Rule 60(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 5983

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 609(1)

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

Inquest into the death of: JOHN FREDERICK REIMERS

Findings of:	**AUDREY JAMIESON, CORONER**
Delivered On:	23 August 2019
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing Dates:	15, 16, 17 & 18 October 2018 and 4 December 2018.
Appearances:	Rachel Ellyard of Counsel on behalf of Mayflower Aged Care (Russell Kennedy Lawyers); Naomi Hodgson of Counsel on behalf of Ambulance Victoria (Minter Ellison): Fatmir Badali of Counsel on behalf of ESTA (K&L Gates Lawyers).
Police Coronial Support Unit:	Leading Senior Constable Tracey Ramsey, Assisting the Coroner.

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I, AUDREY JAMIESON, Coroner having investigated the death of JOHN FREDERICK REIMERS

AND having held an Inquest in relation to this death on 15, 16, 17 & 18 October 2018 and 4 December 2018

at Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was JOHN FREDERICK REIMERS

born on 14 February 1953

and the death occurred on 17 December 2016

at Mayflower Residential Aged Care, 56 Elliot Street, Reservoir, Victoria 3073

from:

1 (a) COMPLICATIONS OF AN INVERTED POSITIONAL EVENT

2 ISCHAEMIC HEART DISEASE, PREVIOUS CEREBROVASCULAR ACCIDENT

In the following summary of circumstances:

John Fredrick Reimers, a resident at Mayflower Residential Aged Care facility in Reservoir died after falling head first from his wheelchair into the bottom drawer of his bedside drawers. He remained entrapped in that position until Ambulance Victoria paramedics arrived at the facility and discovered him to be pulseless and not breathing. Despite removing John Fredrick Reimers from the drawer and commencing cardio-pulmonary resuscitation, paramedics discontinued their resuscitative attempts when they were informed by facility staff that a Not For Resuscitation directive was in place. John Fredrick Reimers was declared deceased at his residential facility. The investigation of John Fredrick Reimers' death predominately relates to the management of him after his fall into the bedside drawers.

BACKGROUND CIRCUMSTANCES

1. John Fredrick Reimers[1] was 63 years of age at the time of his death. He was married to Catherine (**Cathy**) Reimers and together they had two children, Emma and Nicholas. The family resided in Mill Park.

2. Fred's medical history included a right middle cerebral artery infarct (stroke) with consequent left sided paralysis in 2014. He had poor balance and was unable to walk without

[1] With the consent of Catherine Reimers, John Fredrick Reimers was referred to as "Fred" during the Inquest. For consistency, save where I have determined formality requires the use of his full name, I have endeavoured to refer to him only as "Fred" throughout the Finding.

assistance or an aide; he used a 4-pronged stick and electric/motorised wheelchair for these purposes. Fred also suffered from left shoulder pain and low mood.

3. Following Fred's stroke, his family noticed a change to his personality. He was well loved and had been hard working, as well as supportive of others. Subsequent to his stroke, Fred became frustrated at the loss of his independence, impatient, agitated and at times violent towards Cathy. It became increasingly difficult for Cathy to care for her husband in their home.

4. On 2 July 2015, Fred entered residential care at Mayflower Aged Care at 56 Elliot Street, Reservoir (**Mayflower**), a 38-bed residential aged care facility.

5. During his time at Mayflower, Fred experienced several falls including a fall from his bed while attempting to get into his wheelchair and a fall in the toilet. From late 2016, several episodes of inappropriate behaviour by Fred are recorded in his medical records and reflect that Fred had been verbally abusive, impatient with other residents or verbally inappropriate to a staff member.

SURROUNDING CIRCUMSTANCES

6. On 17 December 2016 at approximately 01.00 hours, Fred went to bed under the supervision of Endorsed Enrolled Nurse (**EEN**), Leaonie Coles (**Nurse Coles**). At approximately 05.00 hours, Fred got off his bed and into his motorised wheelchair without calling for assistance. It appears that Fred has lent forward in his wheelchair to open the bottom drawer of his bedside drawers but in the process of leaning forwards has lost his balance resulting in Fred falling forwards towards the floor and his head becoming lodged within the bottom drawer. Due to Fred's left sided weakness he was unable to remove himself from the drawer. Fred called out for help.

7. In response to Fred's calls for help, Nurse Coles and Personal Care Assistant[2] Vicki Portway (**PCA Portway**) attended his room and observed Fred with his head in the bottom drawer. He was yelling at them to get him out. Nurse Coles asked PCA Portway to bring the lifting machine to Fred's room.

8. At 05.10 hours, Nurse Coles telephoned Emergency Services on '000' requesting the attendance of an ambulance to aid with removing Fred's head from the drawer. During her

[2] PCA Portway referred to herself as a Personal Care Assistant and I have continued to refer to the role in this way but for all intents and purposes, there is no difference between a Personal Care Assistant, Attendant, Worker or Provider as they are referred to in various statements and research papers.

conversation with the 000 call-taker, Nurse Coles was advised not to move Fred and was requested to assign someone to wait at the front of the facility to enable prompt entry for the paramedics on their arrival. Nurse Coles was also advised that someone should remain with Fred and that she should call back to 000 if there was any change in his condition.

9. Nurse Coles assigned PCA Portway to remain with Fred while she went to the front of the residential facility to await the arrival of the ambulance.

10. At 05.19 hours, Nurse Coles received a call from Ambulance Victoria (**AV**) Referral Communications team (**REFCOMM**) asking for more details about the position of Fred and what was digging into him – his chest or neck. Nurse Coles responded that she had not actually moved Fred to have a look. She also indicated that she was moving back to the front of the building to await the ambulance.

11. Whilst still awaiting the arrival of ambulance paramedics, PCA Portway informed Nurse Coles that Fred had suddenly gone very quiet. Nurse Coles returned to Fred's room and checked his pulse commenting that it was weak.[3] She then returned to the front of the facility.

12. At 05.40 hours, ambulance paramedics arrived at Mayflower and attended Fred's room at 05.42 hours. They located him lying on his left side with his head inside the drawer and his neck bent over the edge of the drawer. Fred was unresponsive - his airway was fully occluded. Paramedic Curtis Hamid (**Paramedic Hamid**) lifted Fred's head from the drawer effectively clearing his airway. He placed Fred onto his back on the floor of his bedroom and confirmed that Fred was pulseless and not breathing. Cardio-pulmonary resuscitation (**CPR**) procedures were commenced.

13. At the request of the paramedics, Nurse Coles retrieved Fred's file and identified within his file that he had signed an Advance Care Directive on his admission to Mayflower. The Advanced Care Directive indicated that Fred did not want resuscitation attempts to be initiated if he was found to be pulseless and not breathing.

14. At 05.45 hours, ambulance paramedics ceased CPR and Fred was declared deceased.

[3] Statement of Vicki Portway dated 17 December 2016 – Coronial Brief @ pp 32 – 34.

JURISDICTION

15. Fred's death was a reportable death under section 4 of the *Coroners Act 2008* ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

PURPOSE OF THE CORONIAL INVESTIGATION

16. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [6]

17. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[7] Coroners are also empowered to report to the Attorney-General on a death; 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 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.[8] These are effectively the vehicles by which the prevention role may be advanced.[9]

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[4] *Coroners Act 2008* (Vic) s 89(4).

[5] Ibid s 67(1).

[6] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[7] The "prevention" role is explicitly articulated in the Preamble and Purposes of the *Coroners Act 2008* (Vic).

[8] See sections 72(1), 67(3) and 72(2) of the *Coroners Act 2008* (Vic) regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) of the *Coroners Act 2008* (Vic) which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

18. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

19. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

20. In all other circumstances a Coroner may exercise their discretion pursuant to section 52(1) of the Act to hold an Inquest into any death the Coroner is investigating.

STANDARD OF PROOF

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw.[10] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

22. The effect of the 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.

[10] (1938) 60 CLR 336.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

23. On 17 December 2016, Nurse Frances Azzato of Mayflower Reservoir completed a Statement of Identification. On 19 December 2016, I completed a Form 8 *Determination by Coroner of Identity of Deceased* pursuant to the *Coroners Court Rules 2009* (Vic) rule 32.[11]

24. The identity of John Fredrick Reimers was not in dispute and required no additional investigation.

Medical Cause of Death

Post mortem examination

25. Dr Victoria Francis (**Dr Francis**), Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed a full post mortem examination on the body of John Fredrick Reimers and reviewed related materials including the Victoria Police Report of Death for the Coroner Form 83, medical records from Mayflower Reservoir and the post mortem computerised tomography (**CT**) scan.

26. Dr Francis reported that the post mortem examination revealed conjunctival petechiae which are non-specific pinpoint haemorrhages that may be caused by several mechanisms, including asphyxia but also following sneezing and coughing. She stated that there was no evidence of neck bruising or injury but there was a linear mark over his chin. Significant coronary artery atherosclerosis with mild myocardial fibrosis was also identified along with evidence of a remote right middle cerebral artery territory infarct.

Toxicology

27. Toxicological analysis of blood showed duloxetine and paracetamol at levels consistent with therapeutic use.

Forensic pathology opinion

28. Dr Francis ascribed the cause of the death of John Fredrick Reimers to complications of an inverted positional event with ischaemic heart disease and his previous cerebrovascular accident as contributing factors.

