FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 2165/07

Inquest into the Death of BEATRICE IVY BROWN

Delivered On:	19 May 2010
Delivered At:	436 Lonsdale Street, Melbourne 3000
Hearing Dates:	29th and 30th March 2010
Findings of:	JOHN OLLE
Representation:	Ms S. Hinchey for Regis Aged Care Mr T. Wraight for Mr R. Gwatidzo
Place of Death:	Inala Residential Aged Care Facility, Inala Village, 220 Middleborough Road, Blackburn South, 3130
SCAU:	Senior Constable R. Antolini

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

Court reference: 2165/07

In the Coroners Court of Victoria at Melbourne
I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname:	BROWN
First name:	BEATRICE (IVY)
Address:	Inala Aged Care Village, 220 Middleborough Road, Blackburn South, 3130

AND having held an inquest in relation to this death on 29th and 30th March 2010
at Melbourne
find that the identity of the deceased was BEATRICE IVY BROWN
and death occurred on 8th June, 2007

at Inala Village 220 Middleborough Road, Blackburn South, Victoria 3130

from
1a. ACUTE UPPER AIRWAY OBSTRUCTION
1b. ASPIRATION OF FOOD BOLUS

in the following circumstances:

1. Beatrice Ivy Brown was aged 80 years at the time of her death. She lived at Inala Aged Care Village, Blackburn South.

2. On Friday, 8th June, 2007, Mrs Brown was eating an evening meal. She experienced an episode of choking, was assisted to her room and subsequently died.

3. The manner in which staff responded to the choking episode has been the focus of the inquest.

4. A comprehensive review of practice and procedures at the Inala facility was undertaken immediately following the tragic death of Mrs Brown. The new owners of the centre, Regis Aged Care ('Regis'), have provided a comprehensive analysis.

5. A vast array of practice and procedural shortcomings have been identified and remedied by Regis, prior to inquest commencing.

6. Importantly, as a direct result of the review and concessions made by Regis, issues including missed opportunities to identify prior choking episodes, shortcomings in documentation and information transfer, staff training and ambulance access, were identified as problems and have been rectified.

7. Through its counsel, Regis has acknowledged the facility did not 'cover itself in glory'. The submission was a genuine apology to the family of Mrs Brown. The legacy of her death is sweeping change in practice and procedures at Inala.

About an Inquest

8. The Coroners Court is different from other Courts. It is inquisitorial rather than adversarial. In other words, an inquest is not a trial, with a prosecutor and a defendant, but an enquiry that seeks to find the truth about a person's death. But an enquiry that seeks to find the truth about a person's death - to establish what happened, rather than who is to blame. This gives coroners more freedom, but less power. They are more flexible in the evidence they accept, but they can't punish. Instead they make recommendations, if appropriate, that may help avoid similar deaths.

9. Coroners consider all the evidence and material that comes before them. Not every issue makes it way to the finding but everything has been weighed up and analysed.

Issues for the Inquest

10. A coroner investigating a death must find:

- The identity of the person who has died
- The cause of death
- The circumstances in which the death occurred[1]

11. In this inquest, Beatrice Ivy Brown's identity and the medical cause of her death are not in issue. They are recorded on the title page of this finding. My focus is on how and why she died. Specifically I have identified the following issues:

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[1] Section 67(1) Coroners Act 2008.

1. Was the missed opportunity to alter Mrs Brown's diet following a prior choking episode, a cause of her death?
2. Did staff respond appropriately to the medical urgency posed by the choking episode?
3. Was any act or omission of practice and procedure and/or response of staff to the medical emergency a cause of Mrs Brown's death?

Was the missed opportunity to alter Mrs Brown's diet following a prior choking episode, a cause of her death?

