CITATION: *Inquest into the death of Desmond Waight* [2010] NTMC 042

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| FINDING OF: | Mr Greg Cavanagh SM |
| **CATCHWORDS:** | Death from bronchopneumonia, 81 year old man, nursing home resident, palliative care. |

**REPRESENTATION:**

*Counsel:*

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| Assisting: | Ms Helen Roberts |
| Senior Next of Kin | Mr Ben O'Loughlin |
| Masonic Homes | Ms Jodi Truman |
| Dr Fitzsimons | Mr Tass Liveris |

*Solicitors*

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| Senior Next of Kin | Cridlands |
| Masonic Homes | Minter Ellison |

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 217 of 2008

In the matter of an Inquest into the death of Desmond Waight

**ON 23 October 2008**

**AT Palliative Care Hospice, RDH**

**FINDINGS**

Mr Greg Cavanagh SM:

## INTRODUCTION

1. Mr Desmond Waight was born on 10 January 1927 in Portsmith, England. He lived and worked in a number of countries before coming to Australia in 1955. He has one son, John Waight. For most of his life he was a very physically active man. Even after retirement he was riding his bike and living independently until 2006. Unfortunately he developed dementia which increased in severity over the years prior to his death.

2. He had been living in the Tiwi Gardens Nursing home since 16 February 2007. In June 2008 he had a fall and suffered a hip fracture. This was surgically corrected. In August 2008 he suffered another fracture, which could not be surgically corrected, and from then on the deceased was essentially bed bound. He spent a number of weeks in the Royal Darwin Hospital ("RDH") hospice. On 15 October 2008 he was discharged back to the Tiwi Gardens nursing home. On 19 October 2008 a nurse called the ambulance because he was having difficulty breathing. He was admitted to RDH with pneumonia and from that time on, given end of life care only. He died on 23 October 2008.

3. The death was reported to the NT Coroner on 23 October 2008 on the basis that it was believed to be associated with a fall and therefore "directly or indirectly" the result of an accident or injury. It was investigated by Senior Constable Peter Bound of the coronial investigation unit. On 8 May 2009, Deputy Coroner Ganley made a decision under s 16 of the Coroners Act not to hold an inquest, and provided detailed reasons to John Waight, the senior next of kin, as to her decision and findings (Included in Exhibit 1).

4. Despite the deceased's age and ailing health, his son John Waight was not expecting him to pass away as soon as he did, within a matter of days of being returned to the nursing home. John Waight held concerns about the care his father received at the Tiwi Gardens nursing home prior to his death, and made representations to me to hold a public inquest. I exercised my power pursuant to s 44A of the Coroners Act to do so. The evidence I have heard does not contradict the factual findings already made by the Deputy Coroner, but the inquest explored in greater detail the events and circumstances of the last few days that the deceased spent at the Tiwi Gardens nursing home.

5. Counsel assisting me at the inquest was Ms Helen Roberts. John Waight, the senior next of kin of the deceased was represented by Mr Ben O'Loughlin of counsel. Masonic Homes were given leave to be represented by Ms Jodi Truman of counsel instructed by Ms Sophie Cleveland of Minter Ellison solicitors. Mr Liveris of counsel sought and was granted limited leave to appear for Dr Fitzsimons who was called as a witness at the inquest, on the basis that 'on the papers' it appeared there may have been scope for some criticism (see the issue concerning the medication charting error below). In fact, neither her evidence nor her conduct was challenged and indeed I found her a helpful witness and a caring GP. I thank all counsel for taking a cooperative approach to resolving the issues at the inquest.

6. I am pleased to say that my overall impression was that the inquest process was of some assistance to the deceased's family. Mr John Waight and his partner Mr Damien Fagan through their counsel participated in the process in a co-operative and positive way and I hope that they benefited from the process.

**JURISDICTION**

7. Pursuant to section 34 of the *Coroners Act*, a coroner investigating a death is required to make the following findings, if possible:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
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> (i) the identity of the deceased person;
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> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;
>
> (v) any relevant circumstances concerning the death.

8. Section 34(2) of the Act operates to extend my function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

9. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

## FORMAL FINDINGS

10. On the basis of the evidence before me at the public inquest and pursuant to s 34 of the *Coroners Act* I make the following findings:

(i) The identity of the deceased person is Desmond Waight.

(ii) The time and place of death was 23 October 2008 at the RDH Hospice.

(iii) The cause of death is bronchopneumonia. .

(iv) Particulars required to register the death:

1. The deceased was Desmond Waight.

2. The deceased was not of Aboriginal descent.

3. The death was reported to the Coroner.

4. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton.

