



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 21st, 22nd, 23rd and 28th days of April 2010, the 25th, 26th and 27th days of May 2010 and the 18th day of March 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Dawn Patricia Heath.

The said Court finds that Dawn Patricia Heath aged 78 years, late of Helping Hand Health Care, 437 Salisbury Highway, Parafield Gardens, South Australia died at the Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, South Australia on the 21st day of October 2008 as a result of severe burns. The said Court finds that the circumstances of her death were as follows:

1. Preliminary findings

- 1.1. At the conclusion of the evidence and final addresses in this Inquest, I delivered written preliminary findings. The preliminary findings contained a number of recommendations. I directed that a copy of the written preliminary findings and recommendations be furnished to the relevant Commonwealth and State aged care authorities for dissemination to all aged care facilities. 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 and recommendations that I initially delivered and which I now set out shall form part of these findings and recommendations:

'In this matter the deceased Dawn Patricia Heath, aged 78 years, was a resident at the Helping Hand Nursing Home at Parafield Gardens. Mrs Heath met her death on 21

October 2008 having received significant burns that she sustained in an incident at the nursing home.

Mrs Heath suffered from a certain level of dementia. As well, she had a significant deficit in terms of her manual dexterity that included virtual loss of the use of one arm. There were difficulties associated with the use of her other hand.

Mrs Heath was a smoker. She suffered her significant and fatal burns when her clothing accidentally caught alight while she was smoking in a designated outdoor smoking area at the nursing home. The cause of Mrs Heath's death was severe burns.

Mrs Heath was meant to wear a fire retardant smoking apron while smoking but she was resistant to using it. On the occasion in question Mrs Heath was not wearing a smoking apron. Mrs Heath was outdoors smoking and at the time she sustained her fatal burns she was alone and unsupervised by staff of the nursing home. This state of affairs placed Mrs Heath at risk of harm through burns.

These preliminary findings are intended to notify those institutions and facilities that accommodate and care for elderly residents that the practice of allowing residents who are disabled by dementia and/or by deficits in terms of manual dexterity to smoke while unsupervised, is intrinsically unsafe. If it was not clear already within the aged care industry, the evidence in this Inquest has demonstrated that such residents may, depending upon the level of impairment involved, require close supervision either by members of the resident's family or by a responsible member of staff, such supervision consisting of the immediate presence of, and oversight by, the responsible carer.

Secondly, any facility that chooses to permit its residents to smoke on the premises should ensure that in the case of each individual smoker the risk of harm to the resident, having regard to the level of dementia, the loss of manual dexterity of the resident and other matters relevant to the ability of the resident to smoke safely, and thus the need for and level of supervision, is properly assessed. Such an assessment should take place on an ongoing basis having regard to the possibility of deterioration in the level of cognitive ability and dexterity of the individual over time. All staff responsible for care and their supervisor should be made aware of such an assessment.

These preliminary findings are not intended to create public alarm or to reduce confidence in the operations of aged care facilities and in the level of safety provided by them. I add and stress that Helping Hand Care has implemented certain measures to minimise risk to residents who smoke that includes a regime of close supervision in cases of identified risk.

The initiatives that have been created by Helping Hand Care might well be emulated within the aged care industry.

I will deliver my formal findings and recommendations on a date to be fixed. In the meantime I direct that a copy of these remarks be furnished to the relevant Commonwealth and State aged care authorities for dissemination to all aged care facilities.'

2. Background

- 2.1. As indicated in my preliminary findings, Mrs Heath was 78 years of age at the time of her death. She had been a resident at the Helping Hand Nursing Home at Parafield Gardens (the facility) since July 2007. She occupied room 21 in Ruth Eaton House within the facility. Ruth Eaton House was the facility's high care unit. It accommodated 40 residents.
- 2.2. During Mrs Heath's residency in the facility, Mrs Heath's adult children, Ms Kim Norton and Mr Bret Heath, who both gave evidence in the Inquest, visited their mother very frequently. This was particularly so in the case of Mr Bret Heath. Ms Norton had visited her mother for the last time on the day that she died. Ms Norton was not present at the time her mother sustained her fatal burns.
- 2.3. The facility was staffed by registered nurses, enrolled nurses and carers. One registered nurse was on duty until approximately 3pm when another shift for a different registered nurse would begin. There was a brief handover between 3pm and 3:30pm. There were a number of enrolled nurses working throughout the course of the day. In addition there were carers. The carers were responsible to the enrolled nurses who were in turn responsible to the registered nurse on duty. A position known as Care Manager had overall superintendence of the care providing staff. At the time with which this Inquest was concerned that person was Ms Christine Anderson. Ms Anderson gave evidence in the Inquest.
- 2.4. As already seen, Mrs Heath was a smoker. The evidence suggested that Mrs Heath smoked up to 30 cigarettes a day. Given the frequency at which Ms Norton and Mr Heath visited their mother, it appears that a good many of the cigarettes that Mrs Heath would consume were smoked in the presence of either one or both of her children. Mr Heath was also a smoker. He and his mother would smoke together during his long and frequent visits. However, there were times when Mrs Heath smoked without either of her children being present at the facility and it was on such an occasion that Mrs Heath accidentally set fire to herself and died as a result of the burns that she sustained.
- 2.5. When Mrs Heath first took up residence at the facility she enjoyed a measure of mobility and dexterity. However, by October 2008 her mobility, dexterity and general wellbeing had significantly deteriorated. By then Mrs Heath was dependent

upon a wheelchair for mobility and, as I understood the evidence, she was unable to mobilise the wheelchair herself. She required two carers and a mechanical lifter to facilitate her transfer from bed to wheelchair.

