QUEENSLAND COURTS

OFFICE OF THE STATE CORONER
FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stanley Charles ANDERSON**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Gympie
DELIVERED ON:	19 October, 2012
DELIVERED AT:	Gympie
HEARING DATES:	27-29 April, 25 & 26 October, 2011
PLACE OF HEARING:	Gympie
FINDINGS OF:	Coroner Maxine Baldwin
CATCHWORDS:	Death in a Nursing Home, design of the hoist and sling, level of care, whether procedures and protocols were appropriate.

REPRESENTATION:

Counsel Assisting the Coroner:	Mr S Hamlyn-Harris
Counsel Representing Blue Care	Mr AAJ Horneman-Wren

Stanley Charles Anderson was obviously a much loved father and husband. He was 86 years old and lived at Winston House Nursing Home in Gympie at the time of his death on 12 April 2009. As he was being transferred from a trolley bath to a comfort chair in his room, he fell to the floor sustaining fractures to his legs. He was transported by ambulance to the Gympie General Hospital where he succumbed to his injuries and died later that night.

Coroner's Role and Jurisdiction

1. A coroner has jurisdiction to conduct the inquiry into the cause and circumstances of the reportable death. If possible, he/she must attempt to find:
    a. Whether the death happened;
    b. The identity of the deceased;
    c. When, where and how the death occurred;
    d. What caused the person to die.

2. What caused the person to die. To conduct an inquest is to conduct an inquiry. Inquest differs from a trial between opposing parties. In the case of the South London Coroner ex parte Thompson (1996) 126SJ625 the court said: "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."

3. The focus of an inquest is to discover what happened, not to attribute guilt, blame or apportion any liability. The purpose of the inquest is to inform, as far as possible the family of the loved ones and the general public on how the death occurred with an emphasis on reducing the likelihood of similar deaths. Section 46 of the Coroners Act authorises the coroner to make preventative recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

4. Section 45 (5) and Section 46 (3) of the Coroners Act require that a coroner must not include in the findings or any comments or recommendations or statements that a person is or may be guilty of an offence or be civilly liable for something.

5. However, Section 48 of the Coroners Act requires that if the coroner reasonably suspects that a person may be guilty of a criminal affair after considering the information gathered at the inquest, the coroner must refer the information to the appropriate prosecuting authority.

6. Being an inquisitorial inquiry, the proceedings in the coroner's court are not bound by the rules of evidence and the court may inform itself

in any way it considers appropriate. (See Section 37 of the Coroners Act of 2003.)

7. The coroner must apply the civil standard of proof, namely, that of the balance of probabilities. However, the standard established in Briginshaw v. Briginshaw 1938 (60 CLR 336) requires that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely in occurrence, the clearer and more persuasive the evidence needed for the trial of fact to be sufficiently satisfied that it has been proven to the civil standard.

8. The rules of natural justice apply and the Coroner is obliged to comply with them and to act judicially. Consequently, no findings adverse to the interest of any party may be made without that party first being given the right to be heard in opposition to that finding.

9. It is the obligation of any coroner to give considerations to any prospects of making recommendations that would reduce the likelihood of similar deaths occurring in the future or otherwise contribute to public health or safety.

10. I consider it appropriate in this case to comment on some matters pertaining to the systems and circumstances surrounding matters involved in Mr Anderson's death.

11. There are obviously no issues as to Mr Anderson's identity nor the place and time of his death.

12. There is no real issue as to the cause of his death as the autopsy revealed that he died from coronary and cerebral atherosclerosis with other significant conditions listed as fractured leg bones following a fall, as well as bronchitis. No issue was taken with these findings of the Pathologist.

13. The main issue to be determined is how the accident happened and more importantly whether there was any contribution and if so what level of contribution, to the accident by the level of care or the design of the hoist allegedly used.

14. Evidence was received from a number of medical experts including Dr Navim Nadoo and Dr Peter Ellis, who performed the post mortem examination, both of whom gave medical evidence. Evidence was also received from Mr Glen Girdler who was a Workplace Health and Safety investigator together with Mr Harley Matchett. Dr Frank Grigg was an expert witness who had been commissioned by Workplace Health and Safety to provide an expert report on the accident. Evidence was also taken from Mr John Bromberger, the director of the Pelican Company which manufactured the sling.

