CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Malcolm Daniel Moriarty**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	10/10/2024
FILE NO(s):	2022/5420
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Storage and access to medications in Residential Aged Care Facility; Complacency in medication administration.

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Introduction

1. Malcolm Daniel Moriarty (Mr Moriarty) was born on 6 October 1935 and died on 28 October 2022 at a Residential Aged Care Facility (RACF) in Innisfail. He was 87 years old.

2. Queensland Police Service (Police) reported Mr Moriarty's death to the Coroner because his death was identified as sudden or unexpected within the definition of a reportable death in the *Coroners Act 2003*.

3. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

4. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am guided by the principles outlined in *Briginshaw v Briginshaw* (1938) 60 CLR 336. That is, I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

Circumstances of the death

5. Mr Moriarty had a history of Alzheimer's disease. He usually lived with his wife.

6. On 26 October 2022, Mr Moriarty was admitted to the RACF for respite care for two weeks. He was accompanied by his wife and daughter. He was assigned a room which was adjacent to the nurse's station.

7. Mr Moriarty was taking an array of prescription medications. The nursing staff were responsible for the storage and administration of Mr Moriarty's medications. He was not to have any medication in his possession.

8. On 27 October 2022 at approximately 9.30-10pm, Mr Moriarty was found by an Enrolled Nurse (EN) wandering the hallway. He appeared lost. The EN assisted Mr Moriarty back to his room. When he entered his room, he took two tablets from a blister packet of medication on his table before the EN could stop him. She saw that the tablets were 'Sotalol Sandoz'. The blister pack was empty after Mr Moriarty took the two tablets. Mr Moriarty was not prescribed Sotalol. The EN took Mr Moriarty's vital signs and contacted a General Practitioner (GP), who advised he would call back.

9. At or around 2.30 am, the EN handed over to a Registered Nurse (RN). Very shortly thereafter the RN checked on Mr Moriarty. He found another blister pack of two empty capsules of 'Sotalol 160mg' in Mr Moriarty's room. Mr Moriarty and his room had been checked prior and no blister packs had been found. It was assumed Mr Moriarty had taken a further two tablets of Sotalol. The RN conducted a search of Mr Moriarty's room. He found two blister packets of Dabigatran 110mg with no tablets missing and a blister packet of 10 tablets of Sotalol 160mg, with eight tablets missing. The tablets were removed from Mr Moriarty's room and placed in the 'medication trolley' in the nurse's station.

10. Between 3.05am and 5am, Mr Moriarty was continually monitored. At 5am, it was noted Mr Moriarty had become disorientated. He also appeared pale, clammy and was getting cold. His breathing was also noted to be getting shallower. The staff called for the Queensland Ambulance Service (QAS) to attend. While staff were on the phone to the QAS, Mr Moriarty stopped breathing and CPR was commenced.

11. The QAS paramedics took over CPR when they arrived. The RACF staff with the paramedics contacted Mr Moriarty's wife who advised them of Mr Moriarty's medical history and that CPR

could be ceased. Mr Moriarty was declared deceased at 5.43am.

Police Investigation

12. Police from the local Criminal Investigation Branch (CIB) attended the RACF and obtained a version of events from staff as well as a copy of the clinical record. The Sotalol blister packets had already been thrown into the bin and were not retrievable. The medications located by the RN were provided to the Police.

13. Following enquiries, it was identified there was only one resident in the RACF who had been prescribed Sotalol and Dabigatran. That resident was a female and did not maintain possession of her medications. All her medications were stored in the nurse's station. The Police have advised,

    The protocol is that the nurse's station always remained locked and is accessed by an electronic tag assigned to individual staff. The medication trolley is also supposed to be locked. It is common that these are left unlocked, and the doors wedged open, which is against policy within the home. Upon police attendance the nurses station door and the medication trolley were both unlocked.

14. Police have confirmed there was no CCTV around Mr Moriarty's room or the nurse's station.

15. According to a file note of events by the EN, the medication was administered to the resident who was prescribed it, from its original packaging which was stored in the medication trolley. It was last administered by the EN at 7pm. She says the medication was dispensed from the draw and would not be left on the top of the trolley during the round. She says she did not see Mr Moriarty when she was doing her medication round. When she saw Mr Moriarty at 10.15pm, he was settled in bed.

16. The RACF Policy has been provided. It clearly indicated medications were to be stored in the locked medication room when not in use. And that the "*Medication trolleys must never be left unlocked when unattended in public areas*" and "*Medications are not to be left beside bedsides; administering staff must remain with the resident until the medication is seen to be swallowed*".

