IN THE CORONERS COURT
OF VICTORIA
AT SOUTHBANK

Court Reference: COR 2008 002860

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of PETER KOSCIUK

Delivered On:	13 February 2013
Delivered At:	Melbourne
Hearing Dates:	12/04/2012 and 08/02/2013
Findings of:	Iain T West, Deputy State Coroner
Representation:	Mr R. Harper on behalf of Aged Care Services Pty Ltd Mr R. Gibb on behalf of Nurse J. McIlwaine Ms F. Cockram on behalf of Dr Mendis
Police Coronial Support Unit:	Sergeant D. Dimsey

I, Iain Treloar West, Deputy State Coroner, having investigated the death of PETER KOSCIUK

AND having held an inquest in relation to this death on 12/04/2012 and 08/02/2013

at Melbourne Coroners Court

find that the identity of the deceased was PETER KOSCIUK

born on 15 November 1924

and the death occurred on 9 May 2008

at LATROBE REGIONAL HOSPITAL, PRINCES HWY, TRARALGON 3844 VIC

from:

1a. Aspiration pneumonia	1 week
1b. Stroke	More than 10 years
2. Type 2 diabetes mellitus	5 years
Congestive cardiac failure	4 years

in the following circumstances:

1. Peter Kosciuk was an 83 year old male and a resident of Grandridge Lodge, a unit for high care residents of Mirboo North Aged Care. He was admitted on the 9th October 1995, following a cerebrovascular accident (stroke) which prevented him from returning to his home. Secondary to his stroke he suffered dementia, contractures in the right arm and leg and swallowing problems. In addition, Mr Kosciuk had chronic pain, communication problems, congestive cardiac failure, angina, hypertension and Type 2 diabetes. By reason of his condition Mr Kosciuk spent most of his time in bed, or in a special chair. Dr Duleep Mendis, the General Practitioner affiliated with the nursing home, was responsible for his medical care and had treated him since July 2002
2. Mr Kosciuk was of Polish background and was married in 1946. He and his wife Sophie had two sons, Edward and John and he enjoyed an active life with work as a security guard and in addition, he enjoyed gardening, cooking and football. Mrs Sophie Kosciuk died in August 2005, however, prior to her death, she spent most days with her husband at Grandridge, giving him meals and communicating with him in an attempt to assist staff. His Polish cultural background presented some difficulties for his health providers in relation to communication, as he was unable to speak or understand English for the majority of the time. Whilst he appeared to understand basic commands, he had limited verbal communication due to his medical condition, making it even difficult for his family to understand much of what he said.
3. On the 1st May 2008, Nurse Chris Griggs (RN Div 1) was alerted by a colleague at approximately 8.30 am, that Mr Kosciuk was having trouble swallowing his breakfast. Apparently he had spent an uneventful night, however, whilst having his breakfast porridge, it dribbled out of his mouth, with very little being swallowed. Part of his management plan included staff supervising his intake with all his meals and drinks. Nurse Griggs was sufficiently concerned about his change in condition to ring the doctor's clinic, which she did at 8.30 am, leaving a message requesting Dr Mendis' attendance and review. In the message she stated that Mr Kosciuk was not well, was not swallowing and

she may also have queried the possibility of a stroke. She subsequently also left a message for Ed Kosciuk and spoke by phone to John Kosciuk. (At approximately 10.30 am, Ed Kosciuk contacted the nursing home and was updated by Nurse Linda Hillman (RN Div 1). Further updates were sought by him later in the day.)

4. At approximately 10.10 am, Dr Mendis attended and undertook a 20 minute examination of Mr Kosciuk. Nursing staff conveyed the history of difficulty swallowing, that he was refusing to eat or drink and the possibility of a stroke was discussed. Dr Mendis noted that he was alert, afebrile, with a respiratory rate of 18. On auscultation the right lung base had crepitations and he thought that he might have been mildly dehydrated. Central nervous system examination showed no appreciable change, with Dr Mendis concluding that he had not suffered a stroke and that his general changed condition could be attributed to a right sided chest infection. Dr Mendis diagnosed a chest infection with a treatment plan for the administration of antibiotics, an intramuscular injection of penicillin, the performance of full blood examinations and urine test, and review by him as necessary. He believed hospitalization was not required at that stage and that the appropriate course was to keep Mr Kosciuk in the nursing home, to try to push fluids and to see if there was improvement over a 12 hour period.

