No. D-0007

COMMONWEALTH OF AUSTRALIA

ROYAL COMMISSIONS ACT 1902

ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

DARWIN CAIRNS HEARING

ASSISI CENTRE AGED CARE CASE STUDY

SUBMISSIONS ON BEHALF OF DR ERIC TAY

Introduction

1. These submissions are made, in part, in response to the Submissions of Counsel Assisting dated 24 July 2019 (**CA Submissions**).

2. On 10 July 2019 Dr Eric Tay (**Dr Tay**) gave evidence at the Darwin Cairns Hearing in relation to his involvement in the management of the late Mrs Annunziata Santoro (**Mrs Santoro**) at Assisi Aged Care Centre (**Assisi**).

3. In this submission where reference is made to a document it will be footnoted by reference to the tab in the Assisi tender bundle (Exhibit 6-13) and by reference to the specific document number.

4. In these submissions reference will also be made to Exhibit 6-15 – the Witness Statement of Ms Ng dated 18 June 2019 (Document ID WIT.0169.0001.0001) and Exhibit C-16 – the Statement of Dr Tay dated 2 July 2019 (Document ID WIT.0248.0001.001).

5. Where the submissions are by way of response to CA Submissions they will refer to the relevant paragraph(s).

Findings which are critical of Dr Tay – applying the Briginshaw standard

6. The CA Submissions seek findings which are in places critical of Dr Tay's management of Mrs Santoro and/or his administrative practices both generally and in relation to patients at Assisi such as Mrs Santoro. Given the seriousness and significance of findings which are critical of Dr Tay it is submitted that the Royal Commission ought to only make such findings in relation to Dr Tay where it is satisfied that the Briginshaw standard[1] of actual persuasion, in relation to the quality of the evidence, has been reached.

Dr Tay as a witness

7. Dr Tay gave his evidence in an open and candid fashion and readily made concessions and acknowledged shortcomings in relation to his practice, both generally and in relation to Mrs Santoro. It is submitted that the Royal Commission should have no doubt regarding Dr Tay's honesty or candour and should find accordingly.

[1] Briginshaw v Briginshaw (1938) 60 CLR 336

8. It is submitted that where there is any conflict between the evidence of Dr Tay and that of Ms Ng in relation to any communication between them, the evidence of Dr Tay ought to be preferred; for example, in these submissions, we will address the conflicting evidence in relation to the decision to prescribe Quetiapine and the notification of the administration and increased dosing of that medication over time.

Dr Tay as a general practitioner

9. Dr Tay gave his evidence, including his witness statement, in a fashion which demonstrated his experience and competence as a general medical practitioner both generally and in his management of patients at Assisi, and other residential aged care facilities, such as Mrs Santoro. The whole of the evidence demonstrates that Dr Tay actively involved himself in Mrs Santoro's management both in relation to his regular fortnightly attendances at Assisi and other attendances, as indicated, and in the frequency of his communications with staff at Assisi and Mrs Santoro's family; predominantly Ms Anna Ng (**Ms Ng**). For example, we refer to the extensive email correspondence[2].

10. In her evidence Ms Ng[3] stated that the general practitioner managing Mrs Santoro prior to Dr Tay did not want to correspond with her directly or consult with her in terms of decisions he was making in relation to Mrs Santoro's management.

11. At the conclusion of her evidence Ms Ng[4] described Dr Tay as being "*very supportive and incredibly professional compared to the staff at Assisi*" and that he was her best support at that time.

Dr Tay commences Mrs Santoro's management

12. Although it was Ms Ng's evidence that in late 2017 a nurse manager at Assisi recommended Dr Tay take over the management of Mrs Santoro[5] Dr Tay first received a request from Assisi, by email, to accept a new patient (Mrs Santoro) on 17 April 2018[6].