- 2.6. Dr Alfred Hoh of the Munno Para Medical Centre was Mrs Heath's general practitioner. Dr Hoh last saw her on 30 August 2008 at the facility. Dr Hoh provided a statement to the police¹ and he gave evidence in the Inquest. According to his statement, on the last occasion that he saw Mrs Heath she was very unsteady on her feet and needed to be helped to a wheelchair so that she could go outside for a cigarette. He understood that Mrs Heath was liable to become abusive if she was not allowed to smoke and as will be seen the facility records bear this out. Dr Hoh states that as at the end of August 2008 Mrs Heath required assistance with showering, eating and dressing and that she also suffered from a level of dementia. That Mrs Heath had a cognitive impairment was recorded within a Lyell McEwin Health Service Allied Health discharge summary dated 12 July 2007. This document ultimately made its way onto Mrs Heath's resident record at the facility. It was recorded in this document that Mrs Heath was 'cognitively unsafe and has ↓ insight into situation'². Other documentation records that while Mrs Heath was alert and fiercely independent, she suffered from a significant memory and cognition impairment. This was noted at around the time she was discharged from the Hampstead Rehabilitation Centre prior to her commencing residence at the facility.
- 2.7. A letter to Dr Hoh dated 14 April 2008 from Dr Brendan Daly, a consultant physician, identified brain atrophy along with quite severe white matter ischaemic change³. This was said to account for Mrs Heath's then clinical appearance. I note from the report of Dr Karen Heath, a forensic pathologist at Forensic Science SA who performed Mrs Heath's post mortem examination⁴, that neuropathological examination of her brain showed cerebral atrophy and senile plaque deposition consistent with Alzheimer's disease. Dr Hoh told me in his oral evidence that he believed that Mrs Heath's cognitive impairment, which had been recognised in 2007, was a deteriorating condition. He observed this deterioration as he reviewed her from time to time⁵.

¹ Exhibit C18

² Exhibit C14, page 169

³ Exhibit C14, page 154

⁴ Exhibit C2b

⁵ Transcript, page 58

- 2.8. I have already referred to Mrs Heath's manual dexterity deficits. When Dr Hoh last saw Mrs Heath in August 2008 he described her right hand as stiff but observed that she was still able to use that hand to smoke a cigarette. He believed that someone else had to light her cigarettes for her. Dr Hoh was of the view that there was a possible element of paralysis involved with the right hand. Mrs Heath had degloved the skin from a finger on her left hand and as a result the affected finger had to be amputated. I will return to Mrs Heath's manual dexterity in a moment.
- 2.9. Mrs Heath was the subject of a Guardianship Board order that was made just prior to her entering the facility. Mr Bret Heath told me in evidence that the order was made because his mother's impaired cognitive abilities precluded her from making important decisions for herself and that she needed somebody to look after her financial interests as well as her health. The two guardians were himself and his sister, Ms Norton.

3. Mrs Heath's smoking habits and abilities

- 3.1. When Mrs Heath was admitted to the facility a Care Plan was drawn up. This document was tendered in evidence at the Inquest⁶. The Care Plan sets out the particular care needs of the resident. It is a document that can be added to and modified from time to time. The document contains provision for a description of the resident's 'habits' and for a description of the staff assistance that might be required to deal with a stated habit. It naturally lists smoking as one of Mrs Heath's habits. The document stipulates the appropriate staff assistance for her smoking as being 'supervise when smoke'. This entry into the Care Plan was dated 29 July 2007, the month of Mrs Heath's arrival at the facility. There was much discussion during the course of the Inquest as to what such supervision ought to have encompassed. To my mind supervision insofar as it applied to Mrs Heath's smoking should have been an easily enough understood concept. The level of supervision required would need to have been based upon the risk that her smoking presented to her safety at any given time, taking into account matters such as her current level of dementia or cognitive impairment and her lack of manual dexterity. By October of 2008 all of those matters ought to have generated concern, and a high level of supervision should have been identified as being appropriate in her case. In the event, what is clear is that on the day that she fatally burnt herself Mrs Heath was not the subject of supervision at any

⁶ Exhibit C16

level given that when the incident occurred she was utterly alone and had not been sighted for several minutes.

- 3.2. Carers employed at the facility within Ruth Eaton House were expected to be familiar with the contents of a resident's Care Plan.
- 3.3. I heard evidence concerning a disagreement that had taken place between Mr Heath and the management of the facility about his mother's smoking and that of himself. There was an attempt made at one point to discourage Mr Heath from smoking, which he resisted. He believed that he and his mother had a right to smoke at the facility. In particular, his view was that he should be able to smoke so that he could socialise with his mother properly, having regard to the large amount of time that he spent with her at the facility. The difficulty from a management point of view was that complaints had been received from other non-smoking residents and visitors about the smoky environment that was being created in the vicinity of non-smoking resident's rooms. The management of the facility understandably would have preferred a non-smoking policy across the board, but a conclusion was reached that such a policy would be not be appropriate nor feasibly implemented.
- 3.4. In the event a solution was reached that smoking would be banned in the vicinity of resident's rooms, but would be allowed to occur under a gazebo that was situated in an outdoor common area that was not far from the entrance to Ruth Eaton House and, as it transpired, only a short distance from Mrs Heath's own room. It was there that Mrs Heath would smoke her several cigarettes per day, in large part in the presence of one or both of her children. It was in respect of the occasions when neither Ms Norton nor Mr Heath were present at the facility that Mrs Heath's smoking became an issue. It was at the location of the gazebo that Mrs Heath was left alone smoking and where she suffered her fatal burns.
- 3.5. Mrs Heath's smoking was described by her son and daughter. Mr Heath told me that when his mother was first admitted to the facility she could smoke independently. However, having lost the use of one hand completely and having regard to the deterioration in the dexterity in the other hand, her abilities to smoke independently became quite limited over time. She could only take a cigarette out of a packet with great difficulty and by October 2008 she could no longer light a cigarette either with matches or lighter. This pertained for approximately the last 3 months of her life.

