronary artery) and consequent damage to heart muscle, with failure of the heart as a pump.
>
> 2. The presence of scarring of the heart muscle (ie. myocardial fibrosis) is consistent with the effect of long-standing coronary artery disease."

[6] The history of the deceased including his medical history will be detailed in subsequent paragraphs of these reasons for judgment.

[7] The plaintiff's case against the first defendant (Central Australian Aboriginal Congress Inc) is an allegation of negligence in failing to follow up the deceased's diagnosis and treatment, in particular, failing to follow up the recommended testing of his blood cholesterol levels and failing to follow up the deceased's referral by Dr John Dominic Boffa to a specialist physician for assessment of suspected ischaemic heart disease.

[8] The additional case against the first defendant is that it is vicariously liable for the negligence of the second defendant Dr Boffa.

[9] The plaintiff's case against the second defendant (Dr Boffa) is an allegation of negligence for failing to properly diagnose and/or treat the deceased on 2 March 2000 and in then failing to follow up on the deceased's diagnosis and treatment for suspected ischaemic heart disease, in particular, failing to follow up the recommended testing of the deceased's blood cholesterol levels. The details of the "clinical and administration failures of Dr Boffa" as claimed by the plaintiff and the third party are set out later in these reasons for judgment.

[10] The causes of action against Dr Boffa and Congress are for the breach of separate and distinct duties. It is not in dispute that the plaintiff attended Congress on 2 March 2000 and consulted Dr Boffa. Dr Boffa made notes of this consultation. He made an appointment for the deceased to attend a fasting cholesterol test. He made a further appointment for the deceased to attend the next specialist Physician Clinic which was scheduled for

21 March 2000 with a suggestion that the deceased be given an exercise electrocardiogram (exercise ECG).

[11] The evidence is that the specialist clinic for 21 March 2000 was cancelled. The deceased failed to attend appointments made for him to undertake a fasting cholesterol test and subsequently the specialist clinic. The doctor in charge of the specialist clinic on 21 March 2000 had, unbeknown to her, been given the wrong file. The file she received was the file for another person with exactly the same name as the deceased. As a consequence of this there was no follow up action by Congress with the deceased about his failure to attend the Clinic.

[12] There is evidence that on other occasions the deceased did return to Congress and was attended by doctors and health workers. He did not return to consult Dr Boffa. He also attended upon doctors at Alice Springs Hospital with a variety of symptoms. At no time did he advise the doctors at Congress or at Alice Springs Hospital about his consultation with Dr Boffa on 2 March 2000.

[13] Liability has been denied by both defendants. The alternate position of the defendants is that if negligence is established then any loss or damage which may be proved by the plaintiff was caused or materially contributed to by the deceased.

[14] The particulars of contributory negligence, as set out in the "Second Defendant's Defence to Further Amended Statement of Claim", which were adopted by counsel for the first defendant in submissions, are as follows:

> "8.1 The deceased failed to keep the appointment at the physician clinic on 21 March 2000.
>
> 8.2 The deceased failed to follow up with the first or second defendants or any other doctor the fasting cholesterol test, the exercise ECG test or a further specialist appointment.
>
> 8.3 The deceased failed to mention to the doctors at the first defendant's clinic on 23 April 2008, 8 May 2000 or 29 December 2000 or at any other time the fact that he had not undertaken either of the two tests or seen a specialist.
>
> 8.4 The deceased failed to mention to doctors at the Alice Springs Hospital on 15 August 2000, 3 December 2000 and 30 December 2000 the symptoms which he suffered on 2 March 2000 and of which he complained to the second defendant on that day and the first defendant's reference to the possibility of ischaemic heart disease and his referral for tests and specialist opinion.
>
> 8.5 The deceased failed to go back to the first defendant's clinic or the second defendant for further consultation and treatment following the further symptoms he suffered on 15 August 2000, 3 December 2000 and 30 December 2000."

[15] The first defendant filed a Statement of Claim and third party notice upon the third party. The third party filed a defence and subsequently an amended defence which essentially admits that the third party agrees to indemnify the first defendant for the part of the claim against the first defendant arising from the provision of professional services which included inter alia nursing and administrative services to the extent of the policy. In accordance with the specific exclusion contained in the policy, (Item 9 of the Schedule) the third party would not indemnify the first defendant for

that part of the claim against the first defendant with respect to the alleged vicarious liability of the first defendant for the medical practitioners in particular the second defendant.

[16] This amended defence by the third party initially also applied to the third defendant, Noel Robert Morrison, however, the claim against the third defendant has been resolved and is not the subject of adjudication in these proceedings.

Background of the deceased

[17] The deceased was born at the Alice Springs Hospital on 8 February 1975. The deceased was a traditional Arrente aboriginal man. He spoke English, Eastern Arrente (Western Arrente), Pitjantjatjara and Luritja. His country included the Undarana Outstation. He had gained experience working with livestock and acquired associated manual skills such as fencing and welding.

[18] In addition to this the deceased attended school at Amoonguna in Hermannsburg, Sadadeen in Alice Springs and Kormilda in Darwin (Exhibit D6 p145).

[19] On 1 May 1996, the deceased took up a full time position with Alice Springs Hospital as an Aboriginal Liaison Officer. He was engaged essentially as an interpreter. He held this position until 3 March 1997. From 6 March 1997, he was engaged in the same work as a temporary employee to 16 June 1997.

[20] The deceased had a number of convictions for criminal offences. On 29 November 1994, he was convicted of assault and sentenced to nine months imprisonment. He was released on 22 May 1995 after he had served approximately six months.

[21] On the same date, 29 November 1994, he was also convicted of stealing, unlawful entry and unlawful use of a motor vehicle. He was released without penalty on a 12 month good behaviour bond.

[22] On 29 August 1996, he was convicted of offensive behaviour. This was an act of offensive behaviour toward his wife in that he continued to call his wife "a fucking slut" in the carport of the Bloomfield Street flats in Alice Springs. He was fined $200.

[23] On 15 September 1997, he was convicted of unlawful entry/criminal damage and sentenced to two years and six months imprisonment with a non parole period of 15 months.

[24] On 13 March 2000, he was convicted of assault female and released on a 12 month good behaviour bond.

[25] The information concerning his prior convictions is contained in Exhibit D5.

[26] His prison records are contained in Exhibit D6. There is a note on page 29 of this exhibit, dated 6 April 1995, that states "Prisoner has a positive attitude and is of a bright [and] cheery nature". This report also notes that he had completed the Ending/Offending Course.

[27] On a file note dated 27 October 1997 (Exhibit D6 p65) it is noted that the deceased had previously worked with the Alice Springs AIDS Council. He facilitated the AIDS Council and STD's Education program in gaol.

[28] A file note dated 11 July 1998 (Exhibit D6 p95) states:

> "(a) At work:
>
> Currently working in Education assisting the Education Officers. He has been noted as an Excellent Worker.
>
> (b) General:
>
> Since the "Camera" incident on the 17/4/98, his conduct has been satisfactory."

[29] On 18 October 2005 he was awarded two Workskills Training Certificates (Exhibit D6 p99-100).

[30] A further report dated 7 April 1998, prepared by a Senior Community Corrections Officer, is included in Exhibit D6 (p155). The first two paragraphs of this report state:

> "I met Clive today. He is in the cottages and has been attending the horticulture course since March, 1998. He presented as an intelligent, well spoken and educated man. He was very forward with his responses and advised the plans he has thought of.
>
> He intends to apply for parole and said he understands what he needs to do. He still wishes to remain in town so he can 'learn' about parole and may look to go elsewhere when he has settled. He wishes to reside with his wife Rosario Young at House 17 Larapinta Valley. He has two children. He said he was living in town prior to going to gaol most of the time."

[31] The deceased had been given an ultimatum by his wife, following the commission of his offence of unlawful entry/criminal damage for which he

was convicted on 15 September 1997, that if he did not behave himself in the future, she would leave him and take the children.

[32] When released on parole on 11 December 1998, he lived at Undarana with his family and complied with his conditions of parole including a condition that he not drink alcohol (Exhibit D6).

[33] At Undarana the deceased was paid Community Development Employment Program (CDEP) wages. He worked doing fencing and stock work. Whilst he was on parole his wife, Rosario Young, became pregnant with their third child. A file note from his probation officer dated 3 August 1999 (Exhibit D6 p87), states that Rosario Young was flown to Alice Springs because of complications with her pregnancy. On her return to Undarana the deceased cared for his wife as best he could (Exhibit D6 p69).

[34] Raelene Impu was born on 5 October 1999. Rosario Young stayed with her in hospital for "a couple of months". The deceased looked after their two boys at Undarana. However, because of complications with Raelene (she had a "patch on her lungs") the deceased would come into Alice Springs from time to time.

[35] The deceased reported to his parole officer on 2 December 1999 (Exhibit D6 p32), that he would like to have members of his family at his outstation involved in a project supported by the Mereenie Management.

[36] On 10 March 2000, the deceased completed his parole and had positive plans for the future and work that he would be involved with (Exhibit D6 p11).

[37] The deceased and Rosario Young with their two sons moved back to Alice Springs. By August 2000, it was suspected that Raelene had tuberculosis. Rosario Young commenced a thrice weekly attendance at Congress for medication for Raelene (Exhibit D45 p30). There was also a period of inpatient treatment. Due to Raelene's illness, the family were residing at Hidden Valley camp. The deceased did not take up the work opportunities he had at Undarana Outstation. Shortly prior to his death, the family had established a family home in Kurrajong Drive so that they would be close to the hospital (evidence of Rosario Young tp 40).

Background of Rosario Young

[38] Rosario Young is a traditional eastern Arrente aboriginal woman, born at Santa Theresa. Apart from six months schooling in Melbourne, Rosario spent all her early years at Santa Theresa and attended the community school. After leaving school she did CDEP work at Santa Theresa.

[39] At a young age she had an arranged traditional marriage with an aboriginal man from Hermannsburg. They had two children. The marriage broke down and she returned to Santa Theresa to live. Rosario Young gave evidence she fell in love with the deceased while he was working at Santa Theresa. He was three years younger than herself. Their relationship was not in compliance with aboriginal law and did not have the approval of their

respective families. They eloped to Katherine. Rosario Young gave evidence that at the end of one year they received word their relationship had been approved. They returned to Undarana. The evidence of anthropologist, Jane Lloyd, is that the birth of their first and second child cemented approval of their relationship. There were three children born to the relationship, Bruce Impu born 19 September 1994, Norman Impu born 17 July 1996 and Raelene Impu born 5 October 1999.

[40] Rosario Young gave evidence she lived with the deceased and their two young children until the birth of their youngest child Raelene. Raelene was diagnosed with tuberculosis. The plaintiff had to stay in the hospital with her baby. During this time the deceased remained out bush with the two boys, Norman and Bruce. Rosario Young then had to stay in Alice Springs to take Raelene to Congress for medication. The deceased worked at Gondawana doing fencing and stock work. He had the two boys with him. The deceased gave his money to Rosario. The family obtained a house in Kurrajong Drive, Alice Springs because of the need for Raelene to attend Congress frequently.

[41] Rosario Young gave evidence, under cross examination by Mr Abbott, counsel for the second defendant. She was being asked about a note on the deceased's medical record that the deceased had told the doctor on New Year's Eve 1999, that he was under a lot of stress with his partner. Rosario gave the following evidence (tp 90-91):

"Was that true, that you and he were undergoing a lot of stress in your relationship?---No.

Can you think of anything about your life at that time, New Years Eve 1999, which might explain why he would tell that to the doctor, that you and he were undergoing a lot of stress?---We did have a row.

A row, did you say?

THE INTERPRETER: Yeah. We did have a row.

MR ABBOTT: What was that row about?---Because he used to go in the car to nightclub, you know.

To what, sorry?---He used to go in the car. He used to go in the car all the time, you know, til dark. Not every time but sometimes.

And did you know where he went?---No.

You wanted him to stay at home, did you?---Yes.

Where did you think he was going?---I don't know.

You must have had some idea. Where did you think he was going that led you to get angry with him?---He used to say he's going to see the family.

And what was your problem with that?---I was want him to stay with me.

Did this problem, excuse me, go on for a long time?---No.

For how long? It wasn't just a one-off argument was it?---No, just probably two days.

That's all? Two days? You can remember just two days or arguments about that thing, can you?---We had a row at home only twice, at 38.

And what was the other argument about?---He wanted two wives."

[42] Rosario Young gave further evidence that she refused this request and the deceased had accepted this (tp 92). Under re- examination Rosario gave the following evidence on this topic (tp 125-126):

> "All right then. Rosario, yesterday you told us … that Kwementyaye came to you and asked your permission to have a second wife. You remember that yesterday?---Yes.
>
> Now, in the Aboriginal way, does the husband ask his first wife if he can have a second wife?---Yes.
>
> And do some Aboriginal women say yes?---Yes.
>
> And do others say no?---Yes.
>
> And you told us yesterday that you said no?---Yes.
>
> Why did you say no?---I told him that if he want that other woman, to leave me and go, but I have my kids with me.
>
> So you would leave him and go if he took a second wife?---Yes.
>
> And did you have experience in your family of men who take on one wife, two wives and so on?---Yes, my grandfather.
>
> Yes. How many wives did your grandfather have?---About three or four.
>
> And did they live together in the same place?---Yes.
>
> And was that something that you had in mind at the time you spoke to your husband about this issue?---Yes.
>
> And was there something that you thought was wrong with living with three or four wives with one husband?---Yes.
>
> What objection did you have to it?---Usually the men, they just sit around and just wait for the women to do everything.
>
> So the men sits around and waits for the woman to do everything?---Yes.
>
> And you didn't want that, is that right?---No."

[43] The evidence of anthropologist Jane Lloyd, is that it is common for aboriginal males in this region to have an expectation that it is possible for them to have a second wife. Ms Lloyd stated the first wife does have the right to refuse, although the first wife is not always able to refuse.

Ms Lloyd stated that in her experience when the first wife is able to exercise her right to refuse, then the husband will accept this. Ms Lloyd gave evidence that a request for a second wife is a desire for the status and benefits of a second wife rather than signifying anything about the quality of the relationship with his first wife.

[44] Rosario Young, the deceased and their three children were living at the family home at Kurrajong Drive, Alice Spring as at the date of the deceased's death.

[45] In accordance with Arrente custom, on the death of the deceased, the family was obliged to leave the house in Kurrajong Drive and their possessions were taken away from them by the deceased's family. The three children were also taken from Rosario Young by the deceased's family for a period of one year. Rosario Young gave evidence this is in accordance with aboriginal law. She also gave evidence about her anger because she was forced to stay away from her children (tp 42). She felt lost, lonely and started to drink too much. She travelled as far as Borroloola.

[46] At the completion of one year, she was reunited with her children. They are now living in a town camp. Rosario Young gave evidence as to the pressures and stresses of living in a town camp. She does not have a husband to turn away drinkers and trouble makers. She is subjected to the jealousy of other women. It is not a lifestyle she would have chosen had her husband not died.

Medical history of the deceased prior to 2 March 2000

[47] This is contained in the Alice Springs Hospital file (Exhibit D3) and the Congress file (Exhibit P13).

[48] The Alice Springs Hospital file (Exhibit D3) refers to an admission on 18 February 1978 when at the age of three years the deceased reportedly fell from a moving car in which he sustained grazes and a fracture to his lower right arm.

[49] On 25 May 1977, he had been admitted with a history of coughing and vomiting with fever.

[50] On 21 July 1980, he was admitted with a history of jamming his right thumb in a door.

[51] Subsequent admissions include an admission involving surgical reconstruction of his distal urethral sub-incision performed in November 1998. In 1989 he was reported to be suffering a long history of severe headaches. On 18 September 1992 he is reported to have cut his right palm when he got caught in between a fight and tried to catch a knife. On 24 June 1993 he sustained an injury to his left ankle in a basketball game. On 3 July 1994 he is reported to have sorry cuts to his right thigh. On 25 September 1996 he was suffering a painful throat. On 3 July 1997 he is reported to have had pilonidal sinus for 11 years.

[52] The Congress file (Exhibit P13) commences with an attendance on 5 January 1997 to obtain dressing material. On 31 December 1999, the deceased attended complaining of pins and needles in both hands and fingers. There had been no recent trauma to his spine and no chest pain. Results of the examination were noted It was also noted:

> "A lot of stress with partner. Advised strongly to seek medical help if chest pain + further problem.
>
> Spoken to wife
> - started as about to have an argument.
> - started at feet & bilateral tingling hands & feets.
> - Stress +++ in family.
> - symptoms going on for a long time.
> (initialled)"

The deceased's attendance upon Dr Boffa on 2 March 2000

[53] Dr Boffa is a specialist general practitioner. He is an accredited training supervisor in general practice having received that accreditation as a training supervisor. He is the public health medical officer with Central Australian Aboriginal Congress. He commenced working for the first defendant in 1994 as a medical officer.

[54] Dr Boffa outlined his experience with ischaemic heart disease in aboriginal people having worked in Tennant Creek from 1988 until joining Congress in 1994. He wrote the protocols in the CARPA manual on coronary heart disease. The curriculum vitae for Dr Boffa is Exhibit D20. The 1997 edition of the CARPA manual is Exhibit D21. Page 52 of the manual is headed "Chest Pain Assessment". Dr Boffa gave evidence it can be hard to

work out the cause of chest pain. Page 52 of the manual sets out the protocols for making the assessment and page 53 sets out the things that can cause chest pain. The protocol, when a person presents with a heart attack or unstable angina, includes sending the person to hospital straight away by ambulance. I accept the evidence of Dr Boffa that by 2 March 2000 he was well aware of the prevalence of ischaemic heart disease in the indigenous population, that it could occur in young men who may otherwise look well and could present with atypical symptoms.

[55] As at 2 March 2000, Dr Boffa was employed by Congress. There were seven or eight other doctors employed as well as administrative staff and 15 indigenous people employed as health workers. Some doctors also had administrative duties. Dr Boffa was the Public Health Medical Officer and Dr Tatjana Janusic was the Medical Officer Co-ordinator which meant half her time was allocated to administrative duties and as part of that role, she would allocate administrative and clinical tasks to other doctors.

[56] Patients at Congress were not allocated to particular doctors. They would be seen by the first doctor available in order of the patient's arrival, unless that patient had asked to see a particular doctor. Patients could be seen first by an aboriginal health worker. Every doctor was made aware it was important to read the summary sheet on the file containing the patients history and the medication they were on. Dr Boffa gave the statistics as being 6,200 permanent residents who would attend Congress on average of more than

seven times each year and about 2,000 visitors who would each come on average three times a year.

[57] In addition, Congress had a range of specialists who would attend from time to time to conduct a specialist clinic. This included a specialist physician. When a patient was referred by a doctor to a specialist, a pink referral form would be used and placed inside the patient's file.

[58] Terry Braun was an aboriginal health worker with Congress and had been so employed for about six or seven years prior to 2 March 2000.

