CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 23rd and 24th days of November 2009 and the 14th day of May 2010, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Arthur John Hutton.

The said Court finds that Arthur John Hutton aged 87 years, late of St Laurence's Aged Care Facility, 10 Terminus Street, Grange, South Australia died at St Laurence's, Grange, South Australia on the 16th day of January 2008 as a result of asphyxia due to neck entrapment. The said Court finds that the circumstances of his death were as follows:

1. Preliminary findings

1.1. At the conclusion of the evidence and final addresses in this Inquest I delivered preliminary findings and directed that a copy of those findings be furnished to all media outlets and to the relevant Commonwealth and State aged care authorities. I indicated that I would deliver my formal findings and recommendations at a later date. I now deliver those formal findings and recommendations.

1.2. The preliminary findings that I initially delivered shall form part of these findings. Those preliminary findings were as follows:

> In this matter the deceased, Mr Arthur John Hutton, aged 87 years, died at the St Laurence's Aged Care Facility at Grange. Mr Hutton occupied a room on his own at the facility. His cause of death was asphyxia due to neck entrapment.
>
> Mr Hutton was an amputee having had a leg amputated many years ago. At the time of his death he also suffered from dementia. He had a known propensity to fall from his bed to the extent that his bed had been lowered and a mattress had been placed on the floor next to his bed in order to lessen the impact of a fall.

Mr Hutton was located deceased on the morning of 16 January 2008. It is evident that he had fallen from his bed at some time during the night. The fall had caused his neck to become entrapped in the space between a vertical bedpole and the side of the bed mattress.

A bedpole, sometimes referred to as a bedstick, is a device utilised to assist a person's mobility and independence in bed and is widely used in nursing homes and other aged care facilities and in the community generally.

This is not the first occasion in which a bedpole has been identified as having been instrumental in a person's death. In March of 2006 a female resident of a residential hostel in Victoria, whose medication included morphine, died of traumatic asphyxia when she fell from her bed and her neck became trapped between the bedstick and the bed.

These preliminary findings are intended to serve as a warning to those institutions, persons and entities who utilise bedpoles that in certain circumstances there is an element of risk involved in their utilisation. In particular, and without intending to limit the circumstances in which a bedpole may place a user at risk, the evidence before me demonstrates that bedpoles should not be used in circumstances where there is a gap between the bedpole vertical component and the mattress, or potential gap if the device or the mattress moves, and / or where the intended user has a history of recurrent falls from bed, has a cognitive impairment, with or without limited mobility, or where the intended user's faculties are compromised by medication. Any person or organisation that utilises bedpoles must ensure the use of a bedpole is risk assessed in each application.

I add that Anglicare South Australia, that operates St Laurence's Aged Care Facility, has commendably implemented certain measures to minimise risk to residents who utilise bedpoles.

I will deliver my formal findings and recommendations on a date to be fixed.

I direct that a copy of these remarks be furnished to all media outlets and to the relevant Commonwealth and State aged care authorities.

2. Introduction

2.1. Anglicare South Australia operates the St Laurence's Aged Care Facility at Grange Mr Hutton occupied a room in House 10 of a hostel which forms part of the facility. At the time with which this Inquest is concerned House 10 was devoted to the accommodation and care of patients who suffer from dementia. Notwithstanding Mr Hutton's disabilities, he was a man who cherished what remained of his independence. The bedpoles in question had been fitted to Mr Hutton's bed essentially to serve two purposes. Firstly, it provided Mr Hutton with a measure of mobility and independence while in bed insofar as the poles enabled him to move in his bed without external assistance. Secondly, the pole that was situated on the left hand side of the bed enabled him to sit up and swing his legs over to the side of the

bed in preparation for his transfer to a wheelchair. The device was at all times fitted to the bed even when Mr Hutton was in bed and sleeping. I am aware that in the market there are devices that serve the purpose of a bedpole which, unlike the bedpoles with which this Inquest was concerned, can be folded and easily removed from the bed while the resident occupies the bed. However, in Mr Hutton's case the device needed to be in place at all times because it aided in his mobility whilst in bed.

2.2. As indicated in my preliminary findings, Mr Hutton had a known tendency to fall from his bed. It was for this reason that the bed had been lowered and a mattress had been placed on the floor beside it. As well, I heard evidence that he had a habit of getting out of bed on the right hand side, closest to the wall. In order to prevent that from occurring, a bed rail was placed on the right hand side of the bed. The effect of this arrangement was that Mr Hutton's risk of falling out of bed was confined to the left side of the bed and it was there that the mattress had been placed on the floor. I make the observation that Mr Hutton's tendency to fall could have been eliminated altogether by placing a bed rail on both sides of the bed. However, this would have made the fixing of a bedpole apparatus more difficult if not impossible, with the result that Mr Hutton would have been deprived of the benefits that the bedpole provided in terms of mobility and independence. In short, there was a balancing exercise that came down in favour of Mr Hutton's independence and in my view nobody can be criticised in relation to that.

