Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 24/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Nola Inez DANIEL*** *with an inquest held at the* ***Bunbury Courthouse*** *on* ***16, 17 & 19 June 2014*** *find that the identity of the deceased person was* ***Nola Inez DANIEL*** *and that death occurred on* ***7 January 2010*** *at* ***Bunbury Regional Hospital*** *as a result of* ***complications following fracture and surgical repair of the left hip in an elderly lady with underlying chronic lung disease and valvular heart disease*** *in the following circumstances:*

Counsel Appearing:

Ms I Burra-Robinson assisting the Coroner.
Mr N Van Hattem (SSO) appearing on behalf of the Bunbury Regional Hospital.
Mr R Gipp (Barrister) appearing under instruction of Victor Harcourt (Russell Kennedy Lawyers) on behalf of Regis Aged Care/Regis Forrest Gardens and its staff.

TABLE OF CONTENTS

INTRODUCTION

1. Mrs Nola Inez Daniel (the deceased) was an elderly lady who lived with her husband in Australind until shortly before her death.

2. On Christmas Eve 2009 the deceased went into urgent respite care at Regis Forrest Gardens, an aged care facility in Bunbury (Regis Forrest Gardens), which is owned and operated by Regis Aged Care Pty Ltd (Regis). The deceased had a number of falls on Christmas Day 2009 while a resident at Regis Forrest Gardens. On Boxing Day 2009 the deceased was transferred to Bunbury Regional Hospital and diagnosed with a fractured left neck of femur (left hip) and a possible closed head injury.

3. On 29 December 2009 the deceased underwent a left hemiarthroplasty to surgically repair her fractured hip. After the operation the deceased became unwell with a right-sided pneumonia and developed respiratory failure. On 7 January 2010 the deceased went into cardiac arrest and she died that morning.[1]

4. I held an inquest into the death at the Bunbury Courthouse on 16, 17 and 19 June 2014.

5. The inquest focused primarily on the quality of the care provided to the deceased after each fall during her brief stay at Regis Forrest Gardens. This included the decision not to call a doctor or take her to hospital on each occasion, as well as identifying the particular circumstances in which the deceased came to fracture her hip before she was taken to hospital.

6. At the commencement of the inquest counsel for Regis made opening submissions and conceded that there were aspects of the deceased's care at Regis Forrest Gardens that did not meet the required standard. In particular, the deceased should have been medically

[1] Exhibit 1, Tab 28.

examined by a doctor after two of her falls on 25 December 2009.[2]

7. The documentary evidence comprised two volumes, annexing a large number of witness statements and medical records and reports,[3] as well as a few additional documents tendered during the inquest.[4]

8. Oral testimony was given by:

   a) Ms Diana Davidson, the niece of the deceased;
   b) Ms Linda Noakes, who was a Silver Chain Nursing care coordinator in 2009;
   c) a number of the Regis Forrest Gardens nursing and care staff involved in the deceased's admission and care at Regis Forrest Gardens in late December 2009;
   d) Ms Fiona Piggott, the Facility Manager of Regis Forrest Gardens; and
   e) Dr Pratsis, the current Head of Orthopaedics at Bunbury Regional Hospital.

THE DECEASED

9. The deceased was 83 years old at the time of her death, having been born on 21 June 1926. She was married to David Daniel and they lived together in a house in Australind. Until late 2009, she was described as being physically and mentally well for her age,[5] and until a year before her death she walked up to one and a half miles a day.[6]

10. In August 2009 the deceased sustained a mid-back injury when she was gardening, possibly contributed to by her osteoporosis. After experiencing increasing levels of pain and discomfort, a spinal x-ray performed on

[2] T 7 – 8.
[3] Exhibits 1 and 2.
[4] Exhibit 3 – Full Post Mortem Report; Exhibit 4 – Silver Chain Correspondence; Exhibit 5 – Handwritten notes of Nurse Marion Eaton.
[5] T 11 (Davidson, D.C.).
[6] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes, 30.12.09 – Physio.

7 October 2009 revealed a crush fracture of two vertebrae.[7] The deceased was commenced on strong analgesia and given a back brace, but she continued to experience significant pain. Her pain was exacerbated by a persistent cough, believed to be caused by pulmonary fibrosis. She also experienced significant debilitating side effects from her pain medication.

11. The deceased became increasingly frail over this period. Her niece described her as being "on a spiral downhill" toward the end of 2009.[8] She began to experience mobility issues, although she remained determined to walk around her house unassisted.[9] She also appeared to experience some mental deterioration, which was attributed to the effects of her pain medication.[10]

12. Despite her deteriorating health, the deceased had managed to continue to live independently at home in Australind, with her husband providing most of her care needs. However, in October and November 2009 the deceased's husband began to experience his own health problems,[11] which, together with the deterioration in the deceased's health, made it difficult for him to meet all her care needs.

13. Accordingly, in late November 2009 the deceased's niece, Ms Davidson, contacted Silver Chain Nursing, who began to provide some home help and personal care assistance for the deceased.[12]

14. Ms Linda Noakes, who at the time was working as a Silver Chain care coordinator in Bunbury, attended the deceased's home personally nine times between 24 November and 24 December 2009. During those visits she helped plan the deceased's care and assisted her in dressing, undressing and showering.[13]

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[7] Exhibit 1, Tab 27, p. 1.
[8] T 10, 11 (Davidson, D.C.).
[9] T 12 (Davidson, D.C.).
[10] T 12 (Davidson, D.C.); Exhibit 1, Tab 2 [8].
[11] T 13 (Davidson, D.C.).
[12] T 14 (Davidson, D.C.); Exhibit 1, Tab 3, [3].
[13] Exhibit 1, Tab 3 [6], [12].

15. Ms Noakes observed the deceased's mental state on these occasions and formed a similar conclusion to Ms Davidson and Mr Daniel, that the deceased's confusion was attributable to her pain medication, in particular the durogesic patches.[14] Ms Noakes was experienced in dealing with people diagnosed with dementia and she did not see any signs of dementia in the deceased.[15] She recommended that the deceased ask her doctor to review the medication.[16]

16. On 17 December 2009 the deceased presented to the Emergency Department of Bunbury Regional Hospital (Bunbury Hospital) after being referred by Silver Chain.[17] Her doctor had seen her the day before and noted she was 'at the end of her tether' in relation to her pain levels and her medications' side effects.[18] Ms Davidson also described the deceased as "beside herself" with the pain from her back at that time.[19] The deceased was admitted for respite care as her husband had to travel to Perth to undergo some tests.[20]

17. The deceased was discharged from hospital the following day and a suggestion was made that her general practitioner should review her analgesia and consider lowering the dose of her patch.[21] It does not appear from Dr Lee's report that this occurred prior to the deceased's death[22] (although a nurse from Regis Forrest Gardens did try to contact Dr Lee to query the dosage of some of her medications, including her patch, on 26 December 2009).[23]

18. The deceased was also referred for an urgent ACAT (Aged Care Assessment Team) assessment, [24] which had been recommended by her Silver Chain care

[14] T 25 – 26 (Noakes, L.I.).
[15] T 26 (Noakes, L.I.).
[16] Exhibit 1, Tab 3 [19] – [20].
[17] Exhibit 2, Tab 6, Bunbury Hospital Discharge Letter 17 - 18.12.2009.
[18] Exhibit 1, Tab 27, p. 1.
[19] T 14 (Davidson, D.C.).
[20] Exhibit 2, Tab 6, Bunbury Hospital Discharge Letter 17 - 18.12.2009.
[21] Exhibit 2, Tab 6, Bunbury Hospital Discharge Letter 17 - 18.12.2009.
[22] Exhibit 1, Tab 27.
[23] Exhibit 1, Tab 10, Supplementary Statement, 22.4.14 [10].
[24] Exhibit 1, Tab 27, p. 1.

coordinator, Ms Noakes.[25] The ACAT assessment was completed on 21 December 2009 and gave approval for extra help at home and also residential respite care in a nursing home, if needed in the future.[26]

19. On 22 December 2009 another Silver Chain employee visited the deceased at home. After the visit she rang Ms Noakes and informed her that the deceased's husband, Mr Daniel, was very tired. Ms Noakes made an appointment to visit the couple on 24 December 2009 to discuss respite care with them.[27]

20. Ms Noakes attended the deceased's home at about 9.30am on the morning of 24 December 2009. When Ms Noakes arrived she observed that the deceased had some facial injuries, namely a cut and swollen lower lip and a substantial bruise under her left eye.[28] She asked what had happened and Mr Daniel informed her that the deceased did it on a corner of a table after falling. They had not made an appointment for her to see a doctor as the bleeding had stopped.[29] The deceased was quite disoriented due to pain and told Ms Noakes that she was ill.[30]

21. Mrs Noakes discussed the option of respite care with the deceased and Mr Daniel.[31] The deceased was in favour of the idea as her husband was very tired and she wanted him to relax and enjoy Christmas Day with his relatives.[32] For herself, the deceased simply desired "somewhere quiet to rest."[33] Mr Daniel was also planned to have surgery soon and neither the deceased nor Mr Daniel wanted to burden family with her care, although they were aware that their niece was willing (and expecting) to care for her.[34]

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[25] Exhibit 2, Tab 6, Silver Chain Outcome of Assessment/Review 14.12.2009.
[26] Exhibit 1, Tab 18; Exhibit 2, Tab 6, Southwest Aged Care Assessment Team letter 21.12.2009.
[27] T 27 (Noakes, L.I.); Exhibit 1, Tab 3 [22] – [25].
[28] T 29 (Noakes, L.I.); Exhibit 1, Tab 3 [26] – [29].
[29] Exhibit 1, Tab 3 [30] – [34].
[30] T 30 (Noakes, L.I.); Exhibit 1, Tab 3 [36].
[31] T 26 – 27 (Noakes, L.I.).
[32] T 26, 30 (Noakes, L.I.).
[33] T 28, 30 (Noakes, L.I.).
[34] T 14 – 15 (Davidson, D.C.); T 27 (Noakes, L.I.).

