mean that the management of the outbreak would be dealt with by DHS including the taking and testing of samples.)

98. Dr Schifter stated that had he been aware of the extent and spread of the outbreak and obviously the identification of the Salmonella, he would have referred Mr MD to hospital where he would have expected him to receive antibiotic therapy.[66] It was Dr Schifter's evidence that he learned of the deaths at Broughton Hall via television reports on April 14 and that as a result he contacted Broughton Hall to enquire as to the health of the three patients he had seen on April 13 (including Mr MD). He stated he was told they were all "OK".

99. RN Phan gave evidence that she worked on 14 and 15 April morning shifts but was not informed that the Salmonella pathogen had been identified at that time. Consequently she made an assessment of Mr MD that he appeared to be improving.

100. RN Hunt gave evidence that she worked the afternoon shifts of both 14 and 15 April and she was informed that the pathogen had been identified as Salmonella.[67]

101. Upon the decision being made to transfer Mr MD to the Epworth Hospital neither the ambulance staff who arrived to transfer Mr MD nor the receiving hospital, the Epworth, were informed that there was an outbreak of Salmonella gastroenteritis at Broughton Hall. The evidence from Professor Grayson was that had this information been given it is likely that infection control measures may have been more stringently applied in both locations.[68](See Comments)

Communication between general practitioners and locums

102. Given the timing of the outbreak being over the Easter period, it was not surprising that a number of requests for the attendance of doctors during the outbreak were responded to by locum agencies sending locum doctors. In and of itself, that is a

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[66] Transcript 511.

[67] Transcript 35.

[68] Transcript 1168.

sensible and appropriate way to provide medical support to aged care residents after hours and during holiday periods.

103. However, it raises very important system issues during a period of an infectious outbreak in an aged care facility. Where patients may not be able to communicate clearly or at all with a doctor and the locum doctor is not likely to have an understanding of the patient's history or indeed a relationship with the aged care facility, and hence an awareness of who is in charge and who will have correct and up to date information, the potential for valuable information and accurate communications may be heightened.

104. These issues were highlighted in the treatment of Mr MD. Dr Sklovsky was Mr MD's GP and had been since 2005. Dr Sklovsky was away on a break over the Easter period and last saw Mr MD on April 3, 2007.

105. Dr Liu attended upon Mr MD at 19.50 hours on April 7. She noted that Mr MD was febrile and suffering from diarrhoea and vomiting. As noted above Dr Liu also raised the query as to whether or not there was a food poisoning epidemic at Broughton Hall. Dr Liu gave evidence that she did not order a faecal sample at that time as she was the first doctor seeing the patient with this condition and she was a locum. She stated that if she were the second doctor to attend in these circumstances she would have ordered a faecal sample.[69] Dr Liu did recommend a medical review of Mr MD.

106. Dr Sklovsky stated that she had a discussion with RN Phan upon her return from leave and felt satisfied after that discussion that she did not need to attend to review Mr MD. There was some disparity between accounts as between RN Phan and Dr Sklovsky as to what was said during that discussion. In any event, Dr Sklovsky did not re-attend upon Mr MD. Dr Sklovsky's evidence was that given she knew that Mr MD was one of a number of patients suffering "gastro", and the information she had was he was being hydrated and not experiencing on going bouts of vomiting or

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[69] Transcript 326-336,

diarrhoea, she thought it was much more likely he had a viral gastro and he was now recovering from it.[70]

107. Dr Sklovsky also knew that both the locum service and the nursing home could contact her through her pager service.[71]

108. Dr Schifter also recommended a review for Mr MD after his visit on April 13. It was his evidence that although he wished for that review to be conducted the following day, he accepted that it may not happen for 2 to 3 days. He did not make any direct call to Dr Sklovsky but rather put notes into the locum electronic service at some stage on April 13.

109. Dr Schifter did not make a direct call to Dr Sklovsky as he did not consider it urgent enough to do so.[72] It is the evidence of Dr Sklovsky that she believed she checked her "in box" as at 11 am on April 14 but did not find the note there at the time touching upon Mr MD. Indeed, the evidence is that the note was not viewed until Monday April 16.

110. The workings of the locum agency system were not examined as part of this investigation but the question of the effectiveness of the system were raised in circumstances where a 24 hour review of a patient seen by a locum was needed. Dr Sklovsky gave evidence that she has, in the past, been telephoned directly by a locum service or by the locum in circumstances where the locum wanted to confirm that the GP knew the patient needed a review within the next 24 hours.

111. It was submitted by Counsel Assisting that there was a particular imperative for prompt and reliable systems of communication between treating GP's and their locums for vulnerable patients in aged care facilities, in particular where the locum is recommending a review within 24 hours or ordering pathology tests. (See Comments and Recommendations.)

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[70] Transcript 842 to 858.

[71] Transcript 848.

[72] Transcript 536.

Any link between the CEO of Broughton Hall and the lowering of standards and/or effect of the same from the management structure

112. There was a considerable amount of material contained in the Inquest Brief compiled by the investigating member of Victoria Police that touched upon the management structure of Broughton Hall and Benetas. It was clear that there were some very disaffected employees and former employees of Benetas at the time of this outbreak and during the initial investigation conducted by the investigating member.

113. There was some evidence that some of the nursing staff felt at the least some level of unhappiness with the management staff of Broughton Hall at that time. This was expressed by inference through the evidence of nursing staff who were unable to access the infection control procedures on April 7, not having the numbers available to report the outbreak to DHS, and from evidence such as that of RN Hunt that she had thought Ms Varnava, the acting Manager at that time should have come into the facility by April 8 upon learning that six residents of the nursing home had symptoms of gastroenteritis including one who had been taken to hospital.[73]

114. RN Phan stated that she informed Ms Varnava that faecal samples should be taken from the ill residents as she understood it was important to distinguish between a viral or bacterial pathogen. RN Phan also stated that she told Ms Varnava that DHS should be notified of the outbreak.

