IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2006 0650

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: STEPHEN WILLIAM SUMMERS

Delivered On:	5 June 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	2 and 5 May 2011
Findings of:	JANE HENDTLASS, CORONER
Representation:	Ms E. Porter appeared on behalf of the Department of Human Services Ms P. Chatfield appeared on behalf of St Vincent's Hospital
Police Coronial Support Unit	Sgt D. Dimsey appeared to assist the Coroner

I, JANE HENDTLASS, Coroner having investigated the death of STEPHEN WILLIAM SUMMERS

AND having held an inquest in relation to this death on 2 and 5 May 2011

at MELBOURNE

find that the identity of the deceased was STEPHEN WILLIAM SUMMERS

aged 55 years

and the death occurred on 17 February 2006

at St Vincents Hospital, Victoria Parade Melbourne 3000.

from:

1 (a) STAPHYLOCOCCAL SEPSIS

1 (b) COMPLICATIONS OF PRESSURE SORES AND HYPOSTATIC PNEUMONIA

1 (c) CEREBRAL PALSY

in the following circumstances:

1. Stephen William Summers was 55 years old when he died. He suffered from cerebral palsy associated with muscular spasticity, profound intellectual and physical disability, osteoporosis and left eye blindness.

2. Mr Summers was a registered client of Disability Accommodation Services North and West Metropolitan Region of the Department of Human Services.

3. Mr Summers moved around on his bottom or walked using a walking frame but he used a wheelchair for community access.

4. Although he could not walk alone, Mr Summers was usually a very active person. His sister told the Court that:

   "It wasn't very restful when you were with him because he was constantly on the move wanting to do something or go somewhere."

5. Mr Summers had lived at Kew Residential Services at 24-45 Fountain Court in Kew (also known as "Kew Cottages") since he was 12 years old.

6. Mr Summers knew his name and recognised his carers but he was unable to communicate verbally and required full assistance with all day-to-day living and personal care. He had no

challenging behaviours but he enjoyed a lot of 1:1 attention and would sometimes tip over furniture if he felt ignored.

7. On 16 November 2005, Mr Summers and three other residents of Kew Cottages moved to Banksia House which is a Community Residential Unit at 24 Banksia Grove in Tullamarine ("Banksia House") as part of the Victorian Government's long-term strategy to close Kew Cottages by April 2008, deinstitutionalise long-term disability clients and integrate them better into the community.[1]

8. Mr Summers' physical health deteriorated rapidly after he moved to Banksia House. He became lethargic, stopped eating as well as he had previously, expressed dissatisfaction by tipping over chairs, lost the capacity to stand alone and, by 4 February 2006, he had developed pressure sores.

9. On 9 February 2006, Mr Summers was transferred to St Vincents Hospital by ambulance. His condition continued to deteriorate.

10. The Incident Report Form created on 10 February 2006 indicated that the Department of Human Services did not initiate an investigation into the reasons for Mr Summers' deterioration and transfer to hospital.

11. On 17 February 2006, Stephen Summers died.

12. The forensic pathologist who inspected Mr Summers' body was of the opinion that a reasonable cause of death in the circumstances might be formulated as *Staphylococcal* sepsis, complications of pressure sores and hypostatic pneumonia and cerebral palsy.

13. Accordingly, I find that Stephen Summers died from *Staphylococcal* sepsis, complications of pressure sores and hypostatic pneumonia and cerebral palsy.

14. In the absence of an autopsy, I am unable to say whether he also suffered from a longer-term illness that caused his weight loss commencing in October 2005.

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[1] See, for example: Family & Community Development Committee, Parliament of Victoria, *Inquiry into Supported Accommodation for Victorians with a Disability and/or Mental Illness*, December 2009; L. Young & A.F. Ashman, *Deinstitutionalisation in Australia Part II: Results from a Long Term Study*, Brit. J. Developmental Disabilities, 50 (2004) 29-45; C. Rigby, B.K. Cooper & K. Reid, *Making Life Good in the Community: measures of resident outcomes and staff perceptions of the move from an institution*, Department of Social Work and Social Policy, La Trobe University, Melbourne, May 2012.

15. This Finding will review Mr Summers' management at Kew Cottages, transition to community residential accommodation and services, management at Banksia House and treatment at St Vincents Hospital.

16. It will then comment and make recommendations intended to prevent further deaths occurring for the reasons that Mr Summers died.

Kew Residential Services

17. Mr Summers lived in Unit 24 at Kew Residential Services (also known as "Kew Cottages") for 44 years in a cottage with with eight other men who also had severe disabilities.

18. The Smorgan Health Clinic was on site so that clients could be easily reviewed during the day. They also had an inpatient capacity but, at night, they relied on locum medical services.

19. Louise Stastnik and Ulrich Kuhlman shared Mr Summers' case management.

20. Maria Tzouritis was Mr Summers' direct care provider for four years at Kew Cottages. She held a certificate in disability management and had undergone training provided by the Department of Human Services.