[59] The specialist clinic was in a separate part of the building. On the day of the specialist clinic, the medical receptionist would obtain all the files and take them to the specialist clinic. Dr Janusic was in attendance at the specialist clinic and responsible for following up whatever occurred at the specialist clinic. Sometimes the specialist would fill in the pink form and a copy would be put into the doctor's pigeon hole. This did not always happen. The original of the pink form would stay on the file. The file would be put back into the storage system.

[60] A non-attendance by a patient would be noted in the file by Dr Janusic and she would decide the appropriate follow up plan. The referring doctor would not be told about a non-attendance because the follow up of that patient would be handled by the person co-ordinating the specialist clinic, who, at the relevant time, was Dr Janusic.

[61] I accept the evidence given by Dr Boffa that he could suggest an exercise ECG be carried out but it was only the specialist at the Clinic who could order this be done. Similarly, a general practitioner could not order an angiogram, that would require a specialist.

[62] The system, with respect to a fasting cholesterol test, was that it could be done by either a doctor or aboriginal health worker. Persons who attended for a fasting cholesterol test would be dealt with in order of their arrival.

[63] A cardiac enzyme test would normally only be done in the emergency department at the Alice Springs Hospital. Dr Boffa stated he would not consider doing a cardiac enzyme test in a primary health care setting. He would always send the person straight to hospital if he felt a cardiac enzyme test was required. During Dr Boffa's time in Alice Springs, there would have been 20 to 30 occasions when he had sent a patient directly to hospital with a suspected heart attack.

[64] The Congress Clinic's "Policies and Procedure Manual" was tendered Exhibit D22. This manual was put together early in 2001. Dr Boffa referred to it being a work in progress.

[65] Dr Boffa was referred to the Congress file on the deceased (Exhibit P13). It was agreed between the parties that it was unlikely to be in the original order because of the number of people who have since 2 March 2000, referred to that file.

[66] The medical notes made by Dr Boffa on 2 March 2000 in the Congress file (Exhibit P13) are also contained in Exhibit D23 and read as follows:

"Story:	smokes half a packet per day No alcohol No lunch today Stressed +++ about kids, hard work Pain gone now Retrosternal ***discomfort***, not pain No radiation No sweating, vomiting, nausea Felt shortness of breath with pain ECG – December 31 – normal
Observations:	looks well Afebrile Blood pressure 110/70 Heart rate 76 Throat tick (normal) S1-S2 nil added (normal heart sounds – no murmurs) Lungs clear
Assessment:	Episodic chest pain Not related to exercise
Plan:	fasting cholesterol Monday tick appointment Cease smoking Discussed risk factors for ischaemic heart disease Refer specialist clinic as wants further opinion."

[67] The cause of death on 26 January 2001 was, as found by Dr Michael Anthony Zillman, coronary atherosclerosis, which resulted in coronary thrombosis and failure of the heart as a pump. Dr Zillman was of the opinion that the narrowing of the left anterior descending artery would not have changed much in the 11 month period since 2 March 2000 (tp 139).

Dr Zillman gave evidence that in his opinion it was "more likely than not that there have been previous closing episodes on this narrowed coronary artery". This is supported by the evidence of Dr John Sangster in his report dated 22 November 2005 (Exhibit D31).

[68] The evidence is that on 2 March 2000 aboriginal health worker, Terry Braun, first saw the deceased. He took a history from the deceased which he noted down and this comprises the first entry for 2 March 2000 in Exhibit P13. Mr Braun made the following note:

> "(s) pain in and crushing sensation on (L) of chest, finding hard to breath
> (o) BP 110/70, T37."

[69] Under cross examination by Mr Abbott, counsel for the second defendant, Mr Braun stated he knew the term ischaemic heart disease. He knew that if a person came in complaining of chest pain this could be serious and he would have to get a doctor quickly. He gave evidence he had been told to look for symptoms such as breathing discomfort and pain and that someone having a heart attack could complain of crushing pain in their chest. It is Mr Braun's evidence that he had no memory of the consultation with the deceased on 2 March 2000. Mr Braun gave evidence he usually communicated with patients in English. I find on the evidence that the deceased spoke and understood English well.

[70] I do not accept that the deceased used the words "pain in and crushing sensation on (L) of chest" when he spoke with aboriginal health worker

Terry Braun. The reason I have come to this conclusion is because I accept the evidence of Dr Boffa that he did not accept the history of the health worker. I accept the evidence given by Dr Boffa that on 2 March 2000, he was first approached by health worker Terry Braun saying he had a patient in his room who had crushing chest pain and was finding it hard to breathe. Dr Boffa walked quickly to this room because, on this history, he thought the patient may be having a heart attack.

[71] Once in this room, Dr Boffa realised there was a mismatch between the story as related by the health worker and how the patient appeared. He sat down and took his own history. Terry Braun was present at this time. Dr Boffa gave this evidence (tp 247-248):

> "And could you tell the court what ensured?---Well I am very careful in taking – because the history is the most important thing, I am very careful in not asking leading questions, so I asked the patient an open ended question, such as, 'Can you tell me what's brought you to see us today?' And let him talk. And in that he started to describe …. how he felt and his symptoms and when it got to his own description of his chest discomfort, he didn't use the word pain, he said …. he was short of breath and he said he had this funny feeling in his chest. So, I set about as carefully as I could trying to find a word that would fit best with how he felt, and at the end of that process the word we agreed probably best described it was the word discomfort. But even then …. it was sort of the best word we could come up with but we were having ….. difficulty working out how to describe this sensation he had in his chest. But he was very clear when directly asked, 'Would you describe it as crushing?' He said, 'No'. Straight out in front of Terry. …."

[72] I accept the evidence of Dr Boffa that he was well aware of the importance of the sort of pain the patient was experiencing and the necessity to obtain an accurate history.

[73] I accept his evidence that in his notes he underlined the word discomfort to show that the correct description given by the patient was discomfort, not "crushing pain" and not even "pain".

[74] I accept Dr Boffa's own interpretation of his note that he is stating the retrosternal discomfort, which is often referred to as pain by health professionals, had gone by the time he saw the deceased. I do not consider this to be inconsistent with the evidence Dr Boffa gave at the inquest. I accept his evidence at trial that he understood when questioned at the inquest that he was just being asked to confirm the file note and that there was nothing for him to correct because he was not, at the time of the inquest, asked anything further (tp 413). It is Dr Boffa's evidence that when he interviewed the deceased, on 2 March 2000, the patient was telling him about a pain that he had had but that the pain had since gone. I accept the evidence given by Dr Boffa (tp 403) that as a result of his consultation with the deceased, he was certain the deceased had not used the words "crushing pain" and that the deceased had not had that symptom. I accept the evidence given by Dr Boffa (tp 403):

> "… I'm 100 percent certain that as a result of my consultation I was completely certain that he never had crushing pain and he never used that term. Whatever questions I'd asked and whatever conversation happened, I'm 100 percent certain that I was completely certain that he did not use the term and had never had crushing pain, otherwise I would have done things differently."

[75] I reject the submission made by Mr Barr QC on behalf of the plaintiff that in giving this evidence Dr Boffa was reconstructing what had occurred to

protect himself. Dr Boffa gave evidence that if the deceased had used the words “crushing chest pain” then he would have done things very differently.

[76] I accept the evidence of Dr Boffa (tp 393) that after taking the history from the patient and discussing what he had, Dr Boffa had asked him in front of the health worker “Would you describe the pain as crushing?” and Clive Impu had said “No”. It would have been clearer if Dr Boffa had noted, “patient denies above presentation of pain with crushing sensation” but I accept this was inferred when he wrote “retrosternal discomfort not pain”.

[77] I accept the evidence of Dr Boffa that the reason for his subsequent referrals was because he suspected the chest pain was ischaemic in origin.

[78] It is conceded on behalf of the plaintiff that on all the evidence the deceased’s symptoms on 2 March 2000 were probably ischaemic in origin.

[79] It is further conceded that if the symptoms were caused by a clot, it was probably a clot caught in the stenosed section of the lower anterior descending artery.

[80] The evidence of the expert witness, Dr Sangster, was that for Dr Boffa to form a view that it was reasonable the deceased was suffering a recurrence of a panic attack lends support to the evidence of Dr Boffa that the deceased did not have the symptoms of a heart attack as described by the aboriginal health worker on 2 March 2000.

[81] I accept the evidence of Dr Boffa that in making his notes on 2 March 2000 he used the word pain and discomfort interchangeably.

[82] I also accept his evidence that as at 2 March 2000 he linked the symptoms with the record of symptoms that were noted at the deceased's presentation on 31 December 1999 some eight weeks previously. These notes specifically record no chest pain. In the notes dated 31 December 1999 there is a reference to pins and needles in both hands and fingers. There was a reference to "stress +++" in the family and that the deceased had been "advised strongly to seek medical help if chest pain + further problem". Dr Boffa stated it was not clear to him why an ECG had been ordered on the previous occasion. He gave evidence the history recorded on 31 December 1999 was a common presentation for someone who is severely stressed and having an episode of panic with over breathing. Dr Boffa gave evidence that, after a few minutes of over-breathing you start getting pins and needles in your hands and feet. Dr Boffa stated that, in itself, this would not lead to an ECG being ordered. It is for this reason that Dr Boffa asked the deceased to tell him a bit about his presentation two months earlier as it was Dr Boffa's opinion, as at 2 March 2000, that the deceased was presenting with the same problem as he experienced on 31 December 1999. The result of the ECG indicated the patient was sent to the hospital and returned with the results which were NAD "no abnormalities detected". Dr Boffa gave the following evidence (tp 249):

> "… And so my impression was primarily what we were dealing with here was someone who was very stressed, who had emotional upsets happening, who was getting episodes of panic and over breathing. But I was thinking maybe in the heat of those episodes he is getting fixed ischemic chest pain which is a form of chronic stable angina, which is not acute coronary syndrome. And so that's what I was thinking. Here's this man, he's young, getting episodes of severe distress and stress with over breathing at the same time, getting ischemic chest pain, which put him in the category of someone with stable angina because it had been there for several months, at least two months but probably longer. And unstable angina is angina that occurs within four to six weeks, six weeks maximum. So I was wondering whether we had a situation of someone who had potentially or possible stable angina, not in any way someone who's having a heart attack."

[83] Dr Boffa gave further evidence that his postulated diagnosis was that the deceased was in a high stress situation, that this stress was coming from his relationship, his children and his work situation and that he was having a panic attack. It is normal with a person experiencing a panic attack to have chest discomfort which is a muscular tension.

[84] I am satisfied that Dr Boffa was very thorough in his interview with the deceased on 2 March 2000 in carefully analysing the previous presentation on 31 December 1999. Dr Boffa did consider doing another ECG but decided against this as without pain the chances of an ECG showing signs of ischemia were negligible. Dr Boffa also thought it important to be careful what tests he ordered so as not to lose credibility. In his experience young aboriginal men were not good at coming back for appointments and he wanted to pick a test that would give maximum results.

[85] Dr Boffa stated he wanted to find out the cholesterol reading because that was a risk factor of ischaemic heart disease. He gave the deceased an appointment card to come in to Congress on the following Monday for a fasting cholesterol blood test. Dr Boffa stated he could not be sure but he thought the deceased's wife was with him the whole time. There is no evidence from Rosario Young that she did attend on this appointment.

[86] I accept the evidence of Dr Boffa that he spent a considerable time talking to the deceased about the risk factors of ischaemic heart disease which included telling the deceased to stop smoking because this was a risk factor. The deceased's blood sugar level was normal so there was no requirement for a fasting sugar test. The deceased did not have diabetes, his cholesterol was not known but he did smoke. These are the four main risk factors of ischaemic heart disease. I accept the evidence of Dr Boffa that in his discussion with the deceased the deceased was aware of the problems with smoking. I accept that Dr Boffa also explained to the deceased the purpose of an exercise test and advised him he would have to refer him to a specialist to get that done. I accept the evidence of Dr Boffa (tp 257) that he explained to the deceased what ischaemic heart disease was, being an obstruction of the blood vessels in the heart which causes narrowing and can damage the heart muscle. I accept Dr Boffa told the deceased that ischaemic heart disease was a serious problem, although Dr Boffa thought it a small possibility, and that it was essential to do the tests to rule it out. I am satisfied Dr Boffa did explain to the deceased he would have to fast after

dinner on Sunday night for the cholesterol test first thing on Monday. Dr Boffa then completed a pink referral form (Exhibit P13A). He then gave the deceased a yellow appointment card with Monday's date on it, this being the date of the appointment for the fasting cholesterol test. Dr Boffa had made a telephone call and asked for the deceased's name to be put into the appointment book for the next specialist clinic. I accept Dr Boffa's evidence that he then gave the deceased another yellow card with the date of the specialist clinic and the reason for the appointment was "query heart trouble". Dr Boffa could not remember if he filled out the pink form (Exhibit P13A) in the presence of the deceased but said he would normally do it just after the patient left. I accept the evidence of Dr Boffa that in completing this pink form he was letting the specialist know that he could not be certain it was ischaemic heart disease but he thought it could be. Dr Boffa also suggested on the pink form that the patient should probably have an exercise ECG. He also drew to the attention of the specialist that he had made notes concerning chest pain.

[87] I accept the evidence of Dr Boffa that he put this pink form at the front of the file. This is the prompt indicating what needs to be done.

[88] Dr Boffa believed the deceased would attend both his appointments for the cholesterol test and the specialist clinic for the exercise test, particularly as it was the deceased who said he wanted a specialist opinion and seemed keen to follow it through. I accept that two weeks was a reasonable waiting

time for the attendance at the Clinic. This time delay did not put the deceased at risk.

[89] The deceased left the surgery.

[90] It is not in dispute that the deceased failed to attend for the fasting cholesterol test the following Monday and also failed to attend the Clinic for the specialist appointment on 21 March 2000. There is no evidence as to why he failed to attend these appointments.

Medical history of the deceased 2 March 2000 – 26 January 2001

[91] The Progress Notes for the deceased (Exhibit P13), maintained by the first defendant, show that the deceased next attended Congress on 23 April 2000 for boils and was treated for this condition. On 28 May 2000 he again attended Congress complaining of boils and that he had lost his medication. He was treated for this condition. On 29 December 2000 he attended Congress and was treated for a dog bite.

[92] There is no indication that on any of these occasions the deceased raised the matters addressed by Dr Boffa at his attendance on 2 March 2000. There is no evidence he attended upon Dr Boffa after 2 March 2000.

[93] I infer from the notes of his attendance on the three occasions mentioned above, that the doctors or health workers who attended him on those dates did not refer back to the notes made by Dr Boffa on 2 March 2000. None of the notes make any reference to the attendance of the deceased on 2 March

2000 or that any query was directed to the deceased as to what had occurred following his referral for the fasting cholesterol test or his referral to the Physician's Clinic. There is also a brief note made in the Progress Notes on 2 January 2001 which does not take the matter any further.

[94] The deceased attended Congress on 26 January 2001. He was attended to by Dr Morrison who made the following note:

> "26/1/01
>
> 12.30pm (Clinic closing time 12.30pm)
> Call put through to me by receptionist Tracey.
> Spoke to wife of patient. She asked if I minded staying back at the clinic to give her husband some anti-inflammatory tablets for an injury that he had. I said that would be OK.
>
> 1pm Clinic staff go home except for myself.
> Staff that left were receptionist Tracey, Aboriginal Health Worker, Alicia , driver, Sid and Dr Tania Janusic.
>
> 1pm I briefly spoke to Clive Impu and his wife.
> Patient said that he had an intermittent pain in his right axilla that had first occurred about September 2000 at the end of the football season in which sport he was a player. The patient had been waiting in the waiting room for about twenty minutes by this time and did not seem to be in any distress. He was only requesting repeat of the medication that he had been given at the Alice Springs Hospital. I did not examine the patient as he only requested repeat medication. I suggested that patient might be helped by a chiropractor and he said he knew of one in Larapinta Drive, Alice Springs. The patient could not remember the brand of anti-inflammatory tablets that he was taking so I gave him a packet of Celebrex capsules from the clinic pharmacy.
>
> I did not think that the patient had any pain in the clinic. I do not recall him saying he did.
>
> N.B. I did not have access to any past notes relating to the patient as only receptionists access the files at Congress. They are stored under a code number for security purposes. I did not realize that I did not have the patient's file until after the receptionist had gone home.

> 1.45pm I was still doing paper work in the clinic and received a phone call from St John Ambulance saying that the patient had collapsed on his way home from Congress clinic and that he had been taken to hospital by ambulance.
>
> 1.50pm Phone call from a nurse at hospital asking, what tablets had been given to the patient. I said Celebrex only.
>
> 2.00pm Phone call from a police officer informing me that patient had died and would I be able to write a death certificate. I said no, as I did not know that patient had any serious illness.
>
> I then went straight to the Emergency Dept. of Alice Springs Hospital where I spoke to Dr David …… (doctor in charge), police officers and then I personally checked the vital signs of the patient and noted absent carotid pulses and fixed dilated pupils. I then gave my condolences to patient's wife who was sitting in a car outside the Emergency Dept. of ASH.
>
> NB. I checked the patient's box of Celebrex was still full – none missing."

[95] Following his attendance at Congress on 2 March 2000, there is evidence the deceased also attended the Alice Springs Hospital. The evidence contained on the Alice Springs Hospital file (Exhibit D3) is that the deceased attended on a number of dates after his consultation with Dr Boffa on 2 March 2000.

[96] On 15 August 2000 he was attended to at the Alice Springs Hospital by Dr Anthony Seshakumaran Dharmaretnan "with a history of right sided chest pain on and off for the past few days playing football. He thinks it could be due to an un-noticed injury during play. There is not prior history [of] similar nature." Dr Dharmaretnan then noted lack of any respiratory problems and observed the pain was of "muscular skeletal origin". The diagnosis on discharge was "muscular pain".

[97] On 3 December 2000 the deceased again attended Alice Springs Hospital. He was examined by Dr Barbara Allen. The doctor detailed her observations. The deceased complained of pain to his right axilla after "throwing rocks at ducks". The diagnosis was "musculoskeletal problem (R) axilla".

[98] On 30 December 2000 the deceased again presented to the Emergency Department Alice Springs Hospital. The doctor attending him noted "says hurt muscles in (R) arm + (R) side chest after throwing rocks today into a pool!" It was noted he had "no central chest pain nil pain at present". The doctor on that occasion recorded other results of the examination and concluded with the diagnosis "musculoskeletal".

[99] On 2 January 2001 the deceased presented to Alice Springs Hospital Emergency Department "with symptoms of generalised body aches; mild throat soreness, congested eyes and tiredness since this morning".
Dr A. Daftary made detailed notes of his observations and examination. The diagnosis was that the deceased had the flu.