3.6. Mrs Heath was right-handed⁷.

3.7. Mr Heath described Mrs Heath's ability to smoke a cigarette in the following terms:

'She was in her wheelchair and she's usually hunched, and she would just hold the cigarette in between two fingers of her hand - of her right hand, and she would half sort of bring it to her mouth and half sort of meet the cigarette by bending down. Once she finished with the cigarette she was then just able to throw it forward into an ice-cream container that we had on the table that had water in it so it was easily extinguished.'⁸

Mr Heath went on to explain that his mother's inability to bring the cigarette up to her mouth meant that she either had to lean forward to meet it or she would hold the cigarette for a long period of time in her mouth which could result in the cigarette burning down and ash dropping⁹. He said that in order to extinguish the cigarette his mother could use her fingers to flick the butt into the water or just drop it into the water. On occasions his mother seemed to be unaware that the cigarette had been fully consumed. Although doubtful that his mother could light a cigarette herself, Mr Heath believed that she might have attempted to do so if there was nobody there to light it for her. He told me that on occasions his mother would ask for another cigarette while one was already lit¹⁰. On other occasions he noticed that his mother might drop forward as if dozing and that this would sometimes happen when she had a lit cigarette in her mouth¹¹.

3.8. According to Mr Heath, smoking was essentially all his mother had. He believed that if the staff of the facility had refused to allow her to smoke she 'would do her block'¹². There is support for this observation from descriptions of Mrs Heath's behaviour in her progress notes at the facility¹³.

3.9. Ms Norton described her mother's right hand as having become very stiff by the end of her life and was 'tucked in'¹⁴. She told me that Mrs Heath could not use her right arm for anything at all. Ms Norton told me that Mrs Heath had difficulty using a spoon in order to feed herself. Ms Norton confirmed her brother's evidence that cigarettes would have to be taken out of the packet and lit for her mother. On the day

⁷ Transcript, page 243

⁸ Transcript, page 480

⁹ Transcript, page 514

¹⁰ Transcript, page 516

¹¹ Transcript, page 517

¹² Transcript, page 510

¹³ Exhibit C14

¹⁴ Transcript, page 526

of her death, when Ms Norton visited her mother, she had difficulty smoking to the point where, because of a lean to the right and some dribbling, the cigarette became soaked. Ms Norton told me that Mrs Heath had some ability to hold a cigarette in her left hand which was the hand that had sustained the amputation. She said that her mother was capable of taking a cigarette out of her mouth with her hand and putting it back in, but she did so with difficulty. Towards the latter part of her mother's life there was general difficulty with coordination. Sometimes her mother would unsuccessfully endeavour to retrieve the cigarette from her mouth, on other occasions she would just leave it in her mouth. In essence, she had difficulty coordinating her hand with the position of her mouth. Ms Norton described the container of water and her mother's ability to occasionally flick the cigarette into it, or on occasions straight onto the ground. On some occasions when her mother left the cigarette in her mouth the ash would simply drop onto her lap. Ms Norton related one incident where a cigarette had actually burnt down to her mother's fingers. Notwithstanding this, Mrs Heath had not reacted and had to be reminded to drop the cigarette into the container.

- 3.10. On the day of her mother's death, it is clear that Ms Norton drew to the attention of staff that in her assessment her mother was not particularly well. She indicated that she wanted Dr Hoh to see her mother.
- 3.11. Both Mr Heath and Ms Norton acknowledged that there were obvious dangers associated with their mother's smoking habit.
- 3.12. One of the carers, Ms Sheree Morrison, told me in evidence that towards the end of Mrs Heath's life there were occasions when she took Mrs Heath out for cigarettes. Ms Morrison told me that as of October 2008, Mrs Heath's wellbeing had declined insofar as she '*wasn't as strong in herself*'¹⁵. As far as Ms Morrison was concerned, by then Mrs Heath could not do anything with her right hand. She could do things with her left hand but she was a lot slower than she used to be. Ms Morrison's impression was that Mrs Heath's amputated ring finger on the left hand had not had an adverse affect on her manual dexterity. Ms Morrison believed that she could light a cigarette with her left hand and could hold it in the left hand as well. However, she would tilt her head down towards her hand in order to smoke, which is a similar description given by Mr Heath, albeit related to the other hand. Ms Morrison told me that Mrs Heath was capable of dropping the cigarette into the ashtray. While Ms

¹⁵ Transcript, page 365

Morrison did not relate any incident of accidental dropping of the cigarette onto Mrs Heath's lap, she said that she dropped ash into her lap because Mrs Heath would sometimes not ash the cigarette into the receptacle.