12. Opportunities were missed to identify food, such as a sausage roll provided to Mrs Brown on the night of her death were not included in her diet. Stephen Neal[2] and Trish Fairman[3] identified shortcomings which led to the following:

1) Standardization of the procedures across all facilities

2) Improved supervision of residents through mealtime

3) Amendments to documentation, assessments, dietary profiles and care planning

13. Significant training is now provided in respect of these matters as part of Regis, site-specific induction for new staff at Inala. Proper and accurate reporting of all resident incidents is also emphasised to staff to enable near misses and trends to be identified and dealt with.

14. The failure to change Mrs Brown's diet following earlier choking episodes was serious. Altering her diet may have prevented further choking episodes. It is a matter of speculation, however, to find that the missed opportunities were a cause of her death.

Did staff respond appropriately to the medical urgency posed by the choking episode?

15. On the 8th June, 2007 Beatrice Ivy Brown appeared to be choking. The incident occurred between 5.00 and 5.05pm in the dining room. Statements of Ronald Gwatidzo, Registered Nurse Division 1, and Violet Busvumani, Personal Care Assistant, formed part of the inquest brief. In addition, Ms Busvumani gave sworn evidence at the inquest. Mr Gwatidzo was excused from giving evidence.

16. On careful review of the material contained in their statements, and thorough analysis of the evidence of Ms Busvumani, I am satisfied of the following sequence of events:

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2 Exhibit 8
3 Exhibit 9

- at 5.00pm on the 8 June, 2007, Ms Busvumani observed a personal care assistant hand Mrs Brown a bowl of food. Mr Gwatidzo was in the lounge distributing medication to residents.
- Staff became aware that Mrs Brown was experiencing a choking episode. Ms Busvumani noticed Mrs Brown cough up food, lie back on a chair and inhale sharply. She was neither agitated, nor upset.
- Ms Busvumani and Mr Gwatidzo immediately attended her.
- Mrs Brown was able to stand on her own and walk to her bedroom with the assistance of staff.
- Mrs Brown was seated on her bed. Her mouth was checked. Staff ran their fingers around the inside of her mouth to ensure that no food was lodged in her mouth. Nothing was found.
- She continued to have difficulty breathing.
- Mr Gwatidzo smacked Mrs Brown's upper back to free any food which may have lodged in her throat.
- Mrs Brown was then laid in the recovery position, on her bed.
- Mr Gwatidzo again smacked her upper back, however, no food was dislodged.
- Mrs Brown was panting, coughing and struggling to breathe.
- Mr Gwatidzo left the room to call an ambulance. Ms Busvumani remained with Mrs Brown.
- Having called the ambulance, Mr Gwatidzo returned with the blood pressure machine/oxygen cylinder trolley
- Ms Busvumani administered oxygen.
- Records of MAS show call made at 5.09pm.
- Satisfied Mrs Brown's airways were clear and unobstructed, Mr Gwatidzo did not attempt to use suction facility.
- After noting her weak pulse, he commenced CPR. After approximately 7-8 minutes of continuous CPR, Mrs Brown took a breath. He continued CPR and checked her vital signs, however, Mrs Brown did not breathe further.
- Following several minutes performing CPR, Mr Gwatidzo left to investigate the whereabouts of the ambulance. Ms Busvumani remained with Mrs Brown.
- The ambulance personnel were met by Mr Gwatidzo.

Mr Gwatidzo failed to advise ambulance personnel of the resuscitative measures he had performed, in particular, CPR.

17. Whilst Mr Gwatidzo and Ms Busvumani were performing resuscitative measures outlined above, they were unaware the ambulance had responded to the 5.09pm call, arriving at the facility at 5.17pm, unable to obtain access. Shortcomings which then existed at the facility caused a significant delay in ambulance personnel gaining access to the facility.

18. The delay would have caused bewilderment and frustration to both ambulance personnel and care staff.

19. Ambulance personnel approached Mr Gwatidzo. It was important to ascertain information swiftly. Mr Gwatidzo failed to inform them of the extensive resuscitative measures which had been implemented.

