OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Margery Frost**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Ipswich
FILE NO(s):	COR 1725/2009
DELIVERED ON:	31 May 2011
DELIVERED AT:	Ipswich
HEARING DATE(s):	22 June 2010
FINDINGS OF:	D.M. MacCallum, Coroner
CATCHWORDS:	CORONERS: Inquest – Nursing Home, staffing levels, storage of lifting hoist

REPRESENTATION:

Sgt K Carmont	appearing to assist the Coroner
Mr B Mumford	i/b HBM Lawyers appearing by leave on behalf of The Salvation Army
Mr G Rebetzke	i/b Roberts & Kane, Solicitors appearing by leave on behalf of RN Paula Johnstone and Asst Nurse Helen Werder

CORONERS FINDINGS AND DECISION

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the Coroner's written findings must be given to the family of the deceased person and to each of the persons or organisations granted leave to appear at the Inquest. These are my findings in relation to the death of Margery Frost. They will be distributed in accordance with the requirements of the Act.

CORONER'S JURISDICTION

A coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. Where possible the coroner is required to find:

- Whether death in fact happened;
- The identity of the deceased;
- When, where and how the death occurred; and
- What was the cause of death.

An Inquest is not a trial between opposing parties but an inquiry into the death. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and if relevant, recommending ways to reduce the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances. However a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or express an opinion on any civil liability.

ADMISSIBILITY OF EVIDENCE AND THE STANDARD OF PROOF

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate.*" That does not mean that any piece of evidence, however unreliable or irrelevant will be admitted and acted upon. It simply enables the coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable. This means that the more significant the issue to be determined, the more serious the allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence should be.

A coroner is obliged to comply with natural justice and to act judicially. This means that no findings adverse to the interest of any party may be made without that party first being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

BACKGROUND

Mrs Frost was a resident of Riverview Gardens Nursing Home, Riverview at the time of her death and had only moved there on 11th August, 2009 after a stay in hospital. Prior thereto she had been an occupant of Warrina Village Nursing Home, Chelmer. She was occupying Room 23, Oak Wing at the centre. Mrs Frost was a frail, elderly lady who was born on 12th October, 1923. On the day of her death Mrs Frost was visited by both her son William Frost and his daughter Kelly Jean Frost. Mr Frost reports that his mother informed him that another lady had been in the room the night before and that she had hurt her. Mr Frost took little notice of this as he thought it may have been as a result of his mother's dementia.

Mr Frost left his mother prior to 6.00pm on the 12th August, 2009 and she was next seen at about 6.15pm by Helen Werder, a trainee nurse. Ms Werder states that Mrs Frost was still seated in the medical chair which she had been in when Mr Frost left.

At about 7.20pm Paula Johnstone, a registered nurse also in the employ of the nursing home, went to answer an emergency alarm which had been activated in another room. As she passed Mrs Frost's room Ms Johnstone saw Mrs Frost lying on the floor. Mrs Frost's head was lying against a hoist which is used to assist frail patients into and out of bed. The hoist had earlier been seen in the hallway outside Mrs Frost's room. The room across the hallway from Mrs Frost, being room 22, was occupied by another resident Mrs Eva Samford who was at the relevant time aged about 92 years and who was suffering from dementia. Mrs Samford had some history of wandering into the rooms of other residents. When Ms Johnstone arrived she observed Mrs Samford to be seated at the end of the hallway near Room 24 and her walking frame was found in the position where the hoist had earlier been located i.e. the alcove used to store the hoist.

Early investigations by the police ascertained that the hoist was not supposed to have been in Mrs Frost's room and that it had not been used by the nursing staff to assist Mrs Frost.

When Mrs Frost was transferred to Riverview the transfer letter provided with her paperwork stated that she had a history of falls. She was assessed as needing full assistance with all activities and a hoist was to be used to assist her into and out of bed as required. When Ms Johnstone arrived she observed Mrs Frost's head to be on top of the right leg of the hoist. Nurse Johnstone was unable to detect any vital signs.