[100] On 26 January 2001 the deceased was brought into the Emergency Department of Alice Springs Hospital by ambulance. It is noted the CPR started at 1320 hours followed by other resuscitation attempts. He was pronounced dead on arrival at Alice Springs Hospital at 1355 on 26 January 2001.

[101] Under the heading "Relevant History, Investigations, Findings and Unresolved Problems", appears the word "Nil".

Expert Medical Evidence

Dr Michael Anthony Zillman

[102] Dr Michael Anthony Zillman is a specialist forensic pathologist. He carried out an autopsy on the body of Clive Impu on 30 January 2001. The autopsy report is Exhibit P8. A coloured diagram of the heart is Exhibit P9 and a black and white drawing of a heart provided by Dr Zillman is Exhibit P10.

[103] In his report, Dr Zillman gives the cause of death as follows:

> "1(a) Coronary Thrombosis.
>
> 1(b) Coronary Atherosclerosis."

He makes the following comments:

> "1. The cause of death was coronary atherosclerosis (ie. fatty narrowing of the coronary arteries which supply blood to the heart), which resulted in coronary thrombosis (ie. the formation of a blood clot in a coronary artery) and consequent damage to heart muscle, with failure of the heart as a pump.
>
> 2. The presence of scarring of the heart muscle (ie. myocardial fibrosis) is consistent with the effect of long-standing coronary artery disease."

[104] Dr Zillman stated in his results of investigation that there was extensive myocardial fibrosis and the evidence of narrowing to the deceased's left anterior descending coronary artery (LAD). It is Dr Zillman's opinion that the myocardial fibrosis suggests that this is a process that has been going on

for several months to years. There was evidence of myocardial fibrosis on the cross section of the heart muscle. It is Dr Zillman's opinion that it is more likely than not there were previous clotting episodes on the deceased's narrowed coronary artery. Under cross examination by counsel for the first defendant Ms Gearin, Dr Zillman agreed in the case of Clive Impu Jnr the clot was formed by turbulent blood flow. Dr Zillman was taken through the various attendances by the deceased at the Alice Springs Hospital subsequent to his presentation to Congress on 2 March 2000. It is Dr Zillman's opinion that given the history of these subsequent attendances, the narrowing of the artery is likely to have been there for more than 12 months or so. It is his belief that the narrowing was present in March 2000 and during the course of those months to 26 January 2001 would have changed very little. The fact there was intermittent chest pain meant it was more likely than not that the blood clot was forming at the point of narrowing and remaining there long enough for symptoms to be produced. Dr Zillman stated that if the deceased had been diagnosed as having a narrow coronary artery in August 2000, or on any date before his death, then appropriate treatment could have been instituted and it is more likely than not he would have survived. The reference to "marked fatty change. Focal lobular inflammation" in the autopsy report means that within the last few days prior to his death, the deceased had consumed an excessive amount of alcohol.

[105] Under cross examination by counsel for the second defendant Mr Abbott, Dr Zillman agreed there can be ischaemia of the heart without symptoms. He agreed there was no evidence in the heart of a previous infarct.
Dr Zillman agreed that the scarring he saw is likely to have occurred over a period of time and it would be impossible to say that one particular event caused that scarring. Dr Zillman gave evidence that retrosternal discomfort is a much vaguer symptom than crushing chest pain and could not be attributed to myocardial ischemia. He stated that "crushing chest pain" suggests a more severe myocardial ischemia. Dr Zillman expressed the opinion that the deceased had been forming multiple clots of varying size over a long period of time. He agreed there is an association between smoking and the onset of ischemic heart disease.

[106] Under re-examination by Mr Barr QC, counsel for the plaintiff, Dr Zillman gave evidence that the reference to pins and needles when the deceased presented to Congress in December 1999, would not suggest to him that the "origin was a cause in the heart". He gave evidence that a crushing chest pain is a significant indicator of myocardial ischemia (tp 148). It is the opinion of Dr Zillman that the comments of doctors who saw Mr Impu at the various times he attended Alice Springs Hospital after his presentation to Congress on 2 March 2000, do not of themselves indicate myocardial ischaemia.

Dr George Stuart Hale

[107] Dr George Stuart Hale is a specialist cardiologist (tp 291) who is currently a consultant cardiologist at St Vincent Hospital in Melbourne. Reports from Dr Hale are Exhibit P27 and Exhibit P29.

[108] Dr Hale gave evidence that the reference in the Congress notes of 2 March 2000 to "crushing sensation on (L) side of chest, finding hard to breathe" and "retrosternal discomfort", meant that the severity of pain would raise a strong suspicion of a coronary basis for the pain. He stated that in all probability the deceased suffered acute transient obstructions through thrombosis which meant the pain did resolve by the time he was being questioned. This would suggest the obstruction had also been resolved. Dr Hale described what happens to the thrombosis to cause the obstruction to cease. He agreed, after having seen the autopsy report, that it was possible that, after the thrombosis has dissolved, it had spread more diffusely through the coronary arteries. It is Dr Hale's evidence that if a patient presents with any sort of central chest pain it is mandatory to obtain an ECG and a cardiac enzymes test. He stated this was also mandatory in March 2000 and that these tests should have been done as soon as possible after that date.

[109] Having reviewed the notes of the deceased's presentation to the Alice Springs Hospital subsequent to his presentation to Congress on 2 March 2000, it is Dr Hale's evidence that these subsequent presentations did not

paint a picture of ischemic type pain. He queried why there was no communication between Congress and the Alice Springs Hospital to correct the impression that there was no previous history of a similar nature. He stated there was no negligent medical practice by the doctors at the Alice Springs Hospital from August 2000 onward because, if the symptoms are not typical it is very difficult to be sure that the patient has an ischemic condition.

[110] Dr Hale was then asked to give an opinion as to the life expectancy of the deceased assuming he had received the appropriate diagnostic treatment in mid 2000. It is his opinion this would be in the order of 10 to 12 years and if the deceased stopped smoking, the outer limit would probably be 15 years.

[111] Dr Hale was cross examined by Ms Gearin for the first defendant (tp 301). He stated if the deceased had continued smoking this would have reduced his estimates of life expectancy by 20 percent. Dr Hale gave evidence he had not been aware of the deceased's failure to tell anyone at Alice Springs Hospital what Dr Boffa had told him, or that he had failed to attend at the specialist clinic or for the fasting cholesterol test. Dr Hale agreed that given appropriate investigation and treatment in August 2000 when the deceased attended Alice Springs Hospital there would have been a good outcome for the deceased. Dr Hale was provided with certain transcript pages of the evidence given by Dr Boffa. This was the evidence of Dr Boffa as to what he said and did when Clive Impu presented to Congress on 2 March 2000. Dr Hale maintained that if the deceased's presentations at Alice Springs

Hospital were treated as separate and isolated events then there were difficulties in making a diagnosis of myocardial ischaemia in August and December. Dr Hale agreed that if Clive Impu had told the people at Accident and Emergency at Alice Springs Hospital what Dr Boffa had told him in March 2000, it is highly probable he would not have died on 26 January 2001. He stated he still had reservations about whether the history was appropriately taken at all times. Dr Hale was also cross examined by Mr Abbott, counsel for the second defendant (tp 315). Dr Hale agreed that he considered the conduct by Dr Boffa, in referring Clive Impu to a cardiac specialist following a consultation with him on 2 March 2000, was entirely proper. It is his evidence that at the time the deceased presented to Dr Boffa on 2 March 2000, there was sufficient indication to obtain an ECG and cardiac enzymes test as well as the specialist advice. Dr Hale agreed that the only reason for sending Clive Impu for an ECG on 31 December 1999 was because the doctor on that date had some suspicion the heart might have been involved. He stated he found it difficult to understand why an ECG was not done in March 2000 when it had been done previously. He agreed after cross examination about the dates that the ECG on 31 December showing normal and the presentation on 2 March 2000 was more recent than he had previously thought. Ultimately Dr Hale agreed that he could not criticise Dr Boffa's decision on 2 March 2000 to refer the deceased to a specialist with a suggestion that the specialist order an exercise ECG. He agreed that if the deceased did not suffer crushing chest

pain in addition to retrosternal discomfort and that he suffered or complained of retrosternal discomfort and not pain, then the symptoms were not severe in the way he had assumed and that they would be equivalent to the August and December episodes. Dr Hale agreed it was proper for Dr Boffa to refer Clive Impu to a specialist for the purpose of excluding ischaemic heart disease. It is Dr Hale's evidence he would have preferred a referral for an ECG and cardiac enzymes test. He agreed that the exercise ECG test could be normal. It would depend on the level of narrowing in the coronary artery apart from the thrombus.

[112] Under cross examination by Ms Kelly for the third party, Dr Hale gave evidence concerning the importance of a good diet and avoiding foods with a high fat or sugar content. He agreed a good diet and not smoking were important to avoid ischaemic heart disease.

[113] In re-examination Dr Hale stated that in the presence of scarring there would be some abnormality on the ECG with the stress of exercise.

Dr John Sangster

[114] Dr John Sangster gave evidence he is a cardiologist and has practised as a cardiologist in the Northern Territory and other parts of Australia. His report with an accompanying letter from Morgan Buckley to Dr Sangster dated 4 July 2005 is Exhibit D30. Further letters, reports and a curriculum vitae for Dr Sangster were tendered Exhibits D31 to D34 inclusive.

[115] In his report dated 22 November 2005, Dr Sangster had provided answers to a number of questions raised by lawyers for Dr Boffa.

[116] In his evidence to the court he stated that assuming the history that Dr Boffa took, there was no reason for Dr Boffa to order a normal ECG. This is because there could have been many causes for the patient's discomfort. The patient was not recorded as experiencing radiation, sweating, vomiting or nausea and he felt a little short of breath with the pain. Dr Sangster further stated that ordering a blood sample for the testing of enzymes was unlikely to be helpful in that situation unless the pain had been sustained for at least half an hour and probably longer. When asked about the symptoms outlined in the case note of the consultation on 31 December 1999, Dr Sangster stated these were consistent with hyperventilation, being anxious and stressed. They were not symptoms of cardiac problems. He stated that if Dr Boffa formed the view on 2 March 2000 that the symptoms the patient was presenting with on that day were a recurrence of a panic attack which he seemed to have suffered on 31 December 1999, then that was a reasonable conclusion to draw.

[117] This evidence was based on an assumption that Dr Boffa having seen an entry made by the Aboriginal Health Worker about crushing pain or sensation in his chest, took a fresh history from the patient and ascertained that it was retrosternal discomfort and not "crushing pain". It is Dr Sangster's evidence that this, together with the similar history taken on 31 December 1999 that the deceased had felt a similar discomfort in his

chest when he had done the ECG test on 31 December 1999, meant it was reasonable for Dr Boffa to conclude that the 2 March presentation was probably a panic attack or some sort of stress induced symptom.

[118] I have already found that I accept the evidence of Dr Boffa that on 2 March 2000 he had seen the entry from the Aboriginal Health Worker but on making his own further enquiry ascertained the patient had not used the phrase “crushing pain” and that he had never had “crushing pain” but rather had felt retrosternal discomfort.

[119] It is Dr Sangster’s evidence (tp 343), that he is of the opinion Dr Boffa took the proper action in referring the deceased for a fasting cholesterol test and suggesting to the specialist who attended the Physicians Clinic to consider ordering an exercise ECG on 21 March 2000. It is Dr Sangster’s evidence that Dr Boffa was being extremely cautious to make sure there was not a problem. Dr Sangster stated that on the history provided in the notes he would be very surprised if the deceased had suffered a heart attack on 2 March 2000.

[120] Dr Sangster stated that there was a very low chance that a resting ECG would have shown a positive result or show an abnormality given that the deceased had undertaken a resting ECG just over two months earlier which had shown normal. It is Dr Sangster’s opinion that to receive any useful information for or against the presence of heart disease, then Dr Boffa would have needed to do something more than a resting ECG. It is also

Dr Sangster's opinion that ordering a cardiac enzyme test would have an almost zero chance of coming back with a positive result and it would require at least an hour of infarction to produce any rise. Dr Sangster gave detailed reasons as to why it would not have been appropriate to have ordered an angiogram with respect to the deceased. Dr Sangster agreed that the life expectancy of the deceased would be significantly shorter than a man with normal coronary arteries as he had developed coronary artery disease at a young age. It is Dr Sangster's evidence that he would be surprised if any of the myocardial fibrosis evident on post mortem was due to the event on 2 March 2000. Dr Sangster agreed that, from his own experience in the Northern Territory dealing with young aboriginal men, it was important to select a test that would give the most information when trying to exclude a problem. This was why Dr Boffa would have suggested an exercise ECG and not another resting ECG.

[121] Under cross examination by Ms Gearin, counsel for the first defendant, Dr Sangster agreed that when the deceased consulted Dr Dayaratne at the Alice Springs Hospital on 15 August 2000, it would have been very helpful for Dr Dayaratne to have known about the consultation with Dr Boffa some months earlier. Similarly, it would have been helpful if, when attending Dr Barbara Allen on 3 December 2000, the deceased had advised her that he had not attended for the fasting cholesterol test some months earlier and had not attended to have the exercise ECG test. It is Dr Sangster's evidence that the symptoms described in the notes when the deceased attended at the Alice

Springs Hospital on 30 December 2000 and again on 2 January 2001, were not in any way typical of heart disease.

[122] Under cross examination by Ms Kelly, counsel for the third party, Dr Sangster agreed that a diet consisting of food with a high content of saturated fats, fried food and fast food would be a risk factor in heart disease as would a high blood sugar level. He stated he would have ordered a fasting blood sugar test at the same time as a cholesterol test.

[123] When cross examined by Mr Barr, counsel for the plaintiff (tp 357), Dr Sangster gave evidence that even if the deceased had given up smoking, adopted a healthier diet and been placed on an appropriate medication regime, he thought it quite likely the deceased would have died well before the age of 55 years.

Dr Sam Heard

[124] Dr Sam Heard is Chair of the Board of the Northern Territory General Practice Education, Australia. He is a general practitioner who has worked as an academic and teacher as well as clinically in the Northern Territory since 1993. Dr Heard prepared a report on the death of Clive Impu for the Coroner in 2001. A copy of this report, Dr Heard's curriculum vitae and various other documents were tendered (Exhibit D41). A great deal of the report prepared by Dr Heard dated, 6 May 2001, deals with the actions of Dr Morrison and are not relevant to the matters I am required to consider. In reviewing the actions of Dr Boffa on 2 March 2000, Dr Heard concluded

that in his opinion, Dr Boffa's treatment of the deceased was entirely appropriate.

[125] Under cross examination by Ms Kelly for the third party, Dr Heard stated he considered it appropriate to have a medical practitioner reviewing the files for attendees at a specialist clinic because of the judgment involved in deciding what form of follow up action to take. It is Dr Heard's opinion that he would expect in the situation where the medical practitioner in charge of the specialist clinic received a file with a referral to a specialist and that patient had not attended for some months and then only for treatment for physical wounds, then the medical practitioner in charge of the Clinic would make some further inquiries as to why that person had been referred to a specialist clinic. Dr Heard stated he would expect the person administering the Clinic to make enquiries about the referral information and point out the possibility of error.

Findings with respect to the Expert Medical Evidence

[126] I accept all of the evidence given by Dr Zillman. In particular I accept his opinion as to the cause of death. I accept his evidence that the narrowing of the artery he found on post mortem was also present on 2 March 2000.

[127] I accept the evidence given by Dr Sangster that the action taken by Dr Boffa on 2 March 2000 was appropriate and reasonable. Dr Sangster's opinion is supported by the evidence of Dr Heard. I accept the evidence of Dr Sangster that there would have been no point in ordering a further resting ECG or a

cardiac enzyme test. The deceased had been given a resting ECG on 30 December 1999 which showed normal. Dr Hale did not appear to be aware, until it was put to him in cross examination, that in fact it was only a little over two months prior to 2 March 2000 that the deceased had undertaken a resting ECG which showed normal. I accept the evidence of Dr Sangster that a cardiac enzyme test would not have provided the necessary information and was pointless at that time.

[128] Dr Hale based his opinion on a factual assumption that the deceased had attended Congress on 2 March 2000 with "crushing chest pain". This was an understandable assumption from the note of the health worker Terry Braun in the clinical notes for 2 March 2000. However, the evidence of Dr Boffa, which I have accepted, is that the deceased did not have "crushing chest pain" when he attended Congress on 2 March 2000, that it was not the deceased who used that term and that the deceased had never had "crushing chest pain". Accordingly, the opinion formed by Dr Hale was formed on a factual basis that is not supported on the factual findings.

[129] Dr Hale appeared reluctant to accept that the history he had proceeded upon was not the complete history. In his cross examination by Mr Abbott, counsel for the second defendant, Dr Hale appeared to be resisting a request to reassess his opinion in light of a different factual basis to the one on which he had based his written reports.

[130] There is no challenge to Dr Hale's expertise. I accept he is a highly qualified and experienced cardiologist. However, in this particular case, his opinion with respect to the actions of Dr Boffa is rejected because it is not based on the Court's ultimate finding of fact.

[131] In accepting the evidence of Dr Sangster, I accept that Dr Boffa proceeded appropriately in not seeking an angiogram as at 2 March 2000 and not requesting other tests other than making an appointment for the deceased to have a fasting cholesterol test on the following Monday and then an appointment with a specialist at the Physician Clinic on 21 March 2000, being the first Physician Clinic to be held after 2 March. The evidence of Dr Heard is also in support of a finding that what Dr Boffa did on 2 March 2000 was reasonable and appropriate.

[132] I accept the evidence of Dr Sangster supporting the opinion of Dr Boffa, that it is important when treating young aboriginal men to ensure any further tests to be done are those that give the most important information. I accept Dr Boffa has had a great deal of experience in treating young aboriginal men and that his approach in these circumstances was reasonable. I accept the evidence of Dr Boffa that had he considered there was any urgency, he would have referred the deceased immediately to the Alice Springs Hospital.

Dr John Dominic Boffa

[133] The next involvement Dr Boffa had after 2 March 2000 was when he was telephoned on Saturday 26 January 2001 to be advised that the deceased had

died. Dr Boffa stated the deceased's file was extracted and the matter followed up.

[134] It is Dr Boffa's evidence that the system at Congress did not provide for him to be made aware whether or not the deceased had attended for the cholesterol test. Dr Boffa described the access arrangements at Congress and gave evidence that because aboriginal people had such ready access to Congress if they missed an appointment for a cholesterol test it would be done the next time they came in. It is his evidence that with this particular patient if he did not attend for the fasting cholesterol test that would have been picked up when he attended the physicians clinic two weeks later. In all probability, the clinic would have given him a non fasting cholesterol test which would provide them with sufficient information.

[135] The clinic scheduled for 21 March 2000, had been cancelled. It became obvious, during the course of the investigation into the death, that the wrong file had been produced to the clinic on 21 March 2000. There was a note made on that date in another file which bore the same name "Clive Henry Impu". The deceased himself did not attend the clinic.

