Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 39/15

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of ***Brian Keith WOOD****, with an Inquest held at Perth Coroners Court, Central Law Courts, 501 Hay Street Perth, on 13 and 14 October 2015 find that the identity of the deceased person was* ***Brian Keith WOOD*** *and that death occurred on 1 January 2011 at Sarah Hardey House, 222 Cammillo Road, Kelmscott as a result of upper airway obstruction in a man with a clinical history of dementia in the following circumstances -*

Counsel Appearing :

Mr T Bishop assisting the State Coroner

Ms Paljetak (State Solicitors Office) appeared for the Office of the Public Advocate
Mr Hotchkin (Hotchkin Hanly Lawyers) appeared for Uniting Church Homes
Ms Burke (Australian Nurses' Federation) appeared for Nurse P. Stott
Mr Brand (MDA National Insurance) appeared for Dr J. Adesina

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INTRODUCTION

Brian Keith Wood (the deceased) was 84 years old when he died at approximately 9.00am on 1 January 2011 after choking on some food. At the time he had dementia and he resided in Sarah Hardey House, a Uniting Church Home that was an aged care facility.

The carers immediately observed the deceased choking and rendered assistance. The nurse was notified and attended. They endeavoured, without success, to dislodge the obstruction and clear his airway. When the deceased stopped breathing an ambulance was called for. The nurse

in attendance did not make any other resuscitation attempts.

As a result of the deceased's dementia the Public Advocate had been appointed as his limited guardian with the function of consenting to any of his treatment or health care. The deceased did not have an advanced life directive, nor did he have a "*not for resuscitation*" order in place at the time of his death. He died at Sarah Hardey House shortly after choking.

Prior to the inquest Sarah Hardey House informed the court that it did not have a policy that permitted staff to undertake cardiopulmonary resuscitation on residents.

The deceased's death was a reportable death within the meaning of section 3 of the *Coroners Act* 1996 (the Act) and it was reported to the coroner as required by the Act.

By reason of section 19(1) of the Act I have jurisdiction to investigate the deceased's death.

Despite the Public Advocate's limited guardianship of the deceased pursuant to the *Guardianship and Administration Act* 1990, at the time of his death he was not a person held in care within the meaning of section 3 of the Act. Accordingly an inquest into his death was not mandated.

An inquest was desirable pursuant to section 22(2) of the Act.

On 13 and 14 October 2015 I held an inquest into the death of the deceased at the Coroner's Court at Perth. The inquest focussed on the appropriateness of the food provided to the deceased prior to his choking episode, whether the administration of cardiopulmonary resuscitation was indicated and if so, whether it would have prevented his death.

A number of witnesses gave evidence at the inquest and they are, in order of their appearance, Ms Jemimah Giles, a carer in the employ of Sarah Hardey House; Nurse Pixie Stott, a registered nurse in the employ of Sarah Hardey House; Mr Lindsay Scott, a paramedic with St John Ambulance; Ms Pauline Bagdonavicius, Public Advocate; Clinical Associate Professor Peter Goldswain, consultant physician in geriatric medicine; Professor Hugh Grantham, professor of paramedic science, school of medicine, Flinders University; Dr Ricky Arenson, head of service of the sub-acute geriatric rehabilitation and ortho-geriatrics at Royal Perth Hospital and consultant endocrinologist and geriatrician, Murdoch Hospital; Dr Jacob Adesina, the deceased's general practitioner (GP); Ms Karen Hendle, a carer in the employ of Sarah Hardey House; Nurse Kerry Green, a clinical nurse in the employ of Uniting Church

Homes; and Ms Elizabeth Bland, residential manager of Sarah Hardey House at the material time.

The evidence tendered at the inquest comprised documents tabbed 1 to 32 in one lever arch file, which became Exhibit 1.

After the inquest I received submissions from the various counsel in accordance with orders made. I am assisted by submissions concerning resuscitation in the aged care setting from counsel for the Australian Nursing Federation, Ms Burke, on 12 November 2015; from counsel assisting on 13 November 2015 and from counsel for Uniting Church Homes on 9 December 2015.

THE DECEASED

The deceased was born on 30 October 1926 in Coventry, England. In his early years he lived on a farm with his siblings. As a young man he worked in number of occupations, including work in a factory making cars and work as a coal miner. He migrated to Australia in the 1970's and travelled around, before settling in Perth. He did not marry and he had no relatives in Australia.

In 2003, the deceased was diagnosed with dementia. He continued to live in the community, alone in his home but with support from a neighbor and Extended Aged Care at

Home assistance. The Public Trustee as his Administrator had managed his financial affairs since August 2005. In August 2007 the deceased's clinicians determined that he required surgery to assist with his bladder and kidney problems, but due to his dementia he was unable to provide informed consent. This required the appointment of a guardian to address the question of consent on his behalf. On 20 August 2007, the Public Advocate was appointed limited guardian for the deceased for one year under the *Guardianship and Administration Act* 1990 (the Guardianship Act), and delegated those functions to the Guardian, consistent with the Order. The Guardian's functions were to consent to his treatment or health care.[1]

On 13 September 2007, the Guardian consented to the deceased undergoing surgery, namely a transurethral resection of the prostate, which was carried out at Armadale Hospital. The deceased recovered well from his surgery and his health improved. However, his independent living skills deteriorated and it was considered he required a higher level of support than could be provided in the community. He was placed on a list for permanent residency in a hostel and remained in Armadale Hospital while this was managed.[2]

In October 2007 the deceased was moved into the low care but dementia specific unit of Sarah Hardey House, a Uniting Church Homes aged care facility in Kelmscott. Sarah

[1] Exhibit 1, Tab 15
[2] Exhibit 1, Tabs 8 and15

Hardey House accommodated 64 residents in four houses of 16 residents each, and catered for low care, high care and dementia specific patents. The deceased was accommodated into the Jull House unit and he became a permanent resident of the facility in January 2008. Dr Adesina, the deceased's general practitioner since 2007, informed the court that the deceased was moved into the facility due to severe dementia. Dr Adesina attended at Sarah Hardey House as required, to review the deceased, which facilitated continuity of care.[3]

