IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 1527

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***
Amended pursuant to section 77 of the ***Coroners Act 2008***

I, IAIN TRELOAR WEST, Acting State Coroner having investigated the death of Margaret Elizabeth BARTON

without holding an inquest:

find that the identity of the deceased was Margaret Elizabeth BARTON

born on 25 September 1931

and the death occurred on 29 March 2015

at Frankston Hospital-Peninsula Health, 2 Hastings Road Frankston, 3199 Victoria

from:

1 (a) PNEUMONIA COMPLICATING RIB AND PELVIC FRACTURES SUSTAINED IN THE SETTING OF MULTIPLE FALLS IN A WOMAN WITH MULTIPLE MEDICAL COMORBIDITIES

Background

On 30 November 2017, I made findings into Mrs Margaret Barton's death without inquest pursuant to section 67(1) of the **Coroners Act 2008** (the Act). These findings were published on the Court's website pursuant to section 72 of the Act.

On 20 July 2018, the Court received an applicated dated 17 July 2018 from Mrs Barton's son, Mr David Barton, pursuant to section 77 of the Act seeking an order that portions of the 30 November 2017 findings be removed, corrected of clarified.

On 4 February 2019, I determined that it was appropriate to set aside some of the 30 November 2017 findings, namely portions of paragraphs 33(f), 33(g) and 48.

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Margaret Barton was an 83-year-old woman who resided in Mornington.
2. Mrs Barton's medical history included advanced Alzheimer's dementia, ischaemic heart disease, osteoarthritis, hypertension, hypothyroidism, hypercholesterolaemia, Sjogren's syndrome, osteopaenia, and aortic and mitral valve regurgitation. She had also previously sustained multiple fractures of the right radius, left radius, pubic rami and T2 and T12 spinal compression fractures.
3. On 22 January 2015, Mrs Barton was admitted to the Craigcare Mornington (CCM) Residential Aged Care Facility (RACF) for respite care, until a position became available at Mecwacare Park Hill (MPH) (formerly Park Hill Gardens). Her residency at CCM was complicated by confusion, significant agitation, poor oral intake and multiple falls. She was transferred to MPH on 24 February 2015 but continued to experience similar symptoms and falls once there.
4. On 3 March 2015, Mrs Barton was transferred to the Frankston Hospital's Emergency Department (ED) due to a head strike and left eyebrow laceration sustained in a fall. She exhibited an unchanged conscious state, no obvious skeletal injuries, and continued agitation. Mrs Barton had an x-ray (a right forearm haematoma was also identified) but was assessed as low risk for significant head or neck injuries. Therefore, no Computed Tomography (CT) brain or spine scans were conducted. Mrs Barton was subsequently returned to MPH where she was 'specialed' with one-to-one supervision, as she was very agitated, kicking, swearing and spitting. No history was provide to MPH regarding investigations that occurred at the hospital to enable targeted management of actual or potential injuries.
5. At approximately 5am on 20 March 2015, after being reviewed by a locum doctor, Mrs Barton was transferred to the Frankston Hospital's ED for evaluation, management and psychiatric assessment. The transfer was related to investigation for potential unknown infection and delirium. She was subsequently admitted to the Aged Care Psychiatric Assessment Unit and was diagnosed with a delirium attributed to medication changes, altered environment, falls and fractures. A chest x-ray on 24 March 2015 identified that she had right-sided fifth, sixth and seventh rib fractures that were likely subacute in nature, and a 50% loss of height compression fracture of approximately the T11 vertebra. A CT scan had been attempted on the day of her hospital admission, but was abandoned due to Mrs Barton's restlessness.
6. On 25 March 2015, Mrs Barton was moved to a general medical ward for ongoing management where she continued to exhibit behavioural and psychological symptoms of dementia (BPSD). Her poor oral intake and dehydration persisted and she continued to lose weight. Providing adequate analgesia to Mrs Barton for her fractures proved an ongoing issue throughout the admission.
7. On 27 March 2015, in a family meeting with Frankston Hospital medical and nursing staff, it was discussed that Mrs Barton's capacity to recover from her current acute illness was uncertain – as was the possibility of discharge – and she was subsequently referred to the palliative care team to optimise her comfort.
8. On 28 March 2015, a CT scan of the pelvis, spine and hips also revealed subacute and old pelvic fractures, and T2 and L1 vertebral body wedge fractures of the spine. On the morning of 29 March 2015, Mrs Barton became hypotensive and her conscious state deteriorated. She was subsequently declared deceased at 12pm.

9. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine performed an autopsy on Ms Barton and provided a written report of her findings. Post mortem CT scan showed right pelvic ramus fractures and right rib fractures. In the elderly population, skeletal fractures are associated with significant morbidity and mortality. Bone density usually decreases with age and people with osteoporosis are at greater risk of fracture.

10. Post mortem examination revealed fractures on the right ribs which showed evidence of healing. There was bilateral bronchopneumonia on a background of pulmonary emphysema. Rib fractures will increase the risk of pneumonia due to pain and inadequate respiration. Any bone fracture which significantly affects an elderly person's mobility increases the risk of pneumonia and other complications such as deep vein thrombosis.

11. Mrs Barton's heart showed deposition of amyloid. Amyloid is a proteinaceous substance that is deposited between cells in various tissues and organs of the body in a wide variety of clinical settings. Amyloid deposition in the heart ("cardiac amyloidosis") is often an age-related change (so-called senile cardiac amyloidosis or SCA) and may produce restrictive haemodynamics, ("restrictive cardiomyopathy"). Restrictive cardiomyopathy occurs where there is increased stiffness in the myocardium (heart muscle) which in this case, is due to amyloid. This leads to inadequate filling of the heart with blood resulting in reduced cardiac output and eventual heart failure. Neurodegenerative changes were also identified, in keeping with a history of dementia.

12. Toxicological analysis of blood and urine showed citalopram, olanzapine, metoclopramide, paracetamol, temazepam, hydromorphone, oxycodone, irbesartan, scopolamine, and buprenorphine at levels consistent with therapeutic use. Post mortem biochemistry showed a significantly elevated C-reactive protein. C-reactive protein is a molecule that increases in the blood stream in response to inflammation, particularly infections.

THE PURPOSE OF A CORONIAL INVESTIGATION

13. Mrs Barton's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (the Act), as the death occurred in Victoria, and was unexpected and not from natural causes.[1]

14. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

15. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

16. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] Section 4 *Coroners Act 2008.*

[2] Section 89(4) *Coroners Act 2008.*

[3] See Preamble and s 67, *Coroners Act 2008.*

[4] *Keown v Khan* (1999) 1 VR 69.

17. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

18. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the '*prevention*' role.

19. Coroners are also empowered:

    a. to report to the Attorney-General on a death;

    b. to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c. to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] 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 that they caused or contributed to the death.

21. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

Family Concerns:

22. On 1 April 2015 and 12 October 2015, the Court received letters of concern from Mr Andrew and Mr David Barton regarding their mother's care and management at both CCM and MPH. As a result of these concerns, I referred the matter to the Coroners Court Health and Medical Investigation Team (HMIT)[6] for review. The HMIT considered all available materials and also requested further statements from;

    a. Ms Kitty Fausett, Facility Manager at CCM

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[5] (1938) 60 CLR 336.

