IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 0814

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: MARGARET LURLINE MARTYR-PATERSON

Hearing Dates:	21 & 22 November 2011
Appearances:	Mr James Gorton of Counsel - Norton Rose Fulbright Lawyers on behalf of Shoreham House Ms Felicity Cockram of Counsel - Avant Law on behalf of Dr Tom Heaney
Police Coronial Support Unit:	Sergeant Tracy Weir
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	31 March 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000

[1] This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of **MARGARET LURLINE MARTYR-PATERSON**

AND having held an inquest in relation to this death on 21 and 22 November 2011

at Melbourne

find that the identity of the deceased was **MARGARET LURLINE MARTYR-PATERSON**

born on 13 September 1922

and the death occurred on 28 February 2010

at the Alfred Hospital, 55 Commercial Road, Prahran, 3181

from:

1 (a) MULTIPLE INJURIES WITH ISCHAEMIC HEART DISEASE

1 (b) RECENT FALL

in the following circumstances:

BACKGROUND CIRCUMSTACES

1. Mrs Margaret (Peggy)[2] Lurline Martyr-Paterson was 87 years of age at the time of her death. She had five children and had a career in nursing during her working life. She was separated from her second husband, Gerald Paterson.

2. Peggy's declining ability to care for herself due to increasing confusion led to an assessment by the Aged Care Assessment Team and subsequently to her move into Shoreham House[3] Aged Care Facility at 3905 Frankston-Flinders Road, Shoreham on 14 September 2009. Peggy was a "low care" resident.

3. Peggy had a medical history that included ischaemic heart disease[4] with an acute myocardial infarction resulting in the insertion of a stent in May 2009. She also had a history of melanoma on the left calf, anxiety, paroxysmal atrial fibrillation, pulmonary emboli, hypertension, hypercholestraemia and dementia. Prior to her admission to

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[2] Mrs Martyr-Paterson's family requested that she be referred to as "Peggy" during the course of the Inquest. For consistency I have, where practical, also referred to her as "Peggy" throughout the Finding.

[3] Shoreham House is the trading name for Burton Healthcare Pty Ltd.

[4] Ischaemic heart disease is the generic definition for a group of closely related disorders resulting in myocardial ischaemia. Myocardial ischaemia is the imbalance between supply (perfusion) and demand of the heart for oxygenated blood. In greater than 90% of cases this is due to coronary artery atherosclerosis.

Shoreham House, Peggy's daughter Mrs Eileen Meldrum, advised the facility that her mother's medications included aspirin, clopidogrel, coversyl, lipitor, oxazepam (Serepax) at night, paracetamol as needed and xalatan eye drops.

4. From in or around October 2009, there was a notable decline in Peggy's health. Her medical practitioner, Dr Tom Heaney made some alterations to her medications in response to her changing condition including but not limited to Peggy's complaints of headaches and fluctuating blood pressure. Peggy had a fall on 29 October 2009 and sustained an injury to her leg. On 30 December 2009, she had an episode of leg weakness which led to her being referred to Rosebud Hospital for investigations. On 30 January 2010, Peggy was admitted to Frankston Hospital with complaints of chest pain and feeling unwell. There was concern at the facility about Peggy's continuing deterioration in her overall general health including a notable increase in lethargy and confusion. At Frankston Hospital she was diagnosed with hyponatraemia and discharged back to Shoreham House on 10 February 2010 with advice given to the facility to restrict Peggy's fluid intake and for the medical practitioner to monitor her sodium levels regularly. Her medications on discharge included ranitidine, oxazepam, haloperidol (Serenace), metoprolol, paracetamol, sodium chloride, prednisilone, isisorbide mononitrate, irbesartan, aspirin and atrovastatin.