The Guardian also attended upon the deceased at Sarah Hardey House. The observations of the Guardian, following visits with the deceased in November 2007 and April 2008 were that he was settling well, eating and sleeping well, he had gained some weight and he was participating in organised activities. He was well groomed and smartly dressed. He was very well mannered and polite in conversation with her. However, he was not oriented to time or place and thought he had been living at the facility for many years.[4]

On 12 August 2008, just prior to the expiry of the one-year appointment, the Public Advocate's limited guardianship of the deceased was extended for five years. The Order would

[3] Exhibit 1, Tabs 14 and 15
[4] Exhibit 1, Tab 15

have been due for review on 12 August 2013. The appointment was active at the time of his death.[5]

When the Guardian visited the deceased at Sarah Hardey House in October 2008, she noted an increase in confusion, reduced mobility and a need for increased assistance with all activities of daily living. The Guardian observed further deterioration in his working memory during a visit in July 2010. This was consistent with Dr Adesina's observations of the deceased in the three months prior to his death.[6]

The deceased's medical history included hypertension, peptic ulcer disease, osteoarthritis and prostate cancer. He was on medications to treat hypertension and reflux. Dr Adesina last saw the deceased on 16 December 2010 for a urinary tract infection. Dr Adesina informed the court that shortly before his death the deceased was a high-risk patient for falls, aspiration, infection and behavioral problems associated with dementia.[7]

THE ARRANGEMENTS CONCERNING THE DECEASED'S HEALTH CARE

No advance health directive

An advanced health directive is a legal document, voluntarily made by a person with capacity to make

[5] Exhibit 1, Tabs 4
[6] Exhibit 1, Tabs 14 and 15
[7] Exhibit 1, Tab 14

decisions, which sets out the person's instructions about his or her future health and medical treatment. It comes into effect if a person subsequently becomes unable to make his or her own decisions.

Under the Guardianship Act, an advanced health directive containing treatment decisions in respect of a person's future treatment may only be made by a person who has reached the age of 18 years and has full legal capacity.[8]

The deceased had not made an advanced health directive; that option was not available to him when he had full legal capacity. It cannot be known whether or not he would have made an advanced health directive if that option had been available to him. There was no record of his wishes regarding healthcare treatment should he suffer a critical event. Specifically, in the context of this matter, it was neither recorded, nor known, whether or not the deceased would have wished to be resuscitated.[9]

The role of the Public Advocate

At the time of the deceased's death, the Public Advocate was his guardian, appointed by the State Administrative Tribunal. There was no other person suitable, willing, and available to act as the deceased's guardian. By this appointment, the Public Advocate was given legal authority

[8] Section 110P Guardianship Act
[9] T 62

to make decisions about any treatment proposed for the deceased. It included making decisions in respect of life-sustaining measures and palliative care.[10]

Ms Bagdonavicius had been the Public Advocate since 31 March 2008 and she gave evidence at the inquest. Whilst as Public Advocate she had been appointed to consent to, or refuse, treatment on the deceased's behalf, she was unable, as substitute decision-maker, to make an advance heath directive on his behalf. Due to the deceased's dementia, he was unable to make an advance health directive at the time he entered Sarah Hardey House either.[11]

The Public Advocate was required to act in the deceased's best interests. However, it was not her role to anticipate a future critical event and give advance instruction on whether or not the deceased ought to be resuscitated. Specifically, it was not her role to instruct. Her role was to consent, or withhold consent, regarding the deceased's treatment or healthcare when required.[12]

The general rule is that the Public Advocate's decision concerning whether she consents, or does not consent, to cardiopulmonary resuscitation may properly be sought at a time when a person the subject of a guardianship order is

[10] Exhibit 1, Tabs 4 and15
[11] T 58 - 59
[12] T 59 - 66

receiving acute treatment for a deterioration in his or her general health. The Public Advocate, personally or through her delegate, will provide or withhold consent based upon the existing circumstances, including the treating doctor's recommendation and the known wishes of the person.[13]

An exception to this general rule concerns the situation where there is a palliative care arrangement for a person the subject of a guardianship order. In this situation the Public Advocate may be asked to make a decision in advance in relation to cardiopulmonary resuscitation including consenting to a "*not for resuscitation*" order. The Public Advocate does not routinely sign "*not for resuscitation*" forms, but will consider medical information about resuscitation on an individual basis, as part of a palliative approach. For people for whom cardiorespiratory arrest is an anticipated consequence of their illness, the Public Advocate may consent to a request to withhold cardiopulmonary resuscitation, as part of a palliative care plan, when this is in the person's best interests and in line with medical advice and goals of care.[14]

At the time of his death the deceased did not have a palliative care arrangement in place. On 11 March 2009 a nurse from Sarah Hardey House had contacted the deceased's Guardian at the office of the Public Advocate to provide an update on his medical condition and request

[13] T 59 - 66
[14] Exhibit 1, Tab 15, extract from Public Advocate's Position Statement

completion of a Palliative Care Assessment form. At the time the nurse informed the Guardian that Dr Adesina had seen the deceased for a urinary tract infection and that he had commenced him on antibiotics. The nurse added, "*other than that Brian is well.*"[15]

The deceased's Guardian completed and returned the Palliative Care Assessment form the same day, noting on it that the deceased's wishes were not known. In response to the question regarding whether any extra measures or additional treatment was sought, the Guardian responded as follows: "*The Public Advocate requests that the facility contacts the guardian to discuss issues relating to palliative care when the need arises.*"[16]

This was a reasonable and proper response given that the deceased was described as being well save for the urinary tract infection, for which he was receiving treatment. These circumstances did not provide a basis for the Public Advocate making a palliative care decision in respect of the deceased.