[6] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

b. Mr Wayne Lester, Facility Manager at MPH and Ms Lisa Reynoldson, General Manager Residential Services at MPH.

c. MPH Chief Executive, Ms Michele Lewis

d. Dr Oi Kwan Chan, General Practitioner

e. Dr Natasha Aylen, General Practitioner

f. Dr Megan Barrett, General Practitioner

g. Dr Jane Offor, General Practitioner

The HMIT provided a written report of their findings and the issues raised by Mrs Barton's family have been summarised and addressed as follows.

Issue 1

23. **What sedation medication was Mrs Barton receiving at CCM, and was this medication and the dosage appropriate for an elderly patient with dementia?**

    a. In her statement, CCM Facility Manager Ms Kitty Fausett advised that Mrs Barton was confused and paranoid, and was not able to follow instructions or retain simple information. Behavioural assessment documentation was performed by CCM staff throughout Mrs Barton's admission and a summary of her frequent behavioural issues is listed below:

        i. **Early in CCM admission:** Anxiety; angry; restless; wandering; verbally and physically disruptive; verbally and physically intrusive; verbally aggressive; repeatedly stating she wants her husband and to go home; undressing in common areas; urinary incontinence due to confusion regarding the location of the toilet.

        ii. **Additional behaviours midway through CCM admission:** Verbal abuse; physical aggression toward staff and co-residents; delusional; paranoid; attempting to damage furniture; resistive to hygiene assistance from staff.

        iii. **Additional behaviours late in the CCM admission:** Argumentative; resistive; attention seeking; hitting and banging body against furniture; wandering into other residents rooms, requiring one-on-one care.

    b. GP Dr Oi Kwan Chan prescribed an 'as required' prescription for Oxazepam (Serepax) 7.5-15 milligrams (mg) twice daily on 23 January 2015 (the day after Mrs Barton's CCM admission), in an effort to curtail her behaviours that were difficult to manage. Oxazepam is a short to intermediate acting benzodiazepine sedative, commonly used for management of anxiety disorders, as well as for anxiety associated with depression or drug withdrawal. Oxazepam is not a commonly used long-term medication for management of advanced symptoms of dementia.

    c. The Oxazepam order was utilised by staff once per day on most days of Mrs Barton's CCM admission until 15 February 2015, usually either in the early morning, or in the late afternoon to late evening. On every occasion except one, a 15mg dose was administered. The behavioural assessment documentation recorded that the Oxazepam was usually effective (within 30-60 minutes) at reducing or resolving Mrs Barton's acute behavioural issues.

    d. On 16 February 2015, Dr Chan prescribed a regular order of Oxazepam of 15mg to be administered three times a day. Dr Chan did not renew the 'as required' Oxazepam order. The new regular medication dosage time was charted to be given at

6am, 2pm and 8pm, and administration commenced the following day. This new prescription increased Mrs Barton's Oxazepam regimen significantly from approximately 15mg per day to 45mg per day.

e. On 24 February 2015 (the final day of her CCM admission), Mrs Barton was recorded to be abusive, agitated, confused, biting, spitting, scratching, hitting and kicking. After review of the month long CCM behavioural charting, the most common themes were confusion and attention-seeking behaviour, which early in her admission occurred primarily in the mornings and evenings, but eventually occurred at any time. Staff interventions to Mrs Barton's behaviours which included reassurance, redirection and one-on-one time, mostly had little effect, or if they were initially effective, were not sustained.

24. The HMIT noted that Oxazepam should be utilised with caution in the geriatric population, although due to its short half-life relative to other benzodiazepines, if a benzodiazepine is deemed necessary for a short period, Oxazepam is preferred. An initial dosing of 10mg three times per day is recommended, which can be cautiously increased to 15mg three to four times per day, to enable safe evaluation of the effect of the medication. There is no specific warning regarding prescribing Oxazepam for patients with dementia, however listed adverse effects include impaired physical or mental ability due to central nervous system depression.

Issue 2

25. **Mrs Barton did not have a history of falls, however she sustained multiple falls while she was at CCM. Her next of kin was not always informed of each fall. Why did Mrs Barton have so many falls, and were the falls prevention initiatives sufficient?**

a. While the causes of Mrs Barton's multiple previous fractures in her medical history remains unclear, GP Dr Barrett advised in her statement that there was only one previous known fall, which occurred in February 2014. Ms Fausett acknowledged in her statement that a formal falls risk assessment was not performed at the time of Mrs Barton's arrival to CCM, as there was no indication to perform this assessment from the preliminary mobility safety screening during the admission process.

b. Mrs Barton sustained three falls – all unwitnessed – whilst at CCM. The first occurred at 8.45pm on 17 February 2015, shortly after she was administered her second 15mg Oxazepam dose for the day from the new regular medication order. This was the first time Mrs Barton had received more than 15 mg of Oxazepam in one day. She sustained a right wrist skin tear, bruising to her right leg and elbow, and a lump on the right side of her forehead.

c. Mrs Barton's second fall occurred on 18 February 2015 at approximately 2.50pm, after independently taking herself to the toilet. There was no apparent injury. A suspicion by CCM staff that Mrs Barton's falls were related to her new medication was first documented at this time. The following morning, a physiotherapist assessed that Mrs Barton had no fractures or significant musculoskeletal injuries following her falls, and also recorded that she was inappropriately using her single point stick when ambulating, noting that her technique was safer and much improved with a four-wheeled walking frame. The physiotherapist recommended additional falls prevention measures including a sensor mat, low bed and increased supervision, which were promptly implemented.

d. Mrs Barton's third fall occurred on the evening of 19 February 2015. She was discovered on the floor next to her bed, lying on the sensor and padded safety mats. There was no apparent injury. Following all three falls, Mr David Barton was

notified shortly afterward. Ms Fausett advised in her statement that staff followed the CCM falls policy in response to each fall, which included resident assessment, observations (neurological and vital sign observations were within normal range), communication with Mrs Barton's family and GP, and implementation of relevant interventions as required. Mrs Barton was re-categorised as a high falls risk following her first fall on 17 February 2015.

e. After comprehensive review of the CCM records, there is no documentation of Mrs Barton exhibiting drowsiness or an altered conscious state. The falls prevention and management interventions performed by CCM nursing staff were appropriate. GP Dr Natasha Aylen and Nurse Practitioner Candidate Mr Peter Thompson (who regularly attended CCM) were contacted by phone following each fall to discuss monitoring and subsequent management of Mrs Barton. In the afternoon of 19 February 2015, Dr Aylen and Mr Thompson advised to withhold the 2pm dose of Oxazepam from the following day until her discharge from CCM. Consequently, Mrs Barton would receive a twice daily 15mg Oxazepam dose at 8am and 6pm. Her three falls at CCM coincided with commencement of the 3 times per day Oxazepam order prescribed by Dr Chan, and no further falls occurred at CCM after the 2pm dose was withheld from 20 February 2015 until after her transfer to MPH on 24 February 2015.

Issue 3

26. **CCM staff advised that as Mrs Barton was residing at CCM for respite care, until a permanent position became available at MPH, no long-term treatment plan would be established. Further, that the medication prescribed was a short-term management tool until a permanent RACF position and GP could be found, and a long-term care plan developed. This is not satisfactory or convincing.**

a. In a further statement by Ms Fausett, she advised that Mrs Barton was initially admitted to CCM for a two week period of respite, though she remained there for approximately one month, before being transferred to MPH when a permanent position became available. At the end of the two week respite period (approximately 4 February 2015), CCM staff were verbally notified that Mrs Barton would be staying for a further two weeks.

b. Ms Fausett explained that when residents are admitted for two weeks of respite, a comprehensive assessment is not undertaken, as such assessments routinely take two weeks to complete. For respite residents, CCM staff complete assessments only for health and care issues that are relevant to the individual. Ms Fausett explained that when Mrs Barton's behavioural issues escalated and falls occurred, a long term management plan was initiated.

