IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 0594

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: NORMA ALICE BENSLEY

Delivered On:	14 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	14 October 2013 to 16 October 2013
Findings of:	JOHN OLLE, CORONER
Representation:	Ms T. Riddell on behalf of Ms Brianna Benedetti Dr E. Brophy on behalf of Southern Cross Care Mr S. Cash on behalf of Dr Preston
Police Coronial Support Unit	Senior Constable Ramsey

I, JOHN OLLE, Coroner having investigated the death of NORMA ALICE BENSLEY

AND having held an inquest in relation to this death on 14 – 16 October 2013

at Coroners Court, MELBOURNE

find that the identity of the deceased was NORMA ALICE BENSLEY

born on 1 April 1916

and the death occurred on 2 February 2009

at Austin Hospital, 145 Studley Road, Heidelberg 3084

from:

1 (a) ISCHAEMIC HEART DISEASE IN THE SETTING OF INAPPROPRIATE ADMINISTRATION OF ANTIHYPERTENSIVE MEDICATIONS

PURPOSES OF A CORONIAL INVESTIGATION

1. The primary purpose of the coronial investigation of a *reportable death*[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] The practice is to refer to the *medical* cause of death incorporating, where appropriate, the *mode* or *mechanism* of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

2. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[3]

3. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of a death, a coroner can <u>identify opportunities to help reduce the likelihood of similar occurrences in future</u>.

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[1] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdiction nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear "to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury."

[2] Section 67 of the Act.

[3] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

Circumstances

4. At approximately 10am on 2 February 2009, Norma Bensley, a 92 year old long-term resident at the Templestowe Pioneers Village (TPV),[4] was unintentionally administered another resident's medication ('the medication error'). Following initial conservative management at TPV, Norma's condition deteriorated dramatically leading to her transfer, via ambulance, to the Austin hospital. Sadly, Norma died in the early afternoon.

5. The following facts have never been in issue:

   a. The medication error was performed by Nurse Benedetti;

   b. Nurse Benedetti immediately acknowledged and reported the medication error to senior nursing staff;

   c. Senior nursing staff immediately detailed the medication error to Dr Harry Preston, Norma's long term GP .

6. The focus of my investigation has been:

   1. The circumstances in which the medication error occurred;

   2. The clinical response; and

   3. Lessons learnt.

Background

7. Norma was a long-term resident at TPV. In her final years, she "kept good physical health, but suffered from dementia"[5]. She was a popular resident who received consistent professional care and attention.

8. Norma was a member of a loving family. Her daughter, Professor Lyn Littlefield, highlighted the devastating effect suffered by the family following Norma's death.

The Inquest

9. The tone of the inquest was set by Wendy Waddell, Executive Manager at Southern Cross Care, who expressed sympathy and regret to Norma's family. She acknowledged that the incident should not have occurred, stating:

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[4] A facility operated by Southern Cross Care (Vic)

[5] Professor Littlefield – T 3

Southern Cross Care has undertaken a range of additional steps to minimise the possibility of something like this happening again. It will not change what happened, nor the grief that Mrs Bensley's family experienced, but I hope that it will provide some comfort.[6]

10. All interested parties have fully co-operated with my investigation. Witnesses provided frank and forthright evidence at Inquest. Individual short-comings were acknowledged. The witnesses displayed a collective determination to ensure identified deficiencies are never repeated.

11. In addition, I heard expert evidence of Professor Braitberg,[7] Professor Olaf Drummer,[8] Dr Paul Stanton[9]and Michelle Harcourt.[10] I thank them for their valuable assistance.

12. Further, my investigation has been assisted by comprehensive submissions filed by the parties, which I have carefully considered.

13. Following Norma's death, TPV undertook a comprehensive internal review and has subsequently implemented wide ranging systemic improvements. I consider the learnings of TPV, together with several suggestions of Professor Littlefield are applicable across Victoria's aged care sector. They are the subject of recommendations to this Finding.

Overview

14. TPV had met, and continues to meet, its registration requirements. Further, I am satisfied that TPV is a justifiably proud and respected aged care facility. Its staff are conscientious and caring professionals, whom for many years offered Norma professional care and attention. However, on the day in question I am satisfied a medication error occurred in a context in which an inexperienced nurse did not receive an adequate level of support to enable her to fulfil her onerous role.

