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TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0190/2002
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FINDING OF:	Deputy Coroner Elizabeth Morris

CATCHWORDS:

CORONERS: Inquest, death at hospital, staffing levels, Bali bombing, Health Insurance Act, production of documents, quality assurance activity

REPRESENTATION:

Counsel:

Assisting:	Ms Lyn McDade
Health and Community Services	Ms Katherine Gleeson

Solicitors:

Health and Community Services	Solicitor for the NT

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0190/2002

In the matter of an Inquest into the death of

JOHN HENRY COLBERT
ON 16 OCTOBER 2002
AT THE ROYAL DARWIN HOSPITAL
IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

(Delivered 2 July 2004)

Ms Elizabeth Morris

Deputy Coroner:

1. The deceased was born on the 29th March 1947 in Darwin. He grew up in Reta Dixon Children's home in Darwin and resided here all his life. He was employed at one time as a surveyor's assistant. However later in his life he succumbed to alcohol and had an extensive medical history at Royal Darwin Hospital relating to consumption of alcohol and injuries received from his consumption of alcohol. The deceased was diagnosed with Wernicke's Encephalitis, Organic Brain Syndrome and alcohol abuse. He was taking medication for these conditions.

2. On Sunday 13th October 2002 the deceased was at his residence in Palmerston. At about 19:05 hrs Ambulance officers attended the deceased's residence. They found the door ajar and lights on inside. They entered and found the deceased lying on his side in the first room of the house. There was no response from the deceased when spoken to. As Ambulance officers were treating the deceased, he started fitting. The deceased was taken to Royal Darwin Hospital for further treatment.

3. The deceased was admitted at 23:00 hrs on the 13th October 2002 to the Intensive Care Unit of Royal Darwin Hospital. He was heavily sedated and ventilated.

4. At 08:30 hrs on Monday 14th October 2002 the deceased was moved from the Intensive Care Unit to Ward 4A of the hospital. This is a ward for acute care patients.

5. Upon his admission the deceased was assessed as being at high risk of falling under the "Falling Stars" program. This program had been introduced into Wards 4A and 4B in order to prevent or lessen the incidence and injuries caused by falls.

6. At about 06:30 hrs on the 15th October 2002 the deceased managed to climb out of the end of his bed. The side rails were up in an attempt to prevent the deceased from falling out of bed. He then walked, perhaps towards the toilet, where he has fallen over sustaining a cut to his forehead.

7. That afternoon at about 13:30 hrs the deceased again climbed out of the end of his bed and fell to the floor striking the rear of his head. A fellow patient buzzed for assistance and the deceased was returned to his bed. At this time the deceased's pupils were not reacting to light. Dr Raines was contacted and the deceased was moved so nursing staff could monitor him more closely.

8. At 14:00 hrs observations were made and they indicated that the deceased was still conscious.

9. At around 15:00 hrs the deceased was found to be unresponsive. A Code Blue was called and resuscitation commenced.

10. At 18:15 hrs on the 15th October 2002 the deceased was taken to theatre and surgery commenced to release the build up of pressure within the skull caused by bleeding of the brain. During the operation the deceased's

condition became critical. The deceased did not regain consciousness and died at 14:20 hrs on the 16th of October 2002 in the Intensive Care Unit. His death was reported to the Coroner.

11. The death is a reportable death pursuant to Section 12 of the *Coroner's Act*. (the Act) being a death "(iv) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;"

12. The public Inquest in this matter was heard at the Darwin Magistrates Court on 4, 5, 6 and 13 February 2004. This Inquest was held pursuant to my discretion (Section 15 (2) of the Act). Counsel assisting me over the course of the Inquest was Ms Lyn McDade. At the commencement of the inquest, Ms Katherine Gleeson sought leave to appear on behalf of Territory Health Services. I granted that leave pursuant to s40(3) of the Act.

13. Section 34(1) of the Act details the matters that an investigating coroner is required to find during the course of an inquest into a death. The section provides:

> "(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*; and
> (v) any relevant circumstances concerning the death; or
>
> (b) a disaster shall, if possible, find –
> (i) the cause and origin of the disaster; and
> (ii) the circumstances in which the disaster occurred."

14. Section 34(2) of the Act operates to extend the Coroner's function as follows:

"(2) 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."

15. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the Act, which provides as follows:

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

Formal findings

16. The mandatory findings pursuant to s34(1) of the Act are as follows:

(1) The identity of the deceased is John Henry Colbert, who was born in Darwin in the Northern Territory of Australia on 29 March 1947.

(2) The deceased died at the Royal Darwin Hospital Intensive Care Unit at 14:20hrs on 16 October 2002.

(3) The cause of death was as the consequence of head injury from a fall, being contributed to by chronic alcoholism and cirrhosis.

(4) The particulars required to register the death are:

(i) the deceased was male;

(ii) the deceased was an Aboriginal Australian;

(iii) a post-mortem examination was carried out and the cause of death was as detailed above;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Allan David Cala, a Locum Forensic Pathologist at the Royal Darwin Hospital;

(vi) the father of the deceased is Ali Ahmatt;

(vii) the mother of the deceased is Daisy Stella Colbert;

(viii) at the time of his admission to Royal Darwin Hospital, the deceased resided at Unit 1/56 Essington Avenue, Gray; and

(ix) the deceased was not employed at the time of his death.

Relevant circumstances concerning the death

I find on the evidence as follows;

17. Upon admission to Royal Darwin Hospital the deceased was assessed under the "Falling Stars" program. This was a program to assess risk and prevent incidences of falling. It was being trialed at the time of the deceased's admission, and evidence was given that the program has been refined and improved since then.

18. The deceased's assessment sheet for the program was tendered at the Inquest as Exhibit 9. Despite inquiry it is not known who performed the assessment or filled out the form. Ms Denby Kitchener, registered nurse and nursing director for the medical division of the hospital, gave evidence that the deceased was classified as category risk 3, the highest risk. Given the deceased's history, this was an appropriate categorisation.

19. Ms Kitchener told me that the form itself should be filed with patient notes kept on the end of the bed for the entire time the patient is in hospital. Three actual cardboard stars should have been placed at the head of the bed, clearly visible to all staff, and indeed anyone who entered the room.

20. A number of the nurses who gave evidence had no recollection of seeing the stars at the head of the deceased's bed. This perhaps is not surprising given the length of time that has elapsed prior to giving evidence in this Inquest. However given that I am unable to ascertain who performed the assessment, (it may have been Sharon Lowry), I am unable to find definitively that the stars were placed above the bed upon the deceased's admission to the ward.

21. The deceased's treatment proceeded. He was seen at about 09:00hrs on 14 October by Drs Howard and Raines. The rest of that day appears from hospital notes to be relatively uneventful. At 21:30hrs Registered Nurse Pilkington commenced nightshift, and conducted four hourly observations, including neurological observations, upon the deceased.

22. His observations were taken at 22:00hrs and again at 02:00hrs on 15 October. Diazepam was administered at 06:00hrs (the deceased was undergoing alcohol withdrawal) and was observed to be anxious and agitated.

23. Shortly after 06:00hrs on 15 October the deceased was found by Registered Nurse Rosemary Cook, laying on the floor outside the toilet, some distance from his bed, with a cut to his forehead. He was assisted by Nurses Cook and Pilkington to a chair, and his observations were taken and recorded at 06:45hrs.

24. Dr Agnus O'Campo, the night registered medical officer (RMO) was called. Despite her other responsibilities, which included the surgical ward and the paediatrics ward, Dr O'Campo attended within about 15 minutes and assessed the deceased. At that stage, on her assessment, the deceased had a Glasgow Coma Score of 14 out of 15.

25. Dr O'Campo indicated to nursing staff that the deceased should be 'specialled'. This requires one on one care, usually performed by a patient care assistant. She also ordered that four hourly observations continue. Nurse Pilkington recalls telling staff at the handover that the deceased would need to be closely observed and would need to have a "PCA special". (Transcript p83)

26. Dr Raines also attended the deceased after his first fall. He examined him and sutured the wound to his head. Dr Raines discussed with nursing staff

the potential for a further fall, and that something should be done to keep a closer eye on the patient.

27. Nurse Jennifer Palmer was the clinical nurse manager of Ward 4. In her evidence she acknowledged that it was her responsibility to organise the 'specialling' of the patient.

