Coroners Act 1996

[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 11/12

I, Barry Paul King, Coroner, having investigated the death of ***Leon Caporn*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***8 and 9 September 2014****, find that the identity of the deceased person was* ***Leon Caporn*** *and that death occurred on* ***7 July 2010*** *at* ***Rockingham General Hospital*** *from* ***head injury*** in *the following circumstances:*

Counsel Appearing:

Ms I Burra-Robinson assisting the Coroner
Ms B Burke (ANF) appearing on behalf of Ms L Beswick EN
Mr G Bourhill (MDA National) appearing on behalf of Dr K Carthew and Dr J Hilton
Mr G Pynt instructed by Mr Peter Harris (Ilberys Lawyers) appearing on behalf of Bethanie Group Inc

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INTRODUCTION

1. Leon Caporn ("the deceased") had been a resident at Bethanie Waters aged care facility in Port Kennedy (Bethanie Waters).

2. On 2 July 2010 the deceased had a sudden deterioration of his conscious state following an unwitnessed fall early that morning. He was seen by a medical practitioner, Dr Kevin Carthew, who prescribed antibiotics for infection and instructed Bethanie Waters' staff to transfer him to hospital if his condition did not settle.

3. The deceased's next of kin, Philip Langlands, attended Bethanie Waters on the afternoon of 2 July 2010 to visit the deceased and was upset to find that his condition had deteriorated markedly from the night before.

4. That evening, the registered nurse on duty at Bethanie Waters, Cathleen Van Niekerk RN, arranged for the deceased to be transferred by ambulance to Rockingham General Hospital.

5. At hospital a CT scan showed extensive cerebral haemorrhage. Following discussions with Mr Langlands, medical staff provided the deceased with palliative treatment until he died on 7 July 2010.

6. A post mortem examination revealed that the cause of death was head injury.

7. On 8 and 9 September 2014 I held an inquest into the deceased's death.

8. The issues identified by Ms Burra-Robinson for investigation included:

   a) the likely cause of the haemorrhage;
   b) whether the deceased's risk of falling was adequately managed;
   c) whether the deceased was appropriately examined following the fall in the morning of 2 July 2010;
   d) whether the deceased had fallen a second time on 2 July 2010; and
   e) whether the quality of care the deceased received at Bethanie Waters on 2 July 2010 was appropriate.

9. The documentary evidence adduced at the inquest comprised:

a) a report and two volumes of documents compiled by the police officer who investigated the death, Senior Constable Fiona Thorp;[1]
b) a bundle of documents relating to policies and procedures at Bethanie Waters provided by Bethanie Group Inc;[2]
c) telephone records for Bethanie Waters on 2 July 2010;[3]
d) a second bundle of documents relating to policies and procedures provided by Bethanie Group Inc together with an index indicating whether the respective policies were in place in 2010 or currently;[4] and
e) a copy of a Care Recipient Incident Report relating to an unwitnessed fall by the deceased on 27 June 2010.[5]

10. Oral evidence of the relevant events in 2010 was provided by: care workers Lesley James and Sharon Smith; nurses Louise Beswick EN, Cathleen Van Niekerk RN, Melanie Pitout RN and Fu'a Viliamu RN; and doctors Dr Kevin Carthew and Dr John Hilton.

11. Counsel made oral submissions following the oral evidence.

12. While I am satisfied that all of the witnesses attempted to provide as accurate accounts as possible, the considerable passage of time since the events leading up to the deceased's death has meant that in most cases the witnesses had little or no direct memory of the events.

13. Moreover, though each of the witnesses had provided previous written statements, apart from those provided by Dr Hilton and Mr Langlands, the statements were all provided several months after the events, with the attendant potential for unreliability.

14. Fortunately, I am satisfied that the nature of the evidence had little detrimental effect on my ability to determine the material issues.

15. I note, in order to be complete, that David Lyle, who is the current Bethanie Group Inc General Manager Clinical Governance, also gave oral evidence. Mr Lyle described the development of policies and procedures identified in Paragraph 8b and 8d above.

