OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Michael Warren**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO:	00001978/04 (7)
DELIVERED ON:	**25 September 2008**
DELIVERED AT:	Brisbane
HEARING DATE(s):	31.03.2008, 01.04.2008, 02.04.2008
FINDINGS OF:	Christine Clements
CATCHWORDS:	CORONERS: Inquest – Motor Neurone Disease, fire safety, smoking in a health facility with an impairment.

REPRESENTATION:

Mr Simon Hamlyn-Harris, appearing to assist the Coroner
Ms Dianne Condon representing Southside Health Service District

CORONERS FINDINGS AND DECISION

1. 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 person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my finding in relation to the death of Michael Warren. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

The Coroner's jurisdiction

2. Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The scope of the Coroner's inquiry and findings

3. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

4. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

5. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."* [1]

6. 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 with a view to reducing 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 in future.[2] However, a coroner must not include in the findings or any comments or recommendations, statements that a

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46

person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

The admissibility of evidence and the standard of proof

7. Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a 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.

8. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

9. 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.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

10. It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

Introduction

12. Michael Warren (Mr Warren) died in the Royal Brisbane Hospital on 14 August 2004. He was suffering from Motor Neurone Disease (MND), which had only recently been diagnosed by a neurologist. Mr Warren lived with his son Martijn Warren until 9 June 2004 when he was admitted to the Logan Hospital due to deteriorating health. On 23 June he was transferred to the Beaudesert Hospital while awaiting a permanent nursing home placement.

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[3] s45(5) and 46(3)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

13. It was not the direct effects of the devastating MND which caused Mr Warren's death. He died from complications of serious burns suffered on 28 June 2004 in the Beaudesert Hospital when he was smoking a cigarette. This inquest will determine how the injuries were caused and consider ways to prevent such an incident from occurring again.

Evidence from Martijn Warren

14. It is always helpful for a coroner to hear evidence from a family member, as it assists the coroner in forming an understanding of who the person was in life.

15. Mr Martijn Warren informed the court that his father came to Australia from the Netherlands. Mr Warren had worked both in nursing and in the area of research into cancer. He was a survivor of a Japanese internment camp where he had been held as a young child during the Second World War. Despite suffering a significant back injury during this time, Mr Warren was able to fulfil an active adult life. His final work was in the field of home care.

16. In early 2004 Martijn Warren became aware that his father was displaying various symptoms and these were medically investigated. By February, Mr Warren had become forgetful and had lost his power of speech. His walking had deteriorated and his fine motor skills were diminishing. It was on 17 May 2004 that the diagnosis of MND was confirmed by a neurologist, Dr John Corbett. The progression of the disease was rapid and Mr Warren was not expected to live beyond the end of 2004.

17. Martijn Warren said that his father had smoked tobacco throughout his life. As his health deteriorated, smoking remained one of his few pleasures. When the MND robbed him of his previous dexterity, he started to light his cigarettes with matches as he could no longer operate a cigarette lighter.

18. Martijn Warren was concerned for his father's safety at home while he was at work. There were incidents where Mr Warren dropped items and on one occasion he fell and was unable to get up. Finally the decision was made that Mr Warren required admission to hospital for his care and to assess his future needs. He was admitted to Logan Hospital on 9 June. His condition was assessed by the Aged Care Assessment Team (ACAT) as requiring a high level of care and he was transferred to Beaudesert Hospital awaiting a nursing home placement.

19. While in hospital, his son visited twice daily and he found his father remained in good spirits. Although there were obviously episodes and periods of sadness, he considered his father to be reasonably happy despite his condition. I accept Martijn Warren's evidence, which was supported by hospital staff that despite his terminal illness Mr Warren retained a positive outlook.

20. Mr Warren continued to smoke in Logan Hospital. He was still sufficiently mobile to go outside to an open courtyard area. His son said he smoked five to ten cigarettes a day. Father and son smoked together and Martijn noticed that as his father's condition worsened he continuously kept the cigarette in his mouth as he smoked it and did not remove it to tap off the ash. Sometimes Mr Warren would get other people to light the cigarette for him. When he had finished he would lean forward to eject the stub directly from his mouth into an ashtray.

