



STATE

CORONER

VICTORIA

9th May, 2002
Case No: 3753/00

RECORD OF INVESTIGATION INTO DEATH

I, LEWIS PHILLIP BYRNE, Coroner,

having investigated the death of NORMAN ANDERSON with Inquest held at Coronial Services Centre, Southbank on the 9th and 30th May, 2002

find that the identity of the deceased was NORMAN ANDERSON and that the death occurred on the 14th November, 2000 at Toorak House Nursing Home, 1011 Toorak Road Camberwell from traumatic asphyxia in a man with coronary artery atherosclerosis

in the following circumstances:

The deceased Mr. Norman Anderson, an 83 year old gentleman, took up residence at Toorak House a residential aged care facility in about October 1998. Toorak House is a high care facility.

Mr. Anderson's health had deteriorated in the years leading to his death in November 2000. He suffered from Alzheimers disease, Parkinsons disease and dementia. Mr. Anderson was often confused, agitated and extremely restless. In spite of his ailments Mr. Anderson was very active and very obviously a high care resident.

He had suffered a number of falls and had little insight as to his physical limitations. When he first took up residence at Toorak House he was suffering the effects of a broken shoulder, having had a fall at his previous placement. In May 1999, some seven months after entering Toorak House another fall resulted in a broken neck of femur.

It was obvious early in the piece that for his own safety Mr. Anderson would require restraint and in consultation with his family, a restraint authorization was completed for use of, among other things, cot sides at night. After the initial assessment of a need for "restraint", Mr. Anderson was reevaluated as to a need for restraint in December 1998, February 1999, August 1999, October 1999, January 2000, June 2000 and July 2000

Furthermore, in compliance with an expectation of the Aged Care Standards Agency that restraint of residents be (apparently for philosophical reasons) at the least intrusive level necessary to ensure patient welfare, a further assessment was undertaken between 10-15 April 2000.

The assessment concluded:

"Trialled for 1 week without bed rails. Not successful due to restlessness and complete lack of insight into his condition. Norman was at great risk of falling out of bed therefore continued to use bed rails whilst resting in bed".

This trial clearly established, Mr. Anderson continued to need bed rail restraint to ensure his safety.

On 28 August 2000, Mr. Anderson rolled off his mattress into the webbing of the cotside. He was extricated and repositioned in bed without apparent harm.

Overnight on 13 November to 14 November 2000 Mr. Anderson was regularly observed by night shift nurses to be correctly positioned in bed, apparently asleep. In fact, at approximately 3am, Nurse Joanne Hunter attended Mr. Anderson, changed his pad and repositioned him. At 6.15am approximately, Nurse Hunter observed Mr. Anderson in bed in the correct position apparently asleep. That was the last time he was seen alive.

At handover from night shift to day shift at 7am all residents were apparently safe and well. At approximately 7.45am Mr. Anderson was located by Nurse Assistant Fiona Davis entrapped in the mesh/webbing of the cotside face down with his head protruding over the end of the mesh. Photograph 3 graphically depicts the scene that confronted Miss Davis.

Miss Kate Kofoed, the nurse in charge at the time attended Mr. Anderson's room observed the deceased and concluded he was dead. In fact, as appeared, Mr. Anderson had asphyxiated.

In spite of his death between 6.15am and 7.45am on 14th November, I conclude Mr. Anderson was adequately and reasonably checked and monitored by staff on 13th and 14th November 2000 - the reality is that residents can't be continually monitored. That would not be feasible or reasonable. I am further satisfied that staff numbers on the relevant shifts were adequate.

The cotsides utilized on Mr. Anderson's bed, involved in his death, were webbed/mesh cotsides manufactured by Siltex (Australia) Pty Ltd known as "Disappearing Cotsides".

When Blue Cross Community Care Services Group took over the facility from his previous owners it had been placed in a "*facility of risk*" category due to non-compliance / or at least inadequate compliance with relevant standards. Within three months of Blue Cross taking over the facility a review resulted in the "facility of risk" category being revoked.

Again in August 1999 a further review was undertaken by the Commonwealth Department of Health and Family Services, the body responsible for the establishment and maintenance of appropriate standards. Following the introduction of a new system of accreditation, yet a further review was undertaken by The Age Care Standard Agency on 22-23 June 2000. A letter from the agency dated 9th August 2000 advised Blue Cross its application for accreditation had been successful and accreditation was granted for a 3 year period. This advice is accompanied by a copy of the Site Audit Report.