22. Accordingly, Mrs Noakes made enquiries about an available room and booked the deceased into respite care with Regis Forrest Gardens, on the basis of carer stress.[35]

ADMISSION TO REGIS FORREST GARDENS

23. Ms Noakes returned to the deceased's home that afternoon to assist in organising the deceased's transfer from her home to Regis Forrest Gardens. She helped to organise the deceased's medication into a Webster pack and then assisted her to walk to the car.[36] Ms Noakes did not observe the deceased having any trouble weight bearing on her way to the car.[37]

24. Ms Noakes and Mr Daniel both drove separately to Regis Forrest Gardens. They arrived sometime between 2pm and 3pm.[38] Once there, the deceased walked inside with the assistance of her husband.[39] Ms Noakes recalled accompanying the deceased and her husband to the respite room allocated to the deceased. She accepted that the deceased may have been taken to the room in a wheelchair.[40] Ms Noakes stayed for a fair while to help get the deceased settled in to bed and then left.[41] She did not see the deceased again until the deceased was a patient at Bunbury Hospital.

25. Ms Diane McGillivray, a registered nurse, was responsible for admitting the deceased on 24 December 2009. Nurse McGillivray recalled admitting the deceased at about 3pm that day.[42] She escorted the deceased to the respite room, which is room D17.[43] Nurse McGillivray thought the deceased was accompanied by her husband and niece,[44] but I

[35] T 30 (Noakes, L.I.); Exhibit 1, Tab 3 [42].
[36] T 31 (Noakes, L.I.); Exhibit 1, Tab 3 [43] – [48].
[37] T 31 (Noakes, L.I.).
[38] T 33 (Noakes, L.I.).
[39] T 31, 34 (Noakes, L.I.); Exhibit 1, Tab 3 [51].
[40] T 34 - 35 (Noakes, L.I.).
[41] T 31, 34 (Noakes, L.I.).
[42] T 36 (McGillivray, D.E.); Exhibit 1, Tab 5, Statement 1 (27.10.10) [3].
[43] Exhibit 1, Tab 5 Statement 1 (27.10.10) [7] - [9]; Tab 39 [18].
[44] T 47 (McGillivray, D.E.); Exhibit 1, Tab 5 Statement 2 (22.4.2014) [7].

accept the evidence of Ms Davidson and Ms Noakes that it was, in fact, Ms Noakes who accompanied the deceased and her husband that day and Nurse McGillivray was mistaken.[45]

26. After she took the deceased to her room, Nurse McGillivray completed a medical assessment of the deceased and filled in some of the deceased's admission forms.[46]

27. Nurse McGillivray also wrote an entry in the deceased's progress notes in respect of her admission.[47] She noted that the deceased had memory loss and osteoarthritis and some other medical issues. Nurse McGillivray had been told the deceased had fallen at home that morning but had not seen a doctor.[48] She had also been told by the deceased's husband about a fall at night on 22 December 2009, recorded in the admission assessment form.[49] As a result, Nurse McGillivray noted the deceased was prone to falls and required the supervision of a staff member for all activities. She recorded that the deceased had a bruised lower lip and bruising on her left arm from a fall.[50] She did not observe any other bruising to her face at that time[51] and saw no signs that made her think that the deceased had a broken hip or head injury at that time.[52]

28. Because she considered the deceased to be at risk of falls, Nurse McGillivray lowered the deceased's bed to the lowest setting.[53]

29. When she finished her shift shortly afterwards, Nurse McGillivray recalled providing a detailed verbal handover to the incoming registered nurse for the afternoon shift, which started at 3.30pm.[54]

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[45] T 14 – 15 (Davidson, D.C.), 32 (Noakes, L.I.), 40 (McGillivray, D.E.).
[46] T 41 (McGillivray, D.E.).
[47] T 49 (McGillivray, D.E.); Exhibit 2, Tab 3C, RFG Progress Notes, Entry 24.12.09 1500 hrs.
[48] T 40 – 43 (McGillivray, D.E.).
[49] T 46 (McGillivray, D.E.); Exhibit 1, Tab 3D, Assessment, p. 4.
[50] Exhibit 2, Tab 3C RFG Progress Notes, Entry 24.12.09 1500 hrs.
[51] T 40 (McGillivray, D.E.).
[52] T 43 – 44 (McGillivray, D.E.).
[53] T 48 (McGillivray, D.E.).
[54] T 49 - 51 (McGillivray, D.E.); Exhibit 1, Tab 5 Statement 2 (22.4.2014) [13].

30. The next entry in the deceased's Regis Forrest Gardens' progress notes at 9pm that evening records that she was unsettled that first evening. She was found wandering into other rooms, looking for her husband, and had to be 'redirected and re-oriented regularly'.[55] Although the deceased had a call bell in her room, she did not use it.[56]

FIRST FALL

31. Mr Stephen Leggett, a registered nurse, started the night shift that evening at 9pm.[57] Nurse Leggett recalls being told in the verbal handover from the afternoon shift that the deceased had been admitted, she had bruising that had occurred prior to her admission, and she was quite confused.[58] He was firmly convinced that one of her diagnoses was dementia, which was consistent with her presentation while he cared for her.[59] Due to her state of confusion, he noted that the deceased was unable to use the call bell.[60]

32. Nurse Leggett did not read the progress notes relating to the deceased, as there was no time during the shift to do so, given the number of patients requiring his attention.[61] This was consistent with the evidence of the other nurses at Regis Forrest Gardens, none of whom were in a position to read the progress notes of the patients at the commencement of a shift.[62]

33. At about 1.45am Nurse Leggett was alerted by another staff member to the fact that the deceased had been calling out and was found to have fallen onto the floor.[63] Nurse Leggett observed the deceased on the floor on the left-hand side of the bed, wrapped in the blankets,

[55] Exhibit 2, Tab 3C, RFG Progress Notes, Entry 24.12.09 2100 hrs.
[56] T 48 (McGillivray, D.E.).
[57] T 65 (Leggett, S.); Exhibit 1, Tab 9 [4].
[58] T 69 (Leggett, S.); Exhibit 1, Tab 9 [8].
[59] T 68 (Leggett, S).
[60] T 68 (Leggett, S); Exhibit 1, Tab 9 [7].
[61] T 69 (Leggett, S).
[62] T 50, 60 - 61 (McGillivray, D.E.), 100 (Meyer, E.C.), 132 (Eaton, M.J.).
[63] Exhibit 1, Tab 9 [9] – [12].

which were still attached to the bed.[64] The bed linen was wet and the floor was also wet with urine.[65]

34. As the registered nurse on duty, it was Nurse Leggett's responsibility to medically assess the deceased after a fall to look for signs of injury.[66] He checked her from head to toe while she was on the floor. He didn't notice any obvious signs of injury, other than the bruising that she had on admission.[67] Nurse Leggett could not recall if the deceased expressed any pain when he conducted his check on her but, in his evidence, generally recalled that she did not speak to him at all during her admission at Regis Forrest Gardens.[68]

35. After he had checked the deceased on the floor, she was assisted to sit on a commode chair in the room and Nurse Leggett did some further checks on her.[69] He saw none of the usual signs of hip fracture, such as displacement/rotation or shortening of the leg and no obvious signs of pain or distress.[70] The deceased was then assisted back to bed.

