CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF GWENDA MARGARET MEMBERY**
Citation:	**[2017] ACTCD 1**
Hearing Dates:	19 September 2016
Date of Findings:	15 March 2017
Before:	Coroner Morrison
Legislation Cited:	*Coroners Act 1997* (ACT) *Mental Health (Treatment and Care) Act 1994* (ACT)
Appearances and Representation:	Ms Baker-Goldsmith as Counsel Assisting Coroner Morrison Ms Whalan for RSL LifeCare, instructed by Sparke Helmore Lawyers
File Number(s):	CD 153 of 2014
Publication Restriction:	nil

REASONS FOR FINDINGS OF CORONER MORRISON:

1. The death of GWENDA MARGARET MEMBERY was reported to me as an ACT Coroner, on 9 July 2014. The death was reported to me because Ms Membery died in circumstances which fall into one or more of the prescribed circumstances which are listed in section 13(1) of the *Coroners Act 1997*, whereby a Coroner must hold an inquest into the manner and cause of death of the person.

2. The primary legislation regulating my task as a Coroner is the *Coroners Act 1997* ("the Act"), however that statute is not a Code and I retain all the powers at common law of a coroner which do not conflict with the provisions of the Act.

3. I am required by section 52 of the Act to make findings in relation to the manner and cause of death of a person whose death has been reported to me, and whether a matter of public safety is found to arise in connection with the inquest.

4. Some special provisions are made in the Act about "death(s) in custody". Under section 3C of the Act, the death of a person who is subject to an order under the *Mental Health (Treatment and Care) Act 1994* (as it then was) is taken to be such a death in custody. I am satisfied that Ms Membery was at the time of her death subject to a psychiatric treatment order under s 24 of that Act (Exhibit R), such that her death is a death in custody for the purposes of the Act.

5. As a result of that conclusion, other provisions of the Act (to be found in Part 6) place additional obligations upon me. In particular, section 74 of the Act expressly requires me to record any findings about the quality of care, treatment and supervision of the deceased which, in my opinion, contributed to the cause of death.

6. The hearing took place before me on 19 September 2016.

7. Ms Baker-Goldsmith appeared as Counsel Assisting the Coroner and I gave leave for Ms Whalan to appear on behalf of RSL Lifecare.

8. At the hearing I heard testimony from Detective Senior Constable Driessen (primary coronial investigator), Dr Rosemary Austen (a general medical practitioner with an interest in geriatric care who takes part in a scheme known as the General Practitioners Aged Day Service and who saw Ms Membery shortly before her death), Ms Carolyn Kwok (deputy CEO of RSL Lifecare Morshead Home), Mr Belramy Lacsao (a registered nurse employed by the home), and Ms Kris Delos Santos (also a registered nurse employed by the home). In addition a range of documents were received in evidence.

9. Much of the evidence received at hearing was uncontroversial and unchallenged. That evidence supports the following conclusions:

    a. In October 2001, Ms Membery was transferred to RSL LifeCare Morshead Home 26 Archibald Street Lyneham in the Territory (the Home), which remained her residence until the time of her death;

    b. By 2014, Ms Membery required assistance with activities of daily life such as bathing, and required a walker to move around the Home, although she would sometimes try to walk unassisted and required assistance to get in and out of bed or on a toilet;

    c. Ms Membery was diagnosed with dementia and diabetes in later life, and while she had given up smoking two years prior to her death she had been a chain smoker for years;

    d. Ms Membery had age-related hearing loss and poor vision but was able to communicate directly with Home staff if simple words were used;

    e. A few days prior to her death, from at least 28 June 2014, staff at the Home observed that Ms Membery became unwell and displayed cold and flu symptoms;

    f. Ms Membery was seen by general medical practitioner Dr Rosemary Austen and diagnosed on 3 July 2014 with a respiratory tract infection, for

which she was prescribed certain medication and efforts were made by staff over the next few days to reduce her temperature;

g. Ms Membery's condition declined rapidly over the course of the evening of 5 July 2014 to a point where she fell into unconsciousness on the morning of 6 July 2014 and was by ambulance taken to Calvary Public Hospital;

h. Hospital doctors treated Ms Membery but believed that she had a poor prognosis, and agreed with Ms Membery's family that she would not be resuscitated;

i. Ms Membery died at 8:30pm at Calvary Hospital on 7 July 2014;

j. A death certificate was issued by Dr Clarke, the treating doctor at Calvary Hospital, who was unaware that Ms Membery was subject to a psychiatric treatment order.

