Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 32/12

I, Evelyn Felicia VICKER, Acting State Coroner, having investigated the death of ***Violet Beatrice WEBB****, with an Inquest held at* ***Perth Coroners Court, 501 Hay Street, Perth,*** *on* ***24-28 September 2012 and 30 July 2013*** *find the identity of the deceased person was* ***Violet Beatrice WEBB*** *and that death occurred on* ***9 November 2009*** *at* ***Royal Perth Hospital*** *as a result of* ***Diffuse Alveolar Damage in a woman with recent leg fracture and Atherosclerotic Cardiovascular Disease*** *in the following circumstances -*

Counsel Appearing :

Ms Melanie Smith assisted the Deputy State Coroner – 24 to 28 September 2012 and Ms Kate Ellson assisted the Deputy State Coroner on 30 July 2013
Mr Paul Tottle appeared on behalf of Amaroo Aged Care Facility
Ms Courtney Collins appeared for RN Michael Schnieder (instructed by United Voice) in September 2012 and
Mr Simon Millman appeared for RN Michael Schnieder on 30 July 2013

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INTRODUCTION

During the late evening of 22 October 2009 Violet Beatrice Webb (the deceased) suffered a compound fracture of her right ankle when attempting to mobilise in her bedroom at McMahon Caring Centre (McMahon Centre), now Amaroo Aged Care Facility.

The deceased was transferred to Royal Perth Hospital (RPH) by Saint John Ambulance Service in the early hours of 23 October 2009 and underwent open reduction and internal fixation of her fracture on 25 October 2009. Initially her family felt she recovered well, although she had no recollection of the events leading to her injury. Unfortunately her condition deteriorated on 28 October 2009 and she died eventually on 9 November 2009.

The deceased was 83 years of age.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was an 83 year old resident of the McMahon Centre requiring high level care because of her difficulty with mobilisation. She was resident in Murchison.

The deceased's care plan had recently been amended to reflect the difficulties with her transfers and required she be assisted by two carers, with use of a full hoist as a safety precaution for both the deceased and the carers. I note the

deceased frequently became agitated when needing to wait for that assistance and disliked the hoist.

On the evening of 22 October 2009 the deceased became unwell, probably as the result of her high BSL and vomited. She had been placed on a bed pan by the afternoon shift prior to handover, and at handover the afternoon shift advised the oncoming night carers the deceased required their help.

At approximately 10:15pm care assistants Bathuel and Joseph attended the deceased's room to care for her. She had vomited again. They removed her from her bed pan and proceeded to clean the deceased and change her clothing and bedding. They sought the assistance of the RN on duty, RN Schneider. He attended to check her BSL, and attempt to make her comfortable.

The carers settled the deceased back into bed in clean clothing. They placed her commode chair and bed pan in the bathroom and left to attend to other duties. At the time they left the deceased she was being cared for by RN Schneider who was intending to provide her with a warm drink and food in the event she needed it later due to her fluctuating BSL.

I am satisfied some time later the deceased again needed attention and RN Schneider attended upon the deceased,

whilst the carers were in Gascoyne, rather than Murchison. RN Schneider intended to assist the deceased by himself and placed her on a bed pan. Under her care plan this was acceptable.

RN Schneider then left the deceased while he continued with other duties. The deceased was on the bed pan and the commode in proximity to the bed.

On RN Schneider's return to assist the deceased off the bed pan he found her in the process of sliding from her bed onto the floor and rushed to lessen the force of the impact. I have no doubt various things happened in those few moments which were not noted due to the focus of RN Schneider on the deceased's movement downward.

Unfortunately in the course of the arrested fall the deceased's right ankle became trapped under her body mass and sustained serious fracture as a result of the impact when caught between her body mass and the floor. At some point RN Schneider registered a serious wound on the bridge of her foot and made various assumptions when trying to piece together events later. I do not believe his "memory" of seeing that injury while her foot was still on the bed is chronologically reliable. It is unlikely he was even focused on her foot at that point in time. The deceased was falling and he was trying to arrest that fall. He needed to get from the door to the head of the bed in moments. I have

no doubt at the conclusion of the movement when the deceased was on the floor with her foot twisted she had suffered injury. There is no explanation for what the deceased was doing. She may well have thought she would prefer to attempt to move to the commode as she used to do. Or she may have had a reaction to her fluctuating blood sugar levels. We just don't know without making further assumptions.

I am satisfied that when the deceased slid from the bed and landed on her ankle she suffered a compound fracture later described by the doctors at RPH as a high impact injury. By that time her leg had been straightened in an attempt to reduce the weight on her ankle and she had a cut which had bled heavily. This could have happened in a number of ways. I have no doubt the position of items in the room, such as the commode, had altered in the process of assisting the deceased. The reality is the deceased, for her size, was a heavy weight and with her probable osteoporosis was very vulnerable to even minimal trauma.

Once the deceased was on the floor RN Schneider attempted to lessen her trauma by freeing her legs. When he examined the wound on the bridge of her foot he could see the depth of the wound was to the bone and was bleeding profusely. The bones were not protruding through the skin at that time and he could not see evidence of a compound fracture

although he believed a fracture to be possible due to her age and medical history.

RN Schneider wrapped a towel around the deceased's foot and decided she would be more comfortable in her bed rather than on the floor.