36. After the event, Nurse Leggett made an entry in the deceased progress notes at 2am.[71] In the entry, Nurse Leggett recorded "Complaining of sore hips".[72] At the inquest, he had no recollection of the deceased making such a complaint, but he accepted that if he wrote it in the notes, it was something that would have occurred that night.[73]

37. As required by the Regis Forrest Gardens Incident Reporting Policy,[74] Nurse Leggett also completed an incident "flash' report in relation to the fall, which he

[64] T 71 (Leggett, S);
[65] Exhibit 2, Tab 3C, RFG Progress Notes, Entry 25.12.09, 0200 hrs.
[66] T 71 (Leggett, S); Exhibit 1, Tab 9 [13].
[67] T 71 (Leggett, S); Exhibit 1, Tab 9 [14].
[68] T 71 – 72 (Leggett, S).
[69] T 71 (Leggett, S).
[70] T 72 – 73, 77 (Leggett, S).
[71] Exhibit 2, Tab 3C, RFG Progress Notes, Entry 25.12.09, 0200 hrs.
[72] Exhibit 2, Tab 3C, RFG Progress Notes, Entry 25.12.09, 0200 hrs.
[73] T 74 (Leggett, S).
[74] Exhibit 1, Tab 29.15, RFG Incident Reporting Policy – Version 1, 24.11.09.

noted had been done in the progress notes.[75] Nurse Leggett's flash report largely mirrored his entry in the progress notes, including the reference to 'complaining of sore hips'.[76] The only additional information was that she was naked when found. Nurse Leggett classed the incident as a "near-miss, incident level 4" on the flash report, as it was an incident that did not result in an injury but had the potential to cause injury and it fell in the least severe of the four categories as a 'Resident fall – no injury'.[77]

38. At that time the policy at Regis Forrest Gardens was that a doctor only needed to be called after a fall if an injury had occurred. Nurse Leggett did not call a doctor as he saw no obvious signs of injury and didn't think the incident warranted a general practitioner attending.[78]

39. According to Nurse Leggett, there were no other incidents with the deceased during his shift, which concluded at 7am.[79]

40. Nurse Leggett could not recall whether he gave any verbal handover information to Nurse McGillivray, who began her shift at 7am on Christmas Day.[80] He testified that his usual practice was to leave out the progress notes at the nursing station if an incident had occurred.[81] Nurse McGillivray did recall that Nurse Leggett had told her verbally about the deceased's overnight fall, although she could not recall the details of what he told her.[82]

[75] Exhibit 2, Tab 3E, Incident "Flash" Report, 25.12.09, 0200 hrs.
[76] T 75 (Leggett S.).
[77] T 75 (Leggett, S.) - 76; Exhibit 1, Tab 13, Tab 29.15, RFG Incident Reporting Policy: Tab 29.17, Incident Severity & Distribution Matrix.
[78] T 75 (Leggett, S.)
[79] Exhibit 1, Tab 9 [4], [16].
[80] T 77 (Leggett, S).
[81] T 77 (Leggett, S).
[82] T 51 (McGillivray, D.E.); Exhibit 1, Tab 5 [15].

SECOND FALL

41. The deceased's husband, Mr Daniel, visited the deceased on Christmas morning. He spoke to Nurse McGillivray when he arrived, who advised that the deceased had wandered a bit in the night but had been put back to bed.[83]

42. Mr Daniel then visited the deceased in her room. She told him that she had had a fall. He asked if she was hurt and she told him that her left hip hurt a bit but she was okay. He could not see any obvious injuries on her.[84] The deceased appeared listless but he put that down to the continuing effects of her pain control patches.[85] Mr Daniel stayed with the deceased until about 11am.[86]

43. During Nurse McGillivray's shift on Christmas Day she made two entries in the deceased's progress notes. The first entry was recorded at 2pm and indicated that the deceased had spent a quiet day, with a visit from her husband. Nurse McGillivray observed that the deceased remained 'confused and disorientated'.[87]

44. Nurse McGillivray later added in another entry below it, marked as an addition, noting that the deceased had been found on the floor under her bed. The entry records the deceased stated she fell and no obvious injuries were observed.[88]

45. Nurse McGillivray confirmed in oral evidence that the deceased had told her that she had fallen and Nurse McGillivray conducted an examination of the deceased to determine whether she had sustained any injuries in the fall.[89] She saw no sign of obvious injuries.[90] The deceased did not say she was in any

[83] Exhibit 1, Tab 2 [14] – [17], Tab 21 [4] – 7], Tab 24, p. 2.
[84] Exhibit 1, Tab 2 [18] – [21], Tab 21 [8] – [10], Tab 24, p. 2.
[85] Exhibit 1, Tab 24, p 2.
[86] Exhibit 1, Tab 2 [22].
[87] T 51 (McGillivray, D.E.); Exhibit 2, Tab 3C, RFG Progress Notes, 25.12.09, 1400 hrs.
[88] T 51 (McGillivray, D.E.); Exhibit 2, Tab 3C, RFG Progress Notes, 25.12.09, ADDIT.
[89] T 54 (McGillivray, D.E.).
[90] T 59 (McGillivray, D.E.).

pain or show any signs of pain and was able to stand without any trouble. She also showed no sign of rotation; all of which together reassured her that the deceased had not broken a hip in the fall.[91]

46. Nurse McGillivray could not recall whether she read the entry recorded by Nurse Leggett at 2am when she made her entries, although she assumed that she would have.[92]

47. Nurse McGillivray also completed a flash report in relation to the fall at 2.25pm.[93] In the report Nurse McGillivray noted that the deceased was found on the floor under her bed and the deceased had stated that she fell whilst trying to get off the bed.[94] Nurse McGillivray noted that "nil obvious" injuries were observed and categorised the severity of the incident as a level 4.[95]

48. As she observed no injury on the deceased, Nurse McGillivray did not call a doctor.[96]

49. At the completion of her shift Nurse McGillivray handed over to registered nurse Elizabeth (Betty) Meyer.[97]

THIRD FALL

50. Nurse Meyer was a registered nurse working at Regis Forrest Gardens at the time, although she is now retired.[98] Nurse Meyer commenced her shift at 3.15pm on Christmas Day 2009. Nurse Meyer recalled being told by Nurse McGillivray about the 2pm fall that day, but not whether she was also told about the earlier fall that occurred during Nurse Leggett's night shift.[99]

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[91] T 54, 57 - 58 (McGillivray, D.E.); Exhibit 1, Tab 5, Statement 1, 27.10.10, [21] – [23]; Statement 2, 22.4.14, [14].
[92] T 52 (McGillivray, D.E.).
[93] Exhibit 1, Tab 5, Statement 1, 27.10.10, [19].
[94] Exhibit 2, Tab 3E, Incident "Flash" Report, 25.12.09, 1430 hrs.
[95] Exhibit 2, Tab 3E, Incident "Flash" Report, 25.12.09, 1430 hrs.
[96] T 60 (McGillivray, D.E.); Exhibit 1, Tab 5, Statement 2, 22.4.14, [15].
[97] Exhibit 1, Tab 5, Statement 1, 27.10.14, [24].
[98] T 96 (Meyer, E.C.).
[99] T 100 (Meyer, E.C.).

51. Nurse Meyer recalled seeing the deceased during her shift and noticing the drying cut on her lip, but did not recall seeing any bruising on her face.[100]

52. A nursing assistant, Ms Anne Walsh, was also on duty that afternoon. She recalled that during the course of her shift she was required to put the deceased back into bed a number of times.[101] On each occasion she found the deceased half in and half out of bed, often in a state of undress or pulling her pants down.[102] She appeared to Ms Walsh to have dementia and was difficult for staff to control.[103]

53. At about 7.30pm Nurse Meyer heard a noise in the direction of the deceased's room.[104] She went to the deceased's room with Ms Walsh and another staff member. They found the deceased lying face down on the floor next to the bed. She had her underwear around her ankles, and the bed and the floor were wet with urine.[105] According to Nurse Meyer, the deceased was visibly upset and frightened.[106]

54. Nurse Meyer, Ms Walsh and the other staff member picked up the deceased and put her back onto the bed.[107] Nurse Meyer then examined the deceased while she lay on her back. The deceased did not make a specific complaint of pain or soreness, but she was not really "speaking as such."[108] Nurse Meyer did not observe any clinical signs suggesting the deceased had sustained a broken hip in the fall, such as a turned out leg.[109] Nurse Meyer did not check to see whether the deceased could weight bear as she considered the deceased was too upset.[110] Nurse Meyer conceded during the inquest that it was possible that the

[100] T 100, 116 (Meyer, E.C.).
[101] T 121 (Walsh, A.F.); Exhibit 1, Tab 8 [8].
[102] T 121 (Walsh, A.F.); Exhibit 1, Tab 8 [9].
[103] T 121 - 122 (Walsh, A.F.); Exhibit 1, Tab 8 [11], [13], [15].
[104] T 101 (Meyer, E.C); Exhibit 1, Tab 7 [7].
[105] T 101 (Meyer, E.C); Exhibit 1, Tab 7 [9], [11] – [12].
[106] T 101, 111 (Meyer, E.C); Exhibit 1, Tab 7 [15].
[107] T 101 (Meyer, E.C); Exhibit 1, Tab 7 [13].
[108] T 102 (Meyer, E.C.).
[109] T 101 – 102, 103 (Meyer, E.C.); Exhibit 1, Tab 7 [16].
[110] T 102 (Meyer, E.C.).

deceased had fractured her hip in that fall but she missed the clinical signs.[111]

55. Nurse Meyer did observe a lump starting to form on the deceased's left eyebrow.[112] She did not, however, at that time consider that the deceased might have sustained a head injury in the fall.[113]

56. Nurse Meyer was shown a photograph of the deceased taken by her niece shortly after she was admitted to Bunbury Hospital on Boxing Day 2009.[114] Nurse Meyer confirmed that the significant bruising clearly visible to the left side of the deceased's face in that photograph was not present at the time Nurse Meyer attended to the deceased on Christmas night.[115] However, Nurse Meyer accepted that the bruising depicted in that photograph was consistent with the bruising coming from the injury sustained to her head in the fall.[116]

57. Before leaving the room, Nurse Meyer placed the deceased's bed against the wall and lifted up the opposite bedrail, in an effort to prevent any further falls.[117] She also put a protector over the rail.[118] Nurse Meyer did not have a doctor's or family approval to do so at the time (as was required for the use of two bedrails, which was in effect what was put into place here) but she was aware that retrospective approval could be sought from a doctor in the following 24 hour period.[119]

58. Nurse Meyer did not make an entry in the deceased's progress notes about the fall at the time it occurred.[120] She explained her failure to do so on the basis that she

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[111] T 110, 112 (Meyer, E.C.).
[112] T 102, 110 (Meyer, E.C.) – note reference to right eyebrow in Exhibit 1, Tab 7 [13] was accepted by the witness to be an error and it was in fact the left eyebrow.
[113] T 102 (Meyer, E.C.).
[114] Exhibit 1, Tab 1, Photograph of deceased in hospital bed, 26.12.09.
[115] T 108 (Meyer, E.C.).
[116] T 110 (Meyer, E.C.).
[117] T 103, 113 - 114 (Meyer, E.C).
[118] T 114 (Meyer, E.C.).
[119] T 104 (Meyer, E.C.); Exhibit 1, Tab 7 [19] – [20].
[120] T 106, 114 - 115 (Meyer, E.C.); Exhibit 1, Tab 7 [32].

was either busy or something else occurred that caused her to forget to do so.[121]

59. Nurse Meyer did complete a flash report in relation to the incident that evening.[122] She noted that the deceased was found on the floor trying to get out of bed by staff. In relation to any injury sustained, Nurse Meyer noted that there was a small swelling over the left eyebrow.