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[11] Above n 3 s 24.

Conduct of my Investigation

29. The investigation and the preparation of the Coronial Brief was undertaken by Detective Leading Senior Constable Paul Haining on my behalf.

Determination to hold an Inquest

30. Pursuant to section 52(1) of the Act, I determined to exercise my discretion to hold an Inquest into the death of John Fredrick Reimers as I considered that there were matters of public health and safety that warranted further exploration through a public hearing.

Direction Hearing/s

31. Directions Hearings were held on 17 April 2018, 20 June 2018 and 8 October 2018. Leading Senior Constable (**LSC**) Tracey Ramsey from the Police Coronial Support Unit (**PCSU**) appeared to assist me at each of these hearings.

INQUEST

***Viva Voce* Evidence at the Inquest**

32. *Viva voce* evidence was obtained from the following witnesses:

- Catherine Reimers;
- Leaonie Coles, Endorsed Enrolled Nurse;
- Curtis Hamid, Ambulance Victoria ALS paramedic;
- Michael Cornelio, Ambulance Victoria ALS paramedic;
- Professor Debra Griffiths, Head of Nursing & Midwifery, Monash University;
- Robert Gvojic, Registered Nurse & Care Manager/Executive Officer Aged Care, Mayflower Reservoir;
- Wendy Dunn, Registered Nurse & Executive Director, Aged Care and Seniors Living;[12]
- Todd Richards, Investigator, Quality Improvement Team, Emergency Services Telecommunications Authority;
- Flynn Snell, ALS paramedic, Referral Service Team Leader, Ambulance Victoria;
- David Natoli, Clinical Support Officer, Ambulance Victoria.

[12] Wendy Dunn had taken over the position of Executive Director, Aged Care and Seniors Living, from Cath McDonald who had provided a statement to the Court dated 29 January 2018. Ms Dunn adopted Ms McDonald's statement with some clarifications – Exhibit 23.

ISSUES INVESTIGATED AT THE INQUEST

Scope of the Inquest

33. The scope of the Inquest related to:

a) Whether the care provided to Fred after his fall from his wheelchair was appropriate, adequate and consistent with Mayflower's falls prevention and management policy:

b) Whether there were systemic issues within Mayflower related to training and staffing ratios which may have influenced the outcome;

c) Whether the paramedics decision to cease resuscitation attempts were appropriate in the circumstances and aligned with Ambulance Victoria's clinical practice guidelines in relation to the withholding or ceasing resuscitation; and

d) Whether the line of questioning or script embarked upon by the Emergency Services Telecommunications Authority (**ESTA**) call taker was appropriate in the circumstances.

Evidence Arising from the Inquest

Advanced Care Planning

34. On the day that Fred entered the facility, Cathy stated that her husband was asked if he wanted to sign an Advanced Care Directive that resuscitation not be performed on him if he was found to be pulseless and not breathing. The document also allowed for other directives related to pain relief and the people Fred wanted present in that event. Their daughter Emma was present with her parents during this discussion. Cathy said that Fred had previously spoken to her about the possibility of death from another stroke or a heart attack saying words like: '*put a bullet to my head, I don't want to live.*'[13] She said that Fred understood what the discussion was about and was willing to sign the document.[14] However, Cathy did not believe that the discussion involved no resuscitation attempts in the event that an accident occurred.[15] She said that she had not ever considered that the circumstances in which Fred died would be included in the directive.[16]

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[13] Transcript of Proceedings (**T**) @ p 9, 10, 15.

[14] Exhibit 2 – Advanced Care Planning/Directive of John Fredrick Reimers dated 2 July 2015.

[15] T @ p 10.

[16] T @ p 15, 20.

Staff coverage on 16 & 17 December 2016

35. Nurse Coles and PCA Portway were the only members of staff on duty and on site for the night shift commencing 16 December 2016 and finishing 17 December 2016; there were 34 residents at the facility at that time. [17]

36. Nurse Coles stated that she became an enrolled nurse in 1985 and obtained her medication endorsement '*approximately eight years ago*'[18] through Austin Health at RMIT. She had predominately worked in the aged care sector during the previous six years.[19] Nurse Coles was employed at Mayflower from November 2016 through Crewe Sharp Medical Recruitment Agency.[20] She was unable to say how many shifts she had worked at Mayflower in that time. She had also worked at Mayflower sometime earlier during 2016, again, she was unable to provide any specific details.

37. Nurse Coles said that she had familiarised herself with Mayflower's policy and procedure manual when she first began working at the facility because it was protocol to do so, '*given time restraints*'.[21] Nurse Coles stated that this "protocol" was neither at the behest of the Agency who contracted her or of Mayflower but was a '*nursing procedure*'.[22] She was unable to state where Mayflower's policy and procedure manual was kept within the facility and she could not say if she had received any induction from the facility upon her commencement with them. Proof of registration and current continuing professional development requirements including currency of first aid training were provided to the Agency and Mayflower made no personal request to her for the provision of these documents.[23]

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[17] T @ p 30.

[18] T @ pp 24-25, 76.

[19] T @ p 29.

[20] There was some confusion over Nurse Coles' employment status – in a Statement dated 29 January 2018 from Cath McDonald, Executive Director Aged Care and Seniors Living she stated: *Nurse Coles is employed at Mayflower Reservoir as an Enrolled Nurse.* (Coronial Brief @ p 59). In his *viva voce* evidence Robert Gvojic, Care Manager/RN stated that Nurse Coles was *not an employee of Mayflower Reservoir. She is employed with an agency, a nursing agency.* (T @ p 261). Wendy Dunn in her *viva voce* evidence also confirmed that Nurse Coles was engaged through Crewe Sharp Medical Recruitment Agency – T @ p 274.

[21] T @ p 26.

[22] T @ p 26.

[23] T @ pp 26-27.

38. Nurse Coles knew Fred and that he had become a resident at the facility having suffered a stroke with resultant left sided paralysis and behavioural issues. His speech had not been affected by his stroke. She described him as challenging at times and lovely at others.[24]

39. PCA Portway had a Certificate III in Community Services Aged Care which she obtained through TAFE Queensland in July 2010. Nurse Coles had never met or worked with PCA Portway[25] before this shift. Nurse Coles was unaware if PCA Portway had a First Aid certificate but said that she *assumed that every facility gave all their staff first aid training.*[26]

40. On-call for that shift but not on site, was Registered Nurse (**RN**) Robert Gvojic (**RN Gvojic**)[27]. RN Gvojic's primary role at Mayflower was Care Manager, but he also performed the role of on-call RN each fortnight.[28] RN Gvojic lived ten minutes' drive from the facility.[29]

The immediate surrounding circumstances

41. On the morning of 17 December 2016 at approximately 05.00 hours, Nurse Coles and PCA Portway were in the corridor between the office and the kitchen.[30] They were preparing the morning linen trolley to commence their rounds of the residents when they heard a resident calling out for help.[31] Nurse Coles said that she ran approximately 250 metres down the corridor in the direction of the yelling and entered Room 38 where Fred resided.

42. When Nurse Coles entered Fred's room, she could only see Fred's body from the shoulders down. He was on his left side in a twisted position and his head was lodged in the bottom drawer of his beside set of three drawers. She described his head as being face down, jammed/wedged up underneath the second/middle drawer[32] resulting in her only being able

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[24] T @ p 31.

[25] PCA Portway was excused from attending the Inquest to give evidence on the grounds of ill health as depicted in a Medical Certificate provided to the Court.

[26] T @ p 28.

[27] For consistency I have referred to Robert Gvojic as "RN Gvojic" rather than "Mr Gvojic" because he informed me that his registration with AHPRA is current and he acts in the role of Registered Nurse at Mayflower Reservoir regularly although I acknowledge that he is predominantly employed as the Care Manager.

[28] T @ p 231.

[29] T @ p 237.

[30] See Exhibit 7. Later in her *viva voce* evidence Nurse Coles corrected that the trolley preparation was occurring in the corridor closer to the dining room – T @ p 77.

[31] T @ p 66.

[32] T @ p 41.

to see Fred's right cheek and his neck. Fred was yelling "Get me out, get me out" and "I can't move, I can't move."[33] Nurse Coles said that she tried, on her own, to lift Fred by the shoulders to remove him from the drawer but she could not because he was lashing/flailing/thrashing out at her with the right side of his body in an aggressive way. She called for PCA Portway to bring the lifting machine but by the time PCA Portway brought the machine to Fred's room Nurse Coles said that she had reassessed the usefulness and possible risks of using the lifting machine and told PCA Portway to leave it outside the room.[34] In making this assessment Nurse Coles stated that she had done a *basic doctor ABC* – she had removed the wheelchair from the room thus removing the danger; Fred was breathing demonstrated by his yelling, thrashing out and speaking to her; and his circulation, depicted by the colour in his neck and hands, was okay.[35] Nurse Coles said that she was concerned that moving Fred might further injure him given the positioning of his body at the time.[36] She could not see his left side at all because he was lying on it so she could not visualise if he had any injuries but she was sure he had not injured the right side of his body because he was thrashing around with this side.[37]

43. Nurse Coles stated that she and PCA Portway did try to lift Fred out of the drawer at or about the time she decided the lifting machine was not appropriate.[38] She said that they tried to manoeuvre Fred out by his shoulders but had to stop due to his aggression;[39] he was lashing out at them. Intermittent short periods of calmness did not provide any greater opportunity to manoeuvre Fred out of the drawer because he would start lashing out again as soon as he was touched.[40] Similarly, Nurse Coles did not attempt to take Fred's pulse[41] while he was

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[33] T @ p 67.