15. Mr Jeffery Savage was also called to give evidence in relation to the re-enactment of the use of the sling and the accident.

16. Importantly, evidence was received from the only two witnesses to the accident, Assistant in Nursing Ms Leesa Plant and Endorsed Enrolled Nurse, Ms Elaine Ludke. Evidence was also given from Ms Jan Piping, an Allied Health Assistant who worked at the home in relation to the administration of the use of slings. Linda Summers, the then Director of Nursing, also gave evidence on the procedures and protocols at the nursing home.

17. Finally, after a number of witnesses were recalled, Ms Maureen Kennedy was also called. Ms Kennedy conducted the investigation on behalf of Blue Care.

The Accident.

18. Although there was much evidence received in conjecture in relation to how the accident may have or could have happened, there were only two witnesses who were able to give direct evidence on the circumstances surrounding the accident.

19. Ms Leesa Plant and Ms Elaine Ludke both presented as very distressed and upset witnesses but ones who provided their evidence with integrity, honesty and truthfulness. They both gave evidence that they were given instructions to bathe Mr Anderson and then return him to his comfort chair so his bed could air. They subsequently collected him and placed him on a trolley bath and took him to the bathroom where he was showered and then brought back to his room on the same trolley bath.

20. He was then to be transported from the trolley bath to the comfort chair in his room.

21. Generally this manoeuvre was carried out by the use of a hoist with a swing manufactured by Pelican Manufacturing.

22. There is no dispute that Mr Anderson fell and was subsequently injured as he was being transported from the trolley bath to the comfort chair.

23. Four possible scenarios were put forth during the course of the inquest as to how Mr Anderson may have fallen:

    (a) Firstly, that the carers were not in fact using a sling but were transferring Mr Anderson using a sheet and he was dropped.

    (b) Secondly, Mr Anderson slipped through the hole in the bottom of the sling effectively landing bottom first.

    (c) Thirdly he toppled head first out of the sling, and

    (d) Lastly he slid forward with legs first and out of the sling.

24. In regard to the first proposition, this was clearly the proposition adopted by Blue Care following the investigations carried out by their investigator, Ms Maureen Kennedy, who subsequently gave evidence. Ms Kennedy is the senior residential advisor to Blue Care and her report was dated 12 December 2009. Her report was tendered to the Court and it concluded as follows: "The final conclusion is that Mr Anderson did not fall from the sling but was being transferred without the use of the sling." The basis for Ms Kennedy's findings was reflected in a letter from Blue Care to Ms Elaine Ludke dated 21 December 2009. That letter was ultimately produced upon request by the Coroner in the proceedings. It stated: "But you have not been honest in your accounts of the incident. In particular, by way of summary, I note the following evidence which contradicts your claim that Mr Anderson fell from a sling:

    i. Mr Anderson's injuries were confined to the left hand side of his body including his leg. This is not consistent with a fall from the sling in the circumstance you have alleged, that is, a fall which must have resulted in his backside or head suffering the major impact.

    ii. Numerous tests of the sling have demonstrated that it would be physically impossible for a person of Mr Anderson's size, weight and rigidity to fall out of the sling in the manner that you have alleged.

    iii. There are also significant and inexplicable inconsistencies between your recollection of the event and the account given by Leesa Plant."

25. Ms Kennedy gave evidence at the inquest and was able to provide evidence in relation to her report and, in particular, to her conclusions. It seemed to be a very significant issue for her that she could not reconcile the variations in accounts given by Ms Plant and Ms Ludke to various investigators over time. Secondly the suggestion that the hammock style was being utilised by the two nurses was not alleged until some time after the accident.

