CITATION: *Inquest into the death of Kerry James Murphy* [2016] NTLC 020

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
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FINDING OF:	Judge Greg Cavanagh
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REPRESENTATION:

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

No. D0121/2014

In the matter of an Inquest into the death of

KERRY JAMES MURPHY
ON 17 JULY 2014
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh:

Introduction

1. Kerry James Murphy (the deceased) was born 5 November 1940 in Melbourne to Ruby Evelyn Murphy and James Joseph Murphy. He was the oldest of seven children.

2. His family lived in poor circumstances and his father left for extended periods. As a result Kerry and two of his brothers were placed in the care of St Vincent De Paul Boys Home during the week. At the time he was just five years of age. They went home on weekends and maintained a close bond with their mother and other siblings.

3. Kerry left school at fourteen years of age. He obtained work to help support his mother and siblings. He worked in a dairy and later he chopped wood in Gippsland.

4. On 23 March 1959 he joined the army and later that same year on his nineteenth birthday left for the Malayan Emergency. Six years later after discharge he obtained work as a Painter and Docker in Williamstown, Victoria.

5. In those years he married his childhood sweetheart, Brigitte Wunder, and together they had three children, Darlene, Bradley and Jason.

6. The family moved to Darwin in 1972. Mr Murphy and his wife later separated but they remained friends. She eventually returned to Victoria to be with two of the children but Mr Murphy remained in the Territory with his son Bradley, working primarily in small town abattoirs.

7. In 1990 Mr Murphy suffered a heart attack and had a stent fitted in Adelaide. In 1996 he left the Northern Territory to care for his mother in Victoria. She died in the year 2000 and so he returned to the Northern Territory and lived near his son Bradley at Wagait Beach.

8. On 14 July 2014 while at home he became light-headed and fell. He didn't lose consciousness. He rang his son, Bradley, at 9.00am that morning. His son took him to Belyuen Clinic where it was noted that he had symptoms of a fever, a cough and right and left lower chest pain.

9. He was admitted to Royal Darwin Hospital (RDH) Emergency Department at 6.12pm that day. He was diagnosed with pneumonia and having suffered a NSTEMI (Non-ST-elevation myocardial infarction) and injury to his kidneys due to dehydration. However he was alert and at that stage suffering no symptoms. He was given blood thinners, antiplatelet medication and antibiotics and put on a cardiac monitor.

10. His son, Bradley stayed with him through the night. At 4.50am 15 July 2014 Mr Murphy was admitted to the Hospital under the care of the medical team. However due to there being no vacant beds on the ward he remained in the Emergency Department. At that time it was suggested that Bradley go home and get some sleep. He did so.

11. Bradley returned to the Royal Darwin Hospital that evening after 5.00pm. He was told that his father had been discharged.

12. I heard evidence that in 2014 the hospital computer map wasn't able to cope with the situation where the Emergency Department was overcrowded and had people "double bunked". There has now been put in place a contingency for such times.

13. After a lengthy period of insistent questioning by Bradley, it was found that Mr Murphy had been transferred to Darwin Private Hospital. Bradley found his father there and stayed with him until about 8.00pm when his father said he was too tired and asked that he leave so he could rest.

14. Bradley left and returned to Wagait. It was 11.20pm that same evening that he was called by a surgeon seeking consent to operate on his father. He was told that during that day at RDH his father had fallen in the Emergency Department at RDH and was bleeding on his brain. He was now in a coma and needed an urgent operation to release the cranial pressure.

15. The operation was unsuccessful. Sedation was ceased at 5.30am on 16 July 2014. However, neurological function did not return.

16. After a family meeting at 2.30pm on 17 July 2014 it was decided to remove ventilator support. That happened at 4.00 pm. Mr Murphy was declared life extinct at 8.25pm. He died of an acute traumatic subdural haematoma. He was 73 years of age.

The Hospital Admission

17. It was a busy time for the Hospital. All beds were full and the Emergency Department was crowded. Mr Murphy was in cubical 13 "double bunked" with another patient. There were no available beds on

the medical ward. Mr Murphy couldn't be transferred out of the Emergency Department.

18. When he was seen by the Medical Team at 8.50am on 15 July 2014 there was talk about him being transferred to the Private Hospital. However, at the time the Private Hospital was full as well. The medical team indicated that he should remain on cardiac monitoring for 24 hours.

19. Throughout his stay in the Emergency Department he had been on the cardiac monitor. Whenever he had needed to go to the toilet the curtains around the cubicle were drawn and he urinated into a bottle provided.

