CITATION: *Inquest into the death of Margaret Winter* [2008] NTMC 049

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FINDING OF:	Mr Greg Cavanagh SM

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REPRESENTATION:

Counsel:

Assisting:	Dr Celia Kemp
Department of Health and Community Services	Mr Kelvin Currie
Mr Peter Campos	Mr Peter Barr QC

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

No. D0208/2006

In the matter of an Inquest into the death of

MARGARET WINTER
ON 16 DECEMBER 2006
AT THE ROYAL DARWIN HOSPITAL

FINDINGS

(4 September 2008)

Mr Greg Cavanagh

1. Mrs Margaret Winter died at 3:46am on 16 December 2006 in the Intensive Care Unit at the Royal Darwin Hospital from an acute subdural bleed which she sustained after she fell on Ward 4A in the late afternoon of 13 December 2006. The manner of her death was unexpected, whereas, if Mrs Winter had died of complications from chronic liver disease (for which she had been admitted into hospital), then her death would not have been unexpected. After the fall her doctor prescribed ½ hourly neurological observations however there was a period of almost 2 hours where they weren't done, and then she was found, unconscious, and never recovered. I find that her death may well have been preventable. Nursing staffing deficiencies on 13 December 2006 contributed to both the fall and the failure to do observations; the total number of nurses was too low, the proportion of agency and overtime nurses and nurses from a different area in the hospital were too high, and the nursing skills mix was problematic. This situation was compounded by barriers to calling in additional nurses if patient acuity required it. This was not a one-off situation but a representation of a nursing staffing crisis at the Royal Darwin Hospital in 2006-7. Dr Burrow, an experienced neurologist said that 2006 seemed to be a very busy year and that a 'feeling of weariness and low morale was certainly communicated to me on many occasions by the nursing staff' (p126).

2. Mrs Winter's death was both unexpected and as a result of an injury and was thus reportable to me pursuant to section 12 of the *Coroner's Act*. The holding of a public inquest is not mandatory but was held as a matter of my discretion pursuant to section 15 of that *Act*.

3. 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*;
>
> (v) any relevant circumstances concerning the death."

4. 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."

5. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(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.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have

been committed in connection with a death or disaster investigated by the coroner."

6. This inquest was held from April 29 to May 1, and then on June 19 and July 7, in the Darwin Magistrates Court. Dr Celia Kemp appeared as Counsel Assisting me. I note that the initial inquest dates (April 29 – May 1) were advertised in the local papers on Saturday 3 April 2008. Mr Kelvin Currie was granted leave to appear on behalf of the Department of Health and Community Services (hereafter 'the Department'). On June 19 Mr Peter Barr QC was granted leave to appear on behalf of Mr Peter Campos, the Assistant Secretary of the Department. I heard evidence from the Officer in Charge, Brevet Sergeant Anne Lade, Dr Terrence Sinton, Dr Elio Gagliardo, Jacquene Cranna, Dr Susie Seung Mee Bae (by video link), Denby Kitchener, Dr Cameron Jeremiah (by video link), Dr Lai Heng Foong, Hayley Campbell (by video link), Dr Mahiban Thomas, Jodi-May Jones, Sandra Rodrigues, Dr Jim Burrow, Patrick Tshuma, Emma Young, Dr Karl Heinz Blenk (by video link), Professor Di Brown, Mary Vitikus, Penny Parker, Assistant Secretary Peter Campos, Professor Christine Duffield, Yvonne Falckh, Robin Michael (by video link) and Marie Hughes. I have before me the medical records of the deceased and a complete brief of evidence.

7. I would like to particularly thank Brevet Sergeant Lade for the quality and thoroughness of her investigation.

8. Mrs Winter's daughter, Irene Winter, gave evidence on behalf of herself and her brother, Ben, about what her mother was like. It was clearly a difficult thing for her to do and I am grateful for her courage in doing so. She told me that Mrs Winter was a beautiful and elegant lady who was very close to her children and grandchildren. She had a hard life, her mother, husband (Arvi Winter) and son, Paul, all died within a few years in the 1980s. However she kept going, doing volunteer work for the Red Cross amongst other things, and had a rich life with many friends. The loss of their mother has been extremely difficult for Irene and Ben. I would like to commend

Irene for her attendance throughout the inquest and her great assistance with the process.

FORMAL FINDINGS

9. On the basis of the tendered material and oral evidence at the Inquest I am able to make the following formal findings as required by the *Act*.

(i) The identity of the deceased was Margaret Sisko Winter (nee Sisko Marjatta). She was born in Finland on 11 August 1942.

(ii) The place of death was the Intensive Care Unit at the Royal Darwin Hospital. She died at 3:46 am on 16 December 2006.

(iii) The cause of death was an acute subdural bleed which she sustained after she fell on Ward 4A in the Royal Darwin Hospital in the late afternoon of 13 December 2006.

(iv) Particulars required to register the death:

1. The deceased was female.

2. The deceased's name was Margaret Sisko Winter, she was born as Sisko Marjatta.

3. The deceased was born in Finland.

4. The cause of death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination and was an acute subdural bleed that was sustained after she fell on Ward 4A at the Royal Darwin Hospital. The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.

6. The deceased's mother was Elli Sophia Savonen (nee "Stolburg"). The deceased's father was Einara Savonen.

7. The deceased lived 14/8 Tambling Terrace, Wanguri.

8. The deceased was retired at the time of her death.

CIRCUMSTANCES OF DEATH

10. Mrs Winter had a number of known medical conditions; asthma, gastritis, depression, Cutaneous Lupus and Sjogren's syndrome. She was also a heavy drinker. In September 2006 she was diagnosed with chronic liver disease by Dr Elio Gagliardo, a Consultant in General Medicine at the Royal Darwin Hospital. The cause of the liver disease was not clear and so he ordered a liver biopsy which took place on 20 November 2006. Mrs Winter was booked in to see Dr Gagliardo on 11 December 2006 and when she turned up she was in decompensated liver failure and so was admitted to Ward 4A at the Royal Darwin Hospital. It seems likely that the liver failure was triggered both by some bleeding from the biopsy and by Mrs Winter drinking heavily in the time period after the biopsy took place. Blood tests showed that she was 'coagulopathic' with an INR of 1.5, that is that her blood was slow to clot. This is a complication of chronic liver disease. She was treated for the chronic liver disease and given blood products to remedy her abnormal clotting.

11. Her nursing admission was done by Enrolled Nurse Jaquene Cranna. Royal Darwin Hospital uses a fall prevention initiative called 'falling stars' which requires an assessment of the falls risk on a chart and then the implementation of corresponding fall prevention strategies which are documented on the reverse side of the chart. There are four levels; minimal risk, low risk, medium risk and high risk. EN Cranna assessed Mrs Winter's falls risk as being 11 which is the bottom level of the 'medium risk' category. However EN Cranna incorrectly interpreted this figure as being a low falls risk. This meant that only the low risk prevention strategies were implemented.

12. In the late afternoon of 13 December 2006 Mrs Winter got out of bed and fell while walking in her room. She was found on the floor by a visitor who alerted the nursing staff at about 6:30pm. The two nurses allocated to Mrs

Winter (Solace Mufunda and Sandra Rodrigues) were not present amongst their allocated patients when she fell; one was on a break and the other went to relieve a "nurse special" and then was assisting a nurse with another patient. Registered Nurse Hayley Campbell, the team leader, and Dr Susie Seung Mee Bae, the resident doctor, were with Mr Balzar (an unwell patient who died later that night) at the time Mrs Winter was found and were not able to leave him straight away. RN Campbell called for help and Enrolled Nurse Jodi-May Jones, who was working in another area of the ward, came to assist Mrs Winter.