21. Patricia Paterson was Mr Summers' physiotherapist and Jenny Sedgman was his physiotherapy aide. They both knew Mr Summers well. Ms Paterson explained to the Court:

"I knew Stephen for 23 years. I've been at Kew since 1983 and I've known him since then."

22. Ms Sedgman noted that, although he usually used a wheel chair only for community access, he would steal other peoples' wheelchairs and propel himself around or abscond. However, he usually walked using a walking frame or behind an assistant. She also noted:

"He is very fond of food and will not leave the kitchen if thinks he can get more food."

23. Mr Summers' family visited Mr Summers at Kew Cottages on special occasions such as his birthday and Christmas. They had visited more often when Mr Summers' parents were alive and had always been very happy with his care and his physical state.

24. Mr Summers was not on any medication at Kew Cottages and, other than the occasional cold or flu, he was pretty healthy.

25. In particular, as a younger person, Mr Summers' weight varied between over a range of up to 13kg in any one year. For example:

- In May 1986 he weighed 33.5kg. In June 1987, he was 43kg.
- In April 1988, he weighed 38 kg. In October 2008, he weighed 45.5kg.
- In February 1991, he weighed 50.8kg. In February 1992, he weighed 39.25kg.

26. Mr Summers did not have any history of pressure sores while he was at Kew Cottages.

Transition to Community Residential Accommodation

27. On 1 May 2005, Mr Summers was assessed at the Smorgan Health Centre. He weighed 39.9kg and no change was recorded for the last three months. This weight was considered acceptable.

28. In 11 July 1995, plans commenced to move Mr Summers to Community Residential Accommodation.

29. After a period of consultation, the Resident Assessment, Consultation and Planning Team determined that Mr Summers would be most appropriately placed at a Community Residential Unit at 24 Banksia Grove in Tullamarine with 4-6 other adults.

30. These de-institutionalisation arrangements also required the residents to start accessing community services:

- Mr Summers began participating in a day program at the Carinya Society in Coburg ("Carinya") for 12 hours a week.
- Mr Summers' case managers at Kew Cottages transferred Mr Summers' medical care from Dr Rice at the Smorgan Health Centre to the general practice at Tullamarine Medical Clinic in Gladstone Park and provided them with Mr Summers' case notes.

- Mr Summers' case managers also arranged occupational therapy and other allied health services with Dianella Allied Health Services in Broadmeadows and provided them with Mr Summers' case notes.

- Ms Paterson told the Court is was difficult to find any physiotherapist in the community who could provide relevant services.

31. On 31 July 2005, Mr Summers' sisters attended an afternoon tea at Mr Summers' future home. They would have preferred him to live near them in Sunbury so he was placed on a waiting list for accommodation nearer his family when it became available.

32. On 1 August 2005, Mr Summers' health and needs were extensively reviewed by Kew Cottages direct care staff, Ms Sedgman and Lucy Ryan from Carinya.

33. They noted that Mr Summers was an energetic man who kept to himself and tended to interact with other residents only when they had something that he thought belonged to him.

34. Mr Summers was non verbal but Kew Cottages staff who knew Mr Summers prepared a Communication Dictionary to assist his new carers to understand him.

35. In this Communication Diary, Mr Summers' Kew Cottages carers advised that he enjoyed a lot of 1:1 staff interaction and, unlike his communication with other clients, he interacted with staff with whom he had established relationships. He communicated with facial expression or gestures and would laugh or smile when he was happy. He would also communicate by holding a staff member's hand to gain their attention and indicate he wanted something. He would tip over chairs and tables when he was seeking attention but this behaviour was not associated with property damage.

36. Further, Mr Summers was able to understand staff requests and could follow one step instructions. He could make day-to-day choices relating to movement (for example, he preferred to use his wheel chair), his food and drinks and whether or not he wanted to participate in activities. However, Mr Summers could not communicate sufficiently to indicate whether or not he understood the concept of moving to Banksia House and could not nominate the people he wanted to live with.

37. From a health perspective, Mr Summers ' health was recorded to be generally good and he was taking no medication. However, he was noted to have bad circulation and sitting for

more than 15 minutes resulted in his feet swelling. He weighed 42.98kg which was below his health weight range and house staff were advised to monitor him for sudden weight decrease. He did not need regular appointments with Ms Sedgman but he needed to be kept walking using his orthopaedic boots and his frame to ensure his mobility did not further decline.

38. By 11 September 2005, Mr Summers' weight had declined to 42.28kg and Kew Cottages staff noted he was not eating well. Dr Rose thought he could have a gastric upset. He also examined Mr Summers' right ear and prescribed Otodox drops to treat his possible infection.

39. On 12 September 2005, the Deputy Unit Manager at Kew Cottages prepared Mr Summers' Individual Program Plan. This plan included purchase of items for his new bedroom and being involved in making afternoon tea. He would also be given more opportunities to interact with peers and staff.

40. In 26 October 2005, Mr Summers seemed unwell late in the morning although he had eaten breakfast well. He underwent a chest x-ray at St George's Hospital and was diagnosed with right lower lobe pneumonia. Mr Summers was prescribed antibiotics and admitted to the Smorgan Health Clinic for two days. By then his condition had returned to normal. On 3 November, a further x-ray confirmed his chest was clear.