SURROUNDING CIRCUMSTANCES

5. On return from her hospital admission Peggy remained confused and unsteady on her feet.[5] Staff noticed that her dementia had *become a lot worse in the ten days that she had been away.*[6] She was seen by the physiotherapist and provided with a four-wheel walker. She was noted to have developed paranoia, restlessness and agitation. At times she was found wandering around the corridors of the facility in a confused state. She required greater assistance with her activities of daily living. Her son Phil requested that Peggy's telephone be disconnected[7] between the hours of 8.00pm and 7.30am due to the number of calls the family had been receiving from Peggy.

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[5] Exhibit 5 – Statement of Dr Tom Heaney, dated 8 September 2010.

[6] Exhibit 3 – Statement of Denise Osmond dated 22 May 2010.

[7] Exhibit 5.

6. On 15 February 2010 at approximately 8.00pm, Peggy was located wandering in the garden by Registered Nurse (RN) Division 2[8] Janice Lovett. Peggy told RN Lovett that she had climbed out of her bedroom window and demonstrated how she got outside by pushing out the flyscreen. She was provided with 500mcg of Serenace to help her settle. There is no indication that she sustained any injuries. RN Lovett recorded the incident in the Nursing Progress Notes but there is no notation to indicate whether her medical practitioner, Dr Tom Heaney was notified. An Incident Report was not completed. Peggy's family were not notified. A reassessment of Peggy's care needs was scheduled for 17 February 2010.[9]

7. On 17 February 2010 at approximately 2.00am, Lorraine Brookes, RN Division 1 (RN Brookes) found Peggy wandering in the corridors in a confused state. Peggy refused to return to her room and was noted to be edgy and suspicious. RN Brookes decided to let Peggy wander and observed her from a distance.[10] At approximately 4.00 to 4.15am, RN Brookes and Personal Care Attendant (PCA) Barbara Morrison (PCA Morrison) returned Peggy to her bedroom and placed her back in her bed. She was given a cup of tea, her bedside light was left on and she appeared weary but settled.

8. At approximately 4.30am RN Brookes returned to Peggy's bedroom after reading the nursing notes about Peggy's recent use of her bedroom window to exit the building. Peggy was missing from her bedroom and RN Brookes found the window open and the flyscreen pushed outwards. A search of the grounds was undertaken and Peggy was located on the ground approximately 25 metres from her bedroom window, beside a pathway leading to the dining room. Staff members brought Peggy back inside the building and examined her for injuries. She was noted to have a bruised right eye and bruising to the right shoulder along with grazes to the right outer aspect of her ankle, left shin and calf and both knees and toes. She was placed in a "princess chair"[11] and RN Brookes commenced taking periodic neurological observations. At approximately 6.00am a low level care nurse was contacted and requested to attend work early so that she could remain with Peggy and keep

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[8] RN Div 2 nurses are now called Endorsed enrolled nurse – the endorsement relates to training to give out medications.

[9] Exhibit 3.

[10] Exhibit 1, Transcript of Proceedings (T) @ p8

[11] RN Brookes described the "princess chair" as one that can *reduce pressure for residents.. can be reclined* and *makes it easier to move the resident within the facility* as it has wheels. – T @ p 25

her under observation while RN Brookes completed her other duties and provided handover to the staff on the morning shift.

9. At approximately 8.45am the Director of Nursing, Denise Osmond (DoN Osmond) arrived at the facility.[12] She spoke to staff and checked on Peggy but found her asleep. At approximately 9.00am, DoN Osmond examined Peggy and on noting the extensive bruising to her body she consulted with Dr Heaney who was on duty at Rosebud Hospital.[13] DoN Osmond informed Dr Heaney of the situation and arranged for an ambulance to transport Peggy to Rosebud Hospital for medical examination and investigations. She presented to Rosebud Hospital at 11.02am and was examined by Dr Heaney. At that time she was alert and orientated[14] and provided a history to Dr Heaney of having fallen approximately 1 metre onto the footpath whilst climbing out of her bedroom window.[15] A number of investigations were undertaken including a CT scan at approximately 2.45pm which demonstrated, amongst other things, a cervical fracture which was reported to Dr Heaney by telephone. In response, Dr Heaney immediately commenced taking steps to arrange Peggy's transfer.[16]