21. Martijn Warren said his father reduced his level of smoking once he was hospitalised but there was no attempt to give up smoking. It was the difficulty of physically managing to smoke that effectively reduced the number of cigarettes he smoked

22. As Mr Warren had lost the ability to speak (aphonia), his only means of communication was in an abbreviated writing style on a note pad. His writing ability was also affected by his disease.

23. Mr Warren continued to smoke after being transferred to the Beaudesert Hospital. His son would light his cigarettes and place it between his father's lips. Martijn could not recall the last occasion he saw his father light his own cigarette with matches. Martijn Warren was concerned about the issue of safety with his father's smoking. He expressed his concerns to Beaudesert Hospital staff in the context of the safety of the clothing Mr Warren wore in hospital. His son preferred his father to wear his own polyester based tracksuit pants and a jumper rather than the hospital supplied pyjamas. He recalled his father had his own dressing gown which he would wear over the top when he went outside into the courtyard area at Beaudesert to smoke. Martijn did his father's laundry and returned the laundered clothes to the hospital on his visits. The evidence was that on the day of the fire Mr Warren was wearing hospital pyjamas, probably due to his incontinence which required staff to change him into hospital pyjamas until his son returned with clean clothing.

24. On the evidence it appears more probable that it was Mr Warren's own dressing gown, rather than a hospital supplied dressing gown, which was being worn at the time of the fire.

The incident

25. Endorsed enrolled Nurse Maree Whitehead told investigating police that sometime between 4.30pm and 4:45pm on 28 June 2004, Mr Warren came to the nursing station. He was holding up his pyjama pants to be tied and he handed her his dressing gown because he could not put it on by himself. She knew he couldn't talk and he needed help putting the robe on. She tied the sash in a bow so that he would not trip. She noticed he took a cigarette from the dressing gown pocket and held it wrapped in his hand. She interpreted this as Mr Warren telling her he was going out for a cigarette. The cigarette was not alight. He walked off toward the smoking area where she knew he

usually went to smoke. This was an outside courtyard leading off from a television room which could not be seen from the nurses' station.

26. About ten minutes later she walked along the corridor and her attention was drawn to the courtyard used by smokers. She saw Mr Warren standing with his clothing alight. Fire was burning from the bottom of his dressing gown up to his waist and also enveloping his sleeves. Her recollection was that she first saw the fire on the right sleeve and then it appeared to go across the sash of the gown to the other sleeve and then to the gown itself. Mr Warren was walking towards the door to enter the television room from the courtyard.

27. She instinctively ran towards him to try to help. She called out to another nurse (Tracey) because she heard her voice. She grabbed a folded bed sheet from a table as she passed by. She went out into the courtyard and tried to extinguish the fire by wrapping the sheet around Mr Warren's arms to smother the flames, but the flames were spreading from the belt as well and going upwards. Another nurse, Tracey Cross, came to help. They tried to untie the sash but could not because it was burning and pieces of the dressing gown were falling as they burnt. Nurse Cross tried to push Mr Warren to the ground with Nurse Whitehead standing behind to catch him and roll him to smother the fire. They were attempting to bring him to the ground to improve the opportunity to smother the flames which were rising up into Mr Warren's face. The manoeuvre was unsuccessful.

28. Nurse Whitehead said they both ran back through the television room to the corridor and opened the fire extinguisher cupboard. Nurse Cross pulled out the fire hose into the television room but it jammed. The evidence was not clear as to why this happened. Nurse Whitehead referred to an unnamed man who was probably a visitor also being involved in trying to free the hose but without success. This person was not identified or interviewed. They could not get the hose to go backward or forwards on the reel. Then there were problems with trying to turn on the water supply. Nurse Whitehead thought she had turned the water on at the valve in the wall but there was no water coming from the hose nozzle being held by Nurse Cross.