[1] Exhibits 1 and 2
[2] Exhibit 3
[3] Exhibit 4
[4] Exhibit 5
[5] Exhibit 6

THE DECEASED

16. The following information relating to the deceased's background was provided by Mr Langlands in a statement.[6]

17. The deceased was born in Perth and grew up in Kelmscott. He was driven to succeed and became an esteemed accountant with a large circle of friends. He had a life-long partner who was diagnosed in 1995 with motor neuron disease and died from the disease three years later.

18. The deceased enjoyed travelling on passenger ships and travelled the world on them many times until 2006. He was an avid collector of anything to do with ships.

19. In 1986 Mr Langlands became close friends with the deceased and his partner and kept in close touch with them. In 1995 Mr Langlands came to Perth to assist in caring for the deceased's partner. As the deceased did not have children, Mr Langlands became like a son to him. As time went on, Mr Langlands became the deceased's primary carer.

THE DECEASED'S MEDICAL HISTORY

20. The deceased had a medical history which included rectal bleeding from, at the latest, August 1996 when he presented at Rockingham General Hospital with an episode of that condition.[7]

21. In November 2002 he was diagnosed with likely diverticulosis and was transferred to Fremantle Hospital.[8]

22. At about that time he became the patient of Dr John Hilton, a general practitioner in Cooloongup. Dr Hilton treated the deceased until his death for various conditions, including chronic renal failure, congestive cardiac failure, gout, type 2 diabetes, mitral incompetence, thrombocytopenia, atrial fibrillation, depression and anaemia as well as diverticulitis/diverticulosis.[9]

23. By 2010 the deceased had gout and swollen joints with oedema of all limbs, breathlessness, depression and poor mobility.

[6] Exhibit 1, Tab 4
[7] Exhibit 1, Tab 17
[8] Exhibit 1, Tab 17
[9] Exhibit 1, Tab 16

At this time he was living in Golden Bay with Mr Langlands who was his carer.[10]

24. In January 2010 the deceased was admitted into Fremantle Hospital for management of diverticulosis. When he was discharged about six weeks later he again became ill. Mr Langlands took him to Rockingham General Hospital where the deceased was treated for another episode of rectal bleeding, this time complicated by the exacerbation of chronic cardiac failure and chronic renal failure. He was transferred to Fremantle Hospital for further management.[11]

25. On 3 April 2010 the deceased presented at Rockingham General Hospital with fever and a urinary tract infection, and his condition was complicated by rectal bleeding. He was transferred to Sir Charles Gairdner Hospital where stents were inserted.[12]

26. In April and May 2010 the deceased was transferred to Waikiki Private Hospital for rehabilitation.[13] On 6 May 2010 his second right toe was amputated.[14]

27. On 25 May 2010, following a brief admission into St John of God Murdoch Hospital for a femoral angiogram, the deceased was transferred to Bethanie Waters for high level care in the Retreat Wing of the facility.[15] An advantage of Bethanie Waters was that it was close to Golden Bay, enabling Mr Langlands to visit daily.[16]

28. As I understand it, Bethanie Waters is owned and operated by Bethanie Group Inc.

BETHANIE WATERS

29. Upon admission to Bethanie Waters the deceased was assessed as a medium risk of falls, though it was noted that he had not had a fall in the last year. Part of the fall protection strategies in the Retreat Wing was for the residents' beds to be kept at a low height.

[10] Exhibit 1, Tab 16
[11] Exhibit 1, Tab 17
[12] Exhibit 1, Tabs 4 and 17
[13] Exhibit 1, Tab 4
[14] Exhibit 2, Tab 16
[15] Exhibit 2, Tab 15
[16] Exhibit 1, Tab 4

30. The deceased settled in well at the facility, and though he gained a reputation of being boisterous, vocal and independent,[17] he developed a close bond with at least one of the care workers, Lesley James.[18]

31. The deceased's progress notes at Bethanie Waters indicate that his diagnosis at the time of admission was of chronic cardiac failure, atrial fibrillation, chronic renal impairment, recipient embolization for per rectal bleeding, type 2 diabetes, gastric oesophageal reflux disease, liver cirrhosis, diverticulitis and toe amputation. However, the notes show that for the duration of the deceased's admission, he was seen by registered nurses most often in relation to a necrotic wound on his right foot.[19]