5. The deceased usually lived at Tiwi Gardens Nursing Home.

6. The deceased was retired.

## RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

11. On 19 October 2008 a registered nurse on duty at Tiwi Gardens called an ambulance for Mr Waight who was short of breath and unwell. He was

diagnosed with pneumonia and admitted to RDH where end stage of life care only was carried out until his death on 23 October 2008.

12. A post mortem examination was carried out by Dr Sinton, forensic pathologist. His significant findings were: suppurative bronchopneumonia; cardiac hypertrophy (enlarged heart); dilated coronary artery disease; and atrophy of the brain. The cause of death was confirmed as bronchopneumonia, not an uncommon cause of death for elderly and bed bound patients. Dr Sinton explained that the deceased's immobility due to his hip fractures, and his dementia were factors which increased his susceptibility to contract and develop pneumonia (T 16):

> Immobility produces, by its name, an immobility to move around. So, if somebody feels a cough coming up – they want to get up and have a cough. But if you've got a broken leg or some other broken bone or particularly pain from that, the movement to position yourself to spit up the pus becomes awkward and painful. And if there are degrees of brain disease which also inhibit that, what happens is that these secretions that would normally be spat out tend to collect in the lungs and they … produce ideal conditions for bacteria [to grow].

13. On 15 October 2008 when the deceased was discharged from the hospice back to the Tiwi Gardens nursing home, his condition was stable, but his prognosis was poor. Dr Sinton disagreed with a proposition put to him that the decision to transfer the deceased indicated that at least he was in 'sufficiently good health' to return to the nursing home (T 20):

> This man was seriously ill. He wasn't in good health, he was in very poor health … I would think. The fact that patients be transferred between various institutions is not necessarily to my mind a reflection of their condition. I would question, given the chronic nature of the various illnesses that this man had that there was any likely useful improvement … If he's got heart failure it doesn't get better. If he's got insipient lung disease its unlikely to get better in the short term. His brain disease was ongoing, that was not going to get better. His coronary artery disease was not going to get better … I would imagine he was in relatively bad health myself.

14. Dr Maureen Mitchell, the Director of the Royal Darwin hospital palliative care unit, who was the consultant responsible for the deceased's care, gave similar evidence about the deceased's condition on 15 October 2008 (T 77):

> So, in terms of his overall prognosis in terms of, you know, time before death was considered a fairly short period of time. The gentleman had several chronic diseases that in their own right decreased his prognosis, the chronic obstructive airways disease of his lung … chronic congestive heart failure. He had dementia which – just recently there's been a significant article published – that dementia in its own right, severe dementia, is a terminal illness … So then, he had on top of that the frailty associated with his aging and the frailty associated with the [hip] facture that he had sustained … just the sheer inactivity increases your risk of contracting all sorts of diseases … including pneumonia very much so.

15. Dr Mitchell had explained to John Waight that his father's prognosis was poor. However, it was decided, in consultation with John Waight, to transfer the deceased back to the nursing home. At that point, a level of stability had been reached in terms of managing the deceased's pain and behaviour. Dr Mitchell said that whilst she was not surprised by the deceased's death in all of the circumstances, had she predicted it would occur within a week, she would have kept the deceased at the hospice. The deceased's son took the view that his father's rapid deterioration was due to a want of care on the part of Tiwi Gardens nursing home. That issue was pursued at the inquest. Having heard and considered all of the evidence, I do not find that any care (or lack thereof) by Tiwi Gardens staff caused or contributed to the cause of the deceased's death, nor hastened his death. Having said that, the care of the deceased, and the deceased's comfort at the end of his life are matters also relevant to my jurisdiction and were examined at the inquest.

16. In brief, the background history leading to the deceased's admission to Tiwi Gardens was as follows. In December 2002 the deceased was taken to RDH by ambulance where he was diagnosed with a number of medical conditions including: congestive cardiac failure, chronic atrial fibrillation, ankle oedema, chronic obstructive airways disease and delirium. It appears that

after this date his condition deteriorated slowly although he was living independently until 2006. In September 2006 he was again taken by ambulance to RDH, and as a result of this admission, in addition to his previously mentioned medical conditions he was diagnosed with progressive dementia and osteoarthritis of both knees which caused pain and restricted movement.

17. Due to the deceased's dementia he was unable to be discharged home. His son John Waight travelled to Darwin from Sydney to assist the deceased and continued to reside primarily in Darwin from that point. On 16 February 2007 the deceased was discharged from RDH and admitted to the Tiwi Gardens Aged Care Facility (owned by Masonic Homes Incorporated). On 1 June 2008 he had an unwitnessed fall, suffering a right neck of femur (hip) fracture. This was surgically corrected by insertion of a prosthetic device.