10. At approximately 6.00pm on 17 February 2010, Peggy was transferred by ambulance to the Alfred Hospital. Admission diagnosis noted on the e-Medical Deposition Form[17] was:

> *Post-fall from window traumatic injury: small left temporal sub-dural haematoma, fractured ribs 2-5, left lower leg bruising.*

11. Despite ongoing investigations and treatment, Peggy's condition did not improve and on 25 February 2010 she became unresponsive. In consultation with Peggy's family a decision was made to withdraw active management. Peggy died on 28 February 2010 at approximately 12.50pm with the possible cause of death being attributed to:

> *Respiratory depression secondary to closed head injury/respiratory acidosis. Multi organ failure.*[18]

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[12] T @ p60.

[13] T @ p90.

[14] T @ 171-172.

[15] Exhibit 5, T @ p172.

[16] T @ p190, 193.

[17] Exhibit 11.

INVESTIGATIONS

Identity of the deceased

12. The identity of Peggy was without dispute and required no additional investigation.

Cause of Death

13. Dr Paul Bedford, Specialist Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an external examination on the body of Peggy and reviewed a post mortem CT scan. Dr Bedford also reviewed the clinical records, Medical Deposition from the Alfred Hospital and the Form 83 Police Report of Death for the Coroner before reporting to the Coroner that in the absence of a full post mortem examination, a reasonable cause of death could be ascribed to multiple injuries with ischaemic heart disease with the antecedent cause being a recent fall.

Police Investigation

14. The investigation and preparation of the Coronial Brief was undertaken by Senior Constable M. Abbott.

Letters of concern from Peggy's family

15. Peggy's family sent numerous letters to the Coroners Court of Victoria requesting that a full investigation and Inquest be conducted into her death. The letters raised multiple concerns in relation to the management of Peggy by Shoreham House.

JURISDICTION

16. The *Coroners Act 2008* (Vic) has applied to the investigation into reportable deaths from 1 November 2009. The role of the coronial system in Victoria involves the independent investigation of deaths to determine the cause of death, to contribute to the reduction of the number of preventable deaths and for the promotion of public health and safety and the administration of justice.

[18] Exhibit 11.

17. Section 67 of the *Coroners Act 2008* sets out the statutory role of the Coroner in that a Coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

18. A Coroner may comment on any matter connected with the death and may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[19]

INQUEST

19. An Inquest was held on 21 and 22 November 2011.

Evidence at Inquest

20. Evidence was obtained from the following witnesses at the Inquest:

- Lorraine Brooks, Registered Nurse Division 1;
- Denise Osmond, Director of Nursing, Shoreham House;
- Grant Burnell, Approved Provider, Shoreham House;
- Dr Tom Heany, General Medical Practitioner; and
- Sharon Burnell, Registerd Nurse, Division 1 and joint Approved Provider, Shoreham House.

Issues investigated at Inquest

21. A number of issues were identified in the course of the investigation and examined at the Inquest including, but not limited to:

a) The assessment for continuing low care for Peggy on her return from Frankston Hospital on 10 February 2010;

b) The security at the facility;

c) Access and exit from windows at the facility;

d) The monitoring and supervision of residents on afternoon and nightshifts; and

e) The documenting/recording of incidents at the facility.

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[19] Section 72(1) and (2).

22. At the outset of the Inquest Mr Gorton of Counsel on behalf of Shoreham House drew my attention to an acknowledgement by Mrs Sharon Burnell, Director of Nursing that "*something went wrong*". Mr Gorton went on to say:

> *We are not here to say that something didn't go wrong.*[20]

