IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2019 004589**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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|---|---|
| Findings of: | Coroner Audrey Jamieson |
| Deceased: | Elizabeth Ethel Watson |
| Date of birth: | 27 December 1929 |
| Date of death: | 26 August 2019 |
| Cause of death: | 1(a) Complications of fractured neck of femur in the setting of a fall in a woman with multiple comorbidities (palliated) |
| Place of death: | Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168 |

## INTRODUCTION

1. On 26 August 2019, Elizabeth Ethel Watson was 89 years old when she died, following complications from a fall whilst a palliated patient at the Monash Medical Centre in Clayton. At the time of her death, Mrs Watson was a resident at the aged care facility, Oaklea Hall in Hughesdale (**the Facility**).

## THE CORONIAL INVESTIGATION

2. Mrs Watson's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. This finding draws on the totality of the coronial investigation into the death of Mrs Watson including evidence obtained during the course of the investigation. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Circumstances in which the death occurred

Background

6. The Facility is a 46 bed, Commonwealth funded residential aged care facility, operated by Medical and Aged Care Group. It provides round the clock assistance and nursing care to permanent residents, respite care and support for residents with dementia.[2]

7. Mrs Watson was admitted to the Facility on 16 March 2016 with several pre-existing conditions including but not limited to bilateral carpal tunnel, shoulder dislocation, shoulder supraspinatus tear, cognitive impairment, a fracture of her spine and a history of falls.[3]

8. Mrs Watson was assessed as being a high falls risk. She underwent a risk review by a physiotherapist on 17 July 2019, which reaffirmed her high-risk status.

> Regular Physiotherapy assessments completed for Mrs Watson identified strategies for falls prevention, including ensuring that she was supervised, was assisted with transferring and mobilising, was redirected to utilise her mobility aids, ensuring that Mrs Watson had a clutter free environment, wore appropriate non-slip footwear and hip protectors.[4]

9. Most recently before her death, Mrs Watson had a Falls Risk Assessment Tool (**FRAT**) completed by the Facility on 30 May 2019. This was part of her regular review process. She scored 17, again reaffirming her falls risk as being categorically high.[5]

Period proximate to death

10. On 23 August 2019, Enrolled Nurse Tripti Mishra was working her second shift at the Facility. This shift required that she work alongside a registered nurse. Ms Mishra did not have login details for the electronic medical record system (**Autumn Care**) and, subsequently, could not access records.[6]

11. While Ms Mishra was working her shift, she was approached by her manager and senior Registered Nurse, Chandra Sinnathamby. Ms Sinnathamby asked Ms Mishra to work the following day as the "nurse in charge". Ms Mishra detailed feeling apprehensive about

[2] Statement of Judith Knott dated 13 August 2020, paragraph 1.
[3] Statement of Judith Knott dated 13 August 2020, paragraph 2.
[4] Statement of Judith Knott dated 13 August 2020, paragraph 11.
[5] Statement of Judith Knott dated 13 August 2020, paragraph 12.
[6] Statement of Tripti Mishra dated 13 August 2021, paragraph 1.

accepting however felt pressured because the Facility was under-staffed. Ms Sinnathamby is alleged to have assured Ms Mishra that she would be available via telephone if needed. Ms Mishra agreed to work the early shift the following day.[7]

12. On 24 August 2019 at approximately 7.00am, Ms Mishra commenced her shift as the nurse in charge. She was working with three patient care assistants (**PCA**), two of whom were regular staff members and the third PCA being an agency employee.[8]

13. Ms Mishra was given a handover from the night nurse, who detailed several fall incidents overnight, none of which related to Mrs Watson.[9]

14. At approximately 10.00am, Ms Mishra stated that she was notified by a PCA that Mrs Watson had suffered a fall in the dining room. Ms Mishra paused her medication round to attend to Mrs Watson. Mrs Watson was being attended to by the agency PCA when Ms Mishra approached. The Agency PCA informed Ms Mishra that they witnessed Mrs Watson fall and that she appeared to have "*slipped down*" and that there had been no head-strike.[10]

15. Contrary to Ms Mishra's statement, notes taken from an interview with Ms Mishra by Chris Smith, People and Culture Advisor, and Acting Director of Care for Medical and Aged Care group at the time of the incident, detail that Ms Mishra stated that she was notified of the fall at 9.00am and that the fall was witnessed at 8.45am.[11]

16. Ms Mishra stated that she conducted a head-to-toe assessment of Mrs Watson, who informed her that she had not hit her head. Mrs Watson was sitting on the floor with her legs out in front of her and her knees bent. She could move her limbs freely. Ms Mishra observed "*no shortening or rotation of the lower limbs and no sign of the fractured neck of femur*". Ms Mishra assessed Mrs Watson's hips, to which there was no evident localised pain. Neurological observations of Mrs Watson were within normal limits. Mrs Watson was noted as being slightly confused but it was considered that this "*was normal for her*". She denied any headache or nausea and was eager to stand up.[12] Mrs Watson's lack of pain was also documented in Ms Smith's notes from her interview with Ms Mishra.[13]

[7] Statement of Tripti Mishra dated 13 August 2021, paragraph 4.
[8] Statement of Tripti Mishra dated 13 August 2021, paragraph 6 and 8.
[9] Statement of Tripti Mishra dated 13 August 2021, paragraph 7.
[10] Ibid.
[11] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 43).
[12] Statement of Tripti Mishra dated 13 August 2021, paragraph 8-9.
[13] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 43).

