IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 711 / 2009

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: JOAN AMBROSE

Delivered On:	1 August 2012
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	5, 6, 7 and 9 September 2011
Findings of:	PETER WHITE, CORONER
Representation:	Mr C. Tan appeared on behalf of the family of Joan Ambrose Dr E. Brophy appeared on behalf of Great Oaks (Noble Manor)
Police Coronial Support Unit	Leading Senior Constable Greig McFarlane

I, PETER WHITE, Coroner having investigated the death of JOAN AMBROSE

AND having held an inquest in relation to this death on 5, 6, 7 and 9 September 2011
at MELBOURNE
find that the identity of the deceased was JOAN AMBROSE
aged 79 years
and the death occurred on 7 February 2009
at Noble Manor Nursing Home, 33 Frank Street, Noble Park 3174
from:

1 (a) ISCHAEMIC HEART DISEASE AND HEAT EXPOSURE
2 CEREBRO-VASCULAR DISEASE

in the following circumstances:

Background

1. Mrs Joan Ambrose was a resident of Noble Manor Nursing Home an aged care facility in Noble Park at the time of her death. She was 79 years of age and had a medical history of dementia, anaemia, hypertension, agitation and a heart murmur.

2. At approximately 1.06pm on the 7 February 2009, following lunch and a family visit, she exited the premises into an outside secure courtyard, this unbeknown to staff. The conditions outside were extremely hot.[1]

3. The doorway through which she was able to exit the premises allowed free access externally, however it did not allow re-entry back into the premises. Similar arrangements existed with all external doors at Noble Manor at this time.

4. The maximum temperature in the city of Melbourne during the afternoon of 7 February was 46.4°C and given the paved nature of the court yard which Mrs Ambrose had entered, which was also adjoined by an external brick wall, the ambient temperature in the area in which she was located, was almost certainly greater.

5. Mrs Ambrose was last seen in the facility by Mrs Seema Ishaque at approximately 12.50pm.[2]

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[1] Staff had been cautioned by the Premier and the State Government through the then responsible Department concerning the need to prepare for extreme conditions during this period.

[2] See statement of Personal Care Attendant, Mrs Seema Ishaque at exhibit 4, page 2.

6. It is known that she in fact left the premises later at 1.06pm,[3] but was not discovered missing for some three further hours, with a search finally finding her lying in an unprotected courtyard area immediately adjacent to the Kensington Unit, at 4.10pm.

7. A post mortem was conducted by Senior Forensic Pathologist Dr Michael Burke at the Victorian Institute of Forensic Medicine on the 11 February, 2009, in which it was determined that the cause of death was

    1(a) Ischaemic heart disease and heat exposure

    2 Cerebro-vascular disease

8. Toxicological analysis did not identify any drugs or poisons, which may have contributed to her death.

Overview

9. Noble Manor was an aged care facility designed and used primarily for the housing of elderly persons suffering from dementia.

10. During a period of 12 days over January and February 2009, the State of Victoria suffered an extreme heat wave. According to a report completed by the Department of Human Services there were 374 (62%) more deaths over all age groupings during this period than would otherwise have been expected, the majority occurring in those of 75 years or more.[4]

11. It is self evident that the residential population of an aged care facility like Noble Manor may face a greater risk arising from extreme heat than the community at large. Such risk may be offset by the level of care provided by any particular facility.

The evidence

a) The departure of Mrs Ambrose from Noble Manor

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[3] See evidence of CCTV footage of her departure taken at that time discussed below at page 3 of this finding.

[4] See Department of Human Services publication Heatwave in Victoria: An Assessment of Health Impacts. Victorian Govt. 2009. The greatest number of deaths occurred in those aged 75 years or more, representing a 64% increase in deaths from that age grouping.

12. The evidence of Ms Jennifer Garrard[5] concerning the movements of Mrs Ambrose out of the premises were based upon her review of what, I have been informed, is no longer available closed circuit television footage. This material establishes that Mrs Ambrose left via Door 237 at 1.06pm on February 7 and had then turned left.

> *"(Thereafter) she disappeared briefly into a small court yard area outside room 8 and 14, which is not covered by external camera. She quickly reappeared on the path running alongside the building outside rooms 14 and 15. She continued past the camera (outside room 14 and 15), and disappeared from view. She did not reappear on the CCTV footage after that."*[6]

And further,

> *"Were you able to estimate (from the CCTV footage), the time that elapsed from when she left Door 37 and when she disappeared from the view of Camera 15?*
>
> *It probably would have been about three or four minutes."*[7]

13. The evidence does not establish when Mrs Ambrose died and nor I find does it permit an inference in regard to that matter, other than one based upon the opinion offered by Dr Burke.

