FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1884/06

Inquest into the Death of JOAN HENDRICKSON

Delivered On:	8th September, 2010
Delivered At:	Hearing Room, Coroners Court of Victoria, 436 Lonsdale Street, Melbourne 3000
Hearing Dates:	29 and 30 July, 2010
Findings of:	JOHN OLLE
Representation:	Ms Riddell for Sutton Park Assisted Aged Care Mr Harper Dr Hayman
Place of death:	Sunshine Hospital, 176 Furlong Road St Albans Victoria 3021
PCSU:	Senior Constable Kelly Ramsay

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1884/06

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

having investigated the death of:

Details of deceased:

Surname:	HENDRICKSON
First name:	JOAN
Address:	Sutton Park Assisted Aged Care Facility, 126-134 Exford Road, Melton South Victoria 3338

AND having held an inquest in relation to this death on 29th and 30th July 2010
at Melbourne
find that the identity of the deceased was JOAN HENDRICKSON
and death occurred on 9th May, 2006

at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria 3021

from
1a. ASPIRATION PNEUMONIA
1b. EPISTAXIS
1c. TRAUMA TO THE FACE
2. VASCULAR DEMENTIA, PERMANENT PACEMAKER AND HYPERTENSION

in the following circumstances:

1. Joan Hendrickson was aged 78 years at the time of her death. She lived at Sutton Park Aged Care, Melton South ("the facility").

2. Mrs Hendrickson was admitted to the Sunshine Hospital on the 29 April 2006, following injuries sustained in an incident at the facility.

3. The incident is fully canvassed in the coronial brief. Mrs Hendrickson sustained injuries when pushed over by a co-resident JL ("the incident").

4. The injuries sustained by Mrs Hendrickson resulted in marked epistaxis. Though the epistaxis was well controlled by medical staff, the complications of the respiratory state were not responsive to treatment. Mrs Hendrickson died on the 9 May 2006.

About an Inquest

5. 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 inquiry 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 cannot punish. Instead, they make recommendations, if appropriate, that may help avoid similar deaths.

6. Coroners consider all the evidence and material that comes before them. Not every issue makes its way into the finding, but everything has been weighed up and analysed.

Issues for the Inquest

7. A Coroner investigating a death must find:[1]

a) The identity of the person who has died
b) The cause of death
c) The circumstances in which the death occurred

8. In this inquest, Joan Hendrickson's identity and cause of death are not issue. My focus relates to the circumstances in which she died. Specifically, I have identified the following issue:

1) Should "JL" have been referred to APATT prior to the 29 April 2006?

9. At inquest, I heard expert evidence from Maria Stickland, RN, RM, MHA, MRCNA. In addition, Dr Hayman, JL's general practitioner and Janet Pywell, Director of Nursing, Sutton Park Assisted Aged Care Facility. In addition, I received a statement from the former Director of Nursing, Tracey Demaio.

Overview

10. Of note, the facility files reveal a high level of care and attention, offered by facility staff and medical practitioners.

[1] Section 67 Coroners Act 2008.

11. However, procedural short-comings existed which resulted in serious communication break-down. Though not causative of death of Mrs Hendrickson, they should not have occurred. The response of the facility to the tragic death of Mrs Hendrickson, reflects its determination to learn lessons and instigate procedural change to ensure risk assessment, management of challenging behaviours and seamless communication reflects best practice.

12. At the time of the incident, Mrs Hendrickson had resided at Sutton Park Dementia Unit for less than 2 months. JL since 2003.

13. In the six month period, prior to the incident, JL's challenging behaviours were escalating.

14. The following excerpts accurately set out the escalation of JL's behaviour:

> *"Was becoming more aggressive and non compliant with medications during November and December (2005), staff documented strategies and interventions have proved effective at the time."* [2]

15. By 21 December 2005 her:

> *"Aggression was increasing in intensity but still controlled with current behaviours."*

16. By late January 2006:

> *"Aggression began to gradually escalate again... by end of February aggression intensified... aggressive pattern continued through April."*

17. On 29 April, 2006 following the incident:

> *"I authorised an APATT referral the following day. RN informed doctor and requested pathology for APATT review.*
>
> *APATT arrived on the 5 May 2006 and I requested JL be removed from the facility indefinitely until she has complete assessment and medication review."* [3]

18. JL was returned to the facility a month later. Unfortunately, her behaviours continued. She left the facility permanently in June 2006.

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2 Document prepared by Tracey Demaio 12 May 2006.
3 Notes of Tracey Demaio 12 May 2006.

Common Ground

19. A review of the facility progress notes of JL supports Ms Demaio's summation above. Ms Pywell provided a helpful catalogue of incidents.[4]

20. Ms Stickland commented:

> *"A review of the listed reported incidents indicates at least one incident per day being reported involving JL, or approximately 4 incidents every 3 days. Of these incidents approximately 45% involved aggressive behaviours.... it is apparent from various documentation sources that incidents involving aggressive behaviours on the part of JL were ongoing.*
>
> *... it is unclear whether any risk assessments were undertaken in response to incidents involving JL, in terms of the risks for other residents. Such an assessment may have resulted in other options being considered e.g., referral of JL to ACATT/APAT or transfer of other residents to another part of the facility (given that most facilities house some residents with dementia in the same unit as residents who are not cognitively impaired.)"*[5]

21. Dr Hayman explained he was unaware of the significant escalation of JL's challenging behaviours in the months leading to the incident. Importantly, had he known the full extent of the behaviours, he would have referred JL to APATT.

22. Dr Hayman considered a referral to APATT would certainly have been appropriate by late March 2006.

23. The topic of APATT referral was never discussed between staff and Dr Hayman.

24. The 2005 accreditation report at the facility notes:

> *"Specialist services are utilised to assist staff in developing management plans for residents whose behavioural disturbances are particularly problematic or distressing."*[6]

25. In Ms Stickland's view, JL's reported incidents involving aggressive behaviour should have led to a referral to APATT. She explained:

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4 Statement of J Pywell
5 Statement M Stickland 16 April, 2010
6 Statement M Stickland, 16 April 2010

"... physical interactions between JL and other residents appeared to have occurred quite frequently and therefore although unpredictable, would not have been unexpected and could have served as grounds for a referral." [7]

26. Ms Pywell acknowledged there was no evidence an APATT referral for JL was considered by facility staff.

Investigation

27. The investigation has revealed the following shortcomings:

1) No co-ordinated approach to the escalating challenging behaviours exhibited by JL from late November 2005 until the incident.
2) Nursing staff and Dr Hayman did not discuss the nature and extent of the risk behaviour exhibited by JL.
3) A referral to APATT should have been made prior to the incident .

28. APATT referral did not occur. It is a matter of speculation to guage what steps APATT would have instigated. It cannot be said that the failure to make an APATT referral was a cause of death of Mrs Hendrickson.

Lessons Learnt

29. An APATT referral should have been made, prior to the incident.

30. Of note, the APATT response to Ms Demaio's referral following the incident was swift.

31. Ms Pywell has spoken highly of the assistance offered by the Geriatric Evaluation Management (GEM) Unit at the Western Hospital. According to Ms Pywell, GEM offers the advantage of a 30 bed therapeutic setting, specifically for aged care residents.

Catalogue Incidents

32. The list of behaviours exhibited by JL is a stark indicator of the gravity of risk an the need for expert assistance.

33. Ms Pywell undertook to create a risk assessment tool, which catalogued incidents of challenging behaviour and/or aggression.

[7] Statement M Stickland 16 April 2010

Leadership

34. In response to my suggestion that JL needed case management, Ms Pywell explained the role of the team leader, instigated since the death of Mrs Hendrickson, fulfils the case management role. To paraphrase her evidence, the RN1 team leader would:

1) Catalogue challenging behaviours.
2) Collate relevant documentation, including behavioural chart, care plan etc.
3) Ensure a resident's general practitioner is fully informed of the nature and extent of the challenging behaviours.
4) Discuss with the general practitioner and if necessary the Director of Nursing and/or Deputy Director of Nursing, appropriate specialist services to be engaged to assist the relevant appropriate strategies e.g. Alzheimers Association, Geriatric Evaluation and Medical Unit, CPAT and/or APATT referral.

35. Ms Pywell gave evidence of uncertainty amongst aged care facilities of the availability and/or criteria for accessing specialist resources to assist risk assessment and management of residents exhibiting challenging behaviours.

36. At my request, the Coroners Prevention Unit (CPU) has investigated the availability of specialist Mental Health Services, available to Sutton Park. Attached hereto a copy of the CPU analysis.

37. As a result of the CPU analysis, I am satisfied that detailed information in respect to APATT is readily available to Aged Care Service providers.

38. I urge the facility management to familiarise itself with the extensive data sources, readily available.

Post Mortem Medical Examination

39. On 3 August 2006, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, examined the death certificate and medical records of the Sunshine Hospital.

40. Dr Bedford formed the opinion that the cause of death was aspiration pneumonia, epistaxis, trauma to the face with contributing factors vascular dementia, permanent pacemaker and hypertension.

41. I thank Counsel for their assistance.

42. I note the apology offered by the facility to the family.

43. I offer my condolences to the family and note the dignified manner in which members participated in the inquest.

44. I take this opportunity to refer to a letter written by Marilyn Miller dated 10 July 2006 to the Coroners Court. She stated:

> *"It was not until Mum was seriously injured that Sutton Park asked for aged psychiatric assessment team to assess the aggressive resident. She was later moved to a psychiatric centre.*
>
> *I feel, because of her aggression, she should have been assessed by APATT at a much earlier date as she was a potential danger to residents and possibly staff."*

45. For the reasons set out in this finding, I endorse the above view of Marilyn Miller.

46. Under the new regime of team leadership, close liaison with medical practitioners, expanded knowledge of criteria and availability of specialist services, appropriate and timely referrals will be made.

47. Further, in frank evidence, Dr Hayman, a general practitioner of vast experience in aged care, explained he now obtains full and accurate knowledge of his patient/residents behaviour.

48. Finally, the role of family members can never be under estimated. As I expressed at inquest not all residents have the luxury of a loving, supportive family as Joan Hendrickson.

Confidentiality

49. The manner in which a resident is managed and behaviours and medical issues pertaining to the resident are of course subject to privacy and confidentiality. However, if the medical condition and/or behaviours of a resident place co-residents at risk, steps must be undertaken to protect co-residents. Further families of co-residents must be fully informed of incidents, which pose risk.

50. I find the cause of death of Joan Hendricksen is aspiration pneumonia, epistaxis, trauma to the face with contributing factors vascular dementia, permanent pacemaker and hypertension.

Signature:

John Olle
Coroner
Date: 8th September, 2010

ATTACHMENT 1

Hendrickson

Background

Coroner Olle completed the inquest for Mrs Hendrickson on 29th and 30th July 2010. Coroner Olle requested the Coroners Prevention Unit to collate information on the mental health services available in the Inner West area of Melbourne, with specific reference to the services available to the Sutton Park Assisted Aged Care Facility based at 126 - 134 Exford Road, Melton South, Victoria.

Data Sources

The Western Aged Psychiatry Assessment and Treatment Team information was sourced directly from:
Kate Shakespeare - Clinical Manager
Western APATT and Triage Service, Sunshine Hospital
176 Furlong Road
St Albans VIC 3021
Tel. 8345 1335
Fax. 9366 8581

The Aged Care Assessment Team was sourced from:

http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/ACAT%20finder

The DBMAS information was sourced from:
http://www.agedcareguide.com.au/facility_details.asp?facilityid=16048

Outcome

The information regarding the local and national specialist mental health and dementia services that are available to the Sutton Park Assisted Aged Care Facility in Melton is attached.

Specialist Mental Health Services available to Sutton Park Assisted Aged Care Facility based at 126 - 134 Exford Road, Melton South, Victoria

Aged Specialist Mental Health Services provided by Western Aged Psychiatry Assessment & Treatment Team (WAPATT)

1. Assessment & Treatment Services

Aged Persons' Mental Health Program
Centralised Triage Service 1300 427 288
Hours of Service: 9.00am to 4.30pm, Monday-Friday
After Hours: Call number above for re-direction to Area Mental Health Service

24 hour a day contact made through:
Psychiatric triage (information, assessment and referral), 7 days a week
Telephone: 1300 427 288

Criteria

- Client is 65 years of age or over.
- Client under 65 years of age has a diagnosed dementia and significant behavioural problems associated with dementia.
- Client lives within Cities of: Melbourne, Moonee Valley, Moreland and Hume; Hobsons Bay, Wyndham, Maribyrnong, Brimbank, Melton and Sunbury; Darebin (Preston area), Banyule, Whittlesea and Nillumbik.
- Client has a mental illness that requires specialist consultation and can not be managed by the person's General Practitioner.

All clients are referred in consultation with the person's GP where possible. The referring GP is required to completed a personal review of the client and undertake preliminary examinations such as an organic screen.

2. Services Specific to Residential aged Care Facilities, including Sutton Park Assisted Aged Care Facility

The Residential Support Program aims to Support current APATT clients with challenging behaviours, whose accommodation is at risk due to their behaviour or persistent psychiatric symptoms and assist staff in Aged Care Facilities to care for APATT clients with challenging behaviours in the least restrictive environment.

Models of care

The Residential Support Program follows a multidisciplinary team approach model of service offering intensive, specialised support around behavioural interventions in Aged Care Facilities. The service is flexible, holistic and client-focused with a strong emphasis on education and the promotion of positive approaches to behaviour management. The service model incorporates the following elements:

- A 'whole team' approach to the client care, ensuring enhanced responsiveness and a range of views in assessment and interventions offered
- Multi-disciplinary input across all stages of assessment and intervention planning
- A specialised, centralised service which is client-focused, efficient and cost-effective, timely, and quick to respond to case managers' identified needs
- Accessible, direct and offers practical face-to-face interventions
- Targeted education sessions which are responsive to the needs of care staff in Aged Care Facilities
- Supportive of Case Managers in their roles with clients
- Assistance with transition of care for clients moving between an Aged Care Facility and an Aged Persons' Mental Health Acute Inpatient Unit
- Promotion of a positive image of Aged Persons' Mental Health, thereby enabling Aged Care Facilities to accommodate residents with challenging behaviours
- A holistic approach, supporting care staff, residents and carers.

Services offered to facilities

- Assessment of environmental, interpersonal and illness factors in behaviours associated with dementia or other psychiatric illnesses
- Individualised and targeted behavioural interventions
- Support to staff in mainstream Aged Care Facilities around challenging behaviours

- Provision of formal and informal Education to Aged Care Facility staff in managing challenging behaviours
- Support and secondary consultation by APATT clinicians.

Admission criteria for the Residential Support Program

- Currently registered APATT client
- Has either a psychiatric illness or is younger than 65 with diagnosed dementia and has behaviours of concern which put their accommodation at risk, and are non-responsive to the Residential Facility's tried interventions.

Note: The behaviours of concern are characterised by persistent cognitive emotional or behavioural disturbance and impact on the safety or well-being of the client, other residents or staff. Examples of such behaviour include:

- Violent or aggressive behaviour that is dangerous to the client or others.
- Extensive and persistent rummaging or wandering which causes considerable distress to other people or danger to the client.
- Other behaviours which make the person difficult to care for in the current environment, or which causes a residential facility to deny admission.

Referral types

- Residential: APATT clients in a Commonwealth-funded Aged Care Facility.
- Psychosocial: Any APATT client who could benefit from short-term, intensive support from a multidisciplinary team to sustain independent community living, where accommodation is considered to be at risk.
- Transitional: A person with a mental illness and behaviours of concern who needs assistance to make a successful transition between an Aged Persons' Mental Health Acute Inpatient Unit and a mainstream Residential Care Facility or vice versa.

Other Aged Specialist Services available to Sutton Park Assisted Aged Care Facility.

1. Dementia Behaviour Management Advisory Service (DBMAS) Victoria

DBMAS Vic National number - 24 hours - 1800 699 799

DBMAS Vic is a 24-hour telephone-based advice and consultancy service that will be available to family, carers and service providers caring for people living with dementia. Service consumers will be able to access expertise in best practice, evidence-based behaviour management strategies, by method of care planning, education and clinical supervision. This service values cultural diversity and is committed to the continuous improvement of service responsiveness and accessibility for consumers of all cultural and linguistic backgrounds.

2. Aged Care Assessment Service (ACAS) - Western

176 Furlong Road
ST ALBANS, VIC 3021 Contact details
Phone: (03) 8345 1246
Fax: (03) 8345 1806

The Aged Care Assessment Service is responsible for assessing clients for some community and all residential placements. If a resident is no longer appropriate for a facility, a request for a review can be made.