10. Ms Membery's identity was confirmed by her daughter Ms Nicole Malmberg (Exhibit K). A post mortem examination was conducted by pathologist Professor Tim Lyons. His opinion expressed in his autopsy report (Exhibit O) is in the following terms:

> DIRECT CAUSE:
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> Acute bronchopneumonia
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> OTHER SIGNIFICANT CONDITIONS contributing to the death but not related to the disease or condition causing it:
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> Chronic obstructive pulmonary disease
>
> Dementia
>
> Schizophrenia
>
> Type II diabetes mellitus
>
> Chronic renal disease

11. The evidence of that opinion is unchallenged. I add here for completeness that it is apparent that Ms Membery sufferred an unwitnessed fall at the Home before her death, but nothing in the evidence suggests any connection between that event and her death.

12. Against the background of the matters just mentioned much of the evidence at hearing was directed towards the treatment and care of Ms Membery in the lead up to her death.

13. It is convenient to briefly summarise the evidence of Dr Austen, and RN's Lacsao and Delos Santos about that treatment and care.

Dr Rosemary Austen

14. Dr Austen is a general medical practitioner whose primary workplace is the Wentworth Family Practice in Kingston.[1] She has been a GP for 20 years and is a Fellow of the Royal Australian College of General Practitioners.[2] She has an interest and practical experience in geriatric patients, and would tend to treat more elderly people.[3]

15. Dr Austen explained that in July 2014, in addition to working in private medical practice part-time, she worked for the General Practitioner Aged Day Service on a part-time basis and would visit nursing homes on the north side of Canberra.[4] She explained that the Service was provided by the ACT Government to aged care facilities and elderly people confined to their homes, so that if their usual GP could not visit a patient, the GP could recommend a referral be made to the Service for another doctor to visit that day.[5]

16. Dr Austen said that Ms Membery was not her patient at her surgery, and that she saw Ms Membery as a consequence of a referral to the Service by the Home.[6] She recalled that Ms Membery was referred due to a temperature

[1] Transcript P37 L25-28
[2] Transcript P38 L39-40
[3] Transcript P38 L50-P39 L5, P39 L10-17, P39 L47-P40 L8
[4] Transcript P38 L42-P39 L8, P39 L24-26
[5] Transcript P38 L44-P39 L7, P39 L29-41
[6] Transcript P39 L5-8, L10-13

(later confirmed from the records as being 38 degrees[7]) and a cough.[8] She stated that at that time of year it was very common for nursing home patients to present with a fever and cough and respiratory tract infections.[9] Dr Austen did not recall Ms Membery's co-morbidity of chronic obstructive pulmonary disease at the time of giving evidence but indicated she would have familiarised herself with Ms Membery's history at the time of examination.[10]

17. Dr Austen recalled that during the examination Ms Membery exhibited a 'moist' cough. By reference to her progress notes,[11] Dr Austen was able to say that she checked Ms Membery's temperature and found it was 37.1 degrees, and she assumed the reduction in temperature was due to the administration of Panadol.[12] The note also recorded Ms Membery's pulse rate as 105 which was a little bit elevated, her blood pressure was normal, her oxygen saturation was a little low at 89%, and that Dr Austen had heard "crackles" in the right lower lobe of the lungs.[13]

18. Dr Austen noted that 89% oxygen saturation was not uncommon in a patient with chronic obstructive pulmonary disease and that such patients often only have oxygen saturation of 92-95% when well.[14] She advised that the presence of "crackles" was an indication of a potential pneumonia infection, particularly when accompanied by a temperature,[15] however she also noted that some elderly people can have a condition called bronchiectasis which is the result of lung damage and can also present as "crackles".[16]