2.3. The top section, or head, of Mr Hutton's bed was capable of being raised from the horizontal. The head of the bed, being that part of it that supports the head and trunk of a person, could incline in an upward direction. The head of Mr Hutton's bed was raised to what appears to have been an approximate 30 degree angle from the horizontal. The foot of the bed remained in the horizontal position.

2.4. The bedpole apparatus that was fitted to Mr Hutton's bed comprised two vertical poles positioned on either side of the bed. The poles are connected by a horizontal U shaped frame that sits between the mattress and the base of the bed. The poles and the frame are essentially the one piece of metal, bent and thus configured in the shape I have described. The apparatus is known as the KA524 model manufactured by Hills Healthcare, a Western Australian company. For some reason Mr Hutton's apparatus had been positioned in what is believed to have been, for want of a better expression, an unorthodox position. It was generally accepted that the horizontal frame of the device should have been placed with the U section pointing towards the foot of the

bed. In Mr Hutton's case it was positioned underneath the raised head section of the bed with the U section of the frame directed towards the head of the bed. When placed in the orthodox position that I have described, the bedpoles and frame would have a greater measure of stability. The weight of the individual and the weight of the mattress on the horizontal frame would tend to keep it in place. However, in the unorthodox position in which it was located following Mr Hutton's death, the apparatus was loosely fitted beneath the raised section of the bed. This meant that there was no weight on it such that it would have had an ability to move both laterally and longitudinally on the bed base. In addition, forward force on the bedsticks as applied by the occupant would cause the sticks and the frame to move forward. The other effect of the bedpole device being situated in the unorthodox position was that the poles themselves would have been situated closer to the upper body and neck of the patient as opposed to being closer, say, to the waist of the patient when placed in the orthodox position. I do not know exactly why Mr Hutton's device was placed in an unorthodox position except that there was a suggestion in the evidence that it was better for him to have the poles situated closer to the upper part of his body because it better enabled him to use his unusual upper body strength[1].

2.5. A check conducted by St Laurence's staff subsequent to Mr Hutton's death revealed that all other bedpoles fitted to beds within the facility had been fitted in the orthodox manner.

2.6. An examination of photographs that were taken by police of the bedpole device in situ and of Mr Hutton's bed when stripped of its bedclothes reveals that the distance between the two vertical poles that were situated on either side of the bed was greater than the width of the bed itself. This meant that a gap of approximately 100 millimetres could be established between the left hand side of Mr Hutton's bed and the bedpole on that side. The exposure of the horizontal section of the frame created by such a gap provided an effective hanging point between the bottom of the vertical pole and the side of the bed and mattress. The fact that the device was positioned in the unorthodox position underneath the reclining bed head meant that the device could move laterally into the dangerous position I have described. Even if the bedpole was flush with the side of the bed and mattress to begin with, it could easily move laterally thus exposing the horizontal hanging point between the bottom of the vertical bedpole and the edge of the bed.

[1] Transcript, page 71

2.7. I would add here that the gap between the bottom of the vertical bedpole and the side of the bed and mattress could also have existed with the device placed in the orthodox position, although conceivably it might be more difficult to establish the gap with the weight of a person and mattress on top of the device. The difference would be, however, that the bedpole and consequent gap would be further down the length of the bed and not as close to the position of the occupant's neck.

3. The circumstances of Mr Hutton's death

3.1. Mr Hutton occupied Room 12 of House 10 at the St Laurence facility. According to the witness statement of Ms Nicole Foran[2], who was a personal care worker at the facility, checks of residents were conducted at 2 hour intervals. Ms Foran's statement reveals that she 'visited' Room 12 at 11:20pm on the evening of Tuesday 15 January 2008 and at 2am and 4:15am on Wednesday 16 January 2008. Ms Foran did not actually sight Mr Hutton on any of those three occasions. Nor did she open the door. Ms Foran asserts that on each of the three occasions she could hear the sound of snoring emanating from inside Mr Hutton's room and this in her view was sufficient to establish that Mr Hutton was safe. It was said in respect of Mr Hutton that he had an aversion to being disturbed at night by someone entering his room and it was for that reason that no attempt was made to actually sight him.