Issue 4

27. **Was Mrs Barton managed appropriately at both the RACFs, and why did they persist with caring for her despite staff conceding to Mr David Barton that they were not equipped to manage her behaviour? Why wasn't a specialist agency contacted to assess and manage her in a more appropriate placement?**

Care at CCM:

a. Ms Fausett advised that upon Mrs Barton's admission to CCM on 22 January 2015, she was accommodated in the Memory Care Unit, a high acuity care unit for residents with dementia and related challenging behaviours who require active assistance and supervision. CCM staff intermittently documented behavioural

assessments of Mrs Barton throughout her entire stay. Behavioural assessment charting is useful not only to nursing and care staff, but especially so for medical staff who do not spend hours or days with residents, and so rely on such data to form an opinion of appropriate pharmacological and non-pharmacological treatment.

b. On 16 February 2015, Dr Chan reviewed Mrs Barton after previously reviewing her on 23 January 2015. At this consultation, Dr Chan documented that she had been very disruptive and could be aggressive to staff and other patients. At this subsequent review, Dr Chan changed the Oxazepam prescription from an 'as required' order to a regular order.

c. On the afternoon of 17 February 2015, Dr Aylen and Mr Thompson reviewed Mrs Barton following a request from CCM nursing staff due to her ongoing behavioural issues. She was provisionally diagnosed with a delirium and possible underlying depression and anxiety, and a full organic screen (blood and urine tests) was requested. Mrs Barton was commenced on Escitalopram 5mg daily, and the regular Oxazepam order was noted. Dr Aylen and Mr Thompson documented they were happy to be contacted again if CCM staff had any further concerns. The blood test results were largely unremarkable, with the exception of a mildly raised C-reactive protein (CRP) level of uncertain significance.

d. The medical assessments and investigations that occurred on 16 and 17 February 2015 (approximately 4 weeks post admission) ideally should have occurred sooner in light of Mrs Barton's escalating behaviours that CCM staff were finding increasingly difficult to manage. It is unclear whether ongoing uncertainty by CCM staff regarding which GP was caring for Mrs Barton contributed to this delay, however, other avenues for a primary medical review such as by Dr Aylen and Mr Thompson, or a locum medical service, could have been engaged sooner by nursing staff at CCM. Apart from this delay to request further medical reviews by CCM nursing staff, all care provided for Mrs Barton appears to have been appropriate. A referral to the Peninsula Health dementia-specialised service Aged Persons Mental Health Team (APMHT) was completed by CCM Clinical Care Coordinator (CCC) Ms Sarah Mitchell on 17 February 2015. However, the referral does not appear to have been actioned by the APMHT. No record of the referral was found following HMIT review of the Peninsula Health medical records. It cannot be determined whether the referral was actually sent, or sent and received. As there is no evidence the referral was received, this may be explain there being no action by Peninsular Health to enter a screening register onto the Victorian Mental Health Database and scan the screening and referral into Mrs Barton's digital medical record.

Care at MPH:

a. Mrs Barton was transferred to MPH on 24 February 2015, and was admitted as a permanent care resident directly into the dementia care wing. Her behavioural issues listed above in Issue 1 continued at the new RACF. The MPH staff administered medication, from instructions either on the original package or from a dose administration aid; 15mg Oxazepam dose at 6am, 2pm and 6pm on 25 February 2015, along with her other medications. A photocopy of Mrs Barton's CCM medication chart was utilized by MPH staff to sign off the administration, as it was for additional Oxazepam administered up to the 26 February 2015.

b. A statement was requested from MPH regarding Mrs Barton's admission, and was jointly provided by Mr Lester and Ms Reynoldson. Their statement explained that

following Mrs Barton's arrived at MPH, she was first reviewed by her new GP Dr Jane Offor on 26 February 2015 during her weekly Thursday round at the RACF. Dr Offor carried forward Mrs Barton's medication regimen to a new MPH medication chart. She continued the Oxazepam 15mg as a three times per day order. The dosing interval of Oxazepam was shortened to 8am, 12pm and 5pm.

c. There were seven documented falls sustained by Mrs Barton during her period of residence at MPH. Her first was at 6.20pm on 25 February 2015. This fall was unwitnessed, and occurred 20 minutes after receiving her third 15mg Oxazepam dose for the day. The progress notes, however, record no evidence of Mrs Barton experiencing any physical decline related to the medication. A second unwitnessed fall occurred 30 minutes later. On 27 February 2015, Mrs Barton fell and struck her head after losing balance whilst getting up from a chair. This occurred nearly 2 hours after her midday dose of Oxazepam, her second dose for the day. It needs to be noted, that she was also on Citalopram medication at this time, which can have central nervous system impacts, such as vertigo and ataxia. She also fell on 2, 3, 5 and 6 March 2015, with multiple further head strikes.

d. On 27 February 2016, in addition to the regular Oxazepam prescribed by Dr Offor, 'as required' doses were continued on the MPH medication chart. The copy of original Oxazepam 'as required' order on the CCM medication chart appears to have been photocopied and affixed to the MPH medication chart. This transcribed order was utilised multiple times by several MPH nursing staff. In fact, after receiving her three 15mg regular doses of Oxazepam on 2 March 2015, Mrs Barton was also administered additional 15mg doses of Oxazepam at 6.45pm, 10.50pm, and again on 3 March 2015 at 2.30am – a total of 90mg of Oxazepam over the two day period.

e. Neurological observations and vital signs were appropriately assessed following each of Mrs Barton's falls at MPH, in addition to completion of formal Falls Risk Assessment Tool (FRAT) forms. Mrs Barton was also appropriately reviewed by a physiotherapist on multiple occasions in response to her falls, with additional strategies advised and implemented. During a physiotherapy review on 2 March 2015, Mrs Barton was described as requiring two staff to assist with transfers, and "*currently not suitable for gait aid usage due to cognitive impairment.*" Following each fall, Mrs Barton's family and GP (or covering GP) were notified.

f. In Dr Offor's statement, she advised that the usual method of managing MPH residents who sustain a fall was for the nurse to fax her a report, and if they had concerns regarding an injury sustained, to phone her. Following the 2 March 2015 fall, an ambulance was called, but Mrs Barton was deemed to not require hospitalisation following assessment. After a further fall the next day, she developed hypotension and unequal pupils, and so was appropriately transferred to the ED.

g. A urine test collected on 3 March 2015 revealed Mrs Barton had elevated leukocytes but no bacterial growth, so the significance of the result was unclear, but not clearly suggestive of an infection. Dr Offor noted Mrs Barton's largely unremarkable blood test results from 20 February 2015, and requested a further blood test during her regular visit on 5 March 2015 (this blood sample was not collected by the private pathology service until 12 March 2015). Dr Offor ceased the regular Oxazepam order at this time, and a new 'as required' medication regimen of olanzapine, paracetamol, oxycodone (Endone) and Oxazepam was trialled. These 'as required' medication orders were concurrently utilised by the MPH nursing staff from 5 to 12 March 2015, including approximately 2 x 15mg Oxazepam doses daily.