Upon notification to the police, officers arrived and a crime scene was declared. Fingerprints were collected and DNA was also collected. No fingerprints of any value were retrieved and the DNA also was inconclusive.

The autopsy determined that the cause of death was coronary atherosclerosis. Although there was evidence of some minor blunt force trauma and bruising none of this was considered to have had any part in the cause of death. In effect death was from natural causes. The pathologist was

of the opinion that some of her other medical conditions, such as Alzheimer's disease and Diffuse Lewy body disease would have made it difficult for her to seek assistance or complain about chest pain from an impending heart attack.

As Coroner, an Inquest was held because of some concern based on material provided that there may have been some incorrect storage of the hoist and perhaps insufficient staff to care for the number of residents of Oak Wing where Mrs Frost was then residing. There was also concern about what steps were taken to prevent patients known to wander from going into the rooms of frail and defenceless patients. I want to make it very clear that no blame attaches to Mrs Samford.

RIVERVIEW GARDENS NURSING HOME

Riverview Gardens is a Nursing Home operated by the Salvation Army. In about July, 2009 Riverview Gardens became operational. Consequently it had been in operation for only about 1 month prior to the death of Mrs Frost. I am prepared to accept that at that time the staff were getting used to a different work environment in that previously they had worked in a multiple bed ward environment and now the residents were housed separately in individual rooms. This of course is preferable for the patients, affording them more privacy and dignity but it also means that staff do not have patients under almost constant observation.

At the relevant time there was three (3) nursing staff on duty in Oak Wing, these being Helen Werder, Kildip Kaur and Paula Johnstone. After the death of Mrs Frost the home undertook a review of staffing levels and operations and some minor changes were made. These included the appointment of one extra staff member who would float between the various sections as required but is not permanently attached to any particular wing. In addition staff breaks have been staggered so that there is always staff available to attend to the needs of the patients.

LIFTING HOISTS

At the time of this incident the hoists were stored in alcoves located in the corridors. These hoists are battery operated and staff was required to store them in the alcoves with the foot brakes in place. Each alcove has a battery charger built in so that the hoists can be recharged from time to time. There was no other means of securing the hoists and it was up the staff to ensure that after use they were returned to the alcove and the brakes applied. It is clear that on this day that did not occur as the hoist, which it was said by both Ms Werder and Mr Kaur was located in the alcove and had not been taken by them into Mrs Frost's room. How the lift got into Mrs Frost's room and how she was removed from the chair she had been observed to be sitting in by Ms Werder, will always be unclear. It is also something of a mystery how Mrs Samford's walking frame came to be in the alcove and she was found seated some small distance away in the corridor. If she required the frame to move about how did she get from the alcove to where she was found sitting? There has been speculation that she may have used the hoist to walk and gone into Mrs Frost's room for some unknown purpose.

Since Mrs Frost's death the Home instigated an audit process whereby the hoists are checked to be in the alcoves and checked to ensure that the brakes are engaged. I understood this to be a process which would not be a daily requirement but would be done on a "regular" basis whatever that might mean.

FAMILY CONCERNS

The family did not express any particular concerns about the Home and have always expressed that they were satisfied with the care their mother received during the brief time she was there. The Inquest was called due to some concerns about the storage arrangements for the hoist such that it should not be accessed by persons other than trained staff.

ISSUES FOR THE CORONER

Apart from the findings required pursuant to the Act the issues which have arisen are:

(a) the staffing levels at the Riverview Gardens Nursing Home; and
(b) the storage of the lifting hoist.

Staffing at the Riverview Gardens Nursing Home

Since Mrs Frost's death and some of the concerns which I, as Coroner expressed at an early stage have been addressed. I am informed that the home has made some changes which include the following staffing proposals:

(a) an additional staff member to act as a "floater" to assist as required; and
(b) Tea/meal breaks are to be taken so that not all rostered staff are absent at the same time.

Both Counsel for the Home and for the nursing staff Johnston and Werder have submitted that in these circumstances which the Home has now established that no further comment should be made. I accept that those submissions are validly made but it is always of some concern that many of these issues are not addressed until there is an incident. However I equally accept that the Home had not long been operating in these new wings and there was clearly some "tweaking" of arrangements to be made with operational needs. I am satisfied that the Home has made every attempt to learn from this incident and has responded appropriately and quickly.