20. Both of the nurses called to give evidence were of the opinion that he was a significant risk of falling. He had been admitted on a history of dizziness and he had been in bed since admission. The dangers of injury if he fell were greatly exacerbated by the blood thinners and antiplatelet medication he had been given for his suspected NSTEMI.

21. However, at that time, the Emergency Department (unlike the wards) did not have a falls risk policy.

22. There were no strategies put in place to mitigate the risk if Mr Murphy was to mobilise. To the nursing staff that was not an issue, at that stage, because he was not mobilising due to being on the heart monitor.

23. Early in the afternoon he was seen by the Cardiologist team lead by Dr Marcus Ilton (Dr Ilton remembered his attendance being in the morning however the person recording that attendance did not record a time and the weight of the evidence suggests that it was more likely to have been at about 2.30pm). After examination, Dr Ilton indicated that the heart monitor could be removed, the blood thinners and antiplatelet

medication ceased and that Mr Murphy wasto be transferred to the Darwin Private Hospital.

24. At 3.00 pm the heart monitor was removed and Mr Murphy was checked by the nurse coming onto the afternoon shift. It was found that his temperature had risen to 38.8 degrees. The nurse paged the medical team.

25. The nurse that had been primarily caring for Mr Murphy from 7.00am that morning was Registered Nurse Elise Brady. There is no doubt that she provided excellent care.

26. Nurse Brady understood that Mr Murphy was at high risk of falling and of injury if he mobilised unassisted and would have ensured that she assisted him. She indicated that was not only because he had been admitted with a history of dizziness and was on blood thinners but because he had been on his back in bed for almost 24 hours. Nurse Brady was a very impressive and compassionate witness.

27. At the time of his fall in the Emergency Department she was admitting another patient to Emergency.

28. Ten minutes after the heart monitor was removed by the nurse from the afternoon shift, Mr Murphy got out of bed to go to the toilet. There is no evidence that it was suggested that he shouldn't do so without assistance and no person was there to assist. He made it as far as cubicle 10 but became dizzy, he leaned on bed 10 and collapsed backward onto his buttocks and then onto his back. His head was seen to hit the floor "not with any force". It was explained by the nurse that saw him fall that the hitting of his head was not accompanied by any sound. He did not lose consciousness.

29. He was put back into bed and a repeat set of observations were noted to be normal. Nurse Brady asked, "What are you doing up walking"? He said "The doctors said I could come off the monitor".

30. Hourly neurological observations were commenced and the medical team were again paged, this time about the fall. There was still no response and at 3.42pm the nurse telephoned the Medical team intern. The intern said that a member of the team would review Mr Murphy. However it did not happen.

31. At 4.00pm Mr Murphy was transferred to the Darwin Private Hospital (DPH). The medical records of RDH do not record the transfer or any handover.

32. The notes of DPH state the diagnosis to be "Pneumonia/NSTEMI". There is no mention of the fever, the fall, the neurological observations or that he was awaiting medical team review.

33. At 8.15pm Mr Murphy became a little vague and told the nurse he was tired and just wanted to sleep. The nurse asked for a medical assessment and notified the Resident Medical Officer (RMO).

34. At 8.30pm the RMO found that Mr Murphy was difficult to rouse and sweating profusely. The Rapid Response Criteria was activated. The RMO ordered an ECG, Blood Sugar Levels were taken, Oxygen was supplied and Venous Blood Gas was collected.

35. Mr Murphy continued to deteriorate and by 8.45pm he could not be roused except by physical stimuli. His pupils were unequal. The RMO rang the Intensive Care Unit (ICU) and asked for a review. After the call Mr Murphy was no longer responsive at all. He was intubated and transferred to ICU at RDH at 9.40pm.

36. A CT Scan was performed at 10.04pm and showed an acute subdural bleed. At 1.00am on 16 July 2014 he was taken to the operating theatre for a craniectomy and evacuation of the bleed.

37. However, the damage had been done and by the next day it was clear that Mr Murphy was not going to make a recovery. His family was consulted about turning off the ventilator and Mr Murphy died without recovering consciousness.

Issues

38. Mr Murphy was admitted to hospital without life threatening conditions. He died due to a subdural bleed likely to have been caused by his fall while in the Emergency Department.

39. He was admitted with a history of dizziness. He was put on blood thinning and antiplatelet medication. Yet no strategies were put in place to mitigate the risk of a fall. He was in bed for 21 hours before being found at 3.00pm to be running a fever and yet he was permitted to leave his bed unassisted.