h. The MPH joint statement explained that an array of falls prevention strategies were implemented upon Mrs Barton's admission to MPH, including a padded falls mat and low bed. Behavioural assessment charting was documented intermittently throughout her admission, and extensive behavioural support measures complemented the falls risk reduction measures. The MPH joint statement highlighted that the most effective falls prevention strategy was the initiation of intermittent one on one supervision which was identified as necessary from 25 February 2015, the day after her MPH admission. After reviewing the MPH records, it appears that both the pharmacological and non-pharmacological interventions implemented were largely unsuccessful at curtailing or resolving Mrs Barton's BPSD throughout her admission.

i. MPH staff referred Mrs Barton to APMHT on 2 March 2015 by telephone. The clinician who received the referral was told MPH had purported to already have referred her to APMHT, with this being recorded together with a note that referral had not been received. A screening register was entered onto the Client Management Interface and a copy of the screening register was scanned to Mrs Barton's digital medical record. APMHT Registered Nurse (RN) Andrea Keith attended MPH on 12 March 2015, documenting that Mrs Barton was a very distressed, medically complex lady with advanced cognitive impairment, who was difficult to manage due to her behaviours, and who displayed evidence of physical pain (wincing; protecting shoulders / arms). After acknowledging Dr Offor's commencement of Quetiapine (Seroquel) earlier in the day on 12 March 2015, RN Keith documented an appropriate plan for ongoing management of Mrs Barton that included discussing her assessment and management plan with Mr David Barton, an APMHT re-assessment in two weeks, and for a psychiatry registrar review to be scheduled, likely in three to four weeks' time.

j. In addition to commencing quetiapine, Dr Offor had ceased the 'as required' Oxazepam and Olanzapine orders on 12 March 2015. She made further medication changes following consultation with APMHT. MPH RN Sharon Oussa sought assistance from APMHT early on 20 March 2015 due to Mrs Barton's constant incoherent calling out, resistance to care, attempts to ambulate despite being very unsteady, and requiring one-on-one supervision, with no resolution of her agitation from distraction therapies. APMHT advised to consider investigating for an infectious cause of possible delirium. RN Oussa then requested a locum doctor, who attended and subsequently recommended Mrs Barton be transferred to hospital.

The HMIT concluded that the care provided at MPH throughout Mrs Barton's admission was appropriate, except for issues of Oxazepam prescription and administration. These are further addressed below.

Issue 5

28. **Mrs Barton still had oral candidiasis in late March 2015. This likely contributed to her poor oral intake and weight loss. There was no treatment provided for this condition at either RACF.**

a. In her statement, Ms Fausett advised that staff actively observe and assist with the oral intake of residents for all meals at CCM. Any concerns are referred to the RN of the unit, though no such concerns were identified for Mrs Barton. In a Patient Health Summary letter from GP Dr Elizabeth Gascoigne (also from Mount Martha Village

Clinic) to CCM regarding Mrs Barton's admission, Amphotericin (Fungilin) lozenges were listed as a current medication. Whilst Mrs Barton was admitted to CCM, Amphotericin lozenges were prescribed four times per day from 22 until 28 January 2015, at which time they were ceased by Dr Gascoigne.

b. Mrs Barton's insufficient oral intake and requirement for one-on-one assistance with meals were initially identified the day after her arrival at MPH. Her care plan identified the need for a soft diet and thin fluids, as she was forgetting to swallow and was constantly chewing due to her cognitive impairment. Her food and fluid intake gradually declined, and was influenced by the extent of her behavioural issues on any given day. A significant decline in her oral intake appears to have occurred from mid-way through her MPH admission. Whilst no dietician referral occurred, MPH staff did perform formal Nutrition and Hydration Assessments, food and fluid intake charting, and trialled appropriate strategies including increased portion size, high energy supplements, and changes of diet and food consistency, though with limited success. Mrs Barton's weight on 24 February 2015 was 47.5 kilograms. At the time of the post-mortem examination, Mrs Barton weighed 42 kilograms.

c. On 16 March 2015, it was documented that Mrs Barton had dry, cracked lips with bleeding gums, and consequently, her dentures were removed. After review of both RACF medical records, there was no further documentation or treatment of oral candidiasis. However, oral candidiasis (of unknown severity) was once again noted in the Frankston Hospital psychiatric unit discharge summary on 25 March 2015.

d. It is unclear whether Mrs Barton's oral candidiasis had persisted throughout her RACF admissions, but review of the records suggests that it may have resolved and then recurred in the week prior to her death. Nonetheless, whilst oral candidiasis can be uncomfortable and lead to a decrease in eating and drinking, the two factors that likely had a more significant impact on Mrs Barton's nutritional intake and weight loss, were her worsening BPSD which were increasingly refractory to all interventions, and the Oxazepam prescribing and administration.

Issue 6

29. **Why did it take so long to discover the multiple fractures Mrs Barton had sustained, which surely increased her agitation and distress, and possibly led to unnecessary Oxazepam use?**

    a. In the days following her transfer to Frankston Hospital on 20 March 2015, radiological investigations identified that Mrs Barton had likely subacute right-sided fifth, sixth and seventh rib fractures, as well as a 50% loss of height compression fracture of approximately the T11 vertebra. A later CT scan confirmed T2 and L1 vertebral body wedge fractures of the spine (not T11), in addition to subacute and old pelvic fractures. Mrs Barton's T2 and T12 spinal compression fractures had previously been identified in a CT scan from October 2014,[7] and whilst the fractures may have been exacerbated by her numerous falls in the months prior to her death, they were not new. The vertebrae T11, T12, and L1 are adjacent to one another in the lower back. The discrepancy between the identified fractured vertebrae is likely attributable to either incomplete radiography imaging or inaccurate assessment of an image by the reporting radiologists.

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7 T2 and T12 compression fractures identified at the 21 October 2014 CT chest scan, with 30-40 per cent loss of height. No rib fractures were identified on this scan.

b. CCM staff identified that Mrs Barton had sustained bruising and skin tears following her first fall on 17 February 2015, though none of the injuries corresponded to possible rib or pelvic fractures. In the two further falls in subsequent days at CCM, no injuries were identified. That is not to say Mrs Barton did not sustain her rib and pelvic fractures during her three falls at CCM, rather, there was no significant deformity, reduced movement or pain identified that would have given cause to radiologically investigate for fractures.

c. The MPH joint statement was critical of Frankston Hospital ED staff, who did not radiologically investigate Mrs Barton for fractures during her presentation on 3 March 2015 following another fall. However, the location of Mrs Barton's identified acute injuries at this time were her head and right forearm – no significant head injury or right arm fracture was subsequently identified at autopsy. Mrs Barton sustained a total of 10 documented falls from 17 February to 6 March 2015, including two falls after the 3 March 2015 ED presentation. It remains unclear exactly which fall or falls caused Mrs Barton's rib and pelvic fractures.

d. The fractures did likely contribute to Mrs Barton's agitation and distress, and may have led to unnecessary Oxazepam use. However, compounding the difficulty of identifying the need to perform radiological investigations was Mrs Barton's chronically advancing BPSD. Had her fractures been identified prior to her admission to Frankston Hospital from 20 March 2015, it is uncertain whether the medical management would have changed. Mrs Barton returned from Frankston Hospital ED late in the evening of 3 March 2015, and the following day MPH staff began documenting that she was communicating and exhibiting signs that she was in pain. Dr Offor provided a telephone order for 'as required' Oxycodone on 4 March 2015, and on 5 March 2015 she reviewed Mrs Barton and amended the medication chart, appropriately discontinuing the regular Oxazepam, and prescribing simple and narcotic analgesic medications. The nursing and carer management may have changed by the earlier identification of fractures, however, RACF staff may have been more aware of Mrs Barton's pain and associated distress when assisting her with activities of daily living in addition to when deciding to administer the 'as required' analgesia that she received nearly every day from 5 March 2015.