13. It is not contentious that Dr Tay first consulted with Mrs Santoro and Ms Ng on 26 April 2018.

14. Following that initial consultation Dr Tay made arrangements for Mrs Santoro to be reviewed by a geriatrician. A referral letter was sent[7]. Mrs Santoro was reviewed by the geriatrician at Assisi on 15 May 2018. The geriatrician subsequently wrote to Dr Tay by way of letter of report[8].

15. Paragraph 29 of the CA Submissions identifies an illustration of the lack of communication between Dr Tay and Assisi staff on the basis that Dr Tay did not provide to the Assisi staff a copy of the letter he received from the geriatrician. In his evidence[9] Dr Tay stated that there was a copy of the geriatrician's letter in the Assisi records. He was not challenged on that evidence. Relevantly the geriatrician made an entry in the Assisi progress notes[10]. This is a very detailed entry which sets out the relevant history, assessment, involvement of Ms Ng and her brother Frank, the extensive physical examination and recommendations for

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2 Exhibit 6-13, Tab 247 & 248 – DET.0001.0002.0001 & DET.0001.0003.0001
3 Transcript, Annamaria Ng, T3058.30-3059.06
4 Transcript, Annamaria Ng, T3081-41-44
5 Exhibit 6-13, WIT.0169.0001.0001 at 0007
6 Exhibit 6-13, Tab 247 – DET.0001.0002.0001
7 Exhibit 6-13, Tab 246 – DET.0001.0001.0001 at 0045
8 Exhibit 6-13, Tab 246 – DET.0001.0001.0001 at 0053-55
9 Transcript P3091.43
10 Tab 420 – ACL.501.0001.6683 – pages 6837-6541

ongoing management including changes in medication. The geriatrician's recommendations were identified by the Assisi nurse unit manager at that time who made an entry in the progress notes accordingly including changes in medication[11].

16. It is submitted that the relevant information from the geriatrician was immediately available to, and acted upon by, Assisi staff following her assessment and any failure on the part of Dr Tay to provide Assisi staff with a copy of the letter from the geriatrician could in no way have been detrimental to the management of Mrs Santoro.

Record Keeping by Dr Tay

17. In his evidence Dr Tay acknowledged that the entries he had made in the Assisi records and those of the Andrew Place Medical Clinic were less than adequate. He was candid in making this acknowledgement.

18. In his evidence Dr Tay identified that the ideal (perfect) [12] situation would ensure that those involved in the management of a residential aged care facility resident such as Mrs Santoro would have access to both the medical records of the visiting general practitioner and the relevant records of the RACF. It is submitted that there are significant practical considerations, including confidentiality, which might argue against RACF staff having access to the general practice records. It is also submitted that it would be greatly beneficial if visiting general practitioners, such as Dr Tay, were able to have remote access to the RACF records both to monitor the progress of the patient and include information in the records, including the ability to include medical material received at the general practice such as specialists' letters and hospital discharge information.

Chronic Pain

19. It is not clear when Mrs Santoro was first prescribed Norspan (20mcg).

20. In his evidence Dr Tay agreed that in her report the geriatrician had referred to Mrs Santoro having "*chronic pain syndrome*". The geriatrician identified that Mrs Santoro had been prescribed long term opiates. It was the geriatrician, and not Dr Tay, who ordered the initial reduction in dosage of Norspan from 20mcg to 15mcg and in so doing noted "*there are no symptoms of pain and it would be appropriate to try and slowly reduce the dose to the lowest possible dose.*"[13].

21. Dr Tay further reduced the Norspan from 15mcg to 10mcg on 7 June 2018.[14] [15] [16]

22. Mrs Santoro ceased being prescribed Norspan whilst an inpatient at Austin Hospital from 12 – 17 July 2018. She was discharged from Austin Hospital on low dose Targin (Oxycodone – Naloxone) 2.5mg in the morning[17] which was ceased on 21 July but Mrs Santoro continued on prn Endone 5mg[18].