- 3.13. The intrinsic danger associated with Mrs Heath's smoking activities on any description appears to the Court to be more than self evident. Of particular concern in this regard would be Mrs Heath's forgetfulness in respect of the fact that she had a lit cigarette in her possession and her general lack of dexterity in being able to hold an object in either hand and to coordinate the act of bringing a cigarette up to her mouth or retrieving it from her mouth by hand. There would have been danger and uncertainty associated with Mrs Heath's limited ability to properly extinguish a cigarette. The dropping of ash onto clothing would also have been an obvious matter for concern.
- 3.14. The evidence revealed that at the time of her death there were only two smokers in Ruth Eaton House, one of whom was Mrs Heath.
- 3.15. There are a number of references in Mrs Heath's progress notes about her smoking. On 28 July 2007 it was noted that she continued to move outside the house frequently for cigarettes. I took it from that note that at that time Mrs Heath was able to mobilise herself for this purpose. There is a note on 3 August 2007 concerning the need for other residents to assist Mrs Heath with lighting her 'many cigarettes'¹⁶. On 6 September 2007 a concern was expressed in the progress notes about Mrs Heath and another resident smoking away from the nursing home which presented a risk given that Mrs Heath was at that time utilising a walking frame on uneven surfaces. The concern at that point was the possibility of her falling¹⁷. The entry in the progress notes relating to Mrs Heath's 3 monthly review, dated 1 October 2007, contains an entry:

'Likes to go outside and smoke with other residents. Requires supervision for safety concerns.'

¹⁶ Exhibit C14, pages 76-77

¹⁷ Exhibit C14, page 84

There is also a reference in the same note to a deteriorating mental state. On 18 January 2008 there is a notation that Mrs Heath had a fall in the outdoor smoking area that had been caused by her tripping over her walking frame¹⁸.

- 3.16. On 21 January 2008 a nurse noted in the progress notes that when Mrs Heath had been outside smoking during that morning, staff had noticed holes in her nightdress¹⁹. The concern was that these may have been burn holes from cigarettes. The nurse noted that Mrs Heath might need to wear a protective apron. This seems to have been the first occasion on which a suggestion that Mrs Heath should wear a protective apron while smoking was made. That morning the registered nurse, Ms Valerie Scragg, spoke to Mrs Heath and Ms Norton about the risk of Mrs Heath burning herself while smoking in the outside area. It was suggested that Mrs Heath should wear a fire apron when smoking outside to reduce the risk of burning holes in her clothes. A smoking apron was then obtained and when Ms Scragg went to place the apron on Mrs Heath's lap, Mrs Heath refused to have the garment anywhere near her. Mrs Heath had said *'I've never had holes in my clothing since being here - only at home'*. That morning Ms Scragg made notations to that effect in the progress notes. She also altered Mrs Heath's Care Plan. She added to the first page of the document the following entry: *'To wear a fire protection apron 21/1/08'*. In addition, Ms Scragg in identical terms amended the Care Plan itself under the section entitled ADDITIONAL ALERTS AND STRATEGIES. At the same time the Behaviour Management Chart for Mrs Heath was also added to. The 'Behaviour of concern' was described as being *'Danger to self with burning clothes when smoking'*. The required strategies to deal with this behaviour included *'Remind resident to wear a fire protection apron'* and *'Report to RN/CN on duty if resident unresponsive to request'*. RN/CN is a reference to the registered nurse and clinical nurse. Ms Scragg told me that although she expected staff to abide by these instructions, she was conscious of the fact that staff might be reluctant to press the point about Mrs Heath wearing a smoking apron due to abuse that they might receive from Mrs Heath in the attempt and because of her frequent and oppressive requests to be taken out to smoke²⁰.

¹⁸ Exhibit C14, page 100

¹⁹ Exhibit C14, page 101

²⁰ Transcript, pages 420-423

3.17. On 23 January 2008 it was noted in the progress notes that Mrs Heath had made a comment about not wanting to use an apron or a fire blanket whilst smoking. On the same day Ms Scragg had a conversation with Mr Heath about the matter. Unfortunately Ms Scragg's note of what was discussed is somewhat vague and truncated. It simply reads:

'Consulted ÷ son Bret about resident's risk with not wearing fire apron. Said he had discussed it with her already.'

This conversation was the subject of evidence that was given in the Inquest by Ms Scragg and Mr Heath. When asked in evidence to elaborate upon this conversation, Ms Scragg told me that Mr Heath implied that if his mother did not want to comply with a fire apron, then she should not have to do so. Ms Scragg suggested that Mr Heath was in the habit of saying words to the effect that it '*was Mum's way or no way*'²¹. Mr Heath in his evidence seemed unsure of the occasion on which he had spoken to Ms Scragg about the wearing of the protective apron, but conceded that it was possible that he did speak to her about that matter on 23 January 2008. Whenever the conversation was, he did not recall a discussion with Ms Scragg along the lines that she recorded above. In any case, Mr Heath told me that he had discussed with his mother the risk associated with her not wearing the protective apron. He said that he had told his mother that because of her smoking and especially because of her dropping cigarette ash onto herself, the blanket would protect both her and her clothing from burns and suggested that it would also protect her clothing from spilt coffee and the like. He told me that his mother was against using the protective apron. He believed that her reason was based on a desire simply to be obstructive, even though she could see the merit in it being worn. Mr Heath told me that he did not know whether she wore the protective apron when he was not there, but emphasised that he also thought that in any event she was never alone when she smoked. This was a belief that his sister also entertained²². Ms Norton told me that the first she knew that her mother was permitted to smoke alone and unsupervised was the night that her mother died.