60. Nurse Meyer did not call a doctor to attend to the deceased that night. At the time she did not think the injury warranted calling a doctor,[123] although it appears that that was contrary to the policy at Regis Forrest Gardens at the time. Nurse Meyer appeared to accept during the inquest that, in hindsight, she ought to have called a doctor after the deceased's fall at 7.30pm.[124]

61. Nurse Meyer attempted to take observations of the deceased within half an hour of the fall, but the deceased was resistant to the observations being taken.[125] The deceased was not seen to get out of bed again during the completion of Nurse Meyer's shift, even though she was checked on regularly.[126]

EVENTS AFTER THE THIRD FALL

62. Nurse Meyer handed over verbally to Nurse Leggett when she completed her shift at 9.15pm on 25 December 2009. She could not recall the details of the information she provided about the deceased in the verbal handover[127] but she did recall taking Nurse Leggett down to the deceased's room after the

[121] T 109 (Meyer, E.C.); Exhibit 1, Tab 7 [32] – [33].
[122] T 105 (Meyer, E.C.); Exhibit 1, Tab 7 [21]; Exhibit 2, Tab 3E, Incident "Flash" Report, 25.12.09 1930 hrs.
[123] T 113 (Meyer, E.C.).
[124] T 108 (Meyer, E.C.).
[125] T 113 (Meyer, E.C.).
[126] T 114 (Meyer, E.C.); Exhibit 1, Tab 8 [20].
[127] T 108 – 109 (Meyer, E.C.).

handover to show him what she had done with the bedrails.[128]

63. Nurse Leggett could not recall being told anything about the deceased having had a fall that day.[129] He did not mention being taken to the deceased's room by Nurse Meyer, although he did recall checking on the deceased after handover.[130]

64. Over the course of the night the deceased was quite confused and restless. Nurse Leggett and an aide checked on her a number of times and settled her down, rearranging the bedclothes over her.[131]

65. At around 6.15am Nurse Leggett found the deceased lying across her bed with her feet dangling through the partitions of a bedrail. He removed the deceased's legs from the bedrail and placed a second bedrail up to prevent any more falls.[132]

66. Nurse Leggett made an entry in the deceased's progress notes in relation to this incident.[133] In addition, he noted that the deceased had been assisted to use the commode but she had difficulty weight bearing on transfer. Nurse Leggett noted the deceased's difficulty weight-bearing as she hadn't had such a problem before. He did not think her difficulty had any connection with his entry the previous night about a complaint of 'sore hips' by the deceased.[134]

67. Nurse Leggett then wrote that the deceased, "[m]ay need further examination and intervention."[135] He wrote this as he anticipated the staff commencing the morning shift would attend to the task, as it was near the end of his shift.[136] He did not observe any obvious signs that

[128] T 115 (Meyer, E.C.).
[129] T 77 (Leggett, S.); Exhibit 1, Tab 9 [18].
[130] T 77 (Leggett, S.); Exhibit 1, Tab 9 [17].
[131] T 77 (Leggett, S.); Exhibit 1, Tab 9 [19] – [20].
[132] T 77 - 78 (Leggett, S.); Exhibit 1, Tab 9 [21] – [22].
[133] Exhibit 2, Tab 3C, RFG Progress Notes, 26.12.09, 06.15 hrs.
[134] T 79 (Leggett, S.).
[135] Exhibit 2, Tab 3C, RFG Progress Notes, 26.12.09, 06.15 hrs.
[136] T 80 (Leggett, S.).

the deceased had a fractured hip, such as shortening or rotation of the leg, or he would have recorded it in his notes.[137] He considered the further examination to be a precautionary measure as he was not totally aware of her mobility issues and wasn't sure whether to be concerned.[138]

68. Nurse Leggett finished his shift at 7am that morning and handed over to Marion Eaton, a registered nurse who was working the morning shift at Regis Forrest Gardens on Boxing Day 2009. Nurse Leggett believes he conducted a verbal handover with Nurse Eaton, during which he told her of his concerns in relation to the deceased.[139] He also referred in his statement to written handover notes, although it seems they would simply have indicated that the progress notes should be read.[140]

69. The evidence suggests that at the time of these events the primary form of handover between shifts at Regis Forrest Gardens was verbal. However, there were written handover notes, as described by Nurse Leggett, which were primarily designed to prompt the verbal handover.[141]

70. At that time, the written handover notes were generally shredded after three to six months.[142] As a result, no copy of the written handover note was available at the inquest.

71. Nurse Eaton recalls being told in the verbal handover from Nurse Leggett that the deceased had been found lying at right angles on her bed and that they had put her back to bed. She accepted he had also possibly told her about some previous falls, although she couldn't recall that specifically.[143] She expressly did not recall Nurse Leggett telling her that the deceased was having

[137] T 89 – 90 (Leggett, S.).
[138] Exhibit 1, Tab 9 [24].
[139] T 80 - 82 (Leggett, S.).
[140] T 81 - 82 (Leggett, S.); Exhibit 1, Tab 9 [25] – [27].
[141] T 132 (Eaton, M.J.).
[142] Exhibit 1, Tab 4 [18] – [19].
[143] T 133 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10, [4], [16].

trouble weight bearing and/or requiring further examination.[144] In her evidence she indicated she would have acted on that information if she had been told about it.[145]

72. In addition to the Regis Forrest Garden handover notes, Nurse Eaton, who is now retired, had a practise of keeping her own personal set of notes, which she could keep with her during her shift.[146] A redacted copy of Nurse Eaton's personal notes from that shift was tendered at the inquest,[147] and a full copy was contained in the brief of evidence.[148] In relation to the deceased, Nurse Eaton had noted

> fall on? previous day. Staff got her up. In obvious pain. back to bed – obvious # NOF. To hospital. Family upset. She came in late (3pm). Had ? 4 falls in 2 days.

73. According to Nurse Eaton, other than the deceased's name, which she would have entered at the start of her shift, the rest of the entry was written much later in the day, possibly after she finished her shift. The information she assumed she took largely from the progress notes.[149] Given the content of the note, I accept that seems most likely.

74. There is no mention in that note of any problem with weight bearing or need for examination. Nurse Eaton testified that the absence of any such reference in her notes suggests that she wasn't told that the deceased needed further observation and investigation. If she had been told this information by Nurse Leggett, according to her usual practice she would have written it in her notes and would have examined the deceased.[150]

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[144] T 133 - 134 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10, [5].
[145] T 133 - 134 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10, [5].
[146] T 132 (Eaton, M.J.); Exhibit 1, Tab 10, Supplementary Statement, 22.4.14, [5].
[147] Exhibit 5.
[148] Exhibit 1, Tab 12.
[149] T 135 (Eaton, M.J.).
[150] T 134 - 135 (Eaton, M.J.); Exhibit 1, Tab 10, Supplementary Statement, 22.4.14 [5].

75. Nurse Eaton recalls that when she first saw the deceased that morning, at about 8am, the deceased was sleeping peacefully and she saw no indication that the deceased needed to be medically examined.[151]

76. Nurse Eaton saw the deceased again later at about 9.15am to give the deceased her medication. Nurse Eaton accepted that at that time the deceased had significant bruising to her face. The bruising was perhaps not as extensive as depicted in the photograph taken by Ms Davidson in the afternoon, but in Nurse Eaton's own words, the bruising was still "horrible"[152] at that time.