29. In the middle of this, the Director of Nursing (DON) Michael Chalmers and nursing unit manager Christine Marsh arrived on the scene. They raced out to Mr Warren, then Nurse Chalmers immediately returned and grabbed a fire extinguisher. He used this by directing it onto the flames engulfing Mr Warren, extinguishing the blaze.

30. There was no statement taken by the police from Nurse Cross. At the time of their attendance they were investigating a fire rather than a fatality and it seems they did not follow up after Mr Warren's subsequent death.

31. There were some discrepancies between the details of events from Nurse Whitehead and DON Chalmers. I note that Nurse Whitehead and Nurse Cross were at the scene prior to DON Chalmers and therefore I rely on Nurse Whitehead's account up to the time when DON Chalmers arrived and accessed the fire extinguisher.

32. It was an emergency, a highly stressful situation that Nurse Whitehead encountered. She tried but failed to extinguish the fire by smothering Mr Warren with the nearest available article. She and Nurse Cross tried to manoeuvre Mr Warren to the ground but without success. Her efforts to access and use the fire hose were not successful, whereas DON Chalmers was successful by using the fire extinguisher.

33. I accept that for whatever reason there was a problem with unwinding the hose from the reel. I accept that this was not freed until after DON Chalmers used the fire extinguisher and after the emergency trolley had arrived to provide assistance to Mr Warren.

34. Nurse Whitehead previously worked in the old hospital where one of the two fire hoses had a lever action to turn it on. The fire hoses in the hospital at the time of the fire all required a wheel tap to be turned on underneath the hose before water would issue from the nozzle in twisting it. [9]

35. Nurse Whitehead's evidence from her statement was that she had not received training about the need to turn the nozzle to start the water flow. She had turned on the tap at the reel.

36. Mr Peter Jaques was previously involved in fire training at the old Beaudesert Hospital and initially at the new hospital. His evidence was that in training he pointed out the two different types of activation of nozzles in the old hospital and told them they should familiarise themselves with the particular hose in their department.

37. These events emphasize the importance of repeatedly having hands on practical training on how to respond to a fire. Nurse Whitehead gave evidence that this fire reel was different to others she had been trained to use. It is the pressure of a real emergency that will test whether training has been effective in equipping staff with the skills to successfully use fire fighting equipment. In 2004 Nurse Whitehead had not updated her training with a hands on session. Instead, that year the hospital ran questionnaire style training to identify the locations and use of equipment. In the past Nurse Whitehead had participated in manual training.

38. Nurse Whitehead considered it was safer for the patient's airway to try to use the water extinguisher in preference to the chemical fire

[9] Exhibit B18, Statement of Peter Jaques.

extinguisher. Obviously, when this attempt had been unsuccessful it was the appropriate for DON Chalmers to use the fire extinguisher.

39. The evidence was that no one else was in the courtyard when Mr Warren's clothing caught fire. There is no direct evidence about how Mr Warren lit a cigarette that preceded his clothing catching alight but I am satisfied that in all the circumstances the fire was related to Mr Warren smoking a cigarette. It may be that Mr Warren himself attempted to light the cigarette with matches. A box of matches was found in the courtyard as noted by Constable King who attended at the hospital the same day. [10] Mr Warren's son would often light his father's cigarette but he was aware his father used matches to light a cigarette himself. Alternatively, it may have been that a cinder fell onto his clothing while he was smoking and ignited the clothing. When last seen by Nurse Whitehead, before he went out to the courtyard, he was holding an unlit cigarette in his hand.

40. When the fire caught his clothing Mr Warren was helpless. He was alone in the courtyard with no one to intervene. Because of his condition, he could not call out for help. He could not effectively disrobe as he had required help to put on and tie up his robe sash. There was no call button in the courtyard to call for assistance. He could not run, but only shuffle back towards the door into the hospital. It must have been a terrifying and painful experience before help arrived and the fire was extinguished.

