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 14th and 15th days of August 2013 and the 5th day of September 2013, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Ruth Ann Dicker.

The said Court finds that Ruth Ann Dicker aged 83 years, late of Holly Residential Care Centre, 16 Pennys Hill Road, Hackham, South Australia died at Hackham, South Australia on the 10th day of July 2011 as a result of attributed to neck compression from a wheelchair restraint strap. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Ruth Ann Dicker died on 10 July 2011 in the Holly Residential Care Centre at Hackham where she was a resident. A post-mortem examination was conducted by Dr Karen Heath, forensic pathologist. Dr Heath gave the cause of death as attributed to neck compression from a wheelchair restraint strap[1], and I so find.

2. Background

2.1. Mrs Dicker's medical history included epilepsy which was a longstanding condition she had suffered from for most of her life, Parkinson's disease and dementia which she had been experiencing since approximately 2005. Mrs Dicker entered the Holly Residential Care Centre (Holly) in February 2007. At that time it was known by a different name that is not now relevant.

[1] Exhibit C16

2.2. Mrs Dicker had an extensive history of falls during her time at Holly. Ms Durant, the Care Services Manager at Holly and Ms Muller, the Residential Site Manager, both gave evidence that Mrs Dicker was more prone to falling than any other resident they had known. This is significant as it is well known that many nursing home residents are prone to falling. For Mrs Dicker to stand out in that regard is notable.

2.3. Her history of falls is well documented in her Holly records[2]. Exhibit C15 contains at pages 82 and 84 a list of incidents of falling which demonstrates this phenomenon quite clearly.

2.4. Both Ms Durant and Ms Muller have primary qualifications as registered nurses. Ms Durant is now the Care Services Manager and it is her task to oversee residents' complex care needs, to supervise staff and to liaise with families. She also investigates incident reports. She was extremely familiar with Mrs Dicker's history and it was plain from her evidence that she knew Mrs Dicker personally very well. Ms Muller is the Residential Site Manager and has the general oversight of the entire facility which accommodates 140 residents. She too was clearly familiar with Mrs Dicker and her history of falls and it was plain from her evidence that she had a personal knowledge of Mrs Dicker.

2.5. Both Ms Durant and Ms Muller were impressive witnesses. They showed compassion and sincerity in the way they gave their evidence. They both clearly knew Mrs Dicker very well, and had taken a genuine interest in her welfare above and beyond what might have been strictly required. Ms Durant in particular was clearly affected by Mrs Dicker's death. I have no hesitation in accepting the evidence of both of these witnesses.

3. <u>The circumstances surrounding Mrs Dicker's death</u>

3.1. The circumstances of Mrs Dicker's death were very distressing. As will be apparent from the cause of death given by Dr Heath, Mrs Dicker died as a result of the compression of her neck by the lap belt of the wheelchair in which she was sitting. She had somehow moved downwards in the chair in such a manner that the lap belt was no longer around her lap, but under her chin. The first person to see her in that

[2] Exhibits C13, C14 and C15

position was Mr Jarrod Mudie who is a personal carer at Holly. He commenced his medication round at approximately 4:15pm on Sunday 10 July 2011. At approximately 4:25pm he entered Mrs Dicker's room. He gave the following description of what he saw:

> 'On entering I saw Ruth sitting on the floor with her legs straight out in front of her, her back was straight and her head was resting on the seat of the wheelchair. Her back was leaning against it. It looked to me like she had slipped out of her wheelchair onto her bum. I walked around so I was in front of her to see her face. It was now that I saw the seatbelt of the wheelchair was around her throat. It was tight against her throat with her head hanging forward slightly. It looked like the seatbelt was strangling her quite tight, it had no slack in it. Her lip and lower jaw looked blue in colour. I immediately thought she was deceased.' [3]

3.2. Mr Mudie proceeded to alert other staff including Ms Durant who was on duty that day in her capacity as a registered nurse.