23. Mrs Santoro attended Austin Hospital ED on 6 August 2018[19] at which time it was noted that Mrs Santoro was "*not distressed by pain*" and "*her behaviours are at baseline*" and the

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[11] Exhibit 6-13, Tab 420 – ACL.501.0001.6842
[12] Transcript P3088.40
[13] Exhibit 6-13, Tab 246 – DET.0001.0001.0053 & 0055
[14] Exhibit 6-13, Tab 420 – ACL.501.0001.6842 at 6869
[15] Exhibit 6-13, Tab 246 – DET.0001.0001.0053 at 0006
[16] Exhibit 6-13, Tab 169 – ACL.501.0001.0609
[17] Exhibit 6-13, Tab 232 – ACL.001.0004.0252 at 0253
[18] Exhibit 6-13, Tab 183 – CTH.4003.9000.0544 at 0544 & 0551
[19] Exhibit 6-13, Tab 235 – ACL.001.0004.0218

formal pain assessment conducted at that time documented scores of 0 for pain at rest and on movement together with a sedation score of 0. Nonetheless it is recorded that Mrs Santoro was still given Olanzapine due to agitation.

24. It is submitted that Mrs Santoro's pain was a complex issue in relation to which Dr Tay was guided in his management by the actions and decisions of the geriatrician and Austin Hospital medical staff.

Prescription of Quetiapine and Dosing Changes

25. In his statement Dr Tay stated that on 14 June 2018 he proposed to commence Mrs Santoro on Risperidone in order to address concerns regarding agitation / behaviour held by Assisi staff[20]. Dr Tay went on to say that after discussing the question of anti-psychotic medication with both the geriatrician and Ms Ng, a decision was made to commence Mrs Santoro on Quetiapine[21]. In his statement and evidence Dr Tay provided details of the changes in the dosage of Quetiapine from time to time. Whilst Dr Tay acknowledged that he had made no record of Ms Ng's consent to Mrs Santoro being treated with Quetiapine and no record of his discussion with Ms Ng regarding side effects, it was not put to Dr Tay that these conversations with Ms Ng had not occurred.

26. Following the conclusion of Ms Ng's evidence in chief she was asked further questions regarding a conversation with Dr Tay on 14 June 2018 regarding Risperidone and Quetiapine. Ms Ng indicated she did not disagree that such a conversation had taken place[22]. Ms Ng also did not dispute having received an email from Dr Tay on 25 June 2018 which referred to a reduction in the frequency of Quetiapine[23].

27. This evidence from Ms Ng was in contrast to what she had earlier said in examination[24] and at paragraph 75 of her statement[25].

28. In his statement Dr Tay specifically referred to a meeting with Ms Ng and one of her brothers at his rooms on 16 August 2018 in which there was a discussion regarding Mrs Santoro's medication and an agreement that the dose of Quetiapine would be increased to address the family's concerns. Ms Ng did not give any evidence in relation to that meeting which is referred to in both Dr Tay's records and the Assisi records[26] [27]. Dr Tay was not challenged in relation to that evidence.

29. The meeting between Dr Tay and Ms Ng, at his rooms, on 16 August 2018 is also referred to by Ms Ng in her email to him at 6.51pm that day "*I just wanted to say thank you for your time today. Your honesty and frankness was much appreciated.*"[28]

30. On 26 July 2018 Dr Tay received information from the Assisi nurse unit manager that Ms Ng would no longer be the primary contact for Mrs Santoro and that Mrs Santoro's son, Tony, would assume that role[29].