Clothing

41. Evidence from Sergeant Rasmussen, the scientific officer confirmed examination of a red sweat shirt. This article was damaged by fire down the bottom of the front of the garment and rising up in a typical inverted "V" plume. He considered the fire pattern was likely to show fire damage from a cigarette that had fallen while Mr Warren was seated. [11]

42. He also explained that natural textiles are much more likely to support a flame if a match or cigarette falls onto them than a highly synthetic textile. The synthetic textile will melt but usually self extinguish. He tested the flammability of the drawstring pyjamas and demonstrated that a naked flame dropped onto the fabric could spread laterally. I accept this evidence and prefer it to the belief of Ms Jones, who gave evidence about the linen supplied to Queensland Health. She had been informed by her supplier that the pyjamas would not catch alight and support flame if they were brought into contact with a flame. With respect to the hospital pyjamas worn by Mr Warren I conclude that they would support flame.

[10] Page 24, line 13
[11] Page 30, and page 31, line 40

43. Sergeant Rasmussen did not test the dressing gown as it was wet. He noted however that it was a cotton towelling type gown which in his experience would support flaming combustion.[12] His opinion was supported by the fact that a fair part of the dressing gown had been consumed by fire. From his notes he recorded that the dressing gown was a blue terry towelling dressing gown. He could not recall any identifying marking to indicate whether the clothing was Queensland Health property.

44. The overall impression I gained was that the dressing gown was Mr Warren's own attire but the pyjama pants were hospital supplied due to Mr Warren's incontinence and the need to keep changing his pants.[13]

Fire training and equipment

45. This issue has been referred to earlier. The incident reinforces the need for manual training in the practice of using fire fighting equipment. Nurse Whitehead could recall induction training as well as annual fire evacuation procedures which included the use of fire equipment. She also recalled a written format session some months before the fire occurred and education videos.

46. Some twenty four hours after the fire, the fire reel was inspected by Peter Jaques who was at the time the hospital officer with overall responsibility for fire safety. He could find no fault with it, but it is to be noted the hose had been used to hose out the courtyard by this time of inspection and subsequently recoiled onto the reel. It is therefore impossible to draw any inference about its useability at the time of the fire.

47. DON Chalmers confirmed that since the fire there has been a review of training with an emphasis on manual training. A "blitz" programme has been introduced over a six week period to ensure all staff access the training. The provision of more fire blankets has also been reviewed and increased. [14]

48. I remark the documentation of the fire incident itself and the review undertaken by the hospital was minimal. The question on the form was posed;

> *"What actions have been taken to identify the cause of this incident and prevent its recurrence?"*
>
> DON Chalmers wrote:
>
> *"Care plan assessment indicate information on no smoking policy, and district review of no smoking policy."*

[12] Page 33, lines 1-10
[13] Page 81 line 55
[14] Page 130

49. DON Chalmers had difficulty in explaining what this meant. It seems to be the response was to introduce a no smoking policy at the hospital.

50. However DON Chalmers acknowledged that even now some patients go out into the street to smoke. Others go quietly outside, but within hospital grounds, which is contrary to policy. It remains a vexed issue.

Police investigation

51. Mr Warren was injured by fire on 28 June 2004. Hospital staff had used the fire hose to hose out the courtyard area before the arrival of police. There was no sign of the fire. Mr Warren's fire damaged clothing had been placed in bags. Constable King noted a box of matches in the courtyard. He also confirmed there was no call button in the courtyard area.

52. There was information from the investigating police officer that he had spoken with another patient who used the smoking courtyard earlier that day in company with Mr Warren. Although the police officer had been unable to subsequently locate that patient to prepare a formal statement he had notes of the conversation. The woman had lit Mr Warren's cigarette which was already in his pursed lips. She saw him seated in a chair while he smoked the cigarette. He did not remove the cigarette from his mouth while he smoked it. She left the courtyard before he had finished. Constable King understood that this occurred earlier in the day, rather than immediately leading up to the fire in which Mr Warren was injured.