13. Mrs Winter had two small lacerations to her right elbow and a bruise to her right forehead. She was confused. There were otherwise no changes found on examination. Dr Bae formed a judgment after reading Mrs Winter's notes and talking to nursing staff that Mrs Winter's confusion had not increased after the fall. She rang Dr Cameron Jeremiah, the medical registrar on that evening, and Dr Bae's senior, and they discussed what to do. They decided not to order a CT Scan of Mrs Winter's head but to order ½ hourly neurological observations with instructions that if there were any changes that a CT Scan would then be ordered.

14. After Mrs Winter fell two nursing observation charts were instituted; an 'observation special' chart and a 'neurological observation chart'. Neurological observations of the deceased were done at 8:00pm and at 8:40pm and she was stable on both occasions. However after that time neither set of observations were done. One inadequate observation which reads 'asleep but arousable' is recorded on the 'observations special' chart at 9:30pm. At about 10:30pm the deceased was found in her bed, unconscious and unable to be roused. She was taken to the Intensive Care Unit (ICU) and intubated. She had a CT Scan at 11:50pm which revealed that the cause of her deterioration was a very large bleed inside her skull (a subdural haemorrhage), 4cm wide, with evidence that her brain was being damaged by the pressure. I find that it is likely that this was caused by the earlier fall.

15. Dr Karl Blenk, the ICU registrar, contacted the surgical registrar, Dr Arnold Waine who contacted his surgical fellow, Dr Sue Velovski (a fellow is more senior than a registrar but more junior than a consultant). The Royal Darwin Hospital does not have a neurosurgeon on site. Dr Waine and Dr Velovski contacted the neurosurgical team at the Royal Adelaide Hospital for advice. They were asked to send the CT scan with a radiologist report and they did so. There were some discussions about whether the bleed was 'acute' or 'acute on chronic' and the best course of action. Eventually Dr Mahiban Thomas, the General Surgeon consultant was called in and Mrs Winter went into theatre to be operated on at 1:50am on 14 December 2006.

16. The surgical team removed a large amount of fresh clot. However Mrs Winter never regained consciousness and she passed away in the Intensive Care Unit early on the morning of 16 December 2006.

17. Dr Terry Sinton conducted an autopsy. He found that Mrs Winter had died from a subdural haemorrhage. He found that her liver disease was caused by an auto-immune condition called 'primary biliary cirrhosis'.

Mrs Winter's fall

18. There was some information about Mrs Winter that would have resulted in a falls risk score higher than 11 had EN Cranna been aware of it. Dr Gagliardo had diagnosed her with a condition called 'postural hypotension' after she had fallen at home in late September 2006. Both the condition and the fact that she had fallen relatively recently would have increased her falls risk. He did not mention this in his admission notes and it appears Mrs Winter did not mention it to EN Cranna. However even had this been taken into consideration the falls risk would still have been 'medium' not 'high'.

19. EN Cranna mistakenly recorded the falls risk as low. Had the risk been correctly interpreted as being a medium risk then the 'falling stars' initiative required a series of more intensive strategies to be implemented; discussing falls risk with the patient and family, providing assistance and supervision

when transferring or walking, communication of the risk status to all staff involved in care, checking the patient hourly and documenting it, scheduling and documenting 2 hourly toileting regime while awake and the provision of a night light next to the patient's bed.

20. I heard evidence that suggests that some of these strategies are not in fact administered as required even in medium risk patients that are correctly identified as being of medium risk. In particular the documented hourly checks and two hourly toileting breaks are not, as a matter of practice, done. This state of affairs is evidenced by the fact that, after Mrs Winter fell and was reassessed as being of a high risk (which would indicate that she required the medium risk strategies plus additional high risk strategies), these two aspects of the medium risk strategies were not done.

21. I find that the Royal Darwin Hospital Falls Prevention Initiative was not reliably implemented for Mrs Winter and there is some evidence that it is not being reliably implemented generally.

22. I accept that it is impossible to prevent falls happening in hospitals. I am unable to find that had Mrs Winter been given the appropriate level of preventative interventions she would not have got out of bed and fallen on 13 December 2006. However I find that had she been given the appropriate interventions her chance of falling would have been significantly reduced.

Treatment received after the fall

23. The failure to do ½ hourly neurological observations as prescribed for almost 2 hours before Mrs Winter was found unconscious is unacceptable practice. I find that it is likely that the deterioration would have been picked up earlier had the observations been done as prescribed and this would have meant Mrs Winter's bleed was diagnosed earlier and her chance of survival would have been higher. I heard evidence from Dr Jim Burrow, a neurologist at Royal Darwin Hospital, that had Mrs Winter's deterioration

been picked up earlier that it may have made a difference. I find the failure to do the observations extremely concerning (see further comment by me).

24. I have carefully considered the decision not to do a CT Scan. I accept the evidence of Dr Jim Burrow that using current best practice guidelines Mrs Winter does not fall clearly into the category of patients where a CT Scan should clearly be ordered. I note that even if Mrs Winter had received a CT Scan directly after her fall, it may not have shown her bleed and ½ hourly neurological observations would still have been required. I find that the decision to rely on ½ hourly neurological observations was a reasonable one.

25. There was some evidence that the time between the CT Scan and the operation should, ideally, have been somewhat shorter. This time was taken up with discussions between surgeons at the Royal Darwin Hospital and neurosurgeons at the Royal Adelaide Hospital, and I find that it was reasonable to involve specialist neurosurgery expertise. Given this I find that the time taken to operate was reasonable. In any case I find that if there were a delay it did not make a difference to the outcome for Mrs Winter.

FAILURE TO DO THE HALF HOURLY NEUROLOGICAL OBSERVATIONS

What happened?

26. I have closely looked at the nursing situation on ward 4A on 13 December 2006. There were 34 patients. There were 8 nurses on the evening shift and 5 nurses on the night shift. One particular patient on Ward 4A required a full time "nurse special" and a full time patient care assistant. Thus there were 7 nurses on the evening shift for the remaining 33 patients, and 4 nurses on the night shift. In the evening shift the team leader does not have a patient load, meaning the patients were divided between 6 nurses. In the night shift the team leader does have a patient load, meaning the patients were divided among 4 nurses. The nursing staff, in addition to their own patient duties, needed to relieve the nurse special and, to some extent, the

patient care assistant for their breaks. The 8 nursing staff on the evening shift included one nurse doing an overtime shift, three enrolled nurses, two agency staff, and one nurse who was attached to the emergency department but was called into ward 4A for the shift. The 5 nursing staff on the evening shift included one agency nurse and one enrolled nurse. The handover between evening and night shift occurs between 9:00pm and 9:30pm, when the team leader for the evening shift hands over to all the night nursing staff, and then there is nurse to nurse handover. A model of 'team nursing' was in operation at Royal Darwin Hospital at the time, which meant that rather than splitting the patients between the two nurses allocated to a group of patients, tasks were divided between the two nurses.

27. On the evening shift registered nurses Solace Mufunda and Sandra Rodrigues (the nurse that was usually working in the Emergency Department) were allocated to seven patients including Mrs Winter. RN Campbell, the team leader, was responsible for allocation and said that particular group of patients required more intensive care and she deliberately put two registered nurses with some experience in that area. RN Mufunda had responsibility for medications and RN Rodrigues had responsibility for observations. When Mrs Winter fell RN Mufunda had gone on her half hour break. RN Rodrigues went to relieve the nurse special and then, on the way back, was passing a patient allocated to another team and stopped to assist the nurse that was with her. Neither was present when Mrs Winter fell.