15. I endorse the following submission of Professor Lyn Littlefield:

> TPV was under staffed on the day of my mother's death with a newly qualified nurse being left to administer medication to up to 52 residents on her own and needing to

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[6] T – 1-2

[7] [insert qualifications]

[8] Forensic Toxicologist

[9] General Medical Practitioner

[10] Aged care nurse consultant

manage the behaviour and physical risks occurring in a communal area at the same time. Although more senior staff were at TPV during this process very little assistance was given.[11]

16. I concur with Professor Littlefield's statement that:

> Although it is accepted by Ms Benedetti that she made the medication error, the context surrounding that error reveals a lack of support and supervision to a new nurse faced with an overwhelming task.[12]

The medication round

17. Brianna Benedetti (nee Wilson) commenced employment at TPV in 2005, as a Personal Care Attendant PCA. In December 2007, following a day long training course at Mayfield Education, she became a Registered Nurse Division 2. Ms Benedetti qualified as a Registered Nurse Division 1 in December 2008, obtaining registration on 5 January 2009.

18. Counsel for Nurse Benedetti has accurately encapsulated the events which unfolded on 2 February 2009:

    i) Nurse Benedetti's first solo day shift was 2 February 2009. Significantly, this was her first daytime shift being solely responsible for the administration of medications to residents. She was responsible for administering medication to 49 residents. Most residents suffer from some form of physical or mental incapacity, with a number of patients suffering dementia.

    ii) Notably, there was a rostering error on this day which left the facility short staffed of PCA's during the morning shift. A similar rostering error occurred the previous week, but had not been rectified.

    iii) An additional senior RN Div 1 Nurse was on duty during that shift for the purpose of completing paperwork.

    iv) It was during the morning medication round, at approximately 10:00 hours, in the context of distraction by residents, that Nurse Benedetti administered the medication of another resident to Mrs Bensley. Significantly, the medication included three different forms of antihypertensive medications

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[11] Submission Professor Lyn Littlefield

[12] Submission Patricia Riddell

and, notably, three different-acting forms of antihypertensive drugs. Mrs Bensley did not suffer from hypertension at the time of the misadministration.

v) Nurse Benedetti identified her error immediately and reported her mistake to her senior managers. She was distressed at her error. Senior staff made a telephone call to Mrs Bensley's General Practitioner, Dr Harry Preston. They were given advice which in general was that Mrs Bensley should be put to bed for the day and monitored.

vi) At approximately 11:15 hours Ms Bensley's blood pressure was 63/26. An ambulance was called at approximately 11:30 hours and Mrs Bensley was taken to the Austin Hospital where she was admitted at 12:28 hours. Her blood pressure was not recoverable and she died at 13:10 hours.[13]

Baptism of Fire

19. Dr Stanton, a vastly experienced General Practitioner in the field of Aged Care, whose many tasks include critical care incidents and auditing, developing Victorian Health Care Policy, student education, training, and attending numerous aged care facilities across the state, maintained:

> When young people join the health professional workforce, they are entitled to supervision and support.[14]

20. I accept Dr Stanton's opinion that the medication error appeared to be a systems error.[15] Whilst I accept the evidence of Michelle Harcourt, that Nurse Benedetti was a qualified nurse with the attendant nursing responsibilities, from the commencement of her shift, I do not consider nurse Benedetti received the level of support she was entitled to expect.

21. Of the many improvements TPV have implemented since Norma's death, I am particularly pleased to note that TPV now have split medication rounds. No longer at TPV will a nurse be required to administer medication to more than 25 residents.

22. I am further comforted to note that TPV have addressed the rostering issues that led nurse Benedetti being understaffed.

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[13] Submissions counsel for Ms Benedetti

[14] Ex 14

[15] Ex 14

Staff rosters are set for good reason

23. Facilities set staff rosters to ensure staff can provide appropriate care for its residents. It follows that a staff shortage has the potential to seriously undermine the capacity of the facility to provide reasonable care for its residents.