3.3. For her part Ms Durant said that she was informed by enrolled nurse Darren Cooper and Jarrod Mudie that she was needed urgently. They went to Mrs Dicker's room. The door was closed and Ms Durant opened it. She said that Mrs Dicker was in an unusual position. She was low in the wheelchair and the lap belt was in the chin or neck area of Mrs Dicker. Ms Durant went to release the belt. She said that she reacted automatically for the purpose of preserving life, even though it was apparent to her that it was probably too late. She said that the clasp for the lap belt was at the back of the wheelchair and when she released it there was definitely some movement of Mrs Dicker's body. She described it as a forward movement or a movement further down the chair[4]. She said that the body went further down the chair and the chair itself went slightly backwards[5]. The brake of the wheelchair was not activated. Ms Durant said that Mrs Dicker's tongue was protruding slightly.

3.4. Dr Heath gave evidence that she reached her conclusion that Mrs Dicker died as a result of neck compression from the restraining lap of her wheelchair on the basis of the anatomical evidence and the circumstances in which Mrs Dicker was found. Dr Heath said that at autopsy she noted petechial haemorrhages present on the forehead,

---

[3] Exhibit C7a
[4] Transcript, page 99
[5] Transcript, page 100

conjunctiva, upper and lower eyelids and both cheeks[6]. She said that petechial haemorrhages can be seen in asphyxial deaths. Given the absence of any other significant natural disease which could have caused death, and given the circumstances in which Mrs Dicker was found slumped in her wheelchair with the restraint strap positioned around her neck, Dr Heath was of the opinion that death was due to asphyxia from the wheelchair strap. Dr Heath acknowledged the possibility that Mrs Dicker may have experienced a seizure causing her to slump in the wheelchair[7], or fallen asleep causing the same outcome. She said that it was also possible that Mrs Dicker was trying to extricate herself from the wheelchair and became entangled with the strap around her neck in the process. Dr Heath said that the possibility that Mrs Dicker deliberately positioned the strap of the wheelchair around her neck could not be excluded either.

3.5. The last reported sighting of Mrs Dicker was by personal carer, Kym Leane, between approximately 2:20pm and 2:45pm[8]. Prior to that Ms Durant had seen Mrs Dicker at approximately 2:15pm when she had entered her room and put a Frank Sinatra CD on her CD player. Ms Durant said that Mrs Dicker enjoyed listening to Frank Sinatra.

3.6. Ms Gunilla Lindblom is a personal carer employed at Holly[9]. She gave evidence at the Inquest. She said that she was on duty on 10 July 2011 and saw Mrs Dicker just before 12pm. Ms Lindblom saw that Mrs Dicker was in her room in her wheelchair. She had no top on apart from her bra and her lap belt was loose on the wheelchair. Ms Lindblom put a top on Mrs Dicker and adjusted her lap belt so that it was firm but not digging into Mrs Dicker's body. She then took Mrs Dicker to the dining room for her lunch. At the end of lunch Mrs Dicker was very tired and was slumped forward in the wheelchair. Ms Lindblom took her back to her room and assisted Mrs Dicker to the toilet. Ms Lindblom then assisted Mrs Dicker back to her wheelchair. Ms Lindblom clasped the buckle of the lap belt at the rear of the wheelchair but then noted that Mrs Dicker's arm was trapped in the belt. Ms Lindblom freed Mrs Dicker's arm and readjusted the belt. She said it was firm but not digging into Mrs Dicker's body.

---

[6] Exhibit C16
[7] Exhibit C16, page 2 and Transcript, page 14
[8] Exhibit C6a
[9] Exhibit C17

3.7. The evidence contained in Mrs Dicker's records shows that there had been at least one earlier episode in which she was found off the wheelchair with her back against it. That incident refers to the seatbelt as being around her arm. It is not possible to tell from the record whether the seatbelt was still clasped and was sufficiently loose to have wound around her arm or whether it had become unclasped. Given that the sash was meant to be clasped with the clasp behind the back of the wheelchair so that Mrs Dicker was unable to free herself using the clasp, it would seem more likely than not that the clasp was still secured. With the clasp in a secured position, the sash comprised a complete circle making it, effectively, a ligature. It was in this condition that the sash was found when Mrs Dicker was found deceased.

3.8. I should say something about the evidence concerning time of death. Dr Heath was unable to give any opinion on that subject. She did say that death from neck compression can occur in as short a time as 5 minutes, and that 15 minutes would be the approximate maximum time for the process of death to take place. Therefore Mrs Dicker could have died sometime after approximately 3pm (being 15 minutes after Kym Leane's latest reported sighting) and 4:25pm when she was found by Mr Mudie. She may have become entangled in the lap sash belt as late as 4:20pm. There is no basis for finding that she was neglected or alone for an excessive period of time before being found.