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[20] Exhibit 6-16, WIT.0248.0001.0001 paragraph 26
[21] Exhibit 6-16, WIT.0248.0001.0001 paragraph 26
[22] Transcript P3080-41-P30.81-20
[23] Transcript P3081.26-36
[24] Transcript P3068 at 45
[25] Exhibit 6-15, WIT.0169.0001.0013
[26] Exhibit 6-13, Tab 246 – DET.0001.0001.0001 at 0008
[27] Exhibit 6-13, Tab 420 – ACL.501.0001.6683 at 6964
[28] Exhibit 6-13, Tab 247 – DET.0001.0002.0001 at 0049
[29] Exhibit 6-13, Tab 247 – DET.0001.0002.0001 at pages 0025 - 0026

31. In her evidence Ms Ng stated that she had not been aware of the specific drug (Quetiapine) prior to receiving an email from Dr Tay's colleague, who was acting as his locum, on 20 September 2018. It is submitted that Dr Tay's evidence regarding Ms Ng's awareness of Quetiapine should be preferred. The Assisi records contain considerable documentation of Mrs Santoro's "NOK", next of kin and presumably Ms Ng on most occasions and her brother on other occasions, being advised of Mrs Santoro being prescribed and/or receiving Quetiapine and of changes in dosing, for example:

    31.1 At 21.41 on 14 June 2018 an Assisi staff member documents the telephone call from Dr Tay by which he ordered the cessation of Risperidone and change to Quetiapine (6.25mg bd) and that the "*daughter is aware as GP has spoken to her*"[30].

    31.2 On 21 June 2018 the Assisi nurse unit manager records in the progress notes advising NOK of reduction in Quetiapine from 6.25mg bd to mane[31].

    31.3 On 5 July 2018 the Assisi nurse unit manager records advising NOK that Dr Tay had ceased Quetiapine[32].

    31.4 On 9 July 2018 the Assisi nurse unit manager has recorded in the progress notes that she spoke to Ms Ng to advise that since the Quetiapine had been ceased Mrs Santoro had become restless and that Ms Ng was happy for the nurse unit manager to contact Dr Tay to request a phone order to settle Mrs Santoro down. The nurse unit manager also recorded receiving a telephone order from Dr Tay for Quetiapine 6.25mg daily and prn Quetiapine 6.25mg. Later that same day an Assisi staff member recorded in the Assisi progress notes that they had informed the daughter (Anna) of the medication change[33].

    31.5 On 11 July 2018 the Assisi nurse unit manager has recorded in the progress notes that a message was left for the NOK informing of prn Quetiapine being administered[34].

    31.6 From 12-17 July 2018 Mrs Santoro was an inpatient at Austin Hospital. In that time the dosage of Quetiapine was increased to 12.5mcg; that is, a doubling of the dosage of Quetiapine[35].

    31.7 On 18 July 2018 the Assisi nurse unit manager has recorded in the progress notes that prn Quetiapine was administered and the NOK informed[36].

    31.8 On 19 July 2018 an Assisi staff member made an entry in the progress notes that they had informed the daughter (Anna) of the medication change due to Mrs Santoro's unsettled behaviour[37].

    31.9 On 20 July 2018 the Assisi nursing unit manager recorded in the progress notes that prn Quetiapine had been given and the NOK informed.

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30 Exhibit 6-13, Tab 420 – ACL.501.0001.6682
31 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6887
32 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6895-6897
33 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6896 - 6897
34 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6898
35 Exhibit 6-13, Tab 232 - ACL.001.0004.0252 page 0253
36 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6908
37 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6913

31.10 On 24 July 2018 the Assisi nurse unit manager has recorded in the progress notes "*contacting the NOK to advise of a change in the frequency and dosage of Quetiapine and leaving a message on her answering machine*"[38].

31.11 On 27 July 2018 the nurse unit manager at Assisi sent an email to Ms Ng advising that she had given Quetiapine to Mrs Santoro with minimal effect[39].

31.12 On 29 July 2018 an Assisi staff member has recorded in the progress notes administering prn Quetiapine and contacting the NOK (Ana) who advised that her brother Tony should be called and informed of what had happened[40].

31.13 On 30 July 2018 the Assisi nurse unit manager has made an entry in the progress notes advising that prn Quetiapine had been given to Mrs Santoro and NOK informed[41].