3.18. Ms Scragg gave evidence in the Inquest in which she agreed that she had very little to do with the monitoring of whether or not Mrs Heath wore the protective apron after she had altered the care plan and had then spoken to both Ms Norton and Mr Heath

²¹ Transcript, page 423

²² Transcript, page 495

about the matter. She told me on her oath that she had received no reports of refusals on the part of Mrs Heath to wear the apron. She agreed that the issue simply went from her mind from January 2008 until the day Mrs Heath had her fatal accident²³. Ms Scragg also agreed that neither she, nor to her knowledge any other registered nurse, had initiated an assessment of Mrs Heath concerning how safely her smoking habits had been managed²⁴. In the same context she did acknowledge that she had observed Mrs Heath's physical abilities deteriorating since her admission to the facility. In this regard she believed that Mrs Heath had right-sided paralysis and that she had a missing digit on her left hand. She believed that she could still hold a cigarette²⁵. Importantly, Ms Scragg acknowledged that she understood that Mrs Heath had been permitted to smoke outside with no protective apron and no person present²⁶. She maintained that she had drawn Ms Christine Anderson's attention to that issue. She said that Ms Anderson was aware that Mrs Heath would be outside smoking without an apron. Later in cross-examination, Ms Scragg cast some doubt as to whether she genuinely recalled any such discussion with Ms Anderson. For her part Ms Anderson, who also gave evidence in the Inquest, agreed that Ms Scragg had told her that she had arranged for a fire apron to be made available for Mrs Heath to wear when she was smoking, although she was unsure whether she may have actually gleaned that from the daily nursing bulletin²⁷. Ms Anderson suggested that she may have realised that Mrs Heath was resisting wearing the apron and believed that Ms Scragg would speak to the family in an endeavour to enlist their support in respect of that issue. Ms Anderson was never alerted to any ongoing difficulty. Ms Anderson told me it was never brought to her attention that Mrs Heath was smoking alone²⁸. Another registered nurse, Ms Maria Van Der Wijngaart, acknowledged that Mrs Heath was habitually taken to the smoking area by a staff member and usually left there alone to smoke²⁹. The evidence as a whole satisfies me that the practice of leaving Mrs Heath alone to smoke outside was well understood at registered nurse level. There was a lack of insistence that carers administer an appropriate level of supervision in respect of Mrs Heath's smoking. That lax and unsafe practices were

²³ Transcript, pages 423-425

²⁴ Transcript, page 426

²⁵ Transcript, page 427

²⁶ Transcript, page 433

²⁷ Transcript, page 611

²⁸ Transcript, page 615

²⁹ Statement of Van Der Wijngaart, Exhibit C20, page 3

allowed to develop regarding Mrs Heath's smoking activities was unacceptable. I do not understand that the management of the facility would resile from that proposition.

- 3.19. Ms Anderson acknowledged that the simple usage of the word 'supervise' as described in the care plan was inadequate to convey the level of supervision that would have been required in respect of Mrs Heath's smoking towards the end of her life³⁰. Ms Anderson agreed that it was part of a resident's care to ensure that smoking was undertaken in a safe manner³¹. Ms Anderson agreed that the use of a smoking apron would not be a proper substitute for supervision³². Ms Anderson believed that the level of supervision required would involve being close enough to a resident such that the carer could intervene if something went wrong, for example if the resident dropped the cigarette³³. Ms Scragg acknowledged that in hindsight a higher level of supervision would have been appropriate³⁴. In this context she also agreed that it would have been better if the issue of supervision, as described in the care plan, had been highlighted and specifically identified as requiring one-on-one supervision³⁵.
- 3.20. In practice, ensuring Mrs Heath's safe smoking behaviour had not been free from difficulty. Mrs Heath proved to be very demanding of staff and there are instances recorded in her progress notes of her screaming at the top of her lungs to be taken out for a cigarette³⁶. Frequent instances of repeated demands to be taken outside for a cigarette and then to be brought back inside only for a very short time and then to demand to be taken out again are also recorded³⁷. There is also abuse recorded in connection with these demands³⁸. In this regard it will be remembered that Mrs Heath suffered from dementia. Having regard to the known frequency at which Mrs Heath needed to be taken outside for a cigarette and to her attitude towards staff and the obvious limitations on the ability of a busy staff to facilitate all of Mrs Heath's demands and to remain with her at all times while she smoked, it is difficult to say that the expectations of Ms Norton and Mr Heath that their mother would be smoking in the company of a carer at all times were wholly realistic. Nonetheless, Ms Norton and Mr Heath should have been kept informed of the true position in this regard.