The Public Advocate had delegated her functions as the deceased's Guardian. Whilst her Office was contactable at any time, the health practitioners were also able to provide urgent treatment without needing to consult with the Guardian to seek a treatment decision. This is the situation

[15] Exhibit 1, Tab 15, sub-tab C
[16] Exhibit 1, Tab 15, sub-tab C and Tab 24

that arose on 1 January 2011 when the deceased suddenly began to choke on his food, requiring urgent treatment. In those circumstances, the clinician quite properly applied her own clinical judgement.[17]

Due to the urgency of the treatment required for the deceased, and the absence of an advance health directive or palliative care plan, the Public Advocate did not have a role in the decisions concerning the deceased's healthcare treatment on 1 January 2011.

The deceased's dietary requirements

The Uniting Church Homes' medical records disclose that the deceased had regular care plans, physiotherapy assessments and occupational therapy assessments. On 17 September 2010 as part of his ongoing healthcare the registered nurse at Sarah Hardey House performed a swallowing assessment. She determined that the deceased required a soft diet and recorded this on his Routine Care Plan. Also on 17 September 2010 the enrolled nurse completed a Dietary Meals and Drinks Screening form reporting that the deceased was on a soft diet and needed observation/prompting to eat and drink. It was ticked that he could have toast but with no crust.[18]

[17] Section 110ZI Guardianship Act; T 69; T 75 - 76
[18] Exhibit 1, Tab 24

On 18 November 2010 the deceased's general practitioner Dr Adesina having reviewed the deceased, completed a Comprehensive Medical Assessment form in which he recorded: "*Brian has a soft diet due to no teeth.*" At the inquest Dr Adesina explained that when the deceased initially resided at Sarah Hardey House he was eating more or less a normal diet, and the swallowing assessment, being a routine procedure, was related to his difficulty chewing and swallowing because he had no teeth. He recalled making the decision for the deceased to have a soft diet in conjunction with the enrolled nurse on the ward round, and then completing the Comprehensive Medical Assessment form.[19]

On the morning of his death the deceased choked after eating some toast. Before addressing the events leading to the deceased's death, an analysis is warranted of the evidence concerning the reasons for the administration of a "*soft diet*" to the deceased.

At the inquest Ms Giles, the carer who gave the deceased his breakfast on 1 January 2011, recalled that the deceased often had toast. She was aware he was on a soft diet. Her evidence was that other carers had informed her that the deceased could eat soft toast, which she described as bread

[19] T 156 – 158; Exhibit 1, Tab 24

lightly toasted with the crusts off, softened with marmalade or butter and cut into small pieces (the softened toast).[20]

Ms Hendle, a carer at Sarah Hardey House recalled that the deceased's diet fluctuated between "*minced moist*" and "*soft diet*". Her evidence was to the effect that the softened toast would be suitable for a soft diet.[21]

Ms Bland, residential manager at Sarah Hardey House at the material time gave evidence at the inquest. Her evidence confirmed that as the deceased's dietary requirements were updated, in addition to being recorded in the medical files, the relevant details were also contained in a file in the kitchen, that the carers could access. There was also a modified meal poster inside each cupboard door, to assist with meal preparation. She noted that the deceased was on a soft diet and that for breakfast he would ordinarily have porridge and toast with no crusts. Her evidence regarding the appropriateness of providing the deceased with softened toast was consistent with that of the carers, Ms Giles and Ms Hendle.[22]

Nurse Green, clinical nurse in the employ of Uniting Church Homes, with responsibility for clinical governance input, gave evidence at the inquest. Consistent with Ms Bland, she confirmed the process whereby the information

[20] T7
[21] T 167
[22] T 196 - 198

concerning the deceased's modified dietary plan was sent to the kitchen to inform those preparing his meals. She explained that the deceased did not have a problem with his swallowing (dysphagia). Instead, he had a problem with his chewing, due to having no teeth. This is consistent with the information recorded on the deceased's Comprehensive Medical Assessment papers. Nurse Green informed the court that if the staff members had ascertained a problem with the deceased's swallowing, in the usual course he would have been referred to a speech pathologist. Also, if he had an identified problem with his swallowing, toast would have been precluded from his diet.[23]

Nurse Green explained that due to the deceased's advancing dementia he exhibited some behaviour problems, including a disinclination to sit and take the time to eat. He was at risk of malnutrition, and the soft diet was implemented to address his chewing problem and to provide him with food that he liked and could easily eat. In her view the softened toast was an appropriate food for the deceased.[24]

At the inquest Dr Adesina stated that his intention had been for the deceased to have food that he did not need to chew. Whilst he would not have expected the deceased to be given dry toast, or toast as it is ordinarily understood, he would have left it to a dietician or speech pathologist to decide whether the softened toast was appropriately considered

[23] T 177; T 185 -186; Exhibit 1, Tab 24
[24] T 185 - 186

part of a soft diet. He was confident that the staff at Sarah Hardey House would understand what is meant by a "*soft diet*".[25]

The deceased was not reviewed by a dietician or speech pathologist with respect to his dietary requirements. At the time of his death he had no teeth. It is clear that food may be cooked, moistened or cut in order to achieve textual softness. The aim is to minimise the risk of unchewed food particles entering and obstructing the airway.[26]

On all of the evidence before me I am satisfied that the deceased did not have a problem with his swallowing, but he did have a problem with his chewing, due to having no teeth. He was properly reviewed for his dietary requirements, his carers were aware he was on a soft diet and the softened toast that he was provided with on 1 January 2011, prepared in the manner outlined at the inquest by Ms Giles and Ms Hendle, was appropriate to his needs.