115. It was not clear at the commencement of the Inquest however as to whether or not there was in fact any causal connection between the preparation for and management of this outbreak and the disaffection as between the employees and management and indeed the capacity of management itself to respond to this outbreak.

116. Ultimately, at the close of the evidence examined at Inquest, I came to the view that it was not relevant to this inquiry to pursue an examination of the management structure of Benetas or Broughton Hall or the CEO of Benetas in that it was not likely to add

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[73] Transcript 74/75.

any benefit to understanding the circumstances surrounding these deaths beyond what was contained in the material before me for the purposes of a coronial investigation.

Co-ordination and management of the outbreak

117. The effect of the evidence of both Professor Grayson and Ms Jane Hellsten was that the co-ordination and management of an infectious outbreak across an aged care facility is of considerable importance. Effective co-ordination and management ensures that as soon as identification of an outbreak occurs, all of the necessary restrictions, controls and procedures are directed by management to commence and directions are given and overseen about matters such as communication to all doctors attending any resident, discussions and decisions about the taking and testing of faecal samples and generally ensuring that the Department of Health Guide is being applied.

118. This should occur at the outset. Best endeavours to identify the causative pathogen and its possible source should be commenced as soon as possible in such vulnerable environments and upon identification, timely and accurate communication to all treating personnel must occur.

119. It is obviously essential that the person or persons who perform the co-ordination and management of the outbreak must be appropriately trained and up to date with all of the procedures and practices. An analysis of the evidence in this investigation demonstrates the appropriateness and relevance of the aspects of the response now implemented by Broughton Hall.

120. It was a requirement of the aged care facility that an Infection Control Policy be directly available to the nurses and staff involved in the care of the residents[74]. As previously noted, the evidence is that the Infection Control Policy was not available to the nursing staff at the time they identified the outbreak on April 7. Indeed, Broughton Hall's Infection Control Policy document was not available to staff on the

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[74] Transcript 895.

floor of the nursing home prior to April 10. Further, the evidence was that neither the Department of Health Guide nor the "Blue Book" were available at Broughton Hall before April 10.

121. Whilst a range of infection control measures were put in place by Broughton Hall, commenced by the nursing staff on April 7, it was conceded by Broughton Hall that there were aspects of its response that needed improvement and re-development.

Attendance of Council and DHS at Broughton Hall

122. On 10 April, 2007[75] following notification by Broughton Hall of the outbreak to the Council and DHS, DHS sent advice by fax to Broughton Hall in relation to the cleaning of the facility, isolation of ill residents, exclusion of symptomatic staff, restriction of visitors, collection of faecal samples and completion of case lists. DHS also directed the Council officers to attend Broughton Hall.

123. On April 10, the attending council representative to Broughton Hall observed that:[76]

a) Appropriate clean up measures had been implemented;

b) Chlorine was being used to clean up communal areas, bathrooms, toilets, handrails;

c) Carpets had been steam cleaned as a precaution;

d) Ill residents had been isolated;

e) Staff had been separated between the three areas of Broughton Hall: the Hostel, the dementia unit and the nursing home;

f) Cleanup was being conducted in all three areas of Broughton Hall on an ongoing basis;

g) Hand washing stations were operational; and

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[75] Joint Statement to the Coroner (Exhibit 70): paragraph 42.

[76] Joint Statement to the Coroner (Exhibit 70): paragraph 43.

h) The kitchen had undergone standard daily cleaning only.

Infection control measures taken by Broughton Hall during the outbreak

124. The DHS Guide sets out a range of infection control practices that are recommended as best practice for managing infectious outbreaks. These practices cover a range of areas and activities in an aged care facility from kitchen hygiene and food handling to movement of food trolleys and contact with residents and movements throughout the facility.

125. Broughton Hall assisted the investigation in the identification of some shortcomings in the management and control of the outbreak. A considerable amount of the shortcomings were identified with the co-operation and assistance of Broughton Hall. Broughton Hall, through its legal team were very responsive and co-operative in assisting the Court in the identification of improvements that both could and have been made.

126. As noted, nursing staff at Broughton Hall, despite being unable to locate the infection control policy as it was locked in the manager's office,[77] initiated a number of appropriate infection control measures as at April 7, 2007. For example, RN Hunt when nursing Ms TH and Mr MD on the nightshift of April 7 wore gloves and a plastic apron and disposed of the waste and soiled linen in accordance with infection control policy.[78]

127. According to the evidence of RN Leslie, she too implemented infection control procedures on the afternoon of April 7 including hand washing before and after resident contact, the wearing of gloves, gowns/aprons and a double bagging of contaminated linen and the appropriate disposal of contaminated waste. Her evidence was that she also explained to the carers who were working with her the importance of hand washing and the importance of adequate hydration for residents.[79]

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[77] Transcript 113 - 115 and 134 - 136 (Evidence of RN Leslie).

[78] Transcript 141.

[79] Transcript 130.

128. Below is an examination of a range of infection control measures identified by the 2010 Department of Health Guide put into the context of the evidence during this outbreak.

Signs

129. It is recommended as a general infection control measure in the Department of Health Guide that signs should be posted at all entrances stating that a gastroenteritis outbreak is occurring. Signs advising of the requirements for hand washing are recommended to be posted above and washbasins in all toilets bathrooms and kitchen areas.

130. There was some contention in the evidence about exactly when the recommended signs went up at Broughton Hall, but Broughton Hall itself stated that the signs went up on April 9, and conceded that the signs should have gone up upon identification of the outbreak on April 7.