5. Nursing staff, particularly Nurse Griggs, arranged review of Mr Kosciuk's swallowing difficulties by a speech pathologist, with this occurring later in the day due to problems of availability. At approximately 1.00 pm, Mr Kosciuk was spoon fed thickened Milo over a forty minute period, however, he refused lunch. Nurse Jennifer McIlwaine (RN Div 1), who had come on duty at 3.00 pm and after receiving a handover from Nurse Griggs, found no evidence of respiratory distress, dribbling or coughing, but on believing Mr Kosciuk was experiencing some pain, arranged for morphine to be given at 4.00 pm. The speech/swallowing assessment was commenced by Ms Jane Taylor at 4.45 pm and took approximately one hour, with her finding that Mr Kosciuk had a very poor swallowing reflex and no gag reflex and that this dysphagia, placed him at risk of choking with a normal diet. Accordingly, she recommended a smooth pureed diet with extremely thick fluids. It was further recommended that Mr Kosciuk sit upright as much as possible, his medications be crushed in thickened fluid and that staff follow oral care protocols. (Subsequent attempts to administer his crushed medications in thickened fluid failed, as he made no attempt to swallow. There appears to be contradictory evidence in the Progress Notes, however, that they were given at 6.00pm.) In addition, full supervised feeding was necessary, with suction on standby and she suggested there be consultation between Dr Mendis and the family, to discuss the possibility of PEG tube (percutaneous endoscopic gastrostomy) feeding, or palliation. Subsequently, she was able to speak to Dr Mendis when he rang the nursing home enquiring about Mr Kosciuk. Nurse McIlwaine contacted both sons to provide an update of their father's status, with this occurring some time before 6.00 pm. John Kosciuk attended the nursing home at approximately 8.00 pm and requested ambulance transfer to hospital. Nurse McIlwaine told him that she was reluctant to send his father at that hour, as he would require to be fully assessed prior to admission and he would spend most of the night on a trolley in the A&E Department. She then attempted unsuccessfully to contact Dr Mendis, leaving a message on his phone for his input. Nurse McIlwaine then took a call from Edward's wife who was insistent on hospital admission, due to her concerns regarding dehydration. Nurse McIlwaine had not been concerned about Mr Kosiuk's hydration levels, as he did not look dehydrated, he had been incontinent of urine during the shift and she was told that he had taken some fluid earlier in the afternoon.

6. Following further family insistence and on not hearing from Dr Mendis, Mr Kosciuk was transferred at approximately 10.00 pm to Latrobe Regional Hospital, where he was admitted shortly before 11.00 pm. Examination found he was dehydrated, had a chest infection believed to be due to aspiration pneumonia and a Glasgow Coma Score of 8. He

was commenced on intravenous antibiotics and speech pathologist review was arranged the following day. Despite appropriate investigations and ongoing management over several days, Mr Kosciuk's condition continued to deteriorate and palliative care was implemented. Mr Kosciuk subsequently died on the 9th May 2008, with family members present. A natural causes death was certified, with the cause of death being aspiration pneumonia. No autopsy examination was undertaken.

7. The death was reported to the coroner by the Victorian Office of the Department of Health and Ageing. During the course of investigating the circumstances surrounding the death, letters were received from the family, raising concerns regarding Mr Kosciuk's management whilst a resident at Mirboo North Aged Care facility. No concerns were raised regarding management following transfer to the La Trobe Hospital.

COMMENTS

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

8. In so far as the evidence permits, I am not satisfied that all nursing home staff provided care within the parameters of reasonable health care management. The qualification is due to the paucity of entries in the Total Care Progress Notes regarding monitoring of and care attendance upon Mr Kosciuk, following his medical review. No formal nursing assessment was put in place. Nevertheless, aspects of management were appropriate. The need for review was recognized and acted on in a timely manner, thereby ensuring an early assessment by Dr Mendis. An appropriate history was given and examination undertaken, which led to an uncontradicted diagnosis of chest infection. A conservative management plan was put in place by Dr Mendis, aimed at pushing fluids in order to address hydration and to then reassess Mr Kosciuk's condition after 12 hours. I am satisfied that it was a reasonable to initially manage Mr Kosciuk in the nursing home environment, in the light of the diagnosis, his background of medical issues and age. I accept Dr Mendis' evidence that maintaining patients in a familiar environment with familiar staff around them, usually minimizes stress levels and makes management somewhat easier. It was appropriate for the nursing staff to rely on the doctor's assessment that ongoing management be continued at the nursing home, a plan that appears to have been adopted also by the speech pathologist. However, I find it surprising, that Dr Mendis made no order requesting speech pathologist assessment of Mr Kosciuk, with this fortunately being initiated by Nurse Griggs. The order should have been made by the treating doctor, knowing that his patient would be at risk of dehydration (hence the need to push fluids) and being aware of his dysphagia disorder. Nor am I satisfied that he acted sufficiently to ensure that Mr Kosciuk would remain adequately hydrated throughout the 12 hour monitoring period. There is no evidence of any recorded hydration maintenance undertaken by nurses over this period, an omission that is indicative of sub optimal care. Regularly recording hydration maintenance should have been a priority, given Mr Kosciuk's age and presenting medical conditions. On examination following his admission to the Emergency Department of the Latrobe Hospital, Mr Kosciuk was found to be "clinically dehydrated". This was not recognized at the nursing home.