17. Ms Mishra and two PCAs assisted Mrs Watson in standing. She was then sat down in the dining area and given some paracetamol, a cup of tea and a piece of cake. Ms Mishra stated that she continued to monitor Mrs Watson, including performing and recording further observations.[14] This is contradicted in Ms Smith's notes following her interview with Ms Mishra. Namely, "*15 minute obs not done- I did 1 x 24hrs. – I was overloaded… I called the Mgr to ask if I need to send her to hospital… Fromm my Ax there was no urgency to send her to hospital.*"[15]

18. Ms Mishra states that she also contacted Mrs Watson's daughter, Margaret Quinto, to inform her of her mother's fall. Mrs Quinto advised that she was out of town and would not be able to attend.[16]

19. Mrs Quinto denies having been contacted by Ms Mishra. She details that she first became aware of her mother's fall when her father contacted her after midday, as detailed from paragraph 28.

20. At approximately midday, Mrs Watson's husband, Derek Watson, arrived to visit his wife for lunch. He stated that during the meal, Mrs Watson "*seemed herself*". At the end of her meal, Mrs Watson stood up to go to the toilet. She was able to stand and turn but not able to walk to her walker. She was offered a wheelchair by the PCAs.[17]

21. At approximately 1.30pm, a PCA reported to Ms Mishra that Mrs Watson was complaining of severe pain. It is assumed that this report coincided shortly after Mrs Watson stood to go to the toilet and could not walk to her walker. Ms Mishra stated that she instructed the PCAs to use the wheelchair to transport Mrs Watson back to her bed and to make her comfortable.[18]

22. Mr Watson detailed that he was of the belief that his wife was being taken to the toilet and waited in the dining room for her to return. After waiting for an extended period, Mr Watson asked a staff member where his wife was, to which he was informed that she had been taken to bed. Mr Watson then walked to Mrs Watson's room, where he found her highly distressed and screaming out for help.[19]

[14] Statement of Tripti Mishra dated 13 August 2021, paragraph 10 &12.
[15] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 44).
[16] Statement of Tripti Mishra dated 13 August 2021, paragraph 10 & 12.
[17] Statement of Derek Watson dated 30 November 2020, paragraph 2-8.
[18] Statement of Tripti Mishra dated 13 August 2021, paragraph 14.
[19] Statement of Derek Watson dated 30 November 2020, paragraph 7-11.

23. Notes taken following Mrs Watson's death detail that she was taken to the toilet by the PCAs and that she was in a significant amount of pain. She was assisted on the toilet before being put to bed.[20]

24. Mr Watson went in search for a nurse, noting that the nursing office was locked. Mr Watson eventually "*found a nurse*" and called her in to Mrs Watson's room. It is assumed that this was Ms Mishra, as per paragraph 26.[21]

25. Ms Mishra detailed that she was not sure when Mrs Watson's husband arrived at the Facility but that he was present when she attended to Mrs Watson after the PCAs had put her to bed. Mrs Watson was still in pain, so Ms Mishra went to the nearby medication room and got some tramadol from the medication cart.[22] Mr Watson's statement details that the nurse informed him that his wife had suffered a fall in the morning but that she was unable to contact a doctor. Mr Watson suggested an ambulance.[23]

26. Conversely, Ms Mishra's statement details that she informed Mr Watson that the locum general practitioner would arrive shortly to review his wife.[24] This contradicts the notes taken by Ms Smith, which state Ms Mishra said, "*The husband asked me to call the Dr.*"[25]

27. At some point during this interaction, Mr Watson called Mrs Quinto to inform her of the situation. Mr Watson detailed that he put his daughter on the phone to the nurse, who advised that because she did not have login details to Autumn Care, she was unable to call a doctor until 3.00pm.[26]

28. Ms Mishra states that at an undisclosed time she contacted Ms Sinnathamby to inform her of the fall and to ask where she should record the incident.[27] The notes taken by Ms Smith detail that Ms Mishra called Ms Sinnathamby following Mr Watson's request for a doctor. "*…I was panicking as I had 2xfalls = 1 x unwell resident*".[28]

[20] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 40)
[21] Statement of Derek Watson dated 30 November 2020, paragraph 13-15.
[22] Statement of Tripti Mishra dated 13 August 2021, paragraph 15.
[23] Statement of Derek Watson dated 30 November 2020, paragraph 15-16
[24] Statement of Tripti Mishra dated 13 August 2021, paragraph 15.
[25] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 44).
[26] Statement of Derek Watson dated 30 November 2020, paragraph 17.
[27] Statement of Tripti Mishra dated 13 August 2021, paragraph 11
[28] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 45).

29. Ms Mishra stated that she did not have log-in details for Autumn Care. Ms Sinnathamby told Ms Mishra to write her observations down on a piece of paper, as well as an incident report and to slide it under the Manager's office door.[29]

30. In a record of this telephone conversation, Ms Sinnathamby details that she spoke with Ms Mishra at 1.55pm. Ms Sinnathamby states that during her conversation, Ms Mishra was emotional and distressed. Specifically, that she had been "*extremely busy*" with several incidents requiring her attention. Ms Mishra is alleged to have told Ms Sinnathamby that she had not done any of her documentation because she could not access Autumn Care.[30]

> I told her that "she had been provided with a temporary password for now as I had asked the Manager for the day Lauren Muir to print a copy of the email for her (Triptsi [sic]) to get into Autumn Care". (I was also thinking at the time- as to why she had not spoken to staff who would have told her that she/ or anyone can use 'Agency' nurse password which was available to all staff- to ensure she could complete the Documentation.

