CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Fresh inquest into the death of Jarrod Wright
Date of findings:	18 January 2019
Place of findings:	NSW Coroners Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – whether necessary or desirable for recommendation to be made regarding nursing/patient ratios.
File number:	2016/355820
Representation:	Counsel Assisting the inquest: P Dwyer of Counsel i/b NSW Crown Solicitors Office. South Western Sydney Local Health District: P Rooney of Counsel i/b McCabe Curwoods Solicitors. Dr R Chin: C Jackson of Counsel i/b Avant Law. Dr W O'Regan and Dr A Wagh: T Berberian of Counsel i/b HWL Ebsworth Lawyers. Registered Nurses L Irvine, C Thebridge and A Dawson: M Byrne of NSW Nurses and Midwives' Association.
Findings:	It is necessary and desirable to make the recommendation that the Executive Director of the South Western Sydney Local Health District consider releasing as a Policy Directive, the Guideline titled Nursing Workforce in ICU issued in November 2016 (as previously made on 17 December 2018).

These are findings made in a fresh inquest into the circumstances of the death of Jarrod Wright. These findings are made in addition to those made on 17 December 2018 in a previous inquest into the circumstances of Jarrod Wright's death.

The reason for a fresh inquest

1. An inquest into the circumstances of Jarrod Wright's death was conducted on the dates 5 – 9 November 2018 [the previous inquest]. On 17 December 2018 I delivered and published findings as to the date, place, cause and manner of Jarrod's tragic death. Those findings remain in place and are not the subject of the fresh inquest. The fresh inquest concerns the single recommendation made in the previous inquest.

2. The fresh inquest is conducted pursuant to a direction made by the Acting State Coroner under section 83(6) of the *Coroners Act 2009 (NSW)* [the Act]. An application for a fresh inquest was made by the NSW Crown Solicitor and on behalf of Counsel Assisting for the previous inquest, on the basis that new facts existed which made it necessary or desirable in the interests of justice to hold a fresh inquest.

3. The new facts are constituted by written submissions made on behalf of the South Western Sydney Local Health District [the LHD], which was an interested party in the previous inquest. At the close of evidence in the previous inquest, oral submissions were made by the NSW Nurses and Midwives' Association on behalf of Registered Nurses Irvine, Thebridge and Dawson, proposing that an existing Guideline concerning nursing ratios be released as a Policy Directive within the LHD.

4. On 16 November 2018 the LHD filed a written submission arguing against adoption of the NSW Nurses and Midwives' Association's proposal. Unfortunately the submission was inadvertently overlooked. This was not the fault of those representing the LHD, nor of those assisting the inquest. Consequently the information contained in the LHD's submission was not taken into account in my determination of whether it was necessary or desirable to make a recommendation pursuant to section 82 of the Act, adopting the NSW Nurses and Midwives' Association's proposal.

5. In my findings delivered on 17 December 2018, on page 14 I erroneously recorded that the LHD had not responded to the NSW Nurses and Midwives' Association's proposal. In fact as mentioned the LHD had responded with a written submission on 16 November 2018.

6. On 21 December 2018 the Acting State Coroner formed the opinion that it was desirable in the interests of justice to hold a fresh inquest. Her Honour directed that I hold a fresh inquest for the limited purpose of reviewing the submissions of the LHD in relation to the proposal and considering any addition to or substitution for the findings made in the previous inquest in relation to this issue. Given the limited scope of the issue to be determined, it

has been accepted by all interested parties that it would be appropriate to conduct the fresh inquest on the papers.

The proposal of the NSW Nurses and Midwives' Association

7. The circumstances of Jarrod Wright's tragic death and the extent to which an inadequate nursing/patient ratio contributed to it were recorded in the findings delivered on 17 December 2018, and there is no need to repeat them here.

8. In November 2016 in response to Jarrod's death, the LHD issued a revised Guideline concerning nursing ratios within the Intensive Care Unit at Liverpool Hospital. The Guideline extended the category of patients to receive 1:1 nursing to those on continuous intravenous sedation. At the close of evidence it was proposed on behalf of the NSW Nurses and Midwives' Association that there ought to be a recommendation that the LHD consider implementing the revised Guideline as an LHD policy. The effect would be to give the ICU nursing ratios set out in the revised Guideline the status of a mandatory directive, applying throughout the LHD.

The LHD's submission

9. In written submissions those representing the LHD contended that it was neither necessary nor appropriate to make the above recommendation. The submissions were:

   - that the revised Guideline is an effective tool in its current status, as it is appropriately understood and properly regarded by clinicians within the ICU

   - that to give the Guideline a more prescriptive status would cause difficulties if for example an ICU nurse was required to respond to a medical emergency for a patient not under his or her allocated care

   - that it would be procedurally unfair to make the recommendation because the proposal was not put to any of the clinical witnesses who gave evidence in the previous inquest.

Conclusion and reasons

10. I have carefully considered the submissions made on behalf of the LHD. Having done so I maintain the view that it is necessary and desirable to recommend that the LHD consider implementing the Guideline as a Policy Directive. My reasons follow.

11. Implementing the nursing ratio Guideline as a Policy Directive would enhance clinical understanding of and adherence to this critical aspect of ICU patient care. As recorded in paragraph 62 of the previous findings, there can be no doubt that Jarrod's emotional condition on the critical evening ought to have been recognised as meeting the criterion of a patient who was *'restless, agitated and clinically unstable'*. According to the nursing ratio Guideline

which was in place prior to the November 2016 revision, this would have indicated that Jarrod needed to be nursed on a 1:1 nursing/patient ratio. This did not happen, with the evidence at the previous inquest indicating that the then Guideline was neither appropriately understood nor properly regarded by ICU staff. Upgrading the status of the revised Guideline to a Policy Directive would emphasise the importance that is placed on this aspect of patient care and enhance understanding of and adherence to it.

12. Implementing the revised Guideline as a Policy Directive may also alleviate the difficulties which Jarrod's nurses said they felt that evening in requesting additional help with his care. This evidence is set out in paragraph 64 of the findings in the previous inquest. It is acknowledged that nursing and medical staff receive training to assist them with such communication issues. Despite this the personal and cultural impediments to effective communication within hospital hierarchies remain a recurring feature in the circumstances of hospital deaths like Jarrod's.

13. The LHD contends that it would be procedurally unfair to make this recommendation because witnesses did not have the opportunity to comment upon it in the course of the previous inquest. This is not an uncommon occurrence within the coronial jurisdiction given its broad function of conducting inquiries in the interest of public health and safety. In many cases discharging this function would not be possible without a degree of latitude in the rules of evidence and procedure. As a matter of procedural fairness the LHD was entitled to make submissions in protection of its own interests, and did so.

14. Having considered the submissions of the LHD, I conclude that it is necessary and desirable to maintain the recommendation made in the previous inquest that the LHD's Executive Director consider releasing as a Policy Directive, the Guideline titled Nursing Workforce in ICU issued in November 2016.

15. I also take this opportunity to correct a typographical error at paragraph 15 of the findings of the previous inquest, regarding the position occupied by Dr Dean Morris. I confirm that according to Dr Morris' oral evidence, he was at the time of the inquest an Orthopaedics Registrar in the process of applying for the orthopaedics specialist program.

I close this inquest.

E Ryan
Deputy State Coroner
Glebe

Date: 18 January 2019