FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1552/07

Inquest into the Death of ANDERINA LAURA SANDERSON

Delivered On:	14 April 2011
Delivered At:	Coroners Court Level 11, 222 Exhibition Street, Melbourne, Victoria 3000
Hearing Dates:	29 and 30 November 2010
Findings of:	Coroner K M W Parkinson
Representation:	Mr Wallis of Counsel for Central Park Aged Care Facility and the Operator Aged Care Service Australia Group Ms S Keating for the Victorian WorkSafe Authority
Place of death/ Suspected death:	Central Park Nursing Home 101 Punt Road Windsor, Victoria 3181
PCSU:	Leading Senior Constable G McFarlane

FORM 37

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Section 67 of the ***Coroners Act 2008***

Court reference: 1552/07

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: SANDERSON
First name: ANDERINA
Address: 101 Punt Road, Windsor, Victoria 3181

AND having held an inquest in relation to this death on 29 and 30 November 2010 at Melbourne

find that the identity of the deceased was ANDERINA LAURA SANDERSON and death occurred on 24th April, 2007

at Central Park Nursing Home, 101 Punt Road, Windsor, Victoria 3181

from
1a. ISCHAEMIC HEART DISEASE IN A WOMAN WITH A HISTORY OF RECENT ASSAULT

In the following circumstances:

1. An inquest was conducted into the death of Mrs Anderina Sanderson on 29 and 30 November 2010. The following witnesses gave evidence in the proceeding: Dr Michael Burke Senior Forensic Pathologist of the Victorian Institute of Forensic Medicine, Mr Arthur Ian Sanderson, Ms Seyham Yildirim, Ms Angela Sungaila, Ms Leonie Brown, Dr Madeleine Phillip, Ms Karen Yoffa.

2. Mrs Sanderson died on 23 April 2007, shortly after she had been reportedly been the victim of an assault perpetrated by another resident of the aged care facility in which she resided. Police investigated the incident with a view to laying criminal charges. Having regard to the mental status of the male resident, who was assessed by a forensic psychiatrist, no interview was possible and the Director of Public Prosecution determined that it was not in the public interest that criminal charges be laid. The Coroner was advised that WorkSafe Victoria did not investigate the matter.

3. Where a Coroner suspects that the cause of death may be homicide, the Coroner is required by s52 (2) (a) of the Coroners Act 2008, to hold an inquest. In such circumstances, it is necessary and appropriate to examine the circumstances in which the death occurred and to consider any public health issues, which may arise in connection with the death.

4. Mrs Sanderson was born on 11 August 1917 and was 89 years of age at the time of her death. She resided at Central Park Aged Care facility at Windsor, a facility operated by Aged Care Services Australia Group. Mrs Sanderson had a medical history which included epilepsy and dementia and she was prone to falls. Mrs Sanderson was a petite lady small of stature. Mrs Sanderson had take up residence at the aged care facility as a result of no longer being able to care for herself in her own home. In view of her progressing dementia and frailty, relatives were concerned to ensure that she was safe and properly cared for and that this was best achieved in a residential aged care facility. She had moved to Central Park Nursing Home in late 2000 and resided on Level 3 of the facility.

5. Mrs Sanderson's resident care plan identified that she was a person prone to wandering and would often be found walking around the level. It was also noted that she would wander into other resident's rooms on occasions. Staff commented that it was usual for Mrs Sanderson to wander around and they kept an eye on her to make sure she was alright and that she didn't disturb other residents. She was described as a very sweet lady who was not a problem to anyone.

6. Level 3 of the facility was divided into two wings, a north wing and a south wing. Each wing was a mirror image of the other. Mrs Sanderson's room was on the south side of the floor and she would often be found in the opposite room on the north side of the floor. It may be that the design of the building resulted in her becoming confused as to the location of her room.

7. On 19 April 2007, Mrs Sanderson was located on the floor of the bedroom of a male resident on the north side of the floor. It was reported that she had been assaulted by that resident. Staff reported that she was heard to call out and when they attended the room, located the male resident standing over her. Mrs Sanderson was on the floor. Whilst there is a possibility that Mrs Sanderson fell of her own motion, that is unlikely having regard to the context in which she was found and the conduct of the male resident, which was angry and aggressive towards Mrs Sanderson.

