Australia: Coroner finds caesarean death was “preventable”

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A coronial inquest has found that Rebecca Murray, a 29-year-old mother who died following a caesarean delivery at Bathurst Base Hospital in regional New South Wales, died from preventable causes. The findings point to a systemic crisis in Australia’s public hospital system.

Rebecca Murray, mother to Lachlan (5), Emelia (4) and Gracie (now aged 2) died on June 25, 2007 after a postpartum haemorrhage caused multi-system organ failure.

In March 2008 Rebecca’s husband Jim Murray spoke out publicly, bringing to light a series of horrific failures by health authorities. Following surgery, Murray’s wife was left in the care of staff untrained in critical post-natal procedures. Internal haemorrhaging went undetected and the hospital’s non-performance of routine procedures meant that compatible blood supplies were not located in time. Blood transfusion equipment malfunctioned.

An internal investigation conducted at the hospital-a Root Cause Analysis—confirmed these failures, yet the state Labor government’s then health minister Reba Meagher claimed: “This case is a tragedy but should not be used to indict an entire health care system.”

Last month a 12-day coronial inquest into Rebecca Murray’s death found that two primary factors contributed to the young mother’s death. New South Wales (NSW) Deputy State Coroner Carl Milovanovich concluded that the hospital’s “failure to take a full blood count, group and hold and/or cross matching prior to an emergency caesarean” caused a delay that was fatal. Had Murray received a timely blood transfusion “her death would have been prevented”.

A “blood count, group hold and/or cross match” is standard procedure for caesarean patients in metropolitan hospitals. With a patient’s blood type identified, compatible blood supplies are kept on standby in case they are needed for transfusion. Yet Bathurst Hospital policy was that blood count, group hold and/or cross match *not* be conducted. The inquiry found the procedure is commonly not performed in regional hospitals.

In Murray’s case, the risk of severe blood loss was heightened. Her gynaecologist recorded a low platelet count in May. Platelets are cell structures that help arrest bleeding.

Milovanovich found the second primary factor contributing to Murray’s death was the failure by Bathurst Hospital to provide adequately trained nursing staff. After her caesarean, during which she received a tear to the uterus and experienced severe loss of blood, Murray was placed under the care of an anaesthetic nurse who had only limited experience in recovery, and had never been trained to deal with a post-partum haemorrhage.

The coroner estimated Murray “most likely commenced to bleed again internally within a very short time after being received in recovery” but haemorrhaging was not detected until her situation was critical—at about 8.46 am. Then, a series of “systemic” errors meant that Murray only received her first transfusion at about 9.55 am—more than one hour after major blood loss was observed.

Milovanovich’s 18-page report is telling in many respects. Having detailed the hospital’s failure to provide adequate care, the coroner observed: “There was no evidence at this inquest that might suggest that the standard of obstetric care was generally inferior to that of

other regional centres, however, there is little doubt that the same degree of expertise and access to highly skilled clinicians and ancillary medical staff (nurses, midwives etc) is more available and accessible in the larger hospitals located in the Sydney metropolitan area."

"In the perfect world," Milovanovich concluded, "a Base Hospital should be able to provide the same level of service in medical care in the specialist fields it chooses to provide, whether it be obstetrics or any other surgical or medical discipline."

Having made this statement Milovanovich simply moves on. A "perfect world"—in this case "access to highly skilled clinicians and ancillary medical staff"—is, we are left to presume, something that can never be attained. Like countless other coroners' reports and government inquiries, life threatening conditions of under-resourcing and under-staffing are taken as a "given". Only remedies deemed "realistic" generally find their way into official recommendations and findings. Those politically responsible for a system that chronically starves hospitals are never held to account, so the underlying problems continue to fester, giving rise to further tragedies.

Bathurst Base Hospital serves a local population of some 38,000, and between 500 and 600 babies are delivered there each year. But the hospital, like dozens of similar regional facilities throughout Australia, receives nothing like the funding necessary to ensure quality care for all patients.

Milovanovich found that Bathurst Hospital guidelines for dealing with post-partum haemorrhage were not supported by necessary systems of training and dissemination. "This issue does not require formal recommendations" he wrote, "It is common sense that the effective and efficient management of the available skills and resources is a management responsibility."

But while hospital management has a legal responsibility to effectively run hospitals, it is precisely the lack of "available skills and resources" that creates an institutional bias toward error, jeopardising patient lives and harming the professional development and well-being of staff.

The link between under-funding and patient risk is brutally direct. "This inquest" the coroner wrote, "identified that certain drugs that may have assisted in the recovery of Mrs Murray were not available at Bathurst Base Hospital." Misoprostal, a contracting agent, was one such drug. Another, with coagulating properties, was Novoseven. "The drug, the Court has been told, is very expensive."

"Do we have to wait for another mother to die before there are changes" the coroner asked.

Milovanovich made just one formal recommendation in relation to Rebecca Murray's death: "That consideration be given to implementing a uniform policy in all New South Wales Hospitals that provides that a full blood count and group and hold be undertaken for all elective and emergency caesarean sections."

Outside Westmead Coroner's Court Jim Murray told reporters the minister for health shared responsibility for his wife's death. "He's got to take some blame in what you really term the murder of my wife." Murray also defended the nurse involved in his wife's care, saying he wanted changes to the system so that other women's lives would not be jeopardised: "I'm angry that they did that to the nurse, put her in a position where she didn't know what she was doing," he said.

Yet chronic underfunding across both regional and metropolitan hospitals continues. In May, doctors, nurses and ancillary staff at Bathurst and Orange hospitals took industrial action over threatened job losses throughout the Greater Western Area Health Service (GWAHS). Dr Steve Flecknoe-Brown, chairman of the GWAHS advisory council, told ABC news the region has a three-year funding shortfall and required additional federal support.