53. The patient was identified as Karen Bowater and she gave evidence at the inquest. She did not know Mr Warren but had seen him on a couple of occasions in the hospital as he walked past. She remembered that he looked fragile. She recalled he was wearing hospital pyjamas, which she described as the "*the real thin jamas that the hospital gives out*"[15] She could not recall a dressing gown. She saw him walking along the corridor to go to the smoking area. She was uncertain but she thought she could recall another younger man with him in the corridor. She said that only the older man came out into the smoking courtyard where she was smoking. This was some time after lunch. She remembered that Mr Warren walked very slowly and he came past her as she sat on one of the chairs in the courtyard. As he went past her Mr Warren bent down towards her. She said he had a rolly in his mouth and she just presumed he wanted it lit. She lit the cigarette for him. He didn't say anything; he just puffed his smoke and then kept on going. She did not know whether he could speak but she understood from his actions that he wanted his cigarette lit. Ms Bowater saw he went and sat in a chair by himself. She noticed that he reminded her of her grandfather in the manner that he smoked. The cigarette remained in his mouth

[15] Page 40, line 52

constantly. "*he never held the cigarette. It always stayed in his mouth*."[16]

54. She did not see him finish the cigarette. Mr Warren was still seated and smoking when she left to return to her room. She did not see Mr Warren with a lighter or matches.

55. Ms Bowater had seen other patients and visitors using the courtyard to smoke. There was a receptacle with sand to stub out cigarettes and she considered it to be the designated smoking area. In 2004 there was signage indicating the courtyard was the area reserved for smoking although she knew this was no longer the case. The whole hospital is now a non smoking area including the courtyard. In more recent times, when Ms Bowater was a visitor to the hospital she recalled that in order to smoke it was necessary to leave the hospital building, go through the car park area and out near the road side.

56. The examination of the remnants of clothing showed fire damage in the lap area of the pyjamas suggesting that the fire commenced while Mr Warren was seated in the chair in the courtyard.

57. Constable Finney attended the Beaudesert Hospital on 28 June at about 6.10pm. He and Constable Hawkins were the first officers to arrive. They were shown the courtyard area by DON Chalmers. The area was wet and had already been cleaned prior to police arrival.

58. I note there was no real investigation by the police of fire fighting equipment, its adequacy or inquiry made regarding the training of hospital staff.

Mr Warren's physical capability and smoking

59. The inquest had access to medical records from the Logan and Beaudesert Hospitals[17]. On 23 June 2004, Mr Warren was transferred to the Beaudesert Hospital awaiting placement in a care facility. He was admitted by Dr Andrews. At the inquest she was asked about whether there were any concerns for his physical safety while he was smoking. She replied, "*I don't think it's been an issue*."[18]

60. Mr Warren was assessed by speech pathologist (Breanne Hetherington) while he was at Beaudesert Hospital. As part of assessing his capacity to swallow (dysphagia) she noted she was unable to assess his voice. She recalled he relied solely on pen and paper to communicate. She noticed he did not have full dexterity in writing and was concerned that as the disease progressed he would lose this mechanism of communication. She provided him information

[16] Page 44 line28-29
[17] Exhibits C1 and C2
[18] Page 148

about the MND association support group. There was the possibility he could access a special keyboard communication device.

61. At Logan Hospital, Mr Warren's decreased capacity to swallow led to the insertion of a percutaneous endoscopic gastrostomy (PEG) on 21 June which enabled him to receive direct nutritional supplementation. Ms Hetherington noted "*He'd probably be one of the most rapidly deteriorating speech and swallowing patients I've worked with*."[19] She confirmed that people suffering from MND often ultimately died due to respiratory failure associated with the lack of ability to breathe.