26. Leesa Plant gave evidence that she and Ms Ludke were using the sling and that they had placed Mr Anderson on to the trolley bath and had taken him to the bathroom to shower him and had then returned him to his room. Ms Plant then also said that she was in control of the hoist and she was manoeuvring the hoist while Ms Ludke was attending to guiding Mr Anderson's legs towards the chair to ensure that he did not hit the chair. Most importantly, she gave evidence that she simply didn't see Mr Anderson fall. She said he was there one minute and the next minute he was on the floor.

27. Ms Plant gave evidence that Mr Anderson was indeed very frail and that they had a care plan that they were to follow. She gave evidence that on the day of the accident they were instructed by the registered

nurse to get him up and give him a bath and that was what they proceeded to do. She indicated that they were to transfer him from the bed to a trolley bath and that they used a sling and hoist for that and she noted that his sling was in fact in his room, in his wardrobe. She confirmed that she and her fellow nurse, Ms Ludke, took him for a shower and came back and, as they had been instructed to put him in the comfort chair, they brought him on the trolley bath where they dried him off, placed a shirt over him then rolled him from side to side to place the sling under him. She indicated that she and Ms Ludke were on opposite sides and that they rolled him from side to side, placed the sling underneath him and hoisted him up. She indicated that as they hoisted him up they pushed the trolley bath out of the way to create more room. She was pushing the hoist over towards the comfort chair into which they were going to place him. At that point she confirmed that Ms Ludke was guiding his legs just to make sure he didn't hit against the leg of the hoist or the chair and he suddenly fell out of the hoist. She confirmed that the sling was around him on both sides and in fact used the words "we cradled the sling in the position and hooked him up to the hoist". It was put to her whether the hoist was crossed across his legs but she confirmed "no it was wrapped around his legs as a cradle".

28. Ms Plant also indicated that although she believed in her first recollections that they thought they had crossed the hoist over between his legs she said "but in my recollection of events as I sort of kept going over it and over it in my head, I come to the conclusion that's not what we done. We actually cradled him and I did state that in one of my interviews with Blue Care." Although she could remember some coughing in the instance before he fell, she did not recall anything else. Whilst she acknowledged there may have been some wriggling or movement she did not recall any movement other than the coughing. She was able to confirm numerous times that she honestly couldn't recall how he fell. She indicated that he was there one minute and the next minute he was on the ground. Under cross-examination Ms Plant agreed that the fall did not occur when Mr Anderson was being lifted by the hoist but more in transferring him across to the chair.

29. She also confirmed that she did not see the fall when Mr Horneman-Wren put it to her that her eyes were averted from him. She replied "I wouldn't say I can't remember if they were averted or whether I just can't remember how he's fallen out or whether I was using a particular position to position the hoist in or whether I took my eyes off him or whatever. I cannot remember how he fell."

30. She also confirmed that she was convinced that they had used the cradle method saying "as I said before initially I thought because with the majority of residents up there we do cross the sling between their legs but on the rare occasions that I have actually transferred Mr Anderson out of bed we're used the cradle position." She went on to

say “I can’t remember exactly what I’ve done in the past but on one or two occasions when I first started up there I was shown by another nurse how to cradle Mr Anderson through a transfer”. Under further cross-examination by Mr Horneman-Wren, Ms Plant explained how she had been confused by the recollection of events and explained how she had thought about it over and over and she’d subsequently spoken to her partner Elaine Ludke and said, as she quoted “I think we used the cradle and not the crossover position” and that that’s when she brought it up at the next interview with Blue Care. She was able to explain in a plausible way the confusion and the trauma from the event and the fact that initially Ms Ludke had said they used the crossover but she subsequently said to her that she believed they used the cradle and that she intended to tell Blue Care that. Despite the playing of the video re-enactment in which the parties clearly re-enacted what they thought had occurred being the crossover configuration and even the fact that the police officer, Det. Savage, questioned them on an uncrossed position, I am satisfied with Ms Plant’s response that she indicated that after the video and after those questions she began to question and discuss it with Ms Ludke and it was suggested that they had in fact used the cradle position. Despite rigorous cross-examination Ms Plant’s integrity and honesty were not rocked. I am satisfied that on a gradual recollection of events she has recalled accurately the position. Upon cross-examination from Ms Plumb it was also noted that Mr Anderson, in fact, was utilising a catheter and thus it would have been difficult to use the crossover position.