131. Dr Schifter raised a separate but sensible point about the signage. He expected that once the Salmonella pathogen was identified, the signage should have been changed to clearly reflect this rather than the generic advice about "gastroenteritis".[80] This would have alerted all medical practitioners including locum doctors and agency nurses and avoided the risk of miscommunications or lack of communication.

Food trolleys

132. On the issue of the movement of food trolleys, the accepted infection control procedure is to, wherever possible, restrict the movement of staff between units sections and wards.[81]

133. At Broughton Hall, RN Schulz thought she may have informed kitchen staff not to bring food trolleys into the ward but [82] this evidence was at odds with the chef at

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[80] Transcript 528.

[81] See: Department of Health guide for the management and control of gastro enteritis outbreaks in aged care, special care health care in residential care facilities 2010.

[82] Transcript 272.

Broughton Hall, Mr Patrick Leong, who gave evidence that on the afternoon of April 8 he was reassured that catering staff could deliver meals in the usual way but that staff could leave the trolley at the door of the nursing home if they were fearful.[83]

134. The evidence is that catering trolleys were taken from the central kitchen into the nursing home and meals distributed from those trolleys which was contrary to accepted infection control procedures. On 8 April a kitchen attendant was allowed access to the nursing home to deliver the trolley containing the nursing home resident's meals.

135. It was not until April 9 that one kitchen staff member was required to work exclusively on the nursing home and not allowed access to the kitchen and movement of the food trolley was restricted to only the door of the nursing home where the trolley was collected by staff working in the nursing home.

Hand washing

136. The Department of Health Guide notes that during any outbreak effective hand washing is the most important measure in preventing the spread of infection and should be practised by all staff at all times. As at 2010 the Guide from the Department of Health sets out that health care staff may generally use alcohol wipes or anti bacterial gels to reduce the risk of transmission of bacteria whilst going about their routine duties but states that these measures are far less effective against viruses. The Guide states that in outbreak situations where the pathogen is often unknown it is essential that thorough hand washing is undertaken by all staff setting out a procedure for vigorous hand washing with warm water and soap from 40 to 60 seconds.

137. At Broughton Hall, it was not until 10 April that alcohol hand wash was placed on either side of the entrance to the nursing home.

138. Broughton Hall submitted that its nursing staff were well aware of the need for strict hand washing regimes and consistent with the requirements of the DHS guidelines for the control of infectious diseases at that time.

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[83] Transcript 572.

Isolating residents and minimising staff movement

139. Part of the general infection control measures set out in the Guide are that wherever possible the staff should ensure that ill people are isolated from well residents and staff nursing ill patients are not also nursing unwell patients.[84] Further it is recommended that only food handling staff should have access to the kitchen and other food preparation areas and where possible in order to reduce the risk of transmission, assign staff to specific duties during an outbreak, rather than allowing them to undertake multiple tasks in several areas. It is also advised that movement of residents and staff between units sections and wards be restricted. There was evidence that movement as between staff of the nursing home and the hostel was occurring unchecked.

140. There was evidence that nursing staff were endeavouring to apply the recommended procedures but that this was not systematically sustained by management. For example RN Holmes gave evidence that she endeavoured to ensure that the nursing home staff were isolated from the hostel staff and to inform the kitchen that they needed to keep a staff member placed in the nursing home and not to transfer as between the kitchen and the nursing home but that this was not systematically implemented by management.[85]

141. Directions were not given to nursing staff until 12 April not to (i) take meal breaks in the communal staff area (ii) use the toilet in the communal area.

142. The issue of placing affected residents together and separating them from unaffected residents or "co-horting" was the subject of some evidence and submissions. The evidence of the infectious disease experts was that it is best practice in an infectious outbreak to "co-hort" affected residents. The evidence from Benetas was that there are legal and practical difficulties in shifting residents out of rooms that they have been placed in under contractual arrangements. It was submitted by Broughton Hall, and accepted by me, that Broughton Hall would have faced considerable difficulties

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[84] The Guide: P8.

[85] Transcript 393.

with respect to the co-horting of patients given the contractual and legal obligations it has with respect to a resident's use of a particular room and the practical difficulties faced in circumstances where all rooms are occupied.

143. However, whilst one can readily accept the difficulties of "co-horting" affected patients, there was no evidence that attempts were made to discuss the need for co-horting of ill residents with families during the outbreak. The evidence is that affected residents were isolated to the extent possible given the available resources in the nursing home, but no "cohorting of ill patients" was undertaken such that the rooms were grouped together within the nursing home.

Cleaning procedures

144. The 2010 Department of Health Guide sets out a series of general cleaning requirements for infection control during any outbreak. The Guide notes that specific control measures may depend upon the known or suspected pathogen and the setting in which the outbreak has occurred.[86]

145. The Guide sets out general cleaning actions that must be taken in a range of areas with very specific requirements for areas such as the kitchen, the toilet, the bathroom, and resident's bedrooms. The Guide includes advice about cleaning floor surfaces including special treatment of carpets and all items or fittings that are touched frequently such as door and cupboard handles, bath and toilet rails, telephones and bedside tables through to bedpans and commodes. The advice includes minimum temperatures and detergent types and concentrations of disinfectants which should be used such as chlorine.

146. Ms Jane Hellsten gave evidence that the description of the cleaning regime that Broughton Hall engaged in appeared appropriate once it got going but noted that the evidence was silent as to whether or not the chlorine had remained in contact with the surfaces for the required ten minutes.