18. On 28 August 2008 he was again admitted to RDH after displaying signs of increased pain and rotation of the right leg. He was found to have suffered a peri prosthetic right neck of femur fracture. Due to the position of the fracture and the deceased's poor overall health it was decided in consultation with his son that corrective surgery could not be carried out. From this time on he was essentially bed bound. He remained in RDH for some weeks, spending most of that time in the Palliative Care Unit.

19. The purpose of his stay in the Palliative Care Unit was to organise a regime of treatment which could best manage his pain and behaviour and ensure he was as comfortable as possible in his end stage of life. The deceased was often highly agitated and could be physically and verbally aggressive towards nursing staff attempting to care for him. This was due to his dementia but also his pain. Medicating him to manage this behaviour and to minimise his pain had a number of side effects, including increased sedation (and with some medications, increased agitation) and so a difficult balance had to be struck.

20. On 13 October 2008 the deceased was noted to have a "chesty cough" and was prescribed an antibiotic (Augmentin). Dr Mitchell explained that at that stage the oral antibiotic was prescribed essentially as a preventative treatment, in case there was a chest infection. He was prescribed a number of regular medications and some medications on an "as required" basis. On 14 October 2008 a meeting was held about the deceased's planned discharge and care needs. Attendees included staff from palliative care and from Tiwi Gardens, as well as John Waight.

21. On 15 October 2008 in the afternoon the deceased left the hospice and returned to Tiwi Gardens. All medications were written up in the hospital medication charts. Tiwi Gardens uses different charts and requires the medication to be "written up" again, by hand, by a doctor. Dr Emma Fitzsimons, the deceased's general practitioner, was involved in the planning for the deceased's discharge back to Tiwi Gardens. Her intention was to replicate, as far as possible, the medication regime that the deceased had been stabilised on whilst at the palliative care unit. The Augmentin was referred to in the body of the RDH Discharge Summary (although I note it was not on the medication list contained within that summary).

22. Dr Fitzsimons explained that having reviewed the paperwork, she assumes that she made an administrative error in failing to transfer the Augmentin from the hospital medication charts to the nursing home medication charts which were differently structured. This discrepancy was not noticed, or if it was noticed, it was not raised with Dr Fitzsimons by the registered nurse on duty at Tiwi Gardens on 15 or 16 October. It was a regular occurrence for nurses to contact the doctor if they noticed a discrepancy or were seeking a telephone order. As a result the Augmentin was not administered for 1.5 days (3 doses) until the error was noticed by Dr Fitzsimons when she reviewed Mr Waight on the morning of 17 October at a scheduled visit. At that time he still had the "chesty cough" but she did not assess him to have a

severe chest infection and she simply ensured that the medication was continued as prescribed.

23. Dr Mitchell was asked about her opinion of the effect of missing 3 doses on the deceased's health at that time. At transcript p 80:

> Q (Coroner) How significant in terms of the way he died is the fact that three doses of Augmentin were missed? A. Yes, we certainly commenced him on the Augmentin with the diagnosis of probable chest infection and that was just based on a chesty cough. He didn't have any noises inside his chest that would indicate he had pneumonia. He certainly wasn't – he didn't have a fever. But, lots of older people don't have fevers because their immune system is compromised …we did it – and this is my recollection – really as a prophylactic treatment. So, we were concerned that he may have had a chest infection though we didn't have a lot of signs for that other than he had a cough. So we were doing a bit of, preventative, in some ways, medicine. Now, - the chesty cough could have been a little bit of an aspiration then that we heard fluid just inside the airway, so it may not have indicated that he had a chest infection at all. The antibiotics may or may not have helped because its hard to know. He could well have developed the pneumonia within the nursing home because his immune system was compromised so his reaction to any sort of infection would have been very poor, so an infection could have taken fairly quickly.
>
> Q (Ms Roberts) So, the pneumonia that he ended up with may or may not have been related to the chesty cough? A. It may or may not have been, you know. We could have done the chest X-ray before he left and it would have shown us nothing either and then, you know, several days later he comes back with pneumonia.
>
> (T 82) Q (Mr O'Loughlin) And accepting your answer as to the difficulty in saying whether or not [the missed doses] were significant … can you say whether it would be preferable if he had an uninterrupted administration of Augmentin? A. Look it would have been preferable if he hadn't had that interruption but my experience of people who are terminally ill is that even when we have them on IV antibiotics and its uninterrupted they will still die of bronchopneumonia. So, their immune system, no matter how much medication we put in, can't assist them to get over it.