31. Ms Ludke, an endorsed enrolled nurse, was partnering Ms Plant that day and also gave evidence. Her evidence was not as strong as Ms Plant’s. There is no doubt that she answered her questions to the best of her ability and with honesty and integrity. She however seemed to be still somewhat distressed from the events and clearly was bewildered as to how they actually occurred.

32. She confirmed that she’d been asked by the RN to move Mr Anderson out and to shower him. She confirmed that they had obtained his sling from his wardrobe but she also confirmed that she had never got Mr Anderson out and thus she did not know whether there was a usual positioning or style used for the sling. She confirmed that it was all just automatic and that although hammock styles had been used long ago they automatically used the crossover. However she conceded that someone’s physical condition and, of course, the presence of a catheter would make an impact on which method was used. She was somewhat unsure in her recollections but her recollection was that they had used the crossover when they had first taken Mr Anderson to the shower and that she could not recall there being any issues. She confirmed that her conclusion was that she believed they must have used the hammock style when they returned to transfer him to the comfort chair.

33. Similar to Ms Plant, this had been a variation on the earlier assumptions and when that was put to her she said “because months and months down the track when I got myself together I realised he couldn’t have fallen so quick if we’d had him like that because he would have straddled whereas he came out so quick split second I didn’t even see him fall”. In regard to the actual use she gave an indication that she would have used the slings for different patients on average five to seven times per shift so there was certainly a heavy use of the sling and many times to recall individual incidences.

34. Ms Ludke gave evidence that Ms Plant was operating the hoist and she was in front of Mr Anderson with her hands underneath his feet guiding them towards the comfort chair ensuring that they did not hit the hoist or anything else.

35. There is no doubt that the initial interviews and the re-enactments would suggest that the hammock style wasn’t used although this was not specifically dealt. Rather than just accepted that the sling was being used. It may have been the case that at that point in time, the configuration used was not a focus point.

36. There can be no doubt that the letter from Blue Care, which was ultimately tendered to be Exhibit, 39 had a deep impact on Ms Ludke causing her to question the whole incident over again.

37. Both nurses were clearly very traumatised by the incident at the time and this was in fact supported by the evidence of the other witness, Registered Nurse Delwyn Mochalski.

38. There can be no doubt that at the investigation soon after, both of the nurses gave evidence that they were using the cross over style in the sling. It became apparent to them later that they could not have been and must have been using the hammock style. Whilst this gave rise to some scepticism on behalf of the Blue Care investigator it is not totally surprising.

39. The nurses were no doubt extremely distressed. In fact in response to a question about what happened after Mr Anderson’s fall Ms Ludke replied “I swore and started to cry”. She followed it up with that they were ordered out of the room by the registered nurse because “we were both bawling and hysterical”. Ms Ludke was subjected to rigorous cross-examination particularly in relation to her conclusion in relation to the events but her credibility was not really rocked. Although her evidence was far from clear, concise and straightforward, sometimes confused and at times bewildered, a degree of sympathy for her position cannot be avoided. There can be little doubt that given that the fall happened so quickly, Ms Ludke reiterating a number of times that she did not see him fall, it went too quick. When pressed by Mr Horneman-Wren she replied “I wished I had seen him fall then I would know what happened but I can’t say I did when I didn’t.”

40. Despite the fact that she gave evidence that she was guiding his feet and at one stage looking at his legs she is clearly not aware of what happened at that time. She may well have been guiding his feet and therefore should have seen his feet go as he fell but she equally may have been glancing elsewhere especially towards the chair. It does not detract from her credibility.

41. Most importantly in relation to Ms Ludke's evidence it was suggested to her that the hoist perhaps was not being used and that the nurses had attempted a direct transfer using a sheet. Ms Ludke categorically and strongly defended this and said simply it would not happen. She reiterated, when questioned, whether not using the sling and hoist would have been a contravention of the lifting policy she replied categorically "we used the sling and the lifter definitely". When it was suggested that she may have manually handled the residents without the sling she replied "wouldn't think to do it". In response that Mr Anderson was being transferred without the use of the device she replied "no way, we had the sling, we had him up in the sling with the lifter".