41. On 3 November 2005, Mr Summers began a two weeks transition program before he moved from Kew Cottages to Banksia House. This included meeting his future co-residents, visiting Banksia House with his family and helping to select furniture for his new room.

42. During that time, Ms Paterson and Ms Sedgman also spoke to the Banksia House staff about Mr Summers' idiosyncrasies and management. There was no suggestion that Mr Summers was upset by having to move.

43. Mr Kuhlman assisted with the transition arrangements and visited Banksia House on a number of occasions during the transition period. He was unavailable to give further evidence at inquest.

44. By 10 November 2005, Mr Summers' weight had dropped to 41kg. This was about three kilograms below his healthy weight. The dietician attributed a four kilogram weight loss to

his ill health. However, no weight gain occurred after he commenced eating again. She also advised that he needed a further dietary review if his weight fell below 40kg or he failed to gain weight in the next two months.

45. On 15 November 2005, a further Individual Program Plan included objectives such as decreasing the frequency of upturning chairs and more involvement in household activities such as picking up items off the floor and staff assisting him with verbal cues.

Banksia House

46. On 16 November 2005, Mr Summers moved to Banksia House with three co-residents as part of the de-institutionalisation plan. One of Mr Summers' new house mates had shared his accommodation at Kew Cottages.

47. This group home was staffed 24 hours a day with extra staff at peak times and active overnight staff.

48. Ms Stastnik and Mr Kuhlman continued as Mr Summers' case managers. They remained available to discuss any concerns or issues with the Banksia House staff but they were based at Kew and did not visit Banksia House after Mr Summers moved.

49. At Banksia House, Lina Mohammed was the part-time House Supervisor. The other part-time house supervisor had come over from Kew Cottages but she was on leave in January and February 2006.

50. Ms Mohammed had worked with the Department of Human Services for 21 years and she had had many years experience in community residential units. Ms Mohammed also held a Bachelor of Arts in Youth Affairs and an Advanced Certificate in Residential and Community Studies.

51. Sujatha De Silva was a direct care worker at Banksia House. She was an experienced direct care worker for clients with profound disability but she had not met Mr Summers before his transfer to Banksia House. She never met Mr Ulrich.

52. The staffing team at Banksia House was provided with nine days of comprehensive training before the clients moved in. This training included a day of training in how to manage epilepsy, rectal medications and enemas and two afternoons on 10 & 11 November 2005 for

House Orientation and Resident Familiarisation at Banksia House. However, it did not include any training in diagnosis, management and prevention of pressure sores.

53. Ms De Silva also prepared general information about Mr Summers for his new client profile. This indicated that:

"When he's upset or intends to get attention he tips over furniture....

Tipping over furniture – ATTENTION SEEKING BEHAVIOUR...

Stephen likes spending outdoors, interaction with others, enjoys his food, wants his drinks to be slightly warm and attention given by workers."

54. Further, all of Mr Summers' co-residents could walk and move around freely. Ms De Silva told the Court that Mr Summers required more attention than his co-residents. This caused some dissention with the other residents.

55. Banksia House records indicate that Mr Summers seemed well and active throughout most of December 2005. He ate his meals and slept well at night. Mr Summers also continued to attend Carinya on Monday to Friday and went to their Christmas party on 16 December 2005. He also went to Carinya on 21 December for two hours.

56. However, on 17 December 2005, Mr Summers' sister, Christine Lupson, attended the Christmas party at Banksia House. In Court, Ms Lupson described her impression of the changes in Mr Summers' presentation:

"He was very quiet. He didn't indicate that he wanted to go anywhere or for a drive. He just sat. He ate, we fed him and he ate, but normally if there was food around, he always wanted more and on this occasion he was just very, very quiet and at the time I thought, well, it has been a big change for him and I thought, well, he is probably fretting because he hasn't got any of the familiar staff around or anyone that he - it was all new, everything was new, so I put it down to him fretting really at that time."

57. Further, on 22 December 2005, Banksia House staff noticed some redness on his right knee but this declined during the day. They took no further action.

58. On 3 January 2006, Mr Summers seemed unhappy and was turning chairs over continuously. He refused to go in the bus until the wheelchair was brought and yelled while being showered.

59. Mr Summers' case manager at Kew Cottages also noted that his escalating behaviour was affecting the other residents and he requested extra day staff during the holiday period. Therefore, I presume he was consulted about management of Mr Summers' behaviour.

60. On 4 January 2006, Ms De Silva told Ms Mohammed she was concerned about Mr Summers' health. She particularly noted his inability to weight bear and his lack of appetite at times.

61. Ms Mohammed recorded that Mr Summers was still eating and he did not appear unwell. However, she was also concerned about his inability to stand alone.