20. When access was finally gained by ambulance personnel, the staff member had no knowledge of the crisis. Their frustration would have escalated further. Sadly, through no fault of ambulance personnel or Mr Gwatidzo, a significant delay had occurred.

21. An illustration of Mr Reason's frustration is his failure to observe the oxygen cylinder which was clearly in Mrs Brown's room when he attended. This comment is not a criticism of Mr Reason.

22. Mr Gwatidzo did not inform ambulance personnel of the measures he had implemented. Why he failed to do so cannot be known. He did not know why they took so long to arrive. They would have struggled to hide their frustration. Mr Gwatidzo may have interpreted their frustration as anger directed at him. It is speculation.

23. Irrespective, extensive resuscitative measures were undertaken by staff as set out above. Through no fault of ambulance personnel, they were prevented from gaining access to the facility in a timely manner and were not appraised of the extensive resuscitative measures undertaken by care staff, prior to their arrival.

24. In all the circumstances, the response of staff to the medical emergency was not unreasonable. It could not be said to be a cause of Mrs Brown's death.

Was any act or omission of practice and procedure and/or response of staff to the medical emergency a cause of Mrs Brown's death?

25. Common ground resulting from the shortcomings identified post the tragic death of Mrs Brown. Of particular significance to her death are the following:

1) There were opportunities missed; prior choking episodes in which her diet should have been changed to ensure that she was not provided flaky food, such as sausage rolls.
2) Staff were unaware of the dangers flaky foods posed her on the night of the 8th June, 2007.
3) Staff training.
4) Suction should have been used by Mr Gwatidzo, although I accept he had satisfied himself that her airways were clear.

5) Mr Gwatidzo should not have ceased CPR to attend the ambulance and should have continued CPR until the ambulance arrived.
6) Mr Gwatidzo should have fully appraised ambulance personnel of the measures implemented by him.
7) Delay in ambulance access.

26. The various shortcomings rendered Mrs Brown a greater risk of choking. Following an episode of choking, the shortcomings identified by the Regis review placed her at a greater risk of death.

27. Nonetheless, it remains a matter of speculation to find the shortcomings, either individually or collectively, were a cause of death.

Post Mortem Medical Investigations

28. On the 14th June, 2007, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy.

29. Dr Dodd found the cause of death to be acute upper airway obstruction and aspiration of food bolus.

30. Dr Dodd commented:

> *"The cause of death in this case is one of acute upper airway obstruction secondary to the impaction of a large food bolus.*
>
> *The post mortem examination disclosed a large irregular food fragment firmly impacted above the epiglottis and within the proximal half of the laryngeal lumen.*
>
> *The autopsy examination also disclosed evidence of chronic obstructive airways disease and pulmony hypertension.*
>
> *Toxicological analysis of body fluids was non-contributory."*

COMMENTS:

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

1. The death of Mrs Brown has resulted in the wide sweeping and important improvements in the practice and procedure at Inala.

2. It is important to note the evidence of Dr Hammond. He attended Inala and, specifically, Mrs Brown throughout her accommodation at Inala. His evidence was eloquent of the care and attention staff provided to all residents including Mrs Brown.

3. Although there were serious shortcomings in practice and procedures, none included neglect or lack of care of residents by staff members entrusted with their care.

4. Aged Care needs appropriately trained staff.

5. In 25 years experience in aged care, Mrs Rafter had never encountered a situation, confronted by Mr Gwatidzo. Aged care nursing staff are in short supply. They require gold leaf support in terms of training and encouragement to remain in the aged care field.

6. Unlike nursing counterparts in acute nursing settings, aged care staff are rarely confronted with medical emergencies. It is crucially important to train and re-train aged care staff in emergency response.

7. I have attached to this finding a copy of the Action Plan - Wilani Clinical Incident - Updated 2/7/2007.

8. The manner in which the Aged Care Facility in question responded to the circumstances of death of Mrs Brown is exemplary. The lessons learnt by Regis can be applied throughout all the facilities run by Regis Aged Care and across aged care facilities generally.