³⁰ Transcript, page 615

³¹ Transcript, page 617

³² Transcript, page 623

³³ Transcript, page 623

³⁴ Transcript, page 446

³⁵ Transcript, page 447

³⁶ Transcript, page 274

³⁷ Transcript, page 275

³⁸ Transcript, page 275

- 3.21. Regardless of what her children may or may not have understood about their mother's smoking supervision, the fact of the matter is that staff of the facility did owe Mrs Heath a high level of care when she was smoking. Given the intractable nature of Mrs Heath's habit, it would have been unrealistic to expect Mrs Heath not to smoke at those times when neither of her children were present, and the obvious path of least resistance was to place no restrictions on her in that regard. Mrs Heath was allowed to smoke outside and it is evident that this was a dangerous practice that foreseeably could have, and did, end in tragedy. It may well be that by the end of Mrs Heath's life staff at the facility did not have the same level of understanding regarding Mrs Heath's difficulties with smoking as did Ms Norton and Mr Heath, but it was clear from as early as January of 2008 that the matter of Mrs Heath's safe smoking was a live issue to the point where it became a stipulated requirement that she wear a smoking apron. As well, if Mrs Heath had been consistently supervised at the appropriate level, namely one-on-one, it would have been obvious as it would have been to Mrs Heath's children that Mrs Heath was at risk of setting fire to herself if left alone.
- 3.22. The issue as to the wearing of a fire proof apron was the subject of much evidence during the Inquest. But to a large extent the argument about that obscured the main point. While a fire proof apron may have had some protective benefit, the point was that even if it was worn religiously it would have been a poor substitute for one-on-one supervision which in reality was the only means by which Mrs Heath's safety could be assured. It was recognised very early in the piece that Mrs Heath would require supervision when smoking. This was well documented. What failed to be addressed as Mrs Heath declined was the identification of the appropriate level of supervision, ensuring that it was consistently implemented and making Mrs Heath's children aware of what was happening and of the limitations that staffing levels imposed on facilitating Mrs Heath's demands.

4. The events of 21 October 2008

- 4.1. The fatal incident in which Mrs Heath suffered her burns occurred at the facility on Tuesday, 21 October 2008. She died of her burns later that day.
- 4.2. Mrs Heath was visited by her daughter, Ms Norton, that day. Ms Norton arrived at the facility when her mother was having her lunch. She noticed on this particular

occasion that her mother was very badly slumped to the right-hand side and she drew this to the attention of carers. Her mother was also dribbling. This was the first time that she had observed her mother doing this. It may well be that the dribbling was caused by her mother's posture. She also observed that her mother was unable to hold a cup of coffee straight and that Ms Norton needed to continually straighten the cup for her. Ms Norton said that she told Ms Scragg about her mother's condition that day and Ms Scragg in turn suggested to Ms Norton that perhaps her mother had suffered a mini stroke. Whether these specific concerns were indicated or not, it is certain that at the very least Ms Norton's impressions about her mother were drawn to Ms Scragg's attention because that afternoon Ms Scragg noted in Mrs Heath's progress notes the following:

'Kim (daughter) discussed resident's present health state as feels she has slowed down and leaning to side. Wants Dr Hoh contacted.'³⁹

Ms Norton had an expectation that Dr Hoh would be called as soon as possible. On the other hand, this expectation does not appear to have been registered by the facility staff. There was no sense of urgency brought to the task of getting Dr Hoh to see her and he was not asked to see her that day. It is not surprising that such a misunderstanding could have occurred. In any event, I do not doubt that on 21 October 2008 Mrs Heath was not particularly well. I accept the evidence of Ms Norton in this regard. Whether any such subtle deterioration was noted by staff who were later to deal with Mrs Heath is another matter entirely.

- 4.3. Ms Norton left the facility at about 3pm.
- 4.4. I was told in evidence that the first batch of evening meals was served at 5pm. The period leading up to the provision of the first batch of meals was a busy one for carers. Mrs Heath habitually wanted to go outside for a cigarette or cigarettes prior to her late afternoon meal. This day was no exception. She rang her communication bell sometime around 4:30pm. As a result two carers, Mr Adam Robinson and Ms Marietta Tripp, attended her room. It was necessary for two carers to attend because of the requirement that two carers assist in removing Mrs Heath from bed to wheelchair. As well, a mechanical lifter needed to be utilised.

³⁹ Exhibit C14, page128

- 4.5. Mr Robinson gave evidence in the Inquest. Mr Robinson's extraordinary duration in the witness box was, for the most part, caused by his inability or unwillingness to give a straight answer to a straight question. I found it difficult in reaching any firm conclusion as to whether Mr Robinson was completely truthful with the Court. I exercise caution in respect of any evidence that he gave that might disparage any other person.
- 4.6. Mr Robinson was an agency carer who, as I understood the evidence, had a relatively recent connection with the facility. Notwithstanding this, he told me that he had come to know Mrs Heath well and he was able to speak to her in what he termed as '*quite decent conversations*'⁴⁰. He knew that she was a smoker. He asserted that he was not aware of any level of dementia on Mrs Heath's part as she was not in a dementia specific unit. As far as smoking was concerned, he regarded the supervision that would be required for a dementia resident to consist of full supervision, involving a duty to remain with the person during smoking until they had finished. In respect of a non-dementia patient, he would regard the concept of supervision as being something less, namely to see them in a safe environment where they would not be doing any damage to themselves⁴¹. He would have placed Mrs Heath in that latter category. Mr Robinson pointed to the fact that Mrs Heath was allowed to retain her own cigarettes and lighter. From this he concluded that if she had been perceived as a dementia resident, these items would have been removed from her possession⁴². In short, Mr Robinson did not regard Mrs Heath as having any level of dementia that would have required a heightened regime of supervision while smoking.
- 4.7. In relation to the specific incident, Mr Robinson told me in evidence that he did not offer Mrs Heath the use of a fire apron. It is a fact that there was one in her room. Mr Robinson told me about a home-made fire apron that Mrs Heath in any event wore while smoking. I heard some other evidence about this. There was a garment that had been provided by Mrs Heath's children that went over Mrs Heath's lap. It was not really intended to provide protection against fire. In any event from its description, its properties of fire retardation would have left something to be desired and, in the event, it proved to be useless. When asked why he did not offer Mrs Heath the use of the smoking apron Mr Robinson said that his understanding was that she

⁴⁰ Transcript, page 211

⁴¹ Transcript, page 221

⁴² Transcript, page 225

had refused it previously. My view is that in truth on the occasion in question, it never occurred to Mr Robinson to do so.