62. Ms Mohammed also sought advice from Ms Sedgman from Kew Cottages. Ms Sedgman advised that Mr Summers' inability to stand could be behavioural but they should check his footwear and review in a week. Ms Mohammed noted: :

"Please check his feet, shoes, et cetera. If he's not weight bearing at the end of the week he will need to see a doctor, possibly, X-rays. Please document how he goes in his case notes"

63. On 5 and 6 January 2006, Mr Summers was very slow using his left leg but he ate well. On 7 and 8 January, he took his own weight with support from two staff and ate well so he seemed more energetic.

64. Dr Robin Johnstone was now Mr Summers' general practitioner. However, Dr Johnstone did not visit Mr Summers at Banksia House. He saw Mr Summers three times when Banksia House staff took him to the Tullamarine Medical Clinic for review.

65. At 2.10pm on 9 January 2006, Dr Johnstone performed a full annual physical examination at the Tullamarine Medical Clinic in Gladstone Park. His weight had already declined to 33kg and he was still not weight bearing.

66. However, Dr Johnstone noted that he was generally well and did not provide any medical explanation for Mr Summers' refusal to walk. He did not record any lesions or skin breaks when he examined Mr Summers for skin cancer.

67. On 11 January 2006, Ms De Silva reported to the Banksia House Meeting that Mr Summers had become withdrawn and refused to walk over the last 10 days. This was the first time that she reported Mr Summers' deterioration to the staff at Banksia House other than Ms Mohammed.

68. Ms De Silva was instructed to support Mr Summers more, such as by assisting him into his wheelchair and assisting him with eating.

69. However, during January 2006, Mr Summers' mobility remained limited and he frequently refused his food. On 21 January, he was more mobile than recently and he returned to Carinya on 24 January. Mr Summers' mood seemed to improve on the days he went to Carinya.

70. On 3 February 2006, Carinya staff observed skin lesions on Mr Summers' buttocks. They reported these findings to Banksia House staff and it was recorded in the Day Book.

71. Ms De Silva had no training in identification or management of pressure sores. However, Ms Mohammed had previously worked in a high medical needs facility for clients with a disability:

"They were very prone to developing pressure sores. So in that house we had a lot of proactive strategies to prevent people from developing pressure sores. I personally have never seen one."

72. Therefore, on 4 February 2006, Ms Mohammed took Mr Summers back to see Dr Johnstone.

73. Dr Johnstone documented skin lesions or breaks on both of Mr Summer's buttocks, on his right shoulder and below his right knee. He explained to Ms Mohammed that the sores may be due to rubbing of the skin against wet linen and advised use of an incontinence aid at night. Dr Johnstone also ordered application of Betadine to the affected areas and referred Mr Summers to a dietician and physiotherapist.

74. Dr Johnstone retired in January 2008 and the Practice Manager provided the Court with a transcription of Dr Johnstone's general referral to a dietician and physiotherapist from Dianella Allied Health Service at Broadmeadows and a referral to the Royal District Nursing Service. These referrals were dated 6 February 2006.

75. Dr Johnstone did not diagnose pre- patella bursitis or *Staphylococcal* infection. He did not order blood tests that would have assisted in these diagnoses.

76. By 5 February 2006, Mr Summers' pressure areas were bleeding. Ms Mohammed reported Ms Summers' deterioration to the senior planner facilitator at the Department of Human Services because the contact arrangements with Diannella Allied Health Service were unclear and she needed additional resources.

77. In Court, Ms Mohammed explained:

"That was the first time I was made aware of the Dianella Health Services....

It wasn't a direct transfer. They were a community health service so - the residents were to start accessing community health services."

78. Although there remained some doubt about comparing Mr Summers' weights at different times, Ms Mohammed said he appeared to have lost 13kg since moving to Banksia Grove in November 2005. He had developed bedsores on his buttocks. He needed an air mattress.

79. The Department of Human Services Cluster Manager involved in arranging reception of transition clients from Kew Cottages into Banksia House, Paul O'Kelly, also told the Court about differences in reporting practices expected of staff at Kew Cottages and Banksia Grove. At Kew Cottages, any marks would be reported to the house manager who would record it in the client file. At Banksia Grove, staff were expected to record their observations themselves in the client file.

80. On 7 February 2006, Mr Summers's pressure sores were treated by the Royal District Nurse Service and Banksia House staff. The nurse recorded that Mr Summers still had pressure sores on his right shoulder and right hip caused by pressure and friction. She dressed these pressure areas and advised staff about positional changes. She also advised provision of a pressure mattress for Mr Summers and referred him to an occupational therapist for further assessment.

81. Ms Mohammed tried to refer Mr Summers to the Dianella Health Services physiotherapist and occupational therapist for assessment with respect to a pressure mattress but their waiting period was three to four months.

82. Ms Mohammed also made an appointment with the dietician for 13 February 2006. In the meantime, Mr Summers was given Sustagen energy supplements to aid in addressing his lethargy and assist his lack of appetite.

83. On 8 February 2006, Mr Summers' carer from Kew Cottages, Ms Tzouritis, visited Mr Summers. She told the Court that she was shocked to see him so sad and thin and was lost for words. She was also surprised by his rapid deterioration in the two months since Mr Summers left Kew Cottages. Ms Tzouritis asked Ms Patterson and Ms Sedgman to review Mr Summers.