One of the standards that have to be met to obtain accreditation is Physical Environment and Safe Systems. The assessors rated Toorak House compliance with the standard as "satisfactory" as to each of the 8 subcategories of the standard. Somewhat ironically, the assessors commented at 4.4 of the Site Audit Report :

"The services efforts to reduce restraint is noteworthy. Planned purchase of hi-low beds may further reduce the need for restraint".

When Blue Cross took over the operation of Toorak House it "inherited" both what have been described as "metallic cotsides" and "mesh cotside". The "mesh cotsides" the subject of this coronial enquiry (and as will be discussed, several other coronial enquiries) were called "Disappearing cotsides" manufactured by Siltex (Australia) Pty Ltd.

Mr. Daniel Jonas, the Managing Director of Siltex (Australia) Pty Ltd, advised the disappearing cotsides were designed by his late father and first manufactured in about 1982. It would appear the product was not, and apparently still is not subject to an Australian Standard. As I understand, the position restraints (such as "Disappearing Cotsides") are considered "therapeutic devices" under the Therapeutic Goods Act 1989 (Commonwealth), but are exempt from listing.

It would therefore appear the product was never the subject of thorough, comprehensive, independent assessment before it went on the market in the early 1980's.

In answer to a question from me, a question put because I was not sure precisely what these mesh/webbing cotsides were designed to achieve, Mr. Jonas indicated, as I understood him, they were not so much to prevent a person falling off a mattress, but to in effect catch that person in a webbed cradle to prevent the person crashing to the floor beside the bed.

As to the fitting of cotsides, in evidence before me, Mr. Jonas produced a document titled Fitting and Maintenance Instructions. The key first instruction is -

"Clamp each cot side squarely onto frame of bed ensuring that both clamps fit tightly against frame. The cotsides should be placed as close as possible to the head end of the bed."

In evidence Mr. Jonas said the purpose of fitting the cotside as close as possible to the head end of the bed was to

"...avoid the possibility of any part of the upper body of a patient protruding into or through any space between the bed head and the head end of the cotside".

Other than at this inquest the only other comprehensive assessment of the mesh/webbing cotsides undertaken seems to have been undertaken in South Australia, I presume as a result of the death in 1996 of Hayden McFadyen, a 4 year old child with severe disabilities that rendered him virtually defenseless.

The death of Hayden McFadyen was the subject of a formal inquest in Adelaide in February 1998 before Coroner Wayne Chivell. I wish to include in this finding some observation made by Mr. Chivell and others at that inquest. Dr. R.W. Byard Pathologist of the Womens and Childrens Hospital in his autopsy report commented:-

"No traumatic lesions were found at autopsy. Although four years is rather old for a wedging death, Hayden's significant mental retardation and lack of mobility would certainly have contributed to this. Of concern is the arrangement of distensible mesh at the side of the bed. Given the potential of entrapment, it may be appropriate for a product safety expert to assess the device. No safety instruction were visible on the plastic mesh".

It would appear Dr. Byard's suggestion was acted upon, because at the inquest into the death of Hayden McFadyen evidence was given by Mr. P. Thompson the Senior Project Officer with the Injury Surveillance and Control Unit of the South Australian Health Commission. Mr. Thompson said

"Because the vertical support frames of the apparatus are nearly as far apart as the bed is long, and in the absence of any intermediary

supports, the mesh when erected is capable of considerable lateral displacement. Worse still the mesh is provided on a spring loaded roller which can be further extended by the weight of a child's head or neck between the mesh and the side of the bed and/or the mattress could be not only entrapped, but effectively 'clamped'.

Coroner Chivell stated-

"I agree with Mr. Thompson that, when used in the circumstances currently under consideration, in relation to infants or small children with disabilities which prevent them from rescuing themselves from trapping spaces, the use of equipment such as Siltex retractable mesh cotside is hazardous. I note the decision of the South Australia Health Commission to direct that use of such equipment be discontinued in these circumstances."

The coroner further added-

"The information before me is insufficient in my opinion to justify a recommendation that the use of such equipment be banned altogether. It seems to me that when used in relation to adults or larger children for example such equipment may be safe".