31.14 On 30 July 2018 an Assisi staff member has recorded in the progress notes an order from Dr Tay to give Mrs Santoro a dose of Quetiapine and a 5mg Diazepam tablet, both of which were done and that Mrs Santoro's son, Tony, had been informed[42].

31.15 There is also a record in the communication log for Assisi made by a staff member of a conversation with Tony (Mrs Santoro's son) in which Tony "*gave myself a go ahead to contact her GP so he can increase her medication for restlessness*"[43].

31.16 On 2 August 2018 the Assisi nurse unit manager made an entry in the progress notes recording administration of prn Oxazepam, review by Dr Tay of Mrs Santoro's medication with increase in Quetiapine dosage and addition of Oxazepam three times daily with "*NOK contacted and appreciative of the update*"[44].

31.17 On 4 August 2018 an Assisi staff member made an entry in the progress notes of administration of prn Oxazepam (twice) and of a skin tear on the back of the right lower leg with "*son (Tony) informed when visited facility*"[45].

31.18 On 8 August 2018 Mrs Santoro was seen in the Emergency Department of Austin Hospital where a medical practitioner recorded "*patient agitated while in main dept – given Quetiapine*" and "*DW (discussion with) medical treatment decision maker Anna*"[46].

31.19 On 16 August 2018 Dr Tay records in the Assisi progress notes the increase in Quetiapine to 37.5mgs three times daily, "*prn's remain unchanged*" and "*have discussed with family and they are aware*"[47] [48]. The reference to "prns" is a reference to both Quetiapine and Oxazepam.

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38 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6918
39 Exhibit 6-13, Tab 89 – ACL.501.0001.1005
40 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6925
41 Exhibit 6-13, Tab 420 – ACL.501.0001.6682 page 6927
42 Exhibit 6-13, Tab 420 - ACL.501.0001.6682 page 6928-6929
43 Exhibit 6-13, Tab 179 – ACL.500.0001.6228 page 6241
44 Exhibit 6-13, Tab 420 – ACL.501.001.6682 page 4936
45 Exhibit 6-13, Tab 420 – ACL.501.001.6682 page 6942
46 Exhibit 6-13, Tab 236 ACL.001.0004.0213 page 0214
47 Exhibit 6-13, Tab 420 – ACL.501.001.6682 page 6964
48 Tab 359 – ACL.500.0001.9093 at 9096

32. In his statement[49] at paragraph 26 Dr Tay referred to discussing the side effects of Quetiapine with Ms Ng on 14 June 2018. It was not suggested to Dr Tay when giving evidence that he had not had that discussion with Ms Ng. Dr Tay has acknowledged that he did not make an entry in his records of Ms Ng's consent to the commencement of Quetiapine or the discussion of the side effects.

33. When giving evidence it was not suggested to Dr Tay that he had failed to discuss any relevant information concerning the use of Quetiapine with Ms Ng.

34. In his evidence[50] Dr Tay stated that he had provided information to Ms Ng regarding Oxazepam and Quetiapine which "*centred on one major thing – sedation*" and "*there were other side effects discussed including Parkinson like symptoms and cardiovascular complications*". It was not put to Dr Tay that he had not had these discussions with Ms Ng.

35. It is submitted that the evidence before the Royal Commission does not permit a finding as contended by Counsel Assisting, at 92z that "*Dr Tay did not take sufficient steps to obtain informed consent from Ms Ng before the prescription and administration in August 2018 for the late Mrs Santoro of Oxazepam and of considerably higher doses of Quetiapine*".

Mrs Santoro's Hip Wound

36. In his evidence Dr Tay has conceded that he ought to have been more pro-active in aspects of his management of Mrs Santoro including following up a hospital for a discharge summary; in this case being the discharge document following Mrs Santoro's discharge from Austin Hospital on 17 July 2018[52]. Dr Tay also acknowledged that he had some responsibility to know when Mrs Santoro's hip wound was ready for examination by him[53] [54].