84. During the night of the 8/9 February 2009, the active night staff member, Roseanne Goss, turned Mr Summers every 30 minutes. She observed he was very lethargic and a yellowish colour.

85. On 9 February 2006, Ms Paterson visited Mr Summers. She observed he was wasted and would not eat or drink. Ms Paterson formed the view that Mr Summers was depressed, in pain, had no energy because of his weight loss and may have been not wearing his boots to enable him to walk. She did not refer to pre-patellar bursitis. Ms Paterson rang Ms Mohammed for permission to call an ambulance.

86. At 1.55pm on 9 February 20106, Ms de Silva rang an ambulance.

87. The Incident Report Form created by Ms Mohammed on 10 February 2006 indicates that the Department of Human Services did not initiate an investigation into the reasons for Mr Summers' decline and transfer to St Vincents Hospital.

St Vincent's Hospital

88. At 3.00pm on 9 February 2006, Mr Summers presented with Ms de Silva at the Emergency Department of St Vincent's Hospital for further assessment and treatment.

89. Mr Summers was diagnosed with previously unreported *Staphylococcus aureus* chest infection, possible aspiration pneumonia and left pre-patellar bursitis[2] as well as the already well-documented numerous pressure sores. His legs were mottled. He was distressed and seemed scared of the environment. He was unable to follow commands.

90. Mr Summers was admitted to St Vincents Hospital under general medicine, placed on intravenous dextrose fluids and his condition was monitored. He was also referred to occupational therapy for pressure sore management.

91. By 16 February 2006, a medical review recorded that Mr Summers looked better but still unwell. St Vincent's was actively considering discharge options. However, Banksia House reported that they could not cope with the high level of care Mr Summers would require to manage his pressure areas and his functional level if he returned there. No further consultation about placement had commenced before Mr Summers died.

92. During the night of 16 February 2006, Mr Summers' blood pressure dropped. It is believed he went into septic shock due to infection with *Staphylococcus aureus*.

93. On 17 and 18 February 2006, St Vincent's staff noted continuing pressure sores on Mr Summers' right shoulder, elbow, hip and knee.

94. At 1.20am on 17 February 2006, Mr Summers died. He weighed only 34kg. Mr Summers had lost 13kg in body weight in his two months at Banksia House.

95. The forensic pathologist who inspected the body was of the opinion that a reasonable cause of death in the circumstances might be formulated as *Staphylococcal* sepsis, complications of pressure sores and hypostatic pneumonia and cerebral palsy.

96. Accordingly, I find that Stephen Summers died from *Staphylococcal* sepsis, complications of pressure sores and hypostatic pneumonia and cerebral palsy.

97. In the absence of an autopsy, I am unable to say whether he also suffered from a longer-term illness that caused his weight loss commencing in October 2005.

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[2] *Prepatellar bursitis* is the inflammation of a small sac of fluid located in front of the kneecap. This inflammation can cause many problems in the knee.

COMMENTS

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

1. Stephen William Summers was 55 years old when he died. He suffered from cerebral palsy associated with muscular spasticity, profound intellectual and physical disability, osteoporosis and left eye blindness. His general practitioner was Dr Robin Johnstone.

2. On 17 February 2006, Mr Summers died at St Vincents Hospital from *Staphylococcal* sepsis, complications of pressure sores and hypostatic pneumonia and cerebral palsy.

3. In the absence of an autopsy, I am unable to say whether he also suffered from a longer-term illness that caused his weight loss commencing in October 2005.

4. Mr Summers was non-verbal and required full support for all his daily living needs. He moved around on his bottom or used a walker. He also used a wheel chair for community access. He could communicate basic needs to the carers who knew him well.

5. Mr Summers had lived in Department of Human Services Disability Services accommodation at Kew Residential Services ("Kew Cottages") for 43 years.

6. Kew Cottages provided institutional care for Department of Human Services clients with severe disabilities. This care included full-time accommodation, medical and paramedical services and an on-site medical centre and hospital.

7. Mr Summers had a long-term relationship with the physiotherapy staff and his direct care providers at Kew Cottages. However, he had little contact with his co-residents.

8. In May 2001, the Premier of Victoria announced that Kew Cottages would be re-developed. Residents were to be re-located to group homes in the community.

9. The objective of the de-institutionalisation was to improve the quality of life for all residents at Kew Cottages by enabling them to live in quality supported accommodation with staffing levels appropriate to their needs, to access day programmes and activities and to provide support and opportunities to enable them to enjoy a lifestyle consistent with that enjoyed by the rest of the community.

10. In this context, the Department of Human Services Resident Assessment, Consultation and Planning Team determined that Mr Summers was most appropriately placed at a Community Residential Unit at 24 Banksia Grove in Tullamarine.

11. Mr Summers' de-institutionalisation arrangements also required him to access community services:

- Mr Summers began participating in a day program at the Carinya Society in Coburg for 12 hours a week.
- His medical care was transferred from Dr Rice at the Smorgan Health Centre to Tullamarine Medical Clinic.
- Occupational therapy and other allied health services were arranged with Dianella Allied Health Services in Broadmeadows.