[136] I accept the evidence of Dr Boffa that it was not his responsibility to get the file out for the clinic. There is an appointment book which has the client's file number on it. That file had to be extracted by an administrative person in the office and provided to the doctor in charge of the clinic on that

particular day, in this case, being 21 March 2000. On that date Dr Janusic was in charge of the specialist clinic.

[137] The system in place at that time at Congress when a person failed to attend the clinic, was to follow up the patient either by telephone or by facsimile and notify the patient of the need to attend the next specialist clinic. Dr Boffa earlier gave evidence the specialist clinics were held fortnightly.

[138] It is Dr Boffa's evidence that, having referred the deceased to a specialist, he would have subsequently received a letter from the specialist advising of the result. I accept his evidence that there was nothing for him to follow up. It was only the specialist who could order an exercise ECG and then, if appropriate, an angiogram. Dr Boffa stated the doctor organising a particular clinic would be responsible for following up a patient who had failed to attend the clinic. This did not happen in this instance because the wrong file had been produced at the clinic. That was not Dr Boffa's responsibility.

[139] I accept the evidence of Dr Boffa that it was not appropriate for him to order another resting ECG test as the one ordered two months before had shown no abnormality. I accept it was more important for him to concentrate on more significant tests. I find that there was no negligence in failing to carry out a blood test for cardiac enzymes on 2 March 2000 as Dr Boffa had concluded the patient was not having a heart attack and such a test would be

irrelevant. The evidence of Dr Boffa on these matters is supported by the evidence of Dr Sangster to which I have already referred.

[140] I accept the evidence of Dr Boffa that he would normally receive a letter from the specialist as to the result of the patient's attendance. However, he had no responsibility for any follow up procedure because the procedure at that time at Congress was to take any follow up action out of the hands of the medical practitioners and have the doctor in charge of the clinic take the appropriate follow up action.

[141] Dr Boffa was referred to the Congress Clinic Policy and Procedures Manual (Exhibit D22 p48) which provides that stress ECG's, also known as exercise ECG's, can only be booked by Alice Springs Hospital physicians. Page 49 paragraph 7.5 deals with the details required to be included in a referral. Page 50 sets out the steps for making a referral. Paragraph 5 on page 50 sets out the procedure when a patient fails to attend a clinic. This requires a staff member responsible for the specialist clinic to advise the referring practitioner the patient has not been seen. Dr Boffa gave evidence that this procedure had only been adopted in recent months. It was not in place in March 2000. At page 39 the Policies and Procedures Manual provides that it is the responsibility of the Clinic Receptionist to get the patient files out of the filing system and to put the files away. Dr Boffa agreed that if the wrong file was produced then it meant the Clinic Receptionist had obtained the wrong file and given it to the doctor in charge of the clinic who, on 21 March 2000, was Dr Janusic.

[142] Dr Boffa was referred to page 35 of Exhibit D22. The last paragraph under the heading "Following up transport bookings" reads:

> "Drivers are responsible for writing down the outcome for each person whose name is recorded in the transport booking book. Besides being 'brought to the clinic', possible outcomes can include no-one home, at home but didn't want to come in, wrong address etc. If there is anyone at the house, the driver should try and find out where the person is, for example if they are 'up town' or 'gone bush' – if so to where.
>
> Any bookings marked with a * need follow up by Clinic staff if they do not attend. The Clinic Coordinator and Medical Officer Coordinator are responsible for arranging this follow up."

[143] Dr Boffa gave evidence that the system at Congress was, that the responsibility was on the Clinic Coordinator to follow up a non attendance and it was not the responsibility of the referring practitioner. It was not until after the death of Clive Impu on 26 January 2000 that Dr Boffa was made aware the deceased had never attended the fasting cholesterol test or the physicians clinic.

[144] Dr Boffa was asked to look at the Alice Springs Hospital file and the note of attendances by the deceased at the hospital subsequent to 2 March 2000. He gave evidence that had the deceased presented again to himself at Congress he would have wanted to know why there had been no attendance for the cholesterol test or at the clinic for the exercise test.

[145] Under cross examination, Dr Boffa gave evidence that, at the time of the death of Clive Impu that he, Dr Boffa, was the Public Health Medical Officer responsible for the evaluation of systems in place and the ongoing

assessment of quality practise at Congress. On being informed about the death of Clive Impu, Dr Boffa commenced an investigation. Dr Boffa stated this was not a formal investigation which is what Congress would undertake if the death occurred now, but they did look into it. He spoke with Dr Morrison who had seen the deceased within an hour prior to the deceased's death. Dr Boffa was concerned as to the brevity of Dr Morrison's notes. He told Dr Morrison there would be a Coronial Inquiry and it would be very important that Congress have a clear understanding of what had happened so they could assess whether there were any system failures. Dr Boffa described Congress as a clinic providing multi-disciplinary primary health care and stated that it was not a hospital (tp 279). During 2000 and up to 2002, Congress was open from 8.30am – 8.00pm on weekdays with a doctor on call all night. It was open from 8.30am – 12.30pm on Saturday and Sunday with a doctor on call after these hours.

[146] Dr Boffa stated under cross examination by Mr Barr QC, counsel for the plaintiff, that if the deceased did have the symptoms as noted by the Aboriginal Health Worker Terry Braun, he would have sent him to hospital and requested a lot of other tests. Dr Boffa gave evidence that at that time, Congress relied upon an opportunistic system which meant that if patients failed to attend for a cholesterol test, they would be given it on their next visit. A new computer system has since been installed whereby the computer will pick up a non-attendance and flag that for the next

practitioner. In the year 2000 the system relied upon the next practitioner picking up the fact there had been a non-attendance. In this case, it would have been obvious from the notes on the file. A subsequent practitioner or Aboriginal Health Worker would have access to the file. Dr Boffa gave evidence there was, in 2000, a procedure at Congress whereby every aboriginal person over the age of 15 years was to have an annual health check. In this case the prompt already existed in the notes on the summary page that there was a need to follow up the fasting cholesterol test.
Dr Boffa agreed the system had failed because, on the three subsequent occasions that the deceased had attended Congress, being 23 April, 28 May and 29 December 2000, when he was seen by other health practitioners, he was not given any form of cholesterol test. Nor was there any indication that Dr Boffa's notes of 2 March 2000 had been read and followed up by any of the doctors or health workers at Congress who subsequently attended upon the deceased.

[147] The law relating to the duty of care owned by a medical practitioner is set out in *Rogers v Whitaker* (1992) 175 CLR 479 at 483, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ:

> "… The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case."

[148] I accept the submission made by Mr Barr QC on behalf of the plaintiff, that in the present case the standard of care and skill owed by Dr Boffa was that of an ordinary skilled general medical practitioner specialising in the provision of primary health care to aboriginal people in Central Australia, with extensive experience in that role in the Northern Territory since 1988.

[149] I further accept that the content of Dr Boffa's duty required that he take an adequate history of the deceased's presenting symptoms, seriously consider the presenting symptoms and then treat for the possibility, if not the probability, that the deceased had suffered an acute but transient obstruction through thrombosis in his coronary artery and/or that the deceased had undiagnosed ischaemic heart disease.

[150] I do not accept the submission that Dr Boffa had a duty to immediately refer the deceased to the Alice Springs Hospital for an ECG and cardiac enzyme testing or, alternatively, for an assessment by Congress of ECG and cardiac enzyme testing.

[151] Ironically, Dr Boffa was the only doctor, of the treating doctors whom the deceased consulted between March 2000 and the date of his death on 26 January 2001, who raised a concern about possible ischaemic heart problems and who referred the deceased for tests and advised the deceased of his concerns.

[152] Dr Boffa gave reasons, which I have already outlined, as to why he did not refer the deceased to Alice Springs Hospital and why he chose to refer him

for a fasting cholesterol test and to a specialist physician for an exercise ECG rather than obtain another resting ECG and a test for cardiac enzymes. I am not satisfied that, on the balance of probabilities, Dr Boffa was negligent or failed in his duty of care to his patient by proceeding in the way that he did.

[153] Unfortunately, the deceased apparently chose not to follow up on either of the procedures as suggested by Dr Boffa.

Failure to follow up – The case against Congress and Dr Boffa

[154] It is agreed that Congress conducts business as a publicly funded non-government organisation providing health-care services to aboriginal and Torres Strait islander people resident in Central Australia.

[155] I accept the evidence of Dr Janusic (tp 460) that at all material times Congress provided medical services to aboriginal people who were and continue to be, more likely to develop chronic disease such as coronary disease, diabetes, kidney disease and at a much earlier age than non-aboriginal members of the community. It is not in dispute that the deceased was a patient of Congress.

[156] I adopt the submission made by Mr Barr QC dated 24 March 2008:

> "Congress was a multi-disciplinary medical institution which provided a wide range of medical and related services to its patient group. To carry out its role, Congress employed doctors to work in a general practice clinic, and Aboriginal health workers, nursing staff and administrative staff to support those medical practitioners. It

> employed counsellors and a psychologist. It had a dispensary or in-house pharmacy to supply medicines and drugs prescribed by Congress doctors. It conducted a regular diabetes clinic. It facilitated a weekly or fortnightly clinic attended by a visiting specialist physician. It had transport services for collection of patients. It did not have operating theatres or beds for in-patient accommodation, but it otherwise provided or attempted to provide a comprehensive medical service to its patients."

[157] I accept that paragraph 2A.1 and 2A.2 in the Further Further Amended Statement of Claim dated 13 February 2008, which I have set out below, represents a correct statement of the law as to the responsibility at law of the first defendant at all material times:

> "2A.1 owed a non-delegable duty of care, alternatively a duty of care to the deceased to exercise reasonable carer and skill in the treatment and care of the deceased as a patient of the First Defendant's general medical practice and clinic;
>
> 2A.2 owed a non-delegable duty of care, alternatively a duty of care to the deceased to exercise reasonable care and skill in the administration and management of the treatment and care of the deceased by its employed general medical practitioners, nursing and general administrative support staff."

See also *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542 at 561-2 Reynolds JA and *X (minors) v Bedfordshire County Council* [1995] 2 AC 633. The latter case deals with the difference between direct liability and vicarious liability.

[158] In *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553 at 566 per Kirby P:

> "In my opinion, these by-laws, for mutual benefit, tied Dr Chambers inextricably into the organisation of the hospital. True, he could not be directed on how to "hold the knife" (*Cassidy*). But neither could

> the other professional staff be so directed. He was integrated into the discipline and direction of the hospital. What he did in his rooms was his affair. But when he came into the hospital, he was part of the hospital. When working on its premises, he was part of its integrated medical team. Nothing could demonstrate this more clearly than the consent form which patients (including Mrs Ellis) were required to sign upon their admission to the hospital. It is set out in full in the judgment of Samuels JA. It includes the statement: 'I understand that an assurance has not been given that the operation will be performed *by a particular surgeon'* "

I find as a matter of law that the first defendant is directly and vicariously liable in respect of a duty of care owed to their patients. I accept that in the alternative the first defendant is vicariously liable for any negligence by the second defendant, Dr Boffa.

[159] Ms Gearin on behalf of the first defendant, submits that the plaintiff was required to prove:

- The existence of a duty of care to the plaintiff;
- Breach of that duty;
- Damage; and
- Causation in the sense that the breach of duty to the plaintiff caused his damage.

[160] I agree these are the matters the plaintiff is required to prove on the balance of probabilities.

[161] I propose to look first at the responsibilities of Congress and Dr Boffa and then turn to consider the responsibility of the deceased for his own welfare.

[162] I am satisfied that on 2 March 2000, Dr Boffa clearly explained his concern to the deceased that the deceased may have an ischaemic heart problem and for that reason he was referring the deceased for a fasting cholesterol test the following Monday. Dr Boffa made the necessary appointment for the deceased, gave him the card with the appointment and recorded it in his notes. The deceased failed to attend. There is a considerable amount of evidence about the way in which Congress operates. It is providing a service for a particular client group, some of whom are highly mobile and not always easily contactable. There was a practice to catch a patient the next time they attended if they had failed to appear for an appointment. The deceased did have an address in Alice Springs where he could be contacted. It was very important he attend for the fasting cholesterol test in view of the query Dr Boffa expressed about possible ischaemic problems. In addition to this, the deceased himself had asked for another opinion. The deceased did attend Congress on four or five occasions subsequent to 2 March 2000 and prior to his death. On none of these occasions was he asked about the fasting cholesterol test that he had omitted to attend. There is no evidence any reminder letter or other form of follow up was sent to him from Congress or any attempt made to contact him about the missed appointment. There was no system in place to draw to the attention of Dr Boffa the fact that the patient he had referred for a fasting cholesterol test had failed to attend. Dr Janusic gave evidence (tp 452) with respect to failure to attend for such tests:

> "… There was no system of knowing who wouldn't turn up. There was no record kept of who the tests were ordered for, it was all paper based and remained in the file."

[163] In the circumstances of this case where it was not unusual for patients of Congress to fail to attend for appointments, I have concluded that there was a failure on the part of Congress which amounted to a breach of duty of care as defined in *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47-48 Mason J:

> "In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant's position would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff. If the answer be in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do by way of response to the risk. The perception of the reasonable man's response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert what is the standard of response to be ascribed to the reasonable man placed in the defendant's position."

[164] Congress now has a computerised system which is able to pick up patients who fail to attend appointments. However, at the relevant time, Congress essentially relied on picking up a patient who missed an appointment when that patient next attended Congress.

[165] I have concluded that the first defendant had a responsibility to put administrative procedures in place for the situation that arose in this case

where a patient fails to attend for a fasting cholesterol test which is part of the treatment plan for a potentially serious condition.

[166] I have concluded that because of the administrative system that existed at that time within Congress, Dr Boffa was not responsible for following up the deceased's failure to attend for a fasting cholesterol test.

[167] In addition to failing to attend an appointment for the fasting cholesterol test, the deceased did not attend the appointment that had been arranged for him at the Specialist Physician Clinic on 21 March 2000. Had he attended the Clinic it would have been picked up by the doctor in charge of the Clinic that he had not attended for the fasting cholesterol test and arrangements could have been made for this to be done.

[168] The doctor in charge of the clinic was Dr Janusic. Dr Janusic was appointed as the Medical Officer Co-ordinator a position she still held in March 2000. Her job was to determine where the medical practitioners worked, the jobs they did and how much time was allocated to their medical duties (tp 450). In addition to her work as a medical co-ordinator, Dr Janusic was predominantly a medical worker. She performed two administrative functions. The first was to meet with doctors and then relay their concerns to management. Her second administrative role was rostering medical staff and dealing with correspondence.

[169] The specialist clinic included a Physician Clinic and occurred on a Tuesday morning. There was an appointment book with appointments for each of the

clinics. This contained the appointment time, the name and address of the referred patient, the medical record number and a column for whether or not transport was needed. To refer a patient to the clinic, the practitioner completed an internal pink referral form and wrote down the details of why they wanted an opinion from the specialist clinic. The pink form was left in the file. Either the doctor, health worker or, at their request, a receptionist would fill in the appointment book. There was no record kept of who made the entry in the appointment book. One of the jobs allocated to Dr Janusic was to do the follow up of any patients who failed to attend. On the evidence of Dr Janusic, failure to attend ranged from 30-50 percent of all appointments to the Clinic. Prior to the start of the Clinic a receptionist would retrieve the files for the patients scheduled to attend the Clinic that morning. The receptionist would then deliver the files to the clinic. On arrival at Congress, patients were advised by reception to go to the southern wing where the Clinic was held. Their file would be there already. When the patient arrived at the Clinic, the health worker would highlight the patients' name in the appointment book. As the morning progressed, all patients who attended would have their names highlighted. The names not highlighted were the ones who had failed to attend. Dr Janusic stated she would process the files from the physicians clinic and the health worker would process the failures to attend the other clinics, being the podiatry, ophthalmology and diabetic clinics. Dr Janusic stated she would take the files and check she had the right ones from the remaining names in the

appointment book. It is Dr Janusic's evidence that if a person failed to attend and it was their first referral to the physician, it would be an automatic booking for a second appointment at the next available clinic. An appointment card would be written and dropped off to the patient by bus or mailed to them if they had a town address. If they failed to attend a second appointment, they would be given a third appointment and the same process followed. If a patient was a regular attendee to the Physician Clinic or had seen the physician previously and missed an appointment, then there would be an entry in the file to discuss with the patient on his next visit to Congress to make a new appointment.

[170] Dr Janusic gave evidence that it was the receptionist's job to get the files out before the Clinic started at 9.00am and deliver the files to the southern wing of the building. The files and appointment book were placed on top of a metal cabinet in the corridor.

[171] The file for Clive Impu Snr was one of the files remaining at the end of the clinic as having not attended. Dr Janusic gave evidence that the appointment book had the name Clive Impu with no other details. It matched the file that had been retrieved. There was nothing on the file to indicate that there were two patients with the same name. If the deceased had attended the clinic, a health worker would have seen him first, ascertained that he did not have the correct file and obtained the correct file. It would have been drawn to the attention of the senior receptionist who would do what is normally done when this situation arises and marked on

the front cover of both files in Texta or thick ink and in large print “Note: Two files with the same name”. This would be an alert to subsequent practitioners accessing those files. Whoever had filled out the appointment book had not given the file number. Two persons with the same name would have different file numbers. Dr Janusic gave evidence she did not know why the receptionist would have chosen the particular file that was extracted.

[172] Dr Janusic stated she wrote in the file that Clive Impu had not attended the clinic for his appointment. Dr Janusic stated she could not remember if a pink slip accompanied the file. This did not cause alarm because some practitioners forgot to fill in the pink slip and would write a note in the file itself. Dr Janusic stated she was comfortable with stating that this matter should be looked at again next time the patient attended because Clive Impu Snr was attending within two weeks for his medication.

[173] Dr Janusic gave evidence that on 21 March 2000 there was nothing to alert her to the fact that she had the wrong file. It is Dr Janusic’s evidence that she did not have the authority to change any of the administrative procedures although she could make recommendations. Any changes would have to be made at a meeting of senior managers.

[174] Under cross examination (tp 460) Dr Janusic agreed that aboriginal patients had special needs. Diseases such as coronary disease and diabetes are more prevalent amongst aboriginals than the rest of society. Dr Janusic agreed

that Congress had tried to develop simple processes for aboriginal people who did not deal well with the paper work. She also agreed aboriginal people had a great many distractions, such as obligations to attend ceremonies, that could take them away from Alice Springs. She stated that social problems, including living conditions and pressure from relatives in town camps, were a source of considerable stress for many aboriginal patients. Congress had aboriginal health workers, counsellors and transport to assist their patients. The dispensary at Congress was a way of ensuring patients received only their prescribed medication. Dr Janusic stated that each doctor could decide whether to personally follow up with a patient or allow the system to do the follow up. This required clear communication from the doctor referring a patient for treatment. The referring doctor must write clear and unambiguous notes on the patients file for the benefit of any subsequent doctor. Dr Janusic agreed that matters of concern could be written on the Health Summary Sheet just inside the file to alert subsequent health workers about the current progress. They could then look back into the file to see what had been referred and what had been actioned.

