IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 1582

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

Amended pursuant to section 76 of the ***Coroners Act 2008*** *on 10 February 2016*

I, JACQUI HAWKINS, Coroner having investigated the death of Leslie Frederick Alexander without holding an inquest:

find that the identity of the deceased was Leslie Frederick Alexander

born on 8 May 1937

and the death occurred on 1 April 2015

at Maroondah Hospital, Davey Drive, Ringwood East, Victoria 3135

from:

1 (a) SUBARACHNOID AND SUBDURAL HAEMORRHAGE POST HEAD TRAUMA SECONDARY TO A FALL

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

1. Leslie Alexander was 77 years of age at the time of his death. He lived in Croydon with his wife, Christine Alexander. Mr Alexander was a resident at the Opal Gracedale Aged Care Facility (Opal Gracedale) in Ringwood North. His past medical history included congestive cardiac failure and had an automatic implantable cardioverter defibrillator and permanent pace maker, type II diabetes mellitus, chronic kidney disease, depression, anxiety, asthma, gastro oesophageal reflux disease, gout and osteoarthritis.

Surrounding circumstances

2. On 29 March 2015 at approximately 2.55pm, nursing staff responded to Mr Alexander's call bell and found him sitting on the floor next to his chair. Nursing notes report that he was assisted back to a "*comfortable position, nil injuries sustained.*" Neurological observations were commenced and a locum general practitioner was arranged to attend. Mr Alexander's Falls Risk Assessment Tool (FRAT) was reviewed and he was deemed to be a high falls risk.

3. Dr Walsh from the National Home Doctor Service attended and assessed Mr Alexander. He noted that Mr Alexander denied striking his head. Dr Walsh was unable to find evidence of a head injury following assessment. He made a plan that Mr Alexander was to be generally observed and reviewed by his general practitioner if he had any further problems. He advised to cease neurological observations. Later that afternoon, Mr Alexander walked with the assistance of one staff member to the dining room for dinner. He did not complain of pain or discomfort.

4. At approximately 12.30am on 30 March 2015, staff were alerted by Mr Alexander's sensor mat. It was reported they heard a noise and found Mr Alexander "*flat on his back in his room doorway.*" Prior to this he was observed sitting on his chair dozing, with a sensor mat in place. On examination by a registered nurse Eileen McHugh, Mr Alexander was coherent and able to answer simple questions and follow simple instructions. RN McHugh reported she conducted a neurological assessment and found no obvious abnormalities and his vital signs were within normal limits. It was noted Mr Alexander had swelling on the back of his head and a cold compress was applied, however it was later noted that he refused the compress. Staff assisted Mr Alexander to his bed and the locum general practitioner was requested to attend. An additional entry in the nursing notes at 12.45am, reads "*GP and next of kin to be notified by staff in am (sic) shift due to lateness of incident.*"

5. General Practitioner Dr Abraham attended and reviewed Mr Alexander.[1] Dr Abraham noted that on examination, Mr Alexander's pupils were equal and reacting to light and these were described to be "*reassuring neuro obs (sic).*" Dr Abraham documented a plan that neurological observations were to continue, transfer to hospital if any concerns and for Mr Alexander's general practitioner to follow up.

6. RN McHugh reported that "*Mr Alexander was frequently observed throughout the night and displayed no deviation from what was normal for him.*" At 5am, RN McHugh entered into the nursing notes that staff stayed in Mr Alexander's room as he attempted to get out of bed on a number of occasions. He was then assisted to a wheel chair and accompanied staff on a routine care round in the morning.

7. The next entry in Mr Alexander's nursing notes was made at 11.40am by a physiotherapist, who conducted a post fall review. It was detailed that Mr Alexander was drowsy, confused,

[1] The time of Dr Abrahams' entry in Mr Alexander's nursing notes is 3.45pm, however it is most likely this entry was made at 3.45am.

disorientated and was unable to follow verbal commands. He complained of pain in the chest, abdomen and knees. He vomited, an ambulance was called and he was transferred to hospital.

8. Further notes were entered at 12pm by a registered nurse, which elaborate on the events of the morning of 30 March 2015. The entry details that at approximately 10.30am, Mr Alexander complained of pain to his family. When staff attended to him, he was unable to say where he was in pain. He did not follow verbal commands and neurological observations could not be conducted. Mr Alexander was assisted to bed and he complained of chest pain. Staff were unable to give oral medication as Mr Alexander was not following verbal commands. An ambulance was called and it was noted a small bruise was starting to appear at the right eye area. Mr Alexander vomited, after which he was reported to be *"slightly better"* and he was able to follow verbal commands but still appeared drowsy. Mr Alexander was conveyed by ambulance to the Maroondah Hospital.