32. On 12 June 2010 the deceased was transferred to Rockingham General Hospital for assessment of his right foot after a registered nurse contacted Dr Hilton with concerns about it. The deceased was returned to Bethanie Waters the following day with changes to his medication regime.[20]

33. On 17 June 2010 the deceased was showing signs of confusion. A registered nurse instructed a staff member to collect a urine sample from the deceased to test for a urinary tract infection, a common cause of confusion.[21] A wound assessment of the deceased's foot detected *Staphylococcus aureus* and methicillin-resistant *Staphylococcus aureus.* Dr Hilton was contacted and he sent through orders for a change of antibiotics for the deceased.[22]

34. Over the next week the deceased continued to have his foot regularly checked and the wound dressed.[23]

35. On 24 June 2010 the deceased had his first fall at Bethanie Waters. At about midnight his roommate summoned a care worker who found the deceased kneeling on the floor. The deceased said that he had lost his balance when getting off the toilet. There were a small skin tears on his leg and between his fingers. He was assisted back to bed and was told to ring for assistance when he needed to go to the toilet, but he said that he did not want to be a pain.[24]

[17] Exhibit 1, Tabs 5 and 6
[18] Exhibit 1, Tab 5
[19] Exhibit 2, Tab 20
[20] Exhibit 2, Tab 20
[21] Exhibit 2, Tab 20
[22] Exhibit 2, Tab 20
[23] Exhibit 2, Tab 20
[24] Exhibit 2, Tab 20

36. Following that fall, Ms James noted that the deceased's personality changed: he became quieter and more subdued.[25]

37. On 27 June 2010 the deceased was again found on the floor with a skin tear from an apparent fall. He was nonetheless in good spirits that day.[26]

38. On 28 June 2010 an outreach nurse from the Residential Care Line visited Bethanie Waters to attend to an ulcer on the deceased's left foot.[27]

39. On 1 July 2010 a nurse from the Residential Care Line again attended to the deceased's left foot. The nurse suggested that the ulcer be reviewed by a GP for a possible referral to a vascular surgeon.[28]

40. In the evening of 1 July 2010 Mr Langlands visited the deceased as usual. The deceased believed that his health was improving and he was in high spirits.

2 JULY 2010

41. At about 5.20 am on 2 July 2010 the deceased had another fall. It appeared that he had tripped over his Zimmer frame in his bathroom. He had a small skin tear on his upper arm and he said that he felt as if he had broken his back.[29]

42. The registered nurse on duty, Melanie Pitout RN, conducted a head-to-toe examination of the deceased with particular focus on the head and hips to determine whether he had sustained any injuries. She found no obvious breaks and did not identify any indication of a head injury. She helped the deceased walk to his bed and she treated his skin tear. She completed a Care Recipient Incident Report form and a Wound Assessment form and left a message in the progress notes for other staff to notify Mr Langlands and Dr Hilton about the deceased's fall later in the morning.[30]

43. At about 9.30 am, registered nurse Fu'a Mata'afa RN (now Fu'a Viliamu RN) reviewed the deceased. He was feeling miserable and was aching all over. She took observations and called Dr Hilton in order to obtain his authorisation to conduct a urine

[25] Exhibit 1, Tab 5
[26] Exhibit 2, Tab 20
[27] Exhibit 2, Tab 20
[28] Exhibit 2, Tab 20
[29] Exhibit 2, Tab 20
[30] Exhibit 2, Tab 20

test on the deceased. She and Dr Hilton also arranged to ask Dr Carthew to review the deceased that day as, it being a Friday, Dr Carthew would be attending Bethanie Waters to see his own patients as he normally did.[31]

44. At around 10.00 am, Ms Mata'afa RN spoke to Mr Langlands by telephone about the deceased's fall. Mr Langlands had tried to call the deceased on his mobile earlier without success so had called the Bethanie Waters number.[32] Ms Mata'afa RN told him that the deceased was sore and had a small skin tear but was otherwise ok.[33]

45. At about 1.00 pm Dr Carthew reviewed the deceased after seeing his other patients. That the Bethanie Waters nursing staff did not ask him to review the deceased before seeing his other patients indicated to Dr Carthew that they did not have urgent concerns about the deceased's condition.[34]

