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Local Court
New South Wales

Citation:	Inquest into the death of Martha McKEE
Hearing Date(s):	25 and 26 August 2011
Decision Date:	26 August 2011
Jurisdiction:	Lismore Coroner's Court
Before:	Magistrate R Denes
Findings	I find that **MARTHA MCKEE** died at the Mid Richmond Aged care facility in Coraki, New South Wales on 28 July 2010 as a result of asphyxiation due to her neck becoming entrapped on a bed stick following a fall from her bed.
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Legal Representation:	A/Sgt Deb Williamson – counsel assisting Mr Vincent instructed by Church and Grace Solicitors for Baptist Community Services Mr Walsh of Parker Kissane Solcicitors for the family
File number(s):	REF: 0054/10
Place of Hearing:	Lismore

REASONS FOR FINDINGS

Introduction

1 Martha McKee was a 91 year old lady at the time of her death. She was at that time in residential care at the Baptist Community Services (BCS) Mid Richmond Centre in Coraki.

2 Mid Richmond is a low care facility with 45 beds providing residential care. Whilst it is classified as a low care facility, it does care for residents with high needs and special needs such as dementia.

3 Mrs McKee had been married and had three children. Her husband died in 1990. In 2003 she suffered a stroke. She moved into residential care in 2007. She was known as Bub. She was a non-insulin dependant diabetic had declining mobility and had dementia. She also had hypertension, poor eyesight and a hearing impairment. The records also indicate she had a history of falls. There were requirements in relation to moving her regularly and in lowering her mattress. Her care was outlined in a care plan. That care plan is found at tab 16 in exhibit 2.

4 Mrs McKee had a KA524 bedpole (herein after to be referred to as bedsticks or bedpoles). This is a u shaped device that slips under a mattress so that there are effectively two handles that can be used by a patient to assist in sitting up or moving in the bed.

5 On the 4th June 2010 the Department of Health and Ageing released an urgent bulletin in relation to the use of the KA524 bedpole arising out of a South Australian inquest following the death of a resident at an aged care facility. The resident had fallen from this bed causing his neck to be entrapped. The South Australian Coroner released its findings on the 14 May 2010 and made certain recommendations in relation to the use of the bedpoles.

6 The Department's bulletin is in tab 2 of exhibit 2.

7 Martha McKee fell from her bed in the early hours of the morning on the 28 July 2010. The carer on duty, Ms Robson saw her at approximately 2.50am when she was changed and cleaned and given a drink of water. Ms Robson next went into Mrs McKee's room at about 5am. She noticed

Mrs McKee had fallen. The mattress had tipped off the bed. Mrs McKee was face down with a pillow on top pf her. The bed stick was across her neck.

8 The Manager was called and the room was effectively sealed off.

9 It was at approximately 6am before anyone checked for signs of life.

10 Mrs McKee was transported to the Lismore Base Hospital and life was pronounced extinct at 12.22pm.

11 There was an internal investigation by BCS and also an investigation by the Department of Health and Aging. BCS were found to have been in breach of their responsibilities under the Aged care Act in relation to failing to properly implement the recommendations in relation to the bedpoles.

MATTERS FOR CONSIDERATION

12 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 her 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: s82

13 In this case, the identity and date and place of death are not in issue. This inquest has been to consider material relevant to the question of the cause and manner of Mrs McKee's death, and to consider whether there are any recommendations to be made to prevent any similar deaths.

14 It is acknowledged that BCS conducted a thorough investigation after this tragic incident. All the bed poles have now been removed from all BCS facilities. I have also heard from Ms Emma Hill, the General Manager of Strategy and Risk at BCS that there has also been a complete review of their incident management processes. They have also conducted a risk assessment of each resident to determine what equipment would assist with mobility.

15 Having said that, there are a number of issues that have arisen in the course of this inquest that are matters for consideration. Those matters are:

a) Were the staffing numbers at Mid Richmond adequate and are they adequately trained?

b) What are the training and procedures in regard to resuscitation techniques within BCS Mid Richmond and does this need to be reviewed following the death of Mrs McKee?

c) What are the minimum standards of competence to be achieved by staff and are they subject to recertification?

d) Whether the KA524 bedpole is being used in other aged care facilities in New South Wales? If they are, is it a matter where I should make recommendations to discontinue their use?

Staffing Numbers

16 BCS Mid Richmond is what is called a low care facility. There are no Government guidelines or recommendations as to staff numbers particularly overnight. There are no guidelines as to patient to carer ratios. In this instance, Ms Robson is experienced in aged care. She had considerable experience in nursing as an enrolled nurse, even though as at 28 July 2010 that registration had lapsed. She was on night shift with Ms Patricia Sawtell. Ms Sawtell also has a certificate 3. She was 20 years of age at the time and the 28 July was her first night shift. Ms Sawtell said that she was there as the cleaner but was there to assist Ms Robson as required.