17. The toxicology results show Mr Moriarty had 11mg/L of Sotalol in his system. This confirms Mr Moriarty ingested Sotalol, a medication he was not prescribed.

18. The Police reviewed the swipe card access to the nurse's station and the medication room. The nurse's station was opened at 4.49pm on 27 October 2022, with the next access at 9.41am on 28 October 2022. The internal door to the medication room was opened at 01:07pm on 27 October 2022, with the next access on 8.18am on 28 October 2022. Police state,

    Considering that the nurse's station is constantly in use, and the medication room is constantly used, it is likely that these doors were left open during these time periods.

19. Police reviewed the triple zero recordings. It was made by a male nurse. He struggled to provide sufficient and accurate information and took four minutes to provide the address.

ACQASC

20. The RACF had a history of being non-compliant with the relevant aged care Quality Standards since October 2021. A non-compliance notice was issued on 27 October 2022. The RACF was struggling on several fronts including staffing shortages, resignation of senior employees, debt, and financial viability.

21. The owner of the RACF was attempting to sell the facility. The relevant government department had been working closely with the RACF in providing support to try to avoid a disorderly closure.

22. The incident concerning Mr Moriarty was reported to the Aged Care Quality and Safety Commission (ACQSC). The Assessment Team planned to complete an assessment contact on 2 November 2022. On behalf of the family, the Assessment Team spoke with Mr Moriarty's daughter and undertook an inspection of the RACF. They also interviewed staff and reviewed the relevant documentation.

23. On 3 November 2022, a four month sanction was placed on the RACF. The sanctioned required the RACF to take immediate action to rectify the non-compliance set out in the Notices and they were required to develop and implement appropriate procedures and practice to ensure the non-compliance did not happen again. Regarding Mr Moriarty, the ACQSC found the RACF,

> *Failed to provide appropriate care and services to Mr Malcolm Moriarty to ensure his mental and physical wellbeing. You also failed to ensure appropriate medication practices at the service. Both of these deficiencies placed Mr Moriarty at significant risk of serious harm including death.*

24. Noting the nursing home has since been decommissioned, a copy of the Performance Report of 2 November 2022 is publicly available: [Ozcare Innisfail 5076 | Aged Care Quality and Safety Commission]

AHPRA

25. On 6 February 2023, a nurse from the RACF reported the incident to the OHO and advised, Mr Moriarty may have died because of a medication incident.

26. On 3 October 2023, the Nursing and Midwifery Board (through the Australian Health Practitioner Regulation Agency) decided not to take any further action against the EN. The reasons state,

> *Having considered the concerns raised with us, we then assessed the risk that the practitioner may pose in the future by considering:*
>
> > *The fact that the practitioner is no longer registered; and*
> >
> > *The seriousness of the concerns and the public interest in taking action.*
>
> *The individual identified in the notification is no longer registered as a health practitioner. While we might have considered taking action to protect future patients if they were still registered, we do not think this necessary now.*
>
> *The concerns will be recorded on our database with a relevant alert should the practitioner decide to return to practice and apply for registration, the concerns raised in this notification will be considered at that time.*
>
> *The Board acknowledged systemic failures that have occurred and have referred these to the Aged Care Quality and Safety Commission (ACQSC).*

THE RACF RESPONSE

27. The RACF has been decommissioned. However, before that occurred, the RACF had undertaken several initiatives in response to the incident concerning Mr Moriarty.

28. Following the incident, in November 2022, the RACF,

    a. Implemented a new style medication trolley with a better lock system.

b. Existing medication trolleys were checked to ensure they locked as expected.

c. All the medication rooms were checked, and the locking functioning was confirmed.

d. Anything that might be used as a wedge or stop was found and removed.

e. All electronic swipes were checked with only registered staff having access to the medication room.

f. All registered staff received written communication alerting them to the incident and were asked to ensure that all medications are appropriately always secured.

g. The incident was included on the agenda for a mandatory meeting with all registered staff.

h. A program of random checks of trolley and medication rooms for compliance was established.

29. In December 2022,

    a. All staff received training from an external provider.

    b. A medication management competency was completed with all registered staff.

    c. An audit was carried out to confirm the changes made to practice in November 2022 remained in place.

30. In June 2023, the RACF undertook a medication audit and identified,

    a. A lack of awareness on the Medication Advisory Committee (MAC) [item was to be tabled at Clinical meetings and unit meetings];

    b. The medication review dates for four residents were not able to be identified [the GP was contacted to review those residents and their medications];

    c. The medication room did not have a glass window [noted for further discussion];

    d. The medication swipe card system had been installed but remained unactive [it was corrected on the day by maintenance].