Reassessment of Peggy's care needs

23. Peggy's changed condition on her return from hospital on 10 February 2010 was well documented. She was noted to often be found wandering in a state of paranoia. She was scheduled to undergo a formal assessment on 17 February 2010 (the day of her fall) to determine whether she should be transferred to high care. In the event that she had been assessed as requiring high care earlier, there is no evidence to support a conclusion that the transfer would have in fact been completed before that day. It is therefore not possible to be definitive that the events of 17 February would have been prevented merely by the completion of an earlier assessment. Furthermore, I accept that it was a reasonable practice for the facility to "delay" assessments based on their experience of elderly residents returning from a hospital stay, often demonstrating increased confusion for a few days that often resolved. According to Mrs Burnell a transfer to high care too early in these situations has led to the return of the resident to low care. She said:

> *...so it becomes a bit of a general nursing rule of thumb that we would wait five to seven days for them to settle down to get a true picture and an accurate picture.*[21]

24. The shortcoming in this approach however is highlighted in part by Peggy's circumstances where the observation/supervision capabilities in low care did not necessarily meet the needs of a resident for whom a significant decline in their condition had been noted.

The security at Shoreham House Aged Care Facility

25. The overnight security at the facility on 16 February 2010 included:

- One registered nurse in Division 1 and one PCA;
- CCTV cameras positioned at various locations inside and outside the facility; and
- Centrally locked exit and entry doors to the facility.

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[20] T @ p 5.

[21] T @ p 208.

26. Mr Grant Burnell and his wife Sharon Burnell, DoN had been the Approved Providers of Shoreham House since September 2009. Mr Burnell, an accountant by profession assumes responsibility for a number of operational duties including the finances, administration, maintenance and upkeep of the facility. There are CCTV systems covering both high and low care. The low care CCTV system had been in place for approximately 8 months[22] prior to Peggy's death. In addition the facility has a door security system that secures external doors at a central point in the high care nurses station.[23] At sundown, the nurse in charge has the responsibility of securing the doors for the night. According to Mr Burnell the external doors are operated by:

> *...a mimic panel at the high care nurses station so you can flick a switch up or down, it secures it or unsecures the door.*[24]

27. Each bedroom in the facility has an external sliding window that opens to an internal courtyard or outside area of the building. Most of the high care bedrooms are situated on the "high side" of the building necessitating a locking device on the bedroom windows which restricts the opening to 125 millimetres. The low care bedroom windows were not fitted with any limiting device as the outside ground and inside floors were virtually level. The drop from the window ledge to ground is 790 mm.

28. Security lights are positioned around the building at regular intervals. All lights come on automatically via a central sensor to fading light.[25] The lights remain on throughout the night.

29. RN Brookes was rostered to work her usual nightshift on 16 February 2010 commencing at 9.15pm through to 7.15am on 17 February 2010. She was in-charge on the shift and rostered to work with PCA Morrison whose shift commenced at 9.30pm and ended at 7.00am. The two staff members were responsible for the overall security of the facility including the care of 24 residents in high care and 13 residents in low care.[26]

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[22] T @ p112.

[23] Exhibit 4 – Statement of Grant Burnell dated 22 November 2010.

[24] T @ p 118.

[25] T @ p 131.

[26] Exhibit 3, T @ pp13-14.

30. RN Brookes received a handover from the Division 1 nurse in high care at approximately 9.15pm, and subsequently received a handover from the nurse completing her shift in low care. The information RN Brookes received at handover in relation to Peggy was that that she had not quite settled back to how she had been prior to her admission to Frankston Hospital and during the day had been suspicious of staff necessitating closer observation. RN Brookes had told PCA Morrison of Peggy's wandering and asked her to keep a look out for her.[27]

31. After RN Brookes and PCA Morrison returned Peggy to her room at or around 4.15am, RN Brookes decided to move from her usual position at the high care nursing station to sit at the low care nursing station where the CCTV monitoring system was located. She was concerned about Peggy's increasing confusion and wandering. From this position the CCTV coverage covered the hallway outside of Peggy's room so RN Brookes could monitor if Peggy left her room again. Shortly thereafter, RN Brookes heard a noise that she described as "knocking". She could not see anything on the CCTV.[28] She could not locate where it was coming from despite walking around the corridors of the facility. On returning to the nursing station she commenced reading the previous night's Nursing Progress entry in Peggy's file and when she read that Peggy had exited her room via her bedroom window, RN Brookes returned to Peggy's room immediately to check on her welfare.