19. Dr Austen commenced Ms Membery on, a 10 day course of antibiotics (Ceclor), oxygen via nasal prongs when required, and regular Panadol.[17] She directed a nasopharyngeal swab be taken to test for influenza.[18] She said that although

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[7] Transcript P41 L9
[8] Transcript P40 L30
[9] Transcript P43 L8-19
[10] Transcript P44 L11-13
[11] Transcript P40 L40-44
[12] Transcript P42 L8-13
[13] Transcript P42 L13-19
[14] Transcript P47 L45-P48 L5
[15] Transcript P42 L20-22, L37-39; P43 L28-31, L37-39
[16] Transcript P43 L17-43
[17] Transcript P42 L24-26
[18] Transcript P42 L30-33

Ms Membery could have had a cold, it is not appropriate to take risks with elderly patients, particularly a patient with Ms Membery's co-morbidities, and so the antibiotics were prescribed to treat a possible developing pneumonia in the light of Ms Membery's decreased respiratory reserves.[19] She noted in retrospect that she could not rule out a viral cause, but that antibiotics were the common starting treatment for elderly patients regardless.[20]

20. Dr Austen said that at the time of her examination Ms Membery was not unwell enough to require emergency hospitalisation.[21] She stated that nursing home patients often become confused when sent to hospital and find it distressing when moved out of their normal environment,[22] and they do not do well in a foreign environment.[23] She noted that there is often pressure on nursing home staff not to send elderly patients to an emergency department due to the negative effect on the patients, and it was often better to try to treat such patients in the nursing home.[24] She said that hospitalisation would have been required if Ms Membery had showed signs of respiratory distress such as a rapid respiratory rate or signs of struggling to breathe, or any change in Ms Membery's level of consciousness, but that no such signs were present when she examined Ms Membery.[25] She said that if a patient refused to take oral antibiotics, there was little choice but to send the patient to hospital, but that such patients would also make provision of intravenous antibiotics more difficult.[26]

21. Dr Austen went on to say that typically it might be expected that after a couple of days with antibiotic and Panadol treatment a patient's fever should start to drop,[27] that if an infection is bacterial then antibiotics should start to work within 48 hours maximum,[28] and that an infection can take some time to resolve

[19] Transcript P43 L48-P44 L9, L19-26
[20] Transcript P47 L7-12
[21] Transcript P41 L39-40
[22] Transcript P42 L40-42
[23] Transcript P47 L38-40
[24] Transcript P47 L26-33
[25] Transcript P42 L44-P43 L7
[26] Transcript P48 L19-P49 L9
[27] Transcript P45 L38-47
[28] Transcript P47 L13-15, P51 L33-36

depending on the patient's level of mobility and strength of coughing.[29] She said that patients can deteriorate notwithstanding treatment and if a patient started having difficulty breathing within the first 24 hours after treatment it would be appropriate to send them to hospital to receive intravenous antibiotics (as compared to oral).[30] She commented on the difficulty of using oxygen saturation level per se as an indicator of the need for hospitalisation for someone with chronic airways disease but added – "*... but anything dropping – if you see the oxygen saturation dropping, struggling to breathe obviously short of breath, then that is an indicator. ..... I would look more at their struggling to breathe than a temperature actually, but a temperature that's staying up around 38, 39 40 and not getting any better despite oral antibiotics, I would think that would suggest that they might need IV antibiotics as well".*[31]

22. Under examination by Counsel for RSL Lifecare Dr Austen clarified that a change in consciousness would be of concern if the change occurred over 30-60 minutes.[32] She agreed that a patient sitting up and eating dinner 3 days after commencement of antibiotics would suggest efficacy of treatment if the symptoms have improved,[33] but in later evidence also agreed that if the antibiotics were working the fever should have settled.[34]