- 4.8. As to Mr Robinson's perceptions of Mrs Heath as being demented or otherwise, her dementia was the subject of a well documented record. There was reference to it on the front page of Mrs Heath's care plan with which carers such as Mr Robinson would have been expected to have been familiar. When asked by counsel assisting what difference it may have made to him if he had known that Mrs Heath was a dementia affected resident, Mr Robinson said he would have stayed with her while she smoked and ensured that she wore the fire apron. Mr Robinson did not believe Mrs Heath was particularly unwell on this occasion. He told me that she seemed quite bright and alert⁴³.
- 4.9. Ms Tripp, who had worked at the facility for over 10 years, said in evidence that her personal relationship with Mrs Heath was good. She said '*we were really good friends*'⁴⁴. Notwithstanding this, Ms Tripp told me that she had never had occasion to take Mrs Heath out for a cigarette and so she did not really have any knowledge of Mrs Heath's ability to light her own cigarettes and generally deal with them. She knew that Mrs Heath had a smoking apron in her room as she had seen it hanging over the back of a chair. She agreed that she and Mr Robinson were the two carers who attended to Mrs Heath when she wanted to go out for a cigarette before the 5pm meal on the day in question. To Ms Tripp, Mrs Heath did not seem unwell. She did not notice whether Mrs Heath had been slumping to either side or dribbling. When asked as to whether the smoking apron had been offered to Mrs Heath on this occasion, she said that she did not know if Mr Robinson had asked her when he was taking her outside. She said it is usual for the person who takes the smoker outside to offer the smoking apron. I took this to be a 'no' answer on her part as to whether or not she herself had so offered. She said that Mr Robinson had remained at all times in the room while they prepared Mrs Heath to go outside. For his part Mr Robinson denied this and said that he was absent at some point, his implication being that Mrs Heath may well have been offered the use of the apron whilst he was absent. Mr Robinson's evidence was unconvincing in relation to this issue. More than once in her evidence Ms Tripp suggested that she would not have known about any offer of the smoking apron because it would have been Mr Robinson's task to attend to that.

⁴³ Transcript, page 250

⁴⁴ Transcript, page 570

My impression of Ms Tripp's evidence is that it did not occur to her to offer the apron.

- 4.10. The evidence about whether anyone asked Mrs Heath to put the apron on was unsatisfactory. I am satisfied, however, that neither Mr Robinson nor Ms Tripp offered her the smoking apron. Of greater concern, however, was whether Mrs Heath ought to have been accompanied while she smoked on this occasion. Mr Robinson took her outside and left her there alone. This appears to have been nothing out of the ordinary for Mrs Heath. Mrs Heath's only realistic means of communication from that point would have been the bell button that was connected to a locality within Ruth Eaton House. Mr Robinson lit Mrs Heath's cigarette. When asked as to why he did that himself, his definitive answer was:

'Because she only had the use of one arm, one hand.'⁴⁵

It is obvious that Mr Robinson left Mrs Heath with the packet of cigarettes and the lighter. When asked by counsel assisting as to what supervision he imposed after he left Mrs Heath smoking, Mr Robinson told me that he 'would have' been checking on Mrs Heath from some of the facility rooms and also from a room known as the 'blue lounge'. He told me that he was in the vicinity of or in the blue lounge when he noticed that Mrs Heath was ablaze. Mr Robinson suggested that having left Mrs Heath with her cigarette, the time that had elapsed between that and his noticing that Mrs Heath was ablaze was 10 minutes maximum. He said that in the first couple of those minutes he probably sighted Mrs Heath '*once or twice*'⁴⁶. He acknowledged that there was then a gap of 8 minutes in which he had no visual contact with her. There is no evidence that any other person had visual contact with Mrs Heath during this time. To my mind there was simply no measure of supervision of Mrs Heath's smoking on this particular occasion. The lack of scrutiny was a clear contributing factor in her death. Although it appears that neither Mr Robinson nor Ms Tripp themselves detected anything unusual about Mrs Heath on the afternoon in question, it would have been far better if at the handover that had taken place earlier that afternoon, carers had been made aware of any concerns that had been expressed during the day about Mrs Heath's wellbeing, whatever the nature of that information had been and from whatever source.

⁴⁵ Transcript, page 269

⁴⁶ Transcript, page 247

- 4.11. I do not need to recite in any detail the evidence of what transpired when Mrs Heath was found to be ablaze. It is clear that by whatever means, Mrs Heath accidentally set fire to herself in the process of smoking. The evidence satisfies me, and no-one suggested anything to the contrary, that all necessary assistance was brought to bear by staff when Mrs Heath was detected in extremis. It is apparent that many of the facility's staff members who witnessed the incident were traumatised as a result.
- 4.12. Mrs Heath was transported by ambulance to the Lyell McEwen Hospital where it was assessed that she had sustained 55% full thickness burns to the body with severe facial burns, 4th degree burns to both hands and severe airway burns. The injuries were deemed to be non-survivable and she died at 7:50pm that evening. The extent of Mrs Heath's injuries should bring home to carers the devastating nature of injuries that can be caused in the process of smoking a cigarette.

