SYDNEY CORONERS COURT

Inquest:	**IRIS CONYNGHAM**
File number:	**2988/09**
Hearing dates:	**18, 19 May 2011**
Date of findings:	**20 May 2011**
Place of findings:	**GLEBE CORONERS COURT**
Findings of:	**C. FORBES**
Findings:	I find that **IRIS CONYNGHAM** died at the Royal North Shore Hospital, St Leonards New South Wales on 15 October 2009 as a result of a traumatic subarachnoid haemorrhage and an acute and chronic subdural haematoma as a result of a fall.
Recommendations:	
Representation:	

REASONS FOR FINDINGS

Introduction

1. Iris Conyngham (91 years old) died at Royal North Shore Hospital on 15/10/2009 as a result of a traumatic subarachnoid haemorrhage. She suffered that injury the day before when she fell at Bennelong House in the Shalom Centre for Aged Care at Marsfield, which is operated by the Baptist Community Services (BCS)

2. Bennelong House is a "High Care Facility". On 14/10/2009 Iris Conyngham was admitted to that facility at 2.30 pm. At 3.35 pm she was found by staff semi-conscious on the floor near to her bed. No one saw her between 2.50pm and 3.35pm. She may have been lying on the floor for up to 45 minutes before she received assistance. She had only been in the facility all up for 1 hour and five minutes.

3. There has never been any internal investigation or review by BCS of the circumstances that surrounded this fatal fall. The only response by BCS in the eighteen months since this incident occurred was two lines written on an "Accident Report" that say "resident found on floor, face down on stomach unresponsive to speech, responsive to touch"(Tab10) That entry was made on the day, by the manager of patient care, Ms Erica Roy, who actually came upon the incident in her rounds. It was never flagged on that report that the outcome was fatal. She made no enquiries of anyone present as to what happened nor any observations of any of the surrounding circumstances such as whether the bed rails were up, the bed had been lowered, whether the falls policy had been adhered to etc.

4. This incident has not been reported to the HCCC or to the Office of Aged Care Quality and Compliance.

Iris Conyngham: background

5. In 2005 Iris Conyngham moved into Dorothy Henderson Lodge at Marsfield (also operated by BCS) after she had broken her hip.

6. BCS operate three aged care facilities at Marsfield, Cooinda Court, Dorothy Henderson Lodge and Shalom Centre. Cooinda Court and Dorothy Henderson Lodge are low care facilities. Shalom Centre is a high-level care facility. Each facility operates independently and the records of patients are not transferred between the three.

7. On 14 September 2009 Iris Conyngham suffered five falls whilst at the Dorothy Henderson Lodge and was admitted to Ryde Hospital on 15 September 2009. She was diagnosed as having suffered a cerebrovascular accident. She remained at Ryde Hospital for one month, until 14 October 2009.

8. While she was in Ryde Hospital an assessment was done by ACAT (Tab 10). It was decided that she could not return to Dorothy Henderson Lodge and that she needed to be in a high care facility. There was a bed available at Bennelong House in the Shalom

Centre and arrangements were made for her to be taken there. She had never been there before.

Circumstances of Death

9. On 14 October 2009 Iris Conyngham was transported to Bennelong House at the Shalom Centre by ambulance. Her discharge documents arrived with her. They noted that she had had a stroke, multiple falls, was confused, could only be given grade two thickened fluid and was a high risk for falls. (Tab 7).
10. She arrived at 2.30pm. Sister L Pederson was the registered Nurse on duty. Her shift was due to finish at 3.30. A student from Meadowbank Tafe, Ms Aung, was with Sister Pederson. The only other staff rostered at that time were two care service employees, Geeta, and Sepali. (Tab11)
11. Upon Iris Conyngham' arrival Sister Pederson said the ambulance officers brought her to room 65 (photos tab 4) on a trolley and transferred her with a pat slide into bed 65A.
12. Sister Pederson says that at this time she read the discharge summary from Ryde Hospital but she didn't complete any admission chart and doesn't know when she filled out the "Dietary Needs and Dislikes" (Tab10).
13. Sister Pederson left the room and went down to hand over to the afternoon staff.
14. At 3pm she noted in the progress notes that Iris Conyngham had been admitted.(tab 10)
15. At 4.30pm she noted in the progress reports that she had found Iris Conyngham lying face down on the floor at 3.35pm when she went to re check Iris Conyngham's blood pressure with Ms Aung. (She recorded that at 2.50pm the blood pressure had been 203/74.)
16. The BCS Patient Care Manager, Ms Erica Roy, happened to be walking past room 65 at 3.35 when Iris Conyngham was on the floor. Ms Roy completed the accident report. (Tab 10)
17. Iris Conyngham was returned to her bed by the use of a hoist. An ambulance was called and Iris Conyngham was taken to Royal North Shore Hospital where a decision was made to withdraw active treatment and palliative measures were implemented until her death at 3.40am on 15 October 2009.

ISSUES FOR DETERMINATION

At any inquest, a coroner must, if possible, make findings concerning the identity of the deceased person, the date and place of his or her death and the cause and the manner of his or death. A coroner also has discretion, in an appropriate case, to make such recommendations that appear necessary or desirable relating to the death in question: s.82.

WAS THE CARE AND TREATMENT GIVEN TO IRIS CONYNGHAM BY SISTER PEDERSON IN ACCORDANCE WITH PROFESSIONAL STANDARDS?

Was the note in the discharge summary High Risk for Falls attended to?

In light of the fact Iris Conyngham was a high risk for falls patient and she was found on the floor near her bed a primary question is "Were her bed rails put up when she was transferred into bed 65A?"

It is very difficult to make a finding about the position of the bed rails. It appears it is common ground that Iris Conyngham could not have lowered them herself and it is improbable that she climbed around or over them. In those circumstances at least one of the bed rails must have been down.

Sister Pederson gave a statement to police the day after this incident (tab 6). She didn't mention the bed rails, she said

> "*myself and other nurses put Iris to bed …I left approximately 5 mins later leaving other nurses to care for her…at 3pm I gave hand over report…just before handing over the report I asked our student nurse to…do her observations. The student nurse returned with Iris's observations and while looking at it I noticed Iris's blood pressure was high. The student nurse and I returned to Iris at approximately 3.30pm to redo the observations"*

On 3 March 2011 police attempted to further interview Sister Pederson to obtain details however she declined to be interviewed and said she had no more recollection of the days events and could not elaborate. (Tab 1)

In Court, Sister Pederson gave evidence that, after she put Iris Conyngham into bed that she made her comfortable and the *put the bed rails up.* She said later in her evidence that she *put up the right rail* and the others put up the left side.

We have not been able to ask "the other nurses" about what they observed about the bed rails.

Sister Pederson has never nominated who the "other nurses" were that were present in room. In Court she confirmed there were more than one nurse but she couldn't remember whom. She was shown a roster that indicated there was only two other staff at that time. Sister Pederson said she was still unable to say even though on her evidence it must have been those two nurses. The two nurses on the roster were subpoenaed to give evidence at this inquest about the bed rails however they both said they had no recollection of the incident. I find this situation to be most strange.

The student nurse told police that the rails were up when she did the observations but when she returned at 3.35pm the right rail was down. On 1 November 2010 she was interviewed again. She said that when she returned at 3.35pm the left rail was down. In her evidence in Court she confirmed her view that the left rail was down.

Ms Roy, the patient care manager, who entered the room when Iris was still on the floor, did not look to see if the bed rails were up or down.

Sister Pedersen was not an open, clear, consistent witness and I could not describe her evidence as reliable. I am satisfied that at least one of the bed rails was left down on Iris Conyngham's bed.

Was the note in the discharge summary "Special Diet Grade 2 thickened fluid" attended to?

Mrs Conyngham was given a cup of tea on her arrival. It appears most unprofessional in light of the discharge summary.

I note Sister Pederson even wrote in the progress notes that Iris was only to be given thickened fluids and yet went onto to record in the same paragraph that she was given a cup of tea without even noticing the contradiction and possible danger**.**

Was it appropriate that Iris Conyngham was left until 3.35pm to have her high blood pressure reading rechecked?

The progress notes record that at 2.50pm Iris Conyngham's blood pressure was 203/74. I note that Sister Pederson in her evidence in Court said that her progress notes were wrong and that the student nurse didn't take the blood pressure reading at 2.50pm. I do not accept that evidence. Her notes are in accordance with what she told police the day after and are consistent with the student nurse who said that after giving Sister Pederson the results she waited until after changeover and then they went back together to re check the reading.

On any account the blood pressure reading was very high and it appears to be a most unsatisfactory that it wasn't rechecked immediately especially as this was a new admission who had just arrived in an ambulance.

WHAT HAS BEEN DONE TO ENSURE THIS SITUATION WON'T HAPPEN AGAIN?

There has been no investigation of this matter by BCS. In fact the Accident Report and progress notes are the only account of what occurred. The Care Manager was informed of Iris Conyngham's death however it was never noted on the accident report. Certainly I could not find that anything has been done to look at how this situation arose and it follows that no consideration has been given to ensure it doesn't happen again

Findings

I find that **IRIS CONYNGHAM** died at the Royal North Shore Hospital, St Leonards New South Wales on 15 October 2009 as a result of a traumatic subarachnoid haemorrhage and an acute and chronic subdural haematoma as a result of a fall.

Recommendations

To the NSW Nurses and Midwives Registration Board

- I recommend that the Board review the professionalism of the care that Sister L Pederson gave to Iris Conyngham on 14 October 2009.

To the Commonwealth Department of Health and Aging

- I recommend that the Commonwealth Department of Health and Aging review the response of the Baptist Community Services to the fatal fall of Iris Conyngham at Bennelong House on 14 October 2009.
- I recommend that the Department requires all Aged Care facilities to undertake a Root Cause Analysis of all deaths and hospitalizations that occur following a traumatic event within the facility.

Magistrate Carmel Forbes
Deputy State Coroner
20 May 2011