8. The male resident continued to behave in a threatening manner towards staff for a period of time after the incident with Mrs Sanderson. Registered Nurse Division 1, Ms Leonie Brown, who attended the incident, reported to police that she was afraid of being assaulted by the resident and that the resident was banging a rolled up newspaper on the wall in the corridor. When she said to him that it was inappropriate for him to hit Mrs Sanderson, he began to walk towards her saying: *"If you don't shut up I will do to you what I did to her and that will shut you up".*

9. Mrs Sanderson had suffered injury and was complaining of pain. According to the incident report she had sustained a swollen and grazed right eye, a swollen mouth and jaw and complained of pain in her right arm. She had a 3cm skin tear near her right eye. She was transported to the Alfred Hospital where a non displaced fracture to her right arm was diagnosed, together with contusions and abrasions. Mrs Sanderson was discharged back to the nursing home on 20 April 2007, with arrangements made for staff to implement her treatment plan.

10. Mrs Sanderson's health deteriorated significantly over the next two days. Pain management became problematic and as Mrs Sanderson's GP was unable to be contacted, a locum was called who prescribed panadeine forte to assist with pain management. On the evening of 23 April 2007, at approximately 5.30pm, she was noted to be having difficulty breathing and the locum was called to attend. Suctioning was administered to attempt to assist Mrs Sanderson and an ambulance was called, however shortly thereafter Mrs Sanderson died.

11. Nurse Leonie Brown provided a statement to police, which reported that no changes were made to the supervision of the male resident immediately after the incident and that was observed to be the case by Mrs Sanderson's son, Mr Ian Sanderson. When he attended the premises after Mrs Sanderson's death he observed the male resident wandering the corridors without any supervision. The evidence is that the male resident was involved in a further incident of violence in the facility in May 2007 and after an assessment undertaken by MAPS, was transferred to a psycho-geriatric facility in late May 2007.

12. An autopsy was conducted by Dr Michael Burke, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Burke reported that the cause of death was Ischaemic Heart disease in a woman with a history of recent assault. He commented:

> *"Whilst Mrs Sanderson had an underlying disease process that could lead to a sudden death there is a distinct temporal relationship between her deterioration and the sudden death and the episode of assault".*

13. Dr Burke's evidence (T30.14) was that he considered the assault to be a likely cause of her deterioration in that period and that the death was likely to have been associated with the incident. He was of the opinion that had the assault not occurred Mrs Sanderson would have been alive a week later.

Background staffing and supervision arrangements in the facility

14. Mr Sanderson's evidence was that he had noted a decline in the level of care in the facility in recent years. He attributed it to the new operator who had taken over in 2005. It is not within the scope of this inquiry to review the application or operation of Commonwealth Aged Care standards, however the issue of staffing levels in particular, nurse to resident, arose in this case. Ms Yoffa's evidence was that the ratio, on afternoon shift, which was when the assault occurred, was 1 staff member to each 7 residents. Ms Yildirim, a personal care worker at the facility, gave evidence (T55.5) that the ratio was a team of 2 staff members to anywhere between 10 to 14 residents.

15. It is clear that there is no government regulation of staff to resident ratios. It is not possible for me to make an accurate assessment on the evidence, of exactly what staffing arrangements were in place on the day of the incident. The evidence is however, that there was certainly not adequate staffing to allow for one-on-one supervision of the male resident, despite his recent assault upon another resident.

16. Ms Yildirim's evidence was that there was very limited capacity to spend time or to implement strategies with difficult to manage residents. (T57.21) Her evidence also revealed that the staff had a lack of knowledge of any plan being in place to address the violence issues of the male patient. Her evidence was that this was "just the way it goes", "the facility does the best it can". The evidence of the Division 1 Nurse, Ms Brown (T93.28), was that to her knowledge there was no specific plan in place to deal with his violence and that there were no arrangements to isolate him from other residents, nor any discussions held in that regard of which she was aware.

History of the male resident including prior assaults

17. The male resident commenced at the facility in December 2005. He was born 1921 and suffered from Alzheimer's disease, but was otherwise physically healthy and described as quite robust. He had been admitted to the aged care facility as he was no longer able to remain at home due to violent and aggressive behaviour. He was originally located in Level 1 of the facility. The evidence was that on 18 January 2006, notifications of a propensity to aggression and violence towards both residents and staff had been made on the male resident's file. On 21 January 2006, after an assessment by the MAPS, he was moved to Level 3 of the facility.