40. After he fell he was not assessed by the medical team and any handover did not contain information of the fever, the fall, the neurological observation regime, or the continuing need for medical review.

41. Overcrowding of the hospital during that time was obviously a contributor to the fall. But for overcrowding he would have likely been on the medical ward and assessed for his falls risk and the appropriate mitigation strategies put in place.

42. I have held previous inquests that have dealt with the contribution of overcrowding and nurse to patient ratios to falls in the Hospital. However overcrowding was not the only or primary issue on this occasion.

43. The failure to have a falls risk policy in the Emergency Department and the failure to adequately handover when transferring Mr Murphy to Darwin Private Hospital were far more basic.

44. The Director of Emergency Medicine, Dr Didier Palmer, provided a statement and gave evidence during the inquest. I once again thank Dr Palmer for the objectivity he displays, his professionalism and compassion. He stated:

> "In my view it is quite possible even in ideal circumstances (i.e. no overcrowding) that the tragic outcome in this case would have been the same. However, I do feel that we failed Mr Murphy and his family in not attempting to prevent falls and in providing a clearly inadequate handover to DPH. The system changes enacted should decrease the chances of similar events in the future."

45. The system changes of which he spoke followed a Hospital review of the circumstances of the death of Mr Murphy. A Root Cause Analysis (RCA) identified three areas of concern and for improvement:

- Hospital inpatient overcrowding resulting in prolonged length of stay for admitted patients in the ED
- Falls management (risk identification and action and post falls management)
- Clinical handover process

Overcrowding

46. Doctor Palmer provided evidence that the Hospital has over the last three years redesigned their clinical models of care such that they have increased capacity by 120,000 hours per year. He indicated that equates to an extra 13 Emergency bed spaces per day.

47. He also provided an indication that Royal Darwin Hospital is implementing a plan to improve patient flow.

Falls Risk Policy

48. A falls risk policy has been introduced to the Emergency Department. A review was completed at the end of 2015 and an ED Falls Protection Policy implemented with training taking place during April 2016. Compliance is still being audited on a fortnightly basis.

49. The percentage of patients identified at risk but with no intervention strategies implemented has been recorded in those audits. It is of concern that on each audit the percentage falling into that category has increased. On 21 April 2016 intervention strategies were implemented in all cases. However, on 9 May 2016 fourteen percent of patients at risk had no intervention strategies. On 24 May 2016 that figure had increased to twenty percent. On 2 June 2016 it was thirty-three percent and on 16 June 2016 forty percent.

50. No further figures were provided for later audits. It is hoped that those figures are an early aberration. It is important that staff of the Emergency Department adopt and become proficient in use of the Policy.

51. Post falls management has been altered to ensure that a patient is not transferred until the post fall neurological observations and review have been completed.

Handover

52. Previous inquests have highlighted issues with handover, particularly on discharge from Hospital. Two of the more significant were the inquests into deaths of Lennie Pinawrut [2003] NTMC 036 and Peter Limbunya [2008] NTMC 057.

53. The first mentioned inquest related to problems with communication in the Royal Darwin Hospital leading to the discharge of a man back to Katherine with acute renal failure in his pyjamas and holding only his bus ticket. He was found dead near the Tourist Information bureau in Katherine.

54. The second inquest related to the discharge of a man to an airstrip at Kalkaringi where he died.

55. In both cases there was entirely inadequate handover to the communities. In this case the inadequate handover was to the Darwin Private Hospital.

56. The Australian Commission on Safety and Quality in Health Care Standard 6 is titled "Clinical Handover, Safety and Quality Improvement Guide".

57. That Standard states in the introduction:

> "Clinical communication problems are a major contributing factor in 70% of hospital sentinel events leading to an increased risk for adverse events. Adverse events are seen to increase particularly during a transition of care, when a patient is transferred between units, physicians and teams … Standard 6 addresses the need for effective structured communication during clinical handover."

58. In July 2014 RDH had a "Standardised Guideline" titled "RDH: Clinical Handover". It referenced Standard 6.

59. However the handover experienced in the transfer of Mr Murphy was not compliant with the Standard or Guideline.

60. The presenting complaints of NSTEMI and pneumonia were handed over. However the events in the last hour of Mr Murphy's stay in RDH were not. The RCA identified that as an area for improvement.