Mr. Saccardo, acting for Siltex (Australia) Pty Ltd, in this inquest suggested this was an endorsement of the product by Mr. Chivell as it applied to adults. On a careful reading of the Coroner's comments, I do not, with respect, see it that way. At best, the Coroner says it may be safe (my emphasis). Furthermore, in my view, individuals like Mr. Anderson (and indeed Mr. Grace) are in many ways in a similar situation to disabled children in that their disabilities may also prevent them from rescuing themselves from trapping spaces.

The only other observation I make about the Hayden McFadyen inquest is that the South Australian Health Commission directed that the "use of such equipment be discontinued in these circumstances". I take that to mean in respect of the children, although that is not altogether clear.

Mr. Jonas, in evidence, advised that production of the Siltex "Disappearing cotsides" ceased in 1998. However he claimed that was due, not to concerns about the safety of the cotsides, but due to the company redirecting its attention to other projects. Mr. Jonas maintained he was not directly advised the design of the product was such that it was potentially hazardous. He says he was aware in general terms there were some concerns raised in S.A., but he maintains he personally had no reservations about the safety of the product due to its widespread successful use in many institutions such as St. Nicholas and other facilities (with the exception of Hayden McFadyen) without incident.

When I first perused this inquest file I became aware of the death of another person in similar circumstances; a Mr. Richard Grace. Mr. Grace was referred to in the Victoria

Police Form 83 Report of Death and the Post Mortem Examination Report of Dr. David Ranson. Towards the end of the brief was a copy of a chamber finding into the death of Mr. Grace made by Mr. Frank Hender, Coroner, on 4th October 2001.

I subsequently read the comprehensive statement, dated 1st of March 2001 provided by Ms. Lois Lindsay the Executive Director of Nursing of Blue Cross Community Care Services group. I then perused a photocopy photograph of the body of Mr. Anderson in situ. Those copy photographs were not particularly clear. I then called for the "Grace file" and sought original photographs related to both deaths.

The initial impact on me of the original photographs (especially photos 4 and 18) showing Mr. Grace in situ was dramatic, quite frankly I was horrified. I double checked the dates, 23rd of August 2000 Mr. Grace's death and 14th of November 2000, Mr. Anderson's death. I again checked the venue of both deaths and thought to myself how could this possibly happen!

At this inquest two entities were represented by counsel - Mr. Saccardo for Siltex (Australia) Pty Ltd, the manufacturer of the cotsides used on Mr. Anderson's bed and Mr. Noonan for Blue Cross Community Care Services Group, the operator of the nursing home in which Mr. Anderson died, Toorak House.

I propose now to consider whether criticisms/adverse findings should be made against either of these entities.

As I write this finding , I have had the opportunity to consider all the material in the brief, the opportunity of examining in detail the Grace file and even more importantly the benefit of hearing a full day inquest and of course the benefit of submissions from Mr. Noonan for Blue Cross, Mr. Saccardo for Siltex (Australia) Pty Ltd and Miss Nolan assisting.

Blue Cross Operators of Toorak House :

Mr. Noonan, of counsel, submitted no criticism of the operators of Toorak House should be made because they acted reasonably and prudently in not removing the cotsides until after the death of Mr. Anderson. He submitted it is only with the benefit of hindsight that the potential hazard in their continued use is obvious. He submitted management did not perceive a risk, nor should they have perceived such a risk. It is in the context of considering whether an adverse finding can properly be made against Blue Cross that the death of Mr. Richard Grace becomes not only relevant, but important. In short, Mr. Grace also a resident at Toorak House, died on 23 August 2000 from mechanical asphyxia when he fell from his mattress and became entrapped between the upright supporting the webbing/mesh of the cotside and the bed/mattress.

In considering whether adverse findings can properly be made against Blue Cross the operators of Toorak House, responsible for the care of Mr. Anderson, I remind myself first blush initial impressions cease to be relevant. I have to go through the events sequentially,

step by step, and consider what position a party should (or should not) have taken depending on their knowledge and understanding of events as they unfolded.

The question whether the Disappearing Cotsides were correctly fitted has caused me some concern. Mr. Jonas said it was imperative they be placed as near as practicable to the head of the bed. However, he said, as I understood him, that he could not say, looking at the photographs, that the cotsides were incorrectly positioned.