THE EVENTS LEADING TO THE DECEASED'S DEATH

On 1 January 2011, the deceased was sitting in the Jull House dining area eating his breakfast, comprising the softened toast. His carers, Ms Giles and Ms Hendle were working in the dining area. At approximately 8:50am Ms

[25] T 158 - 161
[26] Exhibit 1, Tabs 11 and 21

Giles noticed the deceased looking "*bluer*" and staring, and she realised that he was choking. She attended to him immediately and struck his back several times in an attempt to dislodge the object that he was choking on. The back strikes failed to remove the obstruction so Ms Giles inserted two fingers into the deceased's mouth and was able to remove some toast. The deceased's eyes were open but he did not respond to her call and he struggled to breathe. Ms Hendle heard Ms Giles call out for assistance and she attended. In accordance with the procedures, they promptly contacted the registered nurse, Ms Stott.[27]

Nurse Stott arrived within moments and identified the seriousness of the situation. She observed the deceased to be choking, his mouth was open and she described his colour as "*poor*". With the assistance of Ms Giles and Ms Hendle, Nurse Stott moved the deceased to a nearby office, so as not to upset the other residents. Nurse Stott struck the deceased's back several more times in an attempt to dislodge the obstruction. Nurse Stott instructed Ms Hendle to get the oxygen and suction kit, which she duly did. The kit contains an instrument known as a "yanker" and a suction catheter both of which can be used to suction out blockage from a person's throat.[28]

Nurse Stott inserted the yanker into the deceased's throat but there was only a dry suction. The suction catheter was

[27] T 7 – 9; T 163
[28] T 21 - 22; T 163

inserted into the deceased's throat via his nostril, but it too returned a dry suction. The deceased's blood pressure was measured at 119/77 and his pulse at 86 beats per minute. The dry suction caused Nurse Stott to consider that the deceased might instead be having a heart attack. The deceased became less responsive and she immediately called for an ambulance. No person performed cardio-pulmonary resuscitation on the deceased.[29]

Records reflect that the St John Ambulance received a telephone call at 8.53am and that they departed immediately, arriving at the scene at 9.08am. Records also reflect that Nurse Stott reported to the call taker that the deceased appeared to have had a heart attack, that she was putting the oxygen on, that she had tried suctioning without success, and that he had been seen to be choking at breakfast. On a couple of occasions the St John Ambulance call taker inquired of Nurse Stott as to whether she was going to perform cardiopulmonary resuscitation. Nurse Stott responded that she had the oxygen on, but that she did not have anything to perform cardiopulmonary resuscitation with. The call taker asked whether the deceased was breathing and Nurse Stott responded that he had a pulse. The deceased was placed in the coma position on his left side as instructed by the St John Ambulance call taker. While waiting for the ambulance to arrive Nurse Stott put the blood pressure monitor back on the deceased but on

[29] T 21 – 22; T 163 - 167

this subsequent occasion it did not register a pulse. No further treatment was provided to the deceased pending the arrival of the ambulance.[30]

Upon arrival the St John Ambulance paramedics observed that the deceased was in the right lateral position with no cardiopulmonary resuscitation in progress. He had no pulse, no breath sounds, he had fixed dilated pupils, his upper airway was clear and an ECG showed asystole in all leads. The paramedics declared the deceased dead at 9.10am on 1 January 2011.[31]

CAUSE AND MANNER OF DEATH

On 2 January 2011 forensic pathologist Dr J. McCreath made a post mortem examination of the deceased at the State Mortuary. The examination showed foreign material occluding the large airways. Specifically the examination of the respiratory system showed that: "*pieces of softened pale yellow material up to 50mm in length are seen completely occluding both the left and right main bronchi.*" There was also narrowing of one of the vessels supplying blood to the heart and emphysema.[32]

[30] T 22 – 28; Exhibit 1, Tabs 7, 10 and 13
[31] Exhibit 1, Tabs 2, and 10
[32] Exhibit 1, Tab 11

At the conclusion of the examination the forensic pathologist was unable to form an opinion on the cause of death, and further investigations were undertaken (histology and toxicology). Microscopic examination of tissue showed no significant abnormality. Toxicological analysis was negative for alcohol and common drugs.

On 14 March 2011, following the receipt of the results of the further investigations, the forensic pathologist formed the opinion that the cause of death was upper airway obstruction in a man with a clinical history of dementia.[33]

I accept and adopt the forensic pathologist's opinion on the cause of death.

The manner of the deceased's death was by way of accident.

CPR IN THE AGED CARE SETTING

Aged care providers are obliged to provide nursing care, emergency equipment and emergency assistance under the specified care and services outlined in the Quality of Care Principles.[34]

It is to be borne in mind that residential aged care facilities do not have the same clinical capacity that is seen in a

[33] Exhibit 1, Tabs 11 and 12
[34] Exhibit 1, Tab 32

hospital setting. An aged care facility is not a rehabilitation or acute care facility. The views expressed by Leading Age Services Western Australia, an industry association representing providers of aged care in Western Australia are that it is not always appropriate to provide resuscitation, and that resuscitation should be treated on a case-by-case basis.[35]

SARAH HARDEY HOUSE'S POLICY CONCERNING CPR

Policy concerning CPR as at January 2011

In March 2014, the residential manager of Sarah Hardey House informed the court that the residential aged care facility "*has no current policy that permits staff to undertake cardiopulmonary resuscitation on residents.*" At the inquest, this was clarified to mean that there was no specific "*not for resuscitation*" policy and no specific policy addressing the administration of cardiopulmonary resuscitation. The resident care manual required that in an emergency situation, the registered nurse on duty be contacted, and that an ambulance be called if the situation was deemed to require it. All clinical and care staff at Sarah Hardey House had first aid training and were expected to administer it, consistent to their level of training and their roles. However, the manual did not specify whether the administration of first aid included cardiopulmonary resuscitation.[36]

[35] Exhibit 1, Tab 32; Exhibit 1, Tab 9
[36] T 4; T 172 - 173

There were no instructions in the deceased's records as to whether he was "*not for resuscitation*".[37] No cardiopulmonary resuscitation was performed upon the deceased on 1 January 2011. Nurse Stott, the registered nurse who attended to him, had understood that it was not the practice or policy to do so.