77. Nurse Eaton testified that shortly after that time she checked the deceased's progress notes and confirmed that the facial bruising had appeared to have arisen overnight.[153] At the inquest, Nurse Eaton agreed that she was concerned at that time that the deceased may have been suffering from a head injury, although she makes no mention of this in the three statements she signed prior to the inquest. She did, however, make mention that the deceased's left eye was 'very bruised today' in the progress note entry she made at approximately 1.30pm that day.[154]

78. Nurse Eaton also said in oral evidence that she took observations and concluded they were satisfactory.[155] Nurse Eaton said that she probably wrote the observations down for the hospital transfer.[156] The transfer form does record the deceased's pulse, respirations and blood pressure[157] but there do not appear to be any additional neurological observations as is suggested by the Regis Injury Management Process Guidelines.[158] Nor do the observations appear to have

[151] T 136 (Eaton, M.J.); Exhibit 1, Tab 10, Supplementary Statement, 22.4.14 [6].
[152] T 136 (Eaton, M.J.).
[153] T 136 - 137 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10 [46].
[154] Exhibit 2, Tab 3C, RFG Progress Notes, 26.12.09, 1330 hrs.
[155] T 137 (Eaton, M.J).
[156] T 138 (Eaton, M.J.).
[157] Exhibit 2, Tab 1, Fourth Admission, Regis Resident Transfer Form.
[158] Exhibit 1, Tab 29.29

been taken half hourly, as recommended in those guidelines.[159]

79. When Nurse Eaton gave the deceased her medication at 9.15am the deceased had just finished being given a wash and the nursing aide who had performed this task told Nurse Eaton that the deceased seemed to be in a lot of pain.[160] Nurse Eaton noted that information, and the fact that the deceased looked "uncomfortable,"[161] and suggested that she be taken out of the wheelchair and placed in a more comfortable chair in the lounge room.[162]

80. Although Nurse Eaton testified that she checked the deceased's progress notes within a short time of seeing the deceased at 9.15am,[163] she said that at that time she "didn't suspect a hip problem at the time at all"[164] and did not conduct a medical assessment of the deceased.[165] She apparently considered there was no reason to suspect a fracture, as she worked on the assumption it was up to the staff member present during a fall to assess her.[166] That is somewhat surprising if she had by that stage checked the progress notes, which included Nurse Leggett's entry in the progress notes suggesting a problem with weight-bearing and a need for further examination.

81. Nurse Eaton continued during the morning to work on the assumption that the deceased's pain was due to her known back problem and that the medication she had administered at 9.15am would assist with the pain.[167]

82. Nurse Eaton went back to the lounge room to check on the deceased at approximately 10am.[168] At that time the deceased's husband, Mr Daniel, was with her.

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[159] Exhibit 1, Tab 29.29
[160] T 138 (Eaton, M.J.).
[161] Exhibit 1, Tab 10, Statement 2, 26.10.10 [25].
[162] T 139 (Eaton M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10 [25].
[163] T 136 – 137 (Eaton, M.J.).
[164] T 137 (Eaton, M.J.).
[165] T 138 (Eaton, M.J.).
[166] T 139 (Eaton, M.J.).
[167] T 138 (Eaton, M.J.).
[168] Exhibit 1, Tab 10, Statement 2, 26.10.10 [27].

83. Mr Daniel had arrived shortly before then. On seeing the deceased he had immediately noticed that the left side of her face was blackened by bruising.[169] He asked the deceased what had happened and she replied that she had had a fall or falls in the night.[170] She may also have mentioned that her left hip was painful.[171] According to Mr Daniel, Nurse Eaton arrived shortly afterwards and he asked her what had happened to his wife but she didn't seem to know.[172]

84. Mr Daniel expressed his concern to Nurse Eaton that the deceased was in pain and Nurse Eaton acknowledged that the deceased was in obvious pain at that time.[173] Nurse Eaton recalls that she discussed the deceased's medication with Mr Daniel and she then went and called the deceased's doctor to check her medication dosages as she was concerned that the levels were high and were causative of some of the deceased's confusion.[174] Dr Lee was uncontactable as he did not work public holidays.[175]

85. When Nurse Eaton returned about half an hour later, the deceased was still in pain.[176] Mr Daniel's recollection was that while they were still in the lounge room Nurse Eaton mentioned that the deceased might need to be x-rayed and an ambulance would need to be called, and he agreed to that course.[177]

86. Nurse Eaton differed slightly in her account of events, as she recalled that Mr Daniel was initially unsure whether to send the deceased to hospital and they agreed to put her back to bed first and see if she was more comfortable.[178] As Mr Daniel had sadly passed

[169] Exhibit 1, Tab 2 [26], Tab 21 [14].
[170] Exhibit 1, Tab 2 [27] – [28], Tab 21 [15] – [16], Tab 24, p.2.
[171] Exhibit 1, Tab 24, p. 2.
[172] Exhibit 1, Tab 2 [38] – [40].
[173] T 140 (Eaton, M.J.); Exhibit 1, Tab 10 [27] – [31].
[174] T 143 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10 [32] – [34]; Supplementary Statement, 22.4.14 [10] – [11].
[175] T 137 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10 [34].
[176] Exhibit 1, Tab 10, Statement 2, 26.10.10 [35].
[177] Exhibit 1, Tab 2 [44] – [46], Tab 21 [24] – [26], Tab 24, p. 3.
[178] Exhibit 1, Tab 10, Statement 1, 3.2.10 [11] – [12], Statement 2, 26.10.10 [36] – [38].

away before the inquest was heard, this could not be put to him.

87. In any event, they both agreed that the deceased was taken in a wheelchair back to her room and put into bed before she went in the ambulance.[179] Once she was in bed Nurse Eaton examined the deceased and noted that her left leg appeared shortened and rotated. She had also been in pain, and unable to weight bear, when they put her into bed. On the basis of those clinical signs, Nurse Eaton suspected the deceased may have fractured her hip.[180]

88. An ambulance was requested.[181] Ambulance officers attended and transported the deceased to Bunbury Hospital at approximately 11.45am.[182]

89. After the deceased was taken away by ambulance, Nurse Eaton contacted the Regis Forrest Gardens Facility Manager, Ms Fiona Piggott, who told her to amend the last flash report prepared in relation to the deceased.[183] At that time, Ms Piggott understood the Regis Forrest Gardens policy permitted flash reports to be amended by staff if the added incident related to the original report.[184]

90. Accordingly, Nurse Eaton located the last flash report relating to the deceased, namely the report prepared by Ms Meyer the night before, and made some amendments to that flash report.[185] The amendments she made included noting the significant pain to the deceased's left hip on 26 December 2009 and the fact that the deceased was sent to hospital that day.[186]

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[179] Exhibit 1, Tab 2 [47] – [48]; Tab 10, Statement 1, 3.2.10 [12].
[180] T 140 – 141 (Eaton, M.J.); Exhibit 1, Tab 10, Statement 2, 26.10.10 [41] – [42]
[181] Exhibit 1, Tab 10, Statement 2, 26.10.10 [43].
[182] Exhibit 1, Tab 10, Statement 2, 26.10.10 [43] – [44].
[183] Exhibit 1, Tab 10, Statement 2, 26.10.10 [11] – [12], Supplementary Statement 22.4.14 [7] – [9].
[184] Exhibit 1, Tab 4 [14], Supplementary Statement, 21.3.14 [3].
[185] Exhibit 1, Tab 10, Supplementary Statement, 22.4.14 [7]; Exhibit 2, Tab 3E, Incident "Flash" Report, 25.12.09, 1930hrs.
[186] Exhibit 1, Tab 10, Second Statement, 26.10.10 [13] – [15].

91. Nurse Eaton clarified that she did not select that incident report in the belief that the deceased had suffered the injury to her hip during that fall, but rather because that was the last incident report recorded.[187]

92. At 1.30pm Nurse Eaton also made an entry in the deceased's progress notes relating to the deceased's suspected fractured left hip and subsequent transfer to hospital.[188] She also noted Mr Daniel's concerns about the deceased's medication dosages.[189]

93. There are two more entries in the progress notes after Nurse Eaton's. They were both entered by Nurse Meyer on 26 December 2009 during her shift that afternoon. By that time, the deceased had been taken to hospital.[190] Nurse Meyer noted the first one as a late entry but did not indicate the time she made the entry.[191] She recorded the circumstances of the deceased being found on the floor between the bed and locker the previous evening and the deceased sustaining a large haematoma on her left eyebrow, as well as the steps then taken regarding her bed.[192] In this entry, Nurse Meyer also noted that the deceased's niece had called to inform the staff that the deceased had a fractured left hip and her belongings were to be collected.[193] The last entry, entered by Nurse Meyer at 6pm that night, recorded that the deceased's niece had collected the deceased's belongings and some discussion about the deceased's medications.[194]

BUNBURY HOSPITAL

94. The deceased was taken by ambulance to the Emergency Department of Bunbury Hospital and arrived shortly after midday. The deceased was

[187] T 142 (Eaton, M.J.); Exhibit 1, Tab 10, Supplementary Statement, 22.4.14 [8] – [9].
[188] T 142 (Eaton, M.J); Exhibit 2, Tab 3C, 26.12.09, 1330 hrs.
[189] T 142 (Eaton, M.J); Exhibit 2, Tab 3C, 26.12.09, 1330 hrs.
[190] Exhibit 1, Tab 7 [32].
[191] Exhibit 2, Tab 3C, RFG Progress Notes 26.12.09, Late Entry.
[192] T 107 (Meyer, E.C.).
[193] Exhibit 2, Tab 3C, RFG Progress Notes 26.12.09, Late Entry.
[194] Exhibit 2, Tab 3C, RFG Progress Notes 26.12.09, 1800 hrs.

assessed and diagnosed with a possible closed head injury and fractured left neck of femur.[195] She was sent for an x-ray, which revealed an intracapsular fracture of the left femoral neck.[196] The x-ray revealed the fracture was completely displaced at that time.[197]

95. The deceased was admitted to a ward under the care of an orthopaedic surgeon.[198] A femoral nerve block was administered and her hip was placed in traction.[199] The plan was to take her to theatre for management of her fracture but she was kept under observation for a number of days first to monitor her neurological status due to the possibility of a head injury, with the possibility of a CT scan being performed if her Glasgow Coma Scale score deteriorated.[200]

96. It seems the deceased was very confused and restless while being observed on the ward. She was noted by nurses to repeatedly remove oxygen equipment. A physician noted she had dementia that was probably more severe than appreciated.[201] This seems to have ultimately been accepted as the cause for her confusion, rather than a head injury.