3.2. At about 6:15am Ms Foran and another careworker, Ms Barnett, entered Mr Hutton's room to arrange his morning shower. They discovered that Mr Hutton had fallen from his bed and that his head and neck was caught in the gap between the left hand bedpole and the side of the bed and mattress. His neck was suspended by the exposed section of the horizontal frame of the bedpole apparatus. Mr Hutton was deceased. A post-mortem examination revealed that he had died from asphyxia due to neck entrapment[3]. I accepted that as the cause of Mr Hutton's death.

3.3. Police attended at the facility that same day and photographs were taken of Mr Hutton in the position in which he hade been located. It is clear that Mr Hutton had fallen from the bed onto the mattress on the floor that was there to soften the impact of such a fall. However, although Mr Hutton's lower torso and legs were on the mattress, it is evident that the fall of his head, neck and upper body had been arrested by the exposed horizontal section of the bedpole apparatus that occupied the gap between the bedpole and the side of the bed and mattress. Whether the gap had been in existence

[2] Exhibit C20
[3] Exhibit C19

beforehand, or whether it had been opened up by Mr Hutton's fall causing a lateral movement of the apparatus, is really neither here nor there. Either the gap would have been obvious or the potential for its creation was clearly foreseeable. The net result was that Mr Hutton's neck was caught in the gap and this meant that his head and the upper part of his torso were suspended by the neck with the resulting asphyxiation.

3.4. It is not known whether Mr Hutton experienced any period of consciousness before he succumbed. If he did experience a period of consciousness, it is fairly plain that his lack of mobility would nevertheless have made it quite difficult for him to extricate himself from the position to which he had fallen.

3.5. The bedpole apparatus on Mr Hutton's bed was in the unorthodox position. From what can be seen from the photographs taken by police the bedpole, as seen with Mr Hutton still in-situ, is at the approximate position of his neck and upper torso as they would have been in as he slept. It is difficult to determine whether if the bedpole had been in the orthodox position, and thus situated further towards the foot of the bed, the outcome for Mr Hutton may have been different.

4. <u>The forseeability of Mr Hutton's entrapment</u>

4.1. Having heard from a number of employees of Anglicare I was satisfied that no identifiable person had at any time foreseen the possibility of an entrapment such as that which occurred in respect of Mr Hutton. This is not to say, however, that such an event was not foreseeable on a purely objective basis. Mr Hutton's propensity to fall from his bed was well known and it was for this very reason that his bed had been lowered and a mattress had been placed adjacent to the bed. In addition, the creation of a gap between the bedpole and the mattress was clearly, in my view, also a foreseeable circumstance, even if the gap was not in itself evident at any given time. Certainly the discrepancy between the apparatus and the bed in terms of width could easily have been established by visual observation. The instability of the device when placed in the unorthodox position was also something that would have been obvious. Whether those matters in and of themselves would have made a neck entrapment intrinsically foreseeable is another matter.

4.2. I observe that Mr Hutton's death was investigated by SafeWork SA. The Court received in evidence the report of Mr Grant Ireland who is a Senior OHS Inspector

with the Investigations Team of SafeWork SA[4]. In addition a statement of witness was prepared by Mr Ireland and this was also tendered to the Inquest[5]. There was also a statement of another Inspector by the name of Corinne Harvie[6] tendered to the Inquest. Mr Ireland's report asserts that this was the first known incident where a person or part of a person had become trapped between a bedpole and a mattress[7]. Within its recommendation section the report also asserts that SafeWork SA had determined that the potential for a person's neck area to be caught between the mattress and bedpole was unforeseeable prior to this incident. The report goes on to refer to certain welfare improvement measures and initiatives conducted by Anglicare, the outcome of which was that an incident such as the one that involved Mr Hutton was unlikely to recur.

4.3. Both SafeWork SA and the relevant persons in authority at Anglicare appear to have proceeded on the basis that an incident such as Mr Hutton's, certainly insofar as it caused a death, was unprecedented. This in fact is not the case.