In spite of the position in which Mr. Anderson was found, I can not say, on the evidence, to the appropriate level of satisfaction, that the cotsides were incorrectly positioned.

If management knew, or should have known, the cotsides were hazardous and failed to remove them, that would represent a fundamental breach of care to residents, including Mr. Anderson, and would therefore warrant criticism. I turn to this difficult issue.

The evidence establishes Mr. Grace apparently rolled off his mattress and became entrapped in the mesh/webbing on the 19th of August 2000. He apparently suffered no ill effect and was extricated by staff.

At his point I return to the question of what is the precise function of the Disappearing Cotsides? Mr. Jonas told me the function is to prevent patients who fall from their beds crashing to the floor. In response to a direct question from me he said the mesh or webbing is designed to in effect "cradle" a person who has fallen off the mattress. As I understood him, and I think the design and the material from which the cotside is manufactured support my understanding, the cotside is not designed to prevent a patient rolling off the mattress. If that were its purpose the cotside would need to be far less flexible.

As the cotside prevented Mr. Grace falling to the floor on the 19th of August, it can be reasonably argued the cotside, on that occasion, served the purpose for which was designed and it was not a "near miss".

On the 23rd of August 2000 Mr. Grace again rolled off his mattress and fell into the mesh webbing. On this occasion however, his head became stuck between the upright nearest the head of the bed and the mattress and he died due to mechanical asphyxiation.

It must be borne firmly in mind, I am not holding an inquest into the death of Mr. Grace, the circumstances surrounding his death are relevant to my inquiry only as they relate to the death of Mr. Anderson. Having said that I can't help but conclude it may have been preferable, especially from the point of view of what recommendations (if any) should be made, if inquests into both deaths had been heard together.

What Blue Cross management made of the death of Mr. Grace is critical to the issue of the reasonableness of the position they adopted thereafter.

Ms. Lois Lindsay, the Executive Director of Nursing for Blue Cross in evidence maintains that the cause of Mr. Grace's death was not clear. She claims it was thought the death may

have been due to a stroke or epilepsy, Mr. Grace having suffered at least two previous strokes. Ms. Lindsay said she was awaiting a definitive answer being provided by post mortem examination. She further says her then Director of Nursing, Joan Hargen, made enquiries of the State Coroner's Office but was unable to obtain an autopsy result. It is unclear when these enquiries were made. However, it was in December 2000, after the death of Mr. Anderson following a written request, a copy of the post mortem report was received by Blue Cross.

I have to consider whether the position taken by Toorak House to continue to use the mesh/webbing cotsides after the death of Mr. Grace was reasonable. Of course we know the cotsides were immediately removed after the death of Mr. Anderson. The then Director of Nursing, Annette Snelgar, said in evidence by video link that decision to remove the cotsides was made independent of the Grace matter.

In respect of that, she said whilst she was aware his death had occurred, and that bed rails may have been involved, she understood the precise cause of death was unclear and coroners findings were awaited. It is to be remembered Ms. Snelgar took up her position on the 9th of October 2000, after the death of Mr. Grace on the 23rd of August 2000.

If the Director of Nursing, Ms. Snelgar, ordered the immediate removal of the cotsides after the death of Mr. Anderson independent of the death of Mr. Grace, why were the cotsides not removed after the death of Mr. Grace. I conclude the circumstances surrounding the death of Mr. Grace in combination must have influenced the decision to remove.

The issue of Ms. Lindsay's understanding of the cause of the death of Mr. Grace has greatly troubled me - remember she claims she thought it was due to a stroke or epilepsy, but was awaiting a coronial finding.

If one looks at the graphic photographs of Mr. Grace (especially photos 4 and 18) it would render be virtually impossible to conclude that death was due to anything other than mechanical asphyxiation. However, prior to the death of Mr. Anderson those photographs were not available to Ms. Lindsay, Ms. Snelgar or anybody else associated with Blue Cross/Toorak House. In fact I am not sure whether access to those photographs was given to Blue Cross at all prior to this present matter.

Ms. Lindsay told me monthly corporate meetings were held with her Directors of Nursing - those directly responsible for the day to day running of Blue Cross' aged care facilities. One of the focuses of these management meetings was the Aged Care Standards Agency standards, one of which was Physical Environment and Safe Systems.