97. On 29 December 2009 the deceased had an echocardiogram performed, which showed severe mitral regurgitation.[202] The symptoms of her pulmonary fibrosis also remained.[203]

98. Later that same day the deceased was taken to theatre and underwent a left hemiarthroplasty to surgically repair her fractured hip. The operation and anaesthetic went smoothly with no obvious complications.[204]

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[195] Exhibit 2, Tab 1, Fourth Admission, Emergency Department Triage Assessment and Integrated Progress Notes.
[196] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes
[197] T 181 - 182 (Pratsis, K (Dr)).
[198] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes
[199] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes
[200] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes, 26.12.09, Medical Team Charles Prasad.
[201] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes
[202] Exhibit 1, Tab 28; Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes.
[203] Exhibit 1, Tab 28; Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes.
[204] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes.

99. After the operation the deceased became unwell with a right-sided pneumonia and developed respiratory failure.[205] The medical team were aware that the two main causes of her respiratory failure were pneumonia and congestive cardiac failure, both of which were aggravated by the underlying pulmonary fibrosis.[206] She received intravenous antibiotics, was on supplemental oxygen and was also getting incremental dosages of frusemide to alleviate the fluid overload.[207] Pain management was also implemented.

100. On 4 January 2010 there was some discussion with the deceased's family about the possibility of discharging the deceased at the end of the week or early the following week, with the need for respite care for a lengthy period of recovery.[208]

101. However, a chest x-ray the following day showed signs of fluid overload with increased pulmonary congestion, bilateral basal effusions and an enlarged heart.[209] Her fluid balance was reviewed and a diuretic was administered and repeated the following morning. She was unwell that day and remained very poorly overnight, requiring sedation to help her sleep.[210]

102. At 7.55am on the morning of 7 January 2010 while being bathed on the ward the deceased suffered a witnessed cardiac arrest. Cardiopulmonary resuscitation was continued for 15 minutes but she failed to respond and the decision was made to terminate resuscitation.[211]

103. Sadly, the deceased died while her husband was still in Perth recovering from his own surgery, performed the day before.[212]

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[205] Exhibit 1, Tab 28.
[206] Exhibit 1, Tab 28.
[207] Exhibit 1, Tab 28.
[208] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes, 4.1.10, 11.50 hrs.
[209] Exhibit 2, Tab 1, Fourth Admission, Diagnostic Imaging Report, Exam date 5.1.10.
[210] Exhibit 2, Tab 1, Fourth Admission, Integrated Progress Notes.
[211] Exhibit 1, Tab 28.
[212] Exhibit 1, Tab 2 [62] – [64], Tab 21 [37], Tab 24, p. 3.

REPORTING THE DEATH TO THE CORONER

104. The deceased's death was not initially reported to the Coroner. Dr Neil Barnard, a Medical Registrar, completed a Medical Certificate of Cause of Death[213] and a Death in Hospital form, indicating that the death was not reportable to the Coroner.[214]

105. It was arranged by her family that the deceased would be cremated and her body was released to a funeral director. However, the cremation did not proceed as the second doctor refused to sign the certificate due to an obvious head injury prior to death, which he considered required further investigation.[215] The death was subsequently investigated by coronial investigators, leading to this inquest.

106. Despite the State Coroner accepting the death of the deceased as a reportable death, the Director of Medical Services at Bunbury Hospital, Dr Samir Heble, initially wrote to the Office of the State Coroner indicating that the Director of Clinical Training for the WA Country Health Service – South West (WACHS) maintained the position that the death of the deceased was not reportable.[216] This was apparently because the history of the deceased's falls was not considered as an indirect factor in the death.[217]

107. However, subsequent to that correspondence Dr Heble took the opportunity extended by the Office of the State Coroner to review the hospital's position. Dr Heble advised that after taking further advice the hospital's position had been revised and it now considered the death was reportable as although the falls were not directly related to the death,

> "they played an indirect role in the sequence of clinical events because the falls… caused her to fracture the

[213] Exhibit 1, Tab 32.
[214] Exhibit 2, Tab 1, Correspondence, Death in Hospital form.
[215] Exhibit 1, Tab 37, p. 1.
[216] Exhibit 1, Tab 30, Letter 17.5.13.
[217] Exhibit 1, Tab 30, Letter 27.3.14, p. 2.

left neck of her femur, which required surgical intervention on 29 December 2009 and saw her post operative decline due to respiratory problems and the cardio-respiratory arrest on 7 January 2010."[218]

108. Dr Heble also advised that the WACHS was revising its orientation booklet for doctors to include a specific section on reportable deaths, which will include detailed provisions explaining the expansive meaning of 'indirect' in relation to reportable deaths.[219] Further training has also been provided to relevant staff in relation to reportable deaths.[220]

CAUSE OF DEATH

109. In completing the Medical Certificate of Cause of Death, Dr Barnard, the Medical Registrar, identified the cause of death as pneumonia, with antecedent causes of underlying pulmonary fibrosis and a significant condition of immobility due to neck of femur fracture.[221]

110. Once the matter was reported to the Coroner the deceased was taken to the State Mortuary and a post mortem examination was conducted by a forensic pathologist, Dr J White, on 13 January 2010.

111. The post mortem examination showed an elderly frail lady with heavy fibrotic mottled lungs with a moderate volume of fluid and bilateral effusions. The heart was softened and mildly dilated with an abnormal mitral valve and mild underlying coronary artery disease. The liver appeared chronically congested and the kidneys were scarred. There were scattered soft tissue injuries and evidence of medical intervention.[222]

[218] Exhibit 1, Tab 30, Letter 27.3.14, p. 2.
[219] Exhibit 1, Tab 30, Letter 27.3.14, p. 2.
[220] T 204; Exhibit 1, Tab 30, Letter 27.3.14, p. 2.
[221] Exhibit 1, Tab 32.
[222] Exhibit 1, Tab 25, 26; Exhibit 3.

112. Toxicological analysis showed medications consistent with the deceased's care.[223]

113. At the completion of all investigations Dr White formed the opinion that the cause of death was complications following fracture and surgical repair of the left hip in an elderly lady with underlying chronic lung disease and valvular heart disease.[224] The complications included worsening cardiac failure with the underlying valvular heart disease and mild coronary artery disease, acute on mild chronic renal impairment and progressive respiratory failure with probable pneumonia on a background of chronic interstitial lung disease.[225]

114. I accept and adopt Dr White's conclusion as to the cause of death.

WHEN DID THE FRACTURE OCCUR?

115. There is no doubt that at some stage prior to her attendance at the Emergency Department of Bunbury Hospital the deceased sustained a fracture to her left hip. The question then arises as to whether it is possible to identify exactly when the fracture occurred?

116. Dr Pratsis, the current Head of Orthopaedics at the Bunbury Regional Hospital, gave oral evidence at the inquest. Dr Pratsis indicated that if a person with weak bones (such as the deceased, who suffered from osteoporosis) falls over, they have a pretty good chance of fracturing a bone.[226] Dr Pratsis also advised that falls are the most common cause of neck of femur fractures in elderly patients.[227]

117. Occasionally a neck of femur fracture is the result of an insufficiency of the bone, which can lead to a neck of femur fracture through normal activities, without a

[223] Exhibit 1 Tabs 26 & 31.
[224] Exhibit 1, Tab 25
[225] Exhibit 1, Tab 26.
[226] T 180 (Pratsis, K (Dr)).
[227] T 180 (Pratsis, K (Dr)).

fall.[228] However, Dr Pratsis had reviewed the deceased's x-ray taken on admission to Bunbury hospital and she confirmed that the deceased's fracture was not an insufficiency fracture.[229]

118. The deceased had four known falls over the course of Christmas Eve and Christmas Day 2009, before her neck of femur fracture was diagnosed on Boxing Day 2009. It seems likely that the fracture occurred during one of those falls. The difficulty is in identifying during which of those falls it occurred.

119. Dr Pratsis explained that the clinical signs and symptoms of such a fracture relate to the degree of displacement. With the mildest form of fracture, which is an insufficiency fracture, a person may have some minor pain in the hip and groin but might still be able to walk. In a complete fracture that has not shifted, the person will have more pain and will not be able to weight bear well, or possibly at all. At the stage when a fracture is fully displaced, the person will lose the ability to weight bear through that leg or walk. The leg will also start to rotate externally because the muscles lose their balance. Because of the pull of the muscles the leg will also shorten. Therefore, at the stage of a complete, fully displaced fracture, the person will experience a complete loss of ability to weight-bear, severe pain and deformity of the leg.[230]

120. By the time the deceased presented to the emergency department and was x-rayed, the fracture was completely displaced.[231] In Dr Pratsis' experience, in most cases of a complete fracture, the displacement and the fracture occur at the same time[232] and the shortening and rotation of the leg will be apparent at the time of displacement.[233]

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[228] T 179 (Pratsis, K (Dr)).
[229] T 180 (Pratsis, K (Dr)).
[230] T 182 (Pratsis, K (Dr)).
[231] T 182, 193 (Pratsis, K (Dr)).
[232] T 182 (Pratsis, K (Dr)).
[233] T 182 (Pratsis, K (Dr)).