4.4. As alluded to in my preliminary findings, in 2006 there was an incident in Victoria in which a device described as a 'bedstick' was found to have been responsible for the death of a nursing home resident. The death occurred on 17 March 2006 in Hamilton, Victoria. A coronial finding without Inquest dated 9 May 2006 records the primary cause of death as 'traumatic asphyxia'. The following circumstances, as recorded in the finding, were found to have pertained:

> 'The deceased, who resided in a nursing home, had had her medications changed recently from tramadal to morphine. which was thought to be associated with some confusion. She fell from her bed, and her neck became trapped between the bedstick (a metal frame attached to the bed to aid mobility) and the bed. She was found in this position and an alarm was sounded. She was then removed from that position. The deceased was warm to the touch, but with no vital signs. CPR was administered, but it was unsuccessful. Post mortem examination showed no evidence to suggest any persons were involved in the death.' [8]

4.5. There is no evidence before me as to how widely, if at all, this finding without Inquest was published or otherwise publicly disseminated. I was satisfied that none of the witnesses who gave evidence in my inquiry knew of this previous incident in Victoria.

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[4] Exhibit C9a
[5] Exhibit C9b
[6] Exhibit C9c
[7] Exhibit C9a, page 4
[8] Exhibit C23

4.6. The evidence before me was that the bedpoles deployed in Anglicare facilities did not come with any instruction as to their use and installation. Nor did they come with any warnings. As indicated earlier, the KA524 bedpole is manufactured by Hills Healthcare. A statement of the sales and marketing manager of Hills Healthcare, Mr Greg Pearson, was tendered to the Inquest[9]. Mr Pearson's statement confirms that the device is designed to assist a person to position themselves on the bed and to move from and onto the bed. Mr Pearson's statement also describes the dimensions of the bedpole apparatus and suggests that a slight gap between the bedpole and the side of the bed might be allowed for, but only generally an inch to an inch and a half on either side. The statement suggests that the product was not designed for use by persons with both limited mobility and reduced cognitive skills. Mr Pearson asserts that his company educates their sales team, dealers, prescribers and end users on correct installation and use. Mr Pearson acknowledges that because training was practically based, there were no written training instructions issued by their company for the product.

4.7. The statement of Mr Paul Forster who is the General Manager of Home Health Equipment[10] which retails the KA524 bedpole, suggests that no training in the use of the product ought to be required as it is a commonly used piece of equipment. I take it from that that he means commonly used within the aged care industry. The product is also available to the general public for domestic purposes. Mr Forster asserts that in his time at Home Health Equipment, his company had not received any training from Hills Healthcare in relation to equipment supplied by them. In particular Hills Healthcare had not provided them with any detail about the maximum distance that could be allowed to exist between the upright poles and the mattress. Accordingly, this was something about which their sales staff did not educate purchasers.

4.8. Another statement of Mr Brad Caudle, the sales manager of a company known as Independent Living Care and Mobility Centre[11], asserts that his company supplies bedpoles specifically to the St Laurence's Aged Care Facility. Mr Caudle also confirms that when supplied to his company, there are no installation instructions included with the bedpoles. Mr Caudle's company does not provide training for customers to whom the product is distributed.

[9] Exhibit C8a
[10] Exhibit C7a
[11] Exhibit C6a

4.9. There is no evidence that the risk of entrapment as posed by bedpoles, in whatever position they may have been installed, had been brought to the attention of Anglicare staff or had otherwise been foreseen within that institution.

5. Remedial measures undertaken since Mr Hutton's death

5.1. Since Mr Hutton's death Anglicare have commendably taken steps to reduce the risk posed by the use of bedpoles. An audit that was conducted by Anglicare in January 2008[12] gave rise to recommendations for change including:

- That a risk assessment be carried out on the use of bed poles;
- That all residents are assessed by physiotherapist/OT prior to implementation;
- That a consistent work instruction be formulated and distributed across the network;
- That use and placement of bed poles be formally included in training - on commencement and annually;
- That double beds utilise single bed poles only;
- That if a gap exists between the mattress and the poles, that bed poles are not used until a suitable mattress is in position;
- That where a resident has had multiple falls from bed, bed rails be considered and bed poles not used;
- That where a resident requires the bed to be low to the floor and/or a fall out mat is in place, bed poles not be used;

5.2. Following this audit, a relevant work instruction was promulgated by Anglicare Aged Care South Australia and was circulated within Anglicare aged care facilities. The stated purpose of the work instructions is to ensure that bedpoles are positioned correctly whenever a resident's bed is made. The following instructions were promulgated in respect of the deployment of bedpoles.

> '1. Collect bedsticks from stock as authorised by the prescribing therapist.
>
> 2. Two staff are then required to go to the resident room, raise bed to a suitable height and remove bed linen.
>
> 3. Lift end of mattress and place the bedstick under the mattress so that the U section is placed towards the foot of the bed and the 'sticks' are at Hip level (not shoulder level).