31. Ms Mishra is also alleged to have told Ms Sinnathamby that there had been four falls and that she was trying to monitor everyone, but had not had the opportunity to complete any Incident Reports because she could not access Autumn Care. Ms Sinnathamby told Ms Mishra to ensure the four residents were not in pain and to "*nurse them in bed for the day*". Ms Mishra is alleged to have told Ms Sinnathamby that they were waiting for a locum to arrive. I note this assertion is inconsistent with the evidence that indicates that National Home Doctor Service (**NHDS**) was contacted at 2.47pm.

> As she repeated that she had not been able to enter the incidents in the system, I then directed her to hand-write the details of the incidents clearly, a page each, for all 4 of the incidents, then to photocopy all 4 of them, to keep the copies and to place the originals under the Manager's door for me to look at on Monday. I stressed repeatedly that the documentation must be completed before she left the building. Triptsi [sic] agreed that she would.

32. Ms Mishra stated that she completed her paper-based recording, before calling "13SICK" and booking the locum general practitioner to review Mrs Watson at approximately 2.47pm. She received confirmation that the locum would attend between 3.25pm and 4.25pm.[31]

33. At 3.45pm, the locum general practitioner had not arrived. Ms Mishra's shift was over and she alleges that she handed over "*all the details*", including the paper-based incident report to

[29] Statement of Tripti Mishra dated 13 August 2021, paragraph 11.
[30] Statement of Judith Knott dated 13 August 2020, Attachment 4.
[31] Statement of Tripti Mishra dated 13 August 2021, paragraph 11 & 13.

the nurse in charge on the afternoon shift, Cyrelle Palamine. Ms Mishra states that she asked this nurse to enter the details of the report into Autumn Care because she did not have access.[32] Ms Palamine denies this occurred.[33]

> Ms Palamine states that she instructed Ms Mishra on how to prepare the incident report and reminded her to document the neurological observations. Ms Palamine also printed a copy of a blank incident report form and left it on the desk for Ms Mishra to complete.[34]

34. Ms Palamine is then said to have left to attend to two other residents before returning and finding Ms Mishra had left the Facility and not completed the incident report.

35. The NHDS locum general practitioner, Dr Alexander Burgansky, arrived at the Facility at approximately 5.00pm[35]. The NHDS notes detail that Ms Watson suffered a fall the day prior, on 23 August 2019. Specifically, that she may have rolled out of her low-level bed.[36] This fall is seemingly documented in the Facility's notes following Mrs Watson's death. ""*-h/0 – Betty had a fall in the AM Sat* [sic] *23/8, - 0730- Staff went to change her they called in… I could see…- she was totally nauseous… If staff touched L side and* [illegible]" [37] This account is alleged to have come from Registered Nurse Harmen Kaur.

36. Dr Burgansky's notes detailed that on examination, Mrs Watson's vitals, including temperature, blood pressure, pulse and respiration were all normal and that she was well perfused. Mrs Watson was alert and did not appear to be in acute distress, although she was "*calling out at times and was confused*". This was considered consistent with her usual presentation, given her dementia.[38]

37. Dr Burgansky considered that there were no observable abnormalities detected in Mrs Watson's limbs. Specifically, nothing of concern was found to be wrong with her hips, which would ordinarily be assessed by looking for a shortening and external rotation of the affected limbs. Dr Burgansky queried whether Mrs Watson had suffered a soft tissue injury to her back. He advised staff to administer analgesia in the form of tramadol.[39]

[32] Statement of Tripti Mishra dated 13 August 2021, paragraph 16.
[33] Statement of Judith Knott dated 19 August 2021, paragraph 60.
[34] Statement of Judith Knott dated 19 August 2021, paragraph 61.
[35] Statement of Dr Alexander Burgansky dated 11 August 2021, paragraph 4.
[36] Statement of Dr Alexander Burgansky dated 11 August 2021, paragraph 6.
[37] Statement of Judith Knott dated 19 August 2021, Attachment 4 (page 35).
[38] Statement of Dr Alexander Burgansky dated 11 August 2021, paragraph 7 & 9.
[39] Statement of Dr Alexander Burgansky dated 11 August 2021, paragraph 10.

38. Overnight, and on the morning of the 25th of August 2019, case notes indicate that Mrs Watson was in "*moderate to severe pain*", and "*cried out in pain*" on being moved by staff to the toilet. Staff also tried to communicate with her but despite talking to herself, she would not communicate back to them. Mrs Watson acknowledged pain in her left side when staff touched her, and medication appeared to be having no effect by this time.

39. On 25 August 2019 at approximately 9.00am, Mrs Quinto received a call from the Facility advising that Mrs Watson's condition was considered to be deteriorating and would she like an ambulance to be called. A non-emergency ambulance was booked.

40. At approximately 11.00am, Mrs Watson arrived at Monash Medical Centre Emergency in Clayton. Her diagnosis was fractured left pubic rami, fractured neck of left femur, fractured T4 vertebral body, Non-ST segment elevation myocardial infarction and aspiration pneumonia.

41. After discussions with Mrs Watson's family, the decision was made to palliate.[40] On 26 August 2019 at approximately 9.15pm, Mrs Watson was declared deceased.