12. However, very little effort seems to have been made to ensure continuity of Mrs Summers' support staff during the transition from Kew Cottages to Banksia Grove. In particular:

- Only one of Mr Summers' carers from Kew Cottages transferred to Banksia Grove. She was on leave in December 2005 and January 2006.
- Louise Stastnik and Ulrich Kuhlman continued as Mr Summers' case managers but they did not visit Banksia House after Mr Summers moved.
- Mr Summers only knew one of his co-residents at Banksia House. The others were all mobile and relatively more able to move around and communicate with each other and their carers. They became jealous of Mr Summers' need for more staff attention than they required.

13. Therefore, I find that Mr Summers was moved out of the environment that he had known for 43 years without active support from the carers or allied health workers that he knew well.

14. Further, the Transition Team organised for Mr Summers' participation in the transition arrangements by involving him in a number of tasks and awareness projects before he moved to the Community Residential Unit. These included:

- Mr Summers' sisters attended an afternoon tea at Banksia House with Mr Summers.

- Mr Summers 'chose' the furnishings for his room at Banksia House.
- Mr Summers had a meeting with other co-residents.

15. Clients with profound disabilities like Mr Summers undoubtedly have opinions about the way in which they live and the way in which services are provided to them. However, they are unable to communicate them to their families or carers or co-residents and only those who know them well can hope to interpret even their most fundamental preferences.

16. Therefore, it is unrealistic to say that Mr Summers had been consulted by people who did not know him, could express his opinions about furnishings or accommodation without being able to communicate or could ever be adequately prepared for transition to a new environment which does not include anyone he knew well in 43 years at his old accommodation..

17. Accordingly, I find that the opportunities provided for Mr Summers to participate in planning for his move to Banksia Grove were idealistic for a person with his level of disability and there is no way of really knowing to what degree he understood and was affected by the planning process.

18. Further, in the period leading up to his move to Banksia House, Mr Summers had been relatively well except for a two day admission to the Smorgan Health Centre in October 2005 with pneumonia and gradual weight loss commencing at about the same time.

19. Mr Summers' carers were concerned about his weight loss and failure to improve after his hospital admission. In the context of his general condition, the rate of decline in weight was similar to that he had previously experienced at Kew Cottages when he was younger. Therefore, monitoring was an appropriate response at this time.

20. However, although his medical and allied health services were transferred to community agencies, there was no contact between Mr Summers and his new general practitioner, Dr Robin Johnstone, or any other service providers before his move. Further, Mr Summers' carers at his new Community Residential Unit were not included in the transition arrangements to his community medical and allied health workers.

21. Therefore, this monitoring and access to services did not occur in Mr Summers' first six weeks in his new environment.

22. In the light of subsequent issues that arose in January and February 2006, it would have been better if Mr Summers' new healthcare providers had assessed him prior to his transfer from Kew Cottages to his new Community Residential Unit.

23. On 16 November 2005, Mr Summers moved from Kew Cottages to Banksia House which is a Department of Human Services Community Residential Unit at 24 Banksia Grove in Tullamarine.

24. Lina Mohammed was the part-time House Supervisor at Banksia House. Ms Mohammed did not meet Mr Summers until he moved. She told the Court:

"When I met Stephen I would never, ever have considered Stephen as a candidate for developing pressure sores because he was mobile."

25. Sujatha De Silva was Mr Summers' personal care provider at Banksia House. She was an experienced direct care worker for clients with profound disability but she had also not met Mr Summers before his transfer to Banksia House.

26. Ms De Silva told the Court that Mr Summers looked happy in his new environment. However, she and other staff were unable to communicate with Mr Summers and therefore she could not say whether was happy with the move and his new surroundings.

27. Although he seemed contented at the beginning, Mr Summers continued to lose weight at Banksia House. He also became lethargic and stopped using his walker to move around. This rate of weight loss was now greater than that previously reported at Kew Cottages.

28. On 17 December 2005, Mr Summers' family noticed that he was much less active and out-going than he had been previously. On 3 January 2006, he was unable to walk at all and he became disruptive, turning over chairs continuously. He refused to go in the bus until the wheelchair was brought and yelled while being showered.

29. Ms Mohammed was concerned about Mr Summers' feet but she also told the Court she could not exclude the psychological effect on Mr Summers of transition from Kew Cottages to Banksia House.

30. Ms Mohammed said:

"I didn't know Stephen very well and I don't know why he wasn't weight bearing. I didn't know at that stage why that would have been the case. He was getting to know new people, new staff. How he was reacting to that, I don't know. I don't know if there were any psychological issues, I don't know, no."

31. The only thing Ms Mohammed believes would have helped him would have been having a staff member from Kew Cottages transfer with him:

"Somebody - probably somebody who knew Stephen, who had known Stephen for some time."

32. It is clear that the Banksia House staff did not know Mr Summers well enough to communicate with him in the way that his Kew Cottages carers had been able to manage. However, there is no evidence that the Banksia House staff spoke to his previous carers until his condition had declined beyond recovery.