23. Dr Austen said following her consultations it was normal practice to discuss the patient's health and treatment with a nurse, but she did not have a positive recollection of having done so in relation to Ms Membery.[35] She said that whatever she wrote in the progress notes in relation to medication and treatment would have been conveyed orally to the nurse.[36] She said that she would not have left specific oral instructions in relation to admitting Ms Membery to hospital, as that would be up to the Home to determine if the patient is not responding to treatment or requires follow-up.[37]

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[29] Transcript P50 L18-25
[30] Transcript P49 L34-40
[31] Transcript P48 L6-15
[32] Transcript P42 L44-P43 L7
[33] Transcript P50 L27-30
[34] Transcript P51 L23-36
[35] Transcript P44 L44-P45 L6
[36] Transcript P45 L8-31
[37] Transcript P45 L33-36

Registered Nurse Belramy Lacsao

24. Mr Lacsao is a Registered Nurse employed at the Home. He has been an RN since 2010 and employed at the Home since February 2014.[38] He identified and confirmed a statement he had made on 12 July 2014 in relation to Ms Membery's admission and care at the Home.[39]

25. RN Lacsao stated he commenced work at the Home at 2:30pm on 5 July 2014 and left at about midnight.[40] On this particular night there were five staff on duty consisting of himself as Registered Nurse and four carers, caring for 56 patients.[41] He was asked if, when he started his shift, he would read the progress notes for the patients he was going to be caring for. He responded by saying – *"Yes, but it depends because it's too busy. You don't really have time unless it's stated on the handover by the morning shift."*[42] He said that he had been told at a handover that Ms Membery had been seen by Dr Austen, but he did not think he ever read the notes in relation to Dr Austen's visit.[43] He said he did not specifically recall now the handover he received that day in relation to Ms Membery, but that whatever he had been told did not give him any concern in relation to Ms Membery.[44] He stated that he was aware that Ms Membery had been prescribed antibiotics.[45]

26. RN Lacsao stated that at approximately 6pm on 5 July 2014 Ms Membery had a fall; had been found on the floor next to the toilet;[46] and that observations were commenced for a four hour period following the fall.[47] He thought she had fallen trying to go to the toilet on her own.[48] He confirmed that he took Ms Membery's temperature after the fall, at about 6:30pm, and it was 38.5 degrees.[49] He said that the reading did not cause him concern because Ms

[38] Exhibit GG, [1]
[39] Exhibit GG
[40] Transcript P63 L12-21
[41] Transcript P69 L22-49
[42] Transcript P68 L28-31
[43] Transcript P68 L33-47
[44] Transcript P71 L44-P72 L27
[45] Transcript P69 L16, P72 L31-32
[46] Transcript P70 L14-16
[47] Transcript P64 L15-28
[48] Transcript P70 L7-18
[49] Transcript P75 L10-23

Membery was already on antibiotics, was not having trouble breathing, was not shaking, and was wearing thick clothing, which he decided to change when putting her to bed.[50] He said he gave Ms Membery some paracetamol at that time and she was able to swallow it with water[51]. He said that he had given her one tablet of paracetamol.[52]

27. RN Lacsao went on to say he gave Ms Membery one tablet of paracetamol at about 8 or 9pm that night[53]. He took Ms Membery's temperature at the time, and recalls it being about 38 degrees, but he did not make a corresponding entry in the vitals charge which he acknowledged was an oversight on his part.[54]

28. RN Lacsao stated the last time he personally checked on Ms Membery was at 10:30pm when he concluded the customary neurological observations which took place after a patient had suffered a fall.[55] He said that that during this last test he did not observe Ms Membery to have any trouble breathing, nor to be in any pain, nor to be in any distress.[56]

29. RN Lacsao identified Exhibit E as the observation records he made in respect of Ms Membery, and explained the way in which the observations were made.[57] He also identified a vital signs document on which recordings of Ms Membery's vital signs, and particularly temperature, were kept.[58]