46. Dr Carthew noted that the deceased was quite confused, and he queried whether the confusion was due to head trauma from the fall or was due to the infected wound on the deceased's leg. He directed that the deceased be given an antibiotic and that, if the deceased's condition did not settle within 24 hours, he be transferred to a hospital emergency department.[35]

47. Just before 3.00 pm that afternoon, care workers Lesley James and Sharon Smith started their shift in the Retreat Wing at Bethanie Waters. Ms James was informed at handover that the deceased had had a recent fall and required additional care, support and monitoring.[36] A mattress had been placed on the floor beside his bed as an added protection from the hazard of a fall.[37]

48. After handover, Ms James went to the deceased's room to answer a call bell sounded by the deceased's roommate. The deceased was lying half on and half off his bed, unresponsive and apparently disorientated. He seemed to be trying to get up but was unaware of his environment. Ms James summoned Ms Smith to assist her with the deceased because she did not want to leave him alone.[38]

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[31] Exhibit 2, Tab 20
[32] Exhibit 1, Tabs 4 and 22; Exhibit 2, Tab 20
[33] Exhibit 2, Tab 20
[34] ts 83 per Carthew, K
[35] Exhibit 1, Tab 14; Exhibit 2, Tab 20
[36] Exhibit 1, Tab 5
[37] ts 13 per James, L
[38] Exhibit 1, Tab 5

49. Ms Smith went to the deceased's room and noticed that the deceased was much quieter than usual and that his mouth was droopy to the left side. He kept moving his legs off the bed, so she and Ms James would move them back. She agreed with Ms James that the deceased could not be left alone.[39]

50. While Ms James stayed with the deceased, Ms Smith notified the registered nurse who was then on duty, Cathleen Van Niekerk RN, of the deceased's demeanour and requested that she review him. Ms Smith then went to attend to her other duties.[40]

51. Ms Van Niekerk was unable to review the deceased herself so, it appears, she asked another nurse to do so. While there is some dispute as to the identity of that other nurse, the clear preponderance of the evidence supports the conclusion that it was enrolled nurse Louise Beswick EN.[41] Whether it was Ms Beswick EN or not, it seems clear that at 3.30 pm a nurse recorded the deceased's vital signs, which were reasonably within normal ranges.[42]

52. Ms James remained with the deceased until about 4.30 pm when she was obliged to assist with serving dinner to other residents.[43]

53. At about 5.00 pm, Ms Mata'afa RN made an entry in the progress notes to the effect that she had contacted Dr Hilton because the deceased had another fall and was still confused.[44] That entry led to a conclusion by Ms van Niekerk RN that the deceased had fallen twice that day.[45]

54. In evidence, Ms Viliamu RN accepted that it was unlikely that she meant to indicate in the progress notes that the deceased had fallen twice that day. Her acceptance of that proposition was supported by the fact that she had not completed the other forms that would have been necessary if the deceased had fallen again.[46]

55. It is clear in my view that the deceased did not have another fall after 5.20 am that morning.

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[39] Exhibit 1, Tab 6
[40] Exhibit 1, Tab 6
[41] See Ms Burra-Robinson's submissions at ts 128-129
[42] Exhibit 2, Tab 20; ts 91 per Carthew, K
[43] Exhibit 1, Tab 5
[44] Exhibit 2, Tab 20
[45] ts 57 per Van Niekerk, C
[46] ts 106-107 per Viliamu, F

56. At about 5.00 pm Mr Langlands arrived at Bethanie Waters to visit the deceased. When he saw the deceased with his eyes half open, unable to speak and unable to eat or drink, he knew that something was seriously wrong. He approached Ms Smith with his concerns and it seems that either he or one of the staff at Bethanie Waters expressed those concerns to Ms Van Niekerk RN.[47]

57. Ms Van Niekerk RN arranged for the deceased to be transferred to hospital by ambulance. At about 6.15 pm she completed a transfer form in which she described the reason for transfer as: the deceased's confusion after two falls, a GP's instruction to transfer to ED if he did not recover after starting on antibiotics, the deceased's son's concerns that the deceased be hydrated in ED, and the deceased being very pale, lethargic and verbally unresponsive.[48]