Dr Janusic gave evidence about the red sticker system which was used up to the year 2000. A red sticker was an alert to a serious matter such as suspected ischaemic heart disease that needed significant action. Dr Janusic gave evidence about the confusion this system caused when the red stickers were not removed after the warning had been actioned and, as a consequence of that, became less frequently used. Dr Janusic stated that there was a

meeting of doctors at Congress on Wednesday mornings where there was general discussion as part of the quality assurance program about aspects of their practices and any inadequacies in the system (tp 471). Dr Janusic gave evidence the appointment book had been lost. She had not seen this book since late 2000 or early 2001. She had asked for the relevant page to be extracted after the death of Mr Impu. The appointment time was noted on the page Dr Janusic sighted. The name Clive Impu was there. There was no patient number, known as the COOC number, and no address noted. She stated that she only saw this page on one occasion and that it was her guess that it was Dr Boffa's writing. Dr Boffa was the referring doctor. She stated she could have been wrong about it being his writing. She agreed his writing was messy. The evidence of Dr Janusic about who had written in the appointment book is ambivalent. It appears that when she gave evidence to this Court it was in fact the first time she had ever suggested it was Dr Boffa's handwriting on the relevant page in the appointment book. Unfortunately, it appears the appointment book is missing. It was not available for tender in these proceedings. Searches that have been made by staff at Congress to locate the appointment book have not been successful. I am not prepared to make a finding that, on the balance of probabilities, it was Dr Boffa who wrote in the appointment book.

[175] Dr Janusic gave evidence that she knew, following the deceased's death, that the wrong file, i.e. the file of Clive Impu Snr, had been retrieved. For that reason, she wanted to look to see what she had written on the file (tp 475).

Dr Janusic stated she is certain there was no patient number recorded in the appointment book. It was not unusual not to have the patient number there and the receptionist would have been used to that. Dr Janusic concluded the receptionist must have chosen the file of Clive Impu Snr to deliver to the clinic because there was only one file delivered to the clinic in the name of Clive Impu. It is Dr Janusic's evidence that sometimes in that situation, where there were two patients with the same name, the receptionist would send both files to the Clinic. It was then left to the general practitioner in charge to identify which of the particular two files was being referred to. Dr Janusic gave evidence her role was to see the diabetic patients and to follow up the non-attendance for the Physician Clinic and the diabetes clinic. Dr Janusic stated that with respect to the files for the non-attendees at the Physician Clinic she would write new appointments or an action plan in the notes. On 21 March 2000, one of the non-attendees whose file had been delivered to the Physician Clinic was Clive Impu. The file that had been delivered was for Clive Impu Snr instead of the Clive Impu for whom the appointment had been made. The Physician Clinic was cancelled that day, i.e. for 21 March 2000. Dr Janusic stated she would normally see patients who did attend a clinic which had been cancelled as a regular consultation. Dr Janusic was shown the Congress file for Clive Impu Snr (Exhibit 35). Inside was a note that read "21/3 Physician Clinic cancelled. Why was he referred? Sort this out at the next visit". Dr Janusic gave evidence this note was written in her handwriting and she had initialled the

note. No Clive Impu had attended the clinic. Dr Janusic stated she looked back through the file to identify a specialist referral. She stated it was not unusual to have appointments with no referral, although, to have a referral was the best medical practice and had been raised as an issue at their meetings.

[176] Dr Janusic stated the Clive Impu, whose file she had, was on medication. He had been attending for blood tests to monitor his diabetes and she was confused about why he had been referred to the Physician Clinic.
Dr Janusic said she had no reason to raise the matter with her medical colleagues at the meeting the following Wednesday morning as there was always a 30–50 percent non-attendance rate of patients at the clinic. She stated it was not possible in the time they had for a meeting to make reference to the non-attendees at the Physician Clinic.

[177] Dr Janusic gave evidence that if the file number had been put into the appointment book or if the file cover had noted there were two patients with the same name then she would have picked up the fact that she had been given the wrong file. However, her evidence is there was no file number in the appointment book and the file cover did not make mention of there being two patients by the same name. She agreed that the percentage of Congress patients with the same name was about 9 or 10 per cent and a higher number who had a similar name. Dr Janusic was shown the original file for Clive Impu Snr and confirmed that she wrote her note of 21 March 2000 in red ink as a prompt to subsequent practitioners because it had a more urgent look

than blue or black ink. She agreed that she was disappointed that whoever had seen Clive Impu Snr on the next occasion did not follow up the red alert. A copy of Clive Impu Snr's file is Exhibit P35. The page with the notation made by Dr Janusic is flagged and a copy of her note highlighted in yellow texta.

[178] Dr Janusic gave evidence that after the death of Clive Impu Jnr in early 2001, Congress recruited a new senior receptionist in an upgraded position. A receptionist was also employed to organise the files and put them in order. She gave evidence that doctors had complained about the way the reception area functioned. Dr Janusic agreed that the failure to bring the correct file to the clinic on 21 March was a serious administrative error because it meant that the specialist referral for the deceased was never actioned. Dr Janusic gave further evidence that, as at March 2000, notes in patient's files were not bound or in any way clipped together so that the files could be kept in order. She stated this was now one of the duties for the file maintenance receptionist.

[179] Dr Janusic gave evidence that on the Monday following the death of the deceased she had attended Congress and looked at the deceased's file (Exhibit P13). Dr Janusic says she would have seen the pink referral form that is in the file because she went through every page. She stated it was her task to examine the file following Mr Impu's death. This was because she was the clinical co-ordinator for the medical officers and the person required to report the matter to the insurer. Dr Janusic stated she was aware there

was a likely possibility an Inquest would be held. She had not previously had to prepare for a Coronial Inquest. She sought some advice from Dr Boffa and together they sat down and tried to piece together what had happened. They were puzzled as to why the deceased, who was so young, had died suddenly. They thought there may be a possibility that there was a connection between his death and his attendance on 2 March 2000. Their focus initially was on the brevity of the notes that Dr Morrison wrote on Friday, 26 January 2001, when the patient attended shortly before he died. Dr Janusic gave evidence they did not then, or at any subsequent time, discuss the deceased's consultation with Dr Boffa on 2 March 2000. The report prepared by Dr Janusic for the insurer was done on behalf of Congress not with respect to an individual doctor. It was decided that Dr Janusic would do an internal investigation into the matter. Dr Janusic wrote a report setting out her opinion after she had reviewed the file for the deceased and the file for Clive Impu Snr. In compiling her report she did not speak with Dr Boffa or any of the other practitioners who had seen the deceased. Dr Janusic stated the report she prepared was done for the senior management at Congress and had nothing to do with Dr Boffa (tp 491). Dr Janusic gave evidence that although the pink referral form was on the deceased's file it was not possible to know where it was on the deceased's file at the relevant time. Dr Janusic was taken to a note on the file entered by Dr Yazdani who attended upon the deceased on 23 April 2000 when the deceased presented complaining of boils. She stated it was possible that

Dr Yazdani did not detect the presence of a pink referral form on the file. Similarly, with respect to the attendance by the deceased on 28 April 2000, when the deceased again presented complaining of boils and was seen by the health worker Mr Braun, Dr Janusic suggested that Mr Braun may not have detected the presence of the referral form. The deceased further presented on 29 December 2000, complaining of a dog bite and was seen by a health worker and again no one adverted to the presence of a pink referral form.

[180] Dr Janusic gave evidence it was the responsibility of the receptionist to maintain the files in order. She agreed a doctor may need to organise the papers in the file to ascertain what had occurred on past attendances as this may shed light on the presenting symptoms of the patient. Dr Janusic was taken to a document which was described as an "Emergency Department Discharge Facsimile" from the Alice Springs Hospital to Congress. Dr Janusic thought it more appropriate that she have sole responsibility for reviewing these facsimiles in case there were matters that Congress needed to follow through with, however, the Clinic Manager decided to delegate this task to other practitioners. Dr Janusic agreed that the receipt of this facsimile was a further opportunity for the deceased's file to be retrieved and for the information on the facsimile to be married up with the information on his file. She stated, however, that there were a great many of these facsimiles received from the hospital each day and that this may have been the reason the task of follow up was delegated to a number of practitioners at Congress.

[181] Dr Janusic also agreed that the system at Congress was a multi practitioner practice and that many practitioners relied on the follow up system at Congress rather than following up their referral personally. Dr Janusic said that if she were the person doing the referring, she would write in her diary everyone she referred and then check it in a few months to ensure things had happened. This was for her own development to find out about the more complicated and diagnostically difficult cases. She considered this would also be in the patients best interest.

[182] Dr Janusic said she would do the immediate follow up for the non-attendees at the Physician Clinic and on this particular occasion, she had written an action plan. This would have worked if the right file had been retrieved. Dr Janusic stated that, under the Congress system after a physician to whom a patient was referred had done an assessment, a copy of the report would go into the pigeon hole for that practitioner (tp 502).

[183] Dr Janusic was shown the hand written report that she prepared, being the report from her findings after reading the file of Clive Impu Snr, and the file of the deceased for the purpose of trying to see where Congress could improve. Dr Janusic confirmed that her reading of the attendance of the deceased on 2 March 2000 was that, when he consulted the doctor, the deceased no longer had chest pain but chest discomfort. She stated that she read it this way and that the fact the word discomfort was underlined was to emphasise the fact that the pain had receded into a state of discomfort. Dr Janusic stated in this report that, in her view, the incorrect file was

retrieved on two occasions. She had also identified the fact that there had been a failure by practitioners and aboriginal health workers. This was to emphasise the lack of follow up with the patient. She had also pointed out that correspondence on the deceased's file was not dated and the only way she could infer the ECG referred to was carried out on 31 December 1999, was because this was the only ECG reference in the file.

[184] Dr Janusic had noted some positives which included the fact that there was now a system in place to document the fact that patients had failed to attend for an appointment or that they had attended but left before they were seen by a doctor. There was also a reference to the fact that there were options for placing red stickers onto the file as a prompt to alert the practitioner that action was required.

[185] A copy of the report prepared by Dr Janusic dated 11 May 2001 was tendered and marked Exhibit P36.

[186] Under cross examination by counsel for the second defendant, Mr Abbott, Dr Janusic agreed that as at March 2000 the system in place at Congress was a shared patient system. There were no patients who were exclusively one practitioners, although patients could express a preference to see a particular practitioner. Dr Janusic said that because it was a shared system it was important for doctors who saw patients on subsequent consultations to be aware of what had occurred before and that they ought to have done that by reading the previous progress notes on the file and anything else in the file

that may be significant. She said that if there was no apparent result from the previous notes then the practitioner ought to enquire why from the patient or make any other reasonable enquiry.

[187] Dr Janusic stated the system of using red stickers as a prompt to subsequent practitioners was not in place in 2000 in the sense that red stickers were not at that time used in cases of an urgent condition which might prove fatal if not dealt with in the next few days. It is her evidence that in 2000 everything, including progress notes and test results, worked on a paper based system. A doctor would not record a diagnosis based on suspicion but would have the patient investigated. The diagnosis would only be recorded if the doctor could make such diagnosis clinically. She would not expect the doctor to record suspected ischemic heart disease in the notes until the patient had been investigated.

[188] Dr Janusic stated it was the receptionist's job to complete the Health Summary Sheet with details of the patient's address and Medicare number. This is all provided for in the manual (Exhibit D22 p 4.1), including the fact that it is the receptionist's duty to get out and put away files as needed by Congress staff and file pathology test results.

[189] Dr Janusic gave evidence under cross examination that she came to work on the Monday following the death of Clive Impu Jnr. She was asked by the service branch manager to investigate the circumstances leading up to his death. She discussed the death with Dr Boffa. They looked at the file and

focused on the few lines and lack of information that appeared in the entry for the day of the deceased's death. They discussed how management was to be told about the incident. Dr Janusic consulted with Dr Boffa because he was the more experienced practitioner at Congress at that time. It was clear that the wrong file had been brought for Dr Morrison on the date of the deceased's death. It was then obvious there were two Clive Impu's. The deceased's file was subsequently locked away so that it could be preserved for the inquest and whatever else occurred. This directive came from the services branch manager.

[190] At a later time, Dr Janusic went through both files and wrote her report. She did not consult with Dr Boffa about this. She observed from reading the report of the deceased's file that on 2 March 2000, Dr Boffa had referred the deceased to the specialist clinic. Dr Janusic saw a pink referral form on the file and observed the pink form had the name of the patient, his birthday and a Congress file number. She made a note on page 2 of her report that there was no entry on the deceased's file about the appointment date nor any indication of whether he attended the appointment. There was an entry for 21 March 2000 in the file of Clive Impu Snr indicating the patient had not turned up on that date (tp 518).

[191] Dr Janusic gave evidence that at one time she did have the relevant page from the appointment book. She told senior management that the appointment was not completely written in but she could not remember what happened subsequently. She stated she knew the deceased's file was kept

locked up in the safe. Dr Janusic gave evidence that she had been shown the page from the appointment book prior to the Inquest in 2001. Still under cross examination by counsel for the second defendant, Dr Janusic said there was no way she could have known that the file she made a note in at the clinic on 21 March 2000, was the wrong file. She gave evidence that she had not done anything wrong with respect to her medical duties. She was concerned that she might be caught up in the administrative process on the issue of the insurer. The evidence of Dr Janusic is that the file she was given was the file of a person who was a regular attendee, who was already on medical treatment and had already had blood tests. She said there was no reason to think he was inappropriately there. An examination of the file of Clive Impu Snr in which Dr Janusic had made a note on 21 March 2000, does not support her evidence that he was a regular attendee. Dr Janusic gave evidence she had received a letter from Congress stating that they could not indemnify her because she had worked both as a medical practitioner and as an administrative manager. When she was writing the report (Exhibit P36), Dr Janusic said she knew she had written in the wrong file on 21 March and wanted to find out how this mistake had occurred. She stated "there were no alarm bells to indicate it was the wrong file at the time". She said the person to whom the file referred had multiple medical problems and could have been referred to the specialist clinic for any number of reasons (tp 530). It is her evidence that, even though there was no referral form in the file and no apparent reason for it written in the notes,

this was quite a common occurrence. She said there was adequate information on the file to indicate this was a person with chronic problems whom the physician was likely to be seeing and that it was likely someone would make such an appointment. She stated there was no reason, as at 2 March 2000, to check the appointment book. Dr Janusic was referred to the medical file of Clive Impu Snr and taken to the various entries in the file as to his previous attendances. Dr Janusic said she had to make a decision whether to rebook the appointment or just make a note that he was to be reviewed on his next visit. Dr Janusic did not agree that she should have drawn the inference, when she read the file of Clive Impu Snr on 21 March 2000, that in fact he was not the person who had been referred to the specialist clinic. She agreed the receptionist could have obtained the two files in the name of Clive Impu and checked for a referral form to be sure which of the two patients had been referred to the clinic. Dr Janusic was asked about the doctors meeting at Congress when Dr Boffa had identified the systemic failures that had occurred being, (1) Dr Morrison's failure to examine the deceased before prescribing medication on 26 January 2001; (2) the wrong file being produced on 21 March 2000; and (3) the wrong file being produced on 26 January 2001.

[192] Dr Janusic agreed she had never previously asserted that Dr Boffa had written in the appointment book or that he had failed to put in the file number. Her evidence is that she presumed it was his writing in the appointment book but she was not certain. She agreed the first time she had

ever made such an assertion was in giving evidence to this Court. I have already stated that I do not accept, on this evidence, that it was Dr Boffa who wrote in the appointment book.

[193] Dr Boffa was recalled to give evidence. He stated that he had never received the report which Dr Janusic had prepared for the health services branch manager in relation to this matter. It is Dr Boffa's evidence that he had never seen the page in the appointment book referring to the appointment of Clive Impu on 21 March 2000. It is his evidence that Dr Janusic never asked him if he had written the deceased's name in the appointment book and that she had never told him that whoever had written the deceased's name in the appointment book had failed to note the date of birth and the Congress patient number. He said if Dr Janusic had identified him as the writer in the appointment book with vital information missing, he would have expected that in her capacity as medical officer co-ordinator, she would have approached him and counselled him. He said this did not occur. It is his evidence that the first time he became aware of a suggestion or attempt to place the relevant page from the appointment book in the safe, was when he had a telephone conversation with Dr Janusic about a week before the hearing of this matter in 2008.

[194] Dr Boffa gave evidence that he had put in place steps to try and locate the page from the appointment book on many occasions. He said that there had been an extensive search for the missing page at the time of the initial investigation and on subsequent occasions. Dr Boffa stated that Dr Janusic

was present at Congress meetings where the system failures that may have contributed to the death of the deceased were discussed. He said Dr Janusic did not mention or discuss at any of those meetings the appointment book page that she said she had located.

[195] It is Dr Boffa's evidence that he filled in the pink referral slip for the deceased and that he had also made a copy of it and placed it in the internal mailbox so that whoever filled in the appointment book would have that information to refer to. He agreed that not all GP's at Congress followed that procedure at that time.

[196] He gave evidence that if the receptionists had looked on Comcare and found there were two Clive Impu's, it was within their authority to look inside the file to see whether either file contained a pink referral slip. It is his evidence that the procedure for booking a specialist appointment was to ring the receptionist and ask them to make a booking. Failing that, the doctor would ask the health worker to make the booking and, if neither the receptionist nor the health worker could be contacted, the doctor would track down the appointment book and make the appointment.

[197] He stated in cross examination that he only found out approximately one or two weeks before the hearing that Dr Janusic had found the appointment book. Dr Boffa gave evidence about the telephone conversation he had with Dr Janusic shortly before the commencement of the trial. He said Dr Janusic had confided in him that she was afraid of being sued for

anything she might have done on 21 March 2000. She had asked if Congress would be prepared to give a letter guaranteeing she would not be sued. After speaking with his solicitor, Dr Boffa informed Dr Janusic it was highly unlikely that she would be sued.

[198] Dr Janusic agreed that she had not written a memo about the conclusions she drew from the page from the appointment book. She stated she did not mention it at the Coronial Inquest because she had not been asked about it. She agreed that at the Inquest she had said that if a patient did not attend a specialist clinic their files would be retrieved, that it would be documented in their file that they did not attend and that a judgment would be made as to whether the patient should be recalled, whether a letter should be sent or whether a note should be made in the file to discuss the patient's non-attendance at the next visit. She agreed that at the Inquest she had not volunteered that within the timeframe being discussed it was mostly she who was the doctor making that judgment. She agreed she had not volunteered at the Inquest that she was the doctor who had written the note in the file of Clive Impu Snr about his failure to attend the clinic. She agreed she had not said anything at the Inquest about the deficiency in the appointment book as it was not unusual for the file number not to have been written in. Usually there would be an address so the patient would be picked up. She stated she assumed Dr Boffa had earlier seen the page from the appointment book. She had told senior management about the deficiency

in the page from the appointment book and stated she had never mentioned the appointment page to Dr Boffa as she assumed he had seen it.

