IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2009 2059

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: HAROLD LOUIS

Delivered On:	14 DECEMBER 2012
Delivered At:	MELBOURNE
Hearing Dates:	2 OCTOBER 2012
Findings of:	CORONER K.M.W. PARKINSON
Place of death/Suspected death:	CRANBOURNE
Counsel Assisting	LEADING SENIOR CONSTABLE ANTOLINI – VICTORIA POLICE
Appearances:	DR ELIZABETH BROPHY OF COUNSEL FOR REGIS AGED CARE PTY LTD

I, KIM M. W. PARKINSON, Coroner having investigated the death of Mr HAROLD LOUIS

AND having held an inquest in relation to this death on 2 October 2012

at MELBOURNE

find that the identity of the deceased was HAROLD LOUIS

born on 28 October 1941

and the death occurred on or about 11 April 2009

at Cemetery road, Cranbourne

from:

1(a) ISCHAEMIC HEART DISEASE

1(b) CORONARY ARTERY ATHEROSCLEROSIS

in the following circumstances:

1. An inquest was conducted into the death of Mr Harold Louis. The inquest brief comprised statements obtained from family members, employees of the Sherwood Park Residential Aged Care facility, the Regis Aged Care Group and other witnesses. Dr Melissa Baker, Forensic Pathologist of the Victorian Institute of Forensic Medicine gave evidence in the proceeding and reports were obtained from Associate Professor David Ranson, Deputy Director of the Victorian Institute of Forensic Medicine.

Background

2. Mr Louis was born on 28 October 1941 and was 67 years old at the time of his death. Mr Louis had a history of Alzheimer's Related Dementia, Ischaemic Heart Disease, Type 2 Diabetes Mellitus and Hypertension. He was requiring of personal and nursing care and resided at the Sherwood Park Aged Care facility, ('Sherwood Park') a facility owned and operated by Regis Aged Care Pty Ltd ('Regis').

3. He had transferred from another facility on 6 March 2009 after his daughter, Ms Anne-Lise Saluni who was employed as a nurse at Sherwood Park, arranged with then manager of the facility, Mr Peter Jankowski, for his relocation. This was convenient as she worked at the facility and resided nearby so it enabled her and other members of the family to see Mr Louis more frequently.

4. Mr Louis was admitted as a person requiring 'Low Care' and had been assessed as such by the Aged Care Assessment Team, an assessment team operating under the authority of the Commonwealth Government. The Sherwood Park facility operated a system of ageing in place, which allowed residents to remain in the facility environs to which they had become accustomed even when their health deteriorated and they were requiring of a higher level of care than that for which they had originally been assessed. This meant that even within the low care environment staff were caring for people who had varying levels of care requirement, including high-level care.

5. Shortly after Mr Louis admission, staff noticed a decline in his cognitive state and that he was requiring of care and supervision at a higher level than that anticipated, however no re-assessment of his status was made and no clinical review undertaken. Ms Deborah Winder was employed as a unit manager with responsibility to oversee the wing in which Mr Louis was located, including attending to admission paperwork, liaising with doctors and organising medication. She stated that when Mr Louis was admitted he was initially assessed as being low care, however 'within a matter of days all of the staff in the hostel knew that he was high care because of his dementia'.

6. Mr Louis had a documented history of wandering in the facility and also attempting to leave the facility. Staff also attempted to manage a number of serious behavioural issues including Mr Louis entering other resident's rooms, behaving inappropriately and aggressive behaviour directed towards staff and other residents. Some of those events are set out below.

7. On 18 March 2009, he was located outside of the facility kitchen by a staff member who returned him to his room. Staff were unable to determine how Mr Louis left the building.

8. On 19 March 2009, a note was made in the care plan that more regular monitoring of Mr Louis whereabouts was to take place.

9. On 22 March 2009, he was recorded as agitated and intrusive, wandering around the facility and attempting to get out of the facility.

10. On 29 March 2009, he was located attempting to get out of the front door of the facility several times and trying the key pad.

11. On 10 April 2009, an instruction was issued that staff perform hourly checks upon Mr Louis as to his whereabouts. This occurred in the context of Mr Louis wandering into a female resident's bedroom the previous evening and the more recent concerns, which had been noted.

The events of 11 April 2009

12. On 11 April 2009, Mr Louis was last seen in his room at the facility at 10.45am. He did not attend for lunch and he was unable to be located in the facility at approximately 12.00pm. Police were notified after a search of the premises and its surrounds. Police attended the facility at 3.45pm His daughter was advised and a search beyond the premises was commenced.

