

SOUTH



AUSTRALIA

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Naracoorte and Adelaide in the State of South Australia, on the 1st, 2nd and 12th days of May, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Leslie Walter Copping.

I, the said Coroner, do find that Leslie Walter Copping, aged 84 years, late of Flat 1, 61 Gordon Street, Naracoorte, died at Naracoorte Hospital on the 17th day of March, 1999 as a result of head injuries. I find that the circumstances of death were as follows:-

1. Background

- 1.1 Leslie Walter Copping was aged 84 years. He lived at Flat 1, 61 Gordon Street, Naracoorte. Mr. Copping was in very poor health. He suffered from asthma and emphysema, which was so severe that he required hospitalisation.
- 1.2 In addition to this very severe airways disease, Mr. Copping also suffered from congestive cardiac failure, gastritis, ischaemic heart disease, poor vision and hearing.
- 1.3 Dr. David Harms, Mr. Copping's General Practitioner, said that he also suffered from anxiety, particularly about the cost of his medical treatment and the cost of his probable placement at the Naracoorte Hospital Nursing Home. He was undergoing assessment by the Aged Care Assessment Team (ACAT). Dr. Harms said that Mr. Copping spoke to him on a number of occasions expressing concern about the cost, and Dr. Harms was unable to reassure him despite repeated attempts to do so (T.24).
- 1.4 Despite Mr. Copping's symptoms of anxiety and confusion, Dr. Harms did not consider that he was suffering from depression. Mr. Copping had been prescribed amitriptyline, and Dr. Harms explained that this was for his anxiety, rather than

depression. Dr. Harms said that he ceased that medication because its sedative effect might have depressed his breathing ability even further (T.25).

2. **The events of 17 March 1999**

2.1 Mr. Copping was checked by Registered Nurse Karen Case at about 8.00p.m., when she offered him assistance to prepare for bed. She said that he was sitting on the edge of his bed using a ventolin machine. She said that he responded that he was “OK” (Exhibit C.8, p2).

2.2 At about 8.30p.m., Mr. Eric Lewis was sitting in his car near the main entrance doors to the hospital when he heard the sound of something hitting the ground. He rang the night bell and a nurse came to the door and they both ran over and found Mr. Copping lying on the footpath at the end of the West wing.

2.3 Dr. Harms was called to the hospital from his home. Mr. Copping was taken straight to the High Dependency Unit. Dr. Harms said:

“He was semi-conscious and confused. He was in shock and respiratory distress and bleeding from a head injury. He was given oxygen by mask, an intravenous line was put in the right arm, fluids were started. We intubated him and ventilated on oxygen. A 16 gauge needle was put into the left side of the chest to release a tension pneumothorax. Another 16 gauge IV was put in his left arm and fluids started.

His output reduced to non-recordable levels. He went into ventricular fibrillation, he was cardioverted. He regained rhythm, went in and out of ventricular fibrillation requiring cardioversion on each occasion. He was given adrenalin. He went into ventricular fibrillation again but didn't respond to cardioversion. He became asystolic and was given more adrenalin, there was no response and I certified Les Copping deceased at 9.05p.m.”. (Exhibit C.10, p1)

2.4 Mr Copping's death was investigated by Detective Senior Constable DEJ Warr of the Naracoorte CIB, with assistance from Senior Constable David Veldhoen of Mt Gambier Crime Scene. Following examination of Mr Copping's room, which was a single room, Mr Warr noted that the height of the window ledge above the bitumen roadway below was about 3 metres (Exhibit C7a, p3), that the aluminium window to the room was half open, and the position of dead flies in the window track indicated that the window was not usually opened to that extent. Mr Warr also noted that the rubber seal around the flyscreen had been pulled away. From the presence of dust on the sill, it would appear that the rubber seal had been removed prior to the flyscreen being pushed out. Senior Constable Veldhoen found the presence of fingerprints on

either side of the open window and a small fragment of material consistent in appearance with the material of Mr. Copping's pyjamas. An indentation on Mr. Copping's right knee was consistent with him having knelt on the window ledge prior to falling.

- 2.5 Although the circumstances suggest that Mr Copping deliberately opened the window and removed the flyscreen with the intention of jumping out, I consider that this conclusion does not pay sufficient regard to Dr Harms' evidence about the degree to which Mr Copping was confused. Experience with people suffering from confusion suggests that it is often not possible to form clear conclusions about their intentions after the event. Mr Copping's confusion may have been so intense that he opened the window with the intention to get out and go home. It may also be that he was unaware, or that he forgot, that the room was on the first floor, since he suffered from poor eyesight. Accordingly, I make no finding that Mr Copping intended to take his own life.

3. **Cause of death**

- 3.1 A post mortem examination was carried out on the body of the deceased by Dr. Erwin Foster-Smith, consultant pathologist, at the Mount Gambier Hospital on 19 March 1999. Dr. Foster-Smith found that Mr. Copping had suffered a fracture of the skull on the right side. He also found the presence of subarachnoid haemorrhage, and that the brain was swollen with an area of contusion involving most of the right cerebral hemisphere.
- 3.2 Dr. Foster-Smith also found signs of severe atherosclerosis in both the cerebral and coronary arteries.
- 3.3 Dr. Foster-Smith concluded that the cause of Mr. Copping's death was his severe head injuries (see his report, Exhibit C.2a). He also conducted a neuropathological examination, and confirmed the presence of subarachnoid haemorrhage and cerebral contusions. He also found "mild to moderate generalised atrophy" (Exhibit C.3a, p1), and, on microscopic examination, the presence of senile plaque formation in the cerebral cortex (Exhibit C.3b). Both of these findings were validated by Dr. Grace Scott, neuropathologist (see Exhibit C.3).
- 3.4 These findings may also account for the symptoms of confusion and anxiety described by Dr. Harms.