31. Other improvements the RACF had implemented includes,

    a. Medications audits to be conducted at regular intervals.

    b. Facility staff to check new medication packs against current drug charts.

    c. Registered staff to undergo regular and further training on medication administration.

32. It was noted the RACF had provided education on standard one (aged care standard) in the month of May 2023 with a completion rate of 95%.

33. On 22 July 2023, the RACF advised the Incident Management System (IMS) and Medication Management system had been reviewed and a plan for continuous improvement had been implemented. Further, that the service was working with Nurse advisors to ensure that Risks are mitigated, and the service meets compliance requirements.

34. On 1 December 2023, the RACF's ownership changed and is now operating as Ozcare Innisfail. Since the transition Ozcare has implemented an Incident Management System Tickit, which is the same system used at all Ozcare sites across Queensland. I have been advised this given the local Management Team, Quality Team and Executive oversight of incidents.

35. I have been advised renovation of the nursing home building Mr Moriarty resided in began in February 2024 and is still under renovation. There are no residents residing in this area of the nursing home. The renovation includes a new nurse's station with electronic swipe access to medication store, locked down by access privilege. It will be fitted with new equipment including lockable medication trolley's the same which are used in all other buildings at the RACF.

36. In April 2024, all registered staff underwent refresher training in the electronic management system – MPS Healthstream.

Forensic Pathologist Examination

37. An external autopsy and an internal autopsy to the extent necessary to identify the cause of Mr Moriarty's death was ordered.

38. The forensic pathologist found Mr Moriarty had an enlarged and dilated heart with marked expansion of the major blood vessels of the heart, some heart muscle scarring, and some severe hardening and narrowing of his arteries. There was evidence of other natural disease, including invasive prostate cancer. No significant injuries were identified.

39. The toxicology results revealed Mr Moriarty had Quetiapine (an antipsychotic) at a blood level below the potential toxic range. He had Sotalol at a blood alcohol level in the reported individually toxic range.

40. The forensic pathologist concludes by stating,

> *The cause of death was most probably the combined effects of sotalol toxicity on a background of severe valvular and atherosclerotic cardiovascular disease. Although the latter was of such severity that this would otherwise explain the death, it is nevertheless most likely that the concurrent sotalol toxicity has expedited the death*.

41. The forensic pathologist found the cause of Mr Moriarty's death to be the combined effects of sotalol toxicity, valvular and atherosclerotic cardiovascular disease.

Conclusion

42. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings in relation to Mr Moriarty's death.

43. Mr Moriarty was being cared for at home by his wife. She decided to admit Mr Moriarty to the RACF for two weeks for respite care. Tragically, this resulted the very next day, in Mr Moriarty accessing and taking prescription medication which, he had not been prescribed. While the precise mechanism of how and when he obtained the medications cannot be established, I find at some time during the afternoon of 27 October 2022, Mr Moriarty accessed the top draw of the medication trolley and removed the packets of the medications. The toxicology results confirm he took some of the Sotalol tablets.

44. Mr Moriarty should never have been able to access that medication. The EN who was doing the medication round must have left the unlocked trolley in a position which was accessible to Mr Moriarty. After this had occurred and the EN witnessed Mr Moriarty take two tablets, she closely monitored him and left a message for a GP. It does not appear she undertook a thorough search of his room or his person, looking for other medications. Further, there is no evidence the GP was followed up, or urgent medical assistance was sought by the RN when he located the additional medications.

45. It cannot be determined if earlier intervention would have made any difference after Mr Moriarty ingested the tablets. This given his age, and his co-morbidities, including his poor cardiovascular health.

46. While the EN was deficit in her care, there were several system issues at play. A practice had crept in at the RACF of not locking the medication trolleys and in propping open the swipe access only door to the medication room. There seemed to be a level of complacency. Had the trolley have been locked as required, the incident would not have occurred. There was also a missed opportunity to transfer Mr Moriarty to hospital for urgent assessment once it had been identified he had taken cardiac medication which he had not been prescribed. The incident was reported to Ahpra and in circumstances the EN is no longer registered, they have noted the incident should she seek re-registration.

47. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing) because in my view drawing attention to the circumstances of this death does not warrant holding an inquest. I have though sought approval from Mr Moriarty's family to publish these findings so other clinicians and other RACFs are able to consider and reflect on the events which occurred in this case. Further, that this case may remind clinicians of the dangers when complacency sets in regarding what are standard day to day practices.

48. I accept the forensic pathologist's opinion as to the cause of Mr Moriarty's death.

49. I extend my condolences to Mr Moriarty's family and friends for their loss.

I close the investigation.

Melinda Zerner
Coroner

22 August 2024