42. Given the distress they encountered and the fact that they perform these tasks very regularly and often as a matter of almost robotically they would not have necessarily consciously made a decision on which sling variation to use. After the accident it is plausible and understandable that they had indicated that they had used the sling in the normal way. I accepted the evidence of the nurses and did not find them in any way evasive, untruthful or attempting to protect themselves. I accept their evidence that they had come to the conclusion that they would have used the hammock style in particular in the light of evidence of Mr Anderson's frail body and is consistent with a finding that Mr Anderson could have fallen out of the sling landing leg first.

43. A number of times Ms Ludke referred to it being months and months before she got herself together. She also noted that she thought about the incident over and over again over months. She also said under cross-examination from Mr Horneman-Wren that "after I'd calmly got my head together I used to sit there with a single sheet under my legs pretending I was trying a re-enactment and just sort of, you know, thinking"

44. Ms Summers also gave evidence as she was the Director of Nursing at the time of the incident. Her evidence was somewhat confusing at times as she indicated that, in her experience, it was standard practice to use the crossing method unless there were other specific incidents such as amputees, patients with catheters etc. Initially she indicated that she didn't think Mr Anderson had anything that would contra-indicate using the crossing method but subsequently revised this when she recalled that he, in fact, had been using a catheter. She also confirmed that there was a 'no lift' policy and certainly in her time she had not seen anyone do it and was confident that staff knew

they were not allowed to do that for the sake of their own safety as well as for the patient. The other significant issue of Ms Summers' evidence was the system in relation to the allocation of measuring patients for slings and monitoring their weight. She indicated that the weight chart that was presented to her, which had indicated a weight variance of 42 to 46 kg from 2007 until the date of the incident, was something maintained to ensure that weight was being monitored. She also confirmed that although Mr Anderson shared a room, the other man had a different size sling and, in fact, was out on his sling that day and so rejected any suggestion that there may have been a mix up in the slings used.

45. The registered nurse on duty that day Delwyn Mochalski was also called to give evidence. She confirmed the distress of the two nurses particularly Ms Ludke who, she indicated, could not speak and could not communicate with her. Ms Mochalski's evidence was of limited value given that she arrived after the incident and, as she indicated, she did not take a great deal of notice of the positioning of the hoist and sling as she was concentrating on Mr Anderson. She did say however, that when she returned after the ambulance had transported him, the hoist and sling were over near the window having been put there with the sling slung over the top of it. She inspected both and found them to be working correctly.

Evidence of Mr Bromberger

46. Mr Bromberger was the general manager of Pelican Manufacturing, the manufacturer of the sling used by Blue Care and in particular the sling used to lift Mr Anderson. Upon cross examination Mr Bromberger was asked if it was possible for a patient to slide forward and fall out of the sling, in effect legs first, particularly if the leg part of the sling was longer than the part supporting the body. He replied under cross examination from Mr Hamlin Harris, "If it was fitted in the hammock style – if I understand what you said there, say they used the sling in the hammock style…..and sort of going between the legs and they have the back on tighter than the leg section. The person would be picked up at may be 45 degrees, in other words their legs would be a lot lower than their – hard to explain this… they could sit up legs first then there is nothing between the legs to stop them from slipping."

Evidence of Dr Grigg

47. Dr Grigg is a mechanical engineer with vast experience as an accident investigator although he conceded he was not an expert in bio-dynamics. Since obtaining his engineering degree he has obtained other qualifications including Master of Engineering Science and Doctor of Philosophy. He is a fellow of the Institute of Engineers Australia, is a registered professional engineer in Queensland and a fellow or member of a number of other engineering societies. He has

broad professional experience being on the academic staff of Queensland University in mechanical engineering for some 25 years. He first became involved in giving expert evidence when doing research on tractor rollovers in 1967. He gave evidence that he had been involved in nearly three thousand matters. Most importantly he had investigated other incidents involving the use of slings. With 40 years experience as a professional accident investigator he was indeed an expert. His opinion on likely cause of the accident was to be respected.