After hearing evidence about the cost of CCTV monitoring I would agree that may well be an expensive alternative. Whilst I note both Counsel have been at pains to note there have been no prior incidents similar to that which occurred here nor that there is any direct link between Mrs Frost's cause of death and the lack of staff or the presence of the hoist and whilst I acknowledge the force of those comments, these were still issues which a Coroner did need to consider particularly having regard to Section 28 of the Act.

Storage of the lifting hoist

The second issue of some concern was the storage of the lifting hoist. As noted above it is not clear how the lift came to be in the room of Mrs Frost. Was it placed there by Mrs Samford or another resident or by a member of staff who was called away urgently and simply forgot to relocate it? These are questions which are unlikely to be definitively answered. No staff member who was interviewed by police admitted to placing the hoist there and at the relevant time Oak Wing was effectively unattended due to the staff being on a tea break together. This meant that Oak and Wattle wings were effectively being supervised by staff from Wattle wing.

Again both Counsel for the Salvation Army and the nurses Johnston and Werder submitted to the effect again that there is no direct evidence linking the death of Mrs Frost to the presence of the hoist in her room. I accept that, as it is clear from Dr Urankar's findings that Mrs Frost's death was as the result of coronary atherosclerosis and not related to the hoist in any way or a lack of staff. Whilst it is clear that there was some minor trauma to her head consistent with the position in which she was located on the hoist and this suggests she may have struck her head on a part of the hoist prior to death I accept that there is no evidence that the hoist was directly related to the cause of the death.

After considering the evidence and the submissions made I am prepared to concede that storing the hoist by a locking mechanism additional to the already fitted foot brake may not be practical or necessary. Whilst I note there were submissions that the locking of the hoist may impede its use in emergent situations I doubt this would be the case. However the necessity to lock the hoist would be obviated if the audit process is properly maintained. I am satisfied that the Salvation Army is prepared to continue this process into the future. It is probably as likely that someone would forget to lock the hoist into position as he/she may forget to return it to the designated alcove and apply the foot brake.

During the course of evidence a number of options were visited as to how best to monitor the situation of ensuring the hoists were returned to the alcoves. CCTV monitoring was considered but privacy issues as well as the cost factor realistically make it a non viable option at this time.

Another option of monitoring is by way of the fixing of some type of electronic personal monitor to those residents known to wander. This was a suggestion raised by a member of the nursing staff but it would be an issue that would have to canvassed with patient rights advocates and clearly would need to be a matter of consent from family members. It has attractions, particularly when it potentially could help ensure the safety and well being of a person who may no longer have the capacity to self assess his/her safety needs. However it does not overcome the situation of a patient who misguidedly decides to use the hoist, as any personal electronic monitor would operate only if the resident were to wander outside the grounds. Using it within the home would be impractical and may effectively make residents prisoners within their rooms, a totally undesirable consequence.

FINDINGS PURSUANT TO s 45

Pursuant to section 45 of the Act I am required to find who the deceased was, when and where he/she died, what caused the death and how he/she came by his/her death. I have dealt above with the circumstances of Mrs Frost's death. Given the evidence before me I have no reason to depart from the finding made by Dr Uranker as to the cause of death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings:

(a) The identity of the deceased was Margery Frost;
(b) Mrs Frost died on 12th August, 2009 ;
(c) Mrs Frost died at Room 23, Oak Wing, Riverview Gardens Nursing Home, Riverview;
(d) The cause of death was coronary atherosclerosis with other significant factors being acute bronchitis, emphysema, Alzheimer's disease and Diffuse Lewy Body disease.

RECOMMENDATIONS PURSUANT TO s46

For the reasons which have been canvassed above I do not propose making any recommendations pursuant to section 46 of the *Coroners Act 2003*.

I extend to the family of Mrs Frost my sympathy at the passing of their loved mother.

I now declare this Inquest closed.

D.M. MacCALLUM
CORONER
IPSWICH
31 May 2011