62. Endorsed enrolled Nurse Whitehead described Mr Warren as follows:

> "*He was a frail little gentleman. A very sweet lovely man who could not speak, had difficulty swallowing, was frail, was sometimes a bit unsteady on his feet. Had a lot of muscle weakness, needed help getting dressed, needed help with most things. Needed help to do up his pyjama pants and things like that."*[20]

63. It was clearly known by nursing staff that Mr Warren smoked and he would often be sitting out in the courtyard when nurses came around to perform observations on patients. The area was well patronised by patients. She could remember seeing Mr Warren holding a cigarette in his hand in a modified grip between his thumb and two fingers. She denied ever seeing a cigarette constantly being held in his mouth.

64. Nurse Whitehead assumed he used a lighter and said it was not until after the fire that she became aware Mr Warren could no longer use one and instead used matches. She was also not aware, until after the fire, that other patients would light Mr Warren's cigarettes.

65. Nurse Whitehead told the inquest she would accompany some patients when they went outside to smoke. She recalled a female patient with dementia. She considered that patient was not safe with a lighter. There was no required practice that patients needed to ask permission or tell staff before they went out to the courtyard to smoke. Nurse Whitehead indicated that if a patient was considered unsafe while smoking it would be documented in their nursing care plan. She denied considering Mr Warren was at risk when he smoked. She said no one else had raised it as an issue prior to the fire.

66. I note the nursing care plan, was identified by DON Chalmers as pages 119 and 120 of the paginated medical records. On 23, 24 and 25 June the notation next to the "mobility" heading indicated he required supervision and his risk of falls was high. Curiously, the next page of records for 26, 27 and 28 June record the words "*as able"* next to the

[19] Page 58 line 31-32
[20] Page 66 line 20-25

mobility assessment. His risk of falls was recorded as "low." The only note referring to smoking at all simply records "*mobilising quite well around ward and out for cigarettes*". That was noted on 27 June. He indicated that all of the usual processes of assessing a patient's ongoing condition occurred, but conceded the issue of smoking as a safety issue itself was not specifically raised to his knowledge. DON Chalmers agreed there was an assumption he could safely smoke. In hindsight he recognised there was a risk to Mr Warren in smoking. As Queensland Health has prohibited smoking in facilities it is now easier to manage, but it remains a hospital by hospital based decision how this is applied. He stated it is not feasible to provide nursing staff to supervise patients' smoking given their work requirements.

67. Dr Pamela McCombe is a specialist neurologist in private practice. She works at the Motor Neurone clinic at the Royal Brisbane Hospital. She gave evidence to assist the inquest in understanding MND. She had not met or treated Mr Warren but reviewed his medical records. She confirmed he had well established MND as evidenced by his inability to talk or swallow. He had weakness of the upper and lower limbs. It was explained that it is technically very difficult to measure the rate of progression of the disease. From the information available to her, she considered Mr Warren would have had difficulty smoking a cigarette and would not have done so in the way a healthy person would smoke a cigarette. If he couldn't manage a cigarette safely then it would be desirable for him to be supervised when smoking. As MND is a very rare condition she considered that nurses in a small hospital, such as Beaudesert, may not be familiar with the condition[21] In particular she considered staff may not be aware of the effect the disease has on a person. The care of someone with a severe neurological condition is a highly specialised field.

68. Dr McCombe considered the care required for patients with this disease was very specialised. Mr Warren had been assessed by ACAT as requiring a high level of care. The difficulty is in finding an appropriate placement when they can no longer be cared for in the home. In the last stages of the disease patients are completely dependent for all care. They are unable to move at all requiring two people to roll them in bed and to provide total care of all bodily functions. She identified a need for specialist palliative care for people suffering chronic neurological disease. This required high levels of specialist nursing care rather than highly specialised medical care. The other important issue identified was that a patient with MND may physically appear to be alright but be incapable of movement to feed themselves or perform other daily tasks. The difficulty is compounded once the person has lost the ability to communicate. This of course has safety implications if a person's diminished capacity is underappreciated.

[21] Page 107, line 15; 400-600 people in Australia currently have motor neurone disease in Australia.