Issue 7

30. **Mrs Barton's fractured vertebrae were not identified in the autopsy report findings. This injury should be added as an unrecognised complicating factor that caused pain and accelerated Mrs Barton's decline.**

a. Review of the post-mortem CT scan only identified fractures of the right sided pelvic rami and ribs. However, as explained in response to Issue 6, Mrs Barton's vertebrae fractures were chronic, and had been identified in the year before her death, if not earlier. Whilst her rib and pelvic fractures likely contributed to her agitation and distress, it is not certain whether her chronic vertebrae fractures had a similar impact.

b. Other complicating factors that may have contributed to Mrs Barton's physical and cognitive decline included the multiple falls, the subsequent soft tissue injuries, environment changes including two new RACFs and multiple ED presentations, cardiac disease, decreased oral intake and advancing Alzheimer's dementia.

Issue 8

31. **Did the Oxazepam hasten Mrs Barton's physical decline and her death?**

a. Regardless of the number of Oxazepam dosages administered, there were multiple days of no falls being recorded, (24, 26, 28 February, 1 March 2015) and on one occasion, the fall occurred prior to any drugs being given. Mrs Barton's fall on the 27 February 2015 occurred in the afternoon, two hours after her second dose and a fall on the 5 March, was caused by tripping over another resident's walking frame. In addition, other medications were administered on days when Mrs Barton fell, including ordered laxatives, Olanzapine, Endone, Citalopram, Thyroxine and Paracetamol.

b. Nevertheless, and despite Dr Offer observing no signs of over-sedation, the evidence satisfies me that there is sufficient correlation between Mrs Barton's multiple falls and the Oxazepam, to conclude that the medication regime contributed to her physical decline and death. In addition, it can reasonably be associated with pain from fractures and soft tissue injuries, the subsequent pneumonia, and also possibly Mrs Barton's decreased oral intake and exacerbation of her BPSD.

c. Mrs Barton's three falls at CCM occurred while she was receiving Oxazepam 15mg three times per day, however, she did not sustain any falls when the dosage was temporarily reduced during the final days of her respite admission to CCM. (There is no evidence of this information being communicated to MPH prior to her admission there.) Her falls recurred on the day after her arrival at MPH, when she once again was administered Oxazepam 15mg three times per day, plus additional 'as required', Oxazepam. The regular order of Oxazepam was administered to Mrs Barton over 9 days post admission.

32. Further issues raised by the Barton family regarding the medical management of Mrs Barton at Frankston Hospital are not related to her death, and as such are beyond the scope of my investigation. The Barton family should contact Frankston Hospital directly regarding these concerns, or if required, the Health Complaints Commissioner.

HMIT Assessment of Health Care Diagnosis / Treatment / Follow Up:

33. Prior to respite admission:

a. Dr Barrett, who had been Mrs Barton's primary GP from 2014, had previously referred her to the Peninsula Health APMHT in October 2014, due to worsening BPSD. It is unclear what the outcome of the APMHT assessment was. Dr Barrett advised that Mrs Barton was having trouble or refusing to take her medications at home, so in January 2015, Dr Barrett reasonably minimised Mrs Barton's medications to Paracetamol and Thyroxine. Multiple blood and urine tests were taken in January 2015 due to Mrs Barton's deteriorating mental health. These test results were normal.

Respite admission to CCM:

b. Ms Fausett advised in her statement that no issues were identified following review of the care provided to Mrs Barton during her month long respite admission to CCM. With respect to sourcing a new GP following her initial 2 week respite admission to CCM, Ms Fausett indicated that after CCM staff ascertained that Mrs Barton's regular GP was not available to continue the role whilst Mrs Barton was at CCM, she was placed into the care of Dr Chan.

c. Dr Chan admitted Mrs Barton to CCM on 23 January 2015, and reasonably commenced a low dose 'as required' order of Serepax (Oxazepam) due to her agitation and anxiety. He ordered that Mrs Barton could be given up to two 15mg

doses of Serepax per day. Dr Chan confirmed that he was not requested to re-review Mrs Barton until 16 February 2015. Due to Mrs Barton's constant agitation and aggression, he concluded that the Oxazepam dose was insufficient and decided to trial an increased regular dose. On the assumption that she had been given the maximum daily dose of 30mg, he increased it by 50 percent to 45mg. Dr Chan explained that whilst he felt Mrs Barton tolerated the lower dose well, he was conscious that the increase could be excessive, and so documented that he also considered trialling Risperidone as an alternative treatment.

d. Whilst Dr Chan was only assigned to Mrs Barton temporarily while she awaited a permanent RACF placement, he should have followed up on the effects of the Oxazepam after he commenced the 'as required' order. Had he done so he would have been aware that Mrs Barton had not been receiving her maximum 30mg daily dose. Dr Chan acknowledged in his statement that he was aware the effectively tripled Oxazepam dose he prescribed could be excessive and that he should have more closely reviewed her medication chart. This was less than optimal medical management.

e. Furthermore, pathology investigations for Mrs Barton's sustained / worsening agitation should ideally have been undertaken prior to, or at the time of the Oxazepam increase. Dr Chan advised that he had taken into account Mrs Barton's recent unremarkable pathology investigations ordered by her previous GP just prior to the CCM admission, and that had he been requested to undertake a further review for persistent agitation, he would have requested pathology investigations and referred Mrs Barton to a geriatrician or specialist mental health service. Dr Chan was not requested to re-review Mrs Barton again after 16 February 2015, and was not made aware of any of the falls on 17, 18 and 19 February 2015. Dr Chan subsequently learned that CCM staff thought he was unavailable, and they therefore consulted Dr Aylen and Mr Thompson. He disputes not being available and can't explain why staff thought this, as he was working in his Mornington practice throughout the week commencing the 16 February 2015.

f. A statement was provided by GP Dr Aylen. She explained that she and Mr Thompson visited CCM weekly on a Tuesday and were sometimes asked by CCM staff to review respite residents for whom the usual GP was uncontactable. Dr Aylen and Mr Thompson assessed Mrs Barton and provided advice between 17 and 19 February 2015, but were not contacted by CCM staff again with respect to her. Dr Aylen explained that at a subsequent visit to CCM, she was reportedly advised that Mrs Barton's family had purportedly "*taken Mrs Barton to an undisclosed location unexpectedly*". Dr Aylen further stated that Mrs Barton's son was purportedly not returning phone calls from CCM staff, and so Dr Aylen was unable to verbally handover, or provide a written summary to Mrs Barton's new GP, or RACF. Dr Aylen explained that she requested the CCM to attempt to discover which RACF Mrs Barton had been transferred to, to enable a routine handover to occur. I note in this respect that Mrs Barton's family vehemently deny that CCM staff were unaware of Mrs Barton's discharge destination or that they did not return CCM's telephone calls. As stated in paragraphs 47 (g) and 48 below, there is evidence that CCM staff were aware of Mrs Barton's discharge RACF destination.