48. Dr Grigg's report was tendered to the Court and effectively came to the conclusion that the most likely scenario was that Mr Anderson had fallen backside first through the hole in the sling. He expressed this opinion in his oral evidence. However under cross examination at the resumed hearing it became evident that Dr Grigg was not aware of injuries sustained by Mr Anderson when he prepared his report.

49. He indicated to the Court that this had a significant effect on his opinion as to how Mr Anderson fell. In fact he conceded that his initial conclusions were actually inconsistent with the injuries that Mr Anderson suffered. His oral evidence confirmed a change of opinion in that he said; "I would now regard it as much more likely that he was being supported in a hammock style and that he fell from the hammock style of sling."

50. Dr Grigg was able to elaborate that he believed that Mr Anderson was most likely in a hammock style and sort of sitting upright. He indicated that the actions of Ms Ludke in guiding his feet in particular lifting them to get over the armrest of the chair may well have had the effect of destabilising him in the sling, tending to create a tilting sort of motion. He indicated; "While it would initially tilt him backwards, but it may have resulted in him sliding forwards."

Evidence of Professor Ellis

51. Professor Ellis, who was the Pathologist who performed the post mortem report, was also called to give evidence. Professor Ellis had given evidence about the non specific nature of the bruises and abrasions, particularly in the light of Mr Anderson's age and poor skin integrity. They were consistent he believed, with normal handling of Mr Anderson, or indeed could have occurred when he fell.

52. Professor Ellis outlined the fractures suffered by Mr Anderson and this was significant in light of the issue of how Mr Anderson fell and what part of his body would have impacted with the ground and in what order.

53. It was clear from the evidence of Professor Ellis that he in fact believed that Mr Anderson had suffered the injuries to his legs and that the legs had indeed hit the ground first and he said;

i. “I mean clearly the legs would hit the ground first and that would seem to be consistent with what I saw because it would almost crumble underneath it and that probably would be consistent with what I saw in terms of the autopsy….. All I can say is that as far as I am concerned the legs hit the ground first….. To me that’s a given. The fact is they’re the only injuries that we’ve got and they are consistent with the legs hitting the ground and the body weight itself effectively coming on top of them which is one of the reasons why you’ve got the actually break so exactly how the body does it, bearing in mind it’s all dynamic, the legs will come down, gravity will bring the legs down and then effectively crumples on to the legs”. He continued, “That would certainly explain the injuries that I saw.”

54. Dr McMeniman was not called to give evidence and thus was not cross examined but his opinion was set out in the report dated 18 April 2011. Dr McMeniman is an orthopaedic surgeon and was provided with three questions in relation to Mr Anderson and whether it was likely that he had fallen back side first in the light of his injuries or whether he would have had to have fallen directly on to his feet and legs in order to suffer the injuries in the report. If he had fallen through buttocks first, what injuries would he have suffered?

55. It was clear that Dr McMeniman’s evidence was consistent with that of Professor Ellis in that, had he fallen through the hole, he would have sustained more injuries to his buttocks and lower back as they would have made contact with the floor first. His opinion corroborated that of Professor Ellis in that he opined “I would have thought that it is much more likely that Mr Anderson fell with some degree of weight on his lower limbs as he sustained injuries including the supracondylar fracture of his left femur, a comminuted fracture of the upper third of his right tibia, and a fracture of his left tibia and fibula.”

56. He continued that this would tend to suggest that he sustained direct trauma in the region of his lower limbs either from falling forward or falling on his flexed knees.

Conclusion on mechanism of accident

57. On the evidence before me it is clear that the first scenario is not really open. I reject the notion that the carers were not in fact using a sling but were transferring Mr Anderson with a sheet. There is no evidence whatsoever to suggest that a sheet was used and the evidence provided by the two carers, Ms Ludke and Ms Plant is accepted. They both categorically denied lifting Mr Anderson without a sling and I have no doubt of their honesty in relation to this. I therefore find that this scenario is not one open to a finding of fact.