37. Dr Tay stated that he had no recollection of receiving a telephone call from the Assisi nurse unit manager on 26 July 2018 in relation to a staple in the surgical site. In his evidence Dr Tay stated "*I – on recollection – I did not receive that information*"[55].

38. It was put to Dr Tay that the Assisi records contained a contemporaneous record of a conversation between the nurse unit manager and Dr Tay on 26 July 2018.

39. In the course of the hearing it became apparent that some records held by Assisi were not created contemporaneously. This is referred to in CA Submissions at paragraph 63.

40. Dr Tay did not examine Mrs Santoro's hip wound when he attended upon her on 2 August 2018. Dr Tay said he had no recollection of the hip wound being brought to his attention[56] [57].

41. Examination of the Assisi records in relation to the relevant entries of 26 July and 2 August 2018 suggests those entries may not have been made contemporaneously. Consequently it is submitted that no finding can be made that the Assisi nurse unit manager spoke to Dr Tay on 26 July regarding Mrs Santoro's hip wound or that Assisi staff brought the hip wound to Dr Tay's attention when he attended Mrs Santoro on 2 August 2018.

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49 Exhibit 6-16 WIT.0248.0001.0001 paragraph 26
50 Exhibit 6-16 page 3119 32-35
52 Transcript P3105 line 34 – P3106 line 18
53 Transcript P3115 line 33 - 41
54 Transcript P3114 line 21 - 25
55 Transcript P3114.40
56 Exhibit 6-16 WIT.0248.0001.0001
57 Transcript P3115 27-31

42. In support of that submission we point to the following documentation:-

42.1 Exhibit 6-13 – Tab 420 ACL.501.0001.6683; being the "Progress Notes" contains no entry by the nurse unit manager (see pages 6920-6921) regarding a telephone conversation between the nurse unit manager and Dr Tay.

42.2 Exhibit 6-13 – Tab 194 ACL.501.0001.0131 at page 0132 there is an entry by the nurse unit manager at 1430 on 26 July 2018 which includes "*Dr Tay Informed via phone*". There is also an entry by the nurse unit manager at 1400 on 2 August 2018 which includes "*GP only managed to change her medication overlooked checking her dressing*. *Staples was not removed at this stage. GP informed*".

42.3 Exhibit 6-13 – Tab 180 ACL.500.0001.8543 contains an entry for 26 July 2018 at 09:00 which includes "*GP informed and stated he will review on next visit*". That same document contains an entry for 2 August 2018 at 1430 "*GP to be reviewed for removal of sutures. GP overlooked and forgot. He only reviewed medication changes.*"

42.4 Exhibit 6-13 – Tab 102 ACL.001.0001.0141 – "Progress Notes Detailed" contain two entries by the nurse unit manager of Assisi for 26 July and 2 August 2018 which have the created date 12 August 2018 and, respectively, the times 05:34 and 05:37 which replicate the entries referred to at paragraph 41.2 above and which purport to be entries by the Assisi nurse unit manager at 1430 on 26 July and 1400 on 2 August 2018.

42.5 A further relevant entry appears at Tab 101 – ACL.001.0001.0140 – "Progress Notes Detailed" for an entry by the nurse unit manager of Assisi for 18 July 2018 which has a created date of 12 August 2018 and a time of 05:27.

42.6 The text in the entries in Tabs 101 and 102 for the entries of 18 July, 26 July and 2 August reflect the entries in Tab 194 for those same dates.

42.7 It was put to Dr Tay when he was giving evidence on this issue[58] that the 26 July entry in Tab 194 (page .0132) was a contemporaneous record. It is submitted that the consecutive entries "created" at 0527, 0534 and 0537 on 12 August 2018 in the Progress Notes Detailed would suggest that the relevant entries in Tab 194 were not contemporaneous and appear to have been created on 12 August 2018.