4. <u>Conclusions</u>

4.1. I find that there had been at least one previous occasion when Holly, through its staff, should have been able to anticipate that Mrs Dicker might become entangled in the sash when manoeuvring out of the wheelchair by lowering herself.

4.2. Having said that, it is clear from the evidence that Holly and its staff had exhausted all other opportunities to avoid the use of the lap sash restraint on Mrs Dicker. It had employed a concave mattress on her bed, it had employed a sensor mat by her bed, it had placed her bed against the wall and it had employed hip protectors. The restraint was only applied in the end and with the agreement and consent of Mrs Dicker's next of kin and with the agreement of her general practitioner.

4.3. In general, Mrs Dicker's notes show that her care was to a high standard. Medical intervention was sought on all appropriate occasions. For example, Mrs Dicker had a chronically dislocated shoulder for which appropriate general practitioner and specialist orthopaedic opinion was obtained with a view to treatment. The staff were astute to Mrs Dicker's neurological needs with regards to her Parkinson's disorder. Furthermore, as I have said earlier, Ms Durant and Ms Muller were clearly caring and considerate carers for Mrs Dicker and no doubt for all other residents at Holly.

4.4. Holly was in a difficult position with Mrs Dicker. Sadly, in our aged care system these conditions are not uncommon. While Mrs Dicker's death occurred in disturbing circumstances and while it should have been possible from at least one past event to have predicted that there was some risk of entanglement arising from the use of the lap sash belt, it would be unduly harsh to suggest that Holly should have foreseen that the use of the belt may have resulted in Mrs Dicker's death. I do not overlook the fact that the lap sash belt was not attached to the wheelchair in anyway, and it was the expectation at least of Ms Muller that it would have been. Nevertheless it seems that the risk of the occurrence that led to Mrs Dicker's death would not necessarily have been removed merely by the step of anchoring the sash to the wheelchair itself. I do not consider it necessary to consider that issue further.

4.5. Before leaving this matter, I would like to acknowledge the excellent investigation carried out by Detective Brevet Sergeant Douglas McPherson in this matter. His report[10] was extremely thorough and helpful. I commend his work in identifying alternatives to the lap belt which would represent a safer means of restraint, namely the full pelvic support and the shoulder support methods[11]. Detective Brevet Sergeant McPherson is also to be commended for conducting research in which he identified other instances in other jurisdictions of similar events. I quote from his report:

> 'In April of 2002 at the Hamilton Rehabilitation and Health Care Centre in Norwich, Connecticut (USA) an 82 year old woman slipped won in her wheelchair and choked to death on her lap belt. The death prompted the Department of Social Services (USA) to produce a pamphlet on patient restraints. The Department also stated they discourage the

[10] Exhibit C11b
[11] Exhibit C11b, page 15

use of restraints, but know it is necessary in certain circumstances to restrain residents due to medical conditions.

In October 2005 at a Bupa Care Home in Birmingham UK one of its residents was accidentally strangled by the seatbelt of her wheelchair. Resident Brigid O'Callaghan, 74, died in the accident. A hearing was told how Mrs O'Callaghan had refused help getting into bed and slipped from her wheelchair, causing the lap belt to wrap around her neck.' [12]

4.6. I commend Detective Brevet Sergeant McPherson for his investigation in this matter.

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. I recommend that the Federal Department of Health and Ageing issue a warning to all aged care facilities to note the risks inherent in the use of lap sash seatbelts. In my opinion their use should be discouraged. There are other, better methods for securing people in wheelchairs and these should be drawn to the attention of aged care facilities.

Key Words: Restraint; Nursing Home

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

Seal the 5th day of September, 2013.

State Coroner

Inquest Number 22/2013 (1088/2011)

[12] Note the references provided by Detective Brevet Sergeant McPherson at Exhibit C11b, pages17 and 18

www.bbc.co.uk/news/uk-england-birmingham-12225802
www.thefreelibrary.com/Pensioner+neglected%3B+INQUEST%3A+Patient +died+in+wheelchair.-a0173265642