IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 4244

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of DORIS PEARL TOWNSEND

without holding an inquest:

find that the identity of the deceased was DORIS PEARL TOWNSEND

born 10 February 1924

and the death occurred on 21 August 2015

at McCulloch House, Monash Medical Centre Clayton, 246 Clayton Road, Clayton Victoria 3168

from:

1 (a) KIDNEY IMPAIRMENT AND DEHYDRATION FOLLOWING THERMAL INJURY TO RIGHT LEG IN AN ELDERLY WOMAN WITH CEREBROVASCULAR DISEASE

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Doris Pearl Townsend was 91 years of age at the time of her death. She had lived at Clarinda Manor Aged Care facility[1] in Clarinda since 10 November 2008. Mrs Townsend's medical history included a cerebrovascular accident 15 years ago, congestive cardiac failure, atrial fibrillation, hypertension, chronic obstructive pulmonary disease and hypothyroidism. Following Mrs Townsend's stroke she suffered from dense right sided paralysis involving her right arm and right leg.

[1] I note that Clarinda Manor was formerly known as Embracia on the Park.

2. On 29 June 2015, Mrs Townsend sustained a significant second degree burn to her lower right leg, after her leg fell out of her bed and rested on a heater that was in close proximity to her bed.

3. Over the six weeks following the burn, Mrs Townsend's health significantly declined. Particularly from late July, her oral intake and functioning decreased. Following review by her General Practitioner, a blood test was ordered which evinced acute kidney injury, hypernatraemia, a white cell count of 17.7 and mildly deranged liver function tests.

4. On 11 August 2015, Mrs Townsend was sent to the Monash Medical Centre Clayton for rehydration. On arrival at the Emergency Department, she was assessed to have a Glascow Coma Score[2] of 7 and despite aggressive fluid resuscitation, her blood pressure dropped. After discussion with Mrs Townsend's family she was transferred to McCulloch House on 12 August 2015, under supportive and palliative care. Mrs Townsend was reviewed by the palliative care team and was given 72 hours of intravenous fluids. However, while her kidney function and sodium levels showed mild improvement, her oral intake and functional abilities did not improve. After discussion with her family, Mrs Townsend's intravenous fluids were ceased. Mrs Townsend was made comfortable and was declared deceased at 8.03am on 21 August 2015.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mrs Townsend, reviewed a post mortem computed tomography (CT) scan and e-medical deposition, and referred to the Victoria Police Report of Death, Form 83. Dr Lee reported that the external examination confirmed a significant injury to Mrs Townsend's right leg. She noted that the e-medical deposition from Monash Medical Centre listed a possible cause of Mrs Townsend's death as acute kidney impairment following function decline and decreased oral intake post burn leading to dehydration.

6. On the basis of the information available to her, Dr Lee ascribed the cause of Mrs Townsend's death to kidney impairment and dehydration following thermal injury to right leg in an elderly woman with cerebrovascular disease.

---

[2] The Glascow Coma Scale is a quick, practical standardised system for assessing the degree of conscious impairment in the critically ill and for predicting the duration and ultimate outcome of coma, primarily in patients with head injuries. The scale is now measured out of 15, with 15/15 being the best possible score.

Police investigation

7. Constable Melissa Kennedy, the nominated coroner's investigator,[3] conducted an investigation of the circumstances surrounding Mrs Townsend's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made Clarinda Manor Facility Manager Stephanie Ranasinghe-Mawzoon, Clinical Care Coordinator Rosemary Murray, Team Leader Jennifer Bourke, Personal Care Assistants Marie Limock and Navneet Kaur, Monash Health Inreach Clinical Nurse Ann White, General Practitioner Dr Rohan Abeysinghe, and Palliative Medicine Physician at Monash Medical Centre Dr Michael Franco.

8. Personal Care Assistant (PCA) Marie Limock reported that she and her partner Navneet Kaur attended to Mrs Townsend at 7.15am on 29 June 2015. When they tried to put the hoist sling around Mrs Townsend, PCA Limock saw what she thought was a skin tear on her leg. PCA Kaur stated that he noticed Mrs Townsend's leg was full of blisters from knee to foot and a lot of fluid was leaking from the blisters. PCA Limock observed that Mrs Townsend's bed was near the wall, but did not see her leg against the heater. PCA Kaur noted that the bed was close to the heater, but also stated that Mrs Townsend's leg was not against the heater at this time.