**Identity of the deceased**

42. On 26 August 2019, Elizabeth Ethel Watson, born 27 December 1929, was visually identified by her daughter, Margaret Grace Quinto.

43. Identity is not in dispute and requires no further investigation.

**Medical cause of death**

44. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine, conducted an examination on 28 August 2019 and provided a written report of his findings dated 30 August 2019.

45. The post-mortem examination was consistent with the reported circumstances. Dr Bouwer noted that Mrs Watson's medical history was remarkable for dementia, hypertension, ischaemic heart disease, childhood meningitis and depression.

[40] E-Medical Deposition Form, Case Reference Number: 2019004589, dated 26 August 2019.

46. The post-mortem CT scan showed brain atrophy, bilateral plural effusions, patchy coronary artery calcifications, right pubic rami fractures with callus formation, hypostatic consolidation of the lungs and an acute subcapital left neck of femur fracture.

47. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) Complications of fractured neck of femur in the stetting of a fall in a woman with multiple comorbidities (palliated).

**FAMILY CONCERNS**

48. In an email to the Court dated 16 September 2019, Mrs Quinto expressed several concerns over her mother's last days at the Facility. Specifically, she detailed concern over Mrs Watson's fall on 24 August 2019 and, contrary to Ms Mishra's statement, details that she was not notified of the fall.

49. Mrs Quinto further states that her father was left waiting for her mother when nursing staff wheeled her away to go to the toilet but instead took her back to her room and put her to bed without advising him. When Mr Watson entered his wife's room, she is alleged to have been screaming out for help because she was in pain.

50. Mr Watson called Mrs Quinto to inform her that Mrs Watson was not in a good way. Mrs Quinto details in her complaint that she spoke with the Facility at approximately 2.30pm. She spoke with a nurse, assumed to be Ms Mishra, and asked if a doctor had been called. Mrs Quinto states that Ms Mishra told her that she did not have log in details for Autumn Care and that it would have to wait until 3.30, for the afternoon nurse to arrive.

51. Mrs Quinto details that she was called back later in the evening after Dr Burgansky attended the facility and reviewed Mrs Watson. The nurse advised Mrs Quinto that her mother had been diagnosed with soft tissue damage.

52. Mrs Quinto's letter of complaint further details the extent of distress Mrs Watson was in when her father and daughter arrived at Monash Medical Centre. Her complaint takes issue with the quality of care afforded to her mother in the 24 hours prior to her death. Namely, that given the extent of her injuries, these were not picked up in the period immediately after her fall to the time an ambulance was called the following day.

**REVIEW OF CARE**

53. As part of my investigation, I undertook an extensive review into the care afforded to Mrs Watson in the period leading up to her death. Namely, I sought to obtain documentation relating to the Facility's operations, as well as statements detailing the chain of events leading to Mrs Watson's fall, her care following her fall and her subsequent death.

54. It became apparent early on in the investigation, that there were a significant number of gaps in the information provided, as well as inconsistencies relating to fundamental facts. I subsequently held a Mention Hearing on 8 July 2021 in an attempt to muster more clarity around exactly what happened to Mrs Watson in the period proximate to her death.

55. Senior Constable Dani Lord of the Police Coronial Support Unit (**PCSU**) appeared to assist me. Ms M Fitzgerald appeared on behalf of Ms Watson's family, Ms M Isobel appeared on behalf of Residential Aged Care Group, Mr A Donnan appeared on behalf of Dr Alex Burgansky, Ms S Phillips appeared on behalf of Oaklea Hall and Mr D O'Callaghan appeared on behalf of Ms Tripti Mishra.

56. Unfortunately, despite obtaining several additional statements following the mention hearing there are still inconsistencies pertaining to timing and actions taken as well as a lack of contemporaneous records of the incident. It is therefore impossible for me to ascertain, with certainty;

    a) the exact time Mrs Watson fell;

    b) the actions taken following her fall; and

    c) whether any record of both her fall and treatment at the Facility was ever taken down, as per the Facility's policies.

57. It is apparent to me that the inconsistency of facts across multiple statements, even from the same persons, mean that at best, I can only piece together what likely occurred in the period proximate to Ms Watson's death. In doing so, I will highlight the inconsistencies, errors and areas in which the facts remain unknown.

<u>What time did Mrs Watson suffered her fall?</u>

58. In response to my request, Ms Smith provided statements and documentation. Judith Knott, General Manager, Residential Aged Care for the Facility also provided a statement.

59. The information provided details that Mrs Watson suffered a fall at approximately 8.30am on the morning of 24 August 2019. This contradicts Ms Mishra's statement that details she was notified of Mrs Watson's fall at approximately 10.00am and immediately tended to her.

60. Additionally, the NHDS notes detail that Ms Watson suffered a fall the day prior, on 23 August 2019. Specifically, that she may have rolled out of her low-level bed.[41] Ms Mishra stated at the commencement of her shift during handover, she was not informed of Mrs Watson having suffered a fall during the shift prior.[42]

61. Mr Watson makes it clear in his statement that he believes his wife fell whilst being escorted to the toilet after lunch on 24 August 2019. There is no evidence to support this. While I cannot rule out a fall the day prior which may have caused or contributed to her injury, the evidence supports Mrs Watson having suffered a fall on the morning of 24 August 2019 and that this fall occurred sometime between 8.30am and 10.00am.