69. Dr McCombe acknowledged that one of the principles of care with patients with MND is patient autonomy. There is therefore a need to balance the inherent risks of a MND patient to smoke after MND has affected their ability to do so safely and their desire to engage in this activity. As Martijn Warren explained when Mr Warren's health deteriorated, smoking remained one of his few pleasures. Offering nicotine replacement therapy was a useful alternative but the decision to continue to smoke rests finally with the individual.. Sometimes the individual had insight and acceptance of their diminished capacity to safely undertake a particular activity and would cease of their own accord.

Cause of death

70. Mr Warren received emergency care for his burns at Beaudesert Hospital before being transferred in an ambulance to Royal Brisbane Hospital. He was accompanied by Dr Andrews. The medical record documents the treatment provided which included extensive skin grafts.

71. The pathologist Dr Beng Ong who conducted the autopsy noted the complications of infection. He also noted the history which indicated that Mr Warren's condition of MND worsened his capacity to recover from his injuries. Mr Warren's diminishing muscle response reduced his respiratory effort and resulted in a collapse of a lung. Sepsis developed and he succumbed to the combined effects of the burns and the underlying MND. The underlying disease condition was confirmed at autopsy but the extent was not able to be ascertained as this remains a clinical assessment.

Queensland Health Policy and Smoking

72. I consider any comment on Queensland Health's policy on whether or not there are any circumstances in which smoking is permitted within a Queensland hospital campus to be somewhat irrelevant to the issues of this inquest. Smoking is inimical to good health, but this is beside the point. The risk to Mr Warren was not to his overall health, he was a man dying of an incurable disease. The risk for Mr Warren of smoking was fire. His manual dexterity was diminished, as was his overall mobility. To attempt to light a cigarette was a risk. He could not speak or call out for assistance. He could only hold the cigarette in his lips for the duration of the life of the cigarette, and then he could eject it.

73. Mr Warren's diminished capabilities were known to hospital staff. After all, he had been admitted to Beaudesert Hospital for the very purpose of awaiting placement in a care facility due to his assessment as requiring a high level of care as a result of his condition. His smoking does not appear to have been appreciated as a risk to his safety. It misses the point for Queensland Health to point to policy that now bans smoking within its hospitals. There was evidence that despite such policy there are occasions or situations where smoking occurs. A risk of fire with smoking is always possible but it is greater in certain

circumstances where a patient's physical and sometimes mental capability is diminished. The first responsibility is to actively assess the danger to the patient and to other persons of a fire if it is known a patient is a smoker and there is a probability the patient will smoke during the admission.

74. Mr Kevin Lambkin, the Senior Director of the Alcohol Tobacco and Other Drugs (ATODS) Branch of Queensland Health, explained the policy history concerning smoking at Queensland Health facilities. The policy introduced in July 2006 discourages smoking as much as possible but permits discussion at District levels regarding designated smoking areas. Logan and Beaudesert Hospitals have since decided against any outdoor designated smoking areas. The impact is that if people decide to smoke at Beaudesert Hospital they must leave both the building and the grounds to do so. Mr Lambkin confirmed the expectation remains that the safety of a patient is considered if they leave the building to smoke. He also noted there was a policy to supervise a patient's safety where there were designated smoking areas in any facility. Queensland Health also addressed the issue by offering smoking alternatives to patients through nicotine replacement therapy. The information about a patient's smoking and whether they choose nicotine replacement is now routinely documented in patient's notes. Mr Lambkin also indicated there is a degree of flexibility in crisis situations to permit smoking.

75. What appears to be missing is documentation of a patient's risk assessment regarding their capability to safely smoke and not suffer burns or cause a fire. Mr Lambkin acknowledged that documentation could be expanded to bring this issue to the attention of admitting staff. This would improve safety and of course would also require a continuing assessment given a patient's varying medical condition throughout the duration of their admission.