14. His opinion was that it is more probable than not that she died at a point closer to 1.06pm, than when she was finally located at 4.10pm, and he was unable to go further than that.[8]

15. It is not in dispute that the locking mechanism on the door through which Mrs Ambrose left the premises, was one which allowed for the easy exit by residents and others, by the simple pushing of the door open.[9]

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[5] Ms Garrard was the Clinical Services Manager at Noble Manor at the time of Mrs Ambrose's death.

[6] See transcript page 310.

I note here the family submission that this evidence supports the view that she did not immediately collapse following her departure outside and that this tends to support the view expressed by Dr Burke that the extreme conditions (impacting upon her heart disease), contributed to her death.

See also diagram, exhibit 3(b), which sets out the position of the rooms referred to and the external pathways and court yard where Mrs Ambrose was found.

[7] See transcript at page 319.

[8] See the evidence of Dr Burke from transcript page 16, as discussed below.

[9] Mrs Ishaque testified that she had worked at the Kensington Unit in her capacity as a Personal Care Attendant since its inception and that the doors had always worked in this manner. See transcript at page 160.

16. Re-entry however required that the person seeking to enter gain the attention of someone within, who might then be able to open the door in question from the inside.[10]

17. I further note here that the doors had not been designed to operate in this manner. It is also the case that this arrangement was set in place in uncertain circumstances, and was (appropriately) discontinued immediately following the events, which led to the death of Mrs Ambrose.

b) The external conditions and arrangements made on the 7 February to protect residents at the Kensington Unit, Noble Manor.

18. Noble Manor management and staff were made aware of the heat wave issue. On 3 February 2009, a Mailfax from the Australian Government's Senior Nurse Advisor, Dr Susan Hunt, was distributed to all residential aged care providers, which gave advice regarding their obligations of resident care during heat wave conditions.[11] On 6 February 2009, the then Minister for Aging, the Hon. Justine Elliot, reiterated Dr Hunt's advice[12] in a media release and detailed the action being taken by the Australian Government to ensure the sector was able to appropriately care for residents during extreme heat events.

19. It is also the case that State (as well as Federal Government), Agencies and indeed the then Premier, Mr John Brumby, were active in warning the community about the forecast weather conditions and in particular, of the dangers presented by those conditions for elderly persons.

20. In her statement of evidence Maree McCabe[13] refers to an email dated February 6, 2009, which stated,

> *"Please ensure that staff on duty tomorrow do extra rounds to monitor residents and ensure that their fluid intake is increased. Please arrange for some icy poles for the residents and staff and if you think that extra staffing resources are needed then let me know".*

21. And in a further email sent later that day,

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[10] It is relevantly pointed out by counsel for the family of Mrs Ambrose that both the seeking of that attention and the appropriate response required both parties to have and to be able to exercise, the cognitive ability to so act.

[11] *http://www.health.gov.au/*

[12] *http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je011.htm*

[13] Maree McCabe was the Chief Executive Operations for TLC Care Ltd. See her statement exhibit 11 at page 5 and the Adverse Incident Review undertaken by her at exhibit 11a.

"Hi guys, have received a warning re extreme weather conditions tonight and tomorrow, hot and windy please ensure residents stay indoors and (are) well hydrated, use extra staff if needed."[14]

22. It is also relevant that despite these instructions, a trial reduction in staff levels occurred on this day, i.e. the 7 February 2009.

The coroner:

"... I understand that different staffing arrangements that were put in place on that day, 7 February, (which) resulted in there being only two personal care assistants on duty between one p.m. and three p.m., is that correct?

Yes, Your Honour.

When was that new staffing arrangement announced, do you recall?

Just the day before.

On the day before, ... there was quite a lot of publicity being given by the Premier and others to the risk of fire arising from the heightened weather conditions that were expected to prevail on that following day?

Yes, Your Honour.

You (do) recall that? Do you also recall newscast services about there being an anticipation that the conditions on the Saturday would be very extreme?

Yes, I recall that.

Did anyone to your knowledge link the idea that on this day the reduction in the number of staff that would be available to assist, was made more difficult by the likely conditions that were going to exist that day?

Did anyone connect the two and say, "This is the worst day to be doing it,... look what's going to happen. Look what the Premier says; it's going to be a very hot day, we might need all those extra staff tomorrow, particularly?