9. Team Leader and Enrolled Nurse (EN) Jennifer Bourke reported that she received a call from PCA Kaur at 7.15am on 29 June 2015, informing her that Mrs Townsend had a blister on her right leg. EN Bourke went to her room, assessed the leg and saw a large skin tear on her lower right leg. She covered the skin tear with melonin and a crepe bandage for protection.

10. Facility Manager of Clarinda Manor and Registered Nurse (RN) Stephanie Ranasinghe-Mawzoon reported that on 29 June 2015, she was the Clinical Manager and unofficially acting as the Facility Manager. She was officially appointed as the Facility Manager on 8 July 2015. RN Ranasinghe-Mawzoon stated that she had been shown Mrs Townsend's leg wound by EN Bourke at approximately 8.30am on 29 June 2015. The wound was from ankle to knee and appeared to be a skin tear / burst blister as there was no blood. She observed that Mrs Townsend did not appear to be in any pain while she aligned the skin flap. RN Ranasinghe-Mawzoon stated she remembered discussing with EN Bourke how Mrs Townsend may have sustained such a skin tear, but they also discussed that it was possibly a blister. They considered if it could

[3] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

be a burn and EN Bourke pointed out that an area above Mrs Townsend's knee appeared to be from the grate on the heater. RN Ranasinghe-Mawzoon noted that on looking, it did appear quite similar. As the wound progressed and deteriorated, RN Ranasinghe-Mawzoon noted that it appeared consistent with a burn.

11. General Practitioner Dr Rohan Abeysinghe reported that he inspected Mrs Townsend's wound on 2 July 2015. Mrs Townsend appeared comfortable at the time, and Dr Abeysinghe assessed that she had sustained a large second degree burn to the outside of the lower leg, extending from just above the knee to the ankle. The blisters were intact in most of the areas and Dr Abeysinghe noted that the injury was compatible with the fact that her outer right lower leg had rested against the heater when it had slid vertically from the bed. Dr Abeysinghe reported that Team Leader EN Bourke informed him that as a result of this incident, all residents' beds were moved away from the heaters to prevent any further recurrences. Dr Abeysinghe reviewed Mrs Townsend on five further occasions throughout July 2015.

12. Clinical Care Coordinator and Registered Nurse Rosemary Murray stated that her role involves overseeing the clinical care of all residents at Clarinda Manor, including wound care, pain management, nutrition and hydration. RN Murray reported that she first became aware that Mrs Townsend had a wound on 6 July 2015, when she saw the incident report from 29 June 2015. RN Murray stated that in July she spoke with Mrs Townsend's daughter Julie, who sought to know why she was not informed of her mother's burn. RN Murray explained that staff on duty that day had not found Mrs Townsend with her leg against the heater and had not realised it was a burn until later; they had initially believed it was a skin tear. RN Murray reported that Julie stated that Mrs Townsend's bed had been against the heater for the last three years.

13. EN Bourke reported that she contacted Inreach Wound Nurse, Ann White for a review of Mrs Townsend's wound, and this took place on 7 July 2015. RN White stated that she made an assessment of Mrs Townsend's wound on this day and developed a dressing plan which included pain management. From then on, EN Bourke stated that Inreach took over wound management and staff followed their instructions. RN White reviewed Mrs Townsend on 17 and 18 July 2015 and evaluated the plan with nursing staff. There were no signs of infection and pain was being managed effectively. On 30 July 2015, when RN White last reviewed Mrs Townsend, the wound appeared to be improving. RN White agreed with facility staff that the wound would take some time to heal, due to Mrs Townsend's age and pre-existing medical conditions.

14. Dr Abeysinghe reported that he was informed on 8 August 2015 that Mrs Townsend had lost nine kilograms and had poor food and fluid intake. As a result, he ordered some urgent blood tests, the results of which came through on 11 August 2015 and led to her admission at Monash Medical Centre for rehydration.

15. Dr Abeysinghe opined that Mrs Townsend suffered from progressive fluid loss following her burns as a result of poor oral intake of food and fluid.

16. I noted that the coronial brief also included the minutes from a Buehler Aged Care Quality meeting held on 11 June 2015. A recent incident at another residential facility was discussed, in which a resident fell between their bed and a heater. At the meeting, it was noted that it was common practice for residents to choose to push their bed against the wall and heaters. An action item from the meeting was for there to be an audit of all residents who currently had their beds close to the heater in their room. Rectification was to be discussed with each resident and their family. An email was subsequently sent from RN Ranasinghe- Mawzoon on 24 June 2015, requesting a follow up on the audit of beds against heaters.