17 They were responsible for 45 residents; about 20 of whom were high care residents.

18 Ms Robson's duties were to deliver basic nursing care, administer medication to residents as required and ensure residents were clean and comfortable. In relation to administering medication, she received training through BCS and that proficiency was updated each year to ensure she could safely administer the medication. The medication is pre-packaged by the pharmacist in blister packs. It generally was not schedule 8 drugs like morphine.

19 Ms Robson started her shift at 10pm. She said she may have seen Mrs McKee for the first time that night at about midnight when she did what she called the "pad run" – ie delivering incontinence pads to the residents room in preparation for the night shift. She next saw her at 2.50am when she

and Ms Sawtell had to change her pad and wash her. She was given a drink and settled before the door was closed. Ms Robson was asked why there was a 3 hour period between seeing Mrs McKee when Mrs McKee's care plan indicated that she needed turning every 2 hours. Her response was quite frank – there simply was no time before that. She was caring for and checking on the 45 residents. One other resident had had a fall and needed attending to. All this took time. Ms Sawtell said she only accompanied Ms Robson because she felt a bit scared being there on her own. Ms Robson was effectively on her own caring for 45 residents. That may also explain why she did not hear Mrs McKee crash to the floor. It may technically be called a low care facility but in fact it had at that time about 20 high care patients. I note that it now has 33 high care residents. This certainly raises some concern as to the appropriate care that residents can receive. It also raises a concern as to the stress and fatigue of staff.

20 Ms Hill explained to some degree the classification system within the Aged care Act. Facilities can be either low care or high care facilities. Mid Richmond was low care with residents who were able to remain and age in place. If the facility is a high care facility there would be a requirement to have a registered nurse on duty at all times. There are also different requirements as to fire safety and building regulations. It does not seem to be the case that a facility is re-classified notwithstanding that there may be more than half the residents actually being high care patients. Mid Richmond has been re-accredited and has met all its performance indicators.

21 The issue is whether or not Management should, in reviewing residents needs and safety, consider that a Registered Nurse be on duty for the night shift, or have at least 3 staff members on, when more than half the residents are in fact high care patients. One carer to the 45 residents at Mid Richmond, as it was in July 2010, is unsatisfactory even if it meets the legislative requirements. Ms Sawtell was not there as a carer – she was the cleaner who assisted. I am certainly of the view that BCS should conduct a review of its staffing requirements.

Training, competency and resuscitation

22 Another area of concern that has arisen is that Ms Robson did not check for signs of life when she first saw Mrs McKee on the floor. I have no doubt that what she saw was horrific. Ms Sawtell was still visibly distressed when she was asked to describe what she saw. Having said that, Ms Robson has extensive experience as an enrolled nurse. She is also involved in surf lifesaving and is in fact President of the Evans Head Surf Lifesaving club. One would expect a person with this level of training and experience with first aid to check for signs of life. Ms Robson says she saw that Mrs McKee was deceased. With all due respect to Ms Robson, it would appear she simply assumed that. She based her opinion on how Mrs McKee appeared when she first saw her. She said she looked waxy, she was motionless with a tinge of blue and she was unresponsive to her name. But looking at the photographs of Mrs McKee it would seem that only a small part of Mrs McKee's face was visible – she was facing downwards and her pillow covered part of her face. In addition, she had her arm up covering part of her face. All that is known is that somewhere between 2.50am and 5am Mrs McKee fell from her bed taking her mattress with her. Mid Richmond's policies in relation to a fall require that staff check for signs of life (see exhibit 7). That was not done – in direct contravention of the policy.

23 Mrs McKee's care plan indicated that she was for active management - meaning that if there was an incident, she was to be resuscitated. She was not checked until approximately 6am when the registered nurse, Ms Scotcher arrived. She immediately checked her pulse. Ms Robson did not adequately explain why she did not do that at 5am. She did say that she did not want to move anything. But checking for a pulse or for any reaction to external stimuli need not mean that Mrs McKee needed to be moved.

24 Carol Thurgate, the Manager said very clearly that part of the first aid policy is to check for signs of life. Ms Thurgate was not aware whether or not Ms Robson actually did. All she knew was that she received a phone call at around 5am and it would seem that Ms Robson said that she had checked her pulse – that was simply incorrect. Was it because Ms Robson panicked? I suspect this may have been the case – particularly because of the involvement with the bed sticks - an issue I will come to in a moment.

25 Clearly I cannot say that had Mrs McKee's vital signs been checked at 5am then she would not have died. There is no evidence as to what time she fell. The post mortem makes no reference to what time she may have died. I cannot say that she was or was not deceased when Ms Robson saw her at 5am. What I can say is that, had she still been alive, she may have been able to have been resuscitated.

26 Bronwyn Grill made it very clear that Mrs McKee should have been checked for signs of life.

27 BCS Management should ensure that all staff are aware of emergency care protocols and ensure that all staff understand and are competent to perform resuscitation.