RECOMMENDATION:

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

1. I recommend the audit process undertaken by Regis and the measures set out in the attached Action Plan be distributed by the relevant Minister to all Aged Care Facilities in Victoria.

I offer my condolences to the family of Mrs Brown. The quiet dignity exhibited by them throughout the inquest was noted by all.

FINDING

I find that Beatrice Ivy Brown died of acute upper airway obstruction and aspiration of food bolus.

Signature:

John Olle
Coroner
Date: 19th May 2010

DISTRIBUTION LIST:

Minister of Aged Care
The family

Action Plan - Wilani Clinical Incident – Updated 02/07/07

Issue	Action	Who	When	Comments	Outcome
Appropriate supervision of residents during meals	➢ Review allocation of staff meal breaks RN & PCA ➢ Review number of staff required to assist in the supervision and feeding of residents at meal times ➢ Review menu choices	CM – High Care FM and CM	15/06/07	**14/06/07** No designated staff mealtimes – need to be specified • 1st Break 1800 (1 from each side) • 2nd Break 1830 (1 from each side if applicable) • RN to control the meal breaks and ensure staff go on time or if they are delayed must send someone else • Staff must advise the RN when they are leaving for a break or have returned from a break • Meal breaks to be allocated by the RN at handover • RN1 & Endorsed Div 2/Div 2 to go on separate breaks • • Discuss evening meal choices with Ray Hiskins	**13/6/07** Memo written to all staff. RN in charge will ensure this allocation occurs. For agenda at next staff meeting. Communication has improved at handover **11/07/07** RN's are adhering to meal break allocation. Still some problems in the evening when there are less staff but working through the issue **25/6/07** Meeting held with Ray Hiskins. Menu to be reviewed? Flaky pastry to be

					removed from menu. **16/07/07** Meeting with Ray Hiskins. Flaky pastry products to be removed from the soft diet menu immediately
Documentation, assessments, Dietary Profiles and Care planning	➢ Review dietary profiles for all nursing home residents to ensure that correct diet is being provided. Update kitchen information and care plans if required. ➢ Report any deficits to FM ➢ Review & update/reinforce communication processes for ensuring that changes in diet are passed on to staff and the kitchen & that dietary profile is updated ➢ Review process for completing care plan reviews and updating of care plans as ➢ Review all behaviour charting and care plans	CCC CM CCC CM CCC CM CCC	10/06/07 06/07/07 06/07/07 11/07/07	All Wilani resident dietary profiles and care plans are being reviewed by the CCC and RCS coordinator. 2 deficits found so far and rectified Review dates for Speech pathologist and dietitian have been added to care plans	YJ profiles and care plans now being reviewed All updated in Wilani still need to be done in YJ **11/07/07** Approximately 60% of files done in Jharmbi and 25% in Yana **16/07/07** Memo given to staff with NCP review process attached. Each shift in Wilani has now been allocated specific

					aspects of the review to complete rathe than the AM staff doing all of it. Feedback from staff about this has been positive
Knowledge deficit re the appropriate response to a clinical emergency e.g. 1. Choking 2. CPR	➢ Develop and implement an education plan to cover medical emergencies and appropriate action to take ➢ Contact ACCV to see if they can provide education ➢ Provide education sessions for all RN's	FM – High care CM CCC CCC & CM	22/06/07	Liaise with FM low care to achieve a consistent approach across the site **14/06/07** • Need first aide training to be provided as mandatory o Basic CPR o Other medical emergencies e.g. Choking o Correct use of medical equipment • Need session to be run again on fire and emergencies by facilitator • CCC to provide education session on Oxygen therapy, use of air Viva, Insertion of airway, & suction	**14/6** ACCV has been contacted and have agreed to put something together for us to assist in our education program. **21/6/07** New staff attended orientation education on 21/6/07 **25/6/07** Have commenced emergency response training for all staff in Wilani East and West Wings. 6 sessions booked for education. **12/07/07** All RN's in Wilani completed. One RN repeating this.