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[86] This adds weight to the need to identify the pathogen as soon as possible

147. The cleaning of the kitchen was requested by the Boroondara Council to occur on 10 April but did not occur until April 14. This was accepted by Broughton Hall as a shortcoming on its part. It was agreed as between the Department of Health, the Council and Broughton Hall in the Joint Statement to the Coroner that on April 10 the Council representative directed the kitchen to be cleaned with chlorine on all surfaces including floors, walls, ceiling, shelving, benches and equipment. It was conceded by Broughton Hall that this was not attended to before April 14.[87]

148. On 10 April, 2007 the Council representative also left a list of minor matters requiring attention in the kitchen and it is conceded by Broughton Hall that these matters were not attended to before 13 April.[88]

149. Further, it is conceded by Broughton Hall that on 10 April 2007 the Council representative directed that the sanitiser then in use in the kitchen (which had been approved for use during the food safety audit conducted on 21 March, 2007) should have been replaced with chlorine-based product in light of the outbreak. Broughton Hall did not replace the sanitiser prior to the kitchen being closed on 13 April 2007.[89]

The kitchen clean up

150. The Council did not supervise the clean up of the kitchen as per its directions. In final written submissions the Council submitted that it was appropriate that it did not supervise the clean up[90] submitting that it should be entitled to rely upon Broughton Hall obeying its direction and to rely upon advice from Broughton Hall that it had and would undertake the cleaning as directed. Further, supervision was not a requirement of the Guidelines in force at the time.

151. The City of Boroondara submitted that once notified, albeit delayed as already conceded, it conducted its investigation in accordance with the 2007 DHS Guidelines.

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[87] Exhibit 70: paragraph 44.

[88] *Ibid* at paragraph 45.

[89] *Ibid* at paragraph 46.

[90] Final written submissions of the City of Boroondara: P 10.

152. Council submitted that it gave its cleaning directions to Ms Varnava, the acting manager of the facility at that time and separate directions to the acting manager in the kitchen and further, that it noted that contract cleaners were evident at Broughton Hall. The evidence is that an instruction was given by the Council to Broughton Hall to clean up the kitchen on April 10 and this was not done properly until April 14. It does raise the question of the Council's proper supervision of its directions to Broughton Hall

153. The Council requested Broughton Hall provide its Food Safety Plan on April 10, but this did not occur.

154. I accept the submissions of the Council on this issue. The Council should be able to rely on the representations of a licensed aged care provider. I note, however, that the 2010 Guidelines require the "clean up" to be supervised by the Environmental Health Officer for the Council or an infection control expert.[91] Given the expertise required for such a clean up, supervision and oversight and the concomitant availability of expert advice is good practice.

Disposal of waste and soiled material

155. Storage of soil continence aids was the subject of some evidence during the inquest. Bronwyn Holbeche a division one registered nurse with additional qualifications in infection control, was engaged by Broughton Hall to perform an audit of the infection control practices. She did so on 13 April and found two areas of non-compliance. The first of these related to the storage of soiled continence aids exposed to the elements. The problems associated with such a practice includes the risk that the rubbish may be rummaged through by a cat or a dog who may then make its way into the facility or be touched or patted by staff or resident and thereby contribute to contagion.[92]

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[91] Statement of Ms Liew (Exhibit 66).

[92] Transcript 920.

156. The second related to the bags used to dispose of the soiled continence aids being stored on the floor of residents rooms which should have been placed in bins. [93]

157. Finally, it was conceded by Broughton Hall that whilst double bagging of infected material was appropriately utilised at the commencement of the outbreak, the use of dissolvable bags which commenced from 12 April required correction on 13 April.

Pet policy

158. The evidence was that where an aged care facility has a resident pet or pets it should have a pet policy addressing issues such as the need to contain a pet during a contagious outbreak so as to minimise the risk of spread of infection in the facility. There were resident pets at Broughton Hall but no pet policy was produced by Broughton Hall during this investigation. A resident cat was present at Broughton Hall during the course of the outbreak and a dog was present on the mornings of April 7 and 8.[94] Broughton Hall has further conceded that while it did have a pet policy, it did not address the management of pets during the gastroenteritis outbreak.[95]

Fluid balance and bowel charts

159. According to the evidence Ms Jane Hellsten, it is not sufficient to utilise a resident's progress notes when the resident is affected by symptoms of gastroenteritis. Fluid balance charts are necessary. This is because hydration is a serious matter to monitor during an outbreak of gastroenteritis in an aged care facility and a fluid balance chart gives a easily readable running record for all care staff to easily monitor.

160. As at April 9 there were no fluid balance charts in place to enable accurate monitoring and recording of the intake and output of residents with symptoms of gastroenteritis. Additionally there were no bowel charts in place to describe the faecal matter lost by the residents.

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[93] See exhibit 58.

[94] Final written submissions of Benatas: P19.

[95] *Ibid:* P21.

Education and training on infection control procedures and policy and management of outbreaks

161. At least annual updates on infection control education for all staff including food services staff and environmental cleaning staff is recommended. The evidence in this case was that there was an infection control seminar held at Broughton Hall on 11 April which was a timely and critical opportunity for Broughton Hall to have staff in attendance. Notwithstanding the facility actually being in the grip of an infectious outbreak at that time, the evidence was that only four carers and one division one nurse were in attendance.

162. Whilst the infection control policy of Broughton Hall did contain steps to be taken in the event of the gastroenteritis outbreak, there ought to have been a formal gastroenteritis policy dealing specifically with the management of the outbreak and institutional regular training to ensure **all** staff knew what to do.

What Broughton Hall has done since this outbreak

163. Broughton Hall identified a number of shortcomings in its infection control procedures during this investigation. Having identified these shortcomings, Broughton Hall was keen to identify to the Inquest all of the remedial and proactive actions it has taken since this outbreak.

164. It was apparent in the wake of this outbreak in 2007, Benetas has put considerable thought and work into what happened during this outbreak and where it needed to make changes and improvements in its capacity to respond to and manage any similar infectious outbreak in any one of its facilities.