24. When the medication error occurred, Nurse Benedetti was the sole staff member in the dining area:

> I was already getting quite anxious, … I knew how much being one staff member down would impact the whole team and the whole nursing home.

25. Nurse Benedetti explained the medication error occurred in circumstances in which she had the medication chart of a fellow resident open and had dispensed the tablets into the cup. Whilst doing so, Norma stood and asked to leave, and whilst checking whether Norma could or could not leave and inspect her medication, another resident was walking without a walking frame, causing Nurse Benedetti to rush to the resident to prevent a fall. Nurse Benedetti, as opposed to the carer, was required to go and locate the frame and return it to assist the resident to enable her to continue to move. Yet another resident who was on respite became anxious about her medication, tried to pull Nurse Benedetti aside to clarify medication, causing Nurse Benedetti to explain that she couldn't deal with that now. Upon return to the medication trolley, Norma's page was open and the drugs were next to the book:[16]

> I mistakenly believed I had already checked the right drugs, dose and times against the chart."[17] She frankly acknowledged --- I should have gone right back to the beginning. … I should have started from the beginning and not opened Norma's page.

She explained there were no personal care attendants in the dining room with her at the time.[18]

26. If not short staffed, the other staff member in the dining room would ensure residents had the right food, the right fluids, four-wheel frames, and the like. "There should have been somebody … in the dining room, had we not been short staffed."[19]

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[16] T46-67

[17] P 27

[18] T48

[19] T49

27. A further complexity was that many residents had known her as a personal care attendant, and were clearly fond of her:

> they were all my grandparents, they were all proud and excited that I had moved up the ladder and I had now become a Div 1. They all wanted to have a chat, 'wow you're doing the in-charge job' and they were all very proud, and everybody that I gave medications to had a comment to make. So it wasn't just dropping off the medications it was having a chat with everybody and, yes.

28. In answer to why she could not ask patients to wait until she had attended to a particular task, many elderly residents suffered dementia and would not understand the concept of waiting their turn.[20]

29. Michelle Harcourt, explained that Nurse Benedetti had acquired her nursing qualifications, and was therefore the responsible nurse on the floor. Mrs Harcourt stressed the magnitude of one nurse performing a medication round for 49 residents, stating it "would have been a task for her to do" and "that a ratio of 1 nurse to 52 residents is a large ratio even for an experienced nurse".

30. All members of the nursing staff, including senior nursing staff were under pressure by virtue of the staff shortage. Some assistance was provided to Nurse Benedetti from time to time, but otherwise the responsibility was left to her to seek assistance, if she deemed necessary. In hindsight, senior nursing staff should have ensured that the correct staffing roster was in place throughout the duration of the medication round. Nurse Benedetti should not have been placed in a situation of administering medication to 49 residents, one out, without appropriate uninterrupted support.

31. Ms Benedetti gave compelling evidence. She was a most impressive witness. Her demeanour and candour eloquently explained her popularity with TPV residents and the obvious respect and admiration of TPV work colleagues.

In hindsight

32. At inquest significant time and energy was devoted to the nature and extent of communication between nursing staff and the general practitioner, Dr Preston. Further, the content of communication between nursing staff, Dr Preston and Professor Littlefield.

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[20] T49

33. Professor Littlefield's submission accurately states:

> "After reporting the incident to a more senior nurse, it appears a number of reasonable actions tookplace – my mother's GP was notified as was the Site Manager (Director of Nursing) of TPV. However, it seems that the incident was not assessed to be as serious as it was and appropriate action was not put in place. The GP was operating at the time and seemed not to absorb all of the medications that were administered."[21]

34. Dr Preston was Norma's long term general practitioner. In light of Dr Preston's concession in evidence, that he was told the full extent of the medication error and should have directed immediate hospital transfer, I do not consider it necessary, from a coronial perspective, to analyse the management of Norma post-medication error. In fairness to Dr Preston, he was performing a medical procedure when he took the call from TPV.

35. Nonetheless, the evidence did not disclose that a clear and unambiguous line of responsibility was established at TPV following the medication error. Although not relevant to causation in this case, in my view any critical incident should default up the line to ensure that management of the critical incident default to a senior staff member.