g. In Ms Fausett's second statement, she explained that a transfer letter or verbal handover to the receiving facility would routinely occur when transferring a CCM resident to another facility. Mrs Barton's son was advised prior to and on the day of

transfer that relevant documentation would be provided to the receiving RACF. However, Ms Fausett states that on the day of Mrs Barton's transfer, her son and other family members took Mrs Barton out of the facility quickly, and did not wait for a printed letter or copies of information pertaining to her respite admission, and that CCM staff were not advised which RACF Mrs Barton was being transferred to. Ms Fausett states that the CCC also asked the Barton family to advise the receiving facility to contact CCM if they required any information pertaining to Mrs Barton's care requirements, however no request for information was made. I note that Mrs Barton's family dispute that they removed her quickly from CCM and did not wait for handover documentation. Mrs Barton's son, Mr David Barton, states that he and his family needed to wait for sedating medication provided to his mother by CCM staff to facilitate ease of transfer to take effect. He states that he was under the impression that CCM staff were preparing paperwork whilst this was occurring. He states that once the medication took effect, and due to his mother's distressed state, he and his family were keen to transport her to MPH. He states that he and his family were informed by CCM staff 'not to worry' about the documentation, and that they would forward it to MPH later. Mr Barton also states that he and/or his family communicated CCM's message to MPH; that if they (MPH) required information pertaining to Mrs Barton's care requirements, they should contact CCM.

h. Upon review of the MPH records, the HMIT discovered an APMHT referral form completed by CCM CCC Ms Mitchell on 17 February 2015, which documented that Mrs Barton was a respite resident at CCM, and was expected to be transferred for permanent admission to Park Hill Gardens RACF on 20 February 2015. Also, in an undated letter which accompanied requested CCM records, Ms Fausett had previously advised that a discharge summary had not been completed for Mrs Barton's transfer to MPH, but a verbal handover was provided along with copies of "*relevant documentation and falls strategies.*" Along with the APMHT referral form mentioned above, the documentation from CCM discovered in the MPH records was limited to a copy of Mrs Barton's medication chart, and the 17 February 2015 progress note entry by Dr Aylen and Mr Thompson.

Permanent placement at MPH:

i. In her statement, Dr Offor explained that her admission review of Mrs Barton was limited as Mrs Barton was quite agitated, and it was therefore neither possible nor appropriate to attempt an extensive physical examination at that time. From review of the information available, Dr Offor concluded that there was no evidence of a sudden change or deterioration to Mrs Barton's behaviour, and therefore, rather than make any acute medical management changes, she felt it would be best to see if Mrs Barton would become more calm once she had adjusted to her new environment. Dr Offor also noted there was no signs that Mrs Barton was over-sedated. She considered that Mrs Barton's symptoms of aggression and agitation were due to her advanced dementia and change in environment, in addition to pain from injuries sustained in the falls. Dr Offor noted that blood and urine tests performed in January and February 2015 excluded an acute organic cause which required treatment.

j. With respect to recommencing Mrs Barton on 3 x 15mg per day of Oxazepam at MPH, Dr Offor advised that she did not notice that the midday dose had been withheld for the last several days of her CCM admission and neither was she notified of this information. If Dr Offor did have the administration page of Mrs Barton's CCM medication chart available to review, the HMIT notes that it is difficult to

ascertain from review of the photocopy of the chart that the Oxazepam had been withheld.

k. Dr Offor noted that Mrs Barton was a very challenging patient. She explained that she may have benefited from a personal handover from the doctor who visited Mrs Barton at CCM, and with the benefit of hindsight, conceded that perhaps she should have sought this out. Dr Offor acknowledged that an earlier visit from the APMHT may have been helpful too, but stated that it was unclear at the time what role the use of Oxazepam may have played in Mrs Barton's falls.

l. After the Oxazepam initially seemed to have a positive effect on Mrs Barton's BPSD at CCM, by the time she arrived at MPH, it was becoming less effective. MPH staff continued to administer Mrs Barton Oxazepam 'as required' from the transcribed order in addition to the 3 times a day dose charted by Dr Offor (a midday dose of Oxazepam was withheld on 1 March 2015). By early March 2015, both pharmacological and non-pharmacological interventions were unfortunately having a diminishing effect on curtailing Mrs Barton's increasingly difficult behaviours. While MPH staff appropriately referred her to the APMHT within a week of her admission, ideally nursing staff should have requested either Dr Offor or a locum to review her urgently in light of her repeated significant falls.

m. The MPH joint statement advised that Mrs Barton's death was reviewed internally by the facility manager and the general manager of residential services, as well as at multiple MPH management meetings. MPH identified that CCM failed to provide adequate up to date information to MPH at the time of Mrs Barton's transfer. The handover between RACFs lacked details of Mrs Barton's multiple falls and bruising sustained during the final week of her period of respite at CCM in addition to the care needs she required, and consequently prevented the earlier opportunity for MPH staff to discuss referral of Mrs Barton to a specialist residential psychiatric / mental health service where her care needs may have been more appropriately met.

Identification of Potential Prevention Interventions:

34. A further statement was requested from MPH, and provided by Chief Executive Ms Michele Lewis. Regarding the use of the CCM medication chart at MPH prior to Dr Offor's initial review of Mrs Barton, Ms Lewis advised that under the previous Park Hill Gardens policy, it was standard acceptable practice for staff to utilise photocopied and faxed medication charts from other health care facilities until a Park Hill Gardens medication chart could be completed by a GP. However, since 15 December 2014, new MPH medication policy and procedures required medication charting for newly admitted residents to be undertaken via telephone orders of all medications until a GP / locum can attend the facility. Despite comprehensive on-site education and communication with staff regarding this and other policy changes, the superseded practice was still utilised at the time of Mrs Barton's admission.

35. Regarding the transcribed 'as required' Oxazepam order on the MPH medication chart that was concurrently utilised on multiple occasions with the regular Oxazepam 15mg order, Ms Lewis advised that the order was first signed (at 7pm on 27 February 2015) by casually employed enrolled nurse (EN) Ms Prue Middling. EN Middling was interviewed by MPH, and stated that she could not recall administering the medication. However, Ms Lewis' statement does not definitively advise whether or not EN Middling transcribed the order. MPH also interviewed several other staff members – RNs Robyn Pendlebury, Jennifer

Coombe, Nanette Haynes and Mr Lester – with each confirming they had not transcribed the order.

36. MPH nursing staff advised that in order to administer an 'as required' medication, Mrs Barton would have had a supply of Oxazepam in the medication trolley dispensed from a pharmacy. Therefore, in accordance with previous Park Hill Gardens policy, medications were able to be administered using the prescription label of an original medication container or packaged dose administration aid. The creation of the Oxazepam 'as required' order from Dr Chan's order in the CCM medication chart was likely done to enable documentation of administration until a legal order could be prescribed.

37. The HMIT reviewed a copy of the Park Hill Gardens Medication Management policy provided by Ms Lewis. Point 10 of the policy confirmed that "*New resident's medication can be administered following instruction written on the original drug bottle or pack but medical practitioner must be contacted to order medication within 48 hours.*" An unsigned entry dated 27 February 2015 on a MPH Medical / Health Practitioner communication page documented "*please write up prn Serepax.*" The MPH investigation concluded this entry may have been written by RN Deborah Maxwell-Wright who, during her morning shift, had also documented GP-initiated medication telephone orders for Mrs Barton in her MPH medication chart. Ms Lewis suggested that RN Maxwell-Wright may have advised of the requirement for an 'as required' Oxazepam order when speaking to the GP at this time. MPH did not advise whether or not RN Maxwell-Wright was interviewed. The creation of the 'as required' Oxazepam order using Dr Chan's previous prescription, breached Point 21 of the Park Hill Gardens Medication Management policy, which stated "*Staff must never transcribe medication onto medication charts.*" This practice expectation is reiterated in the current MPH Medication Management policy and procedure, with Point 9 stating that all medications orders must not be transcribed or existing legal orders altered.