13. It appears that Mr Louis left the facility by way of an open front door. The self-closing mechanism had apparently failed and the door had remained open after visitors had left the premises earlier in the day. There was no staff member attending the nearby visitor reception desk and the open door went unnoticed.

14. The aged care Complaints Investigation Scheme ('CIS') attended the facility on 14 and 24 April 2009 to investigate the circumstances of the incident. Their report is attached to the Statement of Ms Daniyela Rob (Exhibit 7- Item 5).

15. As to the security of the physical environment, the CIS investigators were advised by the facility manager Mr Jankowski that the front door of the Low Care area did not automatically lock securely when visitors left the facility. The investigation officers reported that they had "found no evidence that maintenance was attended to ensure that the door closed securely".

16. I have concluded from this report and from the statements of staff members and family that the self- closing mechanism on the front door of the Low Care wing of the facility was not operating as required when Mr Louis left the facility on 11 April 2009. This had not been noted or attended to by management of the facility in the preceding period.

17. Police activated an extensive search of the surrounding area over the following six days including police air-wing, mounted police branch, traffic management unit on motorbikes and divisional van assistance. Foot patrols and residential door knocking was conducted. The search included the Cranbourne Botanical Gardens. The SES and park rangers also provided search assistance, however Mr Louis was not located. An extensive media alert campaign was also initiated. Family and facility staff also continued to search the area throughout that and following days.

18. On 18 April 2009, a passerby located Mr Louis in scrub at Cemetery Road, Cranbourne approximately 10 metres off the road and 30 metres west of the intersection with Sladen Street, Cranbourne. Police and ambulance attended however, Mr Louis was apparently deceased. Police reported that he could not be seen from Cemetery Road, owing to the thick scrub. Mr Louis was located lying in a prone position in the middle of what police describe as an old walking track. Police report that his arms were folded and his hands were close to his ears as if he had been trying to keep warm. His shoes were off and were sitting near his feet. Police formed the view that he had been deceased for some days owing to the amount of decomposition and other scene factors.

19. The location where he was found was approximately four kilometres from the aged care facility and could be reached by a number of routes from the Sherwood Park Aged Care facility.

20. It is submitted by counsel for the facility that there is no evidence that Mr Louis travelled the distance by his own physical efforts and that there may have been intervention of a motorist.

21. Whilst this is a possibility, I am satisfied that it is more likely he travelled by foot to the location. To conclude otherwise would involve acceptance of the proposition that a stranger

would drop an apparently confused elderly man at a location some distance from facilities rather than make inquiries of his residence.

22. Counsel also submitted that there was no evidence that Mr Louis would have been distressed or experienced heightened physical stress as a result of what may have been an "enjoyable stroll" rather than a rigorous physical exertion.

23. The distance Mr Louis travelled, apparently on foot, was approximately four kilometres, a significant distance for an older man with cognitive and physical impairment of a respiratory and cardiac nature. Irrespective of whether Mr Louis was cognitively appreciative of being lost or mentally distressed by his exertion, the physical activity was appreciable.

24. In addition, the cardiac event which occurred and caused his death, occurred in a location where there was no immediate medical or emergency response intervention available and to that extent, the possibility of helpful resuscitation intervention was precluded due to the fact that he had been able to abscond from the security and care available at the facility.

Security arrangements to prevent wandering.

25. Whilst Mr Louis was admitted to the facility as a resident requiring 'low care', it is apparent that his condition had either been understated at his admission or he had deteriorated in cognitive status very shortly after his admission. Staff had implemented a number of measures to attempt to alleviate the deterioration and its impact upon Mr Louis security and the security and safety of other residents, however these were ineffective to protect Mr Louis and to prevent his leaving the facility.

26. At the time of his disappearance from the facility, Mr Louis was documented as requiring hourly observations. It does not appear from the patient care notes that any observation had been made of him in the period from 10.45am to the time the disappearance was noted at 12.30pm.

27. Staff recorded that he was requiring of a higher level of supervision and diversion and there were persistent issues with behaviour related to cognitive deterioration. Initially a process of more frequent review and then of hourly review was introduced.

28. It is unclear why there was no formal review of his care and level of care requirements, in the context of a documented decline in his cognitive status, the attempts to leave the premises and the issues of aggression affecting staff and other residents, all of which were recorded in his patient care record and care plan.

29. It is reasonable to conclude that Mr Louis left the facility by way of the front door on and that the door, which was faulty, did not operate as required to automatically close.

30. An autopsy was performed by Associate Professor David Ranson, Forensic Pathologist and Deputy Director of the Victorian Institute of Forensic Medicine. Associate Professor Ranson reported that the post mortem examination whilst somewhat constrained by decomposition, allowed for a reasonable medical cause of death due to Ischaemic Heart Disease.