9. On arrival at the Emergency Department, Mr Alexander was found to have a haematoma at the base of his skull and bruising over his left shoulder with movement intact. Doctors were unable to complete a full neurological examination as Mr Alexander was reluctant to open his eyes. When his eyes were observed the right pupil was bigger than the left, however both were reactive. Bruising was noted over the medial aspect of the eye. No other injuries or significant findings were recorded. Mr Alexander was very drowsy and an urgent computed tomography (CT) scan of the brain was ordered, which showed acute subarachnoid and subdural haemorrhage. Doctors discussed with Mr Alexander's family the option of surgery however explained that given the extensive haematoma, current neurological status and advanced medical comorbidities Mr Alexander was unlikely to survive surgery or have a good outcome. The decision was made to institute palliative care. Mr Alexander passed away on 1 April 2015 at 9.20am.

CORONIAL INVESTIGATION

10. Police conducted an investigation on my behalf into the circumstances of Mr Alexander's death. Police obtained statements from Sharon Martindale, Facility Manager, Opal Gracedale, documentation from Mr Alexander's resident file and Opal Gracedale's policies and procedures relating to falls, injury prevention and management and also falls risk assessments.

Forensic medical examination

11. On 3 April 2015, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a medical examination on the body of Mr Alexander and reviewed the

post mortem CT scan and the Form 83 Victoria Police Report of Death. Dr Bedford reported the post mortem CT scan confirmed the subarachnoid and subdural haemorrhage. No fracture was identified.

12. Dr Bedford provided an opinion that the medical cause of death was 1a) SUBARACHNOID AND SUBDURAL HAEMORRHAGE POST HEAD TRAUMA SECONDARY TO A FALL.

Family concerns

13. On 28 July 2015, the Court received a letter from Mr Alexander's daughter, Carolyn Alexander expressing concerns about the care of her father at Opal Gracedale on 30 March 2015.

14. On 7 September 2015, the Court received a second letter from Ms Alexander after she had reviewed the coronial brief of evidence. Amongst other things, Ms Alexander raised concern with an entry that had been made in Mr Alexander's nursing notes and then crossed out. The entry reads:

> *"30/3/15 Resident was very wet and tired this morning. Had a shower, was slightly confused and very drowsy."*

The entry was made after the 11.40am physiotherapist's entry. Directly after the crossed out entry a registered nurse noted at 12pm that *"Resident had a good breakfast, all his medication and shower with no issue."*

15. As there appears to be a note made retrospectively at 12pm that is inconsistent with the crossed out note made, I can only conclude the crossed out note was made in error.

Further investigations

16. As a result of these concerns and as part of the coronial investigation, I requested statements to be obtained from three members of staff at Opal Gracedale, including RN McHugh, Physiotherapist, Pratigya Lumsali and RN Sreekarthy Sarasakumary.

17. The evidence of Ms Martindale is that staff followed Opal policies and procedures in relation to falls prevention and management.

18. I referred the case to the Coroners Prevention Unit (CPU)[2] to review the medical care and management of Mr Alexander. The CPU reviewed Mr Alexander's medical records and the medical examiner's report. The review determined that while there were no entries until midday, it was recorded that Mr Alexander was normal over the morning, ate breakfast and showered. He complained of being unwell at 10.30am, was assessed and transferred to hospital.[3] Having considered all of the medical records and statements, the CPU determined that the management of Mr Alexander by medical and nursing staff appeared reasonable.

19. Ms Martindale reported that Mr Alexander had suffered from 10 falls between November 2014 and March 2015.[4] He was assessed by a physiotherapist and had his care plan reviewed every three months. On 4 March 2015, a falls risk assessment and management guide was completed for Mr Alexander. Preventative measures implemented at this time included a sensor mat, monitoring and a low low bed. Mr Alexander was deemed to be a high falls risk.

FINDINGS

20. I find that Mr Leslie Alexander died on 1 April 2015 and his cause of death was 1(a) *subarachnoid and subdural haemorrhage post head trauma secondary to a fall.*

21. I find that the nursing notes made by Opal Gracedale staff on the morning of 30 March 2015 were sub optimal. The notes were difficult to comprehend and timelines appeared to be inconsistent. The notes were also not in chronological order and there were no notes entered between 5am and 11.40am. The entry at 12pm appears to have been made retrospectively but was not identified as such. There was also no explanation as to why a note was crossed out. Poor documentation creates confusion and mistrust to anyone that has cause to review it, such as a coroner or family member. Opal Gracedale staff should be reminded that their documentation is an important means of communication between treating healthcare professionals, is a legal document and should act as an *aide memoir*.

22. It appears that neurological observations did follow Opal Gracedale's post fall guide. I find that when Mr Alexander's decline became apparent, appropriate actions were immediately

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[2] The role of the Coroners Prevention Unit (CPU) is to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. CPU personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

[3] Ambulance Victoria was called at 11.24am and attending paramedics arrived at 11.36am.

[4] This includes falls on 29 March 2015 and 30 March 2015.

taken. However, I am unable to determine whether earlier medical intervention would have led to a different outcome for Mr Alexander.

RECOMMENDATION

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

1. I recommend that Opal Gracedale conduct training to ensure their staff understand the importance of clear and consistent documentation in client and medical records.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that the following be published on the internet:

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

The family of Mr Leslie Alexander;

Coroner's Investigator, Victoria Police; and

Interested Parties

Signature:

Jacqui Hawkins
Coroner
Date: 8 February 2016