Ms. Lindsay indicated in evidence she did not speak directly to staff who were on duty when the body of Mr. Grace was discovered, but obtained a briefing as to the circumstances from Ms. Hargen, the Director of Nursing at the time. Ms. Hargen did not give evidence before me but her statement was available to Coroner Hender who made the chambers finding concerning the death of Mr. Grace. Her statement is silent as to what at the time was considered to be the cause of death.

Nurse Morna Cappelen and nursing aid Maria De Leeuw provided statements for the Grace brief, but were not called before me. Ms. De Leeuw was the first to discover Mr. Grace after his death and Ms. Cappelen was the first registered nurse on the scene. Miss Cappelen was also the staff member who rang police.

It would appear that when the death of Mr. Grace was "called in" it was described by nurse Cappelen as a strangulation.

Had Ms. Lindsay seen the body of Mr. Grace in situ, or interviewed those who did, she would be hard pressed to claim subsequently the cause of his death was unclear, except in a technical sense. She would, I suggest, have had to conclude his death was, in all likelihood, due to mechanical asphyxiation directly related to the cotsides. Had she formed that view an immediate comprehensive review of the use of the disappearing cotsides would presumably have led to their instant removal.

The reasonableness of the position she took is critical to the issue of whether adverse findings should be made against Blue Cross. With the benefit of hindsight, their position is, I suggest, precarious. But again it is not with that vision I consider the matter.

The next relevant incident occurred when Mr. Anderson rolled off his mattress into the webbing on the 28th of August 2000. On one view this could be seen as the cotsides functioning as they were apparently designed to do. However, it has to be viewed in light of the tragic events of the 23rd August Ms. Lindsay claims she did not see the incident as an entrapment. It did not, she maintains, "*set off alarm bells*". There was, however, as a result of this incident, a "resident safety check" undertaken where Mr. Anderson's position in his bed was checked at regular intervals. I think it is fair to say that the review confirmed that the most appropriate form of restraint was still the mesh/webbing cotsides.

Between the 11th and the 18th of September 2000, the annual review of Mr. Anderson's classification status was conducted. It was again determined bed rails were necessary to ensure his safety in bed. I do not think issue can be taken with the need for bed restraint (ie. cotsides or rails of some description) the question is, was it prudent in light of the events of the 19th of August, 23rd of August and the 28th of August, to continue to use Siltex Disappearing Cotsides?

There is no evidence before me that adult death or indeed injury had previously occurred from this quite widely used product. The fact that two deaths in very similar circumstances occurred within approximately 10 weeks at the same facility is, on the face, an extraordinary coincidence.

In considering the question of if and/or when "*alarm bells*" should have sounded in the mind of the prudent operator, I have considered the question at each stage of the sequence, excluding as best one can subsequent knowledge and hence hindsight. If one concludes Ms. Lindsay knew on or soon after the 23rd of August 2000 that the cause of the death of Mr. Grace was strangulation then that is when alarm bells should have rung loud and clear. We

heard Ms. Lindsay say she thought his death was likely due to a stroke or epilepsy, but kept an open mind awaiting a coronial finding. Ms. Lindsay is a vastly experienced nurse, long involved in system improvement, quality care management and presently an accredited Nurse Surveyor for the Australia Council on Health Care Standards.

I must say I have some reservation about aspects of her evidence. In the circumstances to merely conclude a natural cause as the cause of death of Mr. Grace and blandly await a definitive answer from a coroner as to precise cause of death seems artificial. However Ms. Hargen, with whom Ms. Lindsay conferred at the time, has not given evidence in this matter and her statement is silent on critical issues. Further, Ms. Snelgar's evidence tends to support Ms. Lindsay's position. So whilst her position is somewhat implausible, there is no direct contradictory evidence which would enable me to properly reject her evidence as to that issue.

At the end of the day I accept (with reservation) the evidence of Ms. Lindsay and Ms. Snelgar that they had not concluded the cotsides were directly implicated in the death of Mr. Grace, only that it was a possibility. The matter does not end there however, the next question is - Should they have known?