38. It is unclear why Dr Offor back-dated the order to 23 January 2015 (the date of the original order by Dr Chan). Dr Offor re-wrote the order at an undetermined time after 3 March 2015, presumably during her weekly visits to MPH on either 5 or 12 March 2015. Dr Offor's order was written in the space of the transcribed order, likely to support the previous Park Hill Gardens policy that nursing staff could initiate administration of prescribed medications for new residents. However, all MPH nursing staff who subsequently utilised the transcribed 'as required' Oxazepam order also should have recognised that the order was against Park Hill Gardens and MPH policy.

Table 1. MPH nursing staff who utilised the transcribed 'as required' Oxazepam order

Name	Role	Date & Time	MPH employment status
Prue Middling	EN	27 February 2015, 7pm	Current casual employee
Rebecca Cooper	RN	1 March 2015, 4am	Not a current employee
Rebecca Cooper	RN	2 March 2015, 6.45pm	
Nanette Haynes	RN	2 March 2015, 10.50pm	Current part-time employee
Nanette Haynes	RN	3 March 2015, 2.30am	
Nanette Haynes	RN	3 March 2015, 11.55pm	
Bethany Jackson*	RN	8 March 2015, 2.45am	Agency nurse

*** The dose administered by RN Jackson on 8 March 2015 may have occurred after Dr Offor re-wrote the order. Therefore, RN Jackson potentially would not have been aware that the order had been amended.**

39. Ms Lewis advised that all nursing staff interviewed other than EN Middling, had attended scheduled MPH systems and processes orientation sessions in February 2015. EN Middling had worked limited shifts during this period, but advised that she had reviewed the new MPH medication policy. RN Coombe was the nurse on duty on the afternoon shift of 27 February 2015, when EN Middling administered the 'as required' Oxazepam. RN Coombe advised that EN staff did not consistently confirm the appropriateness of administering 'as required' medications with the duty RN prior to administration at that time. No portable phones were available to facilitate ease of communication between staff, who would therefore have to leave their assigned areas to find the RN on duty.
40. Ms Lewis noted that previous Park Hill Gardens Director of Nursing / Operations Manager Ms Rosemary Jackman was the key clinician at the time of transmission of business to MPH, and the facility had limited external peer review of systems and processes. Ms Lewis suggested that entrenched clinical practices at Park Hill Gardens may not have been recognised as outside the parameters of best practice. Ms Lewis also advised that MPH has an organisational structure with significant peer review and governance of clinical systems and practices that is now operational across MPH.
41. Ms Lewis advised that a facility-wide audit of all MPH medication charts was conducted on 30 March 2015, and a number of practices not consistent with the new MPH policies were identified. Consequently, a memorandum was disseminated at MPH in April 2015 advising staff of the issues identified, and reminding them of correct staff practice requirements. The memorandum included a reminder that faxed or photocopied medication charts were no longer acceptable.
42. Summarised below are the organisational changes that occurred at MPH in March 2015, both in response to the internal review of Mrs Barton's death, as well as due to transitional changes following the purchase of Park Hill Gardens by MPH in December 2014.
    a. The MPH Admissions Officer now liaises more significantly with the family of the newly admitted resident, to help determine appropriate clinical and care needs.
    b. Appointment of a Clinical Nurse Manager, who is responsible for clinical leadership and oversight of all resident care and support for RNs on duty.
    c. A portable phone system network was installed. Additionally, the nurse call bell system was improved, so that the alarm sounded for call bell alerts is distinguishable from the sensor mat alerts.
    d. Weekly falls prevention and management meetings between the facility manager, clinical nurse manager, physiotherapist and lifestyle coordinator have reduced the number of resident falls at MPH.
    e. The documented communication method for MPH staff to relay information to the resident's GP was reviewed and improved, and now includes fields to record the date, issues, signature, and date the issue was reviewed by the GP.
    f. Improved processes at MPH to ensure visiting GPs document their assessment and orders directly in the resident's clinical file, rather than nursing staff recording the GPs visit, as was previously the case.

43. Ms Lewis advised that at the time of Mrs Barton's admission, with Dr Offor unavailable outside of her Monday to Thursday work days, there were limited and unreliable arrangements in place for after-hours locum services to attend. Also around that time, Dr Offor had recently taken over the care of a number of residents previously managed by another Mount Martha Village Clinic GP who did provide after-hours support. Since May 2015, an agreement with two locum medical services allows locum doctors to provide adequate after-hours medical care at MPH, including providing completed medication charts for newly admitted residents in a timely manner.

44. Recent MPH Incident Management policy changes include:

    a. Reviewed and updated administrative procedures for logging incidents (August 2015)

    b. Reviewed and updated after-hours and weekend reporting protocols and notification requirements (August 2016)

45. Additionally, recent MPH Falls Prevention and Management policy changes include:

    a. Reviewed and updated notification protocols for GPs (January 2015)

    b. Best practice guidelines for neurological observations included in the policy document (June 2016)

Summary of Contributing Factors:

46. Blood and urine investigations undertaken at CCM, MPH and Frankston Hospital ED in February and March 2015 revealed electrolyte derangement suggestive of mild dehydration, a mildly raised inflammatory marker of unlikely clinical significance, and no significant growth from urine culture testing. These results reasonably support a conclusion that Mrs Barton's worsening behaviours, which were increasingly difficult to manage despite significant staffing time allocated to care solely for Mrs Barton at both RACFs, were not due to an unidentified infection.

47. Forensic Pathologist Dr Francis concluded that Mrs Barton's death was due to pneumonia caused by rib and pelvic fractures sustained in the setting of multiple falls and comorbidities. Listed below are the multiple contributing factors identified by the HMIT which perpetuated both the declining health and delay in appropriate care of Mrs Barton in the months prior to her death.

    a. There were multiple unavoidable transfers to and between unfamiliar environments.

    b. Multiple GPs were involved in Mrs Barton's care in the final three months of her life, impeding care continuity, and resulting in delayed medical reviews, delayed referrals and sub-optimal prescribing.

    c. Mrs Barton's escalating behavioural issues were increasingly difficult for CCM nursing staff, who should have requested a GP review sooner than approximately four weeks after her respite admission. Ongoing staff uncertainty regarding whether Mrs Barton had been allocated a GP may have contributed to this delay.

    d. Dr Chan's prescription of 3 x 15mg of Oxazepam per day on 16 February 2015 effectively tripled Mrs Barton's Oxazepam dosage and was excessive. Whilst Dr Chan did document in the CCM progress notes his intention that the increased dose was a trial, and an alternative anti-psychotic medication may also be trialled later, the brevity of his entry regarding the medication change – "*Trial of Serepax 15mg*

tds as regular,?? Risperidone" – may not have effectively communicated his intentions to the CCM nursing staff. Furthermore, Dr Chan did not follow up on the outcome of his significant prescription change.

e. CCM staff requested Dr Aylen and Mr Thompson review Mrs Barton following the increased Oxazepam order. Ideally, Dr Chan should have been requested to re-review Mrs Barton.

f. Mrs Barton was transferred by her family from CCM to MPH. While it seems that some CCM paperwork was received at MPH, no documentation of Mrs Barton's escalating BPSD, the Oxazepam regimen, recent pathology investigations or the treating GP was provided. It is unclear whether information pertaining to Mrs Barton's multiple falls and the extensive falls prevention measures utilised at CCM was provided and / or received at MPH.