		CCC			YJ working through with RN's most done still to be entered on MQAS **26/6/07** ACCV contacted again to forward quotes for in house education for all nursing staff Checklist for emergency equipment now in place. **11/07/07** Identified that no fire blanket in staff room – ordered. Also not enough fire extinguishers – ordered. Check of new evacuation plans
				• Every RN to redo an orientation program to the unit	RN Competency devised for knowledge and use of emergency equipment. Competencies

					have been commenced with the RN 1 involved in the incident being done first.
Knowledge deficit re reportable death procedure and process for a coroners case	➢ Develop and implement an education plan to cover reportable death policy and appropriate action to take in the event this occurs	FM – High care	22/06/07	Liaise with FM low care to achieve a consistent approach across the site **14/06/07** • FM to do a memo and attach the procedures • FM to follow up with an education session • Education to be provided site wide	**25/6/07** Memo written with attached policy and procedure on reportable deaths for all staff to read. Information posted on notice board for staff to read. Education session booked for July 07.
Breakdown in Communication system between staff	➢ Review communication systems within the nursing home as a whole ➢ Promote the "one NH" concept ➢ Report outcome to FM ➢ Review effectiveness and knowledge of the process for reporting maintenance issues. Determine if this is covered at orientation	CM – High Care and FM high-care CM	22/06/07 Ongoing	**14/06/07** Wilani • Call Bells and door bell not linked to Kirk phone – to be actioned • RN was not carrying the Kirk phone although this is standard practice • Door Bell difficult to hear – need to check where this can be heard and improve if required YJ • Need to promote the concept of 1 nursing home • Leave internal Wilani doors open until the evening – need set times for opening and	**12/6/07** Maintenance department reviewed phone system and front door bell is now linked to all call bell system in East and West wings. Door bell can now be heard clearly in East and West Nurses station. Staff encouraged to leave doors open between wings RN in each wing responsible for this.

		CCC		shutting. This will be the responsibility of the RN in charge • Rotate staff between wings • Promote exchange of critical information between wings e.g. RN to EN, PCA to RN, PCA to PCA etc	Roster currently under review to ensure this occurs.
Availability of emergency response equipment	➢ Determine what we have ➢ Determine anything additional we need ➢ Educate staff in use ➢ Commence audits and develop checklist	CM CCC CCC	15/06/07	Discuss with FM low care and ensure consistency across Inala **14/06/07** • emergency equipment to be relocate to a central spot • Staff to be educated about the location of the ambulance button to turn the red light on • A checklist is to be developed for emergency equipment o Oxygen/suction o resuscitation equipment e.g. Air Viva • Ensure new staff have comprehensive education at orientation to the nursing home	**12/6/07** Have commenced weekly audits for evacuation emergency equipment for both wings to ensure our equipment is in place and sufficient. A check list is now in place for all equipment. Commencing with all existing staff and then to be maintained for new staff.
Staff did not initially answer the door bell	➢ Arrange for maintenance to check the functionality of the doorbell in Wilani and to	CM	12/06/07	**14/06/07** o Maintenance to check doorbell function and	**12/6/07** Quote has been obtained by

	repair as needed ➢ Report outcome to FM ➢ Review process for answering the doorbell ➢ Review effectiveness and knowledge of the process for reporting maintenance issues. Determine if this is covered at orientation	CCC		audibility o Potential to move the switch for the emergency light to front door or have one in each wing being assessed by maintenance	maintenance department to relocate to front door area.
Lighting in carport was not operational	➢ Arrange for maintenance to check the functionality of the lighting in Wilani carport and to repair as needed ➢ Review effectiveness and knowledge of the process for reporting maintenance issues. Determine if this is covered at orientation	CM – High Care CCC	12/06/07 06/07/07	o Function of lighting in carport is being reviewed	Maintenance department have reviewed lighting outside and is functional