165. Benetas provided evidence to the Court of the range of materials it has now produced for its facilities, endeavouring to address in particular those areas which were identified as falling short of what would be expected of the operator of an aged care facility in the event of an infectious outbreak.

166. Benetas advised[96] that in the wake of this outbreak, it has implemented a comprehensive regime for timely notification of an outbreak to DHS and collection of faecal samples.

167. The Benetas facilities, facility managers and members of the senior executive now possess a Critical Events Resource Manual which summarises and clarifies the relevant procedures to be undertaken in the event of gastroenteritis outbreak (as well as other critical events)[97].

168. The Manual sets out procedures which address:

(i) the identification of an outbreak of gastroenteritis;

(ii) the requirement to notify of the outbreak once identified as soon as possible to:

(a) The Communicable Disease Prevention and Control Unit (CDPCU) Department of Health;

(b) the local government environmental health officer (EHO);

(c) the Department of Health and Ageing , Canberra (or the complaints investigation scheme after hours);

(d) the Aged Care Standards and Accreditation Agency (next business day);

(iii) daily reporting must continue to the Department of Health and the environmental health officer using the appropriate outbreak chart documentation recommended by the Department of Health until the outbreak is declared over by the Department of Health or the environmental health officer; and

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[96] Joint Statement to the Coroner (Exhibit 70).

[97] Final written submissions of Benetas: P 21; and the agreed set of facts contained in the Joint Statement to the Coroner (Exhibit 70).

(iv) take appropriate swabs and/or specimens as directed by medical practitioner or environmental health officer. Instruction is provided in relation to the collection and handling the faecal samples.

169. Notification to clinical care staff and treating doctors and any transferring or receiving hospitals has also been addressed in the new Manual.

The Outbreak Management Kit

170. Benetas has also developed an Outbreak Management Kit which contains requirements as to mandatory hand washing for all staff including food handlers cleaners, casual and agency staff; attending medical practitioners; visitors and residents. It includes: laminated signs for external doors; laminated signs for the kitchen doors; laminated signs for a resident door; long-sleeved gowns; faecal specimen pots; pathology biohazard specimen bags; powder free latex/nitrile gloves; goggles; surgical masks; blu- tack; infectious waste bags; dissolvable infectious linen bags and advice as to supplies such as alcohol-based hand gel and hand towels.

171. The kit forms part of the Critical Events Resource Manual, and includes as a cover sheet to the kit, a form to be completed with information including, in relation to each resident, date of symptom commencement; date of symptom conclusion; admission to hospital; collection of faecal specimen and the date on which it was collected (which is intended to prompt the transmission to the local Council by fax of the form once completed and a copy to the Communicable Disease Prevention and Control Unit in the Department of Health).

172. The kit also contains the telephone and fax numbers of the Department of Health Communicable Disease Prevention and Control Unit.

173. The kit requires all residents exhibiting relevant symptoms to be isolated in individual rooms, multi-bed rooms, units or wings; staff to be allocated exclusively to the care of affected residents where practicable; instructions to staff not to enter kitchen areas; consideration of increasing staff levels as required and allocation of equipment exclusively to the care of affected clients where possible/practicable.

174. The kit also directs the staff to notify the outbreak of symptoms to all visiting medical practitioners at the facility; next of kin of affected residents and of all clients in the affected area of the facility; staffing agencies for agency staff dispatched to work at the facility; external contractors engaged to work at the facility; hospitals to which residents may be transferred from the facility.

175. The kit requires that close attention be paid to the hydration status of patients including maintenance of fluid balance charts.

176. The kit also requires that resident movement be minimised and that there be no admission of new clients. In the event of unavoidable new admission, the next of kin are to be informed that the new client will be physically isolated. In addition directions and advice as to the restriction on the presence of visitors and advice to visitors regarding the outbreak of symptoms are contained in the kit.

177. Co-ordination, reporting and overview of the project has been included in the kit. There is a regime of internal reporting of an outbreak within Benetas management structure and a procedure for the maintenance of a Case List of affected residents during the course of the outbreak.

Cleaning of the kitchen, equipment and utensils

178. The kit addresses the actual requirements of the cleaning regime including the need to clean the facility with a chlorine-based cleaning agent. There are also requirements for kitchen management including the collection of samples of leftover food and the disposal of potentially contaminated food. The kit also addresses the handling of linen and waste management.

179. Food handling precautions including isolation of kitchen staff and prohibition of delivery of food to affected residents by kitchen staff is also addressed in the kit.

180. The issue of staff illness is also addressed.

Department of Health (relevant changes since this outbreak)

181. As noted above, the relevant public agencies participating in the Inquest developed some agreed improvements in response to issues highlighted by the evidence as needing improvement. The Department of Health has endeavoured to do its part to guard against a repeat of what occurred in 2007 by publishing its new 2010 Guide for the management and control of gastroenteritis outbreaks in aged care, special care, health care and residential care facilities. The new Guide sets out what should happen in the event of a gastroenteritis outbreak[98] and includes details of whom to notify and how to notify and measures to take control of the spread of the illness.

182. The *Health Act 1958* has been repealed by the *Public Health and Well Being Act 2008*, which came into force on January 1, 2010.

Conclusion

183. In summary, management of Broughton Hall should have acted decisively to ensure that all of the necessary procedures were being initiated and infection control requirements maintained. Expert assistance and advice and extra resources to attend to the demands of looking after all of the affected residents and engaging in the necessary response to the outbreak should have been decisively and expertly initiated.