121. However, Dr Pratsis acknowledged that it is possible for the shortening and rotation of the leg to be present and not be immediately apparent, depending upon the position of the pelvis.[234] A medical doctor will ensure the pelvis is in a square position before conducting an examination for such clinical signs, for that reason.[235] It is easy for someone without that training to miss such signs.[236]

122. Looking then to the four known falls, the first occurred sometime in the morning of Christmas Eve at the deceased's home. After this fall she was seen by her husband and others to have sustained a cut lip and bruised left eye. However, she was seen to stand and weight bear without obvious pain or difficulty after this fall by both Mr Daniel and Ms Noakes.

123. The remaining three known falls all occurred at Regis Forrest Gardens on Christmas Day. The first was at 1.45am, after which the deceased was assessed by Nurse Leggett. Nurse Leggett observed no visible injuries on the deceased after that fall, but did record that she complained of 'sore hips'.

124. The second fall was at 2.30pm, after which the deceased was assessed by Nurse McGillivray. Nurse McGillivray's examination of the deceased revealed no obvious injuries and she was able to stand and weight bear without any obvious pain.

125. The third and final known fall was at 7.30pm, after which the deceased was assessed by Nurse Meyer. Nurse Meyer examined the deceased once she had been put back to bed. The deceased had sustained an obvious injury to her left eyebrow, indicating that the fall was of sufficient impact to cause some injury. Nurse Meyer did not observe any obvious clinical signs that the deceased had fractured her hip, such as shortening or rotating of the leg. However, she did not

[234] T 189 - 190 (Pratsis, K (Dr)).
[235] T 189 (Pratsis, K (Dr)).
[236] T 189 (Pratsis, K (Dr)).

ascertain whether the deceased could weight bear due to the deceased's distress at the time.[237] This may have served as an indicator to Nurse Meyer as to whether there was a fracture.

126. The following morning, without any further fall being known to have occurred, Nurse Leggett observed that the deceased was having difficulty weight bearing when using the commode. In the hours afterwards, the deceased was observed to be experiencing significant levels of pain, not alleviated by her pain medication. By the time Nurse Eaton examined her in her bed mid-morning, she was showing signs of a shortened and rotated left leg. All of these observations were clinical signs of a fractured neck of femur, which was subsequently confirmed by the x-ray later that day.

127. Nurse Meyer conceded in her evidence that it was possible that the deceased had fractured her left neck of femur in the fall at 7.30pm on 25 December 2009 and Nurse Meyer missed the clinical signs.[238]

128. Although no witness is able to say definitively that the fracture occurred after a particular fall, I accept the submissions of counsel that the preponderance of evidence indicates that the fracture arose as a result of the fall at 7.30pm on 25 December 2009.[239] I find that the deceased fell from her bed at Regis Forrest Gardens some time shortly before 7.30pm and fractured her left neck of femur as a result of that fall.

129. It was conceded by Regis at the commencement of the inquest that there were aspects of the deceased's care that did not meet the required standard. The concession was made on the basis that Regis Forrest Gardens' staff members did not follow Regis' falls management policy in 2009. This policy required the resident's doctor to be notified of any fall by a resident which led to that resident sustaining an injury. In this

[237] T 110 (Meyer, E.C.).
[238] T 110 (Meyer, E.C.).
[239] T 199 – 201; Written Submissions on Behalf of Regis Aged Care Pty Ltd [23].

particular case, Regis Forrest Garden's staff did not adopt this practice in relation to the deceased's falls at 1.45am and 7.30pm on Christmas Day.[240]

THE EFFECT OF THE FAILURE TO DIAGNOSE THE FRACTURE

130. It was conceded by Regis that if a medical practitioner had been notified after the fall at 7.30pm, there is every chance that a medical examination would have diagnosed the broken neck of femur (as I have made a finding that one was in existence at that time).[241]

131. The failure to diagnose the deceased's fractured neck of femur at the time of that fall meant that instead of being admitted to Bunbury hospital and receiving appropriate pain relief and management for her fracture that evening, the deceased's admission to hospital was delayed by some 16 hours.

132. Dr Pratsis' evidence was that a fracture of the type sustained by the deceased is extremely painful and can cause the death of the patient if not treated.[242] Dr Pratsis indicated that it is because of the extreme pain caused by the injury that surgical repair is attempted in elderly patients, so long as they are fit for the anaesthetic, even if their life expectancy is not long.[243] Otherwise they require heavy loads of morphine to manage their pain and will experience significant distress.[244]

133. In this case, despite the delay in diagnosis it was still possible to undertake the surgery, and the surgical repair did take place. The surgery itself was uneventful and it appeared the deceased might recover sufficiently

[240] Written Submissions on Behalf of Regis Aged Care Pty Ltd [4].
[241] Written Submissions on Behalf of Regis Aged Care Pty Ltd [16].
[242] T 184 (Pratsis, K. (Dr)).
[243] T 183 - 184 (Pratsis, K. (Dr)).
[244] T 184 (Pratsis, K. (Dr)).

to be transferred to respite care at another care facility.[245]

134. However, as a result of complications arising after the surgery, contributed to by her pre-existing co-morbidities, the deceased's condition deteriorated and she died.[246]

135. Counsel appearing on behalf of Regis submitted that the fractured neck of femur could not be said, in those circumstances, to have caused the deceased's death.

136. At the time the deceased went into respite care at Regis, she was clearly not well. As noted above, her health had been in decline for the latter part of 2009.[247] She was certainly experiencing significant pain as a result of her spinal injury and had experienced a decline in her quality of life. The deceased's general practitioner, Dr Lee considered the deceased had "suffered immensely from the time she fractured her spine" until her death,[248] despite all attempts to alleviate her pain with medication.

137. However, Dr Lee expressed surprise to hear that the deceased had died over the Christmas period, when he was on leave, which indicates her death was not something that he was expecting to occur at that time as a result of her known medical conditions.[249]

138. It is not uncommon to see the health of elderly patients decline rapidly after sustaining a serious injury, such as a fractured hip. A person may be managing with their co-morbidities, but the pain of the injury, trauma of the surgery and complications from the subsequent immobility may act as the final insult to the deceased's system, from which they are unable to recover. That appears to have been the case with the deceased.

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[245] Exhibit 2, Tab 1, Fourth admission, Integrated Progress Notes.
[246] Exhibit 1, Tab 25
[247] T 10, 11 (Davidson, D.C.).
[248] Exhibit 1, Tab 27, p. 2.
[249] Exhibit 1, Tab 27, p. 2.

139. I accept that it cannot be said the cause of death was directly related to the fractured neck of femur, itself a result of the fall. However, as accepted by Dr Heble on behalf of Bunbury Hospital, the fall and subsequent fracture played an indirect role in the sequence of clinical events that ultimately led to the deceased's death. That is also the effect of the post mortem conclusion of Dr White.[250] I find the fall, and subsequent fracture, set off a further decline in the deceased's health, which ultimately ended in her death.

140. It is for those reasons that I find that death arose by way of accident.

QUALITY OF THE CARE PROVIDED AT REGIS FORREST GARDENS

141. What is most concerning is that the deceased suffered unnecessarily for a period of some 16 hours before her hospitalisation. That she had to endure that pain was extremely distressing not only for the deceased but also for the deceased's husband and other family members when they became aware of the situation. Ms Davidson described herself and her uncle as being "appalled" at the treatment the deceased received at Regis Forrest Gardens.[251] They were left to regret the decision to place her in respite care, even though the decision was made with the best interests of the deceased in mind at the time.

142. I have no doubt, having seen and heard the evidence of the witnesses, that the staff at Regis Forrest Gardens were caring and well-intentioned. However, they clearly failed to provide an appropriate standard of care to the deceased while she was a resident there, most particularly in relation to her final fall on Christmas Day.

[250] Exhibit 1, Tab 25
[251] Exhibit 1, Ta 1.

143. I accept that the management of falls risk of elderly residents is difficult and that in the case of the deceased all appropriate steps were taken to manage her risk of falls during her stay at Regis Forrest Gardens. It is not the fact that she fell that is of concern, as such falls can be difficult to prevent.

144. The concern is how the deceased was managed after her falls, and in particular after the fall at 7.30pm.

145. There is no dispute that Nurse Meyer should have arranged for the deceased to be medically examined after that fall.

146. Having not done so, Nurse Meyer also failed to document the event of the fall in the deceased's progress notes. While I accept the evidence of witnesses that the nursing staff did not routinely read the progress notes of residents when commencing a shift, it seems the staff members were generally diligent about entering incidents in the progress notes as they occurred. Accordingly, if Nurse Meyer had recorded a contemporaneous entry in the progress notes, as she was supposed to do, that entry would have been there to alert later staff to a possible injury explaining the deceased's continued pain.

147. As it was, Nurse Meyer handed over to Nurse Leggett that night with no clear evidence as to what she told him about the fall,[252] and no entry in the progress notes to prompt him to consider the greater likelihood of a fracture, given there had been a recent fall, when he made his own entry at the end of his shift about the problem with the deceased's weight bearing.