58. It is clear that Mr Anderson has fallen from a sling but on the evidence of Professor Ellis and supported by the report of the orthopaedic surgeon, Dr. McMeniman, it is clear that Mr Anderson has fallen from the sling and landed on his lower limbs with his legs taking the impact. It is therefore clear that he could not have fallen head first out of the sling as the injuries sustained were not consistent with this.

59. Similarly, I accept on the evidence that he would have sustained more injuries to his buttocks and back had he fallen bottom first and his legs would not have suffered the degree of injuries that he did. Whilst it is possible that after he landed on his buttocks his legs fell and hit the hoist and sustained some of the breaks, it is unlikely on the evidence.

60. I find that the last scenario, that is, that Mr Anderson has fallen forward out of the front of the sling and has landed on his lower limbs as he crashed to the floor is, on the balance of probabilities, the only option open to the Court.

61. Having found that Mr Anderson has fallen from the sling by sliding forward and landing on his legs, I turn to an investigation of why this would have occurred. Ms Pipping gave evidence that she was the person in charge of allocating the slings to the patients. It was evident that these were not reviewed with any regularity. In particular, as patients became increasingly frail and their weight decreased, there was no system in place for consistent review of the appropriate size for each patient.

62. Ms Kennedy was called also to give evidence at the resumed hearing. She's a senior residential advisor to Blue Care and completed a report dated 12 December 2009, which was included in the exhibits. She concluded that Mr Anderson did not fall from the sling but was transferred without the use of the sling. This of course gave rise to letters being written to the nurses and their subsequent responses which I have noted already. Ms Kennedy based on her findings on the fact that over time Ms Plant and Ms Ludke had appeared to give different evidence and accounts of what had happened. I have commented already on the differences in those accounts and of course the degree of trauma suffered by the nurses. Under cross-examination Ms Kennedy conceded that there was a possibility of Mr Anderson slipping out legs first although she noted that she would have thought that he would have had injuries to his buttocks and back as well though this was not consistent with medical evidence. Most of the evidence Ms Kennedy based her conclusions on was, in fact, presented to court although, of course, it was noted by Counsel assisting in his submissions that she did not see the evidence presented by the witnesses and did not see them under cross-examination.

63. Importantly, particularly in light of Ms Kennedy's response, Mr Girdler from Workplace Health and Safety was called to give evidence also. He gave evidence that the carers were interviewed two days after the incident in April 2009 although Mr Girdler was not involved in that particular interview. They were again interviewed separately in February 2010 and Mr Fitzsimmons completed his report approximately a month later.

64. He gave evidence that they re-interviewed to "try and elicit further information from those initial witnesses who'd been interviewed back in April of 2009 to see if there's any further evidence that could be obtained in relation to how the incident occurred and as those statements were taken, other persons were identified as attending the scene shortly after the incident and that was the reason for speaking to the additional persons as well".

65. Despite Mr Horneman-Wren's attempts to have Mr Girdler indicate that there had been considerably different information forthcoming, Mr Girdler's response was "my recollection was additional information, I don't recall that it was significantly different".

66. This is indicative of the process that Ms Plant and Ms Ludke went through, in terms of trying to re-enact in their memory, what had been a very traumatic and unexpected incident. Mr Girdler indicated that he had not been involved in the re-enactment which had been viewed in court where clearly the crossover was used. However it was his evidence that it was his recollection from the conversation he had with Ms Plant that the possibility that a hammock style was used as opposed to the crossover and that that suggestion had come as a result of the discussion Ms Plant had had with the management of Blue Care. He conceded that that time he had spoken with Ms Plant was the first that he had heard of the possibility of the hammock style.

67. Finally, on the last day of the hearing, a demonstration was carried out on the use of both the hoist and the sling. This certainly illustrated the potential vulnerability of the patient's position when placed in the sling. It was clear that the patient could become unstable if the optimal settings on the sling were not chosen. Ms Plant and Ms Ludke indicated that this could happen if they failed to communicate with each other or if they simply failed to adjust it correctly. This also indicated and supported some of the evidence provided by Ms Summers in that if a person was particularly rigid, as it would appear Mr Anderson was, they were also more vulnerable to slipping out.