28. After Mrs Winter had fallen and required ½ hourly neurological observations RN Campbell says she was concerned that there were not enough nurses to cope with the workload. At that time a second patient, Mr Balzar, was also unwell and needed ½ hourly observations. RN Campbell rang the Nursing Resource Co-ordinator (NRC) to ask for extra help. Her evidence as to what exactly she asked for has varied between the statements she has made and in court. The NRC on that evening does not remember receiving this particular call and there are no records in existence now as to

calls received. RN Young, the team leader on the night shift, says she didn't ask for an extra staff member because RN Campbell told her in handover that she had asked for help and was refused because there were no staff available. I accept this evidence and rely on it to find that RN Campbell asked the NRC for extra nursing help and was told that it was not available.

29. Mrs Winters neurological observations were done at 8:00pm and at 8:40pm (a gap of 40 minutes rather than the prescribed 30 minutes) and then were not done again until she was found unconscious at about 10:30 pm. I have looked carefully at what happened for the remainder of the evening shift, that is up to 9:30pm. RN Rodrigues says that after doing the 8:40pm observation she relieved the nurse special for that nurse's second break and asked RN Mufunda to do the observations for her during that time and RN Mufanda agreed. RN Mufunda was not called (as she is in Zimbabwe) and her statement doesn't cover this issue. RN Rodrigues says she went home at 9:20pm and RN Mufunda did the nurse to nurse handover to the next shift.

30. At 9:30pm there is a notation that reads 'pt asleep but arousable' on the 'observation special' chart and no corresponding notation on the neurological observation chart. This is entirely inadequate as a neurological observation. RN Rodrigues says it is not her handwriting and it seems likely that it was written by RN Mufunda. EN Jones, who was allocated Mrs Winter on the night shift, says she was told that the 9:30 observations had been done. She thought it was by RN Rodrigues but she wasn't sure. It seems more likely to have been RN Mufunda given the evidence that RN Rodrigues left at 9:20pm, however I don't think it is fair to make a finding on this point as RN Mufunda was not present at the inquest.

31. On the night shift the team leader was RN Emma Young. The two nurses allocated to Mrs Winter were RN Patrick Tshuma and EN Jodi-May Jones who were responsible for 18 patients between them. Enrolled nurses are unable to give medications. Thus they divided the work between them so that RN Tshuma was to do the medications and EN Jones to do the

observations. I note that EN Jones had also worked the evening shift, she had agreed to do a second overtime shift.

32. EN Jones gave evidence that she had been told at handover that the 9:30 observations had been done and so she thought they were next due at 10 pm. As she started her shift she walked past Mr Balzar, who was extremely unwell, in pain and struggling to breathe. She called for help from RN Tshuma. The team leader, RN Young, also became involved with the care of Mr Balzar. He needed a nebuliser and the machine wasn't working so the nurses procured another one. When EN Jones left Mr Balzar at approximately 10:30 she went straight to Mrs Winter and found her unconscious and called for help. She said that she knew that the 10 pm observations needed to be done but she couldn't leave Mr Balzar because he was so unwell. I note that Mr Balzar died later that night.

Why weren't they done?

33. RN Denby Kitchener (the then Nursing Director of the Division of Medicine, now the Co Director of the Division of Medicine which is the same position but re-named), Dr Diane Howard (Medical Director of the Division of Medicine) and Dr Jim Burrow (Consultant neurologist) conducted an investigation into the care of Mrs Winter. This came about because RN Kitchener suggested conducting a review to Mr Robin Michael, the General Manager, and he agreed. The three met and it was agreed RN Kitchener would write it up as the main issues seemed to be nursing ones. She did this and sent it to the other two for comment but after some delays in the end she signed off on it and submitted it to Hospital Administration. Dr Burrow gave evidence that 'in general' he was happy with the review. The review's findings included that:

> "the inadequate level of staffing for the number and acuity of patients resulted in the inability of staff to deal with a number of acutely ill patients at one time leading to neurological observations not being attended to in the appropriate time frame."

And also that:

> "the change in practice for obtaining increased staffing in acute situations has lead to staff not utilising that option as they see it as an administrative barrier to structurally interfere or stop staff requesting assistance."

34. My office obtained an expert report from, and I heard evidence from, Professor Christine Duffield. She has extensive and impressive expertise in the area of nursing numbers. Her evidence was of great assistance to me and I accepted it entirely. She concluded that ward 4A was significantly understaffed on 13 December 2006. There were 18 nurses for 33 patients over a 24 hour period. She did calculations using two different evidence based methodologies for calculating nursing numbers; the 'nursing hours per patient day' or NHpPD methodology and using ratios of nurses to patients. Her calculations using either method showed that the numbers of nurses were too low. Significantly, she did calculations using the NHpPD number that the Department has since adopted as being appropriate for ward 4A (in the current benchmarking which is discussed later) that is 5.75 hours of care per patient day. Professor Duffield gave evidence that using this figure the actual requirement was in the order of 25 nurses for 33 patients for a 24 hour period. Her report states that having insufficient staff would have impacted on the 'nursing care and surveillance able to be provided on both shifts'.

35. In addition she gave evidence that the skills mix was concerning, that is there was too high a ratio of Enrolled Nurses to Registered nurses. She also said that the use of a high proportion of staff who did not regularly work on 4A was problematic as they wouldn't know the routines or the patients on ward 4A. Finally she said that the use of one overtime staff member on each of the evening and night shifts was of concern as such staff members would be tired and would have particular difficulties dealing with emergencies.

36. There is research nationally and internationally (some of which was conducted by Professor Duffield) which shows that there is a clear

relationship between nurse staffing, that is both the overall number and the skills mix of nurses (that is the ratio of registered to enrolled nurses), and patient outcomes. She said there is some evidence that suggests an increased risk of adverse outcomes if nurses are working overtime. She said that incorrectly indicating the falls risk (that is by placing only one star above the bed indicating a low risk rather than two stars indicating a medium risk) is particularly critical if there are staff that don't know the ward caring for a patient, as occurred in this case.

37. She pointed out that she did not have any information as to the acuity or casemix (that is the diagnoses and comorbidities) of the patients on the ward that day which would provide a better understanding of the workload and so the number and mix of staff required to provide safe care. However there is some evidence that there were high acuity levels on the night which might have meant that a greater number of nurses were required than the above calculations would indicate.

38. On 19 June 2008 Mr Currie handed up a report by Mrs Cheryl Julie Ann Lowe, a Healthcare Consultant, which concludes 'the major factor contributing to the late detection of [Mrs Winter's] deterioration appears to be a lack of prioritisation of patient care, rather than a lack of nursing care hours to complete the task of ½ hourly neurological observations'. Professor Duffield produced a supplementary report in response. She said that Mrs Lowe uses calculations based on nurse patient ratios to state that the staffing levels were 'adequate' for the evening and night shifts. However the calculations do not appear to be correct, based on the information as revealed by the inquest (Mrs Lowe says there was a staff:patient ratio of 1:7 on the night shift, 33 patients to 4 nurses in fact gives a staff:patient ratio of 8.25). Mrs Lowe's conclusion that 'the skill mix appears to be reasonable for the casemix of the ward' was made without sufficient information about the casemix. Mrs Lowe was not present at the inquest and thus did not present her evidence in person, nor have a chance to justify her conclusions. I thus make no further comment in relation to her report except to say that I

do not put weight on the report's conclusion as to the adequacy of the staffing levels and consequently do not accept that the major factor contributing to the lack of neurological observations was a 'lack of prioritisation of patient care'. I accept completely the evidence of Professor Duffield in relation to nursing staffing deficiencies as set out above.