32. On discovering that Peggy was missing, her window was open and the flyscreen pushed outwards, RN Brookes located PCA Morrison to advise what had occurred and that she was going into the courtyard to look for Peggy.[29] RN Brookes released the central lock to the doors and entered the courtyard outside the Oak Room dining area with a torch. She could hear Peggy crying and located her under a tree beside the pathway. PCA Morrison joined her soon after and the staff members lifted Peggy into a standing position and utilised a dining room chair with wheels to return Peggy inside the facility. PCA Morrison retrieved a "princess chair" into which Peggy was transferred and placed in a semi-reclined position. RN Brookes made the observations of Peggy's injuries and did an initial set of neurological observations at approximately 4.45am. With the use of the princess chair, RN

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[27] T @ p20.

[28] T @ p24.

[29] Exhibit 1, T @ p22.

Brookes and PCA Morrison were able to keep Peggy under constant supervision as they did their morning round of the other residents:

> *She was with us as we did our round of high care residents, she was in the chair outside each of those residents' rooms, so she was with us.*[30]

33. RN Brookes made the decision not to transfer Peggy to hospital by ambulance because she would have had to go unaccompanied and because of her confusion and paranoia:

> *...(sic) I felt she was better to stay in our company and be able to be seen by her usual doctor or transferred to be reviewed by her usual doctor later in the day because ...she was reasonably comfortable...and...she had...nothing really obvious that could be or would be treated immediately if she were transferred to hospital.*[31]

34. At approximately 6.00am RN Brookes contacted a low care staff member to commence her morning shift early.[32] At 6.50am RN Brookes gave Peggy two Panadol tablets because she was complaining of a headache[33] and of being *sore all over.*[34] At approximately 6.55am the low care staff member "Mandy" arrived at work and took over the care of Peggy and the other low care residents.[35] At approximately 7.15am, RN Brookes handed over to the morning staff member in high care. At approximately 8.00am, RN Brookes left the facility, and met up with DoN Osmond at approximately 8.15am for a coffee and gave her a handover about Peggy.[36]

Documenting and recording of incidents

35. An Incident Report was not completed after Peggy was discovered in the garden on 15 February 2010. RN Lovett reported that she believed she was not required to complete an Incident Report because Peggy had not sustained any injuries.[37] According to Denise

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[30] T @ p41.

[31] T @ p27.

[32] T @ p26.

[33] Exhibit 1, T @ p29.

[34] T @ p30.

[35] T @ p33.

[36] Exhibit 1, T @ p31.

[37] Exhibit 6 – Statement of Sharon Burnell dated 22 November 2011 (@ p 34-3 IB).

Osmond, RN Lovett had told her she had forgotten to complete an Incident Report.[38] Denise Ormond said that the 15 February 2010 "incident" warranted an Incident Report because it equated to a "near miss" which she stated was:

> *Something that could have happened but did not at the time but it could have therefore it needs to be addressed.*[39]

36. According to Sharon Burnell:

> *The incident of Mrs Paterson climbing out of her window should have been recorded in an Incident Report and written down in the running sheet and thus been information passed on to the nurse and carer on duty on the night of 16 February 2010. Mrs Paterson's family should have been notified.*[40]

37. At the commencement of her shift on 16 February 2010, RN Brookes did not receive any information at the handover about Peggy leaving the building via her bedroom window on 15 February 2010. There was no notation or alert on the "running sheet". According to RN Brookes this document is used for communicating to staff coming onto subsequent shifts *information that you probably need for ongoing care.*[41] RN Brookes stated:

> *I believe that it's essential that subsequent shifts are aware of what's gone on before them.*[42]

38. According to Sharon Burnell RN Division 1 and joint Approved Provider of Shoreham House:

> *The purpose of the running sheet was to record relevant incidents including near misses, as well as changes in medication and the like. It covered the previous two or three weeks and was there to provide a reference to staff on duty as to significant events that had occurred prior to their shift.*[43]

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[38] T @ p98.