42.8 Furthermore and relevantly the Assisi progress notes (Exhibit 6-13 Tab 420 ACL.501.0001.6936) contain an entry by the Assisi nursing unit manager for 2 August 2018 which includes a reference to "*GP came and reviewed all her medication*" but contains no reference to consideration of Mrs Santoro's hip wound or the removal of staples.

43. On 5 August 2018 Dr Tay received information an Assisi unit manager and Ms Ng reporting the assessment by a locum doctor of Mrs Santoro's hip wound with a request that Dr Tay assess Mrs Santoro. Dr Tay was unable to attend on that day and it is submitted appropriately advised Assisi staff to request that Mrs Santoro be reviewed by Austin Health (which duly occurred)[59].

44. The entry made by the locum doctor on 5 August 2018 makes no reference to staples in the context of assessing the hip wound. Neither is there reference in the emails from Assisi

[58] Transcript P3115 – line 20-22
[59] Exhibit 6-13, Tab 247 – DET.0001.0002.0001 at pages 0037 - 0045

staff to Dr Tay on 5 and 6 August to staples[60] [61]. These records indicate that the presence of staples was not brought to the attention of the locum doctor by Assisi staff. The entry by the nurse unit manager of Assisi in the progress notes on 6 August 2018 in relation to Dr Tay's advice that Mrs Santoro be reviewed by Austin Hospital refers to an inflamed wound on her right upper thigh but makes no reference to staples[62].

45. It is submitted that no finding can be made that Assisi staff communicated with Dr Tay in relation to Mrs Santoro's hip wound either by telephone on 26 July or in person on 2 August as the Assisi records do not support a finding that the entries were made contemporaneously and Dr Tay has asserted on oath no recollection of this information being provided to him. Neither did Dr Tay make any reference in the Andrew Place Clinic records for 2 August 2018 to consideration of Mrs Santoro's hip wound or the removal of staples[63].

The pressure sore on Mrs Santoro's heel

46. When Mrs Santoro was discharged from Austin Hospital on 17 July 2018 the discharge document, which was never received by Dr Tay, identified that Mrs Santoro had a pressure injury on her right heel[64].

47. In his statement[65] Dr Tay referred to a recollection of first becoming aware of the heel pressure area at a consultation on 30 August 2018. He made no entry in his records or the Assisi records of having seen the heel pressure area on that occasion. In his evidence[66] Dr Tay stated that he was first aware of the heel pressure area at a consultation with Mrs Santoro on 13 September 2018. He made an entry in the Assisi progress notes "*small mild right heel pressure area being attended to*"[67] on 13 September 2018.

48. At paragraph 66 of CA Submissions it is submitted that there is no entry in the Assisi records of Mrs Santoro's heel wound being brought to a doctor's attention for review until 3 October 2018. The Assisi progress notes[68] contain an entry by Dr Tay's locum doctor who consulted with Mrs Santoro on 28 September 2018 which indicates that the heel wound was brought to the doctor's attention and assessed:

"2. Right heel wound – is looking improved from yesterday according to nursing staff. Being dressed daily and pressure care being done.

Quite painful today.

Pedal pulses palpable"

With a recommendation to "*continue with daily dressing and pressure care please*".

[60] Exhibit 6-13, Tab 169 – ACL.501.0001.0609 at 0611
[61] Exhibit 6-13, Tab 247 – DET.0001.0002.0001 at pages 0037 - 0045
[62] Exhibit 6-13, Tab 420 – ACL.501.0001.6682 at page 6845
[63] Exhibit 6-13, Tab 246 - DET.0001.0001.0008
[64] Exhibit 6-13, Tab 233 – ACL.001.0004.0259
[65] Exhibit 6-16, paragraph 43
[66] Transcript T3116.15-33
[67] Exhibit 6-13, Tab 420 – ACL.501.0001.6683 page 7009
[68] Exhibit 6-13, Tab 359 – ACL.500.0001.9093 at 9099

49. The entries in the Assisi progress notes made by the locum doctors who examined Mrs Santoro's heel wound on 28 September and 3 October 2018 demonstrate that there had been a significant deterioration in the wound in the interim period[69].