[34] T @ p 32. PCA Portway makes no reference to having taken the lifting machine to Fred's room in her statement: Statement of Vicki Portway dated 17 December 2016 – Coronial Brief @ pp 32 – 34.

[35] T @ p 33.

[36] T @ pp 41-42, 59.

[37] T @ p 42.

[38] PCA Portway makes no reference in her statement of an attempt to try to lift Fred out of the drawer: Statement of Vicki Portway dated 17 December 2016 – Coronial Brief @ pp 32 – 34.

[39] T @ p 39.

[40] T @ p 40, 45, 46.

[41] PCA Portway stated that Nurse Coles checked Fred's pulse after she informed Nurse Coles that Fred had suddenly gone quiet and it was then that Nurse Coles is alleged to have said that his pulse *was weak*: Statement of Vicki Portway dated 17 December 2016 – Coronial Brief @ pp 32 – 34.

stuck in the drawer. She said she had no reason to be concerned about his conscious state deteriorating because he was calling out and provided his date of birth when asked.[42]

44. No baseline vital signs were taken.

Contacting Emergency Services

45. At 05.06 hours Nurse Coles telephoned 000/ESTA who are responsible for AV call taking and dispatch functions for the whole of Victoria.[43] In response to a question from the call taker, Fred was able to state his age as 63. He did not say that he was having difficulty breathing during this call and while Nurse Coles was in the room,[44] - he continued to call out and thrash about with the right side of his body. He remained conscious.[45]

46. Nurse Coles agreed that the call taker advised her to not move Fred unless it was absolutely necessary/unless he was in danger. She was also given instruction by the call taker to watch Fred closely and that if he became less awake and vomited he should be turned onto his side and that she should call back immediately if Fred's condition got worse.[46]

Awaiting Ambulance Paramedics

47. Nurse Coles stated that she had left PCA Portway to watch over Fred while she waited for Ambulance Victoria paramedics to arrive. Nurse Coles believed that it would be better[47] to leave PCA Portway with Fred because PCA Portway was a regular staff member and she and Fred were more familiar with each other.[48] She also considered that she was better placed to deal with all the other issues happening on the floor with the other residents as she was more qualified than PCA Portway.[49] She did not believe that PCA Portway had the ability to deal with the residents quickly and effectively as the circumstances demanded. According to Nurse Coles, PCA Portway would have '*mollycoddled them*'.[50]

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[42] T @ pp 44 - 45.

[43] Exhibit 24 – Statement of Todd Richards dated 17 May 2018.

[44] T @ p 67.

[45] T @ pp 68 – 70.

[46] T @ pp 68 – 70.

[47] T @ p 47.

[48] T @ p 46.

[49] T @ p 47.

[50] T @ p 49, 92.

48. However, RN Gvojic did consider that PCA Portway could have attended to these oversight duties.[51]

49. Nurse Coles felt that PCA Portway was competent to make observations in relation to any changes in, *inter alia*, Fred's pallor, breathing and behaviour. Nurse Coles said she was quite confident that PCA Portway could inform her of such changes and that she kept returning to Fred's room to check on both Fred and PCA Portway.[52]

50. According to Nurse Coles, there was no supported means of communication between the two staff members once Nurse Coles had left Fred's room - no two-way radio or telephones.[53] Nurse Coles stated that she did give PCA Portway the same instructions that she had received during her telephone conversation with the 000/ESTA call taker; PCA Portway was to immediately inform her if there was any change to Fred's conscious state, his breathing or if he vomited.[54]

51. Nurse Coles did not contact the on-call RN to advise him of the unfolding situation.

52. Nurse Coles said that she returned to Fred's room several times for verbal updates from PCA Portway while attending the other 33 residents and remaining on the lookout for the paramedics. She stated that she would return to the room and ask PCA Portway if she was okay before rushing away again to attend to the needs of the other residents in the facility. On a couple of occasions, Nurse Coles said that she asked Fred directly if he was okay.[55] Nurse Coles said that, on each occasion that she returned to Fred's room, nothing had changed in Fred's appearance and he was still saying that he wanted to get out of the drawer.[56] Nurse Coles stated that Fred was not showing any signs of distress as far as obstruction to his airway, he was: continually speaking, taking breaths,[57] fully alert and in the same position each time she went to check on him.[58]

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[51] T @ p 247.

[52] T @ p 91.

[53] T @ p 45.

[54] T @ p 50.

[55] T @ p 50.

[56] T @ p 50 – 51.

[57] T @ p 53.

[58] T @ p 59.

53. In her statement to the Court, PCA Portway commented that Nurse Coles had returned to the room and that she informed the nurse that Fred had suddenly become very quiet.[59] She stated that Nurse Coles took Fred's pulse and commented that it was weak before leaving the room.[60] Nurse Coles denied this account.[61]

Attendance by Ambulance Paramedics

54. At 05.07:50 hours, the 000/ESTA call taker advised Nurse Coles that some help had been organised. She conveyed this to Fred by saying that the ambulance is coming as soon as they can.[62] Nurse Coles said that she expected that the Ambulance would arrive within 10 minutes[63] but she conceded that she had not been provided with an estimated time of arrival by the 000/ESTA call taker.[64]

55. Nurse Coles confirmed that the REFCOMM paramedic advised her to immediately re-dial 000 if Fred's condition deteriorated; amounting to the same advice she had received during her initial discussion with the 000 call-taker.[65] Nurse Coles stated that she had not needed to re-contact emergency services as she did not observe a change to Fred's condition.[66]

56. At 05.25 hours,[67] Ambulance Paramedics Hamid and Cornelio of the AV Reservoir Branch received a Code 2 *Ambulance Urgent Within 25 Minutes*,[68] to attend a 63-year-old male at Mayflower Village in Reservoir. On their arrival at Mayflower at 05.40 hours, the Paramedics were met at the main entrance to facility by Nurse Coles and informed that a resident had fallen out of his wheelchair and got his head stuck in an open drawer. Both

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[59] T @ p 45.

[60] Statement of Vicki Portway dated 17 December 2016 – Coronial Brief @ pp 32 – 34.

[61] T @ p 45.

[62] Exhibit 4 – Coronial Brief @ p 104.

[63] T @ p 83.

[64] T @ p 85.

[65] T @ p 70.

[66] T @ p 70.

[67] See Exhibit 10.

[68] Code 2 reflects a job that is semi-urgent – the paramedics drive within normal traffic conditions with no lights or sirens – T @ p 112, 119, 139.

Paramedic Hamid and Paramedic Cornelio believed that they were going to the assistance of a resident that was conscious and alert.[69]

57. According to Nurse Coles' evidence, she directed the paramedics down the corridor and pointed out Fred's room but did not immediately go with them. However, Paramedic Hamid believed that Nurse Coles would have led him and his partner to Fred's room because he would not have otherwise known where it was located.[70] According to Paramedic Hamid, PCA Portway was standing in the doorway to Fred's room facing out into the corridor; she was looking toward the Paramedics as they were arriving. Paramedic Cornelio had a similar recollection.[71]

58. Paramedic Hamid arrived at Fred's room before his partner, he stated:

> *I saw Fred lying left lateral, his face was away from (sic) me facing towards the bed. His airway was fully occluded by the front edge of the drawer and his head kind of leant into the drawer and he was significantly cyanosed and very blue to the face, and there was no movement, sound or anything present at that time and he'd obviously been faecally incontinent.*[72]

59. Paramedic Hamid asked PCA Portway how long Fred had been unconscious for but according to Paramedic Hamid, she was unable to give him any timeframe and he believed that she said, "I thought he was asleep".[73]

60. Paramedic Hamid said that he could not comment on Nurse Coles' perspective in relation to Fred's head being "stuck" in the drawer. However, he said that Fred's head was not trapped when he arrived at the room and he moved Fred's head out the drawer quite easily.[74] He explained that he had approached Fred from behind, lifted his head out of the drawer, straightened his airway out to a neutral position and rolled him onto his back on the floor. Paramedic Hamid stated that he did this by manoeuvring Fred on his own as his partner was

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[69] T @ p 98.

[70] T @ p 120.

[71] T @ p 141.

[72] T @ p 99.

[73] T @ p 103.

[74] T @ p 101, 115.

still coming into the room with their equipment. It required minimal effort on his part, and he met no resistance from Fred.[75]

61. Paramedic Hamid said that once he rolled Fred onto his back on the floor, he noted that Fred was cyanotic[76] from the neck up. He established that Fred was pulseless and not breathing – *'for all intents and purposes he was deceased by the time I moved him'*.[77]

62. Paramedic Hamid instructed his partner, Paramedic Cornelio to commence chest compressions which are recorded as commencing at 05.42 hours. Paramedic Hamid applied defibrillation pads and used his portable radio to request further resources/a MICA Unit to assist with a cardiac arrested patient.