62. There appears to be no contemporaneous record of what occurred, with there being no formal entry of the incident in Mrs Watson's Autumn Care file, until a PCA made an entry at 1.45pm. There is no Incident Form or FRAT on file, nor any formal record of the assessments undertaken, and care afforded immediately following Mrs Watson's fall.

63. It was indicated that Ms Mishra failed to comply with the Facility's policies and with verbal direction, in not filling out an Incident Form and a FRAT. Furthermore, according to the initial statements from the Facility, Ms Mishra is said to have left the Facility without completing documentation and that at the time of the incident, she had lost her login details for Autumn Care.

<u>The issue of Ms Mishra's login details for Autumn Care</u>

64. The assertion that Ms Mishra lost her login details, as opposed to not having any in the first place is contrary to Ms Mishra's statement. Specifically, she details that she did not have login details because it was her third shift. Ms Mishra's assertion is consistent with Mrs Quinto's statement, that details Ms Mishra informed her that she did not have login details and therefore, could not access medical care for Mrs Watson.

65. The Facility maintained in their statements that Ms Mishra did have a way to access Autumn Care, whether by way of her own password or by using another one available at the nursing

[41] Statement of Dr Alexander Burgansky dated 11 August 2021, paragraph 6.
[42] Statement of Tripti Mishra dated 13 August 2021, paragraph 6.

station. Ms Mishra is alleged to have told Ms Sinnathamby that she had not done any of her documentation because she could not access Autumn Care:[43]

> I told her that "she had been provided with a temporary password for now as I had asked the Manager for the day Lauren Muir to print a copy of the email for her (Triptsi [sic]) to get into Autumn Care". (I was also thinking at the time- as to why she had not spoken to staff who would have told her that she/ or anyone can use 'Agency' nurse password which was available to all staff- to ensure she could complete the Documentation.

66. Ms Sinnathamby states that she told "Lauren Muir" to print a copy of an email containing a temporary password for Ms Mishra. There was no evidence presented to the Court indicating that this email had been printed off by Ms Muir and either given to Ms Mishra directly or left in an obvious place for her to find and utilise. Ms Sinnathamby then stated in her notes that she "*thought*" about why Ms Mishra had not asked staff about obtaining the "*agency nurse*" password that was readily available to all staff.

67. I note that "thinking" about a direction and verbally "giving" a direction garner very different outcomes. Ms Sinnathamby missed an opportunity to inform Ms Mishra that a password was readily available to her by way of the utilising the "agency nurse" password.

68. Ms Knott detailed that in preparing her response to the Court, "*we identified that Ms Mishra had not documented any notes at any time in our Autumn Care documentation system for any resident file during her four shifts at Oaklea Hall*".[44] This appears consistent with behaviour from someone who did not have access to the Autumn Care system.

69. What can be gleaned from these inconsistencies is that, whether she had access or not, Ms Mishra believed that she did not have access and this was the result of a lack of training and/ or miscommunication.

<u>Lack of documentation</u>

70. I note that Ms Mishra's 24 August 2019 shift was the third shift, and first unsupervised shift, that she had undertaken at the Facility. I further note that despite it being her third shift and allegedly voicing her hesitation, she was nonetheless made the supervisor that morning.

71. Ms Mishra was new to the Facility and either had no, or believed she had no access to Autumn Care. She states in her own statement that she did undertake a review of Mrs Watson and

[43] Statement of Judith Knott dated 13 August 2020, Attachment 4.
[44] Statement of Judith Knott dated 13 August 2020, paragraph 40.

recorded her findings on a paper report, which she handed to the nurse in charge once her shift ended.

72. Whilst there is no evidence to support whether an assessment was undertaken and a report written, what is certain is that the Facility was responsible for providing appropriate care to, and management of its residents. By placing a new employee, with little experience and no access to Autumn Care in charge, the Facility potentially created a situation where care would fall short of the accepted standard.

> …we acknowledge that it is not helpful for us to point out deficiencies in Ms Mishra's practice without endeavouring to understand how we as the organisation allowed for this to occur. We are responsible for ensuring our staff meet the highest standards. To that end, and to make sure this can never happen again, we have undertaken extensive improvements to our recruitment, training, performance review, and employment support processes.[45]

73. Ms Knott's 13 August 2020 statement also details that Ms Mishra refused to attend the Facility to complete documentation relating to the incident.[46] Ms Mishra provided evidence as part of her statement dated 13 August 2021. Specifically, that she attended the Facility on 28 August 2019 at approximately 7.00am but was not met by management, as per the arrangement. Ms Mishra then contacted head office and was instructed to email a written statement. She was texted the email address of Ms Smith, whom she emailed the same day at 9.29am. This statement is purported by Ms Mishra to relay the same information that she stated she took down on her written report of Mrs Watson's fall on 24 August 2019.

74. Supporting evidence shows that Ms Mishra was contacted again on 11 September 2019 via email. She was contacted by a Caroline Doyle, who introduced herself as the new manager of the Facility. Ms Doyle requested that Ms Mishra attend the Facility that afternoon to sign documentation. Ms Mishra replied within thirty minutes detailing her need to reschedule, to which Ms Doyle replied that she would be in touch with new dates and times.

75. Ms Mishra states she was not contacted again by the Facility.

76. The Facility provided a copy of a letter dated 10 August 2019, with "August" being crossed out by hand and "September" handwritten in its place. The letter is addressed to Ms Mishra and asks her to re-attend the Facility to complete the paperwork. It is signed by Ms Doyle.