If management pursuant to an adequate incident reporting system, had undertaken an immediate and comprehensive debriefing of staff directly involved I believe the view would have been formed there and then that the cotsides directly contributed to Mr. Grace's death and were potentially hazardous. One look at the photo of Mr. Grace in situ when found dead is enough to be instantly alerted to the potential hazard. I have to assume actually observing the scene first hand would have an even more dramatic impact - it is obvious why the staff who discovered Mr. Grace's body "called in" the death to emergency services as strangulation.

I conclude management SHOULD have realised the potential danger associated with the cotsides, but did not due to either an inadequate incident reporting system or, if the system was adequate (and I am not saying it was), failure to comply with the requirements of such a system. Management should have known and had they, a review would have assuredly resulted in the removal of the cotsides prior (rather than immediately after) the death of Mr. Anderson.

I note with interest the Site Audit Report prepared by the Aged Care Standards Agency referring to standard 4. Physical Environment and Safe Systems under the sub-standard 4.5 Occupational Health & Safety, whilst rating the facility as "satisfactory", said:-

"Review of all incident report forms is not always evident and incident forms presented at the meetings are not always signed off. The service would benefit from completing these processes and analysing trends."

"Required Improvements: Review the process of review of all incident report forms and demonstrate analysis of all incidents."

I include in this finding an interesting observation made by State Coroner Graeme Johnstone in an inquest concerning the death of Mr. Eric Jones (deceased) Case 3226/96 - it is an observation with which I concur and add that included in the systems in place should be a comprehensive incident reporting system:-

"In conclusion, clearly there are significant risks with the use of restraining devices. If a careful evaluation of the clinical circumstances requires the use of such devices as this, and other cases have shown, strict and well structured systems must be in place to reduce the risk. Those who are being restrained, because of the very need to use such devices, are not likely to be in a position to protect themselves."

SILTEX (AUSTRALIA) PTY LTD - "the manufacturer"

As there was no Australian Standard for the manufacturer to comply with, an adverse finding could only be made against Siltex if it became aware its product was not safe due to a fundamental design flaw and then did not either seek to withdraw its product, or at least adequately warn users of the product of the perceived potential hazard of continued use of that product.

Mr. Jonas, in evidence, said his product was extensively used in many facilities across the country for many years.

On the other hand, Mr. Jonas conceded he was aware of two formal inquests into the deaths of children where Disappearing cotsides were involved. They were the inquests into the death of Cassandra Gatner in Victoria in 1992 and Hayden McFadyen in South Australia in 1998. In each of these matters, Siltex (Australia) Pty Ltd was, according to the record, represented by counsel. Mr. Jonas did not actually give evidence at either of these inquests and maintains, from what he was told by his legal advisors, he did not perceive his product to be potentially hazardous especially to adults.

However, if either, or both, of Coroner Chivell's recommendations had been acted upon I suggest the potential hazard associated with this product for not only children but certain disabled people would have become apparent.

I accept Mr. Jonas' evidence as to that matter because on a fair reading of the Coroner's findings and recommendations one could reasonably conclude they related to infants and young children. Ultimately, I conclude I could not properly make an adverse finding against Siltex because to do so would be to rely on that enlightening phenomenon - hindsight.

RECOMMENDATIONS

1. In light of the circumstances surrounding the deaths of Mr. Richard Grace and Mr. Norman Anderson, together with the previous recommendations made in 1998 by Coroner Chivell in South Australia in the case of Hayden McFayden, and being

advised the Disappearing cot-sides are still widely used in facilities caring for the aged and the disabled (both young and old) I strongly urge that urgent consideration be given to this particular product being forthwith withdrawn from use.

2. I further recommend this finding (together with the recommendations) be disseminated to:
 - (1) Victorian Department of Human Services
 - (2) The Commonwealth Department of Health and Family Services, and
 - (3) The Aged Care Standards Agency
3. If my first recommendation is not to be acted on, I would then recommend that this product (and others like it) be listed under the Therapeutic Goods Act 1989 (Commonwealth) so an evaluation of safety can be undertaken.
4. My fourth and last recommendation is that Blue Cross Community Care Services comprehensively review (if they have not already done so) their incident reporting systems.

PHILLIP BYRNE
CORONER

Ms. Sue Nolan, Assisting the Coroner

Mr. John Noonan of counsel for Blue Cross Community Care Services Group

Mr. Frank Saccardo of counsel for Siltex (Australia) Pty Ltd