63. Once the ECG monitor was attached, the machine analysed that Fred was in an agonal rhythm or pulseless electrical activity (**PEA**) and thus not conducive to cardio-reversion ("shockable") so the paramedics continued with CPR.[78]

64. Shortly thereafter, Paramedic Hamid asked the staff members for details of Fred's co-morbidities and if there was an Advanced Care Directive in place. A document[79] was subsequently shown to Paramedic Hamid that indicated that Fred did not want resuscitation attempted if he was found to be pulseless and/or not breathing. In accordance with Ambulance Victoria Guidelines,[80] Paramedic Hamid said that they must follow the wishes of the patient.

65. At 05.45 hours, after 3 minutes of CPR, Paramedic Hamid instructed Paramedic Cornelio to stop resuscitation attempts. Paramedic Hamid also cancelled his request for additional ambulance resources and instead requested the attendance of Victoria Police.[81]

66. Paramedic Hamid stated that, had they been instructed that they were to attend on an unconscious patient and not just one that was mechanically stuck as they believed, they would have brought additional equipment with them into the facility. He also said that if they

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[75] T @ p 101.

[76] Cyanosis refers to a bluish tinge / cast / pallor to the skin. It is a symptom of many different health issues that include exposure to cold conditions and constriction of blood vessels.

[77] T @ p 126.

[78] T @ p 126.

[79] Coronial Brief @ p 165.

[80] Exhibit 14.

[81] T @ p 107.

had known earlier that Fred was unconscious '*the job may have been upgraded in terms of its coding so we might have arrived earlier*'.[82]

Adherence to Mayflower's Policy and Procedures

67. RN Gvojic stated that new staff employed on a permanent or full-time basis are provided with induction and orientation which incorporates a buddying up system with another staff member. Agency staff, on commencement of their first shift at Mayflower, are provided with orientation from the EN in-charge of the previous shift before they complete their shift and leave the premises. Orientation relates to: the facility, the emergency procedures, how to use the IT system and how to access contact details, medication management and to the staff and residents of the facility.[83] Orientation is estimated to take approximately 45 – 60 minutes inclusive of handover.[84] RN Gvojic said that an agency nurse '*should already be trained and qualified to be able to attend aged care facilities to commence their shifts and to be fully capable of their duties. So that handover would be sufficient for that agency nurse to be able to attend to the care needs of the residents*'.[85]

68. Nurse Coles could not specifically recall if she had familiarised herself with Mayflower's Falls Prevention and Management Policy but believed that she would have been shown a policy and procedure manual on her first shift at Mayflower. She said that she would have been orientated to where the policy and procedure manual were kept at the facility but there was not any time allocated for that orientation/familiarisation to occur. Nurse Coles agreed that should a situation occur such as the need to transfer a resident to hospital that she would consult with the policies and procedures at that time – there was an assumption by the facility that that would occur.[86] She also believed, at a glance when taken to the document, that Mayflower's policy looked familiar to others that she had read in the past at other facilities. She appeared to understand the basic principles of a falls policy including the importance of an initial set of observations providing a reference base for comparative and communication purposes and she acknowledged that she should have communicated the fact that Fred had fallen to the RN on duty for the shift. She could not recall the name of the RN that was on

[82] T @ p 107.

[83] T @ p 240, 298 (Wendy Dunn).

[84] T @ p 241.

[85] T @ p 241.

[86] T @ p 86.

duty for that shift but knew of the existence of a folder with the contact details.[87] She had never met the RN on any of her shifts at Mayflower as she said she was always on night duty and the RN was never at the facility at that time.

69. Nurse Coles could not recall why she did not immediately contact the RN who also has specific obligations/responses prescribed by the policy.[88] She stated that she regretted that she failed to make that contact at the time.[89] She conceded that she should have called the RN that night.[90]

70. RN Gvojic stated that he would have come to the facility at the time of the incident to assist if Nurse Coles had contacted him.[91] He said that:

> *I would have ensured that observations would have been taken, clinical observations if it was possible to do so. I would have tried to remove Mr Reimers from that bottom drawer or locker if it was safe to do so. But at the same time my advice would have been to call emergency ambulance 000. I would have classified that as a critical incident that someone has fallen and head into the bottom drawer.*[92]

Advance Care Plan/Directive/Not for Resuscitation

71. After removing Fred from the bedside drawers, paramedics assessed Fred as having no pulse/cardiac output and no spontaneous respirations. CPR procedures were commenced before paramedics enquired of Nurse Coles whether Fred was for resuscitation.[93] Nurse Coles was not aware of any specific directives/orders so briefly left his room to retrieve Fred's file. She returned and conveyed that Fred had indeed signed an Advance Care Directive.

72. Paramedic Hamid believed that such directives were very common and often mandatory in a lot of nursing homes[94] and said that in this setting, once it was established that a resident was in cardiac arrest, paramedics would always ask if there was an Advanced Care Directive in place. If that document existed, and depending on the instructions contained therein,

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[87] T @ p 86.

[88] T @ pp 60 – 63.

[89] T @ p 62.

[90] T @ p 88.

[91] T @ pp 236 – 237.

[92] T @ p 246, 248 - 249.

[93] T @ p 65.

[94] T @ p 109, 112.

paramedics would continue with resuscitation attempts or desist. Paramedic Hamid was able to distinguish between a Refusal of Treatment Certificate and an Advanced Care Directive.[95] In Fred's case, the Advanced Care Directive did not contain alternative in relation to when resuscitation should commence, merely that it should not if he was found pulseless and not breathing. Paramedic Hamid said that it is not for paramedics to override the wishes of a patient in a nursing home.[96]

Independent Expert Opinion

73. Professor Debra Griffiths (**Professor Griffiths**), Head of Nursing & Midwifery at Monash University provided an expert opinion to the Court[97] and appeared at the Inquest to provide *viva voce* evidence. Professor Griffiths had been asked to provide an opinion on the appropriateness of the actions of the facility's staff in response to Fred's predicament.

74. Professor Griffiths said that there was nothing in any of the material that she had been provided with that indicated there was other events or concerns occurring in the facility that could be interpreted as necessitating priority over what was happening with Fred.[98] She opined that the more experienced staff member should have been working with and remained with Fred.

75. Professor Griffiths conceded that she did not provide training courses to PCAs at Monash University but that it was her understanding that First Aid was not a mandatory part of the Certificate III course. Similarly, employment in the aged care industry was not dependant on having First Aid training but may be required by individual operators. Professor Griffiths associated diminishing requirements for staff qualifications in the aged care sector with a shift in thinking about what is being provided to residents of these facilities; the facilities are "homes" or "alternative homes" rather than hospitals. Professor Griffiths informed me that this has also had the effect of minimising operational costs, which appears to be the primary impetus for the shift.[99]

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[95] T @ pp 127 – 129.

[96] T @ pp 110-111, 130.

[97] Exhibit 15 – Expert Opinion Report – Professor Debra Griffiths dated 26 September 2018 with amendments.

[98] T @ p 202, 203

[99] T @ pp 165 – 166.

76. Professor Griffiths stated that the staffing mix in aged are facilities should always include a Registered Nurse. Various forms of dementia are common amongst the cohort of people in aged care facilities and there is a mix of high-level and low-level care requirements:

> *...you need someone with expertise with serious critical thinking, and this is what differentiates, it's another differentiation between the registered nurse and the enrolled nurse, is their ability to synthesise and critically think and then put into place care.*[100]

77. Professor Griffiths conceded that an EN rostered on with a PCA may be capable of staffing the facility overnight in the physical absence of an RN. This may be appropriate where the residents of a facility were only low-care and as long as there was an appropriate safety valve plan for emergency situations.[101]

78. In relation to the presence of an Advanced Care Directive signed by Fred, Professor Griffiths commented on the continued lack of use of Refusal of Treatment Certificates, as prescribed in the *Medical Treatment Act 1988.* She opined that they could effectively be used in conjunction with Advanced Care Directives but there appeared to be little uptake on this combination as a means of documenting the individual's preferences for medical treatment. Professor Griffiths also agreed with Counsel for AV that the presence of a Refusal of Treatment Certificate did not abrogate an individual's common law rights to refuse medical treatment. Fred's Advance Care Directive would appear to be a clear expression under the common law that he did not want any kind of resuscitation no matter the circumstances.[102] Professor Griffiths was also not critical of the facility having the conversation with Fred on his admission. She said that she believed it helps everyone – the resident, their family and the health care professionals – if the conversation about end of life events was had early on.[103]

79. On reviewing Ambulance Victoria Guidelines,[104] Professor Griffiths agreed that: they reflected common law rights to refuse medical treatment; Fred's Advance Care Directive appeared to reflect his rights; the Paramedics accepted in good faith from those at the scene that such documentation existed; the Paramedics actions appeared to be in accordance with the AV Guidelines.

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[100] T @ p 182.

[101] T @ pp 182 – 183.

[102] T @ p 173.

[103] T @ pp 218 – 219.

[104] Exhibit 14.