58. Ambulance paramedics stabilised the deceased and conveyed him to Rockingham General Hospital[49] where a CT scan showed extensive acute haemorrhage of the brain with suspected long-standing chronic subdural collections. There was associated subarachnoid haemorrhage and marked midline shift to the right.[50]

59. Following discussions between medical staff and Mr Langlands, the deceased was provided with palliative care in a medical ward until he died in the evening of 7 July 2010.[51]

CAUSE AND MANNER OF DEATH

60. Chief Forensic Pathologist Dr Clive Cooke conducted a post mortem examination of the deceased on 13 July 2010. Dr Cooke found a subdural haemorrhage with softening and swelling of the brain, congestion of the lungs, valvular and ischaemic heart disease, scarring of the kidneys and gangrenous changes to the right big toe.[52]

61. Dr Cooke formed the opinion that the cause of death was head injury.[53]

[47] Exhibit 1, Tab 4; ts 53 and 54 per van Niekerk, C
[48] Exhibit 2, Tab 93
[49] Exhibit 1, Tab 15
[50] Exhibit 1, Tab 17
[51] Exhibit 1, Tab 17
[52] Exhibit 1, Tab 18
[53] Exhibit 1, Tab 18

62. As there was evidence indicating that personnel at the emergency department at Rockingham General Hospital believed that the deceased had suffered a stroke, Dr Cooke was asked to clarify whether he found evidence of a stroke. He found no evidence of a stroke and noted that a radiologist's report of the CT scan taken at the hospital made no mention of a stroke. Microscopic examination showed a lack of cellular healing, indicating that the haemorrhage was no more than a few days old. [54] That finding is consistent with Mr Langlands' statement in which he indicated that the deceased was feeling well on the evening of 1 July 2010.

63. On the basis of the evidence available to me, I am satisfied that the deceased fell and struck his head on the morning of 2 July 2010, causing an injury which led to his death.

64. I find that the death occurred by way of accident.

FALLS PREVENTION

65. The evidence confirmed the widely known fact that falls prevention is an important but difficult aspect of the management of residents in aged care facilities and it was made clear that staff and management at Bethanie Waters appreciated that fact.[55]

66. When the deceased was admitted into Bethanie Waters on 25 May 2010 he underwent a falls risk assessment by a registered nurse and was assessed as being at medium risk of falls.[56]

67. An Initial Assessment-Interim Care Plan provided that the deceased required assistance for bed mobility, transfers, showering and toileting, and that he required a walking frame for mobilisation.[57]

68. Following the deceased's short stay in hospital on 12 June 2010, on 15 June 2010 Ms Mata'afa RN created a Summary Care Plan for the deceased. Under that care plan the deceased was to be given assistance when toileting when required, and a wheelchair with an assistant was required for mobilisation. The deceased was considered to be able to sit independently.[58]

[54] Exhibit 1, Tab 18
[55] ts 67 per Lyle, D
[56] Exhibit 2, Tab 17
[57] Exhibit 2, Tab 16
[58] Exhibit 2, Tab 55; see also: Mobility Assessment - Exhibit 2, Tab 56

69. On 16 June 2010 the deceased was seen by a physiotherapist who noted, among other things, that the deceased used a two wheel frame for ambulation and that he ambulated independently but that there had been a decline in mobility and ambulation distance because of right foot pain.[59]

70. As noted previously, the deceased's bed was at its lowest position in order to reduce the risk of injury from a fall out of bed.

71. The procedure in place generally at Bethanie Waters in 2010 for residents at risk of falls was found in a 'Falls Prevention Care Pathway' which provided for the use of the Fall Risk Assessment Tool upon admission followed by referral to a registered nurse who would then refer the resident to a physiotherapist, an occupational therapist and a general practitioner to identify interventions to address risk factors.[60]

72. That procedure, which on its face seems reasonable, appears to have been appropriately implemented with respect to the deceased.