9. A major concern for the family was the failure of nursing home staff to arrange earlier transfer of Mr Kosciuk to hospital. A number of requests were made, however, they were not acted on, despite both sons having medical power of attorney, recorded with the nursing home. It appears the family formed the view that transfer was necessary believing that their father would be at significant risk of dehydration. I accept that it was reasonable for the staff not to act immediately on these request, but to do what they did, that is advise

the family what the doctor and the speech pathologist recommended. As the family persisted in their request, transfer should have occurred earlier in the evening and not only after further requests and the threat of taking him to hospital themselves. Nevertheless, there is no evidence to suggest that a more timely transfer would have changed the tragic outcome. Nor is there evidence to suggest that Mr Kosciuk would have suffered less, had he been in a hospital environment. The attending ambulance officers arranging the transfer, recorded in their examination history whilst at the nursing home, the patient "doesn't appear distressed".

10. The evidence fails to satisfy me that the family were appropriately kept informed of their father's condition and progress on the 1st May, 2008. Importantly, they were told Mr Kosciuk had difficulty swallowing, however there is contradictory evidence as to what they were told, was the cause. Where there are discrepancies in the evidence given by family members and nursing home staff as to what was said during various phone conversations, I prefer the evidence of the family. Each family member remained adamant in their recollection, despite competent cross examination. In addition, these were not routine enquiries from the family perspective, but were made out of genuine concern for the well being of a loved one. In such circumstances, I believe there would be a greater focus on what was being said and hence recollection of the conversation, than the recollection of the person conveying what might be considered from their perspective, routine information. Accordingly, I accept the evidence of Mr John Kosciuk that he was told his father had suffered a small stroke and that he did not raise or suggest that possibility. I accept the evidence of Mr Ed Kosciuk that he was never advised his father was suffering a chest infection, despite numerous calls to the nursing home and further, he did not enquire as to whether his father had suffered a TIA, or stroke. I also accept the evidence of his wife, Mrs. Alena Kosciuk, that when ringing and insisting that her father-in-law be transferred to hospital because of hydration concerns, she was told this was not possible due to the hospitals being on 'bypass'.

11. A further discrepancy in the evidence relates to whether or not Dr Mendis told one of the nurses, that Mr Kosciuk may have suffered a TIA , but that it had resolved. As the allegation of it being said was not categorically denied by Dr Mendis and as there is a contemporaneous note to that effect in an entry in the Progress Notes made by the nurse, I am satisfied it was said by Dr Mendis.

12. The ACSAG only commenced operating the Mirboo North facility a few weeks before Mr Kosciuk's death and have since implemented staff training programs and processes for auditing compliance with its operating policies and procedures. An experienced nurse educator is responsible for the ongoing education program, with staff assessed to confirm an understanding of training material.

    The facility, in common with all aged care facilities, is subject to review by the Aged Care Standards and Accrediation Agency and in addition, the ACSAG has a Quality Care Team which attends on a regular basis to audit compliance with its policies and procedures.

    The hospital transfer policy in place in May 2008 was that of the Mirboo North Community Centre, (the operator prior to ACSAG acquiring the facility) and was part of its 'Medical Treatment for Residents" policy. It has been replaced by ACSAG's 'Acute Illness Flow Chart,' which ensures the resident receives appropriate intervention and observation prior to medical practitioner assessment and/or hospital transfer. It updates and refines the previous policy and is aimed to emphasize to staff, the requirement to keep the resident's family informed of decision making and treatment plans when the resident is acutely ill and to make appropriate notations in the progress notes. Staff have also received further education from various sources about documentation and accountability.

RECOMMENDATIONS

I do not believe it is necessary to make recommendations in this case, as I am satisfied Aged Care Services Australia Group (ACSAG) have addressed the issues highlighted in the inquest.

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

Family of Mr Peter Kosiuk

Dr Duleep Mendis

RN Jennifer McIlwaine

Ms Julie Reed, Executive Director, Aged Care Services Pty Ltd

Facility Manager Mirboo NorthAged Care

Medical Director, Latrobe Regional Hospital

Coroners Court of Victoria

Signature:

Iain T West

Date: 13 February, 2013