39. The full report of Mrs Cheryl Lowe was handed up to me after counsel assisting had made her final submissions. I accepted it into evidence but am unable to put much weight on it as it was not seen, nor commented on, by Professor Duffield and Mrs Lowe did not appear before me to be cross-examined. I note that neither Professor Duffield's expertise nor her evidence was challenged by the Department when she was called and she was not asked a single question by Mr Currie. Mrs Lowe's report appears to have been commissioned by the Department at a very late stage in the inquest and the Department didn't seek to recall Professor Duffield to cross examine her as a result of Mrs Lowe's report. The very late presentation of an additional expert report and the failure to put the Department's ultimate position to an eminent expert witness who was called does the Department little credit.

40. In the lead up to the inquest I also received a report from Ms Penny Parker, the Quality Manager, Acute Care Division, Department of Health and Community Services. This report stated that 'the timeline of events leading up to the deterioration of Mrs Winter indicates that the major contributing factors were clinical handover and communication rather than a critical shortage of nurses'. Ms Parker gave evidence that she did not specifically consider nursing numbers in preparing her report and thus I put no weight on her conclusion as to the contributing factors. I do, however, agree with Ms Parker that there was poor communication between staff members on the evening, particularly when taking breaks and relieving other staff, and that the clinical handover could have been better.

41. However given the evidence from Professor Duffield in relation to the multifaceted problems with nursing staffing on that evening, and the likely effect of these issues on safe nursing practice, I find that the causal effects of the issues raised by Ms Parker and Mrs Lowe are subsidiary.

Was this a one-off problem or a more general problem?

42. My conclusion that there were significant nursing staffing deficiencies on 13 December 2006 leads to the question as to whether this was a one off situation or whether this is merely a snapshot of a much broader problem.

43. RN Marie Hughes was the Executive Director of Nursing (EDON) from February 2004 to October 2006. The EDON reports to the General Manager at the Hospital, a position held by Mr Robin Michael in 2006. RN Hughes gave evidence that the whole time she was EDON it was a struggle to provide adequate nursing staff to staff the wards at Royal Darwin Hospital, due to both recruitment issues and budget restraints, and the situation became a lot worse towards the end of 2005 and throughout 2006 (p 268). She said 'the practical effect was it was very hard to provide a stable staff in the ward areas of skilled staff…we had to start covering the wards with agency and casual staff to meet the demand of patient care' (p268).

44. Professor Di Brown was the EDON from October 2006 to May 2007. She gave evidence that when she started at RDH 'it seemed to be really hard to increase the number of nurses to match what was required for the number of patients' (p140). She said that gaps were filled with agency or overtime, which meant nurses without experience on a particular ward (or even with the hospital) were caring for patients, and nurses that were tired were caring for patients. She said nursing shifts were not always able to be filled, even with agency or overtime staff. She said that this situation exposed patients to risk (p144). She said she was acting General Manager early in 2007 and she had a meeting about nursing staffing with the other General Managers and the Assistant Secretary and she said 'you realise your decisions are

causing people to be harmed by this, that if we don't have enough nurses it causes harm to patients' and there was no response.

45. RN Kitchener (the Nursing Director of the Division of Medicine in 2006) gave evidence that the shortage of nursing staff was a general problem around that time (p51) and that the lack of nursing resources had created an 'extraordinarily difficult situation to be working in' (p58). Mary Vitikus, who was a Nursing Resource Coordinator in 2006 (and still is) said that she remembers it as being a 'horrible time' and that the dry season in 2006 'was just like a wet season, hardly any staff, no agency and no staff here and I think everyone was just so worn out from doing overtime' (p 9).

46. The evidence of these individuals is supported by a memorandum written by Mr Robin Michael to the CEO of the Department through Mr Campos dated 12 March 2007 which commences:

> "RDH is inadequately staffed by nurses to meet patient needs. To compensate for this, nursing staff are being asked to work increasing amounts of overtime and agency staff are extensively used. Despite this, many of the wards are still understaffed and the skill mix is poor. For example, in the roster period beginning February 8 there were over 1100 unfilled shifts and as many as 55 shifts a day staffed through overtime or agency employment."

47. I therefore find that the nursing staffing issues on 13 December 2006 were not confined to that day but are a snapshot of an ongoing nursing staffing crisis at the Royal Darwin Hospital in 2006/7.

Cause of the problems with staffing of nurses in 2006

48. I heard evidence, which I accept, that it is generally difficult to secure nursing staff due to an Australia wide and international shortage of nurses, as well as the difficulty in getting nurses to come to the Northern Territory. I also accept that there is a particular difficulty in securing nurses to work during the wet season, that is at the time Mrs Winter died. However I do not accept the Department's position throughout this inquest that recruitment difficulties, essentially outside the Department's control, were the key cause

of nursing staffing issues in 2006. I heard evidence about three policy decisions made in 2006 that I consider are likely to have had significant detrimental effects on nursing staffing arrangements, over and above the normal difficulties in recruiting.

(a) withdrawal recruitment delegations in the first half of 2006

49. The administrative tree for Acute Health in 2006 at the Departmental level was (from the top down) the Minister, the CEO (Mr Robert Griew) and then the Assistant Secretary Acute Health (Mr Peter Campos). One step down, at the Royal Darwin Hospital level, was the General Manager (Mr Robin Michael). In early 2006 the CEO of the Department of Health withdrew the delegation to appoint Royal Darwin Hospital staff from the General Manager and gave it to the Assistant Secretary, that is to Mr Campos. This was instituted because the Department wanted staffing levels contained for budgetary reasons. The delegations were reinstated in June 2006.

50. Mr Michael's letter to my office stated 'Mr Campos displayed a very slow (deliberate or otherwise) response time in processing or approving/declining [the applications]' (p2) and he gave oral evidence that he remembered a point where there where 40-50 staffing applications (nursing staff and others) sitting in Mr Campos office without a formal response. His letter says 'the poor-turn around of Mr Campos caused RDH to lose a number of important staff particularly nursing, as these staff applied for different hospitals across Australia and accepted more responsive hospitals before RDH was in a position to respond…consequently RDH went through a period where it was struggling to staff its roster and nurses were required to work extensive overtime to ensure adequate staffing levels' (p2). The Australian Nurses Federation received numerous communications in 2006 and 2007 from nurses who had applied to RDH for work but were told that there weren't jobs available or who had lodged applications but were told they couldn't be processed as there were no vacancies.

51. I find that the effect of this policy was that there were significant delays between applying for a nursing position and being accepted, which meant nurses were likely to accept other positions or make decisions to do something else in the meantime. I heard evidence from Mr Michael and RN Hughes that the start of the year is a particularly crucial period for employment as the dry season is the attractive time of year to work in the Territory and so failure to employ staff in that period cannot be made up by employing staff in the second half of the year. They both stated that the failure to recruit nurses in this period had effects that carried on for many months, and in particular into the following wet season when nursing numbers usually fall. That is, this policy had a significant impact on the hospital for 18 months and beyond.

(b) level of nursing FTE (ie. full time equivalents) set for 06/07

52. I heard evidence that in addition to the problems caused by the slowing down of recruitment of nurses in the first half of 2006, the number of nursing full time equivalents ("FTEs") was set at a level that was too low for the 2006/7 financial year.

53. How these numbers were set was an issue at the inquest and, despite requesting it, I did not receive conclusive evidence on this point. They appear to have been set at a departmental level in response to budgetary considerations, submissions from the nursing directors and past practice. There was some evidence, in particular, that the nursing "FTEs" for 06/07 were based on previous staffing levels (and in particular the nursing numbers/pay during pay periods 18-25 in the 2005/6 financial year, that is the nursing numbers for most of March – June 2006) with the addition of a 3% growth in salaries and some extra nursing numbers required for some new initiatives. It is unclear to me precisely how the numbers were determined, but it is clear that they were not set using any evidence based methodology about the numbers required for safe patient care.