80. However, Professor Griffiths said that you cannot take a person's wishes out of context. She said that a Not for Resuscitation Order/Directive does not apply so broadly that, for example, if the resident falls over and loses consciousness that the person's wishes are immediately applied without rendering any treatment. Professor Griffiths said that these types of Orders usually apply when the resident/patient suffers a cardiac or respiratory arrest – '*a major significant event occur(s)*'.[105] Professor Griffiths said that there is confusion and that grey areas lie in *what is understood by the person making the decision, what is being explained to them and how that's been documented and all too often it's so brief no-one knows.*[106]

81. In relation to the paramedics, Professor Griffiths said that there was really important information about Fred for example, about how long he had been unconscious which would help to inform the paramedics about whether to invoke the Guidelines. Professor Griffiths said that you '*mustn't take NFR or a person's wishes out of context where fundamental first aid might have given us a completely different picture.*'[107] Professor Griffiths clarified that she was talking about the delivery of fundamental first aid before the paramedics arrived. She said '*when Fred was conscious and thrashing around and, in the drawer, that basic attention and first-aid should have been applied at that stage. He should have been monitored and treated appropriately and he wasn't.*'[108] Professor Griffiths said Nurse Coles should have made more effort to remove Fred from the drawer; it should have been Nurse Coles to provide care and resuscitation to Fred before the paramedics arrived.[109]

Post Incident Review by Mayflower

82. RN Gvojic gave evidence about the review instigated by Mayflower after Fred's death. According to RN Gvojic, an internal review commenced immediately after Fred's death and was done in conjunction with Mayflower's Manager of Quality and Innovation.[110] Several documents[111] were created as a result of the incident review, and without detailing the particulars of each document, they addressed assessing identified risks and implementing

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[105] T @ p 189.

[106] T @ p 190.

[107] T @ p 177.

[108] T @ p 191.

[109] T @ pp 212-213

[110] T @ p 265.

[111] Exhibits 18 – 21.

system(s) for improvement and preventing like incidents;[112] including an analysis of what the staff did during the incident[113] and providing a means of informing staff of proper procedures in a critical incident.[114] The Incident Investigation Analysis Tool[115] was completed by RN Gvojic, predominately from telephone conversations he had with Nurse Coles and PCA Portway. Some of the content of this document, as it related to the circumstances of the incident, is difficult to reconcile with the weight of the evidence including that the document states that Fred was still conscious and communicating when the Ambulance paramedics arrived.

83. An audit of the bedside drawers/lockers was also conducted because they were identified as a risk in an Occupational Health & Safety assessment.[116] The audit included assessing the positioning of this furniture in each resident's bedroom with a view to preventing like incidents.

The evidence of ESTA and AV regarding communications with Nurse Coles

84. ESTA call takers receive calls for ambulance assistance from members of the public via Telstra's 000 service. These calls are processed in accordance with AV Service Delivery Requirements (**SDRs**) that require ESTA to employ a formal structured question and answer methodology set down by the USA based International Academies of Emergency Medical Dispatch (**Medical Academy**). The protocol set down by the Medical Academy is known as the Medical Priority Dispatch System (**MPDS**) and the software version is known as ProQA. With 32 available protocols each protocol effectively provides call takers with key questions to event types with the aim of eliciting relevant information from the caller which are entered into the computer aided dispatch system (**CAD**) system where the information converts into a relevant event type for dispatch, assisting dispatchers to determine the priority of attention required. Although events are generally referred directly to an AV unit for dispatch some may be referred to an AV Duty Manager or Communications Support Paramedic for consideration of an alternative dispatch solution. Some matters are also deemed appropriate for referral or secondary triage to AV's REFCOMM which is staffed by registered nurses

[112] Exhibit 18 – Incident Investigation Analysis Tool dated 19 December 2016.

[113] Exhibit 20 - Workplace Incident Investigation Report dated 17 December 2016.

[114] Exhibit 21 – Memorandum to staff dated 19 December 2016.

[115] Exhibit 18.

[116] T @ p 257, Exhibit 22 – Audit of bedside lockers dated 23 December 2016 with attached report.

and paramedics.[117] REFCOMM staff may receive communication directly from the ESTA call taker or the information is placed in a queue awaiting the REFCOMM staff member to call the caller back. The REFCOMM staff member will make their own assessment and can reassign the dispatch coding, transfer the call to non-emergency transport services, provide advice over the phone which may lead to the event being closed and/or arrange for alternate service providers to attend.[118]

85. According to Todd Richards, ESTA Quality Improvement Investigator, call takers have very little discretion to deviate from the ProQA scripts because they are *detailed, succinct and to the point*[119] and ensures consistency across all call takers who are not medically trained. Call takers are trained to recognise compromised breathing through explicit verbal advice from the caller and through recognition through other cues.[120] Phrases commonly used by lay people that may reflect ineffective breathing are provided as guidance to the call takers in the ESTA training manual and if ineffective breathing is identified by the call taker at the outset of the call, they will code priority of the call accordingly – Priority 0. Similarly, call takers are trained to escalate events during a call should they be provided with details of a changing situation or if they themselves pick up on other cues such as background noise.

86. In his second statement to the Court, Mr Richards stated:

> *There is no evidence to suggest that Mr Reimers' airway was in fact obstructed at the time of the triple zero call or what time the airway obstruction commenced.*[121]

87. The call taker, who had a mentor at the time, treated the call from Nurse Coles in accordance with Protocol 17 which relates to a fall and results in the allocation of a priority 3 such that at 05.08.09 hours the event was referred to REFCOMM to make contact with the scene and review the event. However, all the REFCOMM operators were busy so the call was unable to be directly transferred.[122] The call taker remained on the phone with Nurse Coles until 05:10:25 hours during which time advice and reassurance was provided. The call taker also

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[117] Also referred to throughout the evidence as a Referrable Service Triage Practitioner (RSTP) but for the sake of continuity within this Finding I have continued to refer to them as a "REFCOMM operator" or "REFCOMM paramedic".

[118] Exhibit 24 – Statement of Todd Richards dated 17 May 2018, T @ pp 309 - 314.

[119] T @ P 314.

[120] Exhibit 25 – Statement of Todd Richards dated 31 July 2018, T @ p 315.

[121] Exhibit 25, T @ p 319.

[122] T @ p 323.

advised Nurse Coles to reassure Fred '*that help is being arranged*'. While still on the phone to the call taker, Nurse Coles told Fred '*help is coming, okay. I've got the ambulance on the phone and they have assured me that they're on the way*'.[123]

88. The call taker did not correct Nurse Coles that an ambulance was on its way. The call taker did update the CAD chronology to reflect the information conveyed by Nurse Coles that Fred's head was stuck in the drawer and he was unable to be moved out.

89. Approximately nine minutes later at 05.19 hours,[124] a REFCOMM paramedic telephoned Nurse Coles. At 05.25.04 hours, the event was reconfigured to a Priority 2 responding as a Code 2[125] At 05.25.39 hours, an ambulance was dispatched to attend Mayflower on a Priority 2 basis. At 05.40.11 hours, Paramedics Hamid and Cornelio arrived at Mayflower – 34 minutes and 52 seconds after Nurse Coles telephoned 000. At 05:43:19 hours, the attending Paramedics radioed the Ambulance Dispatcher requesting that a Mobile Intensive Care Ambulance (**MICA**) also attend Mayflower as Fred was in arrest. At 05:45:09, the Dispatcher was informed that a "Not for Resuscitation" had been provided to the Paramedics and therefore, no other ambulance units were required to assist.

90. A review of the events by Mr Richards identified that the call taker and the call taker's mentor both treated the caller's depiction of the circumstances in accordance with Protocol 17 – a fall. Mr Richards said that it was an unusual call and difficult from the information being provided by Nurse Coles to discern what had happened to Fred. The event was initially perceived as a fall with a head strike, so Protocol 17 would be the most appropriate protocol to apply. The call taker applied the script of Protocol 17 correctly. Mr Richards' review however determined that Protocol 22 – Inaccessible incident / other Entrapments, would have been more suitable for the circumstances particularly having regard to the information conveyed by Nurse Coles that Fred's head was stuck in the drawer.[126] Had protocol 22 been applied it would have led to a Priority 1 dispatch of units.[127]

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[123] Exhibit 24.

[124] During the course of the Inquest it became apparent that there was a discrepancy between the time the REFCOMM call is recorded as starting in the call transcript and therefore the time the call finishes compared to the CAD chronology (Exhibit 11).

[125] Ambulance to drive normally to traffic conditions without lights or sirens - T @ p 326.

[126] Exhibit 24.

[127] T @ p 329.