61. I was informed that improvement initiatives included:

- An ED transfer checklist to augment clinical handover to wards / DPH
- The introduction of named nurse accountability for each patient in the majors area
- The introduction of nurse pods in the majors area each with a clinical lead who liaises with the nurse team leader in the majors area
- The introduction of "RAPs" (Regular assessment of the Patient). RAPs are a frequent "mini-round of the nurses in that pod of all their patients where they go to the bedside and ensure all nurses in the pod knows each patient and that the patient knows what is happening and can raise concerns.
- The introduction of nursing clinical lead training (for pod leaders and nurse team leaders) dealing with all aspects of communication. The program has also developed a board game for times of overcrowding to encourage innovative and safe troubleshooting when inpatient overcrowding threatens patient safety in the ED.
- The introduction of "Pre-Starts" which are a 10 minute session at the beginning of each nursing shift used by the nurse team leader to inform staff of changes and issues. RAPs, clinical handover, falls package and completion of clinical documentation are standard "Pre-Start" themes.

62. The Top End Clinical Handover Standard Committee was said to also be developing a handover tool specific to transfers to DPH.

63. However the failure did not only relate to a failure of nursing staff. There was no handover of the last hour of Mr Murphy's admission by the medical team to the doctors at Darwin Private Hospital or to the consultant under whom Mr Murphy was admitted to Darwin Private Hospital, Dr Ilton.

64. I heard during the inquest from Dr Rory Hannah. He was the Consultant leading Medical Team 4, the team caring for Mr Murphy. He no longer works at Royal Darwin Hospital and it had been planned that he would be linked to the inquest via video from Adelaide. However due to technical difficulties that did not happen. Instead he gave his evidence over the telephone. That was not optimal.

65. During the course of his evidence he provided the opinion that a member of his team should have reviewed Mr Murphy within 30 minutes.

66. He considered that the medical handover happened when Dr Ilton saw Mr Murphy in the afternoon with his team. However, he conceded that the fall and failure to review happened at a later time and should have been handed over.

67. He considered that there should have been a handover by his team to the Darwin Private Hospital doctor.

68. The failure to handover information about the fall, the absence to that point of medical review and the status of the neurological observations was clearly pivotal in the early detection of neurological changes. Without the proper handover those changes were not detected until they became disabling. That was only shortly before Mr Murphy lapsed into unconsciousness.

Communication

69. The final issue is the lack of communication to the family after the fall, after he was admitted to the Private Hospital, after he became unresponsive and since his death.

70. As I commented during the course of the inquest, such communication lapses tend to breed suspicion and great unhappiness, particularly in the grieving families of a deceased person.

71. If there had been proper, frank and open communication it is unlikely the levels of suspicion and angst would have been elevated to the same levels. That may have meant that the discretion to hold a public inquest may not have been exercised.

72. The Director of Medical Services, Dr Charles Pain conceded that the standard of communication with the family "fell below the standard that we would normally expect".

73. As to the failure to know where Mr Murphy was after his transfer to the Darwin Private Hospital, Dr Pain said: "Clearly we failed in this case. I mean, that's a remarkable omission to not be able to tell the family where he is. I'm afraid it's just not something we can defend".

74. I was told that the Department of health will learn from their mistakes. By the time this matter was heard the Department did appear to be attempting to make amends. I trust those efforts continue.

75. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*;"

76. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Kerry James Murphy born on 5 November 1940 in Melbourne, Victoria.

(ii) The time of death was 8.25pm on 17 July 2014. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was an acute subdural haematoma.

(iv) The particulars required to register the death:

1. The deceased was Kerry James Murphy.

2. The deceased was of Caucasian descent.

3. The deceased was a pensioner at the time of his death.

4. The death was reported to the coroner by the Royal Darwin Hospital.

5. The cause of death was confirmed by Doctor Paul Goldrick.

6. The deceased's mother was Ruby Evelyn Murphy and his father was James Joseph Murphy.

77. Section 34(2) of the *Act* operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

78. In this case the Royal Darwin Hospital has presented significant evidence that they have made or were making changes to their policies, processes and procedures to ensure that the failures identified were less likely to reoccur in the future.

79. Those changes however were not well embedded into the Hospital systems by the date of hearing. The most notable example of that was that the falls risk audits were finding increasing (rather than decreasing) numbers of patients at risk without falls mitigation strategies in place.

Recommendations

80. I therefore **recommend** that Royal Darwin Hospital ensure through continued education and audit that the Falls Risk Policy is appropriately utilised in the Emergency Department.

81. I also **recommend** that handovers (both nursing and medical) and transfers to Darwin Private Hospital continue to be audited to ensure those systems are functioning in the intended manner.

Dated this 1st day of September 2016.

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JUDGE GREG CAVANAGH
TERRITORY CORONER