54. My conclusion that the "FTEs" were too low is firstly based on the evidence of the two Executive Director's of nursing who served in 2006. Their opinion is supported by the memo I cite in paragraph 46 above which commences 'RDH is inadequately staffed by nurses to meet patient needs' and the memo resulted in an increase of 35 "FTEs" in the first half of 2007. I have taken into account also the review on nursing staffing issues commissioned by the Department, which I discuss later, that was concluded at the start of 2006 and identified 'an overall shortfall of approximately 82 nursing (Full Time Equivalent) positions' across the five hospitals in the Northern Territory.

55. I find that the combined effect of these policies, on top of normal recruitment difficulties, was that there was a significant gap between the number of ward based nurses working ("FTE") and the number required for safe care.

(c) barriers to securing patient care assistants and nurse specials instituted in 2006

56. One solution when a patient needs more care than the nurses available on a particular shift could provide, whether because of staffing issues or a particularly high acuity group of patients, is to call in a Patient Care Assistant (PCA), or a nurse special, to be attached to a particular patient. The difficult situation in 2006 was made even more difficult for nurses by a third set of policies that were instituted in 2006, and that required the approval of senior management to put on either a PCA or a nurse special.

57. At the start of 2006 Mr Michael says that 'Mr Campos demanded that I reduce the number of PCAs that the hospital was employing as the number of [PCAs] had grown over the period before my appointment'. Initially the authority to put on a PCA was removed from nursing managers and given to the Assistant Secretary. I had in evidence before me the document setting out this long chain of approval. I find it extraordinary that a policy that required ringing such a senior bureaucrat was ever considered an appropriate

one. I heard evidence that after receiving a call at 5 am very shortly after the policy was instituted the responsibility was devolved a step down, to the General Manager. In addition, in 2006 the authority to put on a nurse special was removed from nursing management and given to the General Manager.

58. The effect of these policies was that to secure extra staff a chain of phone calls was required that ended up with a very senior staff member who was not a clinician. I agree with Professor Duffield in her criticism of these policies as being 'not only cumbersome and time consuming' but also undermining 'the professional judgment and integrity of nursing staff' (p10 of her report). She stated that 'a climate in which senior nursing staff, be that the Nursing Resource Coordinator or the nurse in charge of the ward, do not feel able to ask for additional staff, or are not supported in their decisions about staffing by the General Manager, based on budgetary reasons rather than for patient safety, will inevitably lead to serious consequences for patients' (p10).

59. RN Campbell said that it had become more and more difficult to get extra staff if needed on a particular shift, especially for the 4-6 months before Mrs Winter died (p99). In her statement she said 'I don't think they are allowed to give us staff, so and if they do it is a real battle and it takes a long time' (p12). In court she said 'the word getting around was that it was a budget issue and as far as I know, the NRC had to go to higher management to try and get more staff and it was such a long process to try and get approval for more staff, that that's why it became so difficult' (p99). RN Young said that it was normal for requests for extra staff to be declined (p131) and that she asked less for extra staff because she knew what the answer was going to be before she had even asked. RN Kitchener told me that when she was preparing her internal review she found that nursing staff found it difficult to ask for extra staff (p70). Professor Brown, who was required to ring Mr Michael to get permission for a PCA, said that it was 'quite a challenging experience to be allowed to put another one on.' (p141). Mary Vitikus, a

NRC at the time, said that it could take a number of hours to get approval for a nurse special, if they could get through at all (p5) and there was a 'backlash' if one was put on without getting that approval (p6).

60. I consider that the low baseline nursing numbers and the high use of overtime and agency staff to fill shifts at the time made this cumbersome procedure even more difficult. I heard evidence that there were just not nurses available to call in to act as nurse specials and that people were aware that if they asked for extra staff, their friend who had just finished a long shift was liable to be called and asked to do overtime. This is supported by a document on the brief entitled 'Results from the focus group conducted at RDH on Friday 9 March 2007' prepared by Professor Di Brown which states 'the majority of staff are doing overtime because they want to support their peers and know that if they refuse then they will leave their colleagues with an excessive workload. They find it difficult to refuse when asked for the above reasons and some staff have felt coerced into doing overtime when they are told there's no one else available to do it'.

61. Overall I find that the effect of these policies was a barrier to securing PCAs and nurse specials, which was undoubtedly their aim. The effect of this was that an 'escape valve' to deal with problematic staffing situations on any given night was made much harder to access. This is exemplified by what happened on 13 December 2006; a request for an extra nurse on the evening shift was refused, and the team leader on the night shift said she didn't ask for an extra nurse, despite her belief that there were not enough staff on that night, because she was aware that the evening shift request had been knocked back.

62. It is clear from the above that I reject the Department's view that difficulties with recruitment that were by and large outside their control was the main cause of nursing staffing problems in 2006. In addition, I heard evidence which would suggest that recruitment difficulties would be exacerbated by a situation as described above, that is that the Department may have

contributed to the difficulty in recruiting. Professor Duffield gave evidence that 'workload is tied very tightly to recruitment and retention, and if nurses perceive that the workload is too high, they just abandon the system. And I don't remember the figures for Victoria but when they introduced the nurse: patient ratios there was some significant increase of nurses coming back into the workforce, like several thousand, because they perceived that the workload was going to be much more appropriate. So if you've got a workload that's excessive, nurses just won't work there' (p201).

LACK OF AN EVIDENCE BASED METHODOLOGY

63. I consider that a key reason that the nursing staffing situation was able to develop in such a dangerous way was because staffing numbers are not determined using an evidence based methodology.

64. Nursing numbers appear to have been set at a departmental level in response to budgetary considerations and past practice. The use of such an arbitrary methodology for setting nursing numbers is unacceptable in an era where we have information that enables staffing levels to be calculated using evidence about what is needed for safe care. Professor Duffield told me that by 2001 there was overseas evidence that there was a very strong link between staffing and patient outcomes and since then most states have moved to address it by introducing objective methodologies for staffing. She spoke in particular about two methodologies in particular that are being used in other States; the Nursing Hours per Patient Day model (NHpPD) that is being used in Western Australia and Nursing Ratios which has been implemented in Victoria.

65. The Department is not unaware of such methodologies. The ANF, and nursing management, have been pushing for the adoption of an evidence based methodology for many years. The Assistant Secretary of the Department, Mr Peter Campos, has commissioned two nursing workload reviews (in 2005 and 2007). The 'Northern Territory Nursing Workload

Review – 2005' was concluded in early 2006 and it recommends 'that NHpPD be implemented and evaluated in the five hospitals across the Northern Territory', that the agreed "FTEs" needed be phased in over 3 years, and that work be done on the nursing skill mix (registered and enrolled nurses) amongst other things. The review identified a Territory-wide shortfall of 82 nursing ("FTEs") positions by benchmarking individual wards/units with similar units in Western Australia (who use NHpPD). Ward 4A is given a suggested NHpPD of 5.75 and it is noted that the actual NHpPD at the time was 4.24, that is considerably below the suggested figure.

66. The 'Acute Care Services Nursing Hours Per Patient Day Project Report 2007' was commissioned by Mr Campos with the aim of 'validating NHpPD benchmarking of 2005 review'. It identified an 'overall shortfall of approximately 166 ("FTEs") nursing positions'. Ward 4A still has a suggested NHpPD of 5.75 and the current NHpPD is reported as 5.07, that is an increase on 2005 but still considerably below the suggested figure. The review again recommended that 'NHpPD be implemented in the five hospitals across the NT'.