I accept the Amaroo policy was a client should remain in place after an injury but believe RN Schneider understood the deceased would be more comfortable in bed. He called for the carers and instructed them to remove her from the floor, using the hoist, and return her to bed. He left the carers attending to the deceased whilst he went to the office.

The carers assisted the deceased and cleaned the blood as far as they were able but were concerned the deceased's injury did not stop bleeding and was causing considerable blood loss. Bathuel attended the office and advised the RN he considered the deceased needed further assistance and RN Schneider then called the ambulance. RN Schneider appropriately reported the possibility of a fracture to the ambulance service, however described her BSL as *"hypo"* rather than fluctuating.

RN Schneider's accounts of the incident at the time are conflicting in that he reported to the ambulance officer the deceased had suffered a hypoglycaemic episode when there is no record of a BSL below 11.2. The nursing home

integrated progress notes record an entry by him at 11.30pm of a hyperglycaemic attack, as does his incident form. In a letter to the hospital at the same time he refers to a hypoglycaemic attack. RN Schneider appeared confused as to whether he was dealing with a hyper or hypoglycaemic episode. The recorded BSLs are clearly in the hyperglycaemic range but decreasing. This did not affect the treatment given or required by the deceased at that point in time.

On the arrival of the St John ambulance officers the deceased's ankle was described in the patient care record as very swollen with an open fracture and active bleeding. There was no foot pulse and her right foot was of poor colour and cool to the touch, suggesting a compromised blood supply. She was administered fentanyl for pain relief.[1]

The deceased was transferred to RPH where she received appropriate care and attention for her numerous medical conditions.

On 25 October 2009 she underwent an open reduction and internal fixation of the very comminuted fracture under regional and spinal anaesthetic and appeared initially to respond well.

[1] Exhibit 2

On 28 October 2009 the deceased began to deteriorate and did not fully recover. This was as much to do with her pre existing co-morbidities as the injury. She was treated palliatively from 7 November 2009 until she died on 9 November 2009.

On the evidence available I am satisfied the deceased suffered from a number of co-morbidities and suffered an injury when she fell/sat heavily on her twisted ankle late in the evening of 22 October 2009. Although the compound fracture was repaired it appears to have precipitated general deterioration in the deceased's health, particularly with respect to her cardiovascular capacity.

The injury precipitated the decline in the deceased's health to the extent of her death on 9 November 2009. That is the injury triggered her death at that time because the extent of her co-morbidities compromised her ability to recover from the additional insult of the trauma to her already compromised system.

I find death arose by way of Accident.

COMMENTS ON THE CARE OF THE DECEASED

I am satisfied the deceased was appropriately managed by McMahon Centre and her medical conditions appropriately monitored by the systems in place at the McMahon Centre. The difficulties with the deceased's fluctuating weight and

BSLs were managed as effectively as they could be with the deceased's inclination to eat the wrong foods and not take care of her health responsibly. There was tension in the deceased's care with respect to her diabetes management and her quality and quantity of life. The deceased enjoyed her family and enjoyed her treats and this made her diabetes very difficult to manage. This further compromised the deceased's overall health with respect to her weight, her heart disease, and her mobility. All of these issues contributed to the deceased's deteriorating health and need for additional care.

McMahon Centre responded appropriately by amending the deceased's care plan to accommodate her increase in weight and decrease in mobility.

There was a system in place and it is clear the carers were aware of the system because it was their intervention which had caused the amendment to the deceased's care plan.

I am satisfied RN Schneider understood the issues with the deceased, however, did not anticipate a problem would occur when he left her on the bed pan, leaving the commode in proximity to the bed.

It is not clear why the deceased attempted to mobilise and RN Schneider clearly made some assumptions about events

when trying to provide an account of what happened when asked.

It is my view he was wrong about those assumptions and the chronology of events.

What is clear is the deceased attempted to mobilise and was unable to do so without falling, the very reason for the care plan review. RN Schneider appeared in time to arrest that fall but was unable to prevent the weight of the deceased settling on her twisted ankle on the floor. She suffered serious injury but may not have experienced as much pain as would be expected as a result of her other co-morbidities.[2]

Unfortunately the outcome for the deceased was catastrophic in that the series of events occurring as a result of her fracture injury led to her death although appropriately dealt with at the time.

Her death, while tragic and a huge loss to her family, did not occur as the result of a lack of care. While RN Schneider did not adhere to the first aid safety plan and was confused as to her glycaemic status he did not cause her to fall, nor fail to provide assistance. I have no doubt he fully expected the deceased to recover and provide an account of what happened herself.

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[2] t 30.7.13 p 124

One of the concerns with RN Schneider's employment was the number of hours he was working. There is little evidence RN Schneider was fatigued, although I agree on the evidence there was the possibility of fatigue. It would seem more likely the inaccuracies recorded by RN Schneider were more as a result of an appreciation of the fact it was suspected he had not abided by the system in place for the appropriate care of the deceased, rather than fatigue. While McMahon Centre may wish to consider policies with respect to hours of employment at different facilities I suspect it would not deter a mistaken assumption about the chronology of an event which then leads to erroneous conclusions.

E F VICKER
Acting State Coroner

4 September 2013