Findings

76. Michael Warren was born on 18 April 1940 and died on 14 August 2004 in the Royal Brisbane Hospital.

77. He died due to sepsis and lung collapse which was precipitated by burns to 35% of his body sustained in the Beaudesert Hospital on 28 June 2004. The burns occurred while Mr Warren was smoking alone in a courtyard area of the hospital. His clothing accidentally caught fire. Motor Neurone Disease and coronary atherosclerosis contributed to the cause of death.

Comments pursuant to Section 46 regarding public health and safety and to help prevent another death arising in similar circumstances.

Smoking

78. The inescapable conclusion on the evidence is that Mr Warren accidentally sustained burns which ultimately caused his death while he was smoking alone in a courtyard used by patients at the Beaudesert Hospital. I consider the effect of the evidence from Nurse Whitehead and the concession of DON Chalmers was that staff assumed it was safe (from a fire safety perspective) for Mr Warren to smoke simply because he was managing to do so. There was no evidence of an active and considered assessment of the safety of his smoking. Indeed staff were unaware he could no longer operate a cigarette lighter and variously used matches or indicated to other patients to light his cigarette.

79. Every policy concerning the issue of smoking, or these days non-smoking, must commence from a physical safety assessment of the hazards of fire and the risks of burns to patients and others. Due to the progression of MND, Mr Warren was steadily losing his physical capability, including manual dexterity and strength. But there are many other circumstances where there is a real risk of fire related injury or damage associated with smoking when a person's capacity has diminished. It may be a physical, mental or neurological illness or injury, or even temporary incapacity due to intoxication or diminished level of consciousness that is relevant to the issue of safety.

80. I commend Queensland Health in its policies aimed to ban smoking from its facilities and the assistance they provide in enabling nicotine replacement and other supportive measures. But, irrespective of whether or not Queensland Health has generally banned smoking from its facilities, the reality remains there will be situations where patients, staff or visitors will smoke within a health facility or campus. There was evidence that at district level, campuses can permit limited smoking. A safety assessment of the physical risks of smoking must always be the first step. Consideration of supervision may then be required. A patient's capacity to safely smoke can vary and there is an obligation to continuously assess the safety risk it presents. I note evidence from Mr Lambkin indicating that documentation could be amended to prompt staff consideration of these issues and to record appropriate information.

81. I also remark that Queensland Health needs to consider management of situations where patients at their facilities may choose to smoke in the grounds or peripheries of their facilities.

82. It is a matter for Queensland Health whether they consider there should be consistency in policies across the state or whether districts retain the scope for individual arrangements at particular facilities.

Nursing care for those with motor neurone disease

83. I also recommend to Queensland Health the remarks of the neurologist Dr McCombe who identified the special nursing care needs of people facing the inevitable decline in their capability for independent living due to MND

84. Dr McCombe also drew attention to the risk that MND patients can face due to the uncommon occurrence of the disease. She noted that nursing staff can be unaware of the extent of physical limitation and the progressive onset of the disease. I hasten to add the Beaudesert Hospital appeared to have provided overall good care for Mr Warren. An awareness raising initiative concerning MND could help nursing staff appreciate the particular difficulties encountered by those suffering the disease.

Training in fire fighting

85. I recommend to Queensland Health the importance of regular hands on training of all staff who may be called upon to extinguish a fire or evacuate patients, staff and visitors. Sufficient resources to enable this training must be prioritised.

Conclusion

86. Michael Warren was stoically facing his inevitable decline and death from MND when he accidentally caught his clothing alight while smoking at the Beaudesert Hospital. His inability to call out or put out the fire himself must have caused him terror. He then endured the pain of the burns and treatment required before his ultimate death. His death in this manner was avoidable and is to be regretted. I thank all involved in this inquest. I extend condolences to his son Martijn, family and friends. I hope that consideration of fire safety will be heightened as a result of this inquest. In particular, I hope that a greater appreciation of the inherent safety risks of smoking with an impairment has been achieved.

The inquest is closed

Chris Clements
Deputy State Coroner