67. In addition the 2007 Enterprise Bargaining Agreement with the ANF commits the Department to 'work with nurses and their representatives in developing staffing arrangements based upon the Nursing Hours Per Patient Day Model during the life of this agreement'. The agreement expires in August 2008 and it is clear that staffing arrangements will not be based on this Model at that date.

68. The Department commissioned a third review of its two previous reviews, entitled 'Review of Nursing Hours Per Patient Day Reports' from MDS Patients and which is dated April 2008. The objectives as stated include 'there was some concern that calculations included in the Report indicated a significant shortfall in actual nursing care capacity in Territory Hospitals'. It concludes that the 'FTE requirements in the 2007 report' are 'significantly

overstated' and recommends a benchmarking exercise. Ward 4A has a proposed NHpPD of 5.75 for the benchmarking.

69. The actual nursing staffing levels across the Hospitals in the Northern Territory in between 2005 and 2007 (as revealed by the respective reviews) were significantly less than those recommended by the reviews. I note in particular that both reviews demonstrate a deficiency in nursing numbers for Ward 4A and recommended a significant increase in nursing staffing across all the hospitals and both reviews recommended that 'NHpPD be implemented and evaluated in the five hospitals across the Northern Territory'. The Department has ignored the recommendations of two major reviews and has not yet committed to staffing using the NHpPD model.

70. Instead, at a meeting a week before the commencement of this inquest, they agreed to 'benchmark' the model for a 12 month period. In simple terms this appears to be an agreement to measure the current staffing levels against the NHpPD model, however there is no agreement to put on nursing staff to remedy deficiencies identified. This is a curious decision, the reports from both 2005 and 2007 both measure current staffing against the model and there doesn't seem to be a great deal to gain from doing this a third time. It is very difficult to be confident that this decision to 'benchmark' is a real prelude to actually introducing an evidence based staffing methodology. I note that despite recommendations to this effect dating back to 2006 there is still no actual plan in place to introduce staffing based on an evidence based methodology.

71. In my view, the introduction of an evidence based staffing methodology is long overdue and is essential if Royal Darwin Hospital is to provide a safe environment for patients.

THE LEVEL OF KNOWLEDGE/ACCOUNTABILITY

72. I find that the withdrawal of recruitment delegations, and the setting of total nursing "FTEs" were Departmental decisions, and that Assistant Secretary

Peter Campos was involved in implementing the barriers to recruiting PCAs, and was well aware of the barriers instituted to recruiting nurse specials. Thus I consider that the Department, rather than the Hospital, is responsible for key decisions that created the nursing staffing crisis in 2006.

73. I find also that the very significant concerns of nursing management about the insufficient nursing "FTEs" and the consequent large use of agency and overtime, and the implications this had for patient care, were communicated to senior managers in the Department; that is, they had knowledge of the very difficult situation that had resulted from the policy decisions that were being made in 2006.

THE DEPARTMENT'S RESPONSE TO THIS DEATH

74. I turn now to commenting on the Department's response to the death of Mrs Winter. I have always encouraged a thorough and proactive response by the Department to reportable deaths. Mr Currie conceded that the response of the Royal Darwin Hospital and of the Department to the death was deficient. He said that there 'should have been a [Root Cause Analysis] which would've provided an immediate analysis at the ward and medical level and attempt to ensure that all systems were operating appropriately' (p300). . Ms Parker, who works in Quality and Safety at the Departmental level, told me that 'the system has let us down around follow-up of the incident and any clear documentation or anything, any sort of auditing or anything to check that the compliance rating with the falls policy, to really drill down into the issues, to look at particular cases' (p163).

75. There was an internal review conducted by the Royal Darwin Hospital. However overall neither its methodology nor many of its conclusions appear to have been accepted by the Department. The Department itself ordered two reports in relation to this death. They were both ordered in preparation for the inquest, rather than in response to the death, and neither had any recommendations, and I heard no evidence of any changes that had been

implemented in response to either report. I would be hard pressed to conclude that the purpose of the additional reports was to genuinely find out problems that may have caused the death for the purpose of improving standards and preventing future deaths. When Ms Parker, the quality and safety officer who authored the first report, was asked what had changed since the death to give the community confidence that it was unlikely to happen again, the answer was 'I don't think I can answer that' (p164).

76. I was not surprised to learn that the hospital's quality and safety processes are deficient. I heard evidence that there is a full time quality and safety position at RDH that has been empty for about six months, and that one of the difficulties in recruiting to it is that the unit isn't functioning well. I heard evidence that the unit is not a strong one and that, even if staffed, the position of head of the unit is not very senior.

77. Overall I agree with Mr Currie's very appropriate concession that in this case 'a lot of intense scrutiny of actually how things had happened and then a real will to fix them up' were lacking.

78. I was also very concerned about the Department's response to this particular public Inquest. I have expected, and historically have usually got, full and frank co-operation by the Department with the Coroner's office. In my view, this did not occur in this case.

79. Mr Currie conceded that the Department's preparation for this inquest was 'in part late, was under resourced and in general not particularly well prepared' (p301). I have already commented about the late production of Mrs Lowe's report; this death occurred in December 2006, the summary report was produced to me in June 2008 after most of the evidence had been heard. This was one example of the extremely late production of information. I received graphs from Mr Barr QC setting out total nursing FTEs since 2005 and some information on bed occupancy, after all the

evidence had been heard. They were thus not able to be put to any of the witnesses who were commenting on the issues they sought to address.

80. Aside from the late production of information, I am also concerned by the failure to produce information. My office requested information from the Department in the lead up to the inquest, which included a request for the basis on which the RDH is currently staffing their wards, the current situation as regards obtaining additional staff for a shift if the team leader thinks they are required and the methodology used to set nursing "FTEs" from 2005 to the present. We did not receive information in writing on any of these points.

81. Mr Campos was asked about the methodology used to set nursing staffing as follows:

> "MR CAMPOS: We were using what I said earlier on in, a methodology that's evolved since 1993.
>
> DR KEMP: I don't understand what this methodology is. Expain it to me. What is it?
>
> MR CAMPOS: Sorry I haven't got the fine detail for it, but it's a staffing approach that our nursing directors have been using in, across our hospitals since the early 1990s.
>
> DR KEMP: No I've asked, three weeks I've asked for this methodology. I've received nothing in writing about it. I put it to you that there is no such methodology. In fact the staffing is put at what is doable within the budget and that's been the case for some time?
>
> MR CAMPOS: And I would disagree with you completely.
>
> DR KEMP: So presumably a methodology can be produced for the court?
>
> MR CAMPOS: Umm.
>
> DR KEMP: There must be some documentation of how these matters are calculated, indeed if they're calculated, using a methodology?

MR CAMPOS: You would need to get one of the nursing directors from our hospitals to do that.

THE CORONER: Well look, I'm prepared to have this Inquest part-heard so we can get an answer to this question?

MR CAMPOS: Mm mm.

DR KEMP: What I'd like is the methodologies used for calculating staff for 2005, 2006, 2007 and 2008.

THE CORONER: I think it's a crucial piece of information. Don't you counsel assisting?

DR KEMP: Yes sir."

82. I note that RN Hughes was able to produce e-mails containing a summary of a methodology of sorts for 06/07 within hours of being asked what it was on the day before the inquest resumed on 19 June 2008. Mr Barr, acting for Mr Campos, also produced on 19 June 2008 an e-mail sent to Mr Campos on 8 May 2006 by Robin Michael which set out a summary of the "FTEs" calculations for all staff for 2006/7. It is clear from the e-mails supplied to the inquest that there was ongoing written communication between the Hospital and the Department in relation to how nursing "FTEs" were set in 2006/7.