18. In the period 18 January 2006 to 19 April 2007, the date of the assault upon Mrs Sanderson, he was the subject of a number of incident reports, which specifically related to his aggressive behaviour, including two assaults. As a result of these matters he was moved to Level 3, where it was felt that he would be able to be more suitably accommodated. The most recent incident occurred three days before the assault upon Mrs Sanderson, when on 16 April 2007, he was located by staff member, personal care worker, Ms Belinda McSherry, in the room of a female resident assaulting her by "hitting her repeatedly over the head and face".

19. These incidents were documented in the nursing and patient care notes of the facility by attending staff. However, it appears to me that the language used in the documentation tended to understate the seriousness of the assaults. Counsel for the facility took the witnesses to the documentation in relation to the male resident's history of physical assault, and in particular a 'model care plan', which was described as having been on the resident's file. As I understand it, a model care plan is a broad strategic document developed in generic terms to apply to aged care facilities. There is no evidence before me that any of the staff caring for the resident were familiar with the model care plan, or that anything specific was being implemented to enact a plan to minimise his risk of behaving violently to other residents. There appears to be a great deal of documentation and very little practical implementation.

20. Dr Madeline Phillip was the treating General Practitioner of both the male resident and of Mrs Sanderson. She was notified of the 16 April 2007 assault. She assessed the male resident and notified the facility that there was a need for him to be assessed by a specialist geriatric mental health team (MAPS). She also noted that he ought be under close observation and close supervision (resident progress notes male resident 16 April 2007 brief page 277). The evidence is that 'close observation' and 'close supervision' translated into hourly checks on the male resident, either specific or as staff walked past his room.

21. The MAPS had undertaken an assessment of the male resident after the incident in January 2006 and as a consequence of that assessment, he was moved to the other floor of the facility and into a single occupancy room. No recommendations were made as to transferring the male resident to any other facility such as a specific geriatric mental health facility. The plan remained to treat the male resident's aggression and violence in the facility. It does not appear that any significant changes were made to his care or management consequent upon the assault of 16 April 2007.

22. Dr Phillip was asked about the appropriateness of keeping the male resident in the facility in view of his aggression and engaging in actual violence against other residents. Her evidence was that it was common for there to be physical aggression between residents in residential aged care facilities. She described it as not infrequent that a resident may 'slap' another.

23. Dr Phillip stated that there was limited capacity to obtain an assessment of a patient by geriatric mental health services and that it was her belief that there were insufficient mental health beds available for transfer. She did not believe that there was a mental health bed available in the circumstances of the male resident.

24. She was asked about the appropriateness of the male resident having been admitted to the facility at all in view of his pre-admission history of violence. She advised that he was initially admitted to the facility with the assistance of the Mobile Aged Psychiatric Service team (MAPS). She agreed that he would more appropriately have been initially admitted to a psycho-geriatric unit and that was her view at the time he first arrived at the facility (T121.2). Ms Yoffa, the facility director of nursing gave similar evidence as to the appropriateness of a specific psycho-geriatric admission. Their evidence was also that there was a limited availability of such beds and that an assessment was not easily obtained.

25. It appeared to be suggested by questions directed to witnesses, that the facility operators relied upon and considered they were entitled to rely upon, the medical practitioner and the MAPS to manage the issue of violence in its facility and that they were largely constrained by their response and direction. I do not accept that this is the case and am satisfied that there is an obligation and responsibility on those facilities providing care, to take all reasonable measures to ensure the safety of their residents.

26. I have not been provided with any information, which would suggest that the facility has altered its processes or procedures relating to the actual supervision of potentially violent residents. The evidence of Ms Yoffa was that there was no inquiry into the incident conducted in the facility and that she could not see that there was anything, which might have been done differently to have prevented the incident. Dr Phillips identified that one on one supervision and earlier intervention and transfer of the violent patient would be an appropriate intervention.

Contribution of the assault to death

27. Counsel for Aged Care Services Australia (the nursing home operator), submitted that it was not possible to relate the assault to cause or contribution to death having regard to Mrs Sanderson's age and co-morbidities. Having regard to the report of the forensic pathologist, Mrs Sanderson's relative stability prior to the incident and her rapid decline after the incident, I am satisfied that there is a causal relationship between the assault and the death. I am satisfied that the assault hastened her physical decline and that this in turn contributed to her death.

Fact of the assault

28. Counsel for Aged Care Services Australia, also submitted that there was no evidence of an assault actually having been perpetrated. I am satisfied that an assault was perpetrated upon Mrs Sanderson and that as a result she suffered injury and distress. Whilst there may be some doubt as to the origins of the fracture, there was evidence and treatment of a displaced fracture and I am satisfied that she suffered aggravation of the injury, multiple abrasions and bruising and distress as a result of being assaulted and falling to the ground.