91. Mr Richards reported that *given the unusual and unique nature of the event and given that the ProQA did contain a more suitable protocol for this event it is not considered that greater flexibility or alteration of the existing call taking system is necessary or would be beneficial.*[128] The call taker and his mentor have been provided with feedback about the event and the use of Protocol 22 and the call taker has undergone a number of audits since December 2016 of which he has been mostly compliant. Mr Richards also reported that since Fred's death there has been an alteration to the mentoring process but that it was not in response to Fred's death.[129]

92. The REFCOMM caller, a qualified paramedic, utilised her clinical judgement during the triage process in conjunction with guidelines Case Enhance Call Centre (**CECC**) assessment tool to escalate the Priority 3 attached to the event to a Priority 2. According to Flynn Snell, ALS paramedic and Referral Service Team Leader, the REFCOMM caller '*had concerns regarding the situation that Fred was in, the circumstances, not getting a clear picture of what was happening and concerns regarding his age and his already existing deficits.*'[130] She did not consider that the event warranted a Code 1 – lights and sirens response because Fred appeared stable in that he could be heard still talking in the background while the REFCOMM caller was on the telephone. She was told he was moving his limbs and, although sounding distressed, was not in apparent immediate life threat.[131] According to Mr Snell, REFCOMM's use of a Code 2 is someone who is stable that has a significant potential to deteriorate *and Fred would have definitely fitted that definition.*[132]

COMMENTS

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

1. Cathy spoke highly of the delivery of care to Fred at Mayflower. She said that they were very respectful of her husband, managed his behaviours and communicated frequently with her.

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[128] Exhibit 24 @ paragraph 6.15.

[129] Exhibit 24 @ paragraph 6.19, T @ p 336.

[130] T @ p 378.

[131] T @ p 378.

[132] T @ pp 397 – 398.

She believed that Fred liked living there.[133] I acknowledge that the family had accepted that Fred's death was the result of a *bizarre accident*[134] and that my decision to hold an Inquest would have been confronting and compounding of the family's grief at the loss of their loved one. My investigation into Fred's death did however identify a number of shortcomings in his management.

2. Nurse Coles presented as a caring nurse, but I was left concerned that she did not have the requisite competency levels of a nurse left in charge overnight at a facility with a capacity for 38 elderly residents. On the morning of 17 December 2016, Nurse Coles did not have *'the requisite expertise'* nor *'serious critical thinking'* the situation required.[135]

3. Nurse Coles believed that she did her best she could to explain the position Fred was in and how serious this was to the 000/ESTA call taker and the REFCOMM caller. The seriousness she said was that he was '*jammed in the drawer.*'[136] She felt that she had done everything that she possibly could to help Fred and said she had no regrets about what she did or feel that she could have done anything else.[137] At no time in her evidence did Nurse Coles express her concern or understanding for Fred's wellbeing by expressing an understanding of anatomy and physiology – at no time did she describe or explain Fred's position in terms of the potential risk to structural integrity or respiratory compromise. She appropriately requested an ambulance to attend but at no time did she effectively communicate the seriousness of the situation to either the ESTA call taker or the REFCOMM caller. At no time did she indicate that she was a nurse and that she had undertaken a clinical assessment of Fred and, indeed, at no time did she complete a formal clinical assessment of Fred.

4. It is difficult to reconcile Nurse Coles' evidence of the immediate surrounding circumstances of Fred's death with PCA Portway's evidence of the same, as depicted in her statement dated 17 December 2016.[138] Unfortunately, PCA Portway was not able to attend Court. She was the only other member of staff present but her account was not able to be tested even though the circumstances and the decisions made in respect of Fred's welfare begged for clarity.

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[133] T @ pp 19-20.

[134] T @ p 432.

[135] T @ 182.

[136] T @ p 84.

[137] T @ p 89.

[138] Coronial Brief @ p 32.

5. This scenario is unlikely to have arisen if there had been a Registered Nurse on site at Mayflower. Nurse Coles would not have been placed in the position of being an unsupported decision maker in matters clearly beyond her capabilities and she would not have been left to make the decision to delegate the monitoring of Fred to a person who had no training in the basic principles of first aid including but not limited to, airway management.

6. Ms Dunn vacillated in her support of Nurse Coles. She supported some of the decisions of Nurse Coles including her decision to ring an ambulance and to delegate PCA Portway to the responsibility of monitoring Fred. Ms Dunn also opined that Nurse Coles conveyed the urgency of the situation to emergency services[139] but also said Nurse Coles could have '*been more succinct and more urgent.*'[140] In defending Nurse Coles, Ms Dunn said that Nurse Coles was working on the understanding that an ambulance was on the way because she was reassuring Fred that it was.[141] Ms Dunn also said that *'it is best practice to take some baseline observations and to be able to monitor those observations or the vital signs to be able to see whether he, the resident, is deteriorating in any way.*'[142] At no time did Nurse Coles take any baseline observations/vital signs of Fred.

7. Nurse Coles' evidence about having no means to communicate with PCA Portway from opposite ends of the facility is also difficult to reconcile with the statement of Cath McDonald and adopted by Ms Dunn in her *viva voce* evidence.[143] I was informed that a pager or a DECT phone were available for staff to use at the facility. Neither PCA Portway or Nurse Coles made reference to having been able to communicate with each other after Nurse Coles left Fred's room. In addition and having regard to how the circumstance appear to have unfolded including Nurse Coles' own evidence that she was frequently returning to Fred's room to check up on him, it would appear that both Nurse Coles and PCA Portway were either unaware of such communication devices and/or chose to not utilise them. Either scenario reflects poorly on Mayflower's induction/orientation to agency staff and on its expectations of its own staff.

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[139] T @ p 292.

[140] T @ p 302.

[141] T @ p 301.

[142] T @ p 287.

[143] Exhibit 23, T @ p 303.

8. The circumstances of Fred's death have highlighted a concerning norm in aged care: staffing to patient ratios administered at minimalistic levels which places the delivery of appropriate care at risk. Additionally, the delivery of appropriate care is being further compromised by an industry approach to employing enrolled nurses to act in charge of their shift. In many instances, these enrolled nurses are supported only by a minimally trained group of care providers who, by their mere dominance of presence in the sector, give the impression that they have the status of a profession. Regrettably, and of great concern, is that regulation has not followed minimum standards of training and that measurement of competency levels lack benchmarks and are at the behest of the facility owners. RN Gvojic believed that Mayflower only employed PCAs who had undertaken a component in First Aid as part of their Certificate III in Aged Care or Community Health, but he conceded it was not in fact a requirement of employment at Mayflower[144] either before or subsequent to Fred's death.[145] He said that '*the PCA is there to provide basic care needs which is mainly in regards to the routine activities of daily living.*'[146] Wendy Dunn, the current Executive Director Aged Care and Seniors Living at Mayflower, said that she had worked in the aged care sector for six years and had never worked in a facility that required PCAs to hold a First Aid certificate in order to secure employment. She opined that it '*is a good qualification for anybody to have in the community* (but) *not necessary*' for PCAs in aged care because '*there is always an EN or RN on*' duty.[147] Ms Dunn also said that it was not a requirement for PCAs to hold the Certificate III in Victoria but it was usual practice and indeed the practice of Mayflower to only employ PCAs with the Certificate III qualification.[148] Ms Dunn informed me that there was a trend developing in the aged care sector of a preference by some organisations to employ PCAs without any qualification and to instead train them "in house". She said that because the training of PCAs is quite variable some organisations are '*choosing or tailoring the training around what they perceive to be the real needs so about manual handling and about person centred care and about all that activities of daily living.*'[149]

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[144] T @ p 243.

[145] T @ p 244.

[146] T @ p 244.

[147] T @ p 276.

[148] T @ p 291.

[149] T @ p 301.

9. The Victorian Department of Education and Training (DET) "Skills Gateway" webpage[150] - a site to provide guidance to people wanting to enter certain areas of employment, recommends that PCAs have:

- A Certificate III in Individual Support;
- Completion of Victorian Certificate of Education (VCE) or equivalent;
- Food handling and hygiene Certificate;
- Manual handling and safe lifting practices Certificate;
- Senior First Aid / CPR Certificate;
- Drivers licence;
- Course in Personal Carer Training Using Non-Invasive Ventilation; and
- Certificate IV in Dementia Practice.

However, there does not appear to be any authoritative/legislative requirement that PCAs hold certain qualifications, thus enabling the aged care sector the flexibility/options on employment requirements as indicated in Ms Dunn's evidence.

10. It is interesting but somewhat concerning that although the disability sector mandates certain educational standards for staff/carers, the aged care sector is significantly self-determining in this regard. For example, the Department of Health and Human Services (DHHS) has recently informed me that 94% of Disability Development Support Officers hold a Certificate IV in Disability Service on obtaining employment with the remainder being supported to complete this Certificate after employment. Significantly, all staff must also maintain a current First Aid Level 2 Certificate. Both sectors provide care for a vulnerable cohort in our community who require variable needs of support from carers but the requirements of qualifications for aged care staff are significantly less stringent than the requirements of disability workers.

11. Victoria has sought to provide some certainty to acceptable staff to patient ratios. Nurse and midwife to patient ratios have assisted in maintaining the safety of Victorian patients since they were introduced in 2000 and have been attributed to contributing to better outcomes for Victorians. Services not covered by the Australian Nursing and Midwifery Federation

[150] See the www.skills.vic.gov.au/victorianskillsgateway.

(ANMF) Enterprise Agreement for nurse and midwife patient ratios include private health care services and not-for-profit residential aged care services.[151]

12. On 23 December 2015, the S*afe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (Vic) commenced.[152] The principle objective of this Act relates to patient safety stating:

> *The objective of this Act is to provide for safe patient care in hospitals by establishing requirements for a minimum number of nurses or midwives per number of patients in specified wards or beds, recognising that nursing workloads impact on the quality of patient care.*

13. The *Aged Care Act 1997* (Cth) addresses staffing in residential care in terms of '*appropriate staffing to meet the nursing and personal care needs of the person*' (section 41-3(1)) and that the responsibilities of approved providers include '*to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met* (section 54-1(1)(b))' but does not otherwise specify how "appropriateness" translates into actual numbers/ratios.