[45] Statement of Judith Knott dated 13 August 2020, paragraph 42.
[46] Statement of Judith Knott dated 13 August 2020, paragraph 18.

77. I did not deem the information provided, namely the suggestion that the lack of management's awareness as to what occurred and additional lack of documentation lay solely in the failing of one individual, being Ms Mishra, to be an adequate response. Following the mention hearing, I asked the Facility to provide as much detail as possible of the events leading up to and following Mrs Watson's fall and to then identify any gaps in the Facility's clinical process.

78. In a subsequent statement by Ms Knott, she detailed that the Facility was initially built and operated as a "*low care*" service. She details that the government policy of "*ageing in place*" led to the acuity of several residents increasing to a point that the care required was beyond the Facility's capacity to administer. Namely, the Facility had not adequately prepared for the slow incremental increase in resident acuity. She acknowledges that in 2019, the Facility had not adequately responded to the changing needs of its residents.[47]

79. Furthermore, Ms Knott detailed that the Facility was also dealing with "*an entrenched culture*" that they were working to change. At the time of Mrs Watson's fall, the Facility manager had left and there was no consistent management on site. The Facility was being monitored by various managers from other sites.[48]

80. Since Mrs Watson's fall, the Facility has implemented significant changes to address staffing issues, including but not limited to management and training. I am satisfied that these changes have addressed the gap in managerial oversight and staff preparedness present at the time of Mrs Watson's fall.

81. The Facility acknowledges that staff engagement is an ongoing improvement process and that they have increased their staffing levels by some 20%. While still not best practice, they assert they are working towards the *Royal Commission into Aged Care Quality and Safety* recommendations of 200 minutes per resident per day, 40 minutes of which should be a Registered Nurse.

82. The Facility acknowledges the "*paucity of documentation*" relating to Mrs Watson's fall. The only record of the incident as it unfolded was Ms Mishra's call to Ms Sinnathamby. Specifically, a missed call from Ms Mishra at 1.46pm that was returned at 1.55pm.

[47] Statement of Judith Knott dated 19 August 2021, paragraph 11.
[48] Statement of Judith Knott dated 19 August 2021, paragraph 12.

83. Ms Knott further detailed that Ms Mishra was contacted regarding attending a "*disciplinary meeting*" over her lack of documentation, lack of clinical escalation and failing to comply with the Facility's policies.[49]

84. I am concerned that the Facility appeared to be attempting to pass blame for the events onto a single individual who had been placed in a position of authority beyond her experience and ill-equipped with no login details for Autumn Care. The Facility had a responsibility to ensure that it was staffed adequately, including rostering people with an adequate degree of experience and equipped with everything required to fulfill their duties. The Facility fell short in their responsibilities by rostering Ms Mishra as the nurse in charge on her third shift, first shift unsupervised and with no login details.

85. The Facility stated,

> In retrospect, we should have undertaken a formal investigation immediately after Betty's death, including conducting a file review and obtaining formal written statements from all staff who been [sic] involved in her care.

86. The Facility has updated its policies on incident management and I am satisfied that these amendments address a more thorough approach to record keeping. However, I caution that the flaws in providing appropriate care evident in Mrs Watsons matter are not so much to do with the previous policies, as they were a chain of events stemming from poor decision making. Namely, the staffing of an inexperienced and underequipped junior in a senior position on a weekend.

87. While it is imperative for aged care services and the like to have robust policies in place, it is equally as important to have sound decision making in place to ensure those policies can and will be adhered to.

<u>Should earlier medical treatment have been sought?</u>

88. The NHDS was contacted at 2.47pm, presumably just prior to the shift changeover, when Ms Mishra was able to access the system through someone else's login details. The Facility stated that generally, medical attendances out of medical practice hours are provided by locum medical services. Services are subject to availability.

[49] Statement of Judith Knott dated 19 August 2021, paragraph 19.

89. As Mrs Watson did not appear to be in any pain, it would seem reasonable that Ms Mishra did not escalate on the morning of 24 August 2019, from a clinical perspective. Mrs Watson's lack of pain is consistent in both Ms Mishra's and Mr Watson's statements. Namely, that her pain seemingly started after lunch.

90. It was at this point that the locum doctor should have been immediately contacted and/ or an ambulance requested. Ms Mishra's inexperience both in practice and as a new employee at the Facility, in addition to being in a state of overwhelm with four falls, no access to Autumn Care and her regular duties, resulted in a delay that could have been prevented had a more experienced nurse been rostered on that morning.[50]

91. In having said this, I note that when Dr Burgansky attended at approximately 5.00pm, Mrs Watson was assessed as having potentially suffered a soft tissue injury. Despite her significant injuries that were diagnosed once at Monash Medical Centre, there is no evidence to suggest that her presentation prior to her decline was such that it required an ambulance

92. On the balance of probabilities, it would seem implausible that clinical signs of a fracture were not identified by at least one of the medically trained persons who came into contact with Mrs Watson on 24 August 2019. This includes Ms Mishra, Dr Burgansky and Ms Palamine. As such, I question whether there may have been a fall or additional injury on the night of 24 August 2019 going into the morning of 25 August 2019.