30. In respect of both Exhibits E and HH, RN Lacsao explained that while he took the observations at the times recorded, he did not enter the data into the computer until after his shift ended, which was after midnight, and some significant time after the observations had been made. He said that explained the date appearing on the record, which was automatically based upon the date of data entry and could not be altered.[59] RN Lacsao said that he would make a

[50] Transcript P77 L6-17, L25-38
[51] Exhibit GG, [12]
[52] Transcript P63 L29-31
[53] Exhibit GG, [14]
[54] Transcript P79 L13-24
[55] Transcript P63 L48-P64 L20
[56] Transcript P67 L21-29
[57] Transcript P65 L10-P66 L13
[58] Transcript P74 L26-36, Exhibit HH
[59] Transcript P66 L15-25, P75 L30-37, P85 L11-38

note at the time of taking the observations either on his hand or on a piece of paper, which he would use to enter the data into the computer later after his duties were finished.[60] It is apparent, albeit somewhat surprising, that he was speaking of his general practice and not something which occurred only on the occasion under examination. His evidence was not challenged by Counsel for RSL Lifecare. In response to a question from the bench RN Lacsao indicated he was confident about the times he made the observations because he had made notes and he has learned working in aged care the importance of remembering times.[61]

31. RN Lacsao confirmed the contents of his statement to the effect that, at the time of his handover to his colleague, RN Delos Santos, he told her that if there was a deterioration, or no improvement in Ms Membery's temperature then she may require hospitalisation.[62] He said the thought that Ms Membery might need to go to hospital was in his mind in the sense that it was always on his mind when caring for patients, even though when he finished his shift Ms Membery appeared to be responding to treatment.[63]

32. RN Lacsao stated that when taking observations of patients he would normally only take temperature and blood pressure because they are to hand straight away, and while the Home had a machine to measure oxygen saturation that was not ordinarily measured as part of observations. He did not remember taking any oxygen saturation measurements for Ms Membery.[64] He stated he was unaware that Dr Austen had prescribed Ms Membery supplemental oxygen if required.[65] He said that as he did not see signs of difficulty breathing he did not supply oxygen to Ms Membery,[66] and that even if he had known it had been prescribed as required, on his assessment Ms Membery did not require supplemental oxygen.[67]

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[60] Transcript P66 L32-40, P75 L39-P76 L49
[61] Transcript P66 L10-15
[62] Transcript P79 L33-P80 L18
[63] Transcript P80 L17-24
[64] Transcript P67 L37-P68 L20
[65] Transcript P68 L39-P69 L7
[66] Transcript P68 L22-26, P69 L9-16
[67] Transcript P69 L19-20

33. RN Lacsao was asked if it had occurred to him that Ms Membery's fall might have been because of a deterioriation in her condition. He responded by saying that she had eaten her dinner before the fall and appeared fine.[68]

34. RN Lacsao stated that it was his normal practice to conduct observations of a patient with a fever once on his shift, which would equate to three times a day given the three shifts run by the Home.[69] He said he could not say whether there was a rule of thumb or what specific training he had ever received about the recommended frequency for the taking of observations, and that much depended on the circumstances.[70] He was shown Ms Kwok's "Statement of Expectations" which was Exhibit FF. He said that he was at the time generally aware of the document and he followed these instructions in his practice.[71] He said that point 6 of the document (which dealt with circumstances where a patient's pulse, blood pressure, temperature or BSL fell outside relevant parameters) did not apply to Ms Membery because she was known to be unwell, had already been seen by a doctor and was receiving treatment.[72]

Registered Nurse Kris Delos Santos

35. Ms Delos Santos is a Registered Nurse employed at RSL LifeCare Morshead Home and had been so employed since November 2013, although she had been an RN in the Philippines since 2008. She qualified as an RN in Australia in 2013.[73] She identified and adopted a statement she had made on 12 July 2014 in relation to Ms Membery's admission and care at the Home.[74]

36. RN Delos Santos worked as the night nurse at the Home.[75] She commenced her shift at 10pm on 5 July 2014.[76] During this shift there were a total of four staff on duty: three carers, and RN Delos Santos as the sole RN and the most senior person in charge overnight.[77] RN Delos Santos had care of