148. There was a dispute in the evidence as to whether Nurse Leggett then told Nurse Eaton of his concerns about the deceased's inability to weight bear, when he handed over to her at the end of his shift. It is difficult to resolve this dispute. Nurse Leggett clearly went at

[252] Although I accept the witnesses' recollection of events may have been adversely affected by the delays in the initial investigation and the passage of time before the inquest.

least so far as to make the entry in the progress notes, which points towards a clear intention to pass on that information to the next shift. Nurse Eaton, on the other hand, appears to have been a conscientious nurse, who went so far as to make her own personal notes to assist her to care for residents during her shift, and she makes no note of any such information being passed on to her. In the end, I am unable to resolve this issue. What it does, however, point to (as does the lack of information about the handover between Nurses Meyer and Leggett) is an inadequacy in the handover procedures and communication between staff at Regis Forrest Gardens at that time.

149. Similarly to Nurse Leggett, Nurse Eaton's ability to identify what was the cause of the deceased's pain was also hindered by the failure of Nurse Meyer to document the fall the night before, although Nurse Eaton was not convinced this information would have changed her approach as she was of the view that it would have been the responsibility of Nurse Meyer to properly check for any injury at the time of the fall.[253]

150. Nurse Eaton appears to have paid little regard to the deceased's facial bruising in the morning, although she acknowledged that she observed it and it was extensive.[254] She apparently comforted herself with her knowledge that "[o]ld people do bruise easily,"[255] and that her medication may have exacerbated her bruising.[256]

151. However, without knowing about the fall that had occurred on Nurse Meyer's shift, Nurse Eaton was faced with a situation in the morning where the deceased was newly injured to her face, with significant bruising, suggestive of having hit her head some time earlier. The deceased was in a confused state, which made it impossible to obtain a history from her, or to make any

[253] T 145 (Eaton, M.J.).
[254] T 136 (Eaton, M.J.).
[255] T 137 (Eaton, M.J.).
[256] T 146 (Eaton, M.J.).

real observation of whether she had a head injury from considering her cognitive state. Nurse Eaton said at the inquest she took observations to satisfy herself that the deceased did not have a head injury. She indicated those observations were documented in the hospital transfer form.[257] The extent of those observations appears to be one entry of some limited observations.[258] Nurse Eaton also did try to call the doctor about the deceased's medications, which she considered may have been contributing to the deceased's confused state, but that did not appear to be related to any concerns about a possible head injury.

152. When she was taken to hospital the deceased was monitored for a possible head injury, due to her facial injuries. It seems doctors were eventually satisfied that she did not have a head injury. However, at the time Nurse Eaton saw the deceased, with no explanation for her facial injuries, an obvious confused state and limited observations taken, there could be no sound basis for Nurse Eaton being satisfied that the deceased did not have a head injury. In those circumstances, it is surprising she did not take more extensive and regular observations, or call a doctor/refer her to hospital at that earlier stage. In my view, this should have been done.

153. Also, as noted above, Nurse Eaton gave evidence at the inquest that she checked the deceased's progress notes within a short time of seeing the deceased at 9.15am[259] and "didn't suspect a hip problem at the time at all."[260] She did not conduct a medical assessment of the deceased. That is despite the fact that around this time she apparently read the progress notes, which included Nurse Leggett's entry in the progress notes suggesting a problem with weight-bearing and a need for further examination. She either did not read that entry or failed to appreciate its significance.

[257] T 137 - 138(Eaton, M.J).
[258] Exhibit 2, Tab 1, Fourth Admission.
[259] T 136 – 137 (Eaton, M.J.).
[260] T 137 (Eaton, M.J.).

154. In the end, Nurse Eaton did take the initiative to take the deceased back to her bed and conduct an examination, which led her to suspect a fracture and arrange for the deceased to be taken by ambulance to hospital. That was obviously the right thing to do. However, it is concerning that the events of the morning did not prompt her to do so earlier.

155. It seems then, that there were a number of missed opportunities over the night of 25 December 2009 to 26 December 2009 for Regis Forrest Gardens staff to have communicated important information to each other, that might have led to the deceased's fracture being diagnosed earlier and her care to have been properly managed.

CHANGES AT REGIS FORREST GARDENS RECORDS SINCE THE DEATH

156. The death of the deceased occurred in early January 2010. It is now the middle of 2014, some four years later. In the interim, Regis is to be commended for taking steps to resolve some of the obvious problems that contributed to the failure to diagnose the deceased's fracture at an early stage, prior to the inquest hearing.

157. At the time the deceased was a resident at Regis Forrest Gardens, it was the policy that a resident was only required to be medically examined after a fall if an injury was observed. The policy now in place is that a resident's general practitioner is to be notified after every fall, whether or not an injury is observed, as well as the next of kin.[261] A referral is to be made to the general practitioner and they are to be contacted more urgently if the resident's condition does not stabilise.[262]

[261] T 160, 173 (Piggott, F.); Exhibit 1, Tab 4, Supplementary Statement 21.3.14, FJP1 - Falls Management (Mobility, Dexterity and Rehabilitation) Policy 18.6.10.
[262] T 160 (Piggott, F.); Exhibit 1, Tab 4, Supplementary Statement 21.3.14, FJP1 - Falls Management (Mobility, Dexterity and Rehabilitation) Policy 18.6.10.

158. In addition, the resident is also required to be seen by a physiotherapist, regardless of whether an injury is detected.[263] The physiotherapist reviews all residents post-fall and notifies the resident's next of kin and medical officer.[264] The physiotherapist only works weekdays, so there may be some delay in the resident being reviewed, but it is a helpful supplementary safeguard.[265]

159. Removing the option of not reporting the fall to the resident's doctor if the nurse observes no injury appears to be a positive step. In addition, the Regis Forrest Gardens Facility Manager, Ms Piggott, indicated that there has been an improved follow up of all falls by the registered nurses generally.[266]

160. The Regis policy has also changed so that there is a requirement that staff members must be informed of a fall that happened in the previous shift.[267] This is done primarily in the handover, which is now in a written format.

161. The process of creating handover notes, progress notes, flash reports and clinical records is now done via an electronic record software system known as Autumncare.[268] When an incident such as a fall occurs it is entered by the registered nurse who was present when the fall was discovered or witnessed. The system will allow the information to populate into a flash report and the handover notes. It will then automatically send out alerts.[269] The clinical progress notes still need to be entered separately but the incident will come up as an incident logged, working as a prompt.[270]

[263] Exhibit 1, Tab 4, Supplementary Statement 21.3.14 [7], FJP1 - Falls Management (Mobility, Dexterity and Rehabilitation) Policy 18.6.10.
[264] Exhibit 1, Tab 4, Supplementary Statement 21.3.14 [7].
[265] T 167 (Piggott, F.).
[266] Exhibit 1, Tab 4, Supplementary Statement 21.3.14 [7].
[267] T 162 (Piggott, F.).
[268] T 161, 171 (Piggott, F.).
[269] T 162 - 163 (Piggott, F.).
[270] T 163 – 164, 172 (Piggott, F.).

162. Therefore, the former practice of a primarily oral handover has now changed to a written handover. The handover sheet is printed out at the beginning of every shift.[271] This avoids much of the potential for omission of information or miscommunication between staff. It was agreed by Nurse McGillivray, who is still employed at Regis Forrest Gardens, that the current system is a significant improvement on the former.[272]

163. As the handover sheet is created and stored in an electronic form it is now available permanently, which is also helpful if later investigations occur.[273]

164. The other significant change to the procedure relevant to this inquest is the change of policy in relation to flash reports. Ms Piggott confirmed that it is no longer permissible for a staff member to alter a flash report created by another staff member.[274] Instead, a supplementary flash report must now be prepared to record any additional information or incident following on from the original flash report.[275]

CONCLUSION

165. On Christmas Eve 2009 the deceased went into respite care at Regis Forrest Gardens.

166. The next day the deceased had three falls from her bed. After the first two falls, she was examined by a nurse and found to be uninjured. After the third fall she was assessed by a nurse and seen to have an injury to her head. What the nurse did not see was that the deceased had also fractured her left hip. If the nurse had followed the facility policy, a doctor would have been called and most likely the injury would have been diagnosed.

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[271] T 163 (Piggott, F.).
[272] T 59 (McGillivray, D.E.).
[273] T 172 (Piggott, F.).
[274] T 164 (Piggott, F.).
[275] Exhibit 1, Tab 4, Supplementary Statement, 21.3.14 [3].

167. As it was, the deceased's fractured hip was not identified by a Regis Forrest Gardens staff member until late in the morning of the following day, after her husband had visited her and expressed concern about her condition.

168. The deceased was taken to hospital and had surgery to repair her hip, but sadly died as a result of complications on 7 January 2010.

169. The care provided by the staff at Regis Forrest Gardens did not meet the required standard of care and the deceased suffered unnecessary pain as a result. That is a matter greatly to be regretted.

170. However, since the death Regis, which owns and operates Regis Forrest Gardens, has of its own volition taken steps to improve their systems and educate their staff. As a result, I am satisfied that there is unlikely to be a repeat of the failings that occurred in relation to the care of the deceased. Accordingly, I do not make any recommendations.

S H Linton
Coroner
23 July 2014