No, Your Honour."[15]

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[14] See exhibit 11, also at page 5.

[15] See transcript at page 157, the evidence of PCA Ishaque.

23. As indicated above, the CCTV discloses that Mrs Ambrose left the premises at 1.06pm, ie six minutes after the commencement of the shift, which had staff levels reduced from three personal care assistants to two.

24. The evidence does not establish that she attempted to gain re-entry following her departure (which would have been prevented by the door locking mechanism), or that she was physically or mentally able to so attempt.

c) Cause of Death

25. In his pathology report[16] Dr Michael Burke, offered the opinion that,

> *"it would appear reasonable to suggest that the physiological stress associated with such high temperatures may well have exacerbated the deceased's underlying heart condition and thus could have contributed to death."*[17]

26. His further opinion also set out in exhibit 2 was that,

> *"in the absence of a temperature reading it is difficult to determine the contribution that the extreme hot weather had...However it would appear reasonable to suggest that the physiological stress associated with such high temperatures may well have exacerbated the deceased's underlying heart condition and thus could have contributed to the death."*[18]

27. Dr Burke was cross-examined about his view that the exposure to excessive heat had contributed to Mrs Ambrose's death.

28. In response he stated that:

> *"...is it just coincidence that she just happened to die at that time or was it the fact that she was exposed to a 46 degree Celsius (temperature). Did that precipitate her death?*

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[16] See exhibit 2 at page 7.

[17] See exhibit 6 at page 2. I note that it appears that Dr Burke was more assertive during his testimony in regard to his view as to the contribution of the extreme hot weather to the death, than he had been in this particular passage which was contained in his pathology report.

I find that there is nothing about his approach to this matter which is other than perfectly understandable, and indicative of his further and proper reflection on the issue.

[18] See exhibit 2 page 6.

(See also his evidence at transcript page 66, that there was no evidence of significant dehydration and his further evidence that the absence of a core temperature reading precludes an assessment in relation to the time of death. See also his evidence concerning the possible onset of rigor mortis, from transcript page 58).

And my view is that it did..... I can't be definitive I have no objective evidence that that's the case."[19]

29. And gain,

"there are basically two possibilities in my mind, one is that it is a coincidence and Mrs Ambrose could have died at any time and she just happened to die outside in the heat, or the heat precipitated the heart attack. And I think the second is more likely."[20]

30. And further that,

"I think it is probably likely, why I've given the cause and death as ischemic heart disease and heat exposure is because this was in the setting of a period when we were seeing lots of elderly people dying of heart disease and it seems disingenuous for pathologists just to say heart disease and ignore the fact that this is going on, that people are dying in the community associated with this severe heat.

If it was a coincidence, there were a lot of coincidences? – Exactly ...at the same time?

You can argue till the cows come home about Mrs Ambrose, but you can't argue with the amount of deaths that occurred at that period of time."[21]

Finding

On all the evidence and after a consideration of the submissions of counsel, I am satisfied to a comfortable degree of satisfaction that Mrs Ambrose died from a combination of ischaemic heart disease and heat exposure in a setting of underlying cerebro-vascular disease, this following her unmonitored departure from the Kensington Unit at approximately 1.06 pm on 7 February 2009.

I further find that given the anticipated conditions, about which Noble Manor had adequate prior warning, that management failed to make appropriate plans to protect Mrs Ambrose on 7 February and that this failure contributed to her death.

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[19] See transcript page 53. I also note here Dr Rob's evidence that the court yard area in which Mrs Ambrose was found was, '*blisteringly hot in the court yard...and my impression was that it was a suntrap and significantly hotter than elsewhere in the vicinity..*'

[20] See transcript page 24.

[21] See transcript at page 39.

Specifically and notwithstanding whatever policy may have been appropriate concerning resident departure arrangements on days of non-extreme weather, I find that such policy should have been suspended at least by the morning of 7 February, in favour of a policy designed to ensure that all elderly residents were not permitted to wander outside, and face the extreme conditions which were predicted for that day.