31. Associate Professor Ranson was asked to comment by way of a supplementary report upon whether there may have been any contribution to the cardiac event and cause of death by exertion or distress arising from Mr Louis having left the facility and becoming lost or disorientated.

32. Associate Professor Ranson stated:

> *"An individual with his degree of significant natural disease in the form of severe ischaemic heart disease with evidence of previous myocardial infarction and coronary artery bypass grafts is very vulnerable to death in the presence of extra stressors – heat, exercise, emotional and physical agitation etc.*
>
> *His death appears to be natural causes but many older people with substantive chronic disease and physiologically vulnerable states are at risk of sudden death related to their natural disease when they are placed in physiologically stressful environments such as hot environments. Indeed most people who die in periods of hot weather do not die of direct heat effects on the body but instead have their physiological reserve exceeded so they are very vulnerable to extra stressors that they would normally be able to cope with.*

A man with this level of natural disease could die if physically stressed running, clambering etc. and this risk of death would be increased if it were hot or for that matter very cold.

His mental status could also contribute as his potential inability to understand the risky nature of his environment and any health care problem exacerbation- chest pain, shortness of breath, etc. would mean he would be even more vulnerable".

33. Dr Ranson commented that he did not see any features of unequivocally and uniquely heat related pathology described in his autopsy report. Dr Ranson was unable to provide information as to the timing of the death.

34. Dr Ranson was unavailable to give evidence in the inquest and Senior Forensic Pathologist Dr Melissa Baker attended to respond to questions in relation to the autopsy results and to provide an opinion as to the issues of exertion or stressors and contribution of these factors to a cardiac event.

35. Dr Baker stated that she considered that these factors could be contributing factors to the death in a man with severe coronary artery disease, previous myocardial infarction and coronary artery bypass grafting.

36. Her evidence however was that:

"This man had significant natural disease. He had an enlarged heart, and he had evidence of previous heart attacks from scarring of his heart and coronary artery disease. So people with this sort of disease may just drop dead or they may die in their sleep with no exertion. Dr Baker's evidence was that obviously any sort of exertion such as walking, running, clambering as Professor Ranson said is going to put extra stress on the heart, increase the heart rate. So the heart has to work harder. And that may cause a cardiac arrhythmia or abnormal heart rhythm leading to death. So it is not possible to say that exertion did contribute to death but it certainly may have." (T 33.1)

37. Dr Baker stated that it was not possible to say definitively that it was a cardiac arrest in the setting of exertion, because someone with that degree of cardiac disease could just die while they were asleep and that all she could say is that it would increase his risk of death.

38. There was a failure of the facility to supervise and protect Mr Louis from the traits of his cognitive deficit arising from his dementia, the propensity to wander and to leave the facility, the very purpose for which he had been admitted to the facility.

39. This failure resulted in Mr Louis dying at a location some significant distance away from the care facility, out in the open and absent any medical care or attention being available to him.

40. The failure also resulted in a lack of clarity about the timing of Mr Louis death and an inability to determine exactly what physical impact the fact that he was lost had upon him and whether it was in this context that the cardiac event occurred.

41. In the circumstances therefore, it is not possible to conclude with the requisite level of certainty that the death occurred because Mr Louis left the facility, was unattended and underwent excessive exertion and possibly distress as a result of being lost and confused as contemplated by Associate Professor Ranson in his supplementary report.

42. At highest having regard to the statement of Associate Professor Ranson and the evidence of Dr Baker, it might be concluded that it was possible that these factors may have contributed to the death, however the medical evidence is equally that the cardiac event may have occurred at any location, at any time and without any exertion.

43. It is clear that Mr Louis was unattended for a number of hours and was not observable by staff. Consequently, the opportunity for medical intervention in the event of a medical emergency such as the cardiac event was removed. However even as to this matter I am unable to conclude with the requisite level of satisfaction that medical intervention would have been likely to result in a different outcome for Mr Louis in view of the extensive coronary disease and his complex medical history.

44. It is not possible to conclude with certainty as to the time or date of death. However, having regarded to the evidence as to the scene circumstances, prevailing weather conditions, the

evidence of the pathologist Dr Baker, including as to deterioration of the remains and the fact that Mr Louis went unsighted despite extensive air and ground searches, it is likely that the death occurred within a day or two after Mr Louis left the Sherwood Park premises on 11 April 2009.

45. In those circumstances, I find that the cause of death was Ischaemic Heart Disease and Coronary Artery Atherosclerosis and that the death occurred on or about 11 April 2009.