FINDINGS

68. I find therefore that the deceased person was Stanley Charles Anderson who was born on 7 April 1923 and died in the Gympie General Hospital on 12 April 2009. He had suffered fractures to his legs in a fall at Winston House Nursing Home just after 9.30 that morning.

69. I accept the cause of death as set out in the post mortem report of Dr Ellis that the primary cause of death was coronary and cerebral atherosclerosis with the significant conditions of fractured leg bones following the fall as well as bronchitis.

70. Furthermore, I find on the basis of the evidence before me that Mr Anderson fell from a sling which was attached to a hoist which was being used to transport him from a trolley bath to the comfort chair.

71. I am satisfied on the balance of probabilities that he became unstable in the hoist and slipped forward out of the sling legs first causing him to fall onto his legs and subsequently back onto his back. As a result of the fall he suffered fractured legs and a fractured left hip.

72. He was transported to hospital but died of coronary and cerebral atherosclerosis.

Issues to be commented on in regard to public health and safety or ways to prevent deaths from happening in similar circumstances in the future.

73. It was conceded by the nurses that they had annual training in relation to the use of the hoist and lifting although there was no actual evidence of their training put before the court. Ms Plant however indicated that training was carried out. However the confusion in relation to what constituted a 'near miss' was indicative of the ambiguity and lack of stringent guidelines in regard to that. It is recommended that the training program be reviewed in regard to the use of hoists and slings particularly in regard to this incident and how similar incidents may occur. It is clear from the evidence presented that accidents, although rare, can in fact happen through the use of slings. There seems to be a loose concept of adjusting the straps based on "well we just talk about it". There should be strict guidelines as to how the appropriate level of adjustment is determined to maximise stability for the patient.

74. Similarly, as in this case there should be a clear guideline on what configuration should be used in regard to the sling. In particular whilst there are various options for the use of the sling provided by the manufacturer, there are no guidelines as to which should be used in different cases. Clearly in this case, as Mr Anderson had a catheter and also had some issues with his skin integrity, these

matters should have determined the most appropriate sling for him and the increased risk of using such slings.

75. The selection of the sling was also an area which appeared to require review by Blue Care. It does not appear that an allied health member, such as a physiotherapist or occupational therapist, is always involved in the selection of the slings. It would appear that Ms Pipping is a health assistant and no evidence of professional qualifications were put forth. Although she had been working at the home for 12 or 13 years and had been in that role for approximately 9 or 10 years, she did not actually have any qualifications and gave no evidence of regularly liaising with professionals. She gave evidence that she took into consideration the height and weight of the resident as well as any abnormalities such as contractures or stiffness or skin integrity as well as the width of the resident. She indicated that a particular size sling was allocated, rather than a particular one and indicated that Mr Anderson was allocated a medium long leg. She indicated that at that time a physiotherapist checked it although it does not appear to be the case now. Certainly there was no indication that any professional had any input into how the sling should be used for each particular patient.

76. It is recommended that a professional input be established to ensure that these slings are firstly the correct size and that this be reviewed as the patient's health deteriorates and secondly how the sling should be used for particular patients. In regard to training it would appear that the manuals may need to be reviewed in the light of Ms Plant and Ms Ludke's evidence in relation to the choosing of the sling and the advantages and disadvantages of doing so in the event that a health professional does not determine this for each residence.

77. It is vitally important that all staff understand the importance of near misses. As the manufacturer of the sling indicated, it is important that the manufacturers receive feedback so as to improve their products. It would also be helpful within the work environment for other staff to know where there was an incident to enable them to manage potential risk. It is recommended that a system be established to review incidences and liaise with the manufacturer in regards to possible improvements in design of the slings.

78. Finally I express my sincere condolences to Stanley's family. The sadness of his passing was perhaps increased due to these circumstances and for that I am regretful.

I close the inquest.

Maxine Baldwin
Coroner
Gympie
19 October 20