[199] Dr Janusic stated it would have been impractical to send a memo round to the various doctors on the day following the cancelled clinic to ascertain which doctor had referred a patient who had not attended the specialist clinic on 21 March 2000. Dr Janusic stated this would not be in accordance with good medical practice (tp 549).

[200] Dr Janusic was then cross examined by Ms Kelly, counsel for the third party. Dr Janusic stated that if a patient had a condition that required urgent attention they would be referred to the hospital and if they had been referred to one of the four specialist clinics, then it was not a critical or urgent condition. If the patient failed to attend, a letter would be sent to them or they could be booked into the general clinic the following day. If the patient's condition was not serious, and it was a patient who came in from time to time, then Dr Janusic said she would write on that patient's file "please review next visit and follow up".

[201] Dr Janusic gave evidence that she would, during the course of the clinic, attend to the diabetic patients and would follow up the "did not attends" when the clinic finished. She agreed that, from time to time, a practitioner would refer a patient to the Physician Clinic without filling out a referral form. It was less common but did occur that sometimes there was also nothing written in the progress notes on the file of the referred patient. She

agreed that it was probably only one or two files from each clinic that did not contain sufficient information to allow for a follow up. Dr Janusic stated that she did not consider it was practical to send around a memo about the non-attendees. She said it was no longer an issue as all those details are now placed on a computer system. It was only a doctor who could make a referral or sign off on a referral to the specialist clinic. It is Dr Janusic's evidence that it was not until 2002/2003 that the practice was introduced of having a pink referral form in duplicate, one placed on the file and one given to reception.

[202] Dr Janusic agreed it was not uncommon for there to be two files with the same name. Dr Janusic stated that the practice in those circumstances, was to write in thick ink or texta on the front of the files "NOTE: Two patients with the same name". She agreed that she did know at the time that not every double up had been noted on the files. Dr Janusic was taken to the file of Clive Impu Snr. She agreed there was nothing in the previous entries on the progress notes to indicate why Clive Impu Snr would have been referred to the Physician Clinic. Dr Janusic gave evidence, by reference to the file of Clive Impu Snr, that the various attendances went back to 1998 and that there was nothing to indicate why he would have been referred to a Physician Clinic. She stated that she knew that it was not always noted on the file when there was more than one file with the same name. Her evidence is there was nothing to suggest to her she may have had the wrong file. She agreed that some of the conditions which Clive Impu Snr suffered,

in particular diabetes, could have required urgent follow up. Dr Janusic stated her clinical judgment at the time was not to pursue the matter further, but to follow up the matter with Clive Impu Snr the next time he attended the clinic. Her evidence was that this was the correct clinical judgment. Dr Janusic then gave the following evidence in cross examination by counsel for the third party, Ms Kelly (tp 563-564):

> "And then …. Ms Gearin said to you, 'And so having looked at the information in the file you were comfortable with then saying that he – this should be looked at the next time he turned up'?---Yes.
>
> And your answer was, 'Yes, it would have been within two weeks or so because that's how frequently the patients would come in for their medications'?---Yes, that was from memory.
>
> …. do you accept now, having looked through the file …. that that's incorrect …. that there was no reason to suppose he would be …. coming in within two weeks?---Not within two weeks but he was on medication - I would have remembered the frequency incorrectly but not that he wasn't coming in. He was coming in.
>
> And, Doctor, do you also accept that you …. were mistaken when you said that from memory he had been previously referred to the physician's clinic?---He had been referred to the diabetic clinic so I must have - - -
>
> No, Doctor, if you listen to the question. Do you accept that you're mistaken - - -?---Yes, I do, it was the wrong clinic. Some practitioners would write appointments in the wrong place in that appointment book. So, again, …. having this in front of me, a physician clinic referral without the referral specific for it, sometimes it was actually meant to be the diabetic clinic. So, again, it could have – that was another possibility."

[203] Dr Janusic stated that it was best medical practice for a subsequent treating doctor to familiarise themselves with the past history of a patient. She stated doctors at Congress were under considerable time pressures and efforts had been made to set up systems with appropriate prompts. In this

case three separate health practitioners at Congress had failed to realise, when they saw the deceased after 2 March 2000, that the deceased had failed to attend a Physician Clinic. This was a system failure because there were no adequate prompts to draw their attention to the significance of the entry made by Dr Boffa in the file of the deceased on 2 March 2000. It is Dr Janusic's evidence that, although doctors could make recommendations, the final decision about administrative matters rested with the services branch manager and their team. In re-examination, Dr Janusic gave evidence (tp 569) that there was nothing in the progress notes on the file for Clive Impu Snr to indicate there was anything urgent that needed to be done. If there had been something urgent to be done, the patient would have been referred to the hospital. Pages 146 and 147 of the transcript of the evidence given at the Inquest was tendered Exhibit D37 (tp 570).

Findings with respect to responsibility to follow up the deceased's failure to attend the fasting cholesterol test and the Physician Clinic

[204] I agree with the submission made by Mr Barr QC that Congress had a direct responsibility and duty to the deceased to exercise reasonable care and skill in the administration and management of the deceased's treatment and care by its employed general medical practitioners, nursing and administrative support staff (*Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 at 561-2 per Reynolds JA. See also *Kondis v State Transport Authority* (1984) 154 CLR 672 at 685-6 per Mason J).

[205] I accept the evidence of Dr Boffa that he was not aware the appointment book, or the relevant sheet from the appointment book, had been located until about two weeks before the commencement of the hearing of this matter in February 2008. I accept he was never approached and asked about the entry for the deceased in the appointment book. I would not be prepared to make a finding that it was he who wrote the entry in the appointment book. I am not prepared to find that the file number or any other relevant details were missing in the appointment book. I do not accept the assumption made by Dr Janusic that it was the handwriting of Dr Boffa. I find that such an assumption was only made at the time of her giving evidence to this Court. Dr Janusic appeared to be more concerned with ensuring no blame could be attached to her.

[206] Dr Boffa gave evidence (tp 224) that a cholesterol test was important because high cholesterol was a risk factor for some young aboriginal men who suffered from ischaemic heart disease. The evidence of Dr Boffa is that there was no system in place at Congress at the relevant time to follow up whether a person had attended their fasting cholesterol other than picking it up next time the patient came in. Dr Boffa referred to it as an "opportunistic follow up system". This meant that, at subsequent visits, the doctor or health worker who attended the patient would have to check back in the notes or other references in the file to ascertain whether or not the test had been completed. It is Dr Boffa's evidence that the receptionist was not

permitted access to the information in a patient's file and that this could only be accessed by a medical practitioner or health worker.

[207] Dr Boffa agreed that the system of picking the patient up for the test on the next occasion that the patient attended Congress had failed because the deceased did attend Congress on three subsequent occasions, being 23 April, 28 May and 29 December 2000, and a test was not done on any of those occasions.

[208] I would agree that the "opportunistic follow up system" referred to by Dr Boffa was the system in place at Congress and was inherently unreliable. The system relied upon the subsequent presentation of the patient and the doctor or health worker who saw that patient on that subsequent occasion checking back through the progress notes to ensure there was nothing outstanding to be done. The absence of notes on subsequent presentations of the deceased to the observations noted on 2 March 2000, gives rise to an inference that on the balance of probabilities, the respective doctors and health workers did not check back in the Progress Notes to ascertain if there were any suggested action that had not been followed through. The "opportunistic follow up system" failed.

[209] It was clear from the progress notes written by Dr Boffa on 2 March 2000 that Dr Boffa:

(1) suspected possible ischaemic heart disease;

(2) made an appointment for the deceased to attend for a fasting cholesterol test on the following Monday after the consultation on 2 March 2000; and

(3) referred the deceased to the specialist clinic.

[210] The deceased failed to attend his appointment for a fasting cholesterol test and for the physicians clinic. I find that on the balance of probabilities, the deceased made a decision not to attend either appointment and not to refer to that arrangement again. The medical staff, of whom Dr Boffa was one, had to work within a system that was under the control of the management at Congress. This apparently was a system where an individual doctor was not responsible for the management of a patient. In that situation, the possibility of a patient being lost in the system must be greater than when an individual doctor has responsibility for ensuring that appointments that are made are followed up and acted upon. Dr Boffa was just as much subject to the vagaries of such a system at Congress as were the patients. Whether or not Dr Boffa had received a result from the cholesterol test would not have affected the fact he had no responsibility under the system at Congress to follow up the deceased when the deceased failed to attend the clinic.

[211] Congress took away the responsibility upon an individual doctor to follow up a patient. It was incumbent upon Congress to devise a system that ensured patients were followed up when necessary. The evidence of Dr Boffa is that the system at Congress was better than relying on an individual practitioner. He stated, “It only failed because the wrong file was

there, otherwise it would have worked as it normally did". However, the other aspect to this is that the deceased attended three times after the attendance on Dr Boffa on 2 March 2000 and the doctors who saw him on the subsequent occasion could not have read the notes made on 2 March 2000 or they would have realised there was a serious situation here which had not been attended to. This may have been because the doctors were busy and only had time to attend to the immediate problem, but that is a failure by Congress through its servants or agents, to adequately assess the patient on presentation.

[212] It was a serious administrative error to have extracted the wrong file at the specialist clinic on 21 March 2000, just as it was a serious administrative error to extract the wrong file for the doctor who saw the deceased on 26 January 2001. There should have been administrative procedures in place to ensure that this did not happen. There is evidence it is not unusual for there to be more than one patient with the same name. There are administrative procedures that can be put in place which could have prevented such error. I understand that Congress have now taken steps to address this problem. I am fully aware that we are dealing with a situation that existed eight years ago and that since then safer administrative procedures have been put in place.

[213] Mr Barr QC for the plaintiff, set out a list which he stated was not exhaustive, of the acts and omissions by Congress:

1. “Someone not writing the deceased’s relevant Congress file number in the page of the appointment book.”

The relevant page of the appointment book has been lost. I am not able to make a finding that it was Dr Boffa who had made the relevant entry in the appointment book. Dr Janusic said she thought it was his writing but when questioned further expressed an uncertainty about this. She did agree she had never spoken with Dr Boffa about this. Dr Boffa gave evidence (tp 446):

> “In terms of the first of those alternative, namely that the wrong details had been entered, if you had been the person entering those details, if you compare the details on the referral form that you filled out with the details of the person whose file was actually retrieved, is it conceivable, Dr Boffa, that you would have entered the wrong details?---No, if I had entered them I would have entered exactly the details on the referral form. I would have taken the referral form with me and that would have been used as the basis upon which to enter the details into the specialist appointment book. Even if I had spoken to someone over the phone I would have read out all those details over the phone. In that case I wouldn’t have known that they were - - - all copied into the specialist appointment book, but I would have used the details in the referral form.”

I accept the evidence of Dr Boffa.

I find there was an administrative error, whether, the receptionist made an error in writing the wrong file number in the appointment book or did not write any file number in the appointment book. Alternately, Dr Janusic made an error in not checking the file number in the appointment book with the file given to her or, if there was no file number in the appointment book, querying this with reception.

Whatever may or may not have been written on the relevant page in the appointment book there was an administrative error.

2. "Receptionist retrieving the wrong Impu file, that of Clive Impu Snr rather than the file for the deceased."

There is no dispute on the evidence that this occurred. I agree it is a serious administrative error which led to a failure on the part of Congress to follow up the deceased's referral to the visiting specialist.

3. Receptionist not checking the file for the pink "referral within Congress form".

The evidence is there was a pink "referral within Congress form" in the file of the deceased. This form contained a follow up request from Dr Boffa (Exhibit D13A). It clearly identified the deceased by the insertion of his next of kin and his file number. There was no evidence of a pink referral form in the file of Clive Impu Snr although there should have been one had he been referred to the clinic. The fact that there was no pink referral form in the file of Clive Impu Snr, when it was extracted for the attendance at the clinic, should have given rise to a query. I agree this amounted to an administrative failure.

4. “The files were not marked to indicate there were two files in the name of Clive Impu.”

The evidence is that about 10 percent of patients attending Congress have the same name. The practice was that the receptionist would mark on the files of patients having the same names, with texta, that another file existed which bore that same name. This did not happen with respect to the files bearing the name “Clive Impu”. This was an administrative error. If the receptionist had information there were two files, then any doubts about who the patient was that had been referred to the clinic could have been resolved by sending both files to the clinic with an appropriate note or asking for guidance from the doctor in charge of the clinic.

5. I agree that it was an administrative error that the wrong file was extracted and produced at the clinic, which resulted in Dr Janusic wrongly assuming that Clive Impu Snr had been referred.

6. I also agree with the submission by Mr Barr QC there was an administrative error made when there was a note made by Dr Janusic on Clive Impu Snr’s file to the effect that the matter needed to be sorted out at his next visit. It would appear this was not followed up on his next visit to Congress. Such further investigation may have revealed that it was not Clive Impu Snr who had been referred but rather it was the deceased.

7. I agree it was a failing in the system at Congress that doctors or health workers who saw the deceased when he attended subsequently on 23 April, 28 May and 29 December 2000, did not properly refer back to the notes made by Dr Boffa on 2 March 2000, to alert themselves to the fact that the deceased had not followed up on some important tests. Had this been done, other arrangements could have been put in place for the deceased to attend for a fasting cholesterol test and the specialist clinic.

[214] There was a further administrative error in that when the deceased attended Congress on 26 January 2001, shortly before his death, Dr Morrison, who attended to him, did not have the deceased's file.

Findings on the failure to follow up

[215] I find that the errors on the part of the first defendant, which I have enumerated, amounted to a failure by Congress in its duty of care to the deceased.

[216] I am not satisfied there was a failure to follow up on the part of Dr Boffa with respect to the fasting cholesterol test. The system at Congress was that individual doctors did not have responsibility for the management of particular patients. Patients could be seen by any of the doctors employed by Congress depending on who was available at the time, unless a patient asked for a particular doctor. There is no evidence that the deceased specifically asked to see Dr Boffa. There was no system in place to advise

Dr Boffa that the deceased had failed to attend for a fasting cholesterol test. If it had not been for the error by Congress in sending the wrong file to the Physician Clinic, the failure to attend the fasting cholesterol test would have been picked up at the clinic and the normal follow up procedures would have occurred. It would have been the responsibility of Dr Janusic as the co-ordinator for the Physician Clinic on 21 March 2000 to follow up the non-attendance.

[217] Counsel for the plaintiff referred me to a number of authorities including *Tai v Hatzistavrou* [1999] NSWCA 306. In that case, Dr Tai gave evidence he did not have a system for checking up on patients who had been booked in on waiting lists in the hospital to see what was happening. It was his practice, once he had filled in the form and ensured the patient understood the procedure, to leave it to his patient to follow up the booking. When it was put to Dr Tai that it would be cheap and simple to have a follow up system he did not reply to that question directly but stated once he ensured the patient understood the procedure it was for them to follow up. There was a finding of negligence against Dr Tai because he did not have a system within his own practise to follow up patients referred for treatment.

[218] In *Kite v Malycha* (1998) 71 SASR 321, Perry J found that Dr Malycha fell short of the duty of care owed by a medical practitioner in two ways. His Honour stated (p 336-337):

> "Having performed the fine needle aspiration, he owed a duty to record that he had done so in his notes. He did not do so.

Furthermore, if perchance the cytology report was not brought to his attention, he should have made some inquiry to find out what had happened to it.

At worst, he should have become aware of it when Mrs Kite did not come in for the appointment on 3 January 1995. His review of his notes at that stage should have alerted him to the fact that he had taken a fine needle aspiration and had not seen the result of it.

Not only did he have no note of the needle biopsy, but he missed the reference to it in the file copy of his letter to Dr Sangster.

Obviously the simplest of systems would have provided a more or less foolproof means of checking whether cytology reports had been forwarded to his rooms. All that would have been needed was a simple running sheet, recording that such a report had been requested, with provision for the particular entry to be ticked off when the report was received.

He had no such system.

Mrs Kite's failures to ring him on 4 December or to attend for the follow-up appointment does not excuse the breach of the duty of care imposed upon him in that respect. Irrespective of any initiative taken by the patient, he owed a duty to find out what the outcome of the pathological examination of the fine needle aspiration was. As Mr Wells QC put it during the course of his address, it is 'unreasonable for a professional medical specialist to base his whole follow-up system, which can mean the difference between death or cure, on the patient taking the next step'.

Mr Malycha owed a duty to inform himself of the outcome of the pathologic test of the specimen, and to offer appropriate treatment in the light of the report.

The evidence of Mr Malycha, during the course of his cross-examination, was:

> 'Q. Do you agree that following the forwarding of this request form (the request form to Clinpath) with the sample that you should have followed up that request in order to obtain the result?
>
> A. I agree that it's my responsibility to do that."
>
> In my opinion, the plaintiffs have made out their case in negligence against Mr Malycha.'"

[219] In this case, Perry J found that in the circumstances of that case the failure by Ms Kite to telephone the defendant's rooms to obtain the results of her fine needle aspiration biopsy and her failure to attend a further appointment fixed for 3 January 1995 did not amount to contributory negligence.

[220] I consider these two decisions are distinguishable from the matter before this Court because the findings were that neither of the doctors had in place a system to ensure follow up.

[221] In this matter, Congress did have a follow up system. For all the reasons already detailed, that system failed. This was not through any breach of duty of care by Dr Boffa. I would dismiss the claim for damages with respect to Dr Boffa.

Causation

[222] Ms Gearin, counsel for the first defendant, submits that one of the fundamental elements in the tort which the plaintiff was required to prove was causation, in the sense that the breach of duty to the deceased caused or contributed to the harm for which the plaintiff seeks damages.

[223] It is the submission on behalf of the first defendant that the plaintiff cannot prove, on the balance of probabilities, that if the first defendant had followed up and again advised the deceased to undertake the tests, that he would have done so. Ms Gearin argues that the evidence supports a finding that, for whatever reason, the deceased chose not to have treatment for his

suspected ischaemic heart condition, as was his right. The first defendant attributes the sole cause of death to the deceased exercising a right to allow his ischaemic heart condition to take its course.

[224] I do not accept this submission. On 2 March 2000, at the time when he saw Dr Boffa, the deceased sought another opinion. He was clearly interested at that time to follow up on the consultation with Dr Boffa. This could have been because the deceased did not like the opinion expressed by Dr Boffa that he should undergo tests to exclude the possibility of ischaemic heart disease. This may also explain why he did not tell his wife about the advice he had received from Dr Boffa. However, the deceased did in fact seek medical attention on numerous occasions during the balance of 2000, both at Congress and at the Alice Springs Hospital. These attendances were sometimes for relatively minor incidents. He clearly had a concern for his own health. He took positive action to seek medical attention. He saw a number of other doctors, none of whom mentioned the possibility of ischaemic heart disease. Had they done so, or at least queried why he had not completed the follow up tests, then I am satisfied, on the balance of probabilities, he would have undertaken the tests.