[68] Transcript P77 L47-P78 L23
[69] Transcript P81 L13-20
[70] Transcript P81 L35-P82 L22
[71] Transcript P83 L19-P84 L9
[72] Transcript P84 L20-44
[73] Exhibit II, [2]
[74] Exhibit II
[75] Transcript P87 L31-34
[76] Transcript P94 L20
[77] Transcript P87 L46-P88 L14

approximately 120-130 patients, 79 of which were accommodated in-house in wards and the remainder in independent living units attached to the Home.[78]

37. RN Delos Santos stated that her usual practice was to conduct three checks on the ward patients – at the beginning, middle and end of shift – and to undertake observations of patients if required, but the independent living patients would not be checked unless a call was made.[79] She said that she would be told on handover from the previous shift which patients were sick and requiring observations.[80] She said that in addition to receiving a handover, her usual practice was also to check the computer at the start of her shift to see what patients had been "alerted" in terms of their observations being outside the normal parameters, and thus who required additional checks.[81] She stated that hourly checks would only be implemented if clinically required, which could be indicated by alerts on the vital signs computer document.[82] She clarified that the parameters for an alert are not generated solely by a computer but are set with reference to her own clinical assessment.[83]

38. On 5 July 2014 RN Delos Santos received a handover from her colleague, RN Lacsao in relation to Ms Membery, which she recalled at the time of hearing as being that Ms Membery had had a fall and had an elevated temperature which had been treated with paracetamol.[84] She did not recall whether RN Lacsao had provided specific instructions in relation to checking Ms Membery's temperature or the possibility of Ms Membery needing to attend hospital.[85] She said that she checked the computer and an alert for Ms Membery was present.[86]

39. RN Del Santos said that she subsequently checked Ms Membery's temperature and entered the measurement on the vital signs chart.[87] She said her intention was to conduct two-hourly checks throughout the night to monitor Ms

[78] Transcript P87 L36-44
[79] Transcript P88 L33-P89 L5
[80] Transcript P89 L7-11
[81] Transcript P89 L33-P91 L35
[82] Transcript P89 L13-P90 L18
[83] Transcript P108 L12-22
[84] Transcript P91 L37-20, P92 L46-47
[85] Transcript P91 L22-29
[86] Transcript P92 L31-33
[87] Transcript P92 L35-42

Membery's vital signs and condition and to document those checks in the vital signs chart.[88]

40. RN Del Santos said that at 11pm she directed carer, Teagan Ahearn, to take Ms Membery's temperature, and Ms Ahearn reported the patient's temperature to be 38.4 degrees.[89] RN Delos Santos then checked on Ms Membery and observed her to be sleeping.[90]

41. RN Delos Santos stated she next checked on Ms Membery at midnight, as evidenced by the entry in the vital signs chart,[91] and recorded a temperature of 38.3 degrees.[92]

42. RN Delos Santos went on to say that she checked on Ms Membery again at about 2am.[93] She said that she was unable to check Ms Membery's vital signs at that time as Ms Membery was sleeping, but she observed no signs of distress or discomfort.[94] She was unable to recall at the time of the hearing why it was that she had been able to take Ms Membery's temperature at midnight (when Ms Membery was sleeping) but was unable to do so at 2am.[95] She had made no note of the 2am check but maintained that she had performed that check.[96]

43. RN Delos Santos went on to say that she had not been able to perform the 4am check she intended to make as she was busy supporting carers completing the rounds from 3am and checking other patients.[97] She stated that the night of 5-6 July was a particularly busy night as there were multiple patients with chest infections requiring attention, and an aggressive, wandering resident requiring

[88] Transcript P92 L49-P93 L19
[89] Transcript P94 L24-31
[90] Transcript P94 L33-39
[91] Transcript P94 L10-12
[92] Exhibit HH
[93] Transcript P95 L7-13
[94] Transcript P94 L48-P95 L5
[95] Transcript P94 L33-39
[96] Transcript P94 L23-26
[97] Transcript P95 L31-P96 L7

frequent checks.[98] She said that she had not forgotten Ms Membery, and returned to see her at the end of the rounds.[99]