> "What did you do about organising that, was that your responsibility?---Yes, it's my responsibility.
>
> So, what did you do? --- I rang the Nursing Resource Consultant who are in charge of finding us extra staff and explained what had happened and as far as I was concerned he needed to have a PCA with him. They said, 'Well, we'll see what we can do', but they didn't think they would be able to provide us with anybody and when I spoke to them another – probably only 15, 20 minutes after that, they said they couldn't find us any staff to help out.
>
> What about the existing resources on Ward 4A, could you have done anything with what you had specially?---No really, not- with the staff that I had, do you mean? Not really, each nurse has six patients that she has to care for and we have one patient care assistant who's on the ward, but their role during the day is more of a courier, taking things around the hospital for us or taking a patient down to X-ray or where ever they need to go, so they're quite often not on the ward for much of the day.
>
> Did you have any other patients beside Mr Colbert ---? ---Yes.
>
> --- that was special that day?---Yes, I did.
>
> And where were they?---There was a gentleman in – I think it was bed 11, which was on the other side of the ward, yes.
>
> Wasn't there in fact a group of people that were being looked after by a PCA – a group of patients, about three?---I only remember the one over there, because I'd decided that I would probably move Mr Colbert over next to that other patient, the other gentleman so that the patient care assistance could try and keep an eye on both of them.
>
> Now, that gentleman or whether it was one or more, it matters not, was there a patient care assistance there all the time?---Yes.

> So you had another patient care assistant doing the courier duties?---yes.
>
> Okay and when did you believe that you were going to just Mr Colbert over there so that he could get closer supervision, when did you come to that conclusion?---Straight after hand over or well, after I had spoken to the NRC's and they hadn't been able to provide us with staff, so it was – it would have been fairly early in the morning, between 8 and 8.30 I made that decision.
>
> And so did you communicate that decision to anybody? ---I spoke to the nursing staff on duty and just explained what I was going to do and why we needed to and then I spoke to my ward PCA, Heidi Sutton and just said, 'We need to do this for these reasons' and I wrote it on her whiteboard as a job for her to do. (Transcript p95)

28. It was the practice for instructions to the patient care assistants to be written on the white board. As time passed, without the deceased being moved, Nurse Palmer added "ASAP" on the whiteboard to her previous request. This was after lunch, probably around one o'clock.

29. Detective Henrys, in his covering report to the investigation brief reports that "Investigations have failed to locate any PCA, that has any recollection in regard to the deceased care on the day of his two recorded falls."

30. Helen Nunn, another registered Nurse, took over from Nurse Pilkington on 15 October. She commenced duty at about 07:30hrs (thus after the first fall of the deceased). She observed that the deceased was trying to get out of bed, and had been informed during the handover period, that he had previously had a fall. Nurse Nunn continued taking observations as required. The deceased appeared to be confused and disoriented at times.

31. The deceased's sister, Mrs Valerie Day visited him during the day, noted his injury from the fall, and advised him to do as he was told by the nursing staff. Mrs Day also thought that the deceased was 'sort of glassy eyed and a bit slow'. She assumed that was from a sedative that he had been given. She took his clothes home for washing, and intended to return that evening at around 17:00hrs.

32. Sometime after 13:00hrs, but before 15:20hrs, the deceased was found by Nurse Scheide, again on the floor. When questioned as to whether he was hurt, the deceased made vague reference to having injured the back of his head. Indeed he was found lying on his back.

33. Dr Raines attended again after the second fall, with Dr Vishakantegowda (known as Dr TK). The deceased was assessed to have a Glasgow Coma Score of 3, a code blue was called, and the deceased was resuscitated, intubated again and taken to the Intensive Care Unit, arriving at about 15:30hrs.

34. Unfortunately despite further treatment, the deceased died at 14:20hrs on Wednesday 16 October 2002.

35. Evidence was called from Dr Alan Cala, a forensic pathologist who performed a post mortem examination on the deceased. Dr Cala states in his report

> "I believe the deceased died as a result of the consequences of head injury, the intra cerebral haemorrhage may have been spontaneous on a background of hypertension or may have been due to any of the falls that he has since sustained."