Nurse Stott recalled that when she commenced working at Sarah Hardey House nine years previously, having come from a hospital environment, she asked "*where's the resus trolley and doctors*?" The clinical nurse informed her that they do not perform cardiopulmonary resuscitation, and that if a resident becomes unwell, the procedure is to call a doctor or an ambulance, as required.[38]

Nurse Stott's evidence was that, as at January 2011, the question of whether or not to administer cardiopulmonary resuscitation was not an issue because there was no equipment provided to the nurses for this purpose. Specifically she explained that the nurses were not provided with masks. In her view the masks were important in order to prevent cross infection when performing mouth-to-mouth resuscitation and also to facilitate a seal so as to more effectively administer the breaths. Nurse Stott did not consider the option of administering only chest compressions to the deceased, due to her understanding

[37] T 29
[38] T 21 - 22

that "*we didn't do CPR*". She also did not consider that the deceased would have benefitted from chest compressions alone because she formed the view that he was dying.[39]

Another reason advanced by Nurse Stott for not performing cardiopulmonary resuscitation related to the deceased being frail and aged, thereby making it risky to perform compressions on his chest. Whilst this was expressed by her to be secondary to the lack of masks, it was nonetheless a consideration that affected her decision making on 1 January 2011.[40]

Ms Giles was the first responder to the deceased. Her evidence was that she was under the impression that the deceased was "*not for resuscitation*", having regard to his age, his dementia and his quality of life, as she understood it to be. She believed that was reason for not performing cardiopulmonary resuscitation on the deceased.[41]

Ms Hendle, was the carer present when Nurse Stott attended to the deceased on 1 January 2011. At the inquest her evidence was that Nurse Stott was in charge and made the decision concerning the medical treatment of the deceased. She would not have intervened in that decision making. She was unaware of any Sarah Hardey House policy concerning the decision-making for the

[39] T 26 – 31; T 36 - 37
[40] T 31; T 34
[41] T 15

performance of cardiopulmonary resuscitation upon the aged residents. She was also under the impression that the deceased was "*not for resuscitation.*"[42]

Nurse Green gave evidence at the inquest, concerning the practices regarding cardiopulmonary resuscitation. She was not involved in the decision making on 1 January 2011. Nurse Green has primarily been in the employ of Uniting Church Homes since 1995. Since February 2011, her role has included providing clinical governance and input into clinical and nursing policy in connection with 23 residential care facilities coming under the oversight of Uniting Church Homes. At the inquest Nurse Green's evidence confirmed that as at January 2011, there was no specific policy for "*not for resuscitation*", nor was there a specific policy addressing the performance of cardiopulmonary resuscitation upon the residents. She was aware that cardiopulmonary resuscitation was not part of the training for nurses and care staff and that it was not specified as coming within the terms of the first aid to be rendered.[43]

Nurse Green confirmed that as at 1 January 2011, the clinical decision as to whether or not to provide life-sustaining care, including the administration of

[42] T 164 - 167
[43] T 171 – 172; T 174

cardiopulmonary resuscitation, rested with the attending registered nurse. Nurse Green explained that the registered nurses knew the residents well, and that if an agency registered nurse was on duty, the care staff were a reliable and competent source of information concerning the patient. They would be assisted by the fact that each resident had an individualised and comprehensive care plan.[44]

In providing her evidence concerning the performance of cardiopulmonary resuscitation, Nurse Green pointed to the fact that at Sarah Hardey House, residents are admitted who are very frail, often with advanced dementia and other comorbidities. Accordingly resuscitation is not at the forefront of the decisions that the clinicians make. She described the primary considerations as follows:

> "*We are looking at giving them the best possible care and comfort, doing everything we can to give them a quality of life, both medically, nursing and emotionally, and every possible facet for the time they have with us."*[45]

Where possible, Sarah Hardey House would discuss wishes with family members, but this had not been possible in the deceased's case.[46]

[44] T 173
[45] T 175
[46] T 175

Even though the deceased did not have a "*not for resuscitation*" order in place, Nurse Green supported Nurse Stott's decision not to perform cardiopulmonary resuscitation for the following reasons:

> *"….[he] had advanced dementia, he had a lot of other comorbidities, he was not experiencing a quality of life that we would like if it was a close relative of ours, and therefore, at the time of his choking, if I had been the RN on duty, I would have done everything I could have, as did the RN on duty, to alleviate his choking and to give him the best possible first aid intervention in that situation and call for backup from an ambulance service, because they have the necessary equipment. But I don't believe, if I had have known about Mr Wood and where he was in his life's journey, that I would have done CPR."*[47]

Whilst Nurse Stott was of the view that there was a practice of not performing cardiopulmonary resuscitation on the residents of Sarah Hardey House (consistent with Sarah Hardey's information to the court in March 2014),[48] and Nurse Green subsequently clarified that the decision-making rested with the registered nurse, their evidence regarding the circumstances attending the healthcare rendered to the deceased on 1 January 2011 was consistent.

Dr Adesina, the deceased's GP, gave evidence to the effect that the deceased ought not to have been resuscitated, due

[47] T 175
[48] Exhibit 1, Tab 9

to his co-morbidities.[49]

Ms Bland, residential manager at Sarah Hardey House as at 1 January 2011 confirmed that the decision concerning the administration of cardiopulmonary resuscitation rested with the registered nurse, who would also call for an ambulance.[50]

Policy concerning CPR as at the present

Since the time of the deceased's death, Sarah Hardey House has taken steps to clarify its policy concerning the performance of cardiopulmonary resuscitation on its aged care residents. However, the policy as explained by Nurse Green at the inquest has not changed.