93. Ms Smith is said to have spoken with the involved staff in the days following the incident and made handwritten notes that were provided to the Court. I note Ms Smith no longer works for the Facility. While largely illegible, I question whether the second dash on the first page reads "*2 x falls*". On the second page of these notes three falls are documented "*1x 735*" and "*1x10* and "*1 @ 1505 @ h/o*"[51]

94. These notes are the closest thing to a contemporaneous record of what happened on 24 August 2019. I note the nature of the handwriting makes the majority of this record illegible. Subsequently, I am unable to ascertain if Mrs Watson potentially suffered more than one fall on 24 August 2019, that neither the Facility nor Ms Mishra have disclosed.

95. The Facility stated that overnight, when Mrs Watson was experiencing pain, the locum doctor service was contacted but that there were no doctors available.[52] Whether Mrs Watson's pain

[50] Statement of Judith Knott dated 13 August 2020, Attachment 4.
[51] Statement of Judith Knott dated 13 August 2020, Attachment 5.
[52] Statement of Judith Knott dated 13 August 2020, Paragraph 33.

was such that an ambulance should have been called remains unclear, however, it was documented that her non-verbal signs indicated that she was certainly in a lot of pain.

96. The Facility advised that as an improvement, all general practitioners must now advise them who will be covering them when they are not available. It was further noted that Mrs Watson's regular general practitioner had not advised of his cover. I do not consider this lack of information to have had any bearing on whether adequate medical intervention was accessed. Namely, whether an ambulance should have been called sooner.

97. The Facility further stated that the Post Fall Flowchart, that is readily available to all staff, details that if there is a change to a resident's clinical status, they are required to be transferred to hospital. "*Staff overnight did not comply with this directive. As a consequence, two of the night staff's employment was terminated*." Additional training on pain management and escalation of clinical deterioration has also been provided to staff since Mrs Watson's fall.[53] I am satisfied that additional training relating to escalation cues and procedures was an appropriate action in the wake of Mrs Watson's death.

98. Mrs Quinto stated that she received a call at approximately 9.00am stating that her mother had deteriorated and would she like an ambulance to be called. According to Mrs Quinto's statement, the decision to call an ambulance was placed on her, again indicating that Facility staff were not fully engaged with the degree of Mrs Watson's decline.

99. The Facility stated that the Registered Nurse in charge on 25 August 2019 contacted the ambulance "*immediately after handover*". The login time of the Emergency Services Telecommunications Authority call was 8.05am.[54] The Facility's clinical notes indicate that the nurse suspected a potential fracture. When asked why a greater sense of urgency was not relayed to the operator when ordering the ambulance, the Facility responded,

> Where a staff member explains to the emergency operator the circumstances of the call it is the emergency operator that determines whether 'lights and sirens' are required. In this case the transport was not escalated to 'lights and sirens' by the operator.

100. The ambulance arrived and transported Mrs Watson at approximately 1.30pm.

[53] Statement of Judith Knott dated 13 August 2020, Paragraph 45-46.
[54] Statement of Judith Knott dated 19 August 2021,Attachment 10 [page 69].

101. Mrs Quinto stated that she was called at approximately 9.00am. The Facility further detailed that the delay in Mrs Watson being transported was not a result of waiting for approval from Mrs Quinto. Specifically, the Facility stated,

> In this instance the staff contacted Ms Quinto to inform her of the transfer. Betty's transfer was not delayed by the call to Ms Quinto. Had staff not been able to reach Ms Quinto, Betty would still have been transferred to hospital.

102. The Facility also stated that it was likely that the lack of urgency was a product of relying on Dr Burgansky's diagnosis of a soft tissue injury.

103. I am of the view that a greater sense of urgency should have been emphasised when requesting an ambulance. The nature of Mrs Watson's injuries leaves no doubt that she would have been in a significant amount of pain. The fact that her presentation overnight raised suspicions of a fracture warranted immediate action. Even the slightest suspicion of a fracture in an elderly person with several comorbidities should warrant immediate transfer to hospital.

104. The Facility acknowledged,

> At no time should one health practitioner rely on the assessment of another. All staff have been reminded to undertake their own assessments through reinforcement of the existing policies and additional training.

105. Since Mrs Watson's fall, The Facility states that further training has been provided on documentation and the requirements of communicating with families in addition to escalation procedures.[55]

<u>Ms Mishra's case management</u>

106. The Facility stated that,

> …it appears from our records that Ms Mishra did not comply with several policies, including the Guidelines: Mobility, Dexterity and Rehabilitation; the fall escalation policy; the clinical deterioration escalation policy; and basic nursing care in the management plan.

107. In relation to family contact, I am unable to ascertain with certainty who called who first. Ms Mishra asserts in her statement that she contacted Mrs Quinto, whilst Mrs Quinto maintains that she had no contact from the Facility and that she first became aware that her mother had

[55] Statement of Judith Knott dated 19 August 2021, paragraph 46 (a) and (b) and 50 (a) and (b).

suffered a fall after her father called her. Ms Smith's notes from her interview with Ms Mishra detail that Ms Mishra said

> …she said my father rang me + my mo [sic] had a fall + why wasn't she called- I told her I was about to call- she said she wasn't happy…[illegible]…I told her I was a new nurse and I am trying my best + have given tramadol. – She was not happy and I was on my own… She said she was not happy + would talk to my … When I apologised she told me she is not unhappy [illegible] but is unhappy [illegible] staff are not here.[56]

108. As already detailed, Ms Mishra was rostered on a shift in a capacity beyond her experience and ill-equipped with only three PCAs and no login details for Autumn Care. When she spoke with Ms Sinnathamby, Ms Mishra allegedly expressed that she was feeling overwhelmed and was unable to fill out documentation. Ms Sinnathamby responded by requesting that a staff member from the Parkdale facility be sent over to assist.[57] Clearly, it was recognised that Ms Mishra was attempting to operate at a capacity above what she was equipped to.