[39] T @ p 97.

[40] Exhibit 6 (@ p 34-2 IB).

[41] T @ p43.

[42] T @ p40.

[43] Exhibit 6 – Statement of Sharon Burnell dated 22 November 2011.

Assessment and response to Peggy's changing condition

39. The lack of handover about a contemporaneous event and the absence of an Incident Report and/or the absence of relevant information transcribed onto the "running sheet" were contrary to the system in place at Shoreham House in February 2010 for the reporting of incidents which included near-misses.[44] This lack of documentation denied RN Brookes the benefit of forewarning. RN Brookes only became cognisant of the need to observe Peggy more closely after she checked the Nursing Progress Notes and discovered information about the previous night. By the time RN Brookes returned to Peggy's room it was however too late to implement any additional safety strategies such as placing a dowel in the window frame track[45] to reduce the ease of Peggy opening the window beyond a gap necessary to allow air to come through *but not wide enough for anybody to be able to remove themselves.*[46]

40. The response by RN Brookes to discovering Peggy in the garden was thorough and considered. She did not make any arrangements to transfer Peggy to hospital but instead rearranged how she and PCA Morrison did their rounds in the morning in that they moved Peggy around with them so they could keep a continuous eye on her while they attended to the other residents. RN Brookes also made an arrangement for another staff member to arrive slightly earlier for her shift so that she could complete her obligations to the other residents. RN Brookes did not telephone Peggy's family at the time but I accept that she was satisfied that Peggy was stable. It was reasonable for her to delay such a telephone call. Furthermore, there was no evidence led that an earlier transfer to hospital would have made any difference to Peggy's outcome. On the available evidence I accept the comment of Dr Heaney when he said:

> *..I think even with the benefit of hindsight, taking her to hospital earlier would not have changed her outcome in any way.*[47]

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[44] Exhibit 6 – Statement of Sharon Burnell dated 22 November 2011.

[45] T @ p36.

[46] T @ p47.

[47] T @ p 187.

Changes at Shoreham House

41. At the time of Peggy's death, Shoreham House had a falls policy, risk assessment form and Accident/Incident Management flow chart.[48] RN Lovett had worked at Shoreham House for 10 years and according to Sharon Burnell, she was *capabale, diligent, intelligent and good at paperwork.*[49] Mrs Burnell said that *she was and remained very surprised* that RN Lovett did not complete an Incident Report or record the incident on the running sheet. She had received induction in 2001 which included a requirement to read all of the facility's policies and procedures. On 4 February 2010, RN Lovett's competencies were ticked off by her employer as completed after she produced proof of her registration. However, in the absence of hearing from RN Lovett it is not apparent whether there was any rigour to this process as Mrs Burnell's statement refers to the competencies as being <u>*assumed*</u> (my emphasis) *to be held by any Division 2 registered nurse.*[50]

42. According to Denise Osmond, the facility has introduced a proactive risk plan[51] as part of their response to Peggy's death. Mrs Burnell confirmed she prepared a proactive risk plan in response to the events surrounding Peggy's death with the intention of preventing *what happened from happening again.*[52]

43. The strategy resulted in each window in low care being fitted with a painted wooden stopper/pole which, when in place, limits the opening space to 125mm. The stopper/pole sits in the window track.[53] Residents have the option not to have the stopper in place which the facility supports subject to an assessment of risk. If there are behavioural concerns about a particular resident, the wooden stopper/pole can be screwed into place to ensure it cannot be removed.[54]

44. In addition, there has been an escalation in the provision of information to staff by the Approved Providers regarding the importance of completing Incident Reports and

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[48] Attachment to Exhibit 3 – pp11-14 Inquest Brief.