[225] I agree with the submission made by Mr Barr QC that, as at 2 March 2000, the deceased had some significant distractions in his life. On 13 March 2000, the deceased had to attend Court to answer criminal charges. His youngest child was being treated for a serious condition. He was trying to maintain a home and family at Undurana and Alice Springs.

[226] I am satisfied on the balance of probabilities, that, after a proper follow up he could have been persuaded to take the tests instead of ignoring the advice he had received from Dr Boffa.

[227] Mr Abbott, counsel for the second defendant, argues that death was too remote from Dr Boffa's supposed negligence.

[228] I have made a finding that the plaintiff has not proved negligence on the part of Dr Boffa. Accordingly, I do not proceed to consider the issue of causation with respect to Dr Boffa.

Causation as it affects the first defendant.

[229] There is evidence from Dr Zillman, Dr Hale and Dr Sangster which supports a finding that the tests would have, on the balance of probabilities, detected the presence and causes of the myocardial ischaemia.

[230] In his autopsy report, Dr Zillman noted that the scarring of the heart muscle was consistent with the effect of long standing coronary artery disease. Dr Zillman gave evidence that, on post mortem, he had found irreversible damage to the fibres of the heart. He gave evidence that "this narrowing of the coronary artery would not have changed much in an 11 months period" (tp 139). He further stated at tp 139:

> "…. And so after looking at my findings here at the autopsy and looking at the fact that the scarring is present and therefore there has been significant myocardial ischemia or reduction of the blood supply over a considerable period of time. It is my opinion that it's

more likely than not that there have been previous clotting episodes on this narrowed coronary artery".

[231] Whilst I have not accepted the evidence of Dr Hale based on his assumption that the deceased presented on 2 March with a "crushing sensation on the left side of his chest", I do accept the expertise of Dr Hale and accept his opinion that (Exhibit P27):

> "… However the post mortem report clearly indicated that he had in addition to narrowing to the left anterior descending (LAD) a new or at least recent onset of more severe obstruction to blood flow because of thrombus formation. Therefore it is reasonable to conclude that the terminal event, firstly complaint of right sided chest pain before he left the car and collapse following exit from the car was due to the thrombus formation suddenly occluding the LAD causing massive cardiac ischaemia."

[232] Dr Hale further stated with reference to the autopsy report (Exhibit P27):

> "… The fact that the chest pain was on the left side and not the right side as was the case immediately prior to death does not exclude the presentation in that March as being due to the coronary disease.
>
> It is important to note that the autopsy also found evidence of myocardial damage of long standing, namely the 'patchy' myocardial fibrosis'. This was presumably in the region supplied by the narrowed LAD although the autopsy does not specify this localisation of disease in the myocardium. The fact that there was fibrosis would suggest that muscle necrosis had occurred some months before his death so that his presentation in March could well have been due to myocardial necrosis resulting in transient or partial obstruction of the LAD."

[233] From the report prepared by Dr Hale, the probability of an exercise test showing up positive evidence of myocardial ischaemia ranged from 50 percent to 75 percent. In his response (Exhibit D32), Dr Sangster essentially agreed with this.

[234] The next step would, in Dr Hale's opinion, be a coronary angiogram which would have a greater probability of showing up as a positive test. I also accept the evidence of Dr Hale as to the regime of treatment that could have commenced if the investigations had confirmed the presence of coronary artery disease. This treatment included the introduction of aspirin and beta blocking drugs, the possible use of an ACE inhibitor and the immediate cessation of smoking. If an arteriography had shown severe narrowing in the LAD then there would have been immediate measures to increase blood supply through angioplasty and stent insertion or alternately coronary arterial graft survey. This would, in the opinion of Dr Hale, have increased the chances of the deceased surviving beyond a further 12 months by at least 95 percent. On the evidence of Dr Hale, I accept that an exercise test could have led to further investigation and the implementation of an appropriate treatment regime.

[235] Dr Zillman, who was called for the plaintiff, and Dr Sangster, who was called for the second defendant, stated that the deceased's coronary arteries were narrowed in the same way on 2 March 2000 as they were at the time of post mortem.

[236] Dr Zillman gave evidence that the process of clot formation can arise as a result of turbulent blood flow through the point of narrowing.

[237] I accept the submission made by Mr Barr QC that, taking these matters into account, a clot could have formed at the same narrowed segment in the artery in March 2000.

[238] I have found, on the balance of probabilities, that the deceased did not use the term "pain and crushing sensation on the left chest" and that Dr Boffa satisfied himself the deceased had not in fact suffered a pain of this description. As Dr Sangster pointed out, it was only in retrospect at the time of post mortem that it was possible to link the episode of 2 March 2000 to possible transient obstructions of his coronary arteries. It could also explain his attendances at the Alice Springs Hospital and his presentation with right sided chest pain as described in the Alice Springs Hospital notes of 15 August, 3 December and 30 December 2000. I accept that, looked at in isolation, those presentations did not signify to the respective doctors the possibility of ischaemic heart condition. However, looked at in retrospect with the findings of the post mortem and the deceased's frequent presentations with chest pain, it is difficult to accept they were all entirely divorced from any consideration of an ischaemic heart condition. From a reading of the notes at each presentation, and accepting his evidence as I do, it would appear Dr Boffa made the most thorough examination of the deceased and, in fact, was the only doctor close to diagnosing the real problem. Even though he noted what he referred to as a lot of negative answers to his questions and even though he did not think the deceased showed the classic signs of ischaemic heart disease, Dr Boffa nevertheless

erred on the side of caution. He organised for the deceased to undertake a fasting cholesterol test, referred him to the specialist clinic and emphasised the importance of these tests to rule out the possibility of ischaemic heart disease.

[239] I am satisfied, on the balance of probabilities, that the failure to follow up the deceased with respect to his non-attendance at the clinic on 21 March 2000, meant he was never tested for a possible ischaemic heart condition. Similarly, the failure of medical staff on the deceased's presentation at Congress after 2 March 2000, to pick up the fact that he had not attended for the fasting cholesterol test or at the physicians clinic, meant he was never tested for the possibility that he had an ischaemic heart condition.

[240] I am satisfied on the evidence of the expert witness, Dr Zillman, that the deceased did have a narrowing of the left anterior descending artery as at 2 March 2000.

[241] I am satisfied based on the evidence of Dr Hale and Dr Sangster that this could have been picked up on testing had such tests been carried out.

[242] I am satisfied based on the evidence of Dr Hale and Dr Sangster that the condition from which the deceased was suffering could have been treated such as to extend his life expectancy by 12 years.

[243] I am satisfied the various failures by the first defendant to exercise due care toward the deceased were a direct cause of his death on 26 January 2001.

Contributory Negligence

[244] The first and second defendants have pleaded contributory negligence on the part of the deceased.

[245] Section 11(1) of the Compensation (Fatal Injuries) Act provides as follows:

> "(1) Where a person dies as the result partly of his own wrong and partly of the wrong of another person or other persons, and accordingly, if an action were brought for the benefit of his estate under Part II of the *Law Reform (Miscellaneous Provisions) Act*, the damages recoverable would be reduced, any damages recoverable in an action under this Act shall be reduced to the same extent as if they were damages in an action so brought for the benefit of the estate of the deceased person."

[246] The appropriate discount for contributory negligence is to be determined in accordance with the Law Reform (Miscellaneous Provisions) Act (NT), Part V. The legislation calls for the court to compare the parties respective responsibilities and requires the damages recoverable by the plaintiff "to be reduced to such extent as the Court thinks just and equitable having regard to the claimant's responsibility for the damage".

[247] The second defendant has pleaded the following particulars of contributory negligence in the second defendant's "Defence to Further Amended Statement of Claim". This defence is dated 4 April 2007. Counsel for the first defendant made similar submissions.

[248] The pleading reads as follows:

> "8. If the Second Defendant was negligent, which is specifically denied, any loss or damage which may be proved by the

Plaintiff was caused or materially contributed to by the deceased's own fault.

PARTICULARS OF CONTRIBUTORY NEGLIGENCE

8.1 The deceased failed to keep the appointment at the Physician Clinic on 31 [sic] March 2000.

8.2 The deceased failed to follow up with the first or second defendants or any other doctor the fasting cholesterol test, the exercise ECG test or a further specialist appointment.

8.3 The deceased failed to mention to the doctors at the first defendant's clinic on 23 April 2000, 8 May 2000 or 29 December 2000 or at any other time the fact that he had not undertaken either of the two tests or seen a specialist.

8.4 The deceased failed to mention to doctors at the Alice Springs Hospital on 15 August 2000, 3 December 2000 and 30 December 2000 the symptoms which he suffered on 2 March 2000 and of which he complained to the second defendant on that day and the first [sic] defendant's reference to the possibility of ischaemic heart disease and his referral for tests and specialist opinion.

8.5 The deceased failed to go back to the first defendant's clinic or the second defendant for further consultation and treatment following the further symptoms he suffered on 15 August 2000, 3 December 2000 and 30 December 2000."

[249] Mr Barr QC, on behalf of the plaintiff, submits that there may not necessarily have been a failure on the part of the deceased to give a proper history when he attended Alice Springs Hospital after 2 March 2000. Mr Barr QC points to the evidence of Dr Hale (tp 303) under cross examination from Ms Gearin for the first defendant:

> "Were you aware that this man was fluent in a number of languages and, in fact, had worked as an interpreter at the hospital for some 15 months?---No, I wasn't aware of that.
>
> Now having that knowledge, does the presentation in August when he failed to give a proper history – do you give that greater

significance?---I'm not sure I would agree that he failed to give a proper history. There are two people involved: the interrogator and the patient. Whatever happened, it wasn't a complete history, but I don't regard it as necessarily his fault."

and then (tp 311-312):

"Which is if he had given a proper history when he attended at the hospital with chest symptoms, then the result might well have been very different, mightn't it?---I think .... it would have been different if there had been a higher index of suspicion on the basis of his story.

Exactly. Because when he attended at the hospital in August, and when he attended at the hospital on 3 December 2000, he gave as part of his history an explanation for his pain?---A possible cause.

Yes?---Well, I still don't understand why he presented as if grandstanding. Is that what you're saying?

I'm not suggesting anything. I'm just asking you to answer my question, which is that because he attended in isolation at the hospital without giving a proper history, that he gave an explanation for his pain, that it was appropriate that those people accept that history?---I don't think it's necessary for people to accept that history.

Well, what do you think they should have done?---Well, it's happened two – three times to December.

They don't know about March?---Well, that's a – is there not some problem there with communication?

Yes, the problem, doctor, is that the deceased did not give a proper history. That's the problem?---Well I still find it difficult to regard a history as being improper if he'd presented with some symptom related to the chest. That's simply the crux of it. Whether the medical people should have taken greater care on receipt of that history from him and the possible causes that he suggests, not necessary for the medical people to accept .... those offerings as being the only way to operate from."

[250] It is the submission for the plaintiff that the contention on behalf of the defendants' that the deceased failed to give a proper history implies the

deceased made, or should have made, a connection between his presentation on his attendance on Dr Boffa on 2 March 2000 and his subsequent attendances at Congress and the Alice Springs Hospital. Further, Mr Barr submits that none of the symptoms recorded in the Alice Springs Hospital notes are the same or even similar to that noted at the time of the deceased's attendance on Dr Boffa such as to enable the Court to conclude that the history the deceased gave at each subsequent attendance was "not a proper history".

[251] The record of the deceased's attendance at the Alice Springs Hospital and the history recorded on each of his attendances is set out in Exhibit D3.

[252] The deceased attended the Alice Springs Hospital Emergency Department on 15 August 2000, 3 December 2000, 30 December 2000, 2 January 2001 and the date of his death on 26 January 2001.

[253] I am not able to determine whether or not the deceased "failed to give a proper history" in the sense of whether or not he accurately described his symptoms when he attended at Alice Springs Hospital. The doctors who attended to him at Alice Springs Hospital appear to have made careful notes of the history he gave and of his symptoms on examination. There is no reason to conclude these doctors did not accurately record what they were told by the deceased. I am able to determine that, on the balance of probabilities, he made no reference to his attendance at Congress on 2 March 2000, or to the advice given to him by Dr Boffa. In view of the

importance of that advice and the importance of the subsequent tests that the deceased failed to attend, failure to make reference to this when the deceased consulted doctors at Alice Springs Hospital must amount to contributory negligence. I am satisfied, on the balance of probabilities, that the deceased well understood the advice he was given by Dr Boffa, that it was important for him to attend for the follow up tests for a fasting cholesterol test and attend the physicians clinic. I am satisfied the deceased was clearly told by Dr Boffa that it was important to take these tests to exclude the possibility of a very serious condition with respect to his heart. He chose never to mention this to doctors at Alice Springs Hospital or to advise them he did not attend for the prescribed tests.

[254] Mr Barr QC on behalf of the plaintiff, sought to explain the deceased's failure to follow up his fasting cholesterol test and his appointment at the physician clinic because Dr Boffa told the deceased that he probably did not have ischaemic heart disease and because Dr Boffa did not tell the deceased he could suddenly die without warning.

[255] Dr Boffa was cross examined on this issue at considerable length (tp 408, wrongly recorded as re-examination). The substance of this evidence from Dr Boffa is that he did explain to the deceased the full seriousness of what he suspected the deceased could have, namely an ischaemic heart condition. Dr Boffa gave evidence he detailed the risk factors for ischaemic heart disease to the deceased. He gave evidence that he had explained to the deceased about the obstruction of blood vessels to the heart and the damage

to the heart muscle. Dr Boffa was satisfied he had communicated these matters to the deceased and the deceased had understood all that he had been told.

[256] It is Dr Boffa's evidence that, as at 2 March 2000, he did not think the deceased would die suddenly before he saw the specialist on 21 March. He had told the deceased there was a small possibility he had ischaemic heart disease and that it was essential he take the tests to exclude such a possibility. Dr Boffa was satisfied the deceased understood this advice. Dr Boffa also gave evidence the deceased himself had asked for a further opinion and was keen to undertake the tests and consult a specialist.

[257] Counsel for the plaintiff invited the Court to conclude that the deceased probably felt reassured by the doctor's statement that there was only a small possibility or low likelihood that he had heart disease and so probably did not have heart disease.

[258] I do not draw such a conclusion. I am satisfied, on the balance of probabilities, that Dr Boffa expressed his opinion at the time that there was a low likelihood the deceased had heart disease. I am also satisfied, on the balance of probabilities, that Dr Boffa explained the potential seriousness of ischaemic heart disease and the importance of the follow up appointments he had made for the deceased, so as to ensure the possibility of ischaemic heart disease could be excluded. In accepting this evidence, it appeared that Dr Boffa was striking the right balance between not unnecessarily alarming

his patient but stressing the importance of the further appointments. I accept he was accurately expressing his opinion as at 2 March 2000.

[259] The deceased failed in his own interests to attend either appointment or to ever raise the issue of these tests when he subsequently attended Congress for other unrelated conditions. As such, there must be a discount in the award of damages to the plaintiff for the deceased's contributory negligence.

[260] The deceased owed a duty to exercise reasonable care for his own safety, health and wellbeing. I have found he failed to exercise such reasonable care in the following ways:

- Failed to attend the fasting cholesterol test.
- Failed to attend the physicians clinic on 21 March 2000.
- Failed to ever approach Congress at a later time for another appointment for each test.
- Failed to raise the matter again with a doctor on his subsequent visits to Congress.
- Attended the Alice Springs Hospital with complaints of chest pain but failed to tell any of the doctors who attended him at Alice Springs Hospital about the advice he had been given by Dr Boffa when he attended Congress with chest pain on 2 March 2000.

[261] There is evidence the deceased had a good level of understanding of English. He had been in employment. In particular he had worked as a

liaison officer at the Alice Springs Hospital for over 12 months. He was not an unsophisticated or uneducated man such that he could have failed to understand the significance of the advice he was given by Dr Boffa. The principles of contributory negligence are set out in the written submissions of Ms Gearin, counsel for the first defendant as follows:

> "52. As was pointed out in the recent Northern Territory Full Court decision in *Preti v Sahara Tours and Parks and Wildlife Commission* [2008] NTCA 2 delivered 7 April 2008 at page 7:
>
> > [9] The apportionment of liability where a person suffers damage as a result partly of the person's failure to take reasonable care and partly of the wrong of another person is addressed in Pt V of the Law Reform (Miscellaneous Provisions) Act read with s 11 of the Compensation (Fatal Injuries) Act by providing the damages recoverable in respect of the wrong be reduced "to the extent the Court thinks just and equitable having regard to the claimant's share in the responsibility for the damage". In *Pennington v Norris* the High Court explained the process of apportioning damage in the following terms:
> >
> > > 'What has to be done is to arrive at a 'just and equitable' apportionment as between the plaintiff and the defendant of the 'responsibility' for the damage. It seems clear that this must of necessity involve a comparison of culpability. By 'culpability' we do not mean moral blameworthiness but degree of departure from the standard of care of the reasonable man. To institute a comparison in respect of blameworthiness in such a case as the present seems more or less impracticable, because, while the defendant's negligence is a breach of duty owed to other persons and therefore blameworthy, the plaintiffs 'contributory' negligence is not a breach of any duty at all, and it is difficult to impute 'moral' blame to one who is careless merely of his own safety.'

[10] In *Nance v British Colombia Electric Ry Co Ltd* [1951] AC 601 at 611 it was said that:

> '… when contributory negligence is set up as a defence, its existence does not depend on any duty owed by the injured party to the party sued, and all that is necessary to establish such a defence is to prove to the satisfaction of the jury that the injured party did not in his own interest take reasonable care of himself and contributed, by his want of care, to his own injury.'

[11] An enquiry into contributory negligence is not limited to the specific mechanism of the injury sustained in a particular case but, rather, extends to a broader consideration of the activity in which the injured person was engaged and the general fact of his participation. The issue is concerned with the failure of a plaintiff to protect his or her person against damage, whether or not that failure contributed directly to the accident: *Astley v Austrust Ltd* (1991) 197 CLR 1 at 14. Contributory negligence 'certainly includes failure to adopt reasonable precautions or a reasonable course of action to avoid the consequences or risks which the defendant's negligence sets up.': *Insurance Commissioner v Joyce* (1948) 77 CLR 39 at 56 per Dixon J. The plaintiff is guilty of contributory negligence when the plaintiff exposes himself to a risk of injury which might reasonably have been foreseen and avoided and suffers an injury within the class of risk to which the plaintiff was exposed: *Joslyn v Berryman* (2003) 214 CLR 552 at 558 per McHugh J. There is involved a comparison of culpability, that is, the degree of departure from the standard of care of the reasonable man *(Pennington v Norris* supra at 16) together with a comparison of the relative importance of the acts of each of the parties in causing the damage. The whole conduct of each party in relation to the circumstances of the accident must be subjected to examination: *Podrebersek v Australian Iron & Steel Pty Ltd* (1985) 59 ALJR 492 at 494."

