CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: **AN INQUEST INTO THE DEATH OF EDWARD ROBERT DAVIS**

Citation: **[2018] ACTCD 5**

Date of Findings: 28 February 2018

Before: Coroner P. J. Morrison

Decision:

1. Edward Robert (Ted) Davis died on 18 December 2016 at BUPA Aged Care Facility, 43 Were Street, Calwell, in the Australian Capital Territory;

2. The manner and cause of death of Mr Davis are sufficiently disclosed and a hearing is unnecessary;

3. The cause of death was left frontal lobe haemorrhage due to a fall; and

4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest.

Legislation: *Coroners Act 1997* (ACT)

File Number: CD 303 of 2016

1. Mr Davis was an 88 year old man who resided at the BUPA Aged Care Facility in Calwell. He had a history of epilepsy, stroke and dementia, and was taking blood thinning drugs in addition to other medications. He required significant assistance with his activities of daily living, including washing, dressing and toileting, and would require assistance to get in and out of bed. By the time of the period immediately before his death he had limited verbal communication and was not very responsive to staff or stimuli. Mr Davis had indicated through his family that he did not wish to be resuscitated and did not wish life prolonging measures be taken in the event of serious illness or injury.

2. At about 10am on the morning of 23 November 2016, an Assistant-in-Nursing (AIN) attended Mr Davis in his room to provide assistance with activities of daily living. The AIN sought the assistance of a Nursing Assistant (NA) to use a Stand-Up Lifter to get Mr Davis out of bed, but the NA was not immediately available. While waiting for the NA, the AIN washed and changed Mr Davis, and then assisted Mr Davis to sit up on the edge of the bed and placed the Stand-Up Lifter immediately in front of Mr Davis.

3. The Stand-Up Lifter in question utilised a sling belt to be placed around the patient whereby the power of the machine could be used to assist the lift of the patient without exposing staff to any manual handling risk. It had two large protruding arms either side of the power stem. The standard practice for operating the Stand-Up Lifter at BUPA Calwell appears to have been as follows:

    a. Position the resident on the side of the bed.

    b. Place the stand immediately in front of the resident.

    c. Place the sling belt on the resident once a second worker was present.

    d. Operate the mechanism using a remote control to lift the resident once the resident places their hand on the hand rest.

    e. Once the resident is secure, move the resident as required.

4. It was the policy of BUPA Calwell that this machine could not be operated by a single staff member, but required the involvement of at least two staff members.

5. There was a little delay for the NA to attend Mr Davis' room, and the AIN waited in Mr Davis' room off to one side and behind the Stand-Up Lifter. When the NA entered the room Mr Davis fell forward and to the left from where he was sitting on the bed and fell into the Stand-Up Lifter which was set up directly in front of him. I am told the NA greeted Mr Davis and this may have startled him, but I am also told that Mr Davis would occasionally make sudden jerking movements – in the circumstances of this case it is not necessary for me to determine absolutely the underlying reason why Mr Davis fell. As a consequence of falling forward the front of Mr Davis' head hit the front of the left arm support of the Stand-Up Lifter. Mr Davis was observed by the NA to grunt as a result of the impact.

6. The AIN immediately moved and acted to lift Mr Davis off the Stand-Up Lift and with the assistance of the NA Mr Davis was returned to his bed. Mr Davis was observed to have a small abrasion on the middle of his forehead with a small amount of blood present. A Registered Nurse was called to Mr Davis' room to take observations, and the resident doctor at BUPA Calwell also attended to assess and treat Mr Davis. Mr Davis' wound was treated, and a process of observations to assess his neurological state was commenced.

7. The observations undertaken of Mr Davis identified that his state of consciousness decreased over time and a decision was made on 24 November 2016 (the next day) to refer Mr Davis to the Emergency Department at The Canberra Hospital. A CT scan undertaken there relevantly showed a large hypodense acute parenchymal haemorrhage in the left frontoparietal region measuring approximately 5.4cm anterior to posterior.

8. In accordance with Mr Davis' previously indicated wishes, and the views of his family, Mr Davis was returned to BUPA Calwell on 25 November 2016 for palliative care and support. His condition progressively deteriorated over time until he died on 18 December 2016. I note that Mr Davis' family had advised through Police that they held no concerns about the treatment and care provided to Mr Davis by BUPA Calwell.

9. It seems likely that the impact of the fall on Mr Davis was exacerbated by his taking of taking of blood thinning medications, and the reduction of the size of his brain due to dementia. The fall appears to have been entirely accidental. I make no adverse comment or finding in relation to the conduct of the AIN or NA involved. The impact of Mr Davis' head on the Stand-Up Lifter may however have been preventable because there was no need for the Stand-Up Lifter to have been placed in front of Mr Davis while waiting for a second operator.

10. I wrote to BUPA Calwell in November 2017 to raise my concerns and seek further information. I have to date received no response from that facility. In particular, I have no information as to whether BUPA Calwell was alert to, or identified the risk identified in this case, and whether it has taken any action to correct this risk.

11. In all the circumstances I conclude that BUPA Calwell's current practices in respect of the use of sling lifters give rise to a matter of public safety in respect of persons constituting that section of the public who are residents of the facility. I recommend that BUPA Calwell review and revise their practices, any relevant policies, and staff training in respect of the positioning of sling lifters around patients prior to active deployment of the equipment. I direct that a copy of my findings in this matter be sent to BUPA Calwell.

12. I direct also that a copy of my findings be sent to the Australian Aged Care Quality Agency, which oversees aged care facilities across Australia, for their information and any action they consider appropriate in relation to these types of lifters.

13. A copy of my findings, together with any response received from BUPA Calwell, will be uploaded in due course to the Court website.

14. I extend my condolences to Mr Davis' family.

P.J. MORRISON
Coroner