[49] Exhibit 6 – Statement of Sharon Burnell dated 22 November 2011 (@ p 34-3) IB.

[50] Exhibit 6 – (@ p 34-3 IB paragraph 11).

[51] Attachment to Exhibit 3 @ p16 Inquest Brief.

[52] Exhibit 6 (@ p 34-3 IB paragraph 15).

[53] T @ p120.

[54] Exhibit 4 – Statement of Grant Burnell dated 22 November 2010, T @ p121, 125.

instructions which are now placed on the staff notice board and according to Mrs Burnell, this *just reinforced our current system.*[55] The running sheet has been redesigned and the general policies updated to include explicit reference to the need for an Incident Report to be completed in the event of absconding and "near misses". DoN Osmond also held a series of staff meetings in March 2010 to emphasise that an Incident Report is required for incidents categorised as "near misses".

45. Staff numbers on night shift have also been increased to three[56] however this was more in response to additional residents coming to the facility rather than a response to the events surrounding Peggy's death.[57] Weekly staff newsletters have also been introduced to convey to staff policy or chart changes. The newsletters are placed in the staff room and staff are required to sign off that they have read them.[58]

46. I accept that this is an appropriate response by Shoreham House to the risk to residents using their bedroom window to exit the building in the low care section of the facility. It is not a particularly sophisticated solution but *prima facie* appears an effective one particularly as egress through the windows may be required in some situations[59] and the use of the wooden stopper/pole maintains the option that some other permanent locking device may deny. In addition I accept Mr Burnell's evidence that the facility must try to weigh up the rights of the resident to open their windows against a background of the facility's responsibility to maintain their safety and security.[60]

47. I accept that the facility undertook an appropriate review of the circumstances of the incidents related to and surrounding Peggy's death and have implemented change and additional education to staff members of its' policies and procedures. And I further accept that this was with the aim of preventing like incidents.

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[55] T @ p 229.

[56] T @ pp206-207.

[57] T @ p226.

[58] T @ p 222.

[59] T@ p124.

[60] T @ p 133.

COMMENTS

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

48. The CCTV did not provide any value to either the monitoring of Peggy on 17 February 2010 or to the coronial investigation. Nurse Brookes had positioned herself at the low care nurses station with the intention of watching the monitors however saw no images of Peggy. Mr Burnell accessed the system in late February 2010 in an attempt to clarify the events and reported:

> *I could not find any images of Mrs Paterson on the low care CCTV system however she was visible on one camera on the high care CCTV system. This camera overlooks the paved area which is outside both the low care and high care dining rooms.*
>
> *I saw Mrs Paterson walk into view of the camera from the direction of her room. She appeared to have her dressing gown on and was walking around the paved area for approximately 15 minutes. She also appeared to be steady on her feet and did not seem to be injured although the quality of the picture made this difficult to assess. Mrs Paterson looked in the windows several times and then proceeded to walk towards the path that leads up to the putting green.*
>
> *The next image that came onto the screen was that of our staff Lorraine Brookes and Barbara Morrison who then assisted Mrs Paterson back into the building using a wheeled chair. I think that the time from Mrs Paterson disappearing off the screen up the path and the time staff came into view having located Mrs Paterson was approximately 5 minutes.*[61]

49. In his *viva voce* evidence Mr Burnell said that in the 15 minutes Peggy was in the garden and looking in the windows, she could have been knocking[62] and this is consistent with RN Brookes' evidence. Mr Burnell also said that although he could not see Peggy's face clearly on the CCTV footage, the manner in which she was moving did not indicate to him that she had any injury at that time.[63]

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[61] Exhibit 4.

[62] T @ p114.

[63] T @ p115.