Findings as to cause and contribution

29. I find that whilst Mrs Sanderson was frail and elderly and had multiple co-morbidities, which were likely to cause death, Mrs Sanderson's deterioration was accelerated by the assault, which was perpetrated upon her and consequently the assault contributed to her death.

30. I find that the assault upon Mrs Sanderson caused a more rapid decline in her overall health and well being and as a result of her frailty and existing co-morbidities this contributed to her death.

31. I find that the failure by the facility operators to ensure adequate supervision of the interaction between a known violent resident and Mrs Sanderson contributed to the death.

32. I find that the failure by the facility operator to separate and/or intensively supervise a dementia patient, with a known propensity for violence from other residents, contributed to the death.

33. I find that the lack of availability of geriatric specific mental health beds contributed to the death. The lack of beds resulted in the male resident being admitted to and remaining in the facility after he had perpetrated the recent assault. Had the male resident been moved after the 16 April 2007 event, the assault on Mrs Sanderson would not have occurred.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

34. Aged persons are entitled to at least the same protections as any other member of the community. I note that police were not notified of the original assaults. If they had been perhaps there may have been more effective and earlier intervention and the assault upon Mrs Sanderson

may have been prevented. This also begs the question as to why would police not be called when an assault is perpetrated upon a resident and why would their rights and protections be regarded as any less than those of other members of the community?

35. In this case there was inadequate supervision of the other resident, notwithstanding that Mrs Sanderson was known to attend upon his room and that it was known this was a triggering factor for aggression and violence in the other resident. No steps were taken to prevent this occurring.

36. I am also satisfied that there was a failure to respond to the first incident of assault in a manner, which would prevent or mitigate future incidents. The focus of the response was upon the needs of the resident prone to violence with little if any risk assessment undertaken in relation to the potential for harm to other residents.

37. Whilst it is a feature of dementia that unusual or difficult behaviour might manifest itself without warning that is not the case in this instance. Here there was clear evidence of a risk, which was not seriously addressed.

38. It is not appropriate for frail elderly patients to be accommodated with patients suffering with dementia who are known to be violent or to have a propensity to violence.

39. The Aged Care Amendment Security and Protection Act 2007 (Cwlth) now requires that police be notified in the event of an assault.

40. Dementia specific training for staff is a useful tool, however, in a case such as this, involving significant and repeated violence, training is not a substitute for careful planning and management and allocation of additional staffing resources to direct supervision.

41. The evidence supports a conclusion that the focus was upon the male resident and his management from an organisational point of view, rather than with an eye to ensuring first and foremost the protection of other residents and staff.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the responsible regulatory authorities, Department of Health (Victoria) and the Aged Care Standards and Assessment Agency (Cwlth) review the arrangements for assessment and management of dementia patients with a propensity for violence and their accommodation with frail elderly persons.

2. That the Aged Care Facility Operator review the arrangements for assessment and management of dementia patients with a propensity for violence and their accommodation with frail elderly persons.

3. That the responsible regulatory authorities, Department of Health (Victoria) and the Aged Care Assessment and Standards Agency (Cwlth) clarify the underpinning principles regarding management of dementia patients, with a view to ensuring that the need to ensure the safety of all residents is prioritised, acknowledged and accounted for in any individuals assessment.

4. That the Aged Care Facility Operator review and clarify its processes and procedures regarding management of dementia patients with a view to ensuring that the need to ensure the safety of all residents is prioritised, acknowledged and accounted for in any individuals assessment and in the implementation of any care or management plan.

5. I note that there is now a requirement imposed by the Aged Care Amendment Security and Protection Act 2007 (Cwlth) that any assault of a resident occurring in an aged care facility be reported to police and that staff be informed of their obligation to make such a report and consequently I make no recommendation in this regard.

6. I direct that a copy of these findings be provided to:
Minister for Health and Ageing (Cwlth)
Minister for Health and Aged Care (Victoria)
The Secretary Department of Health and Ageing (Cwlth)
The responsible officer, Aged Care Assessment and Standards Agency (Cwlth)
Chief Psychiatrist Victoria, Dr Ruth Vine

Signature:

KIM M. W. PARKINSON
CORONER

14th April, 2011

Coroners Court of Victoria