24. In summary the evidence establishes that it could have been the case that the chesty cough was an indicator of some aspiration; or that it was the

precursor to the pneumonia which was the ultimate cause of death. If it was the latter, oral antibiotics may have treated the infection or may not have been effective given Mr Waight's low immune status and his multiple co morbidities, all of which individually or in combination increased his risk. Already referred to above, those included dementia, congestive heart failure, chronic lung disease, immobility from the hip fractures, and frailty (due to his old age). The evidence does not support a finding that the missing 3 doses of Augmentin made any contribution to the deceased's death from pneumonia several days later.

25. The deceased was prescribed regular ongoing pain relief. He was also discharged from the hospice with a prescription for a hydromorphone injection to be given "prn" or as required, for breakthrough pain. The RDH nursing notes demonstrate that the 'prn' medication was given quite often prior to showering or other times the deceased had to be moved. The discharge summary stated that medication for 'breakthrough pain' should be given before moving the patient. In part contradiction to this, the Tiwi Gardens progress notes record a recommendation from the Care Nurse Coordinator to the effect that nurses should avoid administering additional analgesia during the day to avoid the result that the deceased would then be extremely sleepy or asleep all day, and awake all night. (It was usual that a major move involving either a shower or a wash was done early in the morning).

26. In fact the additional analgesia was not administered on any occasion by Tiwi Gardens nurses in the days between 15-19 October. The decision as to whether to administer such pain relief was a matter for the professional judgment of the registered nurse caring for the deceased at that time. Registered Nurse Rachel Inglis and Registered Nurse Sylvia Steenkamp gave evidence about the care they provided to the deceased in the days and nights immediately prior to his final admission to RDH. RN Steenkamp had attended the meeting on 14 October 2008 referred to above. RN Inglis had

known the deceased since his admission to Tiwi Gardens some 18 months earlier. She almost always worked weekend night shifts.

27. Both nurses were asked about their decision making regarding the (non)administration of the additional, "as required" analgesia. RN Steenkamp, referring to her recollection of the meeting of 14 October, said (T 68):

> … I do remember [John Waight] saying he didn't want his dad to have so much pain relief on board that he wasn't awake enough to eat and drink and all those sorts of things. He wanted us to balance pain relief against him being awake enough, if I can state it that way.

She said with respect to the administration of the additional pain relief in the hospice as compared with Tiwi Gardens where it was not administered, "the assessment that would be made in a hospice for someone who was palliative and the assessment that would be made in a nursing home are different" (T 68).

28. RN Inglis did not administer additional pain relief over the two night shifts that she cared for the deceased. She had seen the notation referred to above, included in the deceased's patient care notes, about avoiding morning analgesia, but was unsure about whether she had read the discharge summary (which was a separate document). She took into account her understanding, albeit second hand, that John Waight had concerns about the deceased being excessively sedated. She also assessed the deceased at the time (T 57):

> And also the fact that he was really comfortable once we turned him. He would grab out and moan a little bit with more intensity when we did actually turn him, but once we actually turned him and settled him it stopped straight away. And you'd ask him if he had pain and on the day ….he was not asleep which was the day before, actually asked him if he had pain and he did not indicate any pain to us. So, generally on those factors is how I based that decision not to give him stuff.

29. It is possible that there may have been a misunderstanding about John Waight's wishes with respect to breakthrough pain medication, as compared with other sedating medications (anti-psychotics and benzodiazepines), but certainly the concern that he had a firm preference to avoid unnecessary sedation was genuinely held by the nurses. Their opinion was consistent with information apparently given from the hospice and recorded in the patient care notes that the deceased was only in pain for short periods during movement and settled well afterwards. In their judgment this was acceptable when balanced against the other factors.

30. Another matter of particular concern to John Waight was his father suffering from bed sores, which worsened considerably once returned from the hospice to Tiwi Gardens. A person who is bed bound, has poor circulation and thin skin, as Mr Waight did, is susceptible to damage and ulceration of his skin often referred to as pressure sores or bed sores. The prevention for this involves position changes. I heard that position changes for a person in the deceased's situation are quite an involved process, requiring at least two staff members. Position changes were carried out by staff at the nursing home. For the deceased, RN Inglis carried out major turns three times during a night shift, the third one being the morning sponge bath, and a couple of additional minor positional changes as well (T 56). There is a discrepancy between the written record of the number of turns on the resident care notes, and the number of turns the nurses say they did carry out as a matter of routine, but did not record (because they were a matter of routine). Mr O'Loughlin submits that insufficient turns were carried out, contributing to the rapid development of pressure sores on the deceased.