g. Due to contradictory statements by Ms Fausett, it remains unclear whether or not a verbal handover was provided from CCM to MPH. It is also unclear why CCM staff did not adequately record Mrs Barton's RACF destination when there is evidence that this information was available. This communication deficit impeded visiting GP Dr Aylen's ability to handover relevant treatment and investigation information to the receiving RACF and new primary GP.

h. CCM medication charts were inappropriately utilised by MPH nursing staff.

i. The order for Oxazepam 15mg three times per day was continued by Dr Offor upon the medical admission of Mrs Barton to MPH, and was unaware of the recent reduction in dose frequency.

j. The nurse-initiated and continued administration of multiple additional 'as required' Oxazepam doses resulted in even greater daily Oxazepam administration early in Mrs Barton's admission to MPH.

k. Dr Offor prescribed Citalopram 5mg mane (morning) on 26 February 2016, rather than the previously prescribed Escitalopram 5mg mane. While both medications are selective serotonin reuptake inhibitor (SSRI) antidepressants, Escitalopram can also be used to treat generalised anxiety disorders and has a recommended daily dose in the geriatric population is 5-10mg, whereas the recommended daily dosing of Citalopram is 10-20mg. Thus this inadvertent change in medication and equivalent dosing to a sub-therapeutic level may have contributed to the escalation in Mrs Barton's BPSD following her arrival at MPH. Dr Offor acknowledged in her statement that the medication change appeared to have been due to a transcription error. The photocopied CCM medication chart page had been hole-punched, obscuring the beginning of the medication name.

l. The ten day delay between the APMHT referral and their subsequent initial review of Mrs Barton at MPH was less than ideal, however, that constituted seven business days when taking into account the relevant weekend and public holiday occurring during that time. As Peninsular Health aims to undertake non urgent mental health assessments within five business days, the assessment was two days beyond their goal. Urgent or emergency assessments are undertaken at the Emergency Department. In addition, it was less than ideal to have a three to four week wait for the subsequent planned psychiatry registrar assessment. Nevertheless, this needs to be seen in the context of it being considered at the 12 March 2015 assessment, that Mrs Barton's behavioural disturbance was secondary to medical issues rather than a primary psychiatric cause.

48. Aside from the excess Oxazepam administration, the other key factor that adversely influenced many of the management and treatment decisions by multiple health care practitioners, was poor communication. CCM staff did not communicate appropriately with Dr Chan, with each other, and with MPH, despite documentation that shows CCM staff were aware which RACF Mrs Barton was transferred to. Dr Chan did not provide detail in the CCM progress notes regarding his awareness that the increased Oxazepam prescription could be excessive, and how nursing staff should monitor for this. Neither Dr Offor nor MPH staff communicated adequately with CCM, when they could have requested written and/or verbal information pertaining to Mrs Barton's current medical and nursing management.

49. I find that the cause of death of Margaret Barton was pneumonia complicating rib and pelvic fractures sustained in the setting of multiple falls in a woman with multiple medical comorbidities.

50. I further find that Mrs Barton's Oxazepam medication regime contributed to her physical decline and death.

RECOMMENDATIONS:

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I am able to make recommendations in relation to the death. I am aided by the HMIT's review in respect of these matters.

51. With respect to CCM, I make the following recommendations;

    a. The CCM policy "Management of a resident after a fall" was updated in May 2015, with some generalised improvements and greater detail of required care. However, specific details of the complete actions required by nursing staff in response to an unwitnessed fall by a resident are convoluted, referring the reader to multiple other sections of the policy. I recommend that CCM revise this policy to include greater clarity regarding nursing staff requirements for unwitnessed falls management of residents.

    b. Additionally, the CCM "Management of a resident after a fall" policy requires neurological observations to be performed half hourly for at least four hours on a resident who has sustained an unwitnessed fall. Neurological observations were performed far less frequently following all three falls Mrs Barton sustained. I recommend that CCM provide internal education to staff on adequate post fall management, including neurological observations.

    c. There was an apparent internal communication deficit at CCM regarding documentation of Mrs Barton's known impending transfer location. This deficit, amongst other things, impeded visiting GP Dr Aylen's ability to handover relevant treatment and investigation information to the receiving RACF and new primary GP. I recommend that CCM have an internal review of documentation to ensure that information pertaining to the impending transfer location of a respite or permanent resident, is easy to document and readily accessible.

52. With respect to MPH, I make the following recommendations;

    a. The array of practice changes and improvements undertaken by MPH and summarised earlier in the finding adequately addressed many of the issues identified in this report. However, I further recommend that MPH amend its policy to reflect

that for every resident admitted from another health care service, for either respite or permanent residence, an up to date, written care plan or health summary should be requested / received. If such a document is unavailable, every effort should be made to seek a verbal handover from the transferring service.

b. That MPH provide internal education to all staff administering medications, as per Point 6 of the MPH Medication Management Policy and Procedure. The internal education should serve as a reminder to staff of the importance of using "professional judgement in determining the appropriateness of a medication order". Specific high risk medications commonly used in RACFs include insulins, narcotics, sedatives and anticoagulants.

53. That the Australian Aged Care Quality Agency (AACQA) review this case, pertaining to:

    a. The adequacy of clinical governance of medication administration at Park Hill Gardens RACF, which ceased operations in December 2014.

    b. The inappropriate administration of medication ('as required' Oxazepam) by multiple nursing staff at MPH.

    c. The adequacy of communication between RACFs.

54. That the Australian Health Practitioner Regulation Agency (AHPRA) review this case, pertaining to:

    a. The adequacy of clinical governance of medication administration at Park Hill Gardens RACF, which ceased operations in December 2014

    b. The inappropriate administration of medication ('as required' Oxazepam) by multiple nursing staff at MPH.

    c. The significant increase in Oxazepam prescribed by Dr Chan, as well as the absence of follow up review provided.

55. Finally, I recommend that the Royal Australian College of General Practitioners (RACGP) use this case as an educational tool for members to highlight the complexity of care requirements, and to demonstrate the importance of appropriate dementia management, the importance of early escalation of care to specialist services, adequate communication between health services and practitioners, and appropriate prescribing and follow up.

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

Mr Andrew Barton and Mr David Barton

Mrs Kylie Burns, Peninsula Health Medico Legal Department

Ms Kitty Fausett, Facility Manager Craigcare Mornington

Ms Michele Lewis, Chief Executive at Mecwacare Park Hill

Ms Lindsey Taylor, General Counsel at Frankston Hospital

Dr Jane Offor

Dr Oi Kwan Chan

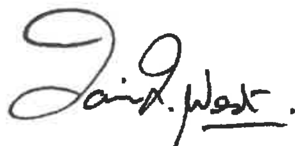
Dr Natasha Aylen

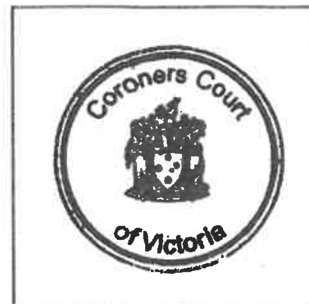
Royal Australian College of General Practitioners

The Australian Aged Care Quality Agency

The Australian Health Practitioner Regulation Agency

Signature:





IAIN WEST
ACTING STATE CORONER
Date: **4 February 2019**