36. After receiving further information regarding the circumstances surrounding the deceased's falls, at the Inquest, Dr Cala concluded:

> "I think it's more likely that the intra cerebral head injury developed as a result of the falls. In all likelihood it sounds like the head injury that he sustained after the first fall resulting in the mild impairment I think of conscious level with perhaps some confusion anyway, in any event the Glasgow Coma Score was I think 14….For some period after the first fall, sounds like that fall was not the major factor in leading to the intra cerebral haemorrhage, but rather it was as a result of the second fall where maybe he sustained an injury to the back of his head. That precipitated – well, following that anyway, it seems like he then became progressively and deeply unconscious and led to the sequences – the sequence of events as we know them to be with craniology and so on. I think that in more likelihood, the second head injury that he sustained, that sounds like it provoked the most

severe form of injury in this man, leading to his death." (Transcript p111,112)

37. Given this evidence I find that it is probable that the injury received from the second fall was the fatal injury. Was this fall then preventable?

38. Ward 4A and indeed the entire Royal Darwin Hospital was exceedingly busy on the 14th and 15th of October 2002. More than 100 critically ill people were being evacuated to Darwin from Bali, following the bombing of the Sari Club and Paddy's Bar. In order to provide care for those people, all patients who could be discharged were being discharged. Wards were running at capacity as patients were moved in order to provide additional bed space for the incoming patients. Nursing Director Denby Kitchener was one of those tasked with organisation of the hospital's services during that time.

> And so would it be fair to say that ward 4A was operating at full if not over full capacity? ---it certainly was. Under those circumstances it's a disaster as everybody knows and we actually a bit like around cyclone time same sort of thing, we actually sent home a large number of patients who – people who are able to go home. At that time mostly because of the patients – we were fairly short at that time – were burns type patients which would go to the surgical floor, a number of those acutely ill surgical patients went up through the rest of the hospital. So for example 4A had a number of surgical patients who were acutely ill so not only have we got rid of some of our patients on the 4th floor that would normally – I guess not so dependent if I could put it that way. We had a whole 34 patients of acutely ill plus the rest of the hospital looking after a significant number of critically ill patients……In 2002 through our emergency department we've usually got around 100 people. Of those 100 people approximately only eight of them would have needed resuscitation, that is near death, needing resuscitation or they would die….we had at that time in the first 24 hours at one time 18 resuscitations going at the same time, and resuscitation means an entire team of nursing staff, medical staff, but not just that – also all the machinery that goes with it….of the 60 people that came to us from Bali, 51 were considered critical.
>
> And were you able to arrange what you thought were as much staff as you needed or did you consider that during that period you were

> short staffed, not just in the specialist area but throughout the hospital? ---We – we had a lot of people working very long hours, there were times when I think we had difficulties getting staff there's no doubt about it. Certainly for the 15th getting PCAs was significantly difficult, nursing staff tended to work longer shifts and we don't like to say that in occupational health and safety, but there were people who were prepared to work 18 hours and things like that which covered more shifts so we actually had the physical being. But our PCAs, we had a casual roster and we had significant difficulties and in fact in Mr Colbert's case we were unable to provide a PCA, because of the entire picture that was going on throughout the hospital. (Transcript p134, 135)

39. Staff were working to capacity, and there was difficulty in obtaining sufficient staff, especially patient care assistants. Ward 4A relied on patient care assistants to perform the tasks of monitoring patients, attending to their daily functional needs and doing some of the physical aspects of patient care, such as moving patients when requested from one area to another. These tasks are essential aspects of nursing and health care.

40. It was clear what needed to be done for the deceased, especially after his first fall. This was recognised at the time by both doctors and nursing staff. Whilst of course even 'specialling' a patient cannot prevent absolutely another fall, it should greatly decrease the risk. The deceased's second fall may have been prevented had he been moved to another bed where closer supervision was possible, or had he been provided with a patient care assistant.

Quality Assurance Documentation

41. It became apparent during the course of the Inquest that staff had written down information in relation to the deceased's death shortly afterwards. This written material was in addition to anything that may have been recorded in the medical file of Mr Colbert. The material was on an "incident report". These reports were called for. They were not produced.

42. It was submitted by Counsel for the Department of Health, on behalf of her client, that these reports were brought into existence by employees of the Royal Darwin Hospital in compliance with the Australian Incident Monitoring System (AIMS).

43. In further written submissions AIMS is summarised as

> "a system of incident reporting managed by the Australian Patient Safety Foundation, which is implemented by the Commonwealth Parliament via the enactment of Part VC of the *Health Insurance Act* 1973 ("the Act"). AIMS is a declared quality assurance activity by virtue of the provisions of section 124X of the Act."