83. Mr Campos gave evidence on behalf of the Department. He was the Assistant Secretary in charge of Acute Care, that is in charge of the five hospitals in the Northern Territory, during this crisis and he remains in this position today. The Department's general attitude to the Inquest was clearly mirrored by Mr Campos in his evidence before me.

84. He was obviously ill prepared in relation to the key issues at the Inquest; he had not read Professor Duffield's report and he said in evidence that he had read 'aspects' of the brief of evidence. His counsel submitted that 'one of the difficulties when Mr Campos first gave evidence…is that he spoke without reference to documents' (p323). For someone at his senior level,

and acting as the Department's representative in relation to this death, his lack of preparation did him, and the Department he was representing, little credit.

85. After Mr Campos gave evidence my office received two letters, unsolicited, from Mr Robin Michael and Ms Yvonne Falckh containing information that was to some degree in conflict with what Mr Campos had told me. The inquest was called on again to call oral evidence from them both and Mr Campos was represented by Mr Barr QC from that point onwards. I have carefully considered Mr Campos evidence in light of all the other evidence before me.

86. I have concerns about the accuracy of Mr Campos' evidence. Mr Campos was asked about the policies imposed in 2006 where Mr Campos' and then the general manager's approval was required to appoint PCAs, and the general manager's approval was required to appoint nurse specials. Some of the evidence Mr Campos gave in relation to these policies was as follows (p184):

> "THE CORONER: So what's come through is that that's a second area where you are quite surprised to hear about and occurred during the reign of Robin Michael?
>
> MR CAMPOS: Yes, that level
>
> THE CORONER: One was the capping and the second is finding that he himself had to be asked about whether an extra nurse special or PCA could be put on at any particular shift?
>
> MR CAMPOS: It seems a large workload and it just sort of seems very strange control.
>
> THE CORONER: How long did he last Mr Robin Michael?
>
> MR CAMPOS: 18 months.
>
> DR KEMP: Are you surprised that your immediate again subordinate wasn't telling you these things? I presume you met regularly with him to monitor what he was doing and monitor your whole area?

> MR CAMPOS: Well generally but I wouldn't get involved into all the you know micro decisions that are made. And some of those I would counsel against as I've indicated simply because if you, in the same manner than when I was put in that position or I was in that position in early 2006. It is not practical to sit down there at 24 hours in the day and get a phone call saying can I employ one person. You've got to set some parameters in there to allow people to react reasonably quickly when a patient presents or when a circumstance requires it."

He also said that during the time when his approval was required (p 183):

> "MR CAMPOS: …and you know it became very evident, obvious early in the piece that discretion had to be provided at the point of care because you can not go putting through administrative interruptions to, to decisions making."

87. The clear impression given by Mr Campos was that apart from a very brief period of time where he was involved in giving approval, he would not have been involved in the decision as to the level to go to for approval of a PCA or nurse special, he would not have known about such policies and, had he known about it, he would have counselled against a decision that the General Manager needed to be involved about it because his belief was that such decisions should be made at the point of care. He said that he would be 'less surprised' if the situation was that the General Manager had to be contacted to put on a PCA only after a certain number of PCAs, which I take to mean that he would have considered this a more reasonable policy, had he known about it, which he had not.

88. In evidence Mr Michael said that Mr Campos had just finished a lot of analysis about PCAs when Mr Michael started (p255). Mr Michael described what happened in relation to the responsibility switching from Mr Campos to himself as Mr Campos saying 'I don't want to do it, you can do it' and himself replying yes (p255). He gave evidence that Mr Campos would 'frequently hear from myself and anybody else involved that it was frustrating' (p243). Mr Michael gave evidence that the decision that the General Manager's approval was required for a nurse special was made by himself but that Mr Campos knew about it. He said that the above quote by

Mr Campos was factually wrong. He said Mr Campos had never counselled him against becoming involved in the decision making to put on a PCA or a nurse special. RN Hughes said that she discussed her concerns with the policy in relation to having to go to the General Manager for a PCA 'many times' with Mr Campos. She said that she can't remember discussing the issues of nurse specials but that 'it would've been part of the general conversation'.

89. In addition Mr Campos' direct interest and involvement in this issue is demonstrated by him having taken the extraordinary step of requiring his own approval for a PCA. I accept the evidence that he was annoyed after being called at 5:00am and thus the responsibility was devolved one step down. I consider it highly unlikely that having taken this extraordinary step in the first place, that after this point, as he claims, he had no idea about the recruitment process for a PCA. I therefore find that Mr Campos was involved in the decision to require the general manager to be contacted to put on a PCA, despite his evidence to the contrary. I find also that Mr Campos was well aware of the recruitment process for nurse specials. That is to say, I do not accept this evidence of Mr Campos in relation to this issue.

90. Another issue that took up some time at the inquest was the methodology used to set nursing "FTEs" for 2006/7 and in particular the use of pay periods 18-25 in the 2005/6 financial year. Mr Campos' evidence in relation to this was, in part, as follows (p168):

> "MR CURRIE: Throughout this Inquest, his Honour has heard about there being a cap on "FTEs" that originated in the middle of 2006 and that cap was determined by an average of the pay periods 18 to 25. Are you able to tell his Honour anything about how that originated and was set in place?
>
> MR CAMPOS: No. I, in terms of a general budget cap we have over the last three or so years have been given not only a financial cap but also a staff employment cap across the public sector."

And then later (p169):

> "MR CAMPOS: …As far as that having the staffing levels set between I think you said pay 18 to pay 25, I don't recollect that being any methodology that we used across the department. It, I have heard subsequently about that within RDH but it's something that I certainly would not have authorised and I, I fail to understand - - -
>
> MR CURRIE: Well who do you think might have done it, Mr Mitchell the evening (inaudible) general manager?
>
> MR CAMPOS: My understanding is that it was done by a Mr Robin Michaels.
>
> MR CURRIE: Sorry that's who I meant, yes?
>
> MR CAMPOS: And it is not something that I would have said is the right way of setting a target given that it, you're only looking at a very short period of time. My preference which as I've indicated both to him and to subsequents is that the people, I mean management there is that my preference is that you would take a three year average because that takes into account all the seasonable impacts plus add to that all the policy increases and if you do that then I think you've got a reasonable identification of the staffing levels."

91. On 18 June 2008 RN Hughes provided to the Coroner's Office some e-mails after she was asked about the use of these pay periods. These included an e-mail Michael Clarke (the finance Director) sent on 30 June 2006 to herself and Len Notaras (the Medical Director), which contained a draft e-mail that was going to be sent to another staff member. This e-mail included the following summary of the methodology used to calculate nursing numbers in 2006/7:

> "Base 6/7 FTE = 1,559 FTE calculated and costed (including extra 3%) using the average of pays 18-25 of 05/06
>
> ADD – new initiatives = 1,590 FTE
>
> ADD – RAPU = 1,673 FTE"

This e-mail also states that Michael Clarke had outlined this methodology at a meeting in town with Peter Campos, Robin Michaels, Robin Smith. He had provided them with a spreadsheet and that he thought that the methodology had been understood and accepted by Peter Campos and Robin Smith. He also said that he had sent the above summary to Peter Campos earlier that week.

92. There is also an e-mail dated 20 June 2006 from Robin Michael to a list or recipients which included Peter Campos about the staffing of RDH which includes the following:

> "…the staff number that is submitted to central government needs to be absolutely realistic…The calculation submitted is based on pays 18 to 25 so is a fair sample of what staffing we have needed to deliver services."