184. The overall effect of the evidence was that there was a level of lack of readiness and lack of procedure in place at the time of the outbreak. Whilst it would appear that earlier reporting to DHS is unlikely to have made any difference to the outcome for Mr PN or Mr AT or Ms TH, it may have made a difference to the outcome for Mr MD. Further, an earlier overall co-ordinated response may have made a difference to the number of residents who suffered the illness and were consequently put at risk.

185. A number of areas requiring improvement and attention were identified in the overall response to this infectious outbreak at Broughton Hall. Many of those areas requiring improvement and attention have been addressed by the work Benetas has undertaken

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[98] Page 5 Of the Guide

in the wake of the 2007 outbreak. The Department of Health has made legislative changes and operational improvements as well as the production of updated written materials. For this reason, the need for far more extensive comments and recommendations was removed. Below are the remaining issues for comment and recommendation.

COMMENTS

Level of co-operation between interested parties

1. This has been a lengthy and complicated investigation which no doubt has added anxiety and distress to all involved including the individual family members as well as the staff and those involved in the care of the residents at Broughton Hall.

2. It is important to record that even though this Inquest has proceeded under the *Coroners Act 1985*, the legal representatives for interested parties engaged with the inquisitorial spirit of the new Act in co-operating with the inquiry. In particular, Broughton Hall, through its legal team in the second stages of this Inquest demonstrated admirable co-operation with the Court's endeavours to establish what happened during April 2007 and address the necessary range of changes and improvements flowing from this case. In this way, Broughton Hall was also able to advise the Court of the number of developments it had implemented in the wake of these events to improve its readiness and responsiveness to outbreaks of infectious disease in its aged care facility. Indeed, ironically, it was even able to demonstrate the efficacy of its new regime in that it had to respond to an outbreak during the course of the Inquest.

Mandatory notifications to Department of Health of infectious outbreaks in aged care facilities and appointment of Infection Control Managers

3. The 2007 DHS Guidelines for investigating gastrointestinal illness provide information to assist in the investigation of outbreaks of gastrointestinal illness including from the initial investigation through to clean up. Since this outbreak at

Broughton Hall, the *Health Act 1958* has been repealed by the *Public Health and Well Being Act 2008*, which came into force on January 1, 2010.

4. The 2008 Act contains a new regime of Regulations for the reporting of notifiable "diseases" including substituting the word "*condition*" for "*disease*" and thereby apparently broadening reporting requirements as well as inserting a new test for mandatory notification for medical practitioners.[99] It has been in the wake of this legislative change, that the 2007 Department of Health Guidelines have been substantially revised and replaced by the 2010 Guidelines.

5. Differing views were expressed during this Inquest about whether or not aged care facilities should be mandated to notify two or more cases of gastroenteritis.

6. Ms Jane Hellsten, and Professor Grayson were both of the view that the Department of Health should require aged care facilities to report two or more cases of gastroenteritis.[100]

7. In essence, the rationale for this view was that mandatory notification to the Department of Health would ensure that proper focus on preparedness, on-going training, appointment of designated infection control managers, the over sighting of proper processes and procedures and training would be given necessary attention by aged care facilities. Further, the mandatory involvement of the Department of Health would provide considerable assistance and expertise and guidance to both the facility and the attending and treating doctors in these circumstances.

8. The law currently does not mandate notification by aged care facilities.

9. Dr Rosemary Lester[101] expressed the view that the current system of voluntary reporting was working quite well. In her evidence, she stated that she accepted that there was an argument for having a statutory obligation on the management of an aged care facility to notify the Department. Dr Lester made this comment in the

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[99] Joint Statement to Coroner (Exhibit 70).

[100] Report of Professor Grayson dated 22 March 2010; Report of Ms Hellsten dated 24 March 2011.

[101] Transcript 766.

context of understanding the evidence in this case around the difficulties that doctors, including locums, may have in obtaining a full picture as to what is occurring inside an aged care facility during an outbreak, together with the vulnerability of the aged care population.[102] Borondara Council supported a continued scheme of voluntary notification by facilities to the Department of Health.[103]

10. Even though there is no statutory obligation to notify, in the Joint Statement to the Coroner, the Department of Health, Benetas and the Council agreed that the operator of a residential care service, acting prudently, should notify the Department of Health within 24 hours when the facility becomes aware that two or more residents and/or staff members are displaying signs of unexplained diarrhoea and/or vomiting within 72 hours of each other.[104]

11. Having considered all of the above, I accept the opinions of Professor Grayson and Ms Jane Hellsten as to the rationale for imposing a mandatory obligation on aged care facilities to notify the Department of Health when there is an infectious outbreak in the facility. Despite the representations made about how the system is working, I am persuaded that a system of mandatory notification will ensure that all aged care facilities pay appropriate attention to the need to not only engage in proper preventative activity against infectious outbreak, but also training and full facility preparation and management co-ordination in the event of one. **(See Recommendation 1 (a))**

Infection control manager

12. There was considerable incidental discussion during the Inquest about the need for the appointment of a person who should have responsibility for the oversight of the infection control policies, practice, training, equipment maintenance and the responsibility for notifying appropriate bodies, agencies and/or persons and to co-ordinate the outbreak. The appointment of an "**infection control manager**" would

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[102] Transcript 771.

[103] Final written submissions from the City of Boroondara: paragraph 107.

[104] Joint Statement to the Coroner (Exhibit 70): paragraph 17.

address a range of issues including outbreak prevention, preparedness for any outbreak, and in the event of an outbreak communications between all relevant agencies and co-ordination of the response to an outbreak. Such a person would be well placed to inform a doctor attending upon an ill patient as to necessary information about the nature and extent of any infectious outbreak in the facility and whether or not any other residents had been hospitalised and the outcome of any test results for other ill patients.