33. On 9 January 2006, Dr Johnstone reviewed Mr Summers in his annual check up precipitated by his deteriorating condition.

34. Dr Johnstone recorded Mr Summers was generally well but he had lost a further 9kg since he moved to Banksia House and was not weight bearing.

35. Mr Summers' decline in health had commenced before he left Kew Cottages. However, his lethargy in 2006, his loss of weight over a number of months and his incontinence of urine at night placed him at particular risk of developing pressure sores on his buttocks, his knee, and his shoulder.

36. Further, Dr Johnstone did not diagnose pre-patellar bursitis which could have explained Mr Summers' inability to stand. In the context of clear changes in Mr Summers' mobility, he did not warn the Banksia House staff to watch for pressure sores and implement prevention strategies. He did not seek an opportunity to review Mr Summers' deteriorating condition.

37. Dr Johnstone had not previously met Mr Summers and seems to have relied on the Banksia House staff assessment of Mr Summers' condition. On the other hand, Mr Summers' carers at Banksia House were seeking guidance from Dr Johnstone because they were unable to communicate with Mr Summers and could not explain his deterioration.

38. This was almost a situation of "the blind leading the blind".

39. Accordingly, I find that Dr Johnstone was limited in his capacity to properly review Mr Summers on 9 January 2006.

40. On 24 January 2006, Mr Summers returned to Carinya after the summer break. On 3 February, Carinya staff observed pressure sores on both of Mr Summer's buttocks, on his right shoulder and below his right knee. They reported these findings to Banksia House staff and recorded them in the Day Book.

41. This is the first time that there is any record of Mr Summers' skin lesions. Therefore, I infer that they were not obvious on and developed quickly in the 10 days after 24 January 2006.

42. Untreated pressure sores can lead to serious health problems including death.

"Pressure sores are easy to prevent but difficult to treat."[3]

43. The staffing team at Banksia House was provided with nine days of comprehensive training before the clients moved in. This training included a day of training in how to manage epilepsy, rectal medications and enemas and two afternoons on 10 & 11 November 2005 for House Orientation and Resident Familiarisation at Banksia House.

44. However, personal care staff at Banksia House were not provided with any education about identifying, preventing or managing pressure sores. Therefore, I am unable to say whether pre-condition pressure areas occurred earlier than this time. **Recommendation 1**

45. On 4 February 2006, Dr Johnstone confirmed the pressure sores and instituted treatment including requesting an air mattress and referring Mr Summers to the Royal District Nursing Service.

46. Ms Mohammed was not really satisfied with Dr Johnstone's review of Mr Summers on 4 February 2006. She told the Court:

"I didn't think he was very thorough. I didn't feel satisfied after having seen him which is why I contacted so many other people. I even recall him saying something along the lines

[3] Department of Human Services, "Managing pressure sores", 2007.

of, "Don't worry so much or don't be too concerned" or something like that. "He's fine, it's OK."

47. Ms Mohammed was right to be concerned. In the context of all Mr Summer's risk factors on 4 January and 4 February 2006, it is clear that there was reason to be worried about Mr Summers' pressure sores and his general health. Further, Dr Johnstone still did not diagnose Mr Summers' subsequently diagnosed pre-patella bursitis or *Staphylococcal* infection. He did not order blood tests that would have assisted in these diagnoses.

48. However, Department of Human Services policy prevented Banksia House staff accessing an air mattress for Mr Summers without physiotherapy assessment. Ms Paterson had been unable to find appropriate physiotherapy services in Mr Summers' new community.

49. On 8 February 2006, Miranda Dunn, Team Supervisor, Client Planning and Services Team, Kew Residential Services wrote to the Broadmeadows Health Service seeking an urgent physiotherapy referral for Mr Summers.

50. Ms Dunn indicated in her letter that the Department of Human Services was already aware of some of the issues facing Mr Summers:

"Mr Summers moved from Kew Residential Services (KRS) in November 2005 to (24 Banksia Grove, Tullamarine) and since this time has lost approximately 13 kg to a current weight of 30kg. He is also suffering from severe bed sores and his mobility has decreased considerably. Direct care staff report that Mr Summers is currently refusing to eat and this could be in relation to reaction to pain he is experiencing from his bed sores, a reaction to his move from KRS to the community and adjusting to living with his new co-residents."

51. However, the failure to make previous arrangements for allied health services in the local community meant that Mr Summers had to wait 3-4 months for a physiotherapy appointment. This means that he would have had to wait that long for an air mattress if other events had not intervened.

52. Further, Ms Patterson told the Court:

"Private physios wouldn't have seen people like the people we had with the lots of deformities that weren't common outside....

We didn't have any communication with the community physio because we couldn't find them, there weren't any"

53. Therefore, there was no reason the presume that the physiotherapist who assessed Mr Summers in over three months time would be able to provide practical and accurate advice about his specialist needs.

54. In accepting responsibility for managing clients with profound disabilities in the community, the Department of Human Services must also ensure continuity of allied health services with experience in providing advice and assessment of these clients in a timely manner. **Recommendation 2**

55. On the night of 8/9 February 2009, the active night staff member at Banksia House observed Mr Summers was very lethargic and a yellowish colour. In retrospect, his *Staphylococcus aureus* infection explains this yellow colour observed by his carers.