93. In addition the inquest heard evidence from RN Kitchener and Professor Di Brown that the nursing "FTEs" were set using pay periods 18 -25 in 05/06. The internal review conducted by the hospital into this death included the following:

> "DHCS accepted staffing targets in an agreement between the CEO and the Departments. The policy required that the average staffing of all work places during pay periods 18-25 in 2006 is the number of staff required for the work unit to function. The staffing levels at the time of Pays 18-25 in 2006 followed RDH management having had its authority to recruit staff removed by the then CEO of DHCS. Ward 4A nursing FTE averages in pay periods 18-25 in 2006 were in fact nine FTE less than required for the 30 bed ward to function. This has had a direct impact on the care of patients as Agency, Casual and overtime nursing staff have had to fill the shortfall to safe staffing numbers. The poor outcomes from this policy on RDH, both for patient care and fiscally, were outlined clearly on its instigation by the Nursing Executive and Management of RDH."

94. RN Hughes, as well as providing the e-mails cited above, gave evidence that she remember Mr Campos being involved in the discussions surrounding the use of pay periods 18-25 (p274).

95. Finally Mr Robin Michael gave evidence on this point. He said that pays 18 to 25 were used to work out the average cost of employment of a nurse and also to calibrate the base number of nurses across a hospital by ward, to which were added numbers of additional nurses that were supplied. This was then submitted up to treasury and once validated became the staff establishment. In 2006/7 there was no additional money for nurses for general medical wards (apart from indexation) and thus the nurse numbers for particular wards ended up being the calculation based on pays 18-25 plus indexation and thus it was 'highly likely' the number of nurses on ward 4A was set using the number during pays 18-25. He said that Mr Campos was 'briefed on the process' and that '[Mr Campos] knew the mechanism that we were using'. He said that Mr Campos may not have 'picked up' the use of pays 18-25 to calculate the base numbers per ward. I find, based on a comparison of Mr Michael's oral evidence with his written statement, that Mr Michael deliberately played down Mr Campos role throughout his oral evidence. Given the weight of evidence described above I do not accept his evidence that Mr Campos may have been unclear on the full use of pays 18-25.

96. I find that pay periods 18-25 were used to calculate the nursing FTEs for 2006/7 and that this was widely known. I find that Mr Campos was actively involved in the decision made to use this methodology and approved it. Mr Campos' evidence that he only became aware that the pay periods were used 'subsequently' was inaccurate.

97. The Department, and Mr Campos in particular, were clearly put on notice by the documents on the brief and in particular the Hospital's internal report, and the request from Dr Kemp before the inquest for the methodology used to calculate nursing numbers from 2005 to the present, that this was a relevant issue for the inquest. Had Mr Campos chosen to look at them, the Departmental records must contain documents setting out the use of these pays period that had been sent to him. Mr Campos' evidence on this point was careless and cavalier to say the least, and it was inaccurate. However,

given the complexity of this issue, and Mr Campos' clear lack of preparation for the inquest, I am unable to determine whether his evidence on this point was deliberately misleading.

98. Precisely where the policy originated from in relation to the putting on of PCAs and what exactly pays 18-25 were used for are not issues of central importance. However Mr Campos' inaccurate evidence in relation to them served, both times, to inaccurately devolve responsibility to the General Manager, Mr Michael. This general tendency to inaccurately devolve responsibility was also seen when Mr Campos told me that the nursing staffing levels were set at the level that 'nurses' wanted; 'the actual staffing, the real, the staffing on the wards is based on the judgements of the nurses in charge, of how many nurses they need …for the patients they have there, the acuity' (p187) and again at (p192) 'the nurses are indicating that these are the, we've got reasonable staffing levels and this is the staffing levels that we need and if we need more based on the acuity we either go into overflow, we get overtime and we get agencies'. He was asked about the situation in 2006 and said that the nursing staffing levels were what the 'aggregate of the nursing core' considered to be reasonable (p192). He said the 'nursing core' was the executive director of nursing, the three directors underneath them and that he also heard from the ANF about nursing staffing. This is clearly not true in relation to 2006 given the evidence from the Yvonne Falckh, the Secretary of the Australian Nurses Federation, from RN Marie Hughes and Professor Di Brown, the two nurses who were in the EDON position in 2006 and from RN Denby Kitchener, one of the directors beneath the EDON position.

CURRENT SITUATION

99. I have found that there was a crisis in nursing staffing in 2006. It thus falls to me to consider whether this crisis has resolved.

100. Despite a written request from my office, the evidence was not entirely clear on the current processes for securing extra staff on a particular night, it seems that the Nursing Resource Coordinator now has power to appoint a nurse special, but there was some contradictory evidence about whether the general manager is still involved in granting permission to recruit a PCA. There is no current written policy and it seems as if there is a level of confusion about the process.

101. I have carefully considered whether the nursing staffing situation has improved. I note that 35 FTE nurses were put on in 2007 in response to the submission from the General Manager to the Department, by converting some of the money being spent on agency and overtime to permanent staff, and undoubtedly this has been of assistance.

102. RN Kitchener gave evidence that things significantly improved after the increase. However I was also presented with evidence that the Royal Darwin Hospital is still using large amounts of overtime and agency staff for their nursing staffing. Yvonne Falckh, the Secretary of the ANF, stated in her letter to me that she is 'being informed by my members at RDH that it is not uncommon for a ward roster of a 28 day cycle to have over 100 vacant shifts due to understaffing…nurses are asked to put their names down for overtime and frequently are contacted during their shift to ask if they would stay at work and do a double shift'.

103. In addition I was supplied with information from the first benchmarking report by MDS Partners (dated 16 June 2008). It shows that the nursing numbers in some units are above the targets, but the numbers on the general medical wards (4A and 4B) are significantly below the targets that have been set, that is that there is still significant understaffing of the general medical wards. In particular ward 4A has an actual NHpPD of 4.91 which is well below the target figure of 5.75, and down from what it was in 2007.

104. I find that the extra 35 "FTEs" has not solved the problem of nursing staffing on medical wards at RDH. I note that the calculation of 35 "FTEs" seems to have been mainly based on a conversion of money spent on agency/overtime, rather than on any calculation in terms of nursing requirements for patient safety or the use of any evidence based methodology.

105. Overall it is not surprising that significant issues with nursing staffing still exist. The Department's persistence in ignoring the recommendations of its own reports, and its' own industrial agreement, in relation to the implementation of an evidence based methodology means the RDH is still setting nursing numbers without sufficient reference to the evidence in relation to the numbers required for safe care.

RECOMMENDATIONS

106. I have serious concerns about the situation revealed by this death and make a number of recommendations in relation to it.

1. An appropriate nursing staffing methodology should be implemented which gives consideration to casemix, acuity and patient turnover. The use of staff working double shifts, agency or pool staff should only occur under exceptional circumstances (such as sick leave, increased acuity, specialling and increased bed numbers) rather than being used routinely to fill shifts in a roster.

2. If additional staff are needed (PCAs, nurse specials, extra nurses for overflow beds) then the Nursing Resource Coordinator should have delegated authority to make this decision. This delegation should be documented in a policy document that is widely available. Reasons for the request, and reasons for any refusal, must be provided and documented so decisions are transparent.

3. Nursing staff should be required to complete either the Observation Special or the Neurological Observation Chart but not both.

4. The quality and safety processes need to be dramatically improved. Senior staff with appropriate authority need to be given the power to conduct reviews and making recommendations, if appropriate, in relation to sentinel events, and there needs to be a commitment at the highest levels to using the reviews to improve practice.

5. That there is an audit of the current compliance with the "falls policy" and, if it demonstrates a lack of compliance, steps are taken to ensure the policy is complied with.

Dated this 4th day of September 2008.

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GREG CAVANAGH
TERRITORY CORONER