MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Geoffrey Raymond Murray,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Geoffrey Raymond Murray;
b) Mr Murray died of natural causes;
c) The cause of death was acute myocardial ischaemia related to stenosis of the right coronary artery; and
d) Mr Murray died on 25 February 2019 at Youngtown, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the investigation into Mr Geoffrey Raymond Murray's death. The evidence includes:

- Tasmania Police Report of Death for the Coroner;
- An opinion of the pathologist who examined the body of Mr Murray;
- Affidavit of Karyn Borsboom, daughter of Mr Murray;
- Affidavits of Peter Wagland, Betty Wagland and Jodie Bennett – friends of Mr Murray;
- Affidavit of Lanny Neal, who was in a personal relationship with Mr Murray;
- Affidavits from attending police officers;
- Medical records and reports;
- An opinion of the coronial medical consultant;
- Taxi records; and
- Mr Murray's mobile telephone records.

Background

Mr Murray was born in Launceston, Tasmania on 3 March 1944. He was aged 74 years and was a widower. Mr Murray lived by himself at Youngtown at the time of his death. He worked as a train driver for Australian National Railways before retiring due to hearing loss.

Mr Murray grew up in Launceston and on the East Coast of Tasmania. He married Jillian Murray in 1966 and they had one child, Karyn Borsboom, in 1967. Mr Murray also fathered a son, David Dollard, in 1965 who was raised by adoptive parents. Mr Murray's wife died in 2017 and, at the time of his death, Mr Murray was in a personal relationship with Ms Lanny Neal.

Mr Murray suffered depression, diabetes, hypertension and chronic obstructive pulmonary disease; all long-standing conditions. He saw his general practitioner regularly and was prescribed medication to treat these conditions. His last attendance upon his doctor was on 3 January 2019 to obtain a prescription, as he was scheduled to travel to Jakarta for a holiday with Ms Neal. His health appeared stable in the months before his death.

Circumstances of Death

Mr Murray returned from his holiday in Jakarta on 19 February 2019, with Ms Neal staying an extra fortnight with family members.

On Sunday 24 February 2019, Mr Murray went to visit friends, Peter and Betty Wagland, at their home. He consumed a very small amount of beer, before telling his friends that he was feeling dizzy and sick. His face appeared very red. He left the home of his friends, stating he would call an after-hours medical service.

At 4.47pm Mr Murray called for an ambulance to come to his home. He then called Mr Wagland, stating that the ambulance was on its way and asking him to look after his animals.

At 5.13pm he presented at the Emergency Department of the Launceston General Hospital with fever and vomiting. Triage staff took his details and performed an initial medical assessment.

At 6.27pm the nursing notes record that he was seen, that clinical observations were done (at 6.15pm), an identification band was placed and his allergy status checked. His only abnormal clinical observation was his temperature, being 38.4 degrees. At 6.35pm or a little earlier, he was given Panadol and ondansetron (an anti-emetic).

Mr Murray was recorded as not being in the waiting room at 6.56pm when it is likely that staff called for him. The hospital notes record that he "did not wait". However, I am satisfied that he was at least somewhere in the vicinity of the Emergency Department at that time. Staff did not telephone him at that time.

Between 6.56pm and 11.10pm Mr Murray continued to wait for full assessment and treatment but he was not attended to medically during this period, nor were further attempts made to locate him.

Telephone records show that at 11.10pm Mr Murray called a taxi asking for transport from the Launceston General Hospital to his home. He could not connect properly and called again at 11.12pm. I find that the taxi arrived very shortly after he called and he was driven directly home. I find that he took this step because he became tired of the lengthy wait for treatment.

At 11.16pm Mr Murray received a telephone call from Dr Subhas Bhetwal of the Launceston General Hospital. I suspect, but cannot find definitively, that the doctor's call to him was triggered by an approach by Mr Murray to hospital staff querying the length of the wait and possibly indicating his intention to leave. In any event, by the time Dr Bhetwal called him, Mr Murray had left the precinct of the hospital and was likely on his way home. Dr Bhetwal recorded that he told Mr Murray that his condition needed to be thoroughly investigated with tests and that Mr Murray agreed to return to the hospital the next morning.

The nursing notes formally record that at 11.30pm that Mr Murray did not wait and he was "clicked off".

Mr Murray did not present again to the hospital the following morning, being 25 February 2019.

Between 25 February and 2 March 2019, several persons unsuccessfully attempted to contact Mr Murray and visit him at his house.

At 8.00am on Saturday 2 March 2019, Mr and Mrs Wagland attended Mr Murray's house and found him lying against a closed door in the spare bedroom of his house. He was deceased.

A full investigation into his death subsequently took place. The police officers attending the scene of death, including forensics and CIB officers, were of the opinion that there were no suspicious circumstances at the scene indicating the involvement of any other person in Mr Murray's death.

He underwent autopsy conducted by pathologist, Dr Terry Brain, who concluded that the cause of his death was due to natural cardiac causes, being an acute myocardial ischaemia related to stenosis of the right coronary artery.

Upon all of the evidence, I find that Mr Murray passed away at his home on 25 February 2019, shortly after his arrival home from the hospital, as a result of acute myocardial ischaemia. His death was likely to have been sudden, as he made no attempt to telephone for assistance.

Comments and Recommendations

One matter for comment arising in this investigation is whether, if Mr Murray had waited in the Emergency Department of the Launceston General Hospital for full assessment and treatment, his death might have been prevented. Upon the evidence, I am not able to determine this question. His medical issue upon presentation to the Emergency Department was fever and vomiting. The condition was not diagnosed subsequent to triage. There is insufficient evidence to enable me to determine the nature of his condition at that time or whether these symptoms would have led to cardiac treatment which may have prevented his death. This issue is also particularly difficult to resolve due to limitations of the autopsy findings by reason of decomposition.

I am satisfied that, at the time he left the Emergency Department, Mr Murray was of sound mind, free of delirium and able to make his own decision to leave the hospital instead of electing to wait for treatment. If he had waited, he would have received medical treatment.

Unfortunately, the hospital records provide inadequate information about staff interactions with Mr Murray and attempts to further contact him between 6.56pm and 11.16pm (when the doctor called him after he had already left.) I am also not able to determine where Mr Murray was positioned in the waiting room (or elsewhere) during that four hour period or the number of patients and workload during that evening, factors which could well assist in understanding the situation. It seems a strong possibility that the Emergency Department staff believed that Mr Murray had departed the hospital before 6.56pm, due to the recorded entry *"did not wait"*.

I **recommend** that the Launceston General Hospital review the adequacy of its procedures for monitoring the whereabouts of triaged patients waiting to be assessed and treated in the Emergency Department.

I **recommend** that the Launceston General Hospital also review the adequacy of its processes for documenting significant interactions with triaged patients waiting to be assessed and treated in the Emergency Department.

I convey my sincere condolences to the family and loved ones of Mr Murray.

Dated: 27 August 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner