IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 1952

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**GREGORY MCNAMARA, CORONER**
Deceased:	**MOIRA MCCARTHY**
Date of birth:	8 April 1928
Date of death:	5 May 2013
Cause of death:	Hypostatic bronchopneumonia complicating fractured occipital condyle and left neck of femur, secondary to a fall
Place of death:	Calvary Health Care Bethlehem, 476 Kooyong Road, Caulfield South, Victoria

BACKGROUND

1. Moira McCarthy was an 85-year-old woman who lived at Brighton East at the time of her death.

2. Mrs McCarthy was a resident receiving a high level of nursing care at Vasey Brighton East, a private aged care residential facility operated by Vasey RSL Care. Vasey Brighton East is a 128 bed facility providing low care (hostel), high care (nursing home) and dementia care.

3. Mrs McCarthy's medical history included dementia, congestive cardiac failure, asthma, hypertension, diverticulitis osteoarthritis, anxiety, depression and left knee replacement. Mrs McCarthy was unable to speak or move and was only able to communicate via touch and facial expression. Mrs McCarthy's daughter Mrs Anne Locco reports that Mrs McCarthy was nonetheless quite alert.

4. Mrs McCarthy required 24-hour nursing care, including the assistance of two staff for all her transfer needs.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Ms McCarthy's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

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

7. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined Ms McCarthy, treating clinicians and investigating officers.

8. I have based this finding on the evidence contained in the coronial brief as well as independent investigations undertaken by this Court. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

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

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

9. On 5 May 2013, Anne Locco visually identified Ms McCarthy's body as being that of her mother Moira McCarthy, born 8 April 1928.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

11. On 7 May 2013, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Ms McCarthy's body and provided a written report, dated 28 May 2013. In that report, Dr Lynch concluded that a reasonable cause of death was '*hypostatic bronchopneumonia complicating fractured occipital condyle and left neck of femur (secondary to fall)*'.

12. Toxicological analysis of the post mortem samples taken from Ms McCarthy identified the presence of morphine.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

13. On 24 April 2013, at approximately 8.25am Mrs McCarthy was being transferred from her bed to a chair by two staff members; personal care attendant (PCA) Omaima (Amy) Abdelbary and personal care attendant (PCA) Hanna Woldeyohannes.

14. Mrs McCarthy had reportedly just been washed and dressed by Ms Woldeyohannes. Ms Woldeyohannes stated she was standing on Mrs McCarthy's left side of the bed next to the window. Ms Abdelbary held the remote control on the bathroom side. The sling was placed underneath Mrs McCarthy's body and connected to the machine. The machine was hooked to the tracking system. The device was activated by Ms Abdelbary via the remote control, elevating the sling and Mrs McCarthy up off the bed.

15. Ms Woldeyohannes stated that as Mrs McCarthy was being lifted up, "*she heard an unusual sound and then looked up and the machine was coming down. The machine was making a 'beem beem beem' sound – this was unusual and I have never heard this noise before. Amy yelled 'take her' and I grabbed Moira in the sling, pulled her towards me and I fell backwards*

as I was unbalanced. I pulled Moira away because I was scared the machine would fall on her head and the machines are heavy. She was still in the sling connected to the machine." Ms Woldeyohannes stated she then lost her balance and Mrs McCarthy fell to the ground, hitting her head possibly on the table first and then the floor.

16. Ms Abdelbary made a short handwritten entry in the patient progress notes at 2.55pm on 29 April 2013. She stated "*Hanna stay[ed] beside the bed. I Stay[ed] beside the bathroom. I start[ed to] lift up the machine and [suddenly I heard sound] 'up normal'. I told Hana you take Moira quickly. The machine fell down on the bed. Moira and Hana were [on] the floor*".

17. Vasey RSL Care care coordinator Aggie Sagin was notified by staff, who in turn notified quality coordinator Kathryn Hunter. Ms Hunter stated she attended the room and found Mrs McCarthy on the floor being attended by the two PCAs who were very distressed. She took both PCAs back to her office leaving other staff members attending Mrs McCarthy. Emergency services were called. Ms Abdelbary and Ms Woldeyohannes were interviewed separately and both made separate statements. Photographic evidence was taken, Worksafe was notified and the Mrs McCarthy's room was secured and locked.

18. Ambulance paramedic Rachel Fisk attended the scene at approximately 9.00 am. She reported Mrs McCarthy was found lying on the ground and had sustained a laceration to the right side of her forehead, upon which pressure was being applied by a Vasey staff member. Ms Fisk reported Mrs McCarthy's left leg appeared to be shortened and rotated, the appearance of which usually indicated a neck of femur fracture.

19. Ms Fiske stated the nursing staff informed her they were using the lifting machine to lift the patient out of the bed and the large box broke from the machine and hit the patient on the right side of the head, which then knocked the patient off the bed onto the ground. Ms Fisk noted "*it appeared from just looking at the lifting machine which was attached to the roof, that something had snapped as there was rope that was still hanging down from the ceiling*".

20. Ambulance paramedic Vanessa Lee stated she was "*informed by staff that the patient had been struck by the lifting machine that had fallen from the ceiling from approximately 1.5 metres. The patient had been struck on the right side of the head and was knocked of the bed onto the floor.*"

21. Mrs McCarthy was subsequently transferred to the Alfred Hospital where it was found she had sustained a left occipital condyle fracture, cervical spine fractures and left frontal cortical contusion. Her injuries were conservatively managed and she was fitted with an Aspen Collar

for twelve weeks. Mrs McCarthy subsequently developed aspirational pneumonia and was transferred to Calvary Health Care Bethlehem for palliation.

22. At 10.20pm on 5 May 2013 Ms McCarthy was pronounced deceased.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Investigation

23. The incident involving Mrs McCarthy was extensively investigated internally by Vasey RSL Care, externally by the Victorian WorkCover Authority and further investigated by a coronial investigator in relation to the equipment used and the relevant work practices at Vasey RSL Care, including staff qualifications, training, work policies, work practices and general facility quality controls.

24. On 24 April 2013, Vasey RSL Care quality coordinator Kathryn Hunter reported she took statements separately from Ms Abdelbary and Ms Woldeyohannes. Vasey RSL Care, quality manager Annette Greenwood reported she was present during a role play to re-create the event.

Lifting machine

25. The machine used in the incident was a Guldmann GH2F Ceiling Hoist 2 Func. Up Down Track Run Loop Hook Belt Drive 200kg, asset number 11652-0003 (Guldmann GH2F). The sling used in the incident was a Guldmann VBEW22.

26. The Guldmann CH2F is a remote controlled, automatic lifting machine which connects to an overhead tracking system. The lifting mechanism appears as a cord running from the ceiling track to a hoist and a spreader bar. The hoist is attached to a spreader bar, which distributes the load evenly. The machine is wheeled into the room, the hoist is connected to the tracking system via a cord to the ceiling with the aid of a hook. The hoist is raised to the ceiling, engaging to the ceiling track using the installation/de-installation mode. A chair-like sling is then placed under the patient and connected to the spreader bar via loops, with the resident's back supported and the part of the sling across the legs is also looped. The device is then switched to the 'lift/lower' mode on the remote control (which has a picture of a patient). This causes a winch like mechanism to raise the sling towards the ceiling hoist.

27. Vasey RSL Care reported the equipment involved had been in use since 2011 and no similar incidents had been reported. The equipment involved was included in the facility's

preventative maintenance program with the most recent inspection being on 4 April 2013, indicating that the equipment was functional.

Independent equipment inspection

28. On 24 April 2013, independent electronics expert Mark Amor from VHHE Mobile Repairs was engaged by Vasey RSL Care to conduct an inspection on the Guldmann GH2F, asset number 11652-0003. Mr Amor reported VHHE Mobile Repairs is engaged to undertake preventative maintenance and repair for Vasey RSL Care as required for a range of mobility equipment including patient lifting devices. Mr Amor reported the machine asset number 11652-0003 had previously been tested on 4 April 2013 by technician Ross Vann De Ven.

29. Mr Amor reported the basic operation of the Guldmann GH2F comprises of essentially two functions; the first is the main lifting function and the second function includes the installation and de-installation of the ceiling hoist from the ceiling track.

30. Upon attending the premises on 24 April 2013, Mr Amor stated he found asset number 11652-0003 was located in Room 96. This room was locked. Mr Amor stated he was instructed not to inspect this equipment pending a Worksafe inspection and investigation. Mr Amor stated he and colleague Andrew Hendy tested other lifting machines in the facility on this day and found all hoists tested were deemed to be safe.

31. On 29 April 2013, Mr Amor re-attended Vasey RSL Care in Brighton East. He reported that upon inspection of the device 11652-0003 he was able to ascertain that the "Emergency Stop" button had not been activated. Mr Amor reported he tested the whole range of functionality and safety features of the machine in question and found all to be functioning correctly. Mr Amor commented that in his experience these particular units are safe. The main issues that would affect the locking mechanism would be the nursing staff catching their plastic gloves into the trolley anchor – but this would not allow the hoist to function due to the built in safety features of the hoist.

32. Mr Amor reported the issue described (that the ceiling hoist had come down from the track on its own without operator input and at a fast rate) could not have occurred with the features functioning correctly. The hoist can only come down from the roof when the hoist handset is in the docking mode. The hoist docking warning alarm will sound which is functional. If the handset is depressed during this time, the hoist will lower from the ceiling as it is designed to do. The hoist is unable to lower whilst in patient transfer mode. The modes are changed on handset via the toggle switch.

33. On 25 July 2013, Vasey RSL Care reportedly informed the installer of the equipment of the incident and reportedly asked for feedback and comments. Vasey RSL Care reported no response had been received at the date of the Vasey RSL Care report writing on 28 August 2013.

34. General Manager of Vasey RSL Care, Janna Voloshin reported that following the investigation by the facility, the cause of the incident remained unclear. Ms Voloshin noted there was no evidence that the incident resulted from the policies or practices at the facility. All staff had received training on the use of the equipment and had been assessed as competent despite not having attended training in 2013 prior to the incident. Both staff had been working with the equipment for eighteen months prior to the incident.

Victorian WorkCover Authority investigation

35. On 24 April 2013, Worksafe Inspectors Andrew Gildea and Stephen Wyley attended Vasey RSL Care to conduct an inquiry into the circumstances surrounding the incident. Included in the investigation were Vasey RSL Care Manual Handling Risk assessment and training documents, statements from Vasey RSL Care nursing and management staff, inspection of the Guldmann VBEW08 asset number 11652-0003 and the Guldmann VBEM22 sling used in the incident. The function of the sling and the hoist was demonstrated by Vasey RSL Care staff Aggie Sangin and Vasey General Manager Joanna Voloshin and found to be in working order.

36. Worksafe inspectors noted that the Vasey RSL Care 'sling audit sheet' did not identify individual slings and the sling register was undated. Inspectors reported if the slings are not inspected and maintained on a regular basis, and the age of the patient slings is not monitored, serious injury could result to the patient and further that failure to have a safe work system for the inspection and maintenance of patient slings contravened Section 23(1) of the *Occupational Health and Safety Act 2004.*

37. On 30 April 2013 Worksafe provided a Worksafe Entry Report (V01021700720L) on the outcome of its investigation and issued an Improvement Notice V01021700720L/111-01 pursuant to Section 111(1) of the *Occupational Health and Safety Act 2004.*

38. On 18 July 2013 Stephen Wyley, Worksafe inspector, provided a statement on the investigation conducted into the circumstances surrounding Mrs McCarthy's fall and subsequent injury.

39. Mr Wyley reported he established that only one of the staff involved with the transfer had undergone training in the use of the ceiling hoist, the sling had not been connected properly at the legs allowing Mrs McCarthy to slip out of the sling on to the floor and that the hoist had been tested independently and found not to have any faults.

40. On 22 August 2013 Vasey RSL Care identified some inconsistencies in the Worksafe report. Firstly, the neck of femur fracture was found not to have been sustained on 24 April 2013. Secondly, the allegation that the sling was incorrectly attached around Mrs McCarthy's legs allowing her to slip from the harness was not found to be substantiated by any staff member present. Thirdly, that the PCAs accounts both stated the incident occurred when the hoist descended rapidly from the ceiling, not from an incorrectly fitted sling.

41. Vasey RSL Care noted the outcome of the Worksafe report which indicated that equipment failure was not identified as a factor in the incident. Vasey RSL Care further noted that this conclusion disregarded the evidence provided by the PCAs who claim that during the use of the machine it descended rapidly towards Mrs McCarthy.

Employee qualifications and training

42. Vasey RSL Care employment records indicate Ms Abdelbary had completed a Certificate III in Aged Care Work in 2008. She had further completed Manual Handling Competency Training on induction to the facility in 2009, again on 5 May 2010 and after the incident on 6 May 2013.

43. Ms Woldeyohannes had completed a Certificate III in Community Services (Aged Care Work) in 2003. She had further completed Manual Handling Competency Training on induction to the facility in 2008, O'Shea No Lift training in May 2009 and September 2009 and after the incident in May 2013. Ms Woldeyohannes stated she was instructed on the use of the Guldmann GH2F on her return from maternity leave.

Vasey RSL Care Manual Handling Policy and Procedures

44. General Manager of Vasey RSL Care, Susan Marsenic, provided information on the facility's manual handling policy and procedures. Vasey RSL Care employs manual handling systems of work to transfer residents requiring a high level of care from their beds. The procedures are detailed in the Manual Handling Procedure and associated documents including; Vasey RSL Care Clinical Manual Handling Training for Residential Staff and Clinical Manual Handling Training for Supervisory / Team Leader Staff. This system is communicated to employees via

annual manual handling training, and at the time of commencement of employment during induction. The procedure and associated documents are available at all times through the electronic document control system.

45. The associated documents include but are not limited to:

- Applying a sling for a resident transfer in lying;
- Applying a sling for a resident transfer in sitting;
- Applying a sling to the lifting machine; and
- Transferring the resident with an overhead tracking system.

Vasey RSL Care, Clinical Manual Handling Training for supervisory / Team Leading Staff (approved February 2012 VRSLC version 1)

46. Vasey Staff training manual page 26 of Form no 32-04 provides instructions for transferring the resident with an overhead tracking system and requires the carer to be able to identify four cases of the hoist not functioning:

- Emergency cord has been pulled and yellow tag needs to be pushed in;
- Battery is flat;
- Hoist has not been locked into overhead tracks correctly; and
- Hoist strap is at an angle, not vertical.

47. Correct attachment of hoist to overhead tracks is demonstrated by the following:

- Uses long handled reacher to pull tracking cord down from ceiling if it is too high;
- Inserts metal dongle on tracking cord into the hoist by unlocking the opening;
- Switches the hoist control to tracking picture (machine will beep);
- Guides hoist out of storage trolley as it is raised to the roof using the hoist control, awaits extended beep to indicate hoist is locked into the overhead tracks;
- Switches the hoist control to the patient picture (beeping will cease).
- Correct removal of hoist from overhead tracks:

- Hoist bar raised to ceiling;
- Switches the hoist control to tracking picture (machine will beep);
- Guides hoist (including bar) into the storage trolley as it is lowered from the roof using the hoist control;
- Switches the hoist control to the patient picture (beeping will cease);
- Removes tracking cord from hoist by unlocking the insertion point; and
- Gently tugs and releases tracking cord so that it retracts into overhead system and is not left hanging below head height.

Vasey RSL Care Response to the incident

48. In response to the Worksafe Improvement Notice Vasey RSL Care reported the facility has implemented various compliance procedures and initiated actions to ensure patient slings are inspected and maintained on a regular basis. Training was also conducted for staff to ensure they are familiar with the relevant recording procedures. Vasey RSL Care reported the following improvements have now been implemented:

    - A Worksafe approved sling register is now maintained which includes the purchase date of the slings, the due date for replacement of the slings and all slings are marked with identification numbering;
    - All slings will be replaced at the end of their five year life expectancy or earlier if they do not pass inspections and a sling replacement program will be implemented as part of the 0213 -2014 planning process;
    - A process has been established whereby all slings are inspected as a part of the hoist preventative maintenance program;
    - A procedure has been created to instruct staff on the maintenance of the sling register and training associated with that procedure; and
    - On 6 June 2013, as a result of the changes implemented to Vasey RSL Care policy and procedures, the Improvement Notice issued by WorkSafe was lifted.

Equipment and site inspection by Coroners Court of Victoria (CCOV)

49. On 6 April 2016, a coronial investigator and CCOV staff attended Vasey RSL Care, Brighton East in order to test the lifting equipment involved in Mrs McCarthy's care. The lifting machine 11652-0003 was demonstrated in the presence of Vasey RSL Care Chief Executive Officer, Quality and Risk Manager, a registered nurse and two other staff.

50. Observers reported it was evident that when someone is lying on the bed waiting to be lifted up they are effectively weightless according to the machine so no safety mechanisms are activated at that time.

51. It was evident to the observers that it was possible that if the controller was switched to the wrong button (that is mobilising the hoist from the roof rather than the patient) if someone pressed the up (to lift up), beeping would occur and the machine would commence lowering from the roof ready for uninstallation. It lowers reasonably quickly.

52. It is also plausible that if the button on the controller was accidentally switched on to the wrong mode when someone went to press up to lift a patient, the machine head in the roof could lower down to the bed and make beeping noises preparing for uninstallation and that this could conceivably cause panic in the user.

53. Coronial investigators subsequently requested further information from the independent investigator VHHE Mobile Repairs. Namely, what tests did VHHE Mobile Repairs conduct when testing the whole range of functionality with asset number 11652-0003? Secondly, did they test the process tested by CCOV staff; that is when the toggle switch is set to the de-installation setting and the raise button depressed whilst the hoist is attached to the ceiling with the lifting hanger attached to the sling on the bed?

54. On 15 April 2016 Mr Amor provided a response to the CCOV on those points raised. Mr Amor reported the initial testing included the standard tests conducted with all hoist products including:

- A check and test of the handset function – Up and Down for both main lift and installation/de-installation functions.

- Check and test installation/de-installation - Connect hoist to pulley and test installation to ceiling then reverse function for de-installation;

- Check and test emergency function – check function in all modes to confirm working status including installation/de-installation stop and start;

- Load test hoist – check all functions as listed above under the load to confirm correct operation;

- Test battery and charger function – Check output under load; and

- Visual inspection – Check hoist for any signs of damage.

55. Mr Amor reported that while the hoist is in installation/de-installation mode, if either button up or down is depressed the mode will activate. This means that if the hoist is 'installed' to the ceiling, the hoist will begin the de-installation process when either button is pressed. Further, the user guide states that to activate this function requires the user to press the Down button and omits any reference to pressing the Up button.

56. However, once entering the installation/de-installation mode, the hoist function is to either install or de-install regardless of the option of pressing up or down. It is fundamentally logical to press down to lower the unit hence the trepidation of staff when pressing the up button de-installs the hoist.

57. Mr Amor accepts it is plausible to accept the user of the hoist may have pressed Up however the audible tone would have been sounding at this time indicating the incorrect mode was selected for lifting a patient. After pressing the button, a further press of either up or down buttons would have stopped the hoist from lowering as is the function of the hoist.

Conclusions

58. It is apparent that the lifting machine Guldmann GH2F Ceiling Hoist 11652-0003 was in safe working order on the day of the incident involving Mrs McCarthy. The Guldmann VBEW22 sling was also found to be in safe working order.

59. Allegations by WorkSafe that the sling had been incorrectly applied and connected were unable to be substantiated. Staff involved were tested and subsequently demonstrated correct sling application immediately after the incident. However, regardless of the correct attachment, Mrs McCarthy nevertheless did become separated from the sling, in all probability as Ms Woldeyohannes hastily pulled her sideways and away from the descending hoist.

60. As Mr Amor reported, the basic operation of the Guldmann GH2F Ceiling Hoist comprises of essentially two functions; the first is the main lifting function and the second function includes the installation and de-installation of the ceiling hoist from the ceiling track.

61. The hoist can only come down from the roof when the hoist handset is in the docking mode (installation/de-installation mode). Upon descent, the hoist docking warning alarm will sound. If the handset is depressed during this time, the hoist will lower from the ceiling as it is designed to do. The hoist is unable to lower whilst in patient transfer mode (Lift/Lower mode). The modes are changed on handset via the toggle switch.

62. Subsequent investigation has established that whilst the hoist is in place at ceiling height and the patient sling connected ready for lifting, the hoist will still descend whilst beeping once the up button is depressed only if the toggle is in the installation/de-installation mode, and that this cannot occur in patient transfer mode.

63. There is no evidence available to firmly establish the cause of the incident. It is a plausible explanation that Ms Abdelbary omitted to change the toggle switch from docking mode to patient transfer mode prior to pressing the Up button. This explanation does provide an answer as to the beeping noise described by the two witnesses, Ms Abdelbary and Ms Woldeyohannes. The lowering of the hoist would normally take place once the sling had been disconnected from the spreader. It is possible that the connection may account for the 'unusual sound' occurring at the start of the lift, such as that described by Ms Woldeyohannes.

64. In such circumstances it is difficult to find fault with the Guldmann GH2F Ceiling Hoist operating procedures. A fundamental function of the machine is the disengagement of the hoist from the ceiling track after use to enable it to be stored and moved from patient to patient.

65. Vasey RSL Care has acted in the aftermath of the incident, by providing staff with additional training on manual handling and the use of the ceiling hoists. Vasey RSL Care reported the facility has also implemented improvements to equipment management processes as a result of which the WorkSafe Improvement Notice was lifted.

66. I am informed by the Victorian Work Cover Authority that in response to this incident and the improvement notice issued the following Procedure 116 Inspection and Maintenance of Lifting Slings has been implemented, relevant training materials have been updated and staff have been made aware via a memo from the General Manager, Residential Services.

RECOMMENDATIONS

67. I make a recommendation to HLS Healthcare, the Victorian supplier and distributor of the Guldmann GH2F Ceiling Hoist, to notify the manufacturer in relation to a possible design review of existing safety features within their ceiling hoist product range in light of the circumstances of Mrs McCarthy's death.

FINDINGS AND CONCLUSION

68. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Moira McCarthy, born 8 April 1928;

    (b) the death occurred on 5 May 2013 at Caulfield South, Victoria, from hypostatic bronchopneumonia complicating fractured occipital condyle and left neck of femur, secondary to a fall; and

    (c) the death occurred in the circumstances described above.

69. I convey my sincerest sympathy to Ms McCarthy's family.

70. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

    (a) Mrs Anne Locco, senior next of kin.

    (b) Vasey RSL Care.

    (c) WorkSafe Victoria.

    (d) Aged Care Complaints Commissioner.

    (e) HLS Healthcare.

    (f) Sergeant Benjamin Deppeler, Victoria Police, Coroner's Investigator.

Signature:

GREGORY MCNAMARA

CORONER

Date: 30/5/17