The KA524 Bed Poles

28 As noted above, the Department of Health and Aging had issued a bulletin relating to the use of the bedpoles. That bulletin is set out in Tab 2 of exhibit 2. The Management of BCS Mid Richmond became aware of this bulletin in June 2010. Ms Hill indicated that the bulletin was disseminated very quickly to all managers to ensure that the risk assessment referred to was conducted. Ms Hill, the Manager of risk and compliance at the time knew there was an issue with the bed poles. A risk assessment of each resident with a bed pole was to be conducted by the Registered Nurses with, where possible, the physiotherapist.

29 Carol Thurgate, the manager at Mid Richmond was aware of the document relating to the use of bed poles. She considered its application at Mid Richmond in discussion with Kerry Scotcher – the other registered nurse. As far as they were aware, the risk related to the gap between the mattress and the bedstick. She did not seem to be concerned that it related to residents who lacked mobility and had cognitive deficits. Mrs McKee was not mobile and she had cognitive deficits. Ms Thurgate was of the view that as Mrs McKee could not move unassisted and did not move around in bed – in fact she needed turning – that the risk of her falling and getting caught by the bed stick was negligible. It seems that as long as the stick was flush with the mattress and there was no gap, Ms Thurgate was of the view there was no risk of harm at all. This risk assessment was not conducted with the assistance of the physiotherapist. Ms Gray,

physiotherapist, provided a statement that she had been asked to conduct such a risk assessment at other facilities but had not been asked by the Coraki BCS (see tab 14).

30 It seems that any further risk assessment that was conducted involved the assistance of David Murphy – the handy man. He was asked to ensure there was no gap between the mattress and the bed sticks. That seems not to be in the spirit of the bulletin from the department or in accordance with the South Australian Coroner's recommendations.

31 The bed sticks were not there for staff. They were to be used by residents to assist them in sitting up or moving. Mrs McKee was immobile. I was told in the inquest that Mrs McKee used them by holding them when she was moved in a sling – that it gave her a sense of comfort. Frankly though – it seems that the real reason that they were not removed is just as Ms Scotcher said, "she had had them for 3 ½ years". I accept the evidence from BCS that the risk assessment was conducted and they were of the view that the risk was negligible. But clearly, she was able to move – even in a limited way – so much so that the whole mattress fell. In those circumstances, one only need read the bulletin that the bed poles should not be used in circumstances that are not limited to where there is a gap between the bed and the pole, but where the mattress may move, where there is a cognitive impairment or where there is limited mobility. The bed poles should have been removed.

32 They are no longer in use in BCS facilities. Ms Hill indicated that she is aware that there are still some aged care facilities in NSW using the bedpoles. I consider there is an unacceptable risk in the use of the bed poles in any aged care facility. There are alternative devices to assist staff and patients with mobility.

CONCLUSIONS

33 I have noted above a number of areas of concern. I have been asked to consider making some fairly broad ranging recommendations in relation not only to the use of the bed sticks, but also to staffing ratios, training but also significantly, a recommendation to the Dept of Health and Ageing in respect to the re-classification of facilities. In relation to this last point, I am loathe to make such a broad reaching recommendation, particularly where

the Dept has not been represented, and in circumstances where I did not hear expert evidence (if I can call it that) as to how facilities are classified and how assessments are conducted. In my view, it would be improper to make recommendations as to that. What I will say is that BCS, and other organisations that own and operate aged care facilities should be constantly reviewing their staffing needs – not only in terms of complying with legislation or regulations, but in terms of ensuring resident and staff safety.

34 I am also loathe to make recommendations in relation to staff training. It would appear on paper that all staff members are fully trained in relation to first aid. What is important, however, is that that be translated into competencies in practice. I suggest then, rather than recommend, that BCS look at the training requirements of staff and ensure that all staff are familiar with the most important BCS policies – such as checking for signs of life. Perhaps this could be done by way of a simulated exercise done on the premises in the way of a staff development day, rather than simply handing out lots of papers at the induction.

RECOMMENDATIONS

One of the objects of the *Coroners Act* is to enable coroners to make recommendations that will improve public health or safety and help prevent future deaths of a similar kind (s3)(e)).

In this case there does appear to be an important recommendation to be made in relation to the use of the KA524 Bed pole.

TO THE FEDERAL AND STATE MINISTER FOR HEALTH AND AGEING

1. I recommend that the Ministers advise the Department of Health and Ageing of the findings and recommendations of this inquest.
2. Further, I recommend that all approved providers be made aware that there is an unacceptable risk in the use of the KA524 bedpole, over and above what was identified by the South Australian Coroner in 2010, and that the KA524 bedpole no longer to be used in aged care facilities.

Magistrate Robyn Denes
Coroner
Lismore Court
26 August 2011