73. In 2012 Bethanie Group Inc established a focus group with the purpose of producing a guide with respect to best practice in relation to falls management. The results of that exercise were implemented primarily in 2012. The main changes from the previous falls management policy were:

    a) a framework that extends from pre-admission to falls prevention and management;
    b) a framework that incorporates all aspects of fall prevention;
    c) fall prevention algorithms which guide different care staff with respect to specific post-fall interventions and management;
    d) the introduction of the Berg Balance Scale to help validate the Falls Risk Assessment Tool score; and
    e) the formation of a clinic governance team to develop policies and oversee clinical care, education and independent auditing, including root cause analyses.[61]

74. I am not in a position to comment on the relative quality of the policies now implemented under this framework; however, in my view the approach by Bethanie Group Inc of reviewing and implementing best practices in relation to falls prevention and management is self-evidently commendable.

[59] Exhibit 2, Tab 67
[60] Exhibit 5
[61] Exhibit 3

MANAGEMENT OF THE DECEASED AT BETHANIE WATERS AFTER THE FALL ON 2 JULY 2010

75. In my view the following events indicate that the deceased was reasonably managed from the time of his fall.

76. Ms Pitout RN assessed and examined him with a particular focus on potential head injury. At that time he appeared shaken by the fall but was able to walk back to his bed. Ms Pitout considered whether he required hospitalisation and concluded that he did not. She arranged for Dr Hilton and Mr Langlands to be notified of the fall and she completed the required paperwork to notify the oncoming shift of the fall.

77. At around 9.50 am Ms Mata'afa RN conducted observations of the deceased. She contacted Dr Hilton and arranged for a urine test and for Dr Carthew, a general practitioner with a great deal of experience in aged and palliative care, to be asked to review the deceased when he attended that morning. She also reviewed the deceased herself at about 12.45 pm to check the wound on his leg.

78. There is no evidence to suggest that anything about the deceased's condition during the morning of 2 July 2010 indicated that he needed urgent attention. Notably, the deceased did not appear to have any external sign of injury on his head.

79. Dr Carthew saw the deceased at about 1.00 pm and noted that he was confused, possibly due to a fall and head trauma or because of an infected wound on his leg.[62] Given that urinary tract infections or other infections appear to be the primary cause of increasing confusion, instability and falls in patients in aged care facilities,[63] it is not surprising that Dr Carthew prescribed the deceased an antibiotic and directed that he be transferred to hospital if he did not improve. Dr Hilton stated, in effect, that he would have done the same thing.[64]

80. After Dr Carthew had seen the deceased, it appears that Ms Mata'afa reviewed him again before calling Dr Hilton in the afternoon at 2.39 pm to get orders to administer antibiotics.[65]

81. From about 3.00 pm to about 4.30 pm Ms James stayed with the deceased. At about 3.30 pm, an enrolled nurse conducted

[62] Exhibit 2, Tab 20
[63] ts 123 per Hilton, J
[64] ts 120 per Hilton, J
[65] ts 119 per Hilton, J; Exhibit 2, Tab 20; Exhibit 4

observations of his vital signs and correctly concluded that the observations were in the normal range. When Ms James left the deceased, it seems that other staff members were in and out of his room so that he was not left alone for longer than 10 minutes.[66]

82. At about 5.00 pm Mr Langlands arrived. Ms Smith and Ms James assisted him with the deceased and in a short time Ms van Niekerk RN became actively involved. Observations of the deceased's vital signs were again recorded and they were still in the normal range. On the basis of the deceased's appearance and Mr Langlands concerns, Ms van Niekerk RN arranged for his transfer to hospital.

83. All of those steps appear to have been reasonable and appropriate to the circumstances.

84. I should mention in passing that, as Mr Bourhill submitted, it appears that the head injury suffered by the deceased was such that, even if the deceased had been transferred to hospital earlier on 2 July 2010, his death stemming from that injury would not have been averted.

CONCLUSION

85. On the basis of the evidence available to me, I am satisfied that the deceased fell and injured his head, leading to subdural haemorrhage which caused his death.

86. I am satisfied that quality of care provided to the deceased at Bethanie Waters before and after his fall was reasonable and appropriate.

87. In particular, I commend Ms James for the care she provided the deceased on 2 July 2010.

B P King
Coroner
2 October 2014

[66] ts 24 per Smith, S