50. In his evidence Dr Tay properly acknowledged that it would have been critical information for his management to know for how long the pressure area had been present[70] and had also acknowledged that he ought to have been more pro-active in seeking out hospital discharge summaries such as the Assisi discharge document of 17 July 2018[71].

Mrs Santoro's weight loss

51. At paragraph 34 of CA Submissions reference is made to Dr Tay's initial comprehensive assessment of Mrs Santoro (on 11 May 2018) using "*the out of date and inaccurate weight records*" for Mrs Santoro. It is submitted that as at 11 May 2018 the weight included in the comprehensive medical assessment document[72] was the most recent (i.e. up to date) weight in the Assisi records at that time. That weight became "out of date and inaccurate" once Mrs Santoro was weighed on the following day (12 May 2018). Confounding this issue is the reference in the letter from the geriatrician of 15 May 2018, following an assessment conducted on that day, that "*there has not been any changes in her weight recently*"[73].

52. There should be no criticism of Dr Tay or his practice nurse for including in the comprehensive medical assessment the most recent weight cited in the Assisi records as at 11 May 2018.

Response to Counsel Assisting's Conclusion

53. As to the findings sought by Counsel Assisting at paragraph 92 of CA Submissions, Dr Tay submits in addition to what has already been specifically addressed in the body of these submissions, as follows:-

    53.1 Paragraph 92m – Dr Tay submits that whilst his acknowledged poor record keeping may have had the potential to compromise the clinical care delivered to Mrs Santoro there is no evidence that would permit a finding that it actually did so.

    53.2 Paragraph 92o – whilst any failure by Dr Tay to duplicate his clinical records for Mrs Santoro in both the Andrew Place Clinic and Assisi records may have had the potential to compromise the quality of clinical care provided to Mrs Santoro there is no evidence which would allow a finding that it actually did so.

    53.3 Paragraph 92p-r – there is no evidence to support a finding that Dr Tay did not effectively communicate with Assisi staff in relation to the management of Mrs Santoro's hip and heel pressure wound from 17 July 2018 onwards.

    The evidence does not support a finding that any shortcoming in Dr Tay's communication of information to Assisi staff compromised the quality and safety of care delivered to Mrs Santoro.

    53.4 Paragraph 92t – the evidence does not support a finding that Assisi staff communicated to Dr Tay any concern regarding Mrs Santoro's hip wound before he

[69] Exhibit 6-13, Tab 169 – ACL.501.0001.0609 at 0615 and 0617
[70] Transcript P3117-40 - P3118-1
[71] Transcript 3106 8-17
[72] Exhibit 6-13, Tab 246 – DET.0001.0001.0001 page 49
[73] Exhibit 6-13, Tab 246 – DET.0001.0001.0001 page 54

received information on 5 and 6 August 2018 in response to which Dr Tay appropriately recommended Mrs Santoro be assessed by Austin Hospital; which occurred.

53.5 Paragraph 92w – Dr Tay's shortcoming in his proper management of Mrs Santoro's hip wound derives solely from his failure to seek information from either Assisi staff or Austin Health about post discharge directions for the management of that wound and not in any way in relation to his management of the wound which solely comprised his appropriate direction to Assisi staff on 6 August that Mrs Santoro be reviewed by Austin Health.

53.6 Paragraph 92z – the evidence does not permit the finding as sought by Counsel Assisting. It is submitted that the evidence supports a finding that Dr Tay and Assisi staff regularly communicated with Ms Ng and her nominated brother in relation to the commencement of Quetiapine and its administration to Mrs Santoro. Dr Tay concedes however that he did not personally keep sufficiently detailed records of his discussions with Ms Ng and the nominated brother in relation to that issue.

1 August 2019

Geoff Black

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