44. The object of the relevant part is "to encourage efficient quality assurance activities in connection with the provision of health services." (Section 124V). In stated furtherance of that object Section 124Y provides

> "Subject to this section, a person who acquires any information that became known solely as a result of a declared quality assurance activity, whether the person acquired the information in the course of engaging in that activity, as a result of a disclosure under section 124Z or in any other way, must not, except for the purposes of that activity or in accordance with an authority given by the Minister, directly or indirectly make a record of that information or disclose that information to another person or to a court."

45. From the evidence called at the Inquest, it was unclear whether or not the information became known "*solely* as a result of a declared quality assurance activity", being AIMS. However I am satisfied that it is open for the Hospital to take objection to the production of the incident reports pursuant to the *Health Insurance Act*.

46. However subsection 124Y(5) of the *Health Insurance Act* provides:

> (5) this section does not prohibit a disclosure of information if the person, or each of the persons, who would be directly or indirectly identified by the disclosure consents to that disclosure of the information.

47. Counsel continued in her submissions:

> "It is submitted that it would be improper for the Coroner to ask employees of the DHCS whether they 'consent' to disclosure of information contained in the incident reports. That is clearly a matter of RDH policy, not an individual decision of the employee. However the next of kin could exercise an individual choice and give their consent to the Coroner for the disclosure of such information."

48. If Royal Darwin Hospital's policy draws from the legislation itself, as claimed in submissions, then surely it must rely on the exceptions as well as the rule. There must be circumstances where disclosure of the information pursuant to section 124Y(5) is permissible. A blanket exclusion goes beyond the ambit of the *Health Insurance Act* where there is clearly an individual right of consent.

49. I do not agree that it is "improper" to ask for consent. That process would had been considerably assisted by the cooperation of the Department.

50. The Australian Council for Safety and Quality in Health Care, established by all Australian Health Ministers, has published an open disclosure standard ("the standard" July 2003). This is a national standard promoting open communication in public and private hospitals, following an adverse event in health care. It forms part of a "wider national initiative of the Commonwealth, State and Territory Governments, …to promote a safer and better health care system." (the standard, p 1) The standard anticipates the involvement of the Coroner, and also anticipates qualified privilege legislation, such as quality assurance legislation.

51. A coroner's duty of investigation and jurisdiction is clearly laid down in the Coroner's Act and has been recited earlier in these findings. Prevention of future similar deaths forms an important part of the coronial process.

> "In the search for a coronial outcome that derives some community benefit from a death, the quest for prevention is foremost" (Selby: The Inquest Handbook, Federation Press, 1998)

52. In any event, I accept the submission of Ms McDade, that there is

> "…enough evidence in relation to what occurred in relation to Mr Colbert and his death and in particular the two falls which the incident reports would related to, to enable you to make a factual finding of the scenario and the circumstances, that is, the relevant circumstances surrounding his death." (Transcript p178)

53. However there may be other deaths, where such incident reports may become crucial to a proper ascertaining of the facts surrounding treatment and death. I agree with the suggestion of Counsel Assisting that the operation and application of the Act to the Northern Territory, and in particular its interaction with the statutory obligations of the Office of the Coroner be the subject of legal opinion and refer the matter to the Department of Justice.

CONCLUSIONS

54. Counsel assisting submitted and I agree:

> "I'm not being critical of the staff in ward 4A, or suggesting for one moment they were not doing their very best. It would appear that at that time, they simply did not have enough hands and bodies to do the very best for John Colbert. He should have been moved. To move him after the second fall was, as I've said, shutting the door when the horse has already bolted." (Transcript p120)

55. The Bali disaster was an extraordinary external event that impacted upon the hospital. It is well known and documented how admirably the hospital coped with this event. It stretched the resources of a relatively small hospital and health system, whilst providing excellent care to critically ill people. Unfortunately this stretching of all available resources snapped when it came to the care of Mr Colbert. As mentioned during the course of the Inquest, John Colbert became another victim of the Bali Bombing.

RECOMMENDATIONS

56. I recommend that any emergency management plan or contingency plan of the Royal Darwin Hospital contains staffing arrangements adequate to cater

for the appropriate care and supervision of patients and that such plans include the provision of additional patient care assistants.

Dated this 2nd day of July 2004.

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ELIZABETH MORRIS
DEPUTY CORONER