[262] I apply those principles to the facts in this case. I find the contributory negligence of the deceased amounts to 50 percent.

Quantum of Damages

[263] In assessing the quantum of damages I have essentially followed the table included in the submissions made by Mr Lindsay, on behalf of the plaintiff, as to what was probable. This is supported on the evidence of Hugh Sarjeant in Exhibits P15, P16 and P17.

Past Lost Dependency

[264] I accept that the deceased would have earned approximately $200 per week net. He had been performing CDEP work earning $150 per week. However he did have a number of skills and work experience, particularly in the health area which would have been a basis for a greater earning capacity. The mathematics is as set out by Mr Lindsay that if the deceased had earned $600 per week net of tax for 10 percent of the period between his death and trial he would have earned an average of $200 per week over that period.

[265] In coming to this conclusion I have rejected the submission made by Ms Gearin on behalf of the first defendant that the deceased had chosen to limit his work involvement to the CDEP program or that he may not have continued with CDEP at all. The deceased had previously been employed outside the CDEP program. He had the skills and ability to do this and there is no reason to assume he would necessarily have gone to gaol again or had some other reason apart from his health, for not working at all.

[266] Evidence as to the earnings of Rosario Young are contained in her tax returns (Exhibit D2). Details of her pension receipts are included in Exhibit P48. At trial, Rosario Young gave evidence she was receiving a pension plus $50 a week for looking after her aunty. The plaintiff earned $200 a week. The plaintiff and the deceased pooled their income.

[267] I accept the that probability is the deceased would have given 63.1 percent of his money to his wife for the support of his family and that this is the level of dependency. I do not accept the submission made on behalf of the defendant that there was evidence of a substantial portion of his income used on discretionary spending by the deceased on petrol for his personal use, or alcohol for his personal consumption.

[268] I agree that there was a total of 340 weeks from the date of death to the commencement of the trial in February 2008. This allows for a deduction of six months to cover the time the deceased would not have been able to work if he had been receiving treatment.

[269] Multiplying these figures comes out to $42,908. Interest at five percent over seven years is $15,017 making a total of $57,925. I would add a further 10 percent for positive contingencies amounting to $63,717.5. The reason I have allowed for a positive contingency of 10 percent is because the deceased was moving into a more mature age group with a wife and young family. He was, in all probability, less likely to commit a crime that would result in a gaol sentence. He had valuable skills and experience that would

make him increasingly useful in the workforce. Either on the day, or the day after his death, his wife was advised that the health problems with their youngest child had resolved which would relieve the family of some of the stresses related to the infant's illness. It would also have opened up other lifestyle options as the family would not have to be basing their lives around the child's need for constant medical care.

[270] The amount that is awarded to Rosario Young, who has had responsibility for the support of the family for the majority of the time since the deceased's death, is summarised as follows:

Earning	$ 200.00 per week
Dependency	63.1 percent
Weeks Since Death	340
Total	$ 42,908
Plus Interest @ 5% over 7 years	$ 15,017

Sub Total	$57,925
Plus 10 percent for positive contingency	$ 5,792.5
	–––––––––
TOTAL	$63,717.5

Future Loss Dependency

[271] I accept the probable earning capacity of the deceased would be $250 per week. This is on the basis of his ability to earn additional income from time to time over and above the CDEP. He had chosen to acquire further skills whilst he had been in gaol. He had been a willing and co-operative prisoner.

He had a growing family to support. He had previously demonstrated a capacity to retain a job at the Alice Springs Hospital as a liaison officer.

[272] The next factor to consider is the question of life expectancy. Dr Hale estimated this to between 10-15 years. Dr Sangster gave a slightly more favourable prediction. Mr Lindsay, on behalf of the plaintiff, was prepared to rely on the estimates provided by Dr Hale. Counsel for the defendants argued that the deceased's lifestyle, nutrition, alcohol consumption and smoking would have continued and reduced his life expectancy to the lower end of the scale namely no more than 10 years. There is evidence that he did drink alcohol. However, there is no evidence that he was a continual heavy drinker. There is evidence he did smoke and had continued smoking. I am satisfied that had he received treatment and with his background in the health area he could have been persuaded to give up smoking. I rely on the evidence of Dr Hale that it sometimes takes more than one warning to make patients give up smoking and doctors will always keep trying to achieve this. I would make a finding that he had a life expectancy of 12 years. I accept the multiplier provided by Mr Lindsay of 286 and the dependency percentage of 66.2 percent making total for future loss dependency of $45,477. I accept the break up in percentages between the deceased's wife and three children as stated by Mr Lindsay in annexure 1 to his written submissions. This is as follows:

[273]

Earning Capacity	250
Life Expectancy	12 years
Multiplier	286
Age of Dependency	18
Dependency %	66.2 %

Rosario	$ 16,370
Bruce	$ 7,921
Norman	$ 10,593
Raelene	$ 10,593

TOTAL	$ 45,477

I would increase this by 20 percent for the positive contingencies which I have already referred to

Rosario	$ 19,644
Bruce	$ 9,505.2
Norman	$ 12,711.6
Raelene	$ 12,711.6

TOTAL	$54,472.4

In addition to those matters the deceased, as he matured, could be expected to become more settled and benefit from increasing opportunities for employment of aboriginal people.

[274] The mathematical calculations provided by Mr Lindsay are not in dispute and I do not consider it necessary to set them out. They are detailed in the various annexures to Mr Lindsay's written submission dated 25 March 2008.

Past Household Services

[275] The next heading under quantum of damages is the "Past Household Services" component. The evidence on this aspect is the evidence of Rosario Young. Mrs Young gave evidence on this issue and has not been challenged. I accept that the deceased would assist his wife by washing the clothes, helping with the cooking, washing the dishes and mopping the floor. Mrs Young stated her husband did these things while she looked after the children. It is her evidence that he used to start early to do things and would do these things on the weekend.

[276] I accept the probable estimate suggested by Mr Lindsay of 13 hours per week at an hourly rate of $22 over the 340 weeks from the date of death to the date of the trial in February 2008, again reducing the time by six months to allow for time with respect to treatment. This is a figure of $97,240 with interest at five percent per year over seven years amounting to $34,034 making a total for Past Household Services of $131,274.

Future Household Services

[277] I then move to consider Future Household Services. The proposal under the heading Future Household Services (annexure "6") prepared by Mr Lindsay

appears very reasonable. The type of services may change to some extent as the children grow older but still involve a considerable amount of work. The deceased had already demonstrated a willingness to share the household chores and provide assistance to his wife. I accept the Future Household Services would be 10 hours a week at $30 per hour with a multiplier of 286. This is a told of $85,800.

[278] I would increase this by 10 percent for the positive contingencies including the fact that as the children grew older, the deceased would have increased his commitment particularly with respect to the work associated with the two boys. There is evidence of Mrs Young that he would take them out bush which involved organising food for them. He would take the boys to football which would also involve some component of household work. This brings the total for Future Household Services to $94,380.00.

Solatium and Consortium

[279] The final head of damages to consider is the solatium and consortium for Mrs Young and the children.

[280] With respect to Mrs Young, I approach this on the basis of the plaintiff's perspective of her loss. There were clearly a number of stresses and strains within their relationship. Mrs Young had to contend with a husband who had gone to gaol for a substantial period of time. He did not always please her with his behaviour. Nevertheless, their relationship held together through a number of significant difficulties, including the initial rejection of

the relationship by their respective families, the deceased's period of time in gaol, the effects on the family of the ill health of their baby daughter and the deceased's request to the plaintiff to take a second wife. Mrs Young gave evidence as to the importance of the deceased in her life. They had three children. He assisted in the home and with the children. He provided her with protection and stopped people humbugging her. She loved him and regarded him as her best friend. Mrs Young detailed the initial affect upon her of his death. The family of the deceased stripped everything from her house and took the children out of her care for 12 months. Counsel for the plaintiff and the first defendant are in agreement with the sum of $40,000 for solatium. I consider that to be reasonable and accordingly award $40,000 to Mrs Young as solatium.

The Solatium and Loss of Care and Guidance in respect of the children

[281] There is evidence of a close relationship between the deceased and his two sons. Mrs Young gave evidence he had taken them out bush, taken them hunting and fishing and taken them to football matches. During the period of approximately nine months that Mrs Young had to take the baby Raelene to Alice Springs Hospital, the deceased was the primary carer for the two boys. I accept the evidence of Mrs Young that both boys were upset and grieved the loss of their father. Their father will not be there at the important time of their initiation ceremonies or to provide love and guidance through their lives. I consider this is a loss which cannot be adequately

replaced by grandparents or other relatives. With respect to Raelene Impu, it is the submission made by Ms Gearin on behalf of the first defendant that Raelene's claim is limited because of her gender and the fact she has no memory of her father. I do not consider the award to her should be reduced on this basis. Her gender does not mean the loss of a father is any greater or lesser than for her two brothers. Her father had stayed within the family unit during the difficult months of Raelene's illness. She has lost a person whom she could have expected to look to for love and guidance for many years. The fact that she may have no memory of her father is, in itself, a source for sadness. I see no reason to distinguish between any of the three children. I would award them each $30,000 for solatium and for the loss of care and guidance.

Summary Quantum of Damages

Past Loss of Dependency	$ 42,908	
Plus Interest 7 years @ 5%	15,017	

	$ 57,925	
Plus 10% for Positive Contingencies	5,792.5	

		$ 63,717.5
Future Loss Dependency	$ 45,477	
Plus 20%	9,095.4	

		$ 54,572.4

Past Household Services	$ 97,240	
Interest 7 years @ 5%	34,034	

		$ 131,274
Future Household Services	$ 85,800	
Plus 10% for Positive Contingencies	8,580	
	---	$ 94,380
Solatium re Ms Young	$ 40,000	
Loss of Care and Guidance at $30,000 for each of the three children	90,000	
	---	$ 130,000
Sub Total		$ 473,943.9

The Award is to be reduced by 50 percent being the level of contributory negligence by the deceased:

TOTAL	**$ 236,972**

The Third Party and the First Defendant

[282] The third party proceedings are a live issue because I have found the first defendant is liable in damages to the plaintiff as a consequence of the first defendant's breach of duty.

[283] The first defendant issued a third party notice originally in the Local Court where these proceedings were commenced. The third party notice claims inter alia:

"3. At all material times the First Defendant had with the Third Party a current policy of insurance described therein as Malpractice Establishments (CGU MAL EST 03/99) (hereinafter referred to as 'the policy').

4. The policy provided *inter alia*, cover of the First Defendant against claims for breach of professional duty in the delivery by the insured of health care services in dentistry, psychology, nursing and administration.

5. By her Statement of Claim filed on 28 February 2003, the Plaintiff alleges *inter alia* an administrative failure on the part of the First Defendant. The First Defendant has duly notified the Third Party of the claim against it and sought to be indemnified as against any judgement, award or settlement pursuant to the claim, as well as its legal costs of and incidental to the proceedings, as provided for under its policy of insurance with the Third Party.

6. The Third Party refuses to indemnify the First Defendant under the policy and denies liability for the whole of any judgement, award or settlement, or legal costs in respect thereof.

7. The First Defendant therefore prays that the Third Party be joined in these proceedings and seeks an order that the Third Party indemnifies the First Defendant in accordance with the policy."

[284] The third party filed an amended defence to the first defendant's Statement of Claim essentially denying the liability of the third party to indemnify the first defendant under the terms of the insurance policy. It was not in dispute that the first defendant held a policy of insurance with the third party being a Malpractice Establishment Insurance Policy which was valid from 4.00 pm 10 July 2000 to 4.00 pm 10 July 2001. The policy number was 04MAL0302118 and included a schedule.

[285] The third party also raised an issue as to whether it should have been joined which is relevant to costs only.

[286] The policy is Exhibit D46. A summary of the relevant provisions of the policy were provided to the Court. The cover that is offered by the policy is set out in s 3 and defined in Special Condition 5 as follows:

> "This Policy covers the Insured for Breach of Professional Duty as Health Care services for the provision of dentistry, psychology, nursing and administration services only. …"

[287] This is limited by an exclusion in special condition 2 in the schedule which is headed "Medical Malpractice Exclusion" and reads:

> "It is hereby declared and agreed that this Policy does not cover any Claim/s against medical practitioners whether such medical
>
> practitioners are employed or acting as a contractor of the Insured entity.
> 'Medical Practitioner' refers to doctors who are medically qualified including but not limited to anaesthiologists, radiologists, pathologists, surgeons, cardiologists or general practitioners. …"

[288] Ms Kelly, on behalf of the Third Party, argues that because of the exclusion clause in Special Condition 2 the policy does not cover Congress against any liability arising out of a breach of duty by a "medical practitioner". That is whether the breach of duty is in the provision of administration services or otherwise.

[289] I accept the principle that where there are two or more concurrent causes of the alleged loss, one of which was an insured event and one of which was an excluded event under the policy, there is no obligation to indemnify under the policy (*Wayne Tank and Pump Co Ltd v Employers Liability Assurance*

Corporation Ltd [1974] QB 57; *Elilade v Nonpareil Pty Ltd* (2002) 124 FCR 1 per Mansfield J [51] to [55].

[290] Ms Kelly asserts that if there was any negligence by Congress, it was a breach of duty by one or more of the three medical practitioners, Dr Boffa, Dr Janusic and Dr Yazdani.

[291] I have already dealt with all of the assertions with respect to Dr Boffa and found that the plaintiff has failed to satisfy me on the balance of probabilities that Dr Boffa was negligent.

Dr Janusic

[292] Dr Janusic was placed in a very difficult position because she had been given the wrong file, being a file for a person with the same name as the person for whom the appointment at the Physician Clinic was intended. The file Dr Janusic had was for Clive Impu Snr, a diabetic. I would agree with Ms Kelly's submission that, as there was no indication on the file of Clive Impu Snr as to why he had been referred and with the possible serious complications of diabetes, it would have been reasonable, in the circumstances, for Dr Janusic to make further enquiries about why that patient had been referred in order to make a clinical judgment about what kind of follow up was appropriate. There was no evidence from the file to indicate Clive Impu Snr would necessarily have presented again within a short space of time so that an opportunistic follow up could have taken place. Clive Impu Snr had attended the clinic on three consecutive dates in

January 2000 for the dressing of a wound. Prior to that, it was nine months before he attended the clinic relating to an eye problem and prior to that, January 1999, with an alcohol related problem. There were earlier entries in 1998 indicating a failure to attending an appointment and attend but not waiting to be seen. The two occasions he was seen were for relatively minor matters. Dr Janusic gave evidence that the file she was given was of a regular attendee who was already on medical treatment and already had blood tests so there was no reason to think he was inappropriately there. No alarm bells went off as far as Dr Janusic was concerned and she believed he would be picked up on the next visit.

[293] However, an examination of the file of Clive Impu Snr reveals that his last attendance prior to 21 March 2000 on 24 January 2000, was for the treatment of a wound. There was no information about why he would have been referred. There was no reason to assume he would be back within a couple of weeks for medication. In fact, it appears from the file he did not return to Congress until 15 May 2000. There is no indication that on that date the reason for his referral on 21 March 2000 was addressed. He was a diabetic and there could have been reasons for the referral that needed further inquiry. These further enquiries included, but were not limited to, an enquiry at the reception desk as to the existence of a referral form which would have alerted Dr Janusic to the possibility of another file.

[294] It was known that approximately 10 percent of patients at Congress had the same name. There must always exist the possibility that there is another file

in the same name. An enquiry at the reception desk could have revealed the existence of the file for Clive Impu Jnr.

Dr Yazdani

[295] The next medical practitioner at Congress to see the deceased after 2 March 2000 was Dr Yazdani. This was on 23 April 2000 when the deceased attended to have boils treated. Dr Yazdani does not appear to have read the note of Dr Boffa on 2 March 2000 which was immediately above the note Dr Yazdani wrote on 23 April 2000. There is no mention of a query as to whether the deceased had undertaken the tests that had been prescribed. Both Dr Boffa and Dr Janusic gave evidence that in accordance with sound practise the next treating doctor should familiarise himself with the patient's history. This was not done. Dr Yazdani also saw Clive Impu Snr on 15 May 2000. There is no indication he enquired about the notation made by Dr Janusic on 21 March 2000 which was the last note on the file. Had he done so the error could have been discovered at that point.

Findings

[296] I have already detailed the findings of administrative failure by the administrative staff at Congress.

[297] Ms Kelly argues that as the medical practitioners contributed to the failures that led to the deceased's death, the exclusion clause in Special Condition 2 of the policy applies and the third party is not liable to indemnify Congress.

[298] Ms Gearin, counsel for the first defendant, submits that any negligent administrative action by medical practitioners is covered by the policy and not excluded.

[299] It was submitted, on behalf of the first defendant, that Section 11 of the policy identifies words with special meanings. "Malpractice" is specifically defined as "[b]reach of professional duty of care in the provision of medical services". Ms Gearin argues that, if the policy was seeking to exclude all actions by medical practitioners, then it would have identified the special condition as "Medical Practitioners Exclusion".

[300] The position for the first defendant is that any negligent administrative action by medical practitioners is covered by the policy of insurance.

[301] I do not accept the submission made on behalf of the first defendant. I do not think it necessary, as counsel for the first defendant suggested, to analyse which actions of either Dr Boffa, Dr Janusic or Dr Yazdani were administrative and which were medical.

[302] I agree with the submission made by Ms Kelly that s 6.11 of the policy clearly states that medical practitioners are excluded from this policy. Section 6 of the policy is headed "What is not covered". Section 6.11 is headed "Medical Practitioners". It then provides:

> "Claims against Medical Practitioners, regardless of whether such Medical Practitioners are employed by the Insured or acting as a contractor of the Insured entity."

[303] The death of the deceased was brought about by a combination of failures, including failures in the administrative system at Congress, failures by medical practitioners at Congress and failures by the deceased himself.

[304] I consider, on the plain reading of the policy, "Medical Practitioners" are excluded from cover under the policy in whatever capacity they may be acting.

[305] I also agree with Ms Kelly that it is the insurance policy which determines the rights as between the first defendant and the third party. The provisions of the Law Reform (Miscellaneous Provisions) Act are not relevant as between the first defendant and the third party.

[306] Accordingly, I dismiss the proceedings against the third party. I enter judgment for the third party on the third party proceedings.

[307] Summary of Orders

1. Judgment in favour of the plaintiff against the first defendant in the sum of $236,972.

2. Judgment in favour of the second defendant against the plaintiff.

3. Judgment in favour of the third party against the first defendant.

4. The parties have liberty to apply on the questions of costs.

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