4. **Previous Inquests**

4.1 I heard evidence from Ms. Susan Williams, who is the Chief Executive Officer of the Naracoorte Health Service. Ms. Williams told me that the Service was eventually notified, after Mr. Copping's death, of findings made by Mr. Garth Thompson, Acting State Coroner, concerning the death of Murray Wilfred Francis (Inquest Number 27/93). The notification came from the S.A. Health Commission on 7 July 1999.

4.2 Mr. Thompson delivered his findings on 22 June 1993 concerning the death of Mr. Francis. Mr. Francis was an elderly man who fell, from an open window, a distance of about 2.7 metres to the ground outside. The Clare Hospital, where he died, appears to have been of similar design to the Naracoorte Hospital, in that both institutions are built on the side of a hill and the section where the deaths occurred are furthest down the hill. Mr. Francis' case bears striking similarity to that of Mr. Copping.

4.3 The management of the Clare Hospital had taken steps after Mr. Francis' death to modify the window concerned so that it could only be opened to a small extent. Coroner Thompson described this as

“an exercise in locking the stable door after the horse has bolted”. (p.10)

He added:-

“I commend to all Boards of all hospitals and all institutions to inspect their premises promptly to ensure that there is no repetition of this accident”. (p.11)

4.4 These issues were also considered by me in Inquest Number 47/95 concerning the death of Ronald Bruce Stephens. Mr. Stephens fell from a window on the fifth floor of the Whyalla Hospital in 1994. In findings delivered on 19 January 1996, I made the following recommendations which are relevant to the issues in this case:-

“Steps should be taken by management and staff of all hospitals to ensure that ... the physical security of hospital buildings is established, and adequately maintained”. (p.15)

4.5 Ms Williams told me that a search back through hospital records indicates that there had been no notification to the Naracoorte Health Service of the results of either of these inquests before Mr Copping's death. Indeed, she said that the first such reference is contained in the notification from the SA Health Commission dated 7 July 1999.

- 4.6 Ms. Williams' evidence is confirmed by a letter to Detective Warr from Mr. John Markic, Manager of the Insurance Services Unit of the Department of Human Services dated 9 June 1999 (Exhibit C.7d). In that letter, Mr. Markic said:-

“I understand that only Clare Hospital had taken action to prevent patients falling from windows following the Coroner's findings in 1992 into the death of Mr. Murray Francis.

Given the recent death of Mr. Leslie Copping, from falling from a window at Naracoorte Hospital, I will now bring to the attention of all country hospitals the recommendation outlined in the Coroner's findings into the death of Mr. Murray Francis”.

- 4.7 In my opinion, this absence of notification to country hospitals of important coronial findings concerning the death of patients is deeply disturbing. Had all country hospitals been notified of these findings in 1993 and 1996, Mr. Copping's death might have been avoided. I have no doubt that the S.A. Health Commission was aware of the results of both inquests. In those circumstances, it is a matter of the gravest concern that the recommendations were not disseminated to country hospitals in South Australia. I draw this issue to the attention of the Minister for Human Services, in the hope that such a failure of communication does not occur in future.

5. **Remedial action**

- 5.1 Ms. Williams told me that all of the windows in the Naracoorte Hospital have now been modified so that they can only be opened to a small extent to prevent egress. Bolts have also been fitted to all external doors so that they can be locked and cannot be opened by patients considered at risk. In two cases where rooms have adjoining balconies, these balconies have been enclosed so that if a patient who is considered at risk must be given an opportunity to smoke cigarettes, this can be done without the risk of falling or jumping from the balcony (T.16).
- 5.2 I do not have evidence of the cost of modifying all balconies at the hospital used by patients to this extent, but the construction does not appear extensive and such modification does not seem impracticable. At the moment, the efficacy of such modifications depends upon an accurate assessment by the nursing staff that the patient is at risk. This is always problematic. It is noteworthy that Mr. Copping was not considered to be at risk.
- 5.3 Dr. Harms told me that, if he had been asked, he would have advised against Mr. Copping having access to an open balcony having regard to his confused state (T.26-27). Dr. Harms was referring to the risk of accidental harm, rather than deliberate

self-harm, but the issues are the same. If Dr. Harms was concerned about Mr. Copping in this way, perhaps better communication with the nursing staff would have led to further measures being taken to protect Mr. Copping.

5.4 Section 25(2) of the Coroners Act empowers me to make recommendations which, in my opinion, may prevent the recurrence of an event similar to Mr. Copping's death. Clearly, Coroner Thompson's recommendations in 1993 were made with that purpose, and might well have prevented Mr. Copping's death. In the hope that more attention is paid to these recommendations, I recommend the following:-

- (1) that the Minister for Human Services consider how communication of coronial recommendations to country hospitals and health units might be improved;
- (2) that a safety audit be carried out on all country hospitals to ensure that remedial action, of the type undertaken at the Naracoorte Hospital, is undertaken at all such hospitals;
- (3) that the management of all such hospitals consider how the assessment of patients who may be at risk of self-harm (whether through suicidal intent or simply because of confusion or other disability), can be made on the best possible basis, involving input from both medical and nursing staff in relation to each patient.

Key Words: hospital treatment; dementia; falling from a height

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 12th day of May, 2000.