36. Professor Littlefield has addressed this issue in submission which I propose to canvass in my recommendations.

Immediate hospital transfer was essential.

37. The evidence of Dr Braitberg and Dr Drummer is clear. Norma should have been immediately transferred to hospital, because her blood pressure would be expected to drop precipitously, irrespective of whether two or three anti-hypertensive medications were administered. Norma's sole prospect of survival was the comprehensive monitoring and treatment which only a hospital could provide.

38. Though Professor Braitberg could not say whether immediate hospital transfer and the resulting monitoring and treatment available, would have saved Norma's life, he maintained:

[21] Submission Professor Lyn Littlefield

"however I do believe that if she had continuously been cardiac monitored, the blood pressure drop may have been identified minutes earlier and inotropic agents may have been started from the time her blood pressure first dropped."[22]

39. I give credit to Dr Preston for his important concession. In light of the medication error, Norma required immediate hospital transfer. In consideration of Norma's age and pre-existing cardiac condition, it is a matter of speculation to find that hospital transfer would have averted the tragic outcome. However, failure to affect her immediate transfer denied her the single prospect of survival.

Lessons learnt

40. According to Dr Stanton, medication errors in aged care facilities are regrettably, not uncommon. Although I accept without reservation that had Dr Preston fully grasped the extent of the medication error he would have directed immediate hospital transfer, nonetheless I consider it essential that whenever a medication error occurs the poisons hotline be contacted for advice. Not merely by doctors but also by the appropriate senior nursing staff member at the facility concerned.

41. On legal advice, Ms Benedetti was suspended at the conclusion of her shift. I accept that TPV did not intend to exacerbate the distress suffered by Nurse Benedetti, however to suspend her employment upon learning of Norma's death was callous and ill-conceived. Nurse Benedetti had made a medication error, which she immediately acted upon. Her distress was apparent to all and her decision to continue her shift reflected extraordinary dedication. When Nurse Benedetti was informed of Norma's death, she deserved support, not suspension.

42. I endorse Dr Stanton's evidence that such conduct, in his vast experience as educator and reviewer of critical incidents in hospital and aged care facilities, is an anathema and should not be tolerated.

43. TPV, and subsequently, the aged care sector, has lost a passionate and talented nurse. Graduate nurses commencing their career deserve significant support. The contrast between the level of support offered to graduate nurses in acute care as opposed to those employed in aged care, appears stark. There should be no distinction.

[22] Exhibit 15

44. Nurse Benedetti explained her current employment in an emergency department of a major Melbourne hospital. Working with nursing graduates, staff proactively work with them and offer appropriate support and supervision.

Significant changes

45. I applaud the changes implemented by TPV. I am particularly heartened to learn that medication rounds of the magnitude confronted by Nurse Benedetti, will no longer be countenanced.

46. I applaud TPV for striving to ensure that nurses no longer arrive at work, faced with staff shortage and the clear pressures which flow to nursing staff, irrespective of their level of experience. I am now confident that junior nursing staff will always be adequately supported.

47. The professionals involved in Norma's case could not have reasonably foreseen her imminent risk of death. I have found that the medication error occurred in a context of system failure. Further, I have found that Norma should have been immediately transferred to hospital. Whether Norma could have been saved, had her precipitous drop in blood pressure occurred in hospital, is a matter of speculation. However, failure to effect immediate hospital transfer denied Norma her sole chance of survival.

48. I find:

    a. Nurse Benedetti was a conscientious and diligent nurse;

    b. the medication error occurred on her first day of duty, whilst performing her first solo medication round;

    c. the medication round was large for an experienced nurse;

    d. the communal area in which the medication error occurred was short-staffed;

    e. the combination of large medication round and under staffing, constituted inadequate support for a nurse on her first day of employment performing a solo medication round;

    f. I consider the medication error occurred as a result of system failure;

    g. Having been informed of the medication error, Dr Preston should have directed Norma's immediate transfer to hospital.

h. Whether or not the tragic outcome could have been averted, the failure to transfer Norma to hospital denied her the sole opportunity of life saving treatment being instituted.