5. Recommendations

- 5.1. 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.
- 5.2. A body of evidence was placed before the Court concerning measures that have been taken within the facility that were designed to address the risk connected with smoking by residents. I need not go into this evidence in any great detail. The most significant change as far as Helping Hand Aged Care is concerned, relates to the level of supervision required when a resident needs to smoke. Ms Anderson explained that staff are required to remain close enough to the resident that they can intervene should something go wrong, for example if they drop a cigarette. Staff are required to remain with the person throughout the smoking activity until the cigarette is butted out or the resident is taken back to wherever the resident wants to go. Cigarettes are not permitted to be kept in a resident's possession. There are other requirements regarding smoking aprons. As it transpires, at the time of the Inquest there was only one smoker resident in the facility.
- 5.3. Ms Anderson also explained a change designed to ensure that alterations to care plans are effectively drawn to the attention of staff. I note that such a measure would address the difficulty experienced in this case of carers not being aware of the actual

level of dementia suffered by a particular patient. It would also address the need for staff, and carers in particular, to be aware of ongoing deterioration in a resident and of the effect that such deterioration may have on motor skills.

- 5.4. I note that no-one has suggested that smoking ought to be banned in aged care facilities across the board.
- 5.5. The affidavit of Ms Tracey Klose⁴⁷, who is the Care Services Manager for Helping Hand Aged Care Metro division, states that a 'smoking risk assessment' measure has been developed across the entire organisation to assist with identifying risks in relation to a resident smoking. A special form has been devised by Helping Hand Aged Care⁴⁸. The form is devoted entirely to the question of the ability of a resident to smoke safely. All residents choosing to smoke must have a smoking risk assessment completed. I take it that this is so regardless of any level of impairment or cognitive deficit. The effectiveness of the risk management strategies identified for a particular resident must be evaluated at each care plan review or as required. The form that is the basis for the smoking risk assessment addresses such matters as observation of cigarette burns in clothing, singed fingers and other indicia of risk. It also addresses 'near misses' resulting from smoking. It also addresses the question of the identification of the disabilities that might be relevant to safe or unsafe smoking practices, including the ability to safely light, hold, control and dispose of a cigarette. In particular it addresses cognitive disabilities that might be relevant including forgetfulness, lack of sense of smell, dementia and depression. Importantly, it also addresses the level of the resident's own awareness of the risk to themselves from smoking. I would add that such a risk assessment would naturally need to be ongoing, having regard to the fact that change in abilities in the elderly can be subtle.
- 5.6. May I say here that the management of the facility, represented by Mr Roder SC of senior counsel, conducted itself with complete candour during the Inquest.
- 5.7. I have considered whether it is appropriate to add to the recommendations and observations that I made at the conclusion of this Inquest as set out in paragraph 1.2 herein. Ms Eszenyi, counsel for Ms Norton and Mr Heath, suggested that a number of recommendations would appropriately be made by this Court. The first such

⁴⁷ Exhibit C29

⁴⁸ Exhibit TK7 to the Affidavit of Tracey Klose

recommendation concerned supervision of residents while smoking. I have already made a recommendation in respect of that issue.

5.8. Ms Eszenyi made other suggestions for recommendation for change. I am persuaded that some of Ms Eszenyi's suggested recommendations would be appropriate.

5.9. Accordingly, I make the following recommendations:

- 1) I repeat the recommendation that I made at the conclusion of the Inquest, namely, that any facility that chooses to permit its residents to smoke on the premises should ensure that in the case of each individual smoker the risk of harm to the resident, having regard to the level of dementia, the loss of manual dexterity of the resident and other matters relevant to the ability of the resident to smoke safely, and thus the need for and level of supervision, is properly assessed. Such an assessment should take place on an ongoing basis having regard to the possibility of deterioration in the level of cognitive ability and dexterity of the individual over time. All staff responsible for care and their supervisor should be made aware of such an assessment;
- 2) That in any circumstance in which the safety of the smoking activity of a resident in an aged care facility becomes problematic, that procedures be put in place within the facility to ensure that any decision made or practice that is maintained within the facility regarding that resident's habit of smoking, is made known to, discussed with and approved by the resident's representatives and/or family;
- 3) That in formulating or altering any resident's care plan, the involvement of the resident him or herself and/or their respective representatives and/or family members, should be secured;
- 4) That aged care facilities create procedures whereby concerns about the wellbeing of residents, as raised by visiting family members, are properly documented at the time and that the concerned family member is given the opportunity to read and acknowledge what is in fact documented;
- 5) That within aged care facilities carers, including agency staff, be required to attend handovers of shifts of staff, or participate in other briefings, in order to familiarise themselves with any adverse issues concerning the current wellbeing of a resident in their care.

6) That within aged care facilities it be a mandatory practice for all carers to acknowledge in writing the fact that they have read changes to the care plan of a resident, especially changes that may be relevant to the safety of a resident.

5.9. I direct that a copy of these findings and recommendations be furnished to the relevant Commonwealth and State aged care authorities for dissemination to all aged care facilities.

Key Words: Aged Care; Smoking; Risk

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

Seal the 18th day of March, 2011.

Deputy State Coroner