14. Research undertaken by Professor Joseph Ibrahim, Head of the Health Law & Ageing Research Unit Department of Forensic Medicine, Monash University entitled *Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services*[153] made a recommendation about skill mix of staff to reduce resident-to-resident aggression (**RRA**). Although not precisely on point with Fred's circumstances, it does relate to how to get the best outcomes for residents. Recommendation 68 stated:

> *That government, health department, regulators, providers and health professional bodies develop national standards describing the skills mix and staffing levels required to manage the needs of residents to prevent RRA.*

15. I support Professor Ibrahim's recommendation and am of the view it could be adopted and extended with the aim of avoiding other preventable adverse events, in particular, deaths associated with unnatural circumstances. Professor Ibrahim and his co-authors stated that they hoped that their research and recommendations would lead to supporting a model where

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[151] Please see the *Safe Patient Care Act 2015* (Vic) at www.health.vic.gov.au/health.

[152] Subsequent amendments to the Act commenced on 1 March 2019.

[153] Professor Joseph E Ibrahim lead author on behalf of the team at the Health Law & Ageing Research Unit Department of Forensic Medicine, Monash University, *Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services* (2017).

every residential aged care in Australia is a high performing organisation which includes implementing '*models of care appropriate for the different needs of residents that are matched with appropriate staffing levels and capability – a fundamental feature for any human service.*'[154] I concur.

16. In 2019, the *Australian Nursing and Midwifery Federation* published a national aged care survey.[155] The survey was open to prospective participants in all Australian States and Territories from 26 March to 12 April 2019. Two separate Survey Monkey® forms were used: one for aged care staff and one for community member participants. The survey provided an insight into concerns raised by those who work in the aged care sector, one quote under the lack of suitable numbers/availability of registered nurses' states:[156]

> *I work in the facility with 120 residents and 2 RNs on the floor which is not safe at all to provide care. PCs made to administer medications to resident because RN is too busy doing administrative workload.*
> *[...]*
> *[RNs] Monday to Friday from 0800 till 1600. But not on weekends, which is likely when they are needed as more families visit then and incidents tend to happen due to less staff on the floor.*

17. The above-mentioned examples of research and opinion voice concerns about staff to patient/resident ratios in aged care facilities. There is disparity in employee training standards, or qualification requirements, across similarly vulnerable cohorts; the qualifications/standards required in the aged care sector is lacking by comparison to, for example, the disability sector. There is enough empirical evidence that warrants a review of the aged care sector and it is hoped that the Royal Commission into Aged Care Quality and Safety will, indeed, do this.

18. I share the concerns of Professor Griffiths that the nomenclature used and discussions about "Nursing Homes" has been systematically exploited to provide justification for decreasing numbers of trained nurses over the rising number of Personal Care Assistants. It is convenient to promote aged care facilities as being an alternative to, but just like ones' home. As RN

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[154] *Ibid* @ pp 28-29.

[155] Australian Nursing and Midwifery Federation: 'The Final Report; National Aged Care Survey.

[156] *Ibid @ p 35.*

Gvojic said: '... *we are a home within itself...we do provide a homely atmosphere for the residents. Their room is their bedroom, they can have their personal mementos in their rooms. So in a sense (sic) it is a residential aged care facility, but in a sense we are a home.*'[157] Wendy Dunn also sought to depict aged care facilities as homes. She explained that the aged care sector had '*moved away from a hospital model*'[158] - that aged care facilities should not be staffed like a hospital; '*it is people's home.*'[159]

19. It is a somewhat compelling statement to depict an aged care facility or the aged care sector *per se* as providing an alternative home – particularly if you are having to make the difficult decision about placing someone you love into an aged care facility. People are generally in aged care facilities because they have numerous medical and/or mental health conditions and/or significant incapacities that necessitates their removal or departure from the home and the instigation of constant care and support. The residents generally need more than company or indeed assistance with activities of daily living; they need their activities of daily living attended to, they need their medication to be given to them, they need to be fed by someone else. In my opinion, many of the residents in aged care facilities have moved well beyond the home environment. But the accuracy of such a statement and other similar pronouncements about aged care facilities being the same as "home" needs greater analysis than I can reasonably justify in relation to my investigation into the death of Fred.

20. I acknowledge the concession made by ESTA that the utilisation of Protocol 22[160] was more appropriate for the circumstances, particularly when regard is had to the evidence that Nurse Coles specifically said that Fred's head was stuck in a drawer. Mr Richards said that Protocol 22 would '*have been appropriate, and the questioning would have been more reflective of the situation.*'[161] Call takers are reliant on the information being conveyed to them by the caller to determine or activate the appropriate protocol and, although Nurse Coles' depiction of the situation to the call taker lacked any indication that she was a qualified nurse, the crucial piece of information that should have dictated the use of Protocol 22 was

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[157] T @ p 265.

[158] T @ p 284.

[159] T @ p 285.

[160] The Protocols utilised by ESTA call takers and the scripts attached to the same are created by AV and as Ms Hodgson stated, "imposed" on ESTA. Any comment, Finding or Recommendation that I make about the use of the Protocols and strict adherence to the attached scripts should be understood to also be directed to the creators, AV.

[161] T @ p 357, 441.

given by her to the call taker. The use of Protocol 22 would have also most likely led to the call taker remaining on the telephone to Nurse Coles '*for the whole event and those questions and that interaction would continue throughout the call.*'[162] The utilisation of Protocol 17 lead to the referral to REFCOMM and ultimately to a delay in dispatchment and thus a delay in the Paramedics arriving at Mayflower.

21. I accept that there is probative value to the ProQA system. I accept also that it provides more often than not, certainty in its application and thus the elucidation of relevant information from callers through the use of the mandated scripts. But in the unique and unusual circumstances surrounding Fred's demise the script does not help the call taker who lacks the privilege of visualising the scene or being offered crucial information about what was the position of Fred's neck and/or was his airway at risk. Compounding the non-visual task of assessing the information being conveyed by Nurse Coles was that Fred could be heard calling out by both the ESTA call taker and the REFCOMM paramedic. An assessment of a risk to Fred's airway was, in the absence of a direct question, totally reliant on Nurse Coles making that assessment.

22. Similarly, advising a caller that "I have got some help organised" is part of the script but it may be somewhat misleading. The call taker knows[163] that an ambulance will not be immediately dispatched when the matter is referred to REFCOMM. However, the language of the script does not indicate that fact by saying, for example: "I am not going to dispatch an ambulance yet but refer you to an AV paramedic to discuss further". Instead, it is language that a caller is entitled to believe means an ambulance is on its way because that is the purpose of their call and what the caller has requested. Scripts that are so rigidly applied that they cannot be deviated from even when the caller has made a clear and unambiguous remark – "I can't see his head at all. It's completely stuck in a drawer" and/or "It's alright Fred an ambulance is on its way", are as in Fred's circumstances, missing critical pieces of information about the patient/victim and at times as we have seen in this matter lead to disingenuous reassurance to the caller.

23. I find it difficult to accept Mr Richards position that allowing the call taker to move '*outside of the scripts you potentially increase the amount of ambiguity and the uncertainty of the*

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[162] T @ p 356.

[163] T @ p 343.

answers coming from the caller.'[164] The effectiveness of assessing the situation in Fred's case was because the REFCOMM operator/paramedic was not constrained by a script.

24. I do, however, acknowledge that the "call exit script" of informing the caller that '*help has been arranged*' is less misleading than saying '*an ambulance is on its way*' if it is not in fact dispatched. I acknowledge that this script was changed in response to the "Thunderstorm Asthma" event. On 21 November 2016, Melbourne experienced the largest recorded epidemic of thunderstorm asthma which placed unprecedented demands on emergency services and in particular, calls for ambulance assistance. There were 10 fatalities[165] associated with this event. The implementation of the altered scripts[166] occurred after Fred's death. Mr Snell confirmed that it was acceptable practice in December 2016 to say that an ambulance was on its way when in fact an ambulance had not yet been dispatched. He also confirmed that this remained the case to date for REFCOMM operators including the use of the phrase '*the crew will be there shortly*' and that the use of these phrases is meant to provide reassurance to the caller.[167] To my mind, the basic principle should be that the information conveyed to the caller should be honest and easily understood.

25. I accept that the attending Paramedics have acted in accordance with their *Withholding or Ceasing Resuscitation Guidelines*[168] as they were at the time of Fred's death. The Paramedics commenced resuscitation attempts after locating Fred pulseless and not breathing and then inquired of the facility's staff if Fred had made any advanced care directives. After viewing a document signed by Fred, the Paramedics have adhered to his apparent wishes and ceased resuscitation attempts as required by their Guidelines. The Paramedics considered that they had '*clear signed evidence of the patient's wishes*' and as such did not feel they could question the expressed wishes in the document, despite the situation in which they found Fred being '*quite bizarre*'.[169]

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[164] T @ pp 354 – 355.