Nurse Stott stated that in 2015 the relevant staff members of Sarah Hardey House received training in cardiopulmonary resuscitation from an external provider, they are now provided with masks for mouth-to-mouth resuscitation, there is better access to information concerning whether a resident is "*not for resuscitation*", and there is further guidance concerning actions to be taken in the event of a resident suffering a cardiac arrest. She confirmed she would now be expected to perform cardiopulmonary resuscitation, as per the training she

[49] T 160
[50] T 199

received. In her view it is still however a clinical decision and with a very frail person it could do more harm.[51]

Nurse Green confirmed that cardiopulmonary resuscitation is now a component of the first aid training, that the registered nurses have an annual refresher and that there are now masks available for use for mouth-to-mouth resuscitation. She did however explain that these are contained in the first aid kits, primarily for use to perform life-sustaining measures on visitors, contractors and staff members. Her evidence was that there is now readily accessible electronic and hard copy information concerning whether a resident is "*not for resuscitation*". However, she would not want the registered nurse to assume that, if a person does not have such an instruction, then cardiopulmonary resuscitation must be performed. It remains a clinical decision for the registered nurse and factors such as frailty and the possibility of doing harm are relevant considerations. In that regard Nurse Green's evidence was that the policy as at the time of the inquest was the same as it had been in 2011.[52]

SJA PARAMEDIC'S VIEWS CONCERNING CPR

Mr Scott was the St John Ambulance paramedic who attended upon the deceased, with his colleague. He has been with St John Ambulance for approximately 38 years,

[51] T 31 – 34; T 38
[52] T 178 - 181

and for 24 of those years, he has been a paramedic. The paramedics attended promptly following the call out. When they arrived at the scene the deceased had passed away.

Upon his arrival, paramedic Mr Scott was informed that no cardiopulmonary resuscitation had been performed upon the deceased. Mr Scott's evidence was that a St John Ambulance paramedic's priority is to save lives and he would both recommend and perform cardiopulmonary resuscitation in all instances to achieve that purpose. In his experience a paramedic would continue to perform life-sustaining measures until s/he is made aware of a "*not for resuscitation*" form. Mr Scott opined that if the registered nurse or even a member of the public performs cardiopulmonary resuscitation, it will enable the paramedics to provide more effective treatment upon their arrival. In his view, performing only compressions (with no breaths) would still be effective, though not as effective as adding the breaths.[53]

Under cross-examination Mr Scott agreed that performing cardiopulmonary resuscitation upon a patient over the age of approximately 65 years would likely result in a breaking of the ribs or sternum, due to the lack of flexibility in the ribs.[54]

[53] T 48 – 55;
[54] T 56

EXPERT EVIDENCE CONCERNING CPR

I accept counsel assisting's submission that there is no one policy that governs resuscitation policy in Western Australia for aged care facilities. The Standards for Resuscitation: Clinical Practice and Education[55] (Resuscitation Standard) provide guidance on the creation and implementation of policy regarding resuscitation and decisions relating to cardiopulmonary resuscitation. The contributors to this publication are the Australian Resuscitation Council, the National Resuscitation Committee (Australian College of Critical Care Nurses) and the UK Resuscitation Council.

At the inquest I heard expert evidence from Associate Professor Goldswain and Dr Arenson (both expert geriatricians) and Professor Grantham (an expert in resuscitation and emergency medicine) regarding the appropriate and practical use of the Resuscitation Standards in an aged care facility.

On all of the expert evidence before me, the first and most important aspect is the ascertainment of the individual's wishes. That may also include discussion with family members. In the deceased's case, having entered Sarah Hardey House with advanced dementia and having no relatives available for such discussion, this was not a matter that Sarah Hardey House was able to address.

[55] Exhibit 1 – Tab 17

All three experts agreed that the Resuscitation Standards apply to residential aged care facilities, by reason of those facilities being a "*health care institution*" for the purposes of those Standards. Uniting Church Homes through its counsel does not dispute that Sarah Hardey House is a health care institution. Part 1 of the Resuscitation Standards states:

> "*Health care institutions have a duty of care to provide an effective resuscitation service for patients within the organisation and to ensure that the staff is educated to recognise acute deterioration*".[56]

That general guideline, applicable to all health care institutions, is to be read in conjunction with the specific guidelines within the Resuscitation Standards. The following extract from the Resuscitation Standards is of particular relevance to the circumstances attending the deceased's death:

> "*Where there is no resuscitation plan and the wishes of the patient are unknown, resuscitation should be initiated if cardiopulmonary arrest occurs. However, a decision not to attempt resuscitation may be appropriate when:*
>
> - *The patient's condition indicates that an attempt at resuscitation is unlikely to be successful in saving life (futility)*

[56] Exhibit 1,Tab 17, page 4

- ….
- ….
- *Where CPR imposes burdens outweighing benefits upon the patient*
- *Successful CPR is likely to be followed by a quality of life that is not in the patient's best interests."*[57]

As at 1 January 2011, Sarah Hardey House did not have a resuscitation team. In such circumstances, the Resuscitation Standards recommend the following:

> *"In institutions where appropriate staff and facilities are not available for a resuscitation team, clear policies on scope of resuscitation practice by staff must be available. Co-ordination of a rapid response may be achieved with the ambulance service. Provision of this service must be organised with the ambulance service with a written service agreement. This rapid response will be achievable following a 000 call to the ambulance service".*

Expert geriatrician Associate Professor Goldswain provided a Report in which he stated that policy on resuscitation should not be made broadly to cover all residents in aged care facilities, but should be made on an individual basis for each resident. In his evidence he opined that in general terms where an individual's wishes are unknown, the decision to resuscitate is to be left to the appropriate staff member in the facility at the time. If

[57] Exhibit 1, Tab 17, page 17

that staff member was comfortable and competent to perform resuscitation, then they may choose to do so.[58]

In practical terms, where such as for the deceased, it had not been possible to ascertain his wishes (nor those of his family) Associate Professor Goldswain's evidence was that the decision concerning whether or not to perform cardiopulmonary resuscitation rested with the registered nurse. In the absence of a policy, Associate Professor Goldswain agreed that it places a burden upon the nurse.[59]

In Associate Professor Goldswain's experience, there may be an understandable reluctance to commence chest compressions upon elderly, frail people who have got osteoporosis and multiple co-morbidities. In order to effectively perform chest compressions, pressure is to be firmly applied resulting in cracking or breaking of the ribs, and the staff member may have "....*an awful sensation, that [you're] damaging the patient*". For the patient who is resuscitated, the consequences of such chest compressions may include ongoing difficulty in breathing, the risk of pneumonia, metabolic consequences for the kidney and liver, tachycardia or heart arrhythmias.[60]