109. Contact with Mrs Watson's family should have occurred immediately after her fall, and it would seem likely that Ms Mishra did not contact Ms Quinto first, given that she did not have access to Autumn Care to obtain numbers and was allegedly overwhelmed with her task list. As detailed in Mr Watson's statement, he became aware that his wife suffered a fall when Ms Mishra verbally informed him in her room after lunch.

110. In both her email statement to the Facility dated 28 August 2019 and her statement to the Court dated 13 August 2021, Ms Mishra maintains that she filled out a paper-based incident report and gave it to the nurse in charge on the afternoon shift.[58]

111. As detailed above, Ms Palamine denies this occurred. In Ms Smith's notes from her interview with Ms Mishra, it is detailed that Ms Mishra said, "*Cyrelle asked me to do the Incident Report + was half way – Kulwinda helped me to do it- I did IR + gave it to Cyrelle in nurses station. I stayed back to do as much as I could. – There is a misunderstanding- I had my notes @* [illegible] *not the incident report.* [59]

112. The Facility acknowledges that it should have conducted an internal review immediately after Mrs Watson's death, including obtaining written statements from all staff rostered on the morning of 24 August 2019. The Facility recognises that its system was flawed and has since

[56] Statement of Judith Knott dated 19 August 2021,Attachment 4 [page 45].
[57] Statement of Judith Knott dated 13 August 2020, Attachment 4.
[58] Statement of Tripti Mishra dated 13 August 2021, paragraph 16,
[59] Statement of Judith Knott dated 19 August 2021,Attachment 4 [page 45].

undertaken a restructure of its policies on incident management. I am satisfied that these amendments, as detailed by Ms Knott, address the gap in procedures at the time of Mrs Watson's fall.

**COMMENTS**

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. The decision to place a loved one in aged care is not one made lightly. It is often one made in the setting of acuity of care exceeding that which loved ones are able to provide in the familial setting and can bring with it feelings of trepidation and guilt.

2. A significant amount of trust is, therefore, placed in the hands of aged care providers. These providers assume the sensitive role of administering care and compassion to some of society's most vulnerable members. It is a role that requires a fastidious degree of attention to detail as it relates to all areas of operation. This matter highlights the tragedy that can unfold when operations do not meet a satisfactory standard.

3. Specifically, the care provided to Mrs Watson appeared to be lacking in a number of areas.

    a) Staffing was inadequate in that an inexperienced endorsed enrolled nurse was rostered on in a capacity above her experience and above her capacity to operate.

    b) Records were not taken and/ or filed due to several administrative failings. The records that were taken, namely Ms Smith's notes, were of such poor quality that they provide little certainty and, in some instances, create more ambiguity.

    c) The investigation was unnecessarily protracted due to difficulty in obtaining statements, inconsistency within the statements obtained and overt efforts from several persons involved to avoid responsibility for their contribution to the failings that led to a delay in transferring Mrs Watson to hospital.

4. I am satisfied that Mrs Watson's condition on the morning of 24 August 2019 did not warrant medical escalation; however, it remains likely that overnight into 25 August 2019, she should have been transferred to hospital. Had adequate records been filed relating to her fall(s), the overnight nurse may have made an earlier decision to transfer Mrs Watson to hospital.

5. Whilst I do not consider that an earlier transfer of Mrs Watson to hospital would have likely altered the outcome, I do consider that this was an opportunity lost to provide her with

appropriate medical treatment including adequate pain management and allow her to pass with some dignity.

6. I am satisfied that since Mrs Watson's death, the Facility have amended its practices and policies to address the failings present in this matter.

7. Finally, I take this opportunity to stress the importance of adequate staffing arrangements, training and administrative infrastructure access. Policies are useless when they are not practiced.

**FINDINGS AND CONCLUSION**

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[60] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Elizabeth Ethel Watson, born 27 December 1929;

   b) the death occurred on 26 August 2019 at Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168;

   c) I accept and adopt the medical cause of death as ascribed by Dr Heinrich Bouwer and find that Elizabeth Ethel Watson died from complications of fractured neck of femur in the setting of a fall in a woman with multiple comorbidities (palliated);

8. Having considered all of the circumstances, I am satisfied that Mrs Watson's death was from complications following her fall at the Facility.

[60] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

9. AND, whilst I find it is unlikely that Elizabeth Ethel Watson's death would have been prevented with earlier medical intervention, I find that the decision to not transport her to hospital earlier represents a missed opportunity to provide her with appropriate medical treatment and adequate pain management.

I convey my sincere condolences to Mrs Watson's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Derek Watson, Senior Next of Kin

Margaret Quinto, Daughter

Judith Knott, Medical and Aged Care Group

Alex Donnan, Avant Law

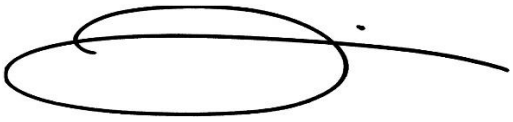
Rosemary Prior, Prior Law

Sabine Phillips, HWL Ebsworth

Lanii Birks, Monash Health

Senior Constable Michael Bassett, Coroner's Investigator

Signature:




AUDREY JAMIESON

CORONER

Date: 27 June 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.