13. For these reasons, in my view, the Department of Health should mandate the appointment of a designated infection control manager inside each aged care facility, given the very clear evidence of the risk to the residents and the complexities of preparation for and response to an infectious outbreak. **(See Recommendation 1(b).)**

Mandatory notification requirements for doctors

14. The evidence was that there was room for improvement between the Department of Health Guidelines and what general practitioners generally understood about their obligations with respect to the reporting of infectious outbreaks. On this topic, Broughton Hall submitted that the Department of Health should provide clear guidelines about the onus to report being a non-delegable responsibility of medical practitioners.[105]

15. As noted above, there was considerable misunderstanding amongst the medical profession about the functions that would be performed by the Department of Health once involved in an infectious outbreak. Seeing these issues played out in the Courtroom, it was not difficult to see how and why the misunderstanding had "grown up." It is most important that it be addressed.

16. The Department of Health in its closing written submissions expressed itself "at a loss" to understand why any medical practitioner would not understand the role of the Department in an outbreak. However, it was clear from the evidence in this case that doctors of considerable years of experience did not understand the Department's role

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[105] Final written submissions from Benatas: P 11

with respect to the directing and testing and reporting upon faecal samples. That is the insurmountable evidence which must be faced.

17. A general practitioner misunderstanding the requirement to request that a faecal sample be taken and to send it for testing may delay obtaining results crucial to the treatment option that the doctor should choose. The Department of Health, whilst expressing its dismay and concern, also accepted the responsibility to address this issue.

18. In closing submissions the Department of Health advised that it proposed to send a written alert to all registered medical practitioners in Victoria detailing the role of the Department of Health in an infectious outbreak and specifically to make clear that the Department will not necessarily test all faecal specimens obtained from affected residents. Further, the alert would also reiterate that the on-going clinical management of the patient remains the doctor's responsibility. The Court was advised the alert will also direct treating doctors to the resources on the Department's website.

19. Further, the Department confirmed that this message would be reinforced during any outbreak where the notification procedure set out/above below was adopted.

20. Whilst this is a laudable initiative, it is important that understanding and awareness be maintained amongst treating doctors.**(See Recommendation 2)**

21. *Changes by Benetas as to notification of outbreak procedures generally*

22. As set out above, Benetas advised that it had now put in place steps to ensure that such a delay would not be repeated in the future. Indeed, Counsel for Benetas brought to the Court's attention an outbreak days before (March 30, 2011) and set out how it had been handled, to contrast the improved system with what occurred in April 2007.

23. It was submitted on behalf of Benetas that during the March 2011 outbreak, within three hours of the outbreak being identified, the care co-ordinator was on-site, the regional manager was on-site, signage was in place, cleaners were notified, infection control measures were in place, waste management measures were in place, kitchen and food management precautions were in place, isolation and restrictions were in place, staffing requirements were in place and the Department of Health was

contacted at the first available opportunity. The evidence as to the value of the Manual and Kit developed and tested by Benetas is a good basis for the Department of Health to reassess its 2010 Guidelines with a view to inserting guidelines about the value and nature of such a resource for aged care facilities. **(See Recommendation 1 (c))**

Reporting back faecal testing results: Proposed new regime

24. On the issue of reporting back faecal testing results, this issue was addressed in the Joint Statement to the Coroner as to a proposed process for the notification of results.[106] A sensible regime for improved communication was settled upon by collaboration between the relevant interested parties during the course of the inquest.

25. What is now anticipated to occur is:

26. The CDPCU (Department of Health Communicable Disease Prevention and Control Unit) action officer will be responsible for the communication of any results from specimens positive for salmonella received by CDPCU;

27. Where CDPCU receives written or verbal information that someone has tested positive for Salmonella (or other causative pathogen) , CDPCU will construct an email/fax for the aged care provider and the local Council;

28. CDPCU will direct the responsible facility to bring the results to the attention of all treating doctors and place a copy on the resident's medical file;

29. It was agreed that this written communication from the facility should confirm to the general practitioners that their patient may not necessarily be tested by the Department of Health and that the ongoing clinical management of the resident remains a matter for the treating medical practitioner;[107] and

30. CDPCU will request a return confirmation that this advice has been received and acted upon.

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[106] Exhibit 70: See paragraph 26 where the proposal is set out in full.

[107] See paragraph 26 Exhibit 70.

31. Whilst both Professor Grayson and Ms Jane Hellsten expressed strong support for the Department of Health to be required to make that communication to treating doctors, I accept the evidence of both Dr Lester and Dr Hogg as to the complexities of the Department of Health being required to notify all of the treating doctors, including locums coming in and out of the facility at all hours. I agree that the better process is to require the facility in which the outbreak occurred to bear this responsibility. It would be a sensible part of the regime and an appropriate "safety net" for the aged care facility to be required to confirm in writing with the Department of Health that it has received the notification from CPCDU and understands its responsibilities and will provide all of the requisite communications. This could properly be the responsibility of the infection control manager to ensure that this is done in a timely and thorough way.

32. Counsel assisting in closing submissions submitted that it would be prudent to also require the affected facility once informed, to attach to the front of each resident's medical file confirmation of the identification of the pathogen affecting some in the facility to ensure that locums and potentially agency nursing staff do not miss this information or have any risk of miscommunication. It would be a sensible addition to the regime to minimise the possibility of any missed or miscommunication.

33. In this case, as will so often be the case in aged care facilities where an outbreak occurs after hours, locum doctors will be used all hours of the night and day. Those treating and attending doctors will not necessarily have a complete picture of what symptoms he or she is assessing if attending upon one patient in the middle of the night. Thus, it is crucial that timely and comprehensive information be available to all attending doctors.