[58] Exhibit 1, Tab 19; T 80 - 81; T 113
[59] T 87 – 88; T 111 - 112
[60] T 115

In his report Associate Professor Goldswain provided an extensive overview of the evidence for success in resuscitation of the elderly and disabled in high-level care. Whilst Associate Professor Goldswain outlined some of the merits of an opt-in model of care (whereby aged care facility residents would not be resuscitated unless they had previously recorded a wish to that effect) he did not advocate for that position. He provided the following information to the court:

> *"Notably end-of-life questions are a recurring consideration. In August 2014 in a "For debate" article in the Medical Journal of Australia*[61] *an appeal was made for open community discussion about end-of-life care and the "de-prescription of CPR. They advocate that CPR should no longer be the universal default procedure. The authors propose an opt-in model of care to drive a discussion and an evaluation of the suitability of CPR for the individual....this seems eminently reasonable".*[62]

Professor Grantham, provided a report in which he stated that resuscitation decisions should be made by individuals and in the absence of a clear indication to the contrary, resuscitation should be commenced following the Australian Resuscitation Council Guidelines, which was a reference to the Resuscitation Standards. Professor Grantham is a Professor of Paramedic science at Flinders University. His

[61] Levinson M and Mills A. Cardiopulmonary resuscitation – a time for change in the paradigm? MJA 2014; 201: 152 - 154
[62] Exhibit 1, Tab 19

expertise is in the area of resuscitation and emergency medicine.[63]

Consistent with views expressed by the attending St John Ambulance paramedic (Mr Scott), Professor Grantham's view was that compression only cardiopulmonary resuscitation is better than none at all, and (in the absence of the patient's wishes to the contrary) compressions should continue until there is a return of a pulse or the situation is deemed hopeless. He opined that in the absence of patient's wishes being known, it should be assumed that the patient wants cardiopulmonary resuscitation. His preferred option is to commence to provide it, and then seek clarification if necessary. He proffered information to the effect that there may be quite good life expectancy in aged persons who are resuscitated. In his view an experienced nurse in a residential aged care facility would have the knowledge to assess whether the situation presents as a potentially reversible emergency.[64]

Geriatrician Dr Arenson provided a report[65] and gave evidence at the inquest. Like Associate Professor Goldswain, he inclined towards consideration of an opt-in policy for cardiopulmonary resuscitation in the residential aged care setting, though he did not advocate for it either. He addressed the complications likely to be suffered by a

[63] Exhibit 1, Tab 16
[64] T 129 – 134; Exhibit 1, Tab 16
[65] Exhibit 1 – Tab 20

frail, elderly person who is successfully resuscitated. Dr Arenson considered it preferable for residential aged care facilities to have a clear policy on the administration of cardiopulmonary resuscitation rather than leaving a registered nurse to make that decision on the spot. The content of such a policy is outside Dr Arenson's area of expertise.[66]

Professor Grantham provided his evidence in respect of the practical application of resuscitative measures, in his capacity as an expert in the area of resuscitation and emergency medicine. The tenor of his evidence was that good outcomes for patients may be achieved in the aged care setting. Associate Professor Goldswain and Dr Arenson addressed resuscitative measures in the context of their experiences and expertise as geriatricians. In their evidence they outlined their concerns about the ongoing health problems suffered by frail, elderly patients who are resuscitated.

All three experts agreed that where the individual's wishes are unknown, the decision to resuscitate should be left to the properly qualified staff member, in this case the registered nurse.

As at 1 January 2011, Sarah Hardey House had no written policy concerning the performance of cardiopulmonary

[66] T 146 - 148

resuscitation on residents whose wishes were unknown. However, Nurse Scott was comfortable in having made the decision not to perform cardiopulmonary resuscitation upon the deceased. I am satisfied that in those circumstances and given Nurse Stott's experience and expertise, Sarah Hardey House's practice was consistent with the expectations evinced by the Resuscitation Standards.

WOULD CPR HAVE PREVENTED THE DECEASED'S DEATH?

I heard evidence from an expert on resuscitation and emergency medicine (Professor Grantham) and an expert geriatrician (Dr Arenson) on the question of whether cardiopulmonary resuscitation would have been likely to have prevented the deceased's death.

On his review of the available information at the time of preparing his report, Professor Grantham opined that the deceased's airway obstruction was very likely avoidable and reversible with appropriate treatment. He addressed the Australian Resuscitation Council's flowchart for the management of foreign body airway obstruction (choking) attached to his report. At the inquest, he explained that the commencement of cardiopulmonary resuscitation in such circumstances would be recommended, due to the potentially lifesaving effects:

> *My rationale is that choking is potentially a reversible problem if you can displace the foreign body, and the choking algorithm,*

which I included in my report, starts with back slaps. If we can't clear it, then it's chest compressions as in CPR. If you can pop the obstructing piece of food out at that point, then there's no reason why this person shouldn't do well. So it's a very simple procedure for a potentially very good result.[67]

Professor Grantham opined that the trigger for full cardiopulmonary resuscitation is the absence of normal breathing. In his experience, it would likely have allowed for a better evaluation when the paramedics had arrived. However, having regard to knowing in hindsight, that the deceased's right and left main bronchi were completely occluded, Professor Grantham did not consider there was a prospect of treating that through the chest compressions.[68]

Dr Arenson did not consider that the deceased's obstruction was very likely reversible by any action that Nurse Stott could have taken. On his review of the results of the post mortem examination, particularly the examination of the respiratory system, he noted that there was foreign material occluding the upper airways. He opined that Nurse Stott acted appropriately by attempting to dislodge the blockage and by thumping the deceased's back, and attempting airway clearance and suction. He supported his opinion with the following explanation:

"Resuscitation guidelines start with "ABC", meaning that the airway (the "A' in "ABC") needs to be attended to as a primary

[67] T 131; Exhibit 1, Tab 16
[68] T 132

need for resuscitation. If the airway is obstructed, there is no purpose in performing CPR. There is no purpose in attempting to blow air against an obstructed airway via a mask. The only procedure that would have been lifesaving in this case was a cricothyroidotomy. Since nurses are not expected to be proficient in this kind of specialised surgical procedure, nurses Stott and [Giles], were helpless to prevent this death. If they were fully trained in advanced life support, [they] would have been aware of the futility of performing CPR and mouth-to-mouth on a patient with a fully obstructed airway, regardless of other considerations."[69]

There are two aspects for consideration, arising from the expert evidence before me. The first is whether the deceased's airway obstruction was avoidable. I have no criticism of the breakfast offered to the deceased on 1 January 2011, including the softened toast. It follows that the deceased's choking was a most unfortunate accident.

The second aspect concerns whether the deceased's airway obstruction was reversible. I am satisfied that in order to reverse the occlusion of the deceased's upper airways, significant medical intervention was required, of a nature that Nurse Stott could not have been expected to provide. I accept the expert evidence of Professor Grantham and Dr Arenson. Nurse Stott applied appropriate first aid and called for an ambulance. The performance of cardiopulmonary resuscitation by Nurse Stott would have been futile. There is nothing that Sarah Hardey House

[69] Exhibit 1, Tab 20

and/or Nurse Stott did or failed to do that would have been likely to prevent the deceased's death.

COMMENTS ON PUBLIC HEALTH

Pursuant to section 25(2) of the Coroners Act I may comment on any matter connected with the death, including public health.

The evidence at the inquest reflected varying views on whether and under what circumstances residential aged care facilities ought to provide life-sustaining measures to residents in their care. The commonly held view amongst the clinicians is that it is best left as a clinical decision to be made by the registered nurse on duty on a case-by-case basis, consistent with the Resuscitation Standards. Where a person's wishes are not known this leaves the registered nurse with the responsibility for making not only a decision as to whether the attempt is likely to be successful, but also in deciding, where relevant in a particular instance:

- whether the burden of cardiopulmonary resuscitation outweighs its benefits; and/or
- whether successful cardiopulmonary resuscitation is likely to be followed by a quality of life that is not in the patient's best interests.

Nurse Stott and Nurse Green both stated they would be comfortable to make clinical decisions on the spot as to whether a resident should be resuscitated.[70] However, for some clinicians, these will be difficult questions to address in the absence of policies or guidelines. The Australian Nursing Federation (ANF), in its recent survey following the inquest, found that the majority of those surveyed did not consider it appropriate to rely on or require registered nurses to make these decisions in the aged care setting (in the absence of knowing a patient's wishes).[71]

Whilst it is acknowledged by the ANF that the survey results do not form part of the evidence tendered to the court, the ANF's submission, through Ms Burke, simply serves to support the self-evident point of it being desirable for there to be some guidance for registered nurses, given the potential for subjectivity in the decision making in the aged care setting. In particular guidance may be considered on when cardiopulmonary resuscitation outweighs its benefits and/or when resuscitation is likely to be followed by a quality of life that is not in the patient's best interests. The absence of guidance risks placing a burden upon some of the registered nurses.

[70] T 28; T 176

[71] The ANF conducted a short informal survey of its registered nurse members who work in the aged care sector, in order to provide a submission that reflects the views of its members. 1859 members were invited to participate in the survey, and 146 responded.

Leading Age Services Western Australia, the industry association representing providers of aged care in Western Australia submits that in an aged care setting resuscitation can be a) futile; b) an undignified way for someone to end their life and c) be very upsetting for all involved (residents, staff and family members).[72]

I accept and adopt Professor Grantham's salutary remarks in his report to the court:

> "*Respecting the choices of individuals who do not wish resuscitation is important and the conversations about advanced care directives should occur early and be appropriately documented.*
>
> *Respecting the choice of those who wish active resuscitation is equally important and should be supported with policy, equipment and educated staff. The aged care industry must be encouraged to maintain this balance and respect the wishes of both groups of patients*".[73]

This inquest highlighted the importance of community members engaging in discussions to consider the appropriateness of an advanced health directive at a time when they have capacity, however uncomfortable such discussions may be, or the choice may in due course of necessity be taken out of their hands. Whilst the preferred course is for decisions about resuscitation to best be made

[72] Exhibit 1, Tab 32
[73] Exhibit 1, Tab 16

by residents and families of residents on admission to a residential aged care facility, leaving it to that point may be unworkable, as in the case of the deceased where, suffering from dementia, he no longer had the capacity to make his choices about his future treatment.

It is also desirable that clinicians working in the aged care setting be supported with guidance and policies that assist them in their decision-making when confronted with an emergency situation, in the context of the patient's wishes not being known. What those policies ought to provide for is not a matter for me to recommend. However, I encourage the aged care industry to engage in these discussions with a view to formulating some guidance on the administration of cardiopulmonary resuscitation in the aged care setting where the patient has not made an advanced health directive and/or the patient's wishes are not known.

CONCLUSION

The deceased was an elderly gentleman who immediately prior to his death suffered from severe dementia and a number of other co-morbidities. He resided at Sarah Hardey House, a residential aged care facility.

On the morning of 1 January 2011 the deceased was provided with his usual breakfast, which included softened toast. The deceased began to choke on his toast and he was

promptly attended to by his carers and the registered nurse. The nurse endeavoured to remove the obstruction and clear his airway but was unsuccessful, due to the obstruction being of such severity as to have required surgical intervention. An ambulance was called for, paramedics promptly attended but unfortunately by the time of their arrival the deceased had passed away.

There was no cardiopulmonary resuscitation performed on the deceased and, had it been performed, it would have been unlikely to reverse the occlusion of the deceased's upper airways and therefore futile.

R V C FOGLIANI
STATE CORONER

23 June 2016