50. Mr Burnell attempted to save the footage but was subsequently unable to access it despite assistance from the installers of the system. Similarly, the Court was not able to view the CCTV footage. Nevertheless, I accept that a CCTV system in an Aged Care facility would *prima facie* provide an additional tool to staff in monitoring the movements of those in their care. The limitations identified in the investigation into Peggy's death are not that I have been unable to view the footage but that the monitors are not located in one central position in the facility. The delineation of the CCTV monitors' focus between high care or low care significantly impedes any practical benefits of the system for the night shift when there were only two members of staff on for the whole facility. The increase in staff numbers on night duty to three may enhance the practical aspect of this observation aid but unless a staff member is located at both sets of monitors the system is at best tokenistic for night staff.

51. The lack of an Incident Report relating to Peggy's first escape through her bedroom window on 15 February 2010 was the catalyst for a break down in exchange of critical information about Peggy's increasing vulnerability to cause harm to herself. Whether RN Lovett forgot to fill in an Incident Report or did not believe one was required in the absence of obvious injuries, is not discernable on the available evidence and in the absence of hearing directly from RN Lovett. Nevertheless, either reason for the omission amounts to the same outcome - the incident was not passed on to oncoming shifts as an event or change of importance. In addition, the incident did not make it onto the Running Sheet but was instead assigned only to the Nursing Progress Notes. RN Lovett's entry in the Progress Notes represents a clear and cogent contemporaneous record of the incident but because these notes are not immediately referred to by oncoming shifts, effective communication did not occur.[64] Furthermore, as the events of 15 February did not get the categorization of "incident" that it should have, the family were not notified and were therefore also denied an opportunity to provide input to risk minimisation strategies.

52. RN Lovett's clear and cogent entry in the Nursing Progress Notes does not reflect a nurse that does not understand the importance of contemporaneous documentation – to the contrary, and it is consistent with descriptions of her professional reputation depicted by

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[64] RN Lovett conveyed to Sergeant Weir in a telephone conversation that she had communicated the event to the RN Division 1 Anne Owen who was in-charge in high care on 15 February 2010. She also maintained that it was her understanding that an Incident Report was not required as there were no apparent injuries to Peggy. (T commencing at @ p 215).

Mrs Burnell in her statement to the Court. In the circumstances I can only conclude that at the time and until the facility implemented improvements to its education strategies for its staff following Peggy's death, its education strategy fell short of ensuring that its' employees were fully cognisant of its policies and procedures. The competencies tick sheet was based on assumptions and not rigour.

FINDINGS

53. I find that the incident on 15 February 2010 warranted the escalation of communication of the incident to an Incident Report, the Running Sheet and to Peggy's family. The absence of this approach was a loss of opportunity to respond to, and implement risk reduction strategies which in turn may have prevented Peggy from exiting her bedroom window in the early hours of 17 February 2010. I acknowledge that Shoreham House has conceded that *there was a system failure, that it was a cause of the fall.*[65]

54. I find a direct correlation between the fall sustained by Peggy on 17 February 2010 and her death.

55. I accept and adopt the medical cause of death as ascribed by Dr Bedford and I find that Margaret (Peggy) Lurline Martyr-Paterson died from multiple injuries arising from a recent fall in association with ischaemic heart disease.

56. In light of the endeavours of Shoreham House to implement change in response to Peggy's death, I make no formal recommendations in the matter.

I direct that the Finding will be published on the internet.

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

Ms Alice Lydall

Mrs Eileen Meldrum

Ganga Narayanan, Norton Rose Fulbright Lawyers (on behalf of Shoreham House)

Vanessa Nicholson, Avant Law (on behalf of Dr Tom Heany)

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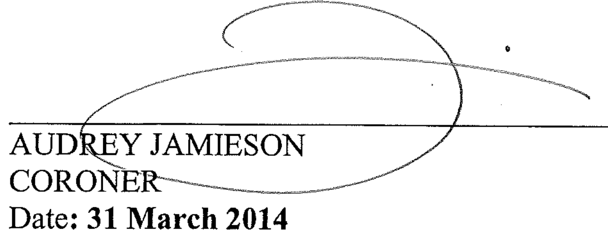
[65] T @ p 245.

Signature:



AUDREY JAMIESON
CORONER
Date: **31 March 2014**