Post mortem medical examination

49. On the 6 February 2009 Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Norma Alice Bensley.

50. Dr Baker found the cause of death to ischaemic heart disease in the setting of inappropriate administration of antihypertensive medications.

51. Dr Baker commented:

> "Post mortem examination revealed evidence of significant natural disease affecting the cardiovascular system with severe stenosis of the right coronary artery ostium due to atherosclerosis, 70% stenosis of the left anterior descending coronary artery and myocardial fibrosis. The severity of this natural disease is such that there would have been a significant risk of sudden death due to a cardiac arrhythmia in the absence of other contributing factors.
>
> The circumstances of this case however, must be taken into consideration. The deceased was inappropriately given five medications (inappropriate in that these medications were not prescribed for her, but for another patient in the same care facility) including three antihypertensive medications. She subsequently developed hypotension (low blood pressure) which was refractory to treatment in hospital, and later died. In an individual with pre-existing ischaemic heart disease, hypotension further reduces myocardial blood flow and significantly increases the risk of death. In my opinion, the cause of death is most appropriately expressed in the narrative form above, and is due to the combined effects of natural disease and inappropriately administered antihypertensive medications. There was no histological evidence of an evolving myocardial infarction to suggest that natural disease was solely responsible for death."[23]

Finding

I find the cause of death to be ischaemic heart disease in the setting of inappropriate administration of antihypertensive medications.

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[23] Comments section Dr Melissa Baker's post mortem report

RECOMMENDATIONS

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

1. I am satisfied with the comprehensive response of Southern Health Care to the death and particularly the steps taken regarding staff-resident ratios, administration of medication and appropriate staff rostering. If other Victorian aged care facilities were also able to learn from this death, it might be possible to lower the risk of other deaths occurring in similar circumstances elsewhere. To this end, I make the following recommendations:

   Recommendation One: To reduce the risk of similar deaths elsewhere in Victoria, the Commonwealth Department of Health's Office of Aged Care and Quality Compliance liaise with Southern Cross Case regarding the learnings from this death and communicate said learnings to all aged care facilities throughout Victoria.

   Recommendation Two: To improve the appropriateness of response to a medication error, the Commonwealth Department of Health's Office of Aged Care and Quality Compliance undertake education and awareness raising activities to all clinicians working in the aged care sector, supporting the Poisons Information Service be routinely contacted when a medication error occurs.

2. Professor Littlefield raised the concern, with which I concur, that senior nursing staff should have responsibility for more junior staff and would accept responsibility in circumstances such as medication error. She expressed valid concern that job description specifications and line management responsibilities may be lacking at TPV. I further note her view that risk management mitigation procedures should also be reviewed and processes for dealing with incidents should they occur be improved. I am attracted to Professor Littlefield's assessment that the Centre Manager has ultimate responsibility, particularly when such incidents occur and would properly exercise this responsibility in such an event, appears to have significant merit.

   Recommendation Three: Roles and responsibilities of senior staff should be reviewed and processes involved in line management in emergency response situations be clearly stipulated.

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

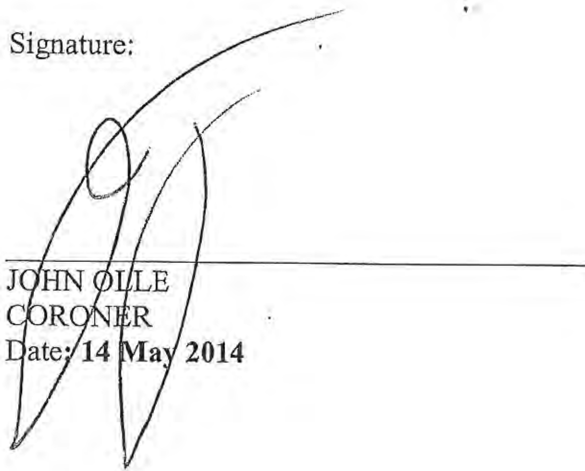
The Family of Norma Bensley

Professor Littlefield

All interested parties

Commonwealth Department of Health's Office of Aged care and Quality Compliance

Signature:



JOHN OLLE
CORONER
Date: **14 May 2014**