Similarly the plan made to reduce staffing during the afternoon shift on 7 February, should also have been postponed, and I find that the decision to proceed with this initiative further compromised management's ability to ascertain that Mrs Ambrose was missing and (as the situation continued), also increased the chance that she would be impacted by a heat related injury.[22]

COMMENTS

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

1. Heat waves such as that, which engulfed Victoria in the latter part of January and early February 2009, are brief periods of unusually high temperatures, which can cause significant harm. Amongst those most vulnerable to this danger are the elderly, especially those who suffer from underlying heart disease.[23]
2. The State Government has had since 2007, a state wide heat wave plan, which was designed to be integrated into existing state and local government emergency management frameworks.[24] The plan features a forecast-based warning system and strongly focuses on the vulnerability of older Victorians.
    a. To assist the residential aged care sector to plan for extreme heat events, the Aged Care Branch of the Department of Health developed the *Residential Aged Care Services Heat*

[22] Mrs Ambrose was not seen in the premises after 11.50am. She was later discovered missing and her body was then not located until 4.10pm, with her death more likely to have occurred before 2.00pm than after. (See transcript page 23).

[23] As a group the elderly are likely to have lower cardio vascular fitness, which is essential for self regulation in response to the effects of heat. The elderly are also frequently on medication which may also impair their response. Other common features of the elderly such as the impaired mobility and impaired cognitive ability suffered by Mrs Ambrose, can add to reduce the capacity to adequately protect oneself.

[24] This plan was modified following the 2009 heat wave.

Wave Ready Resource. While this resource cannot establish any mandatory standards, it provides extremely detailed information for how to develop protective strategies for residents during extreme heat events. The resource states:

> *"During periods of warmer weather, monitoring the whereabouts of residents should also be increased, particularly those residents who are confused and have access to outdoor areas such as court yards. These areas can become extremely hot and even short periods of time in these areas could put residents at risk of dehydration and heat-related illness."*

b. The Australian Government has advised all residential aged care providers that they are required to develop emergency management plans, including those for extreme heat events, as a condition of the Accreditation Standard 4.6 (Fire, Security and other Emergencies). All residential aged care providers are required by the *Aged Care Act 1997* to meet the Accreditation Standards to demonstrate that they are providing an appropriate level of care and amenity for residents.

c. The Aged Care Standards and Accreditation Agency is responsible for ensuring Commonwealth-funded aged care service providers meet their obligations under the Accreditation Standards. This agency has provided residential aged care service providers with guidance in their *"The Standard"* publication for the development of emergency management plans.

d. Under the state emergency management arrangements, the lead agency (termed the *control* agency) for heat waves is Victoria Police.[25] They are supported in this responsibility by a variety of state and local government agencies, such as the Department of Health, local councils and Ambulance Victoria. It is acknowledged that a substantial amount of work has been undertaken since Black Saturday to progress emergency planning in residential aged care. It is imperative, however, that these arrangements are closely integrated with the protocols of those Agencies with statutory oversight for the majority of residential aged care providers - which are the Australian Government Department of Health and Aging, and the Aged Care Standards and Accreditation Agency.

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[25] *http://www.justice.vic.gov.au/emanuals/emmv/default.htm*

RECOMMENDATIONS

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

1. That the Australian Government Department of Health and Aging continue to support residential aged care providers in meeting their emergency risk management obligations under the Accreditation Standards.

2. That the Aged Care Standards and Accreditation Agency specifically require the emergency management plans of residential aged care facilities to strictly control their entry/exit points to prevent the unsupervised departure of residents during extreme heat events.

3. Furthermore, a consideration of adequate staffing levels should also be a key component of the emergency management plans.

4. That the Victorian Department of Health make amendments to their heat wave guidance for residential aged care facilities to specifically describe the severe hazards associated with unsupervised departures during extreme heat events, and provide aged care providers with direction to exercise strict control over resident use of entry/exit points during these times.

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

The family of Joan Ambrose

TLC Aged Care Pty Ltd

Ms Jennifer Garrard

Minister for Health and Aging – the Hon. David Davis, MLC

Department of Health – Chief Health Officer, Dr Rosemary Lester

Department of Health – Aging and Aged Care Branch, Jane Herington, Director

Department of Human Services – Carmel Flynn, Director, Health and Human Services Emergency Management

Victoria Police – Chief Commissioner, Ken Lay

Office for the Emergency Services Commissioner, Michael Hallowes, Emergency Services Commissioner

Department of Health and Aging, Dr Linda Hunt, Senior Nurse Advisor Aging and Aged Care, Office of Aged Care Quality and Compliance

Aged Care Standards and Accreditation Agency, Mark Brandon, Chief Executive Officer, Level 9, 111 Phillip Street, Parramatta, New South Wales 2150.

The Coroners Prevention Unit, Coroners Court of Victoria, Attention: David Hogan

Signature:

PETER WHITE
CORONER
Date: 1 August 2012