[12] Exhibit C9d - Anglicare Investigation by Judy Oates, Senior Manager Residential Aged Care, 23 January 2008

4. Remake bed and then lower bed height.
5. Bed sticks are not to be used
   - If a resident has a history of recurrent falls from bed
   - If a resident has the bed lowered to within 30cm of the floor
   - If a resident has a fall out mat beside a lowered bed
   - If the resident has moderate or severe cognitive impairment.' [13]

I observe that the set of instructions does not stipulate that the bed maker, or other responsible carer, should ensure that there is no gap between the bedpole and the side of the bed or mattress. I note that such an instruction was contemplated within the recommendations arising out of the Anglicare audit. In my view a stipulation that gaps between the pole and the bed should be eliminated ought to be included within the Anglicare instructions. Two photographs that are attached to the work instruction illustrate the correct positioning of the bedpoles. A diagram that illustrates the correct positioning of the bedpole apparatus and which depicts the U shape frame pointed in the orthodox position towards the foot of the bed, has also been created and distributed within Anglicare facilities.

5.3. Ms Lyn Duffy who is the Site Manager at St Laurence's described another remedial measure that has been adopted by Anglicare. Ms Duffy told me that residents who have dementia are no longer permitted to use vertical bedpoles[14].

5.4. Ms Duffy also told me that since Mr Hutton's death, a requirement that staff actually sight residents who are perceived to be at increased risk has been put in place. I was uncertain as to whether this would mean that a person specifically identified as being at risk of falling from bed would require actual sighting during the night. Ms Duffy's evidence tended to suggest that this might be left to the discretion of the individual carer[15]. I would make the observation that listening at the closed door of a resident's room for snoring would not necessarily provide any certain indication that the resident was safe. I make no observation as to whether, if Mr Hutton had been actually sighted throughout the night in question, his fall from bed and death may have been avoided. The intervals between checks were such that they would not prevent a tragedy such as Mr Hutton's taking place, even if a patient was sighted and was found to be sleeping soundly and safely at any given point in time during the night.

[13] Exhibit C9m
[14] Transcript, page 162
[15] Transcript, page 155

6. Recommendations

6.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

6.2. It will be seen from the preceding section of these findings that Anglicare have taken steps to mitigate the risk posed by bedpoles within their facilities. Accordingly, it does not appear to the Court to be necessary to direct any recommendation specifically to the attention of Anglicare South Australia with the exception that, as indicated above, there should be a specific instruction given that gaps between the bedpole and the side of the bed should be eliminated. I recommend accordingly.

6.3. I would made the following general recommendations:

1) That the manufacturers, suppliers and distributors of the KA524 bedpole apparatus ensure that consumers of the product are provided with written instructions as to the correct installation of the product that deal with the following:

   i. The desirability of ensuring that sufficient weight is placed upon the apparatus to ensure minimal movement of the apparatus while the user is in bed;

   ii. That in respect of reclining beds, that the apparatus should be placed beneath the mattress at the foot end of the bed with the U shaped section of the frame pointing towards the foot of the bed and should not be placed beneath the raised section of a bed;

   iii. That any gap between the bedpole vertical component and the mattress be eliminated;

   iv. The desirability of frequent checking of the position and stability of the apparatus as installed in the bed.

2) That the manufacturers, suppliers and distributors of the KA524 bedpole apparatus ensure that consumers of the product are provided with written

instructions as to the dangers posed by the utilisation of the KA524 bedpoles with specific reference to:

i. The need for any person or organisation that utilises bedpoles to ensure that the deployment of the bedpole is risk assessed in each application;

ii. That the product should not be utilised in respect of persons who have a history of falling from bed;

iii. That the device should not be used by persons who have a cognitive impairment;

iv. That the device should not be used by persons who have no access to immediate assistance;

v. The fact that a gap created between the vertical bedpole and the side of the bed has resulted in a fatality by way of head and neck entrapment.

3) That the Australian Government Department of Health and Ageing draw these findings and recommendations to the attention of all Australian aged care services and approved providers.

4) That, if it has not done so already, that SafeWork SA promulgate and distribute a Hazard Alert in relation to the use of bedpoles and the dangers associated with their use.

5) That the Office of Consumer and Business Affairs promulgate and distribute a hazard alert or similar publication in relation to the use of bedpoles and the dangers associated with their use.

6.4. By directing the above recommendations to the manufacturers, suppliers and distributors of the KA524 bedpole I do not mean to imply that any of those entities have been neglectful or are otherwise at fault.

Key Words: Nursing Home; Dementia; Entrapment

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

Seal the 14th day of May, 2010.

Deputy State Coroner