46. I make no other finding as to cause or contribution for the reasons discussed above.

I make the following comment(s) connected with the death including matters relating to public health and safety and (including any notification to the Director of Public Prosecutions under 67(3) of the Coroners Act 2008

47. Counsel for Regis made submissions upon the jurisdiction of the Coroner and the capacity to comment or make recommendations.

48. The capacity of the coroner arising from s67(3) and 72(2) is to comment or to make recommendations upon on any matter 'connected' with a death or fire including recommendations relating to public health and safety or the administration of justice.

49. These sections do not operate to confine the capacity to comment, to only those matters which are causally connected to the mechanism of death but provide for comment in relation to matters which are connected to the death in particular in relation to public health or safety. Deficiencies in arrangements in an aged care facility resulting in an elderly dementia patient absconding from the facility and being found deceased in uncertain circumstance are matters connected with the death and appropriate for comment pursuant to the section.

<u>Changes to security made after Mr Louis' disappearance</u>

50. In a statement dated 31 August 2012, Ms Daniela Robb identified the following improvements including a number, which were made immediately following Mr Louis' disappearance. These were also noted by the CIS investigation officers. These were:

(1) The doors to the low care area had a self closing mechanism attached;

(2) Signs were fixed to the door, both internally and externally to alert staff and visitors of the importance of checking who is exiting the facility;

(3) All residents were reassessed for the risk of absconding; and

(4) A Registered Nurse Division 1 was rostered on to supervise the low care wing and to initiate reassessments of all residents.

51. Ms Rob also reported that in addition to the above matter and as a result of the investigation undertaken by the Aged Care Complaints Investigation body of the Department and Health and Ageing further additional changes were made which included:

i. Distribution of a memo to staff regarding the process to be followed in relation to locking doors, admitting visitors and lighting in the low care foyer;

ii. Updating the behaviour plans of all residents who displayed wandering behaviours;

iii. Development of a continual reassessment plan to ensure that residents are appropriately reassessed and behaviour plans are continuously updated;

iv. Review of staffing rosters and increases to staffing levels; and

v. Review of staff education and the offering of further education.

52. The facility also underwent assessment and re-accreditation audit undertaken by the Aged Care Accreditation Agency. Accreditation was extended initially for six months, then 12 months and in August 2010 having met all compliance standards for care, for a period of 3 years.

53. I have considered the contents of the statement of the Victorian Operation Manager for Regis, Ms Catherine Harper dated 28 September 2012 (Exhibit 6 - in particular paragraphs 25 to 28). The statement details the steps subsequently taken by the group to develop, publish to staff

and implement comprehensive policies and procedures to address matters such as escalation of symptoms, wandering or absconding, reporting and responding to incidents.

54. Concerns were raised by a former staff member, Ms Deborah Winder in relation to the circumstances of the disappearance of Mr Louis, the staffing levels at the facility and the process of documentation adopted by the facility at the time of the disappearance and death of Mr Louis.

55. The information provided by the facility by further statements of Ms Rob dated 31 August 2012 and Ms Harper dated 28 September 2012 acknowledge some of the concerns raised and inform the court as to the investigations undertaken after the disappearance of Mr Louis and the procedures and processes which have been adopted to address the issues raised.

56. Regis conceded that they failed to provide a safe and secure environment in not ensuring that the front door to the low care area locked securely when visitors entered or left the facility. That they did not have instructions for visitors in relation to entering and exiting the premises and did not have staff stationed at the front desk to monitor who entered or exited the premises.

57. It also acknowledged that the strategies they were adopting in relation to managing concerns relating to Mr Louis were not effective and that the additional hourly monitoring was not implemented until a number of days after it was directed.

58. There has been significant assessment and review of the processes and procedures of the facility undertaken by the facility itself and also by the Aged Care agencies responsible for supervising and oversight of the standards of aged care services in Australia. Each of the matters of deficiency, which may have warranted recommendation, have been addressed in these reviews.

I make the following recommendation(s) connected with the death under s72(2) of the Coroners Act 2008:

59. Changes made by the operators to the facility in particular securing entry and exit from the premises as described by Ms Rob were warranted and were undertaken by the operators and in these circumstances I make no recommendations.

60. Changes made by the operators to the procedure for reporting incidents and assessing residents care needs as described by Ms Harper address the issues raised in relation to Mr Louis initial low care assessment and in these circumstances I make no recommendations.

61. I direct that a copy of these findings be provided to the family of Mr Harold Louis, Regis Aged Care Pty Ltd and to the Interested Parties.

Signature:

K.M.W. PARKINSON
CORONER
Date: 14 December 2012