56. On 9th February 2006, Mr Summers was transferred by ambulance to St Vincents Hospital. He was diagnosed with previously unreported *Staphylococcus aureus* chest infection, possible aspiration pneumonia and left pre-patellar bursitis[4] as well as the already well-documented numerous pressure sores.

57. On 17 February 2006, Stephen Summers died from *Staphylococcal* sepsis, complications of pressure sores and hypostatic pneumonia and cerebral palsy.

58. The Department of Human Services did not undertake any systematic review of Mr Summers' deterioration after he transferred to Banksia House or the reasons that he was transferred to St Vincents Hospital and died. **Recommendation 3**

59. Since Mr Summers died, the Department of Human Services has invested in scales with wheel chair capacity in all supported accommodation where they are required. These scales record the weight electronically and provide feed back of changes over time. They may assist in accurate weight recording.

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[4] *Prepatellar bursitis* is the inflammation of a small sac of fluid located in front of the kneecap. This inflammation can cause many problems in the knee.

60. However, in the absence of root cause analysis, scales seem a paltry response to Mr Summers' deterioration and subsequent death:

- They cannot compensate for isolating Mr Summers from his known support system at Kew Cottages without proper long-term active integration transitional arrangements.
- They cannot replace observations of Mr Summers' deterioration over two months after he moved to Banksia House.
- They cannot assist his direct care workers at Banksia House to contact his previous carers at Kew Cottages for advice or to ask them to visit Mr Summers.
- They cannot identify pressure sites which are at risk of developing into pressure sores.
- They cannot account for failure to diagnose the *Staphylococcus aureus* chest infection and possible aspiration pneumonia. and pre-patellar bursitis that were identified when he presented at St Vincent's Hospital on 9 February 2006.

61. Paul O'Kelly was an Area Manager within the North West Region of the Department of Human Services. His role was to support residents and staff transitioning from Kew Cottages to community residential houses including Banksia House.

62. Mr O'Kelly identified different reporting practices expected of staff at Kew Cottages and Banksia Grove. At Kew Cottages, any marks would be reported to the house manager who would record it in the client file. At Banksia Grove, staff were expected to record their observations themselves in the client file.

63. This meant that there was no general oversight of changes in clients' condition over time and between shifts except at staff handover meetings. Further, no one was accepting responsibility for providing longer term supervision of clients' on-going health and welfare.

Recommendation 4

64. Changes in arrangements for accommodating the needs for members of our community with severe disabilities must, by definition, seek to improve the conditions for the majority.

65. I understand that most people with disabilities have and express preferences in relation to living arrangements and service providers. I also accept the model of service delivery which

protects the right of these clients to integrate in to their local communities and make choices about their lives that are consistent with these preferences.

66. However, Mr Summers had profound intellectual and physical disabilities. Accordingly, he was at the outer end of the continuum of disabilities suffered by people living at Kew Cottages. Community residential and service provision arrangements do not change the competence and capacity of Mr Summers and other high acuity clients. It took two months to demonstrate the Mr Summers was never going to fit the model and the model was not flexible enough to fit him.

67. In circumstances where Mr Summers' carers were unable to interpret his fundamental needs and complaints, I cannot hope to improve on their understanding of the issues he faced when his weight was declining, he was quiet and not eating, he was incontinent, his knee was hurting from subsequently diagnosed pre-patellar bursitis and he was suffering a *Staphylococcus aureus* infection.

68. It was similarly unrealistic and dangerous for the Department of Human Services to try and accommodate Mr Summers' s needs within the model of supported community housing that, no doubt, improved the lifestyle of the majority of Kew Cottages' former residents.

69. In these circumstances, the Department of Human Services must accept responsibility for determining the services that disability clients require to maintain their health and dignity in our community and auditing their delivery to ensure that they remain individually appropriate as Government policies and the client's condition changes over time. **Recommendation 5 & 6**

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

I recommend that:

1. The Department of Human Services provide direct care workers in Community Residential Units with education and experience in identifying, preventing or managing pressure sores in disability clients;

2. The Department of Human Services create a pool of allied health service providers with experience in managing disability clients and ensure that they are available to direct care workers for consultation and review of referrals for equipment like air mattresses;

3. The Department of Human Services undertake systematic reviews of the management and other factors contributing to the death of residential clients with severe disabilities

4. The Department of Human Services require direct care workers in Community Residential Units to verbally report to the House Manager any observations they make of deteriorating health of disability clients as well as writing their observations in the Communication Book and the client's record;

5. The Department of Human Services arrange for appropriate provision of community medical and allied health services to clients with profound disabilities who are referred by their carers;

6. The Department of Human Services routinely audit all the community services provided to clients with profound disabilities to ensure they remain relevant to the clients' changing specialist needs and available when they are required.

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

The Secretary of the Department of Human Services

Signature:

DR JANE HENDTLASS
CORONER
Date: **5 June 2013**