Family letter of concern

17. The Court received a letter of concern from Mrs Townsend's daughter Julie Minster, dated 15 September 2015. *Inter alia*, Ms Minster noted that on 29 June 2015, the day of her mother's burn, she received a phone call from a Team Leader at the facility. Ms Minster was told her mother's bed needed to be moved away from the heater as part of a new policy, but there was no mention of an injury or burn having occurred. Ms Minster noted that she only learned the extent and nature of her mother's injury on 14 July 2015. Ms Minster expressed concern that Mrs Townsend was paralysed down her right hand side, with no speech, yet was placed in a bed that was up against a heater.

Further investigations

18. By way of letter dated 16 September 2015, the Court received a letter from Andy Price, Delegate of the Secretary, Aged Care Quality and Compliance Group, Department of Social Services. Within the letter, Mr Price explained that the Aged Care Complaints Scheme was aware of two other elderly Victorians who sustained burns from hydronic heaters in residential aged care services, within a short period of Mrs Townsend's death.

19. RN Nancy Mercer, the Facility Manager at Clarinda Manor from 24 November 2015, provided a statement to the Court dated 5 April 2016. In her statement, RN Mercer noted that a number of restorative actions have been taken since Mrs Townsend's death. In particular, all residents'

beds were moved away from the heaters to prevent any further incident occurring. Initially, there were five residents that signed waivers, not wanting to comply with the interventions in place. Heater guards were installed on their heaters, which was completed on 6 January 2016. However, following further consultation, the five residents subsequently agreed to move their beds away from heaters. RN Mercer noted that no other injuries of a similar type have been sustained to any of their residents since Mrs Townsend's injury.

20. In addition, Beuhler Aged Care implemented a new policy and procedure system from February 2016, in relation to skin and wound management. RN Mercer noted that wound management guidelines are now in place in each trolley for staff to use and follow. All wounds are now reviewed weekly and documented with photos taken. New pain management policies and procedures are also in place. An audit form on 'Living Environment' has also been updated to include heating and cooling systems.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. I acknowledge the grief endured by Mrs Townsend's family and I note the concerns raised by Ms Minster in relation to her mother's care. I share Ms Minster's concerns that Mrs Townsend was effectively paralysed down her right hand side, yet was placed in a bed that was up against a heater. I commend the action taken since Mrs Townsend's death to move residents' beds away from heaters at Clarinda Manor. I note the evidence suggests that steps were being taken in this direction prior to Mrs Townsend's injury, and this new policy will hopefully prevent future like injuries from occurring. It is unfortunate that Ms Minster did not feel properly appraised of the reason for her mother's injury. However, I do note that steps to move residents' beds away from heaters were already being discussed prior to the incident, and that the evidence suggests staff were initially not certain that a heater burn had caused the wound.

2. The evidence suggests that there may be a number of residents living in aged care facilities throughout Victoria, that are sleeping in beds placed against walls and hydronic heaters. It would be unfortunate if the commendable shift to make residential facilities more homely environments also entailed increased complacency about the welfare of infirm, elderly citizens. Hydronic heaters have some worthy safety features. However, it is critical that residents in aged care facilities are not positioned in ways that could lead to them sustaining burns, if they were, for example, to roll off their bed.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of preventing like deaths, **I recommend** that the Commonwealth Department of Social Services and the Commonwealth Minister for Aged Care, consider the need to regulate the configuration of rooms in aged care facilities, to ensure that residents' beds are not placed in dangerous positions, such as being proximate to hydronic heaters.

FINDINGS

On the evidence available to me, I find that it would have been prudent for Mrs Townsend's bed not to be placed next to a hydronic heater, given her significant co-morbidities as at 29 June 2015.

I accept and adopt the medical cause of death as identified by Dr Jacqueline Lee and find that Doris Pearl Townsend, an elderly woman with cerebrovascular disease, died from kidney impairment and dehydration following a thermal injury to her right leg.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Ms Julie Minster

Mr Andy Price, Department of Social Services

Secretary of the Department of Social Services

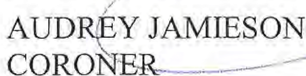
Katherine Lorenz, Chief Legal Officer, Monash Health

The Hon Sussan Ley MP, Commonwealth Minister for Aged Care

Beuhler Aged Care

Constable Melissa Kennedy

Signature:



AUDREY JAMIESON
CORONER

Date: **30 June 2016**