[165] Coroners Court of Victoria reference numbers 2016 5533, 2016 5534, 2016 5536, 2016 5542, 2016 5599, 2016 5616, 2016 5671, 2016 5669, 2016 5824 & 2017 0405.

[166] Exhibit 26.

[167] T @ pp 385 – 387.

[168] Exhibit 14.

[169] T @ pp 158 -159.

26. I do, however, remain concerned that there are several possible scenarios that could lead to a resident becoming pulseless and/or not breathing and which would not be anticipated by the new resident or their supporting loved ones when they are presented with this document on admission to the facility. Becoming pulseless and not breathing, in my view, invokes an image of a natural event only and does not consider the possibility of a precipitating unnatural event such as an assault, a fall, choking on food, the administration of the wrong or excessive medication or indeed such as with Fred, falling head first out of his wheelchair. Clearly, the range of scenarios in this category cannot necessarily be anticipated but cardiac arrest may occur after any of these traumatic events, particularly to those many residents of aged care facilities with pre-existing vulnerabilities. I do not consider it reasonable to exclude the opportunity for a successful resuscitation in these unnatural scenarios for the sake of convenience for the facility requiring residents to complete the form on their admission – a time which must be extremely stressful for many. The Advanced Care Directive is a persuasive enabling document as it provides the resident some control over end of life decisions. If it is truly intended to inform and empower individuals, the document needs to distinguish cardiac arrest from a natural event and cardiac arrest from an unnatural event.

27. It would be of great impost on paramedics *per se* if I adopted the position that they should do anything other than accept Fred's signed wishes *prima facie* but if the Advanced Care Directive made some distinctions, as indicated above, the paramedics would need to consider the surrounding circumstances or as Professor Griffiths stated, put the circumstances into context to finding the resident "pulseless and/or not breathing" before ceasing their attempts at resuscitation. The circumstances of Fred's death indicate that further consideration of possible distinctions is warranted.

FINDINGS

1. I find that John Fredrick Reimers born 14 February 1953 died on 17 December 2016 at Mayflower Residential Aged Care, 56 Elliot Street, Reservoir, in the State of Victoria.
2. I find that Mayflower Residential Aged Care failed to ensure that Nurse Coles had the necessary induction, support and competencies to effectively manage the critical incident that faced her on 17 December 2016.
3. I find that Mayflower Residential Aged Care's adherence to minimum staff with a minimum combination of qualifications – extenuated by the failure to ensure that staff rostered on site between 16 December 2016 and 17 December 2016 had the necessary familiarity with the facility's policies and procedures – contributed to a number of shortcomings in the management of Fred, including but not limited to the fact that the staff failed, or did not have the necessary competencies to:
    a. apply basic first aid to Fred by removing him from the drawer;
    b. take any baseline or subsequent vital signs;
    c. ensure that Fred's airway was protected;
    d. contact the on call Registered Nurse;
    e. use available communication devices;
    f. recognise a change in Fred's condition/conscious state and call back to 000 as advised by the Emergency Services Telecommunications Authority call taker and the Ambulance Victoria Referral Communication System operator, and
    g. recognise that Fred had lost consciousness and died.
4. I find that the continuing use of the Medical Priority Dispatch System or ProQA script prescribed by Protocol 17, despite cues from Nurse Coles that this may not be appropriate, led to a delay in dispatching an ambulance to Mayflower and a consequent delay in provision of paramedic assistance to Fred.
5. I find that this delay was an opportunity lost to alter the outcome for Fred. The delay, created by adherence to Protocol 17, was inevitably time lost that could not be recovered by the subsequent analysis of the situation by the Ambulance Victoria Referral Communication System operator and as we now know, was time critical to Fred's survival. However, I accept that the actual amount of time lost may be '*a matter of conjecture*'.[170]
6. I acknowledge and accept the Emergency Services Telecommunications Authority's concession that the call taker should have implemented Protocol 22, reflecting that Fred was

[170] T @ p 442.

in a situation of entrapment and not in a situation reflective of Protocol 17 – a fall. And, in accepting this concession from the Emergency Services Telecommunications Authority, I acknowledge that it arose out of their own review of the circumstances surrounding Fred's death. Consequently, it was provided with the benefit of hindsight. The concession by the Emergency Services Telecommunications Authority is somewhat qualified because of the submission that there were elements of the information conveyed by Nurse Coles to the call taker that initially supported the use of Protocol 17.

7. I acknowledge and accept that appropriate restorative and preventative measures directed at the call taker and the call taker's mentor at the time have been implemented and in so accepting, I make no further adverse comment about the individual call taker or the call taker's mentor. Save for my comments about the rigid application of the Protocols, I have determined that the concession obviates the need to make recommendations in relation to the ProQA Script in this instance.

8. I find that the Ambulance Victoria Referral Communication System paramedic made an appropriate assessment of the information conveyed to her through the use of the Case Enhance Call Centre Assessment tool.[171] I further find that the Ambulance Victoria Referral Communication System paramedic appropriately escalated the event leading to the change in Priority and the immediate dispatchment of an ambulance on a Code 2.

9. I find that John Fredrick Reimers was still alive when the Ambulance Victoria Referral Communication System call ended at approximately 05.30.39 hours.[172]

10. I find that John Fredrick Reimers was deceased when Ambulance Paramedic Hamid and Ambulance Paramedic Cornelio arrived at Room 38 at Mayflower Residential Aged Care at approximately 05.42 hours. Both Paramedics' evidence about the position in which they located Fred and his level of cyanosis is accepted and preferred to an assessment or attempted analysis of the degree of cyanosis based on photographs taken subsequent to the declaration of Fred's death.

11. I find that Ambulance Paramedics Hamid and Cornelio responded professionally and appropriately when they located Fred deceased in the bottom drawer of his bedside set of drawers/locker. I further find that their enquiries with Nurse Coles about whether Fred had an Advanced Care Directive in place after they had commenced cardiopulmonary

[171] Not a script but a Guideline enabling the use of clinical judgement – T @ p 376.

[172] Time according to the CAD chronology – Exhibit 11.

resuscitation attempts was in accordance with their training and procedures and was appropriate in the circumstances as was known to them. I make no adverse finding against the Ambulance Victoria Paramedics.

12. I find that there is clear and cogent evidence that the death of John Fredrick Reimers was preventable. He was not removed promptly from his perilous position in the bottom drawer of his bedside set of drawers by those responsible for his care and there was a delay in the dispatchment and arrival of paramedics. Tragically, he died in that perilous position in which he had remained for approximately 40 minutes.

13. I accept and adopt the medical cause of death as ascribed by Dr Victoria Francis and I find that John Fredrick Reimers, who had the pre-existing medical condition of ischaemic heart disease and had previously suffered a cerebrovascular accident, died from complications of an inverted positional event.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that Mayflower Aged Care Facility provide appropriate nursing support to its residents by ensuring that a Registered Nurse is always located on site or, at a minimum, reasonably proximate to the facility.
2. With the aim of promoting public health and safety and preventing like deaths, I recommend that Mayflower Aged Care Facility provide appropriate nursing support to its residents by ensuring that all staff are effectively trained as well as providing periodic updates of training in escalation procedures, including but not necessarily limited to when and how to contact the Registered Nurse for support.
3. With the aim of promoting public health and safety and preventing like deaths, I adopt Recommendation 68 of Professor Ibrahim's *Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services*: I recommend that the Australian Minister for Health coordinate with health regulators, health providers and health professional bodies to develop national standards describing the skills mix and staffing levels required to manage the needs of aged care facility residents to prevent adverse outcomes.
4. With the aim of promoting public health and safety, preventing like deaths and improving the delivery of care in residential aged care facilities, I recommend that the Federal and State Government Health Departments legislate minimum ratios of nursing staff to patients/residents of aged care facilities as prescribed by the aforementioned national standards.
5. With the aim of promoting public health and safety, preventing like deaths and improving the delivery of care in residential aged care facilities, I recommend that State and Federal Governments create a legislative mandate requiring Personal Care Assistants to hold a Certificate III in Community and Aged Care as a minimum qualification before they can secure employment in the aged care sector.
6. With the aim of promoting public health and safety, preventing like deaths and improving the delivery of care in residential aged care facilities, I recommend that State and Federal Governments create a legislative mandate requiring Personal Care Assistants to hold a Senior First Aid/CPR Certificate before they can secure employment in the aged care sector.

7. With the aim of promoting public health and safety and preventing like deaths, I recommend that Mayflower Aged Care Facility review its current Advanced Care Directive form for the purposes of providing clarity around the circumstances when a resident does or does not want cardio-pulmonary resuscitation attempts made. Such clarity does not require exhaustive examples but should, as a minimum, distinguish between natural and unnatural events.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

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

Catherine Reimers

Mayflower Aged Care by its legal representative Russell Kennedy

Ambulance Victoria by its legal representative Minter Ellison

ESTA by its legal representative K&L Gates

Australian Government Minister for Health, the Honourable Greg Hunt MP

Victorian Government Minister for Health, the Honourable Jenny Mikakos

Australian Health Practitioner Regulation Agency

Royal Commission into Aged Care Quality and Safety

Professor Debra Griffiths, Monash University

Professor Joseph Ibrahim, Monash University

Signature:

AUDREY JAMIESON

CORONER

Date: **23 August 2019**