44. RN Delos Santos said she checked Ms Membery at 5:25 am, and observed her temperature was 39.3 degrees.[100] She said that at this time she gave Ms Membery a tepid sponge bath to attempt to reduce her temperature, and changed her into lighter clothes.[101] She said that she did not consider at this point that Ms Membery needed hospitalisation, because Ms Membery when woken was not in distress and was able to follow verbal commands, such as turning in bed to allow changing of her pad,[102] although she did not open her eyes. [103]

45. Delos Santos could not recall whether she had made a conscious decision at 5:25am not to administer Panadol, and could not say why she would not have done so at the time.[104]

46. RN Delos Santos said that she returned to see Ms Membery at 5:40am to check if the tepid sponge bath had reduced her temperature. She said that Ms Membery's temperature remained 39 degrees.[105] She said that, at that time, she attempted to administer Panadol to Ms Membery by spoon feeding the crushed tablet, but Ms Membery spat out the medication.[106] She gave Ms Membery another tepid sponge bath.[107] She said that Ms Membery was at that time still responding to voice commands and would nod, although she did not speak.[108] She said that she did not consider taking Ms Membery to hospital at this point because Ms Membery was not in distress and displayed no breathing difficulties.[109] She said that she returned to check on Ms Membery again at

[98] Transcript P96 L30-44
[99] Transcript P97 L9-15
[100] Transcript P95 L28-29, P97 L17-21
[101] Transcript P98 L19-20
[102] Transcript P97 L29-P98 L20, P98 L15, P98 L20
[103] Transcript P98 L13
[104] Transcript P98 L47-P99 L6
[105] Transcript P98 L33-38, P99 L10-14
[106] Transcript P98 L22-27, P 98 L38-45, P99 L20-24, P100 L18-31
[107] Transcript P99 L26, L44-46
[108] Transcript P99 L33-42
[109] Transcript P99 L28-31

6:30am. When asked why she waited so long, RN Delos Santos said that she could not recall but that she was probably tied up with other residents.[110]

47. RN Delos Santos stated she next checked again on Ms Membery at 6:30am.[111] She stated that her temperature at that time was 38.9 degrees.[112] RN Delos Santos said that she administered another sponge bath and then called the ambulance for a hospital transfer.[113] She stated that she made the decision to call the ambulance because Ms Membery's temperature was not reducing over the course of the observations taken throughout the night and because Ms Membery was not taking her medication.[114]

48. RN Delos Santos stated she called the ambulance personally, and the ambulance arrived at the Home at approximately 7:15am.[115] She stated that she measured Ms Membery's oxygen saturation ahead of the ambulance arriving in order to provide a more complete handover.[116]

49. RN Delos Santos was asked on behalf of Ms Membery's family at what particular point a patient's temperature was high enough to warrant hospitalisation. The overall effect of her response was in these terms:

    a. the question could not be answered by reference to a level of temperature alone;

    b. much depended upon the overall circumstances;

    c. a temperature of around 39 degrees would probably influence her decision when accompanied by a patient's inability to take oral medications or obvious signs of distress such as shortness of breath.

50. RN Delos Santos went on to say that Ms Membery was not showing any obvious signs of distress or shortness of breath. She also referred to levels of

[110] Transcript P99 L49-P100 L10
[111] Transcript P99 L48, P100 L35-36
[112] Transcript P100 L38
[113] Transcript P100 L40-41
[114] Transcript P100 L43-P101 L7
[115] Transcript P101 L9-14
[116] Transcript P101 L46-P102 L6

oxygen saturation[117] and later said that an oxygen saturation of 89%, as was recorded for Ms Membery, was in her opinion a fairly good level for a person with infection.[118] She said that she was aware that Ms Membery had been prescribed supplemental oxygen if required, having read that in the notes, but she did not administer oxygen as she had not observed any signs of difficulty breathing or signs of distress in the time she was caring for Ms Membery.[119] RN Delos Santos also said that she did not customarily measure oxygen saturation in patients and that her decision whether or not to do so depended on any clinical indication of difficulty in breathing.[120] She agreed with a proposition that her assessment of whether or not a patient was experiencing breathing difficulties was a critical factor in determining the next steps in treatment.[121]