31. Whilst I do not doubt the honesty of the nurses, a lack of notes leads to problems with reliability of recollections. I repeat a comment I regularly have to make in inquests involving healthcare professionals. It is obvious that better record keeping assists organisations, individual healthcare professionals and concerned relatives to determine what occurred and to

avoid suspicion, misunderstandings and doubts about what took place. I made a similar comment in a situation involving a serious factual dispute about whether a doctor did or did not carry out a physical examination of a baby in a recent inquest (see Inquest into the death of Dailyna Byrnes [2010] NTMC 027).

32. Dr Mitchell explained that pressure sores are difficult to prevent even in her facility which has the resources available to adhere to best practice, and explained the particular difficulties in the deceased's case for pressure area care. The physiotherapy discharge summary from RDH stated that the deceased required an air mattress/pressure mattress to assist with the prevention of pressure sores. This was not arranged in advance by Tiwi Gardens and while some efforts were made to source one from RDH, this was not done until late on Friday afternoon, and was unsuccessful. It was appropriately conceded by Ms Marlborough that given the planning that had taken place prior to the deceased's discharge to Tiwi Gardens, the mattress "should have been on the bed when he arrived" (T 95). Tiwi Gardens has now purchased more air mattresses and has a reliable arrangement with a hire company (T 101). The pressure sores did not cause or contribute to the deceased's death but are relevant to his overall general care and comfort.

33. John Waight and Damien Fagan addressed me both in submissions and in their evidence about their concerns that inadequate staffing at Tiwi Gardens had a negative effect upon the care provided to the deceased. I was not surprised to hear evidence that staffing problems are "endemic" across aged care facilities, and that at Tiwi Gardens nursing home at the relevant time, staff were certainly "very busy". Staffing levels may well have impacted upon quality of note taking, and/or led to staff being required to stay after hours to complete their tasks or notes (as in RN Steenkamp's case on 19 October 2008).

34. However, I find that the evidence at this inquest does not establish a relationship between staffing levels and the quality of nursing care provided to the deceased at Tiwi Gardens on his final days. RN Inglis gave evidence that she believed she had given the deceased the best care she could (T 64). RN Steenkamp said that on 19 October 2008 she took time to feed and care for the deceased herself, because of her "empathy toward people who are under palliative care and … because I knew he was a high risk patient and I wanted to ensure, I wanted to do the assessing myself and make sure he was cared for appropriately" (T 71). It seems clear to me that the nurses took additional time from their busy shifts to care specifically for the deceased. There is no evidence that a lack of staff meant that nurses did not do something they otherwise should have done or wished to do with respect to turning the deceased, administering medication, or taking care with feeding him.

35. I also heard evidence that staffing levels at Tiwi Gardens have now changed, those changes including an increase in care staff on night shifts (T 73).

36. There has also been a particular change relevant to the matters raised at this inquest. Ms Marlborough, Facility Manager, gave evidence that a registered nurse was employed as a project officer for six months to carry out consultations with doctors, nurses and pharmacists to put together a best practice module with regard to medication management (T 94). Tiwi Gardens has also improved systems for communication and cooperation between the facility and RDH for patients being transferred between the two (T 95). There is now a specific position, currently held by RN Steenkamp, who has responsibility for managing the discharge of residents from hospital and checks medication charts and other directions that have been given as part of the discharge (T 73). These changes were put in place after the deceased's death.

## CONCLUSION

37. I note that John Waight is pleased that these changes have been made, but wishes they had been made sooner. It is understandable John Waight would feel distress at the thought that his father was less comfortable than he could have been over what turned out to be the final week of his life. There is no question that the RDH hospice has many more resources and facilities to carry out palliative care than does Tiwi Gardens nursing home (or any aged care facility). It has many more nurses; it has, as but one example, a variety of types of specialised expensive mattresses; it has around the clock access to medical specialists to make decisions about changes to medication management and interventions. It is a matter of fact that a residential aged care facility cannot provide the intensity and level of care that a specialist palliative care facility can. If it had been known that the deceased was going to die when he did, he would have remained in the hospice for his final days, which would no doubt have been more comforting for his family. However, I find on all of the evidence before me at the inquest, that nothing done (or not done) at Tiwi Gardens nursing home between 15 and 19 October 2008 caused or hastened Mr Waight's death.

Dated this 5th day of July 2010.

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GREG CAVANAGH
TERRITORY CORONER