34. In summary, I considered the submissions of the Department of Health a sensible practical solution to this issue of reporting back test results. Importantly, the proposal was endorsed by both the Boroondara Council and Benetas. As the Department say the process of notification of results worked out in this inquest and set out above it is - *"simple, quick, practical and unambiguous. First and foremost, the ACF [aged care facility] needs to know. It has overall management and the total picture of the clinical*

status of all of the residents. It has all of the files at its fingertips. It can readily identify the medical practitioners, be they locum or otherwise. The proposal is fail-safe, in that acknowledgment of receipt of the information is required; confirmation that forward notification has been carried out, is built in."[108]

35. To ensure that the proposed form of communication for the reporting back of test results is adopted for all aged care facilities in Victoria, I have included it as a recommendation.**(See Recommendation 1 (e))**

36. In the regime of reporting results, it is important to ensure that aged care facilities also include in their system procedures for responding to infectious disease outbreaks a process which will ensure that ambulances and receiving hospitals are also notified of any identified or suspected infective pathogen.

RECOMMENDATIONS

For all of the above reasons I make the following recommendations:

1. To ensure appropriate preparation for and management of an infectious outbreak in an aged care facility

(a) That the Department of Health (in consultation with the Department of Health and Ageing (Cth)) introduce a clear regime which mandates aged care facilities to report infectious disease outbreaks in the facility to the Department of Health. An infectious disease outbreak for this purpose is unexplained vomiting and diarrhoea in two or more residents and/or staff within 72 hours of each other.

(b) In consultation with the Department of Health and Ageing (Commonwealth), I recommend that the Victorian Department of Health require aged care facilities to have a designated Infection Control Manager. The role of the infection control manager should include (i) outbreak prevention measures; (ii) ensuring readiness for infectious outbreak via documented procedures that are disseminated to and are accessible to all staff; compulsory training regimes for all staff; availability of all

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[108] Final written submissions of Department of Health: P3.

necessary equipment and manuals and (iii) co-ordinating the management of any outbreak including appropriate communication of all notifications and advice to all relevant entities, staff, treating doctors and affected families; identification of the cause; liaising as between all relevant agencies and persons as to the results of any faecal (or other testing for infectious disease) and notifications to Department of Health.

(c) The Department of Health amend its 2010 Guidelines by inserting a requirement that aged care facilities develop a comprehensive document for the facility which sets out in detail what must be done in the event of an outbreak. To this end, the Department of Health may be assisted by the Critical Resources Manual and Outbreak Management Kit developed by Benetas as a model to assist other facilities

(d) To assist in the overall daily management of an infectious outbreak, consistent with paragraphs 20 to 23 of the Joint Statement to the Coroner[109] , when an outbreak is assessed as possibly food or waterborne, the Victorian Department of Health Communicable Diseases and Prevention Control Unit should establish an Incident Management Team (IMT). This is to ensure that one lead agency has overall control of the outbreak to manage (i) the timely investigation of the outbreak and (ii) to oversee the infection control measures and (iii) communication and provide guidance and expertise..

(e) To ensure state wide understanding and consistency in reporting back test results including faecal test results during an infectious outbreak, the regime set out in paragraphs 23 to 29 in the Comments section of this Finding be incorporated into the 2010 Guide.

2. To ensure the appropriate level of knowledge and understanding amongst the medical profession with respect to their responsibilities for mandatory notification of infectious disease and the role of the Department of Health during any infectious outbreak

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[109] Exhibit 70.

In conjunction with the appropriate Colleges and associations, the Department of Health review the knowledge of general practitioners of the notification requirements as set out in the Regulations and within Departmental Guidelines. This review should be used to inform the nature of measures to be undertaken to improve general awareness of notification obligations upon general practitioners and their knowledge of the role of Department of Health in an infectious disease outbreak including the limits of the Department's involvement

3. *To enhance communication between locum doctors and treating doctors*

That operators of locum services make clear to their agency doctors that it is the locum doctor's responsibility to ensure that if in their view a patient in an aged care facility during an infectious outbreak should be reviewed within 24 hours, that such an opinion be conveyed to the nursing staff, the locum service and the treating doctor in the most practical and effective way possible.

I direct the publication of this Finding on the Internet with the names of the deceased to be represented by initials only.

I further direct that a copy of the Finding be distributed to the following:

The senior next of kin of each of the four affected families –

Ms PN (wife of Mr PN)
Ms TH (niece of Ms TH)
Ms MD (wife of Mr MD)
Ms (daughter of Mr AT)

The investigating member, Sergeant Geoff Enright
Middletons solicitors for Broughton Hall
Maddocks solicitors for City of Boroondara
Department of Health, (Victoria) Principal Solicitor Margaret Mann
The Secretary, Department of Health

RANZCGP
Hunt & Hunt Solicitors for Ms Julia Currell,
Professor Lindsay Grayson
Dr Nick Demeduik
Dr Geoff Hogg
Dr John Myers
Associate Professor Jeremy Hammond
Ms Jane Hellsten
Victorian Infection Control Professionals Association
Department of Health and Ageing (Cth)
Clayton Utz Solicitors for Aged Care Standards and Accreditation Agency Ltd
Dr Emerald Ong
Ms Bronwyn Holbeche
Monahan & Rowell Solicitors for Dr Sam
Ryan Carlisle Thomas Solicitors for Nurses Leslie, Phan, and Hunt
John W Ball & Sons Solicitors for Dr Sklovsky
Avant Law Solicitors for Dr Zdanius Dr Liu and Dr Sammadar
Monahan and Rowell Solicitors for Dr Davidson and Dr Sam
Perry Maddock Trollope Solicitors for Dr Schifter
Lethbridges Solicitors for Janine Walsh

Signature:

JUDGE JENNIFER COATE
STATE CORONER
Date: June 25, 2012

Coroners Court of Victoria