51. RN Delos Santos was asked whether she felt she could get her duties done with the level of staffing at the time. She replied by saying that she could "*but ... it depends upon the situation, because you never know when a patient gets really sick or (an) emergency happen(s)*".[122]

52. RN Delos Santos was shown Ms Kwok's "Statement of Expectations" (Exhibit FF) and said that she was shown the document when she was hired in November 2013.[123] She agreed with a proposition that point 6 of the document did not apply to patients who have already been diagnosed with infection.[124] She did not recall receiving any training as a nurse as to the appropriate frequency of taking observations on a patient with a fever, saying it was a matter of professional judgement in the light of relevant policies and procedures.[125] She said that RSL LifeCare's policy required staff to check on patients who had seen a doctor and receiving treatment at least once a shift.[126]

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[117] Transcript P105 L31-43
[118] Transcript P107 L23-28
[119] Transcript P102 L12-26, P105 L49-P106 L25
[120] Transcript P105 L45-47
[121] Transcript P106 L29-P107 L6
[122] Transcript P88 L27-31
[123] Transcript P102 L28-20
[124] Transcript P103 L35-40
[125] Transcript P103 L45-P104 L9
[126] Transcript P104 L11-19

CONCLUSIONS AND FINDINGS.

53. Not all of the evidence of the observations made of Ms Membery's condition at the relevant times are supported by truly contemporaneous notes by the witnesses. There are however no material conflicts or inconsistencies in the evidence of RNs Lacsao and Delos Santos and nothing about their testimony leads me to question their reliability. I accept the testimony received from them at the hearing.

54. I make the following observations on the evidence of Dr Austen and RNs Lacsao and Delos Santos about what took place in the period leading up to Ms Membery's death:

    a. There is no evidence to suggest that any diagnosis or treatment or lack thereof by Dr Austen in any way contributed to the death of Ms Membery.

    b. I accept that a decision about whether and when hospitalisation for Ms Membery was necessary called for consideration of many factors including her body temperature, her level of apparent consciousness, her oxygen saturation levels, and any signs of distress or difficulty in breathing, as well as any changes in those things just mentioned and Ms Membery's apparent response to treatment by way of the administration of paracetamol, antibiotics and cooling baths.

    c. I accept that consideration of a decision on hospitalisation required nursing staff to make a judgment about the significance of those factors in the context of Ms Membery's overall circumstances at the time. I accept that the decision was properly a decision to be made by nursing staff on duty at the time.

    d. Ms Membery's ongoing high body temperature was a factor weighing in favour of a decision to call for her hospitalisation earlier, but, as against that she did not demonstrate any signs of distress or difficulty in breathing. I accept what I understand to be the professional opinion of Dr Austen that the latter (distress or difficulty in breathing) is a more reliable indicator of

the need for hospital treatment than the former (ie. a high temperature per se).

55. I make a formal finding as to the cause of Ms Membery's death in accordance with the unchallenged expert opinion of Professor Lyons.

56. I find that the decision to hospitalise Ms Membery was made by RN Delos Santos at 6.30am on 6 July 2014. Having regard to the considerations just referred to, the evidence does not, in the circumstances, support a conclusion that the decision should properly have been made at any earlier point in time.

57. Accordingly I make no finding that the quality of care, treatment or supervision of Ms Membery contributed to the cause of her death. Additionally I find that no matter of public safety arises.

58. I extend my condolences to Ms Membery's family.

I certify that the preceding 58 numbered paragraphs are a true copy of the Findings of